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Health Human Resources in Long-Term Care: Ten global insights about how to increase and stabilize the long-term care workforce in Canada

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Executive summary

This Issue Note summarizes our understanding of measures in Canada and among Organisation for Economic Co-operation and Development (OECD) countries that have helped increase the long-term care (LTC) workforce. Lessons for Canada draw from both the published literature and consultations with expert key informants.

Question

In this Issue Note we consider selected measures from Canada and internationally that have helped to increase the LTC workforce, both before and during the COVID-19 pandemic. This includes health care providers (e.g. nurses, physicians) and those who provide personal or community support (whose title varies depending on jurisdiction) in institutional, community, and home settings. Lessons for Canada draw from both published literature and consultations with expert key informants. We answer two questions:

1. **What measures enable recruitment and retention of the long-term care workforce?**
2. **What lessons can Canada learn from other jurisdictions to inform future planning aimed at strengthening and expanding the LTC workforce?**

Summary of measures that help to recruit and retain the LTC workforce

1. Provide less involuntarily part-time work
2. Extend pro-rated benefits and protections to all LTC workers, including self-employed
3. Increase overall public funding to enable wage parity and equity
4. Increase reliability and flexibility of scheduling for workers
5. Transform 'undeclared' work into 'declared' work
6. Create healthier work environments that support purpose, respect, and autonomy
7. Credential internationally trained professionals
8. Modernize national licensure for Canadian-licensed LTC providers, including physicians and nurses
9. Modernize the national health human resource strategy
10. Consider implementing national long-term care insurance to dedicate funding for long-term care services

Limitations

This report was produced under tight timelines. It is intended only as a 'quick look,' not a comprehensive analysis. To comprehensively analyze the measures that enable recruitment and retention for each type of provider in the LTC sector would require a separate report for each which was not possible in the time available. Strategies to recruit and retain nurses will differ for physicians, as compared to nurses, allied health professionals, and personal support workers. We have identified some of the most commonly used measures relevant across most provider types. As such, though we urge caution in interpretation, we suggest it is still reasonable to consider our findings when crafting policy related to the development of the home care workforce.

Introduction

The COVID-19 pandemic has been the breaking point for many health workers who were already in short supply. ¹ Recruiting and retaining enough workers to meet demand and still provide high quality and safe care has become increasingly difficult in Canada and elsewhere.

As we (hopefully) move toward a post-pandemic work world, recruiting and retaining workers will require big shifts in attitudes toward, and strategies for, developing our health care workforce. “At present, prevailing strategies rely largely on outmoded theories of control and standardisation of work. More modern, and much more effective, theories of production seek to harness the imagination and participation of the workforce in reinventing the system. This requires a workforce capable of setting bold aims, measuring progress, finding alternative designs for the work itself, and testing changes rapidly and informatively. It also requires a high degree of trust in many forms, a bias toward teamwork, and a predilection toward shouldering the burden of improvement, rather than blaming external factors. A new healthcare workforce strategy, founded on these principles, will yield much faster improvement than at present.” ²

In this Issue Note we consider selected measures from Canada and internationally that have helped to increase the long-term care (LTC) workforce, both before and during the COVID-19 pandemic. This includes health care providers (e.g. nurses, physicians) and those who provide personal or community support (whose title varies depending on jurisdiction) in institutional, community, and home settings. Lessons for Canada draw from both the published literature and consultations with expert key informants. We answer two questions:

1. **What measures enable recruitment and retention of the long-term care workforce?**
2. **What lessons can Canada learn from these jurisdictions to inform future planning aimed at strengthening and expanding the LTC workforce?**

Methods

Given the tight timeline (approximately 10 days) for this report, we used Google to search the literature for reports, policy literature, white papers, and government documents; we critically evaluated each source, including the authority and objectivity of their authors. To inform our understanding of issues related to recruitment and retention in the long-term care workforce, we also undertook one-on-one, open-ended, telephone interviews with key informants in the LTC sector, both in Canada and globally. (Appendix 1: Consultants.)

Limitations

Given that this report was produced in approximately 10 days, it is intended only as a ‘quick look,’ not a comprehensive analysis. To comprehensively analyze the measures that enable recruitment and retention for each type of provider in the LTC sector would require a separate report for each which was not possible in the time available. Strategies to recruit and retain nurses will differ for physicians, as compared to nurses, allied health professionals, and personal support workers. We have identified some of the most commonly used measures relevant across most provider types. As such, though we urge caution in interpretation, we suggest it is still reasonable to consider our findings when crafting policy related to developing of the home care workforce.

Results

Much of the relevant global evidence on measures to enable recruitment and retention of the long-term care workforce pre-dates the COVID-19 pandemic. But the world of work is changing, and it’s not easy to predict how people will want to work as we emerge into the ‘new normal’ work environments in the pandemic’s “post-peak” period³, on our way to, hopefully, a post-pandemic world. Our results should be interpreted with this caveat of the shifting landscape in mind.

Among Organisation for Economic Co-operation and Development (OECD) countries, including Canada, low retention rates in the LTC workforce have been one of the main policy challenges in recent decades. Prior to the COVID-19 pandemic, almost two-thirds of OECD countries identified LTC worker retention as “one of the highest political challenges within the LTC agenda.”⁴ Difficult working conditions pre-dated the pandemic: “low competitiveness of wages, precarious job status, demanding jobs with high exposure to physical and mental stress, and low job satisfaction—driven by low support and autonomy—explain why it is difficult to retain workers in LTC settings.”⁴ These conditions were exacerbated by the pandemic.

European data from the United Kingdom (UK), Spain, and France show that even before the pandemic more workers in the LTC workforce were looking for another job than were workers in the hospital workforce, “reflecting either dissatisfaction with the [LTC] work or a lack of job security.”⁴ In Scandinavian countries (Finland, Denmark, Sweden) the “proportions of LTC workers looking for new job opportunities” is high, but similar to that of the hospital workforce, where even before the pandemic one-third to one-half reported that they had “seriously considered quitting.”⁴ The current numbers for all geriatric health care providers in the United States (US) have been inadequate for years and the projected number remains inadequate compared to the estimated 2030 demand when all Gen X baby boomers will have reached age 65.⁵ In the US, about 60% of Gen Z and millennial nurses say that they have four common needs—work-life balance, better pay, more support, and improved working conditions—and that as a result of the pandemic, “they will leave or are considering leaving their positions.”⁶

What measures enable recruitment and retention of long-term care workers in institutional, community, and home care settings?

More than half of OECD countries have implemented various measures⁴—some before and some during the COVID-19 pandemic—to enable recruitment and retention of the LTC workforce, including the following:

1. Provide less involuntarily part-time work

Providing optional longer hours for involuntary part-time workers who want to work more may help to retain workers, especially because it may trigger payment of workers’ statutory benefits.^{7,8} In the Netherlands, workers combine hospital work with LTC work as one way to increase working hours for those with low part-time hours.⁴ This trigger challenges a human resource model, often seen in LTC settings, wherein work is constrained to the lowest possible price point and carved up to avoid paying benefits. This model is disruptive for workers and for those in their care, whose continuity of care is interrupted by a parade of different faces, depending on who is their worker-de-jour.

2. Extend pro-rated benefits and protections to all LTC workers, including self-employed

Public policies ought to make sure that every job in the “caring economy”⁹—which covers all of education and health—is a good job, especially since it generates more than 12% of Canada’s GDP and over 21% of all jobs.¹⁰

Extending eligibility for portable, pro-rated, cumulative, benefits and protections—similar to those with employer-employee contracts—to health care workers who are self-employed or who work in precarious arrangements (such as some casual, temporary, or contract workers) may help to stabilize the LTC workforce. This would include paid sick days and compensation for travel time for workers who care for people in different locations. Without protections like this, misclassification of workers as independent contractors rather than employees creates instability through a second-tier of labour rights, denying these workers—primarily women, and mostly racialized—basic employment protections, like paid sick days or jobless benefits.^{11,12} In the Netherlands, for example, paid home caregivers are sometimes hired as ‘falsely’ self-employed workers if they work for just one client who directs their work, meaning the *de facto* employer avoids their social security obligations by not contributing to disability insurance and pensions.⁴ In Spring of 2022, the Government of Canada held a public consultation to better understand the

experiences of gig workers, meaning those who enter into short-term contracts to complete specific and often one-off tasks but who are often misclassified as so-called independent contractors.¹³ As in the Netherlands and elsewhere, some Canadian workers are “improperly or unlawfully denied employment status and the workplace protections that come with it.”¹⁴ There are calls for government to “proactively enforce the law to ensure that gig employers are making their proper contributions pursuant to the *Employment Insurance Act* and the *Canada Pension Plan*, that gig workers are receiving proper employment insurance and Canada Pension Plan benefits, and that those gig workers whose employment falls within federal jurisdiction are receiving their basic protections under the *Canada Labour Code*” and to amend these acts to simplify and clarify the test for employment status.¹⁴

In Canada, women account for 91% of nurses and 90% of long-term care workers, not including the nearly 8 million unpaid workers, two-thirds of whom are women.¹² Best practices to support girls, women, and gender equality could include implementing gender-responsive analysis, budgeting, and auditing processes, and a gender equality marker for tracking and reporting on allocations and expenditures.^{15,16}

3. Increase overall public funding to enable wage parity and equity

Some have said that the underpaying of essential long-term care workers in Canada is the ‘apex of hypocrisy,’ because these workers are essential to the well-being of patients, but they are disposable according to labour laws.¹⁷

Wage differences for the LTC workforce vs. the hospital sector vary across OECD countries, with Canada and the United Kingdom having some of the largest differences prior to the pandemic.⁴ Some provinces took measures to remedy that very early in the pandemic. For example, in April 2020 British Columbia’s Provincial Health Officer started to publicly manage staffing at all LTC facilities. This directive ensured that workers could be restricted to working at just one facility to support infection prevention and control measures. Beyond that, BC’s government also ensured that workers doing the same job across locations were guaranteed equal pay relative to one another—wage parity—through a negotiated provincial labour adjustment process by which they received hourly wages equivalent to the collective agreement in place for the Health Employees Association of BC. In other words, full time union wages for all caregivers working in LTC facilities.^{18,19} This ‘single site model,’ together with the labour adjustment, helped stabilize the workforce which previously had cobbled together work at multiple sites with differing rates of pay.

More than half of OECD countries have increased wages in the last decade, in one way or another. Implementing measures to upgrade wages and benefits may help with recruitment and retention; higher wages are a predictor of longer job tenure among home care workers, for example.⁴ But increasing wages comes with one caution: though intuitively we would assume that increasing wages improves retention, some evaluations suggest that while higher wages influence turnover by reducing it, the effect on retention is small if that is the only change. Unless accompanied by increases in overall funding, wage increases alone may paradoxically lead to precarious employment through employers either reducing hours or increasing workload, or both.⁴ Similarly, ‘pandemic pay’ policies in some provinces had unintended consequences for equity when some providers, such as physiotherapists and social workers in Ontario, were excluded from the pay increase which made them feel devalued.²⁰ Thus, recognizing the lasting impact of “policy on wellness and experience signals its powerful influence” on health care providers.²⁰

4. Increase reliability and flexibility of scheduling for workers

Increasing work arrangements that allow for more reliable flexible scheduling allows LTC workers more control of their work-life balance. “Better organization of daily work and planning shifts and teams are important elements for job satisfaction among workers in Austria, the Netherlands, and Portugal.”⁴ But ‘flexibility’ is a double-edged sword if it means flexibility only for the employer, not the worker. For example, ‘on-demand’ staffing solutions—like the app-based model used by

Uber—provide flexibility for home health care clients, especially when ordering a caregiver is as easy as ordering pizza. But it can undermine autonomy, stability, well-being, and income security for workers. Critics of this ‘gig’ economy for care communities say it results in precarious work and can result in “a lot of turnover” with implications for quality and continuity of care.¹¹ More predictable and flexible working patterns that *also* benefit workers (not just employers) usually requires more staff, so it can be difficult to operate a financially lean health human resource machine and still cover unpredictable changes in staffing complements.

Flexibility for workers can also come through innovative solutions, like the Dutch ‘generation pact’ negotiated in one collective agreement. This “enables workers within four years of retirement to reduce their working hours by 20% with a reduction in pay of just 10%, while the company will maintain its pension contributions at the same [higher] level.”²¹ The extra hours are then shared among younger staff, so that older employees work less and younger employees have a more beneficial contract.

5. Transform ‘undeclared’ work into ‘declared’ work

Undeclared/undocumented private care workers—often migrants or new immigrants, many of whom are registered nurses or other professionals in their home countries but working as home care workers in Canada—aren’t eligible for social protection or fail to build up substantial entitlements because of intermittent and precarious working patterns.⁴ The “bigger the share of migrant workers in the labour market without improvements to their wages and working conditions and paths to permanence, the worse off everyone is.”²² The extent of private undeclared/undocumented care in Canada is unknown. One key informant (working privately as a home health caregiver for clients in their own homes) had this to say about undeclared work:

“From what I see, at least 25% of caregivers work privately in clients’ homes, under the table. Some also work part-time for an agency. But the agencies charge \$35 and pay you only \$17 or \$18...even less after taxes. You can’t support a family on that. Private clients pay \$25-35 so you can double your money...but then no benefits, no sick pay. I’d rather work more hours for an agency, but I can’t afford to.” (Key Informant #1)

Reducing ‘undeclared’^a private work and transforming it into ‘declared’ work may help to recruit and retain workers through various measures, such as subsidized service vouchers or tax credits.⁴ For example, in France, service vouchers are subsidized through the Personal Autonomy Allowance, whereby families can use universal vouchers to buy targeted personal support care (such as Activities of Daily Living, ADL^b) and other home help (Instrumental Activities of Daily Living, IADL^c). Paying with service vouchers essentially turns undeclared work into declared work, which contributes towards workers’ eligibility for various entitlements and protections. This must be carefully designed to avoid unintentionally lowering workers’ net income. Finland incentivizes declared work by allowing a tax deduction for 20% of the wage paid (including social security contributions) to an individual entrepreneur or business enterprise, or 50% of the work compensation paid.⁴

6. Create healthier work environments that support purpose, respect, and autonomy

^a The OECD uses the word ‘undeclared,’ but we recognize that terms like ‘undeclared’ and ‘undocumented’ are imperfect. Canadian community agencies introduced terms like ‘non-status’ or ‘precarious migrant’ as replacements for ‘undocumented’ because most people in this situation are or were with valid documentation, but just no longer have valid or active status. Importantly, almost no one enters Canada without some form of immigration status, whether as visitors, or refugees making asylum claims, or valid student permits, or temporary foreign worker visa status. People become ‘undocumented’ for various reasons, such as because their status or visa expires, or they arrived as children and don’t realize until they become adults that they are ‘undocumented.’²³

^b ADL includes things like dressing, eating, toileting, bathing, grooming, and mobility.

^c IADL includes things like managing finances, cooking, meal preparation, medical management, and transportation.

Healthier work environments are fundamental to building back better from the disruptions of COVID-19 pandemic. Long-term effects of the pandemic on our individual and collective mental and physical health is only beginning to reveal itself. For many, the pandemic has changed the way people view work, rethinking what work means to them. It is well understood that the conditions of work are the conditions of care.²⁴ Wise employers ought to pay attention to this if they hope to recruit and retain workers.

But what does a healthier work environment look like? So much fits into this bucket. This includes creating a health and safety culture to improve workers' well-being and reduce injuries of all types (physical, emotional, and moral); offering opportunities for professional growth; developing on-the-job training and coaching programs (not computer modules completed during lunch); and improving teamwork to support self-managing or self-organizing teams rather than traditional management hierarchies, such as with the Dutch Buurtzorg model of neighbourhood care and its tagline of "humanity over bureaucracy."^{25,26} Buurtzorg is but one innovative organizational model that "shifts power to the front lines and away from central agencies and management. Cells of 6-10 nurses get attached to a community and they self-schedule visits to the home. They decide and adjust care plans in real time. It's basically a 10,000-person healthcare organization with no management."²⁶ The model is apparently working well and spreading to other countries such as Germany, Denmark, Sweden, Taipei, the UK, and more. Ontario's Hope Initiative is based on Buurtzorg, providing a "sandbox and methodology to experiment."²⁷

7. Credential internationally trained professionals

Integrating immigrants and internationally trained professionals into the Canadian workforce was part of Canada's Internationally Trained Workers Initiative (ITWI) first launched in 2005.²⁸ This initiative included the Internationally Educated Health Professionals Initiative (IEHPI), which increased the supply of health professionals by expanding assessment and integration of internationally educated health professionals. Cultivating this untapped talent is more crucial now than ever, given pandemic-aggravated labour shortages. Unlocking this talent will require addressing barriers in several areas, including immigration, registration, and employment.²⁹ This includes removing regulatory hurdles related to immigration status³⁰; creating targeted pathways to permanent residence²⁹; enabling credentialing³¹ and licensure through "fair, accessible, and coherent systems of assessment and training" that lead to registration of qualified professionals; and creating bridges and supports that lead to eventual employment.²⁹ Opening pathways for internationally educated professionals is a complex area at the intersection of health, labour, international relations, and immigration policies and law (and politics) that is beyond the scope of this report, but very well-described elsewhere.^{29,32}

The one serious caveat to facilitating easier entry to professional practice is that Canada must not 'poach' workers from low-and-middle-income countries (LMICs), contributing to 'brain drain' and filling our own needs at the expense of the world's poorer nations.³³ Canada has been criticized for this behaviour, and is "among numerous wealthy nations, including the United States and United Kingdom, that are aggressively recruiting medical workers from the developing world to replenish a health care workforce drastically depleted by the COVID-19 pandemic. The urgency and strong pull from high-income nations—including Germany and Finland which had not previously recruited health workers from abroad—has upended migration patterns and raised new questions about the ethics or recruitment from countries with weak health systems during a pandemic."³⁴

Is there a way to ethically recruit health care workers from LMICs? The WHO's Global Code of Practice on the International Recruitment of Health Personnel recognizes the rights of individuals to migrate, "but calls for wealthy nations to recruit through bilateral agreements, with the involvement of the health ministry of the country of origin."³⁴ Others say that "if they accept a health worker who emigrates on their own from a LMIC, then they must train two individuals with similar skills in that nation."³³ But beyond recruiting health care workers from afar, we could, and

should, invest far more in *retaining* the caregivers already working in Canada, but who are leaving or cutting back their hours for the laundry list of reasons peppered throughout this report.

8. Modernize national licensure for Canadian-licensed LTC providers, including physicians and nurses

Province- and territory-specific licensing of health care professionals is a barrier to redistributing our workforce, including to underserved and remote communities. Currently, most physicians finish medical school by writing examinations for the Canada-wide Licentiate of the Medical Council of Canada (LMCC). They then complete the Canada-wide examinations of the Royal College of Physicians and Surgeons (RCPSC) and are insured by the Canada-wide Canadian Medical Protective Association (CMPA). Yet licensure of regulated health professionals, such as physicians and nurses, is under provincial and territorial jurisdiction resulting in 13 licensing bodies (colleges).³⁵ Obtaining licensure in another province can be prohibitively expensive and time consuming which limits mobility of health care providers, including during the pandemic. National medical and nursing licensure, or what some call a 'national professional passport,'³⁶ would enable nurses and doctors to practice in any Canadian jurisdiction, without onerous applications and fees. Despite all 13 of Canada's provinces and territories having agreed to a national standard of licensure in 2009, this has yet to be implemented.³⁷ This is not a novel idea: Australia has a national system of licensure, as does the UK through the General Medical Council which allows UK-licensed physicians to practice in England, Northern Ireland, Scotland, and Wales.³⁷

Virtual care is here to stay, perhaps one of the few silver linings of the pandemic.³⁸ By virtue of the portability criterion in the Canada Health Act³⁹, health care in Canada is meant to be portable within Canada, whether in-person or virtually. A national licensure framework agreement would enable inter-provincial/territorial practice, facilitated by Interprovincial Reciprocal Billing Agreements intended to ensure portability and accessibility between provinces and territories. Even better would be an agreement developed in the context of a national strategy for health human resources to avoid unintended consequences, such as more transience of providers and, thus, instability for patients if their providers can more easily move around.³⁷ Though some have argued that creating one national system would be difficult because health care is mostly under provincial/territorial jurisdiction, others say "There's certainly lots of room within the constitution for a strong federal role...with constitutional authority to participate in...addressing health workforce challenges."³⁷ We've seen federal leadership on multiple public health-related files, including early learning, childcare, pharmacare, and dental care, bringing stakeholders together to share information and policy approaches.⁴⁰ Initiating discussion with the provinces and territories on national licensure is another opportunity for federal leadership.

9. Modernize the national health human resource strategy

Canada's Pan-Canadian Health Human Resources Strategy was launched in 2004/05 to support effective coordination and collaborative planning across the country.⁴¹ Administered by Health Canada's Health Care Policy Contribution Program (HCPCP), it pursues four key strategic directions: (1) supply of health providers; (2) most effective use of skills; (3) creating healthy, supportive, learning workplaces; and (4) more effective planning and forecasting.⁴¹ Modernizing this strategy by (at least) adding the 10 recruitment and retention strategies discussed in this report would enable planning to help overcome the disruptive effects the pandemic has had on health human resources, including on the LTC workforce. Beyond that, there is a rich body of policy expertise in Canada and internationally on migration and integration³² and on health human resource innovations in OECD member countries⁴² and in the WHO member states⁴³ that could inform an updated strategy. Bringing these resources and experts together to reshape Canada's pan-Canadian Health Human Resource Strategy would be a wise investment in our shared future.

10. Consider implementing national long-term care insurance to dedicate funding for long-term care services

Funding arrangements for long-term care, including home care, vary across OECD comparator countries. Long-term care, including home care, is an integrated part of the health and social care systems in the Netherlands, Denmark, and Germany, enshrined in law. ⁴⁴ Both Germany and Denmark rely on compulsory national long-term care insurance—dedicated social health insurance schemes—to pay for home care, funded by payroll taxes (Germany) or general revenues (Denmark). The Netherlands relies on three integrated laws that enable wrap-around services for long-term care, health care, and social support, with long-term care funded through a combination of payroll taxes, general revenues, and community-rated premiums. Several other countries have universal personal-care benefits, either in-cash (Austria, France, Italy) or in-kind (Australia, New Zealand), rather than a dedicated long-term care funding system. ⁴⁵ The UK (excluding Scotland, which has a universal system) and US have ‘safety net’ or means-tested schemes to cover the costs of LTC. ⁴⁵

Canada, by contrast, relies on a shared funding arrangement between the federal and provincial/territorial governments, with individuals contributing out-of-pocket in varying amounts according to their ability to pay, or occasionally through privately purchased long-term care insurance.

One way to help fund wage parity and improved benefits for long-term care workers would be to implement a publicly-funded national long-term care insurance program, similar to Medicare, to support not only institutional LTC, but also home care for the vast majority of Canadians ‘aging in place’ with a patchwork of publicly- and privately- funded services, or no services at all. The same principles that apply to Medicare could apply to long-term care—public administration, comprehensiveness, universality, portability, and accessibility—consistent with the primary objective of Canadian health care policy to protect, promote, and restore physical and mental well-being and facilitate reasonable access to care without financial or other barriers. ³⁹ Why a publicly-funded national program instead of measures like tax-deductible premiums for private insurance? In part because both empirical and theoretical evidence shows that administrative costs for privately-funded insurance are significantly higher than for publicly-funded insurance because of the number of administrative activities that private insurers have to deal with, such as advertising, underwriting, billing, claims processing/reconciliation, payment processing. ^{46–48} Administrative overhead in Canada’s publicly-funded Medicare insurance plans is less than 2% ⁴⁹ as compared to 18% in the US for private insurance plans. ⁵⁰

Table 1. Summary of 10 Measures to Enable Recruitment & Retention of Long-Term Care Workers

No.	Measure
1	Provide less involuntarily part-time work
2	Extend pro-rated benefits and protections to all LTC workers, including self-employed
3	Increase overall public funding to enable wage parity and equity
4	Increase reliability and flexibility of scheduling for workers
5	Transform ‘undeclared’ work into ‘declared’ work
6	Create healthier work environments that support purpose, respect, and autonomy
7	Credential internationally trained professionals

8	Modernize national licensure for Canadian-licensed LTC providers, including physicians and nurses
9	Modernize the national health human resource strategy
10	Consider implementing national long-term care insurance to dedicate funding for long-term care services

Discussion

What lessons can Canada learn to inform future planning aimed at strengthening and expanding the LTC workforce?

We have known for a long time that the demographics of Canada portend the urgent need to design and implement plans to build up our health human resources to support older adults. The COVID-19 pandemic has shone a glaring spotlight on this, with many workers beyond the breaking point across the health sector, including in long-term care settings. Building back better from the COVID-19 pandemic is going to take courageous leadership and cooperation at all levels of government. Our rapid review reveals 10 measures that could help to improve recruitment and retention of Canada's long-term care workforce. They all converge on the same point: create work that is meaningful and reliable for workers, that recognizes their expertise and professional autonomy, that provides equitable compensation and benefits commensurate with expertise, that occurs in healthy work environments, and that is available to support all older adults who need long-term care, wherever they choose to live, based on need not ability to pay.

Many OECD countries are ahead of us, having met the pandemic with integrated and sufficiently-funded care systems that support older adults. But, like Canada, many are now struggling with retention and recruitment of workers.

Some countries (like France and Finland) have measures in place to transform 'undeclared' work into 'declared' work. Recognizing that both flexibility and reliability is important to workers, the Netherlands has created a 'generation pact' to benefit from the expertise of older experienced workers who still want to work some but not full-time, while simultaneously building up new labour supply among younger workers who want full-time work. Misclassification of workers as independent contractors rather than employees robs them of benefits to which they ought to be entitled, so reducing this is an important retention strategy. The extent to which there is wage parity across health care sectors—home care vs. long-term care facilities vs. hospital—varies among OECD countries, but Canada stands out as having large differences in wages across these sectors. We should aim for equal pay for work of equal value. Healthier work environments—including where workers find purpose, respect, and professional autonomy—are fundamental to building back better from the disruptions of COVID-19 pandemic. Wise employers should pay attention to this if they hope to attract and retain workers. The pandemic has shown us that life is short; workers will be either unwilling to tolerate unhealthy working conditions or they will be forced to tolerate them but at grave risk to their well-being and to workforce stability. Removing barriers to fully integrating immigrants and internationally trained professionals will unlock this talent, but with the caveat that poaching workers from LMICs is unethical, as Canada has been criticized for doing along with the US, UK, Germany, and Finland. National licensure for health care professionals, such as doctors and nurses, is an approach used in Australia and across the UK. Canada has been talking about this for a very long time, and perhaps the pandemic will finally inspire action. But, as with everything, there are trade-offs and unintended consequences to pan-Canadian licensure; updating Canada's national strategy for health human resources could help mitigate these risks. Last, but far from least, is how are we going to pay for all of this? One option would be publicly-funded national long-term care insurance, with dedicated funding like in the Netherlands, Denmark, and Germany, or universal benefits, either in-cash like in Austria, France, and Italy, or in-kind like in Australia and New Zealand.

Conclusion

They say that the measure of a civilization is in how it treats its most vulnerable members. The pandemic has battered many, frayed our health care system, and wrung out our health care workforce. Implementing strategies to recruit and retain long-term care workers will help to protect all of us, including society's most vulnerable members, creating "a more resilient, more talented, and better-paid workforce—and a more robust and equitable society."⁵¹

This will require investing in a workforce of "imaginative, inspired, capable, and...joyous people, invited to use their minds and their wills to cooperate in reinventing the system, itself...They will need to do this together, in teams, to welcome failures of information, to celebrate successes as collective...because of the meaning it adds to their lives and the peace it offers in their souls. A workforce so nobly engaged deserves no less."^{2,52}

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