



# Risk Recognition Policies for the Long-Term Care Workforce during the First Year of the COVID-19 Pandemic: A Multi-Country Study

## RESEARCH

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## ABSTRACT

**Context:** The precarious work arrangements experienced by many long-term care workers have led to the creation of a “shared” workforce across residential, home, and community aging care sectors. This shared workforce was identified as a contributor to the spread of COVID-19 early in the pandemic.

**Objective:** This analysis sought to review policy measures targeting the long-term care workforce across seven high income jurisdictions during the first year of the COVID-19 pandemic. The focus was on financial supports introduced to recognize long-term care workers for the increased risks they faced, including both (1) health risks posed by direct care provision during the pandemic and (2) economic risks associated with restrictions to multi-site work.

**Method:** Environmental scan of publicly available policy documents and government news releases published between March 1, 2020 and March 31, 2021, across seven high income jurisdictions.

**Findings:** While there was limited use of financial measures in the United States to compensate long-term care workers for the increased health risks they faced, these measures were widely used across Canada, as well as in Wales, Scotland, and Australia. Moreover, there was a corresponding use of financial measures to protect workers from income loss in parts of Canada, Australia and the UK.

**Limitations:** Our analysis did not include additional policy measures such as sick pay or recruitment incentives. We also relied primarily on publicly available policy documentation. In some cases, documents had been archived or revised, making it difficult to ascertain and clarify original information and amendments.

**Implications:** While these financial measures are temporary, they brought to light long-standing issues related to the supply of and support for workers providing care to older adults in long-term care homes.

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## INTRODUCTION

The COVID-19 pandemic has disproportionately impacted residents and staff living and working in long-term care homes (Duan *et al.*, 2020; Fisman *et al.*, 2020; OECD, 2020c). Long-term care homes, commonly known as nursing homes or care homes, are facilities that primarily support aging adults with functional, social and complex medical needs (Estabrooks *et al.*, 2020; OECD, 2020a). By January 2021, long-term care residents accounted for a large proportion of COVID-19 deaths globally, making up an estimated 39% of deaths in the United States (US), 59% in Canada, 34% in the United Kingdom (UK) and 75% in Australia (Comas-Herrera *et al.*, 2021).

Long-term care workers, particularly personal support workers—who are also known as health care aides and nursing assistants (Afzal *et al.*, 2018)—are among the lowest paid in the health and aging care sector (OECD, 2020c). Many have multiple employers or work more than full-time hours across several facilities to earn a living wage (Canadian Union of Public Employees, 2020; Eaton, 2020; McGilton *et al.*, 2020). These precarious work arrangements experienced by many long-term care workers have led to the creation of a ‘shared’ workforce with high rates of staff turnover within long-term and aging care sectors across the globe (Duan *et al.*, 2020; van Houtven, DePasquale and Coe, 2020; Gandhi, Yu and Grabowski, 2021). In addition to low pay, there is limited job security, with few permanent or full-time employment opportunities (Duan *et al.*, 2020; McGilton *et al.*, 2020; OECD, 2020b). Furthermore, in the early months of the COVID-19 pandemic, the presence of this shared healthcare workforce among multiple long-term care homes was identified as a contributor to the spread of COVID-19 (McMichael *et al.*, 2020; Office for National Statistics, 2020; van Houtven, DePasquale and Coe, 2020; Chen, Chevalier and Long, 2021).

Single-site work restriction policies, which sought to limit the movement of staff across long-term care homes, and in some cases other care facilities or employment, were introduced or recommended in several jurisdictions during the first year of the pandemic to contain virus transmission. Generally, there were two different applications of single-site restrictions. Single-site restrictions either indicated no movement between facilities was permitted or movement was permitted with a 14-day time-gap between periods of work at different facilities. While the implementation of single-site restrictions may have helped contain the spread of the virus, these restrictions may have had unintended consequences such as exacerbating staffing shortages and financial insecurities among workers (Canadian Union of Public Employees, 2020; Duan *et al.*, 2020).

The objective of this analysis was to document policies targeting the long-term care workforce in seven high-income jurisdictions—the US, Canada, Australia

and the four countries in the UK, in recognition of the increased risks they faced during the first year of the COVID-19 pandemic. Specifically, we considered financial compensation introduced to the long-term care workforce for two broad categories of risk: **(1) health risks** arising from direct contact with infected residents and co-workers; and **(2) economic risks** due to potential reduction in earnings among those affected by single-site work orders. By documenting the strategies taken across multiple jurisdictions in the first year of the COVID-19 pandemic, this analysis provides an opportunity for comparative research and policy learning to address common challenges across long-term care sectors.

## METHODS

We conducted an environmental scan of publicly available policy documents and government news releases, as well as orders, published between 1 March 2020 and 31 March 2021. We collected data at two points in time; first during the early months of the pandemic (March–June 2020) and then at the one-year mark (March–April 2021). When possible, we accessed publicly available archived sources to account for policy changes between data collection points. If the archived sources had been removed from the website, virtual archival platforms were used to obtain these sources. We included documents pertaining to support for the long-term care workforce and measures that were put in place to protect workers and residents in four federations (or quasi-federations in the case of the United Kingdom): the US, Canada, the UK (and its four constituent countries—England, Scotland, Wales, and Northern Ireland) and Australia. These high-income, western liberal democracies are frequently compared in health systems and policy research due to similarities in terms of cultural and historical development, liberal welfare states (Esping-Andersen, 1990), socio-demographic profiles, and membership of the Organization for Economic Co-operation and Development (OECD). The long-term care sectors are also comparable across these jurisdictions in terms of the important role sub-national governments play in regulating and financing long-term care facilities, the mix of public-private financing, and the reliance on needs assessments to determine eligibility (Age UK, 2020; Canadian Institute for Health Information, 2020b; Dyer *et al.*, 2020) (**Table 1**). Lastly, these sectors are comparable with respect to their predominantly female workforce, a median age of approximately 45 years, and a reliance on foreign-born workers, particularly in Canada and Australia (OECD, 2020a).

Our data collection included federal/national, sub-national governmental and long-term care associations’ websites, and focused on information related to the introduction of temporary wage supplements and single-site work orders. The measures included in this study

PRIMARY RESPONSIBILITY FOR REGULATION AND FUNDING	FORMAL LTC WORKERS PER 100 POPULATION AGED ≥ 65 <sup>(1)</sup>	BEDS IN RESIDENTIAL LTC FACILITIES PER 1,000 POPULATION AGED ≥ 65 <sup>(1)</sup>	% OF GDP SPENT ON LTC <sup>(2)</sup>	PERCENTAGE OF TOTAL POPULATION AGE ≥ 65 RESIDING IN LONG-TERM CARE (2017-2019) <sup>(3)</sup>	NURSING AIDES/ PERSONAL SUPPORT WORKERS PER 100 LONG-TERM CARE RESIDENTS AGE ≥ 65 (2017-2019) <sup>(4)</sup>	PERCENTAGE OF POPULATION AGED >80 LIVING IN INSTITUTIONS (2019) <sup>(5)</sup>	ESTIMATE OF PERSONAL SUPPORT WORKERS IN LTC SECTOR IN COMPARISON TO (LOCAL MINIMUM WAGE)
Provincial and Territorial Government	3.5 (2018)	54.4 (2018)	1.2	7.0	2.3	12.4	\$12-24 <sup>(6)</sup> (\$11.45-16 <sup>(9)</sup> )
State Government	5.5 (2018)	33.4 (2016)	0.5	2.4	4.0	6.1	CAD: \$9.5-18.99 (\$9.06-12.66) AUS: \$16.48 (\$14.51) UK: \$11.33 (\$11.07)
Federal Government	6.2 (2016)	51 (2019)	1.2 <sup>(3)</sup>	6.2	4.9	19.7	\$23.09 <sup>(6)</sup> (\$20.33 <sup>(7)</sup> )
Devolved responsibility to the four National Governments	n/a	43.8 (2018)	1.5	n/a	1.2	n/a	£8.50 <sup>(10)</sup> (£8.21 <sup>(10)</sup> )

**Table 1** Comparison of long-term care sectors.

**Sources:**

- (1) [https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH\\_LTCR](https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_LTCR).
- (2) [https://www.oecd-ilibrary.org/sites/health\\_glance-2017-81-en/index.html?itemId=/content/component/health\\_glance-2017-81-en#:~:text=Total%20government%20compulsory%20spending%20on,in%202015%20\(Figure%2011.24\)](https://www.oecd-ilibrary.org/sites/health_glance-2017-81-en/index.html?itemId=/content/component/health_glance-2017-81-en#:~:text=Total%20government%20compulsory%20spending%20on,in%202015%20(Figure%2011.24)).
- (3) <https://agedcare.royalcommission.gov.au/sites/default/files/2020-01/research-paper-2-review-international-systems-long-term-care.pdf>.
- (4) <https://www.cihi.ca/en/new-analysis-paints-international-picture-of-covid-19s-long-term-care-impacts>.
- (5) <https://www.australianagingagenda.com.au/royal-commission/australia-spending-less-than-international-counterparts/#:~:text=%E2%80%9Cwith%20findings%20that%20Australia%20spends,long%20term%20funding%20increase%20C%E2%80%9D>.
- (6) <https://www.theguardian.com/australia-news/2020/nov/12/more-than-200000-aged-care-workers-look-for-pay-rise-in-landmark-australian-case>.
- (7) <https://www.fairwork.gov.au/tools-and-resources/fact-sheets/minimum-workplace-entitlements/minimum-wages>.
- (8) [https://rsc-src.ca/sites/default/files/LTC%20PB%20%2B%20ES\\_EN.pdf](https://rsc-src.ca/sites/default/files/LTC%20PB%20%2B%20ES_EN.pdf).
- (9) <https://www.retailcouncil.org/resources/quick-facts/minimum-wage-by-province/> (10) <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf>.
- (11) <https://www.itsscener.org/wp-content/uploads/2020/09/Making-Care-Work-Pay-Report-FINAL.pdf>.
- (12) <https://www.bls.gov/opus/reports/minimum-wage/2019/home.htm>.

**Notes:**

- \* Care aides in the healthcare sector in 2020.
- ~ This range captures the lowest and highest minimum wage rates across the Canadian provinces and territories as of 2021.
- + Average hourly earnings among care facility aides in 2019.
- \* Median hourly rate for a care worker in adult social care in 2019/20.
- ° National Living Wage.

are limited to government and public health policies that directly or indirectly targeted the long-term care workforce. Specific organizational or corporate policy responses were not reviewed.

To ensure comprehensiveness of the policies reviewed, two data collection templates were developed for the two categories of risks considered. Financial compensation for health risks, which we refer to as *hazard pay*<sup>1</sup> features of interest, included implementation date of program; title of program; type of payment; amount and duration of payment; eligibility criteria; eligible workplaces; eligible roles; limits to eligibility and fund distribution, as well as any other relevant implementation details (Appendix 1). Compensation for any overtime hours was not considered a form of hazard pay for the purposes of this analysis. For compensation for economic risks associated with single-site work restrictions, features of interest included single-site order announcement date; single-site order implementation date; mandatory or recommended order; other implementation details and description of financial protection measures, including protection of hours and income (Appendix 2). With respect to the use of *mandatory* or *recommended* designations, we considered any policies to be mandatory if the choice was not left up to the licensee, long-term care provider or worker itself, but rather was required by a government policy or government agency. As much as possible, we

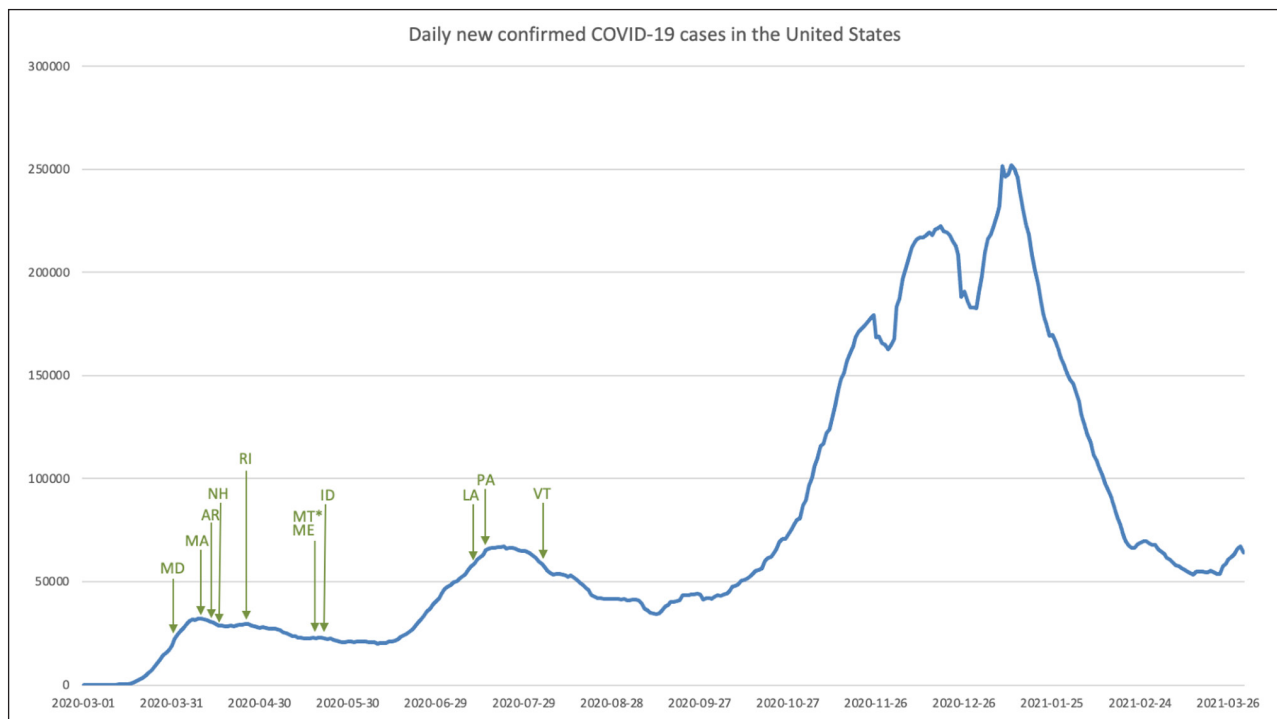
validated our findings with experts and stakeholders in the field (government representatives responsible for long-term care, researchers in the long-term and aging care sector, leaders of organizations that represent long-term care workers) from each jurisdiction.

## RESULTS

### POLICY MEASURES TO SUPPORT THE LONG-TERM CARE WORKFORCE

#### Compensating for Increased Health Risks

By 31 March 2021, 11 US states, all thirteen Canadian provinces and territories, Scotland (UK), Wales (UK), and Australia introduced some form of hazard pay for the long-term care workforce (*Figures 1–4*). These hazard pay programs took the form of an hourly payment top-up, a percentage increase in payment, or a lump sum bonus. Few of these programs targeted long-term care workers exclusively. Rather, the intent of many of these financial measures was to compensate low-income, essential frontline workers broadly, which included some long-term care workers such as personal support workers (Appendix 1). Most programs were introduced between March and June 2020 (*Figures 1–4*). Of those introduced later in 2020, the bonuses were frequently applied retroactively to the early months of the pandemic. Few programs were introduced in 2021.

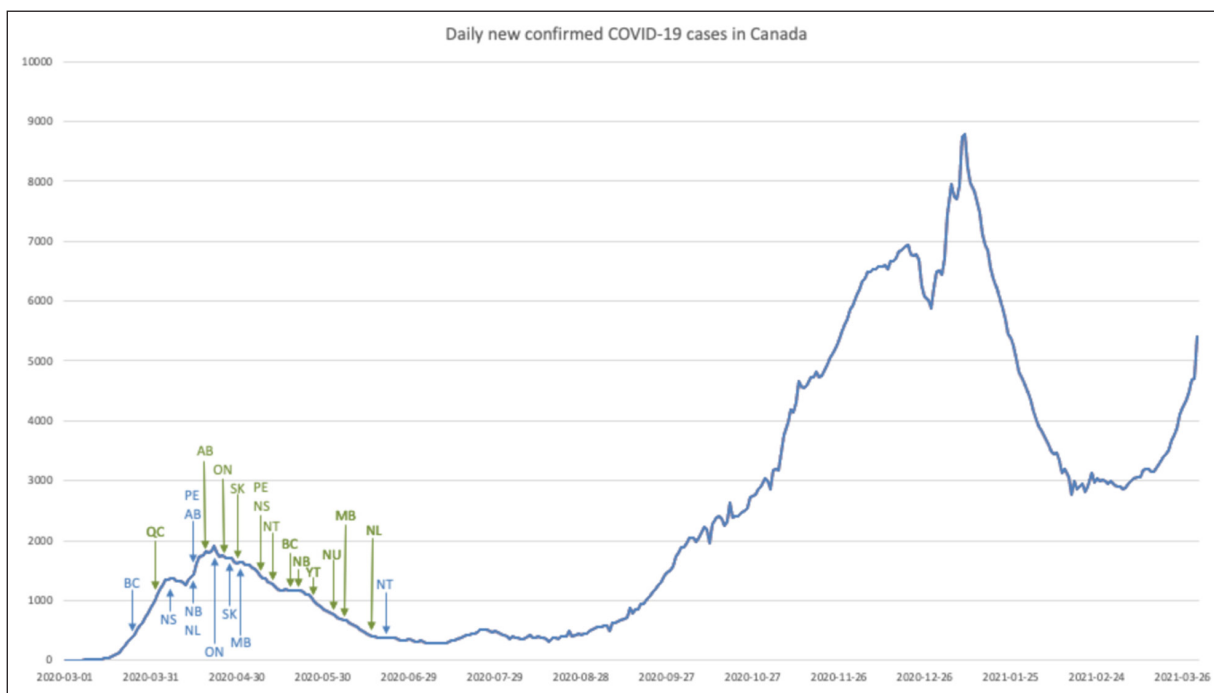


**Figure 1** United States – Timeline of policy measures in long-term care and daily new confirmed COVID-19 cases, March 2020–March 2021. Legend: Hazard pay programs are captured in green.

Note: MD = Maryland, MA = Massachusetts, AR = Arkansas, NH = New Hampshire, RI = Rhode Island, ME = Maine, MT = Montana, ID = Idaho, LA = Louisiana, PA = Pennsylvania, VT = Vermont.

Note: Each marker represents the **first** single site or hazard policy to be introduced within a jurisdiction. Subsequent policies introduced in a jurisdiction are not captured. \* No specific date provided, only month of May, 2020.

Source: Raw COVID-19 case count data was extracted from the COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University.

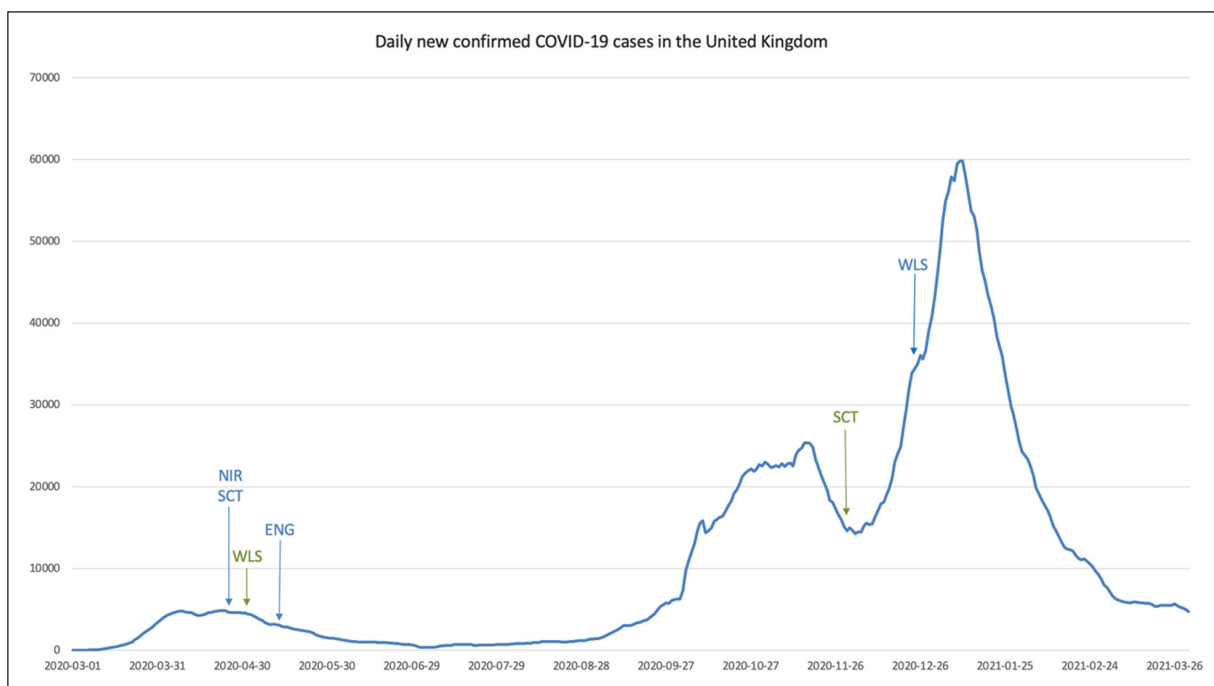


**Figure 2** Canada – Timeline of policy measures in long-term care and daily new confirmed COVID-19 cases, March 2020–March 2021. Legend: Hazard pay programs are captured in green. Single-site orders are captured in Blue.

Note: BC = British Columbia, QC = Quebec, NS = Nova Scotia, AB = Alberta, MB = Manitoba, SK = Saskatchewan, PE = Prince Edward Island, NB = New Brunswick, NL = Newfoundland and Labrador, ON = Ontario, NT = Northwest Territories, YT = Yukon Territories, NU = Nunavut.

Note: Each marker represents the first single site or hazard policy to be introduced within a jurisdiction. Subsequent policies introduced in a jurisdiction are not captured.

Source: Raw COVID-19 case count data was extracted from the COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University.



**Figure 3** United Kingdom – Timeline of policy measures in long-term care and daily new confirmed COVID-19 cases, March 2020–March 2021.

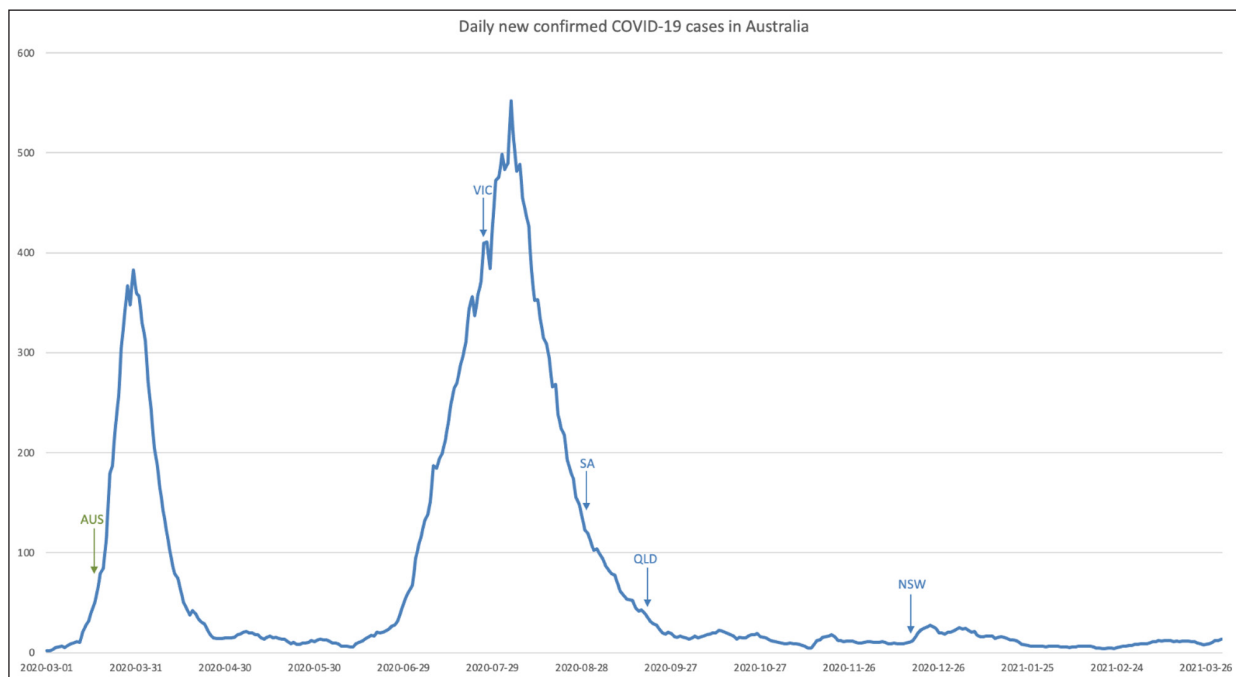
Legend: Hazard pay programs are captured in green. Single-site orders are captured in Blue.

Note: NIR = Northern Ireland, SCT = Scotland, WAL = Wales, ENG = England.

Note: Each marker represents the **first** single site or hazard policy to be introduced within a jurisdiction. Subsequent policies introduced in a jurisdiction are not captured.

Source: Raw COVID-19 case count data was extracted from the COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University.





**Figure 4** Australia – Timeline of policy measures in long-term care and daily new confirmed COVID-19 cases, March 2020–March 2021. Legend: Hazard pay programs are captured in green. Single-site orders are captured in Blue.

Note: AUS = Australia, VIC = Victoria, SA = South Australia, QLD = Queensland, NSW = New South Wales.

Note: Each marker represents the first single site or hazard policy to be introduced within a jurisdiction. Subsequent policies introduced in a jurisdiction are not captured.

Source: Raw COVID-19 case count data was extracted from the COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University.

### United States

While there were proposals to implement federally-funded hazard pay programs in the US early in the pandemic (Kinder, Stateler and Du, 2020a)—including the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (Kinder, 2020) and the Proposal for Pandemic Pay to Reward, Retain & Recruit Essential Workers (Senate Democrats, 2020) in April 2020 and the Patriot Pay in May 2020 (Kinder, Stateler and Du, 2020a)—as of 31 March 2021, none had been passed into law. In fact, the Heroes Fund for hazard pay for essential workers was dropped from the \$2.2 trillion HEROES Act proposal in September 2020. Instead, on March 27<sup>th</sup>, 2020 the US Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act (US Department of the Treasury, 2020). The CARES Act prioritized financial support for hospitals and other healthcare providers such as long-term care facilities (van Houtven, Boucher and Dawson, 2020), and authorized the Nursing Home Provider Relief Fund (PRF), a \$5 billion USD distribution package disseminated to protect long-term care residents during the pandemic (US Department of Health & Human Services, 2020). However, these funds were primarily used for providers' safety needs such as testing and personal protective equipment, as well as hiring, instead of financially compensating staff for the increased health risks they faced (US Department of Health & Human Services, 2020). Further, although \$17.2 billion USD of the CARES Act was directed to the

Department of Veterans Affairs Health System (US Department of Veterans Affairs, 2020), the Department of Veterans Affairs Health System did not use their funds directly for hazard pay (Block, 2020). However, although the CARES Act was not intended to cover hazard pay, some states leveraged CARES Act funds to introduce their own state level hazard pay programs (Kinder, 2021). In January 2021, President Biden announced the American Rescue Plan (ARP) Act, a \$1.9 trillion funding package. Although dedicated federal funding for hazard pay was not included, the ARP Act provided \$350 billion in state and local aid which could be used for hazard pay for workers making less than \$13 per hour or \$25,000 USD a year (Kinder and Stateler, 2021; National Conference of State Legislatures, 2021). Moreover, the ARP provided a 10 percentage point increase in Medicaid expenditures for certain home and community-based services (HCBS) in qualifying states (Department of Health & Human Services, 2021).

Notably, eleven states (Massachusetts, Rhode Island, New Hampshire, Arkansas, Louisiana, Maryland, Pennsylvania, Vermont, Idaho, Maine and Montana) leveraged federal funding to develop their own hazard pay programs (Figure 1 and Appendix 1) (Kinder, Stateler and Du, 2020b; Kinder, 2021). Though there was significant cross-state variability in the eligibility criteria and amount of payment, long-term care facilities were recognized as an eligible workplace in all programs. Arkansas was the only state to provide

hazard pay exclusively to health and long-term care workers, while the remaining states included other non-healthcare essential services, such as homeless shelters, food services and correctional facilities. Furthermore, four of the state programs—Rhode Island (Executive Office of Health & Human Services, 2020), Louisiana (Louisiana Department of Revenue, 2020), Pennsylvania (Pennsylvania Government, 2020) and Vermont (Vermont General Assembly, 2020)—limited payments to low-income workers using income thresholds to determine eligibility. In Pennsylvania, to ensure adequate support for all low-income workers in eligible industries, several factors were considered in the determination of hazard pay including risk level, wage level, and availability of other funding opportunities (Kinder, Stateler and Du, 2020a; Pennsylvania Government, 2020). Although Pennsylvania's \$50 million USD hazard pay program was only able to provide funding to 10% of applicants, long-term care workers were among the biggest beneficiaries (Kinder, Stateler and Du, 2020a). Long-term care providers in other states, such as Connecticut (The Office of Governor Ned Lamont, 2020) and Oregon (DHS Aging and People with Disabilities Program, 2020), received an increase in Medicaid payments for operating costs. At the discretion of the providers, these payments could be used for hazard pay. However, we were unable to find evidence of the implementation of hazard pay programs in these states.

### **Canada**

On 15 April 2020, as part of the 'COVID-19 Economic Response Plan,' the Government of Canada announced it would provide up to \$2.3 billion (\$1.9 billion USD) to increase the wages of 'low-income essential workers' across the country who faced increased risks and to ensure continued operation of essential services (Government of Canada, 2020b). Though these wage top-ups were funded federally, Canadian provinces and territories determined which essential workers would be eligible and how much money they would receive (Department of Finance, Government of Canada, 2020). Thus, while there was consistency in the timing of the implementation of these programs (Figure 2), there was variability in hazard pay programs' implementation timelines, eligibility criteria, as well as the amount and duration of payment (Appendix 1). In our study time period, six provinces (New Brunswick, Nova Scotia, British Columbia, Ontario, Quebec and Saskatchewan) introduced hazard pay programs that were exclusive to health and social care workers.<sup>2</sup> Another six provinces and territories (Newfoundland and Labrador, Prince Edward Island, Manitoba, Yukon, Northwest Territories and Nunavut) implemented hazard pay programs with more general criteria inclusive of a broader range of essential services and workers. A low-income threshold was commonly used to determine eligibility for hazard

pay among the programs that covered a broader range of essential workers. Thus, whether through income thresholds or explicit targeting, low-income long-term care workers such as personal support workers were eligible for financial bonuses in all 12 of these provinces and territories. Furthermore, these programs were introduced for a fixed period of time, with the exception of Quebec, which had no formal end date (Appendix 1).

The province of Alberta was a late adopter of the federally funded hazard payment program. This delay is reported to be due to challenges between provincial and federal government as to how the financial compensation should be issued across the province (French, 2020). However, before much of the rest of Canada introduced their pandemic pay programs, Alberta introduced the *Health Care Aide Wage Supplement* (Government of Alberta, 2020b), which provided a top-up of \$2 CAD (\$1.6 USD) exclusive to personal support workers employed at contracted long-term care and designated supportive living sites in the province (AHS Emergency Coordination Centre, 2020; Government of Alberta, 2020b). This program was intended to remain in place until the end of the pandemic (Government of Alberta, 2020a). Subsequently in February 2021 (Johnson, 2020), the government of Alberta then reached an agreement with the federal government and offered a one-time payment of \$1,200 (\$990 USD) to workers in both the health and social care sectors, as well as the education sector (Government of Alberta, no date). Staff working in long-term care were considered eligible for this payment, however, not if they had collected the \$2 CAD (\$1.6 USD) top-up as part of the *Health Care Aide Wage Supplement* (Government of Alberta, 2021).

Between October 2020 and February 2021, Ontario (Government of Ontario, 2020b) and Manitoba (Government of Manitoba, 2020) introduced new hazard pay programs to temporarily enhance the wages of low-income workers in hospital and residential care services, including long-term care homes. Ontario's program specifically targeted personal support workers (Government of Ontario, 2020b), whereas Manitoba's program was inclusive of other low-income workers such as housekeeping and recreation staff (Government of Manitoba, no date). On 18 March 2021, the government of Ontario announced they would extend their program until 30 June 2021 (Government of Ontario, 2021). In November 2020, both Yukon (Government of Yukon, 2020) and Saskatchewan (Government of Saskatchewan, Ministry of Health, 2020) also announced an extension of their original hazard pay programs.

### **United Kingdom**

Like the US, hazard pay was not widely introduced in the UK. Only the Welsh and Scottish governments financially compensated long-term care workers during the first year of the pandemic (Figure 3). The Social Care

Workforce<sup>3</sup> Special Payment Scheme was introduced in Wales on May 1st, 2020, and provided a one-time payment of £500 (\$705 USD) to over 100,000 eligible social care workers (Welsh Government, 2020). Later, on 17 March 2021, the Welsh Government announced a second hazard pay, the NHS and Social Care Financial Recognition Scheme, which provided a one-time payment of £735 (\$1,260 USD) to social care workers. In Scotland, the Social Care Workforce Payment, announced on 30 November 2020, provided a £500 (\$705 USD) pro-rata payment to health and social care staff employed for at least four continuous weeks during the qualifying period of 17 March to 30 November 2020 (Scottish Government, 2021a). In Northern Ireland, a proposal to introduce a one-time payment of £500 (\$705 USD) to health and social care workers, titled the HSC Recognition Payment (Black, 2021), had not been implemented by the end of March 2021 (Black, 2021; Department of Health—Northern Ireland, 2021). Likewise, in England, despite several proposals and petitions to introduce hazard payments, and the government's stated commitment to supporting the social care workforce, no hazard pay programs had been implemented by 31 March 2021 (UK Parliament, 2020).

In addition to hazard pay programs, the Scottish Government introduced two 'pay rises' to increase social care workers pay to 'at least the Real Living Wage'. The first provided a 3.3% pay rise on 12 April, backdated to 1 April (Scottish Government, 2020) while the second increased the hourly pay to £9.50 (\$13 USD) on May 2021 and backdated to April 2021 (Scottish Government, 2021b). While the pay raise offered to social care workers is not specific to the pandemic, the raise was provided earlier than in previous years to 'support social care workers in recognition of the vital role they are playing during the coronavirus (COVID-19) pandemic' (Scottish Government, 2020).

### **Australia**

On 11 March 2020, the Australian government announced a \$440 million (\$340 million USD) commitment to the long-term care sector (Low, 2020). An additional \$563.3 million (\$434 million USD) in funding was later announced on 31 August 2020, which brought the combined Government support for the sector to over \$1.5 billion (\$1.4 billion USD) (Department of Health, 2020a). Of the initial \$440 million, approximately 53% was allocated to long-term care workers in the form of a 'retention bonus' (Low, 2020). The Workforce Retention Payment initially provided a payment of up to \$800 (\$620 USD) to direct care workers in long-term care in July and September 2020 (Australian Government Department of Health, 2020d, 2020a). The Government extended the program to provide a third payment, with the same eligibility requirements as the first two rounds, in recognition of the ongoing pressures faced by frontline care workers, costing \$154.5 million (\$119 million USD) (Department

of Health, 2020a). While a temporary measure, it was explicitly implemented to support workforce stabilization measures and ensure continuity of care (Australian Government Department of Health, 2020d, 2020a).

### **Protecting Against Added Economic Risks**

In the first year of the pandemic, there were no measures to restrict mobility of long-term care staff introduced in the US, though single-site orders were mandated or recommended in nearly all Canadian provinces/territories, the UK, and 4 Australian states (*Figures 1–4*). While this measure may have limited virus transmission, single-site work orders may also have contributed to a loss of income for long-term care workers (Canadian Union of Public Employees, 2020). In jurisdictions where single-site work restrictions were introduced, a range of financial measures were used to protect workers from income loss. Policy measures that were introduced to protect staff affected by single-site restrictions comprised at least one of the following considerations: **(1)** the allowance of staff to work beyond full-time hours at a single site; and **(2)** the maintenance of, or an increase in, remuneration. In some cases, these were designed to support staff retention as well as compensating for reduced income (Appendix 2).

### **United States**

As of 31 March 2021, there were no federal or state orders or restrictions to limit multi-site work in long-term care.

### **Canada**

In Canada, eight of the provinces and territories *mandated* single-site work orders, while three of the remaining six *recommended* single-site work restrictions early in the pandemic (*Figure 2*). Only those with mandated single-site orders introduced measures to compensate long-term care workers for reduced income. Five provinces with mandatory orders (British Columbia, Manitoba, Saskatchewan, Alberta and later Prince Edward Island) published details on the allocation of hours and remuneration rates for workers affected by the restriction, and, among these, the most comprehensive protections were in British Columbia and Manitoba (described further below). The provincial governments in Newfoundland, Northwest Territories, and Ontario did not provide publicly facing details regarding the allocation of hours and remuneration rates for long-term care staff affected by the mandatory order. However, long-term care homes in Ontario were encouraged to bring part-time staff up to full-time hours to meet the staffing needs (Government of Ontario, 2020a).

In British Columbia, employees restricted to working at one facility by the single-site order were to be paid the highest wage they received while working at multiple facilities (Government of British Columbia, 2020). Moreover, employees previously working at multiple sites could work the total combined hours at a single site up to a maximum



of 1.3 Full-Time Equivalents (FTEs)<sup>4</sup> (Government of British Columbia, 2020) or 48.75 hours per week. This recognizes that many multi-site workers work more than full-time hours to earn a living wage (Canadian Union of Public Employees, 2020). In addition to these measures, the British Columbia government introduced a centralized staffing approach which ensured long-term care staff were paid a 'standardized wage' and were employed on a full-time basis (Duan et al., 2020; Liu et al., 2020). Later in September 2020, British Columbia announced that the provincial government would be investing \$1.6 billion (\$1.3 billion USD) in a fall and winter preparedness plan (British Columbia Ministry of Health, 2020). Within their investment, they allocated \$165.4 million (\$135 million USD) for a 'single site wage top-up', like Alberta, to support staff and service providers with costs related to the single-site directive. Similarly, in Manitoba there were efforts to protect employees who had worked more than 1.0 FTE across multiple long-term care homes before the restriction, as they could continue to work up to 1.3 FTE at a single site following the restriction (Shared Health Manitoba, 2020). Moreover, Manitoba's single-site order specified that staff limited to one facility would continue to earn the remuneration rate for the hours worked at the original facility (Shared Health Manitoba, 2020).

Financial protection measures in Saskatchewan and Alberta were more limited. Long-term care staff in Saskatchewan were only able to work up to 1.0 FTE at a single site (Saskatchewan Health Authority, 2020a). However, like Manitoba, staff affected by the order in Saskatchewan would continue to earn the remuneration rate for the hours worked at their original facility (Saskatchewan Health Authority, 2020a), and employees assigned to a position of a lower pay classification will maintain their original pay rate (Saskatchewan Health Authority, 2020b). In Alberta, long-term care staff with combined working hours above 1.0 FTEs prior to the single-site order were able to make up additional hours to remain 'financially whole', although this was not guaranteed (Alberta Health Services, 2020). However, unlike BC, Manitoba and Saskatchewan, long-term care staff working multiple positions within government-owned long-term care homes in Alberta received the rate of pay for their assigned position (even if that pay was lower than what they had previously earned) (Alberta Health Services, 2020). As noted above, Alberta's *Health Care Aide Wage Supplement* program introduced a wage top-up of \$2 CAD (\$1.6 USD) to healthcare aides employed at contracted long-term care and designated supportive living sites in Alberta (AHS Emergency Coordination Centre, 2020; Government of Alberta, 2020b). Though it was introduced as a hazard pay program, the program also aimed to alleviate the financial burden arising due to single-site restrictions among personal support workers (Government of Alberta, 2020b).

While most provincial and territorial governments in Canada maintained their single-site work restrictions

through March 2021, whether *recommended* or *mandatory*, the government of Prince Edward Island lifted their mandatory restriction on 16 February 2021 (Health PEI, 2020). Though the restriction was lifted, it only applied to fully vaccinated staff and required these staff to adhere to weekly routine testing for COVID-19 (Health PEI, 2020). In the case of an outbreak, staff would again be restricted to a single site (Health PEI, 2021). However, the province provides details for how staff, impacted by an outbreak, would have both their wages and work hours protected (Health PEI, 2021). Staff would maintain their hourly rate for the hours they were already scheduled in the posted and confirmed period when first restricted. Furthermore, their remuneration rate would be carried over for the hours they would have worked at the other site, should an outbreak have not occurred (Health PEI, 2021).

### *United Kingdom*

All four countries in the UK recommended, but did not mandate single-site work (Department of Health, 2020b; Department of Health and Social Care, 2020d, 2020b; Public Health Scotland, 2020). On 15 May 2020, the Department of Health and Social Care announced that it would provide long-term care homes with a £600 million (\$812 million USD) Adult Social Care Infection Control Fund (hereinafter referred to as 'The Fund') (Department of Health and Social Care, 2021a), of which approximately £113 million (\$156 million USD) was allocated to Scotland (£58 million, \$79 million USD), Northern Ireland (£20 million, \$27 million USD) and Wales (£35 million, \$48 million USD) (Department of Health and Social Care, 2020b). The Fund was extended to March 2021 and provided an additional £546 million (\$771 million USD) in funding (Department of Health and Social Care, 2021a).

The Fund recommended that care homes in England restrict the movement of staff to one facility where possible (Department of Health and Social Care, 2020b) with Northern Ireland's Department of Health and Public Health Scotland issuing similar recommendations in April 2020, followed by Public Health Wales issuing their recommendation in December 2020 (Department of Health, 2020b; Public Health Scotland, 2020; Public Health Wales, 2020). Public Health Scotland's non-statutory guidance also recommended minimising the use of external staff, such as agency staff, in long-term care homes (Public Health Scotland, 2020) while the movement restriction issued by Public Health Wales applied to both staff and agency staff (Public Health Wales, 2020).

In subsequent months, the UK Government changed positions on how best to manage staff movement (Dunn et al., 2021). On 18 September 2020, the Department of Health and Social Care's released the winter plan for 2020 and 2021 which told providers to 'limit all staff movement between settings unless absolutely necessary', which would be enforced through regulations

(Department of Health and Social Care, 2020a). Then, the Department announced a proposal to introduce a temporary legislative order that would legally prevent staff providing personal or nursing care from working in more than one long-term care home within 14 days 'in all but limited circumstances' (Department of Health and Social Care, 2020e) by the end of the year (HM Government, 2020). However, these plans were met with concern from the sector, as advocates argued that the introduction of legislation to prevent multi-site work could 'crash the system' and homes would ultimately have to close due to staff shortages (Barnes and Donnelly, 2020; Care England, 2020; NCF Press Releases, 2020; Recruitment and Employment Confederation, 2020). In response, the Department conducted a public consultation in November 2020 (Department of Health and Social Care, 2020c). Following a review of responses, on 27 May 2021, the Government did not proceed with amendments to the regulations to restrict staff movement (Department of Health and Social Care, 2020c). However, the guidance released on 1 March 2021 'Restricting workforce movement between care homes and other care settings', did advise that routine staff movement should not be taking place (Department of Health and Social Care, 2020c, 2021b).

England and Scotland provided guidance on the financial compensation of long-term care staff with respect to single site recommendations. In England, the Fund could be used to 'meet the additional costs of restricting staff to work in one care home' (Department of Health and Social Care, 2020b) and help maintain normal wages of their staff (Department of Health and Social Care, 2020d). On 16 January 2021 the '*Workforce Capacity Fund for adult social care* provided £120 million (\$170 million USD) in additional funding to manage workforce pressures including supporting providers restricting staff movement' (Department of Health and Social Care, 2021c). Likewise, employers in Scotland may reclaim the cost of limiting staff movement, which may include paying staff their expected income (Health and Social Care Scotland, 2020). Guidance from Wales and Northern Ireland to support the staff who were restricted from moving between facilities did not specify any financial compensation (Department of Health and Social Care, 2020d), as infection control funds may be distributed according to each jurisdictions' own funding mechanisms.

### **Australia**

Although there was no national single-site order in Australia, several states introduced single-site orders after the first wave of the pandemic (Figure 4). Victoria, the state that experienced the most COVID-19 cases and deaths in long-term care in Australia, was the first state to introduce a single-site order, in place on 27 July 2020 (Australian Government Department of Health, 2020e).

Subsequent single-site orders have also been made in response to sporadic community outbreaks of COVID-19 in Victoria on 8 January 2021 (Australian Government Department of Health, 2021b) and 12 February 2021 (Victorian Government, 2021), as well as in New South Wales on 18 December 2020 (Aged & Community Services Australia and Leading Aged Care Services Australia, 2020). As of 31 March 2021, Queensland (Queensland Health, 2021, p. 29) and South Australia (Government of South Australia, 2020b, p. 19) continued to recommend single-site work since the initial order introduced on 11 September 2020 (Queensland Health, 2020, p. 9) and 27 August 2020 (Government of South Australia, 2020a), respectively.

In addition, Guiding Principles ('Principles') were developed by industry representatives with support from the Government to assist aged care providers in limiting staff employment to a single site within designated hotspots (Australian Government Department of Health, 2020c). Initially developed in July 2020 to address outbreaks in the Melbourne and Mitchell Shire areas in Victoria (Australian Nursing and Midwifery Federation Victorian Branch, 2020), the 'Guiding Principles for residential aged care – keeping Victorian residents and workers safe' (Leading Age Services Australia and Aged & Community Services Australia, 2020a), were adopted by New South Wales and Queensland. A key component of the Principles was to ensure that no worker providing care to older adults would be financially disadvantaged (Australian Government Department of Health, 2020c, 2020f). Accordingly, this required that sufficient payable hours be offered to long-term care workers to allow them to maintain their income (Guiding Principles Support Hub, 2020), including the capacity to add the hours they would have normally worked at secondary facilities to hours worked at their primary long-term care home (Australian Nursing and Midwifery Federation Victorian Branch, 2020). Under a limited number of circumstances where extra hours are unavailable, the primary employer would pay the employee their remaining total average take-home pay (Guiding Principles Support Hub, 2020). The Principles applied only to long-term care facilities and did not extend to other health care services (Leading Age Services Australia and Aged & Community Services Australia, 2020b). A Support Hub was developed to support providers and staff within hotspot regions who have opted into the Guiding Principles (Leading Age Services Australia and Aged & Community Services Australia, no date).

Residential aged care providers in designated COVID-19 hotspot areas were also able to claim workforce costs, including costs arising from implementing single-site work arrangements and supporting workers affected by the single site restriction (Australian Government Department of Health, 2020c), through the Support for Aged Care Workers in COVID-19 (SACWIC) grant (Guiding

Principles Support Hub, 2020). This grant program was funded by the Australian Government from 4 August 2020 (Aged & Community Services Australia and Leading Age Services Australia, 2020b) as part of the COVID-19 Aged Care Support Program (Guiding Principles Support Hub, 2020). The program included a specific funding stream to ensure workers are not disadvantaged by single-site arrangements (Leading Age Services Australia and Aged & Community Services Australia, 2020b). The funding was extended from the initial eight-week period to a twelve-week period, with an additional \$92.4 million (\$71 million USD) available (Department of Health, 2020a). Aged care providers had to apply to the grant by 30 June 2021 in order to be reimbursed for additional staffing costs, and it was expected that providers who applied for the grant would adopt the Principles (Leading Age Services Australia and Aged & Community Services Australia, 2020b).

The funding support through the Australian Government's SACWIC grant was limited geographically in Victoria to hotspot areas (Aged & Community Services Australia and Leading Age Services Australia, 2020a). As such, the Victorian Government subsequently introduced a funding scheme for which all Public Sector Residential Aged Care Services (PSRACS) in Victoria were eligible (Aged & Community Services Australia and Leading Age Services Australia, 2020a). This funding scheme adopted the same Guiding Principles to incentive providers to limit staff mobility and to ensure workers are not financially disadvantaged (Aged & Community Services Australia and Leading Age Services Australia, 2020a). The funding was available to PSRACS until the end of February 2021 (Aged & Community Services Australia and Leading Age Services Australia, 2020a). The Communicable Diseases Network Australia (CDNA) National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia were also updated by Department of Health, in consultation with the aged care sector, to include information pertaining to the implementation of further single-site arrangements (Australian Government Department of Health, 2020b). As per the Guidelines, ensuring providers offered similar worked hours at a single facility, when possible, was needed to ensure workers were not disadvantaged (Australian Government Department of Health, 2021a).

## CONCLUSION

In the first year of the COVID-19 pandemic, policy measures were widely introduced in Canada and Australia in recognition of the increased risks faced by long-term care workers. In the UK, these were only introduced in Wales and Scotland, and in the US these measures were limited to only 11 states during the first year of the pandemic. In addition, there were widespread

efforts taken to restrict multi-site work in Canada, the U.K, and Australia to limit virus transmission, though with uneven implementation of corresponding economic protection measures to compensate long-term care workers for potential income loss. Although it is difficult to draw direct comparisons across countries in the timing of the implementation of these policy measures relative to the risks faced by the long-term care workforce and resident populations, some variations are notable. Specifically, in Canada the widespread implementation of hazard pay and single-site restrictions by June 2020 was earlier than the other jurisdictions, and at a time when 81% of deaths from COVID-19 had been among long-term care residents, compared to 38% on average for the OECD (Canadian Institute for Health Information, 2020a). While the lower concentration of COVID-19 deaths in long-term care may account for the lagging implementation in the other countries studied, it is also possible that long-term care home providers acted at a provider level, which would not have been captured in our analysis. Furthermore, any potential provider level responses would have made it difficult to comprehensively examine any state, provincial, or federal policy change in its entirety.

While economic measures are insufficient on their own to support long-term care workers, they are one of the tools available to governments to recognize their essential work and to improve retention in the short-term. Notably, however, many of the bonuses and top-ups implemented to recognize the health and economic risks of low-income essential workers and the long-term care workforce during the first year of the pandemic were temporary, with many being introduced for limited time periods only, despite the continued health risks faced by the direct care workforce. Furthermore, many of these measures provided marginal pay increases and did not go so far as to introduce substantial changes to any compensation or employment standards that would begin to address the roots of any longstanding workforce challenges such as few permanent or full-time positions, low pay, or high turnover. Though it may not be surprising that this sort of "band-aid" approach was taken, first because of the need to move quickly and second, because of existing policy legacies within the sector that make major policy change difficult (Béland and Marier, 2020).

Our effort to document the policy measures aimed at supporting the long-term care workforce across a range of jurisdictions had some limitations. While there are common features in the design of the long-term care sector and the composition of the long-term care workforce across these countries, there exists some differences in how long-term care homes are regulated and financed, and the role of the federal and sub-national governments. Furthermore, we did not include additional policy measures such as sick pay or recruitment incentives as part of our analysis. It should also be noted that we relied primarily on policy documentation that was publicly available and accessible

and consulted with local experts and professional networks of our research team, when possible, to verify the information found. However, in some cases, policy documents had been archived or revised, making it difficult to ascertain and clarify original information and changes.

All seven jurisdictions in this study rely on long-term care workforces that are underpaid, often times precariously employed, and in some circumstances rely on multi-site work arrangements, yet the implementation of compensation and support has been uneven. In particular, there were considerable gaps in the US and parts of the UK in spite of considerably higher levels of risk overall as measured by population-level case counts and mortality than in Canada and Australia. Future studies should consider evaluating the impact of these measures and their effectiveness in reducing income loss among long-term care staff as a result of the pandemic. Finally, while this analysis identified measures implemented in the first year of the pandemic to compensate the long-term care workforce for the risks they faced, it is important to consider the structural issues that existed pre-pandemic that have led to these financial incentives needing to be introduced in the first place. The undervaluing of the long-term care workforce, particularly personal support workers, is something governments will be forced to address given their essential role in maintaining the safety, dignity, and well-being of long-term care residents.

## NOTES

- 1 Hazard pay has been defined as “additional pay for performing hazardous duty or work involving physical hardship” (US Department of Labor, no date).
- 2 Broadly defined as a sector comprised of services that provide health care, residential care, community housing, as well as food services and childcare to those requiring assistance (Government of Canada, 2020a).
- 3 In the UK, long-term care is part of the social care system, funded by both the state and individual users, and long-term care workers are referred to as adult social care workers (Comas-Herrera et al., 2010).
- 4 1.0 FTEs is considered full-time employment at 37.5 hours per week (Ministry of Long-Term Care, 2020).

## ADDITIONAL FILES

The additional files for this article can be found as follows:

- **Appendix 1.** Characteristics and implementation details of hazard pay policies introduced across the United States, Canada, the United Kingdom and Australia. DOI: <https://doi.org/10.31389/jltc.110.s1>
- **Appendix 2.** Characteristics and implementation details of single-site policies introduced across the United States, Canada, the United Kingdom and Australia. DOI: <https://doi.org/10.31389/jltc.110.s2>

## COMPETING INTERESTS

Anna Cooper Reed was a part-time employee of a long-term care home during the study period. The authors have no other competing interests to declare.

## AUTHOR CONTRIBUTIONS

Anna Cooper Reed and Maya Murmann authors contributed equally to this paper.

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