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Caring for the elderly in times of pandemic

Families in the reconfiguration of the care resource mosaic[1]

Introduction

In this article we analyse how families who are responsible for the care of elderly and dependent people have had to adjust the forms of care based on the conditions imposed by the pandemic: confinement, vulnerability of the elderly, closure or interruption of services care (day centres, home care services, domestic workers), impossibility of having external support (from the family or the community environment). In many cases there has been a refamiliarisation of care and the return to the home of some people in care facilities (rehousing). We want to address how in this context the resources used to care for the elderly and dependent have been reconfigured, modifying what we call the "mosaic of care resources" (Soronellas, Comas d'Argemir and Roigé, 2020) and how these changes have impacted on the families who have had to care for their dependent relatives.

One of the most important demographic phenomena today is the spectacular increase in longevity worldwide. We can speak of "new ageing" due to the strong presence of

La pandèmia i el confinament han imposat un escenari que ha transformat el conjunt divers (mosaic) de recursos de cura amb què les famílies resolen les situacions d'atenció a les persones grans i dependents. En aquest article analitzem la reconfiguració de les formes de cuidar i el retorn a la família (refamiliarització) i a la llar (rellarització) de les situacions de cura a conseqüència de les circumstàncies provocades per la Covid-19. Les dades empíriques procedeixen d'entrevistes semidirigides realitzades a persones cuidadores a Catalunya, en el context d'una recerca d'àmbit estatal.

La pandemia y el confinamiento han impuesto un escenario que ha transformado el conjunto diverso (mosaico) de recursos de cuidado con que las familias resuelven las situaciones de atención a las personas mayores y dependientes. En este artículo analizamos la reconfiguración de las formas de cuidar y el retorno a la familia (refamiliarización) y al hogar (rehogarización) de las situaciones de cuidado como consecuencia de las circunstancias provocadas por la Covid-19. Los datos empíricos proceden de entrevistas semidirigidas realizadas a personas cuidadoras en Cataluña, en el contexto de una investigación de ámbito estatal.

The pandemic and lockdown have imposed a scenario that has transformed the diverse set (mosaic) of care resources with which families resolve situations of care for the elderly and dependent people. In this article we analyse the reconfiguration of ways of caring and the return to the family (refamiliarization) and home (rehousing) of care situations as a result of the Covid-19 circumstances. The empirical data come from semi-directed interviews conducted with caregivers in Catalonia, in the context of a state-wide research.

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[1] Care matters. Gender impact on caregivers of the elderly and dependents in times of Covid-19 (CUMADE). Overcome Covid-19 Fund Santander-CRUE-Spanish Universities. 1/07/2020 to 30/06/2021. IP: Dolors Comas d'Argemir (URV). Participating universities: Rovira i Virgili University, University of Barcelona, University of Valencia, Euskal Herriko Unibersitatea, Complutense University of Madrid, University of A Coruña, University of Granada, University of Murcia, University of Zaragoza, Autonomous University of Madrid.

older people in our societies (Comas d'Argemir and Roigé, 2018). Forecasts indicate that in 2050, 15% of the Spanish population will be over 80 years old, so that Spain will be the second oldest country in the world after Japan (OECD, 2013), although this percentage may decrease due to the deadly incidence of the coronavirus among the older population. In any case, meeting the care needs of the elderly is a challenge for current societies and for the near future (Carrasco *et al.*, 2011; Pérez-Orozco, 2014; Tobias *et al.*, 2011). The analysis of end-of-life care constitutes a critical point for understanding how an increase in longevity shapes experiences and meanings, mobilises social relations and resources, and is a point of interconnection between the moral economy and the political economy (Buch, 2015). Hence the importance of understanding the extent to which the family continues to be a key piece in the provision of care, which the pandemic has highlighted. The State has assumed the health part of the situation, but has attributed the rest of the fight against the pandemic to households (Durán, 2021). The lockdown, which forced people to stay at home, has put an overload on families and has required work and dedication from people, especially women, which has entailed an extraordinary effort.

This article is based on a wider investigation on the impact of the pandemic on caregivers of elderly and dependent people and covers the Spanish territory (Comas d'Argemir and Bofill-Poch, in press). The fieldwork was carried out between June 2020 and April 2021, and involved conducting interviews, some face-to-face, but mostly virtual, with

Paraules clau: pandèmia, cura social, família, gènere, etnografia

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Keywords: pandemic, social care, family, gender, etnography

The insufficiency of public resources and the high cost of private ones means that the family remains the basic pillar of the social organisation of care for the elderly and dependent. XABIER BALLESTEROS family caregivers.[2] In this text we focus specifically on the analysis of the impact of Covid-19 on the way families are organised to solve the provision of assistance to the elderly who are under what they consider to be their responsibility . We start from the assumption that families are the main providers of direct care and, also, that it is around the family group that the management of the care resources provided by the different integral agents of the "diamond of care" is articulated (Razavi, 2007): the market, public policy, the families themselves and the community. The argument of the article rests on the consideration that the pandemic has had an impact on the mosaic of care resources, especially of people who are cared for in their own environment, because pieces have been lost that have had to be replaced by, above all, a greater dedication of caring relatives, mostly women, and also with an increase in the private hiring of paid carers. The gender approach is an essential axis of the analysis given that the pandemic has starkly highlighted what was already a reality: that care has an impact on women's lives, that it conditions their opportunities and that it creates situations of inequality and social injustice, both for family carers and for paid carers under very precarious working conditions.

The social organisation of care in Spain

Caring for each other: this is what predominates in everyday life and is what self-care consists of, or self-attention in the words of Eduardo Menéndez (1992). But in situations of illness, disability or loss of autonomy, as well as in the case of children, third parties are required to intervene to solve the basic needs of daily life. It is what Daly and Lewis call it *social care*, which they define as "the set of activities and relationships involved in satisfying the physical and emotional needs of dependent adults and children, and the regulatory, economic and social frameworks in which they are assigned and develop" (2000: 284). In addition to the family, as the main care institution, care is also provided by public services and those provided by the market. The need to incorporate the community sector into this scheme means that the triangle of well-being is replaced by the diamond of care, as a representation of the institutional architecture of the provision of care (Razavi, 2007).

In this article we are primarily concerned with the family and its members as providers of long-term care. The presence or absence of a public system involved in the social organisation of care largely determines the responsibility assumed by the other components of the care diamond. In countries with ungenerous social policies, familism in care is exacerbated, but also social inequalities (Saraceno, 2010). The model of care provision is neither gender nor class neutral. It is forced altruism, channelled in terms of moral obligation and established in women as a basic pillar. Faced with the absence of care policies, the market unfolds in a multitude of resources, from the most professional to the most informal, and families, especially those with fewer resources, are forced to assume more directly the management and care of elderly and dependent people. This has created imaginaries of countries (in the south) with familistic care cultures and more individualistic countries (in the north) with institutional care cultures and with families little involved in caring for their members. Thelen (2015) alerts us to the formation of these neocolonial imaginaries in which traditional cultures care in a warm, emotional way, while "modern" cultures provide colder care. In reality, it is not the imaginaries, but the quality and quantity of public investment in social policies that end up shaping care practices.

In 2006, the so-called Dependency Law was approved in Spain as a public commitment to deal with what is technically called long-term care, which meant a strong boost in the creation of economic benefits and services of care[3] But in the years immediately following, Spain experienced the effects of the financial crisis and a deep economic recession.

[2] To prepare this text, data from 20 interviews and two focus groups with family caregivers, carried out in Catalonia and Castellón by members of the URV and UB research teams, have been used: Xavier Ballesteros, Sílvia Bofill, Herena Coma, Dolors Comas d'Argemir, Carlos Chirinos, Maria Offenhenden and Montserrat Soronellas. Also participating in the discussion of the conclusions on family caregivers of the CUMADE project: Marcela Jabbaz, Marta Candeias, Blanca García Peral, Mónica Gil, Nina Navajas, Juan Rodríguez del Pino, Samuel Rubio, María del Pilar Tudela.

[3] Law 39/2006, of December 14, for the Promotion of Personal Autonomy and Care for people in a situation of dependency.

Austerity measures were implemented, with substantial cuts in public spending and a sharp setback in the enforcement of the law. This led to an expansion of market services, a refamiliarisation of care and new burdens for women (Comas d'Argemir, 2015; Deusdad *et al.*, 2016; Ezquerra, 2013; Lombardo and León, 2014). We therefore have close antecedents that show us how the State turns the family into the insurance network in crisis situations and the one responsible for the well-being of its members.

The lack of public services and the high cost of private ones, which has been a constant in Spain, has led to the employment of migrant women to care for the elderly in homes, with precarious wages and working conditions (Offenhenden, 2017). This is one of the characteristics of existing social care and a resource profusely used by families and enhanced by public and migration policies, as it allows considerable savings in social spending, even if it involves a high personal cost for women migrants and their families (Anderson, 2012; Benería, 2006; Razavi and Staab, 2010). This type of arrangement is so widespread that Bettio *et al.* (2006) have come to affirm that in Mediterranean countries there has been a transition from the "family" care model to the "immigrant family" care model.

The traditional response to the care needs of the elderly in Spain comes from the family, especially wives and daughters. But family, demographic and social changes have eroded this model: each generation has fewer children than the previous one; women demand equality in family behaviours and those who participate in the labour market do not want to leave it, which reduces the potential caregiver of families (Soronellas and Comas d'Argemir, 2017). In addition, the diversity of forms of coexistence that exist today in Spain (small families, reconstituted families, single parents, de facto couples, homosexual couples...) modifies the content of kinship ties and the obligations associated with them (Roigé , 2006; Roigé and Soronellas, 2018). The forms of intergenerational family solidarity have also changed substantially, the result of the increase in longevity and the desire for economic and personal autonomy of both the elderly and the younger (Conlon *et al.*, 2016; Lynch and Danely, 2013).

Gender and kinship are significant variables that must be taken into account when assigning care responsibilities (Comas d'Argemir and Soronellas, 2019). In care work, gifts and wages are exchanged, but both dimensions, moral and economic, do not necessarily act separately. Care is work whether it is paid or not (Drotbhom and Alber, 2015). Taking care of the family environment has a strong emotional and subjective charge that contributes to essentialising care and interpreting it under the moral code of kinship that "forces (mainly women) to take care for love". Carrasco *et al.*, (2011: 72) refer to this as the mystique of care, and warn us that this argument is effective in making it invisible as work, in order to hide its hardness and the situations of inequality it entails, to strip it of logic economic and to continue linking it to a certain type of femininity.

The complex mosaic of care resources

Situations of high dependency are very demanding in terms of activities and time; they transform the lives of families, modify the domestic space and change the place of work and care practices. Families are forced to carry out a complicated combination of aid and resources to make possible a culturally majority aspiration in Spain, such as ageing at home.

We define the “mosaic of care resources” as the set of supports and services used to care for older people: involvement of spouses and children, informal support from kinship and community networks, employment of domestic workers, home care from public services, use of day centres, tele-assistance, or community canteens. Assisted living and socio-health care homes involve the institutionalisation of the person cared for and are used in extreme situations from a health point of view.

Family care therefore involves the filigree of matching the different resources provided by the agents represented in the diamond of care: family, state, market and community. The ability to mobilise resources and obtain support depends on the families' economic, social and cultural capital. It is also important to live in an urban or rural area, as the latter usually suffers from a lack of services. Let us see how the mosaic of resources was composed before the pandemic.

a) Family care. In the words of Hochschild (2012), families absorb the impact of the social shock caused by the extension of longevity. In this context, care is clearly gendered and women predominate as caregivers. When it comes to groups of siblings taking care of their parents, for example, there may be a shared commitment, but the most common is for the women to give care and for brothers and husbands to help from time to time. Residential proximity or coexistence play an important role when it comes to distributing care tasks. Male participation is increasing, especially in the case of older men who take care of their wives, when they are the ones who require attention (Comas d'Argemir and Soronellas, 2019)

b) The extended family. This is already a second level of commitment: brothers/sisters, brothers-in-law, grandsons/granddaughters do not tend to exercise direct care, except in situations of great need. Family support is mainly given in the form of accompaniment in the form of visits, in emotional support and occasionally substituting the carer. It is an essential resource when men are the main caregivers.

c) Community support. Family care is also based on the relationships of the community environment, formed by friendships, the neighbourhood or even by mutual aid groups. Much of this support is based on the accompaniment of both the caregiver and the cared for. Mutual aid groups are an important support for carers because they share difficult and stressful situations, complicated to understand for those who do not experience them directly.

d) Paid caregivers. Another essential piece of the mosaic is the work provided by paid caregivers, both through a Home Care Service (SAD in Catalan) and through the private hiring of women who carry out part or all of the household and care tasks. It is the first recourse that is opted for when the relative begins a situation of dependency. In rural areas, where fewer services are available, it becomes an essential resource.

e) Care services (public or private). Care provided from services is also part of the mosaic. The closest and least invasive services to the family model are represented by day centres, as they are a space where the person can go for hours and provide respite for the caregiver. And the last resort is residence. It is not always easy to find an available place, especially if you want to be close and public. In any case, residential care is seen as something undesirable, one used when it is no longer possible to care at home in conditions that generate feelings of guilt among family members.

The impact of the pandemic on the mosaic of care resources. Returning home and refamiliarisation

The impact of the pandemic has involved a reorganisation of activity following the closure of day centres, the interruption or reduction of home care services or the limitation of access to residences. These circumstances have caused a transformation of household structures because they have motivated the return home or the reception in the family home of elderly and/or dependent people who were institutionalised or who were still leading an independent life. Often, this return to the home, caused in many cases by the closure of the day care centres where the people cared for were cared for most of the day, has led to the refamiliarisation of care tasks that were outsourced to caregivers. Both the return to the home (rehousing), own or family, and the refamiliarisation of care work have had a greater impact on the lives of women to whom society attributes, as women and as mothers, wives or daughters, the responsibility of caring. It has also had a greater impact on women and families with fewer resources available to hire such care in the market.

The pandemic has interrupted the process of outsourcing or sharing care that we have described in the previous mosaics. Day care centres, visits from family and friends, even support from SAD or privately hired caregivers failed, especially during the first weeks of the pandemic, when the fear of contagion and mobility was instilled in people's lives. Vicent (C338) is the main carer of his wife, who he takes care of with the support of his daughter. Vicent lives in a town on the Valencian coast, takes his wife to a day centre for the elderly every day and receives community support from friends and extended family who, due to residential proximity, accompany him in many moments of his day-to-day caregiving. The closure of the municipality's day centre, following the declaration of the state of alarm and lockdown, put the full burden of direct care on Vicent and made it impossible for him to carry out his daily routines that before Covid-19 allowed him to enjoy some personal time to meet up with friends or to pick up his grandson at school. Vicent's mosaic of resources was reduced to the minimum expression, centralised in the home and refamiliarised around him with the support of his daughter.

The social organisation of care changed radically. The mosaics lost crucial pieces and everything was left in the hands of the families. Assumpta's parents lived at home, in a village in Tarragona, she lived in the city and travelled to the village at weekends to organise the daily care they needed. She had the support of one of her two sisters and a domestic worker who went a couple of days a week, for a few hours, to her parents' house to look after them. When the state of alarm was declared, and with the possibility of working remotely, Assumpta went to live with her father and mother, who were too vulnerable to be left alone in the context of home confinement.

In the first days of the state of alarm, some care workers who had to travel by car to the homes of the people they cared for asked their contractors to stop going there for fear of contagion and because of the mobility difficulties in a context of restrictions. This is the case of Berta, who on the first day of the state of alarm had to go and find Florència, her mother-in-law, who lived in a town about 40 km away, because the domestic worker who had taken care of her for years had requested medical leave due to the risk that Covid-19 posed to her precarious health. Berta relates it from the bewilderment and discomfort caused by the caregiver's position regarding protecting herself from Covid-19:

> She told us she was *very scared, that she didn't want to come...*, that she was, that she was afraid to spread it, *that she was very sick, that it was very serious, that...*, and we asked her *well, what's wrong with you?* Because of course, we didn't know that this girl was sick too. It's one thing if it's serious, you're not going to work either, you're at home. And we asked her *What do you have then?, Well, I'm very poorly, I'm very poorly, it's very serious. I already told the doctor. And the doctor told me to take sick leave.* (Bertha, daughter-in-law)

Covid-19 has meant the incorporation of Florència into the home of her son's family, a situation that has greatly changed family life and has created stressful situations regarding what care work entails, which Berta undertakes in the majority, and because of the relational difficulty of incorporating a member of the family who was not counted on in domestic life. The reopening of the day centre in the municipality of residence in January 2020 has been a relief for the family, while they wait for a place in a public residence.

The hardest situations have occurred in cases where people who were admitted to the residences have returned to their home or, more often, to that of a close family member, especially daughters. The story of her relatives shows that care, albeit in a different way, continues after admission: "I was going to give him dinner because I thought, who better to give it to him than his daughter" (Conxa, daughter). The moral disposition of care does not end with admission to the residence and the person responsible for managing the situation is blamed for anything that may happen to the person cared for. The closure of the residences caused by the high risk of contagion and the high mortality of the residents has caused a lot of distress among the relatives of the people admitted, to the point of causing, in some cases, the deinstitutionalisation of the residents. Conxa took her mother out of the residence after she fell ill with Covid-19 and suffered a lot from not being able to take care of the situation:

> Yes, out of 190 residents... they had 160 positives. (...) With all this, my mother isolated... I called her and she was asleep and did not call us... We suffered a lot. (...) And she already went through Covid-19, well until time passed and all that, she was isolated in a room, alone... (...) Meanwhile I was, being locked down, *well* calling the social workers... To see the aids that *there would be* if I took her out, because I, the moment they told me she was negative, I took her out of there. I was very clear... And I proposed to my sister and my sister said: "I'm thinking the same thing". I mean, if she has to die, let her die at home... surrounded by her family. Because the fear she had was that she would die alone, and in the hospital she was, alone (stresses). (Conxa, daughter)

The pandemic has had a significant impact on the possibilities of continuing care in the residence, both because of the changes and interruptions that occur in the visitation regime, and because of the anxiety caused by the feeling of guilt it generates, especially in cases where the death of the admitted family member has occurred. The closure of the residences has meant a feeling of fear, helplessness and loss of the ability to decide on the present and future of the elderly resident who, more than ever, remains in the hands of the institution.

We started by reviewing how the pandemic has given a boost to family care and the return to the home. Next, we review how the reconfiguration of the mosaic of care resources has taken place, focusing on the three agents involved in addition to the family: public policy, the community and the market.

Public care resources during the pandemic

The entry into force of minimum services during the state of alarm complicated and intensified the work of caregivers in homes, mainly women. The home care service (SAD) offered by the Dependency Care System, provided for in the LAPAD, is a very widespread resource among people who decide to be cared for at home. SAD was significantly reduced during the state of alarm, as a prevention due to the risk of contagion or because the workers, who were very exposed to the disease, actually fell ill with Covid-19 and the concessionary companies of the service could not cover the whole demand. On the other hand, some families and people receiving care preferred to do without SAD to avoid risks to the elderly, who are very vulnerable to the disease.

Although it is a very extensive resource, the SAD is totally insufficient to cover all the care needs of the people in care. It is common for the service to provide as little as two hours a week or one or two hours a day, depending on the degree of dependence. In any case, it is an insufficient resource that becomes a piece of the mosaic of care that needs to be supplemented with others: paid workers hired privately and, above all, the women of the family. The pandemic has left even more in evidence the insufficient investment in social services, the repercussion of the migration of the public policy of care on the most vulnerable people and the difficulties of an excessively bureaucratised and not agile system to respond to demand on duty. Aloís is the main carer of his wife, who suffers from early Alzheimer's, who is recognised for two and a half hours of SAD support in the afternoons, from Monday to Friday. With the lockdown, she temporarily lost this service and, due to staffing shortages, when she got it back, they offered her substitute carers, fewer hours of service and a schedule incompatible with the routine of the person being cared for:

> The substitutes were sent two days a week for two hours, something like that. Much less time. And then I asked what was going on and they told me that: of course, it's that with the Covid-19 thing, they are now doing minimal services. (...) And they didn't tell me anything else. When they told me: there is no one else. I told them: hey, then hire someone. Hire more people. You're lacking staff. Don't you see that you're lacking staff? (...) The person in charge informed me that (...): I'm informing you that... 'that Silvia's schedule (the SAD carer) will be, from now on it will be from three o'clock...'. I *wrote to him* and then we talked on the phone and I gave him a *real* earful. (Aloís, husband)

Aloís is critical of the lack of quality public resources to support his wife's situation, who he wants to continue caring for, as long as the disease phase allows, in his home. He considers that the management carried out by the social services is not focused on the needs of the caregivers or those of the cared for, but on the business requirements of the organisations that access public contracts for the SAD services.

Also, the interruption of health services and the closure of Primary Care Centres (CAP) has greatly disrupted life and the care situations explained by the people who participated in the research. In their stories, helplessness, fear and an intense sense of vulnerability appear for having felt alone in the face of the need to undertake health care tasks or, even, for having had to make medical decisions for which they were not they felt no less prepared. The pandemic has changed the ways of caring due to the loss of supports and the need to take on new scenarios and care activities. Assumpta explains that she experienced the neglect of health services with anguish:

> And I *spent* practically forty days attending to my mother with the whole problem of herpes. Doctors, "give her I don't know what" calls. The other "give her I don't know *how many*". They didn't have in *these* forty days not even the slightest visit from a nurse, nothing at all, all by phone. Well... today they would give her a medicine, we would go to the pharmacy and they had already changed it. I mean, it was, it was an *ongoing* case of *get on with it* the best way you can. *Get on with it* the best way you can. (...) Total misinformation, total disregard. (Assumpta, daughter)

In short, the services have not been up to par and the caregivers have felt neglected by a collapsed healthcare system and by a public social care system that under normal conditions no longer covers the needs of the dependent adult population and that during the pandemic has practically disappeared, leaving families with all the care responsibility. The weakness of policies and care resources has been evident during the pandemic.

The loss of family and community support networks

The social care from the community, especially present in the villages, has also been affected by the lockdown, which interrupts the ability to socialise with the neighbourhood, with friendships and with the extended family, and with the services and equipment around the home. The lockdown shut in the elderly at home, a situation that has been difficult for them to understand and that has increased their physical and cognitive deterioration. Some participants have expressed to us the difficulty of keeping their relatives at home:

> *In addition* Dad was getting very aggressive, very. One night, because we said to him, "Dad, you can't go out. Dad, you can't do that. This can't be done. It's just that Mum can't eat that. It's just that we can't do that to Mum, we just can't...", as they have *that* tele-assistance, calling the tele-assistance to send him the Civil Guard because his daughters were mistreating him. Just imagine that. (Assumpta, daughter)

The support of the people who make up the relational network is more important for the caregiver than for the cared for. Especially when caring for a person with severe cognitive impairment, the carer needs the community environment in order to have a social space get some relief from the difficulties and isolation that care imposes. The lockdown meant the interruption of the activity of friendship groups or groups of peers with which essential periodic meetings were held to provide emotional support to the people they care for. Covid-19 has cut the social activity of carers and made them feel vulnerable and in need of support. The responsibility to protect the person dependent on the contagion has locked them at home and demobilised them:

> You settle for this and no matter how bad you feel, you think, 'what if I take him out, I'll catch Covid-19, it'll fell me. Will he catch it, won't he catch it?' You prefer not to move at all. And you agree to stay at home knowing that it is not the way, that it won't do you any good, but you end up assuming that there is no other remedy [...] The responsibility you feel is huge. Even more than before. Both to move the dependent person, and to move yourself. If you move and go out, and go with people, you panic... so, you isolate yourself. (Marta, daughter-in-law)

ICTs have helped to maintain the relational and community continuity of the support groups. Caregivers have incorporated telematic means of communication and have felt helped and accompanied by the group which, more than ever, has functioned as a self-organised group. Despite missing the hugs, the support group Colla Cuidadora, from the Esquerra de l'Eixample in Barcelona, found in video conferences and phone calls a way to give each other emotional support. According to one of the research participants, the members of the family care support group are the only ones who can understand the situation:

> These friendships started with the support group. In the support group I was in we have a WhatsApp group and we did the video call thing. What binds you to these people is *something* that does not unite you with any other friend who thinks that we are always going to go on about the same sorrows. On the other hand, with those in the support group you can explain it, and say via WhatsApp what has happened to you and in the end they tell you "it's the same thing that happened to me". And with these we make a group of *support*. (Dolors, daughter)

The community vanished during the pandemic. Home confinement and the fear of contagion have caused social isolation and disrupted community support networks. The impact has been significant for people cared for because they have lost fundamental activity which has caused physical and cognitive deterioration; also for caregivers, because they have lost emotional support and community support, in a scenario of overload caused by the refamiliarisation and recentralisation of care work at home.

Changes in recruitment of paid caregivers

The impact of the pandemic and the overload of care work that the loss of external resources has caused in families has led, in some cases, to the hiring of a caregiver on an intern basis. This is the case of Assumpta, who after the first months of lockdown trying to reconcile telecommuting and caring for her parents in a rural area, decided to hire a 24-hour carer. In less than a month, she had already hired two, because the first one did not meet her expectations. Lucía relates a similar situation: at the beginning of the lockdown, her parents were looked after by a carer who stopped working when the state of alarm began and in a short time had already hired two more. Both emphasise the difficulty of finding the right person, who gets along with the parents and who adapts to their eating habits and daily routines. Without verbalising it, both racialise the caregivers, discreetly referring to their status as foreigners and the difficulties associated with cultural differences.

The families who have removed their relatives from the residences are forced to put together mosaics of care resources. We saw before that Conxa took her mother out of the residence after suffering a lot due to the high incidence of contagion and mortality in the centre where she was admitted. To care for her at home, she has been able to process a public SAD that guarantees her a few hours in the mornings, but she works part-time and this resource does not solve her situation. When we interviewed her, she was in the process of hiring someone on her own to take care of her mother in the afternoons.

The pandemic has therefore brought about important changes in caregivers, in those cared for and in the mosaics and processes of care. It has aggravated and complicated care situations due to the strong impact it has had on the availability and organisation of resources. The closure or precariousness of external aid to family care systems has

Caring activities from the community environment are also an essential part of the social organisation of care that was disarticulated during lockdown. XABIER BALLESTEROS caused a shock in the system that families have had to absorb, especially women who have reported situations of exceptional overload. Isolation, loneliness, incommunicado or fatigue are some of the qualifiers used by the people participating in the research to refer to the first months of the pandemic. The fragile public portfolio of care resources was reduced and families found in the private and precarious hiring of female caregivers a resource that was already overused before the pandemic (Federici, 2013; Offenhenden, 2017), a possible solution, at least partially, to fulfil the moral duty and the commitment to take care of their relatives.

Conclusions

The lack of a public system that can solve the care needs of an ageing population focuses on families the responsibility of providing and organising the available resources for care. The overload of families falls on women because gender and kinship continue to organise, that is to say, distribute care work unequally and unfairly (Comas d'Argemir and Soronellas, 2019). Women care as women, but also as sisters, mothers, wives, daughters, daughters-in-law or grandmothers. Throughout the research we have found that the vast majority of women interviewed normalise and naturalise this task of society and make the responsibility of care their own without questioning it. Men take care only in certain circumstances, when they can reconcile it with work, when they are retired or when they have no other alternative, as is the case of husbands who take care of their sick wives.

Around the family extends the mosaic of care, a concept with which we have referred to the set of resources that are used to care for the people who require it. The mosaics are made up of various fragments that are put together like a jigsaw puzzle and this is so (1) because the families, the women, can no longer and do not want to do the caring as they did years ago, (2) because the men have not taken up their care duties and (3) because public policy is weak in this matter. The pieces of the mosaic are: the more nuclear environment of the family, with the support of the extended family and the community; the public system (SAD, residential places, day centres, tele-assistance...), and the market, mainly the private hiring of paid carers (women). Having a few hours of SAD per week or tele-assistance, or even the day centre, does not completely solve the care needs when the dependent person remains in their own residential environment. Looking at the mosaic of care has helped us to understand the strategies of families that face care situations and also to understand the impact of the pandemic on the set of resources we have described.

The closure of day care centres, the crisis in nursing homes, the reduction of SAD services, the dismissal of some paid workers, the fear of contagion and the strict home confinement of the elderly has returned care to the homes, families and women. Care has been refamiliarised and recentralised in the home in order to neutralise the impact of the pandemic. The mosaic has lost essential pieces and has a less fragmented appearance that we must understand in the context of a health emergency and that cannot have continuity. The direct burden of caring for the elderly can no longer be borne by families who have transformed conjugal and intergenerational pacts and who can no longer, or perhaps do not want to, take it on.

Government support has been greatly weakened during the pandemic. The shortcomings and fragilities of the social care system, and even of the health system, have been evident. The participants report that they have felt alone and neglected in the face of emergencies in the care service for their relatives during home confinement and the first months of the pandemic. The care provided by the community is also gone. Support groups for caregivers, visits from friends, contact with the neighbourhood, leisure activities, even shopping and walks around town or the neighbourhood in the strictest lockdown period, interrupt suddenly and caused the physical and cognitive deterioration of the caregivers and also of the elderly receiving care, due to the social isolation caused by the distance. The burden of care work returned to homes and, to a large extent, to families. All the participants report fatigue and emotional discomfort caused by the isolation and overload of care. Even the relatives of people admitted to nursing homes express the stress caused by the situation, due to the impossibility of meeting and, above all, the fear of not being able to say goodbye to the loved ones they left be forced to distance themselves to avoid contagion.

The pandemic has also increased the commodification of care to the extent that families transfer the pressure that the dismantling of the aforementioned care resources has infringed on them. We have talked about refamiliarisation, but there has also been a recentralisation of care in the home that has pivoted around paid work, in cases where the socio-economic condition has made it possible. One of the strategies to mitigate the increase in family care responsibilities caused by the pandemic has consisted of hiring domestic workers by the hour or on an intern basis. It becomes clear again that as long as public resources are so limited and SADs cover only a small part of the hours that dependent elderly people need to be well cared for, the easiest and most affordable solution for families is "paying for care". The low wages of female workers and the precarious working conditions (working hours and days) explain why this is an option that needs to be taken into account by caring families and people receiving care.

The focused look at the composition of the mosaics of care resources and how they have been affected by the pandemic situation has left in evidence the fragility of a social care system that, despite the fact that it was recognised as a right with the entry into force in 2007 of the Dependency Law, it has been deployed so insufficiently that it has been unable to face and provide solutions to the so-called care crisis (Pérez Orozco, 2006). ■

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