PUBLIC SERVICES
INTERNATIONAL
The global union federation of workers in public services

Decent Work and Quality Long-term Care Systems (Full Report)

This report provides trade unions with an evidence-based resource to promote a suite of practical reforms to national long-term care (LTC) sectors in ways that benefit care recipients and society, as well as the workers who provide care.

JAN 25, 2024

A report by Dr Sara Charlesworth- RMIT University, Dr Ian Cunningham- University of Strathclyde, Dr. Tamara Daly- York University.

TABLE OF CONTENTS

Note: For a summarised version of this report, see our companion document: "Long-Term Care Reforms: Guide for Unions" (available in multiple languages)

Executive Summary

This report provides trade unions with an evidence-based resource to promote a suite of practical reforms to national long-term care (LTC) sectors in ways that benefit care recipients and society, as well as the workers who provide care. It focuses not only on reforms that are relevant to established LTC systems (mainly in the Global North) but also on LTC services and systems that are evolving (mainly in the Global South). The LTC sector includes residential and home care services provided by paid workers, in addition to the informal, familial, and unpaid care labour carried out by households. Long-term care spans aged care services, disability services and health services for the chronically ill. This report is mainly centred on care for older adults.

There are two main subsectors of LTC for older adults. In what is known as residential or nursing home care, higher-level physical health or clinical care as well as social care and personal care are typically provided on an ongoing basis. In formal home care services, people typically receive some combination of health care, assistance with activities of daily life and social support in their own home.

Formal LTC operates in the context of 'familial care', or unpaid care by family members, overwhelmingly women. Familial care remains the main source of support for older adults in both the Global North and the Global South. In many countries there has been a sharp decline in available familial care, because of the migration of younger people to larger cities, the increase in women engaged in paid work, and outbound migration. In most OECD countries, these demographic changes have resulted in some increase in formal services offered directly by the state in public sector services and, increasingly, through outsourcing to the for-profit and non-profit sectors.

This report aims to:

- Provide examples of successful models and reforms that support workers to deliver accountable, high-quality LTC.
- Identify leverage points for Public Services International (PSI) and its affiliates in relation to campaigns, bargaining and public messaging.

Methods

The research that forms the basis of this report was undertaken in four overlapping phases.

1. **Phase 1 Literature Review**: Academic literature as well as policy and non-governmental sources on LTC systems and services in the Global North and Global South were examined in light of factors such as marketization, privatization and individualized or cash-for-care LTC provision. The literature review underpins a detailed analysis of key principles and indicators of good quality LTC as well as the conditions that produce quality LTC services and decent employment conditions, including any impacts of migrant care labour.
2. **Phase 2 Case Studies**: Eight jurisdictional case studies of LTC were conducted: in Australia; British Columbia and Ontario in Canada; Scotland, United Kingdom; France; Chile; India; South Africa; and Fiji. The case studies identify the diverse care, employment and migration policy and regulatory settings in each system.
3. **Phase 3 Typology of LTC Systems**: Based on the case studies, a typology was developed that took account of both variations and commonalities in the eight different systems. This allowed tailoring of approaches relating to the aspects of the proposed reforms advocated, including for each system.
4. **Phase 4 Recommendations**: A set of recommendations based on promising approaches for unions to consider were developed to advance the goals of decent work and good quality LTC relevant to local contexts.

Based on the research and case studies conducted for this study, the report first identifies six key principles as a foundation upon which decent work and good quality LTC systems can be built. These include:

1. **Principle 1**: Public funding that meets the cost of care
2. **Principle 2**: Public or non-profit delivery

3. **Principle 3**: Public Stewardship
4. **Principle 4**: Public Data Transparency and Accountability
5. **Principle 5**: Decent Working Conditions
6. **Principle 6**: Dignity in Care

The report also sets out three key sets of quality indicators to assess a country's approach to care provision for older adults. These include specific indicators to assess:

1. Quality working conditions;
2. Quality care conditions; and
3. Quality systems that support high-quality models of care and adequate staffing.

Decent Work/Quality LTC Typology

The evidence shows that good quality care requires decent working conditions for care providers. While there are several typologies of formal LTC systems, few pay attention to service quality *as well as* the quality of working conditions for workers who provide the services. In this Report, a typology is presented that accounts for variations and commonalities in the care of older adults drawn from the eight detailed country case studies of LTC systems and services. Crucially, the Decent Work/Quality LTC Typology centres the importance of the relationship between decent work and good quality care.

The Decent Work/Quality LTC Typology highlights how a country's approaches to LTC are formed by a range of interlocking sets of rules, laws and norms that structure who gets care, by whom, where, when and who pays for it. These structures can be categorised into three intersecting 'regimes' — care, employment, and migration.

The Decent Work/Quality LTC Typology also forms the basis for a detailed comparative analysis of each of the case study countries. They all differ in their population of older adults, in their approaches to care and LTC, as well as in formal employment protections for LTC workers. In each of our selected countries, the pay and working conditions of those working in LTC is generally poorer than that of most other national system workers, with many workers facing large protective gaps in employment protections. LTC workers in community-based or home care are even more poorly protected than those working in residential aged care. In terms of migration, all the selected OECD countries are 'receiving' countries of migrant workers who migrate to work in or 'end up' in LTC. Migrant LTC workers often experience poorer working conditions than locally-born LTC workers. While the migration picture is more complex in the other four case studies, migrant-sending countries face labour shortages in the local availability of LTC and health workers and also depleted familial care resources with the outbound migration of overwhelmingly women workers.

Case studies

The detailed case studies outlined in the report provide rich narrative details in support of the analysis in this Report. They highlight promising approaches in each country and provide specific recommendations for unions in advocating for improvements to the conditions of work and the conditions of care in LTC.

Conditions that produce 'unacceptable forms of work' and 'unacceptable care'

The report explores in some detail the unacceptable forms of work and care in LTC systems and services that characterise the experience of workers and care recipients in both the selected case study countries and in other countries.

Two key reasons for the growth of unacceptable forms of work in LTC are identified. For the Global North, this growth rests on the introduction of a range of policies pursued by governments associated with the neoliberal marketization of the LTC sector, which perpetuates the undervaluation of the skills of the overwhelmingly female workforce and decrease in care quality experienced by recipients of LTC. In the Global South, which is much more reliant on informal care of older adults, demographic shifts and outward migration reduce the availability of familial care. Yet the burden of care for older adults is not yet met adequately by existing health and social care services.

The report provides a detailed analysis of the consequences of marketisation in LTC and the mechanisms through which it has been implemented in many countries. In highlighting its consequences for pay and working conditions, as well as care quality, it examines in detail:

- Public service supply chain relationships

- Gender and the undervaluation of care
- The use of technology in LTC
- Profiting from LTC through financialisation

The report links trends towards marketisation with the consequences of the global decline in familial care, which is especially acute in the Global South. As forms of marketisation spread from the Global North, the depletion of familial care brings several threats to LTC workers and care receivers in the Global South. The first of such threats comes from the growth of global care value chains, which have led to shortages of health and LTC workers in the Global South, further depleting already limited paid and unpaid care resources. The second threat comes as population ageing occurs in the Global South, with new LTC markets being identified by multinationals for wealthier populations in several countries. Without proper state regulation and commitment, this leaves these states, their workers, and care receivers vulnerable to the financialised strategies of multinationals familiar in countries in the Global North. The growth of LTC activity by multinational corporations in the Global South will present significant challenges for unions campaigning to regulate informal unpaid LTC labour, with financialised practices such as the extraction of value from real estate transactions, the creation of two-tier systems of LTC care and the further degradation of working conditions.

In the context of marketisation, the report analyses the production and reproduction of poor job quality, which is endemic in LTC across the globe in LTC systems and services. It focuses, in particular, on pay and working conditions, job insecurity, work intensification and poor access of LTC workers to support, training and skills development. One of the most pressing issues is the fragmentation of working time. The report highlights the trend, under marketised systems of care, to 'manage' workers' paid time through the introduction of insecure contracts and the fragmented scheduling of shifts to reduce costs, which leads to the degradation of work. A further threat to job quality in LTC is the introduction of new forms of platform work in care, known as 'gigified care', which not only excludes platform workers from labour protections in most countries but also undermines the quality of the care provided to platform users. These pressures for greater flexibility in order to reduce costs are intensified in individualised and personalised approaches to care provision.

The use of migrant workers in LTC in Global North countries and their experience of even poorer job quality than that of locally-born LTC workers has emerged as a significant challenge for unions. Further, these migrants often work in the for-profit sector or in the unregulated 'grey zone' of the economy. Migrant LTC workers often have a precarious visa status and reduced access to social protection, with little practical opportunity to voice their concerns.

The COVID-19 pandemic revealed the fault lines of marketised LTC systems, in understaffing because of poor or non-existent staffing ratios. Historic underfunding meant that national systems were generally ill-prepared to respond to problems related to the pandemic, such as taking on rigorous infection prevention and control measures, absorbing the costs of personal protective equipment (PPE), coping with the training needs of staff, and dealing with worker absence due to illness. Indeed, the low priority given to LTC service users and the LTC workforce were illustrated in many countries in the delays in distributing PPE and undertaking testing for staff in the early stages of the pandemic. However, lessons were learned from the COVID crisis, particularly the strong link between decent work and care quality, and these have begun to permeate into union organising campaigns and bargaining agendas within the LTC sector.

The report's final section examines approaches for unions to achieve both decent work and good quality LTC systems and services. It considers challenges facing collective bargaining in the public sector and key challenges affecting union action in LTC. These include the limited tradition of unionisation in outsourced providers, which makes it difficult for unions to mobilise the LTC workforce, together with the anti-union stance of many for-profit and non-profit providers. Even where unions have a presence, the below-inflationary funding provided by governments limits the prospects for effective collective bargaining, with many LTC unions working in a context of 'concession bargaining' rather than collective bargaining. The report concludes with a broad set of general recommendations for union campaigning to achieve better quality work and better quality LTC services.

Section 1: Introduction: Long-Term Care

Long-term care (LTC) includes residential and home care services provided by paid workers in addition to the informal, familial and unpaid care labour performed by households as part of social reproduction. In this report we focus on care for the older adult population, although these types of support are also available across the life course for younger populations.

In formal home care services, people typically receive some combination of health care, assistance with activities of daily life and social support in their own home. In residential care, higher-level physical health care and social care is normally provided as well as programming for social care needs, food and daily grooming on an ongoing basis. Long-term care spans aged care services, disability services and health services for the chronically ill.

'Familial care', or unpaid care by family members, is the main source of support for older adults due to lack of sufficient publicly-funded LTC. Women are overrepresented in unpaid care work. The International Labour Organization (ILO) estimates that women perform 76% of the total amount of unpaid care work, over than three times more than men; however, this gender division of labour varies by country. For example, women in Sweden do 55% of unpaid care work compared to 61% in France, 60% in Canada, 64% in both Australia and the United Kingdom, 70% in South Africa, and 96% in India (ILO 2018: 55). In many countries there has been a sharp decline in available familial care because of the migration of younger people to larger cities, the increase in women engaged in paid work, and outbound migration. In most OECD countries, these demographic changes have resulted in an increase in formal services offered by the state, the market, or the noon-profit-sector (Hill et al., 2017).

Outside of familial care, in many OECD countries both residential and at-home LTC is funded at least partly by the state and delivered through the public sector and the for-profit and non-profit sectors. In countries that do not have formal state-funded LTC infrastructure, some limited residential care may exist alongside basic community-based services provided to older adults through health services or by workers in the informal economy. In other countries, entitlements or access to LTC via services or cash benefits are either non-existent or extremely limited and, where they exist, are rarely available outside major cities (Kraus and Riedel, 2022).

While limited data is available for some OECD countries, globally the numbers of workers in the formal LTC sector or providing specific services to dependent older adults is impossible to estimate. Overall, the total global care economy workforce totals some 381 million workers. This workforce is highly gendered, with 249 million female workers and 132 million male workers, representing 11.5% of total global employment and 19.3% of global female employment (6.6% for males). Women's participation in the care economy is highest in the Americas, in Europe and in Central Asia, accounting for approximately three-quarters of the workforce (ILO, 2018).

The research undertaken for this report was developed in four overlapping phases.

1. **Phase 1 Literature Review**: we conducted a detailed narrative literature review of key principles and indicators of good quality LTC. We explored the conditions that produce quality LTC services and decent employment conditions, including any impacts of migrant care labour. The literature review involved an exploration of academic literature and policy and non-governmental sources such as unions and the International Labour Organization (ILO); the Organisation of Economic Cooperation; and Development (OECD) and the World Health Organization (WHO). Finally, we reviewed literature on LTC systems and services in the Global North and Global South in light of factors such as marketisation, privatisation and individualised or cash-for-care provision (sections 3 and 5).
2. **Phase 2 Case Studies**: we conducted eight jurisdictional case studies of LTC in Australia; British Columbia and Ontario in Canada; Scotland, United Kingdom; France; Chile; India; South Africa; and Fiji, in several instances informed by conversations with local PSI affiliates. Each case study identifies the care, employment and migration regimes, and draws on academic, non-governmental, national statistics and government policy documents (section 3).
3. **Phase 3 Typology of LTC Systems**: we categorised each of the jurisdictions in a typology by comparing the care, employment and migration regimes (section 3 and 4).
4. **Phase 4 Recommendations**: in the final phase, we devised a set of recommendations based on promising approaches for unions to consider to advance the goals of decent work and good quality care conditions within their context.

Section 2: Assessing Long-term care

Key Principles

Research evidence indicates that underlying principles are a foundation upon which decent work and good quality LTC systems can be built. When systems lag behind with respect of one of the principles, there is room to improve the overall architecture of the system. Assessing system performance can be achieved through the use of indicators. The indicators highlighted here can be used to assess the performance of individual operators, and also how well national systems and services respond to the needs of those who need LTC and those who do the work of LTC.

Principle 1: Public funding that meets the cost of care

The human rights of older adults to adequate care and support are paramount. There is little justification for profit-making in LTC and no evidence that for-profit LTC services or managed market competition lowers cost or improves quality, access or choice. Indeed, it is more difficult to ensure system governance, given the responsibility of for-profit firms to their shareholders.

The limitations of for-profit provision in providing good quality care were revealed during the COVID-19 crisis, with higher fatalities in for-profit services than in public and non-profit services.

Policy and funding at the national and regional levels should be developed with a view to eliminating profit-taking in publicly-funded LTC. For workers, adequately funded public LTC services would bring parity in wages and conditions for both public and non-public sector workers. In addition, it would help end practices such as the widespread use of unpaid overtime, non-payment for travel time, and the proliferation of insecure forms of contract such as temporary, zero or variable hours contracts.

Public LTC funding should include a guarantee from non-government operators that they will meet transparent financial stability requirements and report on multiple indicators of decent work and good quality care.

Public funding should meet the full cost of care by basing services on need rather than financial eligibility. The rationing of LTC through means-testing of income is common in countries such as Scotland, Australia and some parts of Canada. Depending on the level of government service provision, means-testing can prevent or restrict vulnerable older adults from receiving the care they need because they cannot afford to top up state support. Access to care should be based on need, not ability to pay. For example, in Scotland, New Zealand and Ontario, Canada, home care recipients have access to some needs-based personal care without additional out-of-pocket payments, even though the level of care is often considered insufficient and requires familial care or personal payment to increase the hours of care.

Principle 2: Public or non-profit delivery

The best form of LTC delivery is through direct public sector employment and services. The involvement of the private sector brings excessive profiteering, poor quality care and, as evidenced during COVID-19, a reduced capacity to deal with emergency situations. There were significantly higher rates of mortality in for-profit residential facilities compared to their public sector and non-profit counterparts due to the minimisation of expenditure on workers and service users. These savings were drawn from lower staff ratios to service users and through the degradation of working conditions. The activities of large private multinationals are also of concern given the use of financialised techniques that focus on extracting value from real estate, as has been clearly shown in recent research commissioned by PSI (CICTAR 2020; 2022, 2023) and in research discussed further in Section 5. Where private services have evolved because of gaps in public provision, careful auditing of the quality of services and of workforce pay and conditions should be built into regulation.

If non-profit organisations are to deliver services, greater attention should be given to their capacity to innovate and be closer to the needs of particular service users and the community they serve. Their contracts to deliver LTC should not be based on price considerations or the absence, or relative weaknesses, of union bargaining structures. As long as care quality standards and decent employment standards are met, non-profits should be given as much certainty of future income as possible, with limited delays in receiving income, involvement in the planning of services, and the provision of adequate notice of any termination of contract.

Principle 3: Public Stewardship

LTC is a public good. Public stewardship requires that governments act in the public interest to robustly monitor, assess and enforce good quality care and decent work at the system and organisational level. Excellent LTC system stewardship supports the entry of high-quality providers. This means reducing or eliminating for-profit provision given its association with poor care quality outcomes and unacceptable forms of work (Comondore et al, 2009; Harrington et al, 2011; Kaffenberger, 2001; Daly, 2015). The production of good quality LTC outcomes requires governments to ensure that the system and services support decent work *and* quality care. Ensuring those who receive care have a meaningful voice or say in the system's design and its approaches is fundamental to good quality care.

The public funding model should encourage the production of quality outcomes with attention to providing care for people in residential places when needed while also ensuring effective home and community care for people and their families who can manage at home. When LTC is delivered directly by public sector workers, it is typically associated with high-quality outcomes. When it is contracted out to private non-profit and for-profit homes, the government must ensure that effective contracting is in place to monitor the expenditure of public funds and non-compliance by providers. No matter what model of delivery, funding should support minimum levels of staffing, including of nursing-qualified workers as well as of other direct care and ancillary workers. Systems should support funding levels that enable decent working conditions, remunerate workers sufficiently to support a living wage, enabling meaningful and rewarding work, and ensure autonomy in undertaking care work and in decision-making appropriate to the worker's level of skill and training.

Audit and inspection regulation in countries with more private for-profit provision are more standardised, complex and deterrence-oriented. Rather than more prescriptive regulation (Daly et al 2016), we need 'smarter' and better enforced regulation (Armstrong,

2021) that focuses on the structural issues, such as adequate staffing, ongoing training and supportive supervision that supports workers ability to provide good quality care.

There must also be some level of system coordination amongst providers so that information, knowledge, promising practices and challenges can be collectively monitored and addressed. Regulation at the service level should not be prescriptive. Regulatory environments associated with frontline interpretation, professional judgement, professional autonomy and decision-making are associated with more accountability and more likely to be found in countries that have less for-profit provision, better staff to service user ratios, and teamwork that addresses the needs of service users and workers in a relational way that is more fluid and responsive (Daly et al 2016).

Principle 4: Public Data Transparency and Accountability

To support public system stewardship, there must be mechanisms for public accountability for government funding. Data must be publicly reported, including that related to the LTC system's regulatory compliance, the workforce, type of employment contracts, contractors' performance, and the quality outcomes of care provided (Daly, 2019). To accomplish system-level improvements and produce high-quality outcomes for care recipients, providers need to create decent working conditions; publicly report on performance and make the data available for independent scrutiny (Harrington et al, 2011). Those providing LTC services should have maximum transparency in their operations and their outcome data since contracting services to for-profit entities raises significant questions about accountability for spending public funds.

In many countries where governments have outsourced the provision of LTC services to the private sector – including for-profit, non-profit and charitable organisations – accountability often rests on the strength of LTC regulation and enforcement standards. When public funds are not publicly and transparently reported or reporting lacks sufficient detail to be meaningful, there is limited accountability for public funding and LTC service providers should be required to demonstrate maximum transparency of their operations and their outcomes data.

Some examples of indicators that support accountability for public funding by LTC providers include the following:

Provider system level

- Amount of operating and capital funding per LTC provider
- Expenditure on labour costs, including direct care, cleaning, meal preparation, administration
- Staffing levels / hours worked

Provider workforce level data

- Wage rate paid, by occupation and classification of worker
- Form of contract, including permanent, temporary and zero-hours
- Proportion of full-time work by occupation
- Staff numbers by level of qualification
- Turnover and retention rates
- Direct care staffing level/ratio per day, afternoon and night shifts
- Minutes or hours of care provided per resident / client per day in residential care

Provider contracts

- Transparent contract details
- Amount of profit allowed at a service level and per recipient
- Executive and Board compensation (pay and other benefits)

Principle 5: Decent Working Conditions

The principle of decent working conditions draws on the ILO's decent work agenda, defined as 'productive work for women and men in conditions of freedom, equity, security and human dignity'. Decent working conditions in LTC include pay rates and sufficient predictable hours of work to provide a living wage that enables workers to enjoy dignity at work, provision for themselves and their families and an ability to engage fully in life outside paid work. In LTC, decent working conditions also include secure job contracts with access to full-time employment where desired; payment for all time worked, including documentation and travel between clients; access to paid leave and retirement benefits; excellent training and access to meaningful career paths; and safe working conditions.

Decent working conditions in LTC are enabled where:

Employment protections are monitored and enforced by regulators and unions.

Workers are consulted and have opportunities for regular input into decision-making within providers as well as access to collective bargaining; and

Workers are directly employed by providers, rather than via contracted out services, labour hire arrangements or care platforms.

These employment conditions and enablers are vital because, in LTC, the conditions of work are the conditions of care. Without decent working conditions there will continue to be severe understaffing and worker shortages in LTC services leading to a lack of the continuity that is so crucial for excellent quality relationship-based care.

In Victoria, Australia two examples of decent working conditions in public sector-provided LTC are outlined in the Australian case study. The Victorian government operates 178 Commonwealth-funded residential facilities. Each facility has nurse/resident ratios in place, a robust staff skill mix and is covered by union enterprise agreements that provide pay rates and conditions well above the statutory minimum in LTC. Many local governments are direct providers of home care services and are also parties to union enterprise agreements, which provide pay rates and conditions well above the statutory minimum and provide excellent continuity of care to clients.

Principle 6: Dignity in Care

Dignity in care depends on relationships between those needing care and the workers providing care. No matter what the setting, having consistency in care — defined by ensuring LTC workers have time to get to know the service user, their preferences and needs — is critical to dignity. Good quality care is unhurried and allows workers the time required to provide dignified care (Baines and Armstrong, 2015). Dignity in care is also dependent on being cared for by workers who are well-trained, skilled and supported. Being able to exercise choice about the care provided and to have some flexibility as to when care is received are both critical. In home care, having a regular worker show up at the time care is scheduled is important. Likewise, being able to choose when to get up, when to go to bed, and having good quality food available that respects cultural preferences, is critical to dignity in any care setting. Establishing the conditions for meaningful connection matters greatly to ensuring dignity in care.

"Putting relationships at the centre of public policy planning focuses attention on how work is designed and organized to ensure that the care providers can, in fact, have meaningful connections with the people they support. This includes, but is not limited to, ensuring job security, employment benefits, higher staffing levels, improved working conditions and compensation levels, and respectful workplace and injury prevention policies. It also means providing initial and ongoing training and education for all staff, with an emphasis on teamwork, so that they are better able to support the autonomy, dignity, and well-being of people with care needs, even as their health deteriorates." Armstrong and Cohen (2020: 4)

Select Indicators of Decent Work and Care Quality

In most analyses of LTC, there is a focus on process and clinical outcome measures of quality, such as falls and wound management. Importantly, these approaches to quality hide the ways in which decent work is linked with good care. In this section, we highlight three key sets of quality indicators with which to assess a country's approach to care provision for older adults: quality working conditions, quality care conditions, and quality systems that support high-quality models of care and adequate staffing.

Indicator 1: Quality Working Conditions

Key indicators of quality working conditions in LTC systems and services include:

- Pay rates that properly value the skill and complexity of work performed;
- Rights to stable employment through permanent full-time or sufficient hours of permanent part-time employment;
- Providers directly employ workers;
- Rights to, and enforcement of, the same employment protections as other workers in male-dominated industries, including in respect of secure contracts, working time security and predictability and paid leave rights;
- Minimum staffing levels, appropriate skill mix and the allocation of sufficient time to provide quality relationship-based care;
- Home care workers paid for the time taken to travel between clients;
- Safe and healthy working environments including in private homes;
- Rights to employment-related social protection benefits such as retirement funds, pensions and superannuation;
- Rights to ongoing training, education and progression within and between jobs; and
- Migrant workers enjoy the same rights and protections as locally-born workers.

Quality working conditions are underpinned by rights to unionisation and collective bargaining:

- Union recognition of the distinctive nature of care work and of the skills and gendered working conditions of workers in LTC
- Right to collective bargaining
  - Sector-level collective bargaining
- 'Right' to strike
- Social partnership and cooperative bargaining models
- Social unionism and activism advances the overall conditions in the sector, including advancing decent working conditions *as well as* good care
  - Contribution to collective and collaborative issues
  - Ability to collect data and engage in research

Indicator 2: Quality Care Conditions

Some Global North countries assess the quality of care by relying almost exclusively on clinical quality indicators. While these may be important to assess, they do not adequately capture service users' experiences of care quality that support their social, emotional and clinical needs. Indicators of care quality *from the perspective of service users* have focused on the nature of time to care, both enough time spent by workers and flexibility around care routines such as bathing and mealtimes. Aspects such as being treated with respect, trusted relationships with workers and recognition of individual preferences and the physical environment are also important.

A focus on quality assurance systems as an indicator of systematic care quality is also misleading. As a case in point, in cross-national comparison, Australia's LTC quality assurance has been rated as 'highly regulated' despite evidence from the Royal Commission into Aged Care Quality & Safety of poor-quality care and unacceptable working conditions.

Indicator 3: Quality Systems that Support High-Quality Models of Care

A quality LTC system enables straightforward transitions between home, community and residential care for older adults and decent working conditions irrespective of the site of care for workers. As the Australian Royal Commission into Aged Care Quality and Safety found, older adults and their families often face difficulties in accessing appropriate and adequate services and poor working conditions for workers, with the lowest pay and worst protections often found in home care services (Duckett and Swerissen 2021). As discussed above, older people and their families report that the social and emotional dimensions of care are the most valuable features of care quality. These dimensions include having a good relationship with regular workers, workers having enough time to care, and older people feeling valued and comfortable with the care provided.

In most countries, family care remains the main form of care for older adults. But with population ageing, high-quality publicly-funded systems and services that provide a *full* range of supports and services in the community, health and support in private homes, and health and care in residential settings are increasingly necessary. For people to remain living at home, quality LTC systems and services recognise that there are limits to family care: families may not live nearby and, even if they do, the older person's care needs may be beyond the resources of the family.

The most robust systems of formal care for older adults, such as in Norway's system, provide care and support to families and people in need of care with public funding and mostly public delivery provided without expecting family members to do this care. A high-quality system publicly funds care and meets the need for care mostly through public and non-profit providers. The care is documented, without having to comply with regulations that are overly prescriptive, such as those that take time away from the delivery of good quality care (Daly et al, 2016). Quality systems fund a range of care and support, from social and emotional through to health and clinical care. A less balanced system, tilted in favour of clinical or social care, will not be able to meet the varied needs of service users. Quality systems and services also provide the conditions for workers to provide personalised care that meets the individual needs of service users.

Section 3: Decent Work / Quality LTC Typology

In this section, we set out a typology of aged care by setting out the factors that affect care, employment and migration and how different countries compare. The typology accounts for variations and commonalities in the care of older adults drawn from detailed country case studies of LTC systems and services in France, Scotland, Chile, Australia, Canada, South Africa, Fiji and India, while also centring the importance of the relationship between decent work and good quality care.[1] These case studies are set out in Section 4.

There are several recent typologies of formal LTC systems;[2] however, few pay attention to service quality *as well as* the quality of working conditions for workers who provide the services. Further, although integrally linked, most typologies ignore the range of sites of care – from home to community and communal / residential living. However, as evidence shows and as the principles and indicators above highlight, the health and social care needs of older adults and the work of care are impacted by the extent to which a country aims for and achieves these principles.

What a country aims for and achieves in its care for older adults depends on how the country approaches care, employment and migration. A country's approaches are formed by a range of interlocking sets of rules, laws and norms that structure who gets care, by whom, where, when and who pays for it (**Figure 3.1**). These structures can be categorised into three 'regimes' — care, employment, and migration,[3] which shape older adults' access to good quality LTC and LTC workers' access to decent work.

Figure 3.1 Model of Decent Work / Good Aged Care (*)

(*) This model builds on Williams, 2012; da Roit and Weich, 2013; and King-Dejardin, 2019

To compare how different countries approach aged care, we lay out significant factors that construct these three regimes (**Table 3.1**). Within each **regime type**, there are multiple factors, each influenced by laws, rules and norms. We assessed countries' approaches to the various **factors** using **comparators** that are based on detailed country case studies (Section 4) [4]. We assigned a green, yellow or red flag rating. A green flag denotes that a country has achieved or is making progress towards decent work and good quality LTC; a yellow flag denotes mid-range performance towards decent work and good quality aged care with more attention required on particular factors; and a red flag indicates that there is less progress towards decent work and good quality LTC (Figure 3.2). Taken together, the flags show where further action is warranted, and reveal patterns in how the regimes operate in reinforcing ways to produce a country's overarching approach to LTC. In **Table 3.1** we indicate the comparators that align with green, yellow and red flags using coloured text.

Figure 3.2

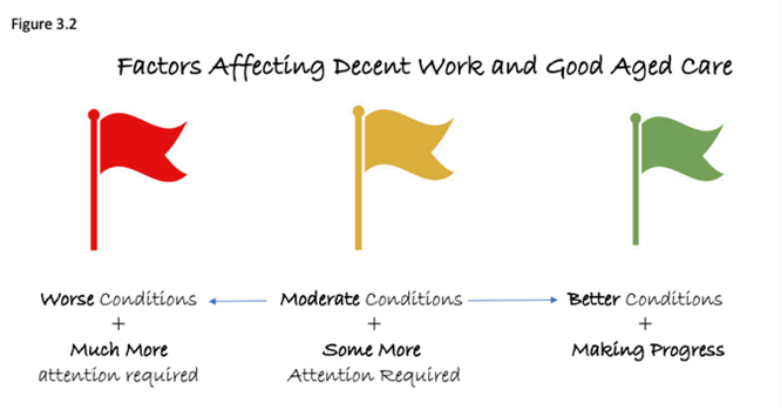


Table 3.1 Decent Work / Good Aged Care Typology

Type	Factors	Comparators
Care Regime	Policy Priority Afforded to Aged Care	Low priority relative to other in-country priorities; Medium priority relative to other in-country priorities; High priority relative to other in-country priorities
	Model of Aged Care	Short-term / Emergency /Mostly Hospital; Emergency + some though not enough LTC & Home Care options; Emergency + robust chronic home care + residential care options
	Availability of formal home, community and residential options	None or very limited; some though not enough availability; Significant Availability
	Ratio of LTC workers to older adults who need care	Low worker to high # older adults needing care (1:12+); Medium worker to # older adults needing care (1:8-11); High worker to lower # older adults needing care (1:7 or fewer)

[1] Aggregate score out of 100. See: https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf

	Extent of reliance on familial and informal relative to formal and paid care	Almost entirely familial; family + some paid care; range of family + paid care options
	Provider ownership types – extent of for-profit provision relative to public / without profit provision	All or mostly for-profit / commercial provision; more balanced between some public / some private provision; mostly public with no or little for-profit provision
	Level of Congruence between Model of Needs Assessment/ Eligibility for Publicly-funded Services Relative to Public Provision	Incongruence -- No Assessment / no public services; Some Congruence --Needs assessment + limited public services; Congruence between needs assessment and public provision of services
	Model of Approval for Publicly-funded Services	Needs-based + means-tested or individual / private responsibility; Some public funding (but not full coverage) for some needs-based users; universal access
Employment Regime	Labour Rights Index total (Access to decent work)[5]	Limited access to decent work (<70); Reasonable access to decent work (71-80); Approaching decent work or decent work achieved (80-100)
	Strength of employment regulation	Weak regulation; some limited regulation; Well-regulated
	Protective Gaps in Formal Aged Care Work: Level of Regulation Relative to Enforcement and Protections	Low regulation, little or no oversight; some regulation, weak oversight and compliance; robust regulation and strong oversight and compliance mechanisms
	Access to Collective Bargaining	Low – no coverage in care work / no broad sectoral agreements; Medium – some coverage for care work; Widespread coverage for care work +/or broad sectoral coverage that includes care work
	Pay & Conditions for LTC Workers Relative to Other National Workers	Poor pay & conditions relative to other skilled workers; moderate pay & conditions relative to other skilled workers; equal pay & conditions relative to other skilled workers
Migration Regime	Capability of Producing a Local Care Workforce Relative to the Need for Migrant Workers	Net receiving country; net sending country; balance between in and out-migration
	Degree of Reliance on Local Care Workers Relative to Migrant Care Workers	Heavily reliant on migrant workers relative to domestic workers; reliant on domestic workers with some migrant workers; reliant on domestic workers
	Legal Supports for Migrant Worker Rights	Weak policy / legal supports / weak enforcement of migrant workers' rights; some policy attention, some enforcement of migrant workers' rights; good policy attention & strong enforcement of migrant workers' rights

The typology links care quality with decent working conditions in national LTC systems/services to assessments of the aggregate 'state of play' through the analysis of national care, employment and migration regimes.

Care regimes for LTC are produced by differences in the conditions for care. The main factors affecting conditions include:

- Policy priority afforded to LTC;

- Model of LTC;
- Availability of formal home, community and residential options;
- Ratio of LTC workers to older adults who require care;
- Extent of the reliance on familial and informal and/or formal and paid care;
- Provider ownership types for LTC and home care reflecting the extent of for-profit provision relative to public sector and non-profit provision; and
- Model of approval for publicly-funded services.

Employment regimes can protect or create risks for aged care workers through limits on the scope of protection and through weak enforcement. The main factors affecting the employment regime include the following:

- Labour Rights;[6]
- Strength of employment regulation;
- Protective gaps in formal aged care work: level of regulation relative to enforcement and protections;
- Access to collective bargaining;
- Pay & conditions of aged care workers relative to other national workers, aiming for equitable pay rates that reflect the skills used and requirements of the work.

Migration regimes are structured by the degree of reliance on workers from other countries or the extent to which a country "produces" care workers for them to then leave to work abroad. The main factors affecting migration regimes for aged care include:

- Capability of producing a domestic care workforce relative to relying on growing the workforce through migrant workers;
- Degree of reliance on domestic workers relative to migrant workers; and
- Legal supports for migrant worker rights, including the extent of employment, political and social protection rights enjoyed by these workers.

The intersection of the LTC approaches with employment and migration regimes in particular countries underpins the production of both the quality of employment in aged care (decent work) and the quality of the care provided (good care).

Section 4: Cases Studies

Overview

The case studies were purposely selected. In all the selected countries, the population of older adults is projected to increase. In Global South countries such as India, older adults aged 65+ comprise a smaller proportion of the overall population than in the selected countries of the Global North; however, they still have very large numbers of older adults.

The cases studies reflect a range of approaches to funding and delivering LTC, with familial care remaining the most common form everywhere. In each case study we highlight the distinctive LTC, employment and migration regimes. Next, we highlight promising approaches and identify key areas and issues for frontline workers and for unions to consider pursuing in order to advance their support for good care and decent work.

Comparing Care Conditions

While all countries rely most on familial care, Australia, Scotland, Canada and France have also developed formal LTC systems that are largely or heavily state-subsidised.

In some places, such as Australia and British Columbia, Canada, LTC services and/or LTC accommodation are means-tested, which can restrict the access of otherwise eligible service users. In Scotland and Ontario, Canada, needs-based home care services and

nursing and personal care in LTC are publicly-funded and free for individual service users. However, there are charges for LTC accommodation, and home care services do not cover all personal care needs. Chile has several public health programmes with LTC components and subsidies for the frail aged and for people with disability. In South Africa, Fiji and India there is some limited formal provision of residential LTC in larger cities. However, care for frail dependent older adults, especially outside cities, is largely inadequate and highly dependent on access to community health services that are primarily focused on maternal and child health. In South Africa, more white than black South Africans are able to access residential care, with the costs almost entirely borne by individuals.

Outside of familial care, LTC systems in most OECD countries are organised by government and delivered by some combination of public, for-profit and the non-profit providers, mostly (but not exclusively) funded by government. There is formal regulation and governance of these systems, including inspection-based oversight, compliance monitoring and public reporting, with emerging formal regulation in Chile as part of wider reforms of the constitution and provision of public services. However, the efficacy of such governance has been assessed as inadequate in Australia, France and in Ontario, Canada. On the other hand, the Scottish Care Inspectorate provides good oversight of care quality, and the Seniors' Advocate in the province of British Columbia audits government and providers and publicly reports on behalf of service users. In other countries where non-familial care predominates, care for dependent older adults is typically provided through informal, paid, or unpaid community care rather than through specific LTC services provided by the government or private sector. There is little formal governance or oversight of the quality of these services. However, nascent formal care services are present in several countries, with emerging government and/or marketised services for older adults such as in Chile and India, most typically in residential or nursing home care, with community-based health services providing some limited care and support for older adults. Such provision in Chile and India is, however, limited due to traditional values across these societies regarding who should provide care and issues of access because of the associated costs.

Although data on LTC expenditure as a percentage of Gross Domestic Product (GDP) is limited, what is available indicates that there is some variation among our selected case countries. In 2018, for example, OECD data indicates that Chile spent just 0.25% GDP on LTC compared to 2.4% by France. ILO data for 2011 suggest that, in India and South Africa, the GDP spend on LTC services is less than 1% (ILO, 2018: 123). The selected countries (both OECD and non-OECD) in this report spend a larger GDP share on health services than on LTC. Indeed, as noted in the Fijian, Indian and South African case studies, the level of health expenditure in these countries means any additional expenditure on specific services for older people will be challenging; the needs of maternal and child health are seen as more pressing.

LTC care systems in most OECD countries have a declining ratio of formal LTC workers, including both nurses and personal care workers, per 100 population aged 65 years and over. While data is unavailable for the UK or for Chile, Australia is the only country among our selected OECD countries that has a better ratio of LTC workers (6.2) than the OECD average (4.9); however, this ratio has dropped since 2011. The consequence of the declining ratio of LTC workers is seen in an increasing incidence of poor job quality in formal LTC reflected in the relatively poor quality of care reported in our selected OECD countries. Furthermore, in residential settings, the ratio of workers to residents is important. For instance, in Australia this ratio is 04 FTE LTC workers to LTC recipients in institutional settings compared to Switzerland with a ratio of 0.7 FTE workers and the USA with a ratio of less than 0.3 FTE (Dyer et al., 2020: 111). These ratios broadly reflect the quality of care in nursing homes in these three countries.

LTC care systems can also be distinguished by the form of ownership of providers, including public sector, non-profit and for-profit owners. The for-profit share of LTC is growing in the selected OECD countries, with an overall decline in public ownership. However, there is considerable variation between countries and even within countries, such as in Australia, Canada and India, as highlighted in the case studies. In France, for-profit ownership of residential aged care is 26%, with 42% operated by public providers. In Australia, while 41% of residential care beds are operated by for-profit providers, only 4% are operated by public providers There is a higher rate of private ownership in residential aged care in Ontario (57%) compared to in British Columbia (BC) (37%) and a related difference in public provision (16% in Ontario and 35% in BC). The remainder are non-profits operating in each province. In Scotland, for-profit provision is lower than in England but it still sits at 83%, with non-profit provision at 13% and public sector provision at just 4%.[7] In Australia, Scotland, Canada and France, the for-profit market is dominated by large for-profit providers, in some cases underpinned by private equity or large publicly traded chain corporations. In Chile, there is growing interest among large for-profit organisations in the care sector, including among multinationals and private equity. There is also some growth in for-profit provision in countries such as India and South Africa, particularly in residential aged care. However, it is important to note that, where residential aged care is publicly provided, as in some regions of Australia and Canada, staffing ratios are higher and are associated with higher quality of care at an aggregate level.

Table 4.1 broadly summarises how each of our countries differ in their **population of older adults** and in their **approach to care**.

Table 4.1 Broad Comparisons of Older Adult Populations & LTC Systems

Countries	**France**	**Scotland**	**Chile**	**Australia**	**Canada**	**South Africa**	**Fiji**	**India**
Demographics								
Average life expectancy (2023)[8]	82 years	81 years	79 years	83 years	82 years	65 years	68 years	70 years
Population 65 + %(#) (2021)[9]	21% (14,446,427)	19% (12,735,560)	13% (2,471,958)	17% (4,256,298)	19% (7,083,670)	6% (3,546,983)	6% (52,873)	7% (95,749,032)
Approaches to Care								
Broad care regime for older adults	Familial/ formal	Familial/ formal	Familial/ informal/ limited formal	Familial/ formal	Familial/ formal	Familial/ Informal/little formal	Familial/ Informal/little formal	Familial/ Informal/little formal
Formal LTC	State-subsidised & means-tested LTC system	State-subsidised – means-tested LTC care, publicly-funded home care	Limited specific LTC provision; home care part of health system	State-subsidised & means-tested LTC system	State-subsidised LTC system-means-testing depends on province; some publicly-funded home care depending on province	Nascent, some public provision, home care part of health programmes	Nascent, some Non-profit provision, home care part of health programmes	Nascent, some FP/NFP provision, home care part of health programmes
Regulation /governance of LTC[10]	Public reporting - varies by admin levels -**inadequate**	Inspection-based - **good**	Emerging - **poor**	Inspection-based **inadequate**	Public reporting - varies by province - **inadequate**	**Minimal**	**Minimal**	**Minimal**
LTC expenditure % of GDP (2018) (OECD average 1.5%) [11]	2.4%	2.0% (UK)	0.25%	1.4%	1.0%	< 1% (2010-2015 only)	NA	< 1% (2010-2015 only)

Health expenditure as % of GDP 2019[12]	11.06%	10.15%	9.59%	9.91%	10.54%	9.11%	3.82%	3.01%
LTC workers per 100 pop 65+ (2016) [13] (OECD average 4.9)	2.3	3.3 (UK)	NA	6.2	3.6	-	-	-

Employment and Migration Regimes

Formal employment protections apply only to the formally employed workforce and, within it, to specific groups of workers. For example, in Australia, employment protections are only available to employees while in Scotland workers are also entitled to some of the employment protections that apply to employees such as the minimum wage, paid holidays, pay slips, written terms outlining job rights and responsibilities and protection against unlawful discrimination. We use the Labour Rights aggregate index to broadly assess the type of access workers have to decent work (Wage Indicator Foundation 2022). The Labour Rights Index is a tool that allows comparative assessments to be made of labour legislation in 135 countries supported by detailed decent work checks.[14] The Index provides an average score out of 100 as well as separate scores out of 100 for selected indicators of decent work.

Based on the aggregate Labour Rights Index, the broad employment regime in France is assessed as the most robust, providing decent work, while the UK is seen as 'approaching' decent work for full-time permanent employees. Canada, Chile and Australia are assessed as having 'reasonable access to decent work' with South Africa, Fiji and India assessed as having 'limited access' to decent work.

Both union density and the reach of collective bargaining are crucial factors in any employment regime. However, the connection between these two factors is not straightforward across our selected countries. While there is a low and declining union density in both France and Australia, union action remains central to achieving improvements in wages and working conditions through sectoral bargaining. In France, while union density sits at just 9% overall, collective bargaining coverage is 98% of the workforce (Wage Indicator 2022). In the French LTC sector, the collective agreements struck provide an important basis for conditions for all sector workers, unionised or not, as do improvements in pay and conditions in LTC sectoral awards won by unions in Australia. In both Australia and Scotland, union-negotiated enterprise level agreements also cover all workers in that enterprise whatever their union status. In contrast, in Canada, with a much higher overall union density than these other countries, collective bargaining, mainly undertaken at the enterprise level, only occurs in unionised workplaces. In countries such as Chile, union density is under 20% with collective bargaining coverage just over 20% (Wage Indicator Index 2022). However, as highlighted in the Chile case study, attention has now moved from a service focus on maternal and child health to union campaigns for decent wages and holidays in services provided to older adults.

In the formal LTC sector, the pay and working conditions in each of our selected countries is generally poorer than that for most other national system workers. In **Australia** and **Scotland**, wage rates sit at just above the statutory minimum wage. In France, pay rates are lower in LTC than in other sectors such as healthcare. Our case studies highlight that there are other gaps in employment protections for those covered by national labour laws. The most common protective gap in Australia and in Scotland is in relation to working time with inadequate employment protections. These protective gaps enable employer-oriented flexibility by flexing the hours of work up and down, even for permanent part-time workers. In **France**, despite strong regulation via sectoral collective agreements, the failure of some employers to comply with protections against temporary contracts is also an issue, as demonstrated most recently in the case of Ophea. In **Chile**, worker insecurity is closely linked with 'funding droughts' at points in the government's financial year when budgets become tighter. This means health and care workers are more likely to be hired on insecure contracts.

In **Canada**, unionised LTC workers have better pay and conditions than LTC workers working in non-unionised workplaces who have to rely on relatively low minimum wages and working time rights set out in provincial employment standards. However, as the case study of **British Columbia**, **Canada** demonstrates, a long campaign by the Health Employees Union has resulted in exemplary government action in raising pay for *all* nursing home workers to public sector levels.

The employment protective gaps in **South Africa** for LTC workers are notable and an area for further attention and response. There is no union specifically supporting LTC workers in **South Africa** and conditions vary considerably depending on the employer. The unionisation of domestic workers in South Africa suggests a path forward, especially for frontline LTC workers. However, despite South Africa's ratification of Convention 189 on Domestic Workers, the South African Domestic Service & Allied Workers Union is still

struggling to make inroads in securing decent work for domestic workers.[15] In India, there are significant protective gaps for Accredited Social Health Activist (ASHA) care workers given they are located in the informal economy and these workers rely on a stipend rather than a salary. Moreover, the minimum wage in India is not binding, thus limiting its reach into care work.

In all countries, LTC workers in community-based or home care are even more poorly protected than those in residential aged care. In Australia, for example, workers are not entitled to be paid for the time travelling between clients, while in Scotland, despite having a legal right to being paid for this time, most employers do not comply, and this right is rarely enforced. Community-based health workers in Fiji and India, who may provide some health-related services to older people in their homes or in the local community, receive little remuneration for their work.

All the selected OECD countries are 'receiving' countries of LTC workers. While most migrant LTC workers are female, men from India and Nepal are increasingly being employed in Australian LTC. Men from Africa are also frequently employed in LTC in Canada, particularly in French-speaking places and organisations. The extent of the LTC sector's reliance on migrant workers varies, however, from very high rates in Australia and Canada to low rates in Chile.

The low rates of pay and poor conditions endemic in Global North LTC systems produce labour shortages. This has resulted in growing employer pressure on governments to increase the supply of migrant workers rather than address the poor wages and conditions at the heart of labour shortages in LTC. The evidence suggests that migrant LTC workers often experience poorer working conditions than locally-born LTC workers (Charlesworth and Malone 2022; King-Dejardin 2019; Bourgeault et. al, 2023). At the same time, migrant-sending countries such as Fiji and India face labour shortages not only in terms of the local availability of LTC and health workers but also in the unpaid care provided by the mainly female migrant workers to their families and communities.

Our assessment of the employment and migration regimes in our selected countries is summarised in **Table 4.2**. It highlights the broad context of employment and migration conditions across our selected countries.

Table 4.2 Broad Comparisons of Employment and Migration Conditions

	France	**Scotland**	**Chile**	**Australia**	**Canada**	**South Africa**	**Fiji**	**India**
Employment Conditions								
Labour Rights Index total (Access to decent work)[16]	92 (Decent Work)	83 UK (Approaching Decent Work)	78 (reasonable access to Decent Work)	77 (reasonable access to Decent Work)	76 (reasonable access to Decent Work)	67 Sub-Saharan Africa (limited access to Decent Work)	N/A (limited access to Decent Work)	65 (limitec access to Decent Work)
Informal employment as % of total employment (2018)[17]	negligible	negligible	29.3%	negligible	negligible	23.6%	60% (2011)	88.6%
Broad employment protection legislation for formal sector	More regulated	More regulated	More regulated	More regulated	More regulated,	Less regulated	Less regulated	Less regulated
Protective Gaps in formal LTC	Strong regulation via union	Regulated via statutory minimum pay	Covered by regulation but some	Regulated via minimum statutory &	Some employment standards	Minimal regulation and little	Some minimum standards for	Limited regulation. ASHA

work: Level of regulation relative to enforcement and protections	sectoral agreements (but some employer non-compliance and weak state enforcement)	& other protections but protective gaps in working time rights	workers have limited rights, especially those on insecure contracts	award labour standards but protective gaps in working time rights	for non-union workers. Well-regulated in most unionised workplaces	enforcement of standards	professional LTC workers - little regulation for non-professional workers	workers ar largely in t informal economy and subje to minimu regulation
Unionisation and Collective Bargaining in LTC	Widespread union sectoral agreements covering all workers; Low rates of unionisation in LTC.	Low rates of unionisation. This varies across sectors, with higher membership in public sector and lower membership in private and non-profits. Collective bargaining is at enterprise level.	Low rates of union coverage.	Low rates of unionisation. Unions negotiate improvements via sectoral awards and single enterprise agreements that cover all workers unionised or not.	High levels of unionisation in residential LTC. Very low levels of unionisation in home care	No specific union coverage of LTC workers.	Some union coverage of nurses in LTC with some sectoral improvements negotiated. No active unions in non-nursing LTC.	Low rates unionisatio There are considera barriers to organizing adult LTC, including having a thorough and accur mapping c the workforce across states.
Pay & conditions of LTC workers relative to other national workers	Poorer	Poorer	Poorer	Poorer	Poorer	Poorer	Poorer	Poorer
Migration Conditions								
LTC sending /receiving / both	Receiving	Receiving	Receiving	Receiving	Receiving	Both	Sending	Sending
Extent of reliance on migrant workers in LTC	Medium	Low	Low	High	High	Low	N/A	N/A

Applying the Decent Work / Quality LTC Typology

Given the country comparisons outlined above and the detailed case studies outlined below, **Tables 4.3** and **4.44** provide an overall assessment of how the countries address each of the factors that produce decent work and good aged care using a green, yellow and red flag system. **Figure 3.2**. considers where countries are along the path towards achieving decent work and good care by

taking account of the number of green, yellow or red flags in each of the three regime types and illustrating whether the country is in one of three zones: making progress, some more attention is required, much more attention is required.

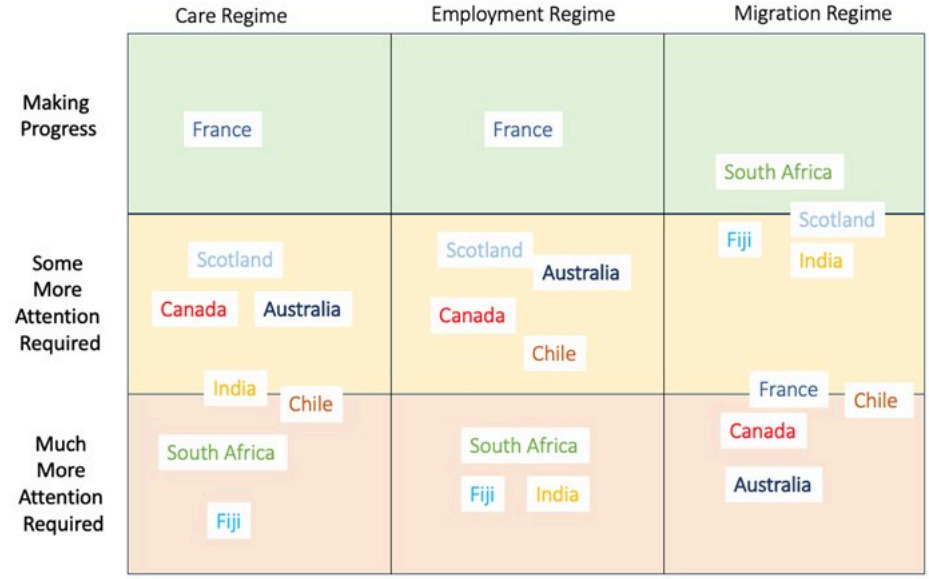
Table 4.3 - Aged care regime

	Aged Care Regime							
	Policy Priority for Aged Care Relative to Other in-country Policy Areas	Model of Formal Aged Care	Availability of Formal Home, Community and Residential Options	Ratio of LTC workers to # Older adults Who Need Care	Extent of Reliance on Familial and Informal Care Relative to Formal and Paid Care	Provider Ownership – Extent of For-Profit Provision Relative to Public / non-profit Provision	Level of Congruence - Model of Needs Assessment/ Eligibility for Publicly funded Services Relative to Public Provision	Model of Approval for Publicly Funded Services
	Low priority relative to other in-country priorities; Medium priority relative to other in-country priorities; High priority relative to other in-country priorities	Short-term / Emergency /Mostly Hospital; Emergency + some though not enough LTC & Home Care options; Emergency + robust chronic home care + residential care options	None or very limited; some though not enough availability; Significant Availability	Low worker to high # older adults needing care (1:12+); Medium worker to # older adults needing care (1:8-11); High worker to lower # older adults needing care (1:7 or fewer)	Family almost entirely; family + some paid care; range of family + paid care options	All or Mostly for-profit / commercial provision; somewhat balanced between some public / some private provision; mostly public with none or little for-profit provision	Incongruence -- No Assessment / no public services; Some Congruence --Needs assessment + limited public services; Congruence between needs assessment and public provision of services	Needs based + Means-tested or individual / private responsibility; Some public funding (but not full coverage) for some needs-based users; universal access
France	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Scotland	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Chile	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Australia	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Canada	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
South Africa	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Fiji	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
India	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩

Table 4.4 - Employment and Migration regimes

	Employment Regime					Migration Regime		
	Labour Rights Index total (Access to decent work)[6]	Strength of Employment Regulation	Protective Gaps in Formal LTC work: Level of Regulation Relative to Enforcement and Protections	Access to Collective Bargaining	Pay & Conditions of LTC Workers Relative to other Workers in the Country	Capability to Produce a Domestic Care Workforce Relative to the Need for Migrant Workers	Degree of Reliance on Domestic Care Workers Relative to Migrant Care Workers	Policy & Legal Supports for Migrant Worker Rights and State Enforcement of Rights
	Limited access to decent work (<70); Reasonable access to decent work (71-80); Approaching decent work or decent work achieved	Weak regulation; some limited regulations; Well-regulated	Low regulation, little or no oversight; some regulation, weak oversight and compliance; robust regulation and strong oversight and compliance mechanisms	Low – no coverage in care work / no broad sectoral agreements; Medium – some coverage for care work; Widespread coverage for care work +/or broad sectoral coverage that includes care work	Poor pay & conditions relative to other skilled workers; moderate pay & conditions relative to other skilled workers; equal pay & conditions relative to other skilled workers	Net receiving country; net sending country; balance between in and out migration	Heavily reliant on migrant workers relative to domestic workers; reliant on domestic workers with some migrant workers; reliant on domestic workers	Weak policy / legal supports / weak enforcement of migrant workers' rights; some policy attention, some enforcement of migrant workers' rights; good policy attention & strong enforcement of migrant workers' rights
France	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Scotland	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Chile	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Australia	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Canada	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
South Africa	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
Fiji	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩
India	🚩	🚩	🚩	🚩	🚩	🚩	🚩	🚩

Figure 3.3 **Achieving Decent Work and Good Aged Care**



Our analysis confirms that no country has a perfect system of LTC. There are many factors that can be addressed to better support decent work and good quality LTC in each of the countries we examined. When we explored whether and how our selected countries are clustered, we found that **France** alone has made good progress across a range of factors affecting its care and employment regimes. However, there are still specific factors that require advocacy, highlighted by yellow and red flags. In addition, more attention is required in countries such as **Canada** and **Australia** across a variety of factors affecting care and employment. There are fewer red flags for **India**, **Fiji** and **South Africa** in terms of the migration regimes – because they do not rely on migration for their domestic care workforce – but, coupled with weaker employment regulation and a lack of care infrastructure, this raises flags about being able to achieve good LTC supported by decent work. **Chile** requires some more or much more attention to most of the care, employment and migration factors we assessed.

The detailed case studies outlined below provide narrative details in support of our analysis, highlight promising approaches in each country, and provide specific recommendations for advocating for improvements in the conditions of work and the condition of care.

France

France has a population of almost 68 million, 21% of whom are aged 65+ and 10% 75+. While the overall proportion of the population in France is ageing more slowly than in many OECD countries due to its higher proportion of younger people, it is estimated that, 28% of the population will be aged 65+ by 2050.[18]

Care Regime

In France, formal care and support is provided to dependent older adults through both the social and health systems. Familial care remains important to both systems and French policies on LTC explicitly assume the availability of familial care (le Bihan 2018; Oung ND). There are different policy and legislative responsibilities for health, social and medico-social services in the provision of formal LTC in France. LTC is funded through a mix of social insurance and taxation revenue (Addati et al 2022: 260) but provision is fragmented and complex as it involves diverse funding arrangements through, and care providers managed by, different levels of government: the state, regions, *départements* and municipalities (Or & Penneau 2021). In respect of LTC, *départements* finance and implement the national personal autonomy allowance (*allocation personnalisée d'autonomie* [APA]), the French LTC cash-for-care scheme for those aged 60 years and over with a medium to high level of dependency, which provides income-related benefits.[19]

In France there are more than 7,200 nursing homes, known as EHPADs (*établissement d'hébergement pour personnes âgées dépendantes*) with over 10,000 home care and support services. Of those aged 65 years and over, 6% use community-based LTC (including in home), while 4.1% use residential aged care facilities (Addati et al 2022: 257). It has been estimated that, of the frail elderly in France, 24% are cared for by family members or friends while another 42% are cared for through a mix of familial and formal care provision. Another 14% receive formal home care and 20% reside in a nursing home (Barczyk & Kredler 2019).

Austerity policies in the hospital sector have excluded the dependent elderly, which has meant that, over time, nursing homes have taken on the care of highly dependent older people, for whom they are inadequately funded. Working conditions have deteriorated as management practices have emphasised cost containment and operating productivity rather than care and support (Nirello et al 2022).

Départements also regulate care services within their jurisdictions (le Bihan & Martin 2019) and, over time, have increasingly contracted out the provision of residential aged care and also home care to for-profit providers. At the same time, due to the introduction of the APA in 2001, used by older people and their families to hire home support workers for domestic work and personal assistance, the grey market for domestic work has become somewhat more regulated (Wollman 2022). In 2018, of the then 6,992 EPHADs, 42% were operated by public providers, 32% by non-profits and 26% by for-profit providers. The 620 private retirement homes were all operated by for-profit providers. In 2008, of the then 6,000 home care and support services, 11% were run by public providers, 60% by non-profits and 29% by for-profits (Or & Penneau 2021: 106). While for-profit providers mainly service highly dependent residents, for which they attract higher fees, the ratio of support workers to residents in for-profit facilities is far lower: 49% compared to 67% in public providers and 53% in non-profits, which both service a more balanced mix of residents (Boutaud 2022).

Two of the largest for-profit LTC companies operating in Europe, Orpea and Korian, are domiciled in France (Investigate Europe 2021). In 2022, Orpea's market share in the French care home 'market' was 5.5% followed by Korian with a market share of 5.4%.[20] In 2022, an independent journalist, Victor Castanet, wrote *Les Fossoyeurs* ("The Gravediggers"), which investigated Orpea's management of EHPADs in France. His investigation highlighted the ways in which the company cut costs, including through rationing medication, food and direct care and by providing very poor working conditions (Boutaud 2022).

There is also some evidence that Orpea has been using temporary employment contracts to replace the permanent contracts employees had been on at its nursing homes in France (Miñano & Drevet 2022). Government investigations into these alleged breaches of labour regulation as well as allegations of institutional abuse and financial offences at Orpea were launched (RFI 2022). In 2022, a French Court upheld calls by the CFDT and other unions to represent Orpea's workers rather than an in-house 'union' whose interests appeared to align with management rather than the company's workers (PSI 2022). In February 2023, Orpea announced a financial restructuring in the wake of having to repay 56 million euros of public LTC funding after an independent audit found evidence of financial wrongdoing, including inflated labour expenses and large payments to third parties.[21]

COVID-19

As of the end of January 2022, there had been 129,747 COVID-19 related deaths, of which 34% were care home residents. In early 2021, there were 47,428 cases of COVID-19 recorded among LTC workers, of whom at least 17 had died (Oung ND). High levels of LTC staff sickness, who faced poor working conditions and limited support, have led to chronic workforce shortages in the LTC sector. The most common reasons given for staff leaving the sector include low wages, and mental and physical exhaustion relating to the pandemic (Oung ND). As in other countries, COVID-19 has both laid bare the structural faults in LTC in France and exacerbated the detrimental effects of austerity policies, reflected in the lack of adequate staff ratios of nursing and other staff and of adequate protective equipment and medication (Nirello 2022).

In 2021, France announced a reform plan in response to the COVID-19 crisis, which proposed a number of measures to improve LTC, including establishing a new financing mix for the supply of LTC to reduce residents' financial contributions, and introducing a new cash benefit for homecare (Oung ND).

Employment Regime

While industrial relations reform in 2017 weakened the individual and collective protections provided by the Labour Code, the French employment regime remains robust by international comparison. Union density is relatively low. However, as in Australia, collective agreements struck between unions and employers apply to *all* employees whether they are union members or not, with the coverage rate of collective agreements in France being one of the highest in the OECD (ETUI 2019). In 2019/2020, almost 100% of the LTC workforce was covered by collective agreements, or an extension of the collective agreements mechanism, including in the private sector though a national collective agreement (Eurofound 2020).

In 2018, PSI reported that the 7,200 EHPADs and 10,000 home care services in France were supporting 1.4 million elderly people and employing over 700,000 workers (PSI 2018). Relative wages in the sector have been deteriorating. In 2014, hourly earnings in residential care were only 82% of average national earnings, down from 87% in 2010 (Eurofound 2020). Part-time work is relatively high, comprising 89% of home care employment and 42% of residential aged care employment in 2019 with relatively high rates of time-related underemployment (Eurofound 2020). Most of the growing number of part-time workers are *involuntary* part-time workers with decreases in average monthly hours to 108 per month in 2017 (CFDT 2019).

The PSI and its French affiliates have expressed significant concern about the structural understaffing and deteriorating working conditions in LTC, which compromise the delivery of safe, quality and dignified LTC services to the elderly (PSI 2018). There are no mandatory staff ratios in EHPADs and staff do not have enough time to undertake basic personal care tasks (CFDT 2019). In early 2018, LTC workers joined others in support of national strikes, with CFDT Health & Social Care (*CFDT Santé Sociaux*) drawing attention to the direct link between decent work conditions and quality LTC service delivery. The union argued for an increase in staffing levels, better pay and career structures, improved working conditions and permanent funding for home support, as well as a new model for the care of the elderly, including minimum 'bedside' worker staffing levels at all EHPADs and more time for home care workers to undertake their work (PSI 2018; CFDT 2019).

The risks due to inadequate funding of the LTC sector and the resulting cost-cutting in facilities has been shifted onto workers. As a result:

> 'employees inevitably perform tasks that extend beyond their job description: they have no choice but to carry out tasks that are essential, but for which they are not qualified, to provide residents with the care and assistance they need (auxiliary staff help with grooming while nursing aids provide medical care). There is a disconnect between the work performed and salary levels, which remain low, making the sector unappealing and as a result, most nursing homes struggle to recruit staff, therefore exacerbating the already low caregiver-to-resident ratio in these facilities' (Nirello et al 2020).

In 2020, in the wake of COVID-19 and staff shortages, care worker pay in the EHPADs was reviewed and increased to make the nursing home sector more attractive to workers, with pay rates for home care workers in the public sector increased from October 2021 by 15% (Oung ND; CFDT 2022).

Migration Regime

In 2015, France was one of the top 10 countries hosting migrant workers (King-Dejardin 2018). As a member of the European Union, the migration of other European nationals to France has been a long-term feature of the migration regime in this country. Migrant workers comprise a relatively small share of LTC workers (around 15%) in France, which is well below the OECD average of 20%. However, the share of migrants in France reporting that they are overqualified for the work they do is greater in the LTC sector than in any other (OECD 2020). As in England, migrant workers in France are employed predominantly in the formal care sector (Eurohealth 2019). However, there are still significant numbers of migrant workers in the grey area of domestic work because home-based personal care and the provision of household services have been covered by different social and public policies since the 1980s (ILO 2018).

Current & Potential Strategic Levers for Action

In the context of the fault lines in marketised LTC laid bare by the COVID pandemic, there has been an argument made for a stronger role for local government in the provision of LTC. Such a proposal is not only a counter to marketisation and the 'entrepreneurial logic' that has so detrimentally compromised the quality of LTC provision but is also about ensuring the operationalisation of LTC in the best interests of local communities (Wollman 2022: 293). In France, in particular, this would be a worthwhile strategy for PSI affiliates to consider given the importance of local government in that country.

French unions have drawn a clear connection between care quality and worker conditions in LTC in their campaigning for decent work in the sector. In advocating for a new LTC model in France, in 2018 the CFDT Health & Social Care endorsed the recommendations made by the Economic Social and Environmental Council (CESE) in its 2018 report 'Vieillir dans la dignité' (Growing Old with Dignity) to:

- Prevent, anticipate and fund the loss of autonomy;
- Adapt residential and home care service provision to meet community needs and expectations, including determining the principles for sustainable affordable funding of home care services;
- Find new ways of working together to respond to the challenge of providing comprehensive and dignified support, including immediately introducing a minimum standard of 0.6FTE per resident 'bedside' staffing levels at all EHPADs;
- Reorganise staff working hours to ensure decent working conditions, including guaranteeing the presence of a registered nurse overnight;
- Make the upgrading of classifications in LTC a priority in social dialogue to reflect the changes in job demands (PSI 2018; Esch 2018).[22]

Scotland

It has been estimated that, by 2035, the proportion of Scotland's over 75s population will have grown by 82% from 8% to 13%. In addition, almost 1.5m individuals will be aged over 65, of whom half will be over 75. The ratio of people of pensionable age to those working is expected to rise from 32% to 38% per 100 (Joseph Rowntree Foundation, 2014). It is estimated that this rapidly ageing population will mean that Scotland requires an additional 80,000 LTC jobs by 2035 (Scottish Trade Union Congress, 2022).

Care Regime

The United Kingdom has a highly regulated LTC system funded through a mixture of private and public resources. The UK has a devolved political administration whereby increasing responsibility for economic and social policy has been passed to the nations of Scotland, Wales and Northern Ireland.

Scotland has shown political will to differentiate its approach to LTC from the largely neoliberal model practised in England. Key points of divergence include policies such as Free Personal Care for the Elderly, the Social Care (Self-Directed Support) (Scotland) Act, 2013 (promoting individualised services), and the Public Bodies (Joint Working) (Scotland) Act (2014), which is designed to integrate health and social care.

The funding of care for the elderly in Scotland is undertaken through a mixture of taxation and personal contributions. Taxation includes personal income tax paid to central government and leading to subsidies to local authorities. Despite 'free personal care' in home care services, care home and nursing home services are means-tested based on eligibility criteria, including personal savings. LTC services have largely been delivered by a combination of public, non-profit and for-profit providers, with the latter providing the majority of services in terms of residential care homes and care at home.

Scotland's LTC system has several features that are seen as best practice, including:

- An LTC inspection regime, through the Care Inspectorate, responsible for enforcing care standards.
- The Scottish Social Services Council (SSSC) regulates the social service workforce, including LTC workers in Scotland. The responsibilities of the SSSC are to register all workers, set standards for their practice, and conduct training and education to support professional development.

Employment Regime

Despite relative prosperity in the UK, workforce problems, including in-work poverty and insecurity, are endemic in the marketized LTC system. Pay and conditions are a major issue. Workers are expected to be skilled, qualified, professionally regulated and rigorously police checked because of the responsible, high-risk nature of their roles, and yet pay is still poor. Prior to 2015, pay in the LTC system was traditionally close to the national minimum wage. The sector was characterised by large numbers of workers on insecure zero-hours contracts (contracts with no guaranteed hours of work). This was especially the case in LTC for the elderly,

where the largest proportion of employees are located. In 2015, under pressure from unions and anti-poverty groups, the Scottish government introduced a commitment to pay every worker in adult LTC the voluntary 'real living wage' (a rate which is marginally higher, based on cost of living and higher than the statutory National Minimum Wage).

The professionalisation of LTC workers and their responsibility to abide by Codes of Practice mean they can be suspended from, or removed from, the register of LTC workers if concerns about their fitness to practise are upheld. Low unionisation in the outsourced for-profit and non-profit services means many workers do not have adequate representation if action is taken against them.

Sustainability of the LTC in Scotland is being threatened by a recruitment and retention crisis. In 2019, worker vacancy rates were highest in home care services (62%) and care homes for older people (59%). This recruitment and retention crisis has not been helped by the UK's changing migration regime following Brexit, as set out below. Prior to the pandemic, EU citizens made up approximately 5.6% of the Scottish LTC workforce but this fell to 5.0% in 2022.

Higher levels of funding have been recommended by the Scottish union movement to increase pay rates for frontline LTC workers, and also to maintain differentials between ancillary and supervisory staff. Increased pay is also recommended to reduce competition for labour with other low paid sectors (retail and hospitality), which can pay the same rates but do not require the same skill levels and responsibilities (Scottish Trades Union Congress, 2022).

The Scottish government has introduced some policy changes that are viewed as progressive. Such measures include a commitment to Fair Work (FW). It is hoped that these initiatives will form an alternative social democratic form of employment relations in Scotland that differs from the neoliberal agenda of England (Heery et al, 2020; Sisson, 2019). In Scotland, FW has five dimensions. The first covers *worker voice* with explicit support for collective bargaining (Fair Work Convention (FWC), 2016).

Under the Scottish Fair Work (SFW) framework, representation through trade unions or other managerially sponsored mechanisms are seen as legitimate approaches to allow workers to contribute to debates and decision-making. The Fair Work Action Plan commits the Scottish government to increasing collective bargaining in LTC along with other low paid sectors (STUC, 2020). Moreover, there is a strong emphasis on 'mutual gains' as representation and voice are seen to benefit employers as well by improving organisational performance (FWC, 2016). Unionisation has been traditionally low in the sector, although larger providers are more likely to recognise unions. Union recognition is lowest in the for-profit sector, which has the most LTC employees. Unions have a stronger presence in non-profits but there have also been cases of anti-union behaviour such as derecognition of unions in this sector (Cunningham, et al, 2022).

The four other FW dimensions are security, respect, opportunity and fulfilment (Fair Work Convention, 2016). In terms of working towards security for LTC workers, the Scottish government's Fair Work plan for adult LTC (2018) pressed for local authorities (the main funders of LTC services) not to engage in contracts with providers that encouraged the use of zero-hour contracts for workers.

In 2015, the Scottish government introduced 'soft' regulation that resourced and committed local authorities to fund the services of outsourced providers so that they were able to pay frontline adult LTC workers the 'real living wage' (RLW) (Cunningham et al, 2018). These provisions were further updated in 2022 so that Scottish local authorities can use contractual terms requiring outsourced providers to pay the RLW. The Scottish government also encourages public authorities and their suppliers to aspire to be FW employers (Scottish Government, 2018). Moreover, in the Statutory Guidance on the Selection of Tenderers and Award of Contracts: Addressing Fair Work Practices (2015) (Updated, June 2023), requirements include the stipulation that providers have appropriate channels for effective voice. Unions are top of the list of recommended voice channels because the guidance cites how countries with higher rates of membership and collective bargaining coverage have high employment rates, strong productivity growth, competitiveness and innovation. The latest version of this guidance includes a requirement that those organisations providing services on behalf of the Scottish government should:

> **"engage with the workforce and unions, where they are present, in defining and monitoring the commitments they make to advancing fair work in the delivery of the contract during the life of the contact" (Scottish Government, 2023, page 9)**[23]

However, FW still has limited statutory power to enforce its principles on employers. This lack of enforceability is because employment law remains a reserved power for the UK Westminster government, not the Scottish government. Studies have subsequently raised concerns about the impact such 'soft' regulation has on employment relations in LTC without the backing of statutory enforcement (Cunningham et al, 2022).

After years of austerity funding of the LTC system, the Scottish LTC system is now also facing a threat brought about by the cost-of-living crisis. The comparative weakness of employee voice in outsourced LTC services compared to the public sector has significant consequences. Projected negotiated uplifts in pay within the LTC public sector will not be passed on to those working in outsourced services. This will exacerbate the pay gap between employees in for-profit and non-profit organisations, and public sector employees. Annual salaries for for-profit and non-profit employees can be as much as £2,000 per annum less than for public sector employees (CCPS, 2023). In addition, there are considerable gaps between public and for-profit and non-profit sector employers in terms of pensions, holidays, sickness entitlements and unsocial hours payments.

Union members have reported how austerity funding in LTC services remains the biggest barrier to the delivery of effective services (UNISON, 2022). Employers also recognise that Scotland's current LTC budgetary settlement is inadequate. A recent survey of employers in the non-profit sector revealed how a majority of providers (63%) are considering reducing services or handing services back to local government because they are not sustainable at current prices (CCPS, 2023).

In parallel with these developments, the 2020 Feeley Report has led to the Scottish government committing to introduce a National Care Service. Feeley's recommendations retain the mixed economy of public, for-profit and non-profit providers rather than nationalisation but also maintain a continuing commitment FW values, including worker voice. Indeed, one of its recommendations has been the establishment of sector-wide collective bargaining. However, this progressive recommendation is in the early stages of construction.

Despite its progressive intentions, and at the time of writing, the National Care Service Bill (2022, June) makes no distinction between the quality of care delivered by public, for-profit and non-profit providers. Statutory duties for LTC are being transferred from local authorities to sit with local Care Boards, which will control the funding. Once the statutory duties of local authorities are removed, there is concern that there will be no reason for local authorities to directly provide any care services. Two-thirds of UNISON members do not support services being removed from councils, and 71% think ending direct public provision will have a negative impact on the people who receive a social care service. Moreover, 77% say the changes will mean insecurity for staff and 64% are concerned about their pension (UNISON 2022b). In response to pressure from stakeholders, including the unions, the Scottish government agreed with local authorities and NHS representatives that councils should retain responsibility for social care assets and continue employing staff. Moreover, it has slowed down implementation of the Bill, so that more debate and consultation. UNISON also has an *Organising to Win**[24]*** strategy, which will be directed at the social care sector, including across the devolved nations in the UK.

Migration Regime

Migration remains a reserved power with the Westminster UK government. All LTC providers in Scotland are regulated by UK's new immigration system, which reduces the free movement of EU nationals and restricts the recruitment of migrant workers into the sector. The changes led to the introduction of the Skilled Worker route, which meant that EU and non-EU citizens could not enter the UK for the purpose of undertaking care work. As from 15 February 2022, care workers can be brought into the UK on the Skilled Worker Visa if they receive a salary of at least £20,480 per year, based on a 39-hour week of £10.10 per hour (Scottish Government, 2022).

Scotland is less reliant on migrants in LTC than England: the latest Skills for Care report for England shows 16% of the LTC workforce were born overseas (9% from non-EU and 7% from EU) (SSSC, 2022). Nevertheless, the Scottish government recognises how Brexit has impacted on recruitment in LTC. Due to restrictions on immigration, there has been a significant reduction in the capacity to grow and staff services to vulnerable people, especially in rural areas such as the Highlands and Islands, and urban hotspots such as Edinburgh (Scottish Government, 2022). Appointing nurses in LTC has also become difficult since Brexit because of perceptions of uncertainty concerning eligibility for visas, and long-term security in terms of achieving settled status for migrant nurses (Scottish Care, 2021).

The Scottish government continues to encourage migration to help alleviate LTC recruitment problems, as well as the falling population and low birth rate (Scottish Government, 2022). In terms of care, this means that social workers from a non-UK country can apply to the Scottish Social Services Council (SSSC) to have their qualification assessed against the SSSC's qualification criteria. Other care workers with non-UK qualifications who are working in a job that requires registration with the SSSC can also have their qualification assessed against the SSSC's qualification criteria if they have European Economic Area (EEA) mutual recognition rights.

Since COVID-19, PSI affiliates have reported significant migration of workers from countries such as Nepal to the UK. UNISON is currently working with other PSI affiliates to develop a greater understanding of the working conditions of these workers on entering the UK system.

Current & Potential Strategic Levers for Action

- Campaign against the potential ending of direct public sector provision of LTC services in Scotland.
- Sector-level collective bargaining.
  Where collective bargaining is not present, as a minimum standard to ensure worker voice, there should be some form of voice forum based on staff preferences to make individual or collective representations.
- LTC contracts to be awarded on condition of giving unions' recognition and access to facility time (time given to union officers to undertake their duties).
- Access for UNISON to speak to all workers in outsourced services and the creation of local forums for trade union representatives to speak to managers about issues in the sector.
- Even where employers do not recognise a union, organisations should support time off for trade unionists to engage with other members, individual representation in discipline and grievance cases, time off for union training and a forum with managers to represent members' concerns.

Australia

Introduction

Australia has a population of over 25 million people, 16% of whom are aged 65 years and over with 2% aged 85 years and over. It is projected that the proportion of older people will continue to grow, with 23% of the total population aged 65 years and over and around 4% aged 85 years and over by 2066.[25]

Australia is a federation and the federal, state and territory governments have different responsibilities in different areas of public policy and service delivery. The Australian government is the primary funder and regulator of the LTC system. It funds aged care providers under the federal Aged Care Act 1997.[26] Providers are accredited, regulated and inspected by the federal Aged Care Quality & Safety Commission (ACQSC), which also deals with complaints against them.

In 2021, the Royal Commission into Aged Care Quality & Safety made a significant set of recommendations to government that sought to address inadequate care quality via a new Aged Care Act, a new funding model for, and improved staffing in, residential aged care (built around having a registered nurse on site 24 hours per day 7 days per week, and a minimum number of care minutes per day per resident) plus further review and monitoring of quality standards, more transparent sector and provider governance, and, importantly, mechanisms to address poor wages and conditions in the aged care sector, as detailed below.[27] In implementing the Commission's recommendations, the current Labor government has to date introduced the *Aged Care Amendment (Implementing Care Reform) Act 2022* and the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022.* From October 2023, all aged care homes will have to meet individual care requirements based on a sector average of 200 minutes of care per resident per day, including an average of 40 minutes of care by a registered nurse.[28]

Care Regime

As in most countries, familial care continues to be the main form of care provided to dependent older adults. Access to government-subsidised LTC is determined by people's assessed need. There are increasing numbers of LTC service users, particularly women, who account for around 2 in 3 LTC service users. Data on aged services and service users is kept by funding programme. In 2021, 191,029 people used residential care and 825,375 used block-funded home care support with 176,157 using individualised home care packages. Service users are getting older[29] and the use of LTC also increases with age. In 2020, 36% of those aged 70 and over and 85% of those aged 85 years and over were accessing subsidised LTC in Australia (ACFA 2021, 30).

COVID-19 has had a disproportionate impact on those living in residential aged care, with residents accounting for approximately one-third of all COVID-19-related deaths in Australia.[30] While data has been kept on the impact of COVID-19 infections on residential aged care service users and staff, adequate data has not been kept on either home care service users or home care workers.

Current LTC context and provision

LTC services are delivered by non-profit, for-profit and government providers, with some services providing both home care and residential aged care. In 2021, 41% of places in residential aged care were provided by for-profit providers, 55% by non-profit and 4% by government. In the home care packages programme, 36% of services are run by for-profit providers with 52% by non-profit and 12% by government providers. The share of for-profit providers has grown rapidly since the inception of the individualised home care packages programme in 2015, when it was just 10% (ACFA 2021).

A 2018 study of for-profit aged care provision in Australia found that there had been a rapid growth in the size and spread of for-profit companies, with the six largest companies operating over 20% of residential aged care places (Ward 2018). In 2017, these companies received more than A$2.17 billion via tax-funded government subsidies, making profits of A$210 million between 2016-2018, after paying only around A$154 million in tax (Ward 2018: 5-6). The study showed that these for-profits used complex taxation structures to minimise tax with little transparency and public accountability for the public funds they received to provide aged care.

The proportion of for-profit provision in LTC has increased over time albeit not as rapidly as in other comparable OECD countries. This may be due to the distinctive tax advantages enjoyed by non-profit providers in Australia, which are registered as charitable organisations. Charitable status allows the use of significant tax concessions, including in the payment of income tax, allowing the payment of board members as well providing for income tax concessions for eligible staff, which most benefits those on larger salaries (Charlesworth and Marshal 2011). A study of nine of the largest non-profit aged care providers in Australia also revealed that their operations are essentially run along for-profit lines with complex tax structures enabling significant minimisation of income tax while prioritising investment and growth over care quality. The study also highlights the use of revenue from publicly-funded residential aged care to fund property investments, while reporting losses. Like the for-profit providers, these non-profits use tax structures to minimise income tax, with major discrepancies between their financial reports and government funding data (CICTAR 2020). CICTAR research on the ways non-profit providers have internalised for-profit practices suggests that privatisation is a systemic source of poor quality LTC services and poor quality LTC jobs.[31]

Marketisation & Individualisation

Prompted by the burgeoning cost of LTC, marketisation in aged care in Australia started in 1997 with the removal of 'critical brakes' on the potential profitability for private providers (Meagher 2021). These brakes included mandated minimum staffing levels and requirements that providers account for their expenditure of public funds on care staff. The removal of such brakes allowed the outsourcing of the federal government's duty of care for older people to private providers, with some of the largest private companies being listed on the stock exchange and making significant profits which, in turn, has led to significant payouts to shareholders (Morton 2020).

During the same period, there was the adoption of the term 'consumers' for service users and a growing emphasis on 'user-pays' contributions, which has allowed providers to charge additional costs in residential aged care. In the home care sector, this shift led to an emphasis on individualisation and 'consumer choice'. In its current iteration, the rhetoric of 'consumer-directed care' underpins the home care packages programme, which as above has seen a rapid increase in the entry of for-profit providers, including international home care franchises. Profit-taking is enabled by charging clients market costs for the care and support provided. These costs come out of the allocated individual annual package together with additional administration and management fees charged by providers. Changes recently introduced in the wake of the Royal Commission will cap these additional charges and require providers to publish their prices for various services.

By relying on market instruments such as competition, consumer 'choice' and private provision to organise aged care, "successive governments on both sides of politics have left older Australians vulnerable to poor care and the care workers who help and care for them vulnerable to exploitation. As big businesses have entered the sector, they have threatened quality, working conditions and the normative underpinnings of the care system" (Meagher 2021). One of the paradoxes in the Australian LTC system has been that, despite the increase in public funding, the amount spent on individual service users has declined by more than 40% over the last 25 years, leaving the basic needs of many service users unmet (Considine 2022: 65). Finally, the rhetoric of individual 'consumer choice', while powerful in Australian LTC policy, has in many instances masked profit-taking and poor care services. Considine notes that the choice model is a trap for the vulnerable and a 'bonanza' for vested interests and argues that policy focus should instead be on consumer 'voice' (Considine 2022: 79, 88).

Employment Regime

By international comparison, Australia has a long-standing and unique system of employment regulation. Historically, industry 'awards', determined by an industrial relations tribunal on the basis of applications from unions and employers, set pay rates, working time conditions and other minimum conditions for all employees, unionised or not, in a particular industry. Awards set out the rights and protections that apply to full-time, part-time and casual employees. Casuals are employed per engagement, with few formal rights to ongoing employment. They are not entitled to paid leave rights but are entitled to receive a 'casual loading' of 25% on hourly award rates of pay.

In LTC, different industry awards provide the conditions for nursing-qualified employees, frontline residential aged care and home care employees. For frontline employees, the minimum conditions of awards in terms of both pay rates and working time are poor and have significant protective gaps. These protective gaps facilitate employer-oriented flexibility through just-in-time rostering, even for part-time employees, and the fragmentation of working time across the day and week leading to high rates of underemployment

(Charlesworth 2021a; 2021b). Unlike in the UK and New Zealand, Australian home care workers have no formal entitlement to be paid for the time they spend travelling between clients.[32]

There is limited specific monitoring of LTC sector employment conditions by the Fair Work Ombudsman and home care workers are sometimes asked by employers to register with the Tax Office as self-employed (Charlesworth & Howe 2018). As well as sham contracting, there has been a growth in LTC employment though care platforms. While widely promoted as merely linking clients with workers, care platforms exercise control over workers by shifting the risks and responsibilities in the provision of care from the platforms to the workers and clients. This is done by pushing the cost of doing business onto workers; dictating contractual arrangements; and through 'monitoring' selected standards of work performed, often via a rating system by clients (McDonald et al 2020).

The significant social and financial impacts on LTC workers caused by employment conditions in the sector was documented in a 2021 Job Security Select Senate Committee Report. This report also highlighted the impact of poor employment conditions on LTC service users and on the safety and quality of care, including through the lack of care continuity caused by employer rostering practices and turnover in the sector.[33]

At the end of 2022, the new Labor government legislated for significant changes to the Fair Work Act 2009, including making *achieving* gender equality a key objective in FWC deliberations on modern awards and in the annual minimum wage review. One of the other significant changes was the establishment of two panels within the FWC, one dealing with pay equity and work value matters and the other with award matters in care and community services sectors.[34] Both reforms offer significant potential for union applications to improve wages and conditions in the feminised and undervalued LTC sector over the shorter and longer-term.

Migration Regime

Historically, Australia is a country of permanent migration. However, over the last two decades migration policy has swung firmly in favour of limited permanent skilled migration, with most reliance on temporary skilled migration. Australian migration policy is again under review, with the Labor government expressing preference for permanent migration, including from the Pacific.

Australia is a receiving country of LTC workers. While professional nurses have had access to skilled migration pathways, there has been no specific migration pathway for frontline LTC workers. However, migrants workers in LTC have entered over time as permanent migrants, refugees, family members of other visa holders and as students (Charlesworth & Malone 2022). The proportion of migrant frontline LTC workers has always been high in comparison to the OECD. The proportion of migrant LTC workers has continued to grow, with workers coming increasingly from non-English-speaking background (NESB) countries rather than mainly from the UK and New Zealand as was the case post war. 2016 labour force data on migrant care workers more broadly show that they are increasingly coming from Southern Asia (mainly India, Sri Lanka, Nepal and Bangladesh), Africa and the Philippines. Of those working as care workers in 2016, 47% had arrived on temporary visas in the 2007- 2011 period, while 76% arrived on temporary visas in the 2012-2016 period. This trend is consistent with Australia's migration policy of temporary migration over this period (Eastman et al 2018c).

Low wages and poor working conditions have long underpinned significant challenges in recruitment and retention in the LTC sector. Particularly since the beginning of the COVID-19 pandemic, which has further depleted the number of workers prepared to work in LTC, there have been calls by employers for increased migration, including from the Pacific Islands, as outlined in the Fiji case study via the Pacific Australia Labour Mobility (PALM) scheme. While migrant aged care workers in Australia are entitled to the same minimum employment conditions as Australian-born workers, being an NESB migrant is significantly associated with both casual status and underemployment. Generally, while this association lessens with the years spent in Australia, exposure to casual employment is amplified over time for NESB residential care workers. Holding a temporary visa increases the likelihood of casual employment for residential care workers and underemployment for home care workers. Working for a for-profit employer was also associated with poorer job quality (Charlesworth & Isherwood 2022).

Current & Potential Strategic Levers for Action

- In order to frame claims for improvement to LTC worker conditions in the relevant LTC awards, unions should explore the potential of the new FWC Care & Community Services Panel & Pay Equity panels.
- Unions need to advocate for the retention of public sector LTC where it exists and for public sector models in union claims in respect of new classification structures in the Aged Care Work Value case, such as those operating in Victorian residential aged care, Victorian local government home care and in the former New South Wales home care service.

- Australian LTC unions should support unions in Pacific Island Countries (PICs) to ensure that the Australian PALM scheme does not deplete informal and formal care resources for older adults in those PICs and advocate for the Australian government to direct aid in order to provide decent care infrastructure in those sending countries.

Canada: a case of Provincial Variation - Ontario and British Columbia

Introduction

Canada is a large country with most of its population residing in cities and in the southern area of the country closest to the US border. Canada's population is 36,991,981 (2021), [35] with 6,835,866 of those aged 65+[36] (2021), amounting to one-fifth (20.2%) of Canada's population; only 2.9% of the population are aged 85+.[37] Canada is considered a diverse and multicultural country. It is home to a high proportion of people born outside the country (23.8% of the total population), who come to Canada with the official designation of refugee or immigrant. Canada is a bilingual country, with English and French the official languages of government; people of both languages are entitled to receive Federal services no matter where they live. It is home to three distinct groups of Indigenous Peoples – First Nations, Métis, and Inuit identity – and who also belong to one of more than 50 nations with 50 distinct languages.[38] As a proportion of the Indigenous population, fewer Indigenous people live on reserve (17.8%) than off reserve (82.1%) and predominantly in Canada's major cities.

As a constitutional monarchy, the country's division of powers is between the federal and provincial / territorial governments. The Federal government has spending power that derives from its income and sales taxation. The provinces receive transfer payments from the Federal government to fund programmes, including health and LTC. Municipal (regional) governments are under the aegis of the provinces so their responsibilities and powers differ across the country. As a result, this case study will compare the provinces of Ontario and British Columbia, each with challenges and promising practices to offer.

Care Regime

The *Canada Health Act*, 1984, governs the provision of health care. Provinces receive funding for hospital, physician, and surgical dental services. These are considered as insured services and governed by the principles of universality, portability, public administration, comprehensiveness, and accessibility. Other health services, notably long-term care, home care, home support and drugs are among the extended services and provinces are not required to use public funds to pay for these services. As each province and territory runs its own long-term care system, there is quite a lot of variation in terms of access and how much people pay out-of-pocket. While there are some common trends, there is variability in how issues are addressed across the country, with promising practices evident in some provinces. Below we outline the LTC systems in the provinces of Ontario and British Columbia and present some promising practices in each.

The average age of those living in LTC in both BC and Ontario is 84. In Ontario, 6.1% of the population in LTC is younger than 65, compared with 5.5% in BC. Over half (57.3%) of LTC residents are in Ontario, and just over one-fifth (22.4%) are living in BC LTC homes. Like other countries, the majority of those living in long-term care are women, with a higher proportion of women in Ontario LTC homes (66.9%) compared with BC ones (62.5%). The rates of dementia are similar, with 65% living with the disease in Ontario LTC compared with 63.3% in BC LTC; however, the rates of severe cognitive impairment are higher at 36.7% in Ontario compared with 30.2% in BC. This rate is important as the needs of LTC residents with severe cognitive impairment can be high while the funding and staffing often do not take account of this. It may also signal that people are accessing LTC very late in their disease process.

Family and Friend Care

Consistent with most other countries, care provided by family and friends is the most prevalent form. Statistics Canada reports that over one-fifth (21%) of Canadians provide unpaid care to adults with long-term health care needs or with disabilities and another 3% are involved in providing paid care work to adults.[39] Less than 1% of Canadians report doing both paid care and unpaid care for older adults. Like most countries, unpaid family care is the predominant form. Of those receiving paid home care, 96% report receiving care from an unpaid caregiver as well. There are high levels of distress associated with unpaid caring, particularly among those providing 38 or more hours per week.[40] Unpaid family care is the most prevalent type of care in Canada. Women do most of the care and it falls into specific categories: house maintenance and outdoor work (46%), personal care (40%), scheduling and appointments (48%), help with health care treatments (37%) and emotional support (83%). The only category in which more men than women do unpaid care work is for outdoor work and home maintenance (61%).[41] Women also provide more hours of care on average (10 hours per week) than men (6 hours).

Current LTC context and provision

In addition to care in private homes from family and friends, provinces publicly support or fund home care, home support, and long-term residential care. There are also a variety of other housing options such as assisted living, supportive housing, retirement homes, and naturally occurring retirement communities. This report focuses on home care, home support and long-term residential care.

Home Care and Home Support

Home care services comprise two different types: home care and support care. The former involves nursing, therapy, or palliative care. Support care attends to personal needs, including grooming, bathing, housekeeping, meal preparation, as well as transportation, and can extend to community support services such as meal delivery from "meals on wheels". In terms of home care, Statistics Canada reports that a total of 6% of Canadian households (921,700) used one of the two types of home care services in 2021.[42] Importantly, another 419,800 households indicated that home care services were required but not received.[43]

The administration of the home care system varies across the country, with those assessed as needing care receiving some publicly-funded home care in Ontario, and other older adults paying out-of-pocket, as with home care in British Columbia. In Ontario, 6.3% of households accessed it, while in British Columbia, 5.5% of households did so. Unmet home care needs were found in 3.1% of Ontario households and in 3.5% of BC ones.[44]

In addition to provincial variation, there is also variation within provinces in terms of access to home care and home support. Unsurprisingly, across the country more households use home care services in neighbourhoods that have a higher proportion of older adults aged 65+ living there (10%), as well as in suburban neighbourhoods with lower socioeconomic status (8%).[45] For neighbourhoods with a high proportion of older adults living there, the rate of home care service receipt was almost double that of other neighbourhoods. Despite the high rate of household usage of long-term care, there is also significant unmet need measured at the level of the household and by neighbourhood type. The highest rates of unmet need were found in multicultural dense urban neighbourhoods (3.9% of households), and in low socioeconomic status suburban neighbourhoods (3.5% of households). In neighbourhoods with a high proportion of seniors a high number of residential facilities, and neighbourhoods that were high socioeconomic status urban neighbourhoods, there was unmet need among 3.3% of households.[46] Smaller proportions of 2.5% of households in neighbourhoods described as having a large concentration of South / East Asians residing there.

Public funding for home care and home support varies by province with some provinces being more generous than others; however, in all provinces public funding supports less service than is required and most families find themselves paying out-of-pocket for care. In British Columbia, the home support programme receives $693 million CAD (2021/22); this amount has grown by 42% since 2015/16. The 40,000 clients receive more than 9 million hours of support, and the hours have increased by 5% since 2015, with 6% more people accessing the services.[47]

Home support is publicly subsidised but clients in British Columbia also pay out-of-pocket and at the highest levels of the whole country, which creates significant financial barriers, particularly for low-income seniors. Currently, the Seniors Advocate for British Columbia reports that for one daily hour of home support services, a BC senior with an annual income of $29,000 CAD would pay 31% of their before-tax income towards that care.[48] Most other provinces publicly fund home support services, and Ontario does not charge for services that are assessed through the home care programme. The result, argues the BC Seniors Advocate, is a rate of admissions to long-term care for low-care needs in BC that is double that of Ontario. For instance, the BC Senior's Advocate reports that 34% of families providing care report distress from their caregiving, and that this percentage is much higher (57%) when seniors receive less than one hour of assistance per day of home support services. In comparison, in Ontario around one-quarter (26.5%) of family and friend caregivers report distress.[49]

In Ontario, 18.1% of people enter LTC from home without any home care services. In BC, 20.5% also enter without home care. A smaller proportion enter having had home care services: 7.1% in Ontario and 10.4% in BC. These figures may be masked by the high proportion who enter from acute care settings: 41.2% in Ontario and 35.5% in BC. Collectively, these figures suggest that the overall investment in home care need to be improved, and the burden on family and friend caregivers relieved.

Long-term Care

There are 2,076 long-term care homes in Canada and 198,220 beds[50]. The number of beds per 1,000 seniors varies across the country from 18-47 beds per 1000 seniors, averaging 29 beds per 1,000 seniors. British Columbia and Ontario are quite average, with 28 beds in BC and 30 beds in Ontario per 1,000 seniors. Overall, the ownership pattern varies across the country but, on average, 46% are publicly owned and 54% are privately owned; the breakdown for privately owned homes is 29% for-profit and 23% non-profit. The average conceals the heterogeneity. In the northern territories, all of the homes are public, while in New Brunswick 88% are non-profits with the remainder being for-profit provision, with no homes publicly owned. In British Columbia there are 308 long-term care homes: more than one-third (37%) are owned by private for-profit organisations and over one-third (35%) are operated publicly by the health authorities; the remaining 28% are owned by private non-profit organisations.[51] Ontario has the most long-term care homes (n=627), followed by Quebec (n=440) and British Columbia (n=308), and is also the province with the highest

proportion of for-profit providers. In Ontario, 16% are publicly owned, 57% are owned by private for-profit organisations and 27% are owned by private non-profit organisations.[52]

Ownership matters in Canada: at an aggregate level, care conditions and working conditions are found to be worse in for-profit providers (McGregor et.al 2005; Hillmer et al 2005, Hsu et al 2016). The finding of lower quality in for-profits is consistent across studies and over time (Comondore et al 2009). Notably, the worse conditions that were associated with for-profit care before the pandemic were then exacerbated during COVID, with for-profit status significantly associated with the total number of COVID cases and more deaths, an effect that was even more pronounced when for-profits were only compared with public homes (Stall et al 2020). Rates of COVID deaths in Ontario were highest in for-profit facilities, with 78% more deaths occurring in for-profits than non-profits. As the case of BC shows, there is good evidence showing that not only do for-profits extract public funding from the system but that publicly-funded hours are also not actually delivered even when they are funded to do so. In contrast, non-profit homes add hours of care beyond their public funding. According to the BC Seniors Advocate, non-profit care homes spent 59% of their revenue on direct care compared with the for-profits who only devoted 49%.[53] Further, 9% of non-profit home revenue in BC was spent on building expenses, which compared with 20% in the for-profit sector.[54] The profit generated by BC for-profits was significantly higher, amounting to 34.4 million compared with 2.8 million among the non-profits.[55] Part of this difference can be accounted for by the non-profits' significantly higher spending on caring for seniors, amounting to an estimate of some 10,000 or 24% more per year per resident on direct care, which reflects the staffing level.[56] This difference resulted in non-profits exceeding what they were publicly-funded to provide by going beyond the 3.36 hours per resident per day average and adding 80,000 hours of direct care to the system.[57] In contrast, the Seniors Advocate found that 207,000 of the hours that for-profits were funded to deliver were not provided.[58] Importantly, it found that the for-profit sector spent 17% less per worked hour and the actual wages could be as much as 28% less than the industry standard (Office of the Seniors Advocate, 2020).

Marketisation with Significant Wait times and For-Profit Housing Options -- Ontario

One of the key challenges in the system is that the waiting lists to access publicly-funded LTC are very long. For instance, in Ontario, as of January 2023, there were 40,000 people assessed as needing LTC who were waiting for one of the provinces existing beds (DeClerq, 2023). While waiting, many people are funnelled towards the province's Retirement Home sector. The fees for these homes range from $6,000 – 10,000 per month for room and board. Like living in a private home, people can access publicly-funded home care but also pay out-of-pocket for any services that exceed their public home care and home support allotments. Nearly all retirement homes in the province are owned by corporate chains. Using long waiting times and giving people little recourse but to move to retirement homes, as well as limiting the extent of home care services received, are interim measures that result in the marketisation of seniors' care.

Contracting Out, Legal Recourse and Constitutional Rights - BC

In 2002, the BC government implemented Bill 29 "Health Services Delivery Improvement Act" to void or re-write provisions of the health care collective agreements, setting aside the collective bargaining of health sector unions, enabling employers to engage in privatisation and contracting out of the work, and firing public sector health care workers. The unions took this to the International Labour Organization and undertook legal recourse through the Supreme Court of Canada. In its landmark June 7, 2007 ruling, the Supreme Court of Canada found that many of the provisions of Bill 29 were unconstitutional. Importantly, it established collective bargaining as a constitutionally protected right in Canada, finding that the Bill violated the Charter of Rights and Freedoms.[59]

Active Advocacy and Coalition Building and Independent Review - BC

In British Columbia, there are a number of outstanding examples of advocacy and coalition building that have had significant impact on the quality of seniors' services. Kim Carter, the BC Ombudsperson, started an investigation into seniors' care in BC in 2008. The subsequent investigation released in 2012 yielded 176 recommendations about fairness, access and quality in order to improve home support, assisted living and residential LTC in the province.[60] Despite the overwhelming support the report garnered from communities across the province, the Ministry of Health's response was lukewarm; it released its own brief report "A Roadmap to Better Seniors' Care in BC" and had only fully implemented 6%of the report's recommendations after 16 months (Cohen and Farrell, 2013). During this period, the BC Health Coalition engaged in significant organising efforts, and *The Province* newspaper provided in-depth coverage of the key issues. The province agreed to establish a Seniors Advocate and, on March 19, 2014, the position was created, the first of its kind in Canada. The position is an independent office of the provincial government, working within government as well as across the sector to act in the public interest.[61] The Seniors Advocate analyses data and produces publicly available reports about the general state of seniors' services and specific issues, such as funding of contracted LTC.

Employment Regime

Employment regulation context

The long-term care sector is highly unionised in Ontario and British Columbia. It is also a highly gendered workplace, with women making up about 90% of the staff. It is also a highly racialised workspace, with about 41% of personal support workers (PSWs) in Ontario identifying as visible minorities.[62]

Low Wages

There are around 100,00 people working in 56,000 full-time equivalent positions in long-term care homes across the province of Ontario.[63] Full-time equivalent positions have increased from 43,023 in 2009 but beds also increased over that period by 2,799. Care Aides (known as personal support workers – PSWs – in Ontario) make up 58% of the work force. PSW pay rates depend on the ownership type of the home, with for-profits paying the least. For-profit rates range from $19.52 -21.15 CAD while non-profit pay rates range from $19.86 - $21.69 CAD and public from $23.58 - $24.99 CAD. PSWs working in home and community care have lower hourly wages (ranging from $16.78 Cad to $17.82 per hour).[64] Approximately 25% of PSWs with two or more years of experience leave the sector every year.[65]

There were 23,701 nurses employed in LTC in 2018, representing 25% of the workforce, the majority working as Registered Practical nurses (62.9%), with 36.5% as Registered Nurses and 0.6% as Nurse Practitioners.[66] The wage rates for nurses vary depending on training, ownership of the LTC facility and whether they work in home and community care. For instance, Registered Nurses (RN) earn $30.02 - $45.14 CAD per hour in for-profit LTC, $31.12-$45.14 CAD per hour in non-profit LTC and $33.13 - $47.40 CAD per hour in publicly owned LTC homes. If an RN is working in home and community care, the pay ranges from $34.90 - $39.05 CAD per hour. In contrast Registered Practical Nurses earn $23.48 - $26.29 CAD per hour in for-profit, $25.13 - $27.26 CAD per hour in non-profit homes and $28.91 - $30.81 CAD per hour in publicly owned LTC homes. If they are working in home and community care, their wage is less, amounting to $23.76 – $26.51 CAD per hour. The minimum wage in is $15.50 CAD per hour (2023) but it will rise to $16.55 an hour on October 1, 2023.

Not only are staff paid less in for-profits but, in Ontario, there are significantly fewer hours of staffing provided in for-profit LTC, especially ones that are chain operated (Hsu et al 2016). Ontario has been facing a health human resources crisis since before the pandemic, and this has only been exacerbated with the demands placed on frontline workers since 2020. For instance, Health Force Ontario indicates that only 50% of the PSW workforce make it past five years, and nearly half of those who left (43%) did so because of burn-out and working short –without the proper allotment of staff.[67] In Ontario, the overall number of people working in the sector dropped by 2.1% in 2020, reflecting the COVID restrictions that were placed on part-time, casual and contract nurses and physicians.

In BC, the multi-union Community Social Services Bargaining Unit, which covers those working in social services in residential and day programmes, has over 200 employers and 19,000 workers across the province. Their most recent agreement allows for a 2.54% wage increase and an alignment of top jobs with those in the health sector.[68] There are some 41,000 workers in the 'facilities collective agreement'. This workforce provides services in a variety of settings including long-term care. Hourly pay ranges from $21.91 CAD to $40.70 CAD per hour. The 'Community Health Agreement' covers 2,300 members of the Hospital Employment Union, who work in home support as well as other community-based health programmes. Hourly pay ranges from $18.23 to $36.79.[69] According to the Seniors Advocate for BC in 2022, "all health care employee registries showed increases this past year … [including a] 10% increase in nurses, 33% increase in care aides and community health workers."[70] To compare, the minimum wage in BC is $15.65 (2023), rising to $16.75 on June 1, 2023.

Wage Top-ups and Wage Levelling – BC

All provinces and territories implemented wage top-up programmes during the pandemic.[71] Ontario paid PSWs a top-up of $3.44 per hour and, in British Columbia, the top-up amounted to $4.00 CAD per hour. The federal government also announced a wage top-up (25% provincial to 75% federal). In addition, in BC in spring 2020, the provincial officer of health, Dr. Bonnie Henry, issued a provincial order restricting workers in long-term care, assisted living and provincial mental health from multi-site employment – defined as working at more than one site – in an effort to reduce the transmission of COVID-19. Multi-site employment was a practice common across the sector because of the difficulty of securing full-time employment. Following the order, union partners worked together with health employers and government to implement a single site transition framework. As a central part of that framework, the province implemented "wage levelling" for members who were in independent agreements not covered by the multi-unit collective bargaining units so that their wages were brought up to the higher hourly rates provided by agreements in the public sector such as the Facilities, Community and Nurses agreements.[72] The wage levelling increased the wages paid at for-profit facilities so that they were on a par with those working in public sector positions, and has since been extended past December 31, 2022 through standardised contracts between health authorities and employers.[73] The Hospital Employees Union (HEU) is also currently pressuring government to provide standardised benefits and working conditions. As part of the provincial order, the union partners secured unpaid leaves of absence for workers. With the repeal of the order, these workers are entitled to overtime rates if they work more than 1.0 full-time equivalent positions.

During COVID, provincial governments provided wage top-ups to retain frontline workers in frontline care. Despite the wage top-ups for personal support workers, Ontario nurses have been restricted to 1% pay increases for three years. Even though this Bill 124 was found to be unconstitutional, the province of Ontario is appealing the decision. Many critics have blamed the stress of the pandemic and the wage restriction of 1% for contributing to rates of turnover among nurses of at least 14.5% and rising (Wallace and Ogilvie, 2022).

More Time to Care with Four hours of Direct Care – Ontario

In 2021, the Ontario government announced that it was increasing the number of direct hours of care in long-term care to 4.0 hours per resident per day.[74] This followed a sustained and robust campaign from the Ontario Health Coalition and sector unions, academics and other advocacy groups arguing for four hours as a minimum standard. The investment is expected to cost $4.9 billion and require 27,000 additional health care workers.[75] The Minister of Long-term Care confirmed that the province is on track to accomplish this by 2025.[76] In addition, the government has invested in 31,705 new and 28,648 upgraded beds.[77] In BC, the standard is 3.6 worked hours, meant to capture the difference between when people are paid but not there to perform the care, such as when they are on vacation.

Migration Regime

Canada is a migrant-receiving country. Prior to World War II, the majority of Immigrants came from the UK and parts of Europe. In the past, immigrants who came to Canada over the age of 18 were more likely to work in nursing and health care support occupations, at 5% of immigrants compared with 3% of the overall Canadian population.[78] This is particularly high among some groups of immigrants, including those born in the Caribbean and Bermuda (13%), West Africa (12%), Central Africa (12%), East Africa (8%) and Southeast Asia (10%).[79] In particular, emigrants from the Philippines make up 13% of the immigrants from Southeast Asia, with 44,380 Philippine immigrants working in nursing and health support occupations.[80]

Canada has different migration categories, including economic immigrants, pilots for Home Support Worker and National Child Care Provider work permits that offer a path to permanent residency, and refugees. The path to care work is varied. When considering those who come under the economic immigrant status, very few had expected to work in these areas despite going into the field: only 2% of those working as licensed practical nurses, or 11% of those working as nurses aides, orderlies or patient services associates. Many immigrants who came as adults (18+) had already completed their education outside of Canada but a significant proportion (40%) coming from some geographical areas completed it in Canada. For instance, two-thirds (75%) of those coming from Bermuda and the Caribbean, two-thirds (60%) of those emigrating from sub-Saharan Africa, one-quarter of those from the Philippines, and one-third (32%) of those from South East Asia. For the group of immigrants who were educated and graduated outside of Canada, they were overqualified compared with their Canadian-born counterparts.

As Bourgault and colleagues (2023) show, the migration pathway for many health care workers is not straightforward and often includes a transit country. In addition, the pathway to health care work may come via the domestic work section, and visas for international students or as caregivers. One direct path to Canada for care workers was through the federal government's live-in caregiver programme. The programme has become a National Child Care Provider pilot and a Home Support Worker pilot. The programmes provide a path to permanent residency after the workers have worked in the programme for 24 months.

Current & Potential Strategic Levers for Action

- In jurisdictions with a Charter of Rights, unions can seek recourse through the courts to protect rights to collective bargaining, and protections and job security from contracting out their positions.
- Through active advocacy and collaboration, an independent Seniors Advocate was created in BC, the first of its kind in Canada. The office studies seniors' services, identifies issues, and creates reports that document system level disparities. Unions and other groups have been able to use the evidence presented in the reports to pressure government to improve working conditions, including wages.
- Unions should advocate to have governments engage in appropriate health workforce planning so as to avoid an over reliance on migration and taking health workers from other countries.
- Minimum staffing standards or fixed minimum hours of care may be one strategy to increase care.

Chile

Introduction

Chile is experiencing significant demographic pressures in terms of LTC provision, as it is predicted to be the most aged country in Latin America, with a rapidly ageing population. In 2021, 13% of the Chilean population were aged 65 years and over, higher than the world average (World Bank, 2021; Dintrans, 2020). By 2050, it is estimated that the proportion of the population over 60 years of age will increase from 15.7% to 32.9%, while those over 80 years of age will reach 10.3% (Slachevsky, et al, 2020). As with all Central and South American countries, this acceleration of ageing is occurring at a much faster rate than in other countries in Europe and North America. The World Health Organization has identified demographic change as the country's main challenge (Dintrans, 2020). Three out of four people over 60 years of age in Chile are reported as having at least one non-communicable chronic disease. The main cause of dependency among the elderly population is dementia (Thumala, 2017). The same study highlights 70% increases in cases of dementia by 2030.

Chile has experienced notable improvements in several measures of wealth and income in recent years. For example, it has experienced a reduction in (income) poverty (defined as those subsisting on less than USD 4 (€3.55 as at 13 March 2019) per day) from 26% in 2000 to 9% in 2017 (ILO, 2019). Inequality remains high, however, and there are concerns that Chileans lack economic security and decent public services (Congressional Research Service, 2022). Chile is an OECD member but records the greatest levels of inequality between rich and poor (World Bank, 2014; Thumala, et al, 2017). The PSI regional affiliate (a representative of PSI for the Southern cone countries, composed of Chile, Argentina, Uruguay and Paraguay) estimates that approximately 10% of the population in the region can be classified as economically 'vulnerable'.

Care Regime

Pinochet's rule established the market economy across Chile. Subsequently, the state has operated more as a regulator than a provider of public services. In Chile this is known as the 'subsidiary state', with, as a result, significant resource transfers from the state to private business for the delivery of public services.

Care in Chile for older adults operates within this neoliberal regime. Dintrans (2018) describes how Chile does not have a LTC system as such, rather there are number of public programmes with LTC components and subsidies for elderly and disabled people. It has been called a model of private care with public support (Arriagada and Miranda, 2021, pp. 168). The absence of a comprehensive national programme means that care work is largely the responsibility of female family members alongside for-profit and non-profit providers, with limited government support (Dintrans, 2018; Palacios et al, 2020). Conditions such as dementia are particularly neglected. There are costs associated with this reliance on familial provision, with 25% of caregivers (largely women) being forced out of the labour market (Dintrens, 2018). Yet this reliance on family intervention is under strain with an increase in labour market participation among women, meaning there are fewer of the traditional caregivers left in the home. Other social supports from extended family or community ties have also diminished (Pereirra, et al, 2016). Moreover, caregivers themselves are seen as being vulnerable to injury and depression due to work overload. Elderly care is also seen as highly complex as the population of Chile is very diverse with approximately 13 different ethnic groups (Salazar, 2017).

Social provision for older adults

Chile's current pension system has been in place since 1981. As part of the military regime's neoliberal reforms, this change established a privatised defined contributions scheme (Salazar, 2017). Reforms through the Law on Social Security Reform of 2008 led to provision for those with no access to private social security. However, under these reforms, the average payment is below the minimum wage level and is seen as insufficient to cover the costs of ageing, and associated illnesses such as dementia. Women are also significantly disadvantaged compared to men in terms of pension income (Salazar, 2017; Thumala et al, 2017).

The health service is made up of a two-tier system of public (FONASA (*Fondo Nacional de Salud*) and private health insurance. The former covers 69% of the population. Others get provision through their employment with public agencies or simply have no cover. Part of the health provision includes the Social Sanitary Beds ('*Camas Sociosanitarias*') designed to reduce hospital stays through home care. The Explicit Guarantee System also provides care for approximately 80 conditions, including many effecting the elderly, but not dementia. There is also the Functional Assessment of the Elderly, EMPAM, which provides a systematic evaluation of the elderly (people over 60) to assess their vulnerability to becoming dependent on LTC. Together, these schemes provide medical assessments and plans of care along with monitoring for those in need. The Ministry of Health has also implemented the programme *Más Adultos Mayores Autovalentes* (More Self-sufficient Senior Citizens), which is intended to preserve functioning through a preventative and community-based approach to healthy ageing (Thumala, et al, 2017).

Public programmes to support the elderly moved from a family based paternalistic model to one that emphasised 'self-reliance' and healthy and active ageing through the National Senior Citizen Service (SENAMA). (Thumala, et al, 2017). This initiative is part of its *Integral Positive Ageing Policy.* Elderly care in Chile includes day centres for those with a low dependency level; homecare for people

with moderate or severe dependency who can continue residing in their homes; and a subsidy to residential facilities administered by non-profit institutions for the elderly with severe dependence. Residential care is delivered through long stay establishments for older adults (ELEAM) organised by the Ministry of Housing and Urbanism, SENAMA and the Social Development Ministry. Adult Day Centres are also supported by SENAMA and the National Disability Service, SENADIS. A Social Protection System was created in 2012 that included a 'Subsystem of Support and Care for the elderly and caregivers'. However, this 'subsystem' only receives 3.7% of the total allocated budget (Arriagada and Miranda, 2021).

Chile's market-based approach has been criticised on a number of grounds. This approach is seen by some as inadequate given that it is focused on self-reliant individuals with limited needs and not the impoverished and dependent older adult population, which has very diverse and significant physical and mental health needs (Pereirra, et al, 2016). There are calls for a more coordinated response to support the diversity of older adults (Thumala, et al, 2017). There is also the problem of LTC coverage. Institutional LTC is seen as too expensive for most people and, in 2002, only 2% of elderly Chileans were in a nursing home. NGOs have been encouraged to participate in the market through social support via 'elder clubs' but they have provided limited access to health services. Although providing increased coverage, NGOs are also undermined by the ongoing under-resourcing of services (Pereira, et al, 2016). EMPAM only covers 40% of the older population and does not necessarily lead to referral to a clinician. SENAMA, in turn, does not cover the full demands of those with moderate or severe dependence (Thumala, et al, 2017). The largest public sector programme for the elderly providing home-based LTC covers just 14% of the elderly population (Dintrans, 2018).

Chile's LTC provision is also undermined by the ineffectiveness of the private health care system for vulnerable groups. In addition, inequities in health and LTC provision increase with age (with old age and retirement leading to dramatic decreases in income, creating economic and social vulnerability) (Dintrans, 2020; Diaz and Mendoza-Llanos, 2021). There has also been a limited public healthcare system in terms of care for and specialisation in issues affecting the elderly (Peralta et al, 2022). Unsurprisingly, ill health among women and men over the age of 75 is significant, with around half of women and a third of men having difficulty with daily activities such as managing money or preparing meals (Pereirra, et al, 2016). As a result, there are calls for a coordinated response to deal with the increasing aged population in Chile (Dintrans, 2018).

Although some of the poorest are covered by the programmes, large parts of Chile's middle class are not, and so must rely on the market, where access is not always feasible because of the cost of services. The market for these services is also dominated by multinationals that have identified Chile as a growing market. The PSI regional affiliate provided examples of access problems in health care and how the public system is systematically undermined by private providers. These problems include pharmacists charging government for costly private drugs, as opposed to those recommended under the public system. Another example is how LTC recipients are sent to private hospitals for treatment (e.g. catheter replacements) and the government is charged for expensive private treatment/equipment despite the use of less costly public sector equipment. The PSI affiliate reported how the harshness of neoliberal life that forced and continues to force the Chilean people to meet essential aspects of their lives such as health and care through the market was a popular source of discontent. Indeed, dissatisfaction with marketisation in care and other services formed the basis of the popular revolt that Chile experienced in 2019.

Employment Regime

The system has a shortage of medical and support staff. During 2018, the country had one geriatrician per 20,000 people. Employment in health and LTC is overwhelmingly populated by women workers (over 70%) (ILO, 2019). In 2016, the greatest share of care workers was employed in the social and communal services sector (accounting for 28% of total employment). At the same time, the care labour market is characterised by temporary contracts and part-time work (ILO, 2019). Care work is associated with a degree of informality and lack of coverage of employment regulation, particularly in areas such as pensions and holiday leave.

Unionisation and Collective Bargaining

Chile's minimum wage covers about two-thirds of the labour force, which means that many workers' incomes are held at this level. The unionisation rate in Chile is low, (Ramos, 2017) which is attributed to the fact that collective bargaining is limited to the enterprise level. However, both collective bargaining and unionisation are slowly increasing. In 2011, 15.6% of private-sector employees were covered by collective bargaining; by 2016, this had increased to 17.9%. Over this period, overall membership rose from 15.8% of employees to 19.6% (ILO, 2019; Arriagada and Miranda, 2021).

PSI affiliates are concerned with the themes of decent work and care work, which are issues across Chile, Argentina, Uruguay, and Paraguay. These countries have approximately 1.5m affiliated members. The key campaigns for PSI affiliates in Chile in recent years have been to establish care as a principle and human right in the proposed new constitution. PSI affiliates are also concerned with problems of working conditions in social programmes linked to care, such as "*Chile Crece Contigo*" (Chile Grows with You, a programme of promoting intersectional child development, regardless of socioeconomic status). This programme relies on precarious workers, and the state has reportedly normalised their recruitment so that they now account for 10% of the public

service workforce. These workers do not, however, have entitlement to annual leave nor rights to social security and, by law, cannot join a union.

Despite, the proposal for the new constitution in Chile being rejected in 2022, the government has recently called for a participatory approach to the development of a comprehensive care policy. Evidence of a participatory approach is now emerging. The PSI affiliate reported that the labour unions, in alliance with other social movement organisations, have made joint efforts to influence the debate for the first time, and to put the sustainability of life as a guiding principle for a new social contract. There is some emerging consensus around an increased role for the state in order to accommodate the variety of territorially-based, cultural, and ethnic demands for care across the country. Feminist movements, for example, have raised the need for a plurinational system of care that respects and promotes the forms of care existing Indigenous Peoples have developed in the country. In terms of decent work in care, PSI affiliates are calling for fair wages, annual leave, and opportunities for union organizing.

Migration regime

To meet the increased demand for elderly care, there has been an emphasis on the need to professionalise the workforce and to attract migrant workers into the care sector (Arriagada and Miranda, 2021). At the same time, there is a need to improve the rights of migrant workers (mainly from Peru, Colombia and Venezuela), especially in terms of their exposure to workplace abuse, poor conditions and the lack of pension entitlements (Arriagada and Miranda, 2021). The roles of these mainly domestic workers were previously undertaken by Indigenous women and characterised by colonial legacies of servitude. The gradual organisation of these Indigenous women and pressure for labour rights led to employers bringing in migrants from Peru and the Philippines. Their work can include live-in work with elderly members and their families. This work is also characterised by examples of exploitative practices such as unpaid labour, and dismissal when asking for higher wages (Chan and Fernandez-Ossandon, 2022).

The concerns of Chile's unions in respect of migrant workers largely lie with the private health sector, especially in primary care clinics, where doctors, nurses, and nursing support staff are hired on precarious contracts. These contracts are usually deployed at points in the financial cycle when the state is running short of money. The PSI affiliate reports how the Worker'' United Centre of Chile (CUT), which its public sector unions are affiliated to, negotiates annually with government to stop these forms of precarious work occurring and ensure all those workers on precarious contracts are made permanent. However, despite government reassurances about ending these practices, these goals have not been secured. In response, PSI has called for the implementation of high-quality public services financed through progressive taxation. PSI campaigns include calls for tax justice to finance public services that will improve working conditions for workers.

Current & Potential Strategic Levers for Action

- A general reorientation of the model of society and state that places the social organisation of care at the centre of society, with the sustainability of life being the guiding principle of this new organisation of society.
- The right to care, to be cared for and to self-care should be a human right.
- The caring state should be the focus of these new public services.
- Care services should be multicultural.
- The de-familialisation and de-feminisation, of paid and unpaid care work. That is: care should not be performed only by women, which means addressing the sexual division of labour.
- The decommodification of care.
- The recognition of unpaid care work as work that generates wealth.
- Public policies should be developed to reward and protect people who perform care work.

Overall, despite the problems outlined above, the PSI regional affiliate felt that the call for a more participatory approach to developing an integrated national care service in Chile presents opportunities for both national and global labour movements to influence what the Chilean government is doing with regard to LTC.

South Africa

Regional Context

The context for long-term care for older people in South Africa is set within a wider context of the region of sub-Saharan Africa. Overall, fewer people are older than younger, and the countries in sub-Saharan Africa are relatively youthful, with a median age of 18.5, and 63% of the regions' population below the age of 25. The older adult population remains low in proportion, at only 4.9%. The region's older adult population is only expected to rise to 7.6% of the overall population by 2050 (Aboderin, 2019). South Africa is a member state of the African Union, and a sub-Saharan African country. The population was 55.7 million in 2016, rising to 60.1 million, showing its significant population growth, even during COVID. There is a high number of working age people compared with people younger than 15 and those older than 64 in the country. About 9.1% are aged 60+ years (Statistics South Africa, 2020). The proportion of 60+ older adults will increase to 16% by 2050 (UN Dept of Economic and Social Affairs 2019). While a relatively small proportion of the South African population is aged 60+ years, the number of older adults are significant, with 54 million older adults now, rising to 166 million by 2050. This represents more people than all of those in Northern, Southern and Western Europe combined. Based on the large size of the ageing population, it is important to consider the needs and policy responses for older adults, particularly given the strain of unpaid care and the difficulties that may be associated with maintaining this as the primary source of care.

Several overarching issues affecting the region contribute to South Africa's challenges in providing care for older adults. Most countries in the region have a high rate of poverty overall, and all have significant poverty even when classified as upper-middle or high-income countries. Sub-Saharan Africa continues to experience economic instability, natural disaster, exposures to disease and familial relationships that are under strain from economic instability and the impacts of HIV/AIDS. In addition, age-discrimination persists across sub-Saharan societies, including in South Africa (South African Human Rights Commission, 2015).

The Organization of African Unity brings the continent's 55 countries together to develop its pan-African vision to advance African peoples' freedom, equality, justice and dignity, and to foster cooperation, and it provides an explicit and formal commitment to provide protection for older adults, particularly women, and those with disability.[81] The union also has a *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa* (African Union, 2020). This protocol is more robust in its provisions for older persons, including covering elimination of discrimination, access to justice and equal protection before the law; the right to make decisions; protections (i.e. from discrimination in employment, social protection, from abuse and harmful traditional practices, for older women, and older persons with disabilities, older persons in conflict and disaster situations). It also has provisions for care and support; residential care; support for older persons taking care of vulnerable children; access to services (i.e., health services, education, programmes and recreational activities); accessibility; awareness of ageing and preparation for old age; duties of older persons; and coordination and data collection.

Informal Care

Importantly, for the purposes of our report, the African Union reinforces the existing familial care structure in Africa by calling on member states, in Article 10 of the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa* (African Union, 2020), to "adopt policies and legislation that provide incentives to family members who provide home care for Older Persons; identify, promote and strengthen traditional support systems to enhance the ability of families and communities to care for Older family members; and endure the provision of preferential treatment in service delivery for Older Persons". It calls for cost, quality and adequacy provisions to be enshrined in local legislation. Specifically, Article 11 of the Protocol calls on member states to "enact or review existing legislation to ensure that residential care is optional and affordable for Older Persons; ensure that Older Persons in residential care facilities are provided with care that meets the National Minimum Standards provided that such standards comply with regional and International Standards; and ensure that Older Persons in palliative care receive adequate care and pain management medication." South Africa is not currently a signatory to the protocol but there is separate South African action addressed below.

While families perform most of the care required by older adults across sub-Saharan Africa, including in South Africa (WHO, 2017), this is paired with a disproportionate need for care amongst older people living in the region compared with those of similar ages and living in the Global North. In South Africa pre-COVID, more than 35% of those aged 65-75, and 45% over the age of 75, required some degree of assistance with essential tasks of daily living (WHO, 2017). Consequently, peoples' access to care is unequal and the burden on unpaid family caregivers is significant.

Formal Care Regime

As a highly racially divided country, there seems to be two separate approaches to LTC, with black Africans mostly providing familial care to older adults as well as to children and grandchildren, and state-funded institutional care, developed by welfare and church organisations, predominantly accessed by older white South Africans. Organised care, in the form of residential facilities or support to help family caregivers is "widely lacking" (Aboderin, 2019). A combination of the focus on other priority populations of children, youth and women, as well as political views that resist residential care as a westernised approach, may explain some of the under-development. There are some 400 registered care homes run by non-governmental organisations and only eight government-run homes. There is some evidence that there are an increasing number of unregistered care homes – with people opening up their own

homes and converting them into residential homes–- and that there may be risks that these homes are financially abusing older adults and their families (Mkhwanazi, 2015). Homes that are registered get a small monthly state subsidy. Residents can access care on the basis of screening for frailty, economic status and family circumstances. Most registered residential care facilities are affiliated with an advocacy organisation called Age in Action, the South African Council for the Aged.[82] This organisation has ties to and is funded by the national Ministry of Social Development. The Ministry follows '*Batho Pele*' (People First) principles, and works in partnership with faith-based communities, non-profit and for-profit organisations, labour unions and other stakeholders.

LTC regulation appears limited. State funding is largely deemed inadequate, and it is not always paid even when allocated. Care facilities lack state monitoring. There was an audit of residential facilities conducted in 2010 by the Department of Social Development to assess quality. It found that most were not in compliance with the Older Persons Act and also required major financial resources in order to be sustained. Abuse is not addressed, and most older adults living in facilities were not aware that they had rights.[83]

In contrast, the health system is more developed than LTC for older adults. Indeed, the South African health system's capability is more robust than in other states in Africa. Its health expenditure is 9.1% of GDP (OECD, 2019), meaning that most of its spending for older adults is focused on health care.[84] In addition, essential health services are mostly covered, and there are free primary health services. Those who receive the state's Old Age Grant also receive free access to secondary and tertiary care (Kelly et. al, 2019). These pension funds often support the entire household although this too comes with benefits and challenges, as it addresses some aspects of poverty while lacking controls on elder abuse (Lloyd-Sherlock, 2018). There is a public and private system, and the quality and waiting times for services vary widely between the two. There are few geriatricians in the country and less research or policy on dementia than required (Lloyd-Sherlock, 2018). Access for poor South Africans, in particular for people living in rural areas, is less than adequate because it is inhibited by weak transport links, too little emergency transport; waiting times that are too long in public facilities; and a lack of access to medicines (South African Human Rights Commission, 2015).

Systemic Challenges

Following an investigative hearing report by the South African Human Rights Commission in 2015, five main systemic issue areas affecting older persons were identified: access to social security; impact of HIV/AIDS; access to health care; residential care facilities; and social abuse. There is some evidence to suggest that older adults may experience elder abuse, or fall prey to loan sharks, robbing them of their social grants. In some places, families are abandoning their family members at health facilities because younger family members may be unwilling or unable to provide care, with older adults left unattended upon discharge. Seniors are the responsibility of a department responsible for all social welfare, so attention to issues for older people is overlooked (South Africa Human Rights Commission, 2015).[85]

Not all areas are equally served by institutional LTC. For instance, some areas such as Mpumalanga and Western and Northern Cape Regions did not have any government-run long-term care homes in 2015. Overall, there are established policies and programmes to support older adults, and laws to support and protect older adults. South Africa enacted the Older Persons Act in 2006.[86] An amendment to the Act was introduced In March 2022 but has not yet been legislated.[87] Despite these protections, there remains tremendous inequality.

As in most parts of Africa, in South Africa older people are the poorest members of society. Like other areas of policy in South Africa, Apartheid casts its shadow over support and services for older adults (Lloyd-Sherlock, 2018). In addition, the devastation of HIV / AIDS[88] and the extent of communicable diseases such as tuberculosis and the needs for reproductive health take primacy in the health system focus. This means that hypertension and stroke are under-diagnosed as a result but HIV testing is also lacking for older adults, with ensuing implications for older people's future needs for care. Furthermore, there seems to be less training for nurses to attend to the needs of older people (Lloyd-Sherlock, 2018).

Owing to pressures to rein in the costs of care homes, the Department of Social Development reduced its subsidy, and it now represents a very small proportion of the overall costs. In turn, this move further discouraged facilities from providing care to those who were unable to afford the costs or to frail older adults who are subsidy eligible. Instead, it is mostly older, wealthier people paying for the places. Furthermore, despite legislation requiring non-discrimination, and facilities' policies affirming this, in reality there are very few homes with different racial groups, and in some homes with multiple races living there, there is a racial separation as well as differences in the standard of care provided. Despite a majority white population of residents, amongst caregivers, more than half are black Africans.

Employment Regime

Following the abolition of Apartheid in South Africa, there was a large increase in the supply of labour but demand was stagnant.[89] While employment in the formal sector declined in 2021, the informal sector–- comprising those who work in places with fewer than five employees and where no deductions are taken from their wages, or where they work in household businesses–- increased from 16.5% (2016) to 17.9% (2021). By 2021, 75% of employees were entitled to paid sick leave. In terms of measures of decent work, a

half of men (50.4%) have employer pensions. One-quarter of those in the formal economy (24.9%) in 2021 were members of a trade union. Despite gains, unemployment remains high across population groups and sex, with an increase from 5.8 million (2016) to 7.7 million (2021). Black Africans comprise 88% of those unemployed, with women comprising 48% of the unemployed..[90] The *Employment Equity Act* (1998) has improved women's formal employment. It is notable that the per capita incomes of black Africans is about one-eighth of its white population, which comprises only around one-tenth of the overall population (Gradin, 2013). Unionisation is a right of every worker in South Africa. While the unionisation of domestic workers has proceeded, there is little unionisation in residential care homes, and workers who care specifically for older adults seem to work outside of the bounds of formal union protections. Furthermore, the focus within nursing has shifted. The South African Nursing Council removed gerontology from its training a long while ago (Lloyd-Sherlock, 2018). Concerns have been raised that older adults do not get the care needed from health care professionals. In health facilities they are not given respect, while in long-term care facilities staff are not trained and there is a lack of skills or little capacity to care. Meanwhile the work is made more difficult due to a lack of proper equipment to provide the care needed.

Migration Regime

Across Africa, there is an African Union protocol guaranteeing the free movement of persons, their rights of residence, and their rights of establishment in member states. However, South Africa is not a signatory state. There are an estimated 3.9 million migrants in South Africa.[91] More data is needed about migration to support policy making. Overall, South Africa continues to be a "sending country", although out-migration is not as high as when it peaked in the 1990s and early 2000s (Labonté et al. 2015). In 2021, the Department of Social Development hosted the first National Migration and Urbanisation Conference. The intent was to gather together stakeholders to form a knowledge base. A National Migration and forum on migration and urbanisation was launched at the conference, with the aim of providing evidence-based policy advice.

Current & Potential Strategic Levers for Action

- Family support is declining across South Africa, while the ageing population is increasing, so South Africa needs to invest in training of both formal and informal caregivers.
- The complexity of the needs of older adults may extend well beyond the care and support families can provide. This can mean that families rely on informal care and unqualified caregivers who may cause harm and abuse to older adults.
- To further develop LTC services, the government needs to focus on the rights of older adults. It also needs to provide more overall support for families in poverty, more skills development for formal care workers, and options for families who are unable to cope. In addition, greater awareness about dementia, and attention to elder abuse is critical to ensure the safety of older people. Unions could encourage nurses to include training about older adults and dementia in their curriculum.
- Unions should push to unionise those working to provide care for older adults in order to extend the employment rights already afforded to domestic workers.

Fiji

Fiji is a small, middle-income, Pacific Island state whose population of 890,000 (UN 2022) lives on 100 of its 300 islands (Yoon et al 2019). Like many Pacific Island Countries (PICs), Fiji has a relatively young population, only 9.9% (8,800 people) of its population were aged 60 years and over in 2019. However, the population share of Fijians aged 60+ is expected to grow rapidly, reaching 13.1% by 2030 and 17.7% by 2050 (UN 2022). The out-migration of the working age population is an important driver of population ageing in Fiji, as in other PICs, and in 2016 Fiji had a crude net migration rate of -6.0% (Anderson & Irava 2017).

Care Regime

Fiji's public health care is financed through general taxation, with health care services spread across its provincial areas. However, a study based on 2007 data suggests some unevenness in the distribution of community health workers across Fiji (Wiseman et al 2019). Health services focus mainly on maternal and child health and both communicable and non-communicable deceases such as diabetes. In 2019, while it was estimated that around 61% of the Fijian population had some access to such health services,[92] the extent or sufficiency of this access is unclear.

One issue raised by a PSI affiliate was the declining number of community health workers and nurses. The population density of nurses and midwifes in 2019 was 39.6 per 10,000 population, well below the ratio in several other Pacific Islands such as the Cook Islands (80) and Nauru (78.5) (WHO data). Community health nurses who provide care and support in regional areas, and train local

volunteers to assist them, have been dwindling in number. The PSI affiliate estimated that, depending on the area, there is only one community health nurse for between 2,000 and 9,000 people.

As in other PICs, the ageing population is not currently a priority in Fiji, and little is known about the cost and affordability of responding to the needs of older adults (Anderson & Irava 2017). While Fiji was the first Pacific Island to develop an ageing policy in 2011, the impact of the policy has not been evaluated. Nor has the effectiveness of any action taken by the National Council of Older People, established in 2013 (Andreson & Irava 2017: 194) in respect of advocating for the needs of frail older adults, especially those without family support.[93] The government provides 50FJD per month to those over 66 years; however, less than a third of those eligible are enrolled to receive these payments (Andreson & Irava 2017: 194).

Current LTC provision

There are strong norms of respect towards elders in Fiji and caring for elders as they age is seen as the responsibility of the family and community structures within which the family is located. However, access to familial care is dwindling. Land lease issues, natural disasters and rising sea levels due to climate change have affected family and communities whose working age members have migrated from rural to urban centres in order to earn a living. This urban drift is also likely to have a negative effect on rural communities (Chandra 2017), especially if elderly people are left behind with no family members to take care of them.

The PSI affiliate reports that there are three government-funded and run nursing homes for the elderly and another three run by the Catholic Church and the Methodist Church. They employ very few qualified nursing staff and depend mainly on non-nursing-qualified 'helpers'. There is some concern about the cultural suitability of nursing homes for Fijians, given the cultural norms of familial care (Fiji Nursing affiliate) and also whether nursing homes could meet the needs of the aged outside larger population centres. It is unclear to what extent the community health workers and the volunteers who assist them focus on the needs of the elderly in the regional areas, especially those without family support. As above, the numbers of community health workers and volunteers are insufficient and are very unevenly spread across Fiji. The PSI affiliate also noted that there is little government support for the network of community volunteers.

The government in Fiji, as in other PICs, already allocates a significant portion of its available expenditure to health services, which suggests a limited capacity to expand public spending on health and support services for the ageing (Anderson & Irava 2019: 196) To date, Pacific Island aid efforts by Australia and New Zealand have not focused on the ageing population.

Employment regime

Labour law in Fiji is regulated mainly by the Employment Relations Act of 2007 (last amended as of 2020), which "governs the terms and conditions of employment such as working hours, holidays, rest periods, wages, overtime, leave and termination of employment, etc. The Employment Relations (National Minimum Wage) Regulations of 2015 govern the national minimum wage",[94] currently FD $4 per hour.[95]

Nursing staff have salaries of around FD$20,000 to FD$28,000 per year, with opportunities for advancement now based on 'merit' rather than seniority as previously, which has caused some friction with more senior nurses (PSI Nursing affiliate). Community health nurses receive a salary of around FD$20,000 per annum. The community health volunteers who assist them are not paid but get a small allowance. There is no available data on the wages of the non-nursing staff in the residential aged care facilities.

The PSI affiliate noted that wages for nurses are low compared to other professionals such as doctors and those in other industries. She reported that, following a wage review, nurses are now paid a salary but receive none of their previous allowances. However, doctors are not only paid $45,000 Fijian dollars per annum but are also entitled to additional allowances such as on-call and environmental allowances.

The new government is involving unions in tripartite structures and this augurs well for some government support to improve employment conditions and for collective bargaining more generally, including the potential for union wide bargaining.

Migration regime

Fiji is a sending country of health and LTC workers, mainly to Australia and New Zealand. In Australian aged care services, the relative pay and conditions of work are much poorer than those for many other workers in other non-care sector industries. With the organisation by employers of frontline work into short-hours work with meagre working time protections (Charlesworth 2021), the poor pay and work conditions of aged care workers have made it hard for Australia to recruit sufficient workers in either residential aged care or home care to meet the needs of Australia's rapidly ageing population. Despite recent union success in securing an interim 15% wage increase for frontline nursing and non-nursing aged care workers in 2022, both the Australian government and employers are continuing to actively look towards migration, particularly from the Pacific Islands, to meet both current and future labour force needs.

The Australian government is training and recruiting increased numbers of Pacific Island workers to meet skill shortages in Australian aged care services outside metropolitan centres. This recruitment is characterised by Australia as part of Australia's aid effort and 'investment' in the Pacific. The current programme, the PALM scheme, is a temporary labour migration scheme that allows eligible Australian businesses to hire workers from Pacific islands and Timor-Leste when there are not enough local workers available.[96] In terms of care for older adults, eligible Australian residential care providers can recruit workers for so-called 'low' and 'semi-skilled' positions as personal care assistants and also as kitchen staff.[97] The policy intent of Australia's PALM scheme has been characterised as a 'triple win': for Australian employers; for Pacific Island workers; and for their countries (Connell 2019). In bringing in temporary migrants to work in care for older adults and childcare, the Australian government has also characterised the PALM scheme as a gender equality initiative because of the skills, experience and opportunities to send remittances home it is seen to provide to the mainly female Pacific Island workers who are recruited into the scheme to undertake care sector jobs (Hill et al 2018).

While Pacific Island workers are expected to receive the same wages as other Australian workers, the upfront costs incurred by their Australian employers such as airfares, visas and vaccinations are deducted from the Pacific Islander workers' wages over time. Other deductible costs may include accommodation, health insurance and transport costs.[98] Currently, as temporary migrants, Pacific care workers have to cover their own costs of health, including the costs of giving birth.[99] Changes to the PALM scheme from the end of 2023 will allow some workers to bring their families with them.[100] However, they may also be responsible for the costs of schooling, charged to non-permanent residents in Australia.

One policy recommendation made in respect of the PALM scheme is that Australia's aid programme should complement this scheme by also investing in public care infrastructure in Pacific Island nations, including care for older adults (Hill et al 2018). It is argued that such support would lead to a broad range of positive outcomes, including supplementing familial care in Pacific Island countries; providing returning migrant care workers with ongoing employment in local care sectors; and contributing to skills training for other local care workers (Hill et al 2018). The Pacific is Australia's top foreign policy priority, with the Australian aid budget to the region being a total of $1.5 billion for 2022-2023, excluding COVID support.[101] Some of this funding could be used to invest in developing and supporting public care infrastructure in Pacific Island countries such as Fiji.

Current & Potential Strategic Levers for Action

- UN/ILO evaluation of elder care needs for care and support in Pacific Island countries, including Fiji, and how they are or are not being met by familial care and by community health networks, including outside urban areas and residential aged care facilities.
- The employment conditions and wages of health workers also need to be evaluated as well as the broader cost to the health care system of meeting /not meeting the needs of the elderly; affordability for service users and the cost effectiveness of responding to the growing needs of ageing population (Anderson and Irava 2019: 195)
- Lobbying of the Australian government to invest in health care and aged care infrastructure in Fiji, both in recruitment and retention of nursing and non-nursing-qualified staff as well as a more coherent system of support for the frail elderly as part of its aid efforts in Fiji and other Pacific Islands so that returning workers can use their skills and experience acquired in Australia and improve outcomes for the frail elderly and their families in Fiji.
- The Fiji Nursing affiliate proposed that Australia should also provide strategic advice as well as financial assistance for targeted retention and recruitment programmes for nurses in order to reverse the decline in and increase the population density of nurses in Fiji through:
- - Australian investment in a programme to engage and train local nurses via a foreign exchange programme with Australia, with the nurses bonded to work in Fijian hospitals on their return.
  - the Fiji Nurses Association to be on the administrative committee of the PALM scheme.
  - Lobbying of the Australian government to ensure Pacific Island aged care nurses and personal care assistants are better supported in Australia, including having their costs for travel and visas met and having access to Australian health care and other social protection while in Australia. Future changes to the PALM scheme that allow some workers to bring their families should also be supported by access to public education and health services while workers and their families are in Australia.

India

Introduction

India's 65+ population is growing rapidly. It is predicted to rise from 7% (2021) to 10% (2036) (Agarwal and Bloom, 2022), with a total of 136 million people. Two-thirds of this population live in rural communities and approximately half are classified as poor and women (Ponnuswami and Rajasekaran, 2017). For such a large population of older people, India spends only 0.1% of GDP on LTC, a comparatively low rate of public expenditure (ILO, 2018; ILO 2015). Health expenditure is also comparatively low: in 2017-18, India spent 3.3% of GDP (OECD, 2020).

Social protections for older adults are limited in India. Access to pension income is poor because most employment remains in the informal sector; only 7% of those aged over 60 have access to a pension on retirement from work. Private health insurance is also only available to 18% of older adults over 60 (International Institute for Population Sciences, 2020). The provisions for seniors' health care reside with the *Maintenance and Welfare of Parents and Senior Citizens Act, 2007;*[102] it attends to older people's health care by making state governments responsible for seniors ability to access hospital beds, and for running 'old age homes'. This includes separate queues for seniors to access hospital care. The *National Policy on Older Persons*, *1999* supports financial and food security, health care, shelter and protection. The *Integrated Programme for Senior Citizens* also grants aid to run and maintain care homes, medicare units and non-profit organisations providing services.

Care Regime – Familial Care in transition

India's LTC system is a mixture of family, community, state-funded and private insurance provision. Familial care has traditionally and continues to be the dominant approach to caring for dependent older adults. However, this approach has been challenged in recent years as in other places with rapid urbanisation, and younger people increasingly moving from rural communities to the city. The gradual loss of familial care has accompanied a significant increase in the population of older adults (Ponnuswami and Rajasekaran, 2017; Sharma and Bhambri Marwah, 2017). Despite less availability of familial care, with the larger numbers of older adults ageing, there remains limited formal or organised public sector delivery of LTC in India's state-run 'old age homes'.

Across different states, there is a fragmented and diverse approach to LTC for older adults. Kerala has one of the largest proportions of population aged 65+. It also has the most robust and integrated approach, characterised by significantly more state involvement in delivery, including an established primary care infrastructure, community-based workers and volunteers (Ponnuswami and Rajasekaran, 2017; Agarwal and Bloom, 2022).

In addition to the state-run 'old age homes', the national care regime policy framework includes LTC components such as the Ministry of Health's *National Programme for Healthcare of the Elderly* (NPHCE), launched in 2010-11. The NPHCE is based on the UN Convention on the Rights of Persons with Disabilities. The aim of this and other programmes is to promote active and healthy ageing through high-quality, long-term and affordable services to the older adult population. Provision includes 18 regional geriatric centres to provide medical facilities for the elderly. Other initiatives include assistive devices and technology and encouraging entrepreneurship (Ministry of Health and Family Welfare, 2012).

Over the last decade, the *National Health Care Programme* has focused on older adults, together with its national action plan focused on the health services, predominantly those located in hospitals rather than in community. Voluntary organisations (NGOs) are attempting to fill service gaps, along with the emergence of larger private multinationals that provide services and are likely attracted by the promise of billions of dollars for rehabilitative and preventative geriatric work for the minority of the population who can afford it. These developments reflect a move towards the neoliberalisation of India's health and care system with increased financialisation, privatisation and inequality (Sathi, 2023). Overall, the main focus of the health and care system remains maternal and child health.

Employment Regime

In terms of care employment, much of the national debate and policy developments in India focus on the health workforce. While the NPHCE trains workers in geriatric care, India relies heavily on community-based workers to provide care and health provision, such as the ASHAs or Community Health Workers. The 900,000 ASHAs are not recognised as employees, however, and are paid the equivalent of US$20 to US$120 a month as 'incentives' linked to piece work or the completion of tasks or targets (Wichterich, 2020; Sinha, 2021). These workers work mainly in maternal and child health services. The work undertaken by ASHAs may include visits to older adults with heart conditions and respiratory issues (Shanthosh, Durbach and Joshi, 2021). However, ASHAs also make up a considerable proportion of caring labour employed by households. They have limited access to employment rights and their skills are undervalued. Precarious ASHA working conditions are also found within formal institutional settings, especially private health care facilities.

A sub-group of ASHA workers are the 'Ayahs' who care for sick, older adults and the infirm in the community and in homes. This role has its origins in domestic work, and it is associated with past colonial abuses. Ayahs are outside regulated employment, and share the insecurity, long and irregular hours, and the lack of a standard income experienced by ASHAs (Shanthos, et al, 2021; Basu, 2020;

Kawade, Gore, Pallave, Uddhavi, Pinnock, Smith, and Suvekar, 2021)). PSI affiliates reported on the general lack of awareness or knowledge, even among international bodies, of the working conditions of this group of largely informal workers.

In India, both the central and state governments set the minimum wages for employment. Minimum wages are fixed across sectors, various occupations, skills and regions in the country. There are differences in pay in public versus private care settings. In the public sector, the minimum wage is observed while, in for-profit providers ranging from large to smaller ones, there are very different pay scales, with workers paid at lower rates than workers in the public sector. In addition, there are many unskilled, unqualified workers employed in these for-profit private settings.

Prospects for further improvements in employment rights appear unlikely. However, in 2020 the *Parliamentary Standing Committee on Labour* called on the government to establish wage thresholds for health and care workers. There are also several Bills (National Platform for Domestic Workers Bill, 2016 and National Policy on Domestic Workers) awaiting final government approval and implementation (ITUC, 2023).

Union organizing

In India, the subsectors of health and LTC are emerging as a priority for unions. Given the social and demographic shifts, including the increasing employment of women, a more robust, informed and rounded debate encompassing LTC, including among domestic Indian unions and policy makers but also international bodies such as the ILO and PSI, is required. In terms of identifying barriers to union organizing of LTC services, the country's trade union movement is more focused on the industrial sector rather than services, including public sector services. Where it exists, in public sector unions the vast majority of organizing work is undertaken on a voluntary basis.

Services in health and LTC for the older adults are devolved to the state level, and many policy initiatives are unintegrated. For example, in West Bengal, households can hire a care worker through private agencies to provide services in the home for a few hours or for 24 hours/7 days a week. The agreement is signed with the private agency, and the agency then pays the care worker. Initiatives such as this are not fully regulated and consequently little is known about the nature of the employment relationship.

> Karela has had a policy of palliative care for the older adult population since 2008. The policy works at local community level, through a mixed approach to delivery through ASHAs as well as through accredited nurses trained in the provision of palliative care in the home. In addition, NGOs and volunteer services are part of the delivery across urban and rural areas. PSI affiliates, however, report that little is known about the scale and nature of employment relationships in this part of the LTC sector and that, given their limited resources, it will be difficult to collect relevant data and information.

At the local official level, voluntary status is a barrier to key tasks such as organising LTC workers. ASHA union activists are overwhelmingly women, many of whom face multiple barriers to participation in union work, including their own unpaid domestic caring responsibilities. The reality for many families is that unpaid union work does not put food on the table.

Migration regime

India is a sending country in terms of care labour. Its health and care workforce contribute to LTC systems in developed countries, including those in the UK, Australia, Japan, Singapore, Europe, the USA and Canada. The number of care workers who migrate is significant; PSI affiliates report that at least 300,000 workers have moved abroad in the past year. This migration is a major 'brain drain' from the Global South to the Global North. Despite its own shortage of such professionals, India is the biggest source of nurses to Global North countries after the Philippines. However, the Ministry of Skills Development has encouraged this migration, especially following the pandemic. The encouragement of global labour mobility is one of the government's solutions to the employment crisis facing India. Health professionals receive higher pay and better opportunities overseas and send remittances home. India is the biggest recipient of remittances in recent years, totalling $US 87bn, ahead of China, the Philippines and Mexico. Remittances also held up well during the pandemic because of the fiscal stimulus plans of countries such as the US. The US has been the biggest source of remittances to migrants in recent years (Economic Times, 2022).

The shortages of health and LTC workers in India continue. Apart from migration, the lack of investment by the Indian government in health and other care also contributes to the shortages. The conditions faced by migrant workers are beginning to emerge as an issue requiring more attention within India. To better understand what happens to these workers once they go overseas, some of India's unions are developing links with overseas unions such as UNISON in the UK.

> **Key agenda items for PSI union bargaining in India include:**
>
> - Funding of LTC services. There are concerns about the inadequacy of the emerging private, public and non-profit mix as familial care diminishes. Given the underfunding of a system facing increasing and more complex demands, full funding of LTC

and related health services is needed to place India's LTC approach on a sustainable footing. PSI affiliates are calling for state and central governments in India to invest more in health and LTC through the taxation of the wealthy. An increase in funding to India's LTC system would contribute to narrowing the economic inequality in the country. ITUC and the ILO (ITUC, 2023) have highlighted how an increase of just 2.09% of GDP expenditure in the care sector would have an enormous positive impact.

- Introduction of proper employment status for ASHAs and Ayahs, including wages rather than stipends as well as training and skills provision for workers and the safety and well-being of the workforce.
- Improved safety for workers in LTC services. During COVID-19 there were no government measures on or guidelines for older adults' care homes in terms of infection prevention, raising questions about the health and well-being impacts on staff. Staff also lacked training in infection protocol measures and strict hygiene practices. Unions have already called for better protective equipment, fixed tasks and regular working hours for ASHAs as well as education and training for a workforce that has to meet the needs of a heterogenous older adult population.

Following COVID-19, PSI affiliates pointed towards the PSI campaign in South Asia for community health workers in relation to better health and personal protective equipment. As part of this campaign, they used the ILO's C149 Nursing Personnel Convention, which requires ratifying states to commit to the education and training of nursing-qualified staff and to the improvement of employment and working conditions, including career prospects and remuneration. Currently, India has not ratified ILO 149. Regionally, however, PSI has been promoting ratification and has developed campaign strategies.

More union resources to protect and organise LTC workers. In 2020, 600,000 ASHA workers in India organised a massive nationwide protest demanding basic terms and conditions and recognition (Sathi, 2023). Unions have also won increased honorariums and incentives for these workers. While efforts to organise workers in urban centres such as Mumbai are difficult because of the large numbers of such workers and the lack of contact details for them, PSI affiliates have continued to attempt to afford these workers greater recognition and status as workers, focusing on access to the minimum wage and pensions. PSI affiliates have also called for government investment aimed at including the ASHAs and Anganwadi in health provision and insurance. Overall, the way forward is seen as building union organising beyond caste, religion, gender, education and private-public segregation. (Wichterich, 2020).

Current & Potential Strategic Levers for Action

- Advocate for government to focus resources on filling care gaps left by the declining availability of familial care for the older adult population, and the provision of more care services, including through higher taxation of the wealthy. In addition, there should be greater focus by locally elected government officials on the provision of LTC services in local communities.
- A union campaign to increase government funding for health and LTC.
- Government should be encouraged to recognise care work as skilled work in the formal economy so that care workers do not have to rely on precarious forms of work.
- PSI to develop a union campaign to raise awareness of the plight of workers in health and LTC, including those working with maternal and child health and dependent older adults. This campaign should also raise awareness and gather data at the international level.
- Within the Indian trade union movement, launch a campaign for health and community health workers (ASHA and Anganwadi) workers to receive equal national status with industrial workers with regard to bargaining, employment rights, security, pensions, pay and other conditions.
- Demand all levels of government better support ASHA and Anganwadi working across public, NGOs and private enterprises.
- Campaign for the eradication of differences in pay, skills, employment status across workers in public and private enterprise in health and LTC.
- More resources and research for Indian unions to map the LTC sector for older adults for the purposes of better understanding of: i.) The different types and levels of provision across states; ii) The mix of private, public and NGO provision within and across states; iii) The increasing role and interests of larger private sector multinationals in LTC; iv) The nature and extent of informal employment in health and LTC in India.

- This mapping should inform a campaign for improved regulation of the status of these workers, as has been the case in maternal and child health services. In this way, unions could work against possible two-tier protection for workers in health and LTC.
- Lessons can be shared across states (e.g., from Kerela and West Bengal) about stronger and more systematic approaches to health and care services. Commentators have called for stronger state-led institutional facilities to oversee quality standards in such services (Sharma and Marwah, 2017).
- Increased focus of unions on the working conditions and rights of Indian LTC migrant workers employed in the Global North. Continue to build international collaboration with unions in the Global North to inform this work.

Section 5: Conditions that produce ''unacceptable forms of work' and 'unacceptable care'

This report has identified key principles and indicators of what makes for good quality care and decent work in LTC. These principles and indicators draw on a worker-centred typology of care employment and migration regimes in selected Global North and Global South countries. The typology is underpinned by extensive desk research and country case studies of Canada, Australia, Chile, France, India, Scotland, Fiji and South Africa.

The purpose of this section is to explore the unacceptable forms of work and care that characterise the experience of workers and care recipients in these and other countries. Unacceptable forms of work lead to high turnover and poor-quality services. Across OECD countries, turnover among LTC staff is higher than among the general workforce. Almost two-thirds of OECD countries have identified the retention of LTC workers as one of the biggest political challenges facing the LTC agenda (OECD, 2022).

Two core reasons for the growth of unacceptable forms of work can be identified from the literature and the country case studies. For the Global North, the growth in unacceptable forms of work in LTC rests on the introduction of a range of policies pursued by governments associated with the neoliberal marketisation of the LTC sector, which perpetuates the undervaluation of the skills of the overwhelmingly female workforce. The second reason is associated with shifts in familial care in the Global South, which has been much more reliant on informal care. While, with demographic shifts and outward migration, the availability of familial care is decreasing, the burden of care for older adults has not been met by existing health and social care services.

The next section outlines the key features of these two trends. The section begins with a broad outline of the characteristics, values and principles that underpin marketisation (including the purchaser-provider relationship, undervaluation of women's skills, the abuses of new technology, and the impact of financialisation). This is followed by an outline of familial care, which is characterised, again, by highly gendered provision, and unpaid labour. In discussing these two explanations, the summary contains two caveats. Firstly, we note that the values or characteristics and their application are not uniform in terms of trends or outcomes. Secondly, the summary is not claiming that they are distinct, but rather that there are a number of current and possible intersections. The summary begins with each explanation in turn and then discusses the consequences for care work and the quality of care. In doing so, the section seeks to highlight a series of warning markers to PSI activists that can be translated into campaigning themes in different countries and contexts.

Marketisation, Work and Employment in Long-term Care

Marketisation in LTC

The marketisation of LTC has followed a similar, but not identical, trajectory across a range of different countries in the Global North. Strategies towards marketising LTC provision have been influenced by the ideas of New Public Management (NPM). NPM, as illustrated particularly in our Australian, Canadian and Scottish cases, encourages marketisation and involves the contracting (hollowing) out of public services from direct state provision and employment to networks of private (for-profit) and voluntary (non-profit) providers (Jessop, 2002). The rationale for such outsourcing is multipronged and inspired by the ideology of the NPM agenda, which includes: the supposed financial unsustainability of services provided directly by the state; the drive to improve quality in services through the placing of market disciplines and risk onto providers of services and their workforces; the introduction of private sector management techniques and innovation into public services; cutting costs and enforcing efficiencies in service provision through competition; the closeness of certain types of provider (i.e. non-profits) to clients and their needs; the

undermining of the regulatory reach of trade unions and collective bargaining; and the erosion of terms and conditions of employment for frontline care workers (Hood, et al, 1991; Baines, 2004: Charlesworth, 2010).

Public service supply chain relationships

Marketised LTC systems bring particular power dynamics to the relationships between private and non-profit providers of care, and the state. Specifically, there is resource dependency by the former on the latter. Directly delivered public services have been steadily 'hollowed out' (Jessop, 2012) through processes of outsourcing, whereby the state, as well as being a provider, becomes an enabler for others to provide LTC. The state both central, regional and local, creates networks of private and voluntary providers, which it leads and coordinates.

Much of the relationship between the state and provider in LTC can be problematic. Cases such as Scotland, Canada and Australia reveal how state funding awards rarely consider the full cost of care, or inflationary pressures. Moreover, the funding is tied to strict key performance indicators (KPIs) which, year-on-year, can demand efficiencies and, in times of austerity, cuts in funding. Provider organisations are particularly vulnerable in relationships where they have one single dominant funder, with no or limited access to alternative funding.

In terms of security and sustainability, constant pressure from funders on provider organisations to make savings and efficiencies has seen organisations pull out of the market either partially or wholly in the form of handing back services to government. Adult LTC in countries such as Scotland have been particularly vulnerable in this regard as it is traditionally more underfunded than children's services.

Marketisation has developed through a combination of NPM and neoliberal values, but also the human rights campaigns of the disability movement. With regard to the latter, we have seen increasing calls for services that place the aspirations and ambitions of service users first, involving them or their representatives in the development, design and delivery of frontline services. Included in this agenda is the notion of service users as consumers or customers expressing individual choice, including over the type of provider (public, private or voluntary), and even down to the individual worker. Moreover, these agenda lead to decisions over the exact timing and number of hours of delivery. In so doing, states (such as Australia, France and Scotland) have further marketised care services by introducing programmes promoting the individualisation or 'personalisation' of care, known as 'cash-for-care'. Here, states have introduced payment schemes where, instead of resources going directly to voluntary and private providers, money through forms of personal budgets is placed in the hands of individuals or care recipients. These schemes are designed to empower those in receipt of care to make choices regarding their lives, rather than 'one size fits all' services provided by the state or providers. In so doing, as in Scotland, individuals can hire their own '*personal assistant'*, or pay and direct a provider to supply services to them. There are multiple rationales for such schemes. As part of the NPM agenda these rationales include: the aspiration to introduce the notion of 'consumer-directed care' into public services and the provision of LTC; to further shift the risk of care provision onto providers and their workforces; to individualise the employment relationship and undermine prospects for collective bargaining; and, because resources devoted to individualised, 'cash-for care' models are always less than state provided collective approaches, there is a clear agenda of enforcing public service cuts, often linked with austerity (Needham, 2012; Meagher, 2021).

Gender and the undervaluation of care

Marketisation also perpetuates the gendered undervaluation of care work, the gendered division of labour and naturalisation of women's caregiving skills. LTC jobs are badly paid because they are overwhelmingly held by women and because care work is associated with the quintessentially gendered role of women, in particular mothers (England, 2005, p. 395). Women are expected to bring skills such as emotional work because they are utilised on an everyday basis in the home in their roles as primary care providers. Subsequently, skills such nurturing and compassion are taken for granted and undervalued.

The prisoner of love thesis (see Folbre, 2001) focuses on the intrinsic motives that drive many care workers, and which make it easier both for the work in care to be hidden and for employers to justify low wages (England, 2005). Here, caring is perceived as altruistic and intrinsically fulfilling, with less emphasis on monetary rewards. Baines (2004a) and Charlesworth (2010) discuss the social norm that women have an infinite elasticity 'to care', which implies they will tolerate significant undervaluation and degradation rather than abandon those for whom they are caring. These gender-based constructions undervalue paid care work by establishing expectations among different actors in the care market. Funders of LTC services, both the state and public sector agencies, are complicit in the undervaluation of women's work by traditionally not setting prices that include accounting for the skills associated with characteristics of the work such as human nurturing (Carmichael and Brown, 2002), or the capacity to connect to users' emotional states and needs (Himmelweit, 1999).

As an example, in Australia, the skills of support workers in the individualised, National Disability Insurance Scheme (NDIS) have been assumed to be entry-level skills, i.e., functions that are routine, with limited problem-solving skills or worker initiative, and readily available guidance and assistance. The overlooking of the complex skills used in care work in consumer-led or personalised

care schemes has limited the prospects of better pay, restricting career progression, and downgrading job classifications (Cortis, et al, 2018).

It is not only social, emotional and other 'soft' care skills that are undervalued. A recent project revealed that, in keeping with the low value ascribed to care workers in society, their ability to learn and adopt new digital skills has also been undervalued and normalised by managers as just a necessary and expected part of the job. The pandemic has led to increasing demands for digital skills among workers. However, a recent study revealed that digital skills in care (seen in other contexts as 'hard' skills and therefore of value) are not being remunerated but 'volunteered'. Training in such skills is minimal and non-engagement based on fear is passed off by reinforcing ageist and sexist stereotypes of older women not being able to cope. Among those who do engage, undervaluation is further justified by a rationale that highlights how workers already possess and utilise these skills in their day-to-day lives (Briken, Baluch and Cunningham, 2022).

The use of Technology in LTC

It is relevant in any discussion of marketisation to highlight the role of new technology in the cost-cutting and austerity measures, and the gendered undervaluation of LTC outlined above. In marketised care systems, information and communication technologies (ICTs) are also characterised by cost saving priorities. Managers delivering public services reportedly see technology as a panacea that can deliver efficiencies, cost savings, plus it helps them introduce new forms of control that reduce worker discretion (Gillingham and Graham, 2016; Richter and Cornford, 2006). The urgency among LTC providers to introduce these technologies has accelerated and intensified within contexts that demand cost savings. In some countries, for example, such as our Scottish case study, recent austerity policies have been supported by new digital technology that embodies policymakers' hopes of obtaining ever more services for the same or less money (Schulzenko and Holmglen, 2020). In 2019, a survey of UK social services directors of adult LTC in public funding bodies found that 96% saw the use of assistive and ICTs as quite or very important in making cost savings. Indeed, it was seen as a key means by which local government can sustain statutory services despite drastic austerity-inspired reductions in their budgets (ADASS, 2019).

The prospects for LTC workers to experience changes to their work, and potential degradation from the introduction of technology, are significant. Technology is a key part of the pressures that bring greater insecurity and intensification of work in marketised LTC work (Gillingham and Graham, 2016; Rubery et al, 2015; Hayes and Moore, 2017). Care technologies are seen as central to cost savings in public services through facilitating outsourcing, but also at the organisational level by reducing the number of levels of hierarchy (Boreham, et al, 2008). Biomechanical devices and assistive technologies substitute for labour to cut costs, impacting on service and job quality (Hester, 2018). Examined in detail in a later section, further reductions in costs through technology in countries under austerity are achieved by public service commissioners increasingly only paying outsourced providers for actual care delivered in the home.

Technology is also implemented within the context of existing, gendered norms or values. Labour substitution has the potential to accentuate existing inequalities as women are forced from paid occupations back into the home (MacLeavy & Lapworth, 2019). The application of technology also has detrimental impacts on care receivers as they, again, experience the diminishment of relational, face-to-face interactions in favour of technological solutions, such as remotes, sensors and robots (Fredirici, 2014; Hester, 2017 and 2018). In addition, multiple strands of accountability mean organisations and workers face more demands to complete reports, or electronic record keeping, which means there is less time for them to spend on social relationships with users. In particular, fears arise over the neglect of the more qualitative, gendered relational elements of the frontline LTC relationships (Gillingham and Graham, 2016). Moreover, the monitoring of the time spent in the user's home through ICTs diminishes the amount of autonomy workers have to engage in the social and relational elements associated with dealing with the most vulnerable. Such gendered skills among the workforce are squeezed or unpaid or become invisible from view, thus undervaluing their contribution to care (Hayes and Moore, 2017; Rubery et al, 2015; Gillingham and Graham 2017).

Profiting from LTC through financialisation

In the case studies in Chile and India, we see emerging interest from multinationals in their evolving LTC systems. Yet another feature within these marketized systems that contributes to unacceptable employment practices is profiteering by large, private multinationals. Recent research by CICTAR and Federation Santé Action Sociale CGT and Federation CFDT Santé Sociaux (2022) found that the company Orpea has reportedly saddled care homes with large amounts of debt, and heavy rental costs. This is undertaken through Orpea selling care homes at a profit, and then leasing back the properties from the new owners. This property speculation is done through a complex web of 40 subsidiary companies established in Luxembourg. There is nothing illegal about these transactions but there are calls for greater transparency (Cictar, et al, 2022). Orpea is not alone in this regard. This form of financialization is common. The UK alone has care assets worth £245bn, with yearly transactions of £1.5bn over the last five years (Cictar, 2023).

The costs (rent and debt) associated with these transactions are consuming the resources of care homes (drawn from public funding) and compromising the quality of care to LTC residents, putting downward pressure on terms and conditions. There are reports of constant efforts to maintain low pay and poor staffing ratios, surveillance and retaliation against union members (CICTAR et al, 2022; CICTAR, 2023). With regard to the former, reports have emerged of rationing of food and basic sanitary items. Private investment is also attracted to more affluent areas, leaving already deprived areas without sufficient capacity in their local care markets (CICTAR, 2023). Our French case study illustrated some of the care quality issues in companies such as Orpea. Moreover, the French case confirms that these forms of financialisation are responsible for very poor working conditions, including the displacement of temporary contracts, and the establishment of alternative employee representation structures that lack the autonomy characterised by recognised unions.

In Scotland there is significant concentration of ownership in private care homes in cities such as Glasgow and Edinburgh. In addition, in Scotland in 2017-20, the largest for-profit providers spent 25% less of their revenues on staff costs than the largest non-profits. The same companies have also claimed government support through COVID-19 grants, while awarding dividends, directors fees and rent. Indeed, STUC is campaigning for the Scottish government to move from its current stance of being 'ownership neutral' in establishing a new National Care Service and has recommended a non-profit public service delivered between local authorities and the voluntary sector (STUC, 2022). This makes the risks of failure of these companies a potentially huge problem for vulnerable people. The same report highlighted how larger care homes were more likely to have complaints upheld against them than smaller ones (Scottish Trades Union Congress (STUC), 2022).

The acceleration and globalisation of marketisation that allows dominant funders to place cost-cutting at the heart of relations with providers continues the gendered undervaluation of women's work, encourages the introduction of technology that focuses on cost control, and allows exploitative forms of financialisation by multinationals has led to a 'race to the bottom' in terms and conditions of employment. Recent years have further seen the introduction, in some countries in the Global North, of austerity funding (e.g., Scotland and Canada), which has accelerated and exacerbated these pressures. Below is a summary of the key trends in working conditions.

The decline in familial care

There are also overlaps between the decline in familial care and the trends towards marketisation. Globally, women engage in the three forms of familial unpaid care work (domestic services for own final use, care services to household members, and community services or volunteering) far more than men, accounting for approximately 80% of such labour (ILO, 2019). These three forms of unpaid care work form the bedrock of much of the global LTC provision. The contribution of unpaid care work to LTC is far more pronounced in the Global South. At the same time, as our case studies reveal, changing demographic, socioeconomic and political trends are seeing a greater fluidity in the traditional reliance on this labour. Each of our Global South cases reveal how industrialisation, urbanisation, greater educational opportunities, shifting population trends, and the creation of global care value chains is seen to be diminishing reliance on familial care. As these changes become more pronounced, large amounts of expenditure in these cases (Fiji, South Africa and India) remain largely dedicated to health services for mothers and young children. Yet, despite rising demand, scrutiny of LTC provision among the cases from the Global South reveals huge gaps in coverage.

Moreover, as forms of marketisation spread from the Global North, the depletion of familial care brings several threats to LTC workers and care receivers in the Global South. The first of such threats comes from the growth of global care value chains. These value chains lead to immigrants replacing local workers from the Global North in what is perceived to be devalued care work (Ostabakken, Orupabo and Nadim, 2022). These migration streams from the Global South to the North, in turn, have led to shortages of health and LTC workers across states in the former, taking further resources away from already limited provision.

The second threat comes as population ageing occurs in our Global South case studies. The cases reveal how new markets are beginning to be identified by multinationals (e.g., in India and South Africa). Without proper state regulation and commitment to engage in building an LTC system, this leaves these states, their workers, and care receivers vulnerable to the financialised strategies of multinationals familiar in countries such as France, Australia and Scotland. The growth of these private forms of delivery in countries of the Global South threatens parallel efforts to organise what, in many cases from our case studies, appears to be a largely informal workforce operating in circumstances familiar to the third category of unpaid work, i.e., providing community services for others through forms of volunteering. The growth of LTC activity by multinational corporations in countries such as India, South Africa and others will present a challenge as financialised practices such as the extraction of value from real-estate transactions, the creation of two-tier systems of care and degradation of working conditions will present significant additional work for unions campaigning to regulate informal unpaid LTC labour.

Poor job quality in LTC_

Pay and Working Conditions

A range of studies into the study of marketisation in LTC have highlighted that pay and conditions are generally low compared with other occupations and rank among the lowest paid occupations in most economies, alongside hospitality and tourism, and retail (McKnight, A, Stewart, K, Himmelweit, SM and Palillo, M, 2016; Williamson and Allen, 2023; Scottish Government, 2019). Working in care can lead to a wage 5-6% lower than that of other workers in non-care jobs, which is seen as a wage penalty for care work (King-Dejardin, 2022). Another study found that, in general, LTC workers receive low wages, work in less favourable working conditions and have less social security compared to other care workers (ILO, 2017b). An EU study further reported that only 22% of workers are 'very satisfied' with their working conditions, fewer than the general workforce (26%) (Eurofound, 2020). In addition, in Australia, the United Kingdom and the United States, care workers earned around half (55-57%) of the average earnings of all occupations in 2014 (ILO, 2017, p. 25, citing ITUC, 2016). When care jobs become too demanding, they move to the equally low paying sectors of retail and hospitality where pay may be slightly better, and/or they have fewer responsibilities (Scottish Government, 2019). In the EU, LTC workers are often paid well below national average wages, with pay in the private sector being worse than in public providers (Eurofound, 2020). Specifically, median wages in the LTC sector are lower (EUR 9 per hour) than hospital workers (EUR 14).

Similarly, in the US, in 2019, the median hourly wage of LTC workers was $15.22, compared to $20.07 in the general workforce. In addition, a clear gender pay gap has emerged with women's median wage being $14.98, compared to $16.32 for men. Moreover, it is noteworthy that in the US, the residential LTC sector disproportionately employs immigrant women, bringing a double disadvantage to this exploited workforce, as they are also concentrated in the low wage occupations of the sector, and can earn around the low $14, compared to white workers at over $16. (Economic Policy Institute, 2022).

Of equal concern is how marketisation has led to a further undermining of employment pay rates compared to those in the public sector. Marketisation in countries such as Scotland and Canada has led to the erosion of other benefits that were comparable to those received by public sector workers undertaking equivalent roles. These benefits include pension entitlements, sick pay benefits, holidays, overtime and other unsocial hours payments. Indeed, increasingly, there are reports that care workers fail to receive even the statutory minimum wage. Such underpayments have occurred in Scotland and the wider UK as price competition among outsourced providers has meant funding has not been sufficient to cover costs such as travel time. The result is that workers in community LTC services travel unpaid between visits, with the result that their average hourly rate of pay falls below the statutory minimum. This is particularly the case for migrant workers (Hayes and Moore, 2017). Technology assists these cost saving measures. ICTs are used for workforce surveillance. Rubery et al, (2015) found that ICTs are used to monitor the commissioned visits to people's homes (sometimes for as little as 15 minutes). To further enforce budget cuts and monitor whether care is actually being delivered at the prescribed time, ICT captures real-time start and finish times through the use of satellite tracking, the activation of sensors on mobile phones as workers enter people's homes, and through the tracking of mileage/travel claims (Gillingham and Graham, 2016, 197).

Such unacceptable practices by funders and employers in the Global North present clear lessons for activists across PSI affiliates embarking on ensuring that LTC workers' status and conditions are formalised and come under minimum wage guidelines. Workers in some LTC services can also be asked to contribute to things such as the purchase of uniforms, and even fees associated with training and professional qualifications. Some authors claim that the steady erosion of working conditions in marketised adult LTC means 'an end to the standard employment relationship', and that all employees are offered is a basic rate of pay and some commitments around induction, training and health, and safety (Rubery and Urwin, 2010).

Insecurity

Work and employment in marketised systems of LTC can also be insecure. Funding uncertainty can stem from changing government priorities and fiscal retrenchment. The austerity in funding renewal facing non-profit and private providers leads to higher than average rates of temporary contracts in many countries (Scotland), or groups of workers being particularly vulnerable to being hired under precarious contracts during specific points in the funding cycle (e.g., in Chile). Across OECD countries, non-standard, temporary employment is almost twice as high among LTC workers compared to the health sector. Data from Europe reveals how more workers among the LTC workforce are looking for another job compared to those in health, and that the reasons for this are linked to job insecurity and dissatisfaction (OECD, 2022).

The individualisation or personalisation of LTC adds further dimensions to insecurity. Such approaches to care add an intensification of market pressures as the recipients of services are seen as 'customers' with choices, including in the selection of who will deliver services. Again, this adds an element of insecurity into the working lives of employees as they can be moved around or even lose their job if they do not exactly match up with service user requirements. There are examples of workers having their job security threatened in circumstances where service users have requested because they do not precisely match their requirements.

Work intensification

Work intensification arises in a number of ways in LTC. Failure to fund travel time adequately and the tendency of workers to stay until the job is done, so going over prescribed commissioned time limits, means they are undertaking unpaid work (Hayes and Moore, 2017; Campbell, Macdonald and Charlesworth, 2019). As with our Australian, Canadian and Scottish cases, rising demand for services coupled with underfunding and staff shortages combine to intensify work for workers. Early studies in LTC show how shortages of staff meant that it was common for workers to work through breaks and do additional hours unpaid. Another common practice was where staff shortages and absence meant that workers would take on double shifts (Baines, 2004a). Again, these sacrifices or unpaid labour donations were seen as part of a largely female workforce's infinite elasticity to care (Baines, 2004a). Sacrifices were made in the name of the service user, labelled 'compulsory altruism', which contains gendered, taken for granted, assumptions that women will undertake unpaid work (Land and Rose, 1985).

Work intensification from high turnover or absence also has its costs in terms of quality and staff and service user well-being. In the first instance, studies have revealed that workers undertaking too many hours can suffer 'burn-out' and stress, impacting on their mental and physical health (Squillace, 2008; Olley, 2023; Mockli, Denhaerynck, De Geest, Leppla, Beckmann, Hediger and Zuniga, 2020). Absence can then occur, putting further pressures on already understaffed services. Physical health can also be put at risk from the effects of work intensification and accompanying fatigue in services where there is challenging behaviour and lapses in concentration can lead to physical assaults on staff (Baines and Cunningham, 2010). Highly demanding jobs, and exposure to physical and mental health factors, leading to low job satisfaction is seen as a prime cause of low retention in the LTC workforce (OECD, 2022).

Poor support, training and skills development

Supervision of workers is compromised in these marketised environments. Underpayment of fees means that time devoted to direct and formal face-to-face (or digital) interactions between frontline worker and their supervisor/line manager is squeezed. Regular and adequate supervision is seen as one of the key elements in providing workers with the support they need to work in challenging environments. Yet, marketised systems and the persistent squeeze on costs allow limited funding for time for workers and their supervisors to come together to engage in supervisory activities (Cunningham, Lindsay and Roy, 2020). This undervaluation of supervision and subsequent gaps in support has been repeated in Australia. The study identified how organisations had fewer line managers and, for those that remained, they experienced increasing spans of control, which meant less time to devote to supervision (Cortis, 2017).

Overall, limited access to supervision training etc. means that many workers in marketised care systems operate without full competence in dealing with dangerous situations, and emergencies with clients.

The Fragmentation of Working time

The organisation of working time is a key component of funder and management efforts to reduce labour costs in LTC. As outlined in the previous section, the application of ICTs can be a tool for organisations to monitor and control working time. In addition, under marketised systems of care, how time is managed through the introduction of flexible forms of contracts, and the scheduling of shifts, further contributes to cost reduction and the degradation of work. Part-time work is sizeable in the LTC workforce, being twice as high as the average rate in the wider economy. For example, 45% of LTC workers in OECD countries work part-time. In the EU, LTC workers undertake rotating shifts, with reports that they feel they have no say in their working time and are often requested to take up shifts at short notice during unsocial hours (Eurofound, 2020). The trend among public service funders to only pay services for time actually delivering care has led to the introduction of forms of insecure contracts. These pressures for greater flexibility to reduce costs are intensified in individualised and personalised approaches to care provision. Personalisation means that the 'customer's' preferences regarding when services are to be delivered are at the centre of the care model and play an increasingly important part in the organisation of working time.

Short-hours, part-time, relief, or zero-hours contracts can proliferate in this kind of marketised environment. The increasing use of these forms of contract to match the demands of funders and service users for flexibility and cost savings means that the hourly rate of pay for which a worker is hired can have limited impact on whether they receive a decent wage that they can survive on: it is the number of hours that is crucial, and these contractual arrangements can make workers 'hungry for hours'. Part-time work is also linked to 'hours poverty'. A proportion of LTC workers in the EU (30% in non-residential LTC, 20% in residential LTC) report that they take up part-time contracts because full-time work is not available (Eurofound, 2020).

Part-time contracts offer the prospect of minimum hours, which can be 'flexed up' to take account of increases in customer demand but similarly 'flexed down' if demand slackens, leaving workers short of the hours needed to make a living. Zero-hours contracts (ZHCs) have attracted particular concern in countries such as the UK. They are particularly common in elderly care, predominantly delivered by private sector providers. They offer the worker no minimum guarantee of working hours and are used largely in forms of domiciliary care. Again, these workers can sometimes have limited or no access to sickness or holiday benefits. There are reports of workers turning up to work and being told they are no longer required because the service user does not require them that day or

has a hospital appointment. In such circumstances, the worker does not receive any pay (Hayes and Moore, 2017). Another feature is how such contracts can lead to the fragmentation of shifts as service users may require them at one time in the day, operate independently for another part of it, and then require the worker again. This splitting of shifts means that workers are, again, not paid for time where there is no direct contact with the service user. Long travel-to-work distances can mean that, if the organisation does not have any similar work for the employee, they are left to their own means, unpaid until the service user requires them again. Sometimes, shifts can be split into small packages of time across a week. Again, given travel-to-work costs and accompanying expenses, these multiple fragmented shifts can mean work does not pay. This problem is especially acute in remote, rural areas where public transport may be scarce.

The individualisation or personalisation of care can also add to the fragmentation of working time. In Australia, 'time' is not recognised in the price setting under the NDIS. The squeezing of time has meant that workers only have time to complete domestic tasks, undermining and minimising the time allowed for them to interact and spend time with service users (Cortis, et al, 2017; Cortis et al, 2017).

The introduction of new forms of platform work in care

In some countries operating marketised care systems, a further feature of public policy reforms linked to the individualisation/personalisation of care and the application of technology has been an increased reliance of care delivery on forms of platform work. The organisation of care work is through digital platforms, where service users select from a range of independent, casualised care workers. Australia has had the most recent experience of the growth of these forms of casualised, platform care worker. The NDIS in Australia has restructured care markets to increase precarious forms of employment, placing the rights of workers in opposition to clients (people with disabilities) (Baines and Young, 2020; Baines, et al, 2020). The introduction of NDIS in 2013 promoted choice for service users with disabilities through a cash-for-care approach, albeit on a system of prices for each hour of disability support (Cortis, et al, 2018). Services were underfunded through contracts, with pricing set too low (Cortis, et al, 2017). Consequently, Australia has seen the growth of gig-like work in care operating through digital platforms, with poor quality of care outcomes (Macdonald, 2021).

Here, the application of this technology means that digital platforms allow employers to act as an electronic interface between workers and care recipients. In these marketised systems, employees face increasing risks in terms of costs and fragmented shift patterns. Work is individualised through the movement of care from an agency setting to largely private homes, introducing isolation among workers. The income of workers in these roles is compromised as the funders do not adequately fund care packages, meaning service users cannot pay for wage rises. These forms of work mimic many of the issues faced by other precarious forms of work such as ZHCs in the UK, i.e., last-minute cancellations, or small shifts with long travel-to-work distances, which are uneconomical. The burden of managing underfunded care packages is placed on the worker in the form of unpaid overtime, and this is common (Baines, et al, 2021). The organisation of workers' shifts is increasingly undertaken through phone apps, which can mean random changes to shift patterns, reflecting a shift to on-demand, platform work (Baines and Young, 2021). In terms of care quality, underfunding means high-quality relational care is undermined (Cortis, et al, 2018). Some workers have even reported how they are told to abandon service users as their care package runs out of funding.

Migrant labour

In terms of understanding the levels of vulnerability that different groups in the care labour force experience in marketised systems, attention must be directed at the situation of migrant labour. Care provided by migrant workers fills gaps in the LTC systems of richer countries. Again, migrant care workers are overwhelmingly women (accounting for approximately 73.4% (or around 8.5 million) of all migrant domestic workers) (King-Dejardin, 2022). Most migration occurs because of financial reasons, poor working conditions or an inability to find a job in their home country (Eurohealth, 2019). As in our Indian and Fijian cases, migrants largely supplement paid and unpaid work in higher income, developed countries to meet national labour shortages caused by the undervaluation of care work. For example, Australia, Canada, France, Germany, Italy, England and Scotland are receiving countries. These workers can provide support to reduce institutionalisation of vulnerable client groups such as those with dementia.

Migrant workers are characterised by multiple forms of disadvantage. There are risks of human trafficking and abuse, as well as challenges to the LTC systems of source countries in terms of creating or adding to shortages of such workers. These pressures among source countries will increase as their own populations begin to age and require services in the coming decades (Eurohealth, 2019). In addition to gendered disadvantages, they face discrimination based on race, ethnicity and nationality. They may belong to an economically disadvantaged class, and their immigrant status may withhold specific labour, social, welfare and political rights from them in the country they are settling in. "The inequalities of gender, race, ethnicity or nationality, class and immigration status are thus intertwined and embedded in migrant care." (King-Dejardin, 2022). For OECD countries in 2012-13, 28.5% of home-based migrant care workers were occupying roles such as nursing, nursing aides and less-skilled care workers providing domiciliary support for older and disabled persons, such as bathing, dressing, and getting in and out of bed. (OECD, 2015). In the EU, only Austria can provide accurate figures on the number of migrant workers because, in many cases, their work occurs in the unregulated 'grey zone'

of the economy where abuse of their vulnerable position can occur, such as insecurity, lower wages, no chance of improving qualifications, poorer working conditions and little chance of having a voice to seek redress. This exists alongside reduced access to social security benefits and labour protection (Eurohealth, 2019).

Country-based studies show that migrant workers suffer additional disadvantage to locally-born care workers. In Australia, workers on temporary visas have suffered unequal rights and working conditions compared to permanent residents (Pillinger, 2012). A recent study in Australia found that migrant LTC workers, particularly those from non-English speaking countries, were more likely to be underemployed and employed on a casual basis compared to locally-born workers (Charlesworth and Isherwood, 2022). Studies from the USA and UK further highlight that migrants suffer disadvantage compared to domestic workers as regards working hours. In particular, their hours are seen as excessive as they are more likely to be expected, and face pressure, to take on overtime (Martin, et al, 2009; Cangiano et al., 2009).

Our cases in Fiji and India reveal how so-called sending countries also suffer disadvantage in these 'care value chains'. In particular, although countries such as India may benefit from remittances sent back to families in their country by LTC workers, these migration flows lead to shortages of workers in their own countries.

Unacceptable working conditions and poor care quality

The underpayment of wages and the insecurity faced by care workers in marketised systems is a false economy, as many services then suffer from chronic turnover and shortages of labour, thus impacting on public sector budgets through perpetual recruitment, induction and training cycles. For example, a 10% increase in turnover is associated with higher mortality among nursing home care residents and a decrease in quality care measured by the physical environment and infection control (Akosa, Antwi and Bowblis, 2016). Single country studies reveal consistent problems with turnover in marketised services. Vacancy rates in LTC in the UK have been reported as being twice as high as in other sectors (Cangiano et al, 2009). Persistent retention problems in the LTC sector are well-documented, with the overall turnover rate reaching 34.4% in the adult LTC sector during the pandemic in 2020-21 (Skills for Care, 2021). In the USA, the median duration of employment as a care worker is five months, with two-thirds of those leaving the sector altogether (Baughman and Smith, 2012). In Japan, turnover is higher than in other industries, standing at 27% (Japan Long-term Working Condition Survey, 2008; Japan Employment Situation Survey, 2008; Hotta). In Australia, the annual turnover rate – at 25% – is higher than in other comparable sectors (Australian Government, 2012).

In personalised services, low prices, or the parallel implementation of austerity measures, has a number of implications for care quality. Workers are often unable to deliver the types of service envisaged by disability and human rights advocates associated with cash-for-care schemes. In Australia, the under-pricing of care has undermined providers' capacity to recruit the number of workers needed (Cortis, et al2018). In Scotland, austerity cuts meant that only those with the highest needs were eligible for services. There was also evidence that care was limited to domestic tasks provided by zero-hour contract workers on limited time slots, losing much of the supposed life building care that the advocates of individualised services promote (Cunningham, 2016).

The link between staff shortages and service quality is profound. For example, during the lockdowns at the height of the COVID-19 pandemic, on the one hand, higher staff ratios in LTC residential care units led to fewer deaths. This was a consequence of workers having to move around less between care recipients, thus reducing the risk of infection. On the other hand, during the pandemic, poor pay and access to other benefits reportedly contributed to increasing infections among vulnerable people. In the UK, for example, the transmission of the virus among workers on low pay and insecure contracts occurred largely among employees in private companies who were not reporting infection, or were asymptomatic. This non-reporting was linked to workers not being entitled to receive sick pay. Over the years, savings made by private providers to generate profits have included cutting back on sickness benefits. Care workers in many cases may also have multiple jobs to make ends meet. Again, during COVID this meant that workers were transmitting the virus to vulnerable people because they were moving between multiple institutions/care homes.

COVID and Long-term Care

The above evidence of 'false economies' associated with marketised LTC was exposed in the COVID-19 pandemic. The advent of the COVID-19 crisis brought significant issues to LTC across the globe as historic underfunding meant national systems were generally ill-prepared to respond to problems related to the pandemic, such as taking on rigorous infection prevention and control measures, absorbing the costs of PPE, coping with the training needs of staff, and dealing with worker absence due to sickness (Langins, Curry, Lorenz-Dant, Comas,-Herrera and Rahan; Eurohealth, 2020).

Fatality rates were higher among the older population (Levin et al., 2020). In a study of 22 countries, up to the end of 2020, it was reported that there were 325,000 deaths of care home residents attributed to COVID-19 (Comas Herrera, Zalakain, Lemmon, Henderson, Litwin, Hsu, Schmit, Arling, Kruse and Fernandez, 2021). Across OECD countries, older people were more vulnerable to the outbreak, as 40% of all COVID deaths were among LTC residents. Australia had one of the highest morality rates and average number of deaths at 75%, along with New Zealand at 63%. The lowest shares were in Greece (8%), Lithuania (12%) and Latvia

(16%) (OECD, 2021a). However, Canada has been reported has having the highest proportion of LTC deaths among deaths linked to COVID-19 at 85% (WHO, 2020). The majority of COVID-19 deaths were among older people, with 93% being among people aged 60/65 and 58% among those aged 80/85 (OECD, 2021a). Another study found that half of deaths from the pandemic in Europe and 35% of the US death toll happened in LTC facilities (Faghanipour, Monteverde and Peter, 2020).

Another study of nine countries found that deaths linked to COVID among people with dementia as a proportion of those who died in care homes accounted for between 75% - 29%, with Spain having the highest level. The vulnerability of people with dementia was due to their inability to fully comply with safety and infection measures due to impairments in cognitive functions such as memory, language and thinking (Suarez-Gonzlez, Livingston, Fay-Low, Cahill, Hennelly, Dawson, Wedner, Bochetta, Ferri, Matias-Guiu, Alladi, Msimi and Comas Herrera 2020).

While vulnerability among the elderly population partially explains these deaths, it has become increasingly evident that it is the place of care that was a major contributor. Overcrowded and high-density facilities with shared occupancy were the common characteristics of LTC residential services that showed higher death rates. Linked to this were poor quality instruments, as the same study found that, at the start of the pandemic, only half of countries had guidelines in place regarding infection control (OECD, 2021a).

The pandemic had a significant impact on the employment regime. Commentators place a significant proportion of the blame for the high number of deaths among people in LTC down to the undervaluation of care and its workforce. COVID-19 revealed the false economy behind years of underfunding and worker exploitation (Faghanipour, et al, 2020). The low priority given to LTC and its workforce was illustrated in the delays in distributing PPE and undertaking testing for staff in the early stages of the pandemic. In countries such as Colombia and the Czech Republic, workers had to contribute to the purchase of their own PPE (Comos-Herrera, et al, 2021; OECD, 2021).

Staffing ratios

The funding deficits experienced by most LTC systems filtered down into insufficient staffing resources on the frontline. Some studies found the risk of death from COVID to be higher than average in for-profit facilities, associated particularly with lower staffing ratios and the older design of facilities (OECD, 2021a). Moreover, training for workers in detecting and isolating COVID cases was slow to be implemented in some LTC settings. Here, staff shortages made it difficult to organise training because of threats to the viability of particular care residences from staff leaving their posts.

Unsurprisingly, nearly all OECD countries took measures to recruit LTC workers to tackle the aforementioned shortfalls in staff (Langins, 2020). This included providing funds to LTC facilities that they were able to use to cover the costs of recruitment, and could include efforts to recruit retired staff, the unemployed or students. In addition, there were increased one-off payments made to reward workers operating under significant pressures. Around 40% of OECD countries provided one-off bonuses to their workers for exceptional service. A small number of countries improved wages permanently (Germany, Czech Republic, Korea and France). Other measures related to the migration regime included temporary extension of visas for foreign LTC workers. Only Colombia, Greece and Latvia took no specific measures (OECD, 2021a).

Sickness absence

In addition, due to workers being potential key transmitters of the virus, it was essential to minimise their movements within and across different places of care (OECD, 2021a). And yet one way that the virus was spread through the movement of workers was because many held more than one job. Across OECD countries, 45% of LTC workers are part-time and many have multiple jobs in order to earn a decent living. Again, during the early part of the pandemic this ‘shared’ workforce was seen to contribute to the spread of COVID-19 (Langins, et al 2020; Reed, Murmann, Hsu, Turnpenny, Low, Hussein, and Alin, 2022).

LTC workers were more likely to take more sick leave than non-LTC workers or have higher recorded sickness levels compared to the pre-pandemic era (OECD, 2021a). This increased incidence of sickness contributed to infection problems. Staff absence made it difficult to ensure that services were properly resourced or had the requisite levels of expertise. Those left in work experienced greater workloads and gaps in staff-care recipient ratios that subsequently increased the movement of workers and thus LTC infections (OECD, 2021a; Langins, 2020).

There were reports from countries such as the UK of workers going to work in LTC settings infected because they received limited or no sick pay. Poor or no sick pay brings a significant financial cost for employees and provided many LTC workers with a reason to be in work despite being infected with COVID-19 (OECD, 2021a). A study in England found that nearly one-fifth of those who needed to self-isolate did not receive any sick pay (Hussein, 2020). Vulnerability is pronounced among workers on zero-hour contracts if they become infected. Their contractual status can mean that they are among those who do not receive any form of payment due to illness. In the UK, even where sick pay is available, many employees – especially in private LTC facilities – only receive Statutory Sick Pay (SSP), one of the lowest payments for sickness across Global North countries. These issues have received attention from

organisations (i.e. OECD) and trade unions as well as academics (Elsen, 2020), who report the need for absence management and structural paid sick leave to re-appear on trade union bargaining and policy agendas. This is especially important considering that, going forward, regular waves of infection at peak times such as the winter suggests a continuing risk of employees becoming infected and having to take time off.

As of April 2022, the Scottish government had reported 4,151 deaths in care homes, representing 13.2% of this population (Lemmonet al, 2022). To avoid issues regarding attendance, sickness and recruitment and retention during the pandemic, the Scottish government introduced measures to ensure the provision of long-term security for staff and the introduction of technology-enabled care. It also launched a national recruitment campaign with a focus on young people and established basic terms and conditions, including support for the health and well-being of staff. A Social Care Staff Support Fund was established to ensure that workers who were ill with COVID or self-isolating would receive their normal income for that period (Lemmon, et al, 2022).

Following COVID-19, PSI affiliates pointed towards the PSI campaign in South Asia for community health workers in relation to better health and personal protective equipment. As part of this campaign, they used the ILO's C149 Nursing Personnel Convention, which requires ratifying states to commit to the education and training of nursing-qualified staff and to the improvement of employment and working conditions, including career prospects and remuneration. Regionally, PSI has been promoting ratification of this ILO Convention and has strategies for running campaigns.

Finally, related to sickness, the pandemic was also seen to negatively impact on other elements of people's health beyond COVID. The mental health of care workers can be affected in several ways. Many workers had to deal with traumatic situations and multiple bereavements, with limited support from their employers (OECD, 2021a). Other issues that may arise could be post-traumatic stress disorder (PTSD)as workers struggle with the level of fatalities in the sector (Faghanipour, et al, 2020). Issues such as burn-out can lead to losses of experience and knowledge to the sector, with limited opportunities to replace these workers given recruitment and retention problems. There is also the relatively unknown consequences of managing sickness in the context of LTC workers who may have contracted long-COVID.

Migrant workers were also vulnerable during COVID as countries quickly closed borders, resulting in isolation from their families (WHO, 2020). However, as can be seen in the individual case studies, LTC regimes in Global North countries have been impacted by COVID and other external shocks and are more heavily reliant on migrant workers. This raises questions concerning the working conditions and rights of these workers.

Going forward, the issues of addressing staff shortages, working conditions and awareness and compliance with occupational health and safety in LTC are seen to be priorities. At least 30 countries have developed policies to improve access to PPE and 24 have prioritised the testing of care home residents and staff. Policies to boost staff numbers exist in at least 26 OECD countries and include funding to hire new staff and students. There is also a greater emphasis on hygiene, which includes the training of workers (OECD, 2021a).

With COVID-19 remaining an active threat, workplace activists and PSI affiliates need to investigate how organisations are managing their sickness absence and workplace attendance. A focus on sickness absence policies is needed due to an observation that recent approaches to managing non-attendance can be coercive and punitive, focusing solely on non-genuine absence (Hadjisolomou, 2016; Taylor, et al, 2010). Such workplace absence cultures have led to workers attending work when sick (ETUC, 2020; Taylor et al, 2010), a behaviour that is worrying during a health crisis period.

Low Levels of Unionisation

The existence and representativeness of workers' organisations covering care workers, as well as the coverage of social dialogue mechanisms, including collective bargaining, play an important role in not only determining the pay and working conditions of care workers (ILO, 2018) but also campaigning for better LTC provision. As previously mentioned, in marketised care systems, union influence is limited as employment is outsourced to areas where collective bargaining has a weak presence compared to direct employment through the public sector. Private and voluntary sector LTC care providers have traditionally been largely non-unionised. Anti-union values stem from fears that activities such as strikes and other forms of action can disrupt services and mission, or the generation of profits in the case of private providers (Baines and Cunningham, 2017). In addition, to this there are problems with mobilising the LTC workforce in private and voluntary organisations to join unions. This is due to a lack of tradition of joining unions, so numbers of organisers are quite low compared to other sectors. There is also a lack of 'a factory gate' or, in the public sector, school, hospital, or administrative offices to engage with workers in a collective manner (Hemmings, 2010). Workers in LTC work part-time, fragmented shifts, sometimes alone and in the community or in people's homes so are difficult to contact. They have a

limited tradition within their ranks of unionisation so are unsure what the movement can offer them (James and Cunningham, 2010). There is also some perception that LTC workers fear unions because of the impact strikes and other disruption can have on the service user (Cunningham, 2000).

Moreover, where unions have a presence in private and non-profit providers, the supply-chain and resource dependency effect make the prospects for effective collective bargaining quite limited. More specifically, the below-inflationary funding settlements granted by government to providers makes the prospect of collective bargaining for wages in outsourced providers keeping up with public sector workers conditions very unlikely (Cunningham, 2008). This limitation in collective bargaining is for several reasons. Firstly, unlike the public sector, collective bargaining will generally be at the enterprise level and not subject to national agreements. Secondly, at the enterprise level, the state acts as 'third-employer' determining the funding settlement that shapes pay agreements while having no direct involvement in negotiations. Unions, in decentralised bargaining arrangements, therefore do not have the power to hold to account or negotiate with the state agency (ies) that holds the purse strings. Moreover, it means that it is difficult for unions to apportion blame and mobilise collective action for poor pay rises on the immediate employer (Cunningham, 2008).

Individualisation and personalisation also have implications for collective bargaining and organising in the sector. Previous research (Bellemare, 2000: Kessler and Bach, 2011: Hickey, 2012) recognises how recipients of care (or end users) can influence the nature of work and industrial relations processes in public services across three levels. The first is co-design, where the service user inputs their needs and contributes to the development of a service. The second is co-production, which allows the service user to influence the operational delivery of services. Finally, co-supervision enables the service user to hold those responsible for service delivery to account (Bellemare, 2000). The power and authority of service users in these individualised schemes are not all encompassing, however, as much depends on the relative strength and influence of the other industrial relations actors – employees, unions and management (Bellemare, 2000). A Canadian study (Hickey, 2012) report reveals that new user rights are written into the language of collective agreements. Moreover, the study notes concerns among unions regarding the effects on labour market outcomes from direct funding models of service provision from, for example, user involvement in areas such as recruitment (Hickey, 2012).

Our case studies highlight how approaches to collective bargaining can offer protection to hard-to-reach LTC workers. In France and Australia, for example, sector-wide collective agreements negotiated by unions cover LTC workers who may not be union members. Moreover, Scotland is currently pursuing a policy of constructing sector-wide collective bargaining in its LTC. In Chile, unions are placing workers' rights in the context of wider campaigning linked to constitutional change and the creation of an LTC system based on human rights.

Moreover, the cases point towards the crucial importance of unions (PSI affiliates) having the resources to pursue the above agendas, including market intelligence. This includes, in Global North countries such as France, Australia and Scotland, the capacity to bring greater transparency regarding the activities of multinationals. The case of India, however, highlights the need for unions to be able to access resources that will provide them with more basic intelligence, e.g., regarding the type of provider and how they organise work and employment in LTC. In addition, the Indian case reveals how unions in the Global South need basic labour market intelligence concerning the size and demographic make-up of the LTC workforce as well as the degree of formality and informality in employment relationships.

Strategic positioning by unions is crucial as is ongoing union advocacy for public sector management of LTC. In France, exposing the gouging of public funds by for-profit providers such as Orpea, resulting in appalling conditions for vulnerable older people, unacceptable forms of work for LTC workers, and a lack of adequate numbers of workers prepared to work in the LTC sector, has been crucial in this advocacy. The CFDT has also made a compelling case for greater community and political awareness of the socioeconomic value of the care provided by LTC workers, arguing that financing the LTC sector, including through additional staffing, professionalisation and skill recognition, together with better remuneration, should be seen as an investment in the dignified care of the dependent elderly (CFDT 2019).

Lessons were learned from the COVID crisis that can permeate union organising campaigns and bargaining agendas within the LTC sector. These include:

- A higher staffing ratio is associated with lower infection and deaths.
- Reducing staff movement (through higher ratios) reduces infection from the virus.
- Staff shortages can only be resolved through better job quality, especially more pay and better conditions.
- Begin improvements in pay by consolidating bonus payments awarded during the peak of the pandemic.

- Development of safety standards and proper training for staff along with monitoring and enforcement.
- Staff mental health and well-being should be a priority, including training of managers in psychological as well as physical well-being.
- Recognise the uncertainty for workers suffering from long-COVID. (OECD, 2020; OECD, 2021b).

Section 6: Approaches for Unions to Achieve Decent Work/Quality LTC

Collective Bargaining in the public sector

There are a number of wider contextual and sector-specific issues that will make organising in LTC difficult for trade unions in the coming years. The wider contextual issues include attacks on the organising capacity of unions. Unions generally have been under pressure for a few decades in terms of their capacity to organise and protect their members. The range of factors that have influenced this greater vulnerability include economic and political context, and labour market changes. The public sector unions have traditionally been seen as more resilient in terms of sustaining their bargaining position, membership, coverage and organising capacity.

Nevertheless, public sector unions face problems in organising LTC and representing employees. Firstly, they have not been immune to the forces that have led to some diminishment of influence and strength across many countries. The global financial crisis (GFC) was at the origin of many of the neoliberal economic policies that have undermined the strength of public sector unions in the last ten years. The GFC and the resulting austerity policies have provided a point from which governments have further consolidated the ideology of free market's hold on society and one of its chief forms of resistance – trade unions and collective bargaining. A common trend across nation states has been to identify GFC as a public debt crisis, blaming unions and their members (especially in the public sector) for the crisis (McBride, 2021).

This rhetoric has led to a series of public policy reforms to collective bargaining in the public sector and union security designed to reinforce deflationary austerity policies. In the EU for example, the coverage of collective bargaining, i.e., the proportion of employees having their terms and conditions determined by collective negotiations, has declined as a result of job losses and various reforms. Countries such as Cyprus, Greece, Portugal, Romania, Slovenia and Slovakia have seen significant decreases in coverage of collective bargaining (Waddington, et al, 2019). This decline in coverage has also been accompanied by a restructuring of collective bargaining in favour of decentralisation. Countries such as Italy, Ireland, Romania, Portugal and Hungary have all undertaken such changes (Waddington, et al, 2019; Meardi, 2012).

In addition, EU countries has been subjected to pressure to moderate pay claims and engage in forms of concession bargaining (Roche and Teague, 2015; Muller et al, 2019), i.e., unions accepting declines in terms and conditions, in many cases on a temporary basis, in exchange for employment security. The above pressures have also been evident at the level at which much of LTC is delivered, i.e., at local government across the EU. Nation states passed austerity cuts to this tier of governance (Leisink and Bach, 2014).

In North America, too, assaults on unions followed the GFC, with long-standing political hostility to the movement finding greater impetus (Cantin, 2012). In the US and Canada (a country that did not suffer the same degree of financial problems as the former or the EU), the GFC opened up opportunities for conservatives to advocate fiscal discipline, downsizing and privatisation of public assets, as blame for the crisis shifted to unions and their members in the public sector (Peck, 2014; Rose, 2016). In both countries, pensions and salaries were attacked, and unions faced state or province level efforts to remove the right to bargain over specific areas such as pensions and health benefits, as well as limitations on pay increases. Such attacks on unions and their members were also predominantly gendered, i.e., falling on occupations largely occupied by women, including care for the elderly but also reproductive health services, prevention of domestic violence, sexual health, and planned parenthood (Abramovitz, 2012).

Implications for union influence and organising in LTC

The existence and representativeness of workers' organisations covering care workers, as well as the coverage of social dialogue mechanisms, including collective bargaining, also play an important role in determining the pay and working conditions of care workers (ILO, 2018). Lydia Hayes (2017) outlines eight reasons why collective bargaining is needed in LTC. These reasons are because:

- Adult LTC is an industry
- Care work is highly skilled and increasingly complex
- Terms and conditions of work are precarious
- Poor quality jobs mean poor quality care
- Individual rights (statutory or otherwise) are insufficient to remedy these problems
- Care workers are silenced by the structure of care markets
- Government needs to raise quality of employment across social care
- Collective bargaining would create decent work and raise quality of care

Key Challenges Affecting Union Action in LTC

Competition for resources

Firstly, even where unions are traditionally strongest and/or have a history of organising in the public sector, their regulatory reach and therefore their capacity to influence public service workers in LTC is more difficult. Many countries also outsource a significant proportion of their LTC to voluntary and private organisations, where unions do not have as great a presence.

Outsourcing to private and non-profit providers and weakened public sector unionism implies some difficult choices for unions in terms of resource allocation. Unions in the public sector may organise across public, private and non-profit sectors. Unions will want to rebuild and strengthen their traditional public sector workplaces, where LTC workers will still have a presence. In marketised care systems, union influence is limited as for-profit and non-profit sector care providers have traditionally been largely non-union. There will, therefore, be competition for resources within unions across the sector, but also with other areas of the public sector domain.

Anti-unionism in outsourced services

Anti-union values stem from fears that activities such as strikes and other forms of action may disrupt services and mission, or the generation of profits in the case of private providers (Baines and Cunningham, 2017). In the case of private sector LTC companies, there has been limited work on unionised private providers because there are so few who recognise unions. However, where unions are present, they have to contend with a number of issues. Some provider profit margins may be small, making it extremely difficult to bargain over pay. In others, where private equity may be present, the complex financial engineering associated with such forms of ownership also make it difficult to bargain because of the lack of transparency in the funding of such enterprises.

Non-profit organisations bring their own specific problems. Attachment to particular values and mission and the rights of certain client groups can often lead to the rights of workers being compromised. Unions are perceived as a barrier to the kind of flexibility and forms of sacrifice that are expected of non-profit workers in order to deliver services. In response to resistance from unions, some non-profit providers have exhibited anti-union attitudes similar to those of the worst for-profit employers. This has led to incidences of a removal of bargaining rights.

Limited tradition of unionisation in outsourced providers

In addition, there are problems with mobilising the LTC workforce in private and voluntary organisations to join unions. This is due to a lack of tradition of joining unions, so numbers of organisers are quite low compared to other sectors. There is also a lack of ‘a factory gate’ or, in the public sector, school, hospital, or administrative offices to engage with workers in a collective manner (Hemmings, 2010). Workers in LTC work part-time, fragmented shifts, sometimes alone and in the community or in people’s homes and so are difficult to contact. They may have limited experience of unionisation so are unsure what the movement can offer them (James and Cunningham, 2010). There is also some perceptions that workers in LTC fear unions because of the impact strikes and other disruption might have on service users (Cunningham, 2000).

Migrant workers

The growth of migrant workers in the care sector is another related complication for unions in the sector. These workers are some of the most vulnerable in LTC due to exploitation around working hours and other terms and conditions. And yet they are difficult to reach for many the reasons outlined above. In addition, recent migrant workers may come to the workplace with limited knowledge or experience of unions. In some cases, their experience of unions may be negative, as has been the case with some Eastern

European migrants where collectivism was associated with former communist regimes. The vulnerability of migrant workers also makes them harder to organise because they may be reluctant to be seen as 'causing trouble' and may have limited rights.

Lack of bargaining power

Even where unions have a presence in for-profit and non-profit providers, the supply-chain and resource dependency effect limits the prospects for effective collective bargaining. More specifically, the below-inflationary funding settlements provided by governments such as in our selected OECD countries dampen prospects that collective bargaining for wages in outsourced providers could keep up with public sector conditions (Cunningham, 2008). This limitation in collective bargaining is for several reasons. Firstly, unlike the public sector, collective bargaining will generally be at the enterprise level and not subject to national agreements. Secondly, at the enterprise level, the state acts as 'third-employer' determining the funding settlement that shapes pay settlements while having no direct involvement in negotiations. Unions, in decentralised bargaining arrangements, therefore do not have the power to hold to account or negotiate with the state agency(ies) that holds the purse strings. Moreover, it means that it is difficult for unions to apportion blame and mobilise collective action for poor pay rises on the immediate employer (Cunningham, 2008).

Thus, even where unions have a presence, the combination of resource dependency in the climate of austerity means that unions may be working in a context of almost perpetual 'concession bargaining' (Roche and Teague, 2014) and consequently struggling to make an impact on raising the pay of workers, as has been the case in Australia in terms of enterprise bargaining in LTC.

Individualisation and personalisation

Individualisation and personalisation also have implications for collective bargaining and organising in the sector. Previous research (Bellemare, 2000: Kessler and Bach, 2011: Hickey, 2012) recognises how care recipients can influence the nature of work and industrial relations processes in public services across three levels. The first is co-design, where the service user inputs their needs and contributes to the development of a service. The second is co-production which allows the service user to influence the operational delivery of services. Finally, co-supervision enables the service user to hold those responsible for service delivery to account (Bellemare, 2000). The power and authority of service users in these individualised schemes are not all encompassing, however, as much depends on the relative strength and influence of the other industrial relations actors – employees, unions and management (Bellemare, 2000).

What should unions do?

Although the preference of PSI is for public provision of LTC, the reality for social care systems across the globe is a mixed provision. In the light of the findings in this report, including case studies, we recommend the following campaign focus:

1. Campaign on the principle that decent work underpins high-quality LTC.
2. Adopt the six principles outlined in this Report as a pathway to campaigning for decent work and decent, quality LTC.
3. Campaign for the principles of decent working conditions to be incorporated into the decision-making of public bodies responsible for LTC procurement and commissioning.
4. Bring all external providers under some form of collective bargaining, where possible. Sector-level collective bargaining is preferable but attention needs also to be given to workplace representation and voice.
5. Evaluate current organising strategies in the LTC sector to effectively target workers for membership across the public, private and voluntary sectors.
6. Advocate appropriate client-staffing ratios in LTC, further underscored by lessons from the COVID-19 pandemic.
7. Campaign for greater transparency in the financial transactions of multinational corporations to ensure that public funds are invested properly in LTC.
8. Campaign for a decent wage that recognises the gendered undervaluation of paid care work, the disparity between private, public and voluntary workers, the erosion of career paths and pay classifications and relativities.
9. Campaign for the full cost of care to be met so that home care workers are paid for the time they travel between clients.
10. Improve other non-wage benefits, with particular attention given to increases paid leave, pension entitlements and job security.
11. Reorganise staff working hours to ensure decent working time arrangements and end underemployment.

12. Avoid work-family conflict by addressing problems of fragmented shifts.
13. End the use of exploitative forms of contract such as zero-hours contracts (such as those common in the UK).
14. Ensure there is worker voice/representation when introducing new technology.
15. Campaign to improve LTC provision by building and strengthening within current health care systems. For countries in the Global South unlikely to have an integrated LTC system, this means ensuring health provision can offer services to older adults.
16. Gather accurate data from Global South countries on the formal and informal care workforce.
17. Focus on ensuring the employment rights of informal workers in countries of the Global South, including the payment of a proper wage rather than stipends.
18. Focus on migrant workers' rights in receiving countries, as well as supporting a greater reliance on creating and sustaining a local care workforce.

Recent wins in aged care employment conditions

In the wake of the Royal Commission, a union-initiated work value case was taken to the Fair Work Commission in Australia in 2021, seeking a 25% wage increase for aged care workers. In late 2022, the FWC awarded an interim 15% increase in award rates to direct care workers, accepting expert evidence on the gendered undervaluation of aged care work.[103] While the new Labor government had broadly supported the union claim, it proposed implementing the 15% wage increase in two tranches between July 2023 and July 2024. The FWC, however, decided in February 2023 to implement the 15% interim wage increase from June 2023. The FWC is still considering further wage increases for direct care workers, wage increases for indirect care workers such as kitchen staff, and a new wage and classification structure in both residential aged care and home care.[104]

References

Abdi, S., Spann, A., Borilovic, J., de Witte, L., & Hawley, M. (2019). Understanding the care and support needs of older people: a scoping review and categorisation using the WHO international classification of functioning, disability and health framework (ICF). *BMC geriatrics*, 19(1), 1-15.

Aboderin, I. 2019. Toward a Fit-for-purpose Policy Architecture on Long-term Care in Sub-Saharan Africa: Impasse and a Research Agenda to Overcome it. Journal of Long-Term Care, pp. 119-126.

Addati U, Cattaneo U & Emanuela Pozzan E (2022) Care at work: Investing in care leave and services for a more gender equal world of work, ILO. Geneva.

African Union, (2020) Protocol to the African Charter on Human Rights and Peoples: Rights on the Rights of Older Persons in Africa

African Union, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003)

Anderson I & Irava W (2017) The Implications of Aging on the Health Systems of the Pacific Islands: Challenges and Opportunities. Health Syst Reform 3;3(3):191-202.

Anderson I, Irava W. The Implications of Aging on the Health Systems of the Pacific Islands: Challenges and Opportunities. *Health Syst Reform*. 2017 Jul 3;3(3):191-202.

Armstrong P (2015) Where do we go from here next? In Baines D and Armstrong P (eds) Promising practices in Long-term Care: ideas worth sharing

Armstrong, P. and Cohen, M. (2020) A Higher Standard, Setting Federal Standards in Long-term Care and Continuing Care, Canadian Centre for Policy Alternatives

Armstrong, P. and Daly, T. (2017) Exercising Choice in Long-term Residential Care, Canadian Centre for Policy Alternatives, pp. 128.

Armstrong, P. And Day, S. (2017) Wash, Wear and Care, Clothing and Laundry in Long-term Residential Care, McGill-Queen's University Press, pp. 217.

Arriagada, I and Miranda, F (2021) 'Social Organization of Care in Chile'. In Guimaraes, N.A and Hirata, H *Care and Care Workers: A Latin American Perspective*. Springer, Switzerland pp. 165-186.

Arunika, A and Bloom, D.E (2022) Long-term care in India: Capacity, need and future. International Social Security Review 75 (3-4).

Australian Aged Care Financing Authority (2021) Ninth Report on the Funding & Financing of the Aged Care Sector July 2020.

Baines D. And Armstrong, P. (2015) Promising Practices in Long-term Care, Ideas Worth Sharing, Canadian Centre for Policy Alternatives, pp. 86

Baines, D (2004) Caring for nothing. Work organisation and unwaged labour in social services. Work, employment and society 18 (2): 267-295).

Baines, D (2010) Neoliberal Restructuring, Activism/Participation, and Social Unionism in the Nonprofit Social Services. *Non-profit and Voluntary Sector Quarterly*, 39(1). 10-28.

Barczyk D & Kredler M (2019) Long-term care across Europe and the United States: The role of informal and formal care. *Fiscal Studies*, 40(3), 329-373.

Barken, R. Daly, T. And Armstrong, P. (2017) family Matters: The Work and Skills of Family/Friend Carers in Long-term Residential Care, Journal of Canadian Studies, 50(2), 321-347.

Basu, H (2020) Working Conditions of Ayahs in Private Healthcare. *Economic and Political Weekly*, LV (5), February 1st.

Blanche Le Bihan. ESPN Thematic Report on Challenges in long-term care. France. [Technical Report] European Commission. European Social Policy Network (ESPN). 2018, 18p. ⟨hal-02613339⟩

Bourgeault, I et al, (2023) Complexities of Health Worker Migration Pathways and Corresponding International Reporting Requirements, Human Resources for Health, 21 (2), https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-022-00780-7#citeas

Boutaud A-S (2022) 'France's Elderly System on the Brink of Crisis', I'MTech, IMT science as technology news,

Bryan S, Murphy J, Doyle-Waters M, Kuramoto L, Ayas N, Maumbusch J, et al. (2010) A Systematic Review of Research Evidence on: (a) 24-hour Registered Nurse Availability in Long-term Care, and (b) the Relationship between Nurse Staffing and Quality in Long-term Care,

CCPS (2023) The Scottish budget for third sector social care: is it all costs, no value? There is no money: The mantra of the moment. CCPS February 2023.

Centre for International Corporate Tax Accountability & Research [CICTAR] (2020) Caring for growth: Australia's largest non-profit aged care operators, A CITAR Report.

Centre for International Corporate Tax Accountability & Research [CICTAR] (2022) Caring for people or profit? The financial engineering and real estate investment of Groupe Orphea A CICTAR Report

Centre for International Corporate Tax Accountability & Research [CICTAR] (2023) Extracting Profits Through Care Home Real Estate: The Billion-Pound Property Speculation Fuelling Britain's Care Crisis, A CICTAR Report.

Centre for International Corporate Tax Accountability & Research [CICTAR] (2020) *Caring for growth: Australia's largest non-profit aged care operators*, A CITAR Report.

Chan, C and Fernandez-Ossandon, R (2022) Companerismo: Care and Power in Affective Labor Relations. *Critical Sociology*, 1-17.

Chandra S (2017) Cultural habitat for the elderly: an aged care facility in a multicultural Fijian society (Master's thesis).

Charlesworth S (2021a) Expert Witness Statement, Fair Work Commission (FWC), Application to Vary or Revoke the Aged Care Award 2010, 31 March 2021.

Charlesworth S (2021b) Expert Witness Statement, Fair Work Commission Application to Vary the Social, Community, Home Care and Disability Services Industry Award, 22 October 2021.

Charlesworth, S. Baines, D., Cunningham, I. Daly, T, King, D. and Taylor, W. (n.d.) A Promising Policy: Scottish Care Inspectorate Quality Standards and Inspection Process

Charlesworth, S., & Howe, J. (2018). The enforcement of employment standards in Australia: Successes and challenges in aged care. *International Journal of Comparative Labour Law and Industrial Relations*, 34(2).

Charlesworth, S., & Isherwood, L. (2021). Migrant aged-care workers in Australia: do they have poorer-quality jobs than their locally born counterparts? *Ageing & Society*, 41(12), 2702-2722.

Charlesworth, S., & Malone, J. (2022). The Production of Employment Conditions for Migrant Care Workers: Cross National Perspectives. *Social Policy and Society*, 1-14.

Charlesworth, S., & Marshall, H. (2011). Sacrificing workers? The curious case of salary sacrificing in non-profit community services in Australia. *International Journal of Public Sector Management*, 24(7), 673-683.

Cohen, M. and Farrell, J. (2013) The Ombudsperson's Report on Seniors Care: A Brief Analysis of the Government's (Non)Response, Behind the Numbers, The Canadian Centre for Policy Alternatives, BC Office,

Colombo, F., Llena-Nozal, A., Mercier, J., & Tjadens, F. (2011). Help wanted. *Ageing and long-term care*, *17*(2-3), 3.

Comas-Herrera, A, Zalakain, J, Lemmon, E, Henderson, D, Litwin, C, Hsu, A, Schmidt, A, Arling, G, Druse, F and Fernandez, J (2021) *Mortality associated with COVID-19 in care homes: international evidence*. International Long-term Care Policy Network, 2nd February 2021.

Comondore, V. R., Devereaux, P. J., Zhou, Q., Stone, S. B., Busse, J. W., Ravindran, N. C., Burns, K. E., Haines, T., Stringer, B., Cook, D. J., Walter, S. D., Sullivan, T., Berwanger, O., Bhandari, M., Banglawala, S., Lavis, J. N., Petrisor, B., Schünemann, H., Walsh, K., Bhatnagar, N., ... Guyatt, G. H. (2009). Quality of care in for-profit and not-for-profit nursing homes: systematic review and meta-analysis. *BMJ (Clinical research ed.)*, *339*, b2732.

Connell, J., & Petrou, K. (2019). Pacific Labour Mobility.

Considine M (2022) The Care-less State: Reforming Australia's Social Services. Melbourne University Press.

Corina Rodríguez Enríquez and Cecilia Fraga (2021) 'The Social Organisation of Care', PSI
Choiniere, J. Doupe, M. Goldmann, M. Jacobsen, F. Lloyd, L. Roothan M. and Szebehely M. (2016). Mapping Nursing Home Inspections and Audits in Six Countries. *Ageing International*, 41(1): 40-61.

Cunningham, I, James P and Baluch, A (2022) "The influence of 'soft' Fair Work regulation on union recovery: A case of re-recognition in the Scottish voluntary social care sector". Industrial Relations Journal. 53(2) 261-277.

Cunningham, I, James, P, Baluch, A (2022) "Introducing Fair Work through 'Soft' Regulation in Outsourced Public Service Networks: Explaining Unintended Outcomes in the Implementation of the Scottish Living Wage Policy". Industrial Law Journal, in press.

Cunningham, I., A. Baluch, A.-M. Cullen and P. James (2018), Implementing the Scottish Living Wage in Social Care. Glasgow, Coalition of Care and Support Providers Scotland and University of Strathclyde.

Daly, T. (2015). Dancing the two-step in Ontario's long-term care sector: deterrence regulation= consolidation. *Studies in Political Economy*, *95*(1), 29-58.

Daly, T. (2019) Public Funds, Private Data, A Canadian Example, The Privatization of Care. The Case of Nursing Homes, Routledge, New York, pp. 16.

Daly, T. And Szebehely, M. (2012). Unheard Voices Unmapped Terrain: Care Work in Long-term Residential Care for Older People in Canada and Sweden, *International Journal of Social Welfare*, 21(2), 139-148.

Daly, T., Struthers, J., Müller, B., Taylor, D., Goldmann, M., Doupe, M., & Jacobsen, F. F. (2016). Prescriptive or Interpretive Regulation at the Frontlines of Care Work in the "Three Worlds" of Canada, Germany and Norway. *Labour Le Travail*, *77*.

DeClerq, K. Jan 13, 2023 Wait list for long-term care beds in Ontario nearly doubled in 10 years, OLTCA says, CTV News,

Diaz, E.M and Medoza-Llanos, R (2021) Membership, Neighborhood Social Identification, Well-Being, and Health for the Elderly in Chile. Frontiers in Psychology, 11:608482.

Dintrans, P.V (2017) Health Systems, Aging and Inequity: An Example from Chile. International Journal of Environmental Research and Public Health. 17, 65-46.

Dintrans, P.V (2018) Long-term care systems as social security: the case of Chile. *Health Policy and Planning*, 33 1018-1025.

Duckett, S. and Swerissen, H. (2021). Unfinished business: Practical policies for better care at home. Grattan Institute

Duray-Parmentier C, Lafontaine JB, Nielens N, Janne P & Gourdin M (2021) Psychological impact of COVID-19 lockdown on staff and residents of nursing and care homes in Belgium and EHPADs France. Geriatr Psychol Neuropsychiatr Vieil 2021; doi:10.1684/pnv.2022.1011

Dyer SM, Valeri M, Arora N, Ross T, Winsall M, Tilden D, Crotty M (2019). *Review of International Systems for Long-Term Care of Older People*. Flinders University, Adelaide, Australia.

Eastman C, Charlesworth S and Hill E (2018a) *FACT SHEET 3: Aged and Disabled Carers*, Sydney: Social Policy Research Centre UNSW.

Eastman C, Charlesworth S and Hill E (2018b) *FACT SHEET 4: Personal Care Assistants*, Sydney: Social Policy Research Centre UNSW.

Eastman C, Charlesworth S and Hill E (2018c) *FACT SHEET 1: Migrant Workers in Frontline Care*, Sydney: Social Policy Research Centre UNSW.

Economic Times, (2022) With $87 billion, India top remittance recipient in 2021.

Erlandsson S., Storm P., Stranz A., Szebehely M., & Trydegård G-B (2013) Marketising trends in Swedish eldercare: Competition, choice and calls for stricter regulation. In: G. Meagher & M. Szebehely (Eds.) Marketisation in Nordic eldercare: A research report on legislation, oversight, extent and consequences (pp. 23–83). Stockholm: Studies in Social Work 30. Stockholm University,

Esch M-O (2018) 'Growing old with dignity', Council Economique Social et Environmental

ETUI (2019) Industrial Relations in France: background summary https://www.etui.org/covid-social-impact/france/industrial-relations-in-france-background-summary

Eurofound (2020) *Long-term care workforce: Employment and working conditions*, European Commission,

Eurohealth (2018) Long-Term Care and Migrant Care Work: Addressing Workforce Shortages While Raising Questions For European Countries

Fair Work Commission Full Bench (2022) Decision [2022] FWCFB200 https://www.fwc.gov.au/documents/sites/work-value-aged-care/decisions-statements/2022fwcfb200.pdf

Fair Work Convention (2016) *Fair Work Framework, 2016*. Edinburgh, Scotland, April.

Feeley, D (2021) *Independent Review of Adult Social Care in Scotland*. (Edinburgh: Scottish Government, St Andrew's House, February 2021).

Gradin, C (2013) "Race, poverty and deprivation in South Africa, *Journal of African Economics*, (22) 2 187- 238.

Harrington C, Dellefield ME, Halifax E, Fleming ML, Bakerjian D. Appropriate Nurse Staffing Levels for U.S. Nursing Homes. *Health Services Insights*. 2020;13. doi:10.1177/1178632920934785

Harrington C, Hauser C, Olney B, Rosenau PV. Ownership, Financing, and Management Strategies of the Ten Largest For-Profit Nursing Home Chains in the United States. International Journal of Health Services. 2011;41(4):725–746.

Harrington C, Kovner C, Kayser-Jones J, et al. Experts recommend minimum nurse staffing standards for nursing facilities in the United States. *Gerontologist*. 2000; 40:5-16.

Harrington, C. Choiniere, J. Goldmann, M., Jacobsen, F. Lloyd, L., McGregor, M. Stamatopoulos, V. Szebehely, M. (2012) Nursing Home Staffing Standards and Staffing Levels in Six Countries, Journal of Nursing Scholarship, 44(1), pp. 88-98.

Harrington, C., Armstrong, H., Halladay, M., Havig, A. K., Jacobsen, F. F., MacDonald, M., Panos, J., Pearsall, K., Pollock, A., & Ross, L. (2016). Comparison of Nursing Home Financial Transparency and Accountability in Four Locations. *Ageing International*, *41*(1), 17–39.

Harrington, C., Carrillo, H., Dowdell, M. Tang, P.P. and Blank, B.W. (2011). Nursing facilities, staffing, residents and facility deficiencies, 2005 through 2010. San Francisco: University of California, Department of Social and Behavioral Sciences. www.pascenter.org; www.theconsumervoice.org

Harrington, C., Tsoukalas, T., Rudder, C., Mollot, R. J., & Carrillo, H. (2008). Study of federal and state civil money penalties and fines. The Gerontologist, 48(5), 679–691.

Heery, E, Hann, D and Nash, D 'Political devolution and employment relations in Great Britain: the case of the Living Wage' (2020) 51 (5) Industrial Relations Journal 391-409.

Hill E, Withers M & Jayasuriya R (2018) The Pacific Labour scheme and Transnational Family Life: Policy brief. Social Policy Research Centre, UNSW.

Hill, E., Ford, M., Baird, M. (2017). Work/Care Regimes in the Asia-Pacific: A Feminist Framework. In M. N. Baird, M. Ford, E. Hill (Eds.), *Women, Work and Care in the Asia-Pacific*, (pp. 1-22). London: Routledge.

Hillmer, M. P., Wodchis, W. P., Gill, S. S., Anderson, G. M., & Rochon, P. A. (2005). Nursing home profit status and quality of care: is there any evidence of an association? *Medical care research and review*, *62*(2), 139-166.

Hood, C (1991) A Public Management for all seasons, Public Administration, 69 (1): 3-19.

Hsu, A. T., Berta, W., Coyte, P. C., & Laporte, A. (2016). Staffing in Ontario's Long-Term Care Homes: Differences by Profit Status and Chain Ownership. *Canadian journal on aging = La revue canadienne du vieillissement*, *35*(2), 175–189.

Ibrahim, J. E., Li, Y., McKee, G., Eren, H., Brown, C., Aitken, G., & Pham, T. (2021). Characteristics of nursing homes associated with COVID-19 outbreaks and mortality among residents in Victoria, Australia. Australasian Journal on Ageing, 40(3), 283-292.

ILO (2018) Promoting integration for migrant domestic workers in France

International Labour Organisation (2020) *Working Conditions in a Global Perspective*. ILO and EuroFound, Geneva, 2020.

International Labour Organisation (ILO) (2019) *The Unpaid Care Work and the Labour Market. An analysis of time use data based on the latest World Compilation of Time-use Surveys*. ILO, Geneva,

International Labour Organization [ILO] (2018) *Care work and care jobs for the future of decent work*, ILO Geneva

Investigate Europe (2021a) *List: Europe's largest for-profit care home operators*

Jacobsen, F and Ågotnes, G. (2019) Accountable for-profits in Nursing Homes? The Privatization of Care. The Case of Nursing Homes, Routledge, New York, pp. 10.

Joseph Rowntree Foundation (2014) *Delivering A Better Life for older people with high support needs in Scotland*. JRF, York.

Kaffenberger KR. Nursing Home Ownership. Journal of Aging & Social Policy. 2001;12(1):35–48. doi: 10.1300/J031v12n01_04.

Kawade, A, Gore, M, Pallave, L, Uddhavi, C, Pinnock, H, Smith, P and Suvekar, S (2021) Interplaying role of healthcare activist and homemaker: a mixed-methods exploration of the workload of community health workers (Accredited Social Health Activists) in India. *Human Resources for Health*. 19 (7), 1-12.

Kelly, G., Mrengqwa, L. & Geffen, L. "They don't care about us": older people's experiences of primary healthcare in Cape Town, South Africa. *BMC Geriatr* **19**, 98 (2019).

Kraus, M., & Riedel, M. (2022). Three dimensions of long-term care provision in middle-income countries—A view across Africa, Latin America and Asia. *International Journal of Social Welfare*, 31 506-519.

Kumar, S (2021) Exporting Indian healthcare workers to the world, Observer Research Foundation, July 2021.

Labonté, R., Sanders, D., Mathole, T. *et al.* Health worker migration from South Africa: causes, consequences and policy responses. *Hum Resour Health* **13**, 92 (2015).

Langins, M, Curry, N, Lorenz-Dant, K, Comas-Herrera, A and Rajan, S (2020) Long-Term Care: What Can We Learn from The First Wave About How to Protect Care Homes? Eurohealth, 26 (2).

Le Bihan B (2018) *ESPN Thematic Report on Challenges in long-term care European social policy network*. European commission

Le Bihan B & Martin C (2019) French social and long term care system

Le Bihan B & Martin C (2020) ESPN Thematic Report: Contribution to the 2021 SPC-COM report on long-term care for older people in the EU France

Leichsenring, K. (2020). Applying ideal types in long-term care analysis. In *Ideal Types in Comparative Social Policy* (pp. 187-206). Routledge.

Lemmon, Bell, Burton, Henderson and Hatton, (2022) *COVID-19 and the Long-Term Care system in Scotland (UK)*. International Long-Term Care Policy Network

Lemmon, E. Bell D. Burton J., Henderson D. Hatton C. COVID-19 and the Long-Term Care system in Scotland. In: Comas-Herrera A., Marczak J., Byrd W., Lorenz-Dant K., (editors) LTCcovid International Living report on COVID-19 and Long-Term Care. LTCcovid, Care Policy and Evaluation Centre, London School of Economics and Political Science

Lloyd-Sherlock, P. (2018). Long-term Care for Older People in South Africa: The Enduring Legacies of Apartheid and HIV/AIDS. *Journal of Social Policy*, 48(1), 147–167.

McDonald, P., Williams, P., & Mayes, R. (2021). Means of control in the organization of digitally intermediated care work. *Work, employment and society*, 35(5), 872-890.

McGregor MJ, Cohen M, McGrail K, et al. *Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? CMAJ 2005; 172:645–9.*

McNight, A, Stewart, K, Himmilweit, SM and Palillo, M (2016) Low pay and in-work poverty: preventative measures and preventative approaches. European Commission, Brussels, May 2016.

Meagher G (2023) Address to ASSA Workshop: Developments in work and wellbeing for contemporary Australia, Canberra 23 March 2023.

Meagher, G (2021) Genealogy of Aged Care *Arena Quarterly* No 6: https://arena.org.au/a-genealogy-of-aged-care/

Meagher, G., Cortis, N. Charlesworth, S., Taylor, W. (2019). Meeting the social and emotional support needs of older people using aged care services. Sydney: Macquarie University, UNSW Sydney and RMIT University.

Milte, R., Ratcliffe, J., Bradley, C., Shulver, W., & Crotty, M. (2019). Evaluating the quality of care received in long-term care facilities from a consumer perspective: Development and construct validity of the Consumer Choice Index – Six Dimension instrument. Ageing and Society, 39(1), 138-160.

Miñano L & Drevet, B. (2022) 'At Orpea group's care homes in France, permanent contracts are nowhere to be found', 2 February 2022,

Ministry of Health and Family Welfare (2012) Operational Guidelines National Programme for Health Care of the Elderly (NPHCE). Government of India.

Mkhwanazi, A. (2015) Unregulated old age homes may be on the rise, *Health e-news*,

Mockli, D, Denhaerynck, K, De Geest, S, Leppla, L, Beckmann, S, Hediger, H, and Zuniga, F (2020) The home care work environment's relationships with work engagement and burnout: A cross-sectional multi-centre study in Switzerland, *Health and Social Care in the Community*. 28 (6), 1989-2003.

Morton R (2020) The Collapse of Aged Care (Part one) *The Saturday Paper* September 12-18 2020 https://www.thesaturdaypaper.com.au/news/politics/2020/09/12/the-collapse-aged-care-part-one/159983280010409#mtr

Nirello L, Douai L & Deloutte I (2020) 'In French nursing homes, the Covid-19 crisis has revealed the detrimental effects of austerity policies' 11 June 2020, I'MTech, IMT science as technology news,

OECD (2020) *Who Cares? Attracting and Retaining Care Workers for the Elderly*

OECD (2020) *Workforce and Safety in Long-term Care during the Covid 19 pandemic*, OECD, 22nd June 2020.

OECD (2021) 'Rising from the COVID-19 crisis: Policy responses in the long-term care sector'

OECD (2021b) *Rising from the COVID-19 crisis: Policy responses in the long-term care sector*. OECD, 15th December 2021.

Office of the Seniors Advocate, 2020 A Billion Reasons to Care: A Funding Review of Contracted Long-term Care in BC,

Olley, R (2023) Hear me, seem, trust you – job burnout and disengagement of Australian aged care workers, Leadership in Health Services, 36 (1), 111-124.

Or Z & Penneau (2021) Case Study: France OECD

Organisation for Economic Cooperation and Development (OECD) (2020) Spending on Long-term Care. OECD Paris, November 2020.

Organization of African Unity, (1981) African Charter on Human and Peoples' Rights,

Ostebakken, KM, Orupabo, J and Nadim, M (2022) The Hierarchy of Care Work: How Immigrants Influence the Gender-Segregated Labour Market. *Social Politics*. Doi.org/10.1093/sp/jxac039.

Oung C (nd) Living report: COVID-19 and the Long-Term Care system in France

Palacios, J and Perez-Cruz, P and Webb, A (2020) The experience of caring for an older relative in Chile: going beyond the burden of care. *Ageing and Society*, 6(2), 1340-1359.

Pereira, J, Angel, R.J and Angel, J.L (2016) A Case Study of the Elder Care Functions of a Chilean Non-Governmental Organization, Centre for Health and Social Policy and Department of Sociology, University of Texas at Austin.

Ponnuswami and Rajasekaran (2017) Long-term care of older persons in India: Learning to deal with challenges. *International Journal of Ageing in Developing Countries*. 2(1): 59-71.

Public Services International [PSI] (2018) 'France; What care model do we want for the elderly?', 12 December 2018,

Public Services International [PSI] (2022) 'PSI congratulates French affiliates as court overturns Orpea management elections, calls for fresh vote', September 13 2022.

Rajagopalan. J, Hurzuk.S, Arshad. F, Raja. P and Alladi. S (2020) *The COVID-19 Long-Term Care situation in India.* 30th May 2020.

Ramos F.B (2017) *Size and profile of the working poor in Chile*. Working Paper Number 10 International Training Centre of the International Labour Organization, Turin, Italy.

Reed, AC, Murmann, M, Hsu, A, Turnpenny, A, Van Houtven, C, Laberge, M, Low, L-F, Hussein, S and Allin, S. 2022. Risk Recognition Policies for the Long-Term Care Workforce during the First Year of the COVID-19 Pandemic: A Multi-Country Study. *Journal of Long-Term Care,* (2022), pp. 22–39. DOI:

Reid, P, Thomas, J, Hanks, J and Ferguson, A (2019) The Implications of National and Local Labour Markets on the Social Care Workforce: Final Report for Scottish Government and COSLA. Scottish Government, Edinburgh, 19th December 2019.

RFI (2022) 'French police launch searches in disgraced Orepa Group nursing homes' 16 November 2022,

Royal Commission into Aged Care Quality and Safety (2021) *Final Report: Care, Dignity and Safety*. Volumes 1 to 4C. Canberra: Commonwealth of Australia.

Salazar, C (2017) Social Contract on Elderly Caregiving in Contemporary Chile. *Anthropology and Ageing*. 38 (1), 60-79.

Sathi, S (2023) How do we pay back? Women health workers and the COVID19 pandemic in India. Globalizations 20(2) 292-303.

Scheil-Adlung, & Xenia. Long-term care protection for older persons: a review of coverage deficits in 46 countries. ILO Working Papers. 2015.

Scottish Care (2021) *Workforce Recruitment and Retention Survey Findings*: Interim Report. Scottish Care, September 2021

Scottish Government (2018) *Best Practice Guidance on Addressing Fair Work Practices, including the Real Living Wage, in Procurement*. Scottish Government, St Andrew's House, Edinburgh.

Scottish Government (2022) *Scottish Government response to the Migration Advisory Committee Call for Evidence on the Impact of the Ending of Freedom of Movement on the Adult Social Care Sector* @ /pages/7/,

Scottish Trade Union Congress (STUC) (2022) Profiting from care: Why Scotland can't afford privatised social care. STUC, Glasgow, June 2022.

Scourfield P. Caretelization revisited and the lessons of Southern Cross. Critical Social Policy. 2012;32(1):137–148. doi: 10.1177/0261018311425202.

Shanthosh, J, Durback, A and Joshi, R (2021) Charting the Rights of Community Health Workers in India: The Next Frontier of Universal Health Coverage. *Health and Human Rights* 23(2), 225-238.

Sharma, R and Bhambri Marwah, E (2017) Rising Demand for Community Based Long-term Care Services for Senior Citizens in India. Indian Journal of Gerontology, 31 (4), 519-528.

Sinha, D (2021) India's community health workers' struggle for recognition. Public Services International (2021) December.

Sisson, K (2019) The Fair Work Wales report: a manifesto for all of us. Industrial Relations Journal, 50 (5): 564–579.

Slachevsky, A, Zitko, P, Martinez, Pernia, D, Forno, G, Court, F.A, Lillo, P, Villagra, Ro, Duran-Anoitz, C, Parrao, T, Assar, R, Orellana, P, Toledo, C, Rivera, R, Ibanez, A, Parra, M.a, Gonzalez-Billault, C, Amieva, H and Thurmala, D. (2020). GERO Cohort Protocol, Chile, 2017-2020: Community-based Cohort of Functional Decline and Subjective Cognitive Complaint elderly. *BMC Geriatrics*, 20, 2-13.

South African Human Rights Commission,(2015) Investigative Hearing into Systemic Complaints Relating to the Treatment of Older Persons

Stall, NM, Jones, A., Brown, KA, Rochon, PA, Costa, AP, For-profit long-term care homes and the risk of COVID-19 outbreaks and resident deaths CMAJ Aug 2020, 192 (33) E946-E955; DOI: 10.1503/cmaj.201197

Statistics South Africa, 2020 Mid-Year Population Estimates published by, https://www.statssa.gov.za/?p=13453#:~:text=South%20Africa's%20mid%20year%20population,%25)%20living%20in%20this%20province

Suarez-Gonzlez. A, Livingston. G, Fay-Low. L, Cahill. S, Hennelly. N, Dawson. W, Wedner. W, Bochetta. M, Ferri. C, Matias-Guiu. J, Alladi. S, Musyimi. C and Comas Herrera. A (2020). *Impact and mortality of COVID-19 on people living with dementia: cross-country report*. International Long-Term Care network. 19th August 2020.

The International Trade Union Confederation (2023) Putting the Care Economy in Place: Trade Unions in Action Around the World International Institute for Population Sciences (IIPS), National Programme for Health Care of Elderly (NPHCE), MoHFW, Harvard T. H. Chan School of Public Health (HSPH) and the University of Southern California (USC) 2020. Longitudinal Ageing Study in India (LASI) Wave 1, 2017-18, India Report, International Institute for Population Sciences, Mumbai.

Thumala, D, Kennedy, D.K, Calvo, E, Gonzalez-Billault, Zitko, P, Lillo, P, Villagra, R, Ibanez A, Assar, R, Andrade, M and Slachevsky, A (2017) Aging and Health Policies in Chile: New Agendas for Research. *Health Systems and Reform*. 3 (4), 253-260.

UNISON (2021) *Effective Voice in a National Care Service*. @ https://unison-scotland.org/wp-content/uploads/Care-Futures-4-Effective-Voice.pdf. October 2021.

Care Futures: Questions for the future of Social Care in Scotland, Issue 4.

UNISON (2022) *Social Work and the National Care Service* E-brief Bargaining and Campaigns, UNISON Scotland.

UNISON (2023) *National Care Service Bill Verdict from Social Work Staff A UNISON survey*.

United Nations Department of Economic and Social Affairs Population Division (2022) 2022 Revision of World Population Prospects

United Nations Population Fund, (2022) Rapid Review of Healthy Ageing and Long-term Care Systems in East and Southern Africa: Country Summary Report – South Africa,

Wallace, K. and Ogilvie M. An Inside look at Ontario's nursing nightmare: Why turnover and vacancy rates are only getting worse, *Toronto Star*, Oct 28, 2022.

Ward J (2018) Tax avoidance by for-profit aged care companies: profit shifting on public funds, A Tax Justice Network – Australia Report

WHO, 2017, Towards long-term care systems in sub-Saharan Africa, WHO series on long-term care on healthy ageing, https://www.who.int/publications/i/item/9789241513388

Wichterich, C (2020) Who Cares about Healthcare Workers? Care Extrativism and Care Struggles in Germany and India. Social Change 50(1), 121-140.

Williamson, S and Allen, L (2023) *The Cost of Caring*, The Health Foundation, Data Impact Blog, 24th January 2023.

Wollmann H (2022) 'New public management-inspired public sector reforms and evaluation: long-term care provisions in European countries'. In *Handbook on Urban Social Policies* (pp. 281-295). Edward Elgar Publishing.

World Health Organisation (2020) *Preventing and managing COVID-19 across long-term care services: Policy Brief*. WHO, 24th July 2020.

World Health Organization. (2017). Technical Consultation on Universal Health Coverage on the Journey Towards Healthy Islands in the Pacific, Suva, Fiji, 21–23 March 2017: meeting report.

Yoon C G, Latianara A, Irava, W, Lee E & Park K (2019) Working conditions and perception on incentives of Fiji community health workers: findings from a survey with a convenience sample in 2016. Journal of Global Health Science, 1(1).

Yoon, C. G., Latianara, A., Irava, W., Lee, E., & Park, K. (2019). Working conditions and perception on incentives of Fiji community health workers: findings from a survey with a convenience sample in 2016. *Journal of Global Health Science*, *1*(1).

---

[1] Decent Work Good Care project: https://decentworkgoodcare.com/project-outputs/

[2] See for example Ariaans et al., 2021; Dyer et al., 2020; Leichsenring 2020. There are limits to cross-national typologies, which are high-level aggregate snapshots at one point in time. They are also limited by the availability, accuracy and usefulness of comparative data on selected national indicators, which assume a homogeneity within countries. Typologies are useful to understand the broad similarities and differences across diverse countries and identify the potential for change.

[3] We draw on the work of Williams, 2012; da Roit and Weich 2013; and King-Dejardin, 2019 to focus on the intersection of these regimes in relation to LTC work.

[4] Our analysis of the cases and our review of the literature provided the basis for identifying the key principles that underpin decent work and good quality services in LTC outlined in Section 2 above.

[5] Aggregate score out of 100. See: https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf

[6] WageIndicator Foundation and Centre for Labour Research, Labour Rights Index, 2022, Aggregate score out of 100. See: https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf

[7] We Own it (2023) Care Belongs in Public Ownership. https://weownit.org.uk/public-ownership/care-work#:~:text=Who%20owns%20our%20care%20services,the%20public%20sector%20just%204%25.

[8] World Bank https://data.worldbank.org/indicator/SP.DYN.LE00.IN

[9] World Bank https://data.worldbank.org/indicator/SP.POP.65UP.TO

[10] For Australia and Canada see Dyer, S., Valeri, M., Arora, N., Ross, T., & Winsall, M. (2020). *Review of international systems of long-term care of older people*. Royal Commission into Aged Care Quality and Safety.

[11] https://www.oecd.org/health/health-systems/Spending-on-long-term-care-Brief-November-2020.pdf

[12] WHO data Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%)

https://apps.who.int/gho/data/node.main.GHEDCHEGDPSHA2011?lang=en

[13] https://www.oecd-ilibrary.org/sites/b768405f-en/index.html?itemId=/content/component/b768405f-en

[14] It should be noted that the construction of the Labour Rights index makes several assumptions, including that the worker is skilled, works in the most populous party of the country and is a full-time worker with a permanent contract. The aggregate score represents the *best-case* employment regime scenarios within countries.

[15] See http://www.sadsawu.com/dw-campaigns.html

[16] Aggregate score out of 100. See: https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf

[17] World Bank Informal Economy Database 2018 https://www.worldbank.org/en/research/brief/informal-economy-database. 2011 data for Fiji from Asian Development Bank and ILO (2015) Fiji creating quality jobs: Employment Diagnostic Study https://www.adb.org/sites/default/files/publication/177741/fiji-creating-quality-jobs.pdf

[18] https://www.ined.fr/en/news/press/le-vieillissement-de-la-population-sE28099accelere-en-france-et-dans-la-plupart-des-pays-developpes/.

[19] In 2015, 8% of the population aged 60 and over were in receipt of the APA (Oung ND).

[20] https://www.statista.com/statistics/1365029/largest-care-home-operators-in-france/

[21] See https://www.reuters.com/business/frances-scandal-hit-orpea-reaches-restructuring-agreement-2023-02-01/#:~:text=Orpea's%20shares%20slumped%20by%2093,found%20evidence%20of%20financial%20wrongdoingand https://www.reuters.com/business/frances-orpea-says-it-will-repay-all-56-million-euros-claimed-by-cnsa-2022-11-22/

[22] In 2019, the Libault Report also proposed reforms of the LTC system in order to develop good quality care both in residential and in-home-based care services including through measures to both grow the workforce, including through improving working conditions in LTC to make the sector more attractive to the increased number of workers required to deliver better care quality (Le Bihan & Martin 2020).

[23] Scottish Government (2023) Fair Work First Guidance Supporting the implementation of Fair Work

First in workplaces across Scotland, Scottish Government, Edinburgh. https://www.webarchive.org.uk/wayback/archive/20230504121107/https://www.gov.scot/publications/fair-work-first-guidance/documents/ Accessed, 27th July 2023.

[24] UNISON (2023) *Organising to Win: Organising and Recruitment Strategy Development (ORSD) Project Report*

2023.

[25] https://www.aihw.gov.au/reports/older-people/older-australians/contents/demographic-profile

[26] It should be noted that some state governments, most notably the Victorian government, provide residential aged care mainly in rural and regional areas. In Victoria, a number of local government authorities also directly provide home care services and subsidise federal aged care funding from local rate revenue to enable them to do so.

[27][27] https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-recommendations.pdf

[28] From October 2024, care minute requirements will increase to a sector wide average of 215 minutes per day, including a minimum of 44 minutes of registered nurse time. https://www.health.gov.au/sites/default/files/documents/2022/06/what-are-care-minutes.pdf

[29] https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care#:~:text=care%20than%20men.-,At%2030%20June%202021%20(or%20during%20the%202020%E2%80%9321%20financial,women%2C%2035%25%20men).

[30] https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care#:~:text=On%2030%20June%202021%2C%20approximately,and%203%2C700%20using%20transition%20care.

[31] See Rosa Pavanelli PSI General Secretary March 14, 2022

https://publicservices.international/resources/news/covid-19-didnt-cause-the-care-crisis---privatisation-did?id=12733&lang=en

[32] See: https://decentworkgoodcare.com/wp-content/uploads/2019/05/DWGC-Promising-Policy-One-NZ-Payment-for-In-between-travel-FINAL-8-May-2019.pdf

[33] See Select Senate Committee on Job Security (2021) 2nd Interim Report: Chapter 3: https://www.aph.gov.au/Parliamentary*Business/Committees/Senate/Job*Security/JobSecurity/Second*Interim*Report/section?id=committees%2Freportsen%2F024764%2F77507

[34] https://www.dewr.gov.au/secure-jobs-better-pay/resources/establishing-two-new-expert-panels-fair-work-commission

[35] Statistics Canada Census Profile, 2021 Census of Population, https://ww12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&DGUIDList=2021A000011124&GENDERList=1,2,3&STATISTICList=1&HEADERList=0&SearchText=Canada

[36] Statistics Canada. Table 17-10-0005-01 Population estimates on July 1st, by age and sex
DOI: https://doi.org/10.25318/17100005501-eng

[37] Statistics Canada Census Profile, 2021 Census of Population,https://ww12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?LANG=E&GENDERlist=1,2,3&STATISTIClist=4&HEADERlist=2&SearchText=Canada&DGUIDlist=2021A000011124

[38] Government of Canada, Indigenous peoples and communities, https://www.rcaanc-cirnac.gc.ca/eng/1100100013785/1529102490303

[39] Statistics Canada, More than half of women provide care to children and care-dependent adults in Canada - 2022 https://ww150.statcan.gc.ca/n1/daily-quotidien/221108/dq221108b-eng.htm

[40] Canadian Institute for Health Information. 1 in 3 unpaid caregivers in Canada are distressed. Accessed April 4, 2023.

[41] Statistics Canada, More than half of women provide care to children and care-dependent adults in Canada - 2022 https://ww150.statcan.gc.ca/n1/daily-quotidien/221108/dq221108b-eng.htm

[42] Statistics Canada, Home care use and unmet home care needs in Canada, 2021 https://ww150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

[43] Statistics Canada, Home care use and unmet home care needs in Canada, 2021 https://ww150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

[44] Statistics Canada Table 1 Formal home care received, and unmet home care needs of Canadian households, by provinces, Canada, excluding the territories, 2021 https://ww150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

[45] Statistics Canada Home care use and unmet home care needs in Canada, 2021 https://ww150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

[46] Statistics Canada, Unmet home care needs by household, by neighbourhood, 2021 https://ww150.statcan.gc.ca/n1/daily-quotidien/220826/cg-a002-eng.htm

[47] Office of the Seniors Advocate, We must do better: Home support services for BC seniors, https://www.seniorsadvocatebc.ca/osa-reports/we-must-do-better-home-support-services-for-b-c-seniors/

[48] Seniors Advocate British Columbia “We must do better: home support services for B.C. seniors” (Feb 23, 2023) https://www.seniorsadvocatebc.ca/osa-reports/we-must-do-better-home-support-services-for-b-c-seniors/

[49] Health Quality Ontario, Home Care Performance in Ontario, https://www.hqontario.ca/System-Performance/Home-Care-Performance

[50] Canadian Institute for Health Information, How many long-term care beds are there? https://www.cihi.ca/en/how-many-long-term-care-beds-are-there-in-canada

[51] Canadian Institute for Health Information, Long-term care homes in Canada: How Many and who owns them, https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them

[52] Canadian Institute for Health Information, Long-term care homes in Canada: How Many and who owns them, https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them

[53] Office of the Seniors Advocate, A Billion Reasons to Care, https://www.seniorsadvocatebc.ca/osa-reports/a-billion-reasons-to-care/

[54] ibid.

[55] ibid.

[56] ibid.

[57] ibid.

[58] ibid.

[59] Hospital Employees Union, Bill 29 Compensation to be Paid to Health Care Workers, https://www.heu.org/news/media-release/bill-29-compensation-be-paid-health-care-workers

[60] Ombudsperson British Columbia, The Best of Care: Getting it Right for Seniors in BC, https://bcombudsperson.ca/investigative_report/the-best-of-care-getting-it-right-for-seniors-in-bc-part-1/

[61] Seniors Advocate Act, 2013 https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/13015_01

[62] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[63] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[64] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[65] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[66] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[67] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[68] HEU members in community social services sector ratify new contract https://www.heu.org/collective-agreements/community-social-services/heu-members-community-social-services-sector-ratify

[69] Hospital Employee Union, Collective Agreements, https://www.heu.org/collective-agreements/community-health

[70] Office of the Seniors Advocate British Columbia, Monitoring Seniors Services 2022 Report, https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2022/12/MSS_Report_2022.pdf

[71] Leah Nicholson, Contrasting Care Provincial variations in care work policy during COVID-19, Sept 9, 2021. https://www.yorku.ca/research/glrc/wp-content/uploads/sites/425/2021/09/Leah-Nicholson-Contrasting-Care-report-2021-09-09-1.pdf

[72] Health Employees Union, Health Ministry Confirms Wage-Levelling to Continue after December 31, https://www.heu.org/news/news/health-ministry-confirms-wage-levelling-continue-after-december-31

[73] BC gov news, Province continues funding fair wages for long-term care, assisted living staff, Dec 16, 2022 https://news.gov.bc.ca/releases/2022HLTH0235-001906

[74] Ontario government Fixing Long-Term Care Act 2021, https://www.ontario.ca/laws/statute/21f39

[75] Ontario Government News Release, Ontario Connecting Long-Term Care Residents to More Hours of Direct Care, https://news.ontario.ca/en/release/1002840/ontario-connecting-long-term-care-residents-to-more-hours-of-direct-care

[76] DeClerq, K. Waitlist for long-term care beds on Ontario nearly doubled in 10 years, OLTCA says, CTV news https://toronto.ctvnews.ca/wait-list-for-long-term-care-beds-in-ontario-nearly-doubled-in-10-years-oltca-says-1.6229216

[77] Ontario Government News Release, Ontario Connecting Long-Term Care Residents to More Hours of Direct Care, https://news.ontario.ca/en/release/1002840/ontario-connecting-long-term-care-residents-to-more-hours-of-direct-care

[78] Louis Cornelissen (2022) Statistics Canada, Profile of Immigrants in Nursing and Health Care Support Occupations, https://ww150.statcan.gc.ca/n1/en/pub/75-006-x/2021001/article/00004-eng.pdf?st=vsd0Z1mL

[79] Louis Cornelissen (2022) Statistics Canada, Profile of Immigrants in Nursing and Health Care Support Occupations, https://ww150.statcan.gc.ca/n1/en/pub/75-006-x/2021001/article/00004-eng.pdf?st=vsd0Z1mL

[80] Louis Cornelissen (2022) Statistics Canada, Profile of Immigrants in Nursing and Health Care Support Occupations, https://ww150.statcan.gc.ca/n1/en/pub/75-006-x/2021001/article/00004-eng.pdf?st=vsd0Z1mL

[81] The *African Charter*, Article 18(4) stipulates that "the aged and the disabled shall also have the right to special measures of protection in keeping with their physical and moral needs" (Organization of African Unity, 1981). South Africa became a signatory in 1996. Article XXII of the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* provides for the special protection of elderly women (Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003). Specifically, the states' parties agree to "provide protection to elderly women and take specific measures commensurate with their physical, economic, and social needs as well as their access to employment and professional training" and to "ensure the right of elderly women to freedom from violence, including sexual abuse, discrimination based on age and the right to be treated with dignity". South Africa became a signatory in 2004.

[82] The South African Council for the Aged, Age-in-Action, https://age-in-action.co.za/

[83] South African Human Rights Commission,(2015) Investigative Hearing into Systemic Complaints Relating to the Treatment of Older Persons https://health-e.org.za/wp-content/uploads/2015/06/SAHRC-Investigative-hearing-report.pdf

[84] Department of Social Development, March 2005, South African Policy for Older Persons, https://www.westerncape.gov.za/assets/departments/social-development/south_african_policy_for_older_persons_2005.pdf

[85] A lack of support for family and education about some of the issues faced by older adults who live with dementia are clear challenges with the overreliance on informal care. In the absence of more support and awareness, financial and social abuse and even deaths have been associated with abandonment and murder (South Africa Department of Social Development, 2021).

[86] Republic of South Africa, Older Persons Act, 2006, https://www.gov.za/documents/older-persons-act

[87] Parliament of the Republic of South Africa, Older Persons Amendment Bill (B11-2022) https://www.parliament.gov.za/bill/2302432

[88] South African Human Rights Commission,(2015) Investigative Hearing into Systemic Complaints Relating to the Treatment of Older Persons https://health-e.org.za/wp-content/uploads/2015/06/SAHRC-Investigative-hearing-report.pdf

[89] Statistics South Africa, Labour market Dynamics in South Africa, 2021, https://www.statssa.gov.za/?page_id=1854&PPN=Report-02-11-02

[90] Statistics South Africa, Labour market Dynamics in South Africa, 2021, https://www.statssa.gov.za/?page_id=1854&PPN=Report-02-11-02

[91] 2020 Mid-Year Population Estimates published by Statistics South Africa, https://www.statssa.gov.za/?p=13453#:~:text=South%20Africa's%20mid%20year%20population,%25)%20living%20in%20this%20province

[92]. https://pacificdata.org/dashboard/sdg-3-good-health-and-well-being

[93] https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/unpd_egm_201902_s7_dilitinambaleinabuli.pdf

[94] https://www.replicon.com/regulation/fiji/

[95] https://fijilive.com/business/2022/12/26/4-minimum-rate-comes-into-effect-on-1-jan/7317/

[96] https://www.palmscheme.gov.au/

[97] https://www.palmscheme.gov.au/sites/default/files/2022-04/Working%20in%20aged%20care%20English.pdf

[98] https://www.palmscheme.gov.au/sites/default/files/2022-04/Working%20in%20aged%20care%20English.pdf

[99] https://www.theguardian.com/australia-news/2022/jul/23/no-support-pacific-island-labour-hire-workers-fear-6000-cost-of-giving-birth-in-australia

[100] https://www.palmscheme.gov.au/sites/default/files/2023-05/Family%20accompaniment%20frequently%20asked%20questions.pdf

[101]https://www.aph.gov.au/About*Parliament/Parliamentary*Departments/Parliamentary_Library/pubs/rp/BudgetReview202223/ForeignAidBudget#:~:text=Australia's%20foreign%20aid%20program%20in,(inclusive%20of%20temporary%20measures).

[102] The *Maintenance and Welfare of Parents and Senior Citizens Act, 2007* https://www.indiacode.nic.in/bitstream/123456789/2033/1/200756.pdf

[103] A summary of the FCW interim decision can e found here: https://www.fwc.gov.au/documents/sites/work-value-aged-care/additional-material/2022fwcfb200-summary.pdf

[104] For a useful summary of the background to the Aged Care Work Value Case see: https://www.anmf.org.au/industrial/work-value-case. A summary of the FCW interim decision can be found here: https://www.fwc.gov.au/documents/sites/work-value-aged-care/additional-material/2022fwcfb200-summary.pdf; and a summary of the FWC on the implementation of the 15% interim wage increase and further stages in the work value case here: https://www.fwc.gov.au/documents/decisionssigned/pdf/2023fwcfb40.pdf

Endnotes

[1] Decent Work Good Care project: https://decentworkgoodcare.com/project-outputs/

[2] See for example Ariaans et al., 2021; Dyer et al., 2020; Leichsenring 2020. There are limits to cross-national typologies, which are high-level aggregate snapshots at one point in time. They are also limited by the availability, accuracy and usefulness of comparative data on selected national indicators, which assume a homogeneity within countries. Typologies are useful to understand the broad similarities and differences across diverse countries and identify the potential for change.

[3] We draw on the work of Williams, 2012; da Roit and Weich 2013; and King-Dejardin, 2019 to focus on the intersection of these regimes in relation to LTC work.

[4] Our analysis of the cases and our review of the literature provided the basis for identifying the key principles that underpin decent work and good quality services in LTC outlined in Section 2 above.

[5] Aggregate score out of 100. See: https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf

[6] WageIndicator Foundation and Centre for Labour Research, Labour Rights Index, 2022, Aggregate score out of 100. See: https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf

[7] We Own it (2023) Care Belongs in Public Ownership. https://weownit.org.uk/public-ownership/care-work#:~:text=Who%20owns%20our%20care%20services,the%20public%20sector%20just%204%25.

[8] World Bank https://data.worldbank.org/indicator/SP.DYN.LE00.IN

[9] World Bank https://data.worldbank.org/indicator/SP.POP.65UP.TO

[10] For Australia and Canada see Dyer, S., Valeri, M., Arora, N., Ross, T., & Winsall, M. (2020). *Review of international systems of long-term care of older people*. Royal Commission into Aged Care Quality and Safety.

[11] https://www.oecd.org/health/health-systems/Spending-on-long-term-care-Brief-November-2020.pdf

[12] WHO data Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%)

https://apps.who.int/gho/data/node.main.GHEDCHEGDPSHA2011?lang=en

[13] https://www.oecd-ilibrary.org/sites/b768405f-en/index.html?itemId=/content/component/b768405f-en

[14] It should be noted that the construction of the Labour Rights index makes several assumptions, including that the worker is skilled, works in the most populous party of the country and is a full-time worker with a permanent contract. The aggregate score represents the *best-case* employment regime scenarios within countries.

[15] See http://www.sadsawu.com/dw-campaigns.html

[16] Aggregate score out of 100. See: https://labourrightsindex.org/lri-2022-documents/lri-2022-final-7-oct.pdf

[17] World Bank Informal Economy Database 2018 https://www.worldbank.org/en/research/brief/informal-economy-database. 2011 data for Fiji from Asian Development Bank and ILO (2015) Fiji creating quality jobs: Employment Diagnostic Study https://www.adb.org/sites/default/files/publication/177741/fiji-creating-quality-jobs.pdf

[18] https://www.ined.fr/en/news/press/le-vieillissement-de-la-population-sE28099accelere-en-france-et-dans-la-plupart-des-pays-developpes/.

[19] In 2015, 8% of the population aged 60 and over were in receipt of the APA (Oung ND).

[20] https://www.statista.com/statistics/1365029/largest-care-home-operators-in-france/

[21] See https://www.reuters.com/business/frances-scandal-hit-orpea-reaches-restructuring-agreement-2023-02-01/#:~:text=Orpea's%20shares%20slumped%20by%2093,found%20evidence%20of%20financial%20wrongdoingand https://www.reuters.com/business/frances-orpea-says-it-will-repay-all-56-million-euros-claimed-by-cnsa-2022-11-22/

[22] In 2019, the Libault Report also proposed reforms of the LTC system in order to develop good quality care both in residential and in-home-based care services including through measures to both grow the workforce, including through improving working conditions in LTC to make the sector more attractive to the increased number of workers required to deliver better care quality (Le Bihan & Martin 2020).

[23] Scottish Government (2023) Fair Work First Guidance Supporting the implementation of Fair Work

First in workplaces across Scotland, Scottish Government, Edinburgh. https://www.webarchive.org.uk/wayback/archive/20230504121107/https://www.gov.scot/publications/fair-work-first-guidance/documents/ Accessed, 27th July 2023.

[24] UNISON (2023) *Organising to Win: Organising and Recruitment Strategy Development (ORSD) Project Report 2023*.

[25] https://www.aihw.gov.au/reports/older-people/older-australians/contents/demographic-profile

[26] It should be noted that some state governments, most notably the Victorian government, provide residential aged care mainly in rural and regional areas. In Victoria, a number of local government authorities also directly provide home care services and subsidise federal aged care funding from local rate revenue to enable them to do so.

[27][27] https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-recommendations.pdf

[28] From October 2024, care minute requirements will increase to a sector wide average of 215 minutes per day, including a minimum of 44 minutes of registered nurse time. https://www.health.gov.au/sites/default/files/documents/2022/06/what-are-care-minutes.pdf

[29] https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care#:~:text=care%20than%20men.-,At%2030%20June%202021%20(or%20during%20the%202020%E2%80%9321%20financial,women%2C%2035%25%20men).

[30] https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care#:~:text=On%2030%20June%202021%2C%20approximately,and%203%2C700%20using%20transition%20care.

[31] See Rosa Pavanelli PSI General Secretary March 14, 2022

https://publicservices.international/resources/news/covid-19-didnt-cause-the-care-crisis---privatisation-did?id=12733&lang=en

[32] See: https://decentworkgoodcare.com/wp-content/uploads/2019/05/DWGC-Promising-Policy-One-NZ-Payment-for-In-between-travel-FINAL-8-May-2019.pdf

[33] See Select Senate Committee on Job Security (2021) 2nd Interim Report: Chapter 3: https://www.aph.gov.au/Parliamentary*Business/Committees/Senate/Job*Security/JobSecurity/Second*Interim*Report/section?id=committees%2Freportsen%2F024764%2F77507

[34] https://www.dewr.gov.au/secure-jobs-better-pay/resources/establishing-two-new-expert-panels-fair-work-commission

[35] Statistics Canada Census Profile, 2021 Census of Population, https://ww12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&DGUIDList=2021A000011124&GENDERList=1,2,3&STATISTICList=1&HEADERList=0&SearchText=Canada

[36] Statistics Canada. Table 17-10-0005-01 Population estimates on July 1st, by age and sex
DOI: https://doi.org/10.25318/1710000501-eng

[37] Statistics Canada Census Profile, 2021 Census of Population,https://ww12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?LANG=E&GENDERlist=1,2,3&STATISTIClist=4&HEADERlist=2&SearchText=Canada&DGUIDlist=2021A000011124

[38] Government of Canada, Indigenous peoples and communities, https://www.rcaanc-cirnac.gc.ca/eng/1100100013785/1529102490303

[39] Statistics Canada, More than half of women provide care to children and care-dependent adults in Canada - 2022 https://www150.statcan.gc.ca/n1/daily-quotidien/221108/dq221108b-eng.htm

[40] Canadian Institute for Health Information. 1 in 3 unpaid caregivers in Canada are distressed. Accessed April 4, 2023.

[41] Statistics Canada, More than half of women provide care to children and care-dependent adults in Canada - 2022 https://www150.statcan.gc.ca/n1/daily-quotidien/221108/dq221108b-eng.htm

[42] Statistics Canada, Home care use and unmet home care needs in Canada, 2021 https://www150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

[43] Statistics Canada, Home care use and unmet home care needs in Canada, 2021 https://www150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

[44] Statistics Canada Table 1 Formal home care received, and unmet home care needs of Canadian households, by provinces, Canada, excluding the territories, 2021 https://www150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

[45] Statistics Canada Home care use and unmet home care needs in Canada, 2021 https://www150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

[46] Statistics Canada, Unmet home care needs by household, by neighbourhood, 2021 https://www150.statcan.gc.ca/n1/daily-quotidien/220826/cg-a002-eng.htm

[47] Office of the Seniors Advocate, We must do better: Home support services for BC seniors, https://www.seniorsadvocatebc.ca/osa-reports/we-must-do-better-home-support-services-for-b-c-seniors/

[48] Seniors Advocate British Columbia “We must do better: home support services for B.C. seniors” (Feb 23, 2023) https://www.seniorsadvocatebc.ca/osa-reports/we-must-do-better-home-support-services-for-b-c-seniors/

[49] Health Quality Ontario, Home Care Performance in Ontario, https://www.hqontario.ca/System-Performance/Home-Care-Performance

[50] Canadian Institute for Health Information, How many long-term care beds are there? https://www.cihi.ca/en/how-many-long-term-care-beds-are-there-in-canada

[51] Canadian Institute for Health Information, Long-term care homes in Canada: How Many and who owns them, https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them

[52] Canadian Institute for Health Information, Long-term care homes in Canada: How Many and who owns them, https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them

[53] Office of the Seniors Advocate, A Billion Reasons to Care, https://www.seniorsadvocatebc.ca/osa-reports/a-billion-reasons-to-care/

[54] ibid.

[55] ibid.

[56] ibid.

[57] ibid.

[58] ibid.

[59] Hospital Employees Union, Bill 29 Compensation to be Paid to Health Care Workers, https://www.heu.org/news/media-release/bill-29-compensation-be-paid-health-care-workers

[60] Ombudsperson British Columbia, The Best of Care: Getting it Right for Seniors in BC, https://bcombudsperson.ca/investigative_report/the-best-of-care-getting-it-right-for-seniors-in-bc-part-1/

[61] Seniors Advocate Act, 2013 https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/13015_01

[62] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[63] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[64] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[65] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[66] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[67] Ministry of Long-term Care, Long-term Care Staffing Study, 2020, https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

[68] HEU members in community social services sector ratify new contract https://www.heu.org/collective-agreements/community-social-services/heu-members-community-social-services-sector-ratify

[69] Hospital Employee Union, Collective Agreements, https://www.heu.org/collective-agreements/community-health

[70] Office of the Seniors Advocate British Columbia, Monitoring Seniors Services 2022 Report, https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2022/12/MSS_Report_2022.pdf

[71] Leah Nicholson, Contrasting Care Provincial variations in care work policy during COVID-19, Sept 9, 2021. https://www.yorku.ca/research/glrc/wp-content/uploads/sites/425/2021/09/Leah-Nicholson-Contrasting-Care-report-2021-09-09-1.pdf

[72] Health Employees Union, Health Ministry Confirms Wage-Levelling to Continue after December 31, https://www.heu.org/news/news/health-ministry-confirms-wage-levelling-continue-after-december-31

[73] BC gov news, Province continues funding fair wages for long-term care, assisted living staff, Dec 16, 2022 https://news.gov.bc.ca/releases/2022HLTH0235-001906

[74] Ontario government Fixing Long-Term Care Act 2021, https://www.ontario.ca/laws/statute/21f39

[75] Ontario Government News Release, Ontario Connecting Long-Term Care Residents to More Hours of Direct Care, https://news.ontario.ca/en/release/1002840/ontario-connecting-long-term-care-residents-to-more-hours-of-direct-care

[76] DeClerq, K. Waitlist for long-term care beds on Ontario nearly doubled in 10 years, OLTCA says, CTV news https://toronto.ctvnews.ca/wait-list-for-long-term-care-beds-in-ontario-nearly-doubled-in-10-years-oltca-says-1.6229216

[77] Ontario Government News Release, Ontario Connecting Long-Term Care Residents to More Hours of Direct Care, https://news.ontario.ca/en/release/1002840/ontario-connecting-long-term-care-residents-to-more-hours-of-direct-care

[78] Louis Cornelissen (2022) Statistics Canada, Profile of Immigrants in Nursing and Health Care Support Occupations, https://www150.statcan.gc.ca/n1/en/pub/75-006-x/2021001/article/00004-eng.pdf?st=vsd0Z1mL

[79] Louis Cornelissen (2022) Statistics Canada, Profile of Immigrants in Nursing and Health Care Support Occupations, https://www150.statcan.gc.ca/n1/en/pub/75-006-x/2021001/article/00004-eng.pdf?st=vsd0Z1mL

[80] Louis Cornelissen (2022) Statistics Canada, Profile of Immigrants in Nursing and Health Care Support Occupations, https://www150.statcan.gc.ca/n1/en/pub/75-006-x/2021001/article/00004-eng.pdf?st=vsd0Z1mL

[81] The *African Charter*, Article 18(4) stipulates that "the aged and the disabled shall also have the right to special measures of protection in keeping with their physical and moral needs" (Organization of African Unity, 1981). South Africa became a signatory in 1996. Article XXII of the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* provides for the special protection of elderly women (Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2003). Specifically, the states' parties agree to "provide protection to elderly women and take specific measures commensurate with their physical, economic, and social needs as well as their access to employment and professional training" and to "ensure the right of elderly women to freedom from violence, including sexual abuse, discrimination based on age and the right to be treated with dignity". South Africa became a signatory in 2004.

[82] The South African Council for the Aged, Age-in-Action, https://age-in-action.co.za/

[83] South African Human Rights Commission,(2015) Investigative Hearing into Systemic Complaints Relating to the Treatment of Older Persons https://health-e.org.za/wp-content/uploads/2015/06/SAHRC-Investigative-hearing-report.pdf

[84] Department of Social Development, March 2005, South African Policy for Older Persons, https://www.westerncape.gov.za/assets/departments/social-development/south_african_policy_for_older_persons_2005.pdf

[85] A lack of support for family and education about some of the issues faced by older adults who live with dementia are clear challenges with the overreliance on informal care. In the absence of more support and awareness, financial and social abuse and even deaths have been associated with abandonment and murder (South Africa Department of Social Development, 2021).

[86] Republic of South Africa, Older Persons Act, 2006, https://www.gov.za/documents/older-persons-act

[87] Parliament of the Republic of South Africa, Older Persons Amendment Bill (B11-2022) https://www.parliament.gov.za/bill/2302432

[88] South African Human Rights Commission,(2015) Investigative Hearing into Systemic Complaints Relating to the Treatment of Older Persons https://health-e.org.za/wp-content/uploads/2015/06/SAHRC-Investigative-hearing-report.pdf

[89] Statistics South Africa, Labour market Dynamics in South Africa, 2021, https://www.statssa.gov.za/?page_id=1854&PPN=Report-02-11-02

[90] Statistics South Africa, Labour market Dynamics in South Africa, 2021, https://www.statssa.gov.za/?page_id=1854&PPN=Report-02-11-02

[91] 2020 Mid-Year Population Estimates published by Statistics South Africa, https://www.statssa.gov.za/?p=13453#:~:text=South%20Africa's%20mid%20year%20population,%25)%20living%20in%20this%20province

[92]. https://pacificdata.org/dashboard/sdg-3-good-health-and-well-being

[93] https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/unpd_egm_201902_s7_dilitinambaleinabuli.pdf

[94] https://www.replicon.com/regulation/fiji/

[95] https://fijilive.com/business/2022/12/26/4-minimum-rate-comes-into-effect-on-1-jan/7317/

[96] https://www.palmscheme.gov.au/

[97] https://www.palmscheme.gov.au/sites/default/files/2022-04/Working%20in%20aged%20care%20English.pdf

[98] https://www.palmscheme.gov.au/sites/default/files/2022-04/Working%20in%20aged%20care%20English.pdf

[99] https://www.theguardian.com/australia-news/2022/jul/23/no-support-pacific-island-labour-hire-workers-fear-6000-cost-of-giving-birth-in-australia

[100] https://www.palmscheme.gov.au/sites/default/files/2023-05/Family%20accompaniment%20frequently%20asked%20questions.pdf

[101]https://www.aph.gov.au/About*Parliament/Parliamentary*Departments/Parliamentary_Library/pubs/rp/BudgetReview202223/ForeignAidBudget#:~:text=Australia's%20foreign%20aid%20program%20in,(inclusive%20of%20temporary%20measures).

[102] The *Maintenance and Welfare of Parents and Senior Citizens Act, 2007* https://www.indiacode.nic.in/bitstream/123456789/2033/1/200756.pdf

[103] A summary of the FCW interim decision can e found here: https://www.fwc.gov.au/documents/sites/work-value-aged-care/additional-material/2022fwcfb200-summary.pdf

[104] For a useful summary of the background to the Aged Care Work Value Case see: https://www.anmf.org.au/industrial/work-value-case. A summary of the FCW interim decision can be found here: https://www.fwc.gov.au/documents/sites/work-value-aged-care/additional-material/2022fwcfb200-summary.pdf; and a summary of the FWC on the implementation of the 15% interim wage increase and further stages in the work value case here: https://www.fwc.gov.au/documents/decisionssigned/pdf/2023fwcfb40.pdf