4. The crisis in the nursing home labour force: where is the political will?

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There is no care without care workers. When it comes to the nursing home labour force, the pandemic turned what was a dire situation into a crisis, with working conditions driving staff out of care. Well before Covid, international reports had been warning that population aging, combined with the poor working conditions in the sector, would mean severe shortages (e.g., Colombo et al., 2011). We also had warning that the increasing shift to for-profit services and to for-profit approaches to the organization of work, combined with "aging in place" policies, was limiting access to care while undermining the quality of work and the quality of care (Armstrong & Armstrong, 2020). As nursing home places failed to keep up with demand, entry into these homes was increasingly restricted to those with complex care needs. Covid turned barely enough care into not enough care as workers became ill or left because they feared getting ill, as part-time employees were restricted to one workplace, as schools closed so children were at home all day, as working conditions deteriorated, and as families were barred from care homes.

In this chapter, we begin by looking at the nursing home labour force in Canada, Norway, and Sweden pre-pandemic. Because Canada has a federal system that leaves responsibility for health care primarily to the provinces and territories, resulting in considerable variation across the country, we focus mainly on Ontario, the most populous province. We draw on our nearly two decades of research employing multiple methods to study nursing homes in six countries (Chapter 1). We then turn to strategies introduced during the pandemic to shore up the labour force, asking whether these strategies are temporary or permanent. Finally, we explore whether these policies address the long-standing issues in the conditions of work that have been identified as necessary to support this labour force.

WHO PROVIDES CARE?

All nursing homes need people to provide social support as well as clinical care, therapy, recreational activities, assistance with daily living, food, clean clothes and environments, maintenance, and management, although the balance among who provides these aspects varies across jurisdictions. However, comparisons across jurisdiction in the nursing home labour force are complicated by the differences in the titles of jobs, the division of labour, and in the kinds of formal and informal education required. Canada has a more detailed division of labour than either Norway or Sweden, with more specifically defined areas of work for each job class (Daly & Szebehely, 2012; Laxer et al., 2016). But even within Canada, there are different job titles and differences in the scope of practice for different occupational categories in different provinces and territories. Moreover, international data comparisons often lump together all long-term care rather than separating out the nursing homes primarily caring for older people, as we do in this book. Nevertheless, it is possible to identify some overall patterns.

The most comparable category is Registered Nurse (RN), with all three countries requiring a university education to qualify for this title. About 30 percent of the workforce in Norwegian nursing homes are RNs, compared to 7 percent in Sweden (OECD, 2020, p. 64) and 8 percent in Ontario (Ontario, 2020, p. 10). At the same time, Sweden has the largest proportion of the workforce that is assistant nurses; they account for almost 60 percent of the care workforce (Socialstyrelsen, 2021), a group roughly equivalent to Registered Practical Nurses (RPNs), who make up about 17 percent of the Ontario care labour force. But unlike the Swedish assistant nurses, RPNs are regulated (Simmons, Rodrigues, & Szebehely, 2021).

In Ontario, most care is provided by care aides who have limited formal training, while this is the case for only about a fifth of the workforce in Norway and Sweden. Meanwhile, physicians, therapists, and others with many years of formal training account for the smallest proportion of the nursing home labour force in Ontario (Marrocco, Coke, & Kitts, 2021, p. 15), and the training they receive is usually not focused on the nursing home population (McGregor, 2016).

In addition to those who provide direct care, there are those who cook, clean, and do laundry. Care aides or assistant nurses do some of this labour, especially in Norway and Sweden. But in all three countries, the heavier aspects are often done by those specifically assigned to this work, with little formal training. This is especially the case with those working for services that are outsourced to for-profit concerns, like the Canadian cleaner we interviewed whose company moved her from a job at the airport to the care home without

providing her with any new training. In Canada, there are also a growing number of personal companions who are hired directly by relatives to make up for the gaps in care (Daly & Armstrong, 2016). There are no legal requirements for those doing this work, but individual homes may restrict their activities.

And there are virtually no requirements for the many relatives and volunteers who do unpaid work in care homes (Chapter 8). Like the paid labour force, most of these workers are women. In Canada, families and volunteers take on a much wider range of tasks than in Norway and Sweden, including tasks that are otherwise done by paid staff. But in all three countries these unpaid workers provide residents with essential social connections.

Care for Women by Women

Care theorists have for years demonstrated that social inequalities related to race, gender, class, and citizenship status shape who does the paid and unpaid care work (Armstrong, 2019; Braedley, 2006; Duffy, 2011). Nursing homes are primarily about care for women by women. In all three countries, nine out of ten nursing and direct care staff are female, and a significant majority of residents are women. That so much of the work is done by those with limited formal training reflects and reinforces assumptions that care work comes "naturally" to women, and thus requires little formal training. That the care is for older women may also be a factor in the undervaluing of the care work, reflecting agism, especially in relation to women (Chrisler, Barney, & Palatino, 2016). Yet when asked about skills, a nurse said she used a much broader range of skills in the nursing home than she ever did in a hospital: "I think the stuff we have to do calls on so many aspects of nursing that would blow a hospital nurse's mind. I really do" (Armstrong et al., 2019).

Working conditions and the valuing of this labour have made it increasingly difficult to recruit staff in these high-income countries, prompting a search for workers from outside their jurisdictions. In all three countries, a growing number of workers are immigrants and many of them are racialized. In 2020, 32 percent of the assistant nurses and 46 percent of the care aides in the Swedish care workforce were born outside Sweden, with male care workers almost twice as likely as their female counterparts to be foreign-born (Statistics Sweden, 2022). At 17 percent, Norway has a lower proportion of foreign-born care workers, but the numbers are growing (Statistics Norway, 2018). In both countries, the majority are from Asia or Africa (Statistics Sweden, 2022; Statistics Norway, 2018).

The proportion of newcomers and racialized people is even higher in Canada (Harun & Walton-Roberts, 2022; OECD, 2020, figure 2.6). Ontario data show that about 40 percent of care aides are racialized (Ontario, 2020, p. 5). And in both Canada and Sweden, around 60 percent of care workers in

urban areas are immigrants (Estabrooks et al., 2020, p. 19; Storm & Lowndes, 2021). These workers often face both discrimination and precarious working conditions (Storm & Lowndes, 2021).

The differences in the composition of the three countries' labour forces are more in degree than in kind. Norway has significantly more RNs, which may mean more effective infection control, but may also mean a greater focus on medical rather than on social care. A 2016 Norwegian study (Kjøs & Havig, 2016) found that "the level of physical and social activities offered to the residents is relatively low, while the general care level is significantly higher." In all three countries Covid highlighted the problem of too many staff with limited formal education and too many part-time workers. It also showed that Canada relies much more heavily than the other two countries on unpaid work by volunteers and relatives. All have a primarily female labour force which includes an increasing number of immigrant and/or racialized workers, factors that contribute to the working conditions and skill requirements in the sector, as we explore in the next section.

WORKING CONDITIONS

Staffing Levels

The most critical working condition is the number of staff. It is not surprising that all the models of care considered in Chapter 6 begin with high staffing levels. Low staffing levels mean heavier workloads for every worker. They also mean a greater focus on tasks, more tasks left undone, and lower quality of care overall (Armstrong et al., 2009; Harrington et al., 2012). Moreover, low staffing levels undermine workers' health because not only are they working too hard and fast, but they have less time to support each other. In our survey of workers conducted more than a decade ago, 58 percent of the Canadian direct care workers said that all or most of the time they had too much to do, compared to 39 percent of the Norwegians and 40 percent of the Swedish respondents (Armstrong et al., 2009, table 7). If anything, things have deteriorated since then, with Covid making it even worse (Simmons et al., 2021).

The needs of the residents are quite similar in these countries. A critical difference, though, is staffing levels. Until Covid, Ontario required only one RN on staff and had no minimum staffing levels, while Norway and Sweden had no legislated staffing levels at all. It is hard to do exact comparisons because of the differences in the division of labour described above, because of the differences within countries in staffing levels, as well as in regulations, and because of the limited data available. Yet however the count is done, it is clear that staffing levels are much higher in Sweden and Norway than in Canada (Harrington et al., 2012; OECD, 2020). At the time of the survey,

staffing levels in Scandinavian care homes were estimated to be two to three times higher than in Canada (Harrington et al., 2012). And staffing levels do not usually count who is actually at work. While in our survey 46 percent of care home workers in Norway and 42 percent in Sweden worked under-staffed at least once a week, 46 percent of Ontario workers experienced working under-staffed on a more or less daily basis (Armstrong et al., 2009, p. 59).

Staffing levels are clearly higher in Scandinavia than in Canada. Current estimates for Sweden indicate that there are 3.3 residents per care worker on weekdays, daytime, and 4 residents per worker on weekends (Szebehely, 2020), while those for Norway indicate more than three times as many care workers and just under three times as many nurses as Canada (CIHI, 2020, table 2). Ontario residents average 2 hours and 45 minutes of care per day (Marrocco et al., 2021, p. 49), well below the minimum of 4.1 hours recommended more than a decade ago when care needs were less complex (Harrington et al., 2020). For-profit homes have even lower staffing levels, bringing down the average.

It is not only the number of staff that has an impact on the quality of work and the quality of care. It is also the proportion of work done by full-time, permanent employees. In all three countries, a significant number of workers are employed part time or on a casual basis, and this is especially the case for women. Part-time staff are less likely to know residents and the care home, making more work for full-time staff and making it harder for those working part time to support each other, undermining both continuity in care and teamwork. Part-time staff can also spread infections when they cobble together a living wage by working in multiple places. Just over half of the the publicly employed eldercare workers in Sweden are employed part time, compared to 70 percent in the private sector. In Ontario, only two-fifths of the nursing and care aide staff are employed full time (Ontario, 2020, pp. 1, 5). Although arduous working conditions or private life circumstances push some to prefer part-time employment, many in all three countries want full-time work (Drange & Vabø, 2021). In Sweden's private nursing home sector, this is the case for two out of five employed, compared to just under a quarter in the public sector (Municipal Workers' Union, 2021), and for half the Ontario care aides and three-quarters of the nurses.

Casually employed and agency workers create similar issues for permanent staff and for care quality, but they are even less likely to know the residents, other staff and the nursing home systems. Increasing numbers of workers in all three countries are employed temporarily by the day or even by the hour (OECD, 2020, figure 4.10). Among publicly employed Swedish care workers, one in four are employed by the hour. In Norway, more of these workers are on permanent contracts but are employed for fewer hours than they want

(SALAR, 2022; Drange & Vabø, 2021) while one in ten Ontario personal support workers are casual (Ontario, 2020, p. 5).

Data on staffing numbers are much more difficult to find for those who do the other work in long-term care, especially if their work is outsourced to other employers. Those in professional categories other than nursing often work part time, such as doctors and therapists, and this may well be the case with those who cook, clean, and do laundry. This was certainly the case in many of the homes we studied and is more likely the case when the work is outsourced to private companies. There is little detailed data on the hours worked by relatives, volunteers, and private companions either. As Chapter 8 shows, this unpaid labour can enhance or undermine the working conditions for paid staff.

In sum, staffing is a critical working condition. Staffing is significantly better in Norway and Sweden than in Canada and is evident in their higher retention and recruitment rates (OECD, 2020, figure 4.3), but Covid revealed weaknesses in all three countries. The Ontario Long-Term Care Commission heard evidence on a correlation between the increased severity of a Covid outbreak and greater mortality with both a lack of staff (especially care aides) and the use of agency staff (Marrocco et al., 2021, p. 21). Similarly, the Swedish Corona Commission pointed at the high levels of casual employment as a risk factor during the pandemic and concluded that "the employers must improve employment security and staff continuity in elderly care and sharply reduce the proportion of staff on zero-hours contracts" (SOU, 2020, p, 5). The parallel Norwegian investigation identified issues related to integrating these workers, and highlighted problems with cleaning and maintenance staff tending to work part time and for a private company (Jacobsen et al., 2021).

Workers' Health Risks

Nursing home work can be dangerous, and low staffing levels increase the risk. In our survey, Canadians were more than five times as likely as their Nordic counterparts to say they faced violence on a more or less daily basis (Armstrong et al., 2009, figure 28). Unwanted sexual attention was also much more common in Canada. Before Covid, the health sector ranked second highest in terms of time lost from injuries and "long-term care workers are among the most at risk for physical injury within the sector" (Ontario, 2020, p. 15). The most common injuries that result in work absences are musculoskeletal disorders, exposure to chemicals or contaminants, slips, trips, falls, and violence.

In both Sweden and Norway accidents are more likely to occur in nursing homes than in hospitals (OECD, 2020, figure 4.12), with Sweden reporting numbers just above OECD averages and Norway just below. Pre-pandemic, Norwegian work absences due to illness or injury were higher than in other

sectors (Grødem, 2018), and in Sweden, assistant nurses in eldercare have the highest absences of all occupations (Swedish Social Insurance Agency, 2022). But documented work absences hide the daily dangers workers face, especially from frustrated residents who lash out when staff do not respond quickly, or have no time to do tasks slowly, or to chat. Staff showed us teeth bites, scratches and bruises, and other injuries that did not get reported. Instead, as one Canadian care aid explained,

> [W]e're told "Suck it up. It's your job." And that's so frustrating because that's not my job. It's not my job to come to work and expect to be punched in the face. You know, it's not my job to come to work and expect to be hurt because you didn't staff the building properly so now I can't take care of my own family. (Braedley et al., 2017, p. 91)

In our survey, 43 percent of Canadian workers said they almost always finished the day mentally exhausted, but this was the case for only 8 percent of the Norwegian respondents and 16 percent of the Swedish ones (Armstrong et al., 2009, figure 23). Canadian direct care workers were more than twice as likely as their Norwegian counterparts to say they almost always ended their shift feeling inadequate (Armstrong et al., 2009, figure 19), and they were almost three times as likely as their Swedish counterparts to say that work keeps them awake at night (Armstrong et al., 2009, table 20). But workers in all countries felt the strain, and current research shows increasing strain (Stranz & Szebehely, 2018). In Ontario, half of care aides leave within five years and 43 percent of them leave because of burnout related to staffing (Ontario, 2020, p. 6).

Racialized staff may face additional health issues. They are more likely to be employed part time and work in multiple workplaces, experiencing precarious conditions that in themselves put them at risk. Indeed, such precarity may be a form of indirect racism that is more common than direct comments and exclusion (Simmons et al., 2021), although racist comments from residents, families, and other staff are common too and our research indicates that men in Sweden and Canada often face both direct sexism and racism (Storm, Braedley, & Chivers, 2017; Storm & Lowndes, 2021).

Limited training to meet current needs also poses a health risk (Simmons et al., 2021, p. 8). The increasingly complex needs of residents require formal preparation not only on entering work in nursing homes but on an ongoing basis. Those coming from another country also need education in the dominant culture and language to feel comfortable, and all staff need training in the residents' different cultures as well as in gender issues to help them avoid stressful interactions.

Pay and Benefits

Pay and benefits determine workers' access to essentials for living but they also indicate the value attached to them and their work. When we interviewed a human resources director in a Norwegian nursing home, we asked what had surprised her in her move from a corporate workplace. "How hard these women work!" she replied. Asked what she would do if she were in charge, she said, "I would pay these women what they pay the men on oil rigs, because the women work harder."

The relatively high rates of unionization in the sector provide some protections for permanent staff in all three countries, but this protection usually excludes those in casual or outsourced jobs. In Canada collective bargaining is often done for each facility and each union within facilities, so it is common for nursing home staff to be paid less than their hospital counterparts and for wages to be relatively low, especially compared to male-dominated unionized sectors. And wages are lowest in for-profit homes (Marrocco et al., 2021). Centralized bargaining helps explain why Sweden pays amongst the highest wages for this sector in the OECD (OECD, 2020, figure 4.5), as does Norway. And Sweden and Norway pay the same rates in hospitals and nursing homes.

Collective bargaining usually provides permanent staff with benefits such as pensions and sick leave. In Canada, paid sick leave is up to the employer or the collective agreement, with unions ensuring permanent unionized staff have some paid sick leave. However, sick leave coverage for part-time workers is limited and it usually does not exist for casual employees. Indeed, saving this cost can provide an incentive to employers to move away from offering full-time work. In Sweden, employers pay sickness benefits but the first day of illness is not paid. The one-day gap can be critical in health care, where workers going in sick put everyone at risk, Moreover, in Sweden, the growing number of casual employees who work in multiple workplaces are paid sick leave only for the days they are scheduled.

All three countries have universal medical and pension plans. Nevertheless, in Canada the kinds of extra benefits that unions negotiate are often denied to non-permanent employees and the growing number of immigrants working in health care can have only limited access to the universal benefits, while the low pay in the sector makes it difficult for them to pay privately. Unions can also provide workers with more power on a daily basis, allowing them the right to say no to unfair requests or conditions, while casual employment limits this power.

Work Organization

The more detailed division of labour in Canada than in the Nordic countries reflects both workers' efforts to protect their areas of work and the regulatory bodies that define scope of practice. These efforts have been shaped by regulatory rigidities (Baines & Daly, 2015) that have frequently been introduced in response to scandals, especially in for-profit homes (Lloyd et al., 2014). In North America, this has primarily meant more regulation of workers and more detailed documentation required of them, increasing surveillance over workers and reducing the time available for care without addressing larger structural issues (Chapter 10).

Nordic countries tend to have a more interpretive approach to regulation, identifying what to do but not when and how to do it, compared with the more prescriptive regulation in Canada that tends to identify what to do as well as when and how to do it (Daly et al., 2016). The Nordic approach may provide workers with more autonomy in applying their skills, although we saw considerable variation in the autonomy experienced by assistive personnel within the three countries (Jacobsen et al., 2017).

The flexible division of labour more common in the Nordic countries promotes the teamwork that allows staff to support and learn, both with and from each other in teams, especially when there is effective leadership and ongoing training (Choiniere, 2017). As one nurse we interviewed put it, "Teamwork is important because when you pull together, you get the best outcome and when you also work as part of a team, you know it makes life more joyous in a nursing home" (Armstrong et al., 2019). However, we also saw teamwork and flexibility undermined by outsourcing, which means staff have multiple different employers and there is more part-time, agency, and casual work and low staffing levels.

Workers in all three countries raised issues about scheduling. The workers we interviewed want more input into scheduling and more flexibility in hours to allow them to have a life outside their work. Some take scheduling into their own hands, trading shifts with other workers. Leadership is important here, as it is in the overall organization. Leaders who work with staff and include them in decision-making can improve both the quality of work and the quality of care. Indeed, involving the entire range of staff, families, and residents in decision-making can improve overall conditions, as they are experts on what is needed.

Workspaces

Physical environments shape both work and health. Factors such as clean air, the limited use of call bells, safe, easy-to-use equipment, flooring that makes

it comfortable to move wheelchairs, toilets placed to fit walkers, and effective lighting are just as important for those who do the work as they are to the residents (Chapter 7). Staff have shown us lifts over beds that cause them to strain their backs, medicine cabinets too high for them to reach, corridors with poor sightlines, and linen bags weighing too much to carry comfortably. These are only some of the features that make their work harder or even dangerous (Armstrong & Braedley, 2016). Larger structural features, such as the location of the nursing home, which determines access for both families and staff, and pleasant, separate spaces for staff to take breaks and to grieve, rather than in dark basements or crowded rooms in public view, are also critical to the conditions of work (Chapter 7). Tapping the expertise of those who work and live in the care home can go a long way towards designing workspaces that work for everyone.

In sum, working conditions are driving workers out of care. When our research began two decades ago, the Nordic countries clearly had significantly better working conditions than Canada. While this is still the case, none of the three countries has sufficiently adjusted staffing and training to meet the increasingly complex needs of residents, and increasingly they have all expected relatives to provide some unpaid care (Rostgaard et al., 2022). Recent Swedish research indicates worsening health and stress issues, along with growing numbers of workers wanting to leave the sector (Simmons et al., 2021; Stranz & Szebehely, 2018). Funding, ownership, regulations, and for-profit approaches to work provide the context. In Canada, for-profit homes "tend to offer lower wages and benefits to their staff, have higher staff turnover, and have lower staffing levels and staff-skill mix" (Marrocco et al., 2021, p. 68). Following Farmer (1996), we argue that these conditions are a form of structural violence that prevents nursing home workers from reaching their potential (Banerjee et al., 2012). Covid has made many of these conditions worse, while adding new ones.

RESPONDING TO COVID

Covid hit nursing homes hard. In Canada, this was especially the case in for-profit homes (Stall et al., 2020). All three countries stepped in and then stepped back in addressing the labour force crisis that was clearly a factor in protecting nursing homes. They initially focused their attention on hospitals, but the rising death rates and a shortage of both workers and Personal Protective Equipment (PPE) rapidly brought attention to nursing homes. All three countries initially banned relatives, until it became obvious that relatives provided social support, often along with other essential care, especially in Canada, where relatives undertook a broad range of tasks (Chapter 8). Many doctors began to work remotely while those providing care faced increasing

stress and issues with communications from governments. Although the countries responded in different ways that reflected their conditions, they all set up special commissions to investigate the crisis and made the labour force a primary concern. The Norwegian commission alone did case studies of nursing homes. But few major reforms have followed, in any of the countries.

Across all three countries, labour shortages resulted from the increasing pressures on staff that reflected both past and current conditions, and from work absences due to Covid and burnout. Workers stayed home because they too were ill or simply could not take it anymore, because they needed to provide care to a family member, or for children when schools closed in Norway and Ontario, or because they feared contracting the disease. The response varied, however.

Ontario suspended inspections and restricted workers (other than those from agencies) to one workplace, without offering any special supports (Carter, 2020). The federal government poured in money for PPE, provided vaccines that Ontario mandated for all health care workers, and sent in the military to rescue four Ontario care homes, all non-government owned. Pre-pandemic, the Ontario government limited wage increases for most health care workers to 1 percent for three years, legislation that further exacerbated the low pay in the sector. Responding to Covid, the government initially provided a temporary three-dollar raise to care aides, a raise made permanent in 2022. Nurses were offered one-time bonuses of $5,000 available to some, but no other wage increases. "A Plan to Stay Open" (Ontario, 2022) included a tuition refund for some nurses working in underserved areas, training for more doctors, and strategies to recruit more foreign trained workers.

Ontario did virtually nothing about working conditions, except for offering temporary, short-term, paid sick leave. The plan to train 6,000 new care aides did not learn from the province of Quebec, which hired and trained nearly 10,000 care aides during the pandemic, only to see 10 percent of them quit within the year because of working conditions (Radio Canada, 2022). In direct contradiction to the stress on the need for more training, Ontario introduced a "resident assistant" category – workers with no formal training or clear job description. Meanwhile, the government is funding new beds, many of which are in for-profit homes where working conditions tend to be even worse than in other care homes. Responding to the Commission, Ontario announced a target of four hours of care per resident per day – a minimum higher than current levels but far below current needs (Chapter 3), and with few penalties for failing to either report or meet these levels. There was limited progress on cleaning the care homes' air and the call for all residents to have private rooms was largely ignored.

During the pandemic, the Swedish government provided increased funding for staffing and for training 10,000 temporarily employed care aides to become

permanently employed assistant nurses. It also temporarily introduced pay for the first day of sick leave. Although the Corona Commission concluded that staff security and care continuity must be improved, it is not clear what is being done (SOU, 2020, p. 5). Following the Commission call for minimum training requirements, the government introduced legislation on a national standard for assistant nurses. In summing up, the Commission's interim report pointed to the "structural shortcomings that have been well-known for a long time … Staff employed in the eldercare sector were largely left by themselves to tackle the crisis" (SOU, 2020, p. 2).

In Norway, decision-makers became increasingly aware of the need for adapting to and caring for residents' families, leading to greater accommodation supporting their participation. However, there has been no parallel increase in awareness of the need for strengthening the support for staff. Although working conditions were highlighted by the pandemic and in reports, there were few permanent or significant improvements in working conditions other than in infection control. Meanwhile, some tasks usually restricted to nurses were temporarily assigned to other staff who did not have the training. Although some issues were raised about temporary and part-time workers, such as cleaners and food service workers, it is not clear what this means in the long term. With responsibility for care homes primarily left to municipalities, concern was raised over national leadership and problems with communications around strategies to address the pandemic. At the same time, however, Norway reported that the pandemic supported more cooperation and cohesion among some staff and increased knowledge of infection control.

All three countries introduced some measures to protect residents and staff, but many measures were temporary, like sick leave and bonuses. Problems with casual and part-time employment were acknowledged. However, little was done to address this issue in the long term. The need for skills was recognized at the same time as those without formal training were required to do the work. Norway, with higher staffing levels and more RNs, did better than either Canada or Sweden (Comas-Herrera et al., 2022).

SUPPORTIVE WORKING CONDITIONS WOULD TRANSFORM NURSING HOMES

The pandemic has made it clear that the conditions of work are the conditions of care, that poor conditions are driving workers out of care and that without a workforce, there is no care. Planning begins with recognizing that nursing homes are places of work and places to live as well as places to receive skilled care and support. It also means recognizing that care is a relationship. A nurse we interviewed explained that the "relationship that you build with them … helps you to care for them because you get to know them on a different level

and you get to know exactly what their needs are and how to approach them when it comes to certain things" (Armstrong et al., 2019). Looking after residents and creating relationships requires looking after staff.

As the Swedish Corona Commission (2021, p. 15) put it, it is necessary "to offer health care staff working conditions that encourage them to remain and develop in their professions." Years of research, years of reports, and years of commissions have identified essential ingredients in those conditions. They begin with an appropriate number of staff, with the appropriate skills (Harrington et al., 2020). Norway was able to limit Covid's impact in part because of the large numbers of RNs on staff. Determining staffing numbers means taking the increasing complexity of resident needs into account, while also understanding the critical importance of social supports for residents, staff, and families. Determining the skills required means recognizing that specialized skills are involved in the entire range of care work – whether it is cleaning or clinical, whether it is done by staff, families, or volunteers. Skills training should be provided as part of the job as the resident population grows and the research develops. These skills include learning about what is called cultural safety (Curtis et al., 2019), understanding the power imbalances related to race, gender, sexuality, and culture for residents, staff, and families.

And staff skills, as well as the demanding and responsible nature of the work, should be recognized in pay, benefits, and work environments. Access to fully paid sick days is important for all the staff, given that they are in contact with people in fragile health every day. Physical and social environments and equipment need to be designed for both safe work and safe living, while recognizing a healthy life involves some risk. At the same time, given the health risks of the jobs, a wide range of injuries and illnesses should be automatically recognized as work-related and deserving of compensation.

To develop care relationships with residents, families and other workers, staff need security. This means permanent employment, whether the employment is full time, which should be the case for the majority, or part time, to allow flexibility. Employment security allows teams to develop, especially when combined with appropriate training for staff, considerable autonomy in applying those skills, and leadership that promotes all of the above. Security and teamwork in turn require that all those working in the home have the same employer, avoiding any outsourcing of services. Unions are important in supporting security in multiple ways.

Care relationships not only take time to build through the continuity that comes with permanent staff employment but take time during the workday and worknight. This means flexibility in the way tasks are carried out and a recognition that care involves much more than a set of tasks (Chapter 3). Care relationships outside the care home also need to be recognized and negotiated in organizing scheduling.

Means for effective communication and meaningful participation of all those who live in, work in, and visit care homes is a critical component in the structures that support working conditions. The pandemic emphasized the need for better means of communicating, better training in communicating, and better content in communications. Effective communications can provide the basis for effective participation in decision-making, which is another critical working condition that requires leadership and structural supports.

All these conditions depend on appropriate funding, regulation, and approaches to care, which our research indicates means avoiding for-profit ownership and methods (Armstrong & Armstrong, 2020). The pandemic has revealed major structural weaknesses in care homes, encouraging many to call for their abolition. Care homes could be transformed to offer a positive living and working space, and the experience of Covid offers the opportunity to learn how to make them as good as they can be. As one nurse explained to us, the work can bring joy:

> It's about making a real difference in my residents' lives. If they are hurting, I can help ease that suffering for the most part. I can make them warm. I can get them something to eat. I can help them find something that's lost. I can help them with social activities. Those little things are all about quality of life. (Armstrong et al., 2019)

The joy requires supportive working conditions. We know what to do, but it requires political will.

REFERENCES

Armstrong, P. (2019). Care summit, University of Toronto. Abridged keynote. (2021). *International Journal of Care and Caring*, *5*(1), 159–164. doi:10.1332/239788220X16081402419391

Armstrong, P., & Armstrong, H. (Eds.). (2020). *The Privatization of Care: The Case of Nursing Homes*. Routledge.

Armstrong, P., & Braedley, S. (Eds.). (2016). *Physical environments for long-term care*. Canadian Centre for Policy Alternatives.

Armstrong, P., Armstrong, H., Choiniere, J., & Lowndes, R. (2019). *RNs in long-term care: A portrait*. Ontario Nurses Association. https://www.ona.org/carenow/

Armstrong, P., Banerjee, A., Szebehely, M., Armstrong, H., Daly, T., & Lafrance, S. (2009). *They deserve better: The long-term care experience in Canada and Scandinavia*. Canadian Centre for Policy Alternatives.

Baines, D., & Daly, T. (2015). Resisting regulatory rigidities: Lessons from front-line care work. *Studies in Political Economy*, 95(1), 137–160. doi:10.1080/19187033.2015.11674949

Banerjee, A., Daly, T., Armstrong, P., Armstrong, H., Szebehely, M., & Lafance, S. (2012). Structural violence in long-term, residential care for older people: Comparing Canada and Scandinavia. *Social Science & Medicine*, *74*(3), 390–398.

Braedley, S. (2006). Someone to watch over you: Gender, class and social reproduction. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy takes on neoliberalism* (pp. 215–230). McGill Queens University Press.

Braedley, S., Owusu, P., Przednowek, A., & Armstrong, P. (2017). We're told, "suck it up": Long-term care workers' psychological health and safety. *Ageing International*, *43*(1), 91–109. doi:10.1007/s12126-017-9288-4

Canadian Institute for Health Information (CIHI). (2020). *Pandemic experience in the long-term care sector: How does Canada compare with other countries*? CIHI. https://www.cihi.ca/en/long-term-care-and-covid-19-international-comparisons

Carter, A. (2020). Loophole in Ontario's Covid-19 long-term care plan allows temp workers in multiple homes. CBC News (April 16). https://www.cbc.ca/news/canada/toronto/ontario-long-term-care-covid-coronavirus-1.5534306

Choiniere, J. (2017). A flexible division of labour. Potential for choice. In P. Armstrong & T. Daly (Eds.), *Exercising choice in long-term residential care*. Canadian Centre for Policy Alternatives.

Chrisler, J., Barney, A., & Palatino, B. (2016). Ageism can be hazardous to women's health: Ageism, sexism, and stereotypes of older women in the healthcare system. *Journal of Social Issues*, *72*(1), 86–104. doi:10.1111/josi.12157

Colombo, F., Llena-Nozal, A., Mercier, J., & Tjadens, F. (2011). Help wanted? Providing and paying for long-term care. OECD *Health Policy Studies*, OECD. https://www.oecd.org/els/health-systems/help-wanted-9789264097759-en.htm

Comas-Herrera, A., et al. (2022). *LTCcovid International living report on Covid-19 and long-term care*. LTCcovid, Care Policy & Evaluation Centre, London School of Economics and Political Science. https://doi.org/10.21953/lse.mlre15e0u6s6

Curtis, E., Jones, R., & Tipene-Leach, D. et al. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *Internal Journal for Equity in Health*, *18*, 174. https://doi.org/10.1186/s12939-019-1082-3

Daly, T., & Armstrong, P. (2016). Liminal and invisible long-term care labour: Precarity in the face of austerity. *Journal of Industrial Relations*, *58*(4), 473–490.

Daly, T., & 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*, 37–71.

Drange, I., & Vabø, M. (2021). A cross-sectional study of sustainable employment in Nordic eldercare. *Nordic Journal of Working Life Studies*, *11*(S7). https://doi.org/10.18291/njwls.128595

Duffy, M. (2011). *Making care count: A century of gender, race, and paid care work*. Rutgers University Press. http://www.jstor.org/stable/j.ctt5hj9gr

Estabrooks, C. et al. (2020). *Restoring trust. Covid-19 and the future of long-term care.* Royal Society of Canada. https://rscsrc.ca/sites/default/files/LTC%20PB%20%2B%20ES_EN_0.pdf

Farmer, P. (1996). On suffering and structural violence: A view from below. *Daedalus*, *125*(1), 261–283. http://www.jstor.org/stable/20027362

Grødem, A. (2018). *ESPN thematic report on challenges in long-term care*. European Commission.

Harrington, C., Dellefield, M. E., Halifax, E., Fleming, M. L., & Bakerjian, D. (2020). Appropriate nurse staffing levels for U.S. nursing homes. *Health Services Insights*, *13*, 1–14. https://doi.org/10.1177/1178632920934785

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), 88–98. https://doi-org.proxy.library.carleton.ca/10.1177/0164027521989074

Harun, R., & Walton-Roberts, M. (2022). Assessing the contribution of immigrants to Canada's nursing and health care support occupations: A multi-scalar analysis. *Human Resources for Health*, *20*(53). https://doi.org/10.1186/s12960-022-00748-7

Jacobsen, F., Day, S., Laxer, K., Lloyd, L., Goldmann, M., Szhebehely, M., Choiniere, J., & Rosenau, V. P. (2017). Job autonomy of long-term residential care assistive personnel: A six country comparison. *Ageing International*, *43*(1), 4–19. doi:10.1007/s12126-017-9291-9

Jacobsen, F. F., Arntzen, C., Devik, S. A., Førland, O., Krane, M. S., Madsen, L., Moholt, J.-M., Olsen, R. M., Tingvold, L., Tranvåg, O., Ågotnes, G., & Aasmul, I. (2021). Erfaringer med Covid-19 i norske sykehjem. *Senter for omsorgsforsknings rapportserie*, NR 1/2021.

Kjøs, B., & Havig, A. K. (2016). An examination of quality of care in Norwegian nursing homes – A change to more activities? *Scandinavian Journal of Caring Sciences*, *30*(2), 330–339. https://doi.org/10.1111/scs.12249

Laxer, K., Jacobsen, F., Lloyd, L., Goldmann, M., Day, S., Choiniere, J., & Rosenau, P. (2016). Comparing nursing home assistive personnel in five countries. *Ageing International*, *41*(1), 62–78.

Lloyd, L., Banerjee, A., Harrington, C., Jacobsen, F. F., & Szebehely, M. (2014). It is a scandal!: Comparing the causes and consequences of nursing home media scandals in five countries. *International Journal of Sociology and Social Policy*, *34*(1/2), 2–18.

Marrocco, F. A., Coke. A., & Kitts, J. (2021). *Ontario's long-term care Covid-19 commission final report.* http://www.ltccommission-commissionsld.ca/report/pdf/20210623_LTCC_AODA_EN.pdf

McGregor, M. (2016). Residential long-term care – Where do physicians fit in (or don't they)? *Journal of Canadian Studies*, *50*(2), 299–320.

Municipal Workers' Union. (2021). *Så mycket bättre?* [So much better?]. https://webbfiler.kommunal.se/sites/default/files/sa_mycket_battre_2021_1.pdf

OECD. (2020). *Who cares? Attracting and retaining care workers for the elderly*. OECD Health Policy Studies, OECD Publishing. https://doi.org/10.1787/92c0ef68-en

Ontario. (2020). *Long-term care staffing study*. https://www.ontario.ca/page/long-term-care-staffing-study

Ontario. (2022). Ontario introduces a plan to stay open. March 29. https://news.ontario.ca/en/release/1001878/ontario-introduces-a-plan-to-stay-open

Radio Canada. (2022). CHSLD: Plus de 1000 préposés qui ont suivi la formation accélérée ont quitté le réseau. https://ici.radio-canada.ca/nouvelle/1901827/chsld-programme-formation-acceleree-departs-preposes

Rostgaard, T., Jacobsen, F.F. & F., Kröger, T. et al. (2022). Revisiting the Nordic long-term care model for older people – still equal? *European Journal of Ageing*, *19*, 201–210. https://doi.org/10.1007/s10433-022-00703-4

SALAR. (2022). Tabell 4. Antal anställningar, faktiska årsarbetare, sysselsatta och helt lediga efter AID-etikett (yrke) i kommuner nov 2020. https://skr.se/skr/arbetsg

ivarekollektivavtal/uppfoljninganalys/personalstatistik/personalenisiffror/tabeller kommunalpersonal2021.62991.html
Simmons C., Rodrigues, R., & Szebehely, M. (2021). Working conditions in the long-term care sector: A comparative study of migrant and native workers in Austria and Sweden. *Health and Social Care in the Community*. https://doi.org/10.1111/hsc.13657
Socialstyrelsen. (2021). *Vård och omsorg för äldre. Lägesrapport 2021* [Health and social care for older people. Status report 2021). National Board of Health and Welfare.
SOU. (2020). Äldreomsorgen Under Pandemin [Eldercare During the Pandemic]. English Summary. https://coronakommissionen.com/wp-content/uploads/2020/12/summary.pdf
Stall, N. M., Jones, A., Brown, K. A., Rochon, P. A., & Costa, A. P. (2020). For-profit long-term care homes and the risk of Covid-19 outbreaks and resident deaths. *Canadian Medical Association Journal*, *192*(33), e946–e955. doi:10.1503/cmaj.201197
Statistics Norway. (2018). Innvandrerne sto for 1 av 6 årsverk innen omsorg - SSB
Statistics Sweden. (2022). Employees (the Swedish Occupational Register) 16–64 years by region of birth, sex, year and occupation (SSYK 2012). https://www.statistikdatabasen.scb.se/pxweb/en/ssd/START__AM__AM0208__AM0208E/YREG53N/
Storm, P., & Lowndes, R. (2021). "I don't care if they call me black": The impact of organisation and racism in Canadian and Swedish nursing homes. *International Journal of Care and Caring*, *5*(4), 631–650.
Storm, P., Braedley, S., & Chivers, S. (2017). Gender regimes in Ontario nursing homes: Organization, daily work, and bodies. *Canadian Journal on Aging*, *36*(2). doi:10.1017/S0714980817000071
Stranz, A., & Szebehely, M. (2018). Organizational trends impacting on everyday realities: The case of Swedish eldercare. In K. Christensen & D. Pilling (Eds.), *The Routledge handbook of social care work around the world* (pp. 45–57). Routledge.
Swedish Corona Commission (SOU). (2021). Summary report. https://coronakommissionen.com/wp-content/uploads/2021/10/summary-sweden-in-the-pandemic.pdf
Swedish Social Insurance Agency. (2022). Försäkringskassans statistik om sjukfrånvaro per yrke, table 4. Sjukpenning och rehabiliteringspenning (forsakringskassan.se)
Szebehely, M. (2020). *Internationella erfarenheter av covid-19 i äldreboenden*. Report for the Swedish Corona Commission.