An overview of union, government, and employer actions worldwide to improve conditions in the Long-Term Care sector during COVID-19

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1. Key points

- Inadequate staffing levels have been a major problem in long-term care (LTC) for decades. Coronavirus outbreaks have exacerbated long-standing problems, and a growing body of research shows that low staffing levels are related to negative outcomes for people living in care homes during COVID-19.
- Pandemic pay, hazard pay, and bonuses have been part of the response for frontline workers, but these interventions will not have lasting impacts on working or living conditions.
- Low wages have hindered the retention and recruitment of new workers to this industry. Inadequate pay also forces many workers to have more than one job, leaving them more vulnerable to increased coronavirus exposure.
- Personal protective equipment (PPE) distribution and access to testing was a problem at the beginning of the pandemic, and it continues to be an issue to this day.
- Vaccines are an important part of the solution, but until more is known about the longevity of the vaccine or if it prevents transmission, other infection control measures remain essential.
- PPE and testing continue to be needed to protect workers and people who use care from the virus
- Sick pay is essential so workers can isolate while they wait for testing results or recover from illness.
- Unionization and access to collective bargaining is an essential element to improving working conditions and living conditions in LTC.

2. Introduction: Better is possible

As the coronavirus pandemic continues to rage, emerging and re-emerging around the globe, we see the disastrous outcomes of a poorly funded long-term care sector (LTC) in virtually every country. Older adults are the most susceptible to COVID-19, and this pandemic is a clear call for immediate action to protect older people, improve our LTC systems, and address the systemic problems which have led to higher levels of deaths in nursing homes.

In addition to identifying these weaknesses, we have had a unique opportunity to shed light on practices that have brought dignity, compassion, and, most importantly, quality care to vulnerable populations around the world. With so much attention on death, sickness, and transmission, this paper is an opportunity to acknowledge progress and to provide hope for both people who use care and workers in the system. Better is possible. And better must happen now.

This paper was prepared by UNI Global Union's UNICARE sector and draws on the experience of our members, representing over 2 million care workers in 80 countries, on all continents.

2.1. Failures in the Long-Term Care sector endanger workers and people who use care

Not only are long-term care facilities dangerous for residents in care homes and other care users, they are also among the most dangerous workplaces in the world. Workers in LTC are dying at an unacceptable rate. However, most countries do not have the means or ability to track worker deaths so we have little worldwide data on the true impact for workers.

In Europe, social care workers, who provide in-home care and residential care, are also at high-risk, accounting for the highest level of fatalities when compared to other occupational groups in the UK (Hodgson, et al., 2020). It is predicted that, if the current rate of workers' deaths continues for one year, LTC work will be the most dangerous job in the world, at more than double the death rate of logging or commercial fishing (McGarry, Porter, and Grabowski, 2020). However, unlike logging or commercial fishing, LTC workers are poorly paid. Their labour is too often framed by the sexist worldview that it is 'woman's work', wrongly diminishing its real value and creating barriers to recruitment and retention in the industry.

Just like those working in LTC are at elevated risk, people living in nursing homes are at the highest risk for COVID-related death (WHO, 2020). In some countries, including France, Spain, Sweden and the USA, more than 5% of all care home residents have died due to COVID-19, that is 1 in 20 residents. (Comas-Herrera, A. et al, 2021).

Age has not been the only risk factor, racial or ethnic minorities within the LTC system have also experienced higher rates of infection (Li, et al., 2020). In a study that looked at 22 U.S. states, they found that nursing homes with majority Black and Latinx residents were twice as likely to suffer outbreaks (Gebeloff, et al., 2020). To make matters worse, globally, people in care homes have not always been able to access the care they need. For example, in Spain, sick residents were unable to be properly isolated, and residents were not transferred quickly enough to hospitals (Bachega, 2020).

Recent research has showed that unionized nursing homes are safer, and “represents a 30 percent relative decrease in the COVID-19 mortality rate compared with facilities without these unions. Unions were also associated with greater access to PPE, one mechanism that may link unions to lower COVID-19 mortality rates” (Dean et al., 2020). This study was limited to New York state, but it makes us question if unions can improve nursing home care worldwide. The fact that unionized workers are accessing PPE at higher rates, and have mechanisms to report problems or push back on employers and governments when things are going wrong does highlight the important role unions have been playing during this pandemic.

In LTC, there is both the immediate and the long-term response needed to improve the system overall. A complete overhaul is necessary if we are going to be able to make the changes required to have a system that will meet the rapid needs of our ageing population. Below we have collected promising practices from around the world. Sharing ideas is going to be one way to improve our systems and to create opportunities to prepare ourselves for the continued fight against coronavirus, as well as other infectious diseases in the future.

3. Promising practices from around the world

3.1. Improving staffing levels

Governments, investors, and operators have neglected conditions in LTC for decades, and staffing levels have slowly decreased year-over-year. During the pandemic, these lower staff-to-resident ratios have been linked to increased negative COVID-19 outcomes (MecGregor & Harrington, 2020). Conversely, higher levels of nursing assistant hours have helped contain the virus's spread as well as the numbers of deaths (Gorges & Konetzka, 2020; Ochieng, et al., 2021).

Despite this evidence, UNI Global Union members report that they struggle to find full-time work and are often stuck in part-time or temporary contracts. Recent findings by the OECD (2020) show widespread reliance on zero-hour contracts, part-time, and temporary work. Many LTC workers are cobbling together piecemeal work to be able to earn a living, which usually means they work more than full-time hours at more than one care facility. Fewer workers and fragmented working arrangements means less time giving care to residents and additional stress for workers. It also diminishes the quality of care and creates fatigue, burnout, and high turnover. More staffing and more time devoted to care may also increase the ability of workers to notice early warning signs of bigger problems, isolate residents, and prevent the spread of the disease more effectively.

In a recent study by the Ontario Government, staffing shortages made the living conditions less safe, resulting in increased falls, levels of depression, infections, errors, complaints, anxiety, and conflict for residents (Government of Ontario, 2020). Sadly, even the most basic of care has at times been put to the side: more than two-thirds of staff said they were so pressed for time that they were unable to help a resident go to the bathroom (Government of Ontario, 2020). Being a care worker in these conditions is exhausting, and leaves workers more susceptible to both physical and psychological harm.

Ireland has launched a national recruitment campaign, and the federal government has stepped in to help with the voluntary redeployment of care staff during the COVD crisis (Pierce, Keogh, and O'Shea, 2020). In Spain, unions CCOO and UGT are taking issue with the government over reliance on temporary, unqualified workers in LTC. After 43,000 jobs have been cut over the past 10 years and temporary care employment has ballooned to 46 percent, the unions are demanding improvements to the enforcement of the collective agreement (CCOO, 2020). Similarly, in Sweden, the Kommunales union is calling for a 90% proportion of full-time jobs in long-term care, arguing that a stable worker base will allow for better continuity of care and a healthier worker and resident population (Vision, 2020).

In Israel, the country was already experiencing a nursing shortage of 1,500 nurses before COVID, and the pandemic forced over 1,000 nurses to quarantine. Those remaining on the job faced unbearable workloads, long working hours, and an overall elevated level of stress (Margit, 2020). In response, the government has promised additional funding for the health system, but it is still to be seen if how much this funding can address the long-standing staff shortages and low pay (Margit, 2020).

Nearly a year into the crisis, it is reassuring to see some governments doing more. Government investment to improve staffing levels is going to be one key element of repairing our LTC system, and strong unions will be needed to ensure workers' voices are heard on policy and shop-floor level interventions. Dignity and health must be the bottom line.

3.2. Pandemic pay, hazard pay, bonuses

During the pandemic, frontline workers have received short-term raises or one-time payments as a reward for their service and bravery and to recognize the essential nature of their work.

These agreements between employers and workers, or as decreed by governments, can be separated into two broad categories. First are bonuses, either a one-time payment or a temporary increase, which will then cease when the either the pandemic or the employers' generosity ends. While these types of payments are beneficial to retention of workers in the short-term, they will fail to address the needs of workers going forward, and therefore are not going to address chronic staff shortages.

Workers received lumpsum payments in: Australia (Low, 2020), Scotland (Scottish Government, 2020), Connecticut (SEIU, 2020), Austria (UNI Global Union, 2020), Germany (Verelnte Dlenstielstungs-gewerkschart, 2020), Wales (UNI Global Union, 2020), Portugal (SINTAP, 2020), Ghana (personal communication), Belgium (SETCa, 2020), the Czech Republic (The Czech News Agency, 2020), Bosnia and Herzegovina, Estonia, France, Greece, Germany, Hungary, Italy, Kyrgyzstan, Romania, Russian Federation, and the Ukraine(Williams et al., 2020). While continuous monthly bonuses were paid to health workers in Albania and Latvia. In Bulgaria a bonus for all workers, even non-medical workers treating coronavirus patients got a monthly bonus till the end of 2020 (Williams et al., 2020). However, without confirmation from the workers it is impossible to know how these programs were implemented, and if care workers on the front lines were all included or if there have been exclusions based on professionalization.

The terms of the payments have been very different in each case, but the common theme is that although these payments have been appreciated, they will not truly improve working conditions over the long-term. Additionally, there has been a dispute over which workers qualify as "frontline" and what is the appropriate appreciation pay amount.

The second broad category is 'changes that were negotiated during the pandemic' and will continue indefinitely. The latter is better for the system should help to retain workers in the long-run and also should attract new workers to the industry, which is so desperately needed. For this reason, we have included the long-term changes in a separate section of this paper.

3.3. Long-term improvements to wages

Long-term wage improvements are part of the solution to the care human resource retention and attraction problems identified by the OECD (2020). Without improvements, the currently strained human resource pool is going to have difficulty meeting a massive rise in demand for new workers over the next 20 years. Take, for example, the sad reality in the United States; nursing assistants in nursing homes make about $590 per week, roughly half of a living wage for

a family of four. These jobs cannot support a family and leave many of these frontline workers hovering at or below the poverty line, relying on food stamps or other social welfare programs to get by. For several months during the pandemic, unemployment benefits were increased to $600 a week for workers who lost their jobs due to coronavirus (McGarry, Porter, and Grabowski, 2020), which left families desperate and without ample financial stability.

However, unions have been able to negotiate significant, permanent gains for their members. In Illinois, SEIU members secured $15 an hour—a significant pay rise—as a permanent increase, in addition to fully paid sick leave and the right to refuse unsafe work (UNI Global Union, 2020). In Belgium, after a long-fought battle, unions like SETCA-bttk, ACV Puls, CNE, CSC, CGBLS, were able to secure €1 billion to improve pay, which translated into a 5-6% wage increase, over and above another €500 million to improve working conditions, a right to training, among other improvements (La Centrale nationale des Employés et des Cadres du secteur privé, 2020; SETCa, 2020). In France, most health workers saw an increase in 2020, with the lowest-paid workers seeing their wages increase by 15%.

Permanent changes like these examples not only address the current problems, but they may also improve retention and recruitment issues. The pandemic has further exposed the high-risk safety environment and low wages in the sector, and wage raises such as these can not only change workers' lives but also the perception of the value of this work more broadly.

3.4. Improved distribution of PPE

Since the beginning of the pandemic, access to personal protective equipment, or PPE, has been challenging. The lack of stockpiles of PPE in many European and North American countries can be attributed to a "*Just in Time"* strategy, originally pulled from the retail industry, this approach means that nursing homes keep only the bare minimum of inventory and only order more when necessary. This allows for companies to only spend capital when needed (Lem et al., 2020). When the pandemic hit, this strategy left nursing homes completely unprepared because the demand for PPE rose sharply, and suppliers were also left without adequate stockpiles. In Ontario, UNIFOR and SEIU along with a coalition of unions launch a judicial review in October 2020 to question the provincial government's approach to PPE. The outcome of this review was a directive which allows for workers to work with employers to maintain adequate stockpiles, it also empowers workers to make demands for increases in PPE when required for riskier procedures (Government of Ontario Ministry of Health and Long-term care, October 5, 2020). It includes access for unregulated health care workers to access protection such as N95 masks as well (Goldfinger, October 9, 2020).

In some countries like the Netherlands, PPE was supplied to all care workers free of charge since May (Kruse, Remers, Jeurissen, 2020). Whereas in other countries, workers struggled to obtain basic protections. For example, in New Zealand, where E tu Union had to fight hard for access (Wylie, 2020). E tu was quick to respond when home care workers were not prioritized for PPE like their health care worker counterparts in the acute care facilities.

One promising example is the Californian Veteran Affairs LTC homes, where they stocked PPE, had rigorous testing protocols, and supported workers who needed to self-quarantine. Their

success shows the importance of leadership acting quickly and in line with public health protocols (Severns, August 10, 2020).

This month, the WHO stated that in addition to PPE there must also be adequate staffing, sick pay, and training for workers (WHO, 2021). The problems with PPE have been widely reported. We do not want to add more to this area of the literature, only to restate that PPE is essential to keeping workers safe and that any response to COVID must include distribution of PPE (including access to vaccines) to all workers on the frontlines.

3.5. Access to rapid testing

Knowing your infection status is a primary step to infection control, and workers who know their status can better protect themselves, their residents, their families and communities. Workers need access to testing and the ability to isolate. Increasing the frequency of testing for all staff can reduce outbreaks and can reduce the spread of the virus (Holmdahl et al., 2020).

In the UK, the initial policy responses did not adequately support workers in the social care and nursing home sector; however, the conditions have improved over time (Comas-Herrera et al., 2020). Workers and care users are now getting access to testing (Salcher-Konrad and Comas-Herrera, 2020). And just recently, the UK government has introduced rapid testing for workers so they can be tested prior to moving from one facility to another, making it less likely that they will be vectors of transmission. In the Netherlands, workers were given access to testing, and the country has worked on steadily increasing their testing capacity (Kruse, et al., November 25, 2020).

In Denmark, if a resident shows symptom, all residents and workers are tested with 24 hours and then retested within seven days, and if a staff member tests positive, all the residents are retested (Rostgaard, 2020). In Malaysia, both registered and unregistered facilities have undergone testing for COVID-19 (Hasmuk et al., 2020). And in Japan, workers are offered free testing when they have had confirmed contact with an infected person (personal communication, August 3, 2020).

The ideas around testing allow for individuals to make decisions and assessments about their risk level. The European Centre for Disease Prevention and Control recommends that in communities where the community viral loads are high, random testing for workers and residents is recommended (European Center for Disease Control, 2020). This recommendation would inform disease prevention protocols and help workers stop community spread.

The critical point here is that workers need access to testing to be responsible, as well as minimize the risk for everyone. Staff infections are linked to community case load (Ochieng, et al., 2020), so when cases are high, testing must be available and done regularly. Access to testing is an essential piece of any infectious disease protocol.

3.6. Sick pay

Sick pay is the practice of wage reimbursement when a worker is unable to carry out their work because they are ill. In some countries, this right is guaranteed through minimum employment

standards, but for millions of workers, sick pay is not available. They are forced to choose between financial survival and their health.

Recently, in Australia, United Workers Union won a specific provision for COVID-19 leave, which entitles both permanent and casual staff to two weeks of pay if they or a family member are recovering from COVID-19 (United Workers Union, 2020; Clayton, & Murray-Atfield, 2020). SIPTU, in Ireland, was able to win basic pay for workers that have to self-isolate or are diagnosed with COVID-19 (SIPTU, 2020). In Japan, workers are entitled to sick leave while they wait for testing. If they do test positive, they are entitled to 100% of the treatment expenses and 80% of their wages under the National Workers' Accident Compensation Insurance scheme (personal communication, August 3, 2020). HC-One, a company operating in the UK and Ireland, has also agreed to pay full COVID-19 sick pay for all their 27,000 workers. In the US the Families First Coronavirus Response Act (FFCRA), which should have given access to sick pay for care workers, has several loopholes, resulting in 1 in 4 health care workers excluded from the benefit.

One of the major downfalls to many sick leave provisions is that to gain access to the compensation, there must be a causal link to the workplace for the illness or injury. Eliminating factors that exclude workers from getting access to sick pay empowers them to take time off that they need. They can stay home without the fear that, due to a technicality, they may later be denied benefits. This leave gives workers security in knowing that infection will not automatically create an enormous personal financial burden.

These examples show significant wins for workplace safety, but in far too many countries and communities, sick pay is denied for COVID-19—even when a workers' job puts them at high risk. We must support workers to stay home when they have been exposed or feel sick. With COVID-19 and high levels of community viral loads coupled with long incubation periods, it is impossible to establish a causal relationship and identify date or time of exposure. Therefore, it becomes imperative that COVID-19 is recognized as an occupational disease, and presumptive policy is in place to eliminate the need to prove a causal link with work exposure. For coronavirus or future infectious disease, universal sick pay is essential to limiting spread.

3.7. Retention of workers for next pandemic

Hong Kong, as well as some other countries which had experienced the SARS outbreak were quicker to respond to COVID-19, and their medical workers had the experience to implement protocols quickly and effectively (Chow, 2021). On a much larger scale, workers who have experience in the COVID-19 pandemic will be essential to addressing new viruses in the future, and their learned behaviours and willingness to implement controls quickly could save many lives.

Staff shortages are mainly due to long-standing inability to retain or attract workers to the LTC industry, for many of the reasons that are mentioned in this paper. Part of the problem is also the gender gap, and we need to do more to improve pay and employment rights if this problem is going to be genuinely addressed (World Economic Forum, July 22, 2020).

We also know that many health care workers seek work abroad, as they do not earn enough in their home country. One in eight nurses currently works in a country other than the one in which they were trained (World Economic Forum, July 22, 2020). Investment by governments is one way that we are going to be able to address the lack of work, as pointed out in the UK: "[i]nvestment in care is not only needed to transform our broken social care system, it is an excellent way to stimulate employment, reduce the gender employment gap and counter the inevitable economic recession as the UK comes out of lockdown." (De Heneau & Himmelweit, 2020). This will most likely be true for many economies as they emerge from multiple lockdowns and the possible successive confinements required to get this virus under control.

FATSA, a care union in Argentina, is largest trainer of care workers nationally. Since the pandemic they have started to include specific training in infection control. They have also made a new agreement to bolster aged care workers in the country and have trained hundreds of new workers for the sector.

UNI Europa is also engaged in a project funded through the EU on the retention of care workers. Care workers were in demand prior to the pandemic, and now with the added dangers of working in this sector we could see a large number of workers leaving. The pandemic could also serve as a deterrent for workers to join the sector, although this has yet to be seen. Retention of workers who have had the experience working during the COVID pandemic should be a priority, and part of our strategic plan going forward to prepare for the next pandemic. It will be imperative that we capture on this institutional knowledge.

3.8. Rapid response teams

In addition to rapid quarantines and strong public health reactions, a rapid response was an essential part of beating the Spanish flu over 100 years ago (Socrates Bardi, April 2, 2007). And when COVID surfaced, the WHO (N.D.) quickly issued an online learning package about the virus. This technical guidance intended to help rapid response teams address the specific considerations needed to combat COVID-19.

During this pandemic, Rapid response teams were created by various levels of governments in countries and cities worldwide to deploy to nursing homes. Comas-Herrera (2020) found that these teams were also dispatched to deal with staff shortages, when suspected or infected staff were required to self-isolate.

Examples of rapid response teams were seen in the United States, Spain (Comas-Herrera, 2020) and Israel (Tsadok-Rosenbluth et al., 2020). However, in other places, for example, Canada (Canadian Patient Safety Institute, 2015), these types of teams have been in use for years. This is by no means an exhaustive list, but these teams are one, widely-used way to support the LTC system, when particular communities need an immediate, large-scale response to a crisis like coronavirus. Along a similar line, both the United States (Myers, July 2, 2020) and Canada (Government of Canada, 2020) have used their militaries to respond to COVID, sending in troops for testing and care support purposes. In Canada, the military also responded to nursing homes that were overwhelmed with COVID-19. Sending the army to LTC facilities in Ontario and Quebec Canada, further highlighted the need for massive reforms to the system (Chan, 2020). Not only were these teams needed in a crisis, but these facilities were operating on the brink of

collapse for a long time. In Maryland, the national guard was used to implement infection control protocols and bolster testing efforts in nursing homes (Kukka, 2020). The UK has also had the largest deployment of military personnel during peace times, currently they are being used to support the logistics of the vaccination roll out as well as testing sites (Forces Net, 2021).

Another good practice is the efforts like the conference calls being held by the Rapid Response Network which has been hosting 20-minute daily calls to provide pragmatic advice, share information, and find solutions for nursing homes that are facing multiple problems during the crisis (Institute for Healthcare Improvement, 2020). This type of information dissemination is not a rapid response team but could be used to inform frontline workers.

On the negative side, rapid response teams must be extremely vigilant that they do not become vectors of community transition. In some cases, temporary workers who were used as a stop-gap measure for emergency staff shortages were also later considered to be spreaders as they travelled between multiple homes (Carter, April 16, 2020). With this cautionary note, rapid response teams can be useful in bringing in much-needed expertise and workload support during a crisis. However, this temporary, stop-gap measure cannot replace a long-term investment in proper staffing and education on infectious disease protocol that is so desperately needed.

3.9. Supporting worker mental health

Early on in the COVID pandemic, a Chinese research group from Wuhan found that workers exposed to caring for people who are suffering from COVID-19, "reported experiencing symptoms of depression, anxiety, insomnia, and distress" (Lai, et al., 2020). Their study, published in March, focused on acute care workers. However, it is likely that nursing home workers are experiencing the same mental strain—and the exponential death toll has exacerbated these issues since Lai et al.'s study was conducted.

Cox, et al., (2021) found that workers' responses to conditions like those created by COVID-19 can be grouped in three categories: resistance, innovation, and improvisation. They write that workers were more confident and more likely to stay at their jobs when policies are designed to support them on the frontlines. In cases where workers' needs are not met, they resist, or if they feel connected to their job, they are more like to be creative and innovate or improvise. It is important that we listen to what workers have faced on the frontlines, for example: times where workers used makeshift gowns, or sewed their own medical masks (Cox et al., 2021). These workers showed resiliency, and we need to acknowledge their efforts.

However, we must also acknowledge the impact that these acts of improvisation may have had on their mental health. The prolonged exposure to deficient working conditions can cause high levels of distress. Observing patients suffering and ultimately passing away is extreme psychological pressure, and it also causes stress as workers risked bringing the virus home to their families (Galehdar et al., 2021). It is also essential that workers have access to breaks, time away from work, and understand the importance of self-care (Xu et al., 2020). Along with the other response to this crisis, we must ensure that workers are both mentally and physically protected (Kruse, Remers, Jeurissen, April 26, 2020).

There have been several initiatives to address mental health during the crisis. In China, the National Health Commission has established a 24-hour crisis support line for workers (Knowles, 2020). This gives workers the ability to seek help quickly and immediately when they are in crisis. In Australia, an employer group supported the creation of an online project called Beyond Blue, which is geared at peer-to-peer mental health support (Knowles, 2020). The Chilean government has also developed materials and mental health recommendations for a variety of people who provide care and support, including formal and informal care workers (Government of Chile, 2020). The Mexican government has launched a campaign that includes telephone support and referral services for care workers (López-Ortega, Sosa-Tinoco, 2020). In Kenya, a virtual peer-to-peer program has been developed. Unfortunately, internet coverage and online fatigue have impacted the program. The government in Kenya has also published guidelines for residents to have access to video chatting and online communications with family to improved care (Musyimi, Mutunga, & Ndetei , 2020). In Malaysia there has been a push to offer support to clients through online sharing activities and exercise videos. Although this is not specifically for workers, it does indirectly benefit workers who are facing higher workloads due to the coronavirus. And finally, is India, where some long-term care workers are being offered regular check-ins and counselling to promote mental health (Rajagopalan et al., 2020). The UK has developed guidance for staff who have experienced trauma from COVID-19 (Hasmuk et al., 2020), but we have yet to see how this will be implemented for frontline staff.

Recent findings from Italy show that care workers are experiencing post-traumatic stress from the first wave of the pandemic (Riello, et al., 2020). More research will be needed to fully understand the impact, but this study does suggest that we need to address psychological health and safety risk factors in the workplace, which may include access to support services, critical incident debriefing, peer support, among others. It is also important to acknowledge that the pandemic has now stretched on for more than one year, leaving health care workers in a state of extreme fatigue, health care workers need counselling and debriefing to be able to continue to deliver care (Galehdar et al., 2021).

Feeling safe physically supports feeling safe mentally. Physical safety measures, such as the availability of PPE helps to lower stress in long-term care facility workers (Senczyszyn, et al., 2020). It has been shown specifically that education about hazards for care workers, supports their ability to deal and cope with dangerous situations (Wong et al., 2017). Psychological risk is decreased when physical health is protected, these findings suggest that until we can protect workers physically, we will not be able to protect their mental health. Therefore we must start to combine efforts to support both mental and physical health.

Addressing the mental health of workers is not only a short-term need, but it will support the long-term by ensuring that workers will be able to continue to work in health care over their entire careers.

3.10. Worker power

The pandemic has been a catalyst for workers to organize in ways that were not possible before. People are starting to acknowledge the systemic problems that have existed in our

health systems for a long time, and workers have become especially ignited as they are more afraid of losing their lives to COVID-19 than losing their jobs.

Nursing home workers are joining unions because they see how their collective action will make a difference. For example, in New Jersey, there has been recent organizing (Retail, Wholesale and Department Store Union, 2020). In Austria, public and private sector unions have joined a 'health offensive' where they want to address long-standing issues related to understaffing and fatigue (VIDA, 2020). The unions are working with the ministry of health to specifically address: staffing, working conditions, training, career development, investment and ensuring service provision (VIDA, 2020). Similarly, in the UK, unions are working for a long-term pay raise, as worker pay has been frozen or raises have not kept up with inflation for ten years (Unison, 2020). In Poland, the newly formed OPZZ Konfederacja Pracy union was able to address understaffing, lack of PPE and low pay as part of their campaign to improve working conditions when an outbreak hit their facility. These workers formed a union and campaigned in numbers with local government to improve working conditions (UNI Europa, November 26, 2020).

In the US, there have been strikes in several states, mostly demanding better staffing and wages. In December, over 700 SEIU nursing home workers in Chicago went on strike and won pay increases, hazard pay, and COVID sick pay. These strikes are the result of workers struggling to manage in conditions that many workers see as unsafe for themselves and their residents (Bloomberg Law, 2020). Workers are exhausted and have started using their collective power to demand systemic change.

Online platforms and social media have offered new ways for people to connect as they have faced isolation due to confinement orders. Worker power is going to be a significant element in establishing a long-term change in the nursing home sector (Ramos, 2020).

4. The path forward

At the beginning of this paper, we promised a positive message, a hopeful solution to the current dire straits of the LTC sector worldwide. It is evident that there is not a one-sized fits all solution, but instead, it will take considerable effort from all stakeholders. Workers, employers, governments, residents, and advocacy groups must work together to achieve the rapid change required to face the on-going pandemic and future health crises.

To succeed, it will take a combination of the following:

1. Increase in union density in the nursing home sector, improving access to collective bargaining, and in turn improving working and living conditions.
2. Increased funding for LTC that includes higher wages, PPE allocations, access to vaccines, access to testing, and higher staff ratios. Funding must be tied to improved working conditions.
3. On-going and updated training for workers to ensure they can keep themselves and others safe.
4. Recognition of COVID-19 as an occupational disease. Workers must have paid sick time while waiting for test results or recovering. Ideally, this would be extended to all infectious diseases, including the seasonal flu.

5. Appropriate staffing levels to decrease psychological trauma on workers as well as provide dignity and higher quality care to residents. Increased staffing will require regional plans to retain and attract new workers.

One thing is for sure, we must start working together now. Delays will only compound future problems and result in more needless deaths.

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