Ad-PHS

Advancing Personal and Household Services

THE SHORT-TERM IMPACT OF COVID-19 ON THE FIELD OF PHS

AND SUPPORT MEASURES IN 21 EU MEMBER STATES

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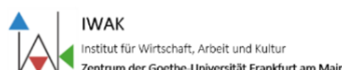


Introduction

The rapid spreading of the COVID-19 pandemic since March 2020 has had a very different impact on sectors. The ones that have been hit hardest are those which provide services that require high levels of physical proximity to customers and have a high share of small or micro-sized enterprises lacking reserves for compensating the decreasing demand for services (Pouliakas and Branka 2020). Very often, these are sectors requiring medium- to low-level skills, recruiting among groups that are strongly exposed to the impact of the COVID-19 pandemic as well as displaying high levels of undeclared work. Besides the tourism and hospitality sectors, the nature of the services, the structure of enterprises as well as employment patterns[1] come together in the field of personal and household services (PHS).

The European Commission (2012) defines the PHS as "[covering] a broad range of activities that contribute to wellbeing at home of families and individuals: child care (CC), long term care (LTC) for the elderly and persons with disabilities, cleaning, remedial classes home repairs, gardening, ICT support, etc." This shows that the provision of PHS helps the elderly as well as persons with disabilities to cope with their daily life, offers families the flexibility of non-institutionalised child-care and enables the utilisation of (highly) specialised services in and around the house. Furthermore, the field of PHS is considered to be a field of employment with high growth potential (Baga et al. 2020). Therefore, this report analyses the steps that governments across Europe have taken to absorb the shocks caused by the COVID-19 pandemic on the scope/quality of services and the level of employment in different PHS sectors. Furthermore, it presents recommendations for furthering the development of the PHS field in the EU Member States.

The analyses are based on findings from a research exploring the short-term impact of COVID-19 on the PHS sectors and corresponding policy responses in Austria, Belgium, Bulgaria, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Italy, Luxembourg, Malta, the Netherlands, Poland, Romania, Slovakia, Slovenia, Spain and Sweden. In the research, a mixed methods approach was applied:

- Survey of PHS organisations, PHS workers and households using PHS/employing PHS workers was carried out;
- Desk research collecting information on policy responses to the effects of COVID-19 in different PHS sectors was undertaken;
- Expert interviews in nine selected countries were conducted.[2]

[1] In this dimension only or some types of services offered in the field of PHS; see Section 2 detailing the diversity of PHS.

[2] The research took place within the Advancing Personal and Household Services (Ad-PHS) project, bringing together seven partners: European Association of Service Providers for Persons with Disabilities (EASPD); European Federation for Services to Individuals (EFSI); UNI Global Union Europa (UNI Europa); European

Impact of the COVID-19 Pandemic on PHS Organisations, Users and Workers

To explore the effects of the COVID-19 pandemic on the fields of PHS, a survey was launched in 27 EU Member States. It provided 215 responses from 15 countries and was carried out between 23 September and 23 November 2020. Most responses came from countries where the field of PHS is more advanced and the PHS providers well organised so that they could disseminate the survey in their close-knit networks: Italy, Belgium, Germany, France and Finland. As 50% of the responses came from Italy, they are considered separately here. Generally, no responses originated from countries where the Ad-PHS project was not present (countries with a less developed field of PHS such as Croatia, Cyprus, Greece, Latvia and Lithuania – with the notable exception of Portugal). As the number of responses is limited, the survey is not representative of the target population. The survey responses were enriched and contextualised with the help of insights from expert interviews with PHS associations (interest representations of employers and workers) from nine countries: Austria, Belgium, Estonia, Finland, France, Germany, Ireland, Romania and Spain.
Focusing on the first wave of the COVID-19 pandemic (February/March-June 2020), the survey explored:

- The impact of the pandemic on these PHS organisations, users and workers;
- The strategies applied by them for coping with the effects of the pandemic;
- The support structures available to them.

65% of the respondents represented PHS organisations, 26% households as both users of PHS/employers of PHS workers and 9% of the responses in the sample came from PHS workers.[3]

Effects of the COVID-19 Pandemic on the Activities of PHS Organisations, Users and Workers

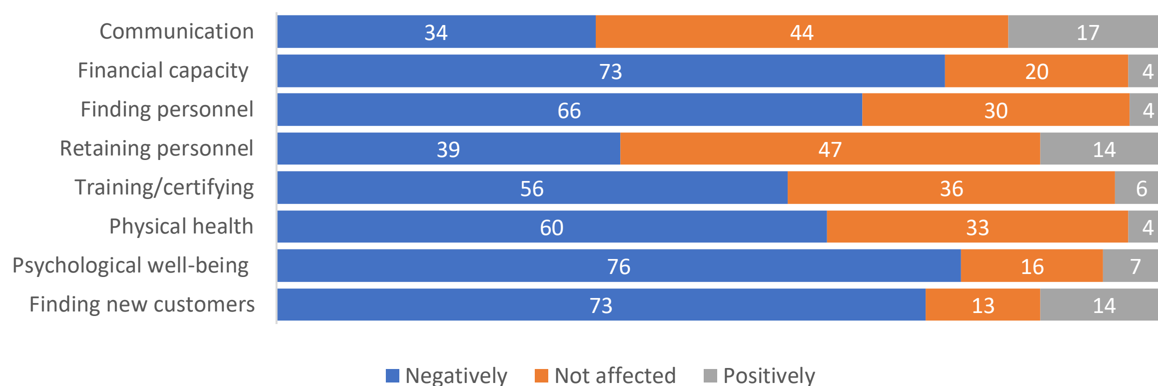
Half of the **PHS organisations** experienced a complete (26%) or partial (24%) business closure during the first period of COVID-19 pandemic. 44% of the survey respondents assessed that the impact of the crisis on their revenue was strong and 39% noticed a moderate influence.

Federation of Trade Unions in the Food, Agriculture and Tourism sectors and allied branches (EFFAT); Diesis COOP; Institute for Economics, Labour and Culture (IWAK) and European Federation of Family Employment (EFFE) (see https://ad-phs.eu/).

[3] The following presentation of survey results does not include responses from Italy; it is therefore based on 108 responses from 14 countries. Deviating from the predominant profiles of PHS organisations, households and workers the respondents indicated that they were mostly providing or using non-care services (e.g. cleaning).

Consequently, 73% of the respondents indicated that their overall financial capacity was negatively affected (Figure 1). As 73% of the PHS organisations responded that it was difficult to find new customers, this is an indicator that the loss of business was hard to compensate. Across different countries, the interview partners reported that PHS customers had various reasons for cancelling services during the pandemic: as they were spending more time at home they were able to do more work in the household, had less financial resources available to them or were worried about the vulnerable groups in their household. While there were differences in expert opinions, the general tendency seems to be that care services were less often cancelled than non-care services, unless they were provided to vulnerable groups.

Figure 1: Aspects of PHS provision affected by the COVID-19 pandemic (February-June 2020): PHS organisations (in %)



Source: Ad-PHS COVID-19 survey (2020).

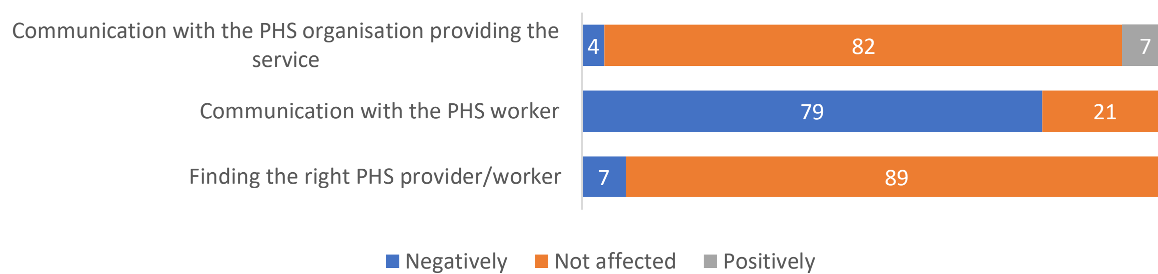
Moreover, the representatives of PHS organisations responded that the psychological well-being (76% of respondents) and physical health (60%) of their personnel were negatively affected, making it more difficult to manage the continuous provision of services. Also the recruitment was negatively impacted (66%) – relevant, for example, in a situation where the customary workers were not available due to illness or family responsibilities. Interestingly, the majority of respondents indicated that in this situation the communication was either not affected (44%) or even positively affected (17%). The interviewed experts reported that the PHS organisations undertook special efforts in the communication with their PHS workers in order to alleviate the uncertainty experienced by them and come up with individual solutions for the households and PHS workers in order to ensure the continuity of services.

The majority of **households** (68% of respondents) claimed that the financial resources available to them for purchasing PHS were not at all affected or that the effects were hardly noticeable (18%). The availability of funds for PHS was affected moderately in 14% of cases. The survey responses indicated, however, that the services continued as usual only in 25% of the cases. In 39% of the cases, the PHS organisation or worker cancelled the services completely and in 14% of the cases partially. Only 11% of the households in the survey claimed that they were the

ones to cancel the services partially and further 11% completely. However, the expert interviews contradicted these findings, reporting that the loss of business and lay-offs in the field of PHs resulted mainly from the households' declining demand, mainly in the field of care services. Therefore, the inconsistence most likely arises from our sample being skewed towards households using mostly domestic cleaning services.

In the opinion of the households, most of the aspects in PHS provision were not affected apart from the change in the communication with the PHS worker, which was predominately rated as negative (79%) (Figure 2). In contrast, the communication with the PHS organisation worsened only in 9% of the cases and even improved in 7% of the cases. It seems that in the situation of uncertainty it was easier for PHS organisations to re-arrange their communication with their clients and workers and offer orientation to them.

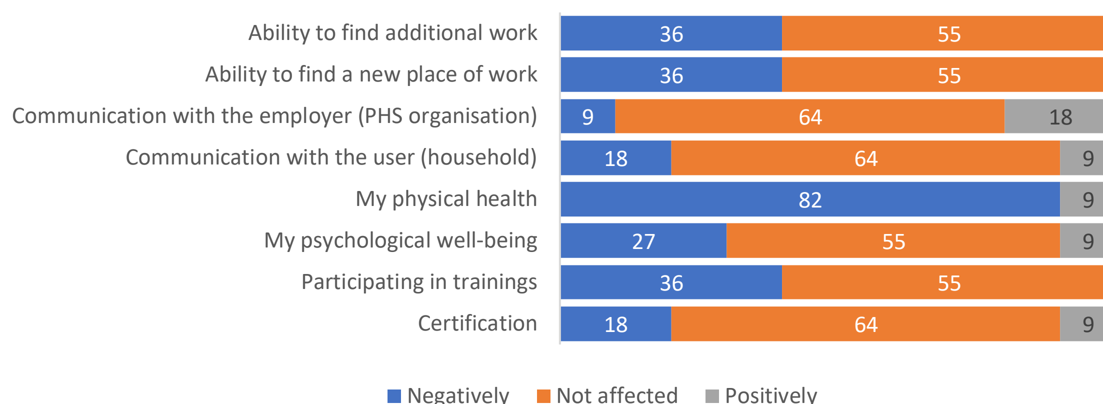
Figure 1: Aspects of PHS provision affected by the COVID-19 pandemic (February-June 2020): households (in %)



Source: Ad-PHS COVID-19 survey (2020).

46% of **PHS workers** replied that their income had not changed at all or had changed hardly noticeably (9%) during the first wave of the COVID-19 pandemic. However, for 27% of the respondents their situation changed moderately and for 9% strongly. When enquired about the changes in their income, 46% of the respondents claimed that their working hours had been reduced and 9% indicated that they had been let go. In this situation of uncertainty, 36% of the PHS workers in the survey stated that their ability to find additional work as well as their ability to find a new place of work had been negatively affected (Figure 3). However, the most important worry of PHS workers was their physical health as 82% of the respondents claimed that the COVID-19 pandemic had had an adverse impact on it. Interviews indicated that this had to do with stress due to the limited availability of personal protective equipment (PPE) during the first weeks of the pandemic as well as the need to work in an environment where the existing certainties of service provision were suddenly disputed. Furthermore, the PHS workers found it difficult to continue working in a situation when their private life had been affected by the COVID-19 pandemic.

Figure 3: Aspects of PHS provision affected by the COVID-19 pandemic (February-June 2020): PHS workers (in %)

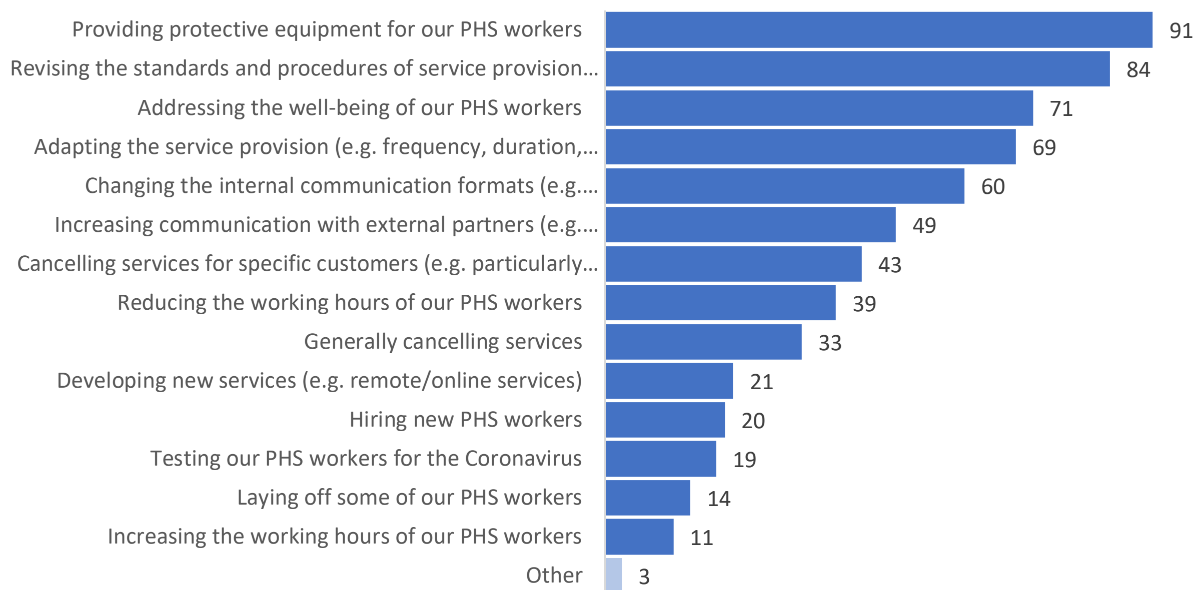


Source: Ad-PHS COVID survey (2020).

Strategies of PHS Organisations, Users and Workers for Coping with the Effects of the COVID-19 Pandemic

Most of the **PHS organisations** indicated that they provided PPE for their PHS workers (91%) and revised the standards and procedures of service provision (84%) (Figure 4). This followed the information campaigns launched in most countries, sensitising for contacts with vulnerable groups and adhering to strict hygiene measures. In line with the new standards for service provision, the frequency, duration and/or nature of services was changed (69%). Both internal communication (60%) as well as contacts with external partners (49%) were areas, which were revised. Also addressing the well-being of PHS workers was a measure that was often named (71%). The answers show that while 39% of the PHS organisations reduced the working hours of their personnel and 11% increased them, more permanent decisions concerning the personnel were taken less frequently: 20% of the respondents stated that they hired new PHS workers and 14% laid off their personnel. Oftentimes the usual channels for personnel recruitment were not available any more, especially if they relied on the accessibility of public authorities. In Germany, for example, PHS organisations could not co-operate with public employment offices for recruiting PHS workers. In Spain, the social security offices involved in registering private carers were not open, making it more difficult especially for the households of elderly persons to recruit PHS workers officially.

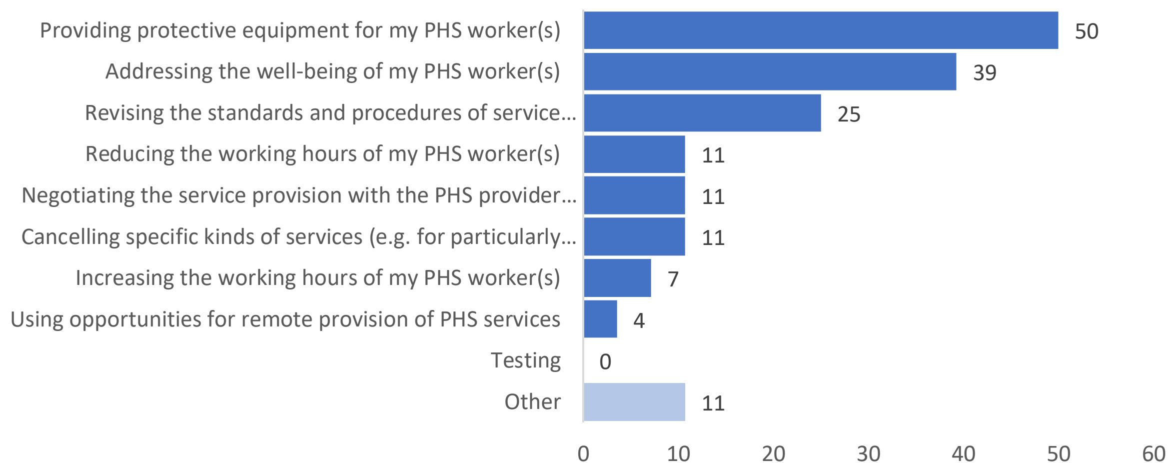
Figure 4: Measures undertaken by PHS organisations during COVID-19 pandemic (February-June 2020) (in %)



Source: Ad-PHS COVID-19 survey (2020).

The main measures undertaken by the **households** were the provision of PPE for their workers (50% of the respondents) or addressing their well-being (39%) (Figure 5). The responses show that a relatively small share of households had decided to fine-tune issues of service provision (e.g. re-defining the standards for service provision or reducing/increasing the working hours of the workers).

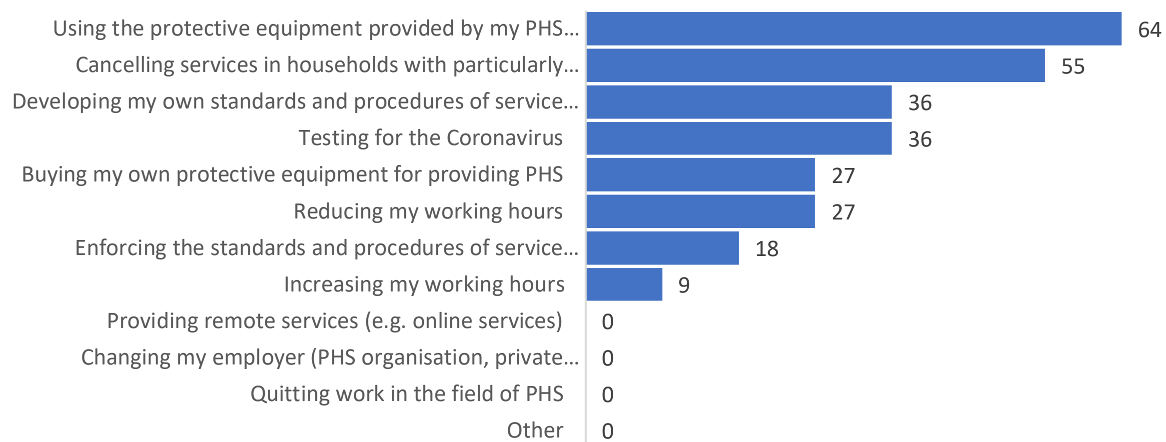
Figure 5: Measures undertaken by households during the COVID-19 pandemic (February-June 2020) (in %)



Source: Ad-PHS COVID-19 survey (2020).

In the case of the **PHS workers**, using PPE either provided by the employer (64% of the respondents) or bought themselves (27%) was the measure most often taken (Figure 6). However, they saw it necessary to cancel services in households with particularly vulnerable groups (55%).

Figure 6: Measures undertaken by PHS workers during the COVID-19 pandemic (February-June 2020) (in %)



Source: Ad-PHS COVID-19 survey (2020).

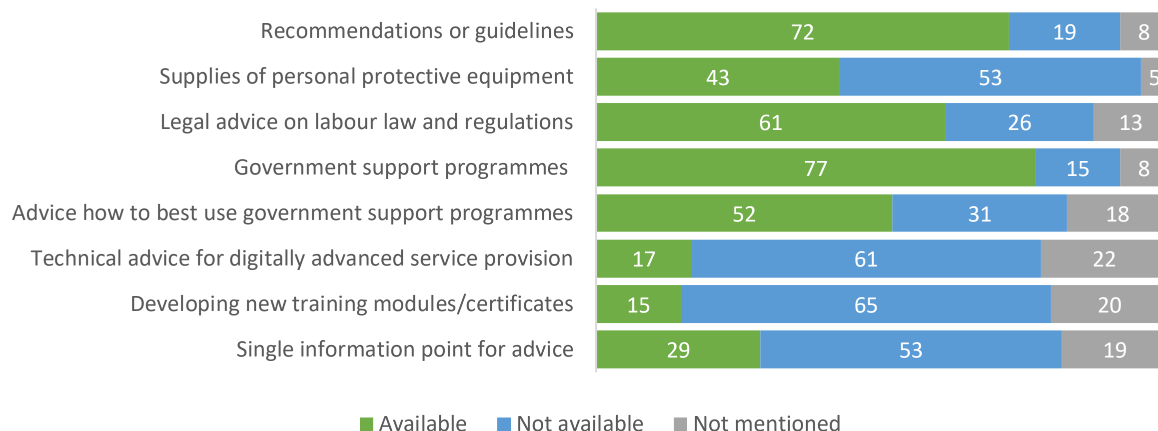
Support Measures and Structures Available for PHS Organisations, Users and Workers

The responses of EU Member States to the COVID-19 pandemic differed to a large extent (Section 3). To get a first overview of the standard support measures across different fields of PHS, we asked the survey participants to indicate if a specific support measure was available or not (Figure 7). 72% of respondents indicated that recommendations or guidelines were available to them, as well as government support programmes (78%). A slightly lower share of the participants indicated the availability of legal advice on labour law and regulations (77%) or advice how to best use government support programmes (61%). As the interviews showed, personnel issues or applications for government support funds were difficult to resolve in the times of general uncertainty and all parties in the fields of PHS were in need of good counselling. In several countries the adopted support programmes for PHS organisations or workers have not yet redeemed their promise of mitigating the impact of the pandemic, since the funds have still not been allocated or are subject to revision and potential restitution if not all conditions have been met.

It is noteworthy that the supplies of PPE were available to only 43% of the respondents. The interview partners across countries confirmed that especially at the beginning of the COVID-

19 pandemic PPE had been extremely difficult to acquire, even though it had been a crucial precondition for continuing/resuming the provision of PHS.

Figure 7: Availability of support measures during the COVID-19 pandemic (February-June 2020): PHS organisations, households and workers (in %)



Source: Ad-PHS COVID<-19 survey (2020).

It is important to note that there were slight differences between the PHS organisations, households and workers. The majority of PHS organisations indicated that government support programmes were available (86%) and also the advice on how to best use the programmes could be obtained by a higher share of respondents (56%). In a situation where the COVID-19 pandemic affected the foundations of the employment relationship (e.g. short-time work, quarantine-related remuneration), 70% of the respondents had access to legal advice on labour law and regulations. Furthermore, 80% of the respondents could rely on recommendation or guidelines for PHs provision. This shows the PHS organisations had a higher capacity to acquire information on the available support measures than households employing PHS workers, for example. Furthermore, many of the instruments were designed around a formal employment relationship with a PHS organisation and were administered through them, thus they were more inclined to engage with the availability of different opportunities for support.

Our interview partners stressed that acquiring an overview of the situation under constantly changing conditions was a major challenge for everyone in the field of PHS. As indicated by the survey respondents, to 53% a single information point for advice was not available (Figure 7). For **PHS organisations**, the first source of information for handling the COVID-19 pandemic were public authorities (49% of respondents) and associations of PHS providers (35%). Also 25% of the **households** as PHS users and in some cases PHS employers consulted the information provided by public authorities first, but the majority (64%) explicitly stated that neither public authorities, associations of PHS providers or trade unions served as the first

source of information to them. The **PHS workers** mainly consulted the information provided by association of PHS providers (36%) or public authorities (27%) first.

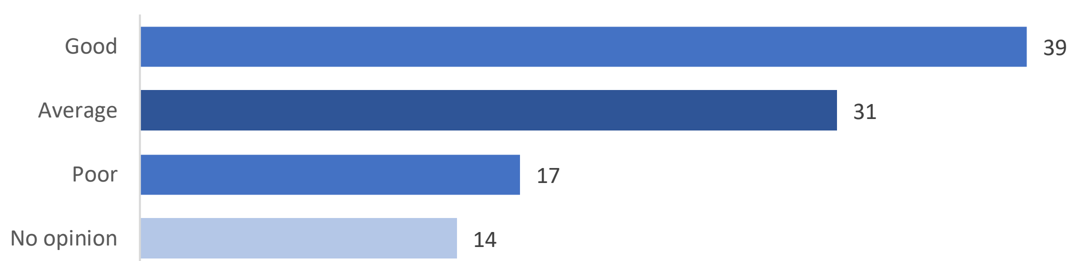
The PHS organisations, households and workers assessed the authorities' response to the COVID-19 mainly as poor (34%) or average (31%) (Figure 8), while 29% were satisfied with the authorities' actions.

Figure 8: Assessment of the authorities' response to the COVID-19 pandemic (February-June 2020): PHS organisations, households and workers (in %)

Source: Ad-PHS COVID-19 survey (2020).

The situation was quite the opposite for the assessment of the PHS associations' actions during the COVID-19 pandemic – 38.9% of the respondents rated it as good, 30.6% as average and only 16.7% as poor (Figure 9).

Figure 9: Assessment of the PHS associations' response to the COVID-19 pandemic (February-June 2020): PHS organisations, households, workers (in %)



Source: Ad-PHS COVID-19 survey (2020).

PHS Organisations, Households and Workers during the COVID-19 Pandemic in Italy

As most of the responses from Italy originated from households using PHS or employing PHS workers (92%), it is possible to describe the effects of the COVID-19 pandemic only on that group in more detail. 47% of the households stated that they provided PPE for their PHS workers in the first months of the crisis(February-June 2020). Furthermore, 37% addressed the well-being of their PHS workers and 36% revised the standards and procedures of service provision. This indicates that the households were trying to keep the services running. However, it needs to be considered that for some households it must have been a struggle, since 14% experienced a strong and 29% a moderate decline of the resources available to them. Consequently, 18% of the Italian households in the survey cancelled the PHS services altogether and 16% partially.

Among the support measures in the field of PHS, the PHS organisations, households and workers indicated that recommendations and guidelines (65% of survey respondents), government support programmes (44%) and legal advice on labour law and regulations (43%) were available. However, 45% stated that advice how to best use government support programmes was not available. Furthermore, 65% claimed that supplies of PPE were missing.

In this situation, 46% of all Italian respondents assessed the authorities' response as poor and 20% as average, while only 23% stated that it was good. The assessment of PHS associations' response was more favourable, with 34% of the survey participants indicating that it was good and 22% rating it as average.

Support Measures Available to the Field of PHS during the COVID-19 Pandemic

During the COVID-19 pandemic, the EU Member States developed very different responses for the field of PHS, even though they were following the same goals: stabilising the provision of PHS for different user groups as well as retaining the PHS as a domain that offers business opportunities for a great variety of providers and employment to a large number of PHS workers. To start with, we will present a broad overview of the main challenges and approaches in the field of social care system that enable vulnerable and/or dependent groups to stay in their own home. Subsequently, we give examples for support measures that addressed the continuity of business activities and employment in the field of PHS.

PHS as Part of Social Care System

The desk research of PHS provision in the social care systems of 21 EU Member States revealed that the entities organising, providing and financing PHS for vulnerable groups were aware of the need to sustain these services. The support measures addressed the municipalities, PHS organisations and PHS workers (enhancing their resilience) or users (enabling them to cope with the particular challenges arising from the COVID-19 pandemic). These selected examples illustrate the different approaches applied in various EU Member States:

- In countries where social care is organised by **municipalities**, the central government increased the ceiling for municipal expenditures related to COVID-19 or allocated additional funding to municipalities so that they could compensate the additional expenses during the pandemic (e.g. in Denmark and Estonia). The Government of Spain set up a fund of €300 million to cover COVID-19 related needs in social service provision. In Bulgaria, the scope of services provided by the ESF-financed project "Patronage care for adults" was extended to include the delivery of food, medicines and other essential goods to the elderly especially in remote areas;
- In Germany, **PHS organisations** regularly providing social care services to persons receiving and allowance of €125 from their care insurance could claim the remuneration of these services from the care insurance even if the services had been suspended;
- In France, it was decided that **workers** providing social care services at home should receive a bonus subject to the amounts specified by the local authorities. However, the political commitment has not materialised yet for all workers as the bonus granted varies substantially among regions ;
- In Poland, the allowance available to **persons** with disabilities for hiring a support person was increased; in Germany the deadline for spending the personal care allowances for social care services were extended.

With the onset of the COVID-19 pandemic, the municipalities saw the need to modify their existing services and to offer new kinds of services. For example, the home visits were substituted by phone calls or virtual visits to check on the well-being of the clients and reduce their loneliness (e.g. Denmark) or find ways how to involve the family and community in the re-organised forms of service provision (e.g. Italy). The restrictions on personal contacts led the municipalities to re-arrange their communication channels like in Bucharest, where a special phone line was opened where elderly who could not rely on a support structure could request for assistance such as cooking, personal hygiene or administering of medicine. In Germany, the care insurance explicitly agreed to remunerate alternative services (e.g. shopping for food or phone calls instead of direct care services) provided by persons with lower levels of care-related qualifications or neighbourhood helpers.

These flexible reactions to the challenges related to the COVID-19 pandemic sought to retain the structures of social care provision in the social care system. In the majority of countries, however, the restrictions were still far-reaching and non-essential homecare activities were postponed, especially for persons who could rely on their own social networks. In Malta, for example, occupational therapy, community and social work services for differently-abled individuals were only offered in cases where they were deemed urgent and essential. To a large extent, this had to do with the immediate availability of PPE as in most countries the needs of hospitals or nursing homes were prioritised. In Slovenia, for example, the National Council of Disability Organisations of Slovenia specifically requested the authorities to include vulnerable persons with disabilities among the priority groups for the delivery of PPE, underlining the dependence of social care services on such equipment.
Moreover, established service provision processes were changed to protect PHS workers: in the Netherlands, special 'Corona teams' providing care only to COVID-19 patients were set up; in Slovakia, working time was shortened or the timing of breaks changed in order to minimise contacts among PHS workers.

In the countries with very strict lockdown rules, PHS staff were considered key workforce and they were granted extended mobility. In Spain, the Article 7 of the Royal Decree 463/2020 granted them the necessary mobility and the right to enter their clients' homes. Also in Italy, PHS workers could continue working, even though the Government suggested suspending the activity unless exceptional circumstances made it necessary. However, it raised questions as to under which conditions services that could not be provided would be remunerated. This depended on the general rules for sick leave, which were changed in several countries (e.g. Denmark and Estonia) and offered in most cases a more generous access to sick benefits. In Italy, domestic workers were entitled to a home isolation or hospitalisation allowance through the healthcare fund Casacolf in the case of contracting COVID-19. Also in Luxembourg, PHS provision in private households was specifically regulated, stating that staff could not refuse work unless they had a medical certificate. Only in cases where a family member was infected with COVID-19 were they exempt from work and entitled to remuneration for cancelled services.

Live-in workers constituted a specific case in the field of PHS as disputes as they were heavily influenced by the restrictions on transnational mobility. In Austria, where most of the live-in carers come from Romania, Bulgaria and Croatia, the central government issued a one-off tax-free bonus of 500 Euro to those who extended their shifts for at least four weeks. Furthermore, special trains and flights were organised to enable carers to circumvent general travel restrictions. During the COVID-19 pandemic, the conditions of live-in carers (both formal and informal) worsened, as the family members reduced their visits to the households of the elderly. Furthermore, migrant live-in carers were less protected from dismissals (e.g. in Poland) and arbitrary reduction of wages. In the Netherlands, the union FNV represented them in labour disputes, suggesting to establish an emergency fund from which to pay those who had lost their earnings. In Italy, an Interdepartmental Decree issued in May 2020 granted immunity to employers who registered their undeclared domestic workers and to domestic workers who had been working in Italy before 31 October 2019 by issuing them temporary residence permits

Modification of PHS Instruments as Means of Supporting the Provision of PHS

In countries where instruments for supporting the use and provision of PHS exist, they were modified to ensure the continuity of business activities and employment in the field of PHS. They were either designed to boost the demand for PHS or – more often – called into existence to mitigating the effects of declining demand for PHS:[4]

- Demand-side:
    - In Luxembourg, the maximum lump-sum tax allowance for employing domestic workers was temporarily increased from €5,400 to €6,750;
    - In Italy, persons who had children under 12 years of age and did not take 15 days of paid leave received a voucher of €600 for childcare services;
    - In Belgium, the validity of service vouchers, the main financial support instrument for inducing demand for PHS, was extended by three months;
    - In Brussels, Belgium, the regional subsidy for service vouchers was increased by €2 per hour from €14.60 to €16.60 between 18 March and 30 June 2020. This additional support was intended to compensate additional PPE;
- Supply-side:
    - In Brussels Region a gross indemnity of €2.5 per hour of temporary unemployment was introduced. It was meant to guarantee a replacement revenue of 95% of the PHS worker's regular salary who in the previous 14 months had worked at least one hour in Brussels Region with their current employer. The Walloon Government dedicated additional €8.6 million in order to guarantee the full wages of further 40,000 PHS workers;

[4] It is possible to present only a selection of such measures here in order to illustrate the range of approaches adopted by the EU Member States.

- In Spain, domestic workers were granted 70% of their salary, provide that they could prove that their jobs had been lost or suspended. From March to September 2020, the Spanish government granted over 23,000 such subsidies to domestic workers;
- In Italy, domestic workers who did not live at their employer's and whose employment contract(s) added up to more than ten hours per week, received a support of €500 in April and May 2020.

In most countries, business credits, tax exemptions or general company support schemes were available (e.g. the French Solidarity Fund for organisations with less than €1 million turnover who suffered over 50% of revenue losses). Even though the support schemes were manifold and were accessible also to micro-enterprises or freelancers, most of them were not designed for the field of PHS and did, for example, not take into account the specifics of the field. The German emergency support scheme, for example, could be used for covering operating costs (e.g. office rent), but not personnel. However, the PHS organisations reported that as the service provision takes place in households, most of their costs are related to personnel. In Austria, emergency aid of €2,000 was available to the self-employed live-in carers. However, as many of them are registered in their home countries and do not have an Austrian bank account, they did not qualify for the support.

Policy Recommendations for Supporting the Development of the Field of PHS

The COVID-19 pandemic posed a serious challenge to the field of PHS: it showed that there is urgent need for policy action to support its resilience under changing conditions. This concerns especially the care services that are provided in the long-term care (LTC) system. The dependence of various PHS users on the reliable provision of services demonstrates the need to recognise the importance of PHS and explicitly address the further development of this field in ongoing or planned reforms of LTC. It is necessary to resolve the questions related to the funding and circle of beneficiaries of PHS as well as the skills profiles and working conditions of PHS workers.

The reviewed approaches in PHS provision during the COVID-19 pandemic reveal the following challenges that need to be addressed in the EU Member States within the larger framework of PHS funding and responsibilities:

- Organising the provision of PHS: it is necessary to find ways to re-organise PHS in the social care system so that families or local communities are involved to a larger extent. Since this entails the assessment of situations of particular urgency and/or complexity including various actors, it is not enough to set up digital platforms for service provision. Rather, it needs to be considered how to combine different offers and re-organise information flows. Furthermore, the relationships between various actors and their responsibilities need to be re-defined;

- Demand for PHS: as a result of suspending especially social care services to vulnerable groups for a longer period of time, a need for PHS has built up. However, as the financial capacities of customers have decreased in many instances, this need for PHS cannot materialise as demand for PHS without targeted support instruments. This issue is particularly pertinent as the COVID-19 pandemic has aggravated the pre-existing shortcomings in PHS provision and funding. Furthermore, instruments for supporting the demand for PHS need to be revised and extended in order to avoid the extension of undeclared work in the field of PHS in a situation where declared services are not affordable or easily available;

- Working conditions of PHS workers: in several countries, the prevalence of undeclared work in the field of PHS meant that the majority of PHS workers did not have access to government support instruments, worsening their working conditions and economic situation. During the first phase of the COVID-19 pandemic also the registered PHS workers experienced extremely high levels of initial uncertainty in service provision, changing framework conditions for service provision and worries about the safety of work both regarding themselves and the customers. Stakeholders from different EU Member States reported that this had to do with the general perception that the field of PHS was secondary to healthcare and LTC. These accounts show

that it is necessary to recognise that the field of PHS is equally important as it is an essential support pillar in the larger systems of health care and LTC provision.

Despite the difficult situation arising from the COVID-19 pandemic, the field of PHS has shown resilience through its responses to the crisis. While mastering various challenges, PHS stakeholders have displayed dedication, creativity and ability to progress, thus demonstrating the innovation potential inherent to the field of PHS. This is the time to make use of these impulses to support the provision of easily accessible and affordable PHS.

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