International Labour Organization

▶ ILO Brief

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COVID-19 and care workers providing home or institution-based care

In the first wave of the coronavirus disease (COVID-19) pandemic, nearly half of infections and a high proportion of fatalities were among elderly care home residents. Their care workers were also disproportionally affected in the early phase of the pandemic and remain at risk as the virus continues to spread among populations. A high number of such care workers are women and migrant workers, who are especially vulnerable to the impact of the pandemic on their health and working conditions.

This brief aims to provide information on the impact of the pandemic on care workers providing home or institution-based care. It also draws attention to a number of early response measures taken by employers' and workers' organizations and governments to mitigate the impact of the pandemic and provides an overview of ILO tools and responses, including international labour standards that can promote decent working conditions for care workers.

The brief draws mainly from examples from developed countries. This is due to a lack of data from developing countries, as well as the fact that institution-based care is less prominent in most African, Latin American and Asian countries.[1]

Scope of this brief

- Care work is delivered at the intersection of health and social systems. The variety of services provided, the heterogeneity of the workforce and the use of different terminologies, such as for example long-term care, home care, elderly care, or health and social care, make a common understanding and description of the sector and its workforce challenging.
- This brief focuses on workers providing basic healthcare, personal care, and assistance with mobility and activities of daily living to patients, aged persons, convalescent individuals and persons with disabilities.*
- Those services are provided in a variety of settings, including clinical facilities, nursing or care homes, communities and private homes. The care workforce includes a wide range of workers, from qualified nurses to workers without any formal care training. A portion of workers, who perform their work in and for private households, referred to as domestic workers, may also provide personal care as part of their duties.
- Care work is provided in both formal and informal employment situations. In addition, much care work is carried out on an unpaid basis.
- For the purposes of this brief, workers falling under the above description will be referred to as "care workers".**

* ILO, International Standard Classification of Occupations: ISCO-08, 2012.
** If other terms are used, they are intended to clarify a specific context.

1 ILO, *Care work and care jobs for the future of decent work*, 28 June 2018.

1. The impact of COVID-19

Care homes have been hit hard by the pandemic with care home residents accounting for up to half of all COVID-19 related fatalities in Europe and the United States of America.[2,3] Care home residents account for some 85 per cent of all COVID-19 related deaths in Canada,[4] 81 per cent of deaths in Slovenia[5], 45 per cent of deaths in Israel[6], and 68 per cent of deaths in Australia[7]. South Africa reported a spike of infections in elderly care centres in the Eastern and Western Cape with 221 confirmed cases among support staff, including nurses.[8] In Germany, one out of five care home residents with COVID-19 has died as a result of contracting the virus, accounting for one third of all coronavirus fatalities in that country. By 22 April 2020, 5,832 nursing home care workers in Germany had been infected and 19 had died.[9] France reported 39,294 COVID-19 cases among staff members of long-term care facilities as of 11 May 2020.[10] An analysis of COVID-19 related deaths by occupation in England and Wales showed that persons working in social care, including care workers, have significantly raised rates of death from COVID-19[11] compared with the rate among people of the same sex and age in the general population.[12]

However, a lack of systematic testing and reporting mean that those numbers most likely under-represent COVID-19 fatalities among residents of nursing homes and care worker infections.[13,14] Furthermore, robust data on infection rates and COVID-19 related deaths among care workers providing home-based care in private households and their patients are unavailable. Systematic reporting mechanisms that distinguish care worker infections by general and occupational exposure are needed to inform the debate on how best to protect those essential workers.

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A staff member of a nursing facility gets tested for COVID-19, United States.

Working conditions

Care workers providing home or institution-based care have been neglected and overlooked for many years and their work has been undervalued.[15] Care work is often considered "low-skilled" and care workers are among the lowest-paid, often earning much less than workers with similar qualifications in the acute healthcare sector. According to a recently released report by the Organisation for Economic Co-operation and Development (OECD), the median hourly wage of care workers in the long-term care sector was 9 euros (€).

2 WHO Regional Office for Europe, "Invest in the overlooked and unsung: build sustainable people-centred long-term care in the wake of COVID-19", 23 April 2020.
3 CMS.gov, "COVID-19 Nursing Home Data" [accessed 08 July 2020].
4 International Long Term Policy Network, "Updated report: The COVID-19 Long-Term Care situation in Canada", 04 June 2020.
5 Comas-Herrera A, et al. *Mortality associated with COVID-19 outbreaks in care homes: early international evidence*. Article in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 26 June 2020.
6 Ibid.
7 Julie Power, "COVID-19 Has Exposed Australia's Aged Care Sector's Flaws, Royal Commission Hears", The Sydney Herald, 10 August 2020.
8 South African Government News Agency "Caring for the elderly", 15 June 2020.
9 Aerzteblatt, "COVID-19: Ein Drittel aller Toten in Alteneinrichtungen", 22 April 2020.
10 ECDC, *Technical Report - Surveillance of COVID-19 at Long-term Care Facilities in the EU/EEA*.
11 This study only adjusted for age. Since other important factors that might have affected death rates were not controlled for, the results cannot necessarily be attributed to occupational exposure.
12 Office for National Statistics, "Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020".
13 Emilio Parodi, "Uncounted among Coronavirus victims, deaths sweep through Italy's nursing homes", Reuters, 18 March 2020.
14 WHO, *Coronavirus Disease 2019 (COVID-19) Situation Report – 82*, April 2020.
15 WHO Regional Office for Europe, "Invest in the overlooked and unsung: build sustainable people-centred long-term care in the wake of COVID-19", 23 April 2020.

For comparison, workers in the same occupation in the hospital sector earn, on average, €14 an hour. Furthermore, care workers are often employed under part-time or temporary work arrangements, or under casual or zero-hour contracts,[16] which often leave them with unpredictable or excessive working hours, job insecurity, limited access to employment and social security benefits, including paid sick leave, and weak or non-existent social protections.[17]

Poor working conditions and severe staff shortages have further exacerbated the devastating impact of COVID-19 on care workers providing home or institution-based care. In Stockholm in March, at the start of the pandemic, 40 per cent of care workers were employed on hourly contracts.[18] In France, a large proportion of care workers are employed by agencies on temporary contracts and, in England, United Kingdom, the share of institution-based workers who depend on zero-hour contracts is high compared with the economy-wide average.[19] Many care workers have been forced to choose between financial or health security and continuing to work while unwell due to lack of social health protection measures, including access to healthcare, paid sick leave or financial compensation in the event that they contract COVID-19. In Sweden, 23 out of 57 workers at an elderly care home in Gothenburg continued to work while sick as they could not afford to stay home. Four of those workers later tested positive for COVID-19.[20]

A lack of full-time employment and low wages means that care workers often have to work in multiple facilities or visit numerous patients in their private homes each day to make ends meet. This puts them at a higher risk of both contracting and transmitting the virus. [21,22]

In some cases, care workers in private homes are expected to be on call 24 hours a day while being paid for fewer hours of work.[23] Many fear the consequences of loss of income with no social insurance or emergency income support.[24] In fact, ILO has estimated that, globally, as many as 74 per cent of domestic workers have been significantly affected by lockdown measures and are at high risk of losing their jobs or income, and that 76 per cent of domestic workers who have been significantly impacted are in informal employment.[25]

Furthermore, in response to the outbreak, many care workers are facing heavy additional workloads, long working hours and a lack of rest periods. Studies have revealed that both patients and care workers who underwent periods of isolation or had to undergo quarantine, experience mental health disorders, including depression, anxiety, mood disorders and psychological distress.[26] Moreover, time constraints, restrictions on the types of care services that can be provided (such as intimate care), higher levels of stress and an increased demand for care services can result in tension and conflict between care workers and care recipients.[27] In addition, many residents and patients are cognitively challenged and find it hard to understand the current crisis or to follow basic hygiene guidelines, including the importance of social distancing, putting staff at risk.

Increased absence of staff, partially due to infections and exhaustion, intensifies workload for remaining colleagues.[28] To address workforce shortages, many of which started long before the current crisis, and to ensure that sufficient numbers of care workers remain available during the outbreak, several countries have sought assistance from the military, rapid response teams or temporary relief workers.[29]

Occupational safety and health

Another critical factor imperilling the health of care workers and patients has been the frequent lack of access to personal protective equipment (PPE) and regular testing. Many workers providing home or institution-based care were not initially identified as frontline workers and were therefore not taken into account in early response mechanisms. Care workers' work requires a high level of physical and emotional contact, making physical distancing almost impossible. This makes them particularly vulnerable to COVID-19 exposure in the workplace.

16 For further information see: https://www.ilo.org/travail/info/fs/WCMS_170714/lang--en/index.htm
17 OECD, *Who Cares? Attracting and Retaining Care Workers for the Elderly, OECD Health Policy Studies*, 2020.
18 Lisa Pelling, "Sweden, the pandemic and precarious working conditions", Social Europe, 10 June 2020.
19 OECD, op. cit.
20 Sanna Arbman Hansing, "23 av 57 anställda på äldreboende gick till jobbet sjuka", Göteborgs Posten, 21 April 2020.
21 Nathan Boucher, "COVID-19 has highlighted the risks home health workers face — here's what can be done to help", The Hill Blog, 8 June 2020.
22 Robert Booth, "Agency staff were spreading Covid-19 between care homes, PHE found in April", The Guardian, 18 May 2020.
23 "Bulgarian care worker takes German nursing industry to court", Deutsche Welle, 15 July 2020.
24 ILO, *Beyond contagion or starvation: Giving domestic workers another way forward*, 2020.
25 ILO, *Impact of the COVID-19 crisis on loss of jobs and hours among domestic workers*, 2020.
26 M. Hossain et al., "Mental health outcomes of quarantine and isolation for infection prevention: A systematic umbrella review of the global evidence", Epidemiol Health, DOI:10.4178 (2020).
27 G.J. Hoffman et al., "A Framework for Aging-Friendly Services and Supports in the Age of COVID-19", Aging Social Policy No. 0, (2020): 1–10.
28 Groenewold MR, et al. *Increases in Health-Related Workplace Absenteeism Among Workers in Essential Critical Infrastructure Occupations During the COVID-19 Pandemic* — United States, March–April 2020. MMWR Morb Mortal Wkly Rep 2020;69:853–858.
29 Adam Carter, "Military report reveals what sector has long known: Ontario's nursing homes are in trouble", CBC, 27 May 2020.

Initial results from a survey conducted in New Zealand show that half of all care workers lacked access to PPE.[30] In Croatia, over 26 per cent of workers in private nursing homes did not feel safe at their workplace, primarily because of their limited access to PPE. Indeed, more than half the survey respondents in Croatia reported that they were unable to access adequate PPE, and more than one third stated that they had purchased PPE themselves.[31] In Brazil, the president of the Association of Retirement Homes of the State of São Paulo (ACRESP) stated that they were out of PPE and were improvising by using hair caps as mouth and nose protection.[32] Similar problems have also been reported from other countries, including the United States,[33] Canada,[34] and countries in Africa.[35] Moreover, care workers have faced disciplinary measures and retaliation when speaking out about working conditions and their lack of PPE.[36]

Transparent and timely information on the transmission of COVID-19 and the availability of PPE are key to protecting workers providing home or institution-based care and preventing them from contracting or spreading the virus. Adequate training on the correct use of PPE and the implementation of specific infection prevention and control measures are also needed, including signs, posters and other awareness raising measures to promote respiratory hygiene, coughing etiquette, visitor protocols and the separation of residents or patients who show COVID-19 symptoms.[37] In cases where care workers provide 24-hour care, often staying with patients in their private homes, special attention needs to be given to care workers' occupational health and safety protection needs.[38]

Furthermore, regular and systematic testing of care workers is critical for infection prevention and control of COVID-19 and to identify asymptomatic carriers of the virus.[39] Conflicting instructions regarding whether tests are required have pushed logistics considerations and costs onto employers and, in some cases, even onto care workers themselves.[40] With a cost of around USD 100 per COVID-19 test kit a nursing home facility with 500 employees, which should be tested twice a week, would need to spend $100,000 a week on testing, placing a huge financial burden on the employer.[41,42] In order to reduce the significant financial burden on employers, Germany has implemented a policy that, in principle, requires health insurance companies to pay for testing, even if an individual shows no symptoms.[43] Meanwhile, Ireland now categorizes individuals providing care as a priority group for testing.[44]

The risk of experiencing work-related violence is high in the health sector, with around 62 per cent of health workers reporting that they have been exposed to a form of violence in the workplace at least once.[45] Recent data show that COVID-19 exacerbates the risk of violence, harassment or the stigmatization of health workers, not only in conflict areas but in all parts of the world.[46] Care workers might also experience violence and discrimination in their communities due to the fear of contracting the virus.

Because of the mental health impact of care work during the pandemic, the provision of support, guidance and information on how to deal with stress and mental health problems must be an integral part of the COVID-19 response for care workers.[47]

Gender and labour migration

The COVID-19 pandemic has posed particular challenges for women, who in some countries comprise 88 per cent of care workers.[48] The majority of women in care work have direct care responsibilities, while managerial jobs tend to be held by men.[49] In addition to paid care work, women often carry the burden of informal and unpaid voluntary care work in their own families and communities.[50]

The low status of care work and the low value for care workers has been associated with gender segregation.

30 E Tu, "Press Release on Home Support Workers: Half Without Adequate PPE", 24 April 2020.
31 Organization for Workers' Initiative and Democratization and UNI Global Union, *Report on the results of the questionnaire on the working conditions during the coronavirus epidemic for private nursing homes and home care workers*, 2020.
32 Breiller Pires, "Sem equipamentos de proteção, casas para idosos temem mortes na pandemia: 'Usamos toucas de cabelo na boca e nariz'", El Pais, 12 April 2020.
33 "Nursing Home Coronavirus Deaths", The Washington Post, 4 June 2020.
34 Ainslie MacLellan, "PPE shortages persist at Quebec long-term care home with more than half of residents infected", CBC, 23 April 2020.
35 M.F. Chersich et al., "COVID-19 in Africa: care and protection for frontline healthcare workers", Global Health No. 16, (2020): 46.
36 Chris Kirkham, "Life Care fired staffer who revealed nursing home nightmare to Reuters", Reuters, 22 June 2020.
37 ILO and WHO, *Occupational safety and health in public health emergencies: A manual for protecting health workers and responders*, 2018.
38 International Long-Term Care Policy Network, "Updates on the Austrian Long-Term Care system COVID-19 challenges", April 2020.
39 European Centre for Disease Prevention and Control, "Surveillance of COVID-19 at long- term care facilities in the EU/EEA", May 2020.
40 Katie Thomas, "Testing Nursing Home Workers Can Help Stop Coronavirus. But Who Should Pay?", The New York Times, 9 June 2020.
41 This example is hypothetical since testing costs depend on different factors and vary from country to country.
42 Emma Court et al, "Employers Find Testing Employees More Trouble Than It's Worth", Bloomberg, 6 July 2020.
43 Germany, Federal Government, *Infektionsketten schneller erkennen Report*, May 2020.
44 WHO Regional Office for Europe, *Strengthening the Health Systems Response to COVID-19 - Technical guidance #6*, 21 May 2020, 2020.
45 J. Liu et al., "Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis", Occupational and Environmental Medicine 76, No. 12 (2019): 927–937.
46 International Committee of the Red Cross, "600 violent incidents recorded against health care providers, patients due to COVID-19", August 2020.
47 For further information see ILO *Sectoral Brief - COVID-19 and the health sector*, 2020.
48 ILO, "These occupations are dominated by women", ILOSTAT Blog (blog), 2019.
49 ILO, *Report: Improving Employment and Working Conditions in Health Services*, 978-92-2-130533-0, 2017.
50 ILO, *A quantum leap for gender equality: for a better future of work for all*, 2019.

Care work tasks have traditionally been seen as "female" tasks that are argued to be devalued by the labour market. In fact, data show that increased participation of women in the workforce is often associated with a decline in wages.[51] Together with the greater physical and emotional burdens stemming from the COVID-19 pandemic, a decline in wages may further discourage care workers to remain in their profession, potentially leading to even higher turnover in the care sector workforce.[52]

Furthermore, the extent to which care workers' jobs are officially recognized varies by and within countries. Care workers are often employed directly by households and are often female migrant workers, including migrant domestic workers. Data show that many European countries depend heavily on migrant workers to perform care work,[53,54] and those workers may face specific challenges linked to their migration status, including discrimination and unequal treatment in employment, wages and occupation.[55] Care workers whose migration status is precarious (including those in an irregular situation), those who are employed under temporary foreign worker schemes that tie workers to one specific employer, and those who are employed directly by older persons and work in private homes, are often exposed to poorer working conditions. The COVID-19 pandemic and the global response to combat the virus have significantly reduced the numbers of migrant care workers travelling internationally to take up employment, leaving destination countries with significant shortages of care workers. During the peak of the pandemic in Europe, the German association for home care and nursing projected that up to 200,000 people would no longer be cared for at home due to insufficient numbers of migrant care workers in the country.[56]

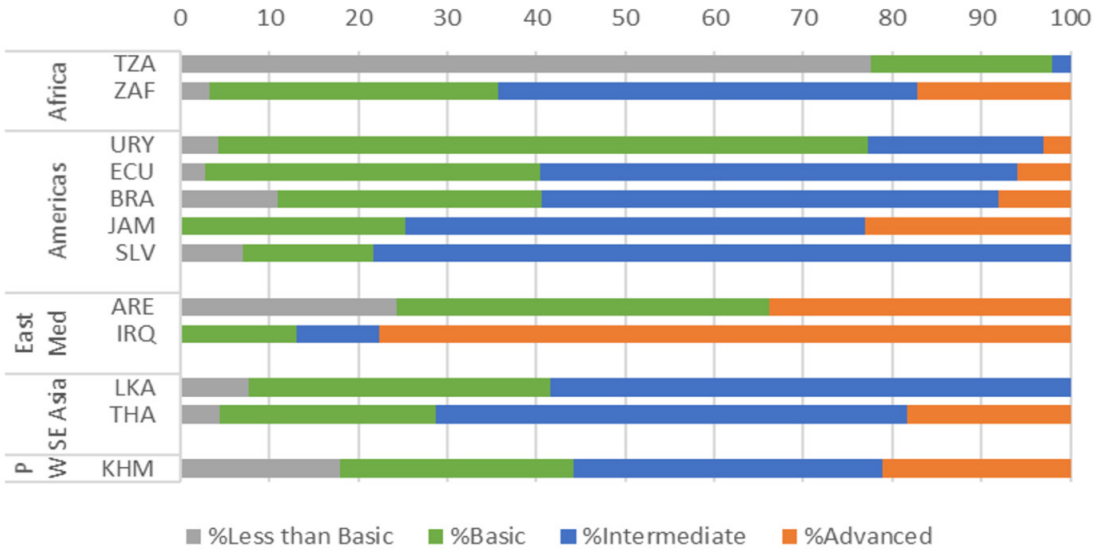
Conversely, many migrant domestic workers providing care went into quarantine with their employers, and were unable to return to their families in their countries of origin. Yet, economic crisis and job or income loss experienced by many household employers has also meant that many migrant domestic workers have not received their wages or lost employment. In some cases, this has led to domestic workers finding themselves on the street, without food, money, or support networks, and leaving them at high risk of being trafficked.[57] This situation underscores that policies to integrate migrant care workers and provide them with robust protections should be an integral part of national strategies to address and recover from the current crisis.

Education, skills and training

Care workers providing home or institution-based care include a wide range of workers with heterogeneous levels of education, skills and training, ranging from highly qualified nurses through care assistants with intermediate training to workers without any formal care training. An analysis of ILO micro data, gathered through labour force surveys, revealed that the majority of personal care workers[58] have received either a basic or intermediate-level education.[59] Figures 1 and 2 illustrate the educational levels attained by personal care workers in selected countries in various global regions.

51 K. Tijdens et al., "Health workforce remuneration: comparing wage levels, ranking, and dispersion of 16 occupational groups in 20 countries", Human Resources Health 11, No. 11 (2013).
52 For further information see ILO *Sectoral Brief - COVID-19 and the health sector*, 2020.
53 Rodrigues, R., Huber, M. & Lamura, G. (Eds.) *Facts and Figures on Healthy Ageing and Long-term Care* Europe and North America, Occasional Reports Series 8. Vienna: European Centre, 2012
54 Francesco Fasani and Jacopo Mazza, "Immigrant Key Workers: Their Contribution to Europe's COVID-19 Response", European Commission briefing note, 23 April 2020.
55 S. Amoy-Agyei, "Analysis of the Migrant Pay Gap", ILO, forthcoming.
56 *Versorgungsnotstand wegen Corona*, 2020.
57 ILO, *Impact of the COVID-19 crisis on loss of jobs and hours among domestic workers*, 2020.
58 In the analysis personal care occupations are defined as only those present in the health sector. They include occupations in group 532 (ISCO 08), and 513 (ISCO 88) "Personal Care Workers in Health Services".
59 For the analysis both ISCED 11 and ISCED 97 versions have been combined to produce the categories "Less than Basic" (no schooling, early childhood education, pre-primary), "Basic" (primary education and lower secondary education), "Intermediate" (upper secondary education, post-secondary non-tertiary) and "Advanced" (short cycle tertiary, first and second stage tertiary, bachelors, masters and doctoral).

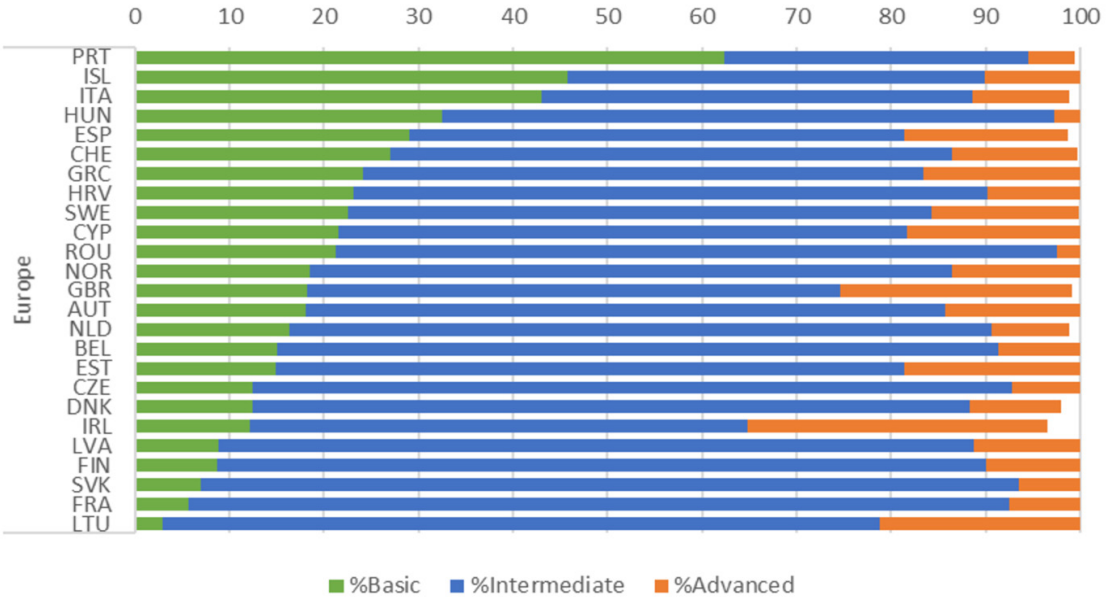
Figure 1. Education levels of personal care workers in the African, Americas, East Mediterranean, South East Asian and Western Pacific regions



(TZA: United Republic of Tanzania; ZAF: South Africa; URY: Uruguay; ECU: Ecuador; BRA: Brazil; JAM: Jamaica; SLV: El Salvador; ARE: United Arab Emirates; IRQ: Iraq; LKA: Sri Lanka; THA: Thailand; KHM: Cambodia).

Source: ILO, 2020, based on Labour Force Survey data (forthcoming)

Figure 2. Education levels of personal care workers in the European region



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(PRT: Portugal; ISL: Iceland; ITA: Italy; HUN: Hungary; ESP: Spain; CHE: Switzerland; GRC: Greece; HRV: Croatia; SWE: Sweden; CYP: Cyprus; ROU: Romania; NOR: Norway; GBR: United Kingdom; AUT: Austria; NLD: Netherlands; BEL: Belgium; EST: Estonia; CZE: Czechia; DNK : Denmark; IRL: Ireland; LVA: Latvia; FIN: Finland; SVK: Slovakia; FRA: France; LTU: Lithuania).

Source: ILO, 2020, based on Labour Force Survey data (forthcoming)

In general, the tasks performed by care workers are complex and can involve complex disease management.[60] Adequate staffing levels, education and training programmes are needed to ensure that residential and home care workers are qualified, well-equipped and adequately supported so that they can perform the tasks and activities that they are likely to encounter in their work.

Evidence shows that patient outcomes are associated with working conditions, staffing levels, staffing stability and the educational level of nurses. A study of nursing homes in the United States, for example, found that nursing homes with higher staffing levels of highly qualified registered nurses have the potential to better control the spread of COVID-19 and reduce mortality rates among residents.[61]

In order to mitigate the impact on overburdened hospitals and protect vulnerable populations, some healthcare providers have restricted access to hospitals for care home residents during the COVID-19 outbreak.[62] In many countries, access to medical care has been disrupted and healthcare providers have been asked to reschedule preventive and routine patient visits where possible.[63] As a consequence, many care workers have had to take on extraordinary responsibilities and have been required to perform additional duties for which they have not been appropriately trained.[64] To try to address that challenge, the international independent medical humanitarian organization Médecins Sans Frontières (MSF) has provided technical support and training to nursing home workers in Belgium, France, Italy, Portugal, Spain and Switzerland.[65]

In the acute phase of the pandemic, many health systems, including those in Italy and the United Kingdom, asked their health workers to take the age of the patient into account when deciding on critical care interventions.[66] Health and care workers involved in and impacted by those decisions, which may have a significant impact on residents, patients and their families, require specialized training in communication skills and mental and psychosocial support.[67]

Structural challenges in the care sector

The repercussions of the COVID-19 pandemic for home and institution-based care have highlight a number of key long-term structural and economic challenges facing the sector.

Home or institution-based care are delivered at the intersection of health and social systems. Coordination between those systems is often poor, however, and, as a result, the care sector is highly fragmented and only partially regulated. The sector, moreover, suffers from a lack of supportive leadership, governance and financing mechanisms.

Services are usually provided by a mix of public, private for-profit and non-profit service providers, some of which operate within and some outside the health system.[68] Public funding allocations are often spread across different levels of governments and ministries. The mix of funding sources can sometimes make it challenging to ensure that care workers enjoy decent working conditions. For example, cost-cutting measures to increase profit margins may incentivize to keep wages low or maintain only minimum staffing levels.[69] While the private sector in many countries is playing an increasing role in the provision of care services, the leading role played by the public sector in upholding the human right of individuals to equal access to healthcare, including care services, has become particularly prominent during the pandemic.

Sufficient staffing is critical to the ability of healthcare providers to deliver high quality care for residents and patients. However, many residential homes were severely understaffed even before the spread of COVID-19, leaving their staff and residents particularly vulnerable to the pandemic.[70] The demand for care workers is likely to grow in future years, with an estimated 13.5 million workers likely to be needed by 2040 in order to continue to provide one care worker for every 100 people aged 65 and over across all OECD countries.[71] This number is likely to increase when accounting for people in need of care and support recovering from severe cases of COVID-19.[72]

60 OECD, *Who Cares? Attracting and Retaining Care Workers for the Elderly, OECD Health Policy Studies*, 2020.
61 Yue Li et al., "COVID-19 infections and deaths among Connecticut nursing home residents: facility correlates." Journal of the American Geriatrics Society, vol. 68(9), September 2020.
62 World Economic Forum "How did these countries protect the elderly from Coronavirus?", 26 May 2020.
63 WHO, "In WHO global pulse survey, 90% of countries report disruptions to essential health services since COVID-19 pandemic", 31 August 2020.
64 NBC News, "The forgotten front line: Nursing home workers say they face retaliation for reporting COVID-19 risks", 19 May 2020.
65 Médecins Sans Frontières, "Out of view, but not out of mind: MSF's response to COVID-19 in care homes", 24 April 2020.
66 Joan Costa-Font, "The COVID Crisis Reveals How Much We Value Old Age", LSE US Centre, 25 April 2020.
67 United Nations, *Policy Brief: COVID-19 and the Need for Action on Mental Health*, 13 May 2020.
68 WHO Regional Office for Europe, *Strengthening the Health Systems Response to COVID-19 - Technical guidance #6*, 21 May 2020, 2020.
69 OECD, *Who Cares? Attracting and Retaining Care Workers for the Elderly, OECD Health Policy Studies*, 2020.
70 Long Term Care Community Coalition, "Nursing homes: Too many facilities severely understaffed before COVID-19", 22 May 2020.
71 OECD, op. cit .
72 Henk Stam, Gerold Stucki and Jerome Bickenbach, "Covid-19 and Post Intensive Care Syndrome: A Call for Action". Journal of Rehabilitation Medicine, vol. 52(4), 2020.

In many regions, the lines between domestic work and home care are blurred, which is often linked to an insufficiency of public care service provision and lack of coverage for long-term care services.[73] The existence of a large informal market for domestic work, providing cheap alternatives to care work for households, drives poor working conditions among domestic workers, posing the risk of undermining working conditions of care workers generally.

High fragmentation, weak or non-existent regulations, high staff turnover and a high proportion of informal employment in the sector also pose challenges to social dialogue in the sector. The heterogeneous care workforce and their often difficult contract situations impede unionization and the organization of workers, especially for migrant workers. Furthermore, care workers who work in or for private households enjoy few if any protections and are often extremely difficult to reach.[74] However, ensuring that care workers, together with their employers and other relevant stakeholders have an opportunity to make their voices heard is critical if they are to play a full and active role in the global response to the COVID-19 pandemic.

▶ 2. Responses by constituents and partners

Government responses

Several governments have recognized the important role of care workers by announcing bonus payments or financial assistance if they fall ill or lose their source of income. Germany has promised workers taking care of elderly people so-called "corona premiums" which are financed through the social nursing care insurance scheme with the help of tax subsidies.[75] Similar approaches have been pursued by the Governments of France and Italy and by the Welsh Government in the United Kingdom.[76,77]

In order to retain migrant care workers, Austria is providing them with a bonus payment of €500 per month,[78] while the Governments of the Czech Republic and Slovenia have both announced a hazard pay provision for workers in the care sector.[79]

Furthermore, some countries have recognized COVID-19 as an occupational disease in order to facilitate the provision of governmental support and provide more robust social protections if workers contract the virus. For example, the Malaysian Social Security Organisation (SOCSO) has categorized COVID-19 as an occupational disease. As a consequence, individuals contracting the virus are eligible for workers' compensation under the 5th Schedule of the Employees' Social Security Act 1969.[80]

Joint statements and agreements

Several international sectoral workers' and employers' organizations have joined forced to address COVID-19 issues efficiently and effectively.

In a joint statement, issued on 5 March 2020, the European Public Service Union (EPSU) and the Federation of European Social Employers called upon European member States and the European Commission to support a set of measures to help the social and long-term care sector through the crisis.[81]

On 1 April 2020, the European Federation of Food, Agriculture and Tourism Trade Unions (EFFAT), the European Federation for Family Employment & Homecare (EFFE), the European Federation for Services to Individuals (EFSI) and the European Trade Union Federation (UNI-Europe), supported by the International Domestic Workers Federation (IDWF), issued a joint statement urging public authorities to issue detailed health and safety instructions, to ensure access to PPE, sick leave and healthcare, to provide exceptions for workers to cross national borders. They also called on public authorities to support and strengthen social dialogue in the personal and household service sector.[82]

73 ILO, *Care work and care jobs for the future of decent work*, 28 June 2018.
74 ILO, ibid.
75 Germany, Federal Government, *Infektionsketten schneller erkennen Report*, May 2020.
76 VOA News, "French Nursing Homes Employees Protest Pay, Conditions", 26 May 2020.
77 Welsh Government, Press Release "Care home staff to receive £500 extra payment", 5 June 2020.
78 WHO Regional Office for Europe, *Strengthening the Health Systems Response to COVID-19 - Technical guidance #6*, 21 May 2020, 2020.
79 UNI Global Union, "Care workers: organising to protect the most vulnerable", 18 May 2020.
80 ILO, "Malaysian Social Security Organisation confirms Covid-19 is an occupational disease eligible for workers' compensation", 18 April 2020.
81 European Public Service Union and the Federation of European Social Employers, "Joint EPSU/Social Employers Statement on COVID-19 outbreak: the impact on social services and needed support measures", 25 march 2020.
82 European Federation of Food, Agriculture and Tourism Trade Unions, European Federation for Family Employment & Homecare, European Federation for Services to Individuals and the European Trade Union Federation, "Joint Statement on the COVID-19 Pandemic in Personal and Household Services (PHS)", 1 April 2020.

In Argentina, an agreement between the Federation of Health Workers' Associations and the Government provides a wage guarantee for all health-care workers that ensures that they will continue to receive their full salaries while in quarantine. In addition, health workers are eligible for free transport during the pandemic.[83]

In Belgium, unions and employers active in the Flemish care and welfare sector successfully concluded an agreement on the temporary deployment of employees across care organizations during the exceptional circumstances stemming from the COVID-19 pandemic. The agreement, in effect between 1 April and 30 June 2020, facilitated the short-term transfer of employees to organizations experiencing staffing shortages.[84]

Global action by unions

UNI Global Union represents over 20 million workers in over 150 countries, including two million care workers through its UNICARE sector, which covers the private care sector and social insurance industry. The UNICARE Day of Action, held on 24 April 2020, drew attention to the importance of workers' access to PPE, decent pay and union rights.[85] Over 80 unions from every part of the world participated in that event.

During the pandemic, UNICARE affiliates have successfully advocated for improvements in working conditions for care workers, including a corona bonus as part of a new sectoral agreement for home care and nursing home workers in Austria;[86] protection against wage losses due to client cancellations and basic pay in case of quarantine or COVID-19 infection in Ireland;[87] and in the state of Illinois in the United States of America, hazard pay for the duration of the COVID-19 crisis, additional fully-paid sick days for COVID-19 related testing, illness or quarantine, and the right to refuse work without adequate protective equipment.[88]

Public Services International (PSI), the global union federation for workers in public services, which represents 30 million workers in 154 countries, has launched the "Public Health Once and for All" campaign. The campaign advocates for changes in health systems to put people first, and underscores the importance of public health systems that are sufficiently well funded, staffed and equipped. At the same it time draws attention to critical measures for responding to the COVID-19 outbreak.[89] Public Services International has also issued a briefing note on union action during the COVID-19 outbreak that provides guidance on key issues relevant to workers.[90]

On International Workers' Memorial Day on 28 April 2020, the Council of Global Unions issued a statement in which it called upon governments and occupational health and safety bodies around the world to recognize COVID-19 as an occupational disease. The Council emphasized, inter alia, that "Such recognition would ensure the right to worker representation and occupational safety and health (OSH) rights and the application of agreed measures to reduce risk. These rights include the right to refuse to work under unsafe working conditions."[91]

The International Domestic Workers Federation (IDWF), which represents over 560,000 domestic workers through its 75 affiliates in 58 countries, has provided crucial assistance to its affiliates to help them deliver humanitarian assistance and PPE to domestic workers in need. This has included the establishment of a solidarity fund to help at least 150,000 domestic workers and their families to cope with COVID-19.[92] The Federation has also issued recommendations to employers, governments and international organizations on measures to ensure the protection of domestic workers in the wake of COVID-19.[93]

83 UNI Global Union, "Argentina battles Covid-19 with trade union support", 2 April 2020.
84 Verso, "Uitwisseling personeel gemakkelijker gemaakt in strijd tegen Covid-19", 2 April 2020.
85 UNI Global Union, "Caring for those who care", 23 April 2020.
86 UNI Global Union, "Frontline Care Workers: Fighting Covid-19 and Fighting for their Rights", 8 May 2020.
87 SIPTU Health Division, "COVID-19 Advice for SIPTU Health members", 16 June 2020.
88 UNI Global Union, "Frontline Care Workers: Fighting Covid-19 and Fighting for their Rights", 8 May 2020.
89 Public Services International, "PSI COVID-19 response: Public Health, Once and for All! – concept note", 19 March 2020.
90 Public Services International, "Coronavirus: Guidance Briefing for Union Action – Update", 13 March 2020.
91 Council of Global Unions, "Council of Global Unions Statement on Recognition of COVID-19 as an Occupational Disease", 28 April 2020.
92 International Domestic Workers Federation, "IDWF Solidarity Fund to Fight COVID-19", 30 April 2020.
93 International Domestic Workers Federation, "Care for those who Care for you", 30 April 2020.

3. ILO tools and responses

ILO fundamental principles and rights at work apply to all workers, including care workers. ILO member States have a duty to apply those fundamental principles and rights as well as the provisions of the ILO Conventions that they have ratified. In addition to the eight "fundamental" Conventions identified by ILO, which include the Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87) and the Right to Organise and Collective Bargaining Convention, 1949 (No. 98), instruments of particular relevance to care workers include: the Social Security (Minimum Standards) Convention, 1952 (No. 102), the Occupational Safety and Health Convention, 1981 (No. 155), the Occupational Health Services Convention, 1985 (No. 161), the Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187), and their corresponding Recommendations. Upholding the standards enshrined in those instruments, requires, inter alia, risk assessments, a hierarchy of controls to prevent and mitigate risks, and the establishment of occupational safety and health committees that include workers' representatives, as set out in the ILO Guidelines on Occupational Safety and Health Management Systems.

The Nursing Personnel Convention, 1977 (No. 149) and its accompanying Recommendation (No. 157) establish minimum standards for decent working conditions for nursing personnel and are applicable to all categories of persons providing nursing care and nursing services. The Convention calls for nursing personnel to enjoy conditions at least equivalent to those of other workers in the country concerned and to receive pay that reflects their qualifications, responsibilities, duties and experience. Conditions that are of particular concern during the pandemic include: hours of work, including regulation and compensation of overtime, inconvenient hours and shift work; weekly rest periods; maternity leave; sick leave; and social security. Paragraph 49 of Recommendation No. 157 is directly applicable to the current crisis, as it provides that:

> "(1) All possible steps should be taken to ensure that nursing personnel are not exposed to special risks. Where exposure to special risks is unavoidable, measures should be taken to minimise it.
>
> (2) Measures such as the provision and use of protective clothing, immunisation, shorter hours, more frequent rest breaks, temporary removal from the risk or longer annual holidays should be provided for in respect to nursing personnel regularly assigned to duties involving special risks so as to reduce their exposure to these risks.
>
> (3) In addition, nursing personnel who are exposed to special risks should receive financial compensation."

Furthermore, paragraph 19(2) of the Annex to Recommendation No. 157 provides: "Overtime should be worked on a voluntary basis, except where it is essential for patient care and sufficient volunteers are not available".

The Domestic Workers Convention, 2011 (No, 189) and the Transition from the Informal to the Formal Economy Recommendation, 2015 (No. 204) establish standards for those who work in or for private households. The Convention recognizes the significant contribution of domestic workers in caring for ageing populations, children and persons disabilities. It calls on Member States to ensure domestic workers enjoy the fundamental principles and rights at work, as well as decent work under conditions no less favourable than those enjoyed by workers generally. Importantly, the Convention recognizes that domestic workers have the right to a safe and healthy working environment.

With a view to the care work being provided by migrant workers, relevant international labour standards on labour migration also apply.[94]

In addition, the ILO Guidelines on decent work in public emergency services, adopted in 2018, outline and promote coherent measures, tools and resources for emergency preparedness, including access to social protection and occupational safety and health. In 2018, ILO and the World Health Organization (WHO) also issued a publication entitled "Occupational safety and health in public health emergencies: a manual for protecting health workers and responders", which provides an overview of the main OSH risks faced by emergency responders during disease outbreaks.[95]

The recently adopted global standards to combat violence and harassment in the world of work, which are set out in the Violence and Harassment Convention, 2019 (No. 190) and the Violence and Harassment Recommendation, 2019 (No. 206), make it incumbent

94 These include the Migration for Employment Convention (Revised), 1949 (No. 97) and Migration for Employment Recommendation (Revised), 1949 (No. 86); the Migrant Workers (Supplementary Provisions) Convention, 1975 (No. 143) and Migrant Workers Recommendation, 1975 (No. 151); the Private Employment Agencies Convention, 1997 (No. 181), and the Maternity Protection Convention, 2000 (No. 183).

95 ILO, *Occupational safety and health in public health emergencies: A manual for protecting health workers and responders*, 26 June 2018.

on governments to adopt measures to protect workers who are particularly at risk of violence and harassment. These include workers in high-risk jobs in the health sector, including care workers and those working for emergency and social services.

The ILO has also issued guidance for tackling the economic and social impact of the COVID-19 pandemic, based on international labour standards. The ILO policy framework structures its key policy messages for response to the crisis around four pillars to facilitate a recovery that is sustainable and equitable.

In response to concrete requests from countries and constituents, ILO has developed a Checklist of measures to be taken in health facilities. That practical tool, which can be used to improve the protection of health workers as part of the COVID-19 response, is based on the ILO-WHO HealthWISE quality improvement tool for health facilities and is designed to help managers and staff improve workplaces and practices by addressing OSH, personnel management and environmental health issues. ILO also provides training on the use of the checklist.[96]

In follow-up to activities of the High-level Commission on Health Employment and Economic Growth, ILO, WHO and OECD joined forces in 2017 to establish the Working for Health programme and the associated Multi-Partner Trust Fund with the aim of expanding and transforming the health and social workforce, fostering inclusive economic growth and achieving the Sustainable Development Goals. Within the context of the COVID-19 pandemic, programme activities had been adjusted to the need of countries to support their response to the crisis.

The COVID-19 pandemic has drawn attention to the already overburdened and understaffed home and institution-based care sector in many countries. It has highlighted the challenges faced in the recruitment, deployment, retention and protection of sufficient numbers of well-trained and motivated care workers. Sustainable investment in health and social care systems, including in the workforce itself, and in decent working conditions and equipment are needed to ensure the preparedness and resilience of the sector in times of crisis and beyond.

96 ILO: *COVID-19 and health facilities: Checklist of measures to be taken in health facilities*, 15 July 2020.

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