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Care Extractivism and the Reconfiguration of Social Reproduction in Post-Fordist Economies

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Contents

Abstract

This paper suggests the concept of care extractivism as a space- and time-diagnostic tool to international political economics in post-fordist societies. Analogous to resource extractivism, care extractivism depicts the intensified commodification of social reproduction and care work along social hierarchies of gender, class, race and North-South as a strategy to cope with a crisis of social reproduction. Extractivist policies result in the creation of a cheap reproductive labour force.

The paper analyses the current national and transnational reconfiguration of social and biological reproduction in Germany/Western Europe interacting with Eastern Europe and Asia. Currently, the most striking features of care extractivism are a) professionalisation for efficiency increase, b) transnationalisation based on import of care workers, and c) transnationalisation of biological reproduction based on reproductive technologies.

The contradiction between the rationale of care and the neoliberal capitalist market logic results in frequent care struggles such as the protests of hospital nurses against the depletion of care resources. The politisation of care by the protesting care workers asks for giving preference to the care economy as a common good over care as a commodity.

Key words: *Care extractivism, care work, care struggles, social reproduction, transnationalisation*

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1 Introduction

Social reproduction and care work have been at the centre of research and theoretical reflections of feminist economics (Folbre 1994; Elson 2002; Sharavi 2004). The initial discourse emerged in the 1970s when feminist scholars and activists kicked off a debate about housework in western societies (Dalla Costa & James 1975; Federici 1975). The aim was to unveil the gender hierarchical division of labour as one of the constituents of gender construction and unequal gender relations in the Fordist patriarchy, and to create visibility, recognition or even remuneration for unpaid housework by women, including cooking, cleaning and caring for children, sick and elderly relatives. Recently, the World Bank (2011), many national governments as well as supranational political institutions recognised care as a relevant micro-economic category when it comes to gender inequalities. This also reflects the need to respond to present crises situations in social reproduction by reconfigurating social reproduction at a national and transnational level in the era of neoliberal globalisation and austerity policies. The International Labour Organisation (ILO) even calls for urgent action to prevent a looming global care crisis (ILO 2018).

My paper intends to contribute to an international political economy of social reproduction in the context of market authoritarianism, neoliberal adjustment and austerity policies. I want to explore the current re-organisation of social reproduction and of care work, which ends up in a new transnational accumulation regime, the making of new labour relations, even new types of labour, and respective labour struggles.

I would like to suggest the concept of care extractivism to international political economics, which includes social, and more recently, even biological reproduction. Care extractivism can be used as a space- and time-diagnostic tool to politicise care and analyse power relations in the organisation of social (re)production and care work. Firstly, it marks the intensification and expansion of the ongoing economisation and commodification of labour and resources in arenas that were not commercialised until recently. Extractivismus is a reckless and careless exploitation and depletion of resources assuming that they are growing naturally and are endlessly available. The concept of care extractivism with its focus on reproductive and affective work is an analogy to the concept of resource extractivism, however countervailing its productivistic and industrialistic focus of value creation. Secondly, from a perspective of neoliberal policies, strategies of care extractivism – like resource extractivism – are well suited to cope with crises situations of social and biological reproduction such as a lack of caregivers and

teachers or an increase in infertility while not burdening the state with additional costs and social responsibilities. Through care extractivism care workers are constructed as cheap workers and as entrepreneurs of the self in care markets along social hierarchies of gender, class, race and North-South as colonial and post-colonial division.

In this paper, I use the concept of care extractivism to analyse the current national and transnational reconfiguration of social and biological reproduction in Germany/Western Europe, interacting with Eastern Europe and Asia, as well as topical responses by the state and the market to crises situations, e.g. overwork of nurses and doctors in hospitals, dramatic lack of care givers for the elderly and declining birth rates of white citizens. The leading questions for this time- and space-diagnostic analysis of care regimes are: a) what is the new quality of the increasingly commodified care and reproductive work in national and transnational markets, b) how are care workers and surrogate mothers constructed as cheap reproductive workers, and c) how do the recent care struggles in health and care systems expose and contest care extractivism and the neoliberal nature of those regimes?

Methodologically I would like to complement structural analysis with components of discourse analysis and an analysis of agency and subjectivities. For this, I will use an intersectional approach, which deconstructs power relations and hierarchies along interacting categories of social inequality. A feminist economics' approach challenges the conventional separation between production and reproduction, market and non-market, private and public sphere, and lays emphasis on the entanglement of commodification and non-commodification, paid and unpaid work, rationality and emotions (Gibson-Graham 2006; Zelizer 2006).

2 Conceptual framework

Following Bakker (2007), social reproduction comprises a) biological reproduction, b) reproduction of labour force, and c) caring for different needs during the life cycle of people by various actors and institutions. Going beyond the Marxian dichotomy of production and reproduction, the notion of care stresses (re)productive labour beyond the mere (re)production of the labour force. Feminist scholars strategically consider reproduction and care as a form of productive labour broadening the Marxian and neo-classical concept of production and value creation.

A crucial theoretical assumption is that the driving rationale of the care economy and logic of the capitalist economy differ significantly from each other. The main goal of the economy of care and social reproduction is provision, satisfaction of needs and well-being while the overall objective of the capitalist market economy is accumulation of money, and its logic is informed by egoistic interests and competition for profit making. When care work is integrated into the labour market as waged labour and gets subjugated to the principles of efficiency and growth, care logic is the 'other' to capitalist logic, and at the same time, part and parcel of capitalist (re)production. Social (re)production and care work have always been the backbone and precondition for social life and economic activities, including all forms of capitalist accumulation. Additionally, commercialised and commodified sectors of social (re)production, health, and education became accumulation regimes themselves, e.g. personal services for the elderly or the reproductive industry.

It belongs to the basic obligations and essential legitimation of political power of modern states to organise the social reproduction of society by means of policies, laws, regulations, and institutions as a public good. In the wake of efficiency- and growth-driven globalisation, states adopt countervailing strategies to organise social reproduction: firstly in the context of structural adjustment programmes and austerity policies, care work gets excluded from the market, and externalised from public welfare portfolio, shifted to the private sphere, household economy or community in order to reduce costs and responsibilities of the state and private enterprises. Unpaid and voluntary work in the reproductive sector upholsters the lack or withdrawal of much-needed public provisions and relieves the state of its welfare strain.

Secondly, care work gets included as waged work into the labour market along axes of social inequality and hierarchy, mainly gender, class/caste, ethnicity/race/colour, rural-urban and North-South. As these hierarchies and social differences become a source of profit making in care markets, an intersectional approach is imperative for the analysis. Market principles like competition, efficiency, growth and profit making expand into earlier non-market, non-commercialised areas, which are socio-culturally constructed as private or even intimate spheres like family, household, friendship and neighbourhood relations. This means a process of capitalist penetration of 'last colonies' (Mies, Bennholdt-Thomsen & Werlhof 1988), another form of 'primitive accumulation by expropriation of women's unpaid labour' (Federici 2004) or 'accumulation through dispossession' (Harvey 2004). A trigger for the further commodification of care work was the increased inclusion of skilled middle-class women into the labour market and their empowerment through employment propagated by many institutions like the World Bank (2006) as 'smart economy', and by the EU as 'adult worker model' (Lewis & Giullari 2005).

Waged care work asks for new analytical categories as it encapsulates and blurs categories of Marxist and neoclassical economics. It implies moral bonds, emotions, and attentiveness (Hochschild 2003). Apart from being considered a natural and renewable female skill, care organised along social and power asymmetries as well as migration make for its little recognition and remuneration (Lutz 2011). Additionally, its low valuation is justified by mainstream and Marxist economics alike because it is deemed to be unproductive and not value- or commodity-creating, but a gain in seemingly non-economic values like well-being, personal development, health and social bonds. As capitalist markets have little appreciation of labour with no increase in productivity, they attribute low value and low payment to care work because it has its own speed, e.g., it is not possible to increase efficiency and productivity of feeding a baby or a dement person as in an industrial process.

Due to the persistent drive for growth, expansion, and profit, accumulation strategies ignore the actual limits to growth in human, social and natural resources, and the need to reproduce labour and consumption force. Thus, capitalism tends to deplete and destroy its own living foundations and causes itself the multidimensional crisis of social reproduction and the environment. At this backdrop, neoliberal policies try to fix the social crises largely by resorting to resource extractivism and to care extractivism as modes of intensification of efficiency and reduction of costs in order to perpetuate growth.

My research in Germany revealed four striking features of care extractivism: a) familiarisation of care as unpaid work, e.g. after quick discharge from hospital post surgery, or mobilisation of honorary work, e.g. the famous welcome culture in 2015 when hundreds of thousands of refugees poured into Germany, b) professionalisation for efficiency increase, c) transnationalisation through import of care workers, and d) transnationalisation of biological reproduction based on reproductive technologies. Hereafter I will focus on paid care work.

WA 16 v/118: Japanische Krankenschwestern in den Krupp-Krankenanstalten in Essen, 20.10.1965

3 Professionalisation of care work and the making of neoliberal subjects

In Western Europe, care work in the health sector, including care for the elderly, has been subjected to a modularisation and standardisation similar to industrial labour. It gets fragmented, taylorised, and scheduled into time units. All activities have to be documented. In hospitals, the US accounting system according to 'Diagnosis Related Groups' classifies hospitalised patients and pays flat rates for standardised medical and care services. This is a mode of cost containment which measures and remunerates care labour like industrial piece work; secondly, it ensures control and transparency and is a way of navigating the public-private-divide in a technocratic, productivist manner; thirdly, it is a form of disciplining care workers, forcing them to permanent self-control and evaluation.

The modularisation of nursing in hospitals and of the care for elderly in old age homes and by ambulant services in private households is considered to be a professionalisation and an indicator for quality in a growing and highly competitive market, mostly organised by commercial agencies. These strategies of rationalisation disembed care from social relations and propel competition while constantly intensifying a care extractivist mode of accumulation. In the neoliberal framework of public management such strategies have been adopted in the public sector. Care workers are constructed as entrepreneurs of the self, as competitive neoliberal market subjects.

The key problem of modularisation from the perspective of caring is that these schedules and modules don't leave any time for showing empathy and applying a human touch towards the patients. In case care workers spend time for a social relationship, this is unpaid work and time. Hochschild (2000) coined the notion of 'emotional work' for the specific nature of care work when she analysed the work of migrant nannies from the Global South taking care of children in the Global North. They are trapped in a contradiction between professionalism and affection, closeness and distance, private and public. The employers expect care workers to be rational and loving at the same time. However, the value added through empathy and affection does not count in wage calculations. Thus, waged care labour is organised in a way that it includes unpaid work, resulting in a systematic underpayment and in the construction of cheap entrepreneurs of care capacities and emotions as human and social capital.

In the case of ambulant services for the elderly in Germany, the modules of rationalisation and industrialisation put a tremendous pressure on the ambulant caregivers who drive in small company cars from one client to the next. Their services and car rides become a race against time and humaneness, with strains on the body, psyche and energy level of the caregivers. The actual conflict between the logic of caring and the logic of profit making is downloaded to their body and mind. They have to manage the time constraints, the bureaucratic requirements of standardisation and documentation, and their inner conflicts between efficiency and emotional bonds.

Standardisation, modularisation, and documentation of care work function also as pre-condition for digitalisation and the introduction of robots in the care and health sector. New growth markets are being created for assistive digital technology, androids, hubots, for robobears who can carry patients, robocoach as future physiotherapists and cuddly animals such as the baby seal Paro, talking robot puppies or roboteddys. In Japan, care-bots are already being used to compensate for gaps in the care of the aging population. The robot manufacturing industry expects US $ 17 billion in surplus revenues in 2020. The capitalist logic of developing machines to replace the living work in the care sector and personal services is another rational, technical and very profitable fix of the care crisis and the lack of nurses and other caregivers. It should be up for public debates and democratic decision making whether people really want care work taken over by robots.

4 Transnationalisation of care in chains and the import of care workers

Transnational care extractivism constructs reproductive regimes, which are based on a new international division of care work. Whether set up by nation states, commercial recruitment agencies, partially legal, semi-legal or illegal, or by informal networks, they centre around cheap care labour, affordable by middle class households, and are organised along social hierarchies of gender, class, ethnicity, race, and North-South. On the national level, migrant care workers from the Global South and East compensate for the acute shortage of caregivers for the elderly in the Global North. On the household level, they cushion the employment and professional career of qualified middle class women and the adult worker model.

An unfolding form of care extractivism in Western Europe are 24 hours live-in services for the elderly with the highest possible degree of just-in-time availability and flexibility, mostly done by migrant workers from Poland and the Balkan states. A popular way of obscuring care extractivism is a discoursive smokescreen of culturalisation, namely, that taking care of the elderly in 'other' than the western individualistic cultures is a prestigious activity and the elderly are much more respected. However, for a number of migrants from eastern Europe or the Philippines who got in their home country professional training and qualifications, the employment in the care sector means deskilling.

These 24 hours services in private households in Germany are arranged either through commercial agencies or through informal networks. It is a semi-feudal mode of care work, often without a proper contract, meaning that care workers are not paid for complete 24 hours because they are supposed to enjoy a lot of leisure time. Thus, the boundaries between paid and unpaid are fluid resulting in an appalling underpayment of live-in workers.

These tensions and contradictions often result in conflicts between employers and care workers. Additionally, many migrant workers struggle with their multiple identities and multiple care responsibilities, vis-à-vis the children or elderly of the employer and vis-à-vis their own kids and the elderly in their own family. As entrepreneurs of their self, they have to navigate between closeness and distance, a professional attitude and affection, manoeuvre between multiple identities as wage worker, as caring mother, daughter, wife etc. The geographical separation, often for years, hampers the practicing of motherhood. Forms of 'transnational motherhood' aim at compensating for separation and psychosocial alienation by frequent social media and IT-based forms of communication, and by material and monetary remittances (Parrenas 2001).

It has to be kept in mind that sending countries out of an interest firstly in reducing their large number of unemployed people and secondly in remittances sent back home in foreign currency, adopt 'labour export policies', the Philippines already had done this since 1974 and Indonesia since 1984. In the countries of origin, opposing narratives about care migrants are articulated: on the one hand, the female migrant worker is constructed as a 'heroine' who sacrifices herself, accepts the separation from her kids and family, and serves the development of her country by sending foreign currency as remittances. On the other hand, due to geographic distance she is out of social control and is easily suspected to lead an immoral life (Widding, Sambasivan & Hochschild 2008).

The German state has a long history of organising transnational care extractivism. When beginning of the 1960es, hospitals in West-Germany suffered from a severe shortage of nurses, the German state entered into a recruitment agreement with South Korea under the auspices of 'technical development aid' and imported 10.000 highly skilled nurses as so-called 'guest workers' within a decade. Their diplomas, however, were not recognised in Germany and thus their work devalued. They faced a clash of care cultures and found it very difficult to adjust to the job description of a nurse in German hospitals including menial and hygienic tasks. They made a clear distinction between themselves as professionals and other migrant nurses from the Global South, in particular those from India.

In the same period of time, through catholic networks 6000 young women from Kerala (India), called 'brown angels', among them many catholic nuns, came to Germany and got a nursing training (Goel 2013). When German hospitals had overcome the shortage of nurses in 1977 the migrant nurses where told to return home. The South Koreans protested, and argued that their services in Germany were 'reversed development aid' and they were 'not a commodity'.

In the recent past, reproductive governance by European states include an increasing legalisation of migrant care workers. Regularly, Italy and Spain pardoned undocumented migrant workers and issued stay permits. Germany legalised shuttle and circular migration from Poland and partial provision of social security for these mobile EU-citizen care workers.

Since a few years, the German government took once again initiative to recruit care workers from the Global South and to normalise transnational care extractivism. The German Corporation for International Cooperation (GIZ) trains caregivers for the elderly in China, Philippines, and Vietnam. The Federal Ministry of Labour and Social Affairs (BMAS) recruits skilled care workers in Bosnia, Serbia, and Tunesia and calls it a 'triple win', actually for the sending country, Germany and the individual worker. Again, in Germany a legitimatory discourse covers up the low valuation and remuneration of care work, namely that migrants are predisposed for the care of the elderly because they have a more loving, respectful, and caring attitude towards them. This is an ethno-racist, culturalistic narrative, which attributes care ethics to 'other' women.

5 Transnational care chains and the export of crises

Care chains are care drain and care gain at the same time. Transnational reproductive networks and care chains withdraw care capacities and emotional work from the Global South and shift care energy from poorer to more affluent households, from poor to richer countries (Yeates 2009). Thereby, the local crisis of social reproduction is transferred from the Global North to the countries of origin of the recruited care worker, a kind of spatial fix of the crisis (Harvey 2001). Due to care extractivism, care and emotional capacities are missing in the households and countries of origin. Production and reproduction being spatially and socially separated, the female care worker from the Global South, as an entrepreneur of her self, has to cope with the care shortage in her own family. Mostly, the care of her own children and of elderly family members is handed over to female relatives, or for a minimal payment to neighbours or migrant women coming from poorer regions or countries, e.g. in Poland to women from the Ukraine. Thus, the migrant caregiver in Western Europe can also become an employer of a care worker in her home country. However ultimately, many care gaps remain unfilled und exert severe strains on the reproductive systems on the microlevel of households and the national level. Care extractivism depletes care as a commons in societies and families of the Global South. This results in a transnational landscape of stratified reproduction, care inequalities, and care shortages (Lutz & Palenga-Möllenbeck 2012; Widding, Sambasivan & Hochschild 2008).

Transnational care extractivism can be perceived as a manifestation of an 'imperial mode of living' based on neo-colonial power relations, with which the global middle classes secure their level of production, consumption, and own reproduction by recruiting, appropriating, and extracting care capacities from less prosperous regions, within a nation state and increasingly from outside (Brand & Wissen 2018). These regimes are driven and governed by a neo-colonial and neoliberal interest in cheap labour force.

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6 Transnationalisation of biological (re)production

Another form of care extractivism is the transnational reconfiguration of biological reproduction with surrogacy as a metapher for a new form of reproductive labour and new labour relations. The narratives of declining birth rates in the Global North, increasing rates of infertility and the risk of extinction of white nationals merge to a biopolitical crisis scenario to which the bioeconomy and reproductive industry offer a technical and spatial fix.

The landscape of bioeconomy, fertility markets, and reproductive tourism is largely mapped out by the laws, licences, and bans by nation states and biopolicies, navigating through the political dilemma between neoliberal economy and ethical concerns. Due to ever new regulations there is a permanent restructuring of reproductive investments and markets along with a shifting and shuttling of various actors including commissioning parents and surrogate mothers, a kind of global fluid map of dos and don'ts for reproductive business (Waldby 2012).

In Germany, in-vitro-fertilisation is provided to childless heterosexual couples and subsidised while surrogacy and "egg donation" are banned. However, in February 2017, the first German fertility fair was organised in Berlin, called an information fair. It advertised reproductive services and clinics in neighbouring countries and abroad, including comparison of prices, regardless of legal provisions and bans in Germany, and invited potential costumers and fertility tourists to foreign markets.

India functioned for more than a decade as a transnational hub for the reproductive industrial complex and fertility tourism based on three comparative advantages: low prices, high level of medical technology and professionalism, and little legal regulation. The surrogacy business got a boost in the financial crisis 2009 when in the West Indian state of Gujarat many male employees in the diamond industry lost their job and their wives had to look for some income.

In order to get a much-desired child, commissioning parents enter a complex market and entrepreneurial actors' network, comprising a local and a transnational recruitment agency; value chains of biomaterials such as egg cells, sperms, and stem cells that are transported deep frozen just in time by logistic firms; a reproductive clinic provides a number of potential gestational surrogate mothers. The pharmaceutical industry delivers hormones and drugs in great quantities; the tourism industry offers hotel accommodation and sight seeing tours. Lawyers provide legal advice with regard to the citizenship of the newborn and its possibilities to enter the home country of the genetic parents even if surrogacy is banned thereover (SAMA 2012).

The whole reproductive-medical process gets subordinated to the market rationale of efficiency and competition irrespective of the surrogates' rights to bodily integrity. With the signed contract, the surrogate mother cedes her rights over her body and reproduction to the reproductive entrepreneurs, mainly the clinic. She gets subjugated to intensive medical interventions with hormones and other drugs, frequent quality control like ultrasound and prenatal diagnostics, and supervision including restrictions imposed on movements and diet (Pande 2014; Rudrappa 2015).

Clinics compete with regard to the success rate of In-vitro-fertilisation (IVF) and nesting of the embryo in the women's uterus. In order to multiply the chances of an embryo to nest, normally five embryos are transferred after IVF, or embryos of one couple are tentatively implanted into two surrogate mothers. If several pregnancies occur the surplus embryos are 'reduced' according to the wish of the commissioning parents, often without informing the surrogate mother (Vora 2013). In particular, the separation of the newborn from the delivering mother who existed together for nine months as an inseparable socio-physical entity is an utmost form of reification and alienation.

For Hochschild (2012), surrogacy in India is a 'backstage', a rather invisible scene of the global free market and an outsourcing of work to poor women who have to manage the tension between emotionality and rationality, productivity and reproductivity, private and public. The disciplinary clinic-hostel regime configures the surrogate's relationship to her own body and self as 'perfect mother-worker' (Pande 2010). They are encouraged to consider the uterus as an empty, unused vessel, which with the help of technology can be used as means of production and income generation (Vora 2013). The legal framework for this work is a contract, which assumes the surrogate mother as an entrepreneur of herself and aims at generating a professional relationship of the surrogate mother with her own body.

7 Surrogate mothers as entrepreneurs of their body

The commodification of surrogacy constructs the surrogate mother's pregnancy and delivery as waged labour, and the woman as a neoliberal subject. Without social or health protection stipulated in the labour contract, surrogacy qualifies as precarious informal labour. After a small first instalment paid after the successful nesting of the embryo, the agreed-upon lump some – called compensation, not wage – is paid only after the delivery of the ordered baby, the quality product. The women carry the full risk in case of a miscarriage or stillbirth.

In order to do justice to the women's specific form of agency and subject positions, feminist researchers appreciate it as a form of productive labour (Vora 2009). The value created is life, a human being, and according to the genetic parents' desire, a 'healthy' child.

However, the agency and labour done by the surrogate mother is disguised by the ideology of gift economy. Since in India infertility is a social stigma, it is easy for the reproductive entrepreneurs to take up the narrative of donation and altruism of 'one woman helping another'. The representation of surrogacy as an altruistic and reciprocal practice justifies low payment and the absence of social protection and labour rights. The surrogates themselves adopt this narrative and use it as moral justification for their monetary motivation. Ultimately, this maternal ethics of care confirms the prevailing stereotype of femininity, namely the woman as self-sacrificing and serving, as a vessel and instrument for others.

The surrogates want their work and their subjectivities to be respected in a contradictory symbolic order that iconises and glorifies motherhood, and devaluates care work. As they are often confronted with a whore discourse, which discredits the commercial usage of a women's body as prostitution in an economy of intimacy, surrogate mothers try to hide this work in the neighbourhood, fake a job as maid in another city or claim that the baby died after birth.

In such complex intersecting power structures, surrogacy for these women is first of all an economic practice in a framework of multiple dependencies and subordination, exploitation, governmentality and outside control. However, it is important to recognize that surrogate mothers are not completely powerless objects or only a bodily resource in the context of neoliberal globalisation as suggested by Floyd (2014). Rather, being agent and victim at the same time, the women form new subjectivities through their agency, motivations, perceptions and dreams in these asymmetric power relations and structures of inequality.

The surrogate mother withdraws care and sexuality from her own family, but returns home with a considerable income, up to ten times the annual income of a seasonal farm worker. This new role as breadwinners boosts their self-esteem. Their key motivation to embark on this dubious job is care for their own kids: 'I do it for my children', in particular for their education (Marwah 2014:271).

Surrogate mothers protested when in 2016 the government announced a ban on commercial surrogacy and egg donation after years of laissez faire and of public debates on the transnational commercialization and industrialisation of (re-)production. The ban, which allows altruistic surrogacy within Indian families only, has not yet passed the parliament. The identitarian Hindu-chauvinist orientation and the claim of moral superiority of the current governing party have gained upper hand over the neoliberal economic interest in fertility tourism. Poor women felt deprived of a rare lucrative income option.

Feminist researchers criticised surrogacy ordered by foreigners and the implied care and bio-resource extractivism as reproduction with neo-eugenic elements. This results in a new stratification of reproduction on a transnational level, and reconstructs social inequalities between women (Ginsburgh & Rapp 1995). Some scholars proposed 'fair trade' surrogacy with labour rights and social security and 'reproductive justice' for the contract mothers (Humbyrd 2009; Rudrappa 2015:173). However, this regulation makes for a normalisation of reproductive work and care extractivism.

The Indian ban set another chain of care extractivism in motion: reproductive entrepreneurs went underground, women were driven into illegality, mobile arrangements, and even greater vulnerability (Narimpally, Banerjee & Venkatachalam 2016). Agencies and clinics set up branches in Cambodia, but when a few months later Cambodia announced its own ban, they moved on to Laos. Presently, Ukraine is the new hub of reproductive technologies, extractivism of bioresources, and care energy.

8 Care struggles and politisation of care

Care extractivism and the clash of the two differing rationales of the care economy and the capitalist market economy have recently been exposed and contested in a growing number of care struggles, protests, and campaigns. An outstanding transnational campaign was the self-organised struggle of domestic workers for an ILO convention, which resulted 2011 in the adoption of Convention 189. Core of the convention is the recognition as 'normal' workers in order to secure labour rights, social security provisions, and a right to organise. However, the adoption of the convention remains a kind of symbolic victory as long as only few countries ratified it: 24 countries in 2017 only.

In the recent past, a large number of labour struggles in Europe were organised in the service and care sector resulting in a trend towards feminisation of labour struggles although women have always been considered to be reluctant to organise and go into conflicts. These labour struggles make two features of the mostly invisible care work visible: a) the little appreciation and remuneration it gets in the market economy, and b) its submission to a tremendous pressure exerted by neoliberal regimes. At the peak of the financial crisis in 2009 in Germany, kindergarten teachers and caretakers in old age homes went on strike and protested against not only low wages and health hazards, but also demanded more recognition highlighting the fact that no economy and no society can run without care work (Artus et al. 2017). Many care workers articulated their concern that the quality of their work in the health and educational sector is torpedoed by the above-mentioned care modules and industrial standards of efficiency and profitability in the corporate sector as well as by austerity measures in the public sector.

In Switzerland, the NGO 'Respect', founded by Polish care workers in cooperation with the public service union (German: Verband des Personals Öffentlicher Dienste (VPOD)), rallied for better payment and labour rights for 24-hours-in-house caregivers. After a successful court case, they got some back pay and continued to campaign around demands for life and work in dignity for the migrant workers. In Spain and Portugal, domestic workers and prostitutes participated in the explicitly non-unionised activities of the 'Precarias de la Deriva', in order to create visibility. The Spanish association of cleaners ‚Las Kerries' protested because they, under the given regime of time pressure and lump payment, were no more in a position to clean hotel rooms properly.

The protests and strikes by the care staff and nurses at the Charité hospital in Berlin, Germany's largest clinic, were paradigmatic in terms of politicising care extractivism in a neoliberal system. They marked a shift of focus from payment to the quality of care. In 2011, the trade-union-supported strike was successful in terms of an increase in salaries. However, the trade-off of this success was that the hospital management reduced staff causing an increase of the work burden for each individual care worker. The intensification and taylorisation of medical and nursing work permanently overtaxes and overburdens care workers, and results in 'burn out' effects. The clinic staff claims that the neoliberal principles governing the health system make care workers sick and render the provision of high quality services impossible. Therefore, the key demand of the late strikes was to employ more staff so that quality care could be provided: 'More of us is better for everybody'.

This slogan actually corresponds with the labour conflicts at Polish hospitals. In October 2017, hundreds of young doctors went on a hunger strike for four weeks against the reckless neoliberal health system that is underfunded and understaffed. The indebted clinics reduce their costs by cutting salaries and increase their revenue by unnecessary treatments, diagnostic methods and surgeries, as well as by clinical tests for the pharmaceutical industry. Patients have to wait months for appointments and operations. Doctors mostly work independently and take up several jobs in several shifts at various clinics to compensate for the miserable payment. Medical and care services are subjected to modularisation and time-intensive bureaucracy. Following severe overwork in 2017, some doctors died in Poland. Thus, the methods of rationalisation and professionalization, which were supposed to solve the financial crisis of hospitals, drove the clinics in an even deeper existential crisis, violating basic health rights of citizens.

Against this background, according to the Polish doctors' association, 10.500 doctors, 2000 dentists, and 17.000 nurses migrated to Scandinavian and western European countries, not to talk about thousands of caregivers of the elderly who work in informal arrangements based on circular migration. Therefore, apart from demands for better payment, the striking doctors asked for an increase in the overall health budget from 4.7 to 6.3 percent of the GDP as a precondition to improve their work situation. Stressing their care ethics, they claimed to go beyond egoistic group interests and to strike for the patients as well.

The demand for improved employee quota per hospital ward spread all over Germany and Poland and resulted in a movement toward easing the burden of workers in the health and care sector. Patients and ordinary citizens declared their solidarity with the striking nurses and doctors, and built a new alliance, jointly politicising the underlying crisis of social reproduction and the neoliberal care extractivism. Quality care, which sustains social and biological reproduction and healthy living conditions, is perceived as a common good for the functioning of society and for a 'good life'.

The strikes of care workers represent a new conflict formation with new political subjects different from the industrial worker. They constitute a social movement of the Polanyian type that opposes the growing expansion of marketisation and commodification into non-marketised areas. The new coalitions of actors increase the power resource of care workers in their conflict with private and public employers. They jointly challenge the intensification of extractivism of care work and energies, which depletes the rationale of caring and social relations. Thus, they go beyond the conventional trade unionist topics of wage and work place conditions to policies of recognition and identity.

The German United Services Trade Union ver.di took up the slogan of striking caregivers for 'revaluation' of care work and asks for a classification of care and education into a higher tariff group. This is necessary in the wake of further automatisation, industry 4.0, and the introduction of robots in the sector of health and care for the elderly. Therefore, it is even more important to fully acknowledge the value of the care work, which can not be substituted by capital. However, the low valuation of these activities is a manifestation of patriarchal and capitalist power relations that can not be changed by the categories of wage employment only.

9 From an anti-neoliberal perspective to a caring economy

Summing up the analysis of this paper, I would like to briefly highlight the main features of current care extractivism and of new transnational accumulation regimes of social and biological reproduction. Care work is increasingly shaped, informed, and transformed by market principles like competition and speed, efficiency and productivity increase, in private and public sectors alike. Commodification and non-commodification of care work are entangled processes aimed at the making of cheap flexible reproductive labour and neoliberal subjects. Mechanisms of professionalisation and rationalisation of care work made the boundaries between paid and unpaid work even more fluid. It ultimately leaves the burden to fix the contradiction between the care and the market economy and to reconcile the public and private spheres, paid and unpaid work to the individual care worker. This tends to undermine the rationale of care with regard to provisioning, humaneness, altruism, attentiveness and care ethics, and makes it impossible to provide quality care. It goes along with a depletion of care energies and care capacities due to permanent overtaxing of care workers.

At the same time, the ongoing depletion of the quality of care work and health of care workers sets in motion care struggles, the formation of new political subjects and a politisation of care that contests care extractivism. The policies of recognition deployed by the protesting care workers and the politisation of care within neoliberal and market-authoritarian power regimes ultimately ask for another perspective on the economy, namely putting people's needs and rights before profit, and the care economy as a common good before care as a commodity. This anti-neoliberal perspective mirrors once again the opposing rationales of the care and the capitalist economy, and challenges market authoritarism and the hegemony of market principles over caring.

Following Joan Tronto, to politicise care means to discuss it as an issue of democracy, justice, and citizenship and implies a political resistance against care extractivism, marketisation, privatisation, and industrialisation with a transformative perspective (Tronto 1993; MacGregor 2004). Presently, people in the Global North explore in a growing number of community-based projects such as housing cooperatives, urban agriculture, self-organised kindergardens and solidarity clinics, the alternative and transformative economic potential of the care economy. This change of paradigm is not only anti-neoliberal; it opens up pathways to eventual transitions to a post-neoliberal economy based on the rationale of caring as suggested by the concept of care revolution (Winker 2015).

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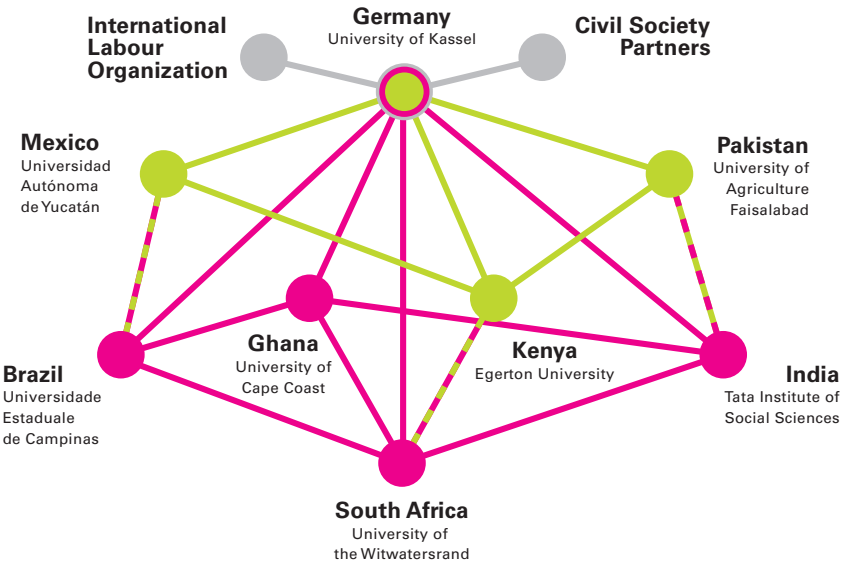

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