Who's going to care?
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1. Introduction

This chapter explores the provision of care and considers possible future developments and the challenges around provision. We begin with a discussion of human resources, posing the question of whether the UK can satisfy the growing demand for carers, both informal and professional. We specifically examine the different types of carer: the self-carer, informal carers and professionals – social carers, nurses, and doctors, and the implications for health and social care policy and consider the implications for these carer roles in society. We also look at current policy on care in the UK.

To encompass all these forms of care, the following working definition is proposed: helping the individual achieve his or her health and wellbeing with the respectful interaction between the person needing and the person giving care. This definition assumes that the type of care being delivered by either an informal or professional will meet certain basic values around respect, dignity, privacy, safety and involvement. (Kendall 2001) The individual has the right to professional care, when their need for care extends beyond their own or any informal carers' ability to deliver it.

Within a health and disease context, there are many different kinds of care. Some definitions of care refer to location (within a hospital setting under professional care, under the auspices of the GP’s expanded facilities, or in the “one-stop health shop” (Davies 2003)), others to who is caring (self-care, informal carer, professional carer), and some to the duration of care or the stage of illness at which care is given (long-term care, residential care, palliative care). Some categories of care overlap. ¹ While definitions are vague on the different types of care, we will point out instead essential features of a successful caring network. The biggest challenge facing us is the current and future shortage of healthcare and social care staff to meet the demand for care. ² This brings us back to the Environmental Scan and the Will Health be a Burden? chapter and the issues of the ageing population and the implications of chronic disease and mental illnesses. One of the challenges must be to think very differently about care, how we deliver it, and perhaps most importantly, how to improve it. For investment into caring, see Who pays and how should the money be spent?

¹ Some examples are of care are self-care, personal care, home care, community care, emergency care, immediate care, intermediate care, long-term care, supportive care, nursing care, social care, hospice and end of life care, palliative care, alternative care, integrated care.
² This workforce is, like the population overall, ageing, yet Wanless predicts that 300,000 more healthcare staff will be needed over the next 20 years - 62,000 more doctors, 108,000 more nurses, and 45,000 more therapists and scientists. Wanless, D. (2002). Securing our Future Health: Taking a Long-Term View. London, The Treasury.
2. The problem of human resources

In this section, we examine the shifting carer roles and point to pressures on the sector, particularly in the area of retention and recruitment. Overall, we are running out of human resources, and we are having trouble retaining and recruiting enough staff. The recent years have seen constant restructuring of the healthcare system in search of the optimum structure. These changes have not been evaluated in terms of cost efficiency and quality – a point we keep coming back to in the chapter. In short, we need research to fill our knowledge gap as to how the restructuring is working before we make more changes.

In the following, we will look at key groups such as informal carers, support workers, and professional carers. Within the professional carers’ group, we will illustrate the problem by looking at doctors and nurses. There are common themes for all staff but we address each group separately.

Self Care

One argument proposed in the Wanless reports is to focus on maximising the individual's self-care potential throughout their life, thereby reducing the need for informal, paid or professional care. (Wanless 2002; Wanless 2004) How this would operate and the investment required in prevention, health promotion, and educational interventions, are areas for further analysis. Not everyone will be capable of caring for himself or herself.

Learning how to self-care will require changes across education and healthcare systems, with more emphasis being placed upon basics such as personal health and wellbeing, fitness, effective parenting and child care, nutrition, and fundamentals of care. As access to information on disease management increases, so self-caring will also extend into the effective and on-going management of chronic illnesses. Initiatives such as the Expert Patient (NHS 2004) and Patient Involvement strategies (CPPIH 2004) demonstrate that individuals prefer to be in control of their own disease management and seek to identify ways of working more effectively with other carers (formal and informal) to help them achieve their optimum healthcare potential.

As the individual’s self-care potential increases, the boundaries between themselves and other carers will be redrawn. Wider issues such as equality of access to information and support (and indeed recognition that some groups may be less equipped to self-care) will require policy interventions. The underlying assumption is that individuals prefer to take care of themselves and that health and social policy priorities are to assist with requisite support mechanisms when self-care starts to fail.
Another dimension of self-care is complementary and alternative medicine (CAM). The drive for alternative and complementary medicine has often happened when patients are not satisfied with conventional healthcare concerning the treatment and the experience of care, and because CAM is seen as safer, more natural, and, most significantly, because patients feel more involved and in control of their treatment. (Lee-Trewek and Oerton 2003) There is a lack of evidence to support CAM, still there has been sustained growth in the UK and this is set to continue. (Dixon, Saka et al. 2003) Such trends need to be monitored carefully in order to understand what it is about CAM that patients like despite the lack of evidence of effectiveness of CAM.

Informal carer

Surveys measuring the hardships of caring may be conducted with carers who are new to the services or who have sought support because they are experiencing difficulties. As such, the survey results should be read with caution but they may illustrate some of the issues facing carers.

It is estimated that there are 16 million so-called informal carers who represent the equivalent of 1.7 million full-time employed care-givers, performing a range of tasks including shopping, cleaning, washing, administering medication, and treating pressure sores. (Henwood 2001) New research has estimated that more than one million young people (7-19 years olds) may be involved in caring roles. (The Princess Royal Trust for Carers 2004)

It is estimated that one in five people will become a carer during their lifetime. (Carers UK 2002) A woman has a 50-50 chance of becoming a carer by her 59th birthday, and a man the same odds by the time he is 74. (Carers UK 2002) Every year, it is estimated that 301,000 people become carers and the number has remained stable since 1985 accounting, on one estimate, for an annual value of £57.4 billion through their efforts. (Carers UK 2002). Over a ten-year period from 1985-95, the proportion of carers providing more intensive care (in terms of hours) has increased. (Carers UK 2002)

Demand for long-term care is highly dependent on the supply of informal care. The number of older people dependent on informal care could rise from 2.5 million to just over 4 million by 2020. (PSSRU 2003) Spouse carers are predicted to increase in numbers as well. (PSSRU 2003) Even with informal carers, PSSRU has estimated that long-term care expenditure could grow between 108-151 percent, depending on life expectancy among older people. (PSSRU 2003)

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Assuming illness rates remain the same, PSSRU have sought to predict the numbers of people reporting long-standing limiting illness, which they suggest could rise from 6.42 million in 1991 to 10.2 million in 2037 while the number of carers could correspondingly rise from around 6 million to 9.1 million in 2037. (Carers UK 2002) While there are difficulties in estimating the numbers of people with limiting illness, the figures indicate that the need for informal carers is not declining. Of course this is tied up to where the locus for care lies. If the state decided to provide more formal care, the need for informal carers would not be so great.

If the ratio of carer to cared-for remains the same, there could be a shortfall in informal carers. (BBC 2004) Although difficult to predict, technological developments and alternative models of care are likely to ease the demand for caring.

If only a small percentage were to give up caring, for example due to ill health or lack of support, the impact would likely be significant in economic terms. (PSSRU 2003) In making estimates of the effect of such a decline, much depends on the extent to which residential and home care substitutes informal care. At the present time, the health and social care system is very much dependent on the efforts of the informal carers.

What are some of the implications and complications of the growing role of informal carers?
Morbidity in one spouse can contribute to morbidity in the other spouse via the caregiver burden. (Christakis 2004) In a caring arrangement, the informal carer will typically place the health needs of the ill person ahead of his or her own requirements. (Guberman, Nicholas et al. 2003) As a consequence, two-thirds of unpaid carers providing more than 50 hours of weekly care report that their health has been adversely affected by caring demands. (Iles 2003) Within this cohort, one tenth of men and one quarter of women suffer from fatigue. (Baggott 1998) Over half of carers providing substantial amounts of care have been treated for a stress-related disorder and half of the same group has sustained a physical injury since they first starting caring. (Carers UK 2002) As a consequence of providing informal care and the ageing population, we may see an increase of ill health in the informal carer.

Financial problems associated with caring arrangements also add to the level of stress. (Baggott 1998) After five years of providing substantial amounts of care, the carer’s financial situation tends to significantly worsen. (Carers UK 2002) Many of the carers who have looked after someone for more than ten years are financially disadvantaged, with a third of all informal carers falling into this category. (Baggott 1998) 78 percent of carers aged 56 to 60 give up work to care and say they are financially worse-off since becoming a carer. (Carers UK 2002) Informal carers who care less than 20
hours per week are more likely to participate in the labour market, but naturally tend to work fewer hours per week than people who do not care. Those who care for more than 20 hours per week are less likely to participate in the labour market and when they do, they earn less per hour and work for fewer hours per week. (Carmichael and Charles 1998)

Reflecting the recognition of informal care and the financial burden it imposes, the Attendance Allowance is available to the person who cares while the Disability Allowance is payable to the person who is cared for. (McLean and Mason 2003) The payment of an allowance to the informal carer for care moves the notion of family care into some form of professionalisation and raises questions about the knowledge and skills of the informal carers. (Forbat and Henderson 2003)

The relationship between the informal carer and the cared-for may also change because there may be more status for the carer than the cared-for, leaving the cared-for feeling dependent and worthless. The relationship between informal carers and the cared-for is an important factor differentiating the type of care from that rendered in an institutional and professionalised setting. While emotions can complicate the provision of care in some senses, research shows that technically competent treatment without personal connection is less effective. (Forbat and Henderson 2003)

Social care workforce

Depending on the definitions used, there are 1.2 million people employed in delivering social care services in the UK including local authority social services staff, residential, day and domiciliary care staff, agency workers. (The Guardian 2004) Traditional social care roles include local authority social services staff, residential, day and domiciliary care staff, agency workers and a limited number of NHS staff. 4

The nature of work within the sector has been greatly affected by demographic and societal changes, rising consumer expectations, and advances in medical technology. Guidelines on the provision of NHS continuing care have also led to changing boundaries, with much of the support traditionally delivered to older people, for example with dementia, in long-stay NHS beds being redefined as social care. The independent sector now employs two-thirds of the social care workforce, although little data exists about its structure. (Eborall and Garmeson 2001)

The sector is suffering from an ongoing recruitment and retention crisis due to its poor image and low status, which are linked with low pay and a lack of career development opportunities. (ECO 2004)
One in nine local authority social services’ posts were vacant in 2002-03, while the annual turnover rate was 13 percent. London has the highest vacancy and turnover rates: up to 39 percent and 24 percent respectively. In general, turnover is higher among unqualified care workers than social workers, higher in the independent sector than in local authorities, and higher among part-time than full-time staff. (Eborall and Garmeson 2001) The shortage of support staff affects the quality, as well as the quantity, of service provision.

Addressing the shortfall of social care and social work and the image problem
Current and future shortfalls in social carer numbers could be addressed by adopting broad strategies to improve recruitment and retention. The low status attached to caring (Research Works 2001) must be addressed, so that carers are not denigrated as unskilled. Proper levels of training should thus become a standard element of recruitment. At present, low pay makes social care work a less attractive option within the UK labour market.

Some local authorities have managed to recruit staff by introducing measures such as part-time or term-time work, job-sharing, weekend-only contracts, childcare and crèches, annualised hours quotas, “golden hellos” (BBC 2004), and more competitive rates of pay. (Eborall and Garmeson 2001) Local authorities have also shown some openness to hiring care staff with other experience and qualifications, and to helping unqualified staff pass exams through training programmes. (BBC 2004)

The stress and demands of the job, the low salaries, time pressure, anti-social work hours, and lack of career development complicate the retention of social carers. In the social care sector, successful measures to improve retention have included consulting staff in decision-making, adopting an open-door policy, and introducing flexible work hours, creating new posts with skills mixes, secondments, staff development programmes, improved physical working environment, respite periods, and career breaks. Reducing bureaucracy and maximising user contact have also been effective. (Eborall and Garmeson 2001)

For social workers, job satisfaction is eroded by staff shortages, excessive work loads, reliance on temporary or inexperienced staff, over-bureaucratic procedures, poor management, inadequate training, and the general stress associated with the particular clients that they treat. (Eborall and Garmeson 2001) A way of addressing the social worker shortfall has been the creation of the three-year social work degree. Since its introduction, there has been an eight percent increase in

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4 Certain definitions of social carer roles also encompass early-years childcare, foster carers, a wider range of NHS staff who do care work, and education assistants in schools.
applications for social work courses, arresting the steep decline experienced over the last ten years. (The Guardian 2004) It is important to bear in mind that this is a longer-term solution as it will be another few years before the first candidates have graduated.

What are some of the implications and complications for social carers?

In an ageing population, more people will have contact with social carers in the future. If services became more preventative and community oriented, this will compound the intensity of social care work within the community. (Kendall and Harker 2002) Preventative care should focus long-term rather than short-term as the benefits of health promotion are yielded in the future and require lasting commitment.

One measure that may improve the quality of care home staff, but may make it more difficult to recruit staff, is that by 2008, 50 percent of the care provided by a domiciliary agency must be delivered by NVQ2-qualified staff. (DoH 2003) At present, training and qualifications are not required. There is concern that staff over 55 years will be reluctant to undertake training for formal qualifications and may leave the workforce. (ECO 2004) Nor is there necessarily agreement among professionals or support staff that is the training requirements are useful. (Rogers 2002; PSSRU 2003) 80 percent of the care workforce and 38 percent of NHS staff have no formal qualifications for their work. (Rogers 2002; ECO 2004)

We need a clearer understanding of roles within the social care sector, and in particular of the nature of support staff roles. By mapping the profession, carers would not only understand better how to change roles and advance their careers, we would improve the image of social care by demonstrating the value and importance of all roles. There also needs to be recognition that for many posts there are increasing demands for flexibility and blurring of roles.

The nursing workforce

The nursing workforce consists of two key groups; those who are registered and a growing number of unregistered healthcare assistants. (RCN 2004) We mainly look at nurses in this section.

Shortage in staff means that nurses have to care for more people with fewer staff while demand for care is rising. (Finlayson, Dixon et al. 2002) Wanless argues that the number of nurses estimated by the NHS Plan (1997) will be needed is sufficient. (Wanless 2002) However, an NHS vacancies survey in 2000 in England suggested there were 10,000 vacancies for registered nurses and midwives, while the Royal College of Nursing estimates there were 22,000 vacancies. (Finlayson, Dixon et al. 2002)
The government promised to recruit an extra 20,000 nurses by 2004 in England, although according to the Royal College of Nursing, even this number will not be sufficient, as 110,000 will be needed by 2004 if retirement levels and other losses remain the same. (Finlayson, Dixon et al. 2002) By 2008, the government’s goal is to recruit 115,000 more nurses. (RCN 2004) The NHS Plan makes a number of recommendations that should free up nurse time with patients. However, there needs to be more work done around how best to utilise nursing time. There is a growing body of evidence that the proportion of registered nurses to patient numbers has an impact on patient outcomes such as incidence of falls, incontinence rates, complication rates. (RCN 2004) However, there is no evidence that trained staff are being deployed to deal with the variations of patient demand.

One in five nurses on the UK professional register is aged 50 years or older and, as younger nurses are not replacing older ones in sufficient numbers, by 2010 it is likely that one in four working nurses will be aged 50 or older. (Buchan 1999; Finlayson, Dixon et al. 2002)

There is a 15 percent turnover of nurses per year, with 38 percent turnover in London. (Finlayson, Dixon et al. 2002; BMA 2004) Among other factors, leaving the nursing role can be attributed to low pay and high costs of living, rising rates of (early) retirement, the perception that nursing is undervalued in society and the workplace, competition from other employment opportunities, the increasing frequency of career breaks (including maternity and paternity leave), the demands of skills upgrading and retraining, jobs abroad, and the experience of racism and violence in the workplace. (Finlayson, Dixon et al. 2002; Finlayson, Dixon et al. 2002) High turnover affects the quality of patient care as existing staff spend time helping the new nurses find their way, and results in higher costs and lower morale. (BMA 2004)

Equally, the impact of the European Working Time Directive on doctors’ hours has a knock on effect on nursing staff. It is not an option to simply delegate doctors’ tasks to nurses as this means that essential nursing care is further compromised.

Addressing the nurse shortfall
A number of strategies have been suggested in order to address the shortfall in the number of nurses. These involve better retention of the existing workforce, attracting younger cohorts into nursing, changing practices and organisation of working to maximise efficient use of medical time, and recruiting more nurses from abroad.

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5 The disparity is due to the way vacancies are calculated. The NHS only counts positions that have been vacant for more than three months, while the RCN counts the post as vacant on the day it becomes vacant.
6 Relative earnings for nurses have decreased in relation to the workforce in general. Especially, London and the Southeast are hard hit because nurses cannot afford to live there on present earnings.
There is a need to assess the professional development and employment needs of the growing number of experienced middle-aged nurses, as a means of retaining this cohort or even attracting recently departed but still qualified nurses back into the profession. (Buchan 1999) Measures to improve nurse retention as the NHS workforce ages could include more flexible working arrangements, increased salaries, providing greater opportunities for career advancement through retraining, and increasing the retirement age. (Buchan 1999) Experienced nurses choose to work in areas with higher levels of part-time work, more choice and more control over working hours. (RCN 2004) Between 1999-2002, only between 3-4,500 nurses and midwives have returned to nursing from other sectors. (RCN 2004) Nurses cited the following factors as influencing their decision about delaying retirement: improved finances, reduced hours (if no effect on pension), reduced stress, feeling valued for their contribution, time out and flexibility of work. (RCN 2004)

At the same time, the nursing profession must be made more attractive to people who are currently not nurses. (Finlayson, Dixon et al. 2002) Many universities are finding it difficult to fill nursing-course spaces, and so places are being filled by overseas students who are less likely to remain in the UK to work. (Finlayson, Dixon et al. 2002) The additional investment in student numbers has not kept pace with the necessary investment in lecturing and clinical supervisory staff. Student placements in the clinical area are a major challenge, with the overall shortage of experienced staff exacerbating problems of student support. Negative clinical placement experiences, problems with variable bursary arrangements (between diploma and degree students) and the sheer pressure of undergraduate programmes are cited as key contributors to high student attrition rates. (RCN 2004) Also, the profile of nursing students has changed in recent years with more mature entrants (average age 29). Future recruitment and retention strategies need to take these factors into consideration. Moreover, 34 percent of new graduate nurses are not registering to practice nursing, and serious measures are needed to lure them into nursing. (Finlayson, Dixon et al. 2002) Also, even if people could be attracted to study, it takes three years to do a degree, and a further six to ten years to have real experience needed for higher level jobs, so increasing numbers will not fix the lack of experienced nurses quickly. (Lister Forthcoming)

At present, nurses (and doctors) spend almost as much time dealing with information (about 25 percent) as they do with patients (about 35-40 percent). (Lister Forthcoming) There needs to be a better organisation of division of labour so that nurses can nurse. Nurses’ time is freed up by deploying healthcare assistants, ward clerks, and housekeepers. (Carr-Hill, Currie et al. 2003) No research has yet investigated the effectiveness, working patterns, or training of healthcare

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7 The employment opportunities have increased for women leading to a greater choice in occupation.
assistants or housekeepers either as a single group or more importantly looking at a range of roles within a caring team.(Carr-Hill, Currie et al. 2003) It is predicted though that ICT will reduce time spent on administration which should alleviate some shortages.(Lister Forthcoming)

Nurses are taking over many of the responsibilities formally the preserve of the doctor. The nurse is now often the first port of call for patients in primary care\(^8\) and the co-ordinator of clinical care in secondary care.\(^9\) (Davies 2003) The Health and Social Care Act (2001) authorised new prescribing powers for nurses and pharmacists. Research is needed to clarify whether this will ensure quality of care and whether it is actually cost-efficient.

Another way to address the nurse shortfall is to recruit from overseas. The UK is becoming increasingly reliant on overseas nurses.(Buchan 1999) In London, in October 2002, 28 percent of all registered nurses were from overseas.(Buchan 1999) Foreign recruitment of health professionals raises the question of standards and cultural compatibility as many recruits now come from developing nations or from the new EU accession countries with different training standards. The brain drain of professionals from both developing countries and the new EU nations is already proving a politically controversial issues.(Buchan and Sochalski 2004; Gerrish and Griffith 2004)

Although nurses may not work within the NHS, they may still be working as nurses.\(^10\) Almost half of the nurses who leave the NHS remain in caring occupations such as social or child care thereby contributing to the care workforce.(Gage, Pope et al. 2001) Approximately 25 percent of RCN members report that they work outside the NHS.(RCN 2004) Of those who remain within the NHS, 33 percent are dissatisfied with their work.

What are some of the implications and complications for nurses?
Policy responses to the shortage of nurses take several forms: pay and conditions, more effective clinical career pathways for nurses, transforming nurse education, and role expansion.

There is a global shortage of qualified nurses, particularly in developed countries. This has led to increasing competition for recruitment of new nurses and retaining those already in the system. Nursing salaries have increased in North America and Australia as a result of such global trends and in the UK the proposed changes within the workforce strategy Agenda for Change acknowledge the

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8  Examples of new roles in primary care are primary care prescription, screening, health promotion, and management of chronic disease.
9  Examples of new roles in secondary care are outpatient clinics, minor injury services, cardiology day care, nurse endoscopist, night nurse practitioner.
10  The number of UK-trained nurses leaving the country to work abroad has increased. More than 8,000 nurses left the UK between 2000/1-2002. See http://news.bbc.co.uk/1/hi/health/3703093.stm
need for nurses and all other health sector workers to be paid on an equitable and transparent basis. (DoH 2004) In addition to improvements in basic salary, terms and conditions of employment – family-friendly policies, more flexible approaches to time off duty and holidays, support for continuing professional development, are aspects of employers’ commitment to growing and sustaining an effective nursing workforce.

Specialist, advanced and consultant nursing roles are emerging as part of an overall strategy to develop a more effective clinical career pathway for nurses. Research has demonstrated that nurses stay longer in clinical practice when they have more control of their work and can operate more autonomously. (Aiken, Clarke et al. 2002) Initiatives such as the new community matron roles in chronic disease management point to the increasing investment in nurse-led services. (RCN 2004)

**Doctors**

The UK has fewer doctors per capita than the rest of Europe. Doctors are ageing and retiring (early), and certain cohorts are not being replaced. Wanless predicts that the rise in primary care activity will require a doubling of GPs in the future and that overall doctor numbers will fall short by 25,000 by 2022. (Wanless 2002) In some cases, an increase in doctor hours per patient improves care outcomes, including lowering the risk of infection and improving survival rates. (Hewitt, Lankshear et al. 2003) However, this is not always the case. (Hewitt, Lankshear et al. 2003) More research remains to be done in order to clearly establish whether increasing doctor numbers always improves the quality of patient care.

The extreme stress levels experienced by many can play a particularly serious role in increasing turnover, which is highest in inner cities, where costs of living are typically at the maximum and lifestyle factors may encourage doctors to relocate. (Peter, Macfarlane et al. 2004) Both doctor shortages and high turnover impacts negatively on patient care, healthcare costs and workplace morale.

The proportion of GPs intending to quit direct patient care in England within five years rose from 14 percent in 1998 to 22 percent in 2001 with the main reasons being increased age, job dissatisfaction, having no children under 18 years of age, and ethnic minority status. (Sibbald, Bojke et al. 2003) The main causes for leaving practice for men were related to age, their own ill health or death, and for women to family, emigration, or taking on a non-medical post. (BMA 2004) A Scottish survey indicates that of those GPs in Scotland now aged 55 and above, at least 71 percent plan to retire at or before the age of 60, with excessive workload being cited as the main reason. (Chambers, Colthart et al. 2004)
In addition to pressure created by the European Working Time Directive\textsuperscript{11}, two European Court rulings have had an impact on the definitions of work and rest time.\textsuperscript{(Sheldon 2004)} Hours asleep, while on duty and if not busy, will be counted as work in Spain, and doctors must have immediate compensatory rest after on-call duties in Germany. This may mean that more doctors and nurses will be needed in the UK as a consequence of the ruling. It may also mean a restructuring of job responsibilities. In some hospitals, a 24-hour matron service has been initiated to replace some of the aspects junior doctors cover.\textsuperscript{(Carr-Hill, Currie et al. 2003)} However, there is no research yet into the impact on quality of care and cost-effectiveness of nurse replacements for junior doctors.

Addressing the shortfall in doctors

Current and future shortfalls in physician numbers could be addressed by adopting broad measures: expanding medical training to admit higher numbers of students, reforming the organisation of medical practices to use physician time more efficiently, taking steps to prevent or delay early retirement, retaining doctors through financial incentives, and recruiting from abroad.

Figures from the Higher Education Funding Council for England show 6,030 students enrolled in medicine in 2003, meaning the number of medical students is up by 2,281, or 60 percent since 1997.\textsuperscript{12} \textsuperscript{(BBC 2004)} Increasing student numbers is a long-term solution as it takes five years to complete a degree, and a further six to ten years to have experience enough for a more senior position.

More than 50 percent of medical graduates are now women, and in 2002, more than 60 percent of those accepted into medical and dental schools were women.\textsuperscript{13} \textsuperscript{(Skills for Health 2003; Royal College of Physicians 2004)} Because women more frequently express the desire for career breaks and part-time work arrangements, the rising numbers of female GPs and hospital doctors will have significant implications on the future organisation of general practice and hospital working arrangements.\textsuperscript{14} As a consequence, the traditional GP partnership may need to be reformed to reflect women doctors’ demands, particularly when considering flexible work-time arrangements, work-life balance, and childcare facilities.\textsuperscript{(Sausman 2003; DoH and NHS Alliance 2004)} Also, women seem more interested

\textsuperscript{11} Doctors are not to work more than 13 hours in any 24-hour period and are to take an 11-hour break before and after such a shift.

\textsuperscript{12} A large part of the increase in the number of students following subjects allied to medicine is largely a product of the shift in funding of nursing courses to the higher education sector. However, there was also a substantial rise in enrolments in pharmacy, audiology, ophthalmics and medical technology.

\textsuperscript{13} There is a continuous debate as to if and how to attract men back into medical school. Ferriman, A. (2002). "Men should be encouraged to apply to medical school." \textit{British Medical Journal} \textbf{325}: 66.
in the “softer” specialties. (Akbar 2004; Laurance 2004; Laurance 2004) Given their increasing numbers, this may result in more severe shortages in some areas, irrespective of patient demand and need. (Harrison and Dixon 2000)

In the interest of using physician time more efficiently, nurses might take over some of the current responsibilities of doctors, leaving doctors to focus only on medical work for which they alone are qualified. (Horrocks, Anderson et al. 2002) As the nurse is cheaper than a doctor, in economic and managerial terms it makes more sense if patients are seen by nurses.15

Improving the quality of doctors’ working lives might help improve retention. (Sibbald, Bojke et al. 2003) The government has introduced financial incentives to encourage hospital doctors to enter general practice and to dissuade others from retiring early. To attract the new graduates, “golden hellos” have been introduced. (DoH and NHS Alliance 2004) GPs have commented that a retention scheme must be flexible and well remunerated. (Chambers, Colthart et al. 2004) The GP contract is seen as a measure to improve the GPs work situation. The contract is between a PCT and a practice rather than an individual doctor, which might mean that GPs can control workload to have more or less leisure time and will allow GPs to earn up to one third more. (Stevens 2004) The GP contract will lead to the non-medical staff taking over some jobs, and practices will become larger with sub-specialisation.16 (Healthcare Commission 2004)

Overseas-trained doctors are filling the gaps in supply. The accession of ten new member states to the EU means that thousands more doctors are eligible to work in the UK. (BMA 2004) A draft directive of the mutual recognition of professional qualifications will ensure patient safety and high standards of medical training. (BMA 2004) In 2003, five percent of all doctors employed by the NHS in the UK had primary medical qualifications from the EEA/EU, and 24 percent had qualifications from non-EEA/EU countries. (DoH 2004) Among general medical practitioners17, 15 percent had qualifications from non-EEA/EU countries, five percent qualifications from EEA/EU countries. (Buchan

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14 Up to 75 percent of female trainees said they planned to work part-time in the future. (Royal College of Doctors, 2001) There is anecdotal evidence that men are expressing more interest in part-time work. (Royal College of Doctors, 2004)

15 However, in its extreme, this delegation of work could mean that the doctor only would see the patient when the nurse or nurse practitioner would not be able to handle the case. Charles-Jones, H., J. Latimer, et al. (2003). "Transforming general practice: the redistribution of medical work in primary care." Sociology of Health & Illness 25(1): 71-92. That could pose a problem because sometimes the seemingly trivial problems are symptoms of something more serious, which only a doctor can diagnose and then this hierarchical delegation of resources becomes a problem. On the other hand, patients think that nurses are better communicators and might view this as an improvement in the patient-clinician relationship. Nurses who substitute doctors spend more time with patients. Wanless, D. (2002). Securing our Future Health: Taking a Long-Term View. London, The Treasury.

16 The family doctor and long-term relationship with the individual will disappear. The patient may be treated at the registered practice, another practice, by staff employed by the PCTs, or a community pharmacist.
An informal study by the BMA shows that only 150 refugee doctors practice in the UK; 123 have qualifications to work but are without a job.\(^{18}\) (BMA 2004) Doctors, who are asylum seekers or refugees, should be allowed to practice once they have been properly assessed, as with other overseas doctors. In the future we can expect to see a rise in doctors with non-British qualifications. Thought needs to be put into what can be done to control or facilitate rising overseas recruitment and what limitations there will be.

**Transforming care: shifting roles and boundaries**

There is a constant shift between primary and secondary care, with more conditions now being managed by primary care.\(^{17}\) (Skills for Health 2003) The erosion of roles between professional groups, between professionals and informal carers, and between forms of care (such as social and healthcare) makes definitional distinctions difficult to uphold.\(^{18}\) (Forbat and Henderson 2003) On one hand, there are demands for professional groups to be flexible and change the way they train and work in the interests of patient-centred care. On the other hand, there is a desire to preserve the highly valued professional status, practices, training, and ethos typical of the health professional.\(^{19}\) (Sausman 2003) Any restructuring of the healthcare system would need to balance these tensions.

The relationship between level of qualification and quality of care does not always correspond. For example, patients have been shown to be more satisfied with nurse practitioners’ care than doctors because nurse practitioners have longer consultation times and make more investigations.\(^{17}\) (Hewitt, Lankshear et al. 2003) Another example is midwifery care, which has been rated by patients as comparable and sometimes better than care provided by obstetricians and doctors.\(^{18}\) (Hewitt, Lankshear et al. 2003) Nurse practitioners are typically able to perform and manage simple procedures as well as doctors, in primary and secondary care.\(^{19}\) (Hewitt, Lankshear et al. 2003) Nurse practitioners’ hours are cheaper, however the cost savings implied may be outweighed by the fact that nurse practitioners are less productive (meaning they take longer to do a given number of procedures).

There is some evidence to prove that more complicated care for more serious cases is better performed by specialists.\(^{19}\) (Hewitt, Lankshear et al. 2003) However, some specific tasks involved in

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17 This includes GMS Unrestricted Principals, PMS Contracted GPs, PMS Salaried GPs, Restricted Principals, Assistants, GP Registrars, Salaried Doctors (Para 52 SFA), PMS Other and GP Retainers. (DoH 2004)
18 Of the 951 doctors registered on the BMA/Refugee Council refugee doctors’ database, 53 are working for the NHS, and some 450 are in various stages of qualifying.
19 Specialists provide better palliative care, A&E care, heart failure, and when treating more rare and serious situations. However, for musculoskeletal diseases there is little evidence that specialist doctors provide better care than generalists. In the case of Parkinson’s disease, a nurse specialist in a hospital setting can improve outcomes and reduce costs. A community nurse can do the same with diabetes.
treating common chronic diseases can be just as effectively performed by someone less qualified than a specialist physician.\(^\text{20}\)(Starfield 2003)

Many of the problems in healthcare services are seen to be a result of failures in working effectively across organisations and professional boundaries.(Carr-Hill, Currie et al. 2003) Some argue this is due to doctors receiving different training from the rest of the health professions.(Carr-Hill, Currie et al. 2003) There is a need for training on how to work as a team. Also, the leaning towards a non-hierarchical team structure will require different skills and attitudes.(Skills for Health 2003) Primary services may need to be provided 24/7 rather than at set hours, as is the case today, which will affect working patterns.(Skills for Health 2003)

An expert group in Scotland is working on a “21st Century Social Work Review”, which will consider whether the tasks of social workers need to be redefined, with more being done by the health or education services. The group will further consider how to improve leadership, training and recruitment and whether there need to be changes to the 1968 Social Work Act.

IPPR has suggested that social workers focus on a certain age group rather than their current generalist approach, a shift which would require more specialist training.(Rogers 2002) In the US, there are currently roughly 80 areas of specialisation for social workers.(Rogers 2002) The appropriate training for this kind of a specialist social worker could be a Master’s degree allowing for specialisation.\(^\text{21}\) While a specialist would require a higher salary, the increase in salary would make social work more attractive and respected to a wider range of people.

In Northern Ireland, health and social services are commissioned and delivered by joint health and social service boards.(Skills for Health 2003) A consequence for older people, especially those with less acute or “intermediate” needs (that is, those who do not need to go to the hospital immediately), is that they may be rationed out, ignored, or treated inappropriately on either side of the boundary.(Lewis 2001) The debate between healthcare, free at the point of delivery, and social care services, which are largely means-tested, continues.(Rummery and Coleman 2003) The Royal Commission on the Funding of Long Term Care recommended that nursing and personal care be provided free at the point of delivery on the basis of assessed need. This has led to different policy directions in England and Scotland with both personal care\(^\text{22}\) and nursing care provided free in

\(^{\text{20}}\)Specific tasks within cancer care are rectal surgery and sigmoidoscopies.
^{\text{21}}\)Scotland is introducing a postgraduate course in leadership skills for council and voluntary sector social work managers.
^{\text{22}}\)Personal care includes bathing, feeding and dressing.
Scotland, but with means-testing for personal care in England. As yet there has been no detailed evaluation of the impact of the free personal care policy.

Integrating social care and healthcare will not be a straightforward process. The NHS and local authorities (responsible for social care) have different planning timescales, accountability, funding and management structures. (Baggott 1998) There are also differences in professional orientation (medicine versus social models of health and wellbeing), professional status, knowledge base (hard sciences versus soft), applications of technology (high and esteemed versus low and not esteemed), action (direct versus vague, for example surgery versus conversation), legitimacy and power (real life-and-death needs versus disputed needs). (Hudson 2002) It seems logical to integrate healthcare and social care because it is seen to enhance care pathways and focus on the patient more so than a divided system. However, before we take steps in that direction, we need to evaluate the integrated care approach of Northern Ireland. It may be that there is a mismatch between policy pointed to integrated care and the reality of integrated care. If we are not careful, integrated care may be seen as just another restructuring that does not work because of the boundaries that exist between healthcare and social care, the confusion over who is responsible, which leads to further confusion of its users.

A new approach is needed to co-ordinate and harness all the caring contributions; Future policy thinking will have to take more account of the informal and support care workers. We should invest in the same strategic planning, investment and educational support for those two groups.

Some general questions for policy

As we witness a shift in society from recognised social obligations to greater individualism, is it realistic to expect informal carers to step into the breach associated with our ageing population? In the area of formal support work, can we satisfy increasing recruitment objectives while rates of pay are so low? Should alternative and complementary care be regulated to ensure a standard of quality? Should GPs perform alternative and complementary therapies if there is so little evidence of its effectiveness? Is the current flow of new nurses and doctors in the NHS sustainable? In particular, can we continue to rely on overseas recruitment to address domestic skills shortages? Should recruitment agencies be regulated? How should the flow of nurses and doctors into the country be monitored? (Buchan and Sochalski 2004)

3. Conclusions

One of the biggest challenges facing society over the next few years will be the current and future shortage of health and social care staff to meet the growing demand for care. The issues of the ageing population and the emergence of more complex chronic diseases and long-term mental
health conditions will require policy makers and professionals to think very differently about care, how we deliver it, and, perhaps most importantly, and how we improve it.

Care is not a clearly defined concept within the health and social policy arena. This leads to blurring of boundaries between who cares (the person, family or friends, a health or social care worker, or a professional), whether they are paid for it (when does informal, unpaid care become paid, formal care?) and where they receive care (in their own home, or an institution). With this lack of conceptual clarity comes the challenge of identifying how we are to evaluate effective caring interventions and who is best placed to provide that care.

Whatever the definition within the current configuration, predictions indicate that there will be an insufficient number of carers to cope with people requiring care, whether that be from informal carers, support workers, or professionals. Workforce strategies will need to address issues of remuneration, intervention recruitment, interagency working and training and development.

4. Policy Recommendations

Essential to the future, is self-care - how it is taught, maintained and sustained. We need to investigate incentives to self-care as well as the effect of educational programmes and the role of IT informing individuals. Triggers that identify when an individual is no longer able to self-care effectively, need systematic investigation.

There is some support for informal carers but caring can be financially impoverishing and stressful. Levels of financial support must be raised. Improving such benefits may save the state money. We must consider the incentives for informal carers to undertake such a role, how they can be best supported financially, and how they can share their expertise.

Social care must be recognised as integral to health, healthcare and wellbeing. The equivalent amount of money invested in the NHS should be invested into social care. We need to shift the provision of care from crisis intervention to long-term preventative strategies.

There are a number of studies that list a wide variety of local policies and interventions of the NHS’ response to staff shortages, however, there is no evaluation of the cost effectiveness of these interventions. Research remains to look into the competitiveness of NHS pay and conditions compared to other areas of employment. It should also investigate how many healthcare workers are actually needed, rather than just call for increases.
For doctors and nurses, we need to monitor pay, terms and conditions and their impact on recruitment and retention. We also need to research their various roles to evaluate their cost and clinical effectiveness on patient care. The delegation of tasks to nurses and nurse practitioners frees up time for the doctor but no research has been conducted into how this time is spent.

With the constant organisational changes, we need to monitor closely the impact of changing roles. We must explore the pros and cons of international recruitment for doctors and nurses, and whether it is a sustainable option for future workforce projections.

As the main reason for women doctors to leave the profession is family, we need to think about how we can accommodate this obligation and possibly part-time work. Since more women are entering the profession, perhaps we need to consider giving men more paternity leave.

Local strategies for recruitment should correspond with local needs. The composition of the local labour markets, ethnic composition, socio-economic status, geography, is crucial to responses to shortages and their competitiveness but often no policies addressing these external factors.


Iles, A. (2003). "Forty per cent of carers have illness or disability." British Medical Journal 327(832).


