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Caring about and Care in Disasters: On Privileges, Marginalisation and the Making of Critical (Social) Infrastructure Protection

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The shortcomings of the regulatory state and its corporate actors in allocating resident physicians in rural areas in Germany

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The German health care system has temporarily prevailed during the crisis, not least due to its decentralized health infrastructure. However, there are several shortcomings leading to supply problems even prior to the pandemic. The ambulatory branch faces shortfalls in the supply of resident physicians, in particular in structurally underdeveloped, rural areas. How do these come about?

Several factors come into play: Roughly a third of resident physicians will likely retire within the coming years. The younger generation has not only become predominantly feminine but has undergone a change in envisioning work life. On the one hand, flexible working conditions, preferably in an employment relationship, are a key request. Additionally, studies show a growing want for soft location factors such as childcare, cultural offerings and employment for life partners. The patients, on the other hand, are similarly affected by demographic changes. Older patients are increasingly dependent on continual access to treatment (multimorbidity). These developments meet rather unfortunate structural conditions in various rural areas. Here, austerity politics have “de-infrastrucuralised” municipalities, which, as a result, are facing brain drain. It is, hence, becoming harder to mobilize successors for outgoing physicians. The total number of medical students is growing since the 1970s and ranks as one of the highest in the world. However, not only are graduates increasingly seeking work in non-curative fields, but the state-regulated allocation practice of physicians is leading to misallocation.

The ambulatory branch has long been organized in a corporatist manner, meaning the state delegates the planning and organization of ambulatory care to the association for resident practitioners and the health insurance companies. They come together and negotiate in joint self-governing bodies. This regulatory structure has in light of the financial crisis of the 1970s and increasing competition-oriented restructuring of the health care system undergone a substantial transformation in the direction of competitive corporatism. Its effects heavily influence the relationships between the actors and their strategic rationales. Political-institutional processes aiming to enclose respective supply shortages, namely the health care reforms of the last two decades, have predominantly fallen short of expectations.

The outlined dilemma at hand underlines regulatory malfunctions. It further emphasizes the need for a paradigm shift away from sectoral boundaries and budgetary measures regarding wages and services. Respective claims by diverse social and political actors are to be discussed.

Care Regimes, Capitalism and COVID-19: Feminist Perspectives on the Governance of Care during the Corona Pandemic

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The current disaster response to the COVID-19 pandemic has amplified the existing care crisis and led to a re-traditionalization of gender relations. Mostly women work in critical infrastructure and in the care sector, while they are at the same time responsible for most of the unpaid care work. Feminist economists and political scientists have repeatedly highlighted the fatal constitution of care regimes in western capitalist societies, which are characterized by the marginalization, marketization and privatization of care and its role in exacerbating intersectional gender inequalities.

In the midst of the global COVID-19 health crisis, care and (health) care infrastructure is on the contrary portrayed as critical infrastructure and its crucial role for our society is emphasized. But is this rhetoric commitment reflected in public policies and the governance of care? This contribution reviews the current governmental crisis response during COVID-19 in Europe and analyses how different care regimes (dual-earner-model, breadwinner model, neoliberal care regime) deal with care needs, relations, actors and resources. By focusing on the ways care is governed during the pandemic, we want to highlight the ambivalent role of care in our society, the capitalist economy and its implications for social and gender inequalities.

Securitization and Economization of hospitals – structural aspects of individual health care and their challenges

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The Covid-19 pandemic illustrates that hospitals are not merely institutions of individual health and care. Since early on last year claims were made internationally to prevent hospitals from becoming overwhelmed by a rapid increase of the number of Covid patients. The protection of the health care institutions themselves seemed paramount for the protection of the diseased people infected by the novel virus. Hospitals were perceived as corner stones of the local health care systems, whose collapse poses a threat to national security, culminating in the iconic slogan to ‘flatten the curve’ as the overarching priority during the pandemic.

This talk is about the shift of attention from the individual health to the institutional or structural level in the context of hospitals. Without neglecting the interdependency of both, a stable and functioning health care structure forming the basis for modern individual health care, it explores the various effects this shift in focus can have. On the one hand it analyses this change based on securitization theory and global health security studies as a process of securitization of health in hospitals against the background of the pandemic. On the other hand it considers the shift in perspective as part as the process of economization of hospitals. Last but not least it examines the effects both tendencies have on each other as well as the ones they have all together.

The claim of this talk is that both processes, securitization and economization of hospitals, and the shift of focus they imply while not without other benefits tend to threaten people’s health on an individual level. It argues, that as a result of a conversion of means and ends, the initial end being the individual health and the institution being the means to provide it, the individual is likely to be disregarded. While the treatment of patients still remains the core function of hospitals, securitization and economization alters the structures, in which such treatments are conducted, and the decisions made surrounding them. As a consequence of this the context, in which health care can be given, is being reshaped.

Determinants of social care organisations' abilities to provide help in times of COVID-19 pandemic

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The Covid-19 pandemic challenges the sustainability of the social care organisations (and those dependent on their services) when services are stopped or restricted to mitigate the spread of the virus. The aim of the study is to examine the outcomes for the social care organisations and their users in the early months (March to July 2020) of the pandemic, and the factors influencing the organisations' abilities to successfully respond to the crisis. The study focuses on the experiences of social care organisations such as residential settings, day-centres and food banks that offer services to individuals in highly precarious situations or the homeless in nine countries: Germany, Italy, Hungary, The Netherlands, Norway, Czech Republic, Finland, Lithuania, Estonia. The study is based on 29 qualitative research interviews with managers and staff at social care organisations and document analysis. The analysis demonstrates that in the context of drastic surge in demand for services, diminishing funding, and lack of crisis plans, the dedication and creative solutions by organisations' managers, organisational culture and intra -organisational cooperation were pivotal in maintaining the care provision. The study offers important insights in terms of potential strategies and the role of social service in health crises.

Crisis vulnerability assessment tool considering human and technological structures as well as social support through private relations and state actors

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The lack of systematic analysis of social vulnerability factors, including those stemming from the inappropriate social infrastructures can be considered as one of the key impediments in preparing for and organising recue and support in crisis in many European countries. This paper reflects on the elaboration of a social vulnerability assessment tool co-created with practitioners in crisis management and social care aiming to fill this gap in comprehensive guidance for analysing social vulnerability, including the accessibility and quality of social infrastructures. The tool follows the dynamic and intersectional perspective on vulnerability and guides relevant stakeholders to systematically think through the possible hazard scenarios, the related factors of vulnerability and the sources of information on these vulnerabilities. The tool guides in explicating different factors of vulnerability along the dimensions of human agency and technological structures as well as social support through private relations and state actors. As one of the key spectrums of factors that shape coping capacities, the tool considers the accessibility of public services aimed at providing medical care and rescue services, social and psychological care, public information services, appropriate provisions to people that are under care, supervision or curfew. The dimension also refers to how the services are tailored taking into account the various needs of individuals.

The applicability of the tool was tested in the crisis cases of a large-scale disruption of electrical supply, COVID-19 pandemic, and a cyber-incident in Estonia. The table-top exercise, interviews, and focus groups (with 64 stakeholder representatives) demonstrated how the factors of vulnerability intersect and their impact may be amplified or attenuated by the situational characteristics. Furthermore, the validation demonstrated that the tool effectively broadened the scope of factors considered inducing vulnerability and enabled to narrow the circle of individuals burdened by certain vulnerability mixes and to whom the support should be directed. The exercise of connecting the vulnerability factors stemming from the (poor functioning of) the public support structures to indicators and information sources that could depict these factors of vulnerability may hint why these factors are rarely considered as impediments to societal coping in crises.

Decentralized support infrastructure and psychosocial support in the COVID-19 pandemic

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The results of a case study will be presented. 20 interviews were conducted with experts from the field of disaster control, city administrations and social services in Germany. The main research focus was the question of who became vulnerable during the pandemic and why (see also Wisner et al. 2004). The experience of the experts, especially from the decentralized support structures, and the extent to which they were prepared for the pandemic will be discussed. It showed how important support structures were and are for many people and especially for vulnerable people. Discussed is to what extent social diversity is considered in the measures of crises management and how vulnerability is contextual and what the influencing factors are. It will be shown how the non-consideration of decentralized support infrastructure worsens the living situation of vulnerable people. Decentralized support infrastructure has an increased workload during the pandemic and is confronted with new tasks in the context of e.g. hygiene regulations and physical distancing. At the same time, the people who need the support are under increased pressure. These pressures are, on the one hand, the pandemic and the containment measures that accompany it and, on the other hand, difficulties that arise when they are not included in the measures (e.g., communication difficulties for people who read lips due to the wearing of masks). A key gap in care emerged regarding psychosocial care during the pandemic. This was already inadequate beforehand and became even worse during the crisis. Little attention was paid to the psychosocial care of the population during the pandemic. During the COVID-19 pandemic, stress and symptoms of mental illness increased while treatment options were overcrowded and could hardly accept new patients. At the same time, mental health care is not perceived as a disaster management responsibility. Most importantly, there is a large gap between the day-to-day decentralized support infrastructure and disaster management in Germany. Through increased communication and cooperation between the two, better basic care for the population can be ensured even during crises.

Wisner, B., Blaikie, P. Cannon, T., & Davis, I. (2004). At risk: Natural hazards, people’s vulnerability and disasters (2. Ed.). Routledge