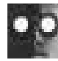
The Capacity to Change? Workforce Growth in the Health Sector: A U.K. Perspective



COMMENTARY

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ABSTRACT

Canada is not alone in having to face up to significant human resource (HR) challenges as it debates how healthcare should be managed and delivered in the 21st century. The United Kingdom is having to deal with many similar issues related to demographic change, skills shortages and the drive to "modernize" public services. This commentary highlights some of the main dimensions of HR-related change in the U.K. National Health Service (NHS) to counterpoint the main messages in the lead paper. The primary focus is on examining the key HR aspects of achieving sustained improvement in staffing levels, mix and motivation.

THE U.K. GOVERNMENT is committed to "growing" the NHS workforce as part of an overall NHS Plan. Increases in NHS staffing growth are being made highly visible by establishing specific growth targets. They are being achieved by providing incentives to attract back "returners" to the NHS (staff who had previously left the NHS), by improving retention, by increasing significantly the numbers recruited from other countries, and by increasing the numbers of student physicians and nurses currently in pre-registration education.

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Associated initiatives are underway to change the pay and career structure in the NHS in order to achieve improved staff retention and motivation and to support new roles and skill mix. This paper stresses that the ultimate target should not be "more" nurses or physicians – it should be better care. It highlights the need for sufficient HR policy and management capacity to align HR objectives with broader health system goals.

"The right staff with the right skills in the right place at the right time." The old mantra of the workforce planner retains some relevance, even at a time of radical change in many healthcare systems. It just gets ever more difficult to determine what is meant by "right."

Canada is not alone in having to face up to significant human resource (HR) challenges as it debates how healthcare should be managed and delivered in the 21st century. The United Kingdom is having to deal with many similar issues related to demographic change, skills shortages, the drive to "modernize" public services and the never-ending search for the healthcare holy grail of getting more for less, without undermining quality of care.

The U.K. National Health Service (NHS) is funded from general taxation and is free at the point of delivery. As with any healthcare system, the NHS is a labour-intensive service industry. The NHS workforce is large, with more than one million mainly unionized staff working in several hundred hospital and primary care units. A truism often used to explain the slow pace of change in the NHS is that it is the third largest employer in the world, after the Chinese army and the Indian railways. This commentary highlights some of the main dimensions of HR-related change in the NHS, to counterpoint the main messages in the lead paper. The primary focus is on examining the key HR aspects of achieving sustained improvement in staffing levels, mix and motivation.

Reforming the NHS

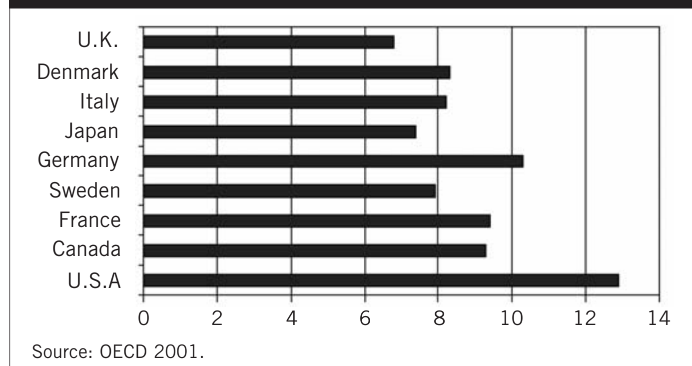
Over the last 10 years there have been two separate and distinct attempts to reform the U.K. NHS: the first by the Conservative governments of 1991–97, the second by the Labour government led by Tony Blair, which has been in office since May 1997. Workforce issues and human resources featured very differently in the two sets of reform packages.

The Conservative reforms of the 1990s, initiated by Margaret Thatcher, were based on decentralization of managerial responsibility and the creation of an internal market. Beyond the general assumptions underpinning the Thatcher reforms that devolution, decentralization and flexibility should be articles of faith in the post-reform management of the NHS, there was no detailed HR blueprint for change. There were, however, plenty of HR assumptions and biases. These included the assumption that the national NHS pay system was ripe for replacement by local pay bargaining and that there was scope to achieve cost savings through changed staffing patterns and skill mix. However, the actual pace of change in the ways NHS HR issues were managed was slow – much slower than the Conservative government would have hoped or envisaged.

Three main factors can be identified that explain the slow pace of change. First, there was not sufficient management capacity in many NHS units to lead and sustain HR-related change. Second,

the 1990s were a time of public sector fiscal restraint, and there was little in the way of additional resources available to underwrite the costs of change. Most initiatives had to be funded from local efficiency improvements. Third, workforce planning and HR were not explicitly considered within the program of reforms. These issues may have been regarded as the means to the end of a reformed NHS, but the "means" were neither articulated fully nor resourced adequately.

Figure 1: Expenditure on Healthcare as Percentage of GDP



Source: OECD 2001.

The election of the first Labour government in almost 20 years, in May 1997, signalled the end of the internal market but further reorganization of the NHS. Lessons could be learned from previous failures with health sector reform and with a relative lack of focus on HR issues (Buchan 2000). Under Labour, there has been a renewed emphasis on partnership with staff, and on managing staff performance. HR is now highlighted explicitly as a key element in improving health service delivery.

The NHS Plan

The last three years in the United Kingdom have been dominated by debate about how, and by how much, to fund healthcare. The United Kingdom has lagged near the bottom of the league table of expenditure on healthcare in developed countries, as measured by proportion of gross domestic product (GDP) (see Figure 1). In 2000, the U.K. government made a commitment to raise expenditure to "the European average."

Having reviewed alternatives, a report on long-term prospects for the NHS (Wanless 2002) has reaffirmed a commitment to a tax-based public sector system. The U.K. government has responded by increasing expenditure on the NHS, and in its budget in April 2002 gave notice that it will raise taxation to support further funding increases over the next six years. The April 2002 projections are for expenditure to increase by an average of 7.5% per annum in real terms in each of the next five years (Department of Health 2002).

The NHS Plan sets out a comprehensive approach to reorganization of the NHS. It was launched in 2000, and all the major health sector unions and professional associations signed up to its approach. It represents a five-year program of reform – "modernization" in the language of "New" Labour. The emphasis in the NHS Plan is on establishing and achieving health gain targets and maintaining a performance management culture. The overall approach recognizes the need to involve healthcare staff in decision-making and to ensure that they are appropriately skilled and are deployed in sufficient numbers.

"Growing" the Healthcare Workforce

It is widely acknowledged that the shortage of skilled staff is one of the main risk areas in achieving the targets. The

Wanless report stressed that "the U.K. does not have enough doctors and nurses" (Wanless 2002). The response by government has been an explicit commitment to "grow" the NHS workforce, made highly visible by establishing specific staffing growth targets, such as the target set in the year 2000 for "20,000 more qualified nurses by 2004" (equivalent to about a 7% increase in nurse staffing).

Table 1: NHS Staff by selected occupation, NHS England, 1999 and 2001, September (Headcount)

	1999	2001	Numerical change 1999-2001	Approx.% Change 1999-2001
Medical and Dental	70,000	73,850	+3,850	+6%
Healthcare Assistants	25,470	32,960	+7,490	+29%
Qualified Nursing	310,140	330,540	+20,400	+7%
Qualified Allied Health Professionals	47,920	51,320	+3,400	+7%
Admin/Estates	204,620	224,030	+19,410	+9%

Table 1 gives details of staffing growth for the main NHS occupations in England for 1999 to 2001. There has been a 7% growth in qualified nurses in just two years. The target for 2004 has been met two years early. Medical and dental staff and qualified allied health professionals have also increased, and high rates of growth have been recorded for other staff groups. In April 2002 new staffing targets were announced in England – to achieve by 2008 a net increase of 35,000 more nurses and 15,000 doctors (Department of Health 2002).

Meeting the first staffing target for nursing has been achieved primarily by providing incentives (funding and refresher training) to attract back "returners" to the NHS (nurses who had previously left the NHS or left nursing), by improving retention, and by increasing significantly the numbers recruited from other countries – mainly the Philippines, South Africa and Australia. In recent years about one in three "new" nurses entering the U.K. register has come from a non-UK source (Buchan and Seccombe 2002). Pay rates for newly qualified nurses have also been increased.

Future growth in numbers will be supported by growth in numbers of student physicians and nurses currently in preregistration education. Intakes to preregistration nurse education in England grew by 16% between 1998/99 and 2000/01 (Buchan and Seccombe 2002), and are projected to continue rising. Preregistration education for health professionals is conducted in the public sector education system, and government can therefore intervene directly to fund additional training places – assuming there are sufficient well-qualified applicants.

While some of the short-term staffing targets have already been met, questions remain. Was meeting a target of an additional 20,000 nurses sufficient? Will meeting a new target of 35,000 be enough? Staff shortages are not uniformly distributed throughout the NHS. The Southeast of England, particularly London, continues to experience difficulties. The United Kingdom is investing in improving its workforce planning infrastructure but remains far short of having perfect information on supply/demand imbalances. How can we be sure that 20,000 or 35,000 "more" nurses will be enough when we do not have a complete assessment of how many we need?

Any health sector worker is well aware that it is not enough just to get staffing numbers "right." It also matters what skills staff have and how they work together as a team. If government focuses only on the staffing bottom line, it will miss the point. It is not just about getting and keeping the "right" number of nurses or doctors to meet a target or to comply with an indicator. It is about supporting them and motivating them to make the best use of their skills in delivering care. The ultimate target is not "more" nurses or doctors – it is better care.

Getting staffing numbers right is therefore only part of the process. If the U.K. government is to deliver its plans for the NHS, these staff will have to be retained and motivated and some working practices will have to change. Hence the new emphasis on partnership between management and staff in the NHS to improve working lives and the attempt to develop a "fairer" career structure for NHS staff.

What About the Workers?

As in Canada, it has been recognized that sustainable improvements in NHS staff retention and productivity will require improvements in working conditions, job satisfaction, career prospects and pay, including tackling the problem of violence against staff.

A series of initiatives to improve working conditions is being implemented in the U.K. NHS HR performance indicators, including staff turnover and absence, are being used as part of the overall performance management system. All NHS organizations in England also have to participate in the "Improving Working Lives" (IWL) accreditation process. IWL sets out a series of linked HR practices, covering flexible working, healthy working, access to training, childcare provision and staff involvement (Department of Health 2001a).

The NHS also needs a pay and career structure that is responsive to the needs of individual workers and that supports the attainment of organizational and individual goals. The current pay system, in some ways unchanged since the NHS was set up in 1948, is accepted by all stakeholders to be a blockage to meeting NHS Plan objectives. Negotiations on a new pay and career structure for all NHS staff ("Agenda for Change") are, at the time of writing, at an advanced stage. The structure is based on a single job evaluation system for all groups and occupations. It will retain a national pay framework but will have greater flexibility for individual jobs to be "priced," and will probably include a mechanism for pay supplements in the more difficult regional labour markets (Department of Health 2002).

More staff, and "better" paid staff. Two ways of delivering more healthcare – but not the most radical, or necessarily the most effective ways. The third area of action being attempted by government is to win some more bang from the extra bucks by introducing new roles and skill mix for health workers. This is the most challenging area of current HR-related interventions and highlights that a funding increase will not in itself stimulate the type of organizational change that the U.K. government wants for the NHS.

New Work, New Workers or New Ways of Working?

The "Changing Workforce Programme" (CWP) (Department of Health 2001b) is the focal point of government-led

initiatives to encourage new roles and new skill mix. This has involved setting up local pilot sites where a range of different and innovative staffing reconfigurations are being evaluated. Many are underpinned by the introduction of care protocols or pathways.

The current evidence base in the United Kingdom, Canada and other developed countries to support widespread implementation of innovative new approaches to skill mix is weak (Buchan, Ball and O'May, 2001). It is "diagnosis heavy, implementation light." We know more about the nature of the problems related to skills and roles, and proposed interventions than we do about the outcome of applying any of these interventions, in specified situations. CWP aims to encourage more innovation and to network the results of innovation.

It is not possible to identify universal or "ideal" models of skill mix within or between any professions or occupations. What works in the United Kingdom may not work in Canada. We have to take account of and surmount constraints on change relating to country and system-specific legislation, professional regulation and associated organizational factors. Various aspects of the regulation of health professionals are under review in the United Kingdom, and many commentators are advocating a move from a uni-disciplinary to a multidisciplinary framework. The limited evidence base does suggest that there is unrealized scope for extending roles of some groups, such as advanced roles for nursing staff (e.g. Horrocks et al. 2002).

In the United Kingdom there are likely to be two main areas of attention: first, developing further the role of nurse practitioner (and other advanced roles for nurses and other allied health professionals) to free up physicians; second, developing further the role of vocationally qualified healthcare assistants (HCAs) to free up nurses and other health professionals. The Wanless report suggested that nurse practitioners could take on about 20% of work currently undertaken by general practitioner physicians and junior doctors, while healthcare assistants could cover about 12.5% of nurses' current workload (Wanless 2002).

Three HR factors undermined the Thatcher reforms of the 1990s – lack of funding, lack of "visibility" of HR interventions in the program of reform, and lack of HR management capacity. This time round, the Labour government is putting additional resources in place, staffing numbers are increasing and the visibility of HR issues could not be higher. The next few years in the NHS will reveal if we also have developed the capacity to plan and manage sustained HR change in the NHS. It will not just be about "the right people in the right place with the right skills"– it will be about developing the right management in the right place with the right HR skills.

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