

Development, management and support of care workers – towards an integrated health and care workforce

Policy options

World Health Organization

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Abbreviations and acronyms

COVID-19	coronavirus disease
CRPD	Convention on the Rights of Persons with Disabilities
ICOPE	Integrated Care for Older People
ILO	International Labour Organization
ISCO	International Standard Classification of Occupations
ISIC	International Standard Industrial Classification of All Economic Activities
NHWA	National Health Workforce Accounts
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organization

Glossary

Care sectors: Health and care work, education, social work *(1)*.

Care work: The productive activities (including both paid and unpaid care activities) that encompass direct care for people (physical, emotional, psychological and developmental) as well as indirect care (e.g. household tasks, including collecting water and firewood, travelling and transporting), taking place within and outside the home *(2)*.

Care workers: Persons performing any form of care work. Specifically, those who "provide direct personal care services in the home, in health services and residential settings, assisting with routine tasks of daily life, and performing a variety of other tasks…." *(3)*. Care workers can be paid or unpaid.

Employer (of care worker): An employer is a person, company or organization that hires another individual, pays the individual a salary or wage, and has the power to control the individual's work duties. An employer hires an individual under an express or implied arrangement that gives the employer the right to dictate the individual's work obligations *(4)*.

Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity *(5)*.

Health system: All the activities whose primary purpose is to promote, restore or maintain health *(6)*.

Informal care (work): Productive care activities not covered by formal legal or regulatory arrangements, whether paid or unpaid. This includes employment not regulated by formal mechanisms as well as non-remunerated work *(7)*.

Informal care employment: Paid care work that is unregulated, or unprotected, often lacking contracts, benefits or social security. It is also often referred to as care work in the informal sector *(7)*.

Integration of the health and care workforce (operational definition for the purpose of this document): The inclusion of care workers in the same or similar policy, governance and management functions that are routinely considered and performed for the health workforce at large; these functions include data reporting, planning, education, regulation, management, supervision and others to deliver continuous, person-centred health and care across the spectrum of service delivery settings.

Long-term care: The activities undertaken by others to ensure that people with a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity *(8)*.

Paid care work: Paid care work refers to "care work performed for profit or pay within a range of settings, such as private households (as in the case of domestic workers), and public or private hospitals, clinics, nursing homes, schools and other care establishments. Care workers may be in an employment relationship where the employer is a private individual or household, a public agency, a private for-profit enterprise or a private non-profit organization, or they may be working on their own account (self-employed)" *(1)*.

Person with a disability: A person with "long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" *(9)*.[1]

Primary health care: "A whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and preferences (as individuals, families and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment" *(10)*.

Social care: A review of the social care concept found it best described as overlapping in three areas: community outreach and social connection; addressing social determinants of health; and integrated personal and social support services *(11)*.

Unpaid care work: Productive care activities provided within a household or community for the benefit of its members without remuneration *(2)*. This encompasses unpaid care work undertaken for someone's own use or purposes and activities such as volunteering, community service and trainee work *(12)*.

> *Note*: For the purposes of conceptual clarity in this document, a **"caregiver"** should be understood as a person performing unpaid care work for family, friend, neighbour or community member, typically in a household setting.

[1] The Convention on the Rights of Persons with Disabilities (CRPD) further explains that any other definition adopted at the national level which is more conducive for persons with disabilities shall be considered, including definitions that recognize temporary disability. CRPD article 5 para 4 states, "Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of persons with disabilities and which may be contained in the law of a State Party or international law in force for that State. There shall be no restriction upon or derogation from any of the human rights and fundamental freedoms recognized or existing in any State Party to the present Convention pursuant to law, conventions, regulation or custom on the pretext that the present Convention does not recognize such rights or freedoms or that it recognizes them to a lesser extent."

Executive summary

Introduction

There is an increasing recognition of the vital role and contributions of care work to population health and well-being, especially considering demographic shifts that contribute to more people living with care needs, including aged care and disability support. Care work includes hands-on "direct" care with activities of daily living, such as dressing, bathing and eating; and "indirect" care with household tasks, such as cleaning, food procurement and transport to appointments. With a growing demand for care work globally, the role of care workers encompasses providing direct personal care in homes, hospitals and other health services and residential care settings, supporting daily living activities and carrying out a wide range of essential, skilled, and often complex tasks *(1)*. Care workers are often overlooked in health workforce guidance, and yet health systems rely on a strong care workforce in order to function.

Objective

Building on the existing international focus and work, the main goal of this work is to guide policy for the planning, management and support of an integrated health and care workforce in order to seamlessly provides people-centred services across the entirety of primary health care-oriented health systems. Recognizing the complex interplay of gender, class, race/ethnicity, migration status and other social determinants shaping the experiences of care workers is essential to ensuring equitable and acceptable care. Taking into account gender and its intersection with other personal identity stratifiers – alongside the broader structural forces that shape who performs care and under what conditions – allows for more responsive, effective and equitable policies and practices.

Methodology

The policy options provided in this document were derived with input from the WHO Technical Advisory Group on Integrating the Health and Care Workforces ("Advisory Group") comprising individuals with subject matter expertise and are based on a global evidence review *(13, 14)*. The academic publication reporting the full findings of the evidence review were published in *Health Affairs Scholar* in 2025 *(15)*.

Policy options

These policy options cover 20 thematic areas of interest (see Table 1), framed by the working lifespan model of human resources for health that considers the entry, working (supportive) and exit stages of a career *(16)*. The thematic areas of interest at the entry stage of the working lifespan are: needs assessment and planning, data and evidence, governance implications, funding, pre-service education and training requirements, and recruitment. The supportive stage includes regulation of care workers, working conditions, compensation and benefits, supervision and management, support systems including communication and technology, continuing education, and career advancement. The exit stage assessed retention, international mobility and migration, retirement and career choice/career pathways. Finally, the Advisory Group identified three cross-cutting themes with implications for issues of equality and human rights, including gender equality, migrant status, and public and private ownership and settings of work.

Using this framework, this document presents policy options in each thematic area across the working lifespan to help strengthen the care workforce in diverse country contexts.

Table 1. Summary of policy options towards strengthening an integrated health and care workforce

Entry stage	
1. Needs assessment and planning	**1.1** Policy-makers to define the scope of work and job tasks for care workers, relative to health system needs and the optimization of skills mix across health and care service delivery settings. **1.2** Planners to develop human resource strategies that meet population health and care needs in national service delivery models using an assessment of health and care labour market dynamics within country contexts.
2. Data and evidence	**2.1** Relevant ministries to conduct systematic and routine collection, reporting and analysis of care workforce data aligned with international definitions of care occupations. • Ministries are encouraged to leverage existing health and care workforce data systems. • Ministries to strengthen disaggregated health and care worker data, reporting and analyses. • Ministries encouraged to develop or strengthen approaches and methodologies that close data gaps on care work and care workers, by improving data collection particularly in underrepresented areas, utilizing innovative forms of data, and valuing diverse forms of evidence, including qualitative data *(12)*. **2.2** Ministries and planners to consolidate and harmonize terminology for care worker roles and clarify definitions in support of workforce information systems that facilitate health and care services planning. • Job titles should harmonize with regional educational qualification frameworks.
3. Governance implications	**3.1** Governments and policy-makers to establish the legislative and governance infrastructure to enhance stability for the care workforce at appropriate jurisdictional levels. • Policy-makers to consider using joint governance structures, at all levels, such as interministerial taskforces or "integration boards" to oversee both health and care workforce services delivery and support the integrated workforce. • Policy-makers to ensure governance structures include representation of care workers and other stakeholders including civil society members and care recipients.
4. Funding	**4.1** Relevant ministries to allocate adequate resources towards expanding care services and corresponding care workforce stewardship and management. **4.2** Governments to align budgeting and accountability for health and care workforce across ministries of health and social services. • Governments and planners to explore novel mechanisms, where appropriate, across ministries or departments, including joint commissioning and blended funding models.
5. Pre-service education and training requirements	**5.1** Policy-makers, together with education institutions, to develop standardized educational pathways that result in a formal credential for care workers based on competency-based curricula and that reflect the value of interprofessional learning and collaborative practice. • Education institutions to consider prior learning and experience in the context of awarding academic credits or credentials. **5.2** Policy-makers and regulatory bodies to establish education standards and accreditation mechanisms (or other quality management approaches) to ensure education programmes meet quality standards. • With the involvement and support of care workers, policy-makers and regulatory bodies to develop evidence-informed and context specific education and accreditation standards. **5.3** Policy-makers together with education institutions to ensure equitable access to care education and training.

Table 1. Summary of policy options towards strengthening an integrated health and care workforce (continued)

Entry stage (continued)	
6. Recruitment	**6.1** Governments and policy-makers to provide guidance around national plans to facilitate recruitment by employers and enhance awareness of care work among the public. • Employers to conduct care worker recruitment according to national (or subnational) health and care workforce strategic plans and to meet population health and care needs, and in observance of applicable global principles of conduct in this area. • Planners and employers to consider incentive structures and/or collaborate with public employment agencies to increase recruitment of care workers from underrepresented groups and to areas of underserved populations. **6.2** Employers to ensure recruitment is fair and transparent and linked to the relevant education credentials, including the consideration of prior learning and experience. • Employers to facilitate induction of foreign-born care workers into new health systems and care contexts.

Working (supportive) stage	
7. Regulation of care workers	**7.1** Governments to adopt regulatory mechanisms for care workers that are proportional to the risk of harm to those receiving care services and aligned with the implementation capacity of the country.
8. Working conditions	**8.1** Governments to ensure laws and policies prioritize the safety and protection of all health and care workers from abuse, attacks, discrimination including any form of sexual exploitation or abuse, harassment and violence, in line with ILO Conventions and the Decent Work agenda *(17)*. **8.2** Employers to implement measures to prevent and respond to burnout and promote mental health and well-being in the workplace, in line with the Global Health and Care Workers Compact *(18)*. **8.3** Policy-makers to ensure labour rights and the rights to organize, recognizing that care workers are often marginalized and face systematic and societal barriers to collective action.
9. Compensation and benefits	**9.1** Governments to ensure decent work (as defined by ILO), which encompasses adequate, fair and equitable pay for care work, commensurate with levels of responsibility and risk, level of training, and consistent across all sectors, including minimum standards that apply to private service delivery sectors. • Governments to encourage transparency in wages, payment models and benefits in the private sector employing care workers, including equal renumeration in line with ILO Convention No. 100. **9.2** Employers should include care workers in benefits such as health insurance, pension schemes, paid leave and occupational health benefits.
10. Supervision and management	**10.1** Employers to optimize supportive supervision and management of care workers, including enabling peer support models across the entire working life of care workers. • Employers, policy-makers and planners to optimize opportunities for integrated supportive supervision of health and care workers through shared codes of conduct, interdisciplinary collaboration and communication protocols, and interdisciplinary training and professional development opportunities. **10.2** Employers to ensure the perspectives of care workers are represented in workplace support and management systems, such as on institutional decision-making bodies and committees, through promotion of collective bargaining rights, and by establishing institutional feedback and grievance mechanisms.

Table 1. Summary of policy options towards strengthening an integrated health and care workforce (continued)

Working (supportive) stage (continued)	
11. Support systems including communication and technology	**11.1** Planners and employers to ensure adequate technological and other support systems to enable effective performance and development of care workers. • Employers to harness appropriate technology and provide training on and access to interoperable digital tools and platforms that facilitate service delivery, with considerations for equity and inclusivity. **11.2** Planners and employers to ensure, where applicable, that referral systems provide necessary links between health facilities and community-based care settings, and that supply chains effectively serve both health and care settings.
12. Continuing education	**12.1** Employers to provide continuing education opportunities for all care workers, building on pre-service education and linking to career advancement, when possible. • Education institutions and employers to reflect best practices in training programmes in terms of teaching and learning methodologies, as well as accessibility and equity with consideration to migrant status, childcare responsibilities, language barriers and rural residence. • Education institutions and employers should provide interprofessional training opportunities and facilitate collaborative practice for health and care workers.
13. Career advancement	**13.1** Planners, with education institutions and regulators, to develop career advancement, education and professional experience pathways for care workers tied to increased compensation. • Employers to create advanced roles for experienced care workers, such as management positions or specialization.

Exit stage	
14. Retention	**14.1** Planners and employers to implement a package of attractive incentives to help retain care workers and to consider, where appropriate, standardized contracts to minimize job insecurity and enhance retention. **14.2** Employers to develop context-specific retention schemes for health and care workers, such as retention bonuses, recognition programmes, lifelong learning and career advancement opportunities, and mental health supports and well-being programmes.
15. International mobility and migration	**15.1** Governments to strengthen adherence to the WHO Global Code of Practice on the International Recruitment of Health Personnel.
16. Retirement	**16.1** Planners and employers to develop retirement plans including flexible scheduling and assignments, mentoring roles for care workers nearing retirement, knowledge transfer to remaining staff and retirement planning services for care workers.
17. Career choice/ career pathways	**17.1** Planners, educators and employers to collaboratively explore "bridging programmes" that facilitate the education and recognition of qualifications of care workers between other occupational groups.

Table 1. Summary of policy options towards strengthening an integrated health and care workforce (continued)

Areas of attention to advance equity	
18. Gender equality	**18.1** Governments to adopt policies that advance gender equality and the empowerment of women and girls in the health and care sector *(12)*.
19. Migrant status	**19.1** Governments to strengthen and enforce ethical, rights-based frameworks governing the recruitment and employment of migrant care workers, including alignment with the WHO Global Code of Practice on the International Recruitment of Health Personnel and its application to health workers employed as care workers in destination countries. **19.2** Planners and employers to implement context-specific support measures for foreign-born care workers, including those in private and household settings, to ensure decent working conditions and promote integration into local communities.
20. Public and private ownership and settings of work	**20.1** Governments to develop and enforce policies that uphold care worker labour rights equally across care delivery settings and employer types. • Ministries to consider developing or strengthening regulatory oversight of private sector employers.

Conclusion

Across all the thematic areas of interest, the evidence and technical advice points to two high priority policy arenas as primary support mechanisms to stabilize and grow the care workforce. First, countries are encouraged to focus on educational oversight as a gateway to workforce development. Second, grounded in the Decent Work Agenda and aligned with the 5R Framework for Decent Care Work – Recognize, Reduce, Redistribute, Represent and Reward *(2)* – countries are encouraged to pursue interventions to improve working conditions, including fair and adequate wages and comprehensive social protection, to strengthen the care workforce.

The policy options illuminate a path forward for countries wishing to better integrate the care workforce into health workforce planning and monitoring. Embedding these priorities within care workforce planning and support efforts will better enable governments to integrate the planning and support of the health and care workforce while advancing labour rights, gender equality and working toward achievement of the 2030 Agenda for Sustainable Development.

Introduction

Health, as defined by WHO, is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Achievement of this vision requires recognizing that health is created not only through health services, but through the daily care and support that enables people to live, function and participate in society. Care, care work and care workers across all settings play an essential role in achieving health for all.

Despite this, health and care remain often separated, planned in siloes, divided across ministries or budget centres and undervalued in resource allocation. This fragmentation weakens workforce sustainability, creates inefficiencies that impact service quality and continuity, and compromises population well-being. As populations age, the burden of noncommunicable diseases rises, disability becomes more prevalent, and budgets stagnate; person-centred integrated care and primary health services capable of efficiently and effectively responding to population needs are essential. This requires workforce strategies that span and integrate both the health and care workforces.

This need for an integrated approach is made more urgent by the unprecedented health workforce shortages countries at all stages of development are facing, a challenge accelerated by the coronavirus disease (COVID-19) pandemic. Health systems across the globe are engaged in planning, monitoring and implementing policy interventions to sustain balanced health workforces that can meet shifting population health needs. At the same time, systems are strained by increasing numbers of people who may need help and routine care in daily life, including older people, persons of all ages with disabilities and people with chronic health conditions. Ensuring that health or health and social care systems can meet these escalating demands requires an integrated, coordinated and forward-looking approach to the health and care workforce.

This requirement can seem elusive and broad: care workers themselves are defined in many ways, sometimes as all workers in the care economy, broadly covering workers in education, childcare, care and support for older persons, persons with disabilities, health care, social work and personal and domestic services *(2)*. This document adopts a health-focused definition, defining care workers as those who provide direct personal care services in the home, in health services and residential care settings, requiring a wide-ranging set of competencies that produce a uniquely valuable contribution within the health and care sector *(1)*. Care work can be paid or unpaid, and globally it is disproportionately carried out by women and girls, often from socially disadvantaged groups *(1)*. Migration also shapes health and care labour markets with migrant domestic workers often providing care services *(19)*. Workers who leave one country to provide paid care in another (typically higher income) country may compound care gaps in their home countries, while the positions these workers fill are often associated with highly precarious working conditions *(20, 21)*.

Recognizing the care workforce as an essential resource within health systems strengthening is an important step. These policy options aim to support countries and planners in better recognizing, valuing and rewarding care workers and advancing towards an integrated model of health and care workforce planning and management.

Purpose of the policy options

The overarching aim of this set of policy options is to inform the planning, management and support of an integrated health and care workforce that seamlessly provides people-centred services across the entirety of primary health care-oriented health systems. This document provides evidence-informed policy options to guide planners' and policy-makers' decisions to strengthen the care workforce.

Government ministries that are often involved in the planning, management and support of care workers include the ministries of health, labour, education, social affairs, finance, planning and development, immigration and foreign affairs, as well as ministries responsible for women's empowerment and gender equality, and ministries of local government.

Rationale

Over recent years, the global health workforce discourse has broadened beyond a traditional focus on health professionals to encompass the wider health and care workforce. As reflected in World Health Assembly (WHA) resolutions WHA78.16: Accelerating action on the global health and care workforce by 2030; and WHA74.14: Protecting, safeguarding and investing in the health and care workforce *(22, 23)*, this signals a growing recognition among WHO Member States that achieving health for all depends not only on clinical services but also on the hands-on daily support of care work.

Despite the essential role of care workers, previous work of WHO largely centred on health professionals and associate health professionals, leaving a normative gap in guidance on the broader care workforce. This gap has become increasingly visible as demographic, social and epidemiological changes heighten the need for integrated person-centred care. At the same time, calls to revalue care work have grown *(2, 24)*, driven in part by the need to address entrenched gender inequalities, including the disproportionate amount of unpaid and low-paid care work undertaken by women and girls *(12)*. Recognizing care work therefore requires engagement with wider policy discussions related to gender equality, economic growth, human rights and structural inequalities related to geography, social class and race or ethnicity. In this context, these policy options seek to strengthen the care workforce and support countries in integrating health and care workforces more fully into planning and management, aligning with global efforts to build more just, sustainable and people-centred health systems. Global policy developments further reinforce the shift towards a more coherent approach to care. The United Nations (UN) system has advanced the 5R Framework for Decent Care Work, a human-rights-based approach grounded in gender equality and social justice. The framework outlines five core policy outcomes:

1. Recognizing care work;
2. Reducing unpaid care work where appropriate and in ways that uphold the rights of care recipients;
3. Redistributing the time, cost and responsibility for unpaid care work among States, the private sector, communities, families and individuals;
4. Representing caregivers (paid and unpaid) and care recipients; and
5. Rewarding paid care workers through decent work and social protection, including for migrant workers – supported through social dialogue, freedom of association and collective bargaining *(2)*.

This holistic framework emphasizes that building equitable, sustainable systems requires embedding labour and human rights in national legislation, policies and budgets, supported by long-term, sustainable investment.

Similarly, the 2025 report of the United Nations High Commissioner for Human Rights on the human rights dimension of care and support (A/HRC/58/43) clarifies States' obligations under international human rights law to respect, protect and fulfil the rights of both caregivers and care recipients, framing care systems as a matter of legal entitlement rather than policy discretion *(24)*.

These developments build on the ILO 2024 policy position which frames care as a universal social necessity governed by rights-based principles, emphasizing both the right to receive care and the right to provide care under decent working conditions *(17)*, as well as the 2025 decision by the Inter-American Court of Human Rights explicitly recognizing care as a human right *(25)*. Taken together, there is growing international alignment around the need for a stronger, more coherent approach to care, grounded in human rights and decent work.

The UN Decade of Healthy Ageing (2020–2030), adopted by the UN General Assembly in 2020, provides a unifying framework that encompasses both integrated care and long-term care as two of its four action areas *(26)*. WHO's progress monitoring indicates that while the proportion of Member States with national policies on comprehensive assessments for older people has grown from 14% in 2018 to approximately 50% by 2025, and those with long-term care policies from 41% to approximately 50%, over a third of reporting countries indicate having no or very limited resources to implement these policies *(27)*. These data highlight the persistent gap between policy adoption and implementation capacity, including in the areas of health and care workforce development and integration.

National and regional contexts

Strengthening long-term care services is already a priority for many countries and regions with direct implications for both the health and care workforces. Countries are adopting a primary health care approach that aims to better integrate the planning, support and management of health and care workers. For instance, the United Kingdom describes an integrated workforce in health and social care as one where staff work collaboratively across organizational and professional boundaries to deliver person-centred, coordinated services that meet individuals' needs. It emphasizes shared ambition, collaborative planning and team-based delivery of joined-up services *(28, 29)*. Similarly, Japan's long-term care insurance system, introduced in 2000, incorporates aligned legislative reform, sustainable financing and health and care workforce regulation to strengthen care systems in the context of rapid population ageing *(30)*. Other countries maintain a more hospital-centric system where health and care systems operate completely independently. Many countries fall somewhere in between.

In August 2024, the Pan American Health Organization adopted the Policy on Long-term Care that promotes investment in long-term care infrastructure, encourages policies that recognize and decrease the burden for unpaid caregivers, and calls for strengthening the formal workforce *(31)*. Across these diverse contexts, a progressive health and care workforce agenda can help identify opportunities for synergy between health and care and strengthen boundaries that promote efficiency and collaboration rather than fragmentation.

Health system perspectives

The world health report 2000 defines a health system as all the organizations, people and actions whose primary intent is to promote, restore or maintain health *(6)*. It explicitly includes home care. WHO promotes a "radical reorientation" of health systems towards primary health care – a whole-of-society approach that addresses most of a person's health needs throughout their lifetime, including physical, mental and social well-being *(10)*. Foundational to WHO's primary health care approach is a continuum of integrated and people-centred health services delivered within and beyond the health sector and throughout the life course *(32)*. As people age, they tend to access both health and care services with greater frequency.

Coordination and cohesion of services across the health and care sectors are important for ageing populations, as are efforts to improve the integration of the workforces providing these services (see Box 1).

Box 1. **Related WHO normative guidance on care for older persons**

In the context of health systems strengthening towards universal health coverage, the Integrated Care for Older People (ICOPE) guidance (second edition) *(33)*, provides practical, person-centred care pathways for primary care and community settings, guiding health and care workers in detecting declines in intrinsic capacity across key domains, as well as assessing carers' needs for support and social care needs. The ICOPE approach is designed to be adapted to each local context and can be implemented by a range of health and care workers, including community health workers. Complementing this, the *Framework for countries to achieve an integrated continuum of long-term care (34)* provides governments and policy-makers with guidance on the key system-level components needed to establish sustainable and equitable long-term care provision, including governance, financing, workforce and service delivery. Most recently, the *Long-term care for older people: package for universal health coverage (35)* offers a comprehensive list of long-term care interventions that all countries could consider, prioritize and integrate within health and social care sectors. Together, these normative products have direct implications for the health and care workforce, as their implementation requires building the capacity of both health and care workers to deliver person-centred, integrated care across the continuum, from community to facility-based settings.

The scale of this challenge is considerable. Approximately two thirds of people who reach older age are likely to need care and support from others to perform activities of daily living at some point *(34)*. The COVID-19 pandemic starkly exposed the vulnerability of older populations and the inadequacy of some care systems: more than 80% of global COVID-19-related deaths between 2020 and 2021 occurred among persons aged 60 years and older *(36)*. Furthermore, unpaid and informal care accounts for as much as 80% of all long-term care provided in the WHO European Region, while formal care services account for the remaining 20% *(37)*. In low-income countries, this share is likely even higher, yet only 16% of low-income countries provide any form of support for unpaid, informal carers *(27)*. These figures underscore the urgent need to strengthen and integrate the health and care workforce to respond to the growing demand for long-term care services globally.

Scope: defining care work and care workers

Care work includes a broad range of personal, social and health-adjacent activities to support people with limited or declining functional ability. Persons may need care services due to ageing, mental or physical illness, or disability. Care work allows individuals to lead meaningful lives as independently and safely as possible and promotes their quality of life. Care is delivered in people's homes, in community settings, in residential facilities and in health-services settings. Care needs can be long-term (e.g. dementia care) or short-term (e.g. rehabilitative and recuperative care).

Care work can be "direct", i.e. help with the activities of daily living such as eating, bathing and dressing. Care work can also be "indirect," i.e. provide support with the instrumental activities of daily living such as housework, transport and attending appointments. While definitions often emphasize basic care needs, activities such as providing emotional support and cognitive stimulation are also important.

Health and care work, whether paid or unpaid, spans formal, informal, household and community settings. The extent to which such work is recognized exists along a spectrum that is shaped by gender norms (see Fig. 1). At one end of this spectrum, unpaid health and care work provided within households remains among the least visible and least measured; it is disproportionately performed by women. Other forms of unpaid health and care work such as volunteering, community service and trainee work get more recognition although they still are not well captured in our economic measures of productivity.

Fig. 1. The spectrum of the recognition of health and care work



Note: Categories of work derived from the 19th International Conference of Labour Statisticians resolution concerning statistics of work, employment and labour underutilization. ILO; 2013 *(38)*.
Source: Fair share for health and care: gender and the undervaluation of health and care work. WHO; 2024 *(12)*.

Box 2. **Fair share for health and care: gender and the undervaluation of health and care work**

WHO's *Fair share for health and care: gender and the undervaluation of health and care work (12)* draws policy-makers' attention to six policy approaches to better value health and care work through gender-equitable investments that help recognize the value of health and care work and drive fairer and more inclusive economies and better health outcomes.

1. **Address the gender gap in care:** Establish care as a right, increase representation of care workers in decision-making, uphold decent work and equal pay for care workers, expand gender-responsive social protection, increase public investment in care services and adopt the 5R Framework for Decent Care Work to recognize, reduce, redistribute, represent and reward care work.

2. **Support gender-equitable labour force participation:** Expand gender-equitable education and career pathways, strengthen labour rights and anti-discrimination laws, ensure access to family planning and gender-balanced leave and flexible work arrangements, remove economic disincentives to women's employment, improve women's leadership and representation, and invest in inclusive infrastructure that enables equal participation in the workforce.

3. **Close the gender gap in earnings:** Equal pay legislation, pay transparency, collective bargaining and compensation for unpaid care work help reduce systemic income inequalities.

4. **Improve working conditions:** Ensure decent work for all, including safe, stable and equitable employment; address harassment and discrimination, informality and non-standard work enhancing overall job quality for care workers.

5. **Strengthen data collection:** Comprehensive, sex/gender-disaggregated workforce data and evidence-informed monitoring improve accountability and support gender-responsive planning and policy-making.

6. **Invest strategically in health and care:** Aligning investments with the Sustainable Development Goals, mobilizing domestic resources, strengthening universal health coverage, and investing in a well-trained, well-protected health and care workforce through progressive taxation, strong public financial management and multisectoral action.

Finally, paid work is the most recognized form of health and care work, but still a hierarchy persists in which more caregiving-oriented roles are highly feminized, often performed in the informal economy (without adequate protections), often undervalued and typically associated with low pay *(12)* (see Box 2 for highlights from *Fair share for health and care: gender and the undervaluation of health and care work*).

Those undertaking care work include a wide and interconnected network of actors spanning both unpaid caregivers and paid health and care workers (see Fig. 2) *(35)*. Unpaid caregivers, such as partners, family members, friends, neighbours and volunteers, often provide the foundation of care, delivering both direct support with daily activities and indirect assistance such as household tasks, transport, emotional support and care coordination, particularly where long-term care systems are limited. At the same time, health and care workers, including domestic workers, personal care workers, community health workers, health professionals and social workers, deliver health and care services across home, community,

Fig. 2. Actors involved in providing care



Source: Adapted from *Long-term care for older people: package for universal health coverage.* WHO; 2024 *(35)*.

residential and health care settings through a range of formal and informal employment arrangements. The boundaries between the caregivers and care workers are often fluid and can vary by country.

As Figs 1 and 2 demonstrate, even if not measured, much of the care work done in societies extends beyond employment. Although this document recognizes and values the diverse forms of care work, the policy options provided are most relevant to the context of employment, including both formal and informal forms of employment.

Table 2 outlines the applicable International Standard Classification of Occupations (ISCO) codes *(39)*.

The International Standard Industrial Classification of All Economic Activities (ISIC) *(40)* also provides globally standardized activity categories for reporting and analysis. ISIC includes the following categories relevant to this work: 86 human health activities; 87 residential care activities; and 88 social work activities without accommodation.

Focus of the policy options

As illustrated in Fig. 1, a substantial share of care work is unpaid. While this document acknowledges the wide range of care activities, the policy options provided here are most relevant to the context of paid care employment, including both formal and informal employment. In alignment with the 5R Framework for Decent Care Work, this document contributes to this agenda by outlining policy actions for strengthening the conditions, protections and visibility of paid care workers.

Accordingly, this document focuses specifically on care employment and paid care workers who provide direct and indirect care to people with needs across the life course due to disability, chronic illness, ageing and/or acute health issues in formal or informal employment in public or private domains.

In doing so, it aims to support coherent policy development that strengthens the integration of health and care employment within broader labour, gender equality, social protection and health systems reforms.

Table 2. Relevant ILO International Standard Classifications of Occupations codes

5321 Health Care Assistants	Institution-based personal care workers who provide direct personal care and assistance with activities of daily living to patients and residents in a variety of health care settings such as hospitals, clinics and residential nursing care facilities. They generally work in implementation of established care plans and practices, and under the direct supervision of medical, nursing or other health professionals or associate professionals.
5322 Home-based Personal Care Workers	Home-based personal care workers who provide routine personal care and assistance with activities of daily living to persons who are in need of such care due to effects of ageing, illness, injury, or other physical or/and mental disability, in private homes and other independent residential settings.
5329 Personal Care Workers in Health Services Not Elsewhere Classified	Providers of routine health and personal care support services not classified elsewhere in Minor Group 532: Personal Care Workers in Health Services. For instance, the group includes occupations such as dental aide, sterilization aide, hospital orderly, medical imaging assistant and pharmacy aide.

Methodology

Refining the scope and methods

This stage included developing a glossary of terms, crafting a shared definition of care workers to be operationalized in the work and discussing possible methods that could be used for a global evidence review. Through this process, realist synthesis review methods were selected in order to prioritize evaluation of workforce interventions in specific contexts to maximize the potential impact of the review.

Realist synthesis review

As the overarching goal of the work is to ultimately inform integrated health and care workforce planning and policies, the original search focused on the concept of "workforce integration". This new concept did not yield many relevant interventions, so the scope was expanded to consider how best to strengthen the care workforce. The final review included 151 peer-reviewed and grey literature sources *(14, 41)*. However, very few sources reported on interventions for the care workforce in low- and middle-income countries, which limits the generalizability of the findings. This and other limitations in the available evidence are described in the section, *Evidence gaps and research agenda*. Findings of the review and details regarding the methodology are publicly available in the published academic article *(15)*.

Advisory Group input

To support this work, WHO created the WHO Technical Advisory Group on Integrating the Health and Care Workforces ("Advisory Group") to provide scientific and technical advice on this topic area. These experts (approximately 30 from 25 countries representing all WHO regions) acted in a personal capacity and did not represent any external entity, authority or government. Declarations of interest were collected, assessed and managed according to WHO policy.

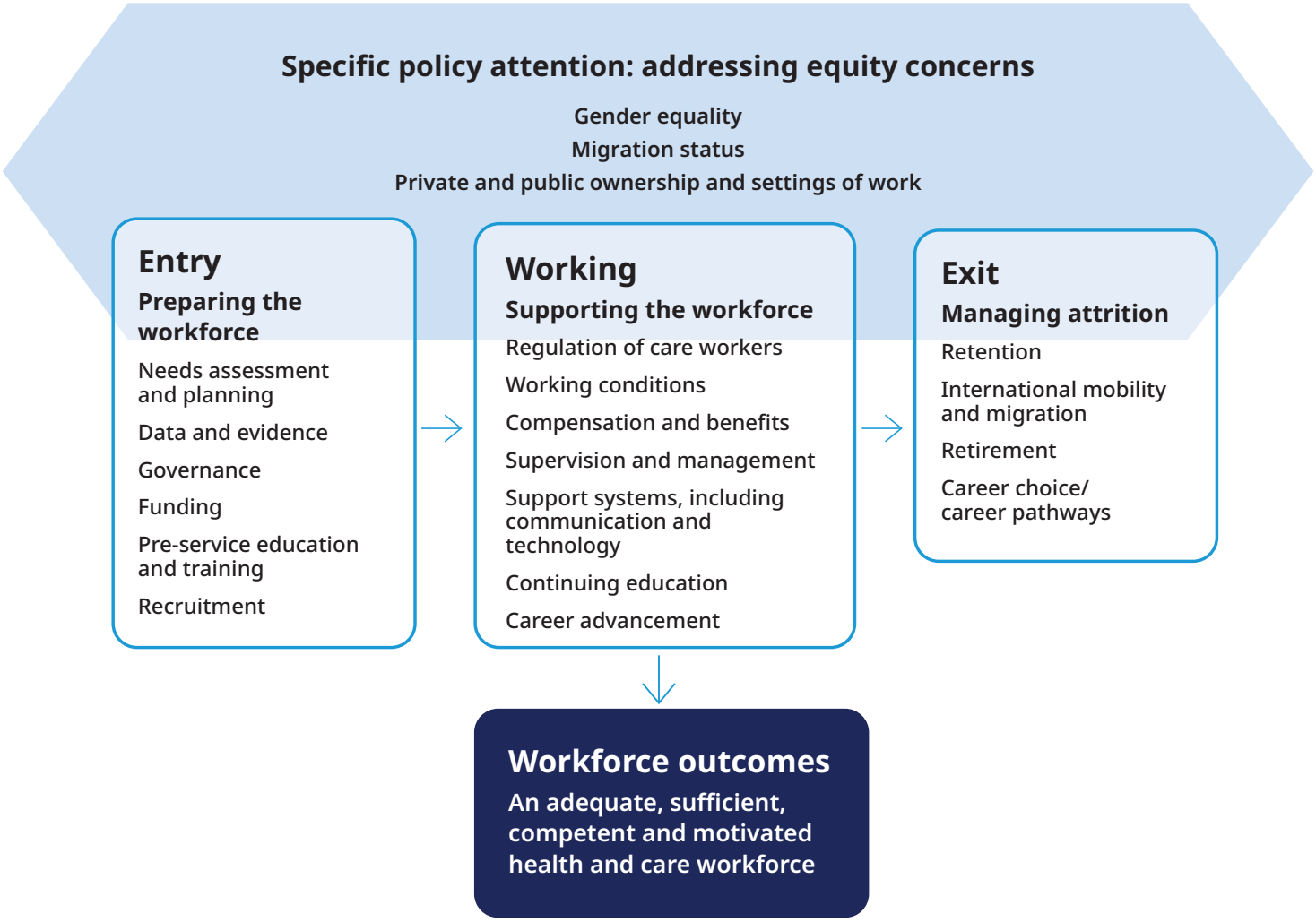
The Advisory Group met early in the process to discuss the scope and advise on definitions, methods and parameters of the review, and later provided input on interpretation of the evidence and evaluated and appraised drafts of output documents. Following publication of the evidence review journal article, the group met for a series of discussions to provide expert counsel on draft policy considerations, most notably where evidence was limited. As such, the policy options presented in this document are based on the findings of the global evidence review, which was primarily limited to sources from high-income countries, and bolstered by the expert opinions of members of the Advisory Group. The Advisory Group deliberated in an iterative, consultative manner and decisions on the scope and contents of the policy options were taken by consensus.

Thematic areas of interest

The policy options provided in this document are framed by the working lifespan model of human resources for health *(16)* (see Fig. 3). The working lifespan model focuses on "strategies related to the stage when people enter the workforce, the period of their lives when they are part of the workforce, and the point at which they make their exit from it". In this model, there are three main stages of workforce planning: entry, working life and exit. The entry stage encompasses workforce preparation, i.e. "strategic investments in education and effective and ethical recruitment practices". The working/supportive stage

addresses concerns related to supporting workers during their active years of employment. The exit stage focuses on managing issues of attrition, international mobility and migration, career choice and retirement. For the purposes of this work, the "lifespan model" is intended to reflect an individual health or care worker who operates under the larger forces of the health labour market *(42)*.

Fig. 3. "Working lifespan" model for human resources for health



Source: Adapted from *The world health report 2006: working together for health*. WHO; 2006 *(16)*.

The policy options are arranged into 20 thematic areas of interest (see Table 3) organized by the three stages of the working lifespan model. Given the pervasive societal attitudes toward caregiving, the policy options also incorporate overarching principles and cross-cutting considerations for policy formulation. In particular, they addresses equity concerns related to gender, race and migration patterns that shape care work globally. Because care workers work across for-profit, nonprofit, and in public, private and informal settings, the policy options also examine how different ownership models influence service quality, accountability, financing and workforce conditions.

Table 3. Brief definitions of the thematic areas of interest

Entry stage	
1. Needs assessment and planning	Population health needs that the care workforce addresses, and physical, social and other needs of care workers
2. Data and evidence	Knowledge requirements for care workforce planning, management and support
3. Governance implications	Governance mechanisms to improve working conditions, enhance workforce performance, and maximize synergies
4. Funding	Financing, funding, transparency and accountability
5. Pre-service education and training requirements	Competency-based education oriented to the needs of care work, and accreditation of education providers
6. Recruitment	Planning for and meeting the growing demand for care services
Working/supportive stage	
7. Regulation of care workers	Extent and approach to regulation of the care workforce, and linkages between care and health sector
8. Working conditions	Government and employer policies regarding safe, healthy and fair working conditions
9. Compensation and benefits	Determination of remuneration and payment mechanisms
10. Supervision and management	Management strategies to ensure adequate motivation, retention, support and supervision of the care workforce in integrated settings
11. Support systems communication and technology	Structures, systems and technology to better support the care workforce
12. Continuing education	Continuing education and training for upskilling and maintaining competence
13. Career advancement	Pathways for care workers to greater responsibility and higher earnings
Exit stage	
14. Retention	Impact of themes and policies on the challenges of turnover in the care workforce
15. International mobility and migration	The movement of persons across an international border to a country of which they are not nationals
16. Retirement	Retirement and succession planning for the care workforce
17. Career choice/career pathways	Options and supports for workers leaving care work, possibly for health work
Areas of attention to advance equity	
18. Gender equality	Equality of treatment and opportunity for women and men, across all aspects of care work and employment, including occupational segregation of the care workforce, especially by gender
19. Migrant status	Issues facing foreign-born care workers in health and care systems
20. Public and private ownership and settings of work	Public and private employment, variations across workplace settings, and participation in the labour market

Policy options

Entry stage: planning the care workforce

1. Needs assessment and planning

1.1 Policy-makers to define the scope of work and job tasks for care workers, relative to health system needs and the optimization of skills mix across health and care service delivery settings.

1.2 Planners to develop human resource strategies that meet population health and care needs in national service delivery models using an assessment of health and care labour market dynamics within country contexts.

Needs assessment refers to the needs of the populations supported by care workers, and the physical, social and other needs of the care workers themselves. The care workforce is an adaptive resource in a health system and is able to respond to changing population health and care needs *(15)*. For example, brief training interventions commonly help the care workforce respond to emerging health issues or new clinical guidelines, especially in interprofessional team environments *(43)*, and care workers are increasingly contributing to dementia care in ageing populations *(44)*.

There is robust evidence indicating that care workers' scope of work expands and shifts as population health needs change, as new guidelines are introduced and/or as new policies are implemented *(45–48)*.

However, there is little consensus of what that scope of work entails and which health and social care needs are addressed by the care workforce. Countries implementing WHO's Integrated Care for Older People (ICOPE) have demonstrated that a variety of health and care workers can effectively deliver initial assessments and care plans, provided they receive adequate training and supervision, with important implications for workforce planning and skills mix optimization *(33)*.

As such, **Policy option 1.1** encourages policy-makers to define and clarify the scope of work for care workers. The Advisory Group indicated that clearly defined job descriptions are fundamental for effective workforce planning, and drew on ILO labour codes and guidance, advising an iterative sequence for workforce planning starting with defining and outlining core competencies. **Policy option 1.2** is based on advice from the Advisory Group, which further articulated that effective workforce planning needs to be sensitive to local and national population needs and must also consider the characteristics of existing labour markets, noting that contextual factors that may need to be factored into workforce planning, such as high stress and burnout among care workers, as well as the preferences of older persons and other care recipients in terms of the services they want (e.g. residential facilities or more in-home care) vis-à-vis current services and setting options.

2. Data and evidence

2.1 Relevant ministries to conduct systematic and routine collection, reporting and analysis of care workforce data aligned with international definitions of care occupations.

- Ministries are encouraged to leverage existing health and care workforce data systems.
- Ministries to strengthen disaggregated health and care worker data reporting and analyses. For example, disaggregation by gender/sex, age, place of birth, place of training, facility ownership and facility type.
- Ministries encouraged to develop or strengthen approaches and methodologies that close data gaps on care work and care workers, by improving data collection particularly in underrepresented areas, utilizing innovative forms of data, and valuing diverse forms of evidence, including qualitative data *(12)*.

2.2 Ministries and planners to consolidate and harmonize terminology for care worker roles and clarify definitions in support of workforce information systems that facilitate health and care services planning.

- Job titles should harmonize with regional educational qualification frameworks.

Data and evidence refer to the knowledge requirements necessary for evidence-informed workforce planning, management and support for the care workforce. The scope includes data collection, mitigation of its absence and knowledge mobilization. The care workforce is difficult to monitor and assess, and there is a wide variety of terms and job titles used across and within jurisdictions. Migrant and immigrant workers can be especially difficult to track, which contributes to their heightened risk of exploitation *(49)*, particularly in contexts that lack clarity around educational credentials and job titles.

The literature commonly describes a lack of reliable data on care workers, and cross-jurisdiction comparisons are very difficult, where possible at all *(50)*. Ministries and planners need to critically assess the current quality of the data and evidence available to them and take steps to ameliorate any deficiencies. **Policy option 2.1** thus highlights the importance of strengthening the information on the care labour force through the systematic collection of high-quality standardized data, collected with appropriate detail and in line with international definitions. Relevant data should be gathered with sufficient frequency to allow for timely assessments.

As noted in the bullets under **Policy option 2.1**, this can be accomplished by including care occupations in existing labour force data tools and using National Health Workforce Accounts (NHWA) platform *(51)* (which includes ILO ISCO definitions) with local, regional and/or national workforce monitoring efforts *(52)*. Furthermore, it is important to have comprehensive workforce data which can be adequately disaggregated to help develop and monitor policy actions and their impacts. The gaps in evidence on care workers highlight the lack of data disaggregated by sex/gender, along with other factors such as age, place of birth or disability. This underscores the need to consider what types of data are required to fully reflect the nature of care work itself which is often not fully captured by existing health information systems; this is especially the case for unpaid care work. Advisory Group members discussed a registration system for care workers, noting issues with feasibility and accuracy of survey methods to capture care workers. Different forms of data and evidence are required, including those that account for unpaid care work in valuing the outputs produced by households *(12)*. Advisory Group members noted the potential for collaboration with academic or research institutions to strengthen data reporting.

There was significant variation in terminology describing care worker titles and roles across the sources collected in the evidence review, and there appeared to be a similar lack of consistency in data collection processes. Competing terminology creates challenges in data harmonization, causes confusion among those needing care, and can lead to misleading credentials and a disordered workforce *(53, 54)*. **Policy option 2.2** calls for consolidation and harmonization of terminology

and for alignment with policy measures for care-related data established by the UN *(2)*. Additionally, the Advisory Group felt certain region-level education qualification frameworks were effective, such as the European Qualifications Framework *(55)* and the ASEAN Qualifications Reference Framework *(56)*.

3. Governance implications

3.1 Governments and policy-makers to establish the legislative and governance infrastructure to enhance stability for the care workforce at appropriate jurisdictional levels.

- Policy-makers to consider using joint governance structures, at all levels, such as interministerial taskforces or "integration boards" to oversee both health and care workforce services delivery and support the integrated workforce.

- Policy-makers to ensure governance structures include representation of care workers and other stakeholders including civil society members and care recipients.

The policy option in this thematic area is based on robust evidence of over 32 sources involving governance requirements to maximize synergies, improve working conditions, and enhance the performance of the care workforce within different health services models.

In the evidence review, governance interventions often focused on addressing health and care labour force challenges *(53, 54, 57)* or on strengthening long-term care systems *(48, 58–60)*, with direct implications for the care workforce, including that the governance structures for long-term care workers may be a different ministry than for health workers. Some studies also examined broader regional and national-level governance mechanisms including minimum wage regulations *(61, 62)* and immigration legislation and labour policies *(63)*.

Policy option 3.1 is based on the results of the evidence review showing that strengthening the care workforce and integrating it into health workforce planning can be enabled by developing clear wage structures *(61, 64)*, educational systems *(65)* and legislative acts *(49, 66)*. The Advisory Group also considered emerging and specific governance structures that support coherent oversight for more integrated health and care workforces *(67)*. **Policy option 3.1** also emphasizes that meaningful representation of care workers and other stakeholders in health system planning and administrative structures is necessary for effective governance *(68)*. The care workforce benefits greatly from collective organizing and collaboration; legislation and other mechanisms that protect workers' rights, specifically the right to organize, will help strengthen the care workforce *(69)*.

4. Funding

4.1 Relevant ministries to allocate adequate resources towards expanding care services and corresponding care workforce stewardship and management.

4.2 Governments to align budgeting and accountability for health and care workforce across ministries of health and social services.

- Governments and planners to explore novel mechanisms, where appropriate, across ministries or departments, including joint commissioning and blended funding models.

This theme addresses service and system funding allocations, challenges, transparency and accountability. Policy options for funding were developed in consideration of widespread documentation in academic and public formats of broadly insufficient financing in the health and care sectors, and funding imbalances between health and care services. More financial allocations will lead to a stronger care workforce, but the challenge remains regarding where to allocate spending. Also, public-private partnership arrangements exist in which care workers are privately employed while their services are publicly funded, including situations where individuals directly hire care workers using public care funds without the involvement of a home care agency or other formal provider.

While recognizing that funds may be limited, and the relevant ministries may differ (e.g. ministries of social development, gender, human rights), **Policy option 4.1** encourages ministries to direct funds into expanding long-term care services in countries experiencing population ageing, disability and/or wishing to improve their overall health and care services. Advisory Group members noted the system in Japan in which funding for long-term care is supported by taxes at different levels of government and long-term care insurance premiums *(70)*. There are suggestions in the broader care literature that directing funds into long-term care may help reduce overall health systems costs *(71)*. It is also important to consider funding availability for care workers in the informal sector, as well as unpaid care work. The need for investing in long-term care workers may be substantial if unpaid care workers are viewed as acceptable "free" labour, without considering the costs to the economy and society by their non-participation in the paid labour market, or considering the implication for the resilience of health systems that are reliant on unpaid care work.

Policy option 4.2 acknowledges that directing funds into long-term care is also supportive for the care workforce, which provides the majority of labour and hands-on support in long-term and community care. Earmarking funds for communication and coordination across health and care systems where these are separate *(72)* and among health and care teams *(73)* may also improve care pathways and reduce the use of more costly health services. Governments often play an important role in establishing working conditions including setting pay in the public settings.

The Advisory Group also agreed that innovative mechanisms may be required to respond to emerging challenges, such as blended funding and pooled budgets in the United Kingdom *(74)*, or the shift to value-based payments for community care providers in the United States *(54)*.

5. Pre-service education and training requirements

5.1 Policy-makers, together with education institutions, to develop standardized educational pathways that result in a formal credential for care workers based on competency-based curricula and that reflect the value of interprofessional learning and collaborative practice.

- Education institutions to consider prior learning and experience in the context of awarding academic credits or credentials.

5.2 Policy-makers and regulatory bodies to establish education standards and accreditation mechanisms (or other quality management approaches) to ensure education programmes meet quality standards.

- With the involvement and support of care workers, policy-makers and regulatory bodies to develop evidence-informed and context specific education and accreditation standards.

5.3 Policy-makers, together with education institutions, to ensure equitable access to care education and training.

This thematic area considered evidence related to competencies required for the care workforce. **Policy option 5.1** encourages policy-makers and educators to develop central resources such as competency-based standards and clear educational levels and/or areas of specialization linked to career pathways *(48, 64, 75, 76)*. Key considerations for the design and delivery of education based on the evidence review include peer mentoring *(77)*, incorporating interprofessional education with health workers *(78, 79)*, and the role of accreditation of education providers *(65)*. The Advisory Group also highlighted that interprofessional education and greater integration between health and care teams may help strengthen the status of care work and lead to improvements in other thematic areas.

Examples included shared modules with nursing, physiotherapy, community health workers and supervised shared practice in community settings.

The evidence for Policy option 5.1 suggested that improved consistency in educational content and requirements substantially benefits the care workforce, assuring common competencies *(80, 81)*, allowing mobility across jurisdictions when accompanied by mutual recognition *(82)*, and increasing the profile and awareness of care workers. It also establishes the significant experience in providing unpaid care work that some students may have.

To support compliance among educators, **Policy option 5.2** suggests countries can consider worker registration and/or certification in tandem with programme accreditation *(50, 83)*. To this point, Advisory Group members discussed useful examples of entry-level education qualification for care workers, such as the certified care worker credential in Japan and the European Care Certificate *(70, 84)*. It is also important to involve care workers, and incorporate the perspectives of care workers and family members (or other unpaid or informally engaged care workers in their settings), in the development of educational interventions and standards.

Finally, **Policy option 5.3** focuses on equitable access to care education and training. Specifically, affordability should also be considered in care worker education programmes, as education is a direct pipeline to recruitment *(81, 85, 86)*. Targeted outreach efforts are encouraged to address inequities related to gender, age, class, migration, civil status and ethnicity by helping students who may need support with the local language, childcare or other needs to begin and complete care worker training. Advisory Group members also discussed the importance of inclusion and accessibility, as persons with disability may be care workers, and considered the usefulness of transition to practice programmes, for example in the situation of care workers in acute hospital settings moving into long-term care.

6. Recruitment

6.1 Governments and policy-makers to provide guidance around national plans to facilitate recruitment by employers and enhance awareness of care work among the public.

- Employers to conduct care worker recruitment according to national (or subnational) health and care workforce strategic plans and to meet population health and care needs, and in observance of applicable global principles of conduct in this area.

- Planners and employers to consider incentive structures and/or collaborate with public employment agencies to increase recruitment of care workers from underrepresented groups and to areas of underserved populations.

6.2 Employers to ensure recruitment is fair and transparent and linked to the relevant education credentials, including the consideration of prior learning and experience.

- Employers to facilitate induction of foreign-born workers into new health systems and care contexts.

Recruitment of new care workers is needed to respond to the growing demand for care services globally, and to fill specific care roles across various settings and communities. The review process sought to identify key elements of recruitment and incentive packages that can facilitate the retention of care workers. Additionally, the review explored how recruitment efforts for care workers can be linked to that of health workers, creating more cohesive workforce strategies across both sectors. These findings were further synthesized by the Advisory Group to arrive at a coherent set of policy options.

Policy option 6.1 is based on the foundational role of national governance to conduct the planning process outlined in thematic area 1 (see *1. Needs assessment and planning*) and address the frequent lack of awareness on

issues related to the care workforce *(12)*, and on the importance of employers using the national plan to conduct institutional planning and recruitment of care workers to meet the local needs. However, planners are cautioned against over-reliance on international recruitment campaigns to expand the care workforce, noting that migrant care workers are at an increased risk of exploitation in receiving countries *(49, 87)* (see *19. Migrant status* for further discussion on this topic).

In discussion, the Advisory Group noted that it is particularly important that care be provided in an equitable and culturally sensitive manner. **Policy option 6.2** calls for fair recruitment tied to educational benchmarks. This reflects the evidence that a clear, affordable and accessible educational system and progression pathway facilitates recruitment *(53, 85)*. Conversely, complicated training landscapes with competing programmes can cause barriers to recruitment *(49)*. The evidence further indicated that recruitment is enhanced by recognizing related credentials for entry-level positions, which could include retired and/or foreign-trained nurses *(88)* and by recognizing knowledge and skills based on experience rather than inserting additional training requirements *(89)*.

Working/supportive stage: enhancing performance and protection

7. Regulation of care workers

7.1 Governments to adopt regulatory mechanisms for care workers that are proportional to the risk of harm to those receiving care services and aligned with the implementation capacity of the country.

The purpose of regulation is to protect the public from harm. Depending on the condition of the care recipient and the environment in which they are served, the risk of harm posed by care workers varies widely. According to the principles of right-touch regulation recommended by WHO, the appropriate regulatory measure is the minimum intervention required to ensure care recipients get access to safe services without facing financial burden *(90)*.

Care workers who provide services to high-needs individuals and/or for specialized services independently pose a different level of risk compared with those serving older adults and those with disability who can make informed choices, are supported by family members or where care workers are under oversight or supervision *(91–93)*. The Advisory Group advised that it may be beneficial to develop appropriate regulations, based on objective criteria, particularly for high-risk settings, taking into account the local context and measures already in place to minimize the risk.

A range of regulatory mechanisms exist to minimize harm, with different levels of resource requirements to enforce it *(90)*. Licensing, registration and certification through statutory regulation require significant resources and are reserved for professions with high risk to patient safety. Risk to the public from care workers can be addressed through non-statutory regulation, which requires fewer resources and is quicker to roll out. This can include one or more of the following: non-statutory certification, voluntary registration, disclosure of quality (e.g. training,

apprenticeships or experience), negative licensing, or employer (or supervisor) responsibility.

Regulatory systems are not static, but undergo reforms based on emerging needs and priorities. Irrespective of the type of regulatory system or intervention, it is necessary to periodically evaluate its effect on patient safety, workforce availability and quality and the cost of services to identify the need for reform. The alignment of regulatory principles for health and care workers as well as for the respective sectors in a jurisdiction will facilitate how the different actors of the health and care sector work in practice, particularly in places that require both health and care workers.

Policy option 7.1 indicates that regulatory regimes should be commensurate with the level of risk and the capacity to enforce the regulations, as described in other thematic areas (see *3. Governance implications, 5. Pre-service education and training requirements, 6. Recruitment*) countries could focus on competency-based standards *(94)*, care worker credentials and accreditation of training programmes *(65)*, registration or certification of individuals *(50, 83)*, and apprenticeships or on-the-job training for entry-level care work depending on the risk assessment and context where care is provided *(90)*.

Determination of entry-level standards and competency requirements should consider the effect on the labour market, on the availability of care workers and the costs to the workers, and to care recipients and the public. Countries can adopt WHO's regulatory practice gap assessment to design the appropriate regulatory structure for care workers in their jurisdiction *(90)*. Having a high barrier for entry-level care work risks reducing the availability of care workers, increases the costs of entry to the worker, and increases the cost of services. However, having no mechanism to check if and how care workers are performing poses a risk, especially if they are working independently, serving vulnerable individuals. The ideal regulatory intervention is one that balances individual safety with worker availability and cost. The requirements for entry and performance of care workers need to be periodically reviewed to assess the costs and benefits, and if the regulatory objectives are being met. This will help address unintended consequences that may arise from regulation and to determine the need to update entry standards.

Additional principles of regulation for health and care workers have been published; some emphasize the importance of moving away from a culture of sanctions and discipline to a culture of support and remediation *(95)*. Recognizing that some countries may be starting from the ground up building such regulatory frameworks, it is important for everyone involved – employers, supervisors, regulators, trainers, and care workers – to use the data on complaints and incidents of patient harm or misconduct to continuously inform, improve and upskill care workers and the patient safety measures to reduce such instances in the future.

8. Working conditions

8.1 Governments to ensure laws and policies prioritize the safety and protection of all health and care workers from abuse, attacks, discrimination including any form of sexual exploitation or abuse, harassment and violence, in line with ILO Conventions and the Decent Work agenda *(17)*.

8.2 Employers to implement measures to prevent and respond to burnout and promote mental health and well-being in the workplace, in line with the Global Health and Care Workers Compact *(18)*.

8.3 Policy-makers should ensure labour rights and the rights to organize, recognizing that care workers are often marginalized and face systematic and societal barriers to collective action.

The working conditions thematic area of interest focused on evidence related to employers' obligations and policy-makers' role regarding safe working conditions and risks faced by workers. The Advisory Group noted the potential challenge of this when care work is performed within or for a household and the relevance of ILO

Convention No. 189 on decent work for domestic workers *(96)*. The Advisory Group considered the evidence found in the review regarding the health and safety of workers (physical and otherwise) and effective approaches for improving working conditions, safety and social protections, as well as routinely noting challenges such as feelings of overwork and burnout, particularly with respect to staffing (or understaffing) and how these issues impact the ability to deliver safe care.

It is widely recognized that health and care workers often face gender and racial discrimination and bias, along with violence and abuse. To address this issue, **Policy option 8.1** charges governments to prioritize the safety and well-being of the health and care workforce in alignment with the UN Decent Work Agenda. In addition Convention No. 189 (Domestic Workers Convention), several other ILO conventions apply: No. 100 (Equal Remuneration), No. 111 (Discrimination), No. 156 (Workers with Family Responsibilities), No. 183 (Maternity Protection) and No. 190 (Violence and Harassment) *(96–101)*.

In the context of the WHO Global Compact for Health and Care Workers, the aims of which are to protect, safeguard and invest in health and care workers worldwide to strengthen resilient, equitable and sustainable health systems, the Advisory Group advised on **Policy option 8.2**, which also reflects sources in the evidence review that documented that training and/or counselling activities aimed at improving the overall well-being and emotional and mental health of health and care staff were well-received by care workers *(102–106)*. Educators may also consider basic pre-service training targeted to avoid high-risk harms in care work (e.g. back injury) and support for unavoidable harms (e.g. the death of a client, charged emotional situations) *(47, 107)*.

Drawing on the evidence review, ministries and employers are encouraged to pilot varied compensation models (see *9. Compensation and benefits*). At the organizational level, the care workforce can also benefit from more secure working arrangements *(49, 63, 69)*, particularly stability and predictability of schedules and working hours *(108, 109)*. Interventions related to working conditions should ideally include care workers in their design and testing to address variation across the needs of workers based on multiple factors such as employer type, role and workplace setting, and personal life stage *(50, 110–112)*.

In terms of material working conditions such as wages and job security, there is widespread recognition of low pay and precarity associated with many care worker positions *(63, 66, 86, 110)*. Unfortunately, there are limited examples of interventions effectively tackling these core issues. **Policy option 8.3** encourages countries to adhere to labour rights as outlined by ILO, particularly the right to collective action to help address these core issues.

9. Compensation and benefits

9.1 Governments to ensure decent work (as defined by ILO), which encompasses adequate, fair and equitable pay for care work, commensurate with levels of responsibility and risk, level of training, and consistent across all sectors, including minimum standards that apply to private service delivery sectors.

- Governments to encourage transparency in wages, payment models and benefits in the private sector employing care workers, including equal renumeration in line with ILO Convention No. 100.

9.2 Employers should include care workers in benefits such as health insurance, pension schemes, paid leave and occupational health benefits.

In addition to overarching working conditions (thematic area 8), this thematic area of interest considered specifically how remuneration for care workers is determined and sought evidence related to payment mechanisms.

Apart from adherence to national or regional minimum wage legislation, pay for care workers is often unregulated and is more likely to be informal than in health employment. In addition, care work

is generally undervalued, given the pervasive attitudes towards caregiving and reproductive labour, based on harmful gender norms *(12)*. As a result, pay for care work tends to be low, is often inconsistent across contexts and employers *(113)*, and is associated with precarity including unpredictable hours, low job security and a lack of standard employment benefits (*54, 61, 114–116*).

Policy option 9.1 recognizes that consistency in the pattern and distribution of wages is vitally important to ensure equity and to improve retention and reduce turnover *(62, 112)*. The policy option reflects the ILO foci on principles of adequacy, regularity, fairness and equal remuneration for work of equal value.

Pay scales should transparently reflect the level of responsibility and specialization required, such as premiums for supporting high-needs individuals, for expertise in a given area of care such as dementia care or palliative care, or for taking on leadership or managerial roles *(47, 76, 77)*. As noted in Policy option 9.2, pay scales should ideally be stratified according to training and professional development milestones *(117, 118)*, and care workers should be included in employment benefits packages, e.g. sick leave, family leave, etc. *(64, 114)*.

10. Supervision and management

10.1 Employers to optimize supportive supervision and management of care workers, including enabling peer support models across the entire working life of care workers.

- Employers, policy-makers and planners to optimize opportunities for integrated supportive supervision of health and care workers through shared codes of conduct, interdisciplinary collaboration and communication protocols, and interdisciplinary training and professional development opportunities.

10.2 Employers to ensure the perspectives of care workers are represented in workplace support and management systems, such as on institutional decision-making bodies and committees, through promotion of collective bargaining rights, and by establishing institutional feedback and grievance mechanisms.

Supervision and management refer to management strategies that are beneficial for motivation, retention, support and supervision of the care workforce. The policy options in this theme are mostly applicable at the organizational or service provider level.

Policy option 10.1 affirms that leadership styles that are open to emerging evidence *(119, 120)* are crucial for creating a positive work environment. Assessing and improving leadership and management skills also facilitates the implementation of workforce interventions ranging from localized efforts *(73, 121, 122)* to system-wide transformation *(123)*. Peer mentoring is also highly effective among care workers *(47, 76, 77)*, often leading to increased confidence, self-efficacy and a sense of empowerment.

The Advisory Group noted the importance of supportive supervision, distributed leadership and management of care workers throughout their careers, which can be fostered through coordinated policies, opportunities with other health and care workers and ongoing professional development.

It is well established that listening to worker concerns and allowing them fair representation leads to better working conditions. Indeed, the meaningful engagement of all types of workers is a prerequisite for a positive work environment *(102, 123)*. **Policy option 10.2** calls on employers to ensure that the voices of care workers are both heard and responded to within and across all organizational processes and policies. Work in related fields have reinforced the importance of this aspect to job satisfaction *(124)*, though Advisory Group members noted that not all countries have such structures in place.

11. Support systems including communication and technology

11.1 Planners and employers to ensure adequate technological and other support systems to enable effective performance and development of care workers.

- Employers to harness appropriate technology and provide training on and access to interoperable digital tools and platforms that facilitate service delivery, with considerations for equity and inclusivity.

11.2 Planners and employers to ensure, where applicable, that referral systems provide necessary links between health facilities and community-based care settings, and that supply chains effectively serve both health and care settings.

This thematic area of interest considered what structures, systems and practices are required to better support the care workforce. Interventions in this theme often reported on the use of technology and information sharing.

Policy option 11.1 acknowledges that improvements in information sharing and communication can support the care workforce and improve referral mechanisms *(125–127)*, particularly patient and client transitions between hospital, residential care, and home and community care settings *(111, 128)*. The sources had mixed results on whether a range of other technological advances were beneficial or not from the perspectives of care workers *(53, 126, 129, 130)*. It was noted by the Advisory Group that care workers in low- and lower middle-income countries may be more likely to be informally contracted or self-employed, and thus may rely on government support to access digital technologies and training and to address their needs for digital health literacy.

Assistive technology and medical devices can reduce the physical and time burden on care workers – from manual equipment such as hoists, toilet chairs or transfer boards, to advanced robotics. Telehealth, where appropriate, can improve access to remote care. However, the provision of both assistive technology and telehealth solutions must be accompanied by training *(131)*. Countries and organizations are encouraged to carefully consider unintended consequences when implementing new technologies such as GPS tracking, remote surveillance, robotics and artificial intelligence. The Advisory Group also considered lessons learned in the health professions to recommend interprofessional hubs for training, research and piloting service innovations, and noted that intersectoral collaboration can support the care workforce and enhance integration with other systems *(72, 73, 125, 132, 133)*.

Policy option 11.2 reflects issues that arose during the COVID-19 pandemic (early 2020s), which, Advisory Group members noted, could apply to armed conflict and natural disasters, and which highlighted the need to coordinate supply chains across health and care settings. It was noted that the timely transfer of information and care from secondary levels of health settings/ hospitals to care homes and communities can improve the ability to deliver appropriate standards of care in care homes and communities. Advisory Group members also emphasized that integrated supply systems are essential for supporting an integrated health and care workforce, as the health and care workforces cannot work together effectively when supply chains remain disconnected.

12. Continuing education

12.1 Employers to provide continuing education opportunities for all care workers, building on pre-service education and linking to career advancement, when possible.

- Education institutions and employers to reflect best practices in training programmes in terms of teaching and learning methodologies, as well as accessibility and equity with consideration to migrant status, childcare responsibilities, language barriers and rural residence.

- Education institutions and employers should provide interprofessional education opportunities and facilitate collaborative practice for health and care workers.

The lifelong learning thematic area of interest encompassed professional development and on-the-job training for upskilling and maintaining competence, as distinct from training required prior to entering the workforce. In developing these policy options, the Advisory Group considered interventions needed to help maintain and expand care worker skills in an integrated workforce context.

Much of the evidence for this thematic area overlapped with the findings related to pre-service education. Like pre-service education, the preferred pedagogical approach emphasizes in-person or blended learning for skills and competencies *(134)*, noting that a series of training sessions rather than a single workshop tends to be more effective at scaffolding and enhancing learning *(120)*. Advisory Group members also noted that digital and hybrid learning opportunities can improve equitable access. As such, **Policy option 12.1** encourages employers to provide lifelong learning opportunities, and explicitly make links across pre-service and ongoing professional development. Advisory Group members noted that, linked with thematic area 11 on technology, continuing education and training may be needed to enhance digital and technological literacy. Training programmes of any kind should be inclusive and consider other contextual factors important to workers, such as costs, transportation, childcare, language support and other factors that may cause barriers to participation *(76, 81, 85, 135, 136)*. Linking lifelong learning to a career ladder or a wage step is a promising model to encourage participation *(77, 118, 137)*. Interprofessional training for ongoing and professional learning has major benefits including enhancing collaboration across organizations and facilitating workforce integration *(79, 119, 133)*.

13. Career advancement

13.1 Planners, together with education institutions and regulators, to develop career advancement, education and professional experience pathways for care workers tied to increased compensation.

- Employers to create advanced roles for experienced care workers, such as management positions or specialization.

The career advancement thematic area of interest refers to opportunities for greater responsibility for care workers.

Policy option 13.1 acknowledges the strong connections between career advancement and educational frameworks that link credentials with opportunities for advancement. Developing routes for career advancement tied to increased compensation is a promising intervention for the care workforce *(54, 57, 69, 118)*. Advisory Group members noted that career advancement pathways could be from entry level to more advanced care roles or to supervisory positions, and that educational pathways could lead to nursing or therapy roles. Advisory Group members also discussed education and career progression which could include pathways for higher qualifications, developed together with universities and health sciences institutions, and the example of the career pathway in Japan involving care managers and chief care managers *(138)*.

Developing additional roles can be effective and meaningful for care workers while also improving care quality. The evidence review provided a few examples of advanced roles for workers with more experience and/or training, including peer mentor, team leader or manager, and specialization such as in dementia care *(72, 77, 121)*. Additional examples of specializations might be in rehabilitation assistance, palliative care or community health support, depending on the context and need. Employers are encouraged to develop opportunities for advancement for care workers that align with their organizational needs.

Exit stage: managing attrition

14. Retention

14.1 Planners and employers to implement a package of attractive incentives to help retain care workers and to consider, where appropriate, standardized contracts to minimize job insecurity and enhance retention.

14.2 Employers to develop context-specific retention schemes for health and care workers, such as retention bonuses, recognition programmes, lifelong learning and career advancement opportunities, and mental health supports and well-being programmes.

This theme incorporates the impacts of other themes and policies on the challenging issue of care worker turnover, with the goal of enhancing retention of the care workforce. In harmony with the policy options outlined in many of the preceding themes, poor working conditions and negative perceptions of care work are believed to be driving factors for care worker turnover and retention problems in multiple contexts around the world *(49)*. Care work can also lead to burnout based on various factors including understaffing, moral distress, and violence *(104, 107, 109, 139)*.

Policy option 14.1 encourages planners and employers to work towards improving the conditions of care work, including increasing wages (see *9. Compensation and benefits*), intervening to improve staff scheduling *(140, 141)*, supporting efforts towards collective bargaining *(69, 86)* and implementing other job re-designs/improvements to promote retention. This "package of attractive incentives" has been found effective in recruiting and retaining health workers in rural and remote areas *(142)*. The Advisory Group also noted the importance of job security to enhance consistency and permanency within the care workforce and how job insecurity is often greater for informally contracted and self-employed care workers.

The Advisory Group discussion underscored that important aspects of decent work can sometimes be absent in the care industry, and developed

Policy option 14.2 indicating that, as a minimum, planners should enforce basics such as seniority payments and pay increases at regular intervals. Employers and planners are also encouraged to recognize that the typical career lifespan of a care worker may be shorter and/or more varied than that of a health professional. Much of the evidence captured within the four preceding themes also tended to show indications of improving retention (see *5. Pre-service education and training requirements, 10. Supervision and management, 12. Continuing education, 13. Career advancement*).

15. International mobility and migration

15.1 Governments to strengthen adherence to the WHO Global Code of Practice on the International Recruitment of Health Personnel including by extending its provisions to health personnel practising as care workers in destination countries.

This theme considers international mobility and migration of care workers, in light of the WHO Global Code of Practice on the International Recruitment of Health Personnel *(143)*.

The *Report of the Expert Advisory Group on the WHO Global Code of Practice on the International Recruitment of Health Personnel (EB158/17) (87)* states that international mobility among personal care workers is increasing, and that when large number of health workers are recruited as care workers, the source country health system bears the impact. This approach may also exacerbate inequities in source countries that may already face health workforce shortages. It can also lead to deskilling of health workers when employed as care workers. The underutilization of skilled health workers is a loss of human capital.

Policy option 15.1 reflects the recommendation by the global Expert Advisory Group that the Code provisions apply to health workers in source countries who are employed as care workers in destination countries *(87)*. Policy options include ethical, legal and institutional frameworks to support international cooperation, with particular attention to the human resources for health situation in low and lower middle-income countries.

16. Retirement

16.1 Planners and employers to develop retirement plans including flexible scheduling and assignments, mentoring roles for care workers nearing retirement, knowledge transfer to remaining staff and retirement planning services for care workers.

The retirement and succession planning thematic area of interest explored the topic of retirement and succession management in the care workforce.

The issue of care worker retirement has lacked attention and there is a dearth of existing policies or plans that address this issue. As such, the Advisory Group noted that there are few examples of policies in place to support workers as they transition out of work. **Policy option 16.1** reflects the need for planners and employers to consider issues of retirement as a part of basic organizational planning. The evidence review showed that older workers have differing needs that influence their ongoing involvement in care work as compared with younger workers, such as needing more flexible schedules or reduced hours *(144)*. It is important that all levels of authority seek to identify the many untapped opportunities to capitalize on the lifelong learning, resourcefulness and commitment of older care workers. Advisory Group members noted that some countries may have laws on retirement age that could limit employer policies, until governments undertake processes to review the social security laws or/and relevant legislation to address health workers retirement conditions through flexible provisions.

17. Career choice/career pathways

17.1 Planners, educators and employers to collaboratively explore "bridging programmes" that facilitate recognition of the qualifications of care workers across related occupational groups and professions.

The career choice thematic area considered evidence related to options and supports for workers leaving care work and pathways that link the care workforce with the health workforce. Career choice/career pathways relate strongly with policy options related to thematic area 13 (see *13. Career advancement*), but differ in that the focus is on integration across the care and health sectors. Advisory Group members discussed the usefulness of transition to practice programmes, e.g. for care workers in acute hospital moving into long-term care.

The review process sought interventions that targeted support for career-related choices and found a few examples of care work as an entry-level position, with educational milestones and qualification levels applied towards nursing training *(145, 146)*. There were also a few examples of interprofessional education interventions that were enhanced when care workers were included as peer mentors and/or peer trainers *(76, 77, 120)*. **Policy option 17.1** was refined and developed based on these example interventions with the additional expertise of the Advisory Group who drew on established modes of support for career pathways in the health professions and other occupational areas. "Bridging programmes" here refer to programmes designed to help workers transition from one field to a related field. Based on these foundations, it is apparent that bridging programmes represent a highly promising opportunity to further the integration of the care and health care workforces.

Specific policy attention to address equity concerns

In addition to the preceding thematic areas based on the working lifespan framework for health and care workers, given the pervasive societal attitudes toward caregiving, this document also incorporates overarching principles and cross-cutting considerations for policy formulation. In particular, it addresses equity concerns related to gender, race and migration patterns that shape care work globally. Because care workers work across for-profit, nonprofit, and in public, private and informal settings, the policy options also examine how different ownership models influence service quality, accountability, financing and workforce conditions.

18. Gender equality

18.1 Governments to adopt policies that advance gender equality and the empowerment of women and girls in the health and care sector *(12)*.

Women provide the bulk of care work, whether paid or unpaid, and this situation is understood as implicit in the low pay and undervaluation of care work. Although the evidence review failed to identify evidence of interventions aimed at gender equity for the care workforce, **Policy option 18.1** directs governments to draw on WHO's *Fair share for health* and care *(12)*; the UN System Policy Paper on transforming care systems *(2)*; and the myriad relevant ILO Conventions previously cited to strengthen the recognition and rewarding of health and care work.

This policy option builds on long-standing international commitments, including the Universal Declaration of Human Rights *(147)* and the Convention on the Elimination of All Forms of Discrimination against Women *(148)*, ILO Convention No. 156 *(99)*, the Convention on the Rights of the Child *(149)* and ILO Convention No. 189 *(96)*, which have progressively affirmed care as essential to human rights, gender equality and decent work. It reflects decades of global policy evolution including the 1995 Beijing Declaration and Platform for Action *(150)*, the ILO's 5R Framework for Decent Care Work *(1)*, the UN Secretary-General's *Our common agenda (151)* and the UN Human Rights Council resolution on the centrality of care and support from a human rights perspective *(152)*, which collectively recognize both paid and unpaid care as foundational to social and economic well-being and call on governments to embed these principles in national policy.

The WHO's *Fair share for health and care (12)* draws policy-makers' attention to six concrete policy levers to better value health and care work through gender-equitable investments that help recognize the value of health and care work and drive fairer and more inclusive economies and better health outcomes. All six of the recommendations outlined in *Fair share for health and care* are highly applicable to this set of policy options (see Box 2). Advisory Group members discussed the potential effectiveness of policies to encourage greater participation of men in care work and to dispel harmful stereotypes about gender roles in care work, and care work as "low skill".

19. Migrant status

19.1 Governments to strengthen and enforce ethical, rights-based frameworks governing the recruitment and employment of migrant care workers.

19.2 Planners and employers to implement context-specific support measures for foreign-born care workers, including those in private and household settings, to ensure decent working conditions and promote integration into local communities.

This policy option relates to policy option 15.1 regarding the recommendation by the global Expert Advisory Group to extend the application of the WHO Global Code on the International

Recruitment of Health Personnel, to health workers employed as care workers in destination countries *(87)*, but with a focus on enforcement of rights in alignment with international labour standards and human rights obligations.

Immigrant, especially migrant, care workers, and particularly women, remain disproportionally exposed to exploitation and marginalization *(49, 82, 86, 153)*. **Policy option 19.1** reflects the clear and growing need to revalue care work, address entrenched gender inequalities, and to uphold international human rights, including protections articulated in the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families *(154)*. This includes addressing discrimination, ensuring decent working conditions, including equal pay, and strengthening mechanisms for redress and accountability *(112)*, and accordance with various ILO Conventions (see *8. Working conditions*).

Policy option 19.2 reflects the discussion by the Advisory Group around how planners and employers can implement appropriate and community-specific supports for foreign-born care workers, for example, a comprehensive induction programme to help individuals better understand the new health systems and facilitate integration into local communities. Such measures should include access to language training, orientation to local systems and rights, mechanisms for reporting and addressing exploitation, and initiatives that foster social inclusion and community engagement.

20. Public and private ownership and settings of work

20.1 Governments to develop and enforce policies that uphold care worker labour rights equally across care delivery settings and employer types.

- Ministries to consider developing or strengthening regulatory oversight of private sector employers.

This theme reflects differences between public and private employment and variations in care work settings. The market for care services in most countries is quite diverse and complex. Health and care services are delivered through a wide variety of ownership and governance models, which complicate efforts to capture a coherent overall picture of both a country's health and care service provider organizations. Provider organizations may include public institutions (delivering public services), non-profit organizations (which may be fully, partially or not publicly funded) and for-profit organizations (which may be publicly contracted or operating partially or entirely on the private market). There is also broad variation in work settings including households, in day programmes and community settings, in retirement communities, in long-term residential settings and in the context of acute health services. This thematic area sought evidence related to documenting how ownership type and workplace setting relate to working conditions and how to mitigate unequal labour conditions.

Policy option 20.1 underscores the importance of greater consistency and better job security for care workers, regardless of ownership type and workplace setting, which may involve stronger legislative frameworks, setting wage floors, improving working conditions and developing enforceable reporting mechanisms *(49, 63, 112, 114, 125, 155)*. Evidence also suggests that turnover and retention can be higher in private for-profit service provider organizations due to issues of higher job insecurity and lower pay *(156, 157)*. Advisory Group members also discussed regulation and oversight of households as employers of care workers.

Evidence gaps and research agenda

The evidence review on the care workforce provided robust information on a number of important thematic areas of workforce planning and management; however, there are various topics that lacked a sufficient knowledge base. The following section outlines these evidence gaps and provides suggestions for a future research agenda.

Conceptual gap: a global definition of health and care workforce integration

Noting the operational definition of an integrated health and care workforce applicable to this document (see *Glossary*), there is no structured and harmonized global definition of health and care workforce integration in the published literature. There are definitions of related terminology, such as *integrated care* referring to a process of coordinating health and care services for an individual to improve efficiency and patient outcomes and *integrated services*, referring to a system with overlapping service programmes. While this document introduces a framework and operational definition of integration of health and care workforces, a formal definition will need to be recognized for a more coherent global approach.

Evidence gap: low- and middle-income countries

Primary research and intervention piloting are needed to expand the evidence base in low- and middle-income country settings. There were very few sources reporting on workforce interventions for the care workforce in low and middle-income countries. Cross-country and regional comparisons would be particularly beneficial for building the evidence base.

Evidence gap: consensus in terminology

There remains an extensive list of terminology used to refer to care workers, with one review documenting 37 titles in use *(158)*. As such, there is a need to map care worker terminology and categorization vis-à-vis recognized frameworks, and for constructive recommendations for improvements to national and international occupational classifications for care work.

Intervention gap: transformative interventions

There are a number of areas of workforce planning and management that require experimentation and piloting. Interventions may be more effective if they aim at a combination of pre-service training, wage models, scheduling solutions, educational oversight, career ladders and interprofessional teams. Additionally, there is a need for more research on how these workforce interventions impact care processes and outcomes; such evidence strengthens the case for the replication and scale-up of promising interventions.

There is a longstanding need for interventions that harmonize and standardize data collection at national levels and allow for disaggregation to inform policy and planning at local levels. The evidence review also found a significant gap in interventions targeting equity outcomes such as gender and racial segregation. It also appeared that integrated training may be highly beneficial by helping to improve the recognition of care work and provide opportunities for advancement for those providing direct care *(159)*.

Conclusion

Integrating health and care workforce planning is an emerging topic – and for integration to be successful the care workforce should be strengthened. While this document includes many policy options, the evidence points to two high-priority policy areas to stabilize and grow the care workforce and enhance integration between the care and health workforces. First, stronger governance of education approaches can facilitate health and care workforce integration; and second, improving working conditions and wages to strengthen the care workforce.

Strengthen education and training

Governance of the education and training of the care workforce has high potential to advance health and care workforce integration. Policy actions could include low-cost or free training to enhance accessibility and align with intersectional and equity-informed approaches. Interventions that clarify entry requirements and provide central resources for educational providers are supportive, as is establishing competency-based standards tailored to a country or regional context. Health and care workforces can be better integrated when their training is more integrated. As such, connections and partnerships between care and health workforce training institutions are likely to have multiple positive impacts, including developing respect across work roles and disciplines.

Interventions that accredit, evaluate and formally recognize individual educational programmes and/or create a worker registry based on graduation lists can help employers and students navigate complex educational landscapes and enable better data collection on the care workforce. Finally, this analysis identifies that it would be beneficial for care workers if education providers were to establish add-on credentials after graduation, allowing for career advancement opportunities, either through specialization or leadership training, and via educational and practical linkages with caring and health professions such as social work and nursing.

Improve working conditions, including wages

Improving working conditions and pay scales for the care workforce is another important policy area, and a vital step for strengthening the care workforce. It is essential to ensure that care work is decent work that "*provides security in the workplace and social protection for workers and their families; offers prospects for personal development and encourages social integration*", as well as a fair income *(1)*. Improvements in these areas will help challenge the social devaluation of gendered work, bolster efforts to promote the recognition of both paid and unpaid care work, support the health and well-being of paid care workers and, ultimately, strengthen the overall care workforce.

In conclusion, although there is growing international acknowledgement of the contributions of care workers, it is essential to understand the evidence to inform the policy steps needed to advance integrated health and care workforce planning. To better integrate the care and health workforces, the status of care must be raised with the recognition that care work has a foundational role in health service delivery. A lack of consideration of the vital contributions of the care workforce can undermine workforce planning efforts and add strain to health services and systems.

It is hoped that the findings of the international evidence review, and the resulting policy options, will help countries consider how to best integrate the care workforce into health workforce planning and policy development.

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