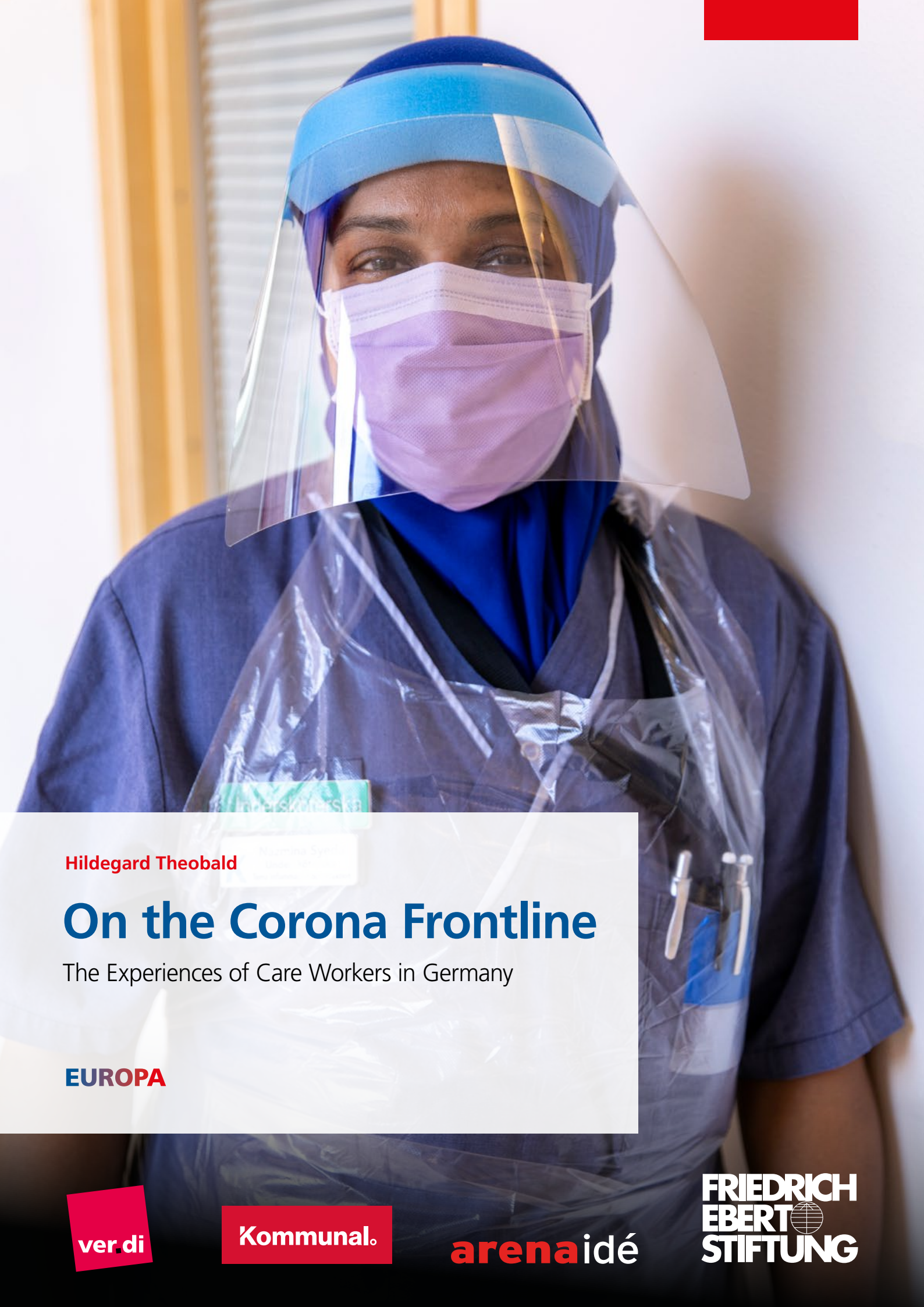

Hildegard Theobald

On the Corona Frontline

The Experiences of Care Workers in Germany

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About this publication

The COVID-19 pandemic strongly affected the situation of care workers and clearly revealed the shortcomings of the elder care sector. Care service providers were not prepared for the pandemic, as symbolised not least by the lack of personal protective equipment. The general low staff levels, staff shortages due to infections and increasing care burdens have resulted in high additional workloads for care workers. The strength of the elder care system depends on the competence of the care workers, a relatively stable care workforce, and their team spirit.

About the Author

Hildegard Theobald is Professor for Organizational Gerontology at the University of Vechta, Germany. Her research focuses on international comparative research on elder care systems, elder care policies, migration, professionalisation of care work and the situation of care workers.

Partner organizations

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

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Dr Philipp Fink, Director, FES Nordic Countries
Iva Figenwald, Social Policy, APuB FES
Josefin Fürst, Policy Officer, FES Nordic Countries

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1 OVERVIEW AND CONTEXT

1.1 The German Elder Care System

In Germany, the mandatory Long-Term Care Insurance (LTCI), which was introduced in 1995/96, is the most significant social policy scheme for long-term care needs. It provides universal coverage in all age groups, with five care grades based on increasing levels of frailty. Due to the age-related distribution of care needs, most beneficiaries of LTCI are 65 years and older. In 2017 81 per cent were 65 years and older and 35 per cent 85 years and older (Federal Statistical Office 2018). LTCI is not meant to cover all costs but rather to grant defined lump sums that are independent of the economic situation of the beneficiaries and are defined by the level of need and type of benefits used. These lump sums must then be topped up with private means, informal family support, or tax-based means-tested social assistance payments. LTCI is financed via insurance contributions. The contribution rates for LTCI are stipulated by national law and lie in 2020 at 3.05 per cent in general (3.3 per cent for childless members), based on gross income. In 2019, the expenditure under LTCI amounted to €45 billion, plus additional social assistance payments amounting to €4 billion (Federal Ministry of Health 2020; Federal Statistical Office 2020; Rothgang/Müller 2018) (for further detail see Box 1).

16 per cent of adults aged 65+ received benefits within the LTCI framework in 2017 (Federal Statistical Office 2018). The beneficiaries of care grades two to five can choose freely between cash payments, home care services and nursing home services. Cash payments can be spent freely by the beneficiaries themselves to support informal (family) care provision or to organise care- or household-oriented services. Moreover, additional types of services, such as short-term care, respite care and day or night care services can be granted. In 2017, 46 percent of beneficiaries 65 years and older used cash benefits to support care provision within the family framework. 26 per cent used home care services and 27 per cent nursing home services. Data from 2015 reveal that 5 per cent of beneficiaries across all age groups used day- or night-care services, 25 percent used respite care services, and 11 per cent used short term care services (Schwinger et al. 2017).

ACCESS TO BENEFITS – THE LTCI FRAMEWORK

The LTCI framework is based on a uniform national assessment system. Since the 2017 reform, the framework now assigns applicants to one of five care grades. Care statistics from 2017 reveal that the majority of beneficiaries 65+ (63 per cent) are allocated to care grades two and three and that only 20 per cent are allocated to the higher care grades (four and five) (Federal Statistical Office 2018). The level of care grade correlates with the use of different types of benefits. Beneficiaries in the lower care grades two and three are most likely to use cash payments. With increasing need beneficiaries use home care services and nursing home services in that order. However, the difficulties for beneficiaries without family support to organise sufficient home care services and the principle of free choice between types of benefits for beneficiaries from care grade two upwards lead to beneficiaries moving into nursing homes on lower care grades. Thus, about half of residents in nursing homes are in the lower care grades two and three. However, 66 per cent of nursing home residents have dementia (Isfort et al. 2018).

Box 1: Social policy schemes in the area of long-term care

The Long-term Care Insurance (LTCI) replaced the social policy scheme "Social assistance to care" (Hilfe zur Pflege), which had been the main social policy scheme in Germany. Beginning in 1961, the earlier scheme had granted public support for home care and nursing-home services based on a means test within the framework of the tax-based Federal Social Assistance Act. This scheme was not abolished with the introduction of LTCI but was redefined and now complements LTCI support as a means-tested benefit for those who are unable to finance their share of the costs.

LTCI is divided into two separate branches: social LTCI (for members of statutory healthcare insurance) covers about 89 per cent of the population, while a mandatory private insurance scheme (for members of private healthcare insurance) covers about 11 per cent of the population. There is no difference with regard to the eligibility criteria, assessment procedures, or available benefits, which are defined by national LTCI law for both branches. The contribution rates for social LTCI stipulated by national law set the upper ceiling for contribution rates within private LTCI. The establishment of two separate systems has been criticised above all for the different levels of insurance contributions that they require (which are typically lower within private LTCI as its members are generally wealthier and healthier) and for the lack of economic redistribution between the two branches due to the separate financing systems (for more details on the debate, see Theobald 2011).

1.2 Elder Care Infrastructure

Prior to the introduction of LTCI in 1995/96, the home care and nursing home infrastructures were underdeveloped. Home care and nursing home services were publicly funded by tax-based social assistance or health insurance funds and mainly delivered by non-profit providers and a smaller proportion of public and for-profit providers. The introduction of LTCI was accompanied by the establishment of a regulated care market that employs a customer choice model to enable a market-oriented expansion of professional care services based on user choice and cost control. Care service delivery is now based on competition over price and quality of care between non-profit public and for-profit providers. Care providers' access to the care market is regulated through accreditation by regional care insurance funds based on national LTCI law and specified by regional framework contracts.

With this framework, the home care provision expanded and became simultaneously marketised – that is, it created considerable openings for for-profit providers. In the home

care sector in 2017, 14,050 care providers (up from 10,820 in 1999) delivered services with for-profit provision accounting for 66 per cent of providers and 51 per cent of users. Non-profit provision accounts for 33 per cent of providers, and 47 per cent of users. These two types of care provision account for almost all service delivery, with public provision representing only a tiny share (Federal Statistical Office 2001, 2018). Most providers are small standalone organisations (55 per cent), while another 22 per cent operate several locations; the remainder are multilevel care service organisations delivering different types of services (home care, day care, nursing home services, and assisted living) (Isfort et al. 2018).

Turning to the residential sector, after the introduction of LTCI the number of nursing homes expanded from 8,859 in 1999 to 14,480 in 2017. Despite the expansion of for-profit provision, non-profit providers continue to constitute the majority (53 per cent of providers, 55 per cent of available beds). The for-profit sector accounts for 43 per cent of providers and 39 per cent of available beds. Moreover, the share of public provision is small (Federal Statistical Office 2001, 2018). In Germany, for-profit nursing homes are traditionally organised as private family-based companies. Only since 2013 (and increasingly since 2017) have private-equity firms from the United States, France, and Scandinavia entered the field of elder care provision, especially in the nursing home sector (Scheuplein et al. 2019).

NEW CONCEPTS OF CARE

The service organisation and concept of care have also changed since the introduction of LTCI. In 2017, 4 per cent of adults older than 65 years used home-care services within the LTCI framework (Federal Statistical Office 2018). Home-care services in Germany are characterised by integrated provision of home nursing financed by Healthcare Insurance and long-term care support (bodily care and household-related services) financed by LTCI through one individual home-care provider. According to a representative survey of managers of home-care services, about 42 per cent of users receive both types of services, 26 per cent only long-term care services, and 32 per cent only home nursing services. Both types of services are equally relevant for the income of the service providers, while only 7 per cent of service providers' revenues come from users' contributions (Isfort et al. 2016).

With the introduction of LTCI, home-care provision came to be based on standardised care packages, which can be freely chosen by the user. A care package, e.g. comprehensive bodily care in the morning, includes exactly predefined care tasks and times. In response to criticism of standardised care provision, home-care providers have since 2013 also been able to offer care services based on precisely defined time quotas. In 2014, 41 per cent of providers offered this type of service (Isfort et al. 2016). Service costs are reimbursed directly by regional long-term care insurance up to the defined lump sum determined by the care grade, and any additional costs must be paid privately or may be funded by means-tested social assistance. 13 per cent of beneficiaries received such social assistance to care benefits in 2015 (Rothgang/Müller 2018). In a representative survey of beneficiaries living at home, Hielscher and colleagues (2017) found considerable private costs of an average of €362 per month (all costs related to care needs), which is particularly burdensome for older adults with low incomes. In addition to private costs, a further concern involves gaps in home-care provision. Despite the expansion, these gaps particularly affect specific services and display regional differences, with an undersupply in rural areas (Isfort et al. 2016).

The residential care sector has also changed considerably. In 2017, 4 per cent of the population aged 65 years and older were living in nursing homes, which is quantitatively the most important form of accommodation for older adults not living in their own home. In addition, 1 to 2 per cent of adults aged 65 years and older live in assisted living facilities (Kremer Preiß et al. 2019). Finally, mainly since 2000, 3,121 independent care living communities have been established in regular, shared flats in order (mainly for older people suffering from dementia) (Klie et al. 2017).

In their national study in 2018, Kremer-Preiß and colleagues (2019) found that assisted living facilities were being used increasingly often by older people with care needs (37 per cent of residents in 2018 were beneficiaries within the LTCI framework, mainly on lower care grades). As a result, 26 per cent of providers had established additional day-care services or 24-hour care services. As LTCI beneficiaries, residents receive benefits to cover home-care services, but not other service and housing costs. In their study, Kremer Preiß and colleagues (2019) found that residents had to shoulder considerable private costs.

Care concepts in nursing homes have also developed since the 1990s. Nursing homes now operate within multifunctional organisations, which also run home-care and day-care services, care homes, and assisted living facilities (with a share of 24 per cent of nursing homes in 2017 see Federal Statistical Office 2018). Today, life in nursing homes is typically organised around group arrangements offering different care concepts. The most recent concept, since 2010, is the "Quartiershaus", a nursing home with strong contacts to local actors. Representative statistics reveal that the proportion of residents living in a single room increased from 48 per cent in 2001 to 66 per cent in 2017 (Federal Statistical Office 2003, 2018). Case studies on the situation in nursing homes reveal a trend of opening up facilities to local actors, such as local associations and volunteers.

Private costs have risen considerably, with average private costs for care-related costs in nursing homes reaching €700 per month in 2017. In addition, residents must pay board and lodging costs and investment costs if the provider has invested in the building. The proportion of nursing home residents receiving additional social assistance payments to cover their costs rose from 35 per cent in 2013 to 41 per cent in 2018 (Rothgang/Domhoff 2019). In Germa-

ny, children of residents were traditionally liable for residential care costs their parents were unable to pay on their own. "Social Assistance to Care" only financed private care costs where the children were unable to do so. Since a change in the law in 2020, only children with income exceeding €100,000 per year are still liable for private costs. A public debate is currently under way on capping private care-related costs within the LTCI framework, with the remaining costs also covered by LTCI (see Rothgang/Domhoff 2019). High private contributions deter the use of nursing-home services and thus limit free choice between the different types of services.

1.3 Changing Situation for Care Workers

In parallel to the expansion and marketisation of the home-care and the nursing-home infrastructure, the number of care workers in home care rose from 183,782 in 1999 to 390,322 in 2017 and in nursing homes from 440,940 in 1999 to 764,648 in 2017 (Federal Statistical Office 2001, 2018). This growth was accompanied by an increase in relative size of the for-profit sector, which accounted for 36 per cent of care workers in home-care services in 1999 rising to 56 per cent in 2017 and 24 per cent of care workers in nursing-home services in 1999 rising to 36 per cent in 2017. This increase in the number of care workers was followed by a vast increase in the proportion of part-time work. In 2017, only 29 per cent of home-care workers and 31 per cent of care workers in nursing homes were employed on a full-time basis (Federal Statistical Office 2001, 2018).

PART-TIME WORK AND ITS EFFECTS

Part-time work arrangements with lower social security standards (marginal part-time work respectively mini-jobs) accounted for 18 per cent of home-care workers and 9 per cent of care workers in nursing homes in 2017 (Federal Statistical Office 2018). Marginal part-time work encompasses employment contracts with defined working hours and wages of up to €450 per month, as well as temporary employment. This type of employment does not include mandatory LTCI or unemployment insurance and includes only limited healthcare insurance rights, without insurance-based sickness benefits. However, as with all employees, individuals in mini-job arrangements have the right to sick pay paid by the employer for the first six weeks. In Germany, there are no waiting days.

With regard to the use of marginal part-time work, considerable differences exist between providers. The proportion of marginal part-time work among care workers is 20 per cent in for-profit home-care services compared with 16 per cent in non-profit and public provision. Among care workers in nursing homes, the proportion is 11 per cent in for-profit provision as compared to 8 per cent in non-profit and 5 per cent in public provision (Federal Statistical Office 2018). The maximum proportion of care workers employed on marginal part time contracts is regulated by the regional framework contracts which regulate access to the care market. Marginal part-time work is particularly relevant for low-skilled care workers. In 2012, 23 per cent of elder carers and 32 per cent of elder care assistants – the most relevant groups among care workers in home-care services and nursing homes – were employed on fixed-term contracts (Bispinck et al. 2013) (for more information on the types of training, see below). Part-time work can be offered to accommodate family responsibilities, but marginal part-time work and fixed-term employment arrangements are particularly often used to rationalise care-work activities, for example extra personpower in the morning or evening when demand for bodily care services is greatest.

In contrast, agency and temporary work is not widespread in Germany. According to a representative survey of home-care services in 2015, 9 per cent of providers used agencies on a regular basis (Isfort et al. 2016). According to a representative survey of managers in nursing homes in 2017, 21 per cent cooperated with agencies, but the number of care workers involved was very limited. When care workers must be replaced temporarily (for example due to illness), permanent staff typically do paid overtime. Research findings demonstrate care workers' dissatisfaction with the impact of these arrangements on their leisure time (Isfort et al. 2018).

THE TRAINING LEVEL OF CARE STAFF

In 2017, the home care sector was dominated by staff who had completed three years of vocational training. 48 per cent of care workers had completed three-year vocational training as a nurse or an elder carer (the latter a more social care–oriented programme), and a further 8 per cent had completed a distinct vocational training programme in the field. 10 per cent of home-care workers were assistant nurses or elder care assistants with one to two years of vocational training, while 31 per cent had completed no or only short care-related training programmes (Federal Statistical Office 2018). This mixture of skill levels was caused by the integrated provision of nursing care and long-term care (mainly bodily care) in home-care delivery (see above). Nursing services are provided mainly by nurses or elder carers and can only rarely be delegated to other care staff. Bodily care is a qualified activity that must be conducted by skilled care staff – nurses or elder carers – or under their guidance. The specific mix of care staff is based on regulations under the regional framework contracts. The availability of the required mix of care staff must be demonstrated during accreditation process. The proportion of staff with a BA in nursing is small, less than 1 per cent of all employees in the sector. These individuals are mainly employed in expert or managerial positions. In 2017, 45 per cent of direct-care staff in nursing homes had completed three years of vocational training as an elder carer or nurse, 9 per cent had completed vocational training as a nurse or an elder-care assistant in a one- to two-year programme, and 36 per cent of care workers had completed only shorter care-related training or none at all (Federal Statistical Office 2018). In 2008, a new, short training programme ori-

ented towards social activities and supervision was introduced. In 2017, 56 per cent of care workers involved in supervision activities had completed only this short training programme. In the nursing-home sector, the proportion of care staff who have completed a nursing programme was low (less than 1 percent (0.5) of staff in the entire sector) and mainly relevant in managerial and expert positions.

The training levels are based on the legal requirements for 50 % of care workers involved in direct care tasks (mainly bodily care activities and supervision) to have completed at least a three-year vocational training programme, normally as an elder carer or nurse. In terms of full-time equivalents, this 50 % quota has been achieved. The situation and trend in both home-care services and nursing homes have been criticised: first, for the low level of training that is viewed as sufficient for supervision and social activities, second, for the considerable proportion of care workers who have completed only short care training programmes, and third, for the low proportion of care staff who have completed BA nursing programmes.

THE SHORTAGE OF SKILLED CARE WORKERS AND ITS EFFECTS

The definition of care work as a qualified activity fosters a demand for skilled care staff, i.e. care workers who have completed a three-year vocational training programme in nursing or elder care. Yet the difficult working, employment, and training conditions render the activity unattractive. This finding is reflected in the increasing shortage of labour for skilled care staff positions since 2010. Several studies have found multiple obstacles to recruiting and retaining staff: low staffing levels, high psychological and physiological burdens of daily care work, general dissatisfaction with the opportunities to provide high-quality care, and low pay (Schmucker 2020).

A number of reforms to improve training, staffing levels, and pay are planned or already enacted (for the trade union perspective on the reforms see below). Since 2012, active labour market policy measures have been successfully introduced to enable access to the three-year vocational training programme in elder care for low-skilled carers who are already working in the field. The Care Professions Act (Pflegeberufereform) introduced in January 2020 unified the separate vocational training programmes in nursing and elder care within a single three-year vocational training programme, which should render the programme more attractive. In addition, new BA study programmes in nursing care have been established at universities of applied science.

Numerous studies have revealed that the number of care staff in nursing homes is too low. Moreover, staffing regulations, which are defined at federal state level in the regional framework contracts, differ considerably and are not defined on the basis of solid research. As a part of the LTCI reform in 2018, an evidence-based national standard procedure for defining staffing levels in nursing homes was supposed to be established. Related research showed that the number of care workers needs to be increased significantly and that this could also be achieved by significantly increasing the number of low-skilled care workers who have not completed a three-year vocational training programme (see Rothgang, Fünfstück et al. 2020). Under this concept, nurses and elder carers are expected to be less involved in daily care provision and more responsible for the organisation and delegation of care work. Moreover, the general quota of 50 per cent skilled care workers is set to be abolished and replaced by an individual quota oriented on the care needs of individual facilities. While the demand for more care staff has been welcomed, the proposal to increase the number of low-skilled care workers and to replace the general 50 per cent quota with individual quotas has been controversial. In the long run, the proposal would lead to a devaluation of some elements of daily care work and risk eliminating the skilled worker quota at the level of individual facilities. Despite this criticism, the Care Improvement Law (Pflegeverbesserungsgesetz), which came into effect in January 2021, aims to create and finance 20,000 new positions for low-skilled care workers as one step in the implementation of the national standard procedure for defining staffing levels in nursing homes.

MEASURES TO RAISE PAY

Final reforms will tackle the low pay in home care and nursing homes and the vast differences between regions, providers, and sectors (home care and nursing home services) (Greß/Stegmüller 2019). According to the Bundesagentur für Arbeit (2020), gross pay for elder carers lies between €2,613 and €3,506 per month (median: €3,032), and for elder care assistants between €1,913 and €2,642 per month (median: €2,146). The low pay levels and the differentials stem from the lack of collective agreements and the fragmented nature of those that do exist. The lack of collective agreements affects mainly for-profit providers (only 16 per cent of which have established collective agreements). In contrast, 81 per cent of public/non-profit providers participate in various collective agreements (Schroeder 2017).

Two measures have been introduced to raise pay and counteract the differentials. In 2010, a statutory care minimum wage (Pflegemindestlohn) was established to secure a minimum wage mainly for low-skilled care workers who conduct personal care tasks (bodily care and – since 2015 – also social activities and supervision). The minimum hourly wage was set in 2010 at €8.50 in former West Germany and €7.50 in former East Germany. In 2020, it was decided that the minimum wage will rise in three steps to reach €12.55 in April 2022 in both Western and Eastern Germany. Beginning in 2021 a separate minimum wage scheme was established to secure minimum wages based on training levels; i.e. for care assistants (one to two years of vocational training) and skilled care workers (three years of vocational training). Pay will rise in two steps to reach to reach €13.20 for care assistants and €15.40 for skilled care workers by April 2022 in both Eastern and Western Germany. Parallel to this reform to the minimum wage scheme,

a preliminary collective agreement has already been negotiated between the trade union (Ver.di) and selected employers' associations in the elder care sector.

2 ELDER CARE SERVICES AND COVID-19

2.1 MARCH-AUGUST 2020 – INFECTION RATES, MORTALITY, AND POLICIES

The first case of COVID-19 in Germany was confirmed at the end of January 2020 in Munich, Bavaria. By the end of February, multiple cases had been confirmed in North Rhine Westphalia and Baden-Württemberg. From the beginning of March, the number of confirmed cases of infection per week rose substantially, particularly during the second half of March. The number of confirmed infections reached its peak of 36,100 cases per week at the end of March, followed by a considerable decline to 7,400 cases per week at the end of April. The number of confirmed cases continued to decline more gradually and reached a new low of 3,200 per week at the end of May. Until mid-July the figure fluctuated between 2,000 and 3,000 per week, with one outlier caused by an outbreak in a meat-processing company. A gradual increase began at the end of the summer, with the number of confirmed cases rising to 8,600 per week at the end of August (RKI 2020a).

The high mortality and severe courses of the illness for older people as well as outbreaks in nursing homes in March and April revealed that older people and especially nursing home residents were particularly vulnerable (Buda et al. 2020). The rate of confirmed cases in nursing homes has closely paralleled the course of the pandemic as a whole. An increased infection rate in nursing homes was seen in March, with an exponential increase and peak following one week behind the general trend. The decline in confirmed infections and the stable phase of low levels of transmission among the residents in nursing homes correlated strongly with the national infection rates as a whole. An increase in the number of outbreaks in nursing homes began again in the middle of September, somewhat later than the increase in the overall number of infections at the end of August (RKI 2020a).

Between 1 March and 31 August 2020, 242,381 cases were confirmed (292 per 100,000 population, 51 per cent female). The average age of those infected was 46 years. 9,298 (11 per 100,000 population) of those infected died from or with COVID-19. Those who died from or with COVID-19 were more often male (55 per cent) and older, with an average age of 81 years. 85 per cent of those who died were 70 years or older, yet only 16 per cent of all individuals infected with COVID-19 were 70 years or older (RKI 2020b). In a comparison of mortality rates based on federal statistics in 2016 and 2020, Nowossadeck (2020) analysed mortality rate in Germany by calendar week. He found an increased mortality rate only for people aged 65 years and older in weeks 11–18 (9 March – 3 May), with a peak in weeks 14 and 15 (30 March – 12 April). He calculated a death rate for those 65 and older of 90.6 per 100,000 population in 2016 and of 96.6 in 2020.

Initially, in February 2020, a local containment strategy was used to minimise the expansion of clusters. From mid-March country-wide measures were introduced to counteract the pandemic. A "shutdown of society" agreed between the federal government and the federal states entailed the closure of day-care and schools, restaurants, and non-essential shops. Strict restrictions were placed on personal contacts outside the household. Another policy focus was efforts to change people's behaviour ("to create a new normal"). New regulations entailed maintaining physical distance between people (social distancing) and specific hygiene rules. From the end of April onwards, the wearing of a non-medical face mask was mandated in situations where physical distancing was difficult or impossible (in public transport, shops and public buildings). Restrictions were gradually eased from the end of April as infection rates declined but not abolished entirely until the end of August.

More specific measures applying to elder care and especially to nursing homes were introduced at state level in an effort to stop the numerous outbreaks in nursing homes and the associated high death rates. Visits and admissions to nursing homes were banned and day-care facilities were closed (with exemptions for emergency provision). These restrictions were not eased until the end of May, when the ban on visiting nursing homes and the closure of day-care services were gradually eased under the premise that the facilities had to develop clear hygiene measures and visitor plans. A number of measures were introduced to support organisations and care workers in the difficult situation. The Hospital Relief Law (Krankenhausentlastungsgesetz) provided financial support for care facilities to cover increased costs (such as very expensive personal protective equipment). Care workers in nursing homes received a bonus for their increased workload during the pandemic.

2.2 COVID-19 and the Elder Care Sector

ELDER CARE SECTOR HIT HARD

The elder care sector was particularly severely affected by the pandemic. Statistics from the RKI (Robert-Koch-Institut, Germany's national public health institute) covering the period between March and August 2020 revealed the impact of COVID-19 in nursing homes: 18 per cent of infected nursing home residents were taken to hospital. A comparison of different settings showed that case fatality rates were highest in nursing homes (where 19 per cent of those infected died), followed by day-care facilities (16 per cent) (Buda et al. 2020). In a representative online survey of nursing homes, home care providers, and day-care facilities conducted between 28 April and 2 May (at the end of the first wave), Wolf-Ostermann and Rothgang (2020) found that 12 per cent of nursing homes had reported a COVID-19 outbreak among residents, with 6 per cent reporting that residents had died. Confirmed COVID-19 infections were even more prevalent among home care users, with 17 per cent of home care providers reporting having had at least one user infected with the virus and 8 per

cent reporting that at least one of their users had died either of or with the illness. Based on their research Wolf-Ostermann and Rothgang (2020) calculated that more than 60 per cent of cases of death related to COVID-19 in Germany concerned the users of elder care services; i.e. users of nursing home services (49 % of cases of death) and home care services (12 % of cases of death). In addition, with a share of 19 per cent among care workers in residential care facilities and 9 per cent among home care workers infected by COVID-19, the rate of infection among home care workers was double the average for the population as a whole, among care workers in nursing homes it was six times the average. Due to the closure of day-care facilities, rates there were low: Only 4 per cent of providers reported infections among users, and only 3 per cent of providers reported infections among care staff (for information on day-care services, see Wolf-Ostermann et al. 2020).

In their survey of home care, day care, and nursing home providers, Wolf-Ostermann, Rothgang, and colleagues also investigated the situation of care provision in greater detail (see Rothgang, Wolf-Ostermann et al. 2020; Wolf-Ostermann/Rothgang 2020; Wolf-Ostermann et al. 2020) and found similarities as well as differences in developments between the different types of elder care provision. In addition to the required modifications of care provision within the organisations, day-care and home care providers were concerned about the closure of their facilities and about the decline in service demand due to the pandemic. 60 per cent of day-care facilities that participated in the online investigation had been closed by their federal state authorities. 32 per cent of providers reported having used short-time working in order to maintain their staff. The difference between the proportion of closed facilities (60 per cent) and the proportion of providers using short-term working compensation (32 per cent) can probably be explained by other public support measures. The Hospital Relief Law (Krankenhausentlastungsgesetz) provided public financial support to temporarily employ day-care staff in other types of facilities (for example in nursing homes). About 40 per cent of home-care providers reported demand for services, with 9 per cent using short-term working.

LACK OF PREPARATION FOR PANDEMIC

Wolf-Ostermann, Rothgang and colleagues identify basic problems and challenges in care provision (Wolf-Ostermann/Rothgang 2020; Wolf-Ostermann et al. 2020). Almost all providers reported that their care training or studies had not adequately prepared them for the challenges of a pandemic. They established internal protocols, crisis teams and strategies to implement hygiene procedures and reduce social contacts in nursing homes and day care facilities. The implementation of hygiene procedures was impeded by a shortage of personal protective equipment (PPE) and surface disinfectants. During the initial phase of the pandemic, the shortage of PPE was widespread and affected about half of nursing homes and home-care providers and one-quarter of day-care facilities. When the survey was conducted at the end of April and beginning of May 2020, 25 per cent of home care service providers, 17 per cent of nursing homes, and three per cent of day-care facilities reported this problem.

Appropriate use of hygiene procedures and PPE requires profound knowledge. Based on a mixed-methods approach that combined a problem-focused interview, focus groups, and an online survey, Evans and colleagues (2020) questioned eighty decision makers involved in home-care and nursing home services in North-Rhine Westphalia about their challenges and coping strategies. The interviewed experts stated that their existing competence in hygiene procedures had played a large role in the care organisations. Wolf-Ostermann and colleagues (2020) found that 91 per cent of nursing homes and 73 per cent of home-care providers had conducted in-house video training sessions of one to two hours on hygiene procedures or the use of PPE. They found that training had been conducted much less frequently in nursing homes where infections occurred among residents.

Approaches aimed at reducing social contacts have been particularly relevant in nursing homes (see Wolf-Ostermann et al. 2020, Rothgang, Wolf-Ostermann et al. (2020). Under state-level legal instruments, nursing homes implemented strict measures to reduce contacts with the outside world up to the end of May. About 90 % strictly restricted the admittance of volunteers (who typically provide important social activities in German nursing homes), and visitors (family) were either entirely prohibited or allowed only in exceptional circumstances. Even access by external providers was strictly restricted. These measures reflect basic dilemmas in nursing homes: On the one hand, restricting social contacts is viewed as significant for reducing the spread of the virus, on the other hand, leads to social isolation and often mental health problems.

PREPARING THE ELDER CARE SECTOR FOR THE FUTURE

In addition to the challenge of tackling the COVID-19 pandemic and counteracting the negative consequences of the measures taken (e.g. reducing social contact), providers have also been affected by staff shortages due to infections and quarantining (see Rothgang, Wolf-Ostermann et al. 2020; Wolf-Ostermann et al. 2020). Nursing homes have been particularly severely affected, with 70 % reporting staff shortages. On average, the shortfall involved 5 per cent of care staff (Rothgang, Wolf-Ostermann et al. 2020). In order to cope with the shortages, nursing homes and home-care providers have used internal staff management measures, such as transferring care workers between different groups, increasing working hours, and introducing bonus payments. The use of agency or temporary work was rarely reported. All types of provider indicated that considerable amounts of additional work had to be carried out by care workers in order to cope with the increasing demands of daily care work (including increased supervision of activities to compensate for the loss of support by family members and volunteers and demands of hygiene proce-

dures) and the increased demands caused by staff shortages. For nursing homes, managers calculated an average additional workload of about one hour per shift and care worker. Day care facilities reported an increased workload of 85 minutes per shift per care worker, and home-care providers calculated an average increase of about 40 minutes per shift and care worker. In the study by Evans and colleagues (2020), managers emphasised that the high level of commitment and team spirit among care workers had been a significant precondition for coping with the situation. For the future, the participants of both studies demanded 1) more care staff, higher wages, and more training, especially in hygiene procedures; 2) new strategies for the availability (storage) and distribution of PPE; 3) the involvement of managers in local decision-making; and 4) the development of recommendations for hygiene procedures and visiting plans that allow visitors, volunteers, and external providers to enter the facilities without increasing the risk of infection in order to counteract the risks of social isolation for residents and the related mental-health problems.

3 THE TRADE UNION PERSPECTIVE[1]

Employees in both elder care and nursing care are organised by Ver.di (United Services Union). Ver.di was founded in 2001 through the merger of various trade unions, including the public service union ÖTV. While nursing care was organised early on within the ÖTV framework, elder care was not added as an independent branch until the late 1980s. This branch grew in importance with the introduction of LTCI and the resulting significant increase in the number of employees. The level of unionisation in the elder care sector is low, at 12 per cent among care workers in 2015 (Schroeder 2017).

The activities of Ver.di to meet the challenges of the pandemic can be divided into three categories – policy reforms to improve the situation in the elder care sector in general, activities related directly to the pandemic in Germany and activities on the European level. Ver.di has pushed three major reforms in the German elder care sector, which in the long run are important to strengthen the capacity of the sector – via increasing staff levels, enhancing training and qualification and raising wages – to meet the challenges of the current and future pandemics.

NATIONAL STANDARD PROCEDURE FOR DEFINING STAFFING LEVELS IN NURSING HOME

Ver.di calls for the introduction of an evidence-based national standard procedure for defining adequate staffing levels in nursing homes, and regards the current proposal only as an interim compromise. The general acceptance of a nationwide standard procedure and the willingness to employ more personnel are regarded as positive. In contrast, the goal to increase staffing levels by employing less qualified care assistants and the possible abolition of the general 50 % skilled worker quota in nursing homes are regarded as negative.

CARE PROFESSIONS ACT

The Care Professions Act merged the separate vocational training schemes for nurses and elder carers to enhance training levels in the elder care sector and increase the attractiveness of elder care work. In the course of the reform process Ver.di felt it was particularly important to ensure that possible specialisations in the third year – e.g. towards elder care – could be formalised by no later than 2025.

STATUTORY CARE MINIMUM WAGE SCHEME AND GENERAL WAGE AGREEMENT FOR THE SECTOR

Due to the very difficult situation in the sector, the introduction of a statutory care minimum wage scheme is regarded as an important first step. However, the main aim is to win higher pay levels through the introduction of a general pay agreement for the elder care sector. Negotiations between Ver.di and selected federal and regional employers' associations have yielded a preliminary result that serves as the basis for negotiations with other employers' associations.

According to Dietmar Erdmeier, expert on European health policy at Ver.di (Berlin), healthcare and elder care workers contribute enormously to managing the pandemic. The greatest possible effort is needed from everyone in order to maintain conditions that enable employees to continue their work without endangering their health. In the course of the pandemic, Ver.di has dealt with labour law issues and thus contributed to reducing the risk of infections at the workplace. COVID-19 has already been recognised as an occupational illness in Germany. In the case of occupational illness, all necessary measures must be taken via coordination between employees and employers in order to enable the employee to return to work. Moreover, the costs of medical treatment must be covered, a pension must be paid in the event of a permanent reduction in earning capacity, and a survivors' pension must be paid in the event of death. Ver.di's central demands are:

- sufficiently qualified personnel, verified and enforced by the responsible supervisory authorities.
- necessary protective equipment and organised instruction from company physicians or safety and hygiene specialists.
- substantially improved working conditions, clearly acknowledging the social partnership with good pay and conditions agreements, workloads reduced, and health and safety secured.

1 This section draws on interviews with representatives of the trade union Ver.di, Dietmar Erdmeier, Expert on European Health Policy and Axel Weinsberg, Expert on Tariff Policy at Ver.di's head office in Berlin and two texts written by Dietmar Erdmeier.

CENTRAL POLICY DEMANDS ON THE EUROPEAN LEVEL

The European Union cannot afford to have underfunded and poorly equipped national healthcare and elder care systems. The spending caps resulting both from austerity policies and from the disciplined expenditure of recent years have significantly widened the gap between resources and the growing need for care in some countries – with fatal consequences. The member states must act together to tackle the crisis. The EU thus plays a crucial role in supporting and coordinating national healthcare systems and in promoting cooperation. In this context, we call for equal access to quality-assured healthcare for all Europeans. No one should be excluded from receiving healthcare or (nursing) care due to poverty. The EU Commission must be supported on the issue of close cooperation between the member states in order to establish minimum standards for healthcare based on reliable and needs-oriented care structures. A corresponding binding directive must be adopted, and the EU Health Union must comply with this directive. The EU must live up to its responsibility for coordination when it comes to reacting to any serious health threats. The member states must provide strong support for the rapid establishment of a common reserve of protective equipment, vaccines, and medicines as well as for the organisation of their fair distribution.

In concrete terms, regarding occupational and health protection throughout Europe, this means:

- recognising COVID-19 as an occupational illness;
- mandatory implementation of the EU guidelines for psychosocial risks, Framework Directive 89/391/EEC;
- mandatory application of administrative controls; sanctions to be imposed in case of non-compliance with occupational health- and safety regulations;
- strengthening public health and social services;
- introducing legally based personnel-assessment systems;
- providing adequate, needs-based financing of healthcare systems to ensure that no expense is spared in occupational health and safety.

4 CONCLUSION

During the first wave of the pandemic in Germany, the number of confirmed infections and the mortality rate increased rapidly and exponentially from the middle of March until the first half of April. Older adults, persons needing care and the professional elder care services were particularly affected. Professional care service providers were not prepared for the situation, and lacked adequate knowledge and sufficient stocks of PPE and surface disinfectants. The shutdown of significant parts of society and policies towards elder care services (e.g. ban on visitors, ban on admission of new residents, and closure of day-care services) can be viewed as necessary measures taken to significantly reduce infection rates and to enable elder care services to adapt their operations to the new situation. However, these measures had negative effects on residents and home care users in terms of the quality of care, as well as negative effects for care workers.

In order to successfully adapt at the organisational level, sufficient care staff with broad care skills must be available, as well as sufficient stocks of PPE and surface disinfectant, targeted training in hygiene procedures, sickness payments that enable care workers to stay at home should they develop symptoms, and a stable work force (which can both reduce the risk of infections caused by staff fluctuation and foster team spirit). Some positive findings for the German elder care system have also been identified: About half of the care workers have completed a three-year vocational training programme, use of agency work is negligible, sickness payments are available for care workers (however for marginal part-time work only during the first period of illness), and the team spirit of care workers has often remained high. Activities of the trade union Ver.di contribute to the reduction of the risk of infections in care facilities.

Throughout the course of the pandemic, the shortcomings of the German elder care system have become clearly visible. One of these is the low staffing level in nursing homes, which impedes care workers' ability to provide good-quality care and to counteract the negative effects of the pandemic in the everyday life of the residents. Increasing staff shortages due to infections and increasing care burdens have resulted in high additional workloads for care workers. Marginal part-time workers face additional burdens, such as sickness payments only for the first six weeks of an illness despite the increased risk of infections in care work. Furthermore, if a care facility is closed or the demand for home-care provision reduced, short-time working and unemployment benefits are not available to them because they are not included in the mandatory unemployment insurance scheme. Since August, the rates of confirmed infections have gradually risen again followed by an exponential increase since mid-October. This second wave reached its peak around Christmas, and has been associated with numerous outbreaks in nursing homes and strongly increasing mortality rates. Since February the figures have fallen sharply again. The second wave hit Germany much harder than the first wave. By the end of February 2021, 2,248,400 cases had been confirmed and 70,045 people had died from or with COVID-19 (RKI 2021c, d). This compares with 242,381 confirmed cases and 9,298 deaths by the end of August.

REFERENCES

Bispinck, Reinhard; Dribbusch, Heiner; Öz, Fikret; Stoll, Evelyn (2013): Einkommens- und Arbeitsbedingungen in Pflegeberufen: Eine Analyse auf Basis der WSI-Lohnspiegel-Datenbank, Düsseldorf: Hans-Böckler-Stiftung.

Buda, Silke; an der Heiden, Matthias; Altmann, Doris; Diercke, Michaela; Hamouda, Osamah; Rexroth, Ute (2020): Infektionsumfeld von erfassten COVID-19-Ausbrüchen in Deutschland, in: Epidemiologisches Bulletin 38, p. 3–12.

Bundesagentur für Arbeit (2020): Entgeltatlas, Nuremberg.

Evans, Michaela; Becka, Denise; Schmidt, Christopher; Weigel, Roland (2020): Was sind erste Lehren aus der Corona-Krise für die Altenpflege? Ergebnisse einer Ad-hoc Studie zur Perspektive der Entscheider, Folienvortrag im Rahmen der Ruhrgebietskonferenz Pflege, 23 June 2020, Essen.

Federal Ministry of Health (2020): Finanzentwicklung der sozialen Pflegeversicherung, Berlin.

Federal Statistical Office (2001, 2003, 2018): Care statistics 1999, 2001, 2017, Wiesbaden.

Federal Statistical Office (2020): Angaben zu Ausgaben: Hilfe zur Pflege 2019, Wiesbaden.

Greß, Stefan; Stegmüller, Klaus (2020): Vergütung von Pflegekräften in der Langzeitpflege, in: Klaus, Jakobs; Kuhlmey, Adelheid; Greß, Stefan; Klauber, Jürgen; Schwinger, Antje (eds.): Pflegereport 2019: Mehr Personal in der Langzeitpflege – aber woher?, Stuttgart, pp. 159f.

Hielscher, Volker; Kirchen-Peters, Sabine; Nock, Lukas (2017): Pflege in den eigenen vier Wänden: Zeitaufwand und Kosten. Pflegeangehörige und ihre Angehörigen geben Auskunft, no. 363, Düsseldorf: Hans-Böckler-Stiftung.

Isfort, Michael; Rottländer, Ruth; Weidner, Frank; Tucman, Daniel; Gehlen, Dany; Hylla, Jonas (2016): Pflege-Thermometer 2016: Eine bundesweite Befragung von Leitungskräften zur Situation der Pflege und Patientenversorgung in der ambulanten Pflege, Cologne: Institut für angewandte Pflegeforschung.

Isfort, Michael; Rottländer, Ruth; Weidner, Frank; Gehlen Dany; Hylla, Jonas; Tucman, Daniel 2018: Pflege-Thermometer (2018): Eine bundesweite Befragung von Leitungskräften zur Situation der Pflege und Patientenversorgung in der stationären Langzeitpflege in Deutschland, Cologne: Institut für angewandte Pflegeforschung.

Klie, Thomas; Heislbetz, Claus; Schumacher, Birgit; Keilhauer, Anne; Rischard, Pablo; Bruker, Christine (2017): Ambulant betreute Wohngruppen: Bestandserhebung, qualitative Erhebung und Handlungsempfehlungen, Abschlussbericht, Berlin: Bundesministerium für Gesundheit.

Kremer-Preiß, Ursula; Mehnert, Thorsten; Klemm, Britta (2019): Betreutes Seniorenwohnen: Entwicklungsstand und Anforderungen an eine zukunftsgerechte Weiterentwicklung, Ergebnisse einer empirischen Studie, Heidelberg: medhochzwei.

Nowossadeck, Enno (2020): Sterblichkeit Älterer während der COVID-19 Pandemie in den ersten Monaten des Jahres 2020: Gab es Nord-Süd Unterschiede?, in: Journal of Health Monitoring 5 (59). DOI: 10.25646/7060.

RKI (2020a): Daily situation report October 27, Berlin.

RKI (2020b): Daily situation report August 31, Berlin.

RKI (2021c): RKI Täglicher Lagebericht, February 23, Berlin.

RKI (2021d): Daily situation report, February 28, Berlin.

Rothgang, Heinz; Müller, Rainer (2018): Pflegereport 2018. Schriftenreihe zur Gesundheitsanalyse vol.12., Berlin: Barmer.

Rothgang, Heinz; Domhoff, Dominik (2019): Die Pflegebürgerversicherung als Vollversicherung: Beitragssatz- und Verteilungseffekte bei Umwandlung der Pflegeversicherung in eine Bürgerversicherung mit Vollversicherung, Working Paper Forschungsförderung 150, Düsseldorf: Hans-Böckler-Stiftung.

Rothgang, Heinz; Fünfstück, Mathias; Kalwitzki, Thomas (2020): Personalbemessung in der Langzeitpflege, in: Klaus Jacobs; Kuhlmey, Adelheid; Greß, Stefan; Klauber, Jürgen; Schwinger, Antje (eds.): Pflegereport 2019: Mehr Personal in der Langzeitpflege – aber woher?, Berlin: Springer-Verlag, pp. 147f.

Rothgang Heinz; Wolf-Ostermann, Karin; Domhoff, Dominik; Friedrich, Anna Carina; Heinze, Franziska; Preuss, Benedikt; Schmidt, Annika; Seibert, Kathrin; Stolle, Claudia (2020): Care Homes and Covid-19: Results of an Online Survey in Germany, LTCcovid, International Long-Term Care Policy Network, CPEC-LSE, 7 July 2020.

Scheuplein, Christoph; Evans, Michaela; Merkel, Sebastian (2019): Übernahmen durch Private Equity im deutschen Gesundheitssektor: Eine Zwischenbilanz für die Jahre 2013 bis 2018, IAT Discussion Papers 19 (1).

Schmucker, Rolf (2020): Arbeitsbedingungen in Pflegeberufen: Ergebnisse einer Sonderauswertung zum DGB-Index Gute Arbeit, in: Klaus Jacobs; Kuhlmey, Adelheid; Greß, Stefan; Klauber, Jürgen; Schwinger, Antje (eds.): Pflegereport 2019: Mehr Personal in der Langzeitpflege – aber woher?, Stuttgart, pp. 49f.

Schroeder, Wolfgang; Ludwig, Christine; Schreiter, Benedikt; Steinmüller, Florian; D'Antonio, Oliver; Futh, Sascha Kristin; Pollner, Katarina (2017): Kollektives Beschäftigtenhandeln in der Altenpflege, no. 373, Düsseldorf: Hans-Böckler-Stiftung.

Schwinger, Antje; Jürchott, Kathrin; Tsiasioti, Chrysanthi (2017): Pflegebedürftigkeit in Deutschland, in: Klaus Jacobs; Kuhlmey, Adelheid; Greß, Stefan; Klauber, Jürgen; Schwinger, Antje (eds.): Pflege Report 2017: Die Versorgung der Pflegebedürftigen, Stuttgart, pp. 255f.

Theobald, Hildegard (2011): Long-term Care Insurance in Germany: Assessments, Benefits, Care Arrangements and Funding, Working paper, Stockholm: Institute for Future Studies.

Wolf-Ostermann, Karin and Rothgang, Heinz (2020): Pflege in Zeiten von Corona, in: Carekonkret, 25 (2).

Wolf-Ostermann, Karin; Rothgang, Heinz; Domhoff, Dominik; Friedrich, Anna Carina; Heinze, Franziska; Preuss, Benedikt; Schmidt, Annika; Seibert, Kathrin; Stolle, Claudia (2020): Zur Situation in der Langzeitpflege in Deutschland während der Corona-Pandemie, Universität Bremen.

Ver.di has contributed to recommendations for care workers and elder care providers:
– https://www.bgw-online.de/DE/Home/Branchen/News/Coronavirus_node.html

Ver.di statements on the pandemic:
– https://gesundheit-soziales.verdi.de/coronavirus

Ver.di statements on the situation in elder care:
– https://gesundheit-soziales.verdi.de/mein-arbeitsplatz/altenpflege/++co++f1eee3ac-b912- 11e9-944d-525400f67940

Ver.di statements on the situation in hospitals:
– https://gesundheit-soziales.verdi.de/mein-arbeitsplatz/krankenhaus/++co++ea26c55e-e39b 11ea-b41a-001a4a160100

Ver.di statements on a European perspective:
– https://gesundheit-soziales.verdi.de/themen/arbeit-in-europa/++co++b2985054-f35d-11ea 9ed1-001a4a160119
– https://gesundheit-soziales.verdi.de/coronavirus/++co++7d5ee758-1915-11eb-9241- 001a4a160117
– https://gesundheit-soziales.verdi.de/themen/gesundheitspolitik/++co++4fc8fd6e-1222-11eb b045-001a4a160119

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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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