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THE SHORT-TERM IMPACT OF COVID-19 ON THE SOCIAL SUPPORT SERVICES SECTOR

Focus on Services for Persons with Disabilities

2020

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This is a report of the European Association of Service providers for Persons with Disabilities (EASPD) subcontracted to Eugenia Atin, Päivi Holopainen, Daniel Kunze, Ciprian Panzaru and Sigrid Rand.

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Contents

Executive Summary

At the start of the COVID-19 pandemic in 2020, governments were mainly concerned with hindering the spread of the virus and ensuring appropriate treatment for the patients who had contracted the disease. Only at a later stage, attention was directed towards social support services and the particular vulnerability of the sector regarding the users and providers of services as well as the workforce. This report analyses the availability of social support services during the first period of the COVID-19 pandemic and explores in how far the nature or quality of these services changed. Furthermore, it considers how the far-reaching health, social and economic crises affected the workforce providing the services. As persons with disabilities were disproportionally affected by the outbreak of COVID-19, the analysis focuses on social services that support them in care homes, day care centres, sheltered workshops or at home.

Methodological issues: to demonstrate the differences in the effects of the COVID-19 pandemic on the sector and government responses during the first phase of the pandemic (February/March 2020 until May/June 2020), the study concentrated on five different countries: Germany, Finland, Ireland, Romania and Spain. It applied a mixed methods approach, combining quantitative and qualitative methods of data collection and analysis. It compiled statistics on companies, services and workforce in the field of Human health and social work activities (NACE Q, disaggregated to the two-digit level: Human health activities (NACE Q86); Residential care activities (NACE Q87) and Social work activities without accommodation (NACE Q 88)). Desk research and semi-structured expert interviews with narrative elements provided additional information as well as the framework for contextualisation.

Governance: in all five countries, the governments reacted to the spreading of COVID-19 by applying laws reserved to a state of exception. In most cases, the laws and subsequently issued decrees/legal acts were used to regulate the restrictions personal freedom (e.g. mobility), closing of institutions (e.g. schools), social welfare payments and economic responses to the crisis caused by the COVID-19 pandemic. Furthermore, they either regulated directly the health care and social services or constituted the basis for the further enactments. Following the general emergency legislation, government measures and specific enactments sought to ensure the continued provision of health and social services. For example, this concerned easing the regulations for service provision to ensure the continuance of services. Many of these measures were targeting the workforce as the most essential component in service provision, e.g. issuing a ban on holidays or mandating overtime work.

Scope and quality of services: despite different measures, it was not possible to ensure the continuance of all social care services. While care homes could continue their operation with a reduced range of services, the activities in day care centres or sheltered workshops were suspended. In many cases, communication was increased to compensate for the lack of personal contact or attempts were made to digitalise the services. However, the persons with disabilities or their families did not always have access to the necessary devices and/or did not possess the ICT skills. Furthermore, in many cases digital services could not substitute the personal contacts. As the primary focus was on the designing and keeping up these substitution services under very difficult circumstances, the providers did not have the resources for quality assurance. Moreover, they were lacking suitable guidelines and experiences in this field. In some countries also the mandatory inspections were suspended during the first phase of the COVID-19 pandemic.

Service providers: to a large extent, the public and private divide between the providers of social support services seems to have determined their main challenges and available coping strategies. This concerned their access to personal protective equipment (PPE), continuity of funding in a situation where services had to be cancelled or availability of supplementary allowances to compensate for additional costs in service provision during the COVID-19 pandemic. Along with acquiring PPE as well as accessing and selecting information concerning hygiene guidelines, measures leading to the (dis)continuation of services and their funding constituted the most pressing issue for service providers. As communication increased significantly in the first phase of the COVID-19 pandemic, it was a challenge to filter the information and ascertain if it was still up-to date. Even though focal points of information existed in most

countries, the information that they provided was not always easy to grasp, unambiguous and relevant to the provision of services for persons with disabilities.

Workforce: data show that in Spain, Germany and Romania the number of employed persons in NACE Q87 and NACE Q88 dropped in April/May 2020, while the number of jobseekers and unemployed persons increased. Due to the effects of the COVID-19 pandemic on employment, governments reinforced their short-time work compensation schemes to recompense workers for their lost income. This instrument has not been relevant for the health and social care sectors before the COVID-19 pandemic. However, starting from March/April 2020 service providers had to resort to using short-term compensation schemes to absorb the shocks on their activities. Considering the insecurity of the situation, the workforce in the service provision demonstrated extraordinary dedication to retaining the services and ensuring their quality. If the services were not closed, in most cases they were transformed, requiring a lot of flexibility from the workers. However, they did not always have the kind of skills for carrying out these tasks. Moreover, the shortage of PPE, having to work in the situation of aggravated staff shortages and to continuously perform tasks beyond the daily routines put a pressure on the care workers and resulted in their exhaustion.

Persons with disabilities and their relatives: in most cases, persons with disabilities were perceived as one homogeneous group, who was above all characterised by their vulnerability in face of the COVID-19 virus. Therefore, all measures aimed at protecting persons with disabilities by separating them from the outside world and segregating them into smaller groups within big residential institutions. This affected their social contacts in settings other than their place of residence as well as their chances to lead a more independent life. In the case of persons who relied on day care, they lost the chance to experience activities and communication outside the family setting. As a result, a considerable strain was put on the families, which could lead to loneliness, uncertainty and anxiety both in persons with disabilities and their informal carers.

Recommendations: in the COVID-19 pandemic, the need for designing specified measures and social support services for persons with disabilities became visible. Ideally, these services would take into account their age, type/degree of disability, health condition and family situation. However, the disproportionate protection and segregation measures were overruling the very principles this strategy would need to follow: autonomy and dignity of individuals. Moreover, it became visible that not all service formats emerging during the COVID-19 pandemic were suited to providing the necessary help and support. A further field of deliberations would be the organisation of services in care homes. Against this background, it is necessary to revise the foundations of funding this sector and start a fundamental discussion about the principles guiding the provision of social support services for persons with disabilities. Further measures arising from the analysis concern the equal treatment of persons with disabilities and persons without disabilities (e.g. in their access to service formats or unemployment measures); developing the quality assurance of services in their design and implementation; skills development of the workforce (e.g. ICT skills or developing/implementing new forms of services for different target groups).

In the recovery from the health, social and economic crisis caused by the COVID-19 pandemic, social support services play an important role. While the service providers and their workforce have made remarkable efforts to ensure continuity in service provision, the sector faces fundamental challenges concerning the funding and organisation of service provision that urgently need to be addressed at national and EU-level. To this end, continued public and social dialogue is needed.

Overview of the Research Results

Introduction

At the start of the COVID-19 pandemic in 2020, governments were mainly concerned with hindering the spread of the virus and ensuring appropriate treatment for the patients who had contracted the disease. Thus, the main focus was on measuring the readiness of health systems for dealing with the pandemic. This resulted in continuous reporting of indicators such as availability of beds for intensive care or number of doctors per capita, which were then compared internationally or EU-wide. Shortly afterwards, the interest was directed towards measuring the short-term effects of lockdown measures on national economies as well as predicting their mid-term and long-term effects. Only very slowly, public attention turned to the most vulnerable groups of the society, such as children, elderly and persons with disabilities, who use social support services for their day-to-day lives. The situation in most EU countries gave rise to concerns that the range, quality and reliability of these services might be affected: after all, the providers had to re-define their hygiene standards and work processes under the new circumstances, at the same time taking into account the personal and health situation of their workforce. In many cases, the provision vital social support services was reduced or stopped altogether during the imposed lockdown, especially in the field of homecare, day care and respite care.

Therefore, it is necessary to take a further step towards understanding how the COVID-19 pandemic affected the social support services sector. Persons with disabilities were found to be disproportionally affected by the COVID-19 outbreak (UN 2020: 4), which resulted in health, social and economic crises. Consequently, the pre-existing inequalities were exposed and the extent of their exclusion even deepened (Ibid.: 2). According to the first surveys on the impact of the COVID-19 pandemic on disability services in various European countries, access to testing and personal protective equipment (PPE) constituted serious challenges for service providers (e.g. EASPD 2020a, EASPD 2020b). Moreover, they had to face additional costs associated with the adapting of services (personnel, equipment, re-organisation). This resulted in declining revenues for service providers and an additional strain on the personnel, aggravating the already existing labour shortages. In this situation, lack of planning from public authorities and insecurities concerning the funding made it more difficult to re-adjust the existing services or devise new ones. Consequently, the closing of some service forms (e.g. day care centres) put a significant burden on the persons with disabilities and their relatives (Ibid.).

Against this background, the situation of the workforce in the health and social sectors was of concern. According to the Cedefop[1] Cov19R index, tasks involving intensive communication, teamwork and customer-handling carry the highest risk of COVID-19-related exposure (cf. Pouliakas and Branka 2020). Therefore, social and personal services were among the sectors displaying the highest risk levels – along with wholesale and retail trade, sales, shop work, accommodation and food services. Consequently, the risk score of care workers, personal service workers and health (associate) professionals was very high, together with hospitality and retail managers as well as sales workers.[2]

These insights constituted the starting point of this research. Its aim was to determine how the COVID-19 pandemic affected the provision of social support services in three aspects:

- ★ To what extent were social support services still available to persons with disabilities?
- ★ Did the nature or quality of these services change?
- ★ How did the crisis affect the workforce providing social support services for persons with disabilities?

1 European Centre for the Development of Vocational Training (Cedefop), www.cedefop.europa.eu.

2 https://www.cedefop.europa.eu/en/news-and-press/news/cedefop-creates-cov19r-social-distancing-risk-index-which-eu-jobs-are-more-risk.

The research was carried out in Germany, Finland, Ireland, Romania and Spain and the results are presented in individual country reports after the general overview of the main findings in this section. While it is important to refer to these country reports for more details, this synoptic view aims to present the common themes emerging from the country-level analysis. To start with, it focuses on the changes in the governance of the provision of social support services to persons with disabilities in the initial phase of the COVID-19 pandemic. In the next step, it describes how the different kinds of services were affected in terms of their availability and changes in their nature. While the summary focuses on the effects that these developments had on the service providers and workforce, it points out what consequences the availability of services and changes in their provision had for persons with disabilities and their relatives. Based on that, it is possible to delineate the main fields of tension that were revived and re-enforced during the COVID-19 pandemic and to give a brief overview of the future developments that various stakeholders in the sector expect to take place. The summary concludes with a set of recommendations arising from the analysis of the situation in the five studied EU Member States.

Methodological Issues

The scope, form and governance of social support services varies considerably across the EU Member States, resulting from the nature of the respective welfare state. To demonstrate the differences in the effects of the COVID-19 pandemic on the sector and government responses during the first phase of the crisis, the study concentrated on five different countries: Germany, Finland, Ireland, Romania and Spain. There are five different types of welfare state among the chosen countries: a continental European, Nordic, liberal, post-Communist and Mediterranean welfare state (cf. Urbé 2012)[3], differing in their modes and scope of service provision as well as regarding the extent of lockdown measures during the first phase of the COVID-19 pandemic.

The report focuses on the first period of the COVID-19 pandemic, lasting from February/March 2020 until May/June 2020. This includes the first stage of lockdowns in countries that were affected by the crisis at an early stage as well as the time-period where the strategies of the service providers addressing the challenges posed by the crisis had already taken effect. When defining the relevant time-period, methodological and subject-related considerations played a role. Relevant data, especially on employment and employment related government measures, usually become available with a delay. Currently, for most countries reliable data can be accessed until June 2020. Furthermore, studying the phase of insecurity, upheaval and re-building enables to analyse the systemic weaknesses and potentials inherent to the provision of social support services to persons with disabilities. Interestingly, the interview partners used their description of the initial challenges during the first stage of the COVID-19 pandemic to address the fundamental issues in service provision for persons with disabilities, such as the guiding principles of service provision or professional self-understanding of the workforce. As the disruptions brought up the unresolved issues and underlying tensions inherent to the sector, it is worth directing our attention to this phase in more detail.

To acquire a broad view of the field, a mixed methods approach was adopted, combining quantitative and qualitative analysis. The research was centred around the **collection of statistics** in three fields: companies, services and workforce. To this end, national statistics in the field of Human health and social work activities (NACE Q)[4] were compiled. In most cases, they could be disaggregated to the two-digit level: Human health activities (NACE Q86)[5]; Residential care activities (NACE Q87)[6] and Social work activities without accommodation

3 In a similar vein, an EU research project identified five types of welfare states: the Bismarck, Nordic, Beveridge, Central and Eastern European and Mediterranean systems (Urbé 2012).

4 NACE (Nomenclature des Activités Économiques dans la Communauté Européenne) is a standard system for classifying business activities. This classification scheme allows economists and others to compare companies economic activities (Eurostat 2008).

5 E.g. short- or long-term hospital activities, specialist medical practices, dental practices or other human health activities such as occupational or speech therapy.

6 E.g. residential care activities for the elderly and persons with disabilities, such as housekeeping/assistance in daily living; nursing care activities for the elderly and persons with disabilities; activities in the facilities of mental health or in the facilities for alcoholism/drug addiction treatment. For the sake of clarity and comparability, please note that the NACE classification uses the term “disabled”.

(NACE Q 88)[7]. In some cases, it was possible to disaggregate the statistics even further: in Germany, for example, data on vacancies enable to determine the number of vacancies in Residential care activities for the elderly and persons with disabilities (NACE Q873) or Social work activities without accommodation for the elderly and persons with disabilities (NACE Q881).[8] In Romania, the number of employees could be displayed at four-digit level, for example allowing to differentiate between the Residential care activities for intellectual disabilities, mental health and substance use (Q8720).[9] However, despite the disaggregation the categories remained very broad so that in most cases it was not possible to differentiate between persons with disabilities and the elderly. In several cases, data could not be disaggregated any further: in Ireland, for example, the average weekly earnings are only available for the general sector of Human health and social work activities (NACE Q).

While the classification of business activities dominated in the relevant data sources, in some cases, other classification systems were used. In Germany, for example, vacancy data were available at a three-digit level of NACE Q (e.g. vacancies in Social work activities for the elderly and persons with disabilities[10] (NACE Q881)), but could be further specified when using the classification by occupations.[11] This way, it was possible to determine the number of vacancies in the Professions in curative care and special education (KldB 8313). However, these minor highlights do not compensate for the lack of specific data on social support services for persons with disabilities.

The issue of disaggregation was closely related to the time-period that the data covered. For some aspects, further disaggregation meant that only quarterly data were available (e.g. in Germany, the number of business registrations and closures could be either presented at two-digit level by quarters or at the level of NACE Q by months). Moreover, across the studied countries big differences existed in the level of detail in data, their availability (e.g. data on company registrations could not be acquired for Ireland) and their relevance (e.g. vacancy data could be collected for Spain, but their significance is limited). This means that the collected data provided a first overview of the developments in the field, but needed to be specified and contextualised by interviews.

For each of the three fields (providers, services, workforce), indicators were developed. To see how service providers were affected by the COVID-19 pandemic, the number of registered companies and company closures was analysed; for the workforce, the number of employed/unemployed persons, new entries into/exits from employment/unemployment, short-time work and the number of vacancies were relevant. In most countries, no data were available for the scope and quality of service provision. Only in Spain, detailed data exist for the users of social support services such as residential care, day care, home care, telecare and preventative services. However, also here it is not possible to differentiate between the different groups of recipients, such as the elderly and persons with disabilities. Furthermore, differences in the availability of data makes direct comparisons difficult.

In parallel to collecting statistics, a **literature review** was conducted. It aimed at acquiring an overview of the service provision to persons with disabilities in a given country (e.g. financing system, provider structure, employee profiles, service users) and identifying research papers, surveys, position papers, press releases and experience reports describing and reflecting on the effects of the COVID-19 pandemic on the sector.

In the last step, additional information on the developments in the field was acquired through **expert interviews**. The interviews were semi-structured, but contained narrative elements to enable the interviewee to narrate their experiences beyond rigid question and answer structures. This method allowed the researchers to respond to issues brought up by interviewees, which might otherwise have gone unobserved or which they might not have been able to address with a more static set of questions. The interviews opened with narrative impulses: “What were

7 E.g. day care activities for the elderly or persons with disabilities; vocation rehabilitation and habilitation activities for persons with disabilities. For the sake of clarity and comparability, please note that the NACE classification uses the term “disabled”.

8 For the sake of clarity and comparability, please note that the NACE classification uses the term “disabled”.

9 For the sake of clarity and comparability, please note that the NACE classification uses the term “mental retardation”.

10 For the sake of clarity and comparability, please note that the NACE classification uses the term “disabled”.

11 The German “Klassifikation der Berufe” (KldB 2010) translates into the International Standard Classification of Occupations (ISCO-08) (ILO 2008) (for the conversion key see https://statistik.arbeitsagentur.de/DE/Navigation/Grundlagen/Klassifikationen/Klassifikation-der-Berufe/KldB2010/Arbeitshilfen/Umsteigeschluessel/Umsteigeschluessel-Nav.html, last accessed on 24 January 2021).

the main challenges for your organisation during the first stage of the COVID-19 pandemic (February-June 2020)?" and "How was your organisation dealing with them?" They were followed by five blocks of questions:

- ★ Conditions for the provision of social support services for persons with disabilities (e.g. regulation, availability of protective equipment);
- ★ Availability and quality of social support services for persons with disabilities;
- ★ Workforce in the social support services for persons with disabilities;
- ★ Support structures and information flows;
- ★ Plans and strategies for the future.

The interviews took place between September and December 2020 and addressed the first period of the COVID-19 pandemic. The sight time lag in relation to the researched time-period meant that the interview partners had reflected on their experiences and put them into perspective. In particular, this had given them an opportunity to consider the fundamental challenges faced by their sector and the future developments that they expected to take place. In many cases, the interview partners pointed out issues that they thought would need to be urgently addressed by policy-makers and stakeholders in the field.

The range of interview partners differed by country, but covered a range of stakeholders for most countries: service providers (for different kinds of services, such as employment support, personal assistance, home care and residential care), associations of service providers, workers' representatives, professional associations and administrators of care provision at regional level. Especially for Spain and Germany as federally organised countries a geographical spread of interview partners was ensured. As the interview partners were asked to talk about a difficult period for their organisation and sector, they were promised anonymity. Therefore, the interviewees or the organisations that they represent are not disclosed.

Finally, it is important to note that there are differences between the terminology used in the country reports. For example, while the Spanish referred to the "users of day-care or residential services, the Romanian report used the term "beneficiary . This has to do with the linguistic traditions of a particular country, but also with the development path of the sector. Therefore, the terminology was not harmonised. In contrast, the terminology used in standard classifications of business activities and occupations is highly standardised, but in the case of business nomenclature contains outdated terms such as "mental retardation instead of "intellectual disability and "disabled instead of "persons with disability . Whenever these statistical terms were adjusted to a more respectful language in the text, for the sake of clarity and comparability a footnote was added stating the term as it is used in statistical classifications. However, there are examples that the terminology can be revised: already in 2013 the Social Security Administration of the U.S. decided to change the term "mental retardation to "intellectual disability , pointing out that it was offensive to many people (Federal Register 2013: 46499). Therefore, it would be important to advocate the modernisation of the terminology used in the Nomenclature des Activités Économiques dans la Communauté Européenne (NACE) (Eurostat 2008) and the International Standard Industrial Classification (ISIC) (UNSD 2008).

Governance of Healthcare and Social Support Services During the COVID-19 Pandemic

In all five countries, the governments reacted to the spreading of COVID-19 by applying laws reserved to a state of exception. In most cases, the laws and subsequently issued decrees/legal acts were used to regulate the restrictions on personal freedom (e.g. mobility), closing of institutions (e.g. schools), social welfare payments and economic responses to the crisis caused by the COVID-19 pandemic. Furthermore, the laws either regulated directly the health care and social services or constituted the basis for further enactments.

The foundations for such regulations differed from country to country, as did their scope. In Spain, the declaration of the State of Emergency on 14 March 2020 was preceded by executive measures taken by regions, issuing sanitary recommendations on hygiene and social distancing. In some cases the measures were more invasive, enacting forced medical controls, requisition of sanitary supplies or regulations concerning the working conditions of health care and emergency personnel (Nogueira López and Doménech Pasqual 2020). In the subsequent days, the State of Emergency was followed by a large number of executive regulations, ensuring the implementation of sanitary measures and assuring the proper functioning of certain services (Ibid.). In Romania, the State of Emergency was based on the Article 93 of the Romanian Constitution and the Emergency Government Ordinance No. 1/1999. The Presidential Decree 195/2020 specified the measures taken during

the State of Emergency (Selejan-Gutan 2020). Even though in Germany the Emergency Law of 1968 exists, enabling the Federal Government to issue instructions also to the federal states, it is considered controversial and has thus never been applied. Also during the COVID-19 crisis, the authorities decided to act on the basis of the Infection Protection Act, a federal statute entitling the authorities to adopt measures for preventing and controlling infectious diseases in their line of competence. The measures were specified by administrative acts, such as executive regulations by the health ministries of the federal states within their line responsibility. Furthermore, the authorities could issue general administrative acts (Klafki and Kießling 2020). In response to the COVID-19 pandemic, the Government of Ireland enacted the Health Preservation and Protection and Other Emergency Measures in the Public Interest Act 2020 with the goal to prevent, limit, minimise or slow the spread of COVID-19. It was flanked by the Emergency Measures in the Public Interest (Covid-19) Act 2020, which defined the economic response measures to the crisis and relaxed the regulations concerning the employing of health professionals (Greene 2020). As the emergency powers arising from the Constitution relate to political violence (e.g. enabling to declare a state of emergency in the time of war or armed rebellion), the enactment of the health and emergency measures stood in conflict with these principles (Ibid.). Also in Finland, the Article 23 of the constitution (2013 version) states that temporary exceptions to fundamental rights are possible during an armed attack against Finland. However, it stipulates that this applies also to other situations of emergency that pose a serious threat to the nation (Schahin 2020). The Emergency Powers Act defines a dangerous contagious illness as a valid emergency situation and it was enacted on 16 March 2020. In the following weeks, several emergency decrees were issued (Schahin 2020).

Following the general emergency legislation, government measures and specific enactments sought to ensure the continued provision of health and social services. In Spain, for example, an Extraordinary Social Fund was endowed with 300 million Euros with the aim to enable residential services to employ more staff as well as strengthen homecare services, such as telecare. The Government of Ireland issued a National Action Plan with the aim of maintaining critical and ongoing services for essential care for elderly persons and persons with disabilities. This concerned both the long-term care as well as home support. In Romania, the military ordinances issued during the first phase of the COVID-19 pandemic stipulated that the activities of residential centres for persons with disabilities, elderly or children had to continue. The Federal Government of Germany issued financial guarantees to care homes and mobile care providers, reassuring that the long-term care insurances will recompense the extraordinary expenses and reduced income of service providers to 100%.

Furthermore, the regulations concerning the service provision were eased to ensure the continuity of services: in Germany, for example, the regular inspections by the Medical Service of the Health Insurers in care homes and mobile care providers as well as physical examinations for assigning care grades were suspended. This was also the case in Finland: there, some municipalities automatically extended their decisions concerning the provision of services for persons which disabilities, which they would have had to revise under normal circumstances. In Spain, the accreditation and operation of services in care homes was made more flexible. At the same time, the centres were required to adopt different organisational measures for managing the care homes (e.g. classifying the residents and designating specific areas to them).

Many of the measures were targeting the workforce as the most essential component in service provision. In Finland, exceptions to the Working Hours Act and Annual Holidays Act were defined both in the public and private sectors, meaning that trained health and emergency care professionals were not able to take their summer holidays or had to reduce them to two weeks. In Romania, service provision in large care homes was organised with half of the staff living in the care home and the other half quarantined at home to avoid the spread of COVID-19 through social contacts. Also here, it affected the Easter holidays of the care workforce, which they would traditionally have spent with their families. The German Health Ministry suspended the existing ratios of care professionals to patients in the hospitals and in Spain newly hired staff were exempt from qualification requirements. Furthermore, in Ireland the freeze on employing nurses and midwives was lifted.

However, the social care sector was affected by diametrically opposed tendencies. In Romania, for example, no new residents were admitted to care homes, there was a ban on visitors and persons with disabilities were encouraged to leave the care homes to go and live with their relatives. While the capacities of health and social care services were increased in the Finnish public and private sectors, non-urgent service activities were reduced. In many cases, the cancelled services were performed by informal carers, i.e. the families. Also in Germany, the various forms of services provided to persons with disabilities were not covered by the

financial guarantees. This concerned, for example, early interventions, social-paediatric centres, medical/social psychiatric centres for grown-ups with disabilities/mental illnesses, day care centres and social therapy.

Scope and Quality of Social Support Services for Persons with Disabilities during the COVID-19 Pandemic

The effect of the COVID-19 pandemic on different kinds of social support services for persons with disabilities varied greatly according to the indispensability and substitutability of a particular service. Centrally organised services by public or private providers such as care homes were particularly exposed to the spreading of the virus – especially in the case of large institutions. However, keeping them open was a priority for the authorities, even if this meant restricting the mobility of the inhabitants, reducing their contacts and imposing constraints on the staff. In all studied countries, the usual provision of services was disrupted. In Finland, for example, even the visits of therapists, interpreters or assistants were prevented in some cases. As the quarantine guidelines were unclear, they were subject to (mis)interpretations, meaning that the practices varied by regions or even by employers. Also in Germany, it was reported that pastors or physiotherapists did not have access to care homes.

Imposing such restrictive measures meant that services could not be provided in the usual form or were cancelled altogether: this concerned common meals, cooking and trips, but also work in sheltered workshops. In Spain, when the clients of special employment centres had cancelled their orders or services, people with disabilities could apply for a regular compensation from the Temporary Labour Adjustment Plan (ERTE). In Germany, the federal states issued "restraining orders"[12] for the sheltered workshops, meaning that persons with disabilities were not able to access their workplace. Besides causing serious problems for completing the orders, this decision impacted also the income of persons with disabilities, since the discontinuation of their work could not be remunerated from the regular short-time work schemes. Consequently, only a small proportion of their loss of income could be compensated from special funds allocated to that purpose. Here, the COVID-19 pandemic exposed an inequality between persons with disabilities and persons without disabilities in the field of employment. Also in Finland, some municipalities stopped paying work compensation for persons with disabilities, which posed a livelihood challenge to them. In addition, for persons with disabilities, working in sheltered workshops possesses a value beyond the earning of income: it structures their days and widens the scope of their interactions. Therefore, the redeployment of the workshop staff to care homes to the COVID-19 pandemic created an opportunity to compensate for the interruption of these activities in a different setting (as reported, for example, for Germany).

Furthermore, the imposed restrictions meant that the usual quality criteria were not possible to apply to services and in some cases the quality controls had also stopped. In Germany, for example, occasion-related examinations by the Medical Service of the Health Care Insurances (MDK) replaced the regular checks. Most of these instances would have been reported by the families of the persons with disabilities, but the ban on nursing home visits made it impossible for the relatives to monitor the situation. Even if the communication between the persons with disabilities and their relatives had been digitalised like in Finland, issues related to the quality of services would have been difficult to detect. However, special efforts were made to continue with the activities in the field of vocational education and training of persons with disabilities. The Federal Employment Agency that funds these activities in Germany agreed to transfer the face-to-face courses to online formats. However, as the sheltered workshops who provide these courses had little experience with these learning formats and were lacking guidelines, the results differed greatly across the providers. In some cases, they experienced limitations to applying online formats in their line of work as many persons with disabilities did not have digital devices (i.e. a phone or computer), meaning that the designed courses also needed to offer the opportunity for off-line learning.

Also in other lines of activity, many care homes made special efforts to compensate for the discontinuation of services: persons with disabilities could profit from additional activities such as arts, ICT as well as audio-visual workshops and exercises. Especially in the field of day care centres, many families had cancelled the services for their relatives (e.g. in Spain). Alternatively, the providers had suspended the services, because they could not adhere to the social distancing rules or because they had deployed their staff in COVID-19 operations (e.g. the municipalities in Finland). Therefore, the persons

12 In German: "Betretungsverbote".

with disabilities who stayed at home had to be monitored by phone or online. Some day care providers in Spain recorded the activities such as exercises and shared them with the users who had returned to their families. As it took time to resume the activities in the day care centres, a differentiated offer of alternative services and communication channels was important for staying in touch with the persons with disabilities and their families. However, in many cases this could not substitute personal contacts. This was especially visible in the special efforts made in Germany to continue the activities in the field of vocational education and training.

Also in other fields of support services for persons with disabilities, efforts were made to move services online. In Finland, for example, there were initial attempts to provide online rehabilitation services, but this proved very challenging. Therefore, most services were cancelled. Also in the field of home care, the services changed from the face-to-face format to remote monitoring. In Spain, this posed a problem because many workers lacked digital skills and the necessary infrastructure for using online tools.

Providers of Social Support Services for Persons with Disabilities during the COVID-19 Pandemic

The effects on the providers of social support services for persons with disabilities are very difficult to measure, since the provider structures are very diverse along the differentiation public/private and non-profit/for-profit. Therefore, the statistics related to this field are scarce and often at a very general level (Health and social care activities (NACE Q) with the option to disaggregate to a two-digit level in only some countries): this means that also businesses like dental practices are included in the data. Also, in Romania and Finland, for example, health and care services are mainly provided by public authorities, which are not reflected in the business registration statistics. Therefore, the data on company registrations and closures offers only limited information, especially concerning the services for persons with disabilities.

Keeping that in mind, we see a drop in the numbers of registered businesses in Q1 and Q2 of 2020 for all countries. In Spain, the number of registered businesses in NACE Q dropped from 51,313 in February 2020 to 49,108 in April 2020. Until June 2020, the recovery from this decline was minor. As such a decline was not visible in the data for 2019, we can exclude seasonal effects here. In Finland, the number of newly established businesses in NACE Q more than halved compared to Q1 2020 (586 in Q1 2020 vs. 281 in Q2 2020). Also in Germany, the effects on business registrations became most visible in April and May 2020.

The public and private divide between the providers of social support services seems to have affected their main challenges and available coping strategies to a large extent. In Romania, for example, private businesses had to finance the additional costs associated with the testing of their workforce, acquisition of PPE and re-organisation of their workforce from their own funds or through private sponsorships, which were not available to all. Furthermore, non-profit organisations funded through public authorities or private sponsors experienced delays or interruptions of funding. While the Government of Spain continued the payments to public service providers even if they had reduced the services, the private providers could only invoice for the services that they actually provided. Also here, private providers incurred additional costs due to investments in infrastructure (e.g. compartmentalisation and sign-posting in the institutions), re-designing of services, retraining of staff and buying PPE. In Germany, the additional costs through PPE and further tasks for the personnel had not been taken into account in the remuneration agreements with the health and long-term care insurances. As many services for persons with disabilities are financed through the Social Code V and not the Social Code XI, for which government funding guarantees existed, there was no remuneration guarantee for services that did not take place. This might have long-term effects on the providers of ergotherapy or physiotherapy. In Finland, the temporary reimbursement of additional costs was provided through municipalities, which are responsible for ensuring the provision of care services. However, the municipalities were in a very different position in preparing for and responding to the pandemic. Concerning the services provided directly by the municipalities, their capacities differed, as large municipalities had better chances to manage the personnel and other resources strategically.

Along with acquiring PPE, accessing and selecting information concerning hygiene guidelines, measures leading to the (dis)continuation of services and their funding constituted the most pressing issues for service providers. Across the studied countries, the interview partners reported that communication increased significantly in the first phase of the COVID-19 pandemic, mainly through newsletters. Especially in federally organised countries

with a complex system of care and social support such as Germany, the same information was often provided by different actors at various points in time (e.g. governments at federal and federal state level, administrative districts, ministries, health and long-term care insurances as well as interest representations. Therefore, it was a challenge to filter the information and ascertain if it was still up-to-date. Even though focal points of information existed in most countries (e.g. the Robert Koch Institute in Germany and the Official State Bulletins issued by the Government of Spain), the information that they provided was not always easy to grasp, unambiguous and relevant to the provision of services for persons with disabilities. Only for Spain it was reported that a practical guide was available for care homes for persons with intellectual or developmental disabilities. Therefore, it happened that the providers received conflicting information and guidance from different sources, or it was open to interpretation. Also in the case of Romania, where public authorities or professional associations provided no information on specific rules or regulations, the providers of social support services experienced high levels of insecurity. Their attempts to obtain information from mass media increased their insecurity even further.

Workforce in Social Support Services for Persons with Disabilities during the COVID-19 Pandemic

In all studied countries, there are abundant data on employment and unemployment of health and social care workforce. As the individual country reports present the data in all their nuances, only the main findings are displayed here. In all countries, the number of **employed persons** dropped in Residential care (NACE Q87) and Social work without accommodation (NACE Q88) activities. However, these developments were strongest in Spain and Germany. In Spain, the number of employed persons in NACE Q87 dropped from 293,671 persons to 288,758 persons between April and May 2020. This constituted a decline of 1.7%. In NACE Q88, the first drop in the number of employed persons could be observed a month earlier: compared to the 323,232 persons employed in the sub-sector in March 2020, the number of employees was only 318,467 in April 2020. The decrease of 1.5% was similar to that in NACE Q87. In Germany, the largest drop in NACE Q87 & 88 could be observed in April 2020, when 6,500 less people were working in the sector – a decrease of 0.3%.[13] Also in Romania, a similar drop in the number of employed persons in NACE Q87 took place between April and May 2020 (a decline of 0.3% from 55,848 employed persons in April 2020 to 55,677 persons in May 2020). In NACE Q88, the number of employed persons dropped also by 0.4% from 28,585 persons in April 2020 to May 2020. In all these countries, the decline in the number of persons employed in NACE Q87 and Q88 continued after the initial shock, even if at a slightly lower rate. The data show that the first effects of the COVID-19 pandemic on the workforce became visible in May 2020, with the notable exception of NACE Q88 in Spain, where the first decline in the number of persons could be detected already in April 2020.

In the studied countries, the numbers of **jobseekers** (i.e. employed and unemployed persons who are looking for a job) and unemployed persons increased. So did the entries into unemployment, while exits from employment decreased. In all categories, the numbers fluctuated strongly between March and June 2020, so that no clear common trend can be detected. In Spain, for example, the number of jobseekers in NACE Q87 increased in April and May 2020, with the highest growth rate (9%) from 73,119 jobseekers in April to 80,603 jobseekers in May 2020. The increase in the number of jobseekers was even more severe in NACE Q88 (29%), from 71,210 persons in March 2020 to 99,684 persons in April 2020. In Romania, which stands at the other end of the spectrum, there is generally a low level of **unemployment**[14] in all sub-sectors of NACE Q resulting from the labour shortages caused by the migration of doctors and nurses. Therefore, the numbers of unemployed persons were very low, ranging from 107 persons in February to 116 persons in April 2020 in NACE Q87. The number of unemployed persons was also very similar to the figures in 2019. In this respect, the situation was different in NACE Q88, where the number of unemployed persons almost doubled in the first six months of 2020 compared to 2019. However, the absolute numbers remained relatively low, ranging from 227 persons in February to 265 persons in June 2020. The interviews specified that mainly workers in the private sector of social care were forced into unemployment due to the closing of some operations during the COVID-19 pandemic and they did not return after the lockdown.

13 For Germany, the data source does not enable a further differentiation into the sub-sectors NACE Q87 and Q88.

14 The different focus of analysis (jobseekers vs. unemployed) arise from the availability of data for various countries.

Due to the effects of the COVID-19 pandemic on employment, governments introduced **short-time work compensation schemes** to recompense workers for their lost income. In Spain, the Temporary Labour Adjustment Plan (ERTE) granted employees 70% of their base salary regardless of their previous contributions. Also in Ireland, the Temporary Wage Subsidy Scheme (TWSS) was available to employers from all sectors (except for the public service and non-commercial semi-state sector) who had lost a minimum of 25% of turnover because of the COVID-19 pandemic.[15] The payments depended on the previous average weekly take-home pay. In addition, employees and self-employed people who lost all their employment due to the COVID-19 pandemic qualified for the COVID-19 Pandemic Unemployment Payment (PUP) linked to previous average weekly earnings. The short-time compensation in Germany entitled workers to the remuneration of the reduced hours. Its amount depended on the terms of the labour contract and was staggered: in the first three months, workers received 60% of the reduced hours (67% if they had a child), in the fourth until sixth month 70% (77%) and from seventh month onwards 80% (87%).

The data on short-time work show that before the COVID-19 pandemic, this instrument was not relevant for the health and social care sectors. To demonstrate how the service providers had to resort to this instrument to absorb the shocks concerning their activities, the data are presented here in more detail for Spain, Germany and Ireland. In Spain, there were two persons from the Residential care activities (Q87) in the ERTE scheme in February 2020, but by May 2020 this figure was as high as 3,338 persons. In the Social work without accommodation activities (NACE Q88), this development was even more pronounced: 16 persons in February 2020 and 43,239 persons in May 2020. The changes were sudden and demonstrate the immediate effect of the COVID-19 on the workforce: while in January and February 2020 no employees in Residential care activities (NACE Q87) were subject to reduced working hours in Germany, in March 2020 there were 3,118 employees in this sector who were claiming government support for short-time work. This figure more than tripled by April 2020. Also in Social work activities without accommodation (NACE Q88), the number of employees subject to reduced working hours rose from 27,510 persons in March 2020 to 71,011 persons in April 2020. In Ireland, the PUP payments for those employed in the Health and social care activities (NACE Q) peaked at the beginning of April 2020 with 18,297 recipients and declined moderately until June 2020. Registrations in the TWSS scheme, on the contrary, settled at a high level early on, but continued to raise and reached their highest point mid-June 2020 with 26,667 persons. The figures of short-time work in the three countries show that the COVID-19 pandemic caused considerable disruption in the social services sector.[16]

The interview partners in the five studied countries highlighted the extraordinary dedication of the workforce to retaining the services and ensuring their quality – especially in the situation when the end of the COVID-19 pandemic was not foreseeable. In all countries, staff were deployed from services that were closed to other areas of the organisation (e.g. from sheltered workshops to care homes), bringing the staff to an unfamiliar setting with different tasks and processes. If the services were not closed, in most cases they were transformed, requiring a lot of flexibility from the workers. This entailed new tasks beyond their work description such as direct care, handing out food, manufacturing PPE, shopping or running errands (e.g. reported for Spain and Finland). Also, if staff worked from home providing remote care services, they had to use their personal devices. However, they did not always have the kind of skills for carrying out these tasks. This did not just concern the ICT skills: in some cases, staff were required to digitalise some services (e.g. vocational education and training provided in the sheltered workshops in Germany) and did not have enough experience and guidelines for designing services in these new formats.

For Finland, Romania and Spain, it was reported that the state could mandate workers to work under changed conditions. In Finland the staff were expected to work overtime, delay their holidays and accept a prolonged notice period of four months; in Romania it entailed being quarantined either in a care home when working the shift or being quarantined at home to reduce the chances of contracting and passing on COVID-19 at workplace. Also in Spain, workers could be mandated to work overtime. The shortage of PPE, working under the conditions of

15 As of 1 September 2020, it was converted into an Employment Wage Subsidy Scheme (EWSS).

16 It is more difficult to present employment data for Finland and Ireland. For the former, data exist only at the level of the general Health and social care activities (NACE Q), making it impossible to differentiate between the developments in the health and social care. For Ireland, only quarterly data are available for NACE Q87 and NACE Q88. This makes it impossible to determine the exact month in which the decline in the number of employed persons set in.

aggravated staff shortages and having to continuously perform tasks beyond the daily routines put a pressure on the care workers and resulted in their exhaustion.

Effects of the COVID-19 Pandemic on Persons with Disabilities and Their Relatives

The described developments in the five EU Member States demonstrate that in most cases persons with disabilities were perceived as one homogeneous group, who was above all characterised by their vulnerability in the face of the COVID-19 virus. Therefore, all measures aimed at protecting persons with disabilities by separating them from the outside world and segregating them into smaller groups within big residential institutions. This affected their social contacts in settings other than their place of residence as well as their chances to lead a more independent life. In the case of persons who relied on day care, they lost the chance to experience activities and communication outside of their family setting. All country reports described how this put a significant strain on the families – especially considering that in many cases the families were requested to take their relatives out of the care homes. As social support services facilitating the coping with everyday life stopped or were provided in another format (e.g. online), this led to loneliness, uncertainty and anxiety both in persons with disabilities and their informal carers. In addition to the mental strain and discomfort, the families providing care to persons with disabilities experienced a drop in their income because of the continuous care tasks that they were providing. In Germany, for example, the Infection Law made provisions to compensate for the loss of earnings of under-age children. However, this was not possible for parents who were caring for their adult children. Furthermore, the remuneration was available for the maximum of six weeks, while the closures of sheltered workshops and day care centres lasted considerably longer. In Finland, the emergence of new services requiring access to electronic devices raised the question of their affordability.

Many interview partners across the studied countries stressed that people with disabilities are an extremely heterogeneous group with very different needs and challenges. Even before the COVID-19 pandemic, it was difficult for persons with disabilities to receive the kind of individualised services that they needed. During the COVID-19 pandemic, they experienced a situation where most of the social support services that they were receiving faced restrictions – and the services had to be planned around them.

Expected Future Developments and Fundamental Fields of Tension in the Provision of Social Support Services to Persons with Disabilities

Against this background, the interviewed experts voiced the necessity to place the needs of persons with disabilities at the centre of planning, providing and funding of services. The COVID-19 pandemic demonstrated the necessity of designing specified measures and services, taking into account the age, type/degree of disability, health condition and family situation of the person. In Finland, for example, the experiences during the first phase of the COVID-19 pandemic led to the fears that the level of services would deteriorate permanently. This issue is linked also to the regional disparities in service provision. Also in Spain, there are concerns that the personal budgets available to persons with disabilities might be reduced in 2021. Both in Romania and in Spain, the adequacy of large care homes in the face of health emergencies is being questioned and would need to be addressed in the coming years. In Germany, the stakeholders are concerned with retaining and ameliorating the complex structure of inclusion services also in the coming years, enabling to provide the medical, vocational and social rehabilitation services to persons with disabilities.

The description of the current situation in social support services for persons with disabilities as well as the voiced expectations for the future exposed four fundamental fields of tension in the service provision:

- **Principles of service provision:** the disproportionate protection and segregation measures raise the questions whether the primacy of infection protection was overruling the principles that had guided the provision of services to persons of disabilities so far: autonomy and dignity of individuals. In most cases, these principles had been enforced through long lasting advocacy endeavours. It needs to be observed in how far and under which conditions the recent changes in the framework of service provision are reversible;
- **Nature of services:** in many instances, the extensive lockdown measures and restrictions to service provision led to changes in the form and quality of services to persons with disabilities. However, not all of these service formats are suited to providing the necessary help and support: there are obstacles to the accessibility of the services (e.g. devices, cognitive

skills). Moreover, the digital or reduced formats do not always satisfy the social needs of persons with disabilities. As care needs of persons with disabilities have been building up during the COVID-19 pandemic, this constitutes an important issue that needs to be resolved;

- ★ **Organisation of services:** during the COVID-19 pandemic, the bad reputation of large care homes deteriorated further, since the institutionalised care setting was particularly prone to a rapid and uncontrolled spread of the virus. However, experiences showed that integrated organisational models (e.g. settings combining care homes, sheltered workshops and day care) were more flexible in their ability to deploy the workforce. However, the segregation practices that were necessary for keeping up the operations of large-scale care homes cast doubt on the validity of this line of argument. Consequently, this is a field of tension in service provision that will need to be resolved in many countries;
- ★ **Professional self-understanding of the workforce:** especially in the care homes, the strict lockdown measures restricted the mobility, autonomy and social contacts of persons with disabilities. This led the workforce to question to what extent they should subordinate their professional ethos to the imperative of infection protection. It has to be discussed how the framework for service provision can be arranged in a way that would enable the workforce to apply the principles of independence, inclusion and respect in their work.

Conclusions and Recommendations

From the start of the COVID-19 pandemic, the providers of social support services have been greatly committed to ensuring the continuance of social support services. They have found solutions to challenges concerning the funding of their operations, acquisition of PPE, re-organising of services and re-deploying the workforce. Also the workers in that sector have made immense efforts to provide the essential services that support the everyday life of persons with disabilities. In various settings, they have displayed flexibility and endurance under very difficult conditions. These concerted efforts of service providers and workers are extremely valuable, the more so that they have taken place in a situation where the past certainties and routines have been suspended. Therefore, it is important to offer the sector of social support services a new perspective and orientation through political commitment at different levels of government.

Concerning the COVID-19 pandemic, several policy briefs and position papers have already pointed out the specific challenges for the field of social support services and have underlined this sector's importance for the recovery from the health, social and economic crisis. The UN Policy Brief, for example, provides a comprehensive set of recommendations for a disability-inclusive COVID-19 response and recovery (UN 2020). As a key action and recommendation, it takes up the issue of funding and stresses the significance of ensuring inclusive investments in the sector to support disability-inclusive outcomes. Furthermore, it underlines the importance of ensuring consultations with persons with disabilities and the organisations representing their interests (Ibid.: 3). A European-level position paper of NGOs advocating for a social Europe points out the need to resolve the challenges that the whole social sector faces, arising from its underfunding, staff shortages and the increasing demand – especially as these long-lasting challenges are aggravated by the COVID-19 pandemic (Position Paper 2020). In particular, it highlights the difficulties experienced by the providers of social support services and the additional strain on the workforce during the health and social crises. As many of the EU Member States have been slow to react to the social consequences of the crisis, it foresees a special role for the European Union: a short-term European Emergency Fund for Social Services during the COVID-19 pandemic would increase the resilience of social services. To that end, an intensified EU-level stakeholder dialogue as well as policy guidance from the EU to social dialogue and legislation at national level are suggested (Position Paper 2020).

The results of the current study can feed into this process, as it identifies the fundamental tensions inherent to the field of support services for persons with disabilities. They highlight the conflict lines for which the policy-makers will have to find long-term solutions in deliberation with different stakeholders. However, the analysis shows that there are concrete mid- and long-term challenges that arise from these pivotal issues:

- ★ **Equal treatment:**
  - › Recognising the importance of employment for the livelihood of persons with disabilities; ensuring equal treatment of persons with disabilities and persons without disabilities in accessing regular unemployment benefits as well as exceptional unemployment measures;
  - › Recognising that persons with disabilities have heterogeneous needs for social support services;

- Enabling persons with disabilities and their families to access innovative services that require specific devices or skills sets;

★ **Quality assurance**:

- Developing guidelines for assessing the quality of the newly developed social support services for persons with disabilities;
- Issuing guidelines for designing and implementing effective and suitable services corresponding to the needs of persons with disabilities;

★ **Training of the workforce**:

- Providing training to the staff that are expected to use ICT in the provision of online services and considering how they can be equipped with the necessary devices;
- Offering guidance to those who are transferring traditional social support services to online or hybrid formats. Depending on the nature of the service (e.g. online monitoring and accompanying of daily activities vs. educational activities) as well as the cognitive and digital skills of its users, the content and communication need to be considered;

Regarding the current work on the Action Plan to implement the European Pillar of Social Rights, the Action Plan for the Social Economy and the European Disability Strategy, the identified areas of action are highly compatible with the priorities of the EU and the social partners involved in the process. Furthermore, the research demonstrates the need to address the employment of persons with disabilities, especially regarding the general restrictions on their mobility and specific access to their workplaces. In an economic crisis with high levels of unemployment, this constitutes a significant disadvantage to the employment of persons with disabilities. Taking this into account, there is a need for a European Action Plan for the employment of persons with disabilities.

The identified topics concerning social support services for persons with disabilities could serve as a starting point for the general monitoring of progress in strengthening the social services ecosystem (cf. Position Paper 2020). This would reassure how important social support services for persons with disabilities are for the development of a more social and inclusive Europe.

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COUNTRY REPORT

Spain

Organisation of Social Support Service Provision for Persons with Disabilities

In Spain, the family has traditionally provided social care. In the 1980s, however, external social assistance services came to existence as a result of sociodemographic changes such as urbanisation and increased employment of women. Furthermore, there was a clear public awareness and investment, leading to the development of the National Health System with the enactment of the General Health Law. At the end of 2006, the Dependency Law (Act 39/2006 of 14 December) (CES 2012) was proclaimed, which acknowledged the universal entitlement of Spanish citizens to social services. Thus, social care became the fourth pillar of well-being along with health, education and pensions. The different Autonomous Communities are responsible for implementing the Dependency Law.

In the next step, a new System for Promotion of Personal Autonomy and Assistance for Persons in a Situation of Dependency (SAAD) was established. As per the Dependency Law, the main features of the SAAD are: publicly funded services; effectively equal, non-discriminatory and universal access for all dependents; commitment to organise services to allow beneficiaries to remain in their community/environment of reference whenever possible; and assurance of services' quality, sustainability and accessibility. The services provided through the SAAD are:[17]

- **Services for preventing dependency situations and promoting personal autonomy**: providing support for healthy living conditions as well as specific preventive and rehabilitation programmes. They are aimed at preventing the appearance and/or the aggravation of diseases or disabilities and their consequences;
- **Telecare**: a permanent communication service that allows the user to request help in emergency situations from home via a device connected to the telephone line;
- **Home assistance**: a whole set of resources aimed at providing support and care at home so that people can retain the autonomy in their daily life;
- **Day care**: individualised and comprehensive day care to people in a situation of dependency, to persons with disabilities and to people with chronic mental illnesses (on a temporary or permanent basis);
- **Residential care**: coexistence services intended to serve as a home for persons with disabilities and in a situation of dependency. It is available to those who cannot adequately meet their needs in their personal or family home.

Depending on the type of disability, persons with disabilities have access to certain types of services. In addition, they are eligible to extra payments, which aim to support their needs arising from their specific circumstances:

- **Cash allowance for care in the family environment and support for non-professional caregivers**: an exceptional personal benefit contributing to the expenses associated with the care of the dependent person at their home;
- **Cash allowance linked to the service**: a personal benefit contributing to the cost of a service in the System for Autonomy and Care for Dependence. The service is provided by a public institution or a private entity duly certified by the regional government;
- **Cash allowance for personal assistance**: persons with disabilities receive a contribution to the hiring of a personal assistant, with the objective to facilitate their access to education or work and enable them to lead a more autonomous life. To access this group of benefits, persons with disabilities must have their disability

17 https://www.euskadi.eus/servicios-sociales-dependencia-riesgo-de-dependencia/web01-a2gizar/es/ (last accessed on 1 February 2021).

status recognised and request the assessment of dependence by their regional government.

The 17 autonomous regions (Autonomous Communities) are responsible for the provision of benefits and services established by the Dependency Law, following a decentralisation of government functions (EASPD 2018). The central government's health and social care responsibilities are more of a coordinating and overseeing nature. There is also a central government plan, the Spanish Disability Strategy 2012-2020 (Ministerio de Sanidad 2021). Cooperation between the National Government and the Autonomous Communities is essential and it is developed through agreements. The National Government guarantees the financing to the Autonomous Communities for the development of a minimum level of protection for the persons with disabilities. Additional resources are provided by each region to complement the contributions made by the national government.

The Laws of Social Services regulate the distribution of responsibilities between the territorial authorities. While the Autonomous Administrations are in charge of the planning, coordination, supervision and control of services, the Local Corporations assume the responsibility for the management, execution and development of the services. As the City Councils and Provincial Councils are closer to the citizen, they play an essential role in service provision. A multitude of additional regional laws regulate different rights, benefits or services in the seventeen Autonomous Communities, being the ones in charge of the implementation of most of these measures concerning persons with disabilities. Typically, the autonomous communities offer the following services for people with disabilities:

- ★ Service or day centre to attend to needs derived from limitations in autonomy;
- ★ Occupational service or centre;
- ★ Night centre to attend to needs derived from limitations in autonomy;
- ★ Residential centres for people with disabilities;
- ★ Respite service;
- ★ Independent living support service;
- ★ Technical aids service (support products) and adaptation of the physical environment;
- ★ Adapted transport service;
- ★ Financial aid for the acquisition of non-recoverable support products;
- ★ Financial assistance to carry out adaptations in the dwelling and in private vehicles;
- ★ Social intervention service in early care.

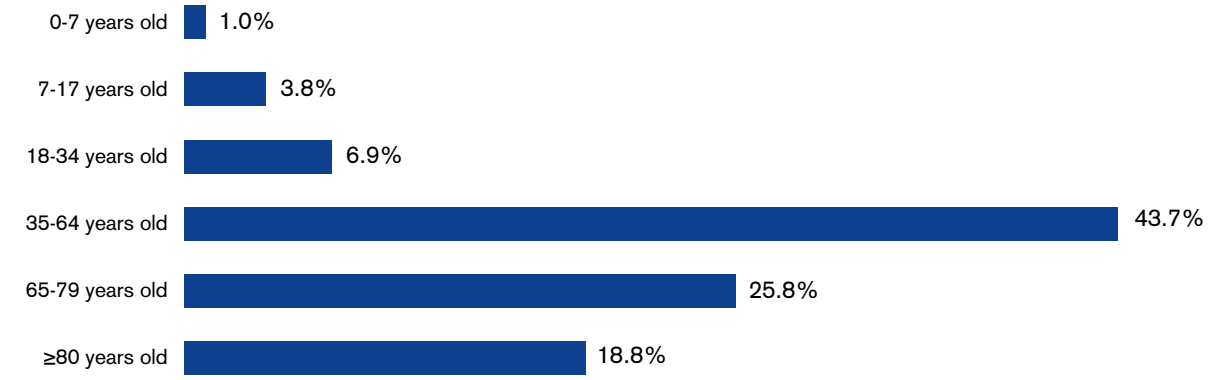
Within this sphere of social services, formal, non-governmental, non-profit and solidarity-based organisations in the so-called third sector traditionally take on an important role (Mestres 2011). The third sector is increasingly recognised in its status and place in the social scene. While the Spanish legislation on social services speaks of a public system of social services and defines the responsibilities and obligations for public administrations in that field, it establishes the possibility for third sector entities to participate in the field of social services. Therefore, the involved parties seek collaboration and synergies between the non-profit sector and the public sector. Non-profit entities contribute to the improvement of the welfare state, collaborating with public institutions in developing initiatives of priority interest to both sides. It is also possible for third sector organisations to manage social services of public responsibility, i.e. social services, which public administrations are obliged to provide and sustain. Therefore, some services provided by third sector organisations are funded by public authorities. Finally, non-profit entities manage private social programmes, for which users can pay in various ways.

Persons with Disabilities

The 2013 General Law on the rights of persons with disabilities and their social inclusion recognises that persons with disabilities is entitled to a series of rights and it is the Government who is responsible for protecting these rights. According to the definition in the Royal Decree 1/2013 of 29 November, people with disabilities have physical, mental, intellectual or sensory deficiencies, predictably permanent, that inhibit their full and effective participation in society on equal terms with the rest.

In Spain, in 2017, according to the Instituto de Mayores y Servicios Sociales (Imserso) data base, there were 3,177,531 persons with a recognised disability. Figure 1 presents the distribution of these persons by age group. However, it must be noted that since the original source does not disaggregate the age band 35-64 years, it visually appears to be the largest group. Nevertheless, if we analyse the data in approximate periods of 15 years, in general, disability appears at a later age. Consequently, one fourth of the total population of persons with disabilities is 65-79 years old and one fifth 80 years old and older.

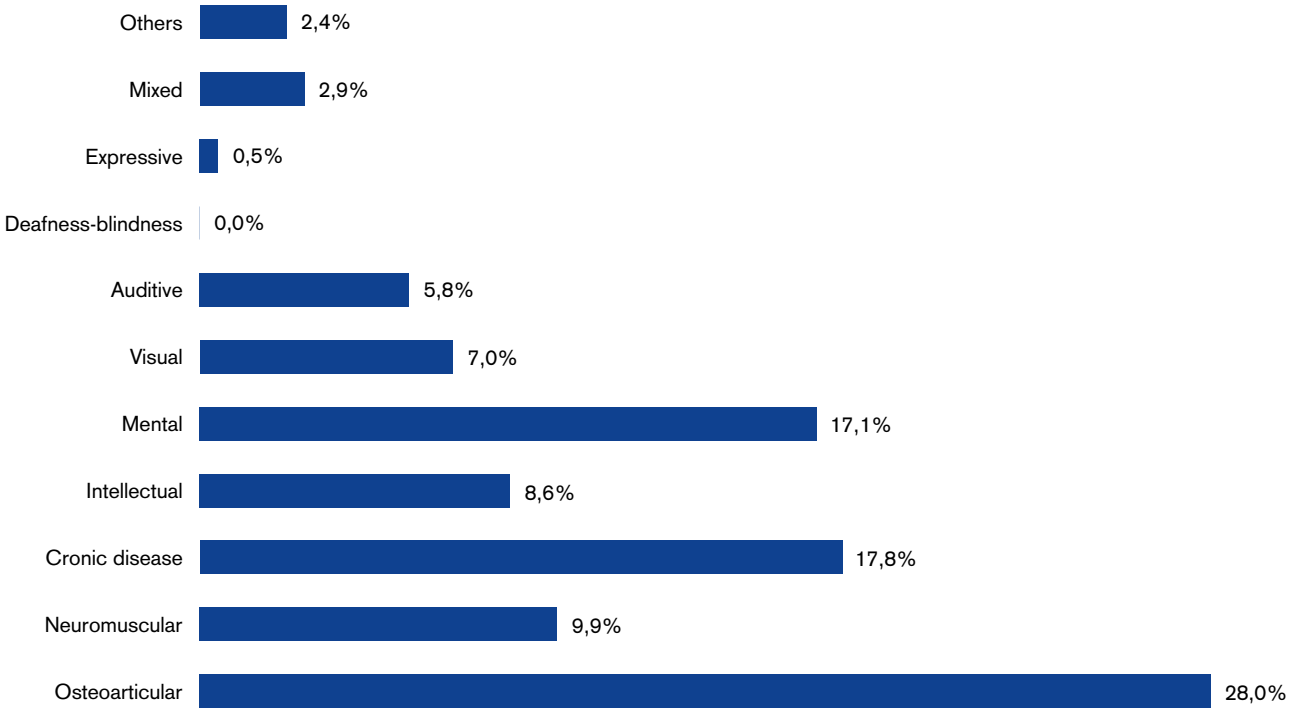
FIGURE 1 | Distribution of people with disabilities by age group (in %, 2017)



Source: own illustration based on Imserso (2019).

Among the persons with disabilities, osteoarticular diseases are most widespread with 28.0%, followed by chronic diseases (17.8%) and mental disabilities (17.1%) (Figure 2).

FIGURE 2 | Distribution of people with disabilities by nature of disability (in %, 2017)

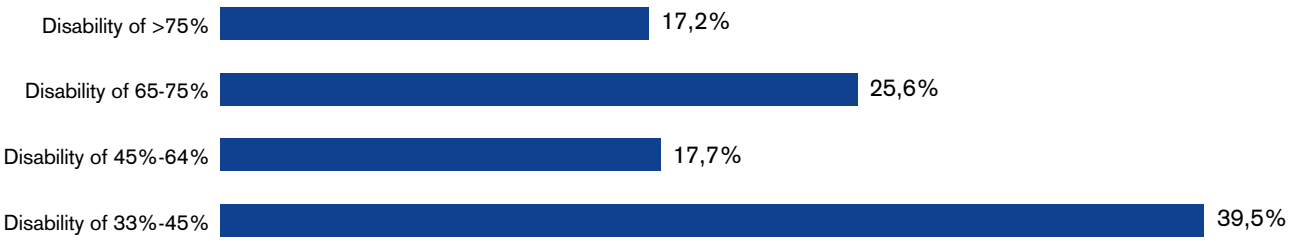


Source: own illustration based on Imserso (2019).

Figure 3 depicts the distribution of persons with disabilities by their degree of disability:[18] nearly 40% of the population has the lowest level of recognised disability of 33-45%. However, it is worth noting that 43% of persons with disabilities has a severe or very severe disability (i.e. a disability of more than 65%). Starting from this threshold, the Spanish regulation grants the most allowances.

18 A recognised disability starts at the disability level of 33%.

FIGURE 3 | Distribution of people with disabilities by degree of disability (in %, 2017)



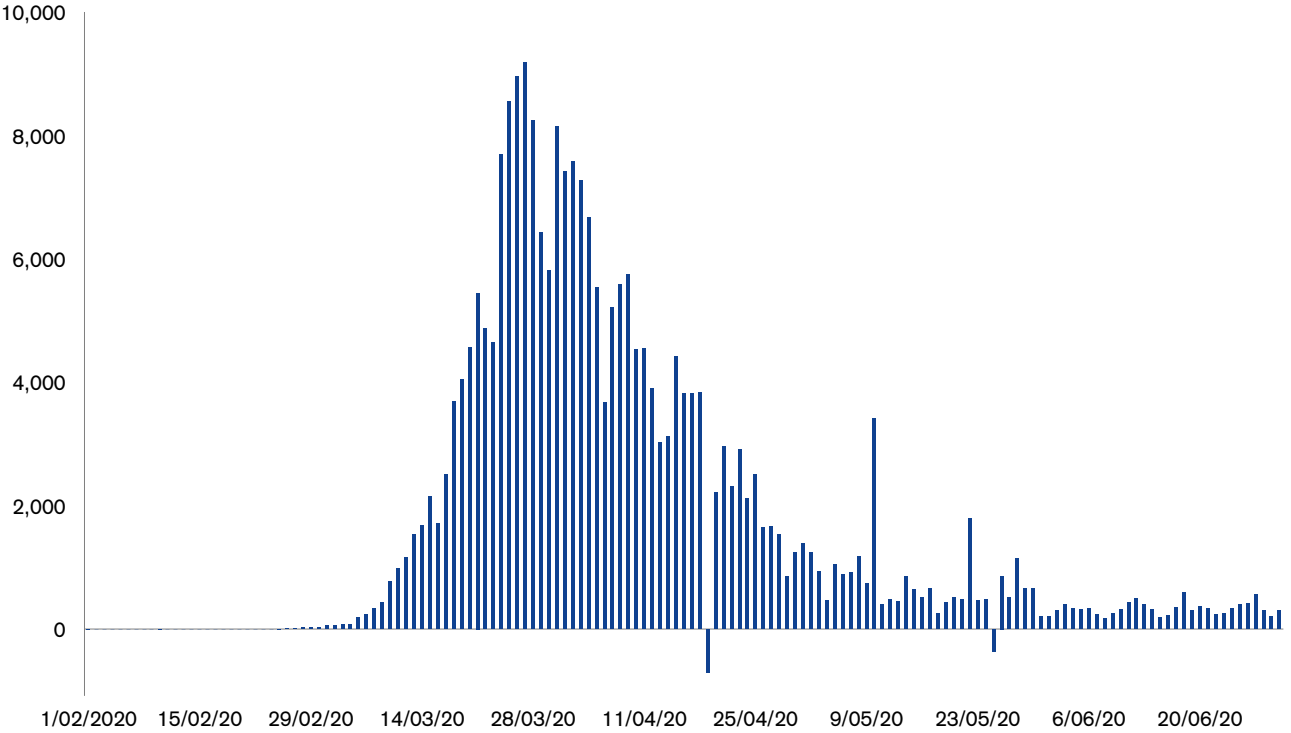
Source: Own illustration based on Imserso (2019).

Government Measures for Coping with the COVID-19 Pandemic

Spain was hit hard during the first wave of the COVID-19 pandemic with nearly 30,000 fatalities. Its first COVID-19 case was a German tourist whose infection was confirmed on 31 January 2020 in La Gomera, Canary Islands. On 26 February 2020, Spain registered its first local case and by 13 March 2020, cases had been confirmed in all 50 provinces of the country.

The first wave of the pandemic in Spain peaked on 27 March 2020 with 9,181 registered infections (Figure 4). The COVID-19 virus spread across the country at an alarming rate, affecting the ability of authorities to respond in a timely manner. Despite widespread knowledge of the impact of COVID-19 on older people, and in particular in the view of the reported death rates in Italy, care homes in Spain were unprepared for the spreading of the virus.

FIGURE 4 | Number of new COVID-19 cases (February-June 2020)



Source: own illustration based on EU Open Data Portal (2020).

To cope with the crisis, the Spanish Government declared the state of emergency on 14 March 2020, as the total number of cases reached 1,683. The national lockdown that took effect on 15 March 2020 was one of the toughest in the world. Everybody was mandated to remain in their homes except to purchase food and medicines, work or attend emergencies. Lockdown restrictions also commanded the temporary closure of non-essential shops and businesses, including bars, restaurants, cafes, cinemas and commercial and retail businesses, while also announcing that the government could be able to take over private healthcare providers.

As one of the first general measures in the field of social care services, the Government of Spain set up an Extraordinary Social Fund of 300 million Euros to help with COVID-19 related needs.[19] This fund's resources were to be transferred to regions and could only be used to finance staff and projects such as:

- ★ Strengthening residential (home care) services;
- ★ Increasing the number of telecare devices and improving their quality;
- ★ Moving rehabilitation services to home care, when necessary;
- ★ Strengthening homeless outreach and engagement efforts;
- ★ Reinforcing preventive measures;
- ★ Hiring more staff for social services and residential centres.

The COVID-19 pandemic also created some changes in the way social care services and long-term care services organise their various roles and responsibilities. At the start of the crisis, the Health Ministry assumed responsibility over a large number of public policies, which included those related to social services. The Autonomous Communities still retained the authority over the management of residential facilities. In some of the most affected Autonomous Communities such as Madrid and Catalonia, care responsibilities of the residences were transferred from the field of social services to the field of health. Furthermore, the Government adopted measures related to the operation of workers in social support services: while they were exempt from some mobility restrictions, they could be requested to provide extraordinary services (the Autonomous Communities could ask the workers to work overtime), or could be assigned responsibilities different from those in their job description, including direct care tasks. Exceptional measures for hiring or reincorporating staff were also put in place, including, for example, exemption from certain qualification requirements for newly recruited staff.

Apart from these general measures, the rapid spread of the COVID-19 virus in residential centres determined how social support services responded to the challenges of the pandemic. By the end of June 2020, 18,833 persons living in residences (both elderly and persons with disabilities) had died, representing 69% of all those who died from COVID-19 throughout the country (Ibañes 2020). In the field of residential care, the central administration decreed various measures: making the resources of private residences available to autonomous communities; making the accreditation and operation of services more flexible during the COVID-19 pandemic; adopting different organisational measures in the management of the centres (e.g. classifying residents in various groups according to their status). Officially, residential care regulation did not differentiate between the care provision for the elderly and persons with disabilities, thus not acknowledging that they required different types of care. Beyond the provisions of these national-level regulations, the regional authorities responsible for managing residential services implemented a multitude of measures to prevent and reduce the spread of the virus in these centres. These included facilitating the hiring of additional personnel for these centres; assigning the inspection of residential centres to the inspection services of the Ministry of Health; transferring residents to special social or health facilities; opening centres for the elderly who were affected by COVID-19, but did not need hospital admission; disinfecting the centres; restricting visits, etc.

19 https://www.mscbs.gob.es/ssi/covid19/ccaa/home.htm (last accessed on 1 February 2021).

Also in the case of residential care, numerous documents, guides and proposals were issued (SIIS 2020). For example, at the beginning of the crisis the Ministry of Health published a first technical document with recommendations for nursing homes and social health centres for confronting the COVID-19 pandemic. At a later stage, a guide for preventing and controlling COVID-19 in nursing homes and other residential social service centres was released. The General Council of Social Care published recommendations to social workers during the COVID-19 situation. For their part, Plena Inclusión (an organisation representing people with intellectual or developmental disabilities in Spain) prepared a practical guide for residences for people with intellectual or developmental disabilities (Plena Inclusión 2020). Furthermore, on 5 March 2020 the central government issued a protocol stipulating the measures that care homes should take to prevent COVID-19 infections. It defined actions to be taken in response to a resident or member of staff becoming symptomatic, thus establishing grounds for isolating residents within the care home. It also stipulated total limitations on visitors, immediately enacted throughout Spain. This protocol was rapidly disseminated, appearing on the day of its publication on major media platforms related to geriatric care or long-term care services. Additional protocols specific to each autonomous administration were also published and disseminated at the regional level within a similar time-frame.

This awareness resulted in the publication of a series of new regulations in the Official State Bulletins (BOEs), starting on 21 March 2020.These defined legally binding measures to be taken by the regional administrations with the aim of halting the spread of infection among care home residents and care workers. They were released together with updated recommendations describing in greater depth all the measures that care homes should take to minimise the risks of COVID-19 and to deal with any infections (24 March 2020). Much of the issued measures were cumulative, with subsequent regulations announced in further BOEs largely building on former specifications. However there is some lack of consistency, notably between the early protocols and later measures. This arose from adjustments in line with the emerging evidence, both nationally and internationally. Figure 5 displays a brief overview of the evolution of preventative measures.

FIGURE 5 | Overview of the measures introduced by Spanish authorities during the first wave of the COVID-19 pandemic (March-June 2020)

* The blue boxes contain information directly related to healthcare as well as services for the elderly and persons with disabilities; the grey boxes display general measures and developments.

Source: own illustration based on Odismet Silván and Quífez (2020).

Effects of the COVID-19 Pandemic on the Provision of Social Support Services for Persons with Disabilities

The COVID-19 pandemic has revealed a general structural weakness in the provision of social support services in Spain. According to the interviewed experts, the primacy of the health system over the socio-sanitary one became particularly visible during the first phase of the COVID-19 pandemic. As the socio-sanitary coordination was poor, the elderly and persons with disabilities were (and still are) very alarmed. So far, the Government has not managed to address the fear and expectations of persons with disabilities.

The impact of the COVID-19 has been especially devastating in the residential care facilities. The high death rate in residences has created great social and political concern and has provoked a debate about the future model of residential care (Zalakaín and Davey 2020). The lack of doctors and staff, protective equipment and infrastructure as well as difficulties in transferring patients from residences to hospitals aggravated the situation. The greatest scandal, which put Spain under the spotlight of global media, occurred on 23 March 2020, when the Spanish Army found elderly people abandoned and dead inside the residences.

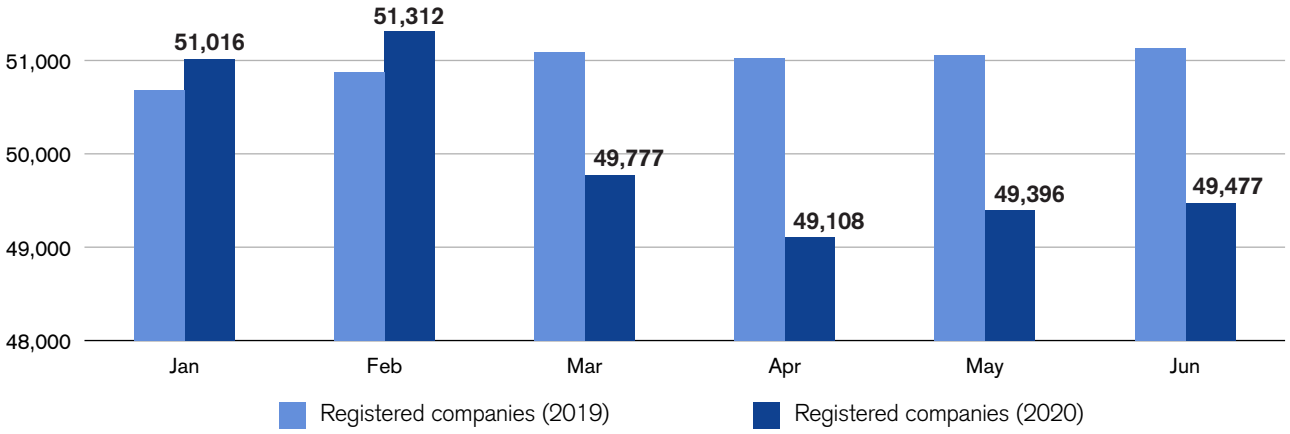
According to the interviewed experts, during the second wave of COVID-19 (September-November 2020), the support services were not paralysed like during the first wave, as they had specific resources at their disposal (e.g. personal protective equipment (PPE) or funds). Furthermore, it was possible to draw on the experience gathered during the first wave of the COVID-19 pandemic and the lock-down measures were not as restrictive as during the first wave. For the future, interviewed experts recommended to rethink the model of social services that we want and to support those projects that empower the persons with disabilities and give them the opportunity to live independently.

It is important to consider in more detail the providers of social care services, the quality and scope of services as well as the workforce in the field. Wherever possible, data are specified for persons with disabilities. To enable us to focus further on persons with disabilities, quantitative information is supported with insights from expert interviews

Service Providers

The COVID-19 pandemic had a visible impact on the companies of Human Health and Social Work Activities (NACE Q) during the first half of 2020. Since March 2020, according to the Seguridad Social (Social Security) data there were fewer registered companies in the than during the same period in 2019. In April 2020, the numbers of registered companies were lowest, while in May and June 2020, as the temporary restrictions on the economy were easing off, a slow recovery can be identified (Figure 6).

FIGURE 6 | Number of registered companies in Human health and social work activities (NACE Q), January-June 2019 and January-June 2020



Source: own illustration based on Seguridad Social (2020).

The interviewed service providers reported that between February and June 2020 their financial situation suffered from the impact of the COVID-19 pandemic. In the case of public service providers, the Government continued paying the provider for the same number of users (e.g. even if the users of day care services stayed at home), whereas for private service providers a 50% of capacity meant half income. The effects of the COVID-19 pandemic were not limited to the initial period: there is uncertainty concerning the financial resources that the Government will allocate to the residences and day care centres for 2021. The service providers of the sector are worried, because the funds per user could be reduced, or the Government might decide to reduce the number of users. At the same time, the prices for service provision have increased as in all cases the service providers have had to defray the costs of the PPE. Furthermore, some experts indicated that they had to fill in the sick leaves with new staff, with the consequent financial impact. Some interviewed service providers maintained that adapting to the new situation necessitated investments in the infrastructure, especially in terms of compartmentalisation, sign-posting, hygienic measures and provision of PPE. In cases where the services providers did not have to change the layout in the buildings to create sectors or compartments, their financial expenditures could be contained.

Regarding governance, the situation was complicated for all service providers. From the first moment, they tried to apply with rigor and intensity the numerous instructions that they received from the health and social authorities. However, even if the flow of communication with their regional governments was good, the situation in general was chaotic as public authorities were in a reactive rather than proactive mode: they issued new regulation and protocols every week, making it hard to keep up with the latest news. Moreover, most regulations were rather for inspection than for support, not catering for the needs of the service providers.

In order to address the confusion and insecurity, the interviewed associations explained that they had been in permanent communication with their associates and had worked a lot in communication and dissemination, sending more news and newsletters than before the COVID-19 pandemic and trying to keep everybody well informed. Since there was no adequate support by the authorities and no specific information concerning persons with disabilities, the associations assumed an important role in simplifying the information and organising the constant regulation for the clients and families. The experts think that these new channels of information are here to stay, since they have proved to be an asset for the associations and their members.

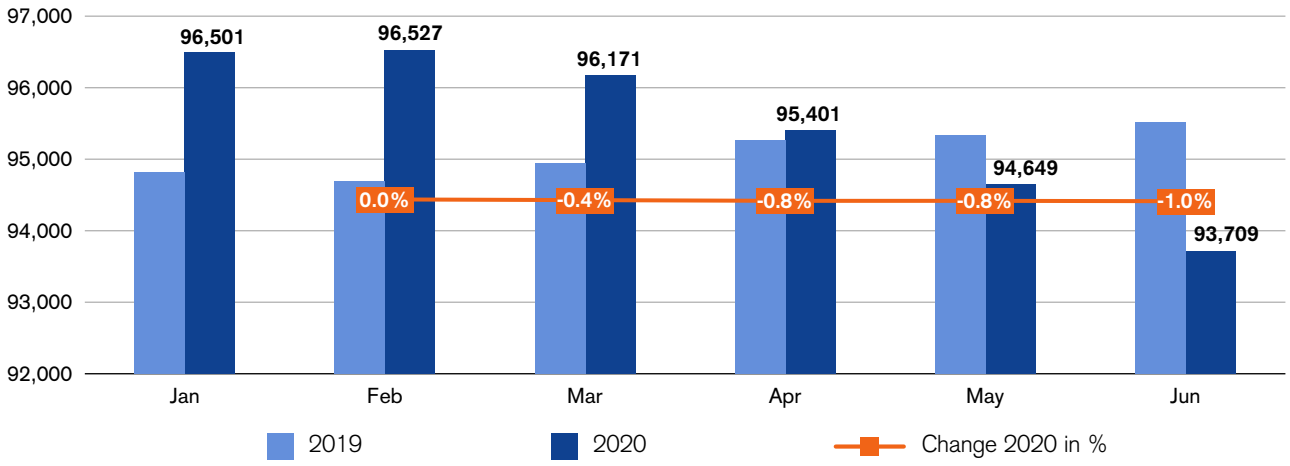
Scope and Quality of Services

Our interview partners stressed that some support services to persons with disabilities were more affected than others, depending on the nature of the services, the restrictions in place and the regulation. The strict lockdown that was established from March-June 2020 forced many of the users of the support services to remain at home alone or with their families, not being able to receive the services they were entitled and accustomed to. During the period March-June 2020, there was no flexibility for switching services, e.g. a user who was receiving home assistance and now needed residential care, could not be changed to this service at the time. In the following, the effects of the COVID-19cpandemic on different types of services will be presented in more detail.

Day care: quantitatively, the number of users of day care services decreased only slightly in during the first period of the COVID-19 pandemic – at a rate of almost 1% per month between April and June 2020 (Figure 7).[20] However, the data do not reflect the reductions and interruptions in the provision of social support services.

20 The number of users includes both elderly and persons with disabilities, as the data cannot disaggregated.

FIGURE 7 | Number of users of day care, January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Imserso (2020).

All day care centres in Spain were closed for nearly three months since 14 March 2020, some even days earlier, because they were already aware of the risk of contagion. As users could not go to day care centres, day care services could not be delivered face-to-face. However, the conducted interviews revealed that the services were changed. Face-to-face services, for example, were interrupted, but periodic remote monitoring was carried out by social workers over the phone, WhatsApp or Zoom. Moreover, the workers of most day care centres created YouTube videos and channels with sessions for the users. Activities that were regularly performed at day care centres were converted to online formats, so if for example they usually had arts, ICT, radio, and audio-visual workshops in the day care centre, the social workers were now proposing similar activities by video that they sent to the users. Similarly, exercises and rehabilitation training sessions were also created in video.

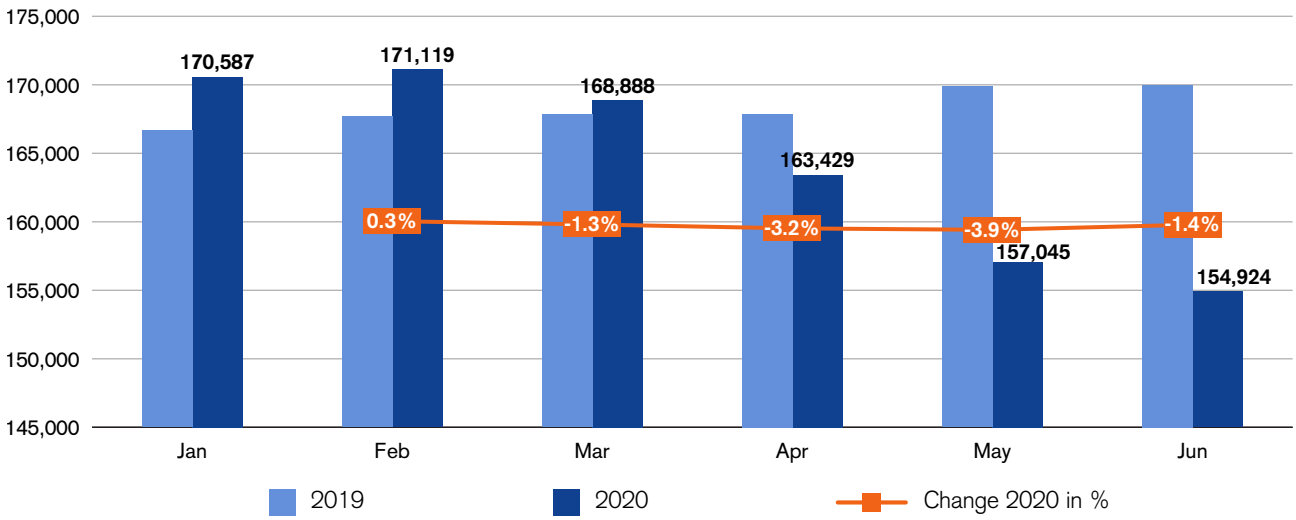
Even though users were encouraged to use videoconferencing with social service workers, as well as video apps, it was not always easy: many users lacked adequate devices, infrastructure or skills to get the tools started. In most cases, families with younger members helped the persons with disabilities, but in other cases, the regular phone served as the main communication channel. In addition, some of the persons with disabilities who usually lived alone moved in with their families in order to be better cared for during the lock-down. As these persons were not in their usual home, in some cases it was harder for them to connect with the social workers. For the future, there is much to do in terms of training and connectivity, both with users and families. When the day care centres reopened in July 2020, they had to adjust their services. For example, they cancelled group activities and therapies, limited the number of users and created rules for social distancing and hygienic measures. The families were nevertheless very worried and many users did not resume the service. Moreover, transport for the users was also very complicated or inexistent. In October 2020, some users had still not returned to the day care centre for fear of contagion, so remote services continue to be available for these users, including both videoconferencing and activity videos for them to follow from home.

According to the interviewed experts, the health and the quality of life of the people with disabilities and their families has been greatly affected by the interruption of the social support services. Their mental or physical condition has in general worsened and the balance of family life and work in the household was greatly disrupted at the time. Furthermore, the interruption of the day care centres also interrupted the Social life of and relationships between persons with disabilities. This has made some service providers to think about new services to strengthen the social network of persons with disabilities. Moreover, even with the reopening of the centres, not being able to organise group activities, no field trips, no physical contact, service providers are rethinking their future service offer to avoid such detrimental effects on the social life of service users.

Residential care: residences suffered the most during the first period of the pandemic (March-June 2020). The number of users in residences, both elderly and persons with disabilities, dropped considerably during this period – especially in April and May 2020 (Figure 8). Altogether, residences lost more than 16,000 users from February to June 2020. This is due to the fatalities

among the residents, but also to the fact that some users were leaving the residence to receive family care in the household. Fortunately, there were much less fatalities among the people with disabilities than among the elderly. In the region of Madrid, for example, according to the Regional Minister of Social Policies, 5,272 users in residences died with symptoms compatible with COVID-19 until the end of April 2020. Among them were 29 persons with disabilities. Facilities for people with mental or physical disabilities are usually smaller than the ones for the elderly, therefore, the virus was a bit easier to contain in these residences. Also, the average age is younger than in the residences for the elderly, where the most vulnerable live and where the virus was more deadly.

FIGURE 8 | Number of users of residential care, January-June 2019 and January-June 2020; change compared to the previous month



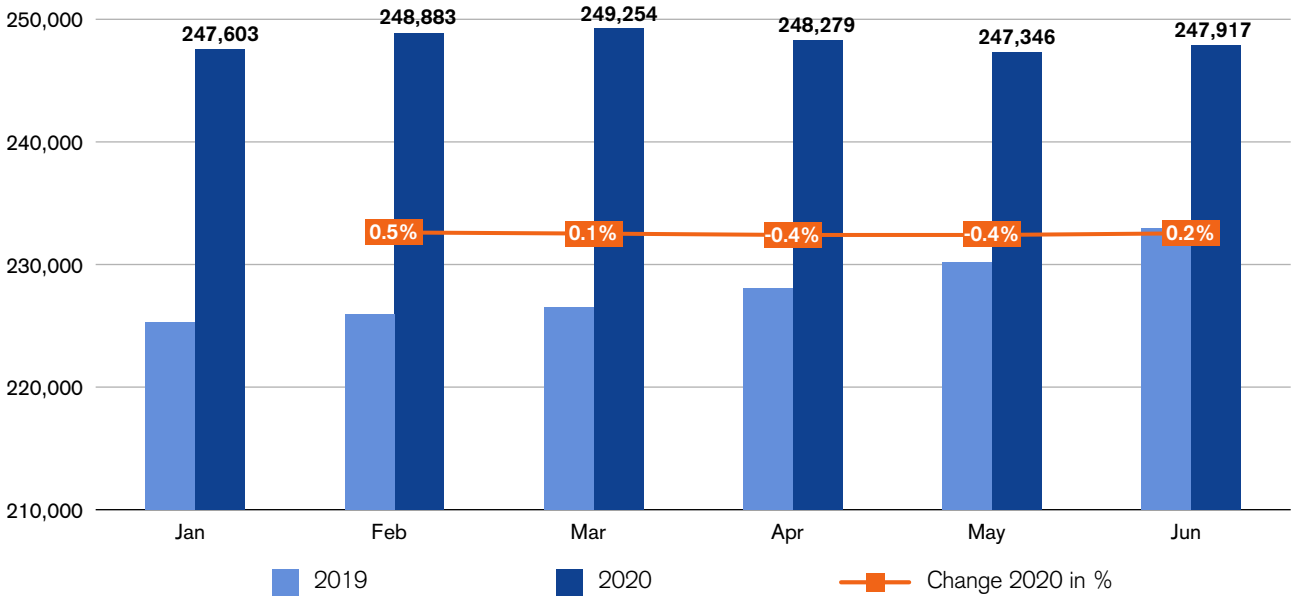
Source: own illustration based on Imserso (2020).

While residences remained open, social support services were deeply affected by the rapid spread of COVID-19. In the residences for people with disabilities, the problems were similar to those of the elderly, but in some cases even more complicated as it was difficult to explain the new situations and requirements to persons with mental disabilities. Also younger residents had trouble accepting the lock-down, the no-visits-regime, etc. According to the interviewed experts, the changes were far-reaching: residents had to be isolated in their rooms for two months, there were no activities for them, they could not use the common areas and did not get a chance to spend time with others. The services necessarily had to reflect these changes and the workers had to adjust also their activities. Their new tasks included bringing food to the rooms, manufacturing PPE, buying goods for the residents and running errands for them. Services were therefore reinvented according to the regulations, the social distancing and the kind of resources that were available at the moment. Moreover, services, treatments, and therapies had to be delivered with the minimum contact with the residential user and limiting the access to the rooms. Like in day care, users of the residential centres were encouraged from the beginning to keep telephone and virtual contact, e.g. by videoconference, with their families. The residence was also providing regular information to the families about the user's health condition, the safety measures that the residence was undertaking and the kind of services they were providing to the user.

Residences did not have a good reputation in Spain, but since the COVID-19 pandemic they have fallen in disgrace. In the future, the concept of residence is going to change. We were already in the process to change, but the crisis has accelerated the need to switch to other models such as supervised housing, apartments or small dwellings.

Telecare services: here, the number of users barely changed during the pandemic (Figure 9). It did decrease slightly in April and May 2020, but the numbers remained higher than in 2019. Already in June 2020, a recovery became apparent, almost reaching the level of users in January 2020.

FIGURE 9 | Number of users of telecare services, January-June 2019 and January-June 2020; change compared to the previous month

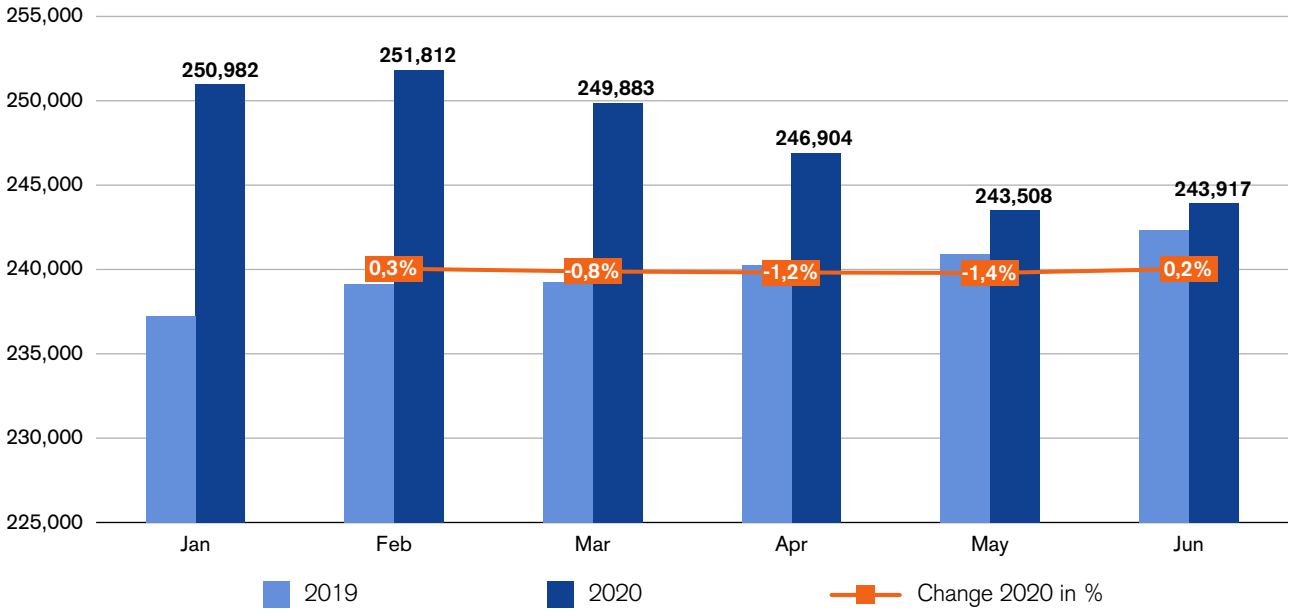


Source: own illustration based on Imserso (2020).

Telecare is the service that worked best during the first wave of the COVID-19 pandemic, mainly because of its nature. Workers could continue checking on users in the same way as before the pandemic. They did have protocols to report COVID-19 cases when these were identified and the steps to be taken were defined. According to the interviewed experts, however, it would have been convenient to have had an emergency plan for telecare service providers. When working from home, they needed to have the necessary equipment and infrastructure and in most cases they had to rely on their personal devices. The interviewed experts confirm that the demand for telecare has increased since then, especially for people who live alone.

Home assistance: the effects of the COVID-19 pandemic are also visible in the number of users of home assistance services (Figure 10): from February to June 2020, there were approximately 8,000 less users including elderly and persons with disabilities. The largest drop in service users was experienced in April and May 2020, where it decreased by 1.2% and 1.4% compared to the previous months. Home assistance as a service was becoming more popular and gaining users every month. Even though the numbers decreased with the progress of the pandemic, they never dropped below the level of 2019. Already in June 2020, an upturn was recorded.

FIGURE 10 | Number of users of home assistance, January-June 2019 and January-June 2020; change compared to the previous month

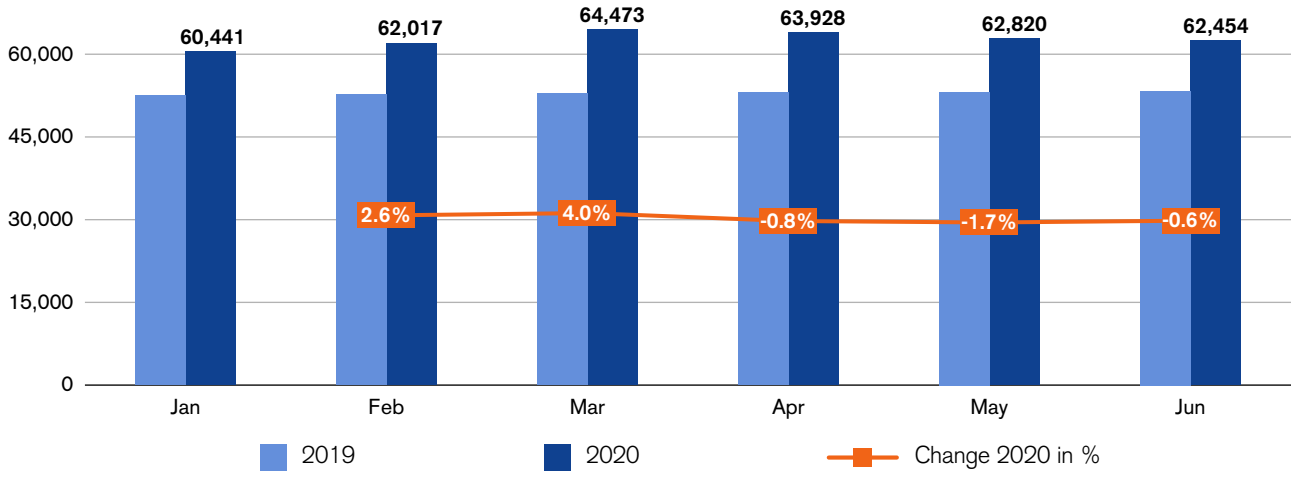


Source: own illustration based on Imserso (2020).

The interviewed experts reported that the service of home assistance was very seriously affected during the first wave, as social care workers limited their visits to the households. Depending on the case/user, it was the social care worker who decided whether to go to the user's home or not. As a result, services changed frequently from a face-to-face assistance to remote monitoring. However, many users and workers were lacking the digital skills and the infrastructures to use videoconferencing tools, so this monitoring was complicated to set-up and did not start right away. Where the social workers did not reach the persons with disabilities, especially those who lived alone relied on the help by volunteers and neighbours who went shopping or to the pharmacy for them and ran other errands. In rural areas, however, this kind of help was harder to organise.

Preventative services: The number of users of preventative services (specific preventive and rehabilitation programmes aimed at the elderly and persons with disabilities) experienced a peak in March and then declined in the next months. The number of service users was growing so fast during 2019 and early 2020 that even though the numbers decreased with the progress of the pandemic, they were still considerably higher than in 2019 and even higher than in February 2020. The largest drop in service users was experienced in May 2020, where it dropped by 1.7% compared to the previous month; however the peak of March 2020 compensated this month's loss as well as April's and June's in the same year.

FIGURE 11 | Number of users of preventative services, January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Imserso (2020).

Preventative services are not stand-alone services, but need to be provided through the day care, residential care, telecare or home assistance programmes. Therefore, the delivery and change in scope and quality of these services mainly depended on the kind of programme to which it was attached to. On the one hand, preventative services provided in rehabilitation centres were interrupted during the first wave of the pandemic with the closure of these centres on 14 March 2020 and the effects were similar to those experienced by day care centres. On the other hand, preventative services that were delivered in private homes continued depending on the severity of the cases. As in the case of home assistance services, the social care worker decided whether and in which form the service continued.

Cash allowances: the number of beneficiaries of the three types of cash allowances in the social care system remained quite constant during the first wave of the pandemic, experiencing fluctuations, which were similar to those reported in the same period in 2019. In order to concentrate public sector resources on those essential activities for the functioning of the country, the Royal Decree Laws 8/2020 and 15/2020 suspended, interrupted or postponed procedures by public sector bodies. Therefore, during the period of the COVID-19 pandemic in March-June 2020 it was complicated for users to modify, start or stop the provision of this kind of benefits.

Employment services: the special employment centres for persons with disabilities remained opened and officially their employees could go to work. However, in many cases, the activity was reduced or eliminated in its entirety. The tourism and catering sectors were affected most, as well as the provision of auxiliary services to other companies, industrial sectors, etc. The persons with disabilities who reduced or interrupted their work had to apply for compensation from the Temporary Labour Force Adjustment Plan (unemployment benefits for reduced working hours) until they returned to work as usual. In June 2020, many persons with disabilities could resume their work, because the economy started recovering. However, those providing auxiliary services to companies depended on the recovery of the parent company.

Special employment centres in essential sectors such as those related to social health, food, distribution, hospital laundries, cleaning of social and health services, waste management, etc. did not stop their activity; on the contrary, their efforts were redoubled. Some special employment centres demonstrated a truly remarkable adaptability when they quickly reconverted and began to do other things to contribute to the joint efforts of mastering the COVID-19 pandemic. This was the case of thousands of PPE that were manufactured by persons with disabilities as well as cleaning services provided for sanitary material.

Workforce

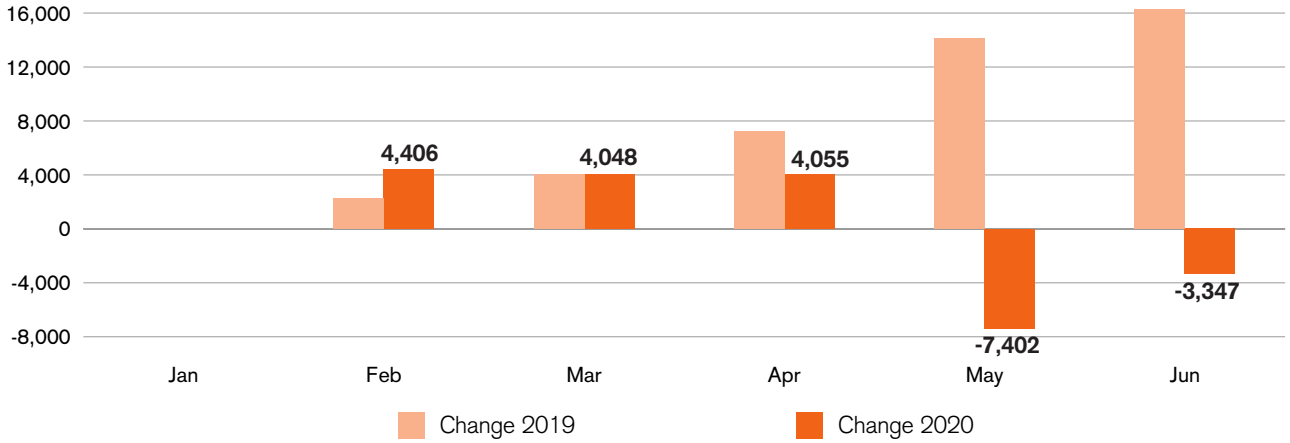
The workers providing support services to persons with disabilities have been making an extraordinary effort to retain the level and quality of services. Their dedication to the users of social support services in a period of uncertainty and no clearly foreseeable end of their endeavours put a pressure on the workers and exhausted them. In particular, the workers at residential facilities were strained during the first months of the COVID-19

pandemic as they did not know what they were facing and were lacking PPE. Workers who were working in the day care, occupational or rehabilitation centres were now deployed in residential facilities, performing in many cases completely different tasks. Moreover, the interviewed experts stressed that during the COVID-19 pandemic, many workers went from giving support to suddenly having to risk their own lives and saving the lives of others. Furthermore, the efforts of the social care workers were not duly valued by the society in general. For the future, the interviewed experts recommend to professionalise the social care services sector: to increase the number of professionals, improve working conditions and social reputation/recognition of the work done.

In the following four sections, we examine the employment, unemployment, vacancies and working conditions to assess the impact of COVID-19 on the workforce of the support services sector. Again, quantitative information is supported with insights from expert interviews.

Employment: The number of employees in the Residential care and Social work activities without accommodation (NACE Q87 and Q88) fluctuated strongly in the first half of 2020. However, this is not especially significant, because such fluctuations are quite usual when taking a look at the previous year (Figure 12). Nevertheless, 2020 brought a strong decrease in employment in NACE Q87 and Q88, which is extraordinary in a growing labour market. While in the first half of 2019 the number of employees in these two activities experienced a considerable growth rate, it declined sharply in 2020, which seems to directly relate to the COVID-19 pandemic.

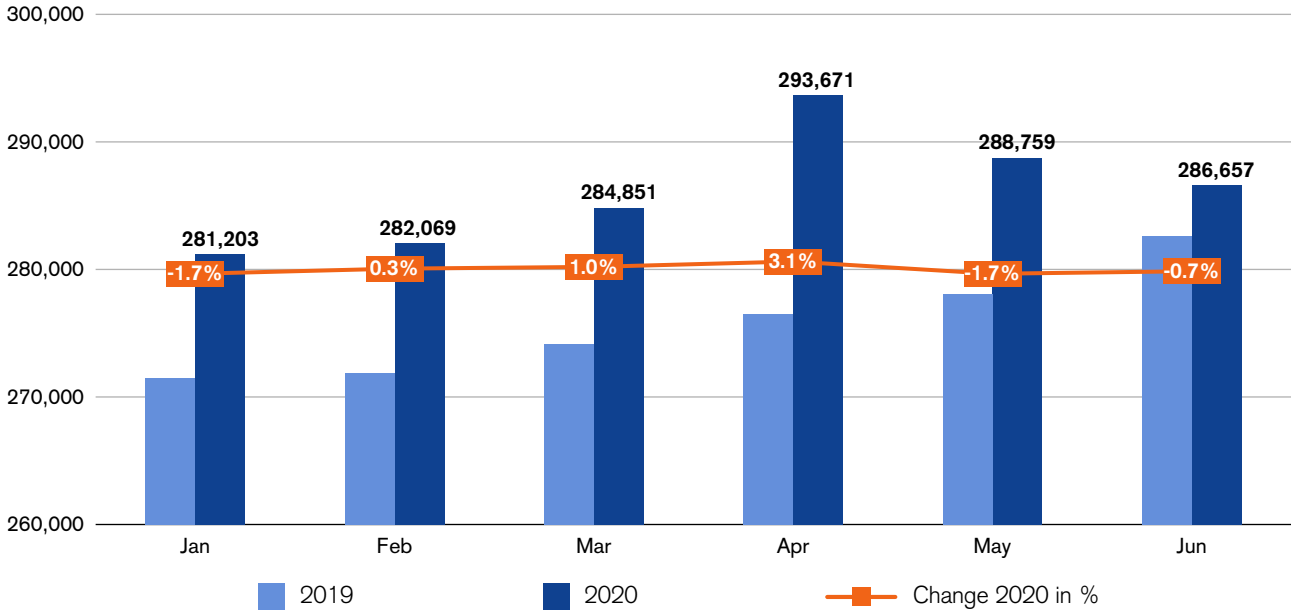
FIGURE 12 | Change in number of employees in Residential care and Social work without accommodation activities (NACE Q87 & Q88) compared to previous month, January-June 2019 and January-June 2020



Source: own illustration based on Seguridad Social (2020).

Concerning the development of employment in Residential care (NACE Q87), it is worth highlighting that there was an increase in employment during the peak of the crisis: in April 2020, 8,821 more employed persons were registered in this sub-sector than in the previous month. This corresponds to a growth rate of 3.1%, which constitutes three times the growth rate of employment during the same month in 2019. Although the downward trend in May and June 2020 practically cancelled out this newly created employment, in June 2020 there were still more employed persons in this sub-sector than at any point during the first quarter of the year.

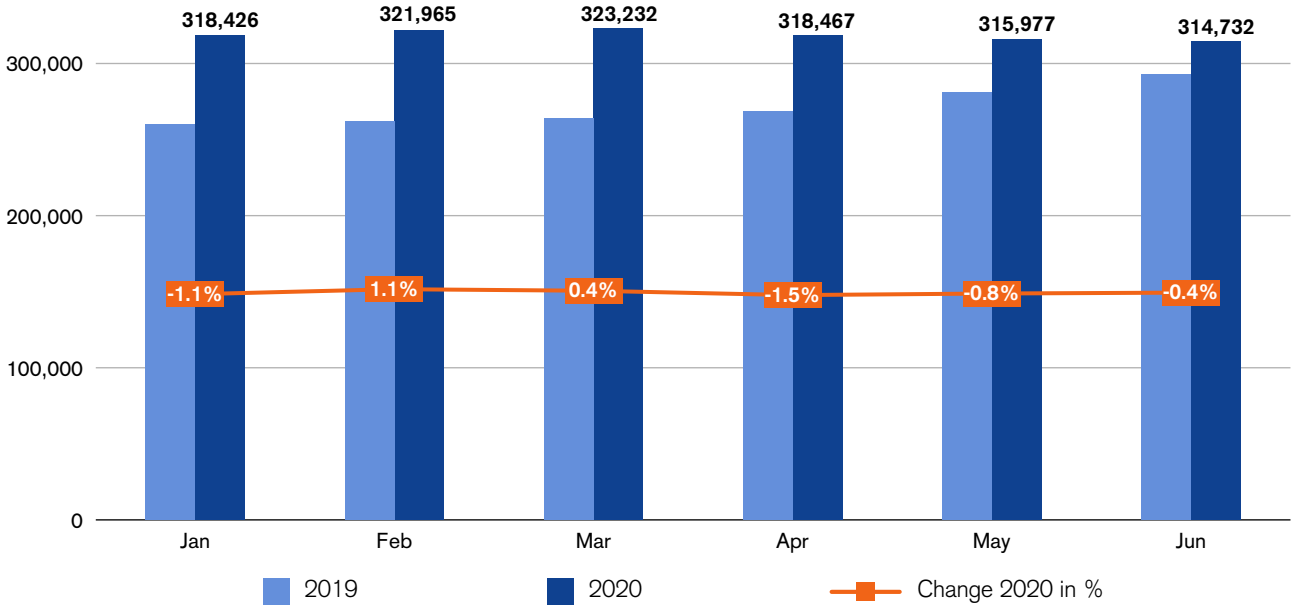
FIGURE 13 | Employed persons in Residential care activities (NACE Q87), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Seguridad Social (2020).

As for employment in Social work activities without accommodation (NACE Q88), the observed trend is quite different from that in Residential care (NACE Q87) since in the period March-June 2020 the number of employed persons decreased by 8,500. While Residential care experienced a peak of employment during April 2020, the Social work activities without accommodation underwent the greatest drop in the same month (-1.5%). The number of employed persons continued decreasing during the next two months, although it still remained higher than in 2019.

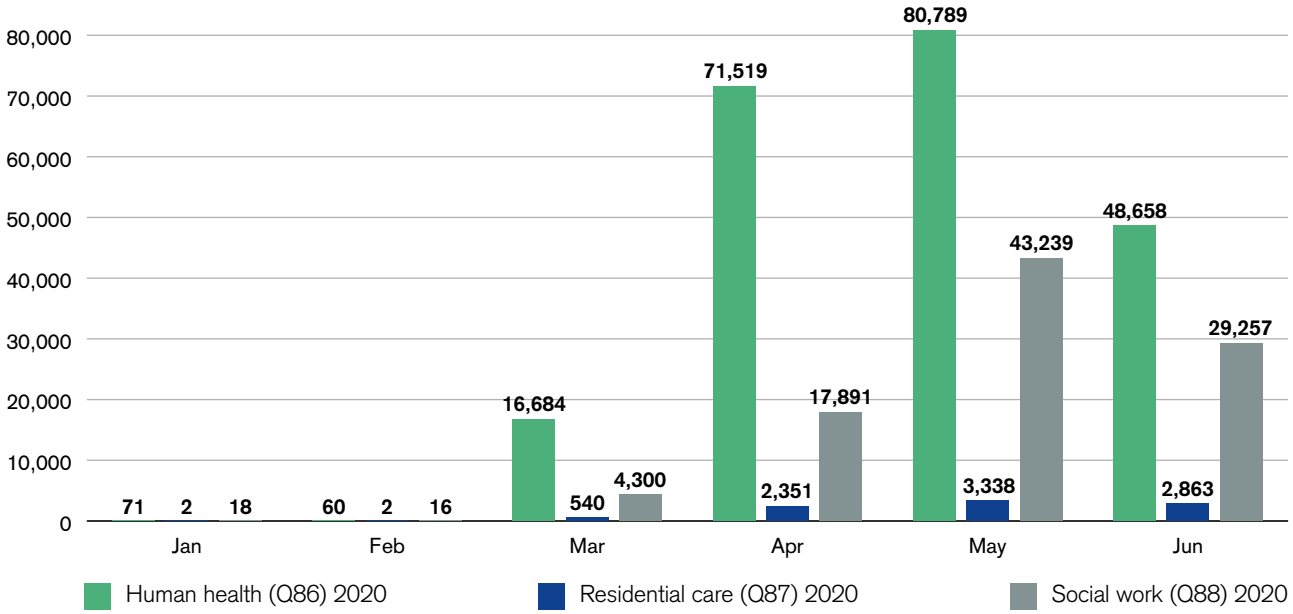
FIGURE 14 | Employed persons in Social work activities without accommodation (NACE Q88), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Seguridad Social (2020).

The Spanish government introduced a measure in mid-March 2020 that allowed companies suffering losses from the COVID-19 pandemic to temporarily send home workers or reduce their working hours. This furlough scheme measure, named Programme of Temporary Adjustment of Employment (ERTE), grants workers unemployment benefits (up to 70% of their base salary) from day one, regardless of their previous contributions and without reducing the accumulated amount of regular benefits a person has gained through their working life. Under this scheme, thousands of businesses have filed for ERTEs. The sectors or Social work without accommodation (NACE Q88) and Human health (Q86) displayed unprecedented numbers of temporarily suspended employment contracts or reduced working hours (Figure 15). Indeed, between March and June 2020, this concerned more than 90,000 workers in the activities of Social work without accommodation (NACE Q88), while these measures affected only 9,000 workers in Residential care (NACE Q87).

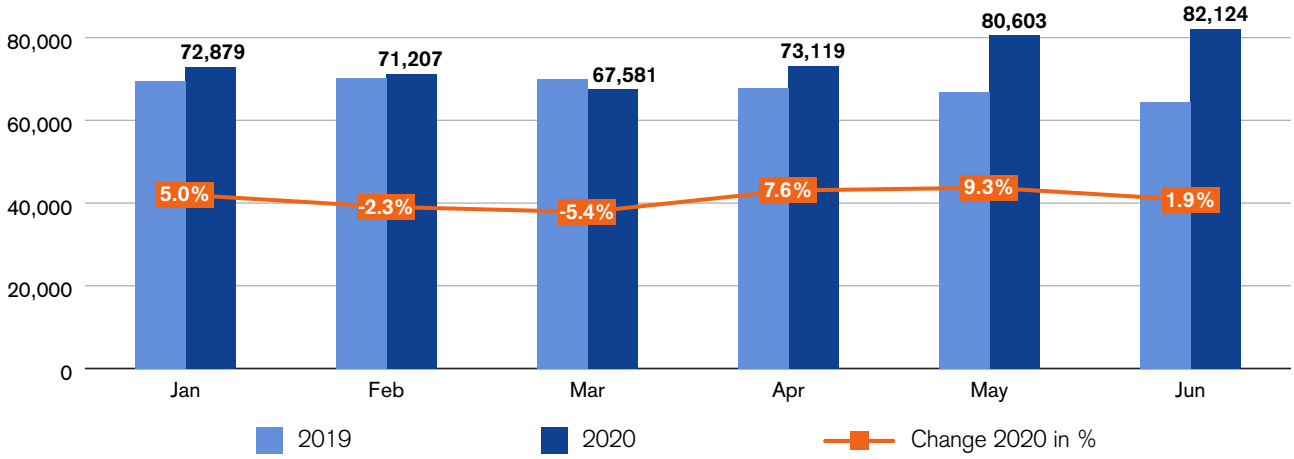
FIGURE 15 | Number of persons receiving compensation for the Temporary Labour Force Adjustment Plans (ERTE) in Human health (NACE Q86), Residential care (NACE Q87) and Social work without accommodation (NACE Q88), January-April 2020



Source: own illustration based on Ministerio de Trabajo y Economía Social (2020).

Unemployment: The number of jobseekers in Residential care (Q87) reached its minimum during March 2020, which marked the beginning of the COVID-19 pandemic and the start of the lock-down measures. In the following three months, the number of jobseekers experienced an upward trend, reaching the peak in June 2020 with 82,124 registered jobseekers for this activity (Figure 16).

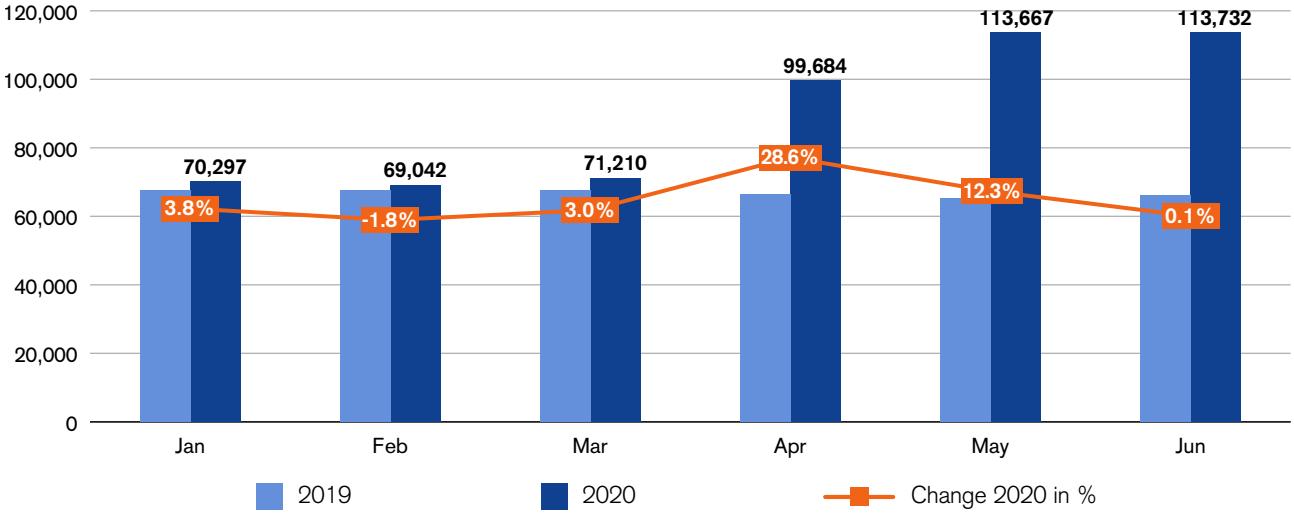
FIGURE 16 | Number of jobseekers in Residential care (NACE Q 87), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Servicio Público de Empleo Estatal (SEPE) (2020).

The case of Social work without accommodation (NACE Q88) is quite different, as we see that the number of jobseekers in June 2020 grew by 65% since February 2020, with the change in April 2020 being most significant (an increase of 28.6% in the number of jobseekers) (Figure 17). The effects of the COVID-19 pandemic on this sector have therefore been more noticeable than in Residential care (Q87), where workers were needed to maintain the functioning of the residences.

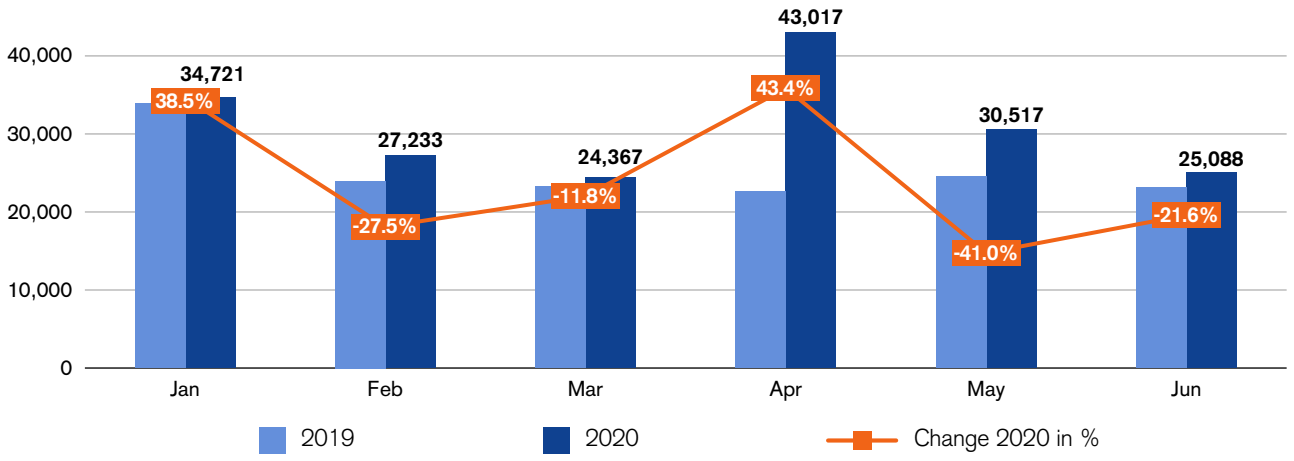
FIGURE 17 | Number of jobseekers in Social work without accommodation (NACE Q88), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Servicio Público de Empleo Estatal (SEPE) (2020).

Regarding the entry into unemployment in the given period, we see that from January to March 2020, the figures in Residential care and Social work without accommodation activities (NACE Q87 & Q88) were very similar to the previous year (Figure 18). However, in April 2020 the effects of the COVID-19 crisis had become visible in the labour market, as the number of entries into unemployment (around 43,000 persons) had almost doubled the figure of March 2020 and that of the previous year (a difference of approximately 20,000 persons). During May and June 2020, when the restrictions started to ease, the labour market reacted and the entries into unemployment fell by 41% and 21% respectively, nearly reaching the pre-COVID-19 figures.

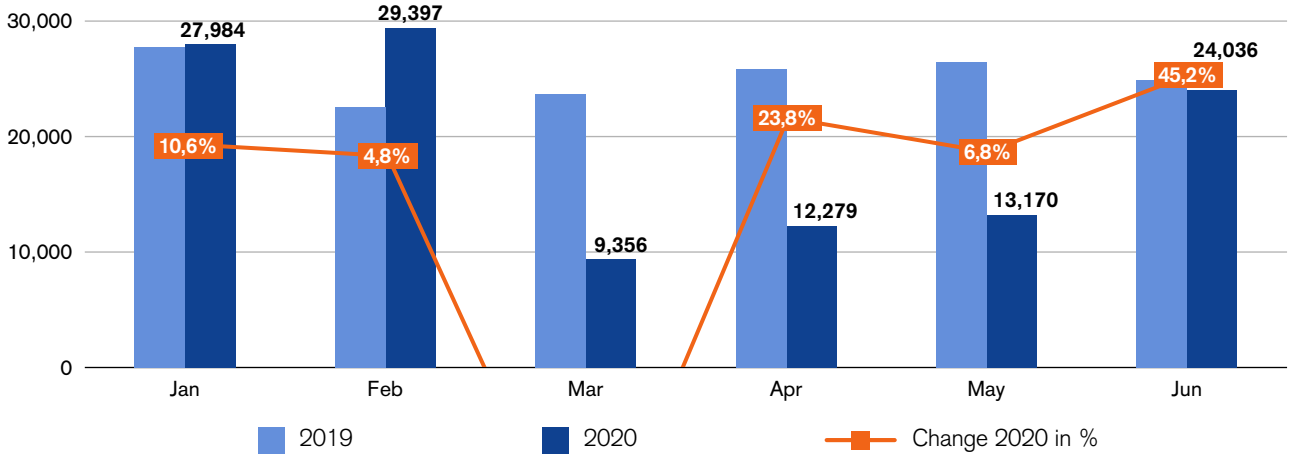
FIGURE 18 | Entry into unemployment in Residential care and Social work without accommodation (NACE Q87 & Q88), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Servicio Público de Empleo Estatal (SEPE) (2020).

In the observed time period, the trend in the exits from unemployment in Residential care and Social work without accommodation (NACE Q87 & Q88) was counter-directional to the entries into unemployment (Figure 19). Exits from unemployment showed a strong decline in March 2020. In absolute terms, in that month about 14,000 fewer persons managed to leave unemployment, compared to March 2019, amounting to a decrease of 214%. Also in April and May 2020, significantly fewer people managed to leave unemployment compared to the previous year. In June 2020, however, entries from unemployment approached the level of the previous year and were a first sign of a relative recovery.

FIGURE 19 | Exit from unemployment in Residential care and Social work without accommodation (NACE Q87 & Q88), January-June 2019 and January-June 2020; change compared to the previous month



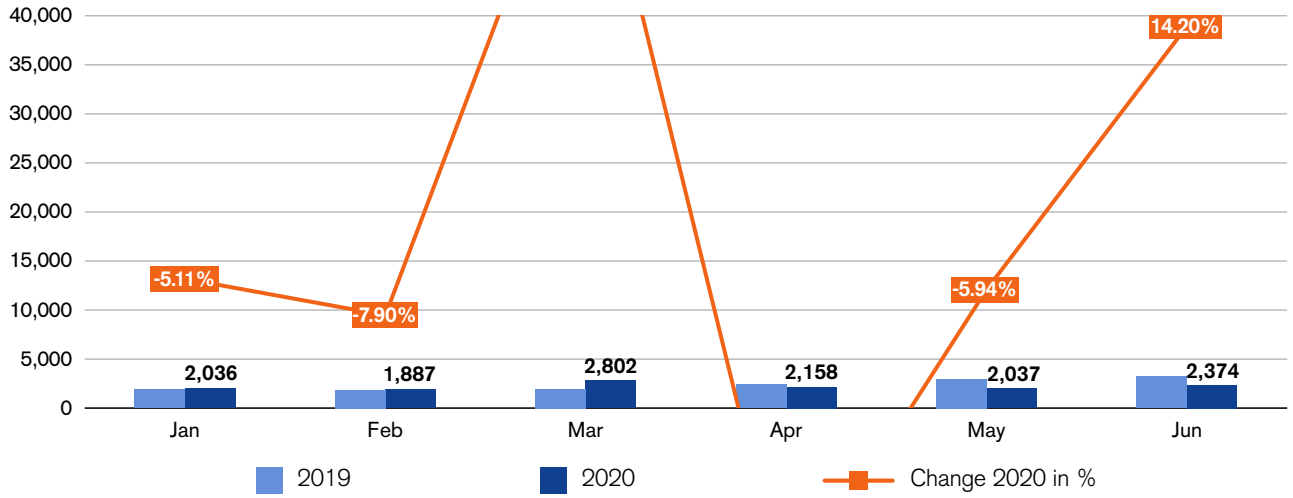
Source: own illustration based on Servicio Público de Empleo Estatal (SEPE) (2020).

Comparing the entries into unemployment with the exits, it can be seen that in February 2020, more people left unemployment than entered it. This means that there were more hires in that month. However, in the following months, the trend was reversed: in March 2020, 15,000 more persons entered unemployment than left; in April 2020 it was 30,000 persons and in May 2020 17,000 persons. This trend levelled off in June 2020, when only 1,000 more persons entered unemployment than left it.

Vacancies: vacancies registered by the Public Employment Service do not represent the labour market reality in Spain, because only few of them are reported to the labour authorities. Although the insights are limited, it is still interesting to analyse the trend of the impact of the COVID-19 pandemic on the registration of vacancies by the Public Employment Service. In the field of Residential care and Social work without accommodation (NACE Q87 & Q88), slightly more vacancies were reported in

the first two months of 2020 than in the previous year (Figure 20). Also in March 2020, there were 30% more vacancies. However, this development reversed during the three following months when fewer vacancies were reported than the previous year.

FIGURE 20 | Vacancies in Residential care and Social work without accommodation (NACE Q87 & Q88), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Servicio Público de Empleo Estatal (SEPE) (2020).

Working conditions: in April 2020, the General Council of Social Work (CGT)[21] conducted a survey among 1,561 Spanish social workers that revealed some of their working conditions during the first wave of the pandemic (CGT 2020):

- **Changes in the services:** 63% of the workers in the sample felt that they were not providing enough face-to-face services. Therefore, physical presence would have been more desirable. Only 15% did not explicitly favour the face-to-face services. Regarding the activation of special protocols for social emergency situations, 25% of the professionals who responded to the survey indicated that no special protocols were activated for social emergency situations in their institution, and 17% were unaware of it. These protocols were activated for 59%;
- **Availability of information:** half of the respondents perceived that they did not receive enough information or that it was scarce, and the other half considered that they had had adequate and sufficient information from the first moment. Almost half (49%) of the respondents expressed that the instructions they received after the declaration of the state of emergency were related to teleworking, followed by instructions and protocols to prevent risks (18%);
- **Changing working conditions:** only 40% of the social workers responding to the survey indicated that they were provided with adequate and sufficient health protection measures. In the majority of the cases, PPE were either not provided or those that were provided were scarce. With regard to telework, only 41% of the people surveyed indicated that they were provided with the technological resources to be able to work from home compared to almost 40% who were not provided with the necessary resources. Regarding the need for training and knowledge for the development of telework, 63% considered that they had sufficient training and knowledge to participate in these developments;
- **Stress and coping with uncertainty:** in spite of elementary PPE being scarce and the situation of uncertainty, 70% of the surveyed workers stated that they had not needed emotional support during the pandemic, while 16% would have appreciated some emotional support and another 17% were not sure.

The issues in the field of social support services to persons with disabilities highlighted by the CGT survey were also central to the expert interviews conducted for this study:

21 In Spanish: „Consejo General del Trabajo Social".

- **Safety of the workers:** during the peak of the pandemic in March and April 2020, workers providing social support services workers were lacking PPE to protect themselves from contagion, resorting to using bleach and garbage bags in some instances. The support from other networks, associations and centres in obtaining PPE was key in the beginning. There were also private donors that became aware of the situation through the social media, resulting in neighbours and associations donating cloth face masks and the meat industry providing overalls and aprons. The support from the public authorities arrived one month later than the civil response. Moreover, PCR tests were not available to social workers like they were to the health professionals;
- **Replacement of staff:** the lack of human resources was one of the most important issues during the first wave. Many workers got sick, others were in quarantine, and, with the schools closed, some had to ask for a leave to take care of their own children or dependents. Work shifts were established, but workers were working overtime and there was need for more staff. Furthermore, workers could not be easily replaced in case of leave;
- **Training:** even though some employers were delivering training and emergency protocols to their workers, in general they were overwhelmed by the urgencies and immediate actions that were required. At the peak of the pandemic, the employers relied on informal training (e.g. by nurses and doctors who were friends) to deliver some short byte-sized training modules to the workers, so that at least they had the basic medical knowledge and knew how to safely put on and take off the PPE, check for COVID-19 symptoms or ease the pain of those who got sick, etc. After the peak of the pandemic, in many cases, the risk prevention companies subcontracted by the employers started delivering training to prevent the specific risks brought on by the COVID-19;
- **Psychological support:** some employers offered psychological support to their workers because they thought that their employers were suffering from stress and fear. However, as revealed by the CGT survey and by some interviewed experts, the workers did not make as much use of this service as was expected. In one case, for example, the employers tried therapeutic groups instead to make it less formal. In this group, the workers received training and techniques for personal growth.

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COUNTRY REPORT

Germany

Organisation of Social Support Service Provision for Persons with Disabilities

For a long time, social support services for persons with disabilities were provided in highly specialised social support structures: in big residential or day-care centres, special-needs schools or sheltered workshops. Valentin Aichele (2019) points out fundamental tension inherent in this system, which on the one hand was trying to offer persons a safe space for persons in need of support and help, but at the other hand was causing their structural isolation from the society. With the introduction of the Social Code[22] IX in 2001 (Rehabilitation and Inclusion of Persons with Disabilities), a first important step was made towards establishing the issue of inclusion in different policy fields and giving persons with disabilities a more active role in making decisions about their life. This change of course was further reinforced by the adoption of the UN Convention on the Rights of Persons with Disabilities in 2009. The most recent milestone for holistic, person-centred service provision was the Federal Participation Law[23] of 2016, designed to take effect in four stages (in 2017, 2018, 2020 and 2023).[24]

In Germany, the provision of care is organised by a range of Social Codes I-XII. The Social Code I defines the fundamental rules for social security in Germany, stipulating the principles of social rights, social services and social security institutions. The entitlement to care provision is regulated by the other Social Codes. For persons with disabilities, specifically the Social Code IX, Social Code XI (Social Care Insurance) and Social Code XII (Social Allowances) apply (Trechert 2018). The Social Code III (Employment Promotion Act) as well as the Social Code IV (Act on Vocational and Social Rehabilitation and Employment of Persons with Disabilities) regulate the employment and vocational training of persons with disabilities (EASPD 2018).

As a result, the different services and the way that they work together constitute a complex structure, which is further complicated by the involvement of various authorities and institutions in the funding, administration and provision of services. Consequently, De Henau and Himmelweit (2020) characterise the German care system as a rather "complex mix of social assistance and social insurance provision". In addition, in the German federal system the regulation of some services can differ from one federal state to another.

Social support services for persons with disabilities cover very different stages of life and are provided at different sites, ranging from early childhood interventions to accommodation in care homes. Since 1 January 2008, §29 of the Social Code IX legally entitles persons with disabilities to a personal budget, which they can send according to their needs and preferences. As a result, recipients can choose to receive a cash benefit from the service providers instead of services or benefits in kind. From this, they pay the expenses necessary to cover their personal assistance needs. A distinction is made between the simple personal budget, where only one service provider is responsible, and the so-called cross-provider personal budget, where several service providers offer different participation and rehabilitation services in one budget. This freedom of choice intends to promote the self-determination and independence of people with disabilities.

Depending on the nature of the service, further costs are covered by long-term care insurance, health insurance or social welfare provided by municipalities. In most cases, they are provided by independent social welfare organisations, such as Caritas, Diakonisches Werk or German Red Cross (EASPD 2018). Especially the field of elderly care is an important business field for private providers, both in stationary and ambulant care services. However, Hendrik Trescher (2018) points out that the Social Codes do not always provide an unequivocal basis

22 In German: "Sozialgesetzbuch".

23 In German: "Bundesteilhabegesetz".

24 https://umsetzungsbegleitung-bthg.de/gesetz/reformstufen/ (last accessed on 6 February 2021).

of decision-making: for example, it has to be considered whether a particular service has a stronger care or social inclusion component. This makes the German care system comprehensive, but difficult to navigate.

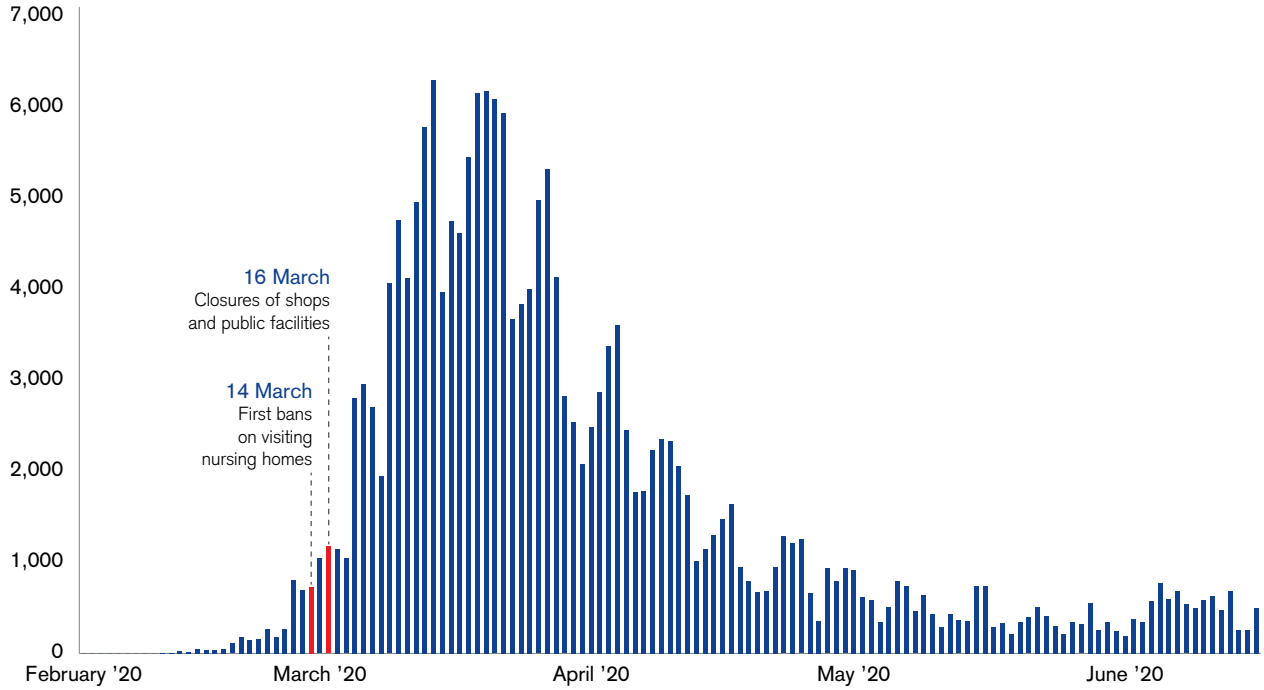
In 2017, 10.2 million people with an officially recognised disability were living in private households in Germany (Statistisches Bundesamt 2020a). The majority of them (around 7.5 million people in 2017), had a severe disability (a disability level of over 50%), while 2.8 million people had with a minor disability (a disability level up to 50) (Ibid.). The more recent numbers show that the number of persons with a severe disability was 7,902,960 persons as of 31 December 2019 (Statistisches Bundesamt 2020b), accounting for 9.5% of the total population in Germany (Statistisches Bundesamt 2020c). Disability is particularly prevalent among older people: in 2017, 75% of persons with disabilities were aged 55 years or older. The corresponding proportion of this age group among persons with no disabilities was only 32% (Statistisches Bundesamt 2020a).

The very general outline of the social care system for persons with disabilities in Germany will serve as a point of reference when studying the effects of the COVID-19 pandemic on social support services. The analysis is based on statements by interest representations, commenting on the effect of laws and regulations issued as a reaction to the COVID-19 pandemic, point out the shortcomings of these arrangements or refer to the experiences of their member organisations. In addition, interviews were conducted with three providers of care and assistance services, an interest representation for sheltered workshops at national level and a professional body representing the care workers in the field of disability services. Finally, the main sources for statistical data were the Business Register and the Federal Employment Agency[25].

Government Measures for Coping with the COVID-19 Pandemic

The first COVID-19 case in Germany was diagnosed on 28 January 2020 and the first wave of the pandemic peaked on 28 March 2020 with 6,028 registered infections (Figure 1). By the end of April 2020, the numbers of new infections had been considerably reduced and remained stable at a relatively low level in May and June 2020.

FIGURE 1 | Number of new COVID-19 cases (February-June 2020)



Source: Robert Koch-Institut (2020).

25 In German: "Bundesagentur für Arbeit" (BA).

The German government introduced different measures to cope with the COVID-19 pandemic in the field of health care and long-term care. Since 1968, the Emergency Law exists in Germany, which would allow the Federal Government to simplify decision-making procedures and centralise the decision-making powers both horizontally and vertically (Thielbörger and Böhlert 2020). However, the law has been contested ever since its enactment and has never been applied (Ibid.). Also during the COVID-19 crisis, the authorities decided base their decisions on the Infection Protection Act, a federal statute entitling the authorities to adopt measures for preventing and controlling infectious diseases in their line of competence. The measures were specified by administrative acts, such as executive regulations by the health ministries of the federal states within their line responsibility. Furthermore, the authorities could issue general administrative acts (Klafki and Kießling 2020).

On 23 March 2020, the Federal Government approved the key points for two draft laws (Bundesministerium für Gesundheit 2020a):

- **Draft Law on Compensation of Financial Burdens Caused by COVID-19 on Hospitals and Further Health Care Facilities (COVID-19 Hospital Relief Law):**[26] besides regulating the operating of hospitals during the COVID-19 pandemic, several issues concerning residential and mobile care were raised. The Medical Service of Health Insurances (MDK)[27] were to temporarily suspend their quality checks of care providers in order to release the pressure on the staff and reduce the risk of infection in care homes. Furthermore, the procedures of establishing care needs (regular assessments of care needs and visits at care recipient's homes) were temporarily interrupted. The long-term care insurance would recompense care homes if they incurred additional expenses associated with changes in care provision (e.g. on personal protective equipment, PPE) or for their loss of income due to the COVID-19 pandemic. Furthermore, it stipulated that in home-based care it was possible to diverge from the regulatory and contractual framework for service provision concerning the nature of services and the qualification requirements towards the personnel. This would allow for additional flexibility during the crisis, prevent a supply gap in service provision and help to retain the existing care structures also for the future;
- **Draft Law on Protection of the Population in an Epidemiological Situation of National Scope:**[28] in order to be able to react better to the challenges posed by the COVID-19 pandemic, the Federal Government was to acquire additional competences. It entailed the right to issue restrictions on national and international mobility, but also measures for ensuring the basic provision of medicines, PPE and availability of diagnostics. It further stated that the regulations in health and residential care organisations can be treated flexibly in line with the current needs. Moreover, it addressed the care needs of parents, who had to take care of their children if schools or kindergartens had been closed.

The temporary care needs resulting from closures of different day-care facilities (e.g. kindergartens, schools, day-care centres or sheltered workshops) were further addressed in § 56 of the Law on Prevention and Controlling of Infectious Diseases in Humans (Infection Protection Law, IfSG)[29]. If the authorities had ordered the facilities to close due to the quarantine regulations, § 56 of the Infection Protection Law granted parents, who had to take on the care for their children, income compensation. It amounted to 67% of their monthly net income (maximum 2,016 Euros for a full month) for up to ten weeks for each parent (20 for single parents) (BMAS 2020a) This applied in the case of children to 12 years, but for parents of persons with disabilities there was no age limit. The regulation was first valid until the end of 2020 and was extended until the end of March 2021.

On 27 March 2020, the Law on the Deployment of Facilities and Social Services for Controlling the Coronavirus SARS-CoV2 Crisis in Connection with a Service Guarantee (the Social Service Provider Deployment Law, Sod-EG)[30]. The law stated that social support services

26 In German: "Gesetzentwurf zum Ausgleich COVID-19 bedingter finanzieller Belastungen der Krankenhäuser und weiterer Gesundheitseinrichtungen" (COVID-19-Krankenhausentlastungsgesetz)".

27 In German: "Medizinischer Dienst der Krankenkassen" (MDK).

28 In German: "Gesetzentwurf zum Schutz der Bevölkerung bei einer epidemischen Lage von nationaler Tragweite".

29 In German: "Gesetz zur Verhütung und Bekämpfung von Infektionskrankheiten beim Menschen (Infektionsschutzgesetz, IfSG)".

30 In German: "Gesetz über den Einsatz der Einrichtungen und sozialen Dienste zur Bekämpfung der Coronavirus SARS-CoV-2 Krise in Verbindung mit einem Sicherstellungsauftrag (Sod-EG)".

and facilities were expected to actively contribute to the controlling of the COVID-19 pandemic, while they would be provided the necessary basic funding to do so. As a starting point, the legislation had recognised that a large share of social service providers were ill-equipped for coping with the pandemic: social welfare organisations generally depend on public contracts, but so far the law did not allow to remunerate services that had not been provided. As non-profit organisations, they had not been allowed to build up reserves and were not allowed to take out loans. The Social Service Deployment Law sought to provide a basis for continuing the payments by the funding agencies (e.g. health insurances, long-term care insurance), independently of whether the service had been provided or not. This "service guarantee" was to take place through monthly payments by the funding agencies to social service providers, covering maximum 75% of the average payments within the last 12 months. The funding authorities or the federal states were free to increase the percentage as they considered appropriate. In return, the service providers were expected to declare that they had attempted to convert their services to an alternative format, making use of the resources available to them (e.g. staff, rooms or equipment). The services were expected to be still related to care, but could also be provided in the field of social support (e.g. help with shopping or visits at the doctor's). Through reacting flexibly to the care needs created by the COVID-19 pandemic, they were expected to help to mitigate its effects on those with care needs (BMAS 2020b).

Other attempts were made to stabilise the system of care provision. For example, care recipients in Germany are entitled to 125 Euros that should support them with using care services. Under normal circumstances, this money can be spent on pre-defined services provided by mobile care services or support services certified by the federal state. Care recipients in Care Band 1 (lowest care level) were allowed use this amount until end of December 2020 also for other support, if the regularly services were not available. These alternative services could be either other professional services or neighbourly help. Moreover, if these support payments had not been spent for year 2019, they could –as an exception – be spent until the end of 2020 (MDS 2020). In addition, if private companies were regularly providing personal and household services to the recipients of the 125 Euro care allowance, they could claim its remuneration from the care insurance.

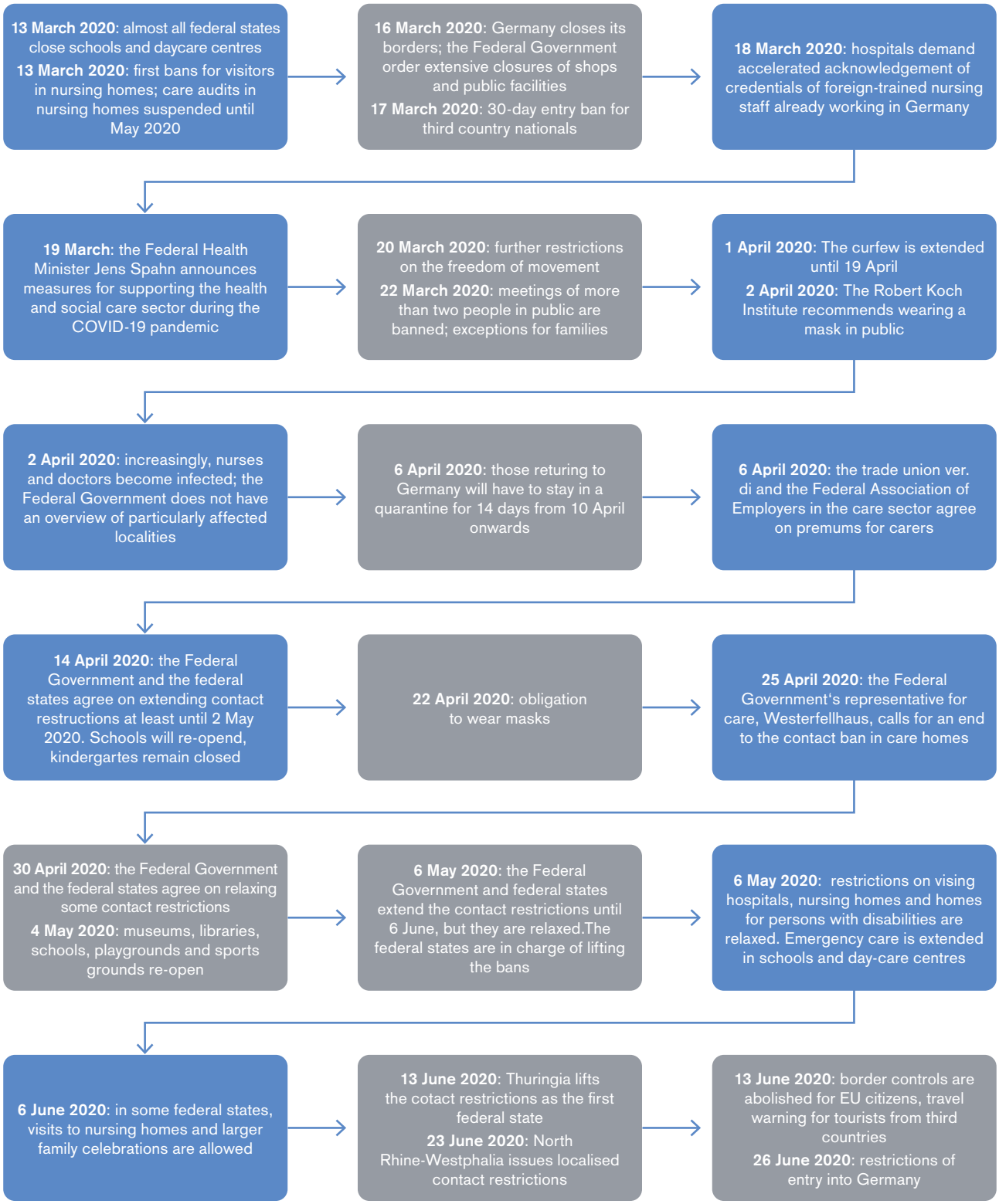
Besides the measures directed towards service providers, the Federal Government sought to provide stability also for the workforce. The situation of the workforce in health and social care was characterised by a work overload for some and reduced work opportunities due to the closure of some facilities. On the one hand, 12-hour working days in care were made possible by adjusting the labour code (COVID-19 Working Time Act – COVID-19-ArbZV) starting from 10 April 2020 and tentatively lasting until 31 June 2020 (Häusliche Pflege 2020). Among other things, it was possible to extend the maximum working hours to 12 hours per day; in urgent cases extend the working hours beyond 60 hours per week and shorten the resting time to nine hours. On the other hand, access to the compensation of reduced working hours[31] was opened up to a larger group of employees. If more than 10% of the employees of a company had to work reduced hours, they were entitled to being recompensed for the missing hours (in the first three months 60%/67% for employee who has children of the missing net income; in the fourth until sixth month 70%/77% and from seventh month onwards 80%/87%). It was allowed to earn additional income with other jobs (e.g. through a minijob, which constitutes a special form of employment not subject to social security contributions up to 450 Euros) as long as the remuneration does not exceed the previous net income from the main job (BMAS 2020c).

In addition to the regulations at federal state level, the federal states were using their leeway to issue measures for acquiring and retaining the health and social care workforce. For example, starting from 1 April 2020, the Bavarian Minister for Health and Care and the Bavarian Minister of Finance decided to subsidise the meals for the health and social care staff (i.e. hospitals and care homes) with €6.50 per member of staff per day (Lorenz-Dant 2020).

Furthermore, the Federal Government granted care workers providing services according to the §72 of Social Code XI (elderly care) for at least three months between 1 March and 31 October 2020 an additional payment of maximal 1,000 Euros. It could be supplemented by payments at federal state level and remained exempt of taxes and social security contributions up to a limit of 1,500 Euros. The exact amount depended on the qualification level and the number of hours worked per month (Bundesministerium für Gesundheit 2020b).

31 In German: "Kurzarbeit".

FIGURE 2 | Overview of the measures introduced by German authorities during the first wave of the COVID-19 pandemic



* The blue boxes contain information directly related to healthcare as well as services for the elderly and persons with disabilities; the grey boxes display general measures and developments.

Sources: Mitteldeutscher Rundfunk 2020; Norddeutscher Rundfunk 2020.

The very structured approach emerging from the legislation and regulation in different fields concerning the provision of social support services is contradicted by the findings of the desk research and expert interviews in several aspects. When asked how the pandemic affected their organisation, the interviewees opened their narration with a description of how they were overwhelmed by information provided by different actors in the field (e.g. governments at federal and federal state level, administrative districts, ministries, the funding organisations of social support services, interest representations). Information offers were often flanked by recommendations and requirements, pointing out the need for quick implementation of hygiene concepts, for example. Information provided by the Robert Koch Institute (RKI) was recommended by the interest representations for managing contact persons as well as management of COVID-19 cases (FMB 2020a). Consequently, even though the individual facilities had not yet experienced a COVID-19 case on their premises, they felt the urgency to act in order to prove that they were trying to protect the clients and personnel. As a result, the clients, their relatives as well as the employees considered the protective measures disproportionate. It rose concerns that infection protection was overruling the principles otherwise guiding the provision of social support services (see Section 3.2).

The main financial guarantees issued by the German Government largely addressed the needs of the hospitals (see the COVID-19 Hospital Relief Law) and nursing homes (mainly with elderly clients using services regulated by the Social Code XI). To a large extent, they did not include the various forms of service provision for persons with disabilities, which are regulated and remunerated according to the Social Codes V and IX. This concerned, for example, early interventions, social-paediatric centres, medical/social-psychiatric centres for grown-up persons with disabilities/mental illnesses, social-psychiatric services, day care centres, social therapy (FMB 2020b). In the case of early life care the guarantee was extended to these services and the continued financing through the health care insurances during the COVID-19 pandemic was secured (Ibid.).

Following the quarantine rules and measures for preventing infections, facilities were mainly closed down in the field of rehabilitation or day care, such as sheltered workshops and day care centres. As the number of patients at social-paediatric centres and medical centres for persons with intellectual or multiple disabilities was reduced and a range of services could not be provided, they could also not be invoiced for. While in some cases alternative services could be provided, in many cases health insurances did not accept the alternative forms of providing medical-therapeutic services (digital or over the phone) in the field of interdisciplinary early intervention and stopped their financing (Ibid.). The press releases of service providers' representations pointed out that the providers needed reliable framework conditions from those bodies financing their activities so that they could offer care services to persons with disabilities (FMB 2020c).

In face of the closures and missing measures for remunerating services that had not been provided, interest representations were concerned with retaining the structures of inclusion services in order to satisfy the medical, vocational and social rehabilitation needs of persons with disabilities (FMB 2020b). By drawing attention to the vulnerability of the service provision, they addressed the mid- and long-term effects of closures on the Residential care and Social work sectors.

Moreover, the responses that the federal states devised to the COVID-19 pandemic differed (for example, see Lorenz-Dant 2020: 10f. for federal state-specific list of regulations and recommendations concerning the new or returning residents to care homes). This made it difficult to keep track of the responses and assess the effects of different decisions. To overcome this, expert interviews were carried out in four different federal states (Bavaria, Hesse, Lower Saxony and Rhineland-Palatinate). However, the analysis of the interviews does not make a claim at completeness or even covering the range of possible responses by the authorities, funding agencies and service providers.

Effects of the COVID-19 Pandemic on the Provision of Social Support Services for Persons with Disabilities

A mixed methods approach was adopted to assess the effects of the above-described measures, which were taken during the first phase of the COVID-19 pandemic, on the provision of social support services for persons with disabilities. It included a desk research, collecting and analysing statistical data as well as expert interviews. The desk research focused on gathering information on the legal and regulatory framework for providing social support services and relied on press releases by the federal ministries. To appraise the effects of the measures on service providers, service quality and the workforce, press releases, statements and strategy papers by different

interest representations were analysed. This information was complemented by six expert interviews, which were carried out with three providers of social support services for persons with disabilities in different forms of service (care home/sheltered workshop, personal and household services as well as personal assistance) and three interest representations (employers' representation, sheltered workshops' association and association of professionals in the field of disability services). In addition, statistical data was collected from different sources: Statistisches Bundesamt (Federal Statistical Office) (Business Register data) and Bundesagentur für Arbeit (Federal Employment Agency) (data on employment, unemployment, reduced hours work and vacancies). However, there were limitations to statistical data: enterprise statistics, for example, become available with a delay of over a year. Therefore, to assess the effects of the COVID-19 pandemic of service providers business registrations and closures in the first half of 2020 were analysed. Furthermore, the international classification NACE[32] was used, allowing to differentiate between Health care activities (NACE Q86), Residential care activities (NACE Q87) and Social service activities without accommodation (NACE Q88). However, these categorisations remain very broad and services provided to persons with disabilities constitute only a minor part in them (see the Section "Overview of the Research Results"). Therefore, wherever possible, further differentiation was undertaken. This was possible in the case of statistical data concerning the workforce, where the German Occupational Classification (KldB)[33] allowed for differentiations such as number of unemployed persons in the field of Curative Care and Special Education (KldB 8313). No statistical data was available on the scope and quality of social support services provided for persons with disabilities. Therefore, this section relies mainly on the statements by interest representations and expert interviews. Finally, wherever possible, statistical data are presented in comparison the figures of 2019 to detect any effects of seasonality.

Service Providers

At the start of the COVID-19 pandemic, availability of PPE and requirements towards hygiene concepts were of primary importance for continuing or transforming the existing services and devising new ones. This was particularly relevant in communal forms of living. Even though the interview partners reported that in care homes generic emergency scenarios for a pandemic and basic PPE supplies existed, still considerable efforts needed to be made for adjusting the plans to the specific situation and acquiring sufficient amounts of PPE. It was frequently stressed that the provision of protective equipment by the federal states or municipalities was not sufficient. As a result, the facilities had to produce their own masks or import them directly from China (BeB 2020). However, the excessive use of PPE was not reflected in the funding settlements that the providers had with the funding agencies such as health or long-term care insurances. While a new regulation was issued to cover the additional PPE-related costs involved in the provision health-related care services, social care services (e.g. personal assistance) were not included in this during the first wave of the COVID-19 pandemic. One interview partner described how they depended on private donations or volunteers sowing the masks.

The prevention and quarantine measures that were gradually set up required not only more financial resources for PPE, but also for staff. For example, persons staying in their living groups needed more intensive care during the crisis and not all facilities could redirect their staff from the sheltered workshops into communal facilities. In that situation, extra staff needed to be hired (Ibid.). However, just like in the case of PPE, additional costs for staff had not been taken into account in the remuneration agreements with the funding agencies.

Moreover, as many services for persons with disabilities are financed through the Social Code V (e.g. outpatient and mobile rehabilitation, functional training and social therapy, sport), there was no remuneration guarantee for services that did not take place. Consequently, providers of ergotherapy or physiotherapy experienced cancelling of services and considerable financial losses (FMB 2020a). Therefore the interest representations pointed out the need to retain service provision in the existing infrastructure, request full remuneration of services if they were provided in an alternative form (e.g. digital meetings, phone calls) (FMB 2020b). However, if no direct alternative to services requiring could be provided, e.g. in social therapy, they still demanded a compensation (Ibid.).

32 Nomenclature des Activités Économiques dans la Communauté Européenne (NACE) (Eurostat 2008).

33 In German: „Klassifikation der Berufe" (KldB).

All interview partners stressed that in their experience exceptions to the initially very strict rules for continuing the service provision without endangering its funding were possible. However, the time spent of communicating both with the customers as well as the funding agencies increased considerably. In some cases, the interview partners reported that exceptional regulations were issued by the authorities enabling the continuation of services, like in the case of integration helpers for schoolchildren. Even though their activities are tied to a specific location (i.e. the school) and only services provided there are generally considered eligible, during the pandemic exceptions were allowed, such as visits at home or over the phone. Of course, exceptions were not available in all cases and some service providers and workers experienced a significant reduction of their revenues and income. This was frequently the case of day care centres (even though some of them retained a small group for emergency care) and rehabilitation facilities.

Sometimes the services were cancelled by the customers, which again raised fundamental issues of service provision. An interview partner illustrated this with a case where a customer had decided to move to their parents for the duration of the first wave COVID-19, making the provision of personal assistance services impossible. In this case, the services that were not provided could not be invoiced to the funding agency, but the 24/7 team still had to be paid according to their contract. The funding agency agreed to remunerate the provider for 4-6 weeks to uphold the existing framework of service provision (i.e. the specialised team, which, once split, would take two to three months to reassemble and make fully functional). However, they stated that if the services were not made use of beyond that period of time, the funds would be curtailed, since the customer had demonstrated that other means of support were available to them.

In the field of personal and household services (PHS), if a company was registered as providing low-level care services, they would continue receiving 125 Euros from the long-term care insurance even if the services were stopped. In the assessment of the interviewed expert, the Federal Government's decision to remunerate to the PHS providers also the services that were cancelled or provided in a different for, aimed at ensuring the continuity of the care support structure. According to this particular service provider, the guaranteed funding for the usual level of services helped them to survive in a situation where a large share of the clients had cancelled their PHS services.

Also sheltered workshops were affected by the COVID-19 pandemic during its first phase. In Germany, sheltered workshops enable over 310,000 persons with disabilities to participate in work life. They are involved in production or offer laundry services for hotels, hospitals or care homes. However, as persons with disabilities can display immune deficiencies or previous illnesses, they were defined as a risk group and the authorities issued "restraining orders"[34] for the sheltered workshops (BAG WfbM 2020). Nevertheless, the facilities tried to keep up the production processes and at the same time substitute the day structures that working in the sheltered workshop would have offered. To that end, staff from the sheltered workshops was deployed in the communal living facilities (Ibid.). The interview partners described how this helped them to retain the staff and maintain the level of services, so that they did not have to apply for payments from the reduced hours work scheme. Moreover, approximately 30,000 persons receive vocational training in sheltered workshops, which is funded by the Federal Employment Agency. As long as the trainings were continued, even though in a different form, the funding was upheld. As a result, the trainers were trying to retain the training through video conferences, phone calls, emails or work in communal living groups (BAG WfbM 2020).

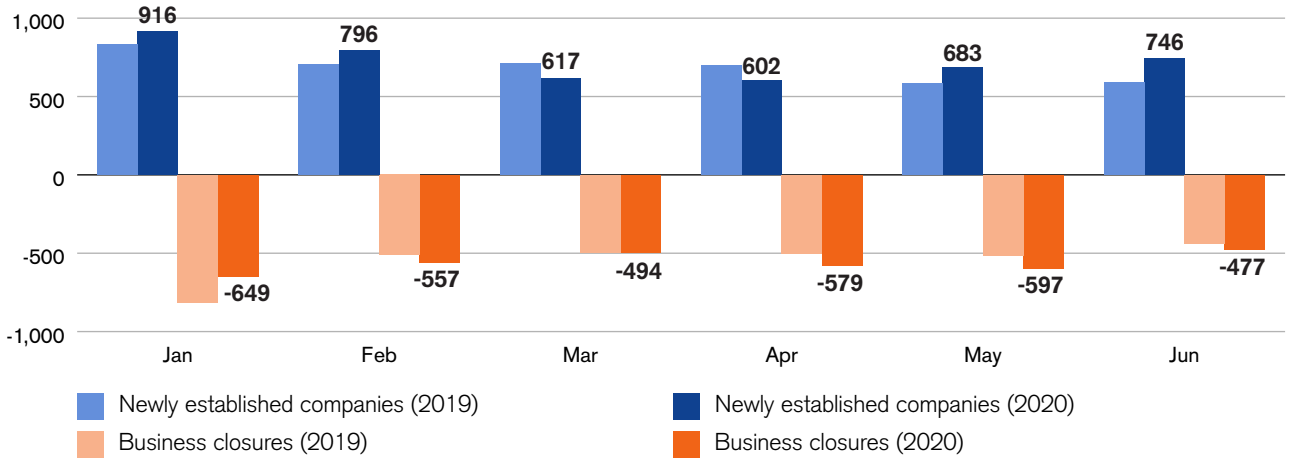
The interviewed experts pointed out that the government support programmes developed to mitigate the effects of the COVID-19 crisis were not suitable for the social support services sector. In the experience of the interview partners it was therefore crucial that the funding authorities sent a message to the service providers early in the crisis, signalling that they would continue the funding of their activities.

While it is not possible to put a number to the loss of revenues of service providers, the effects of the COVID-19 pandemic can be analysed in terms of business registration activity. The statistical data how that the COVID-19 crisis had a visible impact on the sector in the first half of 2020: since February, more businesses were closed compared to the previous year. Moreover, in March and April 2020 there were also fewer business registrations. In January and February 2020, the number of newly established companies in the Human health and social work activities (NACE Q) was higher than during the same period in 2019. However, the number of registrations dropped between February and March 2020 as the first restrictions were introduced (Figure 3). In the same period, there was also an increase in the number of business closures compared to 2019. The number of

34 In German: "Betretungsverbote".

registrations deteriorated even further between March and April 2020, only to increase again in May and June 2020 when the temporary restrictions on the economy were eased off.

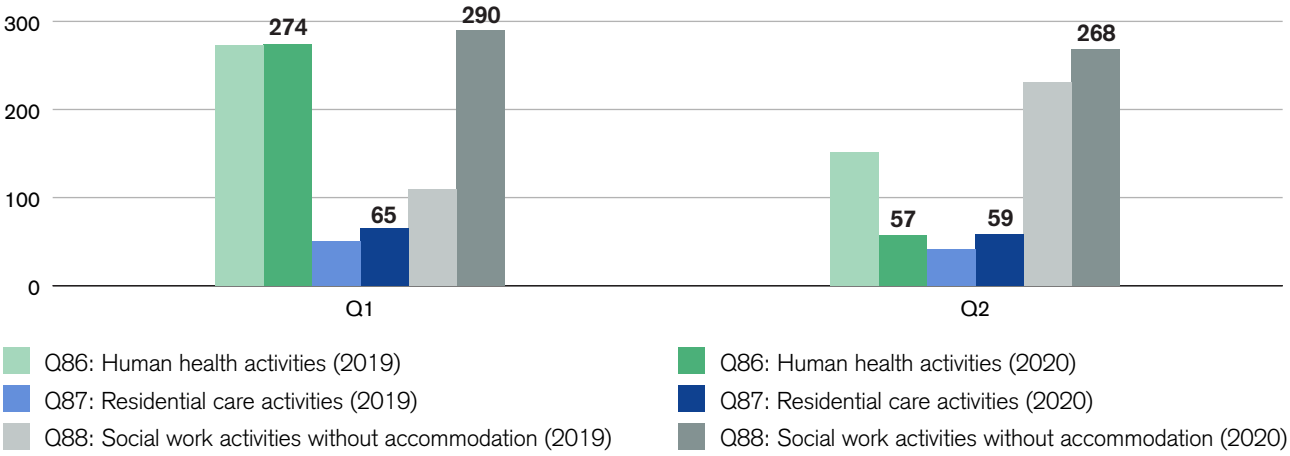
FIGURE 3 | Newly established businesses vs. business closures in Human health and social work activities (NACE Q), January-June 2019 and January-June 2020



Source: own illustration based on Statistisches Bundesamt (2020d).

When grouping together the business registrations and closures in quarters, it is possible to further differentiate between the Social work activities without accommodation (NACE Q88) and the Health care activities (NACE Q86). Figure 4 demonstrates that in the first quarter of 2020 the number of net business formations was considerably higher than during the same period in 2019, especially in the area of Social work activities without accommodation (NACE Q88). In the second quarter of 2020, however, the number of net business formations fell sharply – both in comparison with the first quarter of the same year and with the same quarter of the previous year. This occurred mainly due to the developments in the Human health (NACE Q86), while in the field of Residential care activities (Q87) and Social work activities without accommodation (NACE Q88) the changes compared by the first quarter of 2020 and second quarter of 2019 were considerably less pronounced. Overall, net business formations remain positive, even if the growth rate of the sector slowed down as a result of the COVID-19 pandemic in the first half of 2020.

FIGURE 4 | Net business registrations in Human health and social work activities (NACE Q), Q1-Q2 2019 and Q1-Q2 2020



* Net business formations correspond to newly established companies minus business closures.

Source: own illustration based on Statistisches Bundesamt (2020d).

Scope and Quality of Services

The brief overview of the experiences of service providers and their interest representations at the beginning of the previous section demonstrated that the operating of social service providers was disturbed during the first phase of the COVID-19 pandemic, making changes in service provision (e.g. in terms of the location and form of services) necessary. As the provision of services is a complex interplay of different providers in terms of legal forms and specialisations, whose operating is regulated in different Social Codes and remunerated by different funding agencies, this threw up many fundamental questions. For example, on several occasions expert interviews showed that the providers tried to apply the same kind of legal concepts that had been guiding their operations so far to the new circumstances of service provision, such as assessing the new situations in terms of risk assessment, workplace safety and occupational safety. Based on this assessment, they tried to develop different scenarios or guidelines for their customers and staff. The interview partner at the social assistance service reported that they consulted a specialised lawyer when they were not sure of the possible legal consequences of their decisions (e.g. having the hypothetical right to refuse to provide services to a customer who had contracted COVID-19). Situations such as accepting that an employee decided not to work during the COVID-19 pandemic and asked for unpaid leave were often framed in terms of principles of service provision: in this particular case as a dilemma between the duty to provide a service and the employees' right of self-determination.

Many facilities were offering emergency consultations and care programmes, exploring different ways to provide alternative services (FMB 2020b). The interviewed experts gave examples of services that were moved from the usual location to a private home or care home. In the case of persons with disabilities working with sheltered workshops, there were accounts of some production activities transferred to the care home; alternative offers involved going for walks. These activities were used to structure the days of customers and stimulate them, as especially younger persons were missing the opportunities to go out and meet their friends beyond the close-knit living group that they had to stay with. Also, there were examples of considerable efforts to retain the contacts between persons in the care home and their families and the key persons that they related to in work context (e.g. through group chats, online meetings and phone calls). In some cases, the deployment of staff from sheltered workshops to care homes helped to keep up these relationships.

Furthermore, service offers were frequently transferred to other formats, as the Federal Employment Agency and German Federal Pension fund requested that the vocational education and training offers were provided in an alternative form if their funding was to continue. Therefore, the providers had to very quickly develop digital offers, which were accompanied either personally at another location (e.g. care home or private home) or remotely (per phone or online). However, not all persons in this programme had a phone or computer on which they could have followed the digitalised offers and the necessary Internet infrastructure. So far, the programmes for inclusive employment had invested into infrastructure at work and had not considered other sites for learning and work as relevant. The providers also had different capacities to digitalise their offers: while some of them had already modularised their education and training programmes, others were struggling to find the right balance between the content and form of conveying knowledge and checking how it was received. Furthermore, it needs to be taken into account that the practical part of such programmes was very difficult to cover remotely, especially if it involved operating machines or rehearsing work techniques.

Also the providers of services for persons with disabilities living in their private homes saw the need to reconsider the usual provision of services. In the case of a personal assistance, there was an example of considerations to keep up a part of the services if others had been cancelled, for example by offering a centrally organised shopping service.

The interviewed experts stated that the recommendations and guidelines issued by the Robert Koch Institute constituted an important framework for continuing providing services in care homes for the elderly and persons with disabilities. However, these guidelines were also contested, because they were used to justify quarantine measures in nursing homes (BIVA 2020). In the opinion of the BIVA Care Protection Association,[35] representing the interests of elderly, the quarantine measures were impermissible, since they did not have a legal basis. In their reading of the Infection Protection Act, quarantine measures could have only been introduced in cases of concrete suspicion and by involving the responsible heath

35 In German: "BIVA-Pflegeschutzbund".

authorities (Ibid.). Indeed, the introducing of infection protection measures in the approximately 15,380 care homes in Germany (Statistisches Bundesamt 2020e) reduced the number of quality controls, which are usually monitored by the MDK. Only if the long-term care insurances were informed of abuse or undue practices in individual facilities, occasion-related examinations were to take place. The Federal Association of Municipal Facilities for Seniors and Persons with Disabilities (BKSB)[36] welcomed the decision, as it was alleviating the workload of carers in the facilities. It has to be taken into account, though, that most of these instances would normally be reported by families who were not allowed to enter the nursing homes.

Following the closures of or entry restrictions to sheltered workshops or day care centres, the informal carers had to provide the care of persons with disabilities (FMB 2020b). While the § 56 of Infection Law offered financial compensation to parents who had to take care of their children due to closures of kindergartens and schools, the remuneration was available for the maximum of six weeks, but the restrictions of entry to sheltered workshops or day care centres lasted much longer. In the case of sheltered workshops, however, emergency care for persons with disabilities could be continued if their condition required it or their families were not able to provide the necessary care (e.g. if the parents of persons with disabilities were working in key jobs or were too old and needed support with taking care of them).

In the situation where the regular activities and social contacts of persons with disabilities had been disrupted, the interview partners indicated how surprised they had been to observe the general readiness of persons with disabilities to adapt to the new circumstances. This enabled the providers and staff to try out new things. Especially against this background, the interviewed experts considered it problematic that the authorities did not see persons with disabilities as a heterogeneous group with different kinds of needs, abilities and degrees of vulnerability. Instead of issuing guidelines for service provision, bans and restrictions were enacted. These followed the primacy of infection protection and focused on the living form (care home), rather than the persons with disabilities. Professional care workers in disability field saw that some persons with disabilities living in care homes would have been able to protect themselves and their co-inhabitants in a self-responsible manner. As one of the workers' representative put it, this led to professional care workers to reflect on the fine line between well-meant protection measures in regard to vulnerable groups and deprivation of liberty.

Apparently, in the crisis also the language used in the official communications changed, where in the case of sheltered workshops persons with disabilities were referred to as "protected/looked-after persons" rather than "employees" or an outdated term for care homes was used.[37] Therefore, several interview partners raised concerns about persons with disabilities whose needs were not addressed in a timely and appropriate manner during the COVID-19 pandemic. In addition, they were also worried that the restrictive measures taken during the health and social care crisis might again supersede the recent achievements in the fields of inclusive living and employment. The interviewed experts from interest representations reported that even though social support services were not in the focus of political actors and political/societal discourses to start with, they managed to voice the concerns of the sector in the subsequent political processes. Looking at the time ahead, their aim was to ensure that the above-mentioned fundamental issues would be discussed from different perspectives and addressed in all their complexity.

Workforce

Among the workforce, the COVID-19 pandemic and the associated measures brought about many worries and questions related to the working conditions and working times, but also to workplace safety. Some questions were hypothetical to start with (e.g. Will I have to work if my clients have a COVID-19 infection?), but the interview partners considered it important that these issues were addressed even if no definite answers existed at the time – this signalled to the staff that their concerns were taken seriously. In that respect, the workers' council acted as an intermediary between the staff and management, filtering the information from different sources and passing it on to the staff as well as bundling their questions and presenting them to the management.

Due to the closure of some care sites (e.g. day-care centres and sheltered workshops), persons with disabilities stayed predominantly in care homes or with their families. This caused staff shortages in care homes, which larger providers with different formats of activities

36 In German: "Bundesverband kommunaler Senioren- und Behinderteneinrichtungen" (BKSB).

37 In German: "Betreute" vs. "Beschäftigte" and "Wohnheime" vs. "Wohnformen".

and services could compensate for by deploying staff from day-care centres and sheltered workshops. As the staff from sheltered workshops experienced the persons they had been working in a different environment, they could develop a deeper understanding for their clients. Also the exchange between the care home staff and sheltered workshop staff was considered beneficial. At the same time, deployed staff who were not familiar with the environment of the care home and its inhabitants found it more difficult to handle the situation. As workers were expected to change their workplace or work overtime, there were demands that the care regulation should provide a reliable framework for allowing these changes in the exceptional situation (bpa 2020). In this context, also the issue of adequate qualifications for specific tasks came up and the interest representation demanded that the facilities should be to ones to assess if these shifts are appropriate (bpa 2020).

However, if re-deployment of staff was a viable strategy for large providers with several strands of services, this option was not available to smaller and more specialised providers. In these cases, they had to make use of the reduced-hours work scheme by the Federal Employment Agency, which to this point in time had been unknown to the field of social care. Against this background, one interviewed experts pointed out that at first sight large providers combining several lines of services more flexible and resilient when dealing with the measures adopted during the COVID-19 pandemic. As a result, they expected that this would add a new dimension to the discussions about the advantages and disadvantages of providing social support services in large, complex compound structures vs. small, specialised providers. However, the interviewed experts were also giving examples of larger providers offering temporary jobs to the employees of providers that had to interrupt their services. Also the associated questions regarding subcontracting of work could be clarified.

In a situation lacking clarity and bringing about shifts in care responsibilities, service providers' associations pointed out that not only were the care workers subjected to heightened health risks and work overload, but sometimes also to accusations and demands by the care recipients and their relatives (e.g. bpa 2020). Consequently, there were demands to recognise "the committed and reliable workers in the care facilities for persons as well as social psychiatry" as key workers just like the care personnel working in long-term care and health care. FMB 2020c). This would have enabled them to benefit from the same regulations as health care workers (e.g. the right to emergency child care, which was a frequently mentioned issue in the interviews; see also bpa 2020) and would also have ensured them the same kind of recognition as well as financial rewards. This concerned the COVID-19 bonus, which was differently regulated across the federal states (e.g. concerning the amount) and caused discontent among the staff who did not receive it. A representative of a service providers' association reported that there were cases where within the same organisation staff remunerated for activities on the basis of the Social Code XI (elderly care) would have received a COVID-19 bonus, while their colleagues who were employed for activities regulated by the Social Code IX were not eligible to it. Apparently, there were several providers who decided to pay both groups equally in order to ensure equality of treatment and acknowledge the work of their staff.

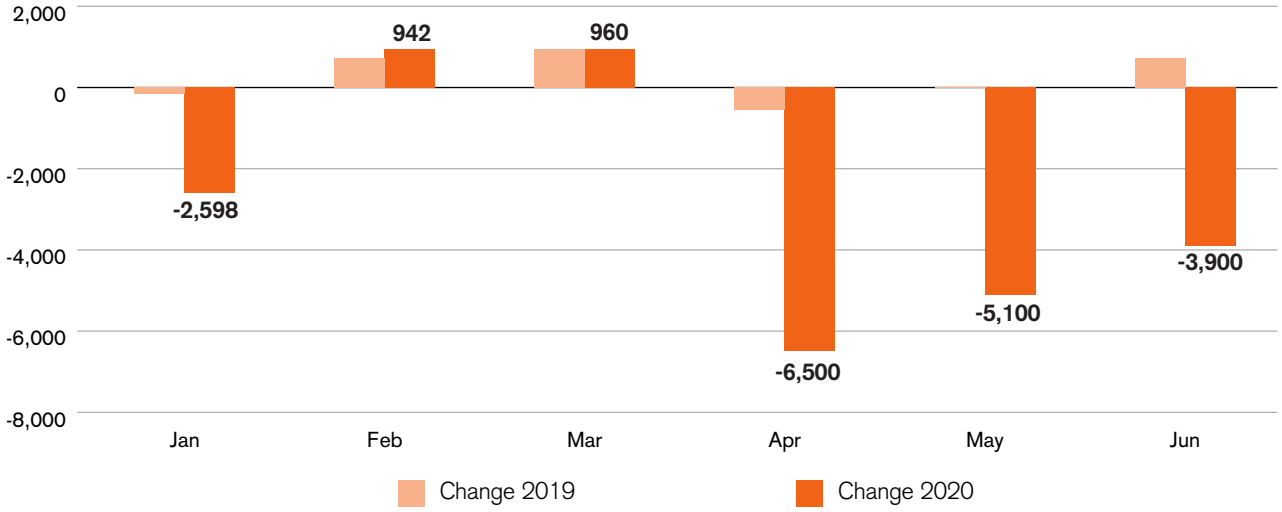
It was reported that the level of sick leaves did not increase, but that the workers has problems with finding suitable child care solutions – especially if they had been deployed and their working hours had changed. According to one interview partner, the changes in the working time were applied in coordination with workers' representation in the care home and in the end worked out more or less well in most cases.

Moreover, the interview partners voiced their concerns that the professional self-understanding of the workforce was challenged through the measures taken during the COVID-19 pandemic. While they had been trained to look for individualised solutions, the recent measures took a broad-brush approach towards persons with disabilities as well as the services that were provided to them. The interview partners considered this a drawback on the road to enhanced inclusion.

Employment: the number of employees in the Residential care and Social work activities (NACE Q87 and Q88) fluctuated strongly in the first half of 2020, especially compared to the previous year (Figure 5). In January 2020, nearly 2,600 less people were employed in these sectors than in the previous month. This change in employment, which to some extent results from seasonal effects, is considerably higher than in January 2019. Furthermore, while in the first half of 2019 the highest change in the number of those employed in the sector was 950, the decline in the number of employees at the peak of the COVID-19 crisis in April 2020 amounted to 6,500 persons. After the first measures to contain COVID-19 were introduced in mid-March 2020, there was a comparatively sharp decline in employment: in April, 6,500 fewer people were employed than in March. This corresponds to a decrease of 0.3% in the total number

of employees in the sector (about 2.45 million people in Germany). This downward trend also continued in May and June, although somewhat more moderately. There were 5,100 fewer persons employed in May and 3,900 in June 2020 than in the previous month (in both cases a decrease of 0.2%), displaying a mild recovery from the severe shock in April 2020.

FIGURE 5 | Change in number of persons employed in Residential care and Social work activities (NACE Q87 & Q88) compared to previous month, January-June 2019 and January-June 2020

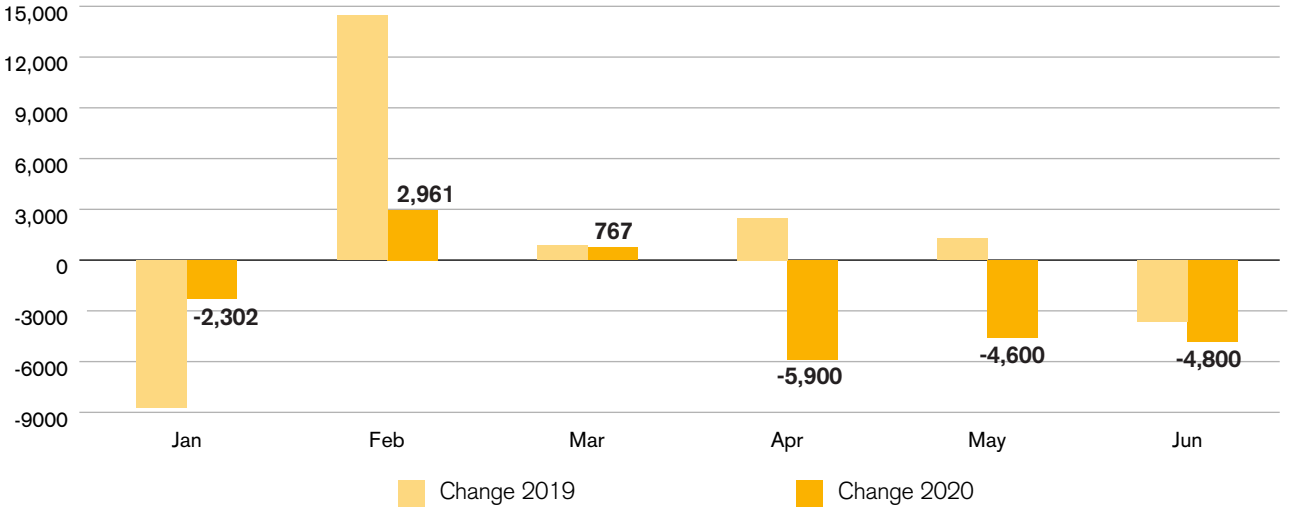


Source: own illustration based on Bundesagentur für Arbeit (2020a).

Compared to the overall development of employment in the Residential care and Social work activities (Q87 and Q88) in Germany, most of the federal states more or less reflect the national German development. However, the four federal states of Baden-Wuerttemberg, Hamburg, Saarland and Thuringia showed a slightly stronger or divergent dynamic, with Thuringia and Saarland standing out in particular. While the number of employees nationwide only fell by 0.3% in April, Thuringia was the first state to record a decline of 0.5% as early as in March. This downward trend then peaked at -0.9% in April and changed only slightly to -0.8% in May. Thus, in relative terms, Thuringia was most affected by a decrease in employment. However, this trend was stopped in June – although there was no growth, the number of employees did not change compared to the previous month. Moreover, there was also a surprising development in Saarland. While nationwide the employment figures were still on a downward trend of -0.2% in May, Saarland saw a relatively strong increase in employment numbers, in total by 1% compared to the previous month. This growth did not continue in June, but there was also no reduction in the number of employees.

In Human health (Q86), it is striking that January and February 2020 showed a much weaker dynamic concerning employment than in the previous year: while there were about 8,700 fewer employees in January 2019 than in the previous month, in February 2019 there was a sharp increase of about 14,500 employees (Figure 6). In comparison, the changes in the first two months of 2020 were rather minor. Here, too, it can be seen that after the introduction of the first COVID-19 measures in mid-March 2020, there was a relatively sharp drop in the number of employees from April onwards, just like in the area of Residential care and Social work (Q87 and Q88). The decline was highest in April with 5,900 fewer employees, which corresponds to 0.2% of the total workforce (about 2.58 million in Germany). In the following months of May and June the reduction in the number of employees continued with 4,600 (-0.2%) and 4,800 (-0.2%) less employees. Also here, the effects of the COVID-19 pandemic on employment levels were most pronounced in April 2020.

FIGURE 6 | Change in number of persons employed in Human health (NACE Q86), January-June 2019 and January-June 2020



Source: own illustration based on the Bundesagentur für Arbeit (2020a).

Concerning the development of employment in Human health (Q86) at federal state level, the developments are broadly in line with those at national level. However, there are also certain federal states in the Human health sector that are more dynamic. In Schleswig-Holstein, employment had already fallen by 0.5% in March compared to the previous month, while this negative trend did not start in the other federal states until April. In addition, the decline in Schleswig-Holstein was the largest in Germany: in April with 0.6% and in May with 1%. In June, two other federal states demonstrated a remarkable development: in Rhineland-Palatinate there was a 1.5% increase in the number of employees in June. This was a strong growth compared to the decline o 0.2% at federal level and also compared to the other federal states. In June, Mecklenburg-Vorpommern experienced the most drastic decline of 0.9% in the number of persons employed in Human health activities, with Schleswig-Holstein also recording a strong decline of 0.6% in a nationwide comparison. Overall, however, the dynamics between the federal states are less pronounced in the Human health than in Residential care and Social work activities.

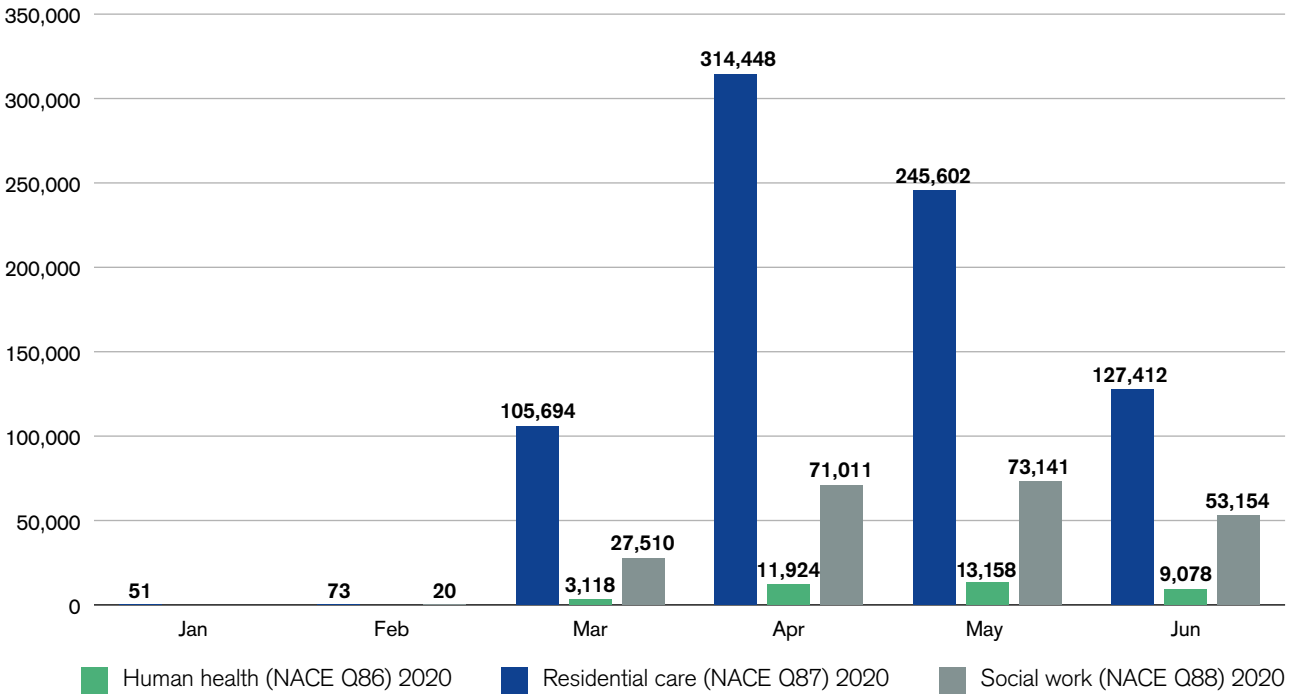
Regarding the development of employment, Human health (Q86) as well as Residential care and Social work (Q87 and Q88) developed very similarly between January and June 2020. In both sectors, the decline in the number of employed persons was most pronounced in April. However, the decline of 0.3% in Residential care and Social work was slightly greater than in Human health (-0.2%). However, the COVID-19 pandemic affected not just the level of employment in Human health and social work activities (NACE Q), but also their working hours of the employees. Short-time work was almost non-existent in these sectors before the COVID-19 pandemic as the numbers of recipients were at a low two-digit level in 2019: Human health activities (Q86) displayed most cases in November and December 2019 (55 persons receiving short-time work remuneration), Residential care (Q87) in May and June 2019 (16 persons) and Social work (Q88) in May and July 2019 (22 persons) (Federal Employment Agency 2020b). However, during the COVID-19 pandemic short-time work became an important instrument for mitigating the effects of the crisis on the health and social care sector (see the Section "Government Measures for Coping with the COVID-19 Pandemic" for an overview of the instrument). In March 2020, 62,601 facilities in Human health (Q86), 200 facilities in Residential care (NACE Q87) and 2,050 facilities in Social work (NACE Q88) registered their employees for short-time work support. Combined, this constituted 11.5% of facilities registered in Human health and social work activities (NACE Q) in 2018.[38] In April 2020, the number of facilities applying short-time work had increased considerably, comprising 62,601 facilities in Human health (Q86), 542 facilities in Residential care

38 2018 is the most recent available year for enterprise statistics at the German Federal Statistical Office (communication on 3 November 2020). Therefore, the calculated relation can only serve as a rough approximation.

(Q87) and 4,692 facilities in Social work (Q88). The share of facilities applying short-time work in the sector had thus risen to approximately 27.9%.

While in January and February 2020 no employees in Residential care (Q87) were subject to reduced working hours, in March 2020 there were 3,118 employees in this sector who were claiming government support for short-time work (Figure 7). This figure more than tripled by April 2020, increased again slightly between April and May 2020 and subsequently dropped by 31.0% in June 2020. Also in Social work activities without accommodation (Q88), the number of employees subject to reduced working hours rose from 27,510 persons in March 2020 to 71,011 persons in April 2020. The number of persons receiving a compensation for short-time work in Social work activities without accommodation (NACE Q88) dropped by 27.3% in June 2020. Similar developments took place in Human health activities (Q86), but the recovery was faster, setting in already in May 2020 and steeper (the number of persons receiving short-term work compensation was almost halved in June 2020 compared to May 2020) (Figure 7).

FIGURE 7 | Number of persons receiving a compensation from the Federal Employment Agency for reduced working hours in Human health (NACE Q86), Residential care (NACE Q87) and Social work (NACE Q88), January-April 2020

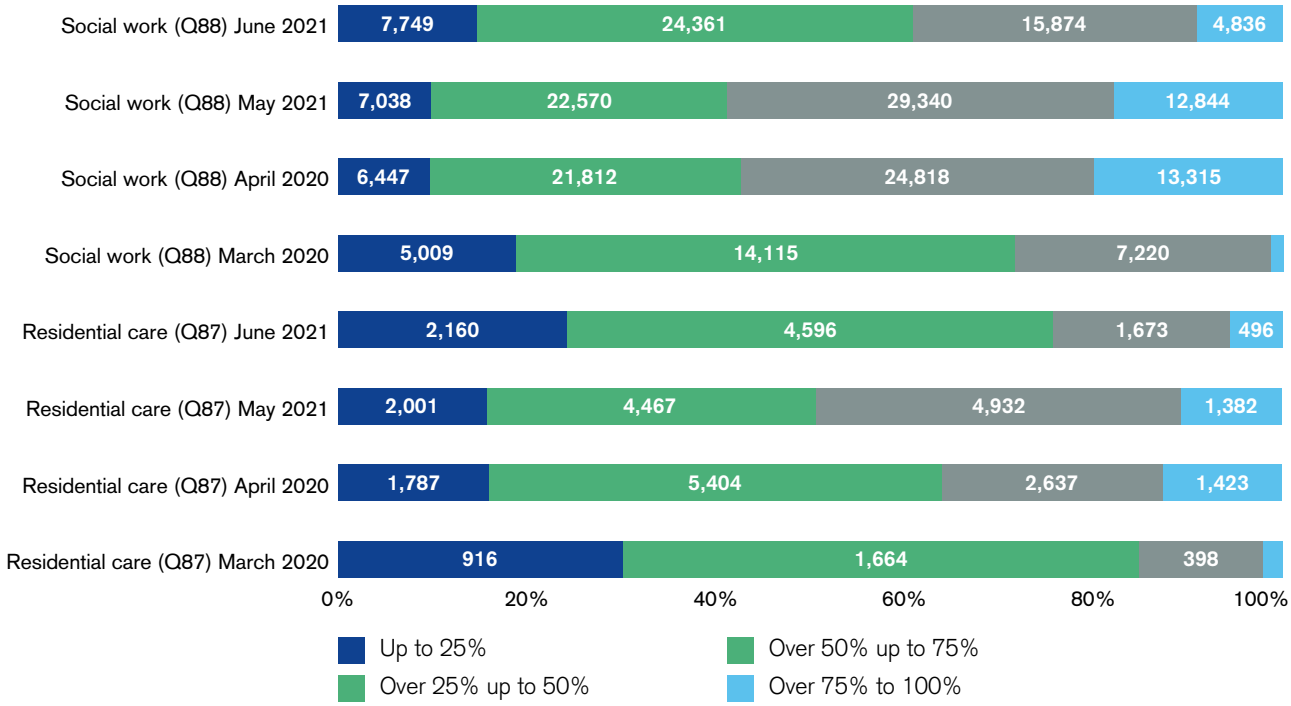


Source: own illustration based on Bundesagentur für Arbeit (2020b).

The extent to which short-time work was applied in facilities differed between March and April 2020. In March 2020, for 84.8% of persons receiving short-time remuneration in the field of Residential care (Q87) the stoppage had constituted up to 50% of their usual working time (Figure 8). By April 2020, this applied only to 63.9% of persons registered for short-time support and the share of those experiencing stoppages of 50% to 100% had increased accordingly. This trend evolved further in May 2020, when 50.6% of persons registered for short-time support experienced stoppages of up to 50% of their usual working time. In June 2020, their share had risen again to 75.7%, which indicates a slight improvement in the employment situation.

Social work without accommodation followed the same pattern (Q88): in March 2020, the majority of short time workers (71.7% of those who had been registered for government support) experienced a stoppage of up to 50% of the usual working time (Figure 8). By April 2020, this share had dropped to 42%, leaving the majority to experience stoppages above 50% of contractual working time. This trend slightly aggravated in May 2020, when 41.2% of those registered for short-time work experienced a stoppage of up to 50% of their usual working time. Also here, the situation improved in June 2020.

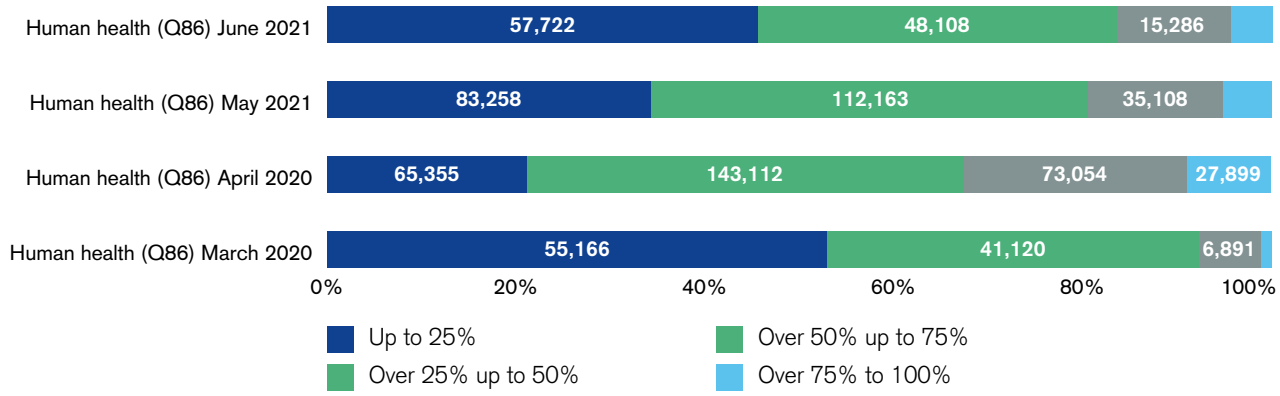
FIGURE 8 | Number of persons receiving compensation from the Federal Employment Agency for reduced working hours in Residential care (NACE Q87) and Social work (NACE Q88) by extent of stoppage, March-June 2020



Source: own illustration based on Bundesagentur für Arbeit (2020b).

Also in Human health (Q86), the scope of stoppages increased between March and April 2020, but the situation improved again somewhat in May and June 2020 (Figure 9). The majority of those who had been registered for short-time payment support were experiencing stoppages below 50% of their contractual working time (92.3% of registered persons in March 2020, 67.4% in April, 80.4% in May and 83.6% in June 2020) (Figure 9). This leaves Social work (Q88) as the sector where employees experienced the strongest curtailing of their working hours.

FIGURE 9 | Number of persons receiving compensation from the Federal Employment Agency for reduced working hours in Human Health (NACE Q86), March-June 2020



Source: own illustration based on Bundesagentur für Arbeit (2020b).

Unemployment: instead of analysing unemployment figures, we have chosen to present data on entries into unemployment and exists from unemployment due to:

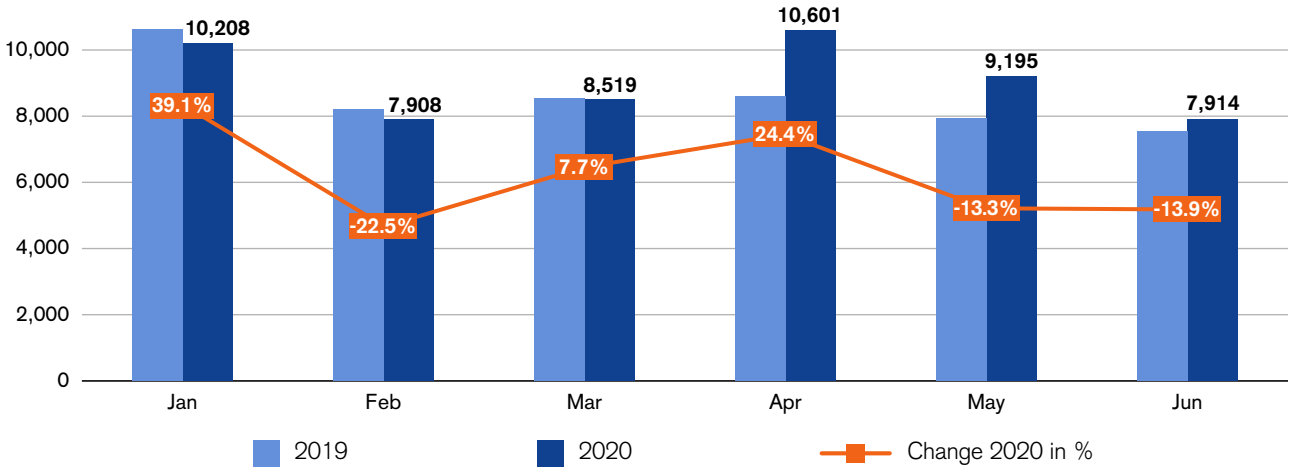
- ★ The availability of data: when the data were collected (June-September 2020), monthly statistics on unemployment were not yet available;
- ★ Explanatory power of data: there is a shortage of skilled workers in Germany, which is why the unemployment figures are not so suitable for tracking developments on the labour market.

The category "entry into unemployment" refers to persons whose labour market status changes from employment subject to social security contributions (excluding self-employed persons) to unemployment. Similarly, the category "exit from unemployment" denotes persons who were previously unemployed and took up a job subject to social security contributions (again, excluding self-employed persons).

The occupational group Curative Care and Special Education belongs to the classification system of the Federal Employment Agency and includes the following professions, among others: Curative Education Nurses; Caregivers for Persons with Disabilities; Travel Assistants for Persons with Disabilities; Special Education Teachers; Sports Teachers in Sports for Persons with Disabilities and Rehabilitation Teachers. This allows to depict what is happening on the labour market for all people who work professionally with persons with disabilities.

The high level of entry into unemployment in January 2020 displays a seasonal effect as many employment contracts expire at the end of the year. From January to March 2020, the figures in Residential care and Social work activities without accommodation (NACE Q87 & Q88) were very similar to the previous year (Figure 10). However, in April 2020 the effects of the COVID-19 pandemic had become visible in the labour market, as the number of entries into unemployment (around 10,600 persons) was much higher than in the previous year (a difference of approximately 2,000 persons). This trend continued in May and June 2020 when compared to the same time period in 2019. In relative terms, April was again the month with the most significant change, where the entries into unemployment increased by 24.4% compared to the previous month (not taking into account January 2020 due to the strong seasonal effects). In May and June 2020, entries into unemployment then fell by about 13% in both month compared to the previous month. In June 2020, entries into unemployment were comparable with previous year's figures.

FIGURE 10 | Entry into unemployment in Residential care and Social work without accommodation (NACE Q87 & Q88), January-June 2019 and January-June 2020; change compared to the previous month

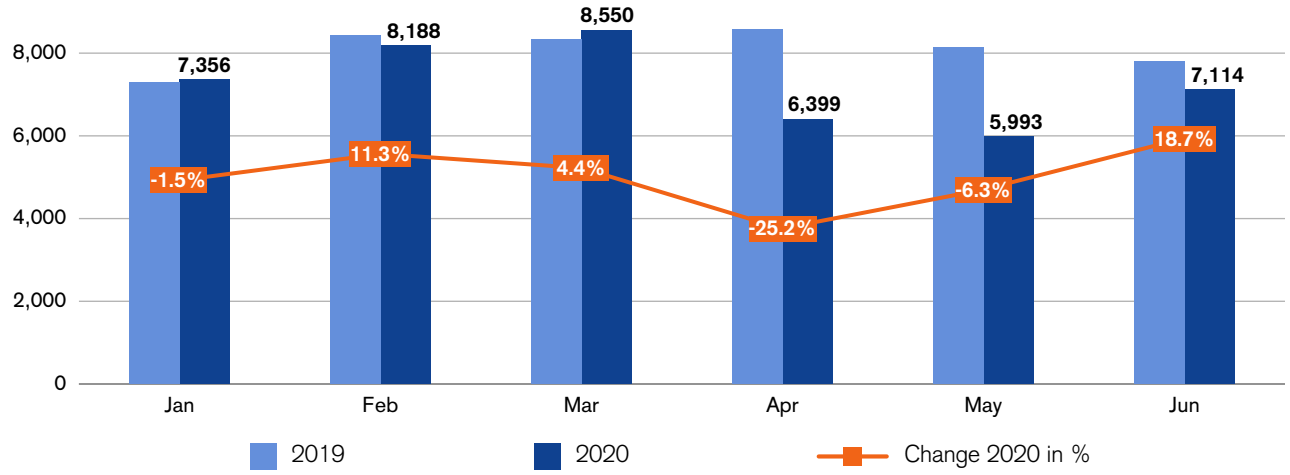


Source: own illustration based on Bundesagentur für Arbeit (2020a).

In the observed time period, the trend in the exits from unemployment in Residential care and social work without accommodation(NACE Q86 & Q87) was counter-directional to the entries into unemployment (Figure 11). While the development between January and March 2020 was relatively similar to the previous year, exits from unemployment showed a strong decline in April 2020. In absolute terms, in that month about 2,150 fewer persons managed to leave unemployment. Compared to March 2020, this is a decrease of 25.2%. Also in May 2020, significantly fewer people managed to leave unemployment compared to the previous year. In June

2020, however, entries from unemployment approached the level of the previous year and were a first sign of a relative recovery. A look at the relative changes makes this clear: the number of exits in June 2020 was 18.7% higher compared to May 2020. Nevertheless, exits from unemployment have not yet reached last year's levels for the same time period.

FIGURE 11 | Exit from unemployment in Residential care and Social work without accommodation (NACE Q87 & Q88), January-June 2019 and January-June 2020; change compared to the previous month

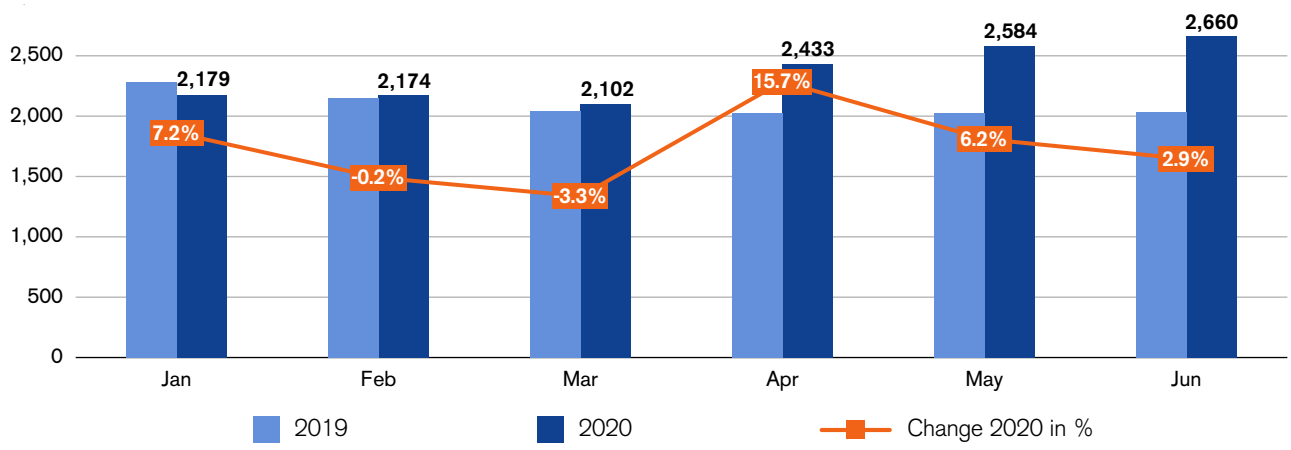


Source: own illustration based on Bundesagentur für Arbeit (2020a).

Comparing the entries into unemployment with the exits, it can be seen that in February and March 2020 there was still a net exit from unemployment: overall, more people left unemployment than registered unemployed in the two months. In April 2020, the trend was reversed when about 4,200 more persons entered unemployment than left. This development also continued in May and June 2020, albeit at a slower pace. In May 2020, net entries into unemployment were 3,200 and in June 2020 800 persons.

Between January and March 2019 and 2020, unemployment was similarly high in occupations in Curative Care and Special Education (KldB 8313). In April 2020, the number of unemployed persons rose by 15.7% compared to March 2020. Also in May and June 2020, unemployment remained high compared to 2019, rising by 6.2% in May 2020 and 2.9% in June 2020. This means that after a considerable increase in the numbers of unemployed persons in this occupational group the recovery was delayed in the subsequent months (Figure 12).

FIGURE 12 | Unemployed persons in Curative Care and Special Education (KldB 8313), January 2019-June 2019 and January 2020-June 2020, change compared to the previous month

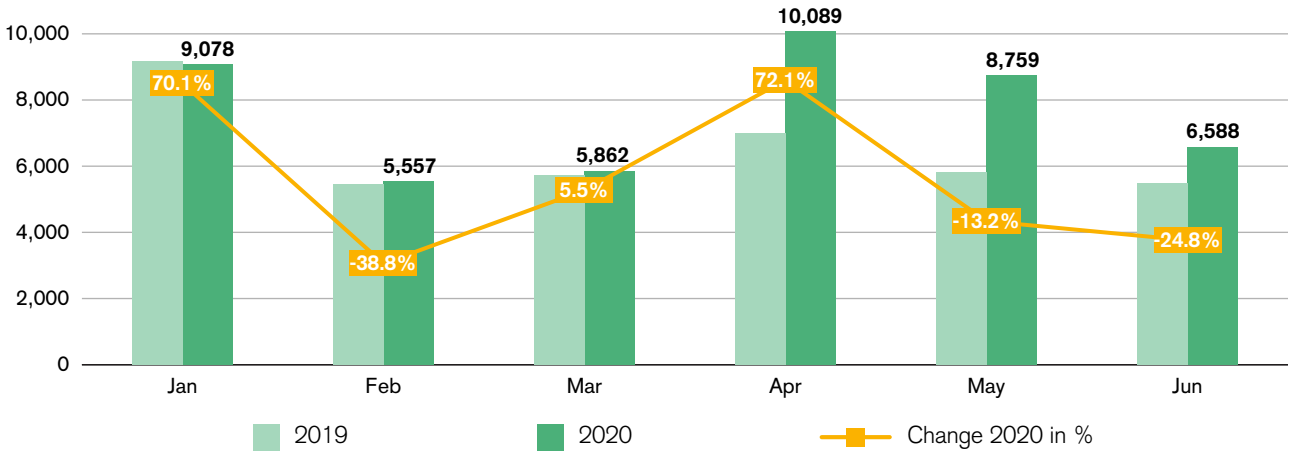


Source: own illustration based on Bundesagentur für Arbeit (2020c).

Regarding the monthly changes in unemployment figures in the occupational group, developments in two federal states stand out in particular: Bremen and Thuringia. In March 2020, Bremen was the first federal state to record a dramatic increase in the number of unemployed persons: it was 23.8% higher than in the previous month. In all other federal states, this development took place in April. At the same time, with -21.4% Thuringia was the federal state experiencing the highest fall in unemployment in March 2020. In April 2020, however, unemployment figures in Thuringia rose by 38.6%, constituting the highest increase among the federal states. Thuringia thus shows both the most dynamic development and the most dramatic increase in unemployment figures in this occupational group.

Between January and March, the number of persons who entered unemployment were very similar in 2019 and 2020 (Figure 13). In April 2020, at the height of the COVID-19 crisis, there was a drastic increase in entries into unemployment: while in March 2020 5,862 persons entered unemployment, the figure was as high as 10,089 persons in April 2020, constituting an increase of 72.1%. Even in May and June 2020, the number of entries into unemployment was still very much higher than the year before. Compared to April 2020, however, the number of persons entering unemployment fell again in May and June 2020; in May 2020 the number of entries into unemployment fell by 12.2% and in June 2020 by 24.8% compared to the previous month.

FIGURE 13 | Entry into unemployment in Human health (NACE Q86), January-June 2019 and January-June 2020; change compared to the previous month

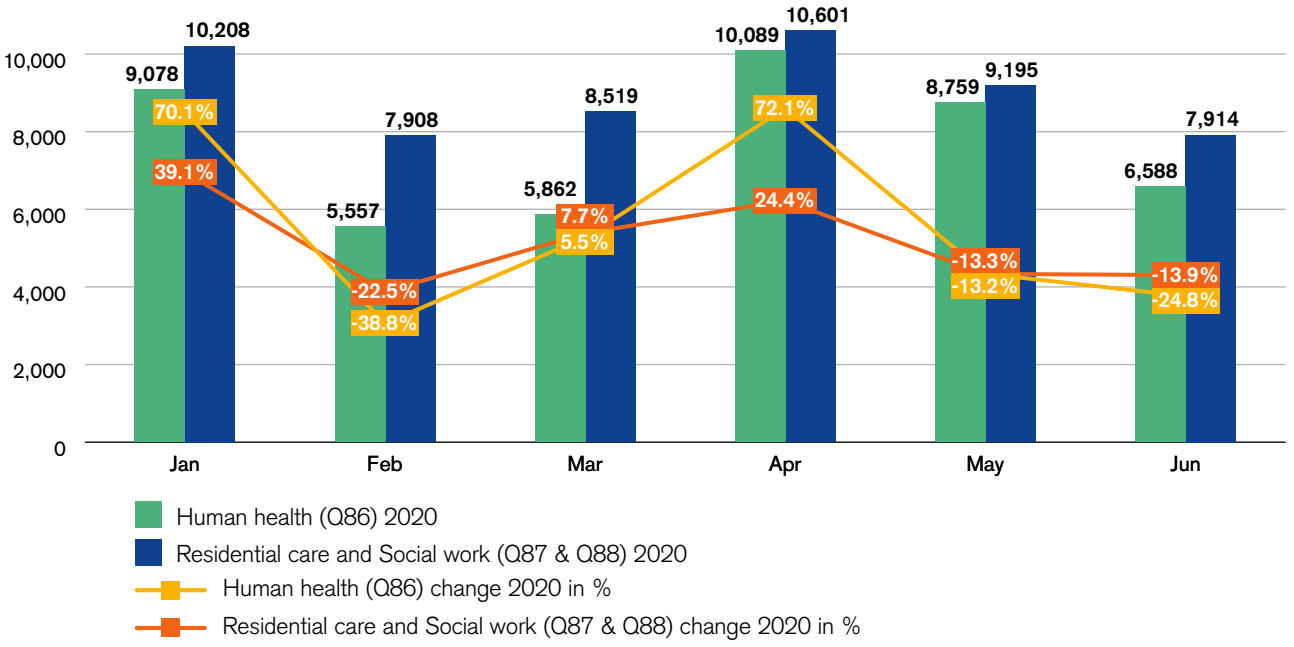


Source: own illustration based on Bundesagentur für Arbeit (2020a).

When comparing the situation in Human health activities (NACE Q 86) with those in the field of Residential care and Social work (NACE Q87 & Q88) for the period January to June 2020, the relative developments are particularly relevant – this is the only way to compare the two sectors due to the differences in the absolute numbers of employees.[39] In both sectors there was a fall in entries into unemployment in February 2020, with a more pronounced fall in Human health activities (-38.8% compared to the previous month) (Figure 14). In March 2020, both sectors display an almost identical slight increase in entries into unemployment. April 2020 then showed very clear differences: while the number of entries into unemployment rose sharply in both sectors, the trend in Human health was particularly dramatic as 72.1% more persons entered unemployment than in the previous month. For a short period of time in May 2020, the trend in the two sectors was similar, with a decrease of around 13% in both. In June 2020, however, the two sectors diverged again somewhat, with Human health activities showing a more positive trend by displaying 24.8% fewer entries into unemployment.

39 When considering changes in the entry into unemployment, January is excluded due to seasonal effects.

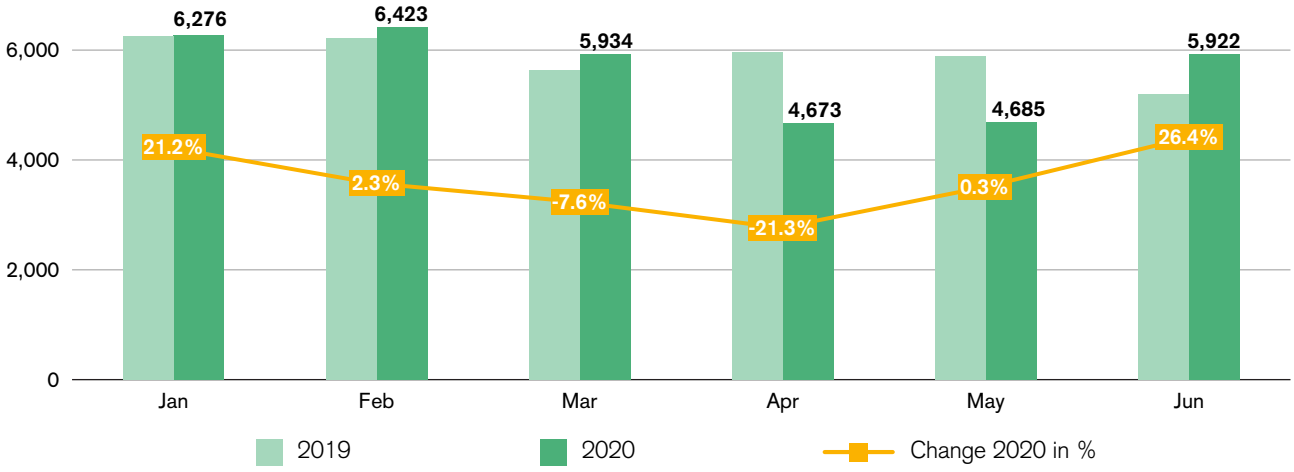
FIGURE 14 | Entry into unemployment in Human health and social work activities (NACE Q), January 2020 to June 2020; change compared to the previous month



Source: own illustration based on Bundesagentur für Arbeit (2020a).

In February and March 2020, the number of exits from unemployment in Human health (NACE Q86) was slightly higher than in 2019 (Figure 15). In April 2020 the number of exits from unemployment dropped, both compared to the previous year and to the first three months of 2020. However, the negative trend already started in March 2020 with 7.6% fewer exits than in the month before. In April, exits from unemployment reached a low of 4,673 persons, corresponding to 21.3% less persons than in the previous month. A similarly low number of persons came out of unemployment in May. It was not until June that the trend here also reversed: Compared to the previous month, the number of exits increased by 26.4% and, at around 5,900, even reached a higher level than in the previous year.

FIGURE 15 | Exit from unemployment in Human health (NACE Q86), January-June 2019 and January-June 2020, change compared to the previous month

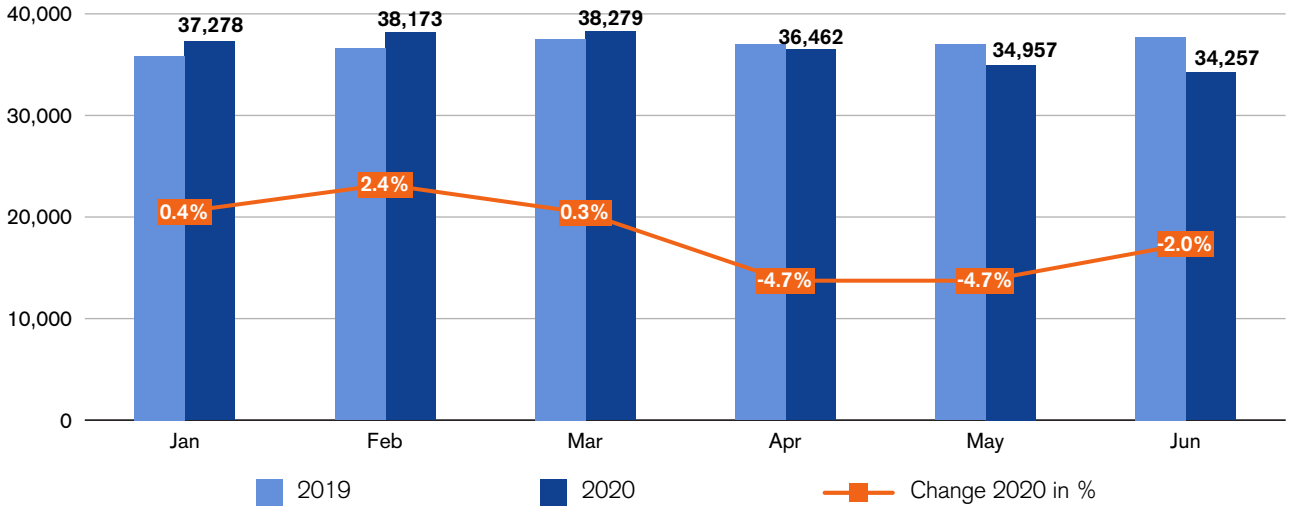


Source: own illustration based on Bundesagentur für Arbeit (2020a).

Looking at net entries, i.e. entries into unemployment minus exits, the picture is clearer: in February and March 2020, more people left unemployment than entered it. This means that there were more hires in the health care system. In April 2020, however, there is a sharp rise in net entries into unemployment: after subtracting the exits from unemployment, about 5,400 persons in Human Health entered unemployment. This figure remained high in May 2020 with about 4,000 net entries into unemployment. Only in June 2020, with around 650 net new entrants into unemployment, a noticeable fall in the figures took place.

Vacancies: in the field of Residential care and Social work (NACE Q87 & Q88), slightly more vacancies were reported in the first three months of 2020 than in the previous year (Figure 16). In April 2020, this development reversed: in total about 1,800 fewer vacancies were reported than in March 2020, constituting a decrease of 4.7%. Also in May 2020, about 1,500 fewer vacancies were registered than in the previous month. In June 2020, this trend weakened, but remained negative. Also in June 2020, 700 fewer job vacancies were reported than in May 2020, representing a decrease of 2%. Even though the decline in the number of vacancies slowly weakened in May and June 2020, it had not reached the level of the previous year by end of June 2020.

FIGURE 16 | Vacancies in Residential care and Social work without accommodation (NACE Q87 & Q88), January-June 2019 and January-June 2020; change compared to the previous month

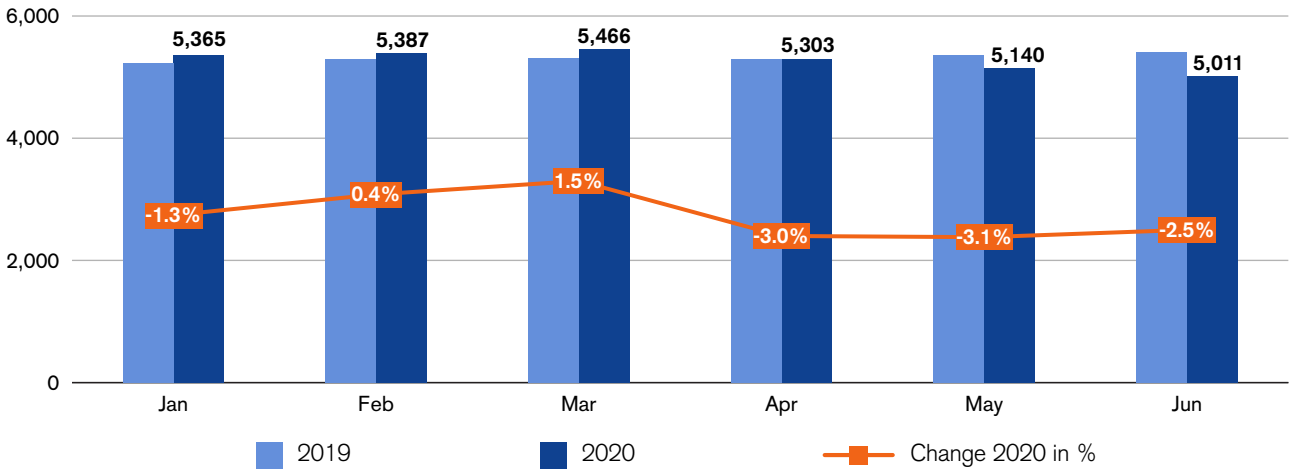


Source: own illustration based on Bundesagentur für Arbeit (2020d).

When focusing on the Residential care activities for the elderly and persons with disabilities[40] (NACE Q873), we observe a small increase in the number of vacancies in February and March 2020, before the number decreases slightly in April 2020 (Figure 17). Interestingly, the decline in April 2020 is less pronounced than in the sector as a whole (Figure 16). The number of vacancies in April 2020 is by about 160 less than in March 2020, roughly at the same level as the year before, representing a decrease of 3%. In May and June 2020, the number of job vacancies also continues to fall and remains below the level of 2019. The developments are therefore only slightly less dynamic than in the sector as a whole.

40 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled".

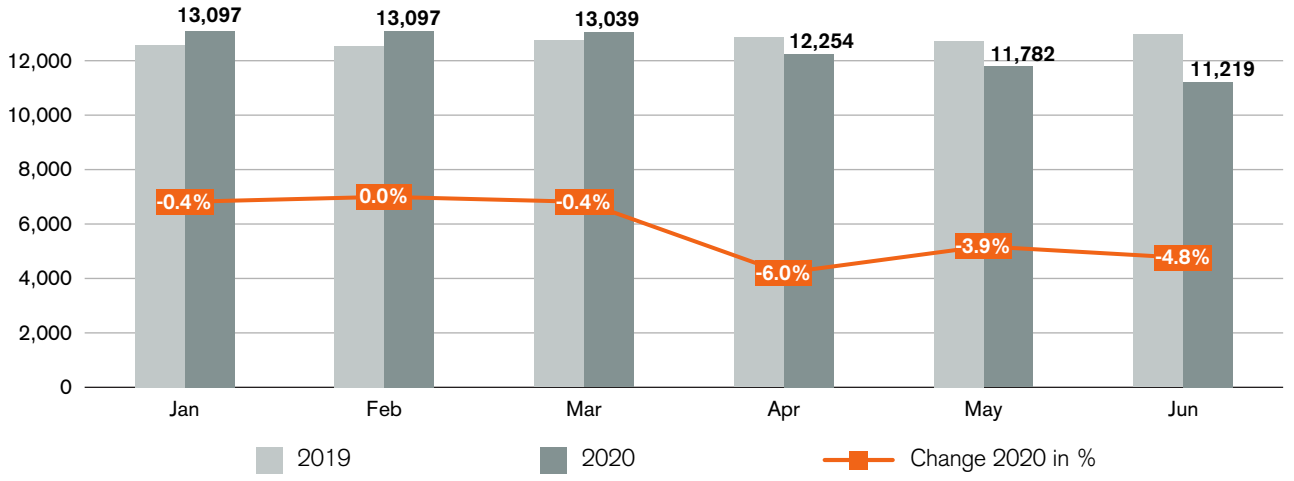
FIGURE 17 | Vacancies in Residential care activities for the elderly and persons with disabilities[41] (NACE Q873), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Bundesagentur für Arbeit (2020d).

Similarly, the field of Social work activities for the elderly and persons with disabilities[42] (NACE Q881) displays a comparatively strong decline in job vacancies in April 2020 (Figure 18). In total, 785 fewer job vacancies were registered in April than in March 2020 – a decrease of 6%. Furthermore, there were 472 fewer vacancies in May than in April 2020 (-3.9%) and 563 fewer in June than in May 2020 (-4.8%). When expressed in absolute figures, about 13,000 vacancies were registered at the beginning of 2020, by June 2020 only about 11,200 vacancies were available. Thus, the decline was much stronger in the area of Social work activities for the elderly and persons with disabilities than in Residential care activities for the elderly and persons with disabilities. It seems that while nursing homes continued to report vacancies, either the personnel needs of mobile disability assistance and similar outpatient services had decreased or the providers did not have the capacity for carrying out recruitment.

FIGURE 18 | Vacancies in Social work activities for the elderly and persons with disabilities[43] (NACE Q881), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Bundesagentur für Arbeit (2020d).

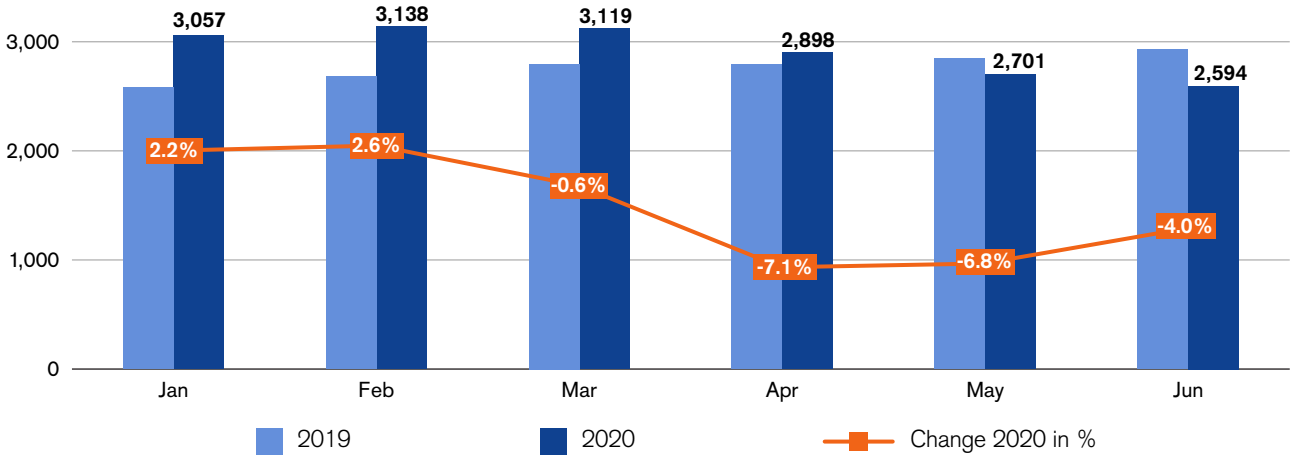
41 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled".

42 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled".

43 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled".

The number of vacancies in the occupational group Curative Care and Special Education (KldB 8313) developed dynamically: in the first three months of 2020 it was much higher than during the same time period in 2019, with an increase of 2.6% between January and February 2020 (Figure 19). In March 2020 there were hardly any changes compared to the previous month, but in April 2020 the number of vacancies in the occupational group shrank by 221, accounting for a decrease of 7.1%. The number of vacancies also fell in May and June 2020, but the decline was slightly less dramatic. However, by end of June 2020 number of job vacancies had not yet reached the level of the previous year during the same time period.

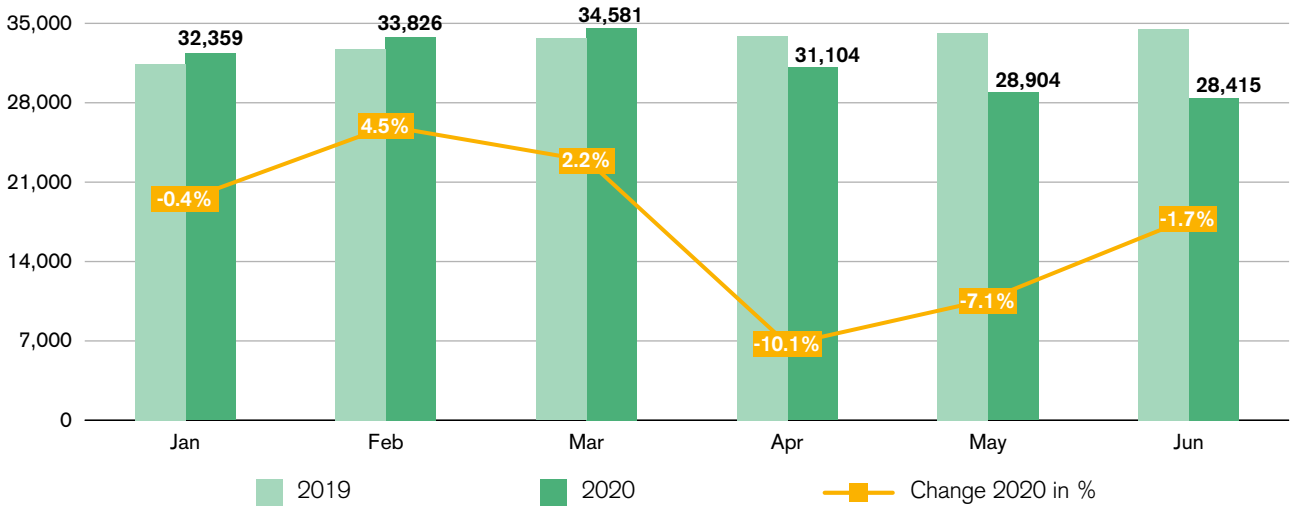
FIGURE 19 | Vacancies in Curative Care and Special Education (KldB 8313), January 2019-June 2019 and January 2020-June 2020; change compared to the previous month



Source: own illustration based on Bundesagentur für Arbeit (2020c).

In Human health (NACE Q86), the number of vacancies during the first three months in 2020 was roughly the same as in the previous year (Figure 20). In April 2020, there was a sharp drop as about 3,500 fewer jobs were reported than in March 2020, representing a decrease of -10.1%. At around 31,100, the number of vacancies in April 2020 was also below the previous year's level. The negative trend continued in May and June 2020: about 2,200 (-7.1%) fewer vacancies than in the previous month were reported in May; this figure was about 500 (-1.7%) in June. By June 2020, the total number of job vacancies had fallen to around 28,400.

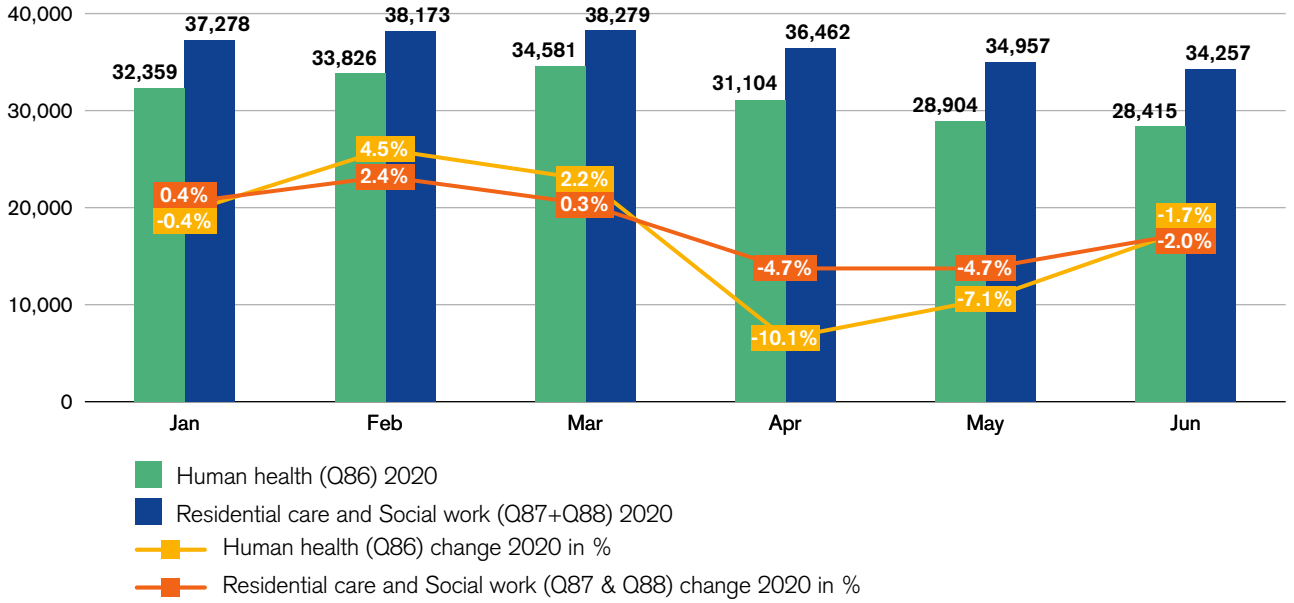
FIGURE 20 | Vacancies in Human health (NACE Q86), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on Bundesagentur für Arbeit (2020a).

Considering relative changes in the number of job vacancies enables us to compare the developments in Human health as well Residential care and Social work activities, which differ greatly in their size (Figure 21). It is noticeable that the decline in job vacancies in April 2020 was much stronger in the Human health sector (-10.1%) than in Residential care and Social work activities (-4.7%). By June, however, the developments had levelled off.

FIGURE 21 | Vacancies in Human health and social work activities (NACE Q), January 2020 to June 2020; change compared to the previous month



Source: own illustration based on Bundesagentur für Arbeit (2020a).

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COUNTRY REPORT

Romania

Organisation of Social Support Service Provision for Persons with Disabilities

In Romania, social services are regulated by Law No. 292 on Social Assistance (Romanian Parliament 2011). Furthermore, social services for persons with disabilities are regulated by the Law No. 448 on the Protection and Promotion of the Rights of Persons with Disabilities (Romanian Parliament 2006). In 2015, the Government of Romania launched a National Strategy in the disability field for the period of 2016-2020 (Romanian Government 2015a). In Romania, social care services are provided for the elderly, persons with disabilities, children with special needs, persons with a chronic disease and victims of domestic violence. They are classified as (EASPD 2018):

- **Primary social care services**: aim to prevent or limit difficult or vulnerable situations that can lead to marginalisation and social exclusion;
- **Specialised social care services**: seek to maintain, restore or develop individual capacities to overcome a social need;
- **Socio-medical care services**: include basic or support services, health care and recovery services.

The Ministry of Labour and Social Protection with the institutions under the authority of the ministry[44] elaborate the public policies, programmes and strategies in the field of social care services, coordinate and control their implementation as well as evaluate and monitor the quality of social services. Both public and private providers of social care services exist, including services for persons with disabilities. Public social services are provided by the local authorities through the county directorates and local offices of Social Assistance and Child Protection (DGASPC). The providers of public services are funded from local budgets, but in case of insufficient funds, transfers from the state budget can be made. The private providers are not-for-profit non-governmental organisations, religious denominations recognised by law, for-profit enterprises or registered self-employed persons. The private social care services are financed from their own resources (e.g. charging fees or receiving support from donors), but also from the state budget (e.g. subsidy or national interest programmes in the case of NGOs) or local budgets (e.g. the same subsidy programmes or externalisations of public services).

In order to provide social services in Romania, the providers of social services, irrespective of their legal form, must be accredited under the law. The accreditation certificate is granted for an indefinite period, but the quality standards are attested by an operating license. The latter is valid for a period of five years, of which the operating licence is considered provisional for the first year. There are about 70 types of social support services in Romania (Romanian Government 2015b): about 15 of these are services providing social assistance for persons with disabilities, within residential centres, day care centres or at home, both for children and adults. The social support services for persons with disabilities are:

- **Residential centres for adults with disabilities**: care and assistance centres, recovery and rehabilitation centres, occupational therapy centres for social integration, training centres on independent living, community services and training centres, crisis/respite centres, protected housing;
- **Residential centres for children with disabilities included in the special protection system**: e.g. placement centres, family-type homes, apartments;
- **Home care services for persons with disabilities**: personal home care services (provided by caregivers), specialised home care services (including a mobile team) and home care services provided by personal assistants;

44 National Authority for the Rights of Persons with Disabilities, Children and Adoptions (ANDPDCA), National Agency for Social Provision (ANPIS), National Agency for Equal Opportunities (ANES).

★ **Community services for adults with disabilities**: community services provided by professional personal assistants as well as support and assistance centres;

★ **Day centres for adults with disabilities**: day centres, ambulatory neuromotor recovery centres;

★ **Day centres for children**: recovery centres for children in families, separated children or children at risk of separation from their parents.

As of 31 March 2020, 4,352 licensed social services were registered. Out of these, 2,429 (55.8%) were public and 1,923 (44.2%) private services (Ministry of Labour and Social Protection 2020a). Services for persons with disabilities were provided in 500 public centres (444 residential centres, and 56 day-care centres) (ANDPDCA 2020a) and in 254 private centres (110 residential and 144 day-care centres).[45] At the same date, there were also registered 278 public residential centres and 14 private residential centres for children with disabilities (ANDPDCA 2020b).

In March 2020, 852,565 people with an officially recognised disability were living in Romania, of which 53.1% were women. The share of persons with disabilities among Romania's population was 3.8%. Among the persons with disabilities, there were 784,118 adults and 68,447 children (ANDPDCA 2020a). Most persons with disabilities are 50 years of age and older (66.9%); among them, people aged 65 years or older represent 42.8% (Figure 1).

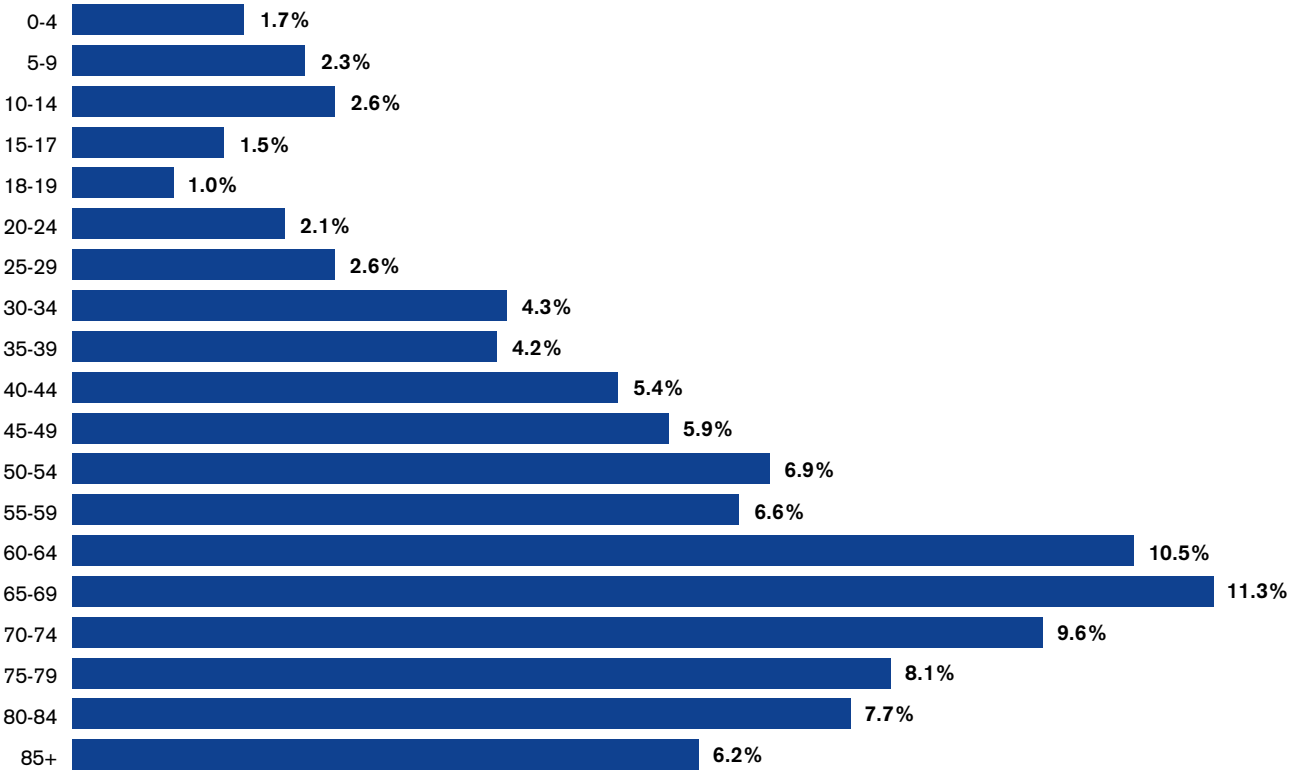


FIGURE 1 | Distribution of persons with disabilities by age group (in %, 2020)

Source: own illustration based on ANDPDCA (2020).

According to National Authority for the Rights of Persons with Disabilities, Children and Adoptions (ANDPDCA 2020a), the majority of persons with disabilities (97.9%, 835,069 people) lived with their families or are independent. About 2.0% of the overall population with disabilities (17,496 people) are adults living in institutions for persons with disabilities (ANDPDCA 2020a). Additionally, there are 4,366 children (0.5% of the overall population with disabilities) living in residential institutions or in placements (with professional maternal assistants

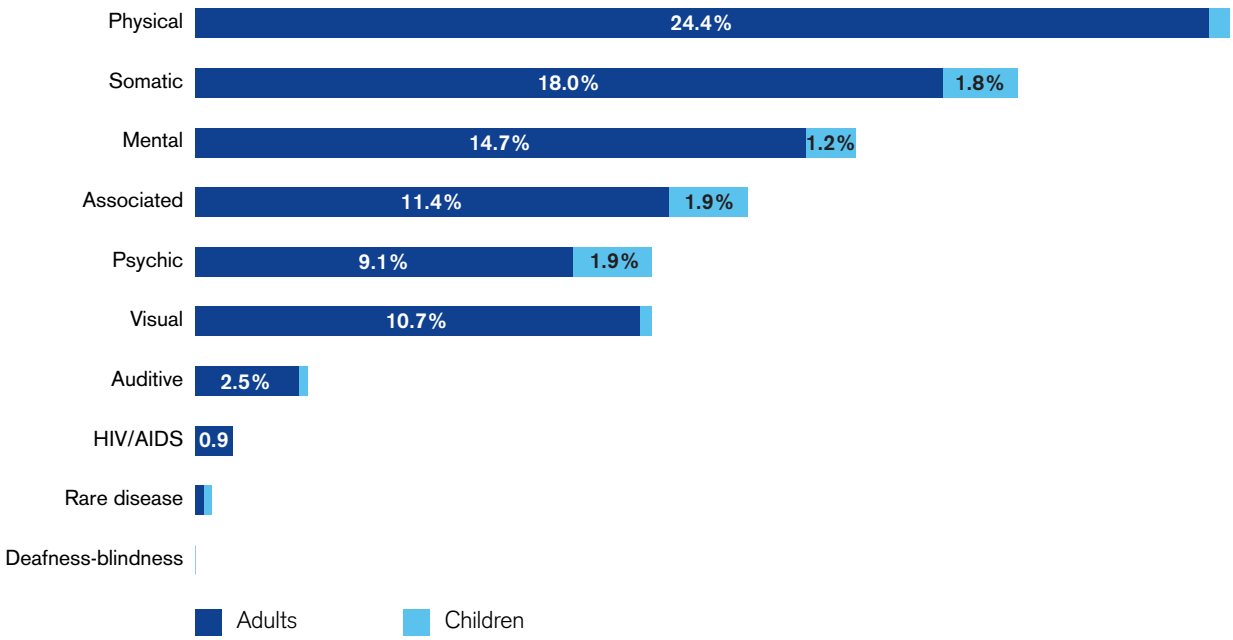
45 Data regarding private centres is estimated based on the number of authorisations issued by the National Authority for the Rights of Persons with Disabilities, Children and Adoptions (ANDPDCA), and Ministry of Labour and Social Protection (2020b).

or substitute families) (Ministry of Labour and Social Protection 2020c).

The characteristics of services provided to persons with disabilities depends on the type and degree of disability. Romanian regulation defines four categories (degrees) of disability: minor (Grade IV), medium (Grade III), profound (Grade II) and severe (Grade I). The disability category is ascertained by a special commission.[46] As of 31 March 2020, out of a total of 852,565 persons with disability 40.0% belonged to Grade I, 48.7% to Grade II, 10.3% Grade III, and 1% to Grade IV (ANDPDCA 2020a). Moreover, people who have lost all or at least half of their capacity to work (either due to work accidents or occupational illnesses, or due to other illnesses or accidents which are unconnected with their work) are classified according to the degree to which their capacity to work is reduced. There are three categories: Category I, which comprises the people who have completely lost their capacity to work and look after themselves (47,471 people in 2019); Category II, which comprises the people who completely lost their capacity to work, but not their ability to look after themselves (212,020 people); Category III, which comprises the people who lost at least half of their capacity to work ,but are still able to work up to half of the full-time hours (248,344 people) (National Institute of Statistics 2019). They receive a disability pension if the age is lower than the standard retirement age. Beneficiaries of disability pension must undergo periodic medical reviews at intervals of between one and three years until they reach the standard retirement age. A specialised commission assesses whether the recipient of the disability pension will remain in the same category of disability, will be re-categorised or whether they have regained their capacity to work. Certain persons are exempt from periodic medical reviews: recipients who suffer from a type of disability that affects their capacity to work irreversibly, recipients who have reached the standard retirement age and recipients whose age is up to five years less than the retirement age and who have completed the full contribution period.

The Romanian regulation (Law No. 448/2006 on the Protection and Promotion of the Rights of Persons with Disabilities) defines the different types of disability (Figure 2). Most of the persons with disabilities have physical disabilities (25.0%), somatic (19.7%) or mental illnesses (15.8%).

FIGURE 2 | Persons with disabilities by type of disability (in %, 2020)



Source: own illustration based on ANDPDCA (2020).

46 Commission for the Evaluation of Adults with Disabilities (SECPAH) for adults and the Child Complex Evaluation Service (SEC) for children, both functioning under Social Assistance and Child Protection Department.

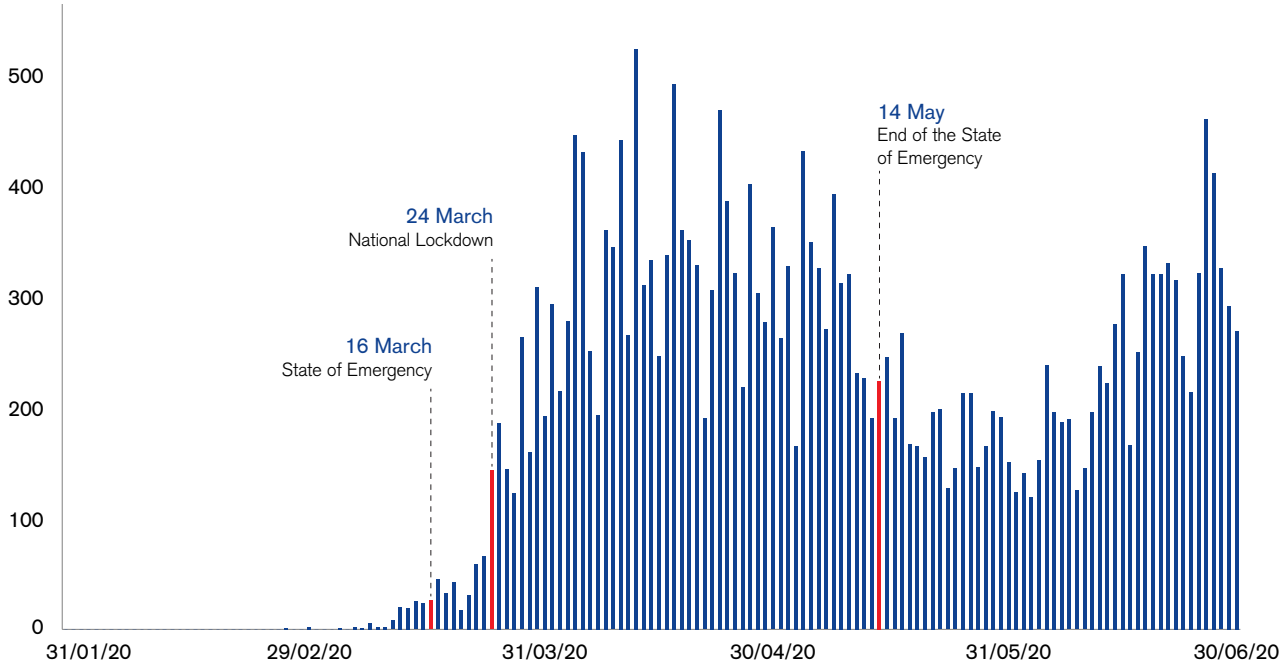
Persons with disabilities, regardless of age, are entitled to cash benefits in the form of allowance, attendant allowance and complementary personal budget (Law No. 448/2006). Benefits are provided from the state budget and are managed by the Ministry of Labour and Social Protection through the National Agency for Payments and Social Inspection. Benefits are calculated according to a Reference Social Indicator (RSI). This is a unit expressed in lei (RON), which is used to calculate various financial social insurance benefits in Romania, including support allowances for persons with disabilities. The RSI is set periodically by the government. For 2020, its value was RON 500 (approx. 103.43 Euros[47]). The RSI has not been updated since 2008, even though there is a project to link it to inflation. As Romania recorded one of the highest inflation rates in the EU (2.6% in June 2020, compared to the 0.8% in the whole of EU, ranking four after Poland (3.8%), Czech Republic (3.4%), Hungary (2.9%)), this issue remains important.

Additionally, disability pensions (Law No. 448/2006, Law No. 263/2010 and Law No. 127/2019) are paid from the Social Security Budget. The amount of the disability pension is calculated on the basis of the contribution period and the level of income earned during the applicants' career, according to their category of disability and the value of a pension point. Since 1 September 2019, the value of a pension point is RON 1,265 (approx. 261.67 Euros). The average disability pension (at the level of September 2019 pension point) was 50% of a pension point for Category I (RON 885.5, approx. 183.17 Euros), 35% of a pension point for Category II (RON 695.75, approx. 143.92 Euros), and 15% of a pension point for Category III (RON 442.75, approx. 91.58 Euros). A pension point was projected to increase to RON 1,775 from 1 September 2020 (approx. 367.16 Euros). However, in August 2020, due to COVID-19 crisis the government approved an increase of only 14% (RON 1.442, approx. 298.28 Euros) as of September 2020. It is expected that the calculation base for invalidity pension will also be modified.

Government Measures for Coping with the COVID-19 Pandemic

The first infection with COVID-19 in Romania was registered on 26 February 2020. During the following two weeks, the number of cases increased slightly and on 8 March 2020 there were only 15 cases (Figure 3).

FIGURE 3 | Number of new COVID-19 cases in Romania (January-June 2020)



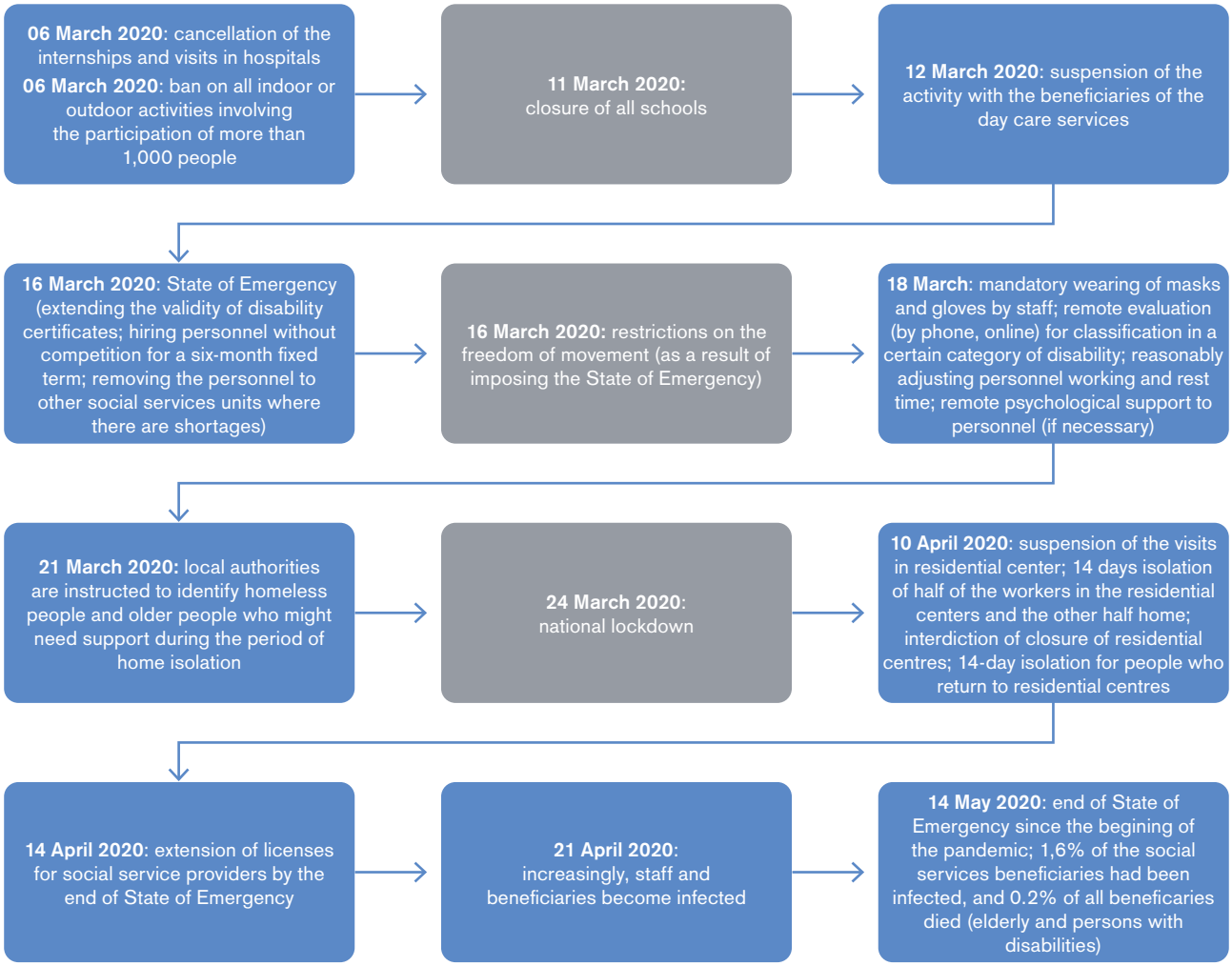
Source: World Health Organisation (2020).

47 At the exchange rate on 31 June 2020.

However, due to public pressure and taking into account the international situation, the Government of Romania took the first measures for coping with the COVID-19 pandemic. Thus, on 8 March 2020, the authorities banned public gatherings and closed schools as well as borders. On 16 March 2020, the authorities declared a State of Emergency, as the total number of cases reached 168. Only one week later, on 24 March 2020, a national lockdown was imposed, as the number of cases reached 794.

Starting with 10 March 2020, the ANDPDCA set up a Coordination Team of Crisis Situation, which ensured the management and implementation of the response measures to the COVID-19 pandemic. Communication and coordination mechanisms with all Departments for Social Assistance and Child Protection (DGASPC) were set up as well as procedures for real-time data collection. Moreover, recommendations and methodologies were distributed to all residential centres and community social services on how to tackle the COVID-19 pandemic (Figure 4).

FIGURE 4 | The timeline of response measures to the COVID-19 pandemic in Romania (March-May 2020)



* The blue boxes contain information directly related to healthcare as well as services for the elderly and persons with disabilities; the grey boxes display general measures and developments.

Source: own illustration.

The local authorities were responsible for identifying the solutions for accommodating staff who were to be isolated within the residential centres, providing personal protective equipment (PPE), daily food as well as the transport for those who needed to commute. The military ordinances[48] enacted mandatory testing for staff and beneficiaries[49] in case of suspected infections. This did not happen every time or happened with delay, being one of the reasons why in some cases the infection spread within residential centres. In many cases, social service providers voluntarily applied extra measures such as preparing locations for isolating their staff (if needed) and accommodation for commuting staff in the residential centre (minimum three to five days) or diminishing the staff rotation by modifying the shifts (Centre for Legal Resources 2020).

On 14 May 2020, the State of Alert replaced the stricter State of Emergency. Therefore, some of the above-mentioned measures were cancelled and others were imposed, such as providing services in day care centres only upon request, restarting group activities with a maximum of five beneficiaries and gradually resuming visits.

Effects of the COVID-19 Pandemic on the Provision of Social Support Services for Persons with Disabilities

Compared to other European countries[50], the number of infections among the residents of social care centres in Romania (including both the elderly and persons with disabilities), remained low during the first wave of the COVID-19 pandemic. Most of the cases were recorded in large residential centres. For instance, on 21 April 2020, over 301 cases (two thirds of the staff and patients) were recorded in the largest neuropsychiatric recovery and rehabilitation centre of the country.[51] On 23 April 2020, 14 cases were recorded in a care and assistance centre for persons with disabilities at Paclisa.[52] By 23 April 2020, 98 death cases were recorded among beneficiaries of all residential centres in Romania (including the elderly). On 8 May 2020, another 167 cases (67 employees and 100 beneficiaries) were recorded in one of the largest habilitation and rehabilitation centre in the country.[53]

At the end of the State of Emergency on 16 May 2020, 1.15% of the persons living in residential centres (both persons with disabilities and elderly) had been infected (657 people, of whom 17 were children) (ANDPDCA 2020c). There were no recorded casualties among children, but 112 adults (elderly and persons with disabilities) died as a result of the COVID-19 infection. This number represents 0.2% of all beneficiaries. On the other hand, 436 beneficiaries recovered. Additionally, 360 infected people and two casualties were recorded among the employees (Ibid.). It is obvious that large residential centres facilitated the spreading of the COVID-19 on a large scale. However, a study of the National Authority for the Rights of Persons with Disabilities, Children and Adoptions (ANDPDCA) indicated that the dysfunctionalities in fast testing of employees and beneficiaries by the Public Health Department (DSP), lack of PPE and lack of differentiated treatment among employees and beneficiaries facilitated the spreading of the virus (ANDPDCA 2020d).

Service Providers

It is undoubted that the COVID-19 pandemic affected the activities of all social service providers. The number of newly established companies in the field of Human health and social work activities (NACE Q) was much lower in 2020 compared to the same period of 2019, except in June 2020 (Figure 5). The most important differences are visible for March, April and May 2020. These months correspond to the period of lockdown when the activities of many public institutions were suspended. In the case of company registrations in Romania, this concerns the case of National Trade Register Office. Furthermore, it is

48 During the State of Emergency, the Ministry of Internal Affairs is responsible for the integrated coordination and issues military ordinances.

49 The term of "beneficiaries" includes here persons with disabilities (adults and children), children without disabilities and elderly living in residential centres (about 57,000 persons).

50 E.g. France: 9,471 of casualties (about 40%) were in the social-medical centers and elderly care centers; Spain: 17,585; United Kingdom: 6,686.

51 Sasca Mică Rehabilitation Centers for Persons with Disabilities, Suceava County.

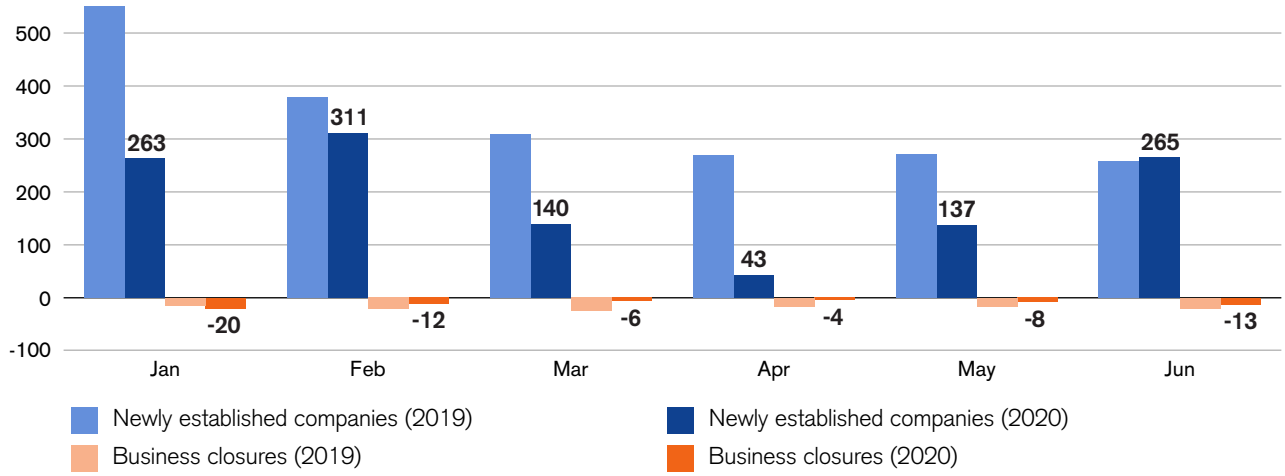
52 Paclisa Care and Assistance Centre for Persons with Disabilities, Hunedoara County.

53 Păstrăveni Recovery and Rehabilitation Centre for Persons with Disabilities, Neamt County.

important to bear in mind that online registration was only partially available.

In case of business closures, less companies were discontinued in March, April and May 2020 compared to similar period of 2019. During June 2020, the number of newly established companies increased slightly compared to June 2019, but this could also be an effect of the National Trade Register Office resuming its activity. The number of business closures increased in June 2020 compared to May 2020, but remained lower than in June 2019 (Figure 5).

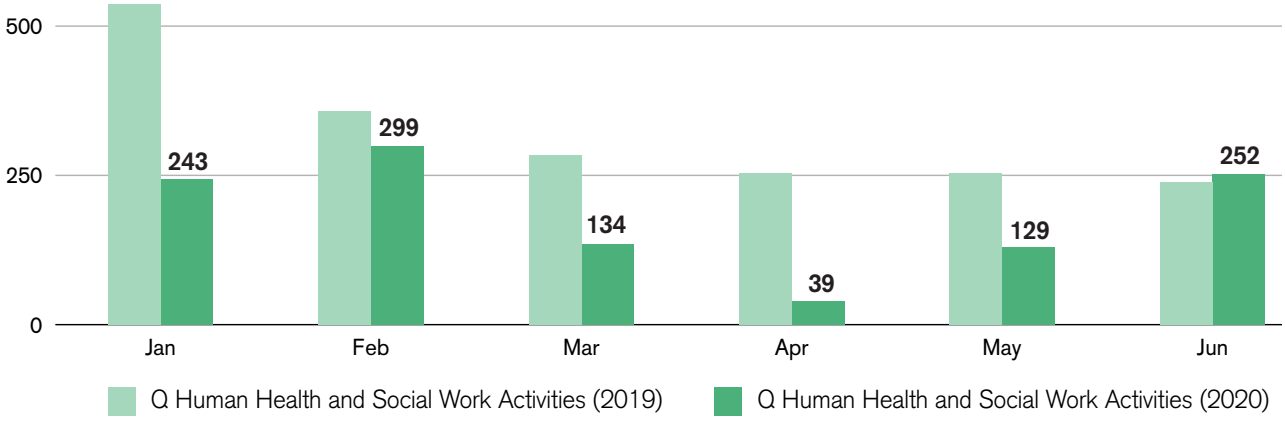
FIGURE 5 | Newly established companies and business closures in Human health and social work activities (NACE Q), January-June 2019 and January-June 2020



Source: own illustration based on National Trade Register Office (2020).

Overall, net business formations remained positive (Figure 6), even though the growth rate was lower compared to 2019. There was a downward trend for the first half of 2019, but the developments in 2020 were different: net business formations decreased from February to April 2020, but started to increase in May 2020 and further in June 2020 as the lockdown ended. It is difficult to say if this evolution represents a direct effect of the COVID-19 pandemic on business in the field of Human health and social work (NACE Q) or rather an indirect effect due to the overall decreasing in the activity of the National Trade Register Office.

FIGURE 6 | Net business formations in Human health and social work activities (NACE Q), January-June 2019 and January-June 2020

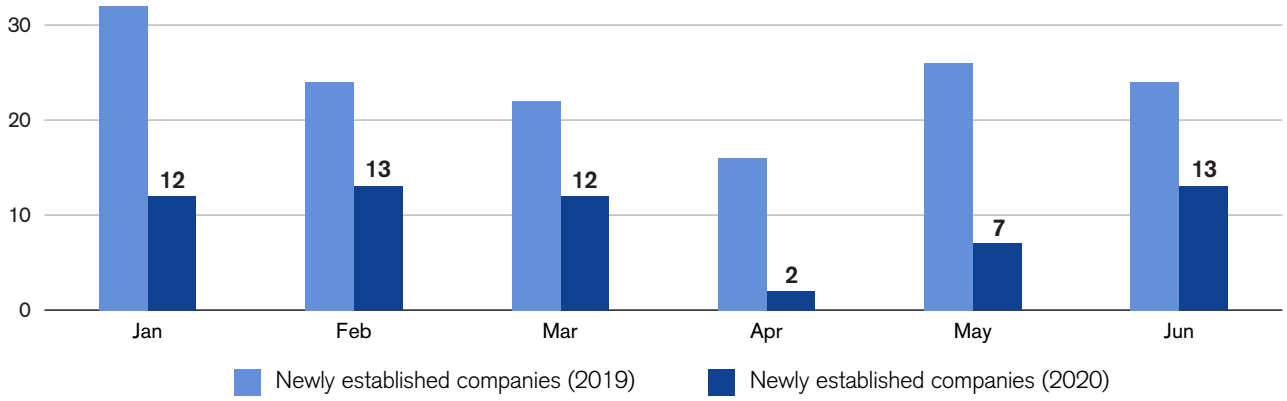


** Methodological note: net business formations correspond to newly established companies minus business closures. These data do not necessarily reflect the situation in the field of disability. The employees in the field of disability fall under section Q of NACE Rev. 2 (Human health and social work), divisions 87-88 (Residential care activities and Social work activities without accommodation), but do not exclusively contain employees who work in the disability area. This limit should be kept in mind when the data from this section are discussed.*

Source: own illustration based on the National Trade Register Office (2020).

In the case of newly established companies in Residential Care and Social work without accommodation (NACE Q87 and Q88),[54] their number was lower in the first six months of 2020 compared to the similar period in 2019 (Figure 7). The differences between 2019 and 2020 were most pronounced in April and May 2020: in April, in the middle of the lockdown, only two companies in the field of Residential care and Social work without accommodation (NACE Q87 and Q88) were registered. Even though a recovery took place in May 2020 and June 2020, overall, the values were far away from the similar period of 2019.

FIGURE 7 | Newly established companies in Residential care and Social work without accommodation (NACE Q87 and Q88), January-June 2019 and January-June 2020



Source: own illustration based on the National Trade Register Office (2020).

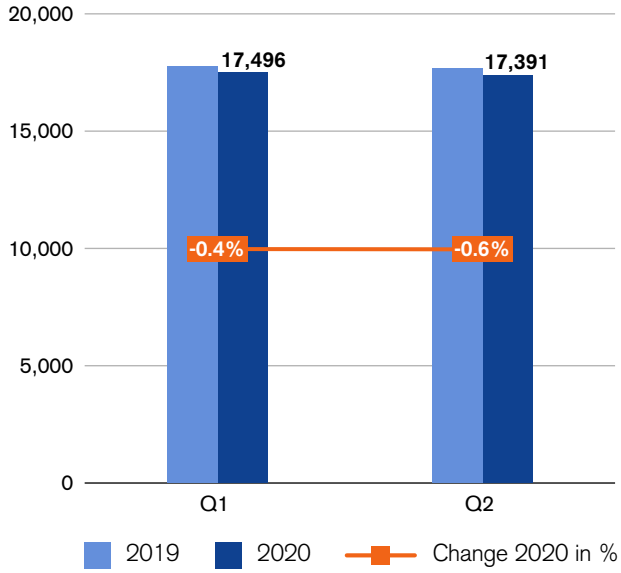
It should be kept in mind that this indicator is relevant only for the private segment of the social services. As the public Romanian social services are provided by local public authorities, data about the newly established companies or business closures do not apply to them.

Scope and quality of services

Social support services for persons with disabilities were strongly affected in terms of scope and quality. Once the State of Emergency was imposed, most of the day care centres limited or even cancelled their activity. Even though the military ordinances clearly indicated that the activity of residential centres for persons with disabilities, elderly or children had to continue, the admission of new beneficiaries to residential centres was stopped (Ministry of Labour 2020d). Furthermore, legal supporters (i.e. families) were allowed (and even encouraged) to take home the beneficiaries from residential centres if they had appropriate conditions for providing care. Against this background, a slight decline in the number of people in residential care took place in Q2 2020, compared to the same quarter of 2019 (Figure 8).

54 No data available for business closures at NACE 2 digits.

FIGURE 8 | Number of people in residential care, Q1-Q2 2019 and Q1-Q2 2020; change compared to the previous month



Source: own illustration based on ANDPDCA (2020).

While in Q2 2019 the net change in the number people in residential care was 74, in 2020 it reached 105. Compared to Q1 2020, the decline in Q2 2020 was 0.6%. This development, however, should be treated with caution given that the current policy in Romania focused on closing large residential centres and reducing the number people in residential care through transferring them to professional caregivers. The interviewed experts[55] also indicated this sort of impact, highlighting the recommendation of authorities for residential centres to identify families that were are able to provide care for persons with disabilities, elderly or children at home.

According to the interviewed experts, one of the main challenges concerning the quality of social support services for persons with disabilities was dealing with the limitations imposed on movement as well as the reduction of the number of beneficiaries who were allowed to participate in various activities. This strongly impacted both beneficiaries and workers. For instance, a representative of an NGO providing day care services reported that they used their own cars to provide transport to beneficiaries as the public transport was limited. Additionally, permanent phone contact was used to be in touch with the beneficiaries who could not participate in the activities of the centre. After the lockdown, the activities were resumed, but with only a maximum of 12 beneficiaries. Another representative of an NGO providing residential care services explained that during the lockdown, only the coordinator of the centre was allowed to travel to ensure the supply of food, medication, etc. Before the crisis, some of the beneficiaries with a moderate disability degree and their own income were allowed to go outside for specific shopping (e.g. medicine). Limitation of movement severely impacted the beneficiaries with specific neuropsychiatric diseases, leading to depressions.

In order to avoid COVID-19 infections among the staff and to keep the service going, a regulation issued by authorities imposed a 14-day isolation of half of the workers in the residential centres and home isolation for the other half. According to the interviews, this was an important challenge, as it was necessary to accommodate the personnel in the centre. This involved difficult decisions as it had to deal separately with each employee, taking into account their family situation (e.g. care-dependent persons in employee's family). In the case of public residential centres, accommodation within the facility was very difficult, mainly due to the large number of employees compared to private residential centres. Moreover, this generated a lot of psychological discomfort amplified mainly by the overlapping of the restrictions period with Easter, which people traditionally spend with their families.

Many services could not be provided at all and other activities such as parties or trips were cancelled. For example, a representative of a private day care centre reported that all activities were suspended during the State of Emergency. Even if the activity was not completely cancelled in some cases (e.g. provision of private day care services), the reconfiguration implied extra work to cover all beneficiaries. An NGO offering day care for persons with disabilities reported that during the COVID-19 pandemic it had to limit the group activities to only five persons instead of the usual 15-20 persons. The re-opening implied a series of limitations such as a ban on providing food in the centre (e.g. breakfast or lunch) and reducing the working programme (09:00-13:00 instead of 09:00-16:00). As a result of this disruption, the number of beneficiaries decreased. In some cases, as a result of school closures, various informal educational activities were delivered in the centres. In case of private residential centres, the beneficiaries were not allowed to leave the centre and all new admissions were subject to the results of a COVID-19 test. Organisations payed for testing from their own fund or from sponsorships, but it was not possible to support all requests.

55 Interviews were conducted with five representatives of both private and public social support service providers.

Furthermore, problems regarding the availability of PPE were experienced by the interview partners. Although its use had been requested from local Public Health Departments, they were not able to provide it due to the lack of stocks. Although the service providers incurred additional costs through the use of PPE, they did not always have the necessary funds for acquiring them. In particular, private NGOs that are funded by public authorities or through sponsorships experienced interruptions or delays of funds. Thus, at least in the case of private providers, PPE was acquired through private sponsorships. In public residential centres, the staff did not need to be familiarised with its use, because they had used it before, for example wearing gloves and mask when preparing food. Also, the disinfectants were used constantly before crisis in the kitchen area and were present in the beneficiaries' rooms. In residential centres, separate circuits for enter/exit flows and with special area for disinfection were introduced. However, in many cases the staff was not able to adhere to sufficient hygiene standards as they had to re-use the PPE. More supply was provided but after the end of lockdown.

The communication in the facilities was strongly affected, as the organisation of the activity during and after the lockdown aimed to limit interactions between the groups of beneficiaries. Contacts with people from outside the centres were limited to only video/audio meetings with the families. Also, communication with the employees was switched to online format, affecting the group cohesion. In this context, the lack of digital skills of the personnel was brought up by the interview partners.

There were not specific regulations or procedures provided by the public authorities or professional associations. Information was mainly obtained from mass media, but in many cases it were considered insufficient and resulted in a high level of uncertainty among the staff. Furthermore, the interview partners mentioned that there was a lack of information regarding about how the activity should resume after the lockdown. A public service provider was dissatisfied with the prioritisation of the health sector in testing, even though their workers were tested for COVID-19 once a fortnight.[56]

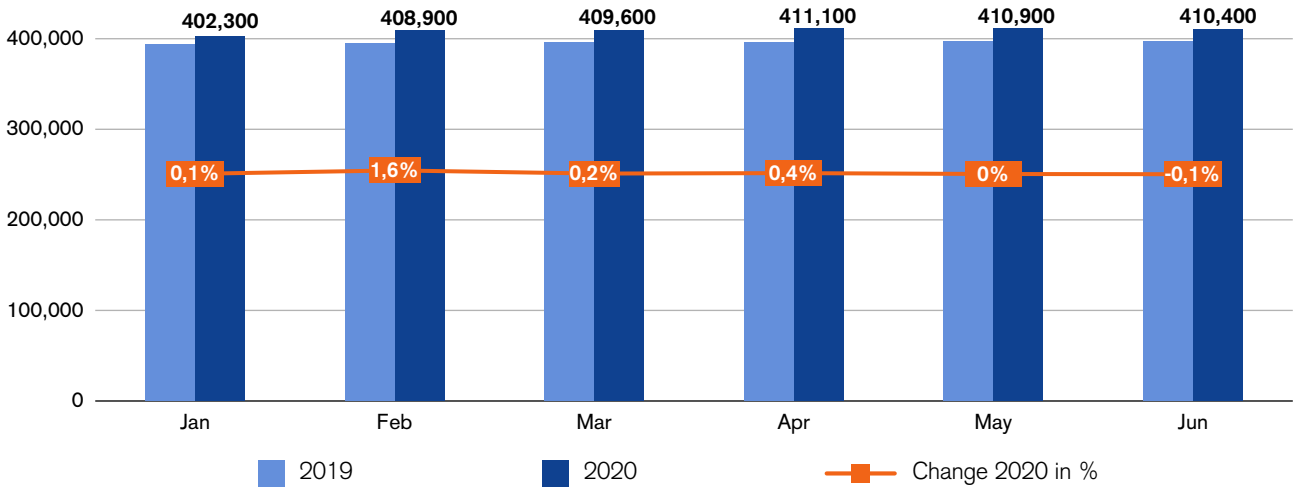
Workforce

Employment: on 31 January 2020, 402,300 persons were working in the sector of Human health and social work (NACE Q), representing about 7.9% of all employees (Romanian Labour Inspectorate 2020). The number of persons employed in Residential care and Social work (NACE Q87 & Q88) represented 21.5% of all employees in the Human health and social work sector (NACE Q). Out of them, 55,674 were employed in Residential care activities (NACE Q87) (14.2% of the workforce in NACE Q) and 28,663 were employed in Social work Activities (NACE Q87) (7.3%).

When comparing the number of employees at the beginning of 2019 and 2020, a slight growth of 2.3% can be noticed. In terms of trends, for the first six months of the year, the increase of the number of employees was higher in 2020 compared to 2019 (Figure 9). However, when analysing these data the overall situation of the Romanian health system needs to be taken into account: authorities are struggling with shortages of medical staff and are constantly devising measures to improve their retention and make employment more attractive (e.g. by a substantial increase in salaries or investments in infrastructure). Therefore, the change in numbers of employees in the health sector from one year to another is mainly an effect of these measures.

56 This was not available for all public residential centers.

FIGURE 9 | Employed persons in Human health and social work sector (NACE Q), January-June 2019 and January-June 2020; change compared to the previous month



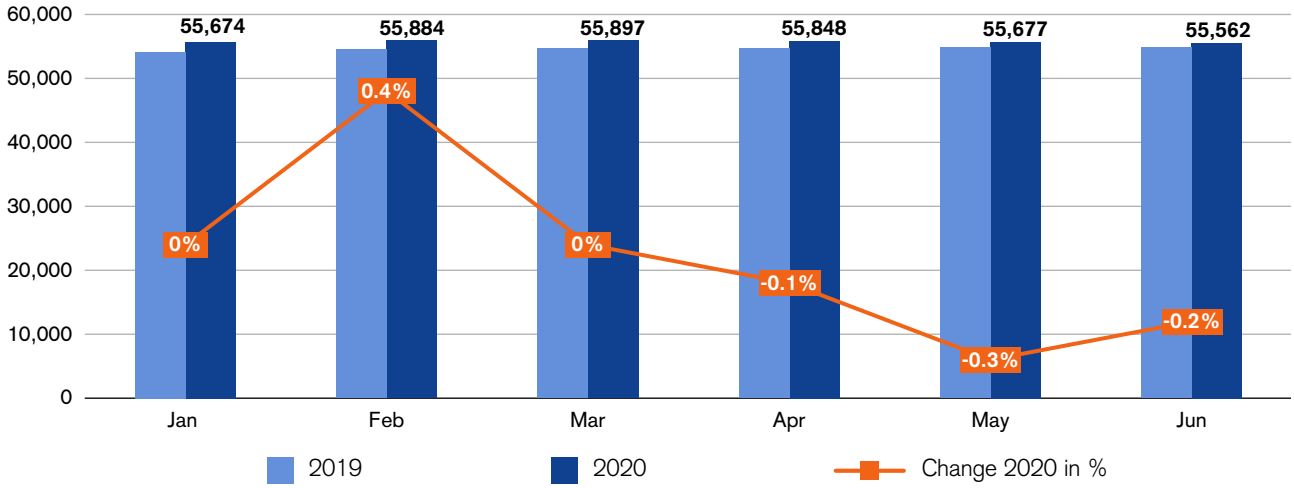
Source: own illustration based on the National Institute of Statistics (2020).

In 2020, the level of change in the number of employed persons differed from one month to another, compared to the similar period of 2019. For instance, in April 2020, in the middle of the crisis, the number of employees in the Human health and social work sector (NACE Q) increased by more than 1,500 persons, representing an increase of 0.4% compared to the previous month; in the same month of 2019, the number of new employees increased by only 200 persons. One explanation could come from the fact that some measures adopted by the Government of Romania as a response to the COVID-19 pandemic allowed employment of additional staff in the health and social care sectors. For instance, the Presidential Decree No. 195 (Romanian Presidency 2020) (published in the Official Journal on 16 March 2020) stated that "Health and social assistance services can hire for a period of six months (fixed-term contract) medical staff, auxiliary staff, pharmacists, laboratory staff and other necessary contractual staff without competition".[57] Additionally, many graduates of medicine faculties were provisionally employed, even though they had not received all professional accreditations. However, once the State of Emergency was cancelled in May 2020, many fixed-term contracts were terminated. This resulted in a slight decrease of 0.1% in the number of employees in the Human health and social work sector in May as well as in June 2020.

When analysing changes in the number of employees separately for Residential care and social work activities(NACE Q87 &88), we see differences compared to the whole sector of Human health and social work (NACE Q), which slightly increased during the crisis (particularly in the first four months of the year of 2020, Figure 9). Figure 10 and Figure 11 clearly show that once the lockdown was imposed in March 2020, the number of employees started to decline. In Residential care activities (NACE Q87), the employment trend was positive at the beginning of the year 2020 – similar to that of 2019. Starting with April 2020, the trend was reversed compared to the same period of the previous year. For example, in May 2020, a decrease of 0.3% compared to the previous month was recorded. The decline in the number of employees at the peak of the COVID-19 crisis in April 2020 amounted to 49 persons, but increased to 171 persons in the in May 2020. It seems that the measures taken by authorities did not stop the decline in this field and the expert interviews revealed that many employees, particularly from the private field of the Residential care sector were forced to go into unemployment due to the diminishing of the activity of some facilities. After the end of the lockdown they did not return, choosing other jobs.

57 Normally, for permanent or fixed-term contracts an open competition must be organised, but the procedures take a long time (at least 30 days). The decision to suspend the competitions aimed to speed up the procedures of hiring medical staff. However, all vacancies still had to be publicly announced and general requirements to fill in the job have remained in use.

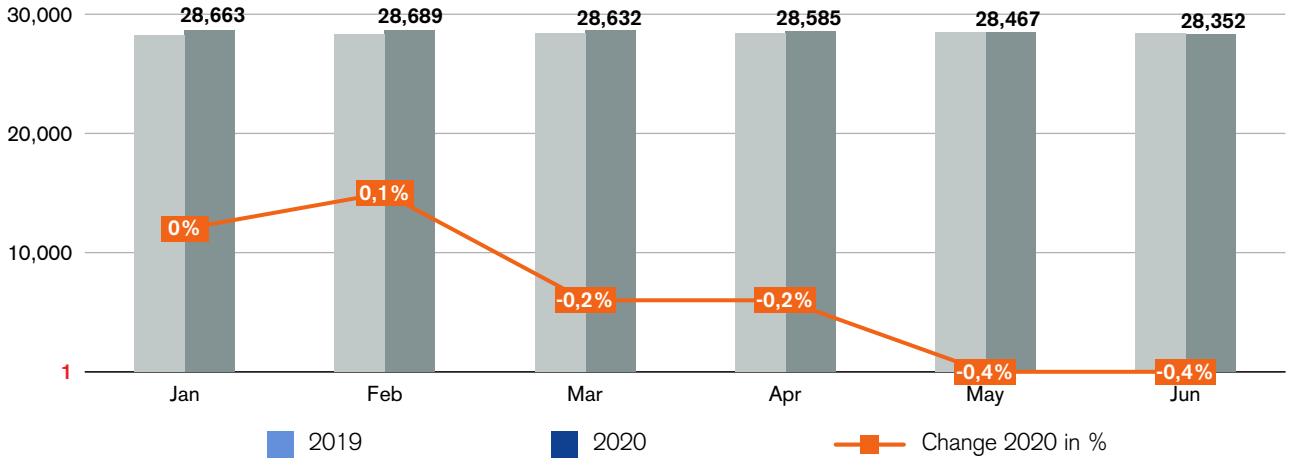
FIGURE 10 | Employed persons in Residential care (NACE Q87), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on the Romanian Labour Inspectorate (2020).

A similar situation could be observed in the field of Social work (NACE Q88): already in March 2020, a decrease of 0.2% was recorded, when 57 less employees were registered in the sector compared to the previous month. The downward trend continued in April 2020 with a decline of 0.2% (47 less employees) as well as in May and June 2020. Actually, the decrease was more substantial in May 2020 and June 2020. For instance, in May the decline in the number of employees amounted to 118 persons compared to April 2020 and in June to 115, compared to May 2020.

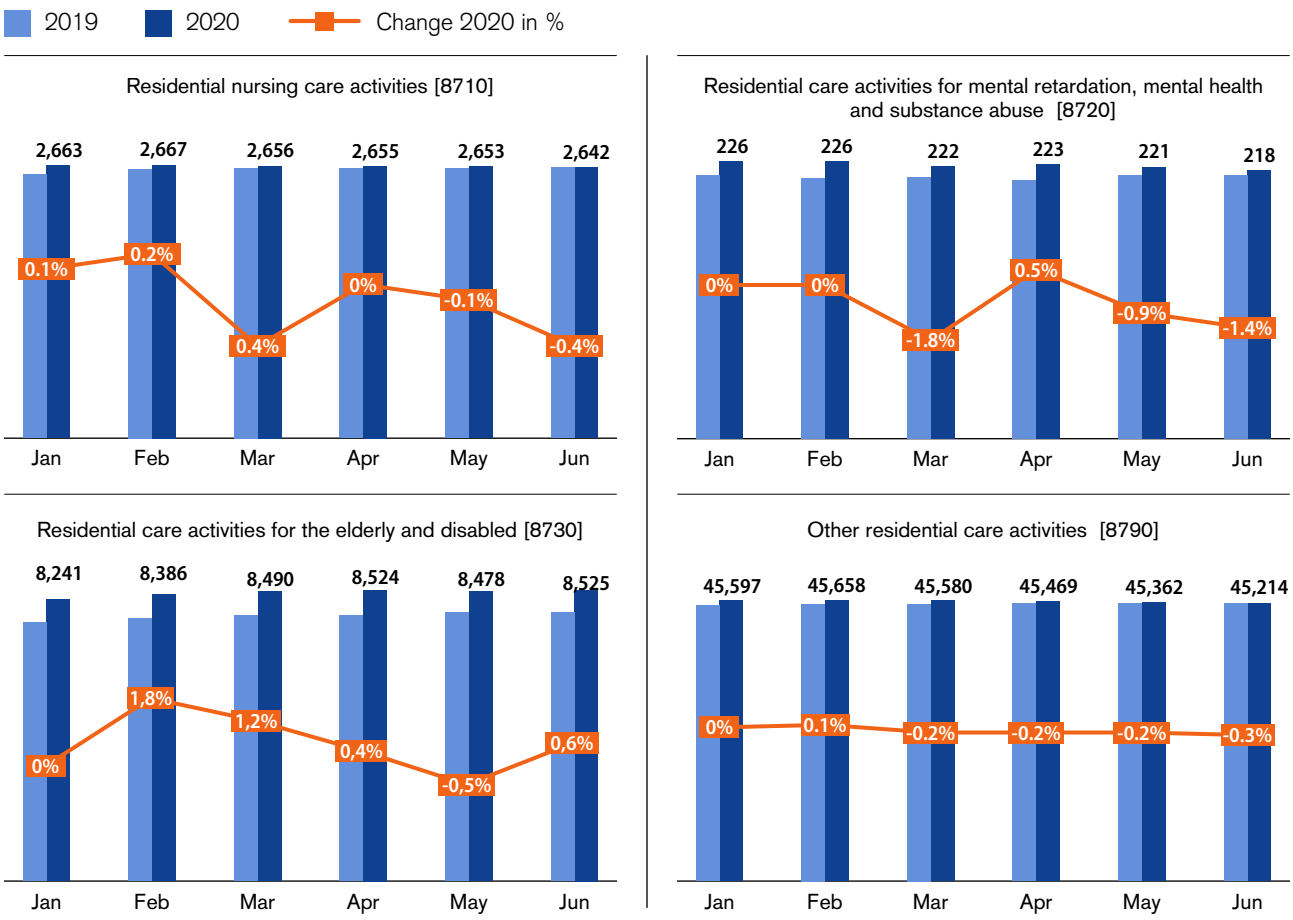
FIGURE 11 | Employed persons in Social work activities (NACE Q88), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on The Romanian Labour Inspectorate (2020).

Data at the four-digit level of NACEQ reveals more accurately the effects of COVID-19 on workforce in the field of disability. Figure 12 details the number of employees for the period January-June 2019 and January-June 2020 within each sub-category of NACE Q87.

FIGURE 12 | Employed persons in residential care activities (NACE Q8710, Q8720[58], Q8730[59] and Q8790), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on the Romanian Labour Inspectorate (2020).

Fluctuations were recorded for all these categories. In the case of Residential nursing care activities (NACE Q8710), the number of employees was by 0.4% lower than in March 2020 compared to the previous month (Figure 12). Even though the decline slowed down after March 2020, it continued during Q2 2020 and even accelerated in June 2020. A similar situation can be observed in the case of Residential care activities for intellectual disability[60], mental health and substance abuse (NACE Q8720), where also March and June 2020 were marked by a consistent decline in the number of employed persons (-1.8% and -1.36%, respectively) compared to the previous month (Figure 12). In April 2020, a slight increase was recorded, but the decline continued then. The most pronounced decline was recorded in the field of Other residential care activities (NACE Q8790). In this case, the decrease in the number of employed persons accentuated from month to month (Figure 12). The only domain where the trend was positive was Residential care activities for elderly and persons with disabilities[61] (NACE Q8730) (except in May 2020 when 0.5% fewer employees were recorded compared to the previous month) (Figure 12). Fluctuations of the number of employees can also be seen for all classes of section NACE Q88 (Figure 13).

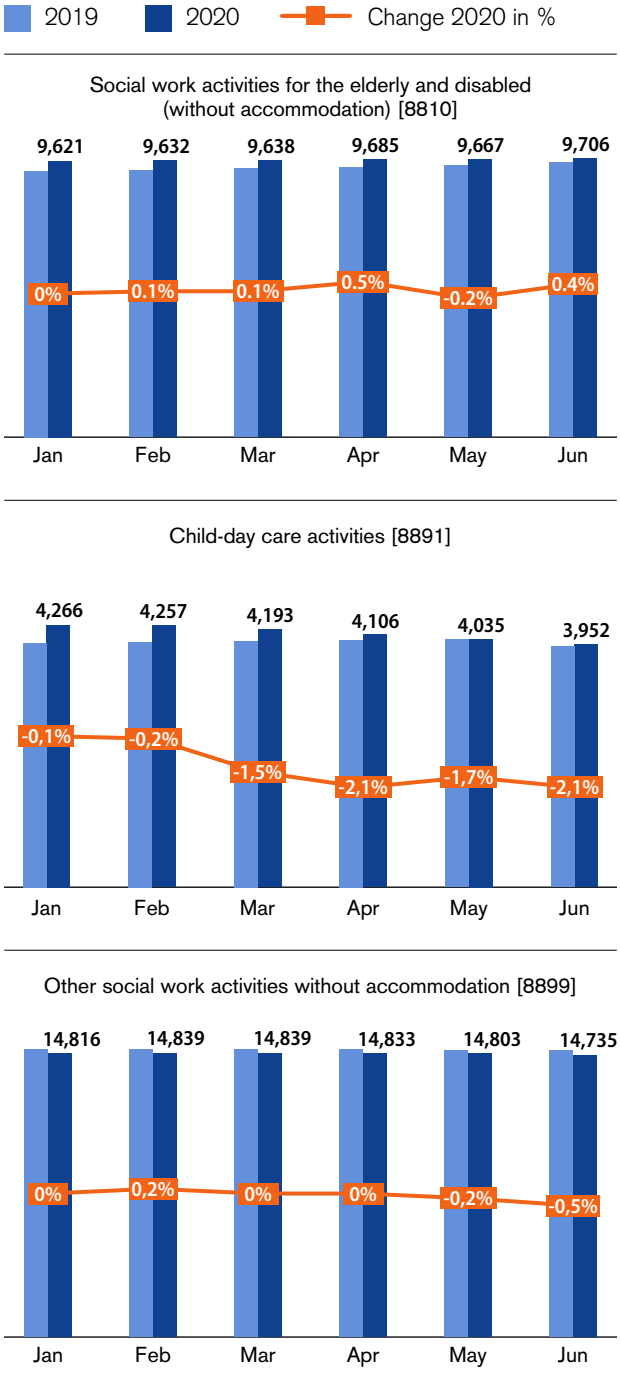
58 For the sake of clarity and comparability, please note that the NACE classification uses the term "mental retardation" instead of "intellectual disability".

59 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

60 For the sake of clarity and comparability, please note that the NACE classification uses the term "mental retardation" instead of "intellectual disability".

61 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

FIGURE 13 | Employed persons in Social work activities without accommodation (NACE Q8810[62], Q8891 and Q8899), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on the Romanian Labour Inspectorate (2020).

For instance, employment in the field of Social work activities for elderly and persons with disabilities[63] (NACE Q8810), May 2020 was marked by the most consistent decrease of 0.2% compared to the previous month. On the other hand, in Child care activities (NACE Q8891) the decline was recorded during the whole first quarter of 2020. It is not surprisingly taking into account that one of the measures introduced to contain COVID-19 pandemic was the closure of day-care centres. This aspect also explains the decreasing number of employees in the Other social work activities without accommodation (NACE Q8899) (Figure 13).

Even though the differences are not very high – in most cases below 1% – overall we can state that the COVID-19 pandemic had a visible impact on the employment in the field of disability, especially if we compare data with those from 2019. This situation is also confirmed by interviews. For instance, many employees, particularly from the private sector of social work have been forced into unemployment due to the closure of some facilities (March-April 2020), and after the lockdown (May-June 2020) they did not return. On the other hand, many employees in the field of disability had part-time contracts (particularly those who worked for NGOs) and were able to return to work as they had to look after their own children. Moreover, in many cases they were sent into technical unemployment[64] from their main job and through preforming a side job they would have revoked their unemployment benefits.

Unemployment: data on unemployment in the sector of Human health and social work (NACE Q) should be interpreted taking into account the overall situation of unemployment in Romania. In 2019, the unemployment rate was 3.9%, much lower than the EU average at 6.3% (Eurostat 2019). However, due to the COVID-19 pandemic, the general unemployment rate increased with every month. At the end of Q1 2020, it reached 5.3% (Eurostat 2020), but with strong disparities between economic sectors. As the Human health and social work sector (NACE Q) is one of the sectors with pronounced labour shortages, the level of unemployment is low. One of the reasons for this is the high migration rate among the workers: the phenomenon of migration of physicians and social workers from Romania is a well-known phenomenon, especially after the country joined the EU

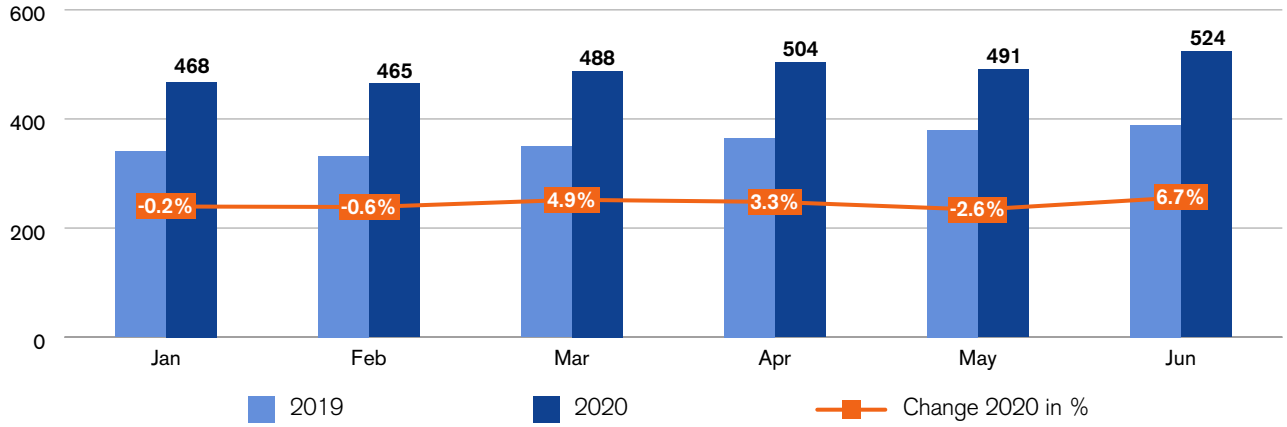
62 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

63 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

64 Suspension of the employment contracts due to the temporary reduction/interruption of the activity.

in 2007 (Panzaru and Reisz 2017). Since then, more than 14,000 physicians have left the country. In 2019, the average number of physicians per 1,000 people was only 2.9 in Romania, compared to the EU average of 3.6. Additionally, National College of Social Workers (CNASR) claims that the deficit of social care workers in Romania is about 20,000 people (Buzducea 2018). There are about 8,000 social care workers in the country, 75% of them employed in the public sector and the others mostly in NGOs. As a result, the number of unemployed persons is very low in the Human health and social work sector (NACE Q) (Figure 14).

FIGURE 14 | Unemployed persons in Human health and social work sector (NACE Q), January-June 2019 and January-June 2020 change compared to the previous month

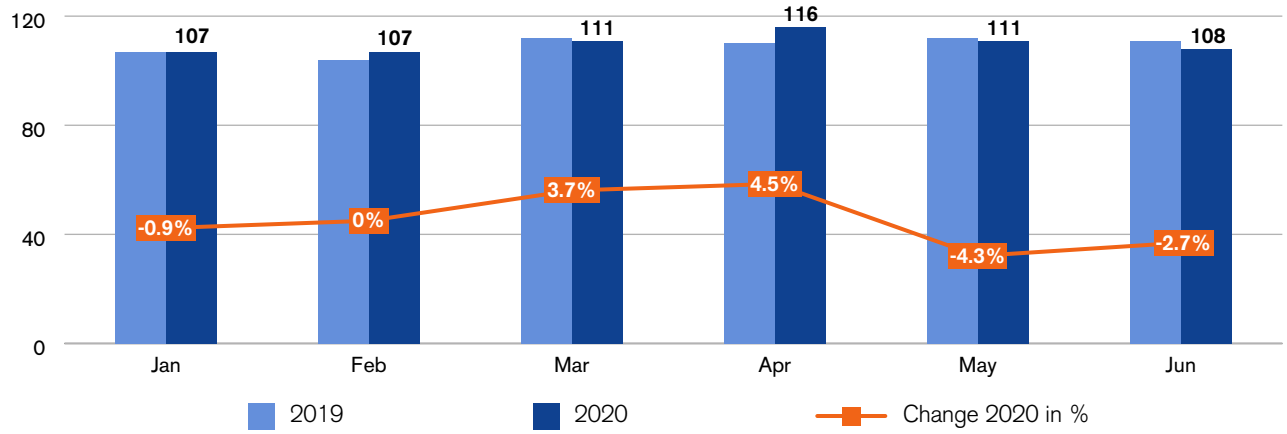


Source: National Employment Agency (2020).

The highest increase in unemployment was recorded in March 2020, as the first measures to confine COVID-19 pandemic were introduced by the authorities: it rose by 4.9% compared to the previous month. Many hospitals were exclusively designated to treat COVID-19 patients, generating dissatisfactions among workers. Under these conditions, many hospitals were confronted with resignations (Forbes 2020). The decline continued also in April 2020 as there were 3.3% more unemployed people than in March 2020, but the number decreased in May 2020 by 2.6% compared to April 2020.

Overall, it is obvious that the unemployment in the first quarter of 2020 was much higher than in the similar period of 2019, with a highest difference in March 2020 when 39.8% more unemployed persons were recorded compared to March 2019. In April 2020, there were 38.3% more unemployed persons compared to April 2019. It is difficult to assess if this development is the effect of the COVID-19 pandemic and measures taken by the authorities (e.g. resignations by or hiring of personnel without competition for a six-month fixed-term contract) or other factors (e.g. difficulties to emigrate due to travel restrictions). However, a similar trend was recorded for the sector of Residential care (NACE Q87) (Figure 15). Also in this case, the number of unemployed persons increased in March 2020 by 3.7% compared to February 2020, and by 4.5% in April 2020 compared to March 2020. After that, in May 2020 the number of unemployed persons returned to the same level as at the beginning of crisis. Compared to the similar period of 2019, the number of unemployed persons in the sector of Residential care (NACE Q87) was almost similar in 2020. This is to some extent logical, as most of the workers from this domain are state employees and dismissing them is difficult. On the other hand, significant labour shortages exist in this sector and an unemployed person can easily find a job in private residential care as many private facilities were opened in the sector during the last years, particularly in the field of elderly care. Since there is a demand for caregivers, particularly in Austria, Italy and Germany, there is also the option to emigrate (Sekulová and Rogoz 2018). The only significant difference was recorded in April 2020, with 5% more unemployed persons compared to April 2019.

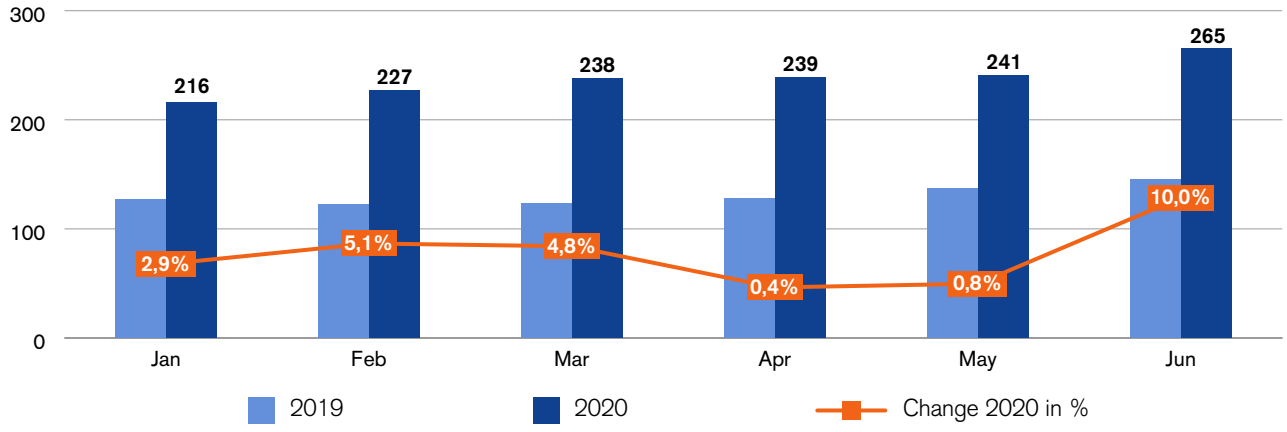
FIGURE 15 | Unemployed persons in Residential care (NACE Q87), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on the National Employment Agency (2020).

The sector of Social work without accommodation (NACE 88) was the only one where the number of unemployed persons increased every month during Q1 2020 (Figure 16). It was also considerably higher than the number of unemployed persons recorded in the similar period of 2019. This could be explained by the closures of day-care centres during the State of Emergency. During the lockdown, the increase in the number of unemployed people was slower (5.1% in February 2020, 4.8% in March 2020 vs. only 0.4% in April 2020 and 0.8% in May 2020; all data compared to the previous month). However, in June 2020, there was a sharp increase of 10% in the number of unemployed persons in the sector compared to May 2020. This could be an effect of the closure of many service providers, reduction in the level of services and provisional suspension of employment contracts. Moreover, interviews also revealed, that many employees, particularly from the private sector of social care work did not return to the job after their employment contracts had been temporarily suspended.

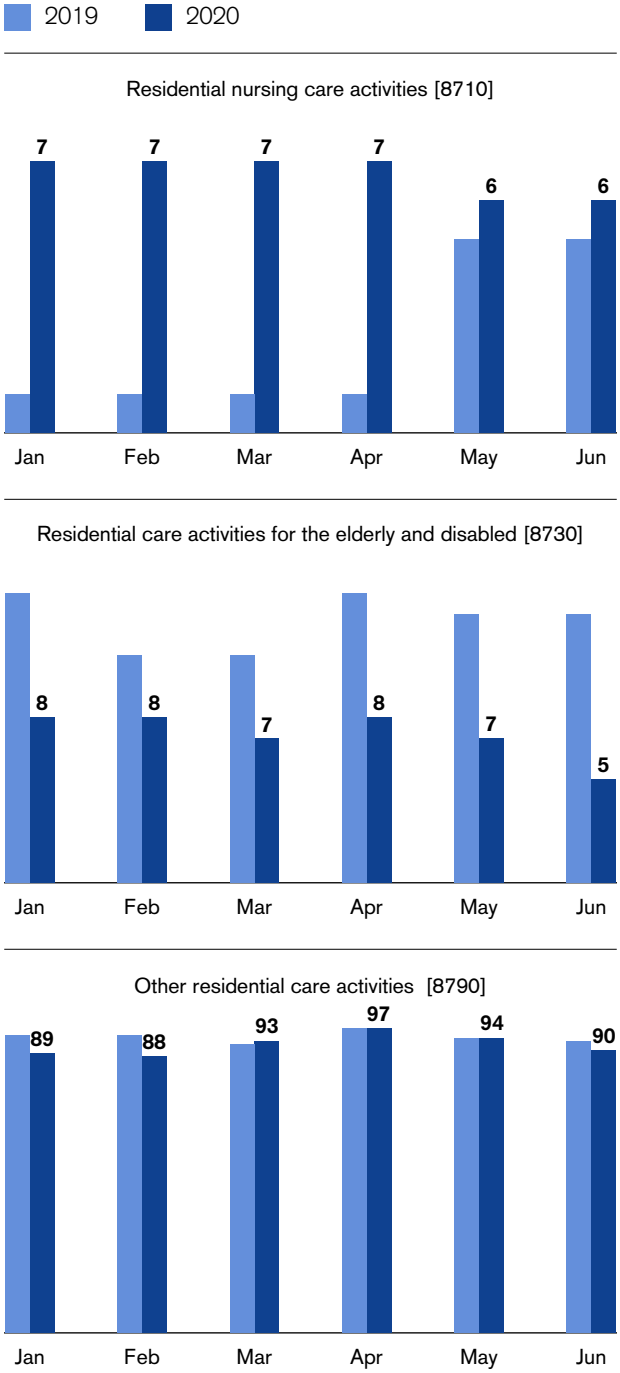
FIGURE 16 | Unemployed persons in Social work without accommodation (NACE Q88), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on National Employment Agency (2020).

Unemployment data are available at NACE four-digit-level both for Residential care activities (NACE Q8710, Q8730 and Q8790) (Figure 17) and Social Work activities (NACE Q8810, Q8891 and Q8899) (Figure 18). However, as the total number of registered unemployed people at this level is very low, the results should be interpreted with utmost caution.[65] For example, for the analysed period, no unemployed person was registered by the National Employment Agency for the category Residential care activities for intellectual disability[66], mental health and substance abuse (NACE Q8720). For other categories, such as Residential nursing care activities (NACE Q8710), Residential care activities for elderly and persons with disabilities[67] (NACE Q8730) (Figure 17) or Child care activities (NACE Q8891) (Figure 18), the unemployment level is expressed in a single-digit number. Due to the small numbers, the trends differ a lot between these categories.

FIGURE 17 | Unemployed persons in Residential Care activities (NACE Q8710, Q8730[68] and Q8790), January-June 2019 and January-June 2020



Source: own illustration based on National Employment Agency (2020).

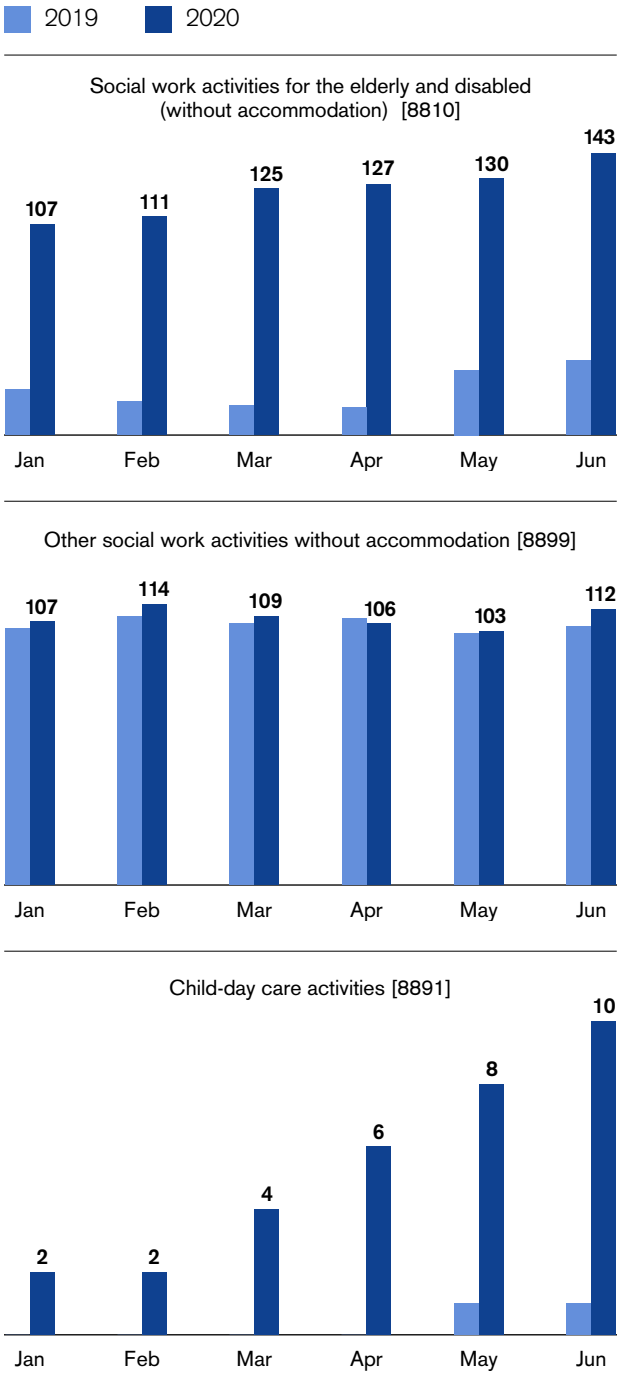
65 For this reason, Figures 17 and 18 do not display the relative change in the number of employed persons compared to the previous month.

66 For the sake of clarity and comparability, please note that the NACE classification uses the term "mental retardation" instead of "intellectual disability".

67 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

68 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

FIGURE 18 | Unemployed persons in Social work without accommodation (NACE Q8810[69], Q8891 and Q8899), January-June 2019 and January-June 2020



Source: own illustration based on the National Employment Agency (2020).

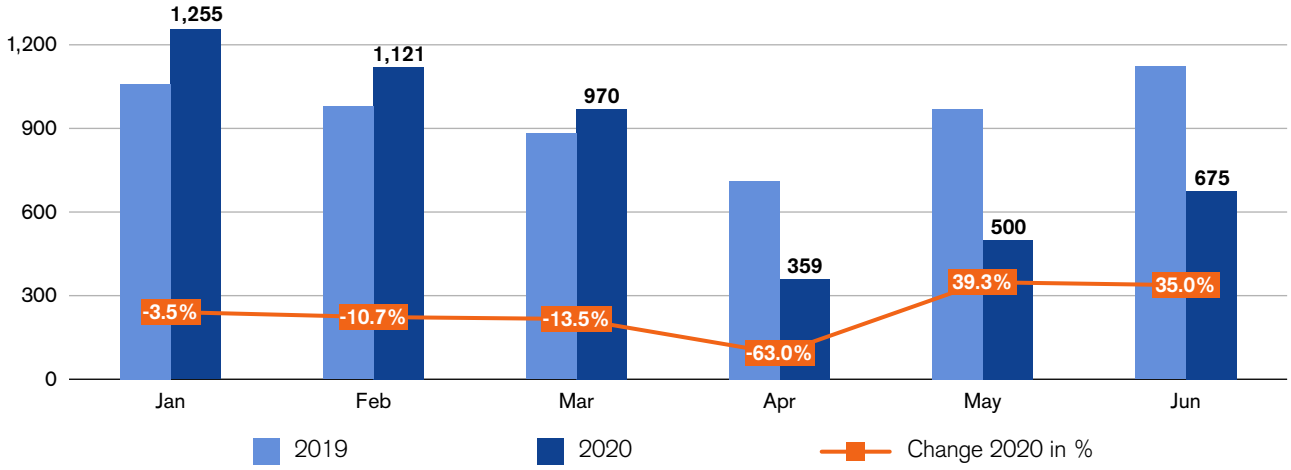
Expert interviews and analysis of the measures taken by authorities help to contextualise the information. For example, in the field of Social work activities for elderly and persons with disabilities[70] (NACE Q8810), unemployment increased in every month of Q1 2020 and was also higher than in 2019. The situation was the same in Child day-care activities (NACE Q8891). In these cases, we can consider that the development was a result of the COVID-19 pandemic as one of the measures taken by the authorities in the field of disability consisted of closing the day-care centres. Moreover, interviews revealed that at the end of lockdown, many employees did not return to work, which explains the continued increase in the number of unemployed persons also in June 2020. Furthermore, the transition of residential care sector in Romania and migration should be taken into account, both influencing the unemployment level. Currently, the Government of Romania is implementing a process consisting of closing traditional (residential) centres for children and reorganising the centres for adults with a capacity of more than 50 beneficiaries. Additionally, migration generates strong labour shortages in the whole sector of Health and social work (NACE Q).

Vacancies: in Health and social work activities (NACE Q), more vacancies were reported in Q1 2020 compared to the same period in 2019 (Figure 19). In April 2020, in the middle of the COVID-19 pandemic, this situation reversed, and the number of vacancies decreased by 63.0% compared to March 2020. Even though in May and June 2020 the number of vacancies slightly increased, with 39.3% and 35.0% respectively, it remained considerably below the level recorded in the similar months of 2019.

69 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

70 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

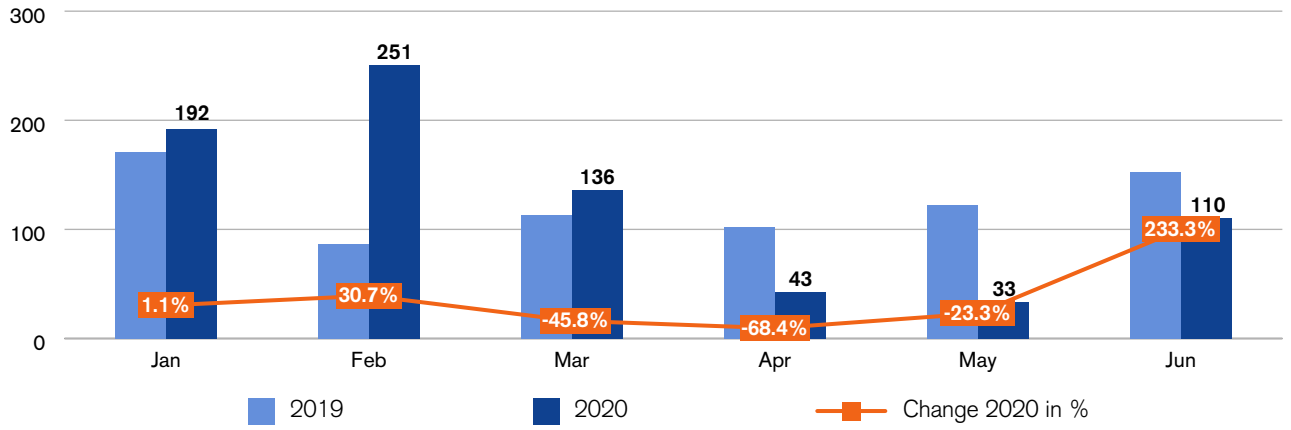
FIGURE 19 | New vacancies in Human health and social work sector (NACE Q), January-June 2019 and January-June 2020; change compared to the previous month



Source: own illustration based on the National Employment Agency (2020).

A similar pattern could be observed in the sector of Residential care (NACE Q87) (Figure 20).

FIGURE 20 | New vacancies in Residential care (NACE Q87), January-June 2019 and January-June 2020; change compared to the previous month

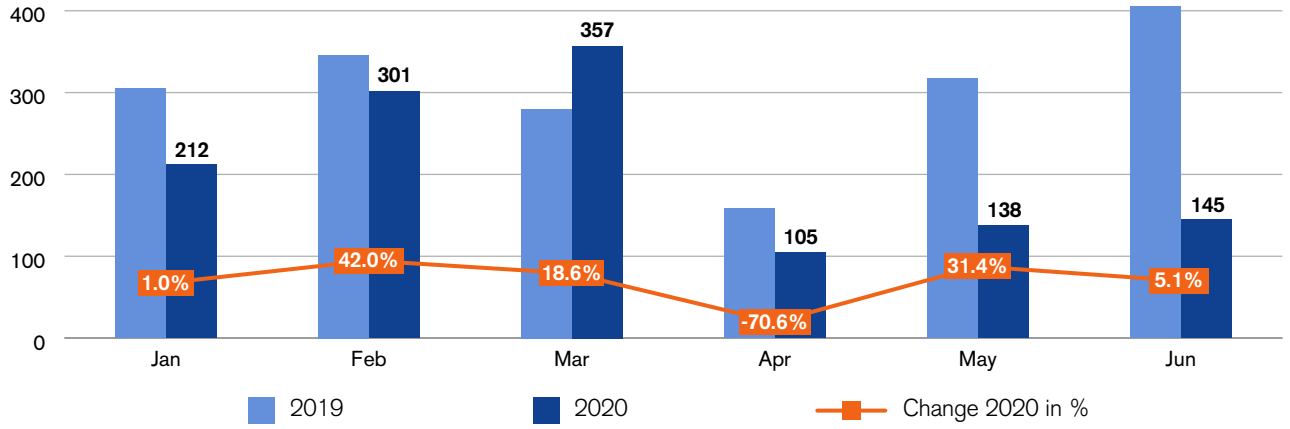


Source: own illustration based on the National Employment Agency (2020).

Also, in Q1 2020, the number of vacancies was higher than in the similar period of 2019. The sharp decrease started in March 2020 when 45.8% less vacancies were recorded than in February 2020. It continued in April 2020 when there were 68.4% less vacancies compared to the previous month. In May 2020, this trend weakened, but remained negative, with 23.3% less vacancies recorded than in April 2020. Surprisingly, at the end of lockdown in June 2020 an important increase in the number of vacancies was recorded, with 233.3% more vacancies compared to May 2020.

In the field of Social work without accommodation (NACE Q88), the number of vacancies increased in Q1 2020, but then sharply decreased by 70.6% at the middle of the crisis in April 2020 compared to March 2020. A slight increase was recorded in May and June 2020, but it had not reached the level of the same period of 2019.

FIGURE 21 | New vacancies in Social work without accommodation (NACE Q88), January-June 2019 and January-June 2020; change compared to the previous month

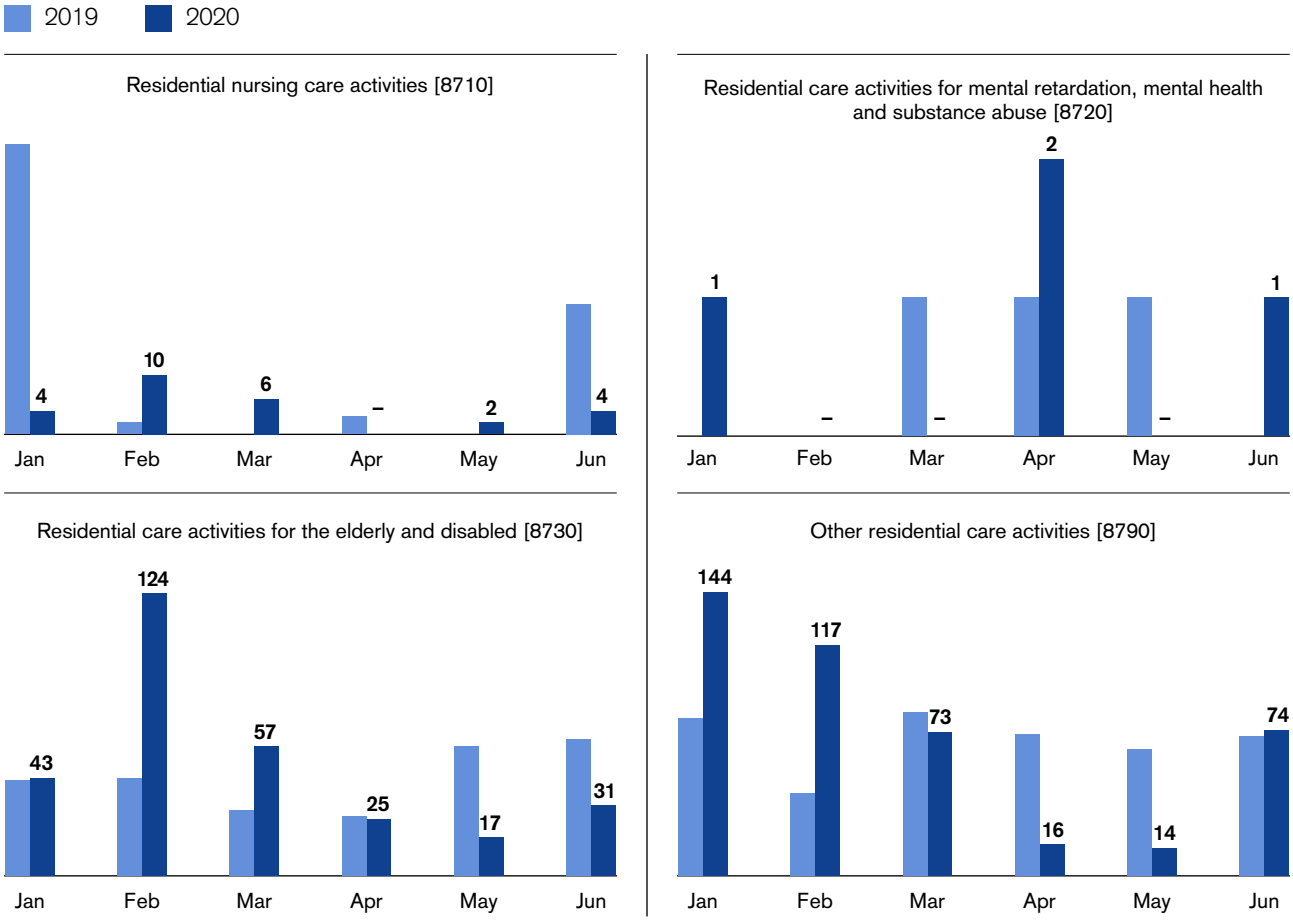


Source: own illustration based on the National Employment Agency (2020).

When focusing on NACE four-digit-level (Figure 22 and Figure 23), the results should be interpreted with caution, because the numbers are very low.[71] For instance, in the field of Residential nursing activities (NACE Q8710) only four vacancies were recorded in January 2020 compared to 49 in January 2019. Furthermore, ten vacancies had been registered in February 2020 and no vacancies in March 2020. In May and June 2020, two and four vacancies were recorded, respectively.

71 Again, Figures 22 and 23 do not contain relative change in the number of vacancies compared to the previous month.

FIGURE 22 | New vacancies in in Residential care activities (NACE Q8710, Q8720*72, Q873073 and Q8790), January-June 2019 and January-June 2020



Source: own illustration based on the National Employment Agency (2020).

In the field of Social work activities, at NACE 4-digits level (Figure 23), data revealed an almost similar pattern for all classes with the number of vacancies decreasing sharply in April 2020, compared to the previous month, while in March 2020 it was an increase also compared to the previous month.

In case of Social work activities for elderly and persons with disabilities[74] (NACE Q8810), in April 2020 there about four times fewer vacancies compared to March 2020 (ten vacancies in April 2020 vs. 43 in March 2020) and seven times fewer, compared to the similar month of 2019 (Figure 23). In the field of Child day-care activities (NACE Q8899), the decreasing in April 2020 was even higher compared to previous month, from 17 vacancies in March 2020 to only two vacancies in April 2020, but in this case the level was similar to April 2019. For both sectors, there was recorded an increase of vacancies in May 2020, to 51 and five respectively, but the level was still below May 2019. For Other social work activities (NACE Q8899) a decrease was recorded in April 2020 (about three times fewer vacancies compared to March 2020, from 297 to 93), but also in May 2020, (from 93 to 82 vacancies) compared to the previous month.

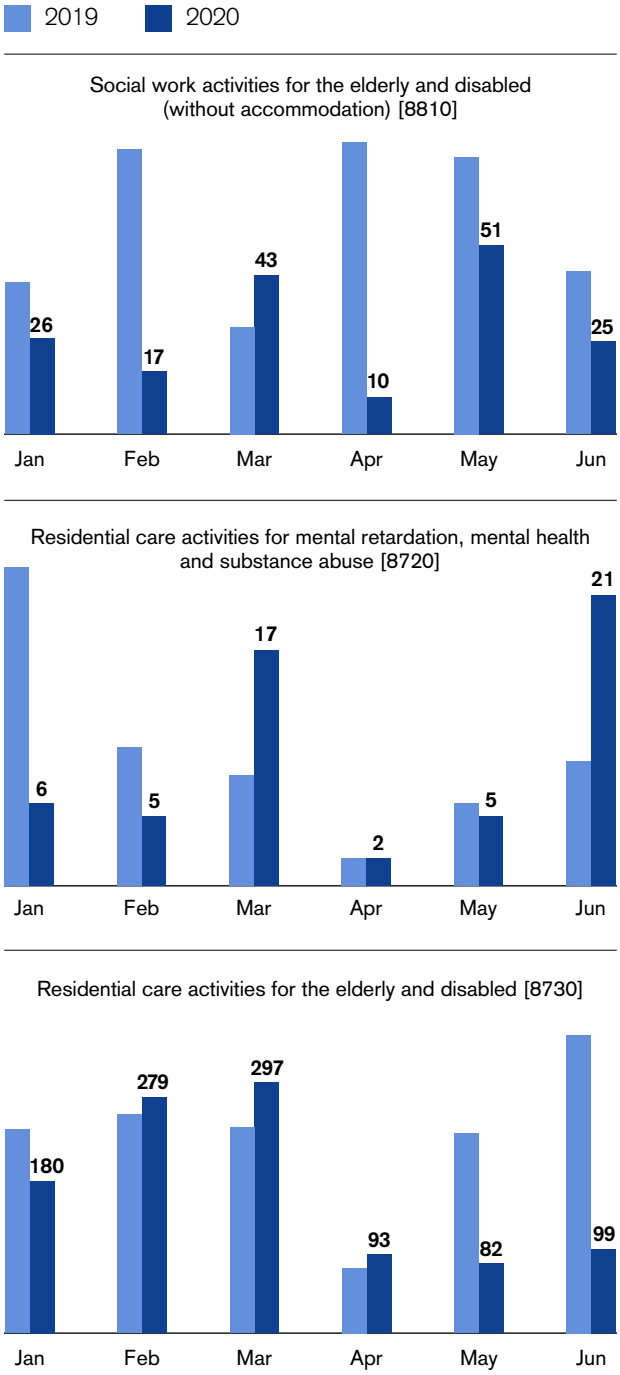
72 For the sake of clarity and comparability, please note that the NACE classification uses the term "mental retardation" instead of "intellectual disability".

73 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

74 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

Unlike in the Social work activities for elderly and persons with disabilities[75] (NACE Q8810) where the number of vacancies decreased in June 2020, in the other two cases (Child day care activities and Other social work activities) the number of vacancies increased in June 2020 compared to May 2020.

FIGURE 23 | Vacancies in Social work activities without accommodation (NACE Q8810[76], Q8891 and Q8899), January-June 2019 and January-June 2020



Source: own illustration based on the National Employment Agency (2020).

75 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

76 For the sake of clarity and comparability, please note that the NACE classification uses the term "disabled" instead of "persons with disabilities".

These developments should be treated in the light of the specificities of the social service system in Romania. As most of the social services are provided by public institutions, the fluctuation of personnel is very low. Also, desk research and interviews revealed that most of the labour fluctuations during the COVID-19 pandemic were in the private sector of social services (e.g. NGOs) and less in the public sector – even though the activities of day-care centres were suspended during the lockdown. The health system constituted an exception, since at the beginning of the COVID-19 pandemic cases of resignation were reported. However, in this case it is difficult to assess in how far these cases were blown out of proportion by mass media as the statistics regarding the number of workers who resigned are not conclusive. Also, many workers were employed as a result of the authorities' decision to allow employment without competition.

Undoubtedly, the COVID-19 pandemic had a profound impact on the workforce in the sectors of Residential care and Social work (NACE Q87 and Q88): the statistics clearly show disruptions and changes in trends during the months of lockdown compared to the period before and after and also compared to the similar period of 2019. However, it should also be taken into account that there are labour shortages, high level of migration among health care and social workers and that most of the social care workers are employed in the public sector of social services.

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COUNTRY REPORT

Finland

Organisation of Social Support Service Provision for Persons with Disabilities

Ageing of the population, together with associated multi-morbidity and related social challenges, has led to an increasing demand for health and social services. The Finnish welfare system follows the Nordic model where most services are funded and provided publicly, also in the case of disability services (EASPD 2018). The Finnish health and social care system is one of the most decentralised in Europe (Keskimäki et al. 2018). The Ministry of Social Affairs and Health coordinates the disability policy in Finland, but local authorities are responsible for its implementation. Municipally organised services and support enable people with disabilities to cope with their everyday life (Ministry of Social Affairs and Health 2020a). In addition to municipal services, the social services are also provided by private companies and non-governmental organisations. Part of the funds are provided by the central government in the form of central grants and also, in a small share, by the service users (EASPD 2018).

As the Finnish social protection system is equal, and people with disabilities have the same rights to pensions, reimbursements from the public health insurance as well as housing and other benefits. Disability services are provided in accordance with the Social Welfare Act (Finnish Parliament 2015), the Disability Services Act (Finnish Parliament 1988) and the Act on Intellectual Disabilities (Finnish Parliament 1977). Disability services and support comprise: providing assistive devices, home renovations, personal assistant, special services for people with intellectual disabilities (e.g. housing services, work and day activities, family care or institutional care), transportation services, rehabilitation, support for informal care, service accommodation and institutional care, family care, adaptation and rehabilitation guidance, financial support, interpretation services and employment. Recent developments in the health and social care system have increased the heterogeneity of the services provided. For example, in some regions, municipalities have merged the functions of primary and social care in joint authorities and hospital districts and formed integrated authorities for all health and social services. In other regions, municipalities have outsourced all or part of health and social services to private or public-private companies (Ibid.).

The Finnish governmental agency in charge of settling benefits under national social security programmes is the Social Insurance Institution of Finland (Kela). Kela provides three types of disability benefits (Kela 2020a): a disability allowance for people under 16 years of age[77] and a disability allowance for people aged 16 years or over[78] is paid to people who have a long-term illness or disability. Pensioners who have a disability or long-term illness can also benefit from a care-allowance.[79] For disability allowances (including the care allowance for pensioners), three rates exist:[80]

- ★ **Basic rate**: payable to people affected by illness or disability continuously for at least a year and the illness or disability causes significant impairment;
- ★ **Middle rate**: payable to people whose disability or illness causes significant impairment or regular need of guidance and supervision or who need continuous assistance with personal activities of daily life;
- ★ **Highest rate**: payable to people who have a severe disability, need high levels of daily assistance, guidance and supervision in personal activities of daily life (e.g. getting dressed, personal hygiene, mobility and social interaction), are blind, unable to move or prelingually deaf or are incapable of using the lower extremities when moving.

77 In Finnish: "alle 16-vuotiaan vammaistuki".

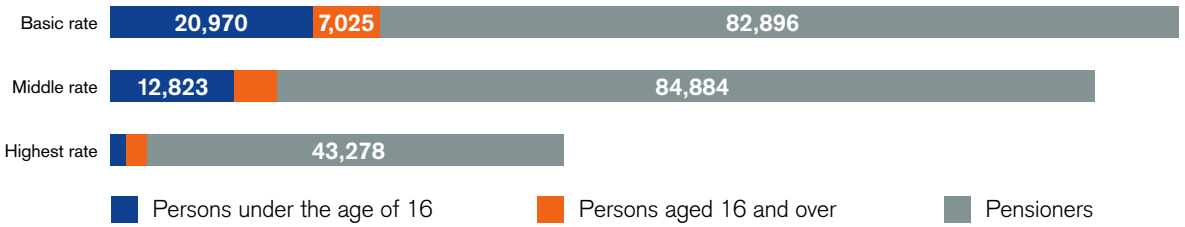
78 In Finnish: "16 vuotta täyttäneen vammaistuki".

79 In Finnish: "eläkettä saavan hoitotuki".

80 The disability allowances (per month) amount to 93.05 Euros (basic rate), 217.13 Euros (middle rate) and 421.03 Euros (highest rate).

Disability pension can be granted to people aged 18-62 who are part of the earnings-related pension system. It is provided to persons whom their ability to work decreased to the extent that they can no longer work. There are four options, which include a full disability pension, a cash rehabilitation benefit for a set period, a partial disability pension and a partial cash rehabilitation benefit.[81] Other special expenses can be covered for people who are entitled to a care allowance at the basic rate and to whom the illness or disability causes special expenses. In this case, they can be awarded a care allowance at the middle rate instead (Kela 2020b). Figure 1 shows the number of persons with disability by type of disability allowances received and age group.

FIGURE 1 | Distribution of recipients by type of disability allowances and age group (June 2020)



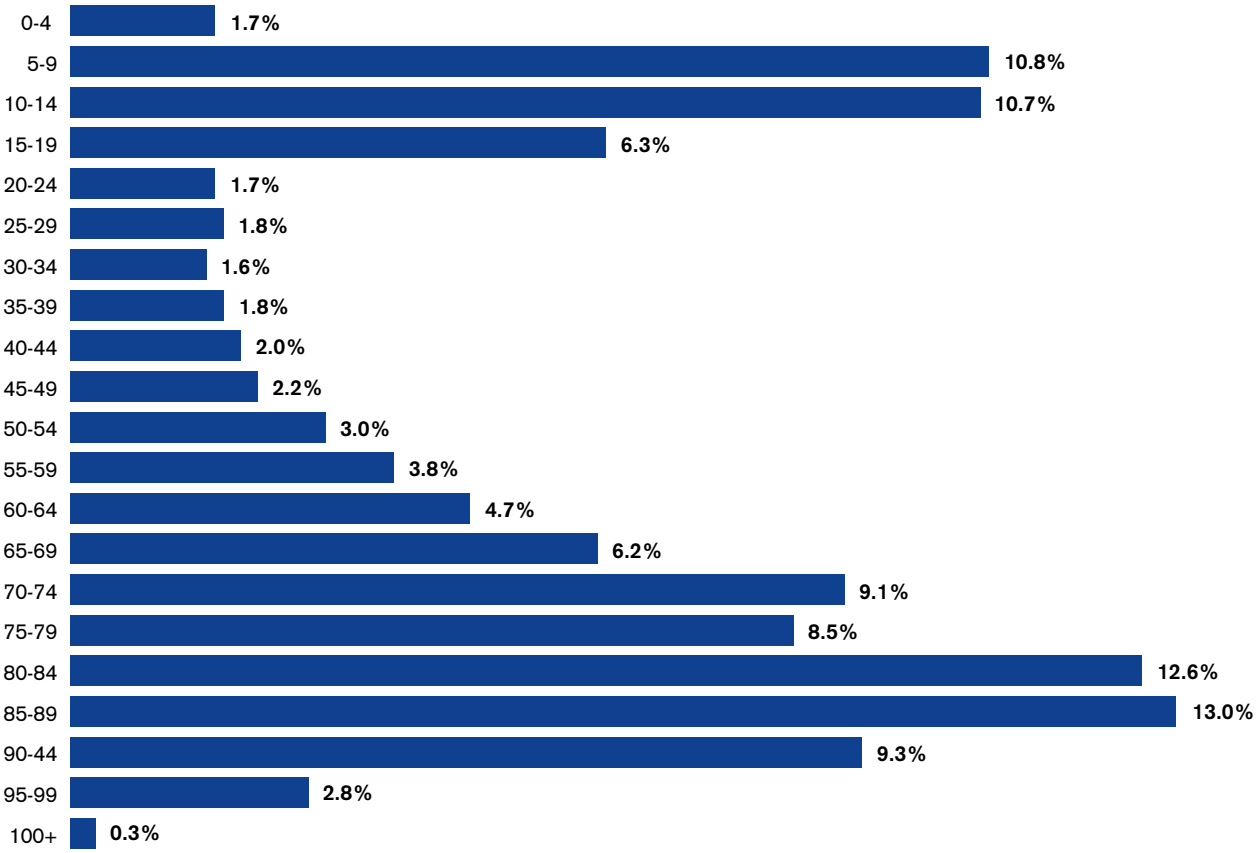
Source: own illustration based on the Social Insurance Institution (2020).

Pensioners are the most numerous recipients of the care-allowances. In 2019, there were 82,896 pensioners who received allowances at the basic rate (representing 74.7% of all recipients at this level). There were also 84,884 pensioners who received allowances at the middle rate (83.1% of those who received allowances at this level). Even though there were less pensioners who benefited by allowances at the highest level (43,278), their number accounted for 91.9% of all recipients of allowances at this level. Pensioners are followed, in terms of number, by people aged below 16. In 2019, they accounted for about 18.9% of those received care-allowances at the basic rate, 12.5% at the middle rate and 3.4%. People with age 16 and over, have represented about 6.3% of all recipients of allowances at the basic rate, 4.3% in case of middle rate and 4.5% in case of highest rate.

Kela also provides statistical data about the number of persons with disabilities by age, sex, categories of disease etc. According to Kela, on January 2020, there were 294,244 people with an officially recognised disability in Finland, which amounts to 3.9% of Finland's population. Among persons with disabilities, women constitute 59%. 23.2% of persons with disabilities were under 14 years old, while the over-50-year-oldse represented about 73.3% of persons with disability (Figure 2).

81 In Finnish: "täysi työkyvyttömyyseläke", "kuntoutustuki", "osatyökyvyttömyyseläke" and "osakuntoutustuki", respectively. Care allowance for pensioners (persons with disabilities) is also payable at the monthly rate of 71.21 Euros (basic rate), 155.15 Euros (middle rate) and 328.07 Euros (highest rate).

FIGURE 2 | Distribution of persons with disabilities by age group (in %, 2020)



Source: own illustration based on the Social Insurance Institution (2020).

In 2019, a total of 17,135 persons with disabilities received assistance in day or sheltered work centres (7,987 and 9,148, respectively) (Kela 2020c, Finnish Institute for Health and Welfare 2020).

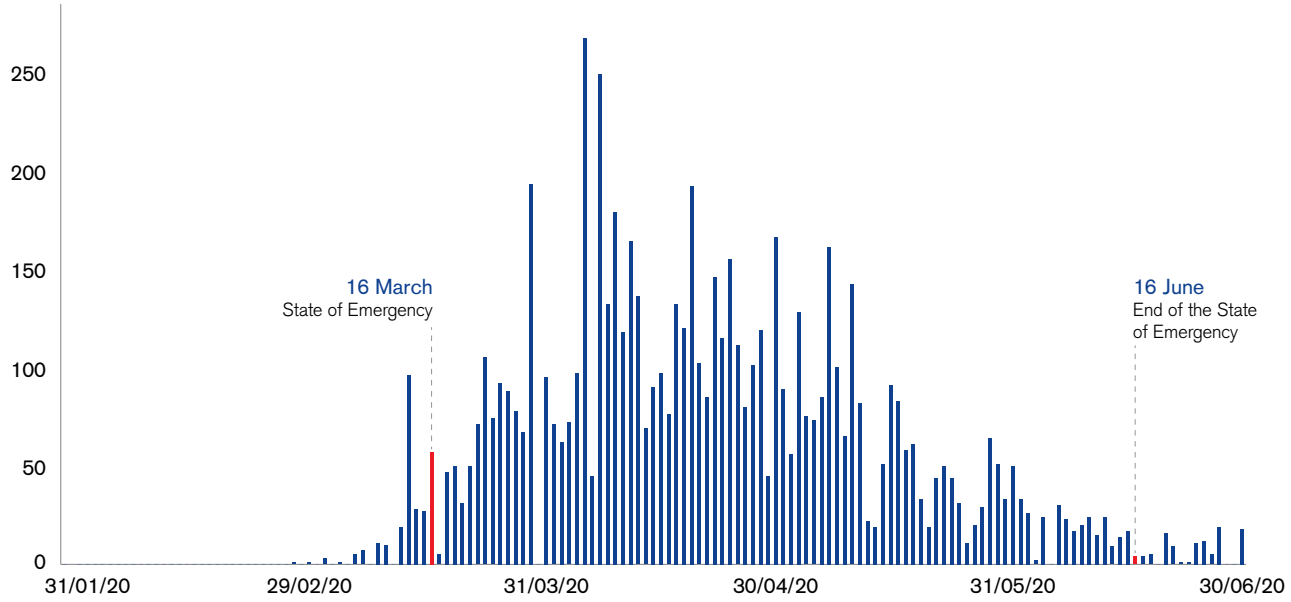
Regarding education, the legislation gives the right to basic education to everybody, including students with disabilities, and obliges public sector to fulfil this aim by, for example, improving the learning opportunities for pupils and students with special needs. The Government provides a special grant to education providers for pupils and students with (severe) disabilities. If their parents wish, children with all kinds of disabilities can study in the geographically closest mainstream school with the support of special teachers or special assistants. However, if children with disabilities cannot benefit from mainstream schooling due to, for example, the severity of their cognitive impairment, only then special education separate from their peers is provided by municipalities. In both mainstream and special schools, municipalities are expected to ascertain the physical accessibility as well as the social/cultural environment to meet the needs of children with disabilities.

Kela provides access to various types of rehabilitation and supports the economic security of clients. It is a way to help persons with an illness or impairment to live a full working life. The rehabilitation promotes the autonomy of persons with disabilities and improves or maintains their work capacity and coping with everyday life. Kela funds rehabilitation services and provides income security (Rehabilitation Allowance) when the person is in rehabilitation. Rehabilitation is based on an individual plan with a set of defined goals (Kela 2020d).

Government Measures for Coping with the COVID-19 Pandemic

The first infection with COVID-19 in Finland was registered on 29 January 2020. In the next two months, the number of cases increased and on 13 March 2020 there were a total of 156 confirmed cases. On 16 March 2020, the Finnish Government (2020a) declared the state of emergency and introduced the Emergency Powers Act. Figure 3 presents the evolution of new COVID-19 cases in Finland between 1 January 2020 and 30 June 2020.

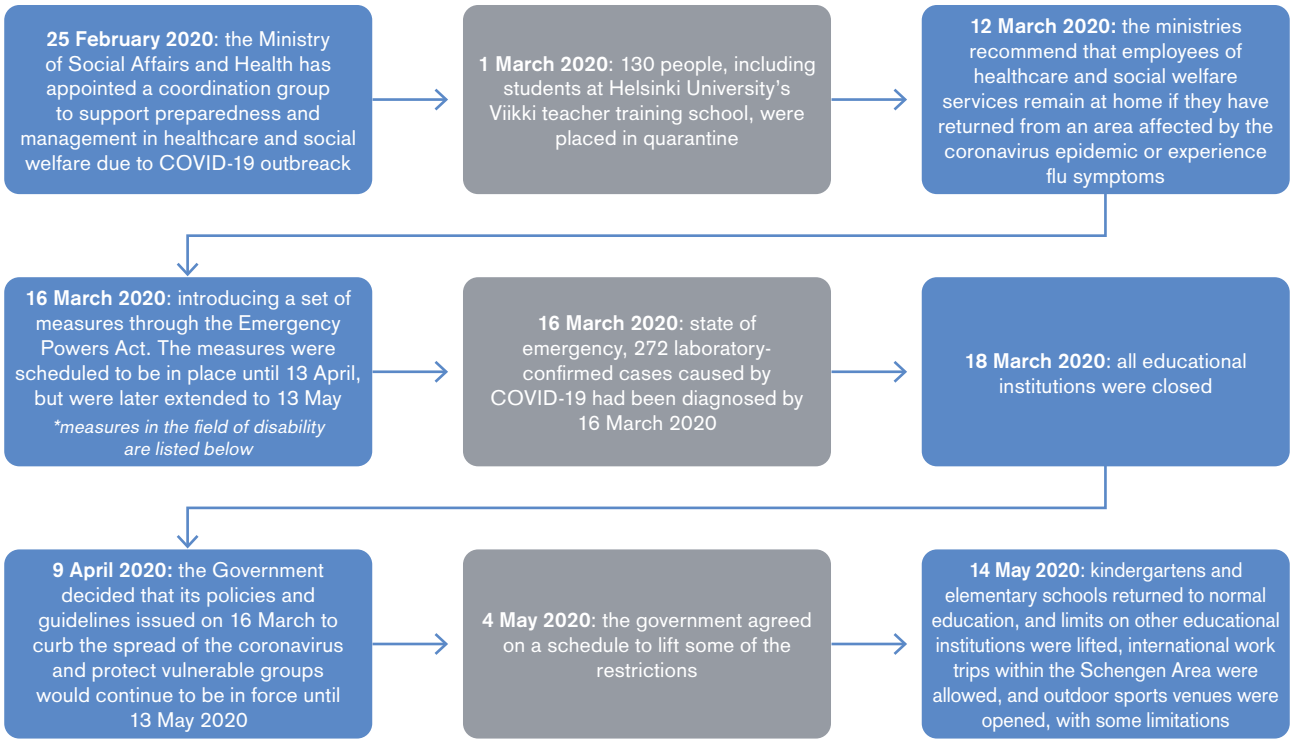
FIGURE 3 | Number of new COVID-19 cases (January-June 2020)



Source: World Health Organization (2020).

The Ministry of Social Affairs and Health (STM) had the responsibility for the general planning, guidance and monitoring of the prevention of infectious diseases. The Finnish Institute for Health and Welfare (THL) was also responsible for guidance and supported municipalities, hospital districts and regional state administrative agencies in their work to prevent infectious diseases. Furthermore, it provided public guidance on how to avoid infection and prevent the spread of disease. A timeline with measures adopted by authorities is presented in Figure 4.

FIGURE 4 | The timeline of response measures to Covid-19 pandemic (January-June 2020)



* The blue boxes contain information directly related to healthcare as well as services for the elderly and persons with disabilities; the grey boxes display general measures and developments.

Source: own illustration.

On 16 March 2020, the Finnish Government launched the following measures in the field of disability (Finnish Government 2020a):

- ★ Visits to housing services for the elderly and other at-risk groups were prohibited;
- ★ Visitors were banned from care institutions, health care units and hospitals, with the exception of asymptomatic family members of children and critically ill individuals;
- ★ Rehabilitation work facilities and workshops were closed;
- ★ The capacity of healthcare and social welfare services was increased in the public and private sectors. At the same time, non-urgent activities were reduced. The capacity of the private sector was mobilised for public use as necessary. At the same time, statutory deadlines and obligations were eased;
- ★ In the case of critical personnel, exceptions were made to the provisions of the Working Hours Act and the Annual Holidays Act in both the private and public sector;
- ★ Arrangements were made to oblige trained professionals in healthcare and social welfare, in particular, to perform work as necessary;
- ★ Off-line teaching continued to be provided for pupils who require it according to a decision on special-needs support; however, parents and guardians who were able to arrange childcare at home were still requested to do so.

During the spring, the instructions of the STM were followed in the implementation of the disability service. In addition, guidance was provided by THL, National Supervisory Authority for Welfare and Health (Valvira) and regional authorities. In early spring, it was stated that social services must be implemented even in special situations in accordance with the Social Welfare Act, despite the problems throughout the COVID-19 pandemic. In the provision of municipal disability services, restrictions were implemented in accordance with the Communicable Diseases Act in the operation of disability services, visiting bans and restrictions on movement. The access of relatives to care homes was restricted, but in some cases this also applied to persons with disabilities. As summer approached, outdoor visits were made possible and finally the visiting bans to care homes for the persons with disabilities were eased. In some localities, the preparation of service plans and special maintenance programmes were postponed to early summer, justified by the additional measures made necessary by the State of Emergency. This was also the case in municipalities with only a few infections or no infections at all. (Rissanen et al. 2020)q While the Emergency Powers Act had been applied to the entire country, the guidelines began to emphasise regional perspectives as the COVID-19 pandemic eased.

During the COVID-19 pandemic, the basic services required by the Disability Services Act were provided (care and treatment), but other social activities and services deteriorated. In general, decision-making processes at the municipal level concerning the services provided for the persons with disabilitie should always aim to resolve individual situations. However, even under normal circumstances, there are not enough individual implementations, and these problems were aggravated during the COVID-19 pandemic. Day care units and sheltered work centres[82] were closed almost completely throughout the country and as a result, some municipalities stopped paying work compensation for those who had received the sheltered work services. The payment of the compensation is at the discretion of the municipality, but the right to receive services in the context of sheltered work did not cease even though the work centres were closed. Therefore, even though the sheltered centres were closed, persons with disabilities should have been given the compensation according to their service plans. When the municipalities stopped paying compensation, this posed livelihood challenges for many persons with disabilities.

Furthermore, open and preventive services were widely wound down and cancelled. Only in early June 2020, the government agreed on resuming preventive activities in the field of disability services. However, the municipalities had reduced all their activities and transferred staff to COVID-19 operations, which is why day activities for persons with disabilities did not start properly until autumn. On 8 May 2020, the Ministry of Social Affairs and Health (2020b) published an information for municipalities, which stated that during exceptional circumstances, social and health care services cannot be completely discontinued and delays in their implementation must not endanger anyone's everyday survival and safety. It emphasised that access to services, especially for the most vulnerable, should be ensured. However, the government allowed the municipalities to deviate from care guarantees. This led to an increase in queues and disruptions in delivering

82 In Finnish: "vammaisten työllistämistoiminta".

the services. Therefore, the municipalities had to carefully consider the possible reduction of basic services, as the sufficiently extensive and active operation of basic services ensures the operational capacity of specialist care (Ministry of Social Affairs and Health 2020c).

Organisations and associations representing the interests of companies providing disability services, employees and the persons with disabilities themselves held close discussions with the STM in order to address the urgent issues in the field. Communication and guidance to members and customers were significantly increased, and websites, telephone services, webinars and newsletters were set up, especially related to information on COVID-19. At the beginning of the COVID-19 pandemic, the Finnish Government Situation Centre[83] asked disability and autism organisations to compile weekly situation reports on the situation of persons with disabilities, their relatives and workers in the field. In the summer, when the situation calmed down, it issued a review every two weeks.

Clarification of the guidelines was needed, to whom the guidelines were actually intended and how they should have been applied. Regulations remained relatively the same throughout the spring period, but as information and protection measures increased, ambiguity eased. Between May-June 2020, more detailed instructions were received, for example, on the user groups affected by the restrictions (e.g. elderly people). Some instructions were available in more language other than Finnish (as there are many persons with foreign background in disability services). It was highlighted the need of continuation of the prohibition of all visits of housing services but except visits by closest ones to the critically ill, children or persons in palliative care – without symptoms – as well as spouses or support persons, which could be authorised on a case-by-case basis.

During the spring of 2020, the caregivers' union was more frequently contacted for advice on how to cope with the pandemic. This resulted in the union extending on-call time and increased their help online and over the phone. The need for information indicated how scattered the information was and therefore it was important to be able to interpret the situation and the instructions of the authorities. The union took a digital leap: events, training, organisational training, information and communication with the field were carried out remotely. Unions and organisations invested in communicating and educating about the changing situation.

On 22 May 2020, restrictions were partially cancelled, but it did not concern older people. The Emergency Powers Act ended on 16 June 2020, since the current situation in the country no longer constituted a state of emergency (Finnish Government 2020b). Since the summer, total restrictions have been gradually eased, in line with the principle of proportionality and the law.

Effects of the COVID-19 Pandemic on the Provision of Social Support Services for Persons with Disabilities

The first phase of the pandemic begun the 20 January 2020 with the THL reporting cases of a new type of coronavirus in Wuhan, China. During the first phase, the disability services' need for information increased. THL provided information and counselling in different languages including sign language and plain language. In addition, counselling for people with disabilities was increased in many municipalities. Disability services have been concerned about protection and the availability of personal protective equipment (PPE). This was due not only to the ambiguity of the situation, but also to the heterogeneity of the group of persons with disabilities: the guidelines did not state very clearly how the protective equipment have to be used in every specific situation. Moreover, at the beginning of the pandemic, there was not enough PPE and then, when it was available, their use was regulated in terms of available quantities mainly because of the costs. Initially, protective measures focused on protecting the customer, but also the nursing staff had a strong concern that they would get sick or carry the virus into their home unknowingly. The mask recommendation was in effect in 24-hour care homes. Home service staff were instructed that masks should be used and should always be exchanged between sites. However, in many cases it was not possible due to the small number of masks available. Protective measures also reduced the time spent with persons with disabilities. Many persons with disabilities are still in constant need of help and support from another person and, therefore, do not have the opportunity to keep contact to a minimum. Protective instructions and the use of PPE were of particular concern to persons in need of personal assistance and their assistants.

83 The Government Situation Centre (in Finnish: "Tilannekeskustoiminta") functions under the authority of Prime Minister Office. It produces real-time reports and snapshots on the basis of information provided by the competent authorities.

There was particular concern among the elderly and those with an underlying risk-increasing illness or with a high degree of disability, e.g. in vital functions. Families and individuals with disabilities are often low-income, and many new services developed during the COVID-19 pandemic (e.g. shopping bag service) may have been financially impossible to use. Several services were also not accessible. There were also problems with the use of banking services. (Rissanen et al. 2020.)

The communication of the Ministry of Social Affairs and Health was the most significant source of information, and the unions, in turn, took the message from the field to decision-makers. There was a need for precise guidance and clarifications, leaving little room for interpretations. The information needs of people with disabilities and their relatives concerned their rights and changes in the services available to them. Some were also concerned about the illness itself.

The second phase of the epidemic, referred to as "Targeted Restrictive Measures", started with the Government resolution on 16 March 2020. It decided to put into effect the Emergency Preparedness Act. The government issued recommendations to avoid public events for more than 500 people. People returning from travel abroad were advised to stay at home in quarantine-like conditions, and teleworking was widely recommended. Other restrictive measures were also imposed, such as the temporary reintroduction of border control, the limitation of contact teaching and the possibility of flexibility in the deadlines for non-urgent health care. Public gatherings were limited to ten people, and those aged 70 and over as well as persons at risk were required to stay away from contact with other people (Government Communications Department 2020).

During the second phase, the needs of the disability services remained the same, but there was pressure to implement new solutions to meet the needs of the users. Disability services are essential basic services and cannot, as a general rule, be interrupted. During this exceptional situation, there were fears that the level of service would deteriorate permanently. Access to health care for persons with disabilities was also a concern for authorities. In the disability services, remote consultations were introduced, and daily services were transferred to the internet, but not everyone had a computer or was able to use it. In the private sector, service providers had already been using remote consultations and services, while to the public sector was lagging behind. Digital solutions (e.g. WhatsApp) were introduced for communication with the relatives of persons with disabilities. Even though they do not replace face-to-face communication, they increased the availability of services. Our interview partners reported that various kinds of services were affected differently: closing work and day activities were disrupted, but the availability of care homes remained unchanged during the pandemic.

Visitation bans were widely introduced in housing services. In some provinces, the Emergency Powers Act was misinterpreted, which meant that relatives of persons with disabilities were not allowed to visit housing services at all or, correspondingly, young people with disabilities were not allowed to go home on holidays. Quarantine guidelines were also unclear, and practices varied by region. PPE was difficult to obtain and the public debate over the use of masks was confusing. There were also some challenges in implementing short-term care.

The COVID-19 pandemic has made the lives of families of children with disabilities more difficult in many ways. There have been major challenges for coping with the situation, while services to support coping have declined significantly. In addition, short-term care sites were closed or advised to be avoided. The livelihoods of many families have been jeopardised. Students with special needs officially have the opportunity to receive education in their own school, but in reality, practices vary from municipality to municipality. (Rissanen et al. 2020.) In the families of children with disabilities, the services were not provided as usual and it was very difficult to get individual support at home. In this case, one or both parents had had to be absent from work.

During the third stage of the pandemic, extensive restrictive measures were introduced, which ended on 16 June 2020. A key restrictive measure here was the isolation of the province of Uusimaa from other provinces of Finland from 28 March to 15 April 2020. In the third phase, service-related practices varied across Finland. Some service providers increased support visits to the home, when others reduced home support and increased telephone support. The need for people with disabilities to talk was still great and calls to housing counsellors increased. The constant change in guidelines was causing uncertainty for both clients and employees. Customer segregation practices and the protection of other customers, as well as the relationship between sovereignty and restrictive measures raise questions about group housing. The guidelines were clarified so that restrictions on visits did not apply to necessary physical therapies or visits by personal assistants to housing units. In general, the continuity of services should have been better ensured. (Rissanen et al. 2020.) Occasionally,

there were problems with the availability and maintenance of assistive devices (assistive device services are provided free of charge to the residents of a municipality).

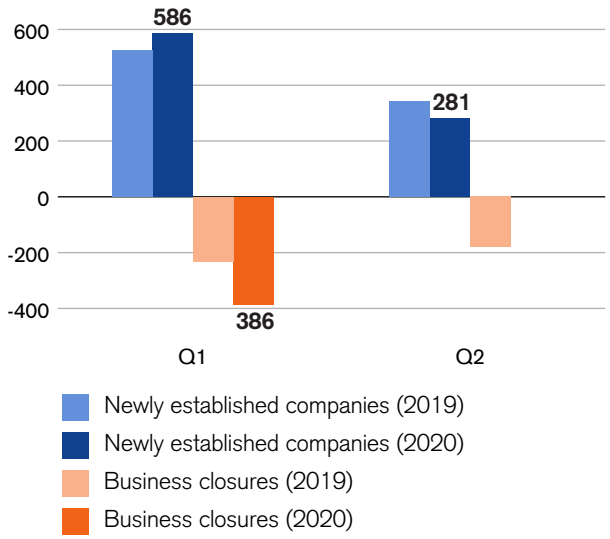
The recommendations on visiting bans concerned housing services for both, the persons with disabilities and the elderly, even though the idea was originally to protect those at risk, especially the elderly. Practices in care homes varied with the providers: some introduced a complete lockdown, which allowed only caregivers to move outside, limiting residents' sovereignty. Parents were also not allowed to meet their children if they lived in supported housing. However, in some units, customers moved normally in and outside the premises. The challenge for the caregivers was to communicate in an understandable and sufficient way to the customers about the pandemic and its potential risks, so that they could decide for themselves. This increased the ethical burden on caregivers. Visitation bans have had a weakening impact on communication for many people with disabilities, because their relatives were not able to help with communicating and interpreting the situation. Therefore, important support needs might not have been noticed or have been overlooked. It was not until mid-June 2020 that the Ministry of Social Affairs and Health stated that the ban on visits was not legally binding.

Municipalities and the areas of co-operation formed by municipalities were in very different positions in preparing for and responding to the pandemic. Currently, regional variations in services are due to the ability of municipalities to decide on the ways in which services are organised and the options available. Large associations of municipalities have had better opportunities and conditions to manage personnel and resources strategically. In integrated organisational models, the workforce has been able to be transferred between primary health care and specialist care, and the sectors have been managed more efficiently, as has the management of the traditional public health work required by the situation. There have been significant personnel changes and transfers between sectors in services.

Service Providers

Even though only partial quarterly data were available, they show that the business dynamic during the COVID-19 crisis differed from the similar period in 2019. In Q1 2020, more businesses in the Human health and social work activities (NACE Q) were closed than in Q1 2019. Also, as some restrictions were imposed, the business registration decreased in Q2 2020 (Figure 5).

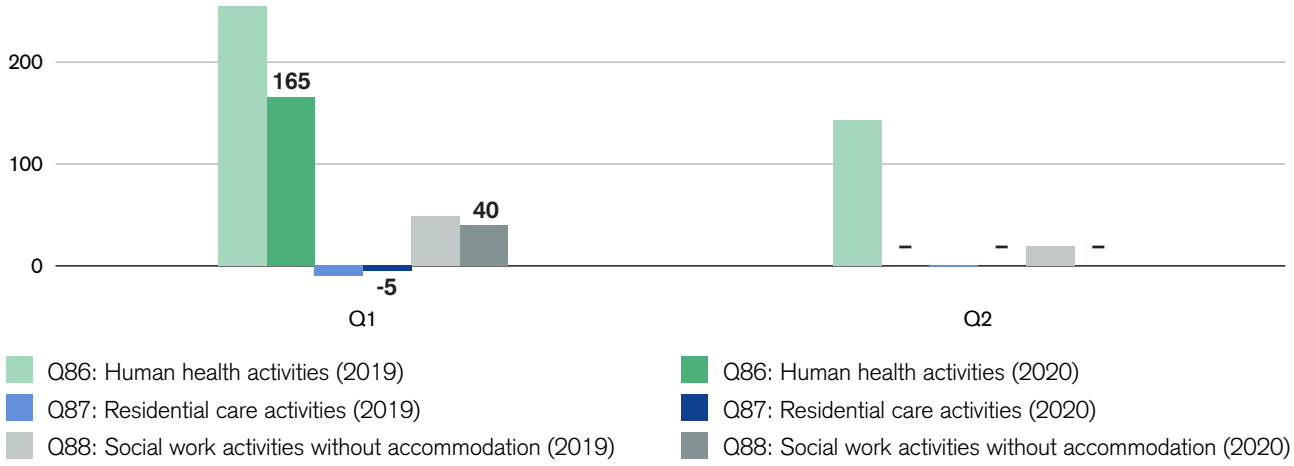
FIGURE 5 | Newly established companies and business closures in Human health and social work activities (NACE Q), Q1-Q2 2019 and Q1-Q2 2020



Source: own illustration based on Statistics Finland (2020).

At the time of writing this report, no data were available yet at NACE Q two-digit-level for Q2 2020 regarding the newly established companies and closures. However, when focusing only on Q1, in 2020 the net business formation for the field of Human health (NACE Q86) and Social work activities (NACE Q88) declined, compared to the same period of 2019 (Figure 6). At the same time, in Residential care (NACE Q87) the number of business closures was higher than that of newly established companies, both for Q1 2019 and Q1 2020. However, the net registration was not as pronounced in Q1 2020 compared to the similar period of 2019.

FIGURE 6 | Net business formations in Human health and social work activities (NACE Q), Q1 2019 and Q1 2020



* Methodological note: net business formations correspond to newly established companies minus business closures.

Source: own illustration based on Statistics Finland (2020).

However, the restrictions in Q1 2020 caused significant financial problems for companies in the field: although the number of customers has been maintained and generated a basic revenue stream, for example the costs of purchasing PPE have been significant. Due to safeguard regulations, service providers had to procure expensive PPE, because they had no emergency storages. While the revenues remained the same, this resulted in increasing costs. The government granted temporary support for the costs, but this support was available under certain conditions. Municipalities also provided support to sole proprietors. The Ministry and the Association of Finnish Municipalities informed that the municipalities were reimbursed 100% of the cost of PPE, but at the time of research the municipalities had not yet passed the compensation that they had received on to private service providers. It has to be noted that companies providing social services do not have the same statutory precautionary obligation as health care units. However, it was assumed that companies should have had stocks of PPE for three months. As most of the persons with disabilities living at their private home and using personal assistants, problems with the acquisition of PPE and compensation arose.

Overall, findings from interviews revealed that the COVID-19 pandemic has not had a particular impact on the large operators. Large players in the field (e.g. big private companies) are economically in a stronger position, but for NGOs that provide disability services on an organisational basis the prolonged pandemic and PPE requirements for can cause corporate reorganisation. Therefore, if restrictions will be imposed repeatedly, smaller players will struggle with continuity.

Scope and Quality of Services

The pandemic has had a major impact on the implementation of social support services for persons with disabilities. Even before central guidance, some municipalities started to provide alternative services, but the implementation varied from municipality to municipality and region to region. In some municipalities, contingency plans were already in place and were updated and implemented quite quickly. However, in some smaller municipalities it took a long time to react – especially if only few specialists were available. New service solutions were also developed during the COVID-19 pandemic (Kestilä et al. 2020) The potential for remote services varies from sector to sector, and especially in areas where physical presence is essential, service needs that have been put aside are building up. Many support measures and services, especially in the field of rehabilitation services, were temporarily discontinued and affected the clients. For example, it was reported that the closure of day care centres and peer support services particularly affected mental health rehabilitation patients. Additionally, there were some misinterpretations in the application processing and decision-making processes. Initially, it was instructed that municipalities could deviate from the assessment of service needs, except in urgent situations. It was later instructed that the right to depart from the due assessments does not apply to disability services and that deadlines must always be respected. Some municipalities ended up easing the situation of their customers and employees by automatically extending fixed-term decisions.

Another problem highlighted by the interviewed experts was the lack of alternatives to providing services for persons with disabilities, even though the legislation is based on individual needs. Temporary and short-term care services were not available and there were problems in obtaining personal assistance, especially in leisure time. Children with disabilities also did not receive sufficient support for distance learning. Initially, rehabilitation services were transferred entirely to remote services, which was perceived as very challenging both by employees and users.

In the basic care, new ways of working were quickly introduced in companies and organisations. In terms of protection, the level of information was good in advance, but it took more time to obtain the equipment. Out interview partners stressed that local municipalities should have guided the measures taken in each municipality (e.g. hygiene instructions). Certain guidelines allowed a great deal of discretion for service providers, and in some regions very categorical, total restrictions were placed on normal operations. As a result, persons with disabilities were disadvantaged, since many of them do not have the capacity to defend their own rights. Moreover, not all municipalities had up-to-date hygiene or contingency plans. Hygiene training and basic protection training were provided in the disability service units and staff were also offered psychological guidance in those units where cases of illness (or deaths) were diagnosed.

During the pandemic, normal social welfare legislation was followed by the service providers. It was outlined at an early stage that services for persons with disabilities should be organised in the usual way and the responsibility for organizing municipal disability services was also not reduced. In reality, suitable forms of organizing the services may not have been available for persons with disabilities. Despite the exceptional circumstances, customers were entitled to the services of their needs, and the employer did not have the right to violate occupational safety regulations, for example regarding lack of protective equipment.

The sudden stopping of services, such as daytime activities, or the inability of a person to return to services, for example after a temporary break at home, due to suspicion of exposure or unit restraint measures, have burdened relatives. For working relatives, situations may have meant compulsory absence from work and, at the same time, loss of earned income when the responsibility for assistance and care has been transferred to the relative. There was only a little co-operation and communication between service purchasers, i.e. municipalities and service providers, although the municipalities should have been guiding the measures taken locally. Service providers conscientiously complied with regulations and sought solutions to secure communication between customers and their relatives.

It is estimated that if the restrictive measures would have continued for another six months or if the restrictive measures had been re-introduced the service needs for the people with disabilities would have remained the same or increased. When, due to restrictive measures, non-urgent care has been postponed in different service entities, service needs accumulate in queues. (Rissanen et al. 2020). The pandemic situation has further demonstrated the weakness of group housing, as large units easily end up in a situation where the disease can spread quickly and cause a lot of destruction. However, the COVID-19 virus did not spread much in care homes for persons with disabilities. The situation was particularly difficult for persons with living on their own, as in many instances they were not able to receive the much-needed services during the COVID-19 pandemic and also their other contacts were reduced to a minimum. As a result, some people with disabilities moved back to their childhood homes.

During the COVID-19 pandemic and Emergency Powers Act, the rights of persons with disabilities to social relations and movement were unlawfully restricted, despite the fact that the pandemic is an exceptional occurrence. Persons with disabilities were concerned for their loss of sovereignty. It is very important to take better account of individual needs in the services and to clear the accumulated care debt. It is also necessary to provide strong support for families left alone during this long pandemic.

Care homes may have introduced regulations and practices that have illegally restricted people's lives. In the early stages of pandemic, for example, the visits of therapists, interpreters or assistants to a resident were in some cases prevented. In addition, the movement of residents inside and outside the unit was controlled without legal grounds. In this context should be noticed a complaint registered at the European Committee of Social Rights regarding the violation of the rights of persons with disabilities in institutions during the pandemic (Collective Complaint, Validity Foundation 2020). One of the main subject of this complaint was regarding the "measures that led to an almost complete isolation of persons with disabilities in these facilities (residential units), depriving them of contact with their families, friends and communities, as well as necessary support services, personal assistance,

rehabilitation, habilitation and medical services that helped them carry out their day to day lives".

In the next few years, disability legislation will be reformed in the context of Finland's health and social services reform. The draft disability legislation is based on individual needs and individual ways of organizing services and follows the principles of the UN Convention on the Rights of Persons with Disabilities. At the same time, the limits of diagnosis would also be overcome, and services would not be provided only according to certain disability groups and presumed service needs but according to individual needs. Health and social services reform would also reduce regional disparities in Finland, which are currently too great.

In the future, technology is expected to affect the way services are implemented, as well as training and competence development in the field. New good practices developed must be continued. The most important new ways of implementing services were different e-services. Also new safer ways to meet the loved ones have been developed, such as meeting outdoors. Considering the limitations of the pandemic, new creative practices have been developed to meet the everyday needs of persons with disabilities. The recovery of the services is still very slow and there is not yet enough variability available.

Furthermore, the interviewed experts reckoned that the cooperation between the private and public sectors will improve in the future, as both actors are important on the social care market. It is expected also that in the future, entrepreneurs, companies and non-governmental organisations will voluntarily better prepare for possible crises and maintain up-to-date self-monitoring, preparedness and hygiene plans.

Workforce

The COVID-19 pandemic had complex effects on employment, unemployment, vacancies, working time and also on the quality of services that employees in the field of disability should provide. The Emergency Powers Act was really significant for nursing staff: it gave the employer the right to deviate from the agreed working hours, not to grant annual leave and extended the notice period to four months. At the same time, some of the staff were laid off, especially those in daytime activities, but simultaneously others had to work overtime. This concerned especially those units where people with disabilities (would have) reacted strongly to changes in their caregivers. Furthermore, closure of work and daytime activities increased staff redeployment as well as workload in housing services units. Overtime was not always compensated in breach of the existing collective agreement.

During the first phase of the COVID-19 pandemic, there were some staff shortages in the social support services, and it has been difficult to get substitutes to the housing units. According to the Emergency Powers Act, health care could be deployed to work in other jobs, but this option was not used extensively. A big challenge in the early stages of the pandemic was finding staff. Therefore, the nursing staff worked a lot overtime. Some housing units did not add cleaning resources, so caregivers and nurses had to perform the required additional cleaning themselves, such as wiping the door handles many times a day. Household chores, such as cooking, which were previously done together with the residents, also remained the responsibility of caregivers due to new hygiene regulations. This reduced the time allocated for care of persons with disabilities. Despite the increase in the need for services (daily activities, information needs), the number of caregivers decreased in general. The prolongation of waiting times for care increased customer restlessness and disruptive behaviour. Some residents of housing units remained in their childhood homes during the COVID-19 pandemic due to visiting bans. As a result, some housing units had more workers than usual in relation to the number of residents. However, the higher levels of staffing did not necessarily result in higher quality of service or the increase in appropriate activities for residents.

In the spring, the caregivers were feeling very tired, without a promise of forthcoming summer holidays, since according to the Emergency Powers Act no holidays were granted or were granted only for two-week periods. Even after the end of the Act, some of the employers were reluctant to grant holidays. During the Act, employees could not even change jobs, as the notice period was extended to four months. The lack of days off and holidays has led to frustration among employees. Moreover, the interviews revealed that the staff have been disappointed that they have had to be inadequately protected at work under the threat of their own health. The unions sought compensation for caregivers, but there was no reply from the state.

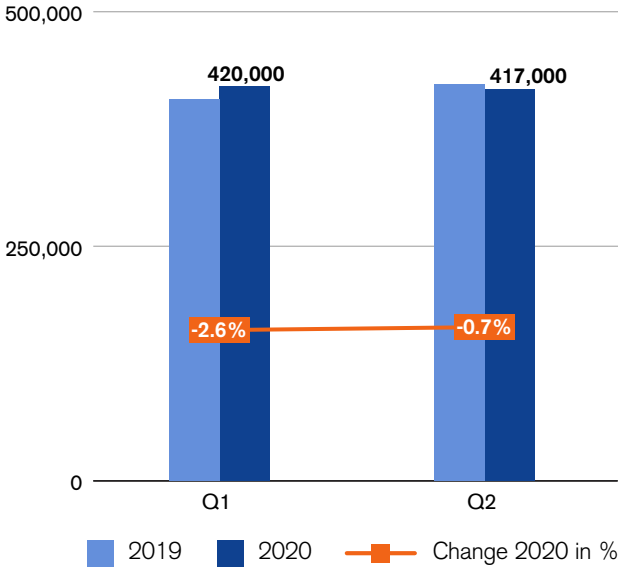
Nursing staff should have had access to the PCR-tests in the first place, but this did not materialise as promised. Some staff were also at work when sick, at the behest of their employer due to the shortage of staff and substitutes. For the staff, the workload, staff sizing, and PPE were the most discussed topics. Moreover, staff absences

increased due to absenteeism for small symptoms and long PCR testing times. Staff working days were long and the number of working days increased significantly for gig workers.

The primary source of information for staff was the employer and then the union representatives or occupational health and safety officer. For example, regarding the use of a mask, the employer defined the course of action. Digital tools were quickly introduced for the services provided, but there was no time to train staff properly. The new tools have required a lot of learning and a change of attitude from many. Also, in the early stages of the pandemic, statutory in-service training for the staff was cancelled or postponed, and vocational training shifted to distance learning. All in all, COVID-19 pandemic has brought up the need for additional training in digital literacy and security practices.

Employment: on 1 January 2020, 407,000 persons were working in the sector of Human health and social work (NACE Q) (Statistics Finland 2020); of these 41.8% were employed in Human health activities (NACE Q86), 24.3% in Residential care activities (NACE Q87) and 33.9% in Social work activities without accommodation(NACE Q88). The number of employees in the whole sector fluctuated strongly in the first half of 2020. About 10,000 less people were employed in the Q1 2020 compared to the previous quarter, corresponding to a decrease of about 2.6%. In Q2 2020, a slight decrease of only 0.7% was recorded, compared to Q1 2020 (Figure 7).

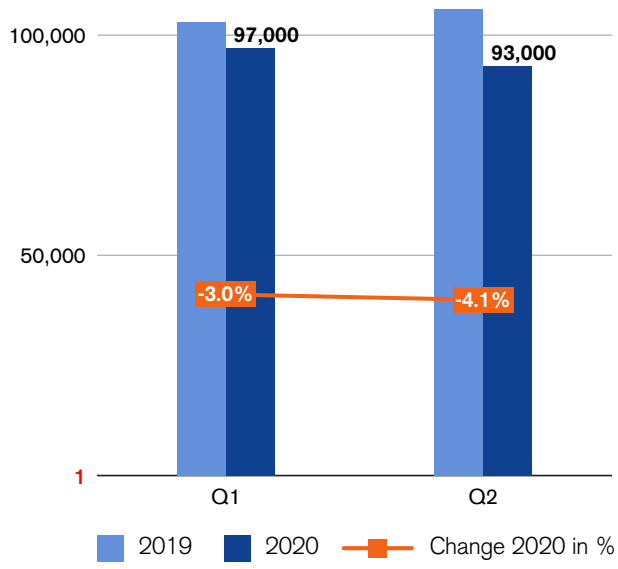
FIGURE 7 | Employed persons in Human health and social work activities (NACE Q), Q1-Q2 2019 and Q1-Q2 2020; change in 2020 compared to the previous month



Source: own illustration based on Statistics Finland (2020).

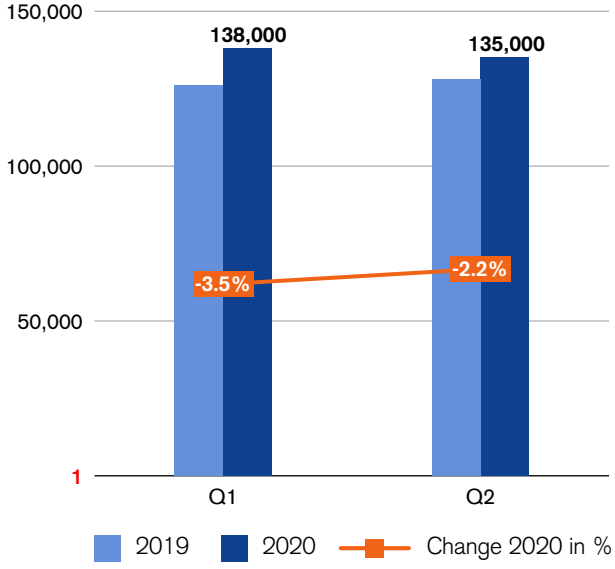
If we look more in-depth at the trends of the employed persons in Human health and social work sector (NACE Q), we see that actually only the trend for Residential care and social work activities (NACE Q87 and Q88) reversed over time, while in the Human health activities (NACE Q86) they kept the same direction. For instance, in Human health activities (NACE Q86) there were more people employed in Q2 compared to Q1, both for 2019 and 2020. However, the increase in Q2 2020 compared to Q1 2020 (2.2%) was lower than in Q2 2019 compared to Q1 2019 (6.2%). On the other hand, in Residential care activities (NACE Q87), trends in the number of employed people were very different in 2020 compared to the same period of 2019 (Figure 8).

FIGURE 8 | Employed persons in Residential care activities (NACE Q87), Q1-Q2 2019 and Q1-Q2 2020; change in 2020 compared to the previous month



Source: own illustration based on Statistics Finland (2020).

FIGURE 9 | Figure 9: Employed persons in Social work activities without accommodation (NACE Q87), Q1-Q2 2019 and Q1-Q2 2020; change in 2020 compared to the previous month



Source: own illustration based on Statistics Finland (2020).

Thus, in Q1 2020 there were 3,000 less persons employed in NACE Q87 compared to the previous quarter (this accounted for a decrease of 3%), while in the same period of 2019 there were about 9,000 more people employed compared to the previous quarter. The decline intensified in Q2 2020 – all this quarter was covered by the state of emergency – when there were 4,000 less persons employed into this sector compared to the previous quarter, representing a decline of about 4%. The trend was reversed compared to the same period of 2019, when there were 3,000 more persons employed compared to the previous quarter.

In the case of Social work activities (NACE Q88) (Figure 9), in Q1 2020, there were more persons employed compared to the same time-period in 2019. In Q2 2020, their number decreased by 2.2% compared to Q1 2020, while in 2019 the trend was reversed: more people were employed in Q2 2019 compared to Q1 2019. In Q1 of 2020, there were 5,000 less persons employed compared to the previous quarter.

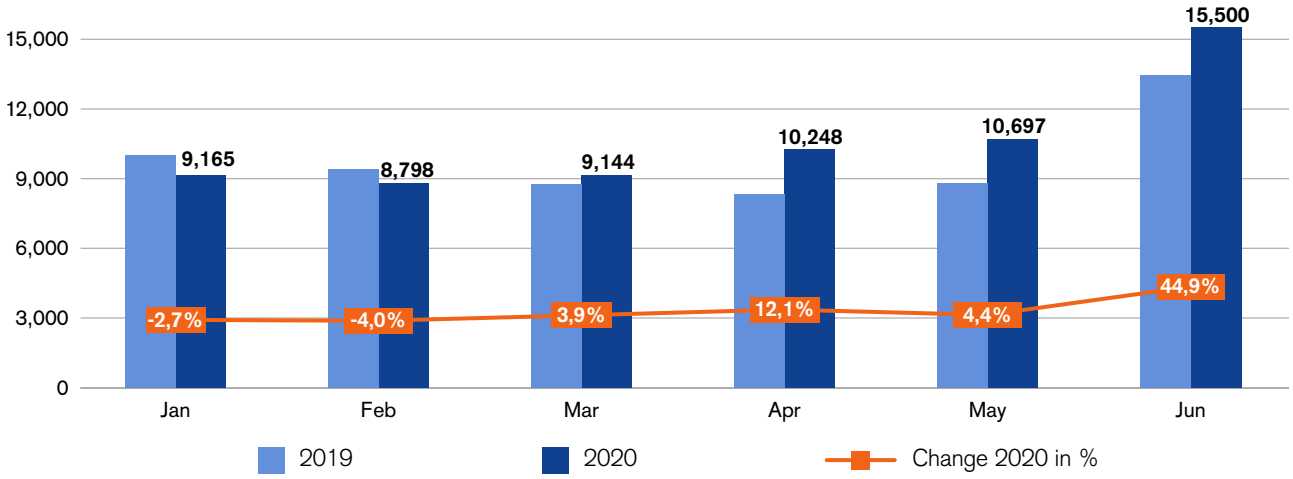
These changes in employment could be, to some extent, a result from seasonal effects, but desk research and interviews confirm also the effect of the COVID-19 pandemic. For example, as the pandemic continued, the risk of fatigue and exhaustion of social and health care personnel increased. In addition, widespread illness of staff led to staff shortages and challenges in arranging replacements. On the other hand, the prolongation of the situation increased the importance of the third sector and volunteering as part of the social welfare system (Rissanen et al. 2020).

Unemployment: data available on jobseekers, laid-off employees and people with shortened working time in the category of Nursing and Social Care Professionals provide an insight on the impact of COVID-19 on disability field.[84] Overall, the number of jobseekers in this category was lower in January and February 2020, compared to the similar months of 2019 (e.g. 9,993 jobseekers in January 2019 and 9,391 in February 2019 vs. 9,165 in January 2020 and 8,798 in February 2020) (Figure 10). However, once the crisis progressed and first restrictive measures were imposed, a reversed trend emerged. Thus, in March 2020, there were 3.9%

84 In this analysis, the Nursing and social care professionals comprise the following sub-groups of ISCO-08 occupational classification: Occupational therapist (32590), Instructor of the handicapped (34121), Social Instructor (34122), School instructor (53120), Practical nurse (53210), Personal assistant (53220), Home assistant (53222), Home service worker (53223), Other home care workers (53229).

more unemployed persons compared to previous month and also 4.4% more compared to the same month in 2019. The increase accelerated in April 2020 (12.1% more jobseekers compared to the previous month) and slightly declined in May 2020 (4.4% compared to April 2020). However, the number of jobseekers increased considerably again with 44.9% between May and June 2020. This could be a seasonal effect, as also in June 2019 the number of jobseekers increased compared to May 2019. The increase reinforced by the new graduates usually entering the labour force in June.

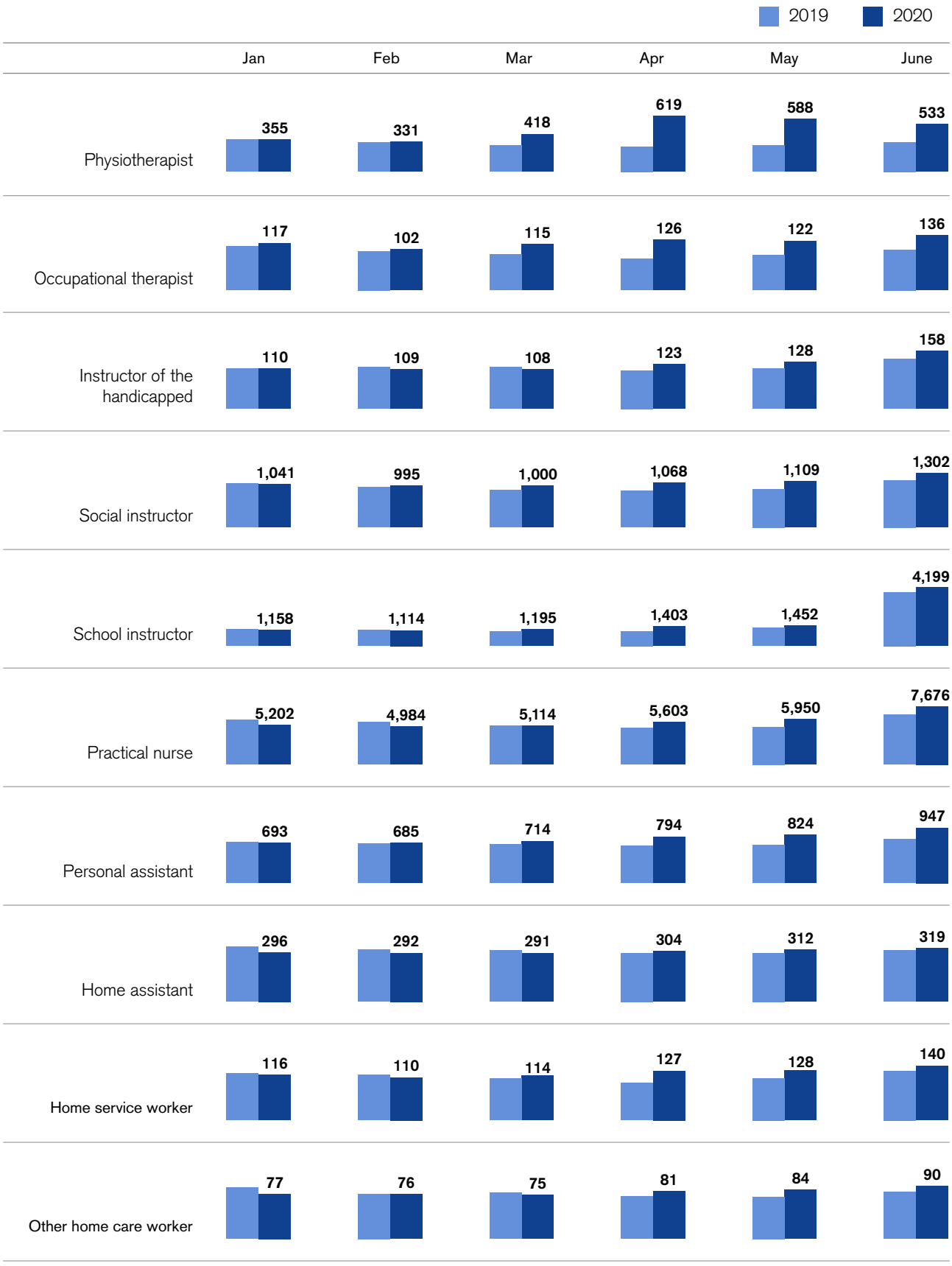
FIGURE 10 | Jobseekers in the category of Nursing and Social Care professionals, January 2019-June 2019 and January 2020-June 2020; change in 2020 compared to the previous month



Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

When focusing on each occupational group from the category of Nursing and Social Care professionals, the exact effects become more visible (Figure 11). The strongest impact was recorded in the occupational group of Practical Nurse. At the beginning of the year of 2020, including March, the number of jobseekers in this group was lower than in the similar period of 2019. However, it rocketed in April 2020 when 782 more jobseekers were recorded compared to April 2019. The number continued to increase in May 2020, with 984 more jobseekers compared to May 2019 and even in June 2020 when there were 1,071 more jobseekers than in June 2019. A strong impact was also recorded in the group of Physiotherapists. In March 2020, there were 124 more jobseekers compared to the similar period of 2019. In the following months, their number increased, so that in April 2020 there were 340 more jobseekers than in April 2019. Also the group Social Instructor was affected, where the number of jobseekers increased sharply in March 2020 with 100 more persons compared to March 2019, and with 187 persons in April and 188 persons in May, respectively (compared to the same months of 2019). Other occupational groups that were strongly affected were School Instructor, Personal Assistant and Instructor of the Handicapped.

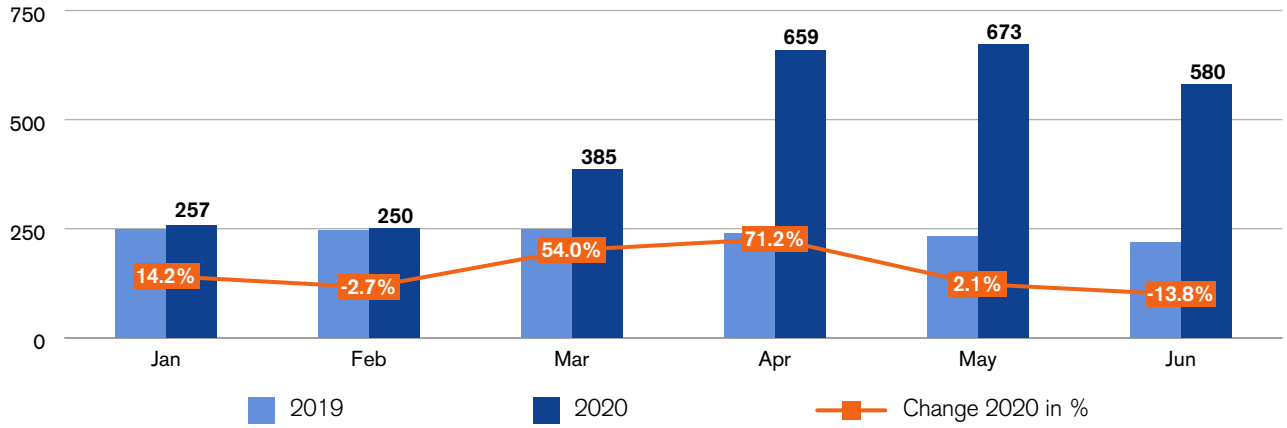
FIGURE 11 | Jobseekers by occupational groups in the category of Nursing and Social Care Professionals (January-June 2019 and 2020)



Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

The changes were not only on the number of jobseekers, but also on number of persons with shortened working time. Once the COVID-19 crisis emerged, the number of people who had their weekly working time shortened sharply increased (Figure 12). For example, in March 2020 there were 54% more people with shortened weekly working time compared to February 2020. At the middle of crisis, their number rocketed, with 71.2% in April 2020 compared to the previous month. Even though in May 2020 the trend stabilised (only a 2.1% increase compared to April 2020), it was, however, by a third higher than in May 2019. In June 2020, the trend started to decrease, being registered 13.8% fewer people with shortened working time than in the previous month, but still much higher than the level reached in the similar period of 2019.

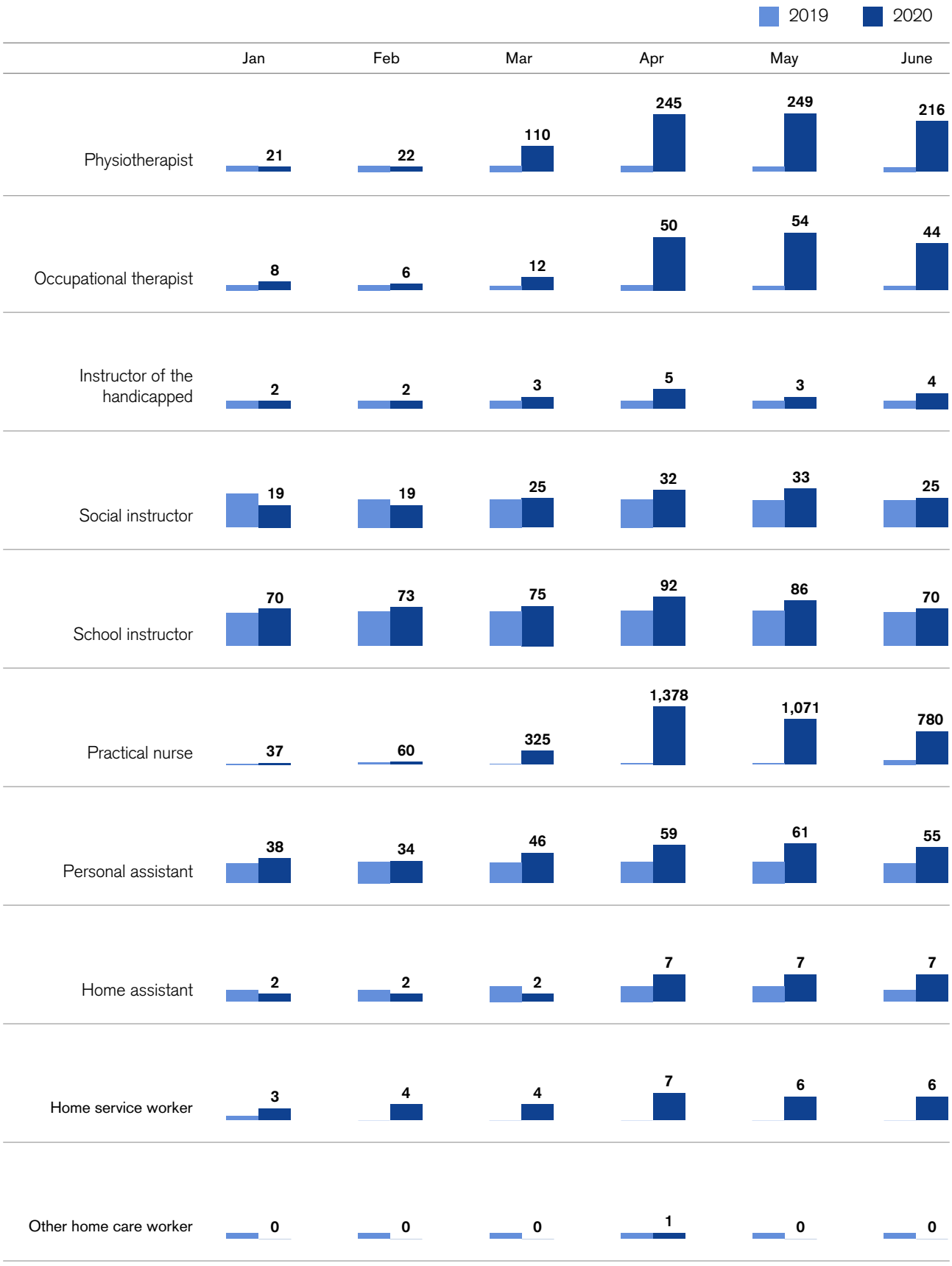
FIGURE 12 | Persons with a shortened working week in the category of Nursing and Social Care Professionals, January 2019-June 2019 and January 2020-June 2020; change in 2020 compared to the previous month



Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

Also, data about people with shortened working week at each occupational group level from the category of Nursing and Social Care Professionals were available (Figure 13). Concerning employees whose working hours were shortened, their number rose sharply in the occupational groups Physiotherapist and Occupational Therapist – and to somewhat lesser extent Practical Nurses – between February and March/April 2020 (Figure 13). Notably, such fluctuations could not be observed during the same time period in 2019. While the situation recovered somewhat in June 2020, the numbers did not return to the previous levels at the beginning of that year.

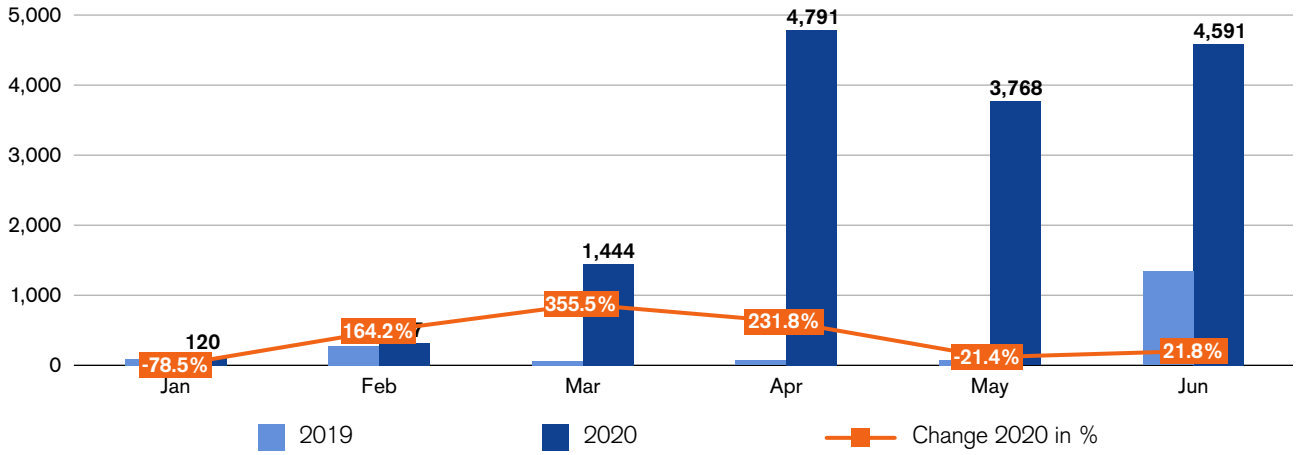
FIGURE 13 | Persosn with a shortened working week by occupational groups in the category of Nursing and Social Care Professionals (January-June 2019 and 2020)



Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

The number of entries into unemployment in the category Nursing and social care professionals was relatively low in 2019 (between 86 persons in January 2019 and 1,338 in June 2019) (Figure 14). However, during the COVID-19 pandemic in 2020, the number sharply increased. For instance, in March 2020 there were 1,444 entries into unemployment (an increase of 355.5% compared to the previous month) and 4,791 in April 2020 (231.8% more than in March 2020). In the same months of 2019 (March and April), only 58 and 68 entries into unemployment were recorded, respectively. In May 2020, a decrease of 24.4% was recorded (compared to April 2020), but an increase in number was recorded in June 2020 (with a 21.8% increase in entry into unemployment compared to the previous month).

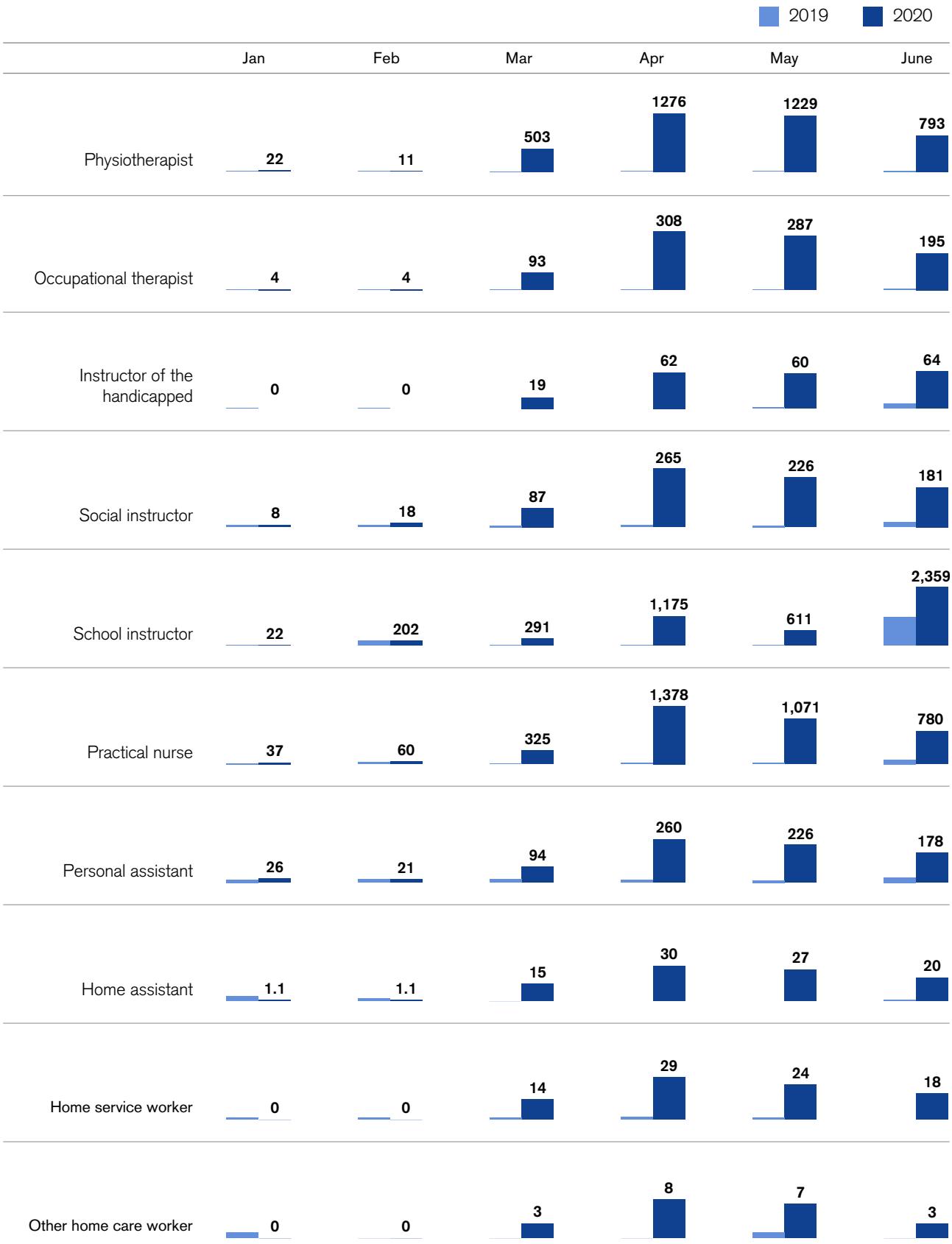
FIGURE 14 | Entries into unemployment in the category of Nursing and Social Care Professionals, January 2019-June 2019 and January 2020-June 2020; change in 2020 compared to the previous month



Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

In all occupational groups, the number of entries into unemployment was much higher in 2020 than in 2019 (Figure 15). In case of occupational group of Physiotherapist, the increase was particularly pronounced in the first months of the COVID-19 pandemic (March-June 2020) compared to the similar period of 2019. For example, in March 2020 503 physiotherapists entered unemployment, compared to only 3 in March 2019. In April 2020, the increase rocketed to 1,276 people, while in the same month of 2019 there were only 7 people. The level remained somehow constant in May 2020 (1,229 people, just 7 in May 2019) and started to decline in June 2020 when 793 entries into unemployment were recorded – considerably more than there had been in June 2019. The effects of the COVID-19 pandemic on the workforce, materialising in increased entries into unemployment, were strongest in April 2020. Once the restrictions were cancelled (by the end of May 2020), the number entries into unemployment started to decline but remained considerably above the level recorded in the same month of 2019.

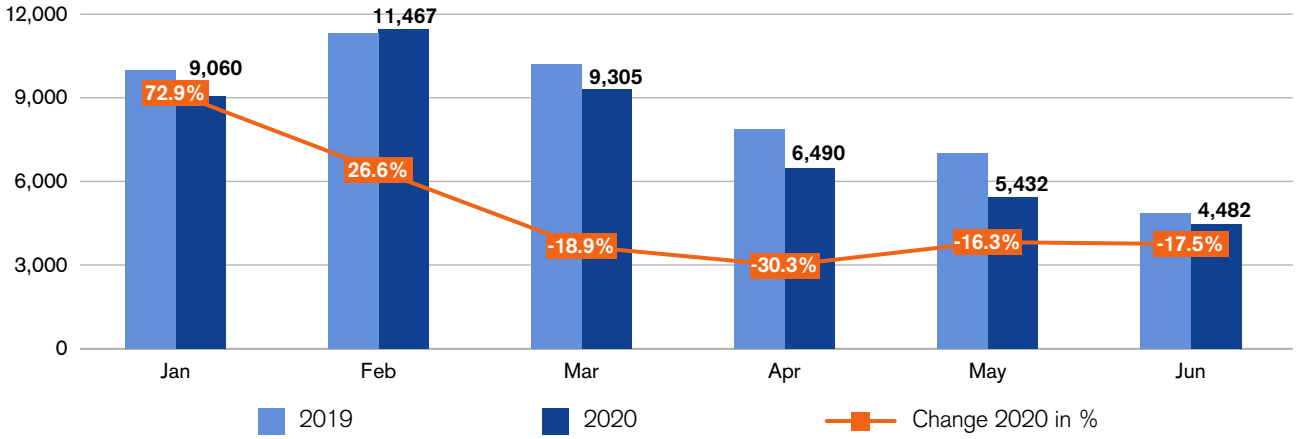
FIGURE 15 | Entries into unemployment by occupational groups in the category of Nursing and social care professionals (January-June 2020)



Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

Vacancies: the vacancies in the field of Human health and social work (NACE Q) increased by 26.6% in February 2020 compared to the previous month (Figure 16). However, once the state of emergency was imposed in March 2020, the number of vacancies decreased every month. The highest decline was recorded in April 2020, amounting to 30.3% compared to the previous month. Moreover, the decreases in vacancies during the COVID-19 pandemic in March-June 2020 were considerably higher than the fluctuations recorded in the same time period in 2019.

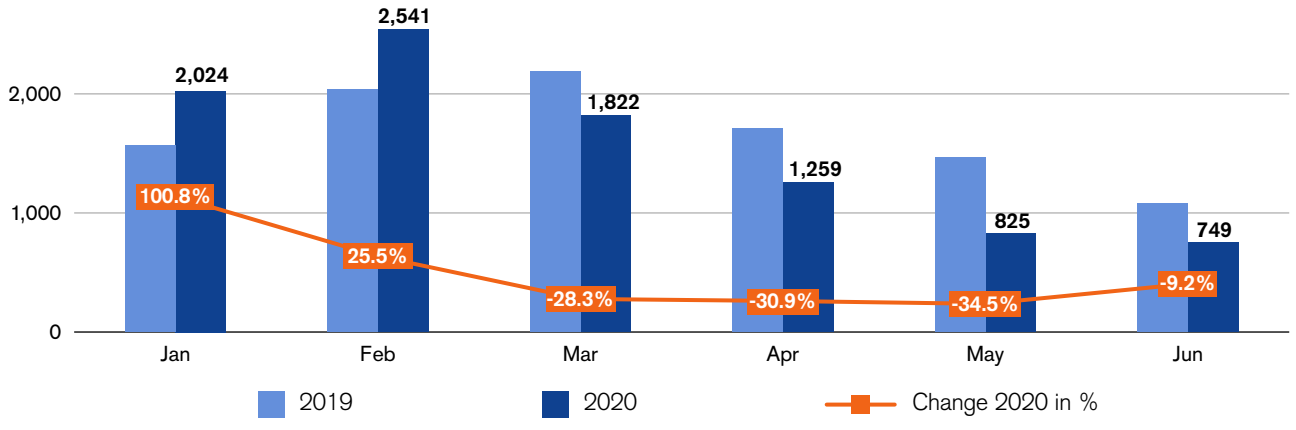
FIGURE 16 | Vacancies in Human health and social work sector (NACE Q), January-June 2019 and January-June 2020; change in 2020 compared to the previous month



Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

When focusing separately on Residential care (NACE Q87) and Social work activities without accommodation (NACE Q88), the impact of measures taken during the state of emergency (March-May 2020) revealed a similar pattern: an increase in the number of vacancies in the first two months of the year (January and February 2020) and a decrease in the number of vacancies in the subsequent four months.

FIGURE 17 | Vacancies in Residential care (NACE Q87), January-June 2019 and January-June 2020; change in 2020 compared to the previous month

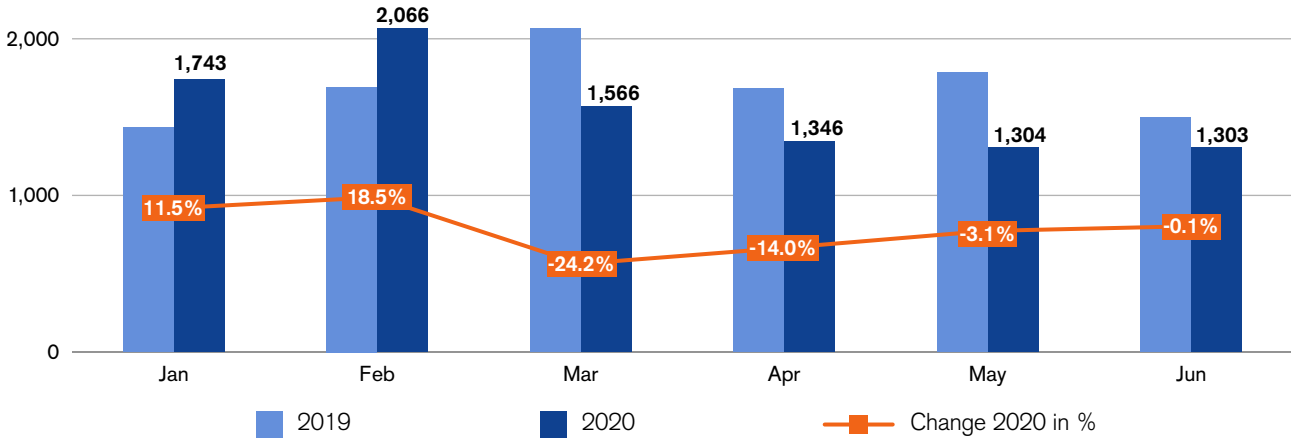


Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

Thus, in the sector of Residential care (NACE Q87) (Figure 17), the number of vacancies increased in the first two months of 2020. Also, in these months, the number of vacancies was higher compared to similar period of 2019. This trend reversed in March 2020 when there were 368 less vacancies in the sector compared to the same month of 2019. Compared to the previous month (February 2020), this decrease was 28.3%. The decline accentuated in the next months during the state of emergency: in April 2020 there were 30% fewer vacancies compared to March 2020. The decline was even more pronounced in May 2020 when there were 34.5% less vacancies compared to the previous month. In June 2020 the trend weakened, but remained below the level recorded in June 2019 with 327 fewer vacancies.

In the sector of Social work activities without accommodation (NACE Q88) (Figure 18), the registered job vacancy trend in 2020 followed the same pattern like in the case of Residential care (NACE Q87). After an increase in the number of vacancies by 11.5% in January 2020 and 18.5% in February 2020 compared to the previous month, the number of vacancies in the field of Social work activities (Q88) started to decline. Therefore, in March 2020, there were 24.2% fewer vacancies compared to February 2020. The decline continued also in April 2020, when 14% fewer vacancies than in March 2020 were recorded. In May 2020, the decline slowed down and in June 2020 the number of vacancies was almost similar to that recoded in May 2020. However, overall, between March and June 2020 less vacancies were recorded than in the same period of 2019.

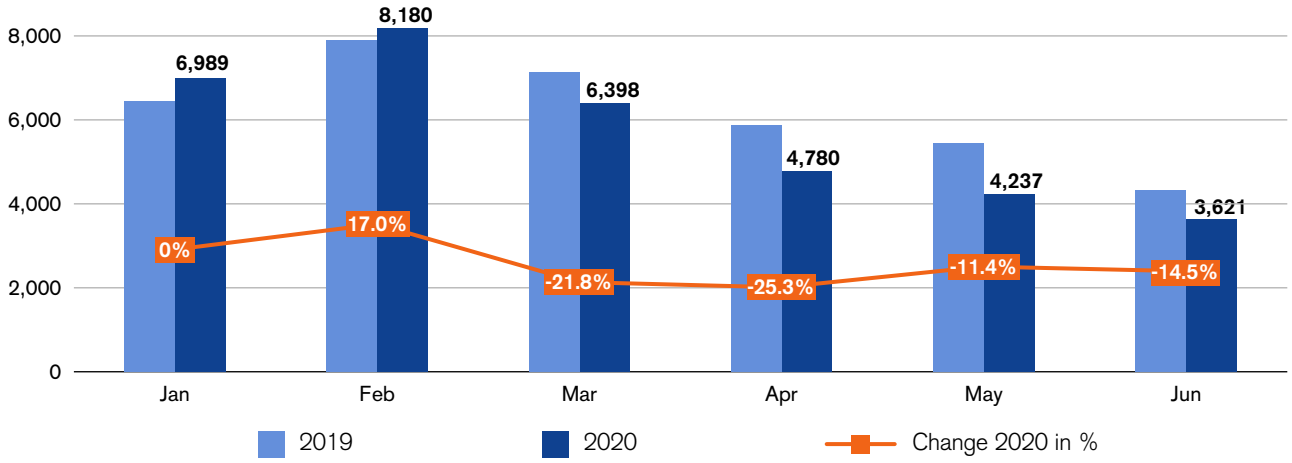
FIGURE 18 | Vacancies in Social work activities without accommodation (NACE Q 88), January-June 2019 and January-June 2020; change in 2020 compared to the previous month



Source: own illustration based on (Ministry of Economic Affairs and Employment, 2020)

The impact of the COVID-19 pandemic on the workforce in the disability field is also confirmed by the vacancy trend in the category of Nursing and Social Care Professionals (Figure 19). The number of vacancies in the category of Nursing and Social Care Professionals was higher only in January 2020 and February 2020, compared to the same months of 2019. In all other months (March 2020 to June 2020), the number of vacancies was lower, compared to the same period of 2019. Moreover, at the middle of crisis (March-May 2020), the decrease was higher than in 2019. For example, in March 2020, the number of vacancies decreased by -21.8% compared to the previous month, while in April 2019 the decrease was only 9.5%, compared to March 2019. Also, in April 2020 the decrease was of 25.3% and in May 11.4%, compared to the previous month (17.7% in April 2019 and 7.7% in May 2019, compared to the previous month). This data reflects more accurately the situation in the field of disability, as divisions NACE Q87 & 88 do not exclusively contain data about labour in the disability area.

FIGURE 19 | Vacancies in the category of Nursing and Social Care Professionals, January 2019-June 2019 and January 2020-June 2020; change in 2020 compared to the previous month



Source: own illustration based on Ministry of Economic Affairs and Employment (2020).

Interviews revealed also various other effects on workforce in the field of disability services. Thus, currently, the big challenge is to provide better work conditions and training to attract skilled workers into the disability sector. Only few students choose disability care as their orientation. The course which labour shortages will take is still unclear. Experts consider it possible that the care sector will attract more new workers who have been made redundant from other sectors due to more secure employment it offers. According to the interview partners, there are currently many untrained workers in disability services and the COVID-19 pandemic has reinforced the view that it is important for workers doing customer care to be trained. Trained nurses currently work overtime, because otherwise there are not always enough professionals with medication and injection licenses on duty. Currently, there is poor access to training, and the training obligation for nursing staff is not being met. During the spring, continuing education was completely at rest. The digital shift in teaching is expected to increase staff access to in-service training. In this context, associations have increased their webinars and are offering more tailored and needs-based training.

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COUNTRY REPORT

Ireland

Organisation of Social Support Service Provision for Persons with Disabilities

In the assessment of the Irish Human Rights Equality Commission (IHREC), care for persons with disabilities in Ireland has moved away from a charitable model of support focusing on medical services towards a more person-centred and rights-based approach (IHREC 2020, cf. Doyle and O'Brien 2020). Its main aim is to support persons with disabilities in leading an inclusive, independent life. These endeavours were reinforced by the ratification of the UN Convention on the Rights of Persons with disabilities (UNCRPD) in 2018, even if Ireland was the last EU Member State to do so and more legislative and administrative efforts are needed to anchor the principles in legal and practical terms (IHREC 2020). According to Laura Doyle and John O'Brian (2020), the main principles for service provision that have emerged in this process are efficiency, accountability and respect for the rights of service users, i.e. persons with disabilities and their families. This development has meant moving away from a situation where ethical positions or identity of service providers offer orientation for professional action. Instead, the rule by statute has emerged as the main principle, entailing actions based on laws and drawing legitimisation from ensuring equal treatment and effective administration (Doyle and O'Brian 2020). The main authorities to issue the relevant standards in the form of guidelines and protocols are the Health Information and Quality Authority (HIQA) and the Health Service Executive (HSE).

In 2016, there were 643,131 persons with a wide range of disabilities, accounting for 13% of the total population. The share of persons with disabilities increases with age (CSO 2016). Only a small number of them need support in their everyday life, but the numbers are dispersed across different sources and use different categorisations (e.g. by place of living, type of disability or age, time period). For example, 19,500 persons with intellectual disabilities live at home with their parents, relatives and foster parents (IHREC 2020). 1,300 persons with intellectual disability aged under 65 are inadequately placed in a care home (DFI 2020). In newspaper articles it is estimated that 9,500 persons with disabilities live in care homes and this number was also confirmed in the expert interview.

In Ireland, care for the elderly and persons with disabilities is mainly provided informally by families and is supplemented by formal home care services. While these services are arranged and financed by the public sector, most of them are yielded by private providers who are approved and contracted by public authorities. Thus, services delivered by the public sector play a relatively small role (Pierce et al. 2020). Private and voluntary (i.e. non-profit) organisations dominate also the care home landscape, accounting for roughly 3/4 of the care homes in Ireland (Ibid.). 70% of these over 400 private and voluntary nursing homes are small family-run owner-operated businesses with less than 60 beds (NHI 2019). While the majority of the persons in nursing homes are elderly persons with dementia, there are 1,500 younger persons with disabilities (Pierce et al. 2020).

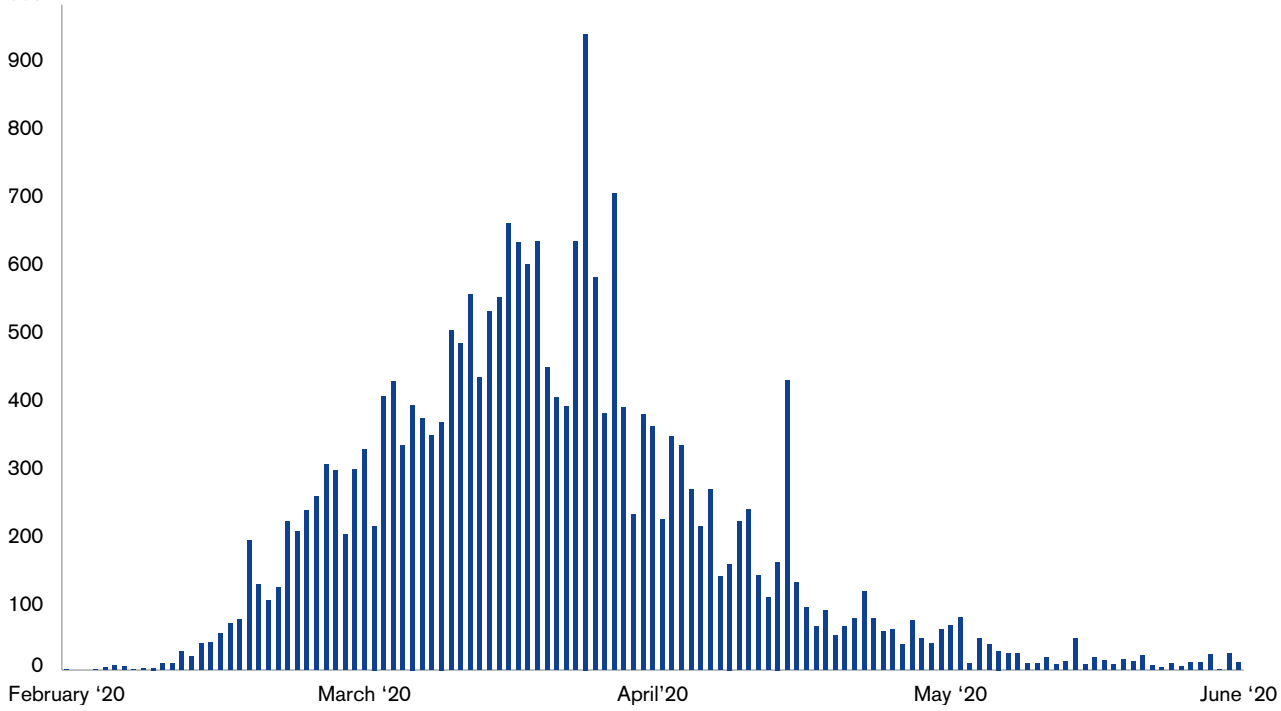
Residential services for persons with disabilities are required to meet the National Standards for Residential services for Children and Adults with Disabilities, issued in 2013 by the HIQA (2013). All centres for persons with disabilities need to register with HIQA (and re-register every three years) and their compliance with the standards is checked. The standards define what can be expected from the services in terms of quality and safety (individualised supports and care; effective services; safe services; health and development) and define the service provision principles related to capacity and capability (leadership, governance and management; use of resources; responsive workforce; use of information) (Ibid.). The compliance with the standards and regulations is checked through inspections, in which inspectors observe and assess aspects of daily life of users, such as quality of accommodation and meals. The experiences of inspectors are combined with other evidence and information from a range of sources. Despite this regulatory framework, investigative journalists and researchers have uncovered situations of human rights abuse in residential settings in the recent years (Murphy and Bantry-White 2020).

Day care is available for persons with physical and sensory disabilities, learning disabilities and mental health difficulties and it is provided by the HSE or voluntary organisations (EASPD 2018). Currently, there are 18,500 adults attending day care services in over 1,000 day service locations (Department of Health 2020). Day care sites range from small units with less than ten people with complex needs to large units with over 50 users. On average, 25 people occupy a day care centre on a daily basis (New Directions Subgroup 2020). HSE and voluntary organisations also offer respite supports for families of persons with disabilities for a period of two weeks.

Government Measures for Coping with the COVID-19 Pandemic

Already on 27 January 2020, the National Public Health Emergency Team (NPHET) was established in the Department of Health to coordinate the development and implementation of the COVID-19 strategy. The first case of COVID-19 was made public on 29 February 2020 and Figure 1 displays the number of COVID-19 cases between February and June 2020, reaching its peak in March/April 2020.

FIGURE 1 | Number of new COVID-19 cases in Ireland (February-June 2020)



Source: Government of Ireland (2020).

On 29 February 2020, the NPHET recommended measures to be applied in the Containment Phase (e.g. identifying all cases at an early stage and tracing their contacts). On 11 March 2020, Ireland moved to the Delay Phase and introduced the closure of schools and childcare facilities, cancelled indoor and outdoor mass gatherings, restricted hospital visits and urged workers to work from home. After a fortnight, people were to stay at home, unless they had to run urgent errands (e.g. concerning shopping for food or going to the chemist's). People over 70 years of age and those with chronical illnesses were advised to cocoon (Pierce et al. 2020).

The National Action Plan was issued on 16 March 2020, stating that it was important to maintain critical and ongoing services for essential patient care, in particular long-term care for older persons and persons with disabilities. On 17 March 2020, the HSE launched a recruitment campaign "Be on Call for Ireland". It addressed job-ready healthcare professionals from a wide range of disciplines who were not already working in the public health system: if they were prepared to work in existing or newly set up facilities, they were asked to register (Pierce et al. 2020). On the same day, Nursing Homes Ireland started a campaign to find staff for the private and voluntary care homes.

It addressed healthcare professionals (e.g. healthcare nurses, physiotherapists and healthcare assistants), but also addressed persons working in hospitality and retail sectors and offered roles on a temporary basis in catering, activities, ancillary or administrative support (NHI 2020). However, the success of the Be on Call for Ireland was limited in scope: out of the 73,000 persons who applied, only 321 persons were recruited by beginning of February 2021. The recruitment campaign cost 600,000 Euros (Brennan 2020a). Furthermore, on 15 April 2020, the HSE and trade unions reached an agreement that the HSE can redeploy existing HSE staff to work in private care homes, as long as the redeployment was voluntary.

On 27 March 2020, Ireland entered into a more intensive phase of restrictive measures, with strict recommendations to remain at home and guidance for those over 70 years of age to remain at home and cocoon. As home care workers were considered essential workers, the were allowed to travel to work (Pierce et al. 2020).

On 26 March 2020, the Revenue introduced the Temporary COVID-19 Wage Subsidy Scheme (TWSS), lasting until 31 August 2021 (CSO 2020a).[85] Its main aim was to keep the employees on the payroll throughout the pandemic, even if the employer experienced significant disruption of its regular economic activities (a minimum of 25% decline in turnover; inability to fully pay normal wages and normal outgoings; same of the employees needed to be temporarily not working/on reduced hours/on reduced pay). TWSS could be applied to some or all workers, but it was not available to the public service or non-commercial semi-state sector.[86] Furthermore, an employee who was claiming the Pandemic Unemployment Payment (PUP) from the Department of Social Protection (DSP) was not eligible for TWSS.

To qualify for the PUP, a person had to be of 18-66 years of age and resident of the Republic of Ireland. They were supposed to have lost their job due to the COVID-19 pandemic, be temporarily laid off or be self-employed with a reduced trading income, not receiving an income and be genuinely looking for work.[87] It also applied in cases where someone was working part-time or could not attend work due to child-minding.

85 It followed replaced the Employer COVID-19 Refund Scheme and was followed by the Employment Wage Subsidy Scheme (https://www.revenue.ie/en/employing-people/twss/information-about-twss/index.aspx; last accessed on 28 February 2021).

86 https://www.revenue.ie/en/employing-people/twss/information-about-twss/qualifying-criteria-for-employers-and-employees.aspx (last accessed on 28 February 2021).

87 https://www.gov.ie/en/service/be74d3-covid-19-pandemic-unemployment-payment/#what-the-covid-19-pandemic-unemployment-payment-is (last accessed on 28 February 2021).

FIGURE 2 | Overview of the measures introduced by Irish authorities during the first wave of the COVID-19 pandemic

* The blue boxes contain information directly related to healthcare as well as services for the elderly and persons with disabilities; the grey boxes display general measures and developments.

Source: own illustration based on Raidió Teilifís Éireann (2020), Landers and Drumm (2020), Murray (2020).

In its analysis of the COVID-19 response in Ireland, the Irish Human Rights and Equality Commission (IHREC) (2020) voiced its concern that the response had concentrate on health care provision rather than on social support services delivered in different settings (e.g. care homes, families, for persons living independently). These services were not always prioritised as essential services throughout the first period of the COVID-19 pandemic, meaning that day care and respite services were not available to 19,500 persons with intellectual disabilities living at home (Ibid.). Also the Nursing Homes Ireland (NHI) expressed their opinion that the care home sector did not receive the necessary attention and support. Furthermore, IHREC criticised that persons with disabilities or the organisations representing their interests had limited opportunities to participate in the development and monitoring of the Government's COVID-19 response. It underlined the lack of measures to address the differential impact of COVID-19 on persons with disabilities depending on their living situation and nature/degree of their disability (Ibid.). Moreover, as the main focus of the authorities was on continuing the service provision, it was overseen that not every adult with a disability uses social support services on a regular basis. Against this background, Murphy et al. (2020) stress the need to consider the situation of persons with disabilities beyond the mere framework of services, e.g. in the fields of work, sports and socialising. In this context, they make the case for ensuring that the rules for reopening are similar to everyone in Ireland regardless of their disability condition.

Prior to re-opening the day care services in August 2020, a national group involving representatives of services, users and families, service providers and the HSE prepared a framework to support service providers in resuming the services (Department of Health 2020). It was clear that the services would not re-open in the form as before (e.g. some of the services would be available only part-time and their ways of working would change) and substitution between service types was necessary (e.g. reduction in day support services would have an impact on other service types such as residential or home supports) (HSE 2020a). Therefore, service providers were to contact the users and families beforehand to discuss the resumption of services. The HSE recognised that the transformation of the service provision resulting from the disruptions caused by the COVID-19 pandemic was to have a long-term effect on the service landscape – both on the services provided and funded by the HSE. It saw the necessity to assess the individual needs and wishes of persons with disabilities and consider how the residential care, respite and home support services as well as personal assistance were to be delivered in the future. The following principles were to be applied in service provision: person-centred, sage, rational, evidence-informed, fair, open and transparent, [including] whole of society (Ibid.).

Also in day care services, the personal plan for service provision, consisting of the person-centred plan (containing services important to the person) and personalised care and support plan (important for the person) were to retain their relevance (HSE 2020b). In their framework for the resumption of adult day care services, the HSE acknowledged the need to address the core value of community inclusion and active citizenship in accordance with the COVID restrictions at the time and the phases for re-opening the country outline by the Government (Ibid.).

Effects of the COVID-19 Pandemic on the Provision of Social Support Services for People with Disabilities

To study effects of the COVID-19 pandemic on the provision of social support services in Ireland during the half of 2020, a mixed methods approach was adopted. It consisted of desk research to collect information on the legal and regulatory framework, analysis of statistical data and an expert interview with two representatives of an organisation representing the interests of persons with disabilities. Statistical data were available from the Central Statistics office (CSO) on the workforce (employment, earnings, employment status, unemployment and vacancies), categorised according to the international classification of economic activities NACE[88]. This allowed to differentiate between Health care activities (NACE Q86), Residential care activities (NACE Q87) and Social service activities without accommodation (NACE Q88). However, these categorisations remain very broad and services provided to persons with disabilities constitute only a minor part in them (see the Section "Overview of the Research Results"). Wherever possible, statistical data are presented in comparison the figures of 2019 to detect any effects of seasonality. Even though the Central Registration Office (CRO) were contacted twice requesting for data on company registrations, no data were made available. Finally, as only one interview was carried out, the report had to focus on analysing

88 Nomenclature des Activités Économiques dans la Communauté Européenne (NACE) (Eurostat 2008).

publicly available documents on social support service provision for persons with disabilities. Consequently, the assessment of the situation relies more strongly on the planned activities and declarative statements, rather than putting them into perspective through the experiences of the interview partners.

Service Providers

In particular, the COVID-19 virus spread in the care homes, since they did not have adequate supplies of PPE and no opportunities were provided for physical distancing. Furthermore, as the staffing levels were low and in some cases staff that had been tested positive for COVID-19 had to continue working, the staff were passing on the disease. Since staff were also working in parallel in hospitals or in more than one care home, it facilitated the spreading of the virus between the settings (IHREC 2020). Moreover, mixed staffing arrangements whereby some staff were living in the care home and others followed a rota, prepared the ground for cross-contamination (Ibid.). While respite and day care services were discontinued, many families also cancelled their home care services as they were worried about the spreading of the COVID-19 virus (HSE 2020c).

Furthermore, non-profit voluntary organisations which acquire part of their funding from fundraising, experienced considerable difficulties as they had to cancel their fundraising events. Enable Ireland, for example, estimated their loss of income in 2020 at 1.5 million Euros after having had to postpone their fundraising events and close their charity shops (Leonard 2020). Also The National Council for the Blind Ireland (NCBI) reported a decreased volume of donations and customers in their shops across the country (Brennan 2020b). However, some charities and service providers (e.g. Family Carers Ireland) stated that they received donations of PPE to use in home care (SBHI 2020). The Disability Federation of Ireland (DFI) estimated the average projected loss of (additional) funds per charity at 650,000 Euros, accounting for 40% of the charities' income (DFI 2020). Considering that the resumption of services would entail additional costs for service providers, they advocated for providing the COVID-19 stability fund with adequate resources to address the funding needs of small to medium community-based disability organisations (Ibid.).

Scope and Quality of Services

Many service users and their families stopped their home supports to reduce the risk of contracting the COVID-19 virus (HSE 2020c). There, the families of persons with disabilities took over the care responsibilities. At the same time, service providers were making significant attempts to provide alternative services that would minimise the health risks. This involved, for example, out-of-home respite breaks in a local park as an alternative to in-home care or out-home respite care. The services acknowledged not only the practical support needs of persons with disabilities, but also their emotional needs during the COVID-19 pandemic. St. Michael's House, for example, substituted the classes usually accessed in day centres through online dance classes or guidelines how to make smoothies. At the same time, regular coffee mornings were offered to prevent loneliness or online video chats with activities based on the goas in the individualised plan of persons with disabilities. Parents were involved in parent-carer support groups.

Enable Ireland, a registered charity with 1,200 staff across Ireland, constitutes another example of a comprehensive approach. It delivers services to 9,200 adults and children with disabilities or their families. Since April 2020, they have developed an extensive virtual service to adults who use their day residential and respite services. For parents, therapists and clinical staff have set up an extensive video library of therapy sources, offering physiotherapy exercises, speech and language activities as well as occupational therapy routines. This supports parents and caregivers with providing alternatives to the usual services. The videos are available on YouTube[89] and cover the field of movement, language and social skills. Furthermore, it entails also background information on complex concepts such as Augmentative and Alternative Communication (AAC) Modelling or guidance on how to deal with the COVID-19 virus. For adults, online tai chi, hair and makeup lessons and music therapy are available (Leonard 2020). The services aim to offer ongoing contact and support in a situation when many persons with disabilities are feeling excluded or vulnerable. Thus, the videos are a mix of introduction to concepts used in disability therapy, practical exercises and information as well as psychological support to deal with the emotional impact of the COVID-19 virus. Facebook groups and video conferencing offer further opportunities for contact.

89 https://www.youtube.com/enableireland/playlists (last accessed on 28 February 2021).

Making sure that these newly developed services cover the needs of persons with disabilities and their relatives was an issue that was addressed by different stakeholders. Enable Ireland, for example, stated that their staff were working in partnership with the HES to that end (Leonard 2020). The HSE suggested to re-assess and prioritise the individual needs of users and families (HSE 2020c). Maintaining regular contact was considered essential, as their needs change with the ongoing loss of access to regular essential support services. Guidelines for determining the priority needs were issued. The factors justifying prioritised support interventions were challenging behaviours, safeguarding concerns, additional family vulnerabilities, living alone, medical needs and limited external supports (Ibid.).

However, the interviewed experts pointed out that the initial focus of the Government during the first months of the COVID-19 outbreak was on care homes as the public health response was not prepared for coping with the situation. This targeted a very small part of the support needs of persons with disabilities. It was a major achievement of the organisations representing the interests of persons with disabilities to draw the attention of government agencies addressing the health and social care issues, pointing out that a wider response was needed to address the needs of vulnerable communities. The interest representations also managed the information flows in the other direction, interpreting general information provided by government agencies in a disability-specific way for families and service providers. According to the interviewed experts, this task was extremely time-consuming and difficult.

Concerns were raised concerning the inadequate provision of PPE to persons with disabilities and their families. Furthermore, staying at home and to some extent substituting the social support services or supporting the alternative services caused additional costs to the service users and their families. These extra costs added to the general cost of disability and increased the persons' risk of poverty (IHREC 2020). Furthermore, the IHREC requested that service providers prevented discrimination and upheld the rights of service users in policies and programmes adopted in response to COVID-19 – both public and private service providers were asked to ensure that their services comply with the Equal Status Act as well as the Public Sector Equality and Human Rights Duty (IHREC 2020).

When preparing for the resumption of day care services in August, the HSE pointed out that service users may be traumatised as a result of the significant change in their routine and in some cases the loss of loved ones. It was assumed that the break from day care services had had an effect on the behaviours of persons with disabilities, leading to an escalation of reduction of challenging behaviour (HSE 2020b).

Workforce

During the first phase of the COVID-19 pandemic, day service providers were requested to identify staff that could be redeployed to residential services. The redeployed staff were directed into the general health system, for example they were given the task of public contact tracing. The interviewed experts pointed out that this left disability services scantly populated and if support needs emerged, there were no resources to cover them. Furthermore, they were asked to report premises that could be used for COVID-19-related work (e.g. for establishing isolation units) and to identify transport fleets that could be used to support the community (HSE 2020b).

Across the social support services, staff health and well-being were of general concern, since there were considerable changes to staff work practices and people interacting with each other. The HSE requested social support service providers to observe any challenges arising from different constellations of teams or changing service patterns and locations (HSE 2020a). It was advised that the staff organised social meetings and non-work related online events such as virtual coffees (Ibid.). Moreover, it was recognised that staff members in social support services themselves might experience anxiety in the workplace or have a relevant medical condition. Therefore, a line manager who could be addressed with these concern was to be designated (Ibid.). Furthermore, staff were referred to government programmes offering advice in the case of workplace stress[90] and the Healthy Ireland initiative.[91]

90 The Health and Safety Authority's (HSA) frequently asked questions on workplace stress (https://www.hsa.ie/eng/Topics/Workplace_Stress/; last accessed on 28 February 2021).

91 In 2013, The Government of Ireland launched a nationwide framework of action to improve the health and well-being of people. It offers advice how to look after one's mental health and well-being (https://www.gov.ie/en/campaigns/healthy-ireland/?referrer=http://www.gov.ie/en/campaigns/together/?referrer=/together/; last accessed on 28 February 2021).

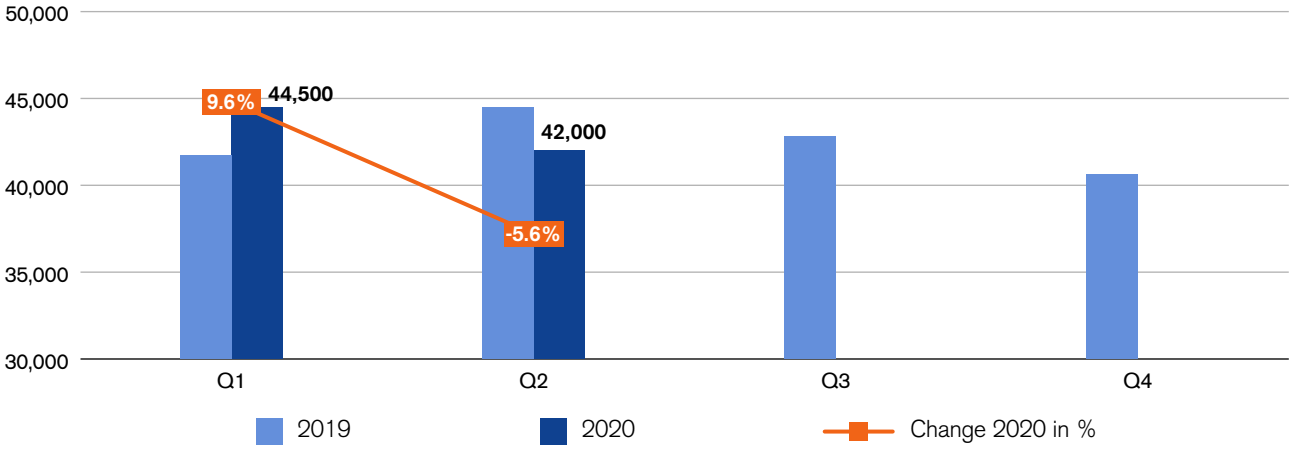
The DFI pointed out that the COVID-19 pandemic had exposed inequalities existing between the employees of agencies funded under Section 38 of the Health Act 2004 and employees of independent non-profit agencies in the private sector, largely funded by the HSE under Section 39 of the same act. While the former were eligible for the COVID-19 sick pay, the latter were not (DFI 2020). For the DFI, this was a further aspect of the wide issue of Section 39 and Section 38 inequalities, calling for further examination of the categorisation (Ibid.).

Already in May 2020, the HSE was starting to prepare the resumption of day care services in August 2020. It referred to the Government's Return to Work Safely protocol, which defined "minimum measures required in every place of work to prevent the spread of COVID-19 and to facilitate the re-opening of workplaces" (Department of Enterprise, Trade and Employment 2020).[92] Further specific measures in particular sectors could be introduced. Therefore, every service provider was requested to develop a return to work safely protocol, taking into account specific requirements arising from the disability care group and the infrastructure that supports the delivery of day care The focus was on minimizing the contacts between staff, service users, families and the public (HSE 2020b). However, it was recognised that maintaining distance was not possible in some of the services where interventions and personal support required contact.

To resume day care services, it was requested that staff that had been redeployed needed to have an agreed plan for repatriation to day services. Furthermore, staff training was needed regarding new ways of working (e.g. new workplace organisation), infection prevention, risk management and the correct use of PPE (Ibid.). Despite the preparations, in the assessment of the interviewed experts, only 40-50% of the redeployed staff of day care services were back in their original jobs in December 2020, leaving the services understaffed and not able to respond to the needs of persons with disabilities.

Employment: in the field of Residential care activities (NACE Q87), the number of employees peaked in Q1 of 2020 with 44,500 employees – both compared to Q4 2019 (40,600 persons) and to the same quarter of the previous year, Q1 2019 (41,700 persons) (Figure 3).

FIGURE 3 | Employed persons in Residential care activities (NACE Q87), Q1-Q4 2019 and Q1-Q2 2020

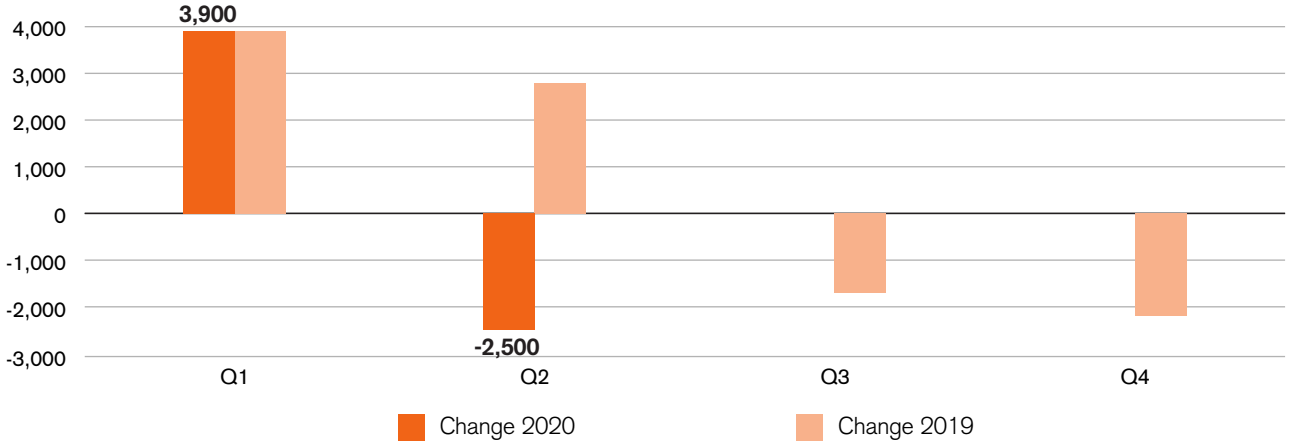


Source: own illustration based on CSO (2020b).

Thus, between the Q4 2019 and Q1 2020, there was a strong increase of 3,900 employees (9.6%) in Residential care activities (NACE Q87) (Figure 3 and Figure 4). In Q2 2020, however, there was a decline in the number of persons employed: compared to Q1 2020: 2,500 (-5.6%) fewer people were employed in the sub-sector. This represents a strong decrease both compared to Q4 2019 and to the same quarter of the previous year, Q1 2019 (Figure 4). This decrease could be related to the spread of COVID-19: at the end of March, the Health Protection Surveillance Centre (HPSC) reported 111 clusters of infections, 22 of which were in nursing homes. A report on the impact of COVID-19 on Irish nursing homes states that some of the nursing staff were frightened and did not return to work because of fear of infection (HIQA 2020).

92 Later in 2020, the Return to Work Safely protocol was superseded by the Work Safely protocol to reflect the Government's Plan for Living with COVID-19 (Department of Enterprise, Trade and Employment 2020).

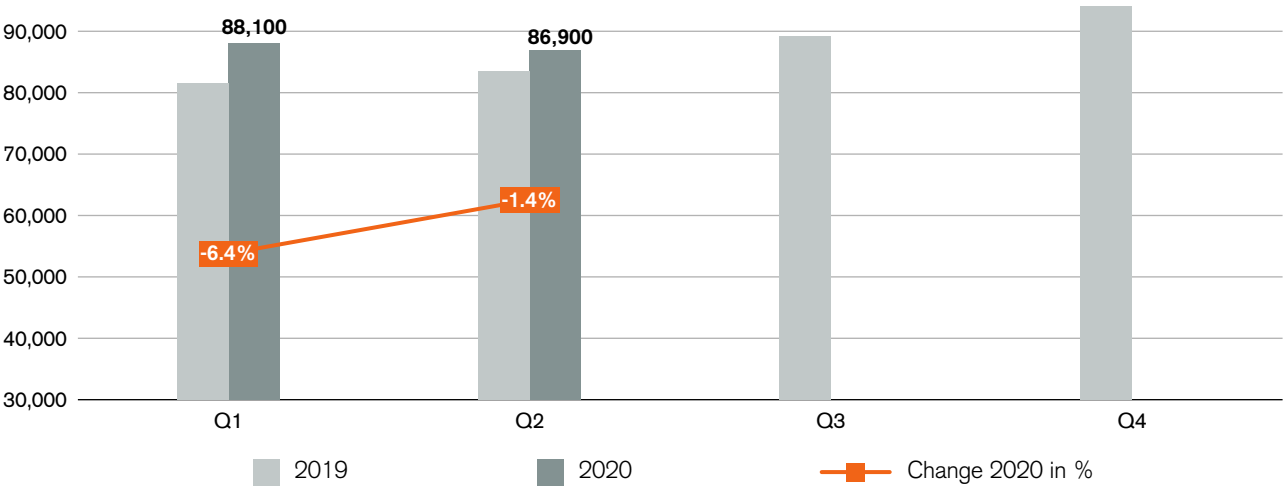
FIGURE 4 | Change in number of employees in Residential care activities (NACE Q87), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

In Q1 2020, there were 88,100 employees in the field of Social work activities without accommodation (NACE Q88), which is considerably higher than in the same quarter of the previous year, Q1 2019 (81,600 persons) (Figure 5).

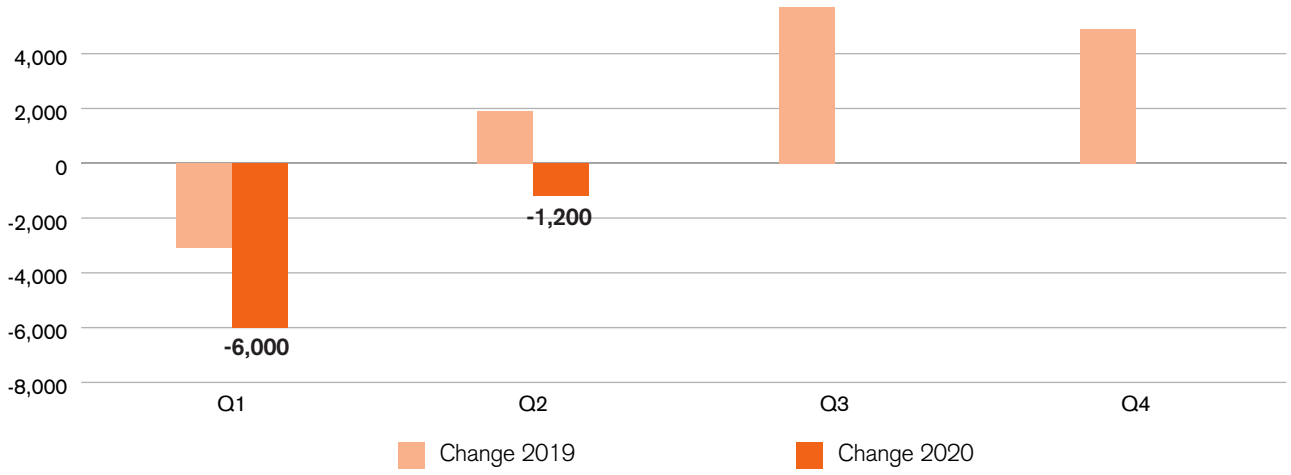
FIGURE 5 | Employed persons in Social work activities without accommodation (NACE Q88), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

Compared to Q4 2019, however, a decrease by 6,000 employees occurred (-6.4%) (Figure 5 and Figure 6). This downward trend could not be reversed in Q2 2020, but with a decrease of 1,200 employees (-1.4%) the development was less pronounced. Nevertheless, the employment figures in the first two quarters of 2020 were still higher than in the same periods of the previous year.

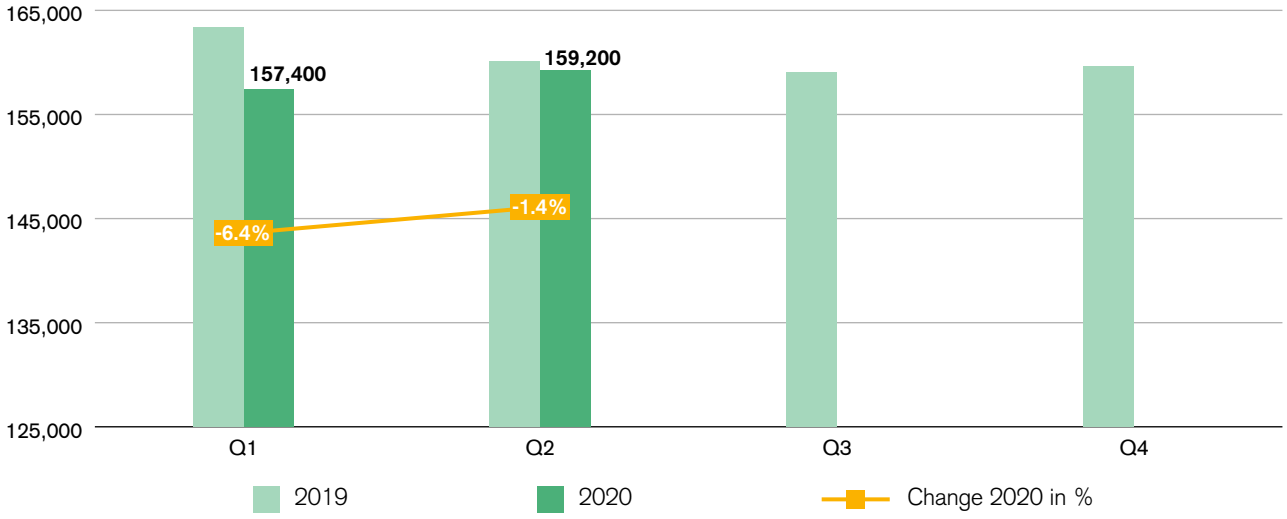
FIGURE 6 | Change in number of employees in Social work activities without accommodation (NACE Q 88), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

In Q1 of 2020, employment in the field of Human health activities (NACE Q86) reached its lowest point with 157,400 persons compared to both Q4 of 2019 (159,600 persons) and to the same quarter of the previous year, Q1 2019 (163,400 persons) (Figure 7).

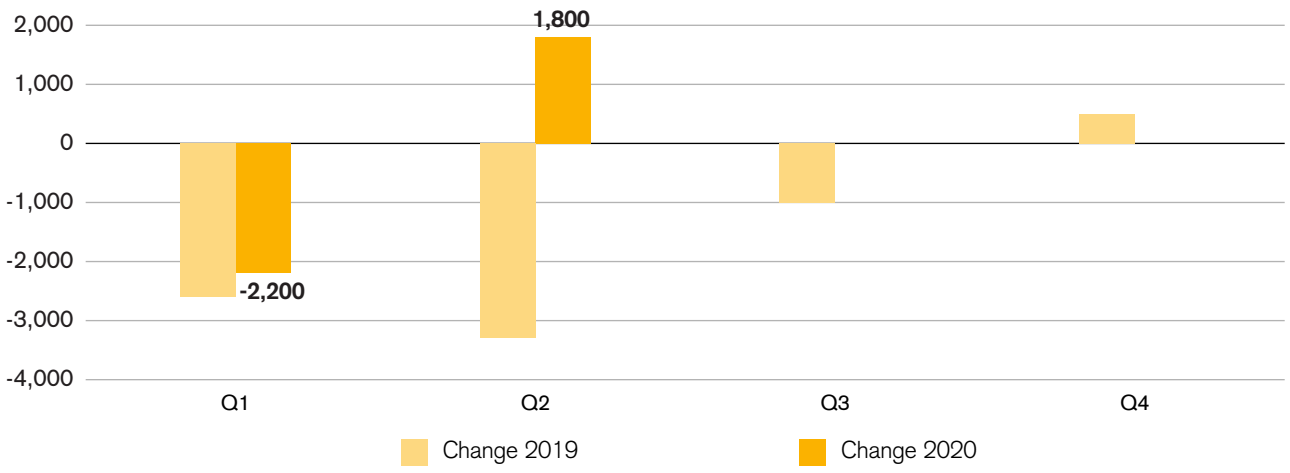
FIGURE 7 | Employed persons in Human health activities (NACE Q86), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

The number of persons employed in the field of Human health activities (NACE Q86) decreased by 2,200 (-1.4%) between Q4 2019 and Q1 2020 (Figure 7 and Figure 8). In Q2 2020, however, this downward trend was reversed with employment figures rising by 1,800 (1.1%). The number of employees was thus almost back at the previous year's level. The increase in Q2 2020 could be related to the public-private hospital agreement adopted by the Irish government on 30 March 2020. This agreement increased overall hospital capacity by 17%, including 11,000 inpatient beds, 47 intensive care unit beds and 54 high dependency beds.

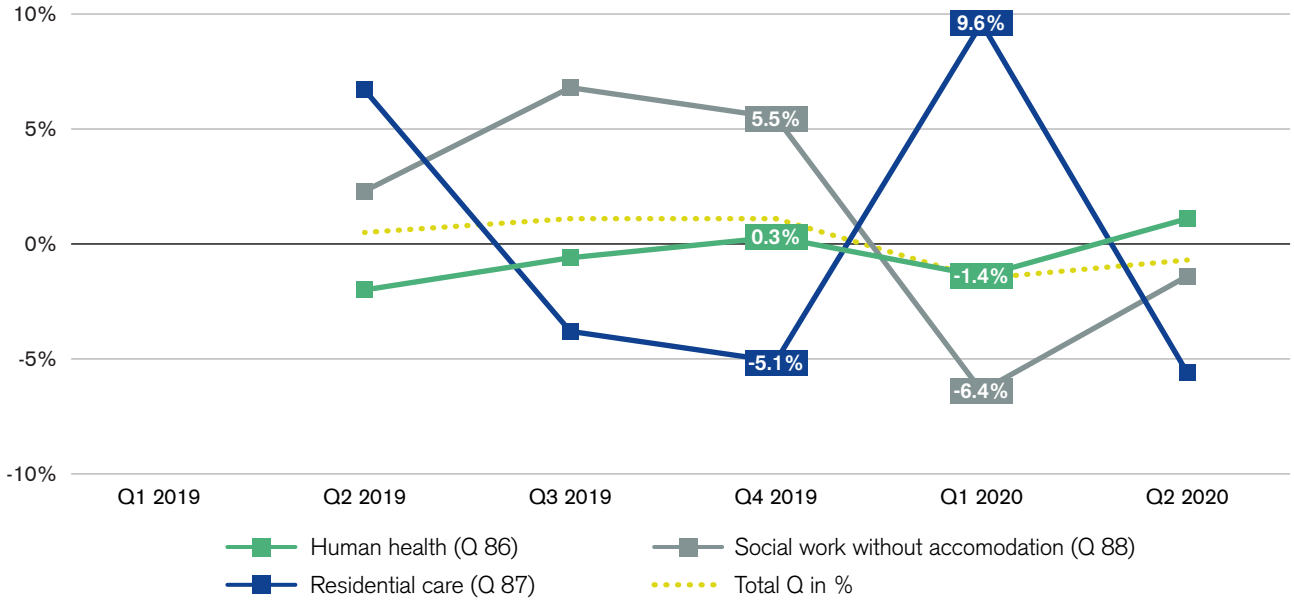
FIGURE 8 | Change in number of employees in Human health activities (NACE Q86), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

To conclude, the percentage change in the number of employees is compared for the three sub-sectors of Human health and social work activities (NACE Q). In Human health activities (NACE Q86), the fluctuations in the number of employees were low between Q1 and Q2 2020. In Q1 2020, there was a decrease in the number of employees by 1.4%, but the following quarter the number of employees rose again by 1.1% (Figure 9). The Residential care (NACE Q87) and Social work activities without accommodation (NACE Q88) displayed a more dynamic development in the same period. In Q1 2020, there was a considerable increase of 9.6% in the number of persons employed in Residential care activities (NACE Q87), while there was a strong decline of 6.4% in the number of persons employed in Social work activities without accommodation (NACE Q88). In Q2 2020, the Residential care activities (NACE Q87) recorded a sharp decrease in employment (-5.6%); the decline in Social work without accommodation (NACE Q88) (-1.4%) was not as strong as in the previous quarter. The data indicate that these exceptional developments in the labour market – especially for those employed in residential care – can be attributed to COVID-19.

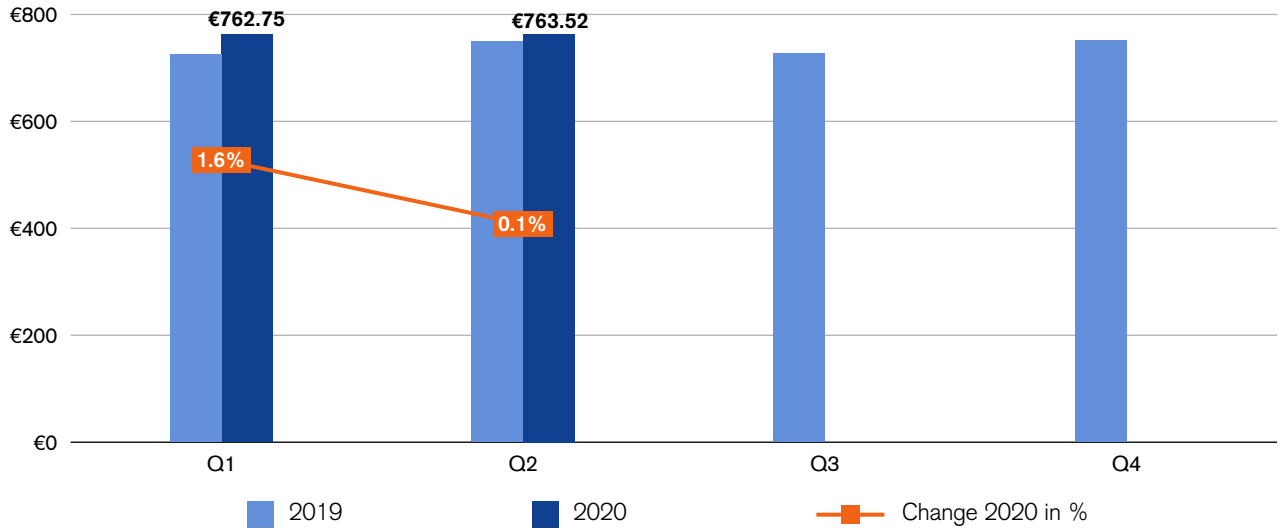
FIGURE 9 | Percentage change in employment by NACE, Q2 2019 to Q2 2020



Source: own illustration based on CSO (2020b).

Earnings: in the first quarter, weekly earnings in Human health and social work activities (NACE Q) averaged €762.75, which was 1.6% above those in Q4 2019 (Figure 10). They were also higher compared to the same quarter of the previous year (€725.28 in Q1 2019). In Q2 2020, the average weekly income increased again by 0.1% and reached a new record level of €763.52. This development is likely to be closely linked to the increase in average weekly working time.

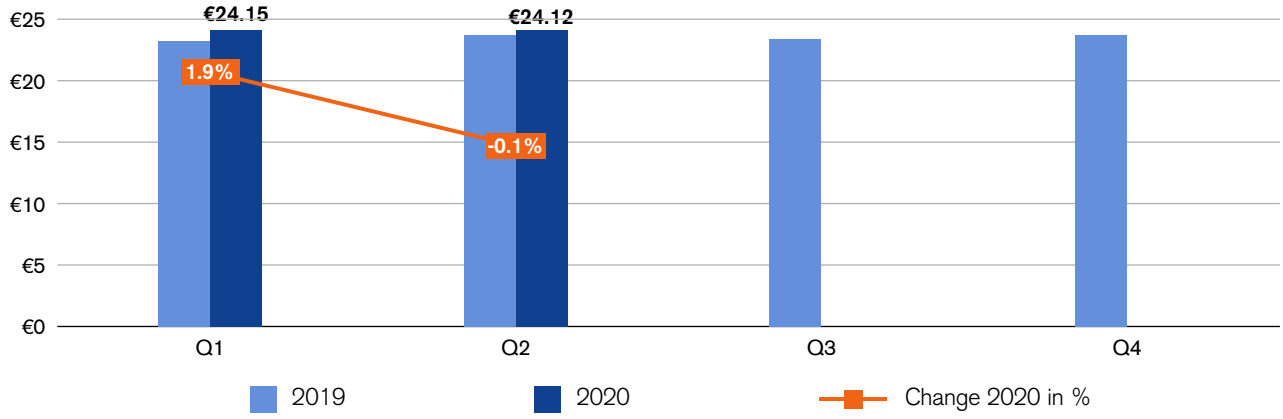
FIGURE 10 | Average weekly earnings in Human health and social work activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020 (in €)



Source: own illustration based on CSO (2020b).

Similarly, average hourly earnings rose at the rate of 1.9% in Q1 2020 (Figure 11). In Q2 2020, the development was similar to that of average weekly wages as hourly wages also stagnated at the higher level they had reached in Q1 2020. These data clarify that the increase in average weekly earnings in Q2 2020 is mainly due to an increase in weekly working hours and is not an outcome of an increase in the average hourly wage.

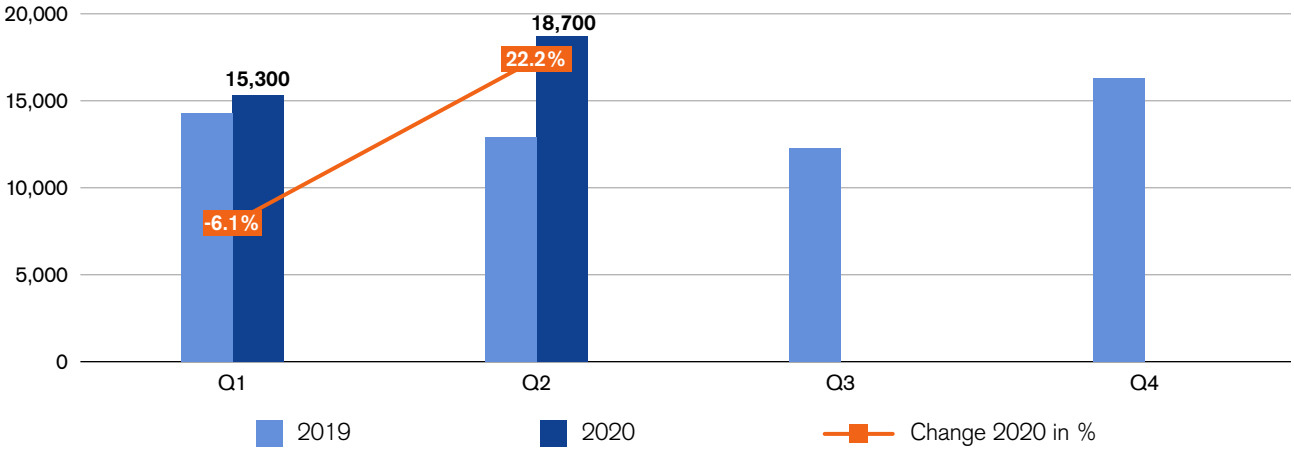
FIGURE 11 | Average hourly earnings in Human health and social work activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020 (in €)



Source: own illustration based on CSO (2020b).

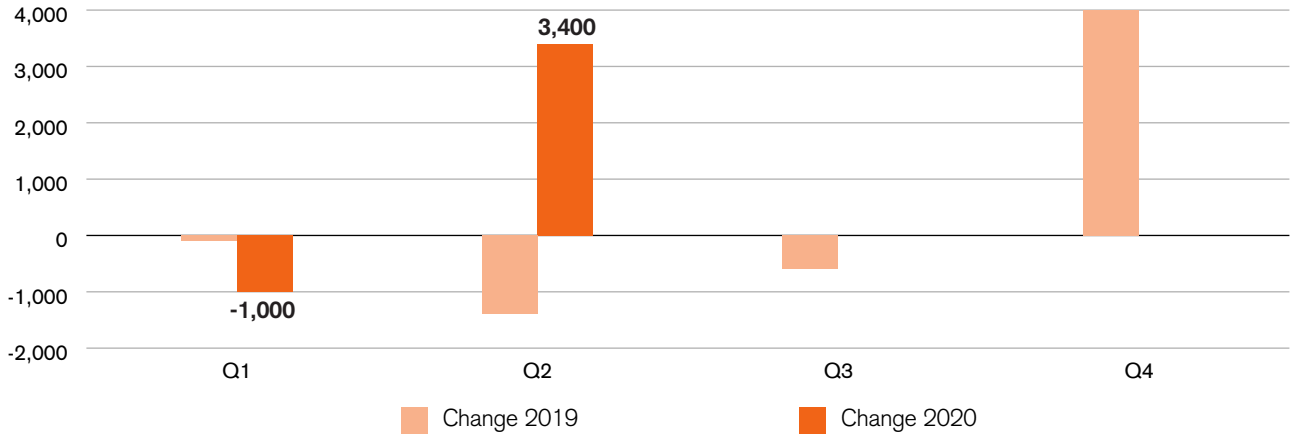
Employment status: in Q1 2020, 15,300 self-employed persons were working in Human health and social work activities (NACE Q) (Figure 12). The number of self-employed was thus slightly higher than in the same quarter of the previous year (14,300 persons). Compared with Q4 2019, there was a decrease of 1,000 self-employed persons (-6.1%) (Figure 12 and Figure 13). In contrast, Q2 2020 is characterised by a strong increase in the number of self-employed in Human health and social work activities (NACE Q) as a total of 18,700 self-employed persons were active. This constituted an increase of 3,400 self-employed persons (22.2%).

FIGURE 12 | Self-employed persons in Human health and social work activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

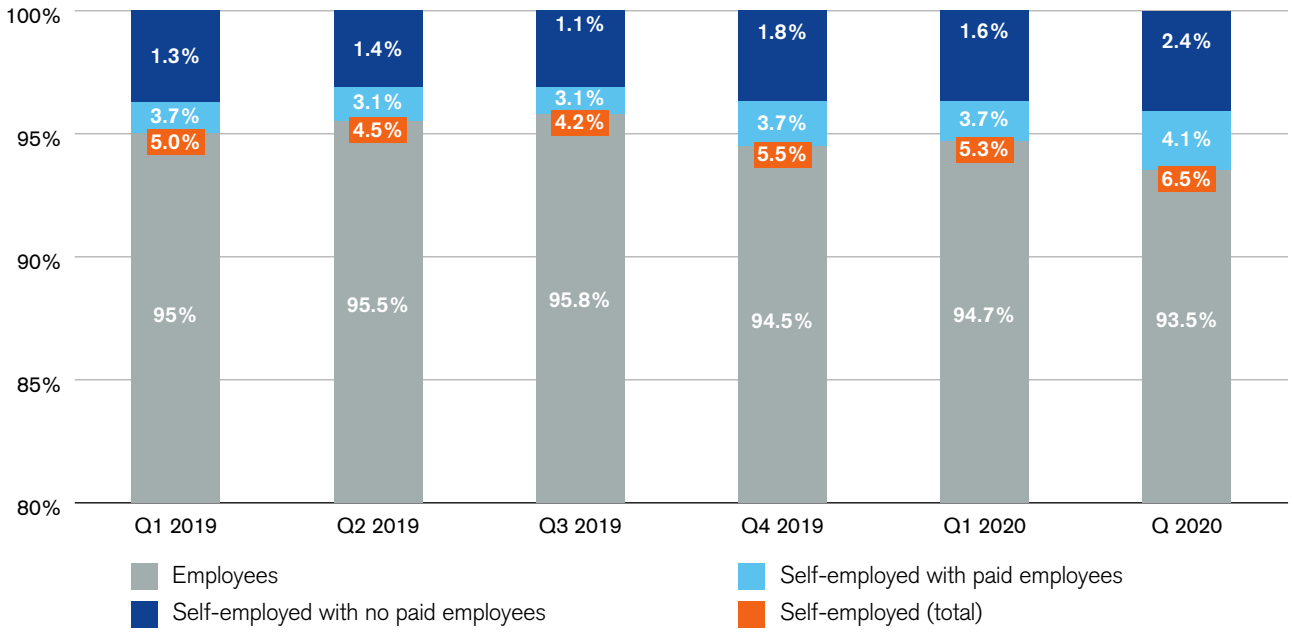
FIGURE 13 | Change in number of self-employed persons in Human Health and Social Work Activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

In Q1 2020, the total share of self-employed in Human health and social work activities (NACE Q) was 5.3%, only slightly lower than in Q4 2019 (5.5%) (Figure 14). Therefore, there was little change between Q4 2019 and Q1 2020. The internal division between the categories "self-employed with employees" and "self-employed persons working alone" also remained rather similar. Q2 2020, however, displays a clear change: the share of self-employed reached a new peak of 6.5% in total. A closer look reveals that especially the self-employed with paid employees showed a relatively strong increase from 1.6% to 2.4%.

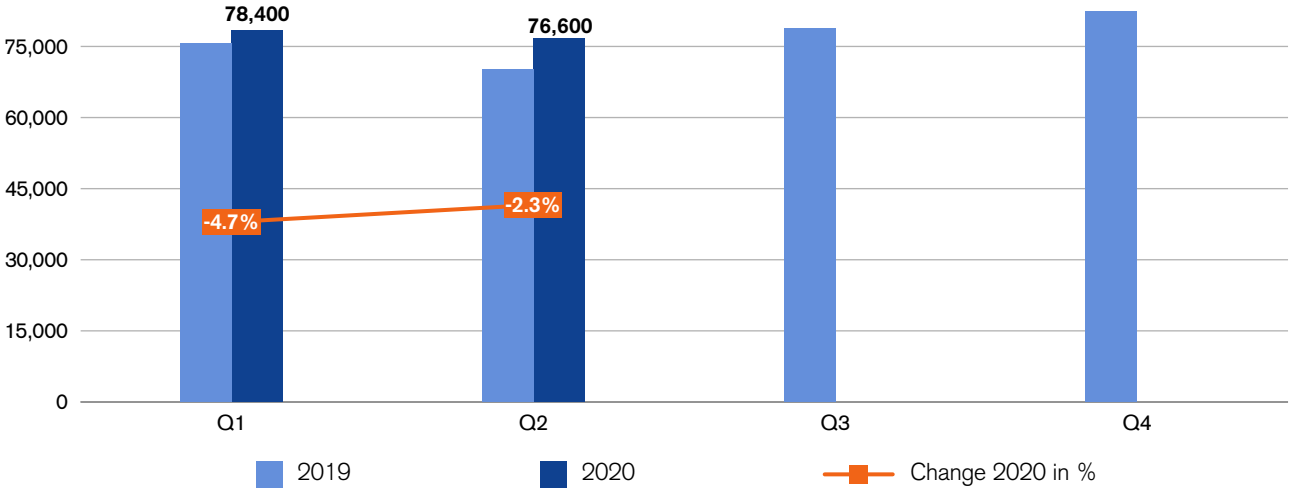
FIGURE 14 | Proportion of the forms of employment in Human health and social work activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020 (in %)



Source: own illustration based on CSO (2020b).

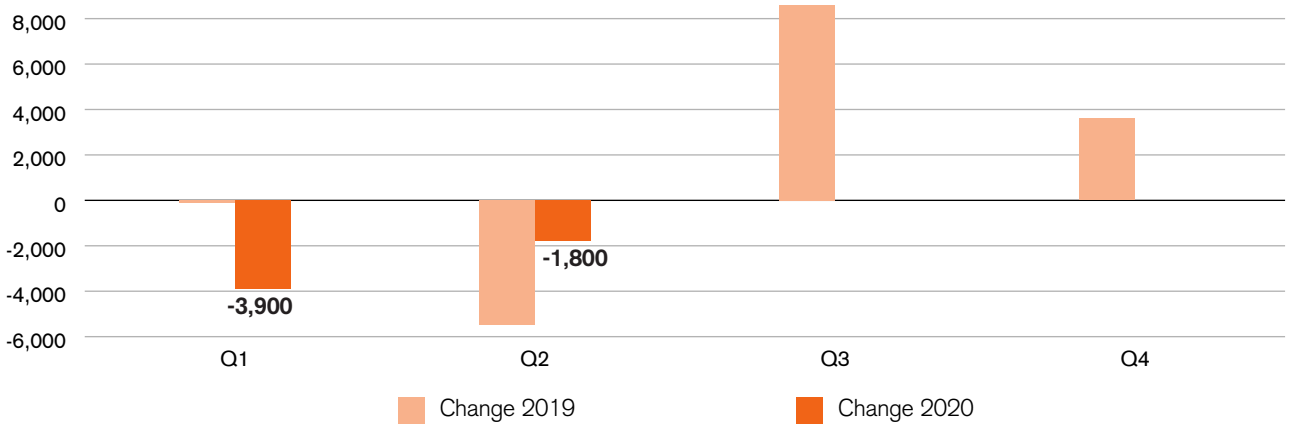
In Q1 2020, a total of 78,400 persons were employed in Human health and social work activities (NACE Q) as part-time employees, which is slightly more than in the same quarter of the previous year (75,600 persons) (Figure 15). Compared with Q4 2019, however, there was a decrease of 3,900 part-time employees (-4.7%) (Figure 15 and Figure 16). The decline continued with 1,800 fewer part-time employees (-2.3%) in Q2 2020, although the rate of decline diminished. Overall, however, the number of part-time employees was higher in the first two quarters of 2020 than in 2019. Unfortunately, the available data do not allow to conclude whether people moved from part-time employment to unemployment or to full-time employment.

FIGURE 15 | Part-time employees in Human health and social work activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

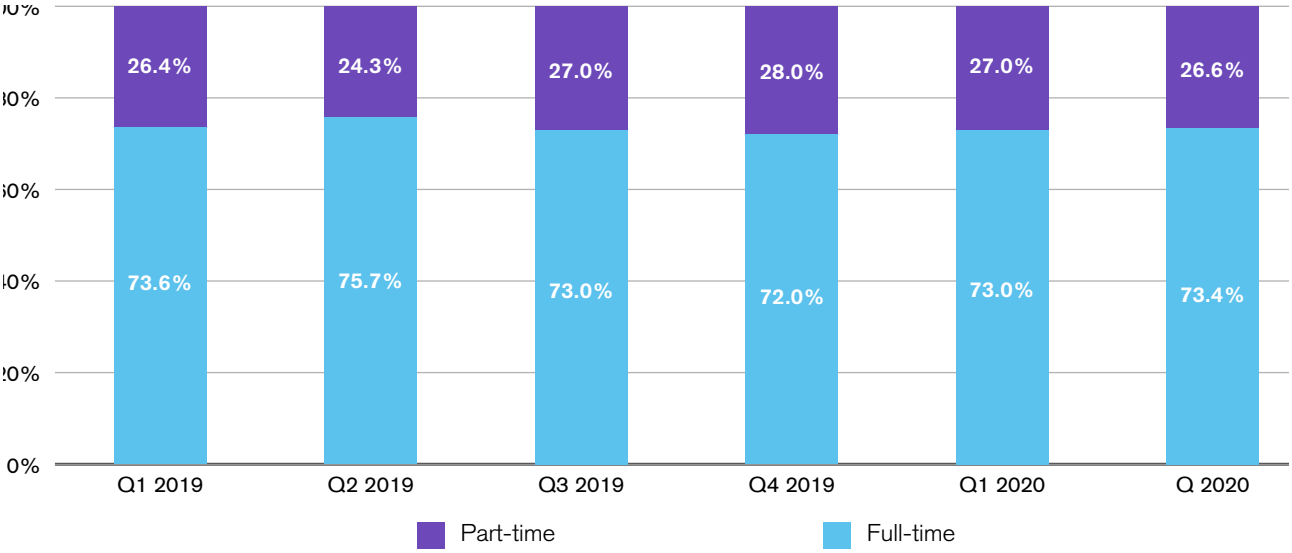
FIGURE 16 | Change in number of part-time employees in Human health and social work activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

In Q1 2020, the share of part-time employees in Human health and social work activities (NACE Q) was 27% and the share of full-time employees 73% (Figure 17). In Q2 2020, there was a slight decrease of part-time employees by 0.4 percentage points. Overall, there were only minor changes in the share of full-time and part-time employees.

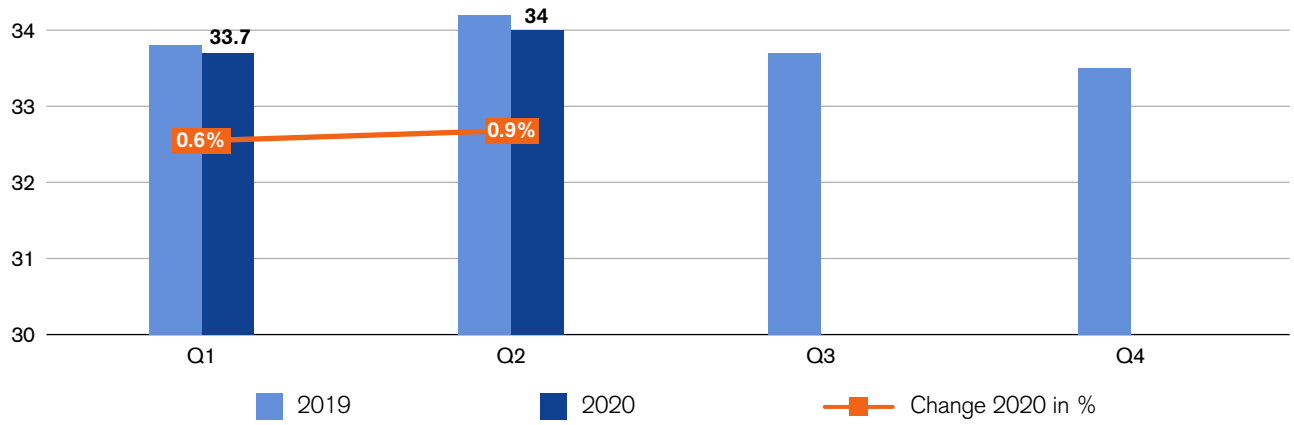
FIGURE 17 | Proportion of full-time and part-time employees in Human Health and Social Work Activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

In Q1 2020, the average weekly working time in Human health and social work activities (NACE Q) was 33.7 hours, only slightly lower than in the same quarter of the previous year (33.8 hours per week) (Figure 18). Since Q4 2019, a slight but continuous increase in average weekly working hours occurred. It increased by 0.6% between Q4 2019 and Q1 2020 as well as by 0.9% between the Q1 and Q2 2020. The increase in average weekly working time is likely to be related to the longer working hours due to COVID-19.

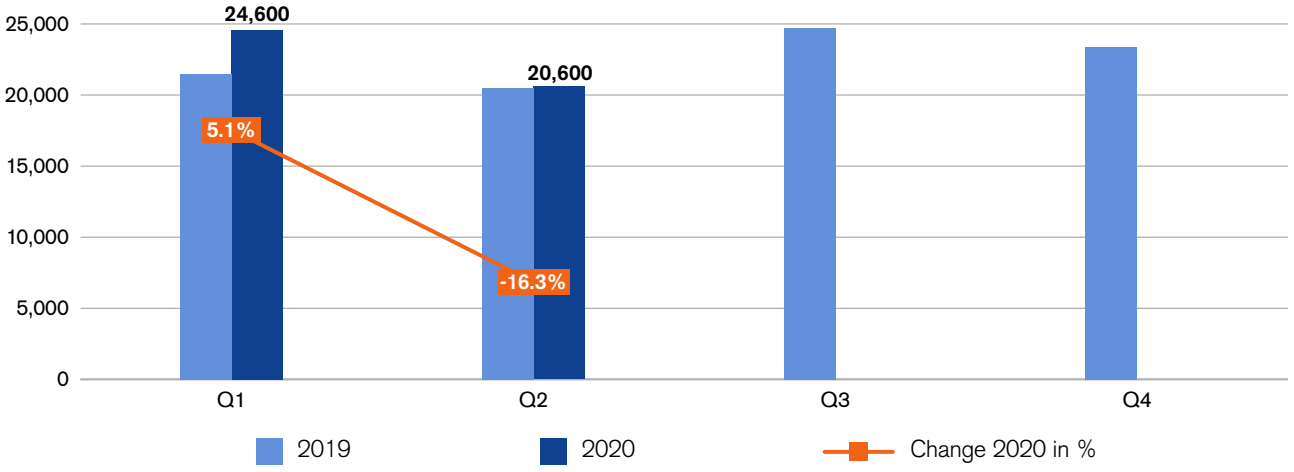
FIGURE 18 | Average usual hours worked per week in Human Health and Social Work Activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

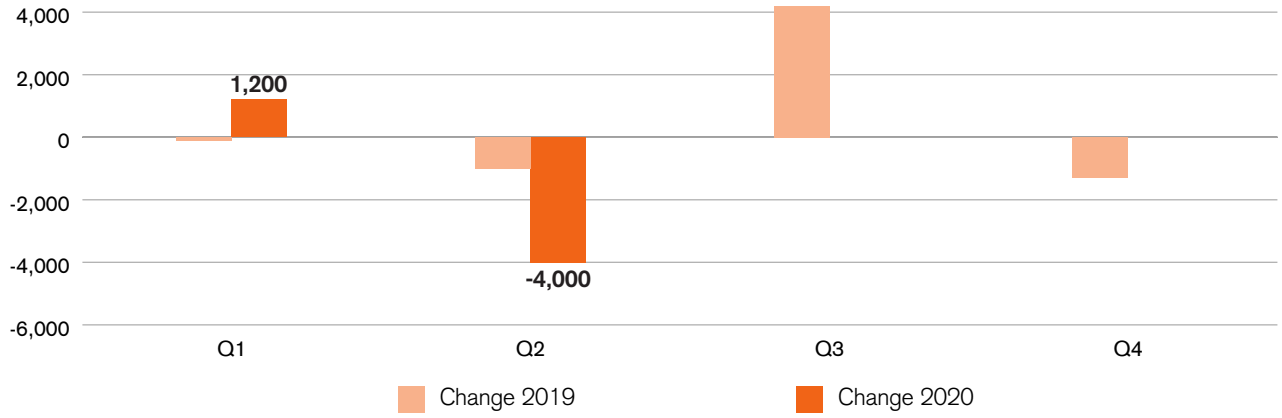
In Q1 2020, the number of temporarily employed persons in Human health and social work activities (NACE Q) was 24,600, which is considerably higher than in the same quarter of the previous year (21,500) (Figure 18 and Figure 20). Compared to Q4 2019, there was also an increase of 1,200 temporary employees (5.1%). Q2 2020, on the contrary, showed a drastic decline in the number of temporary employees as there were 4,000 fewer temporary employees than in Q1 2020 (-16.3%). Unfortunately, the available data do not allow any conclusions as to whether these 4,000 employees changed into permanent employment or unemployment. An obvious explanation could be that many temporary employment relationships in the sector were not renewed due to the COVID-19 measures.

FIGURE 19 | Temporary employees in Human health and social work activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

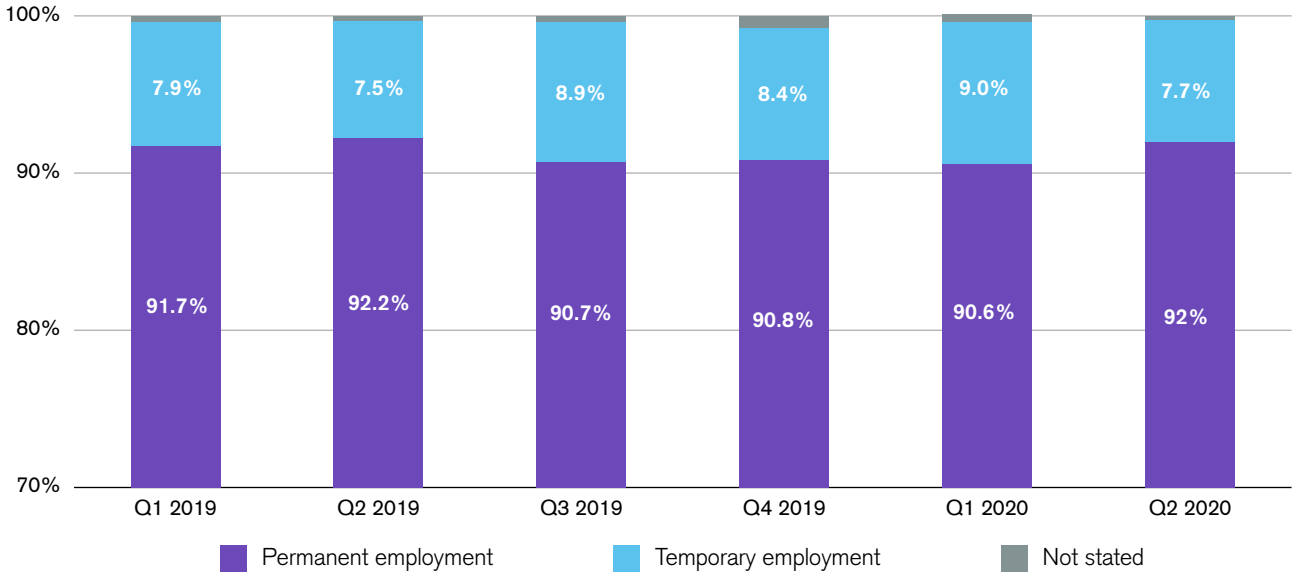
FIGURE 20 | Change in number of temporary employees in Human health and social work activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

In Q1 2020, 90.6% of employees in Human health and social work activities (NACE Q) were permanently and 9% in temporarily employed (Figure 21). At 9%, the share of temporary employees was slightly higher in Q1 2020 than in the same quarter of the previous year (7.9%). However, between Q1 and Q2 2020 temporary employment declined by 1.3 percentage points.

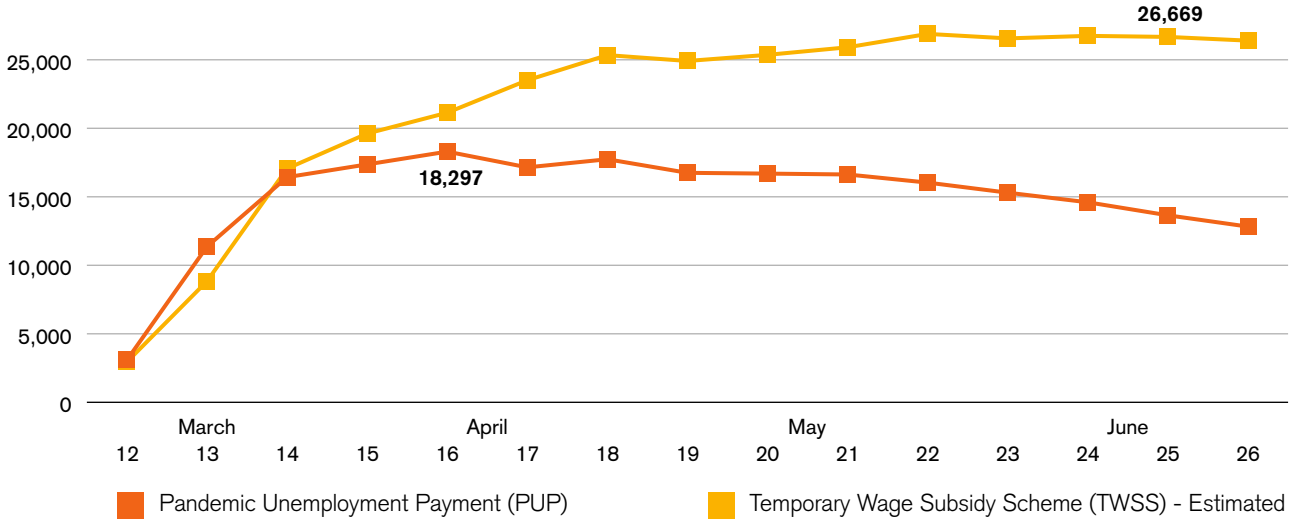
FIGURE 21 | Proportion of permanency of employment in Human Health and Social Work Activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020b).

Unemployment: large number of persons in Human health and social work activities (NACE Q) benefitted from the Pandemic Unemployment Payment (PUP) and of the Temporary Wage Subsidy Scheme (TWSS) in March and April 2020 (see the Section "Government Measures for Coping with the COVID-19 Pandemic" for an overview of the TWSS and PUP schemes). In the case of the PUP, the payments peaked the 16 calendar week (April 2020) 18,297 recipients (Figure 22). From the 19th calendar week onwards, there was a steady decrease in the number of recipients. In the TWSS, the maximum number of recipients (26,669) was only reached by the 25th calendar week, and the number of recipients remained relatively constant until end of June 2020.

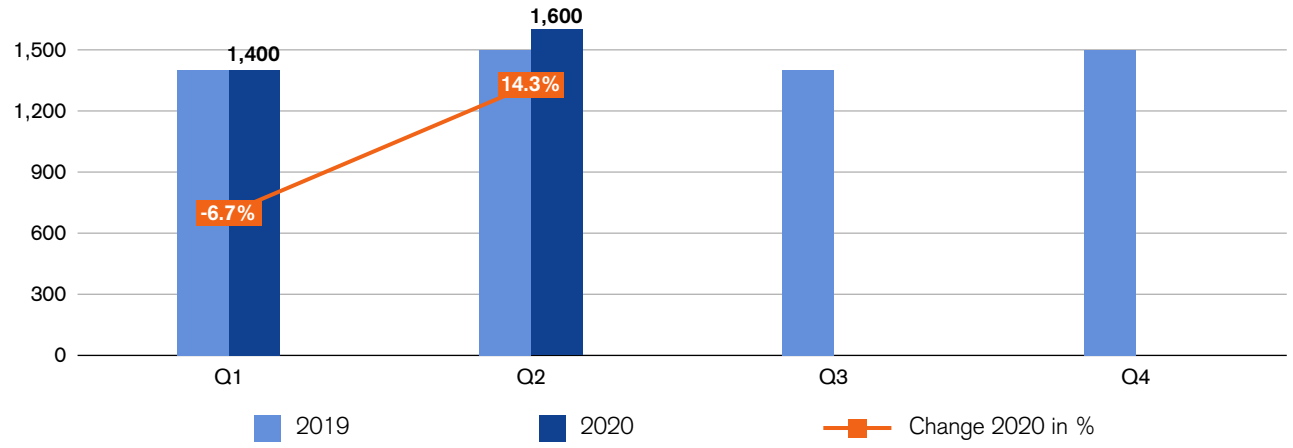
FIGURE 22 | Number of recipients of the Pandemic Unemployment Payment and Temporary Wage Subsidy in Human health and social work activities (NACE Q), calendar week 12-26 2020



Source: own illustration based on CSO (2020b).

Vacancies: in Q1 2020, there were 1,400 job vacancies Human health and social work activities (NACE Q) (Figure 23). This corresponds to 100 fewer job ads (-6.7%) than in Q1 2019, but the number of vacancies remained the same compared to the same quarter of the previous year (1,400). In Q2 2020, the number of job advertisements rose by 200 to 1,600 (14.3%).

FIGURE 23 | Number of job vacancies in Human Health and Social Work Activities (NACE Q), Q1-Q4 2019 and Q1-Q2 2020



Source: own illustration based on CSO (2020c).

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EASPD is the European Association of Service providers for Persons with Disabilities. We are a European not-for-profit organisation representing over 17,000 social services and disability organisations across Europe. The main objective of EASPD is to promote equal opportunities for people with disabilities through effective and high-quality service systems.

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