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The impact of the financial crisis on human resources for health policies in three southern-Europe countries

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ABSTRACT

The public health sector has been the target of austerity measures since the global financial crisis started in 2008, while health workforce costs have been a source of rapid savings in most European Union countries. This article aims to explore how health workforce policies have evolved in three southern European countries under external constraints imposed by emergency financial programmes agreed with the International Monetary Fund, Central European Bank and European Commission. The selected countries, Greece, Portugal and Cyprus, show similarities with regard to corporatist systems of social protection and comprehensive welfare mechanisms only recently institutionalized. Based on document analysis of the Memoranda of Understanding agreed with the Troika, our results reveal broadly similar policy responses to the crisis but also important differences. In Cyprus, General Practitioners have a key position in reducing public expenditure through gatekeeping and control of users' access, while Portugal and Greece seeks to achieve cost containment by constraining the decision-making powers of professionals. All three countries lack innovation as well as monitoring and assessment of the effects of the financial crisis in relation to the health workforce. Consequently, there is a need for health policy development to use human resources more efficiently in healthcare.

1. Policy background

The global financial crisis, which started in 2008, did not affect the member countries of the European Union equally [1–5]. The most affected countries were mainly in the Eurozone, which experienced negative gross domestic product (GDP) growth between 2008 and 2012 [6].

Health workforce costs account for the largest share of health expenditure and represent an important part of public service costs, and consequently, they have been a common target for rapid savings. However, the need for more skilled professionals with new competencies generates need for comprehensive policy responses to address the rising burden of chronic diseases, the ageing of professionals and their increased mobility within countries (rural/urban) and between sectors (public/private) The Recife Declaration [7] recently stressed the need for national policies to improve the availability, accessibility, acceptability and quality of the health workforce in order to progress towards universal health coverage (Table 1). The expected positive effects are multidimensional and include a more efficient use of financial resources and a better adapted healthcare provision to meet demand.

Given that financial and economic shocks can threaten the performance of health services systems or be an opportunity to improve it [1,2], this article analyses policy

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Table 1
Desirable national-level health workforce reforms.

- Develop, implement and monitor plans for a sustainable health workforce
- Enhance health workforce information systems to facilitate labour market analysis
- Transformative education approaches and continuous professional development opportunities
- Prioritize the health workforce at the primary health care level to enhance equity in access
- Equal opportunities for all health workers
- Accountability and transparent processes, including through decentralization, as appropriate, on health workforce governance
- Enhance HRH performance through innovative, effective, targeted management approaches and incentives
- Improve health workforce distribution and retention
- Advance research and evidence-based practice to inform and maximize the return on health workforce investment
- Task sharing, and innovative models for care delivery

Adapted from Campbell and colleagues [7]

responses to the effects of the crisis on the health workforce in countries which received emergency financial aid from the International Monetary Fund, Central European Bank, European Commission, referred to as the "Troika". A choice of convenience was made, which limited the selection to three Southern European countries Greece, Portugal and Cyprus. Despite differences in the architecture of healthcare systems, these countries are generally described as sharing cultural traits such as the important role of family and community networks, tightly regulated labour markets, corporatist systems of social protection and comprehensive welfare mechanisms only recently institutionalized [8,9].

We proceeded to document analysis of the successive versions of the Memoranda of Understanding (MoU) and following reports to document the reform proposals agreed with the "Troika". Using thematic analysis with a focus on the 'content' and the 'outcome' of the reforms, the health workforce related policies were analysed and compared in order to assess the extent to which interventions in these countries took into account the need for better planning and management (Table 1) and the extent to which results met this agenda. We first describe the reform proposals and then how each country responded.

2. Content of the reforms

Financial assistance programmes were signed by the Governments of Greece, Portugal, and Cyprus, respectively in 2010, 2011 and 2013. The programmes imposed conditions leading to policy changes in public services management. Table 2 summarizes the expected outcomes. Two major reform areas were targeting the health workforce itself (wages and control of decision-making) and the accessibility to healthcare services.

2.1. Greece

Two Memoranda of Understanding (MOU) were signed, in 2010 and in 2014. Greece has a highly centralized healthcare system, characterized by underdeveloped assessment mechanisms and poor priority setting, with oversupply of specialists coexisting with a significant undersupply of general practitioners (GPs) and nurses [10]. The number of practicing doctors was 6.2 per 1000 population in 2012, the highest in the European Union, but only about 5% were general practitioners. The number of practicing nurses declined from 4.3 per 1000 population in 2008 to 3.6 in 2012, making the ratio of nurses to physicians the lowest in the European Union [16,33].

The need to reform the fragmented National Health System (NHS) was defined as a priority, which meant addressing deficiencies such as excessive administrative costs, low bargaining capacity and absence of control on users' utilization of healthcare services [11]. The main health workforce reforms envisaged included general wages cuts and a greater control on professionals' decision-making freedom, while improving accessibility to healthcare services. Total health expenditure was reduced from 9.8% of the GDP in 2009, shortly after the beginning of the crisis to 6% in 2012 [16].

Although wages of health professionals were among the lowest in the European Union before the crisis, they were even reduced by 25% for doctors and 14% for nurses [12]. The monitoring of public hospitals' performance and of drugs prescription through compulsory electronic procedures intended to limit doctor's autonomy. Although these changes were by and large achieved, additional reforms are still under negotiation. The formulation of a human resources plan, measures to facilitate the mobility of health workers and a referral system in primary healthcare are regarded as potentially contributing to improving accessibility to health services, however yet to be implemented.

As austerity measures were announced many health care professionals decided to retire, thus distorting staffing levels and distribution even more. Contracts for temporary staff were not renewed and replacement of retiring staff was limited. This stimulated the emigration of many young and well-qualified physicians and other staff, mainly to other European Union (EU) countries [13].

2.2. Portugal

The financial assistance programme was in place between 2011 and 2014. A key request was to tackle high costs of medicines and to limit doctors' prescription autonomy. In 2008, health spending represented 10.2% of GDP and 9.5% in 2012 [14]. A substantial reduction in drug expenditure in the NHS was achieved mainly through introducing clinical guidelines, monitoring systems, compulsory electronic prescription and giving priority to generic drugs in both the public and private sector.

Other savings came from reducing existing staff and limiting recruitment, cutting overtime hours and the amount paid for overtime, reducing retirement benefits, freezing promotions, not replacing leavers, reducing travel and eating expenses and eliminating the possibility of receiving public salaries while receiving a pension.

Physicians' working hours were increased to 40 h per week, while the remuneration of general practitioners became more performance-based [28]. No measures were taken to ensure an even distribution of staff across regions

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Table 2
Policies directly implied on health workforce in selected countries.

Main areas of reform		Greece [21,22]	Portugal [23,24]	Cyprus [25,26]
Wages	Agenda setting	(1) General wage cuts for public servants (health professionals in the public sector included)	(1) Increase the number of GP paid-per-performance in public primary care services (2) Reduce the spending on overtime	(1) General wage cuts for public servants; performance-based appraisal for career promotion and alignment of labor conditions with those in the private sector
	Outcomes	(1) Achieved	(1) Achieved (2) Achieved. Salaries in the NHS fell more than expected due to additional cuts not initially agreed	(1) In progress. No further information
Accessibility	Agenda setting	(1) Extension of working time in hospitals (2) Plan on HR needs (focus on health professionals' mobility within and across regions) (3) Reduction the number of doctors	(1) Plan on HR needs (focus on health professionals' mobility within and across regions) (2) Specialization and concentration of facilities (hospitals and emergency services)	(1) Specialization and concentration of facilities (hospitals) (2) Plan on HR needs (focus on health professionals' mobility within and across regions (3) Increase the availability of health care services: extension of working time and shifts to reduce overtime payments (4) Reduction the number of public health workers
	Outcomes	(1) Achieved	(1) Not achieved. The population without a dedicated GP (remote and deprived areas) is still high. Additional measures to implement: electronic records and telemedicine; increase the number of patients per doctors; open vacancies with non-NHS doctors; extending the working time of GPs	(1) In progress. No further information
		(2) Not achieved. No further information (3) Achieved. The reduction was twice as more than predicted	(2) Achieved	(2) In progress. No further information (3) In progress. No further information (4) Achieved
Decision-making	Agenda setting	(1) Activity of public hospitals monitored by accounting firms	(1) Clinical guidelines and monitoring system to standardize and assess doctors' decision (sanctions and penalties expected in case of non-compliance)	(1) Implementation of 10 new clinical guidelines for the most costly diseases
		(2) Induce physicians to prescribe generic medicines, set of monitoring procedures through e-prescription and benchmarking for comparison	(2) Compulsory e-prescription covered by public reimbursement (3) Induce physicians in public and private providers to prescribe generic medicines and the less costly branded medicines	(2) Give GPs the role of gate-keeping the access to the health care system
	Outcomes	(1) Partially achieved. No further information	(1) Achieved. Additional steps: software improvements; centralization of information on hospital-dispensed and inpatient medicines.	(1) In progress. Continue to publish clinical and prescription guidelines and to audit implementation
		(2) Achieved. Additional compulsory prescription protocols expected, including a prescription budget for each doctor	(2) Achieved (3) Achieved	(2) Achieved

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and the recommendation to expand the network of Family Health Units, seen by the "Troika" as a measure to improve the accessibility and efficiency of services was largely ignored [24]. Since the beginning of the crisis, there has been an increase in the emigration of nurses and more recently of physicians, but this phenomenon has not attracted the attention of policymakers [31]. Data from the United Kingdom show that the number of Portuguese nurses admitted to their register increased from 20 in 2006/2007 to more than 550 in 2011/2012 [35]. In the first ten months of 2012, the Portuguese Nursing Council received 3202 requests for recognition of qualifications, a prerequisite to work abroad, compared with 1724 in 2011 [13], while an estimated number of nearly 1400 doctors left the country between 2011 and 2013 [15]. However, the effects in the health professional workforce and the overall trends are uneven in the two professional groups. From 2008 to 2012 the number of practicing doctors to 1000 population increased from 3.7 to 4.1 (placing Portugal above the OECD average), while the figure for nurses remained stable (6.1) and overall very low; accordingly, the ratio of nurses to physicians slightly declined from 1.5 to 1.4 [16,33].

2.3. Cyprus

Cyprus is in the process of implementing a comprehensive National Health Insurance Scheme to substitute a highly fragmented health sector and to improve the complementarity between the public and private sectors, thereby reducing its high running costs. Cyprus is the only EU country where out-of-pocket health expenditure exceeds public health expenditure [17]. Over the last decade, most newly qualified physicians pursued careers as specialists [18]. No policy is in place to increase the number of general practitioners [19]. Total health expenditure grew on average at a faster rate than the GDP, from 6.0% in 2010 to 7.4% in 2012, but is still one of the lowest within the EU [16]. Only small, if any, effects were found in the ratios of practicing doctors (2.9 in 2008; 3.0 in 2012) and nurses (4.7 in both years) to population [16,33].

The strategies agreed in the financial assistance programme in 2013 differ from those of Greece and Portugal. Reforms aimed at reducing both public and private expenditure while creating conditions for full implementation of a comprehensive publicly funded healthcare system in the upcoming years. Improving the availability of the National Health Insurance services by encouraging workers' mobility and extending the working hours will be a key issue combined with efficiency measures like downsizings, performance-based evaluation for promotions and better working conditions. Doctors as public servants experienced a reduction in their basic remuneration, and in overtime and on-call payment. Rumours about future taxation of retirement benefits and abolishment of permanent tenure generated a wave of doctors to leave the public sector.

Unlike in Greece and Portugal, doctors in Cyprus were given a key position in regulating users' access throughout the healthcare system. Combined with the implementation of clinical and prescription guidelines and the increased use of new information and communication tools, this may help making public expenditure more efficient [18].

3. Outcomes of the reforms

Health workforce reforms outcomes in the three countries have been different from the initial goals; in particular interventions to improve planning and management measures were not implemented. Immediate savings were achieved by salary cuts and downsizing, extended working hours and pay-for-performance mechanisms [6,34]. No interventions were identified to balance health workers' distribution or to

Table 3
Summary of health workforce reforms proposed in the Financial Assistance Programs for Cyprus, Greece and Portugal.

National-level reforms to improve HRH (adapted from Campbell and colleagues [7]	Greece	Portugal	Cyprus
Develop, implement and monitor plans for a sustainable health workforce	Partially defined. Not achieved	Partially defined. Not achieved	Partially defined. Not achieved
Enhance HRH information systems to facilitate labour market analysis in HRH	Defined. Not achieved	Defined. Not achieved	Partially defined. Not achieved
Transformative education approaches and continuous professional development opportunities	Not defined	Not defined	Not defined
Prioritize the health workforce at the primary health care level to enhance equity in access	Defined. Not achieved	Defined. Partially achieved	Defined. Partially achieved
Equal opportunities for all health workers	Not defined	Not defined	Not defined
Accountability and transparent processes, on HRH governance	Partially defined (clinical guidelines). Achieved	Partially defined (clinical guidelines). Achieved	Partially defined (clinical guidelines). Achieved
Enhance HRH performance through innovative, effective, targeted management approaches and incentives	Partially defined (drug prescription). Achieved	Partially defined (drug prescription). Achieved	Partially defined (drug prescription). Achieved
Improve health workforce distribution and retention	Defined. Not achieved	Defined. Not achieved	Defined. Not achieved
Advance research and evidence-based practice to inform and maximize the return on HRH investment	Not defined	Not defined	Not defined
Task sharing, and innovative models for care delivery	Not defined	Not defined	Not defined

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reform education and training. In spite of the consensus that health workforce development is key to sustain and accelerate progress towards universal health coverage [7], none of these countries has moved towards the implementation of comprehensive reforms to better use its human resources for health (Table 3).

Further analyses are required to explore the extent and impact of the migration of health workers on health services capacity to meet population's needs and universal coverage of healthcare.

4. Conclusion

In this article we were exploring how health workforce policy in the three Southern European countries responded to austerity politics arguing that the 'crisis' embody threats as well as pressures towards innovation. In all three countries, we found a lack of monitoring and assessment of the effects of the financial crisis in relation to the health workforce and there was no evidence of substantive innovation in health workforce policy. Hence, there are differences in how the countries respond to the austerity politics and financial constraints. In Cyprus, for instance, GPs are given a key position in reducing public expenditure through the control of users' access throughout the healthcare system, while in Portugal and Greece cost containment is mainly achieved through limiting professionals' decision-making powers.

In summary, there is a need for policy development in all three countries in order to use human resources more efficiently in the healthcare system. While it is legitimate to seek rapid savings through measures such wages reduction or new retirement conditions, it remains imperative to assess their potential effects on the recruitment and retention of health workers as well as on the quality and efficiency of services [20,27,29,30,32]. Developing health workforce planning and management should therefore be a priority goal for health policy.

Conflict of interest statement

The authors declare that they do not have any conflict of interest.

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