

RESEARCH

Fractures in the Austrian Model of Long-Term Care: What are the Lessons from the First Wave of the COVID-19 Pandemic?

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Context: The COVID-19 pandemic highlights limitations of long-term care (LTC) systems in Europe, which continue to be divided between health and social care, and between formal and informal care.

Objective: This article focuses on Austria's LTC sector and its critical features that became visible during the outbreak of the COVID-19 pandemic.

Method: The analysis was carried out via desk-research, which covered literature, on-going qualitative analysis of media coverage, and statements and reports by interest organisations and governmental agencies between March and August 2020. Where necessary, useful and feasible, update information on ensuing developments until the end of 2020 was added during a final revision.

Findings: In Austria, the number of cases as well as the number and share of deaths in care homes were lower than in other countries until August 2020. Yet, the crisis brought several idiosyncrasies to the fore, most prominently a lack of support for informal caregivers and lack of acknowledgements of the rights of live-in personal (migrant) carers. We find that the COVID-19 crisis has shed light on the fact that existing inequalities are being aggravated by gender and migration issues.

Implications: (i) The crisis highlights the need for better communication, integrated care and health information flows between health and social care; (ii) Clear guidelines are required to balance older people's right to self-determination versus (public) health concerns; (iii) Increasing reliance on migrant carers from Eastern Europe has led to a dualisation of the LTC labour market in the past decades, which needs to be countered by increased quality standards and endeavours to fundamentally change the employment situation of live-in carers; (iv) Informal carers are vulnerable groups that deserve special attention and call for expansion of community services in long-term care.

Keywords: divides; informal care; migrant care; Austria

Introduction

The COVID-19 crisis highlights—in an unprecedented manner—the limitations of what has been coined as long-term care (LTC) systems in European countries and beyond (WHO, 2020). The crisis has shown that LTC continues to be characterised by the divisions between health and social care, and between formal and informal care, resulting in a broad neglect of the large number of people involved as users, carers and skilled LTC professionals, particularly in the initial phase of the pandemic. By late 2020, with the onset of the second wave of the COVID-19 pandemic, it remains unclear whether a decent balance

between ensuring older people's dignity and increased protection for them (and their carers) during the pandemic can be found, e.g. in nursing homes (Anderson et al., 2020).

In Austria, the number of cases as well as the number and share of deaths in care homes was lower than in other countries throughout the year 2020 (Comas-Herrera et al., 2020; Schmidt et al., 2020; BMSGPK, 2020). During the first wave of the pandemic between March and July 2020, the country also reported less cases of SARS-Cov-2 infections and deaths per 100,000 inhabitants than other European countries. Despite this relatively favourable situation in its first wave, the COVID-19 pandemic brought several idiosyncrasies to the fore in the Austrian long-term care system, most prominently a lack of support for unpaid care and live-in personal carers. Also, LTC workers and providers in the formal sector were largely left to their own devices (Lebenswelt Heim, 2020). Existing gaps in home care were covered by families and informal carers that provide more than two thirds of all LTC in Austria

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(Nagl-Cupal et al., 2018), as well as by the large group of live-in personal carers (also called '24-hour carers' in a literal translation, despite not being the official name of the model). This article aims to highlight some of the weaknesses in the Austrian LTC system, in particular those that were revealed by the pandemic.

The study presented in this article was carried out as part of the LTCcovid.org collaboration, which was set up as a response to the COVID-19 pandemic. LTCcovid.org represents a hub for ongoing documentation of LTC policies during the pandemic and collects scientific evidence on good practices in the sector. This article synthesizes evidence for the Austrian case and interprets the LTC policies implemented against the overall LTC context in European countries.

With about 1.5 million people over aged 65 years and older (18.2 percent of the population) Austria has a relatively aged population in the EU. Demographic ageing is taking place particularly in rural areas, which presents a specific challenge for the development of long-term care in Austria, with respective problems concerning accessibility and the organisation of support structures in alpine regions. In 1993, a comprehensive system of cash-for-care allowances was introduced which responded to a hitherto fragmented system. Funding for the long-term care allowance (from general taxes) is a responsibility of the federal state while the provincial governments remained responsible for services in kind (Bachner et al., 2018). All citizens in need of care, irrespective of age, are eligible for cash-for-care allowances that are granted without means-testing, based on a needs assessment in seven levels. Provincial governments continue to be responsible for LTC facilities and services, which results in variation both in eligibility and availability of formal LTC services across the country (Waitzberg et al., 2020; Staflinger, 2016; Österle & Bauer, 2012).

A specific feature of the Austrian LTC realm over the past 25 years has been the partial replacement (or supplementation) of family care by live-in personal carers, mainly from neighbouring Eastern European countries. Although live-in migrant care is a widespread phenomenon across Europe (Bettio et al., 2006; Van Hooren et al., 2018), the so-called '24-hour care' model in Austria has had a special status with dedicated legal regulations and funding since 2007 (see Winkelmann et al., 2015; Schmidt et al., 2016). 'Personal carers' are registered as self-employed at the Austrian Chamber of Commerce, although most of them are also dependent on specialised brokering agencies in their home country or in Austria. Due to the geographic situation as well as to unemployment and wage differentials in neighbouring countries, the share of older people in need of care relying on migrant live-in carers has increased to almost seven percent—more than 66,000 personal carers accompany more than 33,000 Austrians in need of care (about 7% of the total) in their own households, while about 47,100 professionals care for about 70,000 residents of care homes per year, and about 18,300 professionals are providing home-based care to about 153,000 clients per year. Altogether, in 2018 there were about 462,000

Austrians of all ages assessed as being in need of care and thus eligible to the federal LTC allowance (BMASGK, 2019).

The Austrian LTC labour market has thus become 'divided by nationality, socioeconomic differences, precarious working conditions, social protection entitlements and labour rights' (Winkelmann et al., 2015, p. 189). The pertaining 'dualisation of the workforce' keeps low-skilled (primarily unorganised) migrant domestic carers in the secondary labour markets and divides the care workforce 'in terms of skills, remuneration and precarious working conditions' (Winkelmann et al., 2015, p. 189). Nevertheless, 24-hour care has become part and parcel of the Austrian LTC system and represents a unique area of regulated live-in personal care in Europe. While helping a significant share of people with LTC needs to continue living at home and saving investments in care homes or alternative services, it adds to the complexity of LTC provision. It thus competes with and likely hampers the development of integrated care and community-based care services.

This article will shed light on some unique features of the Austrian LTC sector, and on its divides, with a view on the societal division of care work. Our key research question is therefore to identify the fractures of the Austrian LTC sector that were exposed by the COVID-19 pandemic, with a view on the political economy of LTC, and which lessons were learnt during this period to prepare for the future. We addressed these questions by desk-research covering literature, media coverage and statements and reports by interest organisations and governmental agencies between March and July 2020.

The first section will briefly outline the methods used for the study and will then present main results regarding the COVID-19 pandemic and its impact on the Austrian LTC sector. Themes that emerged from the analysis are discussed subsequently. The discussion highlights fractures and shortcomings that were made visible by the on-going crisis. The final section will draw some conclusions in terms of potential learnings and future perspectives.

Methods

Data for this article were collected via desk-research covering literature, on-going qualitative analysis of media coverage and statements and reports by interest organisations and governmental agencies between March and August 2020. Evidence was collected in an ongoing process for the LTCcovid.org network, and new materials were synthesized upon their publication. The analysis of the collected materials was carried out in parallel and integrated into different subsections (e.g., informal care, nursing homes and home care), with themes for the analysis emerging throughout the process. Where necessary, useful and feasible, update information on ensuing developments until the end of 2020 was added during a final revision.

Results

The Austrian LTC system has been placed under huge pressure during the COVID-19 crisis throughout the year 2020, as it has not been considered the most important

area of intervention from the onset, despite the fact that half of all women who died from COVID-19 were living in a care home (BMSGPK, 2020). General information about home care services and intermediate care facilities (day-care, short-term care) is scarce, as most of these provisions were discontinued or reduced to a minimum during the lock-down period, yet according to anecdotal evidence only. LTC by family and informal carers was however hardly mentioned in the public debate, even in gender debates (Mader et al., 2020), with few exceptions (Volkshilfe, 2020). In general, there has been an increase in invisible unpaid (household) work carried out by women during the lock-down period in European countries (Blaskó et al., 2020).

However, a first finding at the onset of the pandemic in Austria was that, following ten days of broad neglect, only two aspects of LTC were covered in the public debate—the challenges of 24-hour care and infections in care homes. Only later, the challenges faced by family carers—compared by some to the fire brigades in the COVID-19 crisis (Lorenz-Dant, 2020)—have become publicly discussed, highlighting overburdening of informal caregivers during the crisis (Volkshilfe, 2020). The main fractures identified are described in the following sections.

COVID-19 and the challenges in the area of live-in personal care

The Austrian model of 24-hour care is based on fortnightly (sometimes monthly) shifts of migrant carers. The majority comes from Romania and the neighbouring Slovak Republic, but also from Hungary and a range of other Eastern European countries. As a consequence, the COVID-19 measures with closed borders and travel restrictions were challenging the entire model of '24-hour care'. While most of those personal carers who were in Austria for their 'first shift' in March could be convinced to exceptionally stay for a second shift, their counterparts remained in their home country. The situation compounded when restrictions were extended beyond April, as the burden on carers increased. Regional governments and Chambers of Commerce therefore started to forge strategies to sustain families and personal carers, also by making use of an extraordinary crisis budget of €100 million that was cleared for the LTC sector by the Federal Government. For instance, two provinces (Burgenland, Lower Austria) organised charters to fly in several hundred live-in carers from Romania, Bulgaria and Croatia (Leiblfinger et al., 2020). Upon arrival, carers were directly transferred to a hotel (e.g., in the case of Lower Austria), where they were quarantined for two weeks. During that time, they did not have any income and had to contribute a small amount to accommodation. In the ensuing weeks they then served as backup for those personal carers who needed to be replaced. Regional governments, and eventually the Federal Ministry, decided to offer a premium of €500 to those personal carers who continued to stay in Austria, and a hotline was established to coordinate 24-hour care across the regions. Moreover, an informal network surfaced using social media to mitigate the dropoff of personal carers, supported by interest organisations (Federation

of Nurses, Union, Carers organisation etc.), 24-hour care agencies and personal carers themselves. Later, corridor trains were organised to facilitate the travel of personal carers from Romania to Austria, highlighting the efforts that relevant stakeholders invested in ensuring the continuation of the live-in care model. At the same time, the necessary information and forms were not easily accessible for carers themselves, but in complex and technical German, increasing the carers' dependence on brokering agencies (for more details, see for Austria: Leiblfinger et al., 2020; for migrant carers in general: Kuhlmann et al., 2020).

Impact on family carers

The situation in the 24-hour care sector also impacted on the situation of family caregivers, aggravated by the fact that day care centres and short-term care were also available only to a limited extent (Lorenz-Dant, 2020; Volkshilfe, 2020). A survey among 100 low-income informal caregivers, carried out by an Austrian non-profit care provider offering home care services between May and August 2020, highlights a reduction in support for this group. Fifteen percent of people cared for by the caregivers in the survey discontinued visits in day care centres or professional home care services (e.g., for fear of becoming infected), and 32 percent no longer received therapies or trainings. Most strikingly, however, four out of ten informal caregivers in lower socio-economic groups stopped receiving help from other family members, and 20 percent no longer received help from neighbours. The reduced support within informal caregivers' networks led to higher intensity of care, and in 16 percent of cases resulted in a reduction of paid work (Volkshilfe, 2020).

COVID-19 and the challenges in residential care

International analyses show that overall incidence correlates with incidence in care homes (Comas-Herrera et al., 2020), and similar observations have been made for Austria at the regional level in an evaluation on behalf of the Federal Ministry of Health, covering a third of all care homes (with about 50% of care home places) (BMSGPK, 2020). Overall, the number of cases in Austrian care homes during the first wave was estimated to be low in comparison with other countries. It remains critical to disentangle anecdotal evidence gathered from individual stakeholders media coverage, and surveys that were carried out under difficult circumstances, to provide a first overview on selected issues. This is also valid for one of our key sources for this period, the report on 'COVID-19 in care homes', edited by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection (BMSGPK, 2020). The report publishes results of an online survey among all 930 Austrian care homes, of which 304 completed the questionnaire, and of some online focus groups.

As of 22 June 2020, 923 care home residents from 117 care homes tested positive, with the highest number reported by care homes in the region of Styria. **Table 1** shows the number of care home residents and staff who tested positive. Overall, 28% of infected residents in care homes for older people died. It should be mentioned that

Table 1: Number of cases, care homes affected and incidence by region; age and case fatality rate (as of 22 June 2020).

Region	Cases	Care homes affected		Male		Female		Median age	Incidence		Case fatality rate
		Nr.	%	No.	%	No.	%		per 1,000 residents	per 100,000 population	
Burgenland	6	2	4.4 %	4	66.7 %	2	33.3 %	79.5	2.6	118.6	0 %
Carinthia	0	0	0.0 %	0	0.0 %	0	0.0 %	–	0.0	75.6	0 %
Lower Austria	53	13	11.9 %	18	34.0 %	35	66.0 %	80.0	6.0	176.0	23 %
Upper Austria	59	15	11.4 %	21	35.6 %	38	64.4 %	86.0	5.2	158.6	27 %
Salzburg	49	9	11.5 %	16	32.7 %	33	67.3 %	85.0	10.8	224.1	37 %
Styria	305	23	10.5 %	92	30.2 %	213	69.8 %	86.0	22.5	149.0	27 %
Tyrol	168	24	23.5 %	51	30.4 %	117	69.6 %	87.0	28.1	470.1	24 %
Vorarlberg	46	3	5.3 %	11	23.9 %	35	76.1 %	85.0	19.9	230.0	28 %
Vienna	237	28	31.1 %	70	29.5 %	167	70.5 %	86.0	13.0	193.9	32 %
Austria	923	117	12.6 %	283	30.7 %	640	69.3 %	86.0	12.7	195.4	28 %

Source: BMSGPK, 2020.

in Austria, in contrast to many other countries, no staff in LTC died from or with COVID-19. Later evidence confirms this finding (Comas-Herrera et al., 2020).

By 16 April, the government had announced plans to systematically test all staff and residents in care homes, including people who will be discharged from hospital to care homes. Testing strategies have been implemented reluctantly across services, in particular regarding community care. Some general and specific measures were taken from the range of potential measures to prevent spread of COVID-19 in care homes (Table 2).

However, during the exponential increase of infections in the entire Austrian population from October to December, the aim to shield vulnerable older people in care homes was again not achieved—almost 40% of all deaths occurred in care homes (Table 3). Again, there were huge regional differences reported. For instance, the screenings and the restriction of visits only to public spaces of Viennese care homes seem to have been possibly more successful than the specific ‘Corona traffic lights’ system in Lower Austria, with graded measures according to the level of infections in the local context. In Vienna, the share of deaths during October in total deaths was 43%, while the same share was 91% and 82% in Lower and Upper Austria respectively (Leichsenring et al., 2020).

With new measures less stringent than during the first wave, care homes remained partly accessible. Staff, visitors and residents continue to be subject to risk of SARS-CoV-2 infection, as it is likely that even weekly tests are not able to guarantee virus-free staff. Up to January 2021, residents were scarcely tested, and test results were partly communicated too late. While during the first wave care homes stopped accepting new residents, such stringent measures were not applied from June onwards. Also, hospitals discharged COVID-19 patients to care homes sooner although complete isolation is hardly possible in these settings. Further SARS-CoV-2 clusters in care homes

should be avoided, but notwithstanding some improvements in hygiene standards and the general lockdown, infection rates remained stable at a still high level.

Discussion

In line with many other societal challenges, the COVID-19 pandemic moved the LTC sector to the centre of public attention (WHO, 2020). Although Austrian care homes fared relatively well in terms of lower incidence and death rates during the first wave, this increased attention was triggered by shortcomings that surfaced in particular due to the characteristics of the virus itself; due to the measures taken to flatten the curve of infections; due to the collateral effects of the general focus on the health system, including the lack of coordination and integrated care; and due to the political economy of LTC. These factors are outlined in more details in this section.

Frail older people as a high-risk group

The fact that COVID-19 poses a particular risk to people with multimorbidity, chronic diseases or previous health issues exposes older people in need of LTC as a high-risk group (Mueller et al. 2020; Williamson et al., 2020). This risk is certainly rising if older people in need of LTC cohabit with younger generations, and if a large number of people at high risk cohabit while also depending on professional support such as in residential care. About 20% of Austrians in need of care live in care homes, with an average size of about 80 places each, with important regional disparities. As initially highlighted, care homes were left alone at the beginning of the outbreak of COVID-19. When first cases and deaths in care homes were reported on 8 March 2020, several care homes decided already before the general lockdown to reduce or suspend visitors and to isolate residents in their rooms. During this initial phase, care home managers and staff were not only overburdened with organising protective gear and revising rosters, but

Table 2: Potential strategies to prevent COVID-19 spread and measures taken in Austria.

<i>Potential strategies</i>	Austria	Comment
General measures and guidelines		
National task force	✓	Several task forces at federal and regional government levels, with only 2 representatives of the LTC sector; Regionally diverse ways of multi-level governance and coordination
Information systems (cases, protective gear, additional staff, drugs)	partially	Still not completely implemented by July 2020; lack of data transparency
Guidelines and training for staff	✓	Guidelines at several websites (Ministry of Health, AGES, Regional Departments of Health and Social Care, interest organisations) for all LTC settings; exchange among providers, although criticized for being published too late into the crisis (e.g. in the case of care homes)
Rapid Response Teams	×	
Additional care home capacities and staff	announced	Some care homes needed to close due to infections and lack of staff; alternative settings prepared, but eventually not used; lack of specialist hygiene staff; overburdening of care home staff reported
Assessment of potential for isolation measures	×	Isolation was most often the only alternative chosen; problems in isolating people in rooms with more than one bed
Adaptation of advance care directives	n/a	
Measures to prevent spread of COVID-19		
Visiting restrictions	✓	By 8 March (individual care homes) until 4 May, generally during lockdown; regional variation
Prevention of infection of staff	partially	Lack of protective gear and testing capacities; by 17 April, about 50% of care homes reported sufficient stock, dependent on region and provider
Closure of home care, day-care and intermediate care	✓	During lockdown, closure also of rehabilitation centres; staff was sent on vacation or short-time work ('Kurzarbeit'); a few care homes needed to close down completely due to lack of staff and/or too many positively tested staff
Avoiding infections by new residents or residents returning from acute care	partially	After 7 April (peak use of capacity in hospitals) patients were discharged back to care homes, often without testing; regional variation
Whole-sector screening	✓	Announced on 16 April
Measures to support social distancing in care homes	✓	Most care homes followed strict isolation of residents; initiatives to facilitate video calls with family members for people in care homes and increased social programmes in care homes
Measures to control and monitor infections (incl. contact tracing, isolation)		
Regulations for visits in care homes	✓	By beginning of May and differentiated by region; 'visiting-zones', booths with plexiglass divide
Systematic testing of residents, staff, and visitors	partially	Arrived late in care homes (still lacking by mid-April), differences by regions and providers, no continuity of testing July through September; long waiting times for test results, still no priority of screenings by October
Access to health and palliative care	partially	No access for volunteers and clergy in most care homes; exceptions in care homes implemented for visitors for people with palliative care needs
Additional support by external staff	partially	External staff, incl. occupational and physiotherapy, extremely restricted; access restricted also for inspection and ombudsman; 18% of care homes and 15% of people living at home discontinued therapies

Sources: Comas-Herrera et al., 2020; Lebenswelt Heim, 2020; BMSGPK, 2020; AGES, 2020, Golla, 2020; Volkshilfe, 2020. Note: First COVID-19 cases in Austrian care homes were reported on 8 March, the lockdown started on 16 March.

also by the lack of legal, organisational and ethical certainty (Lebenswelt Heim, 2020). Only later, during the pandemic in May 2020, official guidelines were released (BMSGPK, 2020).

There are no data about infections of older people in need of care who live at home with a personal carer, but it is likely that social isolation of the live-in migrant carers increased, together with growing mental and physical

Table 3: Number of COVID-19 cases in care homes and in the entire population in Austria, cumulated by June, November and December 2020.

Date	Cases in care homes	Cases per 1,000 residents in care homes	Total cases per 100,000 population	Total cases	Total COVID-19 deaths	COVID-19 deaths in care homes	Deaths attributed to COVID-19 as percentage of all care home residents/beds (N = 69,730)
22 June 2020 (1)	923	12.7	195.4	17,380	690	260	0.4%
18 Nov 2020 (2)	5,118	73.4	1,293.8	164,866	2,018	728	1.0%
9 Dec 2020 (2)	10,790	154.1	3,494.4	311,002	4,260	1,550	2.2%

Sources: (1) Data from Ministry of Social Affairs, Health, Care and Consumer Protection (BMSGPK) and AGES (Austrian Agency for Health and Food Safety); (2) Data from Ministry of the Interior (BMI); Staflinger & Leichsenring, 2020.

strain. Isolation has certainly been one of the challenges in the context of these care arrangements already before the crisis (Bauer & Österle, 2013).

The tough choice between safety and quality of life

Although vulnerable older people in care homes had been identified very early as a high-risk group, societal mechanisms were not sufficiently prepared to guarantee safety and security beyond strict isolation. Care home managers and staff most often did not find alternative ways to avoid physical restraints during quarantine, e.g., following residents' visits to the doctor. Others were confronted with legal action by residents' families for negligent homicide so that any measures to improve residents' quality of life during lockdown became a risk for management and staff. Care home managers missed their involvement in regional and national task forces (BMSGPK, 2020). In addition, we know very little of how older people died in care homes. In Austria, palliative care in care homes is provided at a comparatively low level in international comparison and relies heavily on (unpaid) volunteers (Bachner et al., 2018; Bauer & Dixon, 2020). During the lockdown, volunteers had only restricted access or were not allowed to enter care homes at all. The impact of the reduced number and extent of visits on the provision of palliative care can be expected to be detrimental.

However, by the end of April some care homes started to develop creative solutions by establishing 'encounter zones' where families could meet with residents by maintaining physical distance and hygiene standards, e.g., in the garden of the care home or divided by plexiglass. The COVID-19 pandemic and in particular the lockdown period have thus accentuated one of the basic ethical dilemmas pertinent to LTC which is characterised by the impossibility of cure in a strictly medical sense (see also Rodrigues, 2017): Should care and support focus on safety despite potentially being linked to physical and other restraints? Or should the impetus of all person-centred activities foster the best quality of life possible under given circumstances? Following the experiences of complete isolation there was much criticism, including by regulatory agencies that deal with the applications for physical restraints (legally binding in Austria). For instance, it is still unclear how it was possible that these applications were cut in half during

the lockdown. As inspections were not allowed during that period, no further information is available. Proposals for improvement included, among other things, specific staff training and enhanced ethical counselling for and in care homes. These challenges and ethical dilemmas have accompanied long-term care already for quite some time, and there is no dearth of recommendations and related initiatives (cf. Alzheimer Europe, 2015). Still, the dissemination and roll-out of good practice, e.g., ethical dialogues in care homes, including their integration in education and training, need to be pushed as soon as possible.

The unknown collateral damage by fragmented service delivery

Regional authorities responsible for care homes were often overburdened by coordinating between health and social care facilities because of missing structures and routines. While cooperation among care homes flourished, coordination with primary care, mobile services and hospitals was perceived as bumpy, particularly regarding resource allocation and the clear distribution of tasks within regions, and the lack of harmonised measures across regions (Lebenswelt Heim, 2020). This is partly due to the system's decentralised governance structure, which is likely to favour distributional inequity of resources within the country's LTC system (Waitzberg et al., 2020). For many years, fragmentation has been observed and it has been criticised that professionals both within LTC and between social and health care work in 'silos' (Leichsenring et al., 2013). Not only in Austria there is hardly any exchange of and between staff in care homes and in mobile care—only a small share of LTC workers consider networking and working across organisational and sector boundaries as part of their job profile and daily practice (Bauer et al., 2018). This divide resulted in some laxity regarding the LTC sector at the onset of the pandemic, when acute hospitals had a clearly defined priority, with negative consequences for older people in need of LTC. For instance, the lack of administrative data to monitor risks and ensure best care at the right place and at the right time for them. The lack of exchange between acute health care, the residential sector and community care services resulted in one part of health and social care staff that was more or less on hold, while those in acute

care with COVID-19 cases or in residential LTC had to work long hours or even in double-shifts. Mobile services were reduced or even closed down, partly due to the lack of protective gear, partly because of unclear guidelines. Also, the testing strategy implemented in the residential care sector, though with some delay and not sufficiently systematic, was not applied with community care services. The same pattern is repeated in the vaccination-campaign that started by January 2021.

There is only anecdotal evidence from media coverage, but it can be assumed that many people in need of LTC have been and will be at risk due to postponed visits to specialist doctors or delayed examinations. Informal carers who were left isolated and without any respite services during the lockdown had to face additional physical and mental burden that often resulted in additional health problems. In some regions, care organisations have shown that, with sufficient protective gear and hygiene measures, delivering mobile services and short-term care would have been possible. This holds also for live-in personal carers, about 80% of whom are from Romania and the Slovak Republic. As they are working on fortnightly or monthly shifts, one part of them were left alone with their clients in Austria, while the other part was in their home countries without any income and unable to enter Austria. Again, the COVID-19 pandemic made only visible what had been identified as systemic breaking points over the past decades: The hospital-centred Austrian health system needs to invest in more integrated care delivery systems by strengthening primary care and expanding community-based services, including their cooperation with residential care facilities (WHO, 2020; Bauer et al., 2018; Staflinger, 2019; Bachner et al., 2018).

The political economy of LTC in the time of COVID-19

COVID-19 has put care work centre-stage, but with subtle differences along the traditional dividing lines in LTC. Apart from social and health care, there are additional fractures between paid and unpaid care work, between care in institutions and in the community, and between the dual labour markets of formal services and personal care. The existing inequalities that are caused by these fractures are aggravated by gender and migration issues, as both paid and unpaid care work are mainly carried out by women, and to a large degree by females with a migration background, be it as temporary personal carers or in formal LTC services and facilities. In formal care, this is particularly the case in Vienna and in residential care (Bauer et al., 2018).

During the lockdown, many critical observers noticed a general relegation of women to and in the domestic sphere (Blaskó et al., 2020). An Austrian time-use survey during the lockdown showed that mothers worked on average 14.5 hours, 9.5 hours of which were unpaid, while fathers worked 13.75 hours, of which 7 hours were unpaid (Mader et al., 2020). Moreover, and more specific to the LTC sector, concurrent prejudices surfaced, including that care can actually be accomplished by anybody (even without any training), in particular by women. This could be

observed when quality standards and staffing regulations were quickly reduced during the crisis (Staflinger & Tahic, 2020). It should also be noted that general standards in working conditions can be neglected rather bluntly if work is carried out by migrants (Bachmann, 2020).

The general shortages of staff in LTC have been another issue discussed for years (EPiG, 2017; Landesregierung Oberösterreich, 2015; Rappold & Juraszovich, 2019). Even before the COVID-19 pandemic there were several care homes in Austria that could not fill vacancies due to lack of staff (Lebenswelt Heim, 2020). During the pandemic, this scarcity—already identified long before the COVID-19 crisis (Bauer et al., 2018; Glaser & Seubert, 2018; Staflinger, 2016)—has become even more evident, in particular regarding quantitative staffing levels and the qualitative mix of skills among the LTC workforce. This entails the promotion of new job profiles, including case and care management, hygiene management, community nursing as well as occupational and other specialised therapies. However, such measures would also need to be embedded in a general debate about the political economy of care regarding the distribution of paid and unpaid work, and about inequalities created by the employment of low-skilled women in the female dominated LTC sector.

Conclusions

The article highlights the fractures that exist in the Austrian social care system, which have been made visible during the first wave of the COVID-19 pandemic, in particular from March to June 2020. Even before the crisis, a number of reform projects had been launched in Austria, the implementation of which was brought to a standstill in the past months due to the pandemic as well as due to changes in the government at the beginning of 2020. Among the projects to be implemented are pilot projects in the field of community nursing, efforts to increase attractiveness of long-term care as a profession, integrated care, and increased support for informal carers. In May 2020, an online participation process was launched which aimed to involve relevant stakeholder organisations and invited them to state their views on priorities for future reforms in the field of long-term care in Austria.¹

In addition to these existing efforts, a number of lessons can be drawn from our analysis that may be of relevance also beyond the Austrian case itself. First, initial failures to provide sufficient protective equipment for staff in care homes and guidelines on how to deal with SARS-CoV-2 infections in care homes highlight a long-standing divide between the sphere of health care and public health as opposed to the long-term care sector (Leichsenring et al., 2013). Future efforts should focus on improved (crisis) communication between health and social care, and the implementation of integrated care. For instance, community care services need an additional push both in quantitative and in qualitative terms. Case and care management, including coordination with primary care centres, and the now envisaged introduction of community nursing, may contribute to overcome fragmented service delivery.

Second, like in other countries, concerns over the safety of care recipients and safety of care professionals have largely outweighed concerns over quality of life and human rights of older people in Austria throughout the pandemic (see e.g., MSF, 2020). This applies in particular, albeit not only, for people in need of palliative care or with a terminal illness. Clear guidelines for LTC professionals and palliative care teams in all settings (care homes, mobile services, day care) are needed that are based on an understanding of the value of the right to self-determination while protecting health of older people in need of care, and staff in care homes.

Third, the increasing reliance on migrant carers from Central and Eastern Europe has led to a dualisation of the LTC labour market in the past decades (Schmidt et al., 2016). Efforts to improve working conditions in the so-called '24-hour care' sector and to ensure quality standards of care provided by live-in personal carers need to be stepped up further, as do endeavours to fundamentally change the employment situation of live-in carers. The specific situation of live-in carers with their blended identities as women, migrants, family breadwinners and quasi-family members requires further investigation (Giordano, 2020). In Austria, the pandemic made it also more evident that the construction of live-in personal care as an innate pillar of the Austrian LTC system (Weicht, 2010; Leiblfinger & Prieler, 2018) implicates significant minefields in terms of sustainability and working conditions as well as related ethical, gender and legal issues (Leiblfinger et al., 2020; Sekulová & Rogoz, 2019). In addition, the pandemic has shown that current sending countries, too, will increasingly risk suffering from shortages in care personnel, which calls for an increased consideration of the WHO Global Code of Practice on the International Recruitment of Health Personnel in the long-term care sector (Kovács et al., 2017).

Fourth, the crisis has shown in many countries that the most vulnerable groups in society are also the ones to suffer the most from the crisis, while also being at a higher risk of contracting SARS-CoV-2 due to precarious working or living conditions (Frazer, 2020; Takian et al., 2020). Informal caregivers in lower socio-economic groups also deserve increased attention in times of crisis, in particular when unforeseen dropoffs of professional care services occur, which are likely to hit women as the main source of informal care in particular (Lorenz-Dant, 2020; Volkshilfe, 2020). This applies particularly for countries with strong reliance on family care, like Austria (Schmidt and Hanzl, 2020). Again, informal carers need a stronger backup by community care services, the development of which has been hampered over the past decades, due to the expansion of the '24-hour care' sector and funding reforms in residential care. An explicit focus on community-based services will be needed to build a more sustainable LTC system in Austria – during and beyond the COVID-19 pandemic.

Note

¹ For more information (in German), please refer to the following website: https://goeg.at/taskforce_pflege (accessed on 12th August 2020).

Competing Interests

The authors declare to have no significant competing financial, professional, or personal interests that might have influenced this manuscript.

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