1 Overview

This introductory chapter provides an overview of the entire report, drawing on the analyses carried out in the five subsequent chapters. It documents the difficult working conditions many workers in the sector face and the training gaps, given the relatively complex tasks they have to perform. It also highlights the likely shortfall in the long-term care (LTC) workforce, given the rising in demand and little attractiveness of the sector. The chapter also stresses how these structural shortcomings have been fully exposed during the COVID-19 pandemic. It also looks at policies implemented across OECD countries to improve recruitment, training and retention. The report discusses how improvements to working conditions and skills are important to attract and retain workers while improving the quality of care, particularly to address safety. Strengthening co-ordination and increasing effectiveness will also help OECD countries to face the rising demand for LTC while ensuring early recognition of infections and other safety risks.

1.1. How to tackle current and future demand for care workers

The COVID-19 crisis has put the spotlight on the workforce shortcomings of the long-term care[1] (LTC) sector. Estimates indicate that up to 50% of deaths related to COVID-19 are in long-term care (LTC) facilities. Older adults needing LTC often have a compromised immune system or chronic conditions and are at a significantly higher risk of severe complications from the disease. Yet, some of those safety failures could have been prevented with more investment in LTC workforce and infrastructure to ensure suitable levels of trained staff, with decent working conditions and prioritising care quality and safety. Lessons

would have to be learned on how LTC institutions have coped with the spread of the virus in order to better equip them to face similar emergencies, both from a personnel and an infrastructure points of view.

Looking forward, rapid population ageing is adding pressure on the long-term care (LTC) workforce to step up efforts to have sufficient workers to meet the growing demand. This chapter highlights the challenges to ensuring an adequate LTC workforce and the policies to address them – in particular, how poor job quality discourages workers from entering and staying in the sector. Beyond the sheer rising total numbers of workers needed, the elderly population is changing: more people have multiple chronic conditions and/or dementia. The skills profile of LTC workers does not yet reflect these new needs of the elderly population, and their training should be adapted accordingly.

Facing these challenges requires a comprehensive policy approach, focusing on three elements. First, improving working conditions and training is crucial. Second, better use of appropriate technology and improved care co-ordination could also help increase the effectiveness of services provided. Finally, greater use of prevention policies could contribute to delaying LTC needs by helping older people age well, while containing growth in LTC expenditure. Without policy changes in all these areas, recruitment efforts to find new workers are not likely to be fruitful, as LTC worker numbers will not be sufficient, and they will not be working at their full potential.

Key findings

There will be not enough long-term care (LTC) workers without further policy effort to recruit and retain them

- The long-term care workforce is not keeping pace with the growth in the number of older adults who require LTC services. In the past decade, population ageing has outpaced the growth of LTC workers in three-quarters of OECD countries.
- In the coming decades, countries will need additional skilled long-term care workers to respond effectively to growing needs. The number of LTC workers will need to increase by 60% by 2040 or 13.5 million workers across the OECD to keep the current ratio of carers to elderly people. Using technology and changing work arrangements to increase effectiveness of service delivery could halve the additional workers needed by 2040, helping to alleviate the pressures.
- In spite of future forecasted shortages, only half of OECD and EU countries implemented policies or reforms to enhance LTC workers' recruitment since 2011.

Workers in LTC are often not well equipped to do their care job well

- Personal care workers[2] constitute the bulk of the LTC workforce (70%), and have very low entry requirements into the job. Less than half of the OECD countries require that personal care workers hold a minimum education level or provide official certificates, and few guarantee that personal care workers received sufficient training.
- Despite low-skilled workers being the main care providers, LTC requires workers to spend significant time delivering more complex tasks than basic care, including helping with washing, eating and moving. In more than two-third of OECD countries, workers perform activities such as health condition monitoring, communication with families and professionals, and case management.
- LTC workers do not always have enough training on geriatric conditions, interpersonal skills, care after hospital discharges, and management of emergencies or bereavement. This can hamper the quality of care delivered.

Low-pay and stressful jobs limit recruitment and retention in LTC

- Almost two-thirds of OECD countries identify LTC workers' retention as a one of the highest policy challenge. The average tenure is two years lower in the LTC workforce than in the overall workforce. There are more workers looking for another job in the LTC sector than in the hospital workforce, reflecting either dissatisfaction with the work or lack of job prospects.
- Non-standard and often precarious contracts are sizeable in LTC. More than half of LTC workers work in shifts, which has a toll on work-life balance. Part-time employment is on average twice higher than the average rate in the economy. Temporary contracts represent almost 20% of employment in LTC (representing a share that is 25% higher than the average rate) and other new forms of employment raise concerns for job security. Undeclared work, while unknown in size, is also present in the LTC workforce.
- LTC is predominantly a low-paid sector. On average, LTC workers (nurses and personal carers) receive EUR 9 per hour (median wage), compared to EUR 14 for workers in the same occupation in the hospital sector.
- The LTC workforce has a high rate of health problems. The prevalence of health issues related to work is higher than in the hospital sector. More than half (64%) of LTC workers suffer from physical risk factors across OECD countries. In addition, on average just under half (46%) of LTC workers are exposed to mental health risks.

More efforts are needed to improve the effectiveness of care, delay autonomy loss and promote integrated care

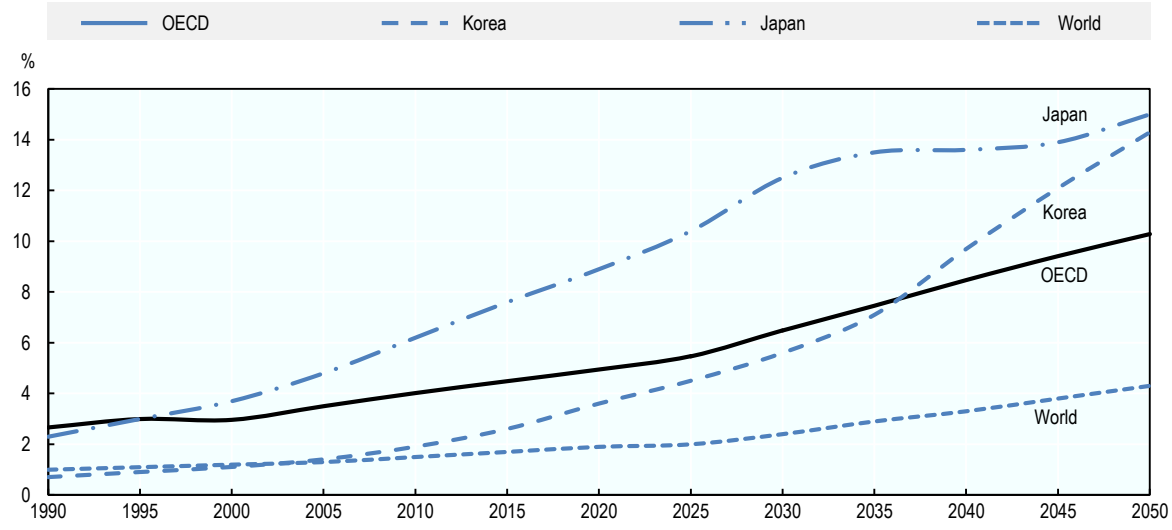
- Innovative technologies are slowly making their way into LTC in a few countries such as Japan and Scandinavian countries. While most technologies currently are simple ones, such as smartphones, alarm systems, sensors, and GPS monitors, more sophisticate devices such surveillance and companionship robots or comprehensive technologies such as self-sufficient smart homes are starting to appear.
- Nurses often perform work for which they are overqualified (e.g. dressing elders). Yet, only one third of countries allow task delegation from doctors to nurses, and from nurses to personal care workers.
- Healthy ageing can lead to a reduction in care needs, thereby resulting in better quality of life for the elderly person, and mitigate pressure on spending. For instance, approximately 28-35% of people aged 65 or over fall each year around the world generating unnecessary suffering, and a deteriorating health, all which could be prevented. Similarly, health-care associated infections are common in LTC institutions.
- Co-ordination of workers is the most important LTC policy concern among countries. Yet, only one third of OECD countries have in place policies to support better co-ordination of services provided by caregivers and promote more integrated care across health and social sectors, and even within different parts of the health sector.
- Many countries rely heavily on informal carers to provide help to the elderly and are expanding formal care provision. Others are considering enhancing informal care given financial pressures or difficulties to expand the formal workforce. At the same time, co-ordination between formal and informal carers ranks low as a priority for countries. Less than half of countries (45%) have implemented policies to strengthen the co-ordination of care provided by formal and informal long-term care workers.

1.2. More carers will be needed

1.2.1. Population ageing will increase demand for LTC services and workers

Over the coming decades, all countries will undergo significant demographic changes due to ageing. On average across OECD countries, by 2050, the proportion of those aged 80 and above will increase from nearly 5% to almost 10% of the population. Population ageing is particularly pronounced in Japan, where the share of the population aged 80 years and older was already nearly 8% in 2015 and is expected to double by 2050 (Figure 1.1). In Korea, the population remains relatively young, but is expected to age rapidly in the coming decades, so that by 2050 the share of the population over 80 will be nearly the same as in Japan. In European countries, such as Italy, Spain, Portugal and Germany, the proportion of the population aged over 80 is expected to more than double between 2015 and 2050.

Figure 1.1. Trends in the share of the population aged over 80 years, 1990-2050



Source: OECD (2019[1]), *Health at a Glance 2019: OECD Indicators*, https://dx.doi.org/10.1787/4dd50c09-en.

As the number of elderly people increases, population ageing also leads to a decline in the potential supply of labour in line with a reduction in the working age population. On average across OECD countries, there were slightly more than four people of working age (15-64 years) for every person aged 65 years and over in 2012. This rate is projected to halve, from 4.2 in 2012 to 2.1 on average across OECD countries over the next 40 years (OECD, 2017[2]).

1.2.2. The numbers of carers relative to elderly people has stagnated in recent years

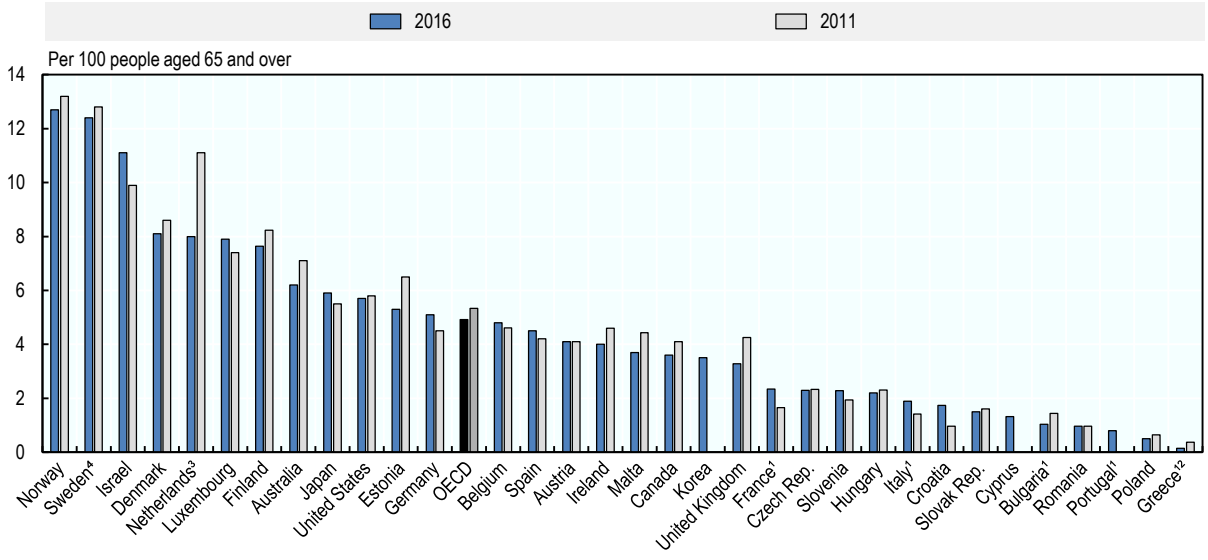
With coming demographic changes, many countries will need to strengthen the supply of formal LTC workers who provide care to recipients at home or in institutions, such as nurses and personal care workers (see Box 1.1 for the definition of LTC workers). While in a number of countries, the total number of LTC workers has increased, it has not kept pace with population ageing. As a result, the supply of LTC workers per 100 elderly people (aged 65 and over) has stagnated in most countries since 2011 (Figure 1.2).

In several countries, the numbers of carers relative to the population aged 65 and over is far lower than the OECD average, raising concerns about capacity. There are, on average, five LTC workers per 100 people aged 65 and over across 28 OECD countries. Numbers are much lower in France and several

southern European (Italy, Portugal, Greece) and central European countries (Slovak Republic, Poland), leading to waiting lists for access to care and insufficient capacity to meet needs (Figure 1.2).

Figure 1.2. In over three-quarters of OECD countries growth in LTC workers per 100 elderly people has stagnated or decreased

Number of LTC workers per 100 individuals aged 65 and over, in 2011 and 2016 (or nearest year)



Note: The OECD data point is the unweighted average of the 28 OECD countries shown in the chart. EU-Labour Force Survey data are based on specific 4-digit codes of the international standard classification of occupations (ISCO) and the 2-digit codes of the classification of economic activities (NACE).

1. Data are based on ISCO 3-digit and NACE 2-digit codes. 2. Data must be interpreted with caution, as sample sizes are small. 3. The decrease in the Netherlands is partly due to a methodological break in 2012 as well as reforms. 4. Data refer only to the public sector in Sweden.

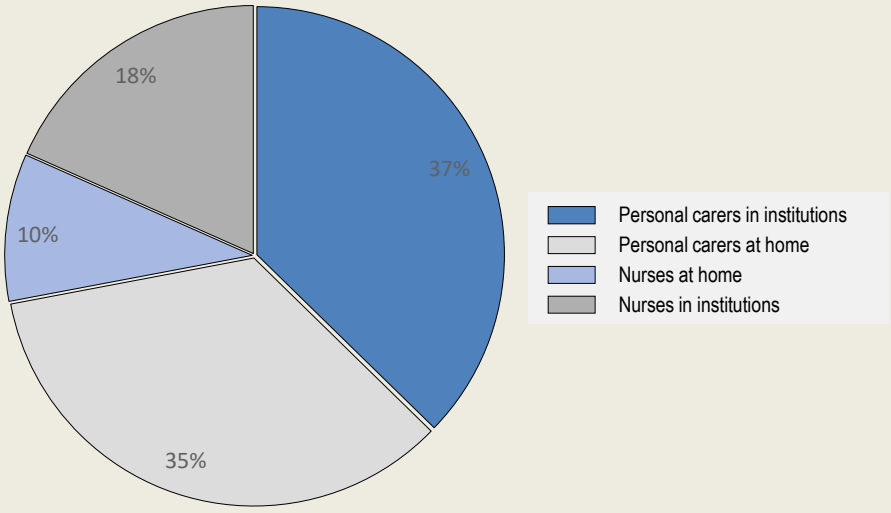
Source: EU-Labour Force Survey and OECD Health Statistics 2018, with the exception of the Quarterly Labour Force Survey for the United Kingdom and ASEC-CPS for the United States; Eurostat Database for population demographics (data refer to 2011 and 2016 or nearest year).

Box 1.1. Defining LTC workers

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 activities of daily living, such as eating, washing and dressing) and assisting them to live independently (through help for instrumental activities of daily living, such as cooking, shopping and managing finances).

LTC workers are individuals who provide care to LTC recipients at home or in LTC institutions (other than hospitals). Following the OECD definition, formal LTC workers comprise two main professional categories: nurses and personal care workers. Over 70% of LTC workers are personal carers across 19 OECD countries, with roughly half of them working in institutions and the other half working at homes (Figure 1.3). Overall, over half of nurses and personal care workers work in institutions. The other professional categories are not included in the LTC workforce definition. For instance, the OECD definition does not consider that doctors who work in institutions are LTC workers. LTC workers can come from the health or the social care branch.

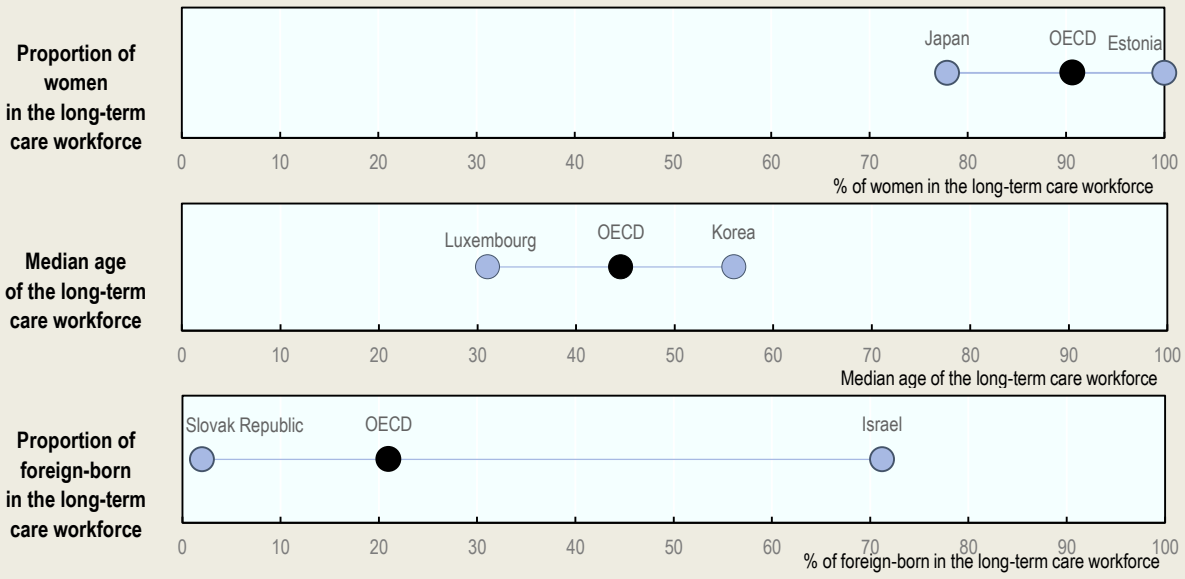
Figure 1.3. Over 70% of LTC workers are personal carers across OECD countries



Note: Data are the unweighted averages of the country-specific shares in 19 OECD countries.
Source: EU-Labour Force Survey and OECD Health Statistics 2018 (data refer to 2016 or nearest year).

The overwhelming majority of LTC workers are women in all OECD countries and most of them are middle-aged (Figure 1.4). While the share of foreign-born LTC carers is substantial on average, it varies widely across OECD countries.

Figure 1.4. LTC workers are mostly middle-aged women with a high share of foreign-born workers in some countries



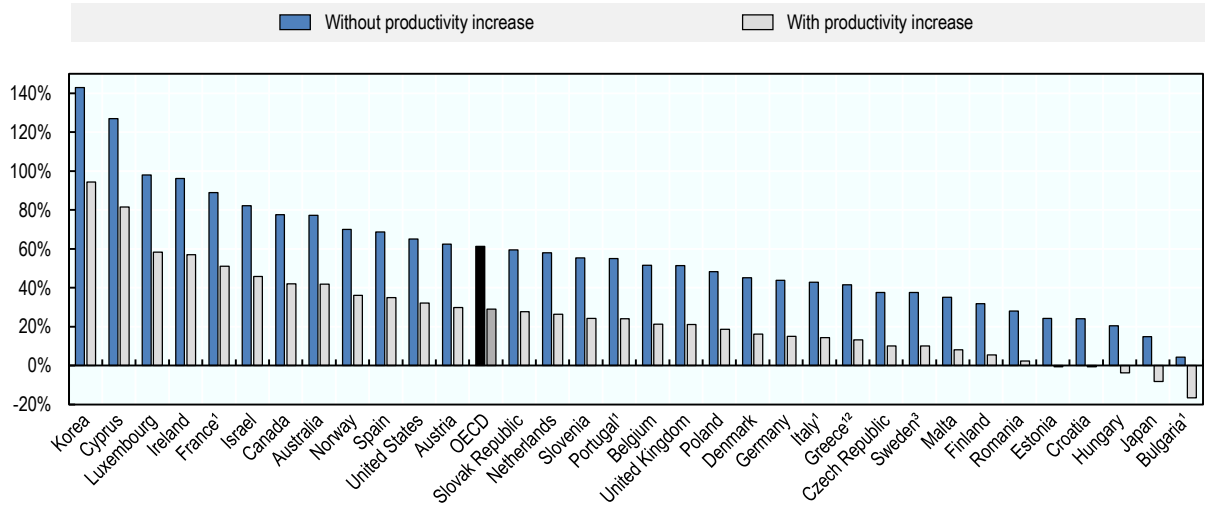
Note: OECD data points are the unweighted averages of 29, 30 and 19 OECD countries for the indicators on the share of women, the median age and the share of foreign-born workers respectively.
Source: EU-Labour Force Survey; the Annual Social and Economic Supplement of the Current Population Survey (ASEC-CPS) for the United States; National Health Insurance System for Korea; Census 2016 for Canada; Labour Force Survey for Israel, Survey on Long-term Care Workers for Japan; OECD estimate based on national source for Australia. Data refer to 2016 or the nearest year.

1.2.3. Shortages of LTC workers are expected in most countries

OECD countries need to increase their pool of LTC workers significantly by 2040 to care for their ageing populations (Figure 1.5). If countries wish to keep the current ratio of caregivers to the elderly population, they need to more than double the current number of LTC workers, on average. For some countries, the increase in relative terms would be small such as Bulgaria (4%); in others, such as Luxembourg and Korea, LTC worker numbers need to increase by 100% or more. A more optimistic estimate, factoring in productivity improvements, which would lead to each care workers being able to look after more elderly people without compromising care quality[3], suggests that the number of LTC workers will still need to increase by 30% to keep the same ratio of caregivers to the elderly population.

Figure 1.5. An additional 60% LTC workers are needed by 2040

Number of additional LTC workers needed by 2040 to keep the ratio constant as a share of the total number of workers in 2016



Note: OECD is the unweighted average of the 28 OECD countries shown in the chart.
1. Data are based on ISCO 3-digit and NACE 2-digit codes. 2. Data must be interpreted with caution, as sample sizes are small. 3. Data refer only to the public sector.
Source: EU-Labour Force Survey and OECD Health Statistics 2018, with the exception of the Quarterly Labour Force Survey for the United Kingdom and ASEC-CPS for the United States; Eurostat Database for population demographics (data refer to 2016 or nearest year).

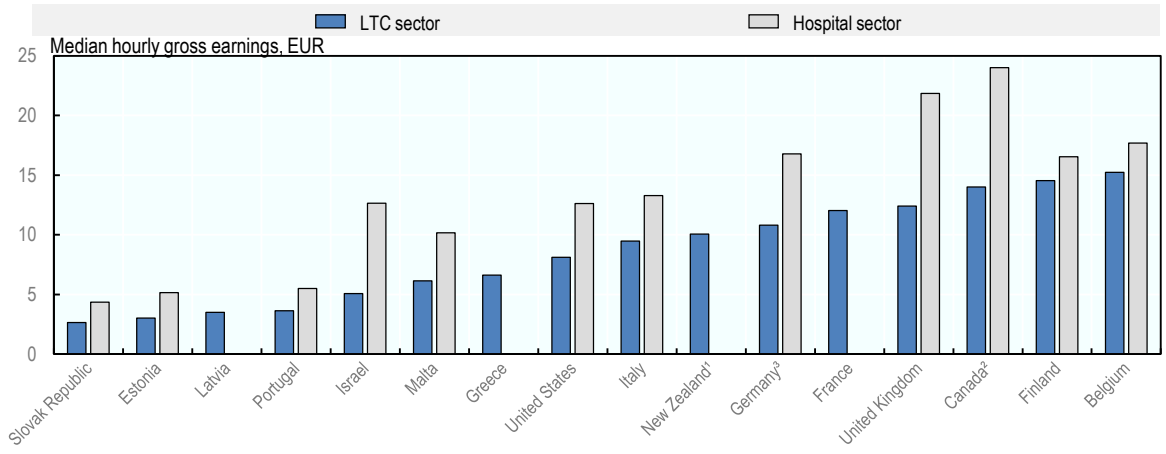
1.3. Poor job quality limits recruitment and retention in LTC

In many countries, the LTC sector is struggling to attract and retain sufficient numbers of workers. In the United States, for example, less than one in five workers stay in the LTC workforce over two consecutive years.

1.3.1. Low pay and poor promotion prospects discourage workers

LTC workers are among the lowest-paid and earn much less than those working with similar qualifications in other parts of the health care sector. The median hourly wage for LTC workers across 11 OECD countries was EUR 9 per hour, compared to EUR 14 for hospital workers in the same occupation (Figure 1.6). In a number of countries, such as Estonia and Portugal, LTC workers earn an hourly rate similar to the minimum wage. In the United Kingdom, the Low Pay Commission has flagged social care as a sector of concern in terms of compliance with the national minimum wage. Low pay also has implications for gender equality, as this is a heavily dominated female sector (see Figure 1.4 in Box 1.1).

Figure 1.6. Median hourly wages are lower in the LTC sector than in hospitals



Note: Wages are compared for workers with the same occupation for different industry codes (hospital and LTC).
1. Data refer only to personal carers. 2. Data cover those working full time, full year. 3. Data on the hospital sector cover those working full-time and assume an equal distribution of nurses and personal carers.
Source: Structure of Earnings Survey (2014), OECD questionnaire (2018) for Latvia, national source for Germany, ASEC-CPS (2015) for the United States, Census 2016 for Canada, OECD estimate based on national source for New Zealand (2016); data refer to 2014 or nearest year).

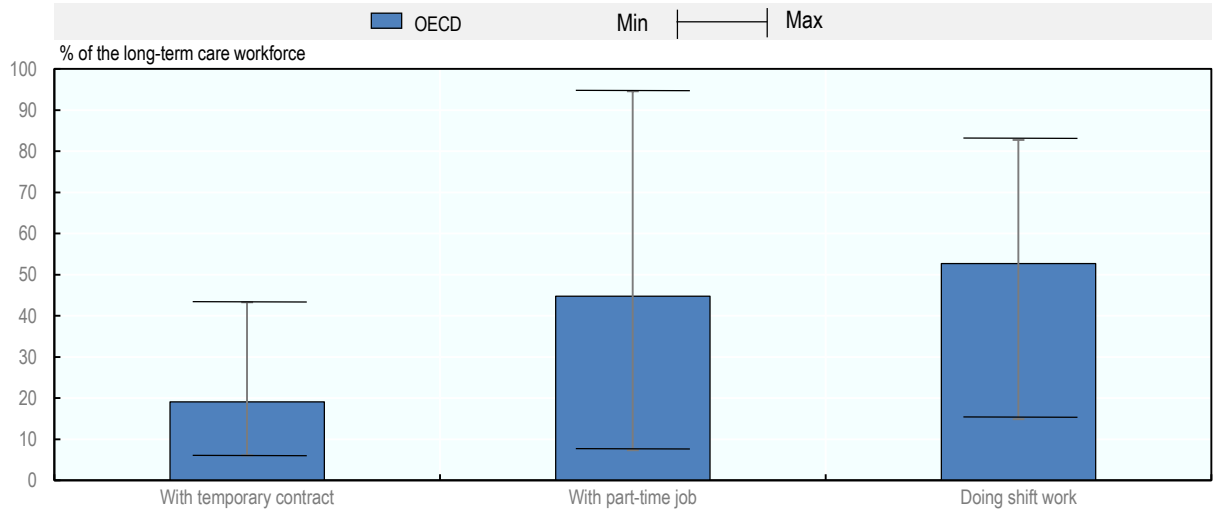
LTC workers are often devoted to their job but dissatisfied with pay and career prospects. Because jobs involving the same types of worker (i.e. nurses and personal carers) in LTC pay less, workers tend to leave the sector to work in hospitals as opportunities arise. Similarly, there are more promotion opportunities in the hospital sector than in LTC. OECD estimates for Europe show that tenure[4] is low in the LTC sector, two years lower than in the overall working population.

1.3.2. Non-standard work generates lower social protection, job insecurity and unpredictable hours

Non-standard employment (e.g. shift, part-time or temporary work) is common in the LTC sector (Figure 1.7). Close to 45% of LTC workers in OECD countries work part time. This is twice the average rate in the economy. Short working weeks are attractive to some, but unattractive to others because of difficulties in obtaining a decent income. As noted in Section 1.3.1, hourly wages are relatively low in the LTC sector, so annual income can be particularly low, especially for personal care workers. Part-time workers are more likely to be poor, often have fewer promotion opportunities and, in some countries, have less access to employment benefits and social protection (OECD, 2018[3]).

Figure 1.7. A substantial share of LTC workers have non-standard contracts

Share of LTC workers with non-standard contracts, in 2016



Note: The OECD data points are the unweighted averages of the 22, 25 and 20 OECD countries for which data are available for respective indicators on temporary contract, part-time job and shift work[5]; the lines represent the countries with the minimum and maximum shares. The bars represent the country-specific lowest and highest values. EU-Labour Force Survey data are based on ISCO 4-digit and NACE 2-digit codes. Source: EU-Labour Force Survey; ASEC-CPS for the United States; Census 2016 for Canada; Labour Force Survey for Israel; Survey on Long-term Care Workers for Japan; National Health Insurance System for Korea; OECD estimate based on national source for Australia. Data refer to 2016 (or nearest year).

Temporary employment is also frequent and new forms of employment, such as casual work[6] and zero-hours contracts,[7] are common in some countries, contributing to job insecurity in the sector. Almost 20% of LTC workers have a temporary contract, a much higher share than in the hospital sector (11%). Workers under this type of contract typically have less access to training, do not always have benefits such as paid annual leave, suffer from low job security and have less access to social protection. In France, for example, one-third of institution-based LTC workers were temporary agency workers. In England, United Kingdom, the share of zero-hours contracts in the sector is high compared to the average in the economy. Lack of continuity in staffing also affects quality of care.

On average, half of LTC workers engage in shift work[8] across 25 OECD countries. A large body of evidence suggests that shift work is associated with a wide range of health risks, such as anxiety, burnout and depressive syndromes. While dependent elderly patients require care 24 hours a day, irregular shifts and the lack of choice about the work schedule can be problematic for care workers and recipients. Workers cannot provide high-quality care unless they have reasonable working conditions.

1.3.3. Jobs in LTC are among the most physically and mentally demanding

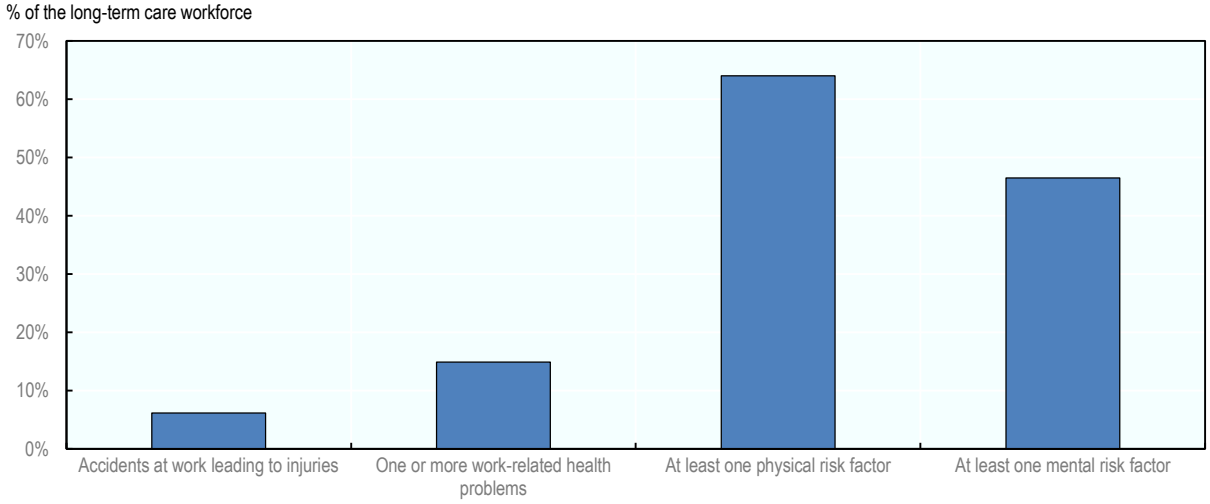
Care work is demanding, and the LTC sector suffers from high levels of absenteeism owing to sickness. More than 60% of LTC workers report being exposed to physical risk factors at work, across OECD countries (Figure 1.8). Among physical health problems, those related to musculoskeletal conditions, such as back pain when lifting patients and bending over a bed while providing care, are widespread.

In addition, on average under half (46%) of LTC workers are exposed to mental well-being risk factors, which generate high psychological stress. They may be subject to stressful behaviour from care recipients, in particular from people with dementia who might exhibit aggressive behaviour. Some LTC workers report

suffering from violence and harassment, or threats thereof. Many have also experienced severe time pressures and constraints, an overload of work and reduced opportunities to use their professional skills and knowledge. Care workers often have high caseloads and limited time with patients, which generates a feeling of frustration and overload.

At the same time, workers report that they do not always have the autonomy to meet patient needs, and have high administrative and reporting requirements. In a number of countries, care work has become increasingly standardised, generating a heavier administrative burden and a feeling of lack of control. In addition, care workers often work alone with the care recipient, especially in home care settings, and have to make difficult professional decisions on their own. Having a supportive manager can bring relief to the strain.

Figure 1.8. Numerous physical and mental risk factors at work can lead to health problems and accidents for LTC workers

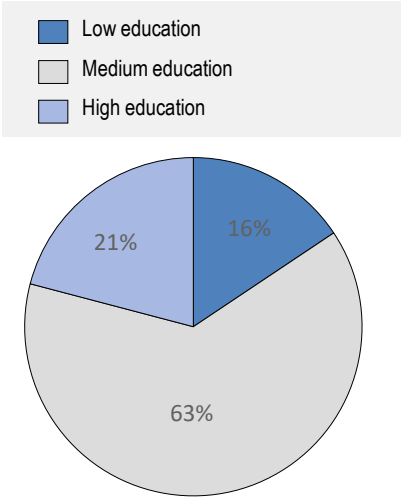


Note: Data refer to the unweighted averages of 21, 23, 19, 18 OECD countries for accidents at work, work-related health problems, exposure to physical risk factors and exposure to mental risk factors. Mental well-being risk factors cover severe time pressure or overload of work, violence or threat of violence, harassment or bullying. Physical risk factors cover difficult work postures or work movements, handling of heavy loads, noise or strong vibration, chemicals, dust, fumes, smoke or gases, strong visual concentration and risk of accidents.
Source: Ad hoc module EU-Labour Force Survey (data refer to 2013); Survey on Long-term Care Workers for Japan.

1.3.4. Training is insufficient for the tasks performed

Personal care workers – people providing routine personal care who are not qualified or certified as nurses – represent 70% of the LTC workforce across OECD countries. The vast majority hold medium levels of educational qualifications: the equivalent of high school or upper secondary schooling. Most workers have obtained a high school diploma or attended vocational schools, while 16% have low education or the equivalent of less than upper secondary schooling (Figure 1.9). LTC workers generally have lower qualifications than health workers.

Figure 1.9. About two-thirds of LTC workers have a medium level of education



Note: Low education corresponds to a lower secondary education (international standard classification of education (ISCED) 0-2), medium education to an upper secondary education or a post-secondary non-tertiary education – vocational schools (ISCED 3-4), and high education to tertiary level of education – university (ISCED 5-8). Data refer to 2016 or nearest year.
Source: EU-Labour Force Survey; ASEC-CPS for the United States; Census 2016 for Canada; Labour Force Survey for Israel; Survey on Long-term Care Workers for Japan. Data are the unweighted averages of the shares of LTC workers by education level across 21 OECD countries.

In more than two-thirds of OECD countries, personal care workers' tasks go well beyond helping with activities such as washing, lifting out of bed and feeding – so-called activities of daily living (ADL). Helping older people perform their ADL still represents the core of what personal care workers do: their six most common tasks are centred on ADL and instrumental activities of daily living (IADL)[9] provision. In addition, personal care workers are also involved in health condition monitoring, participating in the implementation of care plans and maintaining records of health status and response to treatment (Figure 1.10). The identification of distress situations is a central aspect of their monitoring role, as they are often the first professionals to encounter patients in distress.

In more than three-quarters of OECD countries, nurses working in the LTC sector can be involved in case management tasks, which often involve the management of complex interactions between the older person, families and care professionals. Supervising and co-ordinating care with other health care professionals is the most frequent co-ordination task provided by nurses (in 19 out of 26 countries).

Both personal care workers and nurses are also heavily involved in communication tasks, especially providing psychological support, as they are usually one of the principal people interacting with the person being cared for. Providing psychological support through conversation is the third most common task reported for personal care workers. This task requires soft skills – for example, when talking about death with informal care providers.

The LTC sector suffers from skill mismatches. Most LTC workers do not have sufficient geriatric care knowledge, understanding of safety procedures or caring needs after hospital discharge, stress management skills or soft skills. They could also usefully be equipped with skills to manage chronic diseases and complex needs such as dementia. Communication and soft skills are usually not taught in general training, but LTC workers increasingly need to master these skills. At the same time, nurses are in some cases overqualified for some of the basic tasks they perform, frequently providing help with personal care in addition to health care.

Figure 1.10. LTC workers perform several care tasks well beyond basic care

The most common tasks provided by the LTC workforce (personal care workers and nurses) within each function

Note: Functions and tasks are ranked by their occurrence among OECD countries (i.e. functions and tasks presented at the top are the most recurrent tasks). This figure provides a summary of tasks, and aggregates nurses and personal care workers' tasks.
Source: OECD Long-term Care Questionnaire, 2018.

Educational and training requirements for personal care workers are low, which can be problematic if they need to maintain treatment or implement care plans. Less than half of the surveyed countries require that personal care workers hold a minimum education level. Among those that do, it varies from vocational training (Hungary, Luxembourg, the Netherlands and Latvia) to a high school degree (Belgium and Sweden) or a technical degree after high school (Canada/Ontario, Malta and Estonia after 2020). Less than half of the surveyed countries require personal care workers to pass or hold a licence or a certificate showing that they have sufficient competencies and skills.

On-the-job training is not sufficiently available in LTC. Only a few OECD countries provide official certificates to guarantee that personal care workers have received sufficient training (Australia, Canada, Korea and the United States). In addition, because of the prevalence of shift work, difficulties with replacing workers during training explain low take-up of training. Both workers and employers need more incentives to follow training.

1.4. Attracting and retaining LTC workers requires a comprehensive policy package

Over the past decade, OECD countries have implemented policies to prevent future shortages and improve the quality of LTC supply. Three main policy categories have been followed, aiming to widen recruitment efforts to attract new workers, improve retention by enhancing job quality and training, and increase the effectiveness of the services provided – through better use of technology and care co-ordination – while postponing elderly people's needs for LTC.

Challenges in the sector and successful examples from some countries provide insight into future priorities. Given the extent of poor job quality and the high costs generated by turnover, improved working conditions and training prospects are the first policy priority, while a safe work environment should remain the foundation of LTC systems. At the same time, in Scandinavian countries, the Netherlands and Japan,

enhancing productivity in the workforce through the use of technology and better allocation of tasks is perceived as important – possibly even more so than improving working conditions. Both types of intervention will yield better results in the long run than focusing solely on recruitment measures. For instance, the Dutch plan of action for the care sector estimates that future shortages in care sector in the Netherlands will be addressed as follows: 38% via improved working conditions, 16% via better use of technology and 26% via better task allocation (and reduced administration), but only 20% via recruitment (Dutch Ministry of healthcare, well-being and sports, 2018[4]).

1.4.1. Addressing future shortages requires widening recruitment efforts

While improving LTC worker recruitment ranks high in policy priories, only half of countries have implemented policies or reforms to enhance it in recent years. Where recruitment initiatives have occurred, priority has been placed on providing incentives to (re)enter the sector or on improving its image. A third type of policy – recruiting beyond the traditional pool, such as targeting recruitment of men into the LTC workforce – is less prevalent.

Providing financial support for LTC training is an effective policy option, as its impact on recruitment can be large. Japan has sponsored basic training programmes for both new students and experienced workers willing to return to work after a long break. These initiatives led to an increase in the number of LTC workers of around 20% between 2011 and 2015. In the United States, the Health Resources and Services Administration has funded the Geriatrics Workforce Enhancement Program, which is an inter-professional education and training programme. Other countries (e.g. Israel, Romania) have provided financial support and perseverance grants for LTC education to train unemployed people or to assist people to come back into the sector.

Several countries (including Belgium, Portugal and the United Kingdom) have tried to increase the share of students entering the LTC sector – for example, using image campaigns to help make the sector more attractive among young workers and students. In the United Kingdom, the Proud to Care initiative seeks to improve the sector's image, while efforts have been made to improve information for those who provide social care career advice (teachers, staff in job centres and so on) with initiatives such as the Care Ambassadors, who visit schools and job centres to talk about their jobs.

A few countries are expanding recruitment pools, particularly to attract unemployed men. The Norwegian Men in Health Recruitment Programme was set up to recruit (unemployed) men aged 26-55 to the health and care sector. It entails eight weeks of guided training as health recruits in a regional health institution or health care service. The Programme has been very effective in the Norwegian context to motivate men for a job in LTC. In the United Kingdom, Skills for Care commissioned two Men into Care programmes to attract more men into the LTC workforce. Incentivising male recruitment can be a promising avenue, as men tend to stay longer in the sector and work more hours than women, and breaking down gender stereotypes about "male jobs" and "female jobs" serves a wider social and economic purpose.

1.4.2. Enhancing job quality and training are the foremost priorities to improve retention

Retaining LTC workers is not straightforward because of the multiplicity of factors. Low wages present a challenge for staff retention, especially because there are few opportunities for pay progression. However, wages are not the only factor driving low retention: workers also point to working times, stress, heavy workload, and poor support; and addressing these factors is similarly important. Better jobs will mean better quality of care and reductions in the high staff turnover and related costs.

Addressing the poor quality of LTC jobs will help retain more workers

Increasing entry wages and offering opportunities for career progression helps motivation to stay in the sector. There is evidence that wage increases in LTC have led to employment of more workers, longer job

tenure and lower turnover. When higher wages have led to an increase in skilled workers, they have contributed to more consumer value than they cost (Hackmann, 2017[5]). Several countries have tried to improve wages in the sector. For instance, the United States extended the right to the minimum wage to unlicensed home care workers in 2015 and Korea introduced allowances to increase personal care workers' wages. Wage increases need to be properly financed and regulated to prevent a decline in working hours, an increase in non-standard work or higher workloads.

Beyond wages, promoting a healthier work environment by focusing on prevention of workplace accidents and illness linked to the job, and on coaching, can reduce absenteeism and turnover. Stress management programmes (the Netherlands), mentoring programmes (the United States) and counselling services promotion (Japan) are interesting solutions to improve employment conditions. Environmental interventions (Norway, the Netherlands) to assist with sit-to-stand transfers and behavioural management are also useful.

Protecting workers from infections, injuries and severe psychological distress is key to retain workers but also ensure appropriate care delivery to patients. Safety standards related to appropriate and sufficient skill-mix workforce could be developed and enforced to ensure that minimum standards are met. There are numerous innovative models of safety standards, from legislation on staffing ratios to advanced accreditations that may be effective for improving the quality and safety of care provided. Moreover, policies that encourage the accountability of care of patients across the LTC and acute care settings can enhance the safety and quality of LTC care. Several countries, including Denmark, Finland, Norway, Portugal, and Sweden have created national indicators with the objective of increasing quality and safety of LTC residents (de Bienassis, Llena Nozal and Klazinga, forthcoming[6]).

Changing the organisation of work in LTC is a promising strategy to improve LTC worker satisfaction and reduce turnover. In Australia, management models in nursing homes that allow greater flexibility in scheduling and choice over shifts led to a reduction in turnover. Given the high rate of part-time work, especially for low hours of care per week, additional solutions to give workers the option to increase working hours would be suitable. These could involve combining work in LTC with work in other aspects of health care or offering work between various LTC settings, such as home care and day care. Self-managed teams, such as those in the Netherlands, Australia and Japan, provide examples of good practice whereby nurses have more autonomy to decide on not only the type but also the amount of care needed by each client.

Better enforcement in labour contracts through collective bargaining agreements and addressing undeclared work are also essential elements of good working conditions. In a number of countries, providers are not covered by collective agreements; in others, firm-level bargaining is the norm. Such firm-level bargaining, without co-ordination within and across sectors, tends to be associated with somewhat poorer labour market outcomes in terms of productivity and wages (OECD, 2018[3]). Better organised social partners in the sector or, where national legislation and practice permits, well tailored administrative extensions of collective agreements would be likely to have an impact on improving wages and working conditions. Addressing undeclared work is important both for carers and for the quality of the care provided. The provision of service vouchers or tax credits to buy LTC services in France, Finland and Sweden is a measure that has been successfully used to reduce undeclared work.

Reducing the skills mismatch should improve care quality and job satisfaction

Better training for both young and experienced workers would help to achieve a better mix of positions and competencies in LTC settings. While in the future most LTC needs are likely to continue to be addressed by personal care workers providing many low-skilled tasks, LTC workers equipped with more advanced geriatric care and co-ordination care competencies as well as soft communication skills will also be needed. Skills mismatches reduce the ability of LTC workers to provide high-quality and people-centred care.

A few countries have redesigned initial training to address shortcomings in geriatric knowledge and place greater emphasis on communication and interpersonal skills. This includes, for instance, the introduction of scholarships for nurses specialising in geriatric care (Germany, Japan and Israel), the implementation of dual-track programmes in general care and geriatric care for nurses (the Netherlands and Germany), the development of excellence programmes in LTC for nurses and care workers (Canada, Bulgaria) and the promotion of internship opportunities for nurses in LTC (Canada). France and Israel are considering better initial training for personal care workers.

A number of countries have implemented measures to provide better on-the-job training by using telecommunication technologies to increase the flexibility of training delivery (the United States) or improving the modularity of training (Korea). Modular training for personal carers is also under development in other countries, as it provides career perspectives for those seeking to access managerial roles or for nurse aides wanting to become nurses (Denmark, Germany, Korea).

Task delegation can help to address some skills mismatches and increase efficiency, as long as workers are adequately trained. In Belgium, the Wallonia region allows personal care workers to perform nursing tasks when the elderly person needs them and no other care options are available. New technologies will provide increasing opportunities for task delegation. For instance, digital aids assist personal care workers performing tasks such as taking a care recipient's temperature or blood pressure (Israel). Finland and the Netherlands have redesigned competencies for professionals in the LTC sector to ensure better division of tasks.

1.4.3. Increasing effectiveness and promoting healthy ageing will be necessary

Making better use of technology should reduce the work burden and improve quality

LTC is a labour-intensive sector, but greater use of technology could help increase productivity. Because of the relational nature of LTC work, technology in the care sector is more likely to supplement and complement workers rather than replace them. New technologies hold enormous potential to support LTC workers, particularly when it comes to improving communication and monitoring of elderly patients, helping to record and process patient data and improving professionals' working conditions.

The greatest potential of technological use in LTC lies in better networking and communication, easier information gathering and processing. Recording of data on elderly people is a laborious task that is still done by hand in many countries, and nurses and personal care workers spend up to one-third of their time on administrative reporting. For instance, the lack of a uniform electronic record that connects health and social care reduces continuity of care and can lead to poorer care quality, as well as inefficiencies. The Netherlands has implemented new legislation on electronic health records that will lead to LTC professionals being able to use direct electronic recording for medication and the care plan, reducing paperwork for care workers. Germany is also moving towards sharing patient records electronically. This would help to facilitate electronic billing and communicating with doctors and other health professionals.

Beyond communication, new technologies in the areas of assistive technology, remote care, monitoring and self-management hold enormous potential to increase productivity, improve working conditions and enhance care quality. In Norway and the Netherlands, the use of cameras and sensors at night in care homes for elderly people has led to reductions in emergency visits and reduced staff needs. Telecare or remote care assistance can also lead to a reduction in travel time and hospitalisations (Estonia, Israel). Home devices (like intelligent fridges) and medication dispensers can promote self-care and allow better management of elderly people's basic needs. Remote care can also help address shortages of LTC staff, particularly in geographical areas that are difficult to access or rural areas.

The use of technology in the sector has been growing recently, but it remains limited owing to financing barriers, low IT literacy among workers and lack of buy-in from LTC workers. Japan and Germany are supporting the introduction and development of technology in the sector with government grants. In

Germany, the Nursing Practice Centre is testing the application of technology and the transfer of technical support in nursing practice for issues such as pressure ulcers, incontinence and other needs. In Norway, a new nationwide strategy has been introduced to improve the digital skills of care workers during initial education. However, the proper handling of new technologies is often currently neglected in education, training and further education of caregivers.

Enhancing integration between health and LTC and with informal carers will create synergies

Elderly people, many of whom endure several chronic conditions, require attention from multiple providers across often fragmented and poorly co-ordinated health and social care systems. Poor co-ordination increases the risk of unnecessary hospitalisation, long hospital stays and readmission, increasing overall costs. This can be particularly harmful because older patients' health and functional well-being can deteriorate rapidly in hospital settings (OECD, 2018[7]).

Some countries are seeking to increase integration across hospitals and home care. Prompt discharge from hospital requires appropriate follow-up, and "step-down" alternatives can ensure continuity of care at lower cost. There is scope for expanding the role of nurses and personal care workers to perform more duties in monitoring health conditions among elderly people, health coaching and assisting transitions from hospital to home. In Portugal, for example, trained nurses can perform both care and cure, and receive a good level of training, including training in hospital-based management of medical conditions. In the Netherlands, Spain and the United States, nurses are given a key role to ensure timely discharge from hospital and ensure appropriate care at home.

With care becoming more complex as people suffering from combinations of multiple chronic conditions, mental health problems and social problems on top of LTC needs, workers in the sector are asked to do more co-ordination and case management, and such roles require training. Quebec (Canada), the United Kingdom and the United States are encouraging multidisciplinary teams working in communities to enable elderly people to stay at home for longer.

Given the potential shortage of LTC workers, facilitating the work of informal carers and collaboration between formal and unpaid carers, as well as integration of informal networks and associations into the team, is essential. Some OECD countries include carers as part of the care team. In Australia, for instance, family carers have access to shared care planning tools. Professional carers are also increasingly asked to collaborate with family carers, providing skills training and directing family carers to the services available for them.

Several OECD countries have improved the recognition of family carers and their dual role as workers and carers, but better support is still needed to reduce the risks of physical and mental harm. More than three-quarters of countries (30 countries) provide some leave from work to care for a family member – either paid or unpaid. This figure has risen from two-thirds of counties 10 years ago. Few countries, however, have made access to overnight respite care a right for family carers, although Germany offers legal entitlement to a minimum number of respite care and short-term care days per year. There is recent evidence that education, training and information interventions are effective policy interventions to improve the well-being of informal carers. Beyond training, carers who spend a substantial amount of time out of the labour force would also benefit from recognition and certification of skills acquired as carers.

Promoting healthy ageing and rehabilitation will help to postpone LTC needs

Several OECD countries are promoting "healthy ageing" campaigns, aiming to reduce the number of years of disability among the elderly and promoting living independently as long as possible. Japan has implemented an LTC prevention project, which aims to strengthen social connections of older people in their communities, irrespective of their age and condition (mental or physical). Australia has introduced the Commonwealth and Home Support Programme to help frail elderly people living in the community to

maximise their independence through delivery of timely, high-quality entry-level support services, taking into account each person's needs.

LTC workers will be increasingly required to detect health risks and manage health conditions for elderly people. For instance, LTC home care nurses in the Netherlands are also case managers as part of the SamenOud or Embrace model; they provide advice on health conditions, housing adaptation and both health and social care.

1.5. Conclusion

Ensuring that the LTC needs of elderly people are met will contribute to the much needed comprehensive response to population ageing, and will help to improve social outcomes. An effective policy package requires measures to increase the attractiveness of the sector as a source of employment and to improve the productivity of LTC workers through better use of technology, for instance, and care co-ordination.

Retention through better job quality and training is a top policy priority to develop an adequate LTC workforce. Improving the status of care workers, providing stable jobs with suitable hours and a reduction of mental and physical risks will be important to reduce the high costs of staff turnover. The changing characteristics of OECD countries' populations increase the urgency to enhance the LTC workforce's competencies, and governments need to address several challenges as priorities. In the future, LTC workers will increasingly have to master specific skills. Therefore, training efforts need to be pursued across OECD countries to provide sufficient skills in geriatric knowledge, care management, communication and use of technology. The LTC workforce will be able to focus increasingly on outcomes (e.g. disability prevention, re-enablement and healthy ageing) rather than on outputs (e.g. day-to-day tasks that cover the immediate needs of elderly people).

There is a need for providing adequate resources in the sector by having a greater number of workers and with better-quality jobs. As this is likely to put pressure on LTC spending, improving efficiency and co-ordination will also be necessary. Making good use of appropriate technology will increase quality of care and allow workers to make better use of their care time. Increased co-ordination between professionals and between formal and family carers, as well as greater promotion of self-care and healthy ageing, will also lead to greater efficiency and better social outcomes.

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Notes

[1] Long-term care 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 activities of daily living, such as eating, washing and dressing) and assisting them to live independently (through help for instrumental activities of daily living, such as cooking, shopping and managing finances).

[2] Personal care workers include formal workers providing LTC services at home or in institutions (other than hospitals) and who are not qualified or certified as nurses.

[3] The projection assumes that less workers will be needed to take care of the same number of elderly based on technological improvements and changing work arrangements as assumed by similar projections in the Netherlands (Dutch Ministry of healthcare, well-being and sports, 2018[4]).

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

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

[6] Casual employees are employees who do not have regular or systematic hours of work or an expectation of continuing work.

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

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

[9] IADL include activities such as doing laundry, shopping, transportation, meal preparation and housekeeping. They are not considered to be essential for basic functioning but are regarded as important for independent living.