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Commentary: Human Capital in Health Care, A Resource Crisis or a Caring Crisis?

Abstract

Predicting and shaping the human capacity resources for health care globally for the future requires voice and valuation of, and about, caring.

Comments

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Commentary: Human Capital in Health Care, A Resource Crisis or a Caring Crisis?

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Human Capital in Health Care, A Resource Crisis or a Caring Crisis?

That there is a worldwide crisis in human resources for health care is a fact many of us would agree on. We may differ on the extent and depth of the crisis, we may judge it differently within the context of different regions, but, regardless of the country we visit or work in, there is a severe shortage of caregivers and that shortage is felt most strongly in countries that need them most.

We all may agree, too, that this crisis is recent and due to the increasing incidence and prevalence of infections, reemerging and new; living longer with chronic illness; and in adopting life styles that increase vulnerability to disease and illness. However, I beg to differ. This crisis has been in the making for a very long time and at the heart of it is the gender divide. It is a crisis about the value of caregiving in health-care systems as well as in societies around the world.

We can never address health care or caregiving needs without speaking about women as the informal caregivers and without discussing nurses and their roles. Nurses- women and men- are the majority workforce and providers of care in health-care systems. Women provide 90 percent of informal caregiving, and women are the overwhelming majority of nurses. Nurses are also the first to rescue, the first to get infected, and the first to die in any epidemic or natural disaster. Therefore, a framework for health-care resources simply cannot ignore the gender divide.

The nature of the dialogue itself needs to change. When we speak of shortages and surpluses, the dialogue is about adding, laying off, discarding and "poaching" nurses by developed countries from developing countries, by "luring" them away. These are not the best analogies, because they reduce nurses to "discarded possessions" or an "endangered species," usually denoting non-human species. There is also a disregard in these metaphors for the ambitions, the professional interests, or the strategic goals of nurses. There is also lack of attention by these analogies of the centrality of family needs that drive women to change countries.

The "pull" factors that lead nurses to work in more humane environments, to desire better benefits, to advance their careers, and secure better lives for their children, is not front and center in the "brain drain theory." Similarly, the "push" factors of unhealthy environments and meager resources do not inform the "poaching theory." Furthermore, when the crisis is framed in numbers, the solutions are reduced to numbers, and numbers tell only a small part of the story. When using numbers to drive the discourse about inadequate workforces, caregivers are portrayed as a disempowered group stolen or lured away against their will. Being disempowered allows solutions to be imposed by well-meaning but very misinformed patriarchal policy-makers. Therefore, I suggest that none of these solutions would work.

Solutions, such as opening new programs in nursing and medicine, intensifying recruitment into nursing programs, shrinking the number of years in educational programs and/or preventing nurses from immigrating, are all short-term and shortsighted solutions. Nor will the impressive elaborate predictive models used to map out the needs for increases in human capacity resources for health-care work.

Am I pessimistic? Yes. Why? Because the true crisis lies in three fundamental issues that need to be considered as a context for planning, training and retaining human capacity for health care. Ignoring these three fundamental issues will continue to exacerbate cyclical shortages in health care.

The three fundamental issues are: 1) The devaluation of the work involved in formal caring; 2) Ignoring the vital, taken-for-granted formal caregiving role; and 3) The perpetuation of a colonialist male-dominated definition of work. So let me discuss each very briefly. We probably all agree that receiving care is a human right for those who need the care, and we would also agree that, in all parts of the globe, caring for others is viewed as an expectation and a right, even though it may be devalued because it is not compensated for, but it is expected!

Let's look at formal caregiving. Formal caregiving by nurses involves 24/7 (hours/day) of evaluation, assessing, monitoring, education, management of pain, explanation of regimens, support of recovery, clinical judgment diagnosis, and the enhancement of healing. The compensation for this work, in all corners of the world, is not congruent with the emotional and physical demands of the work. Nurses' human rights in the work place are abrogated in many different ways. For example, nurses are the first to be laid off with the smallest hint of downsizing, lower bed occupancy, or budget challenges. We stand by, watch and marvel at how one nurse cares for 30-50 acutely sick hospital patients, forgetting that their human right for a decent work load and that of their patients for quality care are abrogated. When we expect and demand that nurses go on with their work responsibilities in spite of the minimal resources provided them, we have an abrogation of rights and a caring crisis.

The world also stands by watching as caregivers provide care to suffering human beings, without the most basic of resources: disinfectants, antibiotics, pain relievers, infusion tubes, catheters, syringes and other essential life-saving gadgets. When nurses/women are undermined, violated, insulted, subjected to verbal abuses by physicians and hospital administrators, deprived of decision-making, prevented from providing the care for which they were educated, when their fundamental rights to be treated as human beings are not met so that they can care for patients, the whole world sits by and does nothing, when we should collectively be enraged! That is the human resource crisis, a crisis about caring for human beings.

Solving the shortage issues by preventing nurses or restricting them from leaving South Africa and immigrating to the UK, or leaving Zimbabwe for the United States, or the Philippines for Australia is an abrogation of freedom and the fundamental rights to improve one's education, receive financial compensation that reflects the burden of the work, and gain experience that enhances careers. That is a crisis in caring.

Keeping nurses in their own countries by supporting their work through appropriate resources,

and compensating them appropriately for their work, is supporting their basic fundamental rights for meeting their needs, as well as providing them with their rights for options. When nurses are prevented from migrating or immigrating or from choosing to work in another country to develop themselves professionally, to provide better living conditions for their families, to receive better respect for their work, to enhance their lifestyle and receive better education; that is a crisis in caring.

When women provide informal caring for the invalid and chronically ill family members, are expected to care for members of the family with HIV/AIDS or Alzheimer's, and are expected to do so with no compensation, resources, or benefits; that is a crisis in caring.

If informal and formal caring is valued through the media, in financial compensation, in leadership positions, in gaining a seat on policy-making tables, then it is easy to attract and retain caregivers and perhaps cyclical shortages will decrease.

There is more to this caregiving crisis. Care has been defined from a biomedical perspective. Patient and community needs for health care are defined in terms of diseases, surgeries and infections, rather than as needs of patients as human beings with illness experiences, human beings who are members of families and communities, individuals whose caring needs extend well beyond the walls of hospitals. Defining caring as hospital-based and planning resources for hospital care has forced a taken-for-granted-women's-informal-uncompensated-for-caring-work at home and in the community.

This has resulted in equating health-care systems with a narrow focus on hospital settings, and in determining staffing needs in terms of hospital beds/day/acuity, and developing staffing patterns based on diseases, hospitalizations and surgeries. These assumptions further exacerbate the caring crises. People with HIV, AIDS, TB, Ebola and cancer are at home, needing management of pain and other symptoms, coordination of complex treatment regimens, frequent visits to health-care systems, and needing to make decisions on what is normal in the course of an illness and what needs immediate attention. Informal caregiving is becoming the norm, with no compensation or resources. Women are the caregivers; that is a crisis in caring.

I said there are three fundamental issues that frame the crisis in caring- the first is devaluation of formal caring work, the second is ignoring the informal caring work given by family members in homes and in the community. Now to the third fundamental issue, very much related to the work of caring. Work has historically been defined as paid employment and defined through a patriarchal framework.

Socio-cultural norms and values have separated the world into public and private spheres, with the public representing remunerated work and the private, traditionally unremunerated work attributed to women. Industrialization, western colonialism, and now globalization has enhanced the status of the public over the private, leading to a narrow definition of work in terms of employment, achievements and performance. This has added to the devaluation of the informal caring work and contributed to the caring crisis.

As a result, health-care systems shift more of the work that was previously done by professional

caregivers to the family or, more precisely, on women. And why not? It is cheaper and it eliminates that work from the economic equation of the health-care system. It saves money for the health-care system. Or does it? By decreasing formal caregiving, a message is given of its lack of importance. This, in turn, reflects back on that work and devaluates it even more. Patients are at home and in the community, and that is where they continue to need care. That is where we should insure that they receive the necessary continuation of care, which, unfortunately, has been devalued.

Caring for others is taken for granted as women's work, work that should be provided for free and added to all her other roles and responsibilities. It is essential, legitimate, and needed work, and should be treated as such. It should be expected as essential for the welfare and health of families, communities and societies. But it should be compensated for with benefits, privileges and value.

Denying sound and solid educational preparation for the very people who provide this formal care under the pretext that shortages are severe- hence, there is not enough time to educate nurses appropriately- or that it is costly to educate nurses, or that educated nurses tend to be defiant and not sufficiently deferential to physicians, is an abrogation of the rights of nurses as citizens and, more importantly, the rights of people to receiving essential quality evidence-based nursing care.

In summary, health care has been disease-focused rather than caring-focused, hierarchical rather than collaborative, hospital-based rather than family- and community-based, and plagued by an assembly-line mentality. Patients need clinical judgment and critical thinking to care for them. Apprenticeship is not enough to prepare the formal caregivers. What is needed is the belief that knowledge and evidence are needed to deliver care. That acknowledgement and valuation of caregiving may mitigate the human resource crisis.

Global solutions for the human capital as an endangered resource for health care are urgently needed. The framework for these solutions should be gendered and it should be driven by human rights and equity approaches for care, and it should be guided by the needs of family and community for care.

Recently, a British Medical Association task force on improving health and fighting poverty made several cogent recommendations that are useful in dealing with human resource crises.¹

1. All countries must make human capacity building for care a top priority, with the more resourced countries assisting the less resourced.
2. All health-care workers must be educated and well funded.
3. Fund the less-resourced countries that are losing their health-care providers to the more-resourced countries.

4. Fund and support a returned program. Repatriate those who immigrated and make it attractive for them to go home.

These recommendations could help countries to begin to deal with the human resource crisis. However, without addressing the caring crisis, shortages will continue to be cyclical. Therefore, I suggest a two-part action plan for individual and collective actions. There are two "V's" to remind us of the two-part plan.

Voice: Providers of care and recipients of care must give "voice" to women and nurses who are providing the care. These formal and informal caregivers know best what is needed to provide care. Therefore, they need to be invited to the policy table where decisions about needs and resources are made. These knowledgeable caregivers must be in leadership positions to affect changes. They are the ones with the hands-on of care delivery; hence, they must be the ones to decide levels of education and training, how to deliver this care, and where to deliver it. Informal care should be formalized, not taken for granted and expected with no compensation or benefits.

Value Caring: We need to invest in a caring agenda as opposed to a quantitative/shortage agenda. In addition, if we put the same commitment of resources into caring as we put into wars and conflict, all countries could benefit. Health-care policy-makers around the world need to invest in education for caregiving, in compensation for formal and informal caregivers, in redesigning work environments, in translating evidence to practice to provide safe quality care. Societies must invest as well in healthy environments for caregivers. Valuing could only be manifested in resources, resources for informal caregivers and formal caregivers.

In conclusion, predicting and shaping the human capacity resources for health care globally for the future requires voice and valuation of, and about, caring. Imagine for a minute what it would be like if the world politicians, legislators and policy-makers were to speak about, foster, support and invest in caring. Imagine what the quality of health care would be like if there were an investment in word and deed, in those who do the formal and informal caregiving! Imagine what the impact would be on the pain and suffering that patients and caregivers experience! By investing in caring, giving it voice and value, we can dream of equity and humanity in health care systems. And who knows? We may even have peace in the world.

Reference

1 British Medical Association Conference on Improving Health and Fighting Poverty, Focus on Global Skills Drain, April 14-15, 2005, <http://www.bma.org.uk>