



COVID-19 and policies for care homes in the first wave of the pandemic in European welfare states: Too little, too late?

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Abstract

This article examines COVID-19 and residential care for older people during the first wave of the pandemic in 2020, comparing a range of countries – Denmark, England, Germany, Italy and Spain – to identify the policy approaches taken to the virus in care homes and set these in institutional and policy context. Pandemic policies towards care homes are compared in terms of lockdown, testing and the supply of personal protective equipment. The comparative analysis shows a clear cross-national clustering: Denmark and Germany group together by virtue of the proactive approach adopted, whereas England, Italy and Spain had major weaknesses resulting in delayed and generally inadequate responses. The article goes on to show that these outcomes and country clustering are embedded in particular long-term care (LTC) policy systems. The factors that we highlight as especially important in differentiating the countries are the resourcing of the sector, the regulation of LTC and care homes, and the degree of vertical (and to a lesser extent horizontal) coordination in the sector and between it and the health sector.

Keywords

COVID-19, care homes, long-term care policy, Denmark, England, Germany, Italy, Spain, welfare state comparison

Introduction

The transformative power of the COVID-19 pandemic continues to be revealed. Nowhere has the lethal virus

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had more significance than for health and care systems. Thinking in terms of the first weeks and months of the pandemic in particular, the challenges were immense – the virus requiring a major response within a very short period of time from systems that are designed to evolve and change gradually. Countries have varied in how they have acquitted themselves. In a context of varying claims about policy approaches and packages, we question single country narratives as well as pan-EU generalizations by comparing policies across countries that differ significantly in terms of how they organize long-term care (LTC): Denmark, England,¹ Germany, Italy and Spain. The focus is on developments relating to care homes from early 2020 during the first 10 weeks of the pandemic.

We suggest that care homes are a critical case from which to view and assess the early COVID-19 policy response and the factors that conditioned it. As settings of care and accommodation for older and frail people, care homes bring into focus the treatment of LTC as a social risk and expose the relationship between LTC and health policy and provision. As an exogenous shock, the pandemic tested preparedness, knowledge and capacity utilization and laid bare priorities. We focus our lens on the reactive capacity of the system in the first 2 months of the pandemic because this was the period of greatest initial shock.

The article is organized into three main parts. In the first part, the general context and background are briefly set out and the comparative problematic is outlined. The second part of the article undertakes a systematic comparison of key policies in the five countries, detailing in turn the approach to and timing of lockdown, virus testing and the supply of personal protective equipment (PPE). These are chosen because of their significance in the COVID-19 policy portfolio (WHO, 2020). Timing is interpreted in terms of when the measures were taken over the initial 10-week period, with comparison made to the timing of events for hospitals. The third part assembles key elements of the context of the cross-national differences and similarities found. Highlighted here are elements of the treatment/location of care homes within the LTC policy system, such as relative resourcing, degree of regulation and vertical coordination across levels of governance and between the health and social care

sectors. The overall line of analysis is to enquire into how the variations in policies on the virus in care homes are associated with a set of systemic factors and policy approaches that predated the pandemic. This reveals some causal mechanisms at play – although of course we are speaking of just the first wave of the pandemic and even for this period (now over a year ago), some of the data and evidence are weak.

Theoretical and comparative context

The comparative study of social policy is most assured on the territory of welfare regimes although research is increasingly examining care and services as integral to welfare state variation. Some of this scholarship develops the idea of care regimes, a counterpart to the notion of welfare regimes, focusing either on the care of children (Bettio and Plantenga, 2004), the care of older people (Simonazzi, 2009) or both (Saraceno and Keck, 2010). This work demonstrates that care is part of an interlocking system with national variations in the respective responsibilities of state, market, family and community clustering countries into different groupings. Such configurational approaches have value in encompassing, on the one hand, different sectoral involvement in provision and, on the other, different relationships and interactions between sectors (Daly, 2021). We learn from this work that the philosophical underpinnings of both state and society play a very significant role in influencing how social policy deals with care (Saraceno and Keck, 2010). Inspired by this literature, the five country cases have been chosen to represent variation in the organization of care for older people in particular. Taken in broad strokes, Denmark represents the Nordic tradition; Germany the continental European; Italy and Spain two different trajectories from the original Mediterranean model; and England the liberal.

The comparison of care home policy in these five countries during the pandemic enables us to take existing work forward in three main ways. First, we move beyond static, and in some literatures rather old, comparisons. LTC policy is diverse and vibrant with considerable reform in some countries (including Denmark, Germany and Spain from our five-country set). Changes centre especially upon

Table 1. Key COVID-19 mortality data up to May/June 2020.

Date A	Evidence base (B)	Deaths in nursing homes linked to COVID-19* (C)	Number of care home residents/beds* (D)	Mortality rate due to COVID-19 for residents in nursing homes* (E)	Overall mortality rate due to COVID-19** (F)	Ratio mortality rate in nursing homes to overall mortality rate (E/F) (G)
DK 15/06/2020	Confirmed	211	40,000	0.53	0.105	5.0
DE 23/06/2020	Confirmed	3,491	818,000	0.43	0.109	3.9
IT 05/05/2020	Confirmed + suspected	3,772	97,521	3.87	0.577	6.7
SP 23/06/2020	Confirmed + suspected	19,553	322,000	6.07	0.608	10.0
UK 12/06/2020	Confirmed + suspected	21,889	411,000	5.32	0.665	8.0

*Source: [Comas-Herrera et al. \(2020b\)](#).

**Source: [European Centre for Disease Prevention and Control \(2020\)](#).

Notes: In Denmark and Germany, figures include only people who tested positive for COVID-19. In the other three countries, data include also suspected (with symptoms) cases.

Germany: Calculation includes not only residents' deaths but also deaths in communal establishments such as prisons, homeless shelters and so on; the total number of deaths in care homes is likely to be lower.

Italy: The source is a national survey carried out by Istituto Nazionale di Sanità (ISS) in 1356 nursing homes (41% of the total).

Spain: Data collected from the regional governments which used different methods of calculation; the number of confirmed cases is estimated to be 9679.

UK: Calculation includes the number of deaths separately estimated by [Comas-Herrera et al. \(2020b\)](#) for England and Wales, Northern Ireland and Scotland (data updated to 17/05/2020).

the institutional arrangements for LTC; the rights and supports attaching to either providing care or requiring it; a distinct policy preference for home-based care as against institutional care; a shifting of the relative reliance on informal versus formal care; and a growing recourse to market-based provision to sit alongside private family and public provision ([Eurofound, 2017](#); [León et al., 2014](#); [Ranci and Pavolini, 2013, 2015](#); [Simonazzi, 2009](#); [Spasova et al., 2018](#)). Second, we bring care homes to the fore as a core form of LTC provision. On these the literature has been much more silent, although it is known that care homes are a signature component of contemporary policy on LTC for older persons and that countries vary widely in their reliance on care homes ([Eurofound, 2017](#); [Spasova et al., 2018](#)). Third, we place all of this in the context of the COVID-19 pandemic. To the extent that care homes have featured in social policy research on COVID-19, it is mortality that has mainly been under the microscope. A contribution of this article is to assemble and assess the evidence for a systematic

cross-national comparison of relevant policies in response to the initial shock and to situate varying national responses in the context of the pre-pandemic systemic approach to resources, regulation and coordination of LTC and care homes.

To set the scene, [Table 1](#) presents key elements of the cross-national comparison up to mid-2020 in terms of mortality in general and among care home residents. It shows wide variation and therefore hints at an interesting cross-national comparison. The data need to be treated with caution. Many statistics are still being gathered; there is considerable retrospective recalculation; the evidence is patchy for some countries; the methods for and accuracy of illness and mortality measurement vary across countries, especially in regard to whether a positive result on a COVID-19 test was necessary for a death to be attributed to the virus and the practices for counting COVID-19-related mortality in care homes ([Comas-Herrera et al., 2020b](#)).

In general, the evidence on the spread of COVID-19 in care homes in the early months shows strong

correlation with the prevalence of the disease in the general population. Although a strict cross-country comparison carries risks, the data generally place Denmark and Germany similarly in terms of relatively low mortality rates during the period while the other three countries cluster together with high rates (column E). However, when we look at the mortality rate among care home residents vis-à-vis the total population (column G), the cross-country deviation becomes smaller as Denmark and Germany are closer to the other three countries with a mortality ratio of between 3.9 and 5, compared to 6.7 for Italy, 8 for the United Kingdom (UK) and 10 for Spain. This makes the comparison more complicated but also, we suggest, more interesting.

We seek to explore the cross-country dynamics that underpin this comparison. The research question that drives the article asks: Looking at the first 10 weeks of the pandemic in 2020, what was the timing of and priority given to COVID-19 policies for care homes vis-à-vis those for hospitals and how do we explain variation in policy across the five countries? Care homes are defined following Eurofound (2017: 3) as: ‘institutions and living arrangements where care and accommodation are provided jointly to a group of people residing in the same premises, or sharing common living areas, even if they have separate rooms’. They may also be known as nursing homes or residential homes and in this article are set in the context of institutional care for older people.

Empirically, we focus on the three public-health-related policies that the WHO (2020) identified as crucial for effective policy responses in LTC: lockdown; testing for the virus; the supply of PPE. For clarity of comparison and brevity, the details are presented in highly synthesized form. Using data from the European Centre for Disease Prevention and Control (2020), we standardize the timeframe across the five countries to control for differential timing of first reported case in 2020 – week 1 in Italy is the week beginning 17 February 2020; in Denmark, Germany and Spain, the week beginning 24 February 2020 is the starting clock; and for England, it is the week beginning 2 March 2020. In general, the first 10 ‘shock’ weeks are covered for each country. One other point should be noted regarding the national focus – while we recognize that there is

a strong regional and even local dimension to health and care policy and provision in most of our countries, for reach and comparative rigour, we focus on national level policy.

Cross-national comparison

Lockdown

As we now know, the capacity to intervene early has major consequences for containing the spread of the disease, including early lockdown of care homes (Comas-Herrera et al., 2020a). Our early period comparative analyses highlight the specificity and timing of care home closure in comparison to the general lockdown and that of hospitals (Table 2).

First of all it is important to note that in England and Spain, care homes were never officially locked down in the first wave (just included in the general lockdown – although some Spanish regions (for example, Madrid) had mandated closure and isolation of residents before the national lockdown). In Italy, the lockdown of care homes was partial (in that visitors were allowed in special cases, especially family members) and came 2 weeks after a total closure of hospitals was ordered. In contrast, Denmark recommended local authorities to introduce lockdown early, 1 week before the general lockdown (13 March). Although only a recommendation, it was generally effected across the country and was followed up by a national ban on visitors to care homes in week 7. Germany introduced a strict ban on visitors to care homes on the same day as general lockdown (in week 3 – mid-March), having already introduced a partial closure. A very important aspect of the ‘weak lockdown policy’ in England and Italy is that COVID-19 recovering and other patients could be discharged from hospitals to care homes without a negative COVID-19 test until well into the pandemic’s first wave. In some respects, this was the antithesis of a lockdown policy. In UK an estimated 25,000 such discharges from hospitals to care homes took place up to mid-April 2020 (National Audit Office, 2020).

In sum, there is quite significant variation among our countries, not just in terms of timing but also the prioritizing of care homes for lockdown. While

Table 2. Key details of lockdown policy, first pandemic wave 2020.

	Denmark	England	Germany	Italy	Spain
Was there a specific lockdown for care homes?	Yes	No specific lockdown	Yes	Partial	No specific lockdown
In which week was it introduced?	3	4 (with general lockdown)	3	2	2
How long before/after the general lockdown?	-1 week	Same time	Same time	-1 week	Same time
How long before/after the lockdown of hospitals?	Same time	Same time	Same time	+2 weeks	Same time

Germany and Denmark introduced precautionary measures regarding access and isolation early on, in England, Italy and Spain care homes were not prioritized or well protected and one might even interpret the discharge of COVID-19 patients into care homes in Italy and England as a form of relative neglect of care homes.

Testing and monitoring

Testing residents and workers in care homes was one of the most difficult tasks for national governments, especially in a period when tests were scarce and rapid tests hardly invented. All five countries, with the exception of Germany, faced logistical problems in securing sufficient RT-PCR tests (Table 3).

Policy on testing was dynamic and shifting in all of the five countries, reflecting rapidly emerging knowledge on scientific and policy effectiveness (Capano et al., 2020). On the basis of the evidence, testing in the comparative landscape is best understood as shaped by whether a strategy of containment or mitigation was followed. With the exception of Germany, testing was viewed for a considerable period into the first wave of the pandemic as a mitigation tool, necessary to provide adequate health care to patients with symptoms rather than for prevention purposes (as implied by a strategy of containment).

In England, Italy and Spain, testing was heavily rationed, effectively made into a scarce good with supply concentrated on hospitals. Among other things, this meant that the infection and mortality rates in care homes were hidden. Hospitals were prioritized for testing until at least weeks 7 or 8 in all three countries and even

subsequently scarcity of tests made for serious testing restrictions. Only through strong protest from trade unions and patients' relatives and judiciary investigations (in Italy), the intervention of the army (in Spain), media reportage and pressure from academic and other commentators (in England) was the Pandora's box of the pandemic in care homes opened. In many cases, it was too late: thousands of patients had already died, and many thousands more were in a critical health condition.

Denmark, too, had the problem of a shortage of testing equipment. There, however, care homes were neither ignored nor downgraded vis-à-vis hospitals as they were already included in national prevention guidelines. Unlike England, Italy and Spain, the important role of care homes as health/social care institutions had recognition in the Danish policy agenda. In some respects, the case of Denmark shows that a mitigation strategy could be put into action without necessarily neglecting care homes. Germany is probably the exemplar case of the latter though: from week 1 on care homes were recognized as legitimate targets for the testing strategy adopted as part of the country's integrated approach and Germany never officially moved away from a containment strategy in the first period.

Taking an overview, testing was not always effectively used and its availability and roll-out were among the most disputed elements of the policies considered here. Persons with mild symptoms and with no symptoms were not tested from the start in any of the countries. However, the two country groupings generally hold for the wider rollout of testing, with testing a much scarcer resource in England, Italy and Spain as compared with Denmark and

Table 3. Key details of the testing strategy first pandemic wave 2020.

	Denmark	England	Germany	Italy	Spain
In what week was a testing policy introduced in the country?	1	3	1	1	1
Were care homes explicitly targeted at this stage?	No	No	Yes	No	No
In which week were care homes made a priority for testing?	3	8	1	8	7
How long before/after testing in hospitals?	Same time	+5 weeks	Same time	+4 weeks	+4 weeks

Germany and care homes poorly prioritized for testing purposes in the former three countries.

Personal protective equipment (PPE)

We assess this policy along the following criteria: whether there was a specific policy on PPE supply to care homes and timing regarding the policy on the supply of PPE in general to care homes vis-à-vis hospitals. We emphasize here that we are not assessing the effectiveness of policies in reaching those needing PPE.

In regard to whether there was a specific policy on PPE supply to care homes, the evidence in [Table 4](#) suggests that England and Spain stand apart from the other three countries in that care homes were only partially targeted for PPE supply. To take an example, in England, care homes were grouped together with 58,000 different types of service providers (apart from hospitals) and only late in the pandemic received priority for PPE in their own right (and arguably, they were never prioritized at the same level as hospitals in the 10 weeks considered here).

The evidence shows that most countries gave priority to hospitals for PPE supply in the first weeks, apart from Germany which prioritized both hospitals and care homes. Hence, prioritizing hospitals over care homes is not an inevitability. In Denmark, due to shortages, the supply of PPE to care homes was an explicit policy concern from week 4 only (although the supply to hospitals continued to be prioritized until case levels fell). In England and Italy, PPE supply for care homes became a policy concern in week 5, and in Spain, it never figured prominently in policy during the 10 weeks considered. Any conclusions need to be treated with caution though in that in England, Italy and Spain, it is not clear that the announced policy was reflecting what was happening on the ground.

By way of overview regarding PPE, it does appear that Germany is set apart from the other countries in terms especially of its relatively integrated and equivalent treatment of hospitals and care homes. Denmark was generally later than Germany to act decisively in relation to the supply of PPE to care homes, but ultimately, it too adopted guidelines and policies that did not downgrade or seriously under-resource care homes, as happened in England, Italy and Spain.

Taken as a whole, what we have seen is not just a significant cross-national variation and ‘clustering’ of the five countries in the degree to which care homes were prioritized by policy for key COVID-19-related resources but elements of two general policy approaches. The first placed care homes on a more or less equal footing with hospitals from early in the pandemic, whereas the second placed them in a secondary position, viewing COVID-19 as a hospital emergency in which care homes were seen neither as part of the pandemic problem nor as needing a robust response until such a policy was (deemed) unavoidable. Denmark and Germany tend towards the first approach, whereas England, Italy and Spain exemplify the second, having procrastinated on their responses to the virus in care homes.

The next section proceeds to examine the factors that are associated with this variation, concentrating on the institutional features of the LTC system.

Facilitating conditions

There is not yet an explanatory literature to draw on, although emerging work has tried to explain country differences in care home mortality rates. Among the factors that have been studied in this regard are structural features of care home settings (for example, in terms of a positive association between mortality and the number LTC beds per capita) ([Gandal et al.,](#)

Table 4. Key details of policy on PPE supply first pandemic wave 2020.

	Denmark	England	Germany	Italy	Spain
Was there a specific policy for the supply of PPE in care homes?	Yes	Partly	Yes	Yes	Partly
In which week was it introduced?	4	5	2	5	—
How long before/after the general supply for hospitals?	+2 weeks	+4 weeks	Same time	+4 weeks	—

2020). This focus would not go very far in explaining our variation because Denmark, England and Spain have similar proportions of LTC beds per capita 65+² and the proportion is even higher in Germany where policy has been pro-active. In any case, our focus is not on mortality. Other potentially policy-relevant explanations are also ruled out by the case comparison. These include the political tenure of government: at the time period studied Denmark, Spain and Italy shared left-oriented governments, whereas the United Kingdom had a centre-right party in office and Germany had a coalition government of centre-right and social democratic parties.

This prompts us to turn our attention to the role and place of LTC and care homes in the policy system in triggering or influencing responses to the COVID-19 crisis. Drawing from the existing literature, especially that on regimes which emphasizes inter-locking factors, we conceive of the policy system in terms of three elements – resourcing, level of regulation and coordination of governance and provision. This yields a framework that highlights, first, the supply of economic and human capital resources and hence policy capacity and, second, an indirect measure of the degree of official recognition and valuing of care homes. In regard to the analysis that follows, it should be noted that granular data is not available to enable a detailed care home-specific comparison – it is astounding how little is known about care homes across Europe – and so in some cases, our reference point is the LTC sector as a whole.

‘Economic and human capital resources’ as used here express: (a) economic investment in LTC and (b) relative degree of professionalization of the workforce. Together, they give a sense of sectoral capacity and ‘quality’. ‘Degree of care home regulation’ is based on the existence of national legislation for care homes including the establishment of professional, structural and quality standards. The

indicators of institutional ‘coordination’ refer respectively to the strength of multilevel coordination (vertical) which leads to higher or lower regional disparities and the degree of coordination between the LTC and health sectors (horizontal). Countries are classified relative to each other as ‘high’, ‘medium’ or ‘low’ (a classification which is of course bounded by the comparative landscape created by the five countries).

Table 5 provides a highly summarized, qualitative interpretation of how the five countries are placed relative to each other on these systemic factors.

Economic and human capital resources

It can be seen from Table 5 that in regard to public spending on LTC overall (covering both health and social care components), the countries display a pattern which is recognizable from the literature on care regimes, with Denmark having relatively high spending (at 2.5% of GDP) in comparison to the other countries and Italy and Spain making up the rear (0.6% and 0.7%, respectively). England³ (1.4%) and Germany (1.5%) are placed somewhere in the middle. While we do not take account of country differences in GDP size or respective levels of healthiness/frailty among the older population, the evidence suggests variation in the financial resourcing of LTC across the countries in line with the general patterning of care home-related COVID-19 responses (albeit with some exceptions).

The cross-national patterning remains relatively robust when we turn to the second resources indicator: degree of professionalization of the LTC workforce (which refers to the average share of care workers with professional/university education). Denmark scores highly here with, of the five countries, the most professionally-qualified workforce, whereas in England, Italy and Spain the degree of

Table 5. Some key systemic variations in LTC and care home policies (as of mid-2020).

	Denmark	England	Germany	Italy	Spain
Economic and human capital resources GDP expenditure for LTC*	High	Medium	Medium	Low	Low
Professionalization**	High	Low	Medium	Low	Low
Degree of care home regulation	High	Low	High	Low	Low
Coordination degree of vertical coordination of LTC	High	Medium	High	Low	Low
Horizontal coordination of LTC and health	High	Low	Low	Low	Low

*Denmark 2.5%, UK 1.4%, Germany 1.5%, Spain 0.7% and Italy 0.6%, data from 2017 or latest year. Source: OECD, Health Statistics 2019.

**Low here means that the average share of care workers with professional or university education is between 0% and 33%; medium refers to a share between 34% and 66%; high is between 67% and 100%.

professionalization in care work is low (Colombo et al., 2011; Simonazzi, 2009). Germany falls in between. Some of the pertinent details are as follows.

In Denmark, which has one of the largest nursing and care workforces globally, care workers are relatively highly qualified, 81% have formal training in care provision (FOA, 2020; Rostgaard, 2020). By comparison, care work in Germany is more stratified. Less than half of the care workers in German care homes have a professional education (45%) (Statistisches Bundesamt, 2018) and in the German LTC and care home sector there is a stratum of care assistants with relatively low training (Rothgang and Domhoff, 2019). England, Italy and Spain all have lower levels of professionalization of the LTC workforce than seen in Denmark or Germany. In these countries, the skill level of the care workforce and the share of care workers with professional education are both low (Colombo et al., 2011; Skills for Care, 2019).

Degree of care home regulation

A similar country patterning is found for the level of regulation of care homes in terms of stronger and weaker countries. Denmark has national framework legislation, outlining how the 98 municipalities are responsible for organizing, financing and, to some degree, also delivering care home services. Care homes are highly regulated by several internal and external quality controls, with some inspections centrally regulated at government level and others regulated locally by the municipality. Also, care homes are included in the

emergency protocols which were activated once the first case of COVID-19 entered a care home. The level of regulation is also high in Germany and is enshrined in national legislation. The Social Care Insurance Act (SGB XI) regulates and coordinates the conditions and procedures for organizing, financing and delivering LTC and care home services, regulating the price of care, the amount and type of care services at the different care levels, the testing of need, the type of providers which can offer LTC in care homes, and the conditions regarding the quality of care (Eggers et al., 2020).

In the other three countries, care homes face a lower level of regulation. In England, there is overarching national legislation (The Care Act, 2014) which gives local authorities the responsibility for social care generally, including care homes, but these regulatory powers pertain mainly to general safety and wellbeing standards for residents on the one hand and the functioning of a competitive market for service provision on the other (over 80% of care homes for older people in England are provided by for-profit operators) (Blakely and Quilter-Pinner, 2019; Daly, 2020). In Spain, the history is of poor regulation with the first national regulatory and institutional framework for LTC created only in 2006, when Act 39/2006 established a common framework for LTC in regard to in-kind and cash benefits. In Italy, no regulation concerning care homes and their professional or structural standards exists at national level, leaving the sector in an almost unregulated situation. Devolved or weak regulation may have contributed the quite ‘hands-off’ approach taken to care homes during the pandemic in these three countries.

Coordination

As regards vertical coordination between different levels of government, that is, the extent to which local variations in policymaking and/or implementation are governed at central level, Denmark scores highly, indicating a low level of fragmentation across policy levels with planning and implementation of LTC policies highly coordinated across levels. One example of this is the launching of the national action plan on the older medical patient in 2016, which ensures that a similar policy focus is shared between regions and local municipalities (WHO, 2019). Vertical integration of LTC policies is also high in Germany, with strong coordination mechanisms at the level of the central state. Design, planning and implementation of LTC are a central state responsibility, mainly as a top down process, on the legal basis of the SGB IX Act, and are overseen by the Health Ministry. Federal states and municipalities have to guarantee the infrastructure, but have otherwise little space for action (Och, 2015). In the other three countries, central coordination of care homes is weakened by high devolution to lower institutional levels and the lack of strong coordination mechanisms. In England, care homes are embedded in a long and complex policy/governance chain. Statutory responsibilities to meet LTC need and oversee the provision of care in care homes (inter alia) mainly lie with the 152 local councils/authorities. The Department of Health and Social Care retains overview policy authority and part of the funding is national, but overall the degree of centralization and coordination is low. Despite the existence of national legislation in Spain, vertical fragmentation is marked. The regions (autonomous communities) have the main role in policy implementation and funding of care homes. While an agency exists for coordination between the central and regional administrations, the evidence suggests significant cross-regional differences in implementation, co-payment criteria, procedures to access the system, waiting lists and size of the public sector. Differences are such that it has been said that, instead of one single unified LTC system, Spain has 17 systems (Marbán, 2019). In Italy, too, coordination is highly decentralized: all responsibilities for health are delegated to regions, and those for care to local authorities. Local

variability is therefore very high not only between but also within regions. Inter-regional coordination is very difficult and has strongly hampered the intervention capacity of the central government during the pandemic.

Our second indicator on coordination explores the degree of inter-sectoral link-up between the health and LTC sectors. The only country with a high degree of health and social care integration is Denmark where integration was one of the key drivers behind a structural reform instituted in 2007. The concentration of responsibility for regulation and oversight of LTC in a dual-function Ministry of Health and LTC in 2015 furthered integration. In a departure from a high or medium position on the other indicators, German institutions for health and LTC manifest a relatively low degree of integration. The health and LTC systems are two separate, parallel insurance funding, governance, legislative and services systems. They have a separate legal basis and separate governance structures at central and regional levels. The other three countries show a high level of health/care separation also. In England, the National Health Service was established in 1948 as a national service while social care is localized under the auspices of the local authorities. While both fall within the remit of the Department of Health and Social Care, they are effectively two separate treatment, funding, governance, legislative and service regimes. This is true also in Italy and Spain. In Italy, integrating social and health care was a keyword in the national health service reform in 1978, but individual rights to care have been clearly defined only in relation to health services. In Spain, although the 2006 Act aimed at an integrated socio-sanitary system, most experts conclude that this integration is still pending (Rodríguez Cabrero et al., 2018; Marbán, 2019). The evidence on coordination – and especially the case of Germany – suggests that an integrated health and care system is not an essential condition for an integrated and proactive policy response to COVID-19 in care homes.

Taken as a whole, the analyses in this section support the assumption that variations in specific systemic factors – resourcing, the degree of regulation and vertical (but not necessarily horizontal) coordination – are a key part of the explanation for cross-national policy differences. Although we have not been able to

show how these worked specifically as causal channels in the pandemic and the patterning is not perfect across all factors, we are convinced that there is something significant here. The levels of material resources and human capital invested in LTC needs are higher in Denmark and Germany than in the other three countries. The ‘bunching pattern’ of countries is similar also in relation to the degree of regulation of care homes and the LTC sector in general. Equally, a similar patterning prevails for the degree of LTC coordination across local, regional and national levels. The exception to the pattern of cross-national variation is in horizontal coordination with Denmark as the only country marked by a high integration of LTC and health.

Conclusions

This article sought, first, to gain insight into the different national-level responses to COVID-19 in care homes in five different welfare states during the period when uncertainty about the virus and how to respond to it was at its height (that is, the 10 weeks in 2020 of the first wave in Europe). It proved an encumbered task in several respects, not least data shortages and gaps between stated policy and implementation on the ground. Also, of course, the pandemic developed differently within and across the five countries, with Italy and Spain as temporal vanguards among our cases. These factors notwithstanding, the findings clearly highlight national particularities during the early months of the pandemic in policy and timing on lockdown, testing and PPE in care homes and some notable country clustering. All the five countries prioritized hospitals but to a differential degree. Denmark and Germany generally cohered in terms of adopting an approach that integrated the response to care homes into the national response, including that for hospitals, whereas the pattern in England, Italy and Spain was of considerable policy delay (from another perspective: inaction) and downgrading of care homes in comparison to the resourcing and prioritizing of hospitals for equipment and resources.

A second aim was to locate varying policy responses in national policy systems and hence indirectly identify some of the conditions that shaped them. In this, we take only a first step in understanding the

reasons behind the national and cross-national patterning in the treatment of care homes. The analysis undertaken suggests that differential capacity to respond may be located in systemic factors that predated the pandemic, such as the resourcing of the LTC and care home sectors, the degree of regulation of care homes, and factors relating to the vertical integration of the LTC care sector and the degree of horizontal coordination between the health and LTC sectors. Applying this to our cases, it could be argued that relatively strong institutionalization of the LTC sector and a high degree of regulation of care homes in Denmark and Germany enabled care homes to be prioritized in the emergency policy, to be considered an important target for both policy intervention and exceptional measures, and to receive important resources to be used to deal with the pandemic. In the countries where these factors were weaker, care homes were placed secondary to hospitals, emergency measures were applied only with delay, and the homes were poorly resourced and supported. In general terms, an underlying argument is that the policy legacy as expressed in the policy system has played a relevant role in shaping the protection capacity of the sector in a double sense: first, in prioritizing (or not) care homes when exceptional measures had to be introduced; second, in providing (or not) timely and effective regulation and resources to support the emergency situation. This will have to be tested by future work as will the possibility that the national and cross-national patterns in the responses to the pandemic reflect at root differences in the degree of recognition and valuing of care homes and those who live and work in them.

There is also, of course, the subsequent unfolding of the pandemic, which has seen second and even third waves across Europe. Here, we make three observations. First, the emergency situation caused by testing and PPE shortages that characterized the first wave was generally subsequently overcome in all the countries. However, the situation in Germany deteriorated rather than improved: government failed to offer a new plan for care homes and the measures introduced relatively successfully in the first wave – a relatively intensive system of testing, contact tracing and quarantine – did not work well in the second wave. Second, there is some evidence of national learning in that England, Italy and Spain have prioritized care homes for vaccine roll-out, drawing

closer in this regard to Denmark and Germany. Third, apart from some reservations regarding Germany, it does seem that the general comparative picture regarding policy on care homes has prevailed, especially if one starts from the situation (learning) as of June 2020. None of the five countries has subsequently changed their policy approaches significantly, and there have been no sectoral reforms in any of the countries (although somewhat more regional delegation in Spain).

Further research will have to look for eventual policy learning during the next phases of the pandemic. As a step in this direction, research could test our theoretical framework and reading of the developments as highlighting the relevance of pre-existing institutional characteristics of the LTC sector in shaping the different policy capacity of national governments to manage the COVID-19 emergency in care homes.

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Notes

1. For the United Kingdom, England is taken as the focus of study given significant divergences in LTC policy between the four jurisdictions.
2. DK 38.6, Spain 43.7 and UK 43.8 per capita 65+, 2018; Germany 54.4, 2017. Source: [OECD \(n.d.\)](#).
3. Data are for the United Kingdom.

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