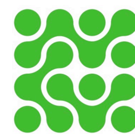

healthclusternet

Europe's health economies exchange

The Pecs Agenda

Health sector employment contributing to regional development

PROJECT PART-FINANCED BY THE EUROPEAN UNION

North East South West
INTERREG IIIC

The challenge

It is shared and common prejudice that the costs for health care are rocketing and approaching the limits of affordability. This is not supported by evidence on expenditure over a 10 year period of economic change, intense health sector reform or consumer preferences and demand. A challenge shared by all European regional health systems in a financial climate where cost containment, restriction and rationalization of health care dominates is that health organisations need to be able to demonstrate the added value of investment and expenditure decisions.

The health sector is much more than doctors, hospitals and pharmacies. The health sector absorbs large amounts of labour, commodities and research and thus creates incomes, which in turn flow back into the economic cycle of locations, regions and the overall economy. Within regions, health sector spending ranges from 5.5% to 11% of regional GDP. This is a significant level of economic activity. But it is not optimized to positively contribute to regional development agendas. Nor is it used to maximise the population health benefit of health care expenditure.

Building and maintaining an effective, flexible, healthy and innovative health sector workforce is one way of achieving these contributions. Encouraging improvements in employment practice among SMEs and NGOs in the supply chain is also important. In combination they should: help create dynamic local businesses that are competitive in wider markets; boost local employment; widen the skills base; improve workplace & population health; and strengthen social cohesion. These are the kinds of added value that we should expect from public organisations spending public money.

Relevance

For **health service decision makers** this agenda shows that health sector workforce decisions need to address the move from acute illness to chronic preventable conditions as the third ‘age’ of health care across European regions. This shift will need (i) cross sectoral service delivery designed around the needs of patients, carers and families (ii) investment in technologies and skilled workforces that minimise hospitalisation (iii) consideration of how to balance immigration and emigration of key health professions. It also supports the development of the corporate social responsibility role of your organisations and also shows your commitment to the health inequalities and health improvement agenda.

For **local health organisations** such as acute hospitals and primary care organisations, this agenda helps show your commitment to joint working with local government and other partnerships to develop fully engaged communities at both individual and organisational levels in service delivery and quality of preventable and minimised affordable care.

For **regional governments**, evidence suggests that effective, sustainable and competitive employment is best managed where there is considerable local autonomy in decision-making, coupled with tightly knit accountability to a region’s population. Overall, the partner case studies indicate that regional health bodies should develop and maintain expertise in anticipating future health demands, understand how to manage relations with other private or public sector providers, and become proficient in speaking the language of the central Finance Ministry.

For **regional economic development agencies and SMEs**, the adoption of this agenda in your region or community, offers a clear basis for creating an approach to building and maintaining healthy competitive and inclusive workforces.

For **relevant European Commission Directorates** (DG Employment, Social Affairs & Equality, DG Internal Markets, DG Enterprise & Industry, DG Research, DG Regional Policy, DG Health & Consumer Protection), this agenda offers a platform for health sector and related supply chain employment that cuts across individual DG competencies in order to achieve added value benefits contributing to sustainable regional development.

Benefits

LIke procurement, capital investment and innovation, inclusive and attractive employment by health service organisations has the potential to stimulate the development of capable local businesses, strengthening their competitiveness in wider

markets and so supporting a positive drive to achieve the goals of the Lisbon Agenda (growth, competition, employment). Specifically, inclusive and attractive employment has proven benefits to the health sector workforce, local economies and regional development. These include:

- Approaches to workforce development (including health professional refugees and immigrants) that enable health care organisations to stay flexible across time will significantly enable regional health systems to adapt to developments in medicine and demands on care and prevention that are emerging in future years.
- In the shorter term, approaches to employment by health service organisations as an incentive to partners and businesses has the potential to stimulate the development of capable local businesses, strengthening their competitiveness in wider markets and so supporting a positive drive to achieve the goals of the Lisbon Agenda (growth, competition, employment)
- Emerging best practice care models e.g. enabling integrated care pathways provide critical frameworks for prioritising investments in employment and workforce development within regions
- Information on and access to diverse employment models made available to regional decision-makers with clear evidence about relevant strengths and weaknesses of the different models with improve planning and financing of health sector workforces
- Workforce development can be done in ways that: help create dynamic local businesses that are competitive in wider markets; boost local employment; widen the skills base; improve workplace & population health; and strengthen social cohesion.

Origins and purpose of the agenda

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

Aims of the agenda

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

Policy recommendations

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

Key developments for all regions

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

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

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

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

6. **Influence Purchasers** - There should be policies for purchasers to consider the suppliers employment situation concerning vulnerable persons.

7. **Support prevention** - Healthier workplaces and life–long learning offer profits for both employee and employer.

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

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

In this group, the key focus is on employment and migration among specific health profession groups. Especially for doctors and nurses the issue of migration of health professionals is quite different through regions. Only South Trans-Danubia and Basilicata seem to have an adequate supply of doctors. In Malapolska the situation is in equilibrium but it is expected that the number of doctors and nurses will lower due to emigration. In Alentejo, Slovenia and Harghita the number of doctors employed is lower than the number actually needed. Sufficient numbers of nurses exist in South Transdanubia, Slovenia and Harghita while demand for them is a priority in Malapolska, Alentejo and Basilicata.

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

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

Overall

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

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

Structural base

10. Regions should consider establishing a multi-agency area partnership of organisations from the publicly or health insurance funded health and social care sectors, the private health sector providers and social enterprises. The purpose of the partnerships would be to agree priorities for and contributions each can make to improving an attractive and competitive multi-agency regional health sector workforce.

11. Initiate and develop health tourism that is private or based on contracts (hip replacement, somatology, movement therapy). A model of good practice already exists between Malopolska and the UK and is a possible solution. In border areas between regions there does exist health tourism based on use of spa’s, wellness facilities and somatology services. However, this functions mainly on individual level and direct payment of services delivered.

12. Establish more sophisticated interregional organized health tourism based on agreements between regional and national health authorities and institutions (public and private) as also with health insurance systems in regions so that

services and treatment such as hip replacement, somatology, movement therapy and others can be offered between regions. In such a way there would be no need to close hospitals or lower the number of employed health workers in regions because additional work would come to the region. Also, in regions with long waiting lists for services, patients could get help in shorter time. These activities would lead also to establishment of equal quality standards in participating regions and also in general through the EU.

Policy level

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

    13.1. Local and regional stakeholders should have innovative ideas and build them in Regional Development Plans

    13.2. Dialogue between local-regional-national level of health, employment and social sector should be established

    13.3. Interregional dialogue/agreement should be achieved as basis for development of new structures

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

Responsibility

14. Particularly for DG Employment, Social Affairs and Equality, there is a need to unify processes between European regions with a goal to achieve comparable services and employment possibilities. This should be complemented at regional level by regional health services providers showing a clear commitment to cross-border collaboration in an environment supported by political decision makers nationally.

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

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

Addressing the seven policy recommendations agreed by this group needs recognition that a number of barriers have to be overcome, that certain incentives can be used to overcome the barriers and that policy action should be underpinned by a clear set of principles.

Barriers	Incentives
Non-alignment of policy, strategy and funding streams Need to refine the definition of social enterprise beyond its current wide meaning Lack of compliance with local financial accountability frameworks Lack of support for entrepreneurial behaviour, especially to promote social enterprises	Reassurance from funders (compliance, service level agreements, community service agreements) Financial incentives to retain scare skilled worker categories.

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

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

This group of partner regions identified the following policy recommendations as a basis for enabling them to maintain progress in ensuring that health sector employment contributes best to regional development.

15. Standardise medical qualification rules and standards across EU
16. Balance between regulations to allow flexibility of interpretation at a local/regional level
17. Encourage social enterprise and SMEs to compete for and provide services in the health and social care sector
18. Countries in the EU15 who are receiving skilled migrants from EU12 member states and beyond should acknowledge the loss to provider countries and act to ameliorate effects through EU structural funds
19. Make it attractive to stay in employment after the retirement age in each EU member state e.g. using pension reform to retain skilled workers
20. Develop more approaches to health and well-being in the workplace.

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

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

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

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

The health care sector has two types of responsibility (i) as an employer and (ii) as an enabler of action across the public, private and NGO/voluntary sectors in regions. A route map for effective and sustainable health sector employment policies at regional and sub-regional level should adopt the following:

The Health sector as employer

21. Inclusive employment policies should be embedded in core business objectives

22. The health care sector as large employer has a special responsibility in promoting the employment of vulnerable people.

23. Show excellence as an employer

24. Not least because of its internal know-how the health care sector can show the chances of fulfilling working-relationships (e.g. working conditions, health & safety, flexible working, continuing professional development)

Health services as enabler

25. Screen (vulnerable patients)

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

26. Support preventive measures

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

27. Seamless joint financed service chains

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

28. Use social clauses within sector contracts

    - Thanks to its strong position the health sector can contribute significantly by using social clauses.

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

Contact: Margit Ohr, Network Manager – ohr@hcn.sote.hu

Edit Sebestyen, Policy Officer - edit.sebestyen@hcn.sote.hu

Marta Arrieta Rodriguez, Programme Lead (Inclusive Employment) - crpsant@mennisant.com

www.healthclusternet.org

Partner regions: Alentejo (Portugal), Basilicata (Italy), Brandenburg (Germany), Del-Dunantul (Hungary), Etelä-Suomi (Finland), Harghita (Romania), Malopolskie (Poland), North East (England, Lead Partner), North West (England), Pais Vasco (Spain), Slovenija (Slovenia), Steiermark (Austria), Västsverige (Sweden).