Present and Future Challenges for Health Care Employment

European and Finnish Experiences

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Title
Present and Future Challenges for Health Care Employment – European and Finnish Experience

Summary
This publication is a thematic report on current and future challenges for health care in Europe and in Finland. This report centres around three broad themes which will be discussed more in detail: retention, recruitment of workforce, and supported work. There are also cross-linking factors affecting these themes: migration, well-being at work, aging of population, reorganization of work to increase efficiency and equality issues.

The EU countries, as well as most of the other Western industrialized countries, are facing acute challenge because of the shortage of health professionals. In Europe especially, there is an increasing flow of healthcare professionals from new member states in the Eastern Europe to old member states in the Western Europe. Regional inequalities in supply of health care services are an on-going problem facing many European countries. Rural and less developed areas are having trouble maintaining adequate level of health care services because of lack of human resources.

The input to health care sector may be increased, by providing more educational facilities at medical and nursing schools. Another way to increase input would be through immigration of health care professionals from other countries. Because recruitment and retention policies are key issues for sustainable employment situation in health care, gaining insights into labour-purchasing mechanisms may permit them to be addressed more effectively.

Although the retention strategy might relieve the situation, recruitment efforts have still been the dominant mechanism to tackle the problem. One of the often overlooked factors in retention and well-being at work is how to decrease work-related stress. One resource for the health work force is the marginalized group of people in the society: the long term unemployed due to industry structural change or after a long term of illness, the mentally or physically disabled, the immigrants and refugees. Setting up social enterprises that adopt an idea of inclusive employment is a solution under widely discussion among European countries

Key words
Health Care, Employment

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PREFACE

The present report has been written as a part of the EU co-financed Interreg IIIc project Health ClusterNET. The Province of Southern Finland acted as one of the 13 partners of the project. From the very beginning we expressed special interest in issues concerning the employment challenges that the health care sector is facing in Europe.

The employment workshop of Health ClusterNET took place in Hämeenlinna, Finland in October 2006. In spring 2007, an idea to write and publish a report based on the Hämeenlinna workshop and the subsequent Pecs policy forum on the employment theme was presented, and a draft version of the report was introduced in the project's final meeting in November 2007 in Brussels.

The report describes the current situation in the European health care labour market in which many serious problems are expected in near future. The fast-growing older age groups together with fewer young people interested in working in health care put the health labour market under a heavy challenge.

The shortage of health care workers is continuously growing, particularly in richer European countries which employ nurses and doctors from developing countries and other countries with lower salaries. This leads to a vicious circle of reduced health care workforce in the countries of emigration.

The current publication describes different strategies and regional programmes to combat the imminent serious shortage of health workers. Inclusive employment is particularly emphasized. The regions and third sector actors are encouraged to establish social enterprises that could support training of many marginalized groups of people to work in health care. These people are an important resource that is often much neglected.

Mr Patrik Nordin, M.Soc.Sc. and Ms Chen Shi Ting had the main responsibility of the writing of the report. Mr Juuso Nieminen, M.Soc.Sc. and Dr Antero Heloma coordinated the publication process and participated in the writing of the report.

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1 INTRODUCTION

Contemporary health systems are faced with an important paradox. On one hand, constant increases in health care investments over the past decades and major developments in biomedical research have resulted in expansion of knowledge, technologies, techniques, skills and resources that make it possible to tackle many major health problems more effectively than ever before. On the other hand, many recent attempts to reform the health care sector have had only limited success in the quest to develop a more effective, efficient, safe and equitable delivery system that achieves the fundamental goal of improving public health. One of the major, but often overlooked, factors in the success or the failure of such efforts is the configuration of the health care workforce. The inability to gain full benefits from current investments in health care arises from the difficulties of creating and maintaining an effective, efficient and motivated workforce.

A host of problems, ranging from looming shortages of health care workers, increasing labour migration, and distributional imbalances of various types (geographic, gender, occupational, institutional) to qualitative imbalances (under qualification or misqualification of health care workers) have undermined the capacity of health care systems to respond effectively to the challenges they face. This has given rise to recognition of the centrality of human resources for health as the source of all health actions (Chen et al. 2004). Some of the countries in Europe are facing particularly challenging workforce issues requiring policy attention, while others have recently engaged in explicit health care reforms with major implications for their workforce.

The key issues in the employment sector in Europe are improving quality and productivity at work and strengthening social cohesion and inclusion. These, alongside with ageing of the population, are leading Europe to face great challenges in the near future. This paper discusses some of the key issues on the employment in the health care sector and combines them with the aims of the HealthClusterNET. This report centres around three broad themes which will be discussed more in detail: retention, recruitment of workforce, and supported work. There are also cross-linking factors affecting these themes: migration, well-being at work, aging of population, reorganization of work to increase efficiency and equality issues.

2 OVERVIEW OF THE EMPLOYMENT SITUATION IN HEALTH CARE

Sufficient supply of human resources is one of the most important challenges the health care sector faces since it is the health care professionals that make all the individual and public health service happen. Undersupply, or shortage, is reported to cause adverse consequences such as lower quality and productivity of health services, closure of hospital wards, increasing waiting time, diversion of emergency department patients, reduced number of staff beds, or under-utilization of trained individuals (Zurn et al 2002).

The EU countries, as well as most of the other Western industrialized countries, are facing acute challenge because of the shortage of health professionals, especially of nurses due to the ageing baby boomer generation and its demand for health care services, including home care for the elderly. Health care is also an exceptionally

labour intensive branch of industry. In most parts of the service system labour costs make up 60-70 percent of total expenditures. However, labour costs are increasing faster than GNP due to the looming lack of educated personnel. Therefore, an ageing Europe hardly can expect to solve the increasing need for care only by increasing the number of health care professionals.

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 its borders 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. Increased migration of health care workers has been particularly strong within the European countries, which account for more than 40% of the foreign-born nurses and doctors working in the OECD area (Martin 2007).

In Europe especially, there is an increasing flow of healthcare professionals from new member states in the Eastern Europe to old member states in the Western Europe. The recent acceleration in flows calls for increased co-operation between origin and receiving countries, to share the benefits of the international mobility of health professionals (Ibid.). Throughout Europe, measures to manage the mobility of health professionals have had high priority, both at national level and among health service providers.

2.1. DEMOGRAPHIC AND EPIDEMIOLOGIC DATA

Life expectancy in Europe is increasing (Table 1), thus meaning longer time period left after ending working career. On one hand this means increasing pressure for health care systems to take care of larger groups of people. On the other hand, general public health situation has improved, leading to a better quality of life among older people, thus decreasing these needs. Still, this increase in the proportion of older people will cause health care spending to spiral out of control or at least lead to increasing strain of the care system in its attempts to meet the demand for services.

One often referred fact is that generally more money is spent on health care with ageing population (e.g. Kekomäki et al 2006). The average annual per capita spend on health care for people 65 and older is approximately three times as high as the average for all age groups, while that of the age groups 75 and over exceeds the average spend by a factor of seven. It is true that health expenditures typically increase with age.

Table 1. Life expectancy of HealthClusterNET member countries in 1995 and 2005.

	Life expectancy at birth (Men)		Life expectancy at birth (Women)	
	1995	2005	1995	2005
Austria	73,4	76,7	80,1	82,3
Finland	72,9	75,6	80,4	82,5
Germany	73,3	76,7	79,9	82,0
Hungary	65,5	68,7	74,8	77,2
Italy	75,1	76,8	81,6	82,8
Poland	68,5	70,8	77,0	79,3
Portugal	71,7	74,9	79,0	81,3
Romania	65,3	68,7	73,3	75,7
Slovenia	70,8	73,9	78,5	80,9
Spain	74,4	77,0	81,8	83,7
Sweden	76,2	78,5	81,7	82,9
UK	74,0	77,0	79,3	81,1

Source: Eurostat 2005.

Alongside increasing life expectancy, people are leaving labour market at 60,9 years old (EU 25 average), thus meaning an average about 20 years of post working life time. Retirement age varies widely between European countries (Table 2). A European-wide analysis (Börsch-Supan et al 2005) suggests that these variances are related to institutional differences: higher or lower retirement age, the presence or absence of incentives to prolong employment beyond the standard retirement age, or the opposite - variation in the extent of early retirement systems established in different countries to deal with the employment problems of elderly. However, these explanations do not fully account for the differences.

Individual preferences concerning retirement age also need to be taken into account. Many factors are responsible for the variation in preferences for retirement age. Satisfaction with work and health status are often considered to be key factors. However, they are not independent of each other: demanding or unsatisfying work may result in poorer health status, or a poor state of health may reduce satisfaction with work. Some widely accepted indicators include an indicator on general satisfaction at work, an indicator of physical severity and an indicator of workload.

Table 2. Average exit age from the labour market in HealthClusterNET member countries 2005.

Country	Age	Country	Age
Austria	59,8	Portugal	63,1
Finland	61,7	Romania	63,0
Germany	61,3	Slovenia	58,5
Hungary	59,8	Spain	62,4
Italy	59,7	Sweden	63,7
Poland	59,5	UK	62,6

Source: Eurostat 2005.

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 United Kingdom and Austria and Poland it is going to take another 5-10 years (Table 3). Migration is not included in these calculations. 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. From structural workforce shortage situations to shortfalls in certain sectors or caused by short term economic circumstances, the range of measures to be put in place, among them taking on migrant workers, obviously differ greatly country- and sector-wise.

Table 3. Labour supply deficit in HealthClusterNET member Countries with the year of occurrence.

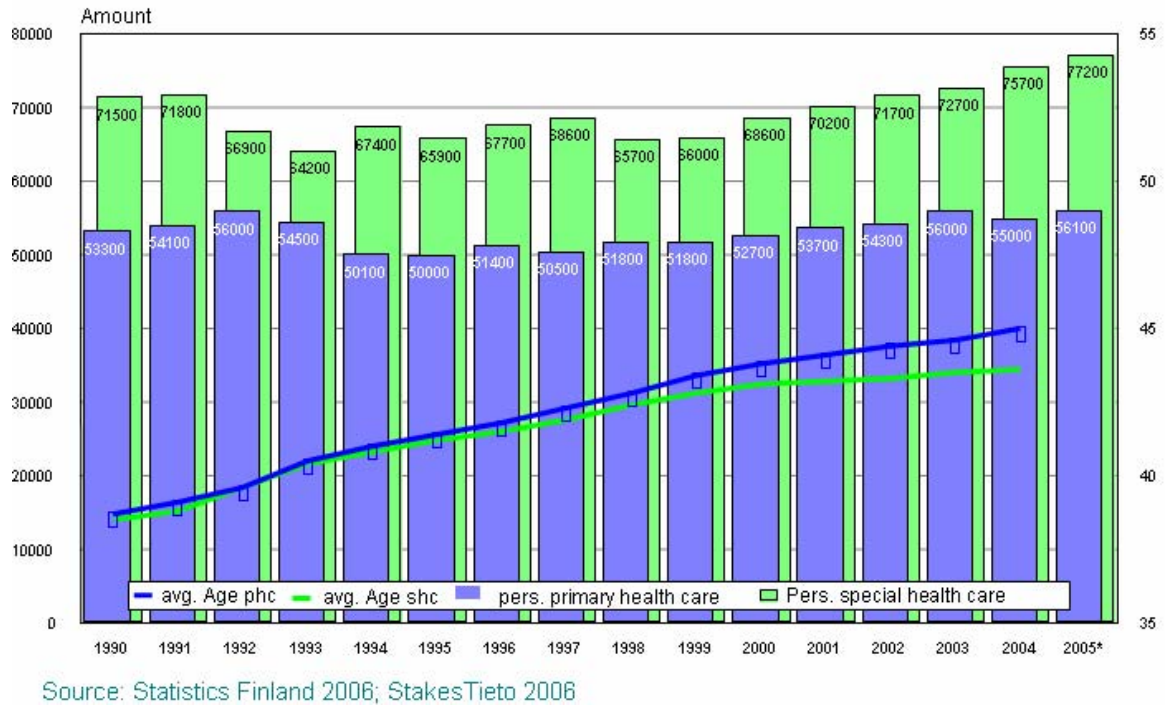
Country	Year	Country	Year
Austria	2012	Poland	2011
Germany	1993	Portugal	2007
Spain	2008	Romania	-
Finland	2003	Sweden	2000
Hungary	2007	Slovenia	2008
Italy	2000	UK	2016

Source: Eurostat New Cronos 2005.

Finland among many other European countries is facing this shortage challenge earlier as the baby boom generation was born in 1945-49 compared to Italy and Spain where it was born in 1970s. In fact, in the Finnish labour market the outflow of workforce at the average age of 60 already exceeded the inflow of young people entering the labour market at the average age of 20 in year 2005.

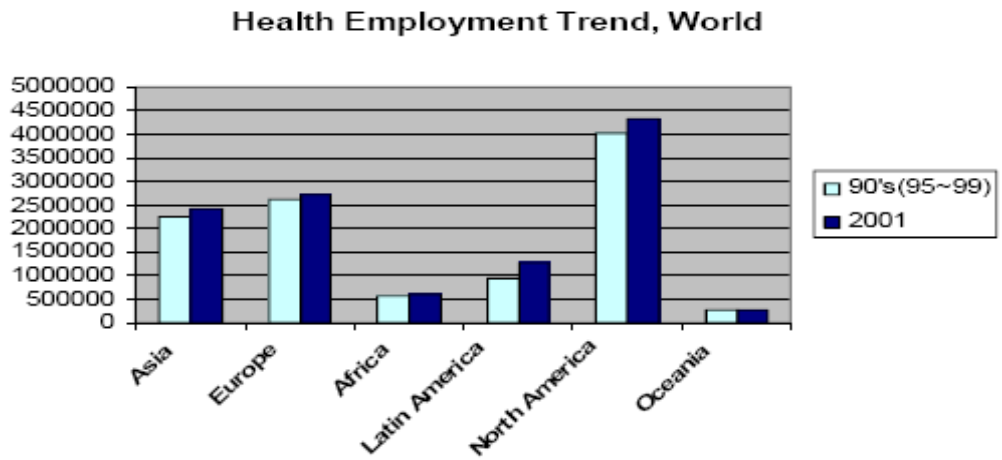
When looking specifically at ageing of health care personnel, it can be seen that in the EU over 50 % of physicians are more than 45 years old, while in the United Kingdom 100 000 nurses are due to retire by 2010. In Norway the average age of dentists is 62 years old (WHO 2003). Finland has also faced the same situation. Figure 1 shows that the average age of the health professionals is increasing each year. By the year 2004 the average age had already reached 45. The ageing process is expected to continue until the next decade and to cause a shortage of health care workforce, especially among nurses.

Figure 1. Number of Health Care Workers in Municipalities and in Federation of Municipalities 1990-2004 (includes those on leave of absence)



On a global scale North America (U.S. and Canada) has the overwhelmingly largest amount of health care workers (Figure 2). There are overall 100 million health care workers world wide, of whom 24 million are registered doctors, nurses, midwives and the rest 76 million informal traditional community and allied workers (WHO 2003). Worldwide shortages of nurses exist (International Council of Nurses 2002) and these shortfalls extend beyond supply-side constraints and cyclical features of labour markets that can possibly be remedied. Instead, shortages signify deep-seated concerns about unattractive pay and working conditions, relative to other occupations with similar educational requirements (e.g. Bach 2003). Similar concerns have emerged in relation to the medical profession (Smith 2001).

Figure 2. Number of Health Care Workers by Continent.



Source: WHO Global Health Atlas 2003

2.2. MIGRATION OF HEALTH CARE WORKERS

It has been estimated that the global shortage of health care workers is approximately four million (WHO 2003) with these divided unequally. In Africa for example, 36 countries do not reach the minimum target of one physician for every 5 000 people. In 2000, the average number of doctors in the OECD countries was 2.9 and the number of nurses 8.2 per 1,000 residents. These global imbalances are reflecting the income inequalities among countries and regions which lead to a negative spiral.

Another example of inequalities is the fact that although Europe and North America have only 20 % of the world's population, they employ half of the physician and 60 % of the nurses. The main source countries for health care workers in Europe are not other European Union countries but the Philippines, South Africa, and Australia, with sizable increases as well from India, Zimbabwe, and a number of other African countries. These numbers follow well-established trade patterns, as is common in international migration (Bach 2003).

In many countries the flows of health professionals go in both directions. For example, whilst attention in the United Kingdom has focused on the recruitment of overseas staff, many United Kingdom-trained nurses and doctors work abroad (e.g. Goldacre et al. 2001). At the same time as Britain is facing nursing shortages, the numbers of nurses seeking work abroad has reached an eight-year high, whilst remaining small in percentage of the nursing workforce (Bach 2003). This can be illustrated by examining the number of verifications of United Kingdom nursing qualifications by nursing regulatory authorities overseas. However, these figures do not distinguish between United Kingdom and non-United Kingdom-trained nurses so it is not possible to establish whether some nurses are using the United Kingdom as an intermediate stopping point before moving to another country.

In Norway, the recruiting of abroad-trained nurses has been active, with the authorizations to nurses from other Nordic countries accounting for nearly 75% of the total number of authorizations granted to foreign nurses in 2003. Still, with the exemption of specific countries, which the Norwegian government has targeted for active recruitment, migration of nurses to Norway has been at a low level. The global trend of increased migration of nurses over the past ten years does not include Norway as a recipient country to any major degree.

The language barrier seems to be the main explanation. With the exception of nurses originating from other Nordic countries, the number of Swedish nurses has been on the rise since 2001, following a decrease over some years prior to that. The amount of Finnish nurses has been in a steady decrease, although Norway has recruited actively from Finland over the past eight years. Of nurses coming from other European Economic Area (EEA) member states, German nurses make up the majority. This is a result from active recruitment from Germany, where nurses have been offered three months extensive language training before departure for Norway. The majority of the nurses, who have come to Norway after 2002, originate from Poland and the Philippines.

For Polish nurses the number was due to an active recruitment campaign, where nurses were offered four months of intensive language training prior to their departure for Norway. Most of the nurses originating from the Philippines were granted a temporary license in 2002. They are now authorized, having met the necessary requirements. In other words, the number is rising due to upgrading rather than authorizing new recruits (Norsk Sykepleierforbund 2004).

Table 3. Norwegian authorizations and licenses to nurses and midwives with foreign citizenship or education from other countries.

Country	Education abroad 2003	Foreign citizens 2003
From Nordic countries	1 395	1 330
From other EEA countries	143	155
From other countries	250	352
TOTAL	1 788	1 837

Source: Norsk sykepleierforbund 2004.

Previously historical (colonial) ties between countries determined mostly the migration flows of health care professionals. As an important facet of the globalization of health labour markets, these historic ties are loosening as destination countries are becoming more utilitarian in encouraging migration primarily on the basis of economic requirements rather than historical or family connections. The migration of health professionals to industrialized countries can be expected to increase, although with the broadening scope of source countries. This reflects the well-known demographic profile of most OECD countries (ageing populations, etc.) alongside the marked reluctance or inability of most governments to train sufficient workers to meet the demands of their health sectors.

If countries choose to cover the lack of healthcare workers caused by migration by training more specialists, it should be noted that the impact can only be seen in several years, as the education cycles are rather long. Training more personnel means fighting the consequences of emigration, but such activities fail to eliminate the reasons for emigration or influence the factors behind the emigration. In addition, it means wasting the resources for training specialists for the state. In order to cover the lack of healthcare specialists caused by migration, it is possible not only to decrease emigration and train more specialists, but also to make better use of the existing resources and recruit personnel from foreign countries. Making better use of the existing resources means encouraging the people who have studied healthcare work not to change for other fields of activity.

Making better use of the existing resources is positive both in decreasing the lack of specialists caused by migration and in making better use of all state resources. However, to make the existing healthcare workers return to the field of healthcare, it is necessary to influence the same factors that influence the decision to work abroad, i.e. salaries and other work conditions.

2.3. ALLOCATION OF SCARCE RESOURCES AND EFFICIENCY IMPROVEMENTS IN HEALTH CARE

Health care sector represents over 60 % of all the municipal workers in Finland (Statistics Finland 2007). By adding resources to health care it is possible to meet the increasing demand for services and new forms of subjective rights. Unfortunately, this increase in resources shows weak productivity measures in statistics. The experi-

enced hurry among health care workers can be due to undersized personnel resources, but also result of badly organized working environment.

In a recent survey among nurses, more time is dedicated to work that does not correspondent to their education than actual nursing. By shifting routine office paper work to office assistants, the nurses' work load could be decreased and redirected into nursing. Same model can be adapted also for doctors. By reducing paper work, the time for seeing a patient could be decreased from 20 minutes to 15 minutes per patient, thus enabling doctors to see more patients as well as reducing waiting times.

By using time-based management and work-in-progress (Peltokorpi et al 2006) there have been successful improvements in the efficiency of industrial manufacturing. The patient-oriented approach is a starting point for analyzing healthcare processes because the value generated by any given situation in healthcare is directly related to the changes in that patient's condition (e.g. Lillrank et al 2003). A patient episode describes the sequence of events following the patient from first contact to discharge. In contrast, patient process describes how healthcare system's resources are organized to provide services. An episode provides a patient perspective and the focus of healthcare should be to eliminate activities that do not directly nor indirectly add value to the patient. It provides the basis for analysis of whether minimizing patient throughput time can lead to more efficient resource use and cost saving in specific patient processes.

2.4. REGIONAL CHALLENGES FOR THE HEALTH CARE SECTOR

Regional inequalities in supply of health care services are an on-going problem facing many European countries. Rural and less developed areas are having trouble maintaining adequate level of health care services because of lack of human resources. One reason is the low attractiveness of working in primary health care among physicians. Special concerns have been expressed on developments in activities for prevention and in health promotion. At the same time, financial conditions and steering methods have changed, giving the municipalities' large freedom to organize their service patterns, thus widening local and regional variations in access, provision and use of health services.

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, the health care system is primarily governed and financed by counties, whereas in Portugal agencies of central government are involved in local decisions. The Finnish health care system can be described as one of the most decentralised in the world. Municipalities, altogether 416, have the responsibility written in law to arrange and finance (partly with state subsidies and user charges) all primary health care. Specialized care is arranged by 20 hospital districts owned by several municipalities together. Another rather unique characteristic of the Finnish system is the existence of a secondary public finance scheme, the National Health Insurance, which reimburses similar services to the municipal health care but provided by the private sector.

Demographic trends are affected by social and economic developments. Migration flows, in particular, are related to regional differences in labour market conditions, people moving from areas of low job growth to ones with more employment opportunities, and, over the longer-term, such differences can also affect birth and death rates. Declining regions in Europe are therefore characterised by low income levels, high unemployment and a large proportion of the work force employed in agriculture and industry. In addition, they tend to have a relatively small number of young people, reflecting their migration to other areas as well as low fertility rates and a low density

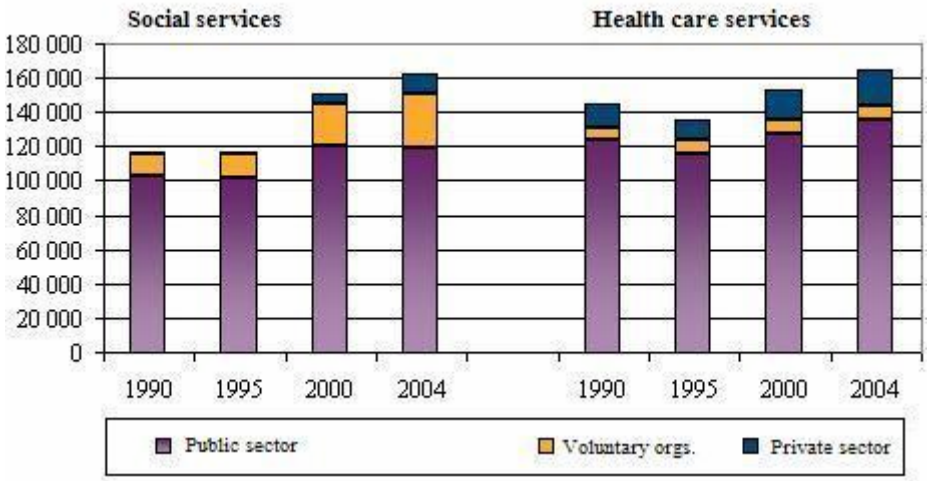
of population, reflecting their rural nature. This increases the demand for health care service at the same time as these regions are having difficulties in recruiting health care workforce.

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. 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.

In addition to the health and social services provided by the local authorities (municipalities) there are today private services produced locally by non-governmental organisations or based on entrepreneurship. About one quarter of social services and almost one fifth of health care services are private services. Services provided by NGOs complement the municipal services for small target groups, in case special expertise is required, and in areas where no service provision based on entrepreneurship has emerged. NGOs produce the major part of private social services and companies produce the major part of private health care services. This has been seen as a way to support local entrepreneurs and thus enhancing the employment situation in the region.

One of the key tools for this has been health impact assessment for regional public policy. It helps to identify and consider the health and inequalities impacts of a proposal on a given population. The usual starting point for an health impact assessment is a policy, programme, strategy plan, project or other development that has not yet been implemented. Its primary output is a set of evidence-based recommendations geared to informing the decision-making process associated with the proposal. Application of health impact assessment to a policy or strategy will necessarily focus on the wider determinants of health.

Figure 3. Personnel in public and private sectors in Finnish social and health care



Source: Stakes 2007.

One of the key tools for this has been health impact assessment for regional public policy. It helps to identify and consider the health and inequalities impacts of a proposal on a given population. The usual starting point for a health impact assesment is a policy, programme, strategy plan, project or other development that has not yet been implemented. Its primary output is a set of evidence-based recommendations geared to informing the decision-making process associated with the proposal. Application of health impact assessment to a policy or strategy will necessarily focus on the wider determinants of health.

3 HOW TO SOLVE THE SHORTAGE PROBLEM?

There have been several proposals to solve or at least decrease the labour shortage problem in health care sector. In theory, there are four ways in which the pool of active health care professionals might be increased. The input may be increased, by providing more educational facilities at medical and nursing schools. However, currently, it seems unlikely that an increase in the provision of training alone will solve the future demands for health care professionals. Among the other reasons, this shortage is due to the relative unattractiveness of health care work (increasing workload, decreasing job satisfaction, and comparatively low pay of especially the nursing profession) to young people in countries such as Germany, Austria, Finland, Poland, and Slovakia (Estryn-Behar et al 2007). However, this situation seems to differ substantially between the European countries, regions and even over time.

Another way to increase input would be through immigration of health care professionals from other countries. Such a migration is currently under discussion at the European level, with consideration of both its positive and negative consequences. Migration mainly occurs from East to West and in the United Kingdom to a larger degree from overseas. Attempts have been made to recruit thousands of doctors and nurses from the new member states of the European Union to countries such as Germany, the Netherlands, and Italy (Ibid.). The success, however, seems to be limited. Language problems and high attachment to their own community in Eastern Europe might be some of the underlying reasons. This so-called high attachment of especially nurses to their community is a complex phenomenon that varies from region to region. It is influenced by the economic situation of family, the lack of means to leave the region, and care obligations at home (Ibid.).

On the output side, rising the retirement age may be regarded by some as a solution to the problem. However, in many countries such as Germany and Italy, only few nurses are active in their profession until normal retirement age. The most effective way of assuring health care professionals in the future therefore seems to be to promote the retention of existing staff. Large employee turnover is a concern to Human Resource Development professionals as their main goal is to develop and maintain human expertise.

Statistics related to the number of physicians and nurses per capita (OECD 2007) show that in Greece, Italy and Belgium in 2004 there were four or more doctors per thousand people while in Japan, Korea, Mexico and Turkey there were two or less per thousand. In the U.S. and Turkey, the number of doctors based in urban regions is extremely high in proportion to the number of people living in the area, leaving the numbers in rural regions low. In Spain and Mexico, there were large regional differences in the number of nurses per thousand in population, while in the United Kingdom and Finland the distribution was more balanced.

Because recruitment and retention policies are key issues for sustainable employment situation in health care, gaining insights into labour-purchasing mechanisms may permit them to be addressed more effectively. This chapter is intended to provide a brief introduction to retention and recruitment of health care workforce and to discuss the mechanisms through which it can have an impact on the delivery of health services and on health system performance.

3.1. RETENTION STRATEGIES

The options available to bolster the supply of health care professionals largely fall into two categories: improving retention (i.e. keeping the people who are already working) and broadening the recruitment base (Buchan & Sochalski, 2004). Most health care personnel are aged between 35 and 49 years with their mean age increasing by five years over the period from 1990 to 2000. The differences in mean age between different functions of health care are not very great, but over the next few years large numbers of pharmacists, dentists and doctors will be retiring. The rate of retirement is rapidly accelerating at the same time as population ageing is driving up the need for health care and social services. Further, special attention must be given to promoting welfare in the workplace and reconciling work and family life.

One of the often overlooked factors in retention and well-being at work is how to decrease work-related stress. Some studies have shown a direct link between the number of hours worked and stress levels, although the number of hours worked is positively related to the perceived availability of social support (e.g. Fielden & Peckar 1999; Cooper 1981). Junior hospital doctors are found to use social support as a coping strategy significantly more often than senior hospital doctors, with both perceiving the hospital environment as a more effective source of social support than the home environment (Fielden & Peckar 1999). For example, Spurgeon & Harrington (1989) reviewed the effects of long working hours on the performance and health of junior hospital doctors. They (Ibid.) concluded that a number of studies have shown that a significant proportion of newly qualified doctors develop some degree of psychological symptoms. They argue that this may be related to sleep loss which probably increases doctors' vulnerability to other work hazards.

The European working time directive was implemented for doctors in training in the United Kingdom and elsewhere in Europe in August 2004. Junior doctors' working hours are now limited to a shift of no more than 13 hours followed by a break of at least 11 hours (Council Directive 93/104/EC). As a result, the work pattern out of hours for most junior doctors at the front line of acute medicine has changed completely from providing on-call cover to working in shifts (Mather & Pounder 2004). The directive aims to reduce working hours in order to improve workers' health and safety, but the current NHS shift system could threaten doctors' and, moreover, patients' safety.

More than three quarters of medical senior house officers and nearly half of specialist registrars in NHS trusts were working seven consecutive night shifts when surveyed in December 2004 (Ibid.). Some 40% of acute hospitals had introduced rotations with shorter and more frequent blocks of three to five night shifts for their medical specialist registrars, but only few of them had devised rotations with one to two serial night shifts. Thus, many of these doctors were forced to work up to 91 hours during the night in one week, as well as traveling to and from home each day. This results in extreme exhaustion as evidenced by the fact that 70% of specialist in one hospital, working the seven consecutive night shifts, slept for an average of two hours per night while contracted to work, and most had problems with sleep in the daytime (Horrocks & Pounder 2005).

In Finland, follow-up data since the 1980s have clearly underscored the high level of physical and mental strain involved in work in the health care sector (Elovainio et al 2004). According to research evidence, experiences of stress and strain increased between 1990 and 2004. Employees themselves thought the reason lay in the increasing knowledge requirements on the job and the increasing workload. Research results on municipal sector employment indicate that the high mental demands and lack of employee participation in decision-making predict sickness absenteeism (Ibid.).

One of the distinctive characteristics of work in the social welfare and health sector is the high level of responsibility for people's health and well-being. This sense of responsibility is reported by virtually all occupational groups from medical doctors to housekeepers (Elovainio et al 2004). Health care is a labour-intensive sector and the deterioration of health among staff members will no doubt adversely affect their welfare in the workplace, drive up employers' labour costs and possibly have adverse effects on the quality of the service provided to clients and patients, even on the outcomes of care.

Health care personnel in Finland have a very high level of education, and they are more or less evenly distributed across the country. The personnel structure has remained more or less unchanged during the 1990s and 2000s. According to Statistics Finland's register of municipal personnel (2007) the number of staff working in health care in 2005 was 138 000 which shows slight increase of the figure recorded ten years previously before the onset of the recession period in the 1990's (121 000). Around two-thirds of personnel are on permanent contracts, although there tends to be some cyclical variation in the figure (65–71% depending on the time of the year). The largest area of employment in health care is specialized inpatient care, which continues to employ more than one-half of personnel in municipal health care services. The majority of health care staff is women, but the gender balance varies widely depending on the area concerned. In administration, for example, men account for 20 % of staff, while the overall average is no more than 9 % (Statistics Finland 2007).

Under the retention strategy numerous measures have been taken to address the problem of the workforce ageing. Among them are reforms in the employment pension legislation 2005, Decision-in-principle on occupational health care 2004, Occupational Safety and Health Act 2003, Occupational Health Care Act 2002. Finland has given high priority to a number of legislative reforms and ageing programmes to remove barriers of older workers employment. There are two prominent national programs which have been launched to tangle retention related problems: Veto and Tykes.

The national programme Veto 2003-2007 was launched to combat the aging problem. The main responsibility of the implementation is carried by the Ministry of Social Affairs and Health. The programme also involves governmental cooperation among the Ministry of Education, the Ministry of Trade and Industry and the Ministry of Labour in various sub-programmes. It includes over 30 different research and development projects commissioned by Veto. The targeted group is middle managers above 45 years old of small and medium size enterprises, occupational health care professionals and organizations.

Various measures have been taken to implement the programme such as building up working life trainer network, holding awareness raising seminar, launching projects in different occupational sectors, developing good occupational health care practice, advising on retirement and continuing working and monitoring retirement agreements and the pathway from unemployment to retirement. The idea is to maintain and pro-

mote the attractiveness of work and working life especially among the retiring age group.

Tykes is a six-year workplace development programme running from 2004 to 2009. The idea of the programme is to promote economic growth by having a positive contribution to both labour input and productivity growth. It is incorporated in the Government's programme and based on tripartite cooperation among work places, policy makers and R&D units. Under the programme there are 1 000 development projects and 250 000 employees as targeted participants (45% over the age of 45; 50% women and 51 000 in SMEs).

3.2. CONTEMPORARY RECRUITMENT STRATEGIES

Although the retention strategy might relieve the situation, in a sense it cannot cover the big supply-demand gap in the health care labour market without recruiting any new employees. Recruitment efforts have still been the dominant mechanism to tackle the problem. Domestically it means providing a broader range of recruits to mature entrants, entrants from ethnic minorities, and those with vocational qualifications or work-based experience (Buchan & Sochalski, 2004). Encouraging nurses to return to the profession is also one of the measures taken by countries like the United Kingdom.

Another example is the Scandinavian countries, which are among the most sparsely populated countries in Europe. This means that health care staff is clustered in and around larger cities and towns while there are shortages in more rural Northern areas of the country. The regional distribution of general practitioners and dentists in particular, is not satisfactory. Norway for example exemplifies a country that has faced difficulties achieving self-sufficiency of health professionals. Although recent government policy has focused on increasing the number of students enrolling at health training facilities, Norway continues to look abroad to recruit health care staff primarily from other Nordic countries and the Baltic countries.

In Finland the shortage of nurses has been increased by migration to countries like Ireland and Norway because of higher salary levels and better working conditions. During 1989-2001 0,9 % of the immigrants in Finland were working in health care sector, this means 2 100 people in practice (Markkanen & Tammisto 2005). Of the immigrants working in health care in Finland 87 % were doctors (Ibid.) as shown in Table 4.

Table 4. Foreign Doctors and Nurses Working in Finland

	EU-countries	Non EU-Countries
Doctors	1376	481
Nurses	202	54

Source: Markkanen & Tammisto 2005.

Another strategy that has gained ground lately is the use of recruitment agencies and temporary work agencies. The Swedish health care sector has shown that intermediaries are not only satisfying employers' demand for labour, but also actively taking part in constructing, influencing and sustaining this demand (Bergström et al 2007). For example the import of health professionals may create an adjustment of organ-

izational routines and practices that stimulate further inflow of workers. Furthermore, the different actions of actors responding to problems of labour mobility, may in themselves contribute to create further mobility. When a hospital attempts to fill vacancies by recruiting nurses from another country, this activity may be regarded as creating or constructing labour flows which may not have existed otherwise.

The use of new technologies, such as internet or recruitment agencies, may have similar effects contributing to the construction of flows of labour by providing access to information which was not available before. Thus, the visible activity of different actors rather than the invisible forces of the market may be regarded as an additional force producing mobility of health professionals. Mobility may also be created through the social networks (Goss & Lindquist 1995). Pioneers create paths for others to follow. This implies that once migration pathways are established they will stimulate further migration.

Temporary work agencies have also become a player in the health sector employment market. The concept of temporary agency workers is characterized by a triangular relationship between three parties: a temporary agency worker is employed by a temporary work agency and is then, via a commercial contract, hired out to perform work assignments for user firm. From a macro economic perspective temporary agency work is often viewed as a tool for promoting flexibility in the labour market. It improves job matching and reduces frictional unemployment (Storrie 2002).

On the other hand, research in the field of working conditions and health impacts indicates that workers engaged in temporary agency work, like workers in other flexible and atypical types of employment, are more exposed to risk factors than permanent workers (Benach et al 2002; Storrie, 2002). Sometimes regarded as second tier employees, the use of temporary health care workers in the Scandinavian countries has become more common. In Finland, 19.5% of all temporary agency workers are employed in health care (Finnish Ministry of Labour 2007). Nowadays 8 % of day care given in health centres in Finland is done by temporary agency doctors (Finnish Ministry of Social Affairs and Health 2006).

On the basis of 1998 law temporary agency workers gain the same pension rights, sick pay and annual holidays as permanent employees. The latest regulatory change in Finland was made in 2001 when temporary agency workers came under the Contracts of Employment Act. This solved the dispute over how temporary agency workers' terms of employment should be determined: their contracts should adhere to the same conditions as for permanent employees. If the temporary agency workers have a collective agreement (as in the case, for example, of restaurant musicians), then that should prevail.

3.3. TRAINING AND EDUCATION OF NURSING STAFF IN FINLAND

The training of nurses and other health care personnel such as physiotherapists and laboratory personnel takes place at polytechnics by municipalities under the guidance and with the financial support of the Ministry of Education. With the exception of a new training programme for practical nurses, there have been no major changes in the education system in recent years. Health care education and the day-to-day operation of health care in Finland have traditionally leaned heavily towards nursing staff: auxiliary, practical, staff and registered nurses account for over 50 % of the total number of qualified health care personnel in the country. The level of education among health care personnel has steadily increased.

From 1980 up to today, Finland has always had the highest number of nurses among the Nordic countries. One reason for this may be that in the past the number of doctors was very low and therefore more nurses were needed for various tasks, particularly as care was rather inpatient-oriented. Second, a large number of public health nurses are needed for the various roles in public health care, especially maternal and child health care, school health care, occupational health care, home nursing. The National Board of Medico-legal Affairs is responsible for licensing, registration and, together with the State Provincial Offices, monitoring of health care personnel. It also undertakes disciplinary procedures concerning health care personnel.

The majority of people employed in health care work for municipalities. Up to the 1990s unemployment among medical doctors and nurses was practically nonexistent, but the economic crisis changed that situation. As the public sector gradually recovers from the crisis, the employment situation has changed. There is already a shortage of doctors and a shortage of other health personnel is very likely in the near future. It has been calculated that between 49 000 and 55 000 employees in the municipal social and health services will be retiring before 2010.

In 2001 a committee under the Ministry of Social Affairs and Health observed that more than 6 000 new workers will be needed to compensate just for the current shortfall of personnel in the care of the elderly. In addition, 12 000 new staff members in different occupational groups will be needed to meet the growing demands in social and health care by 2010 (Finnish Ministry of Social Affairs and Health 2001). In practice this means that the number of student places in initial vocational training and at polytechnics and universities will have to be increased by some 10 %.

At the beginning of 2002, the number of new study places for students of medicine was increased from 550 to 600 (the total number of working age medical doctors in Finland was 17 500 in 2003). In 2004 the intake was 630, which means that more medical doctors graduate than retire. Also in dentistry the number of study places has increased, but not yet sufficiently. In addition, education for other health care personnel (e.g. nurses and practical nurses) has been increased since 2002 (Finnish Ministry of Social Affairs and Health, 2005). The practices are implemented under the guidelines of the committee on estimation of labour demand in social welfare and health care.

3.4. MOBILITY OF HEALTH CARE PROFESSIONALS

The increasingly complex in the European health care landscape has initiated responses to better coordination national policy response. For example, the European Health Policy Forum (2003) noted the need to coordinate different national policy responses in relation to the mobility of health professionals in Europe. Thus, the increasing mobility of health professionals in Europe suggests that the traditional view of the health care system as a national concern may need revision. As Berman (2001) states, health services can no longer assume that they operate within national boundaries, and health service managers will have to be increasingly aware that developments in neighbouring countries might have an impact on their own services.

There is a vast literature elaborating on the reasons for the increasing mobility of health professionals across countries. The most common explanation of this development is that the increased mobility among health professionals is rooted in a growing global shortage of health professionals due to rising spending on health related to GDP in developed countries (Martin 2007). Structural factors, such as ageing populations, lack of training, low fertility rates and labour shortages in specialised areas are major reasons for low labour supply in many EU member states. One way to deal

with this problem is to import foreign labour. By offering higher pay, better living conditions, and professional development, countries with labour shortages pull health professionals to work in the host countries' healthcare sector. Recent policy analysis has tended to focus exclusively on the pull factors arising from shortages in developed countries (Bach 2003). There are also factors that drive or push health professionals to work, temporarily or permanently, in another country.

People migrate for reasons such as poor wage levels, bad living and/or working conditions, or to escape wars, conflicts or chaotic social circumstances. People also move to work in another country simply because there are no jobs in their home country (Buchan 2006). As an example of this has often been named the Maastricht-Aachen area. If a hospital in Maastricht decides to open an orthopaedic unit specialising in joint replacement, it is likely that such a unit might attract orthopaedic surgeons from Aachen, creating in effect a regional supra-national centre of excellence. Such a development might cause a snowball effect attracting patients not only from the Netherlands, but also from Germany and Belgium, and hence inducing doctors also to transfer their practices (Berman 2001).

A mobile workforce is recognized as a key element of a competitive economy. Despite this, labour is less internationalized even though the free movement of people (with capital, goods and services) is a key principle of the European single market. Moreover, mobility in the European Union is low and declining. Only around 5 per cent of those resident in the EU are not nationals of the country in which they live, with approximately 2/3 of that figure coming from outside the EU (third-country nationals). Low and declining levels of mobility have become part of the EU's new economy agenda agreed at the Lisbon summit meeting in March 2000 which has drawn attention to the persistence of boundaries and barriers within the supposedly frontier-free European single market.

The health care sector is a complex and challenging area to explore because of the different national organizational contexts for health care delivery. It is a sector where lower (ancillary and basic nursing) and higher (medical and surgical) skilled migration from within and outside the EU can be observed as a result of demand pressures on health care providers. In Portugal and Italy, for example, private sector has been developed as a result of high health care demand that is not met by state provision. The result has been the recruitment of health care workers from non-EU states, such as the Philippines, into the private Italian sector and of intra-EU migration by Spanish general practitioners into the Portuguese public health care sector. In the United Kingdom health care demands and labour shortages have prompted both intra- and extra-EU recruitment of health care workers (UK Nursing and Midwifery Council 2002).

The health care sector also brings issues associated with Europeanization into view. In particular, the recognition of professional qualifications and the effects of freedom for service providers within the single market. In Germany, for instance, the effects of free movement of service providers on an insurance-based system have been evident during the reconstruction of the traditional welfare system because non-German insurance companies have gained access to the German health care system. Studies across several countries have identified an increasing need for health workers over the next few years (Smith & Seccombe 2001) especially in the caring and personal service occupations with ageing populations across the EU fuelling the widening gap between supply and demand in the sense that they increase the clients while reducing the pool of available workers.

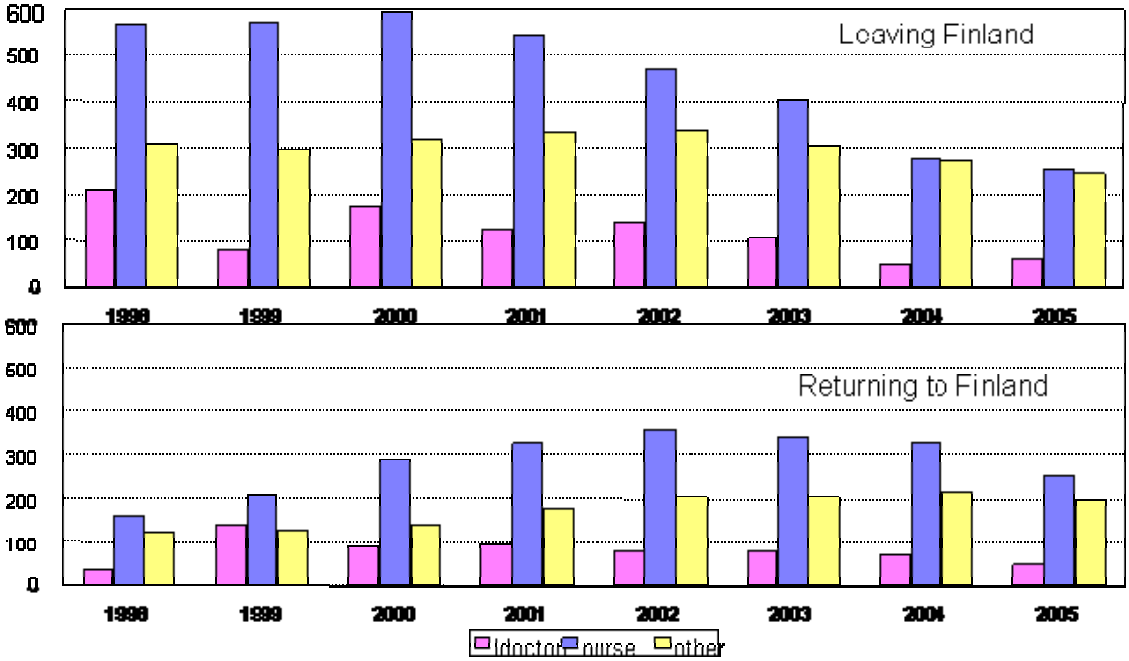
In the United Kingdom there are some signs that historically falling supply of workers in this sector may have been halted or even reversed (Robinson et al 1999), but the large and fragmented nature of the National Health Service as the dominant employer brings a host of recruitment issues. For example, attempts to create a systematic strategy for improving recruitment from minority ethnic communities faltered because of the difficulties of getting the arguments for positive action either widely understood or embraced throughout the NHS (Iganski et al 2001). Same situation applies to countries like Finland, where due to the potential suspicion of the quality of their education and other discrimination barriers the professional refugees have to find a job in low service other than their profession (Markkanen 2006).

Among the EU or European Economic Area countries United Kingdom and Ireland are two of the most active host countries that are in great demand of large amount of foreign nurses, the percent of which is even higher than their own home trained nurses. For years Ireland produced more nurses than it could employ and was a source country for other developed countries. But as a result of booming domestic economy the surge for health care service has brought health personnel shortage. Ireland has become another noteworthy host country for international nurse recruitment from main source countries like Australia, India, the Philippines, South Africa and the United Kingdom (Buchan et al 2003).

Starting from year 1999 the number of foreign nurses from both EU and Non-EU countries has exceeded the number of home medical education in Ireland. In 2001 nurses from Non-EU countries already exceeded those from EU countries (WHO 2004). Some research even classified source countries into different level of income. In contrast to the United Kingdom and Ireland whose source countries are mainly of lower-middle income or low-income, Norway and Australia primarily register nurses from other high-income or high-middle income countries (Buchan et al 2003).

Figure 4 presents the numbers of Finnish health care professionals leaving and returning back to Finland. Still the number is small and does not have big effect on the general supply-demand trend of the labour market.

Figure 4. Migration Abroad of Finnish Health Care Professionals 1998-2005.



Source: StakesTieto 2005

4 WELFARE MIX, INCLUSIVE EMPLOYMENT AND SOCIAL ENTERPRISES AS NEW PARADIGMS

An often ignored resource of the health work force is the marginalized group of people in the society: the long term unemployed due to industry structural change or after a long term of illness, the mentally or physically disabled, the immigrants and refugees. Setting up social enterprises that adopt an idea of inclusive employment is a solution under widely discussion among European countries. Welfare mix provides an umbrella over these in creating the framework under which both inclusive employment and social enterprises can function successfully. Before any further discussion of the topic a clear definition of the concepts involved has to be provided.

4.1. WELFARE MIX

Welfare-mix and third sector models have been proposed to help employ people who in normal situations could have difficulties to get employed (e.g. Simonen 1995; Sipilä et al 1999; Powell et al 2004). Welfare mix is driven by three broad principles, sometimes described as the 3Ds of reform, namely deinstitutionalization (the move away from an over-reliance on long-term care in residential institutions towards more humane and cost effective community-based services); diversification (the promotion of a renewed welfare mix of state and non-state providers including NGOs and the private sector); and decentralization (the transfer of rights, duties and responsibilities as close as possible to local populations). This means also adding resources to preventive health care, which can be seen as means to decrease need to additional resources at health care.

In some welfare mix models, welfare is produced by the actions of and interactions between public agencies in the state, non-governmental, community-based and voluntary organizations in civil society, private agencies in the market, and families and other household forms (Powell & Barrientos 2004; Gough 2001). Newer approaches stress the importance of quality of services without any a priori assumptions of the relative merits or comparative advantages of public or private services per se, advocating ever more complex partnerships between traditionally separate sectors (Beck et al. 2001). The role of quality control, long-term contracting, and financial subsidies remain important, however, if new welfare mixes are not to produce new kinds of inequalities, a recommodification of welfare, and an individualization of the social (Puljiz 2005; Ferge 1997) in which clients become more or less consumers in the welfare market place. At the national level this involves the setting of broad principles and outcome-based targets, as well as ensuring equity across regions.

At sub-national levels, local and regional social planning can be defined as an inclusive process, involving all stakeholders, which maps needs and resources; sets plans for the solution of social problems; commissions specific services; and regularly reviews results. It usually involves the establishment of an agreed planning mechanism which seeks to mobilize existing resources, stimulate new initiatives, and ensure a network of services to meet agreed outcomes and targets (Stubbs & Warwick 2003). It is a crucial part of ensuring that deinstitutionalized, diversified and decentralised services are in line with local needs and attain a level of allocative efficiency.

4.2. INCLUSIVE AND SUPPORTED EMPLOYMENT

A sufficient supply of health personnel and complete health system that could provide a wholesome package of health service to its citizens doesn't guarantee a healthy society. For those belonging to marginalized disadvantaged groups like the long-term unemployed, the mentally or physically disabled, health care services are not adequate since a person's employment situation and social status will affect him or her psychologically and physically. Besides medical measures an inclusion society that provides an effective mechanism to help these people integrate back into the society is a way to improve the health landscape and bring about social cohesion. Inclusive employment is the related concept brought out to march toward the inclusion society (HealthClusterNet 2007).

From the employer or community point of view inclusive employment can be seen as an approach by organizations to encourage growth within and increase job opportunities for local communities. This approach facilitates reductions in intraregional 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.

Another related concept of inclusive employment is supported employment. It presumes that everyone regardless of disability has the capability to do and have a job. It facilitates competitive work in integrated work settings for individuals with the most severe disabilities (i.e. psychiatric, mental retardation, learning disabilities, traumatic brain injury) for whom competitive employment has not traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job.

Supported employment provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision. It can be seen as a way to move people from dependence on a service delivery system to independence via competitive employment, which occurs within the local labour market in community businesses. Recent studies indicate that the provision of ongoing support services for people with severe disabilities significantly increases their rates for employment retention (e.g. Wehman et al 2003). Supported employment encourages people to work within their communities and encourages work, social interaction, and integration.

4.3. INCLUSIVE EMPLOYMENT AND SOCIAL ENTERPRISE

Almost all European countries struggle with high and persistent unemployment. Many people are in danger to be socially excluded. The state and municipalities face difficulties in maintaining welfare services due to the ageing of the population and the limits set to taxation by tightening international competition. Enterprises are increasingly seen as the key to increasing employment and welfare. Social enterprises combine entrepreneurship and a social goal.

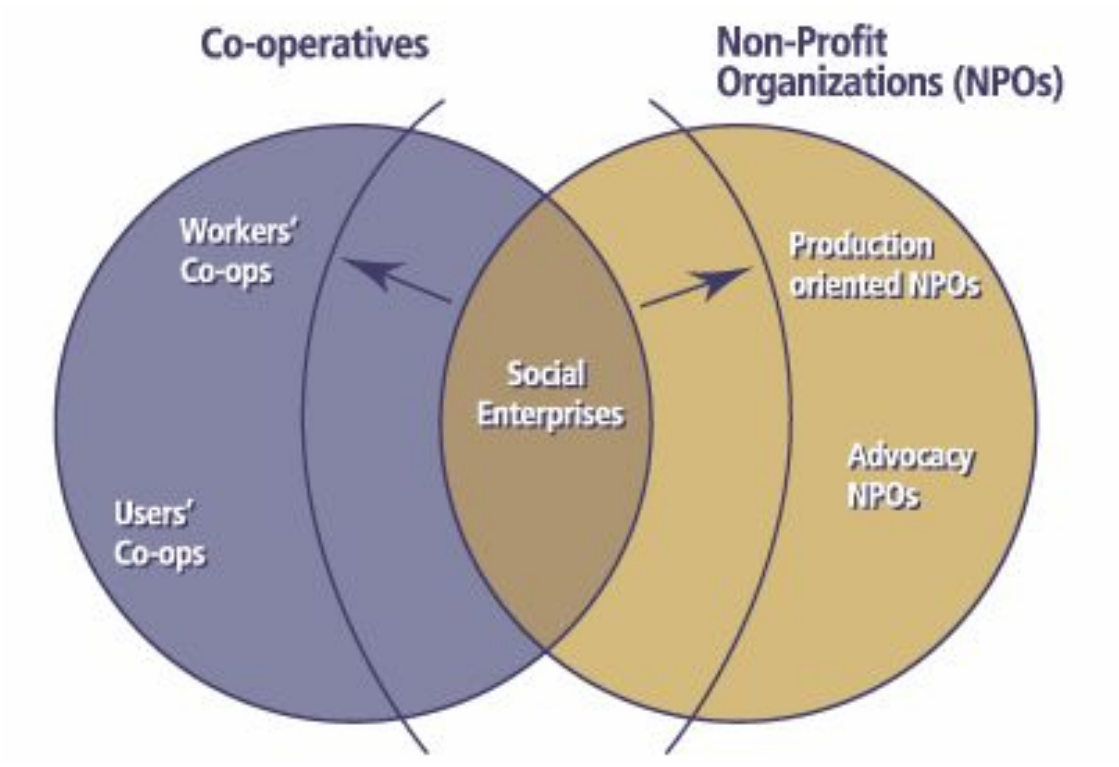
It is no wonder that social enterprises have become a topic of discussion in more and more countries since the 1990s. Social enterprises have started most successfully in Italy and following its example some countries have made laws on social cooperatives. In recent years the focus has been on Great Britain. The British Government

published a social enterprise strategy in 2002, and the British Act on Community Interest Companies (CiC) came into force in 2005. CiC is a company form customised for social enterprises (Spear & Bidet 2005).

The European Commission has supported the promotion of social enterprises with many programmes since the middle of last decade. The Equal Programme has ongoing social enterprise projects. There is no common internationally accepted definition for a social enterprise: Some definitions accept increasing the welfare of a community as a social goal, whereas others require the employment of clearly defined target groups. According to the widest interpretations, any enterprise-like project that operates with public funding can be a social enterprise. The strictest definitions require that a company make profit on its sales (Borzaga & Defourny 2001). Due to the diversity of definitions, the estimated effects of social enterprises on employment numbers vary in the EU 15 countries from four million to 200 000.

In some ways, social enterprises can be seen functioning at the crossroads between co-operatives and non-profit organizations at the same time. Figure 5 presents a conceptual system developed by Borzaga & Defourny (Ibid.) that links co-operatives, non-profit organizations and an emerging new sector that combines social purpose with entrepreneurship. As seen in the figure, some co-operatives and non-profits (e.g. workers' co-operatives and production-oriented non-profits) are closer to the emerging sector than others (e.g. users' co-ops and advocacy-oriented non-profits). The figure suggests that the boundary that surrounds the social enterprise sector is both fluid and growing.

Figure 5. Social Enterprises at the Crossroads of Co-operatives and the Non-profit Sector



Source: Borzaga & Defourny 2001.

Italy has a long tradition of social enterprises, or more precisely, social co-operatives (cooperazione sociale). The first social co-operatives emerged in the late 1970s after downgrading of the state-sponsored mental health system which left patients released from mental hospitals in need of care and support. Major growth followed the enactment of a law on social co-operatives that was first drafted in 1981 and finally passed into law in 1991. The law on social co-operatives clarifies two basic forms.

Type A provides social services, in the areas of health care, care of the elderly, and education; while type B provides jobs for certain disadvantaged groups such as those with physical or mental disabilities, present or former psychiatric patients, drug addicts, alcoholics, young workers from troubled families, and criminals subject to alternatives to detention. The special workers are required to comprise 30 percent of the co-operative's workforce.

Type B social co-operatives enjoy some tax benefits, meaning that the co-operative does not need to make welfare contributions to the state for its handicapped members. It also receives a 25 percent reduction on land and mortgage taxes. The public sector supports social co-operatives by providing them with orders (Barbetta 1996). For example, the City of Turin buys services from social co-operatives to the value of some 13 million euros per year. Public bodies in Italy are able to procure from social co-operatives without a tendering process for contracts valued at under 200 000 euros (Maiello 2000).

There are approximately 1000 type B social co-operatives in Italy. They employ some 11 000 workers, of whom over 5 400 have disabilities. The work of the co-operatives includes mostly maintenance of parks, gardens, and buildings. Italian social co-operative is typically small one, having 40 to 50 workers. Because the co-operatives are so small, a formation of geographic consortia that link all the social co-operatives of a locality or region is coordinating their functions (Borzaga & Defourny 2001). The consortium provides its members advantages deriving from larger economies of scale. It is also politically useful in streamlining dealings between the regional political authorities and the member co-operatives.

The social enterprise sector in the United Kingdom is highly diverse, encompassing co-operatives, development trusts, community enterprises, housing associations, social firms and leisure trusts among others. Social enterprises are generally identified as businesses that trade for a social purpose with profits re-invested for that purpose. According to figures from the Government's Annual Small Business Survey 2005 (UK Department of Trade and Industry 2005) and existing data for the social enterprise sector, there are at least 55 000 social enterprises in the United Kingdom with a combined turnover of £27 billion per year. Social enterprises account for 5 percent of all businesses with employees and contribute £8.4 billion per year to the economy.

The British government launched its own strategy for social enterprise in July 2002. The strategy set out a three-year action plan to tackle barriers to the growth in the social enterprise sector and to achieve three key outcomes: creating an enabling environment, making social enterprises better businesses and establishing the value of social enterprise. According to the strategy, social enterprise can help in delivering many of the government's key policy objectives: helping to drive up productivity and competitiveness; contributing to socially inclusive wealth creation; enabling individuals and communities to work towards regenerating their local neighbourhoods; showing new ways to deliver and reform public services; and helping to develop inclusive society and active citizenship (UK Department of Trade and Industry 2002).

In Germany, social enterprises (Integrationsunternehmen) started in the 1970's when alternatives for sheltered workshops for people with mental health problems were first discussed. Today there are three types of integration enterprises in Germany: those that operate in the open market and pay normal wages, ones that offer employment but only limited additional income for employees and those with projects of limited duration and which fully subsidised the workforce. Those belonging to the first category provide employment for people with disabilities in the open labour market. They are social firms with a workforce of at least 25 %, but not more that 50 % of severely disabled people. Employees in the integration firms have permanent contracts and are paid normal salaries. Recognized integration firms receive compensation for the costs that come from employing people with disabilities and for the lack of productivity. Integration enterprises can receive some grants for small investments, but in general they have to manage without subsidies.

Today there are about 500 market oriented integration companies in Germany. They provide work for 16 000 people of which half have disabilities. These so called "integration enterprises" are strictly defined by law to be a member of the normal labour market with competition with other companies allowed. Alongside integration enterprises there exists another type of social enterprises, Beschäftigungsunternehmen, which are part of government and local government employment schemes, being financed directly by them. These public subsidies restrict the enterprises' fields of operation to some extent. For example, they are unable to act as normal competitors in the market (Gallfuß et al 2007).

Social entrepreneurship is quite a new phenomenon in Finland. The concept originated through the EU-funded projects after Finland joined the EU in 1995. The first social firms were introduced in the country during the late 1990's. The subject became more widely known during the first round of Equal when several different projects promoted social entrepreneurship in Finland. This development was highlighted by the Act on Social Firms that came into force in 2004. According to the Act a social firm is like any other business: its aim is to make profit and it may operate in any sector. However, at least 30 % of the employees must be disabled or a mix of disabled and long-term unemployed people. The social firm must also be registered in the Register of Social Firms maintained by the Ministry of Labour. The act also defines the subsidies for social firms. The starting point is that social firms have access to the same financial instruments as other companies. What is special is that social firms are entitled to longer employment subsidies when hiring a disabled or a long-term unemployed person (Karjalainen et al 2006).

A widely asked question is, can social enterprises play as an important partner in health care sector to deliver public service and provide social goods? International analysis (Salamon et al 1999) demonstrates that non-profit sector employment in the health and social services sector is 38% (health 20% and social services 18%). A report (2005) in the United Kingdom by the Small Business Services of the British Department of Trade and Industry states that 33% of social enterprises derive their trading income as health and social care, mostly daycare and childcare welfare and guidance. One of the ongoing projects in Social Entrepreneurship in Finland is HOT. It promotes new services and new service-providers for the health sector through social enterprises, combining two development trends: ageing population with the need for more services and the ever-persistent unemployment with increasing need for workforce. It target groups are municipalities, private health care sector entrepreneurs and the third sectors as it tries to set up the legalized and operational framework for social enterprise in health care sector.

Although social enterprises could receive various public financial supports for employing disabled and long term unemployed people, the marginality of benefits has not encouraged setting up enterprises. Even the ones that are already actively employing disabled people have not been willing to register as social enterprises in Finland. In 2006 only 49 enterprises had been included into the register. Out of these 26 enterprises had adopted the legal form of a company (many owned by associations or public sector authorities), four were associations, one foundation and three co-operatives, while the rest 15 were other types of registered enterprises like firms with sole entrepreneur or partnerships (Pättiniemi 2006). Due to its essential characteristics of social functions the development of social enterprise has met challenges faced by all the European countries despite the commonly used financial and legal incentives to boost the establishment of social enterprises.

The possible suggestive solutions under the discussion based on the practical experiences are brought by the related parts. The employer should be better informed of the available public financial support to the social enterprise; an innovative model to run social enterprise or the know-how is desperately needed; a whole system of employment service for the disadvantaged especially the disabled group should be set up including assessment of ability level, special training centers corresponding to different level of disability and a network of available vacancies that suit different needs; A new financial tool has to be developed to open more financial resources to meet the demand; most of all the whole society has to adopt an unbiased and tolerant attitude toward disabled people with the awareness that they are also capable of work that suits their ability (Ibid.).

5 CONCLUSIONS

This report has discussed the main topics in HealthClusterNET employment theme by trying to have a deeper view on what the present and future challenges are for sustaining a well functioning health care system as a driver for regional development. The main factors discussed were retention and recruitment strategies for health care personnel on local, national, regional and global perspectives. Alongside this welfare mix as a new paradigm which involves social enterprises and on a broader scale inclusive employment were discussed.

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 have a large impact on these performance measures 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.

The growing proportion of elderly people in Europe is the key driver in all health care reforms. Even if development would lead to substantially improved health for the elderly, pressures on the system can be predicted to increase. The health sector is also going to be affected by this, as more and more heath care professionals are exiting labour market in the near future. Because the resources are not likely to increase, new more effective ways are needed to solve the shortage problem. On a short scale retention strategies as part of well-being at work as means to are likely to lighten this shortage, it is still not going to be a long term solution.

Another proposed solution, recruiting health care work force from abroad has also a downside to it as emigration of health care workers is already weakening the health systems in the developing world (e.g. Hamilton & Yau 2004). At the same time, the aging of the industrialized world has placed pressures on industrialized countries to find a solution for scarce or poorly distributed health care labour to support their aging populations. Nurses, in particular, are leaving their home countries in greater numbers. The number of nurses in the United Kingdom from non-EU countries grew from approximately 2 000 in 1994-1995 to more than 15 000 in 2001-2002.

The real challenge has been to keep people working in the public health care sector after they have graduated; something which can be difficult due to the lower levels of pay combined with more stressful working environment. Temporary agency work has in some degrees managed to ease this by making it easier to hire workforce in large numbers. There is still, though, some debate on how cost-effective this is (e.g. Finnish Federation for Social Welfare and Health 2006; Finnish Ministry of Trade and Industry 2006).

Apart from means to find solutions to workforce shortage in health care sector, also welfare mix and inclusive employment have gained ground as ways to lessen the burden on health care sector by increasing wellbeing among citizens. Through shift from residential institutions to community care-based services, concentrating on preventive efforts and including third sector in a more embedded way, increasing public health and, thus, cost-savings for health care sector are more likely to occur.

Inclusive employment targets vulnerable groups in trying to find means to employ them. 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.

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