Temporary agency work in the Finnish health care sector:
Greater flexibility and freedom in the workplace?

Hannele Palukka and Tiina Tiilikka

Hannele Palukka and Tiina Tiilikka are both researchers in the Department of Social Research at the University of Tampere, Finland.

ABSTRACT
This article explores the views of temporary agency workers on their positions and roles in Finnish health care organisations. It aims to answer the question of how agency doctors and nurses perceive the content and social dimensions of agency work as well as their exercise of self-determination in agency work. The article is based on a questionnaire survey carried out in 2006, which found that agency employment in the health care sector is regarded as a flexible way of working that allows for considerable freedom. Doctors, in particular, have made the conscious choice to take up agency work, which fits in well with their personal life situations. However, there are definite limits to agency work that do not always favour the young worker or the patient. Agency employment does not provide adequate opportunities for guidance and support. Furthermore, young doctors and nurses do not have enough influence over the design of patient care. Even though flexible agency work is a voluntary choice for many health care professionals, it is necessary to ask whether it severs the connections with previous experiences and circumstances on which practical health care provision is based.

Introduction

Temporary agency work is one of the fastest growing forms of contingent or atypical employment in Europe. Research has shown that the use of temporary agency workers both in Europe and the United States has at least doubled since the early 1990s (Bergström, 2003:2; Houseman et al., 2003:105; Storrie, 2003:224; Smith & Neuwirth, 2008:192). However, in the aftermath of the economic crisis, the previously strong year-on-year growth in temporary employment decreased in 2007 (European Commission, 2009:37). In Finland, the use of temporary agency labour was still at a relatively low level in the 1990s, but in the past decade it has really taken off. While in 1999 only around 0.5% of the active labour force earned a living from temporary agency work, by 2005 that figure had climbed to over 3%. The amount of work performed by temporary agency workers totalled 31,000 person-years in 2008. This is equivalent to about 1.5% of the total person-years worked in the Finnish economy that year. In the private sector, the proportion was roughly twice as high as in the public sector. (Kauhanen,
The amount of work performed by temporary agency workers decreased from 31,000 person-years in 2008 to 23,000 in 2009 due to the economic recession (Statistics Finland, 2009).

It is increasingly common for companies to outsource functions that are not their core business and to turn to temporary agency workers in order to meet their cyclical demands for labour. One explanation for the growth of temporary agency work is the current trend of economic liberalism, which places a premium on market-driven flexibility in the workplace. The flexibility of human resources is a major policy priority both in the private business sector and in the government sector. Outsourcing, subcontracting and the use of temporary agency labour are key strategies that allow both private companies and public sector organisations to maximise their labour efficiency in situations of fluctuating demand. This has been driven by organisational decisions aimed at the temporary, flexible and maximally risk-free use of labour (Ministry of Employment and the Economy, 2007; Viitala et al., 2006).

A common motive for the use of temporary agency labour is to cover peak workload demands. Agency workers are quickly and easily available, and they are hired during peak seasons when businesses need them. They are also brought in for project assignments. Employers are spared the burden and expense of recruiting, which is all handled by the agency. Another reason quoted for the use of temporary agency labour is the ease of managing and forecasting labour costs (Ministry of Employment and the Economy, 2007:265, 265; Viitala et al., 2006, 11–13).

A temporary agency contract differs both from an employment relationship of indefinite duration and a fixed-term contract, which are signed between the employee and the employer for whom the work is performed. The use of temporary agency labour means that the traditional contract between employer and employee is replaced by a trilateral arrangement. In legal terms, agency work is based on a contract between the company that provides the service and the entity that buys that service: the employee has a regular employment contract with the agency, but takes job assignments directly from the service user (Kairinen, 1985, 135). The provision of temporary labour differs from subcontracting, for instance, in that supervisory authority over the employee is exercised not by the employer-agency, but by the entity that has purchased the service (Mäkitalo-Keinonen et al., 2005.)

The use of temporary agency labour helps to reduce the service user’s business risks. However there are no risks to the service provider, either. The risks from fluctuation in business volumes are carried by the agency worker. The agency worker cannot, however, be compared to a self-employed entrepreneur because the worker is not in the position to price his or her labour (Viitala et al., 2006:14). Temporary agency workers are most typically hired on fixed-term contracts and therefore have no period of notice. The risk of work drying up therefore remains with the agency worker. Another difficulty for the agency worker is that it is not always clear how responsibilities between the agency and the employer organisation are divided, i.e. which of their two bosses decides on which aspects of the job (Ministry of Employment and the Economy, 2007:265).
Temporary agency labour is used extensively in building construction and in the hotel and catering industry, but demand has also risen in the metal and electronics industry as well as in services (Statistics Finland, 2006). In the social and health care sector, the use of temporary agency labour is a relatively new phenomenon. However it has increased very sharply, in large part because of chronic staff shortages. According to a survey by the Finnish Medical Association in 2006, 9% of all posts for doctors at community health centres were unfilled, 7% were contracted out to private service providers (Finnish Medical Association, 2008.) Agency doctors were hired primarily for emergency duty (Isosaari, 2004:44). Temporary agency workers in health care differ from other temporary agency workers. According to Harjunkoski (2009), agency doctors and nurses are more satisfied with the content and organisation of their work than other temporary agency workers.

There is a relative scarcity of research on temporary agency work, and the results so far are contradictory (Kauhanen, 2001:19). On the one hand it is felt that agency work has an adverse effect on working conditions and on equality at work. Agency workers feel very insecure in their positions (see Storrie, 2002:3; Viitala & Mäkipelkola, 2005; Viitala et al., 2006). The evidence suggests that agency work increases wage discrimination, but also marginalises the demand for permanent labour, effectively slowing compensation growth (Houseman et al. 2003). On the other hand, Toikka (1999) points out that for many agency workers these job opportunities serve as a bridge to permanent employment, or at least as a way out of unemployment (Kauhanen 2001:19). Temporary agency work is often described as an interim step towards a permanent job, better pay and a secure future (Cohany, 1998; Viitala et al., 2006). However, the challenges and opportunities presented by agency work are inherently contradictory: on the one hand agency workers can choose when and where they want to work, but on the other hand they have no certainty about the long-term continuity of their jobs.

Based on their studies of the role of temporary work and temporary work agencies in the health care sector in the Netherlands, Spain, Sweden and the UK, Lars Walter and Stephanie Tailby (2002:23) point out that agency employers have offered doctors and nursing personnel an alternative way of working that has been well received. In Sweden and the UK in particular, agencies providing personnel for the social and health care sector have been able to take advantage of employee dissatisfaction with current pay levels, working hours and working conditions in the public sector. The same reasons lie behind the willingness of Finnish doctors to undertake agency work (Mäkitalo-Keinonen et al., 2005).

This article discusses the growth of agency work in the health care sector from the point of view of agency doctors and nurses. The focus of analysis is on the views and opinions expressed by agency workers about their position and role in the Finnish health care sector. The aim is to find out how doctors and nurses working for temporary agency perceive the content and social aspects of temporary work as well as their self-determination in that work. The findings are considered against earlier, primarily Finnish research on agency work, but also against contemporary analyses of the job markets and the broader debate about changes in the workplace (see e.g. Julkunen, 2001; Jensen et.al., 2009).
Data and research methods

This article is based on the results of a 2006 questionnaire-based survey among agency workers in the health care sector. The questionnaire was administered as part of a research project concerned with the ways that the increasing number of agency workers in the health care sector establish their professional position and seek to carve out their own place in the new dynamics of the labour market (Palukka & Tiilikka, 2007). The social dimension of temporary agency work in health care was approached as both a microsocial and a macrosocial phenomenon. The data were collected in two stages and using two different methods, i.e. a questionnaire and interviews.

The questionnaire was sent out to 158 nurses and 822 doctors on the books of one temporary labour agency, i.e. a total of 980 health care professionals who had done agency work during the three months prior to receipt of the questionnaire. Women accounted for 57% and men for 43% of the questionnaire recipients. The agency itself is one of the biggest private health care providers in the country and runs a nationwide operation.

The questionnaires were sent out in both electronic and paper format. Responses were received from 363 agency workers. However 35 e-mail responses had to be rejected because of technical problems, leaving a final sample of 327 questionnaires. The final response rate was thus 33%. Women accounted for 69% and men for 31% of the respondents. Doctors accounted for 76% and nurses for 24%. The respondents’ occupational status is shown in Table 1.

| Table 1. Respondents’ occupational status |
|------------------------------------------|---|
| Licensed physician                       | 37% |
| Doctor-in-training                        | 27% |
| Bachelor of Medicine                      | 12% |
| Registered nurse                          | 4%  |
| Licensed practical nurse                  | 20% |
| **Total**                                 | **100%** |

The generalisability of the results is limited by the relatively low response rate and by the fact that responses were obtained from just one agency. On the other hand, their reliability is enhanced by the fact that the agency in question is one of the biggest in the country with a nationwide operation.

There are also some validity problems with the questionnaire. Some of the items are not appropriate and cannot be modified for the investigation of agency work because they do not exclude work done by the respondent in the employ of some other company, or workplace relationships that are not associated with agency work. It is also difficult to know from the answers to questions concerning the type of workplace whether the respondent is working in the public or private sector; making the distinction between agency work done in the public and private sector is therefore problematic. However,
since more than 90% of the respondents said they had worked at a health centre, hospital or some other public health service facility during the past three months, there is ample justification for setting the focus here on agency doctors working in the public sector.

The questionnaire was designed with a view to obtaining as clear a picture as possible of agency workers’ professional profiles, their perception of the pros and cons of agency work, and questions of work autonomy. The questionnaire included both structured and open-ended questions. The former were multiple-choice questions about the nurses’ and doctors’ background: gender, age, training, marital status and employment situation. In addition, the questionnaire included a range of multi-part questions concerning such issues as the nature and security of the agency job contract, professional interest representation, the content of agency work, the social dimensions of agency work and questions related to agency work and the family. The latter focus is not covered in this article. Reasons for taking up agency work were probed through open-ended questions.

Social dimensions and content of work were assessed with a series of statements on five-point Likert scales. For instance, respondents were asked to say to what extent they felt the climate in the workplace was harmonious, to assess the openness of communication and to describe relationships of trust between workers. As for the presence of potential problems in the workplace, the respondents were asked whether they were unclear about the objectives of their work, and to what extent there were conflicts between workers. They were also asked to assess communication and cooperation in the workplace. Furthermore, there were a number of open-ended questions in which respondents could describe their social position in the workplace community as well as any experiences or perceived threats of mental or physical violence.

The questionnaire responses were analysed using Tixel statistical software and traditional statistical techniques and methods, i.e. frequencies and percentages for distributions of variable values, cross tabulations and chi-square independence tests. Differences between variables were considered significant at p<0.01.

Respondents were relatively young; 52% were under 30 years of age. Their mean age was 35 years age and typical age 28 years. Three-quarters were doctors, and most of them had completed their medical studies. One-quarter were nurses, most of who had the qualifications of a practical or auxiliary nurse. Half lived in the metropolitan Helsinki area, one-fifth in Hämee and Pirkanmaa and one-fifth in eastern and central Finland.

Almost half of the respondents (46%) worked at a health centre, and some of them (15%) also had another job at a hospital. Overall 11% of the respondents worked at a hospital, and in this group 9% also had some other job, for instance at a private medical centre. One-fifth reported that they worked at a serviced housing unit, a home nursing unit, a private medical centre or in occupational health services. Respondents in this group had one or more jobs. A minority (14%) had had three to six different jobs during the three months preceding the questionnaire.

Working hours arrangements varied, too. By far the most common category here was emergency duty (56%), followed by regular daytime work (17%), regular evening work (3%) and regular night work (2%); 10% worked in two shifts (mornings and
evenings) and 5% in three shifts (mornings, evenings and nights), whilst 7% said that their working hours were irregular in that all of the above were applicable. Most respondents had taken up agency work quite recently: 40% had less than one year of experience and 44% from one to three years’ experience.

Temporary agency work in the health care sector was most typically a part-time job: most respondents had another main job or were studying while working. In addition, agency work was used to help reconcile work and family life. Half of the respondents reported doing less than 21 agency hours, 40% did 20-40 hours and only 9% said they did more than 40 hours a week. The highest reported number of weekly hours in agency work was 60.

Agency work: market conformity, flexibility and individuality

Earlier studies have shown that many people look upon agency work as an alternative to unemployment, or as an interim step on the road to permanent employment and to better pay and benefits (see Viitala & Mäkipelkola, 2005; Viitala et al., 2006:41–42). The focus in these studies has been on shop-floor work, and the participants have been either students or people with secondary-level vocational qualifications. In this study, the respondents were health care professionals with secondary vocational qualifications or an academic degree.

Table 2. Reasons for taking up agency work

<table>
<thead>
<tr>
<th>Reason</th>
<th>No of references (total = 752)</th>
<th>% of all respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>245</td>
<td>80</td>
</tr>
<tr>
<td>Individuality</td>
<td>122</td>
<td>40</td>
</tr>
<tr>
<td>Flexibility</td>
<td>80</td>
<td>26</td>
</tr>
<tr>
<td>Experience, variation</td>
<td>58</td>
<td>19</td>
</tr>
<tr>
<td>Employment relation, good organisation</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>Suits current life situation</td>
<td>37</td>
<td>12</td>
</tr>
<tr>
<td>Maintenance of professional skills/competencies</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>Good availability of job assignments</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>Nature of job</td>
<td>25</td>
<td>8</td>
</tr>
<tr>
<td>Opportunity to work on emergency duty</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Independence</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Reconciliation of work and family life</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Ease of arranging holidays</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Interest in work, clinical curiosity</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Other reasons</td>
<td>31</td>
<td>10</td>
</tr>
</tbody>
</table>

These health care professionals said they had chosen to take up agency work because the pay was good and because it allowed for individual and flexible working arrangements. As many as four in five respondents mentioned the pay factor: agency work paid well enough or was a source of extra income in addition to wages from
the respondent’s main job. Table 2 lists the reasons mentioned by the respondents for taking up agency work.

Based on their studies in the United States in the early 2000s, Susan Houseman, Arne Kalleberg and George Erickci (2003:116) found that agency health care professionals in a strong labour market position could earn up to 70% more than in a regular full-time job. However, pay is just one aspect of the overall experience of agency work (Isaksson & Bellaagh, 1999:2). Other factors influencing the decision to take up agency work included working conditions and values.

Another major reason for the decision to take up temporary agency work was the freedom it afforded individuals to choose their own working hours and place of work. This sense of floating flexibility was clearly an important value for our respondents, creating an image of agency workers as self-employed entrepreneurs but with no entrepreneurial commitments. One-quarter of the respondents mentioned flexibility as a reason for taking up agency work. Some described flexibility as a feature that cut across every aspect of their employment, whereas freedom was more typically associated with being able to decide on one’s working hours. Indeed references to freedom were interpreted as signs of quantitative and temporal flexibility, i.e. the ability of respondents to decide how much work they wanted to do and when (Ministry of Employment and the Economy, 2007:255).

Flexibility is a polymorphous concept. Quantitative flexibility, in the present context, refers to the cyclical movement of the economy: in this instance it is the labour market that exhibits flexibility. This is most typically seen in the growth of part-time and temporary employment, or in the introduction of new pay schemes (Uhmavaara et al., 2005:10–12). Indeed it is quite common that flexibility is understood in quantitative terms only, even though it clearly has a functional or operational element to it, too. For instance, flexibility can refer to flexible work arrangements, which do not require harmonised or unified ways of working. It has been shown that operational flexibility is positively correlated with business success (see Ministry of Employment and the Economy, 2007:267).

In this article, flexibility is taken to mean that temporary agency workers can organise their work flexibly and can pursue their own interests and motives. Our respondents felt that in temporary agency work it was not the worker but the work itself that exhibited the flexibility necessary to accommodate workers’ individual needs (see Kantola, 2006:162). In highly qualified health care jobs, flexibility is an integral part of the application of professional skills and competencies. In reporting that flexibility was one of the most important reasons for taking up agency work, our doctors and nurses also implied that they are in the position to put their professional skills and competencies to work in their job.

Furthermore, our respondents valued the experience they gained from temporary agency work, the variation it offered, and the opportunity it provided to maintain their professional skills (see also Kalleberg, 2000). Almost one-third (30%) mentioned their personal interest in the work offered and ‘clinical curiosity’ among their motives for taking up agency work. Large numbers also said that temping suited their life situation and that it was easier to study and research one’s doctoral thesis, for instance, while
working for a temporary agency rather than in a regular job. Clearly, personal mobility and autonomy were more important to our respondents than membership of some structure.

Professional identities in the health care sector are no longer defined in terms of vocations, at least to the same extent as before. Traditionally, the thinking has been that nurses are in their job to fulfil a vocation with a moral purpose (Alasuutari, 1996:135). This idea began to lose ground in the 1960s, although it has still not disappeared altogether. However, the main motivating factors in the health care sector are pay and the opportunity for self-realisation at work (Siltala, 2004:31–36).

Flexibility and cultural classifications are more important than the stability of work. For agency workers in the health care sector, a stable job or a position in the public sector are no real measures of social appreciation and respect; in fact it seems that such values are now very much in decline. According to Richard Sennett (2007:115), the main measure of appreciation in a global labour market is the ability to work in project environments: the ability to orient to the future, to break loose from framework thinking and to cope with uncertainty.

Employment rates for health care professionals have been consistently high throughout the 2000s. This is in stark contrast to the situation in the early 1990s, when many new health care graduates were at high risk of redundancy (Löyttyniemi, 2001:228). Primary health care services in Finland are still struggling to hire all the doctors they need, even though the number of doctors has more than doubled over the past 25 years (see Finnish Medical Association, 2009). One of the strategies adopted to overcome this labour shortage has been to turn to temporary agency workers (Mäkitalo-Keinonen et al., 2005). Agency doctors have been hired first and foremost for emergency duty at health centres and for cover during holiday seasons (Isosaari, 2004). At the same time as the public health sector is losing its appeal as an employer, the private sector has become an increasingly attractive option for many doctors.

The doctors and nurses in this study felt that agency work was a very useful and worthwhile form of employment. The vast majority (85%) believed that in the near future there would be so much work on offer than they could work as much as they wanted. Only a small proportion (4%) had been out of work during the three months preceding the survey. It is clear then that agency employment was not chosen as a way out of unemployment, but for most it was an alternative to taking up a temporary post as a health centre General Practitioner (GP), for instance.

Since agency work is temporary and for short periods, interest representation was not a matter of much concern. Only very few respondents (2%) had held positions of trust while in temporary agency work. Almost half (44%) didn’t know whether they could bring matters to their union steward or to occupational safety representatives. However, the conclusion is not warranted that professional interest representation is considered insignificant, since 91% of all respondents were members of a trade union. Trade unions, on the other hand, do not seem to place much importance on temporary agency workers as a stakeholder group: almost half (48%) of these workers said they felt their union did not invest enough effort in safeguarding the interests of temporary agency workers.
Temporary agency work is contributing to the erosion of the established mechanisms of workplace regulation, the clear sets of rules that secure the position of both labour and management in the labour market. These mechanisms include coercive legislation and rules that allow for direct agreements between collective bargaining partners as well as coordination procedures. For example, legislative measures to guarantee equality of treatment for all employees are far from universally implemented in the agency labour market. Furthermore, it seems that agency work is undermining the collective bargaining system, the most important pillar of workplace regulation in Finland. Pay structures for temporary agency workers, for instance, are determined not so much by incomes policy agreements as by the current market. This is a direct outcome of the Government's liberal economic policy and the accompanying mounting pressures to create greater flexibility in the workplace.

Temporary agency work is one indication of the current trend towards greater market conformity, individualisation and polarisation in the labour market. Research has shown that the labour market has become increasingly polarised (Ministry of Labour, 2007). The dividing lines run not just between highly educated and less educated groups, or between people with permanent and less permanent jobs. Young academic women, for instance, are more and more often hired on short-term contracts. Likewise, people in atypical employment are divided into two groups. In the case of temporary agency workers, this is seen in the fact that while the majority have no freedom of choice over the type of work they want to do (Viitala et al. 2006, 23), in the health care sector agency workers have every possible freedom. For many temporary workers temporary agency work may mean access to good positions and temporary work can help workers develop their skills as well as provide them with an opportunity for sustained labour market participation (Smith & Neuwirth, 2008:155). Temporary agency work in the health care sector is different in this respect because the decision to do temporary agency work is voluntary for doctors and nurses. Many of them also have regular jobs while doing temporary agency work. Agency doctors, in particular, are a privileged group for whom agency employment is an option and opportunity rather than a forced choice.

**Individual flexibility and the restrictions of temporary agency work**

According to an inquiry carried out by the Finnish Medical Association among its membership, medical knowledge, learning, knowledge management, interaction and co-operation skills and work management are significant factors for expertise in clinical work (Finnish Medical Association, 2009). For example, specialist health care professionals have reported that they feel they cannot manage their work as they would wish, by which they mean that the patient is not sufficiently taken into account (Pietikäinen & Reiman & Oedewald, 2008:53-54.)

Temporary agency work in the health care sector is a flexible and individual way of working. Agency doctors and nurses have made their choice to work this way of their own volition, within the context of their current life situation. For doctors, in particular, this choice is framed by a flexible model that is oriented to the here and now: the main
emphasis is on the individual’s possibility and freedom to make choices as they present themselves, rather than on following a fixed career path over a succession of upward steps (Sennett, 2007:77).

Overall, our agency workers were relatively satisfied with the content of their work in the health care sector, their level of self-determination and the social dimension of their work. Responses to a series of statements concerning the content and social dimension of work showed that, by and large, the workplace climate was regarded as harmonious and workplace communication was described as open. There was a broad sense of mutual trust among workers. Furthermore, respondents were pleased with the intensity of staff interaction. Problems appearing in the workplace were not considered significant, there was little ambiguity about the goals of work, and relations of authority were not considered hierarchical. There were very few conflicts between staff members. Likewise, assessments of information and cooperation in the workplace were positive.

Adequate payment for hours worked and high autonomy are the two main factors characterising the strong position of temporary agency workers in the health care sector (see Siltala, 2004:38-39). However there are definite restrictions in agency employment that do not always favour the individual worker (Pyöriä, 2006). Those restrictions are most clearly seen in younger respondents’ answers to questions concerning their professional position. Early on in their career, young people are often confronted with situations where they would benefit from the support and guidance of a more experienced colleague. This, however, is rarely available in agency work. The market conformity that characterises temporary agency work does not always fit well with the work done in the health care sector.

The reverse side of flexibility is most clearly reflected in young agency workers’ assessments of their level of self-determination in the workplace. Self-determination was measured by asking the respondents to say to what extent they felt agency workers were in a position to influence patient care, multi-professional cooperation, their own time use and the design of facilities in the workplace. Two-thirds of the respondents took the view that they did have some influence over patient care. The same number felt they were able to control their time use. Only 7% felt that administrative duties hampered their work. However a closer examination of statements measuring self-determination at work shows that there are marked differences between the perceptions of younger and older workers.

There are significant age-group differences in perceived influence over patient care. In the age group under 37, only one-fifth of the respondents felt that they had much or very much influence over patient care, whereas in the age group over 36 the corresponding proportion was over one-half. One possible factor behind this result is that younger workers have not yet attained the same level of professional experience and competence as older workers, who have more knowledge of how to go about achieving that influence. For instance, the oldest agency workers believed they were slightly better placed to contribute to multi-professional cooperation in support of holistic patient care than younger workers.

Secondly, it is simply much harder to influence overall patient care in emergency
settings, which was where more than half of the respondents were working. This result reflects the nature of temporary agency work, which is often irregular and short-term: the agency doctor will typically meet the patient no more than once, while the patient’s next appointment in all probability will be with some other doctor. Agency nurses, too, often work in several different units and therefore with different patients.

Age-group differences are also seen in reports of insufficient induction; these differences are statistically highly significant. Whereas among younger respondents over half felt that insufficient induction complicated the planning and conduct of agency work, in the age group 37-46 over half took the view that insufficient induction had no adverse effect on their work.

One of the points made in the public debate on induction training for medical doctors is that it is impossible for the hiring organisation to provide adequate training for young doctors if they are not going to work there for more than a few days or weeks. This is one reason why employers would often prefer to hire people directly on a full-time basis (Mulari-Ikonen & Ekholm, 2007).

A third area where we found significant age-group differences was the frequency of workplace changes. The youngest respondents felt that frequent job changes made it harder for them to do their job well. For older respondents this was no problem: two-thirds of them said that workplace changes had no adverse effects on the planning or conduct of their work.

Age-group differences were also seen in the treatment of patients with multiple diagnoses. Younger respondents took the view that these patients hampered or complicated agency work to some extent or very much. Among older agency workers, no more than one-fifth felt that patients with multiple diagnoses were a complicating factor.

No differences were seen between men and women workers’ responses to statements concerning self-determination at work: they showed more or less the same level of satisfaction with the nature and content of the agency work they did. However most respondents to our survey were young people who have not yet reached the career stage where gender differences begin to surface. Another factor that contributed to preventing gender differences from being significant was the high employment rate among agency workers in the health care sector.

Assessments of the extent to which different factors – such as administrative workload, insufficient induction, requirements of cost efficiency, patients with multiple diagnoses, changes of workplace, demands from multiple sources, uncertainty of work continuity, uncertainty about one’s own position, limited influence over decision-making, and difficulty of controlling time use – hampered the planning and conduct of agency work differed not only between age groups, but also between occupational groups. Overall, these external factors were rated as having only rather limited effects (see Figure 1).

Insufficient induction and patients with multiple diagnoses were considered to have some adverse effect on the planning and conduct of agency work. In particular, Bachelors of Medicine and doctors-in-training felt that patients with multiple diagnoses made it harder for them to plan and execute their work. Nurses rated their chances of planning and executing agency work as lower than other occupational groups. In
particular, their limited influence over decision-making and their being subjected to demands from multiple sources were thought to hamper their work.

Figure 1. Respondents’ assessments of the complicating impact of different factors on the planning and conduct of agency work

<table>
<thead>
<tr>
<th>Factor</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>High administrative work load</td>
<td>0.3115</td>
</tr>
<tr>
<td>Insufficient induction</td>
<td>0.0001</td>
</tr>
<tr>
<td>Requirements of cost efficiency</td>
<td>0.0295</td>
</tr>
<tr>
<td>Patients with multiple diagnoses</td>
<td>0.0022</td>
</tr>
<tr>
<td>Changes of workplace</td>
<td>0.0040</td>
</tr>
<tr>
<td>Demands from multiple sources</td>
<td>0.0059</td>
</tr>
<tr>
<td>Uncertainty of work continuity</td>
<td>0.0091</td>
</tr>
<tr>
<td>Uncertainty about one’s own position</td>
<td>0.0009</td>
</tr>
<tr>
<td>Limited influence over decision-making</td>
<td>0.0030</td>
</tr>
<tr>
<td>Difficulty of controlling time use</td>
<td>0.0327</td>
</tr>
</tbody>
</table>

Although nurses accounted for just 4% of the respondents, this result does raise the intriguing question why nurses feel they have less control over their work than other
health care professionals in agency work. Agency work itself is probably not the answer; the more likely explanation lies in the hierarchical organisation of health care. The people at the top of that hierarchy, i.e. the medical profession, want to exclude from decision-making those who are lower down in the hierarchy, i.e. the nursing profession (see Eräsaari, 2002). Based on this result, however, it is necessary to investigate in more detail the work done by agency nurses.

It is clear from the results concerning inadequate induction training, the high rate of workplace change and limited influence over patient care that agency work is far from unproblematic for health care professionals. They were hampered by constant job changes, having to work with patients with multiple diagnoses and a lack of influence over patient care. It is particularly noteworthy that Bachelors of Medicine and doctors-in-training felt that they were not getting enough induction training for their agency appointments. The reason for this probably lies quite simply in the lack of time, which is necessarily reflected in the quality of patient care (see Siltala, 2004:334–335). Even though the flexible arrangements of agency work are a voluntary choice and opportunity for these health care professionals, they may still sever all connections, through earlier experiences and circumstances, from the tacit know-how and background understanding that lies at the heart of practical work in health care.

Discussion

The results of our survey among agency workers in the health care sector present a rather positive picture of agency employment. For health care professionals, the decision to take up agency work is almost always a voluntary choice. They feel that agency work allows them to apply their skills and competences primarily on their own terms. Agency doctors or nurses do not want to commit themselves to any one organisation or employer. More important than having a steady job is having the freedom to flexibly negotiate working hours and, to some extent, place of work, according to one’s current life situation (Malenfant et al., 2007:825).

Freedom of choice is regarded as one of the definite plus sides of agency employment (Toikka, 1999). However, earlier studies have tended to put more weight on the downsides and specifically on the lack of job security (Viitala & Mäkipelkola, 2005; Viitala et al., 2006). The current trends in the labour market towards market conformity, individualisation and polarisation are particularly pronounced in agency employment. As in the labour market generally, there is a marked polarisation within the agency labour market between those people who have to sell their labour power to anyone and at any price, and those who can choose to whom, when and at what price they want to sell their labour power.

The purpose of using agency labour and other forms of atypical employment is generally to free staff resources to focus on the organisation’s core business. Contingent labour is hired to perform auxiliary functions (Uhmavaara, 2005:101). However, this is not the case with agency work in health care. Agency doctors and nurses are often hired into jobs for which there is a shortage of qualified people and into which the health care organisation has failed to recruit permanent staff. Therefore agency workers are hired not to perform auxiliary functions but core ones. For agency workers this means that their skills
and competences and the work they do must meet the same quality standards as those of permanent staff.

The results of this research, as well as two earlier studies on agency employment (Viitala & Mäkipelkola, 2005; Viitala et al., 2006), make it amply clear that the agency labour market is partly polarised. There are jobs and organisations into which less-educated people are hired to meet cyclical demands; once those demands have been met, the temporary agency workers may go. Agency workers in health care are often in a position to choose what kind of assignment they want to take and how long they will remain on the job. They also have a reasonably high pay level, commensurate with their qualifications.

Agency workers in health care represent the absolute elite of the agency labour market; employers actually compete for their labour input. Young doctors, in particular, are in a position where they can choose where they want to work and for how long. They are also paid very well in view of their experience and the hours they put in. As in regular employment, doctors in agency employment are paid more in the private than in the public sector, even though their hours are actually shorter.

However it is important to note that agency workers in the health care sector have just as little job security as other agency workers in the sense that they can be dismissed without notice. Agency employment is based on fixed-term contracts, which means that agency doctors and nurses do not enjoy the security of continuity that comes with permanent employment contracts (Kovalainen, 2004:206). Agency work and other forms of outsourcing are effectively an exercise of market and hierarchical power (Uhmavaara et al., 2005:171).

The polarisation of the labour market is the outcome of a transition from planned to market economies. Since the 1980s, Finland has followed the lead of other European countries and set out on a path of deregulation, tax cuts, privatisation and competitive tendering even in primary health care and other sectors of society that were previously unaffected by market mechanisms (Alasuutari, 2006). The strong labour market position of health care personnel, therefore, cannot be explained by their skills and competences alone. Other reasons why they are in such strong demand include the changes that have taken place over the past 20 years in the organisation, structure and funding of welfare services.

One of the forces behind these changes is a model of governance described by Raija Julkunen (2001, 11) as a policy of cutbacks, limitation and adaptation following welfare state expansion. Apart from curbing expenditure and containing growth, this policy involves various structural and qualitative changes, such as shifts from the principles of universalism towards individual responsibility. This governance model espouses not only the view but the active endeavour to reduce state intervention into the economy and society, to make way for market relations, to halt the growth of the public sector and to increase its efficiency (ibid. 2001:97). One of the consequences of this policy for health care has been that the public sector is not as attractive an employer as it was before and health care workers have started working for the private sector.

Furthermore, the results here raise the question as to what our respondents’ positive assessments of agency work tell us about the professional identity of agency workers.
in the health care sector, and doctors in particular. It would seem that this is a group whose members are reluctant to commit themselves to one particular organisation, but instead prefer to retain their freedom to move from one organisation to another. Most of the respondents in our survey were young doctors. More than half of them were under 32 years of age, which goes some way towards explaining their perception of the meanings of work. They had graduated or were about to graduate as medical doctors at a time when traditional professional values were clearly at variance with the ever-stronger market orientation of health care (Löyttyniemi, 2004:171). Young doctors doing temporary agency work deny that there is a separate ‘rent-a-doctor’ identity. The medical profession appears to be so strong that the form of employment contract plays no role in doctors’ self-definitions.

Based on the young age of our respondents, another intriguing question raised by our results is whether agency workers in health care can be seen to represent a new culture of work, a group of people for whom the most important values are to avoid falling into a rut, to continue to learn new things and to carve out an exciting and satisfying career (see Sennett, 2002:44). Individualisation in the medical profession does not happen outside established medical, social and cultural patterns of thinking and values. Doctors can promote their own interests and their own careers, but they are always also dependent on other professionals and patients (Löyttyniemi, 2004:171–173). Indeed, the tendency of agency doctors to emphasise the value of freedom must be considered in relation to the general situation in society, its boundary conditions and current challenges.

Agency employment in the health care sector has continued to increase throughout the 2000s, during a period of profound change in the Finnish health care system. Agency work has its own important role to play in the changes that are now sweeping through the welfare state, giving increased prominence to the ideology of free market competition. For health care professionals, the growth of agency employment means that their professional identities and the content of their work are bound to change in one way or another. But how will market conformity impact the values governing health care professions and health care organisations (Löyttyniemi, 2000:242)? The patient work done by agency nurses or doctors may be at variance with the principles of market conformity (Rantalaiho, 2004, 241). What does the growth of agency employment in health care mean for clients and patients? These are some of the important questions that will have to be addressed in future research.

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