ISSN: 2643-6892
Iris Journal of Nursing & Care
DOI: 10.33552/IJNC.2023.04.000583
Iris Publishers

Short communication

Nursing & Care at a Critical Juncture or Impasse?

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Received Date: January 23, 2023

Published Date: January 30, 2023

Abstract

The purpose of this short paper is to set out where the profession of nursing and care may stand – potentially facing a critical juncture or, at least, an impasse with respect to its future direction.

Review

This short paper is intended to enable debate within the nursing & caring profession as to where it may currently "be" as a means of enabling potential future direction. It is not written by a subject matter expert, a nursing academic, or a medical practitioner. It is, nevertheless, written by someone who, humbly, cares and has undertaken deep research into complex socio-info technological (human-IT) systems, over many years. The author has also been a patient and witness, perhaps, both to less good nursing practices, and the very best. This paper considers health economics, with respect to professional development since 1948, and the founding of the UK National Health Service. It looks at the current affordability of nursing and care in the, post-COVID, world.

Health Economics

This paper does not argue that the UK NHS is the best example – there are equally good if not better services, elsewhere. It does, though, represent a useful starting point, at the end of WW2 and about a third the way through the Industrial Age (approx. 1930-1975). In 1948, the life expectancy of a British male was about 65 years (compared to 79, in 2011)[1] and a female, 70 years (c.f., about 83 in 2011). At that time, men retired at 65 and women at 60 (c.f., 66/7 today, for both men and women). It could be argued that, actuarily, the 1948 UK Health Economy was affordable, precisely because there was near-full (male) employment, and the "average" male would not live long into retirement. More recent studies, see, for example, Alemayehu & Warner [1], indicate that: Nearly one-third of lifetime [health] expenditures are incurred during middle age [40-60], and nearly half during the senior years [61-85]. For [those aged] 85, more than one-third of their lifetime expenditures will accrue in their remaining years [86+].

[1]How has life expectancy changed over time? - Office for National Statistics (ons.gov.uk), accessed Jan 2023.

Triage

Triage, from the French trier (to sort, or separate) was practiced by late-medieval armies, before being realised in its modern form during WW1. Where the wounded are divided into three categories:

1. Those for whom immediate care may make a positive difference in outcome (and may return to the front in weeks).
2. Those likely to live, regardless of what care they receive (and who may return to the front in months).
3. Those unlikely to live, regardless of what care they receive (and who will never return to the front).

Triage was based on classical combat fatality-injury ratios of about one fatality, for every 4 (non-related) injuries. The Author examined UK and U.S. reported fatality-injury rates in Iraq, and Afghanistan [2]. These confirmed that the ratio of 1:4 had changed significantly. From one to nineteen during the Vietnam War, to between 1:30 and 1:50 in Iraq and Afghanistan. Lessons from both conflicts, confirmed survivability of seriously injured personnel was significantly improved if they were recovered within the "Golden hour": "the recommended amount of time for [para-] medical services are less than 10 minutes at the location of the trauma before transporting" [3].

Quatrage

Defense economics cost each fatality at about $1Million. What became apparent, was that a fourth level – termed quatrage (after the French for 4) – had emerged. In which severely injured service personnel[2], with multiple trauma injuries were surviving, where they would have died in previous wars [4]. The scale of quartrage-level injuries broke Defense (and Healthcare) economies. Even allowing for a shortened life expectancy of 15-years from injury, quartrage injuries will likely require full-time, 24/7, care for the rest of life. Without, probably, being able to work again. Actuarily, quatrage-level patients may cost between $16.75M and $30M ($1.1-1.9M a year, $200,000 per patient) to look after. Compared to a "one-off" $1M, per fatality. When questioned, A&E medical staff admitted to the author that they were also dealing with quatrage–patients, who may not have survived in the 20th Century.

Health Cost Inflation

Defense Cost Inflation in peacetime runs at a compound rate of between 6-8% a year [5,6]. It is not unreasonable to suggest a similar level of Health Cost Inflation (HCI). Allowing for inflationary-adjusted increases to budgets, a HCI of 8% means "fleet" numbers halving every 25 years. At the same time more- and more sophistication, has been added to the reducing numbers of ships/aircraft/tanks. For fleets, it is possible to read hospitals. Increasing centralization of more sophisticated, specialist hospitals – at the expense of general, community hospitals.

Fractional Specialization

1980s style Performance Management (Lean etc.) introduced job "fractionation" as a way of "reducing costs" (optimizing /efficiency) by "reducing skill contribution" and, thereby, "investment in the individual". "Optimization by fractionation" treats individuals as machines. In the public services, it meant 'more for fewer people' [7]. Or, absurdly, providing more care, through less care! Fractionation may also mean specialization – which can lead to demarcation, and division. Every specialty requiring its own governance and management – often transferring power from the profession to managers. Currently, Australia recognizes six types of nursing, of which other studies acknowledge up to 20 specialist categories[3]. With increasing numbers of nurses specializing, rather than going into management – it could be argued that specialism has defeated generalism? Where the Registered General Nurse may no longer be the benchmark of the profession?

Juncture

The nursing profession might be at a critical juncture – where, through increased demands (ageing populations, quatrage), HCI, fractionation, and [over?] specialization, it is no longer affordable? [8]. Given the nursing population (90.6% female (reducing); average age fifty-two)[4], it may also be unsustainable. Ways might need to be found for increasing recruitment – possibly by returning to generalism? Led by the nursing profession – not the management-accountant elites.

Acknowledgment

None.

Conflict of Interest

No conflict of interest.

[2] According to BBC and *Guardian reporting* (2014), 98.5% of UK fatalities and Injuries in Iraq and Afghanistan were male.

[3]The 6 kinds of nurses in Australia - Hellocare (hellocare.com.au) and Types of Nurses: 20 Growing Nursing Specialties to Start Your Career (gmercyu.edu), accessed Jan 2023.

[4]Nursing Statistics 2022 - By the Numbers | Carson-Newman (cn.edu), accessed Jan 2023.

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