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Employment in health and social assistance sector in European Union

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Abstract
The European Union is currently facing an increased need for social and health care services, considering the ageing phenomenon and the shortage of skilled labour force. Health and social assistance sector gains importance not only at national, but also at European levels. Demographic and economic changes generate consequences in the allotment of financial resources for social and health care services, but also on the recruitment and retention of staff working in public and private organizations. Various studies conducted at European and national levels show that health and social assistance sector is characterized by poor working conditions and low wages, with direct consequences on the ability of providers to attract and to retain highly qualified workforce. In the last years, health and social assistance sector proved to be one of the economic sectors with the highest growth in the European Union (EU). In 2011, about 10% of the total workforce at European level was employed in this sector. Starting from these realities, the present article aims to highlight the importance of health and social assistance activities in the European economy. The second objective is to determine the effects of the economic crisis on the overall employment in this sector at European level. The analysis is based on statistical analysis of Eurostat data and also on latest national and international reports. The final part of the article will allow formulating conclusions regarding the trends in employment at European level.

Keywords: *labour force, health and social assistance sector, employment, economic crisis*

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Introduction

Most of European countries are facing a need for more social and health care services, while there is a shortage of labour force. Health and social care and the sustainability of health care systems (due to the high level of costs associated with health and social care in older age) are essential and the European documents acknowledge that demographic changes create the need for fostering innovation, collaboration between stakeholders, and active involvement of individuals in research. (European Commission, 2012a: 5-6). According to the Statistical Classification of Economic Activities in the European Community (2008), the sector of health and social assistance (HSA) activities comprises human health activities, residential activities and all the social activities that don't imply accommodation. Although the labour market statistics, as well as the contribution of this economic sector to the general European and national outputs, are available for both health and social activities (either residential or not), the development remains unbalanced between activities that pertain to health care and those belonging to social care. Health care services cover the risk of becoming ill, while social services are designed to reduce the social inequalities or to promote social cohesion and inclusion for different types of persons in need. The sector is considered to be very important from the perspective of the European employment goals for 2020, as it concerns the overall health status of the labour workforce, enabling the people to remain economically active and productive. The health and social care services are also generating an important part of the number of jobs in the European economy and in the context of ageing process, these services contribute to the wellbeing of older people. In this article we intend to present the main features of the employment in health and social assistance sector at European level, aiming to identify the main factors that drive the trends in employment in this sector. The article is organised on two parts. In the first part of this article we identify the factors with potential to shape the employment in health and social assistance sector. The second part represents an analysis of the employment in this sector at European level. For the second part, statistical analysis is based on data provided by Eurostat.

Current factors affecting employment in health and social care activities at European level

In an ageing society, health and social care sector becomes increasingly important in Europe. This phenomenon generates consequences in the terms of funds 'spreading for social and health care services, but as well upon the recruitment and retention of staff working in organizations in this area. (Weber and Nevala, 2011:10). Not only the demographic change challenges the employment and the shape of health and social assistance sector, but also the social (changing in family patterns, increased labour participation of women) and the political factors (the ideological orientation of governments, the legislative changes), the economic impact of climate changes, the innovation and the technological development (lead to longer life expectancy with differences between men and women and increased the costs of care in old age), the end-user expectations (better informed users and higher quality of services expected). (Crepaldi, De Rosa and Pesce, 2012: 64-67; Toth, 2012: 164-166; Schulmann and Leichsenring, 2014: 12-14; Howat, Lawrie and Sutton, 2015: 12-15). A number of non-demographic factors (economic and financial crisis, government funding for social services and social care) have influenced the dynamics of this economic sector according to Schulz (2013: 1-2). Labour force migration and the internationalisation of social work

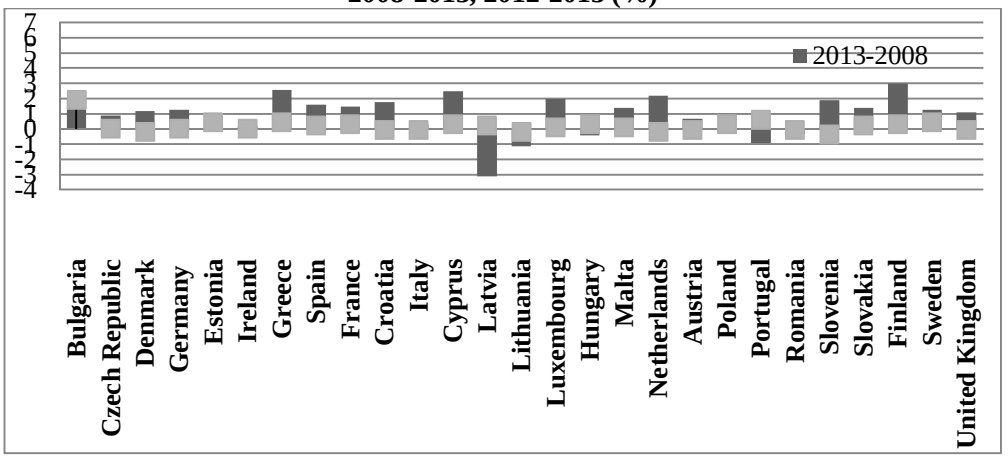
and health care activities have a strong impact on European economies, as they create negative social effects on family (Sănduleasa, Matei, 2015: 197), a shortage of available labour force in sending countries (Schulmann and Leichsenring, 2014: 9), as well as a major loss of investments in education in the countries of origin for migrants (Tilea, Vasile and Tilea, 2013: 31). The internationalisation of social work activities has a recognised potential to generate both economic development and new social problems that requires the intervention of state in different forms. (Grey, Fook, 2004: 630-631) With regards to social care activities, Dominelli (2010a: 4-7, 130; 2010b) appreciates that the globalisation generates changes in the management of social services and human resources, new means of communication, and new social needs and types of beneficiaries. Despite an increase of the labour force, various studies conducted at European and national level show that this economic sector is defined by poor working conditions and low wages, with consequences upon the ability of organizations to attract workforce with high skills and qualifications, especially for the social assistance part. The growing number of the elderly population, the low level of related expenses and the labour force migration stand among the factors with an impact on the employment in health and social assistance sector. In some of the Central and Eastern European (CEE) countries, there is an increased interest in developing models to allow the forecast of skills and qualifications needed in different economic activities (Tudose, Țoțan and Cristache, 2013: 114, 116). A number of recent studies highlight the difficulty to forecast the employment demand in this sector. These difficulties are related to the many factors that affect the health status of the population: on the one hand we consider factors such as the distribution of the population according to age and the average levels of population health status, the disposable income and the accessibility of social and health care services; on the other hand, these matters pertain to technological change and existing infrastructure. (Radvanský and Doválová, 2013: 1-2). A new approach of health and social care services is needed to tackle the demographic and non-demographic challenges and to maximise the use and effectiveness of human, financial and technological resources in this sector. Structural changes in CEE countries are the result of demographic changes, but also of the international division of labor, and could lead to labour market dysfunctionalities. (Tudose, Țoțan and Cristache, 2013: 117). Concerns about the health and the wellbeing of European citizens are not only important in the context of health care policies, since there are other European policies (regional policy, environmental policy, research policy and innovation policy, health and safety at work policy, social security, pensions policy) that integrate these concerns and actions.

Contribution of health and social assistance activities to the economic growth

The contribution of HSA in European economies is represented not only by the potential to generate new jobs, but also by the contribution to the new value created in the process of production. Health and social care organizations are important employers in the national economies of European states (see next sections). The share of gross value added in activities of public administration and defense, education, and HSA was around 20% in 2008. Even in the first year of economic crisis the contribution of the above activities to the total economic output exceeded the EU average (18.2%) in Belgium (21.1%), Denmark (22.5%), France (21.4%) and Sweden (23%). The lowest contribution was recorded in Slovakia (12.1%), while Romania ranked immediately before this country, with 12.2% of the total gross value added resulting from public administration and defense, education, HSA. (Eurostat, 2016e) The gross value added does fluctuate not only from country to country, but also from one year to another. Compared with 2008, the

largest growth recorded in 2013 characterised countries such as Finland, the Netherlands, Belgium, Greece, and Cyprus. For the same period, Lithuania recorded the biggest downfall in the gross value added, of 3.1 pp. (Figure 1).

Figure 1. Gross value added in public administration, defence, education and HSA, 2008-2013, 2012-2013 (%)



Source: Eurostat, online data code: [nama_nace10_c].

The contribution to the output of the European economy is even more significant if we look at the financing and expenditure of health care services. Across the European countries, the financing of health care services depends on the public policy. The total allocation of health care expenditure as a percentage of GDP is an indicator of the level of resources that a country is willing to allocate on the provision of health care services, in direct relation with the economic position and significant for the overall functioning of the health care system (Wendt, 2009: 434).

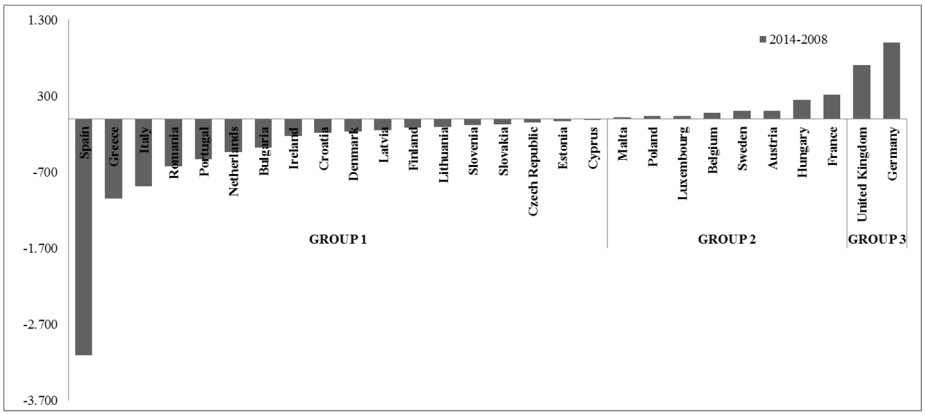
In the European countries, the value of the total health care expenditure as a percentage of GDP decreased in 2011 compared with 2008 only in countries like Estonia, Poland, and Slovakia. The overall decrease from these group of countries is to be found either in the reduction of the government expenditure (the case of Poland), either in the reduction of private investments in health care (Estonia and Slovakia). In 2011 the total amount of spending on health care varied significantly across European states. The share of expenditures allocated to this sector exceeded 10% of gross domestic product (GDP) in countries like Netherlands, Denmark, France, Austria, Germany, and Belgium. The second group of countries comprises states with a medium allocation of spending for health care sector: of six up to nine percentage of GDP. This group is more heterogeneous and includes mostly CEE countries. Romania and Latvia make the third group of countries, with the most modest allocation of spending as percentage of GDP dedicated to health care activities. (Eurostat, 2016h) In terms of total health care expenditure per capita, the lowest level is recorded in Romania and Latvia, while at the opposite are countries like Luxembourg and Belgium. Wendt (2009: 438-439) clustered the European countries in three groups based on both the level of public spending and the health care expenditure. The first group consists of Austria, Belgium, France, Germany and Luxembourg – countries with high level of total health expenditure, a high share of public funding, and moderate private out-of-pocket funding. The second group covers Denmark, United

Kingdom (UK), and Sweden – countries with a medium level of total health expenditure, a high share of public health funding, and a moderate private out-of-pocket funding; and the third group includes Portugal, Spain, and Finland with low level of total health expenditure and private out-of-pocket payments. The level of spending on long-term care services (as a percentage of GDP) continued to grow between 2008 and 2012, but the rates where reduced. Across the European countries, the highest increase was recorded in Nederlands with almost 0.7 pp increase in 2012 compared to 2008. Looking at the statistics for 2012, we could observe that cost-cutting didn't affect the sector of long-term care (with the exception of France and Romania that recorded a decrease of 0.02 pp, each). However the increases between 2008 and 2012 were very modest (bellow 0.2 pp) in most of the European countries (Eurostat, 2016i).

Description of employment in the health and social assistance sector

Significant differences between European countries characterize the sector for the last five years. Since the beginning of the economic crisis, the total population (15-64 years) employed in all economic activities decreased in 2014 compared to 2008, both at EU level (a decrease of 5550.1 thousands persons) as well as in most of the member states. In Figure 2 we depicted the European countries in three groups, based on changes in total employment, between 2008 and 2014: the first group comprises countries with decrease in total employment, the second group consists in countries with small to moderate increases of employed persons, and the third group includes only countries with high increases of total employment. For the first group of countries, the most significant decreases were recorded in Spain (3,106 thousands), Greece (1,043 thousands), Italy (889,100 persons) and Romania (627,800 persons). A small group of European countries recorded modest rises in employment: France (317,700 persons), Hungary (251.9 thousands), Austria (105,500 persons), Sweden (103,700 persons). Germany and UK ranked on the first position among the EU countries recording a growth of employment of 1005.4 thousands, respectively 703,500 persons (Eurostat, 2016a).

Figure 2. Population employed in EU, 2008-2014 (thousands persons)



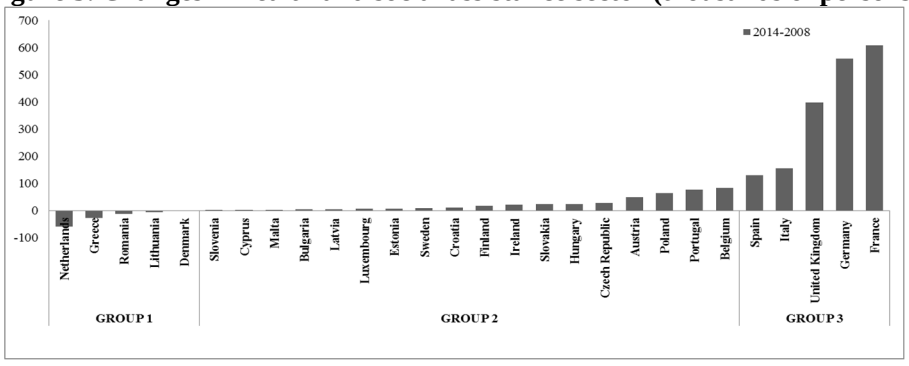
Source: Eurostat, online data code: [lfsa_egan].

These developments were not uniform and an analysis of the employment (15-64) by economic activity does reveal the fact that health and social care activities have achieved the most significant increases, in most of the EU Member States. In 2008, the

employment in health and social assistance activities in the EU28 as a whole represents 9.6%. Six years after, the employment in this sector has increased by 1.3 pp and has reached 10.9% in 2014. Unlike the rest of EU's economic activities, employment in this sector continued its growth throughout the general economic downturn. Similarly to the total employed persons, we can identify three groups of countries. Most of the European countries recorded decreases or modest rises of population employed in HSA activities – Group 1 and 2 of countries depicted in Figure 3. Among the countries with decline of employment in such economic activities, Netherlands recorded 58,800 persons, followed by Greece (26.9 thousands) and Romania (11.6 thousands). France (609,000 persons), Germany (560,500 people), and United Kingdom (397,400 persons) are to be found among the group of countries with no decreases of employment between 2008-2014, but as well among the countries with higher employment in HSA between 2008-2014. (Eurostat, 2016b). In 2008, the highest percentages of total employed population in health care and social assistance activities (HSA) were recorded in Denmark (17.7%), the Netherlands (15.8%), Sweden (15.6%), and Finland (15.2%). The lowest shares for employment in HSA activities were recorded in CEE countries such as Romania (4.3%), Latvia (4.4%), and Bulgaria (4.7%). During 2008-2014, the most significant growths of the proportion of people employed in HSA characterised Portugal (2.6 pp), Ireland (2.6 pp), France (2.2 pp), and Belgium (1.6 pp). Romania registered a small growth of 0.2 pp in 2014, compared to 2008. The main determinants for these increases have been the socio-demographic changes that have boosted the development of social and health care services. In 2014, the share of employed persons in HSA reached the highest values in Denmark (18.8%), Finland (16.6%), the Netherlands (16%) and Sweden (15.5%). Romania has recorded the lowest share of employment in health care and social assistance activities – 4.4%. (Eurostat, 2016b).

Employment growth in Western European countries is balanced by average decreases in CEE countries. 2014 marked an increase of all economic activities and even a stronger one in HSA: 2.6 million jobs were created in all economic activity while 510.2 thousands jobs were created in HSA, compared to the previous year (2013). (Figure 3) A return does occur to the situation recorded in 2008/2009 when 581,300 new jobs had been created in 2009 compared to the previous year. The employment trend in 2014 compared to 2013 was less significant, but was still high in Germany and France. CEE countries (e.g. Romania and Lithuania) have shown signs of employment revival in this sector.

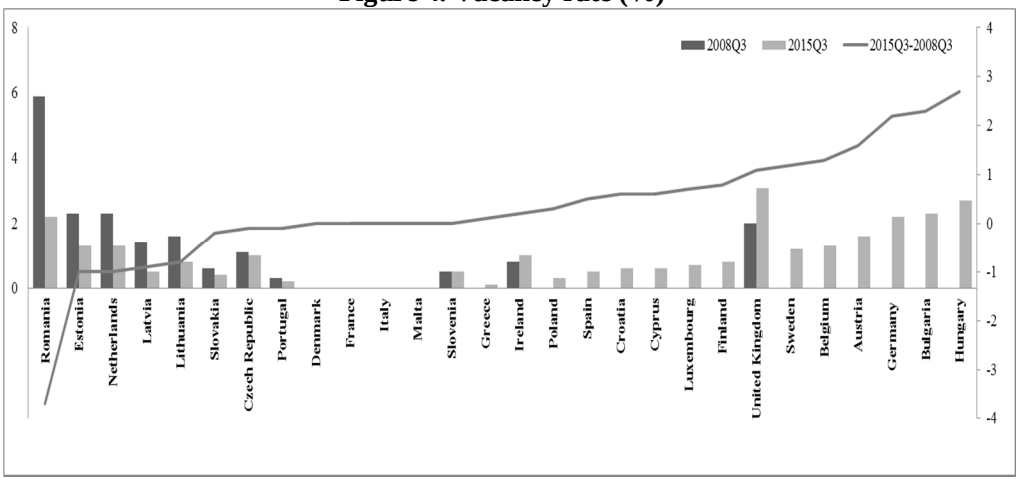
Figure 3. Changes in health and social assistance sector (thousands of persons)



Source: Eurostat, online data code: [lfsa_egan2].

In some EU member states employment in HSA is mainly concentrated in human health services: Romania figures among the member states with a significant share of employment in such activities (over 80% in 2015), together with Lithuania, Cyprus and Greece. Among the CEE countries, Hungary and Slovakia have a more balanced distribution of employment between human health, residential activities and all the social activities without accommodation. Countries with high share of employment in human health activities have a potential to enhance the employment in social work activities, and this represents an opportunity that should be exploited in the next years. For the same year, Western European countries as Luxembourg, Denmark, and France have recorded the highest shares of total employed persons in social work activities without accommodation (values over a third of the total employment in HSA for each country). Part of the increase in employment recorded in 2014 compared with 2008 in France and Luxembourg was in social work activities without accommodation, as the increase of employment for this part of HSA activities was of 3.8 pp in France, respectively of 5.1% in Luxembourg. (Eurostat, 2016c). The evolution of shortage in health and social care sector vary from one country to another. Countries with high share of older persons (65 years and over) and important number of migrants (e.g. Germany) or those with reforms in public health and social care sectors (e.g. Romania where employment in public health care and social care activities was blocked as a response to the economic crisis) are among those with the highest values of vacancy rates in 2015. According to Eurostat (2016d), during the 3rd quarter of 2008, the vacancy rate in HSA reached the highest value in Romania (5.9%) and the lowest ones in Portugal (0.3%) and Slovenia (0.5%). For the same quarter of 2015, the employment rate was reduced to zero in Belgium, Denmark, France, Greece, Spain, Croatia, Italy, Hungary, Malta and Slovenia (Figure 4).

Figure 4. Vacancy rate (%)



Source: Eurostat, online data code: [jvs_q_nace2]
Note: neither seasonally adjusted nor calendar adjusted data.

Taking into account the present and future need of personnel in the health and social care services, strategies to increase the employment should be developed considering the ageing process and the migration flows from CEE countries to Western European countries and between CEE countries.

Characteristics of employment in HSA

The European Commission reports (2012b: 3; 2014: 7) highlighted that between 2008 and 2013 the employment in HSA was represented mostly by women (78%) and that 81% of the new jobs were filled in by women.

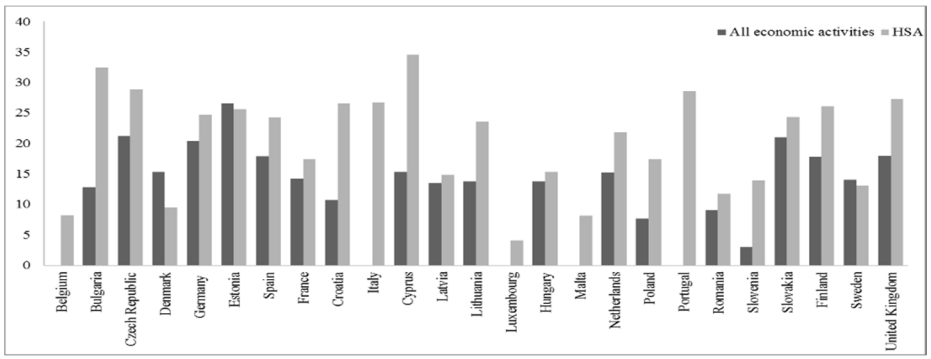
The health and social assistance sector is facing challenges in prevalence of the women employment and large wage differences between men and women employed in such activities (European Commission, 2014: 7). Changes in the population structure by age, changes in the family structure and households do generally affect employment growth in HSA and especially in the services of long-term care (Schulz, 2013: 1; Schulman and Leichsenring, 2014: 9, 47).

The number of women employed in HSA activities has gradually increased from 2008 to 2014, in the entire EU member states with 1,744.1 thousands persons (from 16,474 thousands in 2008 to 18,218 thousands women in 2014).

The dynamics of employment among women for 2008-2014 period shows significant increases in those countries where the total employment in HSA activities grew during the same period: France (up 21.5% - 542.1 thousands women), Germany (an increase of women employment by 459,200 persons), and UK (307.8 thousands persons). Italy and Spain recorded increases of approximately 100,000 women. Central and Eastern European countries recorded decreases in women's employment amid migration female labour force towards Western European countries (Austria, Germany) or towards countries characterized by the prevalence of family care regime, namely Italy or Spain (Eurostat, 2016b; Sănduleasa, 2014: 34; Rubin, Rendall, Rabinovich, Tsang, van Orange-Nassau and Janta, 2008: 2, 17, 43; Schulmann and Leichsenring, 2014: 9, 12).

Thus, in countries such as Romania and Lithuania, the women's employment has declined in 2014, compared with 2008. In 2014, an analysis of the gender pay gap in HSA showed that, in most of the member states, the pay gap between men and women is above the levels registered for the rest of the economic activities. The lower average earnings could be explained by the higher number of migrants and gender. (EASPD, 2010: 3-4) Denmark and Sweden are countries where wage gaps in HSA are lower than the ones recorded for other economic activities. The highest pay gaps are to be seen in some of the CEE countries (e.g. Bulgaria - 32.4%, Czech Republic - 28.8% or Croatia - 26.5%), emphasizing a more pronounced discrimination and inequalities in the labour market. The differences are around a third between men and women in these countries. Even in the Western European countries we can found some examples of high values of gender pay gaps: Germany -24.7%, UK - 27.3%, Portugal - 28.6%. (Eurostat, 2016f) The percentages reveal the dimension of the inequalities in HSA activities and require policy interventions to better recognize the work of women in health and social care (Figure 5).

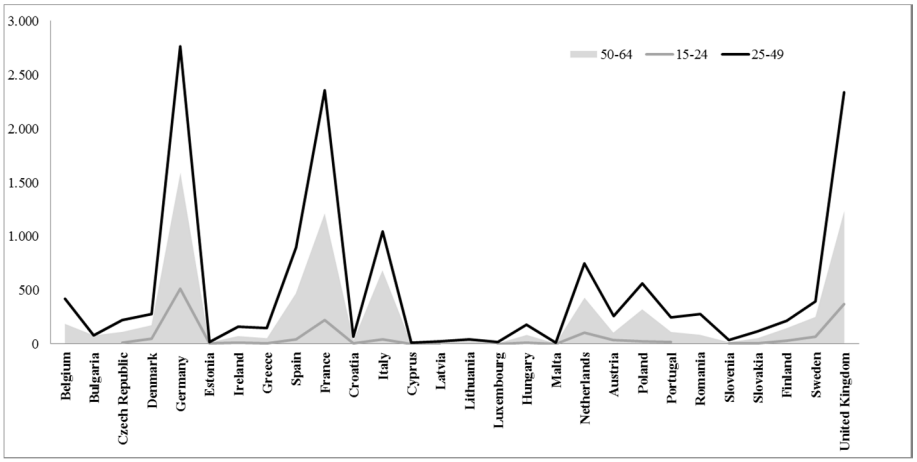
Figure 5. Gender pay gap in HSA vs. all economic activities, 2014 (%)



Source: Eurostat, online data code: [earn_gr_gpgr2].

In 2014, most of the persons employed in HSA at EU level, did belong to the 25-49 age group. Among the European countries, Italy, UK, Germany, and France attracted the highest numbers of young and middle aged professionals in HSA. They represents almost twice the number of professionals aged 50-64 years old in HSA in the same countries. The differences are even more important if we compare the employment for persons aged 25-49 years in these countries with the number of persons aged 15-24 years old. Employment in health and social assistance sector is less attractive among the young employed persons from Luxembourg (only 2.1% of total employed persons in this sector are between 15 and 24 years old), Malta (1.9%), Cyprus (0.8%), Estonia (2.2%) and Slovenia (2.5%). As an overall remark, the distribution of persons employed in health and social care activities is unbalanced between young and older workers, exception being made by Bulgaria with insignificant differences between the persons belonging to the 25-49 age group (76,800 people) and the ones over 50 years old (79,700 persons) (Figure 6).

Figure 6. Employment in HSA, by age, 2014 (thousands of persons)



Source: Eurostat, online data code: [lfsa_egan2].

The dynamics of employment by age groups (2008-2014) does show that countries with employment decreases for the 25-49 age group have high levels of employment among the 50-64 age group. Analyzing the Eurostat data (2016b), it becomes visible that the decline in the young population employed in HSA is more pronounced in Central and Eastern Europe: Czech Republic, Poland, Slovenia, Croatia, Romania and Slovakia, followed by Western European countries: Spain and the Netherlands.

Part-time employment and temporary contracts represents a current practice within the organizations of the HSA sector, especially for the social care organizations (due to the limited number of formal and informal carers). After 2008, the number of part-time workers has increased in almost all of the EU countries. The number of part-time workers in HSA was above the number of part-time workers in total economic activities for the majority of European countries (2014). The countries with the highest share of part-time worker in HSA activities are Nederlands (almost 80 percent in 2014) and Sweden (44.5 percent in 2014). Exceptions were recorded in Slovakia, Slovenia, Hungary, Croatia, Latvia (CEE countries). (Eurostat, 2016g) Female part-time employment in the HSA represented the majority, regardless of the year of analysis, 2008 or 2014. Part-time employment is associated with a large number of women employed, because caring responsibilities for dependents (children, elderly) within the family is still considered a task that should assigned to women. In this conditions, the reconciliation between work and family life remains a challenge for women providing children or elderly care and they tend to involve in part-time jobs (Schutz, 2013: 15; Schulmann, Leichsenring, 2014: 23) The number of temporary contracts in Germany, Spain, and France maintained at the highest level before and after the economic crisis, with decreases in 2014 compared to 2008. In case of some CEE countries the lack of data make difficult to appreciate to what extent we can appreciate that the working conditions in HSA are being precarious.

Quality of employment in health and social care sector

Reports of the European Commission (2014: 11) emphasize that in most of the European countries, workers in the health and social assistance sector have a higher level of qualification than the average of qualification required for other sectors, exception made of Luxembourg and France. Difference of qualifications could be observed between the health care and social care parts. While health care activities are characterized by high level of qualifications, for the social care part additional training is needed (EASPD, 2010: 4; Pîrciog et al., 2013). Difficulties in the provision of health and social care services are related with the lack of qualified personal. Lifelong learning facilitates the adjustments of workers to the labour market requirements (Pașnicu, Tudose, 2012: 1-2) The low level of wages, the significant level of stress and not at least the insufficient recognition of the profession contribute to the shortage of personnel in HSA, in some of the CEE countries (e.g. Romania). The need for continuous training of health and social care staff is acknowledged also in Bulgaria and Latvia. (Pîrciog et al., 2013) A series of studies identified a close connection between the skills and behaviors of the care staff and the quality of the care provided to patients (Dawson, 2009: 13-14; West, Dawson, 2012: 20).

Conclusion

The increase demand for health and social care is a consequence of the ageing of populations and the health status of older people. The health and social care sector has a fundamental role in promoting social inclusion and in reducing the risk of poverty and

social inequality. For the European economy, this economic sector is an actual and future source of new jobs and do have important contributions to the overall economic output. The economic crisis has brought many challenges in terms of budgetary cuts and of employment, as in many European countries the health and social care services depends on the public policy. Among the health care expenditure, the level of long-term care services (as a percentage of GDP) continued to grow between 2008 and 2012, even the rates were reduced. The employment in HSA continued the positive trend from 2008 throughout the general economic downturn. However, the employment growth in Western European countries was balanced by average decreases in CEE countries. Regarding the distribution of employment between main activities comprised in HSA, Romania, Lithuania, Cyprus and Greece are countries with a significant share of employment in human health activities, while other states (Luxembourg, Denmark, and France) record the highest shares of employed persons in social work activities. The vacancy rate remained high in countries with reforms in public health and social care sector. The sector continuous to be defined by gender differences in wage levels and by precarious work conditions, the major challenges will be reflected in the difficulties related to an adequate response towards the demand for health and social services, due to the population ageing. Policy changes should convince the young workers to enter the sector. In the same time more protection and stability should be provided to women involved in health and social care activities. Part-time employment is a common practice within the organizations of the HSA sector, especially for the social care organizations. The number of part-time workers has increased in almost all of the EU countries after 2008 and the female part-time employment in the HSA represented the majority, regardless of the year of analysis: 2008 or 2014. The labour force migration from CEE countries to Western Europe, reveal a gap between the areas of economic activity important at European level and those considered a strategic option at national level. The high demand for these types of services, the structural mutations occurring in the configuration of family and in the access to the labour market of men and women are expected to bring positive effects, to be reflected in employment growth of the sector. However considering the prevalence of part-time employment and the number of working hours in this sector, the limited prospects for career development (especially for the social care part) and the law levels of payments are features that characterize employment in HSA.

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