3 Tasks, qualifications and training of long-term care workers: reducing the skills gap

This chapter presents new analysis of the tasks and functions of long-term care (LTC) workers, providing a comparative overview of what workers do and how this varies across OECD countries. The tasks and knowledge required are compared with their training and education requirements to assess skills gaps. The chapter concludes by discussing policies to improve training and skills: both initial training and life-long learning.

3.1. A better skills match is needed

In many OECD countries, the LTC workforce cannot be identified clearly as part of the health workforce. LTC ranges from improving elderly people's physical and cognitive state to ensuring a better quality of life for vulnerable elderly people and those with chronic illnesses. The LTC workforce consists of a mix of professionals with different levels of training and skills, and different functions/tasks in both social and health care. Exploring the specific role of LTC workers and having a clear vision of their competencies and skills in each country is important when trying to understand the challenges faced by the LTC workforce, to learn from each country's experience and to design policies that meet the LTC needs of ageing populations now and in the future.

The three objectives of this chapter are: to provide a global and comprehensive view of LTC workers' tasks and functions in OECD countries, to explore current skills needs and training rules in the LTC workforce and to explore policy options to improve training participation and to address these needs. It tries to provide answers to several questions that need clarification: What are the specific tasks carried out by LTC workers? Do LTC workers have enough skills to perform these tasks? Do they have access to and participate in geriatric care training? What policies have been implemented to reduce potential gaps in workers' skills?

The remainder of the chapter is organised as follows. Section 3.2 maps LTC workers' tasks and functions, Section 3.3 explores training rules in the LTC workforce, Section 3.4 explores training policies to address the shortfall in skills and Section 3.5 provides a brief conclusion.

Key findings

- LTC jobs are more complex than often portrayed. In more than two-thirds of countries, personal care workers' tasks go well beyond activity of daily living provision. In more than three-quarter of countries, nurses working in the LTC sector perform case management tasks.
- Educational and training requirements for personal care workers are low. In most countries, almost anyone can become a personal care worker. Less than half of the surveyed countries require that personal care workers hold a minimum education level. Among those that do, the requirement varies from vocational training (Hungary, Latvia, Luxembourg, the Netherlands) to a high school certificate (Belgium and Sweden) or a technical qualification after high school (Canada (Ontario), Malta and Estonia after 2020). Very few countries (Canada, Denmark, Germany and Korea) have developed a career structure for LTC workers. This can be problematic when workers are asked to perform tasks beyond basic care, such as medication administration.
- Nurses usually have high education but do not necessarily participate in specialised geriatric care training. Nurses are required to hold a bachelor's degree in half of OECD countries, but only a few (Iceland, Israel, Estonia, Poland, and Sweden) include geriatric care training in the general curriculum, or require nurses to follow such training when working in the LTC sector. In more than half of the surveyed countries, there is no national curriculum for LTC nurses, and geriatric care training remains optional (participation rates can be low). Therefore, nurses in LTC may lack important knowledge in health care for specific conditions of elderly people, such as dementia or osteoporosis, and skills in rehabilitation and complex disease management.
- Geriatric care training participation for nurse students can be increased by sponsoring access to LTC education with the introduction of scholarships (Austria, Israel, and Japan), providing internship and mentorship opportunities (Canada and Korea) and development of "excellence

curricula" in LTC (Canada and Bulgaria), with new advanced professions for nurses (Ireland, Sweden, the Netherlands, the United Kingdom, and the United States).

- Increasing training participation, at least for some personal care workers, should help reaching the right mix of workers/competencies to LTC settings. On-the-job training participation among experienced workers could be increased with tailored learning programmes, financial support (Australia, Austria, Canada, Cyprus, Germany, Iceland, Korea, Latvia, Sweden, the United Kingdom and the United States), career progression perspectives and recognition of prior experience or learning (Australia, Denmark, France, Germany, Korea and the Netherlands).

3.2. While many tasks are low skilled, LTC jobs are more complex than often portrayed

Little is known about what LTC workers do across OECD countries when they provide care to elderly people. This section provides comprehensive mapping of their tasks and functions. It updates and expands previous analyses (Colombo et al., 2011[1]) using new information collected via an international survey specifically designed to map LTC workers' tasks and functions across 26 OECD countries (Box 3.1).

Box 3.1. LTC worker definition

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

This chapter uses data from an LTC workforce questionnaire and a pilot study. Twenty-six OECD countries participated in the LTC workforce questionnaire: Australia, Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Germany, Hungary, Iceland, Israel, Japan, Korea, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Romania, Slovenia, Sweden, the United Kingdom and the United States. The survey focused on several themes: the different tasks provided by LTC workers, the professions that carry out LTC tasks, opportunities for task delegation between professionals, opportunities for career progression and raising status, the specificity of standards and regulations for LTC workers and the initial training and qualification levels in these professions.

This chapter also uses data from O*NET, which is a primary source of occupational information in the United States. The O*NET database contains standardised and occupation-specific descriptors on almost 1 000 occupations, covering the entire US economy. Although focusing on US workers, the O*NET data provide relevant information for other countries. Prior evidence suggests that these data are useful to map skills in other countries such as the United Kingdom or New Zealand (Qian et al., 2012[2]).

Moreover, US workers' main tasks are comparable to those performed in other countries. Note, however, that despite some similarities, these data cannot be interpreted as a direct measure of personal care workers' situation in each country for two main reasons. First, the US system is very focused on institutional care. Workers in countries with greater home-based supply may have to deal with different problems, which could add to the skill set that they require. Second, care workers in countries where the mean length of stay is higher than in the United States could be dealing with more frail individuals or those with more complex needs, which may influence the range of tasks they are expected to cover.

3.2.1. Personal care workers perform several functions and tasks beyond basic care

Personal care workers' activities can cover four main functions (Figure 3.1): i) providing assistance with activities of daily living (ADL) such as getting dressed and feeding; ii) helping with elderly people's instrumental activities of daily living (IADL) such as cooking; iii) communicating with care recipients and their families; and iv) performing health care monitoring. In most countries, they are central actors in preventing elderly people's loss of autonomy. The most common tasks within each function are also listed and include maintaining elderly people's hygiene standards, monitoring their health status evolution and response to care, transporting them from their home to outside places and providing psychological support (mainly through discussion).

Figure 3.1. Basic care, monitoring and communication are the most common functions of personal care workers

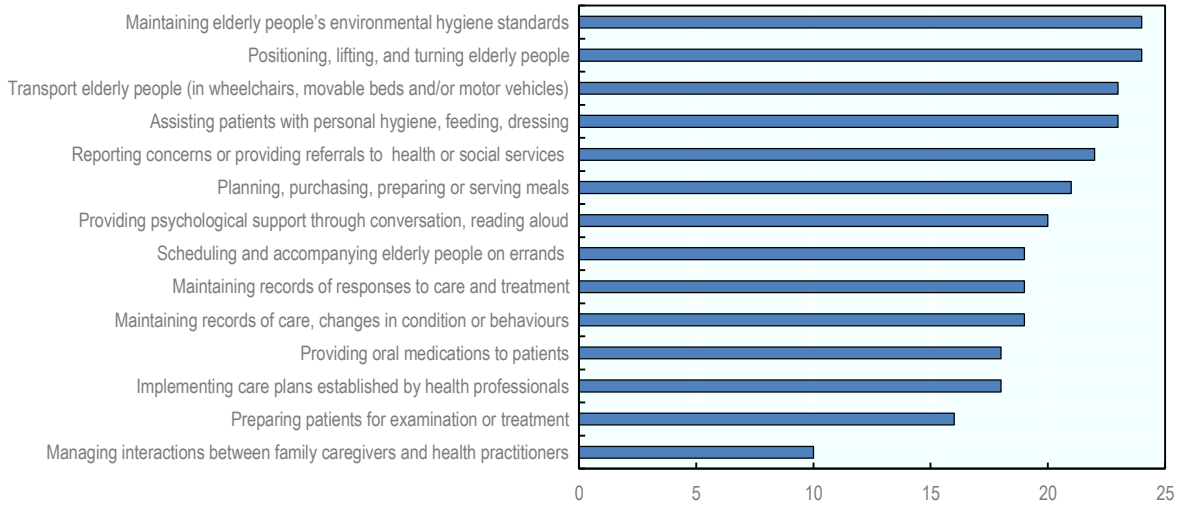
Personal care workers' functions and tasks

Note: The ranking of all tasks is provided in Figure 3.2. Each function (large circle) is followed by its two most common tasks (small circles).
Source: OECD LTC workforce survey (2018).

When investigating whether personal care workers' roles differ from one country to another, the ranking of tasks according to their frequency across the surveyed countries reveals three interesting results (Figure 3.2). First, personal care workers' main role across OECD countries is to provide basic care. The six most common tasks are centred on ADL and IADL provision. Helping elderly people perform their ADL represents the core of what personal care workers do. In most countries, this includes positioning, lifting and turning elderly people, transporting them (via wheelchairs, movable beds and/or motor vehicles) and assisting care recipients with personal hygiene, feeding and dressing. Another aspect of the job mostly involves maintaining environmental hygiene standards (e.g. changing bed linen, washing, cleaning), providing assistance with the planning, purchasing, preparing or serving of meals to meet nutritional requirements and prescribed diets, and accompanying elderly people on errands. Preparing care recipients for examination or treatment is a less common task that personal care workers provide; in some countries (Bulgaria, Estonia, Lithuania, Norway and the United States), they are not allowed to administer medications. Prior empirical work in Australian nursing homes shows that these activities represent more than half of personal care workers' total working time (Qian et al., 2012[2]).

Figure 3.2. Most common tasks of personal care workers involve hygiene, lifting and transporting elderly people

Ranking of personal care workers' tasks



Source: OECD LTC workforce survey (2018).

Second, personal care workers actively collaborate with health care professionals, and this activity is a major component of their role in over 90% of surveyed countries. While they usually do not provide health care *per se*, personal care workers are involved in monitoring care recipients' health status. In almost all surveyed countries, they are in charge of reporting concerns about the care recipient's condition and (when possible) providing referrals to a health or social services professional. They compare the care recipient's evolution to a benchmark of healthy ageing – monitoring, for instance, weight loss or appetite loss, which are usually the first signs of frailty issues. In many countries, they can actively participate in the implementation of care plans designed by health care professionals. They may also have to maintain records of care, responses to care and treatment, and changes in condition or behaviours in many countries. This can involve locating care recipients' records, taking photos of elderly people, viewing results and identifying situations of distress. Being able to distinguish situations needing urgent health care assistance from non-urgent situations is therefore an important skill they need to master. In almost 40% of countries, personal care workers directly manage interactions between family caregivers and health practitioners. Empirical analyses show that in Australia documentation of activities and infection control together represent close to 10% of personal care workers' daily working time (Qian et al., 2012[2]).

Third, 80% of countries report that one of personal care workers' key tasks is communicating with elderly people and their families. In LTC provision, verbal communication is tremendously important to understand people's expectations, culture and habits, to stimulate them and to prevent their social isolation (which can be a risk factor for health deterioration). Communication between LTC workers and informal caregivers is also central for disabled elderly people, who often use a mixture of formal and informal care (Brunel, Latourelle and Zakri, 2018[3]; Bonsang, 2009[4]; Rapp et al., 2011[5]). Providing psychological support through conversation is a common task reported for personal care workers.

Two different models of personal care provision seem to emerge from an international comparison of the specific tasks provided (Table 3.1):

- A few countries seem to strictly limit the range of personal care workers' tasks. This is the case in Norway and Israel, where tasks mostly involve ADL support provision and verbal communication.

- Meanwhile, a larger group of countries (including, for instance, Canada, Korea, Japan, Belgium, Sweden and the Czech Republic) report that personal care workers perform all the listed tasks, and seem to have developed a model of LTC provision where they play a more comprehensive role. In Sweden, for instance, they commonly provide medications. In Korea and Japan, they may even act (and be considered) as case managers: professionals able to aggregate all the micro-services gravitating around elderly people (such as transportation, meals-on-wheels and so on).

Table 3.1. In most countries, personal care workers' tasks are diverse

	Positioning, lifting and turning elderly people	Transporting elderly people (via wheelchairs, movable beds and/or motor vehicles)	Assisting care recipients with personal hygiene, feeding and dressing	Maintaining elderly people's environmental hygiene standards	Planning, purchasing, preparing or serving meals	Scheduling and accompanying elderly people on errands	Preparing care recipients for examination or treatment	Providing oral medications to care recipients	Providing psychological support through conversation and reading aloud	Managing interactions between family caregivers and health practitioners	Maintaining records of care and changes in condition or behaviour	Maintaining records of responses to care and treatment	Reporting concerns or providing referrals to health or social services	Implementing care plans established by health professionals
Australia	●	●	●	●	●	●		●	●		●	●	●	●
Austria	●	●	●	●	●	●		●	●		●	●	●	●
Belgium	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Bulgaria	●	●		●			●							
Canada	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Cyprus	●	●	●	●	●	●	●	●	●				●	●
Czech Republic	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Estonia	●	●	●	●	●	●	●				●	●	●	●
Germany	●	●	●	●		●	●		●		●	●	●	●
Hungary	●	●	●	●	●	●		●	●		●	●	●	
Iceland	●	●	●	●	●	●	●	●	●		●	●	●	●
Israel	●	●	●	●	●	●								
Japan	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Korea	●	●	●	●	●	●		●	●		●	●	●	●
Latvia			●	●	●			●			●	●	●	
Lithuania	●	●	●	●	●				●				●	
Luxembourg	●	●	●	●			●	●	●	●	●	●	●	●
Malta	●	●		●	●		●	●	●				●	●
Netherlands	●		●		●	●	●	●	●	●	●	●	●	●
Norway	●	●	●	●					●					
Romania	●	●	●	●	●	●	●	●		●	●	●	●	●
Slovenia	●	●	●	●	●	●	●	●	●	●	●	●	●	
Sweden	●	●	●	●	●	●	●	●	●	●	●	●	●	●
United Kingdom	●	●	●	●	●	●		●	●	●	●	●	●	●
United States	●	●	●	●	●	●	●		●		●	●	●	●

Note: Poland did not provide information for personal care workers. Dots indicate that personal care workers commonly provide the task.
Source: OECD LTC workforce survey (2018).

3.2.2. Nurses providing LTC are often involved in care co-ordination

Among nursing professionals, LTC can be perceived as less technical than hospital care and less attractive. However, evidence suggests that this perception of the role of nurses in LTC is under-rated, as it can involve complex functions and tasks. Figure 3.3 summarises what nurses do in most OECD countries when they work in the LTC sector. Nurses in LTC are in charge of four main functions: health care provision, health care monitoring, care co-ordination and communication with families. The bulk of nurses' tasks involve providing health care, including medication administration and health status monitoring. They also show the importance of teamwork, as nurses often have to implement care plans and supervise/evaluate the work provided by other staff. Reporting tasks usually require after-hours telephone communication with off-site physicians, during which nurses have to describe patient-related issues to physicians who often lack physical access to the patient and are not fully aware of their medical history (Whitson et al., 2008[6]).

These functions demand soft skills, such as being competent in social and interpersonal relations. They also require specific geriatric care expertise, such as understanding the LTC system as a whole and being able to identify the relevant service providers. In many countries, nurses providing LTC can act as case managers. Their role covers two of its most important aspects (as perceived by both elderly people and nurses): care co-ordination and provision of assistance in accompanying old people.

Figure 3.3. Beyond care provision, monitoring, care co-ordination and communication are also key functions for nurses

Nurses' functions and tasks when providing LTC

Note: the ranking of all tasks is provided in Figure 3.4. Each function (large circle) is followed by its two most common tasks (small circles)
Source: OECD LTC workforce survey (2018).

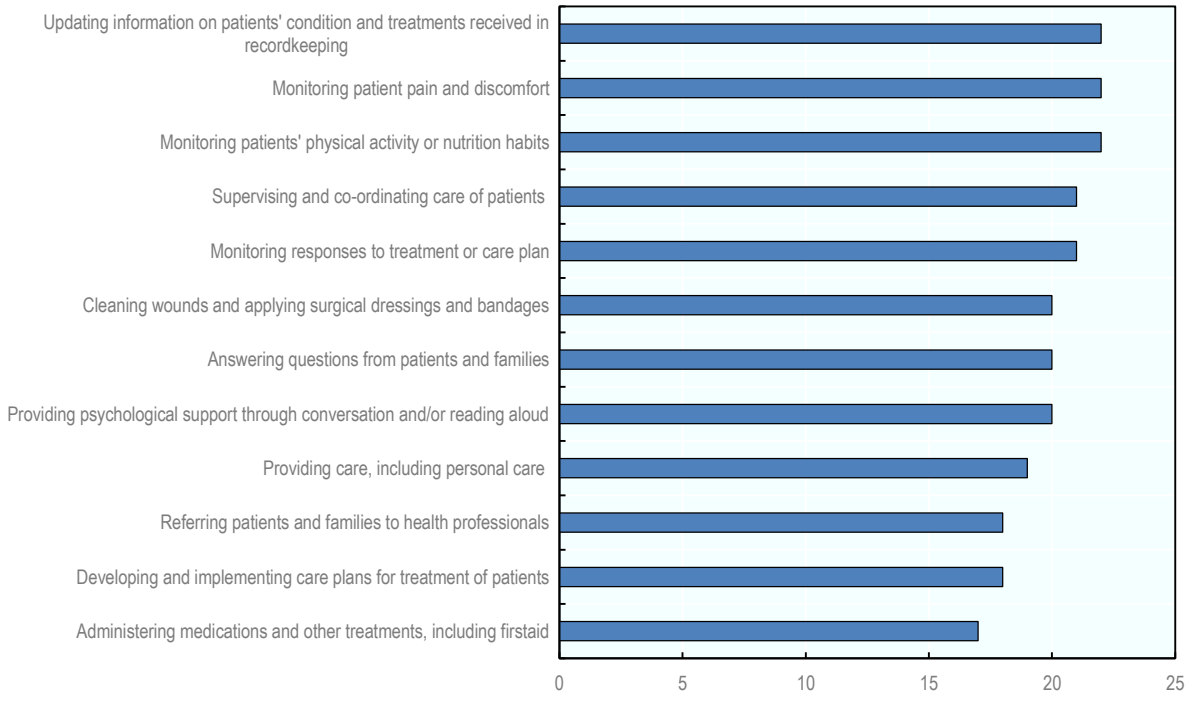
The ranking of nurses' tasks according to their frequency across OECD countries (Figure 3.4) shows two additional results. First, nurses may have less autonomy to provide medical treatments in some countries. While health care provision is also a key aspect of their job, it mostly involves cleaning wounds and applying surgical dressings and bandages. Again, countries have specificities. In Bulgaria and Lithuania, wound care is one of the main health care tasks provided by nurses, while Korean and Slovenian nurses are not supposed to perform this specific task. Administering medications is not a task performed by nurses in many eastern Europe countries (Bulgaria, Hungary, Lithuania and Slovenia) or Australia. Provision of

treatment and personal health care is more frequent when included in a care plan that the nurse has to follow. Most of the role involves management of multiple comorbidities.

Second, the ranking confirms that nurses play a central role in care co-ordination in most OECD countries, often bridging health and social care provisions. Their common activities are associated with the updating, monitoring and record-keeping of care recipients' health status; co-ordination and supervision of care recipients' care plans; and interactions with care recipients, family caregivers, care providers and health care professionals. Care following hospital discharge needs specific monitoring and communication with hospital teams. Supervising and co-ordinating care recipients' care along with other health care and social care professionals is the most frequent co-ordination task provided by nurses (it is found in 19 countries). In Sweden, for instance, registered nurses provide continuous control of elderly people's adherence to pharmaceutical treatments, and act as "vigilant intermediaries" between physicians and pharmacists (Johansson-Pajala et al., 2016[7]).

Figure 3.4. Most common tasks for nurses include health monitoring and co-ordinating care

Ranking of nurses' tasks when providing LTC



Source: OECD LTC workforce survey (2018).

It also appears that the role of nurses in LTC across OECD countries is more homogeneous than that of personal care workers (Table 3.2). Nevertheless, case management tasks seem to be undertaken less frequently in eastern Europe countries. Nurses do not provide care co-ordination support in Bulgaria, they do not participate in referrals of care recipients in Hungary, Lithuania or Romania and they are not in charge of developing or implementing care plans in the Czech Republic, Latvia or Slovenia. Note, however, that the definition and scope of the role can change if LTC reforms are implemented. In Germany, for instance, a change in needs assessment in 2017 led to a change in definition of what constitutes care, which has significant implications for the workforce. While before workers were focused on individual actions to be completed, a more comprehensive approach to care should now encourage workers to make full use of their competencies and think of what can be done to improve autonomy and self-reliance for the care recipient. Nurses can now act on a care plan rather than completing a number of set tasks, which makes better use of their qualifications.

Table 3.2. Nurses' tasks show little variation across OECD countries

	Providing psychological support through conversation and/or reading aloud	Answering questions from care recipients and families	Monitoring responses to treatment or a care plan	Monitoring care recipients' physical activity or nutrition habits	Monitoring care recipients' pain and discomfort	Updating information on care recipients' condition and treatments received in record-keeping	Developing and implementing care plans for treatment of care recipients	Referring care recipients and families to health professionals	Supervising and co-ordinating care of care recipients	Administering medications and other treatments, including first aid	Cleaning wounds and applying surgical dressings and bandages	Planning and providing care, including personal care
Australia	●	●	●	●	●	●	●	●	●		●	●
Austria	●	●	●	●	●	●	●	●	●	●	●	
Bulgaria	●	●	●	●	●	●					●	
Canada	●	●	●	●	●	●	●	●	●	●	●	●
Cyprus	●	●	●	●	●	●	●	●	●	●	●	●
Czech Republic	●	●		●	●	●		●	●	●	●	●
Estonia	●	●	●	●	●	●	●	●	●	●	●	●
Germany	●	●	●	●	●	●	●	●	●	●	●	●
Hungary	●	●	●	●	●	●	●		●		●	●
Iceland	●	●	●	●	●	●	●	●	●	●	●	●
Israel	●	●	●	●	●	●	●	●	●	●	●	●
Korea	●	●	●	●	●	●	●	●	●	●		●
Latvia	●	●	●	●	●	●		●	●	●	●	●
Lithuania	●		●	●	●	●	●		●		●	
Luxembourg	●	●	●	●	●	●	●	●	●	●	●	●
Malta		●	●	●	●	●	●	●	●	●	●	●
Netherlands	●	●	●	●	●	●	●	●	●	●	●	●
Norway	●	●	●	●	●	●	●	●	●	●	●	●
Poland	●	●	●	●	●	●	●	●	●	●	●	●
Romania			●	●	●	●	●		●	●	●	●
Slovenia	●	●	●	●	●	●		●	●			
Sweden	●	●	●	●	●	●	●	●	●	●	●	●
United Kingdom	●	●	●	●	●	●	●	●	●	●	●	●
United States	●	●	●	●	●	●	●	●	●	●	●	●

Note: Japan did not provide information for nurses. Dots indicate that personal care workers commonly provide the task.
Source: OECD LTC workforce survey (2018).

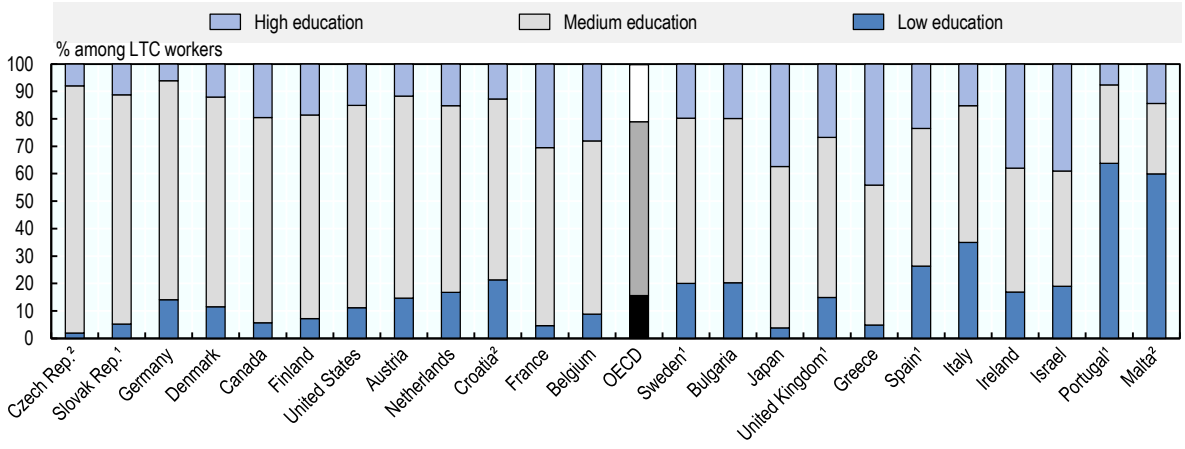
3.3. Current training requirements may not always ensure care quality

3.3.1. Education and initial training requirements are low for personal care workers

A majority of LTC workers hold upper secondary educational qualifications or equivalent (medium education level) across OECD countries (63%). Across OECD countries, 63% of LTC workers have a high school diploma or attended vocational schools, while 16% have lower education and 21% higher education. In Canada and the United States, over 74% of LTC workers have a medium education level (see Figure 3.5). In Greece, Israel, Ireland and Japan, a higher share of LTC workers have high education levels, at around 40% or more.

Figure 3.5. Most LTC workers hold high school diplomas or vocational degrees

Composition of the LTC workforce, by education level, in 2016 (or nearest year)

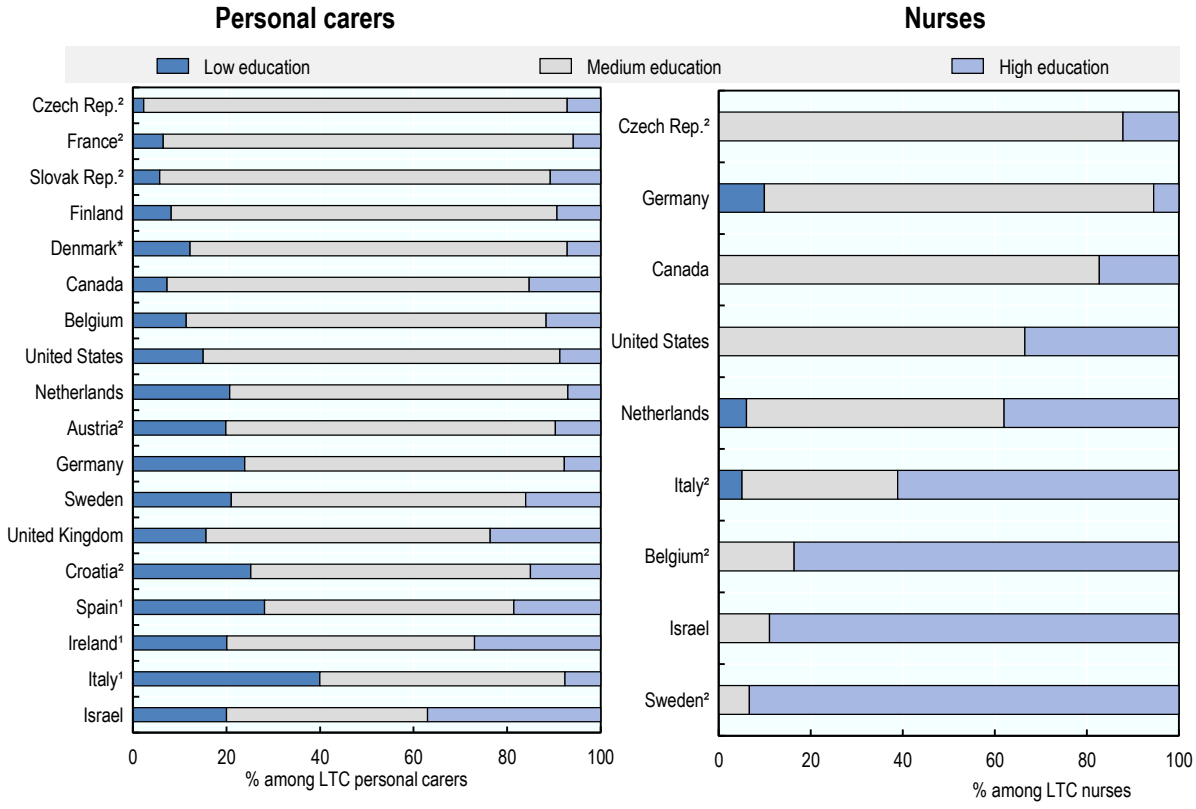


Note: The OECD data point is the unweighted average of the 21 countries shown in the chart. Education was categorised in three groups that follow international standard classification of education (ISCED) 99 code. Low education corresponds to a lower secondary education (ISCED 0-2), medium education 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). EU-Labour Force Survey data are based on the International Standard Classification of Occupations (ISCO) 4-digit codes and the Nomenclature Statistique des Activités Économiques dans la Communauté Européenne (NACE) 2-digit codes. For a detailed description of the data sources, see Annex 2.A in Chapter 2.
1. Data were calculated based on ISCO 3-digit and NACE 2-digit codes. 2. Data must be interpreted with caution, as sample sizes are small.
Source: EU-Labour Force Survey; the Annual Social and Economic Supplement of the Current Population 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 refer to 2016 or nearest year.

The lower education levels among personal care workers drive down the overall LTC workforce's education level on average across OECD countries, since they represent the largest component of LTC workers in most countries. Figure 3.6 provides a comparison of the average education levels between nurses and personal care workers. Not surprisingly, nurses have higher education levels than personal care workers: almost half of nurses have high education levels. In contrast, almost 70% of personal care workers have medium levels of education and 17% have low education levels. The education differences between nurses and personal care workers are particularly large in some countries. In Sweden and Belgium, for instance, more than 80% of nurses participating in the LTC workforce have a high education, compared to less than 20% of personal care workers.

The educational levels of nurses in the LTC sector do not seem to be different from those of nurses working outside the sector (OECD, 2016[8]). Therefore, there does not seem to be selection into LTC among nurses, who receive standard nursing education before joining the LTC workforce.

Figure 3.6. Personal carers are more likely to have lower education levels than nurses



Note: Education was categorised in three groups that follow ISCED-99 code. Low education corresponds to a lower secondary 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). The number of countries is reduced for nurses because data for most countries were not reported as their sample sizes were too small. EU-Labour Force Survey data are based on the ISCO 4-digit codes and NACE 2-digit codes. For a detailed description of the data sources, see Annex 2.A in Chapter 2.
1. Data were calculated based on ISCO 3-digit and NACE 2-digit codes. 2. Data must be interpreted with caution, as sample sizes are small.
Source: EU-Labour Force Survey; ASEC-CPS for the United States; Census 2016 for personal carers and Health Workforce Database, Canadian Institute for Health Information for nurses for Canada; Labour Force Survey for Israel. Data refer to 2016 or nearest year.

Initial training policies for personal care workers are diverse

Minimum qualification requirements offer the guarantee that staff have sufficient knowledge, skills and competencies to provide care to frail elderly people. However, in most countries, almost anyone can become a personal care worker (Table 3.3). Indeed, less than half of the surveyed countries require personal care workers to hold a minimum education level. Among those that do, it varies from vocational training (Hungary, Luxembourg, the Netherlands and Latvia) to a high school diploma (Belgium and Sweden) or a technical degree after high school (Canada, Malta and Estonia after 2020). Conversely, nurses are required to hold high education levels (such as a bachelor's degree) in half of countries.

Table 3.3. Requirements for personal carers are low

LTC workers' minimum education requirements

Personal care workers	Nurses in the LTC sector
No minimum education level (Australia, Bulgaria, Czech Republic, Iceland, Israel, Japan, Korea, Norway, Romania, Slovenia, United Kingdom, United States) **High school diploma** (Belgium, Portugal, Sweden) **Technical degree after high school** (Austria, Canada, Estonia (after 2020), Malta) **Primary or intermediate vocational training** (Hungary, Latvia, Luxembourg, Netherlands) **Other** (40 hours of training in Lithuania, basic knowledge of Greek language in Cyprus, caregiver course/training in Croatia. In Germany, provided that the training for nursing assistants meets the mutually agreed minimum requirements of the federal states, a secondary school leaving certificate (nine-year general education) is a prerequisite for admission.)	**High school diploma** (Croatia) **Technical degree after high school** (Bulgaria, Canada, Hungary, Korea, Latvia, Luxembourg, Poland, Romania, United States) **Intermediate vocational training** (Netherlands) **Bachelor's degree** (Australia, Austria, Cyprus, Czech Republic, Estonia, France, Iceland, Israel, Malta, Norway, Slovenia, Sweden)

Note: Only countries that provided answers to this question are included in the table. Poland did not provide information for personal care workers. Lithuania, Portugal and the United Kingdom did not report training requirements for nurses in LTC.
Source: OECD LTC workforce survey (2018).

Many countries require initial training programmes for personal care workers but there is quite a lot of heterogeneity in the requirements. Training rules and organisation can differ according to the LTC setting (home-based, institution-based) or job title (e.g. nurse aide, social carer). Training often targets institution-based personal care workers, and training participation is often not mandatory for home-based workers. In Canada (Ontario), for instance, training is mandatory only for personal carers working in LTC homes. In the United States, Medicare/Medicaid-certified home health aides must receive 75 hours of training, usually provided by the agency that employs them. Training content and length vary greatly by state. The absence of consistent training for home care aides is observed even when they are paid by public programmes (Spetz and Dudley, 2019[9]). In Sweden, personal care workers can follow a three-year high school professional programme financed by public taxation. In Bulgaria, personal care workers are not obliged to pass or follow any training programme in elderly care, but training opportunities are provided by the National Agency for Vocational Education and Training. In Iceland, personal care workers can receive education or training specific to LTC. Courses take 2-3 months, part time alongside work. For social care workers, formal LTC education usually takes 2 years; for nurse aides, it usually takes 3-4 years. In Korea, a person without any job experience or licence can follow 240 hours of training, involving classroom learning (80 hours), practice sessions (80 hours) and on-the-job training (80 hours).

Less than half of the surveyed countries (Australia, Austria, Belgium, Canada (Ontario), Cyprus, Germany, Korea, Slovenia and the United States) require personal care workers to pass or hold a licence or a certification showing that they have the basic competencies and skills to work in health care and social services for elderly people. Table 3.4 provides examples of the situation in Canada, Romania, Korea, Belgium and the United Kingdom. Both government agencies and private institutions can be involved in the certification process. While the nature of the LTC job (which mainly remains low skilled) is such that many tasks do not require certification, certificates can offer some guarantees, not only for clients but also for workers, in terms of salary.

Table 3.4. Some countries provide certification for personal care workers

	Entities controlling and granting certification	Entities providing training for certification	Specific rules
Canada (Ontario)	Ministry of Training, Colleges and Universities, the National Association of Career Colleges, Ontario Community Support Association	LTC programmes for personal care workers offered in publicly funded colleges, private career colleges and as part of high school continuing education programmes	Ontario introduced a comprehensive mandatory personal support worker registry to ensure greater public protection and personal care worker accountability. Every licensee of an LTC home should ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker programme that meets specific requirements. The registry only accepts workers who are deemed qualified to provide competent and safe care.
Romania	Ministry of Education, Ministry of Labour and Social Justice, and National Authority for Qualification, Order of Generalist Medical Assistants, Midwives and Medical Assistants	Private providers, employers	In Romania, while formal education is required to obtain certification of skills, caregivers in residential centres are not legally required to obtain specific certification before being hired. However, nursing aides have to obtain certification. Employers have to draw up an instructional and professional education plan for their employees, and must offer and facilitate training on a regular basis.
Belgium	Ministry of Employment of the region	Private providers, employers	Flanders has introduced minimum qualification requirements controlled by the region to be registered as a personal care worker. In Wallonia, the Ministry of Employment of the region provides registration and employers provide continuing training programmes.
Korea	Head of local government (metropolitan city mayor or do governor)	Licensed personal care worker education institutions	Different levels of training are often offered, ranging from basic to professional qualification training. The head of local government is in charge of checking that sufficient job training has been received before issuing the personal care worker certificate.
United Kingdom (England)	Care Certificate for National Vocational Qualification	Private providers, employers	The care certification is an entry-level certificate. Personal care workers have opportunities to develop and take further qualifications, varying according to the worker's profile and job role.

Source: OECD LTC workforce survey (2018).

3.3.2. Skills required are not necessarily guaranteed through initial LTC training

While the bulk of LTC work involves ADL (such as dressing, bathing, cooking) support and does not require a high level of training, some basic tasks (like, for instance, administering food) can become complex and require training when disabled elderly people have severe conditions (such as dementia). Analysis from O*NET based on US occupational data shows the top abilities, skills and knowledge required, and records the rating out of 100 for the importance given to each by employers, as well as level required to perform the occupation. For instance, it is important to employers that personal care workers are able to communicate verbally with others (importance of 69), but they are only required to have average levels (52) of communication abilities (Table 3.5).

Table 3.5. Personal care workers' top ability needs are comprehension and communication

Ability	Description	Importance (level)
Oral comprehension	The ability to listen to and understand information and ideas presented through spoken words and sentences	69 (52)
Oral expression	The ability to communicate information and ideas in speaking so others will understand	66 (48)
Problem sensitivity	The ability to tell when something is wrong or is likely to go wrong: this does not involve solving the problem, only recognising that there is a problem	63 (43)
Written comprehension	The ability to read and understand information and ideas presented in writing	53 (43)
Deductive reasoning	The ability to apply general rules to specific problems to produce answers that make sense	53 (43)
Near vision	The ability to see details at close range (within a few feet of the observer)	53 (43)
Written expression	The ability to communicate information and ideas in writing so others will understand	50 (41)
Inductive reasoning	The ability to combine pieces of information to form general rules or conclusions (includes finding a relationship among seemingly unrelated events)	50 (43)
Information ordering	The ability to arrange things or actions in a certain order or pattern according to a specific rule or set of rules (e.g. patterns of numbers, letters, words, pictures, mathematical operations)	50 (41)

Note: the data were collected in the United States, but strong similarities exist for other OECD countries. Since they are key LTC providers, this table focuses on personal and home care aides. This description targets workers whose job consists of assisting elderly people, convalescents or people with disabilities with ADL at the person's home or in a care facility. A score of 100 shows extreme importance or level requirement for the item, a score of 75 shows high importance/level, a score of 50 shows average importance/level, and a score of 25 shows below-average importance/level.
Source: O*NET data online accessed June 2019, https://www.onetonline.org/link/details/39-9021.00.

Similarly, social orientation and social perceptiveness skills are the two most important skills personal care workers need to have, but only average and below-average levels of these skills are required (Table 3.6). For several other skills of lower importance (e.g. decision-making and time management), below-average levels are required.

Table 3.6. Social and interpersonal skills are in demand for personal carers

Skill	Skill description	Importance (level)
Service orientation	Actively looking for ways to help people	72 (54)
Social perceptiveness	Being aware of others' reactions and understanding why they react as they do	66 (45)
Active listening	Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate and not interrupting at inappropriate times	63 (41)
Speaking	Talking to others to convey information effectively	56 (41)
Monitoring	Monitoring/assessing performance of yourself, other individuals or organisations to make improvements or take corrective action	53 (45)
Critical thinking	Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems	50 (43)
Co-ordination	Adjusting actions in relation to others' actions	50 (41)
Instructing	Teaching others how to do something	50 (34)
Judgement- and decision-making	Considering the relative costs and benefits of potential actions to choose the most appropriate one	50 (36)
Time management	Managing one's own time and the time of others	50 (37)

Note: the data were collected in the United States, but strong similarities exist for other OECD countries. Since they are key LTC providers, this table focuses on personal and home care aides. This description targets workers whose job consists of assisting elderly people, convalescents or people with disabilities with ADL at the person's home or in a care facility. A score of 100 shows extreme importance or level requirement for the item, a score of 75 shows high importance/level, a score of 50 shows average importance/level and a score of 25 shows low importance/level.
Source: O*NET data online accessed June 2019 https://www.onetonline.org/link/details/39-9021.00.

Finally, while it is important that personal care workers have knowledge of customer and personal service provision, they are only required to have average levels of needs assessment, quality standards for services and evaluation of customer satisfaction (Table 3.7).

Table 3.7. Customer service, language and psychology are the top knowledge requirements for personal carers

Knowledge	Knowledge description	Importance (level)
Customer and personal service	Knowledge of principles and processes for providing customer and personal services, including customer needs assessment, meeting quality standards for services and evaluation of customer satisfaction	74 (59)
Language	Knowledge of the structure and content of the English language, including the meaning and spelling of words, rules of composition and grammar	58 (39)
Psychology	Knowledge of human behaviour and performance; individual differences in ability, personality and interests; learning and motivation; psychological research methods; and the assessment and treatment of behavioural and affective disorders	50 (48)
Administration and management	Knowledge of business and management principles involved in strategic planning, resource allocation, human resources modelling, leadership technique, production methods and co-ordination of people and resources	48 (29)
Transportation	Knowledge of principles and methods for moving people or goods by air, rail, sea or road, including the relative costs and benefits	43 (26)
Education and training	Knowledge of principles and methods for curriculum and training design; teaching and instruction for individuals and groups; and the measurement of training effects	42 (33)
Medicine	Knowledge of the information and techniques needed to diagnose and treat human injuries, diseases and deformities, including symptoms, treatment alternatives, drug properties and interactions, and preventive health care measures	40 (24)
Public safety and security	Knowledge of relevant equipment, policies, procedures and strategies to promote effective local, state or national security operations for the protection of people, data, property and institutions	40 (27)
Mathematics	Knowledge of arithmetic, algebra, geometry, calculus, statistics and their applications	37 (25)
Therapy and counselling	Knowledge of principles, methods and procedures for diagnosis, treatment and rehabilitation of physical and mental dysfunctions, and for career counselling and guidance	36 (30)

Note: the data were collected in the United States, but strong similarities exist for other OECD countries. Since they are key LTC providers, this table focuses on personal and home care aides. This description targets workers whose job consists of assisting elderly people, convalescents or people with disabilities with ADL at the person's home or in a care facility. A score of 100 shows extreme importance or level requirement for the item, a score of 75 shows high importance/level, a score of 50 shows average importance/level, and a score of 25 shows below-average importance/level.
Source: O*NET data online accessed June 2019 https://www.onetonline.org/link/details/39-9021.00.

It is not clear whether the levels of competency requirements are always sufficient to ensure the quality of LTC provision. The absence of minimum education requirements may not be a problem across all staff, as the bulk of personal care workers' roles involve low-skilled tasks. However, the absence of minimum qualifications could be of concern when workers are allowed to perform specific tasks that require a higher level of expertise and knowledge. Several factors may lead to the importance and level requirements of some of these competencies increasing in the future.

First, elderly people's disabilities may increase with population ageing. LTC provision can become complex for the most disabled elderly people, creating issues when workers lack competencies. This is, for instance, the case when personal care workers provide support to frail elderly people receiving palliative care or need to talk about death with care recipients, their informal care providers and other staff. It can represent an important part of the job, for which they often lack knowledge (Kaasalainen, Brazil and Kelley, 2014[10]). Even some of the most basic tasks (for instance, administering food to elderly people) can become complex and require more advanced competencies when disabled elderly people have severe conditions, such as dementia. LTC workers are likely to face situations requiring higher levels of competency. For instance, carers who deliver home-based care or work on night shifts must be prepared to manage stressful

situations on their own, as events such as falls, fugues and strokes are common issues faced by disabled elderly people. Low levels of competency may be problematic when workers need to identify risks and reduce hazards in their daily jobs, especially when they have to provide care in dementia wards.

Substantial dementia training is rarely included in the minimum training requirements for care staff (OECD, 2018[11]). Although many OECD countries offer voluntary dementia-specific training programmes tailored for or including professional care staff, few countries have dementia-related requirements for training. Many people in care facilities have or will develop dementia, and may display behaviours that are challenging or risky to themselves and the people who care for them. Knowing how to manage these behaviours is crucial to providing high-quality and safe care, for both people with dementia and their carers.

Second, recent evidence suggests the need to raise workers' awareness about basic issues that can have dramatic consequences for frail elderly people. For instance, almost two-thirds of LTC workers surveyed in a large French study declared that they never get a flu shot (Truchot, 2018[12]), although flu can lead to serious health complications among frail and disabled elderly populations. A lack of knowledge of these consequences could be detrimental for the most disabled elderly people.

Third, personal care workers often have to handle many medical devices to manage specific issues that frail elderly people may encounter in their daily lives: back problems, muscular pain, hearing impairment issues, respiratory conditions, vascular issues and so on. Currently, many of these devices (bedpans, canes, back braces etc.) do not require advanced competencies, but the use of oxygen delivery equipment, automatic blood pressure machines or hearing aid devices can require more advanced abilities, skills and knowledge to guarantee their safety and/or effectiveness. The fact that personal care workers are only required to have lower levels of public safety and security knowledge may raise an issue that could grow in the future with the flow of more complex technological innovations in ageing care (discussed in Chapter 6).

Finally, the absence of minimum qualifications and the low levels of competency among personal care workers could be of concern when they are allowed to perform specific tasks that require higher levels of expertise and knowledge. For instance, some countries (Australia, the Czech Republic, Japan, Korea and the United Kingdom) have no educational requirements for personal care workers, even though they commonly allow them to provide oral medication, maintain records of care and treatment, and implement care plans. This may indicate a potential need for training to increase the level of competency among personal care workers involved in these tasks.

Table 3.8. Personal care workers are asked to use many technical tools

Category
Back or lumbar or sacral orthopaedic soft goods
Bedpans for general use
Blood pressure cuff kits
Braille devices for physically challenged people
Canes or cane accessories
Crutches or crutch accessories
Electric vibrators for rehabilitation or therapy
Electronic blood pressure units
Electronic medical thermometers
Glucose monitors or meters
Hearing aids for physically challenged people
Lower extremity prosthetic devices
Medical acoustic stethoscopes or accessories
Oxygen therapy delivery system products, accessories or supplies
Paging controllers
Patient bed or table scales for general use
Patient lifts or accessories
Patient shifting boards or accessories
Shower or bath chairs or seats for physically challenged people
Specimen collection containers
Mobile operating system and touchscreen display
Upper extremity prosthetic devices
Vascular or compression apparel or supports
Voice synthesisers for physically challenged people
Walkers or rollators

Note: the data were collected in the United States, but strong similarities exist for other OECD countries. Since they are key LTC providers, this table focuses on personal and home care aides. This description targets workers whose job consists of assisting elderly people, convalescents or people with disabilities with ADL at the person's home or in a care facility.
Source: O*NET data online accessed June 2019, https://www.onetonline.org/link/details/39-9021.00.

Nurses sometimes lack sufficient geriatric training

In most countries, nurses usually have high education, with several years of training in general nursing, but they do not necessarily have to participate in specialised geriatric care training. Therefore, they may lack some of the specific skills needed in LTC. Given the tasks provided by nurses, training programmes increasingly need to focus on several new aspects of LTC provision: using telemedicine and eHealth, performing preventive actions (especially concerning nutrition) and developing networking skills (in particular to accommodate informal caregivers' needs). In the LTC sector, good knowledge of complex geriatric conditions, caring needs following hospital discharge, case management, bereavement coping and prevention is crucial.

Prior work underlines the need to develop age-appropriate care for chronic diseases in the elderly population (dementia, stroke, chronic obstructive pulmonary disease and vision impairment), with more effective primary, secondary and tertiary prevention targeting older people (Prince et al., 2015[13]). In addition, the increasing prevalence of frailty requires development of screening measures to detect and monitor frailty risks in the elderly population and disability risks in the frail elderly population (Clegg et al., 2013[14]). Nurses can play a major role in improving care recipients' health literacy on important issues, such as flu vaccination for the elderly population (Ellen, 2018[15]). These issues are likely to increase geriatric training needs.

Palliative care issues are not usually taught in general nurse training, while LTC workers increasingly need to master these skills. Palliative care involves discussions with care recipients, their family members and formal caregivers to promote a positive perspective on death (Kaasalainen et al., 2013[16]). Prior work suggests that LTC workers do not always have sufficient knowledge to provide end-of-life care, which usually requires advanced training (Carlson and Bengtsson, 2014[17]).

Finally, it is expected that future LTC reforms will change nurses' roles, requiring further skills. As healthy ageing becomes a policy priority in many countries (see Chapter 6), nurses will increasingly have to learn how to evaluate the overall efficacy of the care provided to elderly people, using evidence-based outcomes, such as changes in grip strength loss, body mass index or walking speed, and signs of exhaustion. They will also have to learn how to monitor and assess the level of burden among family caregivers, to evaluate the risks of emergencies within informal care networks.

Only a few countries include geriatric care training in general nursing curricula, or require nurses to follow such training when working in the LTC sector. In Iceland, training programmes in geriatric care are part of the basic education for all nurses. In Israel, registered nurses receive post-basic one-year training in geriatrics, after which they have to pass a simulation-based registration exam. In Sweden, there is a general university degree for nurses, but students have to choose a specialisation (postgraduate diploma in specialist nursing) in special care for elderly people when they work in LTC. In Estonia, nurses have to spend at least 60 hours per year on training specialising in geriatric care when working in the LTC sector. In Poland, depending on the form of postgraduate education, the time allocated to geriatric care training varies between 1 and 20 months. In Malta, at present, a general degree in nursing is sufficient, but a new degree in LTC nursing has been launched, and it is expected that this will be required in the future to become an LTC nurse.

Most countries offer the option of a geriatric care specialisation for nurses during initial training. In more than half of the surveyed countries (Australia, Bulgaria, Canada, Croatia, Hungary, the Czech Republic, Luxembourg, Cyprus, Latvia, Korea, Portugal, Slovenia, Estonia, Iceland, the United States, the Netherlands and Norway), there is no national curriculum for LTC nurses, and geriatric care training remains optional. In these countries, it is therefore not guaranteed that nurse graduates working in the LTC sector have had any geriatric care training. Recent evidence suggests that participation rates can be low. For instance, a recent survey of a sample of Norwegian nurses showed that less than a quarter of those providing elderly care had received geriatric care training during their nurse curriculum (Sunde, Øyen and Ytrehus, 2017[18]). Nurses in Australia do not have to pass formal education/training in geriatric care, but they have to receive registration from the Nursing and Midwifery Board of Australia and to complete a minimum of 20 hours of continuing professional development per registration period of 12 months. However, it is not guaranteed that they follow geriatric training courses.

3.4. Better training policies can address the shortfall in skills

While in the future the largest share of LTC needs should be addressed with personal care workers providing many low-skilled tasks (such as washing and helping to dress), the LTC workforce will also have to rely on some workers equipped with more advanced geriatric care competencies. Increasing geriatric care training participation for nurse students and experienced workers should help achieve the right mix of workers/competencies in LTC settings.

3.4.1. Nurse students could benefit from improving geriatric care training

Geriatric care curricula are not always attractive to nurse students. They suffer from comparisons with other health care sectors (such as paediatrics or hospital-based practice), which have a better image and different practice environment (including greater team working and technology use). Low training

participation can also be explained by the fact that career progression prospects after graduation can be low, even among nurses with substantial experience.

Various measures have been implemented to increase students' participation in LTC training (Table 3.9). Several initiatives have been developed to increase exposure to geriatric care during nursing training, with the objective of helping students shift their impressions of future career prospects from the start and giving them a better understanding of the realities of the job and the opportunity to acquire specific skills. These initiatives are very important, as geriatric care exposure was found to increase interest in geriatric care professions (Meiboom et al., 2015[19]). Nurse students who go on to specialise in LTC often declare that they were sensitive to the pedagogical atmosphere (personal interactions with the staff), the leadership of the ward manager, and supervisors' attitudes to mentoring (Carlson and Idvall, 2015[20]).

Several countries have provided additional funds for education and/or are redesigning degrees. Germany, Japan, Austria and Israel have sponsored access to LTC education with the introduction of scholarships. Sweden, Canada and Korea have developed internship opportunities and mentorship programmes for nurse students. Germany has completely abolished school fees in their nursing education. In Germany, new legislation will merge three specialised nursing education streams (general, geriatric, paediatric) into a general one from 2020. As the country is expecting a large shortage of nurses, the change in the nursing degree was a move to make the profession more attractive. It is hoped that the new degree will open up career opportunities by being more general, so that nurses can switch between types of practice (working in hospitals, with children and with elderly people) and define which specialisation fits them better. In the United States, the Veterans Health Administration, a large LTC service provider, offers geriatric scholars programmes (Spetz and Dudley, 2019[9]).

Increasing exposure to research and developing excellence programmes is another way of increasing students' interest in LTC professions. Canada and Bulgaria are supporting the development of "excellence curricula" in LTC. In the United States, the implementation of a research internship programme for nursing students successfully raised interest in geriatric care among participants (Mewshaw et al., 2017[21]). Exposure to a research project provided students with an opportunity to learn directly from specialists and gain more field experience. Close interactions with nursing staff also provided a great opportunity to develop interpersonal skills, which are very important in LTC professions. Note that these programmes require some flexibility (both students and mentors have to adapt to each other's schedule) and some commitment from staff to provide mentorship. This requires careful selection of applicants with sufficient motivation and organisational skills to succeed.

Several countries (the United States, the Netherlands, Ireland, the United Kingdom and Sweden) have introduced advanced nurse practitioners, whose role is to be responsible for case management (Ljungbeck and Sjögren Forss, 2017[22]). They are trained to deliver specific LTC tasks of key importance, such as monitoring care plans provided to frail elderly people; managing interactions between frail elderly people, informal care providers, social care workers and health care workers; and detecting loss of autonomy among frail elderly people.

Table 3.9. Several measures could improve initial training for nurses

Measure	Examples
Scholarships for nurses specialising in geriatric care, and funding for training	• In Israel, "perseverance grants" are scholarships for nurses who will work in the LTC sector for four years • In Japan, financial support is given to students applying for certified nursing and LTC training for beginners. • In Korea, the second LTC master plan (2018-22) compensates for training time. • In Austria, training for LTC workers is fully covered by governments and employers.
Adapting nursing degrees to allow students more exposure to geriatric care	• The Netherlands is developing dual-track programmes (including a general nurse and a geriatric nurse track), which are helpful solutions to give students better understanding of the realities of the job and allow them to acquire specific skills. • In Germany, new legislation will merge three specialised nursing education streams (general, geriatric, paediatric) into a general one from 2020. • In Canada (Ontario), in 2016-17, over 100 student received internship initiatives in nursing home placements via the Centres for Learning, Research and Innovation (CLRIs). Over 600 hours of coaching were given to LTC homes, and over 180 LTC homes received formal coaching.
Developing research, innovation and excellence programmes	• In Canada (Ontario), the CLRIs promote a "teaching nursing home" programme model that is unique among OECD countries. In 2016-17, over 360 students participated in programmes made available in LTC teaching nursing home environments, and over 3 800 staff received training/education from the CLRIs. This quality-based programme focuses on resident-centred care issues, such as responsive behaviours, falls prevention, peritoneal dialysis and obstructive sleep apnoea. While successful, however, this programme gives rise to important costs. In 2017/18, the Ontario authorities announced base funding for the CLRIs, representing between USD 2.35M and USD 3.1M each year until 2021. Additional investment in training and education in LTC will relate to: i) new dedicated staff training funding to support medically complex residents, which will also focus on falls prevention, behavioural support, palliative and end-of-life care and medication management; ii) the design of an LTC educational framework aimed at promoting legislative and regulatory compliance, practice excellence and an informed and engaged sector and public; and iii) support of education and training for the provision of culturally appropriate services. • In Bulgaria, the University of Veliko Tarnovo introduced a Master's degree programme on social work in LTC that provides profiled knowledge needed for the profession of social worker in the field of social services for people with special needs. The graduates can become leading specialists and managers in the structures of social services. Their training allows professional recognition in European and international social organisations and specialised social services. Graduates of the programme can apply for doctoral training. • The Norwegian government introduced an ambitious programme to redefine professional roles by 2020. This inter-ministerial established new guidelines for health and social care education with 12 learning outcomes, aiming in particular to increase competences in managing and developing technology and soft skills. One important aspect is teamwork skills to favour inter-disciplinary work (e.g. soft skills, identifying people's needs and case management). This reform applies to nurses, not assistant nurses.

Source: OECD (2018) LTC workforce pilot survey and review of the literature.

3.4.2. Several countries are improving initial and on-the-job training for personal care workers

Given the heterogeneity of skills levels, training requirements and mobility for personal care workers across countries, there is also scope for ensuring better international recognition of qualifications. This could be facilitated by more referencing of the qualifications in the LTC sector (as opposed to the nursing sector) to national qualifications frameworks, and/or at a global level (for instance, in European countries, to the European Qualifications Framework) (Cedefop, 2018[23]). This could include a common understanding of the skills required, preparing curricula for the sector and even for assessment purposes. Some initiatives already exist and could be pursued or adapted to the LTC sector. For instance, the European Care Certificate initiative was developed as a basic entry certificate for the care sector. This created a set of learning outcomes covering essential knowledge that any worker new to care needs to know to work safely and in line with person-centred values. The eight basic European social care learning outcomes covered in the certificate have been shown reliably to cover this essential knowledge. Yet more could be done in this area because it only covers 16 countries and initial entry knowledge. Some other countries are developing initiatives in that direction. For instance, in collaboration with stakeholders, Canada (Ontario) is developing an LTC educational framework, with priorities and demonstration projects to improve skills training and fulfil future staffing needs. In the United States, a recent task force on the LTC workforce recommends creation of a work group, through which several LTC sector representatives (home care aides, home care agencies, home health nurses etc.) should define standards for future curricula to train home care aides (Spetz and Dudley, 2019[9]).

On-the-job training options may not be always affordable, especially because of high opportunity costs. LTC workers can lack time to pursue education, for work or personal reasons, especially when they face important commuting times or difficult working schedules. In Austria, training in the LTC workforce is provided during working time, and the ten weeks of education required to participate in the LTC workforce can be provided on-site, in schools or in universities. In Germany, the education and training initiative for elderly care implemented between 2012 and 2015 extended existing options for shortening training when applicants have relevant knowledge and contributed to an increase in the number of trainees in geriatric care.

Governments can provide financial incentives to both employers and employees. More specifically, they can provide financial support to individuals, encourage the development of training facilities and work with employers' associations and trade unions to make it easier for LTC workers to undertake training. In Austria, Canada, Sweden, Cyprus, Australia and Latvia, continuing training programmes for LTC workers are sponsored by government funding. Agreements between employers and unions can ease access to training (as in the United States, Iceland and the United Kingdom). In 2014, Korea implemented a continuing education programme for personal care workers, which is covered by government funds and employment insurance schemes. Personal care workers must receive continuous training offered by licensed institutions; the programme length depends on the worker's experience. In Iceland, short training is mostly covered by unions or employers, and workers are often allowed to take part of it within working time.

In Norway, the government has strengthened efforts to promote competency-building for personal care workers with formal education in health and social care by increasing funding for basic and continuing education. Specific grants are available for municipalities willing to develop education programmes for personal care workers. The purpose of the funding is to increase recruitment to the sector; stabilise the personnel situation; raise the level of expertise in the services, including in the areas of dementia, geriatrics, mental health and substance abuse; implement life-long learning; and anticipate future needs. In Australia, following the Aged Care Workforce Strategy, the Aged Services Industry Reference Committee is examining how to reform the national training package qualifications and skill sets needed

for LTC, as well as new approaches to career structuring and progression in the sector and scoping opportunities for collaboration across vocational education training, higher education and industry.

In addition, measures have been introduced across OECD countries to make on-the-job training easier for low-skilled workers, which may benefit personal care workers (OECD, 2019[24]). Measures include, for instance; personal training accounts, which open an internet-based account presenting workers' rights for training; personal objectives; training searches results (France); degree study allowances (Estonia); and training vouchers available for specific vocational training programmes (United States). These existing measures may help personal care workers access training and acquire some of the basic competencies they may lack. Also, legal rights for education and training leave represent an important policy tool to guarantee low-skilled workers' rights to training when they need it (OECD, 2019[25]).

Another legal, pivotal policy tool can be comprehensive safety standards, including those mandated through accreditation process, as they can help ensure that minimum standards are met with regard to LTC workers qualifications, whether through initial or on-the-job trainings. In addition, improving qualifications would also contribute to foster higher safety standards for workers and patients – adequate qualifications are intimately linked to safer care. Numerous studies show that adverse events, such as infections or injuries, are not only widespread but also preventable (de Bienassis, Llena Nozal and Klazinga, forthcoming[26]). For instance, a study in Medicare patients in LTC in the United States found that over half of events were preventable, and the majority of these would have been prevented if not for substandard care and medical errors (OIG, 2018[27]).

To make training programmes more attractive, the return to training in terms of salaries and career progression also needs to improve. Indeed, the return on investment is likely to decline for older workers who are facing retirement. This is particularly important in the LTC workforce, which is mainly composed of middle-aged workers, and which has aged over the past decade (see Chapter 2). It is also very important in countries like the United States, where the rate of return on acquiring any college education in terms of additional wages for personal care workers is low: it represents 9% higher earnings for each additional year of schooling compared with 45% for other employees in the United States (Osterman, 2017[28]).

Examples of career perspectives provided by training programmes include access to managerial roles for personal care workers, or access to nurse diplomas for nurse aides willing to progress (Denmark, Germany). In France, a recent report recommends the introduction of a new profession for personal care workers for elderly people and notes that frailty detection should be included in initial training programmes (Libault, 2019[29]). An intermediate professional level to advance the roles of personal carers with specific qualifications would add value to the profession and increase remuneration, and potentially improve retention rates. Korea plans to have more training for personal care workers in the future and to offer a managerial role.

Easing training entry requirements to broaden recognition of prior experience or learning, which can be very valuable for personal care workers, is also a critical issue. However, while some programmes exist in most OECD countries, accessing such initiatives can prove difficult for personal care workers owing to complex procedures or to the courses' duration, which can be perceived as too long. Facilitating personal care workers' take-up of these programmes should therefore be promoted through initiatives like the *validation des acquis* in France, or the *Qualifica Centres* in Portugal, which target low-qualified adults and accompany them throughout the skills recognition procedures (OECD, 2019[24]). For low-skilled workers, strong career guidance is often needed. Indeed, recent OECD work shows that while individual learning accounts are a way of empowering low-skilled workers in their own training decisions, these schemes should be complemented by face-to-face support with specialists. Specifically, specialised career guidance officers could be trained to provide this comprehensive approach and inform workers about the needs of the LTC sector, alongside suggesting the best training options for them. Some countries promote policies increasing training participation among older adults through career transition advice (Australia, the

Netherlands) or programmes encouraging employers to train older workers or low-skilled workers (like the *WeGebAU* programme in Germany).

Even when training is sponsored by governments or employers, there can be a lack of meaningful training options among experienced workers. The heterogeneity of cases makes it difficult to match training to their expectations because their needs are often case-specific. A systematic review of the literature (Surr et al., 2017[30]) underlines that successful programmes for the health and social workforce in dementia care are tailored to participants' experience; involve active and experience-driven participation; and rely on mixed material (such as written material reviews and face-to-face interactive activities). Active participation means listening to workers' specific needs in order to adjust the training length according to their experience, seniority and profile. Several options can be used to expand training options: specialised university training, specific courses from accredited programmes, participation in professional traineeships, practical training in a special social institution and training events and conferences.

Modern learning programmes promote three dimensions of flexibility: time, location and content. They combine a choice of timelines for training receipt, are closely linked to the working environment (residences, homes, care centres) and target workers' specific needs. They are centred on caregivers' specific needs (e.g. language, communication), and the learning activities support the application of training into practice. They provide diversified forms of training (theoretical, practical), with several ways of obtaining credits (course exams, conference participation, training), and provide practical tools to solve daily issues. For instance, use of case studies can provide decision support tools to groups of workers at risk of facing specific issues (such as crisis or death). They promote training with active participation, which is encouraged through small or large group face-to-face learning.

Tailoring learning programmes for experienced workers may not necessarily be expensive or burdensome. For instance, in the United States, a programme implemented through telephone conversations (the Communicating Health Assessments by Telephone Project) to aid LTC nurses with symptom assessment and communication of health information was successful while inexpensive (Whitson et al., 2008[6]). The individualised training sessions providing decision support tools to nurses improved the quality of their communications with off-site physicians.

Table 3.10. Enhanced training for personal care workers is available in some countries

Measure		Examples
	Provide career perspectives to strengthen the motivation of professionals willing to progress.	• In Denmark, experienced personal care workers willing to provide more advanced care and become health assistants have the opportunity to follow a two-year programme and pass a different national examination. • In Norway, assistant nurses are offered numerous ways to specialise after high school. Training courses run for between six months and three years, and can be organised part time. Participants can become registered nurses if, after vocational training, they attend a one-year general study course to access nursing education. • In Korea, the "Centres for LTC workers" provide various services, including counselling, training and job information. • In Germany, one of the aims of new legislation to reform education and training for nurses is to increase the opportunities for further career progression via further training at the university level through bachelor's degrees. The Nursing Profession Act provides comprehensive crediting options of equivalent qualifications for the duration of nursing training. For example, a one-year training programme for nursing assistants can be fully credited towards training of specialists, which is thereby shortened from three to two years. In addition, the Nursing Care Reform Act ensures that retraining for nurses, health and child nurses and geriatric nurses is made possible by employment agencies and job centres.
	Flag experience and prior learning recognition	• In Korea, the Ministry of Health and Welfare plans to build a career ladder for personal care workers by creating a new profession of personal care worker manager. This will allow personal care workers to take a position of director of home care facilities once they have more than five years' job experience in the LTC field. • In France, elderly care training programmes to become an LTC nurse are open to people with a baccalaureate, with at least three years of professional experience in health care or with five years of professional experience in another sector (in which case they need to pass an exam). Applicants who hold an *aide soignante* diploma and have three years of professional experience (working full time) are eligible to take an exam (a written exam looking at three case studies) to determine whether they can access the LTC nurse training programme. Physicians, midwifes, physiotherapists and massage therapists, or medical degree students, are eligible to access elderly care training without having to pass an exam. • In Portugal, the *Qualifica Centres* target low-qualified adults and accompany them throughout the skills recognition procedures.

Source: OECD (2018) LTC workforce pilot survey, and review of the literature.

Moreover, enhancing the use of digital training methods could represent an interesting solution to improve training flexibility without increasing its costs. Online courses could have the advantage of bringing training into nursing homes or wherever the professional is located, and require low equipment needs (a TV or computer screen and an internet connection). Moreover, these courses can be taken whenever workers are ready. Note however, that while Massive Open Online Courses open many opportunities, they are still widely underused because of a perception of low quality. In addition, this type of training can hardly be done for more practical, hands-on subjects such as communication skills. Thus, certification and quality assurance for such courses is important (OECD, 2018[31]). In the United States, internet-based dementia training programmes with video-situation testing improved personal care workers' knowledge, attitudes, self-efficacy and behavioural intentions (Irvine et al., 2012[32]), and allowed them to deal more effectively with aggressive behaviour among nursing home residents with dementia (Irvine et al., 2012[33]).

3.5. Conclusion

While for many tasks LTC jobs require a low level of skill, LTC workers perform a variety of tasks that are more complex. This chapter underlines two important conclusions. First, there is a need to provide basic support to personal care workers; for example, in the form of training. Second, it is also crucial to ensure that in the future part of the LTC workforce will be able to focus increasingly on outcomes (such as disability prevention, re-enablement and healthy ageing) rather than mainly focusing on outputs (such as the day-to-day tasks that cover elderly people's immediate needs). For instance, disability prevention among frail

elderly people will represent a growing issue in the future, in which some LTC workers will have a central role to play (see Chapter 6). Thus, there is a need for better training to enable some LTC workers to take on a more advanced role.

Better understanding of the skills and qualifications of LTC workers helps to formalise their role in the sector and should lead to proper career prospects and structures. Many countries need to have a broad strategy to identify the skills needed among LTC workers and to define a common approach to guarantee that the need for low-skilled task provision is fulfilled while some workers focus more on outcomes. This will help to ensure that most LTC workers receive basic training and promote an advanced role for the most experienced or trained workers. While all these actions contribute to increasing the attractiveness of on-the-job training, they may also contribute to increased service costs in LTC. At the same time, implementation of on-the-job training could be staggered.

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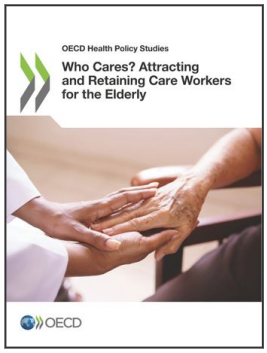

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