Company profile

Colisée

This report is published as part of the project: "Building company networks and EWCs in health and social services II", coordinated by the European public service trade union federation - EPSU

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Contents

Introduction 3
1. Company analysis 4
1.1. Company structure 4
1.2. Ownership and investment 4
1.3. Financial position 5
1.4. Company strategy 6
2. Regulatory framework and industrial relations 6
2.1. State regulation in residential elder care: decentralised governance 6
2.2. Industrial relations: diverse collective bargaining institutions and practices 8
2.3. Conflicts: demonstrations and strikes 9
3. Working conditions 9
3.1 General working conditions 10
3.2 Health and safety 10
3.3 The impact of the COVID-19 pandemic 10
3.4 Interview findings 11
4 Conclusions 12

Introduction

This report summarises research on the Colisée social care company that was carried out as part of the European Commission-funded project, "Building company networks and EWCs in health and social services II", coordinated by the European public service trade union federation – EPSU.

The report is based on desk research using publicly available information about the company and the publications focused on sectoral regulation and industrial relations patterns in the four countries where Colisée operates. It also includes the results of an online survey on working conditions of workers, members of works councils and trade union representatives as well as four interviews with work council members and trade union officers.

The first section of the report analyses Colisée's structure, ownership, financial position, and strategy. The second section examines the main sectoral regulatory features and industrial relations patterns in the four European countries where Colisée operates, considering their implications for management policies and employees' working conditions. The third section looks at the main problems and challenges in terms of working conditions based on the outcomes from the survey and the qualitative interviews.

1. Company analysis

1.1. Company structure

Colisée group specialises in the elderly care sector with its main activities falling within the scope of the subsector of residential care activities for the elderly (NACE rev. 2 87.3). In some countries (mainly France) it also has day centres and offers home health care services through some of its group companies. Established in France in 1976, Colisée has progressively expanded internationally to Belgium, Spain, Italy, and China, becoming the fourth largest European player in patient and elderly care with 240 facilities.

France Colisée has more than 75 establishments providing residential and medical care for dependent elderly people. It is the fourth biggest company operating in the EHPAD sector – French acronym for Establishment of Accommodation for Dependent Old Persons – and offers residences with specific units for caring for people with different pathologies such as Alzheimer's. In addition, Colisée provides home health care services through its company ONELA. This firm was created by Colisée in 2018 with a view to expand the scope of its activities towards home health care. ONELA provides 24/7 home health care services through a network of 70 agencies across France, which employ 2,900 workers, and provide assistance to 12,000 people[1].

Belgium In February 2019[2], Coliseée acquired the Belgian group Armonea which was founded in 2008 through the merger of Restel Residences and Group Van den Brande, making it one of the biggest companies in the elder care sector in Belgium and Spain. This acquisition made Colisée the second largest player in the private for-profit sector in Belgium. Through Armonea, Colisée has more than 80 residences in the country and employs 6,400 workers.

Spain In May 2019, Colisée acquired STS, which mainly operates in Catalonia and, through the Armonea takeover, the Saleta care company which operates in Valencia. Colisée is the sixth biggest player in the Spanish elder care sector, managing 60 residential centres in 13 provinces and employing 4,200 workers[3]. Its central office is located in Valencia.

Italy Colisée has been active in Italy since 2015, when it acquired Isenior, the elder care company which has 14 residences with 1417 beds[4].

China Colisée has had a small presence in China since 2013, where it has two residences.

1.2. Ownership and investment

Colisée is a privately owned company. In 2017, the private equity firm IK Investment Partners became the major shareholder, reflecting a trend of investment funds targeting the elder care sector[5]. The rapidly ageing population across Europe and the opportunities for the private sector make it attractive to investors, particularly in countries such as Belgium, France, Italy and Spain where private firms already have a foothold.

In 2020, IK sold its stake to the Swedish private equity firm EQT Infrastructure[6] which became the major shareholder in Colisée. EQT has a portfolio of companies across the world with a combined total turnover of more than €27 billion and more than 159,000 employees.

> BOX: **Private operators in elder care**
>
> In **Belgium,** public and non-profit organisations have traditionally played the most prominent role in the provision of heath care services[7]. In recent years, there has been however a growing concern about the privatisation of the long-term care sector. In residential care, commercial providers have been increasing their market share, particularly regions such as Brussels, where the private/commercial sector is more important, accounting for over 60% of the market in terms of beds[8].

In **France,** providers within the EHPAD sector, where Colisée mainly operates, are either public, non-profit or private. In 2015 around 50% of care home places (EHPAD) were private (for profit 21% or non-profit 29%) [9].

In **Italy**, elder care services are mainly provided by private accredited providers and, in particular, private non-profit operators, which account for 35% of the market in terms of beds[10].

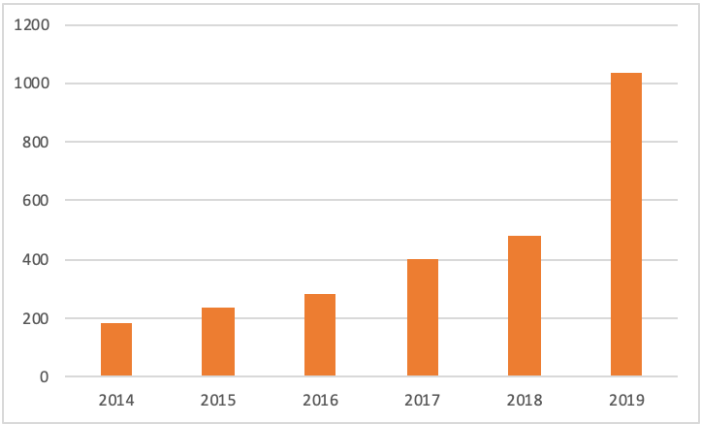
In **Spain,** care services are provided by regional and municipal centres as well as the private sector. Nevertheless, most institutions are private non-profit providers (43% of market share) and private commercial providers (30% of market share)[11]

1.3. Financial position

In 2021 Colisée was operating 287 facilities with 26,000 beds and had revenues of €1045m. The number of beds increased sharply from 9,000 to 26,000 (2019-2021)[12], mainly as a result of the acquisition of Armonea. The company employed 26,000 staff and although a full breakdown is not available there were 6,400 employees in Belgium and other sources indicate that there were 4,200 in Spain.

Colisée group generated €1,033m of revenues in 2019, seeing a moderate annual increase from 2014 to 2018 but then a significant rise (116%), again, mainly explained due to the acquisition of Armonea.

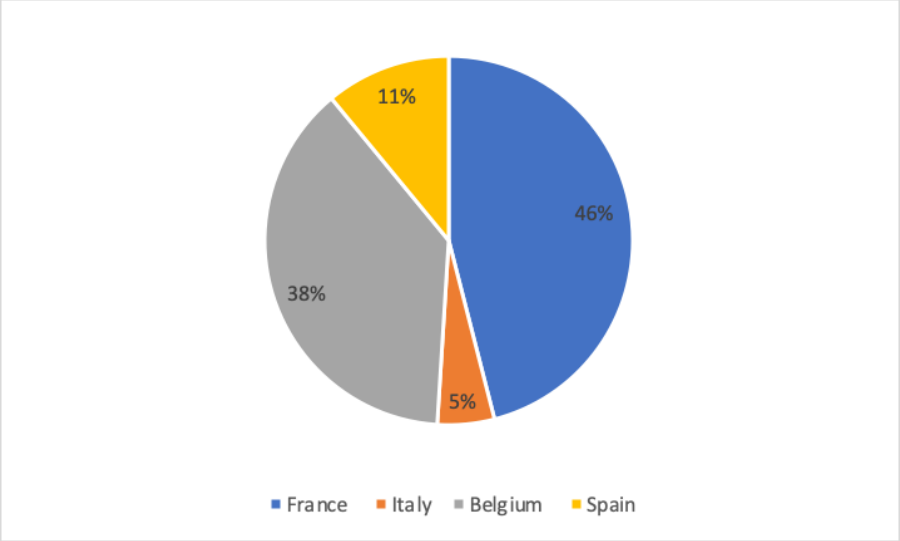
Figure 1. Colisée group revenues. 2014-2019



Source: Colisée group. Company presentation

By 2020 half of group revenues came from outside France but the country still accounts for the highest proportion (46%). Belgium is the second most important market (38%), followed by Spain and Italy (see figure 2 below).

Figure 2. Colisée group revenues 2020 disaggregated by country (%)



Source: Colisée company presentation

In terms of market segments, revenues come mostly from residential elder care (86%) with home health care contributing 7%, day centres 3% and the rest from other unspecified services.

1.4. Company strategy

Colisée's international expansion began in China in 2013 and then in Europe in 2015, with the acquisition of Isenior in Italy. The next key milestone saw IK Investment Partners become the major shareholder in 2017 with the investment provided allowing Colisée to take further steps towards its internalisation, with the acquisition of the Belgian group Armonea and the Spanish groups STS, making the company the fourth biggest player in Europe in residential elder care.

A key aspect of the company's strategy is its specialization in what it calls the "silver economy". Instead of diversifying their services towards different welfare domains, the company has focused on elder care because the ageing population trend points to long-term profitability of this sector.

Expansion outside France has also been important since 2013 and by 2019, 54% of revenues came from other countries.

The company is also looking at how it can exploit digitalisation to improve service quality, communication between patients and families and between patients and care workers and to enhance company accountability.

2. Regulatory framework and industrial relations

2.1. State regulation in residential elder care: decentralised governance

Working conditions in the private health care sector are highly determined by state regulation. As stressed by the works council members who were interviewed, state rules on key aspects such as accreditation systems or ratios of carers to patients have a clear influence on several dimensions of working conditions (work intensity, health, etc.). Comparison of the four countries where Colisée operates show that regional government and institutions play a key role on the regulation, accreditation and supervision of private providers operating in the elderly care sector. This entails that, in each country, there are regional disparities in terms of employment and working conditions.

Belgium

In residential elder care there are two main types of residential facilities: homes for elderly people ("ROB"-"MRPA" facilities), which provide nursing and hygiene services to elderly people who have moderate limitations in their daily activities and/or in their cognitive abilities; and nursing homes ("RVT"-"MRS" facilities), which are for individuals who are heavily dependent, but do not require permanent hospital care. Some years ago, responsibilities for the planning and accreditation of residential care facilities (homes for the elderly and nursing homes) were divided between federal and regional governments and based on protocols between them. Three protocols were concluded in 1997, 2003 and 2005, formulating common objectives for long-term care[13].

Since 2013, however, there has been a substantial devolution of responsibilities for long-term care from the federal level to the regions – including, from 2015, residential care – and different regional regulations have been developed. Regional regulatory decrees address the most important aspects for the provision of residential elder care services, such as the organisation of the provision, the recognition of service providers, the integration of services and quality monitoring. This means that working conditions of employees in private residential facilities for elderly people can vary across regions[14]. The works councillors and trade union officer who were interviewed pointed that some regional norms on the maximum number of living facilities in residential care homes entail work intensity, particularly for cleaners.

In **France,** the governance of the health care system was modified in 2009 (the Hospital, Patients, Health and Territories Act), when new regional institutions representing central government were created. The regional health agencies (ARS, its French acronym) have become most important health institutions, encompassing all existing regional and local health administration (health care, public health and health and social care for elderly and disabled people). The ARSs are autonomous bodies, although formally subsidiaries of the state under the auspices of the ministers in charge of health, social security, the elderly and disabled[15].

Within the EPHAD sector, the remit of ARS includes regulation of providers of health and care as well as authorization of health and care establishments, the surveillance/monitor of their functioning and the allocation of their resources. The main mechanisms to ensure quality assurance of private care provides is the so-called "*Contrat pluriannuel d'objectifs et de moyens*" (CPOMs), which are signed between the organization providing the care services and the ARS. These contracts set up a number of objectives allowing the implementation and monitoring of the regional health project. Recent research poses questions about the quality of residential care in France. A specific programme 'Quality of life in EHPAD' was elaborated in 2010 in order to improve residents' quality of life. However, some structural problems hindered the implementation of the programme, mainly relating to low staff ratios for care, which remained the same from 2011 to 2015 despite an increase in the number of residents. Similar to Belgium, there is also some evidence of territorial disparities in the quality of services and employees' working conditions, due the prominent role played by regional regulation[16].

In **Italy**, regulation and governance of elder care is very complex due to the high level of fragmentation of competences and resources among different institutional actors and a low level of coordination between them[17]. At national level, competences are divided between two ministries (Ministry for Labour and Social Policy and the Ministry of Health). Regions implement sectoral policies through the definition of regional policies and network of services while local health authorities and municipalities manage services and interventions at the local and individual level.

At residential level, there are three different kinds of institutional settings that provide care services, that differ in the type of services they provide and in the characteristics of the service users. *Residenze Assistenziali* (RA) provide basic health care, focusing mainly on social care to self-sufficient elderly persons while *Residenze Socio-Sanitarie* (RSS) provide residential care services that include a medium or high level of health care services together with social integration to dependent elderly persons. *Residenze Socio-Assistenziali* (RSA) provide health care services and specific social support to

dependent elderly and disabled people. These services can be provided by public or private accredited providers and regional governments are responsible for the accreditation and quality control of private providers.

Interviews with trade union officers revealed some criticism of the accreditation system and, in particular, on how they monitor quality control in a context where many private providers subcontract services to third sector organisations (mainly cooperatives) in order to blur responsibilities and liabilities for the workers. Norms regulating each service (RSA or RA) can vary and there are also differences between services across regions and municipalities[18] and in the distribution of residential services across the country[19].

In **Spain,** the health care sector is regulated according to the 39/2006 Law on the Promotion of Personal Autonomy and Care for Dependent People (the so-called 'Dependency Act'). This established that care services (including residential cares services) are provided by regional and municipal centres (around 30% of total residences) as well as by private accredited institutions. Only private accredited providers can to either manage public residences for elderly people (so-called concerted residences) or to admit patients who are entitled to public financial benefits. Health services can also be delivered by non-accredited providers, but the relative costs are fully charged to the users and so only a few companies are interested in those services.

Under this framework, the question of accreditation becomes crucial. The Autonomous Communities (regional governments) are responsible for the accreditation, registration and quality control of all social centres in their territory. At the same time, the minimum criteria for the entire country in terms of the ratio of caregivers per patient, the qualifications of personnel and the material resources, the equipment and the documentation of the accredited care centres are established through the Interterritorial Council of the System for the Autonomy and Care for Dependent People (CISAAD, for its acronym in Spanish) in which the central and regional governments are represented. According to the interviews with trade union officers, the question of "tendering" for concerted residences is not so problematic (minimum of staff is specified in the tenders with a view to prevent "race to the bottom" competence strategies). Similarly, the accreditation system is assessed as working relatively well. Nevertheless, a lack of public funding and low staff/resident ratios do have a negative impact on employment and working conditions.

2.2. Industrial relations: diverse collective bargaining institutions and practices

A comparison of the main sectoral and company-level industrial relations characteristics of the four countries reveals that Belgium, France and Spain have quite robust collective bargaining structures. However, the situation is much more complex in Italy, partly as a result of some institutional specificities such as the lack of legal representativeness criteria for trade unions.

In **Belgium**, there is sectoral collective bargaining at national (joint committee 330, health care private non-profit providers) and regional levels (331 Flanders and 332 French-speaking and German-speaking community), regulating general employment and working conditions. Moreover, trade unions have concluded company collective agreements for Armonea which regulate luncheon vouchers, exceptional bonuses and compensation for working time flexibility. In addition, three regional workd councils (north and south) and two health and safety committees (Wallonie/Bruxelles) deal with information and consultation rights (I&C). There are also workers' delegates at all establishments and the trade union officer and works councillor interviewed said that Armonea meets the legal requirements in terms of I&C procedures.

In **France**, there is secforal collective bargaining at national level and well-developed social dialogue structures where social partners can formally be involved in the regulation of the sector. However, some trade unions are critical on the actual functioning of sectoral social dialogue structures. At company level (Colisée), there are works councils exercising I&C rights.

In **Spain**, the comprehensive national sectoral collective agreement for the social care sector (*Convenio estatal de servicios de atención para las personas dependientes*) coexists with regional sectoral collective agreements. In the Valencia region, where La Saleta operates, there are two different regional/sectoral collective agreements covering, respectively, "concerted residences" and the private residences subsectors. There are no company collective agreements in La Saleta or STS but there are works councils in all centres run by La Saleta and STS. According to trade union officers who were interviewed, I&C are properly exercised at both companies.

In contrast to the the other three countries, there is a very fragmented collective bargaining structure in **Italy**, with 40 multi-employer agreements at national level (interview with trade union officer). The main problem in this context is that some of these agreements are concluded by unrepresentative unions and tend to regulate poorer working conditions, thus favouring social dumping. The CGIL trade union is working to better map business structure and create instruments to be more effective in the application of the collective agreements.

At company level there are no collective agreements but there are works councils in some establishments. Representation at company level is, however, challenging due to complex subcontracting chains through which social care companies provide their services (cooperatives, etc.). A trade union representative who was interviewed said that information and consultation was not institutionalised and that he faced problems getting timely and meaningful information and was barely consulted on work organisation aspects.

2.3. Conflicts: demonstrations and strikes

Information gathered through desk research and interviews show that there have been several conflicts and industrial actions in Belgium, France and Spain calling for better working conditions and, in some cases, trying to stop restructuring processes.

In **Belgium,** trade unions called for strikes at Armonea in some establishments (*maison de repos*) in 2019. The main claims were focused on improving payment (luncheon vouchers and bonuses) and on reducing the share of employees working on a part-time basis. At the end, the company negotiated and accepted some of the workers' demands. In particular, it increased the amount of luncheon vouchers[20]. More recently, in April 2021, trade unions announced a strike in response to the company's plan to close the Sebrechts home in Molenbeek in Brussels with a threat to 108 jobs.[21]

In **France**, there have been several strikes and protests at national level in the residential care sector (EHPAD) with unions calling for better pay, career prospects and more staff. The government offered extra €50 million in funding but unions argued that this was completely inadequate to address the staffing needs[22]. According to the works council member who was interviews there has also been action at regional and company level to demand more staff.

In **Spain**, trade unions called national demonstrations in November 2019 and October 2020 to renew and improve the national sectoral collective agreement and to secure increased public funding and better pay and working conditions.

In **Italy**, there were no strikes or collective actions identified at company level, as confirmed with the interviews.

3. Working conditions

A survey of workers and trade union representative was carried out to explore working conditions, health and safety and the impact of the COVID-19 pandemic crisis. In total, 23 works council members (19 Spain, one each from Italy and Belgium and two from France) and six workers (all from Spain) responded. Accordingly the findings have to be treated with some caution because of the lack of representativeness.

3.1 General working conditions

Responses on working conditions were only gathered from Spain while responses on training and skills were gathered from works council members from Italy and France.

The main concerns for Spanish workers included:

- low wages;
- time pressures
- lack of health workers;
- inadequate career advancement; and
- lack of safe working environment.

Workers were also asked to compare their working conditions with those in other companies in the sector. Most reported that wages were below average as were many aspects of working conditions in relation to use of digital tools and data privacy rights; adjustments to the physical environment; access to training; measures to avoid discrimination; staff/resident ratio; quality and safety standards; job security; promotion and job classification; working time and work-life balance; and the likelihood to promote. The issue of work intensity proved to be somewhat controversial, with a 60% of respondents arguing that it is below average and a 40% stating that it is above average.

There was some input on training and skills from Spanish workers and French and Italian works council members. There were some demand for further training but also an indicationthat the training received in the workplace had been beneficial, particularly in relation to safety at work. However, two Spanish workers report not to having received any kind of training.

3.2 Health and safety

In terms of accidents at work and occupational illnesses over the previous five years, works council members reported different ranges – from 0-20 in Spain, 1-10 in Belgium and 1-15 in France with a very small percentage in Italy. Spanish workers reported to have experienced or been witness of safety issues in four cases.

Survey respondents were also asked to identify the main safety problems at their workplace. In terms of psychosocial problems, the most important related to time pressures, excessive hours, irregular hours and the fear of job loss. Physical problems covered the lack of ergonomic assessment of workplaces, the use of repetitive movements or the impact of harmful positions. Less consistently, workers also reported on impact of dealing with difficult customers as an issue.

Respondents were also asked to report how well the company handles the most important health and safety problems and they identified long or irregular working hours, time pressures and tiring or painful positions at work as not well dealt with by employers.

In terms of information, the Italian respondent reported being well informed as did one Spanish respondent. Otherwise responses were neutral.

3.3 The impact of the COVID-19 pandemic

The survey tried to capture the effects of the COVID-19 pandemic on working conditions, with the majority of workers referring to an increase in activity and negative impacts of additional working hours and overtime. The crisis also triggered the agreements of new safety and hygiene protocols, especially in the Spanish case and increased provision of personal protection equipment.

Table: What has been the impact of COVID-19 crisis been on your working conditions?

	BE	ES	FR	IT	Total
More personal protection equipment	1	15	0	0	16
New safety and hygiene protocols	1	21	2	1	25
Increased activity	1	22	2	1	26
Introduction of short-term working	0	4	2	1	7
Additional working hours and overtime	1	8	2	1	12
Increased staff ratio	0	4	2	0	6
Other	1	5	0	0	6

Question to both works council members and workers in Spain

Having analysed the impact of the COVID-19 on companies, attention has to be drawn to the quality of the company responses, which is shown in the table. While 10 respondents in Spain (and one in Italy) considered the company's response to be inadequate or very inadequate, nine (including one from Belgium) thought it adequate or more than adequate. Seven respondents from Spain were neutral on the question. On the question of whether trade unions and/or works councils could negotiate with the company in relation to the responses to the COVID-19 crisis half said "yes" (eight Spanish plus the Belgian and Italian) and half "no" (all Spanish), with one Spanish "don't know".

3.4 Interview findings

In **Belgium**, interviewees (one trade union officer and two work council members) said that Colisée's acquisition of Armonea hadn't altered existing management and work organisation policies. In terms of working conditions, the problem of absenteeism (sick leave) was stressed, due to difficult working conditions linked to patients with a high degree of dependency. They also mentioned that older workers find the pace of work more difficult to follow but that this is not addressed by the company. It was also noted that cleaners face complex working conditions in terms of the pace of work and work intensity and have been among the most affected by the COVID-19 crisis. However, interviewees positively assessed the company management of COVID-19 crisis, particularly in terms of provision of personal protective equipment and health protocols.

In **France**, the interview with the works council member highlighted issues around the conditions to get a "thirteenth salary" associated to sickness absences. Current conditions prevent many care workers from getting this with the problem exacerbated during the pandemic, as several workers were on sick leave with COVID-19 but also with a higher risk of becoming sick because the work intensity and work environmental factors. As in Belgium, the interviewee has a positive assessment of company management and its response to the pandemic.

In **Italy**, two interviews were conducted with a trade union officer and a trade union representative at company level. The trade union officer stressed the negative impact on working conditions because of the employers' stratey to rely on complex subcontracting chains involving (sometimes bogus) cooperatives. This is a widespread problem in the sector which the union is exploring further. Under this business model, employment has become fragmented and means that some workers do not even know the company they are working for.

The company-level trade union representative said that Colisée operated through different companies and cooperatives, with, in some cases, two different entities carrying out interlinked tasks. For instance, a supervisor visiting care residences was from the cooperative 'Punto Service' while the residences were managed by 'RSA La Villa – Varazze', which was firstly managed by Colisée and later

by Isenior. This situation tended to create problems rooted in different work cultures. Currently, the supervisor is appointed by Isenior and the management has improved.

With regard to the workers, they are all directly hired by 'RSA La Villa – Varazze' and have a genuine employment relationship. Thus, they are not subcontracted to third companies or cooperatives. In terms of working conditions, the trade union representative highlighted lack of staff (in particular nurses) and high staff turnover, exacerbated by the pandemic. In this context, the current staff is very diverse in terms of skills and previous experience in the sector, making complex to set up working teams for the shifts. However, the main problem is linked to the high heterogeneity of the population attended in the residence, with different care needs and rules (worker-to-patient ration, etc.) such as people with mental health problems, elderly people with relatively high autonomy and elderly people with mobility problems.

Finally, the three interviewees from **Spain** (two trade union officers and one works council member) explained that employment and work organisation policies developed in La Saleta have not been altered since the company was absorbed by Armonea and, later by Colisée. They also said that the company provides better working conditions compared to other multinational companies operating in the sector, such as ORPEA. In their view, the main working conditions problems concern work overload and work intensity due to low ratios of carers to residents. Work overload and work intensity are critical psychosocial risks which cause carers musculoskeletal pain to workers. They also highlighted the problem of low remuneration in relation to work requirements and the level of workers' qualifications. It was noted, however, that employees in La Saleta have better wages compared to the national average because of a regional collective agreement. Generally, it was assessed that problems of working conditions have been exacerbated by the pandemic because of new protocols entailing higher work intensity.

4 Conclusions

The four European countries where Colisée operates show some similarities in terms of the sectoral regulatory framework, with regional government bodies playing a key role in the regulation, accreditation and supervision of private providers of elder care. This means that there are some regional disparities in terms of employment and working conditions. With regard to the main sectoral industrial relations' patterns, Belgium, France and Spain have robust collective bargaining structures due to the existence of comprehensive national sectoral collective agreements that regulate general employment and working conditions which, in Belgium and Spain, are articulated with regional collective agreements.

The situation is much more complex in Italy, where collective bargaining is highly fragmented, partly because of institutional specificities (i.e., lack of legal representativeness criteria for trade unions). At company level, in Belgium, France and Spain there is a consolidated trade union presence. On the contrary, representation at company level is particularly challenging in Italy because of employers' strategies relying on complex subcontracting chains. There is also some evidence from Belgium, France and Spain that trade unions have the capacity to mobilise workers at national or company/local level in demonstrations or strikes over jobs, pay and funding.

In all four countries, working conditions are determined by the legal framework and public funds. Indeed, Colisée's acquisition of national companies does seem to have altered employer and work organisation policies. Generally, the main common problems are related to low wages, health and safety, work intensity and working time. In Italy, there is the specific problems of subcontracting and fragmentation which have a negative impact on working conditions and also hinders trade union capacity to enforce the regulation. There is also evidence of understaffing, high turnover and considerable heterogeneity of residents, with different care needs and rules.

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