JOURNAL OF LONG-TERM CARE

Marani, H, et al. 2021. The Impact of COVID-19 on the Organization of Personal Support Work in Ontario, Canada. *Journal of Long-Term Care*, (2021), pp. 283–293. DOI: https://doi.org/10.31389/jltc.70

PERSPECTIVE

The Impact of COVID-19 on the Organization of Personal Support Work in Ontario, Canada

Husayn Marani*, Sandra McKay† and Gregory Marchildon*

The COVID-19 pandemic has exposed fault-lines in the organization of personal support work, including low wages, part-time employment, and risky working condition, despite its essential nature in long-term care (LTC). This is, in part, because personal support work has long-existed on the fringes of what is considered health work, thereby precluding its status as a health profession. In this perspective paper, we explore how the pandemic may contribute to the semi-professionalization of personal support work based on the provision of LTC by personal support workers (PSWs) working in LTC facilities in Ontario, Canada. We first characterize personal support work to illustrate its current organization based on the logics of work control. We then speculate how the pandemic may shift control and map speculated changes onto existing checklists of professionalism and semi-professionalism in health work. We propose the pandemic will shift control away from existing market and hierarchical controls. At most, personal support work may undergo changes that are more characteristic of semi-professional control (semi-professionalism), characterized by the formation of a PSW registry that may improve role clarity, provide market shelter, and standardize wages. We do not believe this shift in control will solve all organizational problems that the pandemic has exposed, and continued market and hierarchical controls may be necessary. This perspective may provide insights for other high-income settings, where the pandemic has exposed similar fault-lines in the organization of personal support work in LTC.

Keywords: Professionalism; semi-professionalism; long-term care; healthcare workers; work organization; COVID-19

Introduction

Healthcare is marked by a complex division of labour comprised of medical professionals, paraprofessionals, unpaid caregivers, volunteers, administrators, managers, and technicians working across several settings, including hospitals, home and community care, and facility-based long-term care (LTC) (Allan & Pilnick, 2005). Despite arguments across global contexts that healthcare as a whole is resistant to change and unadaptable (Bhatia & Coleman, 2003; Mareš, 2018), social change and technological advancements have impacted the forces that control the organization of health work, thereby shaping where and how health services are provided (Wosik et al., 2020), the division and specialization of labour, or who provides health services (Cooper, 2007; Ballantyne, 2007), educational and training standards (Adams & Miller, 2001), remuneration (Freidson, 1985), societal attitudes toward health occupations (Irvine, 2001), and, ultimately, the extent to which a health occupation qualifies as a profession (Brint, 2006).

A number of theories seek to explain the organization of work, including the forces that control the development of labour processes both within occupations by workers themselves and outside the occupation by external forces. Three control logics, summarized in **Box 1**, dominate scholarship in this area: 1) free-market control, 2) hierarchical control, and 3) professional control.

Contemporary scholars of work organization suggest that modern occupations reflect a hybrid of these logics, which shape and interact with each other (Evetts, 2011; Noordegraaf, 2015). But scholars also point out that the extent of any control can shift and transfer easily due to social changes, including political, economic, and cultural events and technological advancements, which can reshape occupational forms and identities (Brint, 2006). For example, Freidson (1985) in particular has written extensively on physicians in the United States. He describes a post-WWII context of economic austerity in which many economic privileges previously enjoyed by the medical profession were removed as a result of standardized fees, bans against competitive bidding, bans on advertising, and competitive incentives that aimed to ensure the cost of professional services would be lower (Brint, 2006).

* Institute of Health Policy, Management and Evaluation (IHPME), University of Toronto, CA

† VHA Home HealthCare, CA

Corresponding author: Husayn Marani (husayn.marani@mail.utoronto.ca)

Box 1: Summary of Work Controls.

1) *Free-market controls* tend to reduce monopoly and privileges of professional groups through competition and pressures to lower prices (Dingwall, 2004; Bird et al., 2010); 2) *Hierarchical controls* embedded within bureaucratic structures reduce professional autonomy (decision-making discretionary judgement) through the development of standards and evaluation frameworks and are characterized by the pursuit of efficiency sometimes at the expense of quality (Aldin & Lundqvist, 2013; Lutzker, 1982; Toren, 1976); and 3) *Professional controls* (or the logic of professionalism), where control is established by members of the occupation itself through values and commitments that then shape the thoughts and practices of the members of the profession (Freidson, 2001).

The majority of scholarship on shifts in the organization of health work focuses on clinicians. Scholarship on the organization of health work for health occupations that exist on the fringes of health service delivery is scant. One such occupation is personal support work. Personal support workers (PSWs) largely work outside formal medical settings (e.g., hospitals) in facilities that provide LTC. We defined facility-based LTC as continuous (24/7) supervised care, including professional health services, personal care, and supportive services, such as meal preparation, laundry, and housekeeping, provided on-site to persons requiring assistance with instrumental activities of daily living, such as toileting and personal hygiene (Government of Canada, 2004).

The COVID-19 pandemic (pandemic) has shown us that PSWs are frontline healthcare providers. It has also exposed deep fault-lines in the way personal support work is organized. Compared to other provinces in Canada, Ontario, which has over 100,000 PSWs working across all healthcare settings (Ontario Ministry of Long-Term Care [MLTC], 2020), has been at the epicentre of the pandemic, with most deaths in the early waves of the pandemic concentrated among residents and PSWs in LTC facilities (Webster, 2021). As of June 2020, roughly 80% of all deaths due to COVID-19 in Ontario occurred in LTC facilities where, at 58%, PSWs constitute the principal workforce (MLTC, 2020). Consequently, across Canada, facility-based LTC has overshadowed other health policy topics, such as universal pharmacare, in terms of media focus and public consciousness during the pandemic (Marchildon & Tuohy, 2021), revealing a window of opportunity (Béland & Marier, 2020) in which personal support work may see a shift in the way it is organized.

In this conceptual analysis, we speculate how the pandemic may shift controls in the organization of personal support work in facility-based LTC away from hierarchical and market-driven controls toward controls that are more characteristic of professionalism or, more accurately, semi-professionalism. Given the paucity of scholarship on semi-professionalism, whether as a precursor to professionalism or its own control logic, we then postulate a preliminary checklist for semi-professionalism that expands on existing scholarship. This analysis may provide insights into what semi-professionalization might mean for other high-income settings, including Europe and the United States (Barker, 2020), where COVID-19 has exposed similar fault-lines in the organization of personal support work in facility-based LTC.

Theoretical framework: Defining a profession and semi-profession

Two theoretical approaches exist to characterize a profession: the 'trait' approach and the 'power' or 'control' approach (Hall, 1994). The most widely applied definition of a profession in the context of work control in healthcare is by Freidson (2001), who presents several attributes of a profession in his logic of professionalism (**Table 1**).

As healthcare is a complex, heterogenous occupational sector, one of the limitations of Freidson's definition of a profession is that it is highly medicalized, focussing on specific attributes developed based on the medical profession. This rejects that modern health occupations now cross interdisciplinary boundaries of knowledge (Breitschwerdt et al., 2019) and, as we argue, both physical boundaries (sites of work) and skill-based boundaries (unskilled vs. skilled). This precludes occupations like personal support work, which largely operates outside formal medical settings and involves tasks requiring varying skill levels, from being considered a health profession, thereby disqualifying them from analyses of work control.

To fill this conceptual gap for non-medical health professions, Weiss-Gal and Welbourne (2008) developed a checklist for social work that merges influences from both trait and control approaches (**Table 1**). Like Freidson's checklist, there are limitations in the application of Weiss-Gal and Welbourne's checklist to personal support work in that certain attributes are partially applicable. For example, PSWs have some discretion, or autonomy, over their actions but generally work under the supervision of a regulated professional. Perhaps, then, personal support work may be better suited to a semi-professional occupational identity, represented by trait and control attributes that are just shy of full professionalism and where hierarchical and market-level controls co-exist.

Again, there are additional limitations in assigning semi-professionalism to personal support work as semi-professionalism is underdeveloped in health work literature. First, there is an assumption that a semi-profession simply falls short of possessing the full attributes of a profession, as Etzioni (1969) suggests of teaching relative to medicine or law (Horowitz, 1985). Thus, little attention has been paid to developing a set of criteria for a semi-professional. This is important as certain health occupations

Table 1: Attributes of professionalism and semi-professionalism in health work.

Author	Control	Checklist
Freidson (2001)	Professionalism (Physicians)	a) a body of knowledge and skill based on vocational training; b) occupationally controlled division of labour involving functional specializations and occupational assistants; c) market shelter, or an occupationally controlled labour market requiring training credentials for entry and career mobility (Timmermans, 2008); d) occupationally controlled training programs segregated from the labour market, which produce the credentials and are organized by academics who also contribute to the production of new knowledge relevant to the profession; e) an ideology that emphasizes devotion to the profession and its patients or clients more than economic reward.
Weiss-Gal & Welbourne (2008)	Professionalism (Social Work)	a) public recognition of professional status; b) professional monopoly over specific types of work; c) professional autonomy of action; d) possession of a distinctive knowledge base; e) professional education regulated by members of the profession; f) an effective professional organization; g) codified ethical standards; h) prestige and remuneration reflecting professional standing.
Simpson & Simpson (1969) via Etzioni (1969)	Semi-professionalism (Nursing)	a) integral to a bureaucratic organizational structure; b) communicating knowledge rather than apply it; c) having limiting commitment (e.g., part-time work hours); d) undergoing short and specific training; e) predominantly female.
Searle (1978)	Semi-professionalism (Nursing)	a) not university educated and those that are not professionals but 'technical personnel'; b) few nurses are self-employed and part of their function is dependent on the discretion of another category of health professional, qualifying them as 'paraprofessionals'; c) few have attained 'high intellectual status' through research and scholarly outputs (e.g., peer-reviewed publications); d) nursing is an applied science in that it draws on scientific findings from other sciences and there are no clearly defined theories that underpin nursing as a science.

like personal support work may be better suited toward semi-professionalism, necessitating a clear set of qualifying criteria.

Another assumption is that many health occupations are already semi-, para-, or quasi-professions striving to professionalize. Hence, analyses of organizational control are concerned with the professionalization of these occupations, not their semi-professionalization. We see this, for example, in studies of organizational control among registered nurses and social workers, where features of these occupations are 'fitted' to a theoretical definition of profession (Weiss-Gal & Welbourne, 2008). Relatedly, among health occupations with an existing occupational identity, there are few that are not already professions or are not in the process of professionalizing. Hence, there has been little impetus to understand semi-professionalism in the context of health work.

Next, current approaches to understanding semi-professionalism in health work need to be revised and updated. As Salvage (2002) notes, conceptual checklists of a semi-professional make several stereotypical assumptions about gender-based divisions in labour and the inferior knowledge of semi-professionals. Etzioni's (1969) work, which proposes that semi-professionals are predominantly female, was highly influential in shaping notions of semi-professionalism in nursing (Simpson & Simpson, 1969) (**Table 1**). Until the 1970s, this was considered a significant barrier to the professionalization of nursing (Ghadirian et al, 2014). While 90% of Ontario PSWs are female (MLTC, 2020), that gender distribution should inform how we conceptualize an occupational identity is inconsistent with both current social attitudes and the distribution of gender across all health work.

Lastly, scholarship on semi-professionalism in health work is based on specific occupational and temporal contexts. This has hindered opportunities to develop a generalizable conceptual checklist of a semi-professional. For example, Searle (1978) proposes a four-item checklist for semi-professionalism in nursing (**Table 1**). Prior to the 1960s, this checklist would have held true for registered nursing in Ontario, where nurses were unable to receive accreditation as a profession and be recognized and paid as such. Today, however, Searle's criteria are outdated. In Ontario, political positioning through powerful unions, an increase in vocational training requirements, and the self-regulation of nursing through the formation of the Ontario College of Nurses are indicative of nursing's professionalization. Similar trends have occurred in other high-income settings (Adams & Miller, 2001; Ghadirian, 2016). While their discretion over decision-making can be disputed, nurses themselves perceive their practice to be professionally autonomous, representing another

commonly accepted attribute of professionalism (Skår, 2010).

As we discuss in the following section, the current controls over the organization of personal support work in Ontario's facility-based LTC sector are largely characteristic of market and hierarchical controls. However, we suspect this control may change as a result of the COVID-19 pandemic. Recognizing the perspectives and limitations described above, we believe these changes are characteristic of semi-professionalization.

Characterizing personal support work in Ontario and its organization in the logics of control

Roles and responsibilities

PSWs may provide any combination of supports described in **Box 2**; however, the Health Professions Regulatory Advisory Council (HPRAC) of Ontario notes that PSWs' roles and responsibilities are not clearly defined or universally agreed-upon (Kelly & Bourgeault, 2015).

Box 2: Summary of PSW Care Provision.

PSW duties typically include a combination of the following: *personal care* (bathing, dressing, grooming, feeding, personal hygiene care); *health-related care* (incontinence care, medication assistance and reminders); *mobility care* (rehabilitation, exercises, ambulation, lifting/transferring); *emotional and social support* (companionship, respite relief care for family caregivers, de-escalating violent or volatile situations among residents of facility-based LTC) (Ontario PSW Association, 2020). PSWs may also provide additional care as delegated by a regulated health professional when it is deemed safe and within provincial legislation.

In Ontario, the title of 'personal support worker' emerged two decades ago. Though this title is gaining popularity, the work performed by PSWs can be performed under other titles. The most variation in titles is in facility-based LTC, where PSWs may be known as a health care aide, personal care aide, continuing care assistant, health care assistant, resident assistant, client care attendant, home support worker, community support worker, unregulated care provider, or personal care attendant (PSQHQ, 2020).

In Ontario, inconsistency in titles could be indicative of market-driven controls and the lack of a clearly defined scope of practice. Private LTC facilities are particularly profit-driven. In an effort to control costs, some facilities may designate PSWs as residential care workers, with remuneration that is a fraction of the value of a PSW (Keung & Miller, 2020). Hiring under a lesser-known title also absolves employers from the responsibility of providing employment benefits to these workers.

PSWs generally work in coordination with a healthcare team. As such, PSWs may have the added responsibility of ensuring program plans prepared by a registered health professional (e.g., registered nurse, rehabilitation therapist) are being adhered to and may also report observations about an LTC resident's situation to a clinical supervisor. Despite performing their actions independently and unmonitored, PSWs have little autonomy, or decision-making discretion, concerning these actions. While this may be true of registered nurses, who we note are considered professionals, unlike registered nurses, PSWs do not claim any specialized body of knowledge and are not self-regulated. This reinforces the professionalism of their regulated superiors, while also reinforcing their treatment as semi-skilled workers and undermining their own claims to professional status. Freidson characterizes this as a kind of 'negotiated order' (Freidson, 2001).

Increasingly, PSWs are performing activities that were previously considered outside the scope of their practice. While most PSWs provide assistance with personal care, some perform more complex care activities that are transferred to them by regulated health professionals (Saari et al., 2018). Relatedly, the number of PSWs is said to far surpass the number of nurses across Ontario healthcare settings (Kelly & Bourgeault, 2015). This has already been observed in facility-based LTC (MLTC, 2020), where PSWs are not only caring for more complex LTC residents with few nursing colleagues present (MLTC, 2020), but also are seeing their roles and responsibilities expanding (Saari, 2018). These examples highlight the lack of professional control (i.e., control from within the occupation by PSWs themselves) that PSWs have in the scope of their own work. Specifically, it highlights a lack of market shelter (or claim to a specific body of knowledge- and skill-based expertise) and reinforces the hierarchical nature of their work, where PSWs cannot control expanding work responsibilities due to a culture of outside control that increasingly pushes complex work on lower wage employees.

Regulation and training

In Ontario, much like in other high-income settings like the United States (Span, 2020), personal support work is not regulated; there is no governing body responsible for credentialing based on standards for the knowledge and skills needed to practice as a PSW and the scope of services they can provide. Though the Ontario government developed a PSW Program Standard in 2014 to standardize PSW education, no specific training is required to be called a PSW. It is possible that the variety of titles associated with personal support type-work encourages inconsistency in training requirements, which could be capitalized on by some employers to evade training expectations given the growing demand for this type of health work, particularly in facility-based LTC settings.

Without a regulatory body, PSWs are not expected to follow a common code of ethics and workplace standards that describe behaviours and conduct expected of them, neither is the public able to understand what to expect when they receive care from PSWs. With no official body that holds PSWs accountable to professional standards, misconduct by PSWs is determined in a provincial court. Judges may discipline PSWs convicted of assault or theft by telling them they cannot work in a facility, but this does not preclude PSWs from working with a client one-on-one in their client's private residence (homecare) (Laucius, 2017). The Canadian Union of Public Employees (CUPE), Service Employees International Union (SEIU), and the Ontario Personal Support Workers Association (OPSWA) have long noted the need for a regulatory framework that establishes standards on educational requirements, ethics of practice, and disciplinary procedures. This would provide protection to the public and PSWs themselves, something that exists in most other health occupations (Payne, 2017a).

Efforts to standardize practice and regulate personal support work have been resisted by the state for a number of reasons, including the ambiguity around their scope of practice, the non-standardized knowledge base, the lack of consensus among key stakeholders, and the possibility that pursuing regulation would entail retraining and human resourcing costs (Kelly & Bourgeault, 2015; HPRAC, 2006). In 2006, HPRAC noted that PSWs should not be regulated, in part because they 'as a group have not convincingly demonstrated widespread support, willingness or likelihood of compliance with regulation' (Payne, 2017a). This resistance is characteristic of hierarchical controls, which aim to centralize control of professions and reduce health system costs by creating efficiencies. By limiting the extent of professional regulation, the government saves the expense of determining and monitoring standards of practice and hiring experts to assist with creating these standards (Brint, 2006). Ontario's decision to create an educational standard as opposed to fully regulating personal support work asserts this hierarchical control.

Employment

PSWs can be independent agents who are hired directly by a facility or individual client through an advertised job posting. Or they may be employees of one or more community service provider organizations (SPO) that contract SPO-employed PSWs out to facilities that provide publicly funded LTC on behalf of the provincial government or directly to private LTC facilities seeking PSWs on behalf of the facility itself. SPOs are not subject to government standards on hiring and may or may not impose training standards on their employees.

This variation in employment channels gives PSWs choice and personal control over the organization of their work and working environment. PSWs who work independently are more likely to work in private homecare settings, characterized by less pay and less supervision and more workplace autonomy relative to facility-based LTC. The work is also less labourious; residents of LTC facilities often have more complex care needs, including severe dementia, than homecare clients. In recent years, these individuals entering facility-based LTC are exceptionally vulnerable as they are arriving much later in their illness or aging trajectory when severity is worse. This contributes to care provision that is both physically and emotionally exhausting (MLTC, 2020).

Hours and salary

Despite their scope and hours of work, PSWs are the lowest paid health workers, sometimes making minimum wage, or $14 per hour (Keung & Miller, 2020). In 2015, the provincial government increased the wage of PSWs providing publicly funded personal support services by $1.50 per hour, from $14 to $19 over three years (Government of Ontario, 2015). In November 2019, the newly elected Progressive Conservative provincial government passed Bill 124, the *Protecting a Sustainable Public Sector for Future Generations Act*, which capped wage increases for PSWs in publicly funded, non-profit LTC facilities at 1% per year. These facilities comprise a quarter of all LTC facilities in Ontario. This decision has been criticized as it disincentivizes PSWs from working in non-profit facilities, which are already understaffed. Critics have also suggested this is not a sustainable wage increase and it reinforces the commodification or marketization of personal support work in facility-based LTC (Noorsumar, 2020). Reportedly, public funding available for LTC facilities often went to top level bureaucrats and not to serving needs within LTC facilities, for example, by improving the quality of life of LTC residents and improving salaries of PSWs (Lindemann, 2020), suggesting hierarchical controls are also at play.

Facility-based PSWs are often hired on a part-time, casual, contract, temporary, or 'just-in-time' basis, meaning they do not have dependable schedules or income (Payne, 2017a). As a result, the majority of PSWs must cobble multiple jobs to make ends meet. This is indicative of market- and profit-driven controls as part-time workers are not afforded a sustainable living wage, benefits, and job security that full-time employment entails, despite the essential nature of their work (Leslie, 2020).

Understaffing

The facility-based LTC sector is understaffed. Ontario has fewer PSWs working in facility-based LTC than the rest of Canada (Payne, 2017b). Understaffing is the result of several system-level issues: PSWs often leave the profession due to dissatisfaction and physical and emotional burnout; fewer are entering training programs; wages are low across all settings where PSWs work; work environments are sometimes unsafe, resulting in injuries among both residents and PSWs; work hours are long and unpredictable; and fewer are entering the profession, meaning non-replacement when older PSWs retire (Lindemann, 2020; Campbell, 2018; MLTC, 2020). Understaffing is particularly acute in rural settings across Ontario, as part-time employment and lack of compensation for transportation-related expenses disincentivizes PSWs from working in these settings (Lindemann, 2020). Further, across all PSW-specific training programs, enrollment is down, which means skilled workers will not be readily available to replace those leaving or retiring from this occupation (Campbell, 2018; MLTC, 2020). Many colleges in Ontario have shut down their PSW programs due to low demand (Campbell, 2018).

As a result of chronic understaffing and an increase in LTC residents across facilities, PSWs are doing more work. This has meant the number of hours of care received by LTC residents has decreased (Hagar, 2017). The LTC sector in Ontario has long been unable to fill these vacancies. To address understaffing, the provincial government has introduced a Canada-Ontario Job Grant Program (Ontario Ministry of Colleges and Universities, 2020; grant number unavailable) that provides special grant funding to limited applicants to cover the cost of tuition for a PSW certificate training program that would lead to immediate, guaranteed employment (The Stayner Sun, 2018). For OPSWA, taking over regulation of this occupation and instituting standards around working conditions and pay are critical in recruiting new PSWs and retaining those already working (Campbell, 2018).

How the COVID-19 pandemic has shifted control

Prior to Ontario's COVID-19 state of emergency, officially declared on March 17, 2020, public discourse on PSWs was largely negative. Media reports painted a picture of elder abuse and lack of compassionate care by PSWs, particularly in LTC facilities, and at the health system level, PSWs had been disregarded as health workers. At the start of the pandemic, public outcry over deaths due to COVID-19 across LTC facilities quickly prompted government-imposed limitations on movement of PSWs between workplaces in an effort to contain community virus transmission. Further, Public Health Ontario (PHO), an arms-length government agency, created the Integrated Public Health Information System (iPHIS) to collate data on five categories of infected health workers: doctor, nurse, laboratory worker, first responder, and 'other healthcare worker/unknown type.' PSWs were put into the latter category, suggesting Ontario was not initially tracking infections of PSWs, specifically (Donovan, 2020).

As time went on, perceptions changed. Most cases and deaths from COVID-19 among health care workers in Ontario have been PSWs. This exposed the precarious (low pay) nature of their work and the hazardous working environment characterized by chronic understaffing and a lack of communication concerning virus transmission and workplace safety procedures, including inaccessible personal protective equipment. Further, evidence that outbreaks of COVID-19 across LTC facilities were the result of living arrangements (residents living in close proximity of one another) challenged the assertion that PSWs were the main vector of transmission between and within LTC facilities (Trinh, 2020; Brown et al., 2021) and reinforced the difficulty in attributing infections to any specific vectors.

As occupational controls are vulnerable to political, cultural, and economic events (Brint, 2006), the COVID-19 pandemic could shift the locus of control in personal support work. Calls for greater public regulation of personal support work prior to the pandemic suggest that the organization of personal support work may already have been undergoing changes that are more characteristic of semi-professionalization. As previously described, PSWs have long-existed in a hierarchical and market-driven system that has worked against them, and while these controls may remain, the strength of these controls on the organization of personal support work may change. With COVID-19 shining a spotlight on how work is assigned to PSWs and the hiring process across LTC facilities, concerns will become less about cost-containment and efficiency and more about quality care and the role of PSWs in caring for aging members of society. We speculate several changes in the organization of personal support work that we describe below.

The emergence of a registry

A PSW registry could ensure greater regulation in the organization of personal support work with the aim of protecting both residents of LTC facilities and PSWs themselves (Kelly & Bourgeault, 2015). Key elements of a registry are summarized in **Box 3**.

A registry was established in Ontario in 2011 but was eliminated after a review found deficiencies in the way it functioned. In early 2018, the then-Liberal provincial government announced the first phase of comprehensive PSW registry pilot developed by Ontario's Michener Institute of Education (Michener Institute, 2018). This pilot has been tabled by the current government; however, we speculate the pandemic may reignite this plan.

A registry falls short of self-regulation, representing a shift in control just shy of full professionalization. However, in the context of personal support work, continued hierarchical control over its organization may better suit this occupation. During the pandemic, a Canadian Armed Forces audit of the state of facility-based LTC in Ontario revealed LTC facilities did not meet regulatory requirements and were understaffed (Boisvert, 2020). Because the provincial government is responsible for ensuring LTC facilities meet legislative and regulatory requirements around standards of care and staffing, this may give the provincial government impetus to regain

Box 3: Elements of a PSW Registry (Payne, 2017b; Laucius, 2017).

a) a clear mandate related to upholding expectations related to personal support work that protect PSWs, residents of LTC facilities, and the public;
b) standards around education and training, including rigorous processes to verify identity and educational credentials;
c) protected title and greater role clarity (for example, ensuring a PSW is suitable to the work being done);
d) a code of ethics/conduct;
e) disciplinary procedures, including policies for reviewing, suspending, or terminating a PSW's registration.

control over factors that could improve quality of care, including PSW education and training and standards around staff working conditions, both of which could be achieved through a registry.

A shift in 'market shelter'

Occupational market shelter creates an environment based on training and credentialing that prohibits others without such training from entering and doing the work of this occupation. The response by the provincial government and LTC facilities during the pandemic has illustrated significant hierarchical control over personal support work and a lack of market shelter. A directive issued by the provincial government early into the pandemic limited the movement of PSWs between facilities to prevent the spread of COVID-19. As personal support work is characterized by employment at multiple facilities, this directive affected nearly all practicing PSWs. In addition, under the *Emergency Management and Civil Protection Act*, several LTC regulations have been amended. LTC facilities are now able to take 'any reasonably necessary measure [...] to respond to, prevent and alleviate the outbreak of coronavirus,' which gives LTC facilities significant discretion in decision-making concerning staffing (Welsh, 2020). Specifically, LTC facility administrators can fill any staff position with a person who, 'in their reasonable opinion,' has adequate skills, training, and knowledge to perform the duties required in that position. These individuals do not have to meet previous training requirements as long as they ensure residents are safe and cared for.

These changes reinforce how Ontario PSWs have no claim to a specific body of skills or knowledge and, thus, lack market shelter. Relatedly, these changes illustrate how little control PSWs have over their own work and their ability to work. This could also lead to increased market-level controls: LTC facilities may be able to hire low-paid workers to fill vacancy gaps given the economic toll of this pandemic on the LTC sector.

This is in stark contrast with Québec, which established a specialized, 12-week, accelerated training program for orderlies that includes 375 hours of theoretical and practical training. This program is expected to yield 10,000 orderlies, akin to PSWs, who will immediately be dispatched to LTC facilities in an effort to address subsequent waves of COVID-19. With competitive pay, Québec's minister of health notes the importance of this training program in improving working conditions of health workers in facility-based LTC (Haines & Laframboise, 2020). Unlike Ontario, which removed the educational requirement and corresponding market shelter of PSWs, Québec's initiative professionalizes the knowledge requirements of PSWs. The province recognizes that personal support work is an occupation that demands a theoretical and practical knowledge base and skillset as we see in other health professions; more specifically, a socialized knowledge base that is holistic in nature, including knowledge of a home, its residents, and longstanding awareness of a residents' disease history and care preferences (Mojtehedzadeh, 2020). Should Ontario move forward with a PSW registry that standardizes educational training for all PSWs, we may see improved occupational market shelter for PSWs.

Title and wage clarity

Issues concerning lack of market shelter relate to the absence of title clarity and, consequently, inconsistency in wage for those who perform personal support-type work. Reports on the state of facility-based LTC during the pandemic have indicated that some LTC facilities have misclassified PSWs as residential care workers, a title associated with a fraction of the wages a PSW makes (Keung & Miller, 2020). Despite this, we have seen provincial efforts to improve PSW wages through a temporary $4 wage increase for PSWs. Some SPOs have offered up to $30 per hour for PSWs working in LTC facilities, an increase from a pre-pandemic average wage of $18–21 per hour. LTC facilities themselves incentivized PSWs to work with residents who have COVID-19 by offering up to $35 per hour (Stone & Keller, 2020). Though these approaches aimed to fill gaps in understaffed facilities and/or mitigate COVID-19 transmission associated with movement between facilities, variability in wage is indicative of the commodification of personal support work as a result of both hierarchical and market-driven controls.

As previously discussed, without a permanent and sustainable living wage and full-time work that includes benefits, PSWs may still be incentivized to work in multiple settings to supplement income. Unlike British Columbia, Ontario has not committed to supplementing income lost as a result of restricting PSWs from working at more than one facility (Frketich, 2020). A registry, if implemented, would impose standards on training/education and hiring expectations across healthcare settings, which would ultimately clarify the specific roles of PSWs, thereby protecting their occupational title. Improving title clarity could also create a minimum expectation for pay, or what the market will bear (Carter, 2010), and create greater continuity across the LTC system: when title defines the work, the work will define the wage. We speculate this may limit opportunities for employers to misclassify the work to offer a lower wage. This would also remove market controls on this occupation and may disincentivize PSWs from working multiple part-time jobs.

The semi-professionalization of personal support work?

This analysis, while speculative, illustrates that COVID-19 has created a unique policy window for major change in the organization of personal support work. Specifically, personal support work, an occupation that has otherwise been regarded as non-skilled or semi-skilled and without the status and privileges of other health professions, is changing in a manner that reflects a kind of semi-professionalization. Although no general checklist for semi-professionalism exists, we can map changes that we believe are indicative of semi-professionalism onto existing checklists to develop a preliminary trait and control checklist for semi-professionalism in personal support work.

Based on these speculated changes, we have come up with six attributes of semi-professionalism in the future of personal support work, many of which are rooted in the formation of a PSW registry (**Box 4**). Many changes reflect attributes of semi-professionalism in existing, albeit

Box 4: Attributes of semi-professionalism in the future of personal support work.

a) a minimum standard of education is required that is shorter than a baccalaureate degree and does not have to be offered at a university;
b) an applied and contextual knowledge base that is not rooted in clearly defined theoretical traditions;
c) performed activities are integral to the functioning of a bureaucratic organizational structure (e.g., LTC facility);
d) some degree of self- or government regulation informs ethical standards and standards of practice;
e) some degree of self- or government regulation exists to clarify roles and ensure monopoly by PSWs over specific types of work;
f) autonomy over decision-making may be at the discretion of a professional.

outdated, scholarship of semi-professionalism in health work [a-c] (Simpson & Simpson, 1969; Searle, 1978). We also adapted attributes of professionalism in health work proposed by Freidson (2001) and Weiss-Gal & Melbourne (2008) [d-f].

Even if full professionalism is not the end-goal, this preliminary checklist illustrates limitations in the achievement of, or what is needed to achieve, full professionalism by illuminating what attributes of professionalism are partially applicable or missing relative to existing checklists of professionalism in health work. Like Searle's checklist for semi-professionalism in nursing, this checklist is unique to personal support work and representative of a specific moment in time, so it is subject to evolution. Given the inconsistency across checklists of semi-professionalism in health work, we exercised some liberty in deciding what attributes to include and exclude. For example, we excluded Simpson and Simpson's (1969) attribute that semi-professionals are predominantly female for reasons previously noted. Further, as this is a preliminary checklist, we do not posit that personal support work must possess all of these attributes to qualify as a semi-profession.

Implications and considerations

Pre-pandemic intentions to develop a PSW registry, akin to semi-professionalization, may be accelerated by the COVID-19 pandemic. A registry would help to clarify training requirements, job title, responsibilities, and wage, thereby creating consistency across the facility-based LTC system and a mechanism of accountability among hiring SPOs and LTC facilities. It would also protect members of the public and PSWs themselves.

There are, however, important theoretical and pragmatic limitations concerning the semi-professionalization of personal support work. First, a registry involves a complex governance structure requiring a significant capital investment from the provincial government. While occupational self-regulation afforded to professions like medicine and nursing saves the government money (e.g., the expense of hiring experts to develop professional standards) (Randall, 2005), we believe the semi-professionalism of personal support work through a public registry will, counterintuitively, necessitate greater hierarchical controls.

Second, personal support work is a high-touch occupation where roles can be designated as skilled and non-skilled. The scope of personal support work can include personal care (toileting and bathing), which does not require vocational training, to medical care, including medication management and chronic disease support. The formalization of credentials and work responsibilities may reduce the number of workers registering to become PSWs and exclude people from entering this occupation, which, again, is counterintuitive considering supply has never met demand. It may also propagate an underground economy comprised of those who may only want to do personal care. These workers may lose access to employment benefits, if any, afforded to them as PSWs. These structures may also create a pseudo-hierarchy of personal support work based on role, akin to the nursing profession consisting of licensed practical nurses who provide basic care and work under the supervision of registered nurses. The question would then be how do we characterize the occupational identity of those workers who provide only personal care and do they qualify as semi-professionals like their PSW superiors? Perhaps, then, personal support work ought to remain under a sustained hold by pre-pandemic market and hierarchical controls and without a specific occupational identity.

Conclusion

The COVID-19 pandemic is an object lesson for all countries on the importance of facility-based LTC as part of any health system. The neglect of LTC as a critical health sector in which non-medical frontline workers operate suggests we need to expand our understanding of the division of labour beyond clinicians and hospital settings to facility-based LTC where the majority of the workforce are neither physicians nor nurses but PSWs. In Ontario, many of the factors that enabled outbreaks of COVID-19 across LTC facilities were propagated by the way PSWs are organized. Unlike hospitals, that LTC facilities are not expected to comply with hiring and training standards for paid staff or safety protocols to keep residents and staff safe illustrates the need for controls that create the structures to support this type of health work. Thus, drawing upon the same logics of control that have historically been applied to medical professions, we predict a shift away from hierarchical and market-based controls toward semi-professional control, characterized by the formation of a PSW registry, which may yield a permanent increase in remuneration, market shelter, and standardization of roles and responsibilities.

Competing Interests

The authors have no competing interests to declare.

References

Adams, D and **Miller, BK.** 2001. Professionalism in nursing behaviors of nurse practitioners. *J Prof Nurs*, 17(4): 203–210. DOI: https://doi.org/10.1053/jpnu.2001.25913

Aldin, C and **Lundqvist, P.** 2013. How does image accompany structure in organizations? Exploring Professionalism and Managerialism in the Organizational Images of Swedish Hospitals. (Master's Thesis), Uppsala University. ProQuest Dissertations Publishing.

Allen, D and **Pilnick, A.** 2005. Making connections: Healthcare as a case study in the social organisation of work. *Sociology of Health and Illness*, 27(6): 683–700. DOI: https://doi.org/10.1111/j.1467-9566.2005.00469.x

Ballantyne, PJ. 2007. The role of pharmacists in primary care. *BMJ*, 334: 1066. DOI: https://doi.org/10.1136/bmj.39213.660394.80

Barker, K. 2020. A Nursing Home's 64-Day Covid Siege: 'They're All Going to Die'. *The New York Times*, 8 June [online access at https://www.nytimes.com/2020/06/08/us/coronavirus-nursing-home-vermont-deaths.html?smid=tw-nythealth&smtyp=cur].

Béland, D and **Marier, P.** 2020. COVID-19 and Long-Term Care Policy for Older People in Canada. *Journal of Aging & Social Policy*, 32(4–5): 358–364. DOI: https://doi.org/10.1080/08959420.2020.1764319

Bhatia, V and **Coleman, W.** 2003. Ideas and Discourse: Reform and Resistance in the Canadian and German Health Systems. *Canadian Journal of Political Science/Revue Canadienne De Science Politique*, 36(4): 715–739. DOI: https://doi.org/10.1017/S0008423903778822

Bird, CE, Conrad, P and **Fremont, AM.** 2010. *Handbook of Medical Sociology*, Sixth Edition. Vanderbilt University Press. DOI: https://doi.org/10.2307/j.ctv16h2n9s

Boisvert, N. 2020. Ontario long-term care homes in scathing report could face charges, says Ford. *CBC News*, May 26 [online access at www.cbc.ca/news/canada/toronto/ontario-military-ltc-report-1.5585131].

Breitschwerdt, L, Lechner, R and **Egetenmeyer, R.** 2019. The "new professionalism" in adult and continuing education – a multi-level perspective. *Journal AED – Adult Education and Development*, 3. Available at https://www.dvv-international.de/en/adult-education-and-development/editions/aed-862019-the-good-adult-educator/section-3-in-the-lab/the-new-professionalism-in-adult-and-continuing-education-a-multi-level-perspective/.

Brint, S. 2006. Saving the "Soul of Professionalism": Freidson's Institutional Ethics and the Defense of Professional Autonomy. *Knowledge, Work & Society*, 4(2): 101–129.

Brown, KA, Jones, A, Daneman, N, Chan, AK, Schwartz, KL, Garber, GE, Costa, AP and **Stall, NM.** 2021. Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada. *JAMA Intern Med*, 181(2): 229–236. DOI: https://doi.org/10.1001/jamainternmed.2020.6466

Campbell, C. 2018. Lack of personal support workers affects local home care and long-term care. *Dundas Star News*, 28 Nov [online access at https://www.hamiltonnews.com/community-story/9055824-lack-of-personal-support-workers-affects-local-home-care-and-long-term-care/].

Carter, N. 2010. Clinical nurse specialists and nurse practitioners: Title confusion and lack of role clarity. *Nursing Leadership*, 189. DOI: https://doi.org/10.12927/cjnl.2010.22276

Cooper, RA. 2007. New Directions for Nurse Practitioners and Physician Assistants in the Era of Physician Shortages. *Academic Medicine*, 82(9): 827–828. DOI: https://doi.org/10.1097/ACM.0b013e31812f7939

Donovan, K. 2020. Province isn't tracking the infections of PSWs: One-sixth of cases are health-care workers and this is expected to rise. *Toronto Star*, 16 May [online access at https://www.thestar.com/news/canada/2020/05/15/ontario-isnt-tracking-the-health-care-job-most-likely-to-get-covid-19-personal-support-worker.html].

Dingwall, R. 2004. Professions and social order in a global society. *Revista Electronica de Investigacion Educativa*, 6(1).

Etzioni, A. 1969. *The semi-professions and their organization*. Free Press.

Evetts, J. 2011. A new professionalism? Challenges and opportunities. *Current Sociology*, 59(4): 406–422. DOI: https://doi.org/10.1177/0011392111402585

Freidson, E. 1985. The Reorganization of the Medical Profession. *Medical Care Review*, 42(1): 11–35. DOI: https://doi.org/10.1177/107755878504200103

Freidson, E. 2001. *Professionalism: The Third Logic*. Polity Press.

Frketich, J. 2020. Hamilton long-term care workers in 'horrible position' of having to choose between jobs. *The Spectator*, 26 March [online access at https://www.thespec.com/news/hamilton-region/2020/03/26/hamilton-long-term-care-workers-in-horrible-position-of-having-to-choose-between-jobs.html].

Ghadirian, F, Salsali, M and **Cheraghi, MA.** 2014. Nursing professionalism: An evolutionary concept analysis. *Iran J Nurs Midwifery Res*, 19(1): 1–10.

Government of Canada. 2004. *Long-term facilities-based care.* Retrieved from Government of Canada website. Available at https://www.canada.ca/en/health-canada/services/home-continuing-care/long-term-facilities-based-care.html.

Government of Ontario Ministry of Health and Long-Term Care. 2015. *Ontario Increasing Wages for Personal Support Workers*. Available at www.health.gov.on.ca/en/news/bulletin/2015/hb_20150622.aspx.

Hagar, L. 2017. In defence of personal support workers. *The Ottawa Citizen*, 9 December [online access at https://ottawacitizen.com/news/local-news/hagar-in-defence-of-personal-support-workers].

Haines, BJ and **Laframboise, K.** 2020. Coronavirus: Intensive 12 week training program launched in Quebec

for future orderlies. *Global News*, 15 June [online access at https://globalnews.ca/news/7066182/coronavirus-quebec-intensive-training-orderlies/].

Hall, R. 1994. *Sociology of work*. Pine Forge Press.

Health Professions Regulatory Advisory Council [HPRAC]. 2006. The Regulation of Personal Support Workers (Final Report to the Minister of Health and Long-Term Care). HPRAC Website. Available at https://www.hprac.org/en/reports/resources/PSW-FinalReportSept27-06.pdf.

Horowitz, T. 1985. Professionalism and Semi-Professionalism among Immigrant Teachers from the U.S.S.R. and North America. *Comparative Education*, 21(3): 297–307. DOI: https://doi.org/10.1080/0305006850210307

Irvine, D. 2001. The changing relationship between the public and the medical profession. *Journal of the Royal Society of Medicine*, 94(4): 162–169. DOI: https://doi.org/10.1177/014107680109400403

Kelly, C and **Bourgeault, IL.** 2015. The Personal Support Worker Program Standard in Ontario: An Alternative to Self-Regulation? *Healthcare Policy*, 11(2): 20–26. DOI: https://doi.org/10.12927/hcpol.2016.24450

Keung, N and **Miller, J.** 2020. Until COVID-19 hit, PSWs went virtually unnoticed. That's changed and some say we have a lot of lessons to learn about the trials they face. *Toronto Star*, 2 May [online access at https://www.thestar.com/news/gta/2020/04/30/until-covid-19-hit-psws-received-almost-no-recognition-thats-changed.html].

Laucius, J. 2017. Personal support workers should have governing body, employee group says; High demand for health-care staff means little attention is paid to qualifications. *The Ottawa Citizen*, 5 July [online access at https://ottawacitizen.com/news/local-news/elder-abuse-case-personal-support-workers-need-governing-body-group-says].

Leslie, K. 2020. Long-term care workers need secure, not precarious, jobs. *The Spectator*, 11 April [online access at https://www.thespec.com/opinion/contributors/2020/04/10/long-term-care-workers-need-secure-not-precarious-jobs.html].

Lindemann, T. 2020. Will Ontario have personal support workers available when you need them? *The Sachem/Glanbrook Gazette*, 10 March [online access at https://www.sachem.ca/news-story/9902715-will-ontario-have-personal-support-workers-available-when-you-need-them-/].

Lutzker, MA. 1982. Max Weber and the Analysis of Modern Bureaucratic Organization: Notes Toward a Theory of Appraisal. *American Archivist*, 45(2): 119–130. DOI: https://doi.org/10.17723/aarc.45.2.n05v8735408776qh

Marchildon, G and **Tuohy, C.** 2021. Expanding health care coverage in Canada: A dramatic shift in the debate. *Health Economics, Policy and Law*, 1–7. DOI: https://doi.org/10.1017/S1744133121000062

Mareš, J. 2018. Resistance of health personnel to changes in healthcare. *KONTAKT*, 20(3): e262-e272. DOI: https://doi.org/10.1016/j.kontakt.2018.04.002

Michener Institute. 2018. *Ontario Launching First Phase of the Personal Support Worker Registry*. Available at https://michener.ca/ontario-launching-first-phase-personal-support-worker-registry/.

Ministry of Long-Term Care. 2018. *Long-term care staffing study*. Available at https://www.ontario.ca/page/long-term-care-staffing-study.

Mojtehedzadeh, S. 2020. Temp workers free to work at multiple care facilities: Critics say exemption from COVID-19 health directives a sign of how desperate industry is. *Toronto Star*, 21 April [online access at https://www.thestar.com/business/2020/04/19/temporary-agency-workers-have-long-been-a-crutch-for-a-care-system-in-crisis-experts-say-now-they-are-exempt-from-new-covid-19-health-directives.html].

Noordegraaf, M. 2015. Hybrid professionalism and beyond: (New) Forms of public professionalism in changing organizational and societal contexts. *Journal of Professions and Organization*, 2(2): 187–206. DOI: https://doi.org/10.1093/jpo/jov002

Noorsumar, Z. 2020. Ford invokes wage-cap law for long-term care workers. *Rank and File*, 22 February [online access at https://www.rankandfile.ca/ford-invokes-wage-cap-law-for-long-term-care-workers/].

Ontario Ministry of Colleges and Universities. 2020. Canada-Ontario Job Grant Program. Available at www.tcu.gov.on.ca/eng/eopg/cojg/.

Ontario PSW Association [OPSWA]. 2020. *PSW Roles and Responsibilities*. Ontario PSW Association Website. Available at https://ontariopswassociation.com/psw-roles-and-responsibilities/.

Payne, E. 2017a. Personal support workers in Ontario lack oversight of most other professions. *Ottawa Citizen*, 19 July [online access at https://ottawacitizen.com/news/local-news/personal-support-workers-in-ontario-lack-oversight-of-most-other-professions].

Payne, E. 2017b. Ottawa personal support worker sounds alarm over long-term care. *The Ottawa Citizen*, 2 August [online access at https://ottawacitizen.com/news/local-news/ottawa-personal-support-worker-sounds-alarm-over-long-term-care].

Personal Support Worker [PSW] HQ. 2020. Position Titles You May be Overlooking in Your PSW Job Search. Available at https://personalsupportworkerhq.com/job-titles/.

Saari, M, Patterson, E, Kelly, S and **Tournageau, AE.** 2018. The evolving role of the personal support workers in home care in Ontario, Canada. *Health and Social Care in the Community*, 26: 240–249. DOI: https://doi.org/10.1111/hsc.12514

Stone, L and **Keller, J.** 2020. Ontario relying on volunteers to help staffing shortage in long-term care as feds release new guidelines. *The Globe and Mail*, 11 April [online access at https://www.theglobeandmail.com/canada/article-ontario-relying-on-volunteers-to-help-staffing-shortage-in-long-term/].

Randall, GE. 2005. Understanding Professional Self-Regulation. 5 May [online access at https://paramedicsofmanitoba.ca/uploaded/web/pdf/Understanding%20Professional%20Self-Regulation.pdf].

Salvage, J. 2002. *Rethinking Professionalism: the first step for patient-focused care? Future Health Worker Project*. Institute for Public Policy Research [IPPR]. Available at https://www.ippr.org/files/uploadedFiles/projects/Rethinking%20Professionalism%20.PDF.

Searle, C. 1978. The Criteria for Professionalism in Nursing in South Africa. *Curationis*, 1(1): a196. DOI: https://doi.org/10.4102/curationis.v1i1.196

Simpson, R and **Simpson, I.** 1969. Women and bureaucracy in the semi-professions. In: Etzioni, A (ed.), *The Semi-professions and their Organizations*. Free Press.

Skår, R. 2010. The meaning of autonomy in nursing practice. *Journal of clinical nursing*, 19(15–16): 2226–2234. DOI: https://doi.org/10.1111/j.1365-2702.2009.02804.x

Span, P. 2020. Navigating Home Care During the Pandemic. *The New York Times*, 6 June [online access at https://www.nytimes.com/2020/06/06/health/coronavirus-home-care-nursing.html].

Timmermans, S. 2008. Professions and Their Work: Do Market Shelters Protect Professional Interests? *Work and Occupations*, 35(2). DOI: https://doi.org/10.1177/0730888407313032

Toren, N. 1976. Bureacuracy and Professionalism: A Reconsideration of Weber's Thesis. *The Academic of Management Review*, 1(3): 36–36. DOI: https://doi.org/10.5465/amr.1976.4400734

The Stayner Sun. 2018. Training future personal support workers. *The Stayner Sun*, 29 May [online access at https://www.simcoe.com/shopping-story/8637114-train-to-become-a-personal-support-worker-for-free/].

Trinh, J. 2020. Video captures residents wandering into woman's room at Ottawa long-term care home hit hard by COVID-19. *CBC News*, 18 June [online access at https://www.cbc.ca/news/canada/ottawa/video-infection-control-lapse-wandering-residents-sienna-living-madonna-care-1.5611750].

Webster, P. 2021. COVID-19 highlights Canada's care home crisis. *The Lancet*, 397(10270). DOI: https://doi.org/10.1016/S0140-6736(21)00083-0

Weiss-Gal, I and **Welbourne, P.** 2008. The professionalisation of social work: A cross-national exploration. *Int J Soc Welfare*, 17: 281–290. DOI: https://doi.org/10.1111/j.1468-2397.2008.00574.x

Welsh, M. 2020. 'This is a very difficult decision to make': Families struggle with removing loved ones from long-term-care homes. *Toronto Star*, 7 April [online access at https://www.thestar.com/news/canada/2020/04/06/families-struggle-with-difficult-decision-whether-to-remove-loved-ones-from-long-term-care-homes-amid-pandemic.html].

Wosik, J, Fudim, M, Cameron, B, Gellad, Z, Cho, A, Phinney, D, Curtis, S, Roman, M, Poon, E, Ferranti, J, Katz, J and **Tcheng, J.** 2020. Telehealth transformation: COVID-19 and the rise of virtual care. *JAMIA*, 27(6): 957–962. DOI: https://doi.org/10.1093/jamia/ocaa067

How to cite this article: Marani, H, McKay, S and Marchildon, G. 2021. The Impact of COVID-19 on the Organization of Personal Support Work in Ontario, Canada. *Journal of Long-Term Care*, (2021), pp. 283–293. DOI: https://doi.org/10.31389/jltc.70

Submitted: 14 December 2020 **Accepted:** 27 June 2021 **Published:** 28 September 2021

LSE Press *Journal of Long-Term Care* is a peer-reviewed open access journal published by LSE Press. OPEN ACCESS