Clean up time! Redesigning care after COVID-19: a position paper on the care crisis from Austria, Germany and Switzerland

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We are a group of social scientists from Austria, Germany and Switzerland who drew attention to the care crisis in a cross-national ‘Care manifesto’ as early as 2013. Since the COVID-19 pandemic, it has become impossible to overlook the crisis of care and we believe this provides an opportunity to correct serious shortcomings in the care sector. That is why we are putting forward a new position paper – ‘Clean up time! Redesigning care after COVID-19’ – aiming at identifying problems in the wake of the pandemic and suggesting goals, as well as the next work packages. We ask you to consider the demands in the position paper, disseminate it and discuss it in your networks and communities. Both the English and German versions are available on our website (see: https://care-macht-mehr.com/).

Key words care crisis • care reform • care mainstreaming • care time • working conditions


Introduction

The effects of the COVID-19 crisis in the care sector are not surprising. We already outlined the crisis of care in our ‘Care manifesto’ in the summer of 2013:

Care is in a major crisis in all of its aspects. This crisis affects essential activities such as education, nursing and personal assistance for others, paid and unpaid support in institutions and in private households, with regard to health, learning, individual welfare and much more – in short: caring for others, for community concerns and as its basis self-care, day after day as well as during the ups and downs of the life course. Care for others can include loving attention and compassion but it can also be stressful and worrisome. Nonetheless care is not a private matter but a social responsibility. Even though certain care issues are currently being discussed in public (e.g. the expansion of
The pandemic shows, yet again and more clearly, that vulnerability and dependency are as much a part of life as independence and autonomy. The current crisis can be an opportunity to organise and to finance our health, social and welfare systems in a more socially responsible manner. That is why we suggest some initial work packages based on our research and illustrate them with some examples. Austria, Germany and Switzerland are our reference points but some proposals could certainly apply to other higher-income countries as well.

**Care reform work packages**

*Introduce care mainstreaming!*

In structural analogy to gender mainstreaming as it has been practised in the European Union since the end of the 20th century, care mainstreaming is a preventive strategic approach to reveal and to spell out the significance of care. Care must be taken into account in every economic and socio-political planning process from the very beginning; care mainstreaming means that every government body has to consider the effects of policy measures on those who are responsible for care, on caregivers and on care receivers as a mandatory part of each decision-making process. We need a debate about how we want to organise care and include the input of all stakeholders. Austria, for instance, has introduced an online forum to discuss the future of nursing, and parliamentary decision-makers will be required to take its recommendations into account.

*Adequate pay and rewards for professional care work!*

Financing of care needs to focus on social policy mandates and not on returns on investment. High-quality care for care receivers and professional caregivers must be the primary concern. The Austrian case shows one way to implement this politically. For example, non-profit nursing homes are compulsory in several of the federal states.

Adequate classification of care work is essential. Since the 1980s, models of job evaluation have been developed focusing on relational skills and direct responsibility for others. For more power in collective bargaining, to say nothing of negotiating better wages and working conditions, significantly more care sector employees have to be organised and employers bound by collective wage agreements. Until then, it is up to politicians to enforce minimum standards, as is currently happening in Germany in the field of nursing care. A ‘care commission’ consisting of employer and employee representatives negotiates a minimum wage for this sector of the labour market. Many other care workers with a low level of organisation would need this as well.

*Improve working conditions in the field of care!*

Adequate care ratios and case numbers, enough time with care receivers, and a modicum of documentation are needed to increase the number of well-trained care employees. Flat hierarchies, participation in the design of work processes and
continuous advanced training opportunities are essential. The ‘nursing initiative’ of the Swiss Nurses Association (SBK) (see: www.pflegeinitiative.ch) supports professionals in doing what they are trained for: to encourage people’s self-sufficiency. In Germany, activist organisation and labour disputes at the Berlin hospital Charité resulted in a better care ratio and an end to the outsourcing of certain groups of employees (for example, cleaning staff and janitors).

Precarious forms of nursing and care, such as 24-hour care provision at home, need to be restructured. A secure residency status, adequate social insurance and wages, fair access to social benefits and recreation, and decent living conditions are crucial. Furthermore, it must be ensured that care workers are not solving problems in one country while exacerbating the care crisis in their countries of origin. A first step would be the ratification (Austria) or implementation (Germany, Switzerland) of the ILO Convention 189 for Decent Work for Domestic Workers. Campaigns of advocacy organisations of migrant domestic workers, unions and non-governmental organisations (NGOs), working together, are also necessary, as well as local campaigns to inform migrant workers about their rights and households about their responsibilities.

More time for care, every day and during the life course!

Care requires time – in the professions and in private. Care tasks are not standardised, and the quality of care depends on being able to take that into account. That is why everyone must receive the right to take time for care tasks when they start their careers. Since increased care needs can occur at any time and are often unpredictable, rigid regulations – for example, after the birth of a child – are not particularly helpful.

Employees need a care time budget for different care tasks over the life course that they can use as they see fit, accompanied by the right to wage replacement and social security. Such an ‘optional time model’ (see: www.fis-netzwerk.de) aims to make career interruptions or reduced working hours for care the ‘new normal’ for all. Gender equality can only be achieved if this is flanked by tax and social security regulations (for example, for pensions) and by abolishing the gender pay gap.

Digitisation and its effects on care work: critical assessment and gender justice!

Massive economic pressure is driving digital rationalisation and standardisation in the field of care. However, care work requires immediate interaction, communication and relationships based on personal trust. One possible danger of digitisation is that technology could be seen as a solution for difficult working conditions, without addressing needed structural reforms. Women in care professions often have less access to advanced training and professional development. Care employees, however, must not be left behind by the development of digitisation in their professions. More women designers are needed who can involve care employees in technology development and take their experiences into account. Clear regulations and company agreements that do not focus exclusively on employer concerns must to go hand in hand with digitisation.

A new precarious market for care is currently spreading as online agencies connect private households with flexible care workers and a number of start-ups make profits with app-based brokering of services. However, the flexibility they advertise comes
at the expense of the workers, who bear the brunt of the risks they pass on. That is why specific labour and occupational safety laws are needed for these care employees.

**Caring communities: support caring neighbourhoods!**

If we have learned anything during the COVID-19 crisis, it is that people are very willing to look out for and to care for one another. Neighbourhoods are important but they cannot simply replace welfare state measures continuously. That is why support structures are needed today as well as in the long run, for example, full-time social workers who can connect and strengthen the contributions of volunteers. Social services should also support and provide information to people who are caring for and supporting others in families, in flat-sharing communities and in the neighbourhood. Neighbourhood cafes and village shops could also act as contact points. Participation in urban and regional planning is important to create meeting spaces and suitable infrastructures, as well as to factor in the needs of people with disabilities.

**Adequate protection against violence!**

Desires, fears, anger, shame and other emotions have to be dealt with, and procedures negotiated or at least mutually accepted, in care contexts. Care can fail due to misunderstandings, neglect, abuse or violence. It is a balancing act between devotion and boundary management, between responsibility and patronisation, and between lack of interest and self-sacrifice. Care relations are especially fragile in asymmetrical contexts, and violence often remains invisible. Assaults have been increasing during the COVID-19 crisis, as it is more difficult to avoid one another and to deal with additional stress. We need further research to examine how violence has changed, as well as to determine the impact and needs of protection and counselling services. The Istanbul Convention of the Council of Europe (effective since 8 January 2014 in Austria, 2 January 2018 in Germany and 4 January 2018 in Switzerland) aims to safeguard the right to physical integrity by calling for regular monitoring of violence against women and of domestic violence, ensuring the protection of all victims of violence, needs-based protection and counselling services, effective protection of the rights of children, and the removal of obstacles to cooperation between participating institutions.

**Take participation rights of care recipients seriously!**

In the course of COVID-19 measures, institutions implemented restrictions such as bans on visits and leaving the house. Not even those responsible for home supervision, legal guardians or adult representatives were allowed to enter. Care recipients, for example, disabled people, were not represented in crisis teams. The legal obligation to provide necessary funding for inclusion was called into question. However, the guidelines of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) have to be enforced in crises too. The same applies to the principles of the Convention on the Rights of the Child. That means that participation as co-determination (‘with us, not about us’) needs to be strengthened and implemented in all decisions affecting care recipients. We need structures and processes that support care receivers’ participation in institutions and social planning.
Strengthen European and international solidarity!

The COVID-19 crisis strengthened the framework of the nation state. That was where solidarity was to be seen most frequently. However, Europe stands for international cooperation, in general and especially in times of crisis. Therefore, civil protection plans across borders, as well as non-bureaucratic collaboration and mutual assistance in the event of care needs, are required. In addition, fundamental rights, such as the right to asylum and the right to reproductive choice, must continue to be guaranteed.


This is far from an exhaustive list of work packages. However, attempts to do too much cleaning up and remodelling at the same time usually do not get anywhere. Therefore, let us start with these points. We do not want to go back to the ‘old normal’!

Forge new alliances!

This will only be accomplished if everyone works together, particularly the various stakeholders. As an initiative of researchers, we can provide social and health science input. However, specialist knowledge is also needed from the field of care practice, from care receivers and from every area of care: nursing and eldercare, personal support, education, counselling, social work, and more. The expertise of charities, administrative bodies, unions and initiatives dealing with individual or general care issues is indispensable as well.

Note
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Conflict of interest
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