OPINION

European Economic and Social Committee

Health Workforce and Care Strategy

Health Workforce and Care Strategy for the future of Europe
[Own-initiative opinion]

SOC/720

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(for/against/abstentions)	194/4/3

1. Conclusions and recommendations

1.1 The EESC firmly stands by the principle that strong and resilient health systems can only be based on and developed by an educated, skilled and motivated health workforce, which is fundamental to delivering a successful health policy and by consequence essential for the achievement of human-centred health coverage for all and the "right to health", as recommended by the Conference on the Future of Europe, guaranteeing all Europeans equal and sustainable access to affordable, preventive, curative, and quality health care.

1.2 The EESC welcomes the initiative for EU-level action to strengthen long-term care and early childhood education and care as envisaged under the European Pillar of Social Rights, which will contribute to high quality, accessible, equitable and affordable care services and help strengthen gender equality and social fairness.

1.3 The EESC calls for a transformative approach to care centred on people, their rights and their needs, including their participation in any relevant discussions, consultations and decisions. It urges the Commission to be ambitious in setting out a care strategy that can contribute to cohesion and upward convergence in healthcare and long-term care among and within the Member States.

1.4 A European Care Guarantee can ensure that everyone living in the EU has life-long access to affordable quality healthcare and care services, address care deficits, and promote decent working conditions, providing training opportunities. Support and better recognition of informal carers and policies geared to address problems in paid and unpaid informal care are key to an efficient use of resources.

1.5 Given that efficient, accountable and well funded public services remain key in ensuring equal access to quality care, the EESC calls on the European Union to ensure complementarity between all providers of care services based on solidarity, encourage investment in public services, the social economy and support social economy actors in the care sector.

1.6 Workforce planning should take into account the development of digital technologies, as innovations in these areas open up opportunities for creating new work environments and settings in which care is delivered, and require new skills. Supporting the digitalisation of LTC services is key in tackling the digital divide and digital poverty.

1.7 The EESC proposes an update of the Action Plan for the Health and Care Workforce in the European Union[1]. The development of integrated health workforce planning and forecasting and the adaptation of health and long-term care workforce skills are essential for improving access to and the quality of these services. An updated plan could ensure better data collection, harnessing the potential of digitalisation across the EU and develop methods to better forecast workforce and skill needs.

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[1] The European Commission published in 2012 its Action Plan for the EU health workforce.

1.8 The EESC emphasises that the right to mobility must be respected within the EU. Cross-border mobility adds an extra dimension to workforce planning, the establishment of a European health workforce surveillance service to assist Member States in establishing and maintaining planning structures, and coordinating cross-border aspects of planning would be a useful long-term infrastructure element.

1.9 Social dialogue involving governments, employers and workers and their representative organisations is key to a transformative care strategy and resilient health and care systems in the EU; care givers and receivers have to be included in charting an inclusive, resilient, gender-equal care and health ecosystem.

2. General comments on care

2.1 Vital for social protection and the wellbeing of EU citizens, long term care comprises a range of services and assistance for people who experience mental and/or physical fragility and/or disability over extended periods of time, depend on help with daily life, and/or requiring some permanent nursing care by professional or non-professional paid/unpaid providers at home or at nursing and residential care facilities[2].

2.2 The COVID-19 pandemic severely tested the resilience and the adequacy of care systems across the EU, indicating structural problems, such as underfunding and understaffing in many countries, which can deteriorate due to ongoing economic/political challenges, inflation, uncertainty and the energy crisis.

2.3 The European Pillar of Social Rights enshrines the right to care and the right for everyone to have access to quality formal care services based on need. Announced by Commission President Von der Leyen in her 2021 State of the Union speech, the new European Care Strategy entails two Council recommendations on childcare (revising the Barcelona targets) and on long-term care. The European Parliament has recommended improving life-long care provision based on the needs of care recipients and providers, urging the Commission to support MS in developing quality care services[3].

2.4 The EESC has adopted several opinions on care provision in the EU[4], stressing the need to invest in high-quality, sustainable and accessible care for all, and address deficits in childcare and LTC. It has identified shortcomings in care provision for all, "in the diversity and fragmented nature of the services on offer, in poorly regulated services, in difficulties in coordinating management levels, in coordination problems between social and healthcare

2 European Commission, DG for Employment, Social Affairs and Inclusion. (2014). "Adequate social protection for long-term care needs in an ageing society: report jointly prepared by the Social Protection Committee and the European Commission", Publications Office, https://data.europa.eu/doi/10.2767/32352 p. 14.https://www.oecd-ilibrary.org/sites/c149d939-en/index.html?itemId=/content/component/c149d939-en

3 European Parliament resolution of 15/11/2018 on care services in the EU for improved gender equality https://www.europarl.europa.eu/doceo/document/TA-8-2018-0464_EN.html.

4 OJ C 129, 11.4.2018, p. 44; OJ C 487, 28.12.2016, p. 7; OJ C 204, 9.8.2008, p. 103; Brochure and EESC opinion on Economic, technological and social changes in advanced services for the elderly, OJ C 240, 16.7.2019, p. 10; EESC opinion on "Towards a New Care Model for the Elderly: learning from the Covid-19 pandemic", OJ C 194, 12.5.2022, p. 19.

services, in the growing commodification of services and in the need for prevention policies and measures"; opposing stereotyping and other discrimination against the elderly, the EESC has called for people-centred care supported by digitalisation. In this context, the EESC recommends full deployment of digitalisation to reduce undue paperwork for care workers and applying the best achievements of smart regulation.

3. A transformative approach to care

3.1 An effective European Care Strategy requires engagement towards a transformative and ambitious approach, which puts at its heart people and their fundamental rights and needs, ensuring their participation in consultations and decisions, with the potential to contribute to cohesion and upward convergence among and within the Member States.

3.2 Embodying this transformation, a European Care Guarantee would ensure that everyone living in the EU has lifelong access to affordable and quality care, provide a cohesive framework for MS to deliver high quality services and lifetime care strategies, and improve working conditions and training for carers and support informal carers.

3.3 Large-scale investment in the care economy and infrastructure is requisite for a transformative approach that would address persistent care gaps, potentially creating ca. 300 million jobs by 2035 that would also enhance gender equality and women's access to labour markets[5].

3.4 While different models exist in Member States, efficient, accountable and well-funded public services remain key in ensuring equal access to quality care, and in supporting unpaid care providers, particularly women. The EESC emphasises the need to maximise complementarity and the synergy between all care and health providers in both the public and private sectors (profit and not profit) to achieve coverage for all[6], taking into account best practices and positive examples in the Member States, and while respecting national specificities and differences.

3.5 Privatisation trends and market-driven practices such as risk selection and maximising profit over care and health can exacerbate inequalities, affecting the most vulnerable with unmet care needs. Based on solidarity, respect of the national competences and subsidiarity, LTC and child care at EU and Member State level need strong social protection systems and public services, social investment and social economy actors – e.g. mutual societies – to provide optimal community and home-based care by adequately trained carers[7].

3.6 EU structural and investment funds can be used to support investment in care. On healthcare and LTC, the Commission should better target its country-specific recommendations within the European Semester and, where needed, help Member States prioritise adequate funding as a productive investment rather than an economic burden.

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5 Addati, L., Cattaneo, U., and E. Pozzan. (2022) Report on "Care at work: investing in care leave and services for a more gender equal world of work". ILO, Geneva https://www.ilo.org/global/topics/care-economy/WCMS_838653/lang--en/index.htm.

6 https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.53.

7 See EESC opinion on "The impact of social investment on employment and public budgets", OJ C 226, 16.7.2014, p. 21.

4. Working conditions, challenges and employment potential

4.1 Around 6.3 million people work in the long-term care (LTC) sector in the EU while 44 million people provide frequent informal LTC to relatives or friends, in one of the fastest growing sectors worldwide[8]. Up to 7 million jobs for healthcare associate professionals and care workers are expected to be created by 2030[9].

4.2 Major challenges for the care sector include staff shortages, unattractive and demanding working conditions, an ageing workforce, and underfunding, due to social and health budget cuts during the 2008 economic crisis, in varying degrees across the MS[10]. In almost all EU countries job growth lags behind increasing demand, owing to mentally and physically arduous conditions that cause care workers to leave the sector – a trend exacerbated by the pandemic, adversely affecting health and safety for both care recipients and workers.

4.3 A transformative approach should promote gender equality, considering that women represent over 80% of the care sector workforce, are principal caregivers and recipients in formal and informal settings[11] and are on average older than the overall EU workforce. As women undertake the vast majority of caring responsibilities in the family, accessible and affordable Early Childhood Education and Care (ECEC) and LTC services would enable more women to join the labour market. The right to at least five working days of carers' leave per year, introduced by the Work-Life Balance Directive, will provide some support to informal carers trying to balance work and caring responsibilities. The lack, however, of adequate paid leave prevents full enjoyment of the Directive's provision of this right and may exacerbate gender inequalities.

4.4 Wages in the sector are below average in many EU countries, despite arduous working conditions, specific requirements in skills/competencies and qualifications, and high occupational health and safety risks[12]. In several MS, unionisation, collective bargaining coverage, job satisfaction and staff-user ratios are at low levels; inter alia, the pandemic exposed deficient provision of personal protective equipment.

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8 Eurofound (2020), "Long-term care workforce: Employment and working conditions", Publications Office of the EU, Luxembourg. https://www.eurofound.europa.eu/nb/publications/customised-report/2020/long-term-care-workforce-employment-and-working-conditions.

9 Barslund, Mikkel et. al (2021). "Study: Policies for long-term Carers" (2021). Brussels, European Parliament, https://www.europarl.europa.eu/RegData/etudes/STUD/2021/695476/IPOL_STU(2021)695476_EN.pdf.

10 https://www.euro.who.int/__data/assets/pdf_file/0011/186932/12-Summary-Economic-crisis,-health-systems-and-health-in-Europe.pdf.

11 European Commission, Directorate-General for Employment, Social Affairs and Inclusion, "Long-term care report: trends, challenges and opportunities in an ageing society". (2021) Vol. I, Chap. 3. Publications Office, pp.12, 28 https://data.europa.eu/doi/10.2767/677726.

12 See footnote 11, pp. 68–70.

4.5 Unpaid informal care, or family care, is a cornerstone of LTC provision in Europe, but home care and community-based care in many countries remain underdeveloped and hard to access[13]. Considering the impact of informal care provision on key life outcomes, the EESC strongly recommends policies which foster the "formalisation" of informal care, support informal carers and contribute to an efficient use of resources.

4.6 The EESC expresses concern regarding widespread precarious care work among undeclared, mostly female domestic care workers who engage in live-in care, mostly coming from migrant groups or mobile citizen categories. Exacerbated by lack of access to formal care and economic necessity, this grey area calls for a cohesive policy approach, with due attention to skill certification, regularisation, and/or resident permit procedures.

4.7 As demand for LTC grows, the sector will benefit from higher and more stimulating wages, effective collective representation and collective bargaining, and more training. Public funding leveraged to improve working conditions (for instance via requirements in public procurement) can help address staff shortages and ensure high quality LTC. Professionalisation, defining quality and elaborating standards to assess/measure quality as well as harmonisation of standards across MS are essential to the renewal of the sector[14].

5. Other comments

5.1 The pandemic has exposed fragmentation and dispersion, particularly in provision and funding responsibilities in many MS, indicating the need for better integration between healthcare and national care systems[15][16], which are best placed to deliver in terms of ensuring access for all and efficiency.

5.2 One emerging major challenge requiring concerted measures in the new care strategy concerns preventing and addressing mental health problems that are a combined result of the pandemic and rising mental health incidences (e.g. dementia) linked to an ageing population.

5.3 As recent experience related to the prevention and control of COVID-19 in long-term care facilities demonstrates[17], effective assessment, efficient and streamlined external supervision and inspection, in both public and private care provision facilities are key in preventing abuses

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13 European Commission, DG for Employment, Social Affairs and Inclusion, (2018) Zigante, V., "Informal care in Europe: exploring formalisation, availability and quality", Publications Office, https://data.europa.eu/doi/10.2767/78836.

Spasova, S., et al (2018). Challenges in long-term care in Europe. A study of national policies, European Social Policy Network (ESPN), Brussels: European Commission. https://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=8128&furtherPubs=yes.

14 See footnote 11, chapter 3.

15 European Commission, DG for Employment, Social Affairs and Inclusion. (2014). "Adequate social protection for long-term care needs in an ageing society: report jointly prepared by the Social Protection Committee and the European Commission", Publications Office, p.36 https://data.europa.eu/doi/10.2767/32352.

16 Pan-European Commission on Health & Sustainable Development (2021). "Drawing light from the pandemic: a new strategy for health and sustainable development. A review of the evidence" https://www.euro.who.int/__data/assets/pdf_file/0015/511701/Pan-European-Commission-health-sustainable-development-eng.pdf.

17 Danis, K., Fonteneau, L., et al.,(2020). High impact of COVID-19 in long-term care facilities: suggestion for monitoring in the EU/EEA,. *Euro Surveillance : European Communicable Disease Bulletin*, 25(22). https://doi.org/10.2807/1560-7917.ES.2020.25.22.2000956.

and ensuring safety and quality, particularly for vulnerable populations, the elderly and children, capitalising on existing good practices in MS.

5.4 Developing EU-wide standardised data collection and LTC indicators is vital for a successful Care Strategy at MS level, including reporting requirements and regular reviews, to be carried out with efficient and streamlined procedures. Adequate child care provision, in particular, requires quantitative and qualitative targets to measure progress and to deliver on and go beyond the Barcelona targets.

5.5 Support for digitalisation of LTC services is key in tackling the digital divide. Special attention needs to be given to accessibility, assistive systems, improving digital literacy and to digitalisation for job quality, upskilling and new methods of diagnosis, monitoring and treatment.

5.6 The EESC condemns war crimes committed by the Russian Federation in Ukraine, targeting care and health workers, patients, children, hospitals and other facilities; alongside deaths and injuries this aggression is gravely affecting Ukraine's health and care system, calling for targeted aid and support measures – also having in mind that the crisis in Ukraine is spreading everywhere and affects many aspects of social and economic environment.

5.7 Social dialogue involving governments, employers and workers and their representative organisations is key to a transformative care strategy and resilient health systems in the EU; importantly, those who receive and provide care have to be included in charting a more inclusive, resilient and gender-equal care and health ecosystem, engaging civil society and other stakeholders, e.g. the church and philanthropy.

6. General comments on health workforce

6.1 Good health care is a pillar of a stable, secure, and prosperous society and its organisation is the government's responsibility. It is common practice in many countries to rely on the low cost and quick recruitment of health workers from other European countries. This is simply acknowledged as a fact of life and left appallingly unaddressed.

6.2 The EESC firmly stands by the principle that strong and resilient health systems can only be based on and developed by an educated, skilled and motivated health workforce, which is fundamental to delivering a successful health policy and by consequence essential for the achievement of health coverage for all and the right to health. The very recommendations of the Conference on the Future of Europe aim to create a "right to health", guaranteeing all Europeans equal and access for all to affordable, preventive, curative, and quality health care.

6.3 The European Health Union should improve EU-level protection, prevention, preparedness, and response against human health threats. In that context, the success of all key initiatives within the European Health Union depends heavily on a high-quality health workforce.

6.4 In a number of opinions[18], the EESC has addressed the issue of the health workforce in a variety of other contexts and activities. Especially during the pandemic, health workers are on the front lines, demonstrating an outstanding level of solidarity during the most difficult times.

6.5 The EESC supports measures that should be taken to make jobs in the health care sector more attractive to young people. This is one of the most important prerequisites for creating sufficient human resources capacity in health care systems to meet healthcare needs, health promotion, and disease prevention.

6.6 Data on numbers, migration, skills, and other specifics related to the health workforce should be standardised and continuously shared among Member States. Numerous events (the COVID-19 pandemic, earthquakes, floods, the Russian invasion of Ukraine, etc.) demonstrate the importance of rapid response, especially in crisis situations.

6.7 Employment in health and social services increased by 48% in OECD countries between 2000 and 2017[19]. As the population ages and changes, the demand for health services will also grow and change: it is estimated that the global demand for health workers will nearly double by 2030[20].

6.8 Even before the COVID-19 pandemic, the capacity to deliver basic health services was limited in many countries due to persistent health workforce shortages and a projected global shortfall of 18 million health professionals by 2030[21].

6.9 It is important to clearly define the principles of the possible transfer or combination of skills and tasks (task shift/skill mix). There is a need to coordinate institutions that train the health workforce to respond appropriately to the needs of the national healthcare system through timely corrections to enrolment rates and curricula.

6.10 The development of human resources in health and social care should follow the principle of coordination, intersectoral cooperation, and integration of care, with the common goal of achieving continuity of care for citizens in the 24/7/365 model.

6.11 Special attention should be paid to the availability of treatment in local communities, especially in sparsely populated areas, remote or isolated rural areas, and islands, where modern transportation and telemedicine solutions need to be used more actively.

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18 OJ C 286, 16.7.2021, p. 109; OJ C 429, 11.12.2020, p. 251; OJ C 242, 23.7.2015, p. 48; OJ C 143, 22.5.2012; OJ C 18, 19.1.2011, p. 74; OJ C 77, 31.3.2009, p. 96.

19 https://one.oecd.org/document/ECO/WKP(2021)43/en/pdf.

20 Liu JX, Goryakin Y, Maeda A, Bruckner T, Scheffler R. Global health workforce labor market projections for 2030. Human Resources for Health 2017;15:11 (https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-017-0187-2).

21 https://www.who.int/health-topics/health-workforce#tab=tab_1.

7. Health workforce planning

7.1 The EESC believes that health workforce planning must aim to create conditions for a professional practice that improves the quality of care and patient safety. At the same time, the capacity for high-quality training must be ensured at all levels.

7.2 The management of the health workforce must be considered a strategically important activity at the level of the whole state administration and through the key role of the Member State government, and must be implemented in a multisectoral way, taking into account different perspectives and priorities.

7.3 Health workforce management must address all phases of the "life cycle of professionals" – from recruiting future students to employing retirees. The process of selecting candidates for training, employment, and promotion should be transparent and fair, without any form of discrimination.

7.4 In planning the health workforce, it is important to consider and clearly represent the needs of citizens and health workers. Planning and management processes must establish the methods by which it is possible to identify all the needs of professionals, from working conditions, material rights, opportunities for advancement, adequate time and resources allocated to learning and research, to the establishment of a sustainable balance between personal and professional life.

7.5 The planning of the health workforce must reflect the planning of the structure, but also the actions and processes to achieve the goals set – to define what needs to be achieved and in what specific way.

7.6 The EESC proposes an update of the Action Plan for the Health and Care Workforce in the European Union[22]. The development of integrated health workforce planning and forecasting and the adaptation of health and long-term care workforce skills are essential for improving access to and the quality of these services.

7.7 Social partners and all interested civil society organisations must play an active role in the health workforce planning process. It is necessary to define the relationships between the different professional groups, the population's specific needs and the system for certain competencies.

7.8 The identification of unattractive geographic areas or areas of activity where there is a shortage of human resources is necessary for safeguarding the rights and provide adequate incentives for health professionals. EESC proposes that the European Commission should issue recommendations on minimum ratios of resources per population unit for baseline universal health coverage and emergencies, taking into account geographic distribution and age profile[23].

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22 In 2012, the European Commission published its Action Plan for the EU health workforce.

23 CPME Policy on Health Workforce (https://www.cpme.eu/policies-and-projects/professional-practice-and-patients-rights/health-systems-and-health-workforce).

7.9 As a basis for these recommendations, it is important to improve international data collection exercises to harmonise data categories where possible in order to identify differences and avoid misinterpretation of data. It is important to reflect national deviations from the harmonised categories across Europe to be able to put data into context[24].

7.10 The issue of financial resources will be addressed differently depending on the economic circumstances in each Member State. Evidence suggests that Member States need to ensure that system planning in general, and health workforce planning in particular, takes into account both the broader environment and the government's relative ability to influence it[25].

7.11 Workforce planning should take into account the development of digital technologies as innovations in these areas open up opportunities for creating new work environments and settings in which care is delivered, and require new skills.

8. Working conditions

8.1 The importance of working conditions as a factor in professionals' decisions to enter, stay in, or leave medical career highlights the importance of coherent policies in areas such as education, employment, family life, finance, and migration. While much discussion of health workforce planning focuses on professional compensation as a key factor in recruitment and retention, access to education and training, including professional development and the ability to maintain skills, practical conditions such as availability of care, official working hours, safe staffing, meaningful professional development opportunities, and work-life balance all contribute to a healthy work environment in which medicine is an attractive and sustainable career choice[26].

8.2 European and international medical organisations note that physicians working in hospitals, general and private practices are increasingly confronted with situations of violence – sometimes extreme – in their daily practice, outside of any conflict[27]. EESC calls on the European Commission and all stakeholders to show political commitment and to be aware of the urgent need to protect the health workforce in the performance of their work.

8.3 Healthcare workers are at risk of contracting infectious diseases through exposure at work. Transmission of diseases leads to absenteeism, morbidity, and in some cases mortality among healthcare workers. These ultimately create a reduction in the workforce and consequently affect the quality of patient care and safety.

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24 See footnote 2.

25 Russo G, Pavignani E, Guerreiro CS, Neves C. Can we halt health workforce deterioration in failed states? Insights from Guinea Bissau on the nature, persistence and evolution of its HRH crisis. Human Resources for Health 2017;15(1):12.

26 See footnote 2.

27 https://www.cpme.eu/api/documents/adopted/2020/3/EMOs.Joint_.Statement.on_.Violence.FINAL_.12.03.2020.pdf.

8.4 Healthcare workers may also suffer from psychological stress and potentially mental disorders that affect both their work and personal lives. In recent years, reports of health care workers reducing professional practice or retiring early due to burnout, depression, or other mental health conditions have increased[28]. The EESC calls for investment in public mental health services to ensure full and free access to these services for all health professionals.

9. Mobility

9.1 The EESC emphasises that the right to mobility must be respected both within and outside the EU. Cross-border mobility should be facilitated for the benefit of the individual worker and the profession as a whole, as it provides an opportunity for knowledge transfer and mutual learning, which benefits patient care and ultimately the entire health care system. In the event of migration due to economic necessity or unfavourable working conditions, it is critical to identify and address the root causes of these dynamics and work toward improving the situation of the health workforce[29].

9.2 Cross-border mobility adds an extra dimension to workforce planning, the establishment of a European health workforce surveillance service to assist Member States in establishing and maintaining planning structures and coordinating cross-border aspects of planning would be a useful long-term infrastructure element. It should be linked to EU processes, particularly the European Semester and pandemic planning envisaged under a future EU regulation on serious cross-border health threats[30].

9.3 Member States must implement ethical recruitment policies in accordance with the WHO Global Code of Practice on the International Recruitment of Health Personnel[31]. Recruitment of professionals from abroad should not be considered a simple means of mitigating the shortage of domestic health personnel. Where there are asymmetric mobility flows, efforts should be made to create balancing mechanisms that work toward win-win exchanges.

10. Other comments

10.1 Effective leadership is crucial for managing health professionals at all levels; it is a complex and highly valued component of healthcare education that is increasingly recognised as essential to achieving high standards of education, research, and clinical practice.

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28 Dyrbye, L. N., T. D. Shanafelt, C. A. Sinsky, P. F. Cipriano, J. Bhatt, A. Ommaya, C. P. West, and D. Meyers. 2017. Burnout among health care professionals: A call to explore and address this underrecognised threat to safe, high-quality care. *NAM Perspectives.* Discussion Paper, National Academy of Medicine, Washington, DC.

29 See footnote 2.

30 See footnote 2

31 https://www.who.int/publications/m/item/migration-code

10.2 Consequently, high-quality and sufficient leadership education and development should be part of the curricula of all health professions[32].

Brussels, 22 September 2022

Christa Schweng
The president of the European Economic and Social Committee

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32 Van Diggele, C., Burgess, A., Roberts, C., & Mellis, C. (2020). Leadership in healthcare education. BMC Medical Education, 20 (Suppl. 2), 456. https://doi.org/10.1186/s12909-020-02288-x