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An International Review of Long-Term Care Workforce Policies and Shortages

Shereen Hussein, MSc PhD
e.mail: shereen.hussein@kcl.ac.uk

Jill Manthorpe

Abstract

The developed world's population is aging, due to trends of increased life expectancies and decreased fertility rates. These trends are predicted to increase demand on long-term care services. At the same time, the long-term care workforce is in shortage in most of the developed world. Moreover, such shortages are expected to increase due to parallel socio-demographic factors. The increase in demand for long-term care, coupled with shortage in supply of care workers, has promoted some attention from policy makers. The current paper provides an international review of institutional arrangements for long-term care in different developed countries and in particular explores different strategies used or proposed to resolve the shortage in the long-term care workforce.

Keywords: comparative care systems, social care workforce, older people, population aging, long-term care.

Introduction

The aging of the developed world is widely acknowledged, although not always celebrated or fully understood. Population aging is the result of trends of increased life expectancies and decreased fertility rates. These parallel trends produce a decline of the total population, a decrease in the absolute number and proportion of young people, as well as an increase in the number and proportion of older people, especially the very old. These trends are predicted to continue and to have substantial long-term effects. For policy makers a main concern is the growth of the older population and its increasing (but not universal) need for support as its disabilities and morbidity rise. In most societies this is played out in concerns about increased demands on the health and social care systems and, in particular, on the long-term care system (see, for example, WHO, 2002b; Gibson et al, 2003; Brodsky et al, 2003). In this paper long-term care is defined as the continuing care of disabled older people whether at home or care facilities.

Table 1 provides details of the proportions of people requiring daily care and the 'dependency ratio', in 2000 and 2020 for different countries based on World Health Organization Global Burden of Disease studies (WHO, 2004).

Table 1: Proportion of people requiring daily care and dependency ratio* in 2000 and 2010 in selected developed countries, WHO 2004

Country	Proportion of People Requiring Daily Care (%)		Dependency Ratio (%)	
	2000	2020	2000	2020
Australia	6.0	6.8	9.5	11.4
Canada	6.1	7.1	9.5	12.0
Denmark	6.5	7.4	10.5	12.7
France	6.5	7.2	10.6	12.7
Finland	6.5	7.6	10.4	13.7
Germany	6.9	7.7	11.2	13.3
Hungary	7.4	8.2	11.7	13.6
Japan	6.9	8.0	11.2	15.0
Netherlands	6.3	7.3	9.9	12.4
Spain	6.7	7.6	10.6	12.6
Sweden	6.7	7.7	11.2	13.6
United Kingdom	6.5	7.3	10.7	12.4
USA	5.9	6.7	9.5	11.4

** (Total number of dependent people)/(Population aged 15-59)*

Table 1 shows that most developed countries currently have comparable proportions of their population requiring daily care, with Australia, Canada and the US with the lowest proportions where their populations are currently the youngest among the developed world. However, by 2020 it is predicted that both the proportion of the population requiring daily care and 'dependency ratio' will catch up. By 2020 the dependency ratio will be highest in Japan followed by many EU countries. It should be noted though that the range of differences is not dramatically wide across the developed world and that 'dependency ratio' measures are crude, in particular they do not reflect large numbers of older family carers.

While some argue that such demographic trends, including population aging, are not guaranteed to continue and other unpredicted factors may change the equation (Friedland and Summer, 1999; Shaw, 2002), the number and proportions of older people are increasing in most developed countries. For example, in Europe, the share of persons aged 65 or more is predicted to rise from 16 percent in 1999, to 21 percent of the population in 2020 and to 28 percent in 2050 (Schulz et al, 2004). However, there is no simple relationship between these demographic trends and a similar increase in demand for long-term care. The level of need for formal or paid long-term care depends not only on life expectancy, but also on health status, marriage patterns, household composition, living arrangements and other factors. Many argue that the need for long-term care depends not only on actual age or life expectancy, rather on problems with 'health expectancy' or limited 'disability-free life expectancy' (Mertens, 1994). Although some predict that the number of disability-free years will increase (Tallis, 1992; WHO, 1998), the net effect of increased life expectancy and disability-free life expectancy on long-term care is not conclusive (Jacobzone et al, 2000).

In providing long-term care for older people, many of the developed countries, especially in Western Europe and Scandinavia, are moving from institutional care to

community or home care provision, encouraging informal family support, implementing direct payments and consumer centered programs and integrating housing, health and social care services (Gibson et al, 2003). However, each country is at a different stage of implementing such policies and other countries are still considering which is the best strategy to adopt.

Informal care providers, such as un-paid family members, as well as formal care providers, such as nursing aides, home care assistants and other paid care workers, constitute two parallel systems of support providing long-term care. At the same time, both informal caregivers and formal care workers, such as homecare workers and staff in residential and nursing homes, are increasingly in short supply in most of the developed world. It is well documented that most care delivered to older people or people with disabilities is provided by families, mainly women, or by other 'informal' caregivers (Sundstrom, 1994). The continued availability of family members is not guaranteed due to many demographic and socio-economic trends. With changes in family structure and increases in the contribution of women to the labor force and population aging as well as other factors, the availability and willingness of informal care are being negatively affected (Brodsky et al, 2000; WHO, 2002b; Eborall, 2003). At the same time, again due to another interrelated set of factors, the formal care workforce is in short supply in most of the developed world (Eborall and Garmeson, 2001; Eborall, 2003; Stone et al, 2003).

The current situation requires attention from policy makers not only to consider the challenge of devising strategies to face the predicted increase in demand for long-term care but also to address the emerging shortages of care workers in most of the developed world. This paper explores different strategies used or proposed to resolve the shortages in the long-term care workforce. Such strategies may target both formal and informal caregivers but this paper focuses on 'formal' or paid caregiving and more specifically on direct care workers. This analysis was conducted through a literature search using the key words: long-term care, workforce, shortage, policies, and care giving in English-speaking databases. Secondary materials have been located and analyzed. The search took into account the considerable variation in terms used for direct care workers, including home helps, care assistants, home care workers, nursing aides, aide domicile, support workers, care assistants and others. Direct care workers are defined as those who are not professionally qualified but are employed to provide care, support and assistance to older people with long-term disability or illness.

Formal Long-Term Care Services

Not all developed countries have recognized population aging at the same time or have experienced it at the same speed; however, most of them are in a situation that has necessitated a review of formal long-term care strategies. While all developed countries provide long-term care services, only few have implemented long-term care systems based on legislation and entitlement principles rather than on budget-limited programs and means testing. Examples of the former are Austria, Germany, Japan and the Netherlands. Formal care for older people with disabilities can be divided: by location, into home care, day care and residential/nursing home care, or by function, into personal care, respite, rehabilitation, and protection. However, differences between types of care services are becoming less distinct with movements away from

institutional provision to supporting older people in their own homes. This makes cross-national comparisons increasingly complex.

Many long-term care policy debates revolve around the issue of whether the individual and family, or society as a whole, should be responsible for providing and caring for older people with disabilities (Wiener et al, 1994). Policies around providing long-term care across the developed world vary and in many cases reflect the political position of some countries. In some, such as the UK and the US, state support is less concurrent and more a replacement occurring after family resources are exhausted. The provision of care is usually mean tested. On the other hand, in countries such as Denmark, Germany and Japan, the availability of informal care is not taken into account in providing services (Cuellar and Wiener, 2000; Campbell and Ikegami, 2000). However, Robinson (2004) observed that many people using the services in Europe do not see their countries have achieved a rational or publicly acceptable division of funding of long-term care between the state, the individual and their family.

In the Europe Union (EU) there is wide variation in services provided by governments to older people. The Nordic and Mediterranean countries are situated at the upper and lower extremes of the range. According to Rostgaard (2002), there are two clearly defined groups of countries at these extremes and a less clearly differentiated group of countries in between. Overall, in the mid 1990s within the EU, Denmark and Sweden have high levels of care for older people; the Netherlands and the UK have slightly less, while Belgium and France have less. Germany together with the Southern European countries have minimal state provided care for older people (Deven et al, 1998).

Such classifications do not reflect major difference between countries. For example, in Sweden, successive governments have prioritized care for older people and a favorable economic situation facilitated the training of well-qualified staff to provide good standards of care (Johansson and Noren, 2002). Here responsibility for the care of older people is split between different levels of government. To reduce expenditure and provide an alternative, public care provision has been opened to the private or commercial sector. Home care is the most commonly used service by older people in Sweden. The aim behind such provision is to enhance the quality of life of older people and it is more economical than residential care (WHO, 2002a). The Swedish welfare system is characterized by universalism, thus it does not focus on certain "disadvantaged" groups and it is not means tested. Reforms across the 1990s emphasize freedom of choice and free market solutions and aimed to improve living conditions for users (Johansson and Noren, 2002).

In contrast, in Denmark most care services are still provided by the public sector. The ideology of this welfare state is that the public sector is the best way to secure the welfare of its citizens. Denmark is recognized as one of the leaders in Europe in the development of home and community based services for older people (Stuart and Weinrich, 2001). Nearly all care services for older people and people with disabilities come under one Ministry (Social Affairs) and a single piece of legislation (Social Service Act). This has happened in close collaboration with the informal care sector, but there is no tradition of charity or voluntary organizations offering practical support for older people (Jensen and Hansen, 2002b). Almost all health and long-term

care services are financed through public taxes and provided to individuals largely without charge (Stuart and Weinrich, 2001). Also there is no strong tradition of private (for profit) care provision for older people, with the exception of the home service schemes, which were introduced in 1996 and are publicly supported (Jensen and Hansen, 2002b).

Although the Netherlands appears similar to Denmark, long-term care is funded through compulsory insurance and is increasingly close to health care (Moss and Cameron, 2002). Here, between 1940s and 1960s, national policy was to encourage old people to move into residential homes. More recently, national policy has prioritized home care. According to Ewijk (2002), the Netherlands has the highest rate among Western European countries, of severely disabled men and women. The Netherlands is considering a policy which aims to reduce demand for formal care by: emphasizing informal care; setting up support systems for informal carers; stimulating solidarity between generations; and expanding respite schemes for family carers. It is also attempting to create new markets by: cash for care schemes; privatization of services; and enlarging choices in care services (Ewijk, 2002).

The United Kingdom has a national care system, delivered by local government. Under the National Health Service (NHS) and Community Care Act 1990 institutional and community long term care services became the responsibility of local government (social services or social work departments). The NHS is responsible for a small portion of long term care that is primarily medical in nature. All local authority social care is means-tested and takes into account both income and the value of an individual's primary residence for residential care (Montgomery and Feinberg, 2003). Care staff are not well paid: Moss and Cameron in 2002 showed that UK formal care workers earn much less than their Danish counterparts who also have better occupational benefits (e.g. better paid maternity and parental leave).

In 1996 Germany adopted a mandatory long-term care system for all citizens, based on the principle of social insurance. Support may be provided in the form of home care services delivered by care workers to people with disabilities or as unrestricted cash payment for disabled people themselves to pay a caregiver (Montgomery and Feinberg, 2003). Formal care services are said to be more involved in providing long-term care, in relation to supporting informal care giving, in East Germany compared to West Germany. This may indicate different cultural expectations and practices regarding the care of older people. It is suggested that in East Germany women are more oriented towards paid work and the state is seen more as the provider of social care (Dallinger, 2002).

Other EU countries, including Greece, Spain, Italy, Hungary and Poland, have continued to rely on the traditional provision of informal care by the family. In these countries the rapid aging of the population is reported as leading to a crisis in family care so that families with some economic means are turning for support to migrant workers (Diaz et al, 2002; Lamura et al, 2003). However, the family care system is also maintained because there are still large numbers of housewives, and because female unemployment is high in all age groups (Diaz et al, 2002). In Hungary, as well, the majority of care for older people is provided by family members (Vajda and Korintus, 2002). In Greece and Poland there is few specialist services, however, older people have the same access to healthcare provision as the rest of the population.

Outside Europe, in the US, twenty-eight states have filial support laws, but their use is rare. The US has no national community-based long-term care program, but Medicare and Medicaid support some long-term care (WHO, 2002a). Medicaid is the largest single payer for long-term care. The majority of its spending is on institutional care, about 30 percent for Home and Community Based Services (HCBS). Some state-funded programs offer HCBS to persons who are not eligible for means-tested programs like Medicaid (Montgomery and Feinberg, 2003).

Japan has the highest life expectancy in the world, both for males and females. In Japan the financing of care of older and disabled people is derived from general revenues and mandatory payroll contributions (Commonwealth of Australia, 2001). In 1989, the government introduced the 'Gold Plan', a ten-year program to promote the health and welfare of older people. The goal of this plan was to establish a long-term care system that focused on home care rather than on institutional care. The Gold Plan aimed to broaden the range of services provided for older people through the expansion of nursing homes and employing more home care workers. By 1999, the Gold Plan was seen as a failure in this regard. In 2000, a second Gold Plan was introduced and the Long-Term Care Insurance (LTCI) program was established offering community services coverage on an individual entitlement basis (Parliament of Australia, 2004).

It is clear from this review that some of the developed countries have more established strategies of providing long-term care, such as the Scandinavian countries, while others, such as Japan, recognize the necessity of developing formal long-term care policies but are still in the early stages of developing them. On the other hand, many other countries, especially in Southern and Eastern Europe still rely heavily on family care and are not currently developing more comprehensive formal long-term care strategies. This is due in large to the fact that unemployment rates, in particular among women, living in many countries in Southern and Eastern Europe are still high (UN, 2002; ILO, 2004). These higher rates of unemployment mean unpaid family care is feasible, at the same time, many governments have not been under public pressured to address formal long-term care arrangement. This section confirms the dependence on informal care as well as the variations in formal care systems in many developed countries. Any formal care system needs a workforce of course. However, this is in short supply in many countries. The next section outlines the nature of the workforce shortage and explores the emerging strategies to resolve such shortages. The focus is on direct care workers, not nurses or other professional groupings.

The Shortage of Formal Care Workers

Paid care workers such as home care assistants, nursing assistants or nursing aides, are the backbone of the formal long-term care system (Gass, 2004). These workers provide essential care and support to millions of older people as well as younger people with chronic diseases and disabilities. As shown in the previous sections, most who require long-term care rely on family members, and friends. However, an increasing proportion of long-term care service users depend, in part or exclusively, on formal long-term services. Paid care workers provide support to older people living in their own homes, residential homes, and nursing facilities. The human relationship between older people and their direct care workers is the core of long-

term care. At the same time, care work is physically and emotionally challenging, yet poorly rewarded financially (PHI, 2003; Stone et al, 2003).

Currently, most developed countries are experiencing a shortage of formal long-term care staff. For example, in the US, a national survey conducted in 2003 found that over three-quarters of states, out of 44 states, identify direct-care vacancies as a serious workforce issue (Harmuth and Dyson, 2004). A study of turnover and vacancy rates conducted by the American Health Care Association reported that 52,000 certified nurse assistant (CNAs) positions are vacant across the United States, with annual nurse aide turnover rates exceeding 60 percent in 32 states, and exceeding 100 percent in 10 states (DECKER ET AL, 2003). These vacancy rates may reflect a shortage of those who can apply for such posts but also may point to unattractive pay packages, coupled with high job requirements. In the United States, long-term care providers have reported difficulty in recruiting and retaining care workers since the 1990s (Kane, 2003). Simultaneously, in the US it is predicted that the total number of long-term care jobs for direct care workers will need to increase by 45 percent between 2000 and 2010 (DOL and HHS, 2003).

A chronic shortage of staff in social care is observed through the UK and in particular in the capital city (Douglas, 2002; Johnson, undated). In 2002, vacancy rates among different social care worker categories ranged from 6 percent to 16 percent in England, with home care vacancies at 11 percent (Eborall and Garmeson, 2001). The Local Government Association's Workforce Planning Group's Recruitment and Retention Survey (England) identifies an average vacancy rate for home care workers of 10 to 12.8 percent, with a higher level in London and the southeast (UNISON, 2003).

There is increasing qualitative evidence, from both the UK and the US, that recruitment and retention problems are affecting both the quantity and the quality of long-term care services. These shortages have placed enormous burdens not only on care providers, but also on already vulnerable service users. Older people using services, especially those receiving home and residential care, often endure rushed care, loss of continuity, higher risk of injuries, and loss of experienced carers (Wilner, 1998; Frank and Dawson, 2000; Callahan, 2001; BBC 2003; CHCF, 2004).

In most countries the majority of paid home care workers are women, in the age group 25 to 49 years and usually from relatively poorer backgrounds with lower educational attainment (Eborall and Garmeson, 2001; Moss and Cameron, 2002). As mentioned above, this pool of potential recruits is not only small but also shrinking in most of the developed world. In addition, other job opportunities now exist for the same pool and are not in favor of the social care system, in terms of pay, flexibility and demands of the work (Kane, 2003). To cap it all, the image and value of social care workers are not positively established among the public (Wilner, 1998; Stone, 2000). As noted earlier, developed countries will experience a consistent increase in their older populations. The result of these demographic shifts is an emerging "care gap" that could severely affect the supply and quality of long-term care.

Although direct care workers usually report high job satisfaction through feeling they are meeting individual needs, such work can be highly physically and emotionally demanding (Eborall, 2003). For example, in Denmark workers caring for older people

report having a higher level of job satisfaction more than the workforce in general, nevertheless, the majority often feel over-loaded by the work. For Danish care workers the job is important because of its content while the salary is a minor factor, but here, exceptionally, the salary of women care workers is not significantly lower than in other jobs (Jensen and Hansen, 2002a). However, this is not generally the case in other countries. For example, in the US Stone and Weiner (2001) find that direct care workers do not feel valued by their employers and in particular by their direct supervisors. Several studies have examined high turnover among direct-care workers in the US and concluded that economic conditions and the level of compensation greatly influence the decision of workers to leave, even the job is satisfying (Banaszak-Holl and Hines, 1996; Leon et al., 2001). These studies clearly indicate that although that job satisfaction is important for direct care workers, levels of payments and benefits may be important in recruiting and retaining them. The Danish example helps to establish that reported high job satisfaction may be due to, in part, to the comparable level of payment of direct care workers with other sectors.

As a whole the research reveals considerable unanimity over the numerous factors contributing to the difficulty of recruiting and retaining direct care workers. Wages are generally low and benefits are poor; job preparation, continuing education and training frequently fail to prepare these workers for what they face in caring for people with increasingly complex needs, and advancement opportunities are often limited. Direct care workers often do not feel valued or respected by their employers and supervisors. Despite having more interaction with people than many other members of the care team, these workers are often excluded from decision-making involving care (Feldman, 1994; Banaszak-Holl and Hines, 1996). Without good pay and with limited job satisfaction direct care workers are likely to pursue jobs in other sectors such as retail or restaurants (Eborall, 2003).

Responses to Staffing Shortages

In order to reduce the observed and predicted shortage in the direct care workforce, both short and long-term strategies have emerged. These strategies reflect twin objectives: to encourage more people to join the social care workforce and secondly to promote retention for longer periods. Because the main catalyst for these strategies is the observed shortages and high vacancy rates, impacts on the quality of direct care workers have been sometimes overlooked (Stone, 2004). Some strategies have acknowledged the importance of the initial training and support of direct care workers (McFarlane and McLean, 2003). Public perception of social care work has also been identified as in need of change (Wilner, 1998; Eborall, 2003; Stone et al, 2003). An attractive image of direct care workers, which emphasizes their importance and the work's benefits, has been propagated through media, universities, and schools in some areas (Stone, 2000).

To achieve both recruitment and retention, responses suggest that employers will need to identify or construct real advantage in choosing to work in social care. In respect of holding on to staff, career paths, or at least opportunities for promotion, are seen as important in retaining care workers (Nakhnikian and Kahn, 2004). Training and opportunities to learn new skills have been evaluated and appear to lead to higher job satisfaction and better levels of retention than employment where these are not promoted (Kane, 2003).

In order to develop and sustain the direct care workforce at both policy and practice levels some consider that a partnership is needed between a variety of services in different areas, such as health, long-term care, labor, welfare, and immigration (Stone, 2004). These partnerships may be able to address both short and long-term goals simultaneously. For example, if a temporary pool of direct care workers is approached, such as high-school students, a long-term may plan need to be in place aiming to attract those who can fill the jobs and stay in the work for as long as possible (DOL and HHS, 2003).

The next sub-section describes some of the current initiatives and arrangements deployed by different countries to develop new pools of direct care workers and retain those already working in the field. Initiatives addressing shortages in direct care workers vary widely across the developed world and many of them focus on local rather than national levels. It was evident in this review that although retention is a common theme of most of the strategies, the focus of activities is mainly on the recruitment of direct care workers. That is especially true in respect of local or small-scale initiatives. The following subsection identifies and describes some of the initiatives adopted by different countries, and local areas, to address these shortages.

Recruitment Initiatives

In the US, the recognition of shortage of long-term care workers in general and direct care workers in particular has prompted the Department of Labor and (DOL) and the Department of Health and Human Services (HHS) to collaborate in developing further strategies to manage this shortage. In 2003 new initiative of a two-year research project was set up to develop a 'toolkit' to enable state agencies, long-term care providers, and worker groups to asses the impact of policy and practice changes designed to reduce vacancy and turnover rates among direct care workers, and to improve workforce quality. In addition, the DOL is engaged in several programs aiming at increasing the supply of care workforce through training programs targeting non traditional groups of people, such as youth and 'hardest-to-employ' groups (DOL and HHS, 2003). In the US, a campaign to improve the image of the social care workforce targeted four groups: newly retired or recently widowed adults looking to fill empty hours; college students looking for part-time or other job options; retail or food-service workers looking for more "meaningful" jobs; and homemakers looking to be paid for their care giving skills (Stone, 2000).

Some states are experimenting with initiatives such as recruiting high school students to the field through programs established by the School to Work Opportunities Act of 1994. A current example is a 'School at Work' pilot project in five states, with 50 worksites, providing training for low-skill, entry-level workers in health care. Another recent project involves cross-training and upgrading the skills of home care workers in New York City in order for them to qualify to provide Medicare services and enhance their employability (DOL and HHS, 2003). Other states are broadening the care workforce pool by considering former welfare recipients as candidates through the Welfare to Work Program (WtW) (Harmuth, 2002). This is not new: in the early 1990s Colorado trained and recruited local homeless people as nursing assistants, through 'Operation Opportunity', however, there has been no formal evaluation of

this program (NCDFS, 1999; Stone, 2000). A retention initiative is the 'Wage Pass-Through' (WPT), where states use some portion of their funding sources specifically to increase wages and/or benefits for direct care workers (NCDFS, 2001). However, most of the WPTs have been 'one-shot' strategies and rely on the initial state budget. Following this, most increases of wages have been relatively modest with limited effects (Stone, 2004).

Throughout Europe, similar approaches have been suggested or implemented to tackle the shortage of care workers. These include: improving levels of education and professionalism (e.g. Denmark, Sweden); improving recruitment strategies, in particular from under-represented groups (e.g. the Netherlands, UK); extending the working lives of the existing workforce (e.g. the Netherlands, Sweden); improving employment conditions (e.g. Sweden); job enrichment and career enhancement (Germany); and a number of other measures such as media campaigns to improve care work's public image (Moss et al, 2002).

Other small-scale initiatives include home-share schemes such as in Barcelona (Spain) where students live with older people; a similar program is found in Australia and other countries. The idea is that students help in the housekeeping and keep the older person company, and they may live there for free (Linden and Steenbekkers, 2003).

The Netherlands proposes to attract new employees through: investing in recruitment strategies; improving the image of care-work; improving working conditions; improving salaries and fringe benefits; raising the average hours worked per week; raising the retirement age; to create new flexible arrangements in relation to family life and life course; and to target new groups such as ethnic minorities, people from abroad, and former care workers (Ewijk, 2002).

Formal care workers in Hungary have one of the lowest earnings in Europe and this consequently means Hungary faces acute shortage of care workers (Moss and Cameron, 2002), and its recent accession to the European Union (2004) may exacerbate this. Hungary has started to address this labor shortage within the care sector and appreciates that one of the causes is the very low level of wages; and the low 'prestige' of care opportunity. However, no formal strategy has yet been currently adopted to address this shortage (Vajda and Korintus, 2002).

Immigration has been suggested as a way of creating new pools of workers (Stone 2000; Callahan 2001). However, there are many aspects to be considered from possible language and cultural barriers between those providing and those receiving care (Stone and Wiener, 2001), to the long-term impact of low-waged immigrants on the political, demographic and social structure of the country. Although immigration may seem as an 'immediate' supply of care workers, new immigrants, most probably, will move on for 'better' careers after few years leaving their positions unfilled. Therefore, a continuous flow of immigrants would be needed if pay and perceptions of such work remain unchangeable and unattractive to the main population. Thus immigration as a tool of creating more supply of direct care workers may prove a short-term solution not a long-term one (DOL and HHS, 2003). Moreover, concerns about immigration, especially in the US, have been aggravated by the war on

terrorism and the post 9-11 attitude complicating the matter furthermore (Stone, 2004).

Nevertheless, some countries such as Japan, Italy and Germany have already begun to pursue active immigration strategies for international recruitment of direct care workers. For example, Italy recruits from Peru, and Japan is encouraging immigration from the Philippines (Stone and Wiener, 2001). In Germany, the literature suggests that there is a tendency for older people and their families to use the cash benefits to finance unofficial care-services, which are cheaper and staffed mainly from Eastern Europe (Dallinger, 2002).

In Denmark, nearly all women in their working age are already working and there seems to be nearly no 'spare labor force' in this category. Moreover, some local governments have problems recruiting enough care workers and others anticipate serious problems in recruiting qualified workers in the future. Some local governments have tried to motivate existing staff to increase their weekly working hours, however, this is usually not feasible as care workers already have a high rate of working hours. Here the government has turned its attention to immigrants already in the country and ethnic minorities to recruit care workers. Other recruitment measures have been taken, such as offering young students a salary as trained care workers, arranging special courses for students from minority ethnic-groups and by campaigns to promote the image and status of working in the care sector (Jensen and Hansen, 2002a; 2002b).

In many countries, such as UK and US, immigration initiatives have been designed to expand the pool of qualified professionals with little attention to the paraprofessional or non-qualified workforce (Stone and Wiener, 2001). As with professionals, one possible solution could be the recruitment of refugees and asylum seekers, and those entering for family unification, already in the country, but little is known of this potential. There is some indication that providing training and language courses and other opportunities might be attractive to refugees who had prior health care experiences in their countries (Stone, 2000; PHI, 2003).

Conclusion

Addressing the direct care workforce shortage is not only a matter of public policy, but also a matter of practical implementations. Current and predicted trends in increased life expectancy coupled with observed and expected shortages in long-term care workforce would seem to require immediate consideration by policy makers in most of the developed world. This review shows that most of the developed world is currently experiencing shortages in the long-term care workforce. It also shows that some countries recognize such shortages and are developing various strategies on response. Policies to resolve such shortages range from small-scale initiatives to wider national strategies. These policies can be summarized into two groups: first, those whose aim is to widen the social care workforce through introducing new pools of workers; such as young people, disadvantaged groups, former service users, immigrants and so on; and second those whose aim is to improve care workers' conditions and thus retention through enhancing their public image, opening new career opportunities and so on; or a combination of both. However, many of these strategies are still in the experimental stage and most small-scale initiatives have not

been evaluated or followed up. This points to the need for longitudinal research into the feasibility and consequences of applying different strategies to address long-term care workforce shortages. Such research needs to reflect local contexts but also global issues, such as migration. It needs to identify recruitment strategies and efforts at retention to say what works, for whom, and why. It needs to consider the views of those who do not join the workforce, those who leave and those who move on to professional training or management posts. Such research also needs to build up further evidence from older people about the characteristics they value among those who are paid to carry out tasks that are sensitive, distressing or intrusive. The involvement of older people in such discussions is very much in its infancy (Andrews et al, 2004; Janzon and Law, forthcoming)

This paper has highlighted some of the factors contributing to the shortage of the direct care workforce, such as: low pay, poor public image and lack of career ladder and training opportunities. It also observes that due to a variety of socio-demographic factors, the traditional pools of supply of both informal caregivers and formal care workers are expected to shrink. Policy makers need to consider two parallel and inter-associated strategies; one to improve direct care workers' job conditions and the other to explore and evaluate the creation of new pools of supply for the growing demand for the social care workforce. It is important to enhance and maintain the quality of direct care workers as well as their quantity. At the moment, evidence suggests that by improving the whole job package job, including pay, career ladder and image, high quality workers from a variety of backgrounds will be attracted to the work and wish to stay.

References

Decker, F., Gruhn, P., Matthews-Martin, L., Dollard, K., Tucker, A. and Bizette L. (2003) *Results of the 2002 AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes,* American Health Care Association, Washington DC.

Andrews, J., Manthorpe, J. and Watson, R. (2004) Involving older people in intermediate care, *Journal of Advanced Nursing* 46(3), 303-10.

Banaszak-Holl, J. and Hines, M. (1996) Factors associated with nursing home staff turnover, *The Gerontologist* 36(4), 512-17.

BBC (2003) A Carer's Story, a Panorama program for BBC News broadcasted on BBC One on Sunday, 16 November 2003 at 2215 GMT.

Brodsky, J., Habib, J. and Hirschfeld M. (2003) *Key Policy Issues in Long-Term Care*, World Health Organization, Geneva.

Brodsky, J., Habib, J. and Mizrahi, I. (2000) *Long-term care laws in five developed countries: A review,* World Health Organization, Geneva.

California HealthCare Foundation (CHCF) (2004) *Snapshot, Nursing Homes: a System in Crisis,* California HealthCare Foundation, California.

Callahan, J. (2001) Policy Perspective on Workforce Issues and Care of Older People, *Generation* 25(1), 12-6.

Campbell, J. and Ikegami, N. (2000) Long-term care insurance comes in Japan, *Health Affairs* 19(3), 26-39.

Commonwealth of Australia (2001) *Australia Japan: A comparison of aged care in Australia and Japan,* Commonwealth of Australia, Canberra.

Cuellar, A. and Wiener, J. (2000) Can social insurance for long-term care work? The experience of Germany, *Health Affairs* 19(3), 8-25.

Dallinger, U. (2002) *Elderly Care in the family in Germany,* Paper contributed to the European Cooperation in the field of Scientific and Technical Research (COST) 13A Meeting, Copenhagen.

Department of Labor (DOL) and Department of Human Health Services (HHS) (2003) *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation, Report to Congress,* Department of Labor and Department of Human Health Services, Washington.

Deven, F., Inglis, S., Moss, P. and Petrie, P. (1998) *State of the Art Review of Reconciliation of Work and Family Life for Men and Women and the Quality of Care Services,* Department for Education and Employment, London.

Diaz, A., Escobedo, A. and Moreno, D. (2002) *National Report, Spain: Surveying demand, supply and use of care,* Care Work in Europe, Thomas Coram Research Unit, London.

Douglas, A. (2002) *Is anybody out there? Recruitment and retention in social care in London.* Community Care: Sutton, London.

Eborall, C. and Garmeson, K. (2001) *Desk research on recruitment and retention in social care and social work*. Prepared for Communication for the Department of Health (COT), London.

Eborall, C. (2003) *The State of the Social Care Workforce in England*, TOPSS England Workforce Intelligence Unit, Leeds.

Ewijk, H. (2002) National Report, *The Netherlands: Surveying demand, supply and use of care*. Care Work in Europe, Thomas Coram Research Unit, London.

Feldman, P. (1994) Dead end: work or motivating job? Prospects for frontline paraprofessional workers in LTC, *Generations* 23 (2), 5-10.

Frank, B. and Dawson, S. (2000) *Health Care Workforce Issues in Massachusetts*. Health Care Forum, Boston, Massachusetts.

Friedland R. and Summer L. (1999) *Demography is not destiny*, National Academy on an Aging Society, Washington DC.
Gass, T. (2004) *Nobody's Home: Candid Reflections of a Nursing Home Aide*, Cornell University Press: Cornell.
Gibson M., Gregory S. and Pandya S. (2003) *Long-term Care in Developed Nations: A Brief Overview*, AARP Public Policy Institute, Washington.
Harmuth, S. (2002) The direct care workforce crisis in long-term care, *North Carolina Medical Journal* 63(2), 87-94.
Harmuth, S. and Dyson, S. (2004) *Results Of The 2003 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce*, Paraprofessional Healthcare Institute (PHI) and the North Carolina Department of Health and Human Services (NCDHHS) Office of Long Term Care: North Carolina.
International Labour Office (2004) *Global Employment Trends,* International Labour Organization, Geneva.
Jacobzone, S., Cambois, E. and Robine J. (2000) *Is the health of older persons in OECD countries improving fast enough to compensate for population Ageing?* OECD Economic Studies 30.
Janzon, K. and Law, S. (forthcoming), *Older People's Influence on Social Care: Research Review on User Involvement in Promoting Change and Enhancing the Quality of Social Care,* Social Care Institute of Excellence, London.
Jensen, J. and Hansen, H. (2002a) *Review of literature since 1990: Psychosocial job environment, job satisfaction, gender and other diversities in the care workforce, and quality of care services: Denmark,* Care Work in Europe, Thomas Coram Research Unit, London.
Jensen, J. and Hansen, H. (2002b) *Surveying demand, supply and use of care: Denmark,* Care Work in Europe, Thomas Coram Research Unit, London.
Johansson, S. and Noren, P. (2002) *National report, Sweden: Surveying demand, supply and use of care*, Care Work in Europe, Thomas Coram Research Unit, London.
Johnson, J. (undated) *Care to stay? A report into the recruitment and retention of social work and social care staff,* Local Government National Training Organisation LGNTO, London.
Kane, A. (2003) Human resources for long-term care: Lessons from the United States. In Brodsky et al. (eds.), *Key Policy Issues in Long-Term Care*, 191-224, World Health Organization, Geneva.
Lamura, G., Melchiorre, M., Mengani, M., Quattrini, S. and Balsucci, C. (2003) *Supporting carers of older people in Europe: a comparative report on six European countries*. Presented at the 11th European Social Services conference- Venice, 2nd – 4th July 2003.
Leon, J., Marainen, J. and Marcotte, J. (2001) *Pennsylvania's Frontline Workers in Long-Term Care: The Provider Organization Perspective*. Polisher Geriatric Institute, Philadelphia.
Linden, M. and Steenbekkers, L. (2003) *Present Practices*, a report on the ELDERATHOME project, European Union, the Fifth Framework Programs, Quality of Life and Management of Living Resources, Brussels.
Mertens, W. (1994) *Health and Mortality Trends among Elderly Populations Determinants and Implications*, International Union for the Scientific Study of Population IUSSP Policy and Research Paper.
McFarlane, L. and McLean, J. (2003) Education and training for direct care Workers, *Journal of Social Work Education* 22(4), 385-99.

Montgomery, A. and Feinberg, L. (2003) *The Road to Recognition: International Review of Public Policies to Support Family and Informal Caregiving,* Family Caregiver Alliance, Policy Brief, Washington DC.
Moss, P. and Cameron, C. (2002) *Care Work and the Care Workforce: Report on stage one and state of the art review,* Care Work in Europe, Thomas Coram Research Unit, London.
Moss, P., Escobedo, A., Fernandez, E. and Moreno, D. (2002) *Surveying Demand, Supply and Use of Care: Consolidated Report,* Care Work in Europe, Thomas Coram Research Unit, London.
Nakhnikian, E. and Kahn K. (2004) *Direct-Care Workers Speaking Out On Their Own Behalf,* Institute for the Future of Aging Services, Washington.
North Carolina Division of Facility Services (NCDFS) (1999) *Comparing State efforts to address the recruitment and retention of nurse aide and other paraprofessional aide workers*, North Carolina.
North Carolina Division of Facility Services (NCDFS) (2001) *Results of a follow-up survey to states on career ladder and other initiatives to address aide recruitment and retention in long-term care settings,* North Carolina.
Paraprofessional Healthcare Institute (PHI) (2003) *Long-term care financing and the long-term care workforce crisis: causes and solutions*, Citizens For Long Term Care, Washington.
Parliament of Australia (2004) *Ageing Society, Japan's Economy Implications for Australia,* Report 2, Japan Politics and Society. Accessed online on 27/1/2004 http://www.aph.gov.au/senate/committee/fadt_ctte/japan/report2/contents.htm.
Robinson, P. (2004) *How do we pay? Funding public services in Europe*, The Institute for Public Policy Research (ippr), London.
Rostgaard, T. (2002) Caring for Children and Older People- A Comparison of European Policies and Practices, *Policy Studies* 23(1), 51-68.
Schulz, A., Leidl, R. and König, H. (2004) The impact of ageing on hospital care and long-term care- the example of Germany, *Health Policy* 67(1) 57-74.
Shaw, F. (2002) Is the ageing population the problem it is made out to be? *Foresight* 4(3), 4-11.
Stone, R. (2000) *Long-term care for the elderly with disabilities: Current policies, emerging trends, and implications for the twenty-first century*. American Association of Homes and Services for the Aging (AAHSA), Washington DC.
Stone, R. (2004) The Direct Care Worker: The Third Rail of Home Care Policy, *Annual Review of Public Health* 25, 521-37.
Stone, R. and Wiener, J. (2001) *Who will care for us? Addressing the long-term care workforce crisis,* The Urban Institute and the American Association of Homes and Services for the Aging, Washington DC.
Stone, R., Dawson, S. and Harahan, M. (2003) *Why workforce development should be part of the long-term care quality debate*, American Association of Homes and Services for the Aging and the Institute for the Future of Aging Services, Washington DC.
Sundstrom, G. (1994) Care by families: An overview of trends. In: Hennessy P. (ed), *Caring for Frail Elderly People: New Directions in Care, 15-55,* Organisation for Economic Co-operation and Development, Paris.
Tallis, R. (1992) Rehabilitation of the elderly in the 21st century, *Journal of the Royal College of Physicians of London* 26(4), 413-22.
UNISON (2003) *Poverty begins at home – Domiciliary care,* UNISON, London.

United Nations (2002) *Women's Entrepreneurship in Eastern Europe and CIS Countries,* United Nations Economic Commission for Europe, Geneva.
Vajda, G. and Korintus, M. (2002) *Surveying demand, supply and use of care: Hungary,* Care Work in Europe, Thomas Coram Research Unit, London.
Wiener, J., Illston, L. and Hanley, R. (1994) *Sharing the burden: Strategies for public and private long-term care insurance,* The Brookings Institution, Washington.
Wilner, M. (1998) *Paraprofessionals on the Front Lines: Improving Their Jobs, Improving the Quality of Long-Term Care,* National Association of Retired Persons, Washington DC.
World Health Organization (WHO) (1998) *Life in the 21st Century - A vision for all: Executive Summary*, World Health Organization, Geneva.
World Health Organization (WHO) (2002a) *Responsibilities for care throughout the life span: A brief look at the family and long-term care laws in Sweden, Canada and the U.S. with a particular focus on the ageing,* World Health Organization, Geneva.
World Health Organization (WHO) (2002b) *Current and future long-term care needs, an analysis based on the 1990 WHO study, the global burden of disease,* World Health Organization collection on Long-Term Care, Geneva.
World Health Organization (WHO) (2004) *Country profiles on long-term care.* Accessed online http://www.who.int/chronic_conditions/countryprofiles/en/print.html