The Commission for
Local Authority Employers
The Association of Finnish
Local and Regional Authorities

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Statement about the European Commission's Green Paper on the European Workforce for Health COM(2008) 725

1. Introduction

The Association of Finnish Local and Regional Authorities promotes the interests of Finnish local and joint authorities. The Commission for Local Authority Employers, the employer organisation in the local government sector, is a part of the Association. At the start of 2009, there were 348 local and 228 joint authorities in Finland. Finnish local and joint authorities employ a total of about 422,000 persons. This means that one in five of all workers are employed by a local or joint authority.

In Finland, the responsibility for social and health services lies with local authorities. Public health services are divided into primary care and specialist care. The medical care service system comprising health centres and hospital districts is complemented by occupational health care and private medical centres.

Over 80 per cent of all the personnel in the Finnish healthcare labour market work in the local government sector. The local government sector employs 131,000 wage-earners in the health sector and 112,000 wage-earners in the social sector. Of local government health workforce, 36.2 per cent work in primary care and 60.1 per cent in specialist care. The local government and private health and social sector together employ 15 per cent of the country's workforce.

2. The position of the Association of Finnish Local and Regional Authorities and the Commission for Local Authority Employers on the Green Paper

The Association of Finnish Local and Regional Authorities and the Commission for Local Authority Employers would like to make the following observations on the Green Paper:

Association of Finnish Local and Regional Authorities
PO Box 200, 00101Helsinki, Finland
Tel + 358 9 7711
Fax + 358 9 771 2291
www.kunnat.net

The Commission for Local Authority Employers
P.O.Box 200, 00101 Helsinki, Finland
Tel. +358 9 7711
Fax: +358 9 701 2239
www.kuntatyonantajat.fi

We find it positive that the Commission has prepared this Green Paper on the European Workforce for Health, aimed at raising awareness and discussion of the challenges faced by the health sector, and in particular health workforce, in the European Union.

However, we would like to emphasise that the main responsibility for the organisation and delivery of health services and medical care lies with the Member States themselves. Some of the possible areas of action proposed in the Green Paper should be left to be determined and implemented at national and local levels. The EU has an important role to play in supporting Member States and adding value such as through networking and sharing of good practice. Any possible measure taken at the EU level should not hamper the provision of health services based on national, local and client needs, or unduly add to the healthcare costs.

Matters that fall within the scope of national health policy should not be interfered with at the EU level. Also regarding other areas, measures should be implemented at the EU level only if, through this, additional value is achieved.

We consider that the Green Paper does not adequately set out the grounds for the possible areas of action that it proposes, nor is it clear what their effectiveness on the demand for, or the number of, health workers would be.

The Green Paper does not adequately detail what the concept ‘health workforce' entails. There is variation in the way that Member States provide health and social services; also, there is no clear distinction between the two sectors. Social and health services are interconnected, and the challenges related to their organisation are mostly very similar, also in terms of the availability of staff.

The Green Paper pays attention to the fact that the participation of women in health workforce has historically been significant and is increasing. However, while the Green Paper places emphasis on measures to promote gender equality, we are of the opinion that it would be important to examine closer – for example as to the body of rules governing family leave – what effect the female dominance of the health sector has on employers as compared to the male dominance of some other professions.

EU legislation and measures other than those specifically concerning health care and health workforce also affect the need for health workforce. It would be important to examine how the EU legislation (the European Working Time Directive, for example) affects the opportunities of Member States to organise health services.

We consider that in spite of a growing demand for the services they provide, the health and social sector cannot expect to recruit a larger share of the country's workforce than is the case now. Service provision must be maintained by means other than staff increases.

In the health sector, it is necessary to examine task structures and improve the division of labour between different professional groups to derive full benefit from their skills and knowledge, and improve performance. To this end, it would be useful to disseminate good practices.

It would be useful to gain information on what steps other countries have taken to optimise the healthcare process from the perspective of human resource use. How the process has been implemented; to what extent and how social partners have participated in the process and how committed they are to the changes made; what has been the effectiveness of the changes on services?

In our opinion it would be useful to compare successful personnel policies, good educational practices and methods of forecasting between Member States.

Further, the Association of Finnish Local and Regional Authorities and the Commission for Local Authority Employers would like to make the following observations on the influencing factors and possible areas of action.

Demography and the promotion of a sustainable health workforce

We consider that many of the factors stated are too detailed and do not take account of how health services are organised. The areas of action listed are best left to national, regional or local level. Measures that will potentially provide additional value are limited to the dissemination of good practices and research data.

If recruitment campaigns are launched, it should be carefully considered whether the campaigns should also be targeted at men so that their proportion in health workforce would increase.

Public Health Capacity

We are of the opinion that health promotion and illness prevention may decrease the demand for nursing and caring services in the future. Health promotion and illness prevention are the primary objectives of Finnish health policy; yet it is not known yet how they will reduce the need for care and demand for workforce. Preventive healthcare places new demands on the competence of health workforce and requires repeated forecasting of workforce needs.

As part of primary care, employers in Finland have an obligation under law to provide preventive occupational health care. Employers may also, if they so desire, provide medical

and other health services. The number of physicians in occupational health care is constantly growing. We consider that the real challenge is to be able to recruit physicians to other areas of public health care.

Education

We consider that skilful management, especially the development of competence management improve the quality of working life and improve performance. The development of manager and organisational skills and the communication skills of superiors increase the attractiveness of workplaces. Participation and the ability to influence one's own work have a positive impact on work welfare and productive commitment to work.

Decisions concerning education should be made at national level. The nature of the measures related to the contents and the provision of further training and education leading to a profession are such that, instead of applying EU level measures, it would be more useful to increase cooperation between educational institutions and workplaces. Each country should be able to make decisions independently based on its own national needs.

Our strategy in Finland has been to educate our own population to meet the labour force needs in the health and social sector. To this end, training supply in the fields of health and social care has been increased. So far, there have been enough applicants to social and health care education, a field that has retained its attraction in comparison to many other fields of study. It is also worth noticing that about 90 per cent of nurses are employed in the sector.

The Finnish legislation provides that specific education and training is a prerequisite for the practice of the healthcare profession or the use of the occupational title of a healthcare professional. Healthcare professionals are either *licensed professionals*, such as physicians and nurses, or *professionals with a protected occupational title*, for example practical nurses. The total number of titles listed in acts or decrees is 40. Only a licensed professional is entitled to practise the licensed profession in question on a regular basis. The profession of professionals with a protected occupational title can also be practised by other persons with adequate training, experience and professional skills and knowledge. They are not, however, entitled to use a protected occupational title.

There are ways to enhance the availability and retention of workforce, such as the organisation of further training for staff on a continuous basis, the application of measures to promote well-being at work and re-training adult population to be healthcare professionals. In Finland, healthcare professionals are obliged by law to maintain and improve their professional knowledge and skills required to carry on their professional activity. Local government employers have an obligation under law to ensure that their personnel participate in further training organised for them, to an adequate degree based on the length of their basic education, job demands and job description. A survey shows that in 2007, 75 per cent of all health workforce participated in further training. Analysed by professional group, physicians, dentists and other university-educated social and health workers were given further training more than other groups.

The Professional Qualifications Directive has specific implications especially for health care and the status of patients. Language skills cannot be a prerequisite for the recognition of professional qualifications. However, healthcare professionals are required to have the language skills needed to perform their duties. Increased EU-funded language training for health personnel is to be welcomed.

We do not think that a European monitoring centre would benefit the planning related to health workforce.

Managing mobility of health workers within the EU

We consider that several of the proposals are too detailed and should be left to discretion at local level. The EU legislation has already facilitated labour mobility, and there is no reason to take additional measures targeting health workforce only.

Also factors other than those directly concerned with the health sector have an influence on how people seek work, especially abroad. One example is the system of social security benefits and the differences in the level and accessibility of the systems in different Member States.

Global Migration of Health Workers

We are of the opinion that the EU should support the WHO in its work to formulate a global code of conduct for ethical recruitment. New, binding rules should not be formulated at EU

level. Any principles that may be established should be merely used as guidelines and assistance by Member States.

The Commission for Local Authority Employers is a member of the European Hospital and Healthcare Employers' Association, HOSPEEM. HOSPEEM has, together with the European Federation of Public Service Unions, EPSU, formulated a code of conduct for recruitment in EU/EEA countries.

The formulation of bilateral and plurilateral agreements should be left to national governments.

Data to support decision-making

In our opinion it may be justified to gather data at EU level. That said, the existing systems and data sources should be used to the full. However, Member States should carefully evaluate how necessary and significant the gathered data would be and whether it would provide real additional value. Data collection should not become an additional burden, and unnecessary bureaucracy should be avoided. The condition for the use of data is their comparability.

The impact of new technology: Improving the efficiency of the health workforce

We consider that the introduction of new technology may improve the quality and efficiency of health care. However, personnel need to be trained to use the new technology and new working methods. This and all other training must be based on the strategies and needs of the employer.

We find the proposals unclear and consider it therefore difficult to take a position on them.

The role of health professional entrepreneurs in the workforce

In Finland, the public healthcare system is complemented by private medical centres and occupational health care that employers are obliged to provide for their employees. Some 20 per cent of health workforce is employed by the private sector. In addition, some of the health services organised by local authorities are purchased from private service providers either by purchasing the service as a whole or by hiring workers. In 2007 the proportion of purchases of primary care operating costs was 4 per cent.

At the moment, only growth centres have a well-functioning market for purchasing social and health services. In regions with no competition between service providers and little available workforce, the purchase prices of services increase and local authorities purchasing the services are forced to accept the conditions set by the service provider. The market for social and health services varies geographically and by sector.

In Finland, the current legislation favours purchases from providers whose legal form is a private limited company; when purchasing services from private practitioners or partnerships (general partnerships, limited partnership companies) local authorities run the risk that the commission relationship will afterwards be interpreted as an employment relationship in terms of tax and pension laws. This will later increase the price of the service when the local authority is obliged to pay, for example, employer's social security contributions. Taxation policies should not, either, influence the form of work or employment relationship chosen. It is not necessarily in the best interest of the society that the difference between the capital and income taxation favours work carried out in other than service relationship.

In a situation where there is a shortage of health personnel, expenses incurred by health services cannot necessarily be cut by encouraging entrepreneurs to enter the healthcare sector and by creating new jobs; instead, such measures will intensify the competition for workforce and, consequently, increase wage costs. Also, the private sector does not automatically provide health services more efficiently and at a lower cost than the public service provider, especially in regions without a functioning market.

In our opinion it is important to examine what the best way to provide health services is. It is also important to invest in the improvement of the profitability and effectiveness of public service provision. It would also be interesting to examine how the EU legislation on competition has influenced the quality of health services, the personnel and the opportunities for SMS businesses to operate in the sector as service providers. The Member States have the responsibility for organising health services, and the decisions and measures to promote entrepreneurship in the health sector should be left at national level.

3. The situation of health workers in local authorities

The ageing of the population and retiring workforce are the main challenges related to health workers in Finland. As the Finnish population ages, workforce will decline and there will be changes in the economic dependency ratio. In Finland, the reasons for the difficulties in matching workforce supply and demand are partly regional. Workforce mobility is also an issue. In some areas, local authorities have difficulties to recruit physicians in particular, and private sector services are not available either. The availability of physicians also varies by field of specialty.

Today, the Finnish social and health sector employs more personnel than ever. To give an example, the number of nurses employed by local authorities has doubled since 1990 and the number of practical nurses has increased by 75 per cent. In future, such staffing increases will not be possible. It is a challenge enough to recruit new people to fill vacancies created by retirements. Economic resources are also limited.

In 2007, 35.1 per cent of the Finnish local government health workforce was aged 51 to 70 years, and the average age of health personnel was 45.0 years. Women accounted for 88 per cent of the total local government health workforce and 59 per cent of physicians.

The forecasts project that, over the next few years, 3,500 to 4,500 health workers and 2,000 to 3,000 social care workers will retire annually. The annual number of workers retiring will increase at a relatively steady pace until 2014, when the growth will slow down and the number will remain at slightly over 4,500 workers. The number of workers retiring is forecast to start decreasing from 2021 onwards. More than a half of all local government personnel will retire by 2025.

Physicians excluded, the availability of workforce in the social and health sector has remained relatively good. However, the availability of educated workforce has declined. As for physicians, the situation has deteriorated slightly over the past years, and there is variation between regions and fields of specialty. Some posts for physicians are left unfilled and the services are purchased.

In Finland, the employment of immigrants in the social and health sector has been scarce, and the recruitment of care personnel from abroad is a new phenomenon. In the 1990’s Finland was a country that exported health workforce, but the situation changed in the 2000’s. In recent years, the migration movement of health professionals has seen almost as many returnees as those going abroad.

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AND THE COMMISSION FOR LOCAL AUTHORITY EMPLOYERS

Director, Social Welfare and Health Care Social Welfare and Health Care	Mr Jussi Merikallio
Chief Negotiator The Commission for Local Authority Employers	Mrs Ulla-Riitta Parikka