The Labour Force in Long-term Residential Care: Comparing Across Jurisdictions

Laxer, Kate; PhD Candidate; York University

RE-IMAGINING LONG-TERM RESIDENTIAL CARE
an international study of promising practices

1. Objectives

The demand for long-term residential care is rising given the growing number of older adults and those living with severe disabilities, and despite the international emphasis on care in private households. Various scandals in these care homes, along with the rising acuity levels of residents, have resulted in calls for more training of those providing care. As McGregor et al. [1] observe for the Canadian context "the seniors in long-term care facilities tend to be older, more disabled and closer to the end of life than were residents a decade ago." They point out that "this shift in resident profile has placed new, more complex demands on staff" [1, p.1]. Concerns have also been raised about the supply of workers [2], drawing attention to the working conditions, including pay, benefits and status attached to work in long-term residential care. This industry has long been seen as an important link in the international care chain, with high income countries seeking workers from low income countries. Yet, cross-national data sources provide very little information on the long-term residential care labour force. This poster will provide a profile of some of what is available from key statistical sources in Europe and North America. It will also review what data are needed in order to develop an accurate assessment of the supply of labour in this critical industry of health and social care.

2. Design

Three sources of data are used to profile paid labour forces in health and social care and long-term residential care. The first is the Comparative Perspectives Database on Precarious Employment (CPD) which houses harmonized labour force data from 33 countries and seven surveys including the European Union Labour Force Survey (EU LFS), the Statistics Canada Labour Force Survey and the United States Current Population Survey [3]. The CPD has not yet been released and data presented in this poster are based upon the calculations from preliminary, unpublished multidimensional tables. The author of this poster is a developer of the CPD module on health and social care. The profile of the Canadian labour force relies on data from Statistics Canada Survey of Labour and Income Dynamics [4] and the Canadian Census [5].

3. Setting

Six countries are included in the profile: Canada, the United States, the United Kingdom, Germany, Sweden and Norway. The European countries [6, 7] and North American countries in this study are all characterized by some combination of formal and informal home care with continued emphasis on long-term residential care with differences between the countries in terms of public funding and levels of private and informal care.

4. Measures

To map paid labour forces in health and social care across the six countries, an occupation variable designed for the CPD is used. This variable harmonizes three occupation classifications: the ISCO-88 (EU LFS), the SOC 2000 (US Current Population Survey) and the NOCS 2001 (Statistics Canada Labour Force Survey). Keeping in mind the need to include all workers in care settings in order to appropriately map the labour force [8] this occupation variable divides the entire health and social care labour force into six categories. These categories are: managers, physicians and other professionals, nursing professionals (including midwives), technical and associate professionals (including licensed practical nurses), assisting providers (including care aides and personal support workers), and support providers (including all other workers in health and social care but are not elsewhere classified, such as clerical, cleaning, food services and other support).

5. Results

5.1 Limitations of Cross-national Statistical Sources

The main sources of comparative cross-national labour force data for European countries are the European Union Labour Force Survey and the European Union Statistics on Income and Living Conditions. Each source has limitations for profiling national labour forces in long-term residential care. The most significant limitation is that Eurostat microdata available to researchers aggregates industry data to the 1-digit level in order to meet criteria for anonymisation. This means data are available at the industry level of health and social care, but not for sub-industries within health and social care. Another limit to these surveys is the lack of data on sector (public, private, for-profit and not-for-profit) and union coverage, both important indicators for mapping context and working conditions for labour forces in health and social care and specifically in long-term residential care [13].

5.2 Paid Labour Force in Health and Social Care

Each country in this study has an aging health and social care labour force with shares of workers over the age of 45 growing for nearly all health occupations (Table 1). Aging of assisting providers, the largest category of direct care workers in long-term residential care, can be confirmed in each of the countries except Germany. Further, a labour force past the age of 65 is also emerging in health and social care for several countries and research has demonstrated that the labour force in long-term residential care has larger concentrations of older workers relative to other sub-industries in care [3, 9]. This suggests several countries will face labour shortages in health and social care, and in long-term residential care, as providers move into retirement age.

Table 1: Percentage of labour force age 45 and over in health and social care occupations, 2002 & 2011

	Canada		United States		Germany		United Kingdom		Sweden		Norway	
	2002	2011	2002	2011	2002	2011	2002	2011	2002	2011	2002	2011
Total	39.8	46.0	39.5	45.8	34.5	44.7	40.9	46.0	44.8	49.7	39.5	44.2
Managers	53.5	61.2	48.6	58.3	63.6	78.2	49.6	57.7	74.2	63.7	-	61.6
Physicians and other health care professionals	39.0	46.3	42.9	51.1	47.7	46.7	31.1	38.2	57.0	50.7	48.2	37.7
Nursing professionals	45.1	49.3	46.1	46.7	*	*	*	*	-	49.4	-	59.9
Technical and associate professionals	30.5	36.3	35.0	45.3	31.3	42.0	34.6	45.8	42.9	60.8	29.7	44.7
Assisting providers	40.2	46.2	33.1	38.5	22.9	-	38.6	40.9	39.5	45.6	39.0	42.3
Support providers	43.5	51.9	39.5	47.1	42.2	51.2	49.4	53.1	56.6	54.6	49.7	43.4

Source: Calculated from unpublished Health and Social Care multidimensional tables, Comparative Perspectives on Precarious Employment Database; Using data from Eurostat EULFS, US Current Population Survey and Statistics Canada Labour Force Survey. * Registered nurses and nurse supervisors are classified with Technical and associate professionals in Germany and the UK. - missing data.

National labour forces in health and social care have very high concentrations of women workers (Table 2) particularly among nursing professionals and assisting providers, both critical groups of providers in long-term residential care.

Table 2: Percentage share of women in health and social care occupations, 2011

	Canada	United States	Germany	United Kingdom	Sweden	Norway
Total	82.2	79.1	76.8	79.4	82.0	80.5
Managers	74.3	66.8	22.5	71.5	73.6	72.7
Physicians and other health care professionals	57.0	52.8	62.9	59.8	61.5	56.6
Nursing professionals	92.8	90.0	*	*	89.9	86.9
Technical and associate professionals	84.3	83.3	86.4	80.6	83.6	70.9
Assisting providers	89.3	88.5	84.4	85.9	86.2	88.4
Support providers	80.2	75.7	67.8	74.3	72.8	79.3

Source: Calculated from unpublished Health and Social Care multidimensional tables, Comparative Perspectives on Precarious Employment Database; Using data from Eurostat EULFS, US Current Population Survey and Statistics Canada Labour Force Survey. * Registered nurses and nurse supervisors are classified with Technical and associate professionals in Germany and the UK.

The occupational division of labour in health and social care (Table 3) varies for the countries in this study. In particular, there are notable differences among shares of managers, assisting providers and support providers. Both Germany and Sweden have smaller shares of workers in management occupations. Relative to the other countries, Sweden and Norway both have larger shares of assisting providers and also smaller shares of support providers. This suggests that assisting providers in both Sweden and Norway have more complex roles and do tasks that are separated out into support provider occupations in other countries (Table 3). Indeed, recent research comparing workers in long-term residential care in Sweden and Canada has shown that the division of labour is very different in these two countries with important implications for how workers experience their roles as providers [10]. The Canadian model of "highly differentiated task-oriented work" is contrasted with the Swedish model of "integrated relational care work" and the authors of this research conclude that "reflecting differences in the vertical division of labour, the Canadian care aides had more demanding working conditions than their Swedish colleagues"[10, p. 139]. Work in long-term residential care is often depicted as unskilled [11, 12], in part related to the high concentrations of women providers [11]. This profile demonstrates the need to investigate further within the sub-industry of long-term residential care where shifts in the division of labour, related in part to funding, are impacting the skills required for this care work along with working conditions.

Occupational division of labour in health and social care, 2011

	Canada	United States	Germany	United Kingdom	Sweden	Norway
Total (100%)	100	100	100	100	100	100
Managers	4.3	6.6	1.3	5.0	2.7	4.1
Physicians and other health care professionals	9.2	10.5	14.9	9.5	10.4	8.7
Nursing professionals	13.4	13.8	*	*	14.7	5.3
Technical and associate professionals	28.7	16.4	46.2	29.7	9.6	13.3
Assisting providers	16.7	24.6	10.6	31.2	51.0	45.9
Support providers	27.7	28.0	27.0	24.6	11.5	22.7

Source: Calculated from unpublished Health and Social Care multidimensional tables, Comparative Perspectives on Precarious Employment Database; Using data from Eurostat EULFS, US Current Population Survey and Statistics Canada Labour Force Survey. * Registered nurses and nurse supervisors are classified with Technical and associate professionals in Germany and the UK.

5.3 National Context: Canada

Statistical data on the labour force within the sub-industry of long-term residential care is available in many countries, however national surveys have limitations. This section will examine the Canadian context. In Canada, long-term residential care is not covered by the *Canada Health Act* and can be provided by all sectors, including for-profit, not-for-profit, publicly owned, and privately owned facilities. Research has demonstrated that staffing levels vary by sector with one recent study showing that not-for-profit government owned facilities in the province of British Columbia had greater increases in nursing hours than for-profit and non-government owned facilities [1]. However, investigating the influence of sector on other aspects of the labour force in long-term residential care in Canada is limited by the variable used to measure sector in Statistics Canada labour force surveys. This variable allows for a comparison of the public and private sectors but does not provide data on the for-profit and not-for-profit sectors [13].

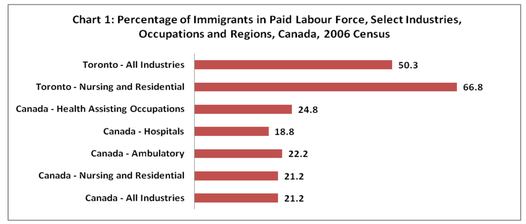
Table 4: Average hourly wage and gap, public and private sector nursing and residential care, Canada, 2009

	Public sector	Private sector	$ Wage Gap	% Wage Gap
Nurse supervisors and registered nurses	$29.92	$28.80	$1.12	3.7
Technical and associate professionals	$22.49	$21.18	$1.31	5.8
Assisting providers	$18.67	$16.65	$2.02	10.8
Support providers	$21.10	$16.87	$4.23	20.0

Source: Calculated from Gender and Work Database multidimensional tables using data from the Statistics Canada Survey of Labour and Income Dynamics.

Nevertheless, important differences are observed for working conditions in the public and private sectors in the Canadian industry of nursing and residential care where long-term residential care is classified. Table 4 shows that average hourly wages are higher in the public sector and that wage gaps are largest for assisting providers and support providers for whom the public sector wage advantage is greatest. This suggests that the working conditions of some groups of workers may be more significantly affected by shifts in sector delivery. Canadian provinces differ in the extent of public, private, for-profit and not-for-profit long-term residential care [14]. They also differ in standards for staffing which vary within Canada but also between and within the other countries of this study, pointing to the importance of sub-national detail [15].

An investigation of the concentration of immigrants in the nursing and residential care labour force in Canada further demonstrates the importance of sub-national profiling. In Canada, shares of immigrant workers are very similar for the sub-industries in health and social care (Chart 1), but concentrations are much higher and disproportionate to the labour force as a whole in the city of Toronto, revealing that the presence of workers originating from other countries in long-term care work differs by geographic location in Canada. Shares of immigrants within assisting occupations, the primary providers of direct care in long-term residential care [13], are also disproportionate to shares in all occupations.



Not all workers in long-term residential care can be mapped in the Canadian context. In particular, personal companions who are hired privately by families or individuals to supplement facility care [16] are especially invisible in statistical terms and cannot be tracked by national labour force surveys. Moreover, the Canadian statistical sources used in this profile have recently undergone changes affecting the ability to track aspects of the labour force in long-term residential care and the Statistics Canada Residential Care Facilities Survey has been cancelled [13].

6. Conclusions

Rising acuity levels in long-term residential care are placing new demands on labour in this industry, contributing to changes in the division of labour and to the skills and training required for this work. Demand for workers is rising, in part related to the aging of the labour force. This poster has examined the many challenges of comparing labour forces in long-term residential care across jurisdictions. Key cross-national sources of labour force data only allow for detailed comparisons at the level of health and social care but not for its sub-industries. Adequate data on the public, private, for-profit and not-for-profit sectors are missing in cross-national sources and also in some national surveys which critically limits the ability to evaluate shifts in delivery models and their effects on the labour force. These shifts, along with staffing standards, differ not only across countries but also within, pointing to the importance of sub-national detail. Some workers are especially invisible in statistical terms. Each country in this study presents a unique and complex context for long-term residential care and cross-national collaboration around data access, collection and comparison may be one way to address some of the statistical limitations in order to better map this labour force.

Author contact information

Kate Laxer: kate.laxer@gmail.com

Acknowledgements

This research was supported by the Social Sciences and Humanities Research Council of Canada as part of their Major Collaborative Research Initiative.

References

[1] McGregor M, Tate R, Ronald L, McGrail K, Cox M, Berta W, Broemeling A. Trends in Long-term Care Staffing by Facility Ownership in British Columbia 1996 to 2006. *Health Reports;* 2010; *21*(4), 27-33.
[2] Organisation for Economic Co-operation and Development. *Help Wanted? Providing and Paying for Long-Term Care.* OECD: Paris; 2011.
[3] Comparative Perspectives on Precarious Employment Database (Unreleased), York University. Health and Social Care Multidimensional Tables. Data from European Union Labour Force Survey, United States Current Population Survey and Statistics Canada Labour Force Survey 2002-2011.
[4] Gender and Work Database, York University, http://www.genderwork.ca. Health Care Multidimensional Tables. Data from Survey of Labour and Income Dynamics 1993-2009.
[5] Canadian Census. Special Interest Profiles, 2006 Census. Statistics Canada Catalogue no. 97-564-XWE2006006. Ottawa; 2008.
[6] Lyon D, Glucksmann M. Comparative Configurations of Care Work Across Europe. *Sociology;* 2008; 42(1), 101-118.
[7] Lethbridge J. Care Services for Older People in Europe: Challenges for Labour. Public Services International Research Unit, University of Greenwich, London UK; 2010.
[8] Armstrong P, Armstrong H, Scott-Dixon K. *Critical to Care: The Invisible Women in Health Services.* Toronto: University of Toronto Press; 2008.
[9] Armstrong P, Laxer K. Demanding Labour: An Aging Health Care Labour Force. Poster Presentation, OLTCA Applied Research Day; Feb 13 2013.
[10] Daly T, Szebehely M. Unheard Voices, Unmapped Terrain: Comparing Care Work in Long-term Residential Care for Older People in Canada and Sweden, *International Journal of Social Welfare;* 2012; 21: 139-148.
[11] Armstrong P, Armstrong H. Contradictions at Work: Struggles for Control in Canadian Health Care. In L. Panitch and C. Leys eds. *Morbid Symptoms*. London: Monthly Review Press; 2009; 145-167.
[12] Palmer E, Evaline J. Sustaining Low Pay in Aged Care Work. *Gender, Work and Organization;* 2012; 19(3): 254-297.
[13] Laxer K. Counting Carers in Long-term Residential Care. In P Armstrong ed., *Troubling Care: Critical Perspectives on Research and Practices*. Toronto: Women's Press; Forthcoming.
[14] McGregor M, Ronald L. *Residential Long-term Care for Seniors: Non-profit, For profit or Does it Matter?* Montreal, Quebec: Institute for Research on Public Policy; 2011.
[15] Harrington C, Choiniere J, Goldmann M, Jacobsen F, Lloyd L, McGregor M, Stamatopoulos V, Szebehely M. Nursing Home Staffing Standards and Staffing Levels in Six Countries. *Health Policy and Systems;* 2012; 44(1):88-98.
[16] Armstrong P, Braedley S. Introduction: Troubling Care. In P Armstrong ed., *Troubling Care: Critical Perspectives on Research and Practices*. Toronto: Women's Press; Forthcoming.