The nursing and midwifery workforce implications of HRH 2030

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Implications of HRH 2030

• The global HRH strategy
• Policy questions
• The evidence base on nursing and midwifery workforce contribution ("value")
• [Ab]using the evidence
• How CC can make a difference
Global HRH Strategy: relevance to nurses and midwives

• The strategy is truly global
• As such, it has a broad focus, with comparative analytics on staffing ratios, expenditure etc
• It makes the key connection between HRH as an input, and improved health as the outcome
• It is not a detailed “blueprint” for any country. Its key relevance is as a frame of reference, setting out broad strategic linkages and essential policies for sustained action on improving HRH
A labour market frame of reference

Education sector:
- High school
  - Training in health
  - Training in other fields
- Pool of qualified health workers
  - Migration
    - Abroad

Labour market dynamics:
- Employed
- Unemployed
  - Out of labour force
- Other sectors
- Health care sector
  - Available, accessible, acceptable health workforce that delivers quality services
  - Universal health coverage

Policies:
- Policies on production
  - on infrastructure and material
  - on enrolment
  - on selecting students
  - on teaching staff
- Policies to address inflows and outflows
  - to address migration and emigration
  - to attract unemployed health workers
  - to bring in health workers back into the health care sector
- Policies to address maldistribution and inefficiencies
  - to improve productivity and performance
  - to improve skill mix composition
  - to retain health workers in underserved areas
- Policies to regulate private sector
  - to manage dual practice
  - to improve quality of training
  - to enhance service delivery

Source: Sousa et al, 2013, Bulletin of the WHO.
Policy questions: what a Health Minister will ask

- How can we plan how many nurses and midwives to educate, and employ?
- How can we improve recruitment, retention and return of nurses and midwives?
- Which incentives are effective in motivating nurses and midwives?
- How can we determine and deploy the most effective skill mix of different roles and staff?
- How do we improve productivity of nurses and midwives?
“...if we do not redress the supply and demand imbalances arising from the rapid ageing of the existing workforce and the expanding demand for services over the next 10 to 20 years we will not be able to achieve improved outcomes without decisive action XXX may have fewer nurses in 2020 than we have at present...our workforce is inequitably distributed......we need consensus with training institutions on how best to expand supply to meet identified ...”
Which country? Which year? (2)

- demand for care outstripping supply
- nurse staffing difficulties in some regions/ specialties
- increasing competition from other employers
- negative media coverage of working conditions in hospitals
- an identified need for increased use of support workers to “free up” nurses to deliver care
- an identified need for increased emphasis on staff retention, and attracting “returners” back to the workforce
- Ministry of Health (xxxxxxx) 'Staffing the hospitals: An urgent national need'.
“...if we do not redress the supply and demand imbalances arising from the rapid ageing of the existing workforce and the expanding demand for services over the next 10 to 20 years we will not be able to achieve improved outcomes without decisive action. **PAPUA NEW GUINEA (2012)** may have fewer nurses in 2020 than we have at present...our workforce is inequitably distributed......we need consensus with training institutions on how best to expand supply to meet identified ...”

- demand for care outstripping supply, nurse staffing difficulties in some regions/specialties, increasing competition from other employers, negative media coverage of working conditions in hospitals, an identified need for increased use of support workers to “free up” nurses to deliver care, an identified need for increased emphasis on staff retention, and attracting married nurses back to the workforce.

- Ministry of Health, **ENGLAND (1945)** ‘Staffing the hospitals: An urgent national need’.
Improving the evidence on nursing and midwifery workforce contribution ("value")

• High-Level Commission on Health Employment and Economic Growth (WHO, 2016)- takes a broad perspective
• Population health = an economically productive population
• Health employment (including nursing and midwifery) = an economic multiplier, contributing to economic growth;
• Health employment (notably nursing and midwifery) = a social multiplier, by encouraging more women into qualified jobs and stable careers in low income countries.
The evidence base on nursing and midwifery workforce contribution ("value")

- Notable single publications that provide systematic reviews (e.g. Laurent et al, 2005) which support scope for advanced practice
- Notable multi site studies (e.g. Aiken et al, 2014) have made an impact.
- (A) notable multi- country assessment that provides analytics for advocacy, policy formulation and benchmarking (The State of the World's Midwifery (SoWMy) 2014)
- **BUT** too much of the remainder of the evidence base is weak, small scale, unambitious, and inward looking: small single site studies that may, at best, have a point- in- time relevance: that can too easily be dismissed as being only of that time and of that place, and not part of the bigger picture.
Evidence does not need to be complex to be compelling

• Between 3 and 12 nurse practitioners can be educated for the price of educating 1 physician [Starck PL. The cost of doing business in nursing education. J Prof Nurs 2005;21:183-190]

• Cost of training a physician (Consultant) =£uk 508,819 ; cost of training a nurse = £uk 80,807. Curtis L. Unit Costs of Health and Social Care, 2015. Personal Social Services Research Unit, University of Kent
[Ab]using the evidence

- “What politicians want is policy based evidence, not evidence based policy”
- Evidence shopping
- Fixing the evidence
- Mishandling the evidence
- Imaginary evidence
- Clairvoyant evidence
- Secret evidence (Henderson, 2013)
How CC can make a difference (1) .......

- It is imperative that nursing and midwifery workforce research must focus on the connections between cost inputs, staffing levels/mix, and outcome measures.
- Most current research does not do this- it either:
  1) focuses on staffing and (perhaps) outcomes, but not on costs, which helps make the case for safe staffing but can be challenged on issues related to resource availability (“need” versus “expressed demand”)
  2) or focuses on costs but not outcomes (which means knowing the cost of nursing/midwifery, but not its value).
How CC can make a difference (2)

- Champion the global HRH strategy, particularly the emphasis on:
  - primary care,
  - outcomes oriented HRH policies,
  - education aligned with population health needs,
  - women’s role and career opportunities,
  - evidence generation and data improvement
How CC can make a difference (3)

- CC can provide more substantive contributions to the evidence base, and can advocate for research funding and the research agenda needed to ensure that the issues related to the value of nursing and midwifery are examined properly.

- (Henderson, 2013) .....Evidence is necessary but not sufficient to achieve change...so.......

- Evidence generation needs to be aligned with an understanding of power relationships, and by the marshalling and use of political power, underpinned by stakeholder mapping, and driven by clear objectives........

- CC must be politically aware and connected, policy oriented, outward looking and networked
References


