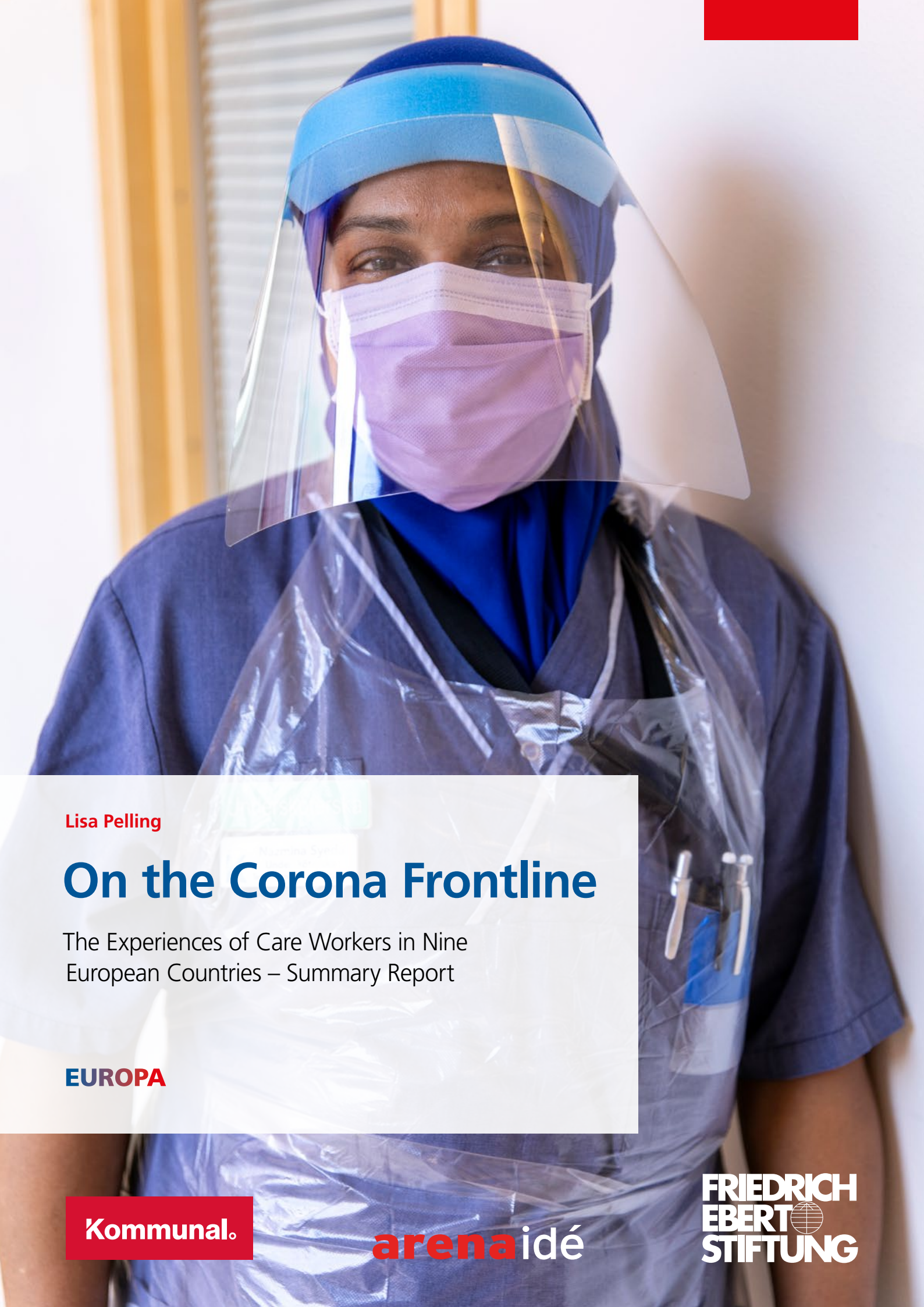


A portrait of a healthcare worker, likely a nurse, wearing a blue hijab, a blue face shield, a pink surgical mask, and a clear plastic apron over blue scrubs. The worker is looking directly at the camera with a slight smile. The background is a blurred indoor setting with light-colored walls and a window with blinds.

Lisa Pelling

On the Corona Frontline

The Experiences of Care Workers in Nine
European Countries – Summary Report

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About this publication

Across Europe, the coronavirus pandemic has hit the elderly hard, and particularly those in elder care, placing care workers on the corona frontline of an underfinanced, understaffed and undervalued care sector. Years of austerity policies and neoliberal new public management have increased the level of privatisation and precarisation, and decreased the rate of unionisation. This report summarises nine country studies on the effect of coronavirus on care workers in Denmark, England, Finland, Germany, Norway, Portugal, Scotland, Spain and Sweden. The report concludes with policy recommendations.

About the Author

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Partner organizations

Arena Idé is a Stockholm-based independent progressive think tank, funded by the Swedish trade union movement. www.arenaide.se

Kommunal is Sweden's largest public sector union with more than 500,000 members. www.kommunal.se

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Lisa Pelling

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The Experiences of Care Workers in Nine European Countries –
Summary Report

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1

INTRODUCTION

The coronavirus pandemic has hit countries differently, and we are yet to understand why the new coronavirus has spread more rapidly in some regions, and why more successfully contained in others. One common denominator across Europe, however, is that the virus has hit older people hard, and particularly those in elder care.¹ Several countries – such as Sweden, the UK, and Spain – have seen devastating death tolls in nursing homes, particularly during the first wave of the pandemic. In all countries, care workers have been at the frontline of the pandemic.

Based on data from 21 countries, in October 2020, the International Long-Term Care Policy Network (LTCPN) estimated that 46 per cent of those who died from or with COVID-19 had been elderly care home residents (Comas-Herrera et al. 2020).

There are urgent lessons to be drawn, and not only national ones. How can we protect our elderly and improve the quality of care? What needs to be improved to secure good working conditions for care workers during these extreme circumstances, and in the long run?

The Swedish Municipal Workers' Union (Kommunal) in cooperation with the Friedrich-Ebert-Stiftung and the progressive think tank Arena Idé has initiated a series of reports that will map how the care sector (both care homes and domiciliary care) has been affected by the spread of the coronavirus in nine European countries and regions: Denmark, England, Finland, Germany, Norway, Portugal, Scotland, Spain and Sweden. The countries and regions have been chosen to represent different parts of Europe, and different ways of organising care for the elderly. In the UK, Scotland and England are covered in two separate reports as devolution has meant that social policy differs in important ways between these two countries.

The report series highlights the trade union perspective on the coronavirus pandemic and care for the elderly. In this report, elder care includes both public and privately funded services and may involve different types of care homes,

domiciliary care and other forms of social care provision. However, it does not include healthcare services.

This report summarises the project's findings. It describes the state of the care sector when the pandemic hit, and the impact that the structure of the sector has had on efforts to contain the spread of the virus. Drawing primarily on data and experiences from the first wave of the pandemic between March and October 2020², it attempts to draw some conclusions for the provision of care in the future. Most importantly, it presents the perspective of the trade unions who organise employees in the care sector, and highlights their pivotal role—and that played by their members—during the pandemic.

¹ This report uses the terms 'elder care', 'care' and the 'care sector', referring to what in the UK is called adult social care for older people. All references to care workers in this report refer to care workers working in the elder care sector.

² Please note that some individual country reports refer to later dates.

2

REPORT STRUCTURE

The report begins with an overview of the way in which elder care is organised, managed and financed in the nine countries and regions. It looks at the sector's share of care homes, assisted living, domiciliary care and other forms of social care. This section also maps the provision of elder care in each country, including the rate of privatisation. The first section describes the working conditions of employees in the sector, and details the strength of the trade unions who organise care workers in the respective countries, including the rate of unionisation.

The second part of the report looks at the care sector and the spread of the coronavirus. It describes the impact of the pandemic on the sector in each of the studied countries, and analyses the reasons given as to when and how the sector was hit. This section includes some comparative data on the spread of the infection, the incidence of COVID-19 and COVID-19 related deaths as well as mortality rates, between the WHO declaration of the pandemic on 11th March and October 2020.

The third part is devoted to the specific working conditions of employees in the care sector during the pandemic in the nine countries studied. It compares the extent to which care workers were informed and trained to deal with and contain the spread of the coronavirus. In particular, this section maps out care workers' struggles for access to personal protective equipment (PPE).

The fourth and final section lists the policy recommendations made by the trade unions in the care sector. These include ensuring adequate PPE, access to testing, and adequate sick pay; giving care workers a say in the development and communication of safety guidelines; ensuring the recognition of COVID-19 as an occupational disease; increasing mandatory staffing levels; and ending the precarisation of care workers, to more general reforms of social care system. It looks at the difficulties and challenges faced by the trade unions and their members, including their victories during the first months of the pandemic.

3

THE CONTEXT: THE PANDEMIC HIT AN UNDERFUNDED, UNDERSTAFFED AND UNDERVALUED SECTOR

3.1 FRAGMENTED ORGANISATION OF THE CARE SECTOR

The organisation of elder care varies from country to country, but there are a number of commonalities. All countries in this study struggle to find the appropriate level of decentralisation of elder care, and all countries face challenges in the relationship between elder care, different kinds of long-term care, and healthcare. In some countries, such as Denmark, Sweden, Norway and Finland, care of the elderly is the responsibility of local municipalities (although in Finland, a reform is underway that will transfer the organisation of care services to 21 health and social service counties at the start of 2023.) In Spain and Germany, federal states have an overriding responsibility for the provision of social care. In the UK, where there is a National Health Service (NHS), there is no equivalent national organisation for elder care, instead, local authorities are responsible for it. In Scotland, unions have successfully campaigned for a reformed social care system, structured around a new national care service. Despite their national laws and regulations, there are important regional and local disparities across the nine countries. As a consequence, elderly people have unequal access to the care system, not only within the European Union, but also within each country.

Access is unequal and the demand for elder care, particularly nursing homes, is larger than the supply. In many countries, such as Finland, policies have aimed to reduce institutional care and encourage the elderly to live in their own homes for as long as possible. That is, to enable—or force—elderly people to continue living at home. This has led to an overburdening of domiciliary care, whose employees have had to take care of those with increasingly complex needs. At the same time, elderly people who are granted a place at a nursing home tend to be older and have complex comorbidities.

A common trait among the nine countries studied in this report is that the care sector tends to be fragmented and dependent upon a multitude of actors. While some care is still provided by (overwhelmingly female) family members, most social care of older people has now shifted to the welfare state. In some countries, such as Portugal, there are important efforts underway to formalise informal care work. Within the same country, indeed the same locality, elder care might be provided by public sector entities as

well as private non-profit organisations (such as religious charities), small private profit-making firms and as large, multinational care companies. Some of the latter are run by venture capital companies or private equity funds. An example of a hugely fragmented and disparate sector is the English care system, with 18,500 employers across nearly 40,000 establishments. Only five providers make up nearly one-fifth of the sector, three of which are private equity funded.

Employment conditions for Europe's care workers therefore also vary hugely: some enjoy full-time, permanent employment and are covered by collective bargaining agreements while others struggle with part-time, temporary or zero-hours contracts in workplaces where trade union density is low, or trade unions are absent altogether.

In a report from June 2020, the OECD notes that the coronavirus pandemic has highlighted the structural problems of long-term care “in terms of insufficient staffing, poor job quality and insufficient skills”, all of which “have a toll on quality of care and safety” (OECD 2020).

3.2 AN UNDERFUNDED AND UNDERSTAFFED SECTOR

In July 2020, when issuing its first policy brief on how to contain the spread of the coronavirus in long-term care, the World Health Organisation (WHO) noted that the COVID-19 pandemic has revealed weaknesses in the response to the pandemic that are due to the fact that long-term care services have been underprioritised. “Resulting in the devastating impact seen across long-term care services globally [...]. These events have highlighted long-standing problems in the long-term care systems in most countries: underfunding, lack of accountability, fragmentation, poor coordination between health and long-term care, and an undervalued workforce” (WHO 2020).

The pandemic has thus exposed problems that existed in the care sector long before the crisis. Throughout the reports, it is evident that the care sector was underfunded—in the UK, total spending on elder care is still lower than it was in 2010—and was suffering a workforce crisis before the pandemic. In many European countries, cuts in spending and financing of the elder care sector were driven by

austerity measures following the global financial crisis of 2007–2008 and the ensuing Euro crisis.

However underfunded the sector is, more funding on its own will not solve the problems due to the extent of ‘output’ in the system. In the UK, where a large share of care is provided by private actors, over a billion pounds goes out of the sector in profits. Leakages are exacerbated by large providers setting up many different structures to extract more value out of the sector, for instance, by money being borrowed between different entities within a bigger umbrella group. While this creates more profit for the company, it is at a cost to the public purse or individuals paying their own care bills.

Precarious working conditions, low salaries and lack of sick pay demonstrate how the care sector has been undervalued. Low pay and low status as well as exploitative employment practices have led to difficulties in recruiting staff, in turn leading to high vacancy rates, and a high turnover of staff, all of which is detrimental to the quality of care. In the reports from England, Scotland and Portugal, the female dominated nature of the sector is given as an explanation for this neglect. While this is important, it should be noted that there is not necessarily a correlation between poor working conditions and high rates of women workers. Ethnic minorities and immigrants are also over-represented in the sector. However, precarious working conditions are also a consequence of years of privatisation and austerity policies. In Sweden, understaffing and time pressure have increased at the same time as job autonomy and support from colleagues have decreased. Taking this into consideration, it is not surprising that the elderly, as well as the sector’s employees, have been significantly affected by the pandemic.

3.3 INCREASING RATES OF PRIVATISATION

It is complex to determine how privatisation has affected elder care. Has increased competition between different actors fostered innovation and improved the quality of care? Has increased ‘freedom of choice’ between private and public employers and the resultant competition in the labour market enabled care workers to negotiate better working conditions? Available research points in several directions. In Canada, long-term care homes run by for-profit providers have been found to deliver inferior care (Stall et al. 2020). An evaluation of care services in Sweden between 1990 and 2009 found, in contrast, that municipalities that introduced increasing competition by opening up to private providers were associated with lower mortality rates (Bergman et al. 2016). One difficulty when analysing the effects of privatisation is associated with the fact that it has often been introduced as a means of increasing efficiency in the sector, and therefore as a cost-cutting measure, not least in the context of austerity measures following the financial crisis of 2007–2008. However, as Robert Sweeney (2020) points out in a recent report on inequality and the care economy, “care work is a face-to-face service which does not lend itself to productivity improvements” (p.25). The el-

der care sector is labour intensive, and, as Sweeney highlights, “costs in care facilities do not fall when more ‘output’ is increased and more people are cared for. If ‘output per hour’, a standard measure of productivity, were increased by compelling carers to look after more patients or clients in a given period, the quality of care would be diminished” (Sweeney 2020: p.25). Efforts to increase productivity by means of privatisation have often led to a deterioration both in the quality of care and the working conditions of the employees.

In January 2021, the non-profit think tank Corporate Europe Observatory (CEO) concluded that the privatisation of health and long-term care “put Europe on a poor footing for a pandemic”. Its report demonstrated how marketisation and public spending cuts, encouraged by the EU, have degraded the capacity of EU member states to deal with COVID-19 effectively (CEO 2021).

One particularly relevant aspect of privatisation of elder care in the context of the coronavirus pandemic is that it tends to lead to a larger fragmentation of the sector, making a swift and coordinated response to the pandemic more difficult.

The rate of private provision has increased in all countries studied in this report during the past few decades. The UK is a case in point. In 1979, 64 per cent of residential and nursing home beds were still provided by local authorities or the NHS. Today, 84 per cent of beds in care homes for older people are owned by private companies, 13 per cent by the voluntary sector and only three per cent by local authorities (Blakeley/Quilter-Pinner 2019). Similarly, 95 per cent of domiciliary care was directly provided by local authorities in 1993. By 2012, it was just 11 per cent. In the UK, unions have drawn the conclusion that privatisation has been damaging for the stability, resilience and cost-effectiveness of the sector.

In Finland, roughly half of the 24-hour assisted living services for the elderly have been outsourced to private actors. In Germany, there has been an increase in the share of care workers employed by for-profit providers. Around 36 per cent of employees in home-care services worked for a private for-profit employer in 1999. In 2017, it was 56 per cent. In 1999, 24 per cent of employees in nursing home services worked for a private for-profit employer, which had risen to 36 per cent by 2017.

In Sweden, approximately a quarter (23 per cent) of domiciliary care hours are performed by private care companies. One fifth of the elderly in long-term care live in a private care home (19 per cent) (Swedish National Board of Health and Welfare 2019).

3.4 DECREASING RATES OF UNIONISATION

In Scotland, the rate of unionisation in the public sector is approximately 65 per cent but decreases to 20–25 per cent in the private and voluntary sector. It is particularly difficult

for trade unions to organise staff in domiciliary care. Potential members are scattered throughout different workplaces, many of which will be their employers' homes. A high turnover of staff and some anti-trade union employers, particularly in the private and voluntary sector, contribute to the challenges.

Nevertheless, the proportion of members in the public sector is still too high considering that most care workers are employed in the private sector. In Scotland, just one in five care workers are a member of a trade union or staff association, while four in five NHS nurses are union members. Those low paid workers with lower levels of qualifications, and lack of individual bargaining power—who would most benefit from union membership—are least likely to join one (Dromey/Hochlaf 2018). Less than one quarter of current members are aged under 34, more than 40 per cent are aged 50 and over (ITUC 2020).

However, the UK is an example of the pandemic having resulted in increased trade union membership, with care workers responding to the trade unions' active campaigns to protect them. Union membership has surged, with largely women joining (Roper 2020), and UNISON recruited 65,000 new members across the UK between January and October. In Sweden, between April and August, Kommunal grew at record speed (an increase of 8,500 members) (Kommunalarbetaren 2020).

4

THE CARE SECTOR AND CORONAVIRUS

4.1 A SECTOR LEFT TO FEND FOR ITSELF

There are around 3.5 million residents living in long-term care homes (such as nursing homes, skilled nursing facilities, retirement homes, assisted-living facilities and residential care homes) in the EU/European Economic Area (EEA) and UK. Residents in long-term care facilities represent 0.7 per cent of the total population (ECDC 2020a).

Early on in the pandemic, it was clear that old age was a major risk factor for falling seriously ill with COVID-19. Still, most countries responded to the need to protect frail elderly people with no more than bans on visits to care homes. For instance, in March, the Swedish government passed legislation restricting non-essential visitors to care facilities, but did not propose any specific policy to deal with the fact that around 71 per cent of people aged 65 years and over are living at home and using municipal home-care services, receiving several visits weekly or even daily. Every fortnight in Sweden, a person using home care services meets an average of 15 health and social care workers, each of whom have contact with more than ten clients (National Board of Health and Welfare 2019).

The European Centre For Disease Prevention and Control (ECDC) has identified residents in long-term care facilities as one of the most vulnerable populations to COVID-19. Besides their physical vulnerability to the coronavirus, these residents are also socially vulnerable to the changes brought about by the pandemic, such as severe restrictions on physical interaction, including visits and social activities (ECDC 2020c).

Despite this, the ECDC has largely failed to issue specific recommendations on how to prevent the spread of the coronavirus to and within the care sector. In a report to the Swedish government inquiry commission on the coronavirus pandemic (Szebehely 2020), Marta Szebehely, Professor Emeritus at Stockholm University and a leading European expert on elder care, notes that, despite the devastating death toll experienced in care homes during the first wave of the pandemic in March/April 2020, and despite the ECDC warning in September that a second wave was about to hit the European member states, the centre did not publish any guidance on elder care. Its report, published on the 24th September, listed a number of ‘non-pharmaceutical interventions’, such as restrictions on public gatherings, school clo-

tures and the compulsory wearing of masks, but there are no recommendations targeted at elderly people, other than to ‘stay-at-home’ (ECDC 2020c).

The same goes for the Oxford Supertracker (Daly et al. 2020), an ambitious effort to list and compare different measures taken against the spread of the coronavirus, including a ‘government stringency index’. There are a total of 136 policy trackers, but only one is related to elder care. Our World in Data’s ‘Government Stringency Index’ which builds on the Oxford COVID-19 Government Response Tracker suffers from the same lack of indicators for elder care: it is based on nine response indicators including school closures, workplace closures, and travel bans (Our World in Data 2020; Hale et al. 2020).

While Portugal put the protection of care homes for the most vulnerable elderly at the top of its priorities, both in terms of public discourse and concrete policy measures, why was there a failure to do the same in the other countries in this report series? The conclusion, drawn from reading the other eight countries’ reports, is that the failure to prevent the spread of the coronavirus in the care sector is symptomatic of the neglect that the sector had suffered before COVID-19 started to spread across Europe at the beginning of 2020.

4.2 ALMOST HALF OF COVID-19 RELATED DEATHS OCCURRED WITHIN THE CARE SECTOR

It is difficult to compare the impact of the pandemic on the care sectors in different countries. When measuring the number of deaths of care home residents, for instance, some countries only record the place of death, while others also report deaths of care home residents in hospital. Some countries include only those that have tested positive, before or after death, while others also record deaths of those suspected to have had COVID-19. The varying testing capacity will also affect the number of deaths attributed to COVID-19, as noted by Marta Szebeheley in her report to the Swedish inquiry commission on the coronavirus pandemic and the care sector. At the beginning of the pandemic in particular, the number of COVID-19 related deaths was probably severely under-reported due both to low testing capacity and a broader range of symptoms in the elderly population (Szebeheley 2020).

4.3 LACK OF COHERENT DEFINITIONS

An additional challenge to international comparison is presented by the lack of a coherent definition of care homes. The terms variously used are 'care homes'; 'senior flats' 'sheltered accommodation' or 'assisted living'—flats targeted at people above a certain age with a minimum of care services provided—long-term care facilities with hospital-like health care provision and advanced care services offered 24/7. In the same sense, the job titles of employees working in this sector vary from country to country.

Bearing these limitations in mind, researchers at LTCPN estimate that the average share of deaths related to COVID-19 taking place at long-term care facilities at the beginning of October to have been 35 per cent in Denmark; 53 per cent in Norway, and 63 per cent in Spain. In Scotland, 46 per cent of all COVID-19 related deaths occurred in care homes. In Finland, 42 per cent of COVID-19 related deaths occurred in elder care 24-hour units. In Germany, 39 per cent of all deaths occurred in 'communal settings', which included those living in facilities for people with disabilities or other care needs; homeless shelters; community facilities for asylum-seekers; repatriates and refugees as well as other forms of shared accommodation (*Massenunterkünfte*) and prisons. In October, the latest available public figure for Portugal was from May, at which time, 40 per cent of all deaths in the country had taken place in nursing homes (Comas-Herrera et al. 2020).

4.4 EXCESS MORTALITY

A more accurate measurement of the impact of the coronavirus pandemic on social care would have been to compare excess mortality. Data from EuroMoMo shows that weekly excess mortality among people older than 65 increased from 2,653 in the first week of 2020, to 167,134 in the nineteenth week and to 317,245 in the last week of the year (EuroMoMo 2021). When comparing the mortality rate in Germany between 2016 and 2020, there is a significant increase between March and April 2020, among people aged 65 or older (Nowossadeck 2020). Researchers calculated that 60 per cent of deaths related to COVID-19 in Germany, could be related to nursing homes (49 per cent) or domiciliary care services (12 per cent) (Rothgang et. al. 2020). While only 14 per cent of the confirmed cases in Portugal were individuals aged 70 years or older, 87 per cent of the coronavirus deaths were in this age group. Until 18 September 2020, deaths of care home residents linked to COVID-19 represented 39 per cent of all excess deaths in England and Wales.

Though most countries were hit by a first wave in March and April (sometimes lasting until May), the pandemic continued well into the autumn, with care workers remaining under enormous pressure and strain. The ECDC defines the transmission of the coronavirus as 'high' when the 14 day case notification rate is 60 per 100,000 inhabitants, that is, 60 new confirmed infections per 100,000 inhabitants within a 14 day period (ECDC 2021). On 8 November 2020, the

ECDC reported that, apart from Finland, all EU/EEA member states and the UK had 14 day notification rates greater than 100 per 100,000 people (ECDC 2020: p. 3). As testing practices have now changed, the highest rates of infection are no longer observed among older people. Instead, since July 2020, rates have been highest among younger age groups, particularly 15 to 24 year olds and 25 to 49 year olds. Even though infection rates have tended to be higher among younger people, they have remained unbearably high among older people. By November 2020, the ECDC was still reporting high notification rates among older people (defined as rates >60 per 100,000 people among those aged 65 years or over) in 24 out of 27 countries where data were available (ECDC 2020: p. 3).

4.5 EXPLANATORY FACTORS

Why have people receiving social care been so severely affected by the coronavirus pandemic? In a report from November 2020, the ECDC published a root cause analysis based on experiences from the UK and Scotland. The analysis identified 12 main factors that contributed to the spread of the coronavirus to and within long-term care facilities. These factors have, to varying degrees, been central to explaining why care homes were so badly hit in the nine countries studied in this project and they are as follows:

- (1) A high community prevalence of COVID-19 in the same sub-national region;
- (2) Larger care home size (>20 beds) and higher occupancy;
- (3) Staff who unknowingly worked while asymptomatic, due to delays/errors in reporting screening test results;
- (4) Staff members (including nurses, carers and kitchen staff) who worked in more than one Long-term Care Facility (LTCF), or who were not designated to floors/units, who continued to work across these sites until outbreaks were confirmed;
- (5) Missed opportunities to identify early warnings in safety data (e.g. staffing absence data, and single positive cases);
- (6) Insufficient training and adherence of staff to Infection Prevention Control (IPC) measures and delays introducing additional Transmission Based Precautions (TBP) when a case was suspected or identified;
- (7) Challenges in implementing the most effective infection prevention control practices (e.g. keeping up to date with the latest guidance and lack of expert advice or specific guidance such as for cleaning products);
- (8) Inadequate staff IPC measures to minimise staff-to-staff transmission (e.g. situational awareness regarding the risk in changing rooms, break rooms, smoking shelters, car sharing and while socialising outside of work);

- (9) Delayed recognition of cases in residents because of a low index of suspicion, i.e. being unfamiliar with the broader syndrome of COVID-19 in older people;
- (10) Delayed identification of cases (e.g. limited availability of punctual testing or test reporting; asymptomatic/pre-symptomatic residents);
- (11) LTCF residents at risk of severe morbidity and death sharing a location, e.g. LTCFs with a high proportion of residents with dementia and receiving end-of-life care;
- (12) Health system arrangements to support staffing in crisis, e.g. for staff absenteeism. For example, larger care homes groups tended to have less well-established relationships with national health services, and had less utilisation of the available and identified support (ECDC 2020: p.6).

4.6 TRAINING AND OCCUPATIONAL TITLES

A case in point has been the issue of training. In Norway, insufficient training among both permanent and temporary staff was identified as a risk factor in the spread of the virus. The Norwegian trade union Fagforbundet points at constant cutbacks in funding and staffing as long-term factors which have aggravated the pandemic. According to Fagforbundet, “[w]hen the pandemic hit, care services were already cut to the bone. Training of personnel had been downgraded over the years. The leaders were too few, and too busy. That complicated the capability to follow the guidelines”.

In Germany, the level of educated staff in the care sector is relatively high. In 2017, 48 per cent of those working in the domiciliary care sector had completed three years’ occupational training, ten per cent had one or two years’ occupational training and 31 per cent had completed either a short course or no training at all. In nursing homes, 45 per cent of staff had completed occupational training of three years, nine per cent had one or two years’ training and 36 per cent had either completed a short training course or had no training (Federal Statistical Office 2018).

In countries such as Denmark, Finland and Norway, there is standardised practical nurse education. For instance, in Finland, ‘practical nurse’ is a protected occupational title for a health and social services professional. Only a person who holds a vocational qualification in practical nursing can use this title, although others with sufficient appropriate training may carry out similar duties. Practical nurse training is an upper secondary level qualification that takes two to three years to complete, depending on prior competence. Practical nurses are also registered in the central register of social and health care professionals. In contrast, the lack of standardisation of the term ‘nurse’ is a long-standing issue in the UK, leaving a *Guardian* article asking “What is a nurse? Baffling number of roles leaves patients and bosses confused” (Leary 2017). Notwithstanding, a professional

nurse is someone who has a nursing degree and is registered with the Nursing & Midwifery Council (NMC). Nursing degrees can also only be obtained from educational institutions approved by the NMC.

Sweden faces a similar situation when it comes to practical nurses. The Swedish Municipal Workers’ Union Kommunal has long fought for national standardisation of practical nurse training and for a protected occupational title for practical nurses, arguing that as long as care work remains unqualified, as work that ‘anyone can do’, both salaries and other working conditions will remain poor. Today, one in five care workers in care homes lack formal education. Yet taking care of elderly patients with a range of comorbidities is a highly skilled job and should be acknowledged as such by both employers and the state.

In Germany, there are inspiring initiatives underway to improve access to qualified staff, and to make care work more accessible and more attractive, not least through a Care Professions Act (*Pflegeberufereform*) introduced in January 2020. The reform unified separate occupational training programmes in nursing and social care into one three-year occupational training programme. A BA study programme in nursing care has also been established at universities of applied sciences. In Sweden, Kommunal and public sector employers are promoting a model in which a healthcare assistant’s education counts towards 50 per cent of a practical nurse’s qualification, which makes it possible to build on previous education and enable career development.

5

WORKING CONDITIONS OF CARE WORKERS ON THE CORONAVIRUS FRONTLINE

Even though there is a lack of comprehensive data, it is clear that the protection of healthcare and other essential workers has not been sufficiently prioritised by governments or employers (Amnesty International 2020: p.15). According to the International Council of Nurses, more than 230,000 healthcare workers worldwide contracted COVID-19 during the first half of 2020. More than 600 nurses had died from the virus by July 2020 (International Council of Nurses 2020). Additionally, data collected by Amnesty International from 63 countries across the globe shows that in July 2020, over 3,000 health care workers had died from coronavirus (Amnesty International 2020: p.14).

By 26 June 2020, 268 deaths of COVID-19 had been registered among health and social care workers in the UK. In Spain (29 May 2020) 24.1 per cent of all confirmed COVID-19 cases were health or social care workers and at least 63 health workers died. In Denmark (at the beginning of May) six per cent of the tested health personnel and 8.4 per cent of the nurses in hospitals had been infected by the virus, in comparison with 3.8 per cent of the general population. These differences have remained: in February 2021, seven per cent of workers in nursing homes had been infected, compared to 4.2 per cent of the total working population. According to Amnesty International (2020), data on infections and deaths of health and essential workers “serves as a crucial reminder of the human costs of this pandemic, particularly of those who were on the frontlines, and their families” (Amnesty International 2020: p.19). In Sweden, up until 1 September, more than 5,000 people had reported being infected with the coronavirus at work to the Swedish Work Environment Authority. Eight out of ten of those infected were women and more than half worked as assistant nurses, domiciliary carers or personal assistants (Hedfors 2020).

The elder care workforce consists to a large extent of women and ethnic minorities. In 2019, the WHO found that 70 per cent of the health and social care workforce consisted of women. In Spain, 76.5 per cent of COVID-19 cases in the care sector were women (Amnesty International 2020: p.18). In the UK, care workers who identify as black, Asian, or minority ethnic (BAME) are over-represented in the total number of deaths related to COVID-19, with some reports indicating that BAME care workers have constituted up to 60 per cent of those deaths. This exposes an undervalued care work sector, in which women and ethnic minorities

face systematic labour market disadvantage, occupational segregation and structural discrimination.

5.1 UNPROTECTED: LACK OF PPE

In July 2020, Amnesty International compiled information on the impact of the coronavirus pandemic on health and other essential workers. Almost all of the 63 surveyed countries reported a lack of PPE (Amnesty International 2020). This is also true for all the countries studied for this report. Although additional PPE was acquired relatively quickly in Finland and Portugal and by May 2020, the situation had improved, with more consistent guidelines. However, surveys by the Finnish Nurse Association found that health workers sometimes used raincoats for protection and were instructed to make face masks out of tissue paper (Sairaanhoidajat 2020; Tehy 2020). In Norway, the country in our report with the lowest rate of infection, one third of municipalities reported a lack of sufficient PPE during the spring of 2020. A lack of PPE in countries such as Sweden led to care workers having to take legal measures to exercise their right to order a suspension of work in order to be granted the right to wear a face mask when caring for nursing home residents with confirmed or suspected COVID-19. In fact, it was not until 25 June 2020, that the Swedish Public Health Agency recommended that staff wear a mask and visor when caring for caregivers and patients with suspected or established COVID-19. According to Kommunal, 42 per cent of domiciliary care workers experienced situations in which they had to work without proper PPE, 84 per cent were worried about the lack of PPE and 48 per cent reported a shortage of PPE (Kommunal 2020).

In England, surveys carried out by the trade unions GMB and Unite, found that care workers who were neither provided with adequate PPE nor being tested, felt unsafe at work. The majority of those without adequate PPE felt that their health was being put at risk and were also worried that they would infect their family or household with the virus. Furthermore, English care workers reported that they did not know where to get tested. Their employers did not provide them with adequate guidance or training for working with service users with COVID-19 symptoms. Due to the lack of testing capacity, some care workers had to travel hundreds of miles to get themselves tested.

Evidence is now starting to emerge on how different professional groups have been hit by the pandemic. In Germany, COVID-19 cases among workers in domiciliary care were double the number in the average population, and the rate of COVID-19 was six times higher among workers in nursing homes than in the average population (Rothgang et al. 2020).

5.2 UNDER-PRIORITISED: LACK OF RESOURCES AND ATTENTION

European societies in general, and their welfare sectors in particular, were not prepared to cope with a pandemic. Not least because cold war civil contingencies of medical equipment and PPE had been abolished, capacities for crisis management were scaled down, forgotten or made obsolete after the end of the Cold War. In most countries covered in this report, the shortage of PPE was aggravated by the fact that their authorities decided to give the highest priority to hospitals during the initial stages of the pandemic. Despite this, transmission was taking place in hospitals, and while the major source of transmission in the care sector probably came from the community (i.e. staff and visitors), an important source of infection and indeed COVID-19 outbreaks at care homes were infections picked up during hospital stays. Patients were not properly tested before being transferred back to their care homes, and brought the virus with them to a setting where staff had no or very little PPE. In the UK, the priority on hospitals put additional pressure on the care sector. Care homes had to receive patients—some who had been tested positive for COVID-19 and others who were waiting for results—from hospitals to free up beds. However, since both groups required strict isolation, additional pressure was put on care homes. At the same time as deaths declined in hospitals in the UK, they increased in care homes and the forgotten frontline of social care workers were unable to adequately protect the elderly (UNISON 2020a).

5.3 UNSUPPORTED: WORKING UNDER UNBEARABLE MENTAL PRESSURE, WITH HUGE RESPONSIBILITIES, AND FAILING WELFARE SERVICES

The reports written for this project bear witness to an increased workload for care workers during the pandemic, as well as increased levels of anxiety and stress. According to two surveys of health workers in Portugal (published in April 2020), almost 75 per cent of health workers considered their levels of anxiety as ‘high’ or ‘very high’ and 14.6 per cent reported that they had moderate or significant levels of depression during the pandemic. In addition to this, 40 per cent of nurses experienced higher levels of anxiety due to increased working hours. 57 per cent of nurses reported that their sleep was ‘bad’ or ‘very bad’ and 48 per cent reported their quality of life as ‘bad’ or ‘very bad’. Only 1.4 per cent had received mental health support (Escola Nacional de Saúde Pública 2020; Azevedo 2020). In the UK, one in two workers in the health and social care sector

felt that their mental health declined during the pandemic. 35 per cent reported having used alcohol to cope with work-related stress, 56 per cent that they were emotionally exhausted and 63 per cent having had difficulties sleeping (Thomas/Quilter-Pinner 2020).

According to a survey by the Danish trade union FOA (24 July 2020), the fear of transmitting the infection at work was most frequent in the care sector (55 per cent). While care staff reported that lack of access to tests was associated with fear of infection and transmission, lack of PPE was only associated with fear of transmission. One employee in a nursing home reported that “[i]t is a great worry for me that I don’t know if I may infect residents of the nursing home. I don’t visit my own elderly parents, because I am worried that I might infect them. I work in the care sector and I don’t have any kind of PPE or protection” (FOA 2020). This illustrates how fear and stress can result in increased mental illness when emotional responses are associated with willingness to work during the pandemic. Moreover, it exposes the need to pay attention, not only to hospital settings, but also to other groups on the frontline that need to protect themselves, their families and their clients from infection.

Besides the huge pressure and responsibility, elder care workers have also been affected by other welfare issues during the pandemic. In England, care workers have been struggling with childcare, accommodation and extra costs, due to, for instance, travel restrictions during lockdown forcing them to find temporary accommodation closer to work. One in three thought that wider provision of hotel accommodation near their workplace should be an immediate government priority. Moreover, they felt that the government should acknowledge a wider range of reasons that workers might need accommodation due to increased travel time and working hours as well as anxiety for their family’s safety.

5.4 UNCOVERED: NO SAFETY NET WHEN ILL AND LIMITED ACCESS TO SICK PAY

Reports from Germany, England and Scotland expose limited access to proper sick pay. In the UK, in mid-April, it was estimated that 16.2 per cent of essential workers (including care workers) were COVID-19 positive. This gives an idea of the number of workers who were forced to stay at home due to falling ill with COVID-19. In Portugal, workers in residential care homes accounted for about a third of COVID-19 related sick leave. In many countries, presenteeism was a problem, with care workers feeling forced to go to work even though they had symptoms of infection.

5.5 UNLIMITED: WORKING LONG HOURS

In all the countries studied for this report, care workers faced an increased workload during the pandemic. They have often been forced to work overtime, sometimes with little or no compensation. As their workload was already

high before the pandemic, some workers have been unable to take annual leave. This has increased stress and anxiety among workers (Amnesty International 2020). However, since 42 per cent of workers in long-term care facilities in the EU work part-time, 58 per cent do not want to reduce their working hours (Eurofound 2020).

5.6 UNDISPUTED: WORKING CONDITIONS ARE CRITICAL TO WHETHER THE CARE SECTOR CAN COPE WITH THE PANDEMIC

The overall rate of infection is the most important explanatory factor when it comes to the rate of infection within the care sector: the higher the rate of infection in society in general, the higher the rate of infection and the higher the rate of deaths among care home residents as well as among their care workers. However, the rate of infection is not the only factor. Adelina Comas-Herrera and her team at ILTCPN have identified a number of different measures to prevent and manage COVID-19 outbreaks in care home settings in May 2020 (Comas-Herrera et al. 2020). Most of these measures depend on the working conditions of the care workers for their success.

1. PREPARING CARE HOMES FOR OUTBREAKS

The researchers emphasised the lack of national guidelines for care homes in terms of PPE and testing, but also that national authorities often lacked an overview, something that the trade union representatives and activists interviewed for our report series have stressed time and again. There is knowledge about the situation in the care sector, and it rests with the care workers who spend their working days there. What authorities and governments at all levels need to do is to listen. This report has shown that trade unions have been increasingly successful in making their voices heard. For instance, some unions have successfully used data from structured surveys of their members, shop stewards and health and safety officers as a basis for their communications, such as Kommunal in Sweden, FOA in Denmark and UNISON in Scotland and other parts of the UK.

2. PREVENTING OUTBREAKS FROM SPREADING TO CARE HOMES

In order for outbreaks in the community to be kept outside care homes, measures such as a ban on visits are important, even though this may have a significant negative impact on the wellbeing of both residents and their families. Under some circumstances, it might be preferable to have limited or scheduled visits under strict preventive measures. It is also important to make sure that care home residents who return from hospital, for instance, are tested before being allowed to move in. However, it is also essential to reduce the number of different staff, since hourly paid and part-time staff often work in several care homes at the same time.

3. PREVENTING THE SPREAD OF INFECTION WITHIN CARE HOMES

The working conditions of employees are crucial. In order to prevent coronavirus from spreading, staff must have access to proper training in hygiene procedures and disease prevention. This chimes with long-standing trade union demands for access to training and adequate levels of staffing for the care sector—with staff that are sufficiently qualified. Access to PPE is also central, as well as repeated and systematic testing of all members of staff.

4. STRENGTHENING THE RESILIENCE OF CARE HOMES

This includes efforts to support the wellbeing of both residents and staff, for example by making sure that the latter have access to psychological support. The ILTCPN conclude that there is “a need to strike a careful balance between maintaining the welfare and quality of life of both the people who live in the care home and the staff who work there, and preventing the spread of infection” (Comas-Herrera et al. 2020).

6

POLICY RECOMMENDATIONS

The COVID-19 pandemic hit an underfinanced, understaffed and undervalued sector suffering from decades of fragmentation, marketisation and privatisation, in which trade unions are under increasing pressure. At the start of the pandemic, the care sector was largely left to fend for itself, when emergency wards and hospitals were prioritised over long-term care facilities. With devastating results: in all the countries studied, almost half the number of deaths occurred within the care sector (Comas-Herrera et al. 2020).

It is largely undisputed that the working conditions of care workers are critical to whether the sector can cope with the pandemic. Yet many care workers have been left unprotected on the coronavirus frontline. There has been a lack of PPE, resources and attention. Many care workers have had to work long hours under unbearable mental pressure, facing not only insecure terms of employment, but also failing welfare services, insufficient personal safety and limited access to sick pay.

Throughout the crisis, the sector's trade union activists and their unions and federations have addressed the situation on the corona frontline, making demands for urgent action to improve the protection of the older people in their care as well as fighting to improve working conditions for all care workers. Trade unions have also stepped up their campaigns for long-term reform of the care sector. This section of the report presents their most important demands and proposals.

6.1 ENSURE ADEQUATE PERSONAL PROTECTIVE EQUIPMENT FOR ALL

The right to adequate PPE has been the key demand of trade unions in the care sector. According to Amnesty International, there have been reports of strikes, threatened strikes or protests due to shortages of PPE in 31 countries worldwide since July 2020 (Amnesty International 2020: p. 20).

Public Services International (PSI), a global trade union federation of 700 trade unions and 30 million workers, collected data up until May 2020, showing that over 60 per cent of unions in 62 countries had reported workers delivering public services who had not been issued with adequate PPE (PSI 2020). Similarly, the International Trade Un-

ion Confederation (ITUC) reported a lack of adequate PPE for health and care workers in 51 per cent of its member countries. In some countries, health workers had to buy and pay for their own PPE as it wasn't provided for them (ITUC 2020).

On April 15 2020, Rosa Pavanelli, the PSI general secretary, noted that PSI was facing "the most acute crisis its members have ever been confronted with", arguing that the trade union movement should focus on two fronts, both on "a set of immediate targeted emergency actions" and on an economic response to the pandemic. The emergency actions demanded by the PSI secretary included, as a first priority, to "use all means necessary to provide PPE to all workers exposed to a high risk of contagion" (Pavanelli 2020).

This position is mirrored in the trade union responses to the pandemic in the countries surveyed for this report. For instance, in Finland, the Trade Union for Public and Welfare Sectors (JHL) also reported that the most critical issue during the first months of the pandemic was a shortage of PPE.

In the UK, trade unions were instrumental in exposing shortages of PPE for carers by, for example, carrying out regular surveys of health and social care workers. Both GMB and Unite surveys confirmed and quantified the lack of adequate PPE. The surveys also found that the majority of those without adequate PPE felt that they risked not only their own health, but also worried that they would expose their families or households to the infection (Unite 2020; GMB 2020).

Similarly, in Sweden, Kommunal's regular surveys among its union representatives and trade union health and safety officers were an important means of raising awareness about the working conditions for care workers, both internally within the union as well as among the general public. The surveys exposed the urgency of the situation in the sector early on and were invaluable in contributing to understanding what measures impact on the containment of the spread of the coronavirus (Pelling 2020).

6.2 ENSURE ACCESS TO TESTING

Lack of testing has been a huge problem for workers in the care sector in all countries studied for this report series. In the UK, for instance, problems with the testing system have

been identified as a key failure of the government's handling of the pandemic. Due to the fragmentation of the social care system, governments have been unable to provide all care workers with access to testing. During the initial months of the pandemic, care workers did not know where to get tested and reported that their employers did not have a procedure in place for when workers and service users have had COVID-19 symptoms.

A more positive example is Denmark, where trade unions managed to negotiate a tripartite agreement on a test strategy, albeit not as successful in implementation as initially planned. In Portugal, a national screening programme was launched in partnership with research centres, allowing for the application of over 117,000 preventive COVID-19 tests among workers of social care facilities. Recently, a second stage of this programme has started, with 50,000 tests already performed in about 880 workplaces, 340 of which had positive cases.

In Scotland, UNISON successfully campaigned for COVID-19 tests for social care workers after research showed that eight per cent of those surveyed had been infected and one in three had to self-isolate after colleagues had been infected (Ferguson 2020).

6.3 GIVE CARE WORKERS A SAY IN THE DEVELOPMENT AND COMMUNICATION OF SAFETY GUIDELINES

When PPE eventually became available, its quality—and insufficient guidelines on how and when to use it—was a major concern for care workers across the nine countries. In Denmark, the main challenge has been, (and still is), that the guidelines keep changing. Up until October 2020, the guidelines on COVID-19 in the healthcare sector had been revised 21 times, and the guidelines on PPE four times. A major trade union victory in Denmark was achieving both sharper and clearer guidelines about when and how to wear PPE.

6.4 INSIST ON HEALTH AND SAFETY INSPECTIONS OF ALL WORKPLACES

Trade unions in Denmark fought hard to make sure there were proper inspections of health and safety conditions in workplaces on the coronavirus frontline—including access to PPE and PPE guidelines. It was a hard-won victory that allowed the Working Environment Authority to resume its on-site inspections in August 2020, after having only carried out digital inspections since March.

In Spain, trade unions have highlighted worker safety as a core issue for the trade union movement, not only in care homes, but also for domiciliary workers whose workplaces are also their clients' homes and where safety risks are possibly even larger due to the fact that they are very difficult—and during the pandemic virtually impossible—to inspect.

6.5 ALL CARE WORKERS SHOULD HAVE THE RIGHT TO ADEQUATE SICK PAY

In all European countries, people were urged to 'stay home if you feel sick'. Despite this central strategy to minimise the spread of the coronavirus, care workers still had to fight for their right to sick pay, that is, to decent pay while, off work with illness and symptoms. This was an important condition demanded by trade unions in several countries.

In Sweden, it was a victory for Kommunal when, at the beginning of March, the municipal employer organisation, the Swedish Association of Local Authorities and Regions (SKR), urged all employers in the municipal sector to extend all temporary contracts to at least 14 days' duration, so that also employees on short-term contracts would be able to benefit from payments when sick.

The right to sick pay was an important demand of UNISON in Scotland and other parts of the UK. A Unison survey of care workers showed that, even by July, far too few care workers were getting proper sick pay, with 52 per cent paid less than 100 pounds a week or nothing at all if they needed to shield or self-isolate. This was despite evidence showing that levels of infection were lower in care homes that paid sick pay to their staff (UNISON 2020b).

In June 2020, an important trade union victory was won with agreement from the Scottish government on the establishment of a social care staff support fund to ensure that workers would receive their normal pay should they fall ill or have to self-isolate on public health advice. (Scottish Government 2020).

German trade unions highlighted the situation of 'marginal' (geringfügig) part-time care workers, who, despite the increased risk of becoming infected that they face in care work, only have access to sick pay for the first six weeks of illness due to the terms of their employment contracts. Furthermore, in the event of a facility closure or a reduced demand for domiciliary care, they are not entitled to any lay-off pay or unemployment benefit.

In Denmark, trade unions fought for employers to follow the guidelines granting sick pay to employees at risk of falling seriously ill from COVID-19, due to prior underlying conditions such as cardiac conditions and asthma.

Although we are yet to fully understand the reasons why the coronavirus has spread more in some countries than in others, there are some indications that the countries with the lowest death rates have the most generous sick leave benefits. Norway is one example: by February 2021, with a population of five million people, it had registered less than 600 deaths related to COVID-19 (FHI 2021). In Norway, employees have 100 per cent sick pay in the first full year of leave. In comparison, Swedish employees normally have no coverage at all on the first day, and receive less than 70 per cent of their salary from the second day onwards (Martos Nilsson 2018).

6.6 RECOGNISE COVID-19 AS AN OCCUPATIONAL DISEASE

Many care workers have fallen ill with COVID-19. In Norway and Denmark, Fagforbundet and FOA secured a big win in COVID-19 being approved as an occupational disease, giving health personnel and other groups the right to compensation if employed in workplaces exposing them to high risks of infection.

In Scotland, trade unions were decisive in forcing the Scottish government to make a one-off payment of £60,000 to a named survivor of any social care worker who dies in service from coronavirus, and whose contracted pension arrangements do not offer death in service cover (UNISON Scotland 2020a).

6.7 INCREASE MANDATORY STAFFING LEVELS

Insufficient staffing levels have contributed to care workers feeling forced to attend work even if they have COVID-19 symptoms. In Portugal, trade unions have pointed out that some care facilities have not complied with legal requirements on patient/staff ratios, and criticised some institutions for asking their employees to work excessively long hours. This led to the adoption of several policy initiatives to reinforce staffing levels in the care sector. There were reports of care homes demanding that their staff work 14 days in a row, in two 12 hour long daily shifts (including the night shift) (STSSSS 2020).

In Spain, a central demand of the trade union movement has been to increase mandatory staffing levels, and to do this by putting in place detailed requirements for each profession [el establecimiento de ratios de trabajadoras por especialidad]. That is, instead of stipulating a given number of staff per resident, the trade unions have demanded that legislators should instead guarantee a sufficient number of staff in each category. For example, that there are enough trained nurses and that the number and training of staff is adequate to the specific needs of elderly residents.

German trade unions similarly demanded that employers ensured that care facilities were staffed with sufficiently qualified personnel, and that staffing levels should be verified by the responsible supervisory authorities and sanctioned if necessary. Another important demand was for employers to reduce the overall workload.

6.8 END THE PRECARISATION OF SOCIAL CARE WORKERS

Trade unions have been sounding the alarm for many years about the increasing precarisation of working conditions in the care sector. When the pandemic hit, these working conditions aggravated the situation, for instance by making it impossible to isolate infected residents in one facility from those in others as yet without infection. In order to

prevent outbreaks from spreading, it is crucial that care workers are granted more permanent contracts, and can be employed full-time at one single facility. As CGTP-IN, the Portuguese trade union confederation, has noted, “precariousness and low wages lead to multi-employment and enhance the import of the virus into [care homes]” (CGTP 2020).

In a report published in December 2020, Kommunal showed that Swedish care homes with COVID-19 outbreaks had a higher proportion of hourly-paid staff. 39 per cent of the care homes with several COVID-19 cases had more than 20 per cent hourly-paid staff, while only a fifth of the care homes without spread of infection had more than 20 per cent hourly-paid staff (Huupponen 2020).

6.9 IN-SOURCING INSTEAD OF FURTHER OUTSOURCING

In the UK, UNISON, GMB, the RCN and the Trades Union Congress (TUC, a federation of trade unions in England and Wales) have all campaigned for limiting private sector involvement in the care sector. Several measures are proposed, such as stricter regulations of private actors, ending contracts for failing services and more transparency. Trade unions have also proposed an ‘insourcing first policy’ for all services, as an essential step towards ending the present for-profit funding model.

6.10 FURTHER REFORM THE SOCIAL CARE SYSTEM

According to Rosa Pavanelli, the PSI general secretary, beyond the immediate emergency response to the pandemic, there is a need to deeply rethink the role of government, not least when it comes to public services. “We don’t want health workers who save lives to be called heroes. They are not heroes! They are professionals who claim and deserve respect, dignity, the right to be protected and recognition of decent wages and working conditions.” (Pavanelli 2020). As the Portuguese trade union STSSSS put it in a statement “it is not enough to socially value” care-workers, but rather “it is urgent to [...] pay fair value for work [and] fight all abuses” (STSSSS 2020).

In Portugal, the Portuguese Unions Confederation (CGTP-IN), one of two main Portuguese trade union federations—with which the STSSSS is affiliated—argues that the pandemic has revealed the fragility of the care system, “with notorious weaknesses in planning, coordination, training [and] wages” (CGTP 2020). This position is reinforced by the General Workers’ Union (UGT), whose Secretary General anticipated that COVID-19 would change many aspects of our life, including “the centrality of the national health system” and “the attention that care homes and support for the elderly receive”.

All through the pandemic, in both the UK and Spain, unions have continued to campaign for longer term reform of

the social care system. In the UK, this includes a properly funded National Care Service, in which private sector involvement is limited and there is proper sectoral collective bargaining to ensure a fairer system of pay, terms and conditions and working practices.

In Spain, it is clear that an improvement of the working conditions of care workers depends on an increase in funding. Improving both the quality of services and the employment conditions in the care sector requires a significant increase in funding. Trade union demands particularly focus on raising the lowest salaries, limiting part-time hiring and reducing temporary employment of workers. The unions maintain that poor quality employment prevents many workers from leading a decent life, highlighting that many female care workers live in-work poverty.

In the UK, trade unions have won important victories on issues ranging from the provision of affordable accommodation for care workers during lockdown to access to testing and adequate sick pay. At the same time, they have also run public awareness campaigns highlighting the role played by care workers and shifting public opinion about the status and value of that care work.

In Scotland, trade unions won an early victory during the pandemic when the Scottish Government and local authority employers met their demands for a Scottish Living Wage to be paid to social care workers immediately, substantially raising the level of wages in the sector. The trade union and the broader labour movement have continued to campaign for the creation of a National (Scottish) Care Service. UNISON Scotland has set out a 'road map' towards the creation of a national care service, identifying several immediate actions, including national procurement, sectoral bargaining, enforcing clinical standards and a national workforce plan. The aim is to achieve proper funding, improved pay and conditions, a workforce strategy and ethical commissioning (UNISON Scotland 2020b).

In many countries, there are calls for the social care sector to introduce national pay scales and pay progression, such as already exist in the healthcare sector.

In Germany, Ver.di's central demands related to COVID-19 and care work include clear policy demands directed towards the European Union. Ver.di argues that the EU cannot afford to have underfunded and poorly equipped national healthcare and care systems. The European Union should therefore support and coordinate national healthcare systems to ensure equal access to quality healthcare and social care for all Europeans, not least by establishing minimum standards. Ver.di calls for a binding directive that the European Health Union must comply with. In a statement, Sylvia Bühler, in charge of health policy on the national board of Ver.di, called on the EU member states to provide "strong support for the rapid establishment of a common reserve of protective equipment, vaccines, and medication as well as for the organisation of their fair distribution" (Ver.di 2020).

7

CONCLUSIONS

Even though the coronavirus pandemic has had different impacts on European countries, one common denominator is that the virus has hit the elderly hard, and particularly those in elder care. This placed Europe's care workers on the coronavirus frontline.

Care workers have been more exposed to the coronavirus than most other professional groups. This is not only because care workers have not been able to stay at home, and have been forced to travel to work, exposing themselves to the risk of getting infected on congested public transport, but also because they have worked with the segment of the population most vulnerable to falling seriously ill with COVID-19. In all countries surveyed for this report, care homes have been hit tragically hard by outbreaks of COVID-19, exposing both their fragile elderly residents and their care workers.

Carers have worried about becoming ill themselves, infecting people in their care at work and putting their own family members at risk. They have been asking: "Can I hug my kids when I come home from work?"

The pandemic hit an underfinanced, understaffed and undervalued sector. Years of austerity policies and neoliberal new public management have increased the level of privatisation and precarisation at the same time as the rate of unionisation has decreased.

Throughout the nine reports produced for this project, it is evident that the pandemic has worsened the already poor working conditions of care workers. Too often, they have had to continue working in understaffed workplaces, increasing an already unbearable workload with even more overtime. In all countries, care workers have suffered from increased physical and mental pressure, sometimes resulting in depression and substance abuse. Despite working longer hours, many were left without proper sick pay.

In the face of these challenges, care workers across Europe have done an amazing job—not least when it has come to ensuring access to PPE and guidelines on when and how to use PPE—and this has often been the result of hard and persistent work by trade union members and their federations. Without their skillfulness, care and relentless effort, Europe's elderly, and society as a whole, would have fared much worse.

Trade unions in these nine countries and regions have fought to ensure care workers have had adequate PPE, the right to sick pay, and access to testing. Beyond dealing with the emergency, and fighting for the urgent needs of their members, trade unions have also campaigned for complete reform of the care sector into one that can offer its workers decent working conditions, adequate pay, and respect.

The pandemic has proven that deficiencies in social care—which trade unions and their members have warned and protested about for many years—such as precarious working conditions, understaffing and underfunding, have been devastating for the ability to protect the most vulnerable during the coronavirus pandemic: the elderly.

It is high time that we listened to them.

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N.B. All country reports will be published here: www.fes.de/en/on-the-corona-frontline

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EUROPA

Covid-19 has uncovered many societal fault lines. The virus hit the elder care sector in many countries especially hard, leading to many deaths and pushing care workers fighting on the corona frontline to the end of their limits. The pandemic has underscored deficiencies in elder care that have been warned about and protested by trade unions for years. Precarious working conditions, understaffing and underfunding devastatingly undermined the ability to protect the most vulnerable during the corona pandemic: our elderly.

It is high time we listen now.

The Friedrich-Ebert-Stiftung has, on the initiative of the Swedish municipal workers' union, Kommunal, and the Swedish progressive thinktank Arena Idé, commissioned reports from several European countries. By focusing on the plight of those in need of care and their caregivers, the reports shed light on the pandemic's impact on elder care and highlights the justified demands of the care workers' trade unions as well as the long overdue need for reform of the sector as a whole.

This report summarises nine country studies on how the effect of the coronavirus on elder care workers in Denmark, England, Finland, Germany, Norway, Portugal, Scotland, Spain and Sweden. The report concludes with policy recommendations.

Further information on the project can be found here:

www.fes.de/en/on-the-corona-frontline