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SUPSI

Report

Putting workers at the heart of the promotion of quality care

By

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In the logic of care, the crucial moral act is not making value judgements, but engaging in practical activities. There is only a single layer. It is important to do good, to make life better than it would otherwise have been. But what it is to do good, what leads to a better life, is not given before the act. ***It has to be established along the way.***

Annemarie Mol (2008) *The Logic of Care: Health and the Problem of Patient Choice*, London: Routledge
p. 75 (emphasis added)

Authors

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This report is dedicated to all the long-term care workers of Switzerland.

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Background and Project Objectives

As the Swiss population ages and chronic conditions become more prevalent, the demand for long-term care (LTC) has been steadily increasing, with labour requirements predicted to increase by 40% between 2023 and 2033 (OECD, 2023). The sector is however already in a crisis scenario as staffing cannot keep up with the demand, making it difficult to provide quality care. The staff turnover rate of LTC thus rose from 24% in 2021 to 28% in 2022 in nursing homes (BFS, 2023). Similar turnover rates across OECD countries have been attributed to the poor working conditions and wages in the sector that do not recognise the experience, skills and resiliency needed to provide good care to residents. The crisis has persisted despite various strategies to mitigate it through technology, immigration, and training incentives. The OECD argues, in its report *Beyond Applause? Improving Working Conditions in Long-Term Care* (2023), that to solve the crisis in LTC, these issues of working conditions and wages must be addressed by policy makers through promoting social dialogue between LTC workers and employers.

We identified a crucial research gap in the research on the LTC staffing crisis: the perspective of frontline workers has not been documented. We decided to explore their views on the challenges in LTC work. SUPSI initiated research with Unia in 2021 to explore the perspective of workers on what “good care” entails. The hypothesis was that the workers could hold the key to identifying current dysfunctions in the sector that contribute to poor working conditions, turnover and the decline in care quality.

Methodology

To capture frontline workers’ perspectives, we developed a qualitative and participatory research project, drawing on *conricerca* and participatory health research, where participants are put at the core of the research to co-develop the questions and lead discussions. We focused on workers who interact with residents daily. The research questions that were co-developed to guide the project were:

1. What constitutes 'good care' from the point of view of workers?
2. How do working conditions influence the quality of care?
3. Does the way care is organised affect workers’ relationships with residents and other staff?

We recruited workers throughout Switzerland, mainly through an online survey. A total of 5 focus groups were organised (2 in German, 2 in French and 1 in Italian), 3 of which were conducted on

Zoom. The interviews were conducted, transcribed then verified by the co-researchers, while the data were coded and analysed by the research team.

Findings: A vicious circle of care

The discussions highlighted deep issues with the way the organisation of work in LTC has been restructured around pre-defined tasks, introducing a standardised labour process reduces the time available for workers to care for residents. The resulting intensification of work not only causes much suffering for workers, but also harms the residents, particularly through the rationing of care that it imposes on the former. The discussions nonetheless conveyed a work force that enjoys doing their job and consider it a *vocation*, albeit only when they have the time to utilise their expertise. The findings thus pinpoint the clash that occurs in LTC between workers and the organisation of work.

Into the circle: Planning meets the unexpected

The organisation of work in LTC is guided by a process that seeks to maximise efficiency to reduce costs, in a sense, applying industrial time to a nursing home. While there is nothing inherently wrong with maintaining financial and productive accountability, problems arise when actual work and planned work clash. Unlike factory work, providing care to another human entail recurrent *uncertainties* as well as certain *complexities.* Caring for a human can typically not follow the linear path expected by the pre-set tasks that make up workers' schedules. Instead, workers are often multitasking, thereby highlighting a mismatch between what is prescribed and the reality of work. There are also uncertainties that make work unpredictable and alter its rhythm. A worker needs to respond quickly, as one participant noted they cannot say "sorry I only have 4 minutes left for you" and leave a resident who still needs care. What the discussions conveyed is that workers follow a *logic of care* (Mol, 2008) or a logic to act ("meeting needs as they arise"), which clashes with the calculated planning of workflows in LTC. The consequences of this constant clash are:

1. Workers are constantly overloaded, a phenomenon amplified by the meticulous documentation required to sustain care planning;
2. Forcing workers to constantly *ration care*; to deal with this, experience is a crucial resource, so turnover is exacerbating the problem.

Exacerbating the circle: Exhaustion

As workers experience the clash between prescribed work and reality, exhaustion begins to set in, both physically and mentally. The discussion groups lamented the toll taken by the demands placed on them, especially when they could not provide adequate care because of the prescribed

workflow. One nurse summarised this feeling: “when my expectations are so high, but the reality is so far removed from them, I go home every evening with my head down”.

Exhaustion increases worker absences, which puts further strain on the people at work. Ultimately it can lead to workers quitting the nursing home or leaving the sector altogether, adding turnover to the vicious circle. When nursing homes experience staff shortages, they request other workers to substitute them on short notice, to the detriment of their personal care responsibilities. The group discussions highlighted that this practice was a source of fatigue, stress and frustration. It also went deeper: workers felt that this reflected an overall lack of recognition, whether financial, professional or personal. The situation is particularly bleak for new workers, as they quickly become disenchanted (despite their initial motivation) when they experience the exhausting workloads. The frequent quitting of staff highlights the limits of current strategies emphasizing training to promote care jobs: what is the point of training new employees if they leave after a short period?

Coming full circle: the impact on residents

After exploring this vicious circle, we see that the LTC sector, through its focus on “performance” (seeking efficiency in performing standardized tasks), is suffocating its workforce. The pressure on workers is all the greater that they experience “contradictory temporalities”; nursing home residents experience a time that passes slowly and are negatively affected by the stress of workers who rush through their days. This ultimately leads to a reduced quality of care, as the lack of time and stress compound each other. The time needed for relationship-building gets crowded out, despite the fact that residents value the social interactions, however trivial – they do, after all, live in nursing homes, which are not hospitals. Relational work also is also crucial to establish the trust needed to deliver care: in the words of one group, “time and relationships are the basis of good care”. This observation is all the more important that more people enter nursing homes with cognitive ailments (such as Alzheimer’s), which tend to deteriorate more quickly when human interaction is lacking.

However, the combined effects of standardised work organisation, turnover and absenteeism make it difficult to establish stable and healthy relationships. As one participant stated, “good care is not just about keeping a body alive”. This points to a fundamental question for LTC: should more attention be paid to quality of life and residents' wishes, while the current emphasis is explicitly on medical aspects? Just as a nursing home is not a factory, it is also not a hospital; the organisation of work needs to account for this.

Breaking the Circle “I wish I could just do my job”

The vicious circle of care engenders deep frustration among workers, who are haunted by the dysfunctions they witness and the resulting difficulties of meeting the needs of residents, whom they know better than anyone else. This project has shown that the crisis of LTC in Switzerland has deep roots in the way work is organised and assessed. In order to break this circle and meet the challenges of LTC in Switzerland (turnover and quality of care), we therefore argue that the *voice* of workers must be heard in future debates, both pertaining to working conditions *and* the organisation of care. It will be especially crucial for workers fully to play their role as "experts by experience" in the following areas:

i Allocation of time
ii Recognition
iii Organisational autonomy

Deutsch

Hintergrund und Ziele

Mit der Alterung der Schweizer Bevölkerung und der Zunahme chronischer Erkrankungen steigt die Nachfrage nach Langzeitpflege stetig an, wobei der Personalbedarf zwischen 2023 und 2033 voraussichtlich um 40% zunehmen wird (OECD, 2023). Der Sektor befindet sich jedoch bereits heute in einer Krise. Der Personalbestand kann nicht mit der Nachfrage Schritt halten, was die Bereitstellung einer qualitativ hochwertigen Pflege erschwert. So stieg die Fluktuationsrate in der Langzeitpflege von 24% im Jahr 2021 auf 28% im Jahr 2022 (BFS, 2023). Die ähnlich hohen Fluktuationsraten in den weiteren OECD-Ländern werden auf die schlechten Arbeitsbedingungen und Löhne in der Branche zurückgeführt, welche weder der Erfahrung, den Fähigkeiten und der Belastbarkeit Rechnung tragen, die für eine gute Pflege der Bewohner:innen erforderlich sind. Die Krise verschärft sich trotz verschiedener Strategien zur Abschwächung des Personalmangels durch den Rückgriff auf Care-Migrant:innen, die Schaffung von Ausbildungsanreizen oder die Einführung technologischer Hilfsmittel laufend. Die OECD stellt in ihrem Bericht Beyond Applause? Improving Working Conditions in Long-Term Care (2023) fest, dass zur Lösung der Krise der Langzeitpflege die Fragen der Arbeitsbedingungen und Löhne von den politischen Entscheider:innen durch die Förderung des sozialen Dialogs zwischen Arbeitnehmer:innen-Organisationen und den Arbeitgebern angegangen werden müssen.

In Anbetracht dieses Pflegenotstands haben wir eine Forschungslücke festgestellt: Die Perspektiven der Beschäftigten selbst auf die Herausforderungen in der Langzeitpflege werden nur ungenügend berücksichtigt. Während die Probleme der Branche bekannt sind, gibt es nur wenig Anhaltspunkte darüber, was die Beschäftigten über die strukturellen Probleme und deren Ursachen denken. Die SUPSI initiierte 2021 gemeinsam mit der Gewerkschaft Unia das Forschungsprojekt mit dem Ziel, die Perspektive der Beschäftigten auf eine «Gute Pflege» zu untersuchen. Die Hypothese war, dass die Beschäftigten selbst den Schlüssel zur Identifizierung der aktuellen Probleme in der Langzeitpflege, den schwierigen Arbeitsbedingungen und der hohen Fluktuation bei gleichzeitigen Problemen bei der Pflegequalität haben.

Methodik

Um die Sichtweise der Beschäftigten zu untersuchen, haben wir ein qualitatives und partizipatives Forschungsprojekt entwickelt. Die Methode stützt sich auf *conricerca* und die partizipative Gesundheitsforschung, bei der die Teilnehmer:innen in den Mittelpunkt der Forschung gestellt werden und eine aktive Rolle bei der Entwicklung der Leitfragen und der Diskussionsleitung einnehmen. Wir konzentrierten uns auf Beschäftigte aus Pflegeheimen, die täglich in Kontakt mit

den Bewohner:innen stehen, um so ein tiefes Verständnis für die Pflege zu erlangen. Folgende, gemeinsam entwickelte Forschungsfragen wurden untersucht:

- Was macht «Gute Pflege» aus Perspektive der Beschäftigten in Pflegeheimen aus?
- Welchen Einfluss haben die Arbeitsbedingungen auf die Pflegequalität?
- Wie beeinflusst die Arbeitsorganisation die Beziehungen zwischen Pflegenden und Bewohner:innen sowie dem weiteren Personal?

Das Projekt rekrutierte Beschäftigte aus der ganzen Schweiz, hauptsächlich mittels einer Online-Umfrage. Insgesamt wurden fünf Diskussionsgruppen (2 deutsche, 2 französische und 1 italienische) mit Beschäftigten aus Heimen gebildet, von denen drei über Zoom geführt wurden. Die Transkripte der Interviews wurden von den Interviewer:innen transkribiert und die Daten vom Forschungsteam kodiert und ausgewertet.

Ergebnisse: Der Teufelskreis der Langzeitpflege

Die Gruppendiskussionen machten deutlich, wie tiefgreifend die Krise der Langzeitpflege ist: Die Arbeitsorganisation in der Langzeitpflege wurde als eine vordefinierte Abfolge von Aufgaben mit Zeitlimits und immer weniger Handlungsspielraum und Autonomie für die Pflegenden selbst umstrukturiert. Dies schränkt die Zeit und die Möglichkeiten zum Beziehungsaufbau mit und der Sorge für die Bewohner:innen massiv ein. Die Intensivierung und Verdichtung der der Arbeit verursacht nicht nur eine grosse Belastung für die Beschäftigten, sondern auch für die Bewohner:innen, insbesondere aufgrund der damit verbundenen Rationierung der Pflege. Trotz dieser Hindernisse wurde in den Gesprächen auch deutlich, dass die Beschäftigten ihre Arbeit gerne machen und sie als Berufung betrachten, aber nur bei genügend Zeit, um ihr Fachwissen einzusetzen. Die Ergebnisse verdeutlichen den Konflikt zwischen den Pflegenden und der Arbeitsorganisation und der eine Ursache für die Krise der Langzeitpflege sein kann.

Der Kreis dreht sich: Planung trifft auf Unvorhergesehenes

Die Arbeitsorganisation in der Langzeitpflege zielt darauf ab, die Effizienz zu maximieren, um die Kosten zu senken, indem im übertragenen Sinne industrielle Produktionsformen in der Langzeitpflege angewendet werden. Zwar ist an sich nichts gegen eine Aufrechterhaltung einer finanziellen und effektivitätsorientierten Rechenschaftspflicht einzuwenden -es führt aber bei Unvorhergesehenem zu Problemen. Anders als Arbeit am Fliessband kann die Pflege eines Menschen viele Komplexitäten und Unwägbarkeiten mit sich bringen. Die Pflege eines Menschen kann selten auf eine lineare Weise erfolgen, wie es die vorgegebenen Aufgaben und die

Pflegeplanung erwarten lassen. Stattdessen sind die Arbeitnehmenden häufig zu Multitasking gezwungen, was eine Diskrepanz zwischen den Vorgaben und der Realität der Arbeit aufzeigt.

Abgesehen von der Komplexität der Pflegesituationen gibt es Unsicherheiten, die den Arbeitsrhythmus durcheinanderbringen. Ein:e Mitarbeiter:in muss schnell reagieren können, denn sie/er kann nicht einfach sagen: «Tut mir leid, ich habe nur noch vier Minuten Zeit für Sie» und gehen. In den Diskussionen wurde deutlich, dass diese Beschäftigten einer Care-Logik (Mol, 2008) oder einer Logik des Handelns folgen («auf die Bedürfnisse eingehen, sobald sie auftauchen»), die mit der kalkulierten Planung der Arbeitsabläufe in der Langzeitpflege kollidiert.

Diese ständigen Kollisionen haben Auswirkungen:

1) Die Arbeitnehmenden sind ständig überlastet, was durch die Dokumentation, die zur Aufrechterhaltung dieser Planungspraxis erforderlich ist, noch verstärkt wird.
2) Die Arbeitnehmenden sind gezwungen, die Pflege ständig zu rationieren, wodurch die Erfahrung noch wichtiger wird.

Die Beschleunigung des Kreises: Erschöpfung

Der ständige Konflikt zwischen Vorschrift und Wirklichkeit führt zu körperlichen und psychischen Erschöpfungserscheinungen. Die Diskussionsteilnehmer:innen merkten an, dass sie sich aufgrund der an sie gestellten Anforderungen seitens Bewohner:innen und Arbeitsorganisation schlecht fühlten und dass sie aufgrund der vorgeschriebenen Arbeitsabläufe keine ausreichende Pflege leisten konnten. Eine Pflegende fasst zusammen, «wenn meine Erwartungen so hoch sind, die Realität aber so weit davon entfernt ist, gehe ich jeden Abend mit gesenktem Kopf nach Hause.»

Die Folge dieser konstanten Erschöpfung ist die Zunahme von Absenzen, was eine weitere Belastung für die verbleibenden Beschäftigten darstellt. Letztendlich führt dies dazu, dass die Mitarbeitenden kündigen oder ganz aus der Branche aussteigen, was einen weiteren Teufelskreis in Gang setzt: jenen der Fluktuation. Wenn es in Pflegeheimen zu unmittelbaren Engpässen kommt, müssen Arbeitskräfte kurzfristig abgerufen werden, welche damit das Privatleben und auch bspw. die Betreuung eigener Kinder dem kurzfristigen Einsatz unterordnen müssen. In den Gruppendiskussionen wurde deutlich, dass diese Praxis eine Ursache von Müdigkeit, Stress und Frustration ist. Die Beschäftigten hatten auch das Gefühl, dass es ihnen insgesamt an Anerkennung mangelt, dass sie in dieser Hinsicht weder finanziell noch beruflich oder persönlich respektiert werden. Besonders düster sieht es für neue Arbeitnehmende aus, da sie (trotz ihrer anfänglichen Motivation) schnell die Lust an der Arbeit in der Branche verlieren. Insbesondere dann, wenn sie die Arbeitsabläufe und die daraus resultierende Erschöpfung miterleben. Dies neutralisiert die Bemühungen der (politischen) Entscheidungsträger:innen mittels Imagekampagnen die Arbeit in der Langzeitpflege als attraktiv darzustellen sowie die politische Strategie, mittels finanzieller

Beteiligung die Anzahl Abschlüsse zu erhöhen. Ein Teilnehmer bemerkte, dass in seinem Pflegeheim seit Jahren Stellen unbesetzt sind und er glaubt, dass «sie wahrscheinlich nie alle besetzt werden.»

Der Kreis vervollständigt sich: Folgen für die Bewohner:innen

Die Vervollständigung des Teufelskreises in der auf «Leistung» (durch Planung und Effizienz in der Umsetzung standardisierter Arbeitsschritte) ausgerichteten Langzeitpflege ersticken die Arbeitskräfte unter dem Zwang «widersprüchlicher Zeitlichkeiten»; die Bewohner:innen erleben eine langsam verlaufende Zeit, welche durch den Stress der Beschäftigten beeinträchtigt wird. Das Ergebnis ist eine geringere Pflegequalität, die auf den Zeitmangel und den Stress der Mitarbeitenden zurückzuführen ist. Dadurch wird Beziehungsarbeit verunmöglicht, obwohl die Bewohner:innen alltägliche Interaktionen, auch banale, suchen und schätzen (sie leben schliesslich in einem Pflegeheim und nicht in einem Spital). Die Beziehungsarbeit ermöglicht es den Pflegekräften auch, Vertrauen aufzubauen: denn «Zeit und Beziehungen sind die Grundlage einer guten Pflege.» Dies wird umso dringlicher, als immer mehr Menschen mit kognitiven Erkrankungen (z.B. Demenz) in Pflegeheimen leben. Diese können sich bei fehlender menschlichen Interaktionen noch verschlimmern.

Die Kombination aus Fluktuation und Absentismus in Verbindung mit der restriktiven Arbeitsorganisation macht es jedoch schwierig, stabile und gesunde Beziehungen aufzubauen. Wie ein Teilnehmer sagte, «geht es bei guter Pflege nicht nur darum, einen Körper am Leben zu erhalten.» Diese Sichtweise führt zu einer Frage, über die man in der Langzeitpflege nachdenken sollte: Müssten die Lebensqualität und die Wünsche der Bewohner:innen nicht stärker in den Vordergrund gestellt werden als die im Moment sehr präsenten medizinischen Vorgaben? So wie ein Pflegeheim keine Fabrik ist, ist es auch kein Spital, und die Arbeitsorganisation muss dem Rechnung tragen.

Den Teufelskreis durchbrechen «Ich wünschte, ich könnte einfach meine Arbeit machen»

Der Teufelskreis der Langzeitpflege beschreibt ein tiefes Problem: Die Beschäftigten sind menschlich bestürzt und grundlegend unzufrieden mit der Arbeitsorganisation. Die Mitarbeitenden leiden unter der Dysfunktionalität des Systems und den daraus resultierenden Schwierigkeiten, den Bedürfnissen der Bewohner:innen, die sie besser kennen als jede:r andere. Um diesen Kreislauf zu durchbrechen und die Herausforderungen der Langzeitpflege in der Schweiz (Fluktuation und Qualität der Pflege) zu bewältigen, muss die Stimme dieser Beschäftigten in die künftigen Debatten über die Arbeitsbedingungen und die Organisation der Pflege miteinbezogen werden. Das Forschungsprojekt hat gezeigt, dass die Krise der Langzeitpflege in der Schweiz tief in der Art und

Weise verwurzelt ist, wie die Arbeit organisiert und bewertet wird, und dass es von entscheidender Bedeutung ist, die Stimme der Arbeitnehmenden in folgenden Bereichen einzubeziehen:

i) Bei der Definition der für Pflege- und Betreuungsarbeit vorgesehenen Zeit
ii) Der Anerkennung der Arbeit
iii) Der Definition der Autonomie der Beschäftigten in ihrer Arbeit

Français

Contexte et objectifs du projet

Avec le vieillissement de la population suisse et l'augmentation des maladies chroniques, la demande de soins de longue durée ne cesse de croître, les besoins en main-d'œuvre devant augmenter de 40 % entre 2023 et 2033 (OCDE, 2023). Toutefois, le secteur est déjà en crise, car le personnel manque pour répondre à la demande, ce qui rend difficile la fourniture de soins de qualité. Le taux de rotation des soins de longue durée est ainsi passé de 24 % en 2021 à 28 % en 2022 (BFS, 2023). Des taux de rotation similaires dans les pays de l'OCDE ont été attribués aux mauvaises conditions de travail et aux bas salaires qui ne reconnaissent pas l'expérience, les compétences et la résilience nécessaires pour fournir de bons soins aux résident-es. La crise persiste en dépit de la mise en œuvre de stratégies s'appuyant sur la technologie, l'immigration et les mesures d'incitation à la formation. L'OCDE affirme, dans le rapport Beyond Applause? Improving Working Conditions in Long-Term Care (2023), que pour résoudre la crise, les décideurs politiques doivent s'attaquer à ces questions de conditions de travail et de salaires en encourageant le dialogue social avec les travailleurs.

Face à cette crise des soins, nous avons identifié une lacune dans les recherches existantes, qui n'ont pas analysé le point de vue des salarié-es sur les défis rencontrés dans les EMS. Si les problèmes du secteur sont bien connus, il existe ainsi très peu de données sur ce que les hommes et les femmes qui travaillent avec les résident-es pensent de ceux-ci, et de leur origine. SUPSI a ainsi lancé une recherche avec Unia en 2021 dans le but d'explorer le point de vue des salarié-es sur ce qui constitue de bons soins, au sens large de care. Notre hypothèse est que ces dernier-ères peuvent détenir la clé pour identifier les dysfonctionnements qui contribuent aux mauvaises conditions de travail, à la rotation du personnel et au rationnement des soins.

Méthode de recherche

Nous avons élaboré un projet de recherche qualitatif et participatif pour recueillir les points de vue des salarié-es des EMS. Cette méthode s'inspire de la conricerca et de la recherche participative en santé, où les participant-es sont placés au cœur de la recherche pour codévelopper les questions et mener les discussions. Nous nous sommes concentrés sur les salarié-es qui interagissent avec les résident-es au quotidien, afin d'acquérir une compréhension approfondie du travail de care dans les EMS. Les questions de recherche élaborées conjointement pour guider les discussions sont les suivantes :

- Qu'est-ce qui constitue de "bons soins" du point de vue des salarié-es ?
- Comment les conditions de travail influencent-elles la qualité des soins ?

- Comment la manière dont les soins sont organisés affecte-t-elle les relations avec les résident-es et les autres membres du personnel ?

Nous avons décidé d'axer la recherche sur les salarié-es qui interagissent quotidiennement avec les résidents, afin d'acquérir une compréhension approfondie du travail de care dans les établissements médico-sociaux. Le projet a recruté des salarié-es dans toute la Suisse, principalement par le biais d'une enquête en ligne. Au total, 5 groupes de discussion ont été formés (2 allemands, 2 français et 1 italien), dont 3 ont été menés sur Zoom. Les entretiens ont été menés, transcrits et vérifiés par les co-chercheurs, et les données ont été codées et analysées par l'équipe de recherche.

Résultats : le cercle vicieux des soins

Les discussions ont mis en évidence la complexité du problème : l'organisation du travail dans les EMS a été restructurée autour de tâches prédéfinies de manière standardisée, ce qui réduit le temps et la capacité des salarié-es à s'occuper des résident-es. Cette intensification du travail est source de souffrance non seulement pour les salarié-es, mais aussi pour les résident-es, en particulier à travers le rationnement des soins qu'elle impose aux soignant-es. Malgré ces difficultés, les discussions ont révélé que les salarié-es aiment profondément leur travail et le considère comme une vocation, mais seulement lorsqu'iels ont le temps de déployer leur expertise. Les résultats illustrent les tensions dans les EMS entre les salarié-es et l'organisation du travail, qui pourrait être à l'origine de la crise des soins.

Là où commence le cercle vicieux : la planification face à l'imprévu

L'organisation du travail dans les EMS cherche à maximiser l'efficacité pour réduire les coûts, ce qui revient en quelque sorte à appliquer le temps de la production industrielle à une maison de retraite. Bien qu'il n'y ait rien de mal en soi à contrôler les dépenses, les problèmes se posent lorsque le travail résiste à la planification. Contrairement à la production à la chaine, la prestation de soins à un être humain peut comporter de nombreuses incertitudes, et constitue un processus relationnel délicat. La complexité des soins prodigués à un être humain ne peut souvent pas être exécutée de manière linéaire, comme le prévoient les tâches prédéfinies. Au contraire, les salarié-es exécutent souvent plusieurs tâches en même temps, ce qui met en évidence un décalage entre ce qui est prescrit et la réalité du travail. Au-delà des complexités, il y a les imprévus qui surviennent souvent et modifient le rythme de travail. Une soignante doit réagir rapidement ; comme l'a fait remarquer une participante, il n'est bien sûr pas possible de dire "désolé, il ne me reste que 4 minutes pour vous" et partir. Les discussions ont montré que les salarié-es sont guidé-es dans leur travail par la logique du care (Mol, 2008), qui est une logique d'action (« répondre aux besoins quand ils émergent

»), qui entre en conflit avec la planification calculée du travail dans les EMS. Ce conflit permanent a plusieurs conséquences :

1) Les salarié-es sont constamment surchargé-es, ce qui est amplifié par la charge de documentation requise pour alimenter la planification ;
2) Les salarié-es sont contraint-es de rationner constamment les soins (souvent implicitement, "sur le moment") ; l'expérience est un atout précieux à cet égard, mais lorsque les salarié-es n'en ont pas, ils souffrent des choix qu'iels doivent faire.

Quand le cercle vicieux s'exacerbe avec l'épuisement

Au fur et à mesure que les salarié-es font l'expérience du conflit entre les prescriptions et la réalité dans leur travail, les effets de l'épuisement commencent à se faire sentir, à la fois physiquement et mentalement. Les participant-es aux groupes de discussion ont déploré le fait qu'iels se sentaient mal à cause des exigences qui leur étaient imposées, qui les empêchaient de fournir suffisamment de soins en raison du flux de travail prescrit. Une infirmière a résumé la situation en ces termes :

"Lorsque mes attentes sont si élevées, mais que la réalité en est si éloignée, je rentre chez moi tous les soirs la tête basse".

Un des effets préoccupants de cet épuisement est l'augmentation des absences parmi les salarié-es, ce qui accroît la pression sur les présent-es. En fin de compte, cela peut conduire les salarié-es à quitter l'EMS ou à quitter complètement le secteur, ce qui enclenche un autre aspect du cercle vicieux : le taux du roulement du personnel. Lorsque les EMS sont confrontés à ces pénuries immédiates, ils demandent à d'autres salarié-es de venir travailler au pied levé, au détriment de leurs propres responsabilités de care vis-à-vis de leur famille. Les discussions de groupe ont montré que cette pratique était une source de fatigue, de stress et de frustration. Les salarié-es ressentent plus largement un manque de reconnaissance, que ce soit sur le plan financier, professionnel ou personnel. La situation est particulièrement difficile pour les plus jeunes, qui sont rapidement désenchanté-es par le travail de soins (malgré leur motivation initiale) lorsqu'iels font l'expérience de la charge de travail épuisante. Les départs fréquents qui en résultent mettent en évidence les limites de la stratégie de promotion des emplois dans les soins (par exemple via le soutien à la formation) : à quoi sert la formation si les nouveaux salarié-es n'arrivent pas à tenir ? Une participante a fait remarquer qu'il y avait des postes vacants dans son EMS depuis des années et qu'elle pensait "qu'ils ne seraient probablement jamais tous pourvus".

Au bout du cercle vicieux : l'impact sur les résidents

Lorsqu'on suit ce cercle vicieux jusqu'au bout, on observe que le secteur des EMS est axé sur la "performance" (via la planification et l'efficacité dans la réalisation de tâches standardisées) et étouffe une main-d'œuvre soumise à la contrainte de "temporalités contradictoires" ; les résident-es des EMS vivent en effet un temps qui s'écoule lentement, et qui est heurté par le stress des salarié-es. Il en résulte en fin de compte une diminution de la qualité des soins prodigués aux résident-es, en raison du manque de temps et du stress subi par les travailleurs. Cette situation évince généralement le temps nécessaire pour le travail relationnel, malgré le fait que les résident-es apprécient les interactions sociales, même banales, qui leur sont nécessaires (iels vivent après tout dans les EMS, qui ne sont pas des hôpitaux). Le travail relationnel permet également au personnel soignant d'établir la confiance nécessaire à la réalisation des soins, car "le temps et les relations sont la base d'une bonne prise en charge". Cela devient d'autant plus urgent que de plus en plus de personnes entrent dans les EMS avec des troubles cognitifs (comme la maladie d'Alzheimer), qui tendent à s'aggraver quand manquent les interactions humaines.

Cependant, la combinaison du turnover et de l'absentéisme avec l'organisation du travail rend difficile l'établissement de relations stables et saines. Comme l'a déclaré une participante, "les bons soins ne consistent pas seulement à maintenir un corps en vie". Cette perspective conduit à une réflexion fondamentale sur les soins de longue durée : faut-il rééquilibrer l'attention portée à la qualité de vie et aux souhaits des résident-es, alors que l'accent est actuellement mis de manière explicite sur les aspects médicaux ? Si un EMS n'est pas une usine, il n'est pas non plus un hôpital, et l'organisation du travail doit en tenir compte.

Briser le cercle vicieux : "J'aimerais pouvoir me contenter de faire mon travail"

Ce que ce cercle vicieux des soins a mis en évidence, c'est que l'organisation du travail dans les EMS génère un profond désarroi parmi les salarié-es des EMS. Celles et ceux-ci sont hantés par les dysfonctionnements dont ils sont témoins et par les difficultés qui en résultent pour répondre aux besoins des résident-es, qu'iels connaissent mieux que quiconque. Pour briser ce cercle et relever les défis des soins de longue durée en Suisse (turnover et qualité des soins), la voix de ces salarié-es doit être incluse dans les futurs débats concernant les conditions de travail et l'organisation des soins. Alors que projet a permis d'identifier que la crise des soins de longue durée en Suisse a des racines profondes dans la manière dont le travail est organisé et évalué, il sera crucial d'inclure la voix des salarié-es dans les domaines suivants afin de leur permettre d'assumer pleinement leur rôle d'"experts par expérience" :

i) l'allocation du temps
ii) la reconnaissance du travail
iii) l'autonomie organisationnelle

Italiano

Contesto e obiettivi del progetto

Con l'invecchiamento della popolazione svizzera e l'aumento delle malattie croniche, la domanda di cure di lunga durata è in continua crescita e si prevede un incremento del 40% nel fabbisogno di personale tra il 2023 e il 2033 in Svizzera (OCSE, 2023). Tuttavia, il settore si trova già in una crisi con personale insufficiente a soddisfare la domanda, rendendo difficile fornire cure di alta qualità; il tasso di turnover in Svizzera è salito dal 24% nel 2021 al 28% nel 2022 nelle case per anziani (BFS, 2023). Tassi di turnover simili nei Paesi OCSE sono stati attribuiti alle cattive condizioni di lavoro e ai bassi salari che non riconoscono adeguatamente l'esperienza, le competenze e la resilienza necessarie per garantire cure di qualità ai residenti. La crisi persiste nonostante l'attuazione di strategie basate su tecnologia, immigrazione e incentivi alla formazione. Nel suo rapporto *Beyond Applause? Improving Working Conditions in Long-Term Care* (2023), l'OCSE afferma che, per risolvere la crisi, i responsabili politici devono affrontare le questioni delle condizioni di lavoro e di retribuzione, promuovendo il dialogo sociale con i lavoratori.

Di fronte a questa crisi del settore delle cure di lunga durata, abbiamo individuato una lacuna nella ricerca esistente, che non ha ancora analizzato il punto di vista dei dipendenti sulle sfide affrontate nelle Case per anziani (CpA). Mentre i problemi del settore sono ben noti, ci sono pochi dati su cosa ne pensano gli uomini e le donne che lavorano con i residenti. La SUPSI ha quindi avviato un progetto di ricerca con Unia nel 2021, con l'obiettivo di esplorare il punto di vista dei dipendenti su ciò che costituisce una buona cura, nel senso ampio più del termine. La nostra ipotesi è che i dipendenti possano avere la chiave per identificare le disfunzioni che contribuiscono ad un vero e proprio circolo vizioso, iniziando dalle cattive condizioni di lavoro, passando attraverso la rotazione del personale e giungendo al razionamento delle cure.

Metodo di ricerca

Abbiamo sviluppato, con la nostra collega della Berner Fachhochschule (BFH), Prof. Dr. Karin van Holten, un progetto di ricerca qualitativa e partecipativa per raccogliere i punti di vista dei dipendenti delle CpA. Questo metodo è stato ispirato dalla *conricerca* e dalla ricerca sanitaria partecipativa (*Participatory health research*), in cui i partecipanti sono posti al centro della ricerca, co-sviluppando le domande e guidando le discussioni. Abbiamo dunque sviluppato le nostre domande di ricerca insieme a un gruppo di dipendenti e sindacalisti che hanno giocato il ruolo di co-ricercatori :

- Cosa si intende per "buone cure" dal punto di vista del personale?
- Come le condizioni di lavoro influenzano la qualità delle cure?

- In che modo l'organizzazione delle cure influisce sulle relazioni con i residenti e il personale?

Abbiamo deciso di focalizzare la ricerca sui dipendenti che interagiscono quotidianamente con i residenti, al fine di ottenere una comprensione approfondita del lavoro di cura nelle CpA. Il progetto ha reclutato i dipendenti in tutta la Svizzera, principalmente attraverso un sondaggio online. In totale sono stati organizzati 5 focus group (2 in tedesco, 2 in francese e 1 in italiano), di cui 3 condotti su Zoom. Le interviste sono state condotte, trascritte poi verificate dai co-ricercatori, mentre i dati sono stati codificati e analizzati dal team di ricerca.

Il circolo vizioso delle cure di lunga durata

Le discussioni hanno evidenziato la complessità del problema: l'organizzazione del lavoro nei sistemi sanitari è stata ristrutturata attorno a compiti predefiniti e standardizzati, i quali riducono il tempo e la capacità dei dipendenti di prendersi cura dei residenti. Questa intensificazione del lavoro è fonte di sofferenza non solo per i dipendenti, ma anche per i residenti, in particolare a causa del razionamento delle cure che essa impone al personale di cura. Nonostante queste difficoltà legate alla nuova organizzazione del lavoro, dai colloqui è emerso che i dipendenti amano profondamente il loro lavoro, ma solo quando hanno il tempo di mettere in campo le loro competenze. I risultati evidenziano le tensioni presenti nelle CpA tra i dipendenti e l'organizzazione del lavoro, che potrebbero essere alla base della crisi dell'assistenza.

Dove inizia il circolo vizioso: la pianificazione di fronte all'imprevisto

Il modo in cui il lavoro è organizzato nelle CpA cerca di massimizzare l'efficienza per ridurre i costi, il che equivale in un certo senso ad applicare il tempo della produzione industriale a una casa per anziani. Benché la gestione attenta delle spese non sia intrinsecamente sbagliata, emergono problemi quando tale strutturazione si scontra con la natura del lavoro. A differenza della produzione in catena di montaggio, la cura a un essere umano è un processo relazionale delicato e può comportare molti imprevisti. La complessità delle cure spesso non può essere svolta in modo lineare, come previsto da compiti predefiniti. Al contrario, i dipendenti svolgono più compiti contemporaneamente, evidenziando una discrepanza tra ciò che ci si aspetta e ciò che è richiesto.

Alle complessità si aggiungono gli imprevisti che spesso si verificano e che cambiano il ritmo di lavoro. Un dipendente deve reagire rapidamente; come ha sottolineato un partecipante alle nostre discussioni, non si può semplicemente dire "mi dispiace, ho solo quattro minuti per lei" e andarsene, anche se un residente richiede maggior tempo di cura. Dalle discussioni organizzate nell'ambito dei gruppi di discussione è emerso che i dipendenti sono guidati nel loro lavoro dalla *logic of care* (Mol, 2008), la quale è una modalità di azione orientata a "rispondere ai bisogni nel momento in cui si

presentano". Questa logica entra in conflitto con la pianificazione calcolata del lavoro tipica dei sistemi di emergenza. Questo conflitto permanente ha diverse conseguenze:

1. I dipendenti sperimentano un costante sovraccarico, accentuato dalla mole di documentazione necessaria per alimentare il processo di pianificazione.
2. I dipendenti sono costretti a razionare continuamente le cure, spesso in modo implicito e "sul momento". L'esperienza si rivela preziosa in queste situazioni, ma quando i dipendenti ne sono privi, si trovano a confrontarsi con decisioni difficili e sofferte.

Quando il circolo vizioso è aggravato dalla stanchezza

Quando i dipendenti sperimentano il conflitto tra prescrizioni e realtà nel loro lavoro, gli effetti dell'esaurimento iniziano a manifestarsi, sia a livello fisico che mentale. I partecipanti ai gruppi di discussione esprimevano disagio a causa delle richieste imposte, che ostacolavano la loro capacità di fornire delle cure adeguate a causa del flusso di lavoro prescritto. Un'infermiera ha riassunto la situazione dicendo:

"Quando le mie aspettative sono così alte, ma la realtà è così lontana da esse, vado a casa ogni sera a testa bassa".

Uno degli effetti preoccupanti di questo esaurimento è l'incremento delle assenze tra i dipendenti, con conseguente aumento della pressione sui presenti. In ultima analisi, ciò può portare i dipendenti a lasciare la CpA o a lasciare del tutto il settore, innescando un altro aspetto del circolo vizioso: il turnover del personale. Quando le CpA si trovano di fronte a queste carenze immediate, chiedono ad altri dipendenti di intervenire con breve preavviso, a scapito delle proprie responsabilità di cura nei confronti delle famiglie. Dalle discussioni nei gruppi di discussione è emerso che questa pratica è fonte di stanchezza, stress e frustrazione. Più in generale, i dipendenti vi percepiscono una mancanza di riconoscimento, sia finanziario che professionale o personale. La situazione è particolarmente difficile per i giovani, che si disamorano rapidamente del lavoro di cura, quando sperimentano l'estenuante carico di lavoro, nonostante la motivazione iniziale. I frequenti abbandoni che ne derivano evidenziano i limiti della strategia di promozione dei posti di lavoro nelle cure (ad esempio attraverso il sostegno alla formazione): a cosa serve la formazione se i nuovi dipendenti non riescono a tenere il passo? Una partecipante ha sottolineato che nella sua CpA c'erano posti vacanti da anni e che "probabilmente non sarebbero mai stati occupati tutti".

Alla fine del circolo vizioso: l'impatto sui residenti

Se seguiamo questo circolo vizioso fino alla fine, vediamo che il settore delle CpA è focalizzato sulla "performance" (attraverso la pianificazione e l'efficienza nello svolgimento di compiti standardizzati) e soffoca una forza lavoro soggetta alla costrizione di "temporalità contraddittorie"; i residenti sperimentano un tempo che passa lentamente, influenzato negativamente dallo stress dei dipendenti. Il risultato finale si traduce in una riduzione della qualità delle cure fornite ai residenti, dovuta alla mancanza di tempo e allo stress subito dai lavoratori. Questa situazione solitamente priva il personale del tempo necessario per il lavoro interpersonale, nonostante i residenti apprezzino le interazioni sociali, per quanto banali, che sono essenziali per la loro esperienza in CpA, che non è un ospedale. Il lavoro relazionale consente inoltre al personale di stabilire la fiducia necessaria per fornire cure, perché "il tempo e le relazioni sono la base di una buona assistenza". Questo aspetto sta diventando sempre più urgente, dato che sempre più persone entrano nelle CpA con problemi cognitivi (come il morbo di Alzheimer), che tendono a peggiorare quando manca l'interazione umana.

Tuttavia, la combinazione di elevato turnover e assenteismo del personale, unita all'organizzazione del lavoro, complica la creazione di relazioni stabili e salutari. Come ha affermato un partecipante, "una buona cura non consiste solo nel mantenere in vita un corpo". Questa prospettiva porta a una riflessione fondamentale sulle cure di lunga durata: è necessario riequilibrare l'attenzione alla qualità della vita e ai desideri dei residenti, considerando che attualmente l'accento è posto esplicitamente sugli aspetti medici? Se una CpA non può essere assimilata a una fabbrica, allo stesso modo non può essere paragonata a un ospedale.

Rompere il circolo vizioso: "Vorrei poter fare il mio lavoro"

Il circolo vizioso delle cure ha messo in evidenza che l'organizzazione del lavoro sta generando un profondo disagio tra i dipendenti, tormentati dalle disfunzioni a cui assistono e dalle conseguenti difficoltà nel soddisfare i bisogni dei residenti, che conoscono meglio di chiunque altro. Per spezzare questo circolo e affrontare le sfide delle cure di lunga durata in Svizzera, come turnover e qualità dell'assistenza, la voce di questi dipendenti deve essere inclusa nei futuri dibattiti sulle condizioni di lavoro e sull'organizzazione delle cure. Sebbene il progetto abbia individuato che la crisi ha radici profonde nel modo in cui il lavoro è organizzato e valutato, sarà fondamentale includere la voce dei dipendenti nelle seguenti aree per consentire loro di assumere pienamente il ruolo di "esperti per esperienza":

i) assegnazione del tempo
ii) riconoscimento del lavoro
iii) autonomia organizzativa

Introduction

Many countries began to see the structural deficits in the long-term care (LTC) sector as their facilities were being ravaged by the Covid-19 pandemic, creating unbearable situations for workers and residents. While Covid certainly made things worse, it would be foolish to treat it as an isolated accident; the crisis of institutional LTC is structural and takes on similar traits across different parts of the world, as was excruciatingly illustrated by a much-publicised inquiry into the corporate giant Orpéa (Castanet, 2022). This report explores the perspective of frontline staff (those who are in direct contact with residents) on the daily functioning of Swiss long-term residential care facilities (LTRCFs)[1] and on what constitutes good care – as well as the obstacles they face in providing it. Although home-based carers make a crucial contribution to elder care in Switzerland as well as globally, we did not research their situation in this report; these workers face peculiar challenges (Poo, 2013 that are different from institutional care.

The crisis of institutional LTC is first and foremost a personnel crisis (OECD, 2023). Medical research has shown that cutting ratios of nursing staff to residents adversely affects quality of care, which is typically measured through a series of medical indicators (Perruchoud *et al*., 2022). And yet, under-staffing is endemic; far from getting better, it keeps increasing as more and more experienced workers resign, unable to cope with harsh conditions and with their disappointment at the level of care provided. Their frustration, which will be a guiding theme in this report, is a direct consequence of their unwavering (and often selfless) commitment to the welfare of the residents under their watch. While it is possible to cope with long and disruptively scheduled hours, work becomes unbearable when its meaning (caring for residents and upholding their fragile dignity) dissolves in a series of systemic failures that workers often perceive to be their own. This is in no small part because workers in LTC are painfully aware that those they care for lack a voice, precisely because they are vulnerable, often afflicted with cognitive problems, and isolated from the rest of society and, often, from other residents[2].

The starting point of this research report is therefore that there are no easy fixes to the crisis of long-term care; if we hope to solve it, we must understand what is happening within institutions. To do this, we need to speak to those who provide care; in (LTRCFs), care is provided by medical-technical staff, such as nurses and nursing assistants, but also by cleaners (who spend more and more time talking to residents, since medical staff have less time for this (Müller et al., 2018)), social workers, as well as cooks. Think about what it means to cook in a care home: every day, you must prepare endless variations of meals to respond to complex individual conditions, from gluten

[1] We will use the terms LTRCF, nursing home, and care home interchangeably throughout this report
[2] On the perspective of residents on LTRCFs, see Eribon (2023), Lambelet *et al.* (2022) and Holder (1987).

intolerance to tongue cancer, some hot, some cold, some liquid, all the while seeking to offer tasty meals to residents for whom food is an important (sometimes the only) source of pleasure.

The invisibility of care work

Throughout the 20th century, with rapidly growing ageing populations, elder care has become an increasingly specialised activity. This reflects, on the one hand, important progress in our understanding of both physical and psychological care needs but also, on the other hand, the (sometimes grudging) acceptance by the state that the rising burden of care cannot be carried by family members alone. While elder care remains mostly performed by female family members in many countries, the growing entry of women into the labour market has led to the development of both paid home carers and of long-term care institutions. The neoliberal era, with its undermining of public welfare financing, has however wreaked havoc for family carers; as Federici (2012: 239-240) points out:

> (…) the transfer of much hospital care to the home, a move motivated by purely financial concerns and carried out with little consideration given to the structures required to replace the services the hospitals used to provide (…) has not only increased the amount of care-work that family members, mostly women, must do. It has also shifted to the home "dangerous" and even "life threatening" operations that in the past only registered nurses and hospitals would have been expected to perform.

The policy emphasis in many countries (including in Switzerland) on promoting home rather than institutional care therefore appears in a contradictory light. While the official reason is that this corresponds to the aspirations of the elderly, the true driver may well be to limit the rising costs associated with the caring needs of an expanding elderly population. Indeed, professional care workers have also been negatively affected by neoliberal reforms, as Federici (*ibid*., 240) continues:

> At the same time, subsidized home-care workers have seen their workload double, while the length of their visits has increasingly been cut forcing them to reduce their jobs "to household maintenance and bodily care." (Boris and Klein: 180) Federally financed nursing homes [in the US] have also been taylorized, "using time-and-motion studies to decide how many patients their workers can be expected to serve." (Glazer, 1993: 174)

The taylorisation of care work identified by Glazer (1993) in her pioneering research has, as we will show in this report, spread from the US to the rest of the world. Paid care work is not only extremely demanding, but also tends to be paid badly, especially for live-in carers (Schwiter *et al*., 2018) and for those who do not have advanced medical qualifications, who make up the majority

of LTC staff. This constitutes a paradox, since the demand for care work is greater than supply (workers available to do the work): why are wages not increasing, then? There are two main explanations for this: the first is that the wages are sticky because supply and demand are not the only factors determining wage levels. One key driver is the interaction between employers and workers; while labour shortage represents a potential advantage for workers to secure better conditions (as it affords them 'market power'), actualising this potential depends on their collective organisation and ability to leverage the power resources at their disposal (Schmalz *et al*., 2018). Employers will keep wages low if they can, especially in the private sector where their profits often depend on the level of wages. This is particularly exacerbated in care, where labour accounts for an overwhelming share of total costs.

The second explanation has to do with the specific situation of care labour. To understand why care workers sometimes find it difficult to mobilise to defend their interests, but also why society appears reluctant to value care work more, it is useful to build on the insights of feminist scholars such as Fraser (2022), who shows how care labour has been systematically devalued and invisibilised. Despite efforts by certain groups (most prominently nurses) to demonstrate the complex, specialised character of their work, care labour, both paid and unpaid, remains considered as a type of work that has an almost "natural" character for women. The corollary is that, in care as in other female-dominated jobs, wages tend to be lower than in predominantly male-dominated jobs. In Switzerland, women thus make up a much greater part of low-wage earners than men (Federal Statistical Office, 2022). Moreover, like other personal services sector, care suffers from Baumol's (1993) cost disease: this means that productivity does not increase as much as in other sectors, such as manufacturing. Baumol identifies two main reasons for this: due to the relational nature of work, the scope for productivity growth through scientific work organisation and automation is limited, making it difficult to standardize the labour process. Secondly, and crucially for care work, the quality of work is intimately tied to the intensity of personal contact, making it impossible to improve or even maintain quality when increasing, for instance, the ratio of residents per care staff.

As a result of the cost disease, growing demand for personal services such as care results in growing staff needs and rising relative costs. Baumol however argues that the cost disease is not so much an economic problem, as society can afford to spend more on personal services owing to rising productivity elsewhere, as a *political* issue. Society will resist the prospect of having to dedicate a growing proportion of resources to such services; this is visible in the strategies explored to respond to the crisis of LTC discussed below. Perhaps surprisingly given their very different perspectives, Baumol's argument thus supports Federici (2012)'s insistence on the necessity to *politicise* discussions on the future of elder care. This entails acknowledging that the major challenges that make up the crisis of care cannot be solved solely through an economic and technical lens, by adjusting organisational processes and limiting cost increases. If a major shift is necessary, it is crucial for those who provide care to make their voice heard on the future of care.

For a start, low wages in LTC, whose workforce is mostly female, are unlikely to increase without a collective push to recognise the professional character of elder care work, as well as its social importance. Overcoming the political reluctance to increase public spending is a particularly acute challenge in Switzerland, where debt brake mechanisms have been adopted in numerous cantons. As we argue in this report, spending more will however not be enough to address the crisis of LTC. The way that care is organised contributes to the frustration of many workers; to address this, as well as employment conditions, will require strengthening the collective organisation and bargaining capacity of care workers. This is how nurses have managed, over decades, to conquer respect and secure better conditions (on the US experience, see Budd *et al.* 2004). As cost saving measures increasingly entail reducing the number of nurses in LTRCFs (simultaneously increasing the number of nursing assistants), it will be critical for broad alliances to emerge that mobilise all workers involved in delivering care. With this research, we hope to contribute to these efforts by making visible the complexity, skilfulness and intensity of elder care work.

Going beyond the current solutions

The urgency to develop worker-centred responses to the crisis of care becomes even more striking when considering the two solutions that are commonly proposed as ways to solve the crisis of long-term care. These solutions – immigration and robotisation – effectively aim to increase the supply of labour available to work *without* raising wages; however, neither can offer sustainable solutions. Immigration creates an unfair competition where the wealthiest countries will attract or rather *extract* care workers from less wealthy countries, a phenomenon referred to as emotional imperialism (Hochschild, 2002). This creates a twofold care deficit where these workers cannot work in care in their countries while also not being able to care for any dependants at home. As a result, many countries are developing strategies to retain these workers (as is the case for all of Switzerland's neighbours) as the demand will only continue to increase.

The second proposed solution, the automation of care through the use of robots, is often viewed as the future, with many observers keenly focusing on the Japanese experience. Japan is often discussed in debates on LTC due to its large senior population, low immigration, and high standard of living demands. Given these factors and its industrial experience in complex machinery, Japan looked towards robots as the solution to rising senior care needs. However, Wright (2023) argues that Japan's use of robots in LTC for medical-technical tasks and companionship did not produce satisfactory results for the residents. Moreover, robots did not allow to reduce staffing; ironically, workers had to refocus away from caring for residents to caring for the robots, which required maintenance. Worryingly, automation could still be viewed as a viable option for the future, given that the workers maintaining the robots require lower technical and language skills.

Both of these proposed solutions share a common focus on squeezing the cost of labour; they are also clearly not sustainable solutions to the core problems of the LTC sector. There is, in

other words, a pressing need for fresh thinking and perspectives on the ways to address a crisis that, if current trends are to continue, could become a major societal challenge of the future. In our research, we have sought to explore the perspective of frontline LTRCF workers on what constitutes quality of care, thereby making an original contribution to the academic and policy debates on the sector. More specifically, we have sought to answer the following three research questions through group discussions held in all three linguistic regions of Switzerland:

- What constitutes "good care" from the point of view of workers?
- How do working conditions influence the quality of care?
- How does the way care is organised affect workers' relationships with residents and other staff?

This report was commissioned by Unia to inform its strategy for the sector but it has broader relevance for the workers and organisations involved in LTC, as well as the scientific community and policy makers. We hope to contribute to the dynamic debates about the future of LTC in Switzerland, while highlighting the value of putting workers' perspectives at the centre of future policy. This is a particularly exciting time to be engaging with these debates, as there is currently a drive to develop new criteria to determine quality of care in Swiss LTC (Curaviva, 2023). It should be noted that our research does not attempt to capture a causal relationship between working conditions and quality of care. Instead, we aim to complement and inspire other research by exploring the perspective of staff on the organisation of institutional care work.

The report is structured as follows: we first present our conceptual framework, focusing on the role of marketisation and new public management in the restructuring of long-term care, and on how work is organised and evaluated, and highlight the resulting dilemma for care workers. We then present our participatory and qualitative research approach, the way we collected and analysed data and the limitations of our method. The perspectives of workers are then presented; we show how care work is caught in a vicious circle, whose consequences we map both for workers and residents, stressing the need to improve the recognition of the workers' central role in care provision. We then conclude the report, reflecting on the prospects for future research, the challenges for LTC and the possible role trade unions can play in addressing them by making the voices of workers heard.

1. Conceptual Framework

1.1 Introduction

The aim of this section is to analyse trends in long-term care, with a particular focus on Switzerland. It begins with an overview of the current state of long-term care in OECD countries and projections of future demand **(1.2)**. This will provide the context for outlining future challenges based on the demographic changes that these countries are facing, which will be compared with the situation in Switzerland. After this overview of the sector, the financing of LTRCFs**,** will be explored, along with insights into the marketisation of the sector, which is a direction many governments are taking to address future challenges **(1.3**). In addition to other cost-saving measures such as the Swiss government's strategy of expanding home care provisions.

We then turn to the implementation of New Public Management (NPM) in LTC management. The concept covers different realities depending on the context; we will here focus on NPM in health care systems and how it has been applied to long-term care **(1.4)**.

We then zoom in on the transformation of care work within institutions, outlining how (industrial) time management strategies have been transferred to service sectors, and the impact this has had for workers. This impact includes deskilling, subcontracting and the role of activity-based funding. Workers' perceptions of not having enough time, lack of autonomy and recognition will be discussed in this sub-section. Particular attention will be paid to how they use the emotional element of their position **(1.5)**.

The final section will explore opportunities available to workers to respond to these challenges, highlighting the role civil society actors and trade unions can play if they become further involved in promoting better work for good care (1.6).

1.2 Increasing demand and turnover: The staffing crisis in LTC

The staffing in LTC has been gaining attention in the political sphere as policy makers prepare to face growing demand with a shrinking available workforce. It is now accepted to talk of a crisis, as evidenced by the recent OECD (2023) report titled: *Beyond Applause? Improving Working Conditions in Long-Term Care*.

1.2.1 Overview and projections

Long-term care has been a continually expanding sector of the economy, with expectations of exponential growth over the next two decades due to the rapid growth of the 65+ population in societies, represented in Table 1.

Table 1

Projected increase in 60+ and 80+ population in EU, 2020 and 2050 (millions) and the Old-Age Dependency Ratio (65+ per 100 people aged 20 to 64)

	2020	**2050**	**Increase**
65+ population	92.1	130.2	41%
80+ population	26.6	49.9	88%
Old Age Dependency Ratio	32	52	62%

Source: Authors' calculation based on European Commission (2021)

As a result, the old-age dependency ratio[3] is projected to increase by 62%, from 32 in 2020 to 52 in 2050. This trend will continue as healthcare outcomes continue to improve and fertility rates decrease or remain stagnant (OECD, 2020). Overall, these projections suggest that the resident demand for long-term care will increase from 30.8 million people in 2019 to 33.7 million in 2030 and 38.1 million in 2050 in the EU-27 (European Commission, 2021).

The increase of demand for long-term care by this aging population is leading to a large increase in staffing demands, given the "cost disease" that characterises the sector (i.e., growing demand is unlikely to be met through productivity increases). Yet, the sector struggles to attract and retain workers. In the EU for example, in 2021 the sector employed 6.4 million people and by 2030 there could be up to 7 million new positions required. In the OECD, this number will need to increase by 40% or 13.5 million workers by 2040 to maintain current staff-resident ratios. However, there has been a *decrease* in LTC care workers per 100 residents, from 4.2 in 2011 to 3.8 in 2016. This trend is attributed to a shrinking available workforce, due to the combination of demographics and the limited appeal of the sector's working conditions and wages. According to a European commission (2021) study, 1 in 3 LTC workers has thus experienced adverse social behaviour at work and 4 in 10 do not believe they will continue their job until 60. This trend exists across OECD countries and will be further explored in sub-section 1.2.5.

[3] It is the ratio of people aged 65 and over per 100 people of working age (between 20 and 64).

1.2.2 Homecare in Switzerland

Homecare has always been popular for seniors and has become the main policy promoted by the Swiss government to address the growing care needs of the aging population in Switzerland. It is viewed as a way to limit spending growth while allowing senior citizens to remain in a familiar environment, as long as their physical and cognitive state allows it. We can see the implementation of this strategy by every cantonal old-age model, and a growing number of municipal ones, now focused on homecare (Althaus, 2021). This outlook was strengthened by the Covid-19 pandemic as residents and families were anxious of isolation in LTRCFs due to restrictive public health measures. While there was a 10% drop of residents entering Swiss LTRCFs from 2019 to 2020, there was already a downward trend reflecting an increase in home-care utilisation amongst Swiss senior dependent citizens (see Figures 1.1 and 1.2). A similar trend has been observed throughout the OECD (de Bienassis *et al.*, 2020).

Figure 1.1

Number of LTRCF residents 65+ per 100 residents 65+

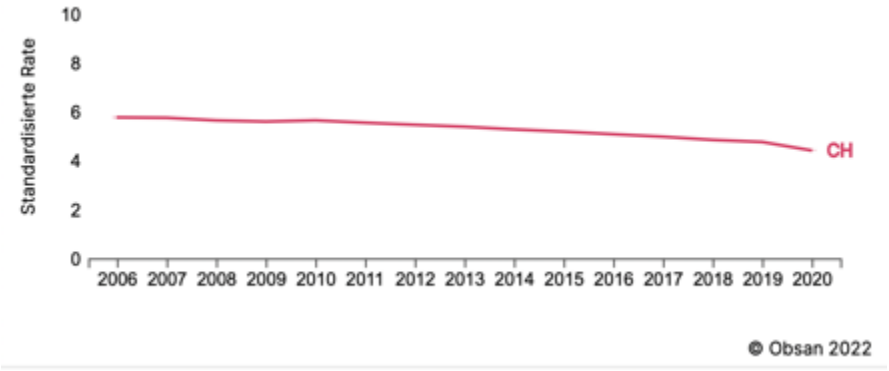


Image Source: Swiss Health Observatory, 2022

Figure 1.2

Number of homecare residents 65+ per 100 65+ residents

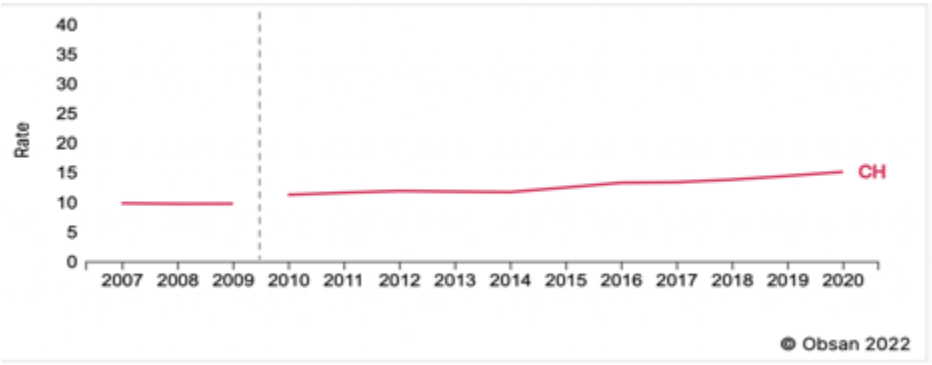


Image Source: Swiss Health Observatory, 2022

More and more Swiss senior dependent citizens are turning to homecare as opposed to LTRCFs; this is reflected in greater spending on homecare, an increasing age when entering LTC institutions, as well as a decrease in time spent on light care[4] in LTRCFs (Figure 1.3). Since the reform of the Swiss Health Insurance Act (KVG) in 2009, LTRCFs became medical facilities and some cantons restricted allowing residents who only needed light care. Residents that only require light care generally face social isolation or difficulty coping with daily life, as it can still prove difficult to complete daily tasks despite having the capacity. (Swiss Health Observatory, 2022).

Figure 1.3

Proportion of LTRCF residents 65+ in need of light care with a maximum of 40 minutes of care per day

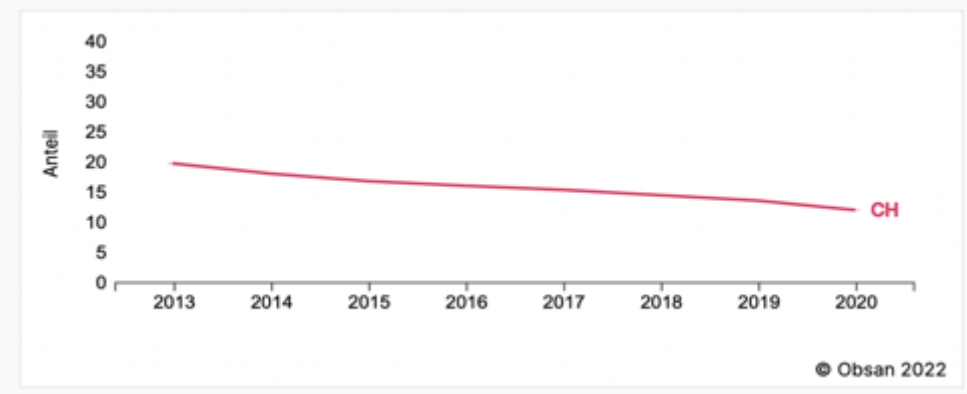


Image Source: Swiss Health Observatory, 2022

The result of this trend is a heavier concentration of high-needs patients in LTRCFs, which are therefore becoming increasingly difficult places to work in. In 2012, 47.4% of Swiss nursing home residents had medically diagnosed dementia, with this number increasing to 64.5% by including residents that have symptoms but have not been officially diagnosed (Bartelt, 2012).

1.2.3 The Swiss context: LTRCFs

LTC in Switzerland also aligns with these trends observed across the OECD and European Union. It is projected in Switzerland that demand for nursing home places will increase from 89,000 in 2021 to 145,760 by 2040 (Swiss Health Observatory, 2022). Figure 1.4 conveys the current

[4] Light care is defined as providing less than 40 minutes of care a day to a resident.

availability of beds each Swiss Canton based on the amount of beds per 100 residents over the age of 65.

Figure 1.4

Places per 100 Resident (65+), 2020

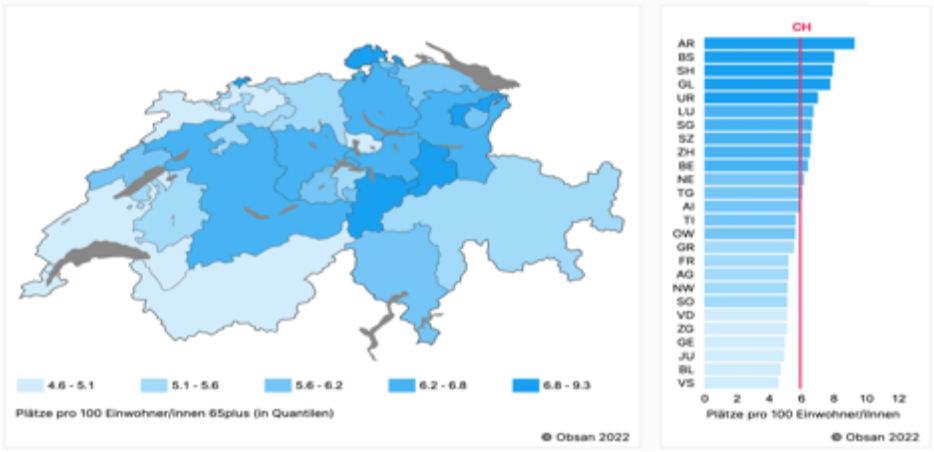


Image source: Swiss Health Observatory, 2022

As seen in Figure 1.5 below, the staffing ratio per 1000 residents has remained stagnant during the last decade despite LTC positions experiencing the most rapid increase from 2012-2019 within the Swiss care sector, with the figure at 100,6400 full-time equivalent (FTE) positions in 2022 (Federal Statistical Office, 2023). A potential factor explaining this stagnant growth of staffing ratios is the challenge of recruiting and retaining workers (SSERI, 2016). The Federal Office of Public Health hopes to address this increase by promoting education programmes and attracting migrant workers (Trein, 2018). Noticeably, the strategy of increasing wages was not explored.

Figure 1.5

LTRCF Worker per 1000 Resident in Switzerland, 2010-2020 (FTE Equivalent)

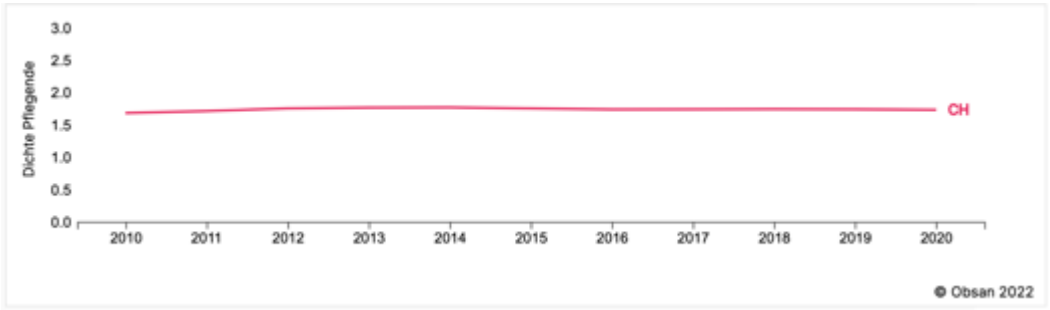
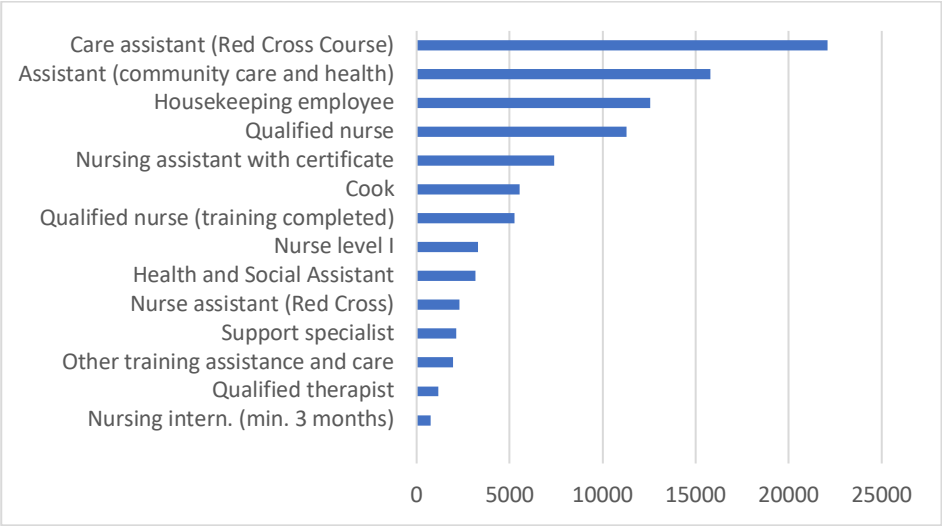


Image Source: Swiss Health Observatory, 2022

There is a broad mix of professions within nursing homes (see Figure 1.6) that contribute to the delivery of care and reflect their function as places where residents are cared for but also live, sometimes for years, best captured in their French name of *medical-social* establishments. The three main professional front-line categories are nursing care (including nurses and nursing assistants), who account for 76% of total staff, hospitality workers (including cooks and cleaners), who represent 20% and social workers, 4%. (Figure 1.7).

Figure 1.6

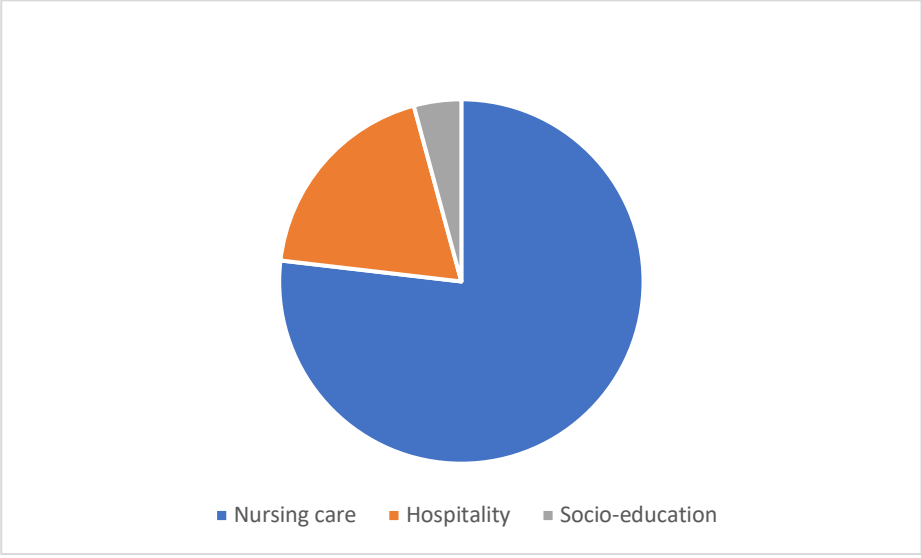
LTRCF staff in Switzerland by professional category, as of December 31, 2022



Source: Federal Statistical Office, 2023

Figure 1.7

Professional areas of LTRCF staff in Switzerland, as of December 31, 2022



Source: Federal Statistical Office, 2023

1.2.4 The long-term care workforce

As is common in care work, the LTC sector is highly gendered: women represent nearly 90% of the workforce in the OECD and 87% in Switzerland (Liechti *et al.,* 2020). There continues to be a high demand for care workers, but given the low wages offered (especially for non-nursing positions), the sector mostly attracts low-skilled workers with limited alternatives, often with a migratory background (Addati *et al*., 2018). There is a high turnover across OECD countries given these low wages combined with poor and precarious working conditions (OECD, 2020). The issue of turnover is long-standing and has continued to increase after the Covid-19 pandemic; governments have attempted to address it by encouraging nationals (specifically targeting groups such as the unemployed and youth) to work in the sector and promoting career paths and financial incentives (Milos and Bergfeld, 2022; OECD, 2020). These strategies have produced limited results as the problems plaguing the sector prevent widespread recruitment. Migrant labour is therefore heavily relied upon, with the sector deploying recruiting strategies to attract new migrants (often highly skilled) from countries with high structural unemployment. The latter are then forced to accept precarious employment or pay levels below their actual level of qualification, as qualifications are not easily recognized or immediately transferrable. On top of this, migrants can face multidimensional discrimination in the labour market and workplace due to racialisation, gender, culture and language (Newton *et al*., 2012; Xu *et al*., 2008).

Migrant workers thus accounted for 35% of the Swiss nursing home workforce in 2021; employers appreciate them because they tend to work longer hours and stay in the same position longer than native workers (OECD, 2020). In Western Europe, many of these predominantly female migrants come from Central and Eastern Europe, while Switzerland also recruits from nearby France, Germany and Italy, as its wages are generally higher (at least nominally). Foreign nurses and health workers are usually reluctant to organize and make demands to change their working conditions and wages, given that these are better than in their home countries (Jorio and Bondolfi, 2020).[5]

These demographic factors highlight the vulnerability of much of the LTC workforce, especially the new arrivals who are filling the labour shortages. The fact that nationals are hesitant to work in the sector suggests that the vulnerability of LTC workers has roots in the very organisation of care work, which makes it difficult for them to defend their interests as workers through a collective voice, and demand "more than applause", to borrow the OECD's phrase.

[5] The sustainability of this reliance on cross-border migrants may be challenged in future as Italy and France, in dealing with their own shortages, are trying to prevent this nursing "brain drain" to Switzerland (Montanari, 2023).

1.2.5 Turnover: The tip of the iceberg?

The increase in demand for long-term care is leading to a rapid growth in staffing needs, but the sector struggles to attract and retain workers (OECD, 2020). Switzerland saw its turnover rate increase from 20.8% in 2013 to 22.4% in 2019 in long-term care (Merçay et al, 2021) while, in LTRCFs, turnover rose from 24% in 2021 to 28% in 2022 (Swiss Federal Statistic Office, 2023). The situation is not better in other countries. A systematic review in the United States found that the one-year rate of turnover in LTRCFs can range from 19% to 55 % (Lee, 2022). The UK's rate stood at 32.2% in 2019, a sharp increase from 23% in 2013 (Shembavnekar, 2020). Additionally, many of the current workers are middle-aged with 45 being the median age across OECD countries and Switzerland (OECD, 2020). We also witnessed many of these exhausted workers resign from their jobs in the health and service sector during the Covid-19 pandemic, exacerbating the labour shortage (on Italy, see Coin, 2023). There is therefore a serious staffing challenge affecting both recruitment and retention, and the horizon appears bleak.

The Swiss government now acknowledges turnover as a major challenge facing the LTC sector (Federal Office of Public Health, 2019), but turnover in LTRCFs has been identified as a critical issue by researchers since the 1970s (Pecarchik & Bardin, 1973; Winn *et al.*, 1978). Since care is labour intensive and emotionally draining, turnover can have a significant impact on the quality of care delivered, by reducing the continuity of care and increasing the number of inexperienced workers, thereby causing emotional and psychological distress for residents (Castle and Engberg, 2005; Perruchoud *et al.,* 2021). As care workers value the ability to provide high-quality care, they are sensitive to the work environment, which can influence their decision to leave (Castle and Engberg, 2006), as they seek and enjoy building relationships with residents (Parsons *et al.,* 2003). As turnover appears to be a major challenge affecting care in LTC, it is important to understand what factors underpin it. In the next sections, we will therefore explore the restructuring, through the deployment of New Public Management and growing marketisation, of Swiss LTRCFs.

1.3 Marketisation and New Public Management in long-term care

1.3.1 Marketisation

The expansion of the LTC sector has made it financially attractive for investors. The reason is not only the projected increase in demand but also the security provided by "captive" government funding that covers part of the resident costs (especially medical costs). Since the 2008 economic crisis, the health and social sectors have been unique in experiencing significant growth compared to other sectors (Farris & Marchetti, 2017). LTC is thus referred to as "grey gold" by investors: as it

is both lucrative and safe, it constitutes a perfect long-term investment – although the strategies deployed unsurprisingly entail seeking to achieve short-term profitability. This is especially common with real estate investment trusts (REIT), which buy nursing homes and proceed to separate building ownership and facility management into different entities. This then allows REITs to boost the real estate holding's profitability by demanding higher rents from nursing homes (financed through cost-cutting strategies), thus paving the way for reselling the buildings at an increased price (Harrington *et al.,* 2017; August, 2021). With the rising participation of the private sector, a trend of marketisation has therefore occurred in long-term care across OECD countries. Brennan *et al*. (2012) argue that marketisation is driven by governments who authorize, support or enforce the introduction of markets in the provision of care. Examples of this include outsourcing care services and providing funds to individuals to source their own care through the market. As a result, for-profit companies have been aggressively entering the sector to take advantage of these new opportunities, deploying classical, profit-maximising corporate practices, such as cost-cutting, especially focused on labour processes (which we discuss in the following subsection), creating a form of corporatisation in the LTC sector (Farris & Marchetti, 2017).

"Grey gold" has attracted a variety of investors, ranging from traditional private operators of LTRCFs, to private speculative funds (see Box 1) and non-traditional operators such as cleaning companies and other corporations whose core business entails the management of large, low-wage workforces (Investigate Europe, 2021; Harrington *et al.,* 2017). An example of the latter is Sodexo, which is France's largest private employer, and has a total of 412,000 employees across 55 countries. It started as a food services company but now provides services and management in areas such as personal care, medical, technological and hospitality services (Sodexo, 2021).

Private companies have been increasingly involved with the provision of long-term care in OECD countries since the 1980s. In 2020 the rate of private for-profit operators of total LTC beds ranges from 6% in the Netherlands to about 81% in the United Kingdom, with the rate in Switzerland at 47% (Cushman & Wakefield, 2020; Federal Statistical Office, 2023). This discrepancy relates in part to the different types of welfare states and how they favour one organisational form over the other, and their respective stances towards the private sector – although the trend over the past three decades has overwhelmingly been favouring the gradual increase in private LTC provision, achieved through neoliberal state restructuring, welfare state retrenchment and the privatisation of social reproduction (Bos *et al*, 2020).

Analysing the effects of growing privatisation in LTC in a study of five OECD countries (Canada, United States, United Kingdom, Sweden and Norway), Harrington *et al.* (2017) find that the number of nursing home beds per 1000 people has *declined* since the 1990s, despite the continued increase of senior citizens. They argue that this occurred as a result of the pursuit of "market efficiency", that is to say private corporations seeking to rationalise (i.e., reduce) costs in order to maximize profits in the homes they manage. Additionally, they contract other companies they own to provide services in the nursing home to further increase profits. Through aggressive

cost control measures, private LTRCFs also apply pressure on publicly owned LTRCFs to compete in terms of (cost) efficiency. In order to achieve the latter, governments have embraced models of New Public Management, which we explore in the next sub-section.

Investigate Europe (2021) found that 80 percent of LTRCFs in Spain are for-profit, 76 percent in the UK and 40 percent in Germany. They also found that the 25 leading companies in LTC have increased their capacity by 22 percent in Europe since 2017, with the growing demand and access to public spending on LTC spurring this privatisation: 220 billion euros of public funds are spent on LTC each year (OECD, 2020). In the EU, despite the scale of public spending for LTC, governments appear to exercise very little oversight on staffing reductions and deficiencies in quality of care, as exemplified by the shocking and widely discussed revelations made in Castanet (2022)'s book *Les Fossoyeurs* ("The gravediggers"), an investigation into market leader Orpéa, which manages 110 000 beds across 1100 LTRCFs in 23 countries. Quality checks and inspections are typically minimal and generally based on paperwork. The efforts to marketize care in LTC through increased efficiencies and cost saving measures to increase profits, often produced poor clinical outcomes and working conditions (Walker *et al*., 2022). Many of these corporations also attempted to deter and prevent workers from organizing for better conditions (Investigate Europe, 2021).

Box 1

The growing financialisation of LTC

Financialisation describes an organisational shift in the LTC sector with private equity and investment firms purchasing a growing number of nursing homes. With aging populations, nursing homes have shifted from being a largely ignored asset to a popular and mainstream option for investors (August, 2021)

Private equity firms will generally operate a nursing home for 5 to 7 years. In this period, firms are under immense pressure by investors to deliver high returns of 20% or more (Bourgeron *et al*., 2021). According to Investigate Europe (2021), 30 private equity funds have entered the long-term care sector in Europe. Many of the private investors in these funds place their assets offshore and therefore pay little to no tax despite receiving billions in public money for the services provided (see Annex 5 for table of select firms). In Switzerland, Tertianum, a leading private operator of LTRCFs, was purchased by the private equity firm Capvis in 2019.

While the consolidation of private LTRCFs into large corporate groups has been continuing at a sustained pace, it has been marred by numerous financial and quality scandals, in Sweden, the USA, Canada, France and the UK (Harrington *et al*., 2017). There is therefore a paradox: private companies are accessing large amounts of state funding but increasingly avoid regulation and oversight to achieve higher profits. The growing marketisation of LTC has thus created challenges for both quality of care and working conditions.

In order to extract profits from LTRCFs, strategies such as cost-cutting have been promoted, especially by private equity firms. The problem is compounded when governments support these private ventures directly (through funding) and indirectly, through insufficient oversight. Crucially, the management of public LTRCFs has followed the managerial trends set by private operators. This will be analysed in the next section, which focuses on the implementation of New Public Management in the LTC sector.

1.3.2 Development of New Public Management

New Public Management (NPM) contains several doctrinal components, but it essentially refers to the implementation of new planning methods in the public sector, forcing it to focus on productivity and efficiency (Ward, 2011; Knafo, 2020). Widely deployed from the 1980s onwards, NPM is inspired by public choice theory, which explains social phenomena as a result of individual freedom and preferences (Buchanan, 1986). As politicians and businesses began to question the usefulness of the state's intervention in the economy, the consensus of the post-war welfare state began to erode. Instead, the new mantra became deregulation, competition and privatisation. Phrases such as 'doing more with less' and 'providing value for money' became mainstream in society and politics (Simonet, 2013); in Switzerland, healthcare spending (including for LTC, see Dupont & Meli, 2023) must thus adhere to principle of cost effectiveness (*économicité* in French; *Wirtschaftlichkeit* in German).

NPM can be a difficult concept to define as it varies across national contexts. For the purposes of this report, we have highlighted the key characteristics of NPM that relate to the long-term care sector and are relevant to the analysis of changes in the labour process of LTRCFs, as described by Ferlie *et al.* (1996: 11):

i) Attention to financial control: value for money and elaborate cost and information systems;
ii) Stronger general management: monitoring of performance;
iii) Extension of audits: increased reliance on standards and indicators;
iv) Response to consumers: market mindset;
v) Deregulation of labour market and increasing workload: erosion of collective bargaining;
vi) New forms of governance: marginalisation of trade unions.

We now look at how these elements were introduced in Switzerland through its unique adoption of NPM and the effects it has had on LTC.

1.3.4 NPM in Switzerland

The first NPM-inspired measures were introduced in Zurich in 1993 under the leadership of Ernst Buschor. A former economics professor and member of the Zurich Cantonal Council since 1975, Buschor admired the NPM-related reforms of New Zealand and the “Neue Steuerungsmodell” of Germany, and referred to the Swiss reforms as "impact-oriented public management". He founded the Swiss Society for Administrative Sciences (SGVW) and his former assistants set up the PuMaConsult consultancy group in order to create a favourable public attitude towards the implementation of these reforms, and in the end Buschor and his colleagues were referred to in the press as "the little family of NPM" (Reber, 2006). From 1990 to 2005, NPM elements began to gain acceptance across Swiss municipalities but they were not introduced as a comprehensive package due to the country’s decentralised governance.

Weil (2017) argues that NPM models are now firmly rooted in the Swiss public sector and should be referred to simply as 'public management'. These reforms have, ironically, led to increased bureaucratisation and a strong belief in indicators to shape public policy. This situation is described by Knöpfel (1995: 467) as a "dictatorship of indicators, which ultimately leads to the dehumanisation of administration". This is an important point in the discussion of care provision in long-term care, as it is inherently a human, relational activity which requires tasks that are not easily captured by indicators. In the next sub-section we explore the transformation of the labour process in LTC based on these elements of NPM found in Switzerland.

1.3.5 NPM in long-term care

As NPM was implemented in the LTC sector, the labour process began to reflect the centrality of indicators. Harrington *et al*. (2017) argue that NPM grew exponentially in the LTC sector during the 1990s in countries such as Canada, Sweden, the United Kingdom, Norway and the United States. This created an environment in which LTC providers needed to focus on the objectives of “efficiency, output measurement and customer orientation” (Bos *et al.,* 2020: 433). In order to achieve these objectives, it was necessary to rely on quality indicators that focused mainly on medical-technical tasks as determined by medical experts.

Private measurement tools (effectively software programmes) have been developed to collect this data; in Switzerland, these include the RAI-NH, BESA and PLAISIR. One consequence of the roll-out of these tools is the increasing amount of documentation required and the growing frustration of workers having to complete it. A study found that 75% of surveyed care workers in Switzerland felt strongly or very strongly burdened by administrative tasks; the most burdensome activity (identified by 75% of respondents) was completing residents’ health records (Ausserhofer

et al., 2023). This situation hinders the ability of care workers to provide more relational work, as they are squeezed between the objectives of NPM and the need to complete documentation.

Taking into consideration the influence of NPM and reliance on indicators, LTC has become a context where the views of workers are largely ignored in how care is delivered and how the labour process is organised. This raises the question of whether NPM can coexist with the provision of quality care, although it is one its proclaimed objectives. At the heart of this question lies a combination of a lack of worker input and the difficulty, or perhaps impossibility, of measuring the relational aspect of care. The next section explores the transformation of care work in long-term care and the impact that NPM has had on the labour process.

1.4 Determining care and transformation of the labour process

1.4.1 The invisibility of workers through taylorisation

The transformation of the labour process in LTC reflects the growing taylorisation of service work; that is, the application of the principles of industrial time management to service activities. Le Dilosquer & De Gasparo (2017) identify time as the central element of the taylorist division of labour, shaping the organisation of work by making it objective, calculated and planned. This approach has become widespread in sectors not related to the production of commodities, such as the public sector and social services. While there is evidence that the increased intensification of work negatively affects workers regardless of the sector where they operate. However, one particular challenge for service activities is that intensification can also affect the quality of outputs (such as care) negatively. Indeed, while it is possible to assess the quality of physical commodities and focus on efficiency gains to reduce their individual processing time, relational activities are more difficult to intensify. A narrow focus on efficiency (measured in the time spent performing an activity) is likely to have a negative impact on the service provided. This is essentially what Baumol (1993) identifies as one of the causes of the cost disease. When work involves providing services to humans, organisations therefore ought to adopt a more qualitative approach that centres on the user's experience and perspective.

Le Dilosquer & De Gasparo (2017) further observed that cleaners were made invisible through their employment at atypical hours, when they did not meet users; this creates a situation where the work performed is only revealed in its absence (for instance when an office is not clean). Care work (which includes cleaning) is also often invisible; as it entails a strong emotional dimension, the labour and skills it requires are often ignored (Gottfried & Chun 2018) and it is only revealed when it is absent, as the tendency to write about it only when scandals emerge suggests.

The Covid-19 pandemic brutally revealed the societal importance of care work, highlighting the tasks performed by LTC workers and the challenges they face. Pre-existing structural deficiencies

were exposed, such as the understaffing of LTRCFs and the resulting difficulty in following Covid-19 protocols and monitoring residents' symptoms (McGilton et al., 2020). The pandemic further demonstrated the importance of activities such as cleaning in the provision of care, rather than as a secondary task. It also conveyed the importance of carers providing relational and emotional support to residents, especially as family members were restricted from visiting and therefore relied on workers to provide more relational care. Workers also needed to engage in more discussions to monitor and identify symptoms of Covid in residents. The invisibility of these non-medical tasks and the workers who perform them appears to be a deliberate design of taylorisation. In an organisation based on NPM objectives, there is no advantage in adopting a holistic approach to the labour process (and to care quality), as this would generally require further expenditure to hire more workers and make it more complex to monitor the work. One strategy to maintain this invisibility is to de-skill the sector, as we will explore in the next sub-section.

1.4.2 Deskilling

The application of NPM through taylorisation has facilitated the deskilling of long-term care to reduce labour costs. Armstrong (2013) found that care workers are unable to demonstrate their professional skills in caring due to time constraints in the workplace. She concludes that NPM has replaced the notion of care service with a detailed measurement of time. The measurement and allocation of time has contributed to a polarisation between caring professions (Fine, 2014), exacerbating the hierarchy of occupations based on skill levels, working time arrangements and wages, which were linked to cost-cutting strategies.

Theobald (2012) argues that taylorisation has been the main driver of deskilling in the care sector; as it has shifted the focus to medical-technical tasks and the time required to perform them, it has hollowed out the sensitivity and complexity inherent in providing care. Deskilling in long-term care has leveraged the normative perception that caring skills are 'natural' (female) attributes, contributing to the devaluation of care work[6]. By using standardised time measures and indicators, care tasks can be assigned to lower-skilled workers in order to reduce costs In the context of the current staffing crisis in Switzerland, the number of mid-level nurses with a Federal Certificate of Proficiency has increased since 2012 (amounting to 35% of total nursing staff in 2018), while decreasing the number of qualified nurses (Liechti, 2020).

[6] This has triggered efforts by workers to assert the professional character of care work, which have entailed making the (relational) tasks it entails visible and highlighting their importance and demanding character; these initiatives can then link the skills required in care work to formal training, wage ladders and prescribed benefits (Benjamin, 2015).

1.4.3 Accounting for care

The cost and accounting controls prevalent in NPM are manifested in Swiss long-term care through the funding structure, where the bulk of medical care is covered by the health insurance companies, while the costs of hospitality are covered by the residents (Trein, 2018). Since 2011, the Federal Law on Health Insurance (*loi fédérale sur l'assurance-maladie*, LaMal) has required health insurance companies to cover part of the medical costs of nursing home residents, depending on the canton. This daily rate increases with the number of minutes required by the resident and is capped at CHF 115.50 after 220 minutes (Dupont & Meli, 2023). It is important to highlight that there is no time for relational care covered by LaMal, which has been a source of frustration among LTC workers.

The assessment instruments (RAI-NH, PLAISIR and BESA) are the primary instrument to establish the care time each resident needs *and* the total funding a nursing home receives, which depends (for medical care) on the degree of dependency of the resident population. The Federal Council, through the Federal Department of Home Affairs (FDHA), decides on the type of care and has divided the procedures into three areas: i) assessment, advice and coordination, ii) examinations and treatments, and iii) basic care. As mentioned above, OPAS requires that patient care in these areas be carried out in a uniform manner based on its list, and this is where the RAI, BESA and PLAISIR play a key role. They can influence the labour process, firstly by shaping the tasks that the workers perform, based on the strict requirements of the OPAS regarding time limits and the interventions that can be used. These requirements must be followed as they are audited based on the OPAS directive that care must be appropriate, adequate and economical (Dupont & Meli, 2023). Secondly, these measurement tools also influence the labour process by increasing the amount of documentation, which is time consuming, as mentioned earlier. On the one hand, these instruments are useful for monitoring and providing care, especially in terms of medical treatments. On the other hand, through the financing and auditing system, these instruments seem to play an oversized role in determining the labour process and influencing the type of care provided.

1.4.4 Measuring care

Since care is the “product” that a taylorised LTC sector seeks to deliver, it is necessary to record when care is provided and its outcome. Although it is difficult to measure accurately what constitutes 'good care', institutions rely primarily on clinical outcomes for residents. This approach to measuring quality aligns LTC with the health sector rather than the social sector, even though it combines elements of both. Under a clinical outcomes approach to quality, a patient enters and

receives treatment, and the latter's success rate is documented. However, the LTRCFs are also living places, where residents sometimes spend years; standards for quality of life would therefore be as important.

As with the measurement tools, clinical outcomes are certainly useful for nursing home management to assess the quality of care provided (Castle, 2003). What is missing from these indicators and outcomes is the relational aspect, which becomes largely invisible in the labour process. It then becomes increasingly difficult to hear (and respond to) the individual concerns of residents and their families about the care they individually want (Spilsbury, 2011). A further tension arises from the fact that professionals from different backgrounds (healthcare, hospitality and social work) work alongside each other in LTC; their respective values and aims do not conflict in terms of core values. However, they tend to disagree on their hierarchy, i.e. which professional norms should guide their daily work, with a frequent tension between autonomy and security (Pichonnaz *et al*., 2020). This further contributes to a dilemma typically faced by workers in the *rationing of care*.

As mentioned above, the key indicators used to assess the quality of care in a nursing home generally follow a medical-technical perspective. This term refers to a focus on tasks related to a resident's medical care and technical tasks, such as cleaning. Favez *et al.* (2020) found that this approach is associated with a primary focus on *negative* quality indicators such as physical restraints, falls, pressure ulcers and weight loss. The six indicators currently used in Switzerland (see Table 2) were selected in 2016 by a broad group of stakeholders, who formed a steering committee. The committee was led by Curaviva and included the Swiss Federal Office of Public Health, the Swiss Conference of Cantonal Health Directors and the Swiss Federal Statistical Office. No body representing workers participated in it.

Table 2

Quality Indicators in Switzerland for LTRCFs

Indicator	**Description**
Polypharmacy	Percentage of residents who took 9 or more active ingredients in the last 7 days
Self-Reported Pain	Percentage of residents with daily moderate or higher pain intensity or residents with nondaily very strong pain intensity in the last 7 days
Observed Pain	Percentage of residents who showed daily

Indicator	Description
	moderate or higher pain intensity or residents who showed nondaily very strong pain intensity in the last 7 days
Physical restraint, trunk fixation or seating that prevents the resident from rising	Percentage of residents with daily fixation of the trunk or with seating that prevented the resident from rising in the last 7 days
Physical restraint, bedrails	Percentage of residents with daily use of bedrails or other devices on all open sides of the bed that did not allow the resident to leave the bed independently in the last 7 days
Weight loss	Percentage of residents with weight loss of 5% or more in the last 30 days or of 10% or more in the last 180 day

Source: Favez et al. *(2020: 4-5)*

The data collected by tools such as RAI-NH is used to assess if these indicators are being met. Although the quality indicators are useful for demonstrating quantifiable outcomes, they do not identify the underlying problems when results are poor. In addition, they do not, in and of themselves, indicate whether the results are clinically meaningful or help LTRCFs to improve (Favez *et al*., 2020).

The taylorisation of the labour process and increasing use of NPM elements of outcome-related accountability have crowded out the relational aspects of care work. When relational work is done, it is often invisible in order to maintain the façade that it is a benign task done by staff and can remain undervalued, despite its significance for the resident. This transformation has been further entrenched by the quality monitoring of LTRCFs through the medical-technical indicators mentioned above. However, as LTC workers deal with people, not cars or sandwiches, there is little choice but to act *outside* of prescribed tasks in response to certain situations. This creates a dilemma for many care workers, which we discuss in the next sub-section.

1.5 The dilemma of care workers: A “prisoner of love”

Care for the seniors has traditionally been provided by unpaid female labour within the extended family. While the demand for senior care work has increased with the ageing of the population, the supply of unpaid female labour has been reduced by the growing participation of

women in the labour market without an equivalent reduction in men's working hours, while communal forms of solidarity have been eroded. As a result, care has become increasingly commodified (performed for a wage), prompting sociological and economic research to capture the specificities of care work when it becomes paid work and is provided to an unrelated person. Paid care work has, like unpaid care work, typically been undervalued, even more so in the case of senior care which, unlike childcare that reproduces the workforce, is often not seen as contributing to the creation of value (Federici, 2009).

Folbre's (2001) "prisoner of love" approach to care work is particularly relevant to this research because she identifies how the worker (often a woman) relates to such work; she argues that care workers develop emotional bonds with residents similar to those they would have with a dependent family member. These relationships discourage workers from making demands for higher wages or better working conditions for fear of affecting the living conditions of those they care for. These prisoners of love have also been described as "emotional hostages" (England, 2005): even when material conditions are inadequate, workers feel compelled to compensate by overworking themselves to provide care and by staying in low quality jobs. When the environment is not conducive to good care, workers tend to go beyond their formal duties by providing additional services, some of which may be restricted by management because they are not outlined in the service contract, as is the case with many non-medical tasks (Kirchoff and Karlsson, 2013). What care workers do, in other words, is to provide – for a wage and under strict rules and organisational constraints – the care that a family member would provide to a child, parent or grandparent. Many of the residents' needs thus include the relational tasks described earlier.

The emotional nature of care work can also act as a barrier for workers' organising and bargaining power. Being an emotional hostage to the residents means that engaging in workplace activism (for instance by joining a union) may be perceived as a threat to this relationship, as organising efforts may have negative consequences for the residents. Nursing home managers are often prone to exploit the guilt generated by these intimate relationships; they may discourage unionisation by portraying it as detrimental to the interests of patients, as is often the case in the United States (National Nurses United, 2023). Overall, union organising in LTRCFs is difficult, and it is even more challenging for workers in lower-paid services than professional nursing, such as cooking, cleaning and other care work. The professional nurses can use their skills for greater bargaining power (they typically have strong professional unions) and have greater job mobility (Coombs *et al.,* 2015). The service and low-paid care positions are more vulnerable to precariousness and tend to be occupied by marginalised groups, such as racialised and migrant women. While the 'prisoner of love' concept provides insight into the vulnerability of workers, it however does not capture the full picture of what makes the labour process of care work challenging.

2. Research approach

Drawing on the literature review, document analysis, and preliminary discussions with Unia members working in LTC, we identified a significant knowledge gap regarding the perspective of workers on the crisis in LTC. This is all the more problematic as staff shortages (linked in large part to absenteeism and resignations) are at the heart of the sector's challenges. We therefore decided to analyse the organisation of work and the meaning of good care from the point of view of workers, with a goal of gaining a better grasp of the impact of recent changes (particularly managerial changes) on the provision of care and on working conditions.

In this chapter, we explain why we decided to draw on *conricerca*, or embedded research, to develop and answer our three research questions:

- What constitutes 'good care' from the point of view of workers?
- How do working conditions influence the quality of care?
- How does the way care is organised affect workers' relationships with residents and other staff?

Through this approach, we have sought to capture what is considered *good care* from the perspective of workers and what factors are hindering its realisation. This section will describe how the research developed and was implemented, including the techniques used for data collection and analysis to answer the research questions.

2.1 The choice of qualitative research

In social science research, data can be collected and analysed either through a quantitative or qualitative method (or a combination, such as mixed methods) (Henry, 2015). We determined that a qualitative method was best suited for our objectives of exploring the perspective of staff on the work and care in Swiss LTRCFs. It would allow us to understand the social reality in a scientific manner and set the foundation for further research. We furthermore found that the conditions for a nationwide quantitative survey were not currently present, for two main reasons that reinforced our decision to adopt a qualitative approach:

i) One of the most important conditions for conducting quantitative research is rigorous sampling. For our project, this would require access to lists and contact data of people employed by all LTRCFs in the country, or in enough cantons to allow sampling. Obtaining such data would have been impossible, as it is not centrally available and would have required asking individual employers or

cantons to provide it. If we contacted LTRCFs for such a project, there would be a very real risk that only those where conditions are relatively better would respond, which would be an unacceptable bias. Additionally, workers can be sceptical of filling out surveys truthfully when they are provided through management, for fear of repercussions. This can happen even if the survey is anonymous. An alternative approach to sampling, such as using a snowballing approach (asking employees to pass the questionnaire to colleagues in their own or other LTRCFs), may produce a good number of responses, but would suffer from a significant criticality: there will always be more responses from LTRCFs where contact has already been made, which would make statistical analysis of the results less than rigorous.

ii) There is another reason why, far from being a problem, these difficulties in starting a quantitative survey represent an opportunity. We do not have enough knowledge of staff concerns to develop a satisfactory questionnaire. Indeed, the other condition for a good quantitative survey is to have precise ideas about the problems and issues on which it should shed light, since a large survey is typically made up of close-ended questions, whose results can then be aggregated and analysed, using statistical or econometric methods, to test hypotheses deductively. The quality of a survey thus depends largely on what you know before you start; labour market surveys are thus adequate to capture well-known phenomena (e.g. workers in permanent employment) but can be prone to ignoring or misrepresenting issues affecting marginalized groups, such as informal workers (Rizzo et al., 2015). An inductive qualitative analysis thus makes it possible to formulate hypotheses in a more open manner (Zhang & Wildemuth, 2009).

We therefore decided to design and conduct qualitative research to refine our understanding of the dynamics at play in LTRCFs. The research was ambitious for three reasons: it was the first of its kind in Switzerland (and, to the best of our knowledge, internationally); it focused on a group that is experiencing very significant stress and is therefore not easy to recruit for discussions; and we decided to cover all three linguistic areas of the country. These difficulties led to some delays, but we feel that our project helped fill an important knowledge gap. Since our aim was to explore the perspective of workers on quality of care, we decided to build on the rich traditions of participatory research.

2.2 Doing research with workers

The research method we developed for this project draws inspiration from Italian *conricerca*, as well as from embedded and participatory research approaches, both of which have been used increasingly in public health and nursing science (Hartung *et al.,* 2020).

Conricerca (or 'researching with') is a research approach focused on workers and the analysis of the labour process; it was developed in northern Italian factories such as Fiat or Olivetti in the 1960s and 70s by scholars associated with *operaismo* (Alquati 1962; 1965). *Conricerca* entails doing research with workers to understand work from their subjective point of view, with the concomitant objective of strengthening their understanding of the organisation of production and their class consciousness. This approach allows for workers to be active participants in the research, overcoming the traditional distinction between "academics" and "workers". It also empowers the participating workers to produce autonomy while producing knowledge (Roggero, 2014).

While Marx's analysis centred on the composition of capital, *operaismo* scholars focused on the role of technology in the "technical composition of the working class". They identified a central tension between specialised and "mass" workers. The former were in charge of operating machinery and derived a strong technical sense of superiority from it (reflected in union demands), while the latter were working on the assembly line, subjected to extreme deskilling[7]. The two categories of workers experienced different political socialisations and had diverse demands as a result. The focus on these tensions within different categories of workers appears to be an important insight for researching a sector such as care, which is characterized by important hierarchical distinctions between workers. We therefore decided to include in our researchers all frontline workers, i.e., those who have direct contacts with residents.

Participation has been a topic in health research since the 1980s. Participatory health research (PHR) emerged from participatory approaches to social research, whose European and North American roots lie in action research and the work of the Brazilian educator Paulo Freire (2000). Its aim is to gain new insights into social problems to design options for action together with those affected (Wright, 2021). Much like *conricerca*, PHR therefore entails a co-creation process in defining problems and finding solutions.

Since the early 2000s, participatory or embedded research has received increasing attention as an effective approach towards public health and research (Allweiss *et al.* 2021; Cargo & Mercer, 2008; International Collaboration for Participatory Health Research / ICPHR 2013; Wright 2021). The central component of participatory research is the active involvement of those whose life experiences are being studied. Different approaches and concepts of participatory research exist in health research, reflecting disciplinary and geographical contexts, e.g. Patient and Public Involvement / PPI (Bombard *et al.* 2018), Service User Involvement (Beresford and McLaughlin 2021), or Community Based Participatory Research / CBPR (Wallerstein 2020).

There is no truly standardised definition in the broad field of participatory approaches in health research. In principle, however, it is always about an attitude and an approach that aims to enable the inclusion of the affected target groups and other important stakeholders. We call these 'experts by experience'. They should not serve the interests of researchers as objects, but rather

[7] Most of the mass workers were migrants from the poorer Southern regions of Italy.

participate in the initiation and implementation of research as people with their own interests and perspectives (Brunsmann 2020). Participatory health research hence means more than just to be a participant in a study. It usually strives for an active participation to identify key issues that were often missed by research (ICPHR 2020). Participatory approaches therefore aim to strengthen the position of patients and other relevant stakeholders and give them an active role in shaping the formulation of research questions and participating in the research process itself.

The Good Care project focussed on the active participation of those who work as employees in long-term care institutions. As their voice and experience is often not heard in the health policy and social debates on LTC, a participatory approach can be considered expedient here in a very similar way. The aim is actively to involve this perspective, which is often not sufficiently taken into account, and to amplify the project work with its creative power. To address LT care workers as active co-researchers allows them to break free from established power relationships and forms of interactions to generate a novel perspective and interpretation of situations and strategies during the research process (Bergold & Thomas, 2012). The project is about what they consider to be the most important issues in relation to providing quality care and its intersection with their working conditions.

2.3 Our research approach: Group discussions conducted by workers and unionists

Building on the above-mentioned experience, we developed our own participatory research approach, in the spirit of “worker-driven” research (Anner, 2023). The latter’s purpose is to design and carry out research with workers to provide an in-depth, from-within understanding of the way work is organised, and how it can be transformed with the active participation of workers. Given the harsh working conditions and vulnerability of many employed in the sector, as well as our close collaboration with Unia, we decided to work with a mixed group of co-researchers, made up of workers and local union officials from Unia. It was our hope that involving activists and union officials would help strengthen their ability to engage with the sector’s challenges; the positive feedback we have received suggests that this has indeed been the case.

After initially aiming to conduct semi-structured discussions, we decided to organise group discussions with 5 to 10 workers in each group, after exchanging with our internal consultant in the project, Prof. Dr. Karin van Holten (BFH). Group discussions represent a dynamic, flexible and participatory way of gathering qualitative data. They entail a “carefully planned discussion designed to obtain perceptions on a defined area of interest” (Krueger, 1994: 6). Researchers use the group discussion method to gain in-depth knowledge of the attitudes, perceptions, beliefs and opinions of specific groups of people on a particular issue (Lamnek, 1998). It is a method of collecting data based not only on individual experience, but on collectively shared knowledge and experience (Bohnsack, 2004). During the discussion, shared orientations and knowledge, which are rooted in so-called

conjunctive fields of experience, are elaborated by the discussants. In our project, participants were expected to share certain experiences as they all work in the context of institutional long-term care in Switzerland.

On the one hand, the group setting allowed for the joint development of issues considered relevant to the research questions. Here, the way in which discussants work through the relevant issues (arguments, counterarguments, conclusions and agreements) provides relevant information about the topic under discussion. On the other hand, the multi-professional composition of the groups made it possible to bring different disciplinary perspectives and areas of experience to the fore. This specific group setting thus allows for the identification of shared experiences and dynamics between different professions and their fields of action in the LTC sector. Group discussions are therefore an ideal tool for exploring the complex issues of quality of care in more depth, as frontline workers have not been the subject of much previous research on quality of care.

Following this participatory research approach, workers and union representatives acted as co-researchers and conducted group discussions with frontline LTC workers. After an initial phase of analysis of existing data and information, accessible documentary sources, and literature in order to draft research questions, the study phase began. The collaboration between the scientific research team (including the two SUPSI researchers and the internal consultant) and the co-researchers took four forms:

- ⇒ Discussing and refining the questions around which the group discussions would be structured
- ⇒ Training the co-researchers to conduct the group discussions
- ⇒ Adjusting the research process when the need arose
- ⇒ Collecting data through group discussions.

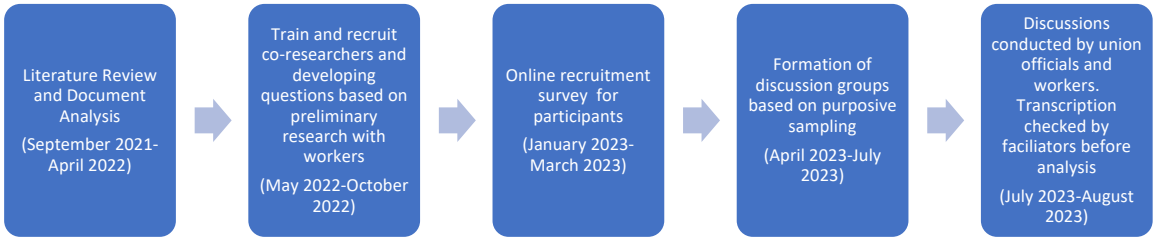
2.4 The research process

The research process consisted of numerous components to complete the project successfully (see Figure 2.1 below). The initial step in September 2021 was conceptualising the project, which we completed through an extensive literature review on long-term care internationally and in Switzerland. We presented these findings in a conceptual framework that was completed in April 2022 and shared with our Advisory Board. The board members provided feedback and inputs on the document, as well as on the methodology and research questions. The next step was to identify workers and trade unionists interested in conducting the group discussions and to jointly develop the stimuli and questions for the data collection. Throughout the summer, workers and trade unionists were recruited for this role with the help of Unia and we formed two groups of co-researchers ready to be trained in French and German. Two one-day training sessions

were organised in October 2022 in Lausanne (French) and Zurich (German) to discuss the research method and develop the stimuli and questions. The training sessions were very rich and provided many useful inputs to formulate and refine the final group discussion guideline.

Figure 2

Overview and timeline of the research process



Once the co-researchers were trained, the next component was the recruitment of participants. Given that we wanted to sample purposively to ensure the representation of different categories of frontline staff, we decided to create an online survey that had descriptive questions as our recruitment tool, using FindMind, with assistance from Silja Kohler of Unia. The survey was online from January to March 2023 and was advertised through social media, Unia's newsletter and promoted through word-of-mouth amongst care workers and trade unionists. In the end, 1505 people took part in the survey with 427 fully completing it. The characteristics of the participants included:

- 90% female
- 70% Swiss citizens
- Age group 45-54 (27%), 35-44 (24%), 55-64 (24%) , 25-34 (17%)
- Employed in semi-public homes (37%), private (23%), public (21%)
- 95% from the care professions
- 55% non-union members

We found the response rate was much higher than we envisioned and this gave us optimism that there would be many who would attend the discussions. This ended up not being the case, and created some disappointment amongst the research team which led to reflections that will be described later in this section.

After the survey closed, we created groups based on the purposive sampling strategy and proceeded to send the group list to the co-researchers to contact participants and organise the discussion groups. Each group had 9 people, with the idea that a few would probably not be able to attend. The co-researchers were encouraged to contact participants through email, SMS, and phone

calls. The latter methods turned out to be the most effective to gain responses. The discussions were scheduled outside of working hours and the workplace, to allow workers to speak freely without concerns regarding employer interference.

As discussed later in the limitation and reflections section, the responses to the invitation were disappointing and we had to explore alternative ways to organise the group discussions. We collectively decided to focus on region-wide discussions based on language and to conduct some of the discussions on Zoom. The groups were finalized in July 2023 and five group discussions were completed in total. The discussions were all recorded with observation notes, and this data was stored on secured folders on SwitchDrive. These folders could only be accessed by the co-researchers for their respective group, as well as by the research team.

After the recordings were uploaded, they were transcribed using various means (due to the linguistic variation), which included: Toeggl (for Swiss German), Microsoft Word (for one French group and the Italian group), as well as by a specialised company for the second French group. The transcriptions were then evaluated and checked by the co-researchers to ensure accuracy. These transcripts were then uploaded on the Switchdrive folders.

The data analysis was completed by the research team in the fall of 2023 by manually coding the discussion transcripts: key themes were noted on a left column, while striking and unexpected comments were discussed in a right column. The two SUPSI researchers coded each transcript separately and discussed after completion to tease out the main points that are presented in the next section.

2.5 Identification and training of co-researchers

The identification of the co-researchers took place, in collaboration with Unia, between June and September 2022, while their training took place during two sessions in October 2022, in French and German. The French training, which took place in Lausanne at Unia's offices on October 7th, involved 6 participants and was led by the project lead researcher and the internal consultant. The following day, the German training took place in Zurich at memox (an independent meeting space) with 12 participants; it was led by the same trainers. This training not only focused on the role of the moderator and note-taker and strategies for group discussions, but it also initiated the process to develop questions for the discussions based on exchanges with the co-researchers. During an exercise, the workers participated in a discussion on the topic of quality of care and working conditions in LTRCFs. They brought up issues of not having enough time to complete tasks and that the work often felt robotic. There were concerns over the amount of documentation and also that all workers had to fill roles beyond their job description due to staff shortages. These discussions allowed us to form the questions to guide the group discussions. This training was complemented by also including pointers and techniques on how to conduct the discussions and solicit responses.

Both groups appreciated these inputs and were provided with written material, including the presentations as well as summary tables of questions and pointers for each of the research questions that they could draw on during the group discussions (see Annex 4). Shortly before the discussions took place, a refresher training session was organised on Zoom for each group on 13 April (French) and 17 April (German).

2.6 Organisation of the group discussions

We initially aimed to speak to about 100 workers through 15 group discussions in order to explore frontline workers' perspective on issues of quality of care and working conditions. By "frontline", we mean workers directly involved with residents of LTRCFs, whether in a medical (e.g., nurses) or other (e.g., catering) function. Although the qualitative sampling process did not aim to create a representative sample, it was nonetheless important to strengthen the research through appropriate representation of key groups within the population, consisting of 83,342 workers in LTRCFs in 2022 (OECD, 2024). These groups of workers included:

- Migrant background
- Funding type of home employer (private, public, semi-public)
- Years of experience
- Gender
- Professional role

We therefore decided to construct a mixed sample, purposefully selecting respondents who have direct contact with residents (frontline workers) while trying to reflect several key characteristics of the overall population. We in particular hoped to have groups made up of all three main categories of frontline workers in LTRCFs: medical, hospitality and social care.

In order to identify and select participants for the group discussions, we created a dedicated website with the help of Unia colleagues[8]. Using a website to advertise the project was a collective decision taken during a meeting with the research teams in September 2022. The process took 3 months, starting in October 2022 to develop the interface and text of the website. There were back and forth discussions between the developer and the research teams to have the project objectives and description outlined but in a clear and accessible form. Additionally, the question wording and format were decided based on the desired sampling. The survey was in all three languages and tested by selected individuals for ease of use and coherence. By the end of December 2022, the

[8] We are extremely grateful to Silja Kohler for her incredible work in the setting up, running and publicising of the research site.

survey was published online via the Findmind platform.[9] Here respondents could express their interest to participate in the discussions during the period of January to March 2023.

We constructed discussion groups for the different regions with these respondents, with a purposive sampling of groups that are underrepresented in long-term care research but whose perspective we wanted to understand better, such as cleaning staff. We did not try to represent each group in the way a random sample would and wanted representation from the 3 groups of frontline professions present in LTC: hospitality, socio-education and nursing care The latter group is the most important numerically and is itself made up of 2 categories that we wanted to represent: qualified nurses and nursing assistants. We also paid particular attention to the make-up of individual discussion groups, as we wanted to ensure that the discussion dynamics within groups would not allow certain groups to "overpower" others; we especially wanted to avoid that the voices from hospitality staff be silenced by staff with greater medical legitimacy. The other characteristics that were considered in the sampling were gender, linguistic area[10], migration background, and geographic location, as well as the type of LTRCF (public, private and semi-private).

However, once the researchers started contacting workers to set up the group discussions, we discovered that our sampling approach was far too ambitious and that securing in-person participation outside of working hours was extremely challenging. While LTC workers had been prompt to respond to an online questionnaire, many of those we approached did not respond, or told us they were not available, although all had indicated their availability for a group discussion at the end of the online questionnaire. Among the factors that led to this situation were the summer holiday break for workers (especially with school aged children) as well as the demanding nature and scheduling of workers' shifts in LTRCFs. This will be elaborated on further in our *limitations* sub-section.

As a result, we shifted our strategy to recruit interested workers from each linguistic region and provided the option of online (Zoom) or in-person discussions. We recognized that abandoning our initial sampling objective was not a problem as the aims of the discussions were not dependent on our initial sampling targets. This decision was taken after we explored various options with the co-researchers into recruiting workers and this included mobilising the militant groups directly by them. This process took a considerable amount of time as there were regular meetings and exchanges between the research team and co-researchers. We express gratitude to the co-researchers for their availability during this process. In the end we were able to organise two German speaking groups, two French speaking groups and one Italian group. The composition of the groups can be seen below in Table 3.

[9] https://findmind.ch/c/was-ist-gute-pflege
[10] In the sense of the 3 linguistic areas of Switzerland, German, French and Italian (in that order of numerical importance).

Table 3 Composition of discussion groups

Discussion group	# of participants	Cantons	Co-Researchers
German 1	2	St. Gallen, Bern	Racha Mestre Manuel Luechinger
German 2	5	Luzern, Bern	Samuel Burri Sandra Schmied
French 1	4	Neuchâtel	David Taillard Alexandre Porret
French 2	5	Valais, Neuchâtel, Bern	Claudia Catellani Maude Rufi
Italian[11]	10	Ticino	Enrico Borelli Jason Schneck
Total:	**26**	**7 Cantons**	**12**

The participants, whose experience in LTC ranged from 1 to 30 years and encompassed public, private, and semi-public homes included:

- 22 female and 4 male workers
- 12 qualified nurses, 9 care assistants, 1 restaurant employee, 1 support specialist, 2 nurse training officers, 1 deputy care manager

The group discussions were led by 2-people teams, drawn from a group of workers and Unia regional secretaries, who had all been trained. One person acted as the moderator while the other was a note-taker and observer that also contributed to the discussion to highlight certain themes that emerged. At a geographical level, the sampling was therefore dictated by where the researchers are based; their distribution across the country nonetheless allows us to achieve a wide coverage of key areas.

2.7 Analysis of the group discussions

The analysis conducted by the research team was done by manually coding the discussion transcripts: key themes were noted on a left column, while striking and unexpected comments were discussed in a right column. The method for the analysis was based on the coding methods from Kelle and Kluge (2010), namely the formation of categories and the different dimensions they represented. These categories were both theoretically driven (based on our literature review and

[11] Only one discussion group was organised in Italian, in Ticino; it took place in a community centre in Russo, near the *Centro Sociale Onsernonese* (CSO), where the lead researcher had done a participant observation in February 2023.

conceptual framework) and then reinforced through empirical data, which also acted as the basis for the "unexpected" categories. Further, we specifically built on the "adapted" version of this method from Pelizzari (2009) as it relates to a vulnerable workforce.

Logistically, it was possible to code manually due to the limited number of group discussions and allowed the research team to explore the contents of the discussions utilising the methods above, without having to adhere to a rigid grid. Such an approach was coherent with the need to tease out insights deriving from this original research. The coding was split between the two lead researchers who then reviewed and enriched each other's coded discussions. They then discussed the key themes that had emerged and wrote the analysis.

2.8 Limitations and strengths of the research process

2.8.1 Sampling

As the research was carried out, we discovered some limitations in the sampling approach as well as in the implementation of the research design. It was difficult to meet the initial sampling design for each research group. We discovered this was owing to the scheduling demands that many of these participants had and the time they could dedicate. Additionally, the amount of time we took to sample between when participants filling out the survey and sending the invite contributed to this difficulty. If they were contacted immediately after completing the survey, we believe we surely would have had more responses. We were able address this challenge by having some of the discussions over Zoom but the work schedules combined with summer vacation proved difficult to overcome. As we could not create the purposive sample groups we desired, some of the groups had supervisory or senior staff that dominated the discussions.

2.8.2 Training and Planning

Scheduling the discussions around the participants' work and personal schedules was a challenge for both the training and setting the discussion dates. There was also a gap in between the initial training and discussions, so we organised a "refresher" session just before the discussions started. To select discussion dates, there were challenges in contacting the interested participants as many did not respond. We discovered that there was a higher response rate with an SMS/WhatsApp message than with email. The personal networks of the union secretaries and discussion facilitators to recruit survey participants was not as effective as we planned. We discovered our most success came from using the pre-existing networks we had, as demonstrated in Ticino. Overall, our timeline should have reduced the amount of time in creating the sample and instead shift to the formation of groups more quickly.

2.8.3 Group discussions

The discussions were overall a success as it was beneficial to have the workers deliver the discussions for incredibly rich data. There were some critiques after the discussions from observations and feedback from the discussion leaders. It was a great difficulty to recruit participants but this reflects the subject we are studying. It owes to the vulnerability and exploitation and lack of voice that workers in LTC. Another reflection was the availability of time for the workers to effectively lead and commit to the transcription of the discussions. We recognized that we underestimated the time needed for this task and reflected on how this could be improved.

3. Analysis: Workers' perspectives on care delivery

The analysis draws on the group discussions we conducted, emphasizing the key points where participants' perspectives converged. We first outline at how a vicious circle of long-term care has developed and map the challenges it presents to workers. We then look at how workers navigate the constant tension between what is prescribed and the reality involved in delivering care. Finally, we explore possible solutions to remedy the hardships workers and residents face, stressing that such solutions must involve all stakeholders in the LTC sector.

3.1 The vicious circle of long-term care

3.1.1 Into the circle

In LTRCFs, the frontline workers, whether they are nurses or work in catering, have a deep concern for the well-being of residents. This commitment to caring for "their" residents can eventually lead workers to overlook their own needs, health or family. Workers feel immense frustration when they are not able to provide the care that they know residents require. Indeed, as workers often lack the necessary time to complete their assigned medical-technical tasks, there remains little to no time to provide the relational aspect of care and build relationships.

Most workers insist that long-term care is at its core relational and that it ought to start from the needs of the residents. The workers spend the most time with the residents, hence know and understand their complex needs, both medical and social. Residents are complex human beings with different wishes, biographies and identities; entering a LTRCF can be traumatic and usually follows a loss of autonomy. Understanding these peculiar circumstances is necessary to be able to form the relationships that underpin care. Yet, it is often challenging to recognise, listen to and understand the wishes of the residents, because their communication options are sometimes limited, for instance by cognitive problems. Workers therefore have to develop trust building strategies, which require time; as we will see below, this clashes with the strategies required to deal with care rationing. As the groups described, it is impossible to perform an assigned care task effectively without having established a rapport with the resident. From a medical perspective, creating such a relationship not only makes providing care more manageable, but it also allows the worker to monitor any health developments that are not overt or apparent. **The relational aspect of care is therefore crucial both in a medical sense and for the resident's quality of life**.

The problem, as evidenced in the discussions, is that workers rarely find the opportunity to provide such care. Many workers complained that this crucial relational time was not incorporated

into work schedules, while such time is both necessary for residents' quality of life and for workers to be able to carry out their prescribed tasks and provide quality care. Workers are typically expected by management to interact with residents while they are performing prescribed tasks, such as bathing. This is possible in some cases, but far from always. During a participant observation at a LTRCF in Ticino, the lead researcher thus helped with the bathing of a female resident who was partly paralysed by a stroke. With utmost care, the four-person team bathed the resident; the researcher was the only one who could talk to her (in German) as she did not speak Italian. Although the bathing was done in an incredibly respectful and professional manner, the resident was clearly embarrassed and, while happy to talk about her home city, was by no means in a situation conducive to a free exchange. This example illustrates that relationship building should happen ahead of prescribed tasks, so that the latter can be carried out in a trusted and comfortable way. **The managerial tactic of asking workers to integrate relationship-building with tasks does not appear to work**, it simply exacerbates frustration.

Highlighting the painful shortage of casual contact time, one cafeteria worker in a French-speaking LTRCF reported that she would often be asked for help by residents (although she would not be allowed to provide it), who complained that care workers were too stressed and rushed from one resident to the next. The cafeteria worker was then providing some of that essential personal comfort that residents were missing, something that cleaning workers often do as well (Müller *et al*., 2018), although they are also pressed for time to move on to the next task. The importance of non-healthcare staff in building relationships with residents is normal, as they are part of the human environment of the LTRCF, or 'medical-social establishment' in French; it is also exacerbated by the decreasing time available to medical workers to interact with residents. This appears to confirm that a conscious involvement of all frontline staff in planning the delivery of care may help improve it.

The discussions conducted confirm that there is a deep crisis of care in Swiss LTRCFs, particularly as workers face time restraints, leading to the well-known phenomenon of **rationing of care**. One group described the situation in their LTRCFs as providing "**dangerous care**", which they feel is increasing. They related this concept to the lack of time to meet residents' demands, with workers being stretched. From this stress of providing care without sufficient time, they then feel the emotional distress of not doing enough or providing care in a rushed manner. As a nurse stated, "when my expectations are so high, but the reality is so far removed from them, I go home every evening with my head down". It conveys that the situation is not only poor for the resident but potentially dangerous, while causing emotional hardship for workers. As we will see, this is how a vicious circle in the crisis of care begins to take shape. What sustains this circle is the permanent race against time and the stress-inducing feeling that one must *rush* to complete tasks. This is a particularly acute problem in LTRCFs, whose senior residents typically live in a very slow life, and for whom the hurry that stressed staff display generates misunderstandings and frustration (Aubry, 2012). The next section will provide a map of this vicious circle of long-term care based on the responses collected from the group discussions.

3.1.2 Mapping the vicious circle of LTC

The strict control of time in care work (called *minutage*, in French and *Minütele* in Swiss German) is key in mapping this vicious circle as it relates to working conditions and providing care. Group discussions revealed that there was seldom "enough" time to complete core tasks, let alone the extra time for providing relational care. One participant questioned who establishes the very specific times set for delivering the different acts that make up care: "Who determines this? Who says how much time is needed for each care service?" Workers were of course aware that these standardised procedures were developed through a systematic process that sought to identify key tasks; they nonetheless resented it because they felt that such an approach did not take cognizance of the reality, within which those individually set tasks are deployed and the concrete obstacles they faced on a daily basis. The question echoes a broadly shared sentiment in the discussions, namely that **the planning of work does not fit with to the reality of the working day**. This paradox reflects **the broader disjuncture between work and its (managerial) evaluation** discussed in relation to NPM earlier and analysed by Dejours *et al*. (2018: 154-155):

> (A)ctual work is structured by specific forms of recognition of the reality and value of the productive activities, including recognition by peers in the work collective and recognition by clients in service relations. But these forms of recognition are plainly at odds with the type of recognition that is involved in performance measurements and conformity to standardized procedures.

The above quote points to what constitutes the essential forms of knowledge and recognition embedded in service work: that of colleagues, who share the same experience and professional norms, and of clients (or patients / residents, in care), who are the direct users of the service provided. While evaluation criteria may have good intentions (for instance capturing what quality is through indicators that appear to correlate with it), they are essentially a managerial tool: their purpose is to assess work *without* the feedback loop of the two core groups. The problem that has been exacerbated with NPM is that managerial indicators tend to substitute what they are meant to measure: the indicator itself becomes what guides work, especially when it is directly or indirectly related to resource allocation. Bedsores are for instance a widely used indicator of the lack of care quality; yet, if funding for institutions is influenced by the number of bedsores, it is likely that they will be re-organised to avoid bedsores at any cost, rather than provide quality care that limits bedsores but is about much more than just that. Concretely, when LTRCFs mandate workers to ensure that residents are turned regularly to avoid bedsores, it is uncertain whether this is a tick-

box exercise or part of a broader strategy to ensure the best quality of care possible. Indeed, herein lies the specificity of personal services discussed by Baumol: while it is possible to measure the physical product made by industrial workers, it is far less easy to assess the outcome of an interpersonal process.

This questioning of the applicability (and legitimacy) of timelines for individual tasks is not abstract but rooted in the everyday struggles experienced by workers. They **resent these rigid timelines that constrain them; they consider them external and feel that their expertise is disregarded, as they know what they should be doing**: one of the most frequent phrases during the group discussions was that, to provide good care, **workers should be allowed to "do (their) jobs".** The very tight planning of the workday, scheduled around a set of rigid times for each task, and little or no time in between, was intensely discussed by the groups. Workers felt that industrial time was being applied in LTRCFs; they sometimes had the impression they were working on an “assembly line”. One effect of this relentless planning of tasks in LTRCFs is that there are occasions where some tasks are inadequately fulfilled, while others are overlooked entirely (see below).

This pervasive time pressure is exacerbated by the heavy reporting requirements linked to instruments such as RAI, Plaisir and BESA, especially for qualified nurses who have to capture activities in the software. Workers strongly resent the reporting burden and its associated technical complexities, with one qualified nurse lamenting “I am not a computer scientist”; they are however cognisant of the fact that “**what is not reported does not exist [for management]**”, and that reporting directly influences the staffing levels LTRCFs are entitled to. Although workers have no choice but to live with this reality, they consistently challenged the logic behind it. The group discussions revealed that documentation acts as a serious strain for workers in LTRCFs, as it interferes with the time to provide care and contributes to workers sometimes working beyond the end of their shift (effectively working for free). This is a result of finding it increasingly difficult to provide individual care while completing all the required tasks *and* documenting them. Workers are thus forced to make on-the-spot decisions about what they prioritise when time runs out; they often choose to care for residents over documenting the care that was provided. When certain tasks cannot be completed, they typically become the responsibility of the following shift, placing a further burden on the next worker and expanding the vicious circle.

Apart from overlooking dedicated contact time, reporting systems in LTC cannot properly capture the care work that is being performed for a simple reason: they focus on work as a series of consecutive actions, while care work typically entails multitasking. Therefore, the reporting logic again forces workers to triage and ration care to prioritise certain tasks and complete the documentation. This echoes the observation made by a social worker (Fuehrer, 2013) who tried to “test” a target-based system of work organisation and found it impossible to capture everything that he was doing – even if the attempt proved to be immensely time-consuming. He made a second observation that has particular relevance for LTC: that workers who “tick all the boxes” may well *not* be doing a good job. Co-workers and residents are ultimately those who can best judge the

quality of care that is provided; cases where a worker 'performs' according to indicators while not doing a good job may be rare, but the fact that they exist is in itself meaningful.

Much of what care requires is indeed simply not reducible to targets and indicators; workers who provide good care do so thanks to training, experience and the work environment, including the feedback of colleagues, management and residents. Crucially, the logic of care that guides their work frequently clashes with the requirements of a taylorised labour process that emphasizes predictability. The latter aims to ensure that (labour) costs are contained and care provided in a standardised way, while the very nature of care (all the more so when it concerns vulnerable individuals) is that it has to be reactive to unexpected events and reactions (we discuss this issue further in the next sub-section). This contradiction is an important source of suffering for many workers: they over-extend themselves to provide the care that residents need but, as they often lack the required time allocation to do so, do it too quickly and often on their personal time. In our discussion groups, the **issue of exhaustion** was thus recurrent, one group agreeing bitterly that "we have to push ourselves until our turn comes to burn out and leave our colleagues to carry the burden". During a discussion that happened with co-researchers who were preparing to lead the group discussions, one of them (a qualified nurse) lamented that she always arrived home exhausted and had no energy left to interact with her family and went to bed almost immediately. That was, in her opinion, the only way to cope with work demands.

It therefore appears that valuing the workers' professional skills and autonomy (and their perspective on how the job ought to be done, which may well vary from resident to resident) would be a key step towards promoting quality care. And yet, workers mentioned in discussions that it was not rare for LTRCF management to encourage compliance with prescribed tasks, for instance by praising the 'worker of the month', a title typically earned with reference to a particular quantified performance (for instance the ability to complete all set tasks). And yet, one of the issues on which all the groups converged was that faster and better were not equal terms when it comes to care.

Some of the groups also noted **flaws with the reporting system** used to assess the state of residents and determine the care "quantities" (in the form of time for different acts) they were entitled to. In some cases, it took time to adjust the resident's rating after a deterioration, increasing time pressure for workers who could simply rush through – thereby contributing to the vicious circle of care. Moreover, since such dependency assessments ultimately influence funding for LTRCFs, some workers reported being pressured to treat some residents as if they were more dependent. This is typically associated with one of the most insidious forms of institutional abuse in LTC: when workers, instead of accompanying residents for daily tasks, thus helping them retain autonomy, simply perform the task themselves, as this is more time, hence cost effective. Such practices, which contradict the principles of needs-based care (Heinzmann et al 2020), are bitterly resented by workers; they however appear to be a direct consequence of the way care work has been restructured.

3.1.3 When the unexpected is recurrent: at the heart of the vicious circle of care

Perhaps the most critical aspect of the vicious circle that workers experience is that, even if there is adequate time for a particular task *if all goes well*, it is very common that not all would go well. A resident can for instance soil themselves after they've been cleaned, requiring workers to clean them again. This may seem obvious, but doing so directly clashes with the projected workflow. We see here a very stark illustration of Mol (2008)'s characterisation of **the logic of care: it is driven by action and entails responding to crises and emergencies when they arise,** mobilising one's empathy and expertise. Not doing so would quite simply constitute a form of abuse, as is clear in the above example. This logic is very much at the heart of the professional ethic that workers feel primarily bound by; as we will see, workers aspire to an organisation of work that reflects, rather than contradicts, this logic.

These recurring unplanned (albeit highly probable) events that temper with pre-established schedules highlight most clearly the problem with the industrial-style organisation of time in LTC: unlike a factory, whose very design aims to remove the possibility of unexpected disruptions, and where the objects being handled cannot react to what is done to them, a LTRCF is an institution where care is provided to vulnerable, frail individuals. Hence, not only do unexpected events occur often in LTC, but responding to them is complex as it involves human beings and not materials and commodities. Even if residents are frail, they still have wishes, preferences and character, i.e. they can be stubborn or sociable, understanding or reluctant, depending on the situation or even the mood of the day. Care, on the other hand, should respond to these personal ways of *care receiving* (Fisher & Tronto, 1990); understanding that care is a *relational* (two-way) process, workers who participated in our discussion groups therefore see responding to needs as they arise (i.e., even if they were not planned) as an essential part of good care.

These **unexpected "disruptions"** (from the point of view of the work schedule) are increasingly frequent in LTRCFs as residents arrive with more acute cognitive and physical ailments. One group of workers mentioned the need to spend additional time with one resident, as otherwise they would behave aggressively throughout the day and abuse the staff. In such a situation, workers might not have a choice but to administer medication as the relationship has broken down to provide care. It generates a lower quality of life for the resident and the workers feel negatively about the situation. This type of scenario conveys the logic of care, as a worker has no choice but to respond immediately to rectify the situation; however necessary (and undoubtedly "part of the job"), this response will have a ripple effect on the rest of the scheduled workday. Concretely, a worker may find herself unable to complete her tasks in time due to such an overflow linked to an event that extended the time required to perform an earlier task – something that gets exacerbated should this happen multiple times. One example provided in the discussions showed that even just an extra ten minutes

with a resident can create an immense time pressure if multiplied by the 30 residents they care for in a day. This directly contributes to the stress workers report and forces them to make **difficult choices, typically between rationing other tasks (often relational, as these are not "counted") or working extra time without receiving extra pay for it.** In either case, this is not a sustainable situation as the pressure keeps weighing on workers' shoulders, and on their families. A worker remarked that "this fast pace does not correspond to everyday life", thereby recognizing that everyday life cannot be planned down to every minute. Such an "uneven" rhythm, by industrial standards, is typical of all care work; as we have seen, the organisation of work induces permanent clashes and forces workers into often impossible trade-offs.

3.2 Mapping the consequences of the tension between prescriptions and the reality of care

This clash between the prescribed work and its reality is not abnormal; according to Dejours (2003), work can be defined precisely as the negotiation of the tension between what is prescribed and the actual work. The mismatch between these two poles in LTC is however so extreme that it **generates permanent frustration for workers and negatively affects the quality of care for residents**.

3.2.1 The time gets to you

Workers are constantly forced to adjust the way they operate, by triaging tasks, rationing care through quick decisions (implicitly) and often over-working. They must triage tasks based on their importance, with medical care generally ranked the highest and any type of relational work last. It should be added that sometimes less critical care, such as nail clipping, are also rationed. This not only can inflict physical discomfort for the resident but can also produce a loss of dignity. In order to meet their objectives, workers effectively have to triage tasks and ration care. This rationing is often done in the moment, where a worker must decide what can wait or not be done with a resident. This is one of the key areas where experience plays a role; participants in our groups emphasized how work experience allowed them to make better choices under pressure. Interestingly, **they emphasized that the "right" way to do it (prioritising the residents' needs) was often clashing with institutional requests**; **this may be an important reason why less experienced workers, who may tend to follow institutional requests ahead of the logic of care, find it unbearable to cope with such contradictions and lose motivation**. The organisation of care therefore contributes to work exceeding the prescribed (and remunerated) hours, at a fast pace.

Not only does this compound the stress workers experience, but it can lead them to overlook certain activities that the residents value. One worker regretted that the "individual needs and

wishes" of residents are often ignored, for such wishes are an integral part of being able to live with dignity. This comment conveys the problematic over-emphasis on the medical-technical dimension in LTC over the social dimension; such an imbalance reflects the way in which the sector is financed and organised, but our research sheds a crude light on its consequences. Residents are not hospital patients; they do require medical care, but the homes are also their living places. Workers are fully aware of this and keen to help residents live in dignity; to do so, they often overextend themselves and work for free.

Workers indeed expressed that they feel an obligation to help individual residents and that they feel guilty if their shift ends before they have been able to provide what *they* consider to constitute adequate care. Across the different groups, participants emphasized that "the residents rely on us to be there for them, and I don't want to let them down". This situates care workers as "prisoners of love" or "emotional hostages" (England, 2005: 390); their commitment to the well-being of residents clashes with the deficient context in which they work, pushing them to make sacrifices. Together with the impressive professional ethics displayed by workers, such feelings are functional to the LTC system in Switzerland, which depends on them and exploits them, whether knowingly or not. This situation is unsustainable as it is both frustrating and exhausting for workers; it is therefore not surprising that so many of them fall ill, must miss work and decide to quit.

3.2.2 Filling the void

Workers feel manipulated, even blackmailed, when they are asked to step in for absent colleagues at short notice, often without any specific compensation and at great cost to their health and personal life. Many of the participants were incensed at the pressure they are put under by management to "plug the gaps". While money was not the main issue for them, the spurious reasons given by many institutions to refuse to offer a premium for such last-minute replacements was deeply resented. Many participants also noted bitterly that they were only valued when their sacrifice was required to save the institution, while their daily efforts were generally ignored (see *infra*). This is why, despite a general resentment towards standardisation, some workers (especially senior nurses) feel that the increasing codification of their work could have another useful function: that of rendering what they do visible, to help affirm their professional ethics. This echoes the frustration of many workers with the low esteem in which society in general, and management in many instances, hold them, dismissing what they do as "natural", "women's work" – an issue to which we return later.

The feelings of individual duty towards residents, while positive in and of themselves, are not an easy prison to escape. They undermine workers' wellbeing given the structural issues plaguing the organisation of LTRCFs. These feelings also act as an obstacle to collective organising or acts of solidarity with peers (for instance through unions), as workers do not want residents to experience

negative consequences from their actions. One worker questioned whether any industrial action would be possible as "you cannot just leave the residents". This holds important lessons for trade unions such as Unia, which we discuss further in the conclusion: they have a crucial role to play given the lack of voice of workers, but securing the latter's commitment will hinge on unions' ability to engage with the problems of work organisation in LTC (including the delivery of care), not only with "bread and butter" issues of working conditions.

3.2.3 Coming full "vicious" circle: Tracing the consequences back to their source

The logical consequence of this circle we have mapped is that **workers become exhausted, unhappy and start experiencing psycho-social issues such as burnout and depression**. This helps explain **the structural absenteeism affecting the sector**, which only exacerbates all the above time constraints and the resulting frustration. Workers understand the rising absenteeism but resent it as it increases their workload, in unison with the pressure put on them to cover the shifts of absent workers, often at short notice and with little financial incentive. The groups noted that the ones who are ready to do this "sacrifice" will do it until they themselves become exhausted and then absent. Eventually it can lead to leaving the position and even the sector entirely, contributing to the other well-known LTC problem: turnover, which makes sustaining positive relationships with residents challenging.

Workers expressed concern that many new workers and apprentices find the situation in LTRCFs challenging, especially as they emerge from training where they have been introduced to a range of ambitious, resident-centred approaches. The learning curve is all the greater for them that the distance between the prescribed and real dimensions of work has increased; as a result, they do not get to enjoy the intrinsically valuable moments of care and instead face a situation of high job demands with minimal training and experience.

Workers also noted that rural LTRCFs were finding it particularly difficult to recruit and retain staff in this context, as the high turnover meant that workers could shift to urban homes. Generally, the rural LTRCFs are less appealing given the distance to get to them and their isolation. One worker from a rural LTRCF said that many positions have been left open and they do not envision them ever being fully filled, adding yet more pressure on current staff.

The groups pointed out that one of the structural reasons for the dire state of work in LTC may have to do with what they perceive as an incoherent financing structure. Indeed, since 2011, the health insurance only covers a contribution towards medical care costs; although the exact amount varies from canton to canton based on local health policy. From the perspective of participants in the group discussions, the financing available for resident care is insufficient from the outset, an issue that is exacerbated by the problems we have discussed in this section, such as the insufficient recognition of the need for social and relational care. The only practical choice available to LTRCFs

is often to squeeze staff or take an operating loss, which is only possible (though not always the case) in non-profit settings. Several participants thus lamented the contrast, in private institutions, between lavish appearances (beautiful facilities and locations, numerous television sets or other amenities) and the dramatic lack of staff, resulting in low quality of care. The feeling that **work pressures were related to cost concerns were however shared by all participants, who resented it strongly**.

After mapping the vicious circle in LTC, we can conclude that the staffing crisis of the sector is understandable; it constitutes a consequence of the problems plaguing the organisation of work and is likely to get worse if nothing changes. Given the need to improve working conditions in order to resolve the crisis, it is worrying that more and more staff are employed with precarious contracts: fees for third -party contractors increased by 44% between 2021 and 2022, to CHF 164 million, in parallel with the growth of private LTRCFs, whose share of total places rose from 45.6% to 47.3% in the same period (Federal Statistic Office, 2023).

The management of time, as seen by workers, reveals the absurdity of a funding model that treats LTRCFs as if they were solely medical institutions, ignoring the highly dynamic character of providing care embedded in social interactions. Yet this dimension is crucial as residents can spend many years in a LTRCF. Their needs cannot be only assessed through a medical lens, especially as quality of life is taken into consideration. Even if it may sound trivial, it is worth repeating that caring for someone is not like producing a physical commodity: **the "objective" measures of product quality (i.e. medical-technical indicators) are useful and valuable, but certainly not sufficient to capture the relational, social element that is a fundamental part of the needs of residents**. This is particularly true when the latter element gets squeezed out. As one worker stated, in organising care, it is "important to consider what the resident actually wants, not just what we prioritise".

Social relationships are thus essential in providing good care and an important element of the job for care workers, whether institutions recognise it explicitly or not. Given the daily contact they have with them, it is not surprising that healthcare and other frontline workers know better than anyone else the needs of residents; the group discussions reflected this sentiment, with a participant expressing how they are "the real experts" on quality of care (echoing the "experts by experience" that constitutes the focus of PHR). Sometimes they will know as much as or more about a resident than caring family members; workers' knowledge and role become even more important when the family is not present.

The relationships between LTC staff and resident families are not always easy but workers take them very seriously and offered very interesting reflections during the group discussions. The families often resent what they perceive as neglect, and the workers empathise with their frustration, even regretting that families only formulate localised complaints, for fear of an aggressive institutional response. One worker was shocked to hear that the management had told an unhappy family to "take the resident back home if they wanted". Workers are not afraid of families complaining, on the contrary, they share their interest in seeing the residents happier: "if

only they could raise their voice!" One example was a daughter voicing a complaint that instead of having a conversation with her mother she had to clip her nails, as workers usually did not have enough time to do it with the required regularity. This again is a product of the overflow of work, triaging and neglect of secondary tasks because of the permanent pressure to limit costs combined with insufficient staff.

Our analysis of the group discussions thus conveys the acute frustration of workers within the vicious circle of LTC. The issues of staffing, care priorities and financing all converge to make daily work frustrating and at times unbearable for workers. **It is likely that the fact that many workers do not want to work full time is a direct consequence of this organisation of work, exacerbating the circle by limiting the available staff in LTRCFs**. It is worth noting that, in Belgium, the union SETCa (*Syndicat des Employés, Techniciens et Cadres*) has mobilised around a demand to reduce the duration of a standard working week in LTC to 32 hours. This may be the consequence of what happens when intense work is further intensified: it simply cannot be done for as long as it used to.

There is a sad irony in the situation of LTC in Switzerland as many workers (certainly the ones we spoke to) are highly motivated but are prevented from providing the care that would fulfil their expectations and the residents' needs. The LTC system then exploits their strong commitment to access "free work" from the workers to fill ever-more frequent and significant gaps. Workers strongly feel that profit-making through cost-cutting contradicts the real mission of care, which workers feel entrusted with. The next section will discuss the importance, for care workers, of the recognition of their critical role in maintaining care in the sector. It will also highlight the role that organising and trade unions could have in achieving greater recognition.

3.3 From recognising the vicious circle to recognising workers

The vicious circle of care is compounded by the acute frustration with the lack of recognition of the work done. The discussions highlighted that workers feel that their contribution is largely invisible, although they perform key tasks for care provision. This lack of recognition stems in part from the prejudice that elements of care work are "natural", in a context where most LTC workers are female. Long-term care work however requires extensive knowledge and complex skills that are both gained formally (through training) but also accumulated through experience. It was clear from the group discussions that lifelong learning is an important element for workers as it provides engagement, rewards, and ultimately helps them provide better care for the residents. Unfortunately, due to the constant tension under which LTRCFs operate, few seemed to send workers to training courses. By investing in lifelong learning, they would affirm the desire to retain workers and empower them to deploy their knowledge and expertise. This should however not obscure the importance of on-the-job learning; the individual experience that workers have acquired is crucial to allow them to perform the complex set of tasks involved in care. It also

highlights that, for LTRCFs to function and quality of care to be upheld, it is crucial to invest in retaining workers. This is not only critical to ensuring continuity of care, but also to enhance quality of care through valuing staff experience.

Many of the groups thus discussed how they can handle complex situations thanks to the experience they gained throughout the years. Seasoned workers know how to triage tasks effectively and ration care in the least damaging way for residents; in other words, **they learn to be innovative in delivering care within the confines of the system**. This however does not mean that the system's flaws should be left untouched; in fact, it seems clear that if the pressures applied on workers increased further, their situation and that of residents could deteriorate rapidly. Highlighting the ability of workers to negotiate the complex demands of LTC however serves to highlight that experience is priceless in the sector. Indeed, the residents are not simply bodies afflicted with one or more conditions; they are complex beings with social needs. The workers who have experience and work with them daily understand that these relationships are critical for care; they are also best placed to understand (through verbal and non-verbal communication) the needs and aspirations of residents. New avenues need to be opened in order to recognise and make the best of this knowledge and experience for Swiss LTC. Recognition takes multiple, interdependent forms: workers need to be better supported, heard, *and* compensated. Indeed, while many made it clear that money was not the main issue for them, the way they are paid (and how this relates to other professions) is perhaps the single most explicit signal of the value society attaches to their work. As the success of the nursing initiative, approved by 61% of voters, demonstrated in 2021, there is widespread support for affording better conditions to nurses in Switzerland.

3.3.1 Workers want to be heard and supported

Encouraging workers to express their voice freely and supporting them in their job are key elements to recognise workers and the unique skills, knowledge and experience they possess to provide care. Support can take the form of effective leadership and giving workers the necessary tools to provide care. Management needs to find the balance to guide work while avoiding micromanaging. Workers in the discussion groups understood that the functioning of the LTRCF is largely dependent on who is leading. One worker said, "The quality of leadership is extremely important and has a significant impact on how I personally feel and how the whole team functions". In terms of recognition, a leader needs to know that their team has expertise and experience, as well as trust their professional decisions. One worker described a situation where the director firmly demanded that the work be completed strictly as it was prescribed – thereby putting the worker in an impossible situation, as they knew this would impede the care delivery, as predicted by Dejours *et al.* (2018). This led to a standoff with the director: "It doesn't work like that. I am a qualified nurse and I act according to my convictions. If you can't handle it, I'm gone". This worker further

emphasized that **supportive leadership** is key and more important than the salary level. We can see from this example that supporting and listening to the frontline workers is crucial to maintaining satisfaction but also to improving the care provided.

Workers however consider that the lack of support from the management is not simply an individual issue, but a consequence of the financing structure of long-term care in Switzerland, which dictates their functioning in a very tight (and inadequate) manner, as described in the previous sub-section. Managers anxiously follow the indicators derived from the reporting instruments which determine the staff they are entitled to employ but also the operating result of the home. During the group discussions, participants lamented that managers are simply implementing a system which is akin to that of a factory.

Support and voice also entail providing workers the opportunity to expand their knowledge and share experiences. This can be done through team meetings and training courses. In meetings, workers can share and learn from each other's individual experiences; these exchanges are fundamental to ensure quality of care, both by improving the flow of qualitative information (which is not always captured in reporting) about residents, but also by providing a space for workers to express their frustration and receive peer support. While formal training (lifelong learning) is seen as important to develop worker competence, it was noted in the discussions that there needs to be more time available for such training. One worker in Ticino remarked that there was more time for training when they started 30 years ago. Another worker pointed out that often there is built in time for the training to occur, owing to a collective agreement, but the (internal) educators are not given the required time and support to deliver effective courses. This results in greater stress for employees delivering the training, as they have limited time to prepare, which adversely affects the workers in the course.

In relation to experience, workers described a situation where there was **not enough time to transfer experiences to other workers, especially trainees**. This is particularly important as their experience is vital for these new workers and can lead to attrition as they feel overwhelmed (Aubry, 2012). It is difficult to retain young workers in LTRCFs in Switzerland as discussed in section 1. Some of the workers appreciated that they had team meetings where they could share their experiences with other workers and offered the opportunity to collaborate and discuss situations, or simply to "blow off steam". These opportunities of training and development are an important aspect to support and listen to workers as it makes them feel valued and worth investing in.

Throughout several group discussions, the **inadequate skill mix** was discussed and the frustration and despair from the workers on the resulting workflow was evident. The skill mix includes the ratio per resident of different types of nurses and care assistants, with different levels and specialities. The workers expressed frustration that there were not enough specialists and managers on shift. Many of the non-specialists thus found that their competencies were stretched and felt uneasy about having to make decisions they were not trained for. One worker lamented that "it would be a real relief if we were not alone". Additionally, since most of the reporting burden

falls on senior nurses, their available time to serve residents and support the other workers is curtailed.

There is consensus in the academic literature about the importance, for medical outcomes in LTC, of the presence of an adequate complement of senior nurses and staff mix (Castle et al., 2011). To deal with this, and with staff shortages more broadly, it is not uncommon for institutions that are made up of multiple homes to adopt a **rotating staff model**, where staff are allocated to different LTRCFs, often on a weekly basis. While a systematic review did not register a significant difference in the quality of care between rotating and permanent staff models, this only referred to a quality-of-care definition based on medical-technical outcomes. The review noted that there were higher outcomes for resident hygiene and personal appearance in the permanent model (Perruchoud *et al.*, 2021). Several participants in our groups worked with such staffing models where specialists were moved around different homes to fill gaps. They all stressed the problems with such a model, both in terms of staff cohesion but also of quality of care from the residents' point of view. This is hardly surprising: as we have seen, ensuring a high quality of care entails building relationships, and paying attention to details that may not be considered crucial from a medical point of view but that are extremely significant for residents, such as maintaining their hair and general appearance. Participants thus agreed that there were clear benefits in having a permanent staffing model for residents as well as for the skill mix, whose practical efficiency largely depends on relationships between different staff categories. **Supporting the workers by having an appropriate staff mix would reduce their stress and allow them to focus on the role that they were trained to do and build stronger and stable relationships with residents**.

What emerges from the research is that, for good care to be provided, workers ought to be empowered to do so rather than told how to act in every situation. Our group discussions showed that care workers aspired to be given the required support to provide better care for residents. Instead, the increasingly demanding labour process deployed in LTRCFs, which delegitimises and negates the expertise of workers, undermines their ability to provide good care.

We can see from the discussions that providing support and empowering workers to express their voice are crucial to improving care, through showing recognition to care workers and what they bring to care work. Several areas form the base of this support such as leadership, training and development, and having an adequate skill mix for team support. In order to utilise the workers' vast potential of knowledge, expertise and experiences, they require their voices heard; this means that the (de facto) important decisions they must take while providing care must be taken seriously within the planning of care delivery. Workers even described situations where **they felt "enslaved" by the rigid ("military") structure of work planning (*minutage*), especially given the constant time pressures they are under**. The use of such strong words suggests that the problem goes beyond "dissatisfaction", that workers feel that **their personal and professional rights are suppressed by an authoritarian work regime**. This is by no means specific to LTC (see for instance Anderson 2017),

but it is worth emphasizing that such conditions are unlikely to be conducive to meaningful forms of empowerment and greater voice in care delivery.

As we have seen, such a labour process makes it nearly impossible to respond to the human, social aspect of care, which entails a naturally unpredictable dimension. Essentially care workers need the freedom to navigate the gap between what is prescribed by the medical experts (and the insurance companies) and what actually happens day to day. By doing this, care can be delivered in a way that benefits the resident and satisfies workers; this requires creating a greater sense of autonomy and improving working conditions.

3.3.2 Compensation

Better compensation, through higher wages, is another element to project a higher recognition for care workers. Although it might seem obvious that workers in these conditions demand higher wages, it is also important to dig deeper into the particularities of the sector. **Workers understood it would be expensive to increase wages but argued the long-term benefits would include reduced absenteeism**; there was also a sense that the current organising of work, driven by indicators, entailed numerous inefficiencies[12].

Additionally, there were **concerns about the wage premiums attached to night shifts or being on-call**. The groups highlighted that colleagues were less inclined to do those shifts as the wage premium is low (although there is often none) given the effect on work-life balance. Given that the **most resented forms of overwork were the short-notice requests for replacing sick colleagues**, changes that would limit absenteeism would also have an overall positive effect. In the meantime, greater recognition of the efforts required by workers to take those shifts, in the form of premiums, would go a long way towards alleviating their frustration.

Perhaps the most crucial element to bear in mind when thinking about wage levels has to do with the consequences of work intensification in LTC and the blurred meaning of full or part-time work. **Many workers feel that their schedule should be 80% with pay equivalent to 100% given this intensity**. This is not surprising given the harrowing conditions induced by the vicious circle of care we have analysed (including the frequent performance of unpaid work); **it also means that most workers earn less than a "full time equivalent" wage as they work beyond those hours. One worker thus highlighted that she needed to work 80% because that was already like working full-time for her**. It is therefore not surprising that many workers struggle to live decently on an 80% (or lower) salary in Switzerland: while wage levels for nurses are considered decent, they are not high by any standard. **In 2021, the ratio of hospital nurses' wages to the average wage was the lowest**

[12] One issue that was raised at one LTRCF during a participant observation was that of pharmaceutical stocks. While these used to be managed for the entire resident population, care financing reforms have required that the pharmacy stock drugs for each individual resident, leading to obvious cost increases and wastage.

in Switzerland among all OECD countries (at 0.9), while the same group's salary in purchasing power parity (taking price levels into consideration) saw Switzerland ranked 13th out of 34 countries (OECD, 2021). We should point out that, in the group discussions, **the salary issue was most forcefully raised regarding nursing assistants**, whose compensation was deemed disgraceful, especially in a context where staff shortages mean they have to perform ever more complex care tasks.

Despite these concerns, a "sticky wage" persists in the sector, due to the lack of recognition of care work discussed throughout this report. **Providing a higher wage and shift premiums combined with greater autonomy from a high level of support and voice of workers, can lead to workers gaining a full recognition**. Although we hope the state and employers will pursue these goals, it appears likely that pressure from workers will be necessary. Federici (2012) powerfully argues that, to overcome the reluctance to invest the required resources into senior (and other forms of) care, it will be necessary to politicise the issue. Thinking back about Baumol's disease, this does seem like the only way forward: society as a whole will have to decide whether it is prepared to allocate the (available but subject to intense competition) resources necessary to break the vicious circle of care.

Participants in the group discussions noted with regret that workers themselves however tend to be reluctant to demand better conditions collectively, as they are anxious about the impact on residents – a fear that management does not hesitate to instrumentalise. Overcoming these fears, and developing organising and mobilisation strategies taylored to the needs and challenges of the care sector, appear as key strategic objectives. It is not possible to provide care when the workers themselves are not receiving care, thereby collective organising may ultimately benefit residents even more than workers. Indeed, despite potential challenges (such as how to accommodate workers' scheduling demands with the needs of residents), building a greater collective voice constitutes a promising direction for the future, as the experience of workers across the different group discussions were strikingly similar.

3.3.3 Developing a collective voice through organising

During the Covid-19 pandemic, many countries promoted campaigns of public applause for healthcare workers who, alongside other categories that had to keep working during lockdown, were dubbed "essential'. LTC workers were also included as the scale of hardship experienced in LTRCFs was publicised. Although this formal recognition was appreciated, it did not address any of the substantial concerns of workers. As Stevano *et al*. (2021: 191) observe, 'the essential work classifications have recognised certain workers as indispensable but have not been used to subvert the relations of power that make them disposable'. To generate real recognition, workers ought to mobilise to be heard, supported and compensated appropriately. The current design of the LTC system and its funding mechanisms do not promote these objectives as central to delivering quality

care, as described in the above analysis. As a result, workers will need to take it upon themselves to initiate the action for change, following the inspiring lead of the Nursing Initiative that was approved in the national referendum of November 2021. It is a significant challenge that will require support from civil society and the public. Such a mobilisation holds great potential not only to improve the working conditions for LTRCF workers and reduce the rate of turnover, mitigating the vicious circle of care, but also to increase the quality of care for residents.

As the research has shown, organising for a collective voice is difficult in the LTC sector due to a variety of obstacles. Some of the workers reflected on why care workers did not network more and that it appeared many were trapped in their own world. With the stress related to the vicious circle of care and harsh working conditions, one worker lamented that there was “no energy left to fight for change, which unfortunately leaves us exploited”. This quote embodies the situation that given shift schedules and the mentally exhausting work itself, it is difficult to challenge the system, which is yet another vicious circle. Another obstacle comes in the form of management sometimes exploiting the personal relationships workers have with residents, effectively pitching a defence of workers’ interest as having an adverse effect on care. We strongly disagree with such a view; as we have shown, workers feel a personal obligation to residents and are committed to doing whatever they can to provide quality care. But they are themselves aware of the fact that, if those who care are not cared for, they will not be able to last. The discussions **revealed both a degree of helplessness and at same time a strong desire for change. A key reason why LTC workers aspire for change is not only for themselves but to have the ability to provide a high level of care for residents.**

With these significant obstacles, the workers in LTC need support to boost their own organising abilities. Although there is a desire to fight for change, as some of the workers were inspired by a strike supported by Unia in St. Gallen’s hospital, there needs to be societal support for workers. Here is an opportunity for trade unions and other social movements to meet with workers at the grassroots to organise and publicize their conditions and vision for change. Such organising would not only build a collective voice but has the potential to catch the attention of the wider public, as with the resounding victory of the Nursing Initiative in Switzerland. We hope that this research, which has sought to bring out the perspectives of LTC workers, can contribute to raising awareness within society about the challenges these workers face and the incredible efforts they deploy to provide the best care they can to residents. We have no doubt that further work to explore the way in which workers provide care on a daily basis would also help empower future efforts to improve quality of care and working conditions.

4. Conclusion

The group discussions we conducted with workers in long-term care institutions allow us to answer the research questions. We first present the main answers, before reflecting on the implications of our research and charting the way forward to achieving people-centred care through the empowerment of care workers.

- What constitutes 'good care' from the point of view of workers?
    a. Building and nurturing relationships with residents and understanding their individual needs (continuity);
    b. A stable and sufficient workforce (both in numbers and in terms of skill mix) is essential to meeting both the medical needs (which form the bulk of the tasks workers have to perform) and the social/human needs of residents;
    c. Having autonomy to organise their work, so as to deploy and develop their experience and knowledge.

- How do working conditions influence the quality of care?
    a. There is not enough time to complete all the tasks and care must be rationed;
    b. The vicious circle of care causes constant stress and exhaustion, leading to absenteeism and low energy to provide care;
    c. Lack of recognition (professional, organisational as well as financial) depletes workers' morale.

- How does the way care is organised affect workers' relationships with residents and other staff?
    a. The taylorised labour process does not leave enough time to nurture relationships;
    b. The lack of time for relational care has negative implications on quality of life for residents and on worker engagement, which is crucial to coordinate work;
    c. Documentation, which is intended to help continuity of care, is resented as a burden by workers; it is pervasive yet fails to capture adequately the work involved in providing 'good care' for residents.

Concluding thoughts

In rich societies, ageing people are increasingly looked after by paid carers. They cook for them and help them eat; keep them clean; administer their medication and look after their health; take them for walks or strolls in wheelchairs. And, very often, paid carers are the main, if not the only, people with whom seniors talk or communicate. As Aristotle remarked more than 2000 years ago, social interactions are what define humans. Daily, paid care workers expand their skills and energy to provide a fundamental service to society in general, and to the residents of LTRCFs and their families

in particular. They do not feel much gratitude, financial or otherwise, for this; in fact, LTC only seems to hit the news when scandals involving improper care are revealed. While these scandals reveal deep problems within the sector, they do not reflect the reality of all LTC institutions. It would however be foolish to assume that LTRCF residents all live happy lives. Many of them are starved of human interaction; their isolation horrifies seniors in other parts of the world, where societies value, rather than manage, their senior citizens[13]. As we have shown in this report, the way the caring labour process is organised has a lot to do with this isolation: by applying the principles of industrial time to try and 'optimise' care, its relational, human dimension – indeed its very logic, as Mol (2008) argues – has been compromised.

Our research on workers in Swiss care institutions has thus revealed that the well-known symptoms of the staffing crisis in LTC (rising absenteeism and resignations, reflected in high turnover) have very real roots in the way the work is organised. The workers who participated in our group discussions feel frustrated when they are unable to care properly for the people under their watch. Even though these people are not their relatives, the workers' dedication to them is impressive. In the context of a structurally unfit organisation of care work, their commitment is however also a trap: workers will often provide the care the residents need even if they are punished for it (because they were too slow, for instance), or not paid for the extra time. Instead of responding collectively to the problem, LTC workers tend to over-exert themselves to fix a broken system, putting their health and well-being on the line in the process. In many cases, workers who earn wages to care for people also find it difficult to provide their family members, whether young or old, with the care they need. This is partly because the work in LTC is physically and emotionally draining; but also because the scheduling of care work is inherently the same whether those requiring care are in a LTRCF or an individual home. LTC residents thus need to be looked after in the morning, to get them ready for the day. Many of the care workers are women who are the primary care givers for their own dependants. At least, those who work in LTRCFs often live close to their loved ones, unlike many live-in carers who are migrants who spend weeks, months or sometimes years away from their family (Poo, 2013; Schwiter et al., 2018).

To address the crisis of long-term care, rich societies such as Switzerland must therefore confront a fundamental contradiction, and the hypocrisy that conceals it: it is not possible to expect paid care workers to provide for all the social needs of seniors. Care can be provided professionally, but not entirely offloaded to workers in LTRCFs. It is crucial, as Federici (2012) argues, to politicise senior care and start a societal dialogue about how it should be organised and financed. The voice of care workers must be heard loud and clear in this debate regarding the organisation and funding of long-term care. It is also undoubtedly important that workers also participate in a reflection on how to make the voice of residents better heard, individually and institutionally, to create the

[13] See 'En Côte d'Ivoire, la première maison de retraite attend toujours ses résidents', *Le Monde*, 28 November 2023 (https://www.lemonde.fr/afrique/article/2023/11/28/en-cote-d-ivoire-la-premiere-maison-de-retraite-attend-toujours-des-residents_6202751_3212.html)

conditions to actualise resident centred models of care. In care work, the technical and emotional dimensions are deeply interwoven; exhausted, angry people do not make good carers. As a society, we must care for those who care. Who can do it better than they themselves? Supporting the emergence of a collective voice articulating worker demands, both in terms of how to provide good care and how to organise their work to do so, is therefore critical. We hope this report will contribute to this.

We have identified a number of issues that would warrant further exploration by researchers concerned with understanding the challenges of the long-term care sector and identifying innovative responses. First, while much research has been dedicated to the role of specialised nurses in care provision, there appears to be a dearth of investigation on less qualified medical staff, such as nursing assistants. This is all the more worrying that this heterogenous group accounts for the majority of staff employed in care homes; it is also the fastest growing staff category in absolute and relative terms. Further research into the role played by other categories of workers (whether social workers or cleaning, cooking or other hospitality staff) in delivering care would also be important to inform future policy decisions.

Secondly, in this report, we have insisted on the importance of putting workers at the heart of the promotion of quality care. But what are the avenues to promote such participation, within organisations and at a sectoral level? Can collective bargaining help in this regard? Given the inadequacy of the current model for organising care work, researchers ought to engage with alternative models that have been implemented in care homes and outside these, such as the ones analysed by Lopez (2006). He analysed a LTRCF in the United States that utilized a working environment he characterised as “organised emotional care”. This strategy gives a high degree of autonomy for care workers to treat residents in both medical and relational terms. It gave the workers resources, time and the recognition of their expertise to respond to residents in an effective manner. Both workers and residents responded positively to this approach and turnover rates were very low at this LTRCF. Such research into “alternatives” should also focus on atypical care homes that seek to accommodate the demands of New Public Management while maintaining a firm focus on the logic of care, such as the CSO in Ticno and Lindenhof in Aargau. One important question to ask of these experiences would be whether they are managing thanks to the system (perhaps because they have found a way to make it work better) or in spite of it.

Last but not least, research into the meaning of and possible ways to assess the quality of care provided should be conducted in a way that challenges the dominant indicator-driven approaches. In particular, how can crucial issues such as resident autonomy and quality of life, and staff well-being and autonomy, be incorporated into a more inclusive understanding of “good care”? Here, the contributions of authors such as Dejours (2003) will be critical, with his insistence on the fact that you cannot resolve the problems revealed by an indicator by “fixing it – i.e. by simply tweaking what workers do to improve the score measured by the indicator. The role of the two main feedback mechanisms for measuring the quality of work (peers and service users) ought to be given

greater consideration. At a broader level, critical feminist scholarship exploring the meaning of care (and reproductive labour) more broadly also holds important lessons. We can see this through recent calls to transform care, such as The Care Collective' *Care Manifesto* (2020), *Clean Up Time! Redesigning Care after Corona* (2022) by Care.Macht.Mehr and Ai-jen Poo's *The Age of Dignity* (2016).

Trade unions such as Unia and others have a critical role to play in supporting LTC workers in regard to the issues described above. Unia's support for and participation in this research indicates that it is taking this task very seriously. One of the main lessons from this research for trade unions is that working conditions and the organisation of the caring labour process are not distinct issues. While unions have traditionally focused their organising efforts on working conditions, especially pay levels, it will be necessary for them to support workers in engaging actively in discussions on how care is provided, organised and funded. Working conditions should of course be part of the demands of unions; many LTC workers are suffering from their conditions of employment and need union support to improve them, not least because the number of precariously employed workers rises to fill the gaps of a system that literally leaks staff.

LTC workers however take the well-being of residents so seriously that they will not be satisfied unless they can provide better care and ensure that residents live better lives. Workers are also best placed to know what is wrong with the organisation of care and understand the needs of residents with whom they spend their days and nights. It will therefore be crucial for workers to participate in debates on how to define quality of care: the current approach appears to be wholly inadequate, as the (mostly medical) care indicators become the very targets around which care work is organised, as opposed to being useful signs to guide it. By transforming the sector's organisation in order to respond to the logic of choice (thereby paving the way for the growing participation of private providers), NPM-inspired reforms have undermined the logic of care that drives the work of professionals[14]. It is time to trust workers to care for the residents.

One alternative that could give workers voice and recognition is a tripartite board that determines not only wages but also dialogue on how the work is organised, such as the one formed in the US state of Minnesota in 2023. This board is unique as it can set policies without requiring a legislative vote; it gives a forum for workers, employers and the state to investigate challenges, discuss solutions, and ultimately enact regulations. The board was established as the Minnesota government realised the extent of the challenges of turnover and working conditions in LTRCFs, while recognising the valuable input frontline workers can provide. Most of the pressure to create this board came from unions representing LTRCFs as they faced opposition from employers and their political allies (Madland, 2023). Despite these obstacles, the workers and unions succeeded as they also leveraged post-Covid public support as a form of societal power.

[14] For a compelling critique of the impacts of the marketisation of long-term care, see Corlet Walker et al., 2022.

As these alternatives suggest, any improved care model is likely to involve bottom-up participation (and mobilisation), rather than simply top-down reform. This represents both a challenge and an opportunity for trade unions in care. The challenge is clear: they are not yet equipped to engage with the 'high level' discussions on the provision of care, which are dominated by medical experts and insurance companies. Nor will it be easy to convince employers and policy makers that workers ought to be included in discussions related to the way in which care provision is organised. At least since the 1920s, the quid pro quo between unions and employers (at least in the Global North) has been that bargaining would be limited to working conditions, while the organisation of production would be the sole domain of the employer, or the lead firm. This had led, according to Anderson (2017), to the acceptance of a despotic form of private government in workplaces. And yet, mobilising care workers and promoting better care for seniors will require challenging this status quo. The opportunity for unions is unique: they can leverage the expert knowledge of their members to transform the way care is provided. If they succeed, they can play a leading role in mobilising society and advocating for the logic of care to take precedence over the logic of choice in how care is organised. In so doing, they will probably have to challenge the commodification of care, which has deleterious effects on seniors and the workers who care for them. The development of a worker-driven *Manifesto for long-term care* could be the spark that ignites this fire.

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Annexes

A.1 Advisory Board Composition

- Francesco Branca, former director of Office of the Elderly and Home Care (Ticino Canton)
- Adrian Durtschi, former head of UNICARE at UNI Global Union
- Prof. Francois Hoepflinger, University of Zurich
- Prof. Carlo Knoepfel, University of Applied Sciences Northwestern Switzerland
- Roswitha Koch, Swiss Professional Nursing Association
- Prof. Alexandre Lambelet, University of Applied Sciences and Arts Western Switzerland (HETSL | HES-SO)
- Prof. Rita Pezzati, University of Applied Sciences and Arts of Southern Switzerland
- Prof. Karin Schwiter, University of Zurich
- Reto Wyss, Swiss Trade Union Confederation

A.2 Survey introduction text for participants (German, French and Italian) on Findmind.ch

Forschungsprojekt «Was ist gute Pflege? Die Sicht des Personals im Mittelpunkt»

Deutsch

Arbeiten Sie in einem Pflegeheim in der Schweiz? Haben Sie bei Ihrer Arbeit Kontakt mit Bewohner:innen? Dann sind wir an Ihren Erfahrungen interessiert und freuen uns, wenn Sie sich an unserem Forschungsprojekt beteiligen.

Sie können sich beteiligen in dem Sie:

- n einen kurzen online Fragebogenausfüllen, Aufwand ca. 5-10 Minuten.
- n an einer Gruppendiskussion von maximal 90 Minuten in Ihrer Wohn- oder Arbeitsregion teilnehmen.

Um was geht es im Projekt?

In unserem Projekt steht die Perspektive der Mitarbeitenden auf die Qualität im Pflegeheim im Zentrum. Wir wollen Ihre Sichtweisen darauf dokumentieren und Ihre Ideen dazu abholen.

Uns interessiert insbesondere Ihre Meinung zu diesen Fragen:

- Was ist aus Sicht der Mitarbeitenden in Pflegeheimen «Gute Pflege»?
- Welche Bedeutung haben die Arbeitsbedingungen des Personals für die Versorgungsqualität?
- Inwiefern beeinflusst die Messung der Pflegequalität die Beziehungen zwischen den Mitarbeitenden und den Bewohner:innen im Pflegeheim?

Unsere Forschungsergebnisse sollen in die politische Diskussion rund um die Langzeitpflege und den Fachkräftemangel einfliessen. Wir wollen damit einen Beitrag zur Verbesserung der Arbeitsbedingungen und der Versorgungsqualität in Pflegeheimen in der Schweiz leisten.

Wer ist am Forschungsprojekt beteiligt?

Die Sichtweise der Mitarbeitenden von Pflegeheimen steht für uns im Zentrum. Wir erheben sie mit Hilfe von Gruppendiskussionen. An den Diskussionen sind Mitarbeitende aus verschiedenen Institutionen aus unterschiedlichen Arbeitsbereichen wie Pflege, Aktivierung, Reinigung oder Gastronomie beteiligt.

Das Projekt wird von einem unabhängigen Forschungsteam an der Fachhochschule Südschweiz (SUPSI) durchgeführt und betreut:

- **Nicolas Pons-Vignon** (Projektleiter), Professor für Arbeitstransformation und soziale Innovation, Kompetenzzentrum für Arbeit, Wohlfahrt und Gesellschaft, Departement für Wirtschaft, Gesundheit und Soziale Arbeit, Fachhochschule Südschweiz (SUPSI)
- **Jason Schneck**, Doktorand, Kompetenzzentrum für Arbeit, Wohlfahrt und Gesellschaft, DEASS, SUPSI
- **Karin Van Holten**, Professorin, Co-Leiterin des Kompetenzzentrums für Partizipative Gesundheit, Departement Gesundheit, Berner Fachhochschule

Das Projekt wird von der Unia sowie von der SUPSI finanziert. Die Unia hat sich zudem bereit erklärt, mehrere Mitarbeitende für die Datenerhebungsphase des Projekts zur Verfügung zu stellen. Die SUPSI hat die alleinige wissenschaftliche Leitung des Projekts inne.

Projet de recherche «Mettre les salarié.e.s au coeur de la promotion des soins de qualité»

Français

Vous travaillez dans un EMS en Suisse ? Êtes-vous en contact avec les résident-e-s ? Votre expérience nous intéresse et nous espérons que vous accepterez de participer à notre projet de recherche.

Vous pouvez participer :

- en remplissant un bref questionnaire en ligne (env. 5-10 minutes) ;
- en prenant part à une discussion de groupe d'une durée maximum de 90 minutes dans votre région de domicile ou de travail.

Sur quoi porte le projet ?

Notre projet s'intéresse au point de vue des employé-e-s concernant la qualité des soins dans les EMS.

Nous sommes particulièrement intéressés par votre opinion sur les questions suivantes :

- Que signifient des « soins de qualité » de votre point de vue?
- Quelle influence les conditions de travail ont-elles sur la qualité des soins?
- Comment la mesure de la qualité des soins influence-t-elle les relations entre le personnel et les résident-e-s dans les EMS?

Les résultats de notre enquête enrichiront le débat public sur les soins de longue durée et la pénurie de personnel qualifié. Nous voulons ainsi contribuer à l'amélioration des conditions de travail et de la qualité des soins dans les EMS en Suisse.

A qui s'adresse le projet de recherche ?

Dans le cadre de discussions de groupe, nous nous intéresserons aux différents points de vue des salarié-e-s des EMS qui ont des contacts directs avec les résident-e-s (soins, activation et intendance).

Le projet est mené et encadré par une équipe de recherche indépendante de la Haute école spécialisée de la Suisse italienne (SUPSI) :

- **Nicolas Pons-Vignon** (responsable de projet), Professeur en Transformations du travail et innovation sociale, Centre de compétences travail, welfare et société (CLWS), SUPSI.

- **Jason Schneck**, Chercheur doctoral, CLWS, SUPSI.
- **Karin van Holten** (consultante), Professeure, co-directrice du Centre de compétence pour la santé participative, Département de la santé, Haute école spécialisée bernoise.

Le projet est financé par Unia ainsi que par la SUPSI. Unia mettra à disposition plusieurs employé-e-s pour la phase de collecte des données du projet. La SUPSI assume seule la direction scientifique du projet.

Progetto di ricerca «Mettere i dipendenti al centro della promozione della qualità delle cure»

Italiano

Lei lavora in una casa per anziani in Svizzera? Nel suo lavoro ha contatti con i pazienti? Siamo interessati alle sue esperienze e saremmo lieti di averla tra i partecipanti al nostro progetto di ricerca.

Può partecipare al progetto:

- compilando un breve questionario online (5-10 minuti);
- partecipando a una discussione di gruppo per una durata massima di 90 minuti nella sua regione di domicilio o di lavoro.

Obiettivi del progetto

Il progetto si pone come obiettivo quello di capire cosa significhi «qualità delle cure» in una casa per anziani dal punto di vista dei dipendenti.

Vogliamo conoscere la vostra posizione in qualità di dipendenti sulle domande che seguono:

- Cosa significa «qualità delle cure» dal punto di vista del personale delle case per anziani?
- Che importanza hanno le condizioni di lavoro del personale ai fini della qualità dell'assistenza fornita?
- In che misura la valutazione della qualità delle cure influenza le relazioni tra il personale e gli ospiti della casa per anziani?

I risultati della ricerca dovrebbero confluire nella discussione politica sulle cure di lunga durata e sulla carenza di manodopera per contribuire al miglioramento delle condizioni di lavoro e della qualità delle cure.

Chi partecipa alla ricerca?

Rileveremo il punto di vista del personale delle case per anziani tramite discussioni di gruppo con i dipendenti provenienti da diversi ambiti lavorativi quali le cure, l'animazione, le pulizie o la ristorazione.

Il progetto è implementato da un team di ricerca indipendente della Scuola Universitaria Professionale della Svizzera Italiana (SUPSI):

- **Nicolas Pons-Vignon** (responsabile del progetto), professore in Trasformazioni del lavoro e innovazione sociale, Centro competenze lavoro, welfare e società (CLWS), Dipartimento economia aziendale, sanità e sociale (DEASS), SUPSI.
- **Jason Schneck**, dottorando, CLWS, DEASS, SUPSI
- **Karin Van Holten**, professoressa e co-direttrice del Centro di competenza per la salute partecipativa, Dipartimento sanità, Scuola universitaria professionale di Berna

Il progetto è finanziato da Unia e SUPSI. Unia ha accettato di mettere a disposizione alcuni dipendenti per partecipare alla raccolta dei dati. La SUPSI è l'unico responsabile scientifico del progetto.

A.3 Training presentation for co-researchers (German)

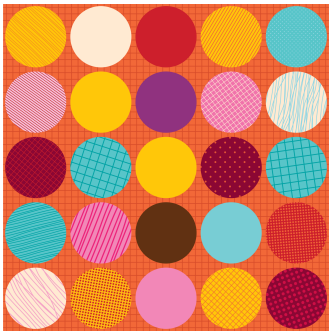
Gruppendiskussion – Vertiefung

Schulung im Rahmen des Projekts «Gute Pflege? Die Sicht des Personals im Mittelpunkt»
17.04.2023 / Nicolas Pons-Vignon und Karin van Holten

▸ SUPSI und BFH, PART – Kompetenzzentrum Partizipative Gesundheitsversorgung

Programm

- Nächste Projektetappen – Was steht an?
  - Information zu den Gruppen (Grösse, Anzahl pro Region)
- Organisatorisches rund um die Gruppendiskussionen
  - Link für sichere Datenablage / Upload
  - Zeitraum für die GD
- Gruppendiskussionen
  - Vorbereitung
  - Durchführung
  - Nachbereitung



Berner Fachhochschule | Haute école spécialisée bernoise | Bern University of Applied Sciences

Gruppendiskussion

Ziel und Leitthemen

- **Teilnehmende diskutieren untereinander, gemeinsam**
- **Fragen - Themenblöcke:**
  - Was ist ‘Gute Pflege’ aus Ihrer Sicht?
  - Wie beeinflussen Ihre Arbeits-bedingungen die Qualität der Versorgung?
  - Beeinflusst die Qualitätsmessung im Betrieb Ihre Beziehungen zu Bewohnenden oder anderen Mitarbeitenden?

Programm

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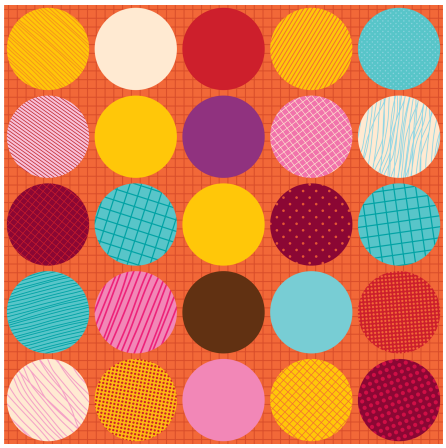
  - Vorbereitung
  - Durchführung
  - Nachbereitung



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  - Beeinflusst die Qualitätsmessung im Betrieb Ihre Beziehungen zu Bewohnenden oder anderen Mitarbeitenden?

Übersicht Schritte Gruppendiskussion

Vorher

- Infomail und Terminumfrage
- **Datum und Ort** festlegen
- **Aufnahmegerät und Akku/Batterie** testen
- Sich mit **Leitfaden für Diskussion** vertraut machen

Während

- Sich **vorstellen**
- **Diskussion erklären:** Infos Projekt, Ablauf und Rollen
- **Fragen beantworten**
- **Vertrauen aufbauen** - joining / small talk
- **Check Aufnahme !**
- **Diskussion starten / Stimulus** setzen
- **Abschluss** einleiten: Möchten Sie noch etwas hinzufügen?
- **Danken!**
- **Aufnahme** stoppen

Nachher

- **Beobachtungs-protokoll**
- **Nachbesprechung** Moderation und Beobachtungen
- **Datensicherung !**
- **Daten-Transfer**
- **Verschriftlichung**
- **Analyse**

Checkliste: Vorbereitung

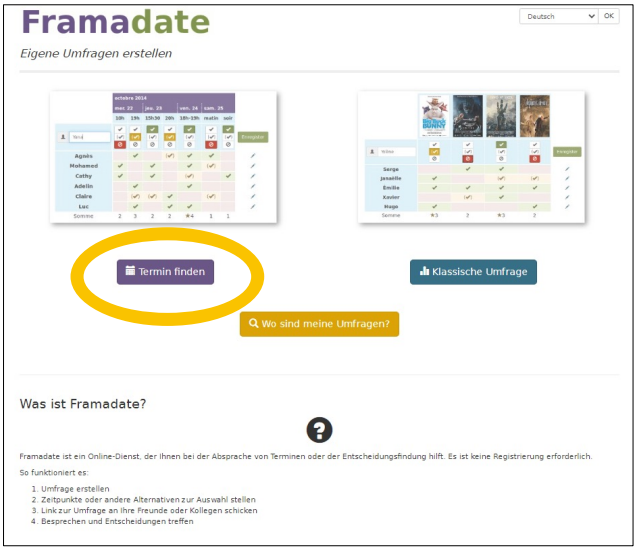
Vorher

- Infomail und Terminumfrage
- **Datum und Ort** festlegen
- **Aufnahmegerät und Akku/Batterie** testen
- Sich mit **Leitfaden für Diskussion** vertraut machen

- ☐ Terminumfrage auf www.nuudel.ch/ erstellen
- ☐ Mail verschicken mit Infos und Link für Termin
- ☐ Ort(e) für Gruppendiskussion suchen
- ☐ Terminumfrage prüfen
- ☐ Ev. Erinnerung verschicken
- ☐ Datum und Zeit bestimmen
- ☐ Datum, Zeit, Ort mitteilen
- ☐ Informationen zu Anreise
- ☐ Aufnahmegerät testen
- ☐ Fragen für Diskussion vorbereiten
- ☐ Rollen klären: wer moderiert? Wer beobachtet und notiert?

- ☐ **Kriterien Ort**: ruhig, einfach erreichbar, geeigneter Raum für Diskussion, WCs

Terminumfrage auf nuudel.ch



- www.nuudel.ch oder www.nuudel.de
- Umfrage erstellen
- Link in Mail einfügen
- Umfrage ausfüllen lassen → mitteilen bis wann!
- Termin auswählen
- Umfrage abschliessen

Checkliste: Gruppendiskussion durchführen

Während

- Sich **vorstellen**
- **Diskussion erklären:** Infos Projekt, Ablauf und Rollen
- **Fragen beantworten**
- **Vertrauen aufbauen** - joining / small talk
- **Check Aufnahme !**
- **Diskussion starten / Stimulus** setzen
- **Abschluss** einleiten: Möchten Sie noch etwas hinzufügen?
- **Danken!**
- **Aufnahme** stoppen

- ☐ Getränke und kleine Snacks einkaufen
- ☐ Akku/Batterien Aufnahmegerät prüfen
- ☐ Raum und Sitzordnung vorbereiten
- ☐ Aufnahmegerät testen!
- ☐ Teilnehmende trudeln ein → SmallTalk: gute Reise? Ort gefunden? Was zu trinken? …
- ☐ Projektinformation
- ☐ Ziel und Ablauf Diskussion
- ☐ Start Aufnahme
- ☐ Vorstellungsrunde
- ☐ Stimulus setzen → Diskussion starten
- ☐ Zuhören – nachfragen – Notizen machen
- ☐ Zeit im Blick haben
- ☐ Am Schluss danken
- ☐ Ausblick: Wie geht es im Projekt weiter?

Verschiedene Rollen

Moderation

- sicheren Raum schaffen
- Prozess gestalten – Orientierung geben:
  → begrüßen, informieren, erklären
- Fragen stellen: Stimulus, Spezifikation
  → nicht lenken, sondern Raum für Diskussion bieten
  → **Wichtig**: alle ansprechen - Blickkontakt!
- Aktiv zuhören
  → Mimik, Gestik, Mhm
  → nonverbale Kommunikation

Beobachtungsprotokoll

- sicheren Raum schaffen
- Beobachtungsprotokoll führen:
  Aspekte, die nicht aufgezeichnet werden können:
  → nonverbale Interaktionen
  → Stimmungen, Auffälligkeiten
  → Momente der Überraschung, Verwunderung, Irritation, …
- Unterstützung der Moderation:
  → wichtige Themen nochmal aufgreifen/vertiefen, Fragen stellen

Berner Fachhochschule | Haute école spécialisée bernoise | Bern University of Applied Sciences

Phasen der Diskussion

Leitfaden für die Diskussion

Thema Qualität	Thema Arbeitsbedingungen	Thema Qualitätsmessung und Einfluss Beziehungen
▸ Einstiegsfrage: **Was ist 'Gute Pflege' aus Ihrer Sicht?**	▸ Einstiegsfrage: **Wie beeinflussen Ihre Arbeitsbedingungen die Qualität der Versorgung?**	▸ Einstiegsfrage **Beeinflusst die Messung der Qualität im Betrieb Ihre Beziehungen zu Bewohnenden oder Mitarbeitenden?**

Tipps für die Moderation und Beobachtung

Moderation

- Fragen und Blickkontakt immer an die ganze Gruppe
- Pausen aushalten – z.B. still bis 10 zählen
- Wenn es nicht läuft – nachfragen:
  - «Also, das ist spannend, kann jemand dazu noch mehr sagen?»
  - «Sehen das alle so?»
  - «Hat jemand ein Beispiel?»
  - «Das verstehe ich nicht, könnt ihr mir das erklären?»
  - Und ganz wichtig – **Humor ist erlaubt**

Beobachtung

- Auf Körpersprache der Teilnehmenden achten (Blicke, Gesten)
- Was passiert in Sprech-Pausen?
- Was passiert, wenn mehrere gleichzeitig reden?
- Welche Themen kommen immer wieder? Welche kommen gar nicht?
- Wie ist die Stimmung / Dynamik unter den Teilnehmenden?
- Was ärgert, irritiert oder freut?

Mögliche Schwierigkeiten – hilfreiche Strategien

- Schweiger:innen

- motivieren durch Blickkontakt oder Frage in die Runde: *«Sehen das alles so?» «Möchte jemand noch was dazu ergänzen?»*
  - KEINE DIREKTE REDEANWEISUNG

- Viel-Redner:innen, dominante Personen

- Gruppe selber kontrolliert Dynamik
- Wenn sie wirklich stören (und nur dann), nochmal betonen, dass wirklich die Sichtweisen und Erfahrungen von allen Platz haben sollen.

- Macht- und Hierachiedynamiken

- Bereits bei der Zusammenstellung der Gruppe beachten

Checkliste: nach der Gruppendiskussion

Nachher

- **Beobachtungs-protokoll**
- **Nachbesprechung** Moderation und Beobachtungen
- **Datensicherung!**
- **Daten-Transfer**
- **Verschriftlichung**
- **Analyse**

- ☐ Kurze Nachbesprechung Moderator:in und Beobachter:in – Notizen festhalten:
  - Was ist gut / weniger gut gelaufen?
  - Was war komisch, besonders spannend?
  - Wo/wann gab es Irritationen, Spannungen?
  - Was ist sonst noch aufgefallen? (Themen, Aussagen, Personen, …)
- ☐ Aufnahme sichern
- ☐ Beobachtungsprotokoll fertigstellen
- ☐ Daten hochladen

A.4 Question guide for group discussions

1. What do you consider to be "good care"?

Questions to get started	Possible topics	How to enquire in more detail
What different aspects make up "good care" for you? What motivates you to provide good care? Describe a scenario in which you felt you were providing good care? And bad or dangerous care?	Is your idea of good care being realised in your LTRCF? What are the obstacles to good care? What role and importance do relationship work and time have in care?	Has Covid-19 changed the way you see good care?

2. How do your working conditions affect the quality of care?

How might your working conditions prevent you from providing care? What do you think are the factors that lead to poor working conditions? OR Do you feel that you manage to be truly "present" with the residents in everything you have to do, or do you feel that you are always thinking about the next task? Why do we carers find it so difficult to say no or distance ourselves? Have you thought about leaving your job OR have you already resigned?	How is the relationship with the quality of care and working conditions developing? Are there enough staff? Is there a difference in these experiences between unionised and non-unionised members? Do you have enough time for emotional labour? How do you make time?	Describe and evaluate specific working conditions that affect the provision of care services. What do you find frustrating? What impact has Covid-19 had on your working conditions? Specifics

3. Does measuring the quality of care affect your relationships with residents or other staff?

How is the care provided in your LTRCF measured or documented? What is measured? Do these measurements or the documentation influence the way you work and your relationships with the residents? Have you ever "acted" in the sense of hiding true emotions when providing care?	Does the measurement/documentation of care capture the right elements? Is documentation an obstacle to the provision of good care? Do you feel that your work is increasingly controlled and standardised, so that the work instructions have elements of the way a supermarket or fast food company works? Keyword: care on the assembly line	What is your opinion on the recording and documentation tools? (RAI, PLAISIR, BESA) How does the task of documentation affect your work and your relationships?

In addition to these questions, you can also ask these questions to keep the conversation flowing:

➢ What was that exactly again?

➢ Can you give an example?

➢ Can you describe what you did in more detail?

➢ How often did you do that?

A.5 Table of select private equity firms in the long-term care sector

Name	**Base Country**	**Owned Care Companies (country)**	**Facilities**	**Beds**
Intermediate Capital Group	United Kingdom	DomusVi (France, Portugual, Spain, Netherlands, Ireland)	354	36000
EQT	Sweden	Colisée (France, Belgium, Spain, Italy)	275	24986
Nordic Capital	Sweden	Alloheim (Germany)	253	23707
Formation capital LLP	USA	HC-One (United kingdom)	329	20175
I Square Capital	USA	Domidep (France, Belgium, Germany)	115	8360
Waterland	Belgium/Netherlands	Schönes-Leben-Gruppe (Germany) Silverstream (Ireland)	73	6548
Bridges Fund Management	United Kingdom	Shaw Healthcare	57	2456

Source: Christoph Scheuplein, Institute for Work and Technologie, Rainer Bobsin, Company websites as cited in "Grey gold – the billion Euro business of elder care" (Investigate Europe, 2021*)*