Hospitals tested by austerity

The austerity policies being followed in most European countries have not spared the health systems. Poor people are not the only ones to suffer. Nursing staff have seen their working conditions deteriorate rapidly over recent years. More and more of them no longer see themselves as part of current developments in the hospital world.

Caroline Verdoot
General Federation of Belgian Labour (FGTB), former hospital nurse

The practice of reporting, adopted from the private sector, has rapidly spread throughout the hospital sector, creating an additional burden for nursing staff.
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The austerity measures applied over recent years in most European countries have of course affected the financing of public health systems. Investment has been constantly reviewed downwards and the share of health expenditure not covered by social security has increased[1].

The spectre two-speed medicine has raised its head. The most well-off patients gain rapid access to care in private clinics, while the public sector, with less subsidy than before the crisis and therefore with reduced financial and technical resources, is finding it more and more difficult to meet the health needs of the majority of the population.

Preferring to spend their money on other things, many Europeans find themselves having to give up monitoring their health or delay expenditure on health care, which may have the effect of aggravating their condition. They are going into the healthcare circuit too late and the number of patients considered to be serious cases is multiplying in care units. As shown by a study covering Greece, Spain and Portugal, the crisis has given rise to an upsurge in infectious diseases, including AIDS, and suicides[2].

1. WHO, Europe Regional Office (2013) Les systèmes de santé face à la crise économique en Europe. Aide-mémoire, Copenhagen and Athens, December 2013.
Burgi N. (ed.) (2014) La grande régression. La Grèce et l'avenir de l'Europe, Le Bord de l'eau.
2. Karanikolos M. *et al.* (2013) Financial crisis, austerity, and health in Europe, The Lancet, 381, 1323–1331, 13 April 2013.

A vocation under threat

Entering the nursing profession is generally seen as taking a vocation as it requires devotion, patience, availability, knowledge, etc. For several years, working conditions have been getting worse and worse. The public health systems have to reduce drastically their spending, while the demand for care is escalating in tandem with the increase in life expectancy. The professionals who work in the sector no longer have any hesitation in taking to the streets to denounce their workload and the pressure they constantly have to endure. Is this unease widespread?

The largest European study to look at the situation in detail was carried out 10 years ago. Between 2002 and 2005, a team of university academics used a questionnaire to survey 10 European countries. Just over 56 000 nursing professionals took part. They worked in various institutions: hospitals, nursing homes, home care institutions and institutions for outpatient care. A total of 15% said that they frequently considered leaving the nursing profession. This was particularly evident among those between the ages of 25 and 35, and among men. Nursing staff working in hospitals and those with the highest qualifications were most likely to consider leaving the profession.

There were significant variations from country to country. The situation was by far the most worrying in the United Kingdom, where 36% of those who took part in the survey said that they were thinking of leaving their jobs. Some distance behind was Italy, where 20% felt the same way. The countries least affected were Belgium and the Netherland, with less than 10%. France was right in the middle of 10 countries surveyed, with 15%.

When it came to the reasons for leaving, the participants were primarily concerned about their health and individual factors (burnout, general health, work ability, physical diseases, age), followed by work organisation.

The 'health and individual factors' indicator highlighted the impact of nurses being overworked. The researchers used a 'burnout scale' to assess the situation among nursing staff in hospitals. The worst scores were recorded in France, Belgium, Slovakia and Poland. These last two countries, where the possibility of giving up work before the legal retirement age is very limited, saw the worst scores in terms of the general health of nursing staff. These results indicate that general health and, to an even greater extent, psychological health (burnout) are clearly associated with the intention to leave the nursing profession.

As regards work organisation, the lack of possibilities for development, influence at work and the requirement to carry out tasks not belonging to nursing were the participants' main complaints.

Twelve months after the first phase of the study, the researchers contacted some of the participants again to find out if they had actually left their jobs. A small majority (54%) had left the institutions they had been in but were still working in the healthcare sector, 13% had taken time out and 9% had left the profession altogether.

Of those who had left the profession, the researchers observed that a key reason for their departure was that the demands on them were too low. These nurses seemed to be seeking greater challenges, wrote the authors. This interpretation was supported by the situation in Sweden, where, unlike the other countries, 'too low demands' did not play a major role. However, nurses in Sweden have greater autonomy and responsibility than in many other European countries.

Source: Hasselhorn H.-M., Hans Müller B. and Tackenberg P. (eds) (2005) NEXT Scientific Report, July 2005. http://www.econbiz.de/archiv1/2008/53604_lifting_bending_tasks.pdf

Nurses, a soft target

In hospitals, short-term reforms, exacerbated by budgetary restrictions with immediate effect, have led to delayed investment, reductions in administrative costs and falls in workers' remuneration. Care staff, in particular nurses, are a soft target for the rapid implementation of savings.

Greece and Portugal have had to suffer the most severe and numerous austerity measures (hospital closures, wage falls, restructuring, privatisation, etc.).

Cuts in health professionals' remuneration have been applied in Cyprus, Greece, Ireland, the Baltic countries, Romania, Spain and Portugal. Wage freezes have been imposed in the United Kingdom (except for the lowest wages), Portugal and Slovenia while, in Denmark, wage increases have been smaller than originally planned. In Portugal and Catalonia, overtime has been less well paid. Finally, staff reductions, including direct redundancies, non-replacements or non-renewal of contracts, have been recorded in nine Member States[3].

In Ireland, public funds allocated to health have been reduced by 17% between 2010 and 2012. These budget cuts have resulted in wage reductions, voluntary redundancies (more and more frequent) and non-replacements. Overall, there has been a staff reduction of 4 000 between 2009 and 2011[4].

According to the WHO's European office, it is possible that the pressure to lower the remuneration of health staff in countries where wages are low has produced short-term savings to the detriment of gains in efficiency. The WHO is worried that some changes risk threatening access to services or damaging the motivation of health staff.

The economic crisis is also having a tremendous effect on the nursing staff themselves. As for other European citizens, the purchasing power of nurses and care assistants has fallen throughout Europe. It depends more and more on payments associated with unsocial working hours such as working on holidays, in the evening and at night. A lengthy illness might put such workers into very precarious situations, since their wages are no longer supplemented by irregular benefits.

All European countries are facing a shortage of care staff. There is a risk that this will deteriorate even further in view of the changing demographics affecting most European countries. While the ageing of the general population means an increase in the need for care, the professional health population is also ageing and becoming scarcer[5].

To mitigate these shortages, the existing staff are compelled to increase their overtime hours, often without pay and very difficult to compensate with time off in lieu owing to the staff shortages.

Since units have to operate with a minimum number of staff per occupied bed, the use of temporary staff is frequent. At least, it was, because today, since they have become too expensive, hospitals prefer to turn to standby teams. These are nurses who move from one unit to another as required by units which are temporarily under-staffed. Temporary staff are still being hired and students require a lot of time and energy on the part of permanent staff, which just adds to their daily workload[6].

In order to deal with the shortage of doctors and guarantee satisfactory access to care, some countries have assigned more complex functions to the most qualified nursing staff. Specialised or advanced nursing positions are being established to a greater or lesser degree, depending on the country, but some tasks usually only performed by doctors are now being undertaken informally by nurses. The OECD has also noted that the introduction of 'advanced nursing practices' may require changes in legislation and regulation in order to remove the barriers to their development[7]. How can these tasks actually be justified in administrative documents which do not provide for them? And, in the event of an accident, how can certain current informal practices by justified, which do not legally form part of the lists of tasks assigned to nurses?

In order to confront the shortage and keep the staff remuneration budget as low as possible, hospitals in western Europe are recruiting foreign care staff (read the article on p. 26).

The shortage of general practitioners and families' and close helpers' lack of time and resources are making public hospitals, and especially their accident and emergency departments, the easiest point of access to the health system, which is resulting in overcrowding and thus an increase in the risks of aggression towards overworked staff (read the article on p. 34). The increase in activities in public institutions is quicker than the increase in staffing.

Shortening times in hospital

In Europe, hospitals consume 20 to 50% of the budgets allocated to the health system[8], while the percentage of GDP allocated to health is roundabout 10%.

In some countries, there has been a switch from global, fixed financing of hospitals to financing for service. Previously, most European countries allocated funds to hospitals according to global fixed budgets based on the number of admissions or the number of beds occupied. This system encouraged hospitals to increase the number of admissions or increase the length of stays in hospital. For more than twenty years, financing for service, inspired by the United States, has been based on diagnosis and therapeutic procedures. It is said to be more efficient (since it is based on *evidence based medicine/nursing*), more objective and more equitable in view of the activities and the difficulty of the tasks, which may vary greatly from one hospital to another. This is actually a statistical tool which is very useful for public health, making it possible to estimate geographic variations in the frequency of certain pathologies or groups of pathologies and medical practises.

However, this system has perverse effects. In Belgium, care units are financed by flat fee based on national average stays in hospital. What is dangerous is that some hospitals reduce their lengths of stay dangerously

3. European Federation of Public Service Unions (2013) Impacts of the financial and economic crisis and of austerity measures on health-care systems, on the health workforce and on patients in Europe, 25 November 2013.
4. Thomas S. *et al.* (2012) The Irish health system and the economic crisis, The Lancet, 380, September 2012.
5. WHO, Europe Regional Office, Nursing and midwifery. Data and statistics.
6. Gheorghiu M.D. and Moatty F. (2013) L'hôpital en mouvement. Changements organisationnels et conditions de travail, éditions Liaisons, 303 p.
7. Panorama de la santé 2013: les indicateurs de l'OCDE.
Delamaire M. and Lafortune G. (2010) Nurses in advanced roles: a description and evaluation of experiences in 12 developed countries, Working Papers, 54, OECD Publishing.
8. OECD, Health data 2010.

The patient-nurse relationship cannot be likened to that of client-trader.

in order to make money. If a patient occupies a bed for less time than the average for such a class of pathology, the hospital is the winner, since it has received a certain sum covering x number of days in hospital.

Since 2008, the activities of both doctors and care staff have been recorded in a joint report. At certain times of the year, all the activities of nurses, from the simplest (for example, making a bed) to the most complex (tending to a wound), are detailed, listed and recorded there. Records used to be kept in hardcopy. Nowadays, more and more use is being made of computerised versions. Hospital managers can make use of this tool to compare their own results with those of other hospitals. They use the data in the management of staff and deployment to the various units.

Clearly, the results risk being biased since the more activities are recorded, the more resources are allocated to perform them. Reported discrepancies are, for example, fictional patient discharges in order to re-record an admission. However, a unit reporting an abnormally high quantity of work in comparison with another of the same type risks attracting the attention of the public authorities.

This benchmarking within hospitals and between hospitals, these quantified performance indicators and the increasing computerisation give rise to stress and uncertainty with regard to the future of working teams. This competition between hospitals encourages mobility of care staff and a high turnover rate.

However, nursing activities are complex and cannot be summarised in figures and percentages. A hospital cannot be organised in the same way as any company attempting to improve its turnover. The patient-nurse relationship cannot be likened to that of client-trader. The relationship and communication aspects, the missions to inform and educate the patient are taken into account less or have to be systematically justified. It should be noted that the time devoted to filling in all the administrative documents eats into that devoted to contact with colleagues, patients and their families and to the training of students.

Thus, so as to increase their financing, it is not in hospitals' interest to keep patients in their beds for too long. The reduction in duration of stays in hospital speeds up patient turn-over, which increases staff workloads. In fact, turn-over is considered, after interruptions during the execution of tasks, to be the main factor contributing to the increase in workload[9].

Professor André Grimaldi, diabetologist and former head of department at the Pitié-Salpêtrière in Paris, explains that it is sometimes necessary to wait for a few hours to obtain a bed in medical intensive care[10]. '"The enterprise hospital" uses a "just-in-time" management system', he explains. Put more simply, this means that there should be no empty beds, since they do not make any money. And a bed, once occupied, is more profitable with a seriously ill patient than with a patient who is less so. Patients therefore play at musical chairs to the detriment of the staff, who are constantly on the go. A patient discharged too soon from hospital risks complications and aggravation of his state of health with, into the bargain, a possible return to the care circuit.

Public hospitals tend to mimic the methods of the private sector[11]. Reports, meetings and projects proliferate and staff (doctors and nurses) are no longer able to devote their time to the patients. Furthermore, it is the human resources staff who organise schedules from their office, without paying much attention to the reality in the field and without leaving much margin for adaptations between colleagues. The consequence being that superiors are leading staff whose jobs they do not know.

Wellbeing of hospital workers

The contradictions between methods of organisation and a hospital's missions and values result in degradation of working conditions and absenteeism owing to sickness.

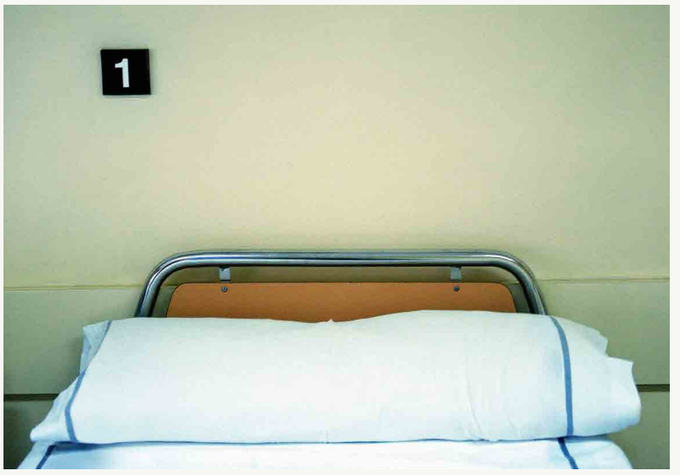
The working conditions in the hospital sector are already very challenging (atypical hours, teamwork, physical work, psychosocial burden, occupational risks associated with exposure to chemical and biological agents, etc.). Over recent decades, the world of work overall, and particularly the public and hospital sector, has been confronted with an intensification of work.

Some nursing staff can no longer see the sense in their work. The French trade unionist Denis Garnier explains that staff are experiencing an ethical conflict between the requirements imposed by the hospital and their wish to perform a job well done[12].

The psychosocial and emotional burdens are increasing both among the teams, reduced to the status of 'human resources', and among the managers who are subject to very great pressure following the implementation of new management systems, systems for comparing units within the same hospital and between hospitals. For some of them, the values which attracted them to healthcare have been shaken by the sometimes abusive use of numerical objectives and the reduction of the complexity of their activities to numerical graphs and tables.

This is supplemented by the requirements for availability and instantaneous information for patients and their families. They demand complete and rapid information, take information from the Internet and can become aggressive or violent. These

9. Myny D. *et al.* (2012) Determining a set of measurable and relevant factors affecting nursing workload in the acute care hospital setting: a cross-sectional study, International Journal of Nursing Studies, 49, 427-436.
10. Grimaldi A. (2009) L'hôpital malade de la rentabilité, Fayard, 278 p.
11. Agostini M. *et al.* (2011) The effects of public hospital restructuring in France, HesaMag, 4, 24-27.
12. Garnier D. (2011) L'hôpital disloqué, Le Manuscrit.



The need to reduce waste and the number of empty beds has become a priority. Hospitals are now managed like commercial enterprises.
Image: © Belga

The values which attracted them to healthcare have been shaken by the reduction of the complexity of their activities to numerical graphs and tables.

situations must also be able to be managed and time has to be devoted to communication, even if such time is not necessarily 'profitable' from a finance point of view.

Finance managers, doctors, families and patients sometimes tend to consider nurses as they are portrayed in the collective imagination, i.e. a stereotype person blessed with patience, compassion and an ability to put up with countless small interruptions during their work or accept last-minute changes in schedule and overtime. Clearly, without imagining that a nurse also has a private life, a life outside the four walls of the hospital.

The population of health professionals is particularly affected by burn-out. Burn-out appears after a period of prolonged exposure to psychosocial risks. It is characterised by exhaustion, depersonalisation (or cynicism) and a loss of professionalism (or a reduction in professional effectiveness). The quality of relationships between nurses and doctors, especially in care units, affects the three dimensions of burn-out[13]. The support of colleagues and line management and good working relations represent a factor in wellbeing at work[14]. It is also essential for the team manager (line management) to be aware of the realities in the field and to be involved both at the level of overall hospital management and at care unit level.

Furthermore, a low level of communication between colleagues and neglected social relationships are associated with depressive symptoms linked with the perception of an imbalance between the effort made and the return (recompense for the work performed) identified by nursing staff[15]. This imbalance is considered to be a psychosocial burden, a source of stress and consequences for physical (cardio-vascular, dermatological, etc. pathologies) and mental (depression, relational problems, sleeping problems, etc.) health of workers. Workers in an under-staffed team have little time to devote to interaction and communication.

Quality of care and patient satisfaction

According to an international study devoted to staff and patient satisfaction, the proportions of nurses considering that they are providing patients with poor quality care vary greatly from one country to another. The rates are close to 50% in Greece while it is 11% in Ireland, 13% in Finland and 28% in Belgium. The burn-out rates run from about 10% in the Netherlands to some 40% in Poland, Ireland and the United Kingdom and up to 78% in Greece.

Despite a quite generalised shortfall in the quality of care in the 12 European countries covered by the study, an improvement in the quality of the working environment and a reduction in the number of patients per nurse are associated with an improvement in the quality of care and increased patient satisfaction.

The models for human resource planning in health institutions are generally based solely on the volume of staff. They have long ignored their effects on the quality of care lavished on patients and on the quality of working conditions. On the basis of data collected in 2010, the Registered Nurse Forecasting (RN4CAST)[16] project investigated, in 30 hospitals in 12 European countries, satisfaction at work and the psychosocial burden. The study showed that an increase in workload per nurse is associated with increased mortality among patients who have undergone surgery, while their level of training is associated with a fall in mortality. The authors concluded that budget cuts for nursing staff could have a negative effect on the health prospects of the patients being treated.

A study published recently in *The Lancet*[17] identified, after having analysed all the scientific literature from 1996 to 2012, the factors essential for the organisation of effective infection prevention programmes. Every year in Europe, healthcare gives rise to more than 4 500 000 infections, resulting in about 37 000 deaths and 16 million extra days in hospital. The authors identified 10 essential elements making it possible to reduce infections and improve patient safety. Of these, sufficient staff in both day units and night units (and in particular avoiding the stand-by team system), a bearable workload (in particular avoiding long working days), optimum ergonomics (as regards both materials and the arrangement of equipment in the workspace) or even appropriate and on-going training are reckoned to be key elements.

In order to protect the health of care staff and provide for the best possible quality of care, it is essential that hospital finance and human resource managers take sufficient account of the human aspect. The same applies for the survival of hospital institutions: as shown by the European Agency for Safety and Health at Work (EU-OSHA), investing in the health (physical and mental) and safety of workers is beneficial for the economy of enterprises and institutions[18].

It is not solely a matter of the quality of life of health professionals, the quality of their care depends on their working conditions. In the interests of public health for current and future generations, all European citizens should demand in-depth consideration of the way in which the political authorities in European countries are managing public health at present. ●

13. Li *et al.* (2013) Group-level impact of work environment dimensions on burn-out experiences among nurses: a multivariate multilevel probit model, International journal of nursing studies, 50, 281-291.
14. Roland-Lévy C. *et al.* (2014) Health and well-being at work: The hospital context, Revue européenne de psychologie appliquée, 64, 53-62.
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17. Zingg W. *et al.* (2015), Hospital organisation, management, and structure for prevention of health-care-associated infection: a systematic review and expert consensus, The Lancet Infectious Diseases, February 2015.
18. EU-OSHA (2014) Estimation du coût des accidents et des problèmes de santé au travail. EU-OSHA (2012) Motivation for employers to carry out workplace health promotion.