Promoting realistic active ageing policies in the hospital sector

Final report to EPSU and HOSPEEM

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1.0 Introduction

This study charts the age profile of the hospital sector workforce in Europe and identifies and analyses initiatives within the hospital sector that have addressed the issue of an ageing workforce. The European Federation of Public Service Unions (EPSU) and the European Hospital Employers' Association (HOSPEEM) commissioned the study, which received support from the European Commission under budget line 04.03.03.01.

The development of European level social dialogue in the hospital sector started with a conference in May 2000. A second conference took place in 2002, which underlined the importance of developing dialogue in the light of enlargement. The conference also highlighted two key issues for the sectoral social dialogue, issues around free movement of workers and skill shortages faced by hospitals in numerous Western European countries. While these issues remain, active ageing is increasingly topical and its profile continues to increase mainly because of the demographic changes, the poor position of older workers in the labour market and recent developments taken by governments to increase retirement ages.

The HOSPEEM / EPSU conference on 16-17 March 2006 was the fourth pan-European meeting with the core aim of formalising the social dialogue in the hospital sector in the EU. The initial findings of this study were presented at the conference. This final report presents the research findings and takes into consideration comments and views from conference participants. More specifically this report provides an overview of the age profile of the hospital sector workforce in the EU (EU-25), as well as outline differences between the 'Old' (EU-15) and 'New' (EU-10) Member States in more detail.

In addition to an overview of the hospital sector, a series of case studies of regional and local initiatives that aim to address the challenges of demographic change and promote realistic active ageing measures among the hospital sector workforce are presented. National initiatives supported both by employers and unions have also been included.

Finally, this report also assesses ways in which sectoral social dialogue at the European level can help to address the issue of an ageing workforce.

1.1 Methodology

Eurostat data has been used to provide an overview of patterns and trends in the age profile of health professionals and workers in the hospital sector across the EU. The analysis concerns the age profile for health and social workers (NACE code N) by gender, and examines trends and patterns between the Old and New Member States. As Eurostat data is not fully comprehensive for all of the New Member States[1] and as a result of concerns over the reliability and representativeness[2] of the Labour Force Survey, European level data has been complemented by statistics from national sources for some of the study countries. It is important to note that Eurostat's detailed data for 'human health workers' has not been analysed as part of this study: discussions with Eurostat revealed that the data is not fully representative and is not available for all Member States.

[1] Particularly Cyprus, Estonia, Latvia and Malta.

[2] Eurostat data may not reliable when the sample size of the Labour Force Survey is low.

To complement the statistical analysis a series of telephone interviews with relevant social partner organisations from the study countries were conducted as well as four detailed cases studies. The study countries were: UK, Ireland, Italy, Denmark, Germany, Sweden, France, the Czech Republic and Poland. Several good practice case studies have been provided, while the case study on Italy examines why the promotion of active ageing is not widespread in Italian hospitals.

2.0 Demographic change

The population of the European Union is ageing as a result of low birth rates and increasing life expectancy. In parallel, the number of young people entering the labour force is declining. By 2015 one in three people of working age will be over 50 years of age and by 2025 the annual rate of population growth will be negative in most EU countries.

The economic and social rationale for active ageing is clear:

- the economic benefits concern the retention of skills, knowledge and experience of older workers, though is an ongoing debate concerning the productivity and efficiency of older workers;
- in social terms an ageing society presents challenges in terms of social protection, pension and health care systems.

Ageing remains a policy concern in the EU and active ageing has been advocated as one of the remedies to counteract the increasing cost of an ageing population and sustaining the financial viability of the social security systems.

Active ageing and the engagement of older workers is embedded in both the Lisbon Strategy, through the aim to increase the activity rates of older workers to 50 per cent by 2010, and associated policy guidance, such as Guideline 17 of the Integrated Guidelines for Growth and Jobs - *Implement employment policies aiming at achieving full employment, improving quality and productivity at work, and strengthening social and territorial cohesion* (adopted December 2005). Indeed, the recent Communication *"Common Actions for Growth and Employment: The Community Lisbon Programme"* (Com (2005), 330 final, Brussels, 20.7.05), stated a commitment from the Commission to help Member State governments develop active ageing strategies as follows:

> *"In order to attract and keep more people in employment the Commission will assist Member States in developing active ageing strategies, including measures to increase healthy life years. To complement the activities of the European Social Fund, the Commission proposed a Lifelong Learning Programme to support EU-wide activities and networking in this field*".

This recommendation to develop active ageing strategies is in line with policy priorities set in the 2003 Kok Report, which recognised that without *"urgent and drastic measures to reverse current trends, there is no chance of getting close, let alone reaching, the European targets for increasing the employment of older workers and raising exit ages from the labour market"*. Indeed, the 2005 Employment in Europe Report reinforces the need for action:

> *"In order to reach the Stockholm employment rate target for older people, it is estimated that employment of people in the 55-64 age group would need to increase by around 7.5 million between 2004 and 2010, or about 1.3million per year. Over the period 2000 to 2004, employment in this age group increased by an average of around 800,000 per year. Therefore, despite the recent improvement in older people's employment rates, efforts need to be stepped up if the 2010 target is to be met."*

In 2005, the European Commission issued a Green Paper on demographic change and solidarity between the generations, which is shortly (May/June 2006) to be followed by a Communication analyzing the responses received and making policy recommendations regarding actions to be taken to make active ageing a reality.

2.1 Employment rates of older workers

The employment rate of older workers (55-64 years) in the European Union has risen from 36 per cent in 2000 to 42 per cent in 2004 (see table 2.1). The growth is evident in both old and new Member States, however the employment rate of older workers in the EU-15 as an average is some eight percentage points higher than in the New Member States (46 per cent in 2004 in the old Member States compared to 38 per cent in the EU-10). By 2004 the target employment rate of 50 per cent had only been achieved in Denmark, Portugal, Estonia, Finland, Sweden and UK. At the same time, however, less than a third of workers aged 55 to 64 were in employment in Slovenia, Slovakia, Poland, Austria, Belgium, Italy, Luxembourg, Malta and Hungary.

Across the EU-15, by 2004, Sweden (69.1 per cent), Denmark (60.3 per cent) and the UK (56.2 per cent) had a notably established and sizeable proportion of older workers active in the labour market, particularly in contrast to Austria (28.8 per cent) and Belgium (30 per cent) at the other end of the spectrum. While there is an upward trend in the employment rate for older workers in Belgium, there was no change in the employment rate among the 55-64 age group between 2000/04 in Austria.

Of the EU-10 member states, Estonia (52.4 per cent) and Latvia (49.9 per cent) have a relatively high proportion of older workers remaining in the labour market - both above the average EU-15 rates. The majority of EU-10 member states have seen an increase in the employment rate in excess of the EU-25 average between 2000 and 2004. Furthermore, despite having the lowest proportion of older workers in the EU-25, Slovenia and Slovakia have nonetheless demonstrated signs of growth in the relative rate of their respective older workforces since 2000 (6.3 per cent and 5.5 per cent increase to 29 per cent and 26.8 per cent respectively). However, in Poland the employment rate for older workers has in fact declined by some 2.2 per cent. In 2004 Poland had the lowest employment rate of older workers among EU-25.

Table 2.1 Employment rates of older workers (55-64) 2000, 2004 and change 2000/04 (%)

COUNTRY	2000	2004	Change 2000/04	COUNTRY	2000	2004	Change 2000/04
Av. EU-15	*39*	*46*	*7*	*Av. EU-10*	*33*	*38*	*5*
Belgium	26.3	30	3.7	Czech Republic	36.3	42.7	6.4
Denmark	55.7	60.3	4.6	Estonia	46.3	52.4	6.1
Germany	37.6	41.8	4.2	Cyprus	49.4	49.9	0.5
Greece	39	39.4	0.4	Latvia	36	47.9	11.9
Spain	37	41.3	4.3	Lithuania	40.4	47.1	6.7
France	29.9	37.3	7.4	Hungary	22.2	31.1	8.9
Ireland	45.3	49.5	4.2	Malta	28.5	31.5	3

COUNTRY	2000	2004	Change 2000/04	COUNTRY	2000	2004	Change 2000/04
Italy	27.7	30.5	2.8	Poland	28.4	26.2	-2.2
Luxembourg	26.7	30.8	4.1	Slovenia	22.7	29	6.3
Netherlands	38.2	45.2	7	Slovakia	21.3	26.8	5.5
Austria	28.8	28.8	0				
Portugal	50.7	50.3	-0.4				
Finland	41.6	50.9	9.3				
Sweden	64.9	69.1	4.2				
United Kingdom	50.7	56.2	5.5				
EU-25	*36*	*42*	*6*				

Source: Eurostat, Labour Force Survey, 2006

Turning to the nine study countries, only Italy and France from the old Member States have an older worker employment rate that is below the EU-15 average. Nevertheless, the employment rate among the 55-64 age group has increased in both countries. The Czech Republic has a consistently higher employment rate of older workers than the average EU-10 rate; is still lagging significantly behind the Lisbon target rate.

In terms of gender, the employment rate of female older workers grew by 7 per cent between 2000 and 2004, compared to a 5 per cent increase in the equivalent male figure. However, while the average employment rate for male older workers was 53 per cent in 2004, the equivalent rate for women remained some 20 percentage points lower at 33 per cent. Differences in the male and female employment rates between old and new member states are evident, though the male employment rate is 4 percentage points lower in EU-10 vis a vis EU-15, though there is a 9 percentage point difference in the equivalent female figure.

Table 2.2 Comparison of employment rates of male and female older workers, 2004

2004	Women	Men
EU – 25	33%	53%
EU – 15	37%	55%
New Member States	28%	51%

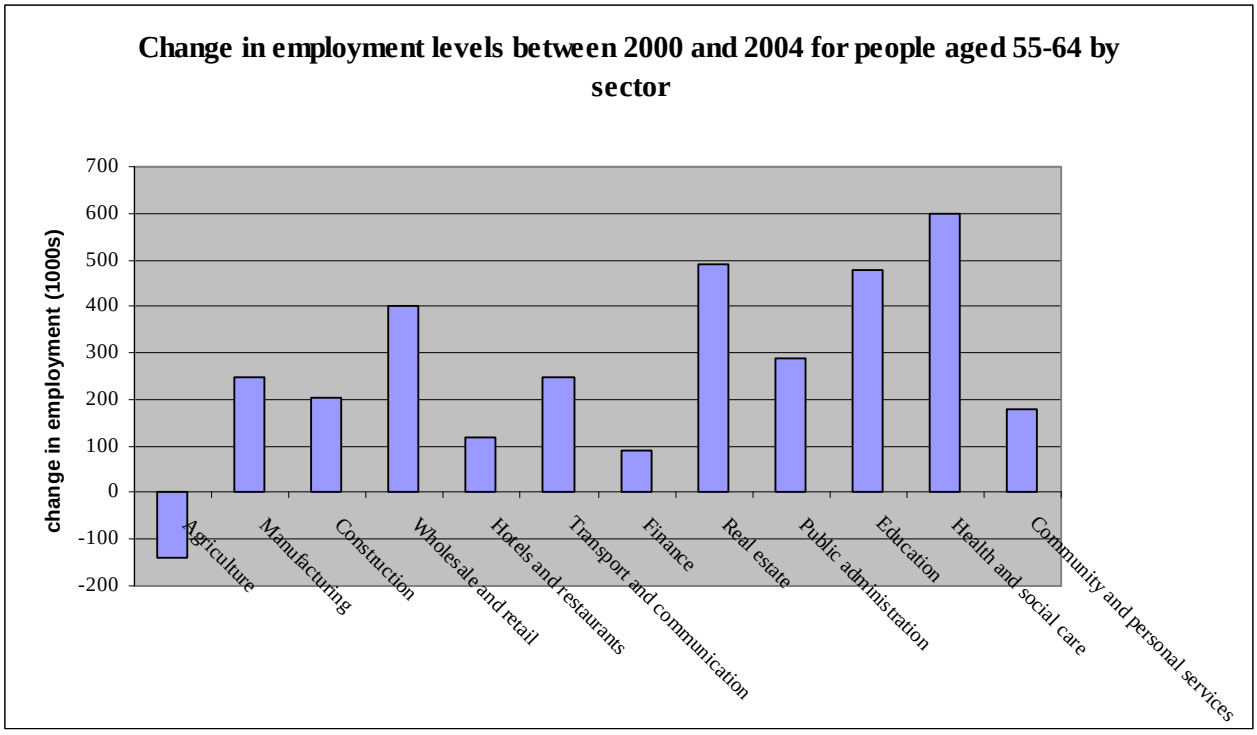
Eurostat, 2006

3.0 Age profile of hospital sector workforce

The workforce challenges facing the hospital sector can be multifaceted and complex. The supply of personnel can be affected by socio-demographic, economic and political factors. The ageing of the health sector workforce is an important socio-demographic factor that influences not only human resource management of each hospital and public policy making at national level and European levels, but can also have a direct impact on every citizen in Europe if an ageing workforce in the sector leads into substantial labour shortages at a time when demand for health services is growing. But before moving on to analyse the challenges caused by an ageing workforce and discussing successful methods to respond to these challenges, this chapter takes a look into the age profile of the workforce in the health and social care sector. It starts by assessing how heavily demographic change is affecting the sector in comparison to 11 other key sectors, before it moves on to a more detailed country and European level analysis.

Figure 3.1 below shows the change in the numbers of people aged 55-64 years employed by sector between 2000 and 2004. Agriculture excepted, there has been an increase in the numbers of 55-64 year olds across all sectors. The health and social sector (NACE code N) has experienced the largest increase in the numbers among this age group in the EU-25. Between 2000 and 2004 the number of 55 to 64 year old employees in the health and social sector has increased by around 600,000.

Figure 3.1 Change in employment levels of people aged 55-64 by sector, 2000 - 2004



Source: Eurostat / LFS, 2005

Table 3.1 below outlines employment in the health and social sector by age cohort at quarter 2, 2000 and quarter 2, 2005 for EU-25, EU-15 and EU-10. The table shows an overall increase in employment for the EU-25 of 13.4 per cent from 16.9 million to 19.2 million.

However, while employment in the health and social sector grew by 15.3 per cent in the EU-15, it declined by 1.8 per cent in the EU-10. The table also shows significant growth among older workers for the EU-25, EU-15 and EU-10. In terms of the structure of employment by age cohort, the patterns of change between 2000 and 2005 differ between the EU-15 and EU-10.

In the EU 15 all but two age cohorts (15-19 and 30-34 year olds) experienced an increase in employment, however the largest proportional increases were among the older age groups. The pattern of employment growth among older age groups is also evident for EU-10, however, it is coupled with much lower base figures than for the EU-15 and is linked to losses across five younger age cohorts.

Table 3.1 Employment (000's) in the health and social sector and per cent change 2000 - 2005

AGE	YEAR	EU-25	% change 2000- 2005	EU-15	% change 2000- 2005	EU-10	% change 2000-2005
15 - 19	2000q02	275		269		6	
	2005q02	271	-1.5	267	-0.7	4	-33.3
20 - 24	2000q02	1,077		966		111	
	2005q02	1,152	7.0	1,074	11.2	78	-29.7
25 - 29	2000q02	1,822		1,635		187	
	2005q02	1,927	5.8	1,736	6.2	191	2.1
30 - 34	2000q02	2,336		2,099		237	
	2005q02	2,273	-2.7	2,035	-3.0	238	0.4
35 – 39	2000q02	2,658		2,395		263	
	2005q02	2,651	-0.3	2,406	0.5	245	-6.8
40 – 44	2000q02	2,742		2,431		311	
	2005q02	3,048	11.2	2,764	13.7	284	-8.7
45 – 49	2000q02	2,452		2,102		350	
	2005q02	2,944	20.1	2,618	24.5	326	-6.9
50 – 54	2000q02	1,940		1,703		237	
	2005q02	2,464	27.0	2,223	30.5	241	1.7
55 – 59	2000q02	1,095		1,000		95	
	2005q02	1,668	52.3	1,536	53.6	132	38.9
60 – 64	2000q02	398		365		33	
	2005q02	622	56.3	568	55.6	54	63.6
65 – 69	2000q02	98		81		17	
	2005q02	135	37.8	115	42.0	20	17.6
Total	**2000q02**	**16,893**		**15,046**		**1,847**	
	2005q02	**19,155**	**13.4**	**17,342**	**15.3**	**1,813**	**-1.8**

Source: Eurostat, 2006

Table 3.2 below shows the proportion of employees by age cohort in the health and social sector. Figures in red show an increase and figures in blue show a decline in the contribution of the age cohort to employment in the sector in percentage terms. For the EU-25, EU-15 and EU-10 there is an increase in the relative contribution of employees aged 50 – 69 in the health and social sector up from around one fifth in 2000 (EU-25 - 21 per cent, EU-15 - 20.8 per cent and EU-10 - 20.6 per cent) to around one quarter in 2005 (EU-25 – 25.5 per cent, EU-15 – 25.7 per cent and EU-10 – 24.7 per cent).

Table 3.2 Proportion (%) of employees in health and social sector by age group, 2000 - 2005[1]

Age group	EU-25		EU-15		NMS	
	2000	2005	2000	2005	2000	2005
Total (000's)	**16,893**	**19,155**	**15,046**	**17,342**	**1,847**	**1,813**
15 – 19	1.6	1.4	1.8	1.5	0.3	0.2
20 – 24	6.4	6.0	6.4	6.2	6.0	4.3
25 – 29	10.8	10.1	10.9	10.0	10.1	10.5
30 – 34	13.8	11.9	14.0	11.7	12.8	13.1
35 – 39	15.7	13.8	15.9	13.9	14.2	13.5
40 – 44	16.2	15.9	16.2	15.9	16.8	15.7
45 – 49	14.5	15.4	14.0	15.1	18.9	18.0
50 – 54	11.5	12.9	11.3	12.8	12.8	13.3
55 – 59	6.5	8.7	6.6	8.9	5.1	7.3
60 – 64	2.4	3.2	2.4	3.3	1.8	3.0
65 – 69	0.6	0.7	0.5	0.7	0.9	1.1

Source: Eurostat, 2006

In the EU-15 there is also an increase in the contribution of workers aged 45-49 which is not evident in the EU-10, where the contribution of this age group has declined. For the EU-10, the relative contribution of the 25-29 and 30-34 age groups has increased though in absolute terms this increase only represents around 5,000 employees.

Turning to gender, the Eurostat data also shows that although there is a considerably higher share of female workers in the health sector, this trend is eventually reversed amongst the older age groups (aged 60 and above). Data show that there is a sharp decline in the number of female workers in the EU-10 and EU-15 from the age of 50 while the employment of older male workers in the sector remains much more consistent, with a less pronounced decrease in employment, to the extent that among the 60 to 70 age group, male employment exceeds female employment. Although the health sector in the EU-10 is smaller in size compared to the EU-15, this trend in gender employment is nonetheless similar.

[1] Please note that data collection in some of the New Member States is somewhat fragmented, thus information should only be seen as an indication.

When analysing the age profile of hospital sector personnel in the nine study countries in more detail (on the basis of Eurostat data), the following table 3.3 demonstrates that Sweden has the biggest proportion of older workers. In Sweden 21.6 per cent of health personnel are 55 years or older, whilst ageing workers constitute the lowest proportion of health care workers in the Czech Republic (only 5.5%). Older employees also make up fairly small proportion of all workers in Poland, just 8.5 per cent.

Table 3.3 Proportion (%) of employees in health and social sector by age group, 2005

	Denmark	Germany	France	Ireland	Italy	Sweden	UK	Czech R.	Poland
15 – 19	20.2	0	0	0	0	10.3	8.7	0	0.0
20 – 24	4.1	8.4	5.5	7.6	2.2	2.8	1.5	22.3	4.2
25 – 29	8.3	10.6	9.6	13.0	7.2	8.0	10.7	4.0	11.9
30 – 34	8.1	10.4	12.4	14.1	15.1	10.1	12.2	4.6	16.7
35 – 39	11.6	14.7	14.4	13.5	16.3	6.4	2.7	48.6	0.3
40 – 44	10.8	17.2	15.8	13.0	17.0	14.1	16.7	4.4	20.8
45 – 49	12.3	15.2	15.7	13.0	17.0	13.8	15.2	5.0	25.2
50 – 54	10.4	12.3	14.8	11.9	14.7	12.8	13.2	5.5	12.2
55 – 59	10.4	7.1	9.7	9.2	7.6	13.2	12.3	4.1	4.9
60 – 64	3.0	3.4	1.9	4.9	2.4	7.7	5.4	1.1	2.3
65 – 69	0.8	0.7	0.2	0	0.6	0.7	1.5	0.3	1.3

Source: Eurostat, 2006

Turning to assess changes in the age profile over the past five years, Eurostat data show that the number of older workers (55+) doubled or nearly doubled over the past 5 years among certain age groups. For example, the number of 60 to 64 year old health care professional doubled over this five year period in Denmark, and the number of 55 to 59 year olds more than doubled in the Czech Republic. The number of employees in the Irish health sector increased more evenly across all age groups during the past five years; indeed every age cohort witnessed an overall increase. The table 3.4 shows that in the Polish health sector the number of workers aged 55 to 64 slightly declined, which is a contrary trend to the other study countries. This trend is similar to the trend of overall decline in the number of older workers in Poland.

Table 3.4 The number (000's) of employees in older age groups (55 - 64) between 2000 and 2005

	DK	GER	FR	IE	IT	SW	UK	CZ	PL
2000	48	345	n.a	15	107	124	404	28	60
2005	86	429	349	26	161	152	595	51	59

Source: Eurostat, 2006

In relation to the age profile of different categories of hospital sector personnel, the statistics from HOPE show that between 1995 and 2000 the number of physicians in Europe under the age of 45 fell by 20 per cent[1]. At the same time, the number of over 45 year old

[1] HOPE (2004) The healthcare workforce in Europe: Problems and solutions.

physicians increased by 50 per cent[1]. In France the average age of doctors increased from 42.4 to 47 between 1990 and 2000. Whilst 55 per cent of the French doctors were under 40 years in 1985, only 23 per cent of doctors were under 40 years in 2000. In Germany the change has not been as drastic; the average age of hospital doctors increased from 38 to 40 between 1992 and 2002. Contradictory trend was found from England where the average age of hospital doctors actually reduced from 39.3 years to 39.2 years between 1992 and 2002.

In Sweden the average age of hospital doctors has been increasing since the early nineties. The average age of hospital doctors went up from 42 years to 45 years between 1994 and 2002[2]. Table 3.5 below presents the age profile of Swedish physicians in 2005 (members of the Swedish Medical Association). While not fully representative of the hospital sector, the table shows some interesting gender differences in the employment of older workers. Some 31 per cent of all Swedish physicians are aged 55, but the 55 and over age group represents only 24.3 per cent of the female workforce, but 36 per cent of the male workforce. Thus, these statistics are in line with the analysis of gender differences in the Eurostat data which found that male employees in the health sector tend to work longer than their female colleagues.

Table 3.5 Age profile of Swedish physicians (% of the total workforce), 2005

	WOMEN		MEN		TOTAL	
AGE	No of employed	% of the workforce	No of employed	% of the workforce	No of employed	% of the workforce
< 29	808	6.7	461	2.8	1,269	4.5
30 – 34	1,487	12.3	1,128	6.9	2,615	9.2
35 – 39	1,502	12.5	1,517	9.3	3,019	10.6
40 – 44	1,529	12.7	1,886	11.6	3,415	12.0
45 – 49	1,988	16.5	2,454	15.1	4,442	15.7
50 – 54	1,821	15.1	2,978	18.3	4,799	16.9
55 – 59	1,914	15.9	3,566	21.9	5,480	19.3
60 – 64	1,011	8.4	2,301	14.1	3,312	11.7
Total	12,060	100	16,291	100	28,351	100

Swedish Medical Association, 2005

In terms of the average age of nurses, in 2002 the average age of a Swedish nurse was 44, whilst the average age of a nurse in England was 40. Between 1994 and 2002 the average age of a nurse increased from 41 years to 44 years[3]. The French nursing sector witnessed a change of 5.5 years in the average age of their nursing staff between 1990 and 2000, the average age went from 37.5 years to 43 years. In England the average age of nurses increased from 38 to 40, although in England certain special areas of nursing witnessed much stronger increase (particularly midwifery).

[1] Ibid.
[2] Ibid.
[3] Ibid.

The following table provides a more detailed breakdown of the age profile of nurses and midwifes in the UK over the last decade. Whereas 10 years ago, over half of nurses and midwives (53.3 per cent) were under 40, some 62.4 per cent of nurses and midwifes are now aged 40 and over. More than one in four nurses and midwives (28 per cent) are aged 50 and over compared to one in five (20.6 per cent) ten years ago.

Table 3.6 Age profile of nurses and midwifes in Britain

Age	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
< 25	4.1	3.6	3.2	3.0	2.9	2.1	2.2	2.1	2.0	1.9
25-29	12.8	11.8	10.9	10.3	9.9	7.3	8.9	8.5	8.4	8.3
30-39	36.4	36.1	35.7	34.8	33.7	31.3	30.6	29.4	28.3	27.4
40-49	25.2	26.7	27.6	28.6	29.6	32.2	32.3	33.3	33.9	34.4
50-54	9.4	10.3	11.0	11.3	11.6	12.8	11.5	11.5	11.6	11.9
55 >	11.2	11.5	11.7	12.3	12.3	13.2	14.5	15.3	15.7	16.1

Source: The UK Nursing and Midwifery Council, 2005

Statistics from Denmark on hospital sector workforce in the Copenhagen region reveal that nearly a third of all hospital sector workers are to retire within the next 10 to 15 years; 32.4 per cent of all employees are 50 years or over (see table 3.7 below). Only a fifth of all hospital sector personnel are male, but their proportion of the total workforce increases by age. Whilst male employees constitute 13.5 per cent of all employees aged 20 to 30, they represent 27.1 per cent of all employees over 60 years of age. These statistics also point out some inconsistencies with Eurostat data with regards to the number of young people (under 20 years) employed in the health sector.

Table 3.7 Age profile of hospital sector workforce in the Copenhagen region, 2004

	WOMEN		MEN		TOTAL	
AGE	No of employed	% of the workforce	No of employed	% of the workforce	No of employed	% of the workforce
< 20	397	0.6	103	0.7	500	0.6
20 – 30	8,527	11.9	1,337	8.9	9,864	11.4
30 – 40	18,797	26.2	3,369	22.5	22,166	25.6
40 – 50	21,734	30.3	4,230	28.3	25,964	30.0
50 – 60	18,791	26.2	4,652	31.1	23,443	27.1
60 >	3,375	4.7	1,256	8.4	4,631	5.3
Total	71,621	100.0	14,947	100.0	86,568	100.0

Source: Dansk Sygeplejeråd

Finally, the proportion of older workers for different categories of health sector personnel (English NHS) is shown in the table 3.8 below. The table shows that support staff has the most ageing profile currently as 18.2 per cent of all support personnel are over 55 years. Managers and administrators come on the second place with 14.5 per cent. This demonstrates an interesting trend from UK where actual health care professionals are younger than those working in non-medical duties.

Table 3.8 The proportion of older workers (%) by different categories of workers, NHS in England, 2003

Staff group	55 - 64	65 +
Medical and dental	10.7	0.9
Nursing midwifery	9.8	0.1
Allied health professionals	8.6	0.2
Scientific and professionals	8.9	0.4
Health Care Ass. & support staff	17.7	0.5
Management and administration	14.1	0.4

Source: NHS 2003

4.0 Challenges caused by an ageing workforce

Two key points emerged from the previous chapter concerning the health care sector: a general trend of employment growth, resulting in skill shortages and a rapidly ageing workforce. Indeed the healthcare sector's workforce is ageing more rapidly than any other economic sector. According to existing studies employment is expected to continue to grow, and based on current trends the workforce will continue to age. Studies for example from the UK have estimated a growth of approximately 4 per cent per annum in the short term future, however in recent months the NHS job cuts have been featuring news headlines, thus contradicting the trend of constant growth[1].

Looking forward, ageing poses a three-fold dilemma (often referred to as 'triple ageing') for the health sector:

- loss of skilled labour
- failure to recruit young people
- an increasing demand for health / hospital services.

This chapter examines these issues and the way in which an ageing workforce is expected to influence the sector in the coming decade.

4.1 Loss of skilled labour / failure to recruit young people

Within a context of employment growth / skills shortage, hospitals have to deal with workforce planning and human resources issues caused by the loss of skilled labour and the failure to recruit young people to enter the sector (in some countries a career in the hospital sector, nursing in particular, is not considered attractive due to relatively low wages). The scale of problem facing the sector is illustrated as follows:

- In 2001 the UK estimated that by 2008 the NHS will need to increase its workforce by 200,000 including: 15,000 new consultants and GPs, 35,000 nurses and midwifes, 30,000 therapists and scientists and 27,000 health care assistants[2]. Furthermore, a shortfall of 25,000 doctors is expected by 2020;
- Social partners from Holland have estimated that the Dutch hospital sector will be facing a shortage of 25,000 nurses in the next decade;
- Some 50 per cent of French nurses are expected to retire by 2015;
- Approximately 100,000 British nurses are expected to retire by the end of this decade.

A further complication associated with the loss of older workers from the health sector is the potential for a widening skills gap. There is no like for like substitution of an older, experienced worker leaving the sector to be replaced by a younger, recently trained worker. Labour market exit in effect means that years of skills and expertise simply leave the sector. Therefore it is essential for the sector to ensure that mechanisms are put in place to harness older workers' skills and expertise. However, any steps taken to harness the skills and expertise of older workers should not discriminate against or disadvantage workers in other age groups: the sector is already experiencing problems recruiting from a decreasing pool of young people so needs to be mindful of the needs of all employees, not just its older workers.

[1] Workforce Development Confederation, 2004

[2] Ibid.

Understanding the reasons why people leave the sector is an important challenge for the future. Generally speaking well educated employees tend to stay in employment longer than those with lower education level. However, health sector studies have found that increases in workload, a lack of recognition, long hours, the need to compromise quality of care, a lack of support, rigid career structure and continuous change are some of the key work related factors that influence early labour market exit. The NEXT study goes a long way in understanding reasons for labour market exit from nursing: the study found that levels of education have an influence on whether nurses want to retire early and that the intention to leave their job is also influenced by the types of working conditions mentioned above.

4.2 Demand for health services

The third dimension is an increasing demand for health and hospital services as the population using its services ages too. By way of example, the following figures present anticipated growth by older age group for 2030:

- 55 to 64 year olds by 15.5%
- 65 to 79 year olds by 37.4%
- People over 80 year olds are expected to grow by 57%.

Recently many countries have witnessed a growth in the proportion of women enrolling in medical schools. This also has implications on the longer term workforce planning in the hospital sector (due to career breaks and part time work).

5.0 Responses to challenges

Promotion of realistic active ageing policies is one of the key policy tools to address the effects of an ageing workforce. From the outset, policy makers tended to identify active ageing solely with policies that encourage people to work longer. More recently European consensus has formed around the idea that active ageing strategies should focus around lifecycle approach entailing at least five additional dimensions: access to training and new skills throughout the working life (LLL), health and well-being of the workforce, changing attitudes towards older workers, quality of working condition & environment and flexible working arrangements. Indeed, the European Commission has recommended Member States to:

- Provide incentives for workers to retire later and for employers to hire and keep older workers.
- Promote access to training for all regardless of age and developing lifelong learning strategies, in particular workplace training for older workers who are underrepresented in training.
- Improve the quality of work to provide attractive, safe and adaptable work environments throughout working life, including the provision of part-time work and career breaks.

This chapter discusses different strategies and initiatives from across Europe that have addressed the issue of demographic change in the hospital sector. Examples have been recommended by national social partner organisations or other health sector professionals and are implemented by individual hospitals, health trusts and/or social partners - or are national programmes / agreements. Most examples tend to come from countries where active ageing policies are most advanced, such as the UK and the Nordic countries. Indeed, this research has found clear indications that whilst the expression *active ageing* is now widely used in the Anglo-Saxon countries in the hospital and health sector, it is not as widely acknowledged or recognised in many of the Southern and Eastern European countries. However, in this chapter we also look into examples from other countries such as Ireland where the retention of older workers is up and coming policy area and we will also examine the situation of active ageing policy in the hospital sector in Italy.

5.1 Comprehensive policy approach

The first case study example is characterised by one of the most comprehensive policy approaches from the hospital sector to active ageing.

The South Downs NHS Trust is a health trust in Southern England providing hospital, health and social services for people in the Brighton and Hove region. The Trust currently employs 2,061 people ranging in age from 16 to 74. In addition to ageing workforce other factors influence the Trust's decision to develop these policies: recruitment difficulties in attracting young workers; increasing housing costs; a loss of skills which were hard to replace (as a result of mandatory retirement age)[1]; requests from staff and managers and the introduction of new age legislation in the UK.

The Trust's active ageing strategy comprises four different strands:

- Promote working in the health sector among young people
- Attract former employees to return to work

[1] abolished in 2003

- Policies regarding retirement and employment of older workers
- Well being and training for the older workforce.

Each of these strands is discussed in turn below.

A. Promote working in the health sector among young people

In order to maintain a balanced workforce in the future, the Trust aims to retain older workers as well as attract young local people to the sector. Traditionally, the Trust has employed few younger staff, partly due to the nature of many posts which require a professional qualification and / or previous experience.
The Trust has worked hard to attract newly qualified, younger nurses in all areas of nursing to work for South Downs NHS Trust, through a closer involvement in the local nurse cadet programme. In addition, the Trust has also reviewed its work experience opportunities with local schools and colleges to promote the benefits of working in the health service. Their work has seen the introduction of Managers' Guidelines for Work Experience Placements. In order to engage with even younger people, the Trust has worked with the local Education Business Partnership and has increased their active participation in careers and industry days.

B. To attract former employees to return to work

As a part of the nurse training programme, the Trust has pioneered new training schemes, such as placements in community settings. The Trust also works closely Brighton and Hove Councils' Supported Employment Team to encourage people who were formerly employed in the health sector to return into employment. Many of the people accessing the project have a good skill base but feel discriminated or lack confidence because of their age. Through this scheme the Trust offers work placements in hospitals or community social care settings and provides people with information about career opportunities.

C. Policies regarding retirement and employment of older workers

Although the Trust had always operated some flexibility towards staff wishing to work after the State pension age, a new older workers policy, introduced in 2003, removed the mandatory retirement age. The new policy gave the staff the right to continue working for as long they wished.
The Trust also promotes a range of options to assist people work beyond state pension age. The following options are available:

- flexible working
- early retirement
- early retirement and return to the NHS
- wind down - reduction in hours in the lead up to a planned retirement
- step down - moving to a lower graded post in the lead up to retirement
- pre-retirement sabbatical (through the Trust's sabbatical policy)
- work as "normal" retiring at 60-65
- retire at 60-65 and return to the NHS
- continue working after 65
- continue to make pensions contributions until age 70 if in NHS employment and the maximum contribution level has not been reached.

The changes identified above resulted from a full review of the Trust's Retirement and Employment policies. This review was conducted by the Joint Staff Committee, head of the Trust and union representatives.

D. Well being and training of older workforce

The Trust is committed to promoting equality and diversity and tackling age related discrimination in the workplace. All of the Trust's recruiting managers are required to attend a Recruitment and Retention training course, which covers discrimination and retirement. No reference to age (upper or lower) is made in any recruitment literature unless there is a legal, insurance or registration issue that requires it.

All staff are encouraged to attend training courses throughout their working careers. The Trust promotes staff development and life long learning programmes including a Return to Learn course. Many course participants are older workers.

For some staff health and performance may decline with age, although the Trust recognises that this is not always the case. Health and performance issues that may arise are dealt with as a capability issue as they would for any member of staff. The Trust also emphasises the value of the diversity that an older person may bring to a team. For example, an understanding of the history of an organisation / department / profession may be as valuable as being able to undertake a high level of physical activity.

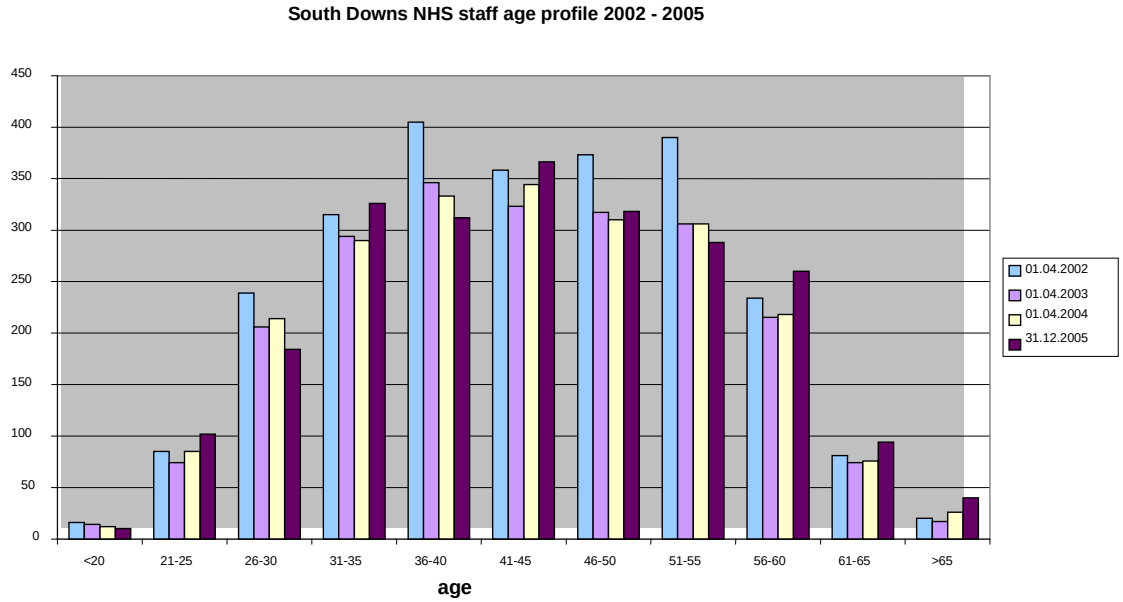
A recent staff survey shows that a significant number of staff have carer responsibilities. The Trust is keen to help staff who have caring responsibilities by helping them balance home and work commitments. This may in turn help them continue working when they may otherwise have thought about taking retirement.

5.1.1 Impact

When assessing the impact of the policy, the first finding is that an increase in the number of people wishing to work after the State Pension Age occurred already within one year of the policy being introduced. The number of staff aged over 65 increased from 17 employees to 26 during the policy's first year of operation. At the same time the Trust has also managed to attract more young people and people aged 55 and over too (see Figure 5.1).

There is also anecdotal evidence that some employees applied to work for the Trust later in their career because they wanted the option to continue working beyond the age of 65.

Figure 5.1 Age profile of the workforce, 2002 - 2005



The representatives of the Trust believe that the introduction of these policies have also led to better understanding of work-life balance issues and the widespread acceptance of flexible working. Indeed, feedback from a recent staff survey demonstrates support from staff for the policy developments too.

5.1.2 Lessons

The experience from the Trust has shown that giving staff rights (rather than managers only) and extensively promoting long-term commitment to new policies to *all* members of staff led to a rapid take up of the new policies and ownership by staff. The Trust wrote to all staff and provided information about the options as well as trained managers about the new policy. Flexible retirement options and the new policy are also promoted in other ways: at induction, the annual staff conference, recruitment fairs, in the staff handbook, via the intranet, monthly newsletter, adult learner weeks and twice yearly pre-retirement courses.

Staff seeking to retire are encouraged to enrol on a pre-retirement course, which have become very popular. These courses, run by the Trust's human resources department provide information about flexible retirement options and provide an opportunity to discuss pensions. The policy also encourages staff and managers to have a dialogue about retirement plans. Early discussions about retirement mean that retirement is well planned and both parties are actively involved in health and capability issues should they arise.

The national social partner organisations also played a role in the development of this policy. The Trust utilised the "5 why's technique", used by the NHS Modernisation Agency to redesign their retirement policies. They also benefited from the NHS IWL[1] standards which

[1] UK National Health Service – programme on Improving Working Lives.

have been developed in collaboration with social partners. The unions and the staff co-ordinator were supportive of the policy developments. The unions were consulted during the development process and their comments were taken into consideration in drafting the policy.

This case shows how important it is to have so-called 'age champion' to take the issue of ageing workforce forward within an individual health trust or a hospital. In this case it was a senior member of the HR department. It is also equally important for the 'age champion' to gain commitment of the management and employee representatives in order to ensure full implementation and continuity in case an individual is to leave the Trust. In the case of South Downs, the Trust's chairman and board and union representatives were very involved and engaged in the development of these policies from the start.

When assessing the effectiveness of different policies introduced the Trust pointed out that it is has been the whole package of policies together that has proved most effective – rather than just certain elements. It has been important for the Trust to provide a good working environment and flexible working options for older workers in order not to lose skilled people purely because of their age but it has also been equally important to engage with young people in order to form a basis for the long-term recruitment strategy of the Trust. In addition, flexible working options have also proved useful in retaining both older and younger employees.

The Trust however, does recognise that there are areas of further improvement, mainly dealing with monitoring, retirement planning interviews and access & uptake of training.

5.2 Addressing the issue through collective bargaining at national level

National level collective bargaining has also been used to counteract effects caused by an ageing hospital sector workforce. For example, in Belgium the social partners in the health sector have negotiated reduced working hours for older workers (32 hours at age of 55).

The Danish County Councils and Local Authorities and trade unions have negotiated a 'senior policy' framework agreement with the aim of helping retain older workers within the local and regional government sector labour force (including hospitals). As an alternative to leaving work, employed people aged 60 and over, that wish to retire, can enter a senior profession with the option of reduced working hours while maintaining a full pension.

The agreement takes into account: an employee's age, length of service (current and previous employment in the sector), as well as whether they are eligible for a part pension, part salary or any other form of supplementary compensation. Blue and white collar staff aged 52 and over are eligible. The framework agreement can be flexible and incentivised:

- They can be timebound, or without a time limit;
- If negotiated in advance, when a person retires after the age of 62 a special bonus is awarded;
- A salary supplement can be awarded if the senior profession salary is lower than the previous position;
- If the change to a senior profession entails a reduction in normal full time hours, a supplement can sometimes be agreed;
- For agreements established since 1 April 2002, white collar staff that switch to a senior profession, have the right to have their pension calculated on the salary and

occupational status in the previous position (this is not available to blue-collar workers);

- If the senior profession salary is reduced significantly, up to 2 years extraordinary pension age can be added to white / blue collar workers that had turned 55 at the time of the change to a senior profession and who remain in work to the age of 62.

However, in some cases, the incentives to remain in work can concern enhancements to an individual's working environment. Another option is "mentoring agreements". Under such agreements, staff agree to stay on longer to mentor more junior staff in return for either a) a salary enhancement; b) an add on to pension entitlements; or c) a mix of these benefits.

5.3 Maintaining the well being and motivation of the older workforce

An earlier analysis of the reasons why health care professionals may wish to leave the profession early or to retire early revealed that both physical and mental well being of the workforce and a good working environment are essential for a long career in the health care sector. The Uppsala University Hospital is an example of an individual hospital, which has looked into the working environment of the older workforce already since the mid-nineties.
The hospital employs over 8,000 persons. The average age of employees in 1995 was 41.3 years and it was estimated to rise to 55 by 2010. In the mid 1990s the hospital recognised the importance of ensuring that the working environment is attractive and pleasant for older workers.

The work to develop these areas started off by carrying out a survey and interviews with the hospital staff in order to better understand the needs and wishes of older workers. The hospital then developed activities in response to the feedback from the staff. These activities included a better provision of continuing education and training for older workers, and addressing issues around working environment and working hours.

An individual from one of the hospital units played a crucial role in the design and implementation of these activities. This case study, however, displays the importance of the management 'buy-in' in ageing strategies since many of the activities have faded gradually out in recent years - after the departure of the individual who developed these strategies. Today most of the activities of the hospital are focussed on *early* prevention of stress related illnesses or physical problems through 'a well being centre' for the staff that looks into the overall mental and physical well being of the workforce. This centre is aimed at all workers and not only at older individuals.

5.4 Development of flexible employment and retirement options

Research by the British Department of Work and Pensions shows that many older people would prefer to continue to work beyond retirement age and that older people wanted to be independent for as long as possible[1]. Currently, those with small pensions are most likely to work beyond the state retirement age, thus suggesting that there is a financial imperative for some to continue working and a desire for continued job satisfaction for others[2].

[1] Hayden et al - Research Report No.102 Attitudes and Aspirations of Older People: a Qualitative Study. Department of Work and Pensions

[2] Disney et al - Research Report No.72 The dynamics of retirement: analyses of the retirement surveys. Department of Work and Pensions

During periods of high unemployment there was a belief in most countries that a fixed retirement age was necessary to ensure job opportunities for younger people. Now health sector professionals and others have come across with a situation where large pools of people want or need to continue to work beyond the state pension age and are fully capable of doing so. At the same time flexible retirement options may encourage some to delay retirement by taking 'a slow step-down option', or encourage some to reduce work participation at an earlier stage rather than retire early, thus improve retention of older workers.

The Hertfordshire Partnership NHS Trust and the Bexley Care Trust are two prime examples of individual health trusts from the UK which have developed provisions for flexible working and introduced flexible retirement options.

The Herefordshire Partnership NHS Trust is a health trust in the Southern England where a third of all medical and support staff are aged 50 or over. This means that a substantial proportion of employees will be making decisions about work and retirement in the near future. Consequently, the Trust has introduced three flexible working options:

- 'Wind down' - as an alternative to simply retiring the staff can opt to wind down by working fewer days/hours than their current post.
- 'Step down' - for staff who would like to give up the pressure and responsibilities of their current role but rather than leave work altogether, step down into a less demanding job but which makes use of their skills and experience.
- Register to work for in the Trust's Staff Bank Bureau – taking retirement, then opting to work on an “as and when” basis, giving an opportunity to pick and choose the hours worked.

The Bexley Care Trust is a health trust in the London region and has been recognised as an Age Champion Employer by the British Department of Work and Pensions. The Trust employs around 700 health care professionals. Their policies were developed in consultation with union representatives and they comprise of the following elements:

- Flexible retirement policy
- Pre-retirement courses
- Recruitment of an Age Champion Leader to work with front line managers, employee representatives and staff to ensure that age equality is at the forefront of all the activities of the Trust
- Updating all HR policies and guidelines jointly with trade unions to ensure they are not discriminatory against any age group
- A mechanism has been developed to monitor the age of staff who apply for internal and external training courses - to ensure no bias in the take up of development opportunities across the entire workforce
- Regular staff surveys to monitor staff views (morale, well being etc.).

Interviews with the Trust revealed that many members of the staff have already taken advantage of the Trust’s flexible retirement policy, and early findings show that they are satisfied with new arrangements. The Trust has also found that promotion of active ageing policies helps them to retain the members of staff with knowledge, skills and experience, which has a positive effect on recruitment costs and patient care. Evidence from the staff surveys and the Trust’s own exit interviews has indicated that staff see flexible retirement as

a way of helping them continue working. It ensures that their skills and knowledge are not wasted and they can help mentor other staff members within the team.

5.5 Managing knowledge transfer

It is important that knowledge, experience and skills of experienced doctors and nurses are transferred to younger health care professionals. Ikävoimat käyttöön - project is a pilot project developed by Kanta-Häme hospital and Kanta-Häme regional hospital trust from Finland. The project aims to identify and implement methods to improve management of change in the workforce demographics - by better managing the transfer of tacit knowledge and experience from older workers to younger ones. The project is being implemented between 2006 and 2008 as a pilot project in one of the hospital units. After the two year pilot period, the aim is to mainstream the practice in all of the hospital units as well as nationally as a good practice tool for other hospitals, health trusts and educational establishments. The objectives of the project are to:

- Improve patient orientated care on the basis of better team working.
- Enhance mental and physical well being of the workforce.
- Support the development of participatory leadership.

The project is currently in its early stages and therefore no conclusive remarks can be made about its success. However, the project is closely following experiences from the Finnish national programme on ageing which has largely been regarded as a success in retaining older workers in employment, and the project is linked to the current national workforce development programme TYKES.

5.6 Mechanisms for better workforce planning

A short term approach to recruitment in the hospital sector is no longer effective in the European countries where significant labour shortages prevail. A short term approach may be sufficient still in some Southern European countries where the supply of health care professionals exceeds the current demand, however, this approach can not be considered sustainable in the longer term future.

Workforce planning is a continuous process of shaping the workforce to ensure that it has the capabilities and the capacity it requires to deliver services. Social partners can play a role in this process by providing tools for hospitals and health trusts. For example, the health sector employers' organisation from the UK, NHS Employers, is in the process of developing a tool for health sector employers to assist age profiling and longer term workforce planning. The tool works by inserting the number of people in employment in the given hospital and the numbers of leavers and joiners by age band into the profiling tool. The numbers should be inserted for as many years as data is available. The tool will then be able to show what effect current patterns will have on the age profile of the workforce in the future. Furthermore, this can be done on an iterative basis, year-on-year, to demonstrate the impact over time of any initiatives and positive action taken to remove age discrimination. The tool will be published in Spring 2006.

5.7 Ergonomic strategies and H&S

Employment in the hospital sector can be physically demanding, but employers can be proactive in building up strategies that enable older workers to remain in employment, even if their physical capabilities were to decline (which is naturally not the case with all older workers). These strategies include, for example, changes in working hours and better partnership working between younger and older workers.

The Varberg Hospital from Sweden is one hospital that has tried to address this issue. In recent years the Swedish health care policy changed in terms of service delivery; from hospital based care to community based care. This led into substantial staff reductions in the hospital of Varberg. The redundancies were made on the basis of the length of service, thus leading to an increasingly ageing workforce. These developments also led to older staff looking after even older patients and soon the hospital saw clear increases in low motivation and sick leave and higher levels of early retirement.

As a response to these developments the hospital wanted to pilot changes in three different wards. These developments included changes to the work environment and provision of education on work ability. In addition, the wards were allowed to recruit new younger staff in order to balance the age profile of nurses.

The project impact was limited in two of the wards. However, activities of one of the wards focussed on changing shift plans to working longer hours but fewer days. This change made employees feel that they had more time to complete their jobs and meet with other staff to discuss patient care. The effects on individual workers were very positive in this case.

Another example is the Hospital Group in the Ile de France region that has carried out studies on work ergonomics and to the mechanisation of heavier duties in hospitals.

5.8 Removing discrimination on the basis of age

Some employers in hospital sector and in general, still assume, often unconsciously, that older workers are less flexible, capable or hard-working. However, research evidence is available to demonstrate that in general terms those perceptions are wrong. For example, of those who do work beyond retirement age 76% of men and 71% of women report their health to be excellent or good as compared to 54% and 49% of non-workers of a similar age[1]. This suggests that people are realistic about their capabilities and continue to work only if their health is sufficiently good. Some studies show that older workers are actually more motivated in their work than their younger counterparts[2].

In the near future hospitals, like any other employers, have to review their existing policies in relation to recruitment, promotion, retention, working conditions and retirement to make sure that none of their activities are discriminatory against any age group. The European Union Council of Ministers adopted the Employment Directive on Equal Treatment in 2000 (the EU Council Directive 2000/78/EC). It establishes a general framework for equal treatment in employment and vocational training and guidance and is designed to outlaw discrimination on grounds of age, sexual orientation, disability and religion / belief. The Directive also

[1] McKay and Smeeton - Research Summary: Working after state pension age: quantitative analysis. Department of Work and Pensions, summary published by Age Positive.
[2] The TNO Work Situation Survey 2002.

requires the Member States to introduce legislation prohibiting direct and indirect discrimination by 2006. The Directive also emphasises that social partners and social dialogue have a role to play in combating discrimination on the basis of age, through monitoring workplace practices, codes of conduct and exchange of good practices.

In response to this, NHS Employers UK has published a practical briefing for health sector employers in the UK on the new legislation on age discrimination – which comes into force in 2006. The briefing also includes a checklist which helps employers in the health sector to cover a range of essential employment practices and policies (including recruitment, training, promotion, harassment, retirement and redundancy)[1]. The NHS Employers also recognise that it is important for employers to raise awareness and change attitudes of staff towards older workers from the point of view of financial management. It has been estimated that the cost of claims made on the basis indirect and direct age discrimination could reach £93 million in any one year (over €134 million)[2].

As earlier case studies have already demonstrated, many British health trusts (including South Downs and Bexley) have systematically reviewed all their employment policies from recruitment to retention to make sure their practices are not discriminatory on the basis of age.

5.9 Access to learning throughout the career

Access to education and training throughout working life is one of the key concepts behind active ageing. Several studies[3] have demonstrated that highly educated workers are less likely to retire early. Thus, it is essential that attitudes which are barriers to training for some older workers are addressed by employers in the hospital sector. For example, some older employees believe they are too old to attend training and others lack confidence due to staying out of training environment for too many years. In some cases older workers may have been previously overlooked or older workers themselves feel that younger colleagues should be given priority.

In Sweden, the Swedish Municipal Workers' Union Kommunal has adopted a pro-active role towards training in the sector and is currently working with a county council and other partners on a sustainable competence development project relating to health sector workforce.

The Bexley Care Trust, UK, has introduced a mechanism to monitor the age of staffs who apply for internal and external training courses - to ensure all workers have the same development opportunities.

[1] http://www.nhsemployers.org/excellence/excellence-361.cfm
[2] Daily Telegraph / Cranfield School of Management 03/02/05
[3] E.g. Statistics Denmark: *Seniors and the labour market.*
Statistics Finland: *Early exit from working life among ageing employees*

5.10 An Irish perspective

The healthcare sector is one of the largest employers in Ireland, accounting for 9.5 per cent of total employment. Employment in the sector has increased substantially, for example between 1998 and 2003 employment in the sector increased by 51 per cent[1]. The Eurostat data revealed that employment in the health care sector increased among all different age groups between 2000 and 2005. A recent survey also reported vacancies in the sector and an overall vacancy rate of six per cent[2].

The demography of the Irish population is slightly younger than the demographics in the most 'old' Member States. Consequently, active ageing has not traditionally been seen as high policy priority as in many other countries. In relation to health sector employment, traditionally the Irish health sector stakeholders have employed immigration as a key strategy to deal with the labour shortages. For example, in 2000 the Irish authorities adopted a 'fast-track' visa/authorisation scheme to facilitate the immigration of suitably qualified non-EEA persons.

While immigration has made an enormous contribution to increasing the supply of healthcare professionals in Ireland, it alone cannot solve sectoral skills shortages. Indeed, immigration can curtail opportunities for young Irish people and retention rates for immigrant workers are lower than those of their Irish-born counterparts. Furthermore, there is no guarantee that Ireland will continue to attract healthcare professionals in the same volume as in recent years.

Therefore one of the more recent strategies considered by the Irish social partners and the government is to increase labour market participation of older, experienced healthcare professionals. This issue has been becoming increasingly topical after the abolition of the compulsory retirement age for new entrants into the public service. In April 2004 the Public Service Superannuation (Miscellaneous Provisions) Act 2004 was introduced. The Act removed the compulsory retirement age for new entrant public servants and raised the standard minimum retirement age from 60 to 65 years.

As a response to these changes, the Irish employers' organisation in the health sector, HSE-EA, has convened a working group to examine issues relating to the employment of older workers (emphasis on health and ergonomics). The working group studies competency, capability and capacity issues of employees from all stages of the working life, while recognising that the natural aging process can affect balance / dexterity, vision, hearing, conjugative functioning, physical strength and decision making. One of the aims of this working group is to identify initiatives to promote the workability of older workers and examine how they can perform their jobs effectively, including pro-active occupational health services, flexible working, improved ergonomics and reduction in the manual handling of components.

A pilot initiative is currently being implemented in Adelaide and Meath hospital in Dublin. The Adelaide and Meath Hospital, which incorporates the National Children's Hospital (AMNCH) is one of the largest hospitals in Ireland. It is a public voluntary teaching hospital, and it provides child, adult, psychiatric and age-related healthcare. AMNCH employs 3,000 people of which approximately 2,700 work full time.

[1] National statistics office.
[2] SLMRU unit in FÁS

The introduction of the Act on new retirement regulations led the hospital to study the needs of older workers and the demands on employers and workplaces. It also encouraged the hospital to examine the potential risk of age discrimination. Consequently, the hospital together with HSE-EA initiated a pilot project aimed at ensuring that recruitment, selection, promotion, progression and retention policies and practices of the hospital are fully proofed against any form of direct or indirect discrimination against older workers and to ensure that employment conditions in the hospital help to retain, attract and enable older workers to develop their potential and make a full contribution. The specific objectives of the project are as follows:

- Identify the barriers to recruitment and selection for older workers
- Examine the promotion of older workers and the opportunities that exist within the organisation
- Promote awareness about the benefits of an older workforce throughout the hospital.

The project is being implemented at the moment and it comprises two phases. Phase 1 has seen the establishment of the Steering Group including key internal and external stakeholders (see box below), clarification of the pilot's ground rules and the development of the terms of reference for the research as follows:

- Research on older workers and employment – examining the issues arising for older workers in Ireland in general and in the health services in particular. The work draws on research published in Ireland, other EU Member States and international organisations, bodies and institutes and explores examples of good practice and innovation in Ireland and other countries.
- Audit of recruitment, selection and progression policies, practices and procedures at AMNCH – to scope age diversity among existing staff, examine internal and external recruitment over the past twelve months.

Internal stakeholders:

- HR Manager
- Staff involved in recruitment and selection, training and development, occupational health, superannuation
- A nursing representative;
- Partnership committee joint chair
- Representatives from IMPACT and SIPTU.

External stakeholders:

- Equal at Work partner organisations
- NCAOP, the National Council on Ageing and Older People
- Age & Opportunity
- Age Action Ireland
- other expert bodies and groups representing the interests of older people in Ireland

The phase two will concentrate on mainstreaming activities with health sector expert groups, user groups and health service providers, and dissemination activities through staff meetings & intranet sites, Equal at Work project meetings, publications, website and events. The project results will be written up and published together with good practice guidelines on the employment of older workers at AMNCH.

5.11 An Italian perspective

The Italian population is ageing and life expectancy is increasing, the birth rate is falling and the employment rate among older workers, at 30.3% in 2003, is low. Early labour market exit through a culture of early retirement persists, though over the past ten years steps have been taken to reform pensions and retirement. Prior to 1992, Italian public sector workers, were allowed to retire after 20 or 15 years of contribution regardless the age. After 1997, these same workers have had to have at least 35 years of contribution and a minimum age of 53 or alternatively 36 years of contribution independent of age prior to retirement. Moreover the pension reform has progressively increased the retirement age. However, no active measures have accompanied the raised retirement age to accommodate older workers in the labour market. To understand how this affects the health sector, the following issues are examined below:

- the structure of the health sector / collective bargaining; and
- issues facing the health sector and social partners' activities concerning active ageing.

5.11.1 The structure of the health sector and the system of collective bargaining

In recent years, the Italian National Health System (NHS) has undergone a period of many important reforms that have aimed to increase efficiency and service quality and curb health spending. One of the reforms has dealt with the health sector only and the other with the public employment as a whole, including the NHS. The reforms have adopted private sector working practices (described as privatisation - *aziendalizzazione*). One of the most important reforms from 1997–1998 was the decentralisation of state functions to regions. In this context all the organisation of the NHS has been devolved to the regional level.

Within this framework, Local Health Units, (*USLs - Unità Sanitaria Locale*) have been replaced by local health companies and hospital companies (ASL or AO –aziende sanitarie locali o aziende ospedaliere) that operate like traditional private companies: they are responsible for budget management and organisation and personnel issues (recruitment and setting wages).

The public employment reform has also had an impact on all public administrations, the NHS included, with the consequence of having two different levels of collective bargaining: national and local. Bargaining at the national level takes place between ARAN[1] and the sectoral unions and their confederations. The national collective contract establishes work relations, rights and duties, working hours, wages and other social and economic benefits and finally rules for the local level bargaining (particularly those related to the productivity).

At the local level health companies have primarily focused on bargaining around the issues that the national agreement defes to the local level. These are linked to productivity, overtime, equal opportunities, job security, training etc. Career management of personnel is in the hands of the health companies and the national contract establishes only the general principles and procedures that guarantee the uniformity of the rules.

[1] ARAN is the agency set up in 1993 which legally represents the public administrations in the national collective bargaining processes.

5.11.2 Issues facing the health sector and social partners' activities concerning active ageing

The rapid change in the workforce age implies a need for a radical change in managing ageing workforce in the hospital sector because in the future the quality of care will depend, in part, on the performance and the productivity of the ageing personnel and therefore on the efficient use of older workers. At the same time, workers in the later half of their working lives have become more aware of the need to improve their employability and career opportunities. Another issue is how to use older and more experienced workers in other activities, such as tutoring and training of younger workers.

In the already existing regulations (laws and national contracts) in Italy there are no specific rules to protect older workers, but rules that are quite general and applicable to all employees. To be more specific, the Italian laws and general employment contracts establish the following:

- The age limit to take part in public exams for public administration employment has been removed by law.
- Employment contracts and the Sirchia law for nurses[1] allow health sector workers re-enter employment after resignation.
- Regional regulations and local bargaining make on-going participation to training (LLL) compulsory. Re-training of older workers has been recently considered as particularly important. However, current training provision has been a subject of debates, particularly among the unions.
- Employment contracts and local negotiations rule that promotions are given on the basis of merit and experience and career breaks do not influence promotion opportunities.
- Part-time work can be used to meet the needs of older workers (in particular by reducing their working hours and avoiding shift work). However, this is used mainly by young women with families or socially disadvantaged workers. In the health sector part-time is restricted to 25% of all employees. A further 10% is possible depending on special family or social situations. This situation is, however, assessed by each individual heath company individually. However, the application of this flexibility with the growing shortage of nurses has worsened the situation in some hospitals, placing the burden of a growing level of shift work on other employees to ensure a smooth service delivery.
- In order to guarantee an efficient use of workers with health problems (both young and old), local bargaining and hospital specific regulations allow these workers to be re-allocated to less demanding jobs.
- Employees in private hospitals can continue working full or part-time after the legal retirement age, but this regulation is still not applicable in the public sector yet.

These examples show that even if specific rules or laws do not exist for older workers, other strategic and systematic measures can be used to tackle the ageing workforce in the hospital sector. Unlike other countries, such as UK[2], France, Germany and Sweden where skills shortages are evident among doctors[3], there appear to be no major skills shortage issues among doctors, other than radiologists and anaesthetics, in Italy. However, there is a

[1] See below for further information.

[2] Note, England identified in the HOPE report

[3] The Healthcare Workforce in Europe: problems and solutions – Final Report of HOPE's study group on workforce issues, Brussels, May 12, 2004

chronic skills shortage among nurses, estimated as a shortfall at some 40,000[1]. This figure is significantly higher than figures quoted in the HOPE report[2]. To combat the shortage of nurses, the Italian Government implemented the Sirchia law with the specific purpose of promoting the recruitment of nurses. However the law also provides incentives for existing employees to remain in work and opportunities for labour market re-entry for retired nurses on temporary or part time contracts, even if the unions have been concerned about the proliferation of short-term employment contracts and wage levels. While not presented as an active ageing policy per se, it nevertheless seeks to address the loss of skilled labour from the sector.

Despite the Sirchia law and efforts to retain employees, there is a general perception that the nursing profession is strenuous and demanding, hence early labour market exit is justified. Indeed, health personnel are perceived to be unfit to perform physically or mentally demanding jobs after a certain age and a recent study carried out highlights that one in five nurses want to leave nursing[3].

5.11.3 Emerging issues

There is evidence that Italian national social partners have included provisions concerning active ageing even though active ageing as a concept is not embedded in Italy in general or more specifically in the health sector, despite chronic skills shortages, particularly among nurses. National contracts negotiated by social partners include provisions aimed at improving the nursing profession. These provisions address the first dimension of active ageing, i.e. incentives for workers to retire later and for employers to hire and keep older workers.

In terms of moving active ageing policies and activities forward, social partners at the national and local level could focus their actions on:

- Increasing the quality of working conditions also to ensure efficient and high-quality service;
- Ensuring that hospitals are adapted to the needs of older workers;
- Changing the perception of active ageing among health personnel;
- Promoting training for older workers;
- Facilitating career progression;
- Providing further incentives to work longer.

[1] Intent to leave nursing in Italy

[2] Op cit, pp6

[3] Next-study. Work and health of nurses in Europe.

6.0 Conclusions

This report has shown that at local, national and European levels the hospital sector faces the challenge of developing strategies to offset staff and skills shortages, as well an increase in service demand. However, one of the key issues for the sector is that the concept of active ageing is not widely recognised in all parts of Europe: a challenge here is in the acceptance of what is in effect an Anglo Saxon concept in Southern and Eastern Europe. The sectoral social dialogue at European level can play an important role in tackling this challenge.

Secondly, it is important that at all levels the potential contribution of older workers is recognised and mechanisms are in place to ensure that they can make an effective contribution to the alleviation of sectoral skills shortages. Age discrimination legislation and associated policy developments have made a difference in terms of addressing ageism: however it is important that employers do not make assumptions about the 'capabilities' of older workers: each individual is unique and it should not be assumed that their age prevents them from doing their job.

Ageing and skill shortage in the health sector is a multidimensional challenge, which is manifested in different ways. Indeed a key dimension will be to challenge individuals themselves: in some cases an expectation of early retirement will be challenged and "cultural norms" of not working beyond a specific age will need to change - the social model is in jeopardy if dependency ratios continue to rise.

Behaviour will not necessarily change over night, but good practice examples, people wanting to continue to work as 'age champions' provide the evidence to start to address alter trends that have seen a massive loss of skilled labour. However, ageing is only one dimension of labour market management: it cannot be treated in isolation. Ageing needs to be seen within the context of active labour market management, a role that social partners need to share at all levels.

Turning to the European level, there is a key role to play in promoting sectoral interests at the European level as well as sharing and cascading examples of good practice to social partners at the national and sub-national levels across Europe. Indeed, to support future activities there is a need to strengthen the available evidence base and conduct further research to deepen understanding of the specific issues facing the sector that will help equip social partners affect change. These are discussed in turn below.

Concerning awareness raising there are a number of activities that can be usefully taken forward:

- Raising awareness of the importance of the demand side dimension of ageing: an ageing population needs access to a health service that meets its needs.
- Encourage social partners at the national level to play a role in the development of active ageing strategies, advocated by the Commission in "Common Actions for Growth and Employment: The Community Lisbon Programme".
- Challenge cultural norms in some countries, which is about breaking the view that early retirement / labour market exit is necessary. Also need to understand what employees want. What are the conditions to encourage participation – but need to be mindful that any proposed changes do not negatively impact on younger workers in the sector. Indeed, most successful approaches to age management take into consideration all employees rather than targeting actions solely and specifically at

older workers. Such interventions may come to late to maintain work ability and employability, or in the worst case scenario even stigmatise older workers.

Social partners can also adopt an active role at the European level to keep sectoral ageing issues high profile / in the public eye. For example, this might include responding to the European Commission Communication on Demographic Change (Spring 2006). It is also equally important to raise awareness about the *urgency* of this challenge. Demographers, academics, health care professionals and policy makers have been discussing the social and economic impact of the ageing workforce already for years. But the future has now arrived, and different national health care systems and individual hospitals have prepared for the changes in different scales and many are yet to examine the organisational capacity to respond to the challenges in the years to come. Finally, social dialogue process at European level can play a role in promoting national / sub-national level awareness raising concerning its role and contribution to lifecycle management.

In addition to efforts to secure economic benefits for workers in the sector, there is a need to explore non-financial benefits. The case studies presented earlier in the report illustrate approaches used to making the sector attractive to new entrants of any age. While remuneration is important, working conditions / patterns and work life balance play an important role in attracting and retaining workers. Particularly the UK case studies illustrate how a package of measures can contribute to attracting new and previous employees into the sector as well as keeping older workers in employment. Indeed, these examples could be used to develop sectoral good practice guidance.

Section 1.1 on the study methodology highlighted issues about the availability of data concerning employment in the health and social care sector. It is imperative that a robust and reliable evidence base is available to support awareness raising activities. Statistical Services should be encouraged to provide detailed information about employment in the sector (e.g. consistent data on employment by occupational group) on a regular basis.

To complement the work of NEXT, there is merit in further research. The following issues could be usefully explored and the findings communicated:

- Why workers (other than nurses) leave the sector;
- What would encourage workers to remain in the sector / return to the sectors.

One might expect that this type of research would examine issues such as the working environment; workplace stress, working patterns (e.g. access to career breaks, flexibility in working hours) and remuneration: need to work at the issues that create a poor occupational health.

At national level, social partners need to work jointly to ensure the sustainability and flexibility of pension provisions. This is best achieved by retaining employees in the workforce as long as possible, but pension systems also need to be flexible enough to allow for different flexible retirement options as presented in some of the case studies. Employees are more likely to leave the labour market altogether if they perceive that taking up option such as part-time working, side-stepping or down-shifting will negatively affect their final salary. Indeed, the case studies have shown that this does not necessarily have to be the case, but *employees need to have an access to detailed information* on all options available and their impact on pension outcomes. In some countries, it is necessary to ensure that such measures are in line with other policies, including taxation rules relating to individuals taking partial retirement options.