EURES

EURES Report on Labour Shortages and Surpluses

2025

Analysis of health care assistants

#EURESjobs

eures.europa.eu

Contents

Executive summary 3
1. Introduction 4
2. Overview of the occupation 5
3. Demand for health care assistants 12
4. Labour migration and mobility 14
5. Skills and qualification gaps 17
6. Working conditions and occupation attractiveness 20
7. Recruitment practices and retention trends 25
8. Measures to tackle labour market imbalances 28
9. References 31

Executive summary

- This occupational fiche on health care assistants (HCAs) (International Standard Classification of Occupations 5321) accompanies the 2025 European employment services (EURES) report on labour shortages and surpluses, and synthesises evidence on the causes of labour market imbalances affecting HCAs across EURES countries.
- HCAs play a vital role in delivering personal and therapeutic care across diverse health and social care settings. However, the occupation is inconsistently defined across EU Member States, with heterogeneous job titles, unregulated roles and varying qualification levels, contributing to perceptions of invisibility in this occupation. While HCAs' roles and responsibilities are expanding, this lack of visibility complicates workforce analysis and policy development.
- Shortages of HCAs were reported by 16 countries in the 2025 EURES national coordination offices s. Changed to urvey. At the same time, demand for HCAs is rising sharply, driven by demographic ageing, increasing dependency rates and the growing prevalence of chronic conditions. The COVID-19 pandemic and climate crisis have intensified pressures on the sector, exposing structural weaknesses and increasing the complexity of care delivery.
- The HCA workforce is predominantly female, reflecting broader gendered patterns in long-term care across Europe. Alongside this, migrant workers have become increasingly essential for maintaining service provision. As the sector continues to face persistent shortages, this reliance on migrant labour has prompted several EURES countries to introduce measures aiming to attract health care workers from non-EURES countries. However, such strategies raise concerns about sustainability and the risk of 'brain drain' in sending countries, highlighting the need for more balanced and resilient workforce approaches.
- Training standards and educational requirements for HCAs vary widely across the EU, resulting in fragmented qualification frameworks and care quality. Continuous professional development is unevenly implemented, and efforts to establish a common training framework have faced resistance. There is limited availability of HCAs with the specialised competencies needed in long-term care settings, particularly in geriatric care and post-discharge support. Furthermore, digitalisation is creating demand for new skills that are not yet widely available.
- HCAs often work part-time or on temporary contracts, with irregular schedules and employment precarity. The physical and mental health risks faced by HCAs often result in musculoskeletal problems, elevated stress levels, absenteeism and burnout. Career prospects are constrained by low pay, limited advancement opportunities and gender pay gaps. Social dialogue and collective bargaining are critical in shaping working conditions for HCAs, but coverage remains uneven across countries.
- Permanent contracts are common among HCAs, but temporary and part-time positions are disproportionately more prevalent in this occupation. High turnover rates are a persistent challenge, driven by unfavourable working conditions, low remuneration and limited career progression. The COVID-19 pandemic exacerbated absenteeism, demand for overtime work and psychological stress, particularly in under-resourced environments.
- Some EURES countries have introduced measures to improve job quality and retention, including wage increases, expanded educational opportunities and initiatives to support work–life balance and improve occupational health and safety. Efforts to recruit foreign-born workers have intensified, with targeted training and integration programmes designed to address workforce shortages. Additionally, some countries have implemented campaigns to facilitate the validation of prior experience. Examples of retention strategies focus on improving job quality, career prospects and working conditions.

1. Introduction

This occupational fiche provides an overview of the labour market imbalances affecting health care assistants (HCAs) in European employment services (EURES) countries, focusing on the determinants and drivers of these imbalances. It accompanies the 2025 EURES report on labour shortages and surpluses, which includes a dedicated analysis of the health and care sector. The fiche covers HCAs as defined under International Standard Classification of Occupations 5321.

An overview of the occupation's employment size and demographic characteristics is provided in Chapter 2. The drivers of labour market imbalances in this occupation were analysed in relation to the following topics:

- demand for health care assistants (Chapter 3),
- labour migration and mobility (Chapter 4),
- skills and qualification gaps (Chapter 5),
- working conditions and occupation attractiveness (Chapter 6),
- recruitment practices and retention trends (Chapter 7),
- measures to tackle labour market imbalances (Chapter 8).

This occupational fiche draws on a comprehensive review of the peer-reviewed and grey literature published between 2019 and 2025 across the 31 EURES countries, alongside secondary descriptive data and microdata or special data extractions. Each chapter presents EURES-level findings and, wherever possible, highlights sectoral and country-specific differences.

This fiche also includes key points from a stakeholder focus group. This focus group brought together seven participants, each representing a key stakeholder group of the HCA occupation. The stakeholders included two social partners, four health and care providers and professionals and one representative from an education, training and research institution. Insights from this focus group are presented in boxes throughout the fiche. Given the limited scope of this exercise, the consultation insights presented reflect the comments made during this specific focus group and should not be interpreted as representing the views of all stakeholders relevant to this occupation.

2. Overview of the occupation

Occupation definition and scope

HCAs play a vital role in delivering personal and therapeutic care across a range of health and social care settings. The scope of their activity encompasses five principal health and care settings, namely:

- hospital care, where HCAs assist patients in acute and rehabilitative wards by supporting hygiene, mobility, feeding and monitoring, in line with treatment plans developed by clinical staff;
- primary care, where HCAs contribute to community-based services by aiding in managing chronic diseases, facilitating communication and supporting therapeutic routines;
- residential long-term care (LTC), where HCAs provide essential assistance to individuals with disabilities or age-related conditions, including aid with dressing, feeding and mobility, while maintaining hygiene standards and reporting changes in health status;
- home care, where HCAs deliver domiciliary support, often performing tasks such as lifting and positioning, administering oral medication or non-pharmacological pain relief, and observing and reporting patient behaviour and condition changes.

However, the occupation remains inconsistently defined across EU Member States, complicating workforce analysis and policy development (Basys GmbH, 2021) . Despite their widespread presence across different health and care settings, HCAs are often absent from policy discourse. This invisibility is reinforced by the use of heterogeneous job titles, unregulated roles and varying qualification levels (European Commission: Consumers, Health, Agriculture and Food Executive Agency et al., 2018; Kroezen et al., 2018).

This lack of visibility is particularly concerning given the growing reliance on HCAs across EU health systems. Demographic ageing, combined with persistent nursing shortages and the ageing of healthcare personnel, has led to a progressive shift in responsibilities, with HCAs increasingly performing tasks traditionally carried out by nurses (European Commission: Consumers, Health, Agriculture and Food Executive Agency et al., 2018). Their employment is often driven by cost-efficiency considerations, as HCAs typically possess lower formal qualifications and command lower salaries (EPSU, 2024). Additionally, the rising emphasis on patient self-management and the empowerment of informal carers is expected to further expand their role within care delivery frameworks (European Commission: Consumers, Health, Agriculture and Food Executive Agency et al., 2018).

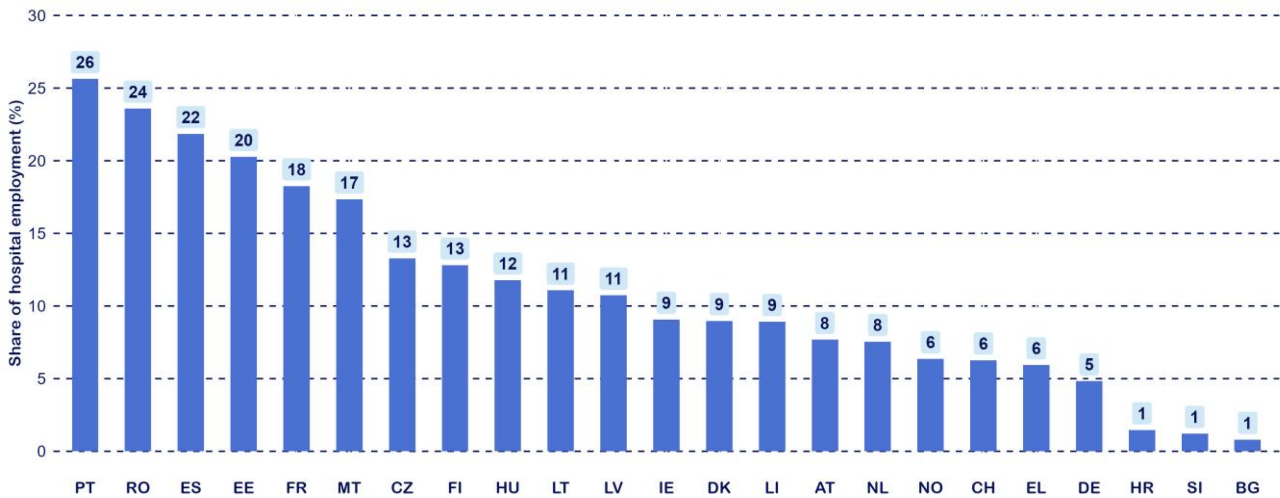
Box 1: Stakeholder consultation: ambiguity in role definition

Some of the stakeholders consulted in the focus group discussed the definition of HCAs, noting some ambiguity and overlap with related roles, such as personal care assistants and informal carers. They expressed that boundaries between these roles are becoming less clear in practice. In their view, the lack of a clear and consistent definition, together with the overlap with other roles, undermines the visibility, status and recognition of HCAs and the development of appropriate training and support frameworks.

Size of the occupation as an employment category

As shown in Figure 1, the proportion of HCAs within hospital employment varies significantly across EURES countries. In Portugal, Romania, Spain, Estonia and France, HCAs constitute a substantial share of the hospital workforce, ranging from 26 % to 18 %. By contrast, Croatia, Slovenia and Bulgaria report a notably lower presence, with HCAs accounting for only 1 % of hospital employment.

Figure 1: Share of HCAs in hospital employment, EURES, 2024



NB: Only for countries with available data.

Source: Eurostat dataset (hlth_rs_prshp2) (15 July 2025).

The LTC workforce, which includes HCAs, constitutes a substantial segment of the European labour market, although its size and composition vary significantly across EURES countries. On average, LTC workers represent 3.2 % of the EU workforce, amounting to approximately 6.3 million people, with national shares ranging from just 0.3 % in Greece to 7.0 % in Sweden (Barslund et al., 2021). Personal care workers (including HCAs, nursing aides and care assistants) make up 78 % of LTC staff in Organisation for Economic Co-operation and Development (OECD) countries, while nurses account for the remaining 22 % (OECD, 2023). These workers are predominantly employed in residential care settings, although a growing proportion work in domiciliary care, reflecting a shift towards home-based ageing and cost containment. HCAs also make up a large proportion of the workforce in social care settings, where they are often referred to as 'care aides' (EPSU, 2024).

The HCA workforce is expected to continue expanding as EURES countries implement reforms to broaden LTC coverage. In Germany, the formal recognition of psychological and mental health conditions led to a 20 % increase in LTC recipients, while Slovenia's introduction of compulsory LTC insurance is anticipated to raise demand for formal care services (Hougaard Jensen et al., 2025). These developments are particularly impactful in residential and domiciliary settings, where HCAs are increasingly relied on to support or substitute for nurses, especially in cost-sensitive environments (European Commission: Consumers, Health, Agriculture and Food Executive Agency et al., 2018).

Countries reporting labour shortages and surpluses

HCAs are consistently identified as a shortage occupation across EURES countries. National coordination office data (Table 1) show that labour shortages were reported in 18 countries, while labour surpluses were noted in 4 countries. The fact that Finland and Sweden appear in both categories highlights the presence of internal disparities, probably driven by regional differences.

Table 1: Countries reporting labour market imbalances for HCAs, 2025

	Countries
Labour shortage	16 countries (Austria, Belgium, Bulgaria, Cyprus, Estonia, Germany, Greece, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Poland, Romania, Slovenia)
Labour surplus	2 countries (Latvia, Portugal)
Both labour shortage and surplus (regional differences)	2 countries (Finland, Sweden)

NB: NCOs from Iceland, Liechtenstein and Switzerland have not provided data on imbalances.

Source: Data submitted by EURES national coordination offices.

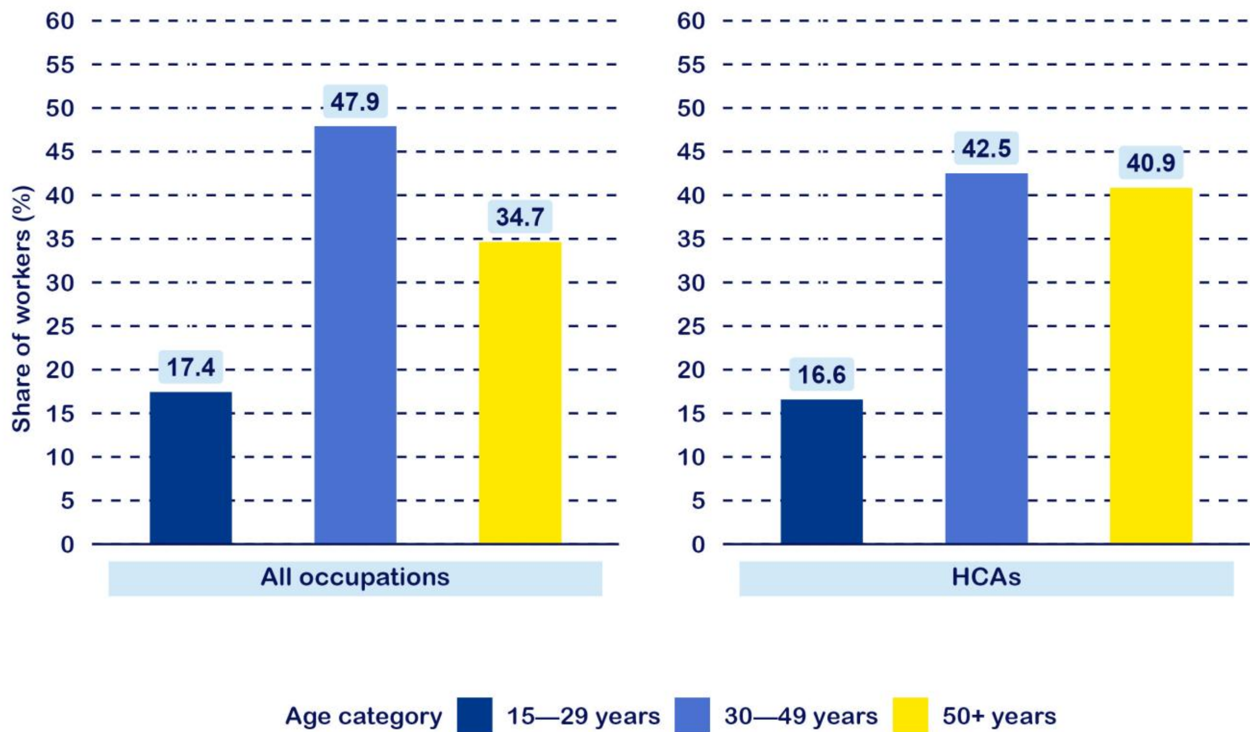
The widespread shortage of HCAs has direct implications for service delivery, contributing to a growing gap between care needs and available support across EURES countries (Hougaard Jensen et al., 2025). Depending on the country, between 23 % and 42 % of individuals with limitations in activities of daily living report unmet care needs (Hougaard Jensen et al., 2025). This gap reflects not only staffing shortages but also unmet needs due to affordability or accessibility for users. Shortages are particularly pronounced in residential care settings, where demand for qualified personnel continues to rise (Barslund et al., 2021).

Looking ahead, the World Health Organization (WHO) Regional Office for Europe projects a shortfall of nearly 950 000 health workers by 2030, with HCAs forming a significant part of this deficit (WHO Regional Office for Europe, 2025). The shortfall is expected to be most severe in rural and underserved areas, where recruitment and retention are particularly challenging. This projection underscores the urgency of implementing strategic measures focused on equitable workforce distribution, improved retention and ethical migration management.

Occupation’s demographics

The HCA workforce is characterised by an ageing profile, with older workers over-represented compared with the general labour market. Figure 2 shows that there is a larger proportion of workers aged 50 and over and a smaller proportion of workers aged 30–49 among HCAs than on average for all occupations across economic sectors.

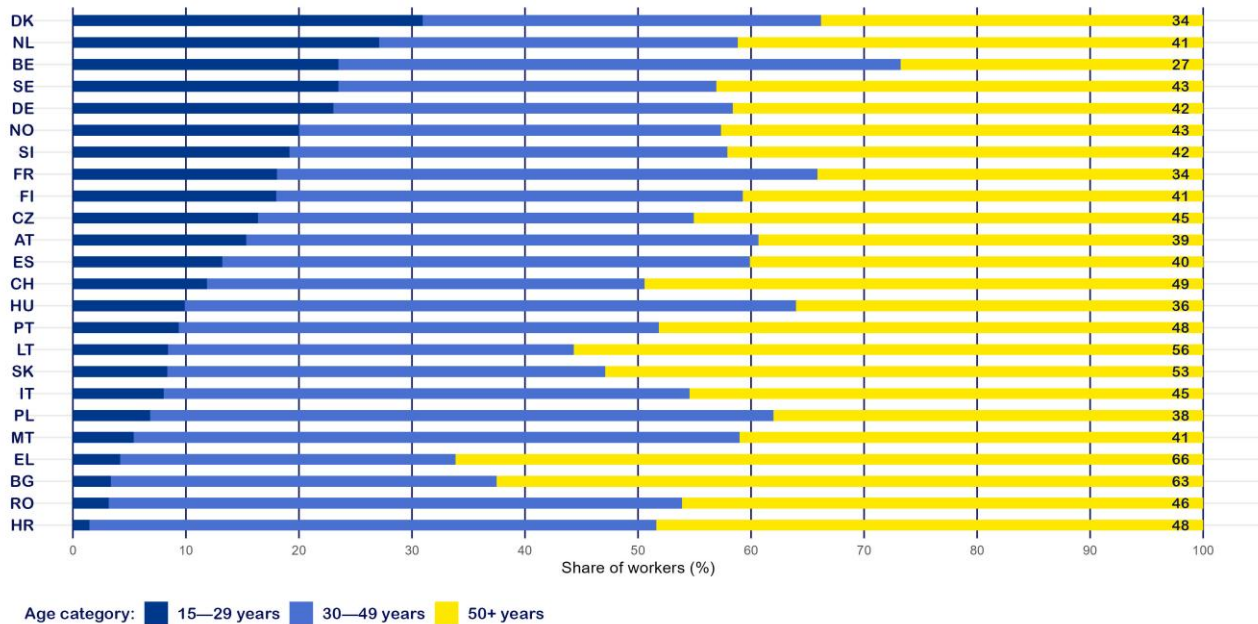
Figure 2: HCAs by age category, EURES, 2024



Source: EU Labour Force Survey special data extraction.

Related to this trend, Figure 3 shows notable variation in the age distribution of HCAs across EURES countries. In Belgium, 27 % of HCAs are aged 50 or above, while in Greece this share rises to 66 %; countries like the Netherlands and Sweden show a more balanced age distribution. Similarly, the European Foundation for the Improvement of Living and Working Conditions (Eurofound) reports that 38 % of LTC workers are aged 50 or above, compared with 33 % in the overall workforce, while the proportion of workers aged 25–49 is lower than the EU average (55 % compared to 59 % in the overall workforce) (Eurofound, 2020; Barslund et al., 2021).

Figure 3: HCAs by age category and country, EURES, 2024

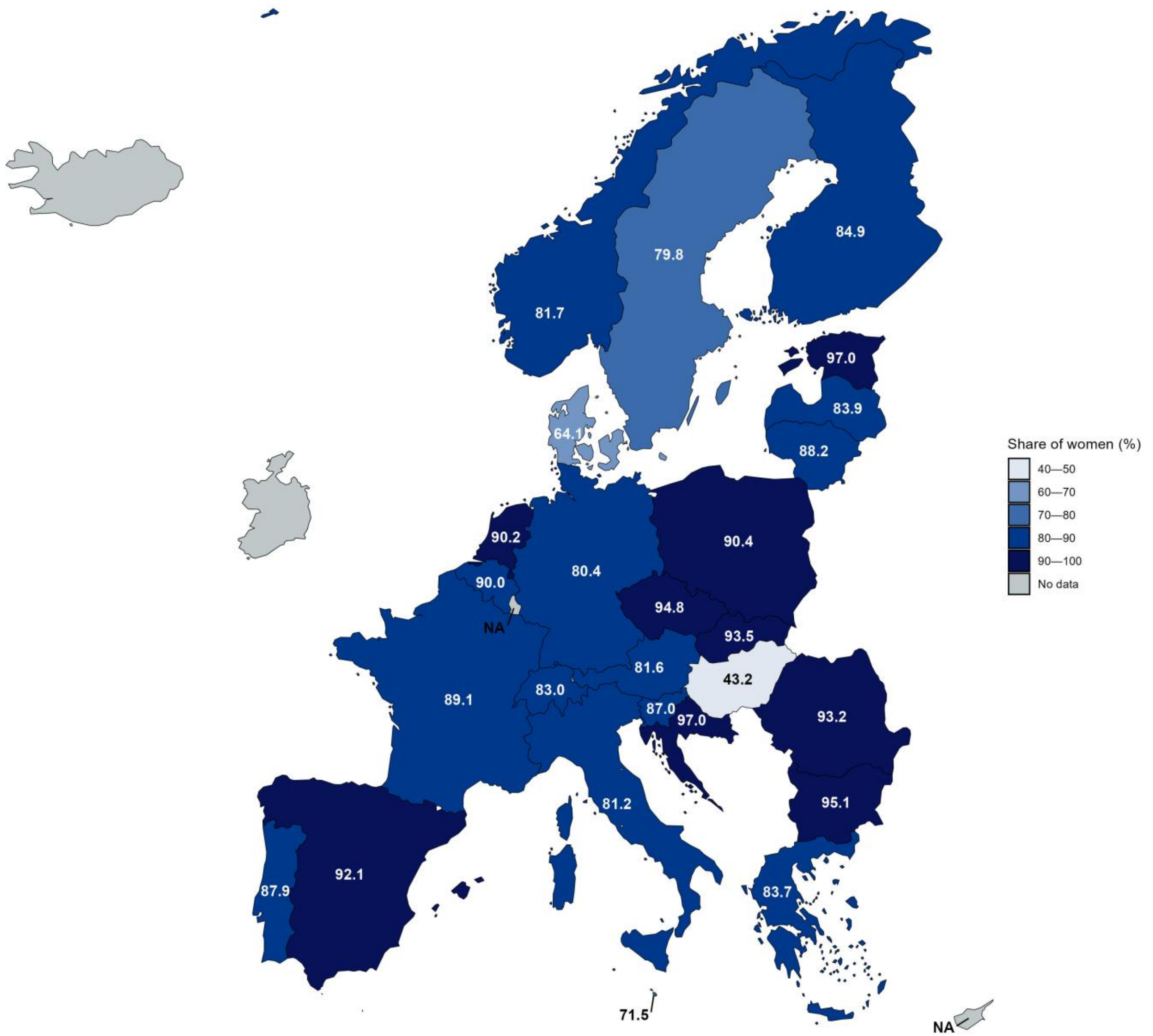


NB: Only for countries with available data.

Source: EU Labour Force Survey special data extraction.

The HCA workforce is also largely female, reflecting broader gendered patterns in LTC occupations across Europe. Figure 4 shows that women account for 90–100 % of the HCA workforce in 9 EURES countries, while in 13 others the share is lower but still substantial (80–90 %). This pattern is corroborated by other sources: women comprise nearly 88 % of personal care workers in OECD countries (OECD, 2023). The feminisation of the sector is even more pronounced among formal care workers, with estimates suggesting that close to 90 % are women (European Parliamentary Research Service, 2022; Caritas Europa, 2023).

Figure 4: Share of women among HCAs by country, EURES, 2024



NB: Legend excludes share range between 51 and 59 % because no country values fell inside this range.

Source: EU Labour Force Survey special data extraction.

Box 2: Stakeholder consultation: gender, migration and workforce diversity regarding HCAs

In the focus group, some of the stakeholders discussed the fact that the workforce of HCAs remains predominantly composed of women. In their view, society often frames care work as an extension of traditionally female roles, which, some believe, contributes to the sector's lower status and pay than those of other health professions. One stakeholder noted that this gendered perception may also affect the professional recognition and career advancement opportunities available to HCAs. They emphasised the importance of addressing these structural and cultural factors to enhance both the attractiveness and equity of the profession.

Some stakeholders pointed to targeted initiatives aiming to diversify the workforce and improve gender balance. For example, one stakeholder referred to Norway's men in health programme (Skills for Care, 2023), which actively recruits unemployed men into the care sector, provides them with training and certification, and places them in work placements. Such initiatives were seen by some stakeholders as promising steps towards challenging gender stereotypes, increasing diversity and potentially raising the status of the profession.

The discussion also addressed the intersection of gender with other workforce trends. Some stakeholders noted that there is a growing share of migrant workers, especially in home care and informal care settings; these workers often face additional challenges, such as language barriers and a lack of recognition of their qualifications. In the stakeholders' opinion, these factors can compound issues of professional invisibility and vulnerability within the workforce.

3. Demand for health care assistants

Impact of demographic trends

Demographic ageing is a key factor influencing the demand for HCAs across EURES countries. The increasing number of elderly individuals, coupled with rising dependency rates, is driving demand for LTC services (Basys GmbH, 2021) . Ageing populations require specialised support for chronic conditions such as dementia and chronic obstructive pulmonary disease, thereby intensifying the need for HCAs, particularly in residential and domiciliary care settings, where they play a central role in delivering daily and supportive care.

The OECD projects that, by 2033, demand for LTC workers will increase by 22 % due to population ageing alone, rising to 32 % when factoring in higher incomes and stagnant productivity in the sector (OECD, 2023). This implies a growing need for carers and support personnel to meet the expanding care requirements of older populations (Barslund et al., 2021)

The ageing of the general population is accompanied by a sharp rise in the old-age dependency ratio, projected to increase from 31.4 in 2019 to 52 by 2050 (Caritas Europa, 2023). This trend is particularly pronounced in countries such as Greece, Spain, Italy and Portugal, where the ratio is expected to exceed 60 by mid century.

Furthermore, by 2040, over 8 % of people aged 60 and over are projected to have dementia in most Member States, placing considerable pressure on LTC systems and HCAs in turn (Hougaard Jensen et al., 2025). Without adequate planning, the growing care needs of ageing populations risk outpacing the capacity of existing LTC infrastructure.

Box 3: Stakeholder consultation: demand and role expansion

According to some of the stakeholders consulted, the demand for HCAs has notably increased in recent years. In their view, this trend is primarily driven by the ageing population and the rising prevalence of chronic conditions. Stakeholders observed that these demographic changes are resulting in more complex care needs, particularly among older adults who suffer from dementia care or chronic disease. As a consequence, there is a growing requirement for a larger and more skilled workforce of HCAs.

Some stakeholders also emphasised that the role of HCAs is expanding beyond traditional medical tasks to include preventive care, social support and the promotion of independence among care recipients. While these trends are not entirely new, many stakeholders perceive that they have intensified in recent years.

Impact of seasonal peaks and health system pressure

The COVID-19 pandemic placed unprecedented pressure on LTC systems across EURES countries, with particularly acute effects on HCAs working in residential and domiciliary care settings (OECD, 2023). In response to the crisis, several countries implemented emergency measures to reinforce LTC capacity. Spain deployed rapid response teams to support institutions; Germany increased public spending to finance higher minimum wages, distribute personal protective equipment and provide bonuses to LTC workers; and France introduced financial support to cover additional institutional costs and reward staff efforts (OECD, 2023).

Despite these interventions, the pandemic exacerbated long-standing structural weaknesses in the LTC sector. Staff shortages intensified, as workers were required to isolate due to suspected or confirmed infections, and informal care provision was severely restricted (Barslund et al., 2021). Deteriorating working conditions and increased rates of dropout or early retirement were widely reported, further destabilising the sector. According to Caritas Europa (2023), the crisis exposed the fragility of LTC systems shaped by years of underfunding, austerity and privatisation, with some for-profit care facilities experiencing severe staff shortages.

The role of HCAs also changed notably in primary care settings during the pandemic. In several countries, HCAs assumed expanded responsibilities as part of broader efforts to reach vulnerable patients more proactively (Groenewegen et al., 2022). For example, in Germany, procedural adaptations allowed sick notes to be requested by telephone, with HCAs preparing the necessary documentation for general practitioner approval. These developments reflect a growing reliance on HCAs in both institutional and community-based care during periods of heightened system pressure.

Box 4: Impact of COVID-19 on HCAs

According to some of the stakeholders consulted, the COVID-19 pandemic had a significant impact on the role, responsibilities and public perception of HCAs. In their view, the pandemic made the work of HCAs more visible to both society and families. One stakeholder noted that social contact for older people was often limited to interactions with carers due to isolation measures. However, many of the stakeholders agreed that this increased visibility did not lead to lasting improvements in working conditions, wages or recognition for HCAs. The stakeholders reflected that, while there was a temporary shift in responsibilities and some improvements, such as a reduction in administrative burdens and a greater focus on direct care, these changes largely reverted to pre-pandemic norms once the crisis subsided.

Expected impact of climate crisis

Climate change is expected to exert pressure on the health workforce across the European region, as escalating climate-related health threats, such as heatwaves, floods and emerging disease patterns, intensify both the demand for care and the complexity of service delivery (WHO, 2025). The Pan-European Commission on Climate and Health, launched by the WHO Regional Office for Europe, warns that these impacts will disproportionately affect vulnerable populations, thereby increasing the burden on health systems and staff already operating under strain. Moreover, the health sector itself contributes approximately 5 % of global emissions, prompting calls for climate-resilient infrastructure and sustainable practices, which will also require workforce training and transformation.

The intersection of climate change, ageing and LTC is becoming increasingly relevant, particularly as older adults, especially those with pre-existing health conditions, are more vulnerable to extreme weather events. These risks are further compounded for women, who experience higher morbidity and are more likely to live alone in old age, making them particularly susceptible to climate-related health challenges and the effects of adverse environmental events (Kalavrezou et al., 2025).

Equipping the healthcare workforce with 'green skills' is increasingly recognised as an important component in enabling health systems to respond to climate-related challenges (Schmidt et al., 2025). These skills may support efforts to (1) address the health risks and unequal impacts of climate change, (2) adapt practices to reduce emissions within health systems and (3) improve the communication of climate-related risks to the public. In the context of ongoing workforce shortages and growing societal support for environmentally sustainable healthcare, education and training initiatives that incorporate awareness of low-carbon and climate-resilient practices are gaining relevance.

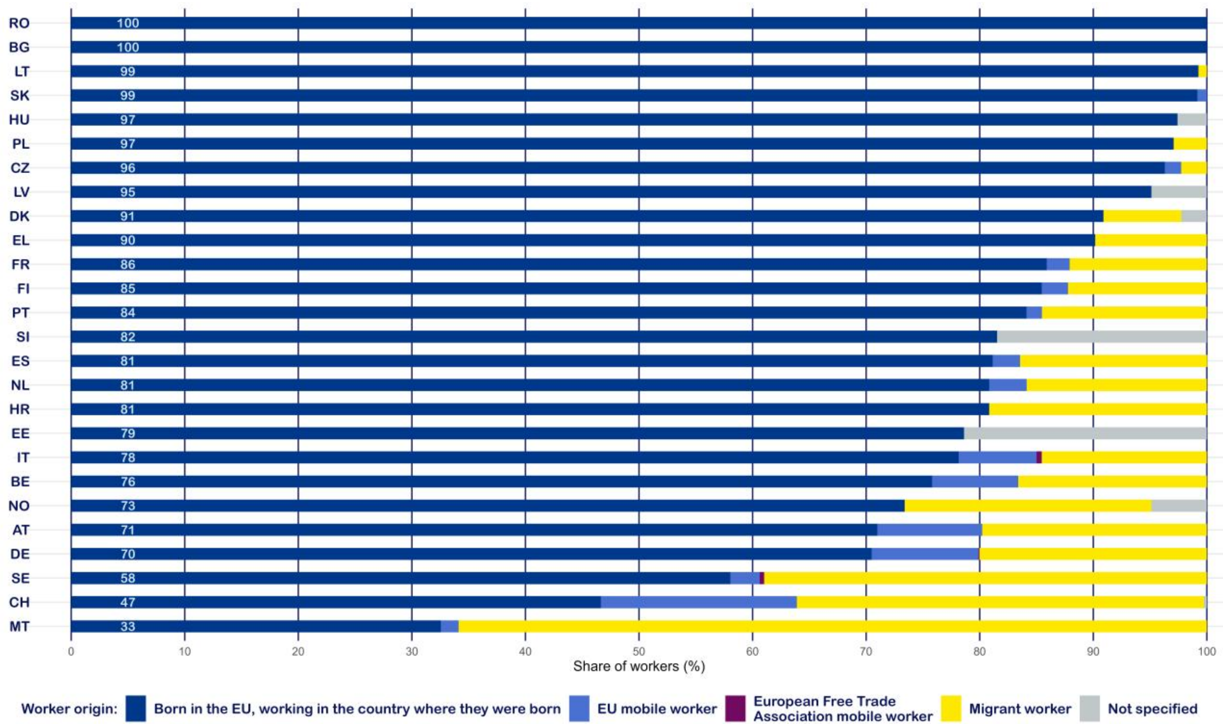
4. Labour migration and mobility

Patterns in intra-EU migration and migration from non-EURES countries

Migrant workers play a pivotal role in the HCA workforce across Europe. Figure 5 shows the diversity of HCAs by country of origin, revealing variations between EURES countries. In Romania and Bulgaria, all HCAs are native-born and employed domestically, whereas countries such as Malta, Switzerland and Sweden report significantly higher shares of migrant and mobile EU workers. In Malta, for example, only 33 % of HCAs are native-born, with the rest predominantly comprising migrant workers.

The presence of migrant HCAs is particularly notable in live-in domiciliary care roles, which are often informal and less regulated. In Switzerland, Luxembourg and Sweden, approximately 40 % of personal care workers are foreign-born, considerably above the OECD average of 26 % (OECD, 2023). Live-in care arrangements, common in Germany, Greece, Spain, Italy, Cyprus, Malta and Austria, are frequently staffed by mobile EU citizens and third-country nationals (non-EURES). In Germany, over 10 % of LTC recipients employ live-in carers, most of whom are women from Poland (Barslund et al., 2021).

Figure 5: Country of origin of HCAs, EURES, 2024



NB: Only for countries with available data.

Source: EU Labour Force Survey special data extraction.

Personal care workers in health services, including HCAs, are among the most internationally mobile occupational groups in the health and care sector, with 20 % of workers being foreign-born (Lehwess-Litzmann, 2022). Migration patterns have changed from a one-directional south-to-north flow into a complex web of long-term relocation, short-term contracts, circular migration and even daily cross-border commuting (WHO Regional Office for Europe, 2025). These dynamics complicate national workforce planning and retention strategies, particularly in countries experiencing large-scale outflows.

Several Member States, such as Denmark and Germany, have introduced targeted measures to attract health care workers from non-EU countries to address LTC workforce shortages (Hougaard Jensen et al., 2025). These measures include streamlined residence and work permits, alongside training and integration programmes. While such policies aim to alleviate domestic shortages, they raise concerns about the sustainability of relying on foreign labour due to the risk of depleting and 'brain draining' the health workforce in sending countries. This poses serious challenges for countries already facing demographic pressures and limited resources (WHO Regional Office for Europe, 2025).

Eastern Member States, most notably Poland and Romania, have experienced significant outflows of care workers to other Member States, a phenomenon often referred to as 'care drain' (Barslund et al., 2021). Romania alone accounts for 48 % of all mobile personal care workers in the EU, with similarly high rates observed for Lithuania and Poland (Basys GmbH, 2021). This migration trend exacerbates staffing shortages in sending countries and undermines their ability to maintain adequate LTC provision. Moreover, it has social consequences for the families and communities left behind, including disruptions to informal care networks and increased emotional and financial strain (Caritas Europa, 2023).

Box 5: Stakeholder consultation: migration patterns and barriers for HCAs

In the view of various stakeholders consulted through the focus group, the recognition of qualifications remains a significant barrier for migrant HCAs, regardless of whether they move within the EU or are third-country nationals (non-EURES). Stakeholders observed that, although many countries actively recruit care workers from abroad, the process of recognising skills and qualifications is often complex and inconsistent.

Some stakeholders identified language as another substantial barrier. They noted that, even when migrant workers meet formal language requirements, they frequently lack the technical and vocational vocabulary necessary for effective communication in care settings. One stakeholder cited the training programme in elderly care and infectious disease prevention for the integration of refugees from Middle Eastern and African countries in western society (HERO) ([1]) as an example of a programme designed to address this gap by developing medical care vocabularies and training modules.

Additionally, several stakeholders consulted agreed that host countries' capacity to provide language and vocational training varies considerably, which can affect how quickly and effectively migrant HCAs are able to integrate into the workforce. They also noted that some countries, particularly in northern Europe, are more attractive to healthcare workers from southern Europe due to their better support structures.

National mobility trends and distribution of health care assistants within countries

A general trend in the European health care workforce reveals a strong urban concentration of physicians, particularly in capital cities and densely populated regions, driven by better infrastructure, professional opportunities and living conditions (Winkelmann et al., 2020). In contrast, nurses and midwives are relatively more prevalent in rural or less populated areas, influenced by decentralised education systems, higher demand for care in ageing rural populations and urban cost-of-living pressures that make city-based roles less attractive. Similar considerations are likely to apply to HCAs, who represent a significant fraction of the LTC workforce and, due to relatively lower wages and limited career progression opportunities, may find urban living economically unfeasible. Additionally, task-shifting policies that expand nursing responsibilities to address physician shortages contribute to this geographical distribution pattern (Winkelmann et al., 2020). Delegating basic clinical and personal care tasks to HCAs may also further incentivise the recruitment of this occupational group in underserved regions to compensate for physician shortages.

([1]) See the website for the HERO training programme (https://hero-erasmus.csl.gr/#:~:text=The%20main%20focus%20of%20the,and%20financial%20integration%20of%20the).

5. Skills and qualification gaps

Fragmentation in training standards

Educational requirements and programme structures for HCAs differ widely across the EU (Kroezen et al., 2018), contributing to fragmentation in qualification frameworks and care quality. Entry criteria range from no formal requirements (e.g. Bulgaria, Latvia, Malta) to the completion of secondary education (e.g. Belgium, Germany, Austria). Programme duration varies from short-term courses of three months (e.g. Lithuania, Romania) to multi-year programmes of up to six years (e.g. Latvia), with theory–practice ratios also diverging significantly. Some Member States favour a balanced 50:50 approach (e.g. Luxembourg, Austria), while others lean heavily towards theoretical instruction (e.g. Germany, Spain).

Furthermore, the definitions and scopes of learning outcomes for HCAs are inconsistent across Member States. France, Latvia, Luxembourg and Portugal include over 20 learning outcomes in their curricula, whereas Denmark, Germany, Ireland, Greece and Slovenia include 8 or fewer (Kroezen et al., 2018). Most outcomes focus on knowledge and skills, with limited emphasis on competencies, and none are universally adopted across all Member States.

Continuous professional development requirements for HCAs are also unevenly implemented. While some Member States mandate continuous professional development (e.g. France, Latvia, Romania), others have no formal requirements (e.g. Greece, Cyprus, Malta, Sweden) (European Commission: Consumers, Health, Agriculture and Food Executive Agency et al., 2018). This inconsistency affects opportunities for skills renewal and career progression and may hinder efforts to harmonise standards across the EU.

Efforts to establish a common training framework for HCAs have faced resistance due to national differences in education systems and legal frameworks. Some stakeholders have expressed concern that assigning a single European qualifications framework level could have unintended consequences for national training, financing and occupational structures (European Commission: Consumers, Health, Agriculture and Food Executive Agency et al., 2018; EPSU, 2024).

Recognition of qualifications and related barriers Several EURES countries recognise prior LTC experience as part of formal training pathways for HCAs (European Commission: Consumers, Health, Agriculture and Food Executive Agency et al., 2018; OECD, 2023). Countries such as Denmark, Ireland, Norway, Portugal, Sweden and Switzerland allow individuals with relevant work experience to receive course credits, which can shorten the duration of formal education or facilitate access to certification programmes. This recognition aims to improve career progression and formalise skills acquired informally or on the job. It supports the transition from informal care roles to regulated employment, particularly for migrant workers and older adults re-entering the workforce. In Switzerland, for example, entire training programmes for some health and social care roles can be replaced by validated work experience.

Box 6: Stakeholder consultation: impact of non-standardised training

According to many of the stakeholders consulted in the focus group, there is a notable lack of standardisation of the qualifications of HCAs. In their view, this fragmentation leads to HCAs receiving varying levels and types of training depending on the programme or provider. One stakeholder explained that workers may be certified for specific tasks but are often required to perform duties for which they have not been formally trained or qualified. Some stakeholders consulted believe that this situation places HCAs in challenging professional circumstances and raises concerns regarding the quality and safety of the care delivered.

Some of the stakeholders consulted also identified the recognition and validation of skills as issues directly linked to fragmented training standards. They observed that training modules and online courses completed in one work setting are not always recognised by other employers, even within the same country. In their opinion, this lack of portability leads to frustration among HCAs, who may be reluctant to invest time and effort in further training if it does not result in tangible career benefits or is not acknowledged by future employers. The absence of a unified framework for recognising and validating skills and training across employers and regions was seen by a few stakeholders as a significant barrier to both professional development and workforce mobility within the sector.

Role of healthcare workforce planning

Strategic workforce planning for HCAs is becoming increasingly essential across EURES countries, particularly in response to escalating healthcare demands and persistent staff shortages (OECD et al., 2024). Although policy attention has traditionally centred on doctors and nurses, HCAs also play a critical role in care delivery and therefore require targeted planning to ensure sufficient numbers and equitable distribution across settings. Achieving this necessitates the availability of robust and granular data on the current composition of the health workforce and on recent trends in recruitment, retention and mobility. However, existing data systems often lack the capacity to accurately capture imbalances between supply and demand across different occupational categories, including HCAs. This data gap hampers effective forecasting and undermines efforts to address workforce shortfalls in a timely and evidence-based manner.

Suitability of medical education systems to meet job market needs

Current education and training systems for HCAs often fall short of equipping workers with the skills most needed in LTC settings. There is a shortage of HCAs with specialised competencies, particularly in geriatric care and post-discharge support (OECD, 2023). This imbalance reflects a broader issue in workforce preparation, where training programmes do not adequately reflect the complexity of the care needs in ageing populations.

According to the OECD (2023), the challenge in LTC is less about mismatches between formal qualifications and job roles, and more about the absence of targeted skills aligned with changing care demands. Many HCAs lack foundational knowledge in managing chronic conditions, understanding safety procedures and supporting patients after hospital discharge. This is especially problematic in home-care settings, where HCAs often work alone and in environments not adapted for care provision.

The OECD (2023) emphasises that current training programmes rarely prepare HCAs to deliver high-quality care or minimise health risks. Training should include practical techniques for safe and ergonomic care delivery, particularly for older people with physical and cognitive limitations. For example, learning proper lifting techniques and ergonomic positioning can reduce musculoskeletal injuries, while specialised training in dementia care can help prevent incidents of violence and improve care outcomes.

Demand for new skills

Digitalisation is increasingly shaping the LTC landscape across Europe, with direct implications for HCAs. First, emerging technologies offer the potential to improve efficiency, reduce physical and mental strain, and enhance the quality of care. According to the OECD (2023), digital tools such as comprehensive software packages can streamline administrative processes and facilitate coordination among care providers, allowing HCAs to dedicate more time to direct care provision. Sensors and remote monitoring systems may reduce the need for physical supervision and transit between care recipients, particularly in domiciliary settings.

Digital tools also have the potential to alleviate the physical burden of care work. Devices such as lifts and care robots can assist HCAs with physically demanding tasks, while digital platforms can reduce mental stress by simplifying documentation and scheduling. These improvements may contribute to lower rates of absenteeism and job turnover among LTC workers, including HCAs. Some countries, such as Germany and Slovenia, have already invested in digitalisation to ease the administrative burden on formal LTC workers (Hougaard Jensen et al., 2025).

However, several barriers continue to hinder the widespread adoption of digital technologies in LTC (OECD, 2023). Financial constraints remain a major obstacle, particularly for the implementation of more expensive solutions such as robotics. Concerns over privacy and data security also limit uptake, underscoring the need for robust data governance frameworks. Additionally, many LTC providers report that care workers, including HCAs, lack the necessary digital skills to operate new systems effectively. Awareness of available technologies is another limiting factor.

Platform-based care services are also emerging in the LTC sector, although they remain relatively rare. These platforms pose additional challenges related to monitoring, safety and the vulnerability of care recipients, particularly in home-based settings (Barslund et al., 2021).

Box 7: Stakeholder consultation: balancing digital competencies and personal care

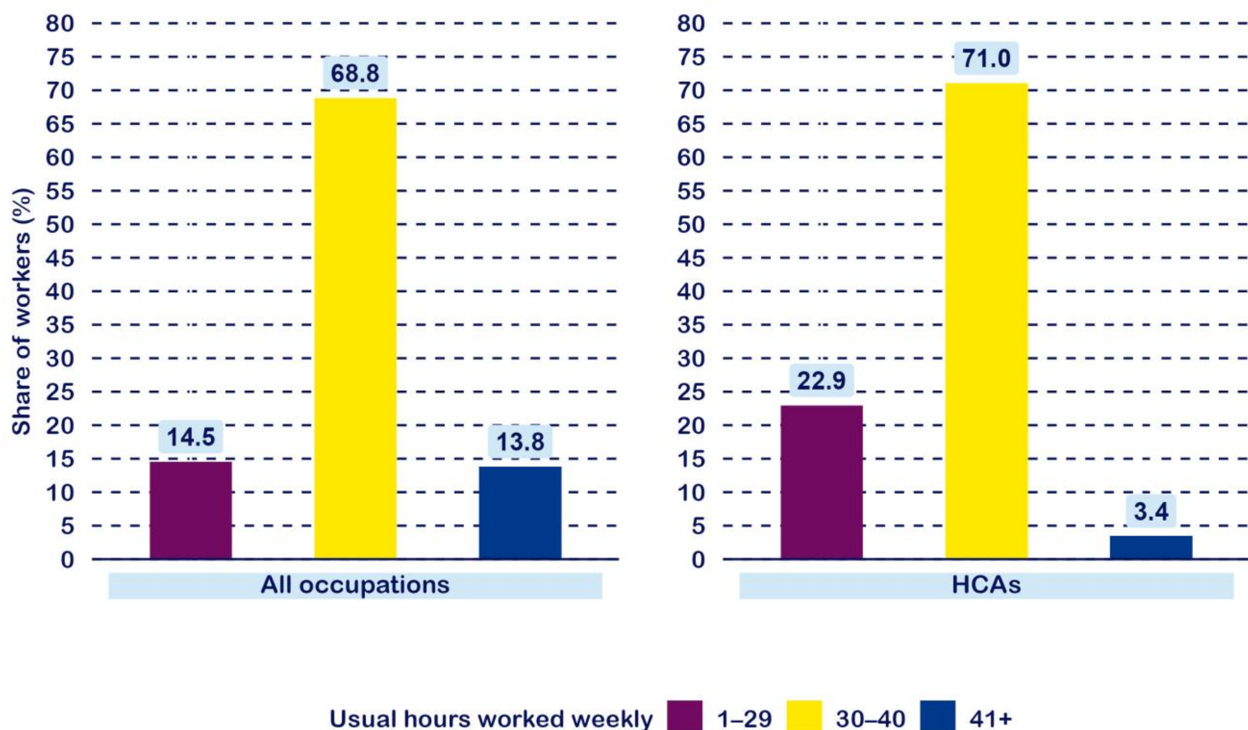
The focus group highlighted a growing demand for new skills among HCAs, with several stakeholders pointing to the increasing influence of technology in care settings. Some felt troubled by this development, as they perceive that digital tools and applications are reshaping the nature of care work, making it more process driven. Some stakeholders expressed their concern that technology, while intended to support care workers, may sometimes hinder their ability to provide personalised care and increase their administrative workload. Some stakeholders suggested that the sector needs to invest in training HCAs not only in the technical use of new equipment and digital tools but also in understanding how to balance technological requirements with the human aspects of care.

6. Working conditions and occupation attractiveness

Working hours and patterns

Figure 6 shows weekly working hour patterns among HCAs, offering insight into the structure and variability of their working time across EURES countries. The proportion of HCAs working between 30 and 40 hours per week is broadly comparable to the average across all occupations (71.0 % and 68.8 %, respectively). However, HCAs are significantly more likely to work reduced hours: 22.9 % work between 1 and 29 hours weekly, compared with 14.5 % across the general workforce. Conversely, only 3.4 % of HCAs work more than 41 hours per week, notably lower than the 13.8 % observed across all occupations.

Figure 6: Usual weekly hours worked by HCAs, EURES, 2024



NB: For readability purposes, not all categories are displayed on the graph and the shares may not add up to 100 %.

Source: EU Labour Force Survey special data extractions.

These patterns reflect broader employment trends in the sector. Nearly 45 % of HCAs work part-time, with particularly high rates in the Netherlands (94 %), Belgium (60 %) and Austria (55 %) (Eurofound, 2020). Temporary contracts and shift-based employment are also widespread, contributing to irregular schedules and employment precarity (Barslund et al., 2021).

Atypical working hours are common among HCAs: 36 % of LTC workers report working night shifts and 70 % work on Sundays, compared with 14 % and 27 %, respectively, of all employees (OECD, 2023). These figures apply to both residential facilities (e.g. nursing homes) and domiciliary care, excluding hospitals.

Live-in HCAs, often face extreme working and on-call hours without adequate rest, privacy or pay. In many cases, they are required to perform tasks beyond their training, such as domestic chores or health treatments (Caritas Europa, 2023). Migrant HCAs also face vulnerable working conditions. In central, eastern and southern Europe, they are often hired directly by care recipients or families, resulting in informal employment arrangements (OECD, 2023). Dependency on employers for residence status further limits their ability to challenge unfair conditions, with many remaining silent due to fear of dismissal or immigration enforcement (Caritas Europa, 2023).

Box 8: Stakeholder consultation: impact of working hours and patterns on HCAs

The focus group discussed working hours as a significant factor influencing the attractiveness and sustainability of HCAs roles. Several stakeholders explained that care work is often characterised by long, demanding and inflexible hours, which can make the profession challenging for many. Similarly, the prevalence of night shifts and irregular schedules can further deter individuals from entering or remaining in the sector, as these patterns are frequently incompatible with family obligations and personal well-being. Some stakeholders also highlighted that the physical and emotional demands of the job are compounded by these working patterns. There were suggestions that improving the flexibility and predictability of working hours could enhance the sector's appeal and support better work–life balance for care workers.

Additionally, the group discussed how workload allocation in care settings is increasingly driven by time-based targets and administrative requirements. One stakeholder mentioned that, for example, HCAs may be assigned specific time slots for each care recipient, with tasks such as dressing, toileting and meal assistance scheduled to the minute. While this approach is intended to optimise efficiency, some stakeholders felt that it reduces the quality of care and increases pressure on workers.

Health and safety concerns

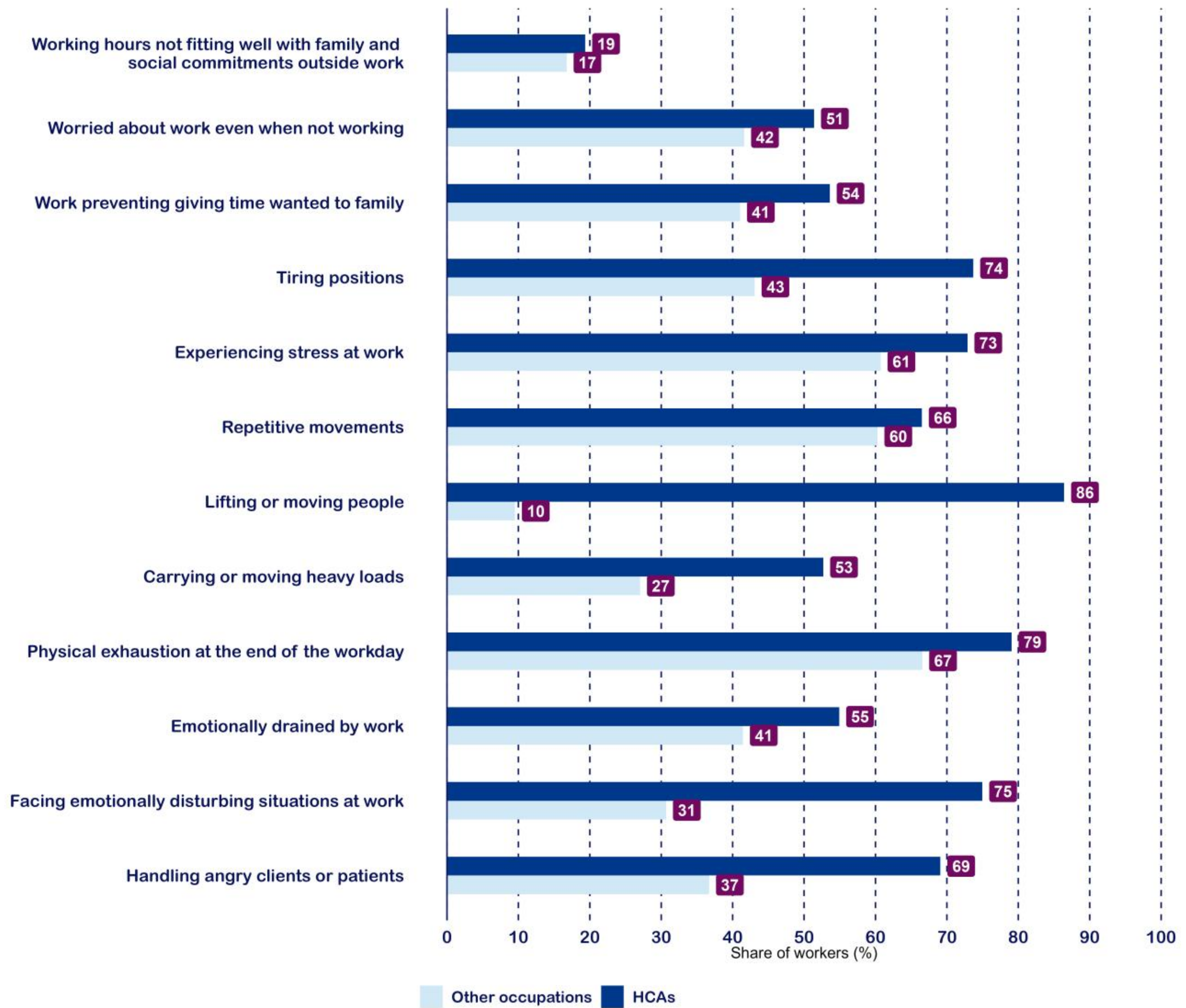
Health and safety risks are a non-negligible concern for HCAs across EURES countries. About three quarters of nurses and personal care workers are exposed to physical health risks, compared with 59 % of all employees (OECD, 2023). As shown in Figure 7, the share of HCAs reporting behaviours or situations that increase the risk of physical strain, such as lifting or moving people, carrying heavy loads and assuming tiring positions, is much higher than for all other occupations.

Other data indicate high workload and time pressure as frequently cited concerns, while handling difficult interactions with care recipients is consistently listed as the main source of stress (OECD, 2023). Verbal abuse, threats, and harassment are widespread, with 75 % of physiotherapists experiencing emotionally disturbing situations at work and 69 % saying they regularly deal with angry clients (Figure 7). Findings from a separate survey of LTC workers, including HCAs, show that 26 % experienced verbal abuse, 11 % received threats and 8 % faced humiliation or bullying in the month before being surveyed (Eurofound, 2020).

These conditions contribute to elevated absenteeism among HCAs. On average, nurses and personal care workers are absent for 1.2 weeks annually due to work-related health problems, compared with 0.7 weeks for the general workforce; the figure for nurses and personal care workers rises to over 2 weeks in countries such as Spain and Sweden (OECD, 2023). The COVID-19 pandemic further exacerbated these challenges, intensifying absenteeism, overtime and burnout, particularly in underfunded or understaffed residential and home care settings (Hougaard Jensen et al., 2025).

Despite these risks, 71 % of HCAs report that their work feels meaningful (Eurofound, 2020). However, studies by Caritas Europa highlight that live-in care workers, many of whom are migrant women, face particularly poor protections, low remuneration and a high likelihood of exploitation, especially in informal or undeclared employment arrangements within private households (Caritas Europa, 2023).

Figure 7: Working conditions for HCAs and all other occupations, EURES, 2024



NB: Figure shows combined share for workers reporting facing the listed situations always, often and sometimes.

Source: European Working Conditions Survey, 2024.

Box 9: Stakeholder consultation: occupational health and safety needs

Some stakeholders consulted identified occupational health and safety as an area requiring greater attention for HCAs. In particular, several stakeholders discussed the need to mitigate musculoskeletal risks, noting that HCAs frequently perform physically demanding tasks such as lifting and moving patients. These activities can lead to musculoskeletal disorders, which, one stakeholder highlighted, are less regulated and supported in the care sector than in other industries. Stakeholders also emphasised the importance of addressing psychosocial risks, highlighting that contributing factors such as exposure to violence have become more prominent since the COVID-19 pandemic. There was a view shared by multiple stakeholders that current training and regulatory frameworks do not always adequately prepare workers for these challenges. As a result, calls were made for more comprehensive training programmes, improved guidance on safe working practices and stronger support systems to help HCAs manage both the physical and psychosocial demands of their roles.

Career prospects

Career prospects for HCAs across EURES countries remain constrained by persistently low pay levels and limited opportunities for advancement. On average, personal care workers in LTC, a category that includes HCAs, earn approximately 70 % of the economy-wide average hourly wage. One quarter of them earn no more than 53 % of that benchmark (OECD, 2023). Even in hospital settings, where wages are slightly higher, only 10 % of personal care workers reach the average wage level. These disparities are particularly pronounced in domiciliary care, where remuneration tends to be lower than in residential care. Gender pay gaps further exacerbate income inequality, with women earning 8 % less than men in similar roles.

Education levels are a key determinant of wage outcomes. However, the educational requirements for HCAs are relatively limited in many countries. Most LTC workers possess medium-level education, and only about 20 % have attained tertiary qualifications (OECD, 2023). The over-representation of women in part-time roles, driven by gender norms and caregiving responsibilities, also contributes to lower aggregate wages in the sector.

The high share of migrant workers in LTC, often employed in informal or precarious arrangements, further depresses wage levels and undermines career stability (OECD, 2023). Despite chronic labour shortages, wages have not risen proportionately, a paradox explained by the low bargaining power of LTC workers, mismatches in labour supply and demand, and insufficient public financing of care services.

Tenure data also reflect the sector’s instability: HCAs have shorter average tenures than other healthcare professionals, with frequent inter-employer mobility driven by poor working conditions and limited career progression (Lehwess-Litzmann, 2022). Comparative income analysis places HCAs near the bottom of the earnings hierarchy among education, health and welfare occupations, with net incomes in countries such as Croatia and Slovakia amounting to just half the national average.

Box 10: Stakeholder consultation: barriers to career progression

Several stakeholders in the focus group highlighted limited career prospects as a key challenge for HCAs. They explained that many HCAs do not perceive clear opportunities for advancement within the sector. Factors such as demanding working conditions often prevent HCAs from accessing training and upskilling opportunities. For example, one stakeholder explained that, when there are not enough staff available, HCAs may be unable to take time off for training because their absence would leave shifts uncovered or increase the workload for the remaining staff. Additionally, long hours and physically or emotionally demanding tasks can leave HCAs too exhausted to participate in training outside work hours.

Some of the stakeholders also pointed out that career development pathways can vary significantly depending on the care setting, with more formal environments sometimes offering greater clarity and support for progression.

Role of social dialogue in protecting and improving working conditions

Social dialogue and collective bargaining play a critical role in shaping the working conditions of HCAs. Nonetheless, coverage remains uneven and often insufficient across EURES countries. Most differences between countries in unionisation levels and bargaining coverage among LTC workers are largely attributable to national variations in collective bargaining systems (OECD, 2023). High and stable coverage is observed only in countries where multi-employer agreements are regularly negotiated and extended to non-affiliated firms. In contrast, in countries lacking sectoral bargaining frameworks, LTC workers can only negotiate at the firm level, if and where they manage to organise.

The ability of collective bargaining systems to deliver improvements is increasingly challenged by the weakening of labour relations in the LTC sector. On average, only one third of employees across OECD countries are covered by a collective agreement, and this figure is often lower among HCAs due to the prevalence of undeclared work, bogus self-employment and workers with migrant status, which hinder unionisation and representation (OECD, 2023). In domiciliary care, the fragmentation of employment and the difficulty of identifying employer counterparts further limit the reach of collective bargaining.

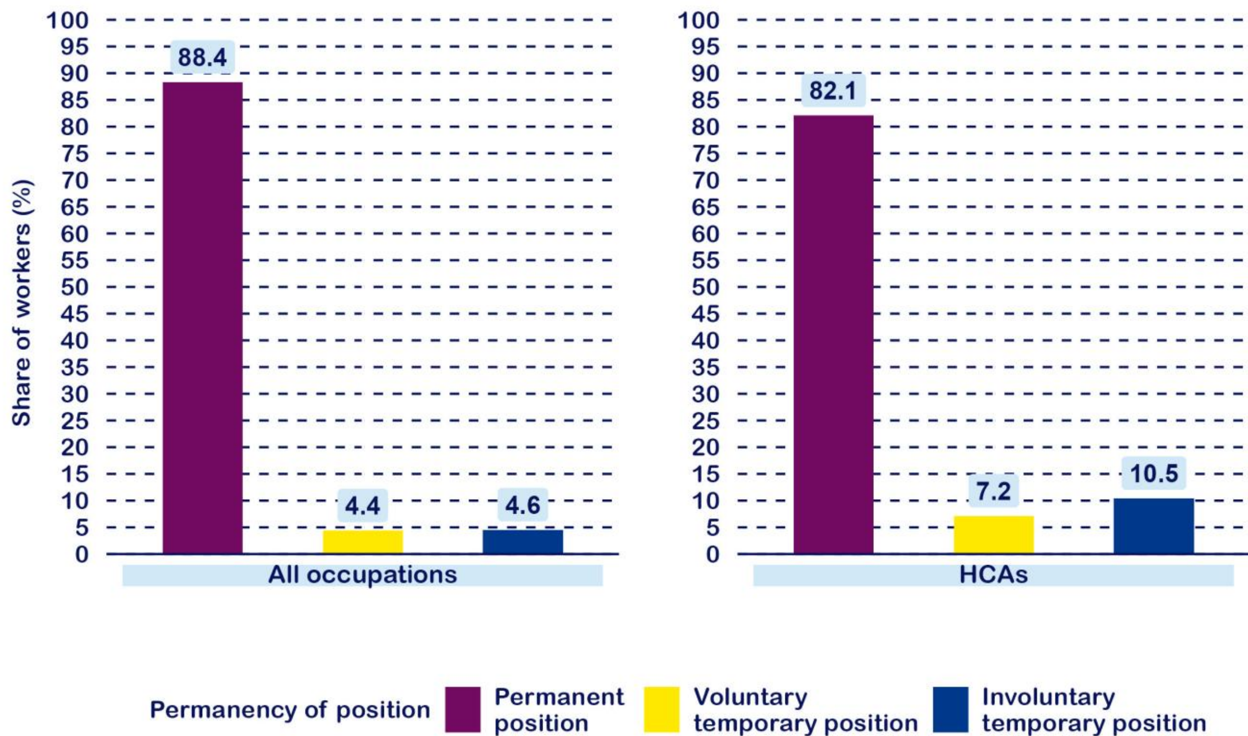
In general, low collective bargaining coverage is a contributing factor to persistently low wages and the widespread use of non-standard employment contracts among HCAs (Barslund et al., 2021).

7. Recruitment practices and retention trends

Employment forms and contracts

Permanent contracts are the predominant form of employment among HCAs (82.1 %), mirroring trends observed across the broader labour market. However, as shown in Figure 8, voluntary and involuntary temporary positions are more prevalent among HCAs than in the general workforce: 7.2 % of HCAs hold voluntary temporary positions (compared with 4.4 % of occupations across all economic sectors) and 10.5 % hold involuntary temporary positions (compared with 4.6 % of occupations across all economic sectors).

Figure 8: Share of temporary positions among HCAs, EURES, 2023

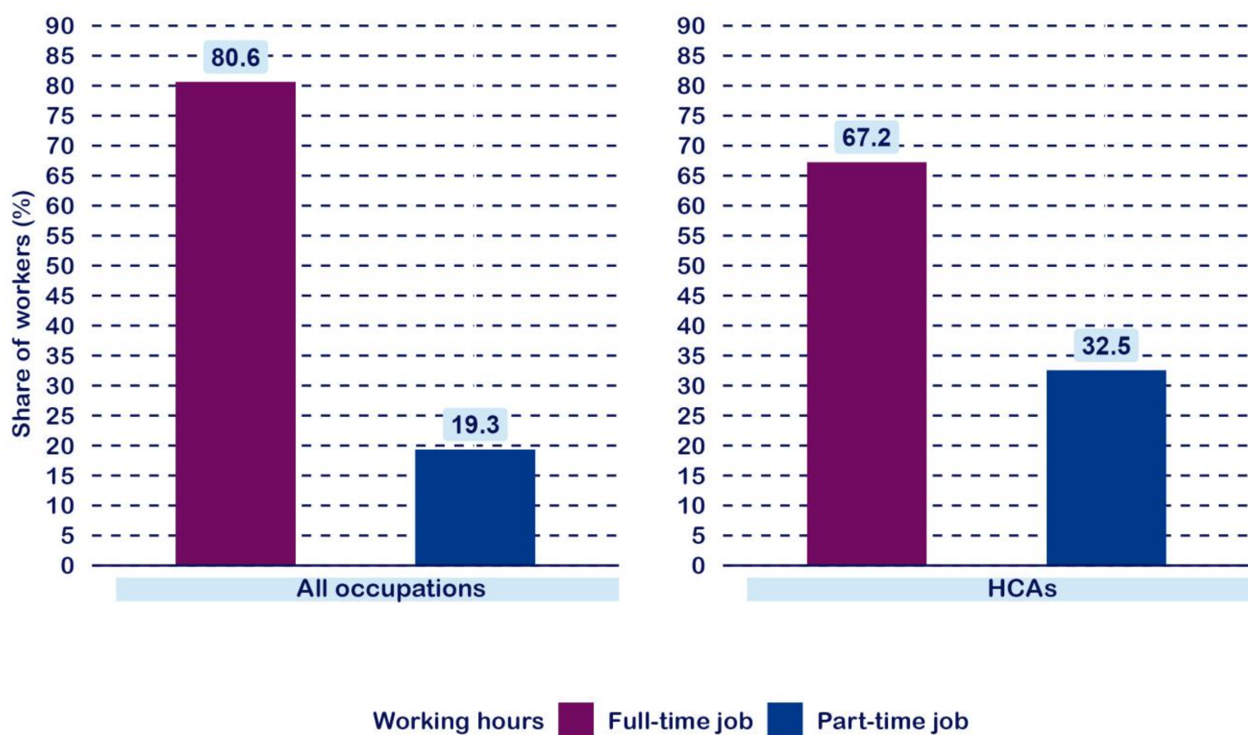


NB: For readability purposes, not all categories are displayed on the graph and the shares may not add up to 100 %.

Source: EU Labour Force Survey special data extractions.

Despite the high prevalence of permanent positions among HCAs, employment forms and contracts in LTC settings point to some degree of precarity and underemployment. In LTC, the share of LTC workers with fixed-term contracts is comparable to that of the general workforce (12 % versus 11 %), yet notably higher than among nurses and personal care workers in the healthcare sector (8 % on average across OECD countries) (OECD, 2023). Part-time work is also disproportionately common in this setting: 32.5 % of LTC workers are employed part-time, compared with 19.3 % of all occupations across economic sectors and 23.8 % of nurses and personal care workers (Figure 9). Despite reported shortages in many countries, some part-time HCAs are unable to secure full-time positions. Migrant HCAs, who form a significant share of the workforce, are particularly vulnerable, often employed informally or under false self-employment arrangements, with very low wages and limited protections.

Figure 9 Share of part-time positions among healthcare assistants, EURES, 2024



Source: LFS special extractions. For readability purposes, not all categories are displayed on the graph and the shares may not add up to 100%.

Early retirement rates and dropouts of incumbent staff

High turnover among HCAs remains a widespread challenge across Member States. Those such as Germany, the Netherlands, Austria, Portugal, Finland and Sweden report particularly elevated exit rates from the LTC sector (Eurofound, 2020). This attrition is closely linked to unfavourable working conditions, low remuneration and limited opportunities for career advancement, especially when compared with roles in hospital settings (OECD, 2020). Health-related concerns and burnout are frequently cited as reasons for leaving the profession. In residential care, 18 % of former workers identified health issues as the primary cause of departure, compared with 12 % in the broader healthcare sector and 10 % across all occupations (OECD, 2023). The COVID-19 pandemic exacerbated these trends, intensifying absenteeism, overtime demands and psychological stress, particularly in under-resourced residential and domiciliary care environments.

Caritas Europa (2023) highlighted significant barriers to retention, particularly in countries such as Czechia and Poland, where non-state providers struggle to compete with public sector salaries. This disparity reflects broader structural inequities in funding models, where financial support is tied to service providers rather than individual beneficiaries, leading to disloyal competition and undermining not-for-profit care provision (Caritas Europa, 2023).

8. Measures to tackle labour market imbalances

Skills mix and role substitution

The LTC sector is predominantly staffed by personal care workers, including HCAs, whose formal training requirements are generally low. While this facilitates rapid recruitment, it also raises concerns about underqualification and mismatches between skills and job demands, especially in residential and home care settings (Eurocarers, 2020; OECD, 2020)

Across EURES countries, the scope of tasks performed by personal care workers varies considerably. Some countries, such as Estonia, Lithuania, and Norway impose strict limitations, restricting HCAs to basic activities of daily living support and excluding responsibilities like medication administration. In contrast, countries including Belgium, Czechia and Sweden have adopted broader models of LTC provision, where HCAs routinely undertake more complex tasks, including administering medications (OECD, 2023). However, only one third of OECD countries permit formal task delegation from doctors to nurses and from nurses to personal care workers, limiting the potential for structured role substitution.

The COVID-19 pandemic exacerbated staffing shortages in LTC, prompting Member States to mobilise workers from other sectors, retirees and medical students, and to allow cross-border movements even during mobility restrictions (Barslund et al., 2021). In response to chronic shortages of nursing professionals, many systems have increasingly relied on HCAs to assume tasks previously performed by nurses (Sloane et al., 2018; Cörvers et al., 2021).

Task shifting has become a defining feature of the LTC workforce's development, with responsibilities cascading from doctors to nurses, and from nurses to HCAs. However, this process is uneven across countries and care settings. The expansion of HCA roles has also led to blurred boundaries and inconsistent expectations, particularly in palliative care, where HCAs often perform duties beyond their formal remit, such as domestic tasks, potentially due to gaps in family or social care support (Fee et al., 2020).

Support measures for labour market entry

HCAs, as part of the personal care workforce, face structural barriers to labour market entry and progression, particularly in sectors subject to strong price regulation such as elderly care and outpatient services. These constraints (low wages, limited career advancement and the undervaluation of the profession) undermine the attractiveness of the occupation and contribute to workforce instability and migration (Basys GmbH, 2021) . In response, several Member States have introduced targeted measures to facilitate entry into the LTC workforce. These include subsidised training programmes, professional certification pathways for informal carers and simplified tools to assess care needs (Hougaard Jensen et al., 2025). Germany and France have also invested in digital infrastructure to reduce administrative burdens and improve working conditions.

Efforts to recruit foreign-born workers have intensified, particularly targeting individuals arriving through international protection or family reunification schemes. Germany has implemented successful training and recruitment programmes targeting third-country nationals (non-EURES) from Indonesia, Mexico, Tunisia and Viet Nam(Barslund et al., 2021). Additional initiatives in Denmark, Germany and Slovenia aim to attract care workers from outside the EU by lowering entry barriers and subsidising training. For instance, Slovenia is financing training programmes using Recovery and Resilience Facility funds under the NextGenerationEU initiative, while Germany has eased residency conditions for immigrants who undertake care training in their country of origin.

However, reliance on foreign labour raises long-term concerns. Migrant-sending countries may face further strain on their own health systems. Caritas Europa (2023) warns against viewing migration as a stand-alone solution to LTC labour shortages, arguing that it merely masks deeper systemic issues such as low pay, poor career prospects and persistent inequalities within and between Member States and non-EU countries. Addressing these root causes is essential to achieving upward social convergence and strengthening welfare systems across Europe (Caritas Europa, 2023).

Strategies to improve the attractiveness of the occupation

Several EURES countries have introduced or planned reforms to improve job quality and enhance the attractiveness of the LTC sector for HCAs. These measures include wage increases, expanded educational opportunities and initiatives to support work–life balance and occupational health and safety (Barslund et al., 2021). Germany and Latvia have recently raised minimum wages for LTC workers, while Hungary (20%), Slovenia (up to 16%) and Lithuania (8% or 13% based on the level of education) have implemented some of the most substantial salary increases, ranging from 8 % to 20 %(OECD, 2023). Other countries, including Belgium, France, Luxembourg, and the Netherlands have also adjusted wages, although the impact has been partially offset by inflation.

Beyond financial incentives, countries such as Luxembourg have introduced additional leave entitlements and guaranteed work-free weekends to improve work–life balance. Investments in assistive technologies are also under way to reduce the physical demands of care work and better support HCAs in their roles (Hougaard Jensen et al., 2025).

Efforts to recognise prior experience have also gained traction. Switzerland allows full training replacement through validated work experience, while Portugal has developed a national system to register qualifications acquired through both training and experience (OECD, 2023).

Public image campaigns have been deployed to raise awareness and attract new entrants to the sector. Germany's 'Make a career as a human!' campaign and Luxembourg's youth-focused social media initiative aimed to improve the societal recognition of care work, although their effectiveness has not yet been evaluated (Barslund et al., 2021). Some countries have also targeted campaigns at the recruitment of men, with Norway's men in health programme cited as a successful example.

Retention strategies across the career cycle

Retention strategies for HCAs in LTC settings focus on improving job quality, career prospects and working conditions. Key measures include raising wages and introducing sector-specific minimums, such as Germany's care wage floor, and ensuring predictable schedules to reduce involuntary part-time work. Several Member States, including Spain, France, Lithuania, Luxembourg, Hungary, Portugal and Finland, have substantially increased minimum staffing ratios from 0.5 workers per client in 2020 to 0.7 in 2023, aiming to ease workload and improve care quality (OECD, 2023). Additional efforts include strengthening collective bargaining; enhancing occupational health and safety; promoting the public recognition of care work; and supporting migrant workers through ethical recruitment and integration agreements, such as those implemented in Germany. Investments in assistive technologies, notably in Denmark, also aim to reduce physical strain and enhance job satisfaction.

Box 10: Stakeholder consultation: initiatives addressing labour market imbalances

The stakeholders consulted discussed concrete measures to address labour market imbalances affecting HCAs. One key initiative was the framework of actions on recruitment and retention in social services, signed in 2025 by the Federation of European Social Employers and the European Federation of Public Service Unions (EPSU et al., 2025). This framework is designed to improve both recruitment and retention across the care sector. Stakeholders explained that it addresses the entire employment journey: from attracting new entrants through education to supporting onboarding, ensuring ongoing training and career development, and strengthening occupational safety, health and collective bargaining. Importantly, this framework is actively implemented and regularly reviewed within sectoral social dialogue meetings. These meetings serve as a platform for stakeholders to discuss the framework's themes, identify priorities and ensure that the actions taken lead to tangible improvements in working conditions and career prospects for care workers.

Another significant measure mentioned by a stakeholder was HERO ([2]), an Erasmus+-funded programme implemented in Greece, Italy, Cyprus and Portugal. The project aimed to address both the growing demand for elderly care and the integration of migrants and refugees from Africa and the Middle East into the European labour market. HERO developed a comprehensive training curriculum for migrant care workers, focusing on technical skills in elderly care and sector-specific language training.

([2]) See the website for the HERO training programme (https://hero-erasmus.csl.gr/#:~:text=The%20main%20focus%20of%20the,and%20financial%20integration%20of%20the).

9. References

Barslund, M., De Wispelaere, F., Lenaerts, K., Schepers, W. and Fries-Tersch, E. (2021), *Policies for Long-term Carers*, Committee on Employment and Social Affairs, Policy Department for Economic, Scientific and Quality of Life Policies, European Parliament, Luxembourg, https://www.europarl.europa.eu/RegData/etudes/STUD/2021/695476/IPOL_STU(2021)695476_EN.pdf.

Basys GmbH. (2021). Health workforce shortage in the EU27 in the light of accounting systems – Draft report. European Institute of Innovation for Sustainable Development (EIHSD). https://eihsd.eu/wp-content/uploads/2021_Feb_HWF_Shortage_BASYS_Draft.pdf

Caritas Europa (2023), *Growing Old with Dignity – The challenges of long-term care in Europe*, Brussels, https://www.caritas.eu/caritas-cares-growing-old-with-dignity-2/.

Cörvers, F., Reinold, J., Chakkar, S., Bolzonella, F. and Ronda, V. (2021), 'Literature review labour migration', *ROA Technical Reports*, No 005, Research Centre for Education and the Labour Market, Maastricht University, Maastricht, https://doi.org/10.26481/umarot.2021005.

EPSU (European Federation of Public Service Unions) (2024), *Wage Watch – A comparative study of healthcare assistant and nurse wages across Europe*, Brussels, https://www.epsu.org/sites/default/files/article/files/Wage-Watch-HCA-EPSU.pdf.

EPSU and Federation of European Social Employers (2025), *Framework of actions on retention and recruitment in social services – 2025*, Brussels, https://www.epsu.org/sites/default/files/article/files/SS-FoA_FINAL.pdf.

Eurocarers (2020), *What Is in It for Carers? 2020 review of the country reports and country specific*, https://eurocarers.org/eurocarers-analysis-of-the-2020-european-semester-is-out/.

Eurofound (2020), *Long-term Care Workforce: Employment and working conditions*, Publications Office of the European Union, Luxembourg, https://doi.org/10.2806/531180.

European Commission: Consumers, Health, Agriculture and Food Executive Agency, NIVEL, KU Leuven, Schäfer, W., Kroezen, M. et al. (2018), *Core Competences of Healthcare Assistants in Europe (CC4HCA) – An exploratory study into the desirability and feasibility of a common training framework under the Professional Qualifications Directive: Final report*, Publications Office of the European Union, Luxembourg, https://data.europa.eu/doi/10.2818/49804.

European Parliamentary Research Service (2022), 'What if care work were recognised as a driver of sustainable growth?', *Briefing – European Added Value in Action*, PE 730.333, https://www.europarl.europa.eu/thinktank/en/document/EPRS_BRI(2022)730333.

Fee, A., Muldrew, D., Slater, P., Payne, S., McIlfatrick, S. et al. (2020), 'The roles, responsibilities and practices of healthcare assistants in out-of-hours community palliative care: A systematic scoping review', *Palliative Medicine*, Vol. 34, No 8, pp. 976–988, https://doi.org/10.1177/0269216320929559.

Groenewegen, P., Van Poel, E., Spreeuwenberg, P., Batenburg, R., Mallen, C. et al. (2022), 'Has the COVID-19 pandemic led to changes in the tasks of the primary care workforce? An international survey among general practices in 38 countries (PRICOV-19)', *International Journal of Environmental Research and Public Health*, Vol. 19, No 22, 15329, https://doi.org/10.3390/ijerph192215329.

Hougaard Jensen, S. E., Pinkus, D. and Ruer, N. (2025), 'Prepare now: Europe must get ready for the coming long-term care surge' *Policy Briefs*, No 02/25, Bruegel, https://www.bruegel.org/sites/default/files/2025-01/PB%2002%202025.pdf.

Kalavrezou, N., Pot, M., Kadi, S., Simmons, C. and Leichsenring, K. (2025), *Facts and figures on healthy ageing and long-term care*, European Centre for Social Welfare Policy and Research, Vienna, https://www.euro.centre.org/downloads/detail/5201.

Kroezen, M., Schäfer, W., Sermeus, W., Hansen, J. and Batenburg, R. (2018), 'Healthcare assistants in EU Member States: An overview', *Health Policy*, Vol. 122, No 10, pp. 1109–1117, https://doi.org/10.1016/j.healthpol.2018.07.004.

Lehwess-Litzmann, R. (2022), 'Frontline workers in education, health and welfare: How much do they earn in European countries? A comparative income analysis based on the EU-LFS', *SOFI Working Papers*, No 28, Sociological Research Institute Göttingen, Göttingen, https://www.ssoar.info/ssoar/handle/document/84595.

OECD (2020), 'Who cares? Attracting and retaining care workers for the elderly', *OECD Health Policy Studies*, OECD Publishing, Paris, https://www.oecd.org/en/publications/who-cares-attracting-and-retaining-elderly-care-workers_92c0ef68-en.html.

OECD (2023), *Beyond Applause? Improving working conditions in long-term care*, OECD Publishing, Paris, https://doi.org/10.1787/27d33ab3-en.

OECD and European Commission (2024), *Health at a Glance: Europe 2024 – State of health in the EU cycle*, OECD Publishing, Paris, https://www.oecd.org/content/dam/oecd/en/publications/reports/2024/11/health-at-a-glance-europe-2024_bb301b77/b3704e14-en.pdf.

Schmidt, A. E., Brugger, K., Horváth, I., Falkenbach, M., Williams, G. A. et al. (2025), 'Green skills for a sustainable future: Building a climate-smart health and care workforce in the European Union', *Policy Briefs*, No 70, European Observatory on Health Systems and Policies, WHO Regional Office for Europe, Copenhagen, https://eurohealthobservatory.who.int/publications/i/green-skills-for-a-sustainable-future-building-a-climate-smart-health-and-care-workforce-in-the-european-union.

Skills for Care (2023), 'What we can learn from Norway's approach to recruiting men in social care', Skills for Care website, 13 September 2023, https://www.skillsforcare.org.uk/news-and-events/blogs/what-we-can-learn-from-norways-approach-to-recruiting-men-in-social-care.

Sloane, D. M., Smith, H. L., McHugh, M. D. and Aiken, L. H. (2018), 'Effect of changes in hospital nursing resources on improvements in patient safety and quality of care', *Medical Care*, Vol. 56, No 12, pp. 1001–1008. https://doi.org/10.1097/mlr.0000000000001002.

WHO (2025), 'The climate crisis is a health crisis – and the European region is in the hot seat', WHO website, 11 June 2025, https://www.who.int/europe/news/item/11-06-2025-the-climate-crisis-is-a-health-crisis-and-the-european-region-is-in-the-hot-seat.

WHO Regional Office for Europe (2025), *Health Workforce Migration in the WHO European Region – Country case studies from Albania, Armenia, Georgia, Ireland, Malta, Norway, Republic of Moldova, Romania and Tajikistan*, Copenhagen, https://www.who.int/europe/publications/i/item/WHO-EURO-2025-10839-50611-76542.

Winkelmann, J., Muench, U. and Maier, C. B. (2020), 'Time trends in the regional distribution of physicians, nurses and midwives in Europe', *BMC Health Services Research*, Vol. 20, 937, https://doi.org/10.1186/s12913-020-05760-y.