



healthclusternet

Europe's health economies exchange

HCN Report 3

How the health sector can contribute to regional development:
the role of inclusive and attractive employment

Authored by:

Jonathan Watson, Executive Director, Health ClusterNET.
Patrik Nordin, Researcher and Consultant for State Provincial Office of Southern Finland
Sanna Markkanen, School of Sociology and Social Policy, University of Leeds, UK.

Many thanks are due to all the participants and organisers (Antero Heloma, Head of Unit at the State Provincial Office of Southern Finland, Juuso Nieminen, Riina Utriainen in Hameenlinna, Peter Szekeres of Baranya County Council and Pecs University in Pecs and Margit Ohr, Network Coordinator) who attended the Hameenlinna Workshop and the Pecs Policy Forum. Special thanks are given to the invited speakers and commentators at both events, namely:

- | | |
|---------------------|---|
| ▪ Jouko Isolauri | Senior Ministerial Adviser, Ministry of Social Affairs and Health |
| ▪ Eveliina Pöyhönen | Project Manager, STAKES, Finland |
| ▪ Ismo Suksi | Project Manager, VETO Programme, Finland |
| ▪ Tuomo Alasoini | Director, National Workplace Development Programme TYKES |
| ▪ Antonella Noya | Project Manager, OECD/LEED Social Innovation Forum |

The opinions and recommendations contained in this report represent the collective view of Health ClusterNET partners and external experts. They should not be taken to represent the views of individual partner organisations, ONE North East (the lead partner) or the Interreg IIIC Programme.

© Health ClusterNET 2007

For further information:

Visit our website	www.healthclusternet.eu
Email our Network Manager	Margit Ohr ohr@policy.hu
Email our Policy Officer	Edit Sebestyen edit@healthclusternet.eu

Executive summary

Introduction

The purpose of this report is to present the knowledge and experiences shared by partners that explored how the health sector can contribute to regional development through its employment activities.

Who should read this report

- For **health service decision makers** this agenda shows understanding that workforce decisions need to address the move from acute illness to chronic preventable conditions as the third 'age' of health care across European regions. This shift will need (i) cross-sectoral service delivery designed around the needs of patients, carers and families (ii) investment in technologies that minimise hospitalisation. It also supports the development of the corporate social responsibility role of your organisations and also shows your commitment to the health inequalities and health improvement agenda.
- For **local health organisations** such as acute hospitals and primary care organisations, this agenda helps show your commitment to joint working with local government and other partnerships to develop fully engaged communities at both individual and organisational levels in service delivery and quality of preventable and minimised affordable care.
- For **regional governments**, evidence suggests that health care workforces are best managed where there is considerable local autonomy in decision-making, coupled with clear accountability to a region's population. Overall, the partner case studies indicate that regional health bodies should develop and maintain expertise in anticipating future health demands, understand how to manage relations with other private or public sector providers, and become proficient in speaking the language of the central Finance Ministry.
- For **SMEs**, the adoption of this agenda in your region or community, offers a clear basis for lobbying for simpler, more transparent procurement processes with less bureaucracy and the development of an enterprise aware culture in health service organisations. In turn, this can contribute to the indirect regional employment impact of the health sector.
- For relevant directorates within the **European Commission** (DG Enterprise, DG Employment, Social Affairs and Equal Opportunities, DG Research, DG Regional Policy, DG Health & Consumer Protection), this agenda offers a platform for an approach that cuts across individual DG competencies in order to achieve European added value.

Key messages

Within partner regions, spending by health services on staff, goods & services, buildings, IT and equipment ranges from 6 to 9% of regional GDP. This is a significant level of economic activity. But it is not optimised to positively contribute to regional development agendas. Nor is it used to maximise the population health benefit of health care expenditure.

If health care employment policy and practice is to contribute to regional development then our workshop, case studies and policy forum identify a number of key messages:

- Where regions have been given responsibility for decisions in any of the basic elements of health care - public health, primary care, rehabilitation services, acute hospitals, mental health – it is vital that they also have the autonomy to plan, finance, and implement solutions to health care needs.
- When thinking about employment and how best to invest in the workforce, it is important to take an integrated approach (see Fig. 1). In other words, investment in the workforce should be considered in the context of shifts in service provision, the needs of other sectors (e.g. social services, community care, regional training and skills development), developments in technology, and broader societal values.

- The health landscape has common elements across regions (cost increase, the move from acute to primary care), but governance, politics, professional and power relationships can vary greatly.
- Differences in employment policy between and within countries make it unlikely that case models can be simply transferred; the key is to understand the principles and processes that lead to success (or lack of success).

Case study examples

Inclusive employment in Alentejo

Alentejo suffers from a lack of adequate health human resources. In particular, addressing workforce needs for continuous healthcare services are critical. Investment in the training of professionals for continuous healthcare services is a priority in Portugal and Alentejo. It contributes to social inclusion in two ways (i) a patient's inclusion in their own environment, avoiding the negative effect of being institutionalised (ii) there is the employment opportunity that continuous healthcare services means for those who have lower academic qualifications, especially women, with difficult integration in the labour market. Specific investment has been made in the development of *geriatric assistants* and *family and community support assistants*.

The *Family and community support assistant* is the professional which, in an autonomous way or under the orientation of a specialized technician, executes basic task of human care to clients at home or in an internship or semi-internship situation in specific institutions such as elderly homes. The acquisition of relevant competences is achieved through the following modules: *basic human and health Care; hygiene and comfort; nutrition and meals confection; behaviour management*.

The *geriatric assistant* is the professional who supports elderly care: mental, physical, social and spiritual. The acquisition of relevant competences is achieved through the following modules: *Elderly accompanying and animation; elderly home support; elderly accompanying and animation in homes and day centres; elderly care in health institutions*,

The receptivity of the labour market to these professionals is a tool for social inclusion by means of employment for a group that, by its characteristics, confronts difficulties to work in a region with the higher female unemployment rate of the country and where 39% of the unemployed population has less than the minimum compulsory education.

MediNet Berlin – strengthening initial vocational training facilities

“MediNet Berlin - Vocational Training Network in the health economy” is a project funded by the Federal Ministry of Education and Research within the framework of the new nationwide "JOBSTARTER - Training for the Future" programme. The programme aims at a better regional supply of in-company training places for young people. It strengthens regional responsibility in the field of vocational training by providing support in networking regional structures so that synergies can be used at best. “MediNet Berlin” helps to secure the procreation of qualified employers in the expanding market of the health economy in Berlin concerning the impending demographic lack of young school leavers in the next years.

The goals of MediNet Berlin concerning initial Vocational Training and Qualification as a strategic field of action are

- Implementation of periodic interdisciplinary conferences concerning initial vocational training for the regional health economy
- Identification of future workforce needs of the different branches of the Berlin health economy
- Promoting the fact, that in-company trained workforce is an underestimated issue for the needs of the future
- Encouraging specially SME's to use their potentials for in-company trainings
- Initiation and management of cooperative trainings and vocational training networks
- Improving transparency for the manifold training facilities in the health sector

- Collaboration incentives for schools and enterprises.

North West England: the Pathways Community Interest Company and the intermediate labour market

Pathways Community Interest Company delivers a programme designed to reduce health inequalities by targeting people who are of working age who are most precluded from the labour market. The project uses local demographic information to target individuals and communities. Recognising that being in work is better for your health than not being in work. Whilst Cheshire is a prosperous area, there are pockets of real deprivation, with a number of wards coming in the top 20% of the Index of Multiple Deprivation. Research carried out by the Primary Care Trust confirms that health inequalities are increasing. Moving people of working age into employment is seen as a key factor in helping to combat health inequalities.

The Project recruits openly within Jobcentre Plus, has Jobcentre Plus referrals, and referrals from health professionals. All by face to face interactions, together with leaflet. Face to face is seen to be the most effective strategy for encouraging people to consider moving closer to work as this takes into consideration all of their personal circumstances

Most of the candidates have mental health issues either as primary or secondary condition. All have low self-esteem, low confidence, and whilst wanting to work are fearful about taking the step back into work. The vast majority of candidates have been out of work for 7 years plus. The project also recognises that many of the candidates face real financial hardship and has in place bursaries to overcome those barriers that may preclude people getting or being retained in employment. All candidates are mentored in employment for at least 6 months to eradicate implications of the extended induction crisis.

To date 28 long-term structurally unemployed people have moved into sustainable mainstream employment. Five further long-term unemployed people are awaiting clearance to move into mainstream employment, and 10 others are on work placements. The cost of the outcomes achieved is £6k per person against a financial backdrop of keeping people on benefits throughout their lives and associated costs of £300,000 per person (Kings Fund). The programme therefore shows value for money.

Health sector employment in the Pomurje region in Slovenia

Pomurje with 130 000 inhabitants is located in northeast Slovenia. The region is predominantly agricultural but has expanded its tourism sector in recent years. GDP per capita is 69% of national average or 52% of EU average. The unemployment rate is 16,8% comparing to a national average of 10%. The health sector in Pomurje is an important employer: 6% of all employed. The majority of employees (70%) are well-educated women, mostly employed in the public sector. The public sector offers higher rates of permanent employment than the private sector. It also ensures financial security and social recognition. However, this does not minimize the impact of shift work on health (and long-term night work), lifestyle (nutrition, physical activity, smoking), family life (organization of everyday activities or additional costs) and stress.

Men and women are legally equal regarding payment, although female salaries are 93% of male salaries (EU-25 average is 88%). About two thirds of all those employed in the health sector have secondary or higher education. We have to consider the cost, time and effort invested in education of highly specialized experts such as doctors in the light of migration of workforce. Slovenia has 2.2 medical doctors per 1000 inhabitants, which is second lowest rate in the EU. The EU-25 average is 3.1.doctors par 1000 inhabitants. Since health care systems usually tend to be better developed in urban rather than in rural areas, Pomurje region is at risk of having limited access to health care services, having 1,6 doctors per 1000 inhabitants.

The Pecs Policy Agenda

Policy recommendations for health sector employment are contained in *The Pecs Agenda* available at www.healthclusternet.org and included in the final section of this report. This Agenda provides a

practical response to the 'health equals wealth' challenge first set out at the European Health Policy Forum in October 2003.

The aims of the agenda are to:

1. To enable regional health systems to more positively engage with regional development through employment policies, planning and actions that maintain and improve a flexible, possibly intersectoral, attractive, inclusive and high quality workforce.
2. To integrate the goal of inclusive employment into mainstream health sector employment policies in order to create more diverse and flexible workforces.
3. To enable European regional health systems to have flexible options regarding approaches to employment that ensure health sector workforces are affordable and capable of allowing health care to adapt to changes in service priorities reflecting local health and well being needs.
4. To create and maintain a health sector workforce that is a sustainable employment opportunity for an ageing workforce combined with recruiting and retaining previously marginalised social groups: long term unemployed, people on incapacity or welfare benefit, the homeless, people with learning disability, refugees.
5. To learn from good practice private sector employers about how to improve the attraction of working life for all employee groups in the public health sector.

The Agenda has been shaped by the practical experiences, evidence and insights generated by regions from across the EU and beyond who are partners in HealthClusterNET. The recommendations are organised into three regional group categories that reflect progress within partner regions in terms of economic performance, Lisbon orientation and engagement of regional health systems with regional development. The first two objective indicators are developed and reported by the European Spatial Planning Observatory Network (ESPON). The third is a self-assessed indicator by each partner region.

Key developments for all regions

The following key developments would enable regions to effectively improve the contribution of health care employment to regional development and delivery of the Lisbon Agenda:

- Shift health policy towards prevention of chronic conditions and promoting well being (this should be done by health care policy makers)
- Develop cross-government and cross-ministry commitments to intersectoral planning, funding, workforce development and implementation at regional levels (national governments need to address this)
- Approaches to employment and workforce development within regions should be linked to and support merging best practice care models e.g. enabling integrated care pathways (Health and Finance Ministries at regional and national level)
- Information on and access to diverse employment models should be made available to regional decision-makers with clear evidence about relevant strengths and weaknesses of the different models (Finance Ministries)
- Responsibility for decision making on health care employment should be clearly devolved to regions and appropriate service organisations (National Ministries with responsibility for Regional Development and Finance Ministries)
- Identify incentives to encourage partnership working between cross-sectoral agencies e.g. through the development and use of integrated performance management frameworks and processes (Finance and Health Ministries, regional health systems)
- Enable the better development of integrated information systems to improve intersectoral decision-making about how to supply and improve better managed care pathways (local, -regional and national information experts and agencies).

Contents

EXECUTIVE SUMMARY	3
INTRODUCTION	3
WHO SHOULD READ THIS REPORT	3
KEY MESSAGES	3
CASE STUDY EXAMPLES.....	4
<i>The Pecs Policy Agenda</i>	<i>5</i>
KEY DEVELOPMENTS FOR ALL REGIONS	6
CONTENTS.....	7
1 INTRODUCTION	9
2 DEFINITIONS	11
3 THE HEALTH SECTOR AND INCLUSIVE EMPLOYMENT.....	14
KEY EMPLOYMENT ISSUES IN EUROPE	15
<i>European Union Employment Strategy (EES)</i>	<i>16</i>
<i>Anticipating work force needs</i>	<i>17</i>
<i>Discrimination against migrant and refugee health workers.....</i>	<i>18</i>
<i>Work related well-being</i>	<i>19</i>
<i>The long-term unemployed</i>	<i>19</i>
<i>The demand for Social Enterprises</i>	<i>20</i>
<i>Welfare mix and employment</i>	<i>20</i>
4 LESSONS FROM PARTNER CASE STUDIES	21
CASE STUDIES	21
<i>Inclusive employment in Alentejo</i>	<i>21</i>
<i>MediNet Berlin – strengthening initial vocational training facilities.....</i>	<i>23</i>
<i>The Pathways Community Interest Company and the intermediate labour market.....</i>	<i>25</i>
<i>North West England: Mutuality through workforce development</i>	<i>26</i>
<i>Pais Vasco: two employment community initiatives</i>	<i>28</i>
<i>Health sector employment in Pomurje region in Slovenia</i>	<i>30</i>
<i>Steiermark Region: Human resources in the health sector</i>	<i>31</i>
<i>The Sjuhärad Region in West Sweden: projects to maintain a healthy workforce</i>	<i>32</i>
5 ECONOMIC AND SOCIAL ISSUES IN EMPLOYMENT	35
HEALTH CARE PROFESSIONAL REFUGEE’S ACCESS TO APPROPRIATE EMPLOYMENT IN FINLAND.....	35
<i>Background</i>	<i>35</i>
<i>Interim findings</i>	<i>36</i>

<i>Potential policy implications</i>	39
6 CONNECTING EMPLOYMENT TO REGIONAL ECONOMIES	41
7 TOWARDS A POLICY AGENDA FOR INCLUSIVE EMPLOYMENT	43
ENSURING THE RELEVANCE OF A POLICY AGENDA.....	43
PURPOSE OF THE AGENDA	44
AGENDA AIMS	44
POLICY RECOMMENDATIONS.....	45
<i>Group A: Economic potential, weak Lisbon orientation, health sector starting engagement</i>	45
<i>Group B: Less clear economic trend, high Lisbon orientation, health sector engaged</i>	48
<i>Group C: Strong economic trend, high Lisbon orientation, health sector engaged</i>	49
KEY DEVELOPMENTS FOR ALL REGIONS	51
OVERALL BENEFITS	52

1 Introduction

- 1.1 This report examines how, and to what extent, health care employment can affect economies and health outcomes at a regional level. It draws on the knowledge and experiences exchanged between HealthClusterNET partners at a three-day workshop in Hameenlinna (October 2006) and a policy forum in Pecs (March 2007), together with further material and analysis supplied by a number of invited commentators. The report is also to be found on the HealthClusterNET website (www.healthclusternet.org) to provide an opportunity for wider consultation on its content and recommendations.
- 1.2 As described by INTERREG IIIC, "HealthClusterNET is intended as a lasting interregional network of 13 regions from across the EU that will build and share knowledge and experience among regional policy makers in order to find out how they can more effectively engage their health sector within the regional development agenda". The four themes that are identified by partners as key interfaces between the health sector and regional policies on social cohesion, and economic competitiveness are: employment, procurement, capital investment, and innovation.
- 1.3 The purpose of knowledge sharing and development through each of these four themes is to focus on **how** the health sector can contribute to regional development and **how** other regional stakeholders can support this engagement.
- 1.4 Health care systems are under great pressure to show that spending on assets including existing and future workforces provides value for money, and that the end results of employment are flexible and adaptable to changing circumstances. Across Europe, governments and citizens expect to see a *return on investment*, in terms of improving:
 - Service to patients
 - Health service finances
 - Regional economic performance
 - Social cohesion.
- 1.5 Although different countries and regions start from different positions, the above principle applies almost everywhere – particularly in the case of countries that will rely on structural aid funding to finance reform of their healthcare infrastructure.
- 1.6 In this context, can social enterprises be considered as valuable partners in delivering quality services to patients and in fostering inclusive employment within the sector? Some of their features suggest that they could be good partners provided that an enabling environment is created to support their development.

1.7 However, it is never easy to arrive at decisions on employment priorities, especially in the face of increasing cost pressures, the rise of chronic illness, and ageing populations. These three factors also put in question the traditional priority given to technology-driven acute hospitals and traditional workforce structures. On a more positive note, we should recognise that healthcare employment can act as catalysts for social and economic regeneration. This was implicit in the Lisbon Agenda, which endorsed the principle that the core business of healthcare is *investment in people*.

1.8 In summary, the purpose of this report is to show how the health sector can contribute to the dynamism of regional and local economies and communities. The inclusive component of the HealthClusterNET programme has therefore sought to encourage:

- Understanding of the linkages between the ageing health sector workforce, health worker migration, the emergence of social enterprises and regional development.
- Promotion of examples of best practice in the interdependent relationships between employment, education, clinical practice, social cohesion and sustainable economic development.

2 Definitions

- 2.1 *Inclusive employment:* 'An approach by organisations to encourage growth within and increase job opportunities for local communities. This approach facilitates reductions in intra-regional disparities between communities in terms of the access to of employment for the unemployed, migrant/immigrant, ageing workers, those with mental health or learning disabilities. Inclusive employment provides these groups with opportunities to gain employment on an equal basis and contribute their creativity, knowledge, skills and experience. Ultimately the benefits should include working towards humane services, work-life balance and quality of life.
- 2.2 *Social enterprises:* The term 'social enterprise' has many interpretations throughout the EU member states. The UK for example follows a more corporate model of social enterprise, whilst many other EU regions look at social enterprise primarily as a means to deliver welfare services and some countries extend the definition of social enterprise to include businesses that have demonstrable socially responsible policies bringing tangible benefits to local communities.
- 2.3 *Flexible work:* Flexible Work is a term to describe a wide range of work styles and employment practices which differ from the traditional 9 to 5 full time job with a permanent contract. It can mean part-time work, flexible working hours etc. that allow groups like young women (mothers) who are sometimes in a disadvantaged position, to enter the labour market.
- 2.4 The "flexible" aspect of jobs of this type can in different instances advantage more the employee, the employer, or both. From the employees' point of view, flexible work may allow them more freedom to organise their employment to fit in with other parts of their lives. However, it can also be a disadvantage not giving the employee the same security of employment as a permanent job does. For the employer, the flexibility may come with the ability to organise labour resources more in line with the varying needs of production and customers.
- 2.5 *Staffing shortage in health care:* Staffing shortages create financial risk, increase the costs of health care in the regions and limit the profitability of health care firms. For the health care employers, both public and private, the cost of an agency doctor or nurse can more than double the salary costs compared to a health care professional on staff.
- 2.6 Staffing is an area that is creating enormous expense inflation for health care providers and presenting one of the biggest areas of uncertainty in assessing an organization's credit quality. Salary and benefit costs are the key determinants of profitability and managing labour costs is critical to achieving profitability, especially as the ability to increase revenue diminishes
- 2.7 As the baby boomer population ages and the demand for health care increases, shortages are expected to grow. Looming retirements in the current health care workforce will further constrain

available staffing. Inadequate staffing is a fertile ground for malpractice and can undermine security in care.

- 2.8 *Learning networks and working life:* Learning networks are a way to foster a different learning culture; develop progression routes from informal to more formal learning; create learning environment that enable different ways to learn; and enable a holistic response to learners' needs.
- 2.9 These networks enable people with lesser or unsuitable education to “learn by doing”, thus increasing their competition value in the labour market. On the other hand, learning networks function as a way of developing non-hierarchical new ways of organizing work because they are less formal than normal top-down decision-making processes. They thus can help to promote equality in the workplace.
- 2.10 *Health care facilities:* Usually refers to hospitals, clinics, and surgeries. However, this term can also refer to the physical parts of a healthcare system that are not normally seen by patients, so we could include administrative buildings, staff training centres, spaces for storing supplies, waste disposal units for example.
- 2.11 *Health care policy:* The overall structure, in terms of legislation, directives and recommendations, which sets the course for health care provision. Such policy may be set at international or national level, with implementation left to local organisations. Alternatively, government may choose to devolve policy-making powers to regional or local government and therefore act in a more advisory role.
- 2.12 *Health care system:* The totality of means, in a society, by which health care is provided. Some definitions see this phrase as encompassing only the assets and services available for health care; other definitions put more emphasis on human resources, technology, or economics. In very general terms, most health care systems include a large public element, with some private or charitable (not-for-profit) involvement as well.
- 2.13 *Local:* What is local? It is a question that troubles anyone dealing with regeneration. We all define local for ourselves. The easiest answer is whatever you consider to be your local area is your local area. For the case studies in this paper, local refers to their region and the communities within that region. We do not seek to challenge what truly constitutes local or not, but rather how to let people use whatever definition inspires them to take action.

2.14 *Masterplan*: A long-term, comprehensive programme for the future provision of health care services in a particular area. As a very brief overview, such a plan will include:

- Demographic and epidemiological data
- What services will be needed
- Which organisations will provide those services
- What resources (buildings, technology, people) will be required
- How the services will be paid for
- How different elements of the service will integrate with each other
- How the proposed health care system will support other policy objectives, such as economic growth.

2.15 *Regeneration* is a short word for 'improving a community'. Regeneration literally refers to the process of giving new life or energy and is commonly used with reference to disadvantaged communities. You may see words like economic development, revitalisation, or renewal. They all have the same meaning.

2.16 Definitions and discussion of terms such as 'procurement', 'sustainable development', and 'value for money' can be found in the Health ClusterNET Report 1 *How the Health Sector can contribute to regional development: the example of local procurement*.

3 The health sector and inclusive employment

- 3.1 In *The contribution of health to the economy in the European Union* (European Commission, DG Health & Consumer Protection, 2005) the authors argue that:

While the economic argument for investing in health in high-income countries may differ in detail from that in low-income countries, we have found considerable and convincing evidence that significant economic benefits can be achieved by improving health not only in developing, but also in developed countries.

- 3.2 In economic terms, health services are clearly important because their efficiency and scope have a direct impact on population health, and thus indirectly on the productivity of the workforce and hence GDP. However, as the authors later acknowledge, it is also true that:

The health sector 'matters' in economic terms simply because of its size. It represents one of the most important sectors in developed countries, representing one of the largest service industries. Currently its output accounts for about 7% of GDP in the EU-15, larger than the roughly 5% accounted for by the financial services sector or the retail trade sector ... Through its sheer accounting effect, trends in productivity and efficiency in the health sector will have a large impact on these performance measure in economies as a whole. Moreover, the performance of the health sector will affect the competitiveness of the overall economy via its effect on labour costs, labour market flexibility and the allocation of resources at the macroeconomic level.

- 3.3 In recent years, the institutional bodies of the European Union have strongly emphasised regional development as a means of tackling economic inequality, encouraging cross-border cooperation, and targeting populations that have most need of resources. More recently the notion of 'sustainable development' (essentially, balancing current needs with those of the future), has been used to provide a framework for regional development (e.g. SUSTAIN in North East England). While the EU provides regional development and structural funds, there is a requirement and expectation that national governments will (a) recognise the importance of decision-making at regional level and (b) ensure that additional resources – financial and human – are made available to complement EU spending.

- 3.4 The importance of health as a fundamental component of strong, competitive economies has now appeared on the international and European agenda (DG SANCO 2005). This amounts to a recognition that health care systems can act as drivers for economic and social regeneration, especially when considered in concert with other elements of social policy. Health sector

investment therefore finds itself both affecting and affected by three principle areas of social and economic activity, as illustrated in Figure 1.

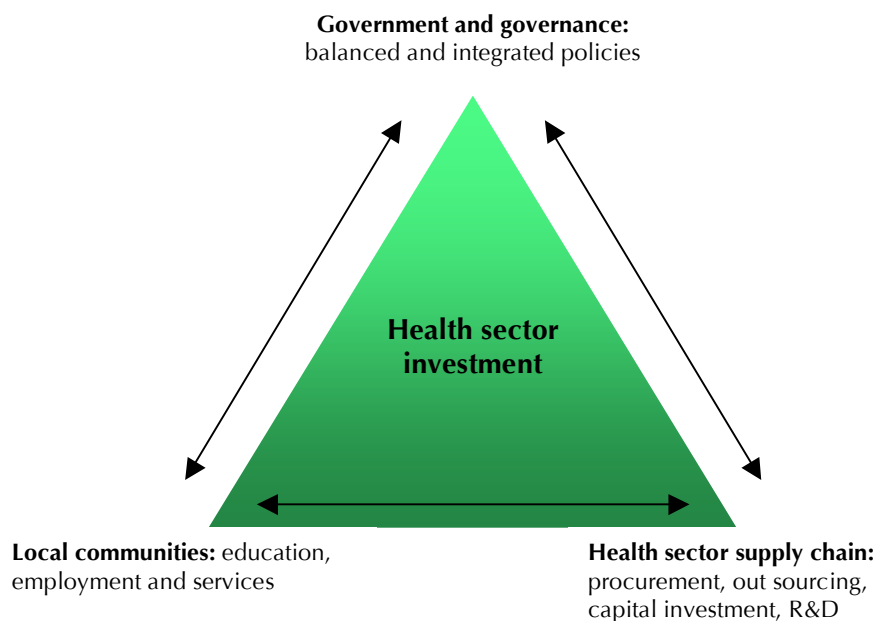


Figure 1: Links between health sector investment and three areas of economic and social policy

Key employment issues in Europe

- 3.5 The key issues in employment in Europe are improving quality and productivity at work and strengthening social cohesion and inclusion. This alongside aging of population is leading Europe to face great challenges in the near future. This annex to the briefing paper discusses some of the key issues in the European Union Employment Strategy (EES) and combines them with the aims of HealthClusterNET. Some of the key issues will be presented here as a base for the HealthClusterNET Employment Knowledge theme in the second part of 2006. This presentation centres around three broad themes that are discussed in a more detail: Migration; unemployment/incapability to work, and age factor in employment issues. A key cross theme for this purpose will be social enterprise as an opportunity to grow inclusive employment approaches.
- 3.6 Migration issues include among others immigrants having difficulties getting employed, new ways of employment as well as positive and negative flows of skilled workers from a region/country to another. Incapability to work discusses managing the return to work and skills escalators that help people to learn by doing at work. While questions around older employees discussed are retaining people at work as well as means to find solutions for increasing labour supply deficit also new ways of knowledge circulation should be addressed. Among old people one central question will be, how to retain them at work. Regarding young people the question is, how to get them interested in working in health care sector. Table 1. summarizes these themes from three different perspectives.

Table 1. Regional, national and global aspects of HCN employment themes

	Migration/Immigrants	Unemployment/ Incapability to Work	Age
Regional/ Local	Migration inside the country	Skills escalators in attracting a wider range of workers including long-term unemployed	Organizing the work so that the strengths and weaknesses of workers of different ages are paid attention to
National	Immigrants getting their qualifications accepted by the employers	Updating competencies of workers in health sector	Making the health sector more attractive in young people's eyes
Global	Migration problem to be addressed from both sides of the coin (immigration and emigration)	Sourcing employees globally and finding ways to create common rules	New ways of keeping the old people at work (part-time work, social enterprises)

European Union Employment Strategy (EES)

3.7 The European Union's [European Employment Strategy](#) (EES) has been in operation since 1997. It enables the coordination of national employment policies at EU level and one of its main components has been the adoption by the European Council of a set of annual Employment Guidelines setting out common priorities for Member States' employment policies. The Member States then draw up annual National Action Plans which describe how these Guidelines are being put into practice nationally.

3.8 There are three main objectives for this: full employment, improving quality and productivity at work and strengthening social cohesion and inclusion. In order to achieve these three objectives the Guidelines focus on 10 policy priorities, rather than grouping a range of guidelines into four pillars, as has previously been the practice. These 10 priorities are:

1. Activate and preventative measures for the unemployed and inactive;
2. Job creation and entrepreneurship;
3. Address change and promote adaptability and mobility in the labour market;
4. Promote development of human capital and lifelong learning;
5. Increase labour supply and active ageing;
6. Gender equality;
7. Promote the integration of and combat the discrimination against people at a disadvantage in the labour market;

8. Make work pay through incentives to enhance work attractiveness;
9. Transform undeclared work into regular employment; and
10. Address regional employment disparities.

Anticipating work force needs

- 3.9 The ageing of populations is very dramatic across Europe, thus there is acute need for more competent personnel. Some of the solutions for this challenge include a healthier work life, systems for retaining people at work, immigrants getting their qualifications accepted by the employers and updating competencies of the workers as well as creation of social enterprises.

Table 2: The supply of health professionals in an ageing population

<p><i>Ageing populations</i></p> <ul style="list-style-type: none"> ▪ UK: 100000 nurses due to retire by 2010 ▪ EU: more than 50% of physicians are aged 45 years and above. ▪ Norway: the average age of dentists is 62 <p><i>Insufficient planning and investment</i></p> <ul style="list-style-type: none"> ▪ USA: by 2020 there will be an estimated 20% deficit in the registered nurse workforce <p><i>Number of trained nurses not practicing</i></p> <ul style="list-style-type: none"> ▪ USA: 500,00 ▪ South Africa: 35,000 ▪ Ireland: 15,000

- 3.10 International migration has become an important feature of globalized labour markets in health care sector. There has been concern about workforce in health care for some years now, but recently the situation has become acute for a number of reasons. One of the most important factors is the aging of population, resulting in staff and skill shortages in the health systems in many countries. Migration policies together with barriers and challenges for foreign work force are therefore at the forefront.
- 3.11 Migration should also be seen from national and regional view. In many countries rural areas and underdeveloped regions lose competent work force to growth centres, jeopardizing basic service production in many areas. Social enterprises and other state supported forms of work can help people to stay in the rural areas. Another solution is enhancing remote work through telecommunications to concern even basic services.
- 3.12 Another measure in preparing for aging of population is work-related well-being. This includes increasing ability to work as well as noticing different age groups and their knowledge and experience in the working environment. The goal with work-related well-being is extending the working life.

- 3.13 At the same time with aging of population large groups are outside labour markets. Especially long-term unemployment together with social exclusion is decreasing ability to work drastically. Welfare-mix and third sector models have been proposed to help employ people who in normal situations could have hard to get employed.
- 3.14 Health sector work is characterized by specialized professions and highly independent labour processes. Because of these features, effective health provision can be jeopardized by even small-scale changes in migration flows amongst specialist groups and therefore undermine a country's health system. The European Union has been keen to promote the free movement of labour within the EU as well as encouraging migration into certain regions. The liberalization of labour markets and the mutual recognition of qualifications are necessary, but not sufficient to stimulate mobility. Focal point here should thus be in addressing the migration issue from both sides: immigration and emigration.
- 3.15 Labour supply deficit describes when age class exiting from labour markets (55-64 –year olds) is bigger than the incoming (15-24 –year olds). In countries like Germany, Italy and Sweden this has already happened, while for example in the UK and Austria and Poland it takes another 5-10 years (Table 3). Migration is not included in these calculations.

Table 3. Labour Supply Deficit by Country

Country	Year	Country	Year
Austria	2012	Poland	2011
Germany	1993	Portugal	2007
Spain	2008	Romania	-
Finland	2003	Sweden	2000
Hungary	2007	Slovenia	2008
Italy	2000	UK	2016

Source: Eurostat New Cronos 2005.

Discrimination against migrant and refugee health workers

- 3.16 Many studies show that especially people with refugee backgrounds have difficulties in finding work that they are qualified to do and that they usually instead have to find other work, most commonly in the low-paid service sector (For example Markkanen 2006; Refugee Council 1999). Because of prejudice based on ethnicity people on refugee status often face discrimination in trying to find work. This ignorance of competent work force, although apparently diminishing

lately, is still an issue that countries can not brush aside because of imminent labour supply deficit facing countries in the EU.

3.17 Refugees as a group suffer from excessive unemployment, inactivity, non-employment, disguised unemployment and under-employment. The real figures relating to refugee unemployment are hard to calculate for many reasons. First, refugees are not easily identifiable as unemployed as they are not separately counted in labour market statistics. Second, an unrealistic percentage of refugees of working age (only 20 to 30% in some countries) are classified as unemployed, since nominally they have to be actively seeking work. Third, there is a two-way movement between inactivity and unemployment, and people move between these two situations fairly often as jobs are insecure and temporary or not satisfactory.

3.18 Also other immigrant groups face difficulties in trying to find a job. The education systems have until 2005 varied greatly from an EU-country to another and in some professions, like in health care sector, there have been national restrictions for foreign work force to get their qualifications accepted in another EU-country. Although prejudice does not occur in same degree among these groups of people, they still face great bureaucratic battle to gain access to work life in health care sector. As a solution for this problem a special European certificate for medical practitioners has been developed, allowing them to work in another EU-country.

Work related well-being

3.19 Apart from need for more competent workforce in health sector also the well-being of current workers is required. Aging of population means that demographic dependency ratios will become unbearable. To ease up this process it is necessary to extend working life of the current workers with ability to work in the forefront. One of the hot topics recently is Age Management, which means planning working tasks in an organization so that suitable tasks are found for all the age groups, depending on their experience and physical attributes. This is in tight connection with adding attraction to working life, which seeks to promote and maintain working ability.

The long-term unemployed

3.20 Long-term unemployment combined with social exclusion are the core factors behind weakened ability to work. Weakened health follows often long-term unemployment, partly because of social exclusion but also because of restrictions in access to public health care services. These restrictions can be results of queues for health care services and lack of comprehensiveness when being admitted. This segmentation shows especially in primary health care special health care that seem to be moving to opposite directions (Aukee 2004). In order to combat weakened ability to work active labour market support is needed.

The demand for Social Enterprises

- 3.21 Social enterprises are functioning between the public and the private sector and break new ground in the allocation and management of economic resources, forming what the European Commission calls the "third system". While they all take a broadly similar approach across countries, these enterprises operate along very different lines. They do, however, seek to achieve the same goals, i.e. re-integrating disadvantaged groups into the labour market and providing goods and services. Social enterprises take an entrepreneurial approach and draw on the local environment to enhance their economic and social performance. Their main characteristics include:
- More flexibility
 - Border-crossing (administratively and spatially)
 - Innovation
 - Combination of different expertises
- 3.22 The situation becomes problematic when social enterprises compete in the same markets with normal enterprises and they receive state subsidies for the same service production.
- 3.23 Some moves to solve this market imbalance are efficient procurement legislation, tighter regulations on VAT and open competition for third sector and volunteer organisations. Therefore a "welfare-mix" has been proposed. In this model municipalities increase buying services from private and third sector organisations.

Welfare mix and employment

- 3.24 Welfare mix is used to characterise the mixture of private capital and state enterprise in producing welfare services. In model economies through which welfare systems are maintained, financed and provided the frequently mixed systems contain public, private and voluntary agencies, as well as mixing systems of formal care such as social services and informal care such as that provided by family or community. In short, in Europe especially, the role of the municipalities is to buy from private and third sector organisations.

4 Lessons from partner case studies

4.1 Health ClusterNET partner organisations were asked to submit case studies of illustrative employment projects, intended to spotlight examples of best practice, innovative solutions to specific needs, or particular challenges faced in a region. A number of invited experts were also present at the Hameenlinna workshop, to share their experience of the linkages between health sector employment and the wider economy of a region, by way of master class sessions and plenary presentations. The rest of this section summarises the key messages and themes, and concludes with a commentary.

Case studies

Inclusive employment in Alentejo

4.2 Providing continuous healthcare services at home aims at the social inclusion of dependents as well as maintaining a life quality that hardly is reached in an internship situation. Nevertheless, the relation between health care services and social inclusion does not end here. Providing health care services counts inevitably on human resources conventionally associated to health and that, in Alentejo, are describe as follows in Table 4:

Table 4 – human resources in health: Alentejo – 2003

HUMAN RESOURCES IN HEALTH	ALENTEJO		PORTUGAL	
	Nº	RATIO/1000HAB.	Nº	RATIO/1000HAB.
DOCTORS	771	0,95	23.020	2,33
NURSES	1.606	2,07	35.077	3,55

Fonte: Direcção Geral de Saúde

4.3 Alentejo suffers from a lack of adequate health human resources. In particular, addressing workforce needs for continuous healthcare services are critical. Investment in the training of professionals for continuous healthcare services is a priority in Portugal and Alentejo.

4.4 It contributes to social inclusion in two ways (i) a patient's inclusion in their own environment, avoiding the negative effect of being institutionalised (ii) there is the employment opportunity that continuous healthcare services means for those who have lower academic qualifications, especially women, with difficult integration in the labour market. Specific investment has been made in the development of *geriatric assistants* and *family and community support assistants*.

- 4.5 In Portugal and Alentejo, there has been investment, since CFI, in these professional's training, mainly *geriatric assistants* and *family and community support assistants*.
- 4.6 The *Family and community support assistant* is the professional which, in an autonomous way or under the orientation of a specialized technician, executes basic task of human care to clients at home or in an internship or semi-internship situation in specific institutions such as elderly homes, day centres, leisure accompanying homes, child support institutions, Human Care Centres and others.
- 4.7 The main activities developed by these professionals are:
- Providing basic health and human care according to the patients needs and the institution's aims
 - To execute tasks of clothes cleaning and treatment
 - To develop all the tasks which are connected to meal services, namely confection and direct service to the client.
 - To provide reception under orientation of the responsible technician
- 4.8 The acquisition of these competences is done through frequency and approval in the following modules: Basic Human and health Care; Hygiene and comfort; Nutrition and meals confection; behaviour management
- 4.9 The *geriatric assistant* is the professional that, based on up to date knowledge on in order to guarantee the personal and institutional balance on the day-to-day relation with the elderly, complements the care mentally, physically, socially and spiritually with the elderly.
- 4.10 The main activities developed are:
- Watch and take care of the elderly, selecting and executing animation activities in their own environment;
 - Watch and take care of the elderly, selecting and executing animation activities in the institutional environment;
 - Care for the elderly welfare, by controlling and following the doctor's prescriptions; by watching over the hygiene; by executing animation activities in the elderly own place;
 - Care for the elderly welfare, by controlling and following the doctor's prescriptions; by watching over the hygiene; by executing animation activities in the institutional place.

- 4.11 The acquisition of these competences is done through frequency and approval in the following modules: *Elderly accompanying and animation; elderly home support; elderly accompanying and animation in homes and day centres; elderly care in health institutions,*
- 4.12 Both courses are destined to initial and professional qualification and for its attendance is needed the minimum compulsory education. Most of these actions are administered by the Portuguese Institute for Employment and professional training and are attended mostly by unemployed women which find it difficult to enter the labour market due, both to age and low qualifications. The receptivity of labour market to these professionals becomes a tool for social inclusion by the means of employment of a group that, by its characteristics, confronts difficulties to work in a region with the higher female unemployment rate of the country (11,5%-INE2005, and where 39% of the unemployed population has less than the minimum compulsory education.

MediNet Berlin – strengthening initial vocational training facilities

- 4.13 “MediNet Berlin - Vocational Training Network in the health economy” is a project funded by the Federal Ministry of Education and Research within the framework of the new nationwide "JOBSTARTER - Training for the Future" programme. The programme aims at a better regional supply of in-company training places for young people. It strengthens regional responsibility in the field of vocational training by providing support in networking regional structures so that synergies can be used at best. “MediNet Berlin” helps to secure the procreation of qualified employers in the expanding market of the health economy in Berlin concerning the impending demographic lack of young school leavers in the next years.
- 4.14 The health economy is assumed to be one of the future markets, as a motor for innovation and growth driven by the increasing expectation of life and health consciousness and by ever shorter innovation circles of new medical technologies.
- 4.15 There are good parameters especially for the Region of Berlin-Brandenburg in the field of health economy with Europe’s largest university hospital, the famous institute of the Max Planck society, three Universities and several Centers of Excellence. More than 160 new biotech companies have chosen to locate themselves in the capital region, creating jobs from knowledge in the last years. Berlin is not a customary place for medtech industries (up to date Berlin has got about 180 Healthcare industries in medical technology), but more important for development forecasts is dynamic growth with 70 new enterprises established solely in the last five years. Furthermore, Berlin is a customary place for pharmaceutical industries, not only with big players like „Schering“ „Berlin Chemie“; but with an huge number of SME’s in this field. In addition we should not forget the workforce needs for administration and management at different levels. So

in general the health economy can be described as a growing sector, including far more branches than only the core center of medical therapy and nursing.

4.16 However, we also have to face expenditure cuts in the public health system and, more close to the field of action for our project, a sinking percentage of in-company apprenticeships despite the impending demographic lack of young school leavers in the next years.¹ There was a clear impact of negative employment trend the last years on supply of training places. The percentage of those starting VET declined considerably. A lot of major and medium enterprises did actually run programmes for early retirements in the 1990ths, while eviting new entries due to the declining economy in the following years. In consequence due to the great homogeneity of age of the staff, there will soon arise an even bigger problem of recruiting new employees, when this generation retires. And last but not least there is a growing disparity between the increasing demands of enterprises and the initial competences of young school leaver for work respective training.

4.17 Therefore MediNet Berlin has to deal with two at first sight contradicting realities. In fact the argument with the impending demographic lack of qualified workforce doesn't work very well specially with SME's considering the current, still existing redundancy of training applicants/ candidates and the problems with their lacking competences for a job adequate training. It's just that, what we are working at.

4.18 The Goals of MediNet Berlin concerning initial Vocational Training and Qualification as a strategic field of action are

- Implementation of periodic interdisciplinary conferences concerning initial vocational training for the regional health economy
- Identification of future workforce needs of the different branches of the Berlin health economy
- Promoting the fact, that in-company trained workforce is an underestimated issue for the needs of the future²
- Encouraging specially SME's to use their potentials for in-company trainings
- Initiation and management of cooperative trainings and vocational training networks³
- Improving transparency for the manifold training facilities in the health sector
- Collaboration incentives for schools and enterprises.

¹ Usually after secondary school young school leavers start up with vocational training in one of the about 350 training occupations recognised under the Vocational training act in our Dual system for initial vocational training. The traditionally great number of vocational trainings offered in a full time school in health economy is not so much due to the massive broadening of educational pathways in the last years due to the lack of in-company training places as for historical reasons – a very special situation in our VET system causing a lot of intransparency.

² The discussion that Germany has a lack of professionals with a university degree is often combined with a misunderstanding of our special dual vocational education training system.

³ For example bringing together actors of health insurances and hospitals concerning the training of a still relatively new recognized occupation, which may be interesting for both sides and which may be trained even in collaboration: the new recognised profile of the health care management assistant.

4.19 For further details contact our homepage www.medinet-ausbildung.de. See also the official homepage of the master plan "Healthcare Region Berlin- Brandenburg" www.healthcapital.de .

The Pathways Community Interest Company and the intermediate labour market

4.20 Pathways Community Interest Company delivers on behalf of Central and Eastern Cheshire Primary Care Trust a programme designed to reduce health inequalities by targeting people who are of working age who are most precluded from the labour market. The project uses local demographic information to target individuals and communities. Recognising that being in work is better for your health than not being in work. Whilst Cheshire is a prosperous area, there are pockets of real deprivation, with a number of wards coming in the top 20% of the Index of Multiple Deprivation. Research carried out by the Primary Care Trust confirms that health inequalities are increasing. Moving people of working age into employment is seen as a key factor in helping to combat health inequalities.

4.21 The Project recruits openly within Jobcentre Plus, has Jobcentre Plus referrals, and referrals from health professionals. All by face to face interactions, together with leaflet. Face to face is seen to be the most effective strategy for encouraging people to consider moving closer to work as this takes into consideration all of their personal circumstances

4.22 Most of the candidates have mental health issues either as primary or secondary condition. All have low self esteem, low confidence, and whilst wanting to work are fearful about taking the step back into work.. The vast majority of candidates have been out of work for 7 years plus.

4.23 Each candidate receives an individual career development plan, which targets areas of development required to move him or her into employment for example:

- Prerequisite qualifications and training required for specific employment
- Literacy and numeracy
- Information technology
- CV building
- How to make telephone enquiries for jobs
- Interview skills
- Taking people to interviews
- Work experience/work trial
- Therapeutic work
- ILM employment
- Better of in work interviews

- 4.24 The project also recognises that many of the candidates face real financial hardship and has in place bursaries to overcome those barriers that may preclude people getting or being retained in employment. Cases supported include
- Purchasing replacement spectacles following domestic violence incident
 - Putting up bonds for homeless people to take on tenancies
 - Paying for car repairs
 - Paying for medication
 - Paying for food
- 4.25 All ultimately leading to mainstream employment. All candidates are mentored in employment for at least 6 months to eradicate implications of the extended induction crisis.
- 4.26 Pathways Community Interest Company was formed on 7 April 2006. 4 members of staff have been employed through the project, all of whom were long term unemployed previously, all people with disabilities, with 3 members of staff seconded from Health Service, all in at risk posts. To date 28 long-term structurally unemployed people have moved into sustainable mainstream employment. 5 further long-term unemployed people are awaiting clearance to move into mainstream employment, and 10 others are on work placements.
- 4.27 Cost of the outcomes £6k per person against a financial backdrop of keeping people on benefits throughout their lives and associated costs of £300,000 per person (Kings Fund). The programme therefore shows value for money. The project is successful as it listens to the needs of individuals, identifies barriers to movement into employment, and then provides a solution-focused approach to moving people into employment. The project has shown its effectiveness in reducing health inequalities. Pathways Community Interest Company needs to move from grant aided to procured service provision.

North West England: Mutuality through workforce development

- 4.28 Central Cheshire health economy faces significant challenges in meeting its workforce needs for the future. For example it is anticipated by 2010 there will be a 4% reduction in young people, and an 11% increase in people aged 65; by 2020 the number of people aged 65 increases to 20% and in some towns this is tended to 28%. The number of people who are within the economically active group is reducing. Only 4% of the workforce was below the age of 25. The numbers of young people within the not in education, employment or training group (NEET) is increasing. It was clear that Health careers were not attractive to local young people. Central Cheshire Primary Care Trust (CCPCT) recognised unless radical solutions were found there was concern that Health will not have the right staff with the right skills and the quality of care will

suffer. It also recognised that social exclusion in children leads to social exclusion in adulthood, and thus suffer poorer health.

4.29 In line with the Minister's Performance and Innovation Unit (2002) views on methodologies to increase social capital, CCPCT had a vision of using public ownership of the workforce development agenda to bring about significant benefits for recruiting Health staff long term. The vision included integrating the workforce development agenda with the regeneration, public involvement and health improvement agendas.

4.30 In January 2004, CCPCT led the development of a workforce development strategy to support recruitment for the future by:

- Engaging with communities the NHS has traditionally found difficult to reach
- Increasing the diversity of the health and social care workforce
- Increasing educational attainment for young people achieving grades A*-C at GCSE
- Creating social capital
- Testing whether a social enterprise could be an effective and responsive way of meeting local needs and maintaining and developing recruitment for the future.

4.31 Partners to the development and implementation of the strategy were young people, communities, Trade Unions, Staff, CCPCT, Cheshire and Wirral Partnership Trust, Mid Cheshire Hospitals NHS Trust, Connexions, Rudheath, Vernon, Woodford Lodge and Weaverham High Schools, Mid Cheshire College, Aimhigher.

4.32 The project aimed to achieve this by:

- Offering 150 outcome focused work experience placements to raise awareness about careers in Health
- Piloting vocational enhancement to the GCSE health and social care curriculum for 30 young people
- Building a business case for the development of a social enterprise
- Offering developmental support and a nurturing environment for the development of a social enterprise.
- Enabling 40 long term unemployed people to gain employment

4.33 Outcomes of the project include 401 people have undertaken outcome related work experience, 60 career events attended, 40 career professionals and school teachers have received individual development sessions, 60 NHS staff identified as career champions, (cost £48000) 30 young people aged 14 have undertaken a Young Apprentice programme are completing BTEC Entry

Level 3, Preparing for Work in Care, ASDAN Personal Effectiveness Award and have undertaken 25 days work experience linked to their studies to date. All are expected to achieve GCSE health and Social Care double award at grades A-C. None of the group are pregnant in comparison to 15% of their peers. (Cost £60,000) 62 young people aged 14 within Not in education, employment or training group have received vocational enhancement to their GCSE programmes (cost £8000). 100% of candidates can talk confidently about career options and are considering progression routes. 25 long term unemployed people move into mainstream employment, 53 long term unemployed people retained on the intermediate labour market programme.

- 4.34 The learning programmes were financed through external funding sources. Kings Fund confirm keeping someone on benefit throughout their lives and the related benefits to their family costs the public purse £300,000. The programme shows clear value for money.
- 4.35 The project methodology is identified as best practice model for reducing the numbers of children entering the not in education, employment or training group by the Learning and Skills Council. The learning has enabled Cheshire to secure one of only 14 Young Apprentice programmes for health and social care nationally, and is recognised for its strong partnership. The learning has enabled staff to be key partners for the development of the specialised diplomas nationally. The Community Interest Company partners has secured new contracts of £180,000 since incorporation.
- 4.36 In line with the *Our Health, Our Care, Our Say: a new direction for community services* CCPCT sees supporting the development of the Community Interest Company as a transformational method of delivering the Workforce Development agenda whilst retaining the ideals on which the public sector has always been founded.

Pais Vasco: two employment community initiatives

- 4.37 Two employment initiatives for people with long-term mental illness are described. The first one, Eragintza Foundation, from the Basque Country, was born in 1991 and was supported by the European Social Found from 1995 to 1998 meeting the needs of about 300 users. The administrative council was set up by the First Lady of the Basque Country's President at the moment (Mrs. Gloria Urtiaga), the Bilbao Bizkaia Kutxa Bank, the Bizkaia Provincial Council, the President of the Enterprises Corporation, and the promoters of the project: Dr. Ozamiz (sociologist) and Dr. Beramendi (Psychiatrist).
- 4.38 As many patients do not go directly from clinical settings to the work place, four different programs were developed in order to progress in accordance with the needs and abilities of the

patients: a vocational rehabilitation centre (social and job training, a job club and a supported employment programme), three occupational centres (bookbinding, gardening and cooking) a social firm (industrial laundry), and a high-quality training programme for professionals working in mental health matters.

- 4.39 The Job Club consist of leisure activities (art works, painting, board games, etc.) as well as training activities (culture, languages, computer courses). Social and job training offered communication and social skills training, strategies for coping with stress, vocational guidance and job-hunting techniques.
- 4.40 The supported employment programme was developed for people with severe disabilities who had held no job in the competitive market, or for people whose job had been shelved due to their disability, and who thus require back-up services to carry out the jobs. The main components of the programme were user assessment, job hunting, placement, training and monitoring.
- 4.41 The user assessment included the evaluation of minimum requirements and risk areas and was concentrated on functional assessment identifying the user's training needs as well as the main resources for successful insertion into the open labour market. Data collection included medical, psychological and social reports, specific tests and interviews and behavioural and situational assessment.
- 4.42 Job hunting included search for jobs suiting the user's training and experience, as well as assessment of his/her performance at the work place, and direct support when necessary. The main services were marketing of the programme, analysis of the job market, a search for suitable jobs, direct contact with entrepreneurs and analysis of the job.
- 4.43 The Placement was a process to adapt a suitable user to a specific job and included task analysis at the workplace, selection of the assessment data and compatibility analysis of the job and the users. Once the candidate was selected there used to be a discussion with the family/derivation centre, etc. Later direct instructions for the specific tasks were provided. The last stage included case control and performance analysis after a period of weeks or months (supervisor's assessment, user's self-assessment, information from colleagues, observation at the workplace, telephone contact, etc.). The training programme for professionals included a job coaching training programme as well as an application of the Attachment Theory to prevention and rehabilitation in mental health matters.
- 4.44 Transnationality work is also described: taking part in the ACCEPT network Eragintza cooperated with different partnerships from Finland (Stakes Consortium), Northern Ireland (ITO), England

(Mental Health Matters), and Germany (Die-Brücke). It was a stimulating learning environment for the staff including exchange of information and benchmarking practice, transferring and adapting tools to situations in other member states and jointly developing transnational products. Change in the core activities and preparation for future collaboration was also possible for the organisation.

- 4.45 The Inicia project was described as a second experience from Cantabria, a province close to the Basque Country, which was also financed by the local government and the European Social Found from 1998-2000 (Horizon III) and developed by three different institutions: Centro Hospitalario Padre Menni, Amica and Ascagam. Inicia initially developed a psychosocial rehabilitation programme in combination with vocational rehabilitation activities and a family support programme, and later was the main contribution to the development of an specific psychosocial rehabilitation network of centres financed by the local government.
- 4.46 The main aim was to provide vocational services for people with long term mental illness (no brain injury or addictive behaviours) with special difficulties to work in the open labour market. The services included vocational training, sheltered employment services, a supported employment programme, occupational therapy and vocational guidance.
- 4.47 One of the main components of the programme was user and family assessment by interviews and standardized tests. User assessment included clinical status, health and daily life issues, social and community participation, educational level, work experience, motivation and expectations, job searching skills, social status, and skills and habits at work. Family assessment included structure and relationships, family needs and expectations. Intervention consisted basically on case discussion and taking decisions in the professional group, and making a vocational rehabilitation programme for each user matching his/her needs and the family's needs (risk areas, resources, lacks and aims).

Health sector employment in Pomurje region in Slovenia

- 4.48 The aim of this case study was to assess the economic and social impact of health sector employment in the Pomurje region. Pomurje with 130 000 inhabitants is located in northeast Slovenia. The region is predominantly agricultural but has expanded its tourism sector in recent years. GDP per capita is 69% of national average and 52% of the EU average (UMAR kazalniki). The unemployment rate is 16,8% compared to 10% of national average. Some health indicators (mortality rate, morbidity of certain diseases or some lifestyle indicators) are worse in this region than nationally. The health sector in this region consists of providers of health care (public and private, out- and in-patient care) and SME's (supplier of goods, producer of medical remedies or pharmaceuticals).

- 4.49 The health sector in Pomurje is an important employer: 6% of all employed. The majority of employees (70%) are well-educated women, mostly employed in the public sector. The public sector offers higher rates of permanent employment than the private sector; therefore employment in health sector ensures financial security and social recognition. Yet, we must not oversee the impact of shift work on health (and long-term night work), lifestyle (nutrition, physical activity, smoking), family life (organization of everyday activities or additional costs) and stress.
- 4.50 Men and women are legally equal regarding payment, although female salaries are 93% of male salaries (EU-25 average is 88%). About two thirds of all those employed in the health sector have secondary or higher education. We have to consider the cost, time and effort invested in education of highly specialized experts such as doctors in the light of migration of workforce. Slovenia has 2.2 medical doctors per 1000 inhabitants, which is second lowest rate in the EU. The EU-25 average is 3.1.doctors par 1000 inhabitants. Since health care systems usually tend to be better developed in urban rather than in rural areas, Pomurje region is at risk of having limited access to health care services, having 1,6 doctors per 1000 inhabitants (Zdravstveni statistični letopis 2004, IVZ).
- 4.51 Because of its size the health is a very important employer in region and the most important service branch. However, the social impact as a provider of well played permanent jobs for women is not recognized enough. Better health as final outcome of health sector contributes to economic development of region (and vice-versa: economic prosperity impacts health). Public money is invested for public good.
- 4.52 The public health sector ensures more permanent jobs as private sector. Two thirds of employees are women. There is development potential in employment and procurement, creating new workplaces (e.g. hospital procurement, home care services), increasing impact on regional economy. Broader impact could be observed in migration of workforce within country, within EU, from Third countries. Overall, the health sector faces growing demands and costs, challenging existing financing modules.

Steiermark Region: Human resources in the health sector

- 4.53 The total number of employees in Steiermark has increased by 3.6% between 1995 and 2004. The services sector overall grew at a rate of 9.5%, while the health, veterinary and social sector reached a rate of 32%. The health care sector thus grew more than twice as rapidly as the services sector, and employment levels rose around eight times more than those in the economy overall. The health care and social sector makes the second highest contribution to the growth of

employment in the EU after the provision of business-related services. The workforce survey reveals that – when all employees are included – the proportion of those employed in the health care system in Austria (8.2%) is below the EU average of 9.7%.

4.54 If we take now a closer look to the separate numbers of physicians and nurses you can see, that the number of physicians in Austria has reach the European standard, but the number of nurses is much lower than the EU average.

4.55 If we analyse the situation in Austria concerning nurses, we find out these facts:

- Total number of nurses in hospital facilities has grown by about 10% in the past decade
- Between 1995/96/97 and 2002, number of nurses in homes for senior citizens/nursing homes rose by 58% and by 78% in the field of mobile services
- Nearly unchanged number of annual graduated nurses and assistant nurses
- Up to 5% of an available permanent posts in hospitals and mobile care are not occupied
- In homes for senior citizens/nursing homes this figure is as high as 10%
- An additional 6.000 nurses till 2010 will be needed in Austria, in Styria 100 per year

4.56 A number of recommended measures are currently being considered in order to address the shortage of nurses:

- Establish a reliable reporting or documentation system for the employment situation of nurses (similar to the system for physicians)
- Undertake supra regional planning of training centres
- Ensure effective communication of information about activity-areas and connected instruction and supervisory regulations
- Review and better define lines of responsibility
- Raise the social value of the Job “nurse” by ensuring provision of quality education at diploma and degree level.

The Sjuhärad Region in West Sweden: projects to maintain a healthy workforce

4.57 The region is a part of West Sweden and comprises nine municipalities working together. The Sjuhärad district has 259 000 inhabitants and constitutes a vital part of the region of Västra Götaland (West Sweden).

4.58 The mission of the Association is to act as regional body looking after common interests of the member municipalities. The object is to bring together the Sjuhärad area and to work for development and effective exploitation of resource within certain areas, such as:

- Regional development, including European issues
- Education / research
- Social welfare
- Improving health

4.59 We work for regional development in the following areas: trade and industry including tourism, infrastructure issues, culture and communications, internationalization and EU development matters. Our duties also include supporting and developing municipal autonomy, safeguarding the mutual interests of the municipalities and promoting co-operation between them, monitoring developments in the outside world and representing members in national and regional situations.

4.60 The main project, *Improving Health in Sjuhärad*, started in 2005 and ends in 2008. The goal of this project is to contribute to new solutions that reduce sickness absence among Sjuhärad's municipal employees and make municipal places of work more attractive. We have about 23 000 employees in our municipalities.

In this respect, we must stimulate: "Increase movability in the labour-market". Today many people feel themselves locked on their jobs. This can be unhealthy.

4.61 Within the larger project is *Medarbetarcentrum Sjuhärad*. Our politicians came to a decision in March 2006, to start this element. *Medarbetarcentrum Sjuhärad* (Collaboratcentre Sjuhärad) involves working preventively. We offer our services to employees in all Sjuhärad's municipalities. We begin to work with persons before unhealthy arise and you need non-rehabilitation.

4.62 The support for our employees includes the following elements:

- Map out your strong sides
- Career planning
- Outplacement
- "Prevent rehabilitation" = try to find out your working capacity – be a trainee at another work/job – vocational guidance = analyse your interest, competence and goals.
- Web database – employees report their will to change work – the municipalities report vacant jobs. Among the employees who will change work we coach towards vacant jobs. The municipalities economize advertise costs if they found new person among them who will change.

4.63 It is hoped that the outcome of the evaluation of project Collaboratcentre Sjuhärad will be positive and that the politicians will decide to support a permanent Collaboratorcentre. Evidence

of effective impact include: s better health at work, more attractive places of work and fewer employees out of work.

4.64 Another point is that the municipalities save money and can work more proactively to develop new solutions for better health at work. The Collaboratecentre model in West may provide a model for use in other countries in Europe. Work preventive before unhealthy arise and you need non or lesser rehabilitation.

4.65 An additional sub-project is '*Better conditions for older skilled workers*'. The aims are to support all seniors who will and can shall have possibility to work to the real pension age and to facilitate Take care of all experience from seniors. This project provides programs for our (seniors) employees in different ages: 57, 60 and 63. In effect, this is active age management.

4.66 For example at the age of 57:

- All employees are offered a planning talk of the nearest ten years at work with closed chief. Then the employee receives an individual development plan towards their time to retire
- Yearly health control

4.67 In the 60th year:

- Skills seniors offer guidance to younger employees in work aa part of their labour time
- Transfer of knowledge/experiences to younger employees in organized way

4.68 In the 63rd year:

- Income 80% - wages 90 %- 100 % pension economize (work lesser and get along longer at work
- Network seniors two hours/month – they try to find out new ways to transfer knowledge /experiences and their skill.

4.69 All at work shall have further education focused on competence development irrespective of age.

4.70 In Sweden and in other countries in Europe the coming years it will be very important to have seniors in the workforce as long as possible before they retire. Currently, many older employees retire each year, more than new come into the workforce. It is a big Europe-wide issue to find solutions for. We must work innovatively, creatively and take care of all employees and ensure that seniors can and will work to a real pension age or longer. Also health care should be a key count component of planning.

5 Economic and social issues in employment

- 5.1 This section presents key findings of a study shared in one of the plenary sessions. This study is based on extensive experience in the UK and Finland giving particular attention to refugee access to health sector employment.

Health care professional refugee's access to appropriate employment in Finland

- 5.2 The presentation by Sanna Markkanen draws on research conducted by her to identify the factors that enhance or inhibit healthcare professional refugees' abilities to re-qualify and to find employment that correspond with their existing qualifications.

Background

- 5.3 Because refugees did not choose to leave their countries of origin and give up their jobs, it can be argued that by accepting refugees, Finland and other countries in the EC should commit themselves to helping refugees rebuild their lives. Many respondents to the source study have pointed out that if Finland is not going to give them a chance to re-establish their professional careers, they should not have been accepted in the first place. This applies particularly to quota refugees. For many highly educated refugees their profession or occupation is the main axis of their identity, and abandoning it would mean not only a loss of status and income, but also a loss of identity.
- 5.4 It is now widely recognised that finding employment is one of the main factors that facilitate successful resettlement and social integration. An integration strategy that focuses narrowly on employment per se, ignoring the importance of the quality of the employment, is insufficient and may even operate counter-purposively to generate labour market segmentation and re-enforce prejudiced attitudes.
- 5.5 The establishment of a strategy that enables more effective integration of healthcare professional refugees' skills into the Finnish workforce will benefit both refugees and the Finnish healthcare system. If Finland does not take an active stance in establishing a new integration policy that considers the needs of highly educated refugees (including more effective language training combined with a structured qualification recognition system) many refugees with useful skills may decide to migrate abroad after obtaining Finnish citizenship.
- 5.6 Finland has a growing foreign-born population and, especially in areas with high numbers of refugees and asylum seekers, refugee doctors' and nurses' cultural knowledge and language skills may enable the public health sector to improve services to newcomers who have not yet learned Finnish and/or who have problems that relate to practices that are condemned by Finnish legislation and/or Finnish people in general. Persons with a refugee background could also help

to provide information to Finnish healthcare professionals about cultural differences and how they affect the interactions between a doctor or a nurse and a patient. A study informant commented that:

Some of the Bosnians, Serbians and Albanians who live in this area call in and ask if I am working that day. And if I am working, they want to come to see me, because it is easier for them to talk to me than to talk to a Finnish doctor. Because it can be difficult for the patients if they can't be sure that they have been fully understood. Even if I can't do anything to help them, they still feel better after seeing me, because they know that I have understood what's wrong with them (Doctor, Kosovo)

Interim findings

- 5.7 An extensive range of inhibiting factors and small group of enhancing factors have been identified from the research.

Inhibiting factors

- 5.8 Overall, there is a long wait while an asylum claim is being processed (and related exclusion from integration services)
- Refugees are too often seen as the victims of their past. This type of 'medicalisation' of the refugee experience, however, can influence refugees to adapt a passive 'victim role'. Although it is undeniable that many refugees have been through some trauma, the 'victimisation' of refugees can result in misguided notions regarding refugees' needs.
 - Because integration services personnel have a significant role in facilitating healthcare professional refugees' access to different types of training. Instead of assuming that refugees need some time to recover from their traumatic experiences they have to realise that for some (such as all of the health professional refugees included in the source study) a sense of being in control of one's own life again is regained best by re-establishing one's career.
 - All of the refugees in the study had either spent several years in doing nothing, or very little, growing increasingly frustrated. It is important to remember that most refugees who come to integration services have either come as quota refugees from refugee camps (where they have often spent several years) or they have been through the asylum hearing process, which also commonly takes 2-3 years. By the time they arrive in Finland or receive a positive decision they are often eager to get on with their lives.
- 5.9 For people with high level of education that often means getting back to work. Instead of wanting some 'time off', the people I interviewed listed getting back to work as soon as possible their number one priority. If integration services do not take this kind of ambition seriously, a disservice is done for both refugees themselves and the Finnish society.

- 5.10 Another common incidence is that integration services personnel's (or international services personnel as they are called in some cities) notions of refugee's language skills leads to the withholding of relevant information regarding qualification recognition training programmes. Refugees themselves, however, expressed a strong desire to be made aware of the different options as soon as possible. Even if their language skills were not sufficient to start the training immediately they considered it to be an important motivating factor to know that as soon as their language skills reach a certain level they will be able to proceed to a qualification recognition training.
- 5.11 However, problems are often caused also by integration services' eagerness to reduce the numbers of people who require language training. While people who work in integration services and employment services understand that level 3-4 Finnish is not sufficient for doctors and nurses, the lack of sufficient language courses often results in some highly qualified refugees being pushed to proceed with their qualification recognition (or a new degree) before acquiring sufficient language skills. However, with lacking language skills the re-qualification process (for doctors) takes much longer. Because nurses have to take an entrance exam in Finnish and then redo their degree in Finnish, insufficient language training makes it impossible to even get started with the process.
- 5.12 While an organised qualification recognition programme exists for doctors in Finland, the requirements are rather complicated, and refugee doctors are often not given sufficient details regarding the process upon their arrival. Furthermore, refugees frequently complain for not getting enough support in terms of finding practical training opportunities, while people who work in employment services often say that are not usually asked to help with finding such positions. Those doctors who have personal contacts with other people who have been through the qualification recognition process or who receive help from the consultant or other doctors at the place where they are doing their practical training often attribute their progress to help of these people.
- 5.13 The Finnish government is aware of the complexity of the qualification recognition process and the lack of available language training (MOL 2002: MOL 2005a: MOL 2005b), but continues to blame inadequate resources. Poor language training has been a factor particularly for those who came as asylum seekers. Several of the respondents told stories of receiving 1-2 hours of language training twice a week. Although the quality of the training has improved from the early 1990s, one of the problems that particularly asylum seekers face is the mixed composition of the groups. Although health professional refugees were well educated and knew the Latin alphabet upon their arrival, they were often placed in same groups with illiterate people, or people who knew how to read and write but were not interested in learning Finnish before receiving a positive decision.

I was placed in the same language class with people who were completely illiterate. I remember them wondering how come the letter 'r' in Finnish language looks different than the letter 'r' in Arabic writing... So I studied Finnish at home by myself, reading the bible in Arabic, English and Finnish (Doctor, Iraq)

- 5.14 While doctors have an established qualification recognition process, nurses and dentists are commonly left to their own devices or in the mercy of the local integration/employment services. It is not uncommon for nurses to be advised to obtain a lower qualification as a nursing assistant or to be told that they need to redo their entire qualification. Although there has recently been a two year-long qualification training courses for immigrant nurses, none of the study respondents had been told anything about these courses by the integration services.

Although I am fully qualified nurse I was told that should take a course to qualify as a healthcare assistant (practical nurse). That took three and a half years. Now I should redo my entire nursing degree. They said that my old degree in nursing is worth nothing here" (Nurse, Iran)

- 5.15 The relatively high unemployment rate among professional refugees and immigrants in Finland is often explained in terms of structural barriers and institutional discrimination, such as authorities' and employers' reluctance to recognise foreign qualifications. Institutional or structural discrimination is a practice whereby discriminatory customs are institutionalised in the sense that they are 'perpetuated', although often unintentionally, through different policies and practices.
- 5.16 The problem with institutionalised discrimination is that charges are only applied to policies and practices that are intentionally discriminating, while policies and practices that have unintentional consequences are often left intact (Jackson 1987). Contradicting some of the earlier studies the healthcare professional refugees interviewed in the source study all appear to understand that some updating of the existing qualifications is necessary.

Enhancing factors

- 5.17 Those who had been lucky enough to get a place on a good language course really appreciated it. Intensive and hard language courses were praised by the respondents as being 'painful but useful'. In addition, having Finnish friends enables refugees to learn more Finnish outside the classroom. Having strong social networks has also an impact on people's general well being, and the respondents who were satisfied with their new lives in Finland were the ones who had Finnish friends or otherwise active social life. One respondent who seemed to be very content with his life in Finland attributed this to his active social life as well as good relationships with his colleagues.

- 5.18 All respondents who had been relatively successful and proceeded quickly attributed this to help from a colleague or someone else who was in a position to help others. I was left with an impression that even a small helpful gesture was always noticed, and the names of those who had been helpful were well remembered.
- 5.19 Those people who had participated in an organised qualification recognition training (doctors only) all thought that the idea of qualification recognition training was good. While some thought that the training has been quite useful, other were more interested in discussing its shortcomings. However, all respondents who had participated in the Tampere training course thought that they had benefited from it at least a little bit. However, it should be noted that organised qualification recognition system (and training) is available for doctors only. Nurses are commonly required to redo their entire degree in order to obtain a license to practice their profession in Finland. All doctor respondents were aware of the qualification recognition requirements. Three doctors had been fully qualified already – none of the nurses who were educated abroad had requalified in Finland.

Potential policy implications

- 5.20 Considering the significant responsibility that doctors and nurses have, it is appropriate to require them to undergo some form of training and examination to ensure that they are fully capable of working in Finland without risking the patients' safety. In order to integrate well educated refugees into the Finnish labour force as effectively as possible, Finland must establish a nationwide policy, whereby all arriving refugees' professional qualification is recorded, and educated refugees are actively recruited for suitable qualification recognition programmes. At the moment, local employment offices do not keep records of refugees' professional qualifications, and no official statistics about refugees' educational qualifications exist.
- 5.21 Many of the factors that currently inhibit healthcare professional refugees' access to qualification recognition training and appropriate employment could be overcome by paying more attention to highly educate refugees' needs and their priorities as defined by themselves. Suggestions for how to improve the qualification recognition training for doctors include:
- Training should start soon after arrival (or after receiving a positive decision). More active involvement of authorities (such as the Ministry for health and Social Affairs) and the professional community would be welcomed.
 - The training should be more comprehensive and more intensive, starting with an intensive language course (6-9 months) and then lasting 9-12 months. The training should contain both theoretical and practical elements (currently the training lasts for 2 months).

- Several respondents noted that it would be beneficial to provide immigrant doctors with high-quality language training with a specific focus on medical vocabulary.
- It was also suggested that past work experience should be taken into consideration, and doctors who have been working in one specific field for decades would be helped to update their knowledge and do some practical training to refresh their memory.
- Several respondents would have welcomed more help with finding practical training opportunities.

5.22 No organised qualification recognition system for nurses or dentists exists – one of the nurses interviewed was seriously considering moving abroad, and one was applying to school to get a degree as healthcare assistant. Also racism at work needs to be taken seriously. Another nurse who had come to Finland when she was a teenager and had been educated in Finland was in the process of moving abroad due to continuous experiences of racial harassment and bullying at work.

5.23 Considering that Finland's population is expected to start declining in 2020s and Finland is not a very attractive destination for the so-called voluntary migrants, we really cannot afford to have a bad reputation among refugees as well. So I would say that it is a high time we start prioritising refugees' own priorities in integration services, and look abroad for some useful hints as to how we can make the qualification recognition processes for highly educated refugees more effective, more practical and more reasonable.

6 Connecting employment to regional economies

- 6.1 The case study presentations and discussion at the Health ClusterNET Hameenlinna workshop illustrated a number of factors that can promote or hinder the effectiveness of health care employment in improving regional economies. These are summarised below.

Decision-making and financial authority

- 6.2 The degree to which regions enjoy responsibility for health care, as opposed to central government, varies greatly from country to country. In Sweden, for example, many aspects of the health system are in the hands of municipalities, whereas in Portugal it is still the case that agencies of central government are involved in local decisions. A key message from earlier HCN workshops was that, where regions have been given responsibility for decisions in any of the basic elements of health care - public health, primary care, rehabilitation services, acute hospitals, mental health – it is vital that they also have the autonomy to plan, finance, and implement solutions to health care needs.

Integrated approach to workforce development

- 6.3 When thinking about employment and how best to invest in the workforce, it is important to take an integrated approach. In other words, investment in the workforce should be considered in the context of shifts in service provision, the needs of other sectors (e.g. social services, community care, regional training and skills development), developments in technology, and broader societal values.

Understanding principles and processes that are effective

- 6.4 The health landscape has common elements across regions (cost increase, the move from acute to primary care), but governance, politics, professional and power relationships can vary greatly. In addition, differences in employment policy between and within countries make it unlikely that case models can be simply transferred; the key is to understand the principles and processes that led to success (or lack of success).

Improving inclusive employment policies

- 6.5 There is a slow decision-making process in several partner regions that is an obstacle to the creation of inclusive employment as a policy goal. There appear to be a range of factors that are blocking efforts to create more diverse and flexible workforces. These include: stigmatisation of people with disability; increasing reduction in tolerance for people from different cultural backgrounds; directing skills health professional refugees and migrants into basic entry-level jobs; lack of clear and supported return to work processes for people out of the active workforce due to severe stress, physical conditions or incapacity; lack of awareness of legal requirements for promoting inclusive workforces e.g. discrimination laws.

Improving the attraction of working life

6.6 This has several elements:

- In a demographic environment in most EC member states where populations are ageing create specific challenges for all employers in the public and private sectors. Combined with groups who are out of work for different reasons, the labour market is tightening. This requires employers to identify, recruit and retain new employee groups
- In a few partner regions, leadership in the private sector appears to be more focused on improving the attraction of working life than the public sector
- Understanding what counts as success differs between the public and private sectors. In the private sector it is largely 'making a profit'. In the health sector it can vary between doctors, nurses, managers, other health professionals and support staff.

7 Towards a policy agenda for inclusive employment

- 7.1 The costs of publicly funded health services are pushing at the limits of affordability. This is a challenge shared by all European regional health systems. In this financial climate, health organisations need to be able to demonstrate the added value of investment and expenditure decisions.
- 7.2 Within partner regions, spending by health services on staff, goods & services, buildings, IT and equipment ranges from 6 to 9% of regional GDP. This is a significant level of economic activity. But it is not optimised to positively contribute to regional development agendas. Nor is it used to maximise the population health benefit of health care expenditure.
- 7.3 Inclusive employment policies and practice in the health sector are one way of achieving these contributions. They should: help create dynamic local businesses that are competitive in wider markets; boost local employment; widen the skills base; improve workplace & population health; and strengthen social cohesion. These are the kinds of added value that we should expect from public organisations spending public money.

Ensuring the relevance of a policy agenda

- 7.4 There are five main audiences for an agenda on health sector procurement:
- For **health service decision makers** this agenda shows understanding that workforce decisions need to address the move from acute illness to chronic preventable conditions as the third 'age' of health care across European regions. This shift will need (i) cross-sectoral service delivery designed around the needs of patients, carers and families (ii) investment in technologies that minimise hospitalisation. It also supports the development of the corporate social responsibility role of your organisations and also shows your commitment to the health inequalities and health improvement agenda.
 - For **local health organisations** such as acute hospitals and primary care organisations, this agenda helps show your commitment to joint working with local government and other partnerships to develop fully engaged communities at both individual and organisational levels in service delivery and quality of preventable and minimised affordable care.
 - For **regional governments**, evidence suggests that health care workforces are best managed where there is considerable local autonomy in decision-making, coupled with tightly-knit accountability to a region's population. Overall, the partner case studies indicate that

regional health bodies should develop and maintain expertise in anticipating future health demands, understand how to manage relations with other private or public sector providers, and become proficient in speaking the language of the central Finance Ministry.

- For **SMEs**, the adoption of this agenda in your region or community, offers a clear basis for lobbying for simpler, more transparent procurement processes with less bureaucracy and the development of an enterprise aware culture in health service organisations. In turn, this can contribute to the indirect regional employment impact of the health sector.
- For relevant directorates within the **European Commission** (DG Enterprise, DG Employment, Social Affairs and Equal Opportunities, DG Research, DG Regional Policy, DG Health & Consumer Protection), this agenda offers a platform for an approach that cuts across individual DG competencies in order to achieve European added value.

Purpose of the Agenda

- 7.5 This Agenda provide a practical response to the ‘health equals wealth’ challenge first set out at the European Health Policy Forum in October 2003. The Graz Agenda puts forward a range of capital investment policy actions for localities, regions, and the European Commission. The Agenda has been shaped by the practical experiences, evidence and insights generated by regions from across the EU and beyond who are partners in Health ClusterNET. Importantly, it also reflects how partner regions are currently progressing in terms of economic performance and Lisbon Agenda orientation.

Agenda aims

- 7.6 To enable regional health systems to more positively engage with regional development through capital investment policies, planning and actions that contribute to affordable, flexible, possibly intersectoral and dynamic health care infrastructure and IT-based services.
- 7.7 The aims of the agenda are to:
1. To enable regional health systems to more positively engage with regional development through employment policies, planning and actions that maintain and improve a flexible, possibly intersectoral, attractive, inclusive and high quality workforce.
 2. To integrate the goal of inclusive employment into mainstream health sector employment policies in order to create more diverse and flexible workforces.
 3. To enable European regional health systems to have flexible options regarding approaches to employment that ensure health sector workforces are affordable and capable of allowing health care to adapt to changes in service priorities reflecting local health and well being needs.

4. To create and maintain a health sector workforce that is a sustainable employment opportunity for an ageing workforce combined with recruiting and retaining previously marginalised social groups: long term unemployed, people on incapacity or welfare benefit, the homeless, people with learning disability, refugees.
5. To learn from good practice private sector employers about how to improve the attraction of working life for all employee groups in the public health sector.

7.8 The Agenda has been shaped by the practical experiences, evidence and insights generated by regions from across the EU and beyond who are partners in HealthClusterNET. The recommendations are organised into three regional group categories that reflect progress within partner regions in terms of economic performance, Lisbon orientation and engagement of regional health systems with regional development. The first two objective indicators are developed and reported by the European Spatial Planning Observatory Network (ESPON). The third is a self-assessed indicator by each partner region.

Policy recommendations

7.9 The following policy recommendations are organised into three regional categories. These categories reflect how two objective indicators and 1 self-assessed indicator define partner regions. The two objective indicators are Lisbon Orientation and Economic Performance and were developed and reported by the European Spatial Planning Observatory Network (ESPON). The self-assessed indicator reflects how partners assessed the extent to which health sector investment in their own regions is contributing to regional development. This self-assessment used agreed criteria to place each partner region into one of three development stages (early development, solid progress, fully engaged).

Group A: Economic potential, weak Lisbon orientation, health sector starting engagement

7.10 Group A includes regions (i) where the health sector is at an early stage of development in ensuring that health sector investment and assets contribute to regional development for regions (ii) that have economic potential but weak Lisbon orientation. In Health ClusterNET the following regions are in this group: *Harghita, South Transdanubia, Malapolska, Alentejo, Basilicata, Slovenia*.

7.11 All regions in this group have a Public Health system that functions in a similar way but there are some differences in funding and organization of health services at local, regional and national level:

- The private health system is actually developed in South Trans-Danubia, Malopolska, Alentejo and Slovenia, but is missing in Basilicata and Harghita.
- Health Funds exist on national level in each of these regions, but in a majority of them functioning is centralized. Only in Malopolska, Alentejo and Basilicata is funding devolved so that regions can influence the expenditure.
- There are also differences between regions on the level and organization of Health Insurance funds. Private health insurance funds are established in Harghita and Slovenia where the free choice of citizens also exists. In Malopolska such a system will be established in the near future and in South Trans-Danubia it is also in development.
- Employment in Health Sector was discussed for specific health professions. Especially for doctors and nurses the issue of migration of health professionals is quite different through regions. Only South Trans-Danubia and Basilicata seem to have an adequate supply of doctors. In Malopolska the situation is in equilibrium but is expected the number of doctors and nurses will lower because of emigration. In Alentejo, Slovenia and Harghita the number of doctors employed is lower than actual needs. Sufficient numbers of nurses exist in South Trans-Danubia, Slovenia and Harghita, and demand for them is stated in Malopolska, Alentejo and Basilicata.

7.12 As result of such state of health workers emigration to places with better working and payment conditions exist especially related to emigration to West European countries. Immigration to countries with higher demand for health workers is still problematic e.g. verification of diplomas, citizenship, language problems, local habits. In general, immigration is mainly individual and not organized or formally regulated between countries.

7.13 Accordingly, this group of partner regions identified the following policy recommendations as a 'route map' to enable them to make progress in ensuring that health care employment contributes best to regional development:

Overall

- EU regions need to develop and implement programs for enabling formal and organized transfer of doctors and nurses from regions with enough staff to regions with a deficit in the workforce. Such programs should represent a regional network accessible for all interested regions. Measures at the national level are also needed (comparable educational programs, equal diplomas, citizenship problems) to ensure an equitable workforce flow.

- Develop and implement programs for involving the health and social workforce in integrated regional employment. Where regions have an under-strength regional health sector workforce the solution could be employment through use of organized immigration of additionally educated and informed professionals. However, regions should also consider employment of own national workforce drawn from other regions in their country.

Structural base

- Regions should consider establishing a multiagency area partnership of organisations from the publically or health insurance funded health and social care sectors, the private health sector providers and social enterprises. The purpose of the partnerships would be to agree priorities for and contributions each can make to improving an attractive and competitive multiagency regional health sector workforce.
- Initiate and develop health tourism that is private or based on contracts (hip replacement, dentistry, movement therapy). A model of good practice already exists between Malopolska and the UK and is a possible solution. In border areas between regions there does exist health tourism based on use of spa's and wellness facilities, dentistry services. However, this functions mainly on individual level and direct payment of services delivered.
- Establish more sophisticated interregional organized health tourism based on agreements between regional and national health authorities and institutions (public and private) as also with health insurance systems in regions so that services and treatment such as hip replacement, dentistry, movement therapy and others can be offered between the regions. In such a way there would be no need to close hospitals or lower the number of employed health workers in regions because additional work would come to the region. Also, in regions with long waiting lists for services, patients could get help in shorter time. These activities would lead also to establishment of equal quality standards in participating regions and also in general through the EU.

Policy level

7.14 The proposed measures could be used for solving problems in the health and social sectors of participating regions. But, successful performance needs several preconditions:

- Local and regional stakeholders should have innovative ideas and build them in Regional Development Plans
- Dialogue between local-regional-national level of health, employment and social sector should be established
- Interregional dialogue/agreement should be achieved as basis for development of new structures

- Mutual benefits for all partners (shorten waiting lists, adequate use of resources...) would be the final result

Responsibility

7.15 The overall responsibility should be at EU level through fulfilment of EU legislation and other existing documents oriented to unifying processes between European regions with a goal to achieve comparable services and employment possibilities. Besides this, the basic conditions interest and responsibility of regional health services providers is important and their will for common collaboration as also important responsibility of local and regional stakeholders and regional and national level of political decision makers exists.

Group B: Less clear economic trend, high Lisbon orientation, health sector engaged

7.16 Group B includes regions (i) where the health sector is making solid progress or is fully engaged in ensuring that health sector investment and assets contribute to regional development (ii) that have less clear economic trend but with high Lisbon orientation. The regions in this group are: *Västsverige, Brandenburg and North West.*

7.17 This group of partner regions identified the following policy recommendations as a basis for enabling them to maintain progress in ensuring that health sector employment contributes best to regional development. Addressing the seven policy recommendations agreed by this group needs recognition that a number of barriers have to be overcome, that certain incentives can be used to overcome the barriers and that policy action should be underpinned by a clear set of principles.

<p><i>Barriers</i></p> <ul style="list-style-type: none"> ▪ Alignment of policy, strategy and funding streams ▪ Refine the definition of social enterprise beyond its widest interpretation ▪ Compliance with local financial accountability frameworks ▪ Lack of encouragement for entrepreneurial behaviour (social enterprise) <p><i>Incentives</i></p> <ul style="list-style-type: none"> ▪ Reassurance for funders (compliance, service level agreements, community service agreements) ▪ Financial incentives to keep scarce skilled workers where they are

7.18 The key principles that would inform the effective and sustainable adoption the policy recommendations are:

- Benefiting from skills of older workforce
- Training and actively recruiting excluded members of the workforce

- Creating new types of social organisation that meet current and future needs in an innovative way
- Developing public/private/Third Sector partnerships to create health skills capacity that are responsive to local employment needs
- Incorporate health development as inclusive part of regional development
- Helping people into work rather than creating barriers

7.19 The main policy recommendations are:

- Standardising medical qualification rules across EU – *UK DH already working on this in EU context*
- Balance between regulations to allow flexibility of interpretation at a local/regional level
- Encourage social enterprise and SMEs in the health and social care sector
- Countries receiving skilled migrants acknowledge loss to provider country and act to ameliorate effects through EU structural funds
- Raise awareness and promote the asset-based community development approach – *Kreitzman, McKnight*
- Make it attractive to stay in employment after retirement age – e.g. pension reform
- Develop more approaches to health and well-being in the workplace e.g. West Sweden

Group C: Strong economic trend, high Lisbon orientation, health sector engaged

7.20 Group C includes regions (i) where the health sector is making solid progress in ensuring that health sector investment and assets contribute to regional development (ii) that have strong economic trends with high Lisbon orientation. The regions in this group are: *Steiermark, Etela Suomi, North East, Pais Vasco*.

7.21 This group of partner regions identified the following policy recommendations as a ‘route map’ to enable them to continue progress in ensuring that health sector employment contributes best to regional development.

7.22 An overview of common issues in the health sector in the countries and the regions in this group include: finance, regional workforce shortages in some professions, access for patients and quality and safety. Relatedly, cost-containment, efficiency measures and outsourcing strategies limit the health sectors ability to employ vulnerable people. This gets more serious compared to previous times. The major part of health sectors workforce is highly skilled and regulated. This is another limitation.

7.23 There is shared concern about too frequent organisational changes running in parallel with too much workforce regulation. The first impedes longer range planning and reliability; the second can be a barrier to local initiatives and sometimes innovation. For the central issues of vulnerable people there was consensus that regulation would be necessary to reach satisfactory results. Moral persuasion and fine tuned incentives would not be appropriate.

7.24 A route map for effective and sustainable health sector employment policies at regional and sub-regional level should be guided by the following:

- **Time horizon** - For employment policies choose an adequate time horizon. Short-term projects are prone to fail. The environment has to adapt. Learning curves need to be considered while outcomes and evaluation take time.
- **Act regionally** - The specific situations of the region have to be taken into account. Other EU projects have shown that regional strategies have a clear advantage,
- **Analyze carefully** - Employment policies should be based on a careful analysis of needs and possibilities. It was an experience of the members in the group that this is often not the case.
- **Regulate Recruitment policies** - Public institutions and businesses contracting with the public sector should have binding guidelines on their employment policy concerning vulnerable persons.
- **Accountable reporting** - Create a system of accountable reporting. This means that institutions that contribute more must have a chance of fair comparisons with other institutions.
- **Influence Purchasers** - There should be policies for purchasers to consider the suppliers employment situation concerning vulnerable persons.
- **Support prevention** - Healthier workplaces and life-long learning offer profits for both employee and employer.

7.21 Building on these guiding factors, the health care sector has two types of responsibility (i) as an employer and (ii) as an enabler of action across the public, private and NGO/voluntary sectors in regions. The basic policy recommendations in these two categories follow.

The Health sector as employer

- Inclusive employment policies should be embedded in core business objectives
 - The health care sector as large employer has a special responsibility in promoting the employment of vulnerable people.
- Show excellence as an employer
 - Not least because of its internal know-how the health care sector can show the chances of fulfilling working- relationships (e.g. working conditions, health & safety, flexible working, continuing professional development)

Health services as enabler

- Screen (vulnerable patients)

The health sector can contribute to personal, economic and social wellbeing in local communities by using supportive and proactive occupational health services to support vulnerable people seeking employment and for people at risk of losing employment.
- Support preventive measures

The health services can contribute on different levels with its know how: By supporting employers (occupational medicine etc.) as well as on individual levels. Sometimes the health services are the last resort vulnerable people have trust to.
- Seamless joint financed service chains

Anecdotal evidence shows that GPs and other health professions have problems to find and collaborate with services that can support vulnerable unemployed or people at risk of unemployment.
- Use social clauses within sector contracts

Thanks to its strong position the health sector can contribute a lot by using social clauses.

7.22 Overall, there was a preference for regulative measures for the central issues. This could be well accompanied by an accreditation model with adequate process measures and indicators for those areas where regulation is not necessary, not feasible or not workable.

Key developments for all regions

7.23 The following key developments would enable regions to effectively improve the contribution of health care employment to regional development and delivery of the Lisbon Agenda:

- Shift health policy towards prevention of chronic conditions and promoting well being (this should be done by health care policy makers)
- Develop cross-government and cross-ministry commitments to intersectoral planning, funding, workforce development and implementation at regional levels (national governments need to address this)
- Approaches to employment and workforce development within regions should be linked to and support merging best practice care models e.g. enabling integrated care pathways (Health and Finance Ministries at regional and national level)

- Information on and access to diverse employment models should be made available to regional decision-makers with clear evidence about relevant strengths and weaknesses of the different models (Finance Ministries)
- Responsibility for decision making on health care employment should be clearly devolved to regions and appropriate service organisations (National Ministries with responsibility for Regional Development and Finance Ministries)
- Identify incentives to encourage partnership working between cross-sectoral agencies e.g. through the development and use of integrated performance management frameworks and processes (Finance and Health Ministries, regional health systems)
- Enable the better development of integrated information systems to improve intersectoral decision-making about how to supply and improve better managed care pathways (local, - regional and national information experts and agencies).

Overall benefits

7.24 In conclusion, the following benefits will emerge if regions are able to address the relevant group recommendations:

- Models of inclusive employment that enable health care organisations to stay flexible across time will significantly enable regional health systems to adapt to developments in medicine and demands on care and prevention that are emerging in future years. In the shorter term, approaches to capital investment by health service organisations has the potential to stimulate the development of capable local businesses, strengthening their competitiveness in wider markets and so supporting a positive drive to achieve the goals of the Lisbon Agenda (growth, competition, employment)
- Inclusive employment policy and practice can be done in ways that: help create dynamic local businesses that are competitive in wider markets; boost local employment; widen the skills base; improve workplace & population health; and strengthen social cohesion. These are the kinds of added value that we should expect from public organisations spending public money.