

The impact of COVID-19 on users and providers of long-term care services in Austria

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Key points

- The Austrian LTC system been placed under huge pressure during the COVID19 crisis as it has not been considered the most important area of intervention from the onset. Masks and security gear were and partly still are missing in care homes and in especially in home care. However, the number of cases as well as the number of deaths in care homes is likely to be much lower in Austria than in other countries.
- The Austrian government has created a 100 million euro LTC support fund to help regional governments find alternative sources of provision, if informal carers who provide more than 70% of all care, or personal carers who cover about 6-7% of people in need of care, cannot might drop out due to illness, travel restrictions or other reasons.
- An issue with the Austrian LTC system is its significant reliance on live-in migrant carers (personal carers) from the neighbouring Slovak and Czech Republics, but increasingly also from Romania and Bulgaria.
- COVID19 travel restrictions are drastically challenging this model and regional governments have done little to safeguard the continuity of care at home by migrant carers. After up to six weeks of round the clock care, carers who normally work two week shifts are suffering from physical and emotional stress, while those who are currently stranded in their home countries and are consequently unable to work, are left with no income during this period

- Further debate about the model of '24-hour care' provision by live-in migrant carers in Austria is needed. This also needs to be addressed in a wider European context, as most countries are using the model without any regulations. This compromises the working conditions and social security of care workers and eventually the safety of people in need of care.

1. Impact of the COVID-19 outbreak so far and population level measures

1.1. Number of positive cases in population and deaths

On 12 April 2020, Austria had 13,945 confirmed cases of COVID19, 350 deaths and 6,987 people who have recovered [1]. The largest proportion of confirmed cases was in Tyrol with 3,324 cases, which is home to one of the most popular ski resorts in Europe. Tyrol is one the outbreak hotspots. The highest numbers of deaths to date have been reported in Vienna, Tyrol and Styria.

1.2. Population-level measures to contain spread of COVID-19

The Austrian government introduced various national measures from early March onwards [2,3, 23,24,25].

- Travel warnings were issued in early March for China, Iran, Israel and South Korea, and Austrian citizens staying in these countries were asked to return. In light of the increasing spread of the virus in Europe, travel restrictions were significantly tightened in the following weeks, starting with refusal of entry from Italy. It might, however, be argued that such restrictions, particularly entry bans from Italy and China, should have been introduced earlier.
- On March 10, the government announced that all Austrian universities and upper secondary schools needed to switch to distance learning. Suspension of classroom teaching was subsequently extended to all types of schools and childcare restricted to parents working in critical infrastructure. While the role of children in transmission of COVID-19 is not yet clear – they tend to show only mild or no symptoms, but may still be able to transmit the virus – this measure was based on the assumption that children could act as facilitators of transmission within families.
- With regards to physical distancing, the government had initially urged the population to voluntarily practice physical distancing and stay at home in case of symptoms. However, Austria soon faced daily infection growth rates of more than 40%, and consequently ordered the first movement restrictions on March 12. Initially these only applied to large gatherings and events but were substantially broadened just a few days later. The restrictions required people to stay at home except for going out to cover their basic needs, assisting others in need, performing essential work and taking walks with members of the same household. The hospitality industry and all non-essential shops were closed on

March 17. Considering the relatively low number of total cases at the time (around 360 on March 12) and the lack of comparable measures in most other European countries, these actions initially appeared rather drastic. However, it is probably due to these measures that Austria's ample bed and intensive care unit capacity never came under pressure. Guidance on these measures came from a 'coronavirus taskforce', a group of medical professionals and civil servants from the Ministry of Health, a 'COVID-19 forecast consortium', and a team of researchers who simulated the spread of COVID-19 while providing a forecast of hospital and intensive care unit use.

- Following the example of its Eastern neighbours, Austria also introduced mandatory use of face masks in supermarkets and on public transport, despite inconclusive evidence regarding their effectiveness.

1.2.1. Numbers of residents and staff in care homes infected and deceased, and impact on community-based care users, unpaid carers, and care staff

By 12 April 1,036 people had been hospitalised, 243 admitted to intensive care because of COVID-19, and 144,877 tested for the virus [1,4]. Overall, the number of cases in care homes is estimated to be low in comparison with other countries. Six-hundred care home residents and staff have tested positive so far with the highest number (200) coming from care homes in Tyrol [4,5]. In the Tyrol region, the number of infected residents was 110 with 96 infected staff (71 frontline workers and 25 administrative staff). In Vienna, 50 care home residents and 100 care home staff have tested positive. In the region of Upper Austria 40 residents and 64 staff tested positive. In the region of Salzburg 32 residents and 23 staff tested positive and in Lower Austria 12 resident and 7 staff members tested positive. In the region of Burgenland only one resident tested positive, and in Vorarlberg 33 residents tested positive while the number of infected staff is unknown. There were no records available for the Styria region.

According to these regional figures, the known number of infected residents is 278 with 290 infected staff. However, the government plans to focus its future testing strategy on care homes, which will provide a more accurate picture. This will be done as part of systematic, nationwide testing of care home residents and staff, including people who will be discharged from hospital to care homes, to free up hospital bed capacity.

2. Brief background to the long-term care system (only as relevant for context)

In Austria, 300,000 people out of 500,000 people with long-term care needs are cared for by family members while 33,000 people are mainly cared for by privately paid 'personal carers' who are often formally self-employed migrant care workers. This represents 60% and 6% of people with long-term care needs respectively [6-8]. Around 80,000 people are cared for in care homes, which are staffed by about 42,000 professionals with about 33,200 full-time employees [9]. Personal carers, or *Personenbetreuer*, of which more than 60,000 are officially registered with the Austrian Chamber of Commerce [6-9], make up an important

part of the total care workforce. They are also called migrant care workers as they commute from a neighbouring countries, such as Bulgaria, Czech Republic, Hungary, Romania, or Slovakia, to provide '24-hour care' to a person in their home. They usually live in the house of the person they care for over a certain period – typically half a month – and return to their home country for the rest of the month. Families who employ personal carers tend to employ more than one worker in order to cover the whole period.

Although this kind of live-in migrant care is a widespread phenomenon in Europe, Austria is the only country with a regulated so-called '24-hour care system'. This system allows privately paid personal carers (mainly migrant care workers) to be employed legally, as self-employed personal carers with formal contracts. These contracts provide workers and employers with some basic social protection and security. While far from perfect, this system is considered a good practice model by some other countries, which do not offer any protection for migrant care workers [10]. While the 24-hour care model has been criticised by some researchers and NGOs, there is still broad consensus in the population for continuing with the model due to its cost-effectiveness and the lack of alternative, qualified formal care staff.

Since 2007, the government has set working conditions, social security, and training competences as well as some quality criteria for migrant care workers and the related brokering agencies [6-9]. To avoid the moonlighting of privately organised care, the regulations also provide a means-tested subsidy that families can apply for to cover the additional costs that accrue for social contributions of personal carers, providing the person requiring care meets a defined level of long-term care need. In 2017, about 25,300 households received a public subsidy for personal carers [9].

3. Long-Term Care policy and practice measures

3.1. Whole sector measures

Various measures have been put in place to increase capacity in the long-term care sector since the onset of the COVID-19 crisis, along with an allocation of an additional 100 million euros to the sector [5-7]. Some of the money has been specifically allocated to increase bed capacity for people with long-term care needs, e.g. via currently closed rehabilitation centres. The funding will also pay for a one-off payment of 500 euros for migrant care workers who agree to stay for another two-week shift in Austria. Regional governments have also taken action to provide additional resources to personal carers.

The government has loosened current staffing regulations to allow people who have carried out national service – mainly men who have opted to carry out civilian duties instead of military service – to provide basic care. The government can enforce their employment as care workers. People currently training to become care professionals, or unemployed people who desire to work in the long-term care sector, could be also asked to step in to increase capacity.

Conditions for licensing and registration of care professionals have been lowered substantially for the duration of the crisis. For example, it is no longer required that care

professionals register with the national registry for health and care professionals, which before the COVID-19 outbreak used to be mandatory. This allows people with a formal qualification in long-term care, but who currently do not work in this capacity, to work as care professionals during the crisis without formal registration.

In addition, The Federal Ministry of Social Affairs, Health, Care and Consumer Protection has published recommendations for preventive and protective measures for personal carers and staff working in semi-residential care and home care. It has also published guidance on the use of face masks for health and social care professionals [11]. Task forces have been established with the responsibility for developing guidance for the long-term care sector (e.g. on palliative care), along with its implementation and monitoring.

The government has also taken various measures to provide up-to-date information and help for people in need of long-term care and their family carers via telephone hotlines.

3.1.1. Care coordination issues, e.g. hospital discharges and transitions between care homes and other facilities)

Various solutions have been explored to coordinate care for people living at home with long-term care needs who, as a result of COVID-19, might be left without care. These are likely to include people whose family carer or personal carers are no longer available, either because they became infected with COVID-19 or because they have left the care arrangement (for example because of closing borders, or because of fears to leave their families alone, or become infected). Measures include the creation of bed capacity in closed rehabilitation centres and the provision of care through home care teams.

The government has also produced multi-disciplinary guidance for supporting infected patients, including those reaching end-of-life. In addition, the government plans to increase number of tests conducted for people with long-term care needs who are currently in hospital, in order to facilitate their discharge to care homes. The government has also increased the capacity of telephone hotlines for people in need of care and their family carers, which includes a telephone line located within the health care sector ('1450') that advises people on which service to use.

Regional and state governments are also reporting the amount of hospital and intensive care beds and ventilators to a centralised crisis management team. These data are used to estimate the number of national COVID19 cases and hospitalisation rates.

In terms of treatment and care capacities, there are around 24,000 acute care beds available for COVID-19 patients with a moderate disease course [11]. Another 7,500 beds can be made available from facilities other than hospitals, such as rehabilitation facilities [11]. In addition, there are more than 1,000 beds for people with COVID-19 who require intensive care. 1,500 ventilators have currently been made available to treat COVID-19 patients [11].

3.1.2. Care homes (including supported living, residential and nursing homes, and skilled nursing facilities)

The government has considered to reopening previously closed rehabilitation centres in order to provide additional bed capacity for people who have been infected or can no longer be cared for in their own homes. In total, as many as 7,500 additional beds could be made available from such rehabilitation facilities (status quo on April 8th, 2020). In addition, regional governments are exploring other options such as additional home care and the provision of virtual care over the internet and phone. Furthermore, defined staffing level requirements have been eased in individual regions, e.g. in Upper Austria and Styria.

According to news reports [13], the situation in care homes in Austria is less pressing than in many other Western countries affected by the outbreak, with relatively low numbers of positive tests among care home staff and residents. However, it is unclear whether this can partly be explained by insufficient testing. Government plans to focus future testing strategies on care homes will provide more accurate numbers.

3.1.3. Prevention of COVID-19 infections

On March 21, rehabilitation facilities closed, except to provide vital acute medical treatment and support services in hospitals. Furthermore, regional governments started closing retirement and nursing homes to visitors [3]. The government plans to increase testing and implement the obligatory use of face masks by citizens. This will be carried out alongside the reduction of some of the stricter lockdown measures [3]. The use of face masks has been required in supermarkets and on public transport since 6th April. On 14th April smaller shops and hardware stores re-opened, but face masks are obligatory as well as keeping a distance of at least one metre [3].

3.1.4. Controlling spread once infection has entered a facility

When infection has occurred in a facility, care homes have moved residents into other facilities, such as hospitals if necessary, or created isolation wards for COVID-19 patients where possible. General guidelines have been published on the Ministry's website [22] and a national protocol will be published soon. Overall, however, regional (state) governments have most of the decision-making power regarding care homes. They take decisions with individual care home providers (50% public, 25% private non-profit, 25% private for-profit) and the Federation of Care Homes. Researchers in a recent blog concluded that care homes are a growing concern as they are ill-prepared for a pandemic [2].

3.1.5. Ensuring access to health care, including palliative care, for residents who have COVID19

The national association for palliative care, Österreichische Palliativ Gesellschaft, OPG, has, in collaboration with various partner organisations and based on Canadian guidance "Palliating a pandemic: all patients must be cared for", published a position paper on palliative care during the outbreak [14]. It specifically provides guidance on how to ensure access to palliative care for people who will, as a result of lack capacity, not receive the intensive care they would have normally received. The statement includes principles of ethical care and guidance for clinical symptom management. OPG has also provided a

number of guidance and resources for family carers and care workers who provide care for someone who reaches the end-of-life during the outbreak. This includes clinical guidelines as well as guidance and advice on bereavement and how to facilitate social support for people reaching the end-of-life when they cannot be visited. The Austrian Society for Geriatrics and Gerontology also published a statement calling for, among other things, tele-rehabilitation services [15].

3.1.6. Managing staff availability and wellbeing

The government has loosened staffing regulations to allow individuals with limited or no qualifications to provide basic care. For the duration of the COVID-19 pandemic, mandatory registration of nurses has been suspended with the transition after the pandemic still to be defined. This measure was introduced to increase workforce capacity from retired care professionals and those with formal training but who work in another sector. Also, people without formal training as care professionals may be asked to carry out supporting activities defined in the second COVID-19 Act [16].

Concerns have been raised about managing the physical and mental wellbeing of personal carers, including those who are not formally registered with the national Chambers of Commerce and therefore not protected by employment law. Currently, even if they are registered, they are not financially compensated if they are unable to continue working – for example if they become infected or because they cannot cross borders. National and regional governments have organised additional payments to personal carers who decide to continue caring during the pandemic. In addition, the Chamber of Commerce has started to offer counselling services for migrant care workers. There are also online support networks that have been created in response to COVID-19 [6-8].

3.1.7. Community-based care

Measures under consideration include mobile home care and extended hours of home care (usually rationed) and day care provision, including through virtual communication.

3.1.8. Measures to prevent spread of COVID19 infection

Measures include a strict lockdown of hotspot areas and a national curfew, as well as the wearing of face masks in supermarkets and on public transport [23,24]. Other measures to prevent the spread include testing, guidance on hand hygiene, quarantine, and physical distancing. Walks or practising sport in the open air are allowed under the condition that a minimum distance of at least one metre is maintained from other people, despite a WHO recommendations of two meters. The government has implemented various channels to record and communicate health information and has plans to enhance monitoring and surveillance, including via Apps e.g. 'Stopp Corona' [17]. The general recommendation to stay at home as much as possible has been followed widely.

3.1.9. Measures to ensure continuity of care and staff wellbeing (including staff retention and recruitment)

Care workers in the long-term care sector include those working in residential care (about 44,000), in home or community care (about 22,000), and personal carers (mainly from Romania, Slovak Republic, Czech Republic and Hungary) working in private households. The latter comprise about 65,000 carers working in about 33,000 households usually in the form of a two-week shift, which requires the employment of two personal carers per private household.

While in the formal care sector it was difficult during the first weeks to provide sufficient amounts of masks and other protective gear, the sector of the so-called '24-hour care' faced specific challenges due to the closure of borders and travel restrictions – some migrant carers were stuck in their home countries, while the others were asked to remain for additional shifts in Austria. This resulted in emotional, mental and physical strain for the latter, with a reduction of income for the former.

The national Chamber of Commerce has set up a telephone line that family carers and (migrant) care workers can call for psychological support. However, it has been challenging to ensure access for all migrant care workers, some of whom do not speak German. There have been difficulties in recruiting counsellors who can offer their support in the mother tongue of migrant care workers such as Bulgarian, Slovak, Polish and Hungarian.

Some movements have been self-organised by migrant care workers via social media to raise awareness about the current situation and their working conditions, and to seek support from individuals and organisations, including via petitions [18]. One such initiative was the Facebook group '[We're helping because it's ethically correct](#),' created during March which now has over 1,800 followers and supporters, including personal carers, advocacy and interest organisations, e.g., the Federation of Nurses, Unions and carers organisation, and 24-hour care brokering agencies.

To address expected shortages in care provided to people in their own home, either by migrant care workers or by family carers, the Austrian Government has allocated an additional 100 million euros to the social care sector, with a one-off payment of 500 euros for migrant care workers who decide to stay in Austria in order to continue caring [6-8]. In addition, regional governments have taken independent action to provide additional resources to migrant care workers. For example, the regional government of Upper Austria will pay 1,000 euros per month to migrant care workers who continue their work [6-8]. The regional government of Lower Austria chartered a flight to bring 250 migrant care workers from Bulgaria and Romania to provide care in its region [6-8].

3.2. Impact on unpaid (family/informal) carers and measures to support them

Measures for family (also called informal or unpaid) carers include telephone hotlines, which provide psychological counselling, self-help through online support networks, and various forms of guidance and resources. The Austrian Red Cross offers an online course for unpaid carers [18]. A full list of links to websites of non-profit organisations offering support for family/informal carers can be found on the websites of the national dementia strategy

, <https://www.demenzstrategie.at/>, and of the Austrian carer association, <https://www.ig-pflege.at>.

3.3. Impact on people with learning disabilities and measures to support them

Österreichischer Behindertenrat, the national organisation that represents the interests of people with disabilities (Österreichischer Behindertenrat) – including intellectual disabilities, has called for the entitlement of leave from work for family carers. This is due to the closure of institutions and services that usually support people with disabilities during the day. They have also called for strict use of protective equipment for family carers of people with disabilities and for people with disabilities.

3.4. Impact on people living with dementia and measures to support them

Questions have been asked about moving people with dementia who currently live at home into residential care units, if the people caring for them can no longer do so. Similar concerns have been raised about people who would need to be moved once the infection enters a facility. Therefore, alternative solutions to move people with dementia into different institutions are being discussed. Alternative measures might include allowing personal carers to cross borders and extending home care provision through mobile services. A number of third sector organisations offer support to people with dementia and their carers. For example, *Promenz* offers three types of services for people with dementia in early stages: (i) telephone counselling, (ii) group calls, (iii) video calls. A full list of support services can be found at <https://www.demenzstrategie.at/>.

4. Lessons learnt so far

4.1. Short-term calls for action

Although a number of measures have been taken to mitigate the potential shortfall of privately paid personal carers, mainly migrant carer workers, during the COVID-19 crisis, the pandemic has brought to light a number of shortcomings of the Austrian long-term care system. In particular, the model of '24-hour care' and the situation of the personal carers themselves need special attention. While most personal carers have agreed to stay with the person they care for, this might cause new challenges to ensure the workers remain physically and mentally well while away from their family and home. In addition, allowing personal carers to travel from their home country to their place of work has become a challenge.

As government measures are currently being loosened, e.g. 80% of shops are being allowed to reopen, and the system moves to a more normal life, measures to protect vulnerable populations become important. The government has responded with testing strategies for care homes however, more measures might be needed to ensure protection and continuity of care for those with long-term care needs.

4.2. Longer term:

The COVID-19 crisis has exposed weaknesses of Austria's long-term care system, including the strong reliance on the provision of long-term care by personal carers from abroad. This acts as a low-cost alternative to other forms of publicly funded home care by profiting from low wages and unemployment in neighbouring East European countries.

Although the Austrian 24-hour care model (to a large extent provided by live-in personal carers) offers at least some basic legal protection, unlike most other systems in Europe where migrant care workers operate, the pandemic has left people with questions about its sustainability or appropriateness. In addition, it is likely that the pandemic has changed attitudes towards the importance of long-term care, and the responsibility of government and society to look after their most vulnerable populations.

Although the pandemic might increase the awareness of the lack of health and social care workers, it is likely that remedies such as 'image campaigns', slightly higher wages and reduced working time will not be sufficient to overcome a number of organisational and structural shortcomings in the long-term care system. The Austrian health care system has traditionally been very much centred on hospitals, rather than on primary care and alternative care pathways. During the COVID-19 crisis, this alleged shortcoming turned out to be a strength as the reduction of hospital capacity had not followed the general international trend [21,23,24]. However, in a mid-term perspective the hospital-centred health care system might need to be complemented by a much stronger development of primary care as well as by more and better integration with all areas of long-term care.

Another aspect that will need to be examined is the collection of and access to data in the long-term care sector. With some exceptions, such as for 24-hour care, which covers care needs of about 6% of all people in need of social care – high-quality and up-to-date data on important indicators of quality of care are scarce. This would include data on numbers of care home residents, users of home care, staffing levels, length of stay, the health status of people using services, and access to specialist health care. This is partly due to the decentralised nature of the long-term care system, in which responsibilities lie with the regional governments. While some centralisation of long-term care has already taken place over the past decades, a new balance between central and regional or local responsibilities will need to be found in the future.

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