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Migrant carers in Europe in times of COVID-19: a call to action for European health workforce governance and a public health approach

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The present study explores the situation of migrant carers in long-term care (LTC) in European Union Member States and the disruptions caused by the COVID-19 pandemic from a public health perspective. The aim is to bring LTC migrant carers into health workforce research and highlight a need for trans-sectoral and European heath workforce governance. We apply an exploratory approach based on secondary sources, document analysis and expert information. A framework comprising four major dimensions was developed for data collection and analysis: LTC system, LTC health labour market, LTC labour migration policies and specific LTC migrant carer policies during the COVID-19 crisis March to May 2020. Material from Austria, Italy, Germany, Poland and Romania was included in the study. Results suggest that undersupply of carers coupled with cash benefits and a culture of family responsibility may result in high inflows of migrant carers, who are channelled in low-level positions or the informal care sector. COVID-19 made the fragile labour market arrangements of migrant carers visible, which may create new health risks for both the individual carer and the population. Two important policy recommendations are emerging: to include LTC migrant carers more systematically in public health and health workforce research and to develop European health workforce governance which connects health system needs, health labour markets and the individual migrant carers.

Introduction

The idea for this study first came up in 2018/19, when Europe was heavily debating over migration policies and refugees. Populist movements were on the increase, creating public health risks and hostile social environments for migrant carers.[1,2] This was the theme of a workshop organized at the EPH Conference in Marseille in 2019, which aimed to illustrate that the migrant/mobile health workforce in the European Union (EU) Member States makes an essential contribution to universal healthcare coverage (UHC) and the functioning of health systems, in particular in high-income Member States.[3]

During this workshop, the focus on macro-level labour market analysis was identified as an important shortfall of contemporary health workforce analysis and policy frameworks, which ignore the human being behind every healthcare worker who has individual preferences, needs and demands. Thus, advocacy for a 'human face' in health workforce research in Europe was emerging as a major goal of public health-based health workforce research. A further important conclusion drawn from the EPH conference workshop was that migration and mobility flows are strongest, and governance is weakest, in the long-term care (LTC) sector. It should be noted that, being EU citizens, the migrant carers enjoy free movement and might therefore better be described as 'mobile' carers; we use these terms interchangeable.[4]

The LTC sector, and specifically migrant carers have been largely ignored in public health research and health workforce analysis.[5–9] Useful information is available from social policy and feminist/gender research. Scholarly debate has emphasized the complexity of governance beyond the institutions of the (welfare) state, like the law, the funding schemes, and the service delivery and organization. Moreover, LTC policy is strongly shaped by gender regimes, family arrangements and cultural values. The LTC care workforce is thus positioned in-between different modes of governing and policy players with potentially contradictory interests. A problematic labour market position is reinforced through a strongly sex-segregated health labour market and gender hierarchy in LTC, which put women and caring at the bottom.[10–17]

Research reveals that, for many reasons, LTC migrant carers are most in need of integrated, trans-sectoral health workforce governance informed by public health ('trans-sectoral' serves our research as an umbrella term to highlight the novel dimension of multi-, inter- and cross-sectoral governance efforts).[18,19] LTC carers are working at the interface of health and social care, formal and informal sectors and public and private arrangements[10,12,14] where low-wage policies create hostile labour market condition for carers, most of whom are women.[13] In the case of migrant carers, problematic labour market conditions may be reinforced through exclusionary migration policies and hostile social environments caused by radical right-wing populist movements.[2] From a labour market perspective, LTC carers are often included in the category of 'home helpers', which is much broader than healthcare staff.[20] They are not monitored by occupation, although many of them even have a

professional qualification.[14] Indeed, the migrant carers are the 'hybrids' of health labour markets and service sectors and may therefore challenge health workforce governance and planning models based on national, sectoral and professional borders. However, the hybrid position of migrant carers not only raises technical challenges, but embodies real-life risks for the frontline carers and for service delivery.

The COVID-19 pandemic has created the strongest ever global 'stress test' for the health workforce governance and has demonstrated that migrant care arrangements can easily collapse. It has suddenly disrupted these care arrangements at a time, where they were most needed. Older people generally have a higher risk of dying of COVID-19, but biological risks are reinforced by system-based failures, as COVID-19 turned residential homes into pandemic hotspots.[21] This was, and still is a problem in many countries, including high-income EU countries.

The pandemic raises questions on the effectiveness and resilience of LTC labour market policies in the EU. It reminds public health researchers that care for patients needs care for the health workforce.[3,22] Most importantly, it also reminds us that 'leaving no one behind' must include the migrant carers. There is an urgent need for improving data and establishing a health workforce monitoring system, which includes migrant carers (it should be noted that the European Commission and OECD are currently taking steps to improve data sources).[14,23]

The present study explores the situation of migrant carers in LTC in EU Member States and the disruptions caused by the COVID-19 pandemic from a public health perspective. More specifically, the research has three main objectives: to introduce an integrated, trans-sectoral approach, thereby expanding health workforce and labour market analysis, to explore the public health risks of contemporary health labour market arrangements beyond COVID-19, and to illustrate the need for EU health workforce governance which helps to balance national interests.

Methods

The study adopted a qualitative explorative approach and developed a novel framework for data collection and analysis. Theoretically, the framework is informed by integrated workforce and trans-sectoral governance[18,19] and a 'whole of government' approach.[5] Three major dimensions of integration across policy sectors were selected for our purpose: the LTC system, labour market policies and migration policies. In practical terms, following the discussion of the EPH Conference workshop in Marseille,[3] an expert group meeting (including some of the authors) was arranged and a short topic guide for gathering material in different countries was developed. This was subsequently adapted to the new COVID-19 pandemic situation and finally comprises four major categories, which serve as a framework for the empirical material: (i) the LTC system (governance, finance and provision), (ii) the LTC labour market, (iii) LTC care migration policies and (iv) COVID-19 specific regulation for the LTC migrant carers. The framework is informed by a directed content analysis (based on predefined categories developed from the literature and theoretical approaches).[24] It is easily accessible and simplified, taken poor data sources in the field of LTC migrant carers into account (Box 1).

Material was gathered in the selected countries in January 2020 and amended for relevant COVID-19-related information until 20 May 2020, drawing on public statistics, document analysis and other secondary sources (a rapid scoping review of the literature) and additional information from experts in the different countries. The cases include five EU countries: Austria, Germany, Italy, Poland and Romania. The selection was informed by theoretical sampling, based on the assumption that mobility flows are strongest in countries with some geographical proximity and in LTC systems which include cash benefits, a culture of familialism and a high percentage of care provided at home.[10–12] At the same time, it represents typically Eastern EU sending countries (Poland and Romania) and receiving countries in the West (Austria, Germany and Italy) and a range of different conditions in LTC labour markets.

Box 1. OECD definition of LTC workers

The OECD defines LTC workers as paid workers who provide care at home or in institutions (outside hospitals). They include qualified nurses and personal care workers providing assistance with activities of daily living and other personal support. Personal care workers are not part of recognized occupations. . . . LTC workers also include family members or friends who are employed under a formal contract by the care recipient, an agency or public and private care service companies.
Source: OECD.[20]

Results

Table 1 below introduces the framework and provides an overview of LTC migrant care workers in context. One important finding is an overall scarcity of data when it comes to care at home and the exact number of migrant carers; the situation worsens for countries not monitored by OECD,[25] like Romania.[8] Second, UHC is not, or to a lesser degree applied to LTC compared with other healthcare sectors.[20] To a large extent, care is provided at home either unpaid within the family or by (personal) carers; services may be financed through cash benefits or other forms of insurance remuneration, but there are usually relevant out-of-pocket payments.[25,29] Third, all countries and all areas of LTC face a shortage of carers and nurses, but this is the strongest in Romania and Poland, where specific compulsory LTC insurance schemes are lacking and care at home makes for a large proportion of LTC. Regional disparities must also be considered, for instance, the shortage is stronger in Eastern Germany compared with the West.[8,9,16,26]

Fourth, migration policies indicate that mobility flows of migrant carers are to some extent targeted by governmental action which creates 'global care chains'.[16] These chains have first been described by feminist scholars and adapted by international organization to highlight the transfer of 'care giving tasks from one to another on the basis of power axes, such as gender, ethnicity, social class, and place of origin'.[30] Within the EU, the care chains reinforce inequality, although countries are committed to the Global Code.[31,32] A simple distinction between sending and receiving countries is no longer applicable, since all countries rely to some extent on migrant carers. However, there are still essential differences in the ways that countries rely on, and target migrant care flows. There are strong country clusters of migrant carers, which underline an East-West flow of carers—for instance, Romania is serving Austria, Germany and Italy, but receives carers to a far lesser degree, and primarily from a EU candidacy country.

The problematic effects of health labour market and migrant care policies based on national interests have been made most visible during the COVID-19 lockdown. This situation will be further illuminated through material from selected countries, which may provide first hints on the complexity of problems and the need for a public health approach in the absence of comprehensive research and data. In particular, the Italian example reveals the institutional deficits in the LTC sector. The Austrian case shows the problematic labour market arrangements on the side of the host country, while the Romanian case brings health risks for individual carers and populations in the sending country into perspective.

Table 1 A matrix to research migrant LTC carers in EU countries

Categories	Austria	Germany	Italy	Poland	Romania
LTC system					
Governance: regulation, legal framework	Federal Long-Term Care Allowance Act (Bundespflegegeld), family subsidiarity, benefits in cash and kind	Statutory LTC Insurance System (Pflegeversicherung), family subsidiarity, cash benefits	No statutory insurance but social right to Cash Allowance, strong family-subsidiarity, cash benefits	No statutory LTC insurance, strong family-subsidiarity, cash benefits	No statutory LTC insurance, strong family subsidiarity, cash benefits
Quality assurance (institutional settings)	Yes, § 33a Bundespflegegesetz (BPGG)	Yes, Medizinischer Dienst der Krankenkassen	Yes, regional regulation	Yes, Social Assistance Act 2004 and regional regulation	Yes, Ministry of Labour and Social Protection (Law 197/2012)
Finance					
LTC (% GDP)[a]	1.1	1.5	0.6	0.4	No data
By mode of provision (%)[b]	R 40 / H 58 / O 1	R 41 / H 57 / O 1	R 51 / H 19 / O 30	R 19 / H 81 / O 0	Residential care is marginal
Provision					
Care provided at home (% of total)	>50	<50	>50	>80	Most of LTC care
LTC labour market					
LTC worker per 100 people aged 65 years and over[c]	4.1	5.1	1.9	0.5	no data
LTC workers, % composition by level of education[d]	High 6 / Middle 80 / Low 15	High 12 / Middle 74 / Low 14	High 15 / Middle 50 / Low 35	No data	No data
Quality assurance professionalization (institutional settings)	Mandatory minimum composition of professional nurses	Mandatory minimum composition of professional nurses	Mandatory minimum composition of professional nurses	Mandatory minimum composition of professional nurses	No formal regulations
Migrant carers (estimations)	Largest group in care at home, relevant proportion in residential care	Largest group in care at home, relevant proportion in residential care	Largest group in care at home, increasing proportion in residential care	Largest group in care at home	No relevant group
Migration policy related to LTC					
Recruitment policy	Active recruitment from Eastern EU, recruitment agencies and state	Active recruitment from Eastern EU and Asia, recruitment agencies	Informal channels, focus on Eastern EU, work permits for carers	Grey zone, non-EU/ post-soviet countries	Not in place, but special agreement with Moldova
Country composition of migrant carers	Eastern EU and candidacy countries, largest groups Romania, Slovakia	Eastern EU and candidacy countries, largest groups Romania, Bulgaria, Poland	Eastern EU and candidacy countries, largest groups Romania, Bulgaria, Poland	Ukraine largest group, some Belarus, Russia, Moldova, Georgia and Eastern EU	Not applicable/ low numbers
COVID-19 policies					
Related to LTC migrant carers (April–15 May)	Special agreements with Eastern EU countries to send carers despite closed borders	Some efforts to open boarders for Romanian and Bulgarian carers, but not in place	Not in place	Some special measures for residence permits	Agreement with Austria to send carers by train despite closed borders

Sources: Own analysis based on[8,9,11,14,17,20,25–28]

a: OECD, 2019[20]; Figure 11.28; Total government/compulsory spending on LTC, including both the health and social care components, % of GDP on average across OECD countries in 2017; StatLink https://doi.org/10.1787/888934018773.

b: OECD, 2019[20]; Figure 11.29; Government and compulsory insurance spending on LTC (health) by mode of provision, 2017 (or nearest year); StatLink https://doi.org/10.1787/888934018792. R = residential care; H = home-based care; O = others.

c: OECD, 2019[20]; StatLink https://doi.org/10.1787/888934018716.

d: OECD, 2019[20]; StatLink https://doi.org/10.1787/888934018678; high, middle, low = as defined by OECD.

How COVID-19 turns LTC into a showcase of system deficits: the case of Italy

Residential care and the traditional solution for home care, based on informal care and migrant care workers directly hired by households, seem to show all their limits to cope with LTC needs in Italy. An important part of the answer could come from professional territorial services, starting with a strong involvement of general practitioners and professional home care services. If the former are actively present in most Italian regions, the latter are scarce. Developing a more general and effective answer to LTC needs, but also a more contingent one to the COVID-19 pandemic and its spreading, Italy would need to have stronger and more integrated territorial and home care services, organized around professionals, helping frail people at home and supporting their families. In this respect, there is an interesting debate on the reasons why among the regions of Northern Italy mostly hit by the pandemic, Lombardy seems to be the worst off. Among many potential explanations, although all of them premature given the scarcity of detailed information we have so far, several experts point to the fact that Lombardy has, compared with Veneto and Emilia-Romagna, a weaker coordination between its hospital system, residential care and territorial and home services (https://rep.repubblica.it/pwa/intervista/2020/04/10/news/walter_ricciardi_coronavirus_lockdown-253609949/; http://www.lps.polimi.it/?p=3454).

How COVID-19 turns migrant care into a showcase of precarious EU labour market arrangements: the case of Austria

COVID-19 brought about increased respect for the carers in Austria, including new wage agreements with a 2.6% increase in salary. However, after the borders closed, it became apparent that further

action was necessary, as Austria did not have enough carers to look after their elderly population. Many of the carers usually work in two-week shifts. They were now unable go back to their home country, as they would have to go into quarantine, take a corona test and lose three weeks should they be tested positive. On 13 April, the Austrian government announced that over 200 000 commuters (including carers, supermarket clerks and harvest hands) were not able to enter the country due to closed borders and travel restrictions. Starting on 14 April exemptions for critical infrastructure jobs from these restrictions were in effect for the Czech Republic and similarly for Hungarians, Slovakians and Slovenians. On 2 May, the Austrian and Romanian governments reached an agreement wherein Austrian care agencies, states and the Federal Economic Chamber could charter trains to bring 24 h carers into the country. These carers must either undergo a 14-day quarantine upon reaching Austria or take a PCR-Test, paid for by their employer. Upon returning to Romania, carers were subjected to a 14-day quarantine (sources: expert and media information).

How COVID-19 turns migrant care into a showcase of risky health conditions: the case of Romania

At the beginning of the pandemic, many Romanian carers were working in Northern Italy. This area was hit early and most severely from the pandemic and with the lockdown, the carers were forced to leave Italy. They returned to their hometowns in large numbers with health controls being performed irregularly. Many of them were from the city of Suceava—one of the poorest regions in Romania, which quickly became a COVID-19 hotspot. Again, appropriate security measurements were lacking. Many people infected with the virus were seeking to hide symptoms, thus the virus was spreading rapidly. Meanwhile, a lockdown was in place in countries like Austria and Germany, but concern over deaths from COVID-19 in the most vulnerable population of older people was growing. Staffing problems were most obvious in residential care and care provided at home, were the migrant carers were missed the most. In this situation, the Austrian government decided to re-open the boarder and establish an airlift for workers from Bulgaria and Romania. The examples illustrate two things: mobile carers turn into 'faceless numbers' to satisfy health labour market demand, and sending countries accept a loss of care workers even in times of a health crisis. The Romanian Ministry has dedicated some trains to bring workers, including care workers to Austria during the lockdown. This illustrates the missing appreciation of care work and the ignorance of population health risks (http://legislatie.just.ro/Public/DetaliiDocument/225457).

Discussion

The present study has demonstrated the usefulness of a trans-sectoral governance approach, which connects different policy sectors following a 'whole of government' perspective.[5,6,19] To our knowledge, trans-sectoral governance theories have not been applied systematically to the governance of LTC migrant carers and no comparative data exist. Our novel framework was able to draw a more comprehensive picture and to highlight the political dimensions[33] of the LTC migrant workforce in times of the COVID-19 pandemic. It has identified country specific LTC system and governance weaknesses and gaps in health labour market policy in the EU.

The results show that undersupply of carers coupled with cash benefits and a culture of family responsibility are predicting high inflows of migrant carers, who are channelled in low-level positions or the informal care sector. The sending countries are characterized by very low expenditure and density of LTC care together with strong family subsidiarity and a marginal role of LTC in the wider healthcare system. Consequently, the LTC workforce is poorly developed precisely in those countries, showing the strongest outflows of carers. Inter-governmental labour market arrangements on LTC migrant care may often reduce costs in high-income countries, but they are threatening the aim of UHC in the sending countries and hamper the development of a sustainable LTC sector.[14,16,17]

The COVID-19 pandemic now teaches us that these conditions embody a number of important public health risks. The pandemic increases the risk of infection for the individual carer if travelling in times of lockdown, coupled with the risk of losing one's job and income if travel is not permitted. It threatens the healthcare systems of the sending country, which is losing carers in a situation of a pandemic, when they are needed the most; and it threatens the provision of care in the destination country, as access and quality of care may worsen if borders are closed and the mobile carers have left. The pandemic has enhanced a debate over problematic global 'production chains' based on cheap labour and a lack of sustainability in European countries, especially in relation to medical protection material. However, very little attention has been paid so far to the 'global care chains'[16,30] and the human resources for health involved in these chains. Finally, from a public health and system perspective, enhancing the mobility of carers through cross-border arrangements during a pandemic is highly problematic and may increase health risks and new outbreaks.

The examples from Austria, Italy and Romania illustrate the complexity of migrant care workers in LTC. The COVID-19 pandemic reveals that weaknesses on the system level (e.g. poor funding), on the level of health labour market policy and migration policy combine and create new health risks for migrant carers, for care receivers and for health systems in EU Member States. Supposedly, no other area reveals the need for both European and trans-sectoral governance approaches to healthcare workforce policy, management and planning as strongly as the situation of LTC and migrant carers in Europe under the COVID-19 lockdown. The disruption caused by COVID-19 may embody new chances to finally understand the relevance of LTC and migrant carers for public health and health workforce development.

The challenges can neither be solved nationally, nor merely on the level of health labour market policy.[4–6] Moreover, there is a need to balance different interests of individual carers (including free mobility) and the interests of sending and receiving countries. This calls for integrated trans-sectoral and transnational governance approaches in Europe.[17,19]

Limitations

The research is explorative in nature and based on secondary sources and selected expert information. Gathering data on the number and composition of the entire LTC workforce seems to be like 'looking into a crystal glass'. Reliable data on the composition and numbers related to the LTC workforce are lacking in all countries, and information is worst for the migrant carer group.[14] Information related to the COVID-19 situation provides an incomplete snapshot of the first phase of the pandemic, which might quickly change in unpredictable ways. Furthermore, there is an overall dearth of knowledge on the health effects and death rates of COVID-19 in the group of migrant carers. These conditions hamper a comparative approach and more comprehensive evidence-based policy recommendations. The results are clearly limited and should be read as a wake-up call to public health researchers and policymakers to pay greater attention to LTC migrant carers, despite the challenges of dealing with poor data sources, especially for non-OECD EU countries. Our analytical framework provides a springboard for future research, which may improve primary sources to inform the development of more integrated and trans-sectoral LTC workforce monitoring systems and, more generally, 'whole in government' public health action.

Conclusion

This article set out to bring the situation of LTC migrant carers in EU Member States and the disruptions caused by the COVID-19

into the focus of public health and health workforce research. We introduced a novel framework, which applies trans-sectoral governance theories and a 'whole of government' approach to the LTC migrant care workforce. This approach helped us to explore the complex political dimensions of the LTC migrant care workforce, which cannot be solved merely on the level of health labour market policy. The results highlight the weaknesses of existing health labour market arrangements in the LTC sector, which stretch far beyond poor workforce management. As the COVID-19 pandemic revealed, these conditions may directly impact population health and the health and wellbeing of the migrant carers, thus becoming fundamentally a public health policy issue. The research also calls for European health labour market regulation and governance models, which help to balance national interests and connect health system needs, health labour markets and the individual migrant carers. Including LTC migrant carers more systematically in health workforce governance and research, therefore, must become an issue of public health and European policy.

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Key points

- Migrant carers reduce shortages and mitigate health labour market failures especially in high-income EU countries.
- A trans-sectoral governance approach is needed to analyze the role of migrant carers and to understand its political dimensions.
- COVID-19 has revealed health policy and labour market weaknesses, which create new individual and population health risks.
- Action has to be taken to develop trans-sectoral EU governance based on solidarity.
- Public health must improve advocacy for the LTC migrant care workforce.

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