4 Addressing retention by creating better-quality jobs in long-term care

This chapter reports new analysis on tenure and working conditions for long-term care (LTC) workers. It highlights in particular the fact that LTC workers tend to have lower than average tenure, and quantifies the extent of non-standard work, low pay and health problems among LTC workers in OECD countries. The chapter also identifies policy options to address challenges in working conditions that may thereby contribute to retaining workers in the LTC sector. These include measures on wages, social dialogue, occupation health and improving workers' autonomy.

4.1. Many more quality jobs are needed

Over recent decades, low retention in the LTC workforce has been an important topic and is one of the main policy challenges encountered in OECD countries. Difficult working conditions, such as low competitiveness of wages, precarious job status, demanding jobs with high exposure to physical and mental risk factors and low job satisfaction – driven by low support and autonomy – explain why it is difficult to retain workers in LTC (OECD, 2019[1]; Osterman, 2017[2]). The Norwegian Nurses Organisation reports that one nurse in five quits the LTC workforce within the first five years of their employment, mainly because of the working conditions affecting their work-life balance and health.

Addressing future LTC needs of the ageing population will not be possible unless more is done to make the sector more attractive and to improve working conditions. Turnover in health facilities reduces the effectiveness and productivity of delivering care (Squillace, 2008[3]). For instance, a 10% increase in turnover was associated with an increase in mortality among nursing home care residents and a decrease in the quality of care measured by the physical environment and infection control, among others (Akosa Antwi and Bowblis, 2016[4])

High rates of staff turnover generate not only a poorer quality of care but also higher costs. Turnover requires hiring replacement staff, which entails recruitment costs and generates periods of understaffing. In addition, newly hired personnel require training in the facility's policies and work procedures. A US study found that the marginal cost savings associated with a ten percentage point increase in turnover for an average facility was 3% of annual total costs (Mukamel, 2009[5]).

The objective of this chapter is to document the working conditions driving poor retention in the LTC workforce across OECD countries and explore policies that could be implemented. The remaining sections are organised as follows. Section 4.2 shows that LTC workers do not stay long with their employers. Section 4.3 shows that LTC workers face low job quality. Section 4.4 investigates how countries are seeking to improve working conditions in the LTC sector. Section 4.5 provides a short conclusion.

Key findings

- Tenure in the LTC workforce is low: LTC workers do not stay long with their employers. The average tenure is two years lower in the LTC than in the overall workforce, and fewer workers consider a long career in LTC work than in hospital work.
- LTC is predominantly a low-paid sector: wages are low, especially for personal care workers. Across 11 OECD countries, LTC workers receive EUR 9 per hour (median wage), compared to EUR 14 for hospital workers.
- LTC job quality is low. Non-standard employment is high in the LTC sector: temporary employment is almost twice as high as in the hospital sector. Half of LTC workers do shift work and 45% work part time. In several countries, part-time workers wish to increase their hours but are not offered longer schedules.
- LTC workers face important work-related health issues. Exposure to risk factors for mental well-being and for physical health issues is high among LTC workers, explaining why sickness leave is high in the profession in many countries. Poor work organisation leads to a lack of job satisfaction and increased stress among workers, and reduces opportunities to maintain a good work-life balance.
- It is unlikely to be possible to attract and retain sufficient workers in LTC to meet the growing demand unless pay and working conditions change. Improving LTC jobs would also improve quality of care and reduce turnover costs.

- More than half of OECD countries implemented measures to improve working conditions and address retention in the past decade. Many measures led to positive results, including improving working arrangements, such as introducing flexible workforce arrangements or increasing autonomy; reducing undeclared work through service vouchers or tax credits; workplace interventions; and improving safety at work.
- Some measures to improve working conditions are promising but have not yet been evaluated: providing longer working hours for involuntary part-time workers (Germany, Portugal), developing coaching programmes (Netherlands) to promote prevention of accidents and burnout in the workforce.
- More than half of OECD countries implemented measures to upgrade wages and benefits in the past decade. Evaluations suggest that while increasing wages influences turnover, the effect is small and, in some cases, may lead to more precarious employment, reduced hours or increased workload, unless accompanied by sufficient funding. Collective bargaining and social dialogue can help to implement comprehensive policy measures, including on pay, training and working conditions.

4.2. LTC workers do not stay long in the sector

This section documents the extent of challenges to address retention among LTC workers. Identifying LTC workers in data sources to have comprehensive picture of their working conditions is not straightforward. Using specific surveys on the sector precludes comparison with other sectors, and such surveys are not always performed on a regular basis across a number of countries. In order to identify LTC workers in routinely collected data, it is necessary to cross-reference information on the specific occupation and industry with a high level of detail (Box 4.1).

Box 4.1. Identifying LTC workers: Data sources

LTC workers are individuals who provide care to LTC recipients at home or in LTC institutions (other than hospitals). Following the OECD definition, formal LTC workers comprise two main professional categories: nurses and personal care workers. Personal care workers include formal workers providing LTC services at home or in institutions (other than hospitals) who are not qualified or certified as nurses.

Few reports provide international comparisons of the working conditions of LTC workers. Routinely collected surveys of workers can be used to explore the characteristics of the LTC workforce, but in order to identify LTC workers, such data sources need to have a high level of detail in terms of occupation (at the 3- or 4-digit level) and need to cross-reference that information with the industry code (at the 2-digit level) to make sure that such nurses and personal care workers are in institutions or homes and not in other health sectors.

For European countries, this chapter relies on the European Union Labour Force Survey (EU-LFS). Identification is based on the Nomenclature des Activités économiques dans la Communauté Européenne [Classification of economic activities of the European community] (NACE) 2-digit (88 social work activities without accommodation and 87 residential care activities) and the International Standard Classification of Occupations (ISCO) 4-digit codes (2221 for professional nurses, 3221 for associate professional nurses, 5322 for home-based personal care workers, and 5321 for health care assistants). In addition, information on wages for Europe comes from the 2014 European Union Structure of Earnings Survey (EU-SES). For health-related information, the 2013 ad hoc module of the LFS includes data on accidents at work and other work-related health problems.

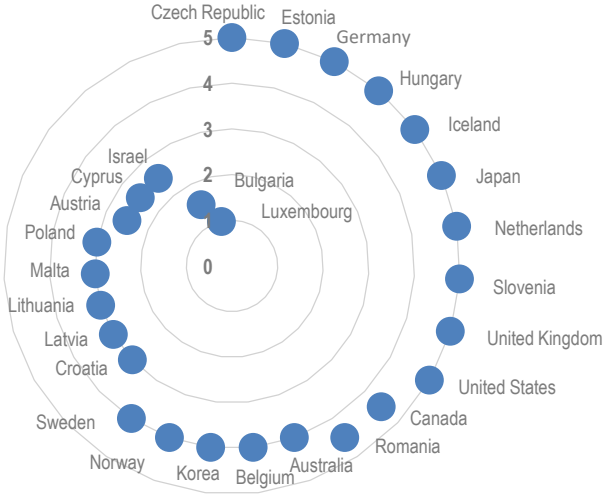
In the United States, the March supplement of the Annual Social and Economic Supplement of the Current Population Survey (ASEC-CPS) is used. The cross-referencing of industry and occupation is based on the North American Industry Classification System (NAICS) codes (8170 for home health care services, 9290 for private households health services, 8270 for nursing care facilities, and 8290 for residential care facility without nursing) and the Standard Occupational Classification (SOC) codes (3130 and 3255 for registered nurses, 3258 for nurse practitioners, 3500 for licensed practical and licensed vocational nurses, 3 600 for nursing, psychiatric and home health aides, and 4610 for personal and home care aides).

In addition, Australia's data were based on the Australia Aged Care Workforce 2016 report, published by the Department of Health of the Australian Government. For Canada, the source was the Census survey of 2016. Israel's data were based on their national LFS. For Japan, the source was the survey on Long-term Care Workers FY2016. For Korea, the source was the National Health Insurance Survey's database for the registry of LTC providers, using the Long Term Care Provider Report for Registration. New Zealand's data were based on the New Zealand Aged Care Workforce 2016 report, published by the New Zealand Work Research Institute.

4.2.1. Addressing retention issues is a top policy priority

Almost two-thirds of OECD countries identified LTC worker retention as one of the highest political challenges within the LTC agenda (Figure 4.1) Failing to address this has implications for both quantity and quality of LTC. High turnover can reduce quality of work, as new workers need to learn the care recipients' preferences; this disrupts elderly people and results in a waste of resources from employers who need to spend time on recruitment and training efforts.

Figure 4.1. Many countries rank retention as a challenge of high importance within the LTC agenda



Note: Countries answered the following question: "On a scale between 1 (low-level) and 5 (high-level), what is the challenge faced to retain LTC workers into the LTC workforce in your country?"
Source: 2018 OECD LTC workforce survey.

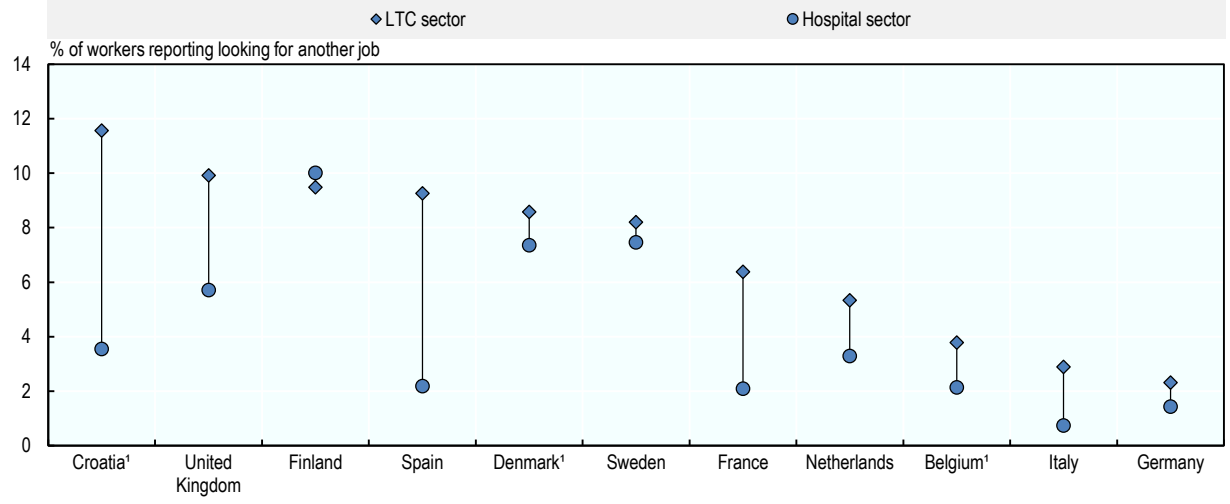
Most OECD countries face high turnover, with workers leaving the sector after a few years. In countries for which data are available, it is estimated that turnover issues affect between one-quarter and one-third of LTC workers. For instance, in the United States, turnover in the overall LTC workforce is a challenging issue: in 2013, 13% of LTC workers were entrants while 21% were LTC sector leavers (OECD, 2019[1]). In

Germany, estimates based on the German Socio-economic Panel show that on average only 68% of LTC workers in a given year keep participating in the LTC workforce the following year. This holds true for people who have recently completed their training, according to the German Institute for Employment Research. However, after that high turnover in the first professional year, the loyalty to the profession remains relatively constant in the following years. Reasons for the high turnover in the first professional year. In Australia, recent evidence shows that, in 2017, 94% of LTC employers had to recruit personal care workers just to cope with turnover issues (compared to 88% in 2014) (Mavromaras et al., 2017[6]). In France, about 20% of home-based positions were estimated to be vacant in 2018 and over 80% of institutions reported at least one vacant position in 2015, the position of personal care workers being the most difficult position to fill in institutions. Overall, it was estimated that 60 000 positions were unfilled in 2019 (El Khomri, 2019[7]). In addition, results from the last wave of the survey on LTC institutions (Enquête auprès des établissements d'hébergement pour personnes âgée/EHPA) survey show that, in 2015, 34.6% of institution-based workers were interim workers (Muller, 2017[8]). In the United Kingdom, the mean turnover rate among care workers between 2008 and 2010 was 23% (Hussein, Ismail and Manthorpe, 2016[9]).

European data show that more workers are looking for another job in the LTC workforce than in the hospital workforce, reflecting either dissatisfaction with the work or a lack of job security (Figure 4.2). In the United Kingdom, almost 10% of LTC workers are actively looking for another job, compared to 6% in the hospital workforce. In Spain, the equivalent proportions are 9% (LTC) and 2% (hospital); in France, they are 6% (LTC) and 2% (hospital). In Scandinavian countries (Finland, Denmark and Sweden), the proportions of LTC workers looking for new job opportunities are also high but are close to the hospital workforce proportions. A large share of care workers (one-third to almost one-half) in Scandinavian countries reported that they had seriously considered quitting; this increased between 2005 and 2015 (Rostgaard et al., 2019[10]).

Figure 4.2. More workers are looking for another job in the LTC than in the hospital workforce

Share of workers reporting looking for another job, by sector, 2016



Note: Data were calculated based on ISCO 3-digit and NACE 2-digit codes. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.

1. Data must be interpreted with caution, as sample sizes are small.

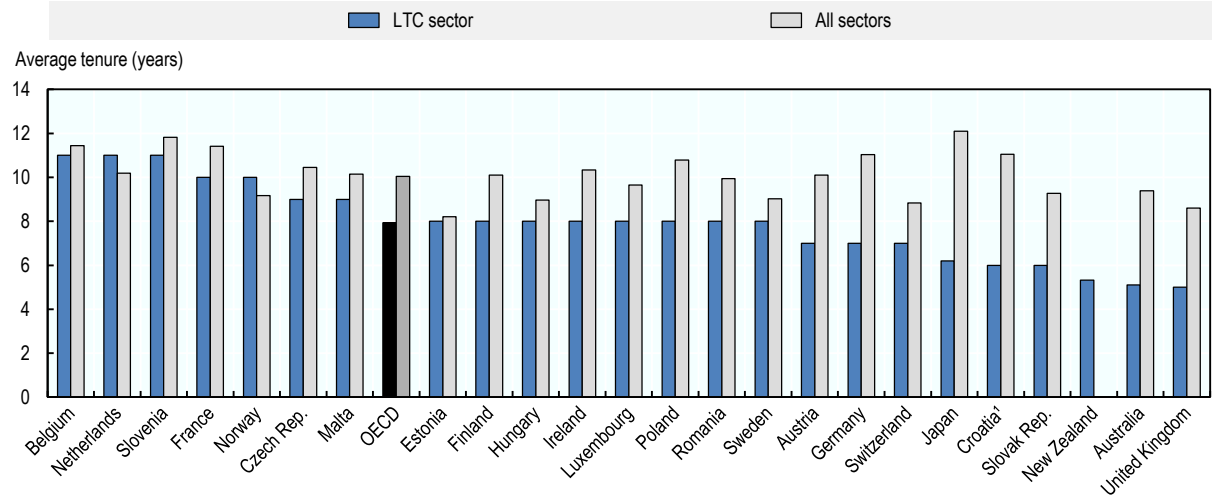
Source: EU-LFS (data refer to 2016).

4.2.2. Tenure is low in the LTC workforce

In most OECD countries, the average tenure[1] rate in the LTC sector is lower than in the overall working population (Figure 4.3), with an overall difference of two years. The exceptions are the Netherlands and Norway, where the average tenure rates in the LTC workforce (11 and 10 years respectively) are 1 year higher than in the overall working population. Since 2011, both countries have implemented a comprehensive strategy to develop their LTC workforces, involving policies to improve co-ordination, retention, prevention and use of technology, as well as recruitment programmes targeting new groups of workers, which may explain in part why tenure is higher.

Figure 4.3. Tenure is lower in the LTC workforce than in the overall workforce

Average tenure of LTC workforce, by sector, 2016



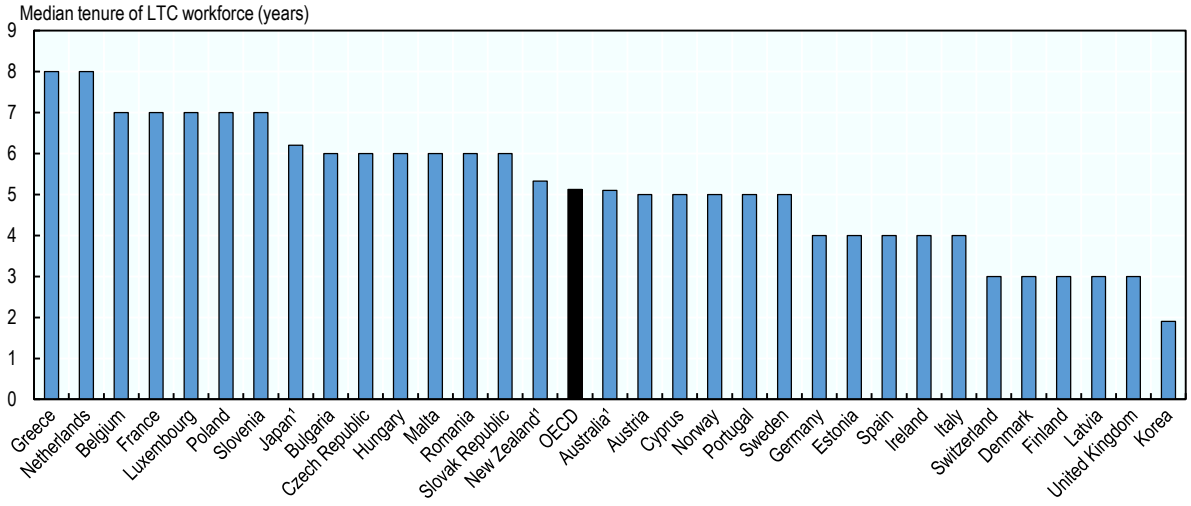
Note: The OECD data point is the unweighted average of the 21 OECD countries shown in the chart. EU-LFS data were based on ISCO 3-digit and NACE 2-digit codes. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
1. Data must be interpreted with caution, as the sample size is small.
Source: EU-LFS; Survey on Long-term Care Workers for Japan; OECD estimates based on national sources for Australia and New Zealand; OECD Database. Data refer to 2016.

In addition to mean tenure, looking at median data provides a better understanding of tenure, in particular if there are many low values because of people leaving the sector early. In OECD countries, the median tenure rate is five years, which is lower than average and confirms that many LTC workers have low tenure (Figure 4.4). Again, there are large differences across countries: median tenure ranges between two years in Korea and eight years in the Netherlands.

Note, however, that because of data limitations, the tenure rates presented in Figure 4.3 and Figure 4.4 aggregate nurses and personal care workers, who often have different tenure rates. In Norway and the Netherlands, nurses have lower median tenure rates than personal care workers, and both countries report that the challenge associated with nurses' retention is higher than the challenge associated with personal care workers' retention. In other countries, such as Austria and Belgium, nurses have a lower median tenure than personal care workers.

Figure 4.4. The median tenure in the LTC workforce varies across OECD countries

Median tenure of LTC workforce, by country, 2016



Note: The OECD data point is the unweighted average of the 29 OECD shown in the chart. For European countries, data refer to personal carers and nurses not working in hospital. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2. 1. Data refer to average tenure.

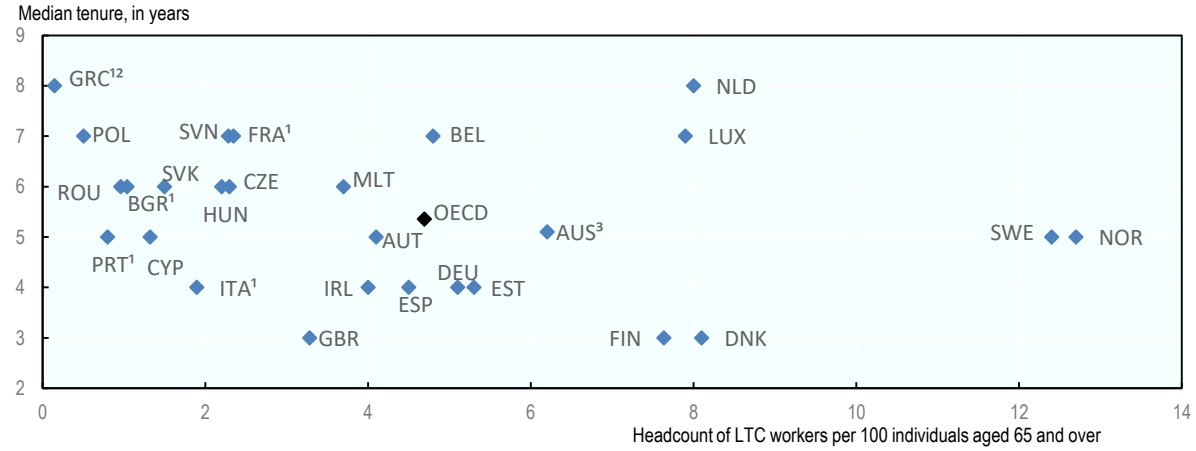
Source: EU-LFS; Survey on Long-term Care Workers for Japan, National Health Insurance System for Korea, OECD estimates based on national sources for Australia and New Zealand. Data refer to 2016.

Figure 4.5 shows the correlation between median tenure rates and the LTC supply per 100 people aged 65 and over. Four groups of countries can be identified:

- In some countries (Luxembourg, the Netherlands, Sweden and Norway), the supply of LTC workers is high, and workers' tenure is greater than or equal to five years. In these countries, both recruitment and retention rates are among OECD's highest. They have been able to develop their LTC workforce successfully since 2011 (both number of workers and experience).
- In some countries (including Estonia, Germany, Finland and Denmark), the supply of LTC workers is larger than or close to the OECD average, but the number of years LTC workers spend with their employer is lower. Therefore, these countries seem mainly to face retention issues.
- In some countries (including France, Slovenia, the Czech Republic and Poland), LTC workers' tenure is greater than the OECD average, but the number of LTC workers per 100 people aged 65 and over is much lower. These countries seem to face greater recruitment than retention issues.
- Finally, certain countries (including the United Kingdom and Italy) face both lower supply and lower tenure of LTC workers than most OECD countries.

Figure 4.5. Tenure and size of the workforce differ across countries

Number of LTC workers per 100 individuals aged 65 and over and median tenure, 2016 (or nearest year)



Note: The OECD data point is the unweighted average of the 23 OECD countries shown in the chart. EU-LFS data are based on ISCO 4-digit and NACE 2-digit codes. A list of country abbreviations is provided in Annex 4.A.
1. Data are based on ISCO 3-digit and NACE 2-digit codes. 2. Data must be interpreted with caution, as sample sizes are small. 3. Data refer to average tenure.
Source: EU-LFS, Quarterly Labour Force Survey for the United Kingdom, ASEC-CPS for the United States, OECD Health Statistics 2018, https://doi.org/10.1787/health-data-en, Eurostat for population demographics; OECD tenure estimate based on national source for Australia. Data refer to 2016 or nearest year.

4.3. Low pay and poor job quality prevail in LTC

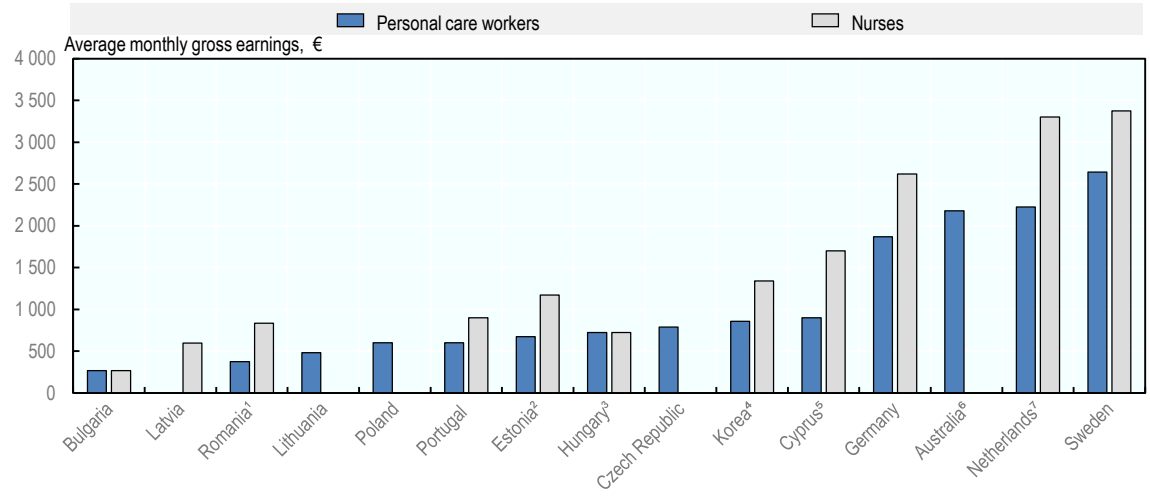
4.3.1. LTC is predominantly a low-paid sector

Current wages in the LTC workforce are low, especially for personal care workers, who often have lower salaries than nurses (Figure 4.6). In several countries, personal care workers are paid the minimum wage. In Portugal, for instance, the average annual salary of a personal care worker is around EUR 600 monthly, roughly the minimum wage (based on 12 monthly payments), while nurses are paid EUR 900. In Ireland, personal care workers (health care assistants) receive an average of EUR 10.40 per hour in the private LTC sector, which represents a wage 6% above the minimum wage but 23% lower than in the public LTC sector.

Earnings in the LTC workforce are significantly lower than in the hospital sector when comparing workers in the same broad occupations (Figure 4.7). Across 11 EU countries, LTC workers received EUR 9 per hour (median wage), compared to EUR 14 for hospital workers. This wage difference contributes to explaining why hospital jobs are more attractive than LTC jobs. The wage difference can be large in some OECD countries (such as Israel, Canada and the United Kingdom).

Figure 4.6. Salaries in the LTC workforce tend to be low

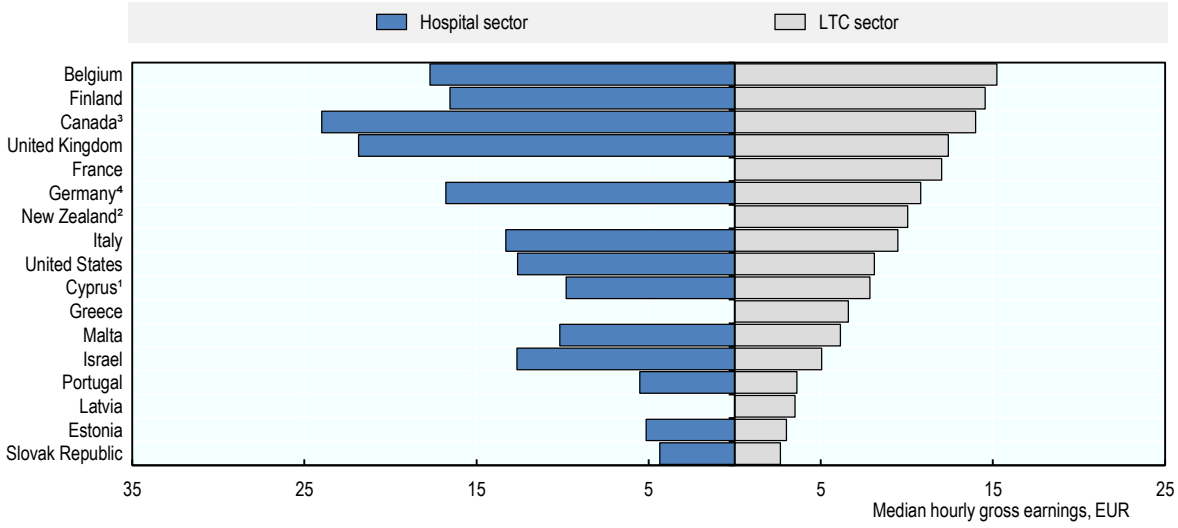
Average gross monthly earnings in EUR, 2017 (or nearest year)



Note: For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
1. Data for personal carers and nurses refer to an average based on different qualifications. 2. Data for personal carers refer to an average based on different qualifications. 3. Breakdown is not available. 4. Data for nurses refer to an average based on different qualifications. 5. Data refer to the public sector. 6. Data refer to the median gross monthly earnings in residential aged care for personal carers. 7. Data for personal carers refer to an average based on different qualifications and data for nurses, excluding irregular earnings.
Source: OECD LTC workforce survey 2018 (data refer to 2017 or nearest year).

Figure 4.7. Workers are paid less in the LTC than the hospital sector

Median hourly gross earnings, population aged 20-59, 2014 (or nearest year)



Note: Data cover those aged between 20 and 59 years old. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
1. Data refer to 2010 and must be interpreted with caution, as the sample size is small. 2. Data refer only to personal carers. 3. Data cover those working full time, full year. 4. Data on the hospital sector cover those working full-time and assume an equal distribution of nurses and personal carers.
Source: European Union Structure of Earnings Survey (2014), OECD questionnaire (2018) for Latvia, ASEC-CPS (2015) for the United States, Census 2016 for Canada, OECD estimate based on national source for New Zealand (2016). Data refer to 2014 or nearest year.

Low wages in some countries are explained by the fact that certain parts of the sector are not fully covered by regulations on wage agreements or fall under special regulations. In the United Kingdom, the Low Pay Commission has flagged social care as a sector of concern due to non-compliance with the national minimum wage. The difficulty of solving underpayment issues (low wages, non-payment of the national minimum wage) has been a factor explaining why the home care sector experiences the highest turnover and vacancy rates in adult social care in England, United Kingdom (Hussein, Ismail and Manthorpe, 2016[9]). In England, between 9% and 13% of care jobs are estimated to pay below the national minimum wage, mostly because of unpaid time, which includes travelling time, training time and "on-call" hours (Gardiner, 2015[11]). Similarly, a study of home care of elderly people in England found widespread use of zero-hours contracts[2] and paid hours restricted to time with patients, with staff uncompensated for travel time (Rubery et al., 2015[12]). In France, the wage agreements for home-based LTC workers, established in 2010, set a gross minimum wage that is now below the national minimum wage (EUR 1 452.6 per month and EUR 1 521.22 per month respectively in 2019) (El Khomri, 2019[7]).

Cost-cutting measures in countries facing LTC system financing constraints can also lead to downward pressure on wages in the formal LTC sector, or lower employment. This is, for example, the case in the Netherlands, where a 2015 reform transferred the LTC insurance budget management to municipalities, which are now in charge of paying LTC workers mostly for household tasks such as cleaning and cooking. The reform was associated with a EUR 0.5 billion budget cut (Maarse and Jeurissen, 2016[13]), which decreased substantially the funds allocated to municipalities, to the detriment of the workforce and employers. It led municipalities negotiating lower tariffs with LTC providers. Providers of domestic help complain that this has led to lower prices per hour for services, resulting in providers going bankrupt, lay-offs, low wages and temporary contracts and/or contracts for short hours.

4.3.2. Non-standard work can affect work-life balance and job security

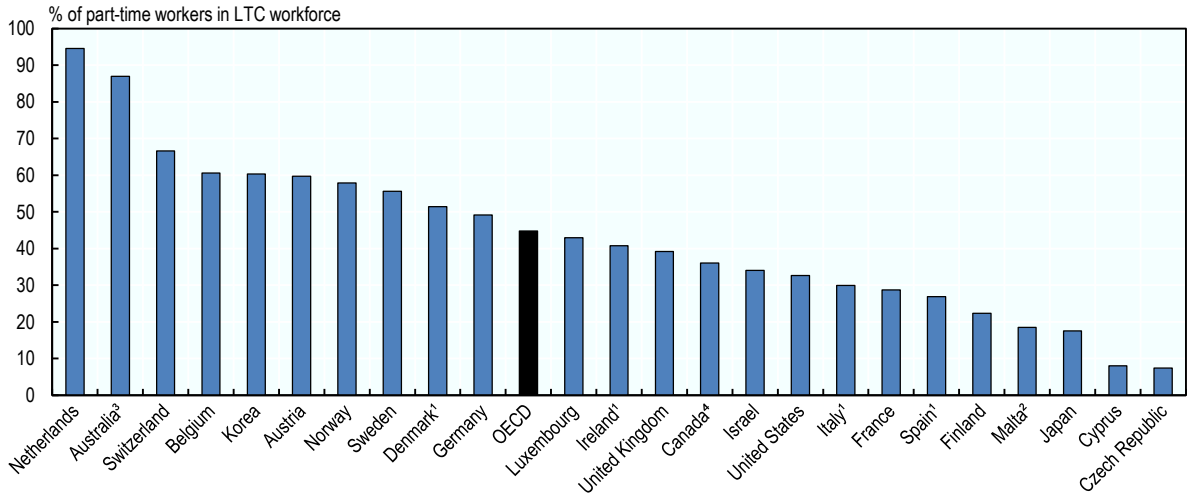
Non-standard employment is high in LTC

Part-time employment is sizeable in the LTC workforce. It is on average twice as high as the average rate in the economy. Figure 4.8 shows that 45% of LTC workers work part time in OECD countries. In northern and central European countries, more than half of the workers have part-time jobs. In most countries, personal care workers and home-based workers are more likely to work part time than nurses and residential-based workers.

While working part time can be a choice, especially among workers wanting a better work-life balance, high rates of part-time work are also due to use of LTC services for reduced hours at specific times of the day. Consequently, part-time contracts usually result in short-hour contracts of 12-18 hours per week; these are often for morning and evening hours to provide help with getting out of bed, going to bed and feeding and washing. In France, for instance, half of the elderly population with LTC needs receive one hour and 10 minutes per day of professional help (Brunel, Latourelle and Zakri, 2018[14]) and almost 80% of home-based LTC employees work part-time (El Khomri, 2019[7]) In this respect, involuntary part-time work can be an issue in the sector. For instance, almost one-third of workers in Australia report that they want to work more hours (Meagher, Szebehely and Mears, 2016[15]). Involuntary part-time work has also been recorded as an issue in Scandinavian countries, especially in Norway, using Nordcare surveys. Part-time work can also affect take-home pay, especially if travel time is not fully compensated for. In the United States, personal care workers wish to work more hours and have to work with multiple clients or agencies to earn sufficient income (Osterman, 2017[2]). LTC work can also be part time because of the heavy workload, which is often cited as a reason to limit working hours.

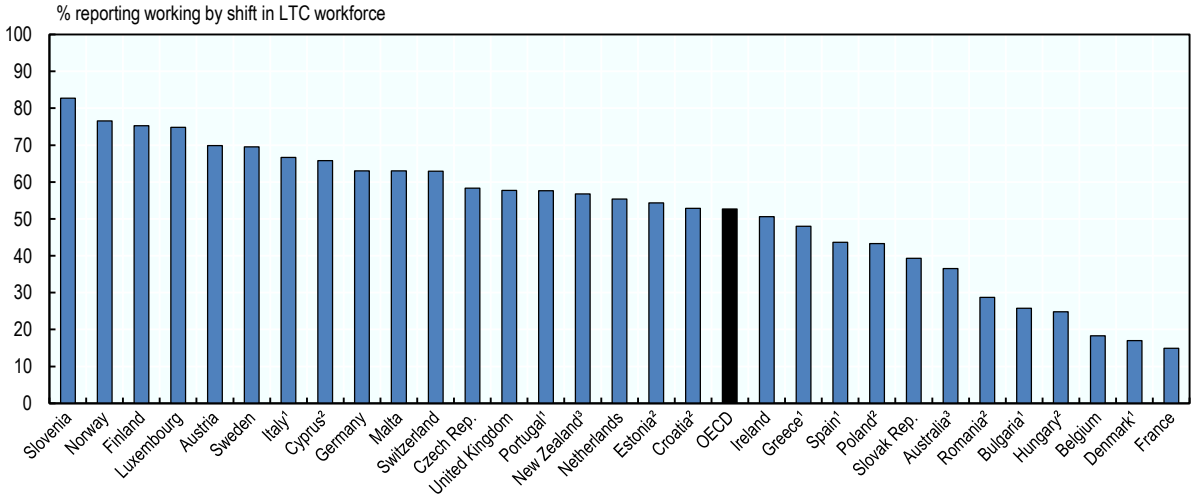
Figure 4.8. About 45% of LTC workers hold part-time positions across OECD countries

Share of the workforce reporting working part time, 2016



Note: The OECD data point is the unweighted average of the 22 OECD countries shown in the chart. EU-LFS data are based on ISCO 4-digit and NACE 2-digit codes. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
1. Data are based on ISCO 3-digit and NACE 2-digit codes. 2. Data must be interpreted with caution, as sample sizes are small. 3. Data cover only those with a permanent position. 4. Data cover only those working mostly full time or mostly part time.
Source: EU-LFS; ASEC-CPS for the United States; Census 2016 for Canada; Labour Force Survey for Israel; Survey on Long-term Care Workers for Japan; National Health Insurance System for Korea; OECD estimate based on national source for Australia. Data refer to 2016 or nearest year.

Figure 4.9. Half of carers work shifts on average in OECD countries



Note: The OECD data point is the unweighted average of the 25 OECD countries shown in the chart. EU-LFS data are based on ISCO 4-digit and NACE 2 digit codes. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
1. Data are based on ISCO 3-digit and NACE 2-digit codes. 2. Data must be interpreted with caution, as sample sizes are small. 3. Data refer to those who do not work regular daytime shifts.
Source: EU-LFS; OECD estimates based on national sources for Australia and New Zealand.

Shift work[3] is widespread in the LTC sector (Figure 4.9): half of LTC workers work shifts across OECD countries, although there are large differences across countries. In Scandinavian and central European countries, more than 70% of LTC workers work shifts, while the figure is less than one-quarter in Belgium, Denmark and France. A large body of evidence suggests that shift work is associated with a wide range of health risks such as anxiety, burnout and depressive syndromes (Saint-Martin, Inanc and Prinz, 2018[16]).

Large differences also exist within the LTC workforce. Compared to home-based carers, those working in institutions are 80% more likely to work shifts on average (in the 14 countries for which data are available). Again, there are large differences across countries. In Finland, Norway, Sweden and Germany, more than half of home-based carers work shifts, while the figure is less than 40% in the United Kingdom and the Slovak Republic.

In addition, LTC workers are also more likely to work on weekends compared to other medical or social professions. For instance, a survey of 6 066 French LTC workers showed that 92.9% of personal care workers and 85.1% of nurses regularly work during weekends, compared to 42% of general practitioners and 35.6% of speech therapists (Truchot, 2018[17]).

Three models of working arrangements in the LTC sector can be identified. In the first, the LTC workforce market relies on high levels of part-time and shift work (Netherlands, Switzerland, Austria, Norway, the United Kingdom and Sweden). In the second, working arrangements mix low levels of part-time work with high levels of shift work (Italy, Denmark and Finland). In the third, working arrangements involve low levels of part-time and shift work (France, Spain and Ireland).

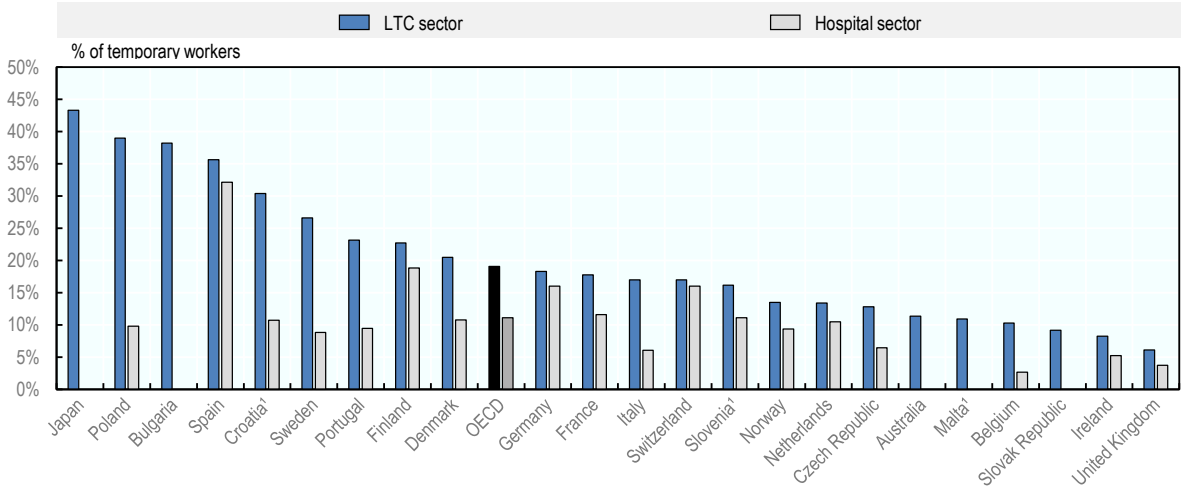
Temporary contracts and new forms of employment raise concerns for job security

The share of temporary employment is high in the LTC sector compared with the hospital sector (and with the average in the economy). This situation reduces job security and career prospects among workers. In the 20 OECD countries for which data were available, 19% of LTC workers on average have temporary contracts (Figure 4.10). This share reaches 30% or more in Poland and Spain, while it is 10% or less in Belgium, the Slovak Republic, Ireland and the United Kingdom. In comparison, the share of temporary hospital workers is 11% on average in the 20 countries. In many countries, temporary workers face a wage penalty and their contracts are not stepping stones to permanent jobs (OECD, 2015[18]).

New forms of employment (such as zero-hours contracts and temporary agency work), while not yet widely used, appear to be prominent in some countries, generating more job insecurity in the sector. In France, institutions employ a great proportion of temporary agency (interim) workers: results from the last wave of the survey on LTC institutions (EHPA) show that, in 2015, 41.1% of institutions and 33.3% of long-stay facilities faced recruitment issues, and 34.6% of institution-based workers were interim workers (Muller, 2017[8]). In England, United Kingdom, the share of workers on zero-hours contracts represents a quarter of the entire workforce in the sector (Eurofound, 2015[19]). In the Netherlands, workers providing domestic help are sometimes hired as “false” self-employed workers, as they typically work for a single employer. This is a means of avoiding social security obligations, since employers do not have to contribute to disability insurance and pensions. In the United States, 10% of personal care workers are self-employed and thus do not have the same access to collective bargaining rights and social protection as those with employment contracts (Osterman, 2017[2]).

Figure 4.10. Temporary contracts are more common in the LTC than the hospital sector

Share of temporary workers in LTC sector and hospital sector, 2017 (or nearest year)



Note: The OECD data point is the unweighted average of the 20 OECD countries shown in the chart. Data are based on ISCO 3-digit and NACE 2-digit codes. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
1. Data must be interpreted with caution, as sample sizes are small.
Source: EU-LFS; Survey on Long-term Care Workers for Japan; OECD estimate based on national source for Australia. Data refer to 2016 or nearest year.

Undeclared work employment is also a concern in the LTC workforce. Undeclared workers are often irregular migrant workers hired privately by households. In the United States, there is also a so-called grey market, where consumers hire and pay LTC workers under the table; this is estimated to include about 300 000 personal care workers, or an additional 20% (Osterman, 2017[2]). In Spain and Italy, the widespread undeclared status of workers can lead to abusive situations, including long working hours and low wages, and a lack of training opportunities (Casanova, Lamura and Principi, 2017[20]). Undeclared workers in LTC are often migrants, and guaranteeing fair working conditions for migrant workers is a major challenge. A particular issue is that undocumented people may often enter the country with a tourist or student visa and perform illicit work as domestic workers but fail to access social security benefits (Luppi et al., 2014[21]). In Latin American countries, such as Colombia, in some cases workers perform their duties following a verbal agreement and work without a contract, without minimum standards.

4.3.3. Work-related health issues are important

Care workers say that their work is often rewarding but emotionally and physically demanding. Between one-third and just under one-half of LTC workers in Scandinavian countries report being usually physically exhausted after a work day (Rostgaard et al., 2019[10]). This figure is comparable to the share of home care workers in Austria (41%) but among residential care workers in Austria the proportion who report being physically exhausted after a work day is 68% (Bauer, Rodrigues and Leichsenring, 2018[22]). This may help to explain why the prevalence of health issues related to work is slightly higher in the LTC than in the hospital sector (Figure 4.11).

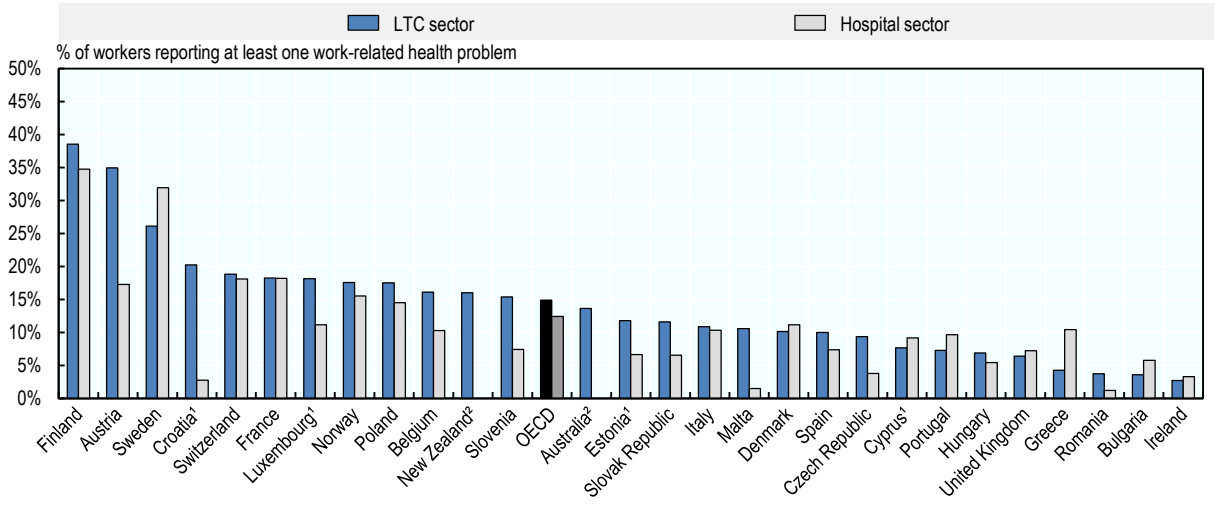
Over 25% of LTC workers in Finland and Sweden report at least one work-related health problem. Among southern European countries, Italy, Spain and Portugal have lower rates, ranging from 7% to 11%. Across OECD countries, 15% of LTC workers reported work-related health issues on average, compared to 12% of hospital-based workers. In comparison, 7.9% of people across all 28 EU countries reported experiencing

work-related health problems in the past 12 months, showing that in most countries LTC workers face larger risks than the overall population.

In some countries (Sweden, the Czech Republic, Switzerland, the United Kingdom and Denmark), work-related issues are less prevalent in the LTC than in the hospital workforce. In these countries, differences are small, except in Sweden, where the difference is six percentage points (26% for LTC workers and 32% for hospital-based workers).

Figure 4.11. Over 15% of LTC workers report work-related health problems

Share of workers reporting physical or mental health problems suffered in the previous 12 months caused or made worse by work, excluding accidents at work, by sector, 2013

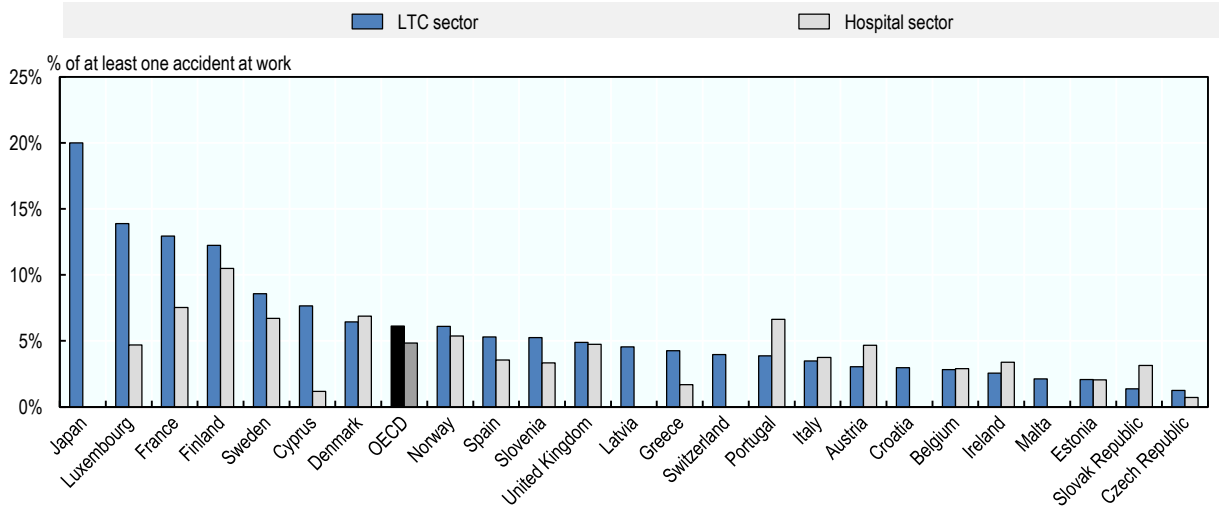


Note: The OECD data point is the unweighted average of the 23 OECD countries shown in the chart. EU-LFS data were calculated based on ISCO 3-digit and NACE 2-digit codes. For a description of the methodology to identify workers see Annex 2.A in Chapter 2.
1. Data must be interpreted with caution, as sample sizes are small. 2. Data refer to those reporting back pain in New Zealand and those reporting at least one illness or injury in Australia.
Source: Ad hoc module EU-LFS (data refer to 2013); OECD estimates based on national sources for Australia and New Zealand (data refer to 2016).

LTC workers have a higher risk than hospital workers of experiencing accidents at work leading to injuries (Figure 4.12). Available data show that the rate varied from 20% in Japan to 1% in the Czech Republic and Slovak Republic. In Scandinavian countries, more than 6% of carers suffer from accidents at work on average. In the United Kingdom and in Spain, the rate was 5%.

Figure 4.12. Accidents at work leading to injuries are higher in LTC than in hospitals

Share of workers reporting at least one accident at work resulting in injury in the previous 12 months, by sector, 2013 (or nearest year)



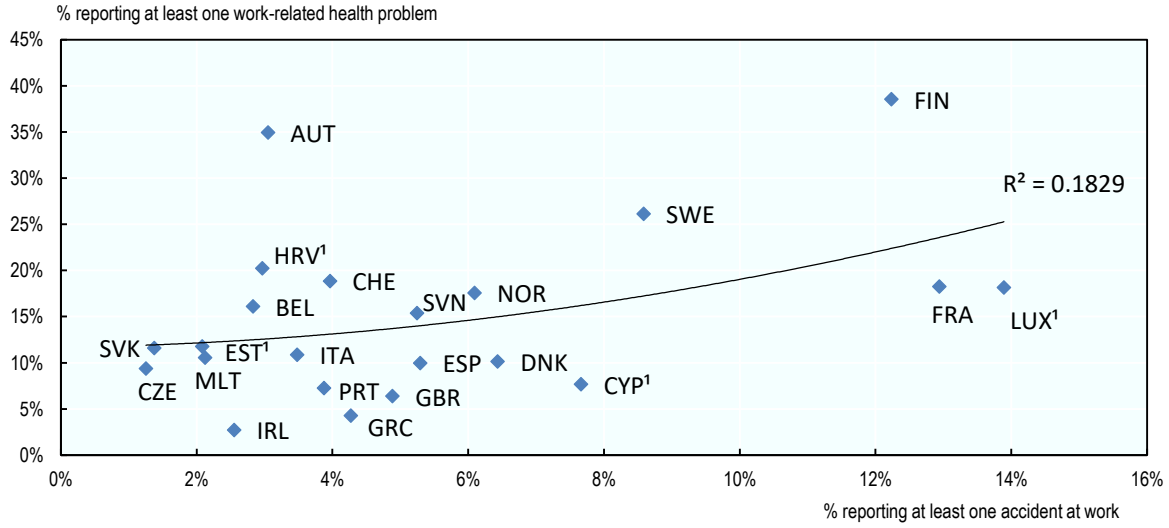
Note: The OECD data point is the unweighted average of the 21 OECD countries shown in the chart. EU-LFS data were calculated based on ISCO 3-digit and NACE 2-digit codes. For a description of the methodology to identify workers, see Annex-2.A in Chapter-2.
Source: Ad hoc module EU-LFS (data refer to 2013); Survey on Long-term Care Workers for Japan (data refer to 2014).

Countries with a high share of accidents also show high rates of health complications. Figure 4.13 shows that the association between accidents at work resulting in injuries and work-related health problems is important (correlation of +0.18). Countries such as France and Finland have the highest shares of LTC workers reporting accidents at work and work-related health problems. In France, the social health insurance (*Caisse nationale d'assurance maladie*) counted in 2017 that 24 000 accidents, 2 000 transport accidents linked to work and 1 200 work-related illnesses occurred in institutions and that another 19 000 accidents happened at homes when working (El Khomri, 2019[7]).

Sickness absence tends to be high in the LTC sector. In Norway, close to 10% of the municipal workforce experienced sick leave, representing 8 million work days annually. Although this figure includes all workers, data show that health care workers are one of the largest groups of sick leave users, so the Norwegian Association of Local and Regional Authorities suggests that extra efforts are needed to reduce sick leave rates in order to meet the 6.7% target defined by the Inclusive Workplace Agreement signed by the Norwegian government and social partners (2014-18). In the Netherlands, sickness absence in the sector is twice the national average. In France, on average, personal care workers take 24 days of sick leave (Truchot, 2018[17]), which is greater than the French average (14.2 days in 2016). LTC, together with health care, has been identified as a sector of priority in Australia to reduce the high rate of work-related injuries and diseases. It ranks high in terms of the numbers of serious worker compensation claims, especially because of muscular stress while handling objects, lifting or moving elderly people.

Figure 4.13. Work-related health problems and accidents at work tend to be correlated

Share of LTC workers reporting at least one accident at work resulting in injury in the previous 12 months and share of workers reporting physical or mental health problems suffered in the previous 12 months caused or made worse by work, excluding accidents at work, 2013



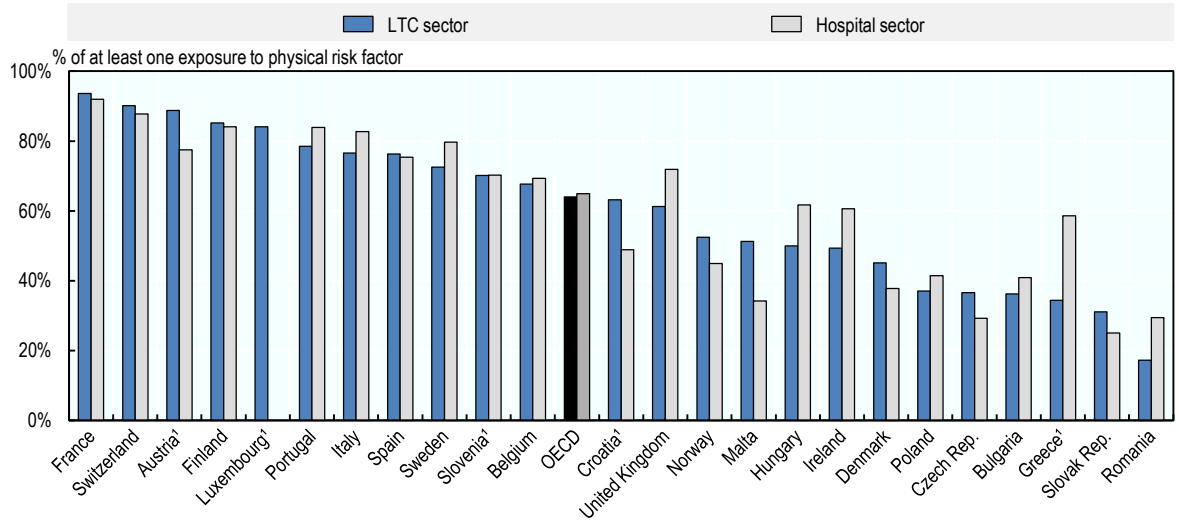
Note: Data were calculated based on ISCO 3-digit and NACE 2-digit codes. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2. A list of country abbreviations is provided in Annex 4.A.
1. Data must be interpreted with caution, as sample sizes are small.
Source: Ad hoc module EU-LFS (data refer to 2013).

LTC workers often face both physical and mental health risk factors

Almost two-thirds (64%) of LTC workers experience physical risk factors across European countries (Figure 4.14), including difficult work postures and handling of heavy loads. The share of LTC workers reporting exposure to physical risk factors varies markedly between countries, from 94% in France to 17% in Romania. Workers in the LTC sector report being as exposed to physical risk factors as hospital-based workers on average across European countries. In half of the countries considered, LTC workers report being slightly more exposed.

Figure 4.14. About 64% of LTC workers report exposure to physical risk factors across OECD countries

Share of workers reporting exposure at work to risk factors that can affect physical health, by sector, 2013



Note: The OECD data point is the unweighted average of the 20 OECD countries shown in the chart. Data were calculated based on ISCO 3-digit and NACE 2-digit codes. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2. Physical risk factors cover difficult work postures or work movements, handling of heavy loads, noise or strong vibration, chemicals, dust, fumes, smoke or gases, strong visual concentration and risk of accidents.
1. Data must be interpreted with caution, as sample sizes are small.
Source: Ad hoc module EU-LFS (data refer to 2013).

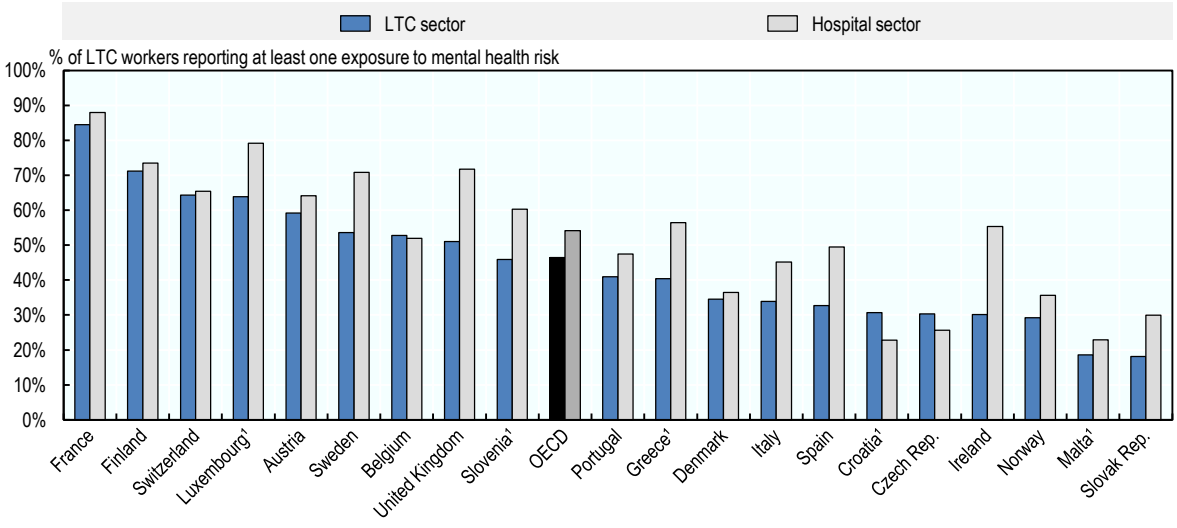
Such high rates of physical risk exposure are explained by the nature of the daily tasks LTC workers have to provide, which often require physical efforts (see Chapter 3). For instance, tasks such as lifting patients and bending over a bed when providing care contribute to develop health problems (Kromark et al., 2009[23]; Dulon et al., 2007[24]). This issue is growing in countries like the United States, where obesity rates in the elderly population are growing. Among physical health problems, those related to musculoskeletal conditions such as back pain are widespread (Simon et al., 2008[25]; Evanoff et al., 2003[26]; Needham et al., 2005[27]; Miranda et al., 2011[28]).

On average just under half (46%) of LTC workers in OECD countries are exposed to mental well-being risk factors on average (Figure 4.15), including severe time pressure or overload of work, violence or threat of violence, harassment or bullying. Exposure to mental well-being risk factor also concerns over half of hospital-based workers across European countries. In most countries, risks to mental well-being are reported more frequently, or at least as often, among hospital-based workers than LTC workers.

These data are in line with previous evidence showing the importance of burnout risks in the LTC workforce (Rai, 2010[29]). In France, for instance, a recent survey (Truchot, 2018[17]) shows that nurses and personal care workers are more likely to face sleep deprivation than other professions (such as doctors and speech therapists). Indeed, 28.8% of nurses and 36.4% of personal care workers face difficulties sleeping almost every night of the week. More than 11% declare that they take sleeping pills at least once a week.

Figure 4.15. About 46% of LTC workers report exposure to mental well-being risk factors across OECD countries

Share of workers reporting exposure at work to risk factors that can affect mental well-being, by sector, 2013



Note: The OECD data point is the unweighted average of the 18 OECD countries shown in the chart. Data were calculated based on ISCO 3-digit and NACE 2-digit codes. Mental well-being risk factors cover: severe time pressure or overload of work, violence or threat of violence, harassment or bullying. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
1. Data must be interpreted with caution, as sample sizes are small.
Source: Ad hoc module EU-LFS (data refer to 2013).

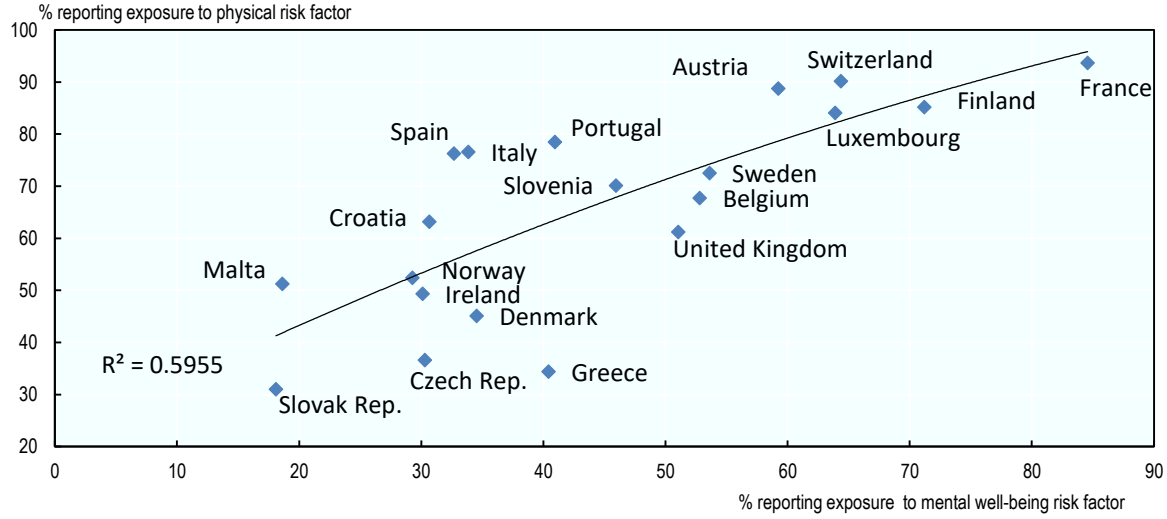
Violence perpetrated by a resident or a resident's visitor is common in the LTC sector, which may further contribute to mental and physical health risks at work. In the United States, a study showed that 48% of institution-based workers had been assaulted at least once in the last three months, 26% had been assaulted 1-2 times and 22% had been assaulted at least three times (Miranda et al., 2011[28]). Both institution-based and home-based workers are exposed to violence from patients, co-workers, patients' families and management, which can include intimidation, degradation, humiliation, verbal abuse, physical abuse and/or constant criticism (Fasanya and Dada, 2016[30]). Moreover, workers are exposed to sexual harassment and sexual aggression, resulting in greater stress, depression, sleep problems and burnout (Perrin et al., 2015[31]). Often, workers do not report this violence because they are afraid of losing their jobs and/or fear retaliation (Fasanya and Dada, 2016[30]). For home-based workers, these issues are more likely to be observed in consumer-driven programmes than in agency-based home care models, because the level of monitoring and supervision is often lower in consumer-driven models (Perrin et al., 2015[31]).

Assaulted LTC workers can experience physical reactions, such as fatigue, sleep problems, headaches and musculoskeletal pain (low back, shoulder, wrist, hand and knee pain) resulting from scratches, cuts and bruises. They can also have emotional reactions, such as anger, sadness, frustration, irritability, fear, self-blame and depression (Needham et al., 2005[32]; Miranda et al., 2011[28]).

Figure 4.16 shows that in most countries the association between mental and physical health risks is strong (correlation of +0.59). LTC workers report the highest exposure to physical and mental health risk factors in France, Finland and Switzerland. In Spain, Italy and Portugal, about 80% of LTC workers report exposure to physical risks, while about 40% report exposure to mental well-being risk factor. In Denmark and Norway, about 50% of LTC workers report exposure to physical risk factors, and about 32% LTC workers report exposure to mental well-being risk factor.

Figure 4.16. Association between mental and physical risk factors is strong for LTC workers

Share of LTC workers reporting exposure at work to risk factors that can affect mental well-being and physical health, 2013



Note: Data were calculated based on ISCO 3-digit and NACE 2-digit codes, leading to the inclusion of midwives working at home. Mental well-being risk factors cover severe time pressure or overload of work, violence or threat of violence, harassment or bullying. Physical risk factors cover difficult work postures or work movements, handling of heavy loads, noise or strong vibration, chemicals, dust, fumes, smoke or gases, strong visual concentration and risk of accidents. Data on mental risk factors for Croatia, Greece, Luxembourg, Malta and Slovenia must be interpreted with caution, as sample sizes are small. Data on physical risk factors for Austria, Croatia, Greece, Luxembourg and Slovenia must also be interpreted with caution, as sample sizes are small. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
Source: Ad hoc module EU-LFS (data refer to 2013).

4.3.4. The LTC workforce does not have a high-quality work environment

A poor work environment – characterised by intensive job demands with insufficient job resources (e.g. feedback and support) – reduces worker well-being, weakens worker engagement and productivity, and increases the risk of physical and mental health problems (Saint-Martin, Inanc and Prinz, 2018[16]).

LTC workers face high demands on their time but lack support

LTC workers often complain of high caseloads and limited time with care recipients, which generates a feeling of frustration and overload. Administrative regulations and organisational processes might also restrict autonomy in decision-making.

Table 4.1 outlines the main concerns about the work environment in LTC. Recurrent issues include regulations that constrain workers' capacity to deliver care according to their best judgement; shortage of workers, which reduces their capacity to deliver patient-centred care; an absence of support from the management hierarchy for the challenges they face on a daily basis (such as changes in regulations, conflicts with other care providers); and the difficulty they face in maintaining an adequate work-life balance (especially when they have to travel long distances from their home to work). These issues are likely to drive job satisfaction down and increase workers' intention to leave their current employment (Kim and Kim, 2017[33]).

Table 4.1. Managerial issues explain in part low workforce retention in LTC

Reason LTC workers leave the workforce	Description of common issues
Regulations are too constraining and they are unable to use their professional judgement.	Constraining rules and regulations often dictate care. LTC staff have low autonomy in decision-making about the best care solution for the elderly person, and are unable to rely on their professional judgement to deliver patient-centred care. For instance, Canadian regulations require that elderly people dine in formal dining places, while this does not necessarily match residents' expectations.
Residences do not always have enough funding to meet patients' caring needs.	Both limited budgets and a lack of flexibility in budget allocation reduce LTC workers' capacity to deliver patient-centred care.
Supportive leadership is absent.	There is a general lack of recognition of LTC workers' performance. Most LTC workers deal with a crisis environment and have to deal with several conflicts (such as with families, staff, regulations, budgets).
It is difficult to maintain an adequate work-life balance.	Personal factors such as children and workplace proximity to home reduce participation. Commuting time is particularly difficult, as most LTC workers have to juggle multiple part-time jobs.

Source: Adapted from McGilton et al. (2014[34]), "Making tradeoffs between the reasons to leave and reasons to stay employed in long-term care homes: perspectives of licensed nursing staff", http://dx.doi.org/10.1016/j.ijnurstu.2013.10.015; Chamberlain et al. (2016[35]), "Individual and organizational predictors of health care aide job satisfaction in long term care", http://dx.doi.org/10.1186/s12913-016-1815-6.

LTC workers face three main stressors. First, they often face conflicting demands: they receive contradictory orders, their work lacks co-ordination with other workers and they risk conflicts with co-workers with whom they may have issues of communication. For example, half of LTC workers in Austria assess that the number of people they have to care for is too high (Bauer, Rodrigues and Leichsenring, 2018[22]). Second, they often have to cope with patients' difficult behaviours, including a lack of respect, physical aggression, excessive demands (from patients and their families) and a lack of adherence to medical advice. Third, their workload can be high because of emergencies (exacerbated by insufficient staffing); for instance, a recent French survey shows that almost half of nurses and personal care workers rarely or never have time to sit down for lunch (Truchot, 2018[17]).

These stressors contribute to reduce LTC workers' perceptions of job control, which increases their intention to leave. Prior work shows that among German nurses working in for-profit care, those in nursing homes have a higher intention to leave than those in home care because they have lower job control (Wendsche et al., 2016[36]). In particular, time pressures and social conflicts were found to mediate workers' intention to leave (Rahnfeld et al., 2016[37]). Similarly, LTC workers in Scandinavian countries are more willing to stay in the job and less likely to quit if they have more autonomy, more support from their managers and an appropriate workload (Trydegard, 2012[38]).

In addition, increased LTC budget constraints are likely to increase pressure on workers, and thus change the way they deliver care. In the Netherlands and Scandinavian countries, reforms have increased monitoring of LTC workers' activities. LTC workers complain about the increasing importance of administrative tasks in their jobs. Because they spend long hours on reporting, they often lack time for more qualitative activities with care recipients (such as cooking, discussions and so on).

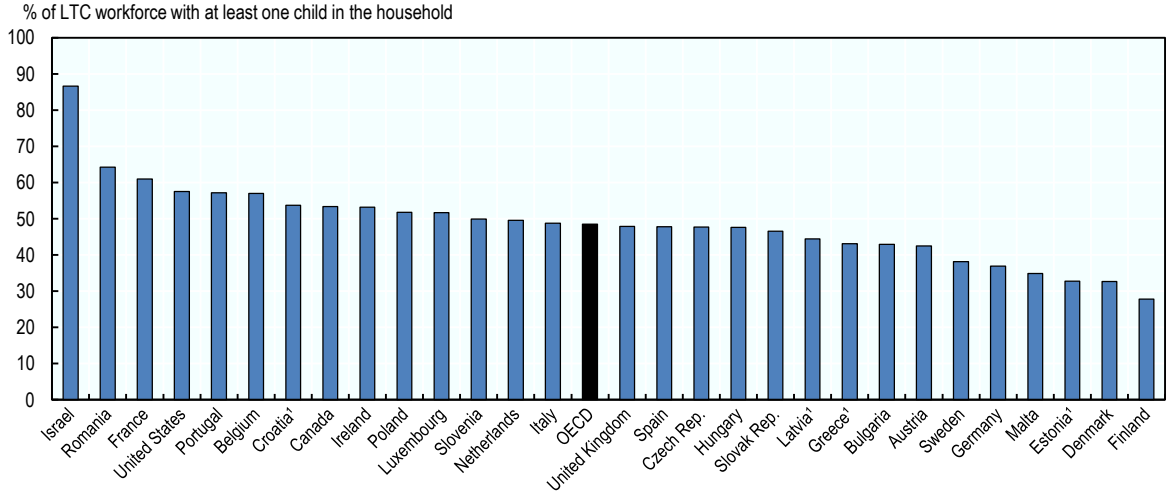
In Scandinavian countries and Austria, pressure is on the rise for LTC workers: since 2005, working conditions have worsened, with an increase in work intensity, less time to carry the work out and less time allocated to each elderly care recipient (Bauer, Rodrigues and Leichsenring, 2018[22]). For instance, the share of workers reporting that they have too much to do and too little discretion to perform their tasks, lack support from their supervisor and lack time to discuss work with colleagues increased between 2005 and 2015 (Rostgaard et al., 2019[10]). In the United States, personal care workers suffer from isolation, especially when working at home: they help elderly people on a regular basis but do not meet nurses or other support people, sometimes for six months at a time, and care coordinators who could provide advice are overloaded (Osterman, 2017[2]).

LTC workers struggle to maintain a good work-life balance

Difficult working conditions (shift work, night work etc.) and important commuting times often reduce LTC workers' capacity to maintain a good work-life balance. In particular, the availability of childcare for those on shift work can be problematic, and the lack of capacity to work regular hours in order to spend mornings and evenings with the family may discourage workers. Figure 4.17 shows that half of LTC workers have children in their household, and micro-econometric analyses confirm that having children is associated with lower workforce participation. In the United States and the United Kingdom, the number of LTC workers' children is associated with a significant decrease in their working hours and tenure (Box 4.2).

Figure 4.17. The majority of LTC workers have children

Share of LTC workers with children, 2016 (or nearest year)



Note: The OECD data point is the unweighted average of the 26 OECD countries shown in the chart. EU-LFS data are based on ISCO 3-digit and NACE 2-digit codes. For a description of the methodology to identify workers, see Annex 2.A in Chapter 2.
1. Data must be interpreted with caution because of small samples.
Source: EU-LFS; ASEC-CPS for the United States; Census 2016 for Canada; LFS for Israel. Data refer to 2016 or nearest year.

Box 4.2. Having children is associated with lower participation in the LTC workforce: examples from the United States and the United Kingdom

In the United States and the United Kingdom, 58% and 48% of LTC workforce participants have children respectively. Regression results suggest that a greater number of children is associated with lower work supply: in the United States, LTC workers with four or more children work on average 11.8% fewer hours than LTC workers with no children (Table 4.2). An increased number of children is associated with a reduced probability of working full time: -3.2 percentage points when the worker has one child, -8.7 percentage points when the worker has four or more children. Finally, having four or more children is associated with a 4.9 percentage points decrease in the probability of staying two consecutive years in the LTC workforce.

In the United Kingdom, a greater number of children is also associated with a reduced number of hours worked per week. For instance, LTC workers with four or more children work 34% fewer hours than LTC workers with no children. Having four or more children also reduces the probability of working full

time by 37.8 percentage points. There is no significant association between the number of children and the probability of staying two consecutive years with the same employer.

Results were estimated using regressions that included variables on age, age-squared, education categories (low vs. medium, low vs. high), foreign-born status (yes vs. no), number of children (0 vs. 1, 0 vs. 2, 0 vs. 3 and 0 vs. 4+), gender, ethnicity (white vs. other) and year dummies. In the model exploring the correlation between age and hours worked per week, the dependent variable was log-transformed. The two other models were linear probability models.

Table 4.2. Correlation between the number of children and LTC workforce participation

Results from multivariate analyses, estimations among samples of LTC workers

	No child vs. 1	No child vs. 2	No child vs. 3	No child vs. 4+
Average effect on the number of hours worked per week				
United Kingdom	-0.167***	-0.243***	-0.316***	-0.340***
	(0.024)	(0.027)	(0.045)	(0.068)
United States	-0.010	-0.011	-0.024	-0.118**
	(0.026)	(0.028)	(0.036)	(0.051)
Effect on probability of working full time				
United Kingdom	-0.191***	-0.293***	-0.336***	-0.378***
	(0.027)	(0.030)	(0.045)	(0.070)
United States	-0.032***	-0.043***	-0.072***	-0.087***
	(0.010)	(0.011)	(0.014)	(0.019)
Effect on probability of staying at least two consecutive years				
United Kingdom	0.019	0.016	0.014	0.045
	(0.024)	(0.027)	(0.040)	(0.060)
United States	-0.003	-0.011	-0.019	-0.049***
	(0.009)	(0.010)	(0.013)	(0.018)

Note: * p<0.10, ** p<0.05, *** p<0.01. Robust standard errors are in parentheses. In the United States, regressions estimate the probability of staying two consecutive years in the LTC workforce, while in the United Kingdom, regressions estimate the probability of staying two consecutive years with the same employer. All regressions for the United Kingdom control for a dichotomous variable, describing whether the worker lives in Great Britain or in Northern Ireland. All regressions for the United States control for state-level fixed effects.
Source: Pooled cross-sections of UK-LFS (2012 to 2016) and ASEC-CPS (2012 to 2016).

4.4. Improving working conditions will contribute to reducing turnover

4.4.1. Compensation upgrades and improved social dialogue are often first on the list of policies

Wage improvements are likely to retain workers

Table 4.3 shows that since 2011 OECD countries have been implementing three main policies to improve earnings in the LTC workforce: wage improvements or guarantees, overtime and travel time pay, and tax benefits/financial incentives.

Table 4.3. Policies improving quality of earnings in the LTC workforce have been implemented since 2011 in some countries

Policy	Countries	Impact
Wage improvements	Austria, Czech Republic, Hungary, Korea, Malta, Poland, Germany, Romania, Slovenia, United Kingdom, United States, Netherland	Empirical evidence suggests a positive impact on retention in the United States and Czech Republic.
Overtime and travel time pay	Netherlands, United States	The scheme has not yet been evaluated.
Tax benefits and financial incentives	Korea	Allowances have reduced the turnover rate in Korea.

Source: OECD LTC workforce survey 2018 and literature review.

Various measures have been implemented to set minimum thresholds in order to improve wages. Changes in minimum wages (access or thresholds) have been an effective way of increasing pay in the LTC sector (Vadean and Allan, 2017[39]; Osterman, 2017[2]). Note, however, that in the United Kingdom, the introduction of the National Living Wage in 2016 may have contributed to an increase in the use of zero-hours contracts (Vadean and Allan, 2017[39]). In the United States, the Department of Labor issued a new regulation in 2013 extending the Fair Labor Standards Act protections (e.g. the right to a minimum wage) to unlicensed home care workers, who had previously been classified as “companion caregivers”. The rule became effective in 2015. In Malta, all salaries in the LTC sector are aligned with public services salaries to ensure that private providers receive the same benefits. In Korea, care facilities are legally required to meet the minimum ratio of labour costs, according to the Policy Rule for Long Term Care Insurance Reimbursement Schedule. The purpose of this regulation is to encourage care facilities to pay fair wages to LTC workers. Germany introduced incentives for adequate salaries for LTC staff in 2010, with the introduction of a minimum wage in the sector, and has reinforced them since 2017 with a guarantee to reimburse collectively agreed wages in fee negotiations. In France, a recommendations for a new legislation proposal include the re-evaluation of minimum wages in the sector to the level of the national minimum wage (SMIC) and that minimum wages become automatically adjusted to the SMIC when the latter increases (El Khomri, 2019[7]).

Several countries have increased overall salaries in the LTC sector. In Hungary, LTC salaries increased by 62% between 2013 and 2018. In Romania, wage increases for LTC workers were included in a more general law (153/2017) on the salaries of employees in public institutions. Wage increases for nurses were implemented in 2018, and for personal care workers in institutions they will be implemented in 2022. In the Czech Republic, substantial increases in the salaries of personal care workers were achieved (with a 4% increase in November 2016, a 23% increase in July 2017 and a 10% increase in January 2017). These have contributed to stabilising the LTC workforce at 100 000 people. In Austria, the professional Association of Austrian Social and Health Companies negotiated wages increases of 3.2% in 2019 in the collective agreements. Norway introduced a new minimum wage for nurses with 10 years’ seniority in the sector, representing a wage increase of 12% for them.

Compensating workers for overtime and travel time is another way a few OECD countries have improved earnings quality (especially for home-based workers). In the United States, the Fair Labor Standards Acts protections give unlicensed home-based workers access to overtime pay: LTC workers who do more than 40 hours per week have the right to be paid for extra hours. The Act also allows travel time compensation. In 2017, Korea introduced an allowance to support transportation costs. Note, however, that this policy aims to improve service quality for service users, rather than support LTC workers.

Finally, some countries (Slovenia and Korea) enhanced benefits and financial incentives for LTC workers to improve income or savings. In Slovenia, adoption of regulations governing compulsory pension, health and unemployment insurances for family (home care) assistants, who represent 7% of the total LTC

workforce, is pending. In Korea, LTC workers (including temporary workers who work more than 60 hours per month) contribute to national pension plans, health insurance plans, employment insurance plans and accident compensation insurance plans.

Prior research shows that wages and benefits in the LTC sector influence recruitment and retention. Higher wages are a predictor of longer job tenure among home care aides (Butler et al., 2014[40]), while increased incidence of real pay below minimum wage levels contributes to explaining significant increases in turnover rates (Hussein, Ismail and Manthorpe, 2016[9]). In the United States, the Medicaid Wage-Pass-Through programmes increased wages, which had a positive (although small) influence on retention: a USD 1 increase in hourly wage reduced LTC workers' propensity to leave the workforce by 2% for a given month (Baughman and Smith, 2012[41]). Similarly, Korea reported that the introduction of specific allowances increasing personal care workers' wages and improving their benefits reduced turnover rates in the LTC workforce. In France, a study focusing on institution-based workers found that an increase in personal care workers' wages was associated with a 1.2-1.3% decrease in the probability of leaving the institution. However, wage increases were not associated with turnover among nurses (Martin and Ramos-Gorand, 2017[42]).

At the same time, initial wage increases are not the sole or only solution. Recognising experience in wage levels is also important. Previous work shows that in countries where agreements differentiate pay scales to years of experience, such as Belgium, the Netherlands and Sweden, retention is higher (Colombo et al., 2011[43]).

Collective bargaining and social dialogue help with pay, training and working conditions

The extent of unionisation levels and social dialogue is uneven across countries in the LTC sector. Home care workers are less likely to be organised and unionised. In Germany, private for-profit providers do not always have collective agreements. Many central and eastern European countries lack appropriate representative employers' organisations in the sector, which renders the social dialogue process more difficult. In the United States, home care workers in Illinois and California won the right to bargain directly with these states, which are considered to be the "employer for the purpose of bargaining", and have achieved wage increases.

Differences in the degree of collective bargaining are leading to different solutions to improve wages and working conditions across countries. In some countries, such as the Netherlands, the major employer and workers' organisations decide on sector-wide national agreements. The most recent one (for 2018-19) agreed a 4% increase in wages in late 2019 for the entire sector to address the issue of low pay. In Finland, public LTC services comply with municipal service agreements. In Portugal, wages in the LTC sector follow salary tables negotiated between the three main unions of providers and the Instituto de Seguranca Social, according to education and experience, but they only cover the non-profit sector. In Austria, collective agreements are carried out at the company level – regularly between management and the work council, and at national levels of industry during annual negotiations or joint professional events (e.g. on working hours, internships). In 2019, the negotiation led to a 3.2% increase in wages for the overall workforce, and also led to paid leave agreements. In the future, unions are planning to negotiate that LTC workers should reduce their working time to 35 hours a week while maintaining their full salary (currently, they work 38 hours a week).

In contrast, in Bulgaria, the Czech Republic and Poland, collective agreements are conducted at the enterprise level and very few agreements exist compared with the extent of the sector. Such firm-level bargaining, without co-ordination within and across sectors, tends to be associated with somewhat poorer labour market outcomes (OECD, 2018[44]). There is thus a need to have well organised social partners in the sector or well tailored administrative extensions of collective agreements.

Beyond social dialogue, New Zealand provides an interesting example of a new wage structure in the sector achieved through a pay equity settlement. Trade unions lodged a claim with the Employment

Relations Authority, maintaining that there was systemic undervaluation of care and support work because it was mainly carried it out by women. The Ministry of Health started to implement new wage rates, which increased the pay scale in the sector in 2017, leading to a rise of between 15% and 50% in hourly wages. At the same time, the way the funding was implemented has led to negative consequences in terms of reduced hours, increased workload and duties, and sometimes reduced quality of care (Douglas and Ravenswood, 2019[45]). In this sense, higher reimbursement rates for LTC services are necessary to guarantee wage rises and increases in quality of care through having more skilled LTC workers (Hackmann, 2019[46]).

Collective bargaining is also needed to ensure that LTC workers receive proper training and have improved working conditions. A large proportion of the LTC workforce is in temporary employment and may not always benefit from the same training opportunities as permanent workers and employees (OECD, 2019[1]). Non-discrimination rules are central to guarantee that temporary LTC workers have equal treatment. Several countries (Poland, Greece, Germany, Belgium and France) have introduced such rules. However, even despite this, significant challenges remain in most OECD countries to ensuring equality of rights and entitlement to training, as LTC workers often lack representation and therefore have little collective bargaining power to negotiate better conditions. For instance, there is a need to adapt the legislative and collective bargaining framework to the increasing importance of own-account self-employed workers who deliver LTC at home. In Austria, collective bargaining in LTC led to the approval of improved working conditions: more vacation and free weekends were negotiated in the collective agreement, along with compulsory supervision in the care sector.

4.4.2. Improved retention will also come from better working conditions and lower health risks

Better organisation of working time is one of the prime demands

Introducing flexible working time arrangements with choice of hours can help to address work-life balance concerns and improve job satisfaction. Switching to self-scheduling, which enables shift workers to have control over which shifts they work, when they start work or when their rest days occur, is associated with improvements in health, work-life balance and organisational effectiveness (Costa, Cesana and Kogi, 1990[47]; Gauderer and Knauth, 2004[48]; Wortley and Grierson-Hill, 2003[49]). Moreover, prior work shows that more flexibility in work schedules is likely to enable better retention, while fuller workloads lead to early retirement (Uthaman, Chua and Ang, 2015[50]). Legislative approaches to guarantee employer provision of some flexible working arrangements, promoting social dialogue on employee-friendly working time and helping companies to adapt work organisation and managerial practice, have proved to be useful in ensuring better work-life balance. In Australia, a new management model (Table 4.3) in nursing homes has contributed to reducing turnover rates among LTC workers. These flexible management models provide LTC workers with more opportunities to control their work-life balance. Better organisation of daily work and planning shifts and teams are cited as important elements for job satisfaction by workers in Austria, the Netherlands and Portugal.

Adapting working hours to caregivers' profiles could also contribute to addressing concerns about older workers who are not able to continue to perform the same physical tasks. While its effect remains untested, Dutch unions are suggesting implementation of a generation pact that would allow workers aged 45 and over to work 15% less while keeping pension contributions at 100%, and would increase by 15% the work provided by the young generations. A more promising solution would be to adapt caregivers' tasks according to their age profile, in which older workers would coach new recruits rather than providing tasks that are physically difficult directly (such as lifting or carrying elderly people).

Given the high rate of part-time work, especially for low hours of care per week, additional solutions to give workers the option to increase working hours would be suitable. In Germany and Portugal, some

companies motivate part-time workers to increase their working hours, or combining different jobs in various nursing homes, or home care and day care in order to reduce involuntary part-time jobs. In the Netherlands, a combination of hospital and LTC work is put forward as a way to increase working hours for those with very low part-time hours. The main trade unions in the LTC sector in Norway have a goal of developing a culture of full-time employment and work at the local level to organise longer shifts, increase the number of weekend hours and fill additional part-time positions through existing part-time employees, among other solutions. Furthermore, to make work more attractive on the weekend there are new minimum rates in Norway for Saturday and Sunday supplements.

Finally, LTC workers' tasks increasingly involve administrative duties (reporting budget use and activities provided on a daily basis, for instance), which are time-demanding. Organisational innovations should allow their timetables to be reorganised so that they have dedicated time for administration, such as during the afternoon when care needs are low. The use of new technologies (tablets, smartphones) is likely to improve work organisation (see Chapter 6). Moreover, the implementation of a unique electronic record should allow better articulation of the health and social care provision, and better record-keeping of the care recipient's health details and circumstances.

Box 4.3. The Adards management model in Australia

In 1991, Adards, a nursing home in Tasmania, Australia, implemented an original management model for dementia care, based on flexibility (Cohen-Mansfield and Bester, 2006[51]). The average annual worker turnover and absenteeism rates in this facility are very low (10% and 0.6% respectively), compared with those observed in other settings, showing the success of this approach. The model underlines four main advantages to flexibility regarding the number of hours worked per shift and per week: it tailors staffing levels to resident care needs, reduces potential burnouts and the caregiving burden, improves LTC workers' work-life balance and attracts employees who would not otherwise have participated in the LTC workforce.

While the shift lengths vary from four to eight hours, the staffing schedule remains constant to ensure that patients' needs are met. Morning and evening shifts are the most demanding. Flexible staff rotation allows LTC workers to change their schedule according to their personal needs. It also ensures that all LTC workers know all the residents. The median number of working hours for Adards employees is 21 per week. Five main principles aim to prevent burnouts and maximise worker satisfaction: shifts must be shorter than eight hours; weekly schedules must be shorter than 40 hours; shifts can be exchanged at LTC workers' convenience; LTC workers alternate three days on duty with three days off; and two shifts concentrate most of the teams' efforts (morning and evening).

Reducing incentives for undeclared work will benefit both workers and care recipients

Many countries face the existence of undeclared private work, which is often the case for foreign workers, especially if undocumented. Individuals under these work arrangements are not eligible for social protection or fail to build up substantial entitlements because of intermittent working patterns and frequent transitions.

A variety of approaches is available to prevent undeclared work and transform it into declared work. The main objective of the approaches consists of making declared work more beneficial and easier, through simplification procedures and help with record-keeping, direct tax and social security incentives. This is often done using service vouchers or tax credits. In France, service vouchers for elderly care are subsidised via the Personalised Autonomy Allowance. Families can use the universal voucher to buy personal care and home help. In Finland, 20% of the wage paid, including social security contributions, or 50% of the work compensation paid to an entrepreneur or enterprise, is tax deductible. Similarly, the tax

deduction for household services in Sweden applies to 50% of labour costs and has led to a decline of 10% in undeclared work in all activities (Williams, 2018[52]). Such schemes need to be designed carefully to avoid partial displacement of workers from the regular market.

Training programmes and improved inspection create a healthier work environment

Good workplace safety not only improves the health of LTC workers but also decreases their intention to leave. Prior work shows that in Sweden work-related exhaustion is one of the strongest predictors of low workplace satisfaction, among both home-based and institution-based workers (Hasson and Arnetz, 2008[53]). In the United States, people reporting that they worked in a less safe environment, in institutions, were almost twice as likely to consider leaving their job in the next two years, compared to those working in a good safety climate (Miranda et al., 2011[28]).

Countries can follow several strategies to promote a healthier work environment, through training but also through a safety culture. Some countries have implemented coaching programmes, especially for stress management. The Dutch government introduced a programme providing 20 000 coaches in the workplace to create a healthy working environment. In the United States, LTC workers (personal care workers or nurses) who work for an agency are likely to have a supervisor or care manager who is in charge of providing mentoring or support. Japan arranges counselling services through professional agencies to provide advice on how to improve employment management in LTC. The Province of Saskatchewan in Canada offers transferring, lifting and repositioning training to reduce the risk of injuries.

Fostering a healthier work environment is also intimately linked to a safety culture, and especially a patient safety culture. Numerous studies show the empirical relationship between patient safety culture, workers injuries and psychological well-being. Creating a safer work environment requires from countries to know how they are performing on worker and patient safety in order to appropriately identify where improvements can be made. As an example, countries can develop and implement appropriate safety standards for institutions to measure patient and worker safety (de Bienassis, Llena Nozal and Klazinga, forthcoming[54]).

Second, prevention tools to improve safety at work and prevent musculoskeletal disorders exist and have proved to be effective. Knowledge of workplace guidelines and management support (for instance, protocols that incorporate requirements on safe patient handling) were associated with sustained use of technical devices (Evanoff et al., 2003[26]). For instance, environmental interventions such as appropriate seat heights to aid sit-to-stand transfers can reduce staff injury and are more effective than training (Coman, Caponecchia and McIntosh, 2018[55]). Workplace interventions including ergonomics, physical training and cognitive behavioural therapy in Norway have proved to be very successful against low back pain for personal care workers who perform physically demanding jobs (Rasmussen et al., 2013[56]). In the Netherlands, the introduction of mechanical lifts reduced musculoskeletal injuries and lost days in several institutions.

Third, countries have implemented measures reinforcing control over working conditions. Effective prevention requires labour inspectorates, occupational health services and general practitioners to work closely with employers and workers' representatives, to create a culture of health in the workplace. With the renewed spread of non-standard forms of work, including (dependent) self-employment, temporary and casual work arrangements in many OECD countries, the need for credible and far-reaching initiatives to promote health at work has never been so strong. Korea is considering extending the Occupational Safety and Health (OSH) Act so that all working people, including non-regular workers are protected. Other countries (including the United Kingdom, Ireland, Canada and Australia) have OSH regulations for employers that are broad enough to cover more than just the traditional employment relationship.

Finally, workplace violence should be prevented by implementation of preventive safety training programmes, along with procedures protecting LTC workers who face these issues (Perrin et al., 2015[31]). In particular, protocols and training should focus on effective prevention and harassment response. These issues should be identified early on (during the recruitment process) and receive constant follow-up with the development of the care relationship between workers and patients. Such policies should include

setting a zero-tolerance rule, clear sanctions against the use of threats, violence and harassment, and implementation of reporting procedures. Finally, workers should be able to leave the patient's home when facing workplace violence without facing the threat of being pursued for abandonment when the patient requires constant care.

4.4.3. The challenge of high demand and reduced support can be addressed by developing teamwork and autonomy

Improved teamwork and leadership in LTC can create a better-quality work environment

High rates of shift work may prevent the development of work relationships between care providers. Indeed, a Swedish study revealed that nurses value the long-term relationships built with patients and staff, and that loneliness may in some cases overcome the positive feeling associated with independence of home-based work (Carlson et al., 2014[57]).

Developing teamwork and engaging all care providers in decision-making are two key strategies to increase job satisfaction. A Canadian study also found that relationships with other staff and professional development opportunities influenced a decision to stay for nurses working in nursing homes (McGilton et al., 2014[34]). This effect could be mediated through reduced levels of emotional exhaustion and higher levels of personal accomplishment. Finally, an Italian study of 28 nursing homes provided evidence that support from colleagues has a positive impact on LTC work engagement (Sarti, 2014[58]). In France, an improvement to LTC worker mentoring was associated with lower turnover among LTC workers in institutions (Martin and Ramos-Gorand, 2017[42]).

Private providers in some countries try to increase job motivation by creating opportunities for different work. In Portugal, for instance, some nursing homes organise teamwork in an innovative manner. Teams are composed of three members at the same level of competence with different titles and roles – a manager, first assistant and second assistant – who rotate roles within this hierarchy. Each team is composed of at least one male worker, as they tend to stay longer in the job. Nursing homes often provide home care services and allow people to switch from one service to the other to allow for diversity in careers.

Prior work also shows that nursing home leadership, in particular from the director of nursing, influences staff tenure (Hunt et al., 2012[59]). Leaders that display individualised consideration towards employees provide intellectual stimulation, act as role models and inspire workers (Atwell, 2011[60]). Encouraging discussion, involving employees in problem-solving to improve resident care committees for informal learning and developing skills are some ways to stimulate employees in LTC. The use of such leadership styles is also associated with improved resident outcomes, such as reduction in pressure ulcers and falls; further, it makes workers feel valued and empowered in their work. In 2018, Hungary introduced a new training system, including specific management training for leaders in LTC work. Its goal is to prepare leaders to practise effective leadership according to new and emerging needs and challenges in the field, in a changing legal environment. In Norway, the government is sponsoring a Master's degree in leadership skills for nurses working in LTC.

LTC workers can benefit from more autonomy to decide on tasks

Scandinavian countries are strengthening highly educated nurses' roles by giving them more capacity to manage budgets and organise LTC. In Norway, nurses are becoming increasingly specialised and taking more leadership roles, especially in conducting assessment needs for services, based on a standardised assessment form that all municipalities are required to use. Nurses are being given more autonomy to decide on the type but also amount of care needed by each client. They are also taking decision-making roles when it comes to managing municipalities' budgets for LTC.

Self-managing or self-organising teams are ways of working without traditional management hierarchies. The Buurtzorg model is a well known example of self-managed teams of nurses, which has attracted interest and been replicated in several countries. The teams, often composed of up to 12 nurses, support 50-60 patients at a time. The nurses provide a wide range of care; they also try to mobilise the client's social network and work closely with general practitioners and other community health care workers. Providing more autonomy to LTC workers can contribute to increasing their satisfaction. In the United States, a survey of health care aides working in LTC found that a greater sense of autonomy leads to longer job retention (Butler et al., 2014[40]). Autonomy may be a particular issue for less senior staff, such as certified nursing aides, who report frequent exclusion from team communication and decision-making. Since 2011, the Israeli government has promoted a policy targeting empowering of nurses, to increase their independent practice in community care and home-based care.

Teams can be self-managed in the sense that they are operationally autonomous and self-governing. Self-managing teams have leadership tasks and operational tasks, resulting in a higher degree of decision-making autonomy and more task variety; supervision is focused on coaching colleagues in tasks. The teams can decide on a range of actions such as hiring and firing, the number of patients served, rostering, planning, individual and team performance monitoring, professional development and care delivery. Everyone in the self-managing team holds a main role and roles are rotated regularly. Coaches are available to solve problems for each team. There is flexibility in work arrangements to meet both nurses' and patients' needs (Box 4.4).

Evidence suggests that self-managed teams led by nurses may be a cost-effective way of delivering LTC services at the community level. A comparison of the Buurtzorg model with another 600 homecare providers showed that this model ranked among the top ten for client satisfaction, annual costs per client were lower (EUR 6 428 compared to the average of all others at EUR 7 995) and around four in five nurses and nurse assistants considered this model attractive (Box 4.4). In addition, costs are 40% lower than other home care organisations, thanks to reduced administration, because at 8% of total costs it has lower overhead costs than other organisations (Ernst & Young, 2009[61]). Compared with other district nurse types of model, self-managed teams have proved better for patient care continuity, multiple long-term conditions and proactive care. From the staff perspective, the opportunity to make decisions and operate as a team helped in supporting service access, response and efficiency, and made the job more attractive (Drennan et al., 2018[62]). Satisfaction among nurses facilitates the recruitment of talented staff as well as reducing absenteeism and turnover (Gray, Sarnak and Burgers, 2015[63]).

Box 4.4. The Buurtzorg model: self-managed home care teams

The Buurtzorg (neighbourhood care) model was initiated in 2006 in the Netherlands. It is an innovative approach for home care service delivery. The main rationale for its creation was to eliminate bureaucracy and hierarchy, and instead focus on building meaningful relationships between caregiver and client.

Decisions are made together: for a solution to be adopted, it is enough that nobody has a principled objection. Team members are responsible for organising work, recruiting staff and determining the best approach to care without a manager. An initial schedule for shifts is made by a co-ordinator and circulated to team members, who are asked to fill it in. The process is repeated until it is acceptable to team members. They are supported by a tailored technology structure, composed of a web server and intranet health care platform that connects teams and ensures knowledge sharing. Time spent on administrative work is monitored, as teams should minimise it as possible. Teams must be available 24 hours a day, seven days a week. Individual team members are expected to meet a productivity

target, which is monitored centrally, the goal being that 60% of time is spend directly with clients. A regional coach – senior nurse – is available for questions.

To ensure effective collaboration and decision-making, new teams receive training on self-management (i.e. group decision-making, conducting meetings, conflict resolution and problem-solving) as well as peer coaching.

The seven roles of Buurtzorg's self-managed teams are: 1) the main role, 2) the housekeeper, 3) the informer, 4) the developer, 5) the planner, 6) the team player and 7) the mentor. Employees decide on their roles. There were 15 coaches for 700 teams in 2015 to provide advice about patient care.

While evaluations of clinical results are not yet available, since its inception in the Netherlands, the Buurtzorg model has been replicated in the United States, Japan, Finland and Sweden.

Source: Rosengren et al. (2017[64]) "Buurtzorg – an innovative model for caring elderly at home", http://www.karelia.fi/ikanyt/2017 13 November/buurtzorg-an-innovative-model-for-caring-elderly_at-home/; Sheldon (2017[65]), "Buurtzorg: The district nurses who want to be superfluous", https://doi.org/10.1136/bmj.j3140; Drennan et al. (2018[62]), "Tackling the workforce crisis in district nursing: Can the Dutch Buurtzorg model offer a solution and a better patient experience? A mixed methods case study", https://doi.org/10.1136/bmjopen-2018-021931.

4.5. Conclusion

The increase in home-based LTC delivery drives the need for tailored solutions to meet the specific needs of each person. However, the current working conditions prevent the delivery of a more elderly person-centred LTC. Working arrangements – which are predominantly shifts, part-time arrangements and temporary contracts – and frequently low compensation schemes lead workers to try to deliver as much care as possible in a small amount of time. The current shortages in the LTC market dramatically increase the pressure on workers, who have to multiply basic and repetitive tasks, and cannot promote people-centred LTC. New LTC market trends could increase that tendency. In the future, policies will be needed to guarantee workers' rights and working conditions, but also to make sure that they provide services centred on elderly people's needs. However, these policies are likely to raise costs, although this should also be compensated in part by reducing the turnover costs.

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Annex 4.A. Country abbreviations

Country abbreviations used in this chapter are listed in Annex Table 4.A.1.

Annex Table 4.A.1. Abbreviations used for countries in Figures 4.5 and 4.13

AU	Australia
AT	Austria
BE	Belgium
BG	Bulgaria
HR	Croatia
CY	Cyprus
CZ	Czech Republic
DK	Denmark
EE	Estonia
FI	Finland
FR	France
DE	Germany
GR	Greece
HU	Hungary
IE	Ireland
IT	Italy
LU	Luxembourg
MT	Malta
NL	Netherlands
NO	Norway
PL	Poland
PT	Portugal
RO	Romania
SK	Slovak Republic
SI	Slovenia
ES	Spain
SE	Sweden
CH	Switzerland
UK	United Kingdom

Notes

[1] Tenure is defined by the number of years LTC workers spend with their employers.

[2] A zero-hours contract is a type of contract between an employer and a worker in which the employer is not obliged to provide any minimum working hours.

[3] Shift work refers to work comprising recurring periods in which different groups of workers do the same jobs in relay.