ICMPD
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Migration Policy Development

*Trend Assessment*

# Long-Term Care Provision
## Current trends and the impact of Covid-19

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## Executive summary

Long-term care (LTC) refers to a range of health, social, and residential services for individuals who are dependent on assistance with their daily activities over extended time periods. LTC can be provided in residential facilities or at home. Residents of LTC institutions (nursing and residential care facilities providing accommodation and long-term care as a package) are generally more dependent upon the provision of services than those residing at home. Home care is seen as guaranteeing a higher degree of autonomy for persons in need of care and enabling them to remain at home in specially designed or adapted living arrangements.

In both, institutional settings and at home, specialised medical support is usually provided by trained personnel, while care givers support their clients in the organisation of daily life. Home care can be provided by mobile care-givers visiting the client regularly for a certain period of time or by care-givers living in the household of the client and supporting the client during the whole day.

The size of the population in need of LTC residing in an institutional setting and at home varies widely in Europe. The exact numbers and correlations are problematic to assess due to a high level of informality of the home LTC sector.

Mobile care workers supporting their clients at home for a limited period of time are usually provided by professional care organisations run by e.g. municipalities, charitable organisations or churches. Informal home care is typically provided either by – mostly female - family members, on an unpaid basis, or through private arrangements, on a remunerated basis[1].

Informal care represents a cornerstone of all LTC systems in European states. As is the case with the precarious employment in other sectors, the LTC work with the least protection and/or access to welfare entitlements tends to be performed by migrants and – within the European Union – by cross-border commuters. Concerning the intra-EU mobility Poland, Romania, and Slovakia, but also Bulgaria, Hungary and Slovenia represent sending countries for commuting and short-term migrant care-workers in the live-in long-term care sector.

The COVID-10 pandemic pose new challenges for European States – both on the sending and receiving end of care labour alike:

- Border closures between the EU Member States have left mobile care workers stranded on both sides. **The crisis thus highlights the existing difficult conditions in care work, as well as the need to protect migrant care providers as essential workers**.

[1] According to the OECD definition, personal care workers (caregivers) include formal workers providing LTC services at home or in institutions (other than hospitals) and are not qualified or certified as nurses. As per the draft definition in the ISCO-08 classification, personal care workers are defined as people providing routine personal care (bathing, dressing, grooming, other as applicable) to persons in their own homes or in institutions. These may be represented by a) nursing aids/assistants and care workers providing LTC services, who do not have any recognised qualification/certification in nursing; b) family members, neighbours or friends employed under a formal contractual obligation and/or declared to social security systems as caregiver by the care recipient, person/agency representing the care recipient, and/or by public care services and private care service companies, to provide the care services to the person in need for care. OECD Health Statistics 2020 Definitions, Sources and Methods. http://stats.oecd.org/wbos/fileview2.aspx?IDFile=25781359-6878-43ee-aa97-561f408756b6.

- The current situation also reveals the shortcomings and v**ulnerabilities of mobility-based care systems**. This may compromise the **sending countries'** capacity to deal with a healthcare crisis like the current COVID-19 pandemic. **Receiving countries**, whose care systems are more reliant on mobility are experiencing different challenges due to the unprecedented lockdown measures than the ones with locally organised care provision.
- It is, therefore, crucial to discuss the **short-term responses in parallel with a long-term vision to improve the sustainability and resilience of care systems and prevent future crises**.

# 1 Context

This Trend Assessment in an ongoing series conducted by ICMPD's Policy, Research and Strategy Directorate. These assessments engage on topics on which ICMPD can contribute knowledge and insight through our expertise. The aim of the series is to contribute to areas where there is currently a dearth of knowledge or research. The trend assessment series focuses on recent migration trends and topics (including migration dynamics, root causes and emerging migration routes), as well as areas of interest where policy making could impact on a recent trend.

Higher life expectancy and longevity of older populations in Europe represent a recent phenomenon and a benchmark of success in terms of health care and social policies. A major achievement of their own, these are accompanied by consistently low birth rates. A combination of these factors inevitably steers demographic projections to a conclusion that the region is turning progressively grey.[2] In fact, a transition towards a much older population structure has already started to manifest itself in the EU MS, with the share of the population aged 65 years and over exceeding 20% in 2019 as compared to under 15% in 1996. Based on the current dynamics, projections suggest that by 2060 one third of the EU's population will be 65 and older.[3] Considering that the definition of population ageing refers to a situation of an increasing median age of a population and an increasing proportion of older persons in a country's overall age structure,[4] this trend represents a reality in all European States.

While older adults vary greatly in terms of their health conditions, demographic characteristics, and demand for care-related services, projections for the utilisation of LTC services indicate that the demand for related services for older adults will rise in the coming decades.[5] According to estimates based on the EU Labour Force Survey, personal care workers already make up approximately 10,3% of the "key workforce" in the European Union, as the fourth largest category after teachers (14,5%),

[2] EC (2018), The 2018 Ageing Report. Economic and Budgetary Projections for the EU Member States (2016 – 2070).
[3] Lutz, W. et al. (2019), Demographic Scenarios for the EU, EUR 29739 EN, Publications Office of the European Union, Luxembourg, 2019, ISBN 978-92-76-03215-1, doi:10.2760/751889, JRC116398. https://ec.europa.eu/jrc/en/events/fact4eufuture/eu-demographic-scenarios/launch-event.
[4] Shrestha, L. B. (2000), Population Aging in Developing Countries. *Health Affairs*, Vol 19, No. 3. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.19.3.204.
[5] Institute of Medicine (US) Committee on the Future Health Care Workforce for Older Americans. Retooling for an Aging America: Building the Health Care Workforce. Washington (DC): National Academies Press (US); 2008. https://www.ncbi.nlm.nih.gov/books/NBK215400/.

agricultural workers (11,9%), and science and engineering professionals (11,1%).[6] This trend is unfolding in a context of an increasing labour market participation of women, with the accompanying necessity to delegate care tasks previously provided within the family mainly by spouses and daughters.[7] Overall, regardless of the exact proportion, informal care at home, as compared to the institutional one, constitutes the bulk of care provided to the persons requiring assistance in activities of daily living across the ICMPD MS.

The observable responses to the recent demographic and social developments that steer the growth of the LTC sector include an increasing reliance upon commuters and short-term migrant labour force: In fact, the growing demand for care services in Central and Western Europe is already to a notable extent met by workers – mostly women – from Eastern European countries. Most of them originate in EU Members States and make use of EU freedom of service and movement regulations, but - mainly in the "new" EU member states - also third countries nationals enjoying labour mobility due to bilateral regulations are increasingly working in the field of LTC.

**Long-term care policies across Europe**: Long-term care policies vary widely among European States. The institutional structure varies widely[8] and the funding structure is highly complex[9]. Independent from different legal, institutional and financial regulations, a relevant share of the GDP is spent for LTC services in Europe. According to OECD data, the top countries with highest spending in proportion to GDP have consistently been Sweden (over 3%), followed by Switzerland, Germany, the Czech Republic, and Austria (up to 2%).[10] At the other end of the scale, Hungary, Poland, and Serbia have reportedly allocated less than 0.5% of their GDP to the delivery of LTC services (2017 data).[11] Due to the growing need for trained care-workers the employment situation in the LTC sector has consistently drawn a varied degree of policy attention, particularly in the view of the mobility of the labour force and strict selection and screening procedures imposed by the public institutions upon the LTC personnel.

**In the context of the increasing care needs, LTC has come to the fore of the policy priorities**. In many European countries, the main policy instrument has traditionally been the introduction of **cash-for-care schemes, in-kind services, and cash benefits, with various level of accessibility.** The latter depend on both care needs and the availability of services at regional level and envisage allowances to persons dependent upon care provision and their families to remunerate informal or employed caregivers or pay for residential care.[12] Hence, the funding for care provided at home is generally

[6] Fasani, Francesco and Mazza, Jacopo (2020): Immigrant Key Workers: Their Contribution to Europe's COVID-19 Response. https://ec.europa.eu/knowledge4policy/publication/immigrant-key-workers-their-contribution-europes-covid-19-response_en
[7] http://ilo.org/wcmsp5/groups/public/---europe/---ro-geneva/---sro-budapest/documents/publication/wcms_503749.pdf
[8] Huber, M. et al. (2009), *Facts and Figures on Long-Term Care*. Europe and North America, Occasional Reports Series 6. Vienna: European Centre. https://www.euro.centre.org/publications/detail/385.
[9] Rodrigues, R. & Schmidt, A. (2010), *Paying for Long-term Care*. Policy Brief 9/2010. https://www.euro.centre.org/publications/detail/390.
[10] OECD (2020), Assessing the Comparability of Long-Term Care Spending Estimates under the Joint Health Accounts Questionnaire. http://www.oecd.org/els/health-systems/long-term-care.htm.
[11] Idem.
[12] Da Roit B. & Le Bihan B. (2011) Cash-for-Care Schemes and the Changing Role of Elderly People's Informal Caregivers in France and Italy. In: Pfau-Effinger B., Rostgaard T. (eds) Care Between Work and Welfare in European Societies. Work and Welfare in Europe. Palgrave Macmillan, London. https://doi.org/10.1057/9780230307612_10. https://link.springer.com/chapter/10.1057/9780230307612_10.

channelled via the persons receiving the care rather than care providers. This format allows greater flexibility for the persons in need of LTC to choose their priorities when it comes to the related services. On the other side of the scale, this puts the family members in a position of dependency upon the good will to be remunerated for their time and efforts. These payments also have allowed the development of an informal live-in care sector either based on a business relationship model (e.g. Austria) or irregular work arrangements (e.g. Italy).

The introduction of varying forms of cash-for-care policy instruments[13] represents a sign of the recognition of the formerly unpaid or underpaid work in the informal care. Additionally, it suggests the acknowledgement of the preference to rely on the individual and family resources rather than on institutional infrastructure in LTC. According to a study of the European Centre for Social Welfare Policy and Research there is clear evidence that intensive caring correlates negatively with being active in the labour market for female family members of the person in need of care, raising the dilemma of finding an appropriate balance between caring and working. This balance can be better met where sufficient formal care is available.[14]

On the other hand, cash-for care policy instruments have stimulated the development of migrant and commuters care-work, leading to a mixed care workforce (informal family carers, migrant workers, personal assistants, formal professional care staff) operating with varying intensity in the planning, organisation and delivery of LTC service provision. The boundaries between informal and formal care are thus became increasingly blurred.[15] It further has led to a growing marketization of this previously vaguely defined sector, and in particular to a growth of placing agencies acting as paid intermediaries between care-workers and their clients. From a policy perspective, these developments suggest that limiting the formal institutionalisation of the sector represents a preferred policy response in many EU Member States.

# 2 Cash for care systems with a mobility component: the examples Austria, Germany and Poland

Illustrating the demand for and relevance of care workers, in Austria alone, with the population of approximately 8,859 million, reportedly, 947,000 persons, of whom nearly three quarters women, are involved in one way or another into a provision of care.[16] In 2018, some 800.000 persons in need for care were reported, approximately 80% living at their private homes and 20% in residencies with

[13] Da Roit, B. & Le Bihan, B. (2010), Similar and yet so different: cash-for-care in six European countries' long-term care policies. The Milbank quarterly, 88(3), 286–309. https://doi.org/10.1111/j.1468-0009.2010.00601.x. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000929/.
[14] Triantafillou, J. et al. (2010), Informal Care in the Long-Term Care System. European Overview Paper. FP7 INTERLINKS. https://www.euro.centre.org/downloads/detail/768.
[15] Idem.
[16] Interessengemeinschaft pflegender Angehöriger (n.a.), Daten und Fakten. https://www.ig-pflege.at/hintergrund/datenundfakten.php.

varying levels of support.[17] Care homes in Austria are staffed by some 42,000 professionals with approximately 33,200 full-time employees, many of them settled third country citizens and migrants from the "new" EU member states. While the vast majority of persons in need of care living at home is cared for by family members, some 25.000 are cared for by registered live-in care givers in 24/7 in-house care.[18] In 2019, the number of self-employed personal care-takers exceeded 63,000. Nearly 800 placing agencies act as intermediaries between care-givers and clients.

Most registered live-in care-workers in **Austria** are European Union citizens, who regularly commute between Austria and their country of origin. In-house care-worker usually do not hold an employment contract, but a service contract as entrepreneurs. They usually do not have access to a private apartment, but live in the household of their client for two weeks or a month, and then commute back to their country of origin, while a second care-worker moves into the household of the client for the next two weeks or month. In practice, these workers enable thousands of persons in need of care to continue living in familiar, albeit adapted, surroundings. While 24/7 in house care previously relied upon workers from the Czech Republic and Slovakia, recently a shift towards caregivers from Romania and Bulgaria has occurred[19], mainly motivated by rising incomes and improved working conditions for care-givers in the Czech Republic and Slovakia.[20]
Austria has established a distinct legal regulation defining this type of 24/7 in-house care-giving as service offered by an entrepreneur, and not as employment according to labour law. Care-worker have to register with the Chamber of Commerce and are defined as entrepreneurs. As entrepreneurs, they have to pay income tax and have access to health, pension and accident insurance for entrepreneurs, which they have to pay out of their income. In addition to defining the status of in-house 24 hours care-workers, the law lays down the basic minimum standards for contractual relations between clients and care-worker, access to social security provisions, and training requirements relevant for access to cash-for-care subsidies. In practice, access to the status of a self-employed 24/7 care provider is only accessible to Union Citizens making use of the freedom to offer services. Third country nationals cannot access this status, as they only will get legal residence as workers employed under regular labour law.
There is growing criticism not only about the legal regulations which are criticised as "bogus self-employment" by the Austrian Trade Union Federation[21], but also about the lack of control of agencies and exploitative relations between the agencies and the care-givers.

**Poland** represents a particular case of both a sending and a receiving country when it comes to LTC workers. Due to higher wages, Polish LTC workers choose employment in Western European countries

[17] Idem.

[18] BMASGK, PFIF- Pflegegeldinformation des HV der SV-Träger, Pflegedienstleistungsstatistik Dez. 2018.
[19] Majority of Romanian caregivers work in four-week rotas, while Slovak carers work in two-week rotas.
[20] Leichsenring, K. et al. (2020), Report: The importance of migrant caregivers in the Austrian Long Term Care system highlighted by the COVID19 outbreak. https://ltccovid.org/2020/04/01/report-the-importance-of-migrant-caregivers-in-the-austrian-long-term-care-system-highlighted-by-the-covid-19-outbreak/.
[21] OTS (2015), Gewerkschaft vida: Faire Arbeitsbedingungen statt Scheinselbstständigkeit bei 24-Stunden-Pflege https://www.ots.at/presseaussendung/OTS_20150213_OTS0072/gewerkschaft-vida-faire-arbeitsbedingungen-statt-scheinselbststaendigkeit-bei-24-stunden-pflege.

rather than locally. Hence the local labour market demands are responded to by citizens of the neighbouring countries (Belarus, Russia, Ukraine) and of Moldova and Georgia, who may work in Poland for a period of 6 months, with a possibility of extension, without the need to obtain a work permit (2006 Regulation of the Minister of Labour and Social Policy). Additionally, the citizens of these states enjoy a simplified procedure to obtain a work permit to access the local labour market in case they have the necessary qualifications to perform care duties at private households (2014 Implementation Plan for the national Migration Policy entitled *Current state of affairs and recommended actions*). As a result, the nationals of these countries could access the local labour market without the obligation to go through the labour market test to receive a work permit to work as caregivers.[22]

While in practice echoing freedom of movement regulations, it is worth noting that, other than in Austria, the conditions for fulfilling the employment criteria largely coincide those of the local workers, including the minimal wage and working conditions. To facilitate the implementation of these conditions, the Chief Labour Inspectorate has launched a hot line for the Ukrainian workers, which provides consultations and legal information assistance.[23] Additionally, the central government has begun to financially support the provision of services to the oldest people living in rural areas and in towns with up to 40,000 citizens. The approximate number of beneficiaries of LTC is estimated at one million, and this number is projected to double in the next ten years.

**Germany**, similarly, partially relies on external labour force in responding to the local needs for LTC workers. Similarly to Poland, special provisions are in place to facilitate work of certain nationals. For example, according to the Federal Employment Agency, out of over 10,000 skilled healthcare workers from Bosnia and Herzegovina employed in the country in 2019, approximately a thousand took advantage of government-backed programmes aimed at filling this market niche. One such programme facilitates the employment of Bosnians with a completed medical high school training as care assistants at hospitals, clinics, or homes for the elderly. The job centres in Germany coordinate the recruitment by providing the candidates with the information about a public call for healthcare workers, thus reducing the time associated with individual search for jobs. Additionally, MYSKILLS programme allows partaking in tests that demonstrate individual professional skills of those persons who do not have a vocational qualification recognised in Germany, including in the area of provision of care for the elderly.[24] In Germany 24/7 live in care is mainly based on the posting of workers regulations, with agencies in Poland employing care givers and posting them into the households of the German clients – a practice critically reviewed as potential misuse of posting of workers regulations by legal scholars.[25]

[22] Kindler, M. et al. (2016), Care needs and migration for domestic work : Ukraine-Poland : Global Action Programme on Migrant Domestic Workers and their Families, an ILO/UE project. International Labour Office. -Geneva: ILO. http://ilo.org/wcmsp5/groups/public/---europe/---ro-geneva/---sro-budapest/documents/publication/wcms_503749.pdf.
[23] https://www.pip.gov.pl/pl.
[24] https://www.arbeitsagentur.de/en/myskills-test-english.
[25] Steiner, J. et al. (2019), Völlig legal!? Rechtliche Rahmung und Legalitätsnarrative in der 24h Betreuung in Deutchland, Österreich und der Schweiz. Österrich. Z Soziol. 44/1-19, https://doi.org/10.1007/s11614-019-00337-4.

Live-in care is not implemented in Northern Europe. There mobile care teams organised by municipalities or specialised provincial government departments support elderly able to live at home. Staff is employed on regular employment contracts. Workers tend to be contracted amongst long-settled migrants, rather than newcomers. In the Mediterranean countries, live-in care is provided either by family members or care-givers in irregular labour settings. In Italy, a large number of care-givers working in the "Badante" – system[26] originate from Romania, while in Spain live-in care often is provided by domestic workers from Latin American countries, also often without regular employment contracts.

# 3 Current trends: Long term care mobility and the COVID-19 crisis

Following the commencement of the COVID-19 crisis, ICMPD member states responded analogously to the health threats associated with the pandemic. In line with the international guidelines, the response and containment steps included restrictions aimed at human mobility. Given that international travel played a role in the initial stage of the pandemic by bringing the virus on the territory of the states, total or partial border closures were implemented in order to halt the spread of the contagion further. In the context of a temporary closure of the European Union's external borders to non-residents, the governments of EU states (Austria, Bulgaria, Germany, Hungary, and Slovenia) unilaterally closed their borders with neighbouring EU countries, and suspended international flights and visa issuance as early as March.[27]
Within the individual states, as in other parts of the world, ICMPD MS implemented measures geared towards a social and economic moratorium. These included restrictions on gatherings and non-essential movement across their respective countries, lockdowns, stay at home orders, suspension of educational and economic activities, and mandatory quarantine for international and internal migrants for a period of up to two weeks.

A combination of restrictions affected intra-EU labour mobility of care workers. One such manifestation has been a return of care workers from their countries of employment for reasons that included loss of employment, precarious working conditions, and limited health insurance. Illustrating the demand for and relevance of migrant care workers, Germany is estimated to rely upon approximately 300,000 non-German nationals in the home-care sector, while Austria reports approximately 100,000 citizens of a country other than Austria working in residential care centres and private homes. The majority of these workers are EU citizens from other ICMPD MSs, namely the Czech Republic, Hungary, Romania, and Slovakia. At the early stages of the pandemic, additional recruitment of care workers for temporary care to those infected with COVID-19 took place in Bulgaria and Romania.[28] The side effect of the measures geared towards the restriction of human mobility has been

[26] Rugulotto S. et al. (2017): How migrants keep Italian families Italian: *badanti* and the private care for older people. International journal of migration, health and social care Vol. 13 No. 2, pp. 185-197. https://doi.org/10.1108/IJMHSC-08-2015-0027.
[27] https://www.migrationpolicy.org/article/covid19-europe-feels-pinch-slowed-intra-eu-labor-mobility.
[28] EURACTIV (2020), Austria Imports Workers from Bulgaria, Romania to Plug Gaps in Covid-19 Care. https://www.euractiv.com/section/economy-jobs/news/austria-imports-workers-from-bulgaria-romania-to-plug-gaps-in-covid-19-care/.

a disruption in the supply chain of services in care provision, particularly in private households employing care-givers regularly commuting home.

The efforts of the governments to respond to the disruption in the care supply chain resulting from restrictions on human mobility were paralleled by a discussion on further developing sustainable policies towards human resources involved into the provision of LTC. An example of governmental response may be found in Austria, where, due to border closures, a sizable number of Intra-EU mobile workers were unable to reach their places of deployment or leave them as a result of the COVID-related restrictions. Following political pressure of the agriculture sector to allow mobility for seasonal workers, the decree published by the Health Ministry on the 30th of April provides for additional exceptions for flights for the transport of not only seasonal workers in the agriculture and forestry sector but also *care and health personnel*. This decree represents a concrete measure to strengthen policy responses concerning the LTC workers under the restrictions on movement.[29]

Another immediate solution implemented by Austria and Romania in the early weeks of the pandemic was to organise special transportation for Romanian care workers towards Austria.[30] The special transport was first organised via two chartered flights (in March and April 2020), then via several special trains from Timișoara (in western Romania) to Vienna (in May 2020). According to "DREPT pentru îngrijire" – a grassroots care workers organisation – in Romania, workers were not provided with all relevant information regarding the conditions of quarantine and the working conditions in Austria[31]. While transportation from their homes in Romania to the Timișoara airport, as well as at the airport, was very crowded and with no physical distancing in place.[32] In Austria care workers observed physical distancing regulations until they were brought in institutional quarantine[33] where two or three shared a room and were able to meet in larger groups. When they showed no symptoms after quarantine, they were assigned to the households of their clients. Workers highlighted that while they had to remain in quarantine for two weeks, care receivers and their families in Austria were not required to do so, nor were they required to test themselves.[34]

To support families in need of care, several federal Austrian states offered a bonus for care workers who, due to international travel restrictions, had to stay longer in Austria than their initial agreed rotas.

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[29] Schmidt, A. E. et al. (2020), The Impact of Covid-19 on Users and Providers of Long-Term Care Services in Austria. https://ltccovid.org/2020/04/16/the-impact-of-covid-19-on-users-and-providers-of-long-term-care-services-in-austria/.

[30] From the Romanian side, the special trains between Timisoara and Vienna (for care workers), have been agreed upon by the Ministry of Transport, Infrastructure and Communications and the Ministry of Internal Affairs. According to the website of the National Railway Company, in order to carry out the program, the following institutions were engaged: the National Railway Transport Company, the local authorities, the Romanian Road Authority and various territorial structures (of the Railway Transport Police, of the Public Health Directorate (DSP), of the Inspectorate for Emergency Situations (ISU), of the County Gendarmerie Inspectorate) https://www.cfrcalatori.ro/comunicate/transport-special-in-austria/.

[31] During quarantine, care workers' documents were reportedly taken from them (*DREPT pentru îngrijire*, personal communication).

[32] Romanian media outlets reported the lack of physical distancing rules and, in general, lack of concern for workers' health also when agriculture seasonal workers from Romania travelled via chartered flights to Germany.

[33] Meseșan, D. (2020), Interesele din spatele zborurilor private care duc sute de îngrijitoare din România la muncă în Austria, în plină pandemie. Oficial sunt „repatriate". Libertatea, 8 April. Available at: https://www.libertatea.ro/stiri/interesele-din-spatele-zborurilor-private-care-duc-sute-de-ingrijitoare-din-romania-la-munca-in-austria-in-plina-pandemie-oficial-sunt-repatriate-2944335 (accessed 20 September 2020)

[34] Leiblfinger, M. et al. (2021), Confronted with COVID-19: Migrant live-in care during the pandemic. *Global Social Policy*. April 2021. doi:10.1177/14680181211008340. https://journals.sagepub.com/doi/10.1177/14680181211008340.

States agreed upon a bonus of 500 EUR. However, in practice, workers received less than 500 EUR, if at all.[35] This was also due to the fact that care receivers had to apply for this bonus which then they were supposed to give to the workers. While some Austrian care receivers passed the bonus on to their care givers, there were situations where this has not been the case.

Romanian care workers who could not travel to Austria during these first months of travel restrictions qualified for the Austrian emergency fund for self-employed who could prove their activities have been affected by the restrictions. However, the fact that the application for this fund is available in German only makes it difficult for Romanian care workers to apply. Some of those who managed to apply already received this support, while others are still waiting.[36]

In the late spring of 2020, the development of PCR and rapid antigen testing became a game-changer. Travel restrictions for commuters and international travellers were eased by shortening quarantine after delivery of a negative test result, and commuting was allowed on provision of a test not older than a few days, or on being tested when arriving at the place of work. Commuting of 24/7 care workers began to return to normal in summer and autumn of 2020.

# 4 Implications for workers, mobility regimes and the organisation of LTC systems

## 4.1 Implications for the LTC workers

The pandemic crisis has drawn the attention to the LTC sector and added visibility to the fragile labour market arrangements concerning the workers.[37] The latter make up a sizable portion of the labour force in areas that continue to operate during the pandemic. In fact, the operational support of the LTC sector greatly depends upon the availability of workers to ensure the delivery of the necessary services.

**Personal LTC-workers have found themselves facing additional risks and strains in performing their duties, on the one hand, and managing the contagion, on the other hand.** The latter task is exacerbated by the fact that COVID-19 has highlighted the vulnerability of older persons, who tend to respond poorly to novel or previously encountered antigens and immune challenges compared to the young.[38] Amongst this category of population, particularly affected were those temporarily or permanently residing in long-term care facilities, which reportedly experienced high COVID-19 incidence, morbidity, and mortality. In this context, the LTC service providers and their clients are

[35] *DREPT pentru îngrijire*, personal communication.
[36] *DREPT pentru îngrijire*, personal communication.

[37] Kuhlmann, E. et al. (2020), Migrant carers in Europe in times of COVID-19: a call to action for European health workforce governance and a public health approach. *European Journal of Public Health*, Volume 30, Issue Supplement_4, September 2020, Pages iv22–iv27. https://doi.org/10.1093/eurpub/ckaa126.
[38] Montecino-Rodriguez, E. et al. (2013), Causes, consequences, and reversal of immune system aging. The Journal of clinical investigation, 123(3), 958–965. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3582124/.

interconnected insomuch as they are in close contact with each other on a regular, at times constant basis. Given that majority of persons receiving the LTC are vulnerable to severe COVID-19, the higher levels of exposure to the disease has disproportionately affected long-term care facilities and persons deployed in the LTC sector.[39] Anomalous reporting of COVID-19-related cases in care homes, particularly in the early months of the pandemic, highlights the threat posed by the virus to older adults and, consequently, to persons involved into the care provision sector. The disproportionate effect of the pandemic on the elderly people suggests that both *living* and *working* in long-term care facilities presents heightened risks to contract COVID-19. The inability to provide the services remotely has led to a high level of exposure to the group at risk, thereby turning the LTC provision into a precarious occupation in terms of COVID-19 proliferation.

**The impact of COVID-19 has been felt amongst the providers of LTC services, both within long-term facilities and in other settings, including home care.** While the COVID-19 death rate seems higher in countries and regions with more long-term care beds,[40] the spread of the contagion is not inevitable among LTC settings, and successful containment in institutional and home setting is possible.[41] Concrete steps in this direction involved nationwide systematic testing of care home residents and staff, including those persons who would be transferred from hospitals to care homes, with the aim to free up hospital bed capacity for emergencies and patients with critical medical condition. [42] Early evidence gathered suggested that it is possible to mitigate the impact of the virus on LTC systems through timely policy action that targets the receipt and delivery of the services. To this end, the shortage or disruptive supply of the personnel was complemented by the optimisation of the use of preventive, medical, protective, and transmission-blocking equipment. Care workers rely heavily on personal protective equipment (PPE) to shield themselves and their customers from being infected and infecting others.[43] From the onset of the pandemic, global shortages of protective supplies have occurred, as a result a drastic rise in demand and excessive hoarding. The ICMPD MS were no exception, and the initial stages the pandemic were marked by a limited and/or unstable supply of the essential equipment. The immediate response represented an increase in the production of sanitation materials, protective equipment, medical kits, and COVID-19 testing units for first responders. In Germany, the Health Ministry stepped in and scaled up nationwide procurement of protective equipment for care workers, amongst other categories of workers. To this end, it launched the purchasing of medical protective gear at the federal government level and supplying it to all states and

[39] WHO (2020a), Preventing and managing COVID-19 Across Long-Term Care services: Policy Brief, 24 July 2020. https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1.
[40] Gandal, N. et al. (2020), Long-Term Care Facilities as a Risk Factor in Death from Cobvid-19. VOX EU Column. https://voxeu.org/article/long-term-care-facilities-risk-factor-death-covid-19.
[41] WHO (2020b), Strengthening the Health Systems Response to COVID-19 - Technical guidance #6, 21 May 2020 (produced by WHO/Europe). https://www.euro.who.int/en/health-topics/Health-systems/pages/strengthening-the-health-system-response-to-covid-19/technical-guidance-and-check-lists/strengthening-the-health-systems-response-to-covid-19-technical-guidance-6,-21-may-2020-produced-by-the-who-european-region.
[42] Schmidt AE, Leichsenring K, Staflinger H, Litwin C, Bauer A (2020) The impact of COVID19 on users and providers of long-term care services in Austria, Country report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 16th April 2020
[43] WHO (2020c), Shortage of Personal Protective Equipment Endangering Health Workers Worldwide. News Release. 3 March 2020. https://www.who.int/news-room/detail/03-03-2020-shortage-of-personal-protective-equipment-endangering-health-workers-worldwide.

public health associations.[44] Alternatively, import-dependent Switzerland has launched a production of masks locally, with the capacity foreseeing to exceed 40,000 pieces per month.[45] In Poland, the government has both increased the domestic production of PPE and the purchasing thereof from external suppliers.[46] Across the states, given the high demand in the PPE amongst the health workers, the priority in the distribution was given to public health institutions in issuing the first deliveries.

## 4.2 Implications for the LTC workers' mobility regimes

Timely policy responses and activities to keep up the LTC arrangements functional under the pandemic and the associated restrictions and limitations are commendable. They highlighted the pillars that ensure the sustainability of the existing models during the COVID-19 and beyond.

**The pandemic has demonstrated that addressing LTC provision models in institutions and families present an area of policy attention at the national and regional levels and are likely to feature prominently on the policy agenda in the near and mid-term future.** To date, a number of implications may be identified based upon an analysis of the new reality in the long-term care sector, which has been recently created by the COVID-19 pandemic and the containment thereof.

**For a long- and medium- term perspective governments may consider a systemic revision and an adaptation of the relevant policies in this particular sector, both in response to the ongoing pandemic and beyond.** The pandemic has highlighted the vulnerability of care regimes dependent on cross-border commuting, while regimes based on regular employment of both nationals and resident migrants did not face similar challenges. Here a plausible example to consider may be the existing practices of the northern European countries, where the institutional LTC provision relies on services provided by public or private care organisations at the municipal level. As these organisations do not find sufficient staff among nationals, they also employ a large number of settled migrants. On the other hand, the widespread usage of PCR and rapid antigen-testing since the second half of 2020 has eased cross-border commuting for care-workers. The access to vaccines against COVID-19, available to the public in most EU countries since early 2021, albeit for different age groups and professions, represents another milestone for easing and ultimately returning to cross-border mobility patterns from before the pandemic.

**The currently well-embedded practices of long-time commuting featuring intense circulation between the country of origin and the country of destination is mainly driven by the massive income differences between the "receiving" and the "sending" EU Member States and freedom of movement regulations allowing free travel and residence**. As the declining number of care-workers

[44] Levine, K. (2020), Coronavirus: Germany to centralize supply chains, set prices on masks, protective gear. DW News. 30 March 2020. https://www.dw.com/en/coronavirus-germany-to-centralize-supply-chains-set-prices-on-masks-protective-gear/a-52952314.
[45] The Local (2020), Coronavirus: Switzerland begins production of protective masks amid international shortage. 14 April 2020. https://www.thelocal.ch/20200414/switzerland-begins-production-of-protective-masks-amid-international-shortage.
[46] https://www.premier.gov.pl/en/news/news/prime-minister-further-personal-protective-equipment-has-arrived-in-poland.html

from Slovakia in Austria after a salary increase in the care sector in Slovakia hints, commuters may turn to employment at home when they see a potential for rising incomes an improved working conditions there.47 Policy priorities will have to be adopted and/or adjusted by the governments in the receiving countries stronger fostering formalised mobile care arrangements over arrangements based on commuting. In the countries of origin, better salary levels in the care sector might on the one hand reduce the brain-and hand-drain in medical and paramedical professions, while on the other hand also affecting those segments of the market that currently thrive on remittances.

**Independent from the way elderly care is organised, the Covid 19-crisis has again highlighted the underlying trend of growing demand for care workers for the elderly, which cannot be met by local labour supply.** Automatisation and the usage of care-robots will support, but not replace human care-workers. While technological innovation in the field of ambient assisted living will ease the daily routines of the elderly, robots cannot deliver the psychological function of human contact and relationship. Thus, the demand for care-workers will not decline. While a number of ICMPD MS have started to retrain unemployed persons who lost their job due to the COVID 19 crisis as care-workers, also this option is limited. Mobility will continue to play and important role in the provision of elderly care.

**Similar to the ongoing COVID-19 crisis, which is being overcome through international cooperation and coordination, the upcoming crisis of the lack of care workers in an ageing Europe may be best addressed and overcome by states working together**. By highlighting common difficulties, the circumstances surrounding the pandemic have also created a momentum to take stock of the already available policies and instruments in both sending and receiving countries of LTC workers, in order to pre-eminently respond to the market, family, and individual needs by developing common approaches to establish fair care mobility models.

## 4.3 Implications for the future organisation of mobile LTC systems

Given the complex and country-specific organisation of elderly care in Europe and the related interests of both receiving and sending countries, **a common vision for fair care mobility in Europe** is needed. In the short term, the pandemic has highlighted the need to recognise care workers, including live-in carers, as essential workforce within the health care system, and to foster their inclusion into the system of paramedical professions.

**In the medium term**, the development of **fair care standards**[48] is essential. They should aim at developing of common training curricula and standards allowing to give care workers an official status in the nursing sector, and a reassessment of the social value of the profession through an increase of wages and improved working conditions. In this context, minimum payment and maximum working

[47] Kindler, M. et al. (2016).
[48] as e.g. suggested by Caritas Europe

times for in-house care and minimum standards for housing and transportation services should be defined.

The path to achieve this should start with **recognition in all EU countries of LTC as a distinct policy field at the intersection of health and social care**. This will enable a holistic approach, which has to take into account, among others, "social protection benefits, care services, leave policies, family-friendly working arrangements and care related public infrastructures"[49]. In addition, the COVID-19 pandemic by exposing the lack of human resources in LTC, highlighted the relevance of migration and mobility policies for ensuring the necessary human resources for care[50].

**In the long run, the harmonisation of long-term care systems in Europe should be envisaged.** LTC policies should be defined as an area of mixed competence of the EU and its Member States including improved access to EU-funding for care work through the Social Funds. Here, the EU Pillar of Social Rights, which represents a reference framework to drive reforms at national level, may serve as a guide for the renewed process of convergence towards better working and living conditions of LTC workers, amongst other categories of population.[51]

[49] ISSA (2021), Long-Term Care in Ageing Societies: Issues and Strategies. https://ww1.issa.int/analysis/long-term-care-ageing-societies-issues-and-strategies.
[50] Grubanov Boskovic S. et al. (2021), Health and long-term care workforce: demographic challenges and the potential contribution of migration and digital technology, EUR 30593 EN, Publications Office of the European Union, Luxembourg, 2021, ISBN 978-92-76-30233-9, doi:10.2760/33427, JRC121698.
https://publications.jrc.ec.europa.eu/repository/handle/JRC121698.
[51] The 20 principles and rights enshrined in the Pillar are structured around three categories: 1) Equal opportunities and access to the labour market; 2) Fair working conditions; 3) Social protection and inclusion.
https://ec.europa.eu/commission/presscorner/detail/en/qanda_20_20.

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