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PSI Response to ILO General Survey

The Decent work deficit in the Social Care Workforce - a response to the General Survey

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The Decent work deficit in the Social Care Workforce - a response to the General Survey, June 2021.

INTRODUCTION

This submission is made by Public Services International (PSI) on behalf of affiliates who represent health workers delivering social care, including **aged care, mental health, and disability care workers** and other unregulated social care workers who should be entitled to the rights detailed in Convention 149 and Recommendation 157. In this submission we refer to these workers as the social care workforce.

Affiliates that have contributed to the submission include ÖGB Younion Austria, CONFETAM Brazil, TEHY Finland, JICHIRO (All-Japan Prefectural and Municipal Workers Union), Japan; Public Services Association, New Zealand and CGIL Italy.

1. National Policy on Nursing Personnel and the Promotion of Adequate Quality Health Services

1.1 Defining nursing personnel.

'Nursing personnel' are defined within C149 and R157 to include 'all categories of persons providing nursing care and nursing services'. The 'nursing aide' category has grown considerably over the past 40 years due to the expansion of residential and home-based aged care and disability care. Registered and enrolled nurses make up a smaller percentage of the workforce in these settings. While there is a clear need to increase the number of professional nurses in social care, it is equally important that social care workers be covered by the provisions of the Convention and Recommendation. It is therefore crucial for the ILO to issue clarification that 'nursing aides' covers a wide section of the unregulated health workforce, and to set out the workforce categories to which the provisions set out in C149 and R157 apply.

Social health care workers in non-clinical settings are often excluded from protections afforded to health workers in hospitals, even though they often perform tasks that involve complex disease management and palliative healthcare. In most OECD countries with well-developed hospital systems, social care workers providing institutional or home-based care are typically afforded the lowest status and are excluded from many of the protections offered to nursing personnel. Despite the majority having basic and intermediate qualifications, they are considered 'low skilled' and are among the lowest paid in health work, and often receive minimum wage.[1] All health workers – especially the occupations that make up the 'nursing aide' category - therefore need to be brought under regulatory frameworks of health policy, be registered through the national health workforce regulation agency, integrated into public health systems and provided with opportunities for further education and career advancement, as per the provisions in the Convention.

1.2 Promotion of adequate quality health services

According to the ILO: 2.1 billion people needed care in 2015, including 1.9 billion children under 15 and 200 million older persons. By 2030, this number is expected to reach 2.3 billion, driven by an

[1] ILO (2020), COVID-19 and care workers providing home or institution-based care, ILO Brief, Geneva, October 2020

additional 200 million older persons and children.[2]. Half of all elderly people worldwide lack access to long-term care. Demographic and social trends, including an ageing population, reduction in traditional unpaid care, combined with shortages in public long-term care fuelled a crisis in aged care prior to the pandemic.[3] The OECD projects that an additional 13.5 million long-term care workers will be needed by 2040 across all OECD countries; however, the COVID-19 pandemic will likely increase this projection due to the impacts of post-COVID-19 syndrome.[4]

Models of aged and disability care vary substantially around the world, but most systems lack the level of regulation, transparency and financing required to deliver universal quality public care systems. The absence of well established, evidence based and evaluated, national aged and disability care policies, has resulted in the growth of an insecure, undervalued and often informal workforce. The Decade of Healthy Ageing 2020–2030[5], declared by the WHO, should provide an opportunity to develop guidelines for governments on national aged care strategies including the development of a professional, recognised and valued, social care workforce.

In many countries, the line between domestic work and home care is blurred, which is often linked to insufficiency of public care service provision and lack of coverage for long-term care services. The existence of a large informal market for domestic work, providing cheap alternatives to care work for households, allows for poor working conditions among domestic workers and undermines working conditions of care workers generally.

1.3 The right to health and the right to care.

The right to health is a well established foundation of international human rights law contained in article 12(1) of the International Covenant on Economic Social and Cultural Rights (ICESCR) and elaborated in several other Conventions[6]. Governments have an obligation to progressively realise the highest attainable standard of physical and mental health for all people to live a life of dignity, at all stages of life. Governments must use the greatest amount of available resources to do so.

These obligations have led to the growing recognition of the right to care and the obligation of governments to ensure that universal, quality public care is available to all. The Australian Royal Commission into Aged Care recommended that the government adopt a new law with an objective

[2] *Care work and care jobs for the future of decent work* / International Labour Office – Geneva: ILO, 2018
[3] ILO (2019), The future of work in the health sector, Working Paper No. 325: Geneva, 3.
[4] ILO (2020), COVID-19 and care workers providing home or institution-based care, ILO Brief, Geneva.

[5] WHO, *Decade of Healthy Ageing 2020–2030*

[6] See article 5(iv) of the Convention on the Elimination of All Forms of Racial Discrimination (CERD , articles 10(h), 11(1)(f) , 12, 14(2)(b) and 16(1)(e) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), articles 24 and 25 of the Convention on the Rights of the Child (CRC) and articles 23(1)(c) and 25 of the Convention on the Rights of Persons with Disabilities (CRPD).

to “provide a system of aged care based on **a universal right** to high quality, safe and timely support and care”.[7]

1.4 Funding public health

The 1980s and 1990s witnessed a rise in the support for and implementation of neoliberal policies - which include deregulation and privatization of previously state-owned sectors, liberalization of trade and financial markets, and an overall withdrawal of the state from public service provision. Some studies have linked neoliberal policies to a deceleration in life-expectancy increases in poor countries[8], while others link economic conditionality policies to higher rates of various diseases such as tuberculosis. [9]

Significant evidence exists of the relationship between increasingly privatized care and inequality. In countries where governments provide guaranteed subsidies for social care, private equity investors have identified the potential for guaranteed profits and growing real estate values. As a result, researchers found that private equity ownership increases the short-term mortality of Medicare patients by 10%, which totalled 20,150 lives lost due to private equity ownership over their twelve-year sample period.[10]. Researchers concluded that profit incentives are misaligned with the social goal of affordable, quality care.

During the Covid-19 pandemic several countries have experienced significant outbreaks in residential aged care homes. However, the mortality rate appears to have been higher in privatised care. In Australia, for example, 75% of the country’s deaths occurred in residential aged care, mostly in the state of Victoria. All deaths occurred in privately run facilities, even though 10% of care is public in Victoria. A clear difference appears to be that public care employ staff on permanent, single facility, contracts avoiding the likelihood that infectious casual workers would transport the disease across sites.

In 1997, the Australian Government transformed the system under the Aged Care Act into a free-market model. Transforming the model of care meant that aged care and health care would be treated as two separate industries. As a result, private investment into aged care was able to flourish, which, experts say, turned people from patients into consumers.[11].

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[7] https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-recommendations.pdf

[8] (Cornia et al. 2009, Navarro 2002, 2007)

[9] (Austin 2015, Maynard et al., 2012,
Stuckler, King, & Basu, 2008).

[10] WORKING PAPER · NO. 2021-20 Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes Atul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta FEBRUARY 202. Page 2

[11] Sophie Cousins ,The Lancet, Experts criticise Australia's aged care failings over COVID-19. October 24, 2020

Social care has been identified as a profitable investment class with income guaranteed by governments and vulnerable residents. The business model increasingly adopted is one where wages are suppressed, minimal training is provided, staff numbers are kept low, and companies are structured through tax havens to minimise tax contributions. This model results in dangerously poor quality of care and the systemic exploitation of staff. Services are usually provided by a mix of public, private for-profit and non-profit service providers, some of which operate within and some outside the health system. Public funding allocations are often spread across different levels of governments and ministries. The mix of funding sources can sometimes make it challenging to ensure that care workers enjoy decent working conditions. For example, cost-cutting measures to increase profit margins keep wages low or maintain only minimum staffing levels. While the private sector in many countries is playing an increasing role in the provision of care services, the leading role played by the public sector in upholding the human right of individuals to equal access to healthcare, including care services, has become particularly prominent during the pandemic.[12]

The global health care 'market' was projected to be worth $11.9 trillion in 2022, close to 10% of global GDP (with 42% of value concentrated in North America). While the Asia-Pacific region has seen the highest rates of growth, an increased demand for care services due to an ageing population trend in many mid- and high-income countries has also seen transformation in the composition of the health sector as multinational nursing home companies in Europe, North America and increasingly Latin America dominate the aged care sector. This is proving a significant liability on all of society, undermining health as a public good and creating the conditions for profiting from the pandemic.

1.5 Staff to patient ratios

The positive relationship between nurse staffing levels and the quality of nursing home care has been demonstrated widely. While nurse to patient ratios have been implemented in some clinical settings, few have set ratios in social care settings. Increasingly unions are campaigning for staff to patient ratios that include legislated requirements for sufficient qualified nurses to be always available to residents / patients, for mandated numbers of allied health staff and for resident to qualified health care worker to patient ratios or time ratios.

In North Carolina, USA, many nursing facilities are understaffed to the point of endangering the health of patients. The Senior Tar Heel Legislature[13] recommended that the General Assembly enact legislation, which establishes either a mandatory Standardized HPPD (hours per patient daily) or minimum staff-to-patient ratios for direct patient care, including enforcement standards and consequences to ensure quality care in nursing homes in the state of North Carolina, regardless of whether they are a for-profit or non-profit organization.

The union CGIL in Italy is fully committed to improving conditions for social service personnel. In the last budget law 2021, the union, together with the national association of municipalities, the professional orders and the Ministry of Labor, has obtained the definition of an "essential level" for

[12] ILO, Sectorial brief, October 2020, page 7.
[13] NORTH CAROLINA SENIOR TAR HEEL LEGISLATURE 2019 FACT SHEET Staff-to-Patient Ratios in Nursing Home

the territorial social service equal to the ratio of 1 social worker for every 5000 inhabitants in the territory. Dedicated funding has been provided for the achievement of this level. The union keeps advocating for an optimal ratio of 1 to 4000.

The Australian Royal Commission into Aged Care Quality and Safety, found that aged care is understaffed, and the workforce underpaid and undertrained. For some years there has been a relative decline in the proportion of nurses in the residential aged care workforce and a corresponding increase of personal care workers. The proportion of registered nurses in the workforce dropped from 21% in 2003 to 14.6% in 2016, and enrolled nurses dropped from 13.1% to 10.2%. In the same period, personal care worker representation has increased from 58.5% to 70.3% of the workforce.[14] The Royal Commission recommended that from "1 July 2022, the minimum staff time standard should require providers to engage registered nurses, enrolled nurses, and personal caseworkers for at least 200 minutes per resident per day for the average resident, with at least 40 minutes of that staff time provided by a registered nurse."[15]

In Finland, the union Tehy reported that under staffing has been a continuous and increasing problem in the social care sector. For many years Tehy has been engaging with politicians, ministers, and officials, about the need of better staffing ratios for aged care and the weaknesses of the legislation. In 2019 a crisis broke out in the aged care sector in Finland due to the lack of nurses. After extensive public debate, *The Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons* was enacted and came into effect on 1 October 2020. A minimum staffing level in units for service housing with 24-hour assistance and for long-term institutional care for older people, was legislated. After the transition period ends, units will be required to have at least 0.7 employees per client. There must also be additional staff employed to carry out non-care tasks such as cleaning and preparing food. In November 2021, 94 % of round-the-clock nursing units for the elderly met the statutory staffing requirement.

In Austria, the union Die Daseinsgewerkschaft has been successfully campaigning for more staff in the health and social services sector at the municipal level. In Vienna, more than 1,300 new positions were created in the health and social services sector in 2020.

Staffing ratios are essential to improve the quality of social care, to address occupational health and safety violations and to retain and attract staff into the sector given the projected needs. To meet the obligations detailed in C149 and R157, governments should urgently move to adopt staffing ratios in social care.

2. Nursing Education and Training

Many countries have failed to regulate the professional qualifications required for social care workers. While institutional care was historically provided by registered or enrolled nurses, the growth in the demand, increased privatisation of the sector and global shortage in nursing personnel, has resulted in a shift to reliance on care workers without tertiary qualifications. Governments must move to provide and regulate recognised qualifications for social care, yet also ensuring that nursing tasks are carried out by qualified nurses only. Too often, social care workers are being required to complete tasks that require hire levels of qualification.

[14] Australian Aged Care Royal Commission
[15] https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-recommendations.pdf

Mr Robert Bonner, Director Operations and Strategy at Australian Nursing and Midwifery Federation (SA Branch) told the Aged Care Royal Commission, 'we are preparing workers at a certain level for roles that are requiring skills, knowledge and competence that are far beyond that'. This has a profound impact on care".

Several unions have reported that qualifications for social care workers have not been standardised and can result in potential workers paying for substandard education. The national regulatory health workforce agencies should set the standards for social care training and qualifications. Training should be provided by public institutions. Social care workers must be provided with opportunities for ongoing professional development.

Unions should be involved in planning and delivery of social care personnel education programmes, including a role in developing education policy. Union membership for students is also important to avoid student exploitation.

3. Working Conditions

3.1 Wages and conditions

A core rationale for the adoption of C149, as set out in the preamble, is to address the shortages of qualified nursing personnel through improvement to wages and conditions. One of the largest projected shortfalls will be in qualified social care workforce. Social care workers receive close to, sometimes less than, minimum wage. Well below the living wages required to support a family. The gendered assumptions of underpaying care workers continue to frame the wages and conditions.

To meet the standards set out in C149 and R157, wages and conditions should: a) reflect the value of the work; b) be commensurate with other professions requiring comparable qualifications, skill and levels of responsibility; c) be comparable across establishments and sectors for similar and equivalent roles; d) take into account the difficult conditions of nursing work, and e) be sufficient to attract and retain workers. Wages and conditions should be preferably determined by collective agreements.

In some countries wages differ significantly across the private and public system and are generally lower in-home care. In Finland, the salaries are negotiated both in the private, public and government sector with the respective employer organizations and wages are highest where unions have negotiated agreements.

In Italy according to the information provided by the union CGIL, the salaries of social assistance workers (social workers, educators, psychologists, mediators cultural, administrative, etc.) are framed in different labor contracts: many services are provided by precarious workers, on a temporary basis. In recent times, also because of the pandemic and in particular in the health care sector, there has been an increasing presence of freelance contracts, with a predefined time and with a salary predefined by law.

The Royal Commission into Aged Care Quality and Safety in Australia identified the difficulties the industry has in attracting and retaining well-skilled people to work in aged care. These include low wages and poor employment conditions, lack of investment in staff and staff training, limited

opportunities to progress or be promoted, and no career pathways. Personal care workers and nurses in aged care are paid comparatively less than their counterparts in other health and social service sectors.

In Australia the Royal Commission identified that about three-quarters of the direct care workforce in aged care are employed on a permanent part-time basis. Casual and contract employment is also common. In home care workers have 'fragmented working hours', shorter shifts and hold multiple jobs. Across the economy, participation in on-demand work—also referred to as platform or gig economy work—is growing.

On the other hand, the Austrian union Die Daseinsgewerkschaft reported that in the public social services sector, there is no danger of precarity, as minimum incomes have been negotiated by the trade union and jobs are considered secure. The union is also campaigning for better conditions for workers with caring responsibilities and for greater work life balance. The union's demands include legal right to a 4-day week, a legal right to parental, age-appropriate working time models and a reduction of working time.

The JICHIRO (All-Japan Prefectural and Municipal Workers Union) outlined that the wages for care workers tend to be lower than the average for all industries, although differences in length of service and other factors make the exact comparisons not easy. High fragmentation, weak or non-existent regulations, high staff turnover and a high proportion of informal employment in the sector also pose challenges.

3.2 Gender pay gap.

Women are estimated to account for 70% of the social and health care workforce.[16] Occupations in long-term aged care are especially undervalued, as care work has traditionally been performed by women without pay. While the work performed by social care workers requires skills and involves a high level of responsibility, the perceived similarity to women's care work has resulted in devaluing and low wages. ILO data indicates that the gender pay gap is more marked in the health sector relative to the average in the overall economy.[17]

According to the Finish Union Tehy; the median of full-time wage and salary earners' total earnings was EUR 3,460 for men and EUR 2,896 for women per month in 2019. In January 2021 the median wage was 2873 euros.

In the UK, the mean hourly gender pay gap in the for-profit social care sector was found to be as high as 28.4%. The most significant gender gaps were found in the provision of bonus pay which was as high as 88.1%.[18]

3.3 Working hours and workloads.

The ILO's extensive investigations of working time arrangements in the health sector demonstrates conclusively that the relationship between low pay, long hours and workforce shortages results in

[16] WHO (2020), State of World Nursing Report 2020: Investing in education, jobs and leadership, World Health Organization: Geneva, 6

[17] ILO (2017), Improving employment and working conditions in health services, Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services: Geneva, 22-25

[18] Sian Norris, Byline Times, The Pay Disparities in Social Care. March 2021.

adverse impacts on worker health and safety, motivation, organisational performance and patient outcomes. The detrimental effects of this situation on health workers included disrupted sleep, damaging health and wellbeing, affecting family and social life, contributing to workplace injuries, fatigue, chronic stress and depression, burnout and absenteeism resulting in high workforce turnover.[19]

In some countries social care workers are not paid for overnight shifts where the worker sleeps at the premises and is available when required. In the UK, UNISON, unsuccessfully supported to legal claim to have these shifts paid at minimum wage.[20]

Due to low pay, social care health workers are often pushed to 'compress' their shifts into a shorter working week to make room for secondary jobs to supplement their incomes.[21] Although various organisational solutions to working hours can be pursued at a workplace level, the problem is structural in nature – ultimately, its resolution requires resolving endemic shortages in the health workforce – and this can only be addressed through improved pay and working conditions, premised on well-funded high quality public health systems.

3.4 Job security

Insecure work is a threat to public health, resulting in poorer recruitment and retention and adverse effects on the quality of healthcare provision. The ILO has previously noted that 'decent work deficits' are among the key barriers to recruitment and retention of well-trained and well-motivated health workers, with problems faced by nearly all countries; to address persistent shortages, investment in the health workforce needs to focus not just on increasing the number of workers but creating decent employment and conditions of work.

This has led to workers being more exposed to 'decent work deficits', including job insecurity, lower pay, gaps in access to social protection, higher OHS risks, limitations on organising and collective bargaining power.[22]

There are significant gender inequality aspects to precarious employment, as women are more likely to be employed on insecure contracts. Workers lacking job security, such as those employed by temporary staffing agencies, are especially vulnerable to experiencing excessive workloads and working hours.[23]

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[19] ILO (2017), Improving employment and working conditions in health services, Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services: Geneva, 29-32

[20] https://bylinetimes.com/2021/03/22/revealed-the-pay-disparities-in-social-care/

[21] Messenger J.C. and Vidal P., (2015), The organization of working time and its effects in the health services sector: A comparative analysis of Brazil, South Africa and the Republic of Korea, Conditions of Work and Employment Series No. 56, International Labour Office: Geneva, 45, 49-51

[22] ILO (2017), Improving employment and working conditions in health services, Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services: Geneva, 21

[23] Messenger J.C. and Vidal P., (2015), The organization of working time and its effects in the health services sector: A comparative analysis of Brazil, South Africa and the Republic of Korea, Conditions of Work and Employment Series No. 56, International Labour Office: Geneva, 1, 4, 53.

The CGIL in Italy reported that the precariousness in the social services affects almost 50% of the workers in municipal social services, which ensure the ordinary operation of services, particularly those working for the elderly and those for the fight against poverty and social exclusion. All these services are therefore as precarious as their workers, and rely on continuous extensions, where made possible by law. The union is fully committed to achieving the stabilization of the current precarious workers, which would also have a positive effect on the beneficiaries of the services provided.

According to data provided JICHIRO Japan, the proportion of regular staff is about 60% in nursing homes and about 30% in home-visit care, with a high proportion of non-regular staff. The Brazilian union CONFETAM has observed that this is one of the most precarious segments in public service, with various forms of contracts, from public tenders to the hiring of social workers, contracts through legal entities, temporary contracts, and even intermittent contracts. Labour reforms and the approval of the outsourcing law in Brazil have contributed to growing precariousness in the sector.

3.5 Occupational health and safety

Longstanding structural deficiencies in health and safety protections, low pay, lack of staff ratios, insecure work and hierarchical work environments are further exacerbated by the hazards arising from the COVID-19 pandemic emergency. Workers are exposed to a variety of occupational risks including biological, chemical, physical, ergonomic and psychosocial. Nursing personnel experience exposure to infectious diseases, musculoskeletal injuries, and mental health impacts including anxiety, depression and burnout and face some of the highest rates of violence and harassment. For health systems to function sustainably, improvements to occupational health and safety must be prioritised in holistic way. This requires eliminating and mitigating immediate hazards, as well as to addressing the underlying causes of unsafe work through improvements to employment conditions.

The health sector is one of the most hazardous sectors for occupational health and safety. Occupational health and safety are intrinsically linked to safe staffing – a reduction of hours and workloads is of paramount importance as many deficiencies in occupational health and safety are linked with overburdening and overwork.

Back injuries from repetitive and heavy lifting of residents / patients are a major occupational risk in the social care sector. In Japan "back pain due to lifting has been identified as a major contributing factor to the large and increasing shortage of care workers in Japan. Unlike several other post-industrial countries including Australia, New Zealand, the UK, and the US, Japan lacks a nationwide “safe patient handling” policy, which is intended to prevent the need for care staff to lift care recipients manually, by implementing mechanical lifting equipment and procedures for its use”.[24] Consequently, the union advocates for increased robotic care designed to lift patients, without relaxing staffing standards.

Outsourcing of social care jobs means that the deficit in occupational health and safety tends to be most extreme among the most precarious workers, as experienced across the world in the disproportionate impacts of the COVID-19 pandemic on certain demographics and segments of the health workforce.

[24] James Wright (2018) Tactile care, mechanical Hugs: Japanese caregivers and robotic lifting devices, Asian Anthropology, 17:1, 24-39, DOI: 10.1080/1683478X.2017.1406576

4. Responding to COVID-19

Covid-19 revealed the vulnerabilities of the social care sector and the dangers of reliance on an insecure workforce. The sector faced elevated risks, including lack of personal protective equipment, exposure to infected patients, work over-load, workers covering multiple sites and poor infection control.[25] Evidence from nursing homes in the United States, where many care workers commonly work in multiple facilities, indicates a strong link between multiple jobs and elevated risks of transmission.[26]

It is now evident that COVID-19 deaths among health workers are highly variable, and disproportionately concentrated in workplaces with poor working conditions, and that this closely reflects racial and socioeconomic disparities. In the first months of the pandemic in the UK, 64% of nursing staff who died from COVID-19 were black, Asian and minority ethnic background despite making up just 20% of the workforce.[27] Similarly, a recent investigation of 3,600 health worker deaths in the United States found that the majority were people of colour, with more than a third born outside the United States. Only 25% of deaths occurred among workers in hospitals, compared to 58% nursing and residential facilities.[28]

There is also evidence that trade union presence reduces risks of COVID-19. For example, one study found a 30% reduction in mortality in unionised nursing homes in the state of New York compared to non-unionised ones. Unionised facilities did not only tend to have better access to PPE, but more stable and secure workforce, higher staff to patient ratios, paid sick leave, higher wages and benefits that reduce workforce turnover.[29]

Increased occupational health and safety risks for nursing personnel due to COVID-19 do not just extend to the direct risks of infections. As the ILO and the WHO have outlined in recent guidance, these risks also involve increased stress, fatigue, skin disorders related to prolonged use of PPE, increased exposure to toxins from increased use of disinfectants, increased psychological distress, chronic fatigue, stigma, discrimination, physical and psychological violence and harassment.[30]

Both in the case of most countries at a national level, as well as internationally, there is a need to establish the presumptive occupational origin in respect to COVID-19 when it is contracted by nursing personnel. This is significant both for protecting health workers and patients in the short

[25] Mhango M et al. (2020), COVID-19 Risk Factors Among Health Workers: A Rapid Review, Safety and Health at Work, 11(3)
[26] Chen, M. K, Chavalier, J. A., and Long, E. F., Nursing home staff networks and COVID-19, PNAS January 5, 2021 118 (1) <https://doi.org/10.1073/pnas.2015455118>
[27] BMA (2021), COVID-19: the risk to BAME doctors, British Medical Association
[28] Guardian/Kaiser Health News (2021), Lost on the frontline: Our key findings about US healthcare worker deaths in the pandemic's first year, Guardian US
[29] Dean, A., Venkataramani, A., Kimmel, S. (2020), Mortality Rates From COVID-19 Are Lower In Unionized Nursing Homes, Health Affairs. 39(11) <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01011>
[30] ILO and WHO (2021), COVID-19: Occupational health and safety for health workers, Interim Guidance, 2 February 2021, 8-9, 11

term, as well in light of the emerging evidence of 'long COVID syndrome' and the implications of increased workforce shortages that threaten to further erode the sustainability of the nursing workforce. To this end also, the ILO's List of Occupational Diseases Recommendation, 2002 (R.194) (last revised in 2010) is in need of urgent revision to include COVID-19.

4.1 Violence and harassment

Violence in the sector is widespread in all countries and the severity of the issue is well documented. Workers in the health sector are at increased risk of violence and harassment because of the characteristics of the services delivered and the existing working conditions. There is a gender-based aspect to this violence and harassment especially against nurses. A key finding from research dating to 1995 was that a quarter of all violence at work occurred within the health sector.[31]

5. Migrant Workers

In recent decades, many developed countries have increasingly relied on foreign recruitment to fill vacancies in health and care sector jobs. Many migrant health workers are concentrated in the more precarious and lower-paid jobs. Especially in cases where their migration status is insecure, they are subjected to additional forms of exploitation to those faced by their non-migrant colleagues.

Systemic violations involve exclusion from basic labour rights such working time and minimum wages, slavery, forced migration, deportation. Social exclusions, including lack of access to social security, is often also faced by social care personnel because of their migration status. In the United States, there are reports of employers retaliating against migrant workers for speaking out against working conditions or even leaving their jobs.[32] The reliance of many health systems in the developed world on international recruitment is largely a result of underinvestment in domestic recruitment, education and training programs. As emigration exacerbates existing shortages of health workers in the global south, the countries that can least afford to lose health workers end up subsidising the cost of recruiting health workers in wealthier countries. Draining the health capacities of other countries is not a solution to domestic health worker shortages.

6. Social Dialogue

C149 and R157 makes significant provisions for the participation of nursing personnel and their representatives in social dialogue in health sector planning and in relation to decisions affect them. This extends national health policy, decisions concerning the nursing profession including the classification structure, as well in determining wages and conditions through collective bargaining and involvement of worker representatives in dispute resolution. Where trade unions are strong and involved in determining decisions, this positively impacts on both nursing wages and conditions as well the capacity of the health system to respond to healthcare emergencies.

The Care Section of the JICHIRO (All-Japan Prefectural and Municipal Workers Union) lobbied the Ministry of Health, Labour and Welfare asking for general support for the retention of care staff, and the improvement of the nursing care insurance system in response to the Covid-19 pandemic. In addition to an engagement in policymaking of the government and political parties.

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[31] Nordin, H. (1995). Fakta om vaold och hot I arbetet, Solna, Occupational Injury Information System, Swedish Board of Occupational Safety and Health

[32] AFT submission

6.1 Social security

There are many instances of deficiencies in social security protection for nursing personnel, where it is inadequate or absent especially for workers in precarious forms of employment. Exclusions of certain categories of workers from social security protections are reported by PSI affiliates, especially concerning informal workers, community health workers, migrant workers. This includes a lack of access to maternity protection, a lack of access to sick leave, and a lack of access to medical and occupational health and safety services.

The pandemic emergency has exacerbated the consequences of excluding precarious and vulnerable groups of workers from social security protections, especially regarding inadequate provisions to sick leave across much of the world. In the United States for example, it was estimated that 17.7 million health workers were initially exempt from access to the coronavirus emergency paid sick leave benefit.[33] A lack of adequate sick leave for health workers in Canada was found to fuel the COVID-19 pandemic, especially in the long-term care sector; 50% of workers in health care and social services workers do not have paid sick days.[34]

There are many instances from both developing and developed countries where health workers providing vital care have not been given the means to isolate and have been compelled to keep working despite knowing they are infected with COVID-19. When nursing personnel are denied access to sickness benefits or prevented from accessing medical care and compelled to work despite their illnesses (including COVID-19 and other infectious diseases) this not only devalues their lives but also undermines the basic function of health systems.

7. Ensuring Compliance

The health sector should always be heavily prioritised for compliance with health and safety and other conditions of work. This is critical considering its deficiencies including high risks for occupational health and safety and its importance for the welfare of the general population. Inspection activities, including enforcement actions where necessary, should be especially prioritised during a pandemic emergency crisis.

There is a chronic lack of labour inspectors in most of the world. Many states have under-resourced this essential civil service while pursuing neoliberal policies including privatisation and outsourcing that have greatly increased the workloads of labour inspectorates. Monitoring and regulation of standards of the health sector is generally pursued in relation to quality of health provision and standards of patient care, and not for compliance with labour laws. In many countries, labour

[33] Long, M. and Rae, M. (2020), Gaps in the Emergency Paid Sick Leave Law for Health Care Workers, Kaiser Family Foundation

[34] DWHN (2020), Before It's Too Late: How to close the sick days gap during COVID-19 and beyond, Decent Health and Work Network: Ontario.

inspectors have a mandate to inspect workplaces only in the private sector but not public institutions.[35]

The ILO has previously noted the need to strengthen labour inspection capacity in the health sector and this should include social care.[36]

8. Impact of ILO Instruments and Prospects for Ratification

The General Survey process is helping to raise the profile and relevancy of the Convention, and engagement with the process is also leading to increased awareness among PSI's affiliates who have coverage of social care. The instrument can support work to ensure unions who have coverage of nurses and supporting health workers, include the social care sector in their membership.

9. Possible need for standard-related action and for technical assistance

C149 and R157 largely retain their relevance. However, these instruments should be supplemented with revisions where needed. A revised instrument should formalise and regulate social health care work and provide more detailed guidance on the meaning and coverage of "nursing aides". The provisions allowing for insecure work should be removed and more attention should be paid to the gendered practices that have led to large wage gaps and a decent work deficit.

[35] SYNDEX (2012), A mapping report on Labour Inspection Services in 15 European countries: A SYNDEX report for the European Federation of Public Service Unions (EPSU), EPSU: Brussels.

[36] ILO (2017), Improving employment and working conditions in health services, Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services: Geneva,