1 Beyond Applause? Improving working conditions in long-term care: An overview

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This introductory chapter gives an overview of the entire publication drawing on analyses carried out in the other chapters, and discusses policy implications. It documents the past evolution of employment in long-term care and projects demand for long-term care workers, which highlights the risk of substantial shortages over the next decades. The chapter flags tough working conditions for long-term care workers, including high physical and mental health risks, low wages in particular for personal care workers and a lack of recognition of both the workers and their competences. It discusses why wages have remained low despite persistent labour shortages in the sector. The chapter concludes with policy measures to improve working conditions and mitigate shortages in long-term care.

Beyond applause: Better working conditions are key to meeting increasing long-term care needs

Images of exhausted care workers have been part of our collective memory since the outbreak of the COVID-19 pandemic. When severe restrictions to mobility were first introduced, many people around the world expressed their gratitude for health and care workers labouring relentlessly and putting their own health at risk by applauding them from their windows and balconies. The pandemic and the ensuing massive rise in health and care needs took the world by surprise. It came at the expense both of care workers, who had to scramble to continue to provide their services in often very difficult conditions, and of vulnerable populations including older people whose quality of life and care were severely impacted.

A second drastic rise in care needs is on its way, although this one has been well predicted. Over the next decades, the demand for long-term care (LTC) workers will increase substantially, mainly driven by population ageing.[1] Several countries are currently facing unmet LTC needs and shortages of LTC workers at a time when the large baby-boom generation is joining the older population requiring assistance in their daily lives for carrying out activities such as washing, eating, and moving. Moreover, care needs are becoming increasingly complex because of the rising share of older people with dementia and co-morbidities. This increasing complexity requires workers trained with greater clinical, communication, teamwork and digital and management skills. Despite the advance warnings, many countries are insufficiently prepared to absorb these increasing care needs.

Tackling poor working conditions of LTC workers including low wages and high pressure is key to ensure that enough people join and remain in the LTC workforce. The situation is particularly dire for personal care workers who make up 78% of LTC workers on average in the OECD, the remaining 22% consisting of nurses – personal care workers are formal workers providing routine personal care, such as bathing, dressing or grooming, to people in needs of care or assistance in their own homes or in institutions and who are not qualified or certified as nurses. This report shows that LTC workers do physically and mentally arduous work often at burdensome hours, all the while receiving below-average wages compared to other workers with similar characteristics. Hence, substantial improvements in working conditions are required to improve the attractiveness of LTC work if countries want to avoid the quality of life of their older population from worsening dramatically.

The report focuses on formal LTC. This is defined as a range of medical, personal-care and assistance services that are provided with the primary goal of: alleviating pain; reducing or managing the deterioration in health status for people with a degree of long-term dependency; assisting them with their personal care (through help for activities of daily living, or ADL, such as eating, washing and dressing);and, assisting them to live independently (through help for instrumental activities of daily living, or IADL, such as cooking, shopping and managing finances). Formal LTC is delivered by nurses or personal care workers, including workers who could be undeclared, especially live-in care workers. The report does not analyse informal care undertaken by family or friends outside a formal labour relationship (for definitions, see Annex 1.A). Yet, as informal care represents a large share of care provided in many countries and can be a substitute for formal care, its impacts on working conditions of formal care workers are discussed.

The LTC sector finds itself between a rock and a hard place as many countries are increasingly facing overall labour scarcity while the demand for LTC workers is growing rapidly. Being able to meet increasing LTC needs is by no means a new concern. Over a decade ago, the OECD study *Help Wanted?* rang the alarm bell over increasing LTC needs and the need to improve the supply and retention of LTC workers (Colombo et al., 2011[1]). *Who Cares?* followed up with an analysis of LTC work and its workforce, suggesting possible pathways to tackle care shortages (OECD, 2020[2]). Unfortunately, the situation has not much improved. And different from a decade ago, LTC shortages now have to be seen in a context of widespread labour shortages in various economic sectors (OECD, 2022[3]). Moreover, *Ready for the Next*

Crisis? illustrates how the COVID-19 pandemic revealed significant understaffing of health systems including frontline services (OECD, 2023[4]).

This report adds to previous analyses through an in-depth investigation of how LTC workers fare along the different key dimensions of job quality, drawing from the OECD Job Quality Framework (Cazes, Hijzen and Saint-Martin, 2015[5]). It explores the role working conditions play in LTC shortages in the context of population ageing as well as what stands in the way of improving these conditions to address the shortages. In a well-functioning labour market, sectoral labour shortages should lead to better working conditions, including higher wages, to attract more workers. Older people receiving care are also affected by many of the problems highlighted as the quality of LTC jobs impacts the care LTC workers deliver; assessing the quality of care, however, is beyond the scope of this report. To go *Beyond Applause* requires to take significant measures to improve wages and working conditions, more generally, for LTC workers in order to ensure that older people requiring assistance in their daily lives receive the care they need.

This overview chapter is organised as follows. The first section describes current shortages of LTC workers and their projected evolution over the coming decades. The second section focuses on working conditions, covering health risks, working times, wages and social recognition. The third section examines why poor working conditions persist despite shortages of LTC workers in many countries. Finally, the fourth section presents the policy implications of the findings.

Box 1.1. Key findings and policy implications

Key findings

Labour shortages and population ageing

- Many countries have reported structural difficulties in recruiting long-term care (LTC) workers for many years. The COVID-19 crisis has resulted in deteriorating working conditions and increased job quits in the LTC sector, potentially intensifying staff shortages.
- LTC workers made up 1.9% of total employment in OECD countries in 2021 and the demand for LTC workers will increase at a fast pace. Given that the working-age population is projected to start shrinking, even by more than 10% in several OECD countries in the coming decade, the increasing demand will be hard to meet.
- The LTC share of total employment would need to increase by 32%, or by 0.6 percentage points, on average in the OECD over the next decade to meet the increase in demand for care workers. This is according to baseline projections combining the effects of demographic changes, higher incomes and no labour-productivity growth in the LTC sector. Even with a much more optimistic scenario assuming annual labour productivity growth of 0.5% in the LTC sector, the LTC employment share would still need to increase by 27%, or 0.5 percentage points, to meet the demand.
- Low pay and more generally poor working conditions as well as poor social recognition limit the attractiveness of LTC work, contributing to structural labour shortages.
- With persistent labour shortages in the LTC sector, market forces should lead to improvements in working conditions to clear the market. Yet a number of factors prevent the market from clearing, including insufficient financing of LTC services, low labour market power of LTC workers and mismatches due to limited geographical mobility within countries and insufficient training. Reasons differ across countries depending on their specific context, implying different policy priorities.
- The development of new technologies is likely to support and supplement LTC workers, but it cannot replace LTC workers entirely for core caregiving tasks. It can help limit the looming shortage of LTC workers by facilitating independent living of older people, reducing the strain of LTC work and raising efficiency in the sector.

Main characteristics of the LTC sector

- The LTC share of total employment ranges from less than 0.3% in Greece, Lithuania and Poland to more than 4.0% in Norway and Sweden. Huge differences across countries may reflect differences in the development of the formal LTC sector, the scope of family care, the extent of LTC provision by hospitals and life expectancy, among others.
- Personal care workers make up 78% of LTC workers on average in the OECD and nurses 22%.
- LTC professions are among those where women are most over-represented. While women account for more than 85% of LTC employment, they still earn less than men doing the same job and having otherwise similar characteristics.
- Foreign-born workers account for 26% of the LTC workforce on average across OECD countries, compared to 20% of all workers. They represent a large proportion of live-in carers.
- Only half of people aged 65+ with severe limitations in activities of daily living receive formal care across European countries, while one-quarter receive neither formal nor family care. According to the *OECD Risks that Matter* survey, the prospect of not being able to access good-quality LTC services is a major concern among adults in OECD countries.
- Investment in new technologies in LTC remains low. On average across 12 OECD countries for which data are available, IT investments make up only 1.0% of gross value added in LTC, compared to 3.2% in the total economy.
- Barriers to implementing new technologies in LTC include the high cost of certain technologies such as robots, concerns over privacy and data security, and the lack of both LTC providers' awareness of some available technologies and LTC workers' digital skills to operate such tools.

Work environment and social recognition

- LTC workers face very difficult working conditions. Physical and psychological strain as well as burdensome working times, such as night and week-end shifts, are part of the main drawbacks of the working environment in LTC. As a result, nurses and personal care workers are more often absent from work than other employees due to work-related health issues.
- About three-quarters of nurses and personal care workers are exposed to risks to their physical health, compared to 59% of all employees. The primary health risks care workers are exposed to are lifting people and providing care while being bent over, resulting in musculoskeletal problems. Abuse from care recipients and exposure to infectious diseases such as COVID-19 may also be important risk factors.
- About two-thirds of nurses and personal care workers are exposed to risks to their mental health, compared to 43% of all employees. The primary mental health risks care workers are exposed to are a high workload and time pressure, and difficult care recipients.
- Studies from Australia and the Nordic countries show that LTC workers feel recognised by care recipients and by their colleagues, but much less so by their managers, politicians and the wider society. This feeling of low recognition is related to poor working conditions including wages and low status. In terms of recognition of skills, personal care workers generally do not benefit from the certification of acquired skills, unlike nurses.
- OECD countries' initiatives to improve the social recognition of LTC workers include increasing remuneration, fighting gender discrimination, recognising LTC experience in education, increasing training requirements for LTC workers and running public information campaigns.

Wages and collective bargaining

- Personal care workers employed in residential and non-residential care earn around 70% of the economy-wide average hourly wage. One-quarter of personal care workers in the LTC sector and in hospitals earn at most 53% and 60%, respectively, of the average hourly wage in the total economy. Personal care workers earn less in LTC than in hospitals.
- Occupational and sectoral effects combine into low wages for personal care workers in the LTC sector. Regarding occupations, personal care workers have hourly wages that are 12% lower than the average across occupations, once individual characteristics such as age, education, gender, sector, etc. are taken into account. Regarding sectors, the LTC sector is estimated to pay workers with similar characteristics 4% less than the average across all sectors, with wages being particularly low in non-residential care.
- In most OECD countries, collective bargaining coverage of LTC workers employed in the formal sector tends to mirror the national average, but collective bargaining coverage of workers on paper is not sufficient to ensure good working conditions. In several countries, workers' representatives in the LTC sector are not strong enough to negotiate tangible improvements in wages and working conditions; and even when they are, compliance is not guaranteed. Furthermore, several categories of LTC workers are underrepresented as they fall outside the scope of existing collective agreements because they work undeclared or as self-employed (including sometimes false self-employment).

Policy implications

A comprehensive policy strategy is needed to tackle poor working conditions and insufficient social recognition of LTC work. This is essential to avoid that LTC labour shortages reach unacceptable levels in the context of population ageing. Such a strategy has to cover several dimensions, with different priorities across countries depending on the diagnosis about the way the LTC sector functions. If regulations including those enforcing competition are effective, then it is probably best to raise funding and leave providers the flexibility to choose a combination of higher wages, more hours or more staff. If, however, despite these regulations high profits are generated among private LTC providers then a more direct intervention on wages or staffing is justified.

- *Increasing public financing and fostering the leading role by governments.* Public finances have been under pressure during the recent and ongoing crises. But improving working conditions today and limiting future labour shortages require a substantial increase in public spending in the sector. Governments can also play a leading role in setting job-quality standards, directly in public institutions and by requiring that LTC institutions benefitting from public funding be covered by collective bargaining and/or adhere to higher job-quality standards.
- *Directly intervening to raise wages and improve staffing requirements.* As part of the leading role played by governments, higher wages paid by public LTC providers may generate spill-over effects to private providers, forcing them to raise wages too, if they are to keep their best staff. Depending on the specific context of each country, other measures covering both public and private LTC providers may include: raising staffing requirements in residential care; improving compliance with staffing requirements and transparency in the communication of effective staff ratios by care providers; enforcing hourly minimum wage regulations while promoting appropriate wages in collective agreements; and, raising the sectoral minimum wage in countries where the instrument exists.

- *Supporting collective bargaining and social dialogue*. Increasing the share of LTC workers effectively covered by collective agreements can be achieved by extending collective agreements to all LTC workers, increasing compliance and enforcement through enhanced labour inspections and clearer information about the content of collective agreements, and by supporting affiliation to unions, for example, through subsidies.
- *Strengthening training*. Training for personal care workers, in particular those providing home care, needs to be enhanced, for example by initial training on care for older people with common physical and mental limitations, supplemented with some continuous courses fitted to the needs of care recipients. For nurses, an increased focus on geriatric care is required in their curricula in many countries. For LTC workers providing home care, increasing access to training reflecting their care recipients' needs is particularly relevant.
- *Promoting social recognition*. In addition to better training and higher wages, information and recruitment campaigns challenging gendered care norms and training certifications are key to strengthen the social recognition of LTC workers.
- *Increasing the use of new technologies*. New technologies can improve productivity and reduce the arduousness of LTC work by limiting the time needed for other tasks than direct care provision, and by taking over the most physically demanding tasks such as lifting people. Barriers to the use of new technologies can be overcome, beyond expanding budgets, by ensuring that data governance frameworks protect privacy, by providing training to improve LTC workers' digital skills, and by informing LTC providers about the technologies available.
- *Strengthening preventive health policies*. Public information campaigns to promote healthy lifestyles and rehabilitation policies can mitigate the increasing demand for LTC services, beyond improving the well-being of older people. LTC workers' role in preventive health can be enhanced through training and guidance on how to help older people stay healthy for longer. Technologies can contribute to reducing health risks, mitigating physical and cognitive decline and facilitating independent living, but successful implementation requires efforts to improve older people's health literacy and digital skills.
- *Promoting transitions of undeclared care workers to formal employment*. With undeclared LTC work being common in several countries especially among live-in carers and in particular among foreign-born workers, promoting transitions to formality is a fundamental prerequisite to improve working conditions in the LTC sector and ensure a higher compliance with the standards set in collective agreements. This could be done by vouchers to purchase declared work, reduction in the cost of compliance with legislation and tax incentives, among others.

In addition to limiting undeclared work, some general policies in other areas would greatly benefit LTC workers, including: fighting discrimination against women and foreign-born workers; eliminating gender stereotypes; and, raising the national minimum wage in countries having such an instrument and where its level is low.

1.1. Labour shortages may reach unacceptable levels in the near future if no decisive action is taken now

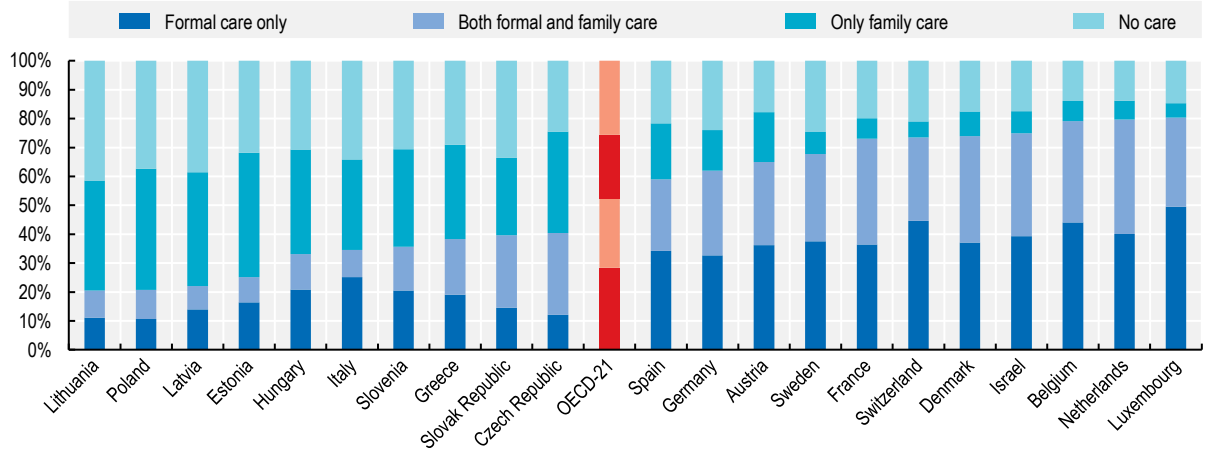
1.1.1. One-quarter of people with severe limitations in activities of daily living receive neither formal nor family care

While one in eight people over 65 report severe limitations in activities of daily living,[2] only half of them receive formal care and one-quarter receive neither formal nor family care across European countries (Figure 1.1). In Estonia, Latvia, Lithuania and Poland, less than one-quarter of older people with severe

limitations receive formal care, while it is more than three-quarters in Belgium, Israel, Luxembourg and the Netherlands. The share of older people with at least three daily limitations receiving neither formal nor family care varies from around 15% in Belgium, Luxembourg and the Netherlands to around 40% in Latvia, Lithuania and Poland. These are worrying numbers while the prospect of not being able to access good-quality LTC services is a major concern among adults in OECD countries according to the Risks that Matter Survey measuring the perception of various social risks in OECD countries (OECD, 2021[6]).

Figure 1.1. Only half of older people with severe daily life limitations receive formal care

Share of the population 65+ with at least three ADL or IADL limitations, by type of care received



Source: Chapter 5, Figure 5.2, https://stat.link/o70bwr.

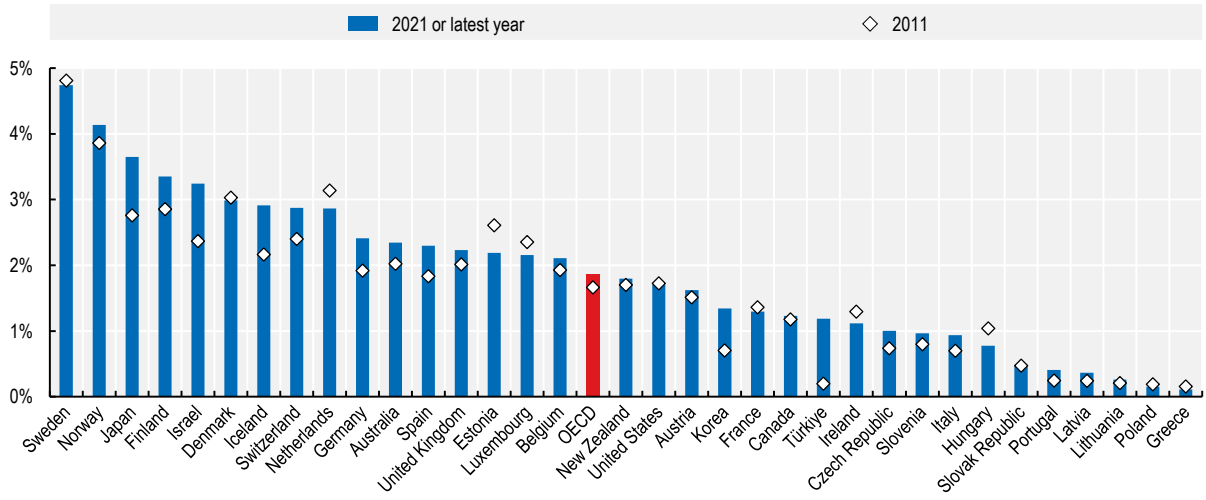
The share of LTC workers in total employment increased over the past decade by 12%, from 1.7% in 2011 to 1.9% in 2021 in the OECD on average (Figure 1.2). Differences between countries in the current share are large, ranging from less than 0.5% in Greece, Latvia, Lithuania, Poland and Portugal to more than 3% in Finland, Israel, Japan, Norway and Sweden. Reasons for this variation are the development of the LTC sector, the scope of family care and the extent of LTC provision by hospitals, among other factors.

Population ageing affects the demand for LTC services through two channels. First, while the number of older people sharply increases, accounting for changes across all older age groups matters as both LTC needs and the share of people with needs using formal LTC rise steeply with age. For example, in the OECD on average, 13% of people aged 65-69 report at least one limitation in activities of daily living (ADL) or instrumental activities of daily living (IADL) increasing to 53% at age 85-89. At age 65-69, 22% of people with a limitation in activities of daily living receive formal LTC, compared with 49% in the age group 85-89. Second, LTC needs at given ages tend to diminish over time due to health improvements.

Overall, the numbers of LTC workers are estimated to have grown in line with those driven by demographic changes on average across countries over the last decade. This means that the staff-to-user ratio has remained broadly stable but was not enough to improve either quality or coverage given that there was no labour productivity growth in the sector during that period (Chapter 5). In total, this also implies that the increase in the number of LTC workers was not sufficient to substantially reduce if at all any past labour shortages, explaining why the latter have persisted. Moreover, although difficult to quantify precisely, there has been a trend in many countries from residential to home care. This typically generates savings as residential care is more expensive, but this may require additional workers to offset the loss of economies of scale in employment depending on the severity of disabilities.

Figure 1.2. The share of LTC workers in total employment is slowly increasing

Number of LTC workers as a percentage of total employment



Source: Chapter 2, Figure 2.4, https://stat.link/nfhsuy.

1.1.2. Many countries have been struggling to recruit LTC workers

Unmet LTC needs do not necessarily translate into staff shortages. There are several reasons why not all people who need LTC receive it: limited access to public funding, underdeveloped LTC institutions and home care services, affordability issues, or even sometimes individual preferences. Surveys, such as HRS or SHARE, ask respondents about their LTC needs irrespective of their income or of the price of LTC services. By contrast, staff shortages depend on wages and prices and point to the fact that the demand for new LTC workers exceeds the supply at current working conditions, which leads to unmet needs. Countries offering limited access to formal LTC may report high unmet needs but no staff shortages as few job offers are posted. Conversely, in countries with well-developed formal LTC services, labour shortages may be the main driver of unmet LTC needs.

Chronic shortages of LTC workers have been reported in many OECD countries and regions over the past decades (Chapter 5). In Australia, the Skills Priority List identifies care workers among occupations with current shortages and significant expected growth in demand. In Ireland, basically all nursing homes report difficulties in recruiting healthcare assistants, while employers in Norway face substantial recruitment issues in both the LTC and healthcare sectors. Portugal, Switzerland and the United Kingdom, among other countries, acknowledge existing shortages of care workers. In Europe more generally, nurses were reported to be among the top shortage occupations in 18 EU countries, and healthcare assistants in 11 EU countries in 2021 (ELA, 2021[7]).

Not only is the quantity of care needs increasing with population ageing, the range of requested tasks has also expanded with care becoming more complex as more people suffer from multiple chronic conditions and mental health problems. While many countries struggle to recruit sufficient personal care workers (Chapter 5), this increasing complexity means that shortages are often particularly pronounced for skilled care personnel such as nurses, including in Austria, Belgium, Estonia, Germany and Portugal (Eurofound, 2020[8]).

The COVID-19 crisis has resulted in deteriorating working conditions and increased job quits in the LTC sector, potentially intensifying staff shortages. More generally, job quits have risen most in sectors with larger shares of contact-intensive, physically strenuous or less flexible jobs (Duval et al., 2022[9]). Large increases in job quits in most sectors in the United States especially, and in particular among prime-age workers, have coined the term of a “Great Resignation”. However, evidence rather suggests high mobility

within sectors in a tight labour market – as hiring rates have also increased sharply – rather than significant outflows from specific industries caused by changes in workers' preferences away from some low-pay jobs (OECD, 2022[3]). High turnover rates could thus reflect a well-functioning labour market with workers taking advantage of a hot labour market to seize new opportunities (Duval et al., 2022[9]).

However, population ageing could structurally threaten recruitment and retainment of nurses and personal care workers. In many OECD countries, high projected increases in the number of older people, and therefore in the demand of LTC services, will be accompanied by labour scarcity in the overall labour market. In a "structurally tight" labour market, workers may be less inclined to accept employment in occupations subject to difficult working conditions, thereby compounding difficulties to fill in job vacancies in the LTC sector.

1.1.3. Demand for LTC workers as a share of total employment is projected to increase by 32% over the forthcoming decade

The demand for LTC workers is projected to increase at a fast pace over the next decades. This results from the ageing of populations in most OECD countries, from increased demand for care services as a result of higher incomes and from low productivity in LTC services (see below). In the baseline projections, combining demographic changes, higher income and no labour-productivity growth in the LTC sector, rising demand for LTC services would increase the LTC employment share by 32% over the next decade, or by 0.6 percentage points of total employment in the OECD on average (Figure 1.3).

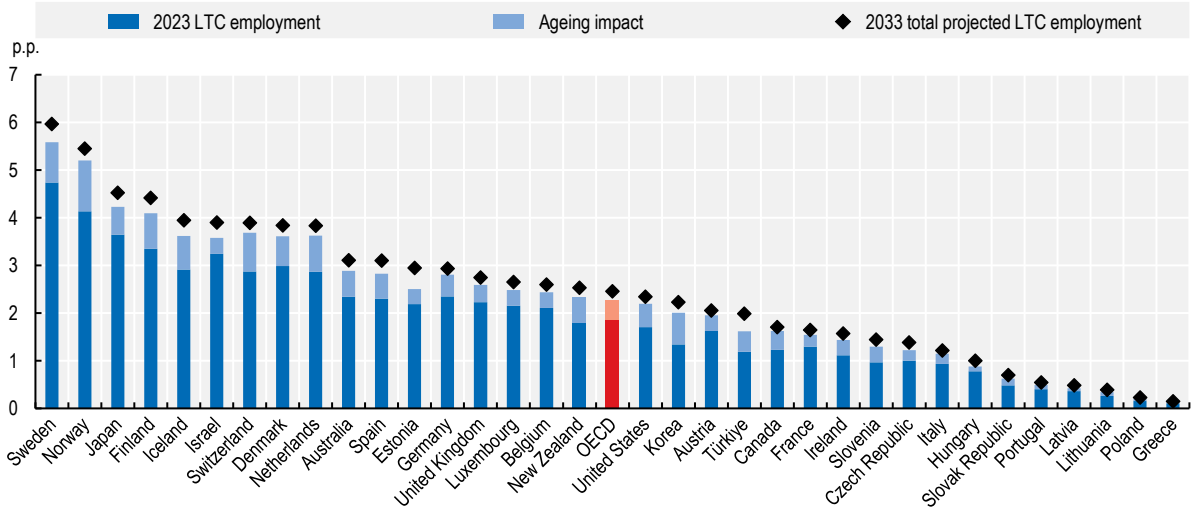
The demand for LTC workers would increase by 0.4 percentage points over the next decade due to population ageing alone or by 22% in the LTC employment share (Figure 1.3). A similar trend is expected to continue over the following decade. This represents a substantial acceleration relative to the past decade for which the estimated ageing impact on the share of LTC workers in total employment was 0.2 percentage points. These projections are based on "no policy change" scenarios, meaning that ageing increases LTC needs but is assumed to affect neither the share of formal-care recipients among people with limitations in activities of daily living nor the number of LTC workers per formal-care recipients (Chapter 5). More precisely, this means that ageing leads to proportional effects on numbers of both LTC workers and family care providers required, and therefore on the number of people experiencing unmet needs. This thus implies low increases in the absolute number of LTC workers (or as a share of total employment) in countries where the initial number of LTC workers is low as the projections do not include any catch-up phase in the development of LTC systems, consistent with past observations. In such countries that also face fast ageing, these projections imply a large absolute increase in the number of people experiencing unmet LTC needs unless counterbalanced by more informal care provision.

Differences across countries in the estimated impact of ageing on the demand for LTC workers as a share of total employment thus depend on projected changes in the number of older people by age groups as well as on the initial size of the LTC workforce (Figure 1.3). The projections of the demand for LTC workers take into account the expected decrease in working-age populations in many OECD countries. While working-age populations are projected to shrink by 2% on average in OECD countries over the next decade, the decrease would be more than 10% in Germany, Italy, Korea, Latvia, Lithuania, Poland and the Slovak Republic.

On top of demographics, economic growth is expected to further raise the demand for LTC services due to the income effect; and the fact that labour productivity growth in the LTC sector is projected to be lower than in the overall economy (Baumol effect). Higher incomes generated by economic growth raise the demand for LTC services and allow people to spend more on LTC or more people to have access to LTC. Higher labour productivity growth in the overall economy than in LTC means that technological progress saves relatively more labour in other sectors. As a labour-intensive sector, LTC records low levels of labour productivity growth. On average among OECD countries, labour productivity declined slightly in the care sectors over the past decades while it increased by 1.5% per year in the total economy. As a result, low labour productivity growth in the LTC sector requires additional workers to meet increasing demand.

Figure 1.3. Demand for LTC workers expected to increase by 0.6 percentage points of total employment in the next decade, or 32%

Projected share of LTC workers in total employment by 2033, baseline scenario



Source: Chapter 5, Figure 5.13, https://stat.link/uagjim.

1.1.4. Labour shortages will grow substantially even with large efficiency gains

Recent OECD publications have highlighted how much scope there is to improve efficiency in the delivery of LTC services in most OECD countries (OECD, 2020[2]). For example, nurses often perform work for which they are overqualified (e.g. dressing older people), and only one-third of countries allow task delegation from doctors to nurses, and from nurses to personal care workers. Likewise, while LTC services remain labour intensive, with very weak productivity growth recorded so far, there is significant potential to make more use of new technologies. This would help reduce the costs of LTC services, containing the otherwise growing employment needs and improving the quality of services. Digital technologies can also facilitate the independent living of older people and reduce the arduousness of LTC work.

LTC investment in new technologies remains low. On average among 12 OECD countries for which data are available, IT investments make up only 1.0% of gross value added in LTC, compared to 3.2% in the total economy (Chapter 5). New technologies in LTC are not limited to IT, although as cost is an important barrier to the implementation of new technologies such as robots, IT technologies including sensors and tablets with specialised applications are attractive as they are cheaper and can reduce the time LTC workers spend on administration, co-ordination, monitoring and transport, and are increasingly used in the sector in both residential and home care settings.

By raising labour productivity, digital and other technologies can limit future shortages of LTC workers. However, it is unlikely that they will replace LTC workers entirely for core caregiving tasks. Employment projections in this report include an alternative, very optimistic scenario of a 0.5% annual labour productivity growth rate in the LTC sector, compared with the baseline zero growth which is consistent with past observed data. Based on this assumption, the LTC sector would be able to save on employment, limiting the increase in the LTC employment share. However, even with such a big upsurge in productivity growth, the increase in the demand for LTC workers would remain very large, reaching 0.5 percentage points of total employment or 27% over the next decade, instead of 0.6 percentage points and 32%, respectively, according to baseline projections.

1.2. Tough working conditions affect care quality and dissuade potential workers

The characteristics of LTC jobs are measured and assessed based on the three dimensions highlighted by the OECD Job Quality Framework (Cazes, Hijzen and Saint-Martin, 2015[5]): earnings quality refers to the adequacy of individual wages and their level compared to those of other workers (Chapter 2); labour market security refers to the risks of job loss and its economic cost for workers (Chapter 3); and, the quality of the working environment refers to non-economic aspects of jobs (Chapters 3 and 4).

LTC workers face very difficult working conditions. Physical and psychological arduousness as well as difficult working times such as night and week-end work are important drawbacks of the working environment in LTC (Chapter 3). Despite demanding working conditions, wages for personal care workers in LTC, particularly those working in home care, are lower than for workers with similar characteristics in healthcare or in other sectors (Chapter 2). And while LTC workers feel the work they do is appreciated by the people they care for, they generally perceive little social recognition from managers, policy makers and the wider society (Chapter 4).

1.2.1. High physical and mental health risks and difficult working hours

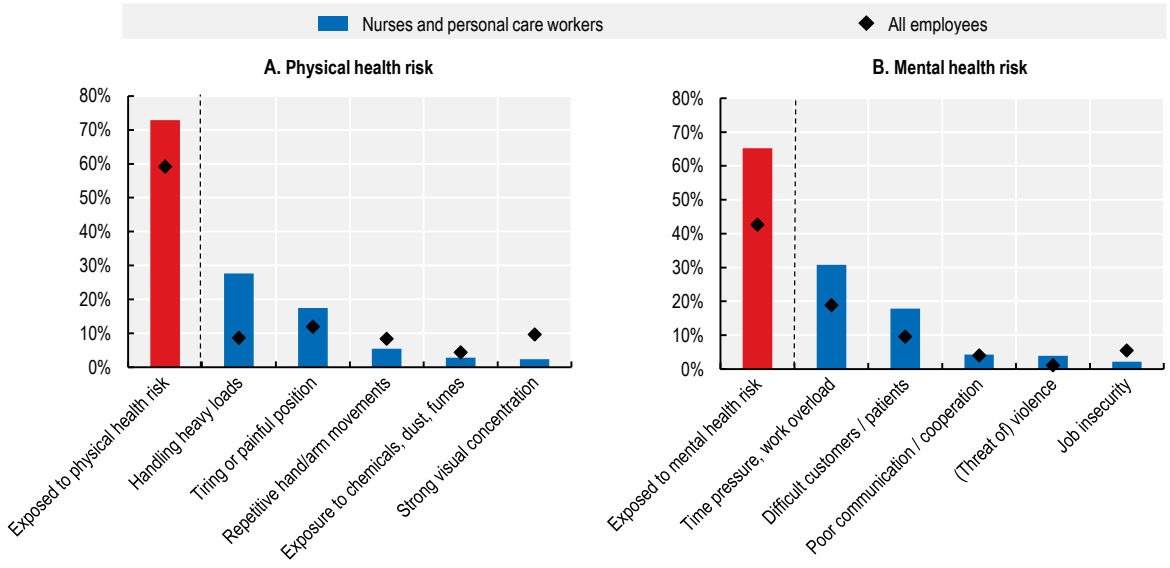
Care work is both physically and mentally arduous. In 2020, about three-quarters of nurses and personal care workers in healthcare and LTC in European OECD countries were exposed to risks to their physical health and about two-thirds were exposed to risks to their mental health, compared to 59% and 43% of all employees, respectively (Figure 1.4). While 27% of nurses and personal care workers indicate that they are not exposed to any large risks to their physical health, a similar share (28%) identify handling heavy loads as the most important risk to their physical health (Panel A). With overweight and obesity among older people on the rise in some countries, the musculoskeletal health impact from lifting people is likely to increase further over time. Another 18% name holding tiring and painful positions as the main risk factor affecting their physical health, for instance as a result of performing care tasks while bent over an older person lying in bed. At 12%, nurses and personal care workers were four times as likely as other workers to flag other physical health risks, which may include abuse from care recipients and exposure to infectious diseases such as COVID-19.

In terms of exposure to mental health risks, 31% of nurses and personal care workers refer to a high workload and corresponding time pressure as their most important mental health risk, compared with 19% for all employees (Panel B). Care workers experience pressure and frustration due to administrative requirements leaving little time to work with individual care recipients. Difficult interactions with care recipients are pinpointed as the main mental health risk for another 18% of nurses and personal care workers. While it is common for care workers to be exposed to various forms of abuse, few care workers identify abuse or the threat thereof as the main risk to their mental health. In another study, Eurofound (2020[8]) reports that 26% of LTC workers have been exposed to verbal abuse, 11% declare to have been threatened and 8% to have been humiliated, bullied or harassed during the month before being surveyed.

The implementation of new technologies can help reduce exposure to physical and mental health risks in LTC work (Chapter 5). The use of robots and lifts for instance reduce the impact of helping people in and out of bed and assisting with bathroom visits on LTC workers' musculoskeletal health. Sensors, tablets and other IT products can reduce time pressure by limiting the time LTC workers spend on other activities than direct care provision. These technologies are increasingly used in LTC, although there is still much room for expansion of their use. The reasons for the limited use of cheaper technologies are not entirely clear, but obstacles may include the lack of both LTC providers' awareness of some available technologies and LTC workers' digital skills.

Figure 1.4. Care workers are highly exposed to physical and mental health risks

Selection of the most important physical and mental health risk factors employees in OECD-25 countries report being exposed to, share of employees, 2020



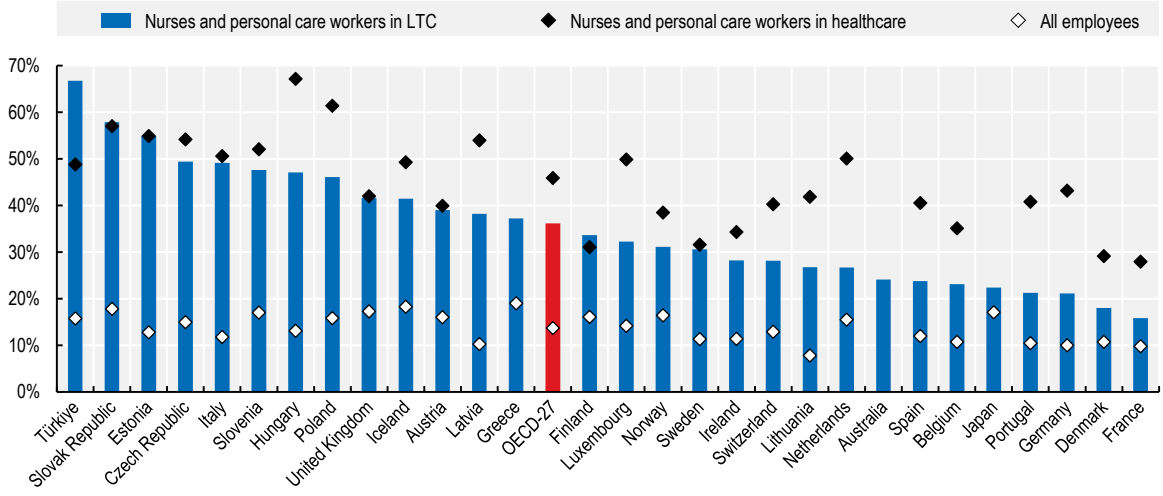
Source: Chapter 3, Figure 3.2, https://stat.link/sfqwto and Figure 3.3, https://stat.link/sn5j2t.

LTC workers are much more likely than other employees to work at times that are difficult to reconcile with family responsibilities or social activities, including night and week-end work. On average across the OECD, 36% of LTC workers sometimes or usually work at night, compared to only 14% of all employees; in the healthcare sector, however, night work is more common among nurses and personal care workers in almost all countries and concerns 46% on average (Figure 1.5). LTC workers are also about 2.5 times as likely as the average employee to work on Sundays (Chapter 3). Of all LTC workers, 70% usually or occasionally work on Sundays, compared to 27% of all employees and 61% of nurses and personal care workers in healthcare.

Part-time work is more common among LTC workers than among other employees. On average across the OECD, 32% of LTC workers are employed on a part-time basis, compared to 18% of all employees and 24% of nurses and personal care workers in healthcare. Even in some countries reporting LTC shortages a substantial share of LTC workers working part-time would like to work more hours.

Figure 1.5. LTC workers are 2.5 times as likely to work at night as the average employee

Share of employees sometimes or usually working at night, 2020-21 or latest year



Source: Chapter 3, Figure 3.8, https://stat.link/bix7ca.

1.2.2. Low wages, especially for personal care workers

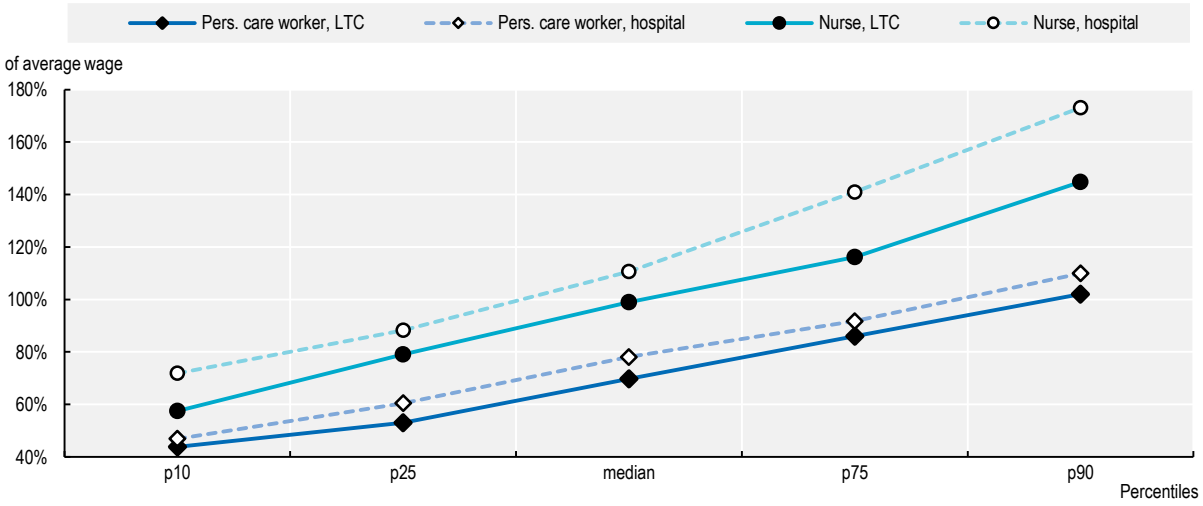
Personal care workers in LTC earn around 70% of the economy-wide hourly wage on average across the OECD. Moreover, in most OECD countries their wages are lower in non-residential compared to residential LTC. Personal care workers earn less in LTC than in hospitals across the whole distribution of wages. For example, one-quarter of personal care workers earn at most 53% of the economy-wide average wage in LTC compared to at most 60% in hospitals (Figure 1.6). Only 10% of personal care workers in LTC earn at least the average wage. Similar to personal care workers, nurses' wages are lower in LTC than in hospitals: the median wage for nurses in LTC is at the economy-wide average wage, whereas it is 11% higher for nurses in hospitals. In LTC, nurses' hourly wages on average are 39% higher than those of personal care workers.

The above numbers are descriptive statistics that are influenced by individual characteristics such as education, gender, hours worked and tenure. But even when these individual characteristics as well as sectoral differences are accounted for, personal care workers still have hourly wages that are 12% lower than the average across occupations (Figure 1.7).[3] This negative 12% occupational effect for personal care workers is similar to that of waiters (-11%), and larger in absolute terms than for hairdressers (-8%) but smaller than for cooks (-16%) or refuse collectors (-36%).[4] Across all occupations, estimates range from -40% for street service workers to +49% among the managers of large companies.

Workers with similar jobs and similar characteristics earn about 8% less per hour in LTC settings than in hospitals. As the raw average-wage difference between both sectors is equal to 31%, this implies that about three-quarters of this large average difference reflect differences in workers' characteristics while the remaining one-quarter is not explained by individual characteristics and may be interpreted as a penalty for working in LTC.

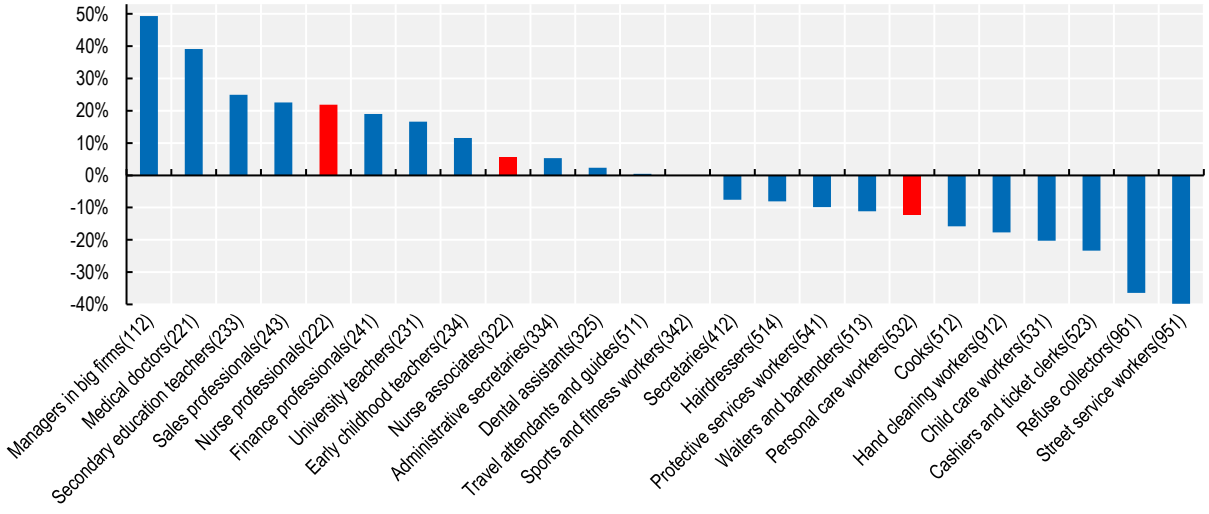
Figure 1.6. About one-quarter of personal care workers in LTC sector earn less than half the average hourly wage

Selected percentiles of wage distribution of selected occupations in LTC and hospital sectors, 2017 or latest year available



Source: Chapter 2, Figure 2.14, https://stat.link/ya1qv5.

Figure 1.7. Occupational effects on wages for workers with similar characteristics, percentage

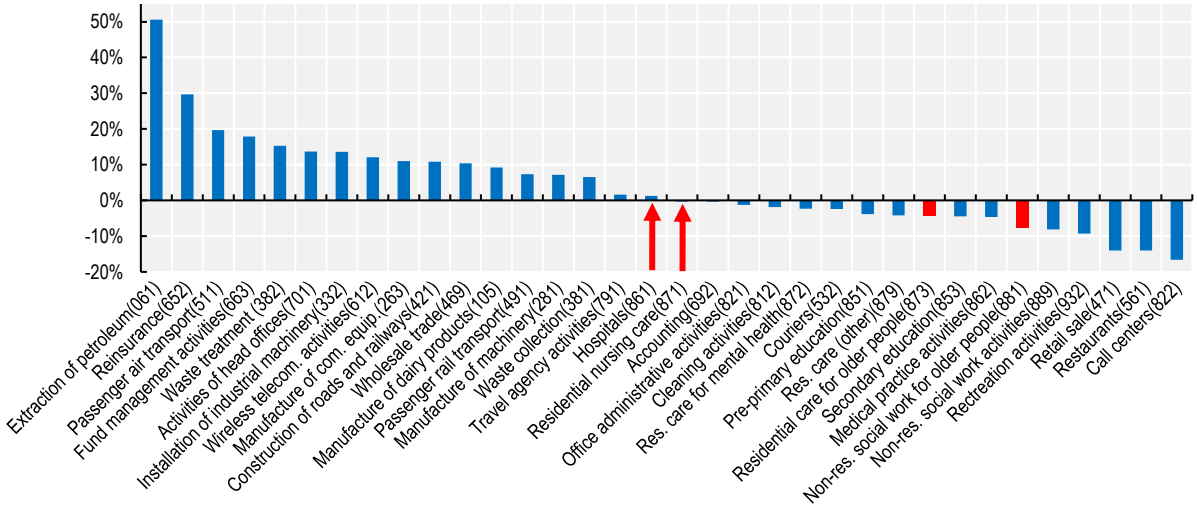


Source: Chapter 2, Figure 2.16, https://stat.link/h1fjwk.

LTC workers on average also earn 4% less than workers with similar characteristics in all other sectors. While wages in residential nursing care homes (i.e. residential care homes also providing medical assistance from nurses in addition to assistance with activities of daily life) are around the average for workers with similar individual characteristics across all sectors, wages are 4% lower in residential care facilities where only assistance with activities of daily life is provided, and even 9% lower in non-residential care (Figure 1.8). These negative wage effects in the LTC sector are also consistent with the estimated wage pattern in labour-intensive service sectors: retail sales and restaurants pay 14% less, all else being

equal, call centres pay 17% less, amusement and recreational activities pay 9% less, and pre-primary education 4% less. By contrast, sectors such as extraction of petroleum or reinsurance pay over 25% more than the average for workers with similar individual characteristics.

Figure 1.8. Sectoral effects on wages for workers with similar characteristics, percentage



Source: Chapter 2, Figure 2.17, https://stat.link/pmdt19.

The gender pay gap is another important factor contributing to low wages for LTC workers, in addition to the occupational and sectoral pay penalties. Female LTC workers are paid 7.6% less than their male colleagues with similar characteristics. This is well below the economy-wide female wage "penalty" of 14.2%, but it is remarkable that even in a sector where women represent more than 85% of employment, they still earn less in the same occupations than men with similar characteristics.

1.2.3. Lack of recognition of LTC workers and of the skills and competences required

Social recognition of an occupation can motivate people to choose it. Social recognition refers to the acknowledgement of a worker's contribution to the community and may give the worker the sense of doing something that is valuable to others. It can take the form of good status, high enough remuneration or gratitude, as was the case with the applause for care workers during the initial stages of the COVID-19 pandemic in many countries.

Studies from Australia and the Nordic countries reveal that LTC workers feel recognised by care recipients and by their colleagues, but much less so by their managers, politicians and the wider society (Chapter 4). The feeling of misrecognition by managers and policy makers is likely connected to poor working conditions and low remuneration, for which LTC workers hold these leaders responsible. Misrecognition by the society is likely driven by the low status of LTC work and is related to a negative perception of the job itself and the skills required. The emotional and psychological competences required to care for vulnerable people are often overlooked.

Gendered care norms downplay the skills needed to provide LTC and the wage levels required to attract skilled and motivated workers to the LTC sector, undermining recognition and valuation of care work. In the traditional gendered division of labour of the male-breadwinner model, care is considered women's work and the skills required for performing care work are wrongly assumed to occur "naturally" in women; moreover, informal care is not viewed as part of income-producing activities and is thus not valued in

monetary terms. While the widespread adherence to the male-breadwinner model is a thing of the past, some aspects of the traditional division of labour are still replicated in society, including the idea of care work as women's work. Therefore, to sustainably improve LTC workers' position in society, and thus go Beyond Applause, it is not only necessary to better recognise care work in terms of increased status and remuneration, but also to tackle gendered care norms.

In addition to tackling these norms, education and training may contribute to boosting LTC workers' recognition as training programmes for LTC workers improve the quality of care delivered and can in addition ameliorate the public image of LTC jobs. Home care workers in particular could benefit from additional training as they often work alone and thus with little support, and as older people's homes often are neither designed nor equipped for LTC provision, meaning that a good mastering of care techniques is important to minimise physical strain. In addition, there is a need for LTC workers to receive more education and training on providing care that is appropriate for the physical and mental condition of the people they care for, and to monitor their development. This is especially the case for dementia care as a growing part of older people receiving LTC are diagnosed with dementia. Training programmes are also important for the successful implementation of new technologies in LTC (Chapter 5). On the one hand, LTC providers may be hesitant to implement new technologies due to worries over their workers' ability to use them, and, on the other hand, training is vital to ensure that newly introduced technologies are used effectively.

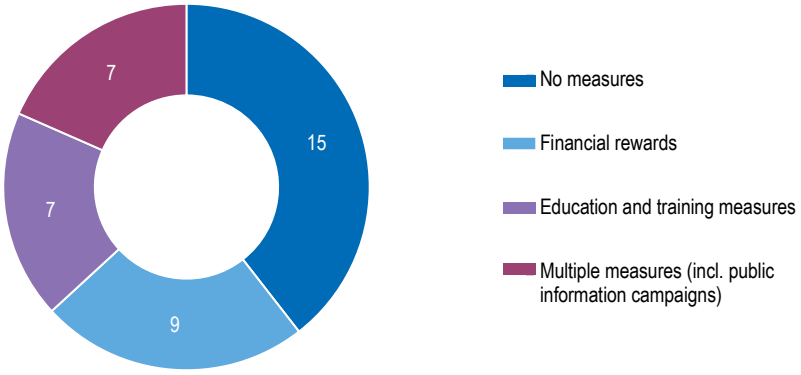
The majority of OECD countries have taken initiatives to improve the social recognition of LTC workers (Figure 1.9):

- Nine OECD countries have improved the remuneration of LTC workers either permanently or via bonuses or temporary wage increases in relation to COVID-19: Canada, the Czech Republic, France, Hungary, Korea, Latvia, Lithuania, the Netherlands and Slovenia.
- Seven countries have taken initiatives in the area of education and training, mostly through recognising previous work experience in LTC by awarding course credits in education programmes, but also through strengthening training requirements for LTC staff: Denmark, Ireland, Norway, Portugal, Sweden, Switzerland, and the United Kingdom.
- Seven countries have combined different measures, of which five have aimed to improve the public image of LTC workers through organising or supporting public information campaigns, in addition to other measures: Australia, Austria, Germany and Luxembourg combined information campaigns with financial measures and Japan with both financial and educational measures. Belgium and the United States combined financial and educational measures.

Care work has repeatedly been described as "undervalued". This can refer to low wages, but this may also be interpreted as meaning that the market value of care is below its social value for the community or society, although it is not clear what the social value of LTC is and therefore how to measure it. It is reminiscent of the concept of positive externalities in economics, referring to others reaping some benefits from a good or a service beyond the buyer and the seller of that good or service themselves. However, it is not clear how personal care work produces benefits for the wider community beyond those for the care recipients and their families. The lack of clarity on the social value of care work does not mean that personal care work is not undervalued in the labour market, which is evidenced by wage penalties to being a personal care worker in the LTC sector.

Figure 1.9. The majority of OECD countries have taken measures to improve recognition of LTC workers

Distribution of OECD countries by type of measures taken to improve social recognition of LTC workers



Note: Public information campaigns to improve the image of LTC work have been held in Australia, Austria, Germany, Japan and Luxembourg, but countries have combined these campaigns with other measures to improve social recognition of LTC workers: Australia, Austria, Germany and Luxembourg combined campaigns with financial rewards, and Japan combined them with financial reward and education and training measures. In the United States, the federal government did not provide bonus payments to LTC workers in response to COVID-19, but several states did.
Source: OECD based on information provided by the countries.

1.3. Why wages are low and working conditions do not improve despite shortages

The relation between poor social recognition and bad working conditions including low wages is a circular one. Bad working conditions impair social recognition, which in turn contributes to maintaining low wages and difficult work environments. In a well-functioning labour market, sectoral labour shortages should trigger an improvement of working conditions including wages to attract more workers in order to meet labour demand. Instead, many countries are struggling with persistent labour shortages in the LTC sector.

The section first provides an overview of key reasons for wages being low in LTC. It then explores possible explanations for why persistent labour shortages have not led to substantial improvements in working conditions so as to increase labour supply. Identifying the key mechanisms at work in wage formation is important as different explanatory factors have different policy implications.

1.3.1. Factors contributing to low wages in the LTC sector

Education levels are important determinants of wage levels and the educational requirements for personal care workers in LTC – who account for almost four-fifths of LTC workers – are relatively limited in many countries. Most LTC workers have a medium level of education: only about 20% of LTC workers, primarily nurses, have attained tertiary education and about 20% have at most a lower secondary education level on average across countries (Chapter 2). In some countries, a majority of LTC workers have no diploma in the field of health or the social sector.[5] However, although LTC jobs are often classified as low-skilled, the skills that are actually needed to deliver good-quality care are complex, and, contrary to nurses, personal care workers generally do not benefit from the certification of acquired skills.

Persistent gender pay gaps also contribute to low hourly wages for LTC workers. These gaps are partly related to the unequal distribution of care work between men and women. The female wage penalty translates into low aggregate wages among LTC workers as LTC professions are among those where

women are most over-represented, accounting for more than 85% of workers. The only other sectors with such a female over-representation are cleaners, clerks and helpers.

The over-representation of women in LTC is related to working-time arrangements and gender norms and stereotypes. In healthcare and LTC, women are twice as likely to work part-time as men, 32% and 16%, respectively (Chapter 4), although part-time work is more common in LTC than in the total economy for both men and women as LTC jobs often offer opportunities for part-time or flexible working hours. In addition, stereotypes and persistent gender biases in unpaid care work at home play a key role. Girls are two to three times more likely to pursue health-related studies than boys, and women tend to be seen as a more natural "fit" for paid care work, which feeds into the gendered care norms discussed above. Tackling these issues requires to fight not only gender discrimination in the labour market, but also gender norms and stereotypes more generally. Particularly for LTC, efforts to broaden the recruitment pool by focusing on hiring more men would greatly help.

The high share of migrant workers in LTC tend to contribute to poor working conditions including lower wages in the sector. Foreign-born workers accounted for 26% of the LTC workforce on average across OECD countries in 2021, compared to 20% of all workers. The actual number of foreign-born personal care workers is likely to be higher than what is reported in particular in countries where live-in care is common, due to migrant workers being less likely to participate in data collection in general and the prevalence of undeclared work in live-in care. Migrant workers often have a small number of decent alternative job opportunities due to language barriers and limited social networks through which to find a job, and because their right to remain in the country may depend on maintaining their current employment. The reliance on migrant workers to fill the employment gaps in the LTC sector is likely to increase further due to population ageing. While the OECD wage analysis did not uncover wage discrimination against foreign-born workers among the LTC workforce, they represent a large proportion of live-in carers; the monitoring of live-in carers' employment conditions, including coverage by employment contracts, is generally very poor, making them vulnerable to abuse for example in terms of long working hours. Increasing the frequency of controls for live-in workers would at least help ensure better treatment.

In addition to personal characteristics such as education, gender and migration background, the availability of informal care – mostly unpaid and often provided by family members – as a possible substitute for formal LTC (Norton, 2016[10]) is a fourth important factor explaining low wages in LTC. While this report focuses on formal care, the large role played by informal care cannot be ignored as it indeed tends to weaken the position of formal care workers. In the European Union, informal carers represent close to 80% of care providers in full-time equivalents (European Commission, 2021[11]). Across Europe, countries with high numbers of formal carers tend to have low numbers of informal carers, and vice versa.

Finally, LTC workers are much more likely than workers in other sectors to perceive their job as meaningful, and even slightly more so than healthcare workers. This may be an important motivator to take LTC jobs (Eurofound, 2020[8]) and could partly explain why these workers accept low wages. Amenities – that is, non-wage characteristics of jobs such as perks or flexible working time options – are largely unobservable but may contribute to explaining low wages in the LTC sector.

1.3.2. Low wages despite persistent shortages

It is a paradox that wages are so low in a sector such as LTC that has been reported to suffer from labour shortages for many years. When market forces are at play, the existence of excess demand for workers should drive wages up to both attract more workers and limit labour demand through higher prices of services, thereby clearing the labour market. Indeed, a tight labour market is often identified by upward pressure on wages. Although causality may work the other way, with low wages resulting in labour shortages, this should only be temporary.

There are reasons, however, that could explain why these market forces do not work properly within LTC and face obstacles that perpetuate the disequilibrium. This report finds that there are three main factors behind this paradox which can all be at work simultaneously: low labour market power of LTC workers; mismatches; and, insufficient financing of LTC services.

Low labour market power of LTC workers

Low wage levels and the insufficient supply of LTC workers suggest that the labour market in the LTC sector may be subject to monopsony power. Monopsony power refers to a situation in which firms have large labour market power and use it to pay workers low wages, maximising their profits despite the negative impact this has on the number of workers willing to work at these low wages. Consistent with this idea, firms may take advantage of limited outside options of certain groups of workers, who therefore have low alternative (or reservation) wages. They may then engage in wage discrimination, paying them lower wages than those of other individuals who are equally productive but benefit from a wider range of job opportunities (they have a higher labour supply elasticity) (Boal and Ransom, 1997[12]). Based on the above discussion, this may apply in particular to women and foreign-born workers, as their over-representation in the LTC sector is likely to weaken the ability of workers in general to negotiate wages in LTC jobs.

Monopsony can explain structural labour shortages. In the case of monopsony, firms are not ready to hire more workers as, within this framework, this would require them to raise wages and cut profits. However, if it were possible, they would hire more workers *at the current wage*, which would increase their profits further. In that sense, surveyed firms can easily declare that they want to hire more workers at current conditions, and that there is a lack of candidates, hence shortages; they may even post job offers, leading to vacancies. In that case, the low level of wages is one factor that structurally contributes to limiting the labour supply of LTC workers. Over the last decade, wages in the LTC sector grew broadly in line with wages in the total economy (Chapter 2) – not less, but not more either – and this could explain why labour shortages persist.

There is mixed evidence of monopsony power negatively affecting nurses. Nurses are often employed in firms that are large relative to their geographical labour market and have a dominant position on local labour markets. Moreover, the labour supply of nurses was found not to react strongly to changes in wages, which makes them subject to lower wages than they could expect under perfect labour market competition (Staiger, Spetz and Phibbs, 2010[13]; Sullivan, 1989[14]). However, Hirsch and Schumacher (2005[15]; 2012[16]) report limited evidence supporting monopsonic labour markets for nurses. Eurofound (2020[8]) found that among LTC workers shortages are most urgent for skilled nurses.

There is no evidence of monopsony power negatively affecting personal care workers, which represent about four-fifths of LTC workers. Furthermore, Prager and Schmitt (2021[17]) show that an increase in labour market concentration following hospital mergers negatively affected wages of only skilled workers, such as nurses, and did not affect wages of lower skilled workers, such as personal care workers. This may relate to the lower concentration of labour markets for personal care workers than those of nurses: only 12% of personal care workers work in moderately or highly concentrated labour markets, compared to 30% of nurses (Chapter 3). Matsudaira (2014[18]) finds that LTC providers in California (United States) who were forced to increase the staffing levels of nurse-aids (a category of personal care workers) after an increase in minimum staffing regulations were able to recruit as many new workers as required at the current wage.

In any case, the assessment may differ strongly across countries. In those countries where the minimum wage is low, low-skilled personal care workers are likely to be affected by monopsony power. In those cases, raising the minimum wage would benefit a large share of these workers while boosting labour supply in the sector.

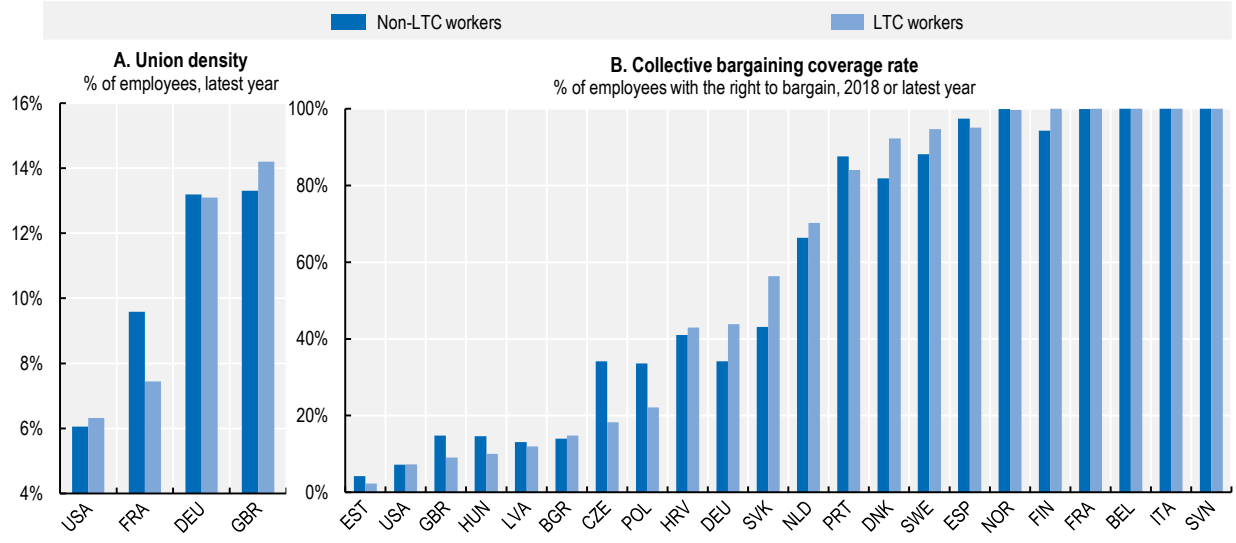
Collective bargaining and social dialogue remain unique tools enabling governments and social partners to find tailored and fair solutions to strengthen workers' bargaining position in negotiating their wages,

enhance job quality or adapt workplaces to the use of new technologies, also in the LTC sector. In most OECD countries, collective bargaining coverage and unionisation of LTC workers employed in the formal sector tends to mirror the national average (Figure 1.10). Among the four countries where microdata allow to measure trade union membership among specific occupations (Panel A), France is the only country where trade union density is lower among LTC workers than among the rest of the workforce. In the large majority of OECD countries shown in Panel B, collective bargaining coverage among LTC workers is similar to that of the rest of the workforce. Only in the Czech Republic and Poland does coverage among LTC workers appear to be significantly lower than among other employees; conversely, in Denmark, Germany and the Slovak Republic, coverage among LTC workers is higher than in the rest of the workforce. For nurses, their basic or minimum pay is typically set by agreements that cover both LTC and healthcare, and differences in pay between these two sectors can mostly be explained by level of training and experience which tend to be higher in healthcare (Eurofound, 2020[8]).

However, as discussed above, the working conditions in the LTC sector are generally worse than for the rest of the workforce in many dimensions. Ensuring the collective bargaining coverage of workers on paper is indeed not sufficient to guarantee good working conditions. In several countries, workers' representatives in the LTC sector are not strong enough to negotiate tangible improvements in working conditions including wages; and even when they are, compliance is not guaranteed. Moreover, large groups of LTC workers are underrepresented as falling outside the scope of existing collective agreements because they work undeclared or asself-employed (sometimes in false self-employment).[6]

Figure 1.10. Unionisation and collective bargaining coverage of LTC workers in selected OECD and European Union countries

Employees in the private sector



Source: Chapter 3, Figure 3.14, https://stat.link/dlr748.

Mismatches

Long-term care shortages may stem from differences between labour supply and demand for LTC workers in terms of the time and place of care as well as the skills required. It is for instance puzzling that even in some countries reporting a shortage of care workers, some LTC workers working part-time would like to work more hours but cannot find a full-time job. For example, in Australia, the share of LTC workers who would like to work full-time is almost 1.3 times the share who effectively do so (Mavromaras et al., 2017[19]).

In non-residential LTC a large share of part-time workers indicates that they work part-time because they could not find a full-time job (Eurofound, 2020[8]). Three types of mismatches may play a role in countries facing LTC shortages while at the same time part of the potential supply of care workers remains unused.

First, limited geographical mobility, in particular between rural and urban areas, can lead to local mismatches between the demand and supply of LTC workers, and in the end to local staff shortages (Chapter 3). For example, older people with unmet care needs in rural areas might have difficulties in benefiting from formal LTC services whereas the LTC workforce is mainly concentrated in and around towns and cities.

Second, there could be mismatches between the times when people would be available to work extra hours and the times when care workers are most needed. LTC workers working part-time may want to work more hours through expanding their current shift, whereas the peaks in demand for care in the mornings and the evenings may mean that working more hours would entail a split shift.

Third, skills mismatches might mean that there are shortages for some LTC workers with specific skills, while the supply of low-skilled workers may be sufficient, limiting wage pressure. Many LTC workers do not have sufficient geriatric care knowledge, understanding of both safety procedures and caring needs after hospital discharge, stress management skills or soft skills (Chapter 2). This situation may be better characterised by the lack of skills that are in demand rather than mismatches per se. Enhancing education and training in these areas is the main way to match excess labour demand. In addition, ICT skills become increasingly important for LTC workers as new digital technologies are being implemented in LTC (Chapter 5).

Insufficient financing

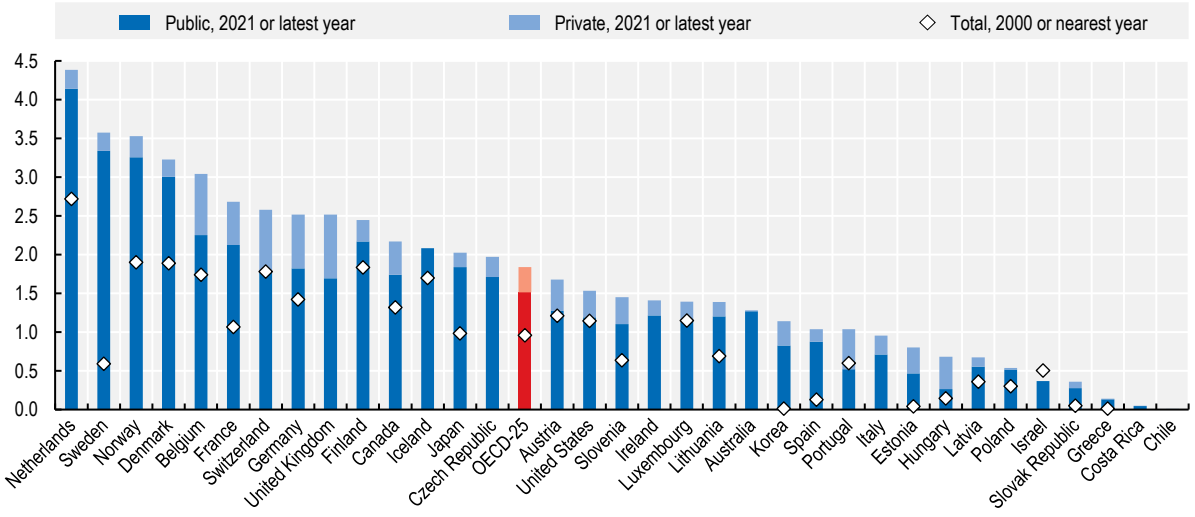
There are typically two main financial reasons why needs may not be fulfilled. First, the person in need is not able or ready to pay the price expected by the service provider due to, for example, low current income, limited savings or insufficient insurance. Analysing weaknesses in insurance mechanisms in LTC is well beyond the scope of this report. However, when there is a lack of insurance instruments, there is a clear need to improve public coverage or mandatory insurance. Second, the state is not ready to spend enough resources to ensure a sufficient service is delivered to meet people's needs, likely resulting in lower wages.

Insufficient financial resources are one important factor explaining why the sustained shortages of LTC workers do not lead to better working conditions to attract more workers. LTC services are, in many countries, largely financed from the public purse. Low wages and low employment in LTC can be the result of state budgets under pressure from, among others, population ageing as well as the political process leading to a relatively low willingness to pay for care-related public services (Hirsch and Manzella, 2014[20]).

Public financing plays a large role in LTC. Across OECD countries, about four-fifths of total LTC spending is funded from public sources (Figure 1.11). Total LTC spending was equal to 1.8% of GDP in the OECD on average in 2021. At 4.4% of GDP, the highest spender was the Netherlands, with Belgium, Denmark, Norway and Sweden spending between 3.0% and 3.6%. At the other end of the scale, Chile, Costa Rica, Greece and the Slovak Republic spent less than 0.5% of GDP on LTC services. This variation mostly reflects the stage of development of formal LTC systems, as opposed to more informal arrangements based mainly on care provided by mostly unpaid family members (OECD, 2021[21]). The value of informal care is not considered LTC spending because it does not involve financial flows. It is likely to be very large, as for example it has been estimated at 3.6% of GDP in European countries on average (Peña-Longobardo and Oliva-Moreno, 2021[22]). Nursing homes account for more than half of LTC spending, hospitals for around one-tenth and about one-fifth was on formal home care provision (OECD, 2021[21]), all being largely financed by public money. In the United States, for example, more than 70% of LTC spending was publicly financed in 2020, mainly through Medicaid, while out-of-pocket expenditure accounted for about half of private spending (Congressional Research Service, 2022[23]). Private spending is likely to be underreported, in particular due to undeclared work.

Figure 1.11. Total LTC spending as a share of GDP, percentage

Total spending (broken down into public and private sources) in 2021 and 2000



Note: Data are missing for the private component in Chile, Iceland and Israel.
Source: OECD Heath Statistics, https://doi.org/10.1787/health-data-en.

StatLink https://stat.link/3ikaed

Overall, it thus seems reasonable to estimate that at least two-thirds of wages among LTC workers are directly or indirectly influenced by public policies. The role of public policies in determining or influencing working conditions including wages can of course vary greatly across countries. When LTC workers are employed in public institutions, the public sector is likely to play the leading role in setting the working conditions. Moreover, wages of nurses, who make up 20% of LTC workers, are likely to be directly regulated.

The independent Migration Advisory Committee in the United Kingdom considers properly funding care facilities as the ultimate key to improvements in pay and working conditions (MAC, 2022[24]). Reciprocally, cost-cutting measures in countries facing constraints to finance the LTC system can lead to downward pressure on wages of LTC workers, or lower employment. This has been the case in the Netherlands where a 2015 reform tightened the LTC budget and led municipalities to negotiate lower tariffs with LTC providers. This resulted in many providers struggling with deficits and some, in particular ADL social care providers, stopping their activities (Maarse and Jeurissen, 2016[25]). Budget cuts were partly reversed from 2016. Funding can also be used to steer working conditions in LTC by making its receipt dependent on fulfilling certain minimum requirements. The comprehensive Eurofound report about the LTC workforce reaches the conclusion that, given the large role public funding plays in LTC, this public leverage can be used effectively in improving working conditions, for instance through requirements in public procurement (Eurofound, 2020[8]).

Interventions in working conditions may have adverse consequences depending on how LTC is financed. When the level of public subsidies depends on the number of older people in residential-care institutions or is based on regulated prices of LTC services, firms are likely to reduce employment, care quality or both when forced to raise wages for given total subsidies. In New Zealand, the 2017 Pay Equity Settlement for care and support workers aimed at addressing gender discrimination that has resulted in poor working conditions including low wages in these sectors where women are traditionally over-represented. The hourly minimum wage for care and support workers with three years of experience and no qualifications was increased by 27%. The Report assessing its impact, however, concluded that the funding was

inadequate to cover the costs associated with the Settlement, which led to severe unintended and negative consequences (Doulgas and Ravenswood, 2022[26]). Those include reduced working hours, increased workloads, lower quality of care and smaller providers in residential care struggling to remain in operation.

The United Kingdom may be facing similar concerns following the increase in the national minimum wage by 9.7% in 2023 after 6.6% in 2022 as these measures have not been met by consistent increases in the financial support provided by local authorities to care providers (Hft and Care England, 2023[27]). As a result, a large share of care providers have had to reduce their activity while not being able to raise wages at the same pace, which makes it more difficult for them to retain and recruit workers. While increasing wages is acknowledged as the main priority to improve the workforce situation, nearly all providers consider that pay is currently the most significant cost pressure threatening their financial position (Hft and Care England, 2023[27]).

Australia is in the process of establishing expert panels for its independent industrial relations tribunal, the Fair Work Commission. One expert panel for Pay Equity and one for the Care and Community Sector will hear applications for equal remuneration and employment conditions. To determine whether an equal remuneration order is to be issued, it will, for example, be assessed whether the work has been undervalued on the basis of gender. To support the panels four Commission members with expertise in gender pay equity, anti-discrimination, and the care and community sector will be appointed. The Australian Nursing and Midwifery Federation considers that the Fair Work Commission will help low-paid care workers bargain for improved wages and conditions (Australian Nursing & Midwifery Journal, 2022[28]).

Providers of LTC services can also be subject to financial constraints due to ongoing demand pressure. Hirsch and Schumacher (2012[16]) suggest that nurse shortages may be explained by the slow capacity of healthcare providers to adjust their budgets to increasing trends in demand and entry constraints in the nursing profession. Ageing trends may be so strong that market conditions do not adjust quickly enough, generating persistent shortages of LTC workers. This is consistent with a situation in which wages, employment and total spending increase while shortages remain (Veneri, 1999[29]).

From a policy perspective, the diagnosis about the way the LTC sector functions determines whether the best way to improve working conditions within private providers is to force wage increases, to tighten staff requirements (increasing staff ratios to improve the work environment as well as care quality) or to raise public funding and let the market work. If regulations including those enforcing competition are effective, then it is probably best to raise funding and leave providers the flexibility to choose a combination of higher wages, more hours or more staff. If, however, despite these regulations high profits are generated among private LTC providers then a more direct intervention on wages or staffing is justified. This means that designing the correct policies depends on country-specific assessments about the functioning of the LTC sector and profit levels. In Australia, the Royal Commission into Aged Care Quality and Safety investigated whether a lack of public funding may have contributed to lower-quality LTC, but found that profit margins in for-profit LTC institutions were comparable to or even exceeding those in several other sectors including production of consumer goods, industry and IT (BDO, 2020[30]). In the case of the Orpea scandal in France, for instance, the LTC provider generated high profit margins with public subsidies making up a large part of its revenues, while at the same time its staff faced poor working conditions and its residents poor care quality or even outright abuse (Castanet, 2022[31]).

Financial constraints can also make LTC unaffordable for many households while contributing to low wages. In this case, however, LTC needs are unmet, but there is no excess demand at current labour market conditions, and therefore no labour shortages, as these households are not ready to pay the price of services or those wages. Unmet needs and low wages are not inconsistent in this case; they even reflect the same binding income constraints households are facing.

Finally, this section implicitly assumes that current shortages of LTC workers are real, although it may be that reports of large shortages are inflated by providers seeking supplementary government funding or trying to bypass complaints from their workers regarding work pressure. Potentially, a significant share of

vacancies are not real in some countries, with firms having no intention to hire more workers, which would relate to stories about fake vacancies and ghost jobs (Wall Street, 2023[32]). This might happen in the LTC sector because, given LTC providers' willingness to maintain profits at the price paid by governments, firms might have little appetite to raise the quality or quantity of services – and therefore increase employment. In cases where this would be correct, labour shortages that are self-declared by firms may not actually refer to a situation where labour demand exceeds supply. Such a behaviour might relate to a strategy to justify bad working conditions and insufficient quality of LTC services or be a tool in bargaining with government over more public subsidies. No evidence of such practices was found for this report to back the idea that this feature commonly happens in the LTC sector.

1.4. Policy implications

The public sector plays a large role in long-term care (LTC) and governments have different cards in their hands to tackle poor working conditions and insufficient social recognition of LTC work. Governments can directly intervene to improve working conditions at public LTC providers, for instance by increase wages, which may generate spill-over effects to the private sector. Tackling these issues among private providers can be done through promoting wage increases, raising staff requirements or increasing public funding while letting the market work, although which of these policies is most effective in a specific country depends on the way its LTC sector functions. Hence, governments have an extensive policy toolbox at their disposal to make the LTC sector more attractive and robust in the face of population ageing.

These issues should be addressed by a comprehensive policy strategy covering several dimensions; priorities within this strategy depend on the specific country context: increasing public financing and fostering the leading role by governments; directly intervening to raise wages and improve staff regulations; supporting collective bargaining and social dialogue; strengthening training; promoting social recognition through information and recruitment campaigns and certifications (licensing); greater use of new technologies; and, strengthening preventive health policies.

Some general policies in other areas would greatly benefit LTC workers, but they are not covered in detail here, however. This applies first to measures that limit undeclared work. Undeclared LTC work is common in several countries; promoting transitions to formality is a fundamental prerequisite to improve working conditions in the LTC sector and ensure a higher compliance to the standards set in collective agreements.[7] In LTC, this applies, in particular, to live-in carers, especially foreign-born workers. Eurofound (2020[8]) highlights several measures in place in some EU countries to encourage declared work in LTC: vouchers that can only be used to purchase declared work, providing social security entitlements to the carer (Belgium); a clear and user-friendly process for declaring LTC work (Austria); and, a reduction in the cost of compliance with the legislation for home care (Lithuania). Second, fighting discrimination against women and foreign-born workers is especially relevant to better protect LTC workers. Third, gender stereotypes extend well beyond the specific context of LTC, and measures taken to eliminate them in the overall society would be beneficial for the LTC sector. For example, reducing the segregation of boys and girls into different education trajectories could have a long-term beneficial impact on the supply of male LTC workers. Finally, many LTC workers would benefit from increases in the national minimum wage in countries having such an instrument.

1.4.1. More public financing and leading role by governments to improve working conditions

Improving working conditions today and limiting future labour shortages require a substantial increase in public spending. This is because public resources play a large role to finance LTC services, although the importance of private financing varies internationally (see Figure 1.11 above). In many countries in Southern, Central and Eastern Europe and in Latin America in particular, the LTC system is underdeveloped and tackling unmet needs will be achieved only with substantial inflows of public money

in the LTC sector. Likewise, to deal with the pressure from population ageing, most OECD countries should be prepared to spend much more as a share of GDP to avoid socially unsustainable shortages of LTC workers in the coming decades. In a quickly expanding sector such as LTC, new workers must be attracted and trained which requires time, money and effort.

This concurs with the assessment by the European Commission that funding is one of the most important factors to ensure an adequate level of physical and human resources. Measures taken before COVID-19 for recruiting additional LTC staff in both home care and residential care have mostly involved higher financial resources dedicated to staffing, as in Germany in 2019 and in Sweden during 2015-18 (European Commission and Social Protection Committee, 2021[33]). In the United Kingdom, the Migration Advisory Committee emphasises that properly funding LTC is ultimately the key to address increasing demand for care, high vacancy rates, low pay rates with little pay progressions and poor working conditions more generally (MAC, 2022[24]).

Beyond providing access to adequate funding, governments can play a leading role in setting high enough job-quality standards, which is likely to spill over to private-sector workers. First, wages in public LTC providers can be directly raised to improve attractiveness. Second, staffing ratios in public institutions can be increased to reduce workload. Third, governments may require that LTC institutions benefitting from public funding be covered by collective bargaining or adhere to higher job-quality standards including minimum wages. Collective bargaining and social dialogue contribute to the determination of both wages and non-wage working conditions and help ensure better protection to workers with a weak bargaining position. They can operate alongside statutory rules for wages and working conditions, but they also provide voice to workers, while giving employers and employees a tool for addressing common challenges.

Fourth, governments can lead by example in collective bargaining. Governments, at national and local level, can promote collective bargaining and social dialogue in the LTC sector by taking the lead in the areas under their direct control. Even where collective bargaining in the private sector is rare and mostly taking place at the company level, what is negotiated in the public sector can influence bargaining in the business sector. Ensuring a regular renegotiation of collective agreements covering LTC workers in the public sector will typically set the example for the private sector and may provide a reference in terms of wages and working conditions. More generally, providing a forum at local, national, or supranational level to discuss the issues specific to the LTC sector, even if limited to the public organisations, would allow to have regular exchanges, monitor the situation and, possibly, find shared solutions that may then be applied more generally. The European Care Strategy includes possible measures to improve social dialogue in LTC by, for example, proposing to increase support for capacity building for social dialogue in the care sector (European Commission, 2022[34]).

1.4.2. Direct interventions: increasing wages and strengthening staff requirements

Raising wages of LTC workers and tightening staff requirements are the most direct measures to improve working conditions, reduce turnover and attract workers. The Czech Republic, for instance, substantially increased the salaries of personal care workers in the public LTC sector by about 50% over 2017-18 (European Commission and Social Protection Committee, 2021[33]). In the French context, a study found that increasing wages can significantly raise retention rates of nursing auxiliaries in private nursing homes (Martin and Ramos-Gorand, 2017[35]).

Increasing wages or staff requirements generate positive effects especially when the bargaining power of workers is low and profits are high. That is, if providers exploit monopsony power which limits both wages and employment. However, if this is not the case, wage increases and stricter employment requirements decided without securing adequate financing from public or private sources may lead to unintended consequences as the case of New Zealand discussed above illustrates.

A large share of LTC workers is likely to be affected by minimum-wage settings. For example, the recent increase in the national minimum wage in the United Kingdom led to wage increases for a substantial part of LTC workers (Chapter 2). In the OECD on average, one-quarter of personal care workers in the LTC sector earn less than 53% of the average wage (Figure 1.6 above). This compares to minimum wages averaging around 45% of the average wage in the OECD countries that have minimum wages. Hence, proper enforcement of national minimum-wage regulations is important as they affect a substantial part of LTC workers.

In some countries, sectoral minimum wages provide a higher wage floor for LTC workers, which can be a tool to promote pay increases and attractiveness. This is the case in particular in countries where collective bargaining is weak. Several countries including Australia, Germany and Latvia have recently boosted the minimum wage for LTC workers (Chapter 4). However, sectoral minimum wages have some potential drawbacks including weakening social dialogue, as social dialogue's strength is built on the capacity to negotiate wage scales, and reducing employment.

Staffing requirements can take the form of setting either mandatory minimum ratios or ratios that are considered appropriate thereby nudging staffing decisions of providers. Staffing ratios can improve working conditions by limiting the workload and improving the quality of care delivered. The United States use the five-star quality rating system to classify nursing homes based on various indicators including staffing ratios. This system helps care recipients and their families compare LTC providers more easily. Few other OECD countries have staffing-ratio requirements including Finland, France, Hungary, Lithuania, Luxembourg, Portugal and Spain. Finland has raised the minimum staffing ratio substantially from 0.5 workers per client in 2020 to 0.7 in 2023.

Compliance and transparency are crucial to enhance the effectiveness of staff-requirement regulations. First, compliance with the regulations should be enforced through adequate control. In Portugal, COVID-19 triggered a strengthening of staffing levels in the care sectors after trade unions had highlighted that some care institutions were not complying with legal requirements (Pelling, 2021[36]). Second, the communication of the effective staff ratios by care providers should be transparent. Transparency is important because it can discipline care providers through pressure from consumer choice. In Australia for example, while providers are asked to report against care quality standards to the regulator, very little of this information seems to be available to older people looking for care options (Duckett, Stobart and Swerissen, 2020[37]). Poor available information may lead unscrupulous providers to skimp on quality. To help deal with this issue, the five-star rating system was introduced in December 2022. This five-star rating system aims to assess the quality of care at all government-funded LTC homes; the staffing component is based on the amount of time care workers spend per care recipient and contributes roughly one-fifth to the overall rating.[8]

1.4.3. Supporting collective bargaining and social dialogue

The working conditions of LTC workers are generally worse than for the rest of the workforce in many dimensions even though the bargaining coverage of those employed with a formal employment relationship tends to mirror the respective national average (Figure 1.10 above). Ensuring collective bargaining coverage to workers on paper is indeed not sufficient to guarantee good working conditions. In many countries, workers in the LTC sector are not adequately represented by unions, and compliance with negotiated agreements is not guaranteed. Often, workers' representatives in the LTC sector are not strong enough to negotiate tangible improvements in wages and working conditions. Furthermore, some groups of LTC workers may be excluded from collective agreements because they work undeclared or as self-employed.

Governments should support efforts to expand union membership to LTC workers and promote collective agreements. While the latter Is a prerogative of social partners, governments can provide the right enabling conditions. This could include supporting affiliation to unions through tax breaks for union membership

fees, as in Finland, Norway and Sweden, given that limited membership may be a major drag on the potential role of collective bargaining for promoting good working conditions. The organisation of non-standard LTC workers, in particular (false) self-employed and those in the grey area between employment and self-employment, is an additional challenge. Over the past decade, unions have responded to the diversity of employment relationships by adapting their structures, opening up to self-employed workers and engaging in specific campaigns and legal battles, in particular to ensure the reclassification of false self-employed workers into employees.

In the absence of broad-based social partners, in countries where collective bargaining takes place at the sectoral level, administrative extensions can also be used to extend collective bargaining coverage to all workers and firms in a sector. This approach is used in Belgium, France and Italy to ensure full coverage of LTC workers. Germany has introduced an obligation for LTC providers to pay their workers at least the collective-bargaining level. Since September 2022, the German statutory care insurance is only allowed to conclude supply contracts with LTC providers if they comply with this regulation. Providers who do not pay wages according to this requirement are no longer allowed to perform care services that are funded by the German statutory care insurance (Chapter 3). In countries with limited sectoral bargaining, as in Australia, wage and staff requirements (see above) represent an alternative approach to ensure basic terms of employment among all firms in the LTC sector. The main challenge of this approach is the difficulty to establish appropriate sectoral standards, as this presupposes detailed knowledge of the sector, which may often require a strong involvement of the social partners.

Efforts to increase compliance and enforcement measures are often warranted. Labour inspections should be enhanced and additional measures can be taken to improve compliance. First, it is important to ensure that legally binding collective agreements are signed only by representative unions and employers' organisations. This is not the case in all OECD countries. Agreements signed with complacent, poorly representative or "yellow" trade unions – that is, trade unions dominated or influenced by an employer and thus not properly independent – undermine existing agreements and undercut workers' working conditions. Second, in order to have access to their rights, workers need to be aware of them. Collective agreements are difficult to access and to understand in most countries. Making the main elements of the content of collective agreements publicly and easily available is an essential precondition to ensure that workers and employers are well informed about their rights and duties. Given the incidence of workers with a migrant background in the LTC sector, this information should be available in relevant languages. Finally, once the content of the collective agreements is made available, an awareness campaign targeted at LTC workers, both offline and online, could be launched to discuss the importance of compliance and present the tools available to employers and workers.

1.4.4. Improving training to reduce arduous work and enhance the quality of care

Current education and training programmes for LTC workers fall short of providing the necessary knowledge and skills to provide good-quality care and reduce health risks in many OECD countries, especially for personal care workers and LTC workers providing home care. Training for personal care workers should consist of an initial training providing the necessary knowledge and skills to care for older people with common physical and mental limitations. Australia, for instance, created thousands of fee-free places for vocational training in LTC in 2023 in order to boost the skills of personal care workers across the country. This should be supplemented with some continuous training courses fitted to the needs and health profiles of the people the worker is caring for, as is the case for instance in Ireland. For nurses, an increased focus on geriatric care in their curricula could mitigate the mental and emotional impact of working with people with dementia. Training programmes preparing LTC workers specifically for work in a home care setting are all the more important because home care workers often work alone, and older people's homes often are not well-equipped for providing care.

Training can improve the working conditions of LTC workers, in particular for personal care workers. Better training typically coincides with improved remuneration, but training is also vital to make LTC work less arduous. Learning, for instance, about proper techniques for lifting people and about ergonomic positions to provide care to a person who is lying in bed, can reduce physical strain on the carer's body. Training on how to care for people with dementia, who make up a substantial and growing group of LTC recipients can reduce both physical and mental health risks related to violence.

Finally, the use of digital and other new technologies should be a core component of training for LTC workers. As LTC providers cite a lack of digital skills in their workers as an important barrier to implementation of new technologies, better training in this area will promote the wider use of digital technologies in the sector. In addition, it will enable LTC workers to assist older people in learning how to use technologies that can allow them to continue living independently in their own homes. In its Skills Partnership for LTC launched in April 2023, the European Commission identified digital skills and soft skills as the two most urgent training needs in LTC and set a target of 60% of the LTC workforce participating in training in these areas each year by 2030.

1.4.5. Promoting the social recognition of long-term care workers

Measures discussed above to improve working conditions including wages are important steps to raise the social recognition of LTC workers. However, more needs to be done to improve status, and in addition to better training and higher wages, information and recruitment campaigns challenging gendered care norms and developing certifications are key to strengthen the social recognition of LTC workers.

Public information and recruitment campaigns can be used to correct the perception many people have of LTC work as women's work of low economic value and can provide a better idea of the skills the work requires. Public information campaigns showing men as LTC workers and giving a balanced view of LTC work including communicative and emotional aspects as well as the physical and technical sides of care work could help in that respect. Furthermore, recruitment campaigns targeted specifically at men may offer an effective tool to draw more men into the sector. Austria, Germany, Japan and Luxembourg have been or are running public information campaigns with the double goal of improving the public image of LTC work and enticing in particular young people to choose for a career in the sector, although none of these campaigns so far have been specifically targeted at men.

Licensing or national registration of personal care workers can also contribute to a better recognition of the work and the required skills. In most countries, qualification requirements can be minimal and almost anyone can become a personal care worker (OECD, 2020[2]). A common practice for nurses, licensing is generally associated with better training and higher wages. This would signal that personal care work is an occupation requiring the development of certain skills, hence raising social recognition and addressing the gender stereotype that women would somehow "naturally" possess the skills LTC provision requires. In Sweden, for instance, the professional title of assistant nurse will be certified as of July 2023. A person will receive the certificate of assistant nurse by completing the corresponding education programme or through gaining the required competences in some other way. Similarly, France introduced a specific job classification of home-care assistant, which is granted based on completing the corresponding education programme, although a majority of care workers still have no diploma (Le Bihan and Martin, 2019[38]).

The introduction of licensing for personal care workers in LTC may generate trade-offs as it can improve recognition but may reduce employment. As with the discussion about higher wages above, licensing tends to increase LTC costs and may need to be accompanied by additional financial resources to avoid detrimental effects on the quantity of care provided. Hence, such a certification is not to be implemented with the idea that all personal care workers should be licensed in order to avoid creating a regulatory barrier to the overall labour supply of LTC workers. Certification can be a significant first step to develop career progressions as a way to raise attractiveness and to streamline training programmes. For example, under

its Aged Care Workforce Strategy, Australia aims to develop career pathways in LTC through redesigning job roles, vocational training and recognition of competences.

One alternative to licensing can be the introduction of a professional register for LTC workers (Hft and Care England, 2023[27]). Scotland, for instance, has a register for both formal LTC workers and informal carers. By registering, these workers subscribe to the care quality standards of the Scottish Social Services Council, and registration can be revoked when these standards are not respected. In addition, registration gives access to free online courses covering a variety of LTC-related topics and levels of complexity, for which LTC workers earn badges when they complete them. The system provides a pathway for the development of qualifications that is designed to improve the formal recognition of LTC workers' skills and knowledge.

In any case, the occupation of personal care worker should also be clearly distinguished from that of domestic workers such as housekeepers. Personal care workers primarily provide personal, not household services, meaning that the content of their work and thus also the skills required depend on the needs of the persons they care for. This could be recognised for instance through personal care work including in home care being covered by collective bargaining for the LTC sector.

1.4.6. Improving efficiency and reducing arduous work through introducing new technologies

By raising labour productivity, expanding the use of new technology can improve efficiency and reduce the demand for LTC workers. Digital technologies, in particular, can limit the time LTC workers spend on other activities than direct care provision. Comprehensive software packages can facilitate the planning of LTC provision and the sharing of information between different actors involved in care provision, reducing the time needed for administration and co-ordination. Moreover, sensors allow for remote monitoring of multiple care recipients simultaneously, which reduces the time required for monitoring itself and for transit between care recipients.

New technologies can reduce both the physical and the mental strain of LTC work, which can reduce both absence from work due to health problems and the number of people quitting the sector. The mental well-being of LTC workers may be improved by software reducing administrative burdens. Other technologies, such as lifts and care robots, can reduce the physical burden on LTC workers by taking over the most physically demanding tasks.

Four important barriers currently limit the use of new technologies in LTC. First, financial constraints limit the budget available to invest in new technologies. This is a particularly relevant barrier for the introduction of more expensive technologies such as robots. Second, concerns over privacy and data security may make care providers and care recipients wary of using technologies recording sensitive data. A data governance framework for the secure use of these technologies and the data they provide is essential to reduce the risk of infringements on care recipients' privacy. Third, LTC providers are worried that their care workers lack the skills to work with new technologies. Hence, proper training can remove an important barrier to the implementation of cheaper technologies such tablets with digital applications for administration, co-ordination of care work and monitoring of care recipients. Finally, LTC providers themselves may be insufficiently aware of the technologies that are available. Information campaigns and industry events showcasing and counselling on new technologies could improve awareness of the availability of tools and the impact they may have in terms of improved efficiency and staff health among LTC providers.

1.4.7. Strengthening preventive health policies to reduce long-term care needs

The share of older people with care needs or care intensity can be reduced through preventive health programmes promoting healthy lifestyles and making older people aware of certain health risks such as

the risk of falling. Public information campaigns and rehabilitation efforts can reduce LTC needs of older people. Nordic countries have rehabilitation or re-ablement[9] embedded as part of the LTC needs assessment and this approach helps to delay LTC needs. Since 2011, Japan has been running an LTC Prevention Project focused on three main objectives: to strengthen social connections of older people in their community, irrespective of their age and mental and physical conditions, and support them in organising exercise classes and other local gatherings; to use professionals with rehabilitation knowledge in their community to help older people live independent lives; and, to develop a local community in which older people can live worthwhile lives and play a role, even if they are in serious need of LTC. Since 2020, the Japanese Government has increased subsidies for municipalities that are actively engaged in the project and has made efforts to expand the communities in which older people can participate for instance by drawing in more professionals.

LTC workers should play a key role in preventive health efforts by detecting possible health risks older people may be exposed to. This consists of picking up early signs of potential health problems and assisting older people in finding supplementary support if needed, for instance by providing information on housing adaptations and helping them apply. Countries can strengthen LTC workers' role in health promotion and disability limitation for older people by establishing national prevention policies that guide LTC workers on how to help older people stay healthy for longer, strengthen professional skills at the primary care level to keep older people out of institutions and improve geriatric knowledge among health and social workers working in the community. The Visiting Nurse Service of New York, for example, trained personal care workers as health coaches; this led to improvements in self-care maintenance and management of heart failure symptoms, and reduced the number of activities of daily living for which older people needed assistance (OECD, 2020[2]).

Self-management technologies can contribute to preventive health efforts and even boost the capacity of older people with health problems to continue living independently. Applications providing physical and cognitive training exercises can contribute to maintaining older people's physical and mental fitness and slowing decline. They can also mitigate exposure to health risks, such as a route planner providing routes for pedestrians with lower falling risk. Smart home technologies, medication management tools and sensors for remote monitoring allow older people to safely continue living in their own homes. They help older people control their own lives and reduce the need for LTC workers to pass by in person for monitoring. LTC workers can provide guidance to older people in selecting appropriate tools matching their needs and learning how to use them.

Improving older people's health literacy and digital skills would facilitate the use of preventive health and self-management technologies. With one-quarter of people aged 55-74 in the European Union using internet only rarely or not at all, in particular older people with lower educational attainment, and one-third of people in OECD countries having low levels of health literacy, significant efforts are needed to boost education and training of older people in these areas (Chapter 5). Workshops for instance have been shown to be an effective tool to improve health-related digital literacy in older people (Pourrazavi et al., 2020[39]). LTC workers have an important role in helping older people improve their health literacy and digital skills, as well as identifying older people who could benefit from specific training in these areas.[10]

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Annex 1.A. Definitions

This chapter uses OECD's definitions of long-term care (LTC), of the LTC workforce and of LTC settings (OECD, 2020[2]).

Long-term care

LTC is a highly labour-intensive sector, which consists of a range of medical, personal-care and assistance services that are provided with the primary goal of alleviating pain and reducing or managing the deterioration in health status for people with a degree of long-term dependency, assisting them with their personal care (through help for ADL, such as eating, washing and dressing) and assisting them to live independently (through help for IADL, such as cooking, shopping and managing finances).

Formal care: Nurses and personal care workers

The LTC workforce consists of individuals who provide care to LTC recipients in residential or non-residential LTC settings (see below), but not in hospitals. LTC workers comprise two professional categories: personal care workers, including nurse aids and care assistants, and nurses, including both nurse associates and nurse professionals. Other professional categories, e.g. doctors or social workers, are not included in the LTC workforce definition.

Nurses in LTC include people who have completed their studies/education in nursing and who are licensed to practise (including both professional nurses and associate/practical/vocational nurses); salaried and self-employed nurses delivering services in residential or non-residential LTC settings (other than hospitals); foreign nurses licensed to practise and actively practising in the country; and nurses providing LTC to care recipients affected by dementia and/or Alzheimer's disease. The following categories of nurses are excluded from the OECD definition (and therefore not covered by the analyses in this report): students who have not yet graduated; nursing aides/assistants and care workers who do not have any recognised qualification or certification as licensed nurses; nurses working in administration, research and other posts that exclude direct contact with care recipients; unemployed nurses and retired nurses; nurses working abroad; nurses providing social services; and psychiatric nurses.

Personal care workers in LTC include formal workers providing LTC services in residential or non-residential LTC settings (other than hospitals) and who are not qualified or certified as nurses. Personal care workers are defined as people providing routine personal care, such as bathing, dressing or grooming, to older people, convalescent or disabled people in their own homes or in institutions. They include nursing aides/assistants and care workers providing LTC services, who do not have any recognised qualification/certification in nursing; family members, neighbours or friends employed (i.e. under a formal contractual obligation and/or declared to social security systems as caregiver) by the care recipient or a person/agency representing the care recipient, and/or by public care services and private care service companies, to provide the care services to the person in need.

Informal care

Informal caregivers provide care to family members, neighbours or friends and are excluded from the category of LTC workers unless they are formally employed by the care recipient. This includes informal

caregivers receiving income support or other cash payments from the care recipient as part of cash programmes and/or consumer-choice programmes, but who are not formally employed, or paid for, by the care recipient (or the person or agency representing the care recipient, including providers or organisations such as public social care services and private care service companies).

Declared and undeclared work

Formal care can be provided by both declared and undeclared workers. Undeclared workers refer to employees who have an employment relationship that is, in law or in practice, not subject to national labour legislation, income taxation, social protection or entitlement to certain employment benefits (OECD, 2019[40]). Thus, informal work refers to undeclared work while informal care refers to care provided by family members, neighbours or friends (see above).

Long-term care settings

Long-term care can be either residential or non-residential. Residential LTC refers to LTC in nursing homes and other residential care facilities, which provide accommodation and LTC as a package. This refers to specially designed institutions or hospital-like settings where the predominant service component is LTC and the services are provided for people with moderate to severe functional restrictions. LTC institutions include nursing and residential care facilities dedicated to long-term nursing care. LTC facilities comprise establishments primarily engaged in providing residential LTC that combines nursing, supervisory or other types of care, as required by the residents. In these establishments, a significant part of the production process and the care provided is a mix of health and social services, with the health services largely at the level of nursing care, in combination with personal care services. The medical components of care are, however, much less intensive than those provided in hospitals. Residential LTC does not include institutions used on a temporary basis to support continued living at home – such as community care, day care centres and respite care. It also excludes LTC services provided in specially designed or adapted living arrangements for people who require help on a regular basis while guaranteeing a high degree of autonomy and self-control (defined as home, and included in the home-based setting). Finally, the definition excludes LTC services provided in hospitals.

Non-residential LTC is provided to people with functional restrictions who mainly reside in their own homes. In addition to home care, this includes the use of institutions on a temporary basis to support continued living at home, such as community care, day care centres and respite care. Non-residential LTC also includes specially designed or adapted living arrangements (for instance, sheltered housing) for people who require help on a regular basis while guaranteeing a high degree of autonomy and self-control, and supportive living arrangements.

Notes

[1] While many care-related sectors struggle with similar staffing concerns, this report focuses specifically on LTC for older people in the light of the increasing needs due to population ageing.

[2] That is, at least three ADL or IADL; and, one in four people with at least one limitation.

[3] When both workers' and sectoral characteristics are controlled for, i.e. for the same age, number of years of education, tenure, etc., personal care workers still earn about 15% less than nurse associates in the LTC sector, compared with 26% less based on raw data. This means that less than half of the observed hourly-wage difference between personal care workers and nurse associates is explained by individual (and firm) differences.

[4] The estimation does not seem to fully capture the intensive education and training of medical specialists: medical doctors earn 39% more than explained by individual characteristics and nurse professionals earn 22% more, in line with sales professionals, while university teachers earn 17% more.

[5] See for example Le Bihan (2018[41]) for France. In California, about 55% of nurse aides have at most a high school diploma and 82% have no college degree of any level (Matsudaira, 2014[18]).

[6] False self-employment refers to cases where individuals are classified as self-employed but, to all intents and purposes, work as employees (OECD, 2019[40]).

[7] As discussed in OECD (2008[42]), depending on the specificity of each country, formalisation can be promoted by improving incentives to employ workers formally through a combination of measures reducing the labour costs when they are excessive, increasing flexibility in countries with stringent employment protection legislation and improving the design of social protection schemes to increase the benefits of affiliation to workers. Better incentives should be complemented by enhanced tax, social security and labour enforcement efforts.

[8] https://www.myagedcare.gov.au/quality-aged-care.

[9] Re-ablement entails a short period of home-based rehabilitation supported by a multidisciplinary team targeting both medical and psycho-social needs, with the aim of strengthening or maintaining functional capacity and thus facilitating people to live their own lives (Gustafsson et al., 2020[43]). Reablement focuses both on (re-)training people to independently execute (instrumental) activities of daily living as well as participate in daily activities that are important to the person.

[10] Austria, for instance, is currently piloting community nursing projects to promote healthy and independent living of older people, in which strengthening self-help and health literacy are key components. Community nurses who completed a tailored training programme provide advice to older people as well as to other actors involved in LTC provision, among others through home visits.