Impact of the Covid-19 pandemic on the social services sector and the role of social dialogue

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1 Introduction

The COVID-19 pandemic has hit Europe unexpectedly, especially hard and to an unprecedented extent. In order to contain the spread of infection, virtually all European countries have implemented regulations to apply 'social distancing'. This impacted immediately on sectors with high direct face-to-face or client contacts, such as the social services. The social services sector is defined as services for children, older persons, persons with disabilities and other disadvantaged persons in both residential and non-residential settings (according to NACE codes 87 and 88).

The workforce (considered mostly as 'essential workers') was strongly affected by the health crisis as social services workers are - by nature of their profession - in close physical contact with multiple clients every day, and even more so in residential settings. They are working in high-risk environments prone to becoming infected. In the long-term care sector, first evidence shows that workers have higher infection and death rates than their other occupational groups (Uni Global Union 2021). Working conditions have become more difficult (e.g. with the need to wear protective gear) and work pressure has increased, especially when infections and quarantines of co-workers occur. Several countries have temporarily closed their borders for person movement, which has created specific problems for the cross-border workforce such as care workers. Staffing levels and user/staff ratios have been adapted out of need in the care sector which already encountered a lack of employees before the onset of the Covid-19 pandemic.

In order to alleviate the negative effects of the crisis, measures have been taken at various levels to support workers (e.g. bonus payments) or organisations/ providers (e.g. Social Care Provider Act providing compensation payments for social service providers in Germany). In many cases, social partner organisations have been involved.

This final report provides the final analysis of the research study for the FORESEE project commissioned by the Federation of European Social Employers (short: the Social Employers) and the European Federation of Public Service Unions (EPSU) on the "Impact of the COVID-19 pandemic on the social services sector and the role of social dialogue". The FORESEE project, co-financed by the European Commission (DG EMPL), is about achieving more attractive social services through social dialogue. It aims to further build capacities of social partners in social services at national and EU level; and by doing so, help the sector better manage current and future challenges.

The report is based on several data sources (Eurostat Labour Force Survey) and research findings and brings together the findings from the literature review and, more extensively, draws on the analysis of expert interviews. Expert interviews with representatives of employer organisations (member organisations of the Federation of European Social Employers) and trade unions (member organisations of EPSU) in nine European countries (those participating in the FORESEE project, i.e. Belgium, France, Czech Republic, Romania, Poland, Germany, Austria, Greece, Portugal) were conducted between July and October 2021. Topics discussed in the interviews include the impact of the pandemic or recruitment and retention of personnel; adaptations of working conditions and their impact on the workforce; actions taken by social partners; key learnings and good practices.[1]

This final report contains the main findings of the study, including figures and an analysis of the trends observed and provide a synthesis including innovative practices and key lessons learned.

Following this introduction (chapter 1), a brief overview of the role of social services in the pandemic is provided (chapter 2). Chapter 3 provides data on the impact of COVID-19 on the employment situation in the sector within the European Union (drawing on Eurostat Labour Force Survey data). Chapter 4 focuses on impacts of the pandemic on specific sub-branches. The following chapters 5 to 9 draw mostly on the analysis of expert interviews: Chapter 5 identifies challenges which the sector faces (before and after the onset of COVID-19), chapter 6 explores the impacts of COVID-19 on working conditions, chapter 7 on recruitment and retention problems. In chapter 8, the role of social dialogue in overcoming the crisis and social partner initiatives at the European level and national level are examined, before key learnings (chapter 9) and recommendations (chapter 10) are drawn. To sum this report up, an executive summary is provided in chapter 11.

1 The interview guideline and a list of all interview partners contacted are included in annex 1 and 2 of this report.

2 The role of the social services sector in the pandemic

Social services have played a crucial role during the COVID-19 crisis, being considered 'essential services' with employees working on the front-line covering the needs of highly vulnerable groups (such as older persons, persons with disabilities or the homeless). In the face of the pandemic, urgent social needs had to be taken care of in uncertain scenarios amid few protocols. At the same time and amid lockdowns and forced isolation and quarantines, new (psycho-)social needs emerged among the vulnerable, putting the social services workforce even more at the frontline. Social services workers have been providing awareness and psycho-social support, as well as advocating for social inclusion for the most vulnerable population (e.g. older persons in nursing homes or people with disabilities in residential care), often at high risks for their own health and safety and that of their families. Still, they have often remained in the background behind health-care workers and the feeling of 'being left behind' - at least at the onset of the pandemic - has been reported by several experts in the interviews conducted for this research report. At the same time, a spirit of optimism was voiced, as the social services sector had been widely viewed as providing essential services and the momentum of a higher recognition by authorities and the wider public should be taken advantage of.

3 Impact of COVID-19 on the employment situation in the social services sector in the EU-27

3.1 Employment in the social services sector in the EU before the pandemic

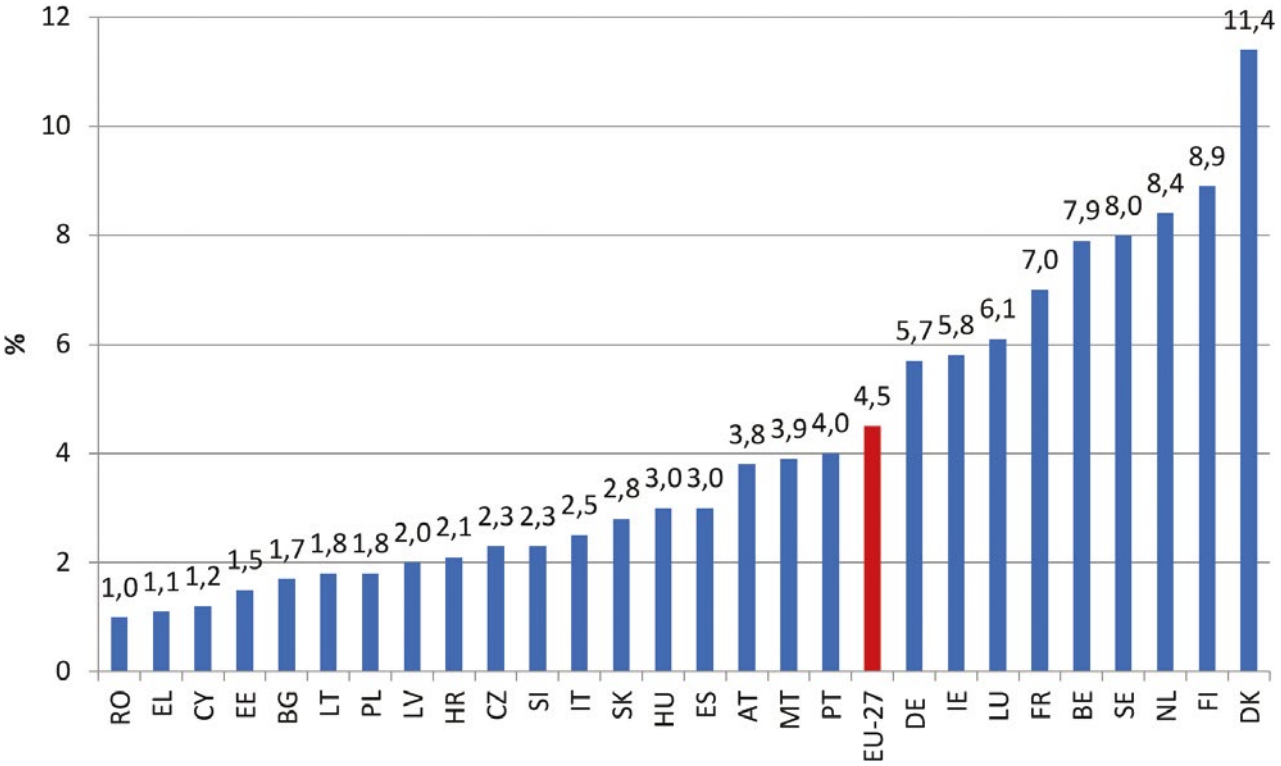
Employment in the social services sector showed a strong dynamic between 2009 and 2018, with an increase of 24% in the number of employed persons (aged 15 years and older) in the EU, while overall employment increased by only 5% in the same time period. Only in the Netherlands, declining numbers of employees were recorded (albeit at a comparatively high level, with the country showing the fourth-highest social services workforce share in relation to the total workforce in 2018 in the European Union). Nine countries (including the United Kingdom) saw below-average rises, with the vast majority of 17 countries showing an above-average dynamic. Seven countries (Hungary, Portugal, Slovenia, Luxemburg, Slovakia, Latvia and Malta) saw an employment growth of even beyond 40% between 2009 and 2018 (Federation of European Social Employers 2019: 9).

According to the majority of social employers' organisations surveyed in 2019, this positive employment dynamic was expected to continue, with a further increase in the number of employees expected in the next two years (Federation of European Social Employers 2019: 10).

3.2 Sectoral employment in the social services sector in the EU

The share of sectoral employment in the social services varies greatly between the member states, from just one percent in Romania to 11.4% in Denmark. Besides the Nordic countries (Denmark, Finland, Sweden), the Netherlands, Belgium, France, Luxembourg, Ireland and Germany have an above-average share of social services employment. On the other end of the spectrum, mostly new member states and Southern countries are found (see figure 1).

FIGURE 1: Share of the social services workforce in relation to total workforce 2020 in the EU-27



Source: Eurostat Labour Force Survey, employment 15 years and over in the social services sector (NACE 87 and 88) as share of total employment (all NACE codes)

3.3 Employment dynamic in the social services sector in the EU during the pandemic

In order to analyse the employment situation before and after the onset of the COVID-19 pandemic, annual employment data collected by Eurostat (Labour Force Survey) are utilised in the following paragraphs. Data differentiated by economic sectors (according to NACE codes) show the evolution of employment in the social services sector in the EU Member States.

3.3.1 Employment dynamic in the total social services sector (residential care activities and social work activities without accommodation)

In 2019, the total workforce (i.e. including self-employed) of the social services sector (NACE 87 and 88) stood at 9.1 million employees aged 15 years and older in the EU-27 countries[2] and at 11.1 million employees if the United Kingdom is also taken into consideration (EU-28). Data for 2020 show that the number of employees declined to 8.96 million; this

2 The comparative number for the EU-27 (i.e. excluding the United Kingdom) in 2018 lies at 8.96 million employees, so an increase in the sectoral workforce of the remaining 27 EU-Member States between 2018 and 2019 is evident.

translates into a reduction in employment of 1.6 percent[3]. This decline in employment numbers was unequally distributed across Europe (see table 1 and figure 2). While in 15 of the EU-27 countries a decline in employment is evident, there were some countries (with a light tendency towards those with lower absolute numbers and a lower sectoral workforce share, cf. figure 1) where this trend was counteracted: In Cyprus, Greece, Slovenia, Latvia, Hungary, the Czech Republic, Ireland, Lithuania, Spain, the Netherlands, Bulgaria and Belgium, a surplus of employment between 2019 and 2020 (and thus during the COVID-19 pandemic) can be detected.

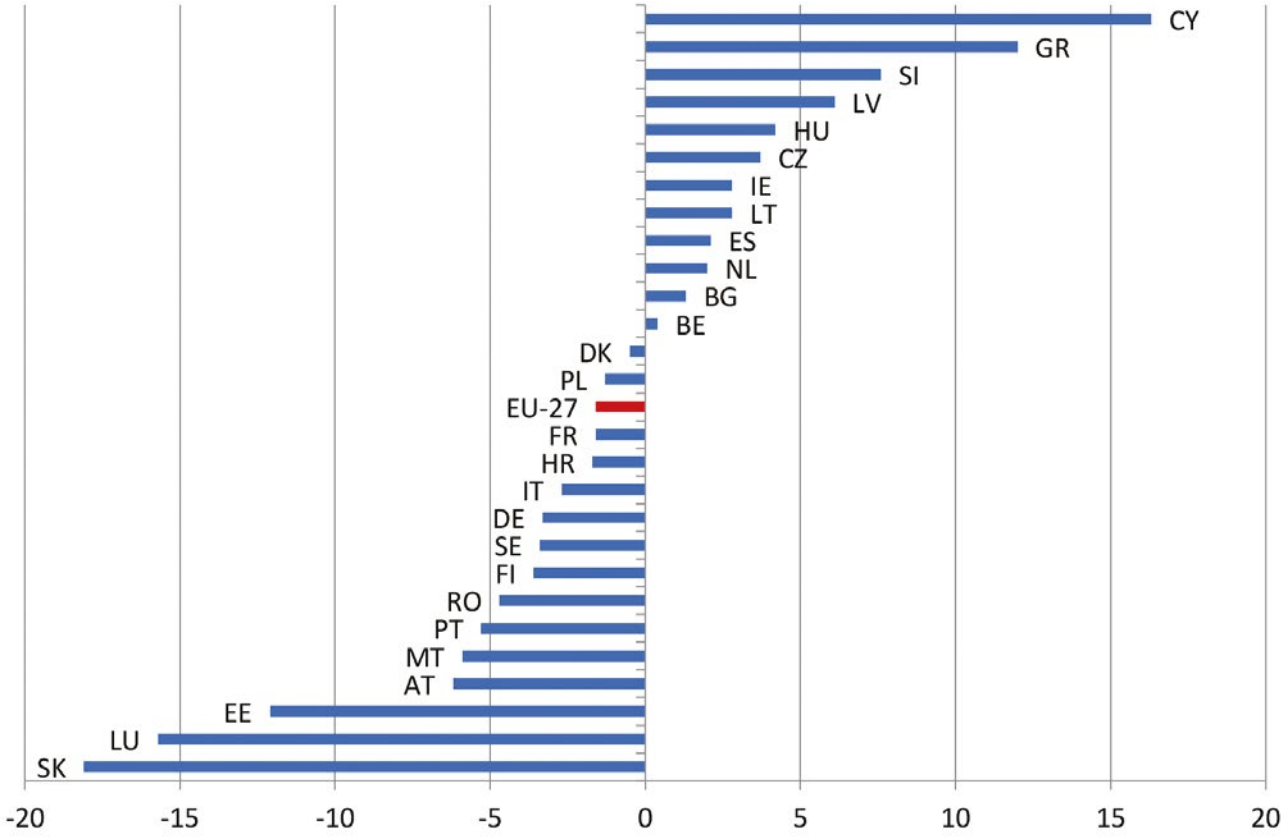
TABLE 1: Total sectoral workforce (residential care activities NACE 87 and social work acitivities without accommodation NACE 88) in million workers 2019 and 2020 in the EU-27 and employment evolution

EU-Member State	2019	2020	Employment dynamic in % NACE 87 + 88
Slovakia	83,600	70,800	-18.1
Luxembourg	20,600	17,800	-15.7
Estonia	11,100	9,900	-12.1
Austria	173,900	163,700	-6.2
Malta	10,700	10,100	-5.9
Portugal	204,400	194,200	-5.3
Romania	89,700	85,700	-4.7
Finland	233,400	225,200	-3.6
Sweden	420,400	406,700	-3.4
Germany	2,460,400	2,381,100	-3.3
Italy	594,300	578,600	-2.7
Croatia	35,700	35,100	-1.7
France	1,930,800	1,899,800	-1.6
EU-27	***9,105,900***	***8,963,000***	***-1.6***
Poland	296,900	293,100	-1.3
Denmark	325,800	324,300	-0.5
Belgium	377,500	379,200	+0.4
Bulgaria	51,700	52,400	+1.3
Netherlands	742,800	757,900	+2
Spain	564,500	576,800	+2.1
Lithuania	24,300	25,000	+2.8
Ireland	129,500	133,200	+2.8
Czech Republic	117,400	121,900	+3.7
Hungary	128,700	134,300	+4.2
Latvia	16,900	18,000	+6.1
Slovenia	20,800	22,500	+7.6
Greece	35,800	40,700	+12
Cyprus	4,100	4,900	+16.3

Source: Eurostat Labour Force Survey, employment 15 years and over in the social services sector (NACE 87 and 88)

3 In the overall workforce (all NACE activities), a decline of 1.3% in employment was evident in the EU-27 (Eurostat LFS). Only Malta, Luxembourg and Cyprus, the three smallest countries in terms of employees, showed (small) employment increases.

Figure 2: Employment dynamic in sectors NACE 87 (residential care activities) and NACE 88 (social work acitivities without accommodation) between 2019 and 2020 in the EU-27 in percent



Source: Eurostat Labour Force Survey, employment 15 years and over in the social services sector (NACE 87 and 88)

When the experts interviewed were confronted with the employment evolution in their countries, they often could not find spontaneous explanations for them. In the Czech Republic, the rise in employment can be attributed to wage increments negotiated before the onset of the crisis and bonus payments (see below). In Germany and Romania, both countries with declining employment figures, the explanation provided was that those on the verge of leaving the sector due to difficult working conditions anyway (Germany) and those close to retirement (Romania) left. The decline in France could possibly be attributed to the non-prolongation of government-subsidised contracts, but in general, the sector would be expected to show an increase of employment again.

3.3.2 Employment evolution differentiated by residential care activities (NACE 87) and social work activities without accommodation (NACE 88)

When analysing the employment development between 2019 and 2020 separately for residential care activities (NACE 87) and social work activities without accommodation (NACE 88), it is shown that the total social services employment reduction is owed to a decline of 9.5% in residential care activities (from 4.45 million employees in 2019 to 4.03 million employees in 2020, see table 2 and figure 3), whereas in social work activities without accommodation (NACE 88), an increase in employment from 4.66 million workers to 4.93 million workers (and thus an increase in employment of 6%) is shown (see table 2 and figure 4).

Generally, residential care services have often been declined to be used during the pandemic, due to fears of becoming infected, concerning the most vulnerable groups. So, relatives often decided to take care of their parents, children, family members themselves. This explains the negative employment dynamic in NACE 87 overall (albeit there are quite large national differences, for which also the expert interviews mostly could not provide sound explanations). Often, as a compensation, day-care services were used instead; thus, the (overall) increase in employment in NACE 88 can be explained, as is for example the case in the United Kingdom (cf. Home Care Insight 2021).

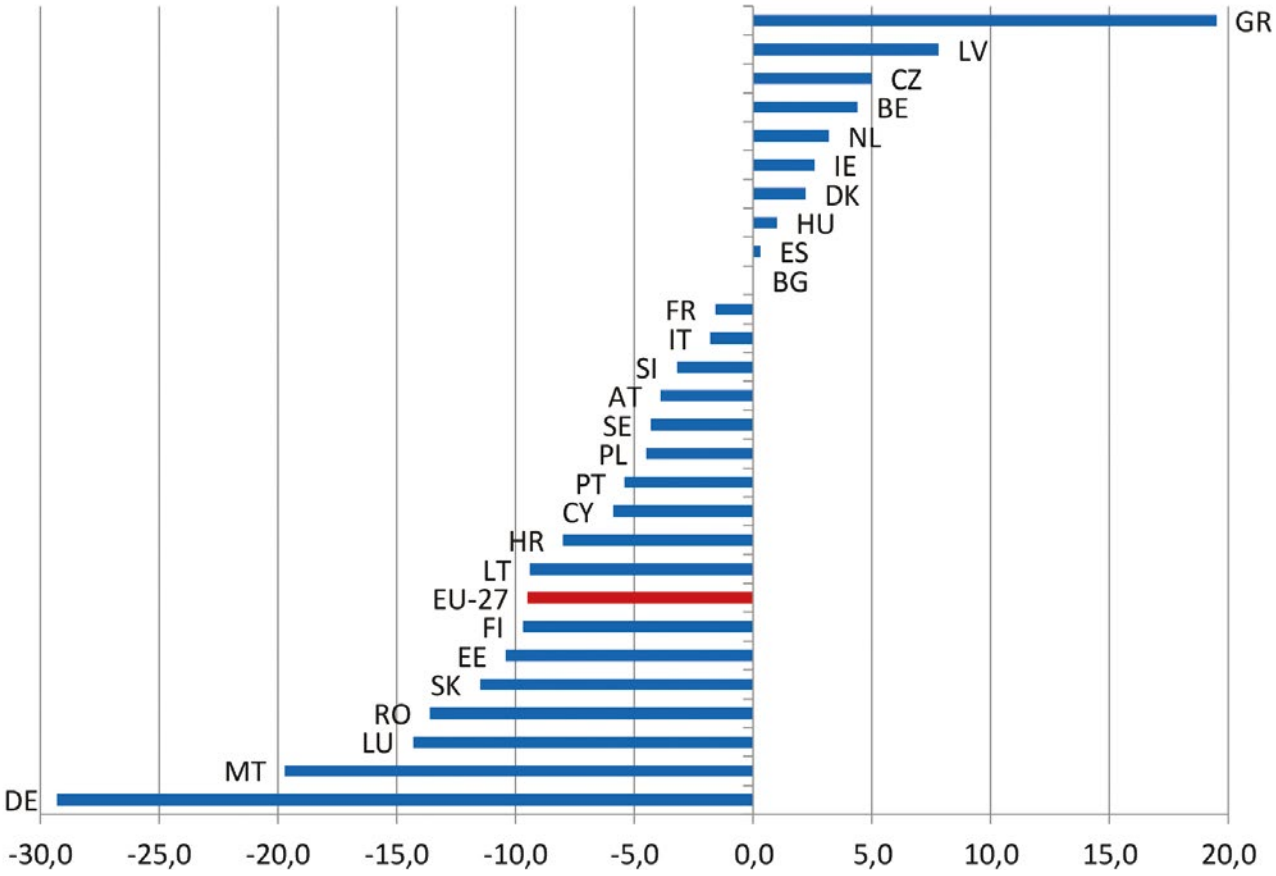
TABLE 2: Workforce 2019 and 2020 and employment dynamic separately for residential care activities (NACE 87) and social work without accommodation (NACE 88)[4]

	NACE 87			NACE 88		
	Year		Employment dynamic	Year		Employment dynamic
	2019	2020	in %	2019	2020	in %
Austria	77,800	74,800	-3.9	96,100	88,900	-7.5
Belgium	175,200	182,900	+4.4	202,300	196,300	-3
Bulgaria	16,200	16,200	0	35,500	36,200	+2
Croatia	17,500	16,100	-8	18,200	19,000	+4.4
Cyprus	1,700	1,600	-5.9	2,400	3,300	+37.5
Czech Republic	74,600	78,300	+5	42,800	43,600	+1.9
Denmark	131,200	134,100	+2.2	194,600	190,200	-2.3
Estonia	7,700	6,900	-10.4	3,400	3,000	-11.8
Finland	101,900	92,000	-9.7	131,500	133,200	+1.3
France	728,300	716,300	-1.6	1,202,500	1,183,500	-1.6
Germany	1,313,700	929,100	-29.3	1,146,700	1,452,000	+26.6
Greece	8,700	10,400	19.5	27,100	30,300	+11.8
Hungary	62,500	63,100	+1	66,200	71,200	+7.6
Ireland	42,400	43,500	+2.6	87,100	89,700	+3
Italy	316,900	311,300	-1.8	277,400	267,300	-3.6
Latvia	7,700	8,300	+7.8	9,200	9,700	+5.4
Lithuania	15,900	14,400	-9.4	8,400	10,600	+26.2
Luxembourg	6,300	5,400	-14.3	14,300	12,400	-13.3
Malta	7,600	6,100	-19.7	3,100	4,000	+29
Netherlands	433,500	447,400	+3.2	309,300	310,500	+0.4
Poland	128,000	122,200	-4.5	168,900	170,900	+1.2
Portugal	132,000	124,900	-5.4	72,400	69,300	-4.3
Romania	41,900	36,200	-13.6	47,800	49,500	+3.6
Slovakia	39,200	34,700	-11.5	44,400	36,100	-18.7
Slovenia	15,600	15,100	-3.2	5,200	7,400	+42.3
Spain	325,800	326,700	+0.3	238,700	250,100	+4.8
Sweden	220,500	211,100	-4.3	199,900	195,600	-2.2
EU-27	***4,450,400***	***4,029,200***	***-9.5***	***4,655,500***	***4,933,800***	***+6***

Source: Eurostat Labour Force Survey, employment 15 years and over in the residential care activities sector (NACE 87)

4 The individual country data will be presented to the interviewees for comments.

FIGURE 3: Employment dynamic in sector NACE 87 (residential care activities) between 2019 and 2020 in the EU-27 in percent

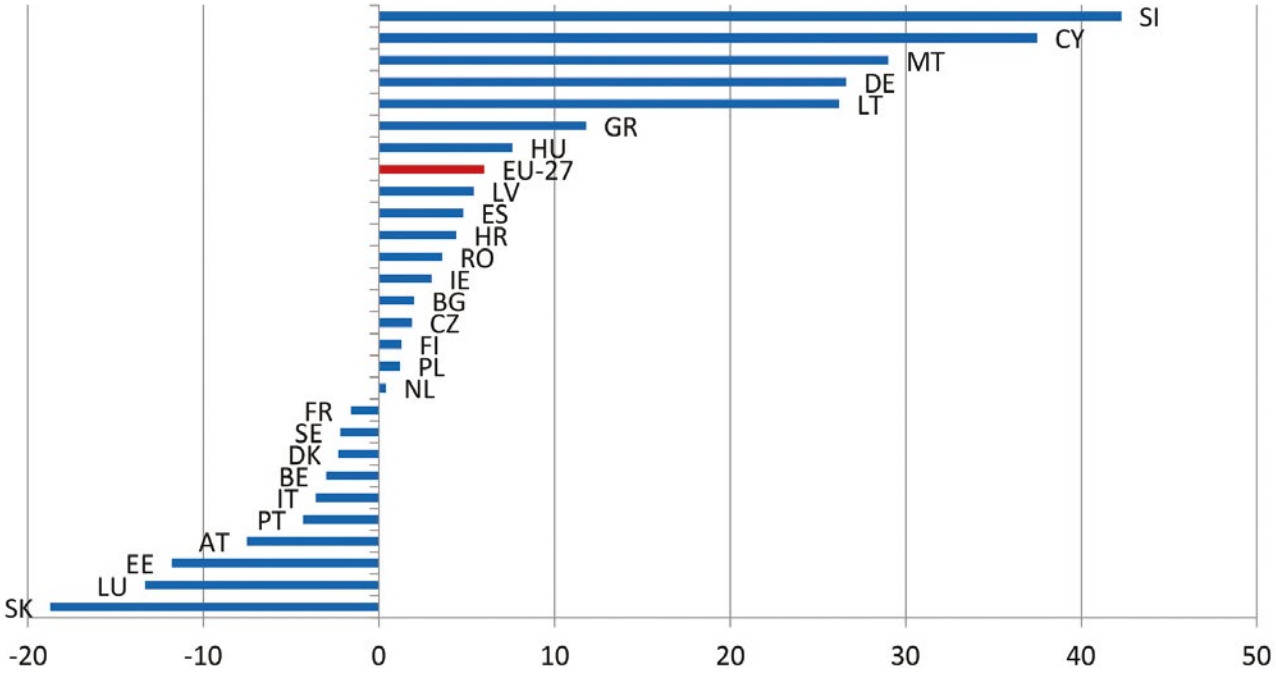


Source: Eurostat Labour Force Survey, employment 15 years and over in the residential care activities sector (NACE 87)

A possible explanation on the vast increase in Greece is that in 2019, the launch of the National Strategic Reference Framework (NSRF) for Supported Living Housing was announced, with new strucures emerging and thus new staff and employment opportunities.

With regards to employment in 2021, the diverging development in the two subsectors (Q87 and Q88) seems to have been continued; quarterly data for Q1 and Q2 show a decline in employment numbers for residential care activities (NACE 87) as compared to the fourth quarter of 2020 (4.07 million employees), but slightly higher numbers than the 2020 annual number (4.05 million workers in the sector in Q2/2021). In the social work activities without accomodation sector (Q88), an increase in employment is evident, which even supercedes pre-crisis levels (5.19 million workers in the second quarter of 2021).

FIGURE 4: Employment dynamic in sector NACE 88 (social work without accommodation) between 2019 and 2020 in the EU-27 in percent



Source: Eurostat Labour Force Survey, employment 15 years and over in the social work without accommodation sector (NACE 88)

3.3.3 Developments in sectoral employment by gender

The gender proportion among employees in the sector has remained stable with a female share of 82% of the sectoral employees in 2019 and 81.8% in 2020 (compared to the female share of 46% in the overall economy). However, when looking at the employment dynamic between 2019 and 2020, it becomes evident that the reduction of employment among males is much smaller (minus 0.2%) than among females (minus 1.9%) (cf. Eurostat LFS, calculations made by authors). This observation is confirmed by recent research that shows that "measures to contain the pandemic took a heavy and disproportionate toll on women's employment in low-paid sectors and increased the amount of time women were required to spend on care responsibilities" (Eurofound and EIGE 2021: 19). Amid lockdowns and school closures, females would rather withdraw from the labour market than men due to childcare duties.

4 Impact of COVID-19 on specific sub-branches and the delivery of social services

The impact of COVID-19 on the workforce in the social services sector, of which a large share is considered 'essential workers', was tremendous. Social services workers who are - by nature of their profession - often in close physical contact with multiple clients every day are working in high-risk environments and often had no possibility of social distancing, especially in residential settings, with telework not possible for the majority of workers. At the onset of the crisis, protective gear was often missing, putting them at even higher risks of contracting the disease (cf. Federation of European Social Employers/EPSU 2020c, 2020d, OECD 2021).

Many essential workers caught the virus and got sick or had to quarantine themselves, which had consequences of an already widely understaffed workforce (OECD 2021: 14). Stress levels went further up, and amid lockdowns, with schools closed, especially female workers were especially strung out (cf. Federation of European Social Employers 2020). In additon, strains on the mental health of social services workers have increased (Hussein 2020).

4.1 Impact on long-term care

Among the social services sector, long-term care was undoubtedly most severely affected by the health crisis triggered by the COVID-19 pandemic. Older people and long-term care workers have been disproportionally affected by infections; according to an OECD report (OECD 2021: 15), data on the incidence on LTC residents and LTC workers " suggests that the spread of the virus varied across countries and that the incidence rate among LTC residents often mirrored that of LTC workers, with larger peaks among LTC residents during outbreaks." The death toll among residents of long-term care facilities has been exceptionally high with estimated 41% of all COVID-related deaths among this group as of February 2021[5] (Comas-Herrera et al. 2021). According to the same report, over 5% of long-term care home residents have died in Belgium, France, the Netherlands, Slovenia, Spain, Sweden, the UK and the USA. According to OECD 2021 (p. 16), the share of LTC deaths in total COVID-19 deaths was about 40% across OECD-countries as of February 2021. But also workers in the long-term

5 The estimate is based on 22 countries reporting; this is lower than reported in previous phases in the pandemic.

care sector have had higher infection and death rates than other occupational groups, according to evidence of the first months upon the onset of the pandemic (Uni Global Union 2021). Many countries have taken measures to contain the spread of the virus and mitigate the effects on vulnerable groups. Resources for the prevention and control of COVID-19 in long-term care facilities have been collected by the European Centre for Disease Control ECDC (available here). Nonetheless, as a report by the German Friedrich-Ebert-Stiftung based on nine country reports concludes, "the failure to prevent the spread of the coronavirus in the care sector is symptomatic of the neglect that the sector had suffered before COVID-19 started to spread across Europe at the beginning of 2020" (Pelling 2021). This conclusion is backed by the OECD (2020), which also highlights that pre-existing structural problems in the sector, like difficult working conditions, skills mismatches, poor integration in healthcare and inadequate safety standards, were exacerbated by the health crisis. The OECD thus concludes that more investments in the workforce and infrastructure would be needed, in order to ensure "suitable levels of trained staff, with decent working conditions and prioritising care quality and safety".

Little evidence on the impact of COVID-19 on the non-residential long-term care sector was identified in the literature. In the survey on personal and household services (EASPD 2020b, see 3.3 for details), which includes e.g. workers providing social care in clients' homes, physical health was the most important worry of workers (for 82%). The very limited availability of personal protective equipment (PPE) at the onset of the crisis caused stress. In general, the social care provision was sought to be retained by organisations offering such services, and this was made available by flexible reactions. For example, where lockdowns were enforced, PHS (personal and household services) staff was considered key workforce and was granted extended mobility, like in Spain or Austria, where special arrangements for commuting live-in long-term carers were implemented (EASPD 2020b: 12f).

In general terms, it can be concluded that COVID-19 has strongly affected long-term care systems all over Europe, not least due to the beneficiaries' high vulnerability to the virus. High mortality rates in residential nursing homes and difficulties in ensuring continuous care were evident; this impacted strongly on the well-being of employees and service beneficiaries (cf. European Commission 2021a: 129ff). Structural challenges many long-term care systems had been facing before the crisis have become exacerbated; they are mainly related to staff shortages. The difficulties in attracting a sufficient and skilled workforce in the sector can be related to the difficult working conditions and little job attractiveness, to workforce trends (mainly female dominated, ageing workforce), a care drain (LTC workers leaving their countries of origin in order to work elsewhere with better pay and better working conditions) and skills requirements (which are increasingly complex) (cf. European Commission 2021a).

4.2 Impacts on services for persons with disabilities

The field of care and support services for people with disabilities also saw massive service disruptions. Service continuity could be provided mostly in care homes, albeit with a reduced range of services. Activities in day-care centres or workshops were suspended at the onset of the crisis, but were taken up again by autumn 2020; even face-to-face encounters became possible again. Service providers showed great flexibility to adapt the provision of services; due to physical distancing, communication was increased to compensate for the lack of personal contacts. Attempts at the digitalisation of services were made, with varying success. Often, persons with disabilities and their family members lacked either the necessary infrastructure or the ICT skills needed for online communication. But also employees (both employees and management staff) often lacked the necessary ICT skills. Furthermore, personal contacts could in

many cases not be substituted by digital ones (EASPD 2020a). EASPD (European Association of Service Providers for Persons with Disabilities) members have stated that there is evidence that "the emphasis on 'protecting persons with disabilities' is in fact leading to less choice and control over their lives – and human rights enjoyment – for many persons with disabilities, including over the services they use. This is against the principles of the UN Convention on the Rights of Persons with Disabilities, as ratified by the European Union" (EASPD 2020a: 3). Instead, service beneficiaries should be provided with a choice and control, and services should be functional.

Also in this area, staff shortages became evident, caused by increased absenteeism, staff leaving, sick leave due to infections or quarantine, and mental health difficulties. The absence of adequate public support to guarantee the financial stability (due to increased costs and reduced incomes) is voiced by EASPD members.

4.3 Impacts on care and support services for children

Only little evidence in the literature could be identified on the impact of COVID-19 on care and support services for children (e.g. non-institutionalised childcare). In the European Commission's report on ECEC (early childhood education and care), the importance of quality childcare at an early age is highlighted: According to the report, the COVID-19 crisis provided "the opportunity to recall the crucial role played by ECEC professionals to support families. While this childcare service is an essential role of ECEC and helps breaking the cycle of poverty, researchers have also proven consistently that provision of quality ECEC is a great tool to support the development of cognitive, social and emotional skills of children, leading to further success in life. It is therefore crucial to recognise that ECEC professionals do not only offer a childcare service which is essential to parent's employment, but they mostly offer professional care and education which supports children's development and well-being." Furthermore, the increased use of web-based learning for training in the sector is appreciated.

5 Challenges for the social services sector

The main consensus among all interview partners is that the challenges that have pre-existed before the onset of COVID-19 have further intensified during the pandemic. In addition, new challenges appeared.

5.1 Challenges pre-existing before the onset of the pandemic

One of the main challenges identified by the interview partners that has existed long before the onset of the pandemic is insufficient **funding** for the social services. This would not allow to employ adequate numbers of personnel and to provide all services. In the Czech Republic, the problem lies not so much in the amount of funding, but rather on how the money is distributed between health and social care (with health care taking also place in care homes and social care taking also place in hospital), two systems not communicating with each other and different ways of regulation, financing, supervision and inspection. There is also no legally established border drawn between health and social care, which could help clearly define the distribution of funds. In Romania, funding problems had been taken to the next level. There, it was reported that the sector is in such a way underfunded as to jeopardise the quality of social services and limit their functionality.

The pandemic and encompassing hygiene standards and regulations caused **additional costs**, which in many cases had to be borne by service providers. Equipment such as protective gear and face masks had to be purchased, but also investments in facilities taken in order to meet hygiene precautions and ensure that all sanitary protocols could be followed. Furthermore, technologies for employees (and beneficiaries) had to be invested in (e.g. for communication). In Romania, those extra expenses were covered by private donations. In the Czech Republic, on the contrary, funding programmes were provided by the national government, something that is considered exceptional within Europe. All costs were paid without any reductions, *"the Czech government paid every single crown of the costs"* (Czech interviewee).

A second challenge that was articulated in virtually all countries was the **lack of qualified personnel**, which has become even more critical. A high turnover in personnel was evident, and cases of **personnel leaving for other sectors** where working conditions and/or pay were deemed more attractive. There are reports of social care staff leaving to work in supermarkets in Poland (where the working conditions and pay had improved over the last years), but also in Austria (no night shifts, Sundays off). Also in Austria, a transition from the private to the public sector was reported (albeit at a small level), as working conditions, staff ratios (including the ratio between highly trained employees and assistants) and pay tend to be more attractive in public settings. A pay reform at the communal setting had been implemented before the pandemic, which follows the logic of being paid for what is being done, and not according to the formal level of education or training. In communal long-term care homes, a large number of beds had to be capped, due to personnel shortages and a large number of at-risk employees (which was interpreted quite broadly and less restrictively than in the private sector), who were voluntarily released from work. At the same time, this had no major effect on the provision of services, as often, alternative solutions to care institutions were looked for. In other countries, social care workers continued to migrate to other countries (e.g. from Poland to Germany, Italy or the UK) with higher pay and better working conditions. In general, a **lack**

of attractiveness and **reluctance to join the sector** was stated; this has aggravated during the pandemic. In France for example, the number of applicants in specialised schools for social workers has been decreasing year after year, as has the ratio between the number of nursery places created, and the number of trained professionals. In Poland, working in the social sector is not well-recognised and a lack of career paths is perceived (i.e. not seen as a job where you can be promoted). During the pandemic, attractiveness of the sector may have deteriorated further due to **increased risks**; to risk your life or to have health issues, working with possibly infected persons.

Connected with the lack of personnel are of course the **working conditions** and **pay** in the sector, which are largely perceived as poor. Compared to the health sector, pay is often lower with (large) salary inequities and in some coutries, like France, it has been worsened by important pay rises reservered, in the beginning to healthcare related workers working in public settings and nursing homes. In Romania, the previous government tried to halt the outward migration of qualified staff by increasing wages tremendously starting in 2018, which was successful in retaining qualified workers, but the spending proved to be unsustainable and is in the process of being taken back. In the interviews, the employer representatives have all stated that work in the sector should be better paid. Being dependent on public funding, it has proven to be a challenge to enforce this.

5.2 New challenges

A **shortage of personal protective equipment** (PPE) like gloves, masks, suits, disinfectants, etc. especially at the onset of the health crisis in spring 2020 was reported in many interviews. Also, protective equipment had been very expensive to purchase due to the increased need globally. The use of PPE also caused problems in personal work with beneficiaries. Upon return to work after the first lock-down, employees were often obliged to wear face masks, which proved difficult with vulnerable groups (e.g. persons facing dementia) or (young) children and babies, as personal contact with facial expressions and gestures is deemed to be very important.

Furthermore, employers and employees in various countries faced **unclear regulations** and insufficient information. With the legal regulations changing often and abruptly (often from one day to another), there was a lack of knowledge on what was to be applied at a given point in time. Often, the interpretation of the recommendations was somewhat difficult and was not entirely clear. This created problems between provider organisations and political authorities, but also caused problems with regard to psycho-social risks for employees. Even within the sector, it could be possible that different guidelines and sanitary protocols would apply (depending on who is financing the service), as reported in France.

Upon return to work after the first lock-down in most countries in spring 2020, new challenges appeared with regards to **staff management**. Employees were *"kind of lost, they had not worked for months in a team, they were worried, they did not know what would happen"* (French interviewee). Also, the abrupt switch to **digital modes of work** and/or service delivery proved challenging, not only in terms of a lack of skills and training or outdated technical equipment, but also in terms of funding guidelines (e.g. no reimbursement for online video counselling). The development of the professionalisation of the sector (having qualified workers, develop training) is seen as key for the sector.

A specific challenge was encountered in several Central and Eastern European countries, when **migrants** who had been working in the social care sector abroad had temporarily **returned to their home countries** upon the onset of the pandemic. In Romania, for example, migrants returned for the duration of one year or longer. In Romania, *"they were not at all prepared to come back, they had no jobs, they came back with their children, but there was no school for the children, because they were not registered at schools. Thus, there were huge problems for the state to solve, from one day to another, and unfortunately, the state was not prepared to solve those problems"* (Romanian interviewee).

6 Impacts of COVID-19 on working conditions in the social services sector

Prior to the pandemic, the working conditions in the social services sector were already generally reported as difficult, with comparatively low wages, physically and mentally demanding work, weekend and night work, and high stress levels, not least caused by a shortage of staff. Details on the perceived working conditions of staff in the social services sector, as collected by the largest Europe-wide survey of its kind, the European Working Conditions Survey (latest data from 2015) by Eurofound, can be found in Federation of European Social Employers report 2019.

The major issues regarding the impact of the pandemic on working conditions for frontline workers can be summarised as follows (Pelling 2021: 11ff):

- high-risk health environment, lack of PPE at the onset of the pandemic
- lack of resources and attention
- high mental pressure and responsibilities
- no safety net in case of illness, limited access to sick pay
- increased workload, working long hours

A recent study on stressors for long-term care (LTC) workers in residential settings in Austria (Brugger et al. 2021) has come to similar results and shows that a range of preexisting stressors, such as a lack of gratification, shortage of personnel, and exhaustion have become exacerbated. In addition, other stressors like contradictory information disseminated, the usage of personal protective equipment and the rapidly declining health of beneficiaries have been identified as newly emerging.

In joint position papers by the Social Employers and EPSU (2020a, 2020b), several recommendations targeted towards recruitment and retention strategies, as well as the protection and safety for service users and workers are provided, amongst them many that would enhance sectoral employees' working conditions greatly.

The following chapters provide a summary of the perceived working conditions amid the pandemic as reported by the expert interviews.

6.1 Occupational health and safety

- **Higher infection rates among workers**

The risk of catching COVID-19 is increased for workers in the social care sector, they have higher infection rates than the general population (see above and OECD 2021: 14). Employees were on the front line in the fight against the pandemic, especially in the "high-risk environment" of old people's homes, where the largest risk groups were, and which were particularly vulnerable to contagion (cf. EPSU 2021: 7). In institutions for persons with disabilities or in children's institutions, they were often unprotected against risk groups who would be negatively affected if their caretaker wore masks, e.g. nursing home residents (with dementia) or small children. An Austrian trade union interviewee stated that *"we have often heard that, yes, wearing face masks is possible during the day, but in the morning, when people with dementia are greeted in their rooms by caretakers wearing masks, that is frightening for them, instead of when they are greeted with a smile"*. Often, infection clusters developed, with entire units lost, and this had

to be absorbed by other employees, in a situation where there is already a shortage of staff. This in turn means even higher workloads and more difficult working conditions due to hygiene measures. Also, the disease patterns of nursing home residents have worsened, due to the exceptional circumstances with long phases of isolation, and many deaths occurred.

- **More difficult working conditions due to the hygiene measures**

In virtually all countries, PPE was missing, especially at the onset of the pandemic, as no stockpiling had taken place before and, in many countries, the LTC sector was not usually prioritised for PPE (see also OECD 2021: 28ff). In Poland it was reported that workers bought the protection themselves, because there was not enough available at work. Also, wearing such protective gear had an impact on employees' work performance, as this was very demanding and employees were even more exhausted.

In the interview with a German trade union representative, several uncertainties with regards to labour law were voiced. The union provided FAQs for their members on questions like whether the employer would be allowed to oblige workers to work without protective equipment, or how set-up times (for putting on PPE) would be regulated. In Germany for example, the set-up time was not taken into account in the staffing ratio; if a worker needs to change several times a day, more time is needed, which is subtracted from work with service users.

6.2 Psycho-social risks and stress

- **Increased pressure and higher work loads**

The deterioration of working conditions was evident. Throughout the pandemic, care workers experienced understaffing, work intensification and dangerous working conditions (EPSU 2021: 8). There are many reports of over-long working hours, exhaustion and an exacerbation of the staff shortages due to infections and sick leaves in the interviews. The pandemic has negatively affected the mental health of LTC workers especially (OECD 2021: 44). The danger of becoming burnt out was mentioned in virtually all interviews. In Austria, reports of many hours of overtime and unpaid working hours and breaks have been provided, often at short notice due to absent or sick colleagues. After the pandemic, an exodus of workers leaving the sector is feared. Minimum staff ratios from before the pandemic have now, in the face of COVID-19, become the new norm, according to an Austrian trade union representative. In Poland, many employees were overwhelmed by the amount of work they had (with 24- to 48-hour shifts, because they could not leave nursing homes because of COVID). In Romania, extra-long working hours were to be provided during a forced quarantine: During the last month of the first lockdown (mid-April until mid-May), social care workers were forced by emergency law to quarantine for 14 days in order to stop the spread of infections in nursing homes and older people's homes. The social care sector was the only sector in which employees had to quarantine, because they were treating very vulnerable beneficiaries. This posed large problems for families, when both partners of a couple were working in the sector and had to quarantine, as to who would stay with their children or older relatives. As a compensation for the forced quarantine, the government promised an incentive of about €500, which only came underway in June 2021 (more than one year later). Thus, in Romania, a lot of workers were lost during these months, with employees having been exhausted and burnt out, *"at a level of exhaustion which was almost unbearable"* (Romanian interviewee). Combined with a lack of funding it was a dreadful combination. Also in Poland, employees were detained at the beginning of the health crisis. Employees were not allowed to go out/home, so they stayed and worked for 72 hours, or even more, for a week (per emergency legislation). In Portugal, there was legislation that the organisation of staff should be managed in a way that more than one group was to be constituted, and the implementation was left to the organisations themselves. So, at the onset of the crisis, many employees decided to be isolated from their families, spending 15 days in residential facilities or sleeping elsewhere, during their work shifts.

- **Increased mental workload**

The fear of employees of getting a COVID-19 infection and taking it home to their families as well as the fear to contaminate service users and colleagues were reported largely in the interviews. Furthermore, the mental stress increased also due to seeing beneficiaries die. This has impacted the workers in the long term, according to a Belgian interviewee. But also on managers, the mental stress has been heavy, often due to different, unclear regulations, which often changed and furthermore differed between authorities (French interviewee). In Greece, increased psychological pressure of personnel was reported, caused by health protocols that the state implemented, but without proper supervision by the state. In Poland, even a fear of attacks by citizens was reported: In small villages, employees working in the social services, but also doctors and nurses were attacked because people thought that they might have caught the infection at work and bring COVID home to their families and villages. There, employees were generally overwhelmed with work and long working hours and reportedly, nothing changed to their rights, no promotions, no special benefits or bonuses were provided.

6.3 Time schedules

The management of employees' time schedules was complex due to the adaptation to new rules (which are not always easy to be put in practice) or the absence of a large number of co-workers, or in case teams were formed so as to safeguard the continuity of service provision in case one team had to quarantine themselves. Often, time schedules were not adhered to and/or were made at very short notice. Scheduling was not plannable and it was basically *"the administration/management of too few staff"* (Austrian trade union representative). Especially during lock-down phases, workers were often not allowed to take time off or to take vacation. The rotation of shifts and distribution of employees to where they were most urgently needed, was common practice, as reported by an Austrian interviewee: *"On the question of rotation, if now level 9 is implemented (last-highest step on the Corona emergency plan), there is no more consideration for you regular shift, you can be taken out of the area and put into another one; that has happened in the private sector before, we have been able to ward it off so far. Rotation is something that decreases job satisfaction a lot. It means, for example, moving from your ward to the neighbouring ward, or one floor higher. That is connected with insecurity - employees don't feel comfortable there, it's not their team, not their residents, some framework conditions are different than on their regular ward, and people don't want that. That breaks with the pandemic and we as union have to look at how we deal with that, because the employees have a contract with a company and not with a specific ward."*

6.4 Staffing levels and ratios

According to an OECD report (2021: 63), the COVID-19 pandemic has highlighted and exacerbated pre-existing structural problems in the LTC-sector - studies suggest that facilities with lower numbers of LTC-workers were associated with higher infection rates. As an immediate effect of the crisis, many workers also left the sector: "Since the onset of the pandemic, Europe has faced a situation of workforce exodus on an unprecedented scale, especially among the residential care workforce" (cf. EPSU 2021: 8). In many cases, staffing ratios have worsened, e.g. caused by infection clusters or quarantine mandates among employees. Especially during night shifts, the personnel situation was worst, as reported in the interviews e.g. for Austria or Germany. Employees were (illegally, out of need) left alone on night duties, forcing them to work through the night (without taking breaks and not even being paid for it). In Germany, when staffing ratios could not be met due to sickness or unfilled posts, temporary agency workers were in some cases filing in at short notice. On other occasions (as reported for Austria), sufficiently qualified personnel were not available. In nursing homes, for example, a registered nurse must be present at all times, but that could often not be fullfilled. Thus, assistant nurses stepped in, which can become a liability problem for the provider; this problem had been exacerbated in the crisis. Union representatives show concern what will happen after the pandemic has receded into the background, when managers might want to compensate for losses they have encountered, whether e.g. capped beds due to acute personnel shortages would be revitalised. On the positive side, "while recommendations or legislative policies on staff to resident

ratios were already in place before the pandemic in about two-thirds of OECD-countries, staff ratios became a renewed source of debate in 40 percent of surveyed OECD-countries since the beginning of the COVID-19 pandemic" (OECD 2021: 65). Since the onset of the crisis, three European OECD member countries introduced guidelines on staff ratios (Lithuania, Netherlands, and Slovenia).

6.5 New ways of service delivery

- **Remote work**

In all countries, remote work was resorted to in the face of the pandemic, albeit at different levels. In many cases, it was newly established and had not existed before. Mostly, it was applied at the administrative level, but also at the level of service provision in innovative ways. Management staff were challenged as they had to learn how to work online – and manage staff remotely – within only few days, but in general, all sectoral workers were more or less confronted with it and had to learn to work with it (to a much lesser degree among those working directly with people e.g. in nursing homes). For middle-aged persons having worked in the sector for a longer period of time, it has proven to be quite difficult to adapt to the new technologies and online meeting arrangements. There was a huge need for specialised personnel in the digital area, since in many cases, the service providers had to provide the services digitally. Often, there were no specifications on the conditions of telework, so its organisation had to be adapted and implemented ad-hoc.

In France, digital platforms were used for the distribution of staff in case of closures of establishments and services. The platforms were used to share this information *("I have a staff member available because the service is closed"*) so that staff could be borrowed to one another. There was also an opportunity for health professionals to support hospitals if the services were closed.

Reactions to a remote service delivery were varied; in Poland, an interviewee reported that not a lot of people wanted it, or had the ability to use it. There is a lot of digital exclusion, especially in small villages where people do not have access to internet.

While it was a big challenge at the onset of the crisis, it is considered a force today and a way of work which will be continued to be used. Via remote staff management, more autonomy is given to staff members, which is also something that is expected to stay – with further training needed.

- **New ways of service provision**

Some of the services provided in the social services sector needed to become adapted in order to provide online, remote social services. In the Czech Republic for example, in the area of social prevention, where home visits to families with problems were conducted prior to the pandemic, it was switched to a remote provision, with virtual visits twice a week and consultancy being provided remotely. In France, it was reported in the interviews that after a period of doubt among employees, a re-invention of the way of working came about, in order to maintain social connections with digital means and redefine relations between organisations and users. For example, as community centers were closed, workers would meet people in open spaces.

But not all employees and beneficiaries were properly adapted for such a switch. If arrangements could be organised in such a way, then psychologists and social workers in Romania were prepared and rapidly entered a new mode to function. Due to the closure of public transportation for a few months, disability determination and assessment in Romania was switched to an online assessment with tools and interviews held online; also consultations were held in this way, mostly over smart phones, as in rural, poor areas, people often do not have computers.

In Greece, the window of opportunity for innovative ways to work was taken, as there was a space for new technologies and new ways to provide services. In the provision of services for persons with disabilities, face-to-face interaction with beneficiaries, educators and caregivers has always been the main means, being most efficient. As there was no possibility to deliver the services face-to-face, the choice was between either abandoning the beneficiaries or finding a new way to provide the services. The Greek FORESEE project partner, a service provider for persons with disabilities, chose to provide their services via online tools and created a platform with Youtube, Google

Drive, Google Classrooms, Zoom, Meet and Skype meetings. Thus, the beneficiaries had the opportunity to collaborate with the educators here. According to the interviewees, this made the service equal and helped the beneficiaries to go one step forward in the technology period that we face. For those lacking hardware, via the sponsorship of an enterprise, tablets and other devices were provided. Furthermore, collaboration with the families to help them get access to the services was initiated. Also, a new service supporting teleworking parents was implemented (in non-COVID times, their children spend around seven hours per day at the center). As many parents were teleworking, with all family members in the same place, there was a need for additional support. The center then created some teams and initiated a collaboration between the workers' department and the families, in order to assist them in this new reality.

6.6 Pay and premiums

Especially during the first wave of the pandemic in spring 2020, many countries issued bonus payments to workers in the social services sector for their exceptional efforts (around 40 percent of the OECD-countries did so, cf. OECD 2021: 39, including France (for workers of health-related categories), Germany, Hungary, Latvia, Lithuania, Netherlands and Slovenia). Few countries also improved wages permanently following the start of the pandemic (e.g. Czech Republic, France, Germany). In some of the countries in which interviews were conducted for the Foresee project, workers in the social services received bonus payments or premiums, to compensate for difficult working conditions, heightened burdens, increased work loads or risk of exposure to infected persons. Such a bonus was provided in various countries, but the highest bonus payment provided was in the Czech Republic: The Czech government decided to give every employee in caring professions a one-off benefit or reward of €4,000 (which is a very large sum considering that the average salary for a caregiver is €1,200, so they got around 3.5 extra salaries), paid in two instalments (less was paid for administrative and technical staff). Thus, there was not a high fluctuation in staff (i.e. not higher than usual). The first instalment was paid in summer 2020 and with the knowledge that the second instalment would be provided in the first half of 2021, employees stayed in the sector, as they knew this reward would be coming. Furthermore, a 10 percent rise in salary was implemented in 2021, which was a further reason to remain in the sector.

Other countries were far less generous. In Romania, a bonus promised for a month-long mandatory quarantine was paid one year after (see above). Romanian workers in the social services sector who had become jobless due to closures were attended to very late by the government. The state reacted by providing support in the form of an emergency employment cash benefit, but with a long delay compared with other sectors, so that social services workers were confronted with no payments for two to three months.

6.7 Training

There were only few reports in the expert interviews conducted on training provision directed towards digitalisation. In Greece, it is reported that sometimes, seminars were organised inside organisations, but there was not a central plan about this. According to the interviewee, training would have been important, as especially in the public sector, some services could not be offered due to a lack of digital skills. But besides training the employees, there is also a need for training and educating other users of the services, like beneficiaries (and their parents in case of children with disabilities). The Greek Foresee project partner organised such a platform, providing an online meeting for the families of its beneficiaries. However, more than a third of them did not have an internet connection or a mobile telephone that could be used for that, so they tried to manage these needs with the provision of sponsored tablets. The sponsorship of digital devices has mainly helped to familiarise staff and beneficiaries with online meetings and has contributed substantially to the training of benficiaries in new media and technologies, but the lack of (stable) internet connections that many families faced, could not be tackled.

7 Recruitment and retention in the face of the pandemic

7.1 Recruitment and retention difficulties

Difficulties with regards to recruitment and retention of personnel have been encountered by all interviewed experts. Especially in elderly care, recruitment is reported to be difficult, e.g. France mostly lacks nurses and assistant nurses, having adverse consequences for service provision. Establishments are the subject of supervisory obligations. A lack of personnel may result in total or partial closure of the establishment. Shortages have been accentuated by the crisis, and recruitment is considered more difficult than in pre-pandemic times, especially in rural areas, like in Romania. There, the government provided a fund, a specific emergency budget line for older people which were isolated. Thus, many social workers were hired for these particular people in rural areas (public). The programme was for the public sector, the private sector was not eligible.

Also, the retention of sectoral workers proved difficult amid the large health crisis. Often, it appeared that employees do not so much deliberately leave their jobs, but are incapacitated or leave for retirement at the earliest chance. Also, persons who had been on the verge of leaving the sector may have used the occassion to leave, as the *"symbolic image of clapping hands is not enough"* (German interviewee).

The lack of career path opportunities (having several consecutive job positions in your career) is also considered as a major downturn to making employees stay in the sector (French interview).

In Greece, additional funds were made available in order to create new jobs in the public sector (e.g. 200 nurses to be employed due to the pandemic instead of 100); thus, many positions were created, however, this triggered a leak from private, non-profit organisatons as personnel left in order to work for the public sector. While personnel do not necessarily earn higher salaries in the public sector, the employment relationship is much more stable (long-term contracts). Nonetheless, the private, non-profit sector could cope and manage the situation. In the public sector, working conditions are sometimes considered worse, e.g. due to many night shifts, which does not suit persons with family responsibilities (children).

Many employees left the sector due to better pay and working conditions elsewhere, either within the country in a different sector (e.g. to supermarkets, see above) or abroad. Qualified people from Central and Eastern Europe often leave their home countries to go abroad and work in Western countries, where they are better paid and they are better recognised as professionals, especially those with a university degree. But this is also true for the carers like home carers or personal carers for older persons, there is an exodus of those people e.g. from Romania, especially towards Spain and Italy (due to the language similarities), and to the UK. This in turn has huge secondary effects in Romania, because those workers leave behind older parents and children. In Romania, around 300,000 children are left behind with huge social and psychological problems. All these additional burdens and aspects reflect on the social sector and the social services have to face all these consequences of the lack of staff and additional social problems.

On the positive side, in Portugal, a recruitment programme for unemployed people to work in residential facilities was implemented in the face of the crisis and amid large staff shortages. The programme started shortly after the onset of the pandemic in spring 2020 (and has been extended until the end of 2021), for unemployed persons who would like to pursue a career in care. The state pays 90 percent of the salary, the organisations themselves ten percent. Organisations will have benefits if they retain those workers with a regular employment contract. The programme participants are low-level workers, with only a short training duration; however, it became visible that much more needs to be invested in training and education programmes, as it is not easy to switch to work in that sector amid such difficult situations. At a certain point, many organisations in very critical situations were desperately looking for staff and this programme was very important, but is not considered sufficient by a Portuguese interviewed expert. So in addition, workers were also hired through temporary agencies; this was especially critical during the winter of 2020/2021, when infection rates had reached a high.

7.2 Low pay as one of the main reasons for leaving the sector

In many interviews, one of the main reasons provided for leaving the sector (besides difficult working conditions) is comparatively low pay. The difference in salaries between the health and social care sectors, which have large overlaps in terms of professional needs, is an important driver of this development. In France for example, after an increase of €183 net in the public hospitals and public nursing homes since late 2020, nurses and assistant nurses in social services, that do not benefit from the wage improvement, leave the sector to get better wages. This phenomenom causes very significant staff shortages in sectors not concerned by the measures. The early childhood sector is also facing this competition between the public sector, which is better paid, and the private sector. In some jobs, there is also competition in the private sector, between for-profit and non-profit structures.

Often, there is a competition for workers within countries, when wage inequalities between the public, profit and non-profit sector appear. The example of Romania shows this clearly: *"In terms of retention of the staff, we see two completely different evolutions: in the public system, the salaries of the staff have been continuously growing, but not sustainably. Meaning now, people there have very high salaries, almost at the average of the EU, which for Romania is not natural, meaning it is much higher than the Romanian average wage. While in the NGO sector, it is exactly the opposite. We are at the limit of acceptance regarding the salaries. What we see, however, is that the public system is not able to maintain these salaries on the long term. It was a push, making sure that the staff is there, but it is not sustainable. So we follow very carefully this trend and we look how the system evolves. It is not very encouraging. We still do not know if people in the public system will really remain there if the salaries will change again. We look at the NGO sector with a lot of concern, because people continue to leave. So I would not say that on the side of retention we have a very encouraging situation. We analyse still the trend, it is an ongoing dynamic. The NGO sector loses to the public sector"* (Romanian interviewee).

The example of France also shows that employees sometimes prefer to work in the public sector and it is difficult for employer organisations in the private sector to bargain for increased funds with the government. Wage increases in the associative private sector can only be made if the financers and especially the state and local authorities provide the financing.

When the difference in salaries is high, staff poaching often takes place. For example in France, it is almost impossible to find nurses close to the Swiss border: *"If you are a nurse in France and you earn around €2.000, you commute 50km to Switzerland and you will earn about €5.000. As the Swiss were missing staff, because they also got COVID, if you are contacted and proposed to earn more than twice what you earn today (this has taken place, not massively, but it was there), then the decision is easy to take"* (French interviewee).

7.3 Measures against recruitment and retention difficulties

In several countries, initiatives to simplify recruitment during the pandemic were implemented. In Romania, the hiring process was shortened by emergency law in order to recruit for imminent shortages. Employees were hired on a short-term basis (i.e. one month contracts, to be extended every month until the emergency period is finished).

In Austria, retraining programmes had been in place, in order to qualify unemployed persons as nursing assistants while receiving unemployment benefits. During the pandemic, the City of Vienna has issued an extra top-up bonus of €400 for those participating in such programmes. According to an interviewee, this was owed to a dynamic, in which the spotlight among the public and media was on the health and social services sectors' systemic deficiencies. This had led to innovation, providing incentives to unemployed willing to re-qualify and pursue a career in the health and social services. At the onset of the crisis, numbers of enrolling students increased, but as it became evident that working conditions would not improve, but would rather become more difficult, numbers decreased again - so a higher take-up was just a preliminary phenomenon during the first months.

In the Czech Republic, the number of students in nursing schools had increased from 2020 to 2021 by 22 percent. While in the past, the case was that there were some vacancies in schools (with capacities in nursing schools filled up by 80 to 85 percent), now students need to be declined due to a rush to schools. The attractiveness of such an education is mostly owed to relatively high salaries in the sector, which had been increased during the last few years (see above).

In the Netherlands, labour market shortages in the long-term care sector increased drastically during the Covid-19 crisis. Additional care workers were needed in order to guarantee the continuity of care services. As a response, the National Care Class (Nationale Zorgklas) was founded in 2020, offering shortened learning trajectories, to enable people with and without experience in care to be employed. The two short training programmes (4 days) focus on the direct skills necessary to support care workers. By May 2021, more than 4,050 volunteers had enrolled in the training programmes.

In Romania, the opportunity to employ a relatively large workforce of returned migrants (mostly home carers who had worked in Spain and Italy) temporarily and for the duration of their stay back home (or even on the long term) was missed, according to an interviewee. No additional funding was made availabe and when those, often qualified, employees had their first chance of going back abroad, they took it. However, earlier (starting around 2018), the Romanian government increased wages of doctors and nurses tremendously (from about €1,500-2,000 to about €3,000-3,500 for a doctor and from around €500-750 to about €900 for nurses or even beyond €1,000 in ICU units), in order to stop outward migration. This move helped, especially for doctors, whose salaries in Western countries are not much higher or almost the same (Romanian interviewee).

8 Social dialogue in the sector in the face of the crisis

8.1 Impact of COVID-19 on social dialogue in the European Union

A range of articles and reports on the impact of COVID-19 on social dialogue in the European Union have been published (e.g. Allinger/Adam 2021, European Commission 2021b, Krokovay 2021, OECD 2020a), but none of them explicitly targeting the social services sector.

In general, social dialogue at all levels, both with (tripartite) or without (bipartite) government participation, has proven to play an important stabilising role, especially in times of crisis; furthermore, the pandemic "has demonstrated that social partners can play an important role in quickly adapting workplaces to new demands" (cf. European Commission 2021b: 143). This is underlined by the OECD (2021: 81), which states that "promoting social dialogue and collective bargaining can be an avenue to improve job quality in the sector and provide solutions for professional development." During the COVID-19 crisis, many countries resorted again to the participation of the social partners in national crisis management, despite some logistical challenges that were caused by pandemic measures (Allinger/Adam 2021, ETUI and ETUC 2020). In a few countries, the temporary implementation of a state of emergency or a state of alert was taken as an opportunity to sideline social partners' participation at the national level. Such a development took place in a few countries, mostly in central and eastern Europe, as well as southern Europe. Overall, though, the social partners were strongly involved in national employment and social policies, and the quality of their involvement has remained stable or even slightly improved over the past years (European Commission 2021c: 13). Instrumental to this is considered the involvement of civil society organisations, which would be "particularly important at a time when strong consensus is needed to ensure a strong recovery and support to the green and digital transitions" (European Commission 2021c: 13f).

Degryse (2021) has looked into the European level of social dialogue in a variety of sectors, including the social services sector (p. 40ff). He highlights the "unexpected ad hoc alliances made with non-traditional economic and social stakeholders, for example associations for people with disabilities, associations of early childhood care providers, associations for the homeless, NGOs, social economy enterprises, etc." and concludes that "the health crisis triggered by the pandemic has clearly brought a European dimension in the social services sector into stark relief."

The four joint texts by the sectoral social partners triggered by the COVID-19 pandemic are summarised here:

Date	Title	Priority 1	Priority 2	Priority 3
25/03/2020	*Joint EPSU/Social Employers Statement on Covid-19 outbreak: the impact on social services and needed support measures*	Protect the jobs, wages and health of workers in the sector in order to ensure the continuity of care and support services; ensure that they are able to cross national borders.	Establish health and safety protocols for nursing and other residential care services, and access to EU and national funds to meet the cost.	Secure the right to paid sick leave and flexible working. Support for childcare for workers' children.
01/04/2020	*EFFAT – EFFE – EFSI – UNI-Europa Joint Statement on the Covid-19 Pandemic in Personal and Household Services (PHS)*	Ensure access to protective equipment and screening tests, and devise protocols to ensure continuity of services.	Ensure that businesses in the sector are eligible for public aid and measures to mitigate the economic impact.	Ensure that workers, including migrants, are eligible for temporary economic unemployment, replacement income top ups; ensure access to social rights.
25/06/2020	*Covid-19 and Social Services: what role for the EU?*	Recognition. Strengthen the essential nature of social services as part of the Recovery Plan for Europe.	Urgency. Establish a European Emergency Fund for Social Services to ensure the provision of these services and access to them.	Resilience. Allocate a minimum of 5% of the Recovery and Resilience Facility to social services, and 25% of REACT-EU to social inclusion measures.
14/12/2020	*'EFFAT – EFFE – EFSI – UNI-Europa Joint Statement on Personal and Household Services – Workers Require Priority Access to Covid-19 vaccine'*	Give priority access to Covid-19 vaccines to PHS workers, recognise them as essential workers.	-	-

8.2 Social partner initiatives at the EU-level

At the European level, the European Social Partners in social services (Federation of European Social Employers and European Federation of Public Service Unions EPSU) held several initiatives.[6] First of all, several joint statement, position papers or letters by the Social Employers and EPSU were published:

At the onset of the crisis (25 March 2020), the social partners issued a joint statement on COVID-19 outbreak: the impact on social services and needed support measures. In the letter, concrete support measures are suggested, including ensuring the continuity of services; guaranteeing income support and prevent job loss; equipping workers with adequate protection material; ensuring safety protocols are in place in residential settings; facilitating access to national and EU funds; securing the right to paid sick leave; ensuring childcare for critical staff members; and making exceptions for cross-border workers.

Only three weeks later (17 April 2020), a joint letter to call to action to tackle the lack of protective equipment to the European Commission was issued, to call to action to tackle the lack of protective equipment for social services workers in Europe. The European Commission was specifically asked to provide support to develop awareness in the member states that social care is to be prioritised in relevant measures to protect staff and beneficiaries; to ensure that an adequate share of PPE is reserved for and made available to social care workers; to urge member states to initiate testing in residential settings; to guarantee workers' access to information and training in safety measures in multiple languages; and to promote the existence of safety protocols in residential settings.

6 An overview is presented here: http://socialemployers.eu/files/doc/Social%20Employers%20Initiatives%20on%20COVID-19-EN%20VS3.pdf.

On 14 May 2020, an open letter was issued by the European Social Partners, together with several other European-level organisations in the sector, following a high-level discussion with the European Commission that had taken place on 22 April 2020. In the open letter, the Commission was urged to take steps in order to promote access to social services for all those people having support needs during the COVID-19 pandemic and several suggestions were presented, including the creation of an Emergency Fund for Social Services and that the European Recovery Plan should be committed to supporting the most vulnerable.

More than half a year after the onset of the pandemic, on 19 October 2020, a joint position paper on preparing the social services sector for the COVID-19 resurgence and increasing its resilience was issued. In the paper, the Social Employers and EPSU provide a set of recommendations for the preparedness of the sector to secure protection and safety for service users and workers. The role of the European institutions and member states, as well as the role of social dialogue and collective bargaining is highlighted.

Besides those issued statements, letters and position papers, the European social partners held several webinars within the last two years:

Right at the onset of the health crisis, on 20 March 2020, a webinar was held to discuss initiatives developed by social services employers to respond to the COVID-19 outbreak in the sector. On 3 June 2020, a Commission Helpdesk was held on the support to social services to respond to the COVID-19 Crisis. The helpdesk provided consultation for the employers on how to access the EU's Coronavirus Response Investment Initiative (CRII and CRII Plus).

A week later, on 9 June 2020, a joint webinar by the Social Employers and EPSU was held on the topic of "Safe and healthy workplaces in Social Services during and after the COVID-19 pandemic and the role of Social Partners".

On 25 June 2020, an online summit "Social Services & COVID-19: what role for EU?" was held, bringing together grassroots workers engaged on the front line facing COVID-19, and European Union spokespersons, discussing the role of the European Union in supporting social services during these difficult times.

Furthermore, various other initiatives were held by the social partners, including a social media campaign (*#SocialServicesareEssentialServices* campaign) and (unilaterally) a survey among Social Employers members and partners.

8.3 Social partner initiatives at the national level

At the national level, the role of social dialogue in the social services sector in the crisis has been varied - while in some countries (Romania, Poland, which do not have any social dialogue structure for social services at the moment), it was reported that no such dialogue had taken place, in other countries, initiatives did take place.

The following initiatives were reported by the social partner representatives in the interviews conducted:

- **Austria: Working time reduction negotiated in collective bargaining process**

The private-sector unions entered the annual collective bargaining round in the social economy sector in spring 2020 with only one demand, to reduce working hours from 38 to 35 hours per week and waive a wage increase. The 35-hour working week had been a long-standing private-sector trade union demand and was strongly demanded by the works councils in the sector. Several rounds of negotiations took place, with the unions mobilising members in demonstrations. After the pandemic hit the country, a three-year agreement between the social partners was found in April 2020. The social partners agreed to wage increases for 2020 and 2021, and to a working time reduction to 37 hours (one hour less than before) from 1 January 2022 onwards. This agreement is considered a milestone by the unions and the mindset among the employees was: *"We have broken this dogma that there is no reduction in working hours, we have our foot in the door and we will get the 35-hour working week next time. But this time (spring 2020) people wouldn't understand that there would be*

strikes (for 35 hours) and nobody would go. They were scared, this was March, April 2020, people were insecure, scared, the problems in the nursing homes had increased." (Austrian union representative). Nonetheless, achieving a further reduction to 35 hours is on the unions' agenda, and some employers already seemed prepared for it in spring 2020, according to an Austrian interviewee.

In addition to the efforts of the private sector, the City of Vienna has started a 3-year evaluation of working time for the public sector. The public-sector union will accompany this evaluation and will show the specific needs of the different health and social care sectors. For health professions, more factors than working time should be taken into account in order to improve working conditions and ensure a high-quality care - the promotion of training and further education, as well as making the various professions more attractive are to be considered, according to the public-sector union.

- **Austria: Corona-bonus negotiated in several sectoral collective agreements**

The social partners for the largest collective agreement in the sector ("Social Economy Austria" or "SWÖ" agreement) were the first to implement a hazard bonus: Those employees with direct personal contact with service users in the period from 16 March 2020 to 30 June 2020 were to receive a one-time Corona hazard bonus of €500 for the additional dangers and burdens that arose during this period as a result of the COVID-19 crisis. The full bonus was granted if during the specified period, 220 or more hours (including travel time for employees in mobile care, i.e. in their clients' homes) were worked in direct patient/service user contacts. If less than 220 hours were worked with personal and physical contact, an aliquot portion of the allowance was paid (with the calculation based on €500 for 220 hours). In the case of an imposed quarantine (by notice or ordered by the employer), which has been caused by professional contact with a person to be cared for, the working time planned for the duration of the quarantine in direct contact was counted as actual hours worked for the assessment of reaching the hourly limit for the bonus. The bonus applies especially to employees in the following areas:

- mobile care services at services users' homes; inpatient nursing, care and residential facilities (also for those working in cleaning, laundry, kitchen, property management) incl. nursing homes, residential and care facilities for people with disabilities, children's and youth living groups, day care facilities for children, facilities for homeless people and refugee care and
- rescue and medical services, blood donation services;

The bonus was to be paid by 3 August 2020. Upon completion of this large sectoral collective agreement, the bonus in this specified form was also implemented in other collective agreements in the private social and health care sector.

- **Belgium: More funds agreed in framework social agreement**

In summer 2020, the government decided to allocate a historical amount for a **framework social agreement** for the whole social sector (profit and non-profit) starting in 2021 and with a recurrent €260 million annual budget until 2024. The social agreement is focusing on the health sector, but almost half of the budget is for the social sector. The goal is to address the issues that the crisis actually raised. At the point of time of the interview (July 2021), the framework social agreement with some major orientations or markers was available. It was being completed with specific measures at the sectoral level and discussed in bipartite discussion between trade unions and employer organisations.

The general markers are:

- The social partners agreed to focus on an increase of salaries with a focus on low wage levels
- Improvement of working conditions, net creation of additional jobs
- Increase attractiveness

The framework social agreement was to be completed with the sectoral agreements in all sectors and the goal was to have the agreements signed in September 2021.

- **France: Social partner fund used to support people upon returning to work**

In France, professional training is funded by employers (2.3% of the salary costs). During the pandemic, the social partners agreed to use those pooled funds to help solving problems that arose due to months of confinement:

- to help workers go back to work and to overcome psychological problems (like anxiety)
- to help managers to rebuild teams, as workers had not been in contact for a while
- to take stock of the developments needed to adjust to the situation with the help of a coach

The programme was organised at the national level, implemented at the local level, and was very open. It took place at the end of the first lock-down, around June 2020 and it was agreed by the social partners to keep it until the end of 2021. Often, different modules were offered (e.g. two two-day modules, on how to rebuild teams and talking about how employees feel). People who went back to work could attend those two days of education. It was available all over France, delivered by different organisations.

- **France: Health insurance fund**

In France, employers and employees together finance and manage a health insurance cash fund. During the pandemic, they decided to dedicate money on three measures, all at the sectoral level, agreed between the social partners:

- An emergency hotline was opened with psychologists to support social services workers. It was completely free for workers, they just had to tell the name of the employer to check if they were in the database and then they could get support.
- The compulsory risk assessment guidelines were adapted quickly to new situations with health issues and health prevention.
- A solidarity fund was opened up for workers who could not work due to changes in/of the organisation. Thus, they could get some compensation.

- **France: Pay rise for care workers**

A pay rise for public healthcare and nursing homes workers was decided within the domain of the Ministry of Health. With the social services social partners' intervention, it was finally negotiated that some other employees, mainly linked to health care in certain social services could benefit from measures, but the process is complicated and at the moment still does not concern all social work activities and workers. This creates large inequities and many resignations, which worsen preexisiting staff shortages.

- **Czech Republic: bonus payments and wage increases**

During the pandemic, more meetings among the social partners were held, in order to negotiate and discuss about conditions of extra bonus payments. While the unions were in favour of providing all employees with the same amount, the employers were in favour of providing liberty in deciding which amount to be paid to which (groups of) employees, arguing that not everybody worked the same amount and had the same exposure to COVID.

About five years before the onset of the pandemic, the social partners managed to raise the salaries considerably. From 2017 onwards, the salaries in the care sector have thus far risen by 66 percent, which is the biggest jump in Europe. Salaries were raised in both the public and private sector (also in healthcare, education, schools) at the same amount (generally, salaries are lower in the private sector by 8 to 10 percent), because if the salaries rise only in the public sector (which has the most employees), the private sector would have to follow, as otherwise, employees would start leaving for the public sector.

- **Germany: Mutual social partner paper on health risk assessments**

At the employers' liability insurance association, employers' representatives and a union have drawn up a position paper together which also includes health risk assessments.

- **Germany: Corona bonus payment in the public sector**

In the large public sector collective agreement, a Corona bonus payment was negotiated in 2020, graded according to pay groups. It amounted to €600 Euro for the lowest remuneration groups 1 to 8, to €400 for remuneration groups 9 bis 12 and to €300 for remuneration groups 13 to 15.

All childcare workers and educators are classified in the first grade level, from level 9 onwards these are mainly management positions. For part-time employees, the Corona bonus was paid on a pro-rata basis. Trainees and interns in the public sector as well as students in training-integrated dual courses of study were to receive €225 Corona bonus in the municipal area. The bonus was tax and duty free, if bonuses had not already been paid out and the total did not exceed €1,500.

8.4 Social partner initiatives at the company level

- **Austria: COVID E-mail address for employees**

A large provider organisation in the sector (Volkshilfe Niederösterreich) set up a COVID e-mail address for employees available 24/7, where personal concerns and wishes could be communicated anonymously and help and support could be sought. This has proved very successful, so that a continuation of this facility for general problems is also being considered after the pandemic is over. It is also important for the management to know what is bothering the employees. At the onset of the crisis, uncertainty and fear were common topics to consult on, while later government policies and vaccinations came into focus. The positive side effect of this communication initiative was that it helped the COVID-19 monitoring in hard-hit areas and could be used for information on potential cases, as well as on quarantine information. The coordination effort involved all levels of the organisation, from management, human resources, to specialised departments and legal counsel. Also the works council was involved. Cooperations were made not only with the local health departments, but also with other service provider organisations and the top-level lobbying organisation. The organisation's learning from this initiative was that swift action in situations like these creates trust, even if the information is changing. It is furthermore crucial to communicate with employees directly and to choose language that is easy to understand. Importantly, the middle management acts as a multiplier. Thus, employees at this level need to be perfectly informed in order to help staff with their personal fears and to keep in contact with them. Lastly, the creation of a hotline (or something comparable) for employees that is staffed 24/7 helps to create trust and enables a provider to react in a timely fashion.

- **Austria: Vienna Health Network (WIGEV) psychological services**

The Vienna Health Network, running hospitals and nursing homes in the capital city, has its own psychological service centre where therapists and clinical psychologists are employed who are exclusively available for all staff members. Employees can receive digital supervision if they need it in a highly acute situation (e.g. a cluster of several COVID deaths, or otherwise difficult situations). Therapists are brought digitally to the team on site, and employees could relieve their stress and burden and get supervision. The programme has been working very well and is highly appreciated by the employees, it is still in use. In addition, the WIGEV uses a network of extramural therapists. This has been used in parallel and independently of the pandemic, especially after employees have encountered violent incidents (verbal, physical). Individual psychological support is generally provided for ten hours to each employee, and can be extended to 20 hours if needed. The offer has been well taken up.

8.5 Unilateral social partner actions and initiatives: good practices

- **Austria: Initiative "Health Offensive" (Offensive Gesundheit)**

Due to the crisis, the four trade unions active in the health and social care sectors (two unions for public sector employees and two for private sector employees) and the two employees' chambers (Chamber of Labour and Austrian Medical Chamber, group of employed physicians) have cooperated intensively, founding an umbrella initiative, the "Offensive Gesundheit" (Health Offensive). The aim of the initiative is a strong lobbying towards the federal government in order to bring about reforms. A care task force has been created, which has presented a programme of the most important points for a (long-term) care reform. While the idea for such an initiative had been developed already before the pandemic, its development was accelerated due to the health crisis and was given a boost. Otherwise, it might not have emerged so quickly; the actors were aware that they had to bundle their ideas and energy in order to successfully approach the government (Health Ministry).

- **Greece: Creation of a new network**

Around summer 2020, a new network, called "The Net", was established by 14 initial members from all over Greece. The Greek Foresee project partner was part of the leaders of this initiatve. The network is open to organisations from the whole country, representing non-profit service providers for people with various disabilities. The first effort for the creation of such an organisation was already 20 years ago, but now - in the face of the health crisis - it finally took place. While it was not accelerated through the pandemic, the health crisis had helped the organisations to be more unified and understand that there are common problems that need to be tackled.

8.6 Social partner and government actions and initiatives: good practices

- **Portugal: Commitment to cooperation in the social and solidarity sector**

In Portugal, four out of the nine organisations represented in the Portuguese Confederation of Social Economy (CPES) signed a "Commitment to cooperation in the social and solidarity sector" on 21 July 2021 for the 2021-2022 biennium[7]. This cooperation between the Ministries of Education, Labour, Solidarity and Social Security and Health and the Union of Portuguese Mercies (União das Misericórdias Portuguesas), the National Confederation of Solidarity Institutions, the Union of Portuguese Mutualities and the Portuguese Cooperative Confederation, CCRL, aims to continue and strengthen the cooperation between the state and social institutions. Six strategic areas of intervention were identified:

1. Social security;
2. Qualification;
3. Health care;
4. Long-term care and social support;
5. Education: expansion and training of the preschool solidarity network;
6. National System for Early Childhood Intervention (SNIPI);

- **Romania: Establishment of emergency centres**

During the pandemic, so-called emergency centres were established as pilot initiatives, in several counties or municipalities of Romania. The centres had a 24-hour phone availability, emergency transportation

7 https://www.seg-social.pt/documents/10152/453857/Protocolo_cooperacao_2021_2022.pdf/94bc9e17-d0e4-4861-aa3f-f2fe8f470172 (accessed on 29 October 2021)

and availability of social workers 24/7 for "acute social cases" like isolated older persons, victims of domestic violence, marginalised or poor households or people with disabilities who had no possibility to travel (transportation was completely closed during the lockdown). Cooperation took place with local emergeny offices, hospitals and municipalities. An emergency network of providers was created that succeeded in responding to the social crisis and the health crisis.

In these emergency centres, adaptations in support of the staff working there had to be made. This concerned especially psychologists and social workers who were normally working in daycare services but were not used as employees as the daycare services had closed. Those workers made a deal with their managers, to remain in their job position and continue to be paid as active employees, if they took over the psychological support and counselling of the (burnt-out, etc.) staff.

The beneficiaries of these emergency centres are older persons, persons with disabilities, and people in rural areas where no transportation was available. Some of these people, even if they had not been vulnerable before the crisis, became vulnerable during the health crisis, for example day labourers with no work permit, or undeclared (black market) workers. From one day to another, they could not earn any money anymore. So, they found themselves in a very critical situation and used the emergency centres a lot. The emergency centres were also ensuring the transportation of food, of goods, to those people in their localities of residence, because other type of transportation was not allowed during the lockdown in Romania. Emergencies, the ambulances and social ambulances were also allowed and were used a lot (social ambulances were used only in the pilot centres mentioned above; the public authorities did not have such services for socially vulnerable people). After the lockdown, some of the mobile services which had been implemented (home care, medical care at distance) remained in place. They are not very much used (especially by older people), but nevertheless provided a good solution for those who did make use of them, sometimes even in domains which were less supposed to be impacted by the pandemic.

- **Romania: Coordination efforts**

Like many other countries, Romania was completely unprepared for a huge, large-impact emergency situation, even though the legislation should - theoretically - have prepared the country. The regions, the municipalities also have emergency strategies. But at the onset of the pandemic, it became evident that they were "useless" (Romanian interviewee) in practice. With few exceptions, in several counties, the local authorities were not coordinated among themselves, people did not know what to do. There was no coordination between the health emergency system, social services, the transportation system, the military, the police, and further actors. From the angle of social intervention, these authorities were forced to come together and plan a tactic locally to deliver services to the most isolated people. And then these local authorities, service providers, donors, citizens, volunteers, all together gathered under the coordination of a prefectura, which is the deconcentrated power of the goverment at the level of regions, counties. The prefects (public servants designated by the government in the counties) became coordination points for all these services at the level of the county and were dispatching the roles between the police, the health emergency services, the hospitals, the social service providers, and NGOs (which played a major role in the pandemic). In the county where FONSS have their headquarters, they were given the role of social coordination of the entire county by the prefect, despite being an NGO. For the social services sector, they were dealing with the social coordination, also with the public system under their supervision. This can be considered a good practice example as it was organised quite fast, people reacted fast, and where the prefects were willing to solve situations in a very efficient way, it worked very well. Not all counties benefitted from the same effectiveness, but the lesson was learned that under these circumstances, coordination and fast reaction is crucial. This led further to the need of creating a structured, more calm action plan for the next situation of a similar kind. In many regions, the local authorities sat together and already created such plans. The actors now have more knowledge on how to better mobilise the health military services, the police, and NGOs, if such a crisis occurs again. According to a Romanian interviewee, this coordination effect can be considered *"the best thing that happened afterwards in Romania"*.

9 Key learnings

9.1 Better preparedness for crises

According to several interview partners, and the EPSU/Social Employers joint paper "Preparing the social services sector for the COVID-19 resurgence and increasing its resilience" (2020b), the COVID-19 pandemic has shown that a better preparedness for such crises is needed, including the development of a proper crisis management (like a department for anticipation). Some interview partners have concluded that organisations are already somewhat better prepared, after the experience of the past 1.5 years. The adaptability and flexibility that developed in the service delivery can be considered an asset, for example the quick transfer to digital work, also for beneficiaries (and their relatives).

The crisis has shown that the resilience of the health and social care systems is not sufficient (cf. also EPSU 2021: 12ff). According to a German interviewee, it is to be ensured that solidarity is exercised, e.g. regarding a common procurement and distribution of protective equipment across Europe. Health and social services need to be considered as system-relevant, and need to be designed in a way that they also function. According to some interviewees, it should be examined whether the privatisation of health and social services is always the best way or whether more state responsibility should be aimed for (again). An Austrian interviewee commented similarly, that a system is needed that is less burdened and has capacity reserves. Due to "neoliberal pressure", reserves have diminished - and when a crisis breaks out, this is painfully noticed.

The integration of health and social care, as was emphasised in an interview with a Czech representative, should be strived for. The focus should lie on the recipients of care services; during the pandemic, healthcare was often prioritised at the cost of social care services.

A Belgian interviewee has remarked that it was interesting to notice a shift in terms of the focus; the added value of the social services sector, in addition to the healthcare sector, could be seen. This would be important to build on. The definition of social care work as essential work and social services employees as essential workers was not obvious before the crisis, so through the pandemic, the image of the sector has improved globally. A similar observation was reported by French and Portuguese interview partners; while at the beginning, there was the feeling of the social services having been left aside (compared to the healthcare sector), with further development of the crisis, the assets of social care were noticed, and the sector was "taken more seriously", also by public authorities, and jobs have received a somewhat higher recognition. Improved relations with public authorities are taken as a positive outcome of the health and social crisis.

The need for a fair access to care for all, available in all EU countries, is emphasised by an interviewee. This would include that (qualified) staff is not taken away from each other.

9.2 Need for more resources

In many interviews, the need for more resources was emphasised, including a cushion to absorb peaks (as the pandemic has been). According to a Belgian interviewee, the key message is to *"ensure the continuity of care and support services, as well as the stability and continuity of the actors. It is important to have an investment in the social sector. We say that because*

in times of the plans to relaunch the economy (additional EU investment), we can say that the social sector is not a priority in this." Support to the sector would also benefit the quality of the services for the beneficiaries and the population.

Furthermore, the topic of evidence-based staffing ratios was brought up in the interviews. This would have been neglected often, due to the focus on a business management view. The education and training of sufficient personnel is also to be ensured, according to a Polish interviewee; *"otherwise, in a few years, we will have no social workers and no people who want to work in the sector"*.

9.3 Focus on digitalisation

There is broad consensus that the acceleration of digitalisation of health and social services, which was brought about by the crisis, is an asset and should be further developed. The need for digital skills is emphasised, as they have proven to be highly useful in adminstrative work and service delivery, as well as in maintaining a social link between people. Nonetheless, the digital divide should be addressed; large education and training gaps with regards to digital tools have been noticed and the focus should lie on the improvement of digital skills (this was mostly brought forward by employer representatives) and on raising awareness. Fears of the unions (digitalisation could mean the reduction of staff) should be taken seriously but are not considered a threat for the near (10-15 years) future.

Thus, the focus should be on (online) training, on ongoing education for personnel in digital skills, according to the interviewed experts.

Remote work or telework has been assessed positively throughout the conducted interviews, maintaining contacts to co-workers, beneficiaries, service providers and authorities without meeting people in person, but providing support via online tools. Organisations have developed and structured their internal system and have seen the advantages of files managed electronically. It is stated that the social services sector is underdeveloped in this area (compared to the hospital sector). At the same time, when additional funds are asked for, this is mostly rejected. *"Local authorities often do not understand that two or three years later it would be a return on investment. The social services do not have the capacity to invest to do such things, so we need some support from the funders."* (French interviewee). Awareness is to be raised, as the following example from France shows:

"In a nursing home, assistant nurses reported it was too difficult to fill in a database, so an assessment was made, and it was evident that all had smart phones. So, the consultant decided with them to adapt the system on the laptop and then, a few weeks after, it was quite simple using the app on the smart phones. So, there is an assessment to do, and you have to be very concrete and pragmatic. Such situations help to think about it and it has to be transformed, developed, and improved."

In some countries, like Romania, no big impact of digitalisation was evident: *"We would have liked to have it, but we do not. We cannot say it in the same tone as other countries. We do not have devices and assistive devices that allow us to claim that the pandemic brought us the opportunity to use it fully or to improve the use of these devices. We want to digitalise some services in the health and social care sector, but the authorities do not have an interest and I think in the national recovery plan this was not taken into consideration. In both sectors, health and social care, we are still working with paper for each patient or beneficiary. We have nothing digitalised."* (Romanian employer representative).

The crisis has opened a reflection on the organisation of work, the need for a transformation of work is seen to be at the centre for services delivered not only at home, but in all settings. The pandemic has changed the mindset, social care work can be delivered less in institutions and more outside, at home, in public, around day-care activities. Capacities would need to be adapted to new needs and situations. Such developments have been called the "re-discovery of the creativity" by a Portuguese interview partner, *"even when working in the most traditional organisations with the most traditional model of care. [...] People were used to think there was only one way,* ***that*** *way,*

with no margins for anything else, and it became very clear that there are lots of things that we could do." In some of the interviewees' experiences, older workers have often been reluctant, but thanks to the pandemic, they have realised, that it brings about advantages.

9.4 Dare to take risks

Last, but not least, some critical remarks on the closure of residential care facilities were voiced, especially where they were closed for visitor for long periods of time: *"We learned what impact social isolation had on the clients. In the Czech Republic, the government decided to close the nursing homes for months to protect the clients. You are protecting them physically, but the mental care, and this was neglected. Sometimes you take the risk to meet your relative; all our lives, we are dealing with risks, but once you become old and you come to these care homes, they are doing a maximum to avoid all the risks, making the residents live an isolated life. It opened the discussion that we should be open to risk, that we should accept the risk, we should work with risk and we should not concentrate only on the physical health, but also on the mental health, social health, the whole part. We did some mistakes, the healthcare ministry did."* (Czech interviewee). Later on, employees did help to enable contacts of residents of social care facilities with their families using social networks, telephone, and protective transparent walls. This view on the need to pay attention to mental health and protect human rights was supported by the Polish interviewee, who stated that a lesson learned for the future should be that *"as long as we can/could, we should not close the centres and also allow people to go out. It was absolutely like in prison, neglecting human rights of the persons, their dignity."*

10 Recommendations

Based on the literature review and on the findings from the interviews with social services social partner representatives and experts, the following recommendations are provided:

First of all, the improvement of the **image** and **visibility** of the social services sector is of very high importance. It is recommended to take up the momentum and build on the publicly perceived added value of the social services sector with its definition of essential work and also to reinforce the attractiveness of the sector for the staff. In the face of the pandemic, in many countries, authorities have shown improved recognition of the role of social support services, and this should be built on.

Secondly, **investments** in the sector are crucial. This refers to more resources and increased funding to the service providers, which in turn can lead to higher pay of the employees, as well as improved staff/user ratios that allow the improvement of working conditions and of service users wellbeing. It also refers to investment in education and training that improves the quality of the services delivered.

All these improvements are necessary in order to tackle the staff shortages and the risk of not being able to answer the growing care needs in the next years.

Thirdly, the further development and acceleration of **digitalisation** of the social services (which includes education and training for personnel in digital skills) is needed. The pandemic has shown that while technologies of course cannot compensate for face-to-face interventions, it can be considered a highly valuable complementary part in order to grasp the social situation of people and to keep in contact.

Last, but not least, the stabilising and supporting role of social partners cannot be underestimated in crisis management, as shown by the diverse initiatives at the European and national level. Thus, it is recommended to further develop **social dialogue** and **social partner actions** at all levels to better face the challenges.

11 Executive summary

Employment evolution in the social services sector between 2019 and 2020[8]

In 2019, the total workforce (i.e. including self-employed) of the social services sector (NACE 87 and 88) stood at 9.1 million employees aged 15 years and older in the EU-27 countries. Data for 2020 show that the number of employees has declined to 8.96 million (around 11.1 million in the EU-28 including the UK); this translates into a reduction in employment of 1.6 percent. This decline in employment numbers was unequally distributed across Europe. While in 15 of the EU-27 countries a decline in employment is evident, there were some countries (with a light tendency towards those with lower absolute numbers and a lower sectoral workforce share) where this trend was counteracted: In Cyprus, Greece, Slovenia, Latvia, Hungary, the Czech Republic, Ireland, Lithuania, Spain, the Netherlands, Bulgaria and Belgium, a surplus of employment between 2019 and 2020 (and thus during the COVID-19 pandemic) can be detected.

When analysing the employment development between 2019 and 2020 separately for residential care activities (NACE 87) and social work activities without accommodation (NACE 88), it is shown that the total social services employment reduction is owed to a decline of 9.5% in residential care activities (from 4.45 million employees in 2019 to 4.03 million employees in 2020), whereas in social work activities without accommodation (NACE 88), an increase in employment from 4.66 million workers to 4.93 million workers (and thus an increase in employment of 6%) is shown.

Generally, residential care services have often been declined to be used during the pandemic, due to fears of becoming infected, concerning the most vulnerable groups. So, relatives often decided to take care of their parents, children, family members themselves. This explains the negative employment dynamic in NACE 87 overall (albeit there are quite large national differences, for which also the expert interviews mostly could not provide sound explanations). Often, as a compensation, day-care services were used instead; thus, the (overall) increase in employment in NACE 88 can be explained.

The gender proportion among employees in the sector has remained stable with a female share of 82% of the sectoral employees in 2019 and 81.8% in 2020 (compared to the female share of 46% in the overall economy). However, when looking at the employment dynamic between 2019 and 2020, it becomes evident that the reduction of employment among males is much smaller (minus 0.2%) than among females (minus 1.9%). One possible explanation for this may be that amid lockdowns and school closures, women would rather withdraw from the labour market than men due to childcare duties.

Challenges for the social services sector

The main consensus among all interview partners is that the challenges that have pre-existed before the onset of COVID-19 have further intensified during the pandemic (insufficient funding, additional costs due to the pandemic, lack of qualified personnel, workers leaving the sector). In addition, new challenges ap-

8 Source: Eurostat, Labour Force Survey

peared (shortage of personal protective equipment, unclear regulations and insufficient information, challenges regarding digital modes of work and staff management).

Impact of COVID-19 on working conditions

Prior to the pandemic, the working conditions in the social services sector were already generally reported as difficult, with comparatively low wages, physically and mentally demanding work, weekend and night work, and high stress levels, not least caused by a shortage of staff. The major issues regarding the impact of the pandemic on working conditions for frontline workers can be summarised as follows (Pelling 2021: 11ff): high-risk health environment, lack of PPE at the onset of the pandemic; lack of resources and attention; high mental pressure and responsibilities; no safety net in case of illness, limited access to sick pay; and increased workload, working long hours. In the interviews with employer and employee representatives participating in the FORESEE project, the following impacts on working conditions were reported:

- The risk of catching COVID-19 is increased for workers in the social care sector, they have higher infection rates than the general population. Employees were on the front line in the fight against the pandemic, especially in the old people's homes, where the largest risk groups were.
- The danger of becoming burnt out was mentioned in virtually all interviews, with many reports of over-long working hours, exhaustion and an exacerbation of the staff shortages due to infections and sick leaves.
- The fear of employees of getting a COVID-19 infection and taking it home to their families as well as the fear to contaminate service users and colleagues were reported largely in the interviews, with the mental stress further increasing due to seeing beneficiaries die.
- The management of employees' time schedules was complex due to the adaptation to new rules or the absence of co-workers.
- Staffing ratios have worsened, e.g. caused by infection clusters or quarantine mandates among employees. During night shifts, the personnel situation was worst.
- New ways of service provision (including remote service delivery) challenged management and staff.
- Impacts on pay have been ambivalent; in some countries, bonus payments were paid, in others, no extra compensation was received and income losses occurred in case of closed services.

Recruitment and retention

Aggravated difficulties with regards to recruitment and retention of personnel have been encountered by all interviewed experts, especially in elderly care. Shortages have been accentuated by the crisis. In some countries, however, initiatives to simplify recruitment during the pandemic were implemented.

Social partner initiatives

The role of social dialogue in the crisis has been varied. Whereas in some countries (Romania, Poland), it was reported that no such dialogue had been taken place, in other countries, initiatives did take place. The range of topics covered include the negotiation of a working time reduction (Austria), of bonus payments (several countries including Austria, the Czech Republic, France), of a framework social agreement directed towards improving working conditions (Belgium), a social partner fund to support employees returning to work and a solidarity fund for employees (both France), initiatives on health risk assessments (Germany, France) and the implementation of hotlines supporting staff (Austria, France).

In addition, unilateral social partner activities were brought about (establishment of a network in Greece and of a lobbying offensive in Austria). The establishment of emergency centres in Romania was initiated by the government, but in the actual implementation at the regional level, the Romanian FORESEE project partner was involved, as well as in large coordination efforts.

Key learnings

According to several interview partners, the COVID-19 pandemic has shown that a better preparedness for such crises would be needed (including the development of a proper crisis management), acknowledging that organisations have learned during the past 1.5 years and would already be better prepared now. The image of the sector has improved globally and the publicly perceived added value of the social services sector and the definition of social care work as essential work would be important to build on. There is also broad consensus that the acceleration of digitalisation of health and social services, which was brought about by the crisis, is considered an asset and should be further developed, with a focus on ongoing education and training for personnel in digital skills.

Recommendations

First, improving the **image** and **visibility** of the social services sector is of very high importance. Secondly, **investments** in the sector are crucial. Both are necessary to address the workforce challenges the sector is facing. Thirdly, the further development and acceleration of **digitalisation** of the social services (which includes education and training for personnel in digital skills) is needed. Last, but not least, it is recommended to further develop **social dialogue** and **social partner actions** at all levels to better face the challenges.

Literature

Allinger, Bernadette/Adam, Georg (2021), Mixed impacts of COVID-19 on social dialogue and collective bargaining in 2020, Eurofound, Dublin. Retrieved from https://www.eurofound.europa.eu/publications/article/2021/mixed-impacts-of-COVID-19-on-social-dialogue-and-collective-bargaining-in-2020

Brugger, Michael et al. (2021), COVID-19 and the perceived stressors of Austrian long-term care workers, Vienna Business University, Vienna. Retrieved from https://www.gpa.at/kollektivvertrag/gesundheit-und-soziales/sozialwirtschaft-oesterreich/archiv/2020/COVID-19-und-die-von-oesterreichischen-langzeitpflegekraeften-wa

Comas-Herrera, Adelina et al. (2021), Mortality associated with COVID-19 in Care Homes: International Evidence, International Long-Term Care Policy Network, CPEC-LSE. Last updated 1st February 2021. Retrieved from https://ltcCOVID.org/wp-content/uploads/2021/02/LTC_COVID_19_international_report_January-1-February-1-2.pdf

Degryse, Christophe (2021), 'Holy union? The sectoral social partners and the COVID-19 crisis in Europe, ETUI, Brussels. Retrieved from https://www.etui.org/sites/default/files/2021-05/Holy%20union%20The%20sectoral%20social%20partners%20and%20the%20COVID-19%20crisis%20in%20Europe_2021_WEB.pdf

EASPD (2020a), 2nd EASPD Snapshot Report: The impact of COVID-19 on disability services in Europe, Brussels. Retrieved from https://www.easpd.eu/sites/default/files/sites/default/files/COVID19/second_report_impact_of_COVID-19_on_disability_services_in_europe.pdf

EASPD (2020b), The short-term impact of COVID-19 on the field of PHS and support measures in 21 EU member states, Ad-PHS project, Brussels. Retrieved from https://ad-phs.eu/ht8ag2/uploads/2021/05/ad-phs-COVID_report_december-2020_final_editing.pdf

EPSU (2021), Resilience of the long-term care sector. Early key lessons learned from the COVID-19 pandemic, Brussels. Retrieved from https://www.epsu.org/sites/default/files/article/files/Resilience_of%20the%20LTC%20sector_V3.pdf

ETUI and ETUC (2020), Benchmarking Working Europe 2020, Brussels, ETUI. Retrieved from https://www.etui.org/publications/benchmarking-working-europe-2020

Eurofound and EIGE (2021), Upward convergence in gender equality: How close is the Union of equality?, Luxembourg. Retrieved from https://eige.europa.eu/publications/upward-convergence-gender-equality-how-close-union-equality

European Commission (2020), ET2020 Working group Early Childhood Education and Care. How to recruit, train and motivate well-qualified staff, Brussels. Retrieved from https://op.europa.eu/en/publication-detail/-/publication/47ba3c3a-6789-11eb-aeb5-01aa75ed71a1/language-en/format-PDF/source-190311791

European Commission (2021a), 2021 Long-term care report. Trends, challenges and opportunities in an ageing society. Volume 1, Brussels. Retrieved from https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8396

European Commission (2021b), Employment and Social Developments in Europe. Towards a strong social Europe in the aftermath of the COVID-19 crisis: Reducing disparities and addressing distributional impacts. Annual Review, Brussels. Retrieved from https://ec.europa.eu/social/main.jsp?langId=en&catId=89&furtherNews=yes&newsId=10039

European Commission (2021c), Proposal for a joint employment report from the Commission and the Council, Brussels. Retrieved from https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8431&furtherPubs=yes

Federation of European Social Employers (2019), The Social Services Workforce in Europe: Current State of Play and Challenges, Brussels. Retrieved from http://socialemployers.eu/en/news/new-report-on-the-social-services-workforce-in-europe-current-state-of-play-and-challenges/

Federation of European Social Employers (2020), Consultation on the Implementation of the European Pillar of Social Rights: The Social Employers' proposals to strengthen social Europe, Brussels. Retrieved from http://socialemployers.eu/files/doc/SE%20Position%20on%20EPRS%20Consultation.pdf

Federation of European Social Employers/EPSU (2020a), Joint Position Paper: Recruitment and Retention in European Social Services. State of play, ways forward and the role of European social dialogue, June 2020, Brussels. Retrieved from https://www.epsu.org/sites/default/files/article/files/Joint%20EPSU_FESE%20Position%20Paper_Recruitment%20and%20Retention%20in%20Social%20Services.pdf

Federation of European Social Employers/EPSU (2020b), Joint Position Paper: Preparing the social services sector for the COVID-19 resurgence and increasing its resilience, October 2020, Brussels. Retrieved from http://socialemployers.eu/en/news/joint-position-paper-preparing-the-social-services-sector-for-the-COVID-19-resurgence-and-increasing-its-resilience/

Federation of European Social Employers/EPSU (2020c), Joint Statement on COVID-19 outbreak, March 2020, Brussels. Retrieved from http://socialemployers.eu/en/news/joint-epsu-social-employers-statement-on-COVID-19-outbreak-the-impact-on-social-services-and-needed-support-measures-/

Federation of European Social Employers/EPSU (2020d), COVID-19: The Social Employers and EPSU Joint Letter to the European Commission, Brussels. Retrieved from http://socialemployers.eu/en/news/COVID-19-the-social-employers-and-epsu-joint-letter-to-the-european-commission/

Home Care Insight (2021), Domiciliary care jobs overtake care home roles for second year running. Retrieved from https://www.homecareinsight.co.uk/domiciliary-care-jobs-overtake-care-home-roles-for-second-year-running/

Hussein, Shereen (2020), The impact of COVID-19 on social care workers' workload, wellbeing and ability to provide care safely: Findings from the UK. Retrieved from **https://ltcCOVID.org/2020/11/09/the-impact-of-COVID-19-on-social-care-workers-workload-wellbeing-and-ability-to-provide-care-safely-findings-from-the-uk/**

Krokovay, Nora (2021), Policy responses from governments and social partners in the COVID-19 pandemic, Eurofound, Dublin. Retrieved from https://www.eurofound.europa.eu/publications/article/2021/policy-responses-from-governments-and-social-partners-to-the-COVID-19-pandemic

OECD (2020a), Social Partnership in the Times of the COVID-19 Pandemic. Retrieved from https://www.theglobaldeal.com/resources/Social-Partnership-in-the-times-of-the-COVID19-pandemic-Global-Deal.pdf

OECD (2020b), Workforce and safety in long-term care during the COVID-19 pandemic, Paris. Retrieved from https://www.oecd.org/coronavirus/policy-responses/workforce-and-safety-in-long-term-care-during-the-COVID-19-pandemic-43fc5d50/

OECD (2021), COVID-19 in long-term care: impact, policy responses and challenges. OECD Health Working Paper No. 131, Paris. Retrieved from https://www.oecd-ilibrary.org/social-issues-migration-health/covid-19-in-long-term-care_b966f837-en

Pelling, Lisa (2021), On the Corona Frontline. The Experiences of Care Workers in Nine European Countries – Summary Report. Friedrich-Ebert Stiftung, Berlin. Retrieved from https://www.fes.de/en/politik-fuer-europa/on-the-corona-frontline

UNI Global Union (2021), The impact of COVID-19 on Long-Term Care Workers in the US, UK, Canada, Ireland, and Australia, Nyon. Retrieved from https://www.uniglobalunion.org/sites/default/files/imce/the_impact_of_COVID-19_fin.pdf

ANNEX 1: Interview guideline

INTRO / BACKGROUND QUESTIONS:

(The intro questions have the main purpose of getting into a conversation with the interview partners ("getting them to talk"), and to get some background information on the countries and organisations interviewed (employer organisations and trade unions).)

A) Could you provide a short background information on the specificities and characteristics of the social services sector9 in terms of business and employment structure in your country?

(e.g. Are there differences between different parts (segments) of the sector? What is the role of public authorities at central state and regional/local level: funding entity and/or employer; role of private sector establishments: not-for-profit vs for profit; proportion of public sector employees, female employees etc.; standard employment relationships vs various forms of atypical employment etc.)

B) Which groups of employers/employees does your organisation represent in the social services sector? What is the share of employers/employees your organisation represents in the sector (no details, just an estimate)?

C) How is the social dialogue organised in the sector? Is there any form of collective bargaining / collective employment regulation (unilaterally determined by the state)? Which parts of the sector are covered? Are there social partner fora or bodies dealing with sector-specific matters (if yes, are national authorities also included)?

For those countries where there is no formal social dialogue, is there informal social dialogue/informal social partnership? If so, please explain:

MAIN QUESTIONS:

1) When looking retrospectively: Which were the main challenges and issues (for the main actors) in the social services sector prior to the outbreak of the COVID-19 pandemic? Have these challenges and issues been intensified/augmented since the outbreak of the pandemic, or have they faded into the background?

2) Can you please give a brief overview of how the COVID-19 pandemic has affected the social services sector in your country?

What were the main challenges? How were they overcome?

9 Social services sector = NACE 87 "Residential care activities" and NACE 88 "Social work activities without accommodation".

3) Which parts of the sector were especially impacted? Why?

Please comment on the following parts of the sector, and in how far they were concerned by the pandemic:

- services for the elderly in residential (nursing) care (incl. nursing homes, assisted living facilities, ...):
- services for the elderly in non-residential settings (incl. day-care activities, 24-hour nursing care, mobile care in elder citizens' homes, ...):
- services for persons with disabilities and other disadvantaged persons (e.g. persons with mental health issues, substance abuse, homelessness, ...) in residential settings (incl. homeless shelters, orphanages, ...):
- services for persons with disabilities and other disadvantaged persons in non-residential settings (day-care activities, visiting, counselling activities for refugees, credit and debt counselling services, vocational rehabilitation activities for unemployed (limited education component), ...):
- services for children: day-care activities for children and disabled children, day nurseries (excluding kindergarten):

4) What impacts did the COVID-19 pandemic have on employment and employment levels in the social services sector?

According to Eurostat statistics, the employment development in your country shows (..... *to be filled in*)

Can you provide an explanation for this?

Which parts of the sector were (mostly) affected?

5) What impacts did the COVID-19 pandemic have on working conditions?

- Implications for occupational health and safety?
- Implications on psycho-social risks and stress/ burnout?
- Impacts on time schedules, time off (e.g. annual leave ban in times of high infection rates)?
- Impact on staffing levels, on user/staff ratios? (e.g. due to absence/illness/quarantine of staff)
- Any other impacts?

6) What impacts did the COVID-19 pandemic have on service delivery in the short term and in the long term?

- What impact did it have on the quality of services and service provision in the sector, as well as on beneficiaries? Short-term effects/ long-term effects/ which effects will remain
- What impact did it have on new ways of service delivery (e.g. remote delivery)? Short-term effects/ long-term effects/ which effects will remain
- Were there any impacts on community-based care? Short-term effects/ long-term effects/ which effects will remain
- Please give your assessment: Was the sector able to recover quickly from difficulties (resilience)?

7) How did the COVID-19 pandemic impact recruitment and retention of personnel (compared to pre-COVID times)?

- What recruitment difficulties did occur due to the pandemic (e.g. concerning cross-border workers)? What parts of the sector were concerned?
- What retention difficulties did occur due to the pandemic? Was there a higher turnover/fluctuation of staff? Which parts of the sector were affected? Which jobs were affected?
- Which effect did the pandemic have on the sector's image/attractiveness (for existing and newly recruited workers)?
- What effects will the experience of COVID-19 have on recruitment and retention of personnel in the future? Do you have an idea/suggestion on what could be done to improve the situation?

8) Have the social partners in your country addressed these challenges (regarding adaptations in working conditions, wages, recruitment and retention policies)?

If so, how were the challenges addressed?

(Teaser: Via social dialogue (between employers/employer organisations and employees/trade unions, with or without the government)? Via other means, like informal dialogue e.g. also at the company level?)

What was the outcome?

Are there lessons learned for the future? Which ones?

9) Are there any (good-practice) examples of social dialogue/actions and measures taken at the *company level* in your country in order to overcome the difficulties posed by the pandemic?

Please provide more information/illustrate:

10) What are key learnings from the effects of the COVID-19 pandemic (which may be carried on in the long term), including impacts regarding digitalisation?

- Which practices, e.g. adaptations in working conditions, are there to stay (e.g. remote work, new tools, now way of working, new information/communication systems)?
- Do you see any innovations in the way services are delivered that will be kept? Which ones?
- Do you see the need for adaptation regarding new skills and training for employees in the sector?
- Do you think there is a better anticipation of potential future health crises in the sector? Is the sector better prepared for future health crises?

11) Are there any other aspects we have not discussed thus far, which are of importance?

Thank you for your time!

ANNEX 2: List of interviewed organisations

The Federation of European Social Employers and the European Federation of Public Service Unions provided the contracted researchers with a list of contact persons of their national member organisations and affiliates. These representatives from all countries participating in the FORESEE project were then contacted with the request for interviews by the beginning of July 2021; reminders were sent in case of non-reply. Interviews were conducted via telephone and (mostly) Zoom meetings between July 2021 and January 2022. The interviews were conducted mostly with one, but in several cases also with two interview partners from an organisation. All interviews were recorded (upon the interview partners' consent) and transcribed. With the exception of the interviews with Austrian and German representatives, which were conducted in German, all other interviews were conducted in English. One interview partner preferred to answer to the interview guideline in written form.

In all countries participating in FORESEE, at least one interview was conducted, in some countries more than one. In the following table, the national organisations with whose representatives interviews were conducted, are listed:

	Employers'/providers' representatives (SOCIAL EMPLOYERS MEMBERS & AFFILIATES)	Workers' representatives (EPSU MEMBERS & AFFILIATES)	Independent expert
Country	**Organisation**	**Organisation**	
Belgium	UNIPSO		
France	NEXEM ELISFA	CFDT	
Czech Republic	APSS CR	OSZSP CR	
Romania	FONSS	SANITAS	
Poland	WRZOS		
Germany		Ver.di	
Austria	SERVICE MENSCH GMBH / NÖ VOLKSHILFE	Vida younion	
Greece	EEA MARGARITA		
Portugal	IPCB		Expert (formerly academic, now employed in public sector)

In some cases, where more than one organisation was listed on either side, the main one was initially contacted and interviewed and further organisations as needed.

In addition to the organisations listed, further member organisations of the Social Employers and EPSU were contacted, but no interviews could be arranged.

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