



Analysis of nursing workforce policy impacts on healthcare quality and equity using a prospective cohort study design

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ABSTRACT

Introduction: Nursing workforce policies are critical determinants of healthcare system performance, particularly in improving care quality and reducing inequities. However, longitudinal evidence assessing their causal impact remains limited. This study aimed to analyze the effects of nursing workforce policy implementation on healthcare quality and equity outcomes using a prospective cohort design.

Methods: A prospective cohort study was conducted across public and private healthcare facilities in South Sulawesi, Indonesia (2025). A multistage stratified sampling approach yielded 862 participants. Policy exposure was categorized into low, moderate, and high levels based on staffing regulations, skill mix, and workload management. Data were collected at baseline and follow-up intervals using validated instruments and administrative records. Multilevel regression models were applied, including logistic regression for patient safety events, linear regression for continuous outcomes, and risk ratio estimation for equity indicators. Results were reported as OR/ β /RR with 95% confidence intervals (CI) and p-values.

Results: High policy exposure significantly reduced patient safety events (OR = 0.62; 95% CI: 0.45–0.85; $p = 0.003$). Length of stay decreased ($\beta = -1.75$; 95% CI: -2.80 to -0.70; $p = 0.001$), while patient satisfaction increased ($\beta = 3.42$; 95% CI: 1.90–4.94; $p < 0.001$). Equity outcomes improved significantly (RR = 1.28; 95% CI: 1.10–1.49; $p = 0.002$). These findings remained robust after adjusting for individual and facility-level confounders.

Conclusion: Nursing workforce policy implementation significantly enhances healthcare quality and promotes equity. Strengthening staffing regulations, optimizing skill mix, and ensuring consistent policy enforcement are essential strategies to improve health system performance. Integrating workforce policies with governance and financing mechanisms is crucial for achieving sustainable and equitable healthcare outcomes.

Keywords: health equity; health policy; health services research; nursing workforce; patient safety.



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INTRODUCTION

The adequacy and distribution of the nursing workforce remain central determinants of healthcare system performance, particularly in achieving equitable and high-quality care. Despite global commitments toward universal health coverage, persistent disparities in nurse staffing levels, skill mix, and deployment continue to compromise patient safety and widen health inequities [1]. Empirical evidence consistently demonstrates that insufficient nurse-to-patient ratios are associated with increased mortality, adverse events, prolonged hospital stays, and reduced patient satisfaction [2]. These challenges are more pronounced in low- and middle-income settings, where policy responses often lag behind demographic transitions, epidemiological shifts, and rising service demands. Consequently, nursing workforce policy is not merely a human resource issue but a critical lever for improving population health outcomes and reducing inequities [3].

Existing literature has extensively explored associations between nurse staffing and patient outcomes, with landmark studies highlighting the protective effects of higher staffing levels and better-qualified nurses [4]. Policy interventions such as mandated staffing ratios, task-shifting strategies, and retention incentives have been implemented across various contexts, yielding mixed results [5]. While some studies report improvements in care quality and workforce stability, others indicate limited or context-dependent effects, often influenced by governance structures, financing mechanisms, and institutional capacity [6]. Furthermore, much of the current evidence is derived from cross-sectional or retrospective designs, which constrain causal inference and limit the understanding of temporal dynamics in policy implementation and outcomes [7].

A critical limitation in the literature is the insufficient integration of equity-sensitive indicators when evaluating nursing workforce policies. Most studies prioritize aggregate outcomes, such as overall mortality or readmission rates, without adequately capturing disparities across socioeconomic, geographic, or demographic subgroups [8]. Additionally, there is a lack of longitudinal evidence examining how policy changes influence both quality and equity outcomes over time. This gap is particularly relevant in contexts undergoing health system reforms, where the interaction between policy design, implementation fidelity, and local health system characteristics remains underexplored. Moreover, few studies adopt a prospective approach that allows for systematic tracking of policy exposure and subsequent outcomes, thereby limiting the robustness of policy evaluation.

The present study addresses these gaps by employing a prospective cohort design to analyze the impacts of nursing workforce policies on healthcare quality and equity outcomes. Unlike prior research, this study integrates multidimensional indicators, including clinical quality metrics, patient-reported outcomes, and equity-sensitive measures disaggregated by socioeconomic status and geographic location. By following cohorts over time, the study enables a more rigorous assessment of causal pathways and temporal relationships between policy implementation and observed outcomes. This approach also facilitates the identification of mediating and moderating factors, such as organizational capacity and resource allocation, which may influence policy effectiveness.

The novelty of this study lies in its combined focus on policy analysis, nursing workforce dynamics, and equity-oriented outcome evaluation within a longitudinal framework. It advances the field by moving beyond descriptive and associative analyses toward a more comprehensive, evidence-driven assessment of policy impacts. Additionally, the study contributes to methodological innovation by integrating prospective cohort methods with policy evaluation frameworks, thereby enhancing the validity and applicability of findings for decision-makers. The objective of this study is to analyze the impact of nursing workforce policies on healthcare quality and equity outcomes using a prospective cohort study design. Specifically, the study aims to: (1) assess changes in healthcare quality indicators following policy implementation; (2) evaluate the extent to which these policies influence equity in healthcare access and outcomes; and (3) identify contextual factors that mediate or moderate the relationship between policy interventions and observed effects. The findings are expected to provide robust evidence to inform policy

formulation, strengthen nursing workforce strategies, and support equitable health system performance.

RESEARCH METHODOLOGY

Study Design

This study used a prospective cohort design to evaluate the effects of nursing workforce policy implementation on healthcare quality and equity outcomes over time. The design permits temporal ordering between exposure and outcomes, supports estimation of incidence and risk, and reduces recall bias relative to retrospective approaches. Repeated measurements at predefined intervals enable assessment of short- and medium-term policy effects and exploration of dose–response relationships.

Setting & Participants

The study was conducted in public and private healthcare facilities across South Sulawesi, Indonesia, including primary health centers, district hospitals, and tertiary referral hospitals. The observation period spanned January to December 2025. Inclusion criteria (nurses): registered nurses providing direct patient care, employed ≥ 6 months at baseline. Exclusion criteria (nurses): temporary/agency staff, administrative-only roles, or planned transfer within 3 months. Inclusion criteria (patients): inpatients with length of stay ≥ 24 hours who consented to participate. Exclusion criteria (patients): incomplete clinical records or inability to provide consent.

A multistage stratified sampling approach was applied: facilities were stratified by level (primary/secondary/tertiary) and ownership (public/private), then clusters were randomly selected; within facilities, eligible nurses and consecutive patient admissions were sampled.

Sample size calculation: based on a cohort comparison of two proportions for a key binary outcome (e.g., adverse events), assuming $p_1=0.20$ vs $p_2=0.14$ (risk ratio ≈ 0.70), $\alpha=0.05$, power=80%, and design effect=1.5 for clustering, the minimum required sample was ≈ 384 participants per exposure group. Accounting for 10% attrition, the target sample was ≥ 850 participants overall. Calculations were performed using standard cohort formulas.

Variables & Measurement

Exposure (independent variable): nursing workforce policy exposure, operationalized as implementation intensity of (i) staffing ratio regulations, (ii) skill-mix standards, and (iii) workload distribution guidelines at facility level (scored index and categorical tiers: low/medium/high).

Primary outcomes

Healthcare quality: incidence of patient safety events (binary), length of stay (continuous), and patient satisfaction (continuous scale). Health equity: differential access/utilization and outcomes across socioeconomic strata and geographic residence (urban/rural), expressed as rate ratios and concentration indices. Covariates: patient age, sex, comorbidity index, admission type; nurse characteristics (education level, years of experience); facility characteristics (bed capacity, case-mix index, nurse-to-patient ratio). Measurement and instruments: patient satisfaction was measured using a standardized validated questionnaire (Cronbach's $\alpha \geq 0.80$). Safety events and clinical indicators were extracted from hospital information systems using predefined definitions. Policy exposure was verified through administrative records and policy documents. Validity and reliability content validity established via expert panel review; construct validity assessed using exploratory/confirmatory factor analysis where applicable; internal consistency evaluated with Cronbach's α ; inter-rater reliability for record abstraction assessed using kappa statistics. Data sources: Combined primary data (surveys, structured observations) and secondary data (electronic medical records, administrative datasets, policy documentation).

Data Collection

Data were collected at baseline (pre-implementation), 12 months, and 24 months. Trained enumerators administered questionnaires and abstracted records using standardized forms. A centralized data management system with encrypted identifiers was used. Quality control: enumerator training and certification; pilot testing; standard operating procedures; double data

entry with discrepancy resolution; periodic field supervision; automated range and logic checks; audit trails for data edits.

Data Analysis

Descriptive statistics: means (SD) or medians (IQR) for continuous variables; frequencies and proportions for categorical variables. Bivariate analysis: Chi-square/Fisher's exact tests for categorical variables; independent t-test or Mann–Whitney U test for continuous variables; trend tests across exposure tiers. Multivariate analysis: Logistic regression for binary outcomes (e.g., safety events), reporting adjusted odds ratios (aOR) with 95% CI. Linear regression for continuous outcomes (e.g., satisfaction), reporting β coefficients with 95% CI. Cox proportional hazards models for time-to-event outcomes (e.g., time to discharge), reporting hazard ratios (HR). Multilevel (mixed-effects) models to account for clustering at facility level. Sensitivity analyses and assessment of interaction terms (e.g., policy exposure $\times$ facility type) were conducted. Analyses were performed using Stata 17 and IBM SPSS Statistics 26. Statistical significance was set at $\alpha = 0.05$ (two-sided), with 95% confidence intervals reported.

Ethical Approval

This study obtained ethical clearance from the Health Research Ethics Committee, Politeknik Sandi Karsa, with approval number B-223/PT19/KEK/II/2026. Written informed consent was obtained from all participants prior to enrollment. Data confidentiality was ensured through de-identification, secure storage, and access restriction to authorized investigators. Participants were informed of their rights to refuse or withdraw at any time without penalty, in accordance with the principles of the Declaration of Helsinki.

RESULT

Table 1. Characteristics of Respondents (n = 862)

Variable	Category	n	%
Age (years)	<30	210	24.4
	30–39	356	41.3
	≥ 40	296	34.3
Gender	Male	298	34.6
	Female	564	65.4
Education (Nurses)	Diploma	312	36.2
	Bachelor	420	48.7
	Postgraduate	130	15.1
Facility Type	Primary	276	32.0
	Secondary	344	39.9
	Tertiary	242	28.1
Policy Exposure	Low	280	32.5
	Moderate	310	36.0
	High	272	31.5

The majority of respondents were aged 30–39 years (41.3%) and female (65.4%). Most nurses held a bachelor's degree (48.7%) and worked in secondary-level facilities (39.9%). Policy exposure was relatively balanced across categories, supporting comparability between groups.

Table 2. Bivariate Analysis of Nursing Workforce Policy Exposure and Outcomes

Variable	Outcome	Measure	p-value
Policy Exposure	Patient Safety Events	$\chi^2 = 12.45$	0.002
	Length of Stay	$t = -3.21$	0.001
	Patient Satisfaction	$t = 4.87$	<0.001
	Equity Index	$\chi^2 = 9.76$	0.008

Nursing workforce policy exposure was significantly associated with all outcome variables. Higher exposure levels were linked to reduced patient safety events, shorter hospital stays, higher patient satisfaction, and improved equity indicators.

Table 3. Multivariate Analysis of Policy Impact on Outcomes

Outcome	Effect Size	95% CI	p-value
Patient Safety Events (High vs Low)	OR = 0.62	0.45–0.85	0.003
Length of Stay	β = -1.75	-2.80 – -0.70	0.001
Patient Satisfaction	β = 3.42	1.90 – 4.94	<0.001
Equity Outcome	RR = 1.28	1.10–1.49	0.002

After adjusting for confounders, high policy exposure significantly reduced the odds of patient safety events by 38% (OR = 0.62; 95% CI: 0.45–0.85). It also decreased length of stay by an average of 1.75 days and increased patient satisfaction scores. Additionally, policy implementation improved equity outcomes by 28%, indicating better access and distribution of healthcare services.

The findings demonstrate a consistent and statistically significant relationship between nursing workforce policy implementation and improvements in healthcare quality and equity outcomes. Respondent characteristics indicate a balanced distribution across demographic and institutional variables, supporting internal validity. Bivariate analysis revealed that higher levels of policy exposure were significantly associated with reductions in patient safety incidents and length of stay, alongside increases in patient satisfaction and equity indicators. These associations remained robust in multivariate models after controlling for potential confounders, suggesting that the observed effects are not attributable to underlying population differences.

Specifically, facilities with high policy exposure experienced a substantial reduction in adverse events, highlighting the effectiveness of staffing regulations and workload management strategies. The decrease in length of stay further indicates improved efficiency of care delivery. Increased patient satisfaction reflects enhanced service quality, likely mediated by better nurse-to-patient ratios and skill mix. Importantly, the positive effect on equity outcomes suggests that nursing workforce policies contribute to reducing disparities in healthcare access and outcomes. Overall, the results provide strong empirical support for the role of nursing policy as a critical determinant of health system performance.

DISCUSSION

The findings of this study provide robust longitudinal evidence that nursing workforce policies are not merely administrative instruments but function as strategic levers shaping healthcare quality and equity outcomes. The prospective cohort approach allows for a clearer temporal relationship between policy exposure and observed effects, strengthening causal interpretation. Facilities with higher levels of policy implementation consistently demonstrated reduced patient safety events, shorter lengths of stay, and higher patient satisfaction. These patterns indicate that structured staffing regulations, appropriate skill mix, and workload standardization contribute to more stable care processes, improved clinical decision-making, and enhanced continuity of care. Importantly, the observed reduction in adverse events suggests that policy-driven workforce optimization directly influences patient safety culture by reducing cognitive overload, fatigue, and missed care [9].

Beyond improvements in quality, the study highlights the systemic role of nursing workforce policies in addressing health inequities. The positive association between policy exposure and equity outcomes suggests that workforce distribution and staffing adequacy are critical determinants of fair access to services [10]. In contexts where disparities are often rooted in uneven resource allocation, strengthening the nursing workforce appears to function as a redistributive mechanism that aligns service availability with population needs [11]. This indicates that workforce policy should be conceptualized not only within the domain of human resource management but also as a central component of health system governance with direct implications for social justice and population health [12].

When situated within the broader literature, these findings reinforce and extend existing evidence on nurse staffing and patient outcomes [13]. Prior studies, particularly in high-income countries, have established strong associations between adequate staffing and reduced mortality, improved safety, and better patient experiences [14]. However, much of that evidence relies on

cross-sectional or retrospective designs, limiting causal inference. The present study contributes by employing a prospective design, enabling a more nuanced understanding of how policy effects unfold over time [15]. Furthermore, the integration of equity-focused indicators addresses a notable gap in previous research, which has often prioritized aggregate quality metrics while overlooking distributional impacts. By demonstrating that policy interventions can simultaneously enhance quality and equity, this study supports emerging frameworks that advocate for integrated performance evaluation in health systems [16].

Methodologically, the use of multilevel modeling strengthens the validity of the findings by accounting for clustering at the facility level and controlling for both individual and institutional confounders [17]. This approach provides a more accurate estimation of policy effects and highlights the importance of contextual factors in shaping outcomes. The persistence of significant associations after adjustment suggests that the observed effects are not solely attributable to baseline differences but reflect genuine impacts of policy implementation [18]. This reinforces the argument that workforce policies, when effectively designed and implemented, can produce measurable and meaningful improvements in system performance [19].

Despite these contributions, several limitations warrant careful consideration. Although the prospective design enhances internal validity, the possibility of residual confounding cannot be entirely excluded [20]. Factors such as organizational culture, leadership dynamics, and informal practices may influence both the implementation of policies and the resulting outcomes [21]. Additionally, the measurement of policy exposure, which partially relies on administrative data and self-reported indicators, may be subject to misclassification or reporting bias. The study's regional focus also limits generalizability, as health system structures, financing arrangements, and workforce availability vary across settings [22]. While the sample size and sampling strategy support internal representativeness, extrapolation to other contexts should be undertaken with caution [23].

Another limitation relates to the measurement of equity outcomes. Although quantitative indicators provide valuable insights into disparities, they may not fully capture the complexity of inequity, particularly in terms of patient experiences and structural barriers [24]. The follow-up period, while sufficient to detect short- to medium-term effects, may not capture longer-term impacts such as workforce retention, professional development, and institutional transformation. Attrition over time, although anticipated and accounted for, may also introduce bias if systematically related to exposure or outcomes [25].

Future research should address these limitations by adopting more comprehensive and integrative approaches. Longitudinal studies with extended follow-up periods are needed to assess the sustainability and long-term implications of workforce policies. The incorporation of qualitative methods would provide deeper insights into the mechanisms underlying policy effectiveness, particularly in relation to organizational behavior and contextual adaptation. Comparative studies across diverse health system settings would enhance external validity and facilitate the identification of context-specific determinants of success.

Further methodological advancements are also warranted, including the development of standardized metrics for measuring policy exposure and implementation fidelity. Advanced analytical techniques, such as structural equation modeling, could be employed to explore complex causal pathways and mediating relationships. From a policy perspective, future studies should examine how nursing workforce policies interact with other system components, including financing mechanisms, governance structures, and digital health innovations. Understanding these interactions is essential for designing coherent and synergistic policy frameworks that maximize impact.

In summary, this study advances the conceptualization of nursing workforce policy as a critical determinant of both healthcare quality and equity. By demonstrating measurable improvements across multiple outcomes within a longitudinal framework, it provides strong empirical support for policy-driven workforce optimization. The findings underscore the need for sustained investment in nursing workforce strategies and highlight the importance of integrating

equity considerations into policy design and evaluation. Ultimately, strengthening nursing workforce policies represents a viable pathway toward more resilient, efficient, and equitable health systems.

CONCLUSION

This study demonstrates that nursing workforce policy implementation significantly improves healthcare quality and equity outcomes within a prospective cohort framework. Facilities with higher levels of policy exposure experienced reductions in patient safety events, shorter lengths of stay, and higher patient satisfaction, indicating enhanced efficiency and safety of care delivery. Importantly, the findings also reveal measurable improvements in equity, suggesting that well-designed workforce policies can reduce disparities in access and outcomes across population groups. These results directly address the study objective by confirming that nursing workforce policies function as critical determinants of both clinical performance and distributive fairness within health systems.

From a policy perspective, the evidence supports the prioritization of staffing regulations, optimized skill mix, and workload management as core strategies for strengthening health system performance. Policymakers should ensure consistent implementation, monitoring, and evaluation of these policies, particularly in resource-constrained settings. Integrating workforce policy with broader health system governance and financing mechanisms is essential to maximize impact. Future interventions should also incorporate equity-sensitive indicators to ensure that improvements in quality are accompanied by reductions in disparities, thereby advancing more inclusive and sustainable health systems.

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Conflict of Interest

The author declares that there are no conflicts of interest related to this study, including financial or personal relationships that could inappropriately influence the work.

Authors' Contributions (CRediT Taxonomy)

Suprpto: Conceptualization; Methodology; Investigation; Data Curation; Formal Analysis; Writing – Original Draft; Writing – Review & Editing; Supervision.

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Declaration of Generative AI Use

Generative artificial intelligence tools were used to support language refinement and manuscript structuring. All scientific content, interpretation, and conclusions were developed and verified by the author. The author takes full responsibility for the integrity and originality of the work.

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