The Pandemic State of Care: Care Familialism and Care Nationalism in the COVID-19-Crisis; The Case of Germany

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Mike Laufenberg & Susanne Schultz *

Abstract: *»Der pandemische State of Care: Care-Familialismus und Care-Nationalismus in der COVID-19 Krise am Fallbeispiel Deutschlands«.* In the COVID-19 pandemic the (nuclear) family, and the private household that is assumed to contain it, receives an enormous revaluation across different welfare regimes. At the same time the notion of a nationally formed welfare state that protects "its" vulnerable national population is re-enacted as a central care entity. From an intersectional and transnational perspective, the article coins the concepts of "care familialism" and "care nationalism" to analyse both the conditions of inequality and the exclusionary effects of these intertwined formations of "home" in the wake of the pandemic state crisis management in Germany. The article presents central dimensions of German care familialism and care nationalism to demonstrate how – and which – hierarchies of care/carelessness are systematically established and deepened within the current state of pandemic policies – from the neglect of those who cannot retreat to a "safe home" to the necropolitics of tightened border regimes and carelessness towards those who are recruited to provide care as live-in or illegalised domestic workers. Against an often-unquestioned methodological familialism and methodological nationalism in current care debates, a research agenda is proposed, which methodologically and conceptually decentres the family and the nation as the dominant formations through which care relations are institutionalised.

Keywords: COVID-19, Germany, familialism, nationalism, care relations, social reproduction.

1. Introduction

Over the last ten years and especially since the onset of the COVID-19 pandemic, debates on care have received an immense increase in attention from

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Historical Social Research 46 (2021) 4, 72-99 │ published by GESIS
DOI: 10.12759/hsr.46.2021.4.72-99

science, politics, and the public. While studying care work and the social organisation of care was a niche feminist theory topic for much of the 20th century, it has recently become a cross-cutting issue in the social sciences and humanities.

However, this mainstreaming of care risks losing fundamental critical perspectives on how dominant care *relations* are hierarchically structured – globally and intersectionally – and to what extent these relations are principally constituted and shaped by institutions such as the family and the nation (state).[1] Accordingly, this text follows a double agenda that, first, critically investigates the COVID-19 care situation in Germany between March 2020 to June 2021 and, secondly, takes a specific perspective on care relations in order to evaluate this conceptual lens. We illustrate this twofold objective by introducing Germany's pandemic care situation from an intersectional and transnational perspective on the care relations that are institutionalised in and through the family and the nation state. We aim to discuss how politics (of care) can critically engage with a pandemic state within which the family or the private household – as well as the notion of a nationally formed welfare state that protects "its" vulnerable national population – receive an enormous revaluation and are thus re-enacted and stabilised as central care instances. In the following introductory section, we first show the focal points we observed in the pandemic care debate and then briefly introduce our conceptualisations of *care familialism* and *care nationalism*.

1.1 Current Focal Points in the Debate about Care During the COVID-19 Pandemic

It is clear that the current "discursive explosions of care" (Chatzidakis et al. 2020, 889) do not only arise from the broad and diverse feminist thematisations of care, but also from the growing realisation by state and social actors that current welfare–capitalist care regimes are in a crisis for which no structural and sustainable answers exist beyond provisional "care fixes" (yet; Dowling 2021; Aulenbacher, Riegraf, and Theobald 2014, 14).[2] This increasing awareness of a crisis of care in the Global North prepared the discursive ground for how the 2020 "coronavirus crisis" could quickly be interpreted by scholars, media, and activists as further evidence of a general "care crisis."

[1] In this article, the term care relations means structural social relations in contrast to interpersonal relationships.

[2] We refer to Emma Dowling's concept of "care fix" to address "the way that care is being reorganised in the face of both an economic and a care crisis. […]– whether it be in families, partnerships, friendships, neighbourhoods and communities, by a [welfare] state, or through the market in commodified forms. A care fix entails the management of the care crisis in ways that resolve nothing definitively, but merely displace the crisis, thereby perpetuating the structural reflex of capitalist economies to offload the cost of care to unpaid sectors of societies" (Dowling 2021, 15).

This framing is exemplified in the manifesto by the UK-based *Care Collective*, which states,

> The current crisis is not only the result of a new pathogen circulating around the world. It is also a crisis of care, the result of decades of neoliberal policies prioritizing profit over people. Years of austerity measures, deregulation and privatisation, alongside the devaluing of care work has meant that neoliberal nation states [...] are unable to cope with the spread of coronavirus. (The Care Collective 2020)

Because the COVID-19 pandemic is acutely with health and survival, many care researchers see it as an exceptional opportunity to promote societal care awareness. For example, Fine and Tronto (2020) comment, "care goes viral" and "has 'come out,'" while Chatzidakis et al. (2020) declare it as the "buzzword of the moment," because "who doesn't care, in the midst of a global pandemic, when acts of carelessness – literally – costs tens of thousands of lives?" The care debate was undeniably given greater impetus during the COVID-19 pandemic than in previous years. However, which topics and problems do researchers, the media, and politics elucidate when they discuss care and reconstruct the COVID-19 crisis as a crisis of care? What ideas and solutions do they propose to overcome the care crisis?

Two (partly overlapping) perspectives on care have dominated the German academic debates since the pandemic's onset: The first perspective problematises the high burden experienced by people with household care responsibilities and focusses on households with (small) children and on the incompatibility between wage labour and care work. Accordingly, this perspective highlighted the gendered distribution of care work within the household as well as between the household and the state/society. For example, Gabriele Winker (2020) states that during the COVID-19 crisis, health care workers and doctors rightly received a lot of attention and appreciation for their work. However, she criticises that

> Those who hardly receive any support are the people who take care of other people at home, in their families. On the contrary. Except for 'essential' workers, parents, especially mothers, currently have to pursue their careers in the home office and, in addition, individually provide all-day care for their children. So, they are also expected to be good teachers, housekeepers and comforters. So, mothers feel even more left alone than is the case in normal times. (Winker 2020)[3]

Many commentators worry that improvements made to gender equality over the last few decades could be reversed during the pandemic. Exemplary for these positions are Jutta Allmendinger's (2021) warnings of a "retraditionalisation" of the gendered division of labour and a reinforcement of gender relation inequalities. Likewise, she asserts that mothers are the "big losers" during the pandemic (ibid.).

[3] This and further translations from German by the authors.

The second perspective is rooted in a broader concept of care that both *describes* a certain form of work, but also *becomes* a normative leitmotif that is central to how the COVID-19 pandemic is addressed (Kunstmann 2020). From this perspective the COVID-19 crisis dramatically exposed the general carelessness of capitalist societies; the advocates demand that society and economy should be need-oriented rather than profit-oriented. One outcome should be increased investments in public healthcare and (vital) care services and supporting people wherever they take responsibility for each other and their environment. This care–ethical perspective views interdependence, vulnerability, and relationality as inescapable conditions of life and society and criticises how they are denied by masculinist fictions of autonomy and invulnerability. A key element of care–ethical approaches is their decidedly affirmative and somewhat romanticised reference to caring as a meaningful, harmonious activity that anticipates the utopia of a need-centred society. This differs from 1970s feminist–Marxist debates that acknowledged the social necessity of certain forms of care work but did not idealise them ethically nor consider expanding them. Certainly, it should be emphasised against simplification that authors frame these two care-political narratives in many different theoretical and political ways. For example, Winker's (2011) radical "care revolution" hardly resembles Allmendinger's realpolitik perspectives as a governmental advisor. Likewise, there is a diversity in how care–ethical concepts are integrated into different theoretical approaches and literature – whether into politico–ethical posthumanism, Marxist–feminist perspectives, or practical policy demands. Nevertheless, within the context of the COVID-19 pandemic, certain focal points and economies of attention characterise these two narratives: The first narrative mostly takes the family and private household for granted and places a strong emphasis on the home office and the gendered division of labour within it. In the second, the care–ethical narrative, prioritising the family somehow becomes decentred in favour of diffusing care into sociality (and society–nature relations) as a whole. However, this often remains abstract or leads to the (often idealised) concept of communitarian relationships without adequately addressing the institutionalised relations between community, public-state, private, and transnational dimensions of care. Moreover, as we will argue in this article, both perspectives often tacitly presuppose the nation-state formation and regulation of care, instead of acknowledging its systemic, violent dimensions of gendered, racist, and classed-related inclusions and exclusions. Furthermore, they fail to account for its world-systemic embeddedness in structures of global capitalist and extractivist exploitation. For example, *The Care Collective* (2020) calls for a "caring state" and a "caring economy," but does not explain which systemic transformations of the nationally formed capitalist welfare state this implies, especially in a current contemporary context that is characterised by the

tension of a re-nationalisation and geopolitical regionalisation of the social in Europe.

1.2 Care Familialism and Care Nationalism: Conceptual Remarks

In light of these observations, we propose developing a more institution-critical analysis of care in times of the pandemic, which adopts a perspective that critiques methodological familialism and nationalism – both of which are core features of the current pandemic state of care in Germany and elsewhere, as analysed in other contributions to this HSR Forum, notably the articles on Greece (Markantonatou 2021), Turkey (Akkan 2021) and Austria (Dursun, Kettner and Sauer 2021). By doing so, we aim to critically examine the central dimensions of the care crisis and the attempts to "fix" it during the COVID-19 pandemic. Our approach does not assume that "care" always entails a given amount of labour that merely requires a different form of distribution, nor does it affirmatively frame it as a relational modality that can be infinitely expanded. Instead, we demonstrate the extent to which care in welfare capitalism is – already – always – constituted and shaped by institutions as well as structural relations that are inherently exclusive and hierarchical. In our opinion, these dimensions of care relations have not been sufficiently taken into account.

This article focuses on illustrating some dimensions of care from Germany's COVID-19 pandemic policy in order to explore how *care familialism* and *care nationalism* structure contemporary care relations: Who is cared for and who is not? Who has to care and who does not? How is care provided? Regarding care familialism, we draw on critiques of familialism (Dalla Costa and James 1975; Notz 2016) and challenge the methodological familialism from the care debate that treats the family (whether the heteronormative nuclear family or more diverse constellations) as the central and unchallenged form of sociality, cohabitation, and interpersonal responsibility. Hence, the fusion of family and private household into a socio–affective–economic unit in bourgeois society is not scrutinised as an effect of certain social conditions. Rather, it tends to be considered a given fact or anthropologised as a self-evident need within human coexistence. Thus, critiquing care familialism enables analysing and questioning the enormous affective charge of the isolated "home" as a protected/protecting space in the pandemic and decentring our analysis in an anti-familialist manner. In this way it highlights the care needs of those who are not familialised (or not in a socially conformative manner) instead of making them invisible. At best, a familialist perspective only regards such groups in an additive way, as specific exceptions from the norm; for example, single parents, childless singles, people who do not organise their relationships via cohabitation, people experiencing homelessness or living in congregate settings like camps and institutions, or (migrant) care

workers – who are often acknowledged as care*givers* but rarely as care *receivers*.

Building on the concept of care nationalism, our critique of "methodological nationalism" (Wimmer and Glick Schiller 2003) examines, first, the extent to which the care debate implicitly presupposes references to a nation-state, society, and population constituted as "national." Secondly, we focus on how much the idea of the nation has been affectively charged and strengthened anew during the COVID-19 pandemic – as an entity that is thought to be affected by the pandemic, but also mobilised to take responsibility for the care of its "own citizens." This has manifold implications for increasing inequality in *glocal,* i.e., simultaneously local and transnational, relations of care. Existing theoretical concepts that address these implications include "care racism" (Sager and Mulinari 2018), "quarantine nationalism" (Mitropoulos 2020a, 2020b), and "vaccine imperialism" (Vanni 2021). Other examples include different analyses of pandemic-related political manifestations of bio- or necropolitics, especially those that focus on global social inequality, migration regimes, and racism (Mbembe 2020; Thompson 2020). In the care debate, however, these systemic effects of the capitalist national welfare state are often not made explicit or remain diffuse. The next two sections illustrate the topicality and impact of care familialism (section 2) and care nationalism (section 3) in German pandemic politics by reconstructing and clarifying some of their key dimensions. In conclusion, we propose ways to incorporate both perspectives into analysis and draw some analytical and political conclusions about the care debate.

2. Care Familialism: The Recentring of the Family "Home" in the Pandemic State

Since the beginning of the COVID-19 pandemic, different lockdown variants have shaped the reorganisation of public and private life in Germany. Few other private institutions have received the same degree of public attention as much as the family household. For example, a joint publication by German Institute for Economic Research, the Scientific Advisory Council of the Ministry of Family Affairs, and the *Frankfurter Allgemeine Zeitung* stated that "Coronavirus has not only shown how important family can be for cohesion in private life, but also for cohesion in society" (Spieß, Deckers, and Fegert 2021). Recently, a resurgence of state familialism in capitalist welfare regimes has received renewed attention from research (Cooper 2017; Notz 2016). In the context of the rise of austerity policies that followed the 2007–2008 financial crisis, many European countries placed the family (again) at the forefront of welfare production to absorb social risks such as unemployment, illness,

and debt (Léon and Pavolini 2014; Papadopoulos and Roumpakis 2020). Because the German federal government used its position of economic power to prevent insolvencies and unemployment on a larger scale through labour market policy and fiscal measures, these familialist effects were less strong in Germany after the financial crisis. However, the ongoing COVD-19 crisis has engendered a stronger recentring and responsibilisation of the private family household in Germany, too.

The prioritisation and (often tacit) presupposition of middle-class family and private household models not only manifest themselves in state strategies of containment (in calls for "social distancing" and to "stay home," as much as in obligations to compensate for income losses and failing public infrastructures in the family). These models are also reproduced by the media, civil society actors, and – as *methodological familialism* – by segments of gender and care research. In this regard, the following explores the complex, somewhat paradoxical and inequality-exacerbating implications of care familialism during the COVID-19 crisis along the three dimensions: lockdown politics familialism (2.1); the intersectionality of "stay home" and the familialisation of solidarity (2.2); and the reorganisation of care during the pandemic crisis (2.3).

2.1 Lockdown Politics Familialism

Internationally, Germany has had one of the longest lockdown phases to date; aside from a four-month break during the summer of 2020, the country's public and social life was impacted by far-reaching contact restriction measures and state-imposed reductions to social life outside of the workplace and the home from May 2020 to May 2021. The German pandemic state's care familialism is articulated in the interweaving of three central lockdown measures: First, a rigid restriction of contact in the private sphere; second, the closure or severe restriction of public facilities such as day-care and schools; third, labour and social policy instruments that enabled a larger (selected) group of waged workers to stay at home, where they were responsible for compensating for the loss of public and commodified care work.

Since the onset of the COVID-19 pandemic, a characteristic of German contact restriction measures has been that most of the economy – from industrial production to logistics to call centres – was not affected. Instead, the measures were unilaterally aimed at the leisure sectors, including the hospitality sector, cultural institutions, non-essential retail, and private gatherings at home and outdoors. This one-sidedness was not only highly inconsistent, but publicly contested. Less problematised in the public debate, however, was that contact restrictions were repeatedly interpreted in an implicitly – or even explicitly – familialist way. On the one hand, "members of a household" with whom contact remained unrestricted often simply became "family

members" in the media debate and political communication (Müssig and Goetzke 2020). On the other hand, an explicitly familialist bias was frequently implemented in Germany's lockdown regulations. For example, the strict indoor contact restrictions were greatly relaxed for Christmas 2020, but only for the "closest family circle." This reinforced the family image but excluded single people and non-kinship constellations of attachment and responsibility (Fangerau and Griemert 2020, 6) as well as people who are not Christian/do not celebrate Christmas.[4] The only exception was the state of Berlin, which did not follow this double standard during Christmas, instead allowing gatherings of up to five people regardless of kinship for this particular event. At other times, however, Berlin also distinguished between family and non-family (Martinez Mateo 2020). In this case though, "family" was interpreted flexibly to allow for members outside of the traditional nuclear family to celebrate Christmas together, since it included all people with care obligations towards partners and children – regardless of how many households the participants were distributed between. Nevertheless, even when flexibilised, a discriminatory and epidemiologically unfounded double standard of distinguishing between family and non-family remained a central, basic assumption of the pandemic state. It is therefore unsurprising that this reinforcement of care familialism in Germany, as in other countries, has been particularly problematised by the queer community as well as care leavers. Members of these groups are more likely to be "survivors of – and refugees from – the nuclear household" (Lewis 2020) and often have a community-based approach to how they organise their care relationships that cuts across the family household. This "includ[es] the friendship networks and the alternative modes of community and kin-making that can form in and around bars, clubs and other spaces" (Trott 2020, 88). Prioritising the private family household while shutting down alternate community spaces takes care rights and care resources away from people who do not conform to nor benefit from the family lifeform.

2.2 The Intersectionality of "Stay Home!" and the Familialisation of Solidarity

From the pandemic's onset, the ubiquitous call to "stay home" coincided with the appeal to isolate oneself as a household community. As a place of retreat, the private household – framed implicitly or explicitly in familialist terms – became the cornerstone of pandemic response. This assumes that the "home" is "the one place we can retreat to for some semblance of safety, a

[4] The normative prioritisation of traditional families contrasts with empirical reality: While single-person households are currently the majority in Germany, only slightly more than every fourth household is a traditional family household, defined as a parent–child community (see Bundeszentrale für politische Bildung 2021).

place where we can control who comes and goes and so fully practice social distancing" (Byrne 2020, 351). The paradox of social distancing is not only its fictionalised connotation of home and family as functional, crisis-proof, and caring institutions that simply do not exist as such for many people. Rather, it is also paradoxical that "stay home!" implies isolating from society in favour of individualised risk management. However, in the context of the COVID-19 pandemic, this isolated individualism is simultaneously framed as an act of solidarity and social cohesion. Nevertheless, the question if (and which) forms of physical distancing are articulated as "practices of collective responsibility and solidarity and not as a suspension of sociality" (Sotiris 2020, 19) depends on several factors that are not adequately addressed by a mere ethos of individualised distancing under state control. First, the material and social conditions that enable social distancing and (extensive) self-isolation require examination: Who do they enable (and who they do not)? What (economic, social, and health) costs do social distancing and isolation in the home create, and at whose expense?

"Stay home!" as a purported sign of solidarity is itself configured by structural conditions, which are rooted in a lack of solidarity that the pandemic state of care actively shapes and regulates. At the international level, the actions by the German state during the COVID-19 crisis were often characterised as "generous" (e.g., Bariola and Collins 2021). This was particularly in reference to the provision of short-time work allowances for 10 million employees, which the German government enacted to prevent mass layoffs. However, the measure's "base income" of 60% of regular take-home pay is the lowest within the EU, and reinforces the existing gender pay gap (Cook and Grimshaw 2020). Even when increased to 80% of regular take-home pay – which employees receive after eight weeks of short-time work – this amount does not fully cover living costs for members of lower income groups. Unlike many other European countries, Germany did not set a minimum rate for short-time allowance based on the national minimum wage (ibid.). Moreover, many women and migrants are marginally employed (salary less than €450 per month) or work in the informal sector, giving them no legal claim to any short-time allowance. The same exclusion applies to millions of freelancers who are not entitled to short-time allowance in Germany, and of whom two million were near over-indebtedness by the end of 2020.[5] In short, while short-time allowances enabled the middle and higher income groups to "stay home" without facing greater financial burdens, the lower income groups and high numbers of informal or self-employed workers without financial reserves experienced a much higher degree of COVID-19-related financial hardship from income or job losses (Datenreport 2021, 479, 493ff.).

[5] Nicole Kohnert, "Millionen Freiberuflern droht Überschuldung," *Tagesschau*, November 10, 2020. https://www.tagesschau.de/wirtschaft/schulden-coronakrise-deutschland-101.html.

In addition, lower income groups – single women more than couples, migrants more than non-migrants – are significantly restricted in their ability to stay home from work, whether by reducing overtime, taking leave days, changing their working hours, or by shifting work to the home office (ibid., 482f.). Because normative couple households (in particular those where one or both partners could "do home office" while simultaneously providing childcare) arguably received the greatest public attention during the COVID-19 crisis, this distorted how home office – as a job- and health-protecting measure – was only available to 26.2% of Germany's employees during the first lockdown, while 57% continued to work on-site (ibid., 480). People in higher income and educational groups were more than three times as likely to switch to the home office as members of lower income and educational groups.[6] Likewise, they were much less likely to be affected by short-time work and income reduction and were better protected against infection – a class-selective dimension of differential care policy.

However, this differential materialisation of the household as a protected site during the COVID-19 crisis only represents one dimension of care familialism. As a social relation, the latter is contradictorily shaped by overlapping structural power relations. Therefore, responsibilising the privatised family household as *the* caring unit in times of crisis can be highly problematic even for persons who have access to it in everyday life: The private household is the main site for forms of violence like sexual violence, domestic and partnership violence, violence against children, and against those in need of more intense care like the elderly, the ill, and the disabled. For women, queers, and children, the family is already the most insecure place in society in regular times; during the pandemic crisis, financial insecurities, job loss, often-cramped living conditions, and a lack of alternative spaces contributed to a significant increase in cases of domestic and sexual violence against women and children in Germany (Steinert and Ebert 2020). However, the strong moralisation of social distancing in public discourse on "stay home!" was mainly directed at the individual behavioural level, while the structurally and intersectionally unequal conditions for staying at home were not systematically taken into account in the fight against the pandemic.[7]

[6] Among those who switched to home office, 41% had formal post-secondary qualifications compared to 13% who had low or no formal educational qualifications (Datenreport 2021, 479).

[7] See also Karsten Schubert's (2020) critique of a "crying for repression" and the rise of an authoritarian "populist biopolitics" during the first lockdown in Germany, which helped framing the problem of (non-)adherence to the regulations predominantly in terms of individualised behaviour. The moralising discourse was especially harsh on social media, where *stay home* quickly became *#staythefuckhome*. See also the "Self-Quarantine Manifesto" on https://staythefuckhome.com (Accessed November 17, 2021).

2.3 Beyond the Gender Care Gap: De-centring Care in the Pandemic

Paradoxically, recentering the family as a privatised care-unit is being promoted at a time when the ideal of "the self-contained household or self-sufficient working family" (Hester 2021) is clearly a misrepresentation of reality. Its social reproduction requires millions of people to perform a high degree of extra-familial reproductive labour and state-institutional support.[8] This predominantly applies to women, among whom migrants are overrepresented. They form the often-precarious "caring classes" (Graeber 2019) on whose exploitation the adult-worker society is based. From a social reproduction perspective, family households are "not-so-nuclear" (Hansen 2005), but rather an element in a complex, increasingly transnational "patchwork-system of social reproduction" (Salzinger 2021, 8), permeated by relations of class and exploitation. After closing public care facilities, especially day care facilities and schools (including meal provision), as well as restricting services (including social and sexual services), those infrastructures of care to which many – especially higher-income – family households externalise a large share of care work were unavailable or severely restricted during the lockdowns. Therefore, care work in the household became more concentrated and intensive, especially for larger families, single parents, and relatives providing informal care. The reorganisation of private and public during the pandemic also had negative effects on many other social groups; for example, during the shutdown, paid care workers were confronted with a disproportionately high amount of income loss and job losses (see section 3); single elderly people in nursing homes or living alone in their own homes were isolated from the outside world for long periods of time with negative mental health consequences; violence against children and adolescents was overlooked more than usual due to the loss of contact with educators, teachers, and social workers. Likewise, single parents who could not switch to home office, and who were not entitled to an emergency place in day-care centres and schools, had to resort to temporary sick-leave or claiming loss-of-earnings compensation worth only 67 percent of their regular income.[9]

Within the general picture of recent German family policies, this rate corresponds to the rate of the 67 percent "parental benefit" rate, which Germany introduced in 2007 to replace its "child-raising allowance," and a centrepiece of Germany's most recent family policy reforms. By linking it to previously

[8] This is especially true for so called adult-worker societies where the female workforce was mobilised for the growing service sector through social and labour market policies since the early 1990s.

[9] The measure, which is limited to 20 weeks, was introduced during the COVID-19 pandemic. For more information see: "Corona-Krise: Welche Hilfen es jetzt für Alleinerziehende gibt," Verband alleinerziehender Mütter und Väter. https://www.vamv.de/faqs-zur-corona-pandemie-1/welche-hilfen-gibt-es-fuer-alleinerziehende (Accessed November 12, 2021).

earned and excluding the unemployed as well as migrant parents holding certain types of residence status, it represents a deterioration compared to previous regulations, especially for people experiencing poverty, while ultimately favouring German middle- and high-income parents. The reform also aimed to increase middle-class birth rates, while institutionally counteracting childbearing in lower income households (Schultz and Kyere 2020). In the attention economy of the pandemic, this class-selective (and institutionally racist) character of current German family policy was prolonged by centring on the white, heteronormative, two-earner household working at the home office (e.g., Allmendinger 2021; Zucco and Lott 2021). This formation generally benefits more from German family policy than other household arrangements, while it positively and disproportionally correlated with material and health security privileges during the pandemic that are denied to most families. While the German COVID-19 lockdown clearly had negative impacts on most family households, including the higher income groups, the emphasis on work–family compatibility in middle-class family households systematically obscures structural inequalities and disadvantages between different household and family constellations, as also addressed in debates on reproductive justice (e.g., Ross 2017). Here, a multidimensional critique of care familialism shows that current care relations must be analysed in a way that goes far beyond the gendered division of care work in the household. Instead, we advocate de-centring the middle-class family household within the care debate in favour of a broader framework that accounts for the described patchwork system of social reproduction and its multiple forms of inequality and exploitation. The COVID-19 pandemic pointedly shows that state care familialism is a regulative through which resources and life chances are unequally distributed, which directly impacts health and survival. Care debates must address the fundamentally ambivalent structure of care familialism more thoroughly; in times of crisis, retreating to the private sphere and falling back on family solidarity represents a resource and place of refuge for some, but is a form of forced isolation accompanied by experiences of violence and dependencies for others. Furthermore, others have no access to the idealised, heteronormative (family) home – or any other form at all – that would ensure solidarity and care in difficult times. This final dimension of care familialism directly links to other state mechanisms of selective care, which form part of what we term *care nationalism*.

3. Care Nationalism: *Glocal* Effects of a (Re-)staged and Institutionalised Pandemic Care Community

Looking at national formations of care and examining how care relations are both locally situated and transnationally connected and structured sheds light on further dimensions of Germany's pandemic state of care. These glocal care relations are currently being reproduced, but also reconfigured, within and through nationalism. This section explores five dimensions of German care nationalism: The epistemic foundation of an epidemiological nationalism (3.1); the politics of population segregation and border closure policies based upon it (3.2); the stigmatisation and exclusion of *Others,* who are constructed as dangerous and contagious and are either less or not worthy of care (3.3); the utilitarian ad-hoc mobilisation of migrant care and essential workers (3.4); the unequal health and socio-economic impacts of the pandemic or pandemic state policy, which care-nationalist narratives make invisible – or even attribute to the responsibility of the affected groups themselves (3.5).

3.1 Epidemiological Nationalism as a Foundational Epistemic Arrangement

The epistemic basis of care nationalism during pandemics is a largely unquestioned, nationally formed production of knowledge about pandemic events. This is the outcome of a general methodological nationalism carried out through statistical–epidemiological population registration and research, and the disease events associated with them (Mitropoulos 2020a, 2020b).[10] This is associated with a strong political and media focus on how national figures on positive cases, vaccinations, intensive care patients, and deaths compare internationally, as well as how national capacities for mask stocks, intensive care beds, testing, and vaccine capacities progress. Publicly, COVID-19 thus emerged as an issue of a nationally framed contagion on the one hand and of available national health resources (or, in the case of vaccines, EU resources) on the other, which favoured national–egoistic reflexes from the pandemic's onset. For example, in March 2020, the German government temporarily banned the export of protective clothing and medical material, and even prohibited parcel deliveries from private individuals to the crisis area in Northern Italy.[11] Meanwhile, the effects of Germany's post-financial crisis

[10] This epidemiological nationalism has further developed in the sense that globally circulating COVID-19 "variants of concern" are linked to their national origins.

[11] Nico Schmidt and Paulo Pena, "Wie die EU in der Coronakrise versagt," *Der Tagesspiegel*, March 23, 2020, https://www.tagesspiegel.de/politik/widerspruechlicher-umgang-mit-dem-virus-wie-die-eu-in-der-coronakrise-versagt/25672594.html.

austerity policy, which was decisively pushed through by the Merkel government – and prompted the dismantling of public healthcare in the most-affected European countries at the time – remained largely forgotten in public debate (Passadakis 2020). Few NGOs expressed outrage at the German government for mercilessly promoting "vaccine imperialism" (Vanni 2021) at the international level, showing no support for emergency initiatives like the *Trips Waiver Programme* to temporarily suspend international patent protection for vaccines.[12] If health policy nationalism was critically discussed at all, it was only regarding the pros and cons of an EU-centric procurement policy versus a nationalist one.

3.2 Institutionalisation of the Border Regime. Policies of Closure and Epidemically Intensified Carelessness

The institutional tightening of the European and increasingly nationally organised border regime is based on this epistemic foundation, as depicted above. From the pandemic's onset, these institutional restrictions were accompanied by national demographic segregation that made blatantly clear whose life should be protected, developing along the constructed line between the national population and "foreign" risk populations towards whose lives nationalist carelessness was legitimised. This segregationist isolationist policy contradicted evidence that mobility restrictions and border closures prove largely ineffective – and even counterproductive – to combatting pandemics (WHO 2020). In Germany, the idea of a national population that should be protected against infection from outside was not only accompanied by territorial closure, but also by an attempt to segregate the population according to citizenship. On the one hand, the government immediately invested in a repatriation campaign for 160,000 German citizens abroad.[13] On the other hand, nationally organised travel restriction and border control policies became increasingly common (Manolova and Lottholz 2021, 4). Even EU citizens were arbitrarily turned away at German airports if they could not provide "essential" reasons for travelling (Manolova and Lottholz 2021). Hence, this pandemically intensified border regime has multiple negative implications for the care relationships of transnationally networked families and friendships, as well as refugees, migrant workers, and other people dependent on international mobility. The crisis that trapped tens of thousands of refugees on Greek island camps under extremely precarious conditions symbolised the continuous carelessness of the inner-European isolation policy.

[12] Julia Borger and Patrick Wintour, "US-Germany rift as Berlin opposes plan to ditch Covid vaccine patents," *The Guardian*, May 6, 2021, https://www.theguardian.com/world/2021/may/06/us-germany-rift-covid-vaccine-patent-waivers.

[13] Even travelling non-German citizens with stable residency status in Germany faced difficulties being included in these return operations: Ute Schleiermacher, "Gestrandet in Kamerun," *taz*, July 28, 2021, https://taz.de/Coronabedingter-Aufenthalt/!5699197.

Despite civil society protests, pandemic nationalism encouraged the German government to adhere to this Dublin regime policy, which they were largely responsible for establishing.[14] Ultimately, focussing on the national "community of common destiny" coincided with an even more open renouncement of humanitarian principles of migration policy. This reflects an escalation of the Mediterranean "leave-to-die" policy[15] and (German) EU Commission President von der Leyen's ability to push forward a migration policy based on externalisation strategies.[16] Moreover, despite the ongoing pandemic, the German government continued to arrange deportation flights to countries for which the Foreign Office had issued urgent travel warnings, whether because of COVID-19 infection risks or the general security situation – with little public protest.[17]

Although these are not new occurrences, pandemic care nationalism has introduced new mechanisms of legitimisation for national and EU border regimes and produced new mechanisms of exclusion. This includes confining people who test positive to quarantine ships off Italy (Tazzioli and Stierl 2021) and new technologies of biopolitical border surveillance, the long-term effects of which are still unclear (Naceur 2020). Likewise, pandemic care nationalism has given rise to new forms of racist stigmatisation towards supposedly "dangerous" travellers. In May 2021, for example, Health Minister Spahn made the statistically unsubstantiated claim that family visits by people returning to Germany from Turkey and the Balkans were responsible for 50 percent of new COVID-19 infections in the summer of 2020.[18]

[14] Despite Germany's pledges after the Moria camp fire, only 150 underage refugees were admitted to the country by the end of 2020, and an additional 150 refugees who were already recognised as eligible for protection (see the statement by the German government: Deutscher Bundestag, Drucksache 19/25072, December 9, 2021, https://dserver.bundestag.de/btd/19/250/1925072.pdf).

[15] Keywords: pushbacks, cooperation with Libyan paramilitaries, and the denial and criminalisation of sea rescue. Naceur 2020 and regular reports by Alarmphone: https://alarmphone.org/en/ (Accessed November 12, 2021).

[16] The 2020 EU Migration Pact provides for faster asylum decisions and deportations as well as European cooperation in "return sponsorships" (Krampe 2020).

[17] For example, Germany deported 10,800 people on flights to Pakistan in 2020 (Pro Asyl 2020; see also: Mediendienst Integration, "Abschiebungen und freiwillige Ausreisen." https://mediendienst-integration.de/migration/flucht-asyl/abschiebungen.html (Accessed November 13, 2021).

[18] Tim Vincent Dicke and Matthis Pechtold, "Viele Corona-Neuinfektionen wegen Migrant:innen? Scharfe Kritik an Jens Spahn," *Frankfurter Rundschau*, May 25, 2021, https://www.fr.de/politik/corona-jens-spahn-inzidenz-deutschland-sommer-2021-lockerungen-coronavirus-pandemie-90657697.html.

3.3 Internal Separation: Collective Quarantine and Continuous Mass Confinement

Protecting "one's own population" from certain "contagious" groups – who are defined along racist and class–hierarchical attributes as not belonging to the national community – indicates another feature of care nationalism that works inwards. Not only do programmes of collective quarantine and the maintenance of forms of mass accommodation fail to protect those affected, they actually increase their health risks (Mitropoulos 2020a, 2020b), as by congregate housing for refugees.[19] For example, "collective quarantines" were enforced at 71 percent of 42 examined facilities at the beginning of the pandemic (Bozorgmehr et al. 2020), which was described as

> a blanket restriction on movement of all persons due to their collective accommodation, regardless of the result of any individual test results, and without a targeted identification of close contacts. This means that contact and curfew restrictions were imposed on all 7,295 residents of these facilities. [...] In some cases, additional fences were erected and compliance with the quarantine was monitored by police forces, private security firms, the German armed forces or helicopter missions. (ibid., 3)

Epidemiologically, this form of collective quarantine proved to be doubly unsuitable for the investigated facilities: Internally, residents were not protected but rather exposed to an increased infection risk. Externally, no health benefit for the population outside the facility could be determined (ibid., 4). However, from March to May 2020 the cramped living conditions in such facilities contributed to 2.5% of all infection outbreaks in Germany, which corresponded to a tenfold higher risk of infection compared to the overall population (ibid.; Hayward et al. 2020). Nevertheless, all attempts to implement decentralised accommodations for asylum seekers were rejected at the federal level by the governing parties.[20] Other examples of collective quarantine included the complete cordoning off of an entire block of flats in Göttingen, which had long been stigmatised as a "troubled area." In total, 700 residents were forbidden from leaving the housing complex, which was barricaded with construction fences.[21] In the public discourse, the residents were accused of not having adhered to pandemic regulations.[22]

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[19] Other examples include shelters for homeless people, prisons, and detention centres.

[20] See, for example, the motion by the German Left Party: Deutscher Bundestag, Drucksache 19/24364, November 17, 2020, https://dip21.bundestag.de/dip21/btd/19/243/1924364.pdf.

[21] Gunner Hinck, "Flucht, Ohnmacht, Sucht. *taz*, June 22, 2020, https://taz.de/Abgeriegeltes-Mietshaus-in-Goettingen/!5690909/.

[22] For resident rebuttals, see Paul Reimer, "Wie kam es zum Corona Ausbruch?" *Neues Deutschland*, June 7, 2020, https://www.nd-aktuell.de/artikel/1137586.corona-in-deutschland-wie-kam-es-zum-corona-ausbruch.html.

3.4 The Utilitarian and Non-caring, Ad-hoc Mobilisation of Migrant Care and Essential Workers

A fourth dimension of care nationalism is that national border controls and closures were withdrawn or readjusted on an ad-hoc basis for certain migrant groups when the provision of supplies or care for the country's "own" population was in jeopardy. However, this was done without considering the care and health situations of those migrant groups. Border closures interrupted European commuter migration and impeded access to the migrant labour force in construction, agriculture, and meat processing as well as domestic care – especially from Central and Eastern European EU states. In one case, entry restrictions were revoked to guarantee the German asparagus harvest, which is symbolic of German cuisine; however, workers were forced to remain isolated from the local population and were mostly housed in collective accommodation ("work quarantine"). The pandemic state did not take into account their health, social, and care situations, let alone the exploitative relations that were structurally anchored in the migration regime or in intra-European social inequality (Birke 2020).[23]

A particularly telling example of care nationalism is how Germany addressed its impending shortage of mostly Eastern European, home-based elderly care workers in March 2020, which concerned up to 500,000 foreign nationals (Safuta and Noack 2020). Again, entry restrictions were lifted or eased (often informally) at the behest of employers (Leiblfinger et al. 2020). In addition, live-in care workers who were working in Germany at the time, and who usually alternated with other workers (every 2 to 12 weeks), were requested not to return, meaning those who were already in Germany often stayed in their clients' households for extended periods and were completely isolated (ibid.). However, the highly exploitative working conditions of live-in care (with pay based on specific contract models that falls far below the minimum wage) remained untouched in this crisis regulation mode.[24] Consequently, there was no concern over the possibility of Eastern European care workers becoming unemployed or that the workers who had to stay in Germany might not be able to care for their own families – at their home locations – as planned (ibid.).

[23] See also Mediendienst Integration, "Wo die meisten Arbeitskräfte fehlen," April 7, 2020, https://mediendienst-integration.de/artikel/wo-die-meisten-arbeitskraefte-fehlen.html.

[24] On June 24, 2021, the German Federal Labour Court ruled in favour of compliance with the statutory minimum wage for Eastern European care workers. It is not yet foreseeable whether and to what extent this will change the sector towards further illegalisation, better pay for a relevant part of the workforce, or whether semi-legal arrangements surrounding fraudulent self-employment and posted workers contracts will persist: Stefan Sell, "24-Stunden-Betreuung: Von einer unlösbaren Gleichung aus den Untiefen der deutschen Pflegepolitik bis hin zu einer scheinbaren Lösung aus Österreich," *Aktuelle Sozialpolitik (Blog)*, June 26, 2021, https://aktuelle-sozialpolitik.de/2021/06/26/24-stunden-betreuung-in-der-diskussion.

Within the framework of a pandemic care nationalism, regulatory intervention only takes place when the provision of care for "one's own" population becomes crisis-ridden. The shortcoming of this logic, which declares some work as "essential" for securing social reproduction while assuming other forms of work are (temporarily) expendable, manifests itself in the German federal government's neglect of another relevant care workforce: the hundreds of thousands of undocumented workers who often clean private households, look after children, or work at restaurants (Vogel and Cyrus 2018), and who have experienced the COVID-19 pandemic as a threat to their livelihood. Unlike Italy or Portugal, who quickly reacted to the pandemic with regularisation initiatives,[25] Germany did not establish any government initiatives to support illegalised people in a situation that confronted them with three types of threats: First, members of this group lose all means of subsistence if they do not work; second, they have no (or at best, extremely precarious) access to health care (Medibüro 2021); third, they are unable to meet their transnational care obligations during extreme crises in their regions of origin (e.g., via remittances).[26]

3.5 Intersectional Dimensions of Health and Socio-economic Inequality and Their Invisibilisation and Responsibilisation

The aforementioned dynamics of care nationalism promote, reinforce, and legitimise diverse intersectional effects of inequality as well as differential inclusion and exclusion during the COVID-19 pandemic. These are mediated by Germany's deep-rooted structural racism and its associated class relations as well as its gendered care relations (as intersectionally differentiated). In Germany the disease-causing or fatal consequences of COVID-19 and the socio-economic effects of pandemic politics are both distributed in a socially unequal manner, despite welfare policies and a relatively robust health system that is organised through statutory health insurance. However, migrants in Germany work more hours than average in positions where it is harder to prevent infection. This includes medical professions, nursing, and care for the elderly as well as cleaning, mail and parcel delivery, and food supply.[27]

[25] Platform for International Cooperation on Undocumented Migrants, "A taboo that isn't one?", PICUM Blog, July 1, 2020, https://picum.org/regularising-undocumented-people-in-response-to-the-covid-19-pandemic/.

[26] For further information, see http://www.respectberlin.org/wordpress/, https://legalisierungjetzt.net/ and https://mediendienst-integration.de/migration/irregulaere.html (Accessed November 12, 2021).

[27] See Mediendienst Integration, "Corona-Pandemie und Migration," https://mediendienst-integration.de/migration/corona-pandemie.html (Accessed November 12, 2021); cf. Hayward et al. 2020. According to the Mediendienst Integration (Migration Media Service), 20.2% of medical professionals and 16.2% of nursing staff were migrants (defined as not born in Germany) in 2020 (OECD 2020). Health care professionals showed the highest percentage of COVID-19 infections

Hence, this unequal distribution of risk requires further analysis through an intersectional lens. Most healthcare and elderly care workers are female (more than 80%), and more than 15% are older than 60 years (which is important, given the correlation between age and disease severity for COVID-19).[28] Besides more infectious working conditions, other circumstances compound the risk of infection; for example, dependence on public transport and, in particular, cramped living conditions, but also pre-existing health conditions or diseases.[29] Reliable nationwide surveys have not yet been conducted for Germany about the effects of structural racism during the pandemic. However, in Berlin, the three districts with the greatest COVID-19 incidences are those with the highest proportions of migrants and non-EU citizens – districts with basic housing, high population densities, little open space, and high unemployment rates.[30] Hence, pandemic activity is closely linked to the socio-economic effects of a pandemic policy that reinforces social inequality in Germany and is a phenomenon observed across the country contexts discussed in the other contributions to this HSR Forum.

Despite these multiple intersectional dimensions of health and social inequalities that have been amplified during COVID-19, care–nationalist narratives prevent a focus on these conditions, which is necessary to provide better care for distinctly affected social groups. Conversely, mainstream media and government representatives have repeatedly attempted (within the rehearsed framework of institutional racism) to accuse and responsibilise those affected. They made them responsible as "migrants" or residents of "troubled areas," as if they were outside the national care community. More or less implicitly, they explained the reasons for higher rates of infection or need for intensive care treatment in "behavioural" or "cultural" terms.[31]

In summary, the illustrated dimensions of care nationalism point to several dynamics that must be considered when analysing glocal and intersectional

during the first phase of the pandemic from March to May 2020 (Wissenschaftliches Institut der Allgemeinen Ortskrankenkasse 2020).

[28] Statisches Bundestamt, "Health Personnel," https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Gesundheitspersonal/_inhalt.html (Accessed November 12, 2021).

[29] Malte Kreutzfeldt and Heike Haarhoff, "Armut macht krank," *taz*, June 26, 2020, https://taz.de/Neue-Coronawelle-in-Deutschland/!5692783/.

[30] See Senatsverwaltung für Gesundheit, Pflege und Gleichstellung 2020. Moreover, unemployment and poverty correlate with a higher average distribution of previous illnesses that have a negative impact on the course of an infection with COVID-19 or increase the risk of a severe or even fatal course, see Mediendienst Integration, "Corona-Pandemie und Migration," https://mediendienst-integration.de/migration/corona-pandemie.html (Accessed November 12, 2021).

[31] For example, there was a regression to the racist discourse of the 2000s when Robert Koch Institute head Lothar Wieler publicly resorted to invoking "parallel societies" and thus insinuated that the prospect of unequal pandemic outcomes was related to a lack of "integration": Ümit Koşan, "Das Märchen von der Parallelgesellschaft," *Frankfurter Rundschau*, March 14, 2021, https://www.fr.de/meinung/gastbeitraege/das-maerchen-von-der-parallelgesellschaft-90241222.html.

care relations in the COVID-19 pandemic. There was an observable increase in the emphasis on caring for "one's own population" and a simultaneous increase in ignorance and carelessness towards the *Others*, who were stigmatised as contagious and dangerous. This manifests itself in the reinforcement of health nationalism or Europeanism, the mobilisation and reinforcement of sealed-off and biopolitically segregated border regimes, and also in the responsibilisation of these *Others* – while ignoring, or simply leaving unquestioned, and accepting more infectious working, accommodation/housing, and living conditions. Care nationalism also makes the embeddedness of local care relations within transnational care chains and structures of "care extractivism" invisible (Wichterich 2019), while imperial ways of life depend on transnational production chains and intensifying, destructive colonial–capitalist extractivism. At the same time, this embeddedness becomes selectively visible when care nationalism engenders various utilitarian ad-hoc mechanisms within its labour policy framework to secure access to migrant labour – without, however, caring about the caregivers' care situations.

4. Entanglements of Familialism and Nationalism: Towards a Critique of the Pandemic State of Care

> "Take care of you and your loved ones." (Merkel 2020)
>
> "Since the Second World War, there has been no challenge to our nation that has demanded such a degree of common and united action." (Merkel 2020)

German Chancellor Angela Merkel's first public speeches about the pandemic, which were characterised by an empathetic and rather non-authoritarian tenor, were not addressed to a general anonymous public, but appealed in a double sense to people as members of an affectionate community: as members of a caring circle of "loved ones" and, simultaneously, as members of a national community with a common destiny. Thus, Merkel's speeches reproduced and reaffirmed pandemic parochialism, i.e., a policy oriented towards solidarity with and protection of "one's own people." However, this parochial dimension of care has received sparse attention during the ongoing debates about care that have flourished during the COVID-19 pandemic.[32] Using examples from German pandemic policy, we have argued that the "we" and the "community" of the pandemic state of care are framed in both familialist and nationalist terms. As the contributions to this HSR

[32] Linnet Taylor (2020, 5), for example, overlooks these dimensions when she refers to Merkel's statement "we are a community in which every life and every person counts" as an example of "an ethics of care" overlooking the "we" and the "community" as a symbolic matrix of exclusion and hierarchisation.

Forum looking at Austria (Dursun, Kettner, and Sauer 2021) and Mali (Hasenöhrl 2021) show very clearly, the affective dimensions of governance are of considerable importance in pandemic management. So too in the German context that we are analysing here. Family and nation have each been remobilised and affectively charged as the central institutions of care and community that must be protected – and as the basic conditions for fighting the pandemic. In this sense, the German COVID-19 crisis management has further strengthened ongoing trends that were driven by multiple previous crises and a deepening social polarisation in welfare capitalist societies, wherein "the retreat to nationalism and domesticity [serves] as a prophylactic against economic redistribution and cultural dissent" (Eng, Halberstam, and Muñoz 2005, 2). While the public space, constructed as dangerous and now also contagious, has become the object of increased control, surveillance, and policing (Thompson 2020), the private sphere of the family, intimate relationships, and the household are presented as a safe haven to which everyone should retreat. Similarly, the nation has been ideologically constructed as a space to be protected, which must be sealed off even more so to avoid supposedly being invaded by infectious travellers and migrants as well as viruses and "mutants" supposedly from outside.

Whereas government policies and liberal public spheres typically harbour a more implicit methodological familialism and nationalism, extreme right-wing discourses make this connection between family and nation evident and explicit. For example, in a parliamentary speech, Honorary *Alternative für Deutschland* (AfD) President Alexander Gauland proclaimed of the pandemic, "in a crisis, people withdraw into solid, familiar structures. On a small scale, that means the family; on a large scale, it means the nation state" (quoted from Blum and Rahner 2021, 5). As Sager and Mulinari (2018) describe for the Swedish context, this double motif of right-wing care racism in the sense of care "for our own people" is not primarily mobilised by hate. Rather, notions of care and love for the family and the community are important affective dimensions, which also contextualise the family and nation far beyond the extreme right within the framework of care. In other words, in its predominant familialist and nationalist form, care becomes a constitutive practice of "home-making," which defines the "home" – both the literal home (household) and the nation – above and against those who are declared as having no part and not being worthy of it (Ferguson 2004, 2).

Even so, how does the pandemic state of care attempt to stabilise and reorganise care relations along family and nation lines, and how can its "care fixes" (Dowling 2021) be conceptualised? In care research, four forms of care fixes have been identified and discussed that can provide answers to the diagnosis of the "exhausted family" (Lutz 2012) in welfare capitalist, adult-worker societies: A (threatening) retraditionalisation of the gendered division of labour within the household; an increased recourse to voluntary and

informal work in/from the community; a recourse to care migration; the expansion of public care services. However, an analysis of care relations during the COVID-19 pandemic that does not presuppose the family and nation, but instead analytically decentres them, requires specifying and differentiating between these care fixes.[33] Moreover, they must be contextualised to give visibility to the intersectional and glocal dimensions of care relations.

For example, while retraditionalisation may seem evident to many family contexts, it is an unsuitable backdrop for the pandemic care division of labour in general. From the perspective of social exclusion, retraditionalisation as a term presupposes as normal the heteronormatively structured family household (and often even the German middle-class family home office arrangement) as both a given and the most vital point of reference or starting point for care research. Meanwhile, the care relationships of singles, single parents, paid care workers, transnational families, queers, and – even – often the many German families without the option to work from home are less scrutinised or completely omitted. By not reflecting upon how the family form in welfare capitalist societies reproduces and reinforces conditions of inequality and exploitation, such a central perspective risks supporting the pandemic hypostatisation of the family and the private household, albeit with a critique of intra-family hierarchies and inequalities.

Likewise, if care migration is only examined as (part of) the solution to the national care crisis, the fact that migrant care workers also have care needs, and should not only – nor primarily – be seen as care givers (as the hegemonic state of care in the pandemic suggests), is made invisible. Moreover, this narrow view of care migration as a "fix" for the care crisis (presupposed as national) risks reproducing methodological nationalism in critical perspectives as well, because for example, it diminishes how transnational care relations are structured by care chains and "care extractivism" (Wichterich 2019), or makes them appear external.

Furthermore, discussing public care services as a further care fix remains insufficient without a critique of the nation state, not only in retrospect of its specific characteristics, but as a defining moment of global care relations. It is quite possible – and this can be seen in the early stages of the German pandemic policy – that in the context of national mobilisation, public care services are indeed expanded and resources mobilised, encompassing everything from investments in infection control to investments in digitalised education and the renationalisation of outsourced "system-relevant" production sites. Only a critical analysis of the national form of this care fix can expose the necropolitical carelessness of the European and, during the COVID-19 pandemic, the renationalised border regime as the other side of a welfare

[33] We could also say – borrowing a term from decolonial critique of Eurocentrism – that the (bourgeois, heteronormative nuclear) family must be "provincialized": not to deny its efficacy, but to better comprehend it (Chakrabarty 2000).

regime that responsibilises, stigmatises, or even completely excludes the most vulnerable and affected population groups from the national care community. Appeals to expand public goods must therefore be examined from the outset in order to readjust and solidify global social rights, which can ensure that care research and politics do not stop at internal and external national borders.

Returning to the two currently dominant care perspectives outlined in the introduction, we have already so far introduced some necessary strategies for decentring and intersectionally revising the "retraditionalisation thesis." Regarding the second perspective – the care–ethical narrative – which strives to recognise the fundamental interdependency and vulnerability of human life and relations, our analysis of Germany's pandemic care fixes also reveals some analytical gaps. These concepts declare care as a normative leitmotif of sociality, which implies a critique of the hypostasis of the family as an isolated care unit. Concerning our analysis of the national structuring of care relations, however, the care–ethical perspective must be critically examined about when and to what extent it can be mobilised by the state or by right-wing actors in the sense of an exclusive solidarity as "care for our own." Moreover, care–affirmative ethics are sometimes unclear about what it means to declare "care as the basis for a new and better society" in the context of a world-systemic global inequality, as Helen Hester has rightly argued:

> Given the ways in which this allows (highly gendered) forms of work to proliferate in unacknowledged forms, and on account of the tendency to downplay the (sometimes profound) difficulties and dissatisfactions associated with this work. (Hester 2020)

A hypostatisation of interdependence and vulnerability as human conditions, which – especially during the COVID-19 pandemic – does not ask, in terms of global social rights, how vulnerabilities and dependencies can not only be recognised, but restructured, redistributed, and, in some respects, *reduced*, comes with particular high political risks as well. It will hardly be able to oppose (enough) the care nationalist and care familialist institutionalisations of care relations that we critically engaged with in this text.

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