Migration for a ‘Better Life’: Migrant health and social care professional women in North West England

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Abstract

This thesis focuses on transnational health and social care professional women working and living in North West England. It draws on interviews exploring participants' personal migration stories, and work and social life in the UK's public and private health and care sectors, including social care, clinical support, nursing, midwifery, and physician roles. In-depth qualitative interviews with sixteen women included one visual data piece per participant. Participants' drawings illustrated their migratory journeys, revealing unique aspects of their aims and reasons. While labour migration literature often focuses on work conditions and healthcare workers' movements to the UK, this thesis also addresses social issues and North West England's socio-economic context in times of austerity and the care crisis. The study explores how participants imagine *better lives* and seek to achieve them through migration.

The thesis argues that an immigrant's life cannot be reduced to work experience; *better lives* are multi-layered and include diverse aspirations and expectations. The idea of a 'better life' is circulated globally and socially constructed, with particular social and cultural values attached. Participants' lives are influenced by UK immigration policies and regulations specific to EU/non-EU countries. This group of women are socially and occupationally divided, valued according to their skill levels and categorised by immigration policies in the country and its specific conditions of entry and settlement. The thesis contributes to sociology research, in general, and migration research, in particular, by examining how participants in different caring roles navigate visa and occupational categories, problematising commonly deployed categorisations such as 'skilled' vs. 'unskilled workers.' Ultimately, the thesis shows that state-driven migration pathways clash with migrants' pursuit of a 'better life,' impeding their settlement and ability to contribute to the UK care sector.

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List of Acronyms and Abbreviations

A8 Accession 8

ABE Adult Basic Education

AfN Association for Nutrition

BAME Black, Asian and Minority Ethnic

BBC British Broadcasting Corporation

BDA British Dietetic Association

BMA British Medical Association

BME Black and Minority Ethnic

BSc Hons Bachelor of Science Honours

BTEC HND Business and Technology Education Council Higher National Diploma

CBT Computer-based Test

CCG Clinical Commissioning Groups

CUKC Citizens of the United Kingdom and Colonies

DBS Disclosure and Barring Service

DHSC Department of Health and Social Care

DVLA Driver and Vehicle Licensing Agency

DVSA Driver and Vehicle Standards Agency

EC European Commission

ECG Electrocardiogram

EEA European Economic Area

EU European Union

Eurostat European Union Statistics Office

GB Great Britain

GDC General Dental Council

GMC General Medical Council

GP General Practice/General Practitioner

GPC General Pharmaceutical Council

HCPC Health and Care Professions Council

ICH Imperial College Healthcare

ICU Intensive Care Unit

IELTS International English Language Testing System

IHS Immigration Health Surcharge

ILR Indefinite Leave to Remain

IMG International Medical Graduate

MAC Migration Advisory Committee

MBBS Bachelor of Medicine and Bachelor of Surgery

MENA Middle East and North Africa

NA National assistance

NAO National Audit Office

NHS National Health Service

NMC Nursing and Midwifery Council

NMDS-SC The National Minimum Data Set for Social Care

NWE North West England

OET Occupational English Test

OSCE Objective Structured Clinical Examination

PBS Points-Based System

PLAB Professional and Linguistic Assessments Board

PPE Personal Protective Equipment

PPP Purchasing Power Parities

PPS Purchasing Power Standards

RCN Royal College of Nursing

RCVS Royal College of Veterinary Surgeons

RD Registered Dietitian

REACHE The Refugee and Asylum Seekers Centre for Healthcare Professionals Education

TMA Turkish Medical Association

UAE United Arab Emirates

UDHR Universal Declaration of Human Rights

UK United Kingdom

UKVRN United Kingdom Voluntary Register of Nutritionists

UNHCR United Nations High Commissioner for Refugees

US United States

USA United States of America

VAT Value-added Tax

WHO World Health Organisation

WW2 World War Two

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I dedicate this thesis to my twins, my daughter Şule and my son Uygar, who were born while I was writing. I love you both dearly, and all my accomplishments are for you.

Finally, I dedicate this work to my participants and all women around the world who put a great deal of effort and care into their work. If this thesis can in any way ease their struggles, I would consider it a great privilege.

Declaration

I hereby declare that this thesis is my own work and that it has not been submitted in substantially the same form for the award of a higher degree elsewhere. Furthermore, I declare that the word count of this thesis does not exceed the permitted maximum.

Buse Ozum Dagdelen
December 2024

Chapter 1: Introduction

My journey in this research started during my undergraduate sociology education in Turkiye when I watched Emel Çelebi's award-winning documentary, 'Gündelikçi,'[1] about rural women striving towards self-dependence in the big city to which they migrated. The documentary ignited my interest in 'migration for work' and 'migrant women.' Later, at the University of Sussex, after encountering JoAnn McGregor's (2007) work on migrant workers in the care sector, I completed my master's thesis on Filipina domestic workers in London under her supervision. My curiosity about the continuation of the stories of these domestic worker women sparked my new interest in immigrant women working in the healthcare sector. I learned that some of the participants in my master's thesis left their roles in the (health)care sector in their home countries, came to the UK and became domestic workers, and that some of them wanted to be employed in the healthcare sector again in this country or their next destination countries. Their stories were not limited to domestic work; their migration journeys involved them in other professional fields, such as health and care.

My research participants work in healthcare sectors and are generally outside of private homes; nevertheless, they perform physically and emotionally demanding work similar to domestic workers regarding their close contact with individuals needing care.[2] In addition, although providing the same healthcare work, thus far, carers were not researched alongside 'skilled' women in health sectors in the literature on women who migrated for work in healthcare. Healthcare workers are often defined in a way that excludes carers, the migration of those who fit this definition is still largely examined today through concepts such as brain drain and push-pull factors, particularly within the literature on human resources and health (Al-Btoush & El-Bcheraoui, 2024; Eaton et al., 2023; Leitão et al., 2024; Sweileh, 2024; Toyin-Thomas et al., 2023; Walton-Roberts & Bourgeault, 2024). Such a gap about carers in migration literature exists as studies conducted with healthcare professionals (Cuban, 2013; Bornat et al., 2011; Lowell et al., 2004; Kofman and Raghuram, 2006; Kangasniemi et al., 2007; van Riemsdijk, 2013; Salami et al., 2016; Zuk et al., 2019) overlook the shared occupational and social life

[1] This word in Turkish, which can be directly translated into English as 'everydayist,' is a term that refers to especially women housekeepers, who go to homes daily and perform the duties included in the domestic work job description, such as cooking and cleaning.

[2] See the section 'Similarities of Domestic and Care Work' in Chapter 3 for detailed information on the similarities between domestic and (health)care work.

experiences of women in a range of health-related occupations, as well as some additional classifications under a single carer category. In this thesis, I aim to foreground the experiences of carer women who immigrated to England to live better lives while trying to achieve this ideal.

It would be a reductionist approach for me to theorise the search for a 'better life' through migration by only considering work experience and material reasons; therefore, I ask my participants to compare their current life with their previous lives and highlight their professional experiences and social life experiences and connections. I ask what that implies for those who wish to migrate for employment to establish a 'good/better life' for themselves, whether they have succeeded in doing so, and if so, under what circumstances.

Ultimately, based on the interviews, I contribute to the migration literature by adding more nuance to what a 'better life' means from the perspective of women immigrant workers. This perspective is different from, for example, that in the 'Lifestyle Migration' studies (O'Reilly and Benson, 2009) focusing on reasonably wealthy or 'privileged' (Benson and O'Reilly, 2018; Benson, 2014) migrants mostly from Global North deciding to move more frequently, drawn by the prospect of a better and more satisfying life where they end up. While a conceptual framework for placing and analysing various privileged migration scenarios, including international retirement migration, residential tourism, second residences, and international counter-urbanisation, is provided by lifestyle migration (McGarrigle, 2022, p. 170), my study focuses on the experiences of working women who seek to build better lives through their work. Benson and O'Reilly's (2018) analysis of lifestyle migration highlights how privilege, shaped by class, race, and ethnicity, can become a self-conscious aspect of migrants' experiences, especially in stratified communities. Their study reflects a context where North Americans and Britons, who occupy relatively elevated positions in Panama and rural France, navigate their privilege—often as a continuation of existing class distinctions. However, my research on migration for a 'better life' diverges significantly from Benson and O'Reilly's focus on 'privilege.' My participants, in contrast, do not occupy privileged positions in their host communities; they are not marked by class, racial, or ethnic advantages, nor are they *motivated* by the choice of a luxurious life. Instead, they mostly seek fundamental improvements in life conditions, driven by necessity rather than the sole pursuit of lifestyle change or continuity of social privilege. This focus allows for a broader understanding of migration that centres on structural inequalities and the aspirations of

migrants seeking viable places to settle, rather than self-aware privilege in an idealised lifestyle context. Through the research question, 'What implications does "migration for a better life" have for the employment, social lives, and migration narratives of immigrant health and social care workers in North West England?,' I investigate how migration or being an immigrant shapes the 'better lives' of women workers.

To that end, this study focuses on immigrant women working in the health and care sectors and living in North West England (NWE) without making any distinctions based on 'skill' or excluding carers from the 'professional' or 'skilled' worker category. Care work should be reconceptualised based on its substance rather than the industry in which it is carried out. The UK's public and private health sectors hire women with specialised vocational training and specific occupational certifications, such as nurses, physicians, support staff, and other health professionals. However, the National Health Service (NHS) privatises 'care' and nationalises 'health' in distinguishing between social care and healthcare (see the subsection, 'Comparing Healthcare with Social Care,' in Chapter 6). Thus, the services provided in the private sphere become less visible and are paid less than those provided in the public sector. The NHS often puts care beyond its remit, does not fund it, and does not recognise 'carer' as a healthcare role. Caregiving is often added to an employee's regular tasks without being specified in their official job descriptions. Immigrant workers who will work in these sectors are devalued and deskilled, and on many occasions, their duties go unrecognised, and the state does not pay them.

By rethinking the carers category, we can see how the fundamental professional skills and characteristics, responsibilities, and duties of a domestic carer who offers in-home care are similar to those of a carer employed by the government. Compared to the NHS's formal definitions of jobs and duties (see Chapter 6), the lines separating the private and public spheres—where domestic and caregiving labour is often done—and the home are less distinct. On the other hand, although the primary duties, skill sets, and activities are similar, caring roles and migrant categories differ in terms of value, recognition, and credentials by the employer and government. Jobs, recognition of qualifications, value of work, and wages are important because migrant carer women build the idea of a 'better life' based on these criteria. While asserting the importance of jobs for better lives, what is novel in this thesis is linking it with the social status, social, family and immigration concerns of the participants.

Finally, my research is spatially located in the North West because the current post-industrial experience of the region (see Chapter 2) indicates that the experiences of

women migrating to this area differ from those working as healthcare professionals in the more affluent South of England. In terms of its history, NWE, once called 'the first industrial region of the first industrial nation' (Stobart, 2004, p. 32), but where deindustrialisation has unfolded, is experiencing the national care crisis more severely than many other regions. Though immigrant carers are still overwhelmingly concentrated in the big cities of the South of the country, the growing demand in the North should be closely watched as it has the potential to alter the long-standing and deeply ingrained interregional distribution of migrant health and social care professionals in the country (Cangiano et al., 2009, pp. 70-71). Women who have moved to NWE from various regions of the world to meet the need for workers in the quickly privatising health and social care sector were interviewed for the project. Given the care crisis and the fact that the international workforce is growing, paying attention to the diversity and size specific to the area is imperative. According to the Office for National Statistics, in 2018, immigrants made up about twelve per cent of 1.9 million people employed in the UK's healthcare workforce, including public and private sector health workers such as doctors, nurses, and paramedics. The proportion of the healthcare workforce with non-British citizenship was measured between 2016 and 2018 as eight per cent for the North West region (GOV.UK, 2019). Regarding which continents this workforce originates from, in March 2021, in the North West, nine per cent of NHS staff, for example, reported a 'nationality' other than British—these were from EU, Asia, Africa, and other countries, such as Ireland, Poland, Portugal, India, the Philippines and Nigeria (UK Parliament, 2021).

The socio-political profile of the North West of England suggests a North-South divide in England (Green, 1988; Martin, 1988), with the North consistently faring worse than the South across socioeconomic variables, such as deprivation, unemployment, electoral preferences and turnout, life expectancy, transport, wages, wealth, and health (Robinson and Pidd, 2020). However, this regional disparity does not imply a homogenous North West, as the region encompasses a diverse range of urban centres and small towns, each shaping migrant experiences in locally specific ways. Participants predominantly live and work in these varied settings (see Figure 4.3), and this intra-regional diversity also influences how they navigate their professional and social lives. Thus, the experiences of the individuals who relocated here highlight the localised social conditions and offer insights into the realities of migration in search of a 'better life' within this region and its complex and diverse localities.

For participants, together with the difficult living circumstances, conditions at work are exploitative or subpar. The situation of impoverished patients in the region makes working conditions less favourable. Treatments are made at the state's discretion for patients who need care but cannot afford it. Patients have difficulties receiving NHS diagnosis and treatment because of concerns like travel expenses, internet access problems, and NHS fee payments (Mallorie, 2024). This is where the participants hit many invisible barriers as they pursue better lives. They came to England with the dream of working in the country with one of the most developed economies in the world, but in reality, they had to encounter the challenges of working and living in the most socially deprived part of the country. Notwithstanding these obstacles, immigrant women persist in their efforts to fulfil their aspirations for their careers and social lives in their new locations. The thesis explores and engages with the reasons for the continued effort of women living and working in challenging conditions and their expectations that a 'better life' can be achieved.

1.1 Main Arguments of the Research and Contributions

The section provides three main arguments and contributions of the thesis. First, the study extends the field of migration studies, developing the concept of 'better life migration.' Second, the research examines the different classifications of immigrant women employed in healthcare. It demonstrates how these divisions sometimes frustrate women's hopes and commitment to pursue a 'better life.' Lastly, by removing settlement from the commonly accepted definition of immigrant integration, the research offers a new viewpoint on settlement within the framework of 'better lives.' Briefly, the thesis will explore how immigrant participants experience the pursuit of better lives and conceptualise migration as a means of achieving a holistic better living by addressing both professional and non-professional lives.

First, the study broadens the scope of how we think about what constitutes a 'better life' for migrants. Migration for a 'better life' is perceived in migration literature as an opportunity to escape poverty and as a way to achieve well-being and economic security (Wright, 2012, p. 8). However, a more complex and sophisticated theoretical understanding of what constitutes a 'better life' is required. In comparison, this study argues that imaginaries of a 'better life' are shared worldwide and associated with social and cultural ideals such as being a 'happy wife' in 'an affluent family' or a 'good

immigrant.' It is in such a 'better life' context that migrant experiences are explored in this research.

The new 'better life' perspective in this research contributes to the fields of migration in several ways and revises 'well-being/happiness' concepts. In examining how individuals migrate to live well or happily, well-being analysis (Wright, 2010) leaves out the experiences of those who, in many respects, 'achieved well-being' in their new locations. Furthermore, ideas of well-being frequently psychologise the problems of happiness and moving abroad to live a 'better life'; whether migrants describe being happy or unhappy in a hedonistic sense is not as important as if they are psychologically well (Wright, 2012). Nevertheless, I will focus on the larger social, relational, or structural issues around 'living better lives' and how this concept attracts migrants. States in the receiving countries may expressly enable or assist the immigration of 'highly-skilled' individuals. As I will show, the NHS, as well as the UK's well-known reputation and core values, draw these individuals to the country, and the lack of response to many expectations on 'work in the NHS' created by the British government, particularly in relation to precarious working conditions, causes disappointments in the search for a 'better life' here. In the concept of migration for better lives, disappointments also impact how expectations and the resulting idealised 'better lives' are fulfilled.

The thesis contributes to the literature on migration by establishing a new connection between labour migration and the notion of a 'better life.' It complements 'labour migration' *motivations*, centring around the 'migration for work' presumptions in the literature, with additional reasons on lifetimes spent out-of-work like autonomy from societal and political influence, children's education, or social networks. It offers a concept of a 'better life' that considers human well-being based on feeling happy or well and career progress, as well as factors in social areas such as being a woman, wife, mother or immigrant.

Second, I problematise the classification/categorisation of healthcare workers. I argue that care workers, who are not customarily considered professionals in the health industry but work in 'less skilled' job roles with less appreciation or money, should be included in the category of 'professionals.' Moreover, by doing this, I hope to identify areas where women in the health sectors with various skill levels and caregiving responsibilities have similar work experiences. These areas have been ignored by migration studies where 'professionals migrating to work in the health sectors' have been central to the research (Cuban, 2013; Bornat et al., 2011; Lowell et al., 2004; Kofman and Raghuram, 2006;

Kangasniemi et al., 2007; van Riemsdijk, 2013; Salami et al., 2016; Zuk et al., 2019). The literature on carer women's migration journeys has received criticism about being too concentrated on domestic worker women and neglecting the women working in 'more skilled' care sectors, such as healthcare (Kofman, 2013, 2014). Efforts in the recent migration studies to compensate for this, reproducing the divisions among women according to 'skills' and discourses on care, have created a hierarchy between women working in healthcare and other sectors of care (Lowell et al., 2004; Kofman and Raghuram, 2006; Kangasniemi et al., 2007; Piper, 2009, 2017; van Riemsdijk, 2013, Salami et al., 2016).

The present study highlights the importance of an inclusive transnational health and social care category, demonstrating how women in related fields serve similar workforces and experience comparable migration and care systems. It also exposes the biases against women with comparable skill sets, core work responsibilities, and duties regarding the value and acknowledgement of those same jobs and abilities. For instance, being recognised as a non-European makes it difficult for carers in the UK to demonstrate their credentials, which results in their deskilling. To be employed in the UK, that is, to return to their primary profession, some participants must demonstrate proficiency in the English language in the fields in which they studied in their countries of origin. Those unable to do this are compelled to accept jobs of lesser status than carers within their profession. Participants lose time achieving their career objectives due to various factors, including gathering documentation, corresponding with their home countries for matters like accreditation, preparing for exams, and enrolling in language classes.

Within an umbrella category of immigrant health and social carers, skilling and classification appear to have a connection with participants' immigration statuses. The literature on immigration in the UK and its immigration regulations has concentrated on the bureaucratic classification of immigrants, frequently using binary terms like 'skilled/unskilled.' With a critical analysis, this study delves deeper into the social immigrant categories and challenges the conventional dual categorisation by highlighting the possibility that additional classifications exist between the two categories above. Further, it examines how participants encountered the 'key worker' category during the Covid-19 outbreak and illuminates potential bureaucratic and societal ramifications.

Proposing that professionals from various types of care be researched under one comprehensive category in this thesis reveals a complicated system of public, private, and intermediary institutions—such as local authorities—in place to facilitate the admission

of immigrant women to the UK health workforce. Workers and members of the public are unaware of the numerous recruitment rules. Amid this uncertainty, participants must traverse societal occupational categories like 'medics/non-medics,' attempt to demonstrate their qualifications through exams and English language ability, and, as a result, reskill or upskill. They aspire to avoid being classified as 'low skilled' or 'unskilled' and to be able to participate in the skilled-based immigration system in the UK, which evaluates their value as immigrants and even as human beings in addition to their professions. This thesis illustrates how uncertainty, devaluation, and deskilling severely shattered migrants' expectations of better lives.

The thesis argues that occupational categorisation is a significant obstacle for immigrants to achieve better lives. Some people find it impossible to immigrate to Britain in search of a 'better life' because the British government supports the immigration of certain kinds of migrant workers while making it difficult for others. When comparing the experiences of 'less skilled' and 'skilled' workers, it becomes clear that working in the UK comes with challenges. The nuances of the immigrant experience and various other categories are new in the labour migration literature. This thesis contributes to the literature in this respect.

Third, using terminology from the care literature, such as 'emotion work' and 'feeling rules' (Hochschild, 1979), I expand on research on the settlement by foregrounding 'daily practices of settling' (Staeheli et al., 2012). I employ a critical perspective on the overall political rhetoric on settlement and integration, which places priority on a migrant's legal status and potential citizenship while downplaying the emotional aspects of daily settling (Favell, 2019, 2022; Phillips and Robinson, 2015; Schinkel, 2013, 2017, 2018; Christou and Kofman, 2022). In order to include a migrant perspective in the understanding of settlement, I expand on Hochschild's research, which I believe is crucial to comprehending the lives of migrants and, ultimately, their emotions. It sheds light on how the socioeconomic setting and individual emotions interact and condition one another.

In short, I delineate in this research an immigrant who has concerns about adjusting to the routine of everyday life in the place that she is moving to (Grzymala-Kazlowska, 2016, 2018a, 2018b, 2020; Grzymala-Kazlowska and Phillimore, 2018), in addition to being required to fulfil the legal criteria to settle in the country for employment or as an immigrant. Feeling valued at work is essential to settling in. Settling down entails adjusting to their new work surroundings and moving toward a 'better life' for

themselves. In defining a ‘better life,’ I contend that settling is a short- and long-term potential that is primarily temporal but occasionally material for immigrants.

1.2 Outline of the Thesis

The thesis consists of eight chapters: Chapter 1 introduces the thesis. Chapter 2 offers a historical overview of labour migration to the health sector in the North West region of England and contextualises the sector in the region as a migration destination. Chapter 3 represents the theoretical framework of the thesis based on the literature on migration for care work and healthcare professions. Chapter 4 is the methodology chapter. Chapters 5, 6 and 7 are the empirical chapters.[3] The fifth chapter discusses the idea of a ‘better life’ and occupational categorisation from a migration viewpoint. The sixth and seventh chapters examine, in order, the field of work and life outside of it. Lastly, Chapter 8 concludes the thesis.

Following the introduction chapter, in which I describe the thesis's aims and objectives, and contributions to the literature, in Chapter 2, ‘North West England: A Local Geography of Healthcare Immigration,’ I consider both the socioeconomic and broader social effects of deindustrialisation on migration trajectories and the lives of women working in the health and social care sector in the North West region of the UK. First, to situate my empirical investigation in its social context, I provide a social history of the UK's care sector on the one hand and of transnational workers working in this sector within the socioeconomic context and through some national and regional demographic indicators. I aim to reach a regional context by exploring the care sector in NWE—the settlement place of the target group in this study. This chapter serves as the foundation for my empirical arguments, providing statistical data characterising the size and diversity of the workforce regionally in light of the care crisis and the growing migrant workforce in the North West of England.

In Chapter 3, I present my theoretical position on the evolution of the conceptualisation of care in the context of migration. Healthcare worker women's migration has been understudied, often viewed as the mobilities of the elite and well-educated, leading to a

[3] The empirical chapters present pre- and immediate post-migration experiences, employment processes, and final settlement experiences, respectively. Chapter 5 looks at the lives of the participants before and just after their migration, including their expectations and reasons for moving, while exploring a ‘better life’ for women who relocate to England. In Chapter 6, the participants' employment and working experiences in the UK are examined in more detail, and the relationship between these experiences and their formal immigration status is discussed. Chapter 7 discusses women's settling into society and the workforce, as well as their final thoughts and evaluations of their movement—in other words, how these migratory journeys have transpired. ‘Better lives’ permeates all empirical chapters.

focus on brain drain and strain (Cuban, 2013; Bornat et al., 2011; Lowell et al., 2004; Kofman and Raghuram, 2006; Kangasniemi et al., 2007; van Riemsdijk, 2013; Salami et al., 2016; Zuk et al., 2019). In comparison, I offer a critical analysis of the migration literature and propose a new understanding of the work of migrant women employed in the healthcare sector. Rather than categorising women workers by skill level, I argue that the fluid and flexible nature of health and care work warrants exploring the experiences of all migrant women who perform it under a single umbrella. Moreover, the concept of moving abroad in search of better lives is introduced in this chapter. The chapter poses questions about and overturns the literature's push-pull arguments and well-being debates to comprehend the effect of social relations and interactions in the concept of 'better life migration.' Lastly, I use terminology from the care literature to engage with the concept of 'settlement,' a crucial component of a 'better life,' and I draw distinctions between my usage and that prevalent in the integration literature.

Chapter 4 lays out the methodological strategy and research techniques utilised in the present study to investigate the experiences of professional women who migrated to the North West of England and were hired to work in healthcare. The chapter summarises the methodology that drove this research, including the techniques used to gather interview and visual material, how participants were recruited for interviews, how interviews were carried out, and how data were analysed. The study was carried out during the Covid-19 pandemic, and the peculiarities of the pandemic had an impact on every stage, its sources, analysis, and outcome. The study's field location was the North West of England from January 2020 to November 2020.

'What are the patterns of migration and aspirations of the individuals who have migrated in quest of a *better life*?' is the primary question that Chapter 5, the first of three empirical chapters, aims to answer. The chapter contributes to migration studies by conceptualising what I call 'migration for better lives.' Moreover, it suggests that the idea of 'better lives' is socially shaped in heteronormative and familial contexts. According to the key argument of the chapter, the quest for 'better lives' is politically fuelled by the ideal of Western-style financial achievement and well-being. However, this ideal is often unmet and is not experienced equally by all women caregivers. While participant women attempted to fulfil their 'better life' aspirations by migrating to the UK, finding a stable location to pursue their careers and lifestyles away from their countries of origin/transit was a notable aspect of the migration of some participating women. When researching possible emigration, they were drawn to the UK's NHS. Ultimately, some could work for

the organisation they aspired to work for, while others experienced various forms of social or professional disappointment. Combined, the substandard living and working conditions in their countries of origin were major reasons for them to leave. This chapter also presents the illustrations utilised in the three empirical chapters of the thesis, elucidating the participants' definition of a 'better life' and how their migration impacts their quality of life. The chapter delves into how immigrants visualise their migration journeys in search of a 'better life' and their drives and expectations.

It was mainly possible for the participants to have better occupations to improve their lives in England. However, the categorisations and deskilling they faced in the work-life dashed such hopes. How are changes such as deskilling, reskilling, and up-skilling experienced, interpreted, navigated, and reconciled with by those whom I argue have been categorised at the intersection of migration and professional environments? Addressing this question, Chapter 6 explores the challenges some participants faced when they tried to work in the UK; it took time, effort, financial and emotional commitment, and hard labour. The women unable to pursue their desired careers through upskilling or reskilling had various psychological and economic coping mechanisms for deskilling. One such tactic was taking up a second job while employed in the healthcare sector. This chapter emphasises how occupational and migration regulations impact skill-building opportunities by reaffirming the dichotomies of 'EU versus non-EU migrants' and 'medics and non-medics' and establishing new hierarchical structures through designating certain workers as 'key workers.' It clarifies how people navigate and move across intricate institutional structures. The chapter makes the case that participants' immigration statuses are tethered to deskilling and categorisations, implying disillusionment with better lives.

The final empirical chapter, Chapter 7, asks about interviewees' settlement experiences and strategies as immigrants in the UK. 'Settlement' was found in this research to be a significant component of the idea of a 'better life' for participants. The chapter discusses whether the participants feel that they 'blend in' in their living and working environments and how they attempt to be 'not different' or 'assimilated language-wise,' in the words of one participant. To emphasise the idea of '(un)settling' in the thesis and make room for the stories of people who feel unsettled or not settled again, I retain the prefix 'un-' in brackets. The goal of improving one's life in England is impeded and may even be jeopardised by unsettling. The chapter also asks, 'In the process of settling down, how do the participating women professionals in health and social care learn about UK society

through their job experiences?.' Here, the thesis connects participant women's social and professional lives in terms of their settlement. Thus, with this subject, I proceed from the public/private context to the professional/personal-social life.

The findings and insights from the empirical chapters of the thesis are discussed in the final chapter. Chapter 8 discusses the theoretical insights that the research findings provide, the strengths and limitations of the study, and recommendations for future researchers on a range of issues that presented themselves during the research but were beyond its scope.

Chapter 2: Empirical Context and Historical Background: Migration for a 'Better Life' and the North West of England as a Dystopia

In this chapter, I set the stage for the migration stories of women caregivers, which will be elaborated on later in the empirical chapters. I mentioned earlier that these women immigrated hoping to find better lives in England. This hope stemmed from the fact that, on arrival to this country, they came with a particular image of England in mind. The idealised England was where they could live and work prosperously in an advanced economy and find a hospitable environment to settle and realise a 'better life.' In this chapter, contrary to such expectations, by marshalling a diverse range of evidence, I argue that North West England is, in reality, far from being a successful incarnation of Western modernity and closer to being a dystopian space. The most notable of these dimensions is that England is divided into the North and South due to historically different patterns of industrialisation and deindustrialisation[1] and that the North, where post-2008 financial crisis austerity and social deprivation are more severe than in the South, is by no means a destination where the achievement of a 'better life' is easy. 'Deindustrialisation' refers to the unprecedented loss of British manufacturing and basic industries from the twentieth century, which has socially and economically devastated towns and regions in the country (High, 2013, p. 1002; Mounfield, 1984, p. 143). And 'austerity' is essentially 'a set of economic policies, usually consisting of tax increases, spending cuts, or a combination of the two, used by governments to reduce budget deficits' (Bondarenko, 2024).

As a further aspect of austerity policies, spending cuts were announced by Chancellor George Osborne and Chief Secretary David Laws for the Coalition Government in 2010 (The Guardian, no date). The imposed cuts in health budgets contributed to the severe effects of the national care crisis on NWE. Following the economic crisis of 2007/2008, austerity measures were practised in many different countries of the European Union (EU), such as Ireland (Creighton et al., 2022) and Greece (Oxfam Case Study, 2013a). However, the UK has been a specific case (Oxfam Case Study, 2013b) with 'austerity' as the most destructive policy in its modern history and 'cutbacks and belt-tightening' (Blakeley, 2023) leading to the greatest crisis in its national health history since the founding the NHS. The UK has had the most prolonged period of austerity in Europe, although the Tories periodically heralded the end of austerity policies in the fourteen years

[1] Scholars hold the deindustrialisation process responsible for the North-South division in England. For a discussion of how deindustrialisation affected the social makeup of England, see Mounfield (1984); Strangleman and Rhodes (2014); Strangleman (2017); and High (2013).

since it was announced in 2010 (Harris, 2024). The current handicaps of the UK's care sector are inseparable from the UK care crisis resulting from 'austerity.' One function of the modern UK welfare state is the provision of healthcare services (Boardman, 2020, p. 208). And when the UK's safety net—protection of the poorest or workers facing considerable economic disruption (Resolution Foundation, 2022)—is porous, and the state pulls out of providing free health services, it creates a sort of race to the bottom by private providers (see the subsection, 'Care Crisis,' in this chapter). The worker group most affected by this situation will be immigrants, who are most relied upon for care work in the private sector (Leon and Broadhead, 2024).

In this chapter, I consider both the socio-economic and broader social consequences of the North-South divide and care crisis on migration and on the lives of women working in the health and social care sector in NWE. The above dimensions suggest some nuances in the experiences of the women who migrate to work as healthcare professionals in NWE. Apart from the difficult living conditions—such as trouble finding a place to live or poor-quality housing (Kofman et al., 2009)—the healthcare sector's working conditions are also challenging and below standards. One example of this is the low pay levels corresponding to a low standard of living. Furthermore, immigrant carer women in NWE encounter patients living in deprivation and substandard conditions in care homes (Marmot et al., 2022). Many of these migrants, even if they earn better wages than in their origin countries, have to face and bear the anti-immigrant public discourse and everyday prejudice and discrimination in the region fuelled by state policies (see Chapter 7).

In what follows, I first offer a social history of the UK's care sector on the one hand and of transnational workers in this sector on the other, within the socio-economic context and through some national and regional demographic indicators. I then hone in on the regional context by exploring participants' living and work environments in NWE shaping their life experiences—a combination of complex factors including deindustrialisation, the North-South Divide and the care crisis in the region.

2.1 Carers' Migration to the UK

Before defining 'health/care worker' and conceptualising the channels migrant workers use to come to the UK, a historical perspective is essential to understanding how the relationship between labour shortages, immigration and public policy in the UK reached its present form. When Britain was about to leave the EU, a new skills-based immigration system—also a harbinger of a future 'Australian style' points-based system—was

introduced by the UK Government (Home Office, 2018; Sumption, 2019). This could be considered a version of the British immigration system since the 2000s when it was claimed that workers' skills primarily matter, not their countries of origin. Nonetheless, the heritage of British colonialism and the 'British Empire' have always shaped immigration policy in the UK. The selective geographic filters used to facilitate or restrict the movement of specific nationalities make up Britain's immigration regime (Consterdine, 2018b, 2023). In social sciences, there has always been a 'problem' between *structure* and *agency* (Pleasants, 2019). Here, Britain Phizacklea and Miles (1980) portray as a capitalist social formation with a history of colonialism and imperialism is the so-called 'structure.' Moreover, structural forces and constructions of labouring bodies underpin the migrant division of labour, and migrant hierarchies are manufactured and reinforced by the state (Consterdine, 2023, p. 3836). As 'agencies,' the addressees of the structural bodies and systems are immigrants, and they must accept the structural conditions. The section will demonstrate that migrants' ability to enter the UK and work since the post-war period has always been influenced by state policies and by local and national discourses on care, home, immigration and race (Anderson, 2007, p. 248), whilst the strength of each element has varied from period to period.

2.1.1 Workforce Supply to the NHS

The country's reliance on the workforce of migrants in the healthcare sector can chronologically be grounded in the post-war labour shortages. A series of labour recruitment policies were introduced to address these issues, starting in the late 1940s (McDowell, 2005; Batnitzky and McDowell, 2011). As Anderson and Ruhs (2011) suggest, labour demand and supply relate to each other in a dynamic and mutually conditioning way, and this relationship in the UK was critically shaped after the Second World War by both welfare benefits and immigration regimes interrelating with changing economic and labour market circumstances.[2]

The need for care among citizens has substantially grown, specifically following the access to free medical treatment (Cuban, 2013, p. 61) with the foundation of the NHS in 1948 and the introduction of the National Assistance (NA) Act of the same year (Thane,

[2] The workforce shortages were a result of several interconnected factors, such as the high casualty count in the war, the exodus of women from the labour force to bear children due to the State's pronatalist drive, policy changes concerning family planning strategy and the rising school-leaving age. For more see Batnitzky and McDowell (2011), Webster (1998, pp. 15-16) and Clarke (1996, pp. 219-220).

2009, p. 6).[3] 'In 1945, a government report had estimated that there was an immediate shortage of about 30,000 nurses, which by 1948 had risen to 54,000, most severe in services for the chronic sick, mental health, and for geriatric care' (Batnitzky and McDowell, 2011, p. 183). During the post-war period in the UK, this growing demand for care led to the active recruitment of health staff from Ireland (Ryan, 2001, 2003, 2004, 2007, 2013, 2015)—'white insiders but cultural outsiders' (Batnitzky and McDowell, 2011, p. 182)—and the former colonies, such as the South Asian subcontinent, the West Indies and the Caribbean, using the relaxed entry controls for Commonwealth citizens (Cangiano et al., 2009, p. 37) at the beginning, but gradually tightened in the 60s and 70s.

Commonwealth immigration was severely restricted from the late 1960s, and there were concerns about 'race relations,' yet there was a continuing need for cheaper labour (Anderson, 1993, pp. 42-43). In the UK, the period after 1962 witnessed a sharp policy reversal—the fast and definitive restriction of Commonwealth migration—and the politics and legal peculiarities of Commonwealth migration in the era of closed borders (Hansen, 2000, p. 6). Until 1962, Citizens of the United Kingdom and Colonies (CUKC) had full rights to move to and reside in the UK under an umbrella citizenship previously introduced in 1948 for British and British colonial subjects. Conservative governments had 'tolerated' the immigrants from the Commonwealth Nations for a time because they came to meet demands for post-war labour. However, the controls on the movements of British subjects (CUKCs from the colonies and citizens from the Commonwealth Nations) to the UK were reluctantly placed in 1962 as numbers surged and domestic opposition grew (Hansen, 2014, p. 201). British subjects (who could enter the UK in high numbers and freely) enjoyed privileged access under a work permit scheme for the Commonwealth from 1962 to 1971. However, this changed with the introduction of the Immigration Act of 1971, which provided a legal framework for migration for the next three decades and, for migration purposes, brought people from the Commonwealth countries on the same legal footing as those from non-Commonwealth ones (other than British subjects) with a few exceptions.[4]

[3] The origins of social care can be also traced to the 1948 National Assistance Act and the birth of the 'Welfare State' in the UK, though the origins of welfare support lie much further back in time, particularly in the 19th century.

[4] Individuals wishing to migrate to the UK could come only as a family member or with a work permit under this act. Those with work permits had to have a job offer, and the company usually applied for work permits on their behalf. If granted, the permit allowed them to work in one position for up to four years. They could then apply for permanent residency (Hansen, 2014, p. 201).

In 1973, in the same bill that ended British subjects' privileged access, European Economic Community workers were given the right to work in the UK. In 1981, the relic of imperial citizenship—CUKC—was replaced with British citizenship (Hansen, 2014, p. 201). With the British Nationality Act of 1981, for the first time, British citizenship was linked with membership in the political entity of the UK and, for the first time since 1962, linked with the full exercise of civic and political privileges enjoyed by members of the British political community. The British Nationality Act was also a significant moment in decoupling nationality law and immigration; immigration and citizenship began to be governed by distinct legal regimes (Hansen, 2000, p. 207).

Eastern Europeans, with family members, in the entire post-war period experienced high rates of emigration to the West, either as 'asylum seekers or economic migrants' (Follis, 2012, p. 118). The UK population had not experienced large numbers of immigrants from that part of Europe before the 2000s. As the EU expanded in 2004 and 2007, the Blair government opened the labour market to citizens of the ten new member states (Consterdine, 2016), which fundamentally affected the migration patterns to the UK (Sumption and Somerville, 2010). However, old colonial links had still not lost their force in the UK. The arrivals frequently showed a high number of women migrating to the UK from the Commonwealth countries (Kofman, 2003, p. 2). From this date, the Department of Health more actively supported health trusts recruiting abroad both within and beyond the EU, and the Home Office allowed health professionals to enter on fast-track work permits for shortage occupations and doctors through its Highly Skilled Migrants Programme (Cangiano et al., 2009, p. 37). In that regard, Allan Findlay (2002, p. 36, 38) acknowledges the specific Work Permit scheme, which came into force in October 2000, as 'the dominant route by which skills needed by the UK labour market are channelled from overseas to employers in the UK.' Based on the evidence in his article, due to a long tradition of international migration of health sector staff to the UK, 31 per cent of doctors and 13 per cent of nurses in the UK were non-UK born in 2002. Kundnani (2007, p. 142) describes this issuing of work permits with the government's new thinking in the immigration policy: a 'positive' immigration policy, in which 'a system of positive selection of those immigrants with most to contribute' is operationalised. Then, through the 'invisible hand' of capitalism, which is the decision-maker in the acceptance or exclusion of foreign labour, the economic requirements of immigration policy are made followable in an 'organised, rational and evidential way' by policymakers. This new approach, designed under a New Labour government towards

the end of the 1990s, allowed the introduction of legal routes for economic migrants with key skills. Employers added thousands of non-EU professionals, such as doctors, nurses, teachers, IT workers and business managers, to the recruitment pool when no such applicants were available in the UK. The number of non-EEA (European Economic Area) nationals admitted as work permit holders or as their dependants in 2002 was 120,000 (Home Office, 2003).

When labour immigration to the UK from non-EEA countries was no longer managed through the work permit system[5], it was replaced by the Points-Based System (PBS) (GOV.UK, 2016), which was initially elaborated in 2006 (Salt, 2010, p. 91). 'The system started with Tier 1 for the highly skilled, which replaced the Highly Skilled Migration Programme in place since 2002, and then rolled out to Tier 2 for the skilled in November 2008' (Kofman, 2013, p. 590). The new points-based system introduced five categories for entry[6] and shortage occupation list (MAC, 2023) which has been controversial and a subject of considerable political wrangling from the outset (Sumption, 2022).

A significant fall in foreign recruitment was observed due to a series of developments in the NHS and the medical and nursing professions. To illustrate, the financial crisis in the NHS led to a freeze in recruitment to many posts in 2005/06, and the surplus of UK-trained medical graduates for postgraduate training positions led to a clampdown from 2007 on doctors from abroad taking up these posts. These cumulatively led to a sharp decline in the number of permits for entry to work in health and medical services in the second half of the 2000s (Cangiano et al., 2009, p. 38). As for nurses, Bach (2007, p. 393) suggests the state's influence on occupational licensing requirements, with authority delegated to the Nursing and Midwifery Council (NMC) in 2004-2005, as the reason for the discouragement of overseas nurses from seeking employment in the UK. NMC

[5] Managed migration in the UK has increasingly become more about 'measuring' the integration capabilities of immigrants after the right-wing critics of multiculturalism have spread to the centre and left of the political spectrum since the riots in Oldham, Burnley, and Bradford in the summer of 2001 (Goodhart, 2011) and the 9/11 terrorist attacks (Onion et al., 2023) shortly afterwards. Arun Kundnani (2007) shows how British liberal intelligentsia has abandoned its earlier tolerance of cultural diversity and adopted the new 'integrationism,' which redefined integration as, effectively, assimilation to British values (see Chapter 7 where I also discussed 'migratism'/'migrantism').

[6] For the highly skilled, Tier 1 allows entry to work in any sector of employment, without a job offer. This route replaces the Highly Skilled Migrants Programme. Tier 2 replaces the work permit system and (currently) covers skilled jobs where the employer has been unable to recruit, and a fast track for shortage occupations, on which the Government takes advice from a panel of experts, the Migration Advisory Committee (MAC). The shortage list will not, as had initially been expected, include most doctor and nurse positions. Tier 3, currently suspended, is intended for temporary low-skilled jobs. It has been the Home Office's intention not to set a precedent by opening up a temporary workers scheme for low-skilled jobs in any sector, and it has shown no sign of wanting to depart from this for social care. Tier 4 is for students and Tier 5 covers youth mobility and certain categories of temporary workers (Cangiano et al., 2009, p. 39).

decisions influenced the number of overseas nurses available to work and caused severe backlogs in their registration. Kofman (2013, p. 590) shows the later period as an economic recession when immigration became increasingly restricted, even amongst the *skilled*. Kundnani (2007, pp. 141-142) makes a similar point as Kofman when comparing the knowledge economy of the US (United States) to Britain's: '…in a knowledge economy, national competitiveness was linked to skilled immigration…Britain, it seemed, ought to reap the economic advantages of following an American-style immigration policy.'

To sum up, the UK government could not limit their immigration under EU law until the withdrawal from the EU in 2020. Although it was entitled to impose transitional controls on workers from new member states following the 2004 enlargement, the UK decided not to apply these controls to the Accession 8 (A8) countries (GOV.UK, 2009; GOV.UK, 2022b; Vargas-Silva, 2014, p. 3). With the enlargement of the EU on the 1st of May 2004, East Europeans from the 'Accession 8' (A8) countries[7] became eligible to work in the UK (Cangiano et al., 2009, p. 38). The UK was one of only three (the other two were Sweden and Ireland) among the existing 15 EU Member States that granted A8 migrants immediate access to the paid labour market at that time (Cook et al., 2011). These arrivals mitigated a few supply bottlenecks in the British labour market (Coombes et al., 2007, p. 345). In contrast, when Romania and Bulgaria (the A2 countries) joined the EU in 2007, the UK government, in response to rising public concerns about the amount and rate of East European immigration following the arrival of A8 nationals, adopted a more cautious approach. Transitional controls were implemented to temporarily restrict A2 nationals' access to the labour market until these limitations were lifted in January 2014. The arrival of the *Euro-migrants* (Lutz, 2010, p. 1657)—who have the right to work and access to welfare services and benefits (Kofman 2014, p. 127) − to the UK and their recruitment rather than from ex-colonies has made a substantial impact on the shaping the new immigration patterns as well as migration regulations of the country.

What, therefore, are the implications for my study in this thesis of the history of healthcare worker recruitment to the NHS, which has evolved from former British colonies to relatively recent European immigrants? Both of these immigrant characteristics are represented in this thesis, and the history I have outlined in this

[7] These A8 states were: Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary and the Czech Republic. Maltese and Cypriot nationals were also part of the 2004 enlargement.

subsection serves as the foundation for the way immigration and recruiting policies operate now and alter over time. The women whose lived experiences inform this thesis came to this country with the hope of building a better life for themselves, navigating both the recruitment and immigration systems along the way. They did so at a time when the UK struggled to develop immigration policies that would provide favourable social and working conditions for the large number of immigrants it needed to deliver critical frontline services.

2.1.2 Definitions and Categorisations

I will primarily touch on three definitions for healthcare professionals in this subsection—the general international definition given by the World Health Organisation (WHO), the definition in the UK labour market, and the definition in the UK immigration system. Hunter et al. (2009, p. 14) defined health workers as 'those with health vocational education and training working in the health services industry.' However, I find the WHO's definition more suitable for the present study. According to the World Health Report 2006, 'all paid workers employed in organizations or institutions whose primary intent is to improve health as well as those whose personal actions are primarily intended to improve health but who work for other types of organizations.' I cannot accept the first definition since this thesis demonstrates that health education or training is not as it first appears and could have varied connotations depending on the health system in place in a given country. Health education and training vary greatly throughout national settings, depending on the availability of resources and national healthcare norms. As a result, what is deemed appropriate medical education and training in a certain country may not satisfy requirements in another.

Furthermore, not all countries recognise credentials in the same way. This makes the term 'health worker,' defined by the WHO and not influenced by national administrative systems, more suitable for this study than Hunter et al.'s definition. The WHO definition is more inclusive in that it also refers to carers working in the social care sector in this thesis. The criteria vary locally and nationally among healthcare workers' job roles, especially in the UK's social care sector (see Department of Health, 2013, p. 11). There is an increasing crossover between social care and healthcare roles, so one could, for example, work as a nurse in a social care setting such as a care home for the elderly

(Smith, 2023). In Table 2.1, derived from the Skills for Care[8] (2018) report, care workers and registered nurses are considered together in the same category of social care job roles.

Table 2.1 Derived from 'The Adult Social Care Jobs by Job Role in England, 2017' (Skills for Care[9], 2018, p. 46)

Job Role	*Number of Jobs (2017)*
All Job Roles	**1,600,000**
Care worker	830,000
Senior care worker	88,000
Registered manager	23,000
Social worker	16,000
Occupational therapist	2,000
Registered nurse	42,000

While the NHS's official classifications offer a general overview of the various job roles that form the sector, research participants' experiences revealed contradictions and complexities. One noteworthy contrast with the way the participants in this study are categorised by the NHS has to do with the descriptions of their jobs. This is because these descriptions tell whether they are engaged in caring activities directly during a working day or not. To give an example, helping service users and enabling washing and dressing, taking food and refreshments, mobility, using the toilet and bed making are counted as the duties of care workers/assistants. Besides, monitoring their conditions by taking temperature, pulse, respiration, and weight is also among the duties of these carers who form the front-line staff in all care settings (Skills for Care North West, 2018, pp. 5-6). This is just one example. After a thorough analysis that I cover in Chapter 6, it seems that the healthcare and social care systems are riddled with classificatory ambiguities, which

[8] The data from Skills for Care reports in 2018 was used by organisations from many planning groups who wanted specific data to support their local work with the Department of Health and Social Care for their planning. Skills for Care's Workforce Intelligence Analysis team declared their aims as helping to create a better-led, skilled and valued adult social care workforce, providing practical tools and support to help adult social care organisations in England recruit, retain, develop and lead their workforce, and working with employers and related services to ensure dignity and respect at the heart of service delivery (Skills for Care North West, 2018, p. 4). 'Detailed workforce information about jobs working in the NHS was not available and therefore could not be included in Skills for Care's estimates by characteristics.' (Skills for Care, 2018, p. 28)

[9] The National Minimum Data Set for Social Care (NMDS-SC) data was used to model the number of jobs offered by different types, sizes and locations of establishments (Skills for Care, 2018, p. 24).

have consequences for the emotional component of care work (Cohen, 2011, p. 2; Twigg, 2000; Twigg et al., 2011). These ambiguities become part of my participants' lives, and they have to grapple with them every day.

Based on the regulatory framework, Jayaweera (2015, p. 13) classifies the migrant *skilled* health workers as doctors, nurses, midwives and other health professionals, taking the conditions of entry and work for EEA and non-EEA national health professionals into account and with the given data for them above. Her report (2015, p. 26) points to the recent aspiration to rely on a 'native' workforce educated and trained in the UK for the healthcare sector rather than on 'foreign' labour.[10] She notes that the Department of Health has a rhetoric, in health policy documents and its language, of the continual tightening of rules and conditions for entry and stay of these migrants, and this is based on the rationale of achieving better integration in their employment and minimising the use of migrant labour.

The recruitment of healthcare workers deemed 'skilled' is also determined by strict rules and varies depending on the workers' countries of origin. In 2020, the PBS governed the conditions of entry and work for labour migrants and their families from outside the EEA. Entry into the country for these migrants' non-EEA spouses or partners was subject to certain conditions and limited. [11] The health professionals who came to the UK to work or study, without any differences in requirements between public and private sectors, applied to Tier 2 (general), Tier 4 (student visa), and Tier 5 visas. For example, an International Medical Graduate (IMG) from a non-EEA country seeking to work as a doctor[12] in the UK must have followed a two-step process, meeting the immigration requirements and registering and licensing with the General Medical Council (GMC). To complete GMC registration, doctors had to have a recognised medical degree and have satisfactorily completed either Foundation Year 1 in the UK or 12 months of similar postgraduate clinical experience (for example, an overseas internship). The GMC did not fully register immigrants without experience in the British healthcare system but prioritised those from the EEA to participate in the Foundation programme that would enable registration. Applicants outside of the EEA could have only applied for it if there were vacancies not filled by eligible candidates who are UK or EEA nationals (NHS

[10] See what Anderson (2010) wrote on the governmental call, 'British jobs for British workers'.
[11] For information on family members of EEA citizen healthcare workers, see NHS Employers (2015, p. 13).
[12] See NHS Employers (2015, p. 11) for full GMC registration requirements—doctors from outside the EEA.

Employers, 2015, pp. 10-17). Moreover, any overseas doctor working in the UK would have been expected to have evidence of 'their ability to communicate effectively' through the International English Language Testing System (IELTS) (NHS Employers, 2015, p. 10), which was controversial in its capacity to measure occupational English (Wright, 2016).

For non-EEA qualified people desiring to work as a nurse or midwife in the UK, similarly to the case of doctors, immigration and professional conditions were both to be met (NMC, 2019a, p. 6). As a specific part of the registration for nurses or midwives, the applicants should have begun their applications online through the NMC website, which required them to complete an online self-assessment to confirm that they meet the minimum requirements, including good health and *good character*. What was meant by 'good character' is that the applicant's character is such that they are capable of safe and effective practice as a nurse, midwife or nursing associate (NMC, 2019c, p. 14). This included a consideration of any criminal proceedings, findings by another regulatory body (including health and social care), and conduct that may amount to a breach of the requirements of the Code.[13] I approach the concept of 'good character' with a distance because it is based not only on avoiding criminal actions but also on judging a person's character in a moral sense. It can also lead to inferences from actions considered morally wrong to more general statements about a person's character (Holt and Gallagher, 2024).

There were no such immigration restrictions for EEA[14] or Swiss nationals to enter and work in the UK until Brexit.[15] The free movement of professionals within the EU was enabled by the recognition of professional qualifications laid down in Directive 2005/36/EC (European Commission, no date). The professions falling under the law were nurses, midwives, doctors (general practitioners and specialists), dental practitioners,

[13] The Code was a commitment for nurses, midwives and nursing associates when they are on the register, including promises such as, at all times, to uphold the reputation of their professions or to act with honesty and integrity, treating people fairly and without discrimination, bullying or harassment (NMC, 2019c, p. 5; NMC, 2018). After passing the eligibility stage, a multiple-choice computer-based test (CBT) tested their theoretical practice-based knowledge. The objective structured clinical examination (OSCE) formed the second part of the competence test for the applicants if they could complete the previous stages successfully (NMC, 2019a). For non-EEA dentists (GDC, no date), pharmacists (GPC, no date) and all other health professionals (HCPC, no date), similar immigration and professional regulation criteria were applicable.

[14] See NHS Employers (2015, p. 10) for full GMC registration requirements—doctors within the EEA.

[15] Except for some registration requirements for the Croatian workers—which have been announced that they will expire on 30 June 2019 bringing their rights to work in Britain in line with other EU citizens: 'When Croatia joined the EU in 2013, the UK and other member states were able to restrict the access that Croatian citizens had to their labour markets for a maximum of 7 years. The UK is one of a few EU countries (Austria, Slovenia and the Netherlands) which applies such measures. The restrictions have meant that, unless an exemption applied, Croatians needed permission from the Home Office to work in the UK.' (GOV.UK, 2018)

pharmacists, architects and veterinary surgeons. For the registered nurses and midwives in the UK from the EU or the EEA with the NMC, based on the type of qualification the applicant holds, there were two routes to apply: automatic recognition or acquired rights.[16] Similar routes for registering other EEA-qualified health professionals under Directive 2005/36/EC were available.[17]

Subsequently, let us examine how the regulatory system applies to workers not classified as 'skilled.' The UK recently saw a high rate of immigration for care work when it opened up a new visa route for foreign workers in early 2022 (McKinney and Sturge, 2023). Visa rules were eased to plug massive staff shortages in the care sector following the Covid-19 outbreak and Britain's exit from the EU. Care work typically requires no specific minimum entry qualifications except industry-standard induction training and food hygiene, first aid, manual handling and other aspects of health and safety training in some cases (Dyer et al., 2008; Skills for Care North West, 2018, pp. 5-6). In Skills for Care North West (2018, p. 79), the proportion of Care Certificate engagement in the North West region of direct care workers who had started in the sector since January 2015 was around sixty-three per cent. This proportion is more striking for the whole adult social care sector workforce, with almost three-quarters (seventy-two per cent) of those having not started or not being engaged with a certificate. All of this implies that social care workers cannot enter the country regularly; instead, temporary visa pathways are established for them in times of critical need, and the qualifications needed to hire them are not highly regarded.

It is clear from this discussion that Britain's new immigration policy declares that immigrants, regardless of their country of origin, would be admitted into the country's workforce and placed in suitable positions only based on their professional skills. On the other hand, the fact that the 'skilled' women's credentials are from EEA nations is one of the most significant indications of how effective the countries of origin are in selecting immigrants to work in the care sector. During the recruitment process, it is critical to know if the women's home countries offer English-language education and if the credentials established in those countries align with those of the British healthcare system. The fact that migrants coming to work as carers in 2022 were mostly from former British

[16] These standards are set out in Directive 2005/36/EC on the Recognition of Professional Qualifications (the Directive).` See NMC (2019b, p. 8).
[17] See (GPC, no date), for example, for EEA-qualified pharmacists.

colonies such as India, Zimbabwe, and Nigeria (Batha, 2024) reflects Britain's dependence and reliance on high labour migration rates driven by colonial ties, while also acknowledging the growing presence of European migrants in the sector. Second, the discussion noted that healthcare workers are classed in several ways based on academic research and occupational regulations. For instance, they may be classified as professionals; the rest are out of focus or *unskilled*. According to this study, women workers who physically and psychologically toil for the health of others are considered 'carers.'

In sum, I note that the labour and migration systems do not define everyone who works for human health as a health worker, as defined by the WHO. To manage the migration of health workers to the country, the labour market classifies migrant health workers and their work, in the most general sense, according to 'health' and 'social' care, while the migration system distinguishes between 'skilled' and 'unskilled.' These definitions and categorisations are cumbersome and complicated because of the uncertainty about the work done in daily life, including qualifications, wages and status. In a situation of migration, professional accreditation-based distinction and recognition are especially slippery and challenging. For this reason, problematising the distinction is very important in my research on migrant workers.

This section examined the visa and recruitment processes women carers go through to come to the UK to work in the healthcare sector. Carers encounter the country's general immigration and recruitment regimes before the regional impacts of settlements, and I argue that it is essential that this thesis foreground their experiences with these structures before looking at the effects of settling in NWE on these women's 'better life' prospects. Immigrant women are directed and classified to certain visa and recruitment routes in this country to the extent that they can prove to the UK that the professions they have acquired in their countries of origin are 'skilled' jobs. If they cannot, they are excluded from the routes I have described above and look for other ways to practice their profession in the UK, which they enter through routes other than labour migration. The ultimate categorisation of women passing through these routes in migration and employment systems creates a starting point for their ideal of better lives in this country, and whether or not this start is a good start depends on how the immigrant woman is categorised when she enters the country. How these categorisations impact the participating women's ideals of better lives will be critically discussed in Chapter 6. This thesis also critically engages with the social construction of categories that define migrant workers. As Dahinden et al.

(2021) argue, categories are socially and politically constructed, and their performative nature influences how people are seen and treated in everyday interactions. While categorisation is a bureaucratic activity, categories, once in existence, acquire a social life of their own and become socially embedded through 'knowledge production' processes that shape the experiences of migrant women in the UK.

2.2 Carers' Migration to North West England

A variety of complex factors are affecting migratory journeys of the health workforce to the country, such as promises for good quality of life and job opportunities, the UK's historical, political and trade relationships with sending countries, developments in health workforce policies and institutions, changing demand for healthcare including in response to population ageing, policies on the licensing or registration of foreign-trained professionals, and British immigration rules and regulations (Siyam and Dal Poz, 2014). However, these factors vary from region to region. According to the estimated proportions of the adult social care workforce in England by nationality and region, London has the highest proportion of migrant workers in the country, with fourteen per cent EU and twenty-six per cent Non-EU, while for the North West, these rates are three per cent and four per cent respectively (Skills for Care Sept., 2018, p. 63). This shows a clear north/south divide regarding the country of origin from which the workforce comes.[18]

For the NHS employment characteristics by nationality,[19] as Carl Baker (2018, p. 5) clarified, a substantial minority of the 1.2 million NHS staff in England were non-British, totalling 144,074 in 2018.[20] There were 172,550 UK-citizen NHS workers in the North West, compared to only 19,978 for non-UK citizens. 'Black, Asian and Minority Ethnic (BAME) workers made up ten per cent of the adult social care workforce in the North West region (Skills for Care North West, 2018, p. 56).[21] Looking at the representation of

[18] That London has received more research than the North should be remembered while presenting these figures.

[19] The NHS was the main source of information I could not cover the number and percentage of migrant carers in England in this section. Besides there is little information on the private sector in NHS sources, and the term 'carer' used in non-state-run studies is not the same as the meaning utilised in this thesis. The statistical information on the immigrant group that this thesis uses to represent the women I refer to as carers in terms of their jobs and responsibilities is limited.

[20] These figures are set to be higher in 2023. In 2023, 264,822 of the 1.51 million NHS staff will not be British citizens (Baker, 2023, pp. 4-6). The proportion of British nationals in the NHS in the North West (87%) is still higher than in London (70%) (Baker, 2023, p. 10). Regarding the statistics on European NHS workers after the 2016 referendum, although the number of workers from the EU appears to have increased from 58,702 in 2016 to 74,142 in 2023, Baker (2023, p. 7) warns that this increase may be misleading, as 60,000 more workers became known of their nationality in 2023 than in the statistics of 2016.

[21] See also Skills for Care North West (2018, p. 60-67).

the staff from a Black and minority ethnic (BME) background, the workforce of NHS in the North regions was the least diverse compared to other regions in 2017 and 2018 (NHS Workforce Race Equality Standard, 2018, p. 14). For 1,700 EU national workers in NWE—around thirty-one per cent—the applications for settled status were not necessary because they already had British citizenship. Forty-four per cent of workers from EU nationalities without British Citizenship will be eligible to apply for settled status, and the remaining twenty-six per cent can apply for pre-settled status (Skills for Care North West, 2018, p. 66-67).

What does it mean for my participants, then, that NWE, in the care sector and the general population, has a lower proportion of non-British individuals than regions in the South? Compared to, for example, London, this region offers its residents fewer opportunities to engage in a cosmopolitan experience; this is especially true in small areas. This suggests that the opportunity for migrant settlement and daily interaction between different ethnic communities may be hindered by additional challenges. The fact that people are less accustomed to racial and ethnic diversity could make minorities, foreigners, and, therefore, my participants feel even more like 'outsiders.' (Song, 2003, 2004; Zwysen and Demireva, 2020) I explore the effects on the lives of my participants of the region's relative lack of ethnic diversity as well as the general living and work environment in NWE in Chapter 7. We can thus better comprehend not only their 'work' but also their everyday social lives with the aid of such information.

2.2.1 North-South Divide in England and Implications for Immigrant Carers

In Europe, the UK is where the spatial segregation (The Economist, 2020) between neighbourhoods, for example, in terms of the highest inequalities in income, is at the highest level and where the sharpest and still growing regional divides are seen (Dorling, 2016, p. xiii). The country has a significant wealth gap due to the North-South Divide in the political economy, with those in the North having lower average earnings, greater unemployment, and a lower level of well-being than people in the South. Deindustrialisation's economic impacts have left many jobless, reliant on benefits, and without access to new job prospects; however, the roots of the inequality lie in the era of industrialisation itself (see Centre for Social Justice, 2018). Margaret Thatcher's neo-liberal economic policies of the 1980s contributed to the industrial production drop in the North while enabling the growth of the service sector in the South (Fisher, 2019). From the beginning of the 1980s, the economic growth of the large ex-industrial towns and

cities of northern Britain, such as Newcastle, Sheffield, Birmingham, Glasgow, and Liverpool, lagged behind the Southern cities. Business closures and lower levels of business investment in these regions reduced the job opportunities and well-paid work, leaving many unemployed, dependent on welfare and often without any opportunities for new employment (Martin et al., 2015).

Hughes and Atkinson (2018) describe the North of England as unique and distinctive from South England, with its particular economic, political, social, and geographic qualities. The North, in this comparison, has been the region in decline. The 'North-South Divide' in the national political economy (Martin et al., 2015, p. 9) has created an enormous wealth divide, and those living in the North of the country have experienced lower incomes, higher unemployment and a lower standard of living than those living in the South (The north/south divide in the UK, no date). The North of England, representing thirty per cent of England's population, includes fifty per cent of poor neighbourhoods (Addison et al., 2018, p. 1).

Further, an article in *The Economist* (*The great divide,* 2012) presented the North of England as becoming nearly another country socially, economically and politically. The recent sharper cuts in the region in public and infrastructure spending and council budgets evidenced the widening regional disparity. There was an estimated forty-nine point one per cent real-term reduction in government funding for local authorities across the country from 2010-11 to 2017-18 (NAO, 2018, p. 7). Compared to other parts of England, cities in Northern England have been most severely affected by the decade of austerity from 2008 to 2018 (Centre for Cities, 2019). Northern cities had an average twenty per cent reduction in government spending in seven of the ten cities, with the worst losses being in the North West, North East, or Yorkshire.

According to the 'All Together Fairer' review (Marmot et al., 2022), the Covid-19 pandemic[22], the present cost of living crisis and a decade of austerity measures have expanded the substantial deprivation in NWE. Austerity policies resulted in worse health and widening health inequalities in the region. Life expectancy stopped increasing in deprived areas, like Cheshire and Merseyside counties in NWE. Marmot et al. (2022, p. 13) found that health inequalities are related to the 'policies of austerity, including deteriorating quality of work, stagnating wages, cuts to public services, local authority funding and benefits, as well as declining investment in deprived communities.' The

[22] See Bambra et al. (2023) for the impact of the pandemic on NWE and how it exacerbated existing health and socio-economic inequalities in the region.

health requirements of those residing in these socioeconomically impoverished regions are the greatest, but general practice receives little funding and is 'under-doctored' in high-deprivation areas (Fisher, 2021). The UK government has promised several policy measures in health, infrastructure, employment, and education with a levelling-up white paper in 2021 to reduce inequality based on where people live. However, only thirty-five per cent of the £10.47bn promised was allocated to local authorities, and just twelve per cent had been spent by September 2023 (Miller and Geiger, 2024; Reuben, 2024).

There have also been many social consequences of deindustrialisation; some forms of social breakdown, such as intergenerational worklessness, 'welfare dependency,'[23] crime, drug use and family breakdown, can be counted among these (Centre for Social Justice, 2018). As Rhodes (no date) says, it is evident that deindustrialisation has not only caused a radical economic transformation and socio-economic polarisation but also stimulated social and cultural processes which altered communities (Strangleman and Rhodes, 2014). Part of such transformation is evident in how economically marginalised communities were stigmatised in Burnley, the former largest cotton producer town in East Lancashire in the UK, approximately thirty miles north of Manchester. With the collapse of industry, many social issues became visible, such as the population decline caused by the lack of opportunities, the poor quality of the town's housing stock, and high unemployment (see Rhodes, 2012).

In sum, cities and towns in NWE have been severely damaged by the extraordinary loss of manufacturing industries and austerity policies. Then, how do the conditions of austerity and social deprivation in the region shape the lives of immigrants, specifically of my participants? The UK's care sector is now experiencing a crisis due to financial cuts and austerity measures. Moreover, the North West, where the majority of people are impoverished, have a high rate of health issues, and have a high demand for healthcare services, is one of the regions most affected by this crisis. Unsurprisingly, this puts an additional burden and pressure on immigrants working in the healthcare sector in this region. I will draw a picture of this environment in the following subsection.

2.2.2 Care Crisis

In this subsection, I clarify how my participants' experiences have been impacted by the care crisis in NWE in two ways: through disruptions to their living and work environments. Firstly, because of their challenging socioeconomic backgrounds, those

[23] For a critique of the discourse of welfare dependency see Hanna (2019).

who are my participants' prospective patients—also their fellow residents in NWE—are often let down by the current healthcare system, which is marred by long waiting times for treatment, poor quality of services, and unaffordable costs. Secondly, participants must work in a healthcare system that is presently facing a care crisis and is inefficient in offering everyone access to essential healthcare services and giving its staff members the sort of environment they deserve at work. I have noted that the English national care crisis includes the North West. What, therefore, should we take away from this crisis? First, let us examine this, and the crisis's geographical ramifications will follow in the subsection.

The UK's population is ageing. In 2016, there were 11.8 million UK residents aged 65 years and over, representing eighteen per cent of the total population, and 1.6 million people aged 85 years and over—two per cent of the total population. This older population is not equally spread across the local areas of the country. The elderly make up higher proportions of the populations of rural and coastal areas than in urban areas (Storey, 2018). In 2017, nearly 1.2 million people (1,183,900) over 65 did not receive the help they needed with essential daily living activities, representing a 17.9 per cent increase from the previous year and a 48 per cent increase since 2010. Nearly 1 in 8 older people lived with a degree of unmet need for social care (Age UK, 2017, p. 4). For primary care, there were difficulties accessing and getting appointments for non-urgent services in local communities like GP (general practitioner) and dental services, particularly for the ageing population in the east of the country in mid-2017 (State of Care, 2019, p. 74). Concerning capacity, the number of residential and nursing home beds fell steadily in all regions for the five years from August 2014 to August 2019, with a six per cent proportion in the North West (State of Care, 2019, pp. 35-36). Waiting times for treatment in hospitals across the UK increased, and from June 2014 to June 2019, the waiting list for elective care rose by forty per cent, to 1.3 million, reaching 4.4 million people. More than 600,000 had been waiting for more than 18 weeks (State of Care, 2019, p. 12). According to the latest numbers available, while writing this thesis, the rate of patients having to wait longer than 52 weeks for a GP referral to start treatment in NWE in 2023 was still an issue with seven per cent (State of Care, 2023, p. 18). It is clear from the demographic trends that the ageing population contributes to increased demand for services that cannot be met in the current state of the care sector.

Furthermore, people with protected characteristics, such as disability and ethnicity, and those in particularly vulnerable situations face more significant challenges accessing the care and treatment they need (State of Care, 2019, p. 15). As an example, healthcare

for people who were refused asylum is made unaffordable by the NHS charging policy in England, causing some delay or avoiding treatment—with more pronounced impacts on pregnant women and disabled people (Equality and Human Rights Commission, 2018, p. 6). Itinerant communities also face difficulties registering at a GP, getting an appointment, and understanding the information from their GP (Sweeney and Stanbury, 2019, p. 1). Finally, the review by the Care Quality Commission (2018, p. 3) noted that the care for many children and young people who develop a mental health problem in the UK is a part of a fragmented system full of complexities. They mostly experience barriers to high-quality care.

People in the UK increasingly struggle to access the care they need and want, and their access to care has been increasingly dependent on where in the country they live. As Tudor Hart (1971, p. 405) explains through his 'inverse care law,' 'the availability of good medical care tends to vary inversely with the need for it in the population served.' This disparity becomes more pronounced in healthcare systems 'most exposed to market forces,' where access aligns more with wealth than with need. Owing to the geographic disparities throughout the UK, some people can quickly get good care in the UK, while others experience disjointed care and poor services (State of Care, 2018, p. 4). In addition to the organisation, funding and delivery of health and care services, personal budgets, and direct payments are the fundamental mechanisms that play a role in having choice and control over the support and services they receive. In 2018/19, the proportion of people who used social care support services and who received direct payments from local councils (or from Health and Social Care Trusts in Northern Ireland) was twenty-eight point three per cent across England, and this was twenty five point four per cent in the North West region (NHS Digital, 2019, p. 23). A little over 16000 adults receiving NHS continuing healthcare in England had a personal health budget planned and agreed upon between them or their representatives and the local CCG (Clinical Commissioning Groups) (NHS England, 2018, p. 79) in the second quarter of 2019, of which 5,548 received this as a direct payment (NHS England, 2019). Prominent obstacles in health service delivery could have a detrimental effect on overall care quality, leading to patients' unmet needs, low satisfaction, and a decline in their trust. Accessible and affordable healthcare services can only be produced by well-designed health systems (Scheffler et al., 2015). Otherwise, immigrant workers will not be able to reach their ideal work environment because they will work in a system where patients cannot properly access health services and the general quality of care is low.

Almost everyone in the UK is exempt from having to pay for medical treatment, but many still spend on care. For example, children under 16 years (or under 18 years if in full-time education) and low-income households are free from all NHS charges. Also, pregnant women, people with selected chronic conditions, and people over 60 are exempt from prescription charges and may be exempt from certain dental charges in some parts of the country. However, in 2014, over one million people, who comprised one point four per cent of households in the UK, overspent on health, primarily driven by out-of-pocket payments for medical treatment and dental care. Over two-thirds of households with catastrophic out-of-pocket payments[24] were in the poorest consumption quintile. Over half of them lived in impoverished households, spending less than £112 a week on average. A factor exacerbating inequalities for healthcare among socioeconomic groups was private medical insurance/voluntary health insurance, which provided only eleven per cent of the population access to acute care faster. Another factor was the tax and benefit changes, which hit the poorest households hardest, further limiting their capacity to pay for healthcare. These explain the social injustice that households facing financial pressure may be forced to delay or forego care while others can afford private treatment (O'Dowd et al., 2018).

Additionally, recent publications (such as The King's Fund, 2018; Greater Manchester, 2019; Adass North West, 2018) have highlighted the current crisis facing the adult social care sector in England and a growing body of literature (Skills for Care North West, 2018) and speculation about the future of the sector have occurred. The key challenges were addressed in these sources as the negative image of the adult social care sector, the substantial labour shortages in the sector, and the sustainability of the adult social care market at risk, to name a few. Whitfield (2015, pp. 64-65), for instance, underlines some factors as the causes of the crisis in care services in his report: public spending cuts, neoliberal public management, imbalance of resources—£121bn NHS budget and £8bn local authority budget for social care, the growth of a care market, inadequate monitoring and contract management, longer-term intergenerational problems as a result of the loss of pension provision for care workers etc. The context of these sources is crucial, as their objectives and intended audiences may influence both the way they are framed and the interpretation of the data they present. For example, Whitfield's (2015) report included a few studies on the health and social care economy. One was a critical analysis of the case

[24] 'Out-of-pocket payments' are an established indicator of financial protection, defined by WHO, and accounted for more than 40% of a household's capacity to pay for healthcare (O'Dowd et al., 2018, p. x).

against selling residential care homes and/or outsourcing adult social care in over 15 local authorities—many in the North West. The European Services Strategy Unit, where the report was published, asserts that they are committed to social justice whereby public bodies democratically provide good quality public services and implement best practice management, employment, equal opportunity and sustainable development policies. This report also contained some health and social reconfiguration recommendations.

The demographic and socio-economic profile of the people in a region likely to be the health and social care system users carries implications for the conditions of the workers serving within that sector, especially for the migrant women, whose experiences form the subject of the current study. This is likely due to an expected positive correlation between welfare in a society and a healthcare sector in a good state. Although Bambra (2011, p. 740) points out that the provision of welfare states varies greatly, she concludes that they are significant decision-makers in health via moderating health's social determinants. Increases in the standard of living lead to rising demand for a more comprehensive and better quality of services and a good health and social care economy, and people who can reach it have positive impacts on jobs in this sector, and so for those with these professions, such as for their pay and conditions, career opportunities, morale and commitment, to name a few (Bambra et al., 2014).

People's housing, education, income, and physical and social environment are the social determinants that drive health (Public Health England and UCL Institute of Health Equity, 2014a, p. 6). In 2011-12, while sixteen per cent of the UK population was in poverty without housing costs, this increased to twenty-one per cent after taking account of housing costs. For the same year, twenty-one per cent of working-age households without children, thirty-five per cent of those living in households with children, and nine per cent of pensioners lived on an income below the minimum income standard (Public Health England and UCL Institute of Health Equity, 2014b, p. 3). House prices in the North West in August 2019 were among the lowest, with an average of £168,000, compared to the average house prices across England, which was around £235,000 (Harari and Ward, 2019, p. 9). Sadly, this is not the end of the story, as the region's socio-economic profile further declines when other indicators are considered.

In 2017, the North West region contributed nine point five per cent of the UK's total economic output, with its 7.3 million people, eleven per cent of the total UK population. The unemployment rate in the region in June-August 2019 was four point one per cent, slightly above the UK figure of three point nine per cent (Harari & Ward, 2019, p. 4).

According to the Office for National Statistics (2013), health and economic inequalities in the North West affect children severely. The proportion of children living in workless households in the second quarter of 2013 was seventeen point eight per cent in this region, which was one of the highest; this was 13.6% for England and 18.7% in the North East. With 77.4 years for men, life expectancy at birth in the North West in 2009 to 2011 was the lowest in England compared with 78.9 years for the country. It was 81.5 years for women, the joint lowest in England with the North East and compared with 82.9 years for England (Office for National Statistics, 2013).

Regarding wages, the North-South divide is the clearest, with most, but not all, of the lowest-paid towns and cities in NWE (Carter and Swinney, 2018). In 2018, Birkenhead and Wigan in the North West, where workers earned £428 and £436 per week on average, followed Huddersfield in the Yorkshire and the Humber region, which had the second lowest wage of any large town and city with workers earning about £424 per week. In 2017, an estimated 635,000 people, twenty-three per cent of the North West workforce, earned less than the Living Wage.[25] An estimated 5.5 million roles, twenty-one per cent of all jobs, earned less than the Living Wage nationally in the same year (Markit, 2017). In 2016, the North West had the highest number of jobs paid below the minimum wage, with 47,000 jobs in other regions (Centre for Social Justice, 2018, p. 31). These numbers indicate that financial hardship in the use of healthcare is a fact for the general population of the North West region of the UK.

What, then, are the health system factors that would have implications for immigrant health and social care professional women in NWE besides the aforementioned socio-economic factors? Despite the expected contribution of migrant workers in health and social care in some main receiving regions such as the South East and London, other areas, like Scotland and the Northern regions, have only recently presented or exceeded their demand for their employment. For instance, according to a review of the size and structure of the adult social care sector and workforce, in 2017 in the North West region, an estimated 2,400 organisations and 5,050 establishments were involved in providing and organising adult social care (Skills for Care North West, 2018, p. 16). This growing adult social care sector of the region considerably relied on migrant health and social care workers to fill the workforce needed; the majority (ninety-three per cent) of the workforce

[25] 'The UK Living Wage is an hourly rate of pay set independently and updated annually. It is calculated according to the basic cost of living in the UK, with employers choosing to pay the Living Wage on a voluntary basis.' (Markit, 2017, p. 4)

were British, but three per cent (5,500 jobs) had an EU nationality, four per cent (7,200 jobs) a non-EU nationality, and twenty-one per cent of registered nurses were non-British (Skills for Care North West 2018, p. 62-63). This growing demand in the North of England should be closely monitored because it can potentially modify the long-standing and entrenched interregional distribution of migrant health and social care professionals in the country.

Today, a striking aspect of this rising employment of health and social care professionals in NWE is that it is newly happening under the privatisation and out-contracting trends which have been seen in the care industry of the country for thirty years (McGregor, 2007, p. 804). Since 2012, there has been a considerable change in the employer-type distribution of jobs in adult social care in the North West region. The sector moved away from jobs for local authorities towards jobs for independent employers and direct payment recipients (Skills for Care, 2018, p. 25; Skills for Care North West, 2018, p. 20). Since 2009, NHS Trusts in the North West have transferred services to seven social enterprises, which account for £18.6m in annual turnover and 643 staff members. These staff employed by companies are no longer public employees (Whitfield, 2015, p. 51). As reported by Whitfield (2015, p. 44), neoliberal ideology has underpinned the transformation of public services towards marketisation and privatisation. He notes how the UK's reform policies increased competition, marketisation and privatisation in the last three decades.

The marketisation and privatisation of health and social care are closely connected and related to cuts to British social welfare programmes and austerity measures at the national level, which started in 2010 and was led by the Conservative Party (Goodman, 2018). Through the recession and austerity policies adopted due to the global financial crisis since 2008, the transformation has accelerated with further deregulation, commercialisation, a flexible labour market, a pro-business climate through corporate representation on public bodies and government-financed market-making activities (Whitfield, 2015, p. 44). Franklin and Urzi Brancati (2015, p. 3), in the report outlining the key findings from research conducted by the International Longevity Centre UK and Independent Age, an independent non-partisan think tank dedicated to addressing issues of longevity, ageing and population change, into the importance of migration to the adult social care workforce in England, identified that social care has been under financial pressure due to a long-term lack of funding: ‘While health spending increased from £97.5 billion in 2010-11 to £116.4 billion in 2015-16 (an increase of 19.3%), over the same

period, social care funding has decreased from £14.9 billion to £13.3 billion (a reduction of 10.7%).' Not even half of the care homes in the North West—only 48%—are fully funded by local authorities. Of the 542 care homes in the region, 21% are self-funded, 14% are partially self-funded, 10% are partly local authorities and/or NHS and/or charity funded, and 7% are fully NHS funded (State of Care, 2019, p. 36).

All of the findings from above paint a complicated and divergent picture of what a 'better life' in England may entail for a care worker who relocated to the North West. These workers must navigate the care crisis they are thrust into, particularly those in social care, to hold on to their dreams of a 'better life.' Due to the low pay and long hours associated with social care, hiring and retaining staff in the sector is highly challenging. Unfortunately, the sector is rife with exploitative practices that affect all carers, including low pay, inadequate sick leave, lack of travel expenses, and zero-hour contracts. Carers struggle to plug the gaps in the severely understaffed sector despite their excessive workload and low pay. Care is in a dire state due to severe underfunding, lack of constructive change, and the government's unwillingness to address workers' demands concerning working conditions and pay. Certain workers receive pay for barely any of their labour or face discriminatory comments, mistreatment, and pressure if they voice concerns regarding the care they provide to their patients (McAnea, 2023; Edwards, 2023).

2.3 Conclusion

There have been detrimental effects of deindustrialisation and the subsequent neoliberal state policies in the health system, both for the local people in the North West region and for the workers who serve them in the healthcare sector, and hence for the immigrant women professionals. The publications, briefings, reports, reviews, and commissions that informed the preceding discussion tell us little about the migration expectations of health and social care professional women living and working in the region, the socioeconomic implications of their journeys, their role in the delivery of care, and how this might evolve in future (Franklin and Urzi Brancati, 2015, p. 2). However, this descriptive statistical information is useful for my study in providing the context of women migrating to NWE to pursue better lives.

The information contained in this chapter forms the basis for the arguments I developed in the succeeding empirical chapters on working and settling in NWE—two aspects of the experience of looking for a 'better life' in NWE. Considering the number

of immigrant carer women in NWE, the region's socio-economic profile, and the region's care crisis, I expressly asked the participating women about their working conditions in our interviews. I requested them to expound their views on how living in NWE and working in its care sector influenced their lasting senses about their migration. In the empirical chapters, I will discuss how this region particularly let down participants' 'better lives,' how working conditions are not what they imagined, and how they face bias and discrimination at work and in their social lives. Thus, this chapter enabled me to pose the following queries, which the subsequent chapters will address: What are the specific economic and social aspirations of women care workers—who mostly take jobs for the local authorities and the NHS in NWE—for their regional migration decisions? And what has been the outcome? These questions will be answered by examining participant experiences in three empirical chapters that follow.

Chapter 3: Literature Review and Theoretical Considerations: The 'Better Lives Migration' of Women Workers in Caring Professions

The thesis examines the work, social life and migration experiences of health and social care professionals pursuing 'better lives' through immigration to NWE. It aims to contribute to critical migration studies with the central argument that immigrants' 'better lives' consist of their everyday social life, work experiences and interactions in transnational spaces. This multifaceted approach contrasts with the economic reductionist view of migration within development perspectives, which often focus primarily on policymakers and the labour market and are limited in capturing the daily and ordinary lives of migrant care worker women despite considering individuals as rational economic actors. Therefore, a more layered and nuanced theoretical understanding of what 'better life migration' is needed. In doing so, I engage with scholarship on immigration hierarchies, particularly those at the meso-level, and how these dynamics shape migrant workers' material and social experiences. Scholarship deploying a meso-level analysis shows how immigration regimes reflect and reproduce these hierarchies and reinforce intersecting forms of racialisation that influence migrant workers' everyday lives (Anderson, 2010; Fox et al., 2015; Lewicki, 2023, 2024; McDowell, 2008; Samaluk, 2014; Song 2003, 2004; Varriale, 2021, 2023; Zwysen and Demireva, 2020). Thinking with this body of scholarship, I build a comprehensive picture of the position of transnational carer women in the UK, not only through their migrant and professional experiences but also their daily life experiences (Kofman, 2000).

The thesis calls into question the economic determinist perspectives of public and policy discourse and some migration studies on labour migration. It offers an alternative to views that reduce 'the search for a *better life* through migration' only to the economic dimension and work experience and ignore the social dimension of immigrants' lives. The lives of participant women are influenced by the UK's immigration policies and regulations specific to EU/non-EU countries. This group of women caregivers is divided socially and occupationally, valued according to their skill level, and classified according to immigration policies that set country-specific entry and settlement conditions. The thesis shows that participants from different care roles navigate various immigration categories beyond the conventions of dual classification, such as 'skilled/unskilled workers' or 'migrants from EU/non-EU countries' (see Chapters 2 and 6) in migration policy and migration research.

The main argument of the thesis contributes to the migration literature by focusing on 'migration for a better life' (Davies, 2015; Diener, 1984, 2006; Fortier, 2021a; Grønseth and Skinner, 2021; Gough and McGregor, 2007; Wright, 2010, 2012), 'migration for care work' (De Haas, 2021; O'Reilly, 2012), and 'settlement' (Favell, 2019, 2022; Phillips and Robinson, 2015; Schinkel, 2013, 2017, 2018; Christou and Kofman, 2022)—the analysis of participants' everyday experiences and emotions while settling in England (see Chapter 7). The chapter shows how I redefine the terms of 'better lives,' 'care work', and 'settlement' to reflect the cases of my participants in this study more accurately.

The first section fleshes out the concept of migrating for 'better lives.' It challenges the 'push-pull' arguments while situating this concept within broader discussions on 'well-being' (Davies, 2015; Diener, 1984, 2006; Fortier, 2021a; Grønseth and Skinner, 2021; Gough and McGregor, 2007; Wright, 2010, 2012). Well-being is a significant part of the search for a 'better life'; the literature has discussed happiness as one of the foremost well-being indicators. Rethinking these debates is necessary for understanding the concept of well-being in migration studies. Here, it is especially worth problematising how some countries distribute a particular idea of the 'good/better life' globally through social, cultural and national values and influence migrants' view of what happiness looks like (Fortier, 2021b, p. 401).

'Better life' is multidimensional, including the controversial concept of happiness in a sociocultural context. Happiness itself is a cultural construct. Erich Fromm emphasises 'having' in the form of consumption as a means of happiness in today's affluent industrial societies. He suggests a formula by which modern consumers may identify themselves: 'I am = what I have and what I consume' (Fromm, 2013, p. 62). Concepts of happiness are associated with a materially satisfied life: a place of one's own, and material goods mark a person of medium or high socioeconomic status. However, happiness is defined differently in different cultures. Therefore, in this thesis, I am pursuing how participants interpret the definitions of happiness circulating in society and culture. Consequently, I shed new light on migration for a 'better life' by considering both literature on 'migration' and 'happiness.'

In the second section of the chapter, I primarily show the development of the conceptualisation of care in the migration context and provide a critical account of the literature considering the migration of healthcare worker women in a much different context than those of other care or domestic workers. A domestic worker who migrates from the global South to the global North (Williams, 2011) became the emblematic figure

in migration studies within the contexts of transnationalism and globalisation (Sassen-Koob, 1984), as in Hochschild's (2000) conceptualisation of 'global care chains.' Migration of women healthcare workers in migration studies is an understudied area. The migration of healthcare workers has been examined in separate pieces of literature, such as human resources and health (Al Btoush & El Bcheraoui, 2024; Eaton et al., 2023; Leitão et al., 2024; Sweileh, 2024; Toyin-Thomas et al., 2023; Walton-Roberts & Bourgeault, 2024), in a way that excludes carers' migration from broader migration studies. Furthermore, when the women were also the subjects of the migration studies, those who migrated for healthcare professions were treated as 'well-educated, highly-skilled, elite, medical,' to name a few, and were conceptualised mainly in the context of brain drain/strain/waste (Cuban, 2013; Bornat et al., 2011; Lowell et al., 2004; Kofman and Raghuram, 2006; Kangasniemi et al., 2007; van Riemsdijk, 2013; Salami et al., 2016; Zuk et al., 2019). However, in this study, I argue that women working in all occupational care roles should be considered together because they are employed in similar sectors, serve a similar labour force, and are exposed to similar systems of migration and care. The skill sets, substantive work roles, and tasks are similar, yet the recognition, credentials, and values of the same type of skills and tasks differ. I explain these in the 'Similarities of Domestic and Care Work' subsection.

In the third section, 'Unsettling the Concept of Settlement,' I unpack how 'better lives migration' and 'care work migration' complicate, shape, and constitute each other through 'settlement.' The section deals with the theory of settlement and criticises policy discourse and the governance rationale underpinning the dominant idea of settlement or integration. The mainstream discourse of settlement and integration shapes the concepts of settling and unsettling but does not fully account for their emotional dimensions. This section explains why emotional dimensions are crucial in understanding women migrants' settlement experiences. It distances 'settlement' from the integration literature by privileging concepts used in the care literature, such as 'emotion work' or 'feeling rules' (Hochschild, 1979). I extend Hochschild's work on emotional labour into the migrant context, which is essential for understanding participants' experiences, not just what they lived but also what they felt in their migration experiences because it provides insights into the interplay of subjective feelings and socioeconomic context. Social areas, which exist alongside the occupational and bureaucratic immigration experience, provide us with an important source of whether, and more critically, how the participants' expectations for better lives are met.

3.1 The Concept of 'Better Life'

The literature focusing on professional experience can no longer be limited to the professional lives of immigrant women. Regulations on immigrants' professions affect their professional identities, social lives and integration, and immigration experiences. Therefore, in this section, I review by prioritising the experiences of being an immigrant and a woman beyond professional life and identity, but by focusing on a different strand of literature. Although material satisfaction is often linked to concepts of happiness, different cultures have diverse definitions of what constitutes happiness. In order to shed new light on migration for a 'better life,' I examine how participants understand these criteria in society and culture while considering research on migration and happiness. Thus, in this section, I theorise about participants' 'better life' experiences and offer a new perspective on the theory of migration for better lives.

Migration for better lives has generally been discussed in the literature concerning economic development. Push-pull models and well-being theories have explained whether immigrants have better lives with their living conditions and the improvement in these conditions. I build my theory of better lives on the arguments that explain well-being in psychological terms, such as subjective well-being, but I take them one step further, considering better lives from a sociological perspective.

3.1.1 Push-pull Models

'Why do individuals move?' has long been asked by many theorists to understand reasons for migrating, and the concepts of *push-pull motivations and expectations* have been much favoured, specifically by economists and sociologists, when responding to that question.[1] Simply put, the reasons pushing or attracting migrants to a particular place are called 'push-pull factors.' While 'push factors' refer to the negative aspects of the origin country and affect people's choice to emigrate, 'pull factors' are the positive ones of a possible destination that encourages people to immigrate (Tataru, 2019, p. 14).

Early migration theories based on functionalist push-pull models (Sjaastad, 1962; Harris and Todaro, 1970; Rosen, 1974; Roback, 1982; Clark and Cosgrave, 1991) were subjected to many criticisms that they remained mired in concepts, models and

[1] The earliest example of such models is in the research of Ravenstein (1889), in which the factors that push people to migrate are defined as 'bad or oppressive laws, heavy taxation, an unattractive climate, uncongenial social surroundings, and even compulsion (slave trade, transportation).' And 'the desire inherent in most men' is the pull factor for migration 'to *better* themselves in material respects' (Ravenstein 1889, p. 286).

assumptions of the nineteenth century (Massey et al., 1993, p. 432) and that they were not able to understand real-world migration processes or to explain migration as a social process (De Haas, 2021, p. 6). To compensate for these gaps in the migration theory, scholars at the level of the *historical-structural* paradigm explained international migratory movements within structured relationships between sending and receiving states (De Haas, 2021, p. 4). According to Morawska (2012, p. 72), this attentiveness to historical processes and the macro-structural force of capitalist globalisation serves as a postulate of any satisfactory social-science account of transnational movements. Later, the concept of 'transnational social space' (Goldring, 1996; Faist, 1998) aimed to connect the practices of migrants to the institutional activities of, for example, nation-states representing their interests to control these spaces and to shape migration. When referring to transnational ties, the involvement of non-state actors—like transnational enterprises, supranational frameworks, and civil society organisations—in these ties was also important (Faist and Ozveren, 2016, p. 4; Faist, 2019, p. 27).

The theory of 'push-pull effects' is grounded in a development framework, according to which the key driver of international migration for healthcare workers would be explained as the demand in destination countries for low-wage labourers in specific healthcare sectors of skills shortage (Black and Skeldon, 2009, p. 17). Simply put, poverty 'pushes' people to migrate through this idea of being recruited within these sectors. However, the definition of migration within this development framing as 'a strategy that improves the ability of low-income migrants to exit poverty and achieve well-being' (Wright, 2012, p. 31) is not enough by itself to fully understand the reasons of the participants in this research to migrate to the UK. This perspective limits migration to economic costs and gains in terms of its causes and consequences, does not consider the perceptions, feelings, and satisfaction of immigrants, and fails to provide a comprehensive definition of life beyond the economic side. Put differently, 'most debates about migration and development privilege the economic at the expense of the social' (Levitt and Lamba-Nieves, 2011, p. 2).

People who migrate are neither 'soulless individual utility-optimisers' as defined by push-pull theories nor 'passive victims of global capitalist forces' who have no free will on their migration as defined by historical structuralists (De Haas, 2021, p. 8). We need to transcend this top-down immigrant typology and highlight these immigrants' social relations and interactions as social individuals. This is not to say that I understand 'society […] primarily as the aggregate of the individuals within it' (Bakewell, 2010, p. 1694).

Rather, I adopt a more general-/meso-level theoretical approach to migrants' aspirations for 'better lives' and, thus, their perceptions and feelings on the 'migration outcomes.'

However, I do not reject the conceptual tools offered by the 'classical' migration theories altogether. Instead, what I do in this research, from the perspective of transnationalism, is to give equal importance to *individuals* and *structures* simultaneously, find a balance between them, and achieve a meaningful understanding of the roles of the two in migration processes. Social networks serve as a bridge between macroscopic push and pull influences and individuals (Light et al., 1989). Moreover, migrant networks imply 'sets of interpersonal ties that connect migrants, former migrants, and nonmigrants in origin and destination areas through ties of kinship, friendship, and shared community origin' (Massey et al., 1993, p. 448). In Chapters 5 and 7, I illustrate that the migration of healthcare workers is also based on several different connections. The women have various sources of information about migration and occupation in transnational networks. They also brought their partners and children to the UK as a host country. They have friends and social activities in the UK at work and in their social life. They made new friends and expanded their social networks through their children's education. While some of them were in contact with the diasporas of their hometowns and still maintain contact with the countries they came from, some preferred not to do so.

3.1.2 Well-being and Migration

Following the shift in the emphasis on the migration-development nexus away from financial remittances[2], Levitt introduced the concept of social remittances[3] (1998, 2001, pp. 54-69). Relatedly, Wright (2012, pp. 9-23), engaging with the literature on financial and social remittances, applied human well-being analysis to the case of international migration by investigating migrants' constructions of 'living well.' Wright (2012, p. 13) described human well-being as something 'travelling' across spatial boundaries, and the needs and goals of migrants are (trans)formed as part of the international migration process (Wright, 2010, p. 368).

[2] 'Financial remittances' refer to the developmental potential of economic transfers; of monies and goods remitted by migrants back to their homelands (Vari-Lavoisier, 2016, p. 2).

[3] Levitt (1998, 2001 pp. 54-69) defined 'social remittances' as 'the ideas, behaviours, identities, and social capital that flow from receiving- to sending-country communities,' or vice versa. Levitt's particular focus was on the transmission of social remittances 'between individuals, within organizations by individuals enacting their organizational roles, or through the looser, informally-organized groups and social networks that are connected to the formal organizations' (Levitt, 1998, p. 936) and on the impact of those remittances on sending-country life at the local level (Levitt, 1998, p. 929).

On the other hand, the broad well-being analysis of the notions of *quality of life, life satisfaction*, *subjective well-being,* and *happiness* (Diener, 1984, 2006; Gough and McGregor, 2007, pp. 25-33) omits the intermediaries, the 'enablers,' of international migration. Wright's (2010, p. 379) work, for example, focuses on 'barriers,' 'deeper losses' and 'obstacles' in her attempt to counterbalance the sole focus in the literature of remittances on the advantages of international migration via the developmental effect of economic and social transfers. *Barriers* here are linked to a mismatch in aspirations and achievements as if migration must necessarily result in 'a limited kind of happiness' (Wright, 2010, p. 375). With barriers, Wright (2010, p. 380) points to, for example, the migration policy of a host country in which the conditions necessary for immigrants to achieve their well-being across material and psychosocial domains were not created. The structural constraints are obstacles migrants face in achieving their goals and meeting their needs.

In contrast, Giddens (1984, p. 25) advised that 'structure is not to be equated with constraint' as it always works as both constraining and enabling. He underlines 'the duality of structure' as being grounded in rules and resources recursively involved in institutions and (re)produced in social interaction just as individuals' actions. My understanding of such a duality is that the structural constraints that apply to some may turn into structural affordance for others and offer favourable living conditions or an idea of a 'better life.' I discuss the tension that arises when considering how state structures and processes control migration: on the one hand, the UK state's policies and visa regimes (the so-called structures) create a desire and make prospective workers believe they can go through visa processes and apply for certain jobs in the UK. The immigrants labelled 'skilled' or 'highly skilled' are encouraged and legally allowed to fulfil these desires. Furthermore, structures enable physical travel from one place to another, but on the other hand, they come with various constraints, limitations, and controls around the 'unskilled,' 'low-skilled' or 'lesser-skilled' migrants. So, the desires are structurally constrained and produced, and discrimination occurs between those eligible and able to apply for a job in the UK and those who were initially convinced that they were not qualified for such an application and should give up.

Migrants cannot act consistently 'meaningfully' (Wright, 2012, p. 2) or rationally and pursue their goals, as a host state would expect. Choices or migration decisions are neither that *simplistic* nor *ambitious*. Movements are not always induced by significant social changes, political turmoil or natural disasters (Lee et al., 2017, p. 227). As Karen O'Reilly

states, albeit writing about a different context[4], those broad-scale changes should be 'negotiated in the context of the agents' own internal structures, habits, desires, needs, goals, and the habits, expectations, norms, rules, and practices of the agents in their communities' (O'Reilly, 2012, p. 10). This offers a perspective on how the idea of a 'better life' will likely change across different social and cultural contexts (De Haas, 2021, p. 15) and makes us think about what life is like in the UK and what is special (or not) about it. What, then, is a 'better life' in the 21st century and the North West of England?

Moreover, 'well-being' analysis tends to see the problems of 'misery' or 'unhappiness' in purely psychological terms outside of its social and developmental context (Davies, 2015, pp. 140, 236, 240). Wright (2012, p. 12), for instance, asserts that it is not vital in the final analysis whether migrants report if they are happy or not in a hedonistic sense, but whether the person is psychologically well or healthy. Nevertheless, 'happiness' is not only a psychological state but at least as much a sociological concept as 'well-being.' More broadly, well-being is a crucial aspect of the search for a 'better life,' with happiness in every aspect and every moment of life being a key indicator.

'Happiness' circulates globally and nationally, says Fortier (2021a). In her recent book, drawing on Ahmed (2010), she notes that people migrate in pursuit of happiness, but that pursuit cannot be dissociated from the global context where some countries are said to promise happiness more than others. In turn, the onus is on migrants who are expected to be happy and to transmit that happiness to their children (Fortier, 2021a, p. 180). Likewise, I see 'happiness' through this lens and add that it is something both influenced by factors created by social and political structures and constructed by immigrants themselves through and in their narratives. What happiness, well-being or a 'better life' means for immigrants and how they are informally spread among migrants is as relevant as politicians' promotion of such concepts. In Chapter 5, I offer a gender critique of the concept of happiness. In the research, I also question the 'macro structures' and exchange them, such as 'nation-states,' with more specific ones like 'safety issues' relying on the research material (see 'In Search of Safety: Socio-Political Factors' in Chapter 5).

[4] 'Lifestyle migration' was introduced by O'Reilly (2012, pp. 48-60). This label is not helpful for this thesis as it is limited to 'the migration of affluent, elite, privileged or leisured individuals' (O'Reilly, 2012, pp. 9-10), or the migration of modern humans who are in despair over fulfilling life goals in agrarian lands and search for better opportunities in cities (De Haas, 2021, p. 26).

Finally, ‘from the perspective of the migrant, the promise of the good life and happiness is not always fulfilled’ (Fortier, 2021a, p. 164). There is no linear relationship between achieving goals or meeting needs in real life and life satisfaction or happiness, as suggested in the analysis of migration and development (Wright, 2010, p. 379). A satisfying quality of life is not something that all migrants can enjoy equally or is not a direct result of migration. Fortier (2021a) used ‘citizenship’ as an example of the (re)production of inequalities for immigrants in the UK that distinguishes these ‘foreigners’ as ‘potential future citizens’ or ‘unfit for citizenship.’ Hence, I fully agree with Fortier (2021a) that citizenship is a source/object of the desire fostered by state structures and practices, and there is a promise of happiness attached to citizenships from the Global North. However, that promise is conditional on the migrants proving their good citizenship potential and fulfilling their duty to enjoy the ‘better life’ that comes with it. While conceptualising a ‘better life,’ one should neither reduce it to (limited) happiness nor think of emotions such as ‘anger,’ ‘unhappiness’, or ‘disappointment’ as independent from social dynamics, structures and relations (Fortier, 2021a, p. 200). The concept of well-being could be better integrated into migration studies by drawing on such critiques of ‘happiness.’ In this thesis, I combine the two bodies of literature on ‘migration’ and ‘happiness’ and conceptualise migration for a ‘better life’ at the intersection of these two.

In a nutshell, while early push-pull models in conventional migration theories examined the *motivations and expectations* of migrants, they overlooked their social relations and interactions. They limited those motivations to economic costs and gains. Beyond solely conceptualising immigrants’ ‘better lives,’ this research problematises the mainstream usage of the concept of ‘better lives’ and takes a critical perspective against it. It looks at the multiple facets and meanings of such a concept and contributes to the theories of migration by demonstrating how gender issues matter in search of a ‘better life’ (see Chapter 5).

Thus far, it has been summarised how ‘better life’ migration theory has drawn insights from well-being discussions. However, rather than taking these theories' emphasis on the individualistic pursuits and financial worries of migrants for granted in this thesis, I shed light on their needs as members of the receiving country's society. In this regard, I think of my participants as individuals who interact with their families, children, friends, patients, employers, and neighbours daily, try to meet complex social and professional

expectations, and expect their complex expectations to be met (see the third section, 'Unsettling the Concept of Settlement').

3.2 Healthcare Work Migration

While reviewing the literature on immigration to the UK to work in healthcare jobs, I start from the domestic and care work migration literature in this section. There are two main reasons why I do this. First, if healthcare worker migration had been taken as the starting point in this section, considerable historical progress in the migration literature would have been ignored. The theory of migration for care employment was primarily developed using the theory of migration for domestic work. An ideal outcome I aim to achieve theoretically in this thesis is to contribute to the literature on workers migrating for healthcare professions by examining their journeys through the lens of care literature. Second, the existing literature portrays migration for employment in the (social) care sector or healthcare sector as different from domestic work, relying primarily on a simplistic division of skills and whether work is done in private/public spheres, which I problematise in this thesis. I discuss how the 'sphere' in which immigrant women work has become the primary determinant of the value attributed to labour in the literature. In short, this section is informed by domestic work migration literature to help us understand the experiences of professional migrants. In the following subsection, I question the mainstream conceptualisation of 'skill' and the differentiation in theorising domestic and healthcare work migrants' lives or migration.

3.2.1 Similarities of Domestic and Care Work

This subsection illustrates that domestic and care work are similar in terms of value, the skills involved in both sectors and the value of care. The section discusses the concepts of domestic work and care work together and underlines the close and transitive job roles in domestic work, domestic care work, and care work, such as a domestic worker performing both household tasks and elderly care duties, a home carer carrying out medical and personal care responsibilities alongside their caregiving tasks, and domestic workers in healthcare settings managing both cleaning and patient care duties. These roles also demonstrate how intertwined the domestic, care and healthcare sectors are. I discuss the overlaps between domestic and (health) care work sectors to motivate my choice of participants in this research from both sectors. Moreover, I critique the tendency in existing literature to treat the two sectors as distinct, which means the experiences of working women who have similar experiences in these sectors are overlooked.

Kofman (2013, 2014) finds that while many studies focus on global labour migration, the focus, however, in the current literature is around the domestic/care worker figure, more skilled care occupations remain largely invisible in today's academic migration research. Although much of this attention has been devoted to the employment of migrant women in domestic and care work, which are highly feminised[5] and *lesser-skilled* reproductive sectors (Zimmerman et al., 2006; Lutz, 2008; Kilkey et al., 2010), international migration, particularly in healthcare workers' brain drain has become a key policy concern regarding migration and development at both global and national levels (Kofman, 2014; Piper, 2017). Piper (2009, p. 20) explains that *skilled* women globally tend to enter occupations that can be broadly classified as welfare and social professions (education, health, social work), that is, jobs that have traditionally been relegated to the woman workforce. Eleonore Kofman (2000) criticises the blindness of feminist research regarding the presence of women immigrants in these sectors. She argues that the preference in mainstream migration literature is problematic towards leaving *skilled* migration to men's domination and, beyond that, rendering women invisible.

Although the above criticism of the migration literature constitutes the theoretical starting point of this thesis, I find the term *skilled* (which I type every time in italics for emphasis) here problematic and discuss what can be a suitable replacement for it in this thesis. My theoretical point of view aligns closely with the observation in this review that women in professions considered more qualified are the subject of less research in the literature. However, as I will show and demonstrate in the chapter, in a small number of studies, feminised roles, especially in the health sector, are treated as if they are very different jobs from domestic and care work and are theorised separately from them.

Before situating this thesis in the broader care work migration context, this subsection gives some background on why and how I conceive the concepts of domestic and care labour as comparable in terms of their reproductive nature and connection to the context of migration. As some of my participants testified, the core skills, work roles, and tasks of a domestic care worker providing home care services do not differ significantly from those of a care worker in the public sector. The boundaries of home-workplace and private-public areas where domestic work and care work are generally performed are blurrier than in NHS definitions (for a broader discussion of the extent to which care work

[5] 'Feminisation' implies a high rate of women's participation in the insecure, low-paid and irregular workforce compared to the type of employment traditionally associated with men (regular, union, stable, manual or craft-based, etc.) (Ehrenreich & Hochschild, 2004, p. 5).

officially counts as public/health work, see Chapter 6).[6] This distinction also appears in social and healthcare, as mentioned in Chapter 6. Although the public-private classification seems to have arisen spontaneously to be used by state institutions to determine the official categorisation of work and wages, it devalues all home care work and those who perform it. What emerged from the interviews was that, in practice, workplace situations often do not conform to the formal NHS job descriptions. My participants perceive that the (health)care tasks they perform and the responsibilities in the NHS or at home, such as giving injections or administering medication, are similar. Finally, with the mobility of migrant domestic care workers across transnational borders, households, the private sector, and governments, as institutions that employ them, keep migrant women's bodies under control (Spitzer et al., 2023, p. 2) (see Chapter 6).

More critically, both in a work institution or at home, care and domestic work are reproductive labour; it is the labour mostly provided by participant women, necessary for the maintenance and reproduction of life, that has historically and traditionally been unpaid or paid less than other types of work.[7] Reproductive labour includes a woman's everyday activities that prepare herself, her husband, and her children for daily life, such as cooking, keeping the house clean, or washing clothes.[8]

Domestic and care work are highly physical, emotional and cognitive[9] labour intensive (Hochschild, 1979; Boris and Parrenas, 2010; Duffy, 2011; Twigg, 2000; Daminger, 2019; Haupt and Gelbgiser, 2024). Wolkowitz (2006, p. 61) sees such labour-intensive work as repetitive 'light' manual labour, relying on migrants working insecure and

[6] My view here echoes the 'work-family balance' (Hochschild, 2001) referring to an integrative relationship between work and family. Unlike other key work-family constructs underlining the directional causal interdependencies between work and family roles, such as work-family conflict and work-family enrichment, the work-family balance has been associated with the combination of these roles (Allen and French, 2022; Greenhaus and Allen, 2011).

[7] 'Reproductive labor refers to the labor needed to sustain the productive labor force' (Parrenas, 2001a, p. 61). Such work 'includes activities such as purchasing household goods, preparing and serving food, laundering and repairing clothing, maintaining furnishing and appliances, socializing children, providing care and emotional support for adults, and maintaining kin and community ties.' (Glenn, 1992, p. 1)

[8] Women's reproductive work, which was invisible in migration literature until the 90s, and the economic and public value of work have long had an important place in feminist literature, especially domestic work. The labour migration literature did not recognise the home as a workplace and did not count the labour here as work. For this reason, in early migration studies, the subject of studies was not the immigrants who took on domestic care work, but rather the migration of *skilled* workers. Focusing on commonalities in women's experience rather than contrasts in professional hierarchy, this thesis demonstrates that immigrant women in all roles in the care sector are subject to similar systems of entry and employment. Although some health roles are classified with higher status and wages than care work, they still involve reproductive labour.

[9] Daminger (2019, p. 609) characterises cognitive labour in household work as gendered, with women performing tasks such as predicting needs, finding solutions for meeting them, making choices, and tracking advancement, in greater proportions. Haupt and Gelbgiser (2024, p. 830) suggest that women suffer family-work conflict from the unequal distribution of cognitive labour, while men do not.

without contracts in low-wage sectors of the economy. This includes light manufacturing in the clothing industry, food processing, agricultural work, cleaning and care work. These roles, often taken by immigrants and other racial groups who are relatively invisible in the economy, are organised around fragmented, repetitive tasks and performed under close supervision. Marchetti (2022, p. 14) adds that this type of body-to-body work is different from work done by machines and even from tasks that do not involve direct physical contact, despite the involvement of humans. Therefore, these jobs require physical strength, attention, emotional sensitivity and endurance, thus putting workers at risk physically and psychologically. Some of the participants in this research have made a similar effort in both the domestic and healthcare sectors. For example, see Didi's and Klaudia's narratives in Chapter 6.

The migration and training paths of immigrant women employed in the domestic and healthcare sectors intersect. Bourgeault et al. (2023, p. 2) describe that (Figure 3.1) when health and care workers leave their source country, they follow a migration path that includes first a transit country where they can gain experience by working or training and then a destination country where they will ultimately settle and work. Nevertheless, this route also may change or work in reverse. Some of the participants in this research had worked in Egypt, the United States of America (USA), Canada, Italy and Germany before coming to the UK. Moreover, some participants felt that the UK might not be the final destination on migration routes and may be a transit country before moving to, for example, Australia (see Chapter 5).

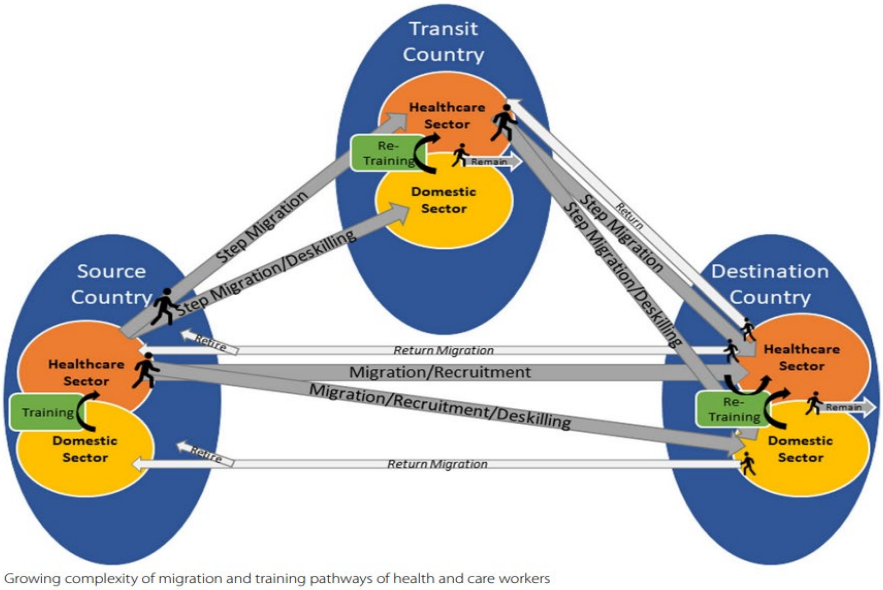


Fig. 1 Growing complexity of migration and training pathways of health and care workers

Figure 3.1 (Bourgeault et al., 2023, p. 2)

Migrant women from healthcare and domestic sectors replace each other's jobs and fill their roles through migration (see Chapter 6 for a fuller explanation of 'task-shifting/task-sharing'). Trained migrants may become deskilled and work in domestic roles, or those deemed unskilled may be trained and start working in the health sector (Bourgeault et al., 2023). 'Career trajectories can intersect with the opportunities and barriers presented by migration' (Bourgeault et al., 2023, p. 3), as I suggest in this research, depending on the receiving country's policies in many areas such as visas, job placement, health, etc. For these reasons, I conducted this research with women migrant care workers in both private and public spheres. My theoretical approach thus seeks to eliminate the divisive attitude against women's labour in the migration and care literature.

Eventually, there is a tension in how care work is conceptualised. On the one hand, there is recognition that certain levels of education and skill acquisition are necessary for providing care. Care workers develop expertise through experience, training, and practical knowledge. On the other hand, many forms of care work, particularly those performed by so-called low-skilled workers, are often perceived as requiring no specialised skills. This contradiction stems from the societal tendency to view care as an innate or instinctive ability rather than a learned profession. As Kofman (2013) argues, care work is associated with embodied knowledge and skills: deeply gendered and often dismissed as something that does not require formal education or structured training. She provides this perspective evident in separating care work from broader discussions on migration and skilled labour, reinforcing the marginalisation of care workers. Recognising the embodied skills and knowledge involved in care work is crucial to challenging the simplistic classifications and highlighting the complexities of care labour.

Kofman (2013, p. 584) argues that care work is devalued as 'embodied knowledge,' as it is perceived to be learned through 'physical presence, practical thinking, material objects, sensory information, and learning by doing' rather than formal education. Such characterisation often isolates workers in their work, employed informally or irregularly, and ultimately classified as low-status and unskilled labour. In contrast, medical/healthcare professions are seen as requiring formal training and are therefore placed outside this framework. However, my empirical findings suggest that this distinction is not always clear-cut. One of my participants, by simply wearing an identification badge, was able to identify as a 'medic' and perform certain medical procedures in a care home (see the subsection, 'Medical Roles: From Clinicians/Non-clinicians to Medics/Non-medics', in Chapter 6). This example highlights the

performative nature of medical work, suggesting that professional status is socially constructed and institutionally validated. While Kofman's (2013) analysis explains the systematic devaluation of care work, my findings indicate that medical professions also contain performative elements, challenging rigid distinctions between skilled and unskilled labour.

To summarise, I have presented the strong connections between domestic labour and healthcare labour in the context of migration. Some of my participants who migrated to the UK to be employed in the healthcare sector had previously worked in domestic jobs in their home countries, some were employed in homes before working in the healthcare sector when they arrived in the UK, and some are working in jobs similar to the definition of domestic labour in the healthcare sector. Migration often entails labour transition, especially in two sectors similar regarding job description and type of labour. Women in both sectors value themselves and are valued according to the division of roles into skilled and unskilled and the wages they earn, and portray a good life accordingly. I argue that domestic and care work should meet on common ground in migration studies. That would strengthen the need to treat the roles academically claimed to require more skills and pay higher wages in the health sector in the same way as care work, which is considered at the bottom of the health sector and the least paid. Only such a theoretical and conceptual perspective made it possible to understand the participants' experiences in the thesis.

In what follows, I present how theories explaining the mobility of women migrating for employment in the health and care sector have evolved, engaged with other bodies of literature, and developed into their current form.

3.2.2 Healthcare Work in the Migration Context

In a social and political context, I draw the theoretical framework of my research through the critiques of the European and North American perspectives on gendered international migration. Kofman (2014, p. 128) stated that, rather than promising that the caring labour is transferred between transnationally distant households by the market, the state's role in producing supply and demand must be considered (Kofman, 2014, p. 128). Under some selective policies, labour demand is formed by immigration regulations, so a complex race, gender and class stratification system emerges.[10]

[10] In the countries of global competition, as in Canada where care work generally does not qualify as skilled work, and the skilled are welcome as migrants who have the possibility of acquiring citizenship, care work was deskilled by the Live-in Caregiver scheme (Stasiulis and Bakan, 2003). Similarly, in Europe, except

Parvati Raghuram (2008, p. 86) confirms that *skilled* migration is governed, yet the state regulation on this type of migration rarely appears in migration narratives. I seek to fill this gap in the literature and take Kofman's and Raghuram's insights a step further in this research, revealing nuances in how women in different healthcare job roles, including care work, are exposed to the UK's immigrant entry and settlement systems. Above all, I identify that participants' entry into health work in the UK involves complex migration and work regulations determined by the state and different institutions such as other public, private, semi-private, and local authorities (see Chapters 2 and 6). Although the skills of domestic and healthcare workers in care work are similar, the migration regime plays a significant role in stratifying the value of labour. The qualifications expected from women determine their value not only as workers but also as immigrants, citizens, women, and even individuals. The women may or may not experience happiness based on this value.

Drawing on the literature above, early feminist studies until the 90s mostly endeavoured to include women in migration studies and to grant them 'a recognised presence' (Morokvasic, 1983, p.18) because migrant women in pre-1970s had been neglected by economic theory on migration research, omitted as productive actors of family and active migrants, and preserved as mothers and wives (Zlotnik, 1995, p. 254; Phizacklea and Miles, 1980; Phizacklea, 1983). The woman worker image was limited to one working in paid industrial or agricultural sector jobs. Ecevit (2011, p. 25) indicates two reasons for this narrow perspective on women's labour: firstly, the countries where women's labour was most researched were the most industrialised, Western countries, and in these countries, both the scholars and the public's perception of work was mainly focused on industrial, paid jobs. Secondly, there was a strong 'family ideology' whereby women needed to do family-oriented work such as homemaking, providing household services and childcare. The 'family' idea ties in with 'a woman's happiness,' which I turn to in Chapter 5. According to this ideology, the work done by women at home was not 'work' but rather a part of being a woman, voluntarily made with a sense of responsibility and love. Rees (1992, pp. 8-9) defined this 'family ideology' as a universal ideal

for Italy and Spain, domestic work was not recognised enough to offer work permits. In their article, Cuban and Stromquist (2009) also, over the example of the Adult Basic Education (ABE) system, tracked the migration management system in the US that subjected women immigrants to the lack of knowledge of social rights or access to them, and that deprived the women of social citizenship.

supported by states in the context of welfare strategies and other provisions, and it shapes both the supply of and the demand for labour.[11]

In 1972, the proposal of housework as an economically productive workplace by Maria Rosa Dallacosta and Selma James was a breakthrough in the literature concerning the comprehension of the value of women's work (Ehrenreich, 2004, p. 86-87). For the first time, the market value of housework − as something for which wages can be demanded − was paid attention. The exploration of unpaid reproductive labour by Marxist feminists[12] (Benston, 1969; Morton, 1970) helped to make visible what is hidden in the paid labour of domestic woman workers, such as 'indoor' racism, defined as the nature of their work in private. 'Unlike factory workers, who congregate in large numbers, or taxi drivers, who are visible on the street, nannies and maids are often hidden away, one or two at a time, behind closed doors in private homes.' (Ehrenreich and Hochschild, 2004, pp. 3-4)

The analysis of unpaid reproductive labour paved the way for the circulation of care labour on a global stage; in her article, where she coined the term 'feminisation of wage labour,' Sassen-Koob (1984) called attention to the systemic relationship between globalisation and the incorporation of the Third World women into waged employment by criticising the typical focus in the studies up to that date on migrant women's family situation and responsibilities. She mentioned certain areas of labour that are characterised by the migration of men in 'modern' sectors and those where women's empowerment is often difficult, such as domestic service and informal occupations.[13] Subsequently, Castles and Miller (1993) further developed the concept of 'feminisation of migration.' The core component of their conceptualisation was similar to Sassen-Koob's. Asian women migrating to Europe, the Middle East and Japan were employed in typically

[11] I address the Eurocentric reconceptualisations of 'family and motherhood myths' elsewhere (Dagdelen, 2018).

[12] Starting from the 1960s and early 1970s, the criticisms offered by feminists that empirical studies conducted by economists and sociologists were androcentric and only reflected men's experience. These critiques targeted the omission of women from the Marxist (Engels 1884; Marx 1867) class analysis (Rees, 1992, p. 12). Meanwhile, academic efforts were observed to include gender in the labour migration analysis. Early structuralist accounts, such as neo-classical theories (Todaro, 1969, 1976), which described the migration decision only as a rational and individualistic issue as a result of push-pull factors, and counter theories, such as Marxist political economy, dependency theory and world systems theory, were criticised as being reductionist and unaware of non-economic factors influencing woman emigration (Kofman et al., 2000, pp. 22-23).

[13] This, of course, does not mean that worker men were necessarily empowered in these capital-intensive sectors, but, what she intended to emphasise was the absence of opportunities for women migrants to be employed in the 'modern' sectors and their prevalence in—traditional, non-modern, labour-intensive—domestic service and in informal activities due to their double disadvantage of sex and class.

woman's jobs: ‘these jobs generally offer poor pay, conditions and status, and are associated with patriarchal stereotypes of female docility, obedience and willingness to give personal service’ (Castles et al., 2014, p. 154).

At the end of the 1990s, the decentring of the nation-state in global capitalism and ‘recent transformations in the global economy from socialist and welfare state models to neoliberal capitalist models centred on the private sector’ (Keough, 2015, p. 6) were followed by the discussion on migration and care in the literature within the scope of the globalisation and transnationalism concepts (Constable, 2007; Koser and Lutz, 1998; Momsen, 1999; Anderson, 2000; Chang, 2000; Kofman et al., 2000; Parrenas, 2001a; Lan, 2003; Ehrenreich and Hochschild, 2004; Hondagneu-Sotelo, 2007; Lutz, 2008; Vertovec, 2009). The studies concentrated on the decision-making processes of migrants and their social networks producing transnational links (Hondagneu-Sotelo, 1994; Grasmuck and Pessar, 1991; Pessar and Mahler, 2001; Schiller et al., 1992). Migration was no longer concerned only with the sending and receiving countries but was also a phenomenon preoccupying and implicating individuals and agencies.

Transnationalism was one of the main integrative migration approaches of the period, explaining these complex relations in migration. Immigrants have been understood to be transmigrants when they develop and maintain multiple relations − familial, economic, social, organisational, religious, and political − that span borders (Schiller et al., 1992, p. ix). From this point of view, migration was discussed in terms of whether it is an opportunity for women to escape from discrimination and a reason for the transgression of the sex roles in the household in this way (Kofman et al., 2000, p. 22). Parrenas (2001b, p. 1134), in her analysis, revealed the shared partial citizenship experience of Filipino women migrants and the denial of their reproductive rights in the receiving countries. According to her, in various destinations of the diaspora, women were not protected by labour laws, and they were left vulnerable to the exploitation of employers, including sexual harassment and abuse, excessive work hours with no overtime pay, and substandard living conditions. Briefly, Parrenas (2009, p. 5) foregrounded the stories of these migrant women starting with the transnational transfer of gender constraints as the result of the transnational economy, such as the women who migrate from one system of gender inequality to another.

For the period from the 2000s, Arlie Hochschild's (2000, p.131) ‘global care chain’ concept referring to the ‘personal links between people across the globe based on the paid

or unpaid work of caring' attracted scholarly attention.[14] This concept was mainly applied to just one group of migrant care workers, the Filipino domestic workers, which was the poster case in the literature (Yeates, 2004), and it 'emerged largely from relatively small in-depth qualitative research projects' (Williams, 2010, p. 393). More recently, the issue of deskilling has begun to be discussed because of the cases in which well-educated immigrant women were hired in low-skilled jobs, such as the teachers turned into domestic workers or professionals who became care assistants in the UK (Piper, 2007, 2008; Cuban, 2013). What makes the 'global care chain' concept still remarkable has been its impact on the recent theoretical understanding of the connection of migrant women with their care and of the transition from global care chains to the global care industry (Cuban, 2013, p.10). Nevertheless, an embedded critical international political economy perspective was missing from that; 'the social field of transnational labor migration is not only economic but also gendered, and controversies over migrant women are structured both by economic shifts and by changing views on the place of women in the economy' (Keough, 2015, p. 8).

To address this, the theory of the new economics of labour migration influenced the migration framework by expanding its primary focus from domestic workers to encompass care workers more broadly (Kofman, 2014, p. 127; Kofman and Raghuram, 2010; Lyon and Glucksmann, 2008). Fiona Williams (2011) proposed a theoretical account of a transnational political economy of care by critiquing the only focus of the global care chains on micro-processes. She studied the transnational movement of care labour and national and supranational states' meso and macro-level political, economic, and social relationships. In this theoretical framework, she defined the situation of a migrant worker differently from the typical one in home-based domestic and care work: a migrant in the transnational connections within regions of the global North and South.[15]

This is where I form my theoretical perspective in this thesis and aim to contribute to the literature. Eleonore Kofman (2014) appreciated the progress above to include the situation of care workers in the literature but, thereby giving inspiration for my research, she detected that there was a missing piece in the transnational political economy of care:

[14] This chain tells the story of a migrant woman caring for other women's children in a rich country, her older daughter caring for her siblings in their poor country of origin, and those children left behind by that migrant mother (Parrenas, 2005, p. 9).

[15] As an example, 'domestic workers from Malaysia go to Indonesia while Indonesian women find work in Singapore and in Saudi Arabia which also provides work for women from the Philippines and Sri Lanka' (Williams, 2011, p. 5).

the role of the state, and its entry and settlement regulations for migrants. The UK enables the entry of the 'skilled' into the country and manages immigration, especially to the cities of NWE. My approach recognises the state's role in shaping demand for migrant labour, but not only from an economic perspective. Instead, I emphasise how this demand interacts with political, social, and regulatory elements, such as immigration policy, labour market division, and the state's impact on societal perceptions of labour value. This approach enables me to reframe push-pull factors as part of a broader framework that considers how social and regulatory contexts intersect with economic needs. So, rather than rejecting 'push-pull' entirely, I critique the model's narrow scope and then offer a nuanced view challenging its binary nature. I move the analysis into an arena that reflects the complexity of migrant workers' experiences (see Chapters 6 and 7).

Examining the gendered nature of international migration by including women's migration into (health)care professions in the literature requires an ultimate focus on migration governance because immigration regulations act as a filter encouraging certain kinds of migrants. More clearly, immigration regulations allow the selective filtering of these migrant workers to meet labour market demands: 'Migration routes would be fine-tuned to the needs of capitalism' (Kundnani, 2007, p. 143). Today, against a hierarchy of stratified statuses, immigration policies increasingly reflect the calibration of desirable knowledge, human capital, and skills (Kofman, 2013, p. 580). In the recruitment process of immigrant workers, in addition to the professional or academic abilities, soft skills and characteristics (Mezzadra and Neilson, 2013, p. 106), such as language (Spencer et al., 2010, pp. 35-36), culture and religion, also play an important role as the indicators of their level of integration capacity.[16] Chapter 7 discusses the aspect of language in more detail. For immigrants, the English language has become more than a professional qualification—a criterion that can make them feel that they are settled and good individuals who have a good life in the country they immigrate to.

[16] In this connection, Mezzadra and Neilson (2013) bring the existing point-system migration schemes of receiving countries to notice: '(…) although these schemes place emphasis on educational qualifications and labor skills for migration selection, they also control many other qualities and attributes that promise to facilitate the migrant's productive integration into the social fabric: linguistic abilities, family connections, health, age, religion, monetary wealth, and even (by means of recently introduced citizenship tests in some countries) familiarity with national culture and values. Prospective migrants provide details of their statuses and accomplishments in each of these fields and are awarded points on a sliding scale that is subject to change with shifts in labor market needs, the number of applicants with similar attributes, and so on. Those who pass a certain threshold are accepted for immigration. For the most-skilled and qualified applicants, there are additional incentives, including fast tracks to permanent residence and sometimes eventually citizenship.' (Mezzadra and Neilson, 2013, p. 139)

In this regard, the state collaborates with other institutions, such as recruitment agencies and professional organisations, mediating immigration regulations, labour markets, and migrants. Given the changing border and migration regimes, 'national borders are no longer the only or necessarily the most relevant ones for dividing and restricting labor mobilities.' On the other hand, 'the nation-state still provides an important political reference from the point of view of power configurations and their articulation with capital-labor relations' (Mezzadra and Neilson, 2013, p. 2).[17] With a similar approach to border regimes (Atac et al., 2017), as the active enabler partner to the market, the 'market-state' provides a control mechanism on immigration whereby borders are used not to prevent the entry of all potential migrants but rather to enable the flow of whatever 'human capital' each sector needs, and to keep the 'unwanted'[18] out (Kundnani, 2007, p. 143). Per the construction of stratifying systems within an overall framework of managed migration (Morris, 2002), the state positions itself both in national imaginaries[19] and global narratives and copes with sophisticated and often contradictory demands between different economic, social, and political interests (Kofman and Raghuram, 2015). That is to say, it is supposed to govern both global capitalism and market forces, as well as nationalist politics.

Finally, looking at the implications of governing the mobility of skills for individuals' lived experiences reflects the changes in the mode of selection and incorporation of skilled migrants (Raghuram, 2008), and it gives a clear hint at 'the state-citizen relationship' (Fortier, 2016) and the modifications of the 'policing the terms of belonging and entitlement to citizenry' (Fortier, 2005, p. 559). The skilled are not only being offered rights to enter but also to stay and develop 'permanent' links with the receiving country. These links are to be cemented by strong territorial identification and a public allegiance

[17] Mezzadra and Neilson's (2013, p. 7) argument takes a critical approach to inclusion, which in most accounts is treated as an unalloyed *social good*, and they see inclusion existing in a continuum with exclusion, rather than in opposition to it. They note that borders, which are equally devices of inclusion, select and filter people and different forms of circulation in ways no less violent than those deployed in exclusionary measures.

[18] 'Britain's borders were no longer directed at an absolute sealing off of its labour market from other countries. Instead, they were meant to filter out the wanted migrants from the unwanted, the temporary from the permanent and the privileged from the unprivileged and maintain, where necessary, the condition of deportability that allowed for migrant workers to be differentiated from non-migrant workers. The managed migration system thus required a large-scale expansion of the state's powers for managing and policing migrant populations.' (Kundnani, 2007, p. 149)

[19] According to Raghuram (2008) Britain, the nation in which skills are a major passport to mobility, affecting both entry and conditions of settlement and the point of governance is increasingly moving towards an assimilationist model, imagines 'unthreatening' migrants and reserves assimilation for them and for those who offer economic advantage.

to the receiving state, with citizenship ceremonies marking the rites of passage from one territorially based national identity to another (Raghuram, 2008). From this standpoint, this research demonstrates that the dyadic figure in the interaction between citizenship and labour, citizen-worker, emerges as the identity an immigrant seeks, with political and economic implications (see, for example, Lila's narrative in Chapter 5).

As a result, as the section indicated, the thesis contributes to the 'Healthcare Work Migration' literature by exploring the commonality between domestic and care work and the importance of how migrants' entry into those sectors is managed. Compared to the numerous studies concentrating on domestic workers, the theory of the migration of care workers to the UK is relatively new to migration studies and is scarce. This study attempts to close this gap by concentrating on healthcare workers' migration in a particular setting. Additionally, a classification between women working in domestic and care sectors is created in the theorisation of the migration of healthcare workers, emphasising how different their labour is from that of domestic workers from a skills aspect. This study shows how problematic this classification is by demonstrating the similarities of the work performed in these two sectors. It makes the case that the migration theories to the two sectors may support one another. While foregrounding the similarities between those two sectors, the key points that have been drawn upon to differentiate those two in the literature are also problematised through evidence. The ultimate purpose was to relate those explorations to analysing participants' 'better life' experiences in the thesis. Lastly, I argued that the skills ascribed to immigrants, when recruited, influence their professional identity and their experience of being immigrants in this country. Based on these skills, in addition to determining the value of the work done by women, an evaluation is also made to decide whether or not they can be individuals who can integrate into the country and even obtain citizenship.

3.3 Unsettling the Concept of Settlement

In this last section, I propose a new understanding of the concept of settlement. I question the governance justifications that support the current ideas of integration or settlement, which prioritise the legal status and prospective citizenship of migrants. The literature reviewed in this study (Favell, 2019, 2022; Schinkel, 2013, 2017, 2018; Christou and Kofman, 2022; Grzymala-Kazlowska, 2016, 2018a, 2018b, 2020; Grzymala-Kazlowska and Phillimore, 2018) suggests that the 'successful' settlement and subsequent integration of an immigrant is valued by state ideology (Kontos, 2014; Boese et al., 2020)

with residence rights being granted in the host country as a result (Pajnik, 2014, p. 112). Everyday settling practices are surrounded by the political rhetoric of integration (Heckmann, 1992, 2006; Spencer and Charsley, 2016, 2021). However, 'settlement' as it is understood by the immigration regimes and by integrationist viewpoints in the literature pays scant attention to the emotional aspects. Participants' felt perceptions of a 'better life' can be understood as engaging with ideas of 'settlement', which may be further explored through concepts from the care literature, such as 'emotion work' and 'feeling rules' (Hochschild, 1979). By presenting insights into the interaction between subjective feelings and socioeconomic context—not just what migrants live through but also what they feel throughout their lives, I expand Hochschild's work on emotional labour into the context of migrants in this research.

In my research, to comprehend how they interpret what makes for a 'better life,' I invite my participants to self-evaluate their everyday lives and express how they feel about their lives as migrants. One of the main concepts that emerged as I coded their narratives was 'settlement.' In this sense, participants expressed whether they had a good life or not by whether they felt settled in the UK. In other words, to be happy with one's life as a migrant, one must feel 'settled.' While settlement is generally explained by legal status in a country or being granted citizenship of that country in migration theory, in this section, I define settlement in the context of the concept of better lives according to how participants make sense of their social life and work experiences, and migrant lives. In order to investigate the social aspect of settlement here, I will problematise it as a typical legal notion. In thinking about the 'good life,' I argue that settlement is both a short- and long-term prospect for immigrants; it is sometimes material and primarily temporal. While settling down means moving towards a 'better life' for them, it also means settling into their professional environment. Getting settled at work means feeling valued at work.

While arguing that the leading condition for a 'better life' and feeling settled is not always an entirely economic dimension, it should not be ignored that the participants achieved a feeling of settlement in an individual sense under some material conditions. In other words, saying that a 'better life' cannot be reduced to workplace and economic conditions does not mean that participants do not think and evaluate some material dimensions. On the contrary, this research reveals that economic expectations, with some professional and family influences, are practical in and after migration and determine the degree to which one feels settled (see Chapter 5). Moreover, settlement depends on where one lives, how much of a part of the society they become, and how long it will take to

settle. So, how was this concept discussed in the literature, and what does 'unsettling settlement' mean?

With a general definition, the settlement concept describes a place-based settling process that occurs in a finite time after arriving in a country. The concept includes key concerns for building newcomers' employment and family and place-based communities (Boese et al., 2020). In this section, I discuss two problems with framing settlement as a finite process. First, such a framing is based on the premise that the settlement will end at some point as if this end will occur with 'integration' into the local and national society. Second, it assumes that movements will end at the end of that settlement (Boese et al., 2020, p. 3278). However, it is not reasonable to expect that immigrants will necessarily feel fully settled at some point, regardless of their length of stay in the receiving country.

Moreover, some may intend to continue their mobility with plans to return to their country of origin or migrate to other countries. In fact, the sense of settlement acquired over time could be, for some reason, interrupted. For example, while not feeling really under a 'threat' of deportation with Brexit because they are the 'right kind of an immigrant': 'white'[20] and 'working for the NHS,' some participants expressed that they felt 'angry,' 'less welcomed,' 'emotionally unsettled,' 'rejected' and 'distant' after the EU referendum. These immigrants now wonder about their status and future in the UK as Europeans (see Chapter 7). In short, settlement and integration are not close-ended processes but contingent, conditional, and subject to reversal.

Settlement might be measured by its length and dimensions, especially how far it has been achieved from the perspective of immigrant integration (Boese et al., 2020, p. 3277). The thesis critically examines how 'successful immigration and immigrant' are idealised by state ideologies or problematises the idea that 'a good immigrant is the one who settles successfully and integrates.' The notion of 'integration' has been the subject of many debates and political interventions. For example, migrants in Western Europe who are 'unwilling to integrate' (Kontos, 2014) were targeted by securitisation and integration discourses. Similarly, migrants in Australia are directed to specific places through visas, relocation and dispersal strategies by the government, and they are attracted and retained in the non-metropolitan locations of the country (Boese et al., 2020).

Concomitantly, the settlement concept has been problematised in critical academic writing as it echoed state discourse (Favell, 2019, 2022; Schinkel, 2013, 2017, 2018;

[20] See Botterill and Burrell (2019), Fox et al. (2015), Samaluk (2014) and Varriale (2021) for a critical 'whiteness' lens.

Christou and Kofman, 2022),[21] especially in places like the UK and much of Europe where political and policy environments are becoming increasingly 'hostile' (Phillimore et al., 2024, p. 4947).[22] Grzymala-Kazlowska (2016) called static and specifically Eurocentric conceptions of adaptation and settlement into question, and she proposed the concept of 'social anchoring' (Grzymala-Kazlowska, 2018a, 2018b; Grzymala-Kazlowska and Phillimore, 2018). With this concept, she aimed to capture the processuality of immigrants' social connections and belongings in the countries where they settled. She defined the psychological mechanisms involved in settlement as coping strategies and the need for safety and stability. These mechanisms are multidimensional cognitive, spiritual and material anchors. In particular, the concept may vary as re-anchoring and un-anchoring and may appear simultaneously in different transnational settings (Grzymala-Kazlowska, 2020, p. 21). I revisit the concept of 'social anchoring' while explaining the situation of a participant as a migrant mother under the subsection of '*Emotion work* of mothering' in Chapter 7.

Following a similar social psychological approach to Grzymala-Kazlowska's, this research aims to deal with 'settlement' sociologically to purge it from the domination of bureaucratic definitions and political discourse. In this sense, I argue that the concept of settlement needs to be reconsidered in the context of how immigrants adapt to the mundane of daily life alongside fulfilling some bureaucratic requirements in a country to settle. Here, formal, legal, and institutional structures, such as laws and social norms, are intertwined with routine practices and experiences of banal everyday life (Staeheli et al., 2012). There is an intersection where a participant acquires the knowledge of the institution of work and the knowledge of the 'ordinariness' of life in the UK simultaneously. For these healthcare professional women, the NHS reflects the everyday practices and values of the society in this country. For example, contrary to a domestic environment where they speak mostly in their mother tongue with their families, the workplace is where the participants actually encounter the English language and British people. Here, the participants become acquainted with the social rules of this country through their British colleagues and patients (see 'Encountering the "British"' in Chapter 7).

[21] While Schinkel (2018, p. 4) notes that the notions of class and race were purified from integration and tries to add them in its conceptualisation, Christou and Kofman (2022, p. 95) endeavour to include gender and sexuality when conceptualising integration.
[22] See Phillimore et al. (2024) for more about 'the problems and potentials of integration scholarship'.

Fleshing out settlement sociologically entails reclaiming it from legal and political discourse. 'Settling' and even '(un)settling' emerge as emotional or psycho-sociological (Grzymala-Kazlowska, 2016) processes in the narratives of migrant women. Beyond, the sense of settlement experienced by participants is socially generated, intersubjective, and related to socioeconomic status. It is about 'arriving in a new country,' 'learning a new language,' 'trying to make friends' and so on. Alternatively, children go to school at some point, and parents meet other parents. So, the idea of settlement varies for each woman. Some participants told me in the interviews about how they try to adapt their family lives, family traditions, culture and religious practices to a hybrid style of life between a British one and that in the origin countries. Immigrants in this country do not understand settling necessarily as settling into the UK, but instead reaching whatever 'family equilibrium' on the transnational scale. The research aims to contribute to the literature on women's migration in the care sector by developing a critical account of the concepts of integration and settlement that emphasises their ambiguities and shows such richness and texture in the banality of daily life. In this manner, we must holistically evaluate the work, family, and social domains in 'better lives.'

3.4 Conclusion

This chapter situated this thesis in a broader context by relating migration for better lives, particularly in the context of women's migration for (health)care work. This thesis problematises an economic determinist approach that explains individuals' mobility and *motivations* through 'push-pull models,' emphasising the interrelationship of social and occupational lives and transnational connections in daily life. How my participants define a 'better life,' achieving it, feeling settled, and being a happy immigrant and employee is not so much about financial concerns but rather as an individual, a woman, and even a mother, both in social life and at work. The chapter revealed that these specific areas, which are less discussed in the literature, have become as politicised as areas where the influence of politicians, the state, and institutions can be directly seen, such as immigration, health, and citizenship policies. More importantly, this is not limited to the policies of the country they migrate to. Therefore, we need to consider the countries the women come from, the transition countries they have been to before, and even the expectations of the countries they want to immigrate next.

The thesis brings the state-imposed definitions and categorisation of 'skills' into question. When women's labour migration is the subject of research, evaluating labour by

‘skill’ cannot be a suitable analytical categorisation due to official job definitions that become complex, variable and flexible, especially regarding healthcare, which includes work done close to the person receiving care services. Moreover, labour shortages are caused by immigrants from states, private health institutions, and households. Workers are informally allocated to multiple roles, and authorities do not oversee their work. Just like in the case of ‘skills,’ the terms ‘qualification’ and ‘competency’ are also undermined. Finally, considering the disadvantages of the UK's immigration policies for workers, for example, not recognising the competence of those who qualify, preventing access to the language, not recognising original professions, not providing equal access to vocational training for all immigrants, and so on, we encounter a much more complex situation for the participants of this research. Therefore, selecting a mixed sample from the sector, regardless of status, fees, title, and qualification, to name a few, was necessary to see all this inconsistency, inequality and complexity. Therefore, this thesis contributes significantly to the literature through interviews with women from various roles in the healthcare sector who have migrated to the UK to have a ‘better life.’ The next chapter will explain the methodology used in this research, focusing on the methods chosen to collect and analyse the interview and visual material.

Chapter 4: Research and Methodological Design

The research question of this thesis is 'What implications does "migration for a better life" have for the employment, social lives, and migration narratives of immigrant health and social care workers in North West England?,' This chapter presents the research design I developed and the methods I used to answer this question. The chapter offers an overview of how I designed and implemented my research methodology: a detailed account of the methods employed to collect the interview and visual material, how participants were recruited, how interviews were conducted, and how data was analysed.

It should be noted here that this research was conducted in the context of the Covid-19 pandemic, and the pandemic impacted each phase of the research, the material collected, the data analysis and the results presented. As health and social care is the work environment most affected by the pandemic, recruiting the participants required more effort than it would have for many other professional groups. For example, participants were key workers in health sectors on the Covid-19 front lines. During the pandemic, they were overburdened with their work's psychological and physical demands, and our interviews often had to be postponed or rearranged. The reflections of some participants were also shaped by their day-to-day experiences; for example, they felt more isolated or anxious than they would otherwise feel.

I paid special attention to ethics in my research. Even before the pandemic, envisioning my research, I was mindful of how I should protect my participants from risks, prevent any discomforts or inconvenience at work, protect their anonymity,[1] respect their autonomy, and make sure that my queries would not distress participants about their relationships, reputation, and migrant status in the UK. What I needed to do was to be aware of the significance of their legal status in this country and be respectful of their sensitivity when they felt reluctant to tell me some of their experiences as immigrants. I tried to anticipate the impact of my approach on the participants, assessing what our encounter might mean for them, whether it would put them in uncomfortable or distressing situations, or whether it would be an undue burden on them. I adapted to the conditions of the participants, I gave them the space to engage and think about my project. This is where pilot interviews were helpful. These early conversations taught me how to

[1] For ethical and privacy reasons, the names of all participants in this study have been pseudonymised.

approach a participant. During these interviews, I gained experience in which format would be more appropriate to ask my questions and how I should introduce my project.

Lastly, I am conscious that conducting this research as a Turkish immigrant living in the UK may have influenced this research. Naturally, I interpreted my participants' stories by reflecting on my background. For example, to some extent, I shared similar migration experiences with my participants because I am a migrant woman living in the UK. However, I may have felt like an outsider to some of them because of my completely different educational background outside of health and social care or my Turkish cultural and linguistic background. To illustrate, during an interview with a participant from a healthcare background, I encountered difficulties in fully comprehending the professional terminology and specific challenges related to their work environment. My education in a different field required me to seek additional clarification to interpret their experiences accurately. Conversely, when engaging with another participant who discussed the emotional challenges of navigating the UK immigration system, I found myself able to relate on a personal level, having encountered similar difficulties. This shared experience facilitated a more open and candid discussion, allowing the participant to express complex emotions such as isolation and homesickness. These contrasting interactions, where I either aligned closely with or felt distanced from the participants, underscored the importance of maintaining reflexivity throughout the research process, acknowledging that my positionality could simultaneously enhance and constrain the depth of understanding of participants' narratives.

4.1 Key Concepts and Definitions

This study takes a distinctive local approach to understanding the global issue of care work migration. While the global has become the scale at which migration of health workers was conceptualised (Kofman, 2014, p. 129), I adopt a different socio-political perspective in this thesis with a specific regional context. The UK context, the migration destination of the participants, is a backdrop to explore the participant women's experiences. In this research, I rethink the global through my participants' lives, which are grounded in the local context. When recruiting women immigrants as participants for this research, I did not focus on any national or ethnic group that immigrated to the UK but deliberately sought a pool of participants from diverse backgrounds. The participant women are from Greece, Romania, Poland, Finland, Germany, Turkiye, the United Arab Emirates (the UAE), India, and the Philippines.

Conceptualising migration trajectories, I examine the experiences of the women who live and work in NWE. Participants' lived experiences offer insight into social issues and show that they seek better lives through migration, although the experiences of this group of women workers who migrated to the UK for care professions are mainly examined in terms of professional working environments and conditions in the migration literature (Cuban, 2013; Bornat et al., 2011; Lowell et al., 2004; Kofman and Raghuram, 2006; Kangasniemi et al., 2007; van Riemsdijk, 2013; Salami et al., 2016; Zuk et al., 2019). When asking participants to compare their current lives in the UK with their past lives before migration and in their transit countries, I highlight these immigrant women's work experiences and their social life experiences and social interactions because it would have been reductionist to assume life consists only of work experience. I ask what such a life means for women who want to build a good/better life by migrating for work, whether they could achieve this life, if so, how they achieved it, or if not, how they did not. The concept of a 'better life' was central to my research but evolved in a more nuanced way during the fieldwork process. While initial theoretical work focused on migration-related aspirations and occupational reasons, the participants' own narratives revealed deeper layers of meaning attached to the idea of 'better lives.' These included elements of settlement, emotional well-being, and family considerations, which were not fully articulated in the early stages of the research design. Through the interviews, it became evident that the notion of a 'better life' was both aspirational and dynamic, shaped by participants' lived experiences and their interactions with the immigration and healthcare systems in the UK and the wider society. For example, one participant's struggle to understand the Northern accent has an impact on how she perceives settlement and her 'better life' in the UK; that is, participants may end up acquiring the Northern inflection in speaking when they settle (see the subsection, 'Encountering the "British",' in Chapter 7).

4.2 Overarching Research Design

This study adopts a biographical approach to explore the migration experiences of transnational health and social care professional women in NWE. By listening to participants' personal migration stories[2], I aimed to understand critical aspects of their lives and experiences. To achieve this, I employed a 'critical events approach' (Webster and Mertova, 2007, pp. 71-88), focusing on the pivotal moments in their narratives that

[2] I use the terms 'narrative,' 'story,' 'history,' and 'experiences' interchangeably throughout the chapter.

marked significant transformations. As Webster and Mertova (2007, p. 72) explain, critical events serve as mechanisms for conveying the most consequential experiences. These events are associated with memorable moments that help participants recall and narrate their stories. This approach allowed me to understand their personal settings better while collecting extensive data. I mapped out chronological portraits that connect different phases or aspects of their stories related to their individual lives (Creswell, 2007, p. 215).

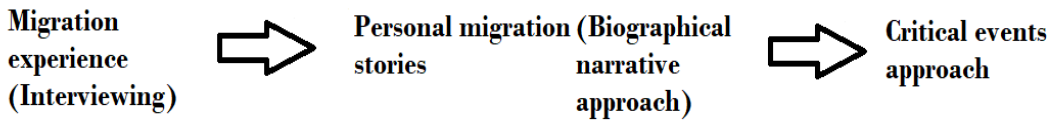


Figure 4.1 A Sequential Research Design

During the data analysis, I systematically coded the interview transcripts—which will be explained in detail in the data analysis section—to identify key milestones that participants highlighted as critical. These events were often educational, migratory, occupational, or personal, such as marriage, childbirth, or the death of a loved one. Drawing on Woods (1993, p. 356), I conceptualised critical events as emotionally charged moments with significant implications for personal change and development. Furthermore, this approach proved particularly effective in interpreting the visual materials participants created to represent their migration trajectories. These visuals underscored turning points in their journeys, helping to trace the spatial and temporal dimensions of their experiences. In this study, the term event refers to trajectory- or path-dependent phenomena shaped transnationally over time and space and a personal migration story is the narration of a sequence of events (Polletta, 2006, p. 91; Caliskan, 2018, p. 6).

The methodological foundation of this research builds on a biographical approach informed by narrative inquiry, life-history methods, and oral history methodologies. These qualitative traditions, pioneered by anthropologists and later embraced by sociology and geography, provided the framework for exploring participants' migration stories (Tracy, 2013, p. 29; Goodson, 2001; Rogaly and Qureshi, 2017; Erel, 2009; Rogaly, 2015; Pinnegar and Daynes, 2006; Caliskan, 2018; Lawler, 2002; Atkinson, 2004, 2006; Kim, 2016). Specifically, I developed a personal migration story approach that centres on the migration-oriented portions of participants' lives rather than their entire

life stories (Figure 4.1). The figure depicts the logic and temporal progression of my exploration of migration experience. It is an abstract representation of how I combined approaches. My approach places migration stories at the core of the analysis, recognising migration as a transformative, critical event that reshapes participants' lives.

The combination of approaches I employed is as follows:

1. A biographical method to structure the participants' migration narratives.

2. A critical events approach to identify and analyse life-changing moments within their stories.

3. A personal migration history framework to emphasise migration as the focal point of their biographies.

This methodological arrangement emerged organically as participants recalled and narrated their migration experiences, facilitating the construction of coherent narratives. The data collected included the migration stories of sixteen transnational health and social care professional women living and working in NWE. These stories were gathered through in-depth interviews and complemented by visual materials created by participants. I chose interviewing as my primary way of data collection because I wanted to delve into participants' lived experiences in search of better lives throughout their migratory journeys. The visual element enhanced my understanding of participants' experiences as both subjects and narrators of their migration journeys.

Informed by Levitt's (2001) focus on everyday life practices and Levitt et al.'s (2003; Levitt and Jaworsky, 2007) exploration of transnational networks, this study situates migration stories at its heart. The personal migration story, starting from the migration decision, serves as a biographical lens through which to examine migrants' transformative experiences. By centring migration as a critical event, this approach highlights migration stories generated from in-depth qualitative and narrative materials that appear as appropriate and relevant instruments (Chan, 2017, p. 27; Lafleur and Romero, 2018, p. 8) and the profound impact of migration on participants' lives, work, and aspirations for better lives.

4.3 Sampling and Participant Recruitment

I began this study by mapping the field in NWE. Following the timeline (Figure 4.2) explaining the process of my fieldwork, I arranged a series of preliminary (pilot) meetings in the summer of 2019 with three potential participants in the target communities/groups (women who had special vocational training and specific occupational qualifications, such as doctors, nurses, support workers, and other health professionals), or in person, to get to know them better and to foster trustworthy researcher-researched relationships with them. They were Stella (Greek/Swiss physiotherapist), Lila (Palestinian clinical support worker) and Kate (Turkish physiotherapist). They agreed to be interviewed in the winter of 2019/20 and to introduce me to other prospective participants. These three participants, who took part in the pilot interviews, were re-interviewed during the main phase of the fieldwork. The main fieldwork for this study was undertaken between January 2020 and November 2020 in NWE and involved multiple facets of data collection. The in-depth semi-structured interviews with sixteen immigrants from different backgrounds, including three women involved in the pilot interviews and part of the total of sixteen participants, were conducted. Apart from the informal conversations with the interviewees as needed and intermittently, we had in-depth interview meetings during the fieldwork. We had an extra appointment with Sunshine, one of the nurse interviewees, where I focused on her daily work routine, feelings, and experiences during the pandemic. The interviews lasted between one and two hours, with an average duration of

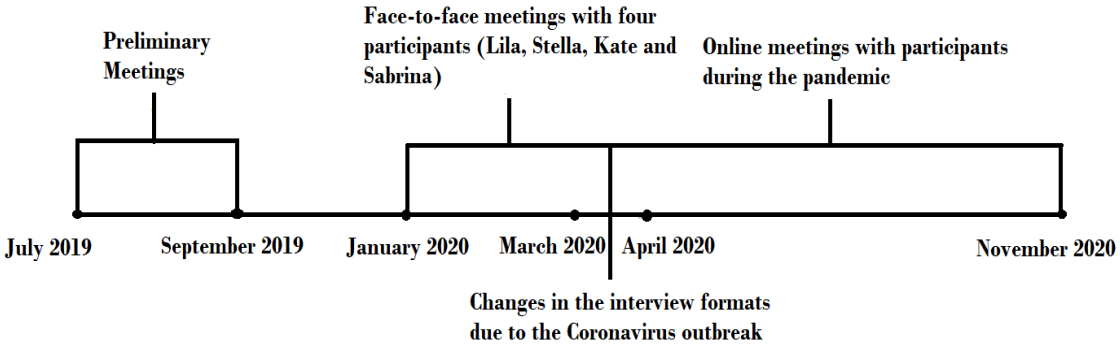


Figure 4.2 Fieldwork timeline

approximately 90 minutes.

I recruited potential participants using a snowball approach (see Bryman, 2012, p. 424), and some of them acted as gatekeepers/key informants, but I later lost connections with some due to the pandemic. Fortunately, I had some participants who knew each other before moving to the UK and acted as intermediaries in each other's migratory journeys with their financial, emotional, and moral support in the visa, employment, and settlement

processes. Those who arrived earlier in the UK took active roles in their friends' decision-making, including where they would settle, triggering significant changes in their migration paths, as is well established in the literature (see Borjas, 1992; Rincon-Aznar and Stokes, 2011 and Blumenstock et al., 2019). Some participants' contacts with friends and networks helped broaden the sample size. My fieldwork was interrupted by the pandemic, the lockdowns, and restrictions in the UK. Within this period, some issues were encountered while recruiting participants. Due to the pandemic's extension of the fieldwork period and the increased difficulty of recruiting participants, by the end of 2020, I decided to maintain the number of participants at sixteen and delve into the lives of the participants I have managed to secure.

Following the ethics guidelines at every stage of my research design, I provided participant information sheets and consent forms to my participants before our online meetings and asked for verbal consent during our interviews. To recruit participants before the pandemic, I handed my leaflets to public/private hospitals, clinics, and nursing and care homes around the North West region.[3] When approaching my potential participants, I asked for permission from relevant NHS staff before advertising my project with flyers on hospital bulletin boards or distributing them in their facilities. I assured employers that I would meet with participants outside of working hours. Through this channel, I secured two participants who came across my flyers, Lila and Sabrina (German psychiatrist), to participate in my research. When the Covid-19 pandemic hit the UK, I had to use only email, telephone, or social media to reach participants through organisations, such as NHS trusts, charities, refugee support groups,[4] migrant groups, etc., to achieve heterogeneity in the target group in terms of demographics. I was able to recruit fourteen participants for my study using these digital channels. Using social media as a participant recruitment strategy during the pandemic, such as advertising my research brief through different social media channels and reaching immigrant women from different nationalities and occupational roles through direct messages, enabled me to reach a wide range of immigrant healthcare professional women in NWE.

Women from most occupational categories in different settings in the healthcare sector were represented in the participant group, and the sample ended up with a mix of

[3] In this leaflet, I invited 'healthcare professionals' to participate in this research from people with qualifications or specialism in the health sector.

[4] Although healthcare professionals do not usually lead these groups, I contacted them at the recommendations of Lila, a refugee research participant. Lila told me that there were health professionals like her in these groups and that they might want to be involved in my research.

professionals, such as social care and clinical support workers, doctors, nurses, midwives, and physiotherapists. This heterogeneity in the sample was intentional, as my stance on occupational categories, which questioned traditional classifications such as 'skilled' and 'unskilled,' was integral to my research framework. The choice to include participants from a wide range of health and social care roles stemmed from my interest in challenging and critically engaging with these categories, which had been a concern in the theoretical framework of my research proposal. This approach allowed me to examine how these categories, often embedded in state ideologies and societal perceptions, were experienced and interpreted by immigrant women in the healthcare sector, with a specific focus on how such categories intersected with their personal and professional identities.

The participants in this study come from diverse socioeconomic backgrounds with varying levels of education and professional experience. Many are highly educated, with previous roles in specialised professions such as nursing, engineering, psychiatry, and dietetics, indicating a background in middle to upper-middle-class positions. For instance, Sabrina, Stella, Kate, Anna, Kani, Voyager, and Nur were highly educated professionals in fields like psychiatry, physiotherapy, and ophthalmology. However, in the UK, several participants have experienced downward occupational mobility, taking on roles such as care assistants or healthcare managers, which has affected their socioeconomic status, often placing them in working-class positions despite their qualifications. This includes participants like Lila, Zei, Gul, Didi, and Sevi, who transitioned from more specialised or higher-status roles in their home countries to lower-status positions in the UK. Regina and Klaudia, who were moderately educated upon arrival in the UK, entered the working class, with Regina working as a healthcare assistant and Klaudia as a social care worker (Figure 4.3).

Pseudonym	Interview Dates and Modes	Ethnic Background/ Nationality	Transits Countries	UK Visa/Immigration Status	Reason for Entry to the UK	Dependants (Including Co-arrivals)	Educational Level	Original Occupational Role	Occupational Role in the UK	Place of Work	Duration of Residence in the UK (as of [2020])	Place of Residence (And Homeownership, If Applicable)	Maternal Status	Visual Material	Language of the Interviews	Transcription
1. Lila	07.01.20 (Face-to-face)	Palestinian/Arab	N/A	Refugee (Indefinite Leave to Remain – ILR Holder)	Family Reunion (as a Dependant of a Refugee)	Two Children	Nursing Degree (UAE)	Staff Nurse	Clinical Support Worker	NHS Hospital in Urban Area	4 Years	Urban Area (Refugee Housing, Tenant)	Mother with Two Children	Drawing- 'Pyramid'	English	Fully transcribed
2. Sabrina	15.02.20 (Face-to-face)	German	N/A	Settled Status	Employment	Spouse	Medical Degree (Germany), Psychiatry Specialisation	Child and Adolescent Psychiatrist	Child and Adolescent Psychiatrist	NHS Hospitals in Urban Areas	24 Years	Urban Area (Homeowner)	Mother with Four Children	Map- 'Connections'	English	Fully transcribed
3. Stella	09.03.20 (Face-to-face)	Greek/Swiss	N/A	Settled Status	Education	N/A	Physiotherapy Degree (the UK)	Physiotherapist	Physiotherapist	NHS Hospitals in a Small Town and Urban Area	27 Years	Small Town	Mother with a Child	Drawing	English	Fully transcribed
4. Kate	09.03.20 (Face-to-face)	Turkish	N/A	British Citizen	Joined Partner	Partner	Physiotherapy Degree (Turkiye)	Physiotherapist	Physiotherapist	Private Clinic in Urban Area	10 Years	Small Town (Homeowner)	No Children	Timeline	English	Fully transcribed
5. Zei	23.03.20 (Online)	Turkish/Kurdish	N/A	Dependant of Ankara Agreement (Turkish Business Person Dependant Visa) Holder	Joined Family Member of Ankara Agreement Visa Holder	Spouse	Undergraduate Degree in Veterinary Medicine, Master's Degree in Health Management (Turkiye)	Veterinarian	Care Worker	Private Care Home in Urban Area	1 Year	Urban Area (Tenant)	No Children	Drawing	Turkish	Fully transcribed and translated into English
6. Sunshine	23.03.20 (Online) and 17.05.20 (Online)	Filipina	Egypt	British Citizen	Joined Spouse	Spouse	Nursing Degree (The Philippines)	Critical Care Nurse	Adult General Nurse	NHS Hospital in Rural Area	6 Years	Small Town	No Children	Timeline	English	1st interview – fully transcribed 2nd interview - fully transcribed
7. Claire	25.03.20 (Online)	Filipina	Egypt	Residence Permit (Tier 2 General Work Visa Holder)	Employment	Spouse	Undergraduate and Master's Degrees in Nursing (The Philippines)	Nurse	Adult General Nurse	NHS Hospital in Urban Area	3 Years	Small Town	No Children	Drawing- 'Stairs'	English	Fully transcribed
8. Anna	02.04.20 (Online)	Finnish	N/A	Settled Status	Joined Partner	Partner	Undergraduate, Master's and Doctoral Degrees (the UK)	Consultant Clinical Psychologist	Consultant Clinical Psychologist	NHS Hospitals in a Small Town and Urban Areas	26 Years	Urban Area	Mother with Two Children	Timetable	English	Fully transcribed

9. Kani	11.06.20 (Online)	Indian	N/A	Tier 2 Dependant Visa Holder	Joined Spouse	A Child	Medical Degree (India)	Junior Clinical Fellow Doctor in Trauma and Orthopaedics	Junior Clinical Fellow Doctor in Trauma and Orthopaedics	NHS Hospital in Urban Area	1 Year	Urban Area (Hospital Accommodation)	Mother with A Child	Timeline	English	Fully transcribed
10. Nur	12.06.20 (Online)	Turkish	N/A	Tier 4 Student Visa Holder	Education	N/A	Undergraduate Degree in Dietetics (Turkiye), Master's Degree in Nutrition (the UK)	Nutritionist-dietician	Fully Registered Associate Nutritionist (She is working online)	Online	2 Years	Urban Area (Student Accommodation)	No Children	Map	Turkish	Fully transcribed and translated into English
11. Voyager	17.06.20 (Online)	Turkish	The USA, Canada	Tier 4 Student Visa Holder	Education	N/A	Medical Degree (Turkiye) - Specialisation in Ophthalmology, PhD in Medical Retina (Ongoing, the UK)	Ophthalmologist	Ophthalmologist	NHS Hospital in Urban Area	2 Years	Urban Area (Tenant)	No Children	Drawing	Turkish	Fully transcribed and translated into English
12. Klaudia	16.07.20 (Online)	Polish	N/A	Settled Status	Language Course	Partner	Two-Year Further Education in Health and Social Care (BTEC HND, the UK), Undergraduate Degree in Psychology (Ongoing, the UK)	Social Care Worker	Social Care Worker	Home Care/ Live-in Care in Urban Area	13 Years	Urban Area	No Children	Timeline	English	Fully transcribed
13. Didi	24.09.20 (Online)	Turkish	N/A	British Citizenship	Employment	N/A	Nursing Degree (Turkiye)	Intensive Care Nurse	Care Manager	Care Home in Urban Area	16 Years	Urban Area (Homeowner)	Mother with Three Children	Timeline	Turkish	Fully transcribed and translated into English
14. Gul	25.09.20 (Online)	Turkish/ Bulgarian	N/A	Pre-settled Status (EU Settlement Scheme)	Joined Spouse	A Child	Midwifery Degree (Turkiye)	Midwife	Healthcare Assistant	Private Care Home in a Small Town	2 Years	Urban Area (Tenant)	Mother with a Child	Map	Turkish	Fully transcribed and translated into English
15. Regina	29.09.20 (Online)	Romanian	Italy	Pre-settled Status (EU Settlement Scheme)	Employment	A Child	High School Diploma Holder (Romania)	Healthcare Assistant	Healthcare Assistant	Private Care Home in a Small Town	2 Years	Small Town (Tenant)	Mother with A Child	Map	English	Fully transcribed
16. Sevi	01.11.20 (Online)	Turkish/Greek	Germany	Pre-settled Status (EU Settlement Scheme)	Employment	Spouse	Engineering Degree (Turkiye)	Environmental Engineer	Healthcare Assistant	Private Care Home in a Small Town	1 Year	Small Town	No Children	Map	Turkish	Fully transcribed and translated into English

Figure 4.3 List of participants

4.4 Data Collection

Concerning the design and execution of interviews, interviewees' voices, with their permission, were recorded and later transcribed verbatim by me for use in the thesis. The simultaneous handwritten note-taking and visual methods, such as drawing social maps and life charts, were part of these interviews, as well. The length of each interview ranged from one to two hours. The interviews were conducted in English and Turkish (since some Turkish participants stated that they would feel more comfortable speaking Turkish with me due to my Turkish background). As an opening broad question in these interviews, I asked my participants about their journeys to and lives in Britain. The semi-structured interview formats were used to keep the flexibility for me to ask the necessary added questions and for the interviewee to make other points about the questions posed. At the same time, with a semi-structured interview guide, I could follow the interview plan (see Appendix 1).

I designed the interviews into four parts without any breaks: preparation, storying, visualising, and finalising. In the 'preparation' part, I learnt about the demographic profiles and backgrounds of the participants. I explored the migration stages of the participants' lives, starting with their migration decisions in the 'storying' part. The participants were encouraged to tell their migration stories and experiences as immigrant professionals—focusing on their work experiences in the questions. The first two phases were carried out earlier than 'visualising' to better understand the participants' drawings and contextualise the drawings on the ground of previously told migration stories to the UK. For 'visualising,' I asked, 'If you were going to draw your migration path from where you were to here, what would it look like?.' I asked the participants to draw something that represented their migration story. I explained that there might be, for example, significant events/persons/moments in maps/graphs/timelines. In the next step, 'finalising,' we talked about what these drawings mean to them and what they tell in the drawings. Moreover, I ended the interviews with the questions 'When you compare your life before and after your migration, what would you say?' and 'How did your migration journey(s) affect your life?' in order to understand how the participants generally feel about how migration has affected their lives.

The pandemic necessitated that I conduct the interviews remotely via video calls on web-based desktop or mobile phone applications (such as Skype, Facebook, and WhatsApp interviews). Due to UK rules on social distancing, it was impossible to reach any more participants and conduct face-to-face interviews. After face-to-face meetings

with Lila, Stella, Kate, and Sabrina in the first two and a half months of 2020, I decided to continue the meetings online as of mid-March. Through digital communication, we could conduct our interviews outside the participants' working hours at their convenience.

I took advantage of some of the benefits of online interviews, which, as Zadkowska et al. (2022, p. 8) suggest, bring a new quality to the research-participant relationship during the pandemic, such as less emotional and time expense and less embarrassment and awkwardness of situations in the face-to-face meetings. These interviews increased the participants' comfort in expressing themselves during the interviews. Interviews in this format prevented, for example, my participants who were tired of the workload and the conditions of the pandemic and were resting at home or who were mothers and needed to take care of their children from spending too much time on the interviews. As a specific example, Didi had the chance to play with her baby on the playground in their garden while making a video call with me and during our conversation. Online interviewing helped alleviate my 'emotional work' (Hochschild, 1979) as a researcher tasked with putting the participant at ease in traditional face-to-face contact, although it caused me to carry new kinds of emotional baggage with me digitally, such as managing technical difficulties, addressing moments of miscommunication, and interpreting emotions through limited visual and auditory cues.

On the other hand, just as the pandemic disrupted familiar human interaction in general, I was aware that online meetings during this period also had disadvantages that would disrupt the kind of traditional face-to-face researcher-interviewer relationship. Online interviews reminded me of discussions I had with my participants in the same physical location, and I think they sometimes undermined my perception of space and the expected contribution of spatiality to my analysis. During the pandemic, I could not experience the joy of travelling long distances to reach the people I interviewed, seeing them in their living spaces or workplaces, or personally being in the places where my participants live every day. Such experience could have enriched the notes I took during and after the interviews and, accordingly, my analysis.

Supplementing the interview material, I offered participants the opportunity to present their stories in the form of a drawing. All my participants consented, and each visualised her migration story on paper. I collected the drawings in which participants visualised their migration stories in the form of, for example, mental maps, timelines, or pictures. I did not suggest what the drawing should look like or what to represent in their images. The content of these visual data mainly emerged naturally. In this way, participants could

articulate their experiences and ideas through visualisation, other than verbal expressions in interviews, without prompting from me as the researcher. Supplementary visual methods allowed me to answer my research question in two ways that could not be done with interviews alone. First, all the pictures helped me and my participants to identify, express, and capture key moments in their stories that are hard to put into words. Some participants had difficulty expressing their migration experiences in words. Drawing facilitated my participants' narrative construction and storytelling, as well as my retrospective explanation of the personal migration story in this research. I gave the participants a new way to express themselves so I could see their stories holistically. Second, I could bridge the abstract nature of interview questions like 'Tell me about your immigration' and everyday experience. The visualisation was a way to overcome this abstraction and the abstractness of the migration concept. In short, it was the way of presenting some people with different forms of expression than using words, being inclusive and increasing engagement with my questions. On the other hand, visuals may not always support the stories heard in the interviews. When this occurs, the researcher should consider why there could be a discrepancy between the participant's account during the interview and the narrative she visualises. This study did not, however, involve any such circumstance.

4.5 Data Analysis

The thesis does not include any material from the pilot interviews, which were conducted to refine research questions and data collection methods. As such, they were not directly incorporated into the main analysis. During the initial stages of the research, I conducted pilot interviews to familiarise myself with the interview process and refine my interview techniques. These pilot interviews were not used in the final data analysis as the questions were intentionally broad and exploratory, focusing on general introductory topics such as the participants' background, their interest in the research, and whether they knew other potential participants. The questions were designed to help establish rapport and guide me as the researcher in formulating more focused and relevant questions for the main data collection. However, given the general nature, the insights gained from these interviews did not fully correspond to the specific research aims or theoretical framework of the study. As a result, I chose not to incorporate the data from the pilot interviews into the final analysis, ensuring that the core data collection was more focused and directly related to the research questions.

After collecting the material from the main fieldwork, I converted the field texts—textual and audio data—into research texts through material analysis and interpretation (Kim, 2016, p. 187).[5] I conducted a thematic analysis by interpreting the interview material. Bryman (2012, p. 717) defines 'thematic analysis' as a term used in qualitative data analysis to generate key themes from participant data. This widely used approach promises the researcher flexibility with few generally accepted principles for identifying key themes in the data. Three broad themes emerged from my reading and re-reading of the material. These themes were, first, 'searching for a better life'; second, 'de-, re-, up-skilling and categorisations'; and third, '(un)settling.'

The analysis and code production were undertaken concurrently with the fieldwork. In this step, I used the notes I took while reviewing the literature, conducting and listening to the interviews and transcribing them into a theme identification list, where I critically discussed and reflected on the participants' narratives. Konecki (2011, p. 142) calls the procedure of labelling parts of the transcribed text 'open coding' and notes that such coding conveys the descriptive thinking of the analyst to a conceptual level. I came up with abstract ideas about some interview passages that included events and concepts my participants highlighted as critical. I labelled those passages with codes. The common codes generated sub-themes. I read the full transcript several times while coding and theme generation—the sub-themes clustered as the features to be subsequently used in building the overarching themes. From Chapter 5 on, the empirical chapters of the thesis were structured accordingly. For example, I tagged the transcription passages where the participants talked about their mothering experiences with the code 'motherhood.' I analysed the passages I gave this code under the sub-theme of 'the emotional work of mothering,' which I will examine under the main theme of '(un)settling' in the seventh chapter.

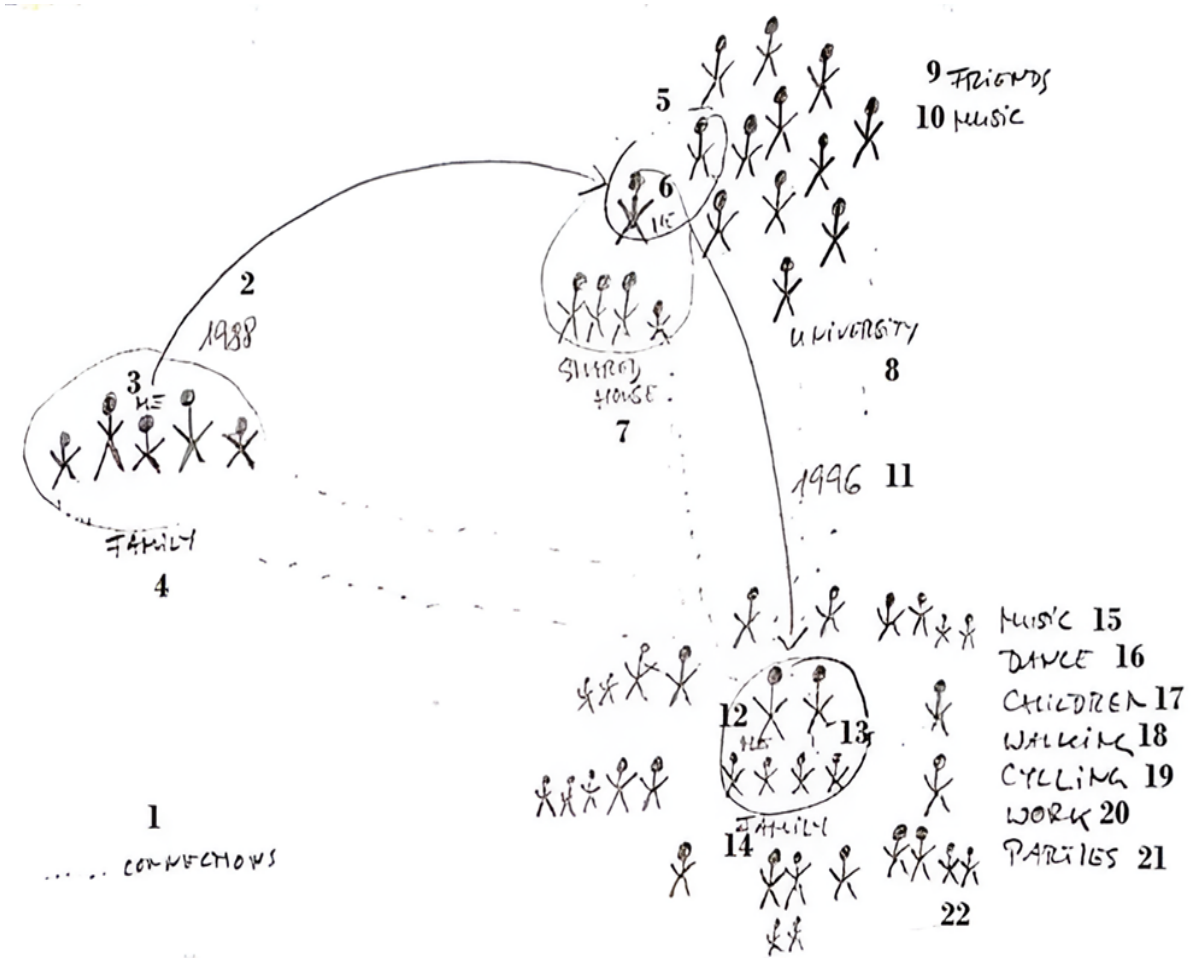
I integrated evidence from interviews and drawings to interpret the data, organising it under various themes and sub-themes. I allowed participants the freedom to articulate new areas and experiences not explicitly covered in the interview, and the inclusion of drawings added significant depth to their narratives. The visual material revealed a variety of graphical representations, such as timelines, mental maps, and location-based illustrations linking different places to depict migratory journeys. These visuals offered insights into the unique and diverse expectations and aspirations of labour migrants,

[5] The analysis in this study was carried out manually rather than using computer-assisted qualitative data analysis.

particularly carer women seeking ‘better lives’ (see Chapter 5). In analysing these drawings, I identified new themes, stories, key locations, milestones, and significant individuals that define the life course in each biography, enriching my biographical approach and deepening my understanding of migration narratives. The variety of graphs highlighted the diversity within my dataset, showing the different ways individuals use to communicate their experiences. Each type of map was analysed using methods tailored to its specific nature, providing a comprehensive understanding of the role of migration in their lives.

Participants conveyed various narratives regarding their migratory biographies, with some centring their stories on temporal aspects, others focusing on specific locations, and still others emphasising social relationships and interpersonal connections. In my data analysis, I paid close attention to these differing focal points within the narratives. Previous qualitative research has demonstrated the value of supplementary visual data in enriching interview findings and providing new dimensions to narrative storytelling. Notable studies, such as those conducted on ‘friendship maps’ by Spencer and Pahl (2006) and Cronin (2014, 2015a, b, c) and on ‘mental maps’ by Buhr and McGarrigle (2017), Desille et al. (2019), and Nikielska-Sekula and Desille (2021) illustrate the effectiveness of qualitative visual analyses in revealing diverse ways of narrating personal experiences. Cronin's (2014) project analysed the spatial and emotional characteristics of friendships, and during the interviews, she told her participants to complete ‘friendship maps’ similar to Spencer and Pahl's (2006) maps. Each of these maps comprised a series of concentric circles, with the participant at the centre, and the closer a participant placed their friend to the centre, the closer they were to them.[6] I gave special consideration to this kind of study since social networks were a significant aspect of the lives of my participants.

[6] Here, I would like to present my special thanks to Prof Anne Cronin for informing me in such detail about her research methodology.



1. 'CONNECTIONS'
2. '1988'
3. 'ME'
4. '... FAMILY' [family in Germany]
5. '...' [partner's name]
6. 'ME'
7. 'SHARED HOUSE ...' [house in Germany]
8. 'UNIVERSITY'
9. 'FRIENDS'
10. 'MUSIC'
11. '1996'
12. 'ME'
13. '...' [partner's name]
14. 'FAMILY'
15. 'MUSIC'
16. 'DANCE'
17. 'CHILDREN'
18. 'WALKING'
19. 'CYCLING'
20. 'WORK'
21. 'PARTIES'
22. '...' [city where she lives in the UK]

Figure 4.4 Sabrina's 'connections' map

Figure 4.5 Regina's map

Like Cronin, I tried to find out who the people on Sabrina's map (Figure 4.4) were, their closeness to Sabrina, and their influence and importance in her migration adventure by discussing the map with her. Alternatively, I understood the order and importance of the elements included in the visuals of the participants by discussing the placement of these elements in the visuals with the participants. As exemplified in Sabrina's map of connections, her image showed the important people and connections in her migration story and life. Sabrina drew those she felt closer to, such as family members, as immediately around her and even represented in the same circles as herself, while she drew further away from herself, such as her friends and neighbours, but still interacting.

Some participants' maps gave me ideas about how immigrants learn to be mobile in a new place to live (Buhr and McGarrigle, 2017). Regina, for example, drew her map (Figure 4.5), describing who she met in her neighbourhood and which places she visited daily to inform me about her social and friend circles in general. Beyond that, the participants in my study were genuinely communicating their emotions about their lives in particular surroundings. This helped me comprehend how my participants felt settled in England. Such maps deal not only with the structure, location, and morphology of settlements but also with the relationship between immigrants and their living environment, including how residents crossed distances there, how space was used, a complex system of practical knowledge and skills, and the methods used to adapt to them (Desille et al., 2019, p. 6).

In conclusion, under the sub-theme of ‘the emotional work of mothering,’ the two representative maps I examined were Sabrina's and Regina’s. Sabrina's map revealed how content she was in her social environment in general. Regina's map displayed the spaces she used to visit with her child in her daily life, but according to Regina, these were the restricted spaces she visited every day. Regina felt lonely there, and this feeling was ultimately linked to her sense of settling. So, when talking about my participants' experiences of motherhood in the interviews, these two maps expressed their settlement in England. Here, I must acknowledge the relative privilege of Western Europeans (German and Finnish participants) over racialised participants from the global south. As will be evident throughout my research, Sabrina and Anna describe living in better conditions than the other participants when it comes to their navigation of the recruitment and immigration systems, and their work and social experiences.

4.6 Conclusion

The methods and justification of the methodological research approach were discussed in this chapter. By pre-mapping the field (pilot study), I carefully selected the interview methods to explore the research question of this thesis. Through the qualitative approach, interviews and ancillary visualisation, I became aware of the importance of the experiences, migration expectations and aspirations of professional migrant women working in the public and private healthcare sectors of NWE. Interview questions were specially designed based on this context.

To recruit a diverse sample of migrant workers, I mainly used snowball sampling and personal contact techniques with a preliminary map of the area. Overall, I completed a valuable series of in-depth, semi-structured interviews in the North West region of England between January and November 2020. Although I gathered most of the material through online interviews, visualisations enriched the research material. Field and interview notes, including facial expressions, gestures, tones, pauses, and smiles, complemented the interviews. The methodological approach (interviews and illustrations) allowed me to delve deeper into individual experiences. Accordingly, the three following chapters are shaped around the experiences of these individuals.

While structuring the empirical chapters, the rich data from the interviews allowed me to focus the thesis on three primary arguments that emerged from my data: 1. ‘Better lives migration’ conveys a ‘cruel optimism’ (Berlant, 2011) in which the promised employment and living are frequently not fulfilled, 2. The work lives of immigrant caregiver women, which are of great importance in their ideal of better lives, are turned into spots of disappointment with migration and skill regimes that deskill and categorise them; and 3. The social and everyday issues in the areas they migrate to make many women feel as though they will never be able to feel settled in these places.

In the following chapter, I substantiate the concept of ‘migration for better lives’ with evidence from my participants' experiences. The ‘Better Lives’ chapter is this thesis's first empirical chapter, foregrounding participants' diverse and rich migration prospects.

Chapter 5: Searching for A Better Life: Migrants' Expectations and Aspirations

This chapter discusses the migration patterns and journeys of participants. I will expand on what 'better lives' mean for my participants, whether they believe they have achieved it, and if so, under what conditions and with the assistance/resistance of whom or what. The latter brings attention not only to the role of their families, friends and other contacts in helping them settle in the UK or maintaining their links to their origin countries (O'Reilly, 2012, p. 6) but also to that of social structures such as states and cultural norms that both constrain and enable their actions (Bakewell, 2010, p. 1695).

This chapter contributes to the literature on 'well-being/happiness' and 'migration' through its analysis and engagement with primary data. Well-being analysis (Wright, 2010), which investigates how people migrate to live well or happily, omits the experiences of those who 'achieved well-being' in their destinations in many ways. Immigrants do not always face structural constraints when emigrating. States frequently attempt to attract migrants they deem skilled, enticing them with promises of 'better lives' and increased well-being within their borders. As I will show in one doctor participant Kani's case, for example, the immigration of 'highly-skilled' persons is specifically made possible or facilitated by the UK (see Giddens' [1984] 'Duality of Structure' in Chapter 3). My examination of some participants' migration stories shows they were attracted to the UK by its NHS and internationally spread reputation and values. Moreover, the theories of well-being tend to psychologise the issues of happiness and migrating to live well. However, in this chapter, I will be more interested in the broader social, relational, or structural questions of 'living better lives' and how it is circulated globally as an idea among migrants.

Drawing on participant interviews, I will unpack what a 'better life' means for immigrant healthcare workers in NWE. On what does such a concept of 'better lives' depend? Which socio-cultural values are attached to it? In this chapter, I aim to illustrate how happiness is promised to the migrants with the idea of migrating for 'better lives' and how the concept of 'better lives' is informed, constructed, and circulated discursively by the migrants themselves. Exploring these, I will also look at various connections,

transnational networks, and sources of information that the women draw on, such as partners bringing their wives/partners and children into the UK as the receiving country.[1]

One question that this chapter explores is where these migrant workers situate 'work' and 'migration for work' in this quest for a 'better life.' How significant are economic and professional gains in the decision to migrate for better lives for these migrant women? Traditional push-pull models in migration theory (Sjaastad, 1962; Harris and Todaro, 1970; Rosen, 1974; Roback, 1982; Clark and Cosgrave, 1991) often reduce migration decisions to economic factors like wage differences and labour supply and demand. However, such models overlook the broader and more complex dimensions influencing migration (see Chapter 3). By focusing solely on economic incentives, these models fail to account for the professional, social, familial, and personal aspirations shaping migration pathways. My approach aims to expand the scope beyond these narrow economic parameters, considering a wider range of expectations, such as the desire for social mobility, improved quality of life, and fulfilment of personal and professional ambitions. This broader perspective provides a more comprehensive understanding of the diverse factors driving migration in this chapter.

The chapter addresses the participants' reasons for emigrating, other than their professional work environment and conditions, as well as socio-political factors such as family reasons, political safety, rights, and freedoms. Using participant drawings, I also examine how they visualise their respective migratory journeys when fleshing out those diverse aspirations and expectations**.** I show that economic and career development are not always the sole expectations of migration. Individuals do not always act on conscious and rational choices; 'migration is more fluid and complex than that' (O'Reilly, 2012, p. 6). A 'better' life is multi-layered. It is not just about the professional work environment and conditions but also about political safety, social issues, personal lives and human rights. Moreover, the participants' lives include but are not reducible to their work experience in this research.

In this thesis, I differentiate between the concepts of 'aspiration,' 'expectation,' and 'motivation' to capture the complex dynamics of my participants' pursuit of a 'better life.' While motivation is generally used in migration studies, especially within push-pull models that emphasise reasons for departure, I focus on aspirations and expectations in

[1] See Kofman and Sales (1997), Kofman (2004, 2018), Kofman et al. (2011), Ramirez et al. (2007) and Sirriyeh (2015, 2017) for the issues and debates on family re-unification/union in the European and broader transnational research.

this research, as these concepts more accurately reflect the participants' evolving ideals and realities. Aspirations represent the broader, idealised visions that guide participants—visions of security, freedom, and improved life quality. In contrast, expectations are more specific, connected to what they practically foresee and hope to achieve, such as opportunities for their children's education, the possibility of homeownership, or whether they will be able to practise their original professions in the UK. The two are interconnected; aspirations provide a foundational vision for participants, while expectations narrow this vision based on what seems achievable as they adjust to their circumstances in the UK. Using both terms allows me to capture the nuanced interplay between participants' broader hopes and the practical outcomes they anticipate in the host society, bridging the gap between ideals and lived experiences.

I start the chapter with the participants' visuals because they are instrumental in showcasing the diverse aspirations behind migration, encompassing not only professional aspirations but also expectations related to participants' social and familial lives. This first section, 'Visualising Migration', introduces the drawings in which the participants visualised their migration stories in mental maps, timelines, pictures, and so on. Drawings set the stage for a more nuanced analysis by offering a glimpse into how migrants imagine and construct their pathways toward achieving better lives.

The second section, titled 'Better Life and Professional Expectations', challenges the predominately economic focus of conventional migration theories and re-examines participants' material and professional expectations from migration through a 'better lives' standpoint. The section discusses how they have sought to satisfy their professional expectations through labour migration to the UK because they were not happy with their living and working conditions in their transit and origin countries. Particular to the NHS worker participants, an interesting finding concerns their idealisation of the NHS as a symbol of stability, opportunity, and professional fulfilment and the role this played in attracting them to the UK. The labour circumstances—especially in the time of the pandemic—and immigration rules they faced, however, were far less favourable than they had anticipated. They encountered exploitative conditions, underemployment, or administrative roadblocks instead of the ideal system they had envisioned. The NHS frequently dashed participants' hopes of a better life, revealing the sharp discrepancy between their ideals and the realities of operating in a strained and underfunded healthcare system. This striking difference demonstrates how structural and policy

shortcomings crushed their aspirations, forcing them to navigate a far more difficult terrain than predicted.

In the third section, titled ‘In Search of Freedom: Socio-Political Factors,’ I show how some participants migrated far from the Middle East, Eastern Europe or the USA (where their countries of origin or transit were) to find a politically safe place to secure ‘free lives.’ This section explores how migration to the UK enables participants to navigate and redefine freedom, balancing personal autonomy, familial well-being, and resistance to gendered and societal constraints from their home countries.

This chapter concludes by emphasising the thesis's contribution to the migration literature by introducing the concept of ‘better lives.’ The chapter also explores how this concept takes shape across various historical-structural, political, and gender contexts.

5.1 Visualising Migration

Before moving on to the analytical discussion of the concept of migration for ‘better lives,’ it would be helpful to take a closer look at the visual representations. By presenting them first, I intend to frame a migrant with multifaceted plans and aspirations. This approach allows the reader to grasp the complexity of the migration experience and appreciate the participants' pursuit of a better life, which involves navigating both career ambitions and social relationships. Viewing these visuals firsthand offers insight, making it possible to understand the variety of expectations that shape the migration journey.

As a part of the interviews, I asked participants, ‘If you were going to draw your migration path from where you were to here, what would it look like?’. In other words, the drawings represent their migration stories. These took various forms, such as maps, charts, and timelines, and some of them signpost important events, individuals and moments in their lives. The visualisations were unpacked by the participants themselves in my discussions with them. The discussions addressed aspects such as what specific things in the visuals meant to them and what they told in the drawings. What did they choose to include in them? How did the participants represent certain elements?

In what follows, the excerpts from the discussions with the participants in the interviews on their drawings mainly fall into three categories. The first is the one representing the ‘arrival story,’ which is generally about the very first day of the travel to the UK. The second category represents the ‘first impression’ about the destination, and the third category, ‘framing migration,’ paints a broad picture of migratory journeys and

interrelated economic, social and political migration expectations. I will integrate images from all these three categories into all empirical chapters.

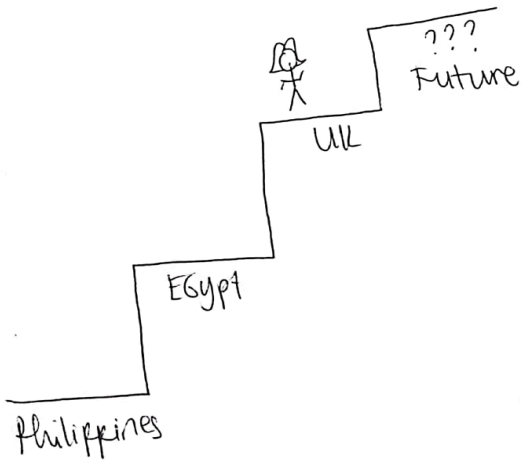


Figure 5.1 Claire's stairs

The drawings in the third category of 'framing migration' allowed participants to make a rough inventory of migration regarding dates, milestones, and critical moments. The mental maps were often generated in the form of linear timelines, but some were also displayed as a pyramid (see Lila's in Figure 5.7) or stairs (Figure 5.1), representing stages where the illustrator puts the elements in a hierarchy of importance. In her image above (Figure 5.1), Claire (Filipina nurse) hierarchised her destinations and travels to these countries. A four-step ladder is drawn in the image: 'Philippines' on the bottom step, 'Egypt' on the second step, 'United Kingdom' on the third step, and 'Future' on the top step with three question marks. Claire depicted herself on step 3, which is the 'United Kingdom.' This picture depicts her journey to the UK, where it began, the intermediate stops and her current location. The final stage implies that she is unsure of what the future holds. In this sense, her next destination after England may be Australia, which she mentioned is 'in her heart.' However, she will make such a dream come true, just like on previous migration routes, on the advice of people around her who have experienced emigration or with information about her next destination, which she has acquired at her current stage in the UK. When Claire was still working in the Philippines, it was her aunt, working in Saudi Arabia as a nurse, who first recommended that she emigrate by saying to Claire, 'You've got better opportunities if you go out of the country.'

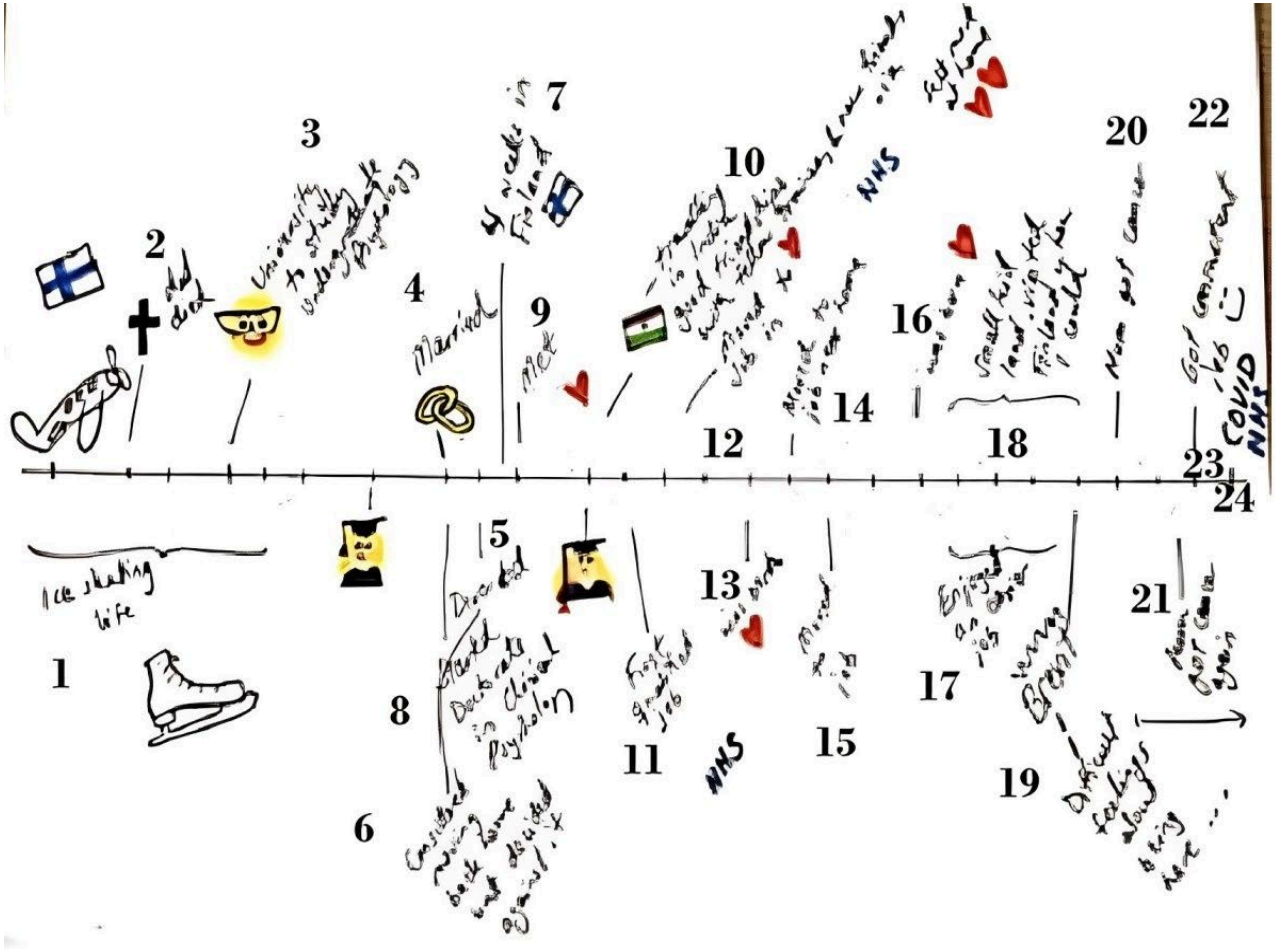
Moreover, Claire's 'best mate,' working in Egypt then, said, 'Why not try Egypt?.' The living and working circumstances in England do not satisfy everyone. As revealed in

this research, many migrants also view this as a stopgap destination since they want to move to Australia and are dissatisfied or disillusioned with the working conditions here. This situation suggests a questioning of the global perception of the NHS; not everything is rosy, and some people are considering leaving the organisation.

The participants, overall, depicted some elements of their migratory journeys, such as public transport vehicles—trains and planes that brought them to the UK or their towns of settlement; flags, suitcases, pets left behind and flowers (see Zei's in Figure 5.4); wedding rings and graduation caps (see Anna's in Figure 5.2);[2] tools used to perform the professions (see Voyager's ophthalmoscope in Figure 5.6). Some used question marks to represent past and future migration decisions and considerations. Some participants also included themselves in these maps and drew themselves smiling.

Some of them illustrated their daily life and routines in the UK: they drew the emblems and buildings of their workplaces, the roads they walked daily, and their homes. Looking at Anna's (Finnish psychologist) timeline that starts with the plane that brought her from Finland (with a Finnish flag above it), what it has is not only the elements, people and institutions related to her work, education and professional life. The items that Anna expresses her personal 'happiness' about by putting 'red hearts' or 'smiling faces' in her migration story are not only related to her psychology expertise but also the items in her private and daily life, such as her partner, children, friends, time spent with these people outside of work-life, vacations, hobbies, and moving to a new home. I benefitted from the diversity and richness of the participants' drawings that showed how diverse the aspirations and expectations of the 'labour migration' of health professionals can be, as opposed to the tendency in the literature to uniformise those aspirations and expectations around the assumptions of 'migration for work.'

[2] Names of individuals, institutions and places have been deleted for confidentiality reasons.



1. 'ice skating life'
2. 'dad died'
3. 'university to study undergraduate psychology'
4. 'married'
5. 'divorced'
6. 'considered moving back home but decided against it'
7. 'four weeks in Finland'
8. 'started doctorate in clinical psychology'
9. 'met ...[her partner]'
10. 'travelling in India, good friendships with fellow trainees, new friends via ...[her partner], felt more at home'
11. 'first qualified job, NHS'
12. 'moved to [the city in the North West region] job in NHS'
13. '... [her first child] was born'
14. 'moved to job near home'
15. 'moved to ...[another city in the North West] job'
16. '... [second child] was born'
17. 'enjoyed an easier job'
18. 'small kid and, visited Finland when I could'
19. 'Brexit-difficult feelings about being here'
20. 'mum got cancer'
21. 'mom got cancer again'
22. 'got consultant job'
23. 'COVID'
24. 'NHS'

Figure 5.2 Anna's timeline

5.2 Better Life and Professional Expectations

Based on the broader context of migration expectations, I begin this section by discussing the living conditions that participants said they were unhappy with in their home countries. In the interview and visual material, living conditions encompassed a wider range of social and personal elements that participants felt influenced their overall quality of life and often described as forming the basis for their particular occupational aspirations. Setting this larger framework makes it easier to see how participants thought their working environments—which I will examine subsequently in the section, albeit distinct, are connected to and impacted by the larger socioeconomic and living conditions they were trying to leave.

5.2.1 Expectations of A Better Life

What does a 'better life' mean, and what are the criteria for such a life for the participants? 'Better' is grammatically the comparative of 'good' or 'well' and refers to the fact that the object that comes after this word had at least certain standards, qualities or a level of effectiveness above the preceding object. That lexically presumes there can be no 'better' without 'good.' However, a 'better life' cannot presuppose that a 'good life' has been experienced before, or vice versa. In fact, in the interviews of this research, almost all participants used different adjectives to describe their lives before migrating and their new lives in England, which I conceptualised as a 'better life' in this chapter.

Some participants said they could have some standard of living, a 'normal,' 'decent,' 'stable,' or 'happy' life very recently and only after they migrated to the UK. For example, Regina (Romanian healthcare assistant) commented: 'I'm doing what I like to do, I have money because I'm working, I have a house… It's better here [in the UK]. I like it more here than in Romania because you can have a normal life…' Sevi, Turkish/Greek healthcare assistant, is happier in the UK than in Turkiye for having some opportunities in the UK that were not there in Turkiye. 'That life in the Philippines was not efficient' for Sunshine, a Filipina nurse. Migration positively affected Kate's life as a Turkish physiotherapist in her [occupational] position. Or, Stella, the Greek/Swiss physiotherapist, anticipated her quality of life would be better here. My use of 'better' is to emphasise betterment in certain conditions in their lives or expectations for improvement because all the definitions of life in the UK that came from participants carried positive connotations in their overall assessment, regardless of the disappointments or dissatisfaction I will discuss later.

So, what should we understand from the 'living conditions' that the participants expect to better while emigrating? International migrants' happiness is often measured in economic terms, and the path to happiness is described as 'prosperity,' 'economic success' or 'economic opportunities' (Gardner, 2015).[3] It is possible to come across such material considerations in the everyday life practices of the participants in this research, who consider factors such as purchasing power, prices, living expenses, salaries, and savings when migrating. These practices are connected to the cultural-historical and gender context and are supported by some social values of happiness (Gardner, 2015, p. 200). Economic and family considerations combine in people's aspirations for a better life. For example, Filipina nurse participant Claire provides financial support to her family in the Philippines and strives to include family members in the 'better life' she is trying to build for herself. She comments on her own thinking about migrating to the UK: 'You'd earn more with the same job that you do, and you can provide more money to your family and hopefully a better life [for them].' Claire's idea of a 'better life' extends beyond her financial desires, as she actively seeks to elevate her family's quality of life through her work in the UK. This goes beyond mere economic support; it reflects the transmission of values and hopes for well-being, aligning with Wright's (2010, 2012) concept of human well-being. Claire's commitment to include her family in her 'better life' illustrates the potential Wright sees in transnational migration to cherish collective aspirations and shared well-being improvements. Then, to what extent does this possibility occur in real life?

I begin by examining Sevi's (healthcare assistant) depiction of her ideal vision of a 'better life' and how she associates this ideal with 'normality' and 'opportunity.' Sevi was an environmental engineer in Turkiye and started making 'overseas plans' after she got married. Turkiye's economy had driven her and her husband to the thoughts of 'let's go,' 'what we will do,' and 'what we should do.' She mentions her life in Turkiye as a 'normal life' with average standards. Nevertheless, the ability to buy or do more things with the salary in the UK than in Turkiye has appealed to her. 'We had our home in Turkiye, we had a car, and when you look at everything we [she and her husband] had, it did not satisfy us financially; neither the working conditions nor the stress associated with purchasing power,' Sevi explained. When she thought that 'both she and her husband were working at that time,' and, with both salaries, 'more could have been done.' Every

[3] See Stark et al. (1997), Akay et al. (2021) and Djajic (1989) for various aspects of the debates around migrants' economic prospects, rationales, and outcomes.

time she went shopping in Turkiye, she imagined living in a place where she knew she could afford to buy something she wanted in a store, even if she was not really going to buy it in the end. She strove for the financial capability to own those goods. As Sevi puts it, despite working at the UK's lowest standards and 'at the bottom' as a healthcare assistant, she believes she is living in better conditions. Sevi's experience of deskilling in the UK reflects the dynamics explored by Parrenas (2015) regarding the migrant statuses of Filipina domestic workers, who experience simultaneous upward and downward mobility—occupational decline alongside financial improvement—in their host countries. Sevi's transition from an engineering position in Turkiye to a lower-skilled role in the UK, despite her improved financial situation, exemplifies what Parrenas (2015, p. 117) describes as 'contradictory class mobility.' Such contradiction is not limited to domestic workers but is also experienced by migrants in various professional fields, highlighting the broader implications of occupational decline in migration trajectories.

When she first moved to her transit country, Germany, Sevi understood that someone in Europe could do many things with just one salary; for example, she could buy three white goods. However, this was impossible for them in Turkiye before July 2020, and she thinks the situation is even worse now. 'Of course, this is also related to the money you receive. For example, some people receive a monthly salary of 10,000 liras or 15,000 liras, we didn't have that kind of income. I always compare it this way.' The salary of people with the opportunities mentioned by Sevi is almost four or five times the current minimum wage in Turkiye: the net monthly minimum wage for 2021 was 2,825 liras in Turkiye (Bianet, 2020).

Voyager (Turkish ophthalmologist), another participant, similar to Sevi, compares the purchasing power in Turkiye when she left in 2014 and settled in the USA—which for her was a transit country—with the current purchasing power based on the gifts she brings to her loved ones during the holidays. For her, Turkiye was more prosperous in 2014 when she was in Los Angeles than in 2020. Her relatives in Turkiye were used to turning up their noses at the gifts she wanted to bring them. This was because they were saying that they could afford everything in Turkiye. 'Branded things really could be bought in Turkiye at that time. When I Ieft, one dollar was 2.5 Turkish Liras, I guess. The purchasing power was lowered. As I said, there is no stability,' she says. Voyager witnesses the worsening of the Turkish economy in a Turkish Facebook group where hundreds of women are doctors and very troubled. This expressed economic situation of Turkiye by Turkish participants seems to be a significant reason for them to emigrate.

Indeed, as participants suggest, purchasing power in Turkiye is below the EU average: According to the results of the European Union Statistics Office's (Eurostat, 2020) Purchasing Power Parities (PPP) study, Turkiye ranked 32nd out of 37 European countries in a ranking based on Purchasing Power Standards (PPS). When we met with Voyager on June 6, 2020, the dollar was trading at 6.8 Turkish lira. The value of the Turkish lira has declined ever since. The day I wrote this, July 31, 2024, the dollar was trading at 33.1 Turkish lira.

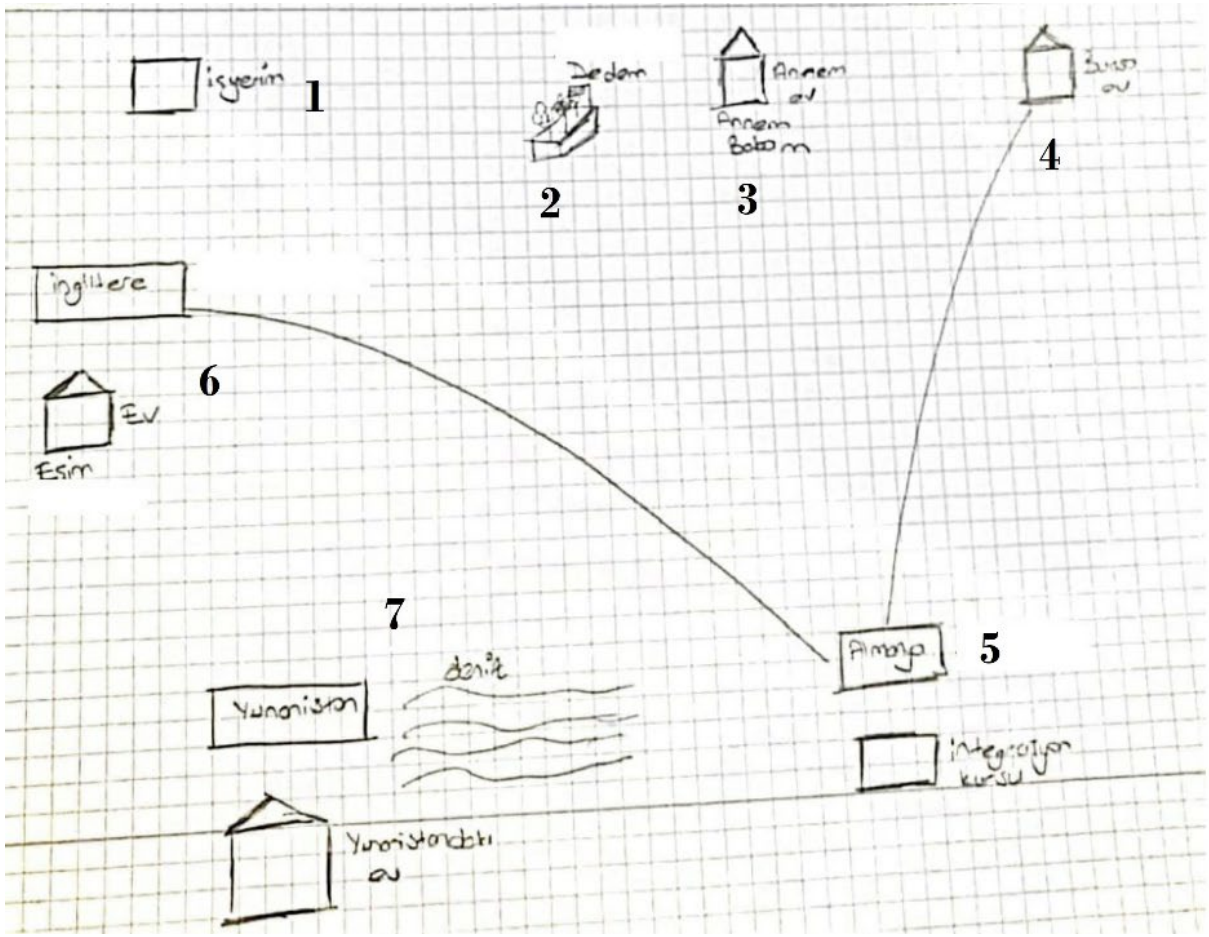
Basic needs were what Sevi thought they could barely own, but extras were luxuries for her and her husband in Turkiye. Of course, what necessities or luxury means is also crucial and relative here. Sevi's one example of an 'extra' was day trips. Although they had a car in Turkiye, they did not go easily out of the city they lived in and always had to calculate the costs when they did; 'we always thought that our going out of a city is 1,000 liras, 1,500 liras. Now we have a car here [in the UK]. One day, we went to Scotland. You can go here everywhere very easily whether you have a car or not.' Sevi also had the impression that the British in England were not as stressed as the Turks in order to save money, and they looked as if they were more 'relaxed' and 'no worries about the future,' whereas the Turks were not like that. She attributes this 'freedom from stress' to the fact that the cost of living is lower in England than in Turkiye.[4]

Why did Sevi want to be able to buy more, save more and do more? 'For herself and her family' is her answer, albeit childless at the time of the interview. Sara Ahmed (2010, p. 32) writes about 'family' as a happy object that circulates even in its absence and fills a certain gap in people's fantasies. People look forward to family and anticipate it will cause happiness. Having children and being a family are the sources of happiness for Sevi and among her plans, but she had never intended to do these in Turkiye as she could not provide better conditions for a child there. Now, she feels excitement and gratitude at being able to buy whatever she wants in a grocery store and having a child, which is a 'great blessing.'

Sevi qualified her migratory aspirations in our meeting, probably with the feeling of not wanting to seem like a materialistic person to me, and shyly, always emphasising, 'maybe this is a self-fulfilment but...,' 'maybe it's a bit of a material perspective but... .' This embarrassment may be because a woman passionate about luxury or who wastes things will be criticised in Turkiye (Yildiz, 2017, p. 389). However, I frequently

[4] This reflects the situation prior to 2022 when the cost of living crisis hit the UK.

encountered such ‘material’ reasoning in other participants' narratives who had a family. Another Turkish participant, Didi (care manager), who gave birth to her three boys in the UK, thought that this was the country with the right conditions to have children. In Turkiye, having three children is ‘madness and luxury’ for Didi. Didi's friends there said to her on the phone that the conditions are very difficult in Turkiye, and they could not work if they had another child because they had to care for that child. At the same time, they would have given the money earned from a job to the nursery. ‘Then, what is the point of giving birth?’ say those friends to Didi. One of those conditions for Didi is to afford a house with a big garden: ‘We are very lucky to live here; the houses with gardens are very beautiful. With a child, you don't have to go somewhere else; you spend time in your garden.’ ‘Houses’ were also important features in Sevi's story and drawing (Figure 5.3). However, she has not been as lucky as Didi on the matter of ‘homeownership’ in her destination.



1. işyerim (my workplace)
2. dedem (my grandfather)
3. Annem ev, Annem Babam (my mother home, my parents)
4. Bursa ev (Bursa Home)
5. Almanya, integrasyon kursu (Germany, integration course)
6. İngiltere, eşim, ev (England, my husband, home)
7. Yunanistan, Yunanistan'daki ev, deniz (Greece, house in Greece, sea)

Figure 5.3 Sevi's map

Sevi's image comprises seven sites, including buildings, houses, and workplaces. When discussing her drawing, Sevi talked about her time in Germany (‘Almanya’ in Turkish in the fifth site), where she went to build a new life ‘with a lot of hope’ and ‘dreaming a lot.’ With her husband, they thought that they could find jobs and a house in Germany. Maybe finding a job could have been more difficult than finding a house. However, unfortunately, a ‘plot twist’ happened in their migration story to Germany, she said; her husband found a job as a porter in a wholesale market, but they had to live in the two-bedroom house of her husband's brother and with his family; the wife and two children. They slept in their living room for eight months. Germany is, therefore, seen as the only country where she did not draw a house among the countries of her story that she temporally connected by lines. There are four houses in Sevi's drawing: the first one (Site 3) is the house where she lived with her parents in Turkiye, the second (Site 4) in Bursa, which is a city in Turkiye, is the house where she and her husband lived in, the third (Site 6) is where they live in England with her husband, and finally the fourth one (Site 7) is the house by the sea in Greece, which she inherited from her grandfather whose cemetery was drawn with flowers in the second site.

Being unable to afford a house disrupted Sevi's life in Germany; they emigrated again and came to the UK this time. However, she still dreams of owning a house because she lives in a rented house in England. Saving enough money to renovate her grandfather's old house in Greece and spending her retirement in this house is her biggest future dream now: ‘I drew the sea about Greece, probably because I missed it so much. It is a special place for us, after all. We go there, we have our own house, we go to the sea there, we can rest our heads. Quiet places. For our future dreams, as I said. If we can retire...’ The site where this house is located is not yet connected with the others by lines but has already become a part of Sevi's story. Thus, it appears that the participants in their drawings include not only their experiences in the past and present but also the future and their expectations for a ‘better life’ even if they have not been fulfilled yet. These long-lasting expectations—often extending throughout their lives—play a central role in sustaining their migratory journeys. ‘Better lives’ are generally constructed and envisaged in an exercise of looking forward.

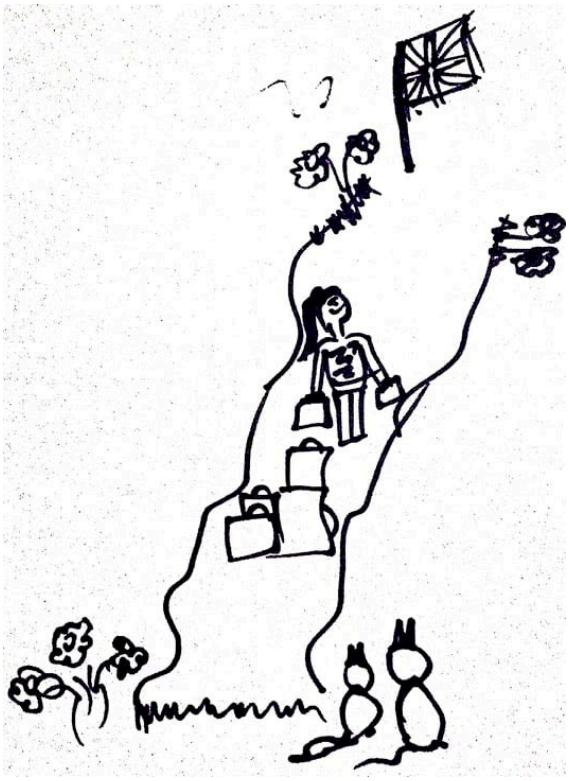


Figure 5.4 Zei's drawing

According to another participant, Turkish care worker Zei's flowers, for example, symbolised her 'expectations,' 'love,' and 'hope' for her journey to England. Zei drew a road in her image. At the beginning of the road where she departed from Turkiye, there are two cats and flowers on one side and a UK flag and flowers on the British side at the end of the road where she leads. Zei drew herself in the middle of this road with two suitcases in both hands. Four more suitcases can be seen on the road. Zei's facing towards the end of the road, and she is smiling: 'The smile on my face is for you to see that I am happy.' With the flowers on the Turkish side of the road, Zei explained that she was expressing that she was still feeling 'love' for her 'own country,' even though she felt that she had to leave it. When she looked back, she used to have a 'sweet life' in Turkiye no matter what: 'So, yes, I was unhappy to live in that country I left behind, but still, I wanted to say with those flowers that I love our country.' But now, on the other side of the road on which she stands, there is a place in front of her that she thinks that she will 'love that place.' While she had some things left that she would miss, such as her cats, Zei did not even want to think that she would be unhappy or want to go back to her country when she moved to England: 'Nothing was scaring me on the way here [to the UK].' Zei had neither vacated her house in Turkiye nor resigned from her job there while

coming to England. When we were interviewing, she was still waiting for the life she dreamed of in England to come true and break such last ties with Turkiye, resign from her job, sell her house there, and feel settled in England.

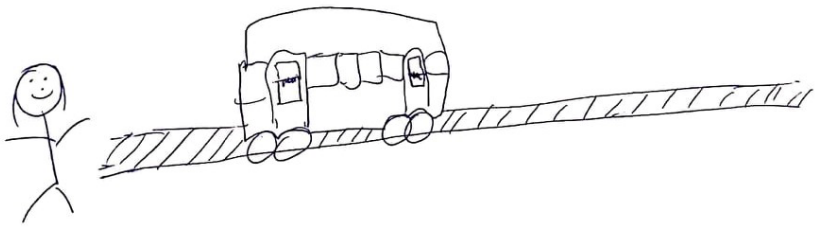


Figure 5.5 Stella's drawing

Arrival stories provide a valuable lens for understanding the link between imagination and lived experience, given the effects of expectations and aspirations on 'motivating and mediating migration experiences' (Roberts, 2019, p. 118). In this research, expectations and disappointments were reflected in the images of the participants telling their stories of arrival. Disappointments in the theory of migration for better lives play a role in analysing whether or not expectations and, thus, the idealised 'better lives' are met. For example, the importance of the physical environment in the destinations, migrants' first impressions of it, or their sensory experiences (Howes, 2006, Munt, 2015, Rishbeth, 2016, Biglin, 2020)—smell, taste, light, colour, weather, and so on—came forward in Stella's account (Figure 5.5): 'During the day when I first came to the UK, when I was a student, the weather was like today, grey and rainy, cold and windy. I wasn't impressed at all.'

Stella's (Greek/Swiss physiotherapist) apparent disappointment with the cityscape she came across on her first arrival to the UK was a sign that her idea of a 'better life' did not quite fit with what she saw upon arrival. At first sight, there were no appropriate physical and environmental surroundings for her expected 'better' living environment. Stella drew a train on the rails in her image. This train took her from the airport where she first arrived in the UK from Greece and brought her to the town where she would live and work in NWE. She had a very 'negative' first impression of this place the moment Stella got off the train: 'When the train stops, you have to open the window, the door, and you have to put your hand out to open the door to get out of the train. So, I wasn't particularly impressed because that didn't look terribly modern to me.'

> I had travelled to Germany on trains, and I had travelled to, in Switzerland on trains. And no need to, to open the window, to get your hand out to open door [laughter]. So, I was assuming, it [England] would be on the same level, but it isn't. It probably was a little bit beneath expectations. I was expecting to be on a par with Switzerland or Germany, in socio-economic affluence, well not socio-economic, just economic affluence. (Stella)

Furthermore, the red-brick, unfinished buildings she encountered and the old train she had just gotten off had made her think she had arrived at a 'poor and unfinished' place. There were no such buildings and trains in Greece. As she said, the only buildings still under construction in Greece could be red brick, and the trains were much newer and had automatic doors. From that very first day, she realised that England would be a place, in her words, 'beneath her expectations' in many ways, particularly in terms of living conditions compared to other European countries. For more than two decades in the UK, Stella has been earning a living for her family, consisting of her partner, daughter, and herself, since her partner was injured in an accident and medically retired.

Stella's first impression of England and the difficulties she has experienced in the UK for twenty years reflects a broader disillusionment with Western capitalist society. Her first impression of the country aligns with my argument that NWE serves as a dystopic region for participants (see Chapter 2). Participants' initial expectations of the region, shaped by ideals of Western civilisation's advancement and development, clash with the stark realities of deep class and regional inequalities they encounter. These inequalities, which the participants gradually absorb, expose the limitations of the region's development trajectory, challenging their preconceived notions. This experience embodies what Lauren Berlant conceptualises as 'cruel optimism,' where the promise of a better life through migration remains unfulfilled due to systemic barriers and socio-economic disparities. Berlant (2011, p. 24) defines 'cruel optimism' as 'a relation of attachment compromised conditions of possibility whose realisation is discovered either to be impossible, sheer fantasy, or too possible, and toxic.' Comments and experiences such as Stella's led me, in this thesis, to argue that the better lives the participants sought initially seemed 'fairly possible' but later turned out to be 'almost impossible.'

To return to the discussions on 'homeownership,' in their research more than two decades apart and in different countries, Australia and Norway, Pulvirenti (2000) and Borchgrevink and Birkvad (2021) have found that immigrants' homeownership is related to their belonging and integration the countries where they reside. In her interviews with participants, Pulvirenti (2000, p. 244) found that achieving homeownership as a 'familial

responsibility,' an indicator of settlement, forms the basis of their idea of living a 'dignified family life.' However, she notes that women take more responsibility for seeing the family's success in owning a house. Otherwise, 'even a *good woman* could be spoken ill of' (Pulvirenti, 2000, p. 245) if she does not watch over her family's achievements. Similarly, Borchgrevink and Birkvad (2021) show that the Somali and Pakistani Muslim professional women living in Norway in their research carry the identity markers such as 'a good citizen' or 'a good Muslim' over their housing choices and decisions.

Gender is a factor when looking at what 'opportunities' in the receiving countries mean for this research's participants. Some of them grasped those meanings fixed to 'how to be happy as women' (Goldstein-Gidoni, 2017, p. 283) in their origin countries and conveyed them to their lives in the destination. In different cultural contexts, the label 'happy migrant' can be translated to and include 'happy woman,' 'happy housewife', and 'happy mother.' Moreover, 'woman' may be reproduced as 'housewife,' 'working wife,' 'housewife with children,' 'working wife with children' (Sato, 2021), and so on. That said, all versions often have the same gendered reference. Sevi senses a cultural separateness from British women with regard to material or family pressures, maybe because she perceived certain gender norms in the UK to be less oppressive or absent as a newcomer in this country. Nevertheless, the 'family' idea, either nuclear or extended, is at the same time very dominant in the UK as it is spread to the world in different forms and inflexions within various national, religious, and cultural contexts. Further studies could help to shed light on the comparisons of such material considerations of immigrants and their gendered effects in different localities.

On the other hand, single women are said to 'lack the skills' to start the so-called normal family and are deemed 'losers' of some societies (Goldstein-Gidoni, 2017, p. 284-285) and are already left out of the definition of such happiness from the outset. Not all women in this research were married and disclosed their financial thoughts for familial reasons. But this did not mean they did not have such considerations about living conditions or were unhappy. For example, Voyager (Turkish ophthalmologist) explained that she knew that a widespread description of the 'stable life' of a doctor in Turkiye is 'dreaming of buying a three-floor house and going on holidays once in a while.' Here, participants' aspirations for 'homeownership' might be seen as a tool of the internationally circulating cultural construction of happiness, echoing Erich Fromm's (2013) criticism of how contemporary consumer cultures link happiness to material possessions and consumption. Such financial aspirations are a product of middle-class well-being.

However, Voyager never enjoyed making a lot of money, especially for a family cause. She prioritised improving the quality of her work and having feedback on that while emigrating. Further, she added that she has never made enough money to do these things in Turkiye anyway, so she did not like working there and the money she earned there.

Voyager, whose drawing is included below (Figure 5.6), thinks that instead of being a 'married woman,' she owes her identity as an 'employed,' 'work-oriented,' and 'single and free' woman to her migration. As she put it, a large part of Voyager's life consists of what she does as work, and she drew it in the interview: 'An ophthalmoscope in my hand is used to look at the back of the eye. It is small, but we come very close to the eye and the patient and look at it. We look at those [eyes] of in-patients with this; we look at those of normal patients with a microscope.' As the conversation progressed, I realised that for Voyager, who portrays herself as a calm woman with a smile on her face in her visual material, the ophthalmoscope symbolises her professional side and her resistance to marriage. Some people wanted to marry her in different countries, and some were insistent.

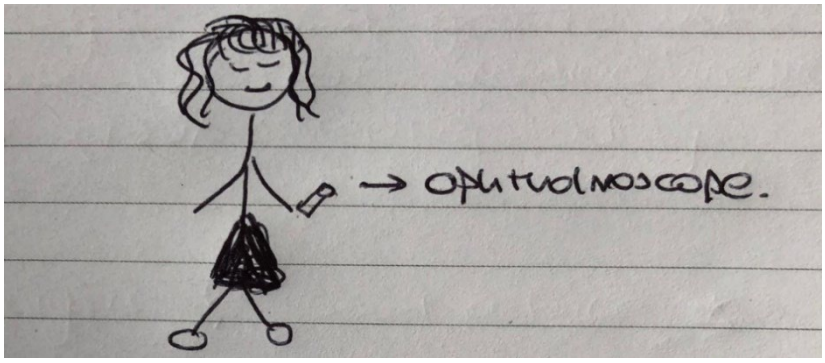


Figure 5.6 Voyager's drawing

Nonetheless, since Voyager moved to England, she says 'there is no going back.' Her family also thinks that her job is a more significant factor in forming her identity and supports her to be a free woman who 'does whatever her heart desires.' Emigrating was Voyager's reaction to the general 'married women are happy' perception in society and a longing to live her own 'single and happy' life.

In sum, rather than preserving the status quo of 'family'—ideally pursuing Western-style, modern, middle-class well-being, what interests me in this section is to show how the participants' idealisation of better lives is socially shaped within a heteronormative cultural context as defined by Sara Ahmed (2014, p. 149): 'a heterosexual coupling may only approximate an ideal through being sanctioned by marriage, by participating in the ritual of reproduction and good parenting, by being good neighbours as well as lovers and

parents, and by being even better citizens.' According to Ahmed, heteronormativity is the way culture is transmitted or reproduced through one's relationships with others. And I contend that in this sense, the culture of happiness and the goal of a better life are heteronormative. The better opportunities that migration is thought to promise become tools that will bring better lives for women and their families in such a context. 'Opportunity' is perceived as paving the way to an 'economically stable family lifestyle.' Furthermore, marriage generally becomes linked to happiness and a 'normal life,' which 'constitutes a normative family, a normative woman and the consequent normative happiness' (Goldstein-Gidoni, 2017, p. 286).[5] Therefore, this reflects a normative culture in which the ability to afford goods, own a house, become 'affluent,' go on day trips, or save money is an opportunity for some participant women to project their idealised future and have happy and better lives with their families.

5.2.2 Working Environments: Health and Social Care Systems

In the interviews, participants examined the differences between health and social care systems in the UK and countries of transition and origin on the following criteria: patient profile and ratio; wages, working hours, workloads and workplace conditions; their reputation, authority and career prospects; and relationships with patients, colleagues, and employers. Exploitative or poor work environment conditions coupled with the aforementioned living conditions were reasons for these healthcare professional women to migrate (McGregor, 2007; Nair and Webster, 2012; Bludau, 2021; Kline, 2003), and they sought a 'better' health system to work for it.

In this subsection on 'work,' I first show the rise of the NHS as a 'world-renowned' among healthcare professionals and the global spread of NHS values. I discuss the NHS as an attractive location that participants think has a good reputation and prestige worldwide. Is the dream of working for this institution also to become part of the 'British dream' for healthcare professionals; is this what my participants pursued via their migration journeys?

In addition, I unpack the participants' comparisons of the private health sectors and national health systems and what they learned from these comparisons. One key factor influencing participants' evaluation of their work environments has been the understanding of health and expectations of medical treatment. For example, 'illness,'

[5] For discussions of how women's family responsibilities are deeply imbricated and constructed through policy across various contexts in history see Goldstein-Gidoni (2017) for the Japanese context, Yildiz (2017) and Sancar (2012) for the Turkish context.

‘health,’ ‘treatment’, or ‘death’ are approached and described differently in various countries. I propose ‘health culture’ as an umbrella term covering nuances in professional and social approaches to health participants' notice.

Finally, this second subsection will also show conflicts between some participants' initial idealisations for the UK's healthcare system and their eventual disillusionment with it. Underlining such comparisons allows me to illuminate the adjustment or adaptation of the participants to the different working environments.

To begin with, Kani's (Indian doctor) life before emigrating to England had revolved around a dream that she had never thought would come true: to pursue her career in the NHS, which is ‘one of the best healthcare systems in the world’ in her phrase, and further, in the country of her dreams since childhood. When she finally achieved it after a long time, she was happy and excited and was ‘literally flying’ on the day of reaching the UK. Then, how is ‘living the dream’ (Vafeas and Hendricks, 2018) in the UK's NHS offered to a migrant healthcare worker?

What emerged from Kani's story was her aspiration to come to the UK and achieve a degree in English from ‘the Royal College,’ which constituted her personal ‘dream.’ In our interview, when I asked Kani why she specifically chose to immigrate to the UK, she told me that she learned the English language at school in India at an early age. ‘Everything was English,’ she says, ‘at school.’ Ever since secondary school, she had dreamt of pursuing higher education or any course in the UK because ‘everybody wants to be trained in the UK.’ Kani later had many doctor friends in India who completed their education in the UK: ‘You can see lots of doctors in the world who have got degrees from the Royal College of the UK.’

The *motivations* of Indian healthcare professionals migrating to the UK are situated in the ‘imperialist set of relations’ (Fitzgerald et al., 2020, p. 1170) between the UK and India. That said, the neo-imperial distribution of the national NHS values is founded on the history of ‘the NHS as an imperially-resourced service’ (Fitzgerald et al., 2020, p. 1163) and also of ‘medical services and disease prevention in colonial India’ (Mushtaq, 2009, p. 6). Britain's imperial relationship with India spans over four centuries. The British Imperial government closely influenced the medical profession in India, displaced the indigenous Indian and Arabic medicine systems in this country and still controls it (Esmail, 2007, p. 827; Mushtaq, 2009, pp. 12-13). The creation of the NHS, which relied heavily on migrant labour due to its colonial ties, also gave rise to an aspiration among India’s ‘highly-skilled’ doctors to work in this ‘great’ institution—they believed that by

doing so, they could enhance their skills, which they envisioned taking back home later (Esmail, 2007, p. 830).

David Goodhart (2013) writes that the NHS and its 'shared values,' alongside a few political institutions such as the Monarchy, the Army and the BBC, has established the 'British dream' and the history of the British Empire becoming 'Britain' in the post-war era. Regardless of his critique of multiculturalism in this book—that is beyond the scope of this section—he detects something important about the healthcare professional immigration to contemporary Britain: 'The picture of NHS hospitals full of front-line staff from African and Asian backgrounds is often used as a powerful image to underline the benefits to Britain of immigration' (Goodhart, 2013, p. 46).[6]

What interests me is that post-war immigration of healthcare workers to the UK has not simply been from the 'Global South' or 'former British colonies' or about a 'British dream' steeped in colonial relations. The NHS also attracts those who are not necessarily directly connected to Britain through colonialism. Emigrating to England and working in the NHS were attractive to most participants from different parts of the world. Depending on the promise of the UK's better working environment, a widely common idea among overseas healthcare worker participants found in the interviews was that the UK's NHS is the ideal system to work in.

The NHS is 'the first institution in the world to work for' and one that should be respected, according to Nur (Turkish nutritionist). For Stella (Greek/Swiss physiotherapist), it is internationally famous and has been one of the attractions for her arrival in the UK, as she was advised as a priority and the best to start her career. Working in the NHS is prestigious for Voyager (Turkish ophthalmologist) and rewarding for Sunshine (Filipina nurse) as well. Sunshine defines it as a world-known agency: 'Everybody knows NHS. Americans are just so jealous that we've got NHS.'

'NHS England' is promoted and advertised globally; it 'attracts and keeps' 'skilled' international workers (Leone, 2019). 'The British public's idealised notions of the NHS' (Warden, 1987, p. 1428) or 'the NHS as a sacred value' (Woodhead, 2020) are not spread only nationally but also internationally. I focus on how the promise of working in the 'world-renowned' NHS is unevenly distributed among healthcare workers worldwide.

[6] According to Katwala (2013), a need is underlined in the book to marry the civic story of the aforementioned popular British institutions with the everyday experience of common life, for example, 'regional accents,' 'getting the joke,' and 'reading the local paper.' In Chapter 7, I will show how immigrants encounter such impositions of British culture in daily life.

For example, for Regina (Romanian healthcare assistant) and Gul (Turkish/Bulgarian healthcare assistant) working in the private sector, working in the NHS is not yet an option, although they currently reside in the UK. Gul was trained as a medical professional in Turkiye, and her English proficiency does not yet meet NHS requirements. Moreover, Regina is neither medically trained nor certified in English. The disparity in the distribution of the dream of working for the NHS can be attributed to the places where English is taught and spoken and the credentials given.

The exploitations at work were evident in Kate's (Turkish physiotherapist) comparison of her working hours and right to sick leave in Turkiye and England. Once, she had pneumonia while still working in Turkiye, and her employers gave her only five days off work in total, and she had to return to work sooner than she would have preferred. 'In this country [in the UK],' however, she believes 'you would get like three weeks [for sick leave].' What is more, Kate was often overworked in this Turkish private clinic. She hardly remembers leaving work at 6:30 p.m., the regular departure time. For Voyager, a Turkish ophthalmologist, the problem was the number of patients she was expected to see on a single working day in Turkiye. While this number was up to 120 patients a day for some of the doctors she worked with in Turkiye, it could be up to half that for her in the UK. Because according to Voyager, seeing more patients to make more money reduces the quality of treatment. 'If you make a proper treatment for a patient, it is impossible to see that number of patients. I don't like a '*yalap şalap* treatment.'[7] According to her, the maximum number of patients seen in one day is 40 in England. Voyager might have overstated the number of patients she used to examine in Turkiye to indicate how unacceptable the numbers were, but the maximum number of patients examined daily in public hospitals in Turkiye is indeed higher than it should be.[8]

On the other hand, the pressures in the UK's NHS general practice—workforce, work patterns and appointment numbers—suggest that the numbers Voyager stated in our interview coinciding the early stages of the Covid-19 pandemic, at a time when GP appointments declined by up to a third, usually are much higher (British Medical Association [BMA], 2021, Baker, 2021). Before the Covid-19 outbreak, GPs saw up to

[7] A Turkish idiom with a similar meaning to the English idiom 'after a sort': 'poorly, imperfectly, or without great care.'

[8] The TMA wrote a letter to the Turkish Ministry of Health on September 7, 2021, regarding the reduction of the appointment interval in the Central Physician Appointment System (MHRS ['Merkezi Hekim Randevu Sistemi' in Turkish]) to five minutes and about asking physicians to examine more than 90 patients in a day. In the letter, it was pointed out that a five-minute period would not be enough and would lead to medical practice errors due to lack of care (TMA, 2021).

70 patients daily in the UK, more than double the recommended safe limit of 25 contacts (Gallagher, 2018).

Judging from what the participants said in the interviews about the comparisons they made between working in the private sector and public hospitals in England, we can understand that working in these two sectors makes a difference in the satisfaction of the participants with their job conditions. For example, Kate, favouring working in England when comparing the working conditions in Turkiye and in the UK by using the examples of sick leave and working hours above, said that if she did not have a private clinic in England and worked in a public hospital, she would not be able to treat her patients with the quality she wanted:

> What I hear from my patients who come to me and go to NHS, come back, most of them think that, in NHS, they [physiotherapists] don't do much hands-on treatment. And, they don't have enough time for each patient because it's, they're very busy. So, my patients usually complain about they haven't stay in the room [examination room] for enough. And, they were, they are usually given exercises, and then for a follow-up appointment, they can't see the physio very often. There is a huge waiting list in NHS, and sometimes GPs tell their patients 'you might, you need a physio, but you might be better off going to a private physio,' for example… At some point, NHS contracted me to treat their staff because they couldn't find any physio in the area [around the town where she lives in the North West] to work for them. (Kate)

Anna, a psychologist in the NHS, described how she experienced the problems that Kate feared she would have had if she had worked for the NHS: 'There's too many expectations, too little time to do everything you have to do. So, that caused this stress,' she says. The aspects of her work environment, specifically 'in a small town in the North West, and not in the private sector but the NHS,' have embodied the feeling that Anna is 'just muddling through doing a good enough job' as she hoped. The work is 'not great' for her; it is more demanding with each passing (promotion) and much busier than it used to be when she qualified in the UK fifteen years ago. There was less pressure in the past on how many clients she saw a day or how she recorded her work. NHS buildings are now often overcrowded and do not always have the right equipment; rooms cannot be booked for examinations. Also, there are not as many specialist services as in the cities, so it feels like working as a general practitioner; she has to know many things and be able to work with anyone. She commented that a further difference in her workplace from big cities is having less funding than London or Manchester would, and their waiting lists are always a challenge.

While Anna's experience reflects some of the challenges that can be encountered in smaller towns in the North West, it is important to note that her perceptions may differ from those of individuals working in more affluent or urban areas of London or Manchester, where resources, infrastructure, and demands may vary significantly. London is often used as a benchmark when discussing NHS conditions because it offers a contrasting environment with more resources and different socioeconomic factors. However, it is crucial to acknowledge that London, like other large cities, is not a homogenous. It presents varying socioeconomic and demographic conditions across its different localities, offering distinct experiences and challenges for residents and workers. Therefore, whereas participants may perceive a different set of expectations and resources in London, these perceptions will be shaped by the specific locality within the city, as well as its unique social and economic disparities. This calls into question the over-simplification of the North-South divide in the UK, suggesting that, when considering localised conditions, the division's generalisations may not fully capture the complexity of intra-regional experiences.

Most participants are confident that they have better working conditions in the UK than they have experienced in their countries of departure. But is the NHS the 'envy of the world' (Andrews, 2021), 'the world's best healthcare system' (Duncan and Jowit, 2018), or 'the best place to work' (Worsley, 2019) in reality as experienced by my participants? The reply is 'not quite' when Anna's reflections contrasted sharply with living the kind of dream Kani describes, so she was not satisfied with the working conditions in the NHS.

In our interview, Voyager did not just explain the decline in the quality of treatment services in Turkiye with the increase in the number of patients but also talked about overprescribing. Health services should not be provided by prescribing medication alone, she commented. Like Voyager, some other participants look satisfied with the British view of health culture, which differs from the understanding of medicine they experienced in their country of origin after emigrating to England. Didi, in particular, told me how she enjoys de-prescription in her current workplace, which is a private UK care home with 'a very large garden,' a lake and ducks in that garden, where she was recommended to apply for as it is 'a very famous company; very posh, very luxurious place, exists all over the world':

> …it [her workplace] was a state hospital in Turkiye, it was very busy, it was a district hospital. The system here [in the UK] is very comfortable. We don't tend

> to give too much medicine here. If you see the medicine cabinet in our hospital, it's tiny. If the patient says, 'I have a headache,' we say 'come on, I'll take you to the lake,' we say 'let's take a look at the ducks.' For example, we have a private music room. For example, the patient says, 'here it hurts,' you cannot give morphine per minute to the patient; morphine becomes useless, how long could you give it? For example, I take the patient to our musical therapy room. I say, 'come on, let's make a cake.' Patients themselves do not want to take too much medicine. They say, 'if I will die, I'd like this way.' (Didi, Turkish care manager)

'We need a conscious society. But this must be reciprocal.,' Voyager adds. Therefore, the excess of prescriptions depends not only on the doctors but also on patient expectations, which I find to be an important indicator of 'health culture.' In this context, medicalisation, which means seeking to legitimise distress and defining what a 'medical' problem is, has primarily been achieved not only through the work of medical professionals or scientists but also increasingly through the efforts of patients or citizens (Correia, 2017). For example, Dumit (2012) illustrates how patients, influenced by pharmaceutical advertising and online information, actively contribute to medicalisation by demanding specific diagnoses or treatments, thereby legitimising their experiences as medical issues.

Diagnosis and treatment form the backbone of communication in doctor-patient interactions. Doctors in Turkiye might tend to treat with medication, perhaps because of a lack of time for appropriate examination, as Voyager stated. Turabian (2019) argues that the workload can lead to a 'defensive medicine,' which describes overprescribing diagnostic tests, procedures, and drugs to compensate for patients' sense of disturbance who would interpret de-prescription as a sign that doctors give up the medical care. In other words, doctors try to preserve the 'peace' between them and their patients. 'Peace' has literally been crucial, especially in the last decade of 'doctor emigration' in Turkiye. The Turkish Medical Association (TMA) announced in September 2021 that, in ten years, 4,891 young doctors emigrated abroad: she stated that all kinds of violence, verbal, physical, psychological, economic and similar, are the factors that push young people to become 'migrant doctors.' There is violence not only from the patients and their relatives but also from the administration, she said (Ersan, 2021). Simply put, I found from the participants' interviews that their patients in their country of origin expected them to prescribe medication almost after each examination.

> Patients are already very conscious [in the UK]. They come to the hospital by answering 20 questions [in pre-treatment questionnaires] as if they were coming to school. It is not a doctor-dominated system. The doctor is not saying that, 'I

> have decided, I will do this treatment.' The doctor says, 'According to the literature, there are four ways: this, this, this and this.' And says, 'I will do whatever you want.' The patient also says, 'Let me think, and I will come again.' (Voyager, Turkish ophthalmologist)

Indian doctor Kani, another participant, made a similar determination for Indian people. According to her, Indian patients aspire to be prescribed medication or hospitalised until they die. Kani noticed a difference between the European countries and India regarding the end stage of 'lifecare.' In Kani's view, Europeans prefer to end their lives peacefully and without stress. Alternatively, for example, if they have terminal illnesses like any kind of cancer, such as lung cancer or colon cancer, they do not prefer to get further treatment. When they know that, even after getting treatment, they are not going to get cured completely, they want to die peacefully, she commented. Kani's one particular example was that these Europeans opted to sign the DNACPR [Do Not Attempt Cardiopulmonary Resuscitation] form, where they stated that they did not want to have chest compressions while in shock or while the heart had stopped suddenly. Back home [in India], she says, even if people know that they are going to die, they do not want to restrict themselves from getting the treatment.

Briefly, many participants regarded the NHS as a representation of the 'British dream' and were lured by the NHS's global reputation for stability and prestige, particularly for professionals from former British colonies, whose historical linkages shaped views of the UK as a desirable place to pursue a healthcare career. A prominent reason some participants were drawn to the UK was that they did not want to work in an environment where medicine was overprescribed and equated with treatment, where they had neither the time for an alternative treatment nor the freedom to choose from other treatment modalities. Their experiences, however, exposed a complex reality: Although the NHS provided advantages such as lower patient loads in certain situations, many participants faced major obstacles, such as a lack of resources, heavy workloads, and structural differences between hospitals in small/rural towns and urban areas. Some were disillusioned as a result of these difficulties, especially in deprived areas, as they struggled with lengthy waiting lists, little patient engagement, and insufficient resources. Private sector employees occasionally had more flexibility, but they were, nevertheless, conscious of the NHS's advantages and disadvantages. Overall, the healthcare workers' reflections show the conflict between their initial expectations and the practical realities of healthcare work in the UK, illustrating an ongoing negotiation between idealised ambitions and systemic challenges, even though migration fulfilled some of their

professional aspirations. In the next chapter, I will discuss what 'medical' is, how effective this concept is in UK hospitals and what impact it has on the work experience of the participants. I will also show how the NHS is still governed by expectations of medicalisation and how it generates divisions among the healthcare professionals as 'medics' and 'non-medics.' For now, I turn to how participants anticipated being able to locate a politically secure area to safeguard their own and their families' lives.

5.3 In Search of Freedom: Socio-Political Factors

> My lifestyle, it was very good there [in the UAE] as financial, I had nice house, nice car, a very good salary there. They give very very good salary for nursing especially. But, you cannot live there happy because it's not money everything, and you don't have safety there anytime. They, like, they told us bye-bye, go! Yeah! So, and, I cannot go to Syria, cannot take my kids and go to Syria, to the war. And where we will go? My husband, he don't have passport to go to Jordan as well. And even Palestine! Palestine, I don't have passport Palestinian, to go to Palestine. So, we don't have a choice; only to come here [to the UK], or any Europe country. (Lila, Palestinian clinical support worker)

The excerpt above shows that Lila had 'other' *motives* than material and professional considerations when migrating; she had a family and children to take care of. Lila, Palestinian/Arab clinical support worker, like many refugees, is a woman with no place to return. She is the daughter of a family with a history of serial migratory trajectories. Her grandparents had fled Palestine during the 1948 Arab-Israeli War, stopped in Jordan, and later, she was born in the UAE, which was her parents' next stop in their migration path. She left the UAE, where she was born and bred, educated, married, and had children, but she was not granted nationality for almost 30 years and lived in danger of being expelled at any time. When the Syrian civil war broke out in 2011, Lila's husband was the one who came to the UK first in 2015, sought asylum, and Lila and their four-year-old girl and two-year-old boy joined him a year later in 2016.

Lila's narrative provides insight into how safety concerns and a desire for freedom can influence refugees' migration decisions. Lila and her family were always in fear of being expelled as they were not granted the privileges of legal citizenship, so even though they were financially secure, they were deprived of basic freedoms in the UAE. Because of the absence of rights and the autonomy afforded by rights, even her successful career in nursing could not make up for the possibility that she and her children may be displaced at any time. Because Lila's roles as a wife and mother influenced her decisions and responsibilities, gender norms also played a part. Although her primary reason for

coming to the UK was safety, it also represented her wish for a secure environment free from the constant risk of expulsion or restrictive movement, where she and her children could enjoy a level of freedom not attainable in her origin country.

'Forced migration' leads us to the movements of people fleeing their homes due to persecution, conflict, and natural and human-made disasters, and it is at the heart of global politics (Betts, 2009, p. 1). The theoretical framework of the 'forced migration' category is confined to the displaced people and their involuntary migration movements. It is based on the assumption that the movements of persons considered under this category are mainly for political reasons and should be discussed in a political context. Faist (2000, p. 32) illustrates that the dichotomous category is used by nation-states that separate displaced people as refugees from voluntary migrants as labour migrants. Therefore, mobilities become manageable for states. States establish definitions for different groups of migrants to count them and, afterwards, justify measures and new policies according to these definitions (Schrover and Moloney, 2013, p. 255). More specifically, the categories of *skilled* workers are determined, under which parameters migrant workers enter the labour market—for example, temporarily or permanently—and to what extent they are allowed to change their employers freely (Bach, 2010, pp. 252-53).

In this section, I go beyond such analytic and political limits and include migrant stories of women who were not 'forcefully' displaced like Lila was, Lila crossed the borders as a refugee and stateless person, but some other participants came to the UK with similar reasons to Lila's. Although they were not refugees, the aspirations for 'better life migration' in the stories of some other participants were not very dissimilar to those in Lila's story when searching for a place to live freely. For the women in this research, having better lives also means being able to live freely.

Safety and freedom are identified within the universal human rights framework as crucial prerequisites to secure well-being and a 'better future' for migrants and their dependants (Chase and Allsopp, 2020, p. 92). At the same time, the Universal Declaration of Human Rights (UDHR, 1948) manifests the right to safety at the global level as a fundamental human right that signifies individuals living in freedom and security. I elaborate on 'freedoms' from a gender perspective in this section by extending the understanding of the liberal ideal of freedom, which defines freedom as living freely without restraint for all humanity (Parrenas, 2021, p. 153). In the interviews, besides the 'freedoms' in the context of human rights violations, a quest for freedom from rigid gender control was voiced, for example, when a participant felt a free individual or a

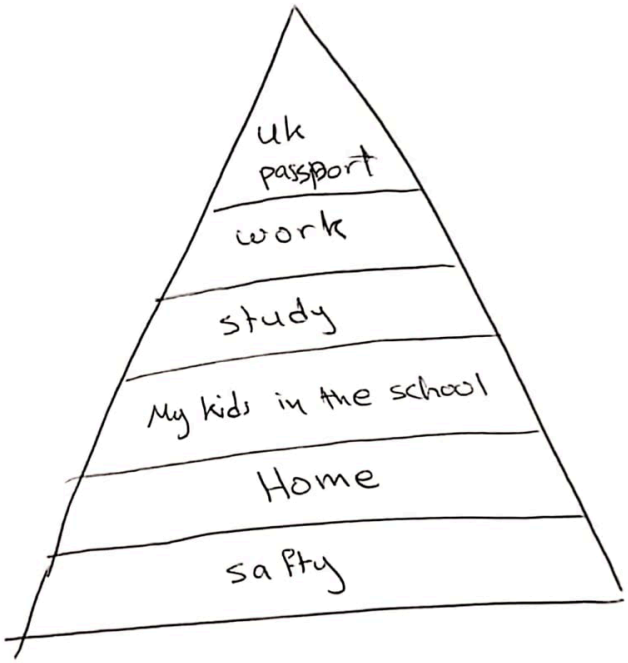


Figure 5.7 Lila's pyramid

woman who could meet people, expand her network and build relationships without constraint. For example, Nur mentioned her experiences in the UK of meeting other people and expanding her network. She is happy with the 'value and freedom given to people'; 'the relationships are better here,' and she feels 'as an individual' who has now acquired what Cin (2017, p. 41) calls 'social capability,' enabling her to engage 'in different social activities and (mixed gender) interactions, networking with other people, freedom of communication and associations, organising social events, taking social responsibility for one's own society without facing oppression and harassment, participating in social, economic, and political arenas, and being treated as a dignified human being without any sort of discrimination.'

I begin with what 'living freely' represents in Lila's story and image and what she dreams of in common with the other participants. Later, I will unpack what 'freedom' means to the other participants.

When I asked Lila in our interview to draw something representing her migration story, she drew a pyramid (Figure 5.7). After she finished drawing, I asked her what this pyramid meant to her. She said she drew the pyramid in temporal order (in a time scale) and considered which element was more important and prioritised in her story. The elements she included in the pyramid in ascending order (starting with what is most important to her, as she said) are: I) 'safety' (the departure from the UAE), II) 'home'

(joining her husband in the UK with the children), III) ‘my kids in the school’ (children's education in the UK), IV) ‘study’ (her language and occupational training), V) ‘work’ (employment for both herself and her husband), and VI) ‘UK passport’ (her settlement process in the UK).

In her image, Lila begins her story with ‘safety’ and builds the other elements in her pyramid on top of that. Lila's entire pyramid represents what she expects from her life in England. To begin with ‘home,’ Lila and her family were still living in the city in the North West at the time of our interview, where the government sent her husband when he was an asylum seeker. Most asylum seekers in the UK do not have the right to work while waiting for their claims to be considered. Therefore, most must rely on state support, such as housing and cash for food, sanitation and clothing (UNHCR, no date). Thus, Lila's access to safe and secure housing was committed by the state of the country she entered, hoping to become a citizen when we look at the ‘UK passport.’ Lila's status of permanent settlement in the UK or being a British citizen is like a happy ending in Lila's story. This commitment has also shaped the integration of herself and her family into the British society and environment in which she lives. Lila's pursuit of UK citizenship, symbolised by the top of her pyramid, aligns with Fortier's (2021a) argument that citizenship is both an object of desire and a promised source of happiness, cultivated by state structures. Her goal of a UK passport reflects the aspirational value attached to Global North citizenships, promising stability and societal integration for herself and her family. Or, for ‘my kids in the school’: Lila, when emigrating to England, hoped that she and her husband might eventually give their children a homeland and promise them a good, safe future and a good education at good schools. Lila positioned ‘safety’ against ‘uncertainty’ as a reason for her migration. She said that she was living with her family in the UAE, happily but not in safety, and they did not have a future plan there as a family. Moreover, ‘study’ and ‘work’ on her pyramid are about Lila's employment experience in the UK, her educational and professional skills and qualifications, which I will return to in Chapter 6.

Using ‘involuntary’ and ‘forced’ migration interchangeably, Abiri (2000, p. 71) highlights the linkage between migration and security in which people, as individuals or in groups, move across internationally recognised borders when experiencing threats to their security. Ozdemir (2018, p. 130), drawing on such a human-centred definition that refers to the security, protection, and survival of forced migrants, confirms that human security is related to protecting individuals' vital freedoms. The term ‘safety,’ which appears at the base of Lila's pyramid and is often used in her words when I discuss it with

her, relates to ensuring vital freedoms in a life that Lila aspires to lead securely and safely with her family and children.

'This is political things… All we are Arab, but they [the UAE] don't want us,' said Lila in our interview. Lila's story shows that 'safety' is highly politicised and carries different meanings in different political contexts, as in the words of Chase and Allsopp (2020). When it is asked of Lila, she notes her ethnic identity to be Arabic and expresses grief about being left 'stateless' by the UAE because, according to her, she and her husband are also Arabs, after all, like the Emiratis. Yet, as she contemplates, she realises they were treated as foreigners in that country because of politics. More specifically, safety is a matter of naturalisation and citizenship in the UAE (Wang, 2015, p. 75). UAE nationality is based on the principle of paternal *jus sanguinis* (line of descent). It means that the father's citizenship determines their child's in that country.[9] Considering that both her parents were expatriate professionals—an officer father in the government and a teacher mother—living in the UAE and relying on only their work visas, Lila remained stateless.[10] The driving force behind Lila's departure from the UAE has been her perception of a political restraint of safety via citizenship there and her sense of discrepancies between institutional and her conceptualisation of safety (Chase and Allsopp, 2020, p. 81). In short, such disruption made Lila conceive of the UAE as 'unsafe.' For the same reasons, British citizenship, at the top of her pyramid, could be the distinguishing criterion for whether the UK will ultimately be a safe country for Lila.

It is worth noting that Lila's feelings on 'safety' were not unique to Lila, the only refugee participant in this study. For example, two political events that took place in 2011—the Egyptian Revolution in Tahrir Square and the subsequent Syrian War—made the Middle East regions unsafe and 'less desirable' locations (Parrenas, 2015) to live and work for Sunshine (Filipina nurse) as well, who was then working as a nurse at a hospital in Cairo, Egypt. She had to take a break from this work in Egypt: 'I went there in 2011, and then I left because of the uprising in Tahrir Square. I don't know if you remember it on television. So, the Philippine Embassy in Cairo has helped us to go back to the Philippines those who wanted. So, I went back to the Philippines.' Sunshine returned to

[9] With the amendment of the law in 2017, the sons and daughters of an Emirati woman married to a foreigner may be granted citizenship from six years old (Abdulmalik, 2017).)

[10] According to the international definition, a stateless person is not considered a national by any state under the operation of its law (UNHCR, 2003, p. 12). As UNHCR reported, there was a total of 444,237 persons under its statelessness mandate in the MENA (the Middle East and North Africa); the region hosting one of the largest populations of stateless persons in the world. This figure was actually much higher, as it did not even include the stateless Palestinians (ISI, 2014, p. 9, Albarazi, 2017, pp. 1-2).

Cairo at the end of 2012 to pursue her career at another hospital. She worked at this hospital for another year before coming to England. Didi (Turkish care manager), for her part, gave up on migrating to the USA because of some safety concerns during the September 11 attacks. In her migration story, 'America' became an 'unsafe country.' When Didi applied for a visa to immigrate to the States in 2001, she was denied a visa, which she believes was due to prejudices against Muslims after the September 11 attacks that took place at the time. After several direct rejections and once after a short interview, she thought it was not a good idea to go there as she felt apprehensive about her safety.

Then, what do the participants in this study, who do not define their migration to the UK as forced, mean by freedom? More importantly, what kind of freedoms do people migrate in pursuit of other than those defined as 'vital?' For Kate (Turkish physiotherapist), migration has been a way to escape the reactions she might see from her family and environment about her older partner. Her parents did not know about her partner at the time, and she kept him a secret for about nine years because she thought they would not accept him because of their significant age gap. 'For any country, it's a huge difference' she says. Before migrating to England, they thought of moving to another city in Turkiye for a while. However, 'I wouldn't be free,' Kate commented: 'It wouldn't be easy to keep as a secret from my parents. So, I was under lots of pressure because of that. So, that contributed to my decision to move to England as well.' Kate's parents had only known about him four years before our interview: 'To look after an elder woman, so I was staying with her [in the UK], they thought. I had to lie to them every time I talked to them because then, we had video calls, and I had to be careful not to show him.'

At the same time, the right to live away from political/religious polarisation and oppression can be shown as a priority among these freedoms for Turkish participants. Kate observed that the UK and Europe are changing politically as well, but 'it is still much much better than Turkiye,' she commented: 'Turkiye was not politically a place that, as a woman, I would like to live forever. I am free here.' Zei (care worker) and Gul (healthcare assistant) also told me in our interviews about how they witnessed the highly politicised atmosphere in Turkiye. Gul was worried about the spread of religious education in Turkiye and the transformation of secular high schools into religious ones under the influence of Islamic conservatism in state policies. Although Gul's baby was only six months old then, the child's future and right to education were a concern in the family. Further, Gul did not want to send her daughter in the future to one of those

religious schools in Turkiye: ‘I migrated to have a good life for my child. I wanted her to be a freer woman; I wanted her to be able to achieve everything she wanted to do in life’ (Gul). Likewise, Lila is happy on the same matter because, for her, life in the UK is better on the side of ‘safety and a good future’ for her children.

Zei worked as a veterinarian in a public institution in Turkiye for a while. She stated she felt under political pressure at work and in the housing where working community members live. Zei's reflections on her work and living experience show how politicised both public institutions and some social areas in life are in Turkiye. Also, like Gul, she intended to flee from Turkiye's political-religious oppression. Zei explained the pressure she experienced in Turkiye through three examples. First, she could not report the disruptions in the service provided by the pro-government subcontractor at work, as they would accuse her of being anti-government. Or else she talked about how the decorations they hung on the door of their house to celebrate the new year were criticised by her colleagues who were living in the same neighbourhood—some Islamist extremists in Turkiye reject New Year's Eve celebrations, which resemble Christmas customs, as they have no place in Islam. Finally, she said that even on the public transport she used to go to work, there were rude people, and they were judging how she dressed.

Similarly, Klaudia (Polish social care worker) complained in the interview about gender inequalities and social oppression in Poland. She complained of racism, homophobia and sexism there:

> It's just the mindset of Polish people because we've had, we've gone through communism, and you know, when I was a teenager that was still only 20 years after we got rid of that, and there were a lot of different things going on, and the country is also, well, worse; not too much now, very catholic as well. So, there are just a lot of things where, first of all, people are, were very negative because everybody's been through so much. Um, secondly, people are very nosy which comes from the communist culture. Everybody wants to know everything about everybody's business which bothers me. That's one of the reasons; I don't have friends here and I don't really like going back to my hometown. Because every year, I go; it's like: ‘Are you married?,’ ‘How many children do you have?,’ ‘How big is your home?,’ and it's, it's just ridiculous, questions like this. And, there is this general narrow-minded attitude of like, you say, you know, in the last few years, there have been issues around abortion laws, gay marriage is still not an option in Poland, and racism is still a problem because, you know, Polish population was wiped out to just blonde Polish people because of the concentration camps. So yeah, it was just a lot of that; I just felt uncomfortable. (Klaudia)

Klaudia, like many other participants, explains the discrimination and oppression she has been subjected to from the political-history and cultural perspective, which is specific

to her country. However, what I want to draw attention to here is more about the social and political-religious restrictions on the freedoms women experience daily, referring to the term 'neighbourhood pressure' coined by Serif Mardin (2007).[11] Although he uses this term, especially in the context of rising conservatism in Turkiye, this concept can also explain the situation Klaudia described above. She described Polish people as narrow-minded in general and was disturbed by the issues around the lack of openness to different types of people in Poland. In the Turkish context, the 'neighbourhood pressure' concept describes how local communities pressure individuals' freedoms and force them to adopt conservative Islamic norms in their values. However, in the broader sense of the concept, we see that the women living in countries with different religious cultures were exposed to similar kinds of neighbourhood pressure and intolerance (Cin, 2017).

So, did the participants feel liberated from such social pressures on their values after immigrating to the UK? Unfortunately, this was not possible for some. In England, they do not reside in a discrimination-free environment. In their everyday professional life, migrant carers experience racial microaggressions based on their names, looks, and English speech patterns (Chapter 7).

In this section, I have included the stories of Kate, Zei, Gul and Klaudia, who were criticised by the normality of the majority, considered different women of their own countries and migrated because they did not feel free in those countries. When the women immigrated to England, they hoped that the oppression and inequalities they experienced in their homeland would decrease or even disappear. Unfortunately, they find that living in England does not mean living in a society without discrimination and exclusion. However, they talk about how this situation can sometimes be turned to their advantage. These immigrant women with different values earn the labels of 'foreigner' or 'outsider.' They are excluded by those 'neighbours' (Mardin, 2007) from the principle that 'people belonging to a community must share common values.'

In short, the UK emerges as a setting where participants can fulfil aspects of their identity suppressed in their own countries, particularly those related to gender and familial roles. For many, the expanded definition of freedom encompasses not only individual rights but also the safety and well-being of their children and families,

[11] Mardin suggests that the concept of 'neighbourhood pressure,' which is translated into English as it is from Turkish, does not have a worldwide equivalent, but instead proposes the concept of 'fundamentalist,' which includes this term (Kongar, 2017). However, I am more adopting the concept of 'neighbourhood pressure,' which refers to the restrictions that people come in contact with every day, come from their close circles, not only religiously based but also socio-political and gender-oriented.

reflecting a profound desire to protect loved ones. Their migration stories reveal the intersections of safety, opportunity, and self-expression, highlighting a pursuit of autonomy to escape gender inequalities and social oppression that restricted their aspirations and freedom. Freedom, for many participants, is a broad and multifaceted quest for security, social inclusion, and empowerment.

5.4 Conclusion

This chapter explored the aspirations and expectations of the participants seeking ‘better lives’ through migration and how they visualised these migration journeys. Both in the excerpts from the interviews and in the participants' drawings, the chapter reveals how diverse and rich their expectations and aspirations can be, different from the ‘labour migration motivations' standardised around the ‘migration for work’ assumptions in the literature. My conceptualisation of a ‘better life’ in this chapter encompasses the work experience of health professional women in this research but is not exclusively concerned with them. Instead, it acknowledges the lives of immigrants to be multi-layered; not only the professional working environment but also family issues, economic and political security and freedoms make up these lives. The participants' aspirations for better living conditions and opportunities (including material considerations such as homeownership) are inextricably intertwined with their professional expectations of getting the chance to work at their dream institution in the NHS, which they idealise imagining it has a good reputation around the world and promotes a new non-medicalised ‘health culture.’

Furthermore, besides the living standards or work environment, ‘better lives’ depend on socio-political factors, such as gender equality, freedom from discrimination, a child's future, right to education and social environment, and independence from social and political pressure. Participants' experiences illuminate an ongoing negotiation between their aspirations that drove them to emigrate and the intricate realities of life and work in the UK, demonstrating both the promises and limitations of ‘better life migration.’ Policymakers should understand the promises, limitations, and complexities of ‘better life migration,’ as these influence how immigrants, particularly in the care sector, integrate into the UK economy. Without this understanding, immigrants' contributions to the sector cannot be effectively harnessed.

Chapter 6: Healthcare Work: De-, Re-, Up-skilling and Categorisations

So far, this study has illustrated that the migration journeys of those who participated in this research are not driven solely and primarily by their career prospects. However, for many participants, obtaining a better job was key to a 'better life' in the UK. In my interview data, there is a clear relationship between work/professional experience (occupational categories, entry pathways, identities, occupational/workplace structure and so on) and the pursuit of a 'better life.' Some achieved these jobs immediately, fulfilled their professional expectations, and were reskilled and upskilled. However, some had to work in other sectors before re-entering the UK's health and social care sector; some took a second job while working there; some were unemployed for a while, and some were deskilled. This has been frustrating and sometimes brought up issues around their professional self-fulfilment.

This chapter scrutinises participants' experiences of professional mobility in healthcare work in the UK. It covers how those experiences are affected by the migration and occupational regulations that underpin the dualities such as 'EU versus non-EU migrants' and 'medics and non-medics' or the new hierarchical mechanisms created by the emergence of new categories such as 'key worker' status during Covid-19. How do the participants navigate these complex institutional arrangements? My overall argument is about how skilling and categorisations connect to the migrant statuses of participants and undermine the ideal of migration for better lives.

This chapter is organised into three sections, each of which investigates the professional trajectories of participants once they arrive in the UK. In the first section, 'Professional Recognition and Testing Systems,' I will show that there are some hurdles for transnational health workers once they have arrived in the UK, such as repeated tests for registration with the councils regulating health professions, delays in those registrations, and changing registration and licensing rules. Besides, further consideration will be required for the employers of the health system in the UK who are measuring these workers' professional credentials and language. This raises the following questions: to what extent are the requirements and expectations transparent for these migrant health workers? How well do they grasp, navigate and satisfy them?

In the second section, 'Occupational Hierarchy,' I will first distinguish between healthcare and social care. I will show how 'medical discourse'—the specialised language

and communication practices used by healthcare professionals and others involved in the medical field to discuss health, illness, treatment, and medical procedures—creates divisions among health workers. I will then examine the 'medics/non-medics' distinction that hierarchises occupationally the migrant healthcare professional participant women in this research. The second section discusses what counts as 'medical,' for whom, and under what conditions. How the women navigate, (re)define, adapt to and contest the professional, bureaucratic and legal categories and hierarchies is constitutive of the healthcare system in the UK. The seemingly fixed formal bureaucratic and legal categories are permeable in practice. The section describes how 'health/medical' is elevated and 'care' is devalued. I contend that without care, there can be no medicine, and without transnational carers, there can be no NHS. The experiences of the women I spoke with challenge the health-care dualism and the hierarchies that result from it.

The third section, 'Key Workers,' addresses how participants experienced a new category of 'key workers,' which the UK government unveiled with the Covid-19 outbreak. In this section, I will examine participants' experiences during the pandemic. There are inconsistencies in the UK's visa policy. This category brings a virtual status of a 'key worker' to these workers who fight against the Coronavirus crisis in the UK as the frontline staff, not a genuine appreciation for what they do. The division above of medics/non-medics would also help conceptualise the 'key workers' category. These divisions—medic/non-medic, skilled/lesser-skilled—are blurred under the 'key workers' category, and I will explore the connections among different migrant categories in the section (Dagdelen, 2020a, 2020b). I include the 'key workers' category within the broader framework of migrant categories, often constructed through media, political, or legal discourses surrounding migrants. These categories are typically framed in binary terms, such as EU/non-EU, skilled/unskilled, or medic/non-medic, and are poorly mapped and insufficiently explored in empirical research (Boeva, 2016; Van Dijk, 2018, p. 231).

6.1 Professional Recognition and Testing Systems

How do distinctions and different categories impact participants' access to their chosen profession, which they identify as essential to achieving a better life? Chapter 2 introduced the role of the EEA/non-EEA distinction in separating health and social care professionals into different occupational categories and how this regulatory register determines the conditions of entry and work for labour migrants from these various areas to the UK. Correspondingly, the visa issue was the biggest obstacle that reinforced the

EU and non-EU distinction among participants and could not be overcome for non-EU participants. We can think of the access of the non-EU participants to their work in the UK in two steps: visa and occupational registration. While for EU migrants, only one step was required: registration.

The first step is getting a visa to enter the UK. Until it changed with the UK government's post-Brexit immigration policy, EU citizens could come into the UK without necessarily having a post within the country, by contrast with those who were coming from non-EEA countries and who were subject to the UK points-based immigration system which is composed of five visa tiers. The second step is occupational registration, where each occupational category in the UK's healthcare sector imposes specific registering and licensing requirements on overseas doctors, nurses, midwives and other health professionals, which is advantageous for European nationals. Given Europeans' easier access to work and recognition of qualifications, the ideal of 'better lives' is not equally distributed among all participants. European women are closer to this ideal than non-European women. Being European in this context does not just refer to citizenship; it goes beyond the geographical boundaries of Europe. Differences are not simply along the EU and non-EU lines. Even within European participants there are differences between Western and Eastern European arrivals, among other dimensions (Fox et al., 2015; Lewicki, 2023).

In this section, I explain how especially being recognised as a non-European in the UK hindered some participants from proving their qualifications and how it made them deskilled. Regaining their original professional credentials and status in England has been costly, and it took time, money and effort. The women pursued some coping strategies with deskilling, such as taking a second job or doing an observership. At the same time, the women were disadvantaged not only when they had to prove their qualifications but also when their proficiency was tested in English. So, how are women's work, skills and duties valued according to the testing systems? Crucially, how do tests fit into the broader UK migration visa regime?

6.1.1 Professional Recognition: Deskilling, Devaluation, and Coping Strategies

Most of the participants felt devalued and inexperienced when they immigrated to England and wanted to find a job there. This is the work of the UK immigration and occupation regulations system and the categories I mentioned earlier. The regime of professional recognition almost 'infantilises' these workers after they enter the country

or even before that. It is a test, but not always in the sense of having to study for an exam and do a test. William Davies (2014, p. 142) explains such valuation with the replacement of 'normative and political judgement by some form of numerical test' under neoliberalism, which becomes a means to test the value of humans (see the sub-section 'Tests' below).

In Chapter 5, I presented how some participants were disappointed with their professional expectations in their countries of origin. Zei was one of them and was unhappy with her life in Turkiye. When she decided to move to the UK, she sought ways to pursue the same profession in this country. Nevertheless, she realised that her veterinarian qualifications were invalid unless they were officially recognised. She needed to find a way to verify those qualifications or retrain as a veterinarian in the UK in a language other than Turkish. She knew that either way, going back to her original job required a tremendous effort:

> If I was told that I did not need to satisfy any requirements for being a veterinarian in the UK, of course, I would turn back to my first career [do a veterinarian job]. However, there are no [occupational] courses for [overseas] veterinarians here, you have to make self-studies. Besides, you have to spend a lot of money to the exams, because they are expensive. Just to say to the authorities that 'Sorry, I want to take this exam, could you have a look at my diploma?,' you have to pay a lot of money. Already, we [as Turks] are not in the EU, the result is obvious. Even for some translations for the paperwork, we have to spend so much money. So, I thought that 'Why I would not spend both my financial and motivational power to any other job.' (Zei, Turkish care worker)

There are some vocational courses in the UK for overseas-qualified veterinary professionals offered by the Royal College of Veterinary Surgeons, but they are only introductory. After a short free training, a certain fee must be paid to continue this training: for example, a communication skills session is £150 + VAT per person (Royal College of Veterinary Surgeons [RCVS], 2021). Still, the point is that Zei felt that enough information was unavailable for her to recognise her qualifications.

> I feel like I was reborn here [in the UK]. I feel like I have never lived for 30 years; I don't have any experience. I am like a little child learning ABC, reading and writing. It is like I have never felt happy, sad, or miserable, and I have never learned from what I lived. (Zei)

Zei feels that she is 'starting from scratch' in every aspect of her life, especially in aspects of her occupation. Unable to return to her job, Zei worked as a care worker in England, served in a coffee shop and sold food on the streets with her husband, a chef. Zei suffered from a sense of loss of professional experiences and skills.

Like Zei, Kate (Turkish physiotherapist) initially felt the same way in the UK. After receiving her UK accreditation as a physiotherapist and when she started to apply for jobs in this country, Kate felt as if she had never had any working experience until then. She says, 'Because I did not work in this country [in the UK], the employers' approach was like I had no experience. That five years [of her work experience in Turkiye] was ignored. I did like fifty [job] applications, not all of them were physio positions, physio assistant positions as well.' When Kate got only one interview out of almost fifty applications, she was afraid that she would not find a job at that time until she opened a private clinic of her own.

Nur, a Turkish nutritionist, is also one of those deskilled participants. 'Sometimes, I think this [nutritionist] is not my main job,' Nur explained. To come to the UK, she applied for a specific visa for Turkish nationals, as though she was a personal life coach, not a dietitian, because she was afraid that she would not be given this visa as she does not hold a bachelor's degree in dietetics in the UK: 'My [Turkish] diploma is not valid here. Very frustrating.' Nur's 4-year dietetics education in Turkiye was not recognised in the UK. If she wanted to be registered here as a dietitian, she would have to study dietetics for three more years at the same level and in English. However, being a registered dietitian in this country would not be enough. She must apply for a dietitian registration in the HCPC (Health and Care Professions Council). There would be an application fee, some documents to be completed, and an exam (IELTS) to be taken. She could only register as a dietitian if she meets those requirements and the authorities accept them. Rather than going that way, Nur chose to be a nutritionist in the UK and enrolled on a master's degree level in nutrition. This seemed more manageable to her for a reason: only those registered with the statutory regulator, the HCPC, can use the title of Dietitian/Registered Dietitian (RD) and the minimum requirement is a Bachelor of Science Honours (BSc Hons) in Dietetics or a related science degree with a postgraduate diploma or higher degree in Dietetics. While there are many degree courses available in nutrition, it is not a legal requirement for a nutritionist to be registered with the United Kingdom Voluntary Register of Nutritionists (UKVRN), which is run by the Association for Nutrition (AfN) (British Dietetic Association [BDA], no date). Therefore, she could have worked when she graduated, gotten a paid job earlier and been registered in this role for a maximum of three years by working as an associate nutritionist. When she spoke to me, Nur had just started her master's degree. However, she received her registration certificate to be an

Associate Nutritionist after our interview and had been working as an online nutritionist/dietitian throughout this process.

The women felt that they had to think positively or have an optimistic outlook to cope with the feelings of deskilling and devaluation, or they already did not have another choice. Zei, for example, would like to consider herself a 'blank page,' in her words, and this page could be 'filled as desired.' It would be an opportunity to be 'free to choose a new occupation' for herself in the UK, and she can 'invest' in herself with education and 'be a science person again.' Bioinformatics interests her; besides being biology-based, she can work from home as it is computer-based. Even so, to plan such a career, for example, to get a master's degree in that field, she needs to save money at her barista job. Or she says it will be up to her husband to take care of the household expenses so that she can plan her new career.

Kate, for her part, had to overcome deskilling with initial unpaid, short-term, and voluntary work. She had observations and the following contracted part-time job in a private clinic for six months. She observed other physiotherapists in the private and public sectors while they were doing their jobs. She evaluates those times as a learning process for her. What she learnt was the language of work in the UK: 'I had no experience with formal writing. I see her writing [the physiotherapist whom she worked with] took notes. Not necessarily how to treat patient but how to document it. For continuous professional development in this country, you have to take courses and refresh your knowledge, or you can have more skills.' Similarly, just like Kate, for her first job in the UK, Kani (Indian doctor) also had an observership in the NHS as she felt she needed 'exposure to NHS' to perform well, which gave her the self-confidence she thought she had lost in the language exams. Also, thanks to this job, she believes she learned how to do her job in England and English:

> I've seen things through my eyes, how it [the NHS] is working, how the doctors communicate with the patients, how they interact with the patients, how they are providing the care packages to the patients and how the GPs are communicating with the specialists in the community hospitals, and in the tertiary care centres… These things gave me a clear idea of how it works. I gain confidence. Even my clinical supervisor told me that 'now you're in the right stage to give the exams, so go on give your exam, clear!' So, I gave the exam [the language exam] just a week or two after finishing my observer-ship. Everything went fine. (Kani)

Kani and Kate, one to gain occupational skills in the public and the other in the private sector, both undertook observational duties which were informally arranged. The NHS designs 'Clinical Observership' programmes that Kani mentions for international medical

graduates who wish to observe clinical work at hospitals for a maximum of eight to twelve weeks. Observers, during the process, are supervised by mentors, are not responsible for or authorised to make decisions or provide advice concerning patients' treatment, and are not paid (ICH, 2021). These programmes differ from formal work experience placements, internships or apprenticeships offered to students interested in a career in the NHS. What Kate refers to as 'volunteering' is a similar experience in the private sector.

So, did 'volunteering' or 'observing' help these deskilled women, and are these activities even considered 'work?' 'Volunteering' might be a positive activity; it provides a workplace where workers can engage in informal learning activities, primarily unstructured and through informal coaching and mentoring (Giancaspro and Manuti, 2021, p. 2). Moreover, it is an opportunity for workers to reconsider themselves and their priorities. It increases self-esteem and confidence, thereby, their desire to apply for better jobs (Giancaspro and Manuti, 2021, p. 7). On the other hand, other researchers assume volunteer work to be similar to informal work. Overgaard (2019, p. 129) scrutinised the notion of 'choice,' especially in social care volunteering and criticised the literature on 'volunteering,' lacking a criticism that 'volunteering is an arrangement that pushes people to work without getting paid for it.' Thinking with her, some participants were persuaded by the assumption of 'volunteering' imposed by the policymakers and researchers of the Western world that such pre-employment experience was essential, or they were choosing 'other jobs' freely or willingly. Moreover, they are made 'to volunteer in situations where better choices about engaging in paid work are unavailable' (Overgaard, 2019, p. 136).

While some dream of returning to their old professions despite difficulties, other women said they could spend the same effort to acquire another profession (as Zei pointed out and Nur did). In contrast, others said they no longer ponder it and endure working in another role for a while, whether in the healthcare industry or not. In the UK, they have had 'alternative careers' (Hennebry and Walton-Roberts, 2019, p. 95) within and outside the healthcare sector that sometimes felt like they were not their profession, which they could not do so fondly or 'choose freely.' Instead, for some, these jobs are income-generating roles and are expected to be temporary.

'Second jobs' have been taken by some women before taking a job in the healthcare sector, or as an extra to and alongside a healthcare job, or instead of such a job. For example, Nur worked as a barista in a café while doing her online nutritionist-dietitian job. Lila, a Palestinian clinical support worker, is taking courses to be a certified Arabic translator alongside her role in a hospital. Klaudia and Didi first worked as au pairs upon

arrival in the UK. Later, Didi worked as a barmaid and a waitress before taking her care manager role. Klaudia found a job in a local club in hospitality service and later worked in manufacturing. She is now a social care worker and running a charity supporting care workers in financial hardship.

Sevi, previously an environmental engineer in Turkiye, wishes for a life where she could make money from a hobby. According to her, women with hobbies could turn them into secondary jobs. However, she does not yet have a hobby she would like to pursue in that way; for example, she can work from home instead of working as a healthcare assistant in a private care home in England. She said such a job would be something she would 'do with love.' She is not sure if she wants her original job back as the effort it requires is intimidating. Although, in her phrase, she did 'little research' about how she could make job applications related to engineering, she is aware of a council in the UK that would require membership and that she would be expected to speak English fluently: 'After all, I'll have to start from scratch here and learn everything from scratch again.'

In sum, although some of the participants were, perhaps in a professional sense, ready to work immediately, they received salaries for their efforts once they could demonstrate proficiency in English in the health sector or the transnational translation of their value. Many had complicated thoughts about whether their work was voluntary or not. Some of those who could not even reach the level of making observations or volunteering in their sector turned to other industries out of necessity, and some willingly. Some could hold on to those fallback options: new 'other' or 'second' jobs. These jobs, which maybe they would not even consider doing if they could do their profession, have become ideal for some participants, such as Sevi. So, the divergent work trajectory participants described to cope with deskilling and devaluation was mainly due to a lack of opportunity and choice.

I see observations, volunteer work, and second jobs as 'distractors' in women's pursuit of their original jobs and better lives because, although these roles provide temporary engagement, they often divert time and energy away from the skills and credentials needed for their preferred careers. While they may seem beneficial—allowing participants to stay occupied, gain some English-language work experience, or take a mental break from the challenges of pursuing their ideal roles—these positions do not typically offer significant advancement in their desired fields. Instead, most of these roles are in the 'unskilled,' informal, and service industries. These positions are often targeted for immigration because they are portrayed as readily available and requiring little effort

or language understanding, an image perpetuated through information sharing among immigrants and reinforced by employers who benefit from a 'low-skill,' readily available workforce. Consequently, these jobs can create a cycle in which women remain in roles far from their aspirations, delaying their original career progression and complicating their paths to a better life.

6.1.2 Tests

Examinations and tests that immigrants must take to be considered professionals in the UK can generally be grouped as professional proficiency exams, language exams, and occupational language exams. The inability of women to pass such exams threatens their careers. Repeating the tests often delays their hiring processes, unemployment during their waiting period, or working with lower status and wages. Qualifications that are not proven in English are invisible to the British authorities.

Indeed, the common problem for many participants, European or not, was obtaining and paying for the 'translation' of their qualifications into English. They experienced delays in recruitment due to this bureaucratic requirement. During these delays, they could not start working and lost their money and time in these stressful waiting periods. For example, Kate (Turkish physiotherapist) lost nine months communicating with the wrong institution in Turkiye regarding her diploma. Kate thought the Chartered Society of Physiotherapy in England corresponds to the Ministry of Health in Turkiye, but it should have been 'Fizyoterapist Dernegi' (the Physiotherapy Association). For the Filipina nurses Sunshine and Claire, the problem was being unable to prove their nursing licences. According to the procedure, overseas nurses wishing to apply to join the register with the NMC could do it after having a nursing qualification that has or would allow them to register as a nurse in the countries they trained in. Even though Sunshine and Claire were trained in the Philippines, they did not get a chance to be registered as nurses in the Philippines and acquire Filipino nursing licenses before moving to Egypt for work. Therefore, it took a while for them to prove their licences, recent employment in Egypt and eligibility to register as nurses in the UK.

> My recent employment was in Egypt. So, all the paperwork they [the NMC] were asking from me, I needed to send to Egypt, and Egypt needed to send it to the Philippines. I had to go to the Egyptian Embassy to translate it [the paperwork] from Egyptian Arabic to English, and then send it from the Philippines to the UK again. So, it took me about a year to process everything. (Claire)

> I had to hire a translator and even the solicitor to get that paperwork from Ministry of Health [in Egypt]. I worked in Egypt, they [the NMC] want to see it. Oh my God! I flew to Egypt once. How many thousands of pounds we've spent just to get this paperwork… So, the NMC was quite reluctant to accept that. 'You can do, it's already stamped!' It's in Arabic, and already been translated in English. It was stamped by their listed Arabic translator that it is correct and concise. But they wouldn't accept it! (Sunshine)

According to the instructions on NMC's website (NMC, 2020) for overseas nurses who want to register, certificates in a language other than English must also be accompanied by an English version translated and approved by the institution where the certificate is issued. This translation should be done by the issuing institution's legally licensed and authorised translator. After getting her paperwork from the Ministry of Health in Egypt, Sunshine had a translator who translated it precisely as requested. However, NMC did not find this document sufficient for a reason Sunshine was unaware of, and Sunshine had to pay a solicitor, as she stated in the above interview extract.

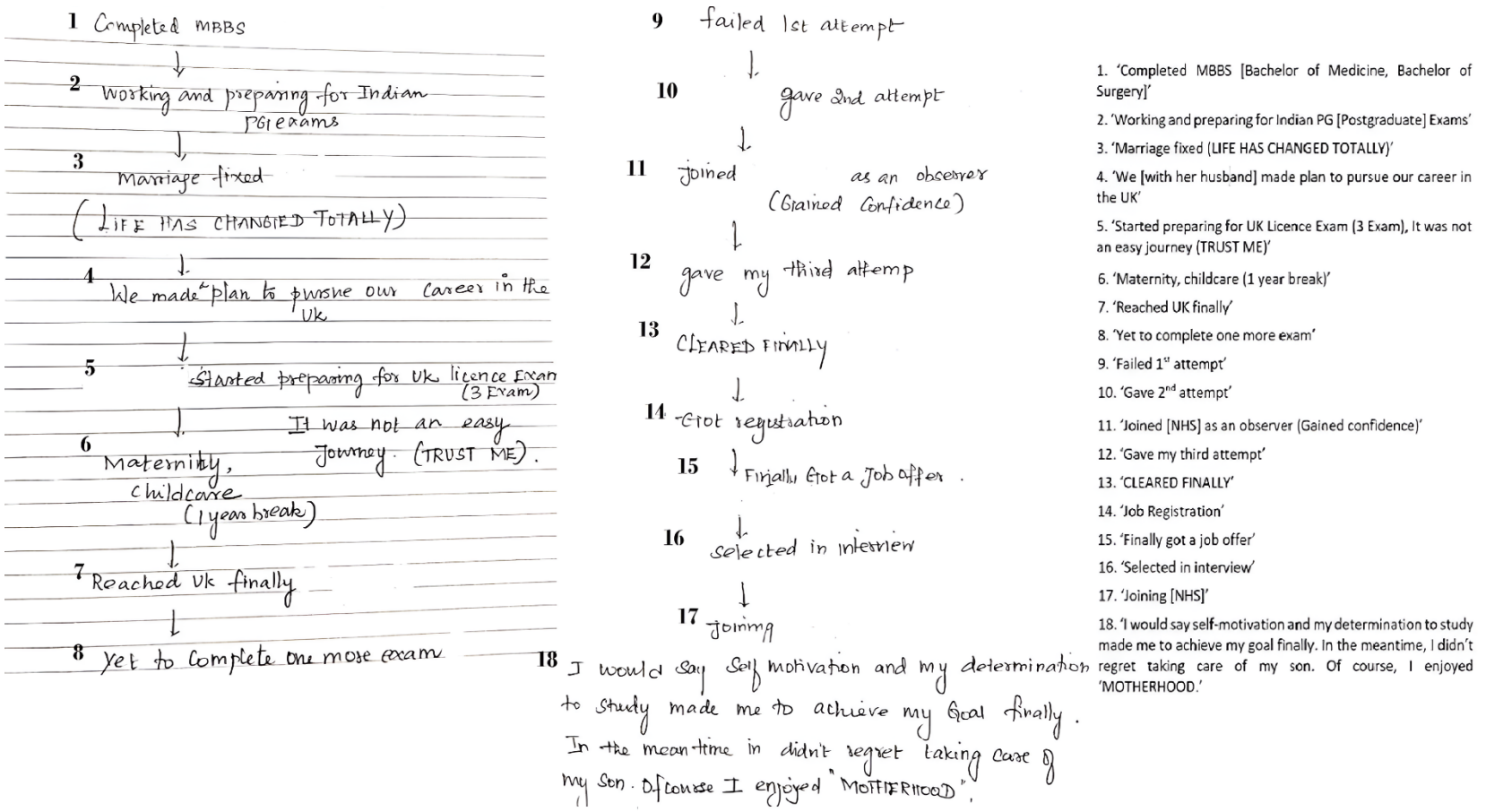
'Translations' seem to become a worry for European participants as well. For example, Anna (Finnish psychologist) says, 'I think it was a bit tricky when I applied to university [in the UK] to prove [her qualifications]. I think I had to get my A-level certificates translated so that they passed here as a good enough qualification to be able to go to university.' Likewise, Stella, Greek/Swiss physiotherapist, expressed how she had to submit quite extensive evidence of her training in Greece, had to report about each lesson she took each semester and have her signature on those papers from the Greek physiotherapy school where she studied to prove that she was 'telling the truth.' She was also asked for supporting documents and reference letters from Greece. Nevertheless, considering the immigration and occupational regulations implemented accordingly in the UK, access to work in this country for the participants who were trained outside the EU was far more difficult. Anna adds that she had never had an English language test/exam in the UK after arriving there. According to her, because Finland and the UK were in the EU, she has never had to prove anything 'any differently to what a British person would have done.'

Davies (2014) shows how the neoliberal world consists of deliberately constructed competition. Such competition in the market is made up of competitors and the experts who 'quantify, distinguish, measure and rank' those competitors. These 'strange forms of authority' or 'new breeds of experts' represent a world 'in numerical hierarchies of relative worth' (Davies, 2014, p. 38). For Davies, measures and tests are grounded in the idea that 'the fairness of market mechanisms rested on an assumption about the

fundamental equality of humans' (List, 2019). Davies describes tests in such a world as the production of neoliberal governance with a pragmatic aim of preventing the differences in 'value,' such as inequalities between two competitors. However, in the case of the participants I worked with, the tests had the opposite effect. We witness here an effect of British migration regimes operating on points-based systems, in which testing systems pretend to provide a formal, 'objective' assessment of someone's professional or language skills. However, their apparent objectivity jars with the personal costs for overseas workers and conceals how they operate as a 'value' judgement of the 'value' of migrant professionals. The EU/non-EU distinction establishes a value judgement about Europeans versus non-Europeans qualifications. This could be political validation of these qualifications' social and economic value or opinions formed by participants about whether their qualifications are valuable based on these external evaluations.

The non-EU participants had to take IELTS several times to demonstrate their competence in four English language skills: listening, reading, writing, and registering in their occupational institutions. Kate (Turkish physiotherapist) states that this process was 'stressful' and 'pressured,' and she believes she had to prove certain skills as a physiotherapist, especially her English proficiency, if she wanted to work in England. IELTS and the accreditation it provides 'assure' the work to Kate:

> I had to take the IELTS before I came here [England], which took me four times to pass. It was difficult, but it earned a high mark. So, it took me a while to pass that. So, you have to get at least 6.5 from each of them [parts]. And the average [required pass mark] should be 7. After the second one that I couldn't pass… I was just missing. I was getting close… I felt like I was under pressure. And at the time, I wasn't working because I shall put all my attention to IELTS, and I went to a course to study for it. It was getting very stressful after the second and third, not passing… And the fourth! When I learnt I had passed, it was a really nice feeling! Yay! If I didn't pass it, I couldn't work. It was a kind of assurance. (Kate)



1. 'Completed MBBS [Bachelor of Medicine, Bachelor of Surgery]'
2. 'Working and preparing for Indian PG [Postgraduate] Exams'
3. 'Marriage fixed (LIFE HAS CHANGED TOTALLY)'
4. 'We [with her husband] made plan to pursue our career in the UK'
5. 'Started preparing for UK Licence Exam (3 Exam), It was not an easy journey (TRUST ME)'
6. 'Maternity, childcare (1 year break)'
7. 'Reached UK finally'
8. 'Yet to complete one more exam'
9. 'Failed 1st attempt'
10. 'Gave 2nd attempt'
11. 'Joined [NHS] as an observer (Gained confidence)'
12. 'Gave my third attempt'
13. 'CLEARED FINALLY'
14. 'Job Registration'
15. 'Finally got a job offer'
16. 'Selected in interview'
17. 'Joining [NHS]'
18. 'I would say self-motivation and my determination to study made me to achieve my goal finally. In the meantime, I didn't regret taking care of my son. Of course, I enjoyed 'MOTHERHOOD.'

Figure 6.1 Kani's timeline

Kate and Kani share a particular experience about the tests. For Kani, Indian doctor, 'clearing the tests' was the most challenging part of her life; 'it was like a hell,' she says. In her visual material represented above as a timeline (Figure 6.1), Kani included seventeen temporal elements describing her professional trajectory that she called 'not an easy journey.' This timeline starts with her graduation from an MBBS (Bachelor of Medicine, Bachelor of Surgery) in India and ends with her recruitment in an NHS hospital in the UK. Six elements on the timeline are about the examination processes that she had to pass through to reach her goal of joining NHS as a doctor: 'Started preparing for UK Licence Exam (3 Exam), It was not an easy journey (TRUST ME),' 'Yet to complete one more exam,' 'Failed 1st attempt,' 'Gave 2nd attempt,' 'Gave my third attempt' and 'CLEARED FINALLY.' The fact that Kani talks a lot about exams in her image shows how important these exams have been in her migratory journey and, therefore, in her life. As she mentioned in the note below her timeline, she needed to motivate herself and be determined to achieve them.

> Since I completed my primary medical qualification in India, I needed to clear some licensing exams before I entered the UK, so for the last three years, I have been struggling with that... I tried with IELTS three times, and the sad thing is that I lost by 0.5 [as a score] in writing. We needed to score 7 in all the sections, I was continuously getting 6.5 in writing, and I was like, it was really tiring and frustrating. (Kani)

The effects of the tests I mentioned above recur in the stories of the nurse participants, who had to take the exams many times. Sunshine and Claire took the OSCE (Objective Structured Clinical Examination) tests to register with the NMC. Because she failed a part of her examination, Claire had to spend over a thousand pounds to retake the exams and work for less money than usual in the UK for a while: 'I am now in Band 5; I was at Band 4 at the time.' (Claire)

On a payment scale system, the NHS pays registered nurses at bands that match their qualifications and experiences. 'Newly qualified, NMC registered nurses start at Band 5, and the most qualified and experienced nursing consultants and specialists can climb to the uppermost pay band, which is Band 9' (Farrah, 2021). As an exception to this rule, student nurses and midwives, by choosing to carry out the final six months of their course as a clinical placement, were asked to consider volunteering to tackle the Covid-19 outbreak. On the 26th of March 2020, Ruth May and Mark Radford, the nursing leaders of the NHS, said in a letter (NHS, 2020) to students that they would be paid at band four during this 'complex, uncertain and difficult time' and might be invited to join a

temporary Covid-19 register promising them a transition to a band five salary. On the 5th of January 2021, this invitation was extended to internationally trained nurses (NMC, 2021) on a pathway to obtaining their OSCE and completing NMC registration, a year later than our interview with Claire. Such a temporary register, even before the extraordinary times of the pandemic, existed de facto for those nurses who were not yet fully registered with the NMC, as it was in Claire's situation. The pay bands not only determine who will earn how much but also are bureaucratic categories that indicate a certain hierarchy of status. They are like a ladder, and workers are expected to aspire to present better sets of skills and conduct broader tasks in each higher step. Although the temporary registration may seem like an opportunity or tolerance given to nurses in this context, the arbitrariness of such practices and the lack of clear formal boundaries can lead to uncertainty and inequalities in the employment of workers.

Sunshine's first attempt at IELTS was in her transit country, Egypt. The exam was difficult for her, and it was frustrating not to achieve the desired scores. The desired score had to be achieved in an IELTS Academic test, not in an IELTS General Training test, she underlined—the former is developed to test candidates' everyday English. The latter is for students who wish to study at a university or for professionals to gain entry into an institution, includes more challenging vocabulary and is more complex in style (IELTS, no date). Although Sunshine scored much higher than expected in other sections, she could only reach this score in the writing section after three attempts. She had to study for one of these exams when she took two months off from work for her wedding in the Philippines. There were also times during this period when she took two practice exams a day:

> I was just getting so frustrated because writing is so difficult! You need to translate bars, charts into your sentences.[1] So, my third take, which I took in the UK, I had all sevens [as scores for each section], no, seven in writing, and a nine in listening! Oh my God! I'm lucky! (Sunshine)

Unlike what she said, Sunshine's passing this exam seems more about her hard work and determination than luck. For her, ‘luck’ is about the happiness of fulfilling such a requirement and finally getting her job. Indeed, many other workers are not that lucky.

[1] The candidates might be asked in IELTS tests to write papers describing bar charts and to analyse the data represented by those charts.

> I give up. To be honest, I was very, very hard studying [for the English fluency test] when I came, but then I said, 'Okay, I will stop. I will take care of my kids, and I will continue this job. (Lila)

Lila, who specialised in nursing in the UAE, speaks above of how futile it is to try to get her 'chosen profession' (Leblanc et al., 2013) back in the UK. If I recall Lila's pyramid drawing in Chapter 5 (Figure 5.7), the first three steps starting from the bottom were 'safety,' 'home' and 'my kids in the school.' The steps upward continue as follows: 'study,' 'work' and 'UK passport.' The two steps, 'study' and 'work,' leading to the 'UK passport' step, which tells about Lila's ultimate desire to become a British citizen, show how vital her training and nursing job in this country are in her ultimate goal. The absence of these two steps can jeopardise her dream of permanent settlement in England. Studying English was the only way to achieve this goal, but doing that is so difficult now because of the simple facts of everyday life, such as the costs of transport or childcare responsibilities, and she is thinking of a 'career break' for her primary profession. She seems to put her struggle on hold to look after her children, and there were the material conditions under which she was expected to fill the language requirements:

> Unfortunately, I stopped going to Manchester [for the language course] because I cannot cover the transport fees for three days [a week]. And, there is no another courses here in …[the city where she lives] related to IELTS or OET [Occupational English Test]. So, they told me study it online. I don't like to study online, on a computer. I like to study face-to-face and so, I decided to stop. I will not study anymore, and I continue with this job. But, to be honest, it is not my job… It is very difficult to me to study at online with my kids at home, or, most of the time, I'm working. (Lila)

However, these were not the only obstacles in her path. The issues are more structural than personal failings. Above all personal effects, there are many challenges in the British migration system for refugees or asylum seekers, so for Lila, who came to the UK with the main reason of seeking asylum. For example, the asylum system and legal restrictions in the UK render refugee healthcare professionals unemployed for the long term, which can lead to their loss of confidence and deskilling (Butt et al., 2019, p. 892). Non-recognition of the qualifications impedes refugees' job prospects (Grierson, 2019).

Like many refugees in the country with high levels of skills but not working in jobs commensurate with their skills and qualifications (Bloch, 2007, p. 21), Lila is also doing something she does not want to be in because she feels that it is not her job. Lila feels frustrated and degraded due to the job she has been prevented from performing. When I asked her about how she feels about being a clinical support worker, she replied:

> It's very bad because it frustrated me and it's a shame to me that I was nursing, then I'm clinical support worker. So, it's very difficult to me to all this, my qualification, I have experience in ICU [Intensive Care Unit] department. No one, they have this experience and when I came here, they didn't value me related my experience. They value me related to my English. (Lila)

Despite Lila's reason with her husband for choosing the UK as the destination rather than European countries, which is that the UK is an English-speaking country, language and formalities have ironically been the biggest obstacles for her to get her nursing accreditation. Despite much effort, Lila could not achieve the required scores. She thinks that this registration process has already been very long, confusing, and hard for her so far:

> Since I came here, I want to go back as soon as possible as a nurse to work. But, unfortunately, it's very long process and not easy because I need to convert my certificate from Arab country to the UK. And it's very confusing. Since I came, I was looking here [general English language courses] in …[the cities in the North West] and every time, they told me I need to finish English course. Two English courses here; level one and two, within two years, I finish it. Then, they told me, if I want to convert my certificate, I need to do English course called IELTS. So, I was going to Manchester every Saturday to study IELTS there. There was this group called REACHE [The Refugee and Asylum Seekers Centre for Healthcare Professionals Education], help the refugee, took to convert their certificate like me. And IELTS is very difficult. They won't score six, six and a half for me to convert it. And my English level, it's 5. In the middle of the courses, there is another course coming, called OET, so if we would like to do it or IELTS, we can convert our certificate. So, this group, REACHE, decide to move to OET. It's easier than IELTS because it's related to the medical. So, I was happy with that but, unfortunately, they asked me to go, three days a week, and it's difficult to me. I cannot go to Manchester three days a week because I need to work here because we need money. I need money to work, to study, to cover the transport fees and everything. (Lila)

The NMC moved the goalposts and announced that it would formally recognise OET for overseas-trained nurses and midwives for registration purposes on 1 November 2017 (OET News, 2017). After spending her weekends far from home, for a total of two years in general English language and IELTS courses, Lila was finally too tired to adjust to a new testing system, even if this OET was much more familiar to her in terms of reflecting real healthcare scenarios in its exams.

This test was much favoured by Kani, the Indian doctor. After her three unsuccessful attempts at IELTS, she finally cleared this new language test that she emphasised as ‘for a person in a medical profession,’ and she did this just on her first try. Kani outlined the ‘good things’ about OET, such as: ‘All the scripts, all the concepts were related to our

profession. So, in writing, they expected us to write a referral letter or any discharge letter. And, in speaking, it was like, all the way you talk to the patient. And, reading, it was like, it was our subject topic. And, listening also, it was an audio will be played regarding the conversation of a doctor-patient conversation, or some lectures, or some medical lectures. So, it was very easy for me.' On the other hand, Sunshine (Filipina nurse) complained of a sudden change in NMC's registration system. The constantly changing registration and licensing rules and having to adapt to them made Sunshine feel that her former efforts went for nothing, just as Lila:

> Back in 2014, the NMC, if you're trained outside of Europe, you have to have your own licence from your own country, which in my position the Philippines. I'm pretty sure, you need to have like one-year experience as well in the hospital. It's like a paperwork from our professional guiding office in the Philippines. You also have to have like a six-months training for you to adapt yourself to the UK or British standards. I took that step but then they were asking me my qualifications in Egypt, so that was the delay… After all this effort, come 2016, they [the NMC] changed the rules! So, you don't need to take those six-months course, the overseas nursing programme course, removed it. You don't need to have experience. Oh, no, you just need… I'm getting confused now. (Sunshine)

Giving up returning to her former career was not an easy or quick decision for Lila to make. She looked for alternatives for a while before doing that. She considered taking an undergraduate nursing course at a British university then. Still, there were the English requirements again, and she needed to pay for tuition and fees, which would be a considerable sum of money for her. Another way was to contact the NMC to prove her English skills; it did not work either. She did not receive a proper reply from the council.

> My English, it's not that bad. I can communicate very well. Even my manager here, she sent letters to the NMC, and wrote that I can communicate very well with the patient, understand well. I put notes so they could exclude me from IELTS test, but the NMC didn't agree… Only they told me 'You have to do IELTS.' (Lila)

Until 1 April 2010, NHS Employers hosted the Refugee Healthcare Professionals Programme to support refugee healthcare professionals in requalifying and contributing to the NHS (NHS Employers, 2009). When this national programme was discontinued, regional projects and organisations were involved in the programme to continue this support (NHS Employers, 2021). As Lila was offered, there are a limited number of organisations in the UK, like REACHE North West, which provides advice and guidance,

CV feedback, preparation for the OET, PLAB[2] (Professional and Linguistic Assessments Board) preparation, placements and support with adaptation to the NHS to refugees, asylum-seeking doctors and nurses (GMC, no date [b]). Based in a teaching hospital environment, REACHE North West appears to be the only organisation in England that provides education and training for all stages of these workers' return to work in one venue, from English language teaching to medical equivalency examinations and preparation for NHS employment (Cross, 2018). However, Lila's case confirms the failure of this organisation to track its members' existing circumstances and provide services. Under these circumstances, integrating all refugee women at equal levels becomes impossible, both into the labour market and society.

As a result, one of the challenges faced by the participant women was the origin of their qualifications. This issue is not only about their nationalities or the distinction between EEA and non-EEA countries, but also whether their qualifications are from the EEA, Global North, or the Anglo-European world. A hierarchy of qualifications exists, where those in English are often viewed as more credible. By 'qualifications in English,' I mean either graduating from university departments that teach in English or, if trained in one's native language, demonstrating professional English proficiency through specific exams. Gul's (Turkish/Bulgarian healthcare assistant) and Voyager's (Turkish ophthalmologist) experiences illustrate the complexities of the EU/non-EU variation. Both women are non-EU-trained professionals. Despite being a European national, Gul could not return to her primary profession in the UK as a midwife. Although she holds dual citizenship (Turkish and Bulgarian), her English proficiency does not meet the level required for a midwifery post in the UK. She did not go through any processes to secure her healthcare assistant role. ‘You are already a midwife,’ said her employers when they hired her. Gul explains that the nurses at the care home where she works are not much more qualified than she is. She is more knowledgeable in some areas but cannot demonstrate these skills due to the lack of an official qualification. This sometimes makes her feel frustrated, as language remains the primary barrier preventing her from working at the same status as nurses. In contrast, although Voyager is not European, she can practice medicine in the UK, just as she did in Turkiye. Voyager had already passed the registration and language exams in Canada, achieving the qualifications expected by the UK. For example, she had met the required IELTS scores and did not need to take the

[2] The PLAB testing system is used by the GMC to issue licence to practice medicine to non-UK graduates (GMC, no date [a]).

PLAB tests. Although Voyager mentioned she did not put much effort into securing employment in the UK, she later revealed that she had to pass four professional exams accredited by the Royal College of Ophthalmologists, with registration fees of around £600-700 each, to enrol in the GMC UK.

This echoes with Raghuram's (2021) argument that discussions on skills are about their acquisition or recognition, and about how they are expected to be utilised. The expectation that 'skilled' individuals should apply their expertise where they were acquired reinforces a nation-state framework of skill governance. For migrant women like Gul and Voyager, this framework creates barriers that extend beyond nationality or migrant status, as their qualifications are not only assessed based on where they trained but also on whether they align with dominant linguistic and institutional norms.

As explained in Chapter 4, the interviews took place at a time (January - November 2020) when Britain was still in the post-Brexit transition period, and some of the regulations discussed here were likely to change. The qualifications expected from migrants might have been more standardised and levelled down to non-EU requirements. The NHS had only formalised the system of registration, which in practice separated healthcare workers not by nationality but by where they were trained. For example, the GMC announced on the 1st of January 2021 that, as to the end of the Brexit transition period, recognition of professional qualifications was no longer automatically available for doctors who are nationals from the EEA (GMC, 2021). However, it was open to those recognised as 'relevant European Qualifications.' This change aimed to accept evidence depending on medical qualifications—not nationality.

6.2 Occupational Hierarchy

> …when you are looking after a patient, then the hierarchy is important when you are doing your job. Because you need to know who to follow and whose orders to follow. (Claire, Filipina nurse)

> Yeah, there's kind of this of one lead psychologist, and then, there's three of us on the kind of next level, and then, there's another level below us, and another one, and another one. So, it's kind of, it is hierarchical to an extent. (Anna, Finnish psychologist)

> My biggest issue with how things are perceived and spoken about. Everybody thinks that care workers are at the bottom of the pile, beneath everybody else. Definitely, there is a hierarchy; health things [healthcare] are so much better than social care, they think. And they treat us with a lot of disrespect. And they're very condescending and patronising. It's very difficult; it's very much reinforced on the health side and reinforced by the public's misunderstanding of what social care does. (Klaudia, Polish social care worker)

As evident in my interviews, migrant women in healthcare settings are occupationally hierarchised when employed. As Klaudia told us above, this hierarchy is sometimes based on how healthcare and social care are seen as separate categories. The NHS is formally organised according to medical hierarchies, governed by expectations of 'what is medical' and 'medical knowledge and practice' (Bradby, 2012, p. 147). These expectations are explained in the context of 'the discourse of medicine' or 'medical discourse,' and the perspective of 'medicalisation' critically engages with that discourse. What is the significance of 'medical discourse?' How does it regulate the hierarchies of immigrant women workers in healthcare? How do the participants of this research define/redefine 'what is medical,' navigate it, and use it as a hierarchical mechanism? In this section, I will show how the NHS is a 'medical' structure and then explain how the participants of this research engage with that structure.

Medicalisation has been a concept used in sociology since the 1970s to define the process by which some aspects of human life that were not considered pathological came to be considered medical (Maturo, 2012, p. 123). The notion of medicalisation has been a critique of medical social control, which is a sociocultural process consisting of 'defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it' (Conrad, 1992, p. 211). Bradby (2012, pp. 146-147) suggests that sociologists should revisit the concept of medicalisation and see the boundaries of medicine as an outcome of socio-economic and political processes.

Expanding such a medicalisation perspective, I argue in this section that 'medical' is a 'situated knowledge' (Haraway, 1988). The phrase refers to any information that is influenced by the position and location of the knower or knowledge producer. The claim that knowledge is always incomplete and context-specific undermines conventional beliefs about knowledge as uninvested and ostensibly impartial (Griffin, 2017, *Situated Knowledge*). I use the term to show that 'medical' discourse—relating to illness, treatment, or medication—works as a hierarchical mechanism at the basis of the division of healthcare and social care. The 'medical/medicine' discourse creates further divisions among the healthcare professionals who perform medical care, such as medics/non-medics, and hierarchises their medical care acts. Furthermore, it elevates people, particularly medics, to the position of saviours, which has broader social implications. Through divisions, health and social care workers navigate various hierarchies, and their professional and social interactions at work vary accordingly. So, this section sums up

why some immigrant women are more likely to occupy the underdefined, 'low-skilled' or 'unskilled' roles, especially in the private social care sectors. The section demonstrates that certain women migrant workers tend to work in *low-skilled* jobs because of the substance of care work. Caregiving is feminised[3] and often associated with domestic responsibilities held by women. It involves emotional and affective aspects and necessitates proximity to patients. It is invisible and belongs inside; immigrants and members of ethnic minorities execute it, and it is underestimated and devalued; it is often conducted in private houses, with limited access to organisational and legal safeguards (Lan, 2022, p. 2). Finally, looking at the study of medicalisation (Bradby, 2014), I also explain the clashes and similarities between the official/legal job definitions and the jobs performed in real life for the participant immigrant workers of both different care systems.

6.2.1 Comparing Healthcare with Social Care

In the public-private distinction in 'care,' patient 'needs' are determined, services are delivered accordingly, and 'health professionals' are classified as those who provide 'high-quality care' (NHS Health Careers, no date [a]). Whereas no single official or legal definition of 'care' exists in the NHS documents, 'carers,' by 'NHS England and NHS Improvement,' were defined in the context of NHS commissioning as people looking after their family members, partners or friends with no pay. The patients are those who live with illnesses, frailties, disabilities, mental health problems or addictions, which can only be addressed with the help and support from their caregivers (NHS England, no date [a]). When it is necessary to introduce the term 'care,' the NHS replies to the question of 'what is social care and support?' instead (NHS, 2021). 'Care' is often used interchangeably with 'social care,' and social care often refers to free or paid services in a private setting, for example, 'help at home,' 'home adaptations,' 'housing,' or 'care homes.' In contrast, 'healthcare' is highly professionalised, often used in the NHS synonymously with 'health' and has references to medical professions (NHS Health Careers, no date [b]). The NHS has been designated as the institution in the UK that primarily regulates and funds health/medical care and recruits healthcare professionals.

[3] According to labour supply, women desiring to combine part-time paid jobs with other family or caring duties are usually employed in the care sector in England. In comparison to other alternatives, this sector attracts fewer men due to the fact that social care has low status and is poorly paid (Moriarty et al., 2008, pp. 5-6). In this context, it was possible to notice the feminised nature of the care work in the North West region of England with 82% women and 18% men workforce in 2017-2018 (Skills for Care North West, 2018, p. 56).

The modern origin of the health and social care divide lies in the establishment of the NHS in 1948 (The King's Fund, 2014, p. 13). Whilst there is no legal definition of a health need, its guiding principles are outlined by NHS Continuing Healthcare (Department of Health & Social Care, 2018, p. 17): 'Such a need is one related to the treatment, control, management or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).' In general terms, the term 'social care need' (under the Care Act, 2014) is about dealing with the needs arising from (or relating to) a physical or mental impairment or illness which results in the patients being unable to achieve daily living, for example, maintaining nutrition, personal hygiene, toilet needs, a habitable home environment, family or other relationships or accessing and engaging in work, training, education or volunteering; which is, or is likely to have, a significant impact on the patients' well-being (Care Act, 2014).

The difference between these two systems is fundamentally about who funds it. Through the UK state's 'primary health needs approach,' it is determined if the patient's primary need is for healthcare, which the NHS will be responsible for, and therefore, the eligibility for NHS Continuing Healthcare, rather than social care, which may be provided by the Local Authority (Department of Health & Social Care, 2018, p. 7). Such a medical care-focused concept prioritises the diagnosis and treatment of the patient and sees it as primarily worthy of funding in the National Framework. However, over the years, many significant shifts have occurred in the health and social care landscape; NHS sources of finance and entitlements to free care have become more complex than before (The King's Fund, 2014, p. 14). Despite the statement in the framework, 'there should be no gap in the provision of care' (Department of Health & Social Care, 2018, p. 19), there are many grey areas where the NHS passes responsibility for funding the care of individuals to the Local Authority. There are conflicts between the patients and the NHS regarding assessing the needs and the definition of the treatments (Davies, no date). Moreover, the recent cuts in government funding for health and social care sectors in NWE, as discussed earlier in Chapter 2, are another issue.

6.2.2 Medical Roles: From Clinicians/Non-clinicians to Medics/Non-medics

Who are those healthcare and social care staff, and what are their tasks? In the last decade, integration between health and social care has been a goal for policymakers in the UK to ease the pressure on the capacity of both care systems stems from the rising demand for

care services and from restricted or reduced funding (Harlock et al., 2020, p. 86, National Audit Office, 2017, p. 5). These policies seek to promote cooperation and collaboration between care provider workers (Raus et al., 2020, p. 1). In the context of such an idea of integrated care, the NHS implies that there might be a crossover between working in health and working in social care for those staff whose roles cover both types of care. Moreover, the NHS maintains that the qualities and values needed for those working in health and in social care may be similar (NHS Health Careers, no date [c]). However, I find NHS guidelines on healthcare still rely too much on medical understandings of care, as I show below.

In its dictionary definition, 'medical' objectively denotes 'relating to medicine, or the treatment of illness or injury' (Cambridge Dictionary, no date). Moreover, medical care needs to be delivered by medically trained staff. The NHS generally defines the medical staff as the clinicians (NHS Northern Devon Healthcare, no date) who are directly involved in the high-quality care and treatment of patients, who work on the front line of a ward, and who see patients. For example, this includes health professionals, such as nurses, doctors and midwives; allied health professionals (NHS England, no date [b]), such as dietitians, radiographers, paramedics and physiotherapists; and others in clinical support roles (NHS Health Careers, no date [a]), such as dietetic assistant, healthcare assistant, and physiotherapy assistants. Among these roles, some have a specific training route and need academic qualifications, such as the allied health professions, medicine, nursing, and pharmacy (NHS Health Careers, no date [d]).

On the other hand, non-clinicians are social carers who generally work outside the hospitals. They are not expected to perform medical duties and are not authorised to undertake such duties. Social carers support people's non-clinical needs in these people's own homes, in residential homes, and in other places like day centres or supported housing (NHS Health Careers, no date [c]).

Participants working in the private sector had not previously undergone registration processes like in the NHS. For example, Regina, Romanian healthcare assistant, asked for help from one of her sister's friends who works in the care home where Regina was looking for a job. Regina requested her friend to mediate between her and the care home manager as she could only speak a few English words then. When this manager was briefed about Regina's situation, an interview was arranged, and later, it was only a phone call from the manager that enabled Regina to enter the workforce in the health sector. At the same time, Didi's (Turkish care manager) employers in the private care home where

she works said she would not need any competency validation in her role; they would 'see her language anyway' and arranged all the registrations on her behalf. As for Klaudia's case, she was occupied in-home care and live-in care in the UK until our interview, and she only needed to go through a short training and check any criminal records. This check can also be the case for a non-migrant person. Klaudia's carer role is one of the jobs in which a DBS check (Disclosure and Barring Service check) is mandatory alongside other roles such as 'working with children and vulnerable adults (paid or voluntary), teacher and teaching assistant, trainers, tutors and assessors—when working with under 18s or vulnerable people, NHS medical professional' (Johnson, 2021). These requirements are not specific to migrants and apply to everyone, including non-migrants.

> There are no registration processes in England for care workers. I didn't have to do an English test, but my English was very good anyway. With my first caring job, what I needed was DBS and then to do training and induction. (Klaudia)

In short, there is a gap in the NHS regulations regarding who will take on the non-clinical caring roles in hospitals. In addition, it is not clearly stated who are the people who work in both health and social care and have similar roles in both types of care. When exploring their practical abilities, we see that immigrants in this research fulfil and conduct unpaid tasks beyond their status and role, such as social care worker participants Klaudia, Gul and Lila, who perform medical and non-medical duties in their daily caring routine. As far as the participants told me in our interviews, their situations at work in practice do not often fit the NHS's formal definition of jobs and duties above. I have not found such clear and sharp distinctions from most of my participants' material, neither in the job descriptions nor in the tasks they perform. Depending on their roles, working in the NHS or the social care sector does not differ much in terms of whether to perform medical duties or not. Anna, Finnish psychologist, explains below how she finds, on the one hand, her psychology expertise and duties similar to, for example, a social worker's, nurse's or psychiatrist's, but on the other hand, how she would sometimes feel a hierarchy among themselves. When speaking of psychiatrists, she also refers to the medic/non-medic distinction discussed in the next subsection.

> We have sometimes slightly complicated relationships with social work and nursing colleagues. We do a similar job. And, sometimes there's a resentment about us being paid more than nurses or social workers typically do. We would have the same resentment with psychiatry to an extent, sometimes, where we think; 'hang on a minute, we're doing a similar job! Why are you exempt from

this that or the other?' So, there are sometimes kind of some tensions about roles, money and power. (Anna)

What is considered 'medical' is more in demand and valued by employers in the UK. Those licenced to speak in the name of 'medicine' due to their training and accreditation acquire and exercise more power in clinical settings than those who do not (Bradby, 2014). However, the information about what 'medical' is not clear enough for the participants. Therefore, the women felt it was necessary to define the hierarchy between themselves and their colleagues according to a self-defined 'medicalness' based on their work experience. The confusion of the NHS's official job descriptions and legislation about the boundaries of roles in health and social care sectors paved the way for these workers' hierarchisation according to self-defined categories of 'medics/non-medics.' A new social categorisation of medics and non-medics is defined. Participants fill the idea of what counts as 'medical' with meaning derived from their experience and prior work settings. These meanings are not necessarily the same as those proposed by the NHS. This discrepancy between policy and experience raises several questions: How is the participants' knowledge of 'what is medical' re-generated? Is there also a hierarchy within medical tasks performed? Are there further sub-categories besides 'medics/non-medics' for these healthcare professionals? These questions suggest that the term 'medical' does not hold the same meaning for all participants; medical expectations apply differently to each, and different values are attributed to their particular acts of care. It is to these questions I now turn.

Contrary to the NHS's clear distinction in descriptions of roles in healthcare given above, participants of this study self-categorised and were categorised by others (colleagues, employers) according to a highly subjective medical understanding. The boundaries of what counts as medical or not vary from hospital to hospital or place of care. Medical discourse, therefore, is not merely about formal procedures but also shaped by healthcare institutions' various de facto, often invisible, structures. Furthermore, the informal organisational 'cultures' engender implicit understandings and interpretations of these boundaries. That is to say, 'what is medical' is perceived along with the differentiation of the medical acts in these institutions and from what is suggested by the NHS.

Klaudia and Gul, although the NHS officially defines their jobs as non-medical or non-clinical and they are not recognised, valued or paid as medics in the final evaluation, both participants perform certain tasks in practice that they consider medical. Klaudia, an

Eastern European social care worker, explained that medical and non-medical duties were expected of her in every role she has ever had in the UK, whether in London or Yorkshire. Klaudia says she does a medical job because her patients need medical treatment. Her particular everyday medical task is to ensure that correct medication is taken by her patients, which include 'old adults, [with] conditions ranging from muscular dystrophy, MS, dementia; two people who are quadriplegic and bed-bound; severe asthma, epilepsy, post-stroke recovery… Those are the main ones. Well, obviously diabetes type 2, clinical duties around stoma bags, catheters, tracheostomies, medication administration including controlled drugs…'

However, this medical task does not elucidate what Klaudia does as a live-in carer. If you are a live-in carer, you basically '*live someone else's life for a period of time,'* she says:

> In live-in care, you live with the person 24 hours a day, sometimes you get a break, sometimes you don't which means you are supporting the patient of everything in the day; personal care, meals, appointments and arrangements, the psychological well-being, medication, family relationships, friendships and cleaning… That's the whole role. You basically living somebody else's life for a period of time, you're with them which emotionally is very draining. (Klaudia)

This type of labour involves bodywork and emotional work. Klaudia talks about care work as the issue of gender:

> There are a lot of gender issues there as well, because care work used to be what women did as part of their role as a housewife who didn't have a job. And, it's still perceived as unskilled duties that anybody can do, and women would just do, and nobody would even notice. (Klaudia)

Indeed, caring as a profession, which includes bodywork and excludes any medical tasks, seems so far removed from the top of the hierarchy in healthcare. Care work is identified explicitly with direct physical contact with a patient and the treatment of the patient's naked body. Twigg (2000) says that bodywork/care work is constructed around gendered assumptions that it is generally performed and received by women and linked with women's bodily functioning, like motherhood and nurturance. Care work brings poor pay and employment esteem to its performers. On the other hand, it is undoubtedly as important as medical knowledge and practice because patient treatment must be holistic.

Moreover, care can deliver more powerful life-sustaining effects than medical interventions.[4]

Gul, a Turkish-speaking Eastern European healthcare assistant, works in a private care home in the Lake District, generally in 12-hour long night shifts. Her patients are primarily elderly, and there are also the ones with Down's syndrome in their 45-50s. She is responsible for their hygiene and ensuring their nutritional needs are met. There are some bed-bound patients, and she has to change their position frequently to prevent muscular fatigue or, worse, dystrophy. She checks them regularly every two hours. She records all these assignments and does other paperwork as well. Apart from all these, because she had previously received midwifery training, Gul has been assigned some medical duties such as administering medication or getting blood from the patients. Such medical duties are not officially involved in her job description, and she thinks someone in her role should not normally do such duties. Gul distinguishes between medics and non-medics in her workplace: while only nurses can legally do the medical work she mentioned, she just needs to deliver care. However, as she said, her employers trust her and let her do such tasks some nights because she is trained as a midwife and has worked in this care home for two years.

Although both Gul and Klaudia have not received formal medical training in the UK, they are tasked with certain ‘medical’ responsibilities within their respective roles. Gul, who has a background as a midwife, was medically trained and thus allowed to perform more invasive medical tasks such as collecting blood samples from patients. However, it is important to note that Gul's midwifery training is not officially recognised in the UK, which adds an element of ambiguity to her permission/qualification to perform these tasks per UK regulations. On the other hand, Klaudia, despite having completed a two-year applied vocational training programme in Health and Social Care at a further education college, is only authorised to perform less invasive medical tasks, such as administering medication. This division of responsibilities is directly linked to their educational backgrounds, with Gul's prior experience in midwifery enabling her to perform more invasive medical procedures, while Klaudia's qualifications restrict her to less intrusive roles. What stands out in this case is the contradiction within the healthcare sector. Informal qualifications and work experience can sometimes be prioritised over official certification. This discrepancy highlights the flexibility, or perhaps inconsistency, within

[4] See Fong, 2023 and Nilsson et al., 2020 for more on the importance of postoperative care, particularly, as a teamwork.

the healthcare system when it comes to defining and allocating medical tasks, especially in non-clinical settings.

There is a hierarchy in the 'medical tasks' performed by these two 'non-medics.' Taking blood samples and giving prescribed medication that counts as medical by the participants are not at the same level of skills. I find the hierarchical importance of blood-taking as a medical task here as it comes from the fact that it is a means of ruling or having power over bodies, as Foucault (2003) has shown in his magisterial work *The Birth of the Clinic.* From the perspective of the sociology of intervention in the body (Okumus, 2009), a needle which is inserted into the patient's vein, putting the patient in some discomfort, appears to be a symbolic element of a relation of power in the doctor-patient or nurse-patient encounter (Waitzkin, 1989). Such an effect could also exist in giving medication to a patient, but probably much less because the degree of intervention on the patient's body from someone else is less intrusive. So, from the interviews with participants, the hierarchy of the medical tasks performed appears from top to bottom as 'prescription,' 'blood-taking,' and 'giving medication.'

In contrast, for the nurse participants, the opposite of Klaudia's and Gul's situations is seen; even though they are expected to do only medical duties in a ward, they also perform non-medical duties. Sunshine, for example, the Filipina adult general nurse, is often expected to meet her patients' food and cleaning needs without extra payment, although separate non-clinical roles need to be defined for these jobs. Sunshine shoulders many caring duties as an adult general nurse, including physical care. She defines her job: 'washing them [the patients], helping them to get from bed to the chair, and share to bed [deciding which patient will stay in which bed], and maybe marching in place, maybe outside a bit….' She maintains that she does what a nurse typically does in an ICU department in the hospital: 'In critical care, you've got loads of contraptions. You've got like central lines, sometimes you're in a high flow oxygen. So, it needs to be a nurse who will assist them [the doctors] because we do know the troubleshooting.'

Didi, a private care home worker in the North West, generally works with terminal cancer patients. In our conversation, Didi stated that her work does not always involve medical tasks as per her job description;[5] moreover, 'the staff hesitate to give medication

[5] There is confusion about how Didi refers to her work. She talks about herself as a nurse but, as I was talking with her, she presents herself as a care manager. The care home that she works for describes the duties of a care manager as 'assisting with housekeeping, laundry, dining services, activities, and more.' And 'manage' here is used to mean 'managing care' rather than 'managing other carers.' It is unclear what is Didi's formal status within the system of that care home.

to patients on every occasion because it is more like a rehabilitation centre rather than a hospital.' However, some medical duties are also carried out by the staff alternately. For example, if Didi is required to do a medical job that day, she wears a badge that says: 'I will do today's medical work.' This badge allows her to 'do everything, all the intervention' in the hospital, such as giving medication to the patients. She can do 'morgue operations and CPR [cardiopulmonary resuscitation] works' then as well as 'looking after the relations with the family and relatives of the patient.' She received training for this work, including 'use of tools, patient treatments,' etc. Although Didi's official title is 'care manager,' she believes she is taking on a nursing role at the care home where she works.

Moreover, when a nurse can perform the medical duties in their 'hospital'—as she calls it—that a doctor does typically, doctors will have no other tasks than formalities like filling out the forms when a patient dies, as Didi says. This badge puts nurses on par with doctors for the medical tasks they can perform, according to Didi: 'When you are trained staff, I mean if there is a special unit staff member, there is no need for a doctor. Frankly, you do everything.'

In her work on the emigration of doctors and nurses from sub-Saharan Africa to the Global North, Bradby (2014) argues that such a 'task-shifting/task-sharing' movement in source countries could challenge the presumption that only skilled healthcare professionals could have positive effects on the health of a population. She describes the term as redistributing menial or repetitive tasks to occupational divisions with less training and lower pay (Bradby, 2014, p. 590). Her research showed that workers with reduced training can provide health services in resource-poor settings, such as nurses who successfully undertake cataract surgery in Bangladesh and caesarean sections in Mozambique. However, looking at the situations of the participants in this thesis—not only the situations of doctors and nurses but also considering care workers' experiences—'task-shifting/task-reorganisation' (Crowley and Hodson, 2014, p. 96) works as one means of maintaining medical professional dominance in the neoliberal setting of the UK (Weinberg and Gordon, 2011, p. 10). In addition, the employment of non-nurses to work as nurses in NHS hospitals, for example, is a current case because of the shortfall of registered nurses in the UK. NHS trusts which recruit workers without the right qualifications and who are unregistered with any councils were recently warned by the Royal College of Nursing (RCN) against this practice as it may leave patients without professional nursing care and compromise safety (Campbell, 2021).

What I have heard from my participants is not a ‘success story’ where these ‘less-trained’ health workers showcase their skills and are rewarded for their efforts, as Bradby describes it. On the contrary, the participants still have to be content to feel like ‘medics’ by performing tasks that ‘highly-skilled’ medical superiors would not even consider ‘medical,’ and only as long as these superiors allow them. On the other hand, I do not underestimate the feelings of ‘being a medic’ or ‘re-medicalisations’ of participants, nor do I interpret the feelings as negative. Instead, I believe this gives us a clue about the ambiguity of the categories, tasks and statuses shaped around the medical discourse. Moreover, their ways to reject, redefine, or cope with ‘medical’ can be identified through these self-definitions/-identifications as ‘medics.’

‘Medical,’ in Didi's case, appears to be a form of ‘situated knowledge’ (Haraway, 1988). Following Donna Haraway, we need to think about how the ‘boundaries’ of being a medic materialise in the social interactions of healthcare professionals. Haraway (1988, p. 595) notes that ‘boundaries are drawn by mapping practices; *objects* do not pre-exist as such.’ Drawing on her perspective, the knowledge of ‘what is medical,’ in Didi's case, is ‘embodied, situated, and embedded in practices’ (Law and Singleton, 2013, p. 486). This also aligns with Kofman’s (2013) discussion of embodied knowledge, which is often associated with care work and framed as informal, experience-based, and lacking the status of formally recognised expertise. While embodied knowledge often leads to the devaluation of care work, it plays a central role in constructing authority through performative markers affirming professional status in the medical profession. One such performative marker is Didi’s badge, which becomes central to her professional identification as a medic. Such performativity at hospitals is intrinsic to the staff experience and could include other theatrical components such as jargon, name tags, white coats, and uniforms (Jowsey et al., 2020). Carrying this badge on her clothing enables Didi to present her medical work, perform medical skills, and see herself as a medic. This is not to say that Didi's status as a medic no longer ‘exists’ when she pulls her badge off; it still exists in her mind. Didi understands herself as a medic and can confirm this when she performs particular medical tasks. Performativity here is affirming as well as generative. In this sense, Didi’s performative medical identity demonstrates how embodied knowledge is not inherently devalued; rather, its recognition depends on institutional and social configurations (Dahinden et al., 2021).

What other impacts of ‘medical’ are there on the participants' hierarchies and their social and occupational relations? Let us take a closer look at the steps in constructing the

occupational hierarchy of the present study's participants. So far, the study has shown that medical discourse is constitutive of their occupational hierarchy, and they move between the categories of healthcare occupations. I will now use the division of medics/non-medics as an important determinant for the analytical scrutiny of women's experiences under the broader theme of de-, re-, up-skilling and categorisation in the health work. In other words, the relationship between the categories of medics/non-medics and the skilling experiences of the participants will be discussed. A final query is: What does whether or not a woman's job is 'medical' mean in her quest for a better life through immigration or in her work experience?

Relating to the previous section, the perceptions I documented among immigrant women of their occupational statuses and qualifications are directly influenced by the processes of their professional recognition by the UK health sector and the discourses on skills by the government. The hierarchical ranking for my participants is usually the top healthcare workers who do only medical duties, for example, Sabrina and Voyager; below them are those who do both medical and non-medical duties, such as Lila; and the bottom are only those who do non-medical duties, for example, Zei. The status of being a medic remains contested and blurry at every level of this hierarchy. While some participants are taking advantage of being a medic, redefining that category for their benefit, others who earn less are less visible and less appreciated.

Sabrina, a psychiatrist working for NHS, in a specialist community, child and adolescent mental health service, has the highest income. By doing the 'medical task' which she describes as specific to her psychiatry job, such as patients' psychiatric examinations and prescribing medication for them, Sabrina places herself at the top of an occupational hierarchy among her colleagues. She is a 'medic' and the only one who can prescribe medicine in her work team.

Sabrina describes the path patients follow until they see her: 'It is quite a long way [for many patients to reach my office and], actually to see me, and a lot of waiting time.' If young people's emotional, mental, behavioural, or relational difficulties cannot be dealt with by their GPs, they are referred by the GPs to either specific therapies or to Sabrina's team. When the latter happens, generally, 'somebody who is not a medic' among other team members makes these patients' initial assessment. Sabrina sees them for in-depth assessment at the final stage, and then she prescribes medication if needed. She needs to see these patients regularly to know how the medication works. Such a description of a treatment path gives us an idea of how Sabrina also describes a hierarchy between her

and other doctors in her work team and even the GPs she talks about. Although both 'General Practice (GP)' and 'Psychiatry' are defined among the roles for doctors and a general medical practitioner is described by the NHS as a medical doctor, Sabrina is distinguishing herself as a consultant here with her specialisation in psychiatry and gains a higher status than a GP (NHS Health Careers, no date [e]; NHS Data Dictionary, no date). For Sabrina, patients only reach her after following a long route and being evaluated by many staff she called non-medical. In this respect, providing a medical service puts Sabrina apart from others and, indeed, in a higher hierarchical position in her mind.

Sabrina separates herself from anyone in her work team, both at work and in her social life. She says she does not socialise with them: 'I have always felt like I don't really mix home and work that much. I have never been, you know, the sort of person who goes out with the colleagues. I have never been close friends with somebody from work.' In this context, she also built her sense of distance from others at work through a concrete physical distance. She has her own office, as opposed to working in a shared space:

> As a consultant in the team, you have a quite separate role. This is about medics and non-medics. For example, I have my own office. Nobody else has their own office. It puts distance between you and the other workers. It is like a consulting room. But everybody else is in their shared offices, and they have to book rooms to see families. It is because of my job title, my training. When I was a junior doctor, I did not have that. (Sabrina)

Sabrina sees 'separateness' as a positive thing here because she already does not want to confide in gossip with others. She likes her freedom and believes that this distance from other colleagues is an opportunity to avoid social pressure or expectations. She also seems to like the status and speaks of it as an achievement that was not there when she was a junior doctor. Besides, returning to the point of performance, 'office' is a physical, material boundary that performatively positions her higher in the hierarchy, as 'separate' as she puts it.

In contrast, Voyager, who has also studied medicine like Sabrina, applies a 'medics scale' wider than Sabrina's. Voyager is a Turkish ophthalmologist in an NHS hospital. She calls herself highly skilled. Saying that doctors are again at the top of the hierarchy, Voyager thinks that only the employees in the hospital without a medical degree may not be called medics:

> I cannot call them [other doctors in her work team] non-medics. All of them are under the same group. I might be wrong, but we have some technicians working with us together, or engineers… The technicians are doing imaging, like, taking

> the photos of the back of the patients' eyes, making tomography scans. I am not either sure that if they can be evaluated as non-medics but as their backgrounds, they don't have to be graduated from medical faculties. Even with a short-term training, anyone can be a technician. This short-term [to be a technician, probably after a first radiography degree (NHS Health Careers, no date [f]) is changeable between, maybe, six months and a year. They don't have to have sophisticated backgrounds. If you are asking me who is the boss, it is the doctors [laughing]. In the clinic there are people who have professorships and in the executive roles. For example, one of my supervisors is the head of the department of ophthalmology, and a supervisor, and a teacher, doing teaching, and also is an executive, in some administration roles. This is because someone out of the clinic could not know something even about the administration jobs there. As far as I know, doctors are in charge of the executive roles. Out of medicine, of course, there are secretary, but for executive or consultant roles, doctors are in charge. (Voyager)

Voyager mentions a similar superior-subordinate relationship to that of the NHS between health professionals and allied health professionals mentioned in this section. Radiographers/radiology technicians, whom Voyager calls technicians 'taking the photos of the back of the patients' eyes, making tomography scans' are put together with engineers and secretaries in the same spot as non-medics according to Voyager because they are not medical faculty graduates. In Voyager's and Sabrina's understanding of the hierarchies of healthcare workers, medical careers can be promoted and upskilled by specialising in the profession and taking executive roles.

Lila, in comparison, is a nurse who has been deskilled, serving as a clinical support worker in a hospital in NWE since July 2017. As she has not yet passed the English language test for her occupational registration as a nurse with the NMC, she could not reach the occupational registration testing step. For Lila, anyone could work as a support worker at the same clinic as her, and there is no need to be qualified to provide non-medical care. Lila's example was a colleague who worked in a shop before her role in the clinic.

> Our job, it's like a nurse assistant. Like, we assist the staff nurse by doing bed making, helping patient to go to the toilet or giving bath to some patient. If I'm working in elderly unit or surgical ward, if no one can take a bath so we clean him and give him back. We serve food during lunchtime and dinnertime. This is, most of our job, but recently I did this phlebotomy[6] course so, in this oncology clinic, I have a chance to take a blood and send it to the lab. My feeling is 'now, it's better' because it's like I'm improving. It's not like a nurse but, at least, now I'm doing something medical and collecting blood. I wish, in the future, they [the hospital management] make a lot of courses like, to improve ourselves here in

[6] 'A procedure in which a needle is used to take blood from a vein, usually for laboratory testing.' (National Cancer Institute, no date)

> the hospital. Rather than I'm waiting this qualification to convert it [her nursing certificate from Arabic to English and recognise her qualification as a nurse], maybe, I can do a lot of courses and do a lot of things that I'm already experienced. Because I'm experienced in blood-taking, cannulation, venous catheter, ECG [electrocardiogram], all the job of nursing. (Lila)

Lila distinguishes medic/non-medic between her original nursing and support work roles. From what Lila says above, it can be understood that undertaking medical procedures, such as taking blood, occupies a prominent place for her in distinguishing nursing from support work. This is because she does not count blood-taking among the tasks of her clinical support work routine. More importantly, for Lila, collecting blood specimens from patients is a sign of professional development; it gives her hope. It also performatively asserts her sense of herself as a medic. She is so close to her chosen nursing role and upskilling with this new clinical skill. She is now not just a clinical support worker; she destabilised this category and began practically to occupy a higher occupational level between that and nursing. For now, this is a bearable in-betweenness for Lila to take her original job back in the UK.

Finally, Zei, Turkish veterinarian, could be that 'anyone' Lila refers to. She had a carer job in a private care home with short, caring training. Zei filled out an online application for this carer job. Her employers gave her a date for an interview. They talked to her referees. She went through a DBS check and started work. She had to undertake online training for a week and work simultaneously. She spent time with mentors in a shadowing process. She was in face-to-face training in a class group for three days with eight other people. She says that she passed some short exams. Zei did not register for any councils or healthcare organisations; she was neither required nor was such a thing suggested. She was not required to show any proof of her English language proficiency. She only had a 45-minute interview, and she thinks it was enough for the employers to test her English language skills.

Zei delivered a range of physical and emotional duties during this job, which could be counted among the activities of 'intimate labour' (Boris and Parrenas, 2010, p. 2, Duffy, 2011, p. 6)—for example, bodywork (Twigg, 2000) including bodily upkeep, personal maintenance, and also bodily/emotional closeness and close observation. She helped the residents in the care home prepare for the day, assisted them in eating and prepared meals for the elderly who were on special diets. She was responsible for ensuring they took their medicine on time, serving tea and coffee, having chats with them, helping them with anything they needed daily, providing personal care, etc. Her patients were primarily

women. Some of them needed intense care because of dementia, for example. She worked for 44 hours, four days a week and earned 1600 pounds a month.

Briefly, a very subjective and fluid scale of medics and non-medics could be defined among the participants, with Sabrina and Zei at both ends. While Sabrina and Voyager have been preserving and upgrading their standing as medics by reskilling and upskilling, Lila still tries to rejoin medics by upskilling herself. Zei seems stuck in the category of non-medics here because she does not have a clinical background in human health.

In conclusion, it is already well known from the literature that there is a hierarchy in the health system, and the work of those with medical training is valued more than those without such credentials. However, what is overlooked is what counts as 'medical,' its boundaries, and how it applies to the real-life hierarchical order in health. This section shows how the participants in my thesis experience these hierarchies in practice and which social and professional relations followed that. By attending to those experiences, I found that work performed within the NHS does not fit the job definitions and that hazier conceptions of what is medical seem to underpin the actual operating hierarchies. Although there appears to be an objective medical hierarchy among health workers in the order determined by the NHS, not by laws but by regulations, this 'medicalness' is constantly being redefined and diversified by health workers and employers and a 're-medicalisation' happens. 'Medical' categories are contested by the 'medics/non-medics' categories, as I demonstrated. The objective categories of medical occupations that the health staff in the sample perform the predefined functions countered bottom-up with 'the situated knowledge of medical' in the section. A critical perspective on 'medical' unveiled the flexibility of the capital that the women possessed with their medical abilities and recognised credentials such as language skills. This capital is flexing so that women situate themselves within a hierarchy (holding on to it or using it as a stepping stone to a higher position) or take advantage of being a medic. There are overlaps between what constitutes a medical and a 'professional' or a 'skilled worker,' for example, in terms of qualification recognition in the UK. This brings us to the heart of the story, which is the participating women's entry to the UK/immigration status. The 'medicalness' of work and the associated recognition of language proficiency add to the discussion of the state's role in the transnational economy of care (Kofman, 2014). Women whose work is deemed a medical value arrived in this country through skilled immigration channels, while women whose jobs do not entail medical labour are still struggling to establish the value and necessity of their work—and, by extension, their worth. Yet again, by remaining flexible,

these workers utilise language and other abilities as leverage to negotiate regulatory systems, which eventually affects their prospects in the hierarchical healthcare system in the UK.

6.3 Key Workers

The ‘key worker’ term had been used long ago before the pandemic and has never directly referenced immigrants. It has no legal definition and can mean different things in various contexts, but it is formalised and regulated to some extent. For one of the earliest uses of the term, the Blair Government introduced The Key Worker Housing initiative in 2001. The staff for the essential public services, like the NHS, teaching and policing, were supported in buying or renting a home. They could access Affordable Housing specifically provided for them by housing associations and other providers (Airey and Wales, 2019, p. 6). However, the concept has become topical with the pandemic. Sectors where employees have been pronounced as ‘critical’ regarding the response to the Coronavirus disease are listed by the UK government as health and social care; education and childcare; key public services; local and national government; food and other necessary goods; public safety and national security; transport, and utilities; communication and financial services (GOV.UK, 2022a). Moreover, from a pre-pandemic NHS Business definition, ‘a key worker is a care professional who takes a key role in co-ordinating the care of the patient and promoting continuity, ensuring the patient knows who to access for information and advice.’ (NHS Data Model and Dictionary, no date)

At the start of the pandemic, the 'key worker' title implied some privileges to the workers classified as such. Special key worker privileges were, for example, access to school for critical workers' children (BBC News, 2020a), online coronavirus test registration (BBC News, 2020b) and booking for theory driving tests (DVSA, 2021). However, participants did not experience much change in their statuses, and few enjoyed the rights granted to them during the pandemic. Voyager, Nur, Anna, Sunshine and Kani appreciated the concept of a key worker as ‘important,’ ‘a positive thing,’ ‘a good idea’ in general, but they did not do this by relying on their own experiences. Although she did not use such a service herself, Kani (doctor) liked the idea of key workers’ access to a government website to apply for emergency driving tests so they could easily reach their isolated patients.

Similarly, according to Anna (psychologist), defining some frontline workers in the pandemic process as key workers might be a good idea, for example, for identifying only them to be able to continue to send their children to school. She and her partner did not need such a right because they worked remotely and were available at home to look after their children. Nevertheless, again, Anna thought that workers who had not had the chance to stay home during the lockdowns, such as the 'supermarket staff, people who collect rubbish, delivery drivers and care workers,' were indeed the vulnerable group who should have key worker rights.

In the context of migrant women who care for others, I shall discuss the idea of key workers in this section. This is because, even outside of the pandemic, immigrant carers emerged as the ones who took on the most demanding and pressing tasks in the UK's healthcare sector. As a result of their position at the forefront of the pandemic, these professionals should have been given the greatest consideration when identifying 'key workers.' However, was the key worker identification as useful as the participants hoped above for their occupational or social statuses? How did that feel for the participating women? In the interviews, it turned out that the participants mostly did not feel any different than before the pandemic. Claire (nurse) said they did their jobs like before: 'Even before this pandemic, I considered all these people who work in hospitals to be key workers. Everybody was doing their jobs even before the pandemic.' Similarly, for Gul, there was not much contribution of that category in her life, and it was not helpful. 'There has been no change in our standards. Everything continued the same.,' she said. She added that she saw some news appeared only on social media about key workers, but she has never felt appreciated as a key worker:

> Frankly, I didn't feel much. Maybe they did something to motivate workers on social media, but still, I didn't experience anything that could motivate me in particular. There has been nothing for me anyway; I am always motivated. In general, nothing extra happened. (Gul)

The government's messages to the British public regarding the category of key workers differed entirely from what these workers experienced on the ground. As I explain elsewhere (Dagdelen, 2020a), the 'key worker' concept came along with contradictions during the Covid-19 outbreak. When the pandemic raged and 'key workers' were celebrated as 'heroes,' the then Home Secretary Priti Patel made a statement in February 2020 about the UK's new points-based immigration system (GOV.UK, 2020a), which categorises the same people who earn less than £25,600 in a year as 'low-skilled' or

'unskilled,' and she had declared 'no immigration routes' for these workers (UK Parliament, 2020). Besides this political spin, some inconsistencies in the UK's policy regarding migrant healthcare workers occurred. Those government policies regarding the pandemic processes have been important in participants' perspectives in order to situate themselves within the fight against the pandemic. They rethought how they should feel about the newly attributed classification 'key worker.'

In the British context, the category of key worker is laden with a heavy subtext of British nationalism. The nationalist politics underpinned the warrior figure of NHS staff (Dagdelen, 2020b). From the coronavirus outbreak onwards, it was claimed that the world has witnessed tighter border controls, more protectionism and more local production, but the trust in global institutions and global supply chains has lessened (Moloney, 2020; Rachman, 2020; Legrain, 2020). While the worldwide comeback of nation-states with the coronavirus crisis was discussed, that was unsurprising for the UK. Despite the worsened staff shortages in the NHS and in private care sectors around the country (West, 2019; Lintern, 2020), the British post-Brexit policies and points-based immigration system were maintained as planned whilst seeking to build partnerships to secure access to vaccine doses (see Hervey, 2020, BEIS, 2020, for more on this).

The Health and Care visa (Tier 2) issued to the so-called 'the brightest and best global talent' (DHSC, 2020) by the UK government in August 2020 was a product of the policies of this post-Brexit period. Here, whereas the desired 'highly-skilled' was prioritised, the 'low-skilled' migrant was not qualified for the visa. This health visa, which is a part of the Tier 2 (General) visa route, during the pandemic, offered a reduced fee and fast-tracked entry route into the UK and exemption of the Immigration Health Surcharge (IHS) for eligible health and care professionals[7] and their dependents. However, care home workers were initially excluded from this health and care visa system (Clarke, 2020; Brown, 2020). In 2022, they were included, but on the condition of meeting salary requirements and being paid at least £25,600 per year (GOV.UK, no date [b]). The visa extensions and health surcharge had already been the main controversies for immigrant non-clinical workers from the beginning of the pandemic. The lifting of the charges to use the health system for all NHS staff on the 21st of May 2020 (Proctor, 2020) was a change in the UK's migration policy (Dagdelen, 2020b). Privileges were recognised based

[7] For the full list of professions which, in 2022, qualified for a Health and Care Visa see (GOV.UK, no date [a]).

on ‘skills’ by the key worker category and were only made equally accessible to all employees through public pressure and campaigns (RCN, 2020).

> We need to think our family as well. We just think about the family of four; the husband is a doctor, his wife is not working, he has two children. So, four people are in the house. So, if they want to apply for a visa for a year, it will come around 3-4 thousand pounds. Just think about his financial burden! He is earning like an ordinary person in the UK. Then, how come he can compromise? It's very difficult for him in that situation to pay the visa fees for all the members. And our family is paying back home. Our families [left behind] are not in this family [in the UK], we need to travel our country, at least, once a year, to visit our parents. So, we need to have some kind of savings. We raised our concern and government was not ready, finally they come up with the reducing the health surcharge. (Kani)

Kani, a doctor, is one of those deemed ‘wanted’ migrants in the UK. Nevertheless, she did not get easily and without campaigning what she thought she deserved as a key worker. As frontline workers during the pandemic, Kani and other international medical graduates like her raised concerns about getting automatic and free visa extension rights or indefinite leave to remain (ILR). It was not just for themselves; their families also mattered. In the above quote, Kani imagines an immigrant family of four, a doctor father, with his wife and two children. It exemplifies what kind of expenses this family can have while living in England, such as remittances, savings, travel fees, and so on, and how difficult it could be to afford visas for all family members. Further, Kani emphasises the toll the application process to extend a visa takes as ‘tedious’: ‘You need to spend at least 2 or 3 days to sit and apply for you and your family members.’

However, far from getting ILR, doctors, nurses and paramedics had to be content with the cuts in the health surcharge on the 31st of March 2020 (GOV.UK, 2020b). Yet again, Kani seemed happy with what they achieved because that fee was ‘a real financial burden’ to them, she says. ‘It might seem that we are getting paid more [as doctors]. We are just paid [during the pandemic] as if all normal [before the pandemic].’ When we had our interview in 2020, Kani was not yet paid extra because she was a key worker. In 2022, just a 3% pay rise was offered to key workers, and that is only for NHS nurses, paramedics, consultants, dentists, and salaried GPs (GOV.UK, 2021a). Thus, NHS unions cautioned the government that many health staff who are already fragile against soaring living costs actively seek alternative employment or consider a job move (Gorton, 2022).

Furthermore, Kani explains that ‘at the end of the day, the government take most of that salary in the form of tax.’ In terms of taxes, as Malik (2020) wrote, IHS, rather than ‘a fair contribution towards NHS’ as the former Health Secretary Matt Hancock (2019)

claimed, was to charge migrant workers twice as they already pay taxes such as income tax, National Insurance, and value-added tax (VAT) on purchases (Vargas-Silva et al., 2022, p. 2). Nevertheless, doctors, the healthcare workers at the top of the sectoral hierarchy, were eventually waived from IHS, while thousands of other migrant health and care workers were left out:

> I do not find government policies quite sufficient at this time [of the pandemic]. I mean, nurses, doctors, and so on had a march for a while because of these things [key worker rights]. I do not think much of a contribution to us, so it was not much helpful. (Gul)

Furthermore, the grant of ILR for the family members of an overseas NHS key worker (including support staff and contractors, or a healthcare or social care worker) was linked to the bereavement scheme (GOV.UK, 2021b) such that only if the worker dies as a result of contracting Covid-19 only in such a case are these relatives eligible for ILR free of charge. This scheme, again, initially omitted 'low-paid' people, such as care workers, hospital cleaners, or porters (Siddique, 2020). Yet, according to the data from the Office for National Statistics—statistical bulletin showing the deaths registered between 9 March and 28 December 2020 in England and Wales, social care workers, among other occupational groups, had significantly higher death rates involving Covid-19 than those in the same age and sex. This group included 'care workers and home carers' who accounted for most of the deaths with 347 out of 469 deaths (74.0%) and 'social workers,' 'managers of residential care institutions,' and 'care escorts' (Windsor-Shellard and Nasir, 2021, p. 8).

Therefore, the announcement of the 'key worker' category was linked to a resurgence of British nationalism in the Covid-19 era. This category confirms the shared value of the NHS as a national institution and its idealisation, which I mentioned in Chapter 5. The media operation on the disease has been the constitutive feature of that value. The UK government has often resorted to nationalist sloganeering, such as 'stay at home, protect the NHS, save lives' which was shifted later into 'stay alert, control the virus, save lives.' Will Davies (2020) argues that the first slogan overshadowed the second in time for the ambition of protecting the NHS, and the defence of the NHS was elevated above the defence of the public. As Davies writes, 'This was an ingenious piece of political rhetoric, side-lining the methodical and morbid question of body counts, and replacing it with a national story of collective identity and sacrifice.' In short, while the people's national feelings were exploited here, the damaging policies adopted during the pandemic were

covered up. In addition, slogans that emphasised only the NHS ignored other healthcare providers in the country and their problems during the pandemic. Furthermore, a war-like language was adopted in press conferences and campaigns in the struggle against the pandemic by the Queen and the Prime Minister (Rawlinson, 2020, Euractiv, 2020). The NHS workers who were mobilised on the frontline of this war with coronavirus as the key workers have been entangled with WW2 (World War Two) veterans. This has led to a more rigid dichotomy between the country's NHS and private health sectors and the value placed on their work. Klaudia (social care worker) emphasised below that the social care sector and care workers are, in practice, excluded from the key worker category:

> At the government level, there is a huge lack of understanding and willingness to learn about what care, social care actually does. Everybody rallies behind the NHS and health because it's much easier to understand. All of the resources during the pandemic were very much pushed towards health, social care was absolutely neglected in that case. And that has cost a lot of care workers, their lives and their health, and a lot of lives of people who were in social care, especially in care homes. But that is down to the national government. The public still does not understand and there needs to be a big educational campaign done about it that care workers are not part of the NHS, social care is separate, budgets are separate. If you raise money for NHS charities, none of that will go to care workers. And care workers are super important to their society and to the economy. And the fact that; a lot have struggled getting access to supermarkets in special hours because they weren't deemed worthy, just shows how rubbish their understanding out there is. And the government's immigration policy having been reiterated after the worst of the crisis to still classify care workers as low-skilled, to still give them no exemptions for visa. It's just terrifying, that kind of lack of understanding. And it's going to potentially destroy the sector. Care workers are leaving, managers mainly… Because they're just fed up. Key workers in a pandemic fight and nobody gives a monkey's about them… (Klaudia)

Klaudia criticised the government for creating a public perception that the country's employees fighting the coronavirus were represented only by the NHS. However, she thought that the budgets of independent sectors were separate from the NHS, that they should also be given financial support separately and that they should be made visible and respected with this awareness. The ‘clap for carers’ tribute by the public has provided the recognition Klaudia hopes for care workers. From the survey carried out by YouGov on the 4th of June 2020, seven in ten British respondents—an estimated 37 million people across the country—have taken part in the weekly round of applause for ten weeks during the first national lockdown, to say ‘thank you’ to key workers dealing with the pandemic (Abraham, 2020, Mitchell, 2021). Delivery drivers, supermarket staff, care workers and

bin collectors were finally among those recognised, remembered and celebrated. Wood and Skeggs (2020, p. 641) depict the events as such:

> ‘Clap for carers’ sees neighbours stand on their doorsteps every Thursday at 8 pm, banging pots and pans, sometimes accompanied by supportive police sirens and flashing lights…the nation's windows are adorned with children's pictures of rainbows; buildings are lit up in the blue of the NHS; murals of masked nurses as heroes are springing up on the side of buildings; farmers are ploughing NHS signs into their fields; and some people have even put their Christmas lights back up.

On the other hand, over time, this ‘spirit of spontaneous solidarity has thickened into something more forceful and censorious, potentially something angrier’ (Davies, 2020). In other words, this social movement has become politicised in time. The Royal Family and the Prime Minister began to accompany the well-wishers, flocking to their balconies and windows and applauding (BBC News, 2020c). Moreover, the ‘genuine appreciation’ that ‘clap for carers’ constituted melted into ‘a competition to see who can make the most noise’ (Mackay, 2021, p. 217). In addition, applause took on meaning as if it was assigning them to a national duty rather than motivating these workers.

According to the article (Manthorpe et al., 2021, p. 1) showing the data from an online nationwide survey of health and social care workers conducted between May and June 2020, 2,541 free-text comments revealed that it was not believed that clapping could translate into workforce improvements and political commitment to further funding of health and social care. Respondents valued clapping as illustrative of community cohesion, and few mentioned ‘heroes.’ Similarly, the research participants rejected the notion of heroism brought up by the clapping. For Sunshine (nurse), it was ‘just basically doing her job.’ Fast entries to supermarkets with NHS ID cards, NHS discounts and voucher codes from shopping were a part of ‘Clap for Carers’ campaigns during the pandemic (Clap for Our Carers, no date). The UK's largest trade union, UNISON, advised not to push key and vulnerable workers to the back of the queues to ensure public service workers get the food they need (UNISON, 2020). However, Sunshine refused to show her NHS badge to gain priority to enter a supermarket:

> Well, to be honest, everybody, some people have asked me about this, if I feel I'm doing a big part of this conquering coronavirus. I'm just doing my job. That's how I feel. And, you know, when we go to the supermarket we don't have to queue up, we just have to show our NHS badge; I don't think, I've never used it. I think, I refuse to use it because, if it's sunny, why not, we might as well just queue up and enjoy this [the weather]. But I've never felt that I have got… We have got a saying in the Philippines; ‘lumalaki ang ulo,’ it means my head

> becomes bigger. Because they consider us as key worker, never! We are basically doing our job. (Sunshine)

'Lumalaki ang ulo' is a metaphor in the Tagalog language meaning 'big head (proud, boastful)' (Palmer and Occhi, 1999, p. 194). With the phrase, Sunshine specifies above that she declines to praise herself and what she has done. Enjoying the weather and 'sunshine'—just like her pseudonym, taking a break and breathing a sigh of relief was what everyone who worked under the great pressure of the virus needed the most sometimes. However, as Claire also states below, from the government's side, these workers were also human beings; they also had feelings, needs, families, friends and loved ones but were ignored on the whole:

> The [British] society highlighted that [key workers] of this pandemic, but, on our regular lives, that's what we do. Only thing for me has changed is this, an unknown virus, and everybody is scared including myself. I'm scared… (Claire)

At that very moment, Sunshine told me so humbly that she did not accept privileged entry to a supermarket with her badge; she was bearing scars from wearing face masks for extended periods after a long shift. Sunshine talked about how the pain of these wounds seemed so insignificant compared to her mental breakdown:

> To be honest, you've interviewed me, I'm in one of my low moods now, and my husband said that I've hit the wall. I think, I must have been feeling alone for nearly a week. It's, because of my face, it's quite pink now. Sometimes it would bleed, I think, it's the prolonged use of the mask. I think, I've got an allergic reaction to here now because of the prolonged use. So, that's why, as you can see, it's pink here [she shows her scars and bruises on her cheeks]. So, you don't really died of it now, I know, I look ugly. I'm tired maybe. (Sunshine)

Sunshine said she felt alone among the crowds that applauded and proclaimed her a hero. During the pandemic, Sunshine had to move into the house of her friend, who was also a nurse, for weeks. Due to the risk of contracting the virus, they could not stay in the same house with her husband. In this process, she saw him only while walking outside, with a social distance. Sometimes, she would go to the backyard of her own house and chat with her husband, that is all. The balance between work and family life is being deteriorated in this instance. Living through the pandemic was 'quite awkward' for Sunshine, especially working in the hospital. When Covid-19 reached the UK, the government's pandemic response stock had no gowns, visors, swabs or body bags (BBC News, 2020d).

Moreover, in May 2020, when I spoke to Sunshine, the UK faced a severe shortage of Personal Protective Equipment (PPE). PPE available to the NHS and, even more so, for

the social care providers was insufficient. In 2020-21, the government wasted £10bn on defective or unsuitable PPE (Neville, 2022). Although Sunshine herself has never experienced any PPE procurement problems in the hospital where she works, she tells the stories of friends of hers in what follows:

> I have heard from a friend of mine that they would just use surgical masks to look after Covid patients. So, that is not appropriate because they [NHS] said that, for you, to wear an FFP3 [Filtering Face Piece mask, and the number '3' is for the best protection]. So, I would say, in ICU, I did not feel the lack of PPE because we were abundant of it and I never felt that I had to prolong my [use of PPE], going to the toilet [washing and reusing PPE], just to save PPEs… I've never had that, in that situation. But lots of, lots of my friends who are nurses said that it is quite different in the wards. Like they [NHS] say that, they would, when the coronavirus hit, the infection control department was quite busy. They [NHS] were changing the policy like as often as they could. It depends on the material of the PPE that they have. So, it wasn't really clear. They [NHS] said that they [staff] will have to use… At first, they [staff] will have these FFP3 masks, and then, people are using it and then obviously the supply will run out. So, it went down to FFP2 [Filtering Face Piece mask with lesser protection] which is also similar as this. But the particles that could go in this more, I don't know the scientific of it. And then, it came to the point now. I think the one that they've [staff] been using now is, they're using surgical masks and then a visor. And sometimes, they [NHS] would say that, now, they would use the normal plastic pinny [pinafore], apron that you find in the hospital. Whereas, in the very first few weeks of coronavirus, they [NHS] said that you should have a long apron or a long gown to protect yourself. So, that's the story I've heard. (Sunshine)

Sunshine's friends, nurses like herself, had to repeatedly wash and use the disposable respiratory masks recommended by the NHS. When this equipment ran out, they had to turn to less protective respiratory masks or surgical masks. Or, when they could not find the long gowns recommended to be worn in the quarantine rooms, they wore ordinary plastic ones.

In addition to Sunshine's medical and non-medical duties that I presented in the previous section, listening to those kinds of stories and seeing the death were added to her everyday 'to-do list' at the hospital. Still, there was significant and emotional work left. No matter how tired the staff was, some patient relatives were waiting for good news. These workers were the ones who had provided moral support to both the patients and their relatives and ensured contact between them, even if it was from a tablet computer:

> Speaking to relatives is quite important nowadays because they can't go to the hospital and visit them. So, in the hospital, we had this system. You know, we've got our iPad [tablet computer] that we could come back the next of kins of the patients, and if we would do video call… But it still depends on the relatives

> because some get quite shocked when they see their loved ones tubed and unconscious. (Sunshine)

In the interview, Sunshine appeared cheerful and made jokes, probably to keep her sanity in those extraordinary times. When I asked her about any wage changes, she told me they had not yet received [pay rise]. Nevertheless, from the people in the local community, the hospital staff had received loads of toiletries for use and cakes to eat during long shifts. 'Super love those cakes! And now, just eating sweets, and we're all diabetics [laughing].' (Sunshine)

To conclude, when I wrote a short piece about the 'key worker' category, I articulated that some overseas health and social care professionals would experience a 'virtual status' (Dagdelen, 2020a) during the pandemic, especially those deemed 'low-skilled.' Undoubtedly, when this category came up, it suspended the law in a way, for example, regarding visa extensions, and had legal ramifications for the migrant workers in the country. So, it somehow made changes in some people's statuses. On the other hand, the category created an effect where every health worker has equal value in terms of the tasks fulfilled during the pandemic, but it did not value these workers and their jobs equitably. It did not guarantee them better pay and better social status. In fact, the pandemic intensified existing inequalities, with BAME and migrant groups, especially East and Southeast Asians, facing compounded disadvantages. Hu (2020) highlights how these intersecting inequalities deepened economic hardship for BAME migrants, while Yeh (2020) emphasises how the racialisation of the virus as 'Chinese' triggered unprecedented racial violence, disproportionately affecting healthcare workers, including Filipinx, who already had high death rates.

If 'fighting for the UK nation' is the matter, the migrant women, whose pandemic experiences I explored in this section, have just become a part of this nation or are trying to be yet. They are already putting their lives at risk for the people living within the borders of this country, as Kani expresses below:

> And, we have come to a new country. This is not the country where we were born, right? So, we are risking our lives and work and helping your people! Just we made this consent to God! We are risking our lives and we are helping the people in your country. And, at the same time, we need to take care of our family, kids, husband… (Kani, Indian doctor)

Participants expect far beyond a power play on the British political scene, empty promises or flattery for their pride as they do their job without expecting more than they deserve from the government and can be happy even with a slice of cake as a thank you

from the public. They do not chase the hero or a warrior status. Even if they are quite modest, considering the struggles they face every day, treating them like heroes does not alleviate those struggles, grant them a legitimate social and professional standing or make their lives any better.

6.4 Conclusion

This chapter discussed how participants envision the better lives they seek through their migration to the UK in terms of their jobs. It examines the professional trajectories and skilling experiences of the participants in this country while also exploring the effects of categorisation on experience and vice versa. UK's immigration policies and the literature on that have mainly focused on the bureaucratic categorisation of immigrants, often in binary order, such as 'EU/non-EU.' Correspondingly, this chapter commences with a critical look at these binary frameworks, explores social immigrant categories more closely, and highlights the existence of other classifications that challenge and go beyond traditional dualistic categorisations commonly used in such discussions. In addition, this chapter contributes to the literature by analysing how participants experienced the 'key worker' category during the pandemic, revealing what the bureaucratic and social implications of this new discursive category might be.

As a result, what we see in this chapter when we look at the professional experience of women, including their occupational categorisation and hierarchies, is that, in the entry of these immigrant women to health work in the UK, there is a complex arrangement by different institutions; by the public, private and others in-between such as the local authorities. The knowledge of the various recruitment guidelines shared with the public is limited, even to the employees. In the middle of such confusion, immigrant healthcare workers have to navigate social and occupational categories such as 'medics/non-medics,' trying to prove their qualifications through tests and proficiency in the English language and, therefore, to be re-skilled or up-skilled. Thus, they hope not to be labelled 'low skilled' or 'unskilled' and to exist in the UK's skilled-based immigration system, which tests their professionalism and worth as an immigrant and even as a human being. Other strategies for migrant workers to cope with deskilling and a sense of devaluation are found as volunteering, second jobs or observations.

Based on the respect they get in their social lives, at work, and as immigrants, the women in this study assess if their lives in England are better than in the past. Their notions of better lives are thus harmed by being steered along a deskilled occupational

route upon entering the country and by the challenges they face in attempting to stray from this path and pursue the professions they prefer. Concurrently, we witness a healthcare system that runs on the fruits of their labour. However, it is evident that the system is not as sound as previously believed when considering the care crises in NWE and the unaffordable carer shortages, particularly during the pandemic. These workers do not require titles that do not guarantee the promised status, like the key worker category; instead, a system is necessary for recruiting carer immigrants according to the value of the work they do, and that also takes into consideration the social inequities and health service deficiencies of the country. This calls for adjustments to immigration regulations as well as healthcare systems. The next chapter concentrates on the interviewees' strategies to settle as immigrants in the UK under the theme of '(un)settling.'

Chapter 7: (Un)Settling: Settlement Experiences and 'Ordinary' Achievements

Until now, I have written about the migration decisions of participant women, their 'access to work' experiences, and their occupational categorisations. The previous chapters explored how they aim to 'do everything right' in their daily life on their migration route, for example, looking for work or surmounting all obstacles. In this chapter, I problematise the idea of settlement and integration as defined in the main policy agenda, argue that settling and unsettling are ongoing everyday processes, and consider their emotional, affective, and transnational dimensions. Under the theme of '(un)settling,' I show how participants experience everyday life's 'ordinariness/banality' in the UK. The 'un-' in '(un)settling' underlines the ambiguity of 'settling' or 'settlement.' I use it to create space for the narratives of those who feel unsettled or not settled yet. Settlement becomes a critical component of participants' pursuit of a 'better life' in this chapter, as it encapsulates their efforts to bridge the gap between expectations and the realities of everyday life in the UK. This ongoing process reflects their desire for stability and fulfilment, even as they navigate emotional and cultural unsettlement moments.

In the chapter, by extending the idea of (un)settling beyond a host society-centred viewpoint, I situate it in a 'transnational social space' understood as 'combinations of social and symbolic ties, positions in networks and organizations, and networks of organizations that can be found in at least two geographically and internationally distinct places' (Faist, 1998, p. 8). The chapter illustrates how immigrants find activities that locals in the receiving country take for granted as exceptional and how emotional work is required to become accustomed to this 'extraordinariness.' I show that social expectations, guidelines, values and habits shape the emotions and feelings of immigrants. I am using a global viewpoint and transnational locations to comprehend the overarching regimes of emotions. The expectations established in the transnational social spaces, namely the UK-Turkiye or the UK-Romania, do not correspond with those of the host community. This indicates a discrepancy between the expectations of the home and host nations. The participating women's vision of better lives is suspended due to this discrepancy, which makes them feel unsettled in England.

This chapter analyses the settlement experiences in three sections: first, in 'Feelings and Emotions in Settling,' I present a general perspective on settlement related to an

immigrant's emotions and feelings under the influence of the social structures in the country where she settles, and that it is shaped on her perception of settlement that is shaped in a transnational space even before migrating. In this section, I introduce my use of the 'emotional work' perspective throughout the chapter to analyse participants' settling experiences in the UK.

Second, 'Encountering the "British"': as I heard from them, their relationship with an understanding of 'Britishness,' 'Britain' and the English language have been important in participants' settlement. These understandings occur as the subject of the UK's border control. Research participants felt discriminated against based on how they spoke English and how they looked. These feelings require me to draw on the concepts of 'migratism' and 'racial microaggressions' in this section. An illustrative case among the participants in this section arises between those who speak English and those who do not speak English or between those who speak fluently and those who do not. Having settled in North England, participants have difficulties understanding local accents. This raises questions about what counts as proper/standard English and about language ideologies around accent differences in England (Coupland and Bishop, 2007). Coupland and Bishop (2007, p. 74), in their research reporting from a large survey in the UK, found that accents associated with 'standard' speech, for example, 'London English,' were much more favoured by respondents in prestige and social attractiveness rather than those spoken in English Midlands or Birmingham. The participant women came to the UK expecting a certain kind of English, and now they are just puzzled by the accents they encounter daily. Drawing on accents and a South-North England divide in the language, I specify the experiences of participant women employed in the healthcare sector or living in the North West. In addition to the discussions in Chapter 6 about the English language within the context of the qualifications and language proficiency through tests, this section considers the relationship of participants with the local speakers of different accents/dialects of English in different counties/districts of North West where they reside is and how this relationship affects their sense of settlement in the UK.

The third section is 'Achieving the "ordinariness" of life in the UK.' Actively participating in widely shared, well-established and often respected cultural practices (eating and drinking patterns, humour, sports and entertainment, ceremonial events, and media content discussions) not only gives social status to those who are considered to belong to a group but can also be comforting and enjoyable (Skey, 2018, p. 609). Migrants seek to learn about 'life in the UK,' share some aspects of their lives with non-migrants,

and participate in ‘ordinary’ life activities with all its pleasures, pains and disparities (Fortier, 2021a, p. 185). In this section, I highlight two salient examples, ‘driving’ and ‘mothering,’ considering that they are influenced by the social structure of both the sending and receiving countries.

7.1 Feelings and Emotions in Settling

Some women have networks in the UK through work, friends in social life, children's friends or everyday activities. While some of them embrace diasporic relations, some others reject them deliberately. Some participants maintain their relationships with their countries of origin through remittances or communications. Stella, one of the research participants, feels that ‘England is home as much as anywhere else [Greece], even more than anywhere else.’ As she put it, England feels like home to Stella, but it is ‘in a bit of distance.’ She thinks that she looks like a British woman normally, but when she speaks, people can understand that she is not local due to her Greek accent:

> If I keep my mouth shut, obviously, I blend in. Colour-wise, you think I am local, look-wise, you think I am local, but when I open my mouth, I am not local anymore. I think, there are discriminations on looks, and I do think it is easier in England look-wise. (Stella)

I investigate the extent to which, in the words of Stella, participants ‘blend in’ their working and living environments in the North West and what this ‘blending in’ means to them. Participants feel that ‘blending in’ in a receiving country is necessary. It is something that the host society expects them to feel. ‘Blending in’ is the motive of the ‘emotion work’ when someone directs a microaggression at the participants, and they have no option other than ignoring such acts. In the face of such a situation, they are expected to stay calm as immigrants, not make a ‘fuss,’ and accept it because they need to blend in, and they would not want to draw attention from the host society to themselves.

Hochschild (1979, p. 563) talks about emotions appropriate to feel in certain situations, which means feeling rules tell us what emotion to feel, how and when. Emotions are ruled and managed. Social guidelines guide the ‘feeling rules,’ which are socially shared and not noticed unless acted upon; those guidelines are present but not obvious. Moreover, ‘emotion work’ means trying to feel what we should. Hochschild (1979, p. 565) notes that individuals often compare and measure their experience with an idealised expectation. We may experience a certain dissonance between ‘what I should feel’ and ‘what I try to feel’; as an emotion work, we attempt to reduce this emotional dissonance. Then, the participants' experiences of ‘better lives’ in the UK are shaped by the

dissonance between their ‘blending in’ ideals and their feelings of ‘unsettling’ since the pursuit of better lives through migration is an emotional work.

The emotional work of settling is further complicated by external political shifts, such as Brexit. Stella, who had previously felt settled in the UK, describes how the Brexit referendum disrupted her sense of stability:

> Brexit has been emotionally unsettling for me. I do remember getting up in the morning and going on the tablet and seeing in the news the result of the referendum. And, it did feel like a rejection, even though obviously it was no[t] personal. It did feel like that and still feels like that. But, until then I was settled. I am still settled but likely less so. (Stella)

Stella's sense of stability was moreover disrupted by the bureaucratic changes brought about by Brexit. As she reflected:

> Because of EU I did not need to apply for anything. But because of the Brexit, there was a new thing of settled status, that is why I applied.

Brexit not only introduced material uncertainties, such as changes in visa conditions and shifting immigration hierarchies (Consterdine, 2023) but also altered the emotional landscape of settlement. For many EU migrants, the referendum and its aftermath signified a symbolic rejection, creating an atmosphere of exclusion. Stella's experience highlights the emotional dissonance between her prior sense of belonging and the unsettling reality of feeling unwelcome in a place she once considered home, having never needed to apply for settled status since arriving in the UK in 1995—until Brexit changed everything. This feeling of exclusion was not necessarily overt but was reinforced by media narratives, political rhetoric, and the actions of various political and social actors. As knowledge activists, government actors, and vigilante activists contributed to shaping the post-Brexit border regime, their activities were part of a larger strategy to perpetuate anti-immigration sentiment across national borders. These dynamics show how media, political discourse, and grassroots actions intertwine to influence public attitudes towards migration and bolster the exclusionary atmosphere that many migrants now face (Lewicki, 2024, pp. 3-4).

The shifting politics of immigration following Brexit also intersect with racialised experiences of settlement, though some participants' experiences predate this period. While Stella, as a white European, discusses a shift in her perceived belonging, other participants, particularly non-Europeans, navigate long-standing racial hierarchies that shape their everyday encounters. Unlike Stella, who could previously ‘blend in’ before speaking, many racialised migrants experience immediate forms of othering that are not

contingent on speech or accent but rather on visible markers of difference. In the next section, I explore how these experiences manifest through microaggressions, which further complicate the emotional work required for migrants to sustain their sense of belonging in the UK.

The governmental policy of integration and settlement is very much host society focused, whilst the experiences of migrants are transnationally shaped. While the participants carry the burden of their expectation of 'blending in' in the receiving country, as in Kani's and Regina's cases I present in this section, they also have to think about their families in the countries of heritage and the culture, values and habits they came with. So, the balance that the participants try to establish between their lives in the countries they arrive at and their transnational lives is an emotion work.

Bearing in mind that it will not happen equally for every participant, we can say that those who think they can achieve blending in are 'well settled' from the standpoint of the dominant discourse and existing policy of settlement and integration. However, this is only one side of the story. Settling and unsettling are multi-dimensional. The other dimension is that the settlement is related to the host society and the family in the home country. One particular example that demonstrates multidimensionality in settling comes from Kani, who explained that after migrating to England, they are, with her husband, still trying to maintain a strong bond with the Indian culture and their families in India as an Indian family. She says that she and her husband are both from 'traditional' families, and the only thing their families back in India expect from them is to stick to their Indian traditions in the UK and 'not to follow the Western cultures.' This warning from their families was likely that following British culture could erase their Indian identity or cause it to be cast aside. It seems that the traditions that Kani was explicitly asked to follow by her family were about how they practised religion in India: 'We need to go to the temples, we need to make some poojas [Prayers], we need to worship God [in the UK],' she says. However, Kani also accepted the necessity of adapting to British culture. This balance between the two cultures applies to the participants' children while being raised. Therefore, as parents, Kani and her husband support their child to interact with British people to adapt to British society and British culture:

> At the same time, we want him [her son] to learn our [Indian] traditions as well. So, this is what we have been taught. We have to be like Indians, but, at the same time, we have to adapt to the British culture. (Kani, Indian doctor)

> I'm in Romania, I'm going to church, but here, I'm going as well, but they are the English people, it's very different, like the relationship with God. It's very different from Romanian people. So, this affects me, to say, this is not good for me because I am… Like Christians, we're going after the Bible, what it's saying, but they [British people] just know what the Bible says, but they are doing different things. And [they think that] 'if you go and stay right,' it's like, 'oh it's okay,' 'it's fine.' But, it's not fine! The Bible is not saying that. So, I think this is the main reason I don't like [going to church in the UK]. (Regina)

On the other hand, Regina, who comes from Romania, seems to have not yet achieved the kind of settlement she hoped to achieve in the UK. If Regina decides to return to Romania at some point, she believes the cultural-religious conflict in the quote above will be the sole cause. We understand from Regina's description that she could practise religion in her country of origin much more conservatively than in England. Regina has had difficulties integrating into the English church in terms of how religion is experienced. For example, she is bothered by the LGBTQ+ inclusion and affirmation within the community group of the church that she goes to in England. She described this as a situation she had not encountered in the Romanian church services. For example, she said that men would not attend church wearing 'earrings or dress[ed] femininely.' Regina feels challenged by her socially conservative views, and confronting beliefs she does not share makes her uncomfortable and deeply unsettles her. She expresses her (un)settlement by comparing British and Romanian religiosity. Such an unsettling hinders her aim of living a better life in England and may even endanger this aim.[1]

Finally, settling is also temporal. One moment, participants can feel more settled, but at some point, when, for example, a family member begins to feel ill in the country of origin and does not have anybody to look after, they would suddenly be unsettled by this fact.

> We have a small family [in Turkiye]. And, I'm very close with my mom. She was diagnosed with cancer. So, so we've been struggling with that really for four, four and a half years. So, it's sometimes difficult to be here [in the UK], and because of that but… (Kate)

> I don't have my parents now, both died. But, I've got three brothers. Two are financially stable, so they don't really get support from me because they are also professionals. But, we've got one brother who, I send money to [the Philippines] every month, which is very minimal. And, we all do actually, all three of us are sending cash to him. When my mom was living, still here, he [her brother] was the sole caretaker of my mother. So, it's actually that he did not pursue his career or his studies to look after my mom. All three of us have been studying and going

[1] Although I see the potentially problematic nature of these viewpoints, it is outside the purview of this study to problematise or challenge Regina's ideas.

> abroad. Though now, that my mom's gone, we're returning the favour. (Sunshine)

Migrants feel they need to care for their family members left behind, find a comfortable place, and have a happy life in the UK. That brings another dimension of unsettling as they leave behind family members getting older and having different care needs. Family crises can emerge, and those can cause moments of unsettlement. In this regard, I frame unsettling as how participants perceive themselves, where they are in their lives and the transnational social space, and I deploy 'emotion work' as an overarching theoretical angle to understand those perceptions.

7.2 Encountering the 'British'

Kate told me that her patients when they look at her and listen to her, they understand that she is not British, and they call her very often a 'Turkish woman.' She thinks that this is just because they cannot pronounce her name:

> I have not come across any discrimination from my patients. Sometimes, they are afraid to offend me by saying 'Turkish.' Sometimes, they ask me where I am from. Obviously, I am not from this area. They say, 'I am sorry, do you mind if I ask you where you are from?.' (Kate)

Like Kate, some participants experienced what Tudor (2017, 2018; Tudor and Ticktin, 2021) termed 'migratism' and Anderson (2013, 2019) 'migrantism.' Tudor (2018, p. 1058) used the term 'migratism' to theorise the power relationship that attributes migration to particular bodies and establishes non-immigrating as the norm of national and European belonging. In short, 'migratism' describes 'discrimination based on the ascription of migration' (Tudor, 2017, pp. 23-24). According to Anderson (2019), migrantism is a term that helps us grasp social and legal understandings of who counts as 'immigrant' and 'citizen' and the difference between the two. In political debates on the control of immigration, an 'immigrant' is assumed to be a person whose movement or existence is considered a problem. 'Immigrants' are persons subordinate to 'citizens.' In their workplace, participants interacted with patients who were unfamiliar with their names and frequently asked what these names meant or guessed where the women came from because of their names and appearance. Participants are guided about how to respond emotionally to their patients' migratist microaggressions and how they should feel about these attitudes. Staying calm against such migratist approaches, ignoring them, tolerating them, and similar behaviours are serious emotional tasks.

In addition to ‘looks,’ language provides a cue for locals to ‘spot’ a foreigner. This is where ‘hearing’ and ‘seeing’ intersect (Fortier, 2021a, pp. 116-154) and racialization and languaging align. By the language used by participants, they are ‘migratised’ by anti-migrant policies and discourses, with Fortier's (2021a, p. 118) term expanding the theory of ‘languaging’ (Chow, 2014) further. Chow (2014, p. 9) defines ‘languaging’ as ‘being racialised by language and languaged by race.’ For Fortier and Chow, this is about how regimes of visibility (or regimes of seeing) and regimes of audibility (regimes of hearing) work together in the racialisation of a subject. Here, we are talking about the image we have in mind when we hear but do not see someone speak a minoritised language or English with an accent or what we hear when we see a minoritised subject speaking (Fortier, 2021a, p. 118).

In this section, going beyond discussing the politics of ‘migratism,’ I aim to explore how this concept is articulated through the participants' encounters with people in everyday life in England. Moreover, following Tudor (2017, p. 24), I analyse the participants' experiencing ‘migratism’ in relation to racism since, for example, the racial microaggressions that the participants are exposed to are evidence of the everyday racism in their narratives. ‘Racial microaggressions’ are defined in the social psychological literature as ‘brief and commonplace daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color’ (Sue et al., 2007, p. 271). So, migratism or racism appears in the form of a microaggression that may centre, for example, on the names of some participants and on how they speak English. Deskilling is reproduced in wider society through racism and sexism, not only as a consequence of immigration regimes, professional bodies, or hiring institutions but also as a reflection of broader social hierarchies, as Raghuram (2021, p. 9) highlights. ‘Skill, instead of measuring one’s ability to do a job, functions merely as a marker of social and legal difference that sorts people into different strata of the social hierarchy. It defines how one is allowed to move, live, eat, think, work, and behave both on and off the worksite.’ (Liu-Farrer, 2024, p. 10) From this perspective, the racial microaggressions experienced by the participants are not just instances of harmless banter or prejudice; they are targeted actions that contribute to the devaluation of their skills. How participants' names and accents become sites of microaggressions reflects broader societal and immigration hierarchies (Consterdine, 2023) that shape whose skills are recognised and valued. This suggests that responsibility for deskilling extends beyond professional and institutional structures to

the everyday interactions that reinforce racialised and gendered inequalities in skill recognition.

Participants consistently received seemingly complimentary comments from colleagues or patients about how they use the English language. However, to feel settled here, some had to tolerate or get used to living in the way the local people define them. On one of her working days, Sunshine heard a sentence starting with 'Is *that* even English?' from an elderly British woman patient, but she felt she had to ignore her. She believed her patient was only confused by her advanced age and did not mean to humiliate and dehumanise Sunshine. Perpetrators who engage in such communication when interacting with racial/ethnic minorities often lack the self-awareness that what they are doing can be experienced as a microaggression (Sue et al., 2007, p. 271). So, maybe her patient was 'unaware' of what she did as Sunshine had hoped. In other respects, this expression from Sunshine's patient explicitly suggests that she is invoking an insular idea of what 'English' means to otherise people who do not fit that narrow understanding. Therefore, this 'unawareness,' is perhaps, letting them off the hook easily. At the end of the day, Sunshine went through this reaction from her patient, more than likely because she did not want to experience any disruption in the flow of her daily life in the country where she lived as an immigrant at that time.

Sabrina also thinks that she sometimes feels on the outside, although she feels very integrated with everybody or has close friendships. Hence, she has always tried to make herself 'not different' in the UK. She 'assimilated herself language-wise,' in her words. To protect herself from possible exclusion by people in the UK, she went to great lengths to fit into the identity she felt should define her. Thus, in the end, as Sabrina spoke and looked like so much, a patient of hers thought that she was British like himself and complained to her about Germans at a workday:

> I never thought about it [in Germany], and suddenly, there's a whole new identity. When I was a junior doctor, I worked on the wards, and I had a German colleague. And, I've never had a very strong [German] accent. So, people didn't ever really sort of put me into that box [of foreigners] immediately. But, this German colleague, he had a very strong accent, and he'd seen this old man in A&E, and then he [the patient] was transported along. And then, this man said to me, when I'm gonna talk to him, he said, 'Oh, I saw this doctor.' And he was, I can remember exactly where he was sort of voicing off, and the guy's saying, 'I really don't like the Germans and all that, all the rest of it' [laughing]. So, I didn't say that I was German to him; I just listened to it, you know. I never encountered it myself. So, it's in a way, you know, when I said earlier about feeling separate, and different, I'm also, I said from a language point of view;

> I've always really tried to assimilate. So, I tend to automatically adopt the way that people speak around me. (Sabrina)

English is a 'world language' (Fortier, 2021a, p. 14) in an extension of the colonial past of Britain. As Heller and McElhinny (2017, p. 3) suggest, language establishes boundaries that help produce, reproduce, or counteract the unequal distribution of types of resources, such as natural or human resources. However, language also operates as a resource and is distributed unequally. This is how I read this inequity as a two-way measure for my participants: while some were unequal in terms of resources in accessing language, some were unequal with others in accessing opportunities due to difficulties in language skills. Sabrina is a German woman striving to speak English like a British person in Britain. She states that she can 'pass' as a native-English speaker, or at least as non-German, thanks to her fluency in English: 'I was already interested in languages, it was French really, I really liked it. I was good at languages. I think my English was always okay.'

Sabrina is 'different' from Britons as an immigrant, but this difference fades occasionally. For her, 'there was an openness,' in her phrase, to choose to migrate anywhere. She 'followed social encounters, friendships and social opportunities rather than occupation opportunities.' Even before she immigrated to England, her English was so good that she quickly picked up the accent in Northern Ireland, where she once went for work experience. Sabrina's situation, in this sense, is in contrast to the general profile of the participants. Her upper-middle-class position highlights that she has little in common with other care-professional participating women. As one of the biggest dilemmas of everyday life, for example, even when the racism was not overt in words or specific behaviour, most of the participant women have had a sense of exclusion or rejection against them:

> I personally haven't experienced anything, but in our workplace, there are people from India, for example, I generally think they [the Britons at work] are very racist towards them [the Indians at work]. They always have a problem with them. These Indians are immigrants, they had just arrived. Obviously, something is happening against them, so I feel it. (Gul)

> A few of the consultants whom I worked there [at the hospital where she works], I felt like they show some kind of racism, not sure, just because I am from a different country. Even if I wanted to discuss something with her [a British consultant], she just ignored that. So, I felt very bad at that moment. I felt it was something odd. It was blatantly obvious, she was interacting with other colleagues in a nice way… Even a few of my colleagues just ignored me when I approached them. To just have a little chat… So, they just ignored it. One

> positive thing I've felt is that all my fellow Indian colleagues, not only Indians, people from Pakistan, and people from Africa region, most of them were very kind to me. (Kani)

In the above quote, Kani mentions how some British consultants and colleagues ignore her when she speaks. She specifically mentioned that although she wanted to ask a British consultant some questions on a day when she was the only 'foreign' worker among other local colleagues at work, she was almost invisible in the eyes of this consultant. Unlike her, this consultant approached and listened kindly to other colleagues. Even though Kani has said she does not have an opinion, we have good reason to believe that this may be because of the way she looks or speaks, as there have been instances of both individual and institutional racism against foreign employees of the NHS (Allan et al., 2004).

Participants anticipate that they would not experience the problems they had in their everyday lives if they could speak English like the locals, even with their accents. These expectations of what it takes to 'integrate properly' are critical to achieving a comfortable point of settlement. Then, what does shape those expectations in the first place? Fortier (2018, p. 1265), in her article about the language requirements for immigrants applying for settlement or citizenship in Britain, mentions that a Filipina refugee participant believes that the UK government makes Filipinos appear dumb, claiming that they cannot speak English. In this chapter, we see that not only people coming to this country from the South Asian subcontinent or Global South but also Europeans who speak English with an accent feel their language proficiency is inadequate. Although the women thought their English was good, they were treated as if they did not speak English well enough to be understood or heard by the British. This explains how macro-scale regulations are reflected in micro-social interactions in daily life.

The 'un-settling' in the title of the chapter describes not only the inability to feel belonging somewhere but also the anxiety or restlessness caused by being an immigrant or a foreigner. These feelings sometimes become justified suspicions, and the participants feel somewhat prepared for such discrimination. Even though Regina has never been told this directly, she thinks her English colleagues do not like her; she says she could not make many friends in England. Regina explained that she had few British friends because of the language barrier. Regina suspects that when the British usually say one thing, they may have meant something else. British colleagues tell Regina that they would not be bothered if she did not speak English well enough and that if they were in her shoes and

had to speak Romanian, they would never have done it as well as she was good at speaking English. Regina thinks these people do not sound natural or honest.

Another point where Regina has a problem with language is that she finds the Northern English accent in her area difficult. She says this accent is very different from the one she encounters on television, for example, while watching the news: 'They [her British colleagues] are eating the words, they are not saying all. I'm saying, "Would you like some water?" and they say, "Wo'ah?".' While Regina explained that she had difficulty understanding different English accents, she viewed the Southern accents more positively than those spoken in the North. According to Regina, she will be able to understand and speak English better in the future. She believes working in an English-speaking place or attending a church in England will also help. Further, although Regina worried that her daughter might have trouble learning English for a while, she says she is used to school now and speaks so much English that she forgets even how to speak Romanian.

Kate also, when she first arrived in the UK, lost her social confidence because she could not understand people in the town where they were living at that time with her partner. People were speaking fast, and it was hard to understand their North West accent. She avoided talking to people. She says that they could not understand her either. She had to repeat what she had said to them again and again. She felt isolated.

> I was under extreme stress; one is I thought my language was good, my English was good, but I couldn't understand people. So, that was a big impact first. And then, I wasn't working, I wasn't driving. And it took nine months to get my accreditation to be able to apply to the jobs. So, I didn't know what to do in that nine months. If it was me now, I would go and work in like volunteer, in some places, charities or something, to improve my language and to have a bit of like social, and socialise. I didn't have any friends. (Kate)

Regina's familiarity with Southern English and attitude towards Northern English speech in England might have been affected by the language-based prejudice of the local people in the country. This prejudice is based on a North-South divide in England, and 'southern England has traditionally been viewed to represent Englishness and England' (McKenzie and McNeill, 2022, pp. 3-4). Reviewing studies of explicit and implicit English language attitudes, McKenzie and McNeill (2022, p. 46, 48) summarised the results from these studies as follows: English national participants in these studies often rated non-standard speakers as less intelligent and educated than standard English speakers, while Southern British Standard English speakers were more intelligent, wealthy, self-confident and educated. This North-South divide, it suggests, is largely

culturally conspicuous rather than a geographical distinction between the North and South of England or a linguistic reality between Northern and Southern English (McKenzie and Carrie, 2018, p. 840). How Southern Englanders view the English spoken in the North is related to being British. Images such as 'looking like an English woman' and 'speaking like an English woman' were formed in the minds of the participating women before they arrived in this country and generally describe a woman from London or the South. Therefore, being critical of the Northern accent brings participants closer to the British woman they know.

As an outsider who is not very knowledgeable about the variations and regional diversity of the English language, Regina's expectation before arriving here was based on an image of English that had been presented until then. While her expectation was shaped in a transnational arena on a 'standard' British accent of the kind she had heard on the BBC or an 'elite' one spoken by the Queen, in reality, she had to deal with another, Northern, accent she had encountered and was unfamiliar with. Internationalised English, or the standardised English circulating worldwide, is not the Mancunian English that Kate has trouble understanding. Such a clash of expectations and reality about language explains why the participants do not feel settled in the UK. At the same time, it shows that as much as British society has expectations from immigrants, even before migration and while in their homelands, immigrants had some expectations from England as a country where they intend to settle and that the lack of response to these expectations is also effective in their sense of settlement. This disconnect between Regina's and Kate's expectations and reality reflects how unfulfilled expectations affect immigrants' well-being, as highlighted by well-being theories (Wright, 2010, 2012). It shows how structural factors—like regional linguistic variety—might make immigrants feel less satisfied. Well-being analysis reveals that such policy and structural constraints mould immigrants' experiences, which in turn impacts their general well-being and settlement, and ultimately 'better lives.'

7.3 Achieving the 'Ordinariness' of Life in the UK

The migrant statuses of participants and their 'migratisation/self-migratisation' shape their settlement experiences. So, for example, things that seem 'ordinary' to non-immigrants in everyday life may seem extraordinary to immigrants. The things migrants do in the natural course of the day in the countries they come from, such as walking to work, taking the bus, participating in physical activity (Soltani et al., 2021) or speaking a

language without thinking, may turn into activities they do with difficulty after they migrated. However, immigration can create new challenges in their lives. These strains affect how settled they feel in a country or how much they can mix with the people of that country. In this section, I will analyse the experiences of 'motherhood' and 'mobility,' which the participants stated in our interviews as the themes determining how they feel daily. These themes are not only about the UK, the country of destination of the participants but also about a transnational migrant experience.

7.3.1 'Emotion Work' of Mothering

The language barrier is not Regina's only challenge in the UK, as it turned out in our interview. Regina was unemployed for a while when she immigrated from Romania, first to Italy and subsequently to England, because she had a daughter needing care. She worked as a housekeeper at a hotel for a while and later as a healthcare assistant in a private care home. Regina is a single mother and the only person responsible for caring for her child. In this sub-section, I use Regina's parent-child relationship as an example of how 'emotion works.'

Hochschild's (1979) concepts of 'emotion work' and 'feeling rules' are central in the settling of the participants in the UK who are immigrant mothers. Understanding how feelings are ruled plays a role in navigating ideals and stereotypes around migration and mothering (Herrero-Arias et al. 2020, p. 1233). Migrant mothers can feel lonely and isolated in their early stages of migration (Ryan, 2008), and the feelings about being a migrant mother could often be contradictory, inconsistent and ambiguous (Maehara, 2010). 'Becoming a mother implies a journey of navigating cultural and gender norms, values, expectations, mothering practices, and emotions.' (Herrero-Arias et al., 2020, p. 1232) Regina is here, in the UK, because she thought her daughter would have a better future in England; although she felt quite lonely in England, she did not have many people around (financially) support her while she was raising her child, and although she thought that maybe it would be much better for her social life if she returns to Romania. Even though Regina says that she does not have many friends in the UK yet, that she does not like people here very much because they are so different from Romanians, and that she sometimes wants to return to Romania, albeit jokingly, she still considers the possibility of her daughter staying here longer. She talks about how she wants her to learn English well.

In the return plan, we came across other participants' concerns about their children's future. In our interviews, they spoke about their decisions to stay or return to their countries of emigration. As we shall see, these decisions play a vital role in determining the next step in the lives of women who come to England hoping for a better life. For some participants, ‘returning’ is a closure that will show that their migration story ends happily, that they experience a sense of satisfaction and reach certain living conditions. Just like in immigration decisions, the future of their children is significant for the women in their decision to return, even if they leave their children behind in the end and return separated. Some participants say they can return to their countries only by maintaining/guaranteeing certain living standards at retirement. For example, Didi shared that if she and her husband return to Turkiye one day, they do not want their children to come with them so that they can stay here and continue their education.

Regina's struggle in England is her effort to ‘anchor’ here as a mother. To be settled or ‘anchored’ is for Regina to restore her sense of safety and socio-psychological stability in her new living environment in the UK (Grzymala-Kazlowska, 2020, p. 30). Regina's parenting role, which Grzymala-Kazlowska (2016) defines as one of the ‘social anchors,’ for example, along with ‘being an immigrant,’ is expected to allow her to locate her place in her world, give form to her sense of being and provide her with a base for psychological and social functioning (Grzymala-Kazlowska, 2016, p. 1131). However, this becomes very difficult for her with the responsibilities of motherhood (especially as a single parent), along with many difficulties in material terms in daily life.

The only person supporting Regina in the UK is her sister. Regina sketched the area she lived in during our meeting (Figure 6.2). On this map, she represented the places she visited during the day in her neighbourhood. The areas on this map where Regina is with any acquaintances are only the house of another participant, Gul (‘My friend house’), who is a healthcare assistant like herself, and her sister's house, which she could not fit into the map but opposite the bridge she drew:

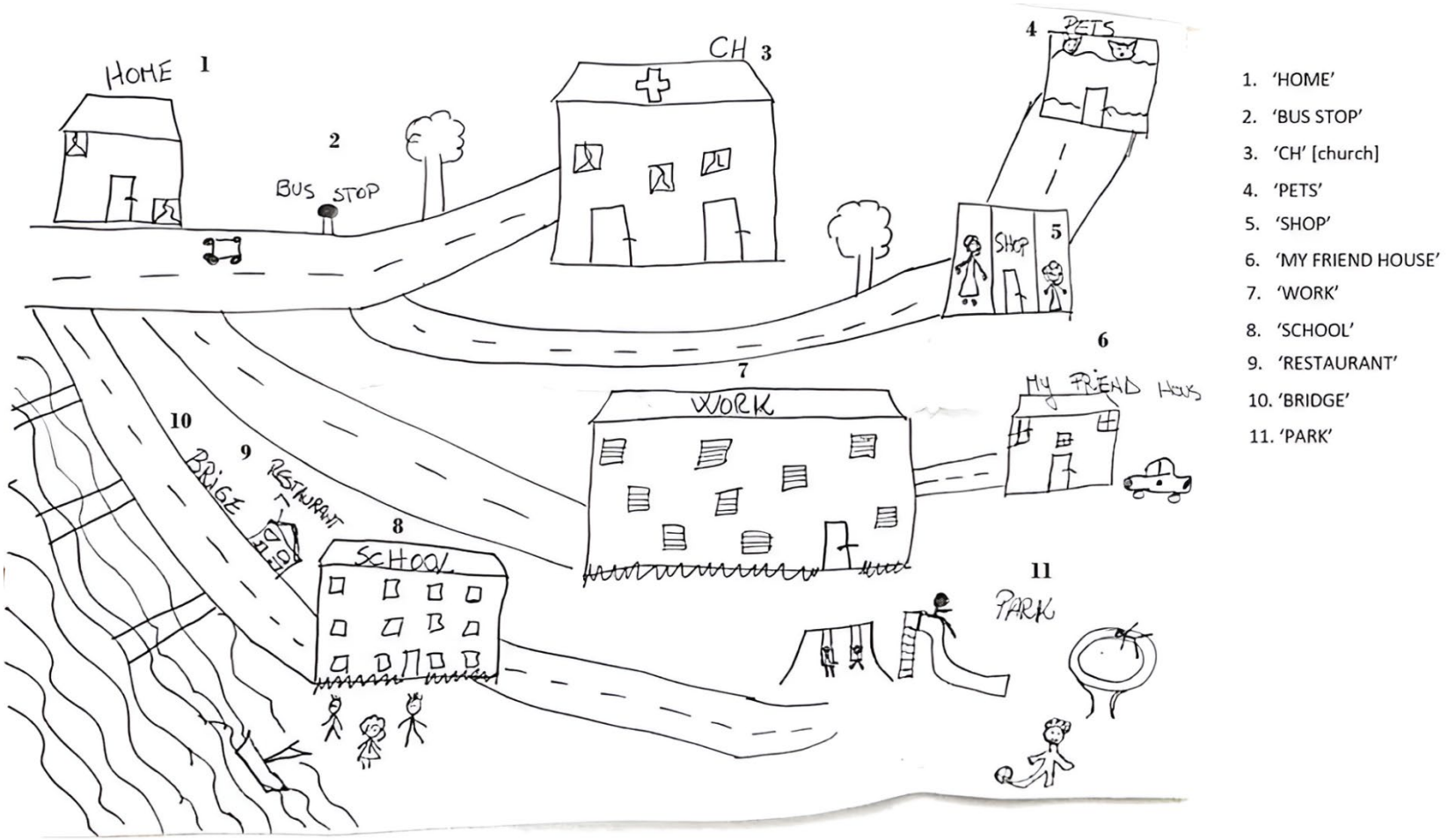


Figure 6.2 Regina's map

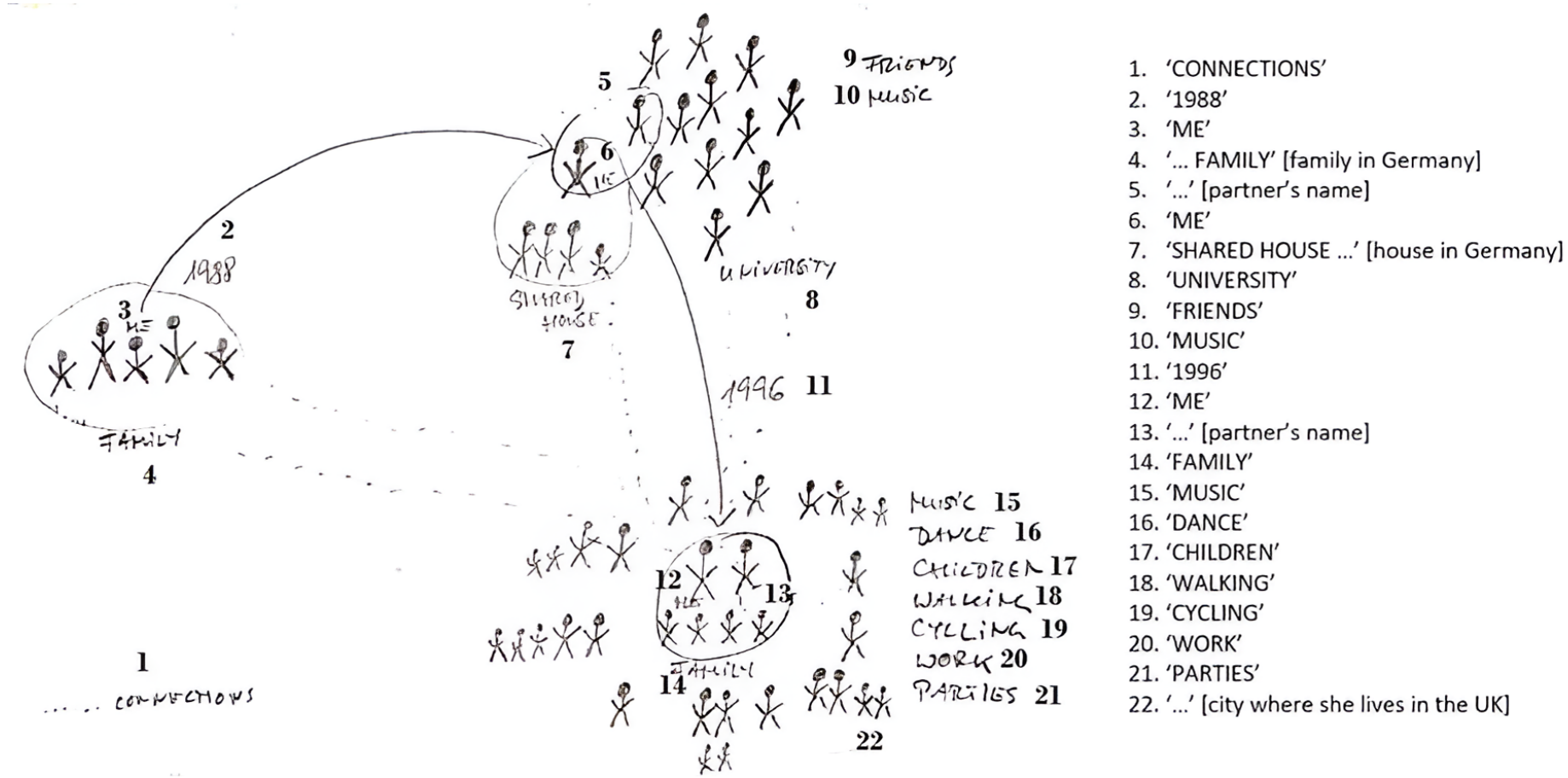
Apart from those houses, Regina always illustrates the places she goes with her daughter, for example, her daughter's school and the park where her daughter plays with her sister's daughter: ‘Well, um, we [with her daughter] are fine together, sometimes she misses the father, but we are good together, just like doing things together and stay all the time together. Just when, when she's at school or when I'm working we are separate but, you know, all the time together. She loves me!’ Regina expressed that she could be much more social in Romania or Italy than in the UK and would like to live there again, but it was impossible before her daughter was old enough to be alone in their home in England. See below a quote from our conversation on Regina's map:

> Sometimes my daughter asks me: ‘mum, you've got a friend.’ I said ‘okay, who is that?.’ ‘On the phone, in Romania.’ Yeah, I've got many friends. Because some people, you know them when you just grow with them. We don't speak every day but we're still friends. Some are saying ‘how much you're gonna stay there?’ Yeah, I am half and a half [on whether to return to Romania]. Sometimes I am fine here. And you know, I just miss my friends and my church and everything. (Regina)

Moreover, Regina cannot earn much at work. For example, another building she drew is a pet shop. Regina said she loves pets but has been unable to buy one from this shop because they are too expensive.

Looking at the image she drew (Figure 6.3), we see that, unlike Regina, Sabrina draws herself in crowds: ‘I'm sort of involved with my friends, we go cycling and walking, or playing a band, do sport.’ Sabrina, in our interview, mentioned her ‘lifestyle choices.’ She had the opportunity to make those choices. After leaving her family, she went to another city in Germany for university and later immigrated to England; she built up, in her own words, ‘some sort of social circle,’ which she drew on her map in stages two and three. Sabrina's ‘connections map’ below shows her connections, and she has a network in the city where she lives. She stated she has never put her work first in choosing where to live but was motivated by her connections with her friends. This city is a good place for her to bring up children. Her four children could expand their world here and, for example, walk or cycle everywhere, she says:

> We moved here, so initially, we were in our twenties. And you know, everybody was playing music, dancing, doing pottery. And that’s, going for walks and parties and things like that. And then, over time, people also had children. And then our children's friends, with friends' children... (Sabrina)



1. 'CONNECTIONS'
2. '1988'
3. 'ME'
4. '... FAMILY' [family in Germany]
5. '...' [partner's name]
6. 'ME'
7. 'SHARED HOUSE ...' [house in Germany]
8. 'UNIVERSITY'
9. 'FRIENDS'
10. 'MUSIC'
11. '1996'
12. 'ME'
13. '...' [partner's name]
14. 'FAMILY'
15. 'MUSIC'
16. 'DANCE'
17. 'CHILDREN'
18. 'WALKING'
19. 'CYCLING'
20. 'WORK'
21. 'PARTIES'
22. '...' [city where she lives in the UK]

Figure 6.3 Sabrina's 'connections' map

Sabrina has a financially stable life, many activities in her social life and a wide circle of friends. She believes she raises her children in a safe environment and has determined where to live and work in line with her 'free choices' rather than financial concerns. She represents her children in a 'safe family circle' in the visual she drew. So, do all these 'safe' and 'stable' anchors that Sabrina talks about ensure that Sabrina will be a 'happy woman' and a 'good mother,' feel settled in England and have a 'better life?' Or is it a feeling rule that creates such social expectations/perceptions? Images of child rearing and motherhood are socially constructed (Hays, 1998, p. 19) and guided by Western and middle-class values (Herrero-Arias et al., 2020, p. 1232). The feeling rule in which one has to follow family/gender norms and childrearing ideals—originated both in home and host countries—to be happy imposes that 'money,' 'prestige,' 'opportunities,' or 'status' must affect migrant mothers' (un)settling in the host countries. Here, as in Regina's case, women are overwhelmed by the difficult conditions and the worries that they will not be happy and settled while living under these conditions.

Moreover, these negative feelings of failing to satisfy some social expectations and the emotional work of coping with such feelings make them feel unsettled just as much as the material reasons. In sum, what I mean by a 'feeling rule' is how people are pushed to think that if they do not have 'social capital' in their lives, their lives would not be as happy as others who have that. Not only 'social capital' but others' material conditions, family relations, jobs, money, status, etc., could be desirable for a happy and settled life.

7.3.2 Driving

Women who ask public authorities for permission to drive a car often experience constraints and harassment while travelling that may inhibit or reduce their mobility (Priya Uteng, 2008, p. 78; Pooley and Pooley, 2021, p. 495). Kate's lack of a driver's licence for a period of time fundamentally affected her daily mobility and negatively affected her access to work, opportunities to engage in social activities and a higher quality of life (Priya Uteng, 2008, p. 98). Women's relationship with car driving, in other words, with 'automobility,' has been examined in the literature as 'gendered mobilities' (Pooley and Pooley, 2021) since, still in the twenty-first century, a motor car in most developed and developing societies is assumed as a masculine vehicle in terms of both its technology and use (Walsh, 2008, p. 376). However, automobility, owning their cars and being allowed to drive them publicly, indeed can be seen as the simultaneous achievement of autonomy and mobility for women (Hannam, 2017, p. 54).

Learning to drive in a new country has been a big deal for Kate, and it was crucial for breaking the isolation. As she describes, in a town two hours away from Manchester, Kate and her partner lived in a house on the top of a pedestrian-unfriendly hill. It was a difficult period for her. Kate's driving licence has been a sign of integration for her here. She gradually socialised when she got her licence and used it as a strategy to deal with the senses of stress, loneliness and isolation at the beginning of her settlement:

> We were living in a house on top of a hill. And you had to, it was difficult to, you could walk to it, but it was difficult to drive as well because it's like a thin and steep hill. And, I wasn't driving at the time. That was the first thing, I did to get my driving licence. When you don't drive, you are a bit restricted. I felt very lonely and isolated. But then, gradually, once you start working on things, it [those feelings] gradually goes. (Kate, Turkish physiotherapist)

Then again, these feelings do not seem to disappear in their new place either. Kate still had barriers in her relationship with the local people in the town they live at the time of our interview: 'People are friendly but here is a small place and traditional, people are usually born here, they live here forever, they know each other from childhood, school and work. So, it is a big difficulty to break in, getting in as a foreigner. There is a kind of, difficult barrier to get in.'

While a licence may seem 'ordinary' to many people, learning to drive in another country, especially in the UK, where traffic is left-handed unlike many other countries, becomes quite 'extraordinary' for immigrants. In particular, women immigrants may have only used public transportation and never used their vehicles until they migrated due to gender inequalities in the countries they came from. For example, although there was a significant increase in the numbers between 2007 (the rate was 16.7% in this year) and 2017, it was announced by the General Directorate of Police (EGM-Emniyet Genel Müdürlüğü in the Turkish language) that women made up only 24.1 per cent of the total number of drivers in 2017 (CNNTurk, 2018) Unlike, according to the statistics revealed by the Driver and Vehicle Licensing Agency (DVLA), in 2018 in Great Britain (GB), the split between 40,361,967 drivers was more balanced—54 per cent were men (21,819,606 licence holders) and 46 per cent were women (18,542,361 licence holders) (O'Grady, 2018). Briefly, migration may be unsettling since it causes one to reassess the familiar and take something unusual for granted.

On the other hand, for immigrant women, the home/host dichotomy, which states that the homeland equals oppression and the host country equals freedom (Priya Uteng, 2008, p. 98), may not always be valid. Even if migrant women have their driver's licences when

arriving in the UK, not all have the right to exchange their non-British driving licence for a British licence. Foreigners who passed their driving tests in other countries rather than in the EU, GB or Northern Ireland, Jersey, Guernsey or Isle of Man, or in a 'designated country or territory' (countries or territories with exchange agreements with GB) can drive for up to twelve months on a foreign licence. However, they must take a theory and practical test to get a GB-issued driving licence after twelve months (GOV.UK, no date [c]). Further, official statistics and studies on the experience of migrant women getting a driver's license and driving are scarce. Migrant women in the country, as in Kate's example, suffer from the issue of immobility caused by restricted automobility.

On the contrary, the issue needs urgent political and scholarly attention as part of an overall re-evaluation of the societal significance of 'better life migration.' As a result, driver's licences impact participants' everyday mobility, access to employment, social interactions, and overall quality of life. For women, automobility—the possession and public use of a vehicle—can be understood as the simultaneous realisation of their autonomy and mobility and settling in a new country, as in the case of my participants.

7.4 Conclusion

Settlement is a managed, continuous, and ongoing emotional work in which sometimes the participants' knowledge of the places they plan to settle in does not match the reality after migrating to the place. Sometimes, they try to achieve the settlement process in the place they relocate to by taking the information in their own countries as a reference, and sometimes, they try to achieve it only according to the rules they discovered while trying to adapt to the place they live. As this chapter has shown, the state of being settled or not settled is related to how the participants are socially expected to make sense of it. In other words, participants mostly learn how to feel settled after they migrate. Over time, participants understand what criteria they will meet to feel settled and how to feel about their new life. In this country, they are learning what they should be 'good at' or what they should feel they are 'not good enough at yet' as an immigrant.

What settlement means to them is to live a happy family life, for example, not losing the ethnic identity but preserving a transnational family equilibrium simultaneously. A 'good immigrant' who will have a 'good life' has sometimes to be a devoted 'good mother,' sometimes speak with a certain English accent, adapt her religious practices to the daily life of the country in which she is settled, and even have a certain physical appearance. In this chapter, I discussed how participants' emotions are socially

constructed and how they are ‘supposed to feel’—feeling rule, act, and represent themselves.

Consequently, I demonstrated how my participants still feel unsettled despite their so-called nominally settled status, permanent residence or UK passports. They believe they do not fit the transnational social norms that define what constitutes a ‘successful migrant.’ When participants feel guilty about not being well enough to fit in within the host society, they are unsettled and uneasy as migrants. In order to understand the discrepancy and people's feelings of guilt and their feelings of why they do not fit in, why they feel unsettled, and why they have to constantly make efforts to blend in, I take emotional work as a theoretical lens in this chapter. Therefore, it becomes possible to understand different dimensions involving participants' versions of settlement and unsettlement.

Chapter 8: Conclusion

This thesis explored the experiences of migrant carer women and their pursuit of 'better lives' in NWE. The experiences of this group of women workers who migrate to the UK for caring professions are primarily examined in migration literature in relation to their professional work environment and conditions; migration *motivations* are mainly reduced to material aspirations. The thesis's main argument is that a migrant worker's life cannot be reduced to professional experience; instead, better lives have many facets, encompassing a range of aspirations, expectations and reasons. The concept of a 'better life' is created, disseminated, and associated with specific social and cultural values worldwide.

The thesis scrutinised a 'better life' as an ideal that is Western-style but ubiquitous and transnationally shared, advertised as easily attainable, and stuck in the middle-class type of well-being—which refers to a steady income or home ownership, as participants expressed in the interviews. The thesis also revealed that the UK government makes this ideal a mirage for some immigrants by certain occupational and immigrant classifications from the beginning of their journey. The search for a 'better life' becomes even more difficult, especially for immigrants who settle in the North West region of England, experiencing a post-industrial care crisis, which does not offer the living conditions expected or idealised by the immigrant workers and instead is a region known for decline and deprivation. Despite all these challenges, immigrant women have not given up trying to realise their expectations regarding their profession and social life in their new destinations. The thesis investigated the reasons for this optimism and effort. While this thesis examined how immigrant women try to realise 'better lives,' it showed what the concept implied sociologically. It inspected what social and political influences were involved in constructing this idea and how the idea of a 'better life' resonates in real life.

This chapter will provide a brief overview of the thesis's main findings, elucidate the conceptual and empirical contributions made by the study to the field of migration studies—especially to the labour migration analysis, discuss the implications of the findings, consider limitations, and suggest some directions for further research.

8.1. Key Findings, Contributions and Implications

'What implications does "migration for a better life" have for the employment, social lives, and migration narratives of immigrant health and social care workers in North West

England?' is the primary research question I posed in my thesis. To find the answers to this question, I draw upon three primary findings of the study, their theoretical and empirical significance, and implications for this section.

8.1.1 Introducing A 'Better Life Migration' Concept to the Literature

I contribute to thinking about changing dynamics of expectations throughout the migration process (see Chapter 5). Participants' expectations and aspirations extend beyond the typical 'migration for work' framework, reflecting a broader vision of a 'better life' that includes family, economic stability, and socio-political freedoms. This conceptualisation acknowledges that immigrants' lives are multi-layered, blending aspirations for improved living conditions with professional goals, as well as hopes for social and political security in the UK. In this vein, this thesis goes beyond the push-pull models (Sjaastad, 1962; Harris and Todaro, 1970; Rosen, 1974; Roback, 1982; Clark and Cosgrave, 1991; Massey et al., 1993; De Haas, 2021) and well-being theories (Diener, 1984, 2006; Gough and McGregor, 2007; Wright, 2010, 2012) which view 'migrating for a better life' as a chance to break free from poverty and attain prosperity, and ultimate happiness (Gardner, 2015). Economically determined views of a 'better life' simplify the reality of migration by limiting it to its financial aspects alone and fail to capture the realities that migrant care worker women face daily (Wright, 2010, 2012). The feelings and emotions of immigrants and their social relations and intentions are absent or overlooked in such approaches.

The notion of 'lifestyle migration,' which is 'intended to capture the movement and (re)settlement of relatively affluent and privileged populations in search of a better way of life,' is not how I see migration for a 'better life' (Benson & Osbaldiston, 2014, pp. 2-3). This is because I purposefully avoided utilising the lifestyle notion before questioning whether my participants could be classified as affluent or privileged given their socioeconomic situation. The idea of lifestyle reduces migration to an elite's choice of lifestyle. Without touching on the idea of 'elite' here, I avoid the term 'lifestyle' because it downplays the combined impacts of the decisions made by those not included in the 'elites,' which Veal (1993) describes as 'ordinary people.' The 'lifestyle' idea tends to view meaningful lifestyle choices as exclusive to the affluent (Veal, 1993, p. 246).

The thesis foregrounds not just how immigrant carer women navigate their lived experiences but also how they feel. It challenges the cultural, political, and societal frameworks that dictate how they should feel while centring their experiences of better

lives. For instance, the participants said that being employed by the NHS, an English national institution, and speaking and appearing like an English woman are happy spots. However, as this thesis demonstrates, this is a perception that the British government has fostered to draw in immigrants. I also found that some research participants understand what constitutes happiness for women in their home countries and apply that understanding to their lives in the destination. This is significant because it demonstrates how cultural and globally dispersed influences may affect people's conceptions of better lives and draws our attention to the fact that the idea of 'better lives' is contextually defined, and no universal benchmark exists.

By offering a thorough description of life beyond the economic aspect, this thesis addressed a gap in the literature on better-life migration by addressing participant narratives' emotional and social components. It demonstrated the multifaceted nature of immigrant lives, which comprise not just the formal job environment but also family concerns, social and political security, and cultural liberties. It showed that the migrants' daily behaviours, like buying or renovating a house, going on vacation, sending money to their families in their countries of origin, and dreaming of a financially comfortable retirement, are significantly influenced by material variables such as purchasing power, prices, living expenses, incomes, and savings. What is novel about these activities, however, is that certain societal norms of happiness support them, and cultural, historical, and gender settings influence them. In people's hopes for a 'better life,' familial and financial factors play a vital part, and participants expect that the life they dream of awaits them in England, where they think they have more advanced life and job opportunities than the countries of their heritage. The desire to live in a secure nation through migration was a worry shared by some participants regarding their families. In addition to the wish to live in freedom far from areas where there are risks of human rights abuses, political/religious polarisation, gender inequalities and social oppression, participants also expressed a desire for freedom when they felt free to meet new people, enjoy a social life, and form connections without restriction. However, they do not live in a discrimination-free environment in England. Migrant carers encounter racial microaggressions in their daily work lives based on their appearance, names, and how they speak English. Participants in the ideal of better lives frequently experience disappointment when reality diverges significantly from their expectations.

Better lives, therefore, need a balance between social and professional happiness, enforcing financial stability, and pursuing an ideal that is frequently imagined through outside interventions (for example, with the advice of a colleague who migrated to the UK before or through advertisements of jobs on the shortage occupation list), but is very challenging to fulfil.

8.1.2 Revealing Deskilling and Categorisation in Care Work

I pose the question: how should we conceptualise the relationship between 'labour' and the notion of a 'better life' within the context of labour migration? (see Chapter 6). Work plays a crucial role in shaping work migrants' experiences and understanding what constitutes a ‘better life.’ Yet deskilling and barriers to pursuing their desired careers frequently thwart their hopes for a ‘better life.’

Studies on carer migration have come under criticism for giving too much attention to women who work as domestic workers while ignoring those who work in supposedly ‘more professional’ care industries, including healthcare (Kofman, 2013, 2014). Academic and policy research on immigration in the UK has focused on the bureaucratic categorisation of immigrants, frequently using dichotomous words such as ‘skilled/unskilled’ (Cuban, 2013; Bornat et al., 2011; Lowell et al., 2004; Kofman and Raghuram, 2006; Kangasniemi et al., 2007; van Riemsdijk, 2013; Salami et al., 2016; Zuk et al., 2019). The nature of the work carried out was of greater significance to my perception in this thesis than how the skill level was formally classified. This made it easier to pinpoint where women with various skill levels and caring obligations in the health sector have comparable employment experiences. Women who migrate from the domestic and healthcare sectors take on each other's tasks and replace their occupations through task-shifting/task-sharing (see Chapter 6). Immigrants who have received training may start working in the health industry, while those who have not may begin working in domestic duties. This thesis demonstrated the value of having an inclusive transnational health and social care category by showing how women working in related sectors serve workforces similar to each other and go through similar migration and care systems.

On the other hand, when it comes to the worth and recognition of those same sorts of occupations and talents, my study revealed prejudices against women who have the same skill sets, primary work responsibilities, and obligations. The similarity between the nature of work in healthcare and domestic sectors is important for literature on the

migration-care nexus as it reveals a shared experience of migrants who take caring responsibilities. Caregiving is overwhelmingly gendered and frequently connected to women's 'duties' in the home. It covers various activities and includes intimate labour and personal work, frequently done in private homes. Such activities often have emotional and affective dimensions, which largely are underappreciated and undervalued when performed by immigrants and members of ethnic minorities, with little access to legal and organisational safeguards (Lan, 2022, p. 2; Zwysen and Demireva, 2020).

I interviewed women migrant care workers in both the public and private sectors when conducting this research. The study's data shows the relationship between skilling and occupational categorisation in relation to participants' immigration statuses under this encompassing perspective. My study reveals the role of the migration regime/visa policies/categorisation in the job-seeking journeys and professional experiences of migrant carer women. A crucial finding of the present study is that the paramount understanding of what participants perceived as a 'better life' in the UK was having decent work that paid well and gave them prestige. Ideally, they could attain this in the professional roles they held in their home countries. However, after coming to the UK, the participating women faced several challenges, including retaking registration exams, delays in registering with the councils that oversee the health professions, and modifications to licencing and registration requirements. According to the findings, a convoluted network of intermediary, private and governmental organisations is in place that makes joining the UK's health sector for immigrant women a confusing, exhausting, and often overwhelming undertaking. The recruitment process is supposedly based on 'a regime of skills' (Shan and Fejes, 2015, p. 227). In the context of the labour market, the word describes a new style of control and prohibitive regulation that defines the attractiveness of persons based on their skills and competency in various domains of practice. 'Skill and competency' are considered objective benchmarks by policymakers and employers. Workers' and migrants' subjectivities, sensibilities, and emotional well-being are shaped by the skills regime, which also results in the daily challenges they face in the workplace. I found in this research that the general public and employees are generally unaware of many recruiting regulations, the so-called 'regime of skills.' In reality, skill and competency are not objective; the expectations of their determinants—such as educational backgrounds, work experiences, and linguistic ability- are constantly changing and complex. Under such complexities, candidates must navigate social and

occupational classifications such as ‘medics/non-medics,’ try to prove their skills through tests and English language proficiency, and reskill or upskill.

Migrants' professional paths are contingent upon the migration regime—the policies of the receiving nation about several aspects, including health, employment placement, and visas, play a significant part in shaping their professional trajectories. Different visa entrance procedures and migration management differentiated immigrants based on their place of origin (EU or non-EU) and the type of healthcare industry they worked in (private or public). EU nationals were able to enter the UK without a work permit prior to the UK government's post-Brexit immigration policy taking effect. This contrasted with non-EEA nationals subject to the UK's points-based immigration system, which consists of five visa tiers. Several participants found it difficult to demonstrate their degrees, and their status as non-Europeans in the UK caused them to be deskilled. Regaining their original professional standing and qualifications in England was cost-prohibitive and required patience and effort. They were not paid until they demonstrated proficiency in English in the health sector, and many had mixed feelings about their voluntary work. Some attended medical observerships during this time, and some turned to other sectors such as the hospitality industry. Some women found these jobs ideal, while some participants like Sevi, who worked as an environmental engineer in Turkiye and was hired as a healthcare assistant in a private care home in England, found it difficult to find work in her original profession. The divergent work trajectory was often due to a lack of opportunity and choice. In short, the experience of immigrant carer women in this thesis confirms that their recruitment processes occur at the intersection of skills and migration regimes.

In sum, the thesis revealed how the UK healthcare system is shaped by how women negotiate, redefine, adjust to, and challenge professional, bureaucratic, and legal classifications and hierarchies. In actuality, these ostensibly rigid formal classifications are porous. Immigrant women entering health work in the UK face complex arrangements by public, private, and local authorities. The UK's skilled-based immigration system tests their professionalism and worth as immigrants, but the competence of migrants and workers regarding recruitment guidelines remains limited. Difficulties disrupt the ‘better life’ expectations of immigrant women. The present study outlined how some of the women who expect to work in ‘the best, most prestigious, most respected healthcare system in the world’ and, accordingly, to realise their ideals of better lives are not included in this system from the very beginning because they are not allowed to complete a

recruitment procedure. Others who secured a job often did not encounter the healthcare system or job they were expecting. Such discrepancy between the ideals and the reality substantiated a central argument of the study: the ideal of better lives in the UK is not distributed equally to all immigrants; it is conditional and discriminatory.

8.1.3 Rethinking (Un)Settlement

In this study, the pursuit of a 'better life' among migrants is deeply connected to their subjective sense of being settled (see Chapter 7). Depending on how settled they felt, participants indicated whether they were happy in the UK. Put another way, the study found that one is content with her life as a migrant when she has achieved a subjective sense of being settled. Finding a balance between leading a fulfilling life as a multinational family and a career was one of the descriptions of what it means to settle in this thesis. Despite having a UK passport, permanent residency, or even a 'nominally settled' status, some participants still expressed feelings of unease, this highlights that formal markers alone do not equate to the experience of a 'better life' or fulfilment as a migrant. The notion of integration informs our everyday understanding of what it means to settle and unsettle (Heckmann, 1992, 2006; Spencer and Charsley, 2016, 2021). However, it largely overlooks the emotional and everyday components of settling. The study found from the literature (Favell, 2019, 2022; Schinkel, 2013, 2017, 2018; Christou and Kofman, 2022; Grzymala-Kazlowska, 2016, 2018a, 2018b, 2020; Grzymala-Kazlowska and Phillimore, 2018) and the primary data that an immigrant's integration and settling down is idealised by state ideology as a 'success' (Kontos, 2014; Boese et al., 2020) and a condition for residence rights in the host country (Pajnik, 2014, p. 112). My contribution to migration literature here is to emphasise the everyday practices through which migrants experience and negotiate integration. For many participants, driving represents a significant capability, a salient case of what it means to settle.

The research pushed the field forward and addressed the concept intending to reframe the term 'settlement' away from policy and scholarly understandings of settlement, which are, for example, 'absorption, adaptation, race relations cycle, assimilation, acculturation, inclusion, incorporation integration' (Heckmann, 2006, p. 8). Despite the definition of 'integration' as a success, as I set out in my thesis, that women who could not drive in their own country were getting a driver's license in the UK, for example, intrigued me as significant accomplishments for immigrants. I used the theoretical framework of

‘emotional work’ (Hochschild, 1979; Ryan, 2008; Maehara, 2010; Herrero-Arias et al., 2020) to assess multiple facets of what participants think of settlement and unsettlement.

The thesis emphasises the value of living freely for migrants and examines the idea of ‘freedoms’ from a gender perspective. It also emphasises how sociopolitical elements—like gender equality, the absence of prejudice, a child's future, the right to an education, and freedom from political and social pressure—prompt people to seek better lives. The thesis uses women's ability to drive or hold a driving licence in England as evidence of better lives there for women. The idea of driving appealed to some of my participants from countries where women's driving rights are restricted; it represented freedom to them. For example, Kate's everyday mobility, access to employment, social interactions, and overall quality of life were all adversely impacted by her time in the UK without a driver's licence. For women, automobility—the possession and public use of a vehicle—can be understood as simultaneously realising their autonomy and mobility. Not all of them can convert their non-British driving licence into a British one, even if they hold their driving licences when they arrive in the UK. Such everyday realities of immigrant lives demonstrate that they cannot achieve complete freedom in England or attain total autonomy.

In order to grasp what it means to settle, we need to go beyond legal and political discourses and account for how immigrants simultaneously adjust to the routine of everyday life and meet certain legal conditions to settle within the borders of a nation-state where they were not born. Participants in the research reported feeling singled out for discrimination because of their appearance and accented English. There was also a division among the participants between those who spoke English and those who did not or between those who spoke the language fluently and those who did not. After relocating to the North of England, participants found it challenging to comprehend regional accents. The participating women found the accents they encountered in daily life puzzling once they arrived in the UK, expecting the standard British television accent heard in films or the news. In a nutshell, by providing a critical interpretation of the ideas of integration and settlement that highlights their uncertainties and demonstrates such complexity in the texture of everyday life, this thesis contributed a new understanding of settlement to the body of knowledge on women's migration in the care industry.

In conclusion, the study's empirical findings provide insights into the complexities in immigrants' lives, illuminating issues with families, freedoms, economic and political security, and ultimately, better employment and a sense of final settling. Every

component can occasionally outweigh the others and take centre stage at different stages of migrants' lives, as the empirical chapters demonstrated. Therefore, I refrained from reducing the lives of carer women to their professional aspirations and their happiness to the outcomes of those aspirations in this thesis. Instead, I highlight that 'better lives' have numerous sides, including emotional and social elements and various expectations and aspirations. Consequently, this thesis does not ascribe the outcomes of expectations—that is, achieving better lives or feeling disappointments—solely to financial gain or loss.

Moreover, this study contributed to the migration literature by showing that the UK's immigration system profits from maintaining the delusion that a 'better life' is possible through luring immigrant women into labour with the prospect of future rewards. The process of achieving a 'better life' is ridden with several barriers and takes a long time to become a reality. This is what Fortier calls being 'caught up in the relation of cruel optimism' (2021, p. 139). Berlant's (2011, p. 3) description of 'the good life' is 'the social democratic promise of the post-Second World War period in the United States and Europe,' and it constitutes 'upward mobility, job security, political and social equality, and lively, durable intimacy.' The participants in this thesis can be said to be caught up in the circle of 'cruel optimism' as they search for better lives in England in the sense of unravelled optimistic scenarios and the following dramatic stories.

8.2 Limitations

This research is not without limitations. Some of these, such as participant recruitment, timing and travel constraints, are common in qualitative studies, especially during the Covid-19 pandemic. The fieldwork was carried out throughout the Covid-19 pandemic, with the features and consequences of the pandemic influencing each stage. The participants were important frontline health sector professionals who frequently had to reschedule or postpone interviews due to the psychological and physical difficulties they dealt with. During this period, several individuals experienced anxiety or loneliness. The pandemic made it clear that strong research ethical guidelines were necessary to safeguard participants from dangers and discomforts at work and outside.

However, some issues are unique to this research. This section summarises what this research may have missed due to limitations. I am aware that the sole voices in my work are those of carer migrants who are women. Because of this, the thesis only looks at gender issues from the standpoint of women. Further research exploring the experiences of gender-diverse people would be worth pursuing. The thesis does not specifically

address any particular sexualities or gender identities. However, the idea that people migrate in search of better lives may be extremely helpful in shedding light on the experiences of LGBTQIA+ people (Usta and Ozbilgin, 2023) who work in the healthcare industry and have gender or sexuality-based migration *motives*.

While this thesis engages with scholarship on immigration hierarchies and the intersection of race, ethnicity, nationality, class, and gender in migrant carers' experiences, it could, due to constraints of scope, not provide an in-depth analysis of how racial and ethnic identities specifically shape their working conditions and settlement trajectories in their pursuit of 'better lives.' Future research could examine these dimensions in greater depth, particularly in the UK context, where racialised hierarchies persist in health and care work as well as in everyday life. Likewise, although participants' narratives were shaped by the increasingly restrictive immigration regime and the evolving 'hostile environment' (Consterdine, 2018a, c, 2024) in the UK, the timing of the fieldwork—conducted during and in the immediate aftermath of the Brexit transition—meant that the research was not positioned to assess the longer-term consequences of these political shifts. As a result, the study offers only a limited account of how post-Brexit developments may have influenced migrant carers' evolving sense of settlement, perceived professional value, and their ability to attain a meaningful and satisfying version of the 'better life' they had envisioned. Moreover, it was beyond the scope of this study to comprehensively explore whether these changes altered their sense of belonging or prompted reconsiderations of their future in the UK.

This study conceptualised migration for better lives by focusing on the labour migration of women carers, and its conceptual focus is therefore limited. The concept of better lives can also be expanded by focusing on family migration (Kofman et al., 2022)—parental, marriage, humanitarian, irregular, and so forth. For example, Carranza (2022), in her work that tells the stories of transnational families' children left behind in El Salvador and Nicaragua, pushes the framework of the migration-development nexus further. Her perception of migration for a 'better life' goes beyond providing economic security by migrating one or more family members, increasing the financial security of themselves and those in their country of origin. She focuses on the unmet emotional needs of those children and contributes to the literature on the psychological and emotional consequences of family migration for better lives. Studies on topics similar to those in Carranza's work, in transnational areas, can contribute to the multifaceted understanding of better lives put forward by this thesis.

This thesis does not focus on transnational experiences but rather on destination experiences, although as I have discussed and shown in the empirical chapters, these experiences are embedded in a complex web of transnational networks and relationships. Comparing my participants' experiences in their home countries and transition countries with their experiences in the UK enriched the idea of better lives in this thesis. Therefore, I included a transnational life experience in the thesis. Still, I did not focus on the specific experiences on topics related to the families left behind by my participants or family reunification, marriage, and so on. Furthermore, the impact of sending country's emigration or care policies on the ideal of women emigrating for a 'better life' is not the subject of this study. New projects can be created with each of these new focuses.

In addition, this thesis's care work migration literature focuses on a limited area. For example, while the thesis expands care in the health field, it is impossible to simultaneously cover all the issues in the sociology of health and illness/medical sociology. As a result, I decided to focus more of my study on the care work migration. Moreover, the racialised nature of care work, particularly in the UK, where migrant women are often positioned as essential yet undervalued, requires further exploration. Research could engage with how racial and ethnic stereotypes influence the roles assigned to migrant carers and how these dynamics impact their career development and everyday lives.

Finally, while political inferences can be made from the thesis on the daily work and social lives of immigrant caregiver women living in England, and useful policies can be produced based on these inferences, this thesis does not contribute a policy analysis. The political and legal information used in the thesis is limited to the documents published by the government and relevant institutions on migration. Far from making direct policy recommendations, the thesis highlights the political implications of the exclusions the current immigration regime engenders with a view that the findings of this study will benefit policymakers, institutions that mediate workers' search for political rights, and the workers themselves. For instance, I address in this thesis the key worker category—health and care professionals at the forefront of the disease's battle—that the UK government declared during the Covid-19 pandemic. Public opinion and national discourses support this category lacking a formal counterpart. I take issue with the fact that this category does not genuinely give workers professional status or pay. In doing so, I contend that the British government should formally recognise this group, that working women are

content to get recognition from the public and the government, and that if they are given professional recognition, their social status will improve.

8.3 Future Research Directions

The ‘better life’ concept can be applied to migrant men's situations so that it could contribute to the growing field of men's studies in the context of migration (Wojnicka and Pustułka, 2019; Wojnicka and Nowicka, 2022) and to the research from the perspective of ‘masculinities’ (Connell and Messerschmidt, 2005; Connell, 2014). The analysis of masculinities could expand the concept of migration for a ‘better life’ to reveal how men experience ‘manhood’ while searching for better lives in different locations (Ucok, 2020). In this framework, Connell (2014, p. 5-6) points to how happiness is linked to the patterns of masculinity which define men's gender practices.

The interference by the British state in migrants' pursuit of better lives is another subject of debate for further investigation. Former home Secretary James Cleverly promised in late 2023 ‘the biggest ever cut in net migration’ and a tightening of the Health and Care Worker visa (GOV.UK, 2023). The government announced new rules on February 19, 2024, banning overseas care workers from bringing their dependents to the UK (Cleverly, 2024) and exempting doctors and nurses working in the NHS (Paul, 2023). This ban undermines the potential of building a ‘better life,’ as I outline in my thesis, one that is strengthened by a hospitable social and professional environment and works against my arguments in this thesis by advancing occupational classifications. The UK's current immigration system, imposing this new ban, reduces these workers to their worth to the economy and treats them as expendable commodities (Tonkiss, 2023). Such an extreme change in the rules will likely trigger new crises and contradictions where caregivers are needed to fill urgent vacancies in the UK's care labour market on the condition that they will not settle and bring their families. They are only eligible to enter the country if they accept family separation. The ban will likely discourage prospective employees from moving to the UK, worsening the care industry staff shortages. This situation poses a new question: What impact will this new immigration regulation have on the conceptualisation of women care workers' pursuit of a *better life* in England? This is worthy of being the research question of a new study.

Future research should explore the long-term impacts of Brexit on migrant experiences, particularly focusing on the changes in immigration status, visa regulations, and professional recognition. As outlined in previous chapters, the post-Brexit

environment has changed the professional registration processes and immigration hierarchies (Consterdine, 2023), particularly for healthcare workers from the EU and non-EU countries. Research could further investigate the emotional consequences of these policy shifts as migrants navigate new feelings of uncertainty, exclusion, and disruption to their sense of settlement. Furthermore, a deeper exploration of racialisation in post-Brexit migration experiences is warranted, especially concerning non-European migrants, who continue to face microaggressions and deskilling in their respective fields (Lewicki, 2024). The impact of the changes on migrant healthcare professionals' career trajectories and their ability to achieve a ‘better life’ in the UK deserves further attention, as the Brexit-induced policy changes might have created new barriers to professional progression and settling in. Finally, the analysis of how Brexit and emotional settlement experiences among EU migrants intersect could provide insight into political shifts that influence migrants' perceived stability, particularly those who had previously felt more settled in the UK.

The thesis subject can also be studied in other disciplines, such as law or politics. However, this thesis aims instead to introduce a fresh idea of better lives and keep it within the boundaries of a sociological framework. Its development and application to various fields have the potential to significantly impact migration literature and push that in different directions.

Appendices

Appendix 1: Interview Plan

Interview Format	Part 1 **Preparation and Opening**	Part 2 **Storying**	Part 3 **Visualising**	Part 4 **Closing/Finalising**
Content and Themes	Demographic information about the participant, clues to her potential narrative.	Detailed migration story, work and daily life in the UK.	Visualising migration history and labelling the life events.	Recapping.
Method	Semi-structured interviewing.	Biographical/narrative style.	Visual methods; maps, charts etc.	Semi-structured interviewing.
Interview Scenario	The interview opens with a reference to the initial contact. Following that, the participant is expected to answer the questions about her demographic information and provide some clues to her migration story.	This part of the interview begins with follow-ups on the aspects that emerged during the previous part and proceeds to the participant's migration story in depth. The participant is encouraged to tell her story with questions like 'What do you mean by that?' or 'Could you tell me more about that?'	In this part of the interview, the participant is asked to help visualise her migration path from where she was to the UK. She can draw the schemas herself or contribute to or complete her life charts or maps prepared by the interviewer.	In this part, the participant can summarise what she has already narrated, or she is prompted to express her vision of her life and migration story. She is asked if there is more to add.

Question Schedule (These are the sub-headings from the information to be captured.)	-Age, marital status, racial or ethnic heritage, place of birth, nationality. -Visa status in the UK and the length of the stay. -Life in the origin country before migration. -Migration decision, experience, route and expectations/reasons to migrate and to work abroad. -Specific reasons for the UK as the destination country. Arrival story. Feelings about being here.	-Requirements met to come to the UK. Routes to be recruited, occupational registering processes to organisation/ council etc. -Help, support, sponsorship or any contact with an agency related to migration. -Specific reasons for taking a job in the private or voluntary care sector/ the local authority/ the NHS in North West England and the specific local area of this region. -Educational background and job qualifications, job/work description. -Working conditions (working hours/ workload/ wages) and relationship with employer/ client/ the person in care. -Family members, marriage, spouse and children and relationship with them (e.g. frequency of contact, economic support). -Experiences during the current Coronavirus situation. -One-day work during the Coronavirus crisis.	-Life charts, social maps, life events.	-Problems, difficulties and ways to negotiate them. -Membership of a social, occupational or political organisation/ group/ community and so on. -Future plans.

Examples of Questions	‘Do you remember the first day I met you, could you tell me a little more about yourself?’ ‘How would you describe your life before your migration journey(s)?’ ‘I would like to hear about your story of the first arrival in the UK.’ ‘How do you feel here?’	‘Now, you can tell me about your migration to the UK starting from your decision, and your life here.’ ‘Could you tell me about your job experience in the UK?’ ‘Please, tell me about your family.’ ‘How do you negotiate the difficulties?’ ‘Are you a member of a social, occupational or political organisation/ group/ community and so on?’ ‘Could you tell me about your experiences during the current Coronavirus situation?’	‘If you were going to draw your migration path from where you were to here, what would it look like?’ (This question was planned intentionally open-ended. The path mentioned in the question can mean a geographical path, or a social, personal, emotional path.)	‘When you compare your life before and after your migration, what would you say? How did your migration journey(s) affect your life?’ ‘What would you tell me about your future plans?’ ‘Is there anything else you want to add?’

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