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Covid-19 Crisis = Care Crisis? Changes in Care Provision and Care-Givers' Well-Being During the Covid-19 Pandemic

Ulrike Ehrlich and Daniela Klaus

6.1 Key Messages

The proportion of care-givers increased. In 2017, 16 per cent of all 46–90-year-olds provided care for family members, friends, or neighbours in need of support and care. This compared to 19 per cent during the first wave of the Covid-19 pandemic. This increase was mainly due to women, whose care-giver rate increased from 18 per cent to 22 per cent.

Care provision for neighbours increased significantly. The proportion of those providing care for neighbours increased from seven per cent (2017) to 17 per cent (2020). But the proportion of friend care-givers also increased from seven per cent (2017) to eleven per cent (2020). The most common care recipients in 2020 were still parents-(in-law) (55 per cent).

Care-givers' self-rated health declined slightly during the Covid-19 pandemic. Among care-givers, the proportion who rated their health as (very) good declined from 59 per cent to 56 per cent. However, this change was statistically non-significant. In contrast, non-care-givers rated their health as significantly better during the Covid-19 pandemic than before.

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Care-givers' mental well-being declined during the Covid-19 pandemic. The proportion of care-givers with depressive symptoms increased between 2017 (six per cent) and 2020 (15 per cent). The same was true for the proportion of care-givers who felt lonely: Eight per cent felt lonely in 2017 and 13 per cent in 2020. Women were more affected by these negative trends than men.

Care-givers reported a lack of informal and professional help. A quarter of the people who supported or cared for others during the first wave of the Covid-19 pandemic would have liked more help and relief in this regard, especially from family members.

6.2 Introduction

The Covid-19 pandemic and the governmental regulations to slow down the spread of the Covid-19 virus presented everyone with diverse and lasting challenges. The measures taken to protect the population had to be carefully weighed in their effects and – if necessary – supplemented. For example, studies have shown that the contact and mobility restrictions introduced in March 2020 certainly helped protect people against contracting Covid-19, especially of people in poor health and in need of care. At the same time, however, these restrictions abruptly made it much more difficult to provide help, support, or care for these vulnerable persons. For example, multi-week bans on visits to care homes, social isolation or postponed medical appointments or visits to the hospital were suggested to have negative consequences for the health and well-being of those in need of care (Damerow et al. 2020; Halek et al. 2020).

With the onset of the pandemic, there was a significant additional burden and workload especially for professional care workers, whose great importance was proven once again: Their work was described as “essential” and the debate that has been going on for years about care professionals’ poor working conditions gained fresh impetus. However, individuals providing help, support and care without pay for family members, friends or neighbours are also central to maintaining the health and well-being of individuals in need of care, albeit these supportive individuals are often invisible to the public (e.g. German National Association of Senior Citizens’ Organisations 2020). Their unpaid care activities constitute the backbone of the German care system (Ehrlich and Kelle 2019) and are the focus of this chapter. The unpaid family-and-friend care may encompass at least one of these activities: personal care (e.g. toileting, dressing or feeding), household tasks (e.g. shopping, cleaning or cooking), supervising or looking after

the person in need of care, performing medical-related or nursing tasks or providing emotional and psychological support (Ehrlich et al. 2020). Throughout this chapter, we use the terms “care” and “care-giver” to refer to the various support and care tasks unpaid family and friend care-givers can perform.

The employment and earnings reductions that arise in response to caregiving have long been known (e.g. Ehrlich et al. 2020; Kelle 2020). In addition, care-givers face threats to their mental and physical health (e.g. Kaschowitz and Brandt 2017; Nowossadeck et al. 2016; Zwar et al. 2018). Moreover, support and care activities are unequally distributed between women and men: Not only do women take on these tasks more often and invest more time than men; they are also more often exposed to the double burden of paid work and caring activities, with negative consequences for their well-being (e.g. Ehrlich 2019; Klaus and Tesch-Römer 2017; Klaus and Vogel 2019; Wetzstein et al. 2015). And while men more often organise care, women more often provide personal care or help with household labour (Dosch 2016).

With the Covid-19 pandemic, these pressures increased and new challenges were added. For example, many care-givers were forced to reorganise their care arrangements, as day-care facilities were closed, and outpatient care services were temporarily overwhelmed due to staff shortages or a lack of protective materials (Wolf-Ostermann et al. 2020). Paid 24-h migrant home care workers (so-called “live-ins”) left and were unable or unwilling to re-enter Germany. The pandemic-containment measures made it difficult to move around the country and led to breakdowns in the informal support network of family-and-friend care-givers. Above all, caring for family members who did not live in the same household or lived further away became more difficult. Bans on visits to nursing homes made it impossible to maintain in-person contact with family members residing there. In addition, special caution was required regarding hygiene measures to protect care recipients who were at risk of infection. Due to their pre-existing illnesses and their often-advanced age, these people were at a very high risk of contracting a serious disease, not to forget that many of those providing support and care were in the risk group themselves. As a result, many care-givers faced the dilemma of maintaining the care of their family members and thus bearing the risk of infecting them or themselves or of limiting contact and thus also care. In view of these dramatically changed circumstances, many care-givers reported a worsening of their care setting and a significantly increased additional workload in the early summer of 2020 (Eggert et al. 2020; Geyer et al. 2020; Horn and Scheppe 2020).

Based on these changed circumstances for persons providing unpaid care to family members, friends or neighbours suffering from poor health, disability or

age-related frailty in the first phase of the Covid-19 crisis, we will explore the following questions in this chapter:

- 1) Proportion of care-givers in the adult population: Were more people involved in care during the first Covid-19 wave than before the Covid-19 crisis, or was there a decline? Were there signs of a convergence of gender differences in taking on these tasks or were more women than men also involved during the first Covid-19 wave?
- 2) Care recipients: Did the recipient structures change? Could people continue to provide the widespread care of parents(-in-law-), even if it is typically provided outside the care-giver's own home environment? Did people stop providing support and care to non-relatives as a precaution or did they increase the care they provided so that care recipients did not have to leave the house? Were there gender differences here?
- 3) Care-givers' well-being: Was there a change in the well-being of those providing care? Were women and men affected differently by possible changes? We considered self-rated health, depressive symptoms and loneliness here.
- 4) Care-givers' support needs: How many care-givers wanted more help during the first Covid-19 wave but did not receive it? Whom did they direct these expectations for help to and were there any gender differences?

6.3 Data and Methods

To answer the research questions, we used the data of the German Ageing Survey (DEAS) from the in-person survey in 2017 and the written short survey in 2020 (Vogel et al. 2020). We looked at the changes in the care situation between these two survey years, that is, at a time before the Covid-19 pandemic (2017) and during the first wave of its spread (June/July 2020). Through this approach, we hope to obtain indications of Covid-19-related changes, although no clear attribution of causes is possible. Observed changes may have also been the result of general social changes or other historical events between 2017 and 2020. This should be considered when interpreting the findings.

In this chapter, we report weighted percentages. This means we can draw conclusions about the population living in private households in the year and thus describe the changes between the two observation points. In addition, we examined whether trends found between 2017 and 2020 or differences between women and men were statistically significant. For both survey years, we considered people aged between 46 and 90: 6468 (2017) and 4763 (2020).

The data reported here were collected with the following questions or scales:

Care-givers: In the German Ageing Survey, care-givers were identified via the following question: “In the last 12 months (2017)/in the last 3 months (2020), were there people you looked after or cared for regularly due to their poor state of health, either on a private or voluntary basis? Respondents who answered “yes” to this question were described as care-givers.¹

Recipients: Respondents were then asked what their relationship is to the person or persons they cared for. In this chapter, we distinguished between (1) (marital) partner, (2) parents(-in-law) and (3) other persons with whom there was no family relationship (neighbours, friends, other non-relatives). Several persons could be mentioned.

Care-givers’ well-being was captured via three measures.

Self-rated health: Self-rated health is understood as a global health measure that includes many factors such as physical and mental health but also health behaviour (Spuling et al. 2019). Respondents were asked to rate their current health status on a five-point scale. The gradations range from (1) “very good” to (5) “very poor”. People with scores of 1 and 2 were grouped and interpreted as having good and very good health.

Depressive symptoms: On the basis of nine statements (e.g. “During the last week I felt exhausted”) of an established survey instrument, the survey records depressive symptoms (CES-D depression scale according to Radloff 1977). The respondents could indicate how often they had experienced each symptom in the last week, ranging from (0) “rarely” to (3) “always”. These nine statements were summed up (range 0–27). Persons with a value above the cumulative mean of 13.5 were deemed to have depressive symptoms (based on chapter “How did individuals in the second half of life experience the Covid-19 crisis? Perceived threat of the Covid-19 crisis and subjective influence on a possible infection with Covid-19”).

¹Due to the significantly shorter reference period of three months in 2020 (compared to twelve months in 2017), it can be assumed that the proportion of care-givers in 2020 is underestimated compared to the 2017 survey. In addition, it must be taken into account that the German Ageing Survey covers a comparatively broad range of care-givers. Thus, it considers a broad spectrum of care tasks, ranging from household tasks to personal care and medical-related or nursing tasks. Moreover, the temporal scope of these activities is not predefined, and in addition to services provided privately, those provided in the context of voluntary work are also taken into account. Accordingly, the proportions determined here are higher than the care-giver proportions, which are predicated on a narrower definitions of care.

Loneliness: This was measured using the short version of an established scale for surveying loneliness (de Jong Gierveld and van Tilburg 2006). Respondents could rate six statements (e.g. “I often feel rejected.”) from (1) “strongly disagree” to (4) “strongly agree”, from which an individual mean value (range 1–4) was calculated. People with a score of 2.5 or over were considered lonely (Huxhold and Engstler 2019).

Need for support: In the 2020 survey, all care-givers were asked whether they would have liked more assistance from others with this task but did not receive it. If this was the case, they were also asked from whom they would have liked more help: (1) family or relatives, (2) neighbours or friends or (3) professional service providers (such as nursing services or paid household staff). Multiple answers were possible here.

6.4 Findings

The share of people providing care increased

The results show that the proportion of people who provided care increased significantly from 16 per cent in 2017 to 19 per cent in 2020 (Fig. 6.1). This means that more people were involved in providing care during the first wave of the Covid-19 pandemic.

Women were more likely to provide care than men

This increase, however, primarily occurred because a higher proportion of women provided care: there was a significant increase in the rate of care provision in this group by four percentage points from 18 per cent in 2017 to 22 per cent in 2020. In contrast, the increase of about one percentage point for men was not only smaller but also statistically non-significant: While 14 per cent of men provided care in 2017, 15 per cent did so in 2020. This development widened the pre-existing gender gap in care provision, which increased from five percentage points to seven percentage points.

Slight decrease in partner care

During the first wave of the Covid-19 pandemic, there was a slight but statistically non-significant decline in care for (marital) partners (Fig. 6.2): in 2017, 17 per cent of all care-givers were providing care for their partners. Three years later, the figure was 15 per cent. This decline was more pronounced among men (Fig. 6.3): in the first months of the pandemic, they were four percentage points less likely to provide partner care (15 per cent) than in 2017 (19 per cent), while there was a decline of only one percentage point among women. However, these changes were statistically non-significant.

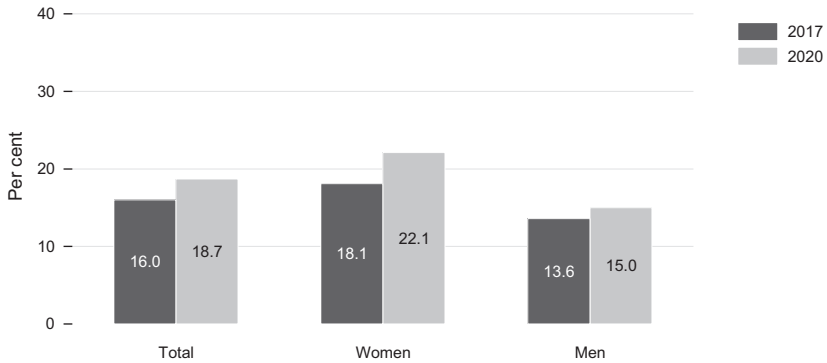


Fig. 6.1 Share of people providing care to people with health impairments, in total and by gender, in 2017 and 2020 (in per cent). *Source* DEAS 2017 (n = 6424), DEAS 2020 (n = 4374), weighted analyses, rounded estimates. Statistically significant ($p < 0.05$): Increase between 2017 and 2020 total and for women

No decline in parent(-in-law) care

There were no signs of a decline in intergenerational solidarity: parent(-in-law) care remained at a high level. It even increased slightly from 49 per cent (2017) to 55 per cent (2020) (Fig. 6.2). However, these changes were statistically non-significant.

Daughters(-in-law) were involved in care provision more often than sons(-in-law) (Fig. 6.3). Their share of parent(-in-law) care increased by eight percentage points between 2017 and 2020, from 49 per cent to 57 per cent. Among sons(-in-law), the increase was just two percentage points, from 49 per cent to 51 per cent. Again, these changes were statistically non-significant.

Care for non-family members increased significantly

Finally, there was an increase in the share of care-givers who took care of people whom they were not legally related to. Figure 6.2 shows an increase from 21 per cent (2017) to 25 per cent (2020). Neighbours provided care and support to other neighbours significantly more often during the first wave of the pandemic than three years earlier. Here, the share more than doubled, from seven per cent (2017) to 17 per cent (2020). Support and care from friends also became significantly more important, with an increase from seven per cent (2017) to eleven per cent (2020).

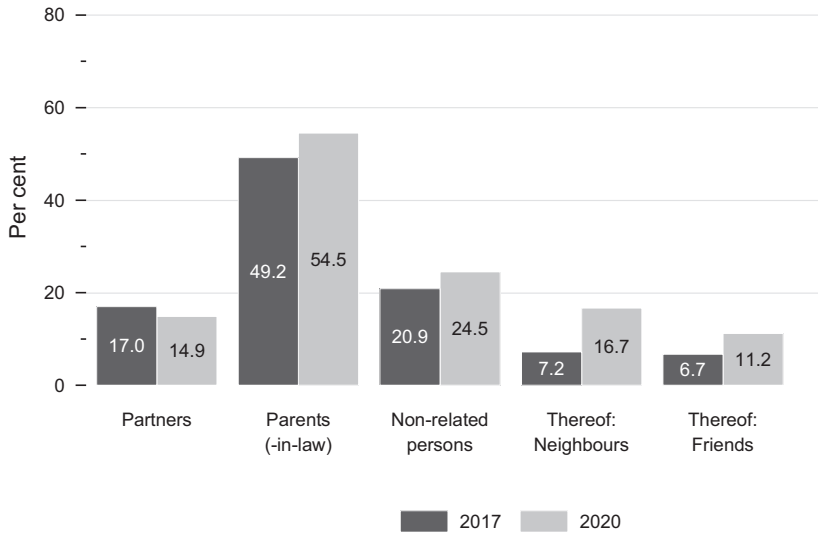


Fig. 6.2 Care recipients, in the years 2017 and 2020 (in per cent). *Source* DEAS 2017 (n = 1100), DEAS 2020 (n = 699), weighted analyses, rounded estimates. Statistically significant ($p < 0.05$): Increase between 2017 and 2020 for neighbours and friends

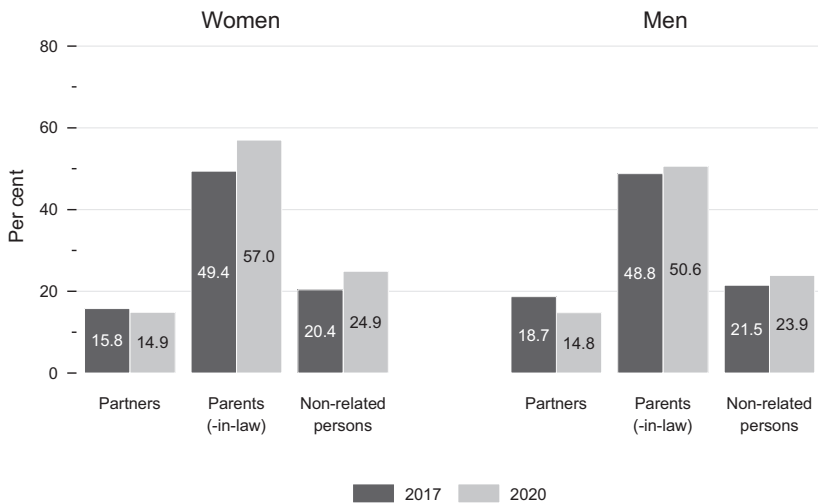


Fig. 6.3 Care-givers' care recipients, by gender, in 2017 and 2020 (in per cent). *Source* DEAS 2017 (n = 1100), DEAS 2020 (n = 699), weighted analyses, rounded estimates. Changes between 2017 and 2020 are statistically non-significant ($p < 0.05$)

During the first Covid-19 wave, women and men provided care to persons with whom they were not legally related at the same rate (Fig. 6.3).² There was a more substantial increase for women (by five percentage points) than for men (by two percentage points) between the observation points. However, again, these changes were statistically non-significant.

Findings differed for care-givers' physical and mental well-being

Findings differed for the dimensions of well-being considered here. Below, we present the results comparatively for care-givers and non-care-givers. This approach is useful for identifying possible trends between 2017 and 2020: were potential changes in well-being also observed among those who did not provide care or were they only evident among care-givers?

The share of care-givers reporting (very) good health slightly declined

Figure 6.4 (left part) shows that the share of care-givers in (very) good health decreased by three percentage points between 2017 and 2020. However, this decrease was statistically non-significant and did not suggest a general deterioration in health. In contrast, there was a clear (statistically significant) increase among non-care-givers reporting (very) good health, from 54 per cent to 61 per cent (Fig. 6.4, right part).

Furthermore, differences to the disadvantage of men are evident. First, the share of male care-givers reporting (very) good health fell more sharply (six percentage points) than among female care-givers (two percentage points) (Fig. 6.4, left part). However, these changes were statistically non-significant. Second, there was a smaller increase in the proportion of respondents reporting (very) good health among non-caregiving men (six percentage points) than among non-caregiving women (eight percentage points) (Fig. 6.4, right part). Non-caregiving men thus benefitted somewhat less from the upward trend in health than non-caregiving women.

The share of persons suffering from depressive symptoms increased significantly among care-givers

During the first Covid-19 wave, significantly more people exhibited depressive symptoms than three years earlier (Fig. 6.5). However, the increase was

²It was not possible to differentiate between neighbours and friends any more due to the small number of cases.

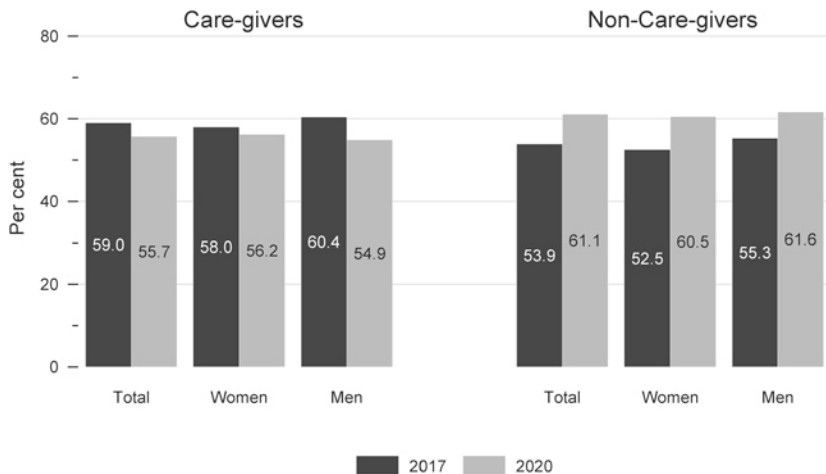


Fig. 6.4 Share of care-givers/non-care-givers reporting (very) good health, in total and by gender, in 2017 and 2020 (in per cent). *Source* DEAS 2017 (n = 6421), DEAS 2020 (n = 4319), weighted analyses, rounded estimates. Statistically significant ($p < 0.05$): non-care-givers: Increase between 2017 and 2020 for total, women, men

somewhat higher among those with care responsibilities. Among this group, the share doubled from six per cent to 15 per cent (Fig. 6.5, left part). By contrast, the increase among non-care-givers was less pronounced, from seven per cent to eleven per cent (Fig. 6.5, right part). This indicates that care-givers faced quite a high mental burden during the first Covid-19 wave. This trend was more pronounced among caregiving women (Fig. 6.5, left part): In the first months of the pandemic, 16 per cent of them exhibited pronounced depressive symptoms. This was an increase of nine percentage points compared to 2017. Depressive symptoms also increased among caregiving men, albeit to a slightly lower level, from five per cent (2017) to 13 per cent (2020). However, this change was statistically non-significant. There was a slight but statistically non-significant increase in the gender gap, from two percentage points (2017) to three percentage points (2020).

Increasing loneliness – especially among caregiving women

A greater proportion of people felt lonely during the first Covid-19 wave than three years earlier (Fig. 6.6). Here, too, there was a slightly greater increase among care-givers, from eight per cent to 13 per cent (left part), than among non-care-givers, who experienced an increase from nine to 13 per cent (right part).

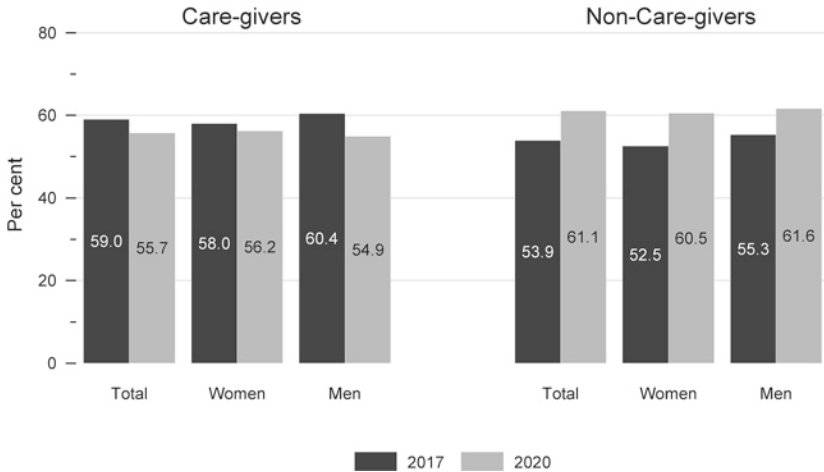


Fig. 6.5 Share of care-givers/non-care-givers with depressive symptoms, in total and by gender, in 2017 and 2020 (in per cent). *Source* DEAS 2017 (n = 6420), DEAS 2020 (n = 4354), weighted analyses, rounded estimates. Statistically significant ($p < 0.05$): for care-givers: Increase between 2017 and 2020 for total and women. For non-care-givers: Increase between 2017 and 2020 for total and men, gender difference 2017

While caregiving men and women diverged in their experience of depressive symptoms, the same did not apply to their feelings of loneliness, which converged (Fig. 6.6, left part). This was because, on the one hand, more male care-givers felt lonely before the pandemic (ten per cent) than female care-givers (seven per cent). On the other hand, loneliness increased significantly among caregiving women (by six percentage points), while among caregiving men the increase was smaller and non-significant (three percentage points). Overall, caregiving women experienced the largest increase in feelings of loneliness.

A quarter of those providing care would have liked more informal or professional help

The more extensive and demanding people's caregiving responsibilities are, the more important it is for them to have access to a well-functioning network of complementary support. This may not have been possible after the onset of the Covid-19 pandemic. And so, about a quarter of all care-givers in the first months of the pandemic reported a lack of help. Women (28 per cent) reported wanting help slightly more often than men (25 per cent) (not shown).

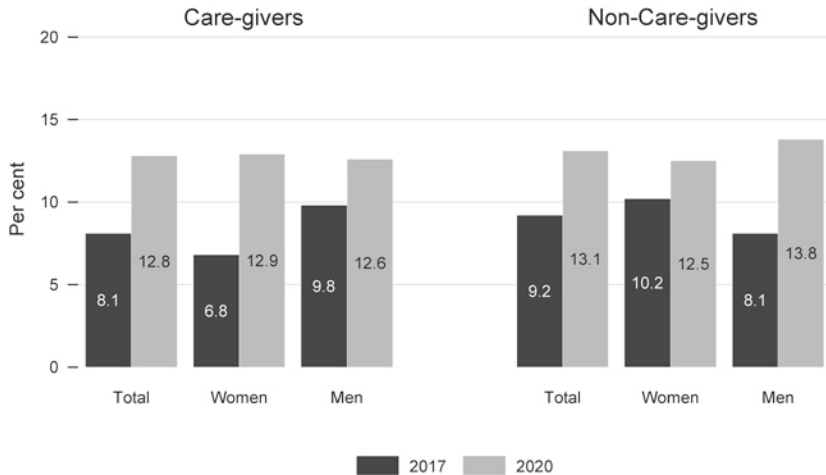


Fig. 6.6 Share of care-givers/non-care-givers feeling lonely, in total and by gender, in 2017 and 2020 (in per cent). *Source* DEAS 2017 (n = 5421), DEAS 2020 (n = 4346), weighted analyses, rounded estimates. Statistically significant ($p < 0.05$): care-givers: Increase between 2017 and 2020 for total and women. For non-care-givers: Increase between 2017 and 2020 for total and men

Care-givers mainly expected to receive help with caregiving tasks from family

Furthermore, Fig. 6.7 shows that women had hoped to receive more help from family members (53 per cent) and the wider private/neighbourhood environment (20 per cent) than men. For them, the respective shares were 45 per cent and nine per cent. Men, on the other hand, indicated wanting support from professional services more often than women: 34 per cent of men expressed this need compared to 32 per cent of women. However, the observed gender differences were statistically non-significant.

6.5 Conclusion

Care provision remained high

At the beginning of the Covid-19 pandemic, many care-givers reported an increased care burden and a deterioration of the care situation due to restrictions on contacts outside the home and the limited availability of professional

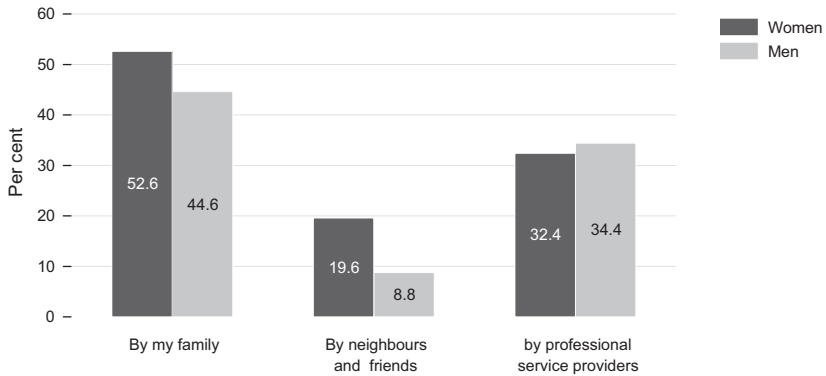


Fig. 6.7 Desire for more supportive help, by gender, 2020 (in per cent). *Source* DEAS 2020 (n = 155), weighted analyses, rounded estimates. No statistically significant gender differences ($p < 0.05$)

care and support services (e.g. Eggert et al. 2020; Geyer et al. 2020; Horn and Scheppe 2020). Our findings confirmed that despite these extremely difficult circumstances, people continued to provide high levels of private care for family members, friends and neighbours during the first Covid-19 wave: 19 per cent of 46–90-year-olds reported providing care. Furthermore, we showed that more people were thus involved in supporting and caring for others at the beginning of the Covid-19 pandemic than in 2017. This even applied despite the fact that the 2020 survey asked people to report on care provided in a shorter period of time of only three months than was the case in 2017. However, this was not the only reason why we regard the increase as substantial. At three percentage points, the increase was similar to, and in some cases even higher than, changes in the caregiver rate found for earlier survey years in the six-year period (Klaus and Tesch-Römer 2017). Social trends, such as an increasing number of people in need of care, cannot be ruled out as alternative causes of this increase. Nevertheless, it can also be understood as a reaction to the increased demand for help in the family and private environment related to the Covid-19 pandemic, a time of abrupt changes and diverse concerns and challenges.

Care for neighbours and friends increased

The increase in care activities for neighbours and friends was particularly strong: here, the shares rose from seven per cent to 17 per cent and from seven per cent to eleven per cent. How sustainable this trend is will only become clear upon further

observation. A recent study suggested that this may indicate a temporary increase in sporadic help with household tasks – above all due to geographical proximity – and may not represent new long-lasting care relationships (Rodrigues et al. 2020). However, this already reveals the potential of these relationships to be activated in emergency situations for the provision of care tasks – at least in the short term – to people in need of care in the neighbourhood and among friends.

The relatively stable share of parent(-in-law) care-givers also indicates a large support potential given that parent(-in-law) care often does not take place in the adult children's own household (Ehrlich and Kelle 2019) and adult children faced social distancing measures. Moreover, quite a few of them also have employment or other family responsibilities such as caring for children living in the household. Hence, adult children made an enormous effort to compensate for Covid-19-related care shortages faced by their parents.

Care-givers' well-being decreased

According to our results, there was no substantial deterioration in self-rated health among care-givers in the first months of the Covid-19 pandemic. The share of people in (very) good health decreased by only three percentage points and was statistically non-significant. However, this slight negative trend contrasted sharply with the significant increase of seven percentage points in the share of non-care-givers. This surprising finding is in line with other studies that indicated a general increase in satisfaction with health in the pandemic compared to previous years (Entringer et al. 2020). It is likely that these positive assessments of individuals' own health were predicated on comparisons with the health of Covid-19 sufferers. This trend may have been less optimistic if individuals had compared their specific illnesses or symptoms. However, this mechanism apparently did not apply to care-givers or may have been outweighed by an opposite effect – an actual deterioration, for example. Moreover, we cannot rule out that physical health consequences only become apparent in the medium or long term, especially when stressors persist for a longer period of time or become excessive. For example, in a survey conducted later, more than half of working-age family care-givers stated that their health had deteriorated during the pandemic (Rothgang and Wolf-Ostermann 2020). These initial findings on health status might reflect the additional burdens and concerns of care-givers that various studies have found (Eggert et al. 2020; Horn and Schweppe 2020; Rothgang and Wolf-Ostermann 2020).

Also, in line with other studies (Entringer et al. 2020; Rodrigues et al. 2020; Rothgang and Wolf-Ostermann 2020), our study showed a deterioration in mental well-being. The findings indicated a greater increase in depressive symptoms

and loneliness among care-givers compared to non-care-givers. Moreover, such increases were more pronounced among female care-givers. Indeed, caregiving women were the most negatively affected group: in 2017, seven per cent exhibited pronounced depressive symptoms and seven per cent felt lonely. Three years later, about twice as many caregiving women did so: 16 per cent and 13 per cent respectively. These results are a cause for concern. They point to an urgent need for action, with a special focus on caregiving women. Information provision, psychological counselling services (such as telephone hotlines or online services) and therapeutic support for care-givers must be further expanded, promoted and made easily accessible. Here, quick solutions and offers are important because persistent stress not only directly affects the well-being and health of sufferers but can also have a negative impact on the care-giver-care recipient relationship. Already at the beginning of the pandemic, the vast majority of care-givers reported that their relationship to the care recipient had deteriorated (Horn and Schewpe 2020), which could also have led to conflicts up to and including violence (Nägele et al. 2010, among others).

Care-givers needed more informal and professional support

Overall, our results underlined the enormous importance of family and friend care, even in times of crisis such as the Covid-19 pandemic. At the same time, they point to existing support deficits. A quarter of care-givers stated that they would have liked more involvement from others and more relief from professional care services. Another study showed that one third of care-givers reported having no one to talk to or ask for help (Horn and Schewpe 2020). About two thirds felt that politicians had left them alone or not noticed them during the first Covid-19 wave (Horn and Schewpe 2020; Rothgang and Wolf-Ostermann 2020).

The German government did quickly launch a support package for care-givers in May 2020 that offered financial relief, easier access to respite care (*Verhinderungspflege*), more flexible use of relief allowances (*Entlastungsbetrag*) and extensions in short-term absence from work (*kurzzeitige Arbeitsverhinderung*) for employed care-givers as well as options to more flexibly use (family) care leave (*Familienpflegezeit* und *Pflegezeit*). However, these offers were expected to be rarely used (Eggert et al. 2020; Horn and Schewpe 2020), possibly because only a few eligible recipients know about these offers or because they do not meet care-givers' needs. The Covid-19 crisis thus pointed to a problem that had already existed for a long time: information and counselling about existing policy packages for care-givers is insufficient (e.g. Döhler and Köhler 2012) and urgently needs to be expanded. At the same time, different actors still need to be brought together to maintain care provision for persons in need of care. The distribution

of these tasks on as many shoulders as possible does not just help to ensure quality but also helps avoid the overburdening of caregiving individuals. Care-givers must be enabled to call in external help quickly and reliably when needed. This explicitly includes a rapid strengthening and stabilisation of professional care and support structures. The partial failure of these structures at the beginning of the pandemic meant that family-and-friend care-givers had to cope with more tasks and responsibilities.

So, did the findings presented here reveal indications of a crisis in care as a result of the Covid-19 pandemic? On the one hand, our results demonstrated the great potential of care provided by family, friends and neighbours – especially in times of crisis. At the same time, however, they also documented a deterioration in care-givers' well-being as well as deficits in care-givers' support network. Basically, the Covid-19 pandemic made pre-existing problem situations more evident. The risks faced by those providing care in the private sphere intensified and gender inequalities widened. Quick solutions are needed, not least because of the still-high infection rates. The well-being of both sides has to be protected: those who need care and those who provide it.

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