Could we reduce nursing shortages in the pandemic by paying people more?

Nursing shortages are endemic in the NHS. Would paying nurses more change that? ***Heather Loane (LSE)*** *explains the changes that would be more likely to motivate staff to work during a pandemic.*

Space, stuff and staff all limit the ability of healthcare staff to look after COVID-19 patients. Of these, shortages of skilled staff are the most difficult to tackle at scale and quickly. So knowing what drives workforce participation can help with planning the healthcare budget.

The available evidence – from surveys during previous outbreaks of infectious disease, or studies of motivation in non-pandemic conditions – suggests paying people more would not reduce nursing shortages during the pandemic. Nurses are already highly motivated to work, so wages are unlikely to be a key motivator. What nurses want is a safe environment in which to work and recognition of their caring responsibilities outside of the work environment. Using the healthcare budget to provide these will likely improve workforce participation more than simply raising nursing wages.

A nurse in Sheffield rallies for a 15% pay rise, September 2020. Photo: Tim Dennell via a CC-BY-NC 2.0 licence

What motivates nurses in non-pandemic conditions?

A shortage of healthcare workers, particularly qualified nurses, has been an issue for many years. As in other jobs, these workers might increase or decrease their hours based on money, the conditions under which they work, and the value they place on their time outside of work.

Wages are not the main driver of the decision for a nurse to increase her or his hours. A study of nurses in the UK National Health Service found that they are relatively underpaid compared with people of similar levels of education. But international examples suggest that increasing pay would not increase the supply of nurses. For example, an earlier study of nurses in Finland found that increasing a nursing wage by 10% would only increase the chance of a non-working nurse going back into nursing by 0.1%. There is still a shortage of nurses in the United States, where nurses are relatively overpaid compared to other equivalently educated people. In Australia, nurses and midwives would be willing to earn less if their job provided them with autonomy, preferred working hours, and processes to deal with workplace violence and bullying. Furthermore, there is evidence to suggest that raising the wages for a specific types of nursing like the night shift might make these more attractive, but would not lead to an increase in the overall workforce. Instead, it could come at the expense of other types of nursing.

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Nursing remains a profession dominated by women. Flexible jobs that can align to family and childcare responsibilities are favoured. Nurses are less likely to work increased hours if their partner is well-paid than if they are single or the partner is unemployed or low-paid. And nurses with young children are less likely to work than nurses without children. Employer-sponsored childcare is associated with an increase in hours worked.

What about working in a pandemic?

The willingness to work during a pandemic has been considered many times by economists and managers, but there is little consensus globally. The majority of information comes from surveys. While survey respondents are always readier to work in an imagined scenario than they are in real life, overall healthcare workers are willing to work – and many even believe they are obliged to do so. Non-clinical support staff are less likely than doctors and nurses to be willing to work, and this extra workload can fall onto nursing staff.

But sometimes healthcare workers work when their patients may prefer them not to; there are no studies available yet on healthcare worker behaviour in the COVID-19 outbreak, but a survey in 2015 found that 40% of healthcare workers would go to work with influenza-like symptoms. Common reasons for this are “I didn’t think I was contagious”, “I wasn’t feeling bad enough”, “I have an obligation to my co-workers” and “it is difficult to find cover”. Among low-paid workers, particularly in long-term care, “I could not afford to lose the pay” is the most common reason for going to work with flu-like symptoms.

Nurses are less likely to work if they believe there a personal danger to themselves or the risk of taking the contagious disease home to their families; according to previous studies, people with children, elderly relatives and even pets may be less willing to work. Based on the gender imbalance in care responsibilities, it follows that women are less likely to be willing to work than men.

Is the COVID-19 pandemic different?

This pandemic is different from previous pandemics. Previous pandemics have not caused a major economic crisis in addition to the one in public health. When we look at nurse willingness-to-work during an economic crisis, rather than during a pandemic, it is clear that rates of pay become important. If their partner becomes unemployed, previously non-working nurses will re-enter the workforce. Globally, the nursing labour force tends to increase during recessions, with household income being a key motivator.

What can management do?

Many of the barriers to willingness or ability to work are at least partially amenable to interventions.

- Firstly, perceived risk of physical illness to a worker and their family can be reduced by providing adequate supplies of Personal Protective Equipment (PPE), with training in donning and doffing safely.
- Secondly, staying at home when unwell helps to prevent the spread of illness. This behaviour must be encouraged through education and through staff screening policies. It must also be supported financially with paid sick leave through employers or through statutory sick pay. Filling gaps caused by sick leave is necessary for morale.

That said, an undersized workforce and a high patient turnover rate make it more difficult to practice adequate infection control and this can lead to staff becoming overwhelmed. Contract labour is of limited value, because of lack of skills and local knowledge. Consequently, local staff should receive extra training as soon as possible, in anticipation of losing some employees. The length of physically and psychologically intense shifts should also be considered. Although academic modelling suggests that batching groups of healthcare workers together into longer days will limit potential exposure to infection, lengthening the work day in response to short-staffing is associated with a reduction in morale and an increased risk of error.

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Psychological overwhelm can also be addressed by timely and relevant communication. A recent study in Spain compared the leadership and management style in hospitals with low and high rates of staff infected with coronavirus. Staff infection rates were higher in hospitals where staff did not display trust in their management and vice versa. Hospitals where management provided enough information for shared decision making, including clear communication of priorities and objectives, had the lowest level of staff infection.

The COVID-19 crisis is likely to require millions of additional nursing work hours. Further research is urgently needed to determine nurses' motivations in this twin crisis that affects both health and the economy. The economic downturn may be enough to lure nurses back into the workforce, particularly if rates of pay are increased. Keeping those nurses in the workforce will require investment in provision of sick pay, sick pay for all workers, ensuring adequate PPE is available in all healthcare settings and ensuring staff get timely communication and support to allow them to provide high quality care.

This post represents the views of the author and not those of the COVID-19 blog, nor LSE.

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