

#2004-07  
June 2004

## **Long-Term Workers in Five Countries: Issues and Options**

by  
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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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## **Acknowledgments**

The author thanks Dr. Anna L. Howe, consultant gerontologist, past director of the Australian Commonwealth Government's Office for the Aged, and past deputy director of Australia's National Ageing Research Institute, for helpful insights into the interpretation of data on Australia, and Professor Françoise Acker of the Centre de Recherche Médecine, Sciences, Santé Et Société (CERMES), Paris, France, for her generosity with French sources. All errors are solely the author's responsibility.

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## Foreword

According to the United Nations, persons aged 65 and older accounted for nearly 7 percent of the world's population of 6 billion in 2000. This share is projected to exceed 10 percent by 2025 and approach 16 percent by 2050.

The aging of the population will bring with it increased needs for long-term services and supports. The United States is currently experiencing problems attracting adequate numbers of qualified direct service long-term care workers. Turnover is high; wages are low; training is not always adequate or consistent; and working conditions are often lonely, difficult, and unrewarding. Options for improving recruitment, training, financing, and retention of the long-term care workforce in the United States have been explored in detail elsewhere.

Rather than examining the U.S. situation, this report looks outward. It surveys selected long-term care workforce developments in five countries: Denmark, France, the Netherlands, Canada, and Australia. AARP asked the author to describe both "big-picture" policy directions and small, low- or no-cost operational changes taking place in these countries. While the scope of the report does not address *why* these approaches succeed or fail, it provides a window through which key features of each country's system can be viewed.

The report concludes that increasing the supply of workers serving the aged and persons with disabilities and improving their working conditions present similar challenges in all the study countries. But it illustrates that there are options, both large and small, to meet these challenges.

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## Executive Summary

### Background

According to the U.S. Bureau of Labor Statistics (BLS), the United States will need nearly 900,000 new paraprofessional long-term care workers between 2002 and 2012. The nation is currently experiencing a severe shortage of these workers, who are the main concern of this report.

### Purpose and Methodology

While the United States is facing an increase in its older population, many other countries are further along in the aging process. Many developed countries organize their health care and long-term care systems differently from the United States. The United States can learn from countries that have adopted different institutional and policy arrangements for meeting the challenges of an aging population.

This report examines selected aspects of both policy and performance in the long-term care workforce in Denmark, France, the Netherlands, Canada, and Australia. The report is not intended to provide a comprehensive analysis of any country's system, but rather describes selected aspects of systems that are unique to each country. Because home and community care are becoming an increasingly important part of long-term care policies around the world, this report focuses largely on conditions facing the home care workforce.

**Workers considered.** The report focuses on frontline workers, including nurse's aides, personal care workers, personal assistants, and other similar occupational categories as these are understood in other countries. These workers have frequent, usually daily, contact with clients. Nurses, physicians, middle managers, and social workers, who also play a frontline role in some instances, are generally excluded from this report.

**Countries chosen.** Choosing only five countries to study involved some personal judgment. The countries were selected to complement and contrast with each other and with the United States. The workforce problems discussed in the five countries are not unique to these countries, though they may manifest themselves differently as a result of differences in economic, political, or institutional arrangements.

### Major Findings and Conclusions

The long-term care workforces in the study countries share many features with one another and with that in the United States. The overwhelming majority of care workers in the study countries are female, and many are aged 45 years and older. Care work is frequently part time and often pays at or near the minimum wage. The comparison of conditions in the study countries yields several major conclusions.

**Funding.** Funding shortages have led to inadequate staffing and service shortages in Canada, Australia, and the Netherlands. Added funding can probably be usefully spent on pay and benefits, training, and restructuring jobs to create more career paths, provide stable income for employees, and attract both younger workers and men.

**Pay and unions.** Both Denmark and the Netherlands have relatively high-paid care workers and strong unions, but Denmark has fewer staffing shortages. One difference between the Danish and the Dutch experiences is that Denmark has integrated training with employment, offering aspiring professionals a chance to earn income and gain on-the-job experience as they study, and creating career paths that can reward further training.

**Hours.** Part-time or temporary work clearly suits some people. However, such jobs are not typically considered “good” jobs by many prospective employees, especially the younger workers many countries want to attract to care work.

Work hours can be a particularly difficult issue in home care. Workers may be required to work split shifts, with some hours in the morning and some later in the day, and agencies may subdivide shifts even further. Such hours can be particularly punitive for workers who must travel long distances and are not paid for travel time between clients. Many researchers believe that this kind of scheduling leads to a limited availability of workers and a high turnover rate that adversely affect the quality of care.

Experience in the study countries suggests that the care sector’s problems of recruitment and retention can be alleviated by offering guaranteed hours, with adequate wages and benefits. The sector may need to address such issues as paying for time spent in staff and planning meetings and travel time between home care clients.

**Training.** There may be few alternatives to employer or public sector funding to train care workers. Since care work is generally a low-paid field, prospective employees are unlikely to have or be willing to invest their own funds to acquire needed qualifications. Unless workers acquire these qualifications, however, many may face barriers to employment or limited career paths. To the extent that the qualifications are relevant to job performance, the quality of care will suffer if untrained workers are hired or if they do not receive training after being hired.

Some research suggests that training models and approaches for direct care workers may need to be revised. In many countries, there is easy access to lower skilled occupations in elder care, but little vertical or horizontal mobility once workers are in the profession, let alone access to more professionalized occupations, such as nursing, that require formal advanced training. This lack of career mobility can make care work a dead-end occupation, both in the perception of potential employees and in fact.

**The care worker’s role in service delivery.** Care workers are often not considered members of their clients’ health care and long-term care teams, despite their extensive contact with the client

and understanding of the client's needs. Consequently, the care worker is not included in care planning, which can reduce care workers' job satisfaction as well as the quality of care.

**Conclusions.** All five study countries face problems concerning pay, hours, training, and the care worker's role in service delivery. Adequate pay is the foundation on which workforce improvements must be built, but the experiences of the study countries suggest that other elements are also important. Many care workers put in uncompensated time—in care planning and client-to-client travel, for example—that decreases their effective earnings per hour. Many want full-time jobs, with adequate wages and benefits, rather than part-time or irregular hours.

Training care workers—particularly those who provide home care—becomes more important as medical advances permit more persons with complex needs to live in the community rather than in specialized institutions. Training—whether in the classroom or the workplace—also is necessary to provide the horizontal and vertical career mobility that will keep workers in the profession.

Moreover, the care worker's frontline role needs to be recognized in service delivery. A better paid and better trained workforce will provide better care, which should be the ultimate goal of workforce policies.

Care work is often “invisible” work. Care workers may be low-paid, part-time, or temporary workers, and in the case of home care workers, may not have a usual workplace where they can receive professional supervision, collegial support, and training. But these workers are not invisible to their growing ranks of clients. The findings of this report suggest that improving the economic and professional status of these workers is likely to improve the quality of care as well.

## INTRODUCTION

In the United States, the paraprofessional long-term care workforce suffers from well-documented problems: turnover is high; wages are low; training is not always adequate or consistent; and working conditions are often lonely, difficult, and unrewarding (Stone and Wiener 2001). Many employees work part time. Part-time workers generally earn less per hour than full-time workers doing the same work, and part-time jobs are less likely than full-time jobs to offer employer pension or health care coverage. And the work can be dangerous. For example, long-term care workers who provide care in clients' homes are more prone to work-related injuries from trying to move clients without the necessary equipment and without assistance.

This workforce is projected to account for important job growth in coming decades. According to the U.S. Bureau of Labor Statistics (BLS), 2 of the 20 fastest growing occupations between 2002 and 2012 and 3 of the 20 occupations with the largest job growth are related to the provision of long-term care services and supports in residential facilities and in clients' homes:<sup>1</sup>

- Home health aides provide health-related services that help elderly, convalescent, or persons with disabilities live in their own homes rather than in a long-term care facility or other institution. The need for home health aides is projected to grow by 48 percent between 2002 and 2012.
- Personal and home care aides provide housekeeping and routine personal care services that are instrumental in helping persons with disabilities live in the community. The need for personal and home care aides is projected to grow by 40 percent between 2002 and 2012.
- Nurse's aides, orderlies, and attendants (about half of whom are employed in nursing homes), along with personal and home care aides and home health aides, are among the top 20 occupations projected to add the most jobs over the next decade.

Together, these three occupational groups will require nearly 900,000 workers by 2012 (see table 1).

The BLS is projecting only *needs or job openings* for workers; that is, the hiring required to meet net employment growth and to replace workers who leave each year (Horrigan 2004). It is not projecting the *supply* of workers; that is, the number of workers who will actually emerge to occupy these jobs. Therefore, shortages in particular occupations may occur. Such shortages could result in persistent vacancies, despite rising wage offers to fill the vacant jobs, wage growth in excess of that prevailing in the general economy, or various dynamic adjustments by

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<sup>1</sup> Occupations projected to add a large number of jobs may not necessarily also be growing rapidly in percentage terms, while those growing rapidly in percentage terms may be adding only a small number of jobs because they are growing from a smaller base. Thus, the same occupations will generally not appear in both the "fast growth" and "job gain" categories. The BLS projects future needs for more than 500 detailed occupations.

employers, such as changing the way jobs are defined or performed or hiring contract workers, immigrants, or offshore labor.

Options for improving the management of the U.S. long-term care workforce have been explored in detail elsewhere (see, for example, Stone and Wiener 2001). This report looks outward. Demographically, the United States is young among developed countries; many countries are further along in the aging process (Angle and Newman 2002).

In addition, many developed countries organize their health and long-term care systems differently than those in the United States. The United States can learn from countries that are facing specific challenges and have adopted certain institutional and policy arrangements for meeting those challenges. The report surveys selected long-term care workforce developments in five countries—Denmark, France, the Netherlands, Canada, and Australia. It describes both big-picture policy directions and small, low- or no-cost on-the-ground operational changes, placing them in the context of each country's health and social services system. The scope of this report precludes a comprehensive view of any one country's system; the intent is to provide a look at key features of each country's system and to suggest useful lessons for the United States. The principal focus of the report is on home care, because this is the main focus of long-term care policies in most developed countries.

Doty (1990) cautions against assuming that other countries have solved their long-term care problems, pointing out that means-testing and cost-sharing for long-term care are commonplace; that many countries have fragmented long-term care systems, just as in the United States; and that other countries do not necessarily do a better job of preventing the institutionalization of the elderly. Many workforce problems—low status, difficult working conditions, limited career paths—are common to most developed countries. This report attempts to focus on what makes each country a little different and on how those differences may matter in solving the core policy and human resource problems of care work.

The report begins with a discussion of methodology. It then turns to demographic conditions in the United States and the five study countries, and a brief comparison of the countries' long-term care systems. Finally, it reviews selected current issues related to the care workforce in each country, beginning with the three European countries and concluding with Canada and Australia.

## **METHODOLOGY**

### **Workers Considered**

The report focuses on frontline workers, including nurse's aides, personal care workers, personal assistants, and other similar occupational categories as understood in the United States and the five other study countries. These workers have frequent, usually daily, contact with clients. Except to the extent that data cannot be satisfactorily disaggregated, the report does not

consider nurses, physicians, middle managers, and social workers. Even though these professionals also play a frontline role in the provision of long-term care, the challenges they face are different from those faced by the workers who provide services on a direct, daily basis (van Ewijk, Hens, and Lammersen 2002a).

Reflecting the prevailing usage in the study countries, the workers are referred to as “care workers.” This term is often applied to persons who provide support services and health care to clients and patients across the age spectrum; therefore, depending on the context and data source, it is not always possible to distinguish workers who provide services to children and young people from those who deliver home care or other services to the elderly or persons with disabilities.

### **Countries Chosen**

Choosing only five countries to study required some personal judgment. A first screen for selecting countries was that the issue of long-term care for the elderly and persons with disabilities, and the paraprofessional workers who provide this care, should be receiving some public attention. This attention included national reports and analyses as well as legislative or regulatory changes.

The countries were also selected to complement and contrast with each other. Australia was selected because, like the United States, it is a multiethnic English-speaking country. Canada was selected because it is a close neighbor of the United States and, like the United States, organizes its long-term care system largely at the subnational (provincial and territorial) level. France was selected because it explicitly uses long-term care workforce policies not only to deliver services but also to provide employment opportunities for lower skilled and unemployed workers. Denmark and the Netherlands were selected because they contrast with France and with each other. France strictly separates the delivery of health and social services to the elderly and to persons with disabilities; in Denmark and the Netherlands, the delivery of both kinds of services is substantially integrated. Denmark is also of interest because of its strong attention to the training of care workers.

The selection of these five countries by no means implies that developments in other countries are not of interest or worth considering as policy models; that worthwhile efforts are not being made elsewhere; or that these countries represent the full range of workforce issues, challenges, and solutions in developed countries. Nor are the workforce problems discussed in the five study countries unique to these countries, although they may manifest themselves differently in different countries because of variations in economic, political, or institutional arrangements.

### **Sources of Information**

The information used in this report was compiled from a wide range of sources, including government and special commission reports; studies by nongovernmental organizations (NGOs);

books, conference presentations, and journal articles; news publications; government and nongovernment agency Web sites; and personal communications from long-term care experts in selected countries.

## **Data Comparability**

Much of the research consulted for the report notes the difficulties in finding comparable transnational data on long-term care use and on the care workforce. One comparability problem arises from the fact that different countries have different terms for what may be substantially the same kind of employee or type of living arrangement for elderly persons or those with disabilities. Other comparability problems stem from cross-country differences in health status, educational and social insurance systems, occupational recognition and regulation, and political and economic institutions.

## **Issues Not Covered in This Report**

This report does *not* cover several major policy issues related to long-term care:

**Informal care.** The report largely excludes the topic of informal care—care provided without charge by family, friends, or volunteers. It is generally agreed that such care accounts for 70 to 80 percent or more of all long-term care provided to older adults. Informal care is a very large subject in itself and has been the subject of extensive research (see, for example, Keefe and Fancey 1998; World Health Organization (WHO) 1999).

**Medical care.** The scope of the report is limited to workers who provide social services rather than medical care. However, some countries integrate the delivery of social services and medical care, which makes it difficult to draw this distinction consistently. This issue is examined further in the country discussions.

**The content of training.** The report discusses who pays for training (government, employers, or trainees); which jobs generally require formal training and at what level; and, when the information is available, whether experience can be substituted for training to earn credentials. It does not cover the content of training or differences in training among workers in residential and home care environments. Like the topic of informal care, this is a very large subject worthy of separate treatment.<sup>2</sup>

**The supply of frontline care workers.** The BLS projects U.S. demand for direct care workers to provide services to persons with disabilities, but neither the BLS nor this report projects the supply of such workers. Such projections would depend on a number of factors that are difficult to project, including overall economic conditions that influence employment choice; demographic factors such as fertility rates; and political decisions concerning such diverse issues

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<sup>2</sup> The research literature on training also tends to be highly country-specific, and therefore has little transferability to an international audience (WHO 1999).

as immigration policy, the funding of health and social services systems, policies regarding welfare and unemployment benefits, and training for occupations in the care work domain.

**The role of immigration.** Immigrants are important in the care workforces of many countries. However, immigration policy is outside the scope of this report, and it does not discuss options for altering immigration policies to increase the supply of care workers.<sup>3</sup> Rather, the report focuses on structural problems in care work that deter prospective employees from selecting it and on improvements in workforce policies to make care work more attractive for both native-born and immigrant workers.

**Number of care workers.** The report does not extensively discuss the number of care workers in each country. Because the five study countries vary widely in population, a discussion of the size of the care workforce would have to take into account not only need levels in each country but also differences in political and program philosophies that make eligibility for long-term care universal in some countries and means-tested in others.

**Comparison with the United States.** The purpose of this report is to draw lessons for U.S. policies regarding the long-term direct care workforce, but space and time limitations preclude direct comparisons of the U.S. system and policies with those in the study countries.

**Other system elements.** The report focuses on describing workforce conditions and policies but does not explore in detail the factors that affect the development of these conditions and policies. Such factors include national and local labor force policies; government structure and the division of responsibilities among levels of government; the roles of private and public sector providers of health care and long-term care; and financing of the health and long-term care systems.

## **BACKGROUND**

The United States and the five study countries differ in their demographic profiles, their current and likely future long-term care needs, and the structure of their long-term care systems. In contrast, their care workforces bear remarkable similarities.

### **Demographic Profiles**

One important way to understand a country's long-term care needs is through its demographic profile. The larger the relative size of a country's elderly population, the greater its long-term care needs will generally be.

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<sup>3</sup> The United States offers H-1B visas to nonimmigrant aliens who will be employed temporarily, primarily in specialty occupations. A specialty occupation is defined as one requiring theoretical and practical application of a body of specialized knowledge, along with at least a bachelor's degree or its equivalent ([www.uscis.gov](http://www.uscis.gov)). Care workers do not generally have a college or university degree, although some categories of care workers may have formal postsecondary training that is creditable toward the acquisition of such a degree. Care workers as defined in this report are not generally eligible for U.S. immigration visas under the H-1B program.

The United States, Australia, and Canada are the younger countries in this report, while the three European countries are older. In the younger countries, less than 13 percent of the population was 65 years or older in 2001–2002 (table 2). In the Netherlands, Denmark, and France, the percentages were 13.6, 14.8, and 16.2, respectively.

### **Long-term Care Needs, Projections, and Care Systems**

**Needs.** A useful way to compare long-term care needs across countries is by examining disability projections based on the Global Burden of Disease (GBD) project<sup>4</sup> and United Nations population projections.<sup>5</sup> These projections have been used to estimate the number of persons who need assistance with activities of daily living (medical care needs are not included) at least once a day and project this number forward to 2050 (Harwood and Sayer 2002).<sup>6</sup> Daily care needs can be met in an institutional setting as well as in the community or home.

**Projections.** Over the period 2000–2050, long-term care needs in the United States and the five study countries are projected to rise sharply between 2000 and 2030, as measured by the percentage of the population that will require care more than once a day (table 3). After 2030, the growth of this population is projected to level off in all six countries.

The advantage of projections based on the GBD project is that the underlying approach is standard for each country, and thus the data have a uniform interpretation. But projections of long-term care needs depend on definitions and assumptions. The health conditions included in the GBD project and the care demands associated with these diagnoses affect projections of care needs; including different conditions and associating different care needs with them would alter the projections.

Likewise, the GBD project assumes that age-specific patterns of disability—and hence care needs—will remain constant over the forecast period. This assumption may be unduly pessimistic—not taking into account improvements in technology, medical research, and self-care. Or it could be unduly optimistic, according to researchers who see increased disability rates among working-age adults in the United States. Increased disability rates resulting from problems such as obesity could reverse the decline in institutionalization observed in the current elderly generation (Lakdawalla, Goldman, and Bhattacharya 2003; Lakdawalla et al. 2003). This point of view is controversial; some observers project declines in disability rates (Manton 2003).

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<sup>4</sup> The GBD project is run jointly by the World Health Organization (WHO) and the Harvard University School of Public Health. The GBD projections are currently being updated and revised.

<sup>5</sup> The GBD project estimates the long-term care needs of disabled children and young adults as well as those of working-age adults and the elderly. The original mandate for the present study was to examine the long-term care needs of adults age 50 and older. Because of the way GBD data are presented, the discussion in this section includes adults age 45 years and older.

<sup>6</sup> Harwood and Sayer (2002) explain the seven disability categories surveyed in the project (two of which are presented in tables in this report) and discuss empirical validation of the GBD estimates.

**Long-term care systems.** Most developed countries have adopted a national policy aimed at encouraging home care rather than group residential care for elderly persons in need of services.<sup>7</sup> Data on service use must be interpreted carefully because of cross-national differences in definitions of home care and institutional or residential care that may not always be fully reconcilable (Gibson, Gregory, and Pandya 2003). However, with these caveats, several conclusions can be drawn about the general outlines of the long-term care systems in the six countries considered in this report:

- Home care serves more individuals than institutional care among the population age 65 and older in all countries except France (table 4).<sup>8</sup> Elderly persons are from 50 percent more likely (Netherlands) to almost four times more likely (Australia) to receive home care than to live in an institution.
- Both institutional and home care rates vary widely across countries. For example, the institutional care rate in the United States is less than half that in Denmark, while the home care rate in France is about a quarter that in Denmark (table 4).
- Institutional and home care rates are not always related. For example, Australia has the second-lowest rate of institutional care and the second-highest rate of home care. But Denmark has the highest rates of both institutional and home care. Thus, while government policies may promote home care as an alternative to institutional care, many other factors influence the proportion of older persons receiving each type of care. These factors include the specific design and implementation of long-term care policies in each country (which are discussed in the country sections below) as well as the relative health of elderly persons in each country.

### **Long-term Care Workforces in the Study Countries**

This section provides a summary of selected features of the long-term care workforces in the study countries (excluding the United States). While the data used in this overview are not comprehensive or fully comparable (see Data Comparability, above, as well as country discussions), several common features emerge.<sup>9</sup>

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<sup>7</sup> For an overview of the delivery, organization, financing, and quality of long-term care services in developed countries, see Gibson, Gregory, and Pandya (2003).

<sup>8</sup> However, special provisions in French labor law under which many care workers are employed may lead to undercounting of home care employees (see discussion in this report in the section on France).

<sup>9</sup> Data for the European countries include both home and institutional or residential care workers in selected occupations, while those for Australia and Canada are limited to workers who provide community care services. For sources and cautions on the interpretation and comparability of the data for the three European countries, see Escobedo, Fernandez, and Moreno (2002). Because of differences in the type of wage information available for the various countries, pay and benefits are discussed as part of the country narratives but are not presented in chart 1.

**Gender.** Care workers are overwhelmingly female, with women accounting for 80 percent to over 96 percent of care workers in the countries and employment categories considered (chart 1).<sup>10</sup>

**Age.** Differences in age between care workers and the rest of the workforce are not dramatic, but care work attracts somewhat older workers. From one-third to over 40 percent of care workers in the three European countries and over half in Australia are 45 years or older (chart 1 and author's calculations based on Australian Institute of Health and Welfare 2003a). By comparison, the total workforce age 45 and older in these four countries ranges from a low of 31 percent in the Netherlands to a high of 37 percent in Denmark and France (author's calculations based on International Labour Organization 2004). Nearly three-quarters of care workers in Canada are 35 years or older, compared with 61 percent in the overall workforce (author's calculations based on International Labour Organization 2004).

**Hours.** Country patterns vary substantially, but care work is frequently part-time work. Part-time care work in the study countries ranges from about one-third to over 90 percent (chart 1). Full-time work tends to be more common in institutional settings (Christopherson 1997).

Part-time work may suit the needs of students, parents, and others with family responsibilities. It may also meet the needs of clients who require help at set intervals during the day rather than continuously. But part-time work can contribute to the overall invisibility of care work. Part-time workers may not invest as much in training as full-time workers, since their earnings are lower. They may not remain in their jobs, or in the sector, as long as full-time workers. They may lack social insurance protections such as pension coverage and sick leave.<sup>11</sup>

**Job status and tenure.** Most care workers are permanent workers, and the majority have been in their current job more than one year (chart 1). But up to a third have less than a year in their current job; short tenure is most prevalent in Denmark.

**Unionization.** Unions can influence not only wages and working conditions but also national policies toward the care sector and the training of care workers. Except in Denmark, most care workers are not directly covered by collective bargaining agreements (chart 1). However, workers who are not union members may benefit from the terms of collective bargaining agreements; practices in this area are covered in the country discussions.

## COUNTRY DESCRIPTIONS

### Denmark

Of the six countries, Denmark has gone furthest in promoting home care over residential or institutional care for elderly persons in need of services. No conventional nursing homes have

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<sup>10</sup> The country discussions also refer to various features in this chart.

<sup>11</sup> This issue is discussed further in the country sections.

been built since 1987. According to the Danish Ministry of Social Affairs, most elderly persons currently live in ordinary housing (Ministry of Social Affairs 2003). Very few live in housing specially adapted to their needs, and very few live with their adult children.<sup>12</sup>

## **Service Delivery**

Local municipal councils, organized under national regulation, are responsible for providing home care. Comprehensive provision is based on citizenship rather than on insurance rights (Smith 2003). Beginning in January 2003, most local councils were to have in place a system under which older people could choose from among two to five service providers preselected by the local authority.<sup>13</sup>

**Preventive care.** Every person age 75 or older must be offered a home call at least twice annually. The home call is a preventive care service designed to create a sense of security and well-being and an opportunity to provide advice and guidance about public and private activities and support services. Another objective is to support elderly people in putting their personal resources to better use and maintaining their functional capacity for as long as possible.

**Service coordination.** Unlike many other countries, Denmark substantially merges the delivery of health and social services provided to the elderly. Denmark and the Netherlands (discussed later in this report) have adopted this approach to overcome conflicts in professional roles between social workers and nurses and to permit a more flexible approach to case management (Walker and Maltby 1997). Coordination includes multidisciplinary teams that work across care settings; service responsibility that is decentralized to small areas through health centers; and common training programs (Smith 2003).

Whether health care and social services for the elderly are merged or provided separately is relevant to the country's choice of who pays for social care. In Denmark and the Netherlands, eligibility for home care is universal and cost-sharing for home care is limited (Gibson et al. 2003). In France, in contrast, health care and social services are delivered separately, and the state provides a safety net only for those with limited resources (Christopherson 1997).<sup>14</sup>

## **Working Conditions**

Working conditions for Danish care workers reflect the attention given to care work as a matter of public policy.

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<sup>12</sup> However, Leeson (undated) reports research findings showing that older people in Denmark are active in satisfying and extensive familial networks.

<sup>13</sup> An anonymous reviewer reports that provider choice is evolving slowly, however, and that most elderly people do not yet have a choice of providers.

<sup>14</sup> The three countries' policies on coverage and cost-sharing for institutional care follow the home care patterns, with Denmark and the Netherlands offering universal eligibility and France offering means-tested eligibility; all three countries impose some cost-sharing on residents (Gibson et al. 2003).

**Unionization.** Trade union membership is estimated at 80 percent of the care workforce (Moss and Cameron 2002). The effect of unions is even broader, however, as collective bargaining agreements are used as guidelines throughout the public and private sectors (U.S. Department of State 2003a).

Unlike the situation in the United States, where a given union may represent a wide range of occupations, Danish unions are organized mainly on an occupational basis. The Danish Trade Union of Public Employees (*Forbundet af Offentligt Ansatte*, or FOA) is the principal union representing paraprofessional care and health workers, who account for 100,000 of its 180,000 members (van Ewijk et al. 2002a). In the public sector, collective bargaining is conducted between the employees' unions and a government group led by the Finance Ministry (U.S. Department of State 2003a).

Unions also play an important role in broader policy issues concerning the care sector. For example, FOA has been active in the discussion of the use of private firms to provide care, and FOA and the trade union representing nurses have published materials relating to ethical issues in care work. Danish trade unions are also engaged in debates over training issues, the quality of care, and the image of the care sector as a whole.

**Hours.** The standard work week is 37 hours. Average hours worked by care workers are increasing. In 1980, the typical care worker worked 60 percent of full time, or about 22 hours a week. By 1999, the typical care worker was working about 83 percent of full time, or about 31 hours (calculations based on data in Jensen and Hansen 2002a).<sup>15</sup>

**Training.** A recent study of care workers in selected European countries found that those who work with elderly people tend to have lower levels of required training than those who work with children and young people (van Ewijk et al. 2002a). For example, most care workers who provide services to children, even at the preprimary level, have at least a tertiary (university) level qualification, while those who work with the elderly are likely to have upper secondary level qualifications or less; that is, no formal job-related training other than what they receive on the job. In Denmark, care workers for the elderly typically have training at the upper end of this range; that is, most have at least an upper secondary education.

Students are enrolled in training courses after obtaining an employment contract with the local or regional government. Thus, the authorities' hiring decisions have an important influence on the number of students receiving training. Students in the basic social and health services training program receive an employer-paid salary as trained care workers rather than the usual government grant provided to students (Jensen and Hansen 2002b). Unlike a loan, a salary carries no repayment obligation if the student interrupts or does not complete training. To the extent that time spent as a student also counts toward seniority in one's career, getting paid a salary while in training could be a powerful incentive to continue training and to develop one's career path.

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<sup>15</sup> These data are calculated on a different basis from those presented in chart 1 and may be more reliable (Escobedo et al. 2002).

Training for elder care workers has undergone several improvements since the early 1990s, with positive impacts on recruitment. In 1991, five different training courses in the social and health services sector were replaced by a single basic training system (Jensen and Hansen 2002b). This change was made in part to increase workforce flexibility. Since January 2002, the training for social and health service helpers and assistants has been extended by two months, and new subjects have been introduced to ensure that students have sufficient qualifications to continue to higher education.

The training is structured in phases that offer students the option to work after completing the basic training or continue with their education; some students work and then return for further training. Two objectives in coordinating employment with training were to increase the students' motivation for acquiring added training and to solve some of the problems of recruiting care workers, especially for elderly care.

**Recruitment.** The number of both social and health service helpers and assistants completing training grew by nearly 11 percent per year between 1995 and 1998 (calculation based on data in Jensen and Hansen 2002a). A majority of those who complete training start working, but as many as a third continue with additional training instead. Many of the training innovations are too new to have had a clear impact on retention.

Despite the already high emphasis on training for care workers in Denmark, Danish observers argue that even more attention should be paid to the quality of training in the future (Johansson and Cameron 2002). Better training—for example, in the management of aggressive dementia patients—can improve the work environment by improving awareness of treatment options. Better training also can help attract young people to the field, because it contributes to career options.

**Wages and benefits.** Care workers in Denmark are generally well paid by national standards. While some categories of care workers earn less than the economy-wide average, their degree of disadvantage tends to be less than in other European countries (van Ewijk et al. 2002a). In comparison with care workers in Spain, Sweden, and the United Kingdom, Danish care workers hold an uncontested lead in earnings. For example, full-time personal care workers, who typically have an upper secondary education, earn about 93 percent as much as the average full-time Danish worker, compared with a low of 67 percent of the national average for the same occupational category in the United Kingdom (author's calculation based on data presented in van Ewijk et al. 2002a). Full-time domestic helpers, who typically have less than an upper secondary education, earn 76 percent of the national average wage in Denmark, compared with a low of 63 percent in the United Kingdom.

Several factors account for this discrepancy. Workers in countries with strong unions earn more than those in countries without strong unions. High levels of training also have an impact (van Ewijk et al. 2002a). Some observers caution against assuming that strong unions automatically lead to high levels of training and wages, however. Rather, they argue, both health

and social services care work in Denmark are part of a political system under which many care activities are collectivized rather than considered the responsibility of the family (van Ewijk et al. 2002a).

Care work—particularly work with the elderly—also must be considered within the broader social context. Stone and Wiener (2001) put it succinctly in describing U.S. workforce issues:

Frontline worker jobs in long-term care are viewed by the public as low-wage, unpleasant occupations that involve primarily maid services and care of incontinent, cognitively unaware old people.

Tackling this issue head-on, Denmark and Sweden have generated some of the more detailed research literature on job satisfaction in the care workforce (Moss and Cameron 2002). Denmark also has launched campaigns aimed at altering the image and status of working in the elderly care sector (Jensen and Hansen 2002b). While a comprehensive evaluation of job quality and satisfaction is not available, Denmark is judged to have made care work into quality employment by focusing on professionalism, training, and pay (Moss and Cameron 2002).

## **France**

As in most European countries, social policy in France stresses allowing the elderly to remain at home as long as possible (Bresse and Dutheil 2003). This trend may have started earlier in France than in many countries, dating to a key 1962 commission report known as the Laroque Report (Lamura 2003).

### **Service Delivery**

Several characteristics of the elder care service delivery system in France are of interest. France maintains perhaps the strictest boundaries of any European Union country between its health and social services systems (Lamura 2003). Since the 1980s, the development of long-term care services has reflected an employment policy intended to increase labor force participation among low-skilled persons (Bresse and Dutheil 2003, Dherbey, Pitaud, and Vercauteren 1996). However, like many other countries, France has faced a trade-off between increasing access to employment for untrained workers and increasing employee qualifications to improve service quality.

**Health versus social services for the elderly.** France has been recognized as having one of the world's best health care systems.<sup>16</sup> Spending is reimbursed generously; patients have a wide choice of providers; and resources allocated to health care are extensive by international standards (Imai, Jacobzone, and Lenain 2000). The health care system provides universal coverage, financed principally by the government and through supplemental policies issued by

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<sup>16</sup> In its *World Health Report 2000*, the World Health Organization (WHO) ranked the French health care system first among all WHO member states in overall health system performance (WHO 2000).

private insurers. Co-payments are imposed for most services, but certain pensioners and persons with long-term illnesses are exempt from such payments. Home nursing care services are fully financed by the health care system (European Union 2002).

In contrast, social services such as home help and nursing home care are means-tested; that is, eligibility is based on the recipient's income (European Union 2003). Home help provides assistance to persons 60 years or older with activities of daily life to permit them to remain in their homes. Persons who need assistance access home care services by qualifying for the *allocation personnalisée d'autonomie* (allowance for loss of autonomy, or APA).<sup>17</sup> The APA is based on the individual's needs as evaluated by a medical-social team and on the beneficiary's personal resources. Co-payments for home help are waived for very low income pensioners. Persons who qualify for the APA receive between 3 and 15 hours of assistance weekly, depending on their degree of disability (Bresse and Dutheil 2003). When fully phased in, the APA is expected to go to about 6.4 percent of individuals over age 60, of whom about two-thirds live at home.<sup>18</sup>

**Employment versus service.** The French policy toward care allowances is distinctive in explicitly linking the provision of services to the elderly (and other family services) to the provision of jobs, specifically, to the reduction of long-term unemployment (Dherbey et al. 1996, Jenson and Jacobzone 2000). The APA and its predecessor allowance were designed both to address the needs of vulnerable populations and to create jobs. Not only must French beneficiaries of home care allowances spend the allowances on care (and be able to prove they have done so). If they use the allowances to purchase care from family members (other than spouses or partners) those family members must otherwise be unemployed.

The APA is relatively new, and estimates of its labor market effects were not available for this study. However, estimates based on earlier forms of the allowance suggest that it achieved its primary goal of expanding employment and formalizing care arrangements (Jenson and Jacobzone 2000). Recipients of earlier allowances (with different eligibility criteria and other requirements) tended to hire outside caregivers over family members by a margin of two to one.

Treating care work as a source of jobs and using it to provide needed services are goals that are not necessarily in conflict. However, some observers believe that the emphasis on jobs has created conflicts in the design of French elder care policy (Dherbey et al. 1996). If one designs a program to meet the needs of the long-term unemployed (or those never employed), the result may be to create an employment sector reserved for those with no other options; such a program could produce jobs, but jobs for an underclass, in effect, that do not offer career tracks and upward mobility.

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<sup>17</sup> The APA was established pursuant to the Elderly Dependency Act of July 20, 2001, and took effect in January 2002. It replaced a previous allowance that had more restrictive features, such as the possibility of recovery from the beneficiary's estate.

<sup>18</sup> Persons who require constant attendance may qualify for the *majoration pour aide constante d'une tierce personne* (supplement for permanent assistance of a third party). Either this allowance or the APA may be used in a nursing home or in the recipient's own home; however, no one may receive both allowances at once.

On the other hand, if one focuses on the needs of the service user, the emphasis shifts to developing appropriate professional skills and the tools to measure and promote quality, rather than the program's impact on employment. Some observers believe that the system has emphasized employment generation over quality of care (see further discussion under Training, below).

## **Working Conditions**

**Unionization.** About 10 percent of the private sector workforce is unionized, but collective bargaining agreements apply to most employees, whether or not they are union members (U.S. Department of State 2003b). As a result, over 90 percent of the private sector work force is covered by collective bargaining agreements negotiated at national or local levels (U.S. Department of State 2003c).

Home care workers are represented by the *Fédération ADESSA*, formed in 2002 as a merger of two unions representing *aides à domicile* (home helpers) and *aides familiale* (family helpers) (Fédération ADESSA 2003). The federation has a membership of 25,600, representing professions ranging from home health aides to physicians and managers.

As in the Netherlands and Denmark, the union takes an active policy role in matters relating to the elderly and persons with disabilities. For example, it worked toward the addition of a “fifth risk”—dependence—to the French social security system (the others are disease, industrial accidents, old age, and family issues).

The impact of the unions on wages and working conditions is difficult to gauge, however. Various laws, prominently a 1991 law creating the job category of family employment (*emplois familiaux*), have made it easier for individual workers to establish private contracts with clients rather than working through private or government agencies. These arrangements added a substantial number of jobs in the late 1980s and early 1990s (Christopherson 1997). However, many of these self-employed workers are counted as domestic workers rather than home care providers, complicating efforts to understand workforce dynamics in the home care sector.

Private contracts tend to pay less than formal jobs offered by private or government agencies (see discussion of wages below), and they do not offer a career ladder. Lower wages provide limited incentives to employees to seek training that can improve their earnings, career mobility, and the quality of care they give. Consequently, while both the allowance and the availability of family employment may have increased the number of formal care jobs, they may also have increased the proportion of care jobs governed by inherently precarious personal services contracts rather than more stable employer-employee relationships (Christopherson 1997).

**Hours.** Full-time employment ranges from 35 to 39 hours weekly. The typical part-time worker works less than half time (chart 1). Unlike the situation in the Netherlands and Canada, however, there is no policy impetus in France to increase the number of hours worked by employees already in the field. Rather, government policies have encouraged the reduction of hours worked

in general as a means of reducing unemployment, and employers receive tax incentives for creating part-time jobs for the parents of young children. By law, most employers were required to shift to a 35-hour week by January 1, 2000, or 2002, as a means of reducing unemployment (Trumbull 2001).

**Training.** The care workforce in France has been split into two broad groups. One group of workers has the formal training necessary to carve a career path; the other group is essentially unskilled, with few prospects of upward mobility (Christopherson 1997). The evolution of training in the French home help sector has reflected the tension between the development of home help as a service with increasingly complex professional demands and as an employment program.

The *aide à domicile* was, until 2002, qualified by a state diploma known as the CAFAD (*certificat d'aptitude à la fonction d'aide à domicile*, or certificate of aptitude in home help functions). Researchers have questioned whether the credential contributed to improving the quality of services (Dherbey et al. 1996). The certificate was not obligatory and was acquired in the course of employment; one was required to be employed in the sector to pursue the designation. However, because training is financed by the government and relatively little financing was available for this training, it would have taken 30 years to qualify just those *aides à domicile* employed as of 1996 (Dherbey et al. 1996).

An added complication is that training programs may be hard to target to those who most need them. Evidence from Australia and France suggests that members of the labor force who are already more skilled are more likely to participate in training programs than those without skills (Organization for Economic Cooperation and Development (OECD) 1995).

In 2002, the CAFAD was replaced by the *diplôme d'état d'auxiliaire de vie sociale* (literally, state diploma of the social life assistant). This diploma/professional definition now encompasses three professions: the *aide à domicile*, the *aide ménagère* (household assistant), and the *auxiliaire familiale et de vie* (family and life assistant). The credential is voluntary and employment-based. Added funding has been dedicated to financing the training of *auxiliaires de vie sociale*, but it is too soon to measure the impact of the new credential and expanded funding on the supply of credentialed employees. *Validation des acquis de l'expérience* (credentialing on the basis of experience)<sup>19</sup> will be another option, but the timetable for making it available has not been disclosed.

**Recruitment.** Unlike the situation in the United States, female unemployment rates in France tend to be higher than those for males, and women make up the majority of the unemployed (Bazen, undated). Nevertheless, recruitment of institutional and home care workers is difficult, as working with the elderly is not highly valued (Crumley 2003).

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<sup>19</sup> The right to substitute experience for education is recognized in the French labor and education codes, but formal procedures must be instituted to make this option available for each credential (Government of France, 2002).

The institution of the APA tripled the funding available for elderly assistance and created the need for up to 20,000 full-time equivalent (FTE) care workers (European Union 2002). Given that current home care employment totals 85,000 (38,000 FTEs), this will mean an increase in FTE employment requirements of about 50 percent.

**Wages and benefits.** Wages are set by collective bargaining and differ by region and according to whether the worker is employed by private contract or through an agency. While pensioners employing home help are subject to all the requirements applicable to employers, they benefit from an abatement of payroll taxes on wages paid to these workers. Private contracts—in which the beneficiary is the employer—tend to pay at or about the minimum wage, while home care jobs through agencies pay as much as 50 percent more (author’s calculation based on Government of France 2003). However, the minimum wage is judged to provide a decent standard of living for a worker and family, and it is revised whenever the cost-of-living index rises 2 percentage points (U.S. Department of State 2003c).

### **The Netherlands**

The Netherlands began building a welfare state in the 1960s—and then curtailed it barely two decades later (van Ewijk et al. 2002b). The growing care sector has been an important target for both budget restraint and new privatization approaches.

For about 15 years after World War II (1945–1960), Dutch national policy was to encourage the elderly to move into old people’s homes (van Ewijk 2002). This policy was seen as a way to alleviate a severe national housing shortage—homes were scarce and small in relation to family size. Thus, every village had an old people’s home. Similar policies were applied to persons with disabilities.

Currently, the national policy (as in many other European countries) is to substitute home care for residential care, less specialized nursing homes for specialized homes, and nursing home care for hospital care. The percentage of elderly persons (65 years and older) in residential care declined from 11 percent in 1975 to 8 percent in 2000 (Escobedo, Fernandez, and Moreno 2002). Over the same period, the number of residential care beds declined from 34 to 18 for every 100 elderly persons (van Ewijk 2002). These changes reflect the development of a social policy that encourages the delivery of care in the home, or “aging in place.”

Current policies also attempt to reduce the demand for formal care by paying families to care for disabled or elderly persons and by enacting leave policies that give people time to care for their parents, partners, and other relatives. Finally, there is a policy direction toward “cash for care” plans and away from the provision of services in kind. Care stipends for individuals and/or caregivers are expected to create new markets and increase consumer choice in services and vendors (Wiener, Tilly, and Cuellar 2003).

## Service Delivery

The Dutch and Danish elder care systems have some similarities in that health and social services are closely integrated in delivery. Like Denmark, the Netherlands has been a high provider of institutional care and other types of residential care services for its older population, although a smaller percentage of elderly persons receive home care than in Denmark (table 2).

While there are problems in collecting and interpreting the data, the Netherlands Institute of Care and Welfare estimates that, as of 2002, more than 30,000 persons were on nursing home waiting lists; 26,000 persons were on waiting lists for home care; and more than 6,000 persons were on waiting lists for residences for the mentally disabled (van Ewijk 2002).<sup>20</sup> There has been an ongoing debate over whether waiting lists are an efficient way to ration scarce social resources or whether they signal unmet social needs and urgently need to be shortened.

One problem in the Dutch care workforce (a problem by no means unique to the Netherlands) is that different areas of care work carry different opportunities and demands. Care delivered in residences such as nursing homes may require more professional skills, because residents are often more frail and require more in-depth care (Christopherson 1997). On the other hand, home care may entail unique pressures, such as working in isolation or without proper tools. As care provision becomes more extensively the province of private firms and even individuals rather than social services agencies, care users and their families are increasingly “customers” who put together packages of services and shop for the best provider (van Ewijk et al. 2002a).

## Working Conditions

**Unionization.** Care workers in the Netherlands are unionized on a sector basis; for example, workers who care for persons with disabilities bargain separately from those who care for the elderly in residential settings. Trade unions represent about 30 percent of the Dutch workforce, but unions representing care workers play a strong economic and professional role on behalf of the entire sector, not just their members; collective bargaining agreements are applied to all care workers, whether or not they are union members (Moss and Cameron 2002).

However, the government, local authorities, and insurance companies that employ care workers or provide reimbursements for care services do not necessarily increase their overall spending on care or reimbursement rates in proportion to the outcome of union negotiations (van Ewijk et al. 2002b). Consequently, a large increase in pay can reduce the number of jobs that are funded.

Unions also play a role in training. Social partners (the two main trade unions and employer organizations) are expected to define the competencies and qualifications needed for beginning

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<sup>20</sup> In Denmark, in contrast, some workforce shortages have emerged, but local authorities can be fined if care plans for elderly citizens are inadequate.

professionals. This information is applied to curriculum development in middle and higher vocational schools.

**Hours.** Dutch care workers are overwhelmingly part-time workers, working an average of less than half time (chart 1). Accordingly, one policy direction is to attempt to offer more hours to those already employed (van Ewijk et al. 2002a). Offering more full-time work can make jobs more attractive and improve retention.

**Training.** Employer-sponsored training is important in the Netherlands; nearly half of all private employers with at least five employees provide some form of training (van Leeuwen 1999). However, the high proportion of part-time care workers in the Netherlands may complicate training efforts. Employers finance most on-the-job training, and they prefer training full-time over part-time workers (van Leeuwen 1999). One problem with training part-time workers is that scheduling issues can interfere with on-the-job training (van Ewijk, Hens, and Lammersen 2002c). The high proportion of part-time workers in the Dutch workforce means that many workers do not have opportunities for training.

**Recruitment.** While Denmark and the Netherlands have taken similar approaches to the management of elderly care and the care workforce, they do not seem to have had similar results. The Dutch care workforce is about 35 percent smaller (on an FTE basis) than the Danish care workforce in relation to the population needing care (including children and the elderly) (calculation based on van Ewijk 2002a). Similarly, while the care workforce in Denmark appears to be displaying a healthy growth rate, vacancies in care work grew at an average annual rate of 17 percent in the Netherlands between 1995 and 2000 (van Ewijk 2002a).

To help promote more efficient use of the workforce and thereby alleviate the worker shortage, the Dutch government implemented a new care worker category in 2000 (van Ewijk, Hens, and Lammersen 2002b). The category of “care assistant” requires either no training or short, on-the-job training and qualifies the employee to function in less complex situations and take responsibility for domestic tasks. This strategy is referred to as “downward job differentiation.” By leaving simpler tasks to less qualified staff, this strategy can give more highly trained workers time for specialized tasks. Researchers are uncertain, however, whether this approach has created many new jobs for unskilled workers (van Ewijk et al. 2002c).

Many countries, including the United States, are in the process of raising the age at which government old-age pensions are available; others are debating such changes (Gillion et al. 2000). Because the care workforce already attracts older workers, Dutch analysts hope that raising the age at which workers can collect pensions will increase the supply of care workers (van Ewijk 2002).

**Wages and benefits.** Despite the predominance of part-time workers, Dutch care workers’ earnings are comparable to the overall national average (Moss and Cameron 2002). Given that both care work and part-time work tend to be lower paid than other work, this parity is evidence of a relatively strong economic position.

## **Canada**

Canada is increasingly focusing on home care as a cornerstone of its long-term care policy:

- The final report of the Commission on the Future of Health Care in Canada (2002), which proposed sweeping changes to Canada's national health care system, described home care as "The Next Essential Service."<sup>21</sup>
- A multiphase government-sponsored study of the home care workforce examined various aspects of the profession (Canadian Home Care Human Resources Study 2002, 2003). The study produced a total of 437 pages of analysis based on, among other sources, a literature review of some 300 published sources, more than 60 interviews with key informants, and several surveys conducted specifically for the study. The study provides extraordinary documentation of problems that are common to all the countries considered in this report.<sup>22</sup>
- On February 5, 2003, Canada's first ministers (the collective term for the prime minister and the provincial heads of government) agreed on national health plan reforms that included first-dollar coverage for short-term acute home care (including acute community mental health care) and end-of-life care.

## **Service Delivery**

Home care in Canada is considered to have three functions: (1) maintaining the ability of persons with disabilities to live independently; (2) meeting the needs of persons with disabilities who would otherwise require institutionalization; and (3) meeting the needs of persons who would otherwise have to be in acute care facilities (Canadian Home Care Human Resources Study 2002). Currently, an estimated 5 percent of publicly funded health expenditures are devoted to home care (Coyte and McKeever 2001). As hospitals release their patients "quicker and sicker" (an accusation not unknown in the United States), the acute care aspect of home care is becoming increasingly important.

An estimated 70 to 80 percent of paid home care services are provided by home support workers, also known as homemakers, home health aides, personal care workers, and home health attendants (Canadian Association for Community Care 1995).

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<sup>21</sup> While home care received its own chapter in the commission report, both the report itself and associated discussion papers dealing with human resources issues made only indirect references to staff in long-term care facilities (see, for example, Armstrong and Armstrong 2002, Dallaire and Normand 2002).

<sup>22</sup> The Canadian study deals with workers who provide both short- and long-term care, because home care programs in Canada offer both types of care. An analysis of long-term care workers only might have yielded different results and identified different issues.

Home care services are funded and managed under provincial control. The federal government funds some programs as well, such as those for military veterans (Canadian Home Care Human Resources Study 2002, 2003).

Provincial control results in a variety of approaches to home care, both in the public sector and in public-private mixes. For example, all jurisdictions cover certain basic services, such as assessment and case management, nursing care, and home support for eligible individuals (Canadian Institute for Health Information 2001). In some provinces, additional benefits (such as various types of therapy) are provided through publicly funded home care programs; in other provinces, services beyond the basic set are paid for privately or through insurance.

Budgets have become more constrained even as clients' needs have become more extensive. As a result of budget cuts, waiting lists have emerged. Pressures on home care have been felt primarily in support services, which many observers believe are critical to maintaining the independence of the frail elderly.

### **Working Conditions**

While working conditions in institutional long-term care can be difficult, those in home care can be worse. Home care workers often work alone, late at night, and in remote areas, leading to safety concerns. Because the workplace is a client's home, it may not meet minimal workplace safety standards for air quality, fire hazards, or cleanliness (Canadian Association for Community Care 1996). Violence and verbal abuse may be concerns, and basic amenities such as drinking water and bathroom facilities may not be provided. These conditions are not unique to Canada—just perhaps more fully described (see, for example, van Ewijk et al. 2002a).

**Unionization.** Unions work to promote awareness of home care issues and have addressed training issues and working conditions (Canadian Home Care Human Resources Study 2003). Union rules can also make it easier for employers to discipline workers who do not report for work or otherwise meet their obligations.

About 43 percent of all home health care workers are unionized (chart 1). By comparison, an estimated 29.5 percent of the total civilian workforce is unionized (U.S. Department of State 2003d). Unionization rates vary widely by province and by employment sector.<sup>23</sup> In British Columbia, 91 percent of home care agencies are unionized (British Columbia Association of Community Care 1997). Unionization rates are also high in Quebec. Some two-thirds of publicly employed home care workers were unionized in the late 1990s—about twice the rate among home care workers employed in private agencies (Keefe 1999).

**Hours.** Working hours can be one of the most difficult aspects of home care employment. Standard work hours are limited by the provinces, but in all provinces overtime pay is not required until the number of hours worked exceeds 40 or 48 hours per week (U.S. Department of

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<sup>23</sup> In the discussion of provincial features, it is useful to remember that in 2003, 63 percent of the Canadian population of 31.6 million was concentrated in Ontario (39 percent) and Quebec (24 percent).

State 2003d). Two-thirds of home care workers work full time, defined in government statistics as 31 hours or more per week (chart 1).

Unpaid time can be substantial. Frontline workers report that they work unpaid hours if sufficient hours are not authorized to complete the client care tasks assigned, and nearly 90 percent are not typically paid for planning and preparation time (Canadian Home Care Human Resources Study 2003). A particular concern is split shifts, which may require workers to be on the job for 12 to 14 hours to accumulate 6 to 8 hours of paid time (Health Canada 1999).

Another source of unpaid time for home care workers is time spent traveling from one client to another, which is typically not compensated by employing agencies, further reducing the average compensation per hour. Offering such compensation could help relieve shortages of home care workers, especially in isolated rural areas, where travel time between client homes can be substantial (Canadian Home Care Human Resources Study 2003).

**Training.** Training is not normally a requirement in contracts between government bodies and providers; when it is, it typically excludes for-profit agencies. One problem that can arise when workers seek formal training is that community college programs are directed at both home care and institutional workers. Once they are trained, workers often opt for more secure and typically better paid jobs in institutional care (Health Canada 1999).

Training may be prohibitively expensive for low-wage workers, many of whom can afford neither the cost of training nor the time away from work. Some government funding for training is available, but it often excludes the training of unskilled staff who may have extensive experience.

Like the United States, Canada is a multicultural society. One unmet need in native communities is for training in English as a second language (see also the section on Australia).

**Recruitment and retention.** Comprehensive data on turnover among home care staff are not available and, because of the high proportions of temporary and short-term staff, might not be meaningful. On a provincial basis, annual turnover rates in home care agencies have been as high as 56 percent (Canadian Home Care Human Resources Study 2002). In 2001, 16 percent of home health care employees had been on the job less than one year (chart 1).

In an effort to reduce turnover, many agencies are increasing the proportion of jobs designated as full time or permanent part time, and jobs with guaranteed hours.

**Wages and benefits.** In 2001, the average home care worker (including nurses, registered nurse assistants, nursing aides, homemakers, and other workers) earned CA\$16.11 per hour, or CA\$515.21 per week (Canadian Home Care Human Resources Study 2003). Average hourly wages by home care occupation ranged from a low of CA\$12.71 for home service workers to a high of CA\$24.38 for registered nurses.

Wages paid to home support workers vary widely across the provinces, and province-to-province comparisons vary over time. In the late 1990s, wages were highest in British Columbia. In 2001, however, average wages were about 10 percent higher in Ontario than in British Columbia (Canadian Home Care Human Resources Study 2003).

In Newfoundland, in contrast, starting workers earn only the minimum wage. Minimum wages are set by province or territory and raised at irregular intervals. As of early 2004, minimum wages ranged from CA\$5.90 to CA\$8.50 (Government of Saskatchewan 2004). As in the United States, a family whose only employed member earns the minimum wage is considered to be below the poverty line (U.S. Department of State 2003d).

In Ontario, home care is coordinated through Community Care Access Centers (CCACs). Workers for a home support agency that contracts with a CCAC have a protected minimum wage, but few have benefits such as pensions, sick time, or holidays. Employers often hire employees on a temporary or short-term basis to avoid providing benefits. Because of their lower earnings, care workers also receive lower contributions to the Canada Pension Plan.

## **Australia**

Australia is, in some respects, much like Canada and the United States. All three are English-speaking countries,<sup>24</sup> are significantly populated by immigrants, and have culturally diverse populations.

### **Service Delivery**

All Australians qualify for long-term care services; however, the services a person receives depends on need, as well as income and assets. In addition, funding for hostel accommodations (much like assisted living in the United States) includes a requirement that residents pay a capital contribution or entry fee to the facility (Howe 2000).

Under the Aged Care Reform Strategy, which was developed in the 1980s and early 1990s and still guides Australian elder care policy, the balance has been shifting away from residential care and toward home and community care. The key to the long-term care system for most users is the Aged Care Assessment Program, under which Aged Care Assessment Teams (ACATs) advise the frail elderly and assess their eligibility for various services (Commonwealth Department of Health and Ageing 2002).

ACATs may refer clients to residential care (either low or high level, depending on need); a Community Aged Care Package (CACP); or the Home and Community Care (HACC) program. CACPs are coordinated packages of community care aimed at frail elderly persons whose needs would otherwise qualify them for entry to an aged care home. The government target is to provide 12 CACPs per 1,000 elderly persons (Howe 2000). The federal government provides

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<sup>24</sup> Canada, of course, is officially bilingual.

both residential care and CACPs, while the HACC program is a joint federal-state program with significant local participation in funding and management. ACATs refer more clients to community services than to residential care (Howe 2000). Residential care charges are income- and asset-tested, while beneficiary cost-sharing for home and community care is based on an income test.

Two caregiver allowances also provide financial support for home care (Jenson and Jacobzone 2000):

- The carer allowance is a small cash benefit (equivalent to about 5 percent of average weekly full-time earnings), not means- or asset-tested, that can be paid to family members supporting a person who requires chronic nursing care at home.
- The carer payment, also paid to someone responsible for the daily care of a highly dependent person, is means-tested. It is intended to compensate persons who are unable to maintain paid employment because of their caring responsibilities and requires that the recipient not engage in paid or volunteer work for more than 20 hours a week.<sup>25</sup> The carer payment is paid at the old-age pension rate (25 percent of average weekly full-time earnings) and can be converted to the old-age pension when the carer reaches the age of pension eligibility (as of 2002, this age was 65 for men and 62 for women).

Both allowances may be payable, depending on the client's circumstances.

While services are nominally available to all Australians in need, over a third of providers reported waiting lists. Even the broad prevalence of waiting lists may understate service limits, as some organizations manage demand by reducing services to individual clients or refusing referrals for a period rather than by maintaining waiting lists (Anglely and Newman 2002). However, service limitations are believed to be more the result of funding shortages than staffing shortages.

All persons who have moderate to severe disabilities are considered potentially eligible for HACC services, but in 2000, only an estimated one in three of the frail elderly in this category were covered (Howe 2000). More recent data suggest, however, that only about one in three elderly in the targeted group have home care needs that are not being met, at least in part, through either formal or informal care.<sup>26</sup> Another way to look at coverage of HACC services is the ratio of clients to potential users who are at least 65 years old and have a severe or profound restriction in basic activities. Using this standard, HACC services reached 81.4 percent of their target population in 2001–2002 (Australian Institute of Health and Welfare 2003a).

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<sup>25</sup> As a practical matter, however, few persons charged with sole or principal care of a person with a disability would be able to maintain even a part-time work or volunteer schedule.

<sup>26</sup> Personal communication from Anna L. Howe. Dr. Howe points out, however, that because of the great popularity of the HACC program among both clients and caregivers and the diversity of services offered under the program, “need” may be difficult to differentiate from “demand.”

## Working Conditions

**Unionization.** About one in four Australian workers belongs to a union (U.S. Department of State 2003e). Long-term care workers may be represented by a number of unions. Unions campaign for long-term care funding, improved working conditions, and equity in treatment among full-time, part-time, and temporary employees.

**Hours.** Comprehensive data on hours and working conditions across care occupations are difficult to compile, in part because of deficiencies in data on workers in aged care settings (Wheeler 2002). National data show that 64.5 percent of persons working as aged and disabled carers work part time, or fewer than 35 hours<sup>27</sup> a week (chart 1).

A survey of 159 home care providers in the state of Victoria, home to a quarter of the nation's population, confirms that direct care workers are overwhelmingly temporary part-time employees (Angley and Newman 2002). Among responding organizations, 85 percent offered no full-time positions at all. Part-time staff tend to work between 15 and 24 hours a week. Some organizations included in the Victoria study explicitly limit the number of hours they permit an employee to perform home care to 15 to 25 hours, on the basis of occupational health and safety considerations (Angley and Newman 2002).

The study also found that many workers employed in part-time and temporary positions would prefer full-time, long-term employment. In particular, guaranteed minimum hours are considered to have potential for attracting younger workers and men to the care field.

**Training.** Care workers may acquire qualifications recognized under the Australian Qualifications Framework, a unified system of 13 national qualifications offered in schools, vocational education and training, and higher education. Vocational education and training includes four certificates (I through IV), a diploma, and an advanced diploma. Certificates I through IV may be applied toward completion of the Senior Secondary Certificate of Education,<sup>28</sup> but some are also issued in the higher education sector. Recognition of Prior Learning (RPL) allows workers to substitute experience for formal training.

Employers often support training, but support varies widely among home care providers. Some offer no support, while others not only pay fees but also offer paid time to attend training (Angley and Newman 2002). Training for Certificate III, which is a basic qualification for a home care worker, is more likely to be supported than training for Certificate IV (for a community services worker) or a diploma<sup>29</sup> (Angley and Newman 2002). Some employers support training that includes learning a second language and acquiring computer skills.

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<sup>27</sup> This is the definition of part-time work used in Australian Institute of Health and Welfare (2003b).

<sup>28</sup> This credential is roughly equivalent to a U.S. high school diploma, but direct comparisons are difficult. For example, Australia requires six years of secondary schooling for university entry, while the United States requires four.

<sup>29</sup> Some diplomas, which are vocational credentials, can be credited toward university degrees (Australian Qualifications Framework 2002).

However, some organizations are not willing to hire workers who have not already acquired appropriate qualifications (Angley and Newman 2002).

The federal government funds training programs for care workers and has recently stepped up its commitment to do so. Government funding can come from labor force programs, which include apprenticeships and traineeships for people without prior qualifications or those who wish to upgrade their qualification. State-funded training is also available in registered training organizations (Angley and Newman 2002). In May 2003, the federal government announced a four-year plan to spend AU\$21.2 million on training for staff in smaller, “less viable” aged care homes across the country (Global Action on Aging 2003).

**Recruitment and retention.** Adequate staffing in the elder care field is an ongoing problem that includes medical practitioners and nursing staff as well as paraprofessional workers (Myer Foundation 2002). Recruitment of care workers is also complicated by the Australian cultural context; Australians have traditionally disdained occupations perceived as domestic help (Cant 2002; Howe undated).

Annual home care staff turnover is reported at 20 to 30 percent, although researchers believe that these estimates are low (Angley and Newman 2002). Concerns about recruitment are reported to be high, with the greatest problems experienced in staffing categories that require a qualification before employment.

To reduce recruiting costs and improve retention, some home care organizations advertise information sessions rather than specific job openings (Angley and Newman 2002). These sessions provide detailed and accurate information about the nature of work with the elderly and persons with disabilities. Some organizations have reported improved retention among employees who attended an information session, because those who proceeded with an application after the session were better informed about the nature of the work and the opportunities involved.

The Royal Freemasons’ Homes of Victoria Ltd., a not-for-profit provider of both residential and community care, has a particularly detailed recruiting process. Potential recruits attend information sessions and are sent on rounds with community care workers to observe the job in detail. The Homes’ annual staff turnover rate of 4 percent—in an industry where 100 percent is not uncommon—is believed to reflect the care devoted to recruitment.

At least one study has attempted to explore whether unemployed and underemployed<sup>30</sup> Australians, especially older workers, would consider employment in the care sector (Price et al. 2002). Focusing on persons age 40 years and older, the study found a high prevalence of negative attitudes toward working in long-term care. The results suggest that increasing the proportion of older workers willing to train for long-term care will require increased public sector funding, as workers are unlikely to pay for the training themselves.

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<sup>30</sup> Underemployed persons were defined as those working 15 or fewer hours a week but actively seeking additional employment.

**Wages and benefits.** Government regulations and the decisions of federal or state industrial relations commissions prescribe a 40-hour or shorter workweek, paid vacations, sick leave, and other benefits. The minimum standards for wages, working hours, and conditions are set by a series of "awards," or basic contracts for individual industries. Differing minimum wage rates for individual trades and professions cover 80 percent of all workers. The minimum wage provides a decent standard of living for a worker and family (U.S. Department of State 2003e).

Most workers receive more than the minimum wage as a result of contracts negotiated at the enterprise or individual level. Problems in identifying aged care occupations (see Hours, above) also extend to the analysis of wages, but some limited national information is available. In 2002, the average full-time personal care and nursing assistant received AU\$631.40 a week, or about 50 percent more than the minimum weekly wage for that year (author's calculations based on U.S. Department of State 2003e and chart 1).<sup>31</sup> However, the time home care workers spend traveling among clients is often not reimbursed, reducing the effective compensation per hour worked (Angley and Newman 2002). In addition, even temporary home care workers are often required to have their own vehicle for traveling among clients, although they usually receive some reimbursement.

Care workers may face important gaps in benefits. Unlike the system in France, where family and other care workers paid by a care allowance earn retirement credits, family care workers paid by the Australian care allowances do not earn retirement credits, even if their payments exceed the earnings threshold that would otherwise qualify them for such credits (Jenson and Jacobzone 2000).

Some nonfamily care workers may also not earn retirement credits. For the 2003–2004 tax year, employers are not required to make contributions to the national retirement system (called the Superannuation Guarantee) for employees who earn less than AU\$450 a month (Australian Tax Office 2003). Since the federal minimum wage for that year is AU\$448.40 for a 38-hour week (Australian Council of Trade Unions 2003), anyone working at minimum wage for less than about 10 hours a week for a single employer would not qualify for retirement contributions. The earnings floor for contributions is applied on a per-employer basis, so home care workers with more than one part-time job might receive no retirement contributions, even if their total earnings from all employers would qualify them if they were paid by only one employer.

## CONCLUSIONS

Care work is often "invisible" work, in part because workers are often low paid, part time, or temporary workers. Home care workers may not have a conventional workplace where they can receive professional supervision, collegial support, and training. But these workers are not invisible to their growing ranks of clients. The findings of this report suggest that improving the economic and professional status of these workers is likely to improve the quality of care. This

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<sup>31</sup> The source data do not indicate how many of these workers were employed in institutional versus community care settings.

section summarizes the policy implications that can be drawn from the similarities and the differences among the study countries.

**Funding.** Funding shortages have led to inadequate staffing and service shortages in Canada, Australia, and the Netherlands. Added funding might usefully be spent on pay and benefits, training, and restructuring jobs to add more career paths, provide stable income for employees, and attract younger workers and men.

**Pay and unions.** Labor unions typically advocate for better wages for their members. The experience of the study countries suggests that this connection is important in care work: Both Denmark and the Netherlands have strong unions and relatively high-paid care workers.

Yet the Netherlands suffers from serious shortages of care workers, while shortages are less problematic in Denmark. The Danish reforms are still relatively new, and theorizing on the basis of limited experience is risky. But one difference between the Danish and the Dutch experiences is that Denmark has integrated training with employment, offering aspiring professionals a chance to earn income and gain on-the-job experience as they study, and creating career paths that can reward further training.

A country's overall wage structure is also relevant to public policies toward care workers. To the extent that care workers are paid at or near minimum wage, the adequacy of the minimum wage itself becomes an issue. Minimum wages in France and Australia are sufficient to provide an adequate standard of living, while those in Canada and the United States are not.

**Hours.** Part-time or temporary work clearly suits some people. However, such jobs are not typically considered "good" jobs by many prospective employees, particularly the younger workers many countries want to attract to care work.

The structure of the workday can be a particularly difficult issue in home care. The practice of split shifts was noted in the discussion of Canada; such hours can be particularly punitive for workers who are not paid for travel time among clients. Care work can also require 24-hour staffing, which can mean long or nonstandard hours. Nonstandard hours, such as night work or varying shifts, can lead to health problems among workers resulting from disrupted sleep patterns (van Ewijk et al. 2002c). Payment for time spent in staff and planning meetings and travel time among home care clients needs to be addressed.

Experience in the study countries suggests that the care sector's problems of recruitment and retention can be addressed by offering guaranteed hours—at adequate wages and appropriate benefits—to employees who want them. More alternatives to part-time work can be good not only for workers but also for the sector as a whole. Some policymakers see increasing the hours of part-time workers as a solution to worker shortages (see, for example, the discussion in van Ewijk 2002). Make the work more attractive and better paying, the reasoning goes, and the workers already in the jobs will upgrade their skills, work longer hours, and make a career of the jobs they already hold, thus alleviating coming shortages. Many researchers also believe that the

limited availability (because of short hours) and high turnover rate of care workers adversely affect the quality of care, particularly with regard to mental functioning among aged clients (see, for example, Angley and Newman 2002; Stone and Wiener 2001).

**Training.** A key finding of this report is that there may be few alternatives to employer or public sector funding for training care workers. The Canadian experience suggests that appropriate training may be out of reach for many workers if they must not only pay for the training but also forgo wages during the training period. Australia has also faced this issue. Since care work is a low-paid field in many countries, prospective employees are unlikely to have or be willing to invest their own money to acquire qualifications. But without qualifications, they may face barriers to employment or limited career paths. In addition, to the extent that the qualifications are relevant to job performance, the quality of care will suffer if workers are hired without training and do not receive it after they are hired.

The Danish experience seems to show that serious policy attention to training care workers makes a difference. In particular, the reforms of the past decade in Denmark are distinguished by the integration of vocational and higher level training with employment.

Some research also suggests that training models and approaches for direct care workers may need to be revised. In many countries, there is easy access to the lower skilled occupations in elder care but little vertical or horizontal mobility once in the profession, let alone access to more professionalized occupations, such as nursing, that require formal advanced training (Christopherson 1997). This lack of career mobility, combined with such trends as increased self-employment among care workers (as in France, for example), can make care work a dead-end occupation, both in the perception of potential employees and in fact. The lack of mobility can be particularly devastating to home care recruitment efforts, as home care often competes for employees with hospitals, residential institutions for the aged, and hospitality and leisure services, where qualifications required for entry may also be low but career paths are usually clearer.

One option for carving career paths for care workers is allowing credit for experience in place of formal training for the achievement of credentials (Christopherson 1997). Such a program is available in Australia, and one is planned in France in conjunction with the recent revision in care work credentials.

Recognition of skills and experience can encourage employees to upgrade their skills and make the acquisition of those skills more visible to employers. Christopherson (1997) points out, however, that there could be a conflict between professionalizing care work, on the one hand, and opening it up to workers with little or no training, on the other. Deemphasizing skills can increase worker access to the elder care profession, at least at the lower rungs. But the French experience suggests that moving the unemployed into the workforce without at least some training can create an underclass of precarious jobs that offer little or no upward mobility.

**The care worker's role in service delivery.** Frontline care workers are often not considered members of their clients' health care and home care teams, despite their extensive contact with the client and understanding of the client's needs (see, for example, Canadian Home Care Human Resources Study 2002). As a result, the care worker is often not included in care planning. Recognizing and enhancing the care worker's role in service delivery can enhance the worker's job satisfaction and the quality of care.

**Summary.** All five study countries face problems concerning pay, hours, training, and the care worker's role in service delivery. While this report does not focus detailed attention on the U.S. care workforce, these problems are endemic in the United States as well and can complicate efforts to recruit and retain care workers.

Adequate pay is the foundation on which workforce improvements must be built, but the experiences of the study countries suggest that other elements are also important. Many care workers put in uncompensated time—in care planning and client-to-client travel, for example—that decreases their effective earnings per hour. Many want full-time jobs, with adequate wages and benefits, rather than part-time or irregular hours.

Training care workers—particularly those who provide home care—becomes more important as medical advances permit more persons with complex needs to live in the community rather than in specialized institutions. Training—whether in the classroom or the workplace—also is necessary to provide the horizontal and vertical career mobility that will keep workers in the profession.

Finally, the care worker's frontline role needs to be recognized in service delivery. A better paid and better trained workforce will provide better care, which should be the ultimate goal of workforce policies.

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## Tables

**Table 1. U.S. Employment Needs in Selected Elder Care Occupations for 2002 and Projected Needs for 2012 (numbers in thousands)**

Occupation	Employment		Projected Change	
	2002 (actual)	2012 (projected)	Number	Percent
Nurse's aides, orderlies, and attendants	1,375	1,718	343	25
Home health aides	580	859	279	48
Personal and home care aides	608	854	246	40

Source: Hecker 2004.

**Table 2. Percentage of Population Age 65 Years and Older, by Country, 2001–2002<sup>1</sup>**

Country	Percentage
Australia	12.7
Canada	12.7
Denmark	14.8
France	16.2
Netherlands	13.6
United States	12.4

<sup>1</sup> Data for Australia and Canada for 2002, all other countries for 2001.

Source: Organization for Economic Co-operation and Development 2003.

**Table 3. Total Population and Percentage of Population Age 45 Years and Older Requiring Long-Term Care, by Country, 2000–2050.**

<b>Total Population (in millions)</b>						
Year	Australia	Canada	Denmark	France	Netherlands	United States
2000	19.1	30.8	5.3	59.2	15.9	283.2
2010	21.0	33.2	5.4	61.2	16.3	308.6
2020	22.7	35.6	5.4	62.4	16.5	334.2
2030	24.2	37.7	5.3	62.9	16.6	358.5
2040	25.4	39.2	5.2	62.7	16.3	378.8
2050	26.5	40.4	5.1	61.8	15.8	397.1
<b>Percentage of Population Age 45+ Requiring Care<sup>1</sup></b>						
2000	2.5	2.5	2.9	2.9	2.7	2.4
2010	2.8	3.0	3.3	3.2	3.2	2.8
2020	3.2	3.5	3.7	3.6	3.7	3.1
2030	3.4	3.8	4.0	3.8	4.0	3.4
2040	3.6	3.9	4.1	4.0	4.1	3.5
2050	3.6	3.9	4.1	4.1	4.2	3.5

<sup>1</sup> Projections of daily care needs are based on the two most severe disability levels (levels 6 and 7). Persons in this category are judged to require assistance with daily activities more than once during the day.

Source: Author's calculations based on World Health Organization 2003.

**Table 4. Share of Population Age 65 Years and Older in Institutions and Receiving Home Care, Various Years (in percentages)**

<b>Country (year)</b>	<b>Percentage of Population Age 65 Years and Older</b>	
	<b>In institutions</b>	<b>Receiving home care</b>
Australia (2003)	5.7	21.0
Canada (1993)	6.2	17.0
Denmark (2001)	9.1	25.0
France (1997)	6.5	6.1
Netherlands (2003)	8.8	12.5–13.0
United States (2000)	4.2	8.7

Source: Gibson, Gregory, and Pandya 2003.

**Chart 1. An Overview of Selected Components of the Care Workforces in the Study Countries**

Workforce Characteristic (measurement units)	Personal Care and Related Workers (2000)			Domestic and Related Helpers, Cleaners and Launderers (2000)		
	Denmark	France	Netherlands	Denmark	France	Netherlands
<b>Gender (%)</b>						
Women	90.0	92.4	96.3	86.2	79.9	80.1
Men	10.0	7.6	3.7	13.8	20.1	19.9
	100.0	100.0	100.0	100.0	100.0	100.0
<b>Age (%)</b>						
15–24	16.1	6.2	14.5	35.8	6.2	24.1
25–44	49.7	56.2	53.8	26.4	49.8	41.2
45+	34.2	37.6	31.6	37.8	44.1	34.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
<b>Working Time (hours)</b>						
Average weekly hours	33.0	33.4	19.0	24.7	26.8	15.3
Full-time employees	39.1	40.3	37.0	36.7	38.0	38.3
Part-time employees	25.5	22.3	17.6	16.8	18.4	12.6
<b>Job Status (%) d/</b>						
Full time	53.9	61.7	9.6	38.2	43.0	10.7
Part time	46.1	38.3	90.4	61.8	57.0	89.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Permanent	80.1	84.8	84.4	86.1	83.9	80.8
Temporary	19.9	15.2	15.6	13.9	16.1	19.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
<b>Union status e/</b>						
Covered	80.0	10.0	30.0	80.0	10.0	30.0
Not covered	20.0	90.0	70.0	20.0	90.0	70.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
<b>Tenure in current job f/</b>						
One year or less	31.0	16.2	17.5	38.2	18.1	15.6
More than one year	69.0	83.8	82.5	61.8	81.9	84.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Chart 1, continued.

Workforce Characteristic (measurement units)	Persons Employed in Community Services as Carers for the Aged or Disabled		Home Health Services Industry a/	
	Australia (2001–2002)		Canada (2001)	
<b>Gender (%)</b>				
Women	84.8		93.0	
Men	15.2		7.0	
Total	100.0		100.0	
<b>Age (%) b/</b>				
15-34	23.7		28.0	
35-54	60.0		55.0	
55+	16.3		17.0	
Total	100.0		100.0	
<b>Working Time</b>				
	<b>Hours</b>	<b>%</b>	<b>Hours</b>	<b>%</b>
	1-24	41.8	1-29	35.4
	25-40	41.6	30-39	35.1
	41+	8.8	40+	29.5
Total		100.0		100.0
<b>Job Status (%) d/</b>				
Full time	35.5		66.0	
Part time	64.5		34.0	
Total	100.0		100.0	
Permanent	c/		86.0	
Temporary	c/		14.0	
Total			100.0	
<b>Union status e/</b>				
Covered	25.0		43.0	
Not covered	75.0		57.0	
Total	100.0		100.0	
<b>Tenure in current job f/</b>				
Less than one year	c/		16.0	
One year or more	c/		84.0	
Total	c/		100.0	

Sources: Author's calculations based on Australian Institute of Health and Welfare (2003b), Canadian Home Care Human Resources Study (2003), and Care Work in Europe (2000). Countries are presented in an order that most easily accommodates differences in data formats.

a/ Occupations include nurses, registered nurse assistants, nurse's aides, homemakers, and other occupations. While this report is generally not concerned with nurses, this grouping of workers was selected to avoid losing detail about distributions of various characteristics. Nurses account for about 26 percent of the care workforce in Canada.

b/ These age categories apply only to Australia and Canada. For Australia, 56 percent of workers in the 35–54 category are 45 years old or older (Australian Institute of Health and Welfare 2003b).

c/ Not available.

d/ For Australia, part-time workers include all those working fewer than 35 hours weekly. For other countries, part-time and full-time workers are as reported in source data.

e/ Terms of collective bargaining agreements may apply to workers regardless of their union membership; see text for country-specific provisions.

f/ Note that tenure categories for Canada are different than those for Denmark, France, and the Netherlands.