Policy brief: Implication for health system reform, workforce recovery and rebuilding in the context of the Great Recession and COVID-19: a case study of workforce trends in Ireland 2008-2021. BMC—May 2022.

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Context

The COVID-19 pandemic arrived as health systems emerged from the austerity era following the 2008 financial crisis. Juxtaposed with the austerity era, the COVID-19 pandemic response saw unprecedented measures taken to meet extra demand and facilitate surge capacity.

Evidence suggests that community-based healthcare delivery was compromised, and health workforce resilience was pushed to its limit, not least due to staff shortages resulting from restrictive policies and budgets.

What did we do?

To examine the impact of health service staffing trends with a view to understanding resource allocation in community and acute settings across three key periods; **'Recession'** (December 2008-December 2014), **'Recovery'** (December 2014-December 2019) **'COVID-19'** (December 2019-August 2021).

Our research was carried out to uncover whether skill mix and staff capacity are aligned with policy intent and the broader reform agenda to achieve universal access to integrated healthcare, in part, by shifting free care into primary and community settings.

Key messages

- The impact of the 2008 financial crash succeeded by the COVID-19 pandemic manifested in a conflict between policy intent and implementation of increasing care in community settings. This highlights a need to revisit recruitment strategies to ensure the most appropriate skill mix is available in the right (community) settings.
- A rethink of workforce governance in order to mobilise, train and deploy a sufficient health workforce with the skills required while also making effective use of technologies is required to develop a positive legacy for future shocks.
- Staff were left vulnerable to exhaustion and burnout by persistent waiting list numbers, diminished working conditions, growing demand for care services, and a lack of adequate staffing levels in the correct care setting. This created a legacy for future shocks.

Findings

1) Staffing levels

Recession – Overall decrease of 8.1% (9,333).
Recovery – Staff levels rebound and increase by 15.2% (16,789).
COVID-19 – Accelerated during the COVID-19 period by a further 8.9% (10,716)
→ Whole-time equivalent (WTE) increased by 25% from 2008 - 2021

2) Changes by staff group

Recession – General downward trend across five of the six staff categories. The 'Medical & Dental' staff category increased by 8%.
Recovery – Steady increase across all staff groups, except for General Support staff which remained static.
COVID-19 — Increase across all categories, likely to be a direct response to the COVID-19 pandemic.

3) Acute/community split (Fig. 2)

Recession – Overall staff numbers across the community and acute settings dropped. In 2013, staff in acute services surpassed those employed in community services.
Recovery – Acute setting staff gains of 33.5% (17,354) compared to 18.2% (8,548) in community services over the same period.
COVID-19 – The gap between acute and community staff levels had tripled by August 2021—13,645 more whole-time equivalent (WTE) in acute settings compared to community settings.

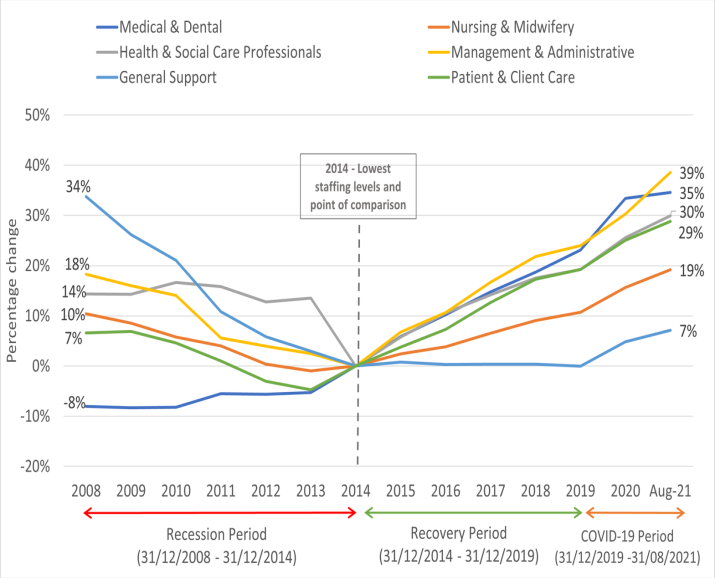

Fig 1. Percentage change within staff category pre- and post-2014.

4) Redeployment during COVID-19

COVID-19 – 3,555 WTE community staff were redeployed. This redeployment placed a strain on non-COVID-19 primary and community care services. Redeployment was recognized as placing strain on non-COVID care reducing delivery capacity and challenging the resilience of the primary care workforce.

5) Absence rate

Absence is important to understand the level of staff who are consistently at work providing care during 'normal' times and a shock. Moreover, the absence rate is useful for determining resource allocation amid times of increased pressure – which influences longer-term decisions regarding skill mix and capacity.

Recession – Absence reached a high of 5.8%.
Recovery – Absence dropped to a low of 4.2%.
COVID-19 – Overall absence rates peaked during COVID-19 (6.1% in 2020) and reached a high of 10.4% in March 2020. Notably, non-COVID-19 absences dropped below average.

What do the findings tell us?

- Controls to introduce efficiencies (recruitment moratorium) exempted certain roles (mainly clinical) pointing to a bias toward acute care (a).
- COVID-19 saw huge investments in staff, albeit in areas driven by crisis rather than policy response (a).
- The impact of shocks on the current reform agenda reveals a conflict between the intent of transferring more care to the community and implementation on the ground (a,b).

Reorganisation and Governance

- Testing and vaccination centres were deployed to deal with demand. However, the recorded place of employment remains largely in favour of acute settings (d).
- Learning from governance changes is required to strengthen workforce resilience in the future – legislative changes, negotiations with professional bodies, and approval for additional funding (d).

Staff recovery and rebuilding

- Austerity followed by the pandemic increased concerns about the cumulative effect on absence, burnout, turnover and early retirement.
- Internationally, frontline staff in residential care facilities, COVID-19 wards, emergency departments and ICUs suffered psychological, physical and social costs (c,e).

Key trends

(a) Surge capacity measures accelerated divergence and tripled the gap between acute and community settings between 2008-2021. (Fig 2.)

(b) Private nursing home staff doubled from 14,000 (2007) to 36,000 (2019).

(c) Increased waiting lists.

(d) Disruption of non-COVID-19 medical care in private and specifically community-based services.

(e) 68% of 1,905 Nurses and Midwives considered leaving the profession following COVID-19.

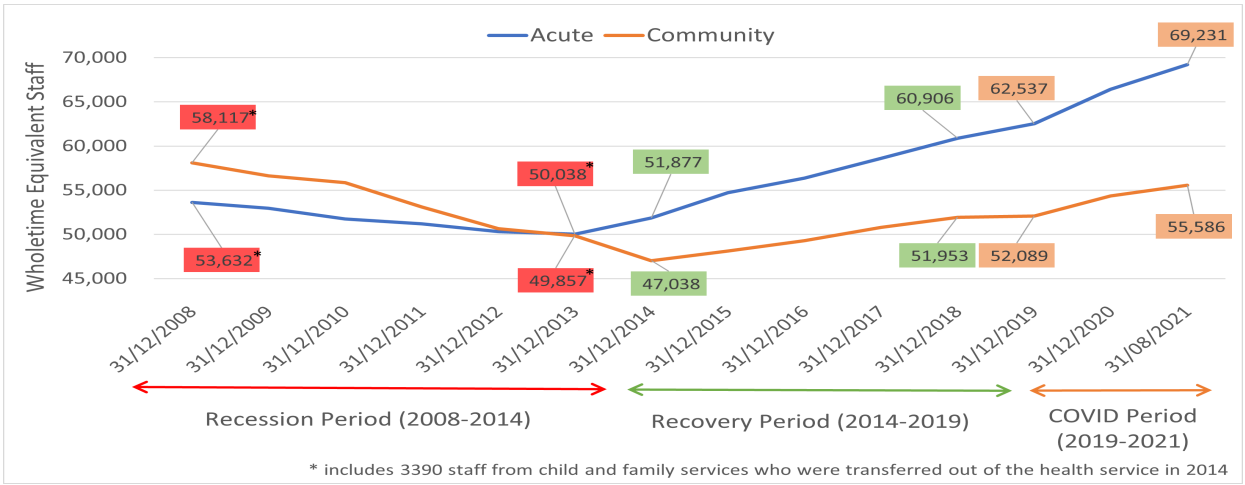

Fig. 2 Trends in acute and community staffing levels 2008-August 2021.

Recommendations

1. Support workforce personnel through key decisions on healthcare being supported by national/regional government policies enabling staff to recover, rebuild and repurpose.
2. Legislative changes, negotiations with professional bodies, and approval for additional funding can ensure workforce personnel are supported, well-resourced and situated in the appropriate (community) care setting.
3. Regulation for professional councils to define roles and standards to create a sustainable model built on staff mix and staff capacity.
4. Increasing the role and remit of employers and management to determine pay levels and working patterns. As a result, staff retention and recruitment with an overall goal of protecting staff well-being while also meeting policy targets can be achieved.
5. Align policy with practice through concerted actions, improving infrastructure, and a permanent redistribution of personnel, ensures progressive and sustainable lessons are learned.

Conclusion

The response to the COVID-19 pandemic broadly aligned with the health system reform agenda. Namely, a universal community-based approach to COVID-19 care, while demonstrating opportunities for collaboration and clearer governance between public and private healthcare providers. Notwithstanding the agility of the system and the commitment of staff to responding to the pandemic, the mismatch between policy and practice underscores the need to assess recruitment strategies to ensure the most appropriate skill mix is available in the correct (community) settings.

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