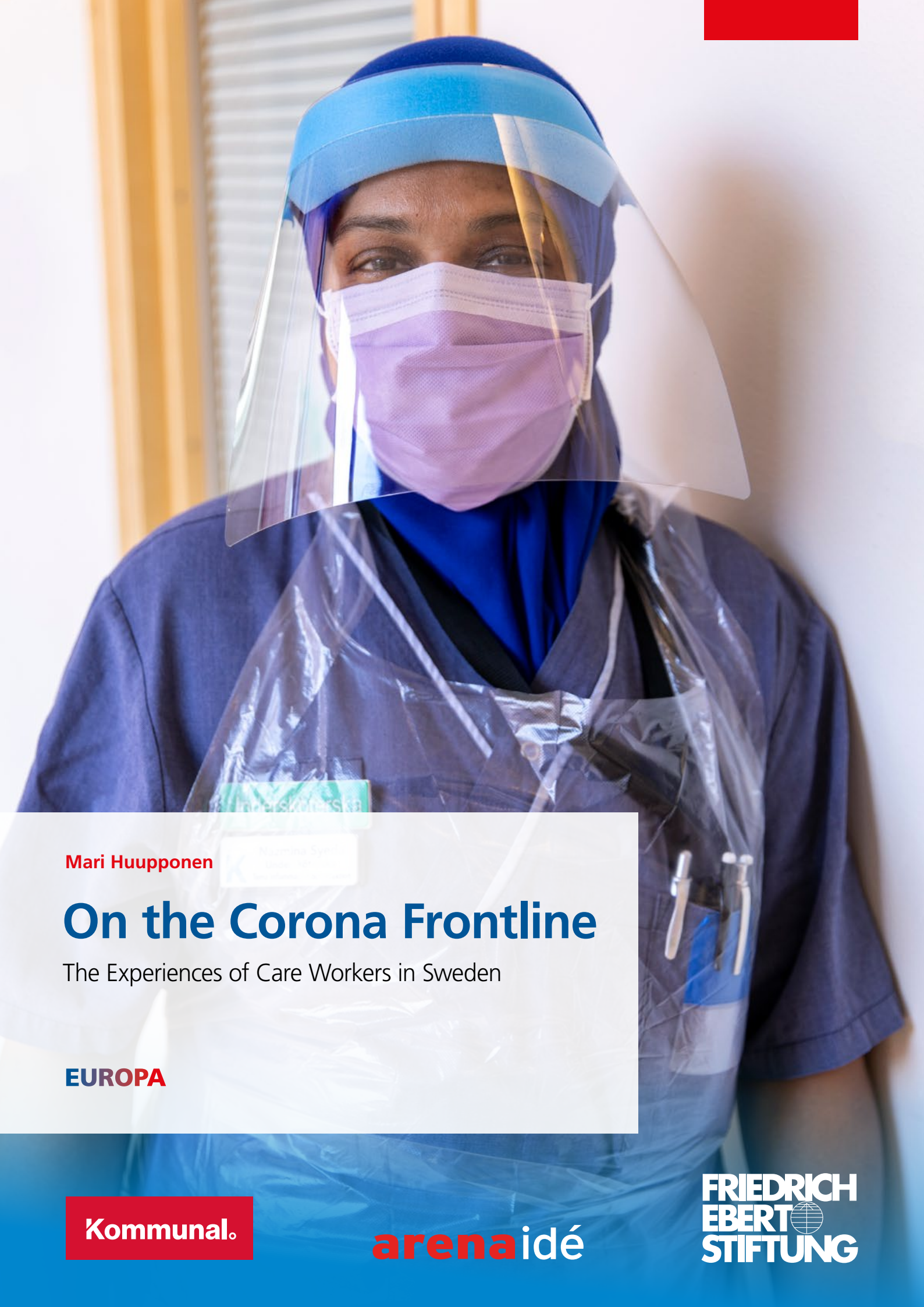


A healthcare worker, a woman wearing a blue hijab, is shown from the chest up. She is wearing a blue surgical cap, a clear face shield, a pink surgical mask, and a clear plastic apron over her blue scrubs. Her scrubs have two pockets with silver clips. A name tag is visible on her chest. The background is a blurred indoor setting with light-colored walls and a window with blinds.

Mari Huupponen

On the Corona Frontline

The Experiences of Care Workers in Sweden

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About this publication

Swedish elder care was in crisis before the Covid-19 pandemic. The sector is underfunded, understaffed and the Swedish population is ageing. There is a shortage of trained care workers. Pandemic planning was inadequate. Although some improvements have been introduced in the course of the pandemic, municipalities and regions will need additional tax funding to finance growing care needs and improve the work environment. The elder care sector needs to be prioritized politically and to be given the opportunity to raise standards. This report discusses how the first wave of the pandemic hit the Swedish elder care sector.

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THE STRUCTURE OF THE ELDER CARE SECTOR

The 290 Swedish municipalities are in charge of elder care,¹ as well as some health care, while the 21 regions are otherwise responsible for health care. Municipalities can choose to outsource elder care (through public procurement) to private for-profit or non-profit companies, run their own care homes and domiciliary care units, or establish choice models (called “lagen om valfrihetssystem”, LOV), where private and public care providers compete. The municipality always retains overall responsibility for areas such as funding and allocating domiciliary care and places in care homes. Each municipality sets its own rates for elder care. The cost depends on factors such as the level or type of help provided and the recipient’s income. Care costs paid by recipients themselves are subsidised and based on specified rate schedules. The maximum charge for home help, daytime activities and certain other kinds of care in 2020 was SEK 2,125 (€209) per month. Most elder care is funded by municipal taxes and government grants. In 2017, the total cost of elder care in Sweden was SEK 121.7 billion (€11.6 billion). Over the years, media investigations have revealed deficits at several private care companies (for example, the Carema scandal of 2011–12). The companies were accused of prioritising profit over standard of care.

Since the 1990s an increasing share of elder care has been provided by private, for profit companies. There are differences between municipalities in the degree of privatisation. Approximately one-quarter (23 percent) of domiciliary care hours are performed by private care companies. One fifth of older people in long-term care live in a private care home (19 percent) (The National Board of Health and Welfare 2019).

CARE RECIPIENTS AND CAREGIVERS

On average, a resident lives 22 months in a care home and 20 per cent die within six months of moving in (Szebehely 2020a). This is an important context for understanding the impact of the pandemic on the Swedish elder care system: care home residents are frail. Four per cent of Sweden’s two million over 65s (82,217 individuals) live in care homes (*särskilt boende för äldre; äldreboende*). Among people over 80 years, 22 per cent receive domiciliary care and 11.9 per cent live in a care home (The National Board of Health and Welfare 2019). There has been a decline in care home coverage, from 20 per cent of the population aged over 80 years in 2000 to 12 per cent in 2019. Consequently, care home residents now tend to be older and frailer. The average age of a person moving into a care home is 86 years. 78 per cent of residents are 80 years or older, and at least 70 per cent have dementia.

There are approximately 200,000 care workers (practical nurses and care aides) and 17,000 registered nurses in social (incl. elder) care; around 60 per cent work in care homes. Approximately 25 per cent of long term care (LTC) workers (in care homes and in domiciliary care) are employed by the hour, and one in five care workers in care homes lack formal education, 4 in 10 care workers lack practical nurse education. On average, there are three care workers and 0.4 registered nurses per ten residents in a care home for older people (Stranz/Szebehely 2018). Marta Szebehely’s studies comparing the working environment of Swedish elder care workers in Sweden and other Nordic countries show that Swedish elder care has fewer supervisors and supervisors have less contact with employees. Sweden also employs fewer registered nurses than Norway. Swedish practical nurses have various levels of education (unlike other Nordic countries there is no national standard or formal education requirements), one fifth of the monthly employed lack formal education or training, and 28 per cent of employees have temporary hourly contracts (for example zero hour contracts) (Szebehely 2020b).

Swedish elder care workers (practical nurses and care aides) are organised by the Swedish Municipal Workers’ Union (Kommunal), whereas registered nurses are organised by the nurse union (Vårdförbundet) and supervisors are organised by the trade union Vision. The union density is 65.8 per cent in public sector elder care (practical nurses and care aides, i.e. Kommunal members).

Figure 1
Social and health care personnel in municipalities

Registered nurses	18 429
Practical nurses, mental care workers	122 264
Care aides	63 868
Other	1 543
Social and health care personnel in municipalities	206 104

EMPLOYMENT STANDARDS

Practical nurses in Sweden work in health care (inpatient and outpatient care) and social care (elder and disabled people). A practical nurse (undersköterska) has two-and-a-half to three years of vocational training (upper secondary), while a care aide (vårdbiträde) has approximately zero to eighteen months of training. Although there are currently no formal standards of qualifications, Kommunal and the public sector employers promote a model where a care aide’s training covers 50 per cent of the practical nurse training, which makes it possible to acquire further education on top of a previous CA education – which provides a possibility of career development. There are currently no regulations on staffing levels or staff training: the quality of the services is the responsibility of the care provider.

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.

The health and social care sectors are underfunded and understaffed, while the population is ageing. There is a shortage of trained care personnel. Although improvements have been made in response to the pandemic, municipalities and regions would need additional tax funds to finance growing care needs and to improve the work environment for care workers. But the current political situation with a centre-right majority makes hard to find comprehensive, long-term solutions that would gain a majority in parliament.

The average monthly pay for a practical nurse is SEK 26,200 (€2,581), for a care aide SEK 22,500 (€2,217). Average pay in Sweden in 2019 was SEK 35,300 (€3,478) – SEK 33,500 (€ 3,301) for women and SEK 37,200 (€ 3,665) for men.

A SUBSTANDARD WORKING ENVIRONMENT

Chronic understaffing leaves the health and social care sectors struggling to fill vacancies and even to hold onto existing staff. Many workers are considering quitting or choosing to work fewer hours, since the work is often too physically and mentally exhausting to be manageable as full time employment. Before the pandemic, the Swedish Work Environment Authority (Arbetsmiljöverket) reported working environment deficits in almost 90 per cent of inspected care homes. All in all, the authority recorded 3,500 work environment problems that needed to be addressed. The biggest problem is usually a lack of systematic preventive measures, organisation, resourcing and work stress. A survey of Kommunal members in 2017 found that seven in ten practical nurses experience an inadequate staffing situation every week, and one in two is considering quitting because of the tough working conditions. In addition to shortages of trained staff, employers may be deliberately understaffing to cut costs.

As in many other countries, elder care in Sweden has been affected by spending cuts and organisational changes inspired by New Public Management, with negative consequences for care workers' working conditions, professional autonomy and ability to meet the growing needs of care users. Care workers experience increasing time pressure and understaffing, while perceived workplace autonomy and time for support from colleagues and managers have decreased. Care workers find their jobs increasingly physically and mentally demanding (Strandell 2020).

ELDER CARE AND COVID-19

Sweden has been badly hit by the Covid-19 pandemic. The overarching strategy in Sweden has been to minimise mortality in the population while protecting risk groups (with no special emphasis on elder care in official recommendations). The Swedish strategy builds on a strong tradition of individual responsibility and voluntary measures, with a combination of legal requirements and non-binding recommendations. During the first wave of the pandemic, the

official recommendations (to stay at home when sick, wash hands frequently, keep physical distance and limit travel) were largely followed. To avoid people going to work when sick, the government introduced pay from the first day on, on 11 March 2020.

SWEDISH STRATEGY FAILED TO CONSIDER STRUCTURAL SHORTCOMINGS OF ELDER CARE

In mid-March 2020 the Public Health Agency (Folkhälsomyndigheten) recommended self-isolation and physical/social distancing for people over 70 years of age and a few weeks later the government enacted legislation restricting non-essential visits to care facilities and special accommodation for older people. However, many older people rely on outside help from informal caregivers, and around 71 per cent of people aged 65 plus in ordinary housing use municipal domiciliary care services. This makes "perfect" adherence to distancing rules almost impossible (Baxter et al. 2020). For example, it is estimated that over a two-week period, a person using domiciliary care services meets an average of 15 health and social care workers, each of whom have contact with more than ten clients (The National Board of Health and Welfare 2019).

The problems also include quality deficits resulting from cuts to health and social care funding, unstable working conditions and precarious employment contracts. As noted previously, one quarter of the elder care workforce is employed by the hour, and at the beginning of the pandemic staff shortages caused by regular staff being on sick leave or in self-isolation led to even greater use of temporary workers with varied levels of formal training. In response to problems with hygiene routine compliance reported throughout the spring, a national e-training program was quickly developed and has been completed by more than 140,000 care workers (Socialstyrelsen 2020a).

The government appointed a commission to investigate the Swedish Covid-19 strategy. One of its tasks has been to investigate the recommendations and actual measures taken to limit transmission in elder care services and to evaluate whether problems in work organisation, working environment and employment conditions contributed to the many deaths in the sector. The commission's first report, released on 15 December 2020 found that there were well-known structural shortcomings in the sector before the pandemic. They were one of the most important factors behind the high infection and mortality rates in Swedish elder care: "These shortcomings left elder care unprepared and ill-equipped to deal with a pandemic."

MORTALITY IN THE OLDER POPULATION

As in other parts of the world, Covid-19 deaths in Sweden occurred mainly among older people. 6 percent of all confirmed cases (6,157) recorded by early October 2020 occurred in care homes (but note that testing was inadequate

during the spring and statistics on confirmed cases are not always reliable). Of those who died of Covid-19 by early October 2020, 46.3 per cent lived in care homes and 26.5 per cent had domiciliary care, representing 3.3 per cent of care home residents and 0.9 per cent of domiciliary care users.

Mortality was clearly higher among the older people living in care homes than among those with domiciliary care, which was in turn higher than among older people living at home without domiciliary care. This is also the case under normal conditions, but it is undeniable that care homes were affected particularly badly during the first wave of the pandemic.

It is hard to say what elder care mortality would have looked like without Covid-19. In April and May 2020 there was demonstrable excess mortality in Sweden, which returned to normal levels in June. One reasonable hypothesis is that a time effect occurred: frail older people who would under normal circumstances have died later in the year did so earlier as a result of contracting Covid-19. The excess mortality returned again in November 2020. It is no surprise that older people living in care homes die from infections. They are often already frail and seriously ill when they move in. Unfortunately, there are no official statistics on transmission or mortality for individual care homes. It is known that infections were unevenly distributed geographically and between care homes. Although the Stockholm region was most severely affected at the beginning of the epidemic, many care homes managed to keep infections under control or avoid them completely. This demonstrates that simple infection control measures can prevent transmission and associated fatalities.

THE WORK ENVIRONMENT DURING THE PANDEMIC

The low level of preparedness for a pandemic had consequences for elder care employees and their work safety. During the first months of the coronavirus outbreak there was a great shortage of protective equipment, including masks and visors. Between March and May 2020, Kommunal conducted five surveys of safety representatives in health care and elder care to gain insights into its members' work environment, including access to protective equipment.

Today, all elder care staff working with individuals with suspected or confirmed Covid-19 must wear a mask and a visor. That was not the case at the beginning of the pandemic in March 2020. Then, the main recommendation was to avoid spreading the virus by following hygiene routines, hand-washing and using rubbing alcohol in "near-patient situations". Kommunal was critical – there are almost no situations in elder care that are not "near-patient".

The first time the Public Health Agency (Folkhälsomyndigheten) mentioned the use of masks and visors in elder care was on 7 May 2020, in a document about hygiene routines published on the agency's website. The document

still emphasised basic hygiene routines, and left the question of use of mouth protection and visors to the employer's discretion (in consultation with the local authority). Only much later, on 25 June 2020, did the Public Health Agency explicitly recommend that staff wear a mask and visor when caring for residents and patients with suspected or confirmed Covid-19.

In April 2020, the Work Environment Authority decided that both a visor and a mask were required for work close to the patient at the Serafen care home in Stockholm. But after discussion with the local authority employers' organisation, Sweden's Municipalities and Regions (SALAR, SKR in Swedish), the Work Environment Authority issued a new statement emphasising that the decision should not be regarded as a general recommendation. This decision was repealed by an administrative court and it was said, on the contrary, that the issue of mask use would be decided locally. Kommunal's health and safety representatives felt that the bar was set very high locally. In Gothenburg, a district director considered that the masks could only be used in the event of "extreme risk of bodily fluid exposure".

By the summer, the Public Health Agency had concluded that local risk assessments were not functioning adequately and tightened its recommendations, requiring masks to be used under the visor. The Work Environment Authority argued that local risk assessments were still needed. These ambiguities exacerbated concern and uncertainty among care workers.

Access to personal protective equipment has improved in health care settings in the course of the pandemic. Many employees in elder care feel there has been a hierarchy where health workers have received PPE before elder care staff. Kommunal safety representatives confirm this.

TRADE UNION PERSPECTIVES AND RECOMMENDATIONS TO LIMIT THE SPREAD OF THE VIRUS

Kommunal has both short-term and long-term policy recommendations to limit transmission of the virus in elder care settings.

In the short term, work should be organised in a manner that prevents transmission. Employers and municipalities should invest in continuity of care, limit the number of temporary workers and avoid staff moving between locations. In domiciliary care separate dedicated teams should attend to infected patients. Temporary workers employed by the hour should have economic security to stay at home if they show symptoms, without having to fear loss of income or future employment. They should be offered longer contracts (and in the long run, training and permanent employment). "Overstaffing" is a good strategy – increasing staffing levels during the pandemic to reduce the need for temporary staff and improve the possibilities to provide good quality care, for example by being able to quarantine infected residents and comply with the hygiene guidelines.

Staff need ongoing guidance, information and instructions concerning hygiene. Personal protective equipment and testing must be available.

In the long run we must build a robust elder care system that is equipped to handle a pandemic. Elder care needs higher status and adequate funding. Elder care workers need better pay and working conditions and good, secure jobs. Those who rely on elder care need good quality care by trained professionals.

Kommunal believes that the idea of “unqualified care work” implies that care work is less worthy work, work “anyone can do”. But it is a qualified job to take care of older patients with multiple comorbidities. Practical nurse training has already been standardised in Denmark, Finland and Norway; in Denmark and Norway practical nurses are registered health care staff, something that Sweden is still working on. Standardising the training will allow us to standardise the skill level of practical nurses, to the benefit of the labour market as a whole.

SICK PAY

Sick pay and sick leave was the main question for Kommunal at the beginning of the pandemic. In Sweden sick pay is 80 per cent of salary but is not paid for the first day of absence. This may be a factor that contributes to high levels of sickness presenteeism as the deduction of the qualifying days (“karensavdrag”) is a significant expense especially to the members of Kommunal who often have low incomes. The deduction was abolished on 2 February 2020 for those with confirmed or suspected SARS-CoV-2 infection. In such a situation, one can also apply for “virus carrier compensation” (“smittbärarpeng”): 80 percent of the salary (however, a maximum of SEK 804 (79.4) per day), without the first day sickness leave deduction. In practice, however, it can be difficult to get a doctor’s certificate. And even those who do not meet the requirements for virus carrier allowance must stay at home when they have symptoms. The government cancelled the first day sickness leave deduction on 13 March 2020, after demands from Kommunal among other unions.

SHORTAGE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

From March onwards, a shortage of PPE became a serious issue, as did the official guidelines for its use. Both have been vital questions for Kommunal throughout the crisis.

The lack of protective equipment in elder care was already causing concern by mid-March. The doctors’ union, Läkärförbundet, warned that PPE could start to run out in hospitals, and Kommunal received alerts about a lack of protective equipment in elder care, with members contacting the union on social media or calling the union hotline. On March 16, Kommunal held a video conference with union health and safety representatives. On 23 March, both Kommunal

and the public sector employers’ organisation SALAR raised the acute shortage of PPE at a meeting with Labour Minister Eva Nordmark. The first requests for protective equipment according to a work environment complaint (so called 6: 6a) were already made in the third week of March, and on March 25, the Kommunal website published guidance for safety representatives responding to a lack of PPE. During the last week of March, Kommunal held a meeting on the acute PPE shortage with Health and Social Care Minister Lena Hallengren and officials at the Work Environment Agency.

The shortage of PPE was global as well as local, and PPE for health care and hospitals was obviously the official priority. Municipalities were not prepared for a crisis of this magnitude and lacked PPE reserves. Kommunal tracked the PPE shortage using online surveys and tried to communicate the results with employers, government and the media. In May 2020, polling company Novus conducted a survey on behalf of Kommunal among a representative sample of the union’s members working in domiciliary care and care homes, to investigate their experiences concerning PPE during the pandemic. More than one in three said they had worked without proper PPE at some point, and more than one in six had done so in the weeks preceding the survey. The survey also found that half of all employees were worried about PPE supplies and 5 per cent had chosen to go to work despite having cold symptoms, in most cases out of loyalty to colleagues in severely understaffed elder care settings.

PPE GUIDELINES

In addition, the PPE guidelines were insufficient. In early April 2020 at the Serafen care home in Stockholm, Kommunal’s safety representative demanded that staff wear a IIR-standard mask under their visor when working with suspected and confirmed Covid-19 patients. The employer (City of Stockholm) objected, arguing that a global shortage made it impossible to provide masks (it remains unclear whether this was actually the case). On 7 April the Kommunal health and safety representative decided to halt work at the Serafen care home, as the employer was not providing adequate PPE for personnel working in contact with persons with suspected or diagnosed Covid-19. The government work environment officials agreed with Kommunal that a mask and a visor were needed when working with suspected or confirmed Covid-19 patients. Kommunal believed that the decision would set a precedent for elder care in Sweden. However, a few days later the government officials (the Work Environment Authority included) issued a statement that the decision should not be viewed as a precedent. Later, the public service TV revealed that the statement had been specifically requested by the employers’ organisation SALAR at a meeting where Kommunal was not present (Grill Pettersson 2020).

The Public Health Agency did not change its guidelines until 25 June. After previously recommending a mask/visor combination in close care contact “at your own risk assess-

ment”, it now recommended that visor and mouth protection always be used in all patient-related care and care in case of suspected or confirmed Covid-19.

Officials took the line that each care home should conduct its own local risk analysis, making it hard for Kommunal to keep track of all the different local recommendations. Kommunal would have preferred a national guideline, as both the virus and elder care settings are similar everywhere.

STAFF DENSITY

On 25 November 2020 Kommunal published a report, “Pandemi på äldreboendet” (Pandemic at the care home), analysing the differences between care homes with and without virus outbreaks on the basis of a comprehensive nationwide survey during first months of the pandemic (Kommunal 2020).

Those who participated in the survey were Kommunal workplace and health and safety representatives who answered a web survey in the end of June 2020. A random selection was made and the final sample represents over 50 per cent of the Swedish care homes (where one single observation represents one care home). The study compares structural factors between care homes with 0 Covid cases, 1 Covid case and more than 1 Covid case (category referred here as “outbreak”). The survey found that care homes with virus outbreaks had a higher proportion of hourly-paid staff. 39 per cent of care homes with multiple Covid-19 cases had more than 20 per cent hourly-paid staff, while only 22 per cent of care homes without infection had more than 20 per cent hourly-paid staff.

One reason for this may be, of course, that regular staff got sick. 30 percent of respondents working in care homes reported that they suspected that staff had been infected during working hours, which would lead to a greater need for temporary staff. Care homes with outbreaks were, however more likely to have already been understaffed before the pandemic. 39 percent of the care homes with outbreaks responded that their staffing had been adequate just before the pandemic, compared with 50 per cent of care homes without outbreaks. It is obvious that far too many care homes are understaffed.

Care homes with more than one Covid-19 case were more likely to have staff who treated both healthy and sick residents (57 per cent) than care homes with only one Covid-19 case (47 per cent). It is possible that a better staffing situation enabled cohort care, where infected residents are cared for by dedicated staff who have no responsibilities elsewhere in the unit. 93 percent of care homes with only one case had been able to isolate people with symptoms, compared with 73 percent in care homes with multiple cases.

Lower staff density and the use of temporary staff may have led to sickness presenteeism. Care homes with virus outbreaks were more likely to have had staff who went to

work despite showing symptoms: 28 per cent compared to 10 per cent in care homes without outbreaks. It is also possible that the outbreak itself led to sickness and sickness presenteeism, but sickness presenteeism can always be considered an indicator of poor organisational conditions such as a stressful work environment and insecure working conditions.

The PPE situation was also worse in care homes with virus outbreak. Care homes without outbreak respond to a greater extent that the staff had not worked without the adequate protective equipment (25 per cent) than care homes with outbreak (54 per cent). Lack of PPE may thus have increased the risk of transmission from sick and/or asymptomatic residents and staff.

RESTRICTIONS ON VISITORS

The period of time when the care homes had a ban restricting visitors to care homes seems to have played a lesser role if one compares care homes with virus outbreak and those without, but 26 per cent of responding care homes believe that the infection entered the facilities via visiting relatives before the visit ban (there was a national ban 31 March – 1 October). Most respondents believe that the virus got in via regular staff (46 percent) and temporary staff (41 percent) (multiple responses permitted).

HYGIENE ROUTINES

Care homes with stronger hygiene compliance had fewer outbreaks according to Kommunal’s study. Care homes with multiple cases were more likely to have staff who had difficulty complying with hygiene procedures (27 per cent) than care homes without a confirmed outbreak (15 per cent). The figure was lowest (13 per cent) in care homes with only one Covid-19 case. One reason for the prevalence of hygiene compliance deficits may be lack of formal training and hygiene competence among temporary staff. We already know that there is a relationship between formal education level and compliance with hygiene routines. That said, in Sweden responsibility for instituting hygiene routines and ensuring compliance always lies with the employer.

CONCLUSIONS

It is obvious that Sweden was not prepared to face a pandemic of this magnitude. Parts of the welfare system were not equipped to handle a pandemic, and lacked staff and material resources. It is possible that a better-resourced and better-staffed system would have brought a very different outcome.

Pandemic preparedness was low in the Swedish elder care sector, although the sector’s underfunding and stressful working conditions are not unique to Sweden alone. Years of successive cuts and political deprioritisation have led to

inadequate staffing, unsustainable working conditions, precarious, often zero hour contracts, a workforce that often lacks formal training and a fragmented care system. The Swedish pandemic strategy lacked a plan for elder care. There was a shortage of PPE and the guidelines were perceived as vague and obscure, especially regarding the protective equipment. The staff was under a lot of stress and had concerns regarding PPE and work safety. In addition, parts of Sweden were hit by a much greater virus outbreak than our neighbouring countries.

Unfortunately, the detailed data at care home level required to identify causes is not yet available (as of 2 December 2020), but it is likely that a combination of organizational factors affected the risk of virus outbreaks in elder care. Anyone familiar with elder care research knows that specific factors characterise well-functioning workplaces. According to Kommunal's data, staff at care homes with multiple cases of Covid-19 tended to lack access to adequate protective equipment (Kommunal 2020). Care homes with multiple Covid-19 cases were more likely to report insufficient staffing before the pandemic, the proportion of by the hour contracts was greater, sickness presenteeism was more common, and hygiene compliance was lower. Care homes with only one Covid-19 case were better able to isolate infected patients than those that had multiple cases of Covid-19.

Quality elder care requires professional staff with safe working conditions both in time of crisis and in everyday situations. Some of the indicators listed in Kommunal's reports are interrelated: it is difficult to isolate infected patients if the care home is understaffed, or to ensure hygiene compliance if hourly-paid staff are not aware of the routines. Hygiene compliance requires time and availability of PPE, uniforms, soap and alcohol rub. Chronically understaffed care providers often have a high proportion of temporary workers. Precarious employment heightens the risk of sickness presenteeism as zero-hour workers cannot afford to stay at home.

Like other frontline public services, elder care personnel have done their best to provide care during the pandemic. Practical nurses and care aides have done their utmost in unreasonably stressful, precarious and often dangerous conditions. Almost one-third (30 percent) of respondents in Kommunal's care home survey suspect that staff have become infected at work. Elder care staff have paid a high price for their work during the pandemic. Even before the pandemic, poor working conditions led to high sickness rates and uneven care quality. Kommunal's 2017 member survey found that 42 percent of staff considered understaffing so extensive as to pose a risk to care recipients at least a few days a week. The Health and Social Care Inspectorate, the National Board of Health and Welfare, the Work Environment Authority and Kommunal have all warned about the issues.

Responsibility for the consequences of the pandemic is political. The crisis exposes shortcomings that have existed in elder care for several decades and highlights the need for

change in both the short and long term – for the sake of both care recipients and care staff. Whether or not there is a global pandemic – elder care cannot rely largely on staff with precarious working conditions and patchy formal training. Politicians must ensure that employers hire sufficient numbers of skilled staff as elder care personnel. They must provide safer employment conditions. It is also apparent that the system for sick pay that economically penalises employees for sickness leave leads to dangerous sickness presenteeism. Elder care needs higher status. It is time to acknowledge the skill and effort professional elder care requires, and resources must be distributed accordingly. The system must be changed.

Some improvements and reforms are already under way. The "elder care boost" ("Äldreomsorgslyftet") announced by the Swedish government in June 2020 seeks to improve skill levels in elder care by funding municipalities' and private caregivers' training initiatives for practical nurses and care aides. Staff will receive their normal wages during training and be employed by the same employer on a permanent contract after finishing. The project is a joint effort of Kommunal, the employers' organisation SALAR and the state.

In addition, standardised vocational care training is on its way. From July 2021, there will finally be a national standard for vocational Practical Nurse training. The government also wants to introduce a licence for practical nurses, as in other Nordic countries. Kommunal was already working for these reforms long before the pandemic.

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Friedrich-Ebert-Stiftung

The Friedrich-Ebert-Stiftung (FES) is the oldest political foundation in Germany with a rich tradition dating back to its foundation in 1925. Today, it remains loyal to the legacy of its namesake and campaigns for the core ideas and values of social democracy: freedom, justice and solidarity. It has a close connection to social democracy and free trade unions.

FES promotes the advancement of social democracy, in particular by:

- political educational work to strengthen civil society;
- think tanks;
- international cooperation with our international network of offices in more than 100 countries;
- support for talented young people;
- maintaining the collective memory of social democracy with archives, – libraries and more.

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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.

Further information on the project can be found here:

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