Double Fragility: The Care Crisis in the Time of the Pandemic

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Abstract: The COVID-19 pandemic exposed and reinforced the structural crisis in paid and unpaid care work. On the one hand, pandemic-related closures of schools and childcare facilities increased the fragility of unpaid care arrangements, which are mainly organised by women. On the other hand, high infection and hospitalisation rates exacerbated the difficult working conditions in health-care professions, ranging from low wages and long working hours to high levels of mental and physical stress. Drawing on interviews conducted in an ongoing project in the German and Austrian health-care sector, this article investigates, from a gender perspective, how employees in health-care professions, who are at the very centre of both the unpaid and paid care crises, experienced this precarious situation during the pandemic. We suggest that the female-dominated sectors of paid and unpaid care work experienced further devaluation during the COVID-19 pandemic, while attempts to valorise their work were rather short-lived. We further argue that the structural crisis in paid care work is threatening the functionality of the health-care sector.

Keywords: care-work, health-care sector, crisis of social reproduction, Corona/COVID-19 pandemic

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In the course of the COVID-19 crisis, the structural fragility of current care arrangements became more evident and exposed the lack of any forward-looking solutions to overcome this problem. During the 'lockdowns' imposed in Germany, Austria, and many other countries in 2020 and 2021 to prevent the spread of COVID-19, schools

and childcare facilities were partially or completely closed. This political decision raised awareness of the need for a better work-life balance and highlighted the question of how childcare is managed within families and between parents (i.e. Kohlrausch, Zucco 2020; Hipp and Bünning 2021). The arrangement of childcare became a macrosocial and political question – even though in recent decades it has predominantly been organised 'individually' within the family and mainly by women.

At the same time, the pandemic also intensified the fragility of paid care arrangements as it posed major challenges to public health-care facilities. High infection rates led to increasing patient numbers and caused a considerable intensification and compression of work – especially in hospitals, which were the focus of political and public attention at the beginning of the COVID-19 pandemic. Studies show (Mulfinger et al. 2020; Silies et al. 2020; Häussl et al. 2021) that during the COVID-19 pandemic, health-care workers often had to work longer hours and under more stressful working conditions. However, many of the challenges are not genuinely 'new' but represent a pandemic-induced intensification of structural problems in public health care. For instance, in Germany and Austria, public health care for years has been based on a fragile system that often cannot ensure adequate care for patients: It is characterised by staff shortages, limited resources, and increasing commercialisation, which negatively affects the quality of care as well as the quality of caregivers' working conditions (Schmucker 2020). As so-called 'women's jobs', health-care work is also relatively low-paying in both countries (Scheele 2019), even though in Germany wages have risen significantly more than in the economy as a whole over the past ten years (Statistisches Bundesamt 2022).

The structural fragility of paid and unpaid care work has been labelled a care crisis by various researchers (Dowling 2021; Scheele 2022; for a critical take see Maier and Schmidt 2019) and can also be observed at the personal or family level, where those trying to juggle workplace demands and care needs at home – predominantly mothers – experience a physical and mental overload (Schutzbach 2021). During the COVID-19 pandemic, the closure of schools and childcare facilities, on the one hand, and increasing patient numbers in hospitals, infections rates, and deaths in hospitals and elderly care homes, on the other hand, rendered this multi-faceted and strongly gendered crisis much more visible.

Parents working in health-care professions were at the centre of both the paid and the unpaid care crisis during the pandemic: Being the main caregivers both in care professions and in families, they were particularly affected by the limitation and suspension of institutional childcare as well as by the growing demands for care in public health-care facilities, such as hospitals, which were of specific relevance in the COVID-19 pandemic. Since health-care workers are classified as essential workers, health-care facilities were not affected by the general lockdown and the ensuing shift

to remote work. This means that nurses and doctors were not only required to spend more time performing paid care but also had to work on site, which created new and intensified already existing problems regarding the unpaid care of their children. Although 'emergency care' arrangements were set up for children (grades 1–6) of parents working in essential professions (called 'system-relevant' jobs in Germany), the list of jobs that were considered essential was modified several times and varied between different federal states as well as between Germany and Austria. Parents working in essential jobs were not automatically entitled to childcare spots. Rather, they were encouraged to seek other options.

Drawing on an extensive qualitative study of four hospitals in Germany and Austria,[1] this article investigates, from a gender perspective, how employees in health-care professions experienced this precarious situation and managed their (double) care responsibilities. Our main research focus is, first, to identify the strategies health-care workers used to handle the double crisis on the individual level and, second, to discuss what this tells us about the structural fragility of both the unpaid and paid care system. We will analyse how the COVID-19 crisis exposed the structural contradictions between paid employment and care work, on the one hand, and within paid (health) care work, on the other hand. By providing empirical evidence of employees' strategies in the health-care sector from both Austria and Germany, we can better grasp the care crisis and show that it is not an incidental problem resulting from a specific political and social context but is a structural problem in capitalist societies. In this regard, we will explore how the partially obscured weaknesses of the past – pre-COVID-19 – organisation of paid and unpaid care became more apparent during the pandemic. We argue that the structural crisis is driving people with care responsibilities to the limits of their resilience, and that this is already threatening the quality of health-care services and the functioning of the overall health-care sector. In addition, private childcare can no longer be provided in the way that it would need to be in order to support the psychosocial development of children. We interpreted the double burden of these frontline workers as a 'double and interlocked care crisis'.

The article is structured as follows. First, we will develop our theoretical framework. Drawing on a feminist critique of capitalism, we will explain the care crisis as part of the crisis of social reproduction. After briefly describing the health-care sectors in Germany and Austria during the pandemic and our methodological design, we

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will present empirical findings from our research project and demonstrate the stark contrast between public recognition of the daily performance of essential workers and their actual working conditions, which make adequate recognition nearly impossible, and which are in fact rather an expression of a permanent devaluation of care work. We will then analyse the fragile care arrangements of health-care professionals during the different stages of the COVID-19 pandemic in Germany and Austria. In our conclusions, we will discuss our findings and explore perspectives for a more crisis-resilient care/career system.

Care crisis: a manifestation of the global crisis of social reproduction

In both Germany and Austria, unpaid childcare has always been based on a certain arrangement that was rarely questioned. In both countries, the welfare state was originally based on the so-called male breadwinner family model. This model has only been changing for a few decades and a modernised version of it has emerged in which the majority of women with children work part-time. In both countries, the latter arrangement has become the most common one among parents with (pre-)school children (Bergmann and Schiffbänker 2016). Currently, a shift from the modernised male breadwinner model to an adult worker model is being promoted politically (Rubery 2015). The aim, in accordance with the different EU goals set in the past two decades, is to attain the equal participation of women in the labour market. Nancy Fraser (2009) views this as a shift from what she calls 'state-organized capitalism' to 'neoliberalist capitalism', the latter requiring a flexible workforce and employment opportunities for women all over the world. As a result of these structural changes in the labour market, the gender division of labour in unpaid care work within the family – work often performed by women – is increasingly being challenged (Scheele 2013). The entry of women into the labour market creates a contradiction regarding care work, which in many cases leads to a double socialisation of the woman as an employee who is also, and additionally, responsible for private care requirements (Becker-Schmidt 2011). Despite the overall expansion of childcare facilities, most notably the availability of all-day schooling or childcare for children under 3 years and after-school care at schools, the adult worker model and its orientation towards the full use of the resource of 'labour' as a productive force does not answer the question of who assumes these reproductive responsibilities and how or the question of how to ensure 'life care' (Klinger 2013) as a social foundation. Instead, this paradigm shift and the increased participation of women in the labour market has created a vacuum around unpaid care work (Funder 2014: 186), which has led to a care crisis (Dowling 2021). This means 'a state in which the means for a society to regenerate itself are no longer available'

(Mulvaney 2013: 28) and affects childcare, elderly care, and other care arrangements necessary for the reproduction of labour (Scheele 2022).

Like a magnifying glass, the COVID-19 pandemic augmented this crisis of paid and unpaid care work, while highlighting the extent to which the social organisation of reproduction rests on the shoulders of women, who are integrated into the labour market while also performing (unpaid) care work at home (Villa 2020). The outbreak of the virus showed how the double crises of reproduction and paid care work are interwoven and mutually reinforce one another.

At this point, our intention is by no means to exalt a traditional model that has often led to discrimination against women in terms of access to resources and participation in social contexts and has led to the perpetuation of gender inequality. Rather, we understand this care crisis as a structural crisis. Feminist theorising of the crises of capitalism (Fraser 2016; Mulvaney 2013; Dowling 2021; Plomien et al. 2022) focuses on the contradictions between capitalist production and social reproduction. It shows how capitalist societies neglect the fact that the means and activities of social reproduction are the necessary preconditions of capitalist accumulation, since that requires a workforce and thus people who have been 'produced as *biological and social beings*' (Plomien et al. 2022: 140; quoting Nelson 1998). This means that the accumulation of capital is secured not only by the exploitation of waged labour(ers), but by the exploitation of unpaid reproductive labour(ers) as well (Mulvaney 2013).

The feminisation of paid and unpaid social reproductive activities – both in the private and in the public sector – are an expression of the connection between gender and production relations (Haug 2018: 34–35), which allows for these activities to be exploited. Social reproductive activities continue to be low-paying, even as these activities enter a process of commodification and are valorised in private households or in nursing and care institutions. Paid care work is mainly performed by women and therefore considered to be a task which doesn't require a high level of professional qualifications and could be done by anyone. Moreover, due to the high number of part-time workers in this 'feminised' sector, it is expected that care workers perform those jobs as a source of 'extra income' – in accordance with the modernised male breadwinner-model mentioned above, resulting in wages and salaries that remain far below other professions (Scheele 2019).

This is also a characteristic of the health-care sectors we analysed in Austria and Germany. Although the provision of health-care services is a condition for the well-being of societies and the importance of such services became even more apparent during the COVID-19 pandemic, past neoliberal transformation processes, including budget cuts and the privatisation of hospitals as a decisive element of the care infrastructure (Gerlinger 2014), have left both countries less capable of providing

sufficient and quality care. The working conditions of the predominantly female nursing staff changed for the worse, leading to a situation where the needs and requirements of both care recipients and caregivers (e.g. nurses, doctors) are not being met (Scheele et al. 2023; Schmucker 2020).

Below, we will briefly describe the current situation in the health-care sector and hospitals in Austria and Germany before and during the COVID-19 pandemic before moving on to the results of our qualitative research.

A description of the health-care sector in Germany and Austria

Health care is a sector that has seen strong increases in employment numbers over the last decade in both countries. In Germany, 1,347,524 persons were working in hospitals in 2020, which is about 20% more than in 2010. The number of full-time doctors was 200,565, while the number of non-medical staff was 1,028,228 – with 486 085 employees working in the nursing service (Statistisches Bundesamt 2022). In Austria 15.6% more persons were working in paid health care in hospitals in 2020 compared to 2010. Out of the 122,843 persons working there in 2020, about 62,000 were nurses and about 26,000 doctors (Statistik Austria 2022: 15).

In both countries, paid health-care work is predominantly carried out by women. According to the EU Labour Force Survey, women in Germany make up about 77% of all employees in human health activities, while in Austria the percentage is in line with the EU average of about 75%.[2] In some sub-categories of human health activities, the proportion of women is even higher: the proportion of women in nursing professions in Germany is 83% (Bundesagentur für Arbeit 2022: 11). Despite some differences in the calculation basis, the figures for Austria indicate similar trends: 82% of employees in nursing professions and 80% in the field of medical assistance are women (Schönherr and Zandonella 2020: 3).

Occupational fields with a high proportion of women are often low-paying, and the health-care sector appears to be no exception (Öz 2020). According to Eurostat data from 2018, the mean hourly earnings in human health and social work activities were 19.04 euros in Germany and 17.32 euros in Austria (Eurostat 2018; Tavora and Rubery 2021). According to the German Institute for Economic Research, wages in health care are below the German national average: While in 2010 the average gross hourly wage for all professions in Germany was 17 euros, employees in health care and nursing professions (including emergency medical services and obstetrics) earned an average of 16.50 euros per hour (Koebe, Samtleben, and Schrenker 2020: 4).

[2] https://eige.europa.eu/gender-statistics/dgs/indicator/ta_wrklab_lab_employ_selected_healthcare__lfsa_egan22d_hlth/bar/year:2021/geo:EU27_2020,DE,AT/nace_r2:Q86/age:Y_GE15/unit:THS/sex:T,M,W

Beyond gender ratios and earning levels, the Austrian and German health-care sectors are quite similar in terms of working conditions. Although the social necessity of adequate health care and freely accessible health services is broadly recognised in both countries, most of the German and Austrian health-care workforce is facing difficult working conditions, such as long working hours or shift work (DGB 2020: 5; Schönherr and Zandonella 2020: 7–8; Schmucker 2020). According to Bergmann et al. (2019: 681), especially 'full-time employees suffer from physical strains and psychological stress'. Due to the demanding working conditions in health-care professions and because many of the female employees have to carry out private care work, the percentage of part-time employees is relatively high in both countries (Auffenberg et al. 2022).

Health-care work during the COVID-19 crisis

In response to the fast-spreading COVID-19 virus, the Austrian and the German governments declared nationwide lockdowns on 16 March 2020,[3] which significantly shut down public life. Schools and other care facilities were among those affected. During this time, distance learning was implemented, leaving parents largely responsible for helping their children with schoolwork. While employees in many occupations were put on reduced hours or were able to work from home, the work of medical and nursing staff was labelled as 'indispensable for the functioning of society' (Koebe et al. 2020: 1) and hospital employees, classified as 'essential workers', had to continue working on site while facing various pandemic-related challenges at their workplace. For health-care workers, the fear of getting themselves or their family members infected caused mental stress (Gorini et al. 2020; Kramer, Thoma and Kunz 2021), especially during the initial phase of the crisis, when testing capacities and vaccinations were not yet available and protective equipment was scarce (Begerow, Michaelis, and Gaidys 2020: 232). Female employees, especially, are at higher risk of developing stress symptoms (Conti et al. 2020).

The fact that nurses, doctors, and other hospital employees made a great effort to ensure the provision of health care and did so despite their increased infection risk during the pandemic was noticed and highlighted by the public. As in many other countries (Tavora and Rubery 2021: 76), hospital employees in Germany and Austria were portrayed as everyday heroes (for a critical take see Hürtgen 2022). In a coordinated nationwide show of appreciation, people would gather to applaud in recognition of the hardships of essential workers who kept the critical infrastructure operating. Care work also received more attention in the political sphere, and some

[3] This first lockdown was lifted in Austria on 1 May 2020 and in Germany partly on 4 May 2020.

politicians expressed their gratitude.[4] Members of the German Bundestag gave a standing ovation on 25 March 2020 to those 'who provide care for the population on a daily basis despite the increased risk of infection'.[5] The media also began to cover the efforts and travails of hospital staff.[6]

To demonstrate recognition, both countries opted to pay individual bonus payments after a few weeks. On 14 May 2020, the German Bundestag passed the 'special benefit during the coronavirus SARS-CoV-2 pandemic', which was paid as a tax-free bonus to caregivers on a tiered basis starting in September 2020.[7] Finally, in late summer 2021, after months of political discussions, the Austrian federal government awarded a COVID-19 bonus to approximately 189,000 employees in the hospital and nursing sector. The personnel received an average of 500 euros tax-free to honour their achievements during the COVID-19 pandemic.

These symbolic acts as well as monetary benefits were meant to acknowledge that the first hard lockdown did not affect everyone equally and that the pandemic imposed an even greater workload on some employees, such as nurses and doctors. This valorisation of care work can be seen as a motivational boost to the already highly dedicated employees working in hospitals. Even before the COVID-19 pandemic, a connection had been established between job satisfaction in the care sector and the recognition and appreciation of the work of hospital staff (Eurofound 2006: 31–32).

However, these measures had no substantial or sustainable impact on the working conditions of hospital workers, as we will show below based on our research. In the following sections we present our empirical findings and describe our methodical approach.

Methods and sample

The empirical findings in this article are based on semi-structured interviews with hospital employees in Germany and Austria that were conducted as part of the research project 'Double Fragility: The Care Crisis in the Corona Crisis' focusing on

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[4] https://www.kleinezeitung.at/international/corona/5904269/CoronaKrise_Van-der-Bellen-dankt-Intensivpersonal-per-Video.

[5] Speech by the then President of the Bundestag, Wolfgang Schäuble. See the Stenographic Report of the 154th session of the German Bundestag, p. 19117. https://dserver.bundestag.de/btp/19/19154.pdf, Retrieved 29/12/22.

[6] In Austria, 5.7% of the articles on COVID-19 and care work in the print media we analysed (4 out of 70) included one of the terms 'applause', 'celebrated', 'her(in)es', and 'clap'. In Germany, it was 7.8% (26 out of 332); see Linshalm et al. (forthcoming).

[7] https://www.bundesgesundheitsministerium.de/pflegebonus.html.

work-family balance in essential jobs during the COVID-19 pandemic. Our sample includes hospital employees from different occupational groups, such as nurses, doctors, and ward managers, with children aged 15 or younger. Moreover, we also interviewed work council members as well as administrative, management, and HR representatives with (and without) children to obtain a comprehensive picture of key individual and structural challenges in hospitals during the pandemic. We conducted the interviews at different stages of the pandemic in order to draw conclusions about the situation before, during, and at a later point during the COVID-19 era – even without following the approaches of a longitudinal study design. To mitigate the risk of infection, almost all the interviews were conducted online or via telephone.

Because of the different requirements for obtaining access to the field in Germany and Austria, the sample structure varies between the two countries. We ensured the comparability of the results, however, by basing the interviews on a common set of questions in both countries, which were revised and adapted during the survey stage of the research. We then conducted a systematic analysis of the interviews using MAXQDA software. Following grounded theory methodology, we applied codes retrieved from the literature and added new topics that emerged from the data, so both deductive and inductive coding was used.

In Austria, interviews took place between May 2021 and October 2021 in two institutions in different regions and with different contextual conditions. In Germany, interviews took place between May 2021 and February 2022. Like the Austrian sample structure, the focus of the interviews was on employees of two different hospitals located in different parts of the country. The sample was further supplemented by some one-off interviews with employees of other hospitals and health-care facilities.

Table 1: Interviewees in Austria and Germany[8]

	Austria		Germany	
	Female	Male	Female	Male
Care workers (directly working with patients):	**12**	**1**	**6**	**0**
– Doctors	3	1	2	0
– Nurses	3	0	2	0
– Ward managers	6	0	2	0
Management and administration (managing organisational units):	5	1	8	0
– HR	0	1	1	0
– Nursing management	2	0	6	0
– Others	3	0	1	0
Work council members and other stakeholders	3	2	0	1
Total	20	4	14	1

Source: Authors.

Empirical findings: manifold care crises in Germany and Austria

As news of rising infections and critically ill people in intensive care in other countries spread daily, and the striking pictures of the transport of deceased people from the northern Italian town of Bergamo were released, care workers gained a new sense of the importance of their profession. Several interviewees emphasised that they did everything they could to help prevent such a health catastrophe. They perceived the COVID-19 crisis as a phase in which they were needed. Some care workers also emphasised that they love their job and see their profession as their vocation:

> *Our professional ethos obliges us to be there in situations like this – especially in a situation like this – and to live for the job.* (A_Int6)

This vocational ethos and the high level of commitment enable employees in hospitals to place their job above all other responsibilities, prioritising care activities in the hospital while putting childcare at home second (Scheele et al. 2023).

[8] Further information on the job position and the number and age of the children of the respondents in our sample can be found in the attached table.

The crisis in the provision of health care

Nurses and doctors voiced the expectation that the COVID-19 pandemic would shed light on the importance of the health sector to society and that this sector would therefore receive more resources (budget, personnel, training):

> *And we clearly recognised the important role or great significance of hospital care, its great significance for Austria.* (A_Int3)

However, the hopes for an improvement in the situation with resources did not materialise. Instead, the workload in the care sector increased heavily, and health-care workers in Germany and Austria faced many problems and challenges.

The risk of infection

Initially, there was a *high risk of infection* at the workplace since care work does not allow for physical distancing. This risk affected our interviewees in several ways. On the one hand, they had to meet additional demands and requirements in their everyday work. For instance, hygiene regulations became stricter and changed frequently. Even contact with colleagues during breaks was restricted to reduce the risk of infection. On the other hand, our interviewees were afraid that they themselves or their family members would get infected, especially during the initial phase of the crisis, when testing capacities and vaccinations were not yet available. They were worried that they would be absent from work and that the children's care would no longer be secured. In the words of one interviewed nurse: *'If I catch an infection or if I have to be hospitalised, who will look after the children?'* (A_Int14)

Like the study by Kramer, Thoma and Kunz (2021), our interviews show that the risk of infection, as well as the associated *changes in daily work routines*, were experienced as an additional mental burden by many hospital employees. A nurse in a leading position noticed the strong sense of fear and insecurity in her team, which also made her own work more difficult:

> *I will never forget receiving a phone call from a colleague at about 1 o'clock in the morning [chuckles], telling me that he was supposed to receive a patient from the emergency room, but he didn't know his test result yet. (…) So, there were fears. I noticed that colleagues became reluctant to make their own decisions, for fear of doing something wrong.* (G_Int6)

Consequently, the hospital employees we interviewed underlined how they had to deal with 'constant change' (A_Int14) and the often-changing formal requirements and safety regulations that applied to themselves, patients, and visitors.

The re-organisation of work

Interviewees reported that they constantly and rapidly had to *re-organise work*, restructure departments, and alter processes, all while wearing protective gear and relocating heavy equipment. Their aim was to guarantee the protection of patients at all times, which made their work more difficult. Many interviewees stated that adapting to these changes was very labour-intensive. As visits to patients, for example, were limited or even completely prohibited for a long time, many hospital employees had to spend more time talking to relatives and explaining the regulations to them:

> *[A]t some point during the pandemic, visitors were no longer allowed, or relatives were only allowed one-hour visits with the patients. So we had to discuss the rules with the relatives, or rather explain them in a comprehensible way. (…). It was really a challenge – especially because everyone was at their limit, anyway.* (G_Int6)

The limits – or, for COVID-19-positive patients, complete ban – on visitors further worsened the mental and physical load, since care workers, already under a very heavy workload, were also expected to provide their patients with social care and empathy.

Personnel shortages and stress symptoms

Quarantine regulations, COVID-19 infections among staff, and the higher proportions of 'seriously ill patients' (G_Int5) also exacerbated already existing personnel shortages in many wards, further increasing the high levels of physical and psychological stress on the remaining staff. The hospitals, which were particularly challenged by the admission of COVID-19 patients, therefore expected a high degree of flexibility from the employees when it came to work tasks and scheduling, as wards were merged and, in some cases, completely reorganised. Planning and organisational demands increased, especially for nursing staff with managerial tasks and ward managers. Their daily work was increasingly dominated by the challenge of procuring sufficient staff for the next few days, as one of our interviewees explained:

> *(…) the ward managers are constantly busy trying to cover the shifts. They sometimes sat [in their offices] until midnight to get enough staff for the next day. This is, I would say, a huge problem that still dominates the wards and that will continue to do so for quite a long time, I think.* (G_Int1)

Ward managers were exhausted by the poor plannability of working hours as team members became infected and work shifts had to be rescheduled. Their task was to motivate their colleagues and plan staffing so that care could be provided adequately.

Organising flexible scheduling is one of the core tasks of ward managers, who heavily relied on their teams' flexibility. Employees not only had to be very flexible to cover for colleagues infected with the virus, they also had to work longer shifts, which strongly affected their time for recovery. They had to find a balance between the team's availabilities and the changing organisational requirements.

A quality manager in a hospital summarises these burdens:

> *How do we manage the staff, since the wards have been closed, and how do we reallocate? This [short pause] EXTREMELY high workload (…) was my BIGGEST challenge. You had to give one hundred percent or more every day, always, ALWAYS. And there was no time to come down, to relax, to go on vacation.* (G_Int4)

The clash between workers' continued commitment to work and structural problems in the sector

All these professional demands were non-negotiable for employees in hospitals. They simply had to persevere and try to keep going. However, their attitude consistently showed a strong sense of responsibility towards the patients, their colleagues, and the hospital as a whole. All our interviewees demonstrated an extraordinary work ethos and were highly committed to their work during the pandemic (Scheele et al. 2023). The strong sense of responsibility was also expressed in the fact that some of them feared a COVID-19 infection more because of its potential impact on their colleagues and patients than because of its consequences for their own health. For example, a ward manager expressed her concern:

> *My biggest fear has always been that I [must] go into quarantine and, God, what will my ward [do]? 14 days trapped at home. Those are the kind of things that always kept me worried.* (G_Int5)

Against the background of these multiple burdens, hospital workers received the symbolic moments of recognition described above, as well as the bonus payment, with mixed feelings, and not all employees appreciated the applause as public acknowledgement of their work:

> *What does applause do for me? It does nothing at all. Everyone is sitting at home, and we have to expose ourselves to the whole thing. Well, I was really pissed off at first, at the way they were all out there on their balconies, and everyone was clapping. I really didn't feel like a hero, and certainly neither did my colleagues. We were at the front line right from the start, and it certainly wasn't easy.* (A_Int1)

For this interviewee, the applause highlighted the contrast between the parents who were working from home and able to care for their kids and the hospital employees who were not able to stay at home, while also being in direct contact with COVID-19-infected patients.

The 'COVID-19 bonus' also was not perceived as appropriate appreciation by all, especially in Austria, where some hospitals converted the bonus into days off, with two additional days off for people working directly in COVID-19 departments, and one additional day off for other employees. Interviewees reported that these days had to be taken by the end of 2021, which was tricky because at the time of the interviews, in autumn 2021, the workload in hospitals spiked again due to high infection rates and the resulting high hospitalisation rates. The additional time off was not well received by the interviewees since it was next to impossible to even make use of these additional days. Many interviewees felt that money would have been a much better token of appreciation. Instead of a one-time payment, a basic salary raise would have been more appreciated:

> *There was a one-time payment [the bonus], but I think a permanent raise of our basic salary would make more sense.* (A_Int6)

A staff manager of a nursing department in Germany pointed out that the COVID-19 bonus does not help solve personnel shortages and that substantial (new) regulations are needed instead:

> *Personally, I perceived the bonus as a nice token of recognition. However, I would have preferred it if there had been more relevant regulations for health-care work at the federal level.* (G_Int1)

During the second and third wave of the pandemic, the nursing staff situation became even worse. Although hospitals developed certain routines to handle the pandemic, the hospitals in our sample simply lacked the (human) resources to adequately manage the increasing numbers of infections in the fall and winter of 2020/2021. While the protective measures (e.g. vaccinations, testing infrastructure, and free antigen tests) improved over the course of the pandemic, many hospital employees not only felt extremely exhausted during this stage of the pandemic, but also experienced a feeling of powerlessness. One ward and quality manager in a hospital in Germany remembered the period before Christmas 2021 as 'the most drastic experience' (G_Int8) during the pandemic. She said that she was not sure whether the hospital 'would be able to take care of all the patients over the holidays' (G_Int8) and further explained:

It was not a question of whether we would be able to provide adequate care, but whether we would be able to care for them at all. (…) And that was a moment when I thought: Oh my God, we are no longer in control of the situation. We are at the mercy of all of this. (G_Int8)

Many hospital employees reached their mental and physical limits during the pandemic. As one nurse in a management position, for instance, explained:

I simply had no life anymore (…) It only consisted of working, keeping working – and in the evening, hoping (…) that the next day would work out better. So (…) I can say that everything came up short. (G_Int9)

The limits of individual resilience were sometimes far exceeded, and, as is now apparent, the number of hospital employees who went on sick leave increased in many hospitals after the second and third waves. These dynamics further intensified the workload in the wards, making reforms of the health-care system even more urgent. Even before the COVID-19 pandemic, the frequent changes in work demands were drivers of psychological stress and led people to reconsider their career choices (BMSGPK 2021: 13). The longer the pandemic lasted, the more the atmosphere changed, and employees felt overburdened. Employees in hospitals in Austria reported that the continuation of stress and pressure over such a long period was likely to cause more care workers to quit their jobs. For instance, a ward manager in an Austrian hospital argues:

The mood is very bad, a lot of people are leaving, (…) people are switching, not only teams, but actually entire clinics, as we now keep hearing. Many also no longer want to work in the profession at all, (…) so it is already very clear that people want to change, that they are exhausted, worn out, or burned out. That is already blatant, actually. (A_Int6)

A former nurse who is now working in professional development for nurses in Germany explained that staff shortages in health-care professions mainly result from the fact that highly qualified staff are leaving the profession because of the difficult working conditions.

The crisis in the provision of childcare

In addition to all these challenges in the workplace, many health-care workers also faced pandemic-related challenges in the private sphere. Due to the recurring nationwide and/or regional closures of day-care centres, preschools, schools, and

holiday and recreational facilities, parents working in health-care professions were forced to re-organise private care arrangements. Most children had to be looked after and cared for at home for months, meaning that parents of school-aged children were also responsible for facilitating their children's online schooling. As some interviewees told us, many children were either underchallenged or overburdened by school assignments during the lockdown. Especially younger children were often overwhelmed by the assignments and unable to accomplish the tasks on their own:

> *And the school assignments were very extensive. The amount of homework and tasks the children had to do (…) was really extensive. Sometimes it was impossible for the children to handle all the tasks on their own. Parents had to help.* (G_Int2)

Since teaching models changed frequently (in-person instruction, hybrid in-person instruction, and online learning), health-care workers with children also had to readjust their reactions to re-organise childcare multiple times and it was almost impossible for them to restructure their everyday family life in a way that could create longer-term reliability.

Because of the increased care demands in the private sphere in terms of both time (school closures and limited early childhood care) and what the care entails (distance learning), parents working in health-care professions were particularly exposed to multiple stresses, which further exacerbated the crisis of social reproduction. The heavy workload in the hospital had a direct impact on their ability to care for their own children – leading to a situation in which the demands of work took precedence over the demands of childcare. Since hospital employees were urgently needed at work and wanted to be there for their team and their patients, there was hardly any time left for childcare. Some hospital employees stated that they did not even have time to doubt their decision, to think about their children, and what impact their absence would have on them:

> *I found it difficult. I didn't get to think about much during that time because I was so busy in the hospital. I was busy around the clock, and even when I wasn't on duty, I was working on various issues (…) But I would never leave my children alone like that again. That was a big sacrifice, and I only became aware of it afterwards. I understand everyone who chose not to do that, but I probably only understand it better in hindsight.* (A_Int2)

There 'was nothing else' besides the demanding work in the hospital. Therefore, health-care workers needed others to support them and take over some of their care responsibilities. While most health-care workers relied heavily on grandparents, friends,

and/or additional support – such as private day-care and cleaning staff – prior to the pandemic, many of these arrangements and support structures collapsed when the pandemic began. For instance, grandparents were no longer involved in childcare in many families out of fear of infecting them. Instead, our interviewees sought other options to re-organise everyday family life within the nuclear family and/or with the help of younger relatives. In some cases, older children assisted their parents with childcare and household chores. They picked up their younger siblings from emergency care or assisted them with distance learning whenever their parents had to work.

Some interviewees reported that a lack of time meant that their children were less cared for. One mother who felt overburdened reported that because of her heavy workload, her daughter missed many online classes and her son played video games instead of attending his classes; another interviewee felt annoyed because she had to study for hours after her working hours without the skills for teaching and stated that you 'just somehow try to muddle through the daily programme that you have' (A_Int12).

Moreover, some health-care workers also changed their work schedules and/or tried to do administrative tasks from home. If necessary, they also made use of options such as taking extra care time or vacation or reducing overtime hours. Additionally, they even reduced their recovery times by getting up earlier, staying awake longer, or forgoing leisure activities. Some interviewees reported that they did schoolwork with their children early in the morning before work and/or late after work:

> *During the first lockdown, the daily routine was as follows: I came home from work and immediately started working with my children on their online schooling. I tried to explain things to them and basically took on the role of the teacher. I helped with long-term assignments. Even on weekends, I was busy helping the children with some long-term projects, explaining math tasks, catching up on English vocabulary, or printing worksheets and preparing for the next week.* (G_Int10)

Some of our interviewees also re-negotiated care responsibilities with their partners. In cases where both parents were working in health care, they tried to divide up the (additional) care responsibilities in a fair way and tried to arrange alternating shifts, ensuring that one parent would always be available to look after their children. However, most of our interviewees considered the scope of action to be rather limited in this regard. Even in families where partners were able to switch to remote work, care responsibilities usually did not alter significantly. Some partners even decided to reject remote working because they were not able to balance remote working and childcare properly.

Although hospital employees theoretically had the option of sending their children to 'emergency care' (Notbetreuung), only a small part of our sample took advantage

of this offer for different reasons. On the one hand, interviewees feared the higher risk of infection when their children are in contact with others.[9] On the other hand, the timing and organisation of the services did not always meet their needs and the quality of the emergency care offered in preschools and schools was questionable (A_Int15). Parents whose children spent their days in emergency care often claimed that the children did not get enough learning done there, and that parents had to catch up on school assignments with their children after work. Some criticism of the quality of the emergency care also referred to the instructors' varying levels of dedication, their IT skills, and the variety of different learning platforms that were used and overwhelmed both parents and children.

Considering all these challenges, some hospital employees in Austria decided that the best thing for their children was for them to stay with the grandparents the entire time and not have contact with their parents to prevent infection. As a result, these parents could only see their children virtually. In one case, a nurse did not get to see her own children for a total of 21 weeks.

As all these examples show, strategies to re-organise childcare and household chores varied greatly within the sample and depended on various contextual factors such as family support, family structure, or the professional situation of the partner. Strategies also sometimes changed over time and were combined in different ways. However, in most cases, mothers took on the role of the main caregiver, which included the additional pandemic-related care responsibilities such as supporting their children in distance learning. In contrast, fathers were more likely to help out on weekends or on a few days during the week and took on a more supportive role. Some (female) respondents blamed themselves for this uneven distribution of care responsibilities, while other interviewees stressed that they felt they had been pushed back into the traditional caregiver role. In some cases, the additional care responsibilities even led to arguments with their partners, while in other cases women assumed the additional care responsibilities without question, since doing so corresponded with their self-perception as a mother.

In many of the interviews, parents also reflected in a critical way on the strategies they used to organise childcare during the pandemic. For instance, they expressed their concern that they had not invested enough time in caring for their children and worried that their children would suffer disadvantages at school. One interviewee even saw herself disadvantaged in two ways because many employees outside the health-care sector were able to work from home during the pandemic and were thus able to care for and support their children better than health-care workers working on site in a hospital could:

[9] Webers (2022) qualitative study of elderly care workers shows similar findings.

> *Shortly after the lockdown, I held a seminar with educators who told me: 'When the children returned to school, the children whose parents had been at home with them had progressed so well.' (…) I felt it was mercilessly unfair that my children were doubly disadvantaged, right? First, because they couldn't go to school, and second, because of my job; because I was not able to work from home and was therefore unavailable to help them.* (G_Int1)

In some cases, hospital employees also realised that they were not able to adequately address their children's challenges and problems and subsequently to provide them with sufficient support. They were alarmed that their children would suffer longer-term consequences from receiving less care and attention from them. Some children also developed depression and sleep disorders, which were attributed, among other things, to a lack of contact with their social environment. Some of our interviewees told us that their children gained weight, became increasingly addicted to media, and felt lonely.

Not all respondents realised the extent to which they had prioritised their paid hospital work over childcare until they voiced it in the interview, and some started crying. It is apparent that in addition to the emotional demands of nursing work in hospitals, there is now a second dimension of 'care', which is to care for the psychological and physical well-being of one's own children as well as for their development and education. What this reveals is how hard it was for our respondents to cope with the double crisis of the increased demands in their paid care work and their increased childcare demands at home. It became apparent to these parents that they paid a high price for being committed to their work. Their high level of commitment for paid care work can be interpreted as an expression of a strong work ethic, nourished by a strong belief in their vocation, the bond with their team, but also out of concern for their patients' well-being. This work ethic thus provided a momentum of resilience that prevented the collapse of the care system (Scheele et al. 2023). The structural weaknesses of the health-care systems in Germany and Austria were (and still are) compensated for by the exemplary sacrifices of hospital staff, which is why any approach to strengthening the systems must first and foremost address the needs of the employees. Forms of recognition must be found that prevent further resignations and offer employees better prospects for the future.

Conclusion

Our research findings show how health-care workers not only mastered the COVID-19 crisis, but fundamentally helped combat the already existing crisis of social reproduction (Fraser 2016; Dowling 2021; Plomien et al. 2022) from being exposed. However, it is evident that this way of delivering care is fragile and cannot be a permanent

solution to the systems' various crises. Paid care in hospitals is characterised by a heavy workload, which became even worse during the COVID-19 pandemic, with more patients and constant changes in the organisation of work. The high commitment to paid care work that the nursing staff voiced and showed can be interpreted as a manifestation of a strong work ethos, nourished by a strong belief in their vocation, their bonds with their team, but also their concern for their patients' well-being. The COVID-19 crisis has shown the relevance of this work, and society demonstrated in symbolic and material (though financially not very generous) ways that it valued these efforts. Yet this symbolic and material valorisation of this work did not change the structural contradictions between capital and care and 'capitalism's longstanding entanglement of gender and social reproduction' (Fraser 2016: 113).

Our findings show that the provision of both paid health care and unpaid childcare is ensured by exploiting, and in some cases over-exploiting, the labour of women. Given the structural staff shortages at hospitals in Austria and Germany, the exhaustion levels have increased. Even before the pandemic, it was difficult for health-care workers with children to reconcile the demands of their work and family lives and ensure the care of their children. The lockdown and the additional burden of paid care work exacerbated this strain and many health-care workers did not have the time, let alone the psychological and physical capacity, to care for their families. As paid and unpaid care are predominately female, it was female health-care workers in particular who experienced this physical and mental overload at work with more time spent in the hospital, while at the same time having less time for (organising) care and schoolwork at home. It was thus mainly women who suffered exhaustion, had to take sick leave, or decided to completely give up their paid care jobs. In this way the 'double crisis' ended their careers in the public health-care sector.

In summary, our empirical study shows that the crisis of social reproduction affects both paid care work, which does not meet the demands and requirements of either the care workers or the patients, and unpaid family care work, which can no longer be performed satisfactorily. The care workers we interviewed felt that they had strongly demonstrated their commitment to care for the sick and greatly contributed to the continued functioning of society during the pandemic. Yet there is no sustained appreciation of these efforts, as the long-standing devaluation of the health-care sector remains unaddressed. The health-care workers in our studies argued that, after this exhausting period, structural changes are required, like more personnel, better worktime regulations, more training, and better incomes. The COVID-19 pandemic illustrated that having a sufficient number of health-care workers is crucial for the functioning of our society. Yet the health-care sector in both countries is facing personnel shortages, which had already become apparent before the COVID-19 pandemic. Given that even before the pandemic, hospitals in Germany already had a shortage of more than 100,000

full-time nurses (while Austria had a shortage of 76,000),[10] the fear is that the nursing crisis will worsen if, due to the pandemic, a large number of nurses consider leaving the profession and/or not enough young people enter the profession. Tackling this crisis of social reproduction will require systemic change.

Interviews Overview

Int. No.	Country	Gender	Job/position	Number of children (incl. age)
A_Int1	Austria	Female	Doctor	Three children (ages: 2, 2, 4)
A_Int2	Austria	Female	Doctor	Two children (ages: 13, 17)
A_Int3	Austria	Female	Works council	No children
A_Int6	Austria	Female	Departmental coordinator (management)	One child (age: 6)
A_Int12	Austria	Female	Medical consultant; Doctor	Two children (ages: 7, 9)
A_Int14	Austria	Female	Nurse	Two children (ages: 3, 5)
A_Int15	Austria	Female	Nurse	Two children (ages: 2, 5)
G_Int1	Germany	Female	Nursing management	Two children (ages: 15, 17)
G_Int2	Germany	Female	Nursing management	Three children (ages: 7, 10, 13)
G_Int4	Germany	Female	Nursing management	Two children (age: 12)
G_Int5	Germany	Female	Ward manager	One child (age: 14)
G_Int6	Germany	Female	Ward manager	Two children (ages: 2, 5)
G_Int8	Germany	Female	Nursing management	Two children (ages: 2, 6)
G_Int9	Germany	Female	Nursing management	Three children (ages: 6, 8, 10)
G_Int10	Germany	Female	Nurse	Three children (ages: 7, 12, 14)

References

Auffenberg, J., D. Becka, M. Evans, N. Kokott, S. Schleicher, E. Braun. 2022. 'Ich pflege wieder, wenn …' – Potenzialanalyse zur Berufsrückkehr und Arbeitszeitaufstockung von Pflegefachkräften. Ed. Arbeitnehmerkammer Bremen. Retrieved 31 August 2022

[10] A report on working conditions in the Austrian care sector argued that that by 2030 around 76,000 new employees will be required, but only about 5,000 people complete nursing training each year (BMSGPK 2021: 5). The number of people in various nursing training programmes is assessed as too low to replace all care workers who are slated to retire in the next few years – without even considering the high fluctuation due to COVID-19.

(https://arbeitnehmerkammer.de/fileadmin/user_upload/Downloads/Politik/Rente_Gesundheit_Pflege/Bundesweite_Studie_Ich_pflege_wieder_wenn_Langfassung.pdf).
Aulenbacher, B. 2015. Kapitalismus als Herrschaftszusammenhang und die Unterordnung des Lebens. Pp. 13–53 in B. Aulenbacher, B. Riegraf, S. Völker (eds.). *Feministische Kapitalismuskritik*. Münster: Westfälisches Dampfboot.
Becker-Schmidt, R. 2011. 'Verwahrloste Fürsorge' – ein Krisenherd gesellschaftlicher Reproduktion. Zivilisationskritische Anmerkungen zur ökonomischen, sozialstaatlichen und sozialkulturellen Vernachlässigung von Praxen im Feld 'care work'. *Gender* 3: 9–23.
Begerow, A., U. Michaelis, U. Gaidys. 2020. Wahrnehmungen von Pflegenden im Bereich der Intensivpflege während der COVID-19-Pandemie. *Pflege* 33 (4): 229–236.
Bergmann, N., H. Schiffbänker. 2016. Work-Life Balance and Men in Austria? – Empirical Evidence at Company Level. Pp. 113–127 in *Balancing Work and Family in a Changing Society. Global Masculinities*. New York: Palgrave Macmillan.
BMSGPK (Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz). 2021. *Arbeitsbedingungen in Pflegeberufen. Sonderauswertung des Österreichischen Arbeitsklima Index*. Vienna: SORA.
Bundesagentur für Arbeit. 2022. *Arbeitsmarktsituation im Pflegebereich*. Retrieved 12/04/2023 (https://statistik.arbeitsagentur.de/DE/Statischer-Content/Statistiken/Themen-im-Fokus/Berufe/Generische-Publikationen/Altenpflege.pdf?__blob=publicationFile&v=7).
Conti, C., L. Fontanesi, R. Lanzara, I. Rosa, P. Porcelli. 2020. Fragile Heroes. The Psychological Impact of the COVID-19 Pandemic on Health-Care Workers in Italy. *PLoS ONE* 15 (11): 1–17.
DGB (Deutscher Gewerkschaftsbund). 2020. *Weiblich, systemrelevant, unterbezahlt. Arbeitsbedingungen in vier frauendominierten Berufsgruppen.* DGB-Index Gute Arbeit. Kompakt 01/2020. Berlin.
Dowling, E. 2021. *The Care Crisis. What Caused It and How Can We End It?* London & New York: Verso.
Eurofound. 2006. *Employment in Social Care in Europe*. Luxembourg: Office for Official Publications of the European Communities.
Eurostat. 2018. Mean Hourly Earnings by Sex, Age and Economic Activity. Online Data Code: earn_ses18_13. Retrieved 26/08/22 (https://ec.europa.eu/eurostat/web/main/data/database).
Fraser, N. 2009. Feminism, Capitalism and the Cunning of History. *New Left Review* 56: 97–117.
Fraser, N. 2016. Contradictions of Capital and Care. *New Left Revie*w 100: 99–117.
Funder, M. 2014. In Zeiten der Ungewissheit – Geschlechterverhältnisse in Bewegung? Zum Spannungsverhältnis von Wirtschaft und Geschlecht am Beispiel des Finanzsektors. Pp. 181–199 in T. Jung, A. Lieb, M. Reusch, A. Scheele, S. Schoppengerd. (eds.). *Arbeit: Emanzipation. Feministischer Eigensinn in Wissenschaft und Politik.* Münster: Westfälisches Dampfboot.
Gerlinger, T. 2014. Gesundheitsreform in Deutschland. Pp. 25–69 in A. Manzei,

R. Schmiede. (eds.). *20 Jahre Wettbewerb im Gesundheitswesen. Gesundheit und Gesellschaft*. Wiesbaden: Springer VS.

Gorini, A., E. Fiabane, M. Sommaruga, S. Barbieri, F. Sottotetti, M. T. La Rovere, E. Tremoli, P. Gabanelli. 2020. Mental Health and Risk Perception among Italian Healthcare Workers during the Second Month of the COVID-19 Pandemic. *Arch Psychiatr Nurs* 34 (6): 537–544.

Häussl, A., E. Ehmann, A. Pacher, K. Knödl, T. Huber, L. Neundlinger, A. Osmanovic, A. Plank-Straner, P. Walter, S. Schüssler, D. Schoberer. 2021. Psychological, Physical, and Social Effects of the COVID-19 Pandemic on Hospital Nurses. *International Nursing Review* 68: 482–492.

Haug, F. 2018. Selbstveränderung als gesellschaftliche Praxis. Pp. 24–39 in A. Scheele, S. Wöhl (eds.). *Feminismus und Marxismus*. Weinheim: Beltz Juventa.

Hipp, L., M. Bünning. 2021. Parenthood as a Driver of Increased Gender Inequality during COVID-19? Exploratory Evidence from Germany. *European Societies* 23 (sup1): 658–673.

Hürtgen, S. 2022. 'Helden' oder Arbeiter*innen? Systemrelevanz und Demokratie. *Arbeit* 31 (1-2): 115–132.

Klinger, C. 2014. Selbst- und Lebenssorge als Gegenstand sozialphilosophischer Reflexionen auf die Moderne. Pp. 21–39 in B. Aulenbacher, B. Riegraf, T. Hildegard (eds.). *Sorge: Arbeit, Verhältnisse, Regime. Soziale Welt Sonderband 20.* Baden-Baden: Nomos.

Koebe, J., C. Samtleben, A. Schrenker, A. Zucco. 2020. *Systemrelevant, aber dennoch kaum anerkannt: Entlohnung unverzichtbarer Berufe in der Corona-Krise unterdurchschnittlich.* DIW aktuell, No. 48. Berlin: Deutsches Institut für Wirtschaftsforschung.

Kohlrausch, B., A. Zucco. 2020. Die Coronakrise trifft Frauen doppelt – Die Folge der Re-Traditionalisierung für den Gender Care Gap und Gender Pay Gap. *Feministische Studien* 38 (2): 322–336.

Kramer, V., A. Thoma, M. Kunz. 2021. Medizinisches Fachpersonal in der COVID-19-Pandemie: Psyche am Limit. *InFo Neurologie + Psychiatrie* 23 (6): 46–53.

Lindner, U. 2007. Die Krise des Wohlfahrtsstaates im Gesundheitssektor. Bundesrepublik Deutschland, Großbritannien und Schweden im Vergleich. *Archiv für Sozialgeschichte* 47: 297–324.

Maier, F., D. Schmidt. 2019. Das Gespenst der Care-Krise: Ein kritischer Blick auf eine aktuelle Debatte. *PROKLA. Zeitschrift für kritische Sozialwissenschaft* 49 (2): 239–258.

Mulfinger, D. N., J. Lampl, A. Dinkel, K. Weidner, M. E. Beutel, M. N. Jarczok, G. Hildenbrand, J. Kruse, T. Seifried-Dübon, F. Junne, P. Beschoner, H. Gündel. 2020. Psychische Belastungen durch Epidemien bei Beschäftigten im Gesundheitswesen und Implikationen für die Bewältigung der Corona-Krise: eine Literaturübersicht. *Zeitschrift für Psychosomatische Medizin und Psychotherapie* 66 (3): 220–242.

Mulvaney, K. 2013. For What It's Worth: An Examination of the Persistent Devaluation of 'Women's Work' in Capitalism and Considerations for Feminist Politics. *GENDER. Zeitschrift für Geschlecht, Kultur und Gesellschaft* 5 (2): 27–44.

Nelson, J. A. 1998. Labour, Gender and the Economic/Social Divide. *International Labour Review* 137 (1): 33–46.

Öz, F. 2020. *Löhne und Gehälter in systemrelevanten Berufen: Gebraucht und geschätzt,*

aber unter Wert! Eine Analyse auf Basis der WSI-LohnSpiegel-Datenbank. IAT Discussion Paper No. 20/02. Gelsenkirchen: Institut Arbeit und Technik.

Plomien, A., A. Scheele, M. Sproll. 2022. Social Reproduction and State Responses to the Global COVID-19 Pandemic: Keeping Capitalism on the Move? Pp. 139–152 in A. Kupfer, C. Stutz (eds.). *COVID, Crisis, Care, and Change? International Gender Perspectives on Re/Production, State and Feminist Transitions.* Opladen: Verlag Barbara Budrich.

Rubery, J. 2015. Austerity and the Future for Gender Equality in Europe. *ILR Review* 68 (4): 715–741.

Scheele, A. 2013. Frauenerwerbstätigkeit im Spannungsfeld von 'Prekarisierung' und 'Guter Arbeit' – Geschlechterpolitische Erweiterungen. *Arbeit. Zeitschrift für Arbeitsforschung, Arbeitsgestaltung und Arbeitspolitik* 22 (3): 187–198.

Scheele, A. 2019. Abwertung von Care-Arbeit durch Vergeschlechtlichung. Pp. 24–36 in C. Rudolph, K. Schmidt (eds.). *Interessenpolitik und Care - Voraussetzungen, Hürden und Perspektiven kollektiven Handelns.* Münster: Westfälisches Dampfboot.

Scheele, A. 2022. The Role of Gender in the Making of Global Labour Markets. Pp. 87–100 in U. Mense-Petermann, T. Welskopp, A. Zaharieva (eds.). *Search of the Global Labour Market.* Leiden: Brill Publisher.

Scheele, A., H. Schiffbänker, D. Walker, G. Wienkamp. 2023. Fragile Sorge: Zumutungen und Konflikte während der COVID-19-Pandemie. *Femina Politica.* 32 (1): 38–53.

Schmucker, R. 2020. Arbeitsbedingungen in Pflegeberufen. Pp. 49–60 in K. Jacobs, A. Kuhlmey, S. Greß, J. Klauber, A. Schwinger (eds.). *Pflege-Report 2019. Mehr Personal in der Langzeitpflege – aber woher?* Berlin: Springer.

Schönherr, D., M. Zandonella. 2020. *Arbeitsbedingungen und Berufsprestige von Beschäftigten in systemrelevanten Berufen in Österreich. Sonderauswertung des Österreichischen Arbeitsklima Index.* Vienna: Kammer für Arbeiter und Angestellte für Wien.

Schutzbach, F. 2021. *Die Erschöpfung der Frauen. Wider die weibliche Verfügbarkeit.* Munich: Droemer.

Silies, K., A. Schley, J. Sill, S. Fleischer, M. Müller, K. Balzer. 2020. Die COVID-19-Pandemie im akutstationären Setting aus Sicht von Führungspersonen und Hygienefachkräften in der Pflege – Eine qualitative Studie. *Pflege* 33: 289–298.

Statistik Austria. 2022. *Jahrbuch der Gesundheitsstatistik 2020*. Retrieved 21/06/23 (https://www.statistik.at/fileadmin/publications/Jahrbuch-der-Gesundheitsstatistik_2020.pdf).

Statistisches Bundesamt. 2022. *Zahl der Beschäftigten im Pflegedienst in Kliniken binnen zehn Jahren um 18 % gestiegen*. Pressemitteilung Nr. N026 vom 11. Mai 2022. Retrieved 12/04/23 (https://www.destatis.de/DE/Presse/Pressemitteilungen/2022/05/PD22_N026_2313.html).

Statistisches Bundesamt. 2022. *Personal in Krankenhäusern: Deutschland, Stichtag.* Ergebnis 23111-0002. Retrieved 29/12/22 (https://www-genesis.destatis.de/genesis/online?operation=previous&levelindex=3&step=3&titel=Ergebnis&levelid=1672308217442&acceptscookies=false#abreadcrumb).

Tavora, I., J. Rubery. 2021. The COVID-19 Crisis and Gender Equality: Risks and Opportunities. Pp. 71–96 in B. Vanhercke, S. Spasova, B. Fronteddu (eds.). *Social Policy in*

the European Union: State of Play 2020: Facing the Pandemic. Brussels: ETUI and OSE.
Villa, P. I. 2020. Corona-Krise Meets Care-Krise – Ist das systemrelevant? *Leviathan* 48 (3): 433–450.
Weber, L. 2022. Nach der Krise ist vor der Krise ist in der Krise: Geschlechtliche Arbeitsarrangements und ungelöste Care-Konflikte aus der Sicht von Pflegekräften während der Corona-Krise. *Arbeit* 31 (1-2): 95–113.

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