Workforce and Safety in Long-Term Care during the COVID-19 pandemic

Updated 22 June 2020

The COVID-19 crisis has put the spotlight on the long-term care (LTC) sector. Elderly people and their care workers have been disproportionately affected by the COVID-19 pandemic. Many OECD countries have taken measures to contain the spread of the infection and mitigate its impact on vulnerable groups. Yet the health crisis is highlighting and exacerbating pre-existing structural problems in the long-term care (LTC) sector. Care workers experience difficult working conditions. In addition, there are skills mismatches, poor integration with the rest of health care and inadequate or poorly enforced safety standards. Looking forward, more investment in LTC workforce and infrastructure to ensure suitable levels of trained staff, with decent working conditions and prioritising care quality and safety are required.

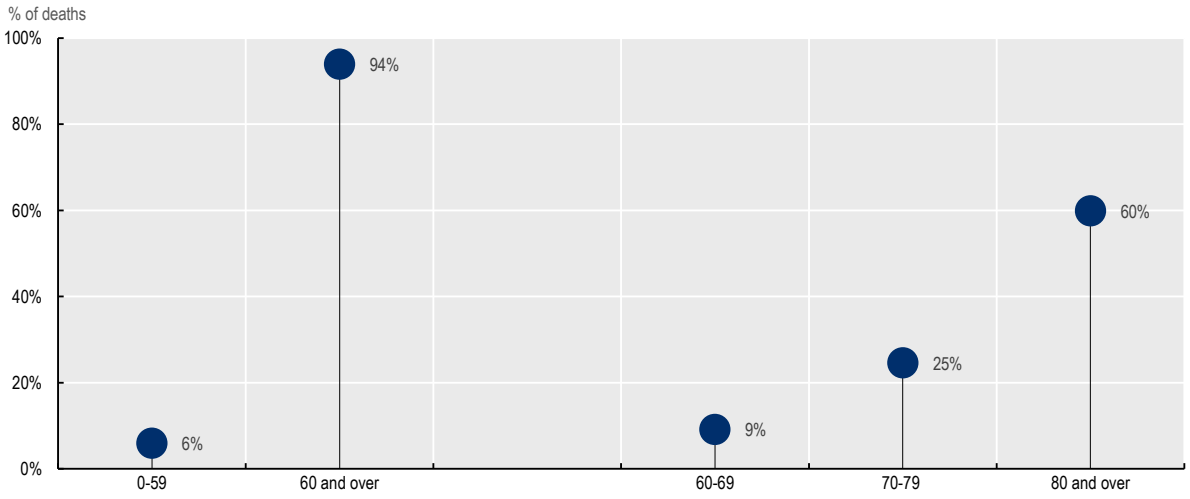
The long-term care sector is particularly vulnerable in case of epidemics

Long-term care (LTC) services help people live as independently and safely as possible as they age. The COVID-19 crisis is hitting the LTC sector very hard, given the large numbers of people dependent on care falling ill as well as the added exposure of LTC workers to infections. The bulk of COVID-19 deaths is among the elderly, especially those aged 80+ who represent 50% of those receiving LTC (Figure 1).

Some of the most affected countries, such as France, Italy, Spain, and the United States, have seen a high death toll among nursing home residents. While nearly seven in ten elderly receive care at home, other countries like Australia and France have much higher shares of elderly people living in institutions (45% and 41% respectively). In France, about 50% of total COVID-19 deaths are estimated to be nursing home residents; in Belgium, half of COVID-19 deaths occurred in LTC facilities. The actual numbers could even be higher because many LTC residents have not been tested. People living at home are not immune from risks either, both from the virus itself, and from the social isolation and loneliness that can accompany social distancing efforts.

Figure 1. Percentage of total accumulated COVID-19 deaths by age, latest month available

Share of deaths caused by COVID-19 by age group, in selected OECD countries



Note: Countries included are Australia, Canada (Québec), Germany, Italy, Japan, Netherlands, Spain and Sweden as well as France, UK (England and Wales) and USA for the age groups 0-59, 60 and over and 80 and over. For the UK, data cover those aged over 65 and 85. For the US, data cover those aged over 65 and 75. Data available as of 14 June 2020. Deaths registration differs by country.
Source: OECD calculation based on national daily update briefs and other national sources (data refer to deaths caused by COVID-19 from January to 14 June 2020).

LTC workers, who are themselves exposed to the risk caused by the pandemic, are overwhelmingly female and among the lowest-paid in the health care sector. Work conditions are often very difficult and demanding and staff turnover is high. Some 55% of OECD LTC workers are in institutions. More than 90% of LTC workers are women.

Many OECD countries are taking steps to mitigate the impact of the COVID-19, both on elderly people and on LTC workers. Measures to limit spread of infections in LTC institutions include banning visits, isolating affected residents and heightened cleaning. Nursing homes are also limiting group activities in Spain and France, for instance. Korea has included care homes as a priority group for diagnostic testing.

Yet, in spite of the pandemic disproportionately affecting the elderly, steps taken are often too few, too late. Care workers are suffering from a lack of protective equipment and testing, which are required to slow transmission in most countries. Both home care workers and carers in institutions are at high risk of infection and of infecting patients as many work in several locations. Discharged hospital patients who are transferred back to nursing homes can also spread the virus.

Several OECD countries have increased funding for LTC to face the increased costs caused by the pandemic response. Australia has issued plans to increase staffing and Spain has set up rapid response teams to intervene in certain institutions. Germany has issued financial support for LTC, especially to increase minimum wages in the sector, promote bonuses for LTC workers and facilitate the distribution of personal protective equipment. France has also announced support in the form of bonuses for workers and sharing additional costs for institutions.

The pandemic is highlighting LTC's structural problems in terms of underinvestment, staffing and safety. LTC workers do not always have the appropriate health care training or ability to implement infection protocols or other prevention activities. Infection outbreaks often cause staff absenteeism, as workers take sick leave or are afraid to go to work. In the home care sector, absenteeism of LTC workers also increases the burden on informal or family carers.

Lack of sufficient, qualified medical staff and structural problems with insufficient co-ordination with the rest of the health care system are making the crisis more acute in LTC. Correct identification of symptoms among residents and staff may also be limited due to limited access to health professionals. There are also opportunities to improve co-ordination with the acute care sector, for example, enhancing the availability of respiratory therapy services in LTC settings.

Insufficient and inadequate workforce in the sector

With OECD populations rapidly ageing, demand to provide more LTC, and to older people, is growing. On average across OECD countries, the proportion of those aged 80 and above will increase from nearly 5% to almost 10% of the population by 2050. In the coming decades, the number of LTC workers will need to increase by 60% by 2040 – equivalent to an additional 13.5 million workers – across the OECD to keep the current ratio of carers to elderly people (OECD, 2020[1]).

The needs of the dependent elderly population are also becoming more complex. More dependent people live with multiple chronic conditions and/or dementia. While the health profile and dependency of residents has worsened, the workforce mix and level has remained relatively unregulated and static. Less than one-quarter of LTC workers hold tertiary education across the OECD. Personal care workers – who are not qualified as nurses – constitute the bulk of the LTC workforce (70%), and have very low job entry requirements.

The services delivered in LTC and the knowledge, competencies and skills of LTC carers are misaligned. Less than half of the countries require that personal care workers hold a minimum education level or provide official certificates, and few guarantee that personal care workers received sufficient training. The most common gaps in LTC workers' skills include: knowledge of geriatric conditions (dementia, frailty etc.), safety, caring needs following hospital discharge, crisis management and supporting end-of-life care.

Poor working conditions exacerbate challenges in LTC

LTC workers are among the lowest-paid and earn much less than those working with similar qualifications in other parts of the health care sector. The median hourly wage for LTC workers across 11 OECD countries was EUR 9 per hour in 2014, compared to EUR 14 for hospital workers in the same occupation. Low wages are one of the reasons for the high turnover in LTC.

Non-standard employment (e.g. shift, part-time or temporary work) is common in the sector, too. Temporary employment is frequent and might bring flexibility to both employers and workers but also contributes to job insecurity in the sector, lower social protection and lack of continuity for patients. On average, half of LTC workers engage in shift work (e.g. working mornings or afternoons only) across 20 OECD countries. Shift work is associated with a wide range of health risks, such as anxiety, burnout and depressive syndromes.

Care workers in LTC face physically and psychologically demanding working conditions. Many workers have experienced severe time pressures and an overload of work. Because care work is demanding, the LTC sector suffers from high levels of absenteeism owing to workers' sickness.

Close to two-thirds (65%) of LTC workers suffer from physical risk factors across OECD countries. Workers' risks of injury are high as they move, transfer, and reposition patients. In addition, 46% of LTC workers are exposed to mental well-being risk factors, such as stressful behaviour from care recipients, in particular aggression from people with dementia. Some LTC workers report suffering from violence and harassment.

The LTC sector is prone to safety risks

Preventable safety failures are widespread. Research shows that over half of the harm that occurs in LTC settings is preventable, and over 40% of admissions to hospitals from LTC are avoidable (OECD, forthcoming[2]).

Residents in LTC facilities often have compromised immune systems or chronic conditions that place them at heightened risk of infection, especially, but not only, during the COVID-19 crisis. Close proximity and constant contact of residents with health care staff and other residents can facilitate the spread of respiratory and other infections (Stuart, Lim and Kong, 2014[3]). As a result, even before the COVID-19 crisis hit, health care-associated infections were common in LTC – averaging a prevalence of 3.8% among LTC facility residents in OECD countries in 2016-17 (Figure 2).

Poor safety in LTC is in part due to lack of resources: access to appropriate staffing, supplies, and treatments can pose a challenge for the delivery of safe and quality LTC. The root causes of most safety events can be addressed through improved prevention and safety practices and workforce development – including promoting training for more advanced qualifications and/or specific certification among some staff.

Only one third of OECD countries have in place policies to promote more integrated care across health and social sectors, and even within different parts of the health sector. Poor co-ordination can be particularly harmful for the elderly, and increase their risk of unnecessary hospitalisation, long hospital stays and readmission.

Investing in human resources is crucial

Better jobs will mean better quality of care, reductions in the high staff turnover and improved care delivery. Increasing entry wages and offering opportunities for career progression helps motivation to stay in the sector. France, for example, has announced a bonus for care workers during the COVID-19 crisis.

Beyond wages, Norway and the Netherlands are promoting a healthier work environment through better prevention of workplace accidents and illness, which in turn can reduce absenteeism and turnover. Changing the organisation of work with more flexibility in work schedules, better organisation of daily work and planning shifts in LTC and improving leadership in nursing homes to empower employees will also be necessary.

Safety standards should be developed and enforced to ensure that minimum standards are met, such as staff ratios and qualifications, infrastructure, and better living environments. Moreover, these standards must be properly measured and enforced. Denmark, Finland, Norway, Portugal, and Sweden, for instance, have national indicators to monitor quality and safety of LTC residents.

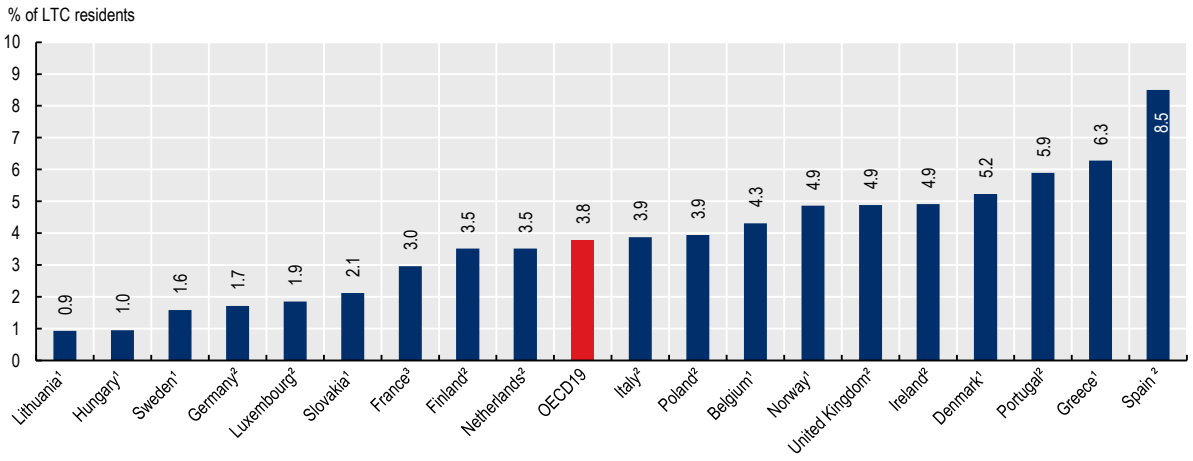
In the future, most LTC needs are likely to continue to be addressed by personal care workers providing many low-skilled tasks. But there is also a need for LTC workers who are equipped with more advanced geriatric care and co-ordination care competencies as well as soft communication skills. Policy design must ensure appropriate staffing levels for the management of medically complex cases among nursing home residents. In Germany, a scientifically based skill mix determination tool is currently being developed for this purpose.

Fit-for-purpose technology and better co-ordination with the rest of the health system will be beneficial

Greater use of fit-for-purpose technology in LTC could help increase productivity. This could free professionals' time from tasks that can be automated, allowing them to focus on activities most important for people in need of care. Recording of data on elderly people is a laborious task that is still done by hand in many countries. Nurses and personal care workers spend up to one-third of their time on administrative reporting. Electronic devices can help to automate the registration of patient data for monitoring and enhance communication across teams (e.g. between a nursing home and a hospital). In Norway, for instance, a nationwide strategy aims to improve the digital skills of care workers.

Finally, as the COVID-19 crisis is demonstrating, the important links between LTC, primary care and acute care cannot be ignored. Better coordination with acute care and safety improvements during the COVID-19 epidemic are conducive to higher care quality by ensuring early recognition of infections, implementing staff training on preventive measures and treating more severe cases who require for instance ventilation support in hospitals. Improved co-ordination with primary health care is key to improve the outcome of care for elderly with multiple chronic conditions and reduce the risk of unnecessary hospitalisation. LTC professionals should be working more in teams with other health professionals in monitoring chronic conditions and prioritising prevention and safety mechanisms. Japan, for instance has opened community-based integrated care centres in every district with care managers coordinating different services for the elderly.

Figure 2. Percentage of LTC residents with at least one health care-associated infection, 2016-17



1. Under 45% of residents sampled were wheelchair bound or bedridden. 2. Over 45% of residents sampled were wheelchair bound or bedridden. 3. No data was available on the proportion of wheelchair bound or bedridden residents.
Source: ECDC, CDC.

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https://www.oecd.org/health/long-term-care.htm