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Health and social services from an employment and economic perspective

Social Europe

This supplement to the Quarterly Review provides in-depth analysis of recent labour market and social developments. It was prepared by L. de Dominicis and J. Lüttge from the Employment Analysis and Social Analysis Units in DG EMPL and by B. Steppe from the Social Inclusion and Poverty reduction Unit. The box on *Working conditions and job quality in the human health, residential care and social work sectors: main findings from the 5th European Working Conditions Survey* was prepared by Felix Wohlgemuth and Gijs van Houten from EUROFOUND

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Health and social services from an employment and economic perspective

Introduction

This supplement provides an overview of relevant data and information showing the importance of health and social services in the European economy. It updates the supplement published in 2012, and analyses the developments in this sector since 2008, with a special focus on most recent developments, from 2011 to 2013.

Health and social services[1] are a fundamental part of social protection systems as they cover different types of risks which an individual can face during his or her life course. They play a pivotal role in ensuring effective and efficient social protection by promoting social inclusion and reducing the risk of poverty and inequalities as well as improving social cohesion. To achieve these goals, the quality, access, coverage, and affordability of social services are essential.

The Social Investment Package (SIP) published in February 2013[2] emphasises the important role social services, highlighting that social services represent a smart and sustainable investment in that they do not only assist people but also have a preventive, activating and enabling function if well-designed.

The supplement is organised as follows. The first part of the analysis (Section 2) documents the fact that health and social services is a dynamic sector that constitutes a significant source of job creation in large parts of the EU and brings important added value to the economy. Section 3 highlights some of the structural challenges faced by the sector due to the particular characteristics of its jobs and its workforce. Section 4 deals with some of the difficulties of delivering adequate social services under the cross pressures from severe budget constraints and growing demand.

The statistical analysis in this text draws on data provided by EUROSTAT, notably the Labour Force Survey (LFS), but also the European System of Integrated Social Protection Statistics (ESSPROS), the European Union Statistics on Income and Living Conditions (EU-SILC) and the European Population Projections 2013 (EUROPOP2013)**.** The LFS data covers 'human health and social work sector' that is composed of human health, residential care and social work activities.[3]

[1] The term "social services" covers a large variety of services such as, for instance, early childhood education and care (ECEC, also known as childcare), long-term care for the elderly and for people with disabilities, social assistance, social housing, training and employment services. See also Communication on "Implementing the Community Lisbon programme: Social services of general interest in the European Union" (COM (2006) 177 of 26 April 2006).

[2] See Commission Communication "Towards Social Investment for Growth and Cohesion – including implementing the European Social Fund 2014-2020" (COM (2013) 83 final of 20.02.2013).

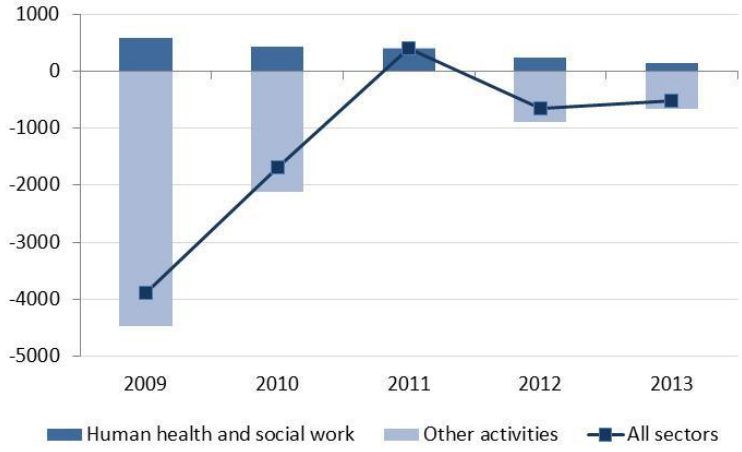
[3] Definitions provided by the Statistical Classification of Economic Activities (NACE) under Rev. 2. In a more detailed breakdown of economic activities, *Human health* (Q86) includes *Hospital activities, Medical and dental practice activities,* and *other human health activities. Residential care* (Q87) includes *Residential nursing activities, Residential care activities for mental retardation, mental health and substance abuse, Residential care activities for the elderly and disabled,* and *Other residential care activities. Social work activities* (Q88) include *Social work activities without accommodation, Social work activities without accommodation for the elderly and disabled,* and *Other social work activities without accommodation.*

1.1 Recent trends

- The number of workers in health and social services has increased steadily in recent years including during the economic crisis, when employment was decreasing in other sectors.
- The increase in employment is not shared equally across Member States, with some Member States showing an increase of over 20% and a few a fall in employment.
- In some Member States, employment in the health and social services sector is mainly concentrated on health services suggesting room for further employment developments in social work.
- The sector has an important economic weight counting for 7% of the total economic

From 2008 to 2013, total employment in the EU fell by 2.9% among the working-age group (15-64), leading to a net destruction of 6.3 million jobs. These developments were, however, not uniform across all sectors. The human health and social work sector performed relatively better than the rest of the economy. In 2013, the number of workers in this sector aged between 15 and 64 stood at 22.8 million, i.e. 10.7% of the total in all sectors. Unlike in the total economy, the number of workers in this sector had been steadily growing, and showed an increase even during the crisis years, amounting to a net creation of 1.3 million jobs between 2009 and 2013 (Chart 1).

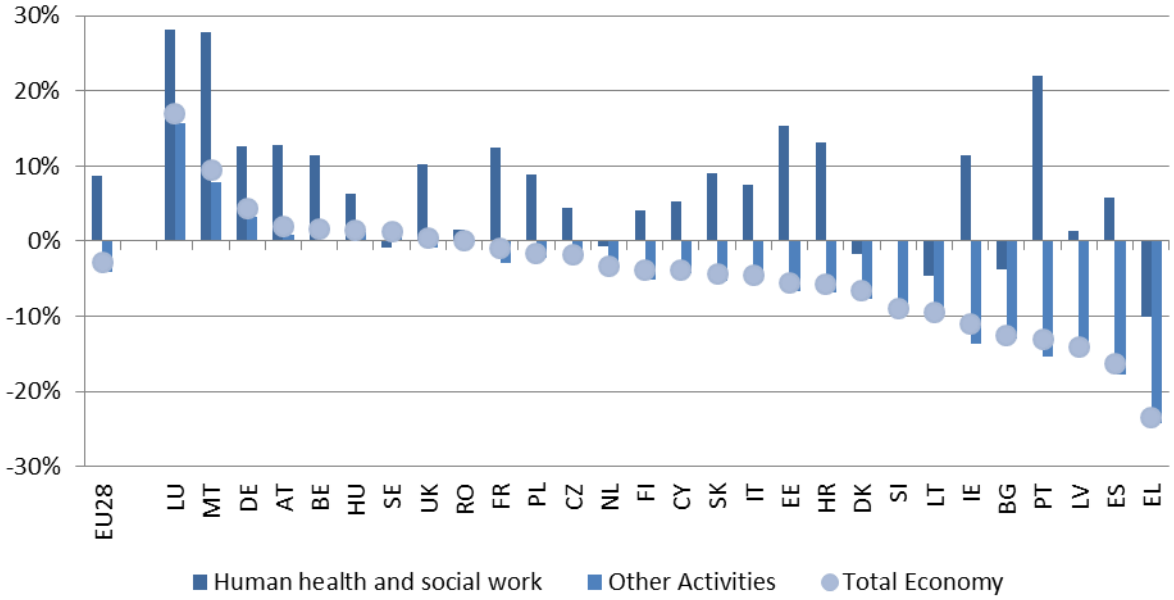
Chart 1: Employment changes by sector EU28, 15-64 year olds. Human health and social work, and other sectors, 2009-2013, changes on previous year in thousands.



Source: Eurostat, LFS

The EU average, however, masks significant differences between Member States (Chart 2). From 2008 to 2013, the highest growth in employment in the human health and social work sector was recorded in Luxemburg, Malta and Portugal (by over 20 per cent). On the other hand, employment in this sector fell in Greece (by 10%), Lithuania, Bulgaria (both by roughly 4 per cent), Denmark, Sweden and the Netherlands (by less than 2%).

Chart 2: Employment growth of 15-64 year olds in human health and social work compared to other sectors, 2008 to 2013.

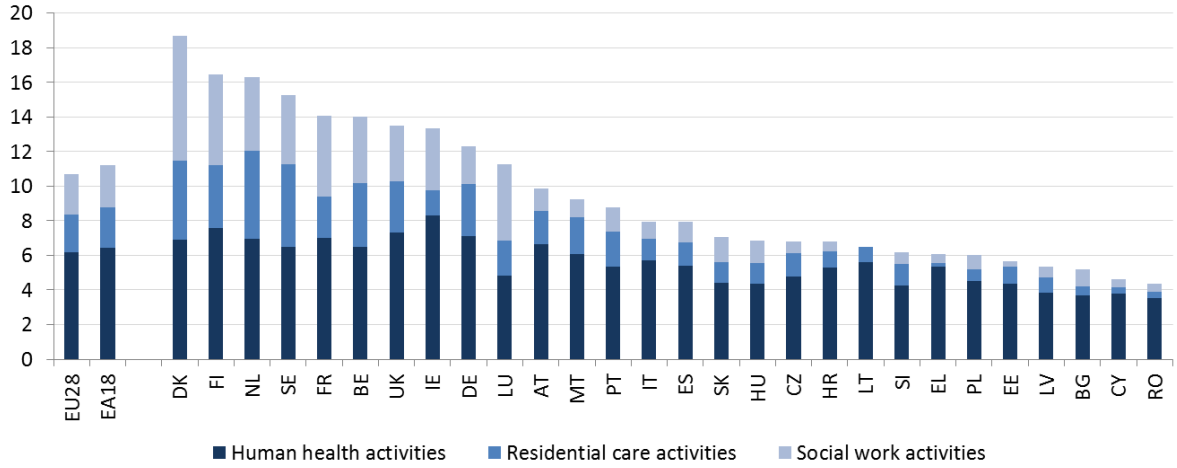


Source: Eurostat, LFS

Chart 3 shows the share of employment in the human health and social work sector in the 28 Member States. The share is the highest in the Nordic Member States (Denmark, Finland and Sweden) and the Netherlands, with between 15% and 19% of total employment, constant compared to 2011). Lower, but still above the EU average of 10.5%, are Belgium, the UK, France, Ireland and Germany. In 2013, the share of employment in the human health and social work sectors was the lowest (below 5% of total employment) in Romania, Cyprus, Bulgaria and Latvia. It was only slightly higher in Poland, Estonia, Greece and Slovenia (not higher than 6%).

The Health and Social Services sector is composed of Human health, residential care and social work (see footnote 3 for a breakdown of the classification). In some Member States, such as Greece, Latvia, Cyprus and Romania, more than 80% of the employment in the health and social services is in human health activities because its other components are small. In contrast, in Member States such as Denmark, Finland and the Netherlands, residential care and social work are larger and thus employment is more equally spread across the three sub-sectors.

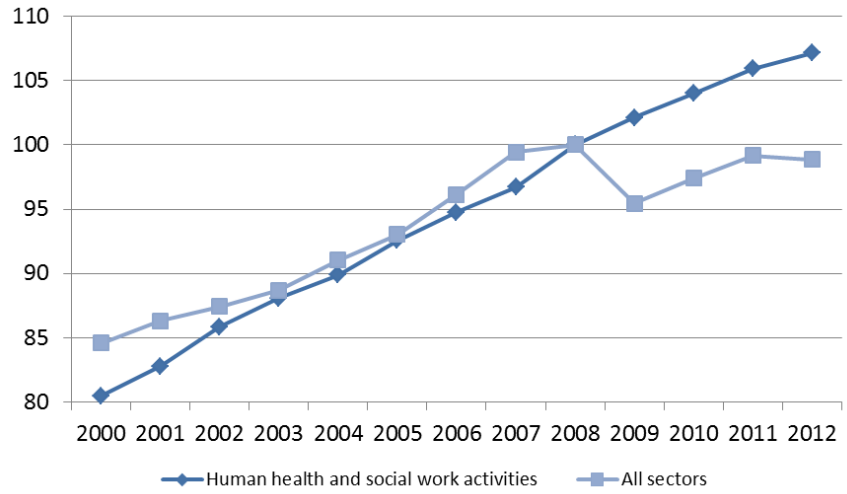
Chart 3: Share of employment in human health and social work sectors on total employment (in per cent, 2013).



Source: DGEMPL calculations, based on Eurostat, LFS

In addition to being an important source of job creation, the health and social services sector has an important economic weight, as it generates around 7% of the total economic output in the EU-28 and appears to have suffered from the crisis, as Chart 4 shows.

Chart 4: Evolution of output (gross value added) in all sectors vs. health and social work, 2000-2012, EU (25 countries, HR, IE, MT missing). 2008=100.



Source: DG EMPL calculations on Eurostat National Account

1.2 Structural features and challenges of the health and social services sector

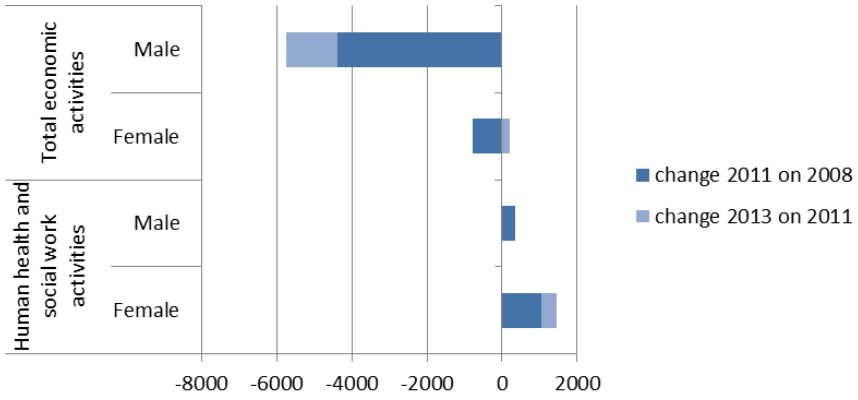
- The workforce in the health and social services is mainly female; with women representing 78% of all employment in the sector.
- 81% of the newly created jobs in the sector are occupied by women.
- The difference in earnings between men and women is higher than in other sectors.
- Workers in the health and social services sector are on average better skilled compared to the average in other sectors.
- Part-time work is more common in this sector than in the whole economy and the share of part-time work in the sector increased during the crisis.

The health and social services sector is confronted with several challenges. Its workforce is overwhelmingly female but facing and important gender pay gap. The workforce is ageing at a faster pace than the rest of the sectors. There are large imbalances in skill levels and working patterns and recruitment and retention are conditioned by demanding working conditions. These challenges are analysed in this section.

1.2.1 Gender bias

The workforce in health and social services is largely made up of women who in the EU make up nearly 78% of total employment in the sector (i.e. amounting to 17.9 million women in 2013 working in this sector). 81 per cent of the net 1.8 million new jobs created in the sector between 2008 and 2013 are occupied by women.

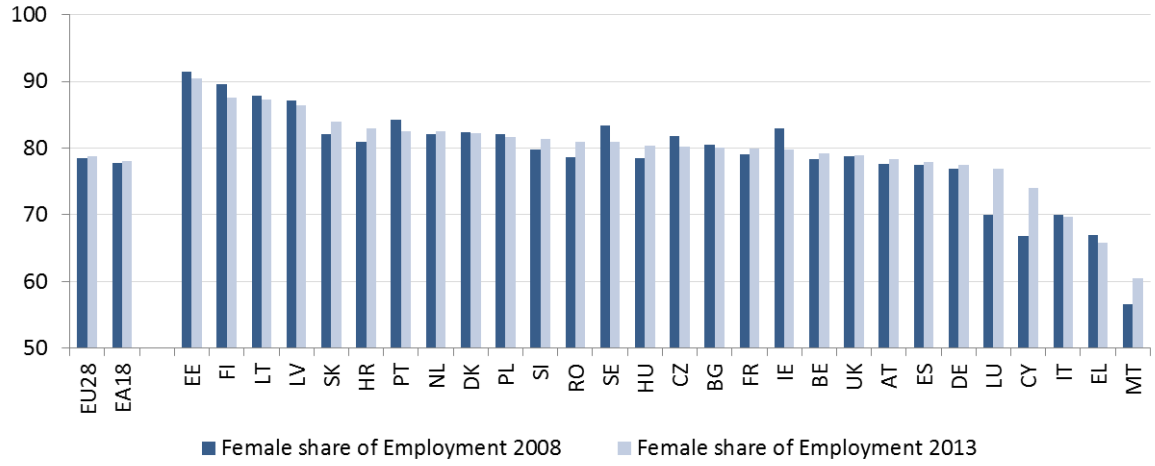
Chart 5: Employment changes in all sectors vs. health and social work, 2008-2013, in thousands.



Source: DG EMPL calculations based on Eurostat National Accounts.

The share of female employment in the human health and social work sector has been stable at around 78% in the period between 2008 and 2013. The largest increases in the period 2008-2013 were registered in Member States where the sectoral female employment share is among the lowest in the EU, such as Malta and Cyprus. On the other hand, the sectoral female employment share decreased slightly in Member States with an initially high share of women working in the sector, such as Estonia, Finland, Lithuania and Latvia (Chart 6).

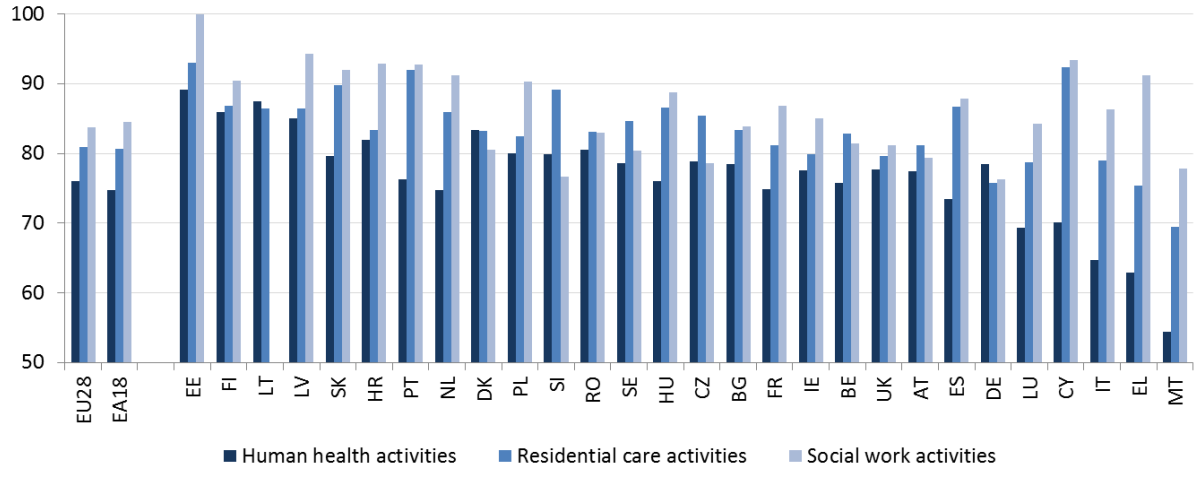
Chart 6: Female employment share in total employment in human health and social work sector, in per cent, 2008 and 2013.



Source: Eurostat, LFS

In the EU, in 2013, female workers constituted the large majority of the workforce in residential care (80.9%) and social work activities (83.7% of the workforce in the sector).Compared to their EU counterparts, female workers are less represented in the human health activities in some countries such as Malta, Greece, Italy, Luxembourg and Cyprus.

Chart 7: Female employment share in total employment in human health and social work sectors, in per cent, 2013.



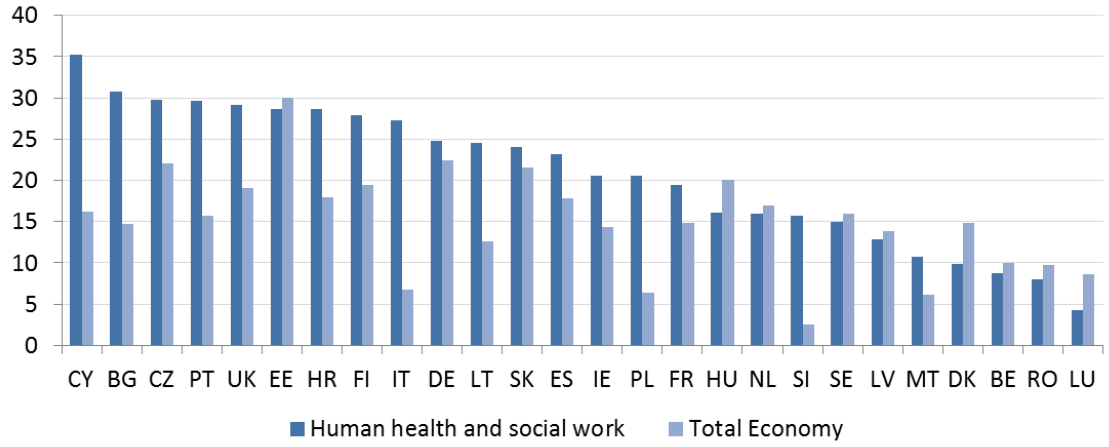
Source: DG EMPL calculations, based on Eurostat, LFS

Apart from this uneven gender balance, Chart 8 shows that in many Member States the difference in hourly earnings between men and women working in the health and social services sector is higher than in the whole economy. The difference between the (unadjusted) gender pay gap in the human health and social work sector and that in the whole economy is the

largest in Italy (20.6 percentage points, pps), Cyprus, (19.0 pps), Bulgaria (16.1 pps), Poland (14.2 pps), and Portugal (14.0 pps).[4]

On the other hand, in some Member States (Denmark and Sweden) the gender pay gap is actually smaller in this sector than in the whole economy. In Hungary, there is no significant difference.

Chart 8: Unadjusted gender pay gap in human health and social work and in total economy, 2013.



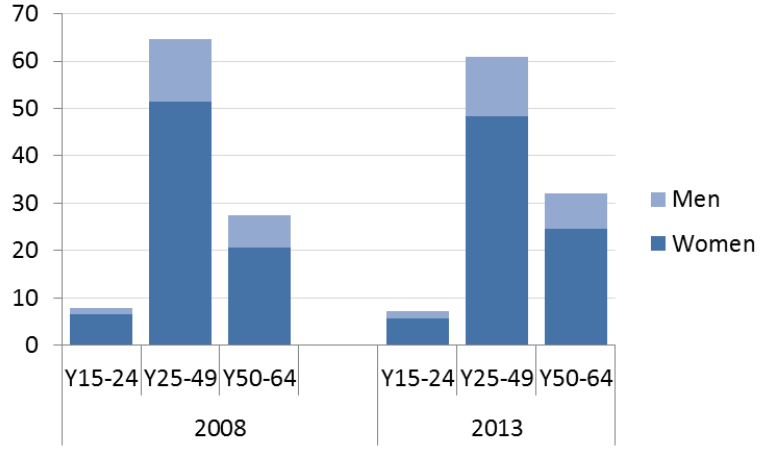
Source: Structure of Earnings Survey (SES)
Note: Data for AT not available.

1.2.2 Ageing of the workforce

The vast majority of the people working in human health and social work sector belong to the age group 25-49 years. However, the share of people above 50 years working in this sector increased from approximately 27% to 32% between 2008 and 2013 in the EU-28 (Chart 9), most likely due to demographic trends, which shows that the workforce in this sector is ageing. That it has been ageing faster than the workforce in the rest of the economy suggests, on the one hand, that this sector might have been an important source of employment of older workers, but also that for various reasons (i.e. regulation or employment constraints due to the crisis) there might be non-negligible barriers to entry for younger cohorts.

[4] The unadjusted Gender Pay Gap represents the difference between average gross hourly earnings of male paid employees and of female paid employees as a percentage of average gross hourly earnings of male paid employees. Unadjusted means that it is not adjusted to individual characteristics that may explain part of the earnings difference (i.e. education, numbers of hours worked, sector of activity etc.).

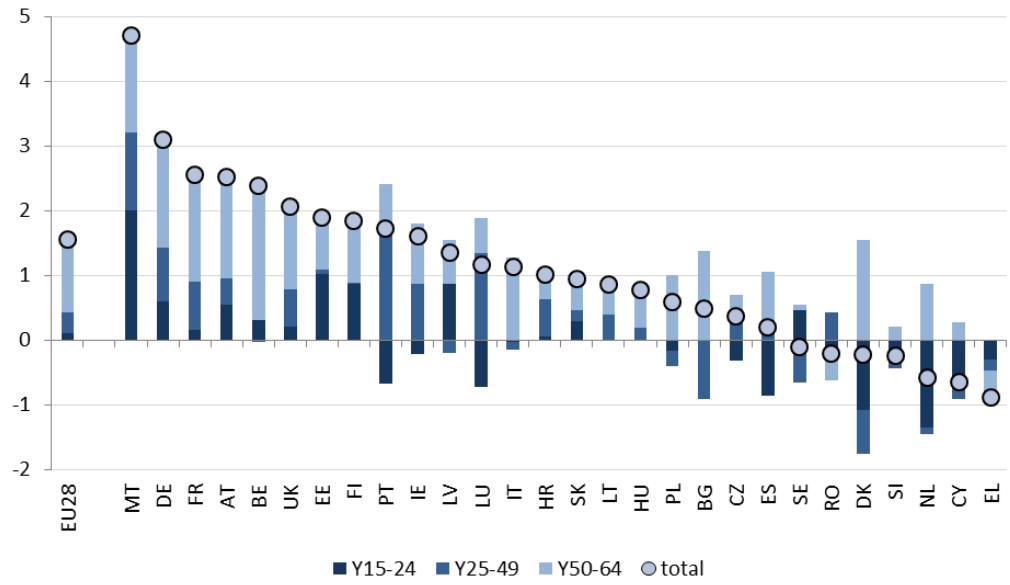
Chart 9: Employment shares in human health and social work by age group, 2008 and 2013, EU-28.



Source: Eurostat, LFS

Between 2008 and 2013, the sharpest increases in the share of older people working in the human health and social work sector were registered in Belgium, Germany, France, Austria, Denmark and Malta (above 1.5 pps), and in Bulgaria, the UK, Italy and Poland (above 1 pp). The Netherlands, Denmark and Spain recorded the biggest declines in the share of younger workers in this sector (Chart 10).

Chart 10: Change in employment rates in human health and social work by age group, 2008-2013, EU-28.



Source: Eurostat, LFS

The male workforce in the health and social services sector is generally older than the female workforce (33.2% of the male workers belong to the 50-64 age group compared to 29.3% of the female workers in the same age group, while only 6.8% of male workers in the sector belong to the 15-24 age group compared to 7.9% of the female workers in the same age group). A probable partial explanation for this is the gender difference in occupations. Men are overrepresented in those occupations that require longer education and training: the proportion

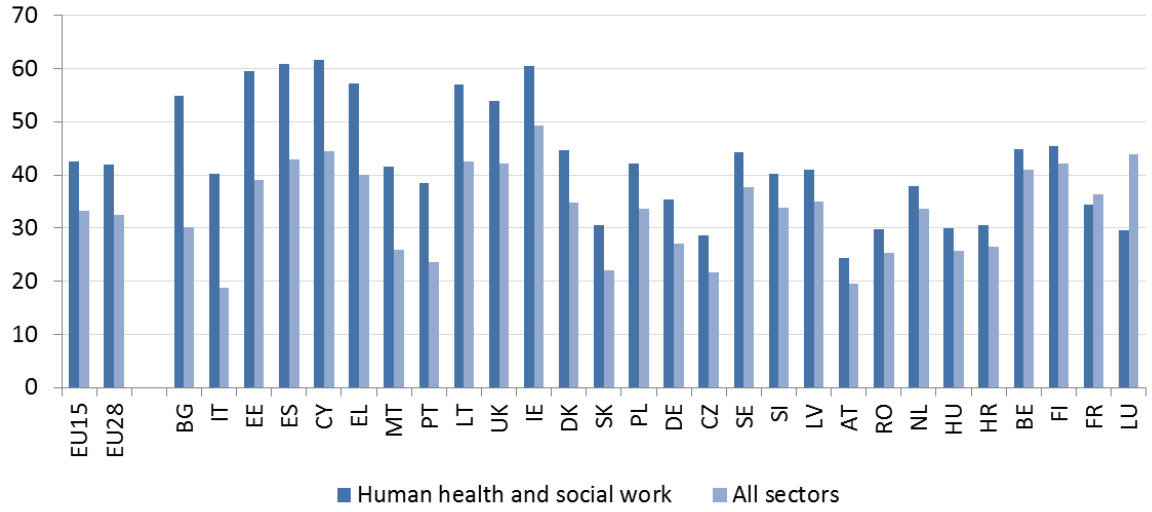
of men in the sector who are doctors is larger (19 per cent) than the proportion of women in the sector who are (6 per cent); while women are overrepresented in nursing and personal care (43 per cent of women hold these occupations against 22 per cent of men).

1.2.3 Skill-level

Workers in the human health and social work sector often have a medium (upper secondary and post-secondary non-tertiary education) or a high level of education (tertiary education). Compared to the average in the EU economy, employees in this sector are better skilled. This holds true in all Member States, except Luxembourg and to a lesser extent in France. In 2013, at EU level, 42% of employees in this sector held a degree in higher or tertiary education, against 33% in the total of the EU economy (Chart 11). This can be explained by the specialised training requirements in the sector. All doctors have tertiary education and in many countries also nurses do. In addition, there are high education requirements for managers, social assistants, etc.

Chart 11 shows the share of high-skilled workers by occupation in the human health and social work sector and in the whole economy. The difference between the share of high-skilled labour in the human health and social work sector and in the whole economy is the largest in Bulgaria, Italy and Estonia (around 20 to 25 pps). On the other hand, the difference is the smallest in France, Finland and Belgium (around 4 pps). It is negative in France and Luxembourg (-1.9 pps and -14.2 pps respectively).

Chart 11: Share of high-skilled employees in human health and social work versus the whole economy, EU-28, 2013, in per cent.



Source: Eurostat, LFS

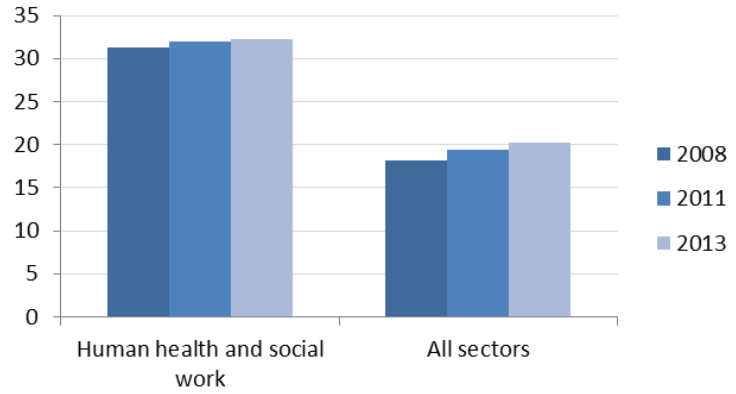
Addressing skills mismatches in the health sector is important: over-skilled workers may cause possible inefficiencies in health service delivery and waste of human capital, causing job dissatisfaction and turnover, while under-skilled workers raise concerns about quality of care and patient safety. Drawing on data from PIACC[5] and the European Working Conditions Survey[6], a 2013 OECD analysis concludes that there is considerable skills mismatch in the health sector. This makes initial education and training in the health sector an important area for action and there is a need for better allocation of skills and tasks across the spectrum of health professions.

[5] 2011-2012 Programme for the Assessment of Adult Competencies, OECD
[6] 2010 European Working Conditions Survey, Eurofound

1.2.4 Working patterns

Part-time work is a common feature in the human health and social work sector, as 32% of persons employed in this sector work under this regime. As recalled in the ESDE 2012 fluctuations in the number of jobs in the EU since the crisis have been driven mainly by part-time work. Part-time employment accounted for a significant share of the overall expansion in employment in the EU since 2000 and its growth was uninterrupted by the crisis. While the total employment figure contracted between 2008 and 2013, and the number of full-time workers shrank by 6.3 million, the number of part-timers increased by 2.1 million. Between 2008 and 2013, part-time work gained more ground at global level (in all sectors, its prevalence rose from 18.1% to 20.3%). I also increased in human health and social work, from 31.3 to 32.3% (Chart 12).

Chart 12: Share of part-time employees in human health and social work sector versus the whole economy, 2008, 2011 and 2013, EU-28, in per cent.

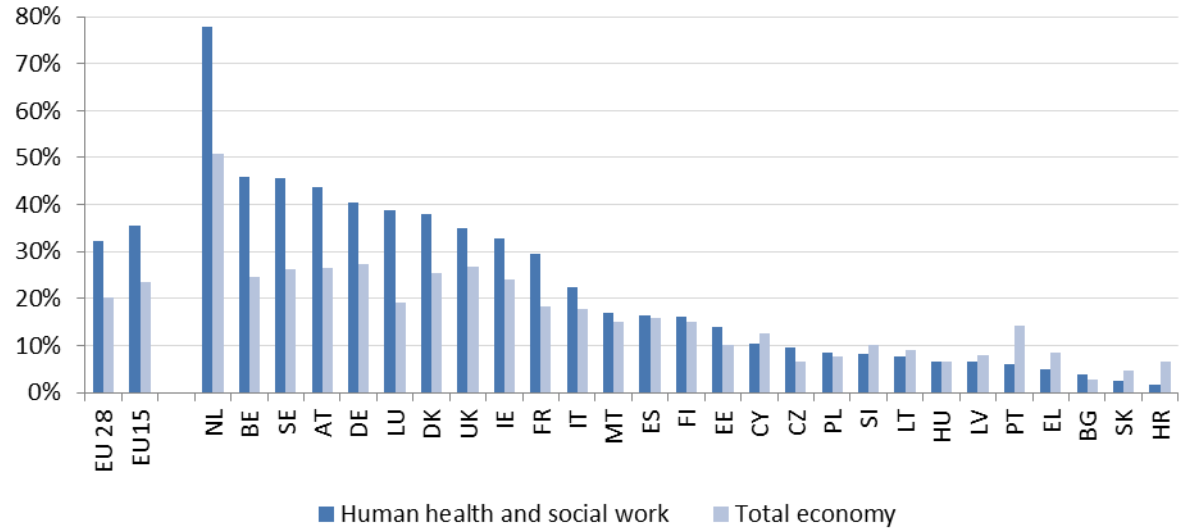


Source: Eurostat, LFS

As Chart 13 shows, the Netherlands clearly dominates the ranking of Member States in terms of the percentage of part-time workers in all sectors (over 50% in 2013), and in the human health and social work sector in particular (above 77%). With a few exceptions (such as Portugal, Greece and Croatia), corresponding to those countries having very low percentages of part-time workers both generally and in the human health and social work sector, all other Member States showed, in 2013, a higher share of part-time workers in this sector than in the whole economy.

At EU level, the gap between the human health and social work sector and the whole economy was 12 pps in 2013. The most significant gaps (more than 20 pps) were noted in the Netherlands (27 pps), Luxembourg and Belgium.

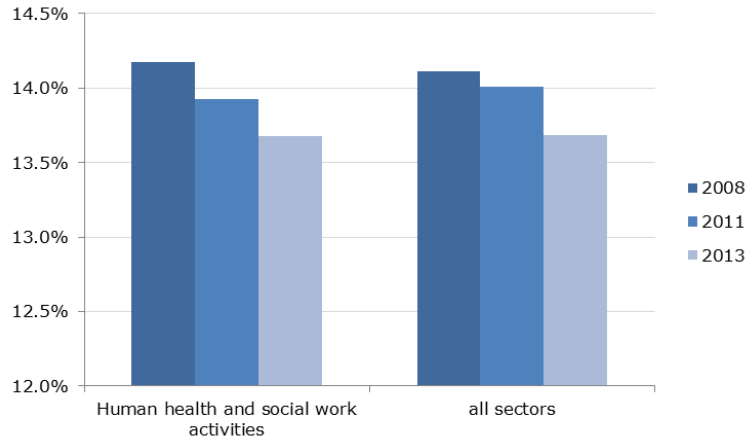
Chart 13: Share of part-time workers in the human health and social work sector versus the whole economy, 2013, in per cent.



Source: LFS
Note: data not available for RO.

The percentage of employees working on temporary contracts is roughly equal between the human health and social work sector and the whole economy, at around 13.7% (Chart 14). This type of work proved to be a major adjustment variable for companies as temporary contracts have been the most reactive segment of the labour market since the onset of the crisis. At the level of the whole economy, the share of temporary employees in the total number of employees which stood at 14.1% in 2007, had fallen to 13.7% by 2013. In the human health and social work sector the share of employees with temporary contracts fell slightly, from 14.2 to 13.7% in the five years to 2013.

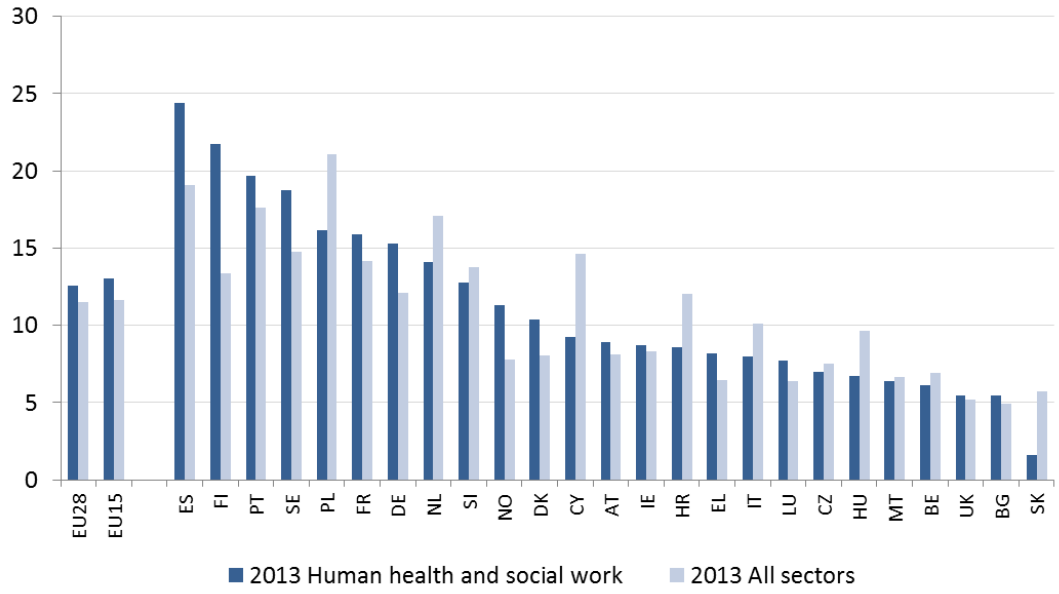
Chart 14: Share of employees aged 15-64 with temporary contracts in human health and social work sector versus the whole economy, 2008, 2011 and 2013, EU-28, in per cent.



Source: Eurostat, LFS

Chart 15 highlights the country-to-country differences in the share of employees under temporary contracts. While these percentages are rather close in most Member States between human health and social work on the one hand, and all sectors on the other hand, some major gaps arise in certain countries. In Poland, Cyprus, Italy, the Netherlands, Hungary and Slovakia, the share of temporary contracts is significantly lower in the human health and social work sector than on average, while for example in Finland and Spain it is significantly higher.

Chart 15: Share of employees with temporary contracts in all sectors and in human health and social work activities, 2013 in per cent



Source: Eurostat, LFS
Note: Data not available for EE, LV, LT and RO

As Chart 16 shows, at EU level, full-time workers in the human health and social work sector tend to work fewer hours than in the whole economy on average: in 2013, 40 hours per week for full-time workers against 41.5 hours in the whole economy. The picture is reversed for part-time workers where more hours are worked in the human health and social work sector (22 hours) than in the whole economy (19.9 hours). This has not changed much since 2008. Full-time workers in this sector work most hours in Austria, Slovakia and Malta (more than 42 hours per week) and fewest hours in Denmark and Italy (below 38 hours per week). On the other hand, part-time workers work most hours in Sweden, Belgium and France (between 24 and 27 hours per week) and fewest hours in Greece, Portugal and Croatia (less than 19.5 hours per week).

Chart 16: Average number of usual weekly hours of work for full-time workers, in human health and social work sector compared to the whole economy, 2013

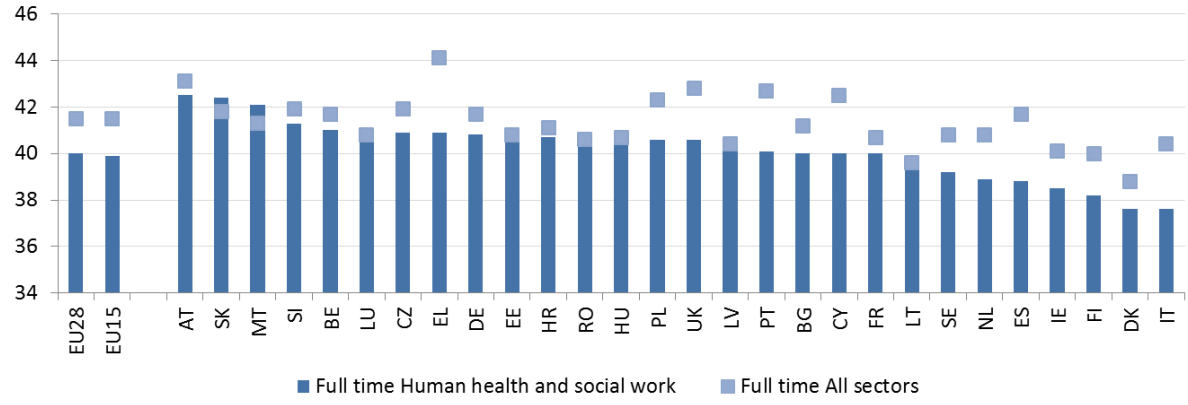
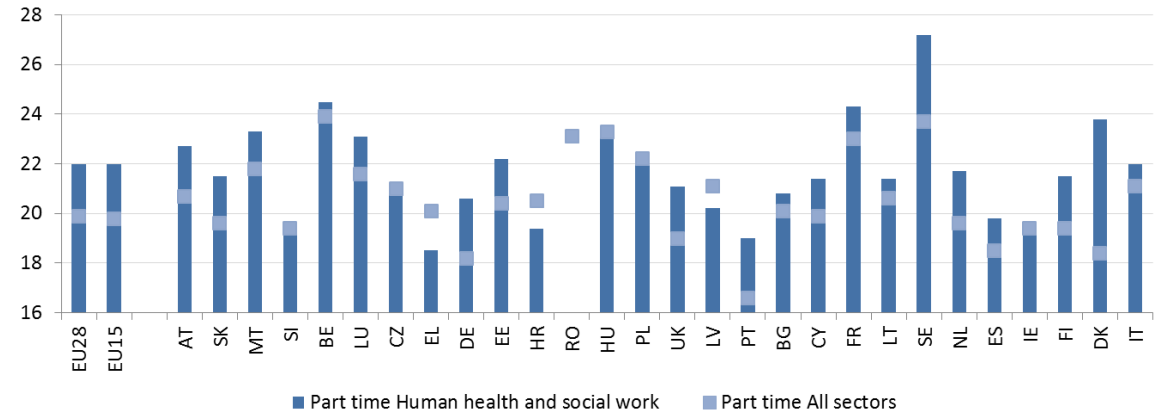


Chart 17: Average number of usual weekly hours of work for part-time workers, in human health and social work sector compared to the whole economy, 2013



Source: Eurostat, LFS

BOX 1: Working conditions and job quality in the human health, residential care and social work sectors: main findings from the 5th European Working Conditions Survey (Prepared by EUROFOUND)

The fifth European Working Conditions Survey was carried out among almost 44,000 workers in 34 European countries, including 2,271 workers in the human health sector, 543 workers in the residential care sector and 875 workers in the social work sectors.

Structural characteristics

The three sectors are female dominated. Although the proportion of workers who reported having a female boss (60%) was much higher than in the EU28 as a whole (29%), it still falls well short of the percentage of female employees (75%). Part-time work is relatively prevalent in all three sectors, with levels of part-time work being highest in the social work sector, where 28% of men and 50% of women work part-time compared to 13% and 38% respectively in the EU28 as a whole. The proportion of employees aged 50 and older was above average in the residential care and social work sector (31% in both sectors and 27% in the EU28).

Working conditions

Relatively few workers in the three sectors reported to have experienced a decrease in their income or working hours since the economic crisis and the majority of workers reported no change in income or working hours. However, the proportions of reported increase in working hours and income in all three sectors were higher than the corresponding EU28 averages. Reorganisation and restructuring were more prevalent in the human health sector than in the other two sectors and the EU28 as a whole.

Workers in the care sectors work fewer hours than the EU28 average (34 to 35 hours in contrast to 38 in the EU28). Nevertheless, a relatively high proportion of female employees in the residential care sector (32%) and of male employees in the health care sector (40%) report to prefer working fewer hours than currently. Reversely, workers in the social work sector (18%) and men in the residential care sector (18%) reported a higher preference for working more hours than currently in comparison to the EU28 as a whole (14%).

Among men in all three sectors and also among women in the residential care sector working atypical hours is much more prevalent than in the EU28 as a whole. Similarly, men in all three sectors are relatively likely to experience irregular working hours. Consequently, a relatively large proportion of men working in the health care and social work sector report a poor work-life balance. However, this difference is not found in the residential care sector, and women in the social work sector even report better work-life balance than the EU28 average.

Teamwork, particularly autonomous teamwork, is relatively prevalent in all three sectors. Similarly, the proportion of workers in the sectors rotating tasks is higher than in the EU28 as a whole. In all three sectors roughly half of the workers reported that their skills correspond well with their duties. In the social work and in the health care sector around 20% and in the residential care sector 16% of the workers stated that they need further training, exceeding levels in the EU28 as a whole (13%). The difference in the proportion of 'under-skilled' is most pronounced for micro-workplaces (1-9 employees). Interestingly, employees in the three sectors also more frequently reported that they received employer-paid training in the last 12 months than the EU28 average.

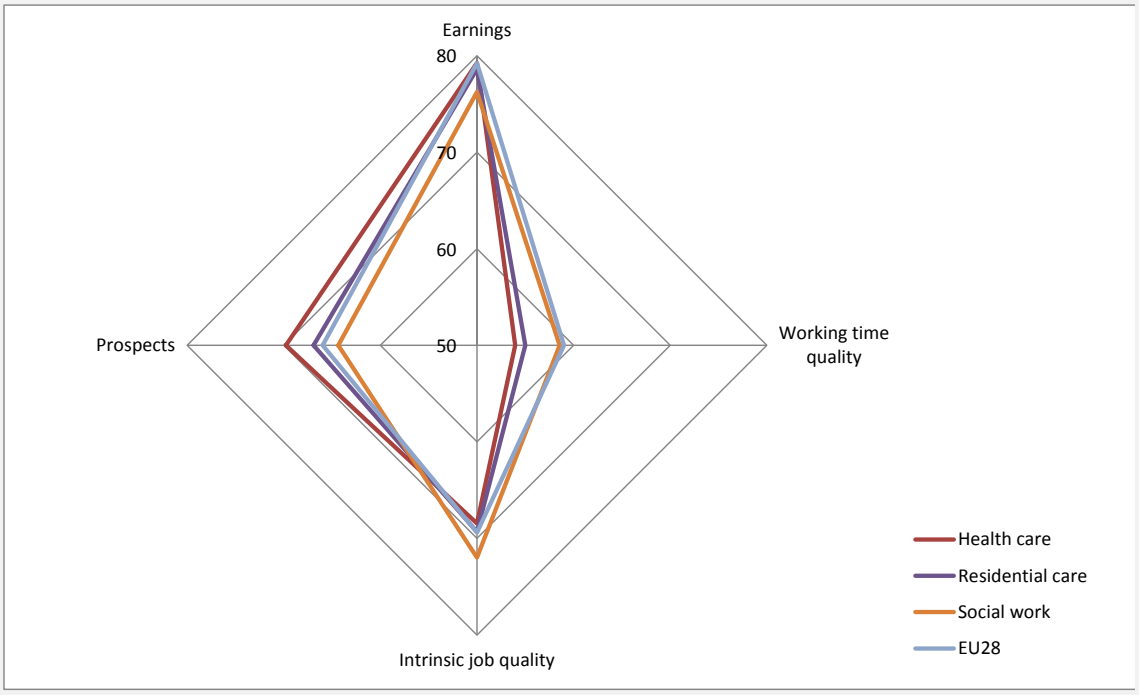
Physical environment

Workers in the health care sector reported the highest level of exposure to biological and chemical risks among all sectors in the EU28 and workers in the residential care sector had also a relatively high level of exposure to biological and chemical risks. On the other hand, the levels of exposure to ambient risks are relatively low in all three sectors and exposure to posture related risks only in the social work sector. Workers in the three sectors also reported to be better informed about the risks than the average EU28 worker.

Job Quality

Job quality is considered a characteristic of the job rather than the worker, and to capture it four dimensions are distinguished: earnings; working time quality (e.g. duration, scheduling, discretion over working time and short-term flexibility); prospects (e.g. job security, career progression and contract quality); and intrinsic job quality (e.g. skills and discretion, good social environment, good physical environment and work intensity; for more information see here). Workers in the health and residential care sectors had lower scores on working time quality than workers in the EU28 as a whole.

Job quality



Note: Scores on all four indicators range from 0 to 100. Controlled for structural characteristics (age, gender, workplace size, education level and country)

However, workers in the health care sector also had better job *prospects*. Employees in the social work sector, on the other hand, reported better *intrinsic job quality*, lower *earnings* and poorer job *prospects* than the average EU28 worker.

More information on working conditions and job quality can be found in the Report 'Working conditions and job quality: Comparing sectors in Europe' and in the corresponding 'Sectoral information sheets'. An overview of case studies exploring policy initiatives to improve the quality and thereby attractiveness of jobs in the sector can be found here.

1.3 Main challenges in addressing the demand for health and social services

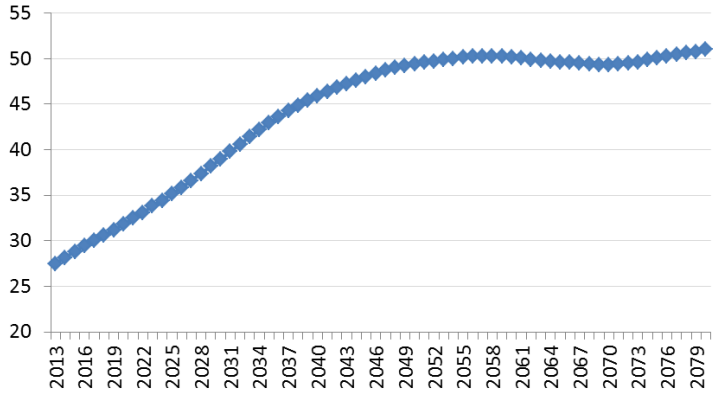
- The ageing of the population is a key driver in the demand for health and social services thus representing an opportunity to create new jobs.
- Member States spend the biggest share of their social on in-cash benefits rather than on in-kind benefits.
- The spending on social protection decreased during the crisis mainly on in-kind benefits.
- The ageing of the population as well as an increased demand for complex needs has put an increased pressure on public finances.
- Maintaining a balance between adequate and quality supply of health and social services and containing public budgets remains a challenge for public authorities.

1.3.1 A growing demand for health and social services

Ceteris Paribus (i.e. without a change in ill-health patterns), the ageing of the European population will continue to be a key driver of the growing demand for health and social services. The relative size and share of old (aged 65 and more) and very old (aged 80 and more) population is growing fast. The size and share of very old is growing at a faster pace than any other age segment of the EU's population. In the EU28, between 2013 and 2060, the population aged 65+ is projected to increase from 92.2 to 149 million, while the population aged 80+ is projected to increase from 25.6 to 63.8 million. The share of those aged 80 years or above in the EU-28's population is projected to more than double between 2013 and 2080.[7]

The old-age dependency ratio[8] measures the level of financial support given by the working-age population to the older cohorts of the population. The old-age dependency ratio for the EU-28 was 27.5 % on 1 January 2013, and is projected to almost double to 50.0 % by 2055 (Chart 18).

Chart 18: Old age dependency ratio (65+ to 15-64 year olds) for EU28, 2013 to 2080.



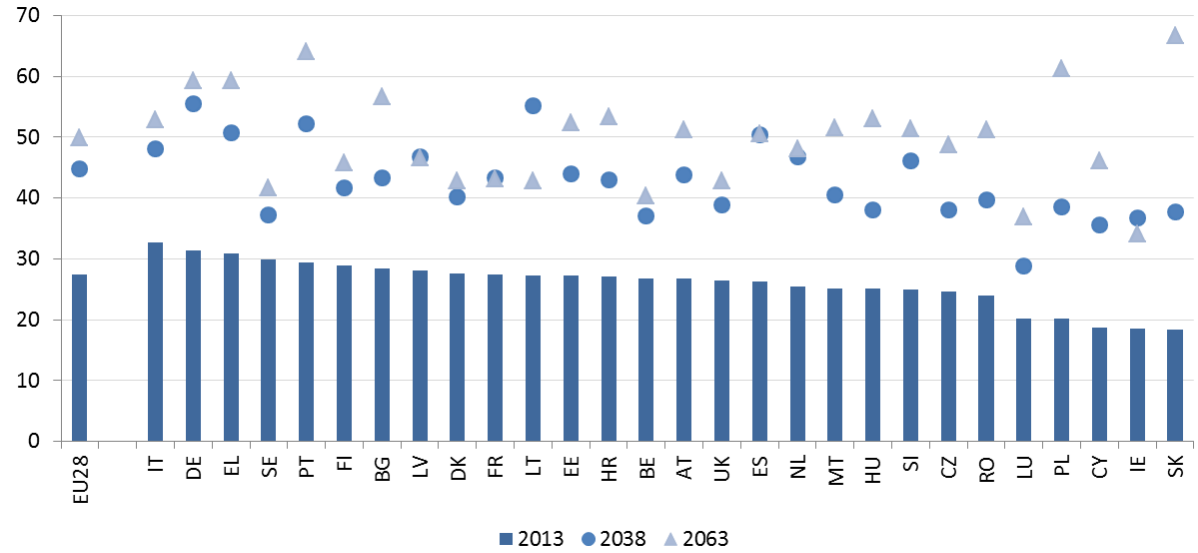
Source: DG EMPL calculations based on Eurostat EUROPOP2013

[7] For details see:
http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Population_structure_and_ageing

[8] The old-age-dependency ratio is the ratio of the number of elderly people at an age when they are generally economically inactive (i.e. aged 65 and over), compared to the number of people of working age (i.e. 15-64 years old).

Chart 19 shows that in absolute terms the highest increases in the share of the older population between 2013 and 2063 are expected in Slovakia, Poland and Portugal. However, in relative terms older population is projected to grow the most in Slovakia, Poland, Cyprus and Portugal.

Chart 19: Old age dependency ratio (65+ to 15-64 year olds) by Member State 2013, and projections for 2038 and 2063



Source: DG EMPL calculations based on Eurostat EUROPOP2013

Ageing can bring with it new patterns of morbidity (multiple chronic diseases, disability and dependency) spread over a long period of time. Evidence shows that the need and demand for health care and social services is strongly and positively correlated with age: health deteriorates with age and correspondingly, the demand for health and social services increases with age.[9] This means that due to the ageing of the population, there will be greater pressure to provide more and substantially different care and social services in the future than it is currently the case.

The "caring dependency ratio" shows how difficult or easy is for a person in the age-group 45-64 (where the peak on the provision of caring time is generally observed) to take care of those who are 65+ or 80+. The ratio of those 65 years old and over to those aged between 45 and 64 years old is projected to almost double by 2060, while the ratio of the 80+ to the 45-64 increases from 17.8 in 2010 to 51.3 in 2060, i.e. a bit less than tripling.[10]

While the demand for long-term care services for the elderly will substantially increase, the availability of informal carers (family, friends and other relatives) may be further limited by the changing family structures, more equal gender participation in the labour market and the increased workforce mobility. The decrease in the number of informal carers may in turn lead to a marked rise in the demand for formal care, which will further increase the trend towards employment growth in health and social services.[11]

[9] Joint Report prepared by the European Commission and the Economic Policy Committee (AWG), *The 2009 Ageing Report: economic and budgetary projections for the EU-27 Member States (2008-2060), February 2009.*
[10] Lipszyc, B, Sail, E. and Xavier, A. (2012), Long-term care: need, use and expenditure in the EU-27, European Economy, Economic Papers 469, November 2012.
[11] See also the report "Adequate social protection for long-term care needs in an ageing society - Report jointly prepared by the Social Protection Committee and the European Commission, 2014

The growth in the demand for social services will also reflect other deep-rooted trends in the European economies and societies resulting from changes in gender roles and family structures (e.g. an increase in single households, increased participation of women in the labour market), from more flexible labour markets as well as from technological change and globalisation. Due to these trends, the demand for social services is becoming more complex: an increasing number of people will require efficient services adapted to diversified needs and choices.

Thus, a higher demand for formal health and social services is likely to act as a driver for increasing labour demand.

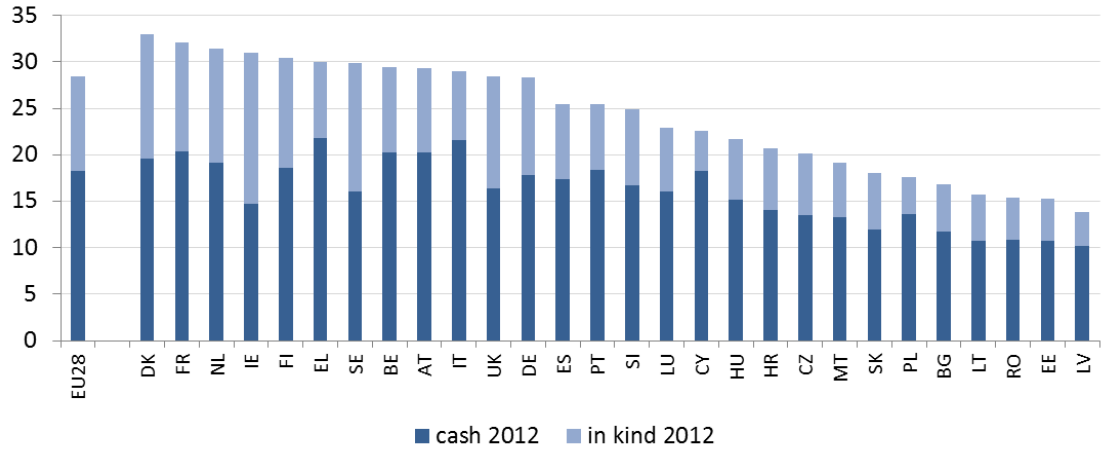
1.3.2 Developments in expenditure on health and social services

Recent developments

Expenditure on social protection is mainly financed from public budgets. It can be disaggregated into cash benefits and benefits in-kind. Cash benefits include pensions, maternity payments, sick and parental leave, family allowances and unemployment benefits. Benefits in-kind, i.e. benefits granted in the form of goods and services, encompass health care services, social assistance and services such as childcare and care for the elderly and disabled. While only part of the spending on cash benefits is intended for the consumption of social services, practically all the spending on benefits in kind finances social services. Therefore, the rest of this section will refer interchangeably to benefits in kind and health and social services.

In the EU in 2012, social protection expenditure reached 28.4% of GDP. Of this, 10.1 pps were spent on benefits in kind and 18.3 pps were spent on benefits provided in cash (Chart 21).[12] Usually, Member States that in total spend a higher proportion of their GDP on social protection tend to provide a larger share of social protection benefits in kind. The largest share of GDP (10% or more) was dedicated to benefits in kind in Ireland, Sweden, Denmark, the Netherlands, UK, France, Finland and Germany. On the other side of the spectrum were Latvia, Poland, Romania, Estonia and Cyprus that spent less than 5% of GDP on social protection benefits in kind.

Chart 20: Social protection spending on cash and in-kind benefits as % GDP, 2012



Source: ESSPROS

[12] For a more detailed description of social protection spending in the EU, e.g. with the dimension of spending functions, see the 2012 Employment and Social Developments in Europe Annual report (ESDE) 2012 report (http://ec.europa.eu/social/BlobServlet?docId=9604&langId=en).

Chart 21 shows the average annual change in real expenditure on social protection benefits in kind in two periods (2007–2010, and 2011–2012). In the first period, the highest average annual growth of real social protection benefits in kind was recorded in Romania, Ireland, and Bulgaria (10-15% per year). On the other hand, a decrease in social protection benefits in kind was recorded in Hungary (by 0.7% per year).

In the second period, when public budgets got under big pressure, real spending on social protection benefits in kind decreased in 23 Member States. The largest decrease (by 5% or more per year) was recorded in Greece, Romania, Portugal, and. In Greece and Portugal, in particular, the main driver was falling health care and sickness benefits.

On the other hand, in Ireland, spending increased significantly (by 7%), with health care and sickness benefits being the main driver.

Chart 21: Change in expenditure on social protection benefits, 2007–2010 average annual change (top panel) and 2010–2012 average annual change (bottom panel), by function (percentage change in national currencies deflated by HICP)

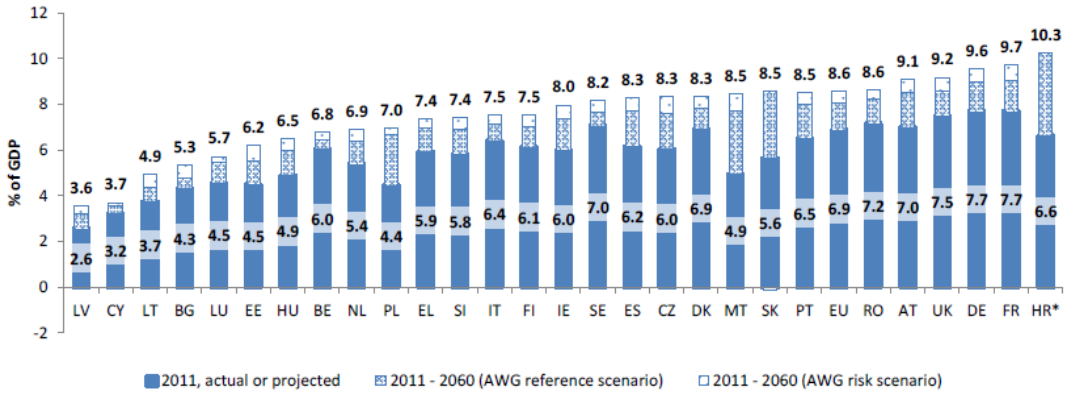
Source: DG EMPL calculations on ESSPROS data

Future expenditure developments

The ageing of the population coupled with the ageing of the workforce and with the 'elder ageing' (i.e. the rapid increase in the number of people aged 80 and over), or so-called "triple ageing" phenomenon, will have marked implications for health and social services expenditure.

If age-disease patterns remain unchanged, public expenditure levels will increase in line with population ageing. According to the 2012 EPC/EC projections, public expenditure on health in the EU-27 will increase by 1.4 pp of GDP by 2060 due to population ageing, i.e. a 20% increase with respect to 2010 spending, from 7.1% to 8.5% of GDP. This increase will range from around 0.5% of GDP in Cyprus and Latvia to 3.2% of GDP in Malta, with most Member States registering increases in public health expenditure between 1 and 2 pps of GDP (Chart 22).

Chart 22: Current (2011) and projected (2011-2060) public expenditure on health

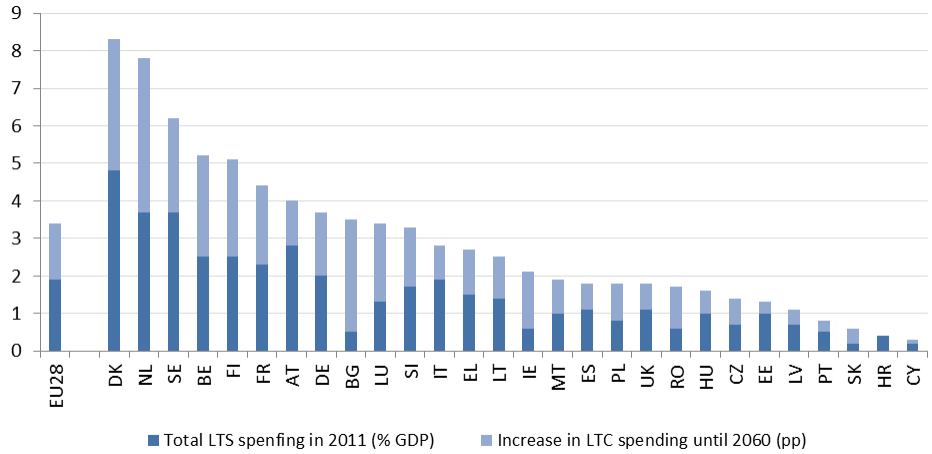


Source: Source: 2012 Ageing Report, Fiscal Sustainability Report 2012, European Commission, own calculations.
Notes: The ranking of the countries deviates from the ranking in the Ageing Report, as the 2011 data has been updated for some countries according to data availability. Data for Croatia includes the projection of long-term care spending based on national sources, as no separate projection for health care and long-term care is available. No risk scenario is available for HR either.
Data excludes spending for long-term nursing care (HC.3 category of the system of health accounts).

According to the 2012 Ageing Report, public expenditure on long-term care (LTC) will rise at a higher rate than GDP growth: public spending on LTC is expected to increase by 1.5 pps of GDP due to ageing-related factors even if one accounts for some improvements in disability status of the population (the so-called "AWG reference scenario"). This corresponds to a potential increase from 1.9 % of GDP in the EU in 2011 to 3.4% of GDP in 2060. The projected expenditure increase in LTC represents on average more than 40% of the total age-related increase in public spending till 2060.[13]

[13] European Commission (2014), *Identifying fiscal sustainability challenges in the areas of pensions, health care and long-term care policies*, DG ECFIN Occasional Papers nr. 201.

Chart 23: Public expenditure on long-term care as % of GDP, 2011-2060



Source: DG EMPL calculations based on 2012 EPC/EC Ageing report (EPC Ageing Working Group reference scenario)

This variation of the projected changes in public expenditure on long-term care reflects the current situation of formal care provision. In those where the public expenditure on long-term care and its projected increase are low (below 1% by 2060) – such as Cyprus, Latvia and Bulgaria – reflect a situation where long-term care needs are to a large extent met by informal carers (family, friends, relatives or other informal carers). By contrast in Member States where the public expenditure on long-term care is above the EU-28 average and is projected to more than double by 2060 – such as in the Netherlands, Belgium, Finland or France – the elderly population currently relies and is assumed to rely more on the formal care providers. Changes in household composition, gender patterns and family relations towards smaller households and a greater participation of women in the labour market may change the current provision pattern in countries were informal provision is now widespread.

1.3.3 Unmet needs

The rising public expectations regarding the quality, accessibility and affordability of health and social services and the context of pressure on public budgets due to the crisis has increased the challenge on some Member States to reach adequate levels of spending on health and social services while for others, the challenge remains to keep adequate levels of spending to ensure quality services.

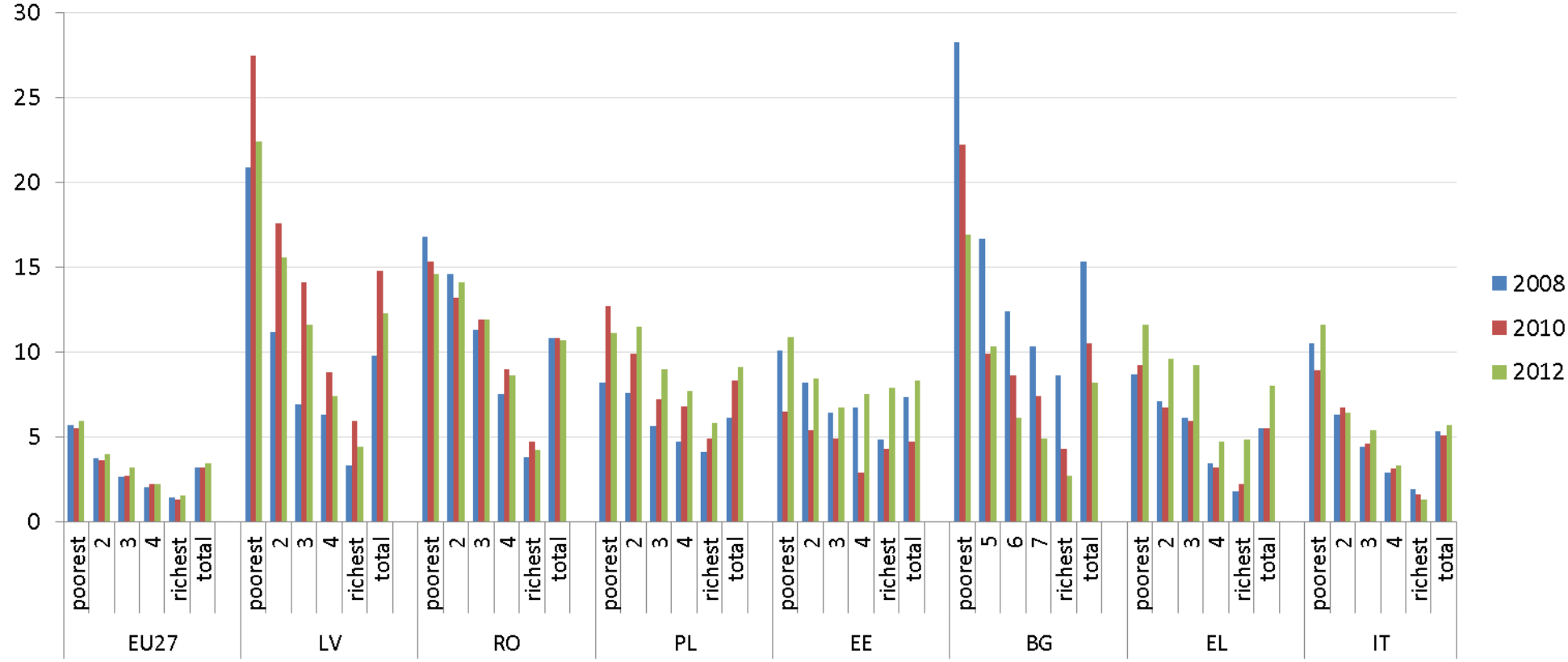
Poor health or lack of access to health care are important dimensions of social exclusion. The impact of the crisis on them is more difficult to capture, but they are likely to have long-term detrimental impacts on the population if not tackled.

The indicator of 'unmet need for care'[14] is here used to monitor access to healthcare. In the EU27[15], on average, after a period improvement between 2008 and 2010 (which started already in 2007) the situation has worsened between 2010 and 2012 (latest data available). Access to healthcare appears to be particularly problematic in Latvia, Romania, Poland, Estonia, Bulgaria, Greece, and Italy, all these countries where 5% of more of the population in 2012 reported an unmet need for care. Between 2010 and 2012, the situation worsened considerably in Greece and Estonia (Chart 25).

Charts 24-26 show also the developments for the EU Member States by income quintiles. Between 2010 and 2008, at the EU27 level, the situation worsened among all income quintiles, with access to healthcare being particularly a concern for the poorest income group.

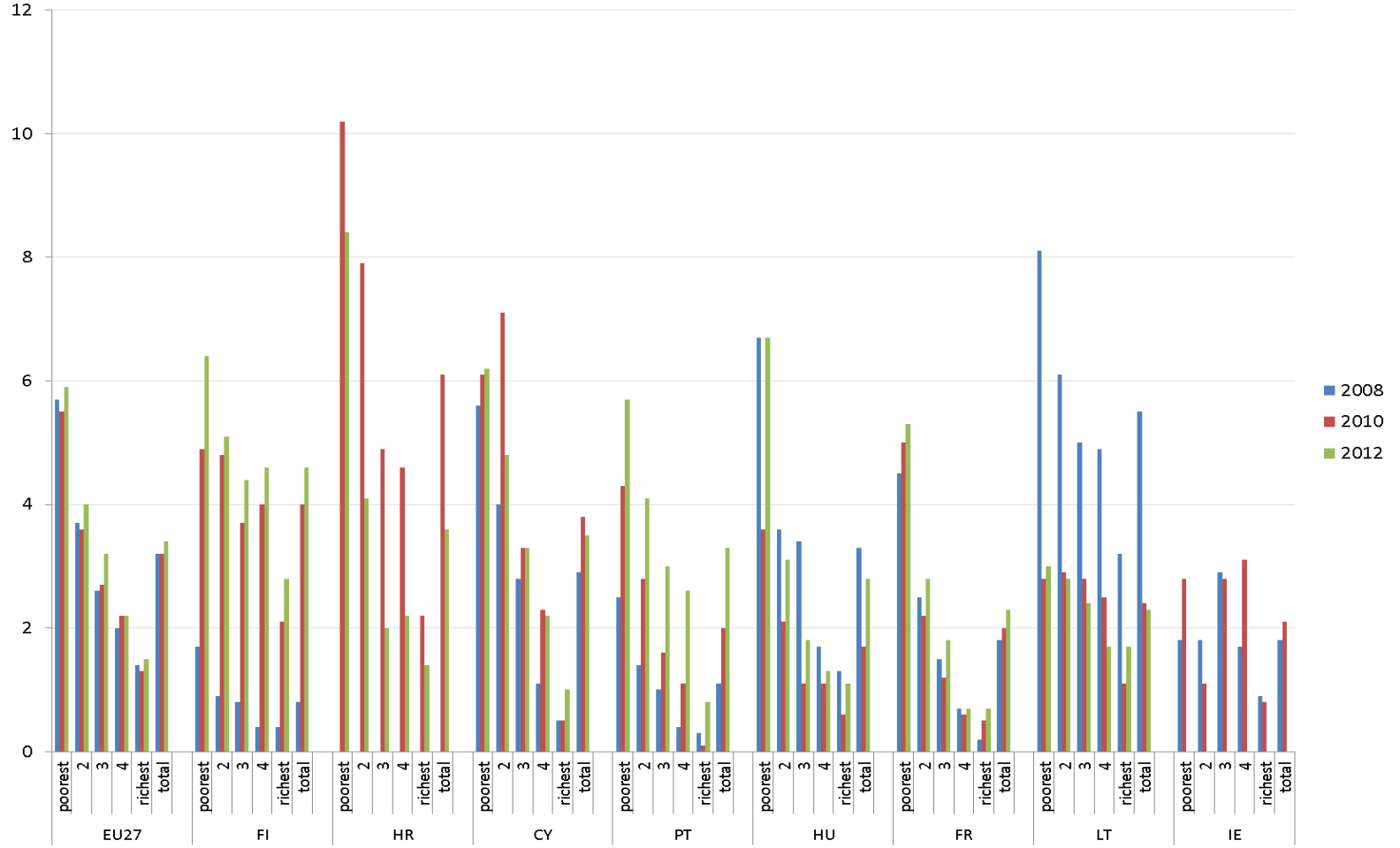
[14] This indicator is defined as the share of the population perceiving an unmet need for medical examination or treatment for different reasons. The reasons considered in this analysis are: [i] could not afford to, [ii] waiting list, [iii] too far to travel.
[15] The EU27 average is here used for consistence with the previous waves of EU-SILC (2008 and 2010).

Chart 24: Unmet need for health indicator, by income quintiles in MS with total over 5 per cent, 2008, 2010, 2012



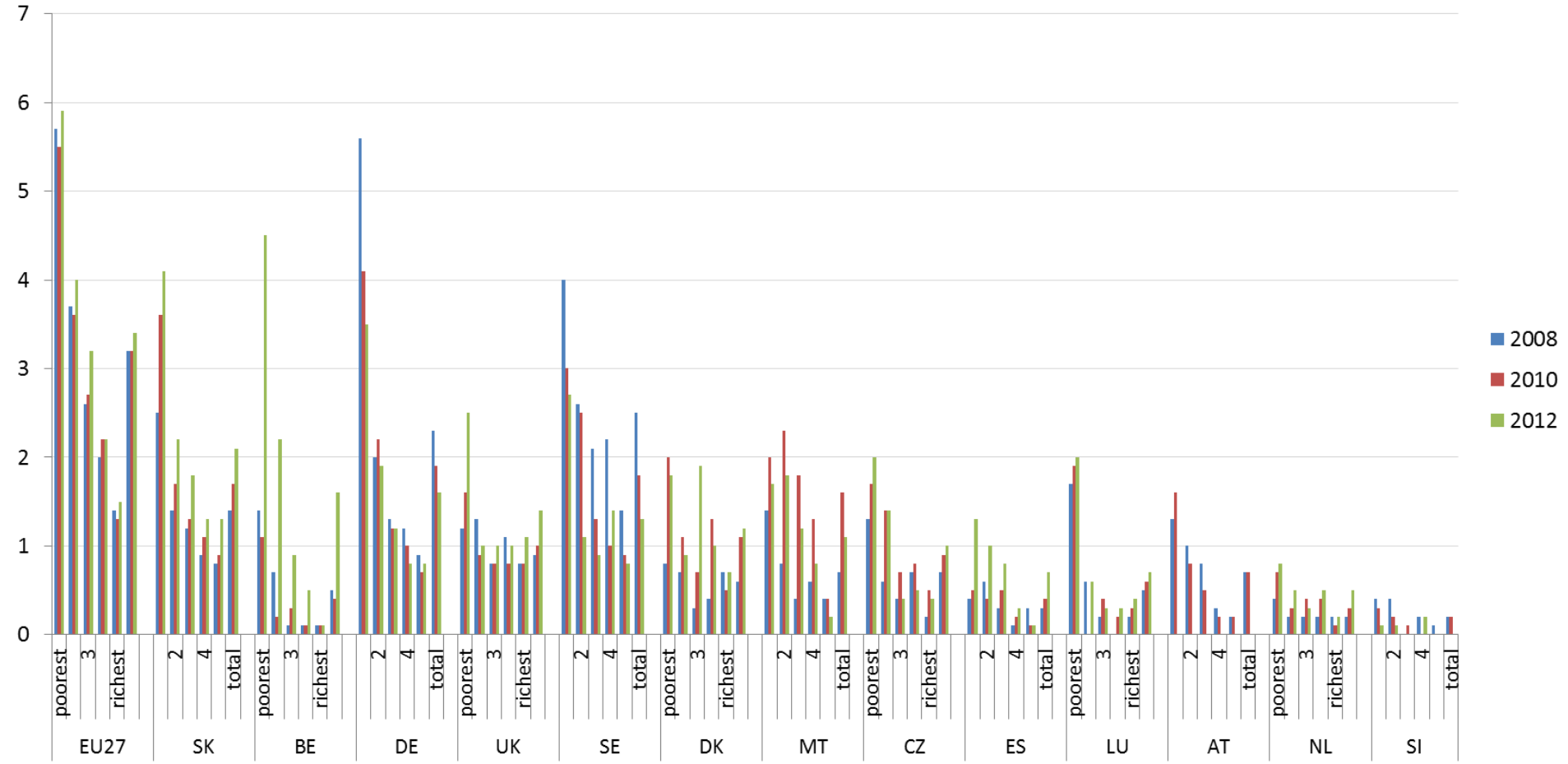
Source: EU SILC 2008 2010 2012

Chart 25: Unmet need for health indicator, by income quintiles in MS with total between 2 and 5 per cent, 2008, 2010, 2012



Source: EU SILC 2008 2010 2012

Chart 26: Unmet need for health indicator, by income quintiles in MS with total under 2 per cent, 2008, 2010, 2012



Source: EU SILC 2008 2010 2

1.4 Conclusions

Health and social services play an important role in EU economies and societies. They play a pivotal role in ensuring effective and efficient social protection by promoting social inclusion and reducing the risk of poverty and inequalities as well as by improving social cohesion. They also generate many of the newly created jobs and are a source of new jobs in the years to come. Nevertheless, in some Member States, social services are underdeveloped and access to health and social services could be improved.

The economic and financial crisis has played a double role in relation to health and social services: on the one hand, it has shown that these services can cushion the impact of the crisis. On the other, budget constraints have had an impact on the financing of health and social services through significant cuts in the spending on in-kind benefits.

The health and social services sector is characterised by a better skilled workforce than the rest of the economy but also by a higher gender pay gap, harder working conditions, in particular with respect to working time, and a high rate of part-time work which might lead to challenges in attracting new workers into the sector. Nevertheless, the sector will generate an increased number of jobs due to ageing labour force in the sector, increased demand due to the development of new needs driven by the demographic changes, the economic and social consequences of the crisis, growing inequalities, technological developments or changing social patterns.

Strategies to develop the job potential in the sector of health and social services should focus on creating more secure, quality and better paid jobs in order to fulfil the growing demand. This could be done through the development of more efficient learning and training schemes, in order to acquire, certify and recognise qualifications, better career prospects and job security, better pay and working conditions.