Chapter 6

How to Prepare for the Future Long-term Care Workforce?

Although the effects of the economic crisis may mitigate shortages of LTC workers in the near future, an integrated approach is required to prepare for the LTC workforce in the longer term. Measures can be targeted at education, recruitment and retention, as well as at job content, productivity and quality. These can cover subsectors (home care, day care, residential care) but could also take the form of integrated sector approaches. Furthermore, for different categories of workers (nurses, lower-level workers), specific policies may be required, as for nurses an LTC career often is not a natural choice, while for lower-level workers LTC jobs are often not perceived as a "profession" but as "dead end job", with few options for progressing other than finding a job elsewhere. This can lead to high turnover and limited job retention, with subsequent high cost for employers, public finances, those in need of care and their families. Potential measures look at valuing LTC work and the workforce and may require substantial change in the organisation and management of care. Moreover, while in some countries foreign-born workers will represent sizable shares of the LTC workforce, there may be questions about the sustainability of such an approach. This chapter explores policies to improve inflows, retention, and productivity of LTC workers.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

6.1. The future challenge for the long-term care workforce

The after-effects of the economic crisis are impacting on health and long-term care systems in complex ways. On the supply side, funding levels for health and long-term care services may face pressure (Marin *et al.*, 2009). Demand may increase due to deterioration of health status (SPC, 2009) or as a consequence of unemployment, which may deteriorate people's financial capacities and thus may lead to *increased* demand on public systems (Cangiano *et al.*, 2009b). The crisis after-effects may also affect LTC labour markets. For instance, turnover of LTC workers may be mitigated as people seeking employment may be more inclined to enter the sector. LTC workers may stay longer and retire later than expected.

Vacancy rates dropped in the LTC sector in the United Kingdom, the Netherlands and Japan (Eborall *et al.*, 2010; Eggink *et al.*, 2010; Cangiano *et al.*, 2009a, 2009b; Hotta, 2010a). Indeed, there are signs that LTC could be acting as a safe haven: in the United States, retention of certified nursing aids is higher in areas with high unemployment (Wiener *et al.*, 2009). At the same time, strained public finances can affect the available training opportunities negatively (European Commission, 2010), for instance for nurses (OECD/WHO, 2010), hereby increasing gaps in the availability of global nursing services. The main challenge, however, is for the longer term. While the LTC workforce is currently a relatively small share of the total workforce, its size is set to grow. The challenge will therefore be to develop a sustainable quality LTC workforce that can meet growing demand.

The following section discusses countries' efforts to improve recruitment and retention. The next two sections describe these issues in more detail. Section 6.5 touches upon productivity. Section 6.6 provides final remarks.

6.2. Improving recruitment and retention: Overview of national policies

Many OECD countries already experience or expect recruitment and retention problems in the LTC sector, and most have developed and implemented measures to improve recruitment and retention in the sector (Table 6.1). These widespread problems signal a major overall problem of the LTC sector: its strong relationship with a context of deterioration of human daily capabilities. Moreover, they signal the struggling of OECD countries with the consequences of ageing societies.

Some OECD countries have workforce planning initiatives, such as Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States (McHale, 2009; Afentakis and Maier, 2010; Zorginnovatieplatform, 2009; SPC, 2009; Badkar, 2009; Cangiano, 2009 and 2009b; IOM, 2008). Most countries report measures to stimulate entry into LTC through traineeships (United Kingdom), additional job creation (Austria created 2 000 extra jobs; and Norway funded 10 000 new full-time equivalent workers), additional public funding for training (Australia, Belgium), the development of a standardised training course (New Zealand) or new curricula (United States). Ireland and England aim to recruit more LTC workers by offering the option of entering without qualifications under the requirement that relevant qualifications will be gained during employment. New Zealand

Table 6.1. **Workforce policies to increase the supply of LTC services**

	Recruitment measures	Public funded training	Wages and benefits increases	Improvements in working conditions	Raising status/job profile	Management improvement	Career creation	Workforce certification	Workforce planning	Other retention measures
Australia	√	√					√			√
Austria					√		√			
Belgium	√	√	√						√	
Canada	√								√	
Czech Republic		√	√							
Finland		√		√						
France	√	√	√	√	√	√	√			
Germany	√	√	√	√	√	√			√	
Ireland	√				√					
Japan	√		√	√	√			√		
Korea	√		√	√	√			√		
Mexico										
Netherlands	√					√			√	√
New Zealand	√	√	√						√	
Norway	√	√		√	√	√	√	√	√	√
Slovak Republic			√							
Slovenia			√							
Switzerland		√		√					√	
United Kingdom	√	√			√	√	√	√	√	√
United States	√		√	√		√	√	√	√	√

Note: Canada and Switzerland report regional initiatives, Sweden and Finland report local initiatives; United Kingdom refers to England Working to Put People First (Department of Health, 2009).
Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing, and additional documentation.

has developed public-private partnerships, where employers provide mentoring, on-the-job training and help job seekers to obtain a certificate. Some countries offer financial incentives to re-recruit workers (Australia), while other countries specifically aim efforts at specific target groups, such as young people, those re-entering the labour market and under-represented groups or alternative labour pools (Germany, the Netherlands, United Kingdom, United States). Japan has implemented various policies to attract and retain LTC workers (Box 6.1).

Box 6.1. **LTC workforce policy reforms in Japan**

Labour market conditions in Japan changed after 2002 resulting in a tighter labour market, making it necessary to implement better policies in order to retain or attract workers. Fee levels are set centrally and are revised every three years. The 2009 revision enabled many employers to increase wages by around JPY 9 000 per month (EUR 79.6 per month). At the same time, a fund was set up to assist providers in offering higher salaries. The fund was set at the prefecture level and providers submitted applications to obtain the financial aid. This is expected to raise wages by 15 000 yen per month (EUR 132.6 per month). Moreover, providers receive an extra fee if they have a higher number of certified care workers or, since 2009, if they employ more than three care managers.

The fund is not limited to wage subsidies, but is a part of an overall package to improve working conditions in LTC. For example, providers receive subsidies for introducing LTC equipment, such as lifts, that promote welfare and reduce the burden of care workers. Another tool to improve working conditions is the Labour Stability Centre. This is a private

Box 6.1. **LTC workforce policy reforms in Japan** *(cont.)*

certified institution, which provides advice on working conditions after on-site visits. Evidence from evaluations so far is promising, showing a 10% decrease in turnover, observed in the facilities that followed the advice.

Training is another important element for attracting and retaining LTC workers. While there is renewed emphasis on training and career plans, each institution has managerial freedom to set up their own training programmes.

At the governmental level, there are various subsidies available to attract young people in the LTC sector. Such subsidies include training for job leavers or for those who are currently working in other sectors. LTC training is free for job seekers and it is organised through the Public Employment Services ("Hello Work"). It includes commissioned training at specialised private institutions or training schools. Even though LTC trainees constitute around 10% of total trainees, their employment in the LTC sector is quite high. The government also subsidises the cost of hiring replacements, when staff is sent to training.

In addition, training subsidies are granted as part of an increasing capacity-building initiative for care workers. Such subsidies help set up career plans, develop know-how on training for institutions and practical courses. LTC capacity-building advisors and career consultants located at 47 branches of Care Work Foundation (CWF) nationwide provide consulting and support services by visiting homes or institutions, telephoning and e-mailing.

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

Some countries report measures related to wages and benefits, and a fewer focus on working conditions. Among other things, Japan, aims at improving the working conditions in long-term care by enhancing employer compliance to labour law. Where federal structures exist, such as in Canada and the United States, the options available to the federal government to influence recruitment and retention of LTC workers can be limited. Jurisdictions may not have specific powers over employers to improve working conditions. In the United States, the federal government provides financial aid to the states so as to increase wages.

Eight OECD countries report measures related to continued education and training, for instance, for enrolled nurses to up-grade to registered nurses (Australia), or the requirement for all LTC workers to acquire specific targeted skills, such as gerontological skills (Finland). The United States supports specific training on dementia and abuse prevention. Only a few countries invest in measures aimed at career building, for instance by means of scholarships (Australia), or modular educational pathways (Austria). More countries aim at improving the quality and job status in long-term care, either by developing national profiles (Austria) or curricula (Germany), by professionalising the sector (France), or by ensuring more trustworthy care by requiring workers to be certified (Korea). In Germany, in particular, the federal government pays for the whole three years of further LTC education. The United States, the United Kingdom and some other OECD countries are working towards accreditation schemes and public registers of LTC workers. England, for instance, is preparing a *voluntary* register for home-care workers (Department of Health, 2009). In other European countries, this is still far-fetched (European Foundation for the Improvement of Living and Working Conditions, 2006, p. 43). Some Italian regions have taken the initiative to register foreign-born care workers (Di Santo and Ceruzzi, 2010). The United States is also taking steps to require criminal background checks.

Some countries devote efforts to leadership and management improvement or restructure care provision. England is undertaking efforts to remodel the workforce. The Netherlands aims at innovating care processes and stimulates regional co-operation between employers and educators. France aims to modernise services, especially at home. Germany has not only introduced national educational requirements for elderly care nurses, but also, in 2008, a new job category in nursing homes, especially targeted at social and IADL types of work. Workforce prognoses have become important instruments for many countries.

6.3. Ensuring an adequate inflow of long-term care workers

Ensuring adequate inflow requires a continuous effort to secure an enough and adequately trained LTC workforce. This implies both a better use of available recruitment pools of human resources, as well as seeking new recruitment pools.

Using the available workforce pools better

Young people are a natural source for LTC jobs, but competition for youngsters will get fiercer as the share of youngsters in the population is below replacement level in many countries. While new training programmes could be set up to better attract young people to the sector, such programmes are more successful if they provide a realistic image of the sector, for instance by means of internships or a preview when applying. As young people are among the most likely to leave an LTC job early, measures to prevent young workers to quickly depart, for instance by providing career opportunities, are crucial (Hotta, 2010 a). So far, however, there is little evidence of successful efforts to improve entry of young people in vocational education and training for the sector, and subsequent successful bridging of education and enduring LTC employment. Norway has recently adopted initiatives in this direction.

The second major source – especially for lower-level LTC workers – is women re-entering the labour market. Older women are an important segment of the LTC workforce. In the United States, for instance, older workers appear to be evalued by employers. In Germany, older LTC workers seem to have high job satisfaction (BGW, 2007). Targeted approaches may be able to better reach these women. In the United States, tax benefits aim at providing older LTC workers with greater access to education and training, while, for lower-income older adults, additional federal funding is available for training and employment.

As for nurses, current nursing education curricula often give little attention to management of chronic and long-term conditions, or geriatric issues (IOM, 2008), while there are often wage and career differences with the acute-care sector. Without specific LTC knowledge, experience or other incentives, nurses are less likely to see LTC as a sector of interest. Initial education, for instance by conditional loan forgiveness, scholarships and internships, could stimulate nurses to work in the LTC sector, as suggested for the United States (AAHSA and IFAS, 2007). Specific public funding streams could be allocated to employers or to the care workers interested in further qualifying into a nursing profession. Such schemes can be found in Australia.

Similar to delegation to nurses of tasks normally performed by doctors (Buchan and Calman, 2008; Delamaire and Lafortune, 2010), delegation of nursing tasks to lower-level workers could be fruitful to address shortages of nursing staff in LTC. A pilot in the Netherlands, in which lower-level care workers in nursing homes could work more independently with patients with both dementia and depression, based on developed

nursing guidelines, proved positive for both the safety and quality of life of patients, as well as for work satisfaction of the staff (Verkaik *et al*., 2010b). In the United States, several projects aim to achieve such delegation. For instance, in the Nurse Delegation Pilot Program in New Jersey, voluntarily participating registered nurses formally delegate tasks concerning medication for patients to Certified Nurse Assistants (CNAs). As often nursing aids are insufficiently trained in this field (IGZ, 2010), the New Jersey nurses association developed guidelines to decide in which cases delegation would be possible and how. The volunteering registered nurse instructs and supervises the lower-level care worker.

One often-used method to improve recruitment is through media campaigns. Fujisawa and Colombo (2009) report mixed results. Experiences in the United States suggest that such campaigns might lead to "the wrong people at the door" (Box 6.4). England developed a national social-care contest among workers, with media attention for the winner, hoping to improve attractiveness of the sector. Consequences for sector image, attractiveness and possibly higher recruitment rates are unknown as yet.

New employment pools

The largest potential recruitment pool consists of men. In 2005, Germany introduced a new policy (*Neue Wege für Jungs,* New Avenues for Guys), offering young men, amongst others, the opportunity to participate in caring work for elderly or children.[1] While 70% of the participating young men surveyed were positive about "atypical" professions (amongst which child and elderly care), the available data suggest that numbers may be low relative to forecasted need.

Several countries have programmes to lead the unemployed to the LTC sector. The United Kingdom, for instance, targets young people who have been unemployed for more than a year, while in Japan "Hello Work" employment agencies seek to recruit unemployed people to the LTC sector by providing vocational counselling, employment placement opportunities, seminars on work in the long-term care sector, and guided tours of social welfare facilities. Such schemes typically focus on lower-level care work (see for example, Box 6.2 on Finland).

Box 6.2. **Work reactivation and elderly care in Helsinki (Finland)**

Orienting unemployed people to LTC work is not an easy task. In Helsinki, long-term unemployed people are encouraged to re-ender the workforce by helping elderly people living at home with their household management and errands. The unemployed are offered the option, supported in taking responsibility for their process, and enticed to work in the caring industry. Work trainers, together with home-care workers, provide guidance. The city activated 60 to 70 long-term unemployed people at a time at the cost of the salaries of seven work trainers (a total of EUR 20 000 per month). Approximately 40% of the home-care support groups moved on to paid work or to study for an occupation. The project aided 14 000 elderly with IADL services as well as with escorts to medical services and outdoor activities. The city saved EUR 300 000 a year, even with those involved received an additional EUR 8 per day. Interviews suggest that the workers required less social and health services and that their mental well being, way of life, and readiness to return to work improved.

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

Other programmes aim to recruit people who may not consider entry into the LTC sector. England, for example, focuses on underrepresented groups. The Netherlands experiences a strong underrepresentation of people from a Turkish and Moroccan background, both in vocational care education and in the LTC workforce. The government also intends to enable more care provision by workers from this background, especially for people from the same ethnic groups (Ministerie van VWS, 2008). Some countries also invest in efforts to re-recruit workers that left the LTC workforce, for example Australia (for nurses), Ireland and Germany.

A relatively new option consists of family members that are hired through cash-benefit programmes. There is some evidence that family members and friends who successfully cared for a loved one as a paid caregiver, can be attracted to the "regular" workforce, although in many other cases, their caring position did not last beyond this one-off process. Family members, who in some cases can be hired and compensated through cash-for-care benefits, offer a partly "hidden" supply that could lead to additional inflow in the "regular" LTC workforce.

Generally speaking, the success of activation programmes and target group-based recruitment in the LTC workforce is not always positive. Many of the targeted people actually use LTC as a first step towards further employment. Long-term evaluations often are lacking and may not focus on their effects for LTC job tenure, but on employment in general.

Foreign-born workers

In several OECD countries, demand for foreign-born LTC workers keeps growing. Between 2008 and 2009, over half of the 6% increase in institutional care employment in the European Union – the third fastest growing sector in numbers of workers – was accounted for by foreign-born workers. In the United States, the fourth largest growth in foreign-born workers can be seen in social assistance (18.2%) (OECD, 2010a, pp. 112-113). Such data suggest that foreign-born LTC workers are likely to continue to play a substantial and possibly increasing role (Cangiano *et al*., 2009b; McHale, 2009, for Canada).

Many OECD countries have a history of and act as immigration countries. Some of these are targeting LTC workers, for example specific programmes exist in Canada and Israel. Broader LTC migration initiatives and *ex post* regularisation programmes have been implemented in other countries (Box 6.3). However, given the importance, and expected growth in the migrant care phenomenon, the lack of reference to long-term care in migration programmes of many OECD countries is conspicuous.

While foreign-born care workers in LTC can be a short-term mechanism to address care needs, in some countries they form a structural component of the LTC workforce. However, as options for legal entry for lower-skilled jobs are limited in countries such as the United States, Italy and Spain, the irregular inflow exceeds the regular inflow by far (OECD, 2009, p. 125). In 2009, estimates of the share of irregular migrants in OECD countries ranged from 0.17% in Japan to 3.94% in the United States, with irregular migrants shaping between 3.7% (Austria) and 63.5% (United States) of all foreign residents (OECD, 2009). For Canada, it was estimated that about 60 000 migrants were in the country illegally, most of which refugees (Bourgeault *et al*., 2009). Unregulated/illegal care workers can undermine a country's stability and social systems.

Box 6.3. **Immigration policies related to LTC workers in selected OECD countries**

The **Canadian** Live-In Caregiver Programme (LCP) enables immigrants to obtain permanent residence after two years of full-time work as "live-in carers". The programme is employer driven, meaning that employers must first offer a job. The arrangement requires the carer to remain with the same employer for two years. There are no formal caps, but the number of LCP work permits issued is determined by the processing capacity of visa offices.

Applicants for the LCP must have an education level equivalent to Canadian grade 12, six months caregiving training or experience, and sufficient English or French language proficiency to provide care in an unsupervised setting. After completing two years of live-in caregiving work, within 3 years of arrival, care workers can apply for permanent residence, which will then require them and their dependent family members (spouse and children) to pass medical, criminal and security examinations. When permitted permanent residence, they can work in any occupation (OECD Questionnaire on Long-term Care Workforce and Financing, 2009; Bourgeault *et al*., 2009).

In 2008, approximately 13 000 foreign nationals entered Canada on LCP work permits. Most participants are women from developing countries, such as the Philippines (83%). The programme is being further developed, introducing more thorough checks on employers by 2011, as well as, in 2010, assisting the live-in carers to better meet the requirements for permanent residence, as working overtime can speed up the application process, while the application period can also be extended, for instance in the case of illness (Citizenship and Immigration Canada, 2010).

Long-term care is the main route through which foreign workers enter **Israel**. In 2009, the 54 500 migrant workers in the care sector represented about half of total employment in the sector and almost all provide live-in care. Since 1988, an LTC benefit has provided subsidies, enabling elderly people to employ migrant care workers. Although no quotas are imposed, eligibility criteria exist for both migrant candidates (*e.g.* language skills) and employers (*e.g.* ADL score, medical records). The criteria for issuing permits to employ foreign caregivers are expected to be restricted, limiting eligibility to individuals who require 24 hours home care (OECD, 2010b; Kemp, 2010).

Migrant caregivers can work in Israel for a maximum of 63 months, but have no option of permanent residence afterwards. The visa may, however, be extended if the caregiver has been working with the same employer for at least one year, and if the employer is dependent on home care. At the same time, migrant carers are not allowed to change employers (Israel Government Portal). Foreign-born care workers must be registered with licensed recruitment agencies, which place them directly with a patient (OECD, 2010b). New legislation requires recruitment agencies to find new jobs for unemployed foreign caregivers, in order to minimise fee-bringing international recruitment. However, this is not enforced, leading to new inflows while other foreign-born workers are unemployed.

If the subsidy pays for part of the care, the worker is jointly employed by the agency and the recipient, in which case care receivers are to pay social contributions to the NII, but they do not have to provide workers with pay slips. More than half of the foreign care workers, however, are employed directly by the receiver without NII subsidy (OECD, 2010b). In Canada, again, the Temporary Foreign Worker Programme allows employers to hire migrant workers on a temporary basis, when Canadians or permanent residents are not readily available.

Box 6.3. **Immigration policies related to LTC workers in selected OECD countries** *(cont.)*

Other examples

In some other OECD countries immigration policies that can apply to LTC workers exist. In **Italy**, LTC workforce immigration has been supported through *ex post* legalisations of foreign workers (Box 5.3) (Lamura, 2010). In the **United Kingdom**, LTC caregiving is an occupation with recognised shortages, under Tier 2. This means that applicants are provided easier access and the job is not subject to a resident labour market test, facilitating foreign carers' entry in the country. Entry, however, has been recently limited (OECD Questionnaire on Long-term Care Workforce and Financing, 2009). In **France**, care workers (*aide-soignants*) are on a shortage list for EU citizens, and house workers are on a shortage list targeted at the Senegalese population (Immigration Professionnelle, 2008). Housework may refer to ADL caregiving for the elderly, too. The **Spanish** shortage list of professions included caregivers up until 2008 (Fujisawa and Colombo, 2009). Persons with the skills and experience required to work as a LTC worker may be able to migrate to **Australia** through General Skilled Migration (GSM) and employer nominated visa programmes such as the Employer Nomination Scheme (ENS) and Regional Sponsored Migration Scheme (RSMS). Furthermore, through the Family Stream, an individual can obtain a visa to care for a relative who has a medical condition (OECD Questionnaire on Long-term Care Workforce and Financing, 2009). Finally, **Japanese** bilateral agreements with Indonesia, Vietnam and the Philippines allow immigration of a limited number of care workers in the country. However, the requirements to pass language tests and Japanese national qualifications reduces inflow, even though qualified LTC workers can stay in the country indefinitely (Fujisawa and Colombo, 2009; Cortez, 2009).

Beside *ex post* regularisation initiatives, some countries have developed policies to reduce uncontracted, black labour in LTC. Germany issued special working permits for domestic workers, *Haushaltshilfen,*[2] entering from countries that entered the European Union in or after 2004 (van Hooren, 2008). France developed tax deductions and lighter administrative regimes for those hiring LTC workers formally. Germany, too, introduced a tax benefit, which can save up to 20% of the costs of legally hired care. In 2007, Austria developed a framework to regularise previously illegal care workers, enabling a legal provision for round-the-clock work at home and, per 2008, pardoned those having hired undeclared migrant carers if they registered those workers with the social insurance institutions. Such measures may or may not be accompanied by awareness raising campaigns about the risks and punishment of those employing black labour (Switzerland).

OECD (2009) has developed guidelines for labour immigration policies. They can apply to foreigners working in LTC. The main steps are listed below.

Identify unmet labour needs. Provide work permits in numbers commensurate with the extent of labour needs

Only a few countries, such as Australia, the United Kingdom and Canada, have immigration programmes that can apply to long-term care workers (Box 6.3). Germany's bilateral agreements with Croatia do not include care migrants. Quotas can control inflow but require enforcement. Quotas are considered necessary to adjust available supply to limited employment options in the receiving country. In Israel, 10% of the labour force consists of foreign-born temporary workers, most of which are care workers. While in

early 2009 a registry of unemployed foreign-care workers was installed to prevent new entries when unemployment among foreign-born workers became too high, the register has been set on hold because agencies continue to recruit from abroad (OECD, 2010b).

Develop means for matching migrant workers to jobs, either overseas or in the country

For care workers, a job offer often is a prerequisite to enter the country. Intermediary agencies can support such processes. However, in most countries, there are few or no certified intermediaries. Special job-search visas could enable *legal* employment, and thus redirect employment practices. When a job is found, a residence permit and work permit could be provided.

Work towards efficient permit processing and delivery procedures

As the example of Italy showed (Box 5.2), getting a visa may be hampered by formal requirements, while the need to match demand and supply may require speed. Thus, especially in the case of privately hired care workers, adaptations of the process may be desirable.

Develop means for employers to verify the status of potential employees

Specifically for home care – or live-in care work – it may be difficult for both the prospective employer and the potential worker to decide whether the other person is trustworthy. The efforts in some Italian regions (Di Santo and Ceruzzi, 2010) to develop registers of home assistants are a means to achieve this, if only from the employer side.

Effective border control and workplace enforcement procedures

While border control is a logical link in the process, in the European Union this may be difficult to achieve, due to its internal open borders. Workplace enforcement may furthermore be difficult in the case of live-in long-term care. The 2011 changes in the Canadian Live-in Carer Programme suggest, however, new options to protect the care workers by means of more *ex ante* employer checks. Another example of how to deal with this issue can be seen in France where the receipt of targeted subsidies requires reporting on employment status. Another method is to combine inspections with major fines. In the context of those in need and receiving a cash benefit, it could be envisaged withdrawal of the cash benefit, such as can happen in the Netherlands in case of fraud with the personal budgets.

While recruitment may sometimes be easy, hurdles with retention may be as important an issue as for native-born workers. For instance, while Martin *et al.* (2009) report foreign-born nurses in the United States starting their own care agency to provide services for frail elderly from their own cultural background, and while some of the participants in the Canadian Live-In Carer Programme seek work in LTC after fulfilling the requirements of the programme (Bourgeault *et al.*, 2009, p. 63), Chaloff (2008) states that "many immigrants working in the private care sector are not interested in investing in a care career".

Finally, there are some concerns regarding the impact on quality of care. Language and cultural differences can affect the quality of care due to higher error rates associated with barriers in communication, lack of familiarity with equipment, medicines or practices (Dussault *et al.*, 2009, p. 25). There are also some concerns about short job tenures of many migrant LTC workers who are only looking for temporary jobs.

6.4. Improving retention: Valuing work, building careers

A major challenge for the sector is to better value LTC work and the LTC workforce. This may require a mix of general as well as sector-specific measures. For instance, Japan aims to boost LTC workers' compliance with general labour law as a means to improve working conditions in the sector. More specific, sector-based approaches will, however be required, too.

Recruitment and initial training costs associated with high turnover can be saved by improving job quality and workplace conditions, thereby improving retention and the sector image (Seavey, 2004). However, initial investment cost can be high and there is often limited evidence to assess the cost-effectiveness of alternative interventions. In addition, the costs of increasing retention in LTC may be borne by some stakeholders, while benefits may go to other parties. For instance, improved LTC nurses' retention in the United States' may imply higher wages for Medicaid, while savings – reduced hospital stays and re-hospitalisation – accrue to the Medicare programme. Still, measures to improve retention can have a good return on investment, such as lower turnover, higher job satisfaction and better quality of care, as reported for example in Japan (Onodera *et al.*, 2006).

Enabling LTC workers to work more hours

If LTC workers worked more hours per week and for longer periods in their working carriers, this could reduce recruitment needs. For instance, one estimate from the Netherlands suggests that these measures would attenuate the need for new workers by 125 000 FTE LTC workers by 2025 (Zorginnovatieplatform, 2009). A substantial number of LTC workers have more than one job or work part-time, suggesting that they could work more hours in LTC than they do now. Although not specific to LTC jobs, 16% of part-time working women across the OECD signals a willingness to work more hours.[3] Stimulating LTC workers to stay in the sector and delay retirement could also reduce recruitment needs.

Competitive wages and benefits matter, but are not the magic bullet

Increasing wage levels can reduce turnover (Smith and Baughman, 2007; Ministry of Health/University of Auckland; Hotta, 2010a and 2010b). Belgium, Luxembourg, the Slovak Republic, the Czech Republic, France and New Zealand have recently implemented wage increases. New Zealand reports higher wage increases in home care than in residential care. Slovenia plans further wage increases for in 2011, after a 10-15% wage increase in 2008. In 2009, Japan increased the long-term care insurance fees by 3%, after a long period of constant fees, enabling employers to raise workers' remuneration. Germany, which does not have a federal minimum wage, implemented a mechanism whereby LTC workers earn at least the usual *regional* minimum wage. In the United States, additional federal funding has recently been directed to states with the purpose of facilitating wage increases.

However, wage increases are not the sole or only solution. In the period 2003-08, while wage increases in the English social care sector were 4% higher than in other jobs (and 20-30% higher than in other low-paid jobs), turnover remained high (Cangiano *et al.*, 2009b). Even substantial and structural increases may have short-lived effects in terms of recruitment and retention if not accompanied by other measures.

One option is to better recognise experience in wage levels. Collective labour agreements typically differentiate pay scales according to years of experience. In countries where this occurs, such as Belgium, the Netherlands and Sweden, retention is higher. One-off financial incentives, such as bonuses, as tried in the United States did not reduce

turnover, vacancies or increase job satisfaction significantly, as amounts were too small and taxed. In Canada, non-financial incentives have been tried, like giving nurses 20% of their time to spend on professional training.

Entitlement to work-related benefits can help job retention and satisfaction. In some OECD countries *(e.g.,* Denmark, Germany, Belgium, the Netherlands), collective labour agreements regulate paid sick leave, health insurance, paid travel to and from work, or between work settings (including travel time, especially in home care), extra pay for inconvenient hours and rosters, and paid work meetings. In others these conditions depend on bilateral agreements between employees and employers.

German and Swedish data (BGW, 2007; Swedish Association of Local Authorities and Regions, 2007) point to high job appreciation and low tendency to leave, where work-related benefits are provided. Turnover in Sweden is 5%. In the Dutch system, benefit packages for LTC workers, such as annual wage increases reflecting work experience, extra compensation for irregular hours and – limited – compensation for travel costs for home-care workers go together with high loyalty to the sector (van der Velde *et al.*, 2010). In the United States, the idea of health coverage provided a clear incentive for workers to stay (Box 6.4). However, recent analyses also showed no significant effect of health insurance coverage on job retention, while a USD 1 increase in hourly wages could increase job tenure by an additional 2.1 months, just as a pension benefit led to increased retention (Wiener *et al.*, 2009).

Implementing worker centred workforce policies

The high job appreciation by many LTC workers contrasts starkly with high turnover. According to a study on nurses in Europe, nurses that feel able to provide the care they think is required are less prone to burnout (Schoot *et al.*, 2003), while good working conditions improve retention (Hasselhorn *et al.*, 2005). Worker-centred policies increase the likelihood that workers feel valued in their work and increase worker control over the job. In the United States, two major demonstration projects showed that a combination of measures can contribute positively to worker satisfaction and retention, as long as the LTC worker feel that care work is valued (Box 6.4). Key aspects relate both to a worker's situation in the life course as well as to the organisation and communication patterns. An example from Germany is illustrated in Box 6.5.

Efforts to retain LTC workers, amongst which nurses, could have most impact if applied at early stages of training and employment and when workers have higher prospect of job tenure. In the United States (Box 6.4) and in Japan (Hotta, 2010), organisations geared towards the worker, for instance by means of coaching supervision, enhancing work-related discussions, and modes of continuous training, succeed in retaining LTC workers longer. According to a repeated survey among home nurses in California, job tenure was the main important predictor of intention to stay (Ellenbecker *et al.*, 2009).

Appropriate human-resource management strategies reduce work-related stress among LTC workers and improve the well-being of LTC recipients. For those working in Japanese nursing homes, mentoring opportunities at provider levels, and merit-based remuneration mechanisms had negative associations with their stress levels. Workers were also less stressed when they had opportunities to learn about provider's management principles, care strategies and LTC-system reforms (Hotta, 2010a and 2010b). Evaluating performance and assignment of responsibilities was associated with a reduction of care-worker burnout, thereby raising worker confidence (Hotta, 2007; 2010a and 2010b). Other studies also indicate that establishing staff-appraisal mechanisms, career ladders,

Box 6.4. **Projects to improve LTC workers recruitment and retention in the United States**

During the early 2000s, the federal Centres for Medicare and Medicaid Services (CMS) funded ten demonstration projects aimed at improving recruitment and retention of direct care workers. The "Better Jobs, Better Care" (BJBC) programme, financed by the Robert Wood Johnson Foundation and Atlantic Philanthropies, aimed to reduce high vacancy and turnover rates among direct care workers in LTC and to contribute to improved workforce quality. The total investment was USD 25 million. Evaluations of results showed the following and, especially, that much of the worth of the initiatives appears to be in demonstrating to the workers that they are valued.

	Effect on:				
	Turnover	Vacancies	Job satisfaction	Intention to stay	Retention
Health care coverage*	Health care coverage critical to retention of workers#				
Wages# (fair compensation and benefits, competitive wages)			+		+
Realistic job previews/targeted recruitment campaigns*	–	–	+	+	
	Increase job satisfaction for workers with long tenure				
Realistic job previews*	–	–			
	Especially when preview matched job content, done prior to hiring and combined with post-hire initiatives. Mass marketing led to inflow of unsuitable candidates				
Coaching and supportive supervision#			+		+
	Supervisors require targeted training				
Peer mentorship*	+	+			–
	Probable cause: lack of funding and structure				
Worker recognition*	–	–	+		
Financial recognition*	Rewards were small and temporary especially when a bonus instead of wage increases, moreover taxation reduced amounts				
Merit recognition*		–	+	+	+
	Creating a community larger than the agency gave workers a support system and a sense of pride and job identity				
Training*	+				
	Causes: major participation problems; lack of identification of worker needs				

Older workers#: Were considered more stable, providing better care than younger workers. They seemed to prefer working in home-based setting (more supportive tasks than hands on care), while stereotypes about physical capacity did not apply.

Family and friends as pool#: substantial shares of those providing paid care for a family member were interested in further work in LTC; their motivation to start was often "to make a difference". Those who continue to provide care after this care process stressed the aim to "help others" or "affect people's lives". Paid family and friend caregivers who did not stay in LTC tended to earn "more" than as paid care workers).

Supervision#: coaching (instead of command) supervision and showing respect was critical to job satisfaction and worker retention, suggesting that worker autonomy should be accompanied by good supervision. However, many supervisors felt ill-prepared for the job. Clear recommendations were shaped for targeted education and training for supervisors.

Job satisfaction#: high job satisfaction was associated with low turnover and positive interactions among staff.

Career#: more than half of the direct care workers wanted to leave the work within three years, of which almost half wanted to become licensed practical (or registered) nurse.

Quality of care#: greater job commitment of direct care workers was associated with better care for residents.

Retention efforts#: a "retention specialist"*(e.g.,* trained team, with dedicated time and financial and administrative support) was more favourably perceived by workers in the agency administration.

Initial training#: was often perceived as not enough; it should last longer and focus on hands-on work, communication skills, and dealing with problem behaviours.

(Employer-based) continuing education#: should be fit to suit all workers' circumstances and be flexible, address communication and team work, take place in the context of stable management and require management commitment as well as clear co-ordination.

Cultural competence#: zero tolerance on racism and train staff in cultural diversity and cultural competence in care, including non-verbal communication are important and should include communication with residents and family members. Higher cultural competence is associated with higher job satisfaction.

Sources: *: Engberg *et al.* (2009); #: Livingston (2008).

Box 6.5. **Germany: Initiatives to enhance care work**

The New Quality of Work Initiative (abbreviated to INQA in German) is a joint project by the federal government, the federal states, social insurance institutions, social partners and businesses. The Initiative's members aim to promote a new quality of work, stimulate good working conditions and employee-oriented staffing policies in the service sector, including health and care. INQA stimulates public debate, organises knowledge transfer, supports innovative projects and draws media attention to examples of good practice. Together with the Professional Association of Health and Welfare Services (BGW), INQA organises an annual contest for the best health and care employer. For the BGW – executor of the statutory accident health insurance for more than six million policy holders – the primary purpose is the prevention of occupational accidents, occupational diseases and work-related health hazards.

In 2007, INQA produced a memorandum on *healthy nursing,* defined as oriented to prevent overburden, worker oriented, embedded in a healthy-work and co-operation culture, communication enhancing within the organisation and with those in need and their families, care-recipient oriented, aimed at developing personal competences, taking place in a healthy workplace, and flexible.

The Joint Labour Protection Strategy (*Gemeinsame Deutschen Arbeitsschutzstrategie,* GDA*),* a collaboration of federal and state-level stakeholders, also focuses on care, especially to prevent muscular skeleton problems, psychological stress and improve safety. It has online self-assessment tools for preventive measures, trains managers to implement risk assessments and holds regional information meetings to improve the culture of prevention and health literacy of employees.

Source: OECD 2009-10 Questionnaire on Long-term Care Workforce and Financing.

promoting work-life balance (Suga, 2007) and involving staff in decision-making (Matsui, 2004) reduce stress levels, although the appropriate approaches seem to differ by type of institutions (Jeong Jang, 2007; Nagami and Kuroda, 2007).

Worker recognition, especially merit recognition (including membership of a professional organisation or a trade union), proved to be advantageous. Countries with well-developed social dialogue and a structured approach to the recognition of worker's needs, such as the Netherlands, Norway, and Sweden, manage better retention than others with a limited development of structural dialogue. In the Netherlands, a new concept of care provision was developed by LTC workers, who started a new type of organisation to provide better care while giving the care worker recognition (*Buurtzorg)* (Box 6.6).

Box 6.6. **More responsibility to the care professional? *Buurtzorg Nederland* in the Netherlands**

Buurtzorg Nederland is a care provider organisation offering high-level care and giving as much responsibility as possible to the carer. According to *Buurtzorg Nederland*, nationwide implementation could help save resources while at the same time improving quality. The concept works with self-responsible teams, without management and minimal support services, with overhead reduced to an optimal information process through high quality ICT.

Started in 2007, 260 teams were active as of September 2010, consisting of 1 700 workers with higher vocational education and 1 000 intermediate vocational qualifications. The number of clients is approaching 35 000. Active interest for the concept exists in Belgium, Sweden, Switzerland, Japan and the United States.

Source: Information provided by *Buurtzorg Nederland.*

Implementing life-course and age-related measures

These policies help workers to better juggle life-specific challenges and work. Such measures can be included in general labour-market policies, but also be sector specific, due to the gender composition of the LTC workforce and harsh working circumstances. The difficulties in combining work with caring for a child or an elderly parent are a barrier for 40% of women working part-time to work more hours (OECD, 2004). Although older LTC workers seem to be better valued than younger workers, age-related workforce policies – that is, policies that take the consequences of one's age into account – become increasingly important given the ageing LTC workforce.

Safety at work

A care worker in bad health may not be able to provide the care required and may endanger the care recipients' health. Worker-health measures relate to occupational health and accident prevention. Given the occupational hazards related to LTC, policies to support LTC workers, such as those described for Germany in Box 6.5, are crucial. Supportive measures can be taken by having workers use specific tools or equipment, but more generally, by monitoring the functional, mental and health status of the worker. These health and safety measures are even more important for workers in home care, but also more difficult to implement and monitor without intruding into the care recipient household.

Work organisation and process

Management in long-term care facilities appears to be lacking in quality and efficiency. This has detrimental effects for both the worker and care recipients. Some OECD countries are therefore implementing policies to remedy this situation (Table 6.1). In Sweden, for instance, the government has recently initiated a management and leadership programme for LTC managers.

Many LTC workers also lack a say in planning and responsibility in care provision, even if they are those in closest contact with the care recipient. Several options can be implemented to improve worker voice, amongst which self-steering teams, who plan and share workload based on the needs of the care recipients. Mentorships and coaching may stimulate workers – if properly organised – while also acting as means for informal learning. Work-related measures that have been shown to improve retention of nurses are also applicable to the LTC workforce. These include overtime strategies, flexible work arrangements, family care initiatives, leave and compensation, health and well-being, work environment and safety practices, as well as a supportive organisational culture, and union and management support. A trust relationship between employer and employee and good management modalities are a contributor factor to successful retention (Simoens *et al.*, 2005). Japanese policies to promote stability of the LTC workforce by supporting improvements of the working environment also seem to require managerial change. Instead of management working strictly top-down, LTC management could be motivated to work in different modes, enabling and supporting LTC workers in their professional roles. However, professional management skills are often lacking in LTC settings.

The English National Social Care Skills Academy, established in 2009, provides evidence for and options to improve LTC management. The Academy aims to provide training support to small and medium-sized care providers in particular, in recognition of their limited training budgets. It also provides training programmes for employers and includes an accreditation

scheme to encourage consistency in the quality of employer- provided training of care workers. In 2010, the Skills Academy hosted the finals of the Worldskills UK Caring Competition, in an effort to raise the profile of social care, where care workers competed in role-playing scenarios (*www.nsasocialcare.co.uk*). Germany has a contest for the best care employer. Box 6.6 provides a recent Dutch example of successful LTC workers' organisation and practices.

Educating the LTC workforce: Life-long learning and employability

Basic education

Depending on the job level and country, basic training for LTC may be limited (Chapter 5). This lack of targeted (vocational) training implies that many workers, when entering the LTC sector, may not be adequately prepared to do their work. However, the nature of the job, which can be physically, emotionally and psychologically enduring, requires know-how. Furthermore, technological progress and the use of ICT in the sector may change the care process. Not being properly prepared to enter the LTC workforce may therefore imply not being able to respond adequately to the challenges of care provision, which risk hampering quality of care and retention. For instance, in Japan, training and improving caregiving skills has been associated with reduction of care-worker burnout and better co-worker relationships (Hotta, 2007; 2010a and 2010b).

Austria and Germany, together with regional jurisdictions, have national requirements for care workers. The Austrian agreement on social-care professions, which was enacted into regional laws early in 2009, aims to implement a wide system of training in social care and to better integrate medical care professions. To improve job attractiveness, the law creates flexibility and mobility in the labour market. In the case of Germany this applies to elderly care nurses (2004). In 2008, Germany created a new job category in nursing home care, that of IADL assistant. The work is specifically targeted at assisting people suffering from dementia and related illnesses. The United States, as part of the measures to be implemented with the health reform, will devote efforts to develop core competences for LTC workers (Harahan and Stone, 2009).

Continued education and training

Educational innovation can enhance recruitment as well as retention (Dill *et al*., 2010) but can also, when not targeted at the care-workers' wishes, desires or circumstances, actually lead to increased turnover. Worker education and development is often not part of the strategic management of LTC organisations, while employees' individual needs are not sufficiently taken into account (*Sosiaali Ja Terveysministeriö*, 2004). Even if they are, worker education tends to be aimed at adjusting to changes in direct job requirements, than at efforts to stimulate qualification levels. The low upward mobility in the sector gives some evidence to this notion, even though the differences in initial qualification requirements between two job levels may be limited (one extra year of education for a higher job-level, for instance).

Still, several countries among which Australia, France, New Zealand and Switzerland aim to boost training of the LTC workforce. Germany has recently increased public funding for the third and last year of training of older workers who want to change career into LTC, where it previously only paid for the first two. The United States has several initiatives to assist workers wishing to raise their qualifications. However, it may well be that there is more targeted – continued – training available in health care than in LTC. Especially lower-level care workers in home care receive fairly little continued education and training, as in the Netherlands (Verkaik *et al*., 2010a).

Differentiated policies may be required to stimulate educational levels among different workers' categories. Other options include flexible worker-based education, including e-learning. In some countries, the relatively high shares of high – but not LTC-targeted – qualified workers in the sector, could be a basis for focused training and education. For instance, Germany and the Netherlands recognise previously gained competences, enabling those with relevant knowledge, skills and experiences, to skip parts of the vocational education. Australia aims to rehire and up-skill associate nurses into LTC and qualifying them as registered nurses. For relatively low-educated workers, additional efforts and measures may be required to increase participation in training as there are indications that these workers are less aware of the positive economic returns of education. For instance, taking away fear of exams and guidance could increase their successful participation in training (Fouarge *et al.*, 2010). This suggests that the low-educated LTC workforce may need different modes of continued education than higher-educated LTC workers.

In some countries LTC work is differentiated depending on complexity of tasks and responsibilities. As turnover tends to be highest in the lowest-level jobs, these workers can be stimulated to perform more complex tasks by targeted education. Workers doing these other tasks can then also be stimulated to be further trained. Constructing such a "ladder of training" has been tried in the United States and proved to be successful. Such a process could, ultimately, assist in reducing shortages.

Careers in LTC

As jobs in LTC in most countries are dead-end jobs, building a career implies further education and training. For this purpose, Austria implemented a modular training system that allows for flexible use and is geared towards smooth transition between occupations. France, too, invests in developing career-like options and the United Kingdom invests in career pathways. As yet, however, there is little known about the results.

Finding the right balance between work requirements and the development of options for professional and personal growth is a challenge. Task integration may be a mode to increase job satisfaction and retention by creating more attractive jobs and minimising job fragmentation (Oschmiansky, 2010). In the United States, the Green House project required workers to provide more integral care by doing hands-on work – both IADL and ADL support. This approach led to reduced job fragmentation and increased continuity in the carer-LTC recipient contacts. The system is cost effective due to reduced turnover, a reduced need for middle management, even though the – better trained – workers earn more than Certified Nurse Assistants. Belgian nurses in LTC also provide ADL support.

Nevertheless, improving career-building options in LTC may well require a change in perspectives. Four blocks to building more professional careers in LTC come into play. First of all, part-time workers – a very common category of worker in LTC – are not the most likely candidates to be stimulated by employers to participate in education or career-building initiatives. Second, a major share of LTC workers is ageing. Ageing workers are not the most likely candidates to whom employers offer targeted (further qualifying) education, nor are these workers the most likely to *desire* such trajectories. Older workers in adult social care in the United Kingdom are often seen as lacking flexibility and up to date knowledge (Hussein, 2010). Moreover, there is little evidence of successful career building in later life. A third issue relates to the fact that women, in many countries, appear less career-oriented than men and thus less likely to enter into targeted education (and are

less likely to be *offered* education). Finally, as discussed elsewhere in this chapter, there may be hindrances for lower-level care workers to participate in educational trajectories as they may not see themselves as likely candidates to participate or succeed.

6.5. Increasing productivity among LTC workers?

Clear-cut, widely-accepted options to increase productivity in LTC are scarce, as is the evidence about such options. Only a few countries report approaches to increase LTC workers' productivity. Canada reports some tele home-care initiatives having shown a reduction in hospital admissions, while improving clients' self-management ability and enhancing staff satisfaction. The Dutch health-care innovation platform aims to enhance and stimulate innovation in care, while a "transition programme" aims at better care co-ordination, using screen-to-screen communication, and monitoring through video and sensors. The Czech Republic reports the availability of emergency care for elderly living at home. For other countries, although improving productivity is an important issue, there are still no or little outcomes to report. Individual country efforts, albeit limited to a few, suggest that there are possible options for productivity improvements in long-term care, although uncertainty exists about how this can be achieved.

Increasing the role of technology is often seen as an important option to improve user friendliness and quality of services, care co-ordination and personalisation of care, as well as a means to improve worker productivity and communication. A key issue is whether workers can work smarter. Additional skills and technological tools can help workers better cope with the demands of their work. Administrative handling can be automated, making major reductions of overhead possible, while modern tools such as smart phones can be used especially in home care to reduce the administrative handling and enhance connectivity between users, their families, and care provider. However, technological developments can add to work pressures and workload (Evers *et al.*, 2009), while the desire for slim and flat organisations with little overhead may sometimes be at odds with supervisory and clinical requirements.

A related issue is whether productivity improvements via technology and work reorganisation are compatible with quality enhancement goals. In the Netherlands, for example, productivity developments in elderly care have been associated with quality loss (Van der Windt *et al.*, 2009). However, this is not necessarily a trade-off. Win-win solutions can imply smarter use of technology to improve processes and quality of care. For instance, the implementation of Electronic Medical Records (EMRs) in nursing homes in the New York area led to time savings and reductions in medical errors, as well as to improved recruitment ability, lower level of workplace conflict one year following the adoption of EMRs, and increases in communication levels between employees and supervisors (Lipsky and Avgar, 2009).

Such experiences suggest that LTC may need to undergo some change in *modus operandi*, embracing different modes of thinking and unorthodox options. For example, instead of the nurse going to the patient at home (which takes costly working time), in some cases the provision of a transport service for the care recipient to go to and from a nursing station may be cheaper and result in a higher patient/nurse ratio with the same quality. But change risks being relatively slow. In many countries, LTC is a fragmented sector, which prevents quick entry and wider implementation of technological and process innovations. It is also a traditional sector with limited technological or workforce innovations. In the Netherlands, this line of thinking led to the installation of the "care

innovation" platform, aimed at speeding up innovations for better care by stimulating continuous "social innovation" by providers and investment in labour-saving technology, especially ICT and home automation (Ministerie van VWS, 2007).

However, technology is no cure for all. For instance, the use of remote monitoring may not lead to a substitution of labour for dementia-suffering clients and can raises ethical questions, for instance related to privacy (Depla *et al.*, 2010). Telemonitoring proved not to improve heart failure outcomes in a large trial study (Sarwat *et al.*, 2010). More generally, there is a dearth of scientific evidence on the cost-effectiveness of most technologies used in LTC settings, which often do not undergo randomised clinical trials, particularly in home-care settings (Rand Health, 2010).

6.6. Conclusions

As in most OECD countries the share of the LTC workforce is still relatively small, there seems to be growth potential for the sector in these countries. LTC can incorporate a share of the growing female labour-force participation because it offers flexible and part-time work, in line with preferences of many women. However, high turnover reflects the difficulties in retaining workers. Supporting these workers in their endeavours may not only serve the worker's goals but also those of the sector as a whole.

There are options to increase the size of the LTC workforce. Indeed, Germany and Japan, some of the fastest ageing countries in the OECD, managed to quickly expand LTC systems and LTC workforces. At the same time, an "old" country with a large LTC workforce, the Netherlands, prepares to meet shortages with a native-born LTC workforce by 2025.

The LTC sector faces a number of challenges linked to its workforce. In a context of ageing societies and growing demand for care, the LTC sector will compete with other labour market sectors for scarce manpower. Even though an oversupply of low-skilled workers is expected in some countries, for instance in Germany, given the increasing complexity of LTC recipients' statuses, more skills may be required in LTC. All of this may imply increased pressures to improve the sector and its attractiveness, while at the same time its image will be more deeply affected by the increasing prevalence of dementia.

The expected reliance on foreign-born care workers in some OECD countries may have consequences on the quality of care if measures aimed at workforce development do not reach foreign-born care workers, especially those who may aim to work in LTC on a temporary basis with little inclination to invest in an LTC career. Some may lack the language capabilities required to successfully participate in retention and professionalisation initiatives, especially if the complexities in LTC work increase.

Supporting care workers in their work and life and valuing them for what they do have clear and positive relevance for job satisfaction, turnover, and intention to stay. But such measures, as well as measures to address workforce shortages, are likely to increase the cost of LTC. This will put public expenditures which is already under increased fiscal pressure, under even higher strains.

The increasing diversity in modes of employment of the LTC workforce results in several challenges. One challenge is that in unregulated systems, cash benefits offer clear incentives for black labour. Another challenge relates to the question of how to integrate irregular – or black – workers, self-employed workers and family carers that received

remuneration out of cash-benefit programmes into LTC workforce programmes aimed at retention, quality enhancement and safety. A further issue relates to the quality of working conditions for these different groups.

Continued education and (on-the-job) training are widely used to support and retain care workers, but are primarily aimed at helping workers do their job better and are mostly not targeted at improving qualification levels or developing career options. On the other hand, cost, content and time required may all be hindrances for LTC workers to participate, while fear of exams is also observed. When educational efforts are not associated with better job prospects, they may have limited impact on participation, including the intent to stay in the sector, even when training is targeted to workers' needs and enables them to do their work better. A clear improvement in many countries could be through accreditation mechanisms, which can also improve the attractiveness of training. Continued education or training may serve both the employer's, and worker's needs. There is, however, no evidence about the actual value of accreditation of continued education related to LTC.

Work organisation and culture may require changes in many countries to better comply with worker's wishes and needs, while also better adjusting to the needs of the populations served. While such changes may be burdensome and sometimes difficult to achieve, there may be significant positive returns on investment in terms of job satisfaction, retention as well as quality of care.

If the current mode of production remains unchanged, many countries are likely to face challenges in meeting the future workforce requirements, especially in light of the reduction in the female "recruitment réservoir". This implies that recruitment efforts need to be improved and diversified, and that the current highly labour intensive mode of care production re-examined via, for example, improved productivity.

Notes

1. *www.neue_wege_fuer_jungs.de/Neue_Wege_fuer_Jungs/Das_Projekt* (German language only).
2. Many of these household workers can provide care.
3. *http://stats.oecd.org/Index.aspx?DatasetCode=INVPT_I*. In 2000, this share was 13%.

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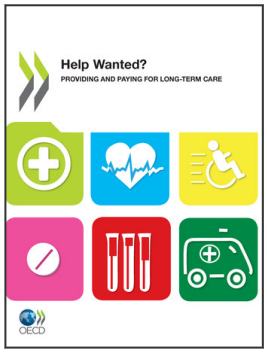

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