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Article

The European care border regime: Theorising extraction, exploitation and East–West inequalities in cross-border care work in central Europe

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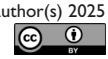
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Abstract

In the European Union (EU), a significant portion of migrant care workers comprise European citizens from Central and Eastern EU member states. Partly due to the closing of EU inner borders in response to the COVID-19 pandemic, East–West inequalities and the exploitation of cross-border EU workers have become a visible public topic. The article suggests that the intra-EU workers' border crossings provide an important sociological insight into the marketised geographies of care and how the – open-yet-bordered – EU arena contributes to social categorisations of people and the continued systemic devaluation of care. The author draws contours of the European care border regime and analyses how it is enacted in the geographical space of central Europe, adding nuances to a critique of ethno-racialised hierarchies of the EU care market. In particular, the article focuses on cross-border care mobility between Czechia, Germany and Austria to explore the connections between extractive and exploitative dimensions of the European care border regime. Contrasting the position and experiences of live-in and residential care workers, the author outlines an understanding of the extractivist regime of exploitation and how it consolidates, produces and legitimises the systemic devaluation of care and structural inequalities between EU citizens. The article also contributes to current debates on the racialised in-between position of Central and Eastern Europe as white-but-not-Western.

Keywords

care work, East–West inequalities, extraction, intra-EU mobility, social reproductive contradiction

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Introduction

In the European Union (EU) today – like elsewhere in the world – various care services are increasingly being governed by the market principles that are now also shaping public welfare provisions. It is well documented that the marketisation of care is connected to migration in complex ways, as migrant women and women racialised as non-white are overrepresented in various care services (Anderson & Shutes, 2014; Aulenbacher et al., 2018; Ehrenreich & Hochschild, 2002; Glenn, 2012). However, which migrants or othered women are considered to fit the category of care workers varies contextually. In the EU, a significant number of migrant care workers are European citizens from Central and Eastern EU member states (Aulenbacher et al., 2024; Katona & Melegh, 2020). Despite a growing body of research highlighting the intrinsic contradictions between calling for decent pay and working conditions for all care workers and a care system built on underpaid migrant care work (translated as affordable), this seems to be the direction of European care politics (Thissen & Mach, 2023; Zacharenko, 2023). Most notably, 24-hour live-in care, which is gradually becoming one of the mainstays of long-term care for older people, even in EU countries with a historically strong formal social welfare system, depends significantly on migrant and mobile women care workers.[1] It is often proposed that the way to overcome the exploitation and precarity associated with this kind of work arrangement is through policies to formalise it. Nevertheless, there are solid arguments that within the context of the current EU labour market the work of 24-hour live-in care is inherently incompatible with social justice and labour rights considerations (Aulenbacher et al., 2020; Palenga-Möllenbeck, 2022; Uhde, 2016).

In this article, I examine the European care border regime and how it is enacted in the geographical space of central Europe. I focus on the mobility of intra-EU care workers, who enjoy freedom of movement and work, but who nonetheless are also a living argument that the liberal proposal of open borders is not enough, and that it is necessary to consider the conditions under which borders are open. I draw on interviews with Czech cross-border care workers working in Germany and Austria, which were conducted at the end of the COVID-19 pandemic that highlighted the existing structural inequalities and bordering functions of open EU borders. I contrast the position and experiences of live-in and residential care workers. I will explore the connections between the extractive and exploitative dimensions of the European care border regime and outline an understanding of the extractivist regime of exploitation and the ways it consolidates, produces and legitimises the systemic devaluation of care and structural inequalities between EU citizens. In this way, I add nuance to the critique of the marketisation of care and the ethno-racialised hierarchies that are embedded in the political economy of social reproduction and underpin the racialised privilege to-be-cared-for. This research also contributes to the current debates on the racialised in-between position of Central and Eastern Europe (CEE) as white-but-not-Western (Balogun, 2024; Boatcă, 2006; Krivonos, 2023; Lewicki, 2023; Nachescu, 2022; Narkowicz, 2023; Safuta, 2018).[2]

In the next section, I define the contours of the European care border regime that is built on East–West inequalities, the open-yet-bordered EU internal geopolitics, and the marketisation of care. I then outline the theoretical background to understanding the relationships between processes of exploitation of care workers, the extraction of care,

and mobility. After introducing my methodological approach, I analyse cross-border care mobility between Czechia, Germany and Austria, shedding a more nuanced light on individual workers' experiences in relation to different mutations of care work, bordering processes, the in-between positionality of the CEE and care marketisation.

The European care border regime

The European care border regime has taken shape over the past two decades in a context of neoliberal reforms, the increased marketisation of care and the underfunding of the care sector, coupled with an ageing population, the enlargement of the EU and the persistence of East–West economic inequalities. I coin the term European care border regime to denote the structural entanglements between the EU border regime (Engbersen et al., 2017; Walters, 2002) and the political economy of care and social reproduction (Fraser, 2016; Mezzadri, 2022; Williams, 2018). The gendered division of labour and its geopolitical imprints on the East–West divide lay the foundations of the European care border regime.

The EU project has been accompanied by the institutionalisation of the European border regime, which created a notion of internal and external borders and markedly modified geopolitical, national and biopolitical borders (Rigo, 2005; Walters, 2002). The enlargement of the EU between 2004 and 2013 shifted Europe's internal and external borders.[3] This was sustained by the transformation of the economies of the former 'Eastern bloc', which adopted a neoliberal model of privatisation, deregulation and marketisation. An opening of Eastern markets benefited Western economies and companies and transformed CEE[4] into a region that was competing for investments with skilled but cheap labour. Over several years, the Schengen zone expanded, and labour markets in Western economies opened up to mobile labour from the new member states, usually after a transition period limiting access to the labour market for CEE citizens. The 1990s were characterised by a paternalistic discourse of 'catching up with the West', which, after the EU's enlargement, evolved into a more nuanced blend of inclusion as cheap labour and exclusion from enjoying all the rights of full-fledged EU citizenship (Uhde & Ezzeddine, 2020).

Substantial wage differences among EU member states motivate internal EU labour mobility. However, the structural push of women on the move into the sector of care and reproductive work is constantly being produced by the care, labour and migration policies of the state and by a political economy that systematically devalues care and reproductive work. Research on the European modalities of hired domestic work and care work migration has exposed the creeping marketisation of care, the neoliberalisation of welfare and the increasing dependency of care provision on migrant and cross-border workers (Aulenbacher et al., 2018, 2024; Bahna & Sekulová, 2019; Kuchyňková & Ezzeddine, 2015; Lutz, 2011; Lutz & Palenga-Möllenbeck, 2011; Palenga-Möllenbeck, 2013, 2022; Uhde & Ezzeddine, 2020; Wichterich, 2020). The European care border regime also produces care workers' structural position on its external borders – the non-EU migrants working in the care sector face, in many respects, more exploitative and vulnerable conditions. However, the European care border regime relies significantly on circular mobility within the EU and its ethno-racialised representations. Thus, within the

EU's internal borders, de-bordering practices of opening borders have been sustained by multiple ongoing and new everyday bordering practices (Kulawik & Kravchenko, 2020).

Within the construction of Europeanness as an internally structured ethno-racialised white identity, 'Eastern Europeans' are positioned as an inferior European other, but they are still part of the category of whiteness as a global position of privilege. They occupy an in-between position and are racialised as white-but-not-Western (Boatcă, 2006; Hendl, 2022; Krivonos, 2023; Lewicki, 2023; Nachescu, 2022; Narkowicz, 2023). Lewicki (2023, p. 1494) argued that the ambivalent representation of Eastern Europeans as a stereotyped categorisation of several nationalities from a diverse region served to justify Western governments' active institutionalisation of mobile workers from CEE as precarious and disposable labour, and that this 'racialisation of "Eastern Europeans" is co-constitutive of the political-economic peripheralisation of the region'. She concluded that CEE workers' structural disadvantages in the labour markets in wealthier EU countries cannot be wholly attributed to discrimination against them as migrants; the hierarchical racialised categorisation within Europeanness co-produces this particular social order. Krivonos (2023) contributed to this debate by raising a discussion of racial capitalism and analysing the entanglements between capitalist accumulation and processes of racialisation. She suggested that positioning Eastern Europeans as white-but-not-Western subjects 'enables their inclusion as cheapened labour without challenging racial composition of the white majority while dividing workers along racial lines' (Krivonos, 2023, p. 1501). Safuta (2018) pointed out that in the private space of the home, CEE domestic workers' peripherally white position provides a 'comfortable alterity': not too different to create discomfort and cultural unease, but different enough for an authority and hierarchy to be established in the employment relationship.

While the practice of employing migrant women in care services, live-in care and other domestic work is not new, European institutions have only recently begun to openly endorse reliance on migrant and mobile care workers as an inevitable strategy to meet growing care demands (Zacharenko, 2023). A noticeable number of care workers are from outside of the EU, but the distinct European care border regime is, to a large extent, built on the circular mobility of EU citizens from CEE and on naturalised East–West structural and ethno-racialised inequalities. Moreover, in the context of increasingly restrictive approaches to migration management and the dependency of the long-term care sector on cheap migrant labour, the intra-EU mobility of care workers plays into this dynamic. CEE care workers thus contribute to sustaining the long-term care sector in wealthier EU countries without challenging the connection between Europeanness and whiteness. These notions converge in the idea of a white European community of imagined European values, which is used to legitimise the exclusion of non-EU migrants and internal non-white 'others' (Balogun, 2020; Boatcă, 2006; Dodevska, 2023).

The extraction of care and exploitation of care workers

Social reproduction and care are activities that capital depends on but treats as unlimited external resources, producing what Fraser (2016) called the fundamental capitalist social-reproductive contradiction. Fraser (2016, p. 100) argued 'that every form of capitalist society harbours a deep-seated social-reproductive "crisis tendency" or contradiction: on the

one hand, social reproduction is a condition of possibility for sustained capital accumulation; on the other, capitalism's orientation to unlimited accumulation tends to destabilise the very processes of social reproduction on which it relies'. Feminist social reproduction theory offers important insights into re-centring human labour not only as waged labour but as the totality of caring relations and labour reproducing society as a whole (Bhattacharya, 2017; Federici, 2012; Mezzadri, 2022). Bhattacharyya (2018) then used the lens of social reproduction to develop further the concept of racial capitalism and highlighted the productive role racialisation processes play in capitalist development through the extraction and appropriation of value from the sphere of social reproduction. She argued that racialised subjects have been systematically targeted by extraction, expropriation and dispossession, but racial capitalism's 'techniques of othering and exclusion utilise the logics of race, regardless of the targeted population' (Bhattacharyya, 2018, p. x).

The political economy of social reproduction in late capitalist society involves the appropriation and expropriation of value from economically non-remunerated care and reproductive labour, which is termed non-work. A considerable proportion of care and reproductive labour is provided by unpaid and largely invisible labour and mostly by women. If we understand extraction in an expanded sense, 'extraction involves not only the appropriation and expropriation of natural resources but also, and in ever more pronounced ways, processes that cut through patterns of human cooperation and social activity' (Mezzadra & Neilson, 2017, p. 194).] In this sense, unpaid women's work has historically functioned as a central mechanism for the extraction of care. However, care is also paid work. Advancing marketisation encroaches on spheres of social life previously outside direct market governing, which intensifies care relations as a site of exploitation and its social dimension of racialisation that realigns with processes of extraction of care. Market norms are also gaining traction in welfare states that are undergoing a restructuring according to the principles of new public management, which emphasises individualisation, social investments, efficiency, reportability, outsourcing and privatisation, coupled with the use of various consumer-oriented cash-for-care and voucher schemes. Aulenbacher et al. (2018) perceived this shift as a new stage in the marketisation of care under finance capitalism and the quasi-marketisation of the welfare state.

Care is both a resource that is being extracted and labour that is being exploited. Wichterich (2020, p. 122) coined the term 'care extractivism' to chart the changing practices of the devaluation of care and the exploitation of care workers stemming from the neoliberal politics of care at the national and transnational levels. However, she suggested replacing the concept of exploitation with the concept of extractivism. On the other hand, Mezzadra and Neilson (2017) do not see extractivism as the new dominant paradigm of the operations of capital. They argued that the accumulation of capital relies on resources external to the productive process. However, extractive operations require not only the expropriation and appropriation of resources but also the exploitation of the labour involved. I agree with their conclusion that the task is to explore how the current proliferation of extractive operations modifies and amplifies relations of exploitation.

Wichterich (2020) mapped the multiple strategies behind care extractivism at the national and transnational levels. At the transnational level, she then described care extractivism with the metaphor of the care drain parallel to international resource extraction. I would argue, however, that it has a problematic consequence that equates mobility

and migration with care extractivism. The recruitment of trained nurses from poorer countries to work in wealthier countries, to which Wichterich referred, evokes a mode of the extractive colonial economy, draining resources and appropriating the value in the geopolitical power centres. Nevertheless, there are limits to analogies between the extraction of care and the colonial extraction of natural resources, which treat people as living resources. Cross-border mobility is not always that. The concept of the care drain (Hochschild, 2002), like the brain drain, gains its critical and normative legitimacy from methodological nationalism and the presupposition that people naturally belong to a specific national community (Sager, 2018). Even though Wichterich recognised migration as an opportunity for individual women, she did not engage with the tension that her understanding of transnational care extractivism implies that restricting people's mobility in order to fulfil their imagined moral obligation to ensure social reproduction in their native countries would resolve the problem of transnational care extractivism. It imposes responsibility for the social reproductive contradictions of global capitalism on individuals. I suggest the task is to explore when and how mobility is used to amplify the extraction of care and its relation to the exploitation of care workers.

EU open borders for labour mobility removed several legal and institutional restrictions for migrant workers, which exacerbate migrants' vulnerability to abuse and exploitation, in particular tying an entry visa and a residence permit to an employment contract. However, the European care border regime activates everyday bordering practices beyond these migration status-related restrictions. These everyday bordering practices institutionalised by states and market actors build on and further produce economic inequalities and peripheralisation of the CEE region in different mutations of care work. I suggest that contrasting different mutations of care work within the European care border regime casts a closer light on how the white-but-not-Western structural position of CEE citizens is used to realign processes of extraction of care and exploitation of care workers that both underpin the transnational political economy of social reproduction. In the following analysis, I aim to show that the employment of cross-border workers in residential care facilities in wealthier EU states operates through the exploitation of care workers in the capitalist mode of devaluing reproductive labour beyond state borders. In contrast, 24-hour live-in care work in the EU is designed for cross-border EU workers from CEE, resembling the guest worker scheme of the Fordist era, yet in an opaque way without the necessity of a state-led migration recruitment programme. I will argue that it institutionalises the extractivist regime of exploitation that manifests the racialised extraction of value from the sphere of social reproduction within the category of whiteness, amplifying the exploitation of mobile care workers.

Methodological notes

This article draws on interviews with mobile cross-border workers from Czechia working in Germany and Austria in the long-term care sector (14 in Germany and 7 in Austria). I used this empirical material to analyse cross-border care mobility in the geographical space of central Europe. There are no exact statistical data on the number of cross-border care workers in the EU. However, we can get a picture from an estimate of the number of registered live-in care workers there are in Austria and Germany, the vast majority of

whom come from Central and Eastern EU member states. The number of registered live-in care workers in Austria is above 60,000, and the estimates are above 300,000 in Germany (Prieler, 2021; Thissen & Mach, 2023, p. 93). Women from Poland, Slovakia and Romania make up most of the care workers in these two countries (Aulenbacher et al., 2020; Bahna & Sekulová, 2019; Lutz & Palenga-Möllenbeck, 2011; Palenga-Möllenbeck, 2022; Prieler, 2021). Czech cross-border care workers account for a smaller share of CEE mobile care workers. Although they are in a relatively less precarious structural position than non-EU migrant care workers or those from poorer EU countries, this does not shield them from institutionalised exploitation and discrimination (Ezzeddine, 2024; Uhde & Ezzeddine, 2020). However, because of this relatively privileged position, I suggest that this case study contributes to a more complex understanding of the structural injustice inherent in the European care border regime.

Semi-structured interviews were conducted between 2021 and 2022 with 21 women living in Czechia who work abroad in either institutional formal care (8 in residential care facilities, 2 in field care services) or live-in home care (11 interlocutors). I supplemented these interviews with observations of general social media discussions and news reporting. In the vast majority of cases, my interlocutors started or continued working abroad during the COVID-19 pandemic, which, among others, reconstituted state borders as physical barriers and made visible the risks of some non-standard forms of employment. However, while many sectors of the economy closed, the long-term care sector abroad provided an opportunity for income for new care workers or an opportunity to move from live-in to residential care with a regular employment contract. The participants' ages ranged from the early 20s to the early 70s. Except for one, they all had children, from one year of age to adults, and their private life arrangements differed (single, married, divorced, living alone, with the family or cohabitating with someone else). Most of them lived in the border regions; however, several resided in Prague, showing that cross-border employment in the long-term care sector is a work strategy used not just in the poorer border regions.

The interviews lasted between one and two hours and were conducted online with audio-visual connections or over the phone if the internet was not available. Online interviewing has gained acceptance with the rapid development of new technologies. While this mode of interviewing may provide less insight from body language, it has its own specific advantages (Kozinets, 2010). This approach fit the circumstances of movement restrictions during the COVID-19 pandemic, but it also offered the necessary flexibility in terms of the geographical and time availability of care workers and their preferred anonymity. An individual communication preceded each interview to ensure that they fit the sample. The fieldwork, data collection and data storage are all in compliance with the European Code of Conduct for Research Integrity (ALLEA & European Science Foundation, 2023). The interviews were conducted and analysed in the Czech language and structured around the decision to work abroad in the care sector, their experiences in different jobs, and their biographical interpretations as shaped by cross-border work. A critical thematic analysis (Lawless & Chen, 2019) was used to analyse the interviews. The interviews were transcribed and coded using open coding, followed by the identification of thematic categories and closed coding. The critical thematic analysis identified connections between the narratives and a structural interpretation of the interlocutors'

lived experiences with societal ideologies and power structures. In the analysis, I contrasted the lived experiences of live-in care workers with those of employees of residential care facilities.

Trajectories of Czech cross-border care workers

The closure of intra-EU borders in response to the COVID-19 pandemic played a role in making East–West inequalities and the exploitation of cross-border EU workers a visible public issue again. Doctors and nurses were praised as essential workers. However, the sudden closure of internal EU borders also put care workers from outside of the EU and mobile cross-border workers from Central and Eastern EU member states in the spotlight (Ezzeddine, 2024; Leiblfinger et al., 2020). Allowing the cross-border mobility of care workers to continue became a top priority of inter-governmental negotiations over night, as many wealthier European countries were confronted with the risk of facing an acute shortage of these workers. This clearly highlights how East–West inequalities are inscribed in today's European cross-border care market (Lewicki, 2022; Safuta, 2018; Sojka, 2020; Uhde & Ezzeddine, 2020).

Care work in higher-wage EU countries, though it is undervalued in comparison to local labour market standards, presents a better earnings opportunity for mobile workers from CEE than what they could earn at home (Bahna & Sekulová, 2019; Katona & Melegh, 2020; Leiblfinger et al., 2020; Palenga-Möllenbeck, 2013; Uhde & Ezzeddine, 2020). Although for Czech women in general care work abroad has become increasingly less lucrative relative to potential domestic earnings, it still offers a wage that is motivating, especially compared to pay in some regions or some other occupations. The majority of job openings in cross-border care are concentrated in the long-term care sector. Pursuing an employment contract in a residential care facility or in field care services is often a strategy for those who plan from the beginning to work abroad on a long-term basis. Language skills and the necessary professional qualifications were two common conditions they had to meet. These positions are characterised by higher wages, access to social benefits (e.g. child benefits and national retirement programmes), protected labour rights and formal employment contracts. Often, they also allow workers to commute daily or at short intervals. The majority of my interlocutors, who worked in residential facilities and field care services, were able to organise their work shifts to accommodate their different private life needs or ideas about a good life. However, this is not always the case. Some had to change their employers abroad to improve their working conditions. According to their experiences, working conditions varied depending on the type of the care facility owner and the level of neoliberal intensification of labour.

Nevertheless, many mobile care workers work in 24-hour live-in care in the home, or at least they do so initially. This means that they live in their clients' homes and are usually supposed to be present and on-call 24 hours a day, with some breaks negotiated individually or in the contract. They usually stay for two to six weeks and then return home for the same period. Numerous non-standard forms of contract are used in this sector, from non-declared work and work on a trade licence (from the country in which they work or the one in which they reside) to posted work and other forms of short-term

contracts arranged through an agency. There is an increasing trend to formalise 24-hour live-in care work on the basis of a trade licence, following the Austrian model introduced in 2007. This kind of formalisation of 24-hour live-in care is used as a strategy to bypass labour laws related to employee rights as care workers are not employees but quasi-self-employed entrepreneurs.[5] Families who hire 24-hour live-in care workers can only afford to do so because it is much cheaper than other care services. For cross-border live-in care workers, on the other hand, this arrangement makes sense only because of the disparities in wages and the cost of living between the two states.

Czech cross-border live-in care workers in Germany and Austria usually earn €60–90 a day, sometimes also with extra travel expenses. This amounts to between €840 and €1260 for a two-week rotation, which equals their monthly salaries before taxes. Nevertheless, this wage is less than €3–4 per hour. By contrast, in 2022 in Germany, the minimum hourly wage for unqualified care workers was €13.70. Among my interlocutors, a starting monthly salary in residential care homes, which is more prevalent for cross-border care workers in Germany than in Austria, was around €1800 before taxes; they were also entitled to child benefits (in Germany a minimum of €219). To compare, the average salary for care workers advertised by the Czech Labour Office was between €900 and €1130 per month before taxes, depending on qualifications, region, etc.[6] It seems that salary incentives to work as live-in care workers have recently been almost eliminated in the care sector. However, there are individual and regional differences, and long work shifts and general underfunding and understaffing in care facilities in Czechia play a role in people deciding to engage in live-in care work across the border. All the women I talked to stated financial reasons as the key factor in their deciding to work abroad.

Given the differences in the institutionalised rights and work statuses attached to different kinds of care work, it is revealing to contrast the experiences and positions of live-in mobile care workers and mobile care workers employed in publicly regulated residential facilities and field care services. The first category of workers is structurally pushed into more precarious and exploitative forms of 24-hour live-in care work. The second category is included in the formal workforce, which allows them access to more secure and higher salaried care jobs. The state thereby produces two categories of care workers, which are not necessarily defined simply by migration status but draw on everyday bordering practices and categorisations between different nationalities and social classes of EU citizens. Moreover, more formalisation of live-in care work does not yield more rights; rather, the use of various non-standard forms of contracts, such as a trade licence, which was prevalent among my interlocutors, institutionalises exceptions and exemptions from labour rights, including minimal wage, paid overtime, obligatory breaks, and health, social security and other welfare provisions.

The in-between positionality of Czech care workers

Filling labour shortages in the long-term care sector's underfunded institutions with intra-EU mobile workers keeps the institutions afloat by shifting the problem borne from the inherent social-reproductive contradictions of capitalism (Fraser, 2016) further to the east. It mitigates how these contradictions are experienced in wealthier countries.

Inspired by Tronto's (1994) notion of privileged irresponsibility, describing social power relations that by devaluing care allow those in a privileged position to deny their dependency on those who provide care, and following Bhattacharyya's connection of racial capitalism with social reproduction, I suggest that one form of structural white privilege that in racial capitalism is embedded in the political economy of social reproduction is the privilege to-be-cared-for. However, this privilege is differentially distributed, not only along gendered and class lines but also according to geopolitical markers of difference within the category of whiteness.

The interlocutors were self-aware of their othering based on their positionality as 'Eastern Europeans'. They positioned themselves as cheap labour, cheaper than Western Europeans but not as cheap as 'other' Eastern Europeans, more reliable and cleaner than other Eastern Europeans, and more confident and empowered than other Eastern Europeans. This was particularly salient among live-in care workers. The following quotes illustrate how they used different markers of difference to outline racialised divisions.

> During this time, I met Polish women. There is not that big a problem with them. Czechs and Slovaks, they are mostly okay. . . . But the absolute worst experience I have had is with care workers from the Balkans. Croatians and even Hungarians, it's an absolute tragedy when it comes to their cleaning and caring for these people. (Romana, live-in worker in Germany, 59 years old)

> For example, families boast about having a Romanian woman for a few euros. Then they find out that the Romanian woman can't even cook for them and that she doesn't keep the house clean, that it's on a completely different level than with Czechs and Slovaks. And then they didn't want them, even though they could have had them for half the price. . . . Actually, it's tolerated that we [live-in care workers] are underpaid, on an hourly wage. In fact, it's forbidden, to work for a such a low hourly wage. That's why the pay's not counted by the hour. . . . no Austrian would ever do this work. So the family may like you for doing it. . . . But they also think these women are doing it just for a few crowns. So, they put us on a different level than themselves, for sure. (Veronika, live-in worker in Austria, 67 years old)

To rationalise their position, women working in 24-hour live-in care referred to the naturalised hierarchies of Europeanness, reaffirming the superiority of Western whiteness, using economic and class markers, but deploying a broader range of markers to justify Eastern inferiority. Whereas Western whiteness was largely unmarked, the white-but-not-Western position needed further categorisation. However, the interlocutors, through the categorisation and demarcation of their boundaries, also articulated a critique of live-in care work.

In contrast to the ethno-racialised hierarchies strongly imprinted in the live-in care sector, care workers in residential facilities and field care services praised the fact that they felt they were treated the same as their local colleagues.

> I just had to learn by doing it, by commuting abroad. . . . Sometimes I was more angry, sometimes less. But I am grateful to have the opportunity to work; I am well-paid. The salary, the treatment, the fact that I am treated like a professional, that I am on the level of a Bavarian today – I am treated really well. (Erika, employed in field care service in Germany, 48 years old)

> I have managed to work my way up a little bit. . . . Which I think is no small thing for a foreigner. I mean, I have been here in this home for ten years. . . . We are all on the same level. That's the advantage of the state or county facilities; they all follow a salary table, based on a collective labour agreement. There, the head nurse cannot say: Well, you are Czech, so we'll give you 300 euros less; it's just not possible. This, of course, happens elsewhere. (Marta, employed in residential care in Austria, 49 years old)

Interestingly, though, these quotes illustrate that the equal treatment was not taken for granted, as it was acquired by merit, and it was appreciated as something possible particularly in public or publicly regulated care institutions. In their narratives, they usually did not engage in contrasting between different groups of 'Eastern Europeans' but they sometimes made the comparison with German care workers, highlighting Czech workers' dedication to hard work. Some complained that their Czech education and qualifications were not recognised and as a result, they had to work in lower-qualified and lower-salaried positions. They also told me about the everyday instances of othering they experienced – for example, experiencing stricter monitoring of cigarette breaks or being told to behave when speaking Czech among themselves.

> Only foreigners work full-time to make it worthwhile because they commute. Germans work less, 80 percent at most, no one has a full time. . . . Nobody makes a difference, it depends on how you work. If one is always going out for a smoke or a coffee, then one has a problem. Czechs are now forbidden to do that. The Germans do it, but if they see a Czech joining in, it's a problem. (Anna, employed in residential care in Germany, 57 years old)

> I think Czech women are much more hardworking than German women, even some Germans admit that, they say that they don't know how we do it, but that everything is always in order after us. But the beginnings there were not easy at all. (Frieda, employed in residential care in Germany, 38 years old)

Despite these stories, their subjective feeling of equal treatment and social recognition at work was stronger than that described by mobile live-in care workers. When we contrast the narratives of the two differently positioned categories of cross-border care workers it shows how institutional conditions of care work lead to different ethno-racialised experiences. Twenty-four-hour live-in care work is designed for mobile workers, both intra-EU mobile workers and non-EU migrant workers. For intra-EU cross-border care workers, the live-in care arrangement consolidated everyday bordering practices and ethno-racialised othering within open EU borders. Care workers in residential facilities experienced bordering practices too. However, they seemed more satisfied with their merit-based recognition, through which they benefited from their in-between position as white-but-not-Western.

The narratives of my interlocutors, in particular of 24-hour live-in care workers in a more precarious position, illustrate the aspiration of belonging to European whiteness that accompanies the othering of 'other' Eastern Europeans. This othering is often done using the category of nationality, which, however, could be interpreted as racialised othering. In this sense, the care workers' narratives confirm the findings of other scholarship focusing on how the CEE region contributes to reproducing a global racialised order

(Baker et al., 2024; Balogun, 2020; Krivonos, 2023). However, it also illustrates how the structural privilege to-be-cared-for is linked to Western Europeanness as a geopolitical marker of whiteness. The CEE's white-but-not-Western positionality masks the racialised foundations of this privilege. In other words, it enables the production of bordered Europe as a racialised space of whiteness without undermining the Western white privilege to-be-cared-for.

Twenty-four-hour live-in care work as a strategy of the extractivist regime of exploitation

The expansion of the field of 24-hour live-in care work is not simply a reaction to East–West economic inequalities, which motivate the circular mobility of cross-border workers from CEE. The care and labour policies of wealthier EU states produce and amplify these inequalities. Different schemes of cash-for-care, care vouchers and tax credits promote the marketisation of care (Ungerson, 2000; Williams, 2018). States also legislate different non-standard forms of contract for live-in care work, such as posted work or trade-licensed work, which makes this arrangement cheap and exempts live-in care workers from access to labour rights protection (Aulenbacher et al., 2024).

Nearly all of the live-in interlocutors had unsettling work-related stories to share, including restrictive household regulations applied to their bodies and behaviour (restricting the food they could eat, the number of showers they could take, their phone conversations in Czech, having to share a bedroom, etc.), experiences of sleep deprivation and a lack of breaks leading to physical exhaustion, instances of abuse, and even exposure to life-threatening situations (physical attacks, sexual assaults, etc.). This is a well-described aspect of the 24-hour live-in care work.[7] However, women spoke also about the positives of live-in care work. Some workers highlighted that they preferred to have two weeks off in a row (especially those who had not been working in live-in care very long). They stressed that this could be a good enough job if the worker could find a good family with a self-reliant care recipient who sleeps during the night. Importantly, though, the conditions described as good to work in corresponded to a level of care that could be covered by field care services, if such public services were available and accessible. Moreover, several of my conversation partners realised the disadvantages of having a non-standard form of employment and working precariously as a self-employed worker in times of crisis or transitions – for example, they were not entitled or only to a small benefit during the COVID-19 pandemic; they were not entitled to sick leave benefits when they became ill; after years of working abroad their pension was very low, etc. Besides, when they had health emergencies or other care issues, the costs of their health care were outsourced to Czechia.

The interlocutors' narratives clearly confirmed that the 24-hour live-in care arrangement is not suited for cases in which the client's health condition requires round-the-clock care. Caring for older people with advanced dementia or other serious health conditions is demanding, both physically and psychologically, and more so in isolated one-to-one care-intense situations. This view was reflected in all the interviews.

> In that man's family, there was no time off; I could only go out to shop, on my bike. . . . but I didn't even know how to do that unless the patient was asleep after lunch. But you have some fear in you. I'm responsible for that person, so I'd just go to shop in a hurry. I don't know, in half an hour I was back, and I ran straight to the man to see if everything was okay. That's how I had to do it, only to shop; otherwise, there weren't even any breaks. (Lenka, live-in worker in Austria, 60 years old)

> In the residential facility, it's definitely physically demanding, but in family care it's very demanding psychologically because you are separated from everybody, not only from your family, but also from your friends and others. Actually, you are always, always with the person. . . . you are with this person from morning to night, you are always alone in this kind of isolation, you don't live your own life. You are entirely living the life of somebody else. You take on somebody else's daily routine; it's complicated. And so, I was thinking about this, and I told myself that for me it's not worth it anymore. (Sára, live-in in Germany, 44 years old)

> Slowly, it stopped paying off as well, because social and health insurance and everything else was rising in price, but the money was the same. And I didn't want to live someone else's life anymore. Often, you have to function all day, even if you haven't slept at night because the client wanted something or was raging. . . . During the pandemic, I started working in a seniors' home. And thank God, now I work six-hour shifts and drive home. It was much worse before, enduring all that for 24 hours. (Cecílie, used to work as live-in, now works in a residential care facility in Germany, 47 years old)

The colonisation of live-in workers' time is an inherent feature of the live-in care arrangement, not only in cases when the workers' legal status essentially makes them indentured workers (Parreñas, 2017), but also in situations where live-in care workers are in a position to leave an abusive employer and are not bound by a restrictive migration status, such as in the case of intra-EU mobile workers. Moreover, the home environment activates gendered strategies to extract care through an understanding of care as non-work, since it is seen as the kind of work women usually do at home. It constructs live-in care as only partial work, which in combination with ethno-racialised markers of Eastern Europeans justifies the payment of extremely low wages as well as exemptions from labour rights entitlements.

> They think you are their slave. . . . They are really trying to put you down. I always say we don't live in trees in Czechia. . . . Of course, they take us for fools. What do you think? A German wouldn't do this for them. An Austrian wouldn't do it for them either. Because nowadays, an Austrian or German caregiver gets 12 or even 16 euros an hour, I don't know. (Hana, live-in worker in Austria, 59 years old)

The extraction of the time and labour of live-in care workers goes beyond the logic of just the exploitation of wage labour. While live-in care is not historically new, it is gradually returning as one of the cornerstones of European care politics. The 24-hour live-in form of care work combines evolving ways of labour exploitation that circumvents standard employment contracts, the devaluation of reproductive labour, the gendered extraction of care as non-work and the racialised hierarchies within these schemes. I

suggest it is a paradigmatic example of the extractivist regime of exploitation within the European care border regime. The 24-hour live-in care work model is made possible and sustained by cross-border intra-EU labour mobility. The European care border regime relies on open borders, which allow circular mobility of live-in care workers, whilst persistent bordering practices operate on economic, institutional and symbolic registries.

In contrast, cross-border care workers employed in residential facilities and field care services benefit more from open borders. However, the opening up of these care jobs to cross-border workers is occurring alongside processes in which capital exploits care workers and externalises the costs of social reproduction to the state and individual workers. In the geographical space of central Europe, the white-but-not-Western positionality of Czech cross-border care workers working in formal, publicly regulated residential and field care provides them with enough privilege to 'deserve' to be treated as equal; equal, however, among the exploited.[8]

Conclusion

In the geopolitical imaginary of the Global North and South, the former 'Eastern bloc' is mostly subsumed under the North or left as a blank spot. In the European context, however, considerations of East–West hierarchies provide important insight into the marketised geographies of care and into how the processes of extraction and exploitation play out within the – open-yet-bordered – EU arena, where it contributes to social categorisations and the continued systemic devaluation of care. I suggest that the border crossings of intra-EU workers provide an important sociological viewpoint. The position of CEE care workers as white-but-not-Western makes it possible to sustain the racialised privilege to-be-cared-for in wealthier EU countries without challenging the trends towards restrictive migration policies along global racialised power hierarchies. Contrasting the trajectories of Czech cross-border care workers working in 24-hour live-in care and those employed in residential care, nevertheless, challenges an understanding of labour mobility as such as a form of transnational care extractivism. Women should not be regarded as resources belonging to the nation-state. Nor should the circular mobility of care workers be legitimised as the temporary borrowing of living care labour from poorer countries. It is important therefore to shift the perspective away from methodological nationalism to explore how states and market actors use mobility to institutionalise new mutations of care work by reinventing the relation between the gendered and racialised extraction of care and the exploitation of care workers. In this sense, the EU's open borders are being redrawn as labour borders between different categories of care workers and differently racialised EU citizens.

Live-in care work, in particular, reveals the major cracks that exist in European neoliberal integration and its nation-state-driven care systems. It demonstrates that the persistence of East–West inequalities is not simply a residual of the past that contravenes the EU normative framework. The institutions and laws governing care work in the EU and member states perpetuate this hierarchy, which is naturalised through several markers of difference that make it easier to justify extractivist and exploitative relations in the home environment and care relations. In live-in care work, capitalising

on open cross-border labour mobility, the state and the market are institutionalising a particular strategy of the extractivist regime of exploitation.

The COVID-19 pandemic and the associated border closures made visible the dependency of the long-term care sector on a transnationalised care market and cross-border labour mobility. The care response to the pandemic was distributed very unevenly, and this exposed how social hierarchies along class, gender, racialised and geopolitical differences became naturalised as taken-for-granted explanations for injustice. In this respect, the pandemic seems to be a missed opportunity to redesign the European care border regime. In the aftermath, we have seen the consolidation of the live-in care sector, driven by a political nationalism that aims to secure long-term care for national citizens at the expense of mobile care workers. The legality of the work (in contrast to the informal and undocumented care work of many migrants) is no guarantee of decent working conditions or of the valuation of care work. Ultimately, the European care border regime is an adaptation strategy that maintains the modus operandi of the capitalist mode of devaluing reproductive labour by integrating it with the nuanced hierarchy of whiteness that plays out in Europe.

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Notes

1. I refer to 'mobile (cross-border) workers' as care workers who are EU citizens working in other EU member states benefiting from a more flexible mobility and access to more rights in comparison to 'migrant workers' with non-EU citizenship.
2. Nachescu (2022) used the designation 'white-but-not-Western'. I agree with her that it succinctly characterises the in-between position of CEE.
3. Legislative changes in CEE candidate states towards a more restrictive and criminalising approach to Eastern migration and asylum policies was one of the key conditions for EU accession. 'Effective' border control was discursively equated with proving to belong to Europe (Rigo, 2005).
4. Generally, the East–West divide in Europe today coincides with the former political boundary between the capitalist and state-socialist worlds, although the construction of belonging

to the East is shifting and depends on the vantage point. The term 'Central Europe' is often contested for its underlying tone distancing Central Europe from Eastern Europe proper and for indirectly affirming the superiority of Western Europe. My goal is not to reproduce these distinctions; however, I use the collocation Central and Eastern Europe as it is commonly used in the region itself, where it stresses the different geopolitical positions of countries due to the redrawing of European political borders after the EU enlargements. I also use the term central Europe in a geographical sense as a space where the East–West divide runs inside the EU supranational unit.

5. Brokering agencies in particular are lobbying for the legalisation of the self-employment model of live-in home care in Germany and Switzerland, as Aulenbacher explains in the interview (see also Aulenbacher et al., 2024). https://crossroads.transistor.fm/episodes/brigitte-aulenbacher-live-in-care-markets-provide-decent-care-under-poor-working-conditions
6. https://prace.kurzy.cz/urad-prace/osetrovatele-a-pracovnici-v-socialnich-sluzbach-v-oblasti-pobytove-pece-5321/ (accessed12 November 2023).
7. The 2024 survey among 24-hour live-in care workers in Austria found that 45% of the respondents experienced verbal, psychological/emotional and/or physical violence, 14% experienced sexual harassment/violence, and 23% experienced racism in the workplace (Mairhuber et al., 2024).
8. This is not to idealise residential care facilities and belittle the underlying institutional practices of the othering and exclusion of Central and Eastern Europeans from 'Western civilizational norms' (Lewicki, 2022, p. 929); however, the narratives of my interlocutors suggest that their phenotypes and geopolitical identities offer the possibility to 'deserve' equal belonging, but it is equal among the exploited.

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