Long-Term Solutions for Long-Term Care

Analyzing provincial COVID-19 responses to LTC staffing to improve working conditions and seniors care

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We want to express our deep gratitude to health care workers for the incredible bravery they showed, the sacrifices they made and the risks they took to provide essential care during the COVID-19 pandemic. We endeavour to achieve working conditions that reflect the heroic effort and the skill you bring to your jobs every day, conditions that allow you to care for residents and patients with the excellence you strive for and the excellence they deserve.

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Executive Summary

In 2020 alone, during the 'first wave' of the pandemic, 14,000 seniors and several staff in long-term care homes lost their lives to COVID.[1] The pandemic exposed longstanding, system-wide deficiencies in the long-term care sector, putting seniors and many of our most vulnerable citizens at risk.

Governments, health authorities and long-term care (LTC) home operators across the country worked frantically to help prevent the spread of the virus and to care for those infected. A review of measures in B.C., Alberta, Ontario and Quebec reveals a wide variance in tactics, implementation and success.

In British Columbia, the provincial government took decisive action that helped stabilize the sector through this period. By collaborating with unions and health care employers, it quickly and effectively implemented measures to both improve the working conditions of health care workers and protect seniors in long-term care. Three key measures were:

01 **single-site orders** to limit the flow of staff and thus the virus, and provide workers with stability

02 **wage incentives and standardization** to compensate workers for additional duties and increased risk during the pandemic and to subsidize the wage difference between public sector and private sector LTC workers during and following the pandemic and

03 **a robust, tuition-free training program** to address the acute staffing demands of the pandemic.

The BC government's success was, in no small part, due to its collaborative working relationship with the Hospital Employees Union (HEU) and other partner unions. Together, the B.C. government, the Health Employers' Association of BC, and the HEU ensured they knew how these policies and initiatives would impact care aides and the seniors they serve. While more can be done to improve seniors' care—including increasing LTC staffing levels—the key measures and collaborative approaches that B.C. took during the pandemic have had positive outcomes and should be permanently adopted throughout Canada's LTC sector.

Now is the time. The number of seniors in long-term care will double to nearly 400,000 Canadians in the next decade. By working collaboratively, government, health care employers and unions can provide the quality of working conditions that will ensure the quality of care our seniors deserve.

Introduction and Scope

The COVID-19 pandemic had lasting impacts on the health care system in Canada, particularly in seniors' care. During the 'first wave'[2] of the pandemic alone, 14,000 seniors and several staff in LTC homes lost their lives to COVID.[3] While seniors accounted for three per cent of all COVID-19 cases in Canada, they accounted for 43 per cent of COVID-19 deaths.[4] Many seniors who died in care homes had little, if any, contact with family members in their final days because of policies enacted to prevent the spread of the virus.

It was an exceptional and frightening time to be in a care home or to have a family member in one.

Governments, health authorities and long-term care (LTC) home operators across the country worked frantically to put measures in place to prevent the spread of the virus and to care for those infected. Care home operators were desperate to maintain staffing in their residences to meet the additional demands of the crisis.

Some provinces put pandemic LTC staffing measures in place, helping prevent the death rate from climbing higher than it would have otherwise. Provinces in more dire straits called in the military to assist but were not as successful in lessening the death toll on seniors.

In B.C. the death rate in LTC during the first wave of COVID-19 was 2.6 per 100,000 population, lower than that of Alberta's 3.2, and much lower than that of Ontario's 13.5, and Quebec's 43.2. Many variables were at play in determining these rates. We do know enough about the virus's transmission however, to know that successfully limiting the number of people in contact with seniors, including LTC staff played no small role in limiting COVID-19's spread and related deaths.

The pandemic exposed systemic deficiencies in the LTC sector across the country: shortages of personal protective equipment (PPE), inadequate infectious disease protocols and workload issues related to chronic short-staffing. The pandemic's spotlight also provided provincial governments an opportunity to implement new policies to remedy long-standing issues that likely would have continued to go unaddressed.

Healthcare workers, particularly those in LTC and assisted living facilities,[5] were on the front lines of the pandemic. It is often said of senior care homes that "The conditions of work are conditions of care."[6] Unfortunately, the conditions of work in many LTC facilities were not adequate to provide the care needed during this unprecedented health crisis.

The Hospital Employees' Union (HEU) represents more than 60,000 health care and community social service workers in long-term care facilities, hospitals, community agencies and First Nations health centres. Policies that the B.C. government implemented during the pandemic significantly affected the lives and working conditions of our members. Consequently, HEU was and continues to be invested in how policies created during the pandemic impact staffing levels, wages and working conditions for health care workers in the LTC sector.

In this paper, we examine the governmental policies enacted to support workers and seniors in LTC during the COVID-19 crisis, providing:

- a case study of how B.C. governmental interventions and policies impacted the province's LTC sector and its workers and
- a comparative analysis of how four Canadian provinces—B.C., Alberta, Quebec and Ontario— addressed key policy questions during the first two waves of the COVID-19 pandemic in 2020 and 2021.

We answer the following questions:

- What policies did provinces enact to address short staffing in LTC and how did these policies fare?
- What can we learn by studying B.C.'s policy response and comparing it with those of Alberta, Ontario, and Quebec?
- How did communication and government relations between labour unions and provincial governments influence pandemic policy responses?
- Based on these experiences, what are the implications for future policy approaches to recruitment and retention of LTC care staff?

Overall, we aim to provide insight and recommendations that will improve the working conditions and patient care in the LTC sector in Canada.

Background on LTC

6.8 million

6.8 million people age 65 and older.

5%

Almost 5 per cent of all seniors living in long-term care facilities.

200,000

There are close to 200,000 beds across the country.

+ 200,000

Demographics indicate that we will need another 200,000 more by the year 2035 to meet the growing need as the baby-boom generation ages.

In Canada, there are more than 6.8 million people age 65 and older[7] with almost 5 per cent of all seniors living in long-term care facilities.[8] There are close to 200,000 beds[9] across the country. Demographics indicate that we will need another 200,000 more by the year 2035 to meet the growing need as the baby-boom generation ages.

Care aides provide the majority of resident care for seniors and others requiring LTC. They are referred to as *health care aides* in B.C. and Alberta, *personal support workers* in Ontario, and *préposés aux bénéficiaires* (patient care attendants or orderlies) in Quebec. Their duties consist of day-to-day assistance with eating, grooming, getting in and out of bed, toileting, companionship and emotional support throughout seniors' time in care, including their final days. The bulk of care, anywhere from 75 to 80 per cent,[10] is provided by a largely female and highly racialized workforce.

In 2021, the number of nurse aides, orderlies, patient service associates and other assisting occupations in support of health services employed in Canada was 347,400. In British Columbia, in 2019/2020, there were about 36,000 nurse aides, orderlies and patient service associates.[11] According to the Census, B.C.'s nurse aides numbered more than 39,000 in 2021.[12]

Between the growth in the sector and the need to replace current workers as they leave their jobs, shortfalls are already being predicted for 2031.[13] In the 10-year period from 2022 to 2032, BC Labour Market Data expects more than 18,000 care aide job openings.[14]

The LTC sector in Canada consists of a mix of for-profit, not-for-profit, and publicly owned and operated facilities. It is governed not by Federal regulation but "by a patchwork system of provincial and territorial legislation, policies, and regulations."[15]

There is little consistency between provinces and territories in regulations, standards, funding models and allocations, and types of service provision. However, there are similar challenges.

IMPACT OF EXCLUSION FROM THE CANADA HEALTH ACT

Despite forming a critical part of the health care team, LTC is excluded from the Canada Health Act. This exclusion has led to increased privatization, chronic underfunding, a decrease in regulatory oversight, and a crisis in staffing levels. Other studies show how underfunding of LTC contributed to a recruitment and retention crisis, resulting in a higher workload for staff.[16]

Unfortunately, B.C. is a prime example of what happens when provincial governments use legislation to promote privatization in the LTC sector. The Health and *Social Services Delivery Improvement Act* (Bill 29) in B.C., enacted January 28, 2002, removed contracting-out protections in collective agreements between health care unions and the Health Employers Association of BC.[17] In 2003, B.C.'s *Health Sector Partnerships Agreement Act* (Bill 94) created incentives for private operators to build facilities and exempted them from being part of the public sector agreement. This gave them the freedom to pay lower wages and benefits.

Together, Bills 29 and 94 fragmented the LTC sector in B.C. and facilitated the privatization of health care services.[18] As a result, the number of long-term care beds operated by public sector health authorities and by non-profits decreased by 11 per cent between 2001 and 2019, while the share operated by for-profit providers increased by 54 per cent.[19]

In Ontario, the concentration of privately owned care homes is even greater. The government has been unsuccessful in meeting target staffing levels, with an attrition rate as high as 25 per cent for care aides. Up to a quarter of the profession leaves annually! Low wages and working conditions are cited as key issues.[20]

Across Canada, the long-standing shift to privatization has put big for-profit chains like Age Care and Extendicare in charge of an increasingly larger share of our country's long-term care beds. The influx of corporatized seniors' care over the last two decades has fed business models that depend on reduced staffing costs to deliver profits. There is little to ensure high-quality standards of care and conditions of work to attract and retain care aides.

Ownership models matter: for-profit, private-care facilities provide an inferior quality of care compared to non-profit and public facilities.[21]

DETERIORATING CONDITIONS OF WORK IN PRIVATE, FOR-PROFIT CARE HOMES

- **Skeletal staffing with crushing workloads.** In B.C., private, for-profit employers tend to operate with skeletal staffing, regularly running with less scheduled staff than their non-profit counterparts,[22] and failing to backfill vacations and sick time, leaving remaining staff to struggle with crushing workloads. Other studies show similar findings across Canada: Heavy workloads have left many care aides feeling burnt out and in moral distress.[23]

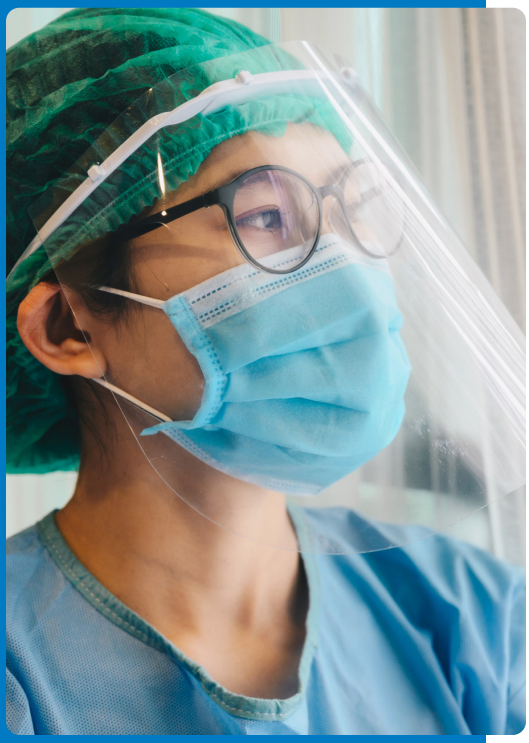
- **Lower wages, fewer permanent full-time positions.** In the public sector, full-time jobs constitute just 38 per cent of all positions. Private, for-profit employers offer a combination of lower wages and even fewer permanent full-time positions. This often forces care aides to split their time between two, sometimes three, jobs to earn an adequate income. During the pandemic, this spread the virus from one facility to another.[24]

- **Fewer health and welfare benefits.** Private sector care aides typically have fewer health and welfare benefits, less vacation and sick time, and no pension plan—a far less substantive compensation package overall than their public sector counterparts.

- **Higher turnover.** Many care aides try to leave their jobs in the private sector to secure positions with higher wages, more benefits, vacation days and stability in the public sector.[25] This constant turnover creates a lack of continuity of care.

Clearly, increased privatization of the LTC sector has not been good for care aides or seniors. The deterioration in working conditions has contributed to the current recruitment and retention crisis in Canada's LTC sector and, ultimately, led to lower quality of care for seniors long before COVID-19.

Single-Site Orders



Single-site orders (SSO) introduced in the spring of 2020[26] were among the first policies implemented during the pandemic to reduce the spread of COVID-19. In the LTC sector, many care aides worked at multiple sites to economically support themselves. SSOs sought to limit health care workers to working at only one site.

The fact that SSOs helped, in part, to ensure sufficient staffing at each site underscores the need for more staff and a legislated standard of hours in LTC. No province in the country currently has a legally required level of care home staffing that is meaningful and enforceable. The COVID-19 crisis illuminated not just isolated instances, but rather an entire country's care homes operators—responsible for delivering care to a largely frail and elderly population—doing this at deficit staffing levels. And that was *prior* to the pandemic.

B.C. was the first province to announce an SSO in April 2020. Alberta, Ontario, and Quebec all introduced a mandate restricting the movement of health care workers between sites shortly after B.C. did. However, these orders looked quite different in scope, implementation dates and duration.

BRITISH COLUMBIA'S SINGLE-SITE STAFFING ORDER

B.C. announced its SSO on April 10, 2020, and by June 18, 2020, all 501 care sites under the SSO had implemented single-site staffing plans.[27] B.C.'s SSO lasted nearly two years and was rescinded in December 2022.

The implementation of the SSO in B.C. was the result of weeks of discussion and collaboration between the Government of British Columbia, union representatives and employers. It was no easy task. The LTC sector in B.C. was fragmented, with varied forms of ownership, contracting out, multiple employers and collective agreements, wage disparities and chronic short-staffing. As a result, many workers in LTC held multiple jobs, which proved challenging for the government to collect the data it needed to effectively implement the SSO. It was almost impossible to know who worked where and whether or not they held a job at more than one facility.

The B.C. government worked closely with unions and employers to address data collection and potential impacts on collective agreements. B.C. was the only provincial government to consult with unions in drafting and implementing the SSO. The collaborative process, said one Health Employers Association of B.C. (HEABC) representative, worked extremely well. "We were able to, in a matter of three or four weeks, negotiate the single-site transition framework, which was an agreement between six parties."[28] The collaboration between HEABC, unions and key interest-holders was one of the reasons the SSO was so successful in B.C. Even so, the implementation of the SSO in B.C. was not without challenges.

SSO CHALLENGES TO RESOLVE

- **Lack of data.** There was no centralized database of employees, nor was there an obligation or procedure for LTC operators who contracted out care staff to provide employee information to health authorities. An HEABC representative said it was difficult to know exactly how many people worked at each facility across the sector. "HEABC obviously is able to engage with our members but we don't have a direct line of communication to non-member employers and we don't have any authority to [communicate with them], or to speak for them or to resolve issues on their behalf."[29] Fortunately, the HEU was able to provide the government with data on the HEU membership—which comprises a significant percentage of workers in the sector—providing invaluable insights on the number of health care staff that held multiple jobs between different employers and regions.

  The piecemeal data collection across the sector proved to be such a challenge that the B.C. Government commissioned a study by Ernst and Young. The report, published in October 2020, noted the Ministry of Health should continue to collect health human resource and financial data needed to support informed decision-making during emergency situations.[30] And, it concluded, it is critical to establish a formal data collection framework, with standardized reporting expectations and processes in the LTC sector.

- **Discrepancy between hours worked vs. hours paid.** Private operators are not required to report to government on the hours staff worked versus the hours the facility is funded for. This had the potential to misrepresent staffing levels and hours in the allocation process for the SSO. For example, if operators did not replace staff who were sick or on vacation, staffing levels would be overestimated. Operators could then use this inflated number to make their case for being allocated more staff during the crisis.

- **Independent SSOs**. A few employers had implemented their own internal versions of an SSO prior to the governmental order. These independent SSOs were a challenge. They had the potential to violate collective agreements and could make certain facilities appear more appealing for workers. Restricting workers from working at other sites for other employers required agreement from the union. It is not something the employer could unilaterally establish in the absence of a government issued emergency order. Raising wages to entice workers to stay or to come to work at a facility would allow the market to determine the allocation of staffing resources rather than a carefully considered method utilizing province-wide knowledge that allocates on the basis of need.

The challenges related to data collection and employee information were addressed through the *Information Collection to Allocate Staff Working in Facilities Order* that was issued by the Provincial Health Officer in late March 2020. This order required all employers, contractors and subcontractors to upload the names of employees, full-time equivalency (FTE) and status. The *Facility Staff Assignment Order* followed two weeks later, laying out the process for single-site work to be determined in each region by its Chief Medical Health Officer. On April 10, 2020, the *Health Care Labour Adjustment Order* (Ministerial Order M105) was issued by the Minister of Public Safety and the Attorney General with details outlining the *Single Site Staffing Order*.[31] The HEU was consulted on all.

From the three focus groups HEU conducted with care aides, we learned how specific policies in B.C. played out in specific sites and the ways in which workers felt supported by their union and government. In terms of specific policies, some care aides spoke of increased bullying and tensions between co-workers because of staff shuffling due to the single-site order. Mostly, we heard first-hand stories about exhaustion, burnout, mental health problems and fear that persisted for health care workers in B.C. throughout the pandemic: "You worry for your safety, you worry for your family's safety and your resident's safety, the declining residents, since the last time they see their family–so you are scared."[32]

COMPARING AND CONTRASTING THE SSOS OF OTHER PROVINCES WITH B.C.

During our research, it became apparent that the experiences of union leaders trying to implement SSOs in other provinces were vastly different to those in B.C.

- **Lack of coordination and collaboration between government and unions.** In Alberta, Quebec and Ontario, unions were provided with little notice about the SSO before their governments announced the orders to the public.

  The Government of Alberta created an Advisory Committee in early 2020 that was eager to discuss the SSO. However, there was no real consultation or collaboration. According to a union leader in Alberta, "[We] did make recommendations on a ministerial order which were not followed. However, it did result in more discussions about compensation issues.

Compensation was a major concern during discussions of the single-site order as workers would choose different sites based on wage levels. So, the model was a mess from the beginning."[33]

The notice given to labour leaders in Alberta was abysmal. One union representative summarized the common type of notice he received from the government: "It's 2:45pm. I get a call from their Director of Labour... 'Hey, there's an announcement being made at 3 p.m.'"[34] This exemplifies the extent of consultation in Alberta.

Delays. Staff mobility contributed to the spread of COVID-19 in long-term care, especially in provinces that were not as quick to implement a single-site order, such as Quebec.[35] In Quebec, unions had to repeatedly call on government to implement an SSO, even though evidence from B.C. showed it was effective in reducing the spread of COVID. Key informants shared that a form of SSO was eventually implemented in Quebec, but it was not similar to B.C.'s.

In Alberta, there were a few for-profit facilities that tried to implement their own SSOs because they felt the government was acting too slowly. Union staff had to negotiate these 'independent' SSOs, similar to the experience in B.C., and then support dismantling them when the province finally implemented one.

Excessive flow of agency workers in LTC. Care facilities can hire contract workers from agencies to augment their regular staff workforce. Even with an SSO, all provinces felt a degree of concern about the number of agency workers—who could still move from site to site—allowed to work in LTC.

In Quebec, agency staff could limit and choose the hours they worked. At the same time, permanent staff were unable to choose vacation time, and some occupations had to do mandatory overtime. In B.C., the use of agency staff created resentment from regular facility staff who viewed agency workers as having greater freedom to move to different sites and potential to make more money. At a time when all staffing resources are needed, and the job was becoming increasingly difficult, this difference in treatment for staff working in the same facility had the potential to result in regular staff quitting.

SUMMARY

Single-site orders were one of the first policies implemented in all provinces during the pandemic. They limited the flow of staff and thus the virus, provided workers with stability, and offered unions an opportunity to contribute to policy change. In some ways, SSOs created an opportunity in which unions could work with governments to create further policies, like wage incentives. However, this opportunity was utilized differently depending on the government in power. Communication and collaboration around the SSOs varied considerably from province to province.

Wage Incentives and Wage Standardization

During the first two waves of the pandemic, most provincial and territorial governments implemented a wage incentive for workers on the front lines. Some incentives were temporary, often referred to as "pandemic pay," and, in B.C., the most substantial one—wage standardization—has continued. Though all wage incentives were under the jurisdiction of provincial governments, some of the funding was federal. The provinces we reviewed all implemented some type of wage incentive, although the implementation date, length and amount of the benefit varied widely. Wage disparity remains in all provinces except B.C.

B.C.'S $4/HOUR WAGE INCENTIVE

The B.C. government provided temporary pandemic pay, cost-shared with the federal government. It provided $4/hour for a 16-week period starting March 15, 2020, for workers in Healthcare, Social Services & Corrections. This temporary wage incentive was not meant as a substitute for safe working conditions. Rather, the incentive recognized the additional risk workers were taking and financial impacts they might face. Some of these risks included risk of infection when commuting by bus, the cost of staying in hotels to avoid bringing COVID home to families, or being forced to drive and pay parking fees.

The wage incentive also helped balance out the stress of an increased workload and additional duties for care aides during the early days of the pandemic. One focus group participant said, "[Residents] didn't get any contact with

anybody. At one time, they were all eating in their rooms. [During lockdown], we had trays we had to deliver, so that took more time. People were eating cold food."[36] As this quote illustrates, care aides were tasked with delivering and clearing food trays, alongside giving extra emotional support for residents who were isolated and unable to visit with family due to visitor restrictions.

B.C. STANDARDIZES LTC WAGES ACROSS PRIVATE AND PUBLIC SECTOR IN LTC

In April 2020, the government standardized wages to the B.C. public sector collective agreement called the Facilities Bargaining Agreement (FBA). Acting from an equity approach to health care workers employed during the pandemic, the B.C. government wanted to ensure that, going forward, workers mandated to follow the SSO would not lose wages. This effectively subsidized the wage difference between public sector and private sector LTC workers. For care aides, that hourly wage was $25.33 at that time, significantly increasing the wages of many workers outside the public sector.

In July 2024, the B.C. government followed through on its commitment to maintain wage standardization in LTC beyond the pandemic, announcing long-term funding of $232 million over the next five years. This money comes out of an agreement between the federal government and the B.C. government.[37]

We believe B.C.'s wage standardization will have the greatest long-term impact on improving the working conditions and continuity of care in the LTC sector. The HEU had campaigned hard on this issue for well over a decade, monitoring the gap that had grown between the public and private sectors in wages and working conditions in LTC. The union understood that the same work demanded the same pay and benefits no matter the employer and the HEU knew 'levelling the playing field' was key to reducing turnover and promoting continuity of care for seniors. This equity needed to be part of any single-site order and should remain intact moving forward after COVID.

Many of the HEU members in our focus groups were supportive of wage standardization. One participant reflected on B.C.'s wage standardization:

> "We all do the same job and there shouldn't be any reason for wage discrepancies from facility to facility. It's stupid to me that some people are making $5 or $6 more for doing the same job. I really think it takes away from residents when there [are] better facilities that staff would rather work at because they make more money. The main focus should be on residents and if eliminating different wages in different places is one less thing that anyone has to spend time on, it shouldn't even be a question. Everyone across the board should make the same amount and level the playing field."[38]

For some care aides working in the private sector, wage standardization to the hourly wage provided in the public sector's FBA Collective Agreement was life-changing. One HEU focus group participant working in the private sector said, LTC workers "were really happy with the $25.33 an hour because, like I said, it was a significant increase. And [it] just made people happy to come to work for a period of time, of course. And when we got the $4 pandemic pay, that was really a great boost. People showed up."[39]

CARE AIDE WAGES ACROSS CANADA

Prior to the pandemic, differences as large as $8 and $9/hour between the lowest and highest paid care aide were common in provinces across the country. Care aides could make as little as $13/hour in New Brunswick or as much as $26.39/hour in Ontario. The median wage for Canada was $20.88/hour. The $8 and $9 gaps within provinces persist today with B.C. being the exception. (See Table 1 below).

PROVINCE/TERRITORY	2020 LOWEST WAGE	2020 HIGHEST WAGE	2020 MEDIAN	2022 LOWEST WAGE	2022 HIGHEST WAGE	2022 MEDIAN
CANADA	$15.38	$25.00	$20.88	$16.98	$26.00	$22.00
ALBERTA	$17.00	$25.00	$21.00	$17.75	$26.00	$22.62
BRITISH COLUMBIA	$18.30	$25.33	$22.75	$20.00	$26.00	$25.00
MANITOBA	$14.00	$22.00	$19.40	$15.30	$22.00	$19.23
NEW BRUNSWICK	$13.00	$22.00	$16.00	$14.75	$23.17	$18.00
NEWFOUNDLAND AND LABRADOR	$13.50	$24.00	$17.55	$15.00	$23.74	$17.35
NORTHWEST TERRITORIES	$15.20	$44.60	$37.64	$25.00	$40.00	$35.00
NOVA SCOTIA	$15.00	$20.35	$18.00	$16.00	$23.64	$19.00
NUNAVUT	N/A	N/A	N/A	$19.00	$46.19	$20.74
ONTARIO	$16.00	$26.39	$20.82	$17.00	$27.47	$22.00
PRINCE EDWARD ISLAND	$14.00	$24.62	$21.00	$15.50	$25.00	$20.74
QUEBEC	$14.50	$22.50	$20.56	$17.50	$25.80	$21.86
SASKATCHEWAN	$15.67	$24.00	$22.00	$17.00	$24.86	$23.00
YUKON TERRITORY	N/A	N/A	N/A	$28.85	$37.00	$31.65

In B.C., there was a significant wage gap between some privately owned-and-operated LTC sites and public ones operated by health authorities. For example, prior to the wage standardization, care aides at Eden Care Centre, a private for-profit facility, were making $7.49/hour less than those covered by the FBA.[40] The disparity between care aides in the public (FBA) and private sector was, on average, $3.67/hour. Workers in the same classification faced considerable wage disparity in other provinces as well.

WAGE INCENTIVES IN OTHER PROVINCES

Quebec's $4/hour increase and $1,000 premium. For example, in Quebec, care aide wages were as low as $14.16/hour in the private sector in 2020.[41] The Province of Quebec implemented several types of wage incentives. Private operators received individual letters from the Ministry of Health committing to allocate funds for higher wages for the duration of the pandemic, an increase of up to $4/hour, but this wasn't made public. Wages in the province, particularly in the private sector, were notoriously low. The government was subsidizing these employers at that point. The province created an additional temporary wage incentive. Workers who were directly in contact with patients, such as orderlies and housekeepers, received an eight-per-cent increase per hour, whereas workers who worked indirectly with patients, such as receptionists, would receive a four-per-cent increase per hour. The funding came from both the federal and the provincial governments.[42]

To incentivize staff to work full-time hours, they offered a further temporary incentive of an extra $1,000 per month for those who worked full-time. From our interviews with key informants in Quebec, we learned the limitations of this wage incentive. Workers could not miss a single day of work, not even for illness or emergencies such as funerals.[43] As one key informant shared, "There were some heartbreaking decisions that had to be made by our workers. Because if you're missing one day of job, for example (…) one of our members had a funeral for her father that had just died. If she had missed one day to go to the funeral, she would lose her $1,000 premium."[44] The Government of Quebec was disconnected from the needs of LTC workers, which created upstream challenges for recruitment and retention in the sector.

Alberta's complicated process and delays. Although temporary pandemic pay was offered in all provinces, in Alberta it was a complicated process and a minor wage increase compared to others. The first top-up introduced was set to $2/hour, and the second one was a one-time lump sum payment of $1,200. Only employees who met threshold hours for a three-month period at the end of 2020 were eligible for the latter.[45] The Government of Alberta was initially hesitant to announce wage incentives and, in fact, delayed distributing the incentive to workers. By January 27, 2021, nearly one year into the pandemic, the Alberta government was still sitting on $675 million in unspent funds from the federal government allocated for pandemic relief and health care workers.

Ontario's $4/hour pandemic pay and $2-$3/hour wage enhancement. Ontario provided a temporary $4/hour pandemic pay and a $1,000/month lump-sum payment[46] for eligible employees which ran April to August in 2020. In addition, the province provided a Temporary Wage Enhancement, which began on October 1, 2020, increasing wages by another $3/hour for PSWs (care aides) working in LTC and community care.[47] Workers in hospitals had their wages increased by just $2/hour to reflect their already higher wages. The increases continued and were made permanent with the passing of the 2022 Pandemic and Emergency Preparedness Act.[48] While the increases are welcomed, wage disparity continues between PSWs in Ontario, depending on what type of employer they work for. This invites staff turnover in pursuit of superior working conditions and wages. The increase also fails to address the inequity of lower wage PSWs performing the same work as their higher-paid counterparts.

CONCERNS OVER DOUBLE-FUNDING TO PRIVATE OPERATORS

For the most part, wage incentives were welcomed by workers and celebrated by unions. But, like other pandemic policies, there were challenges with transparency and accountability related to private operators.

In B.C., the presence of private-for-profit LTC facilities resulted in some on-going financial challenges for the government. Wage standardization for private sector workers cost the B.C. government about $165 million annually,[49] on top of the regular base funding the province already gave to private care facilities. Publicly operated LTC facilities received the same base funding as the private sector. However, the public sector LTC sites were able to pay their staff $25.33/hour with this base funding, while private operators, particularly for-profit private employers, often chose to pay substantially lower wages. This has resulted in the B.C. government "double-funding" private operators. This leads to questions of transparency in how public money is spent by private operators in the LTC sector.

Throughout Canada, the continued privatization in the LTC sector has led to major concerns about transparency in funding, spending and profit-making in private-for-profit LTC facilities. A 2022 study by *Canadians for Tax Fairness* reported that for-profit LTC facilities in Ontario have diverted billions in public funding into profits. According to this study, "Core public funding for LTC is 'unrestricted,' which means it can be spent however a facility chooses and any unspent money does not have to be returned to the government. This is the money that for-profit owners can claim as profit. We estimate that more than half of this money—$440 million in 2019—was diverted into profits."[50] The authors estimated that "Ontario's for-profit LTC facilities have extracted over $3.8 billion from public funding for LTC."[51]

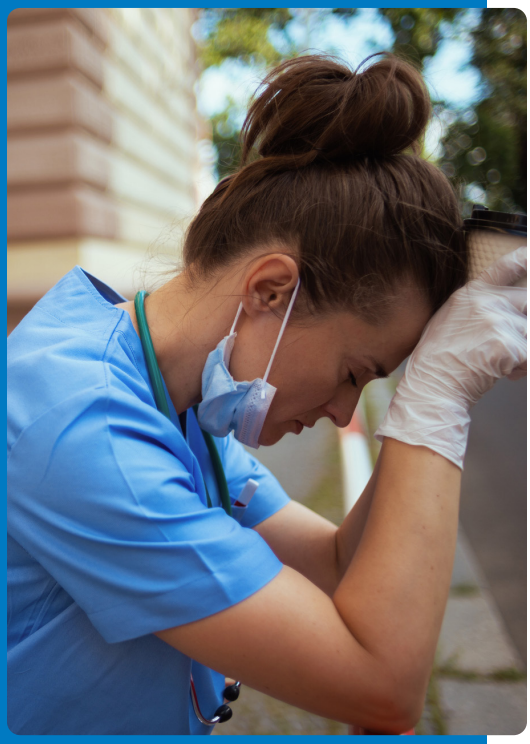
A similar lack of transparency in LTC was recently acknowledged in a report by B.C.'s Office of the Senior's Advocate (OSA). According to the OSA, most private facilities receive more revenue than they spend, thus creating surplus or profit. "Currently, 80 per cent of profit is concentrated in 20 per cent of facilities, most of which are for-profit. Overall, the for-profit sector is generating seven times more profit/surplus than the non-profit sector."[52] This review demonstrated that B.C.'s

current funding model for LTC is not transparent to the taxpayer. This report acknowledged that currently there is no standardized approach for what is counted as profit. B.C.'s OSA recommends that revenues and expenditures for publicly funded care homes be made available to the public. As it stands, there is little transparency regarding where the almost billions of dollars in public funding to for-profit LTC goes and how much is diverted to profits.

SUMMARY

All provinces reviewed provided wage incentives to support LTC staff during the pandemic. British Columbia was the only province to eliminate wage disparity by standardizing wages between the private and public LTC sector beyond the pandemic. While Ontario has continued its $3/hour wage enhancement, both Alberta and Quebec ended their time-limited wage incentives. Wage disparity persists in Canada's LTC sector, especially between public vs. private sector care homes. We echo the call made by Armstrong et al that all jurisdictions standardize private and public sector wages during and beyond COVID, following B.C.'s lead.

Training Programs



As the pandemic went on, it became clear that provincial governments needed to respond to the chronic short-staffing and on-going recruitment and retention crisis in the LTC sector. Staff in LTC were working too many overtime hours and burning out. As one focus group participant shared, "In the last five months, our overtime is insane. In the last month alone, any time I'm not working or on days off I'm called for overtime. My co-worker has worked the last eight days at overtime."[53] Appropriate staffing levels are directly tied to the quality of care that can be provided.

Unfortunately, no province has a meaningful legislated staffing level and the actual staffing levels vary significantly. Quebec has no legislated staffing level for LTC. The government of Ontario has committed to raising staffing levels in LTC to 4 hours per resident per day (hprd) by 2025 and has increased funding. Reports acquired through a freedom of information request, however, indicate they are not on track with their goal and may currently be sitting at levels as low as 3.25 hprd, attributable to staff shortages.[54] B.C. does not have a legislated level but rather a guideline of 3.36 hprd. The most recent annual report released by the B.C. Seniors' Advocate finds that LTC facilities in the province were funded for an average of 3.42 hprd. Experts advise that a minimum of 4.1 hprd[55] is required to maintain the health of seniors entering care, others recommend an hprd as high as 4.55.[56]

All provinces reviewed in this research struggled to find enough staff. During the pandemic, many created training programs specifically for care aides working in seniors' care.

B.C., ONTARIO AND QUEBEC CREATED TUITION-FREE TRAINING PROGRAMS

B.C.'s Health Career Access Program. In January 2021, B.C. announced it had begun to provide free, on-the-job and in-class training with an income for new workers. Through the *Health Career Access Program* (HCAP), new hires could start working as health care support workers to provide non-direct, non-clinical care at a long-term care home, assisted living facility or in the community. In exchange, the participants sign a return-of-service agreement, obligating them to work with their 'training' employer for a period after graduation. The educational component ran the full eight to 10 months of the regular college course offered to health care assistant (HCA) students. In the first year, HCAP created 600 new seats at public post-secondary institutions to meet the demand for training.[57] As of November 27, 2023, more than 7,000 people have been hired through the program.[58]

In our focus groups, participants discussed the impact of HCAP students. One said, "I think they do a good job. It's a big help because by the time we are doing something with residents or the clients, they are doing tables, they are doing the bibs, help them with laundry, they're doing beds."[59] Another said, "Because we [have] 20 open lines, people found [HCAP students] very helpful because they could free up the care aides to do the hands-on care. So, [care aides] were very appreciative of the care that they provided."[60]

B.C.'s HCAP was the only training program with an inclusive hiring practice component, providing equal opportunity for participation to underrepresented groups. Before HCAP, there had been very little training investment in a female-dominated and largely racialized care-providing sector, despite government awareness of the growing need for more health care workers. The historical devaluation of female-dominated care work, coupled with a societal dismissiveness around aging and seniors' health care are largely to blame. In essence, HCAP is the largest paid-for, female-dominated apprenticeship program that we have seen in B.C.'s history.

Ontario's Personal Support Worker (PSW) accelerated program. Ontario's version of the HCAP is the *Personal Support Worker accelerated program*. The significance of these training programs should not be overlooked. As one Ontario senior union staff member with vast experience in the healthcare sector said, "To be perfectly honest, [it's] the first time I have ever seen a tuition-free, paid training program in a female dominated workforce. It's a model that we've seen in the trades for years. I don't think they intended it to be a gender breakthrough, but it really is, fundamentally."[61]

Quebec's Orderly Training Program. Early on in the pandemic, Quebec implemented a new orderly training program.[62] The province faced more dire circumstances because of lower wages and severe shortages of care aides. It created a condensed three-month program, hoping to put help in place quickly. However, care aide work is highly

complicated work, requiring skills and knowledge to meet a resident population in need of increasingly complex care. As a result, this program had a large attrition rate.[63] Less than 50 per cent of people trained continued with their positions after they completed their return-of-service agreement.

Alberta's Comfort Care Aide (CCA) Temporary Position. Unlike the other provinces, Alberta did not create a training program for care aides. Instead, it created a new, temporary Comfort Care Aide (CCA) position to reduce some of the workload of care aides. Because the government created the CCA position outside of collective agreements, CCAs were not allowed to conduct all care aide job duties. This limited the degree of usefulness of the position. CCAs were able to assist Registered Nurses, Licensed Practical Nurses and Health Care Aides by supporting residents with activities and mobile communication devices, and assisting with some basic personal care, cleaning, and screening.[64]

The recruitment process for CCAs was also unique. The Alberta Health Services (AHS) contracted Manpower Staffing Services to recruit, interview, perform background checks, onboard all CCAs and assign them to public or contracted facilities.

The CCA position elicited mixed responses from other health care workers. Some appreciated having parts of their workload reduced. However, this resulted in the more physically intensive and higher responsibility duties remaining with regular care aides.

The Alberta government excluded the CCA position from unionization, which raised concerns from health care unions. Not only did it potentially violate collective agreements, but it also created a new, temporary, position where workers did not have established job descriptions or the same rights as unionized workers in the same facility. The role also created confusion. As one key informant shared about CCAs: "They were portering residents or they were doing a lot more duties in there. Because it wasn't really clear who was supposed to manage them, it was our members that were sort of supervisors to these Comfort Care Aides. In addition, the Comfort Care Aides, most of them came in with zero to no training. They do not know how to deal with residents. Some of them were put on dementia wards and they have no experience even with what dementia is. So then, it was our members specifically in recreation that are kind of supervising these Comfort Care Aides."[65]

COMPARING SUCCESS ACROSS THE PROVINCES

As the above examples show, care aide training programs across provinces were very different.

B.C.'s HCAP had a high success rate. In B.C., the educational component wasn't condensed, so B.C. students were better prepared than Quebec students. A recent survey conducted by the HEU of its member HCAP participants found that 87 per cent felt prepared for the work after

completing the program, and more than 70 per cent see themselves staying with their current employer for at least the next few years.[66] The consultation and continuous communication between the government, educators and union interest-holders allowed for input to and a smooth rollout of the training program. The union's collective agreement rights were respected by government—the HEU negotiated the duties, wage rate and return of service agreement for the health care support worker position, ensuring that they were desirable jobs to attract and retain staff.

The ongoing staffing shortages demonstrate the continued need for HCAP and other comparable health care training initiatives. As Ernst & Young's report noted, the LTC sector needs to address critical staff shortages by "redesigning employment pathways that attract, train, and retain staff to enable the professionalization of the workforce."[67]

SUMMARY

New training programs for care aides were a good first step in helping to relieve the recruitment and retention crisis in the LTC sector. They provided skill training, new jobs, and support for staff that were exhausted and burnt out from working the frontlines of the pandemic. Provinces should maintain these programs, tying their recruitment and retention strategies to meaningful, legislated staffing levels. These programs offer opportunities to assess what works to attract, train and retain staff to provide the continuity of care our seniors deserve.

Communication and Engagement with Interest-Holders

In B.C., the collaboration and coordination between the government and key interest holders, such as unions, appears to have been a contributing factor to the successful implementation of pandemic policies. However, similar collaboration did not take place throughout Canada.

B.C.'S EXPERIENCE

In early 2020, the HEU participated in regular check-ins with the Ministry of Health (MoH) as COVID-19 was being detected in China, Europe and Eastern Canada. Around that same time, the MoH and the Office of the Provincial Health Officer held weekly calls to update interest-holders in the health care sector about COVID.

During our interviews, several union leaders said that, after March 14, 2020, HEABC determined there was a need to establish a forum to develop principles for responding to COVID and to discuss the possibility of restricting the movement of workers across the system, especially in LTC. In B.C., a strong foundation of communication and collaboration was established early on. This was integral to creating an SSO that would impact more than 20,000 workers and cover hundreds of collective agreements. To quote Jennifer Whiteside, former secretary-business manager of the HEU, "How do you restrict workers' rights but retain their ability to earn a living and ensure that workers can continue to work [and] support residents? It was the very definition of a wicked problem."[68]

Unions in B.C. were active contributors to discussions with several government ministries. An HEABC representative reflected, "I think in terms of the labor relations, engagement, it's the most effective process I've ever been involved in."[69] Other provinces had drastically different experiences.

INTEREST-HOLDER ENGAGEMENT IN ALBERTA, ONTARIO AND QUEBEC

Governments in Ontario, Quebec and Alberta would notify unions of orders and major announcements with very little time in advance, sometimes only an hour, and often without any opportunity for collaboration in the development of policies. Engagement with key interest-holders was minimal and, at best, token.

Ontario. "We did have a number of what they would call consultative meetings. But they were essentially us being summoned to a meeting the night before some hammer was going to drop and tell us what hammer was being dropped the next day."[70] Most often, the order had already been made and Ontario union leaders "were just being told, like 12 hours in advance, what was going to be announced the next day."[71]

Alberta. Key interest-holders in Alberta were forced to work with a very anti-union government, posing ideological and logistical challenges. The Alberta government even sought wage rollbacks for healthcare workers throughout the pandemic. Many union leaders we interviewed said how challenging it was to work and communicate within an adversarial environment. As a result, there was a substantial lack of true consultations in Alberta. Union leaders were often given a heads-up that a policy would be implemented, sometimes hours before it was announced publicly. Union representatives felt they were "basically told what to do." Collaborations mainly consisted of last-minute invitations for consultations, though it was clear that decisions were made and the public announcement was imminent.

While the Ministry of Labour organized a Government of Alberta Advisory Committee to promote interest-holder engagement, the Ministry of Health (MoH) was not involved in it. This proved challenging as the MoH issued new ministerial orders impacting healthcare workers, and union leaders had no forum to provide feedback or engage in thoughtful discussions with the MoH. According to an Alberta health care union representative, "They got in the habit of call-us-late-on-a-Friday or call-15-minutes-before, saying 'We are doing this. That's going out to all your staff and all your members.'" This was standard 'consultation' and 'collaboration' in Alberta.

Ontario. The province used COVID-related mandates to suspend union rights, unilaterally allocating staff to LTC sites that were in dire situations. Ontario's redeployment order often violated collective agreements. As one key informant explained, "It allowed homes to take reasonable measures in the alleviation and

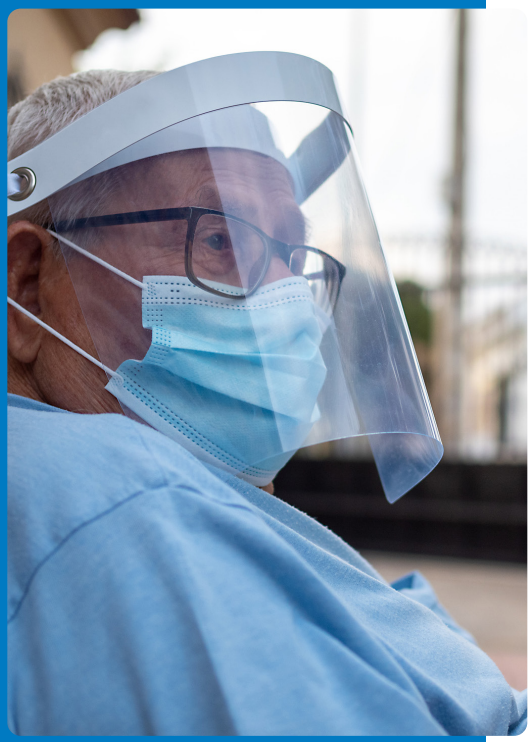
prevention of COVID without regard to collective agreements."[72] It enabled employers to eliminate protections for staff. In one southern Ontario care home, staff redeployed found horrible conditions, including dying residents in common areas of the home. "They didn't have the proper protection. They were given, you know, surgical masks and needed a higher level of protection."[73]

Quebec. The Minister of Health and Social Services implemented Order 2020-007 on March 21, 2020, suspending several collective agreement provisions. Workers in Quebec were consistently denied vacation and other leave requests. We learned from key informants that this exacerbated stress and burnout for workers and contributed to the recruitment and retention crisis of care aides.

SUMMARY

There was a stark difference in attitudes towards unions between provincial governments. Many unions outside of B.C. had to respond to adversarial, dismissive governments, who were unwilling to adapt and learn from the on-the-ground expertise of members and their unions. The collaborative process in B.C. was an anomaly in Canada. An HEABC representative reflected, "I think in terms of the labor relations, engagement, it's the most effective process I've ever been involved in."

Conclusion



British Columbia led the nation in responding to the devastating impact of COVID-19 in long-term care homes. By comparing B.C.'s pandemic policy responses to those in Alberta, Ontario and Quebec, we learned what enabled B.C. to respond quickly to curb the deadly toll of the virus, to provide support for exhausted front line care aides and to begin to rectify the systemic deficiencies in LTC revealed by the pandemic.

B.C.'s quick implementation of the Single Site Order saved lives. B.C.'s SSO—the first in Canada—reduced the number of care aides moving between facilities for work, reducing the risk of exposing seniors to the virus. The B.C. government's collaborative approach enabled it to work with HEU and HEABC to create policies that limited the flow of staff while providing stability and protections for workers' rights. This approach was crucial for quick and efficient implementation of the SSO, helping to save lives.

Wage incentives provided short-term help, but only permanent wage standardization will provide a long-term solution. Every province provided temporary wage incentives, subsidized by federal funding, to recognize the additional risk workers were taking and financial impacts they might face. All the time-limited incentives ended. In all provinces except B.C., wage disparity persists. Only in B.C. has government introduced wage standardization for care aides at privately and publicly run care facilities. 'Levelling the playing field' is key to reducing turnover and promoting continuity of care for seniors.

The fragmented and increasingly privatized LTC sector has deteriorated care for seniors. The lack of oversight of private and contracted-out LTC operators became all too apparent through the pandemic. Lack of regulation and standards led to extreme differences in the conditions of work—including wages, benefits and staffing levels—for health care aides. This severely impacted the type of care and support seniors received during COVID-19. Furthermore, in Ontario and B.C., lack of public transparency and accountability for provincial funding to private LTC operators led to 'double-funding,' enlarging corporate profits with public money during a time of crisis.

Tuition-free training programs are a good first step to address the LTC staffing shortage. B.C., Ontario and Quebec all created tuition-free training programs for care aides to address the chronic short-staffing and on-going recruitment and retention crisis in the LTC sector. While all were a good first step, B.C.'s program provided the most comprehensive training, producing preparedness for the work and a high likelihood of retention. Wage standardization underpins B.C.'s successful program, guaranteeing a good wage for all care aides, whether their return-of-service agreement is at a public or private care home or in community. This type of training—in contrast to Alberta's temporary Comfort Care Aide position—not only creates opportunities for people to enter the sector in meaningful roles, but also offers other LTC workers, such as dietary aides and housekeeping staff, new and upwardly mobile job opportunities.

Legislated staffing levels are the missing link to ensure quality care for seniors. Staffing levels are still a great concern in the LTC sector. Given the relationship between the conditions of work and the conditions of care,[74] it is clear that the federal and provincial governments need to prioritize staffing levels in LTC. Experts advise that a minimum of 4.1 hprd[75] is required to maintain the health of seniors entering care; others recommend an hrpd as high as 4.55.[76] The federal government must establish legislated minimum staffing levels needed to provide quality care. The staffing levels should be based on research and verified data. Accountability measures and standardized funding approaches must be in place to make sure minimum staffing levels are met. Establishing a long-term recruitment and retention plan—*one that incorporates meaningful, legislated staffing levels*—will not only help the sector recover from the pandemic and years of privatization, but will also help create a strong and robust workforce.

Frequent communication and genuine collaboration between government, unions and employers yielded better policy outcomes. Throughout our research, it became evident that the path to successful policies during the pandemic lay in the collaborative relationships between government, unions and employers. In B.C., the HEU contributed from the onset of the pandemic. We provided meaningful input on the single-site order, training programs, wage standardization and more, problem-solving as a valuable interest-holder. Sadly, the type of collaboration we saw in B.C. did not exist in other provinces during the pandemic. There were big inconsistencies in how each province navigated the challenges presented by COVID-19 in LTC. Health care workers and seniors suffered as a result. These differences bolster the call for federal governmental oversight in this sector.

The lessons learned in long-term care over the course of the pandemic could not be more well-timed. Demographics indicate that we will need 199,000 more beds by the year 2035 to meet the growing need as the baby-boom generation ages. The number of Canadians requiring LTC will more than double.[77] Together, governments, unions and health employers can solve the LTC staffing crisis and improve conditions of care. Continued collaboration and greater oversight are the cornerstones of better outcomes. We must create strong working conditions, meaningful staffing levels and effective training programs for health care aides—all of which are essential to providing the quality long-term care our seniors deserve. The suffering the pandemic caused was tragic; to fail to learn from it is unacceptable.

Recommendations

Facilitate on-going communication and consultation between provincial governments, healthcare unions, LTC employers and other key interest-holders regarding working conditions in the LTC sector.

- Create and initiate annual interprovincial tables on health human resources involving all key interest-holders.
- Establish ongoing tables between unions, government, and employers in LTC to strategize on safety plans and pandemic and natural disaster preparation, and to proactively establish clear ongoing lines of communication for future crises (for example, implementation of SSOs).
- Establish a consistent and transparent system for collecting and communicating data for all worksites, regardless of ownership type, to promote more efficient implementation of emergency measures such as single-site orders.

Create provincial recruitment-and-retention strategies for LTC that include training and decent wages.

- Set and maintain a sectoral standard wage and benefit package that supports families and keeps up with rising costs of living.
- Ensure that a sectoral standard for wages and benefits is incorporated into all operating and/or funding agreements with LTC employers, especially in the private sector.
- Base funding for care aide education programs on existing *and* future needs.
- Increase on-going funding to public education institutions and provide regular funding to subsidize students' costs.
- Offer tuition-free training to students at public institutions.

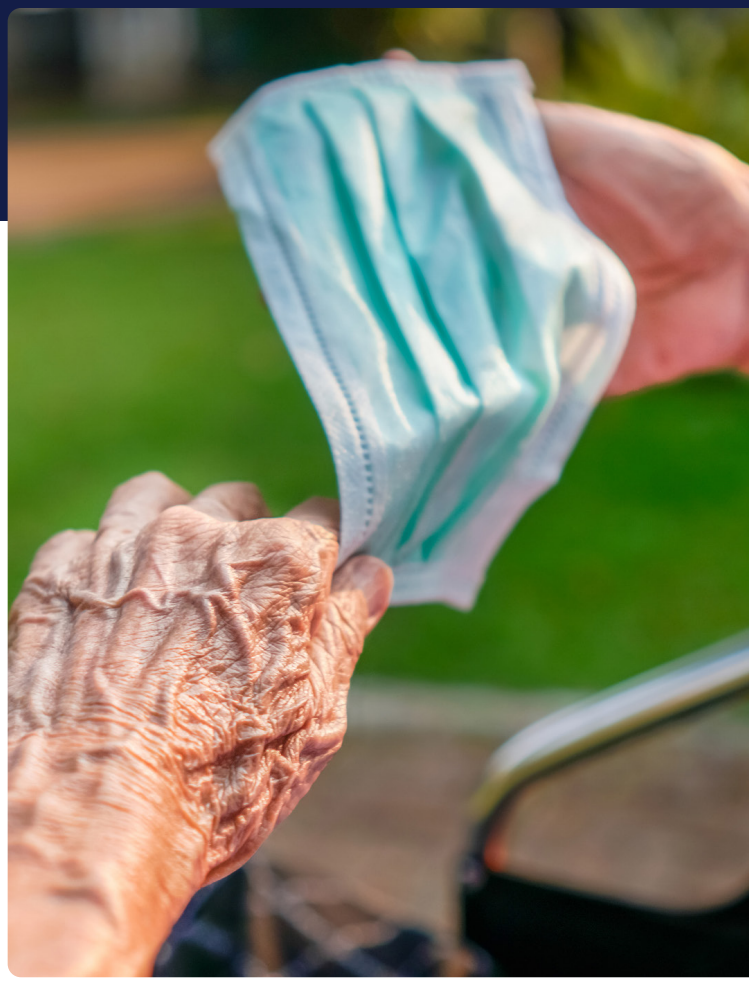
Facilitate decent and safe working conditions with increased staffing levels and support for better work-life balance for health care aides.

- Mandate increased and permanently funded staffing levels. The levels must be meaningful and appropriate.
- Regularize job positions and increase full-time and permanent positions.
- Guarantee the ability for care aides to use their vacation time, take paid and unpaid leaves, and not feel constant pressure to work overtime.

Create an environment of accountability in the LTC sector across Canada.

- Create a model similar to the *Canada Health Act* to ensure sustained federal funding, and establish national standards and oversight for the LTC sector.
- Increase federal government funding for LTC to the provinces and territories.
- Make all new LTC builds publicly owned and operated.
- Bring all contracted services in-house and eliminate contracting out.
- Ensure that provincial funding intended for care staff is spent on care staff.
- Establish, monitor and enforce staffing levels to an appropriate, agreed-upon level.
- Enable an effective and transparent process where provincial governments, which fund LTC, have the appropriate powers to audit payroll data.
- Hold all LTC operators to the same standard of data collection and sharing.
- Create and establish clear obligations for all employers and all worksites to collect and share data with key interest-holders.
- Make staffing data accessible—for example, accurate staff turnover rates—to support the creation of a strong recruitment and retention plan, and to inform families' and seniors' decisions when seeking care, similar to the way staffing levels are accessible publicly in B.C.

Methodology



This paper is based on qualitative research conducted between 2021 and 2022, specifically:

01 **17 key informant interviews** of labour, government and advocacy organizations from B.C., Alberta, Ontario, and Quebec who were active in early pandemic discussions policies on PPE, infectious disease control, and staffing

02 **three focus groups** of HEU health care aides and

03 **an extensive literature review** including analysis of key primary documents and policies, legislation, and media coverage.

Key informant interviews provided insights that spoke to details not available in government legislation or media reports about specific challenges or collaborations that took place in the implementation of policies, such as single-site orders, in LTC facilities. We are grateful for the assistance key informants provided and the documents they shared, not all of which were readily or easily accessible to the public.

Focus groups with HEU health care aides, including one with all racialized members, provided first-hand accounts of how policies and initiatives, such as training programs and wage incentives, affected workers.

For the literature review, we analyzed policy papers, reports and academic articles that addressed key concerns and experiences of the pandemic in Canada. Many of these materials examined the impacts of the long-term care system on patients and staff. For each province, we also conducted extensive reviews of key policy documents, legislation, and media reports on each policy discussed in this paper. Our methodology provided us with a broad scope of personal experiences, insight, and documented policies that impacted the LTC sector in four provinces during the first two waves of the pandemic.

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