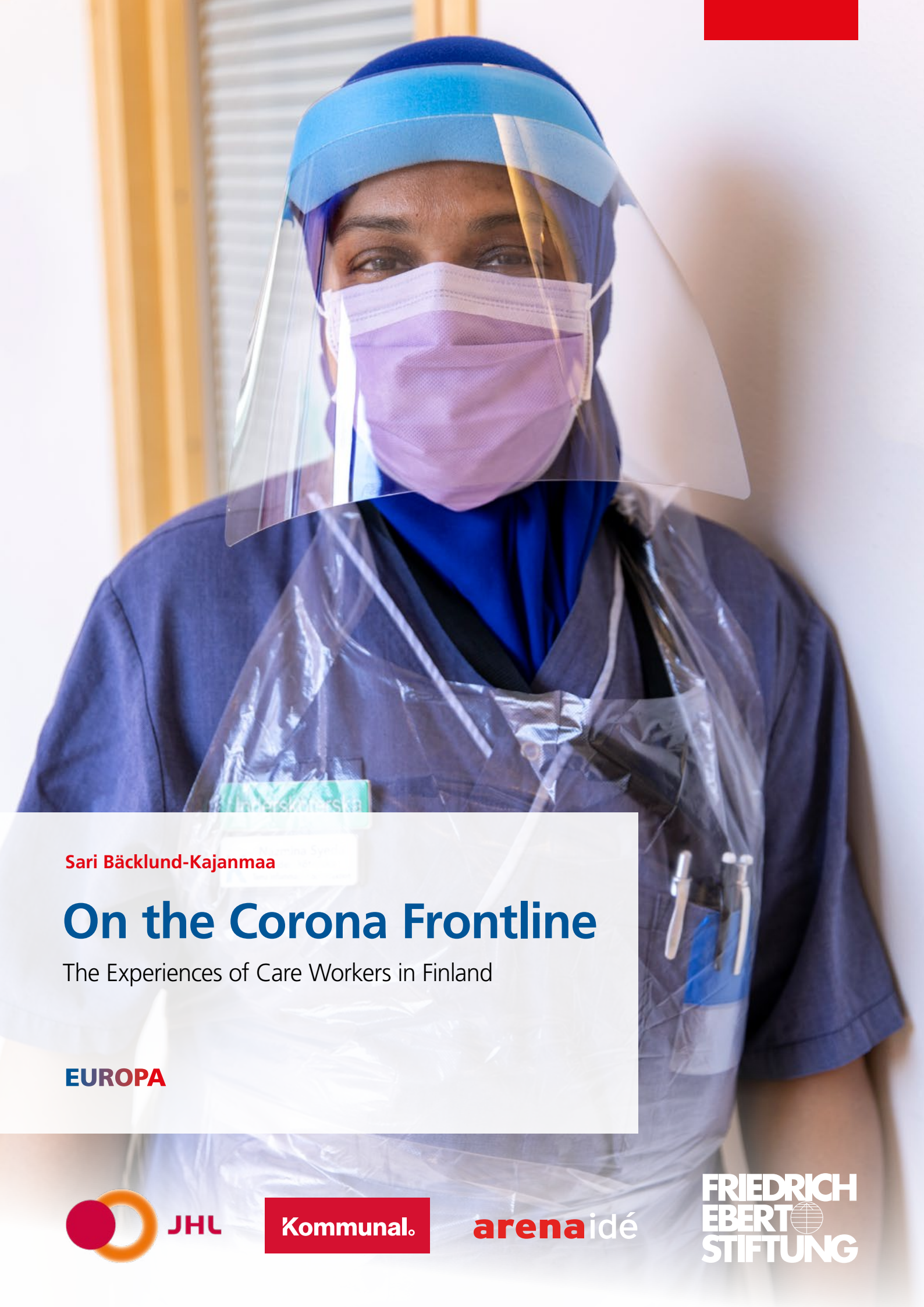

Sari Bäcklund-Kajanmaa

On the Corona Frontline

The Experiences of Care Workers in Finland

EUROPA

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About this publication

Covid-19 began spreading more extensively in Finland in early March 2020. The health care sector quickly became overwhelmed, and the situation was exacerbated by the initial lack of clear guidelines on the use of personal protective equipment. Testing capacity was also limited. During the spring there were major outbreaks in several care homes. Elder care services were given clear guidelines on the use of personal protective equipment (PPE) later than, for example, hospitals. The trade union JHL has demanded that employees who are exposed to the virus in their jobs be given a coronavirus pay raise. Despite the strained situation, social services and health care personnel have managed to cope, but a so-called 'care debt' has accumulated.

About the Author

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Partner organizations

Arena Idé is a Stockholm-based independent progressive think tank, funded by the Swedish trade union movement. www.arenaide.se

Kommunal is Sweden's largest public sector union with more than 500,000 members. www.kommunal.se

JHL is a trade union for people working in the public services and in private welfare services. It is the second largest trade union in Finland with 200 000 members, of which 70 procent are women. JHL negotiates approximately 100 collective agreements and is also highly influential in developing the Finnish working environment.

Responsible for this publication within the FES

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INTRODUCTION

The novel Covid-19 virus began spreading more extensively in Finland in early March 2020, and various restrictions were imposed throughout the country in spring. Schools were closed and teleworking was widely recommended. In March, the Emergency Powers Act was invoked for the first time in Finland's history, allowing broad intervention in employees' contractual terms of employment if deemed necessary.

The health care sector quickly became overwhelmed, and the situation was exacerbated especially by the initial lack of clear guidelines on the use of personal protective equipment. Testing capacity was also limited.

It quickly emerged that the novel virus was also spreading within care services for older people, and in spring there were major outbreaks in several care homes. Elder care services were given clear guidelines on the use of personal protective equipment (PPE) later than, for example, hospitals.

The tight restrictions were very effective, and transmission rates remained low through the summer. A second wave started in autumn 2020, and restrictions were once again introduced.

The situation persisted throughout the entire year, causing a tremendous burden on social services and health care personnel. As a trade union, the Trade Union for the Public and Welfare Sectors JHL has demanded that employees who are exposed to the virus in their jobs be given a coronavirus pay raise. Despite being overwhelmed, social services and health care personnel have managed to cope with these acute situations, but a so-called 'healthcare debt' of accumulated care needs (e.g. operations postponed because of Covid-19) still needs to be attended to.

THE STRUCTURE OF THE ELDER CARE SECTOR IN FINLAND

In Finland, the Ministry of Social Affairs and Health is responsible for services for older people, determining the course of service development, drawing up legislation and overseeing the implementation of reforms.

Municipalities are responsible for managing social and health services.They are responsible for ensuring that there are enough services available, but they can either outsource the provision of the services or provide them theirselves. Finland's health and social services reform, which is currently under way, will see responsibility for the organisation of services transferred to 21 health and social service counties at the start of 2023 (Valtioneuvosto 2020a). Helsinki would continue to manage its services independently. The objective of the health and social services reform is to improve the availability of and equal access to services, and to stem their rising costs. The ageing population and the falling share of the working age population present challenges for the funding of social and health servicessituation. Although people are nowadays living longer and healthier lives without extensive need for services, the need for assistance increases especially during the last years of life. In home care, too, clients are increasingly ill and frail and require more help.

Although responsibility for organising the services rests with the public sector, it does not have to provide the services itself. Roughly half of the 24-hour assisted living services for seniors is outsourced (Mielikäinen/Kuronen 2020). Home care is mostly provided by the public sector. Major problems, particularly in private sector services, have come to light in recent years: Staffing levels have been too low, the personnel structure has not corresponded to what has been agreed on, and there have been significant management and customer service deficiencies. Although the public sector has not been without its problems, the most serious issues have appeared in the private sector (Ranta 2019).

REDUCING INSTITUTIONAL CARE

The aim of services for older people – as for others in need of services – is for seniors to live in their own home for as long as possible. Services for older people mainly consist of home care, assisted living, enhanced (24-hour) assisted living and institutional care. Home care means that an older person can continue to live in their own home, but receiving various kinds of help at home. This can be, for instance, assistance in washing and getting dressed, or medicinal care. Assisted living is required when it is no longer possible for an older person to live in their own home. In this case, a care home will provide a place to live and other services such as meals, cleaning, medicinal care etc. Enhanced (24-hour) assisted living is otherwise similar to assisted living, but the personnel are available around the clock. In elder care, institutional care primarily means hospital-like conditions.

A long-standing goal has been to reduce institutional care, and its share of services for older people has been in steady decline. At the end of 2019, 18 % of those over 75 and 37 % of those over 85 were receiving at least some services. The need for services is particularly focussed on the last years (Mielikäinen/Kuronen 2020). There are some indications that there are not enough enhanced assisted living places, and home care is still being offered to people who need another type of service.

DETERMINATION OF SERVICE NEEDS

The Social Welfare Act and the Act on Social and Health Care Services for Older Persons, as a *lex specialis*, guarantee those over 75 the opportunity to have their service needs assessed (Sosiaali- ja terveysministeriö 2015). The assessment is carried out by a social or health care professional. When determining the need for services, the elderly person's functional capacity must be examined comprehensively, including the person's ability to cope with their

ordinary daily routines in the present housing and living environment and their needs for support and help.

After the assessment, a service plan defining the social and health care services that are needed must be drawn. The service plan must be revised without unnecessary delay if changes the client's functional capacity affect their service needs.

FUNDING OF SERVICES

The services are primarily funded through tax revenues. Finland spends approximately 1.5–1.6 % of its GDP on elder care services, which is far less than what the other Nordic countries spend.

Income-based client payments can also be used to cover some of the costs (Sosiaali- ja terveysministeriö 2021). An individual who receives short-term institutional care can be charged a daily fee. There is an annual ceiling on the fees paid by the client, beyond which the fee to be collected decreases.

For long-term institutional care, the client fee is determined according to the client's ability to pay. For a person living alone, the fee must not exceed 85 per cent of their net income, and at least 110 euro per month must be left for their personal use (in 2020).

No provisions have been laid down for housing service fees, however, which means the party arranging the service decides on the fees within the framework of the general legal provisions. The fees vary between municipalities. In addition, roughly half of the 24-hour housing places are in the private sector, which sets its own prices at will. Municipalities do not have enough of their own housing service units, and in practice a large proportion of older people receive a municipal payment commitment or service voucher, which covers most of the costs of the private service. However, part must still be paid by the clients themselves.

Enhanced (24-hour) assisted living is almost always the result of a referral by a municipality's social services authority. Enhanced assisted living often costs several thousand euros per month, and even with a municipal service voucher, the client must still pay various costs him-/herself, depending on the municipality and the client's income.

Lightly subsidised assisted living means living nearly independently in a care home and is applied for either through a municipal referral or on one's own initiative. Either a municipal service voucher or, if the service is applied for independently, social benefits from the Social Insurance Institution of Finland (Kela) can be obtained for assisted living (Kansaneläkelaitos 2017). Personnel is not available at all times and the fee usually consists of rent, a service package and other possible services that can be purchased separately. The purchasable service package typically includes, for instance, cleaning once a week, meals and an emergency phone, depending on needs. Various recreational activities are also usually organised in subsidised assisted living units. The cost of the service package varies, but it is often as high as 1,500 euro/month, on top of housing costs (rent). A service voucher granted by the municipality covers only the cost of care and not, for instance, rent, whereas Kela's housing allowance covers only the housing costs, not services.

A SHIFT FROM INSTITUTIONAL CARE TO HOME CARE

The goal in Finland is for older people to live in their own homes for as long as possible and for the services they need to be delivered to their home (Terveyden ja hyvinvoinnin laitos 2021a). Institutional care has been being cut back for some time now, and enhanced (24-hour) assisted living has been increased. The number of home care visits has also increased considerably. The number of home care personnel has not, however, increased in the same proportion. Home care clients are also in increasingly poor health; some have substance abuse problems or mental health issues and many have memory disorders. This has led to a situation where home care service is rushed and both clients and staff are often unsatisfied with the situation. The client pays an income-based monthly fee for service given regularly at home, for home service and for home nursing care (these services include e.g. medicinal care or services that support the client's functional ability) the fee is determined according to the configuration of services, the gross income of the service user and the size of the family.

A regular home care client is entitled to support services arranged by the municipality. These include meals, laundry, bathing, shopping and day centres. The cost of a home-delivered meal is typically 7.50 euro, and the shopping service charges 10 euro per delivery. The cost of support services varies considerably between municipalities, as they are not stipulated in detail in the legislation.

A reform of the Finnish Act on Client Charges in Healthcare and Social Welfare is currently in the pipeline. It will harmonise the costs of institutional care and enhanced assisted living as well as the costs of assisted living and long-term service provided at home (Sosiaali- ja terveysministeriö 2020a).

LEGISLATION AND GUIDELINES ON SERVICES FOR THE ELDERLY

The Finnish Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons (the Act on Services for Older Persons) regulates, among other things, the types of services that are available to older people and how they are provided (Sosiaali- ja terveysministeriö 2013). The Act also defines qualifications and staffing levels. In autumn 2020, after many years of campaigning, a minimum staffing level of 0.7 employees per resident was introduced for 24-hour assist-

ed living. The Act will take effect gradually over a transition period, with the minimum staffing level applying in full by 1 April 2023 (Sosiaali- ja terveysministeriö 2020b). Trade unions have expressed concern over the long transition period. However, due to municipalities' poor economic situation and the shortage of needed additional personnel, officials do not believe the minimum staffing level can be implemented right away. Under the new Act, a distinction is made between direct and indirect work such that the minimum staff level only applies to personnel who work directly with clients. This definition entered into force already in October 2020. Indirect work is, for instance, laundry and property maintenance, food preparation and heating and administrative work. There will be practical challenges in differentiating between direct and indirect work. In principle, heating up food or clearing away dishes is indirect work; on the other hand, if this work is carried out together with the client, it is direct work. Nurses' duties may, also in future, include indirect, assistive work, in which case those hours have to be calculated and they cannot be counted in the staffing level.

In November 2020, the trade unions JHL, SuPer and Tehy sent their members and shop stewards a questionnaire asking how workplaces have responded to the new distinction between direct and indirect work. On the basis of the questionnaire, it seems that the distinction between direct and indirect work has not yet been put into practice sufficiently at workplaces.

THE EFFECTS OF INTRODUCING MINIMUM STAFFING LEVELS

Trade unions are concerned about the impacts that enhanced assisted living staffing levels will have on home care. The aim of the minimum staffing level is to improve the enhanced assisted living situation for staff and residents. This is also expected to positively affect employees' ability to cope and remain at work. Home care does not have a minimum staffing level as yet, and the fear is that home care nurses will switch from home care to the enhanced assisted living side. A minimum staffing level for home care is in preparation, but information on its substance or date of completion is not yet available.

In addition to the Act on Services for Older Persons, the provision of services to older people is also regulated, e.g. by a quality recommendation that was reformed in the autumn of 2020. The recommendation contains guidelines for developing the structure of the services and the living and care environments, as well as the number, competence and management of personnel (Sosiaali- ja terveysministeriö 2020c).

Despite good legislation and recommendations, the practices do not always match the objectives. Staffing levels are often insufficient, which has at times led to serious deficiencies in senior services. The social welfare and health care sector's licensing and supervisory agency Valvira is the national guidance and supervisory authority for social services. Valvira had to suspend the operations of a few private care homes in 2018, for example due to persistent neglect (News Now 2019).

EMPLOYMENT STANDARDS

Professionals from a range of sectors work in elder care. The majority of people who work with the elderly, in both home care and institutional and housing services, are practical nurses who hold a vocational qualification in social and health care. Registered nurses also work in elder care to some extent, as do social workers, care assistants and facility caretakers.

Two main types of professionals work in health and social services: those with a protected occupational title and those who hold a license. Valvira grants licensing or protected occupational titles upon application and enters the person in the register of professionals. The register is public and anyone can access it to see if a person is registered in it (Valvira 2021). Nurses are licensed health care professionals. This means that only a person who holds a nursing degree can work as a nurse. Nurses receive their education at universities of applied sciences, and the nursing programme is approximately 3.5 years. Practical nurse is a protected occupational title for a health and social services professional. Only a person who holds a vocational qualification in practical nursing can use this title, although others who have sufficient appropriate training may carry out similar duties. Practical nurse training is an upper secondary level qualification that takes 2–3 years to complete, depending on prior competence. Practical nurses are also registered in the central register of social and health care professionals.

There is no official mandatory training for care assistants, but in practice the training has consisted of two parts of the vocational qualification in practical nursing and lasts roughly 8 months. It is not, however, a formal qualification. The long planned new Act on Services for Older Persons, adopted in autumn 2020, reinforced the status of care assistants as part of services for older people, and care assistant training and education is being reformed. The Ministry of Social Affairs and Health (STM) is planning to develop the education and training for care assistants. The idea is that it should be partly based on a practical nurse qualification, making it easier to continue studies to become a practical nurse later on. The work of a care assistant is considered direct work, but tasks related to indirect work may also be included in the job description, provided that they are also taken into account in the staffing level. Working as a care assistant involves certain restrictions; for instance, care assistants must not work alone during a shift, and their training does not entitle them to participate in medical treatment. The employer may, however, train care assistants in limited medical treatment duties.

The majority of employees within elder care, about two thirds, work in 24-hour care. About 20,000 of them are practical nurses, and less than 3,000 are registered nurses.

So far the number of care assistants is under 1,000. In home care, the proportions are similar: There are about 12,000 practical nurses and less than 2,000 registered nurses.

SHORTAGE OF QUALIFIED STAFF

Social services and health care have experienced a shortage of qualified employees, particularly in elder care, for a long time now. Some 4,500 practical nurses focusing on work with older people graduate every year. It is estimated that approximately one fifth of the sector's personnel will retire by 2030, so there is a great need for additional labour. The Ministry of Social Affairs and Health sees increased training and education of care assistants as one way to respond to the labour shortage. Also, in future, the majority of employees in the sector will be practical nurses, and finding new practical nurses in the coming years will be a major challenge. In terms of social services and health care professionals, there will be a particular shortage of specialists in gerontology, memory disorders and rehabilitation.

JHL believes that care assistants can be a source of suitable additional labour in the area of elder care. Furthermore, some care assistants are likely to later continue their studies and become practical nurses, which may in turn help stem the nurse shortage. The salary of practical nurses is approximately 2,100 euro per month, registered nurses earn 2,500 euro, care assistants 1,800 euro and social workers about 3,500 euro per month. On top of the basic salary, evening, night and other supplements are paid. For the most part, employees are permanent and full-time. However, temporary employment is fairly common, largely because a female-dominated sector needs frequent substitutes, for instance to cover family leave.

There are essentially four trade unions involved in elder care in Finland. Not all of their members work in elder care.

- SuPer, which represents practical nurses, has approximately 90 000 members. SuPer is the largest trade union in elder care.
- Tehy, with 160 000 members, represents qualified health and social care professionals, mostly nurses. Most Tehy members do not work in elder care.
- Talentia, with 26 000 social workers and elder care professionals, represents, in elder care, mostly those who make decisions on what kinds of services are provided.
- JHL, whose members represent all professional groups, including practical nurses, care assistants and facility caretakers, is the second largest trade union in Finland with 200 000 members.

A majority of workers in Finland still belong to a trade union, although membership has been declining in recent years.

COVID-19 IN FINLAND AND THE EMERGENCY POWERS ACT

The first cases of Covid-19 in Finland were recorded in February 2020 among travellers returning from abroad. The Ministry for Social Affairs and Health and the relevant authorities jointly co-ordinated guidelines and briefings related to the coronavirus, and the Ministry's website contains extensive material on the guidelines and recommendations issued during the pandemic.[1] Soon after the first confirmed cases, at the beginning of March, recommendations were issued to limit international travel and large social gatherings, and people were advised to avoid contact with older people if they had any flu-like symptoms. On 4 March 2020, the Ministry of Social Affairs and Health called on municipalities and hospital districts to prepare for an epidemic, in particular urging them to look after the situation of older and chronically ill people and to prepare for possible quarantine measures. The number of people infected began to rise rapidly. The coronavirus had already been added to the list of generally hazardous communicable diseases in the Finnish Communicable Diseases Act on 24 February, making it possible, e.g. to place a person in quarantine even against their will. Under the Communicable Diseases Act, an employee who has contracted the coronavirus or who has been placed in quarantine due to the coronavirus can apply for full compensation for the loss of income (communicable disease allowance) from the Social Insurance Institution of Finland (Kela) if he/she has a physician's statement on the quarantine as referred to in the Act (Kansaneläkelaitos 2021). This compensation for the loss of income considerably eased the financial situation of those who fell ill.

The Communicable Diseases Act and the measures it enables were not, however, sufficient, and on 16 March the Finnish Government took the historic decision to invoke the Emergency Powers Act. The latter gives the authorities additional powers to respond to situations such as war – or a major outbreak of a serious communicable disease. It was the first time in Finland's history that the Emergency Powers Act was invoked. It took effect on 18 March (Eduskunta 2020). The Emergency Powers Act restricts citizens' rights and normal life through government-issued decrees. The Act is intended precisely as a last resort measure in the event of a serious disturbance, as stated in Section 1 of the Act: "The purpose of this Act is to protect the population and secure its livelihood and the national economy, to maintain legal order and constitutional and human rights, and to safeguard the territorial integrity and independence of Finland in emergency conditions." (Oikeusministeriö 2012). In Finland, this meant, for example, that the Act could be invoked to close schools, libraries, theatres, restaurants and other recreational facilities. A public authority may make its own decision to close its premises and operations; for instance, the City of Helsinki can independently decide to close its libraries. The Emergency Powers Act was needed in particular to order the closure of private business activities – such as restaurants.

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1 stm.fi/en/frontpage

On 17 March 2020, the government issued a decree under the Emergency Powers Act that had repercussions for the position of employees and public officials who perform so-called critical duties. Under the decree, employees in sectors critical to the functioning of society include those who work in health care and social welfare, employees of emergency response centres, and employees of the Border Guard, Defence Forces and police. For these employees, the Emergency Powers Act allowed e.g. derogations from the provisions of the Working Hours Act concerning rest periods and overtime, from the regulations on the granting of annual holidays. Under the decree, the employer can outsource overtime work by unilateral announcement, change work shifts, transfer employees between work stations and cancel confirmed holidays of employees performing the above-listed duties. This means, e.g., that a practical nurse can be transferred from working in early childhood education to a hospital or nursing home, or a registered nurse can be transferred to a hospital's emergency unit.

The implementing decree also included powers to requisition health care staff, but they were never used.

The Emergency Powers Act was in effect until 16 June 2020. Thereafter, compliance with the Working Hours Act, the Employment Contracts Act, the Annual Holidays Act and the provisions of collective labour agreements was resumed. Now, as the second wave of the coronavirus intensifies, there is again discussion about implementing the Emergency Powers Act or other, stronger exceptional measures. The Communicable Diseases Act is also being amended to give authorities the power to take stronger measures without invoking the Emergency Powers Act. No new regulations had been issued by 26 January 2021, however.

THE SPREAD OF THE VIRUS

There are, in January 2021, still some municipalities and areas in Finland where the rate of Covid-19 infection is very low. These are mostly small and sparsely populated rural communities. There have been outbreaks of the disease in various parts of Finland at different times, but the chains of infection have been kept quite well under control, and rapid restrictions have helped prevent the virus from spreading further. In spring, tight restrictions and the lockdown of the entire Uusimaa region from the rest of Finland between 28 March and 15 April, except for essential travel, helped stop the large-scale spread of the virus to the rest of Finland. Public facilities, such as libraries, indoor swimming halls and gyms, were also closed in the spring. Restaurants were closed initially, but a little later, take-away was permitted. Social gatherings were limited initially to 500 people, and later to ten. Schools, universities and other educational institutions were also closed, with teaching taking place remotely. Day-care centres were open the entire time, although in spring the recommendation was to keep children at home if possible. Everyone for whom teleworking was possible was advised to do so, and people whose jobs involve close contact with others were strongly recommended to use masks and other PPE. Levels of compliance were very high. Outdoor recreation was not restricted at all, and Finland saw an unprecedented increase in the use of outdoor recreation areas during the spring. Travel abroad was essentially not recommended at any point after March and, still in December 2020, Finland remains one of the strictest countries in Europe in terms of restricting access to the country.

The pandemic situation eased in the summer, and only a few cases were confirmed each day. The need for intensive care was very low, and the restrictions were lifted one after the other. Life was almost back to normal in the summer, although, for example, the size of public events was still limited and restaurants were subject to tighter restrictions. In autumn, schools started the school year almost as usual, but universities continued with remote teaching. People also continue to work remotely, although not to the same extent as in the spring. With restrictions for the most part lifted, ordinary people have begun to live as though there were no virus. There has been extensive of social contact, celebrations in restaurants, and a return to day-to-day life. The consequence of this is that there is now a strong uptick in new cases. Since September, restrictions on gatherings have been tightened again and many areas of Finland are once again finding themselves in the Covid-19 spreading phase.

Finland has divided the spread of the virus into three levels: a baseline, accelerating and spreading phase. Spreading phase is referred to when e.g.:

- The seven-day incidence exceeds 15–25 cases per 100,000 residents and the fourteen-day incidence exceeds 25–50 cases per 100,000 residents.
- The daily growth rate of new cases exceeds 10 %.
- The positive rate exceeds 2 %.
- Less than half of sources are traceable.
- The need for hospitalisation and intensive care increases significantly.

The largest outbreaks have been in the Helsinki Metropolitan Area, As of 30 November, the spring-time restrictions had been partly reimposed, meaning the city's swimming halls, libraries and gyms were closed and social gatherings were limited to ten people. Upper secondary schools were also closed for the most part, with teaching taking place remotely. Teaching in universities been remote since March. Private gatherings of more than 10 people are also discouraged. Citizens were strongly recommended to avoid all non-essential close contact with people outside their own family. The restrictions do not concern private companies, as without the Emergency Powers Act, the authorities do not have the power to intervene in the activities of private enterprises. Under the regular legislation broader restrictions cannot be placed on restaurant opening hours and number of customers allowed, but earlier restrictions on alcohol licensing hours and the number of customers permitted are still in effect.

Prime Minister Sanna Marin has announced several times that if the situation does not improve, the government is

prepared to enact stricter measures, like in spring. Currently, in November, we are in a phase where although the load on health care capacity is not the same as it was last spring, the Helsinki and Uusimaa hospital district has raised its level of preparedness to the highest level, pointing especially to the major spike in cases. Contact tracing is no longer adequate either. In early December, the incidence of the disease increased in all regions.

What is especially concerning is that while the cases during the autumn mostly involved younger age cohorts, figures from January 2021 are again showing a clear increase in infection rates among older people. The older the person affected, the more likely he or she is to end up in hospital and in intensive care. Several cases were also reported in care homes in early 2021, and those contracting the virus have been both residents and staff.

THE ILL AND THE DECEASED

As of 22 January 2021 there are 148 patients being treated in hospital for Covid-19 in Finland, 26 of whom are in intensive care. Since the start of the year, a total of 41 565 confirmed cases have been reported, and by 19 January 2021, altogether 437 patients required intensive care. Of the intensive care patients, 67 % were men. The incidence rate in Finland is on average 66.3/100,000 inhabitants. However, there is a lot of regional variation (Terveyden ja hyvinvoinnin laitos 2021b).

The total number of Covid-related deaths reported since the spring is 638. Men account for 49 % and women for 51 % of that figure. The median age of the deceased is 84. Over 95 % of the deceased were people with one or several chronic conditions. Altogether, 33 % died in enhanced (24-hour) assisted living. Overall, however, the statistics do not appear to show excess mortality.

THL compiles statistics on a daily basis from various hospital districts on the number of people who have tested positive for the coronavirus. The data is published on THL's website.[2]

ELDER CARE AND CORONA

During the Covid-19 period, social services and health care personnel have been under extreme pressure. Work that was already demanding became even more so, and not just the physical load, but also the mental load increased significantly. Employees are being pushed to their limits due to the constant haste and uncertainty, and the fear of becoming ill or of a loved one becoming ill adds to the mental stress. Right from the start, the aim was to focus on health care, particularly on successful intensive care, when trying to control the coronavirus. Elder care received less attention, and this became apparent especially in the early stage of the pandemic, when the coronavirus spread in several care homes. There were also problems in home care, as nurses would visit several clients a day, often with insufficient PPE. From the beginning, trade unions expressed concern over insufficient preparation within elder care. However, only in the course of spring was a recommendation eventually issued seeking to minimise the transfer of personnel between different workplaces such that the same employees would only visit the same clients. Efforts were also made to limit movement between workplaces/buildings in assisted living services.

In Finland Covid-19 can be classified as an occupational disease if exposure likely and primarily happened at work, near the workplace or at a work-related training event. If exposure at work is not likely to be the main cause, the illness cannot be compensated as an occupational disease. One example of this is if someone in the employee's immediate circle has already been infected and investigations provide no information as to whether the exposure was likely to have happened primarily at work. By the end of December 2020, the Employment Accidents Compensation Board (Tako) had processed 175 claims of coronavirus exposure, 138 of which were found to meet the criteria for an occupational disease (Tapaturmavakuutuskeskus 2020).

Covid-19 is not automatically compensated as an occupational disease for any professional group; instead, the same clarifications are required for everyone.

PERSONAL PROTECTIVE EQUIPMENT AND TESTING

Broad debate took place in Finland concerning the use of masks and other PPE among care personnel and citizens when the pandemic erupted in the spring of 2020. At the time, there was a shortage of PPE, which also may have affected the tone of the debate. In social services and health care, primary responsibility for PPE supplies lies with the social and health care units, which should have a three-month emergency stock of such equipment. In spring 2020, after discovering that the stocks were insufficient, the health care units turned to the National Emergency Supply Agency,[3] which is the authority in charge of maintaining security of supply of critical health care supplies and medications. The Agency also lacked a sufficient supply of protective gear for social services and health care at the time, which may have played a part in the lack of clear guidelines on using PPE in the beginning. In the spring, various authorities (STM, THL) also issued partly contradictory guidelines. In addition, social services and health care employers may have given their personnel guidelines that differed from the authorities' recommendations. The inconsistent guidelines caused some confusion among employees. Particularly in the early stage of the pandemic, employees and trade unions criticised the lack of personal protective equipment, the poor effectiveness of the PPE

2 thl.fi/en/web/thlfi-en

3 huoltovarmuuskeskus.fi/en

(e.g. some of the PPE used in elder care consisted of washable fabric masks or even buff scarfs) or the unclear instructions for using it. Additional PPE was acquired relatively quickly, and in May 2020 the situation became clearer and the guidelines more consistent.

In spring and summer 2020, masks were not really used by the general population. The Ministry for Social Affairs and Health published a report on mask use in May, and based on the report, no recommendation to use masks was issued. The primary means of protection against the virus were considered social distancing and practicing good hand hygiene (Sosiaali- ja terveysministeriö 2020d). A general recommendation to wear masks was issued only in autumn, according to which masks should be used in public transport and other spaces where keeping a safe distance is not possible.

Employees – and other segments of the population – were not tested regularly at first. There were also testing capacity issues until mid-April, and only people with clear symptoms were tested. Some confusion also arose in terms of how those in the close circles of an infected person should be quarantined. Practices may have varied by region, which added further confusion to the situation.

After the challenges of early spring, even those with mild symptoms were urged to get tested, but testing was still backed up, and the wait to get tested and then to get the results could take several days. Tests were carried out by both public sector and private sector health clinics. The situation calmed down in the summer, and the number of new infections clearly decreased.

A second wave of the pandemic began to appear in August in Finland and elsewhere in Europe and was still accelerating in November. Testing was backed up in August, as school started up and people returned to work from their summer holidays. Currently, testing takes place quickly, but there are challenges in tracing the chain of infection, and only roughly half of the sources of infection can be determined.

INFECTED PERSONNEL

All cases of Covid-19 infection in Finland are recorded in the National Infectious Diseases Register. According to THL's report, 5,599 confirmed cases of Covid-19 infection among working-aged people were recorded in Finland in spring; of these, 949 were health workers. Health workers accounted for approximately 17 per cent of all confirmed cases of Covid-19 among working-aged people in spring.

In summer, when it was easier to control the spread of the virus, there were 1,027 confirmed cases of Covid-19 by the end of August. Of these, 883 were among working-aged people, 47 of which were among health workers. Health workers thus accounted for roughly 5.3 per cent of all confirmed Covid-19 cases in the summer among working-aged people (Terveyden ja hyvinvoinnin laitos 2020).

Of the health care workers infected with Covid-19 in spring, 652 were known to have been in close contact with a person who tested positive for the virus. Of that figure, more than half (367) had close contact with the infected person at work, and 285 elsewhere. The source of infection of just under one third of health workers was unknown. Of the infections among health workers in the summer, just under half (20 cases) were such that contact with an infected person was known. Seven of those occurred at work. The source of a total of 27 cases, i.e. more than half, was unknown.

The median age of health workers contracting Covid-19 was 35.

GUIDELINES FOR OLDER PEOPLE

In mid-March, restrictions on visits to older people were issued. Visits to care homes were prohibited (with the exception of those in palliative care), and all persons over 70 were advised to stay home (Valtioneuvosto 2020b). This led to a situation where the vast majority of older people living in their own homes were isolated there for several months (the isolation recommendation for those over 70 was withdrawn on 23 June), and they were dependent on the help family and friends, for instance, for food shopping. Whenever possible, people kept in touch via video calls, but this was not always easy, especially with people suffering from memory disorders. Many older people had a hard time understanding why their family and friends stopped visiting. This was challenging for personnel. In addition, the situation was complicated by the use of PPE, which was difficult for some elderly to understand.

The older people felt guilty about the situation, and many felt the isolation recommendation was a punishment. At the same time, various rehabilitation and recreational activities for seniors were suspended, which caused a clear decline in their physical condition. The situation also had significant impacts on mental health.

TRADE UNION PERSPECTIVES

The Trade Union for the Public and Welfare Sectors JHL broadly represents caregiving personnel and child care personnel, as well as support service personnel, such as facility caretakers and technical personnel. These are groups that experienced great challenges during the pandemic. Particularly during the spring, there were problems in elder care caused first by the shortage of PPE, then by the quality of the equipment and the insufficient guidelines on its use. Personnel were also concerned both about getting sick themselves and about infecting those close to them. In early childhood education, the use of masks was initially not recommended at all in order to ensure that interaction with children was not compromised. JHL considers it important that employers ensure an appropriate level of occupational safety during the pandemic and that they provide sufficient supplies of masks and guidance in using them, if necessary.

The broader recommendation on the use of masks has also led to a debate over who is responsible for ensuring their availability and whether they are suitable for the intended use. In fact, the matter is unequivocal: it is the employer's responsibility to ensure occupational safety, and therefore the use of masks, when the job requires them. Problems may also arise if the use of masks is only a recommendation, not a binding obligation. All in all, after difficulties with the guidelines in the spring, there have not really been any problems with the availability of masks in the autumn.

THE IMPORTANCE OF CARE WORK

If anything good can be found in this pandemic, it is that it has especially highlighted the importance of nursing and care work. In Finland, as in many other countries, there has been a growing appreciation of nurses and care personnel in public speeches, and their continued efforts have been praised. Unfortunately, this appreciation has not extended to their salaries. Apart from a few local exceptions, nurses in Finland have not been paid a special coronavirus increase. Nursing trade unions have demanded a coronavirus pay raise for nurses, and JHL has likewise demanded that all professional groups who are at risk of contracting the virus at work receive a pay raise.

Besides nursing staff and early childhood education, many other professional groups have been overwhelmed at work due to Covid-19. Work in the cleaning industry in particular has increased significantly as cleaning standards have increased everywhere. Those working in public transit, public safety officials and others who cannot carry out their work remotely and who are continuously in contact with other people as part of their job have also been worried about their health.

As mentioned above, the Emergency Powers Act gave employers exceptionally broad authority to change the shifts of employees working in sectors critical to society and to cancel leave to ensure sufficient staffing cover. The trade unions have also learned that employers unfortunately tried to exploit this opportunity even when other means were available.

OCCUPATIONAL SAFETY STILL NEEDS TO BE IMPROVED

Throughout the spring and now during the second wave in the autumn, it has been noted that there is still room for improvement in employees' occupational safety. The Centre for Occupational Safety's Municipal Group (an action group made up of municipal labour stakeholders and specialists from the Centre for Occupational Safety) conducted a survey in spring 2020 on the impacts of coronavirus on occupational health and safety co-operation, and on the occupational health and safety matters that have emerged during the pandemic. Work communities adapted quickly to remote work, or to other new situations, but there could have been more psychosocial support in particular (Kommunarbetsgivarna 2020). The physical and mental load has been extreme in many industries, and there has not necessarily been knowledge about how to prevent and treat the stress. If the aim is to keep social services and health care personnel at work even in future, attention must be paid to their ability to cope at work, especially during exceptional conditions. In the survey, it came to light that occupational health and safety co-operation personnel, particularly employees' occupational health and safety representatives, were not included in the planning of coronavirus measures at workplaces.

The Trade Union for the Public and Welfare Sectors JHL issued guidelines for its members right at the start of the pandemic, in member letters and on its website (www.jhl.fi). We also organised webinars and looked into PPE and other occupational health and safety related matters by conducting surveys. The pandemic did not affect the union's membership numbers, as our members mostly represent fields that have not really suffered from the pandemic the way, for example, the travel and restaurant industries have.

IN CONCLUSION

Finland has managed the coronavirus pandemic relatively well, measured by the number of confirmed cases and deaths. In December 2019, Finland faced a politically challenging situation that led to the appointment of a new prime minister, Sanna Marin, who had served as the minister of transport and communications in the previous government. When the first wave hit, the Finnish government reacted quickly by invoking the Emergency Powers Act, essentially enabling an extensive shutdown of society. The public's response to the regulations and guidelines was mostly positive, and in true Finnish style, the official guidelines were largely complied with. The global pandemic was a challenge for all of Finland, and, quite extraordinarily, even the opposition did not criticise the government's actions; instead, all political parties agreed nearly unanimously on the main policies. The pandemic inspired a certain national team spirit and a determination to make it through the crisis together. Thanks to the tough restrictions of the spring, the national situation was brought under control, and in June it was possible to partly lift the restrictions.

In August, when the second wave began to rear its head, that same national team spirit was nowhere to be found. Political differences between the parties and especially between the opposition and the government began to emerge, as did criticism of the prime minister. Finns could no longer be bothered to comply with the recommendations with the same diligence as they did in the spring, and the number of new cases began to rapidly increase.

Economically, the pandemic has naturally hit the travel and restaurant industries the hardest – everywhere in Finland, but particularly in the Helsinki area and Lapland. Many companies have faced tremendous challenges as their sales

have essentially ceased completely. Finland has adopted several different support systems in an effort to enable businesses to continue operating during this difficult economic situation (Työ- ja elinkeinoministeriö 2021).

Nevertheless, the number of unemployed and employees on short-time working is growing. Surprisingly, the number of bankruptcies has not increased; on the contrary, the number has decreased somewhat compared to last year (Tilastokeskus 2020). This is partly due to a temporary legislative amendment that entered into force on 1 May 2020, restricting a creditor's right to petition for bankruptcy against a debtor. The temporary law is valid until the end of January 2021, after which a significant increase in the number of bankruptcies can probably be expected.

Social services and health care resources have focussed on pandemic response since the spring, which means other areas of social services and health care have unfortunately fallen considerably short of their targets. Finland has a statutory duty to take care of the health of its citizens (care guarantee). The guarantee defines the limits for non-urgent care and specific non-urgent surgery. The Emergency Powers Act also allowed deviations from this care guarantee, which in turn has caused a significant backlog in care services not related to Covid-19. Health care waiting lists shortened somewhat during the summer, but the situation is starting to get worse again now in the autumn. The danger is that, e.g. cancer has been able to go undetected during the pandemic or other diseases have worsened without treatment. People's own behaviour has also partly contributed to this situation. When recommendations were issued in the spring to only take care of essential matters, some people cancelled their already booked doctor's appointments or failed to show up for examinations to verify a suspected new disease.

Hopeful news that a Covid-19 vaccine has been successfully developed came in December and Finland could also start vaccinations in late December.

If we face this kind of situation again in the future, the country will be considerably better prepared. Government leaders have learned how to co-operate in preparing for a crisis, communication responsibilities between the various authorities have been defined more clearly, and certain laws, such as the Communicable Diseases Act have been updated to better respond to the needs of this kind of crisis.

Hopefully, another lesson of the pandemic is that social services and health care personnel are an especially valuable resource that must be invested in also during normal times. If personnel's or health care's resources overall are stretched to the limits and already under-resourced, it may not be possible to find the ability or even the desire to be flexible during difficult times.

REFERENCES

Eduskunta (2020): Beredskapslagen under coronatiden, https://www.eduskunta.fi/SV/naineduskuntatoimii/kirjasto/aineistot/kotimainen_oikeus/LATI/Sidor/valmiuslain-kayttoonottaminen-koronavirustilanteessa.aspx (26.01.2021).

Kansaneläkelaitos (2017): Housing costs for which allowance can be paid, https://www.kela.fi/web/en/housing-allowance-for-pensioners-housing-costs?inheritRedirect=true (03.12.2020).

Kansaneläkelaitos (2021): Update on the coronavirus situation, https://www.kela.fi/web/en/corona?inheritRedirect=true (03.12.2020).

Kommunarbetsgivarna (2020): Arbetarskyddssamarbetet borde utnyttjas mer i coronatider, https://www.kt.fi/sv/nyheter-och-pressmeddelanden/2020/arbetarskyddssamarbetet-borde-utnyttjas-mer (26.01.2021).

Mielikäinen, Lasse: Kuronen, Raija (2020): Tilastoraporti 45/2020, 06.11.2020, https://www.julkari.fi/bitstream/handle/10024/140657/Tr45_20.pdf?sequence=5&isAllowed=y (01.12.2020).

News Now (2019), Valvira orders Esperi Care to fix problems at residential homes for elderly people; https://newsnowfinland.fi/domestic/valvira-orders-esperi-care-to-fix-problems-at-residential-homes-for-elderly-people (18.2.21).

Oikeusministeriö (2012): Beredskapslag, https://www.finlex.fi/sv/laki/ajantasa/2011/20111552 (03.12.2020).

Ranta, Elina (2019): Katso lista hoiva¬kodeista, joissa on havaittu ongelmia – Attendo ja Mehiläinen kärjessä, IS, https://www.is.fi/taloussanomat/art-2000005982461.html (01.12.2020).

Sosiaali- ja terveysministeriö (2013): Laki ikääntyneen väestön toimintakyvyn tukemisesta sekä iäkkäiden sosiaali- ja terveyspalveluista, https://www.finlex.fi/fi/laki/ajantasa/2012/20120980 (21.01.2021).

Sosiaali- ja terveysministeriö (2015): Sosiaalihuoltolaki, https://finlex.fi/sv/laki/ajantasa/2014/20141301 (21.01.2020).

Sosiaali- ja terveysministeriö (2020a): Asiakasmaksulain uudistus, https://stm.fi/asiakasmaksulain-uudistus (21.01.2021).

Sosiaali- ja terveysministeriö (2020b): Personaldimensionering i långvarigt serviceboende med heldygnsomsorg och långvarig institutionsvård för äldre, https://stm.fi/sv/aldre/personaldimensionering (03.12.2021).

Sosiaali- ja terveysministeriö (2020c): Kvalitetsrekommendation för att trygga ett bra åldrande och förbättra servicen 2020–2023 : Målet är ett åldersvänligt Finland, https://julkaisut.valtioneuvosto.fi/handle/10024/162456 (21.01.2021).

Sosiaali- ja terveysministeriö (2020d): Report on the use of face coverings to prevent coronavirus infections: large variation in country-specific policies and only little research data available, https://stm.fi/en/-/selvitys-kasvosuojusten-kaytosta-koronavirustartuntojen-ehkaisemisessa-laajaa-vaihtelua-maakohtaisissa-linjauksissa-ja-vahan-tutkimustietoa (26.01.2021).

Sosiaali- ja terveysministeriö (2021): Social and health care client fees, https://stm.fi/en/client-fees (01.12.2020).

Tapaturmavakuutuskeskus (2020): 138 ammattitautina korvattavaa koronatartuntaa, https://www.tvk.fi/uutiset-ja-blogit/uutiset/2020/138-ammattitautina-korvattavaa-koronatartuntaa/ (22.01.2021).

Terveyden ja hyvinvoinnin laitos (2020): Terveydenhuollon henkilökunnan osuus koronavirustartunnan saaneista laski kesän aikana, https://thl.fi/fi/web/guest/-/terveydenhuollon-henkilokunnan-osuus-koronavirustartunnan-saaneista-laski-kesan-aikana (23.01.2021).

Terveyden ja hyvinvoinnin laitos (2021a): Muuttuvat vanhuspalvelut, https://thl.fi/sv/web/aldre/foranderlig-aldreomsorg (03.12.2020).

Terveyden ja hyvinvoinnin laitos (2021b): Tilannekatsaus koronaviruksesta, https://thl.fi/en/web/infectious-diseases-and-vaccinations/what-s-new/coronavirus-covid-19-latest-updates/situation-update-on-coronavirus (21.01.2021).

Tilastokeskus (2020): Konkurssien määrä väheni tammi–lokakuussa 2020 edellisvuodesta 15,4 prosenttia, http://stat.fi/til/konk/2020/10/konk_2020_10_2020-11-18_tie_001_fi.html (26.01.2021).

Työ- ja elinkeinoministeriö (2021): Toimintaohjeita yrityksille koronavirustilanteessa, https://tem.fi/en/coronavirus/guidance-for-businesses (26.01.2021).

Valtioneuvosto (2020a): Sote-uudistus, https://soteuudistus.fi/etusivu (21.01.2021).

Valtioneuvosto (2020b): Mitä yli 70-vuotiaan pitää ottaa huomioon koronavirustilanteessa?, https://valtioneuvosto.fi/-//1271139/mita-yli-70-vuotiaan-pitaa-ottaa-huomioon-koronavirustilanteessa- (26.01.2021).

Valvira (2021): JulkiTerhikki/JulkiSuosikki, https://www.valvira.fi/web/sv/valvira/register/yrkesutbildade_personer_inom_halsovarden/julkiterhikki (21.01.2021).

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EUROPA

Covid-19 has uncovered many societal fault lines. The virus hit the elder care sector in many countries especially hard, leading to many deaths and pushing care workers fighting on the corona frontline to the end of their limits. The pandemic has underscored deficiencies in elder care that have been warned about and protested by trade unions for years. Precarious working conditions, understaffing and underfunding devastatingly undermined the ability to protect the most vulnerable during the corona pandemic: our elderly.

It is high time we listen now.

The Friedrich-Ebert-Stiftung has, on the initiative of the Swedish municipal workers' union, Kommunal, and the Swedish progressive thinktank Arena Idé, commissioned reports from several European countries. By focusing on the plight of those in need of care and their caregivers, the reports shed light on the pandemic's impact on elder care and highlights the justified demands of the care workers' trade unions as well as the long overdue need for reform of the sector as a whole.

Further information on the project can be found here:
www.fes.de/en/on-the-corona-frontline

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