European Commission

EU Employment and Social Situation

Quarterly Review

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Special Supplement on Health and Social Services

Social Europe

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Special Supplement on health and social services: employment patterns and role in the economy

Introduction

This analysis presents an overview of data and information pointing to the importance of social services in the European economy. It focuses on the developments in this sector since 2000.

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 considerable 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 (in particular the Labour Force Survey (LFS)). These data cover the 'human health and social work sector' that is composed of human health, residential care and social work activities.[1]

Employment trends

- Employment in the human health and social work sector accounted for more than a third of the new jobs created in the EU between 2000 and 2011.
- Employment in this sector was growing even in the crisis years in the EU, when it was declining in the rest of the economy.
- The share of employment in this sector has grown in most Member States since 2000.

From 2000 to 2008 total employment in the EU grew by 9.6 % among the working-age group (15-64), resulting in the creation of 19.1 million new jobs (net). In 2009 and 2010, due to the crisis, employment declined by 2.3 %, and in 2011, despite a moderate recovery, it remained 2 % below the 2008 level. Therefore, over the whole period between 2000 and 2011, 14.7 million new jobs (net) were created.

These developments were, however, not uniform across all sectors. The human health and social work sector usually performed better than the rest of the economy, especially in times of slow growth or economic decline. In 2011 the number of workers in this sector aged 15 to 64 stood at 22.3 million, i.e. 10.5 % of the total in all sectors, having grown by 5 million since 2000, thus accounting for more than a third of the new jobs across the economy. Unlike in the economy as a whole, the number of workers in this sector was steadily growing, even in the crisis years. This was reflected in an increasing share of employment of this sector in total employment.

The average masks significant differences between Member States, however (see Chart 1). In the period 2000–2011, the highest growth in the share of employment in the human health and social work sector was recorded in Ireland (an increase of 5 pps) and the Netherlands (3 pps). On the other hand, the share of employment in this sector fell in Sweden (by 3 pps) and in Poland, Bulgaria, Slovakia and Latvia (by 1 pp or less). In general, the drivers of growth included population ageing and an expansion of services to better meet quality requirements and rising demand following a lag in investments during a lengthier period of restrictions on budget growth.

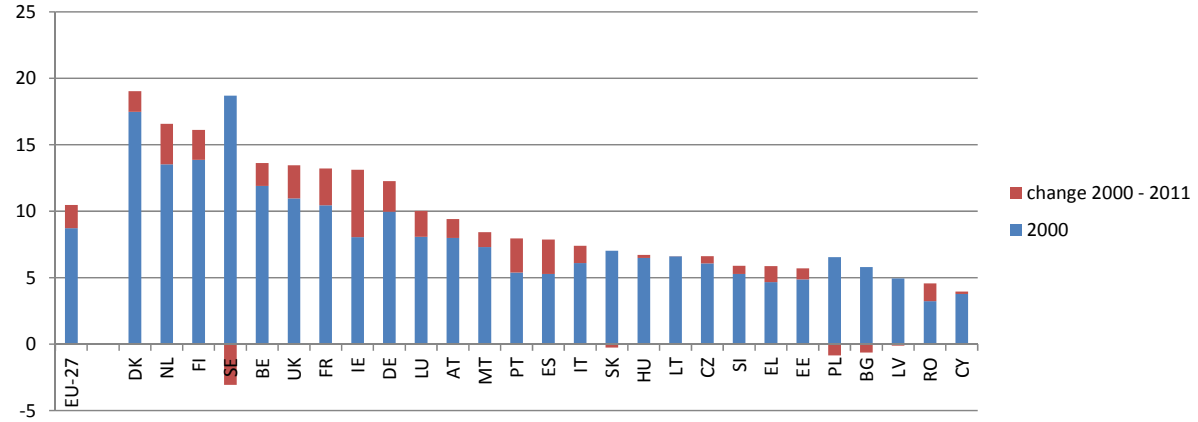
As a result of these developments, in 2011 the share of employment in the human health and social work sector was the highest in Denmark, the Netherlands, Finland and Sweden, at between

[1] Definitions provided by the Statistical Classification of Economic Activities (NACE) under Rev. 1 (for data collected before 2005), Rev. 1.1 (for data collected between 2005 and 2008) and Rev. 2 (for data collected after 2008).

15 % and 19 % of total employment. Lower shares, but still above the EU average of 10.5 %, were found in Belgium, the UK, France, Ireland and Germany.

The share of employment in the human health and social work sector was the lowest (below 5 % of total employment) in Cyprus, Romania and Latvia. It was only slightly higher in Bulgaria, Poland, Estonia, Greece and Slovenia (not more than 6 %). In the remaining Member States, such as the Czech Republic, Slovakia, Italy, Spain and Austria, the figure was between 6 % and the EU average. Of these, the share rose most significantly in Spain and Portugal.

Chart 1: Employment in the human health and social work sector as a share of total employment (in %, 2000–2011)



Source: LFS

Structural features and challenges of the health and social services sector

- The workforce in the human health and social work sector is dominated by women, who hold nearly 78 % of the jobs in the sector.
- The difference in earnings between men and women working in this sector is mostly greater than in the economy as a whole.
- The workforce employed in this sector is ageing rapidly.
- Workers in the human health and social work sector often have a medium or high level of education.
- The prevalence of part-time work and temporary contracts is higher in this sector than in the economy as a whole.

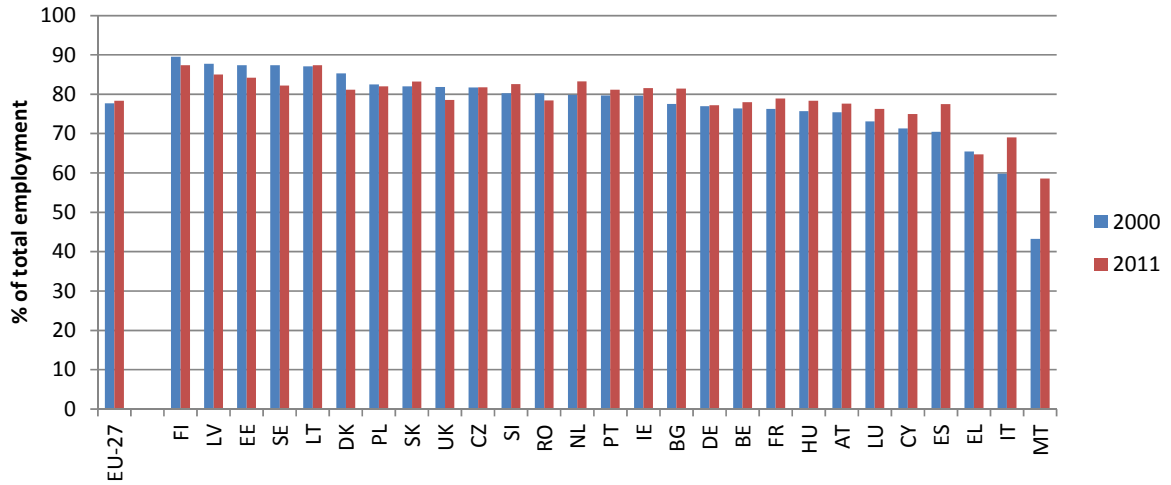
The health and social services sector is confronted with several challenges. Its overwhelmingly female workforce is ageing. There are large imbalances in skill levels and working patterns, whereas recruitment and retention are hampered by demanding working conditions. These challenges are analysed in this section.

Gender bias

The workforce in health and social services is dominated by women, who in the EU hold nearly 78 % of all jobs in the sector (amounting to 17.5 million women working in this sector). Of the 5 million new jobs created in the sector between 2000 and 2011, 4 million were occupied by women.

The rate of female employment in the human health and social work sector rose in the EU by 2 pps between 2000 and 2011. The largest increases in the share of women working in this sector were registered in Member States where the sector's female employment rate was among the lowest in the EU, such as Malta, Italy and Spain (but not Greece). On the other hand, the sector's female employment rates decreased slightly in Member States with initially high shares of women working in it (e.g. Finland, Latvia, Estonia, Sweden and Denmark).

Chart 2: Female share of total employment in the human health and social work sector, 2000 and 2011



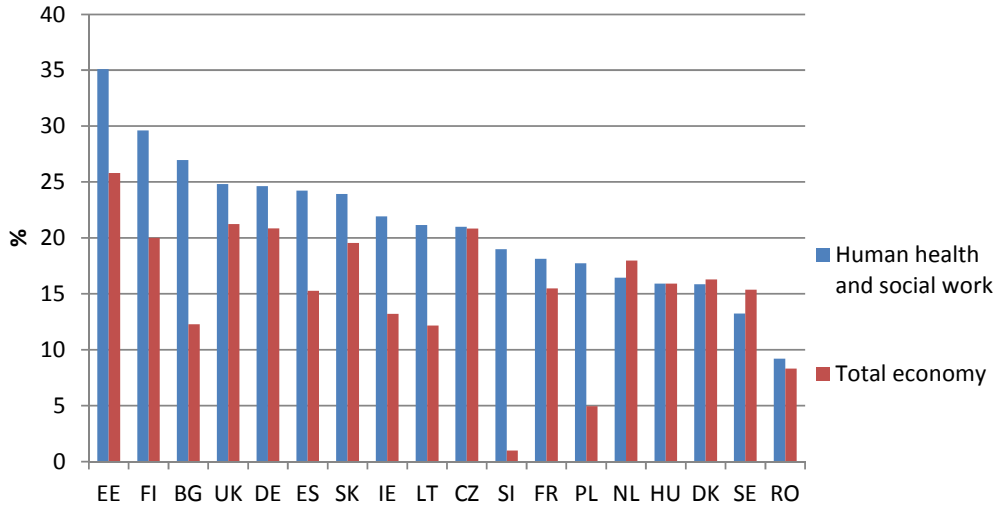
Source: LFS

The gap between the share of women and men employed in the sector stopped widening in 2008 and it seems that the share of women in this sector has stabilised at 78 %.

Apart from this uneven gender balance, Chart 3 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 gender pay gap in the human health and social work sector and that in the whole economy is the largest in Slovenia, Bulgaria, Poland, Estonia and Finland (between 9 and 18 pps).

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

Chart 3: Gender pay gap in human health and social work and in total economy, 2010

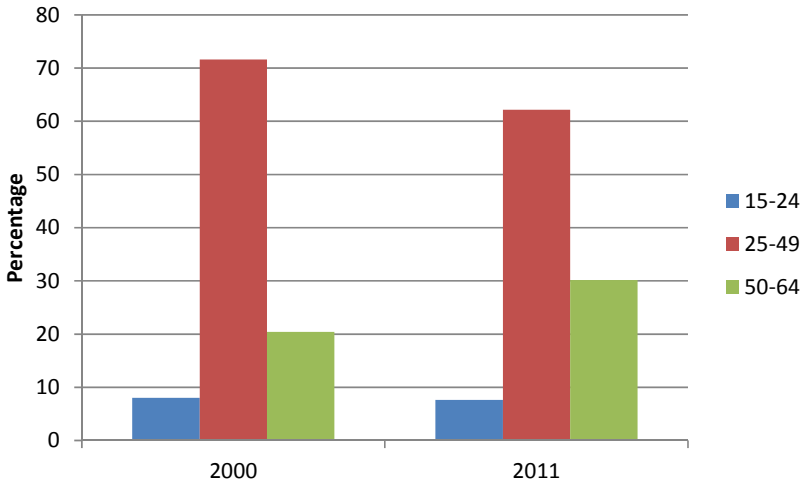


Source: Structure of Earnings Survey

Ageing of the workforce

The vast majority of people working in the human health and social work sector belong to the 25-49 age group. However, the share of people over 50 working in this sector increased from approximately 20 % to 30 % between 2000 and 2011 in the EU-27 (Chart 4), which shows that the workforce is ageing. It has been ageing faster than the workforce in the whole economy, suggesting that this sector has been important for the employment of older workers.

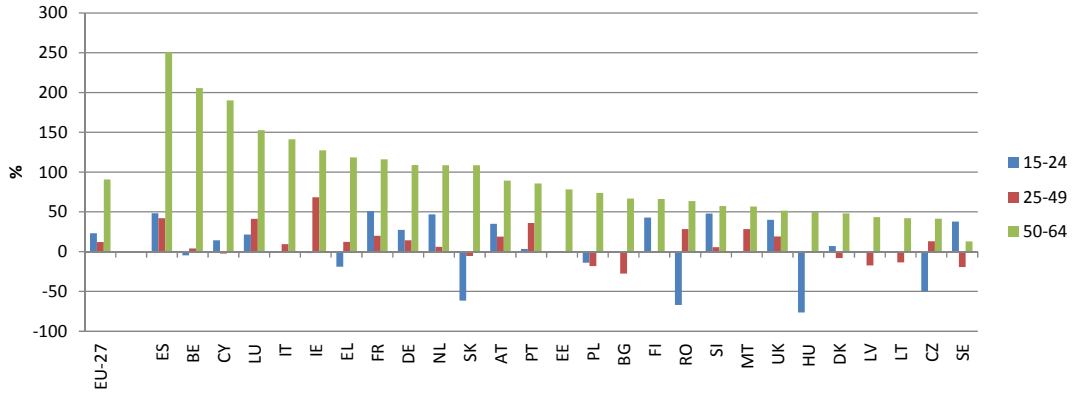
Chart 4: Employment shares in human health and social work by age group, 2000 and 2011, EU-27



Source: LFS

The sharpest increases in the share of older people working in the human health and social work sector were registered in Spain, Belgium, Cyprus and Luxembourg (over 150 %), and in Italy, Ireland, Greece, France, Germany, the Netherlands and Slovakia (over 100 %). Hungary, Romania, Slovakia and the Czech Republic recorded the biggest declines in the share of younger workers in this sector (Chart 5).

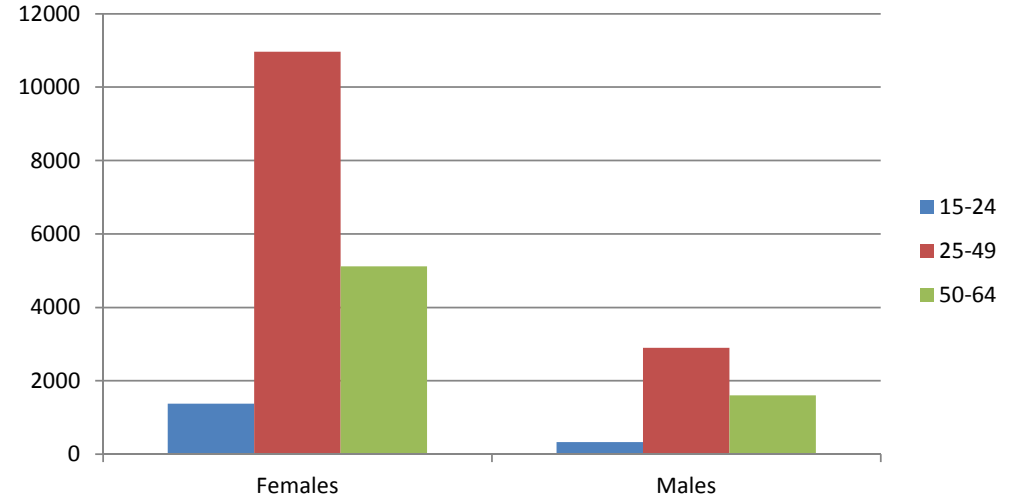
Chart 5: Change in employment rates in human health and social work by age group, 2000-2011, EU-27, in %



Source: LFS

The male workforce in the health and social services sector is generally older than the female workforce (33.2 % of male workers belong to the 50-64 age group compared to 29.3 % of female workers, while only 6.8 % of male workers in the sector belong to the 15-24 age group compared to 7.9 % of female workers).

Chart 6: Employment in human health and social work by gender and age group, 2011, EU-27



Source: LFS

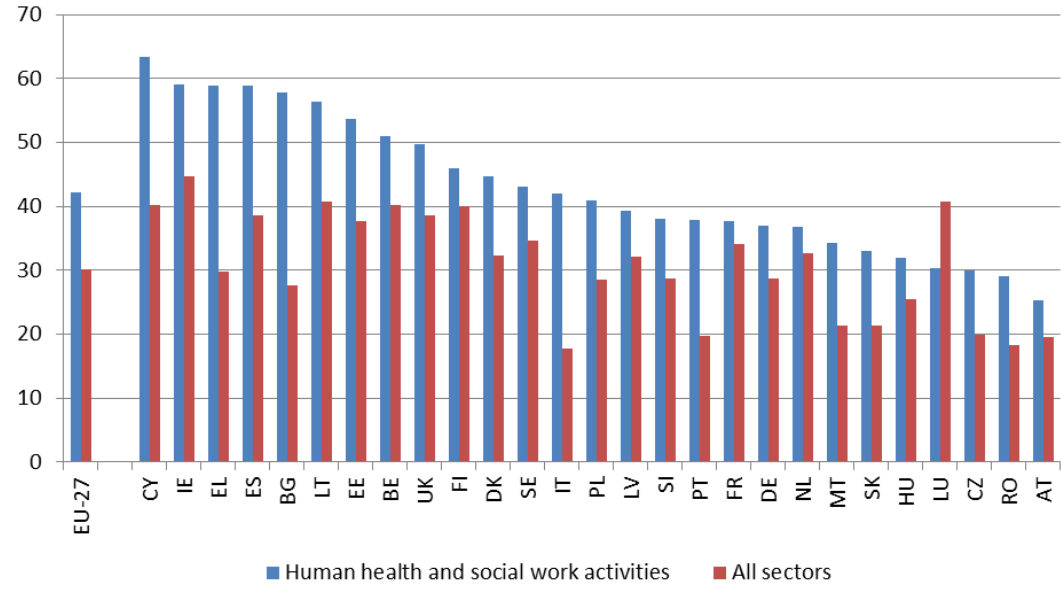
The positive side of this gender bias and ageing pattern in the health and social services sector could be that the sector is possibly used in efforts to boost the labour market participation of groups that are currently under-represented in many Member States, such as women and older workers.

Skill level

Workers in the human health and social work sector often have a medium (upper secondary and post-secondary non-tertiary) or high (tertiary) level of education. Compared to the average in the EU economy, employees in this sector are proportionally better skilled. This holds true in all Member States except Luxembourg. In 2011, at EU level, 42 % of employees in this sector held a degree in higher or tertiary education, against 30 % in the EU economy as a whole (see Chart 7).

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 and Greece (around 30 pps), followed by Italy and Cyprus (around 24 pps) and Spain and Portugal (around 19-20 pps). On the other hand, the difference is the smallest in the Netherlands and France (around 4 pps) and Austria (6 pps). It is negative in Luxembourg (-11 pps).

Chart 7: Share of high-skilled employees in human health and social work versus the whole economy, EU-27, 2011, in %

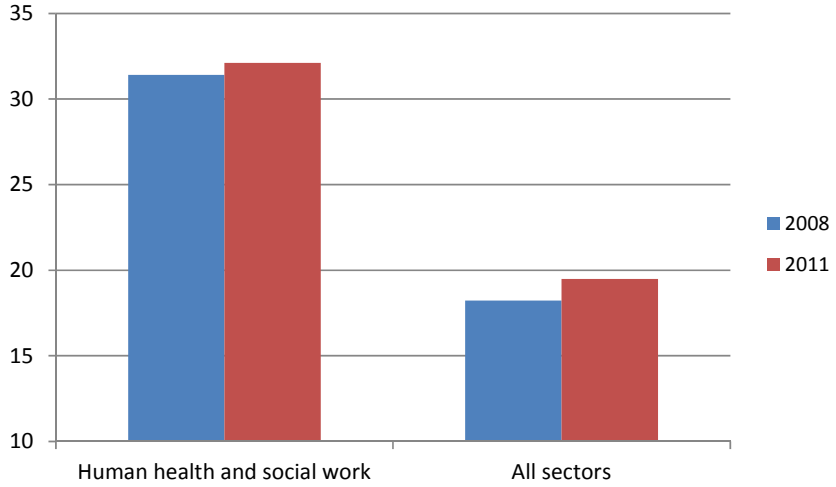


Source: LFS

Working patterns

Part-time work is a common feature in the human health and social work sector, accounting for 32 % of persons employed in it. As stated in the ESDE 2012 report, fluctuations in the number of jobs in the EU since the crisis have been driven mainly by part-time work. Part-time employment has 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 2010, and the number of full-time workers shrank by 6.2 million, the number of part-timers increased by 1.1 million. Between 2008 and 2011, while part-time work gained more ground at global level (in all sectors, its prevalence rose from 18.2 to 19.5 %), it also increased in human health and social work, from 31.4 to 32.1 % (see Chart 8).

Chart 8: Share of part-time employees in the human health and social work sector versus the whole economy, 2008 and 2011, EU-27, in %

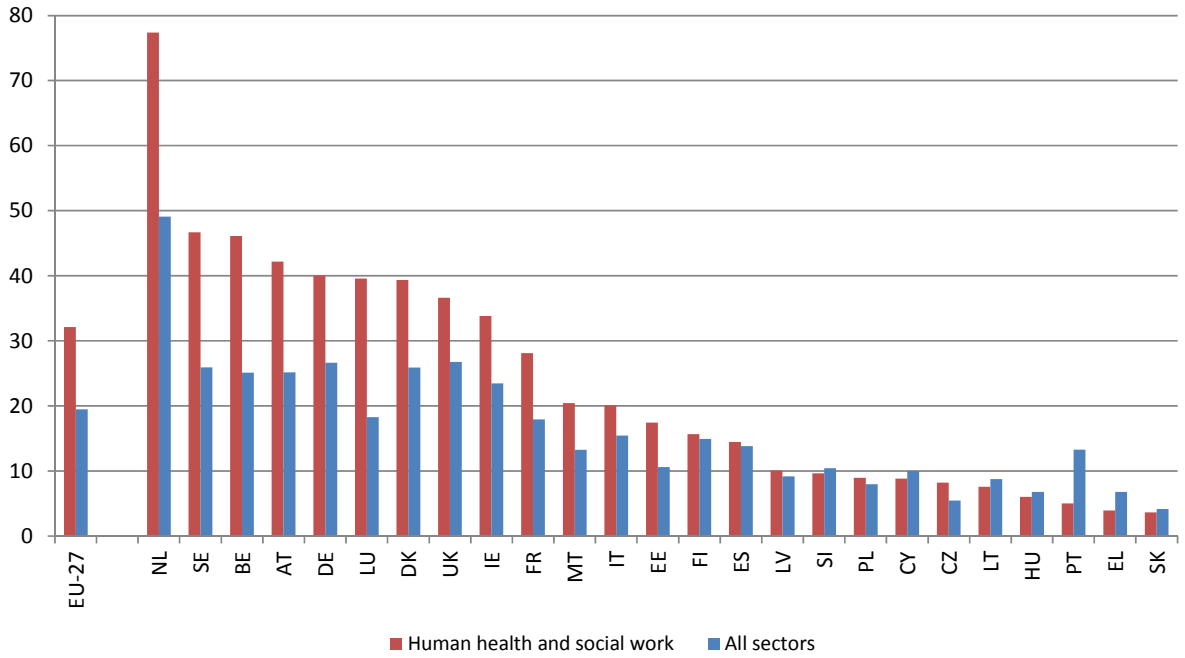


Source: LFS

As shown in Chart 9, while the Netherlands clearly dominates the ranking of Member States in terms of the percentage of part-time workers in all sectors (nearly 50 % in 2011), it does so also in the human health and social work sector, at more than 77 %. With a few exceptions (such as Portugal, Greece and Lithuania), corresponding to those countries having very low percentages of part-time workers both generally and in the human health and social work sector in particular, all other Member States showed, in 2011, 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 nearly 13 pps in 2011. The most significant gaps (more than 20 pps) were noted in the Netherlands (28 pps), Luxembourg, Belgium and Sweden.

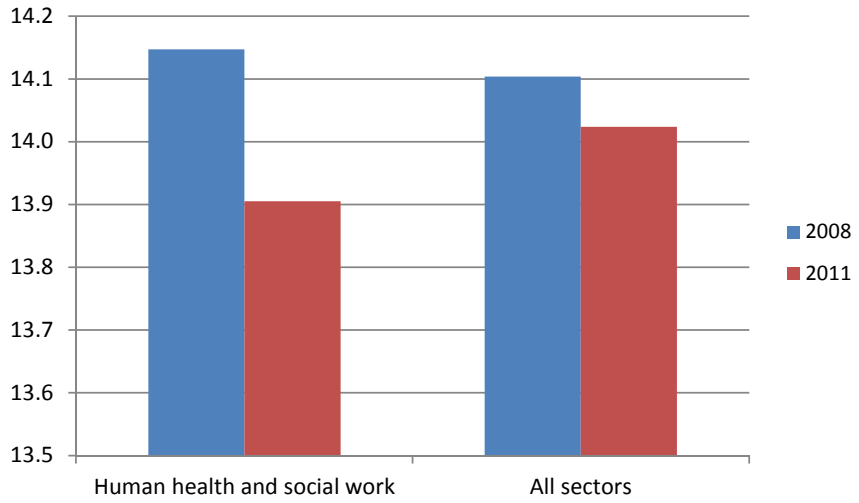
Chart 9: Share of part-time workers in the human health and social work sector versus the whole economy, 2011, in %



Source: LFS
Note: data not available for BG and 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 14 %, as can be seen from Chart 10. 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 crisis first broke out. At the level of the whole economy, the share of temporary employees in the total number of employees rose from 12.2 % in 2000 to 14.6 % in 2007, before falling to 14.1 % and 13.6 % in the following two years, when the crisis started to affect the labour market. It then rose again to 13.9-14.0 % during the timid recovery in 2010-2011. In the human health and social work sector too, the share of employees with temporary contracts fell slightly, from 14.1 to 13.9 % in the three years to 2011.

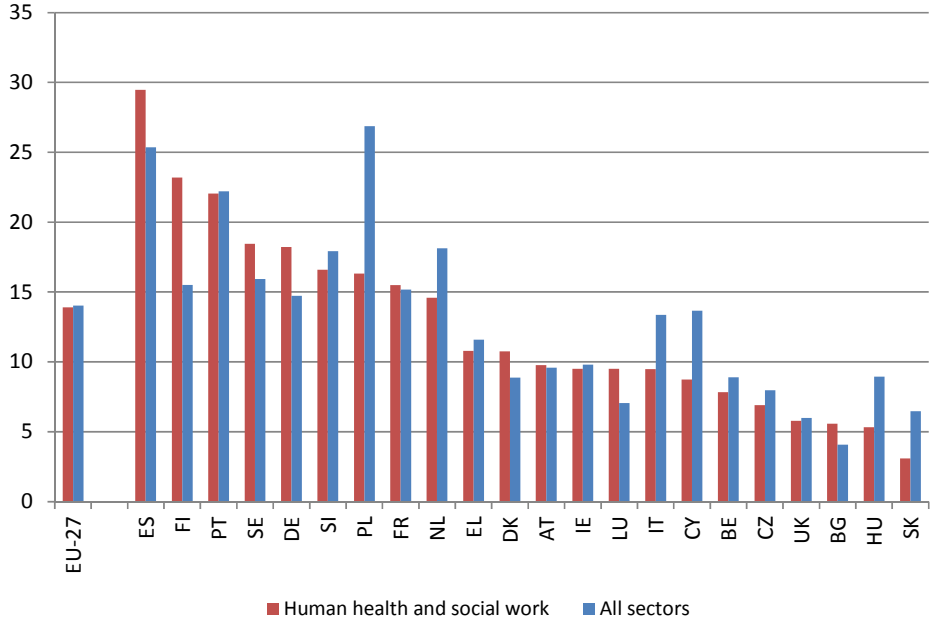
Chart 10: Share of employees aged 15-64 with temporary contracts in the human health and social work sector versus the whole economy, 2008 and 2011, EU-27, in %



Source: LFS

Chart 11 highlights the country-to-country differences in the share of employees under temporary contracts. While these percentages are rather similar in most Member States between human health and social work on the one hand, and all sectors on the other, some major disparities 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 e.g. in Finland and Spain it is significantly higher.

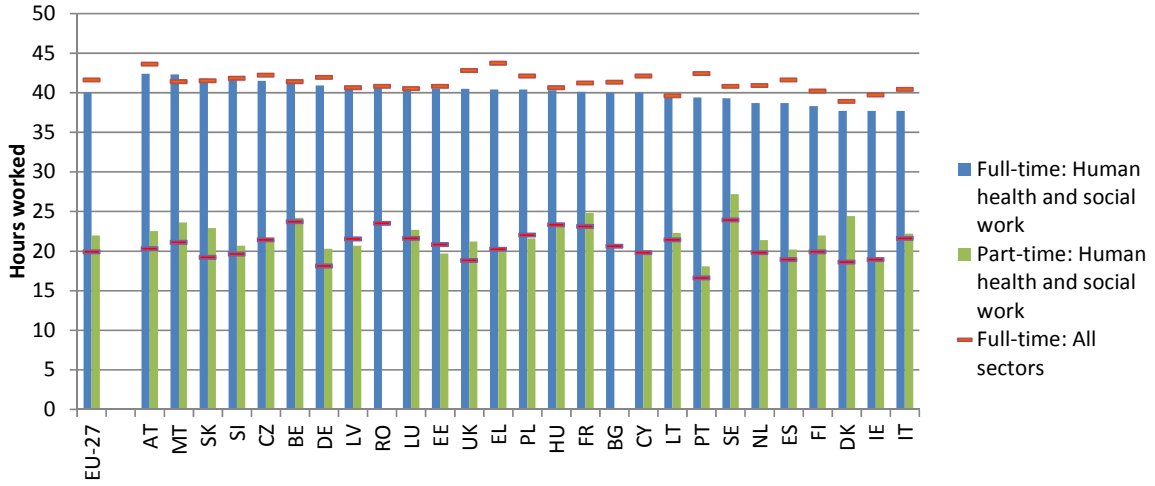
Chart 11: Share of employees with temporary contracts in all sectors and in human health and social work activities, 2011



Source: LFS
Note: data not available for EE, LV, LT, MT and RO.

As shown in Chart 12, at EU level, full-time workers in the human health and social work sector tend to work fewer hours than on average in the whole economy: in 2011, 40 hours against 41.6 hours per week. On the other hand, part-time workers tend to work more hours: 22 against 19.9 hours per week in the whole economy. This has not changed much since 2008. Full-time workers in this sector work the longest hours in Austria and Malta (more than 42 hours per week) and the shortest hours in Denmark, Ireland and Italy (less than 38 hours per week). On the other hand, part-time workers work the longest hours in Sweden, France, Denmark and Belgium (between 24 and 27 hours per week) and the shortest hours in Estonia, Ireland and Portugal (less than 20 hours per week).

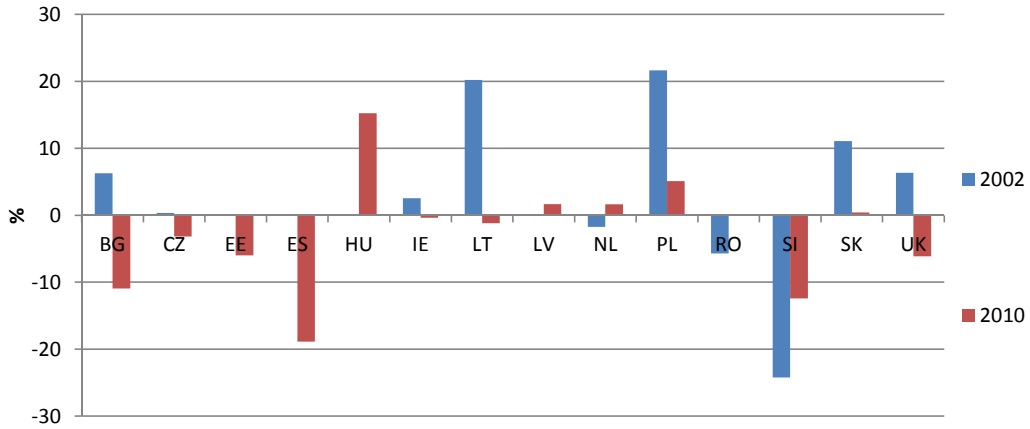
Chart 12: Average number of usual weekly hours of work for full-time and part-time workers, in the human health and social work sector compared to the whole economy, 2011



Source: LFS

Compared to the whole economy, the level of hourly earnings has improved in the human health and social work sector. Chart 13 shows that in 2002, in seven Member States out of ten for which data are available, earnings in this sector were lower than in the whole economy, i.e. there was a positive gap in hourly earnings. On the other hand, in 2010 hourly earnings in this sector were higher than in the whole economy, i.e. there was a negative pay gap, in nine Member States out of thirteen for which data are available. In 2010, the largest difference in earnings was recorded in Spain (2 euro per hour) and in Slovenia and the UK (1 euro per hour).

Chart 13: Gap in hourly earnings in the human health and social work sector compared to the whole economy, 2002 and 2010, in %



Source: Structure of earnings survey 2002 and 2010

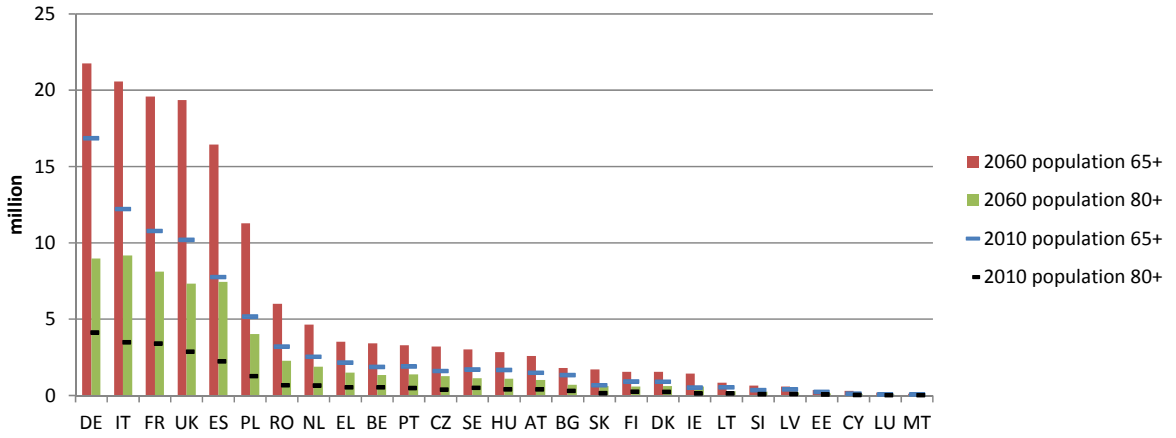
Main challenges in addressing the demand for health and social services

- Ageing of the European population is a key driver of the growing demand for social services, which can be an opportunity for creating new jobs.
- In 2010 expenditure on social protection benefits in kind nearly stagnated in the EU although the needs for social services of general interest did not.
- Maintaining an adequate supply and standard of health and social services under increasing budget constraints is a key challenge faced by policy makers.
- The economic, social and employment potential of social services of general interest is clearly underexploited in some Member States and in some the indicator of unmet needs in health care suggest that these services are not accessible to all those in need.

A growing demand for health and social services

The ageing of the European population will continue to be a key driver of the growing demand for health and social services. In the EU-27, between 2010 and 2060, the population aged 65+ is projected to increase from 87 to 153 million, while the population aged 80+ is projected to increase from 23 to 62 million. Chart 14 shows that in absolute terms the highest increases in the older population are expected in Germany, Italy, France, the UK, Spain and Poland. However, in relative terms the older population is projected to grow the most in Cyprus, Ireland, Luxembourg, Slovakia and Poland.

Chart 14: Projected population for ages 65+ and 80+ by Member State, 2010 and 2060



Source: Eurostat — Population projection 2010

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.[2] 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 is currently the case with a younger population structure.

The projections in the 2009 Joint Report by the European Commission and the Economic Policy Committee[3] show that the number of elderly people with a disability who rely on informal care is likely to nearly double in the EU-27 by 2060, increasing by more than 120 % in the Czech Republic, Ireland, Cyprus, Luxembourg, Poland, Romania and Slovakia.

While the demand for long-term care services for the elderly will increase substantially, the availability of informal carers (family, friends and other relatives) may be further limited by changing family structures, growing participation of women in the labour market and 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.

The growth in the demand for social services will also reflect other deep-rooted trends in 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), more flexible labour markets and 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 needs and the creation of new jobs.

[2] 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.*

[3] Ibid.

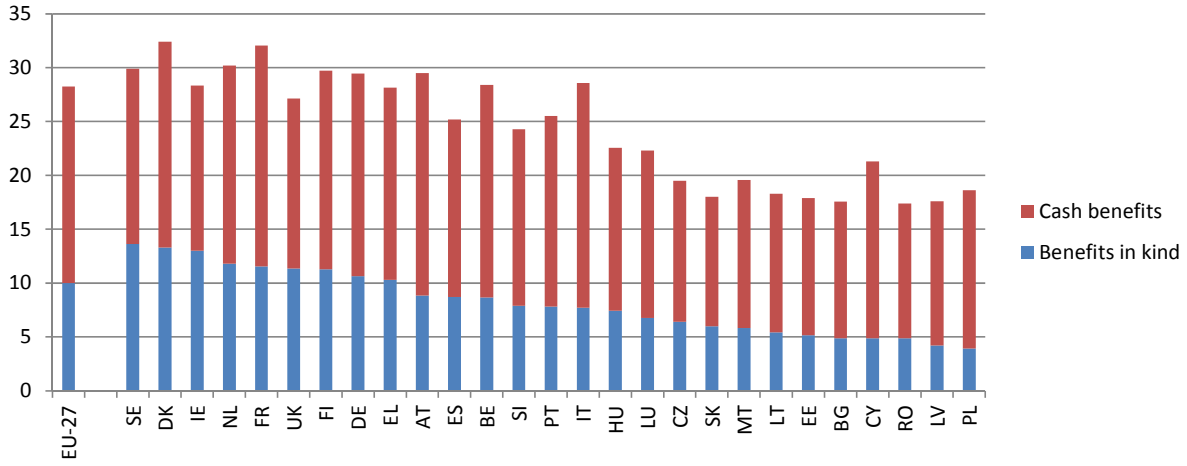
Developments in expenditure on health and social services

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 2010, social protection expenditure reached 28.2 % of GDP. Of this, 10 pps were spent on benefits in kind and 18.2 pps were spent on benefits provided in cash (Chart 15).[4] 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 Sweden, Denmark, Ireland, the Netherlands, the UK, Finland, Germany and Greece. On the other side of the spectrum were Bulgaria, Cyprus, Romania, Latvia and Poland that spent less than 5 % of GDP on social protection benefits in kind.

Chart 15: Social protection spending on cash and in-kind benefits, 2010



Source: ESSPROS

Chart 16 shows the change in real expenditure on social protection benefits in kind in two periods (2007–2009, when the average annual change is shown, and 2009–2010). At EU level, while in the first period this expenditure grew by 5.4 % yearly on average (4.5 pps of this growth were due to sickness and disability benefits), in the second period it rose by only 0.9 % (of which only 0.4 pp was due to an increase in spending on sickness and disability benefits).

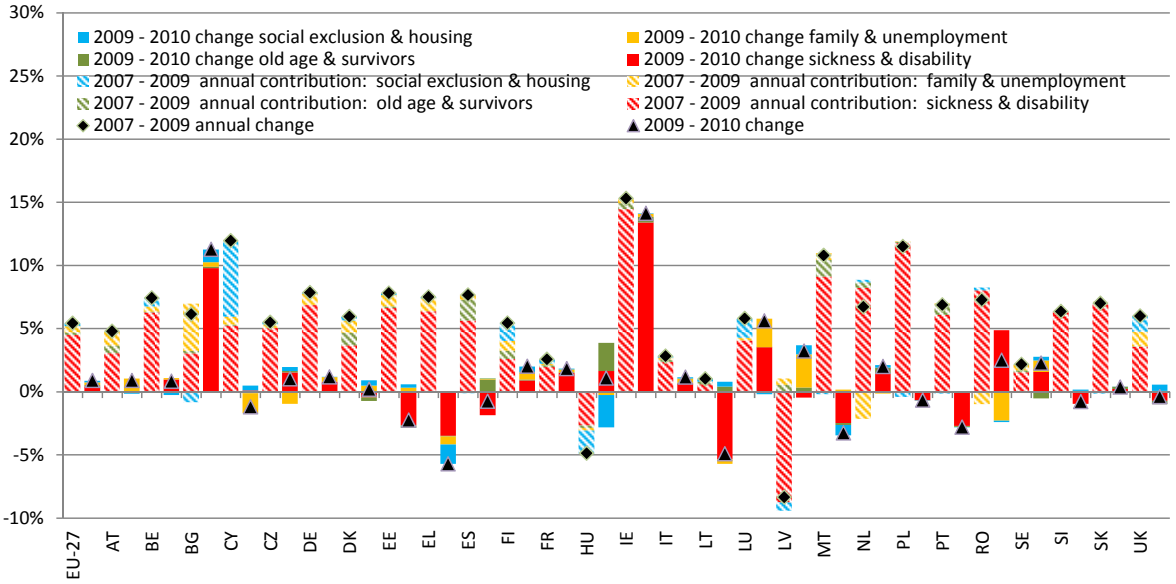
In the first period the highest average annual growth in real social protection benefits in kind was recorded in Ireland, Cyprus, Poland and Malta (10-15 %). In all of them, except for Cyprus, this increase was mainly driven by health care and sickness benefits. On the other hand, a decrease in social protection benefits in kind was recorded in Latvia (by 8 % annually) and Hungary (by 5 %). Especially in Latvia this change was mainly driven by a fall in health care and sickness benefits.

In the second period, when public budgets came under heavy pressure, real spending on social protection benefits in kind decreased in ten Member States. The largest decrease (by 2 % or more) was recorded in Greece, Lithuania, Malta, Portugal and Estonia. In all these countries, the main driver was falling health care and sickness benefits. Spending also decreased in Cyprus, Slovenia, Spain, Poland and the UK, Cyprus being the only country where the main driver was benefits other than health and sickness.

[4] For a more detailed description of social protection spending in the EU, e.g. with the dimension of spending functions, see the ESDE 2012 report.

On the other hand, in Ireland and Bulgaria spending increased significantly (by 11-14 %). These countries were followed by Luxembourg, Latvia, Romania, Sweden and Finland (a rise of 2-6 %). In all of these with the exception of Latvia the main driver was again health care and sickness benefits.

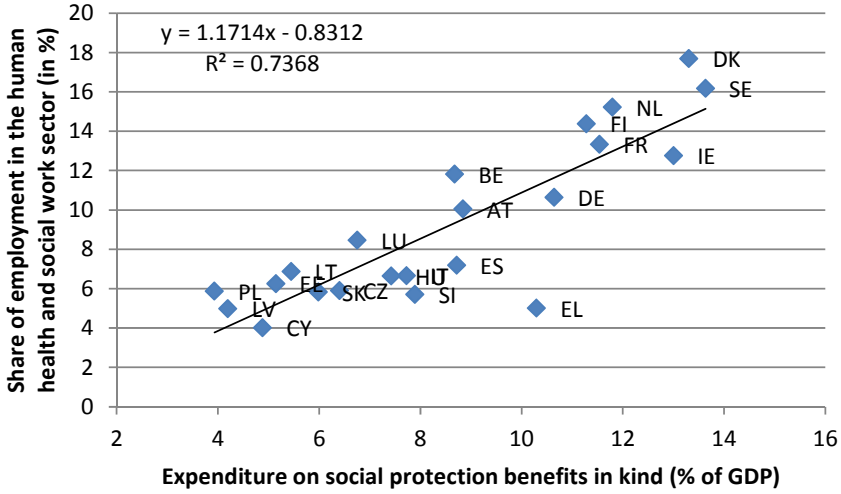
Chart 16: Change in expenditure on social protection benefits in kind, 2007–2009 average annual change and 2009–2010 change, by function (% change in national currencies in constant prices)



Source: ESSPROS

The level of expenditure on social protection benefits in kind is strongly correlated with the proportion of people employed in the human health and social work sector (see Chart 17). Thus, in Member States such as Poland, Latvia and Cyprus, where the level of spending is low (below 5 % of GDP), the employment rate in this sector is also rather low (below 6 % of total employment). On the other hand, in Member States such as Sweden, Denmark, Ireland, the Netherlands, France or Finland, a high level of expenditure on in-kind benefits (above 11 % of GDP) is linked with a high share of employment in health and social services (over 12 % of total employment).

Chart 17: Share of employment in human health and social work sector versus expenditure on social protection benefits in kind, 2010



Source: National Accounts and ESSPROS

The main explanation for the strong correlation between expenditure on social protection benefits in kind and the employment rate in the human health and social work sector appears to be the

relatively large weight of wages and salaries in spending on benefits in kind, as wages can account for up to 80 % of total expenditure in sectors such as long-term care, disability care or childcare.

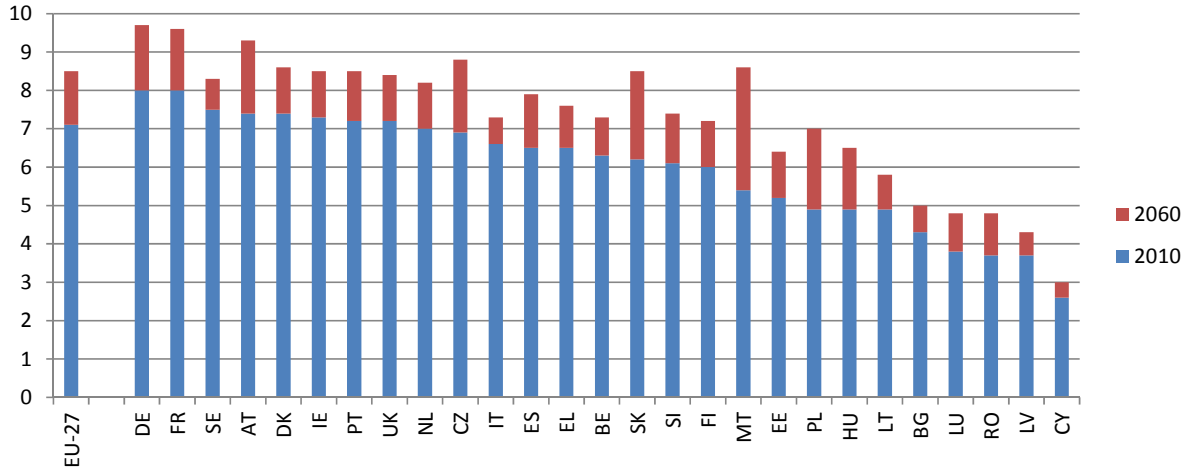
As for the effect of social protection spending on poverty,[5] while the effect of spending on cash benefits is direct, as it increases the disposable income of households, the effect of spending on benefits in kind on the at-risk-of-poverty rate tends to be indirect — as currently social protection benefits in kind are not imputed in the disposable income of households, and therefore cannot influence the measure of poverty — and is two-fold. It has a positive effect on employment from the demand side (spending on social services of general interest is linked with the number of jobs in this sector), but also from the supply side, as it enhances the labour force, from the point of view of both health and availability (health care benefits and e.g. child care or long-term care, respectively).[6]

Expected expenditure developments

The ageing of the population coupled with the ageing of the workforce and with 'elder ageing' (i.e. the rapid increase in the number of people aged 80 and over) — the 'triple ageing' effect — will have marked implications for health and social services expenditure.

If age-disease patterns remain unchanged, 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 (see Chart 18).

Chart 18: Public expenditure on health care as % of GDP, 2010-2060

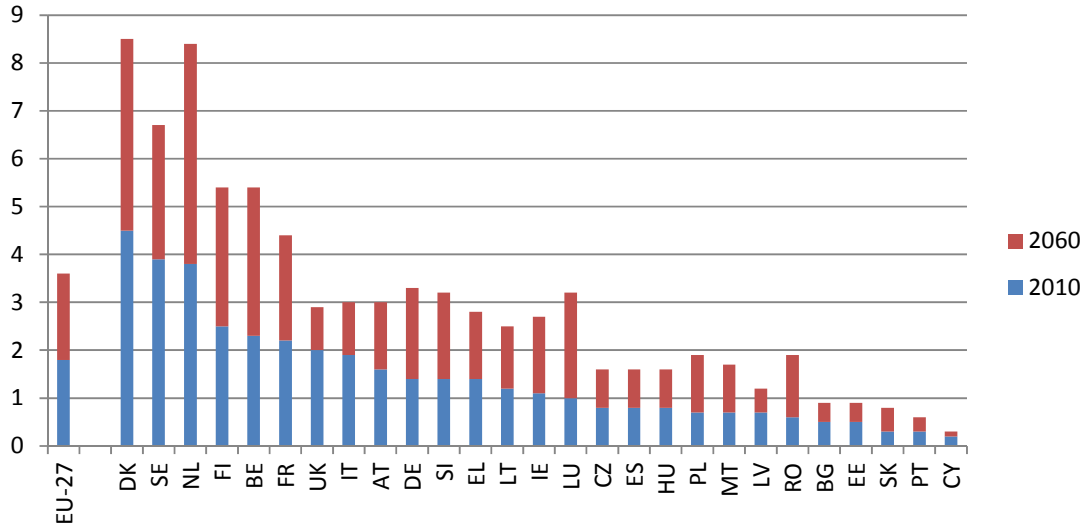


Source: 2012 EPC/EC Ageing report (EPC Ageing Working Group reference scenario)

By 2060, public expenditure on long-term care is projected to increase by 1.8 pp, i.e. a 100 % increase, from 1.8 % to 3.6 % of GDP. The increase is expected to range from less than 0.5 pps in Cyprus, Portugal, Estonia and Bulgaria to more than 4 pps in the Netherlands and Denmark and more than 2.5 pps in Belgium, Finland and Sweden (see Chart 19).

[5] In this analysis, poverty is defined as the at-risk-of-poverty rate. For an analysis of the effectiveness and efficiency of social protection spending see the ESDE 2012 report.
[6] The positive impact of benefits in kind on poverty was analysed in more depth in the Economic and Social Developments in Europe 2011 report.

Chart 19: Public expenditure on long-term care as % of GDP, 2007-2060



Source: 2012 EPC/EC Ageing report (EPC Ageing Working Group reference scenario)

This diversity in the projected changes in public expenditure on long-term care reflects the situation of formal care provision and its expected development in the Member States. In those where public expenditure on long-term care and its projected increase are low (below 1 % by 2060) — such as Cyprus, Latvia and Bulgaria — the need for long-term care services will continue to have to be met by informal carers, family, friends or relatives. By contrast in Member States where public expenditure on long-term care is above the EU-27 average and is projected to more than double by 2060 — such as in the Netherlands, Belgium, Finland or France — the elderly population will rely more on formal care providers, reflecting the changes in household composition, gender patterns and family relationships towards smaller households and greater participation of women in the labour market.

Unmet needs

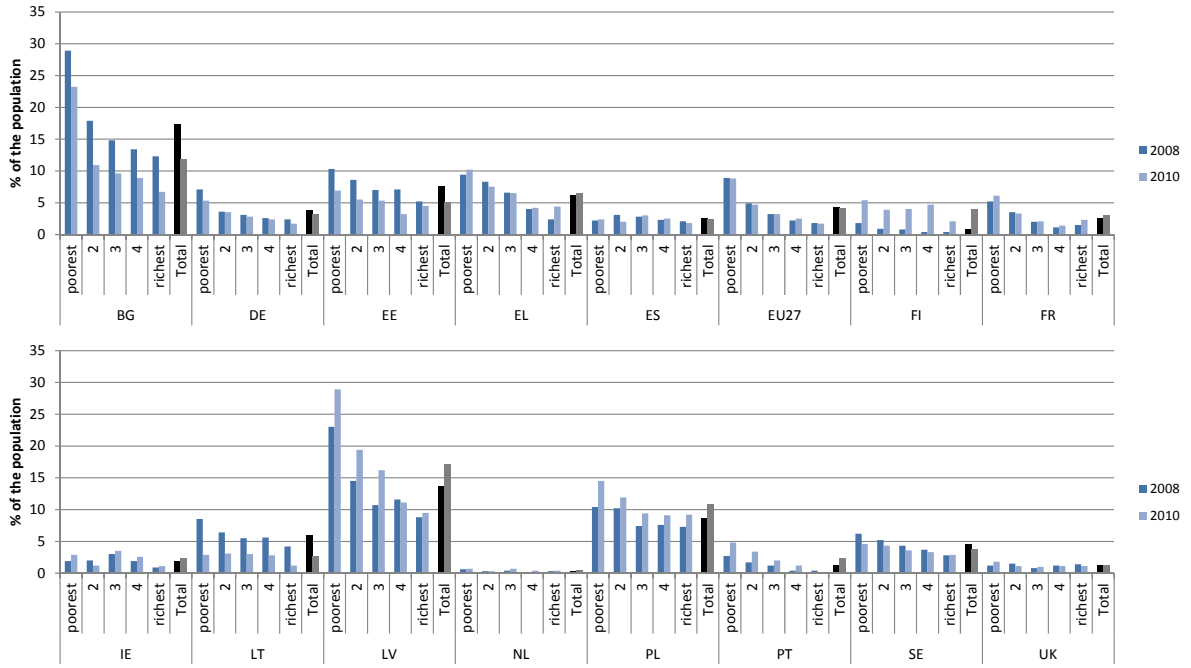
Maintaining adequate levels of spending on health and social services while containing the growth in public expenditure is a challenging task for policy makers in Member States, especially in the light of rising public expectations regarding the quality, accessibility and affordability of social services and in the context of pressure on public budgets due to the crisis.

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' is used to monitor access to health care. In the EU on average, the situation improved slightly between 2008 and 2010. The situation improved most in Bulgaria and Lithuania and deteriorated most in Finland and Latvia.

Chart 20 shows the developments for selected Member States by income quintiles. In Bulgaria, Lithuania and Estonia the situation improved significantly for the poorest quintile (often more than for the other quintiles), but in Latvia, Poland and Finland the situation of the poorest deteriorated (again mostly more than for the other quintiles).

Chart 20: Unmet need for health indicator, by income quintiles in selected Member States, 2008 and 2010



Source: EU SILC 2008 2010

Conclusion

The human health and social work sector plays a significant role in the economies and societies of the EU Member States. This sector meets essential social needs and generates employment on a large scale. Yet, at the moment, its size varies widely across the EU. Its economic, social and employment potential is clearly underdeveloped in some Member States and in many of them the access to social services, particularly health care, is limited, often more for the poorer than for the more affluent.

Yet, irrespective of the extent of its development, the human health and social work sector has come under serious pressure in all Member States as a result of the economic and public budget crisis. The contracting economy has caused both the need and the demand for services to rise and, at the same time, has significantly constrained the financing basis in public budgets.

When analysing the features of employment in the human health and social work sector compared with the rest of the economy, it appears that workers in these services are generally better skilled than in the economy as a whole. However, there is a larger share of non-standard working hours, a wide gender pay gap and difficult working conditions (such as night shifts).

Possible consequences of these trends are that it will become more difficult in the future to attract qualified employees and this, coupled with the ageing of the workforce in the sector, could lead to staff shortages or a reduction in the quality of health and social services in the future. Other challenges for the sector are the ageing of the population, as well as the changes in gender roles and household composition that will lead to an increasing demand for health and social services in the EU.

Creating more secure, better skilled and better paid jobs and fulfilling the growing demand for services in a cost-effective way will require comprehensive strategies to be developed in which EU-facilitated policy learning and transfer of best practices can play an important role. These strategies must be coordinated with sustained efforts to improve the working conditions and professional development of workers in the human health and social work sector through a broad range of measures. Such measures include the development of more efficient learning schemes for acquiring, certifying and recognising qualifications in health and social services, better career prospects and job security, on-the-job training and opportunities for learning and personal improvement, and better pay and working conditions.