Dave Watson

On the Corona Frontline

The Experiences of Care Workers in Scotland

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About this publication

Even before the Covid-19 pandemic arrived, Scotland's devolved social care system was in crisis after years of neglect. The pandemic has highlighted many failings with tragic implications for older persons, particularly those in residential care. Inadequate pandemic planning led to early failures in testing, track and trace and provision of personal protective equipment. In particular, patient transfer from hospitals to care homes without testing resulted in the spread of the virus to a vulnerable section of the population. The fragmented and largely privatised social care system was unable to cope during the first infection wave in 2020.

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INTRODUCTION

This paper will set out how the Covid-19 pandemic has impacted on older persons in Scotland and how the care system has responded during the first infection wave in 2020. It will also show how the trade union movement has reacted to the pandemic and its programme of reform to address the issues the pandemic has highlighted.

The focus of this paper is on what in Scotland is called adult social care. That means residential and domiciliary care services as distinct from the hospital services provided by the National Health Service Scotland (NHS Scotland).

CONTEXT – OLDER PERSONS IN SCOTLAND

Scotland acquired the status of a devolved administration within the United Kingdom in 1999. Most public services and legislative powers are devolved to the Scottish parliament and government. Health and care services are all devolved (apart from minor aspects concerning professional regulation).

Older persons are defined as those over the state retirement age, although increasing numbers of people are working past this age. From 1 October 2020 this increased from 65 to 66 years of age for men and women. The state retirement pension is currently worth £ 175.20 (192 euro) per week for those who have 35 years of qualifying national insurance payments. However, many people – typically women due to work breaks for child care – do not have the required contributions and therefore receive a proportionately lower state pension. 82 % of households in Scotland have some private pension wealth, with an average of £ 125,500 (143,024 euro). However, the figure varies enormously from £ 1500 (1,709 euro) in the lowest decile to £ 1.4m in the top decile (Scottish Government 2020). In general terms, Scotland's high levels of income and wealth inequality, only partially offset by public service provision, lead to equally high levels of health inequalities. For pensioners on weekly incomes below £ 173.75 (198.01 euro) (£ 265 or 302 euro for couples) the state pension is topped up by a social security benefit called Pension Credit. Some 120,000 older people (12%) are already living in poverty, and 60,000 pensioners (6%) are assessed to be in material deprivation (Housing and Social Justice Directorate 2020a).

Scotland's population of 5.46 million is projected to age as the bulge around age 50 in 2016 become age 75 by 2041. The number aged 75 and over is projected to increase by 79% by 2041. This is the effect of the baby boomers of the 1960s ageing over the next 25 years. The working population is expected to become a significantly smaller proportion of the total population over the same period (NRS 2016).

However, Scotland's life expectancy has stalled after three decades of increasing and is now 77.0 for men and 81.1 for women. This hides considerable variations: In Glasgow it is only 73.3 for men (78.7 for women), meaning more than half of men would never reach State Pension age. Healthy life expectancy is considerably lower, at 62.6 years for women and 62.3 for men – around a year lower than the UK figures. Scotland's population profile is also older than the UK as a whole.

The ageing population has implications in terms of greater long-term care needs and a smaller working population to support them, both in terms of taxation and the numbers joining the care workforce. In recent years the gap between the birth and death rate has been bridged by immigration. However, immigration has been reduced by the UK exiting the European Union and introducing stricter immigration controls.

HEALTH AND CARE STRUCTURES

Scotland had a distinctive health and social care system even before devolution, and the differences have increased since then. In particular, the first Scottish government in 1999 – led by Labour – rejected the marketisation of health care adopted in England. That approach has been continued by the current Scottish National Party (SNP) government (Socialist Health Association Scotland 2014).

NHS Scotland manages Scotland's public health care system, which is free at the point of need and funded from taxation; its budget for 2021/22 is over £17 billion. There is only a small private health care sector. The NHS runs the hospitals and primary care, with over 90% of people accessing the system on the basis of need through General Practitioners based in every community. NHS Scotland is administered by 14 territorial NHS health boards, seven special health boards and one public health body, and employs more than 140,000 staff. Each NHS board consists of appointed persons, local authority representatives and a trade union representative. Health boards are accountable to Scottish Ministers through a performance management system, which sets national priorities but leaves health boards to deliver frontline healthcare services.

For older persons in particular, NHS Scotland has a strategy of delivering care closer to the person's home, using emerging technologies and making greater use of community-based services. This has resulted in the closure of over 1,400 hospital beds since 2008/9, primarily long-stay beds for the elderly (Public Health Scotland 2020a).

The social care system has been through many iterations, seeking to improve the integration of health and care services. One early post-devolution reform was the introduction of free personal care for the older people, now extended to those under 65. This only covers care needs, while accommodation costs are recovered from the care user's assets with a cap at £ 27,250 (31,055 euro). This means around one-third of care home residents fund their own accommodation costs, with considerable variation between areas. The Self-Directed Support Act (2013) introduced personalised budgets (where the user has some control over how their own care budget is spent) (Housing and Social Justice Directorate 2020b).

The current structure of Integrated Joint Boards (IJB) involves pooled budgets and strategic commissioning across NHS and local authority services. However, delivery remains with staff employed by the NHS, local authorities and contractors in the private and voluntary (mainly charities) sector. IJBs control budgets totalling over £ 8bn, with £ 5bn coming from the NHS and £ 3bn via local authorities. 60% of frontline NHS budgets are delegated to IJBs, and all council adult social care budgets are included, together with some children's services. Over the past ten years spending on community services has increased somewhat faster than hospital services, but there has been no significant shift in the balance of care. There has been a 10% increase in care at home hours while residential care home places have remained unchanged. Hospital activity rates have increased over the past ten years in most specialties.

RISING COSTS OF HEALTH AND CARE

International studies conclude that the demand for health and care will increase faster than the rate of growth in the economy. This will result in increased costs driven by price inflation, an ageing population and the introduction of new technologies, drugs etc. An Institute of Fiscal Studies (IFS) report calculated that this is likely to require a real-terms increase of 3.9% per year (Institute for Fiscal Studies 2019). If there is no system change, that will mean a net increase of £ 1.8bn over 15 years.

Scottish Government policy assumes that shifting the balance of care, greater productivity, better collaboration, and improved public health will help to bridge the gap. Although this is probably optimistic, the medium-term financial strategy details their bridging analysis, and identifies £ 683m for social care demand growth. The Scottish Government is also committed to abolishing the remaining social care charges for the under 65s. While this will be welcomed, not least because of local variations in charging, it is an additional cost, on top of the £ 30m needed for the extension of free personal care to the under 65s.

The Scottish Government's current plans do not consider any additional funding streams for meeting the growing cost of social care. The 2015 Quality Care Commission did outline some options, including an increase in National Insurance contributions (Socialist Health Association Scotland 2015). The UK Government has shown little urgency to address this issue other than a commitment to a Green Paper. However, the problem will not go away, and they will be under increasing pressure to find a solution for England. This is important for Scotland because part of the Scottish Government's funding is adjusted in proportion to English public spending (the Barnett Formula).

For a small country, Scotland has a large number of private and voluntary sector social care providers, including more than one thousand care at home providers registered with the Care Inspectorate (Care Inspectorate/SSSC 2020). As a consequence, service delivery is fragmented with a high level of duplication in management and back-office functions. The Scottish Government and local authority commissioners have attempted to "nudge" the sector into rationalising services or at least considering shared services. However, there has been very little progress, and given the vested managerial interests, few expect that to improve quickly.

There are at least 759,000 unpaid, informal carers aged 16 and over in Scotland and 29,000 young carers. The value of care provided by carers in Scotland is over £ 10 billion per year. Three out of five people will become carers at some stage in their lives, and 1 in 10 are already fulfilling some caring role. Support for carers is at best patchy despite the intentions of the 2016 Carers Act. A social security benefit, Carers Allowance, of £ 65.25 (74.36 euro) per week is payable to those who look after someone with substantial care needs. The latest annual survey of informal carers shows that only one-third felt supported, and 62% said their role had a negative impact on their health. Surveys show the problem is getting worse each year. Carers' organisations have outlined a range of measures to strengthen support for carers including care breaks and health, employment and end of care support.

Some 200,000 people work in the social care sector: around 40% in the private sector, 30% in the public sector, and 30% in the voluntary sector. 74% of care homes for older persons are privately owned. The Scottish Government has published its first integrated health and social care workforce plan, and there are detailed plans for health staff, reflecting long-standing workforce planning systems (NHS Scotland 2019). For social care staff, the plan is focused more on the planning process, reflecting the difficulties in delivering workforce planning over such a fragmented service. The headline estimate is that Scotland will need 20,000 more health and care workers by 2023/24, which they hope can be reduced by up to 10,000 through mitigating actions like efficiency savings, technology and redesign. The significant number is over 14,400 extra domiciliary care staff, in a group that is likely to be impacted by Brexit and the UK government's immigration policies.

The social care sector already has high turnover rates, particularly in the private sector. The overall vacancy rate in social care is almost twice the Scottish average. The Scottish Social Services Council data shows that 52% of private care homes for older people reported nursing vacancies (SSSC 2016). This compares to a nursing vacancy rate of only 15% for voluntary/not-for-profit homes and 9% for local authority homes. 74% of care homes for older people are privately run as a consequence of increasing privatisation in the last decade (Public Health Scotland 2020b). All but one of the Care Inspectorate's "weak/unsatisfactory" ratings were in the private sector; none were in the public sector (Care Inspectorate/SSSC 2020).

EMPLOYMENT STANDARDS

Pay and conditions in the social care sector vary significantly between employers with limited collective bargaining outside the public sector. More than 200,000 people work in

social care in Scotland, representing 7.7% of the overall workforce; about 82% are women. Outside the public sector contract conditions can be deplorable, with workers on zero-hours contracts and expected to work excessive hours at very short notice. Sick pay, pensions, uniform arrangements, mobile phones and other conditions also vary considerably.

The Scottish Government has attempted to improve pay in the sector by requiring employers delivering state-funded care to pay at least the Scottish Living Wage, currently £ 9.30 (10.59 euro) per hour (Living Wage Scotland 2020). The Scottish Living Wage is a voluntary wage rate, which is higher than the statutory National Minimum Wage and the confusingly (and inaccurately) named National Living Wage, of currently £ 8.21 (9.35 euro) per hour (less for workers under 24 years of age). There have been problems in enforcing the Scottish Living Wage as implementation was left to individual local authority contract negotiations with providers.

In the Scottish public sector, wage rates are collectively bargained at the national level, although the grading staff are paid on will vary between local authorities depending on the job description and evaluation outcomes. They will typically be significantly better than the Scottish Living Wage. The better and larger voluntary sector employers also recognise trade unions and bargain collectively as individual employers, again generally with better pay and conditions outcomes for care workers. There is a particular issue with care workers employed directly by care users under the self-directed support provisions. A survey undertaken by the University of Strathclyde identified high levels of mutual appreciation but also highlighted concerns over job security, training, pay and conditions (University of Strathclyde 2018).

The undervaluing of care work is, to a large extent, linked to the prevalence of women workers in the sector. Women face systematic labour market disadvantage, including occupational segregation, discrimination and an institutionalised gender pay gap. Black, Asian and minority ethnic (BAME) individuals are also subject to structural discrimination in the workforce, and are overrepresented in the care sector. The UK Equalities and Human Rights Commission has announced that it will conduct an inquiry into BAME inequalities in the health and social care sector.

UNISON is the largest trade union in the social care sector,[1] and the GMB also has a significant membership. Several other unions, including the Royal College of Nursing (RCN) and Unite the Union represent smaller groups in the sector. There are no accurate figures on union density. Surveys indicate around 65% in the public sector, down to 20–25% in the private and voluntary sector (Fair Work Convention 2019). Even in the public sector, the disparate membership, particularly in domiciliary care where staff often work from home, creates organising challenges for trade unions. These are most prevalent in the private and voluntary sector, where staff turnover is high and some employers are anti–trade union . However, the pandemic has boosted trade union membership in the sector as workers have responded to active campaigns to protect them. UNISON has recruited 65,000 new members across the UK since January 2020.

The Scottish Government and trade unions have also sought to improve pay and conditions in the care sector through the Fair Work Convention and Framework (Fair Work Convention 2016). This Framework aims to ensure that people in Scotland will have a world-leading working life by 2025, where fair work drives success, wellbeing and prosperity for individuals, businesses, organisations and society. It seeks to encourage employers to adopt the framework through limited use of levers like procurement, although it could certainly do more. The Framework does not change statutory employment rights, which is reserved to the UK Government.

Most social care workers now have to be registered with the Scottish Social Services Council (SSSC), although some will be registered with other regulatory bodies, such as the Nursing and Midwifery Council for nursing staff. Registration includes holding or agreeing to work towards the appropriate qualifications do, known as Scottish Vocational Qualifications (SVQ). It also requires workers to abide by professional conduct and practice as set out in the respective Codes of Practice (SSSC 2021). Despite these regulatory efforts, many social care workers start work with no formal qualifications and minimal experience. Training is often basic and older workers in particular face challenges in moving towards a qualification-focused system. Unlike the situation in the NHS, there is only limited government support for building workforce capacity and capability in the social care sector and for provision of training costs to achieve SSSC recognition. A number of local authorities have signed up to UNISON's Ethical Care Charter (UNISON Scotland 2012), which commits them to training standards at no cost to workers and enabling care workers to meet and share best practice to overcome their isolation.

A report on the care sector published by the Fair Work Convention in February 2019 highlighted the undervaluing of social care work, the lack of workforce voice, limited training, budget pressures and poor commissioning practices. It made a series of recommendations, including the establishment of a sector-wide body to bring together all stakeholders as well as developing minimum employment standards and reforming commissioning (Fair Work Convention 2019). Sadly, little progress has been made in implementing these recommendations, and the pandemic has cruelly exposed the need for action.

ELDER CARE AND THE CORONAVIRUS

On 25 October 2020, 4,482 deaths had been registered in Scotland where Covid-19 was mentioned on the death certificate (Public Health Scotland 2021). 3,913 of these were people past the age of retirement (65+). 46% of registered Covid-19 deaths occurred in care homes, 47% were in hos-

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[1] UNISON Scotland represents over 150,000 mostly public sector workers in Scotland, including all health and care professions except for doctors and dentists.

pitals, and 7% were at home or non-institutional settings. There were 5,012 excess deaths in the same period, of which 2,184 were in care homes. A person is twice as likely to die from Covid-19 in the most deprived areas of Scotland compared to the least deprived areas. Overall, Scotland's excess death toll has been slightly lower than in England but is significantly higher than in similar countries in Europe.

The social care challenges set out above have been magnified during the pandemic. The lack of personal protective equipment, inadequate testing, minimal sick pay, and use of agency staff, have all contributed to the tragic deaths in care homes and amongst social care staff. Staff on the frontline did not have the PPE they needed and were not routinely tested until four months into the pandemic. The use of temporary agency staff meant workers could be moving between social care settings with an enhanced risk of transmitting the virus. There is little evidence that the Scottish Government heeded the recommendations of their planning exercises, Iris and Silver Swan, which warned of unpreparedness in social care in the face of a virus.

A recent Public Health Scotland report confirms that between 1 March and 31 May, 123 patients were discharged from hospital into care homes after testing positive (Public Health Scotland 2020b). A further 3,061 untested patients were discharged from hospital to care homes, 112 of which remained untested after the guidance on testing changed on 22 April. While the Scottish Government has asserted that the discharges were unlikely to be a significant cause of outbreaks, 38% of homes with one or more discharge had an outbreak, compared to only 13% of homes with none.

The tragic consequences of repeated policy failures have hit residential care badly. A report by the University of Stirling found that two-thirds (65%) of Scotland's 1,057 care homes had suspected or confirmed cases of Covid-19, compared with 44% of homes in England, 37% in Northern Ireland and 33% in Wales (Public Health Scotland 2020c). A report for the think tank Common Weal outlines the series of failures which led to the death toll in Scotland's care homes. The report author describes the handling of this as "the single greatest failure of devolved government since the creation of the Scottish Parliament" (Kempe 2020).

Care at home has also been impacted by care packages being reduced or abandoned. Informal carers have all too often been left to pick up the pieces. In Glasgow, domiciliary care support packages were slashed by 60% at the start of the pandemic and are only now recovering. Scotland's leading charity for older people, Age Scotland, is concerned that the removal of social care packages and/or reduced access to medical care contributed to a 25% rise in excess deaths of people living with dementia, diabetes and other conditions. One user-led organisation told researchers from the statutory Scottish Human Rights Commission (SHRC) of: "a lot of examples of people left in dire situations […] unable to get out of bed, unable to wash and dress themselves, having to move in with family [… family members being forced into caring roles that they haven't done before and some having to give up employment to do that" (SHRC 2020).

The Scottish Government has committed to a public inquiry on the handling of the Covid-19 pandemic, and the Scottish Parliament demanded that it begin "immediately". This will be human rights–based, as called for by the Scottish Human Rights Commission and the human rights group Amnesty International.

TRADE UNION PERSPECTIVES

The pandemic highlighted long-term failures in the social care system that trade unions have been campaigning to rectify for many years. The trade union response has focussed on providing immediate support to members, negotiating with employers and government, and campaigning for service reform.

The organisational challenges in supporting a disparate membership are exacerbated in a pandemic when the mitigation measures drastically limit traditional face-to-face organising. Trade unions have therefore made increased use of social media (particularly Facebook) to reach members and recruit non-members. One excellent example of this is UNISON's Facebook page, UNISON Care Workers for Change – Scotland, which uses a combination of practical advice and campaigning memes to create a community of support for care workers.[2]

One crucial victory for trade unions early in the pandemic was an agreement with the Scottish Government and local authority employers that the Scottish Living Wage would be paid immediately. In June, a further agreement was reached on the establishment of a social care staff support fund, to ensure that workers receive their normal pay if they fall ill or have to self-isolate on public health advice (Community Health and Social Care Directorate 2020). Statutory sick pay is meagre in the UK, and only the better employers (generally those covered by collective bargaining) top it up to something close to full pay. The Scottish Government also agreed to make a one-off payment of £ 60,000 (68,378 euro) to a named survivor of any social care worker who dies in service from coronavirus, and whose contracted pension arrangements do not cover death in service (UNISON Scotland 2020a).

Another trade union campaign achieved Covid-19 tests for social care workers after UNISON research showed that 8% of those surveyed had been infected and one in three had been required to self-isolate after colleagues had been infected (UNISON Scotland 2020b. That same research showed that only 18% of care workers felt safe at work, and that they were generally unsupported and poorly in-

2 Care workers for change Facebook group: https://www.facebook.com/groups/unisonscotcommunitysec

formed at work (Ferguson 2020). Testing is vital for workers and residents because, as a recent study shows, four in ten healthcare workers who test positive for Covid-19 show no outward signs of the disease.

Access to PPE was abysmal at the start of the pandemic, but has improved significantly – mainly thanks to trade union campaigns.

Such campaigns also helped to increase public support and awareness of the work social care staff undertake. This was always high for NHS staff, with the public coming out on their doorstep every week to clap them. Social care workers are less visible, but trade union campaigns have helped to raise their profile while making the point that clapping does not pay their bills.

REFORM OF SOCIAL CARE

The trade union and labour movement reform campaign has focussed on the creation of a National (Scottish) Care Service. The concept is not a new one, as it has been Scottish Labour policy for several years, for example as a manifesto commitment in the 2019 UK General Election. A Scottish Labour discussion paper and survey published in summer 2020 showed a very high level of support for social care reform, including the removal of the profit motive (Scottish Labour 2020).

UNISON Scotland has published what it describes as a "road map" towards the creation of a national care service (UNISON Scotland 2020c). The document also identifies several immediate actions including national procurement, sectoral bargaining, enforcing clinical standards and a national workforce plan. This would lead to proper funding, improved pay and conditions, a workforce strategy and ethical commissioning.

More work is needed on how the national care service would operate in practice. There seems to be a consensus in favour of a national framework rather than a service delivery organisation or making it part of NHS Scotland, not least to recognise the different models of care. But that leaves open what the National Care Service would undertake directly and what would be the governance arrangements. A national framework approach must end the current marketisation of social care. It could set consistent standards, contracts and charges for services not covered by free personal care. Most importantly, it would include a statutory workforce forum to set minimum terms and conditions, organise effective workforce planning and put a new focus on training and professionalism.

If the service is going to be delivered locally, this leaves open the question of local governance and ownership. As the Accounts Commission (local government auditor) noted in its annual overview, the current system of Integrated Joint Boards has struggled to deliver integration or a shift in spending from hospitals to community care (Audit Scotland 2020). There have been many attempts to improve integration in Scotland since the 1970s joint finance arrangements and all have struggled. It may be that this iteration will eventually deliver. Still, many will argue that it requires stronger democratic accountability to make difficult decisions, and that means a more prominent role for local authorities. This happens in other parts of Europe, but even there, they have not always shifted resources from hospitals to community services.

The Scottish Government launched a national reform programme for social care in 2019, although it had made limited progress before the pandemic. As a consequence of the pandemic and political pressure led by the opposition Scottish Labour Party, the Scottish Government announced a new review of social care in Scotland. An expert panel chaired by a former civil servant reported in February 2021 (Scottish Government 2021).[3] The report recommends the establishment of a National Care Service and workforce reforms that have been welcomed by the trade union movement. However, the proposed structures are highly centralised, largely removing local democratic accountability, and does not do enough to rein in the marketisation of services. While the need for a significant increase in funding is recognised, the report makes no recommendations on how this should be financed.

The fragmentation in service delivery is a significant problem that does need to be addressed, together with the scandal of care home firms registered in tax havens. In the short-term, the pandemic has highlighted the need for greater coordination on issues like procurement. Abolishing the market, standard contracts and common workforce standards will help shift resources to the frontline. In the medium-term, there should be greater common ownership, particularly in residential care.

Common ownership does not preclude innovative voluntary sector operators who can meet the new standards as the best in the sector already do. The private sector likes to make a false link between personalised care and marketisation. All care should be personalised, and that requires a range of services, driven by the needs of service users, not care budgets. It does not require a range of ownership models. Local delivery should also be about greater innovation in service delivery, trying new models of care that integrate people with care needs into communities.

Finally, there is the tricky issue of funding. Scotland cannot merely hope for the funding consequentials of reform in England to plug the current funding gap, let alone future demographic pressures. It requires an adult conversation with citizens about taxation.

Social care is not delivered in a silo. Joined up services need to recognise the role of housing, social security, public transport and leisure services. It needs to be seen in the context of building stronger communities – an issue addressed in a recent Jimmy Reid Foundation paper (Reid

3 https://www.gov.scot/groups/independent-review-of-adult-social-care/

Foundation 2020). That paper points to a wealth of evidence that place impacts on health and wellbeing and contributes to creating or reducing inequalities. Communities with strong social capital and infrastructure are always better insulated against a health crisis.

CONCLUSION

Scotland's social care system was in crisis before the Covid-19 pandemic arrived, the consequence of years of neglect. The pandemic has highlighted many of those failings with tragic implications for older persons, particularly those in residential care.

Pandemic planning was inadequate, and this led to early failures in testing, track and trace, and provision of personal protective equipment. In particular, patient transfer from hospitals to care homes without testing resulted in the spread of the virus to a vulnerable section of the population. The fragmented and largely privatised social care system was unable to cope.

Trade unions responded by supporting their members, organising, and negotiating a range of new agreements on testing, sick pay and PPE, which all made a significant contribution towards addressing these issues. They have also campaigned for a reformed social care system which is properly funded, ends the marketisation of care and values the workers who care for the most vulnerable members of society. As Madeleine Bunting puts it in her new book on the crisis of care:

> *"Capitalism seeks to quantify and extract value, and when such disciplines are applied to the care worker, it is a tragedy. Because what is at stake is the reciprocity of human hearts, the need for comfort, and our innate human capacity to nurture wellbeing and ease suffering" (Bunting 2020).*

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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 Europeans 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

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