From Shortage to Strength: Reshaping the Health and Care Workforce for the future

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World Health Organization
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75 HEALTH FOR ALL

The bottom line up front

There is no care without caregivers! A gender-balanced, adequately sized, trained and managed care workforce is a necessary condition for a functioning long-term care system, the principal driver of quality but also of costs

There can be no evidence-based policy without a strong evidence base! Our understanding of the structure and capabilities of the workforce is severely limited by pressing data gaps, poor characterization (lack of comparable definitions) and high degrees of informality. In turn, planning capacity remains very low

Improving training and professionalization of the care workforce is possible and pays off!

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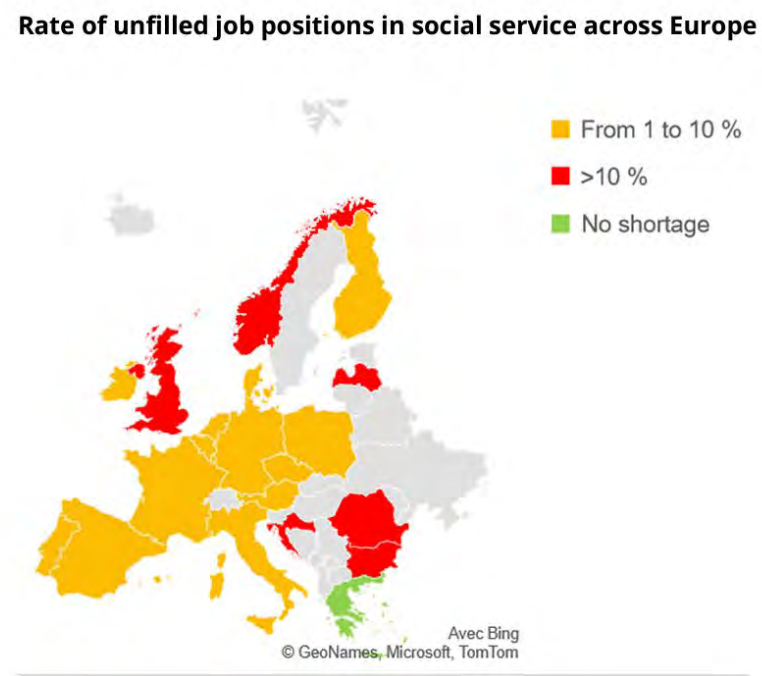
Severe shortages of nursing personnel and LTC workers

- CEDEFOP Policy report (2023):
  - **421.000 residential care workers across EU-27 left the care sector** between 2019-2021
- European Labour Authority's (2023) Labour Shortages Report identifies the **shortage of nursing professionals in the EU as both widespread** (17 out of 30 surveyed countries reporting deficits) and **severe** (more than 50% of EU counties rated the shortage as high magnitude at national level)
- In some EU countries, human resources constraints are becoming more pressing than financial constraints – difficult to staff funded services, for which there is a clear demand



An estimated **4.3 million** openings in the care workforce will need to be filled by **2035**

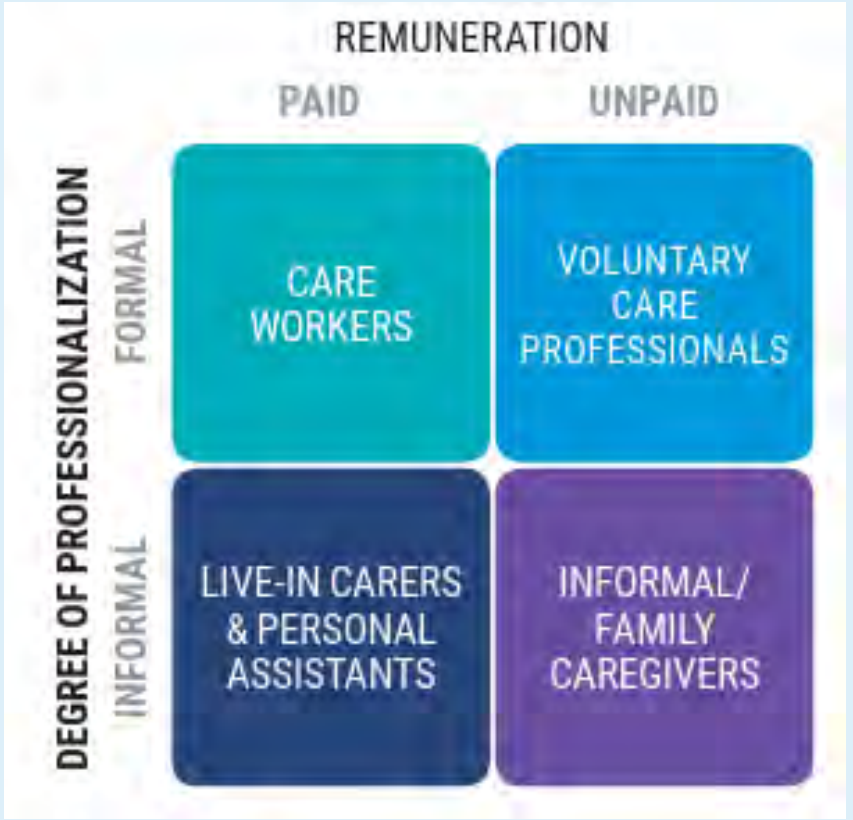
Source: CEDEFOP (2024)

What is the LTC workforce?

All persons providing long-term care and support:

- Within the remits of a formal employment contract?
- Within the remits of informal agreements, for pay?
- Within a social/ familial network of support?

Caregiver type by level of professionalization and remuneration



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Source: Rebuilding for sustainability and resilience: strengthening the integrated delivery of long-term care in the European Region. Copenhagen: WHO Regional Office for Europe; 2022

Value of the (**in**)formal care workforce

Around **3.1 million** were employed as care workers in 2023 in the EU – **1.5% of total EU employment** — but this underestimates the level of demand.

Even though Europe boasts the world's most generous formal LTC systems, around **80% of long-term care** is estimated to be provided by informal carers.

In the EU, it is estimated that **12-18%** of the population aged 18-75 provides informal care **(~44 million carers**)

With rising population demand, the number of people in the EU in need of long-term care is projected to increase from **30.8 million in 2019 to 38.1 million in 2050**, requiring an increase in the care workforce.

All expenditure for formal LTC is valued at

1.7% of GDP

While informal care is valued at

~3.65% of GDP

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Actors in the LTC systems

Identifies **26 categories of actors**, among which:

- Carers, domestic workers, personal carers, home aides, volunteers
- Nursing professionals, nursing associate professionals, community health workers
- Generalist doctors, specialist doctors, therapists, pharmacists
- Social workers … and others

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Source: Long-term care for older people: package for universal health coverage. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Actors in the LTC systems

But many of these professions are **not clearly or consistently defined** (e.g. personal worker, domestic aid, nursing assistant), and even those that are can be very difficult to trace in statistics

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Source: Long-term care for older people: package for universal health coverage. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Identifying the LTC workforce in international statistics

We rely on the intersection of International Standard Classification of Occupations (ISCO) codes – currently ISCO 08 (soon to be updated) and NACE Rev. 2 - Statistical classification of economic activities codes

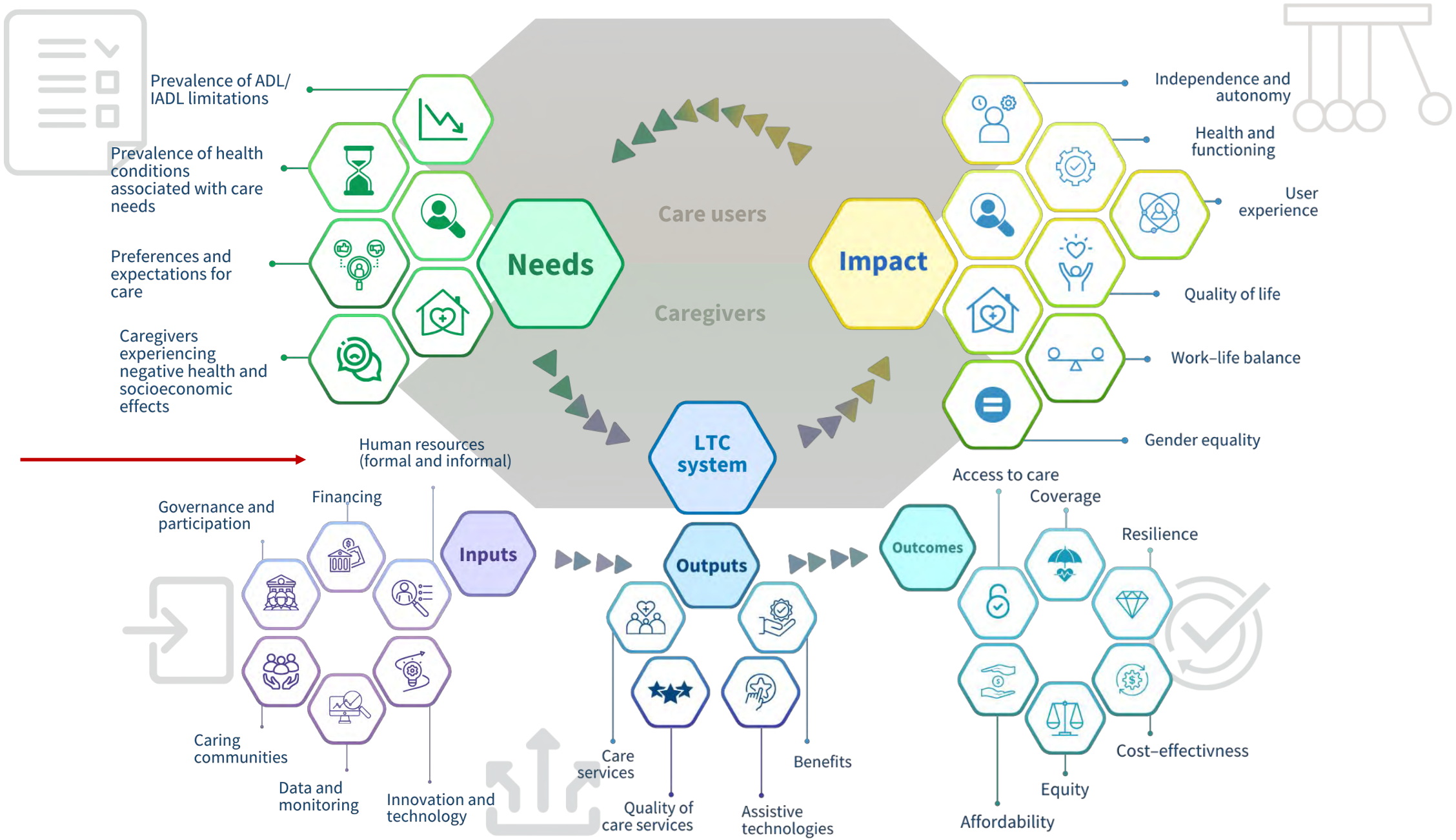
ISCO 08		NACE 2 / NACE 2.1					
		86.9	87.1	87.2	87.3	88.1	97.0
		Other human health activities	Residential nursing care activities	Residential care activities for mental retardation, mental health and substance abuse	Residential care activities for the elderly and disabled	Social work activities without accommodation for the elderly and disabled	Activities of households as employers of domestic personnel
2211	General medical practitioners						
2212	Specialist medical practitioners						
2221	Nursing Professionals						
2264	Physiotherapists						

Across different economic sectors (NACE codes), different shares of professionals (ISCO codes) should be identified as care workers – and these shares are country specific!

Identifying the LTC workforce in international statistics

ISCO 08		NACE 2 / NACE 2.1					
		86.9	87.1	87.2	87.3	88.1	97.0
		Other human health activities	Residential nursing care activities	Residential care activities for mental retardation, mental health and substance abuse	Residential care activities for the elderly and disabled	Social work activities without accommodation for the elderly and disabled	Activities of households as employers of domestic personnel
2635	Social Work and Counselling Professionals						
3221	Nursing Associate Professionals						
3255	Physiotherapy Technicians and Assistants						
5321	Health Care Assistants						
5322	Home-based Personal Care Workers						
9111	Domestic Cleaners and Helpers						

Not all ISCO codes can be clearly identified in national statistics for all European countries – for example nursing assistant or personal care workers are not a recognized profession, with standard educational requirement in all countries.


Prevalence of ADL/ IADL limitations
Prevalence of health conditions associated with care needs
Preferences and expectations for care
Caregivers experiencing negative health and socioeconomic effects
Needs
Care users
Caregivers
Impact
Independence and autonomy
Health and functioning
User experience
Quality of life
Work–life balance
Gender equality
LTC system
Human resources (formal and informal)
Governance and participation
Financing
Inputs
Caring communities
Data and monitoring
Innovation and technology
Outputs
Care services
Quality of care services
Assistive technologies
Benefits
Outcomes
Access to care
Coverage
Resilience
Cost–effectivness
Equity
Affordability

What do we want to know about the care workforce?

3.4.1.1 Please provide information on the structure of the formal LTC workforce,* separating by care profession and role. Please include only those professionals working in LTC services and settings.

	Total FTE† (number)	Of which women (%)	Of which 50+ years (%)	Rate per 1000 aged 65+ years
Nurses*				
Nursing/care assistants*				
Personal care workers*				
Doctors				
Social workers*				
Licensed therapists (e.g. occupational therapists, physiotherapists, etc.)				

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Source: State of long-term care: step-by-step implementation guide. Web annex: data collection template. Copenhagen: WHO Regional Office for Europe; 2024.

What do we want to know about the care workforce?

3.4.2 Training/requirements of the formal care workforce (Council Recommendation Art. 8a)
3.4.3 Working conditions (Council Recommendation Art. 7 a,b)
3.4.4 Recruitment, retention and turnover
3.4.5 Wages, social protection and support (Council Recommendation Art. 8e)
3.4.6 Workforce planning and data

3.5.1 Availability and identification of informal caregivers
3.5.2 Access to and recognition of training, skills and competencies
3.5.3 Regulations and mechanisms to protect informal caregivers
3.5.4 Coordination of informal caregivers with formal workforce
3.5.5 Benefits for informal caregivers
3.6 Live-in carers and undeclared care work

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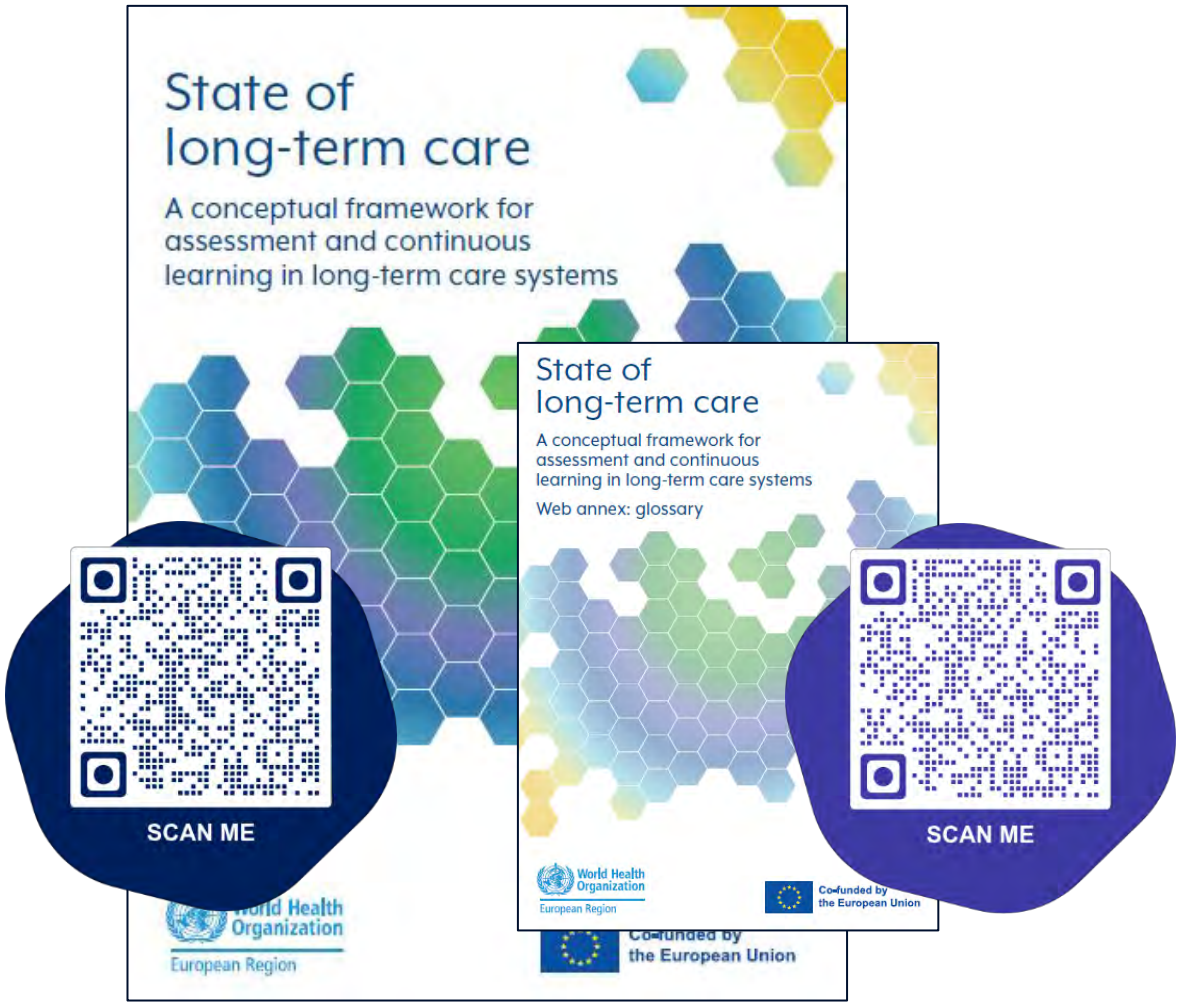
Source: State of long-term care: step-by-step implementation guide. Web annex: data collection template. Copenhagen: WHO Regional Office for Europe; 2024.

The State of LTC toolkit



Despite these challenges, we know that the health and care workforce is …

Gender imbalanced
Ageing rapidly
Affected by precarity and informality
Insufficiently professionalized and trained

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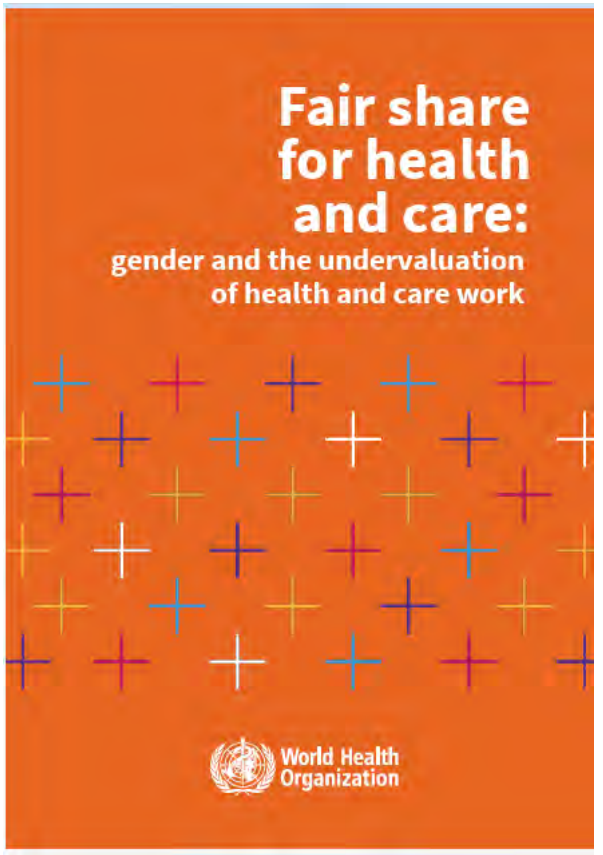
The gender value gap**S** in health and care

1. Gender Gap in Care – Unpaid health and care work largely by women
2. Gender Gap in Participation – Women dominate workforce but underrepresented in leadership
3. Gender Gap in Earnings – Women earn less than men
4. Gender Gap in Working Conditions Gap – Women concentrated in insecure roles
5. Gender Gap in Data – Lack of sex-disaggregated data hides inequalities
6. Gender Gap in Investment - Constant undervaluing of the health and care contributions of women under the tag of cost-effectiveness



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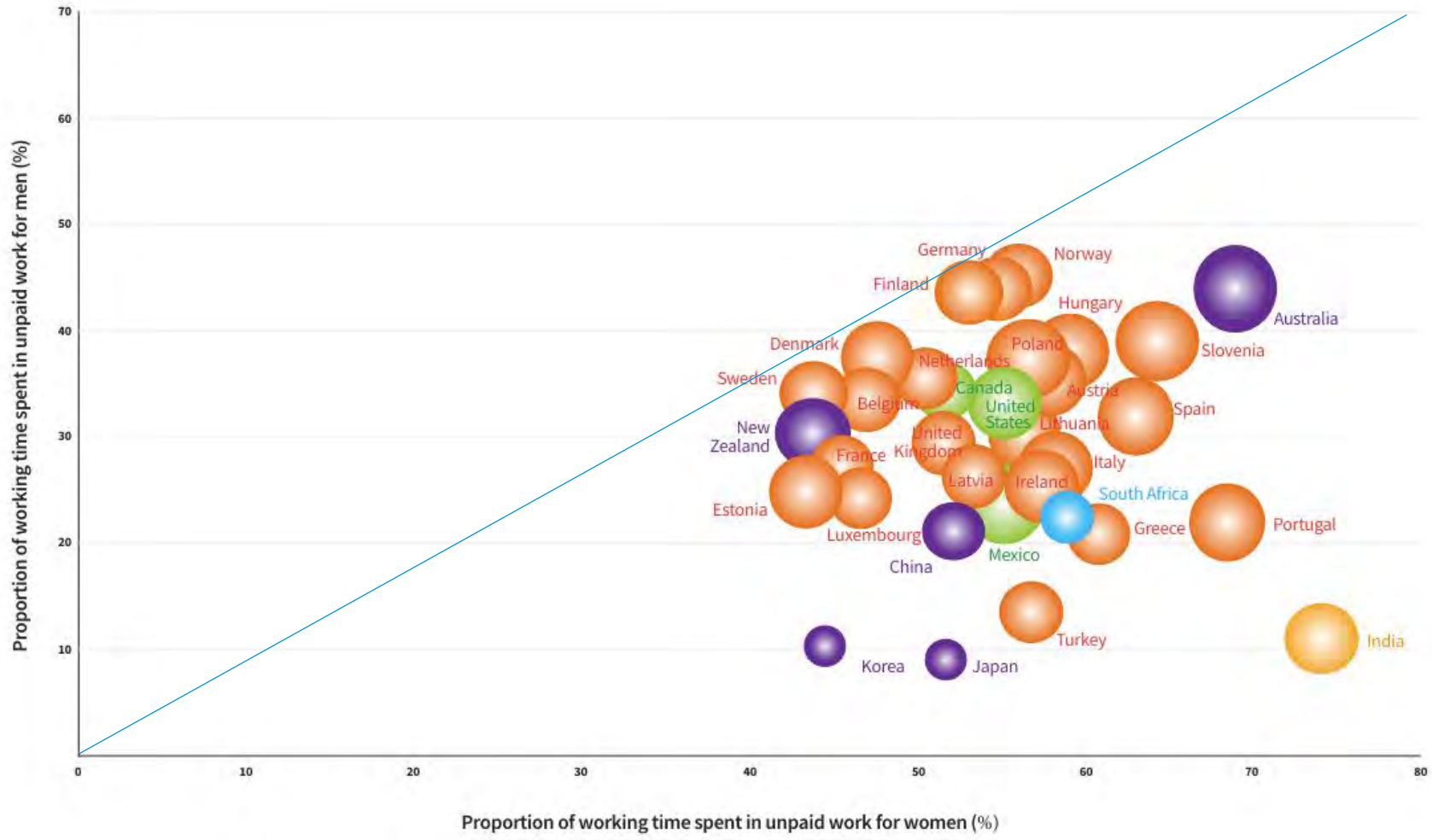
Proportion of daily time spent on unpaid work by sex and country



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Source: Fair share for health and care: gender and the undervaluation of health and care work. Geneva: World Health Organization; 2024

Delivered by women, led by men

67% of health and care workforce

over-represented in lower status roles (globally **30 – 100% of nursing staff** are women)

under-represented in higher-status and leadership roles (globally **25 - 60% of doctors** are women)

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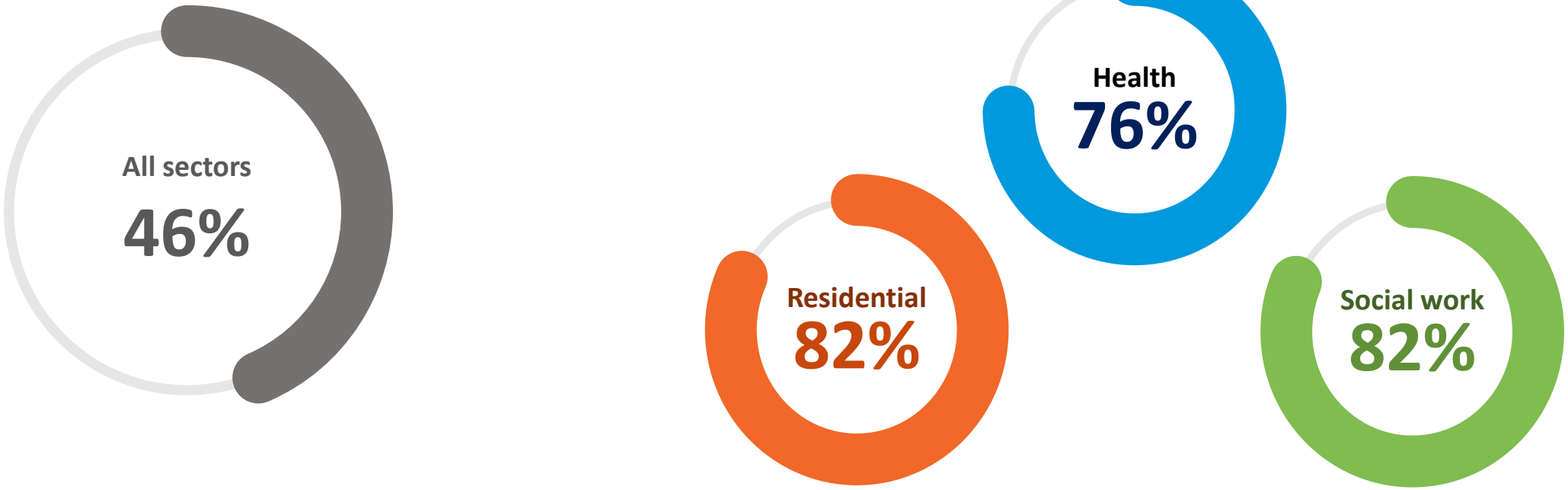
Share of women in employment by sector



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Source: EU-OSHA (2024) OSH in figures in the health and social care sector

The health and care workforce is …

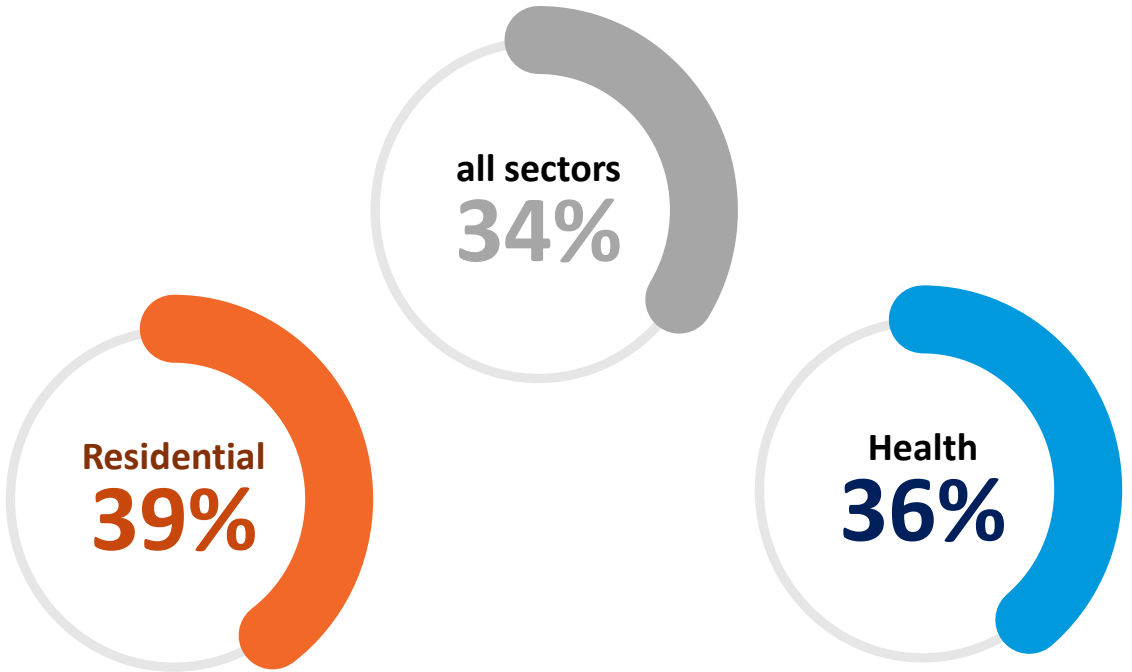
Gender imbalanced

Ageing rapidly

Affected by precarity and informality (undeclared work)

Insufficiently professionalized

Share of workers in **aged 50 and over** employment



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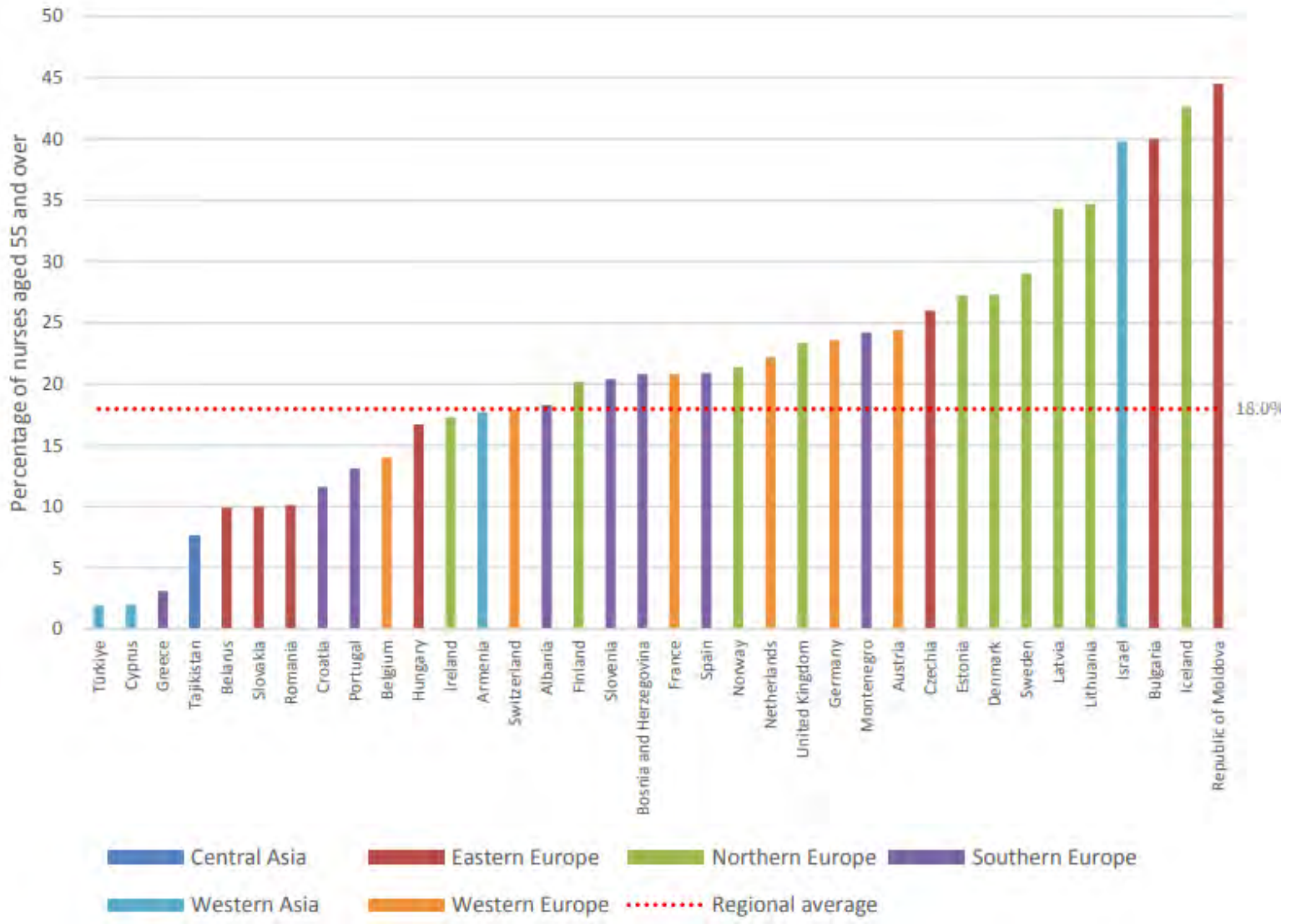
Source: EU-OSHA (2024) OSH in figures in the health and social care sector

Percentage of nurses aged 55 and above by country



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The health and care workforce is …

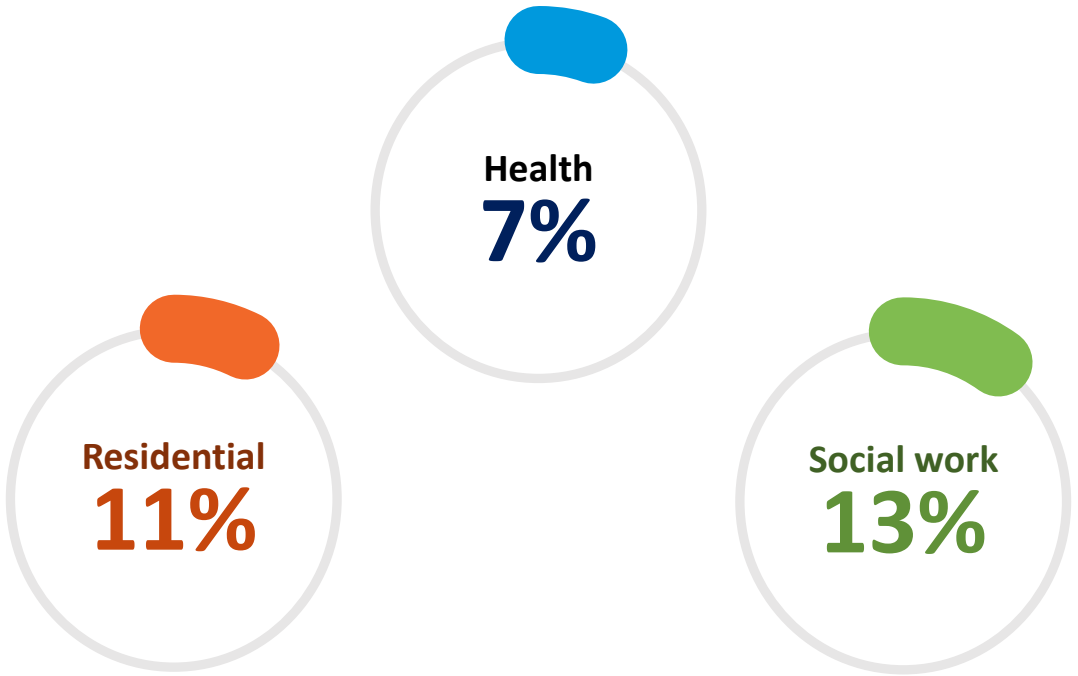
Gender imbalanced

Ageing rapidly

Affected by precarity and informality (undeclared work)

Insufficiently professionalized

Share of health & care workers in **precarious** employment



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Source: EU-OSHA (2024) OSH in figures in the health and social care sector

The health and care workforce is …

Gender imbalanced

Ageing rapidly

Affected by precarity and informality (undeclared work)

Insufficiently professionalized

Share of employees in **Part-time** employment (2021)

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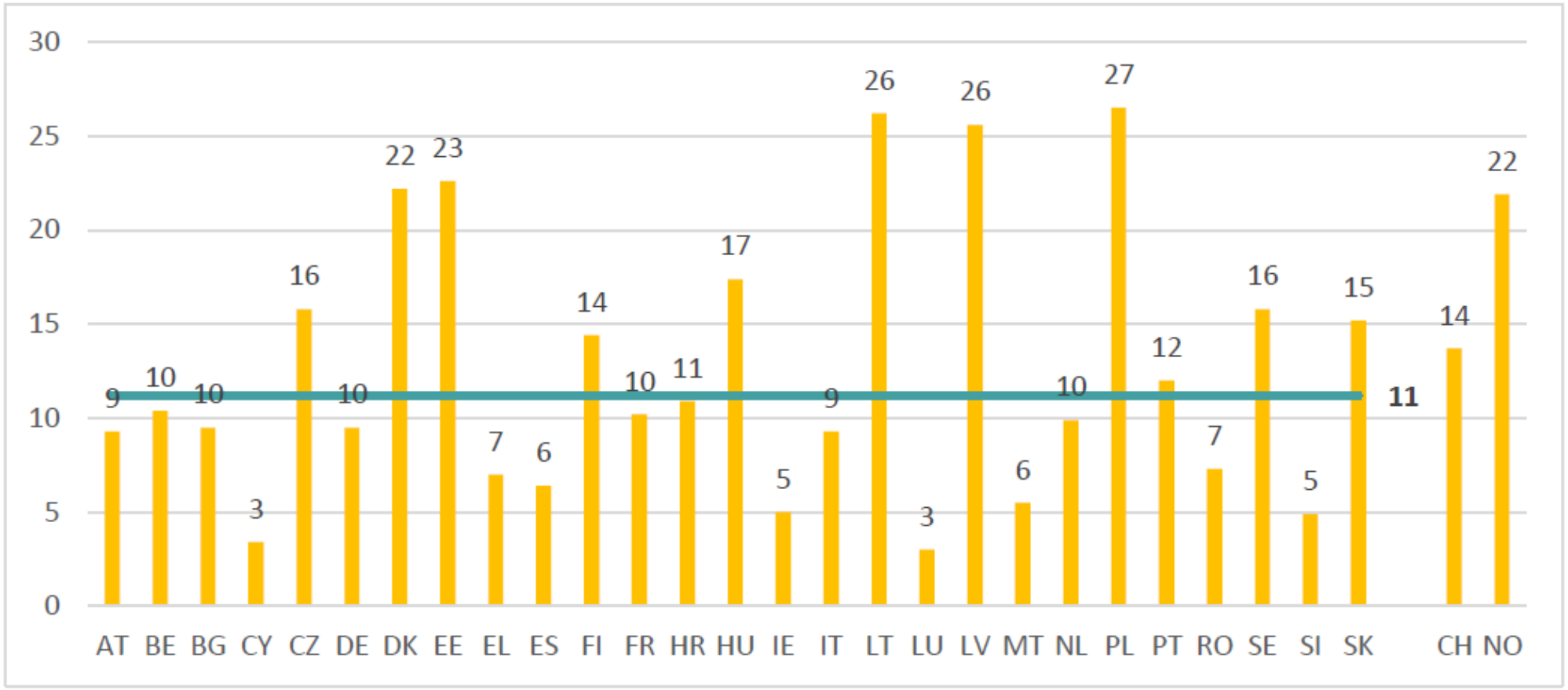
Source: EU-OSHA (2024) OSH in figures in the health and social care sector

Percentage of health and care workers holding multiple jobs, by country, EU-27 (+ CH and NO), 2021 (%)



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Source: EU-OSHA (2024) OSH in figures in the health and social care sector

The health and care workforce is …

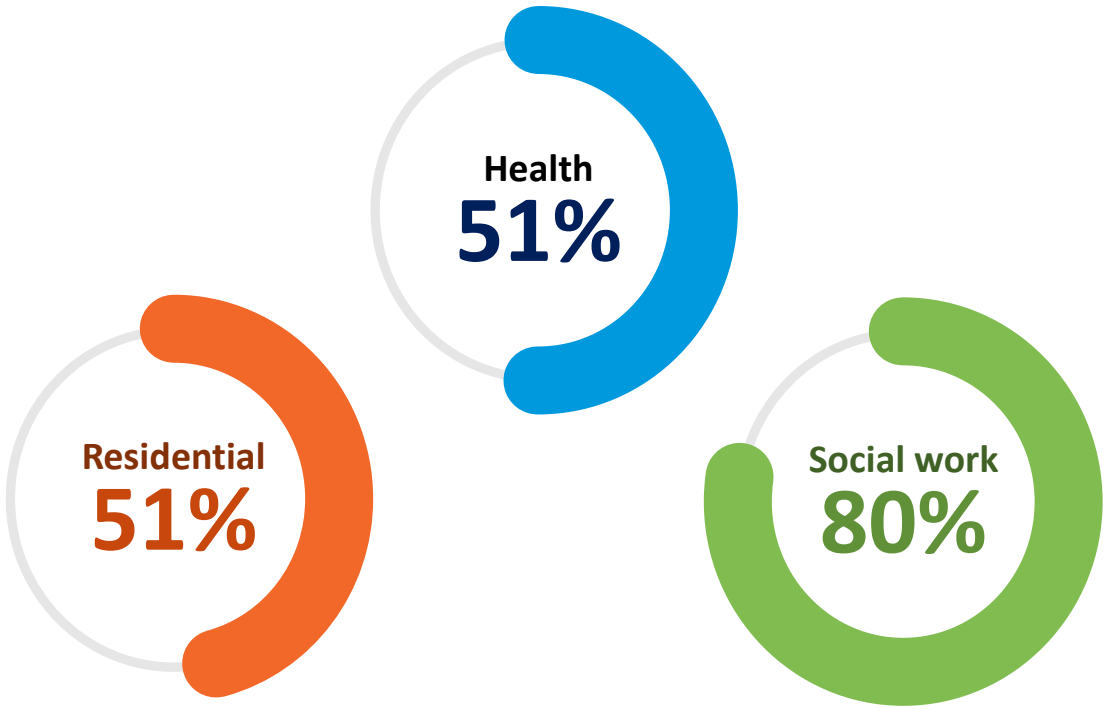
Gender imbalanced

Ageing rapidly

Affected by precarity and informality (undeclared work)

Insufficiently professionalized

Share of health & care workers who received **no on the job training**



Source: EU-OSHA (2024) OSH in figures in the health and social care sector

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Professionalization and competencies in the LTC workforce

Selected European examples

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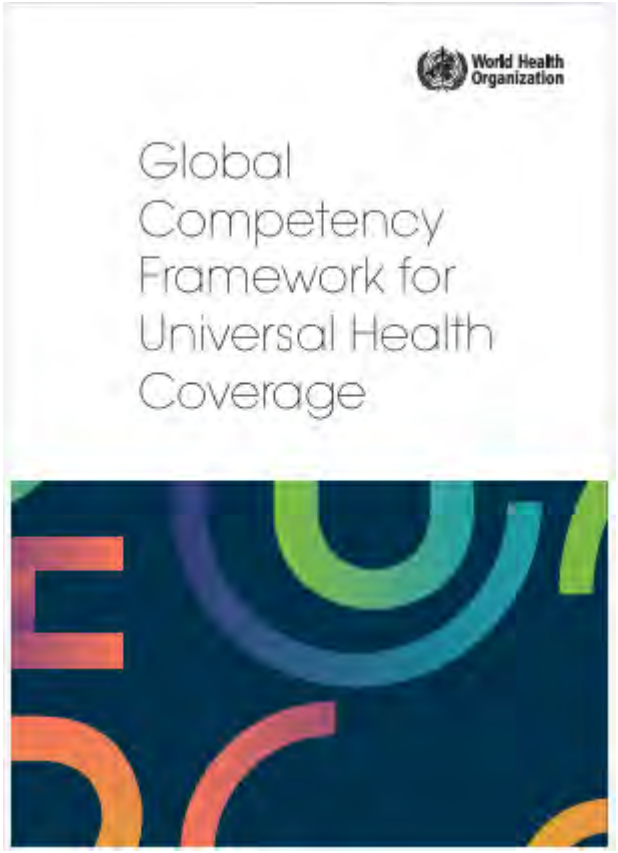
What are we training for?

Competencies
The abilities of a person to integrate knowledge, skills and attitudes in their performance of tasks in a given context. Competencies are durable, trainable and, through the expression of behaviours, measurable

Skill
A specific cognitive or motor ability that is typically developed through training and practice and is not context specific

Task
Observable unit of work within a practice activity that draws on knowledge, skills and attitudes. Tasks are time limited, trainable and measurable



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Global competency framework for universal health coverage. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/352710).

Competency framework for Universal Health Coverage

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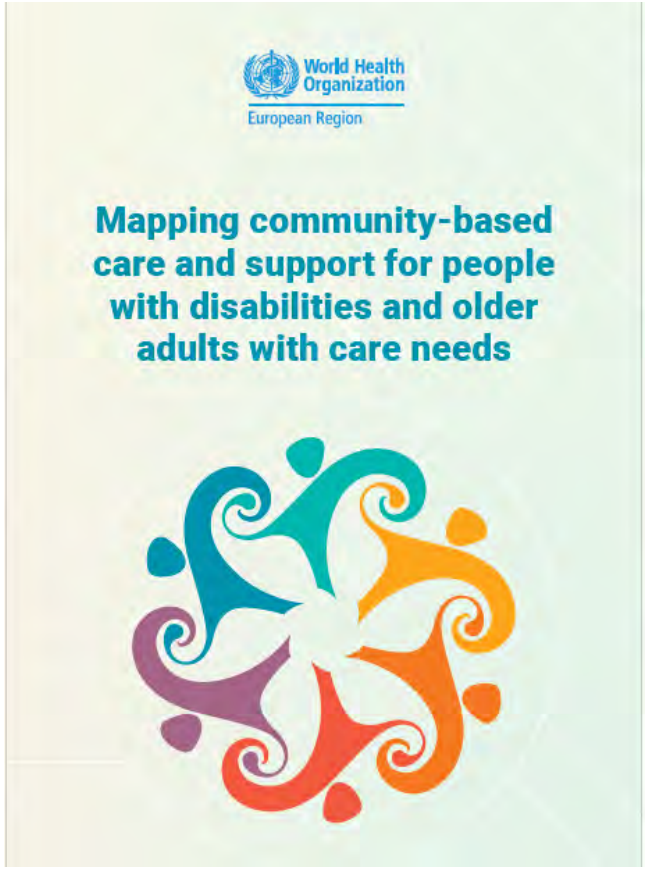
Selected non-clinical competencies for community-based care workers



People-centredness

Knowledge of human rights-based and person-centred approaches to care (i.e. promoting independence, choice, autonomy, cultural awareness, empowering recipients as decision-makers for their own health and support, supported decision-making, informed consent, etc.) and the legal/policy instruments protecting and promoting the rights of people with disabilities and older adults with care needs and those of their informal caregivers

Decision-making

Knowledge of available care/support resources and pathways (both medical and social) and of disability/care determination for referrals, as well as competency in system navigation, to facilitate referrals to needed services and benefits and to navigate the care (eco)system

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Source: Mapping community-based care and support for people with disabilities and older adults with care needs. Copenhagen: WHO Regional Office for Europe; 2025.

Selected non-clinical competencies for community-based care workers

Collaboration

Relational and communication skills for building and maintaining empathetic, trust-based relationships and supportive environments and for handling emotionally charged situations

Awareness and ability to work seamlessly and collaboratively with other professionals and informal caregivers in interdisciplinary teams and environments, as well as with recipients, to support them in developing their care plan

Evidence-informed practice

Knowledge of and ability to understand and implement evidence-based practices and to relate to practical screening and care tasks linked to key concepts of disability, intrinsic capacity, functional ability and functioning, independent living and carer-friendly practices

Awareness of quality standards, including how to meet quality standards, how to collect and provide data needed for quality monitoring, etc.

Knowledge of and ability to implement guidance on hygiene and managing infections in community-based care settings

Communication

Interpersonal communication skills and knowledge of communication strategies (including knowledge of support resources if needed, e.g. interpretation, sign-language) which enhance the ability to elicit, understand and flexibly adapt care tasks to respond to evolving individual support needs and preferences

Knowledge of and ability to use communication and consensus-building approaches for encouraging collaboration and co-production of care with informal caregivers

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Source: Mapping community-based care and support for people with disabilities and older adults with care needs. Copenhagen: WHO Regional Office for Europe; 2025.

Denmark – care worker profiles

LTC, social & health helpers (*Social- og sundhedshjælpere*)

- Around **half** of LTC workers
- **Tasks**: providing help with everyday activities (cleaning, cooking, personal care) at home, in care centers or residential facilities; helping with rehabilitation; using digital aids and welfare technology; noticing changes in health and well-being

Social & health assistants (*Social- og sundhedsassistent*)

- Around **one-third** of LTC workers
- **Tasks**: providing nursing and personal care at home, in care centers, in hospitals or residential facilities; supporting and guiding people undergoing treatment; helping with rehabilitation after injury or sickness; collaboration across professional groups

Nurses (*Sygeplejerske*)

- Around **10**% of LTC workers
- **Tasks**: clinical decision-making on health and illness in health centres, residential facilities or at home; monitoring systems; coordinating and taking responsibility for nursing care.

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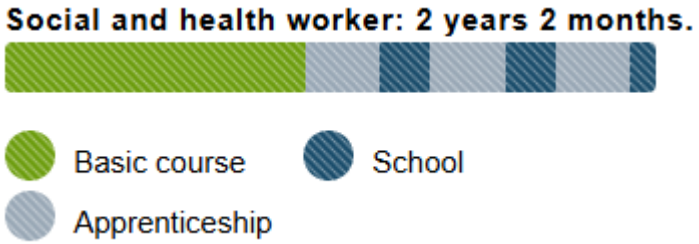
Nationally set education requirements

Denmark - Social & health helpers

- **Education**: 2 years 2 months of training consisting of basic course of 20 or 40 weeks, and the remainder alternating between theoretical courses and apprenticeship
- **Structure of education:**
  - Basic course at a vocation school lasting 20 or 40 weeks
  - Alternating periods of main course provided at a social and health school and apprenticeship for practical training
  - Education completed with an exam and certificate
- **Continuing education**: can continue to become Social or health assistant, or work towards specializing (e.g. dementia, welfare technologies, etc.)

Training overall focuses on:

- Role of social and health helper
- How to help with care, personal care and practical help at home
- Health & well-being
- Health promotion, prevention & rehabilitation
- Recognizing changes in physical or mental health & well-being
- How to guide and motivate recipients
- Communication & collaboration



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Denmark - Social & health assistants

- **Education**: either 3 years 10 months or 4 years 7 months, with same initial training as helpers, but with additional time for theoretical training and apprenticeship
- **Structure of education:**
  - Basic course at a vocational school for 20 or 40 weeks (same as with social & health helpers)
  - Alternating periods of main course at a social and health work school and periods of apprenticeship
  - Education completed with an exam and certificate
- **Continuing education**:
  - Access to many full-time higher education programmes, such as nurse, physiotherapist, or midwife
  - After 2 years of work, individuals can pursue a 1-year academic degree part-time (e.g. health practice, HR, management)
  - Additional short competency-based courses (e.g. pharmacology, rehabilitation, working with relatives)

Training overall focuses on:

- Detecting signs of illness or discomfort
- Providing professional care and nursing
- Pharmacology & medication management
- Guiding recipients about health and illness
- Health promotion, prevention & rehabilitation
- Communication, listening to recipients
- Ensuring coherent care processes

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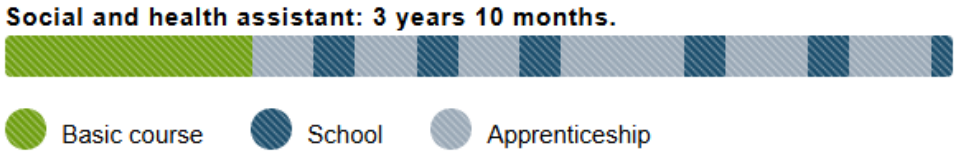

Denmark - Nurses

- **Education**: bachelor degree of 3.5 years based on a mix of theoretical and clinical/practical teaching (lectures, classroom teaching, project work, simulation teaching)
- **Structure of education:**
  - 7 semesters at university: first 4 semesters are set, the last 3 vary across education institutions
  - Internships comprise 40% of the education
- **Continuing education**:
  - Opportunities for specialization trainings (intensive care, cancer, community-based, etc.)
  - Diploma programs (e.g. health professional diploma program)
  - Master's degree programs

Training overall focuses on:

- Observation and assessment of patient and citizen health challenges and disease contexts
- Clinical decision-making in stable and complex care and treatment processes
- Clinical leadership of patient and citizen processes
- Situational communication in interaction with patients and citizens, relatives and professionals in and across sectors

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Denmark – Authorization & monitoring

Authorization register

- **Nurses and social & health assistant** are **protected titles,** meaning there is a process required to be **authorized to work** in these roles
- **Receiving authorization** requires:
    1) Passing either the bachelor's degree in nursing (nurses) or the vocational training (social and health asssistants)
    2) Submitting an application and paying the fee (DKK 1,295)
- Authorization register is **available online** and publicly accessible

Ongoing monitoring

- **Danish Patient Safety Agency** (*Styrelsen for Patientsikkerhed*) is charged with monitoring quality and competencies of staff
- Professional activity of accredited workers is monitored
- **Reactive supervision of professionals**: supervision is only initiated if there is a concern
- **Supervision** through inspections, feedback from care users, complaints registered, monitoring of prescriptions, autopsies, court judgements, etc.
- Supervision case can result in a **sanction and removal of license** (extreme cases)

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Austria – care worker profiles

Nursing assistant – level 1 (*Pflegeassistenz/in*)

- **Tasks**: supporting qualified nurses by carrying out basic nursing tasks with supervision, providing care assigned to them by senior staff, participating in diagnostics and therapy, acting in emergencies, etc.
- **Educational requirement**: 1 year full-time/1600 hours of theory and practical training provided by an adult education institution focusing on health and social care
- **Training** is based on the fundamentals of nursing, therapy and medical diagnostic
- **Further opportunities**: to continue studying to become a nursing assistant (level 2)

Nursing assistant – level 2 *(Pflegefachassisten/in)*

- **Tasks**: independent performance of tasks assigned by senior nurses/doctors; participation in nursing assessments, monitoring state of health, acting in emergencies, nursing care tasks, etc.
- **Educational requirement**: 2 years full-time/3200 hours of theory and practical training provided by an adult education institution focusing on health and social care
- **Additional training opportunities**: e.g. on culture and gender-sensitive nursing, gerontological nursing, home nursing, validation, palliative nursing, etc.
- **Further opportunities**: can transition into Bachelor's degree for nursing

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Difference between the 2 roles: tasks by level 1 nursing assistants are carried out under supervision of qualified nurses, while level 2 nursing assistants have more independence

Austria – care worker profiles

Home helpers (*Heimhelfer/in*)

- **Tasks**: ensuring the cleanliness of the home, assisting with daily life activities (e.g. cooking, laundry, personal hygiene, assisting with medication, etc.)
- **Education requirement:** 200 hours of theory, 200 practical hours with a company/provider
- Requires completion of the **final examination**
- **Training** offered by educational organisations and health and nursing schools, as well as NGOs, private care organisations, BFI Austria (continuing vocational education organization), etc.

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Austria – care worker profiles

Qualified social workers (*Diplom-sozialbetreuer/in)*

- **Tasks**: providing independent care and advice; assisting with some daily living activities; conceptual and task planning; designing care plans to improve quality of life; supporting individuals and their families, etc.
- **Education requirements**: 3 years/1800 hours of theory, 1800 hours of practical work
- **Education provided** at schools for social work professions
- **Step before qualified social worker** includes becoming a specialized social worker based on 2 years/1200 hours of education. Activities are similar to qualified social workers but with less independence and personal responsibility

Nurses *(Diplomierte Gesundheits- und Krankenpfleger/in)*

- **Tasks**: provide nursing care, plan care measures, independent assessment of care needs, health advice and health promotion, collaboration with other medical professionals
- **Educational requirement**: 3 years/180 ECTS at a university of applied sciences (bachelor's degree) covering the fundamentals of nursing and advanced aspects
- **Further opportunities**: Master's degree in nursing on advanced nursing practice, extended care advice, nursing science, etc.; specializations possible such as paediatric nursing, psychiatric nursing, intensive care, etc.
- **Additional training opportunities**: e.g. on culture and gender-sensitive nursing, gerontological nursing, home nursing, validation, palliative nursing, etc.

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Nationally set education requirements and further training obligations

Austria – continuing education

- Wide range of **specialized training and academic courses** available for individuals with a professional license in the field of health and nursing
- Certain professions are **required by law to pursue continuous training** to remain up to date with latest developments in the field:
  - **Nursing assistants (level 1 and 2):** at least 40 hours required every 5 years
  - **Nurses:** at least 60 hours required every 5 years
  - Care workers must receive a confirmation of attendance at the training course
- Care workers can pursue **additional education** to expand their knowledge/skills through courses lasting 4+ weeks
  - Must pass examination and obtain certificate confirming completion

Topics can include:

Care for older persons, Gerontology, Intensive care unit, Family social care, Cardiological care, Continence advice, Emergency care, Oncological care, Palliative care, Care for persons with dementia, Care for people with disabilities, Preclinical care and nursing, Practical instructions, Wound care and many more.

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Austria – authorization to work

- All of these roles are **regulated** (apart from home helpers) with **protected titles** based on the Federal Act on Health and Nursing Care
- After completion of the prescribed education, roles must be registered in the **Register of Healthcare Professions** (subject to renewal every 5 years)
  - The **Chamber of Labor (AK)** handles registration for AK members within each region, including nursing assistants and nurses
  - For all other professions, the **National Public Health Agency** (Gesundheit Oesterreich GmbH) is responsible for registration
  - **Registration requires** proof of identity, proof of qualification in line with professional regulations, criminal record check/trustworthiness check, proof of german language competence, etc.
- Registered care workers receive a **professional ID** confirming their authorization
- Employers must **verify registration** of new employees

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Stepping up investment in the health and care workforce

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Supporting women's leadership in health and care

1. **Building a legal foundation for equality** in the workplace (prohibit discrimination, ensure equal pay, family friendly workplace policies, legislate against violence and harassment)
2. **Addressing social norms and stereotypes** (recognize the value of care, engage girls in STEM, targeted campaigns to attract underrepresented groups)
3. **Addressing workplace systems and culture** (targets and quotas for gender equity in leadership, gender transformative recruitment and retention strategies)
4. **Enabling women to lead** (peer support, mentorship, increase visibility of women leaders, collect and publish Key metrics)

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Invest in education and training

Co-develop Standardized, Competency-Based Training Curricula and incentivize professional leadership

Introduce Workplace Learning and Mentorship Programs

Continuous Professional Development programs with interprofessional components

Leverage digital tools to enhance and diversify training opportunities

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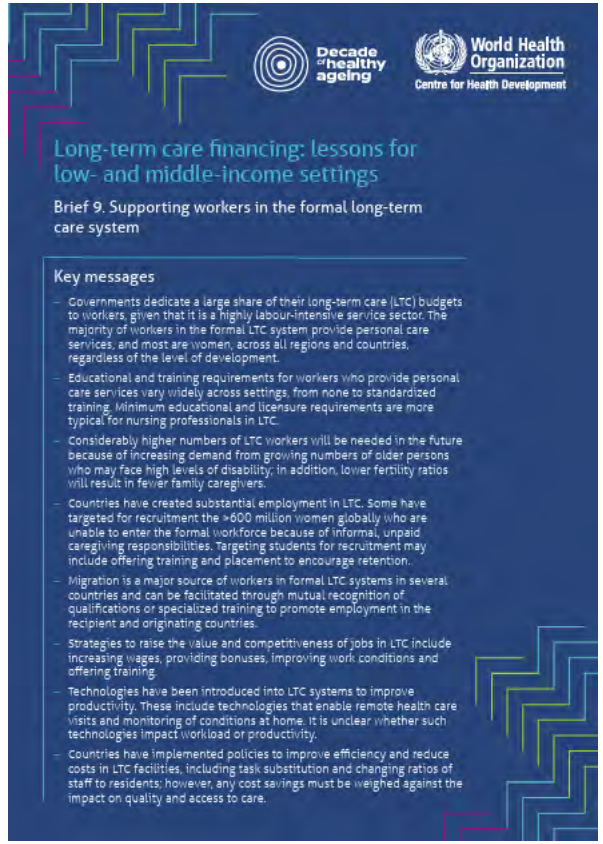
Strategies to improve recruitment into the formal long-term care workforce

- Promote returning to work or delaying early retirement- e.g. Australia, Estonia, Germany, Japan, the USA
- Abolish apprenticeship fees and remunerate trainees – e.g. Germany, Japan, the United Kingdom
- Establish training programmes with job opportunities for participants who complete training – e.g. Australia, Canada, Estonia, Germany, Sweden, the USA
- Launch campaigns to improve the attractiveness of the long-term care sector – e.g. Belgium, Czechia, Netherlands (Kingdom of the), Portugal, the United Kingdom



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Thank you!

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75 HEALTH FOR ALL