

The health service employs over 1¹/₄ million people. Two thirds of spending on the health service is on pay. Changes in the pay and productivity of the health service workforce are an important driver of future health care spending. Having the right number of people with the right skills will be critical to delivering a high quality health service. Some of the main points are:

- the UK does not have enough doctors and nurses. Plans are in place to increase the numbers. However, if current trends are allowed to continue there could be a greater increase in doctors than nurses. In 20 years, the number of doctors will increase from 1.7 per thousand of the population to 2.4 and nurses from 4.5 to 5.0 per thousand of the population;
- the UK does not have enough social care staff (current workforce of 1 million). Plans are in place to increase the number of social workers in training by 5000 by 2004. Recruiting and retaining social care staff (most of whom are low skilled) is a significant problem;
- over the last 20 years, staff costs have increased by 2 percentage points more than inflation in the economy. This is in line with the trend rate of growth of health service and economy-wide labour productivity;
- the next 20 years are likely to see substantial changes in the roles and responsibilities of health care professionals. There is a scope for much of the work undertaken by doctors, particularly in primary care, to be provided by suitably trained nurses. Expanding the number and roles of health care assistants (HCAs) will be necessary to free up nurses to take on new clinical roles;
- the role of social care staff will increase, as more people are supported to live in the community;
- medical care will increasingly be provided by consultants and specialist doctors. Technology is likely to make it possible for many more diagnostic and treatment services to be provided in primary care;
- primary care doctors are more likely to focus on patients with more complex needs and provide a wider range of services to them; and
- GPs have traditionally provided continuity of care and ensured that specialist services are used appropriately. Maintaining these benefits in a potentially more fragmented system will be a key challenge.

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Introduction

- 11.1 Health and social care are labour intensive services. The health service employs more than 1¼ million people in the UK. Social care employs between 875,000 and 1.25 million people, depending on which staff groups are included. Combined, the health and social care sectors employ one in ten of the working population.
- 11.2 Staff costs account for around two thirds of all NHS expenditure. The number and mix of staff in the health service is a major determinant of the volume and quality of care, its efficiency and total cost. A health service without the right number of people, with the right skills, in the right locations will not deliver a high quality, comprehensive service to patients over the next two decades. Workforce issues are key to the Review of the long-term trends affecting the health service.

The current health care workforce

- 11.3 The health service workforce differs from the whole economy workforce in a number of important ways. The health service workforce:
- is highly educated – graduates make up 12 per cent of the UK workforce but 20 per cent in the health service;
 - has a high proportion of women – almost 80 per cent of health service staff are women compared to 45 per cent of the UK workforce;
 - is characterised by significant occupational segregation – 87 per cent of nurses are women compared to just 37.5 per cent of doctors;
 - is less likely to employ women in senior positions than would be expected based on the overall numbers in the workforce. Women make up around 80 per cent of the workforce, but less than a quarter of NHS Trust Chief Executives and a fifth of hospital consultants are women;
 - relies heavily on international migration – almost a third of doctors and one in eight nurses were born outside the UK, compared to one in thirteen of all public sector employees;
 - is marked by strong demarcations of roles and responsibilities between different staff groups often backed up by legislation or regulation;
 - has more people from ethnic minorities – 8 per cent of the health service workforce are from an ethnic minority group compared to 6.7 per cent of the workforce for the economy as a whole; and
 - is ageing markedly – almost half of the nursing workforce is over 40.

- 11.4 The length of time it takes to train doctors, nurses and other professional staff in the NHS means that gaps between the demand for staff from the NHS and the supply of suitable staff are difficult and costly to manage and can have a significant impact on the quality and efficiency of the service.
- 11.5 Furthermore, as the NHS is such a dominant employer of these skills, the Government takes prime responsibility for organising and funding most of the training for the future health service workforce. The NHS currently spends some £2.5 billion a year supporting training and education for professional staff, with more spent locally on staff development and training. It takes around 12–13 years to train a consultant, at a cost to the taxpayer of up to £250,000. For nursing, midwifery and allied health professionals, it takes three years to achieve professional registration at an average cost of £36,000.

Social care workforce

- 11.6 The personal social services sector is highly fragmented. It operates in different settings, with different providers, for users ranging from small children to the very elderly. There are many different types and levels of workers. In contrast to the health care workforce, the social care workforce has much lower levels of training and education. Around 80 per cent of the approximately one million staff have no relevant social care qualifications. The workforce is dominated by part-time, female staff. Independent providers are major employers, employing two-thirds of the total and this proportion is set to rise.

The personal social services workforce¹

- over 80 per cent of staff are female;
- half of all staff work in a field work or area office setting;
- just over a quarter of staff work in residential care. This has fallen by 18 per cent since 1994;
- 58 per cent of all staff work on a part-time basis;
- more than 40 per cent of staff work with children, while a further 22 per cent work with adults;
- 28 per cent of staff are employed in health settings or specialist teams, and this is expected to rise; and
- surveys show that just over a third of the local authority workforce hold relevant qualifications. This figure is lower in the independent sector².

¹ Department of Health Statistical Release, September (1999).

² Local Authority Social Services Workforce Survey (1999).

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Trends in the workforce

11.7 The overall numbers, skill mix and roles of staff in the NHS have changed substantially since the health service was founded. The number of people working for the NHS has more than doubled to meet the needs of an expanding and ageing population, with higher expectations and new technologies opening up new treatment and support options.

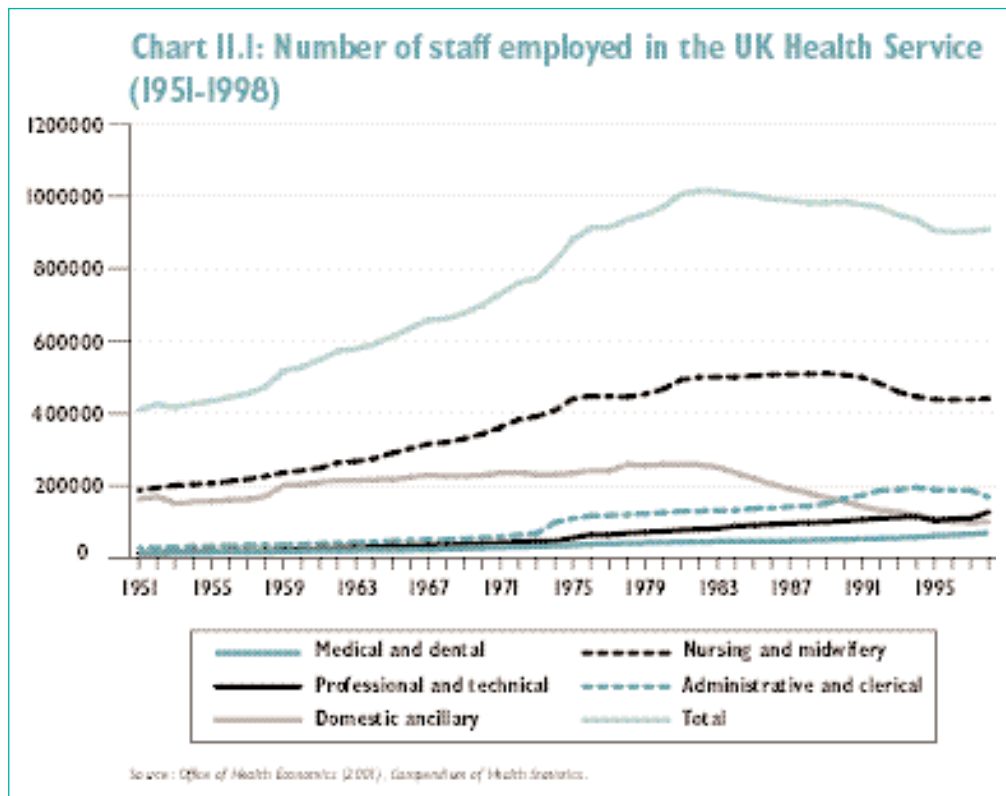


Chart 11.1 shows how the number and mix of people working in NHS hospitals has changed since the health service was founded (this accounts for around 75 per cent of the total NHS workforce). In addition to the large change in the total number of people working in NHS hospitals, the mix of skills has also changed considerably. The NHS now employs a much higher proportion of highly skilled, specialist staff than it did at its inception. The key trends over the last 20 years include:

- the hospital workforce has fallen by around 10 per cent;
- the number of hospital nurses has fallen in line with the total reduction in staff numbers (although the fall was largely due to a definitional change as student nurses are no longer counted as nursing staff);

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- despite the overall fall in numbers, some groups have grown. There has been a large increase in medical staff (up by 55 per cent) and professional and technical staff (up by 63 per cent) and a smaller growth in administrative and clerical staff (up by over 30 per cent); while
- the big fall has been in directly employed domestic ancillary staff (down by 62 per cent). This fall in domestic ancillary staff reflects the increased outsourcing of services such as catering and cleaning. The shift of services from direct to contracted provision reduces the number of staff directly employed by the NHS. The cost of the contracted provision is borne elsewhere in the total budget.

11.8 For most staff, roles have changed over time, albeit relatively slowly. There has been:

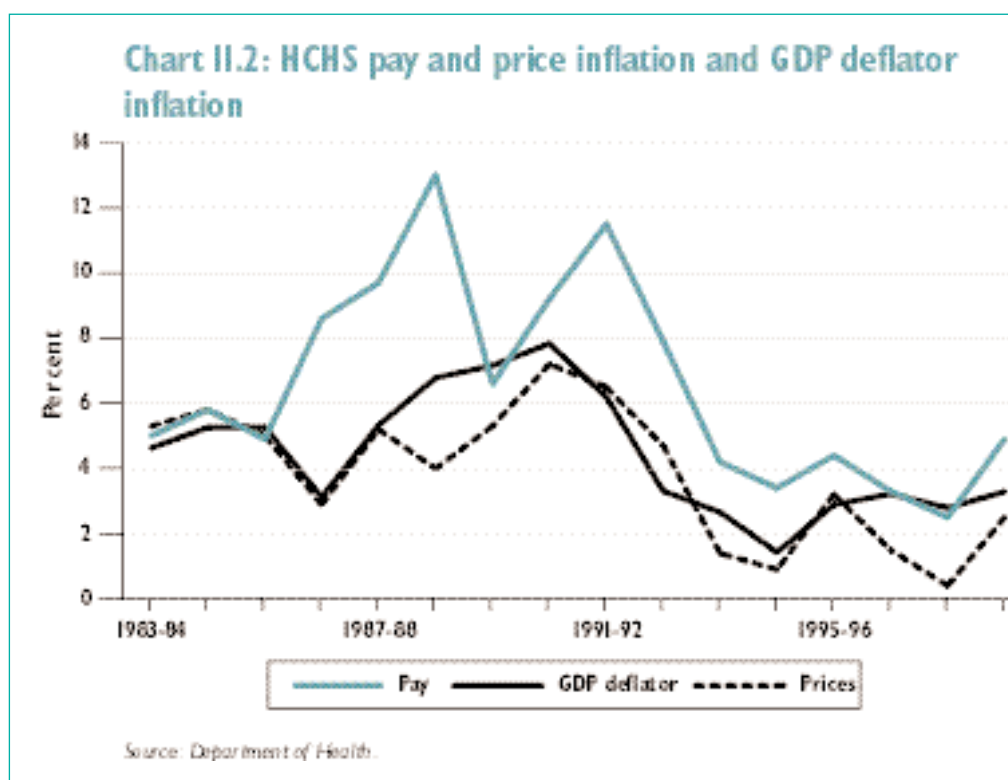
- a rise in team working within primary care – with the move from single handed to large GP practices and direct employment of a wider range of staff, including social care staff;
- more emphasis on health promotion and disease prevention; and
- the movement of services from secondary to primary care, for example with the expansion in minor surgery carried out in local surgeries and health centres, and the increasing management of chronic conditions and supporting people to live independently.

11.9 Much of this change has been gradual and incremental, but the past two decades have been a period of more rapid change. For example, the number of practice nurses directly employed by GP surgeries rose more than ten-fold between the early 1980s and mid-1990s (from 1,515 in 1982 to 18,000 in 1995 in England).

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Trends in pay

11.10 Trends in the pay of health and social workers are an important driver of spending on health. The pay bill is the main driver of inflation in the health service. Over the past two decades, inflation in the health service has exceeded general inflation by an average of 1.5 per cent a year³. As chart 11.2 shows, price increases in the goods and services purchased by the health service are very similar to general inflation. The excess of medical inflation over general inflation is almost completely accounted for by rises in pay. Over the last 20 years, staff costs have increased by 2 percentage points a year more than whole economy inflation.



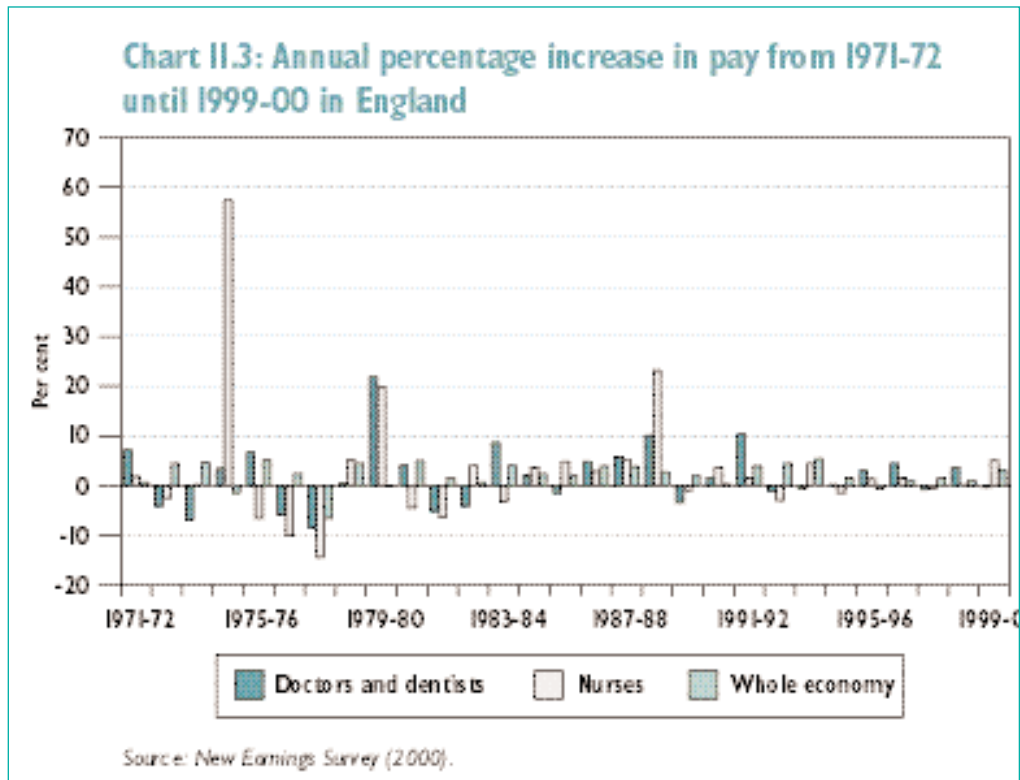
Health service earnings have been increasing at above the rate of earnings growth for the economy as a whole. Total hospital and community health service earnings have risen by an average of 3.2 per cent a year since 1986–87. This is significantly above the increase in average earnings across the economy which, according to the measure used, has averaged between 1.9 and 2.4 per cent a year.

11.11 The increase in the total health service pay bill was significantly above the average increase for specific staff groups, reflecting the change in the staff

³ General inflation has been measured by the GDP deflator and health service inflation by the HCHS Pay and Prices Index.

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mix over this period. There has been an increase in the number of doctors and reduction in ancillary and support staff. Historically, changes in skill mix have increased earnings in the hospital and community health services by around 0.6 per cent a year.



As chart 11.3 shows, annual increases in pay for doctors and nurses exhibited a higher degree of variation than earnings in the economy as a whole. For nursing, looking back over a longer time period to the beginning of the 1970s, the data show that the average increase in nurses' pay was 2.5 per cent compared to a whole economy average growth in earnings of 2.2 per cent. But the pay of nurses is dominated by three main pay reviews: Halsbury in 1974, Clegg in 1980 and the 1987-88 Clinical Grading Review.

11.12 Pay in the social care sector has increased at a much lower rate than the health service. Since the mid-1980s it has increased by an average of almost 1½ percentage points a year less than pay in the health service⁴. This reflects the much higher proportion of unskilled or low skilled workers in the social care sector. Across the economy earnings for skilled workers have increased at a faster rate than for people with poor qualifications. For example in the mid-1970s men with an A-level earned 22 per cent more than those without qualifications, but by the mid-1990s this had more than doubled to 46 per cent.

⁴ This is based on provisional data from the Department of Health.

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Relative pay trends

11.13 The changes in the health service pay bill are an important driver of total expenditure on health. For recruitment and retention, another key factor is relative pay, i.e. how the pay of health service staff compares with that of people in other occupations and sectors. Overall NHS earnings have been increasing at a faster rate than whole economy earnings – but this does not necessarily mean that relative pay has improved. As explained above, much of the increased cost is the result of skill mix changes rather than above average increases in the pay of specific groups of staff such as doctors or nurses.

11.14 Over the past two decades, doctors have broadly maintained their position in the earnings ranking for the workforce as a whole. In the period from 1975 to 1979 male doctors' earnings were higher than between 85 and 92.5 per cent of working men, depending on their age. By 1999 they earned more than 90 percent of men aged between 31 and 50. For female nurses, however, the increases in pay over the last 20 years have not been sufficient to maintain their position in the overall labour markets earnings scale. An additional 8 per cent of women earn more than nurses in 1999 than did so 20 years ago. The decline in female nurses' relative earnings reflects the increasing range of alternative, higher paid employment opportunities which have become available to women over this period.

Table 11.1: Percentile position of female nurses and male doctors in the overall pay structure

Age	Female nurses		Male doctors	
	31–40	41–50	31–40	41–50
1975–79	64.2	66.6	84.6	92.5
1980–84	61.9	66.2	89.4	94.0
1985–89	57.8	64.9	91.5	93.1
1990–94	57.5	62.6	91.8	94.8
1995–99	56.1	59.2	87.9	89.6
1999	56.1	57.9	89.3	90.5
Change in position between 1975-79 and 1999	-8.1	-8.7	4.7	-2.0

Source: Nickell S and Quintini G (2001), *The Consequences of the Decline of the Public Sector Pay in Britain: A Little Bit of Evidence*.

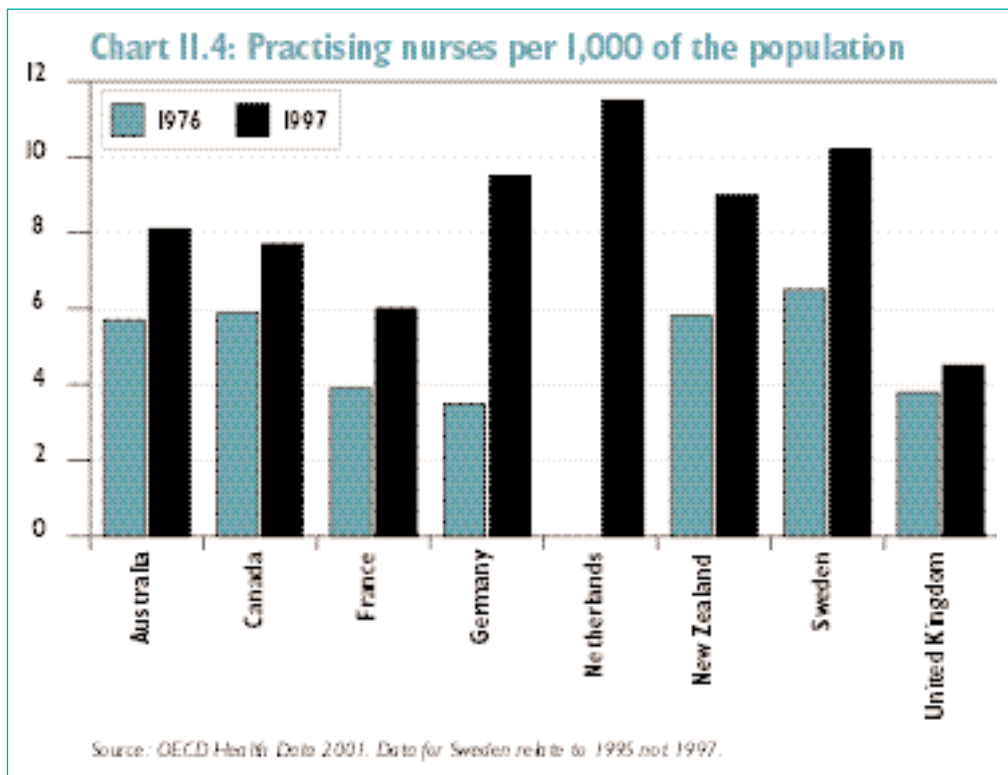
11.15 The position of doctors and nurses in the whole economy earnings' scale are the average for Great Britain. The NHS employs doctors and nurses in every town and city in the country. But geographical variations in health service pay within the UK are muted compared to variations in other sectors of the economy and compared to the cost of living. Relative pay in specific locations may vary significantly from this overall position.

The changing workforce

11.16 The next two decades will see a further acceleration in the pace of change for the NHS workforce. As the NHS Plan recognises, the health service needs more staff. But it also needs to change the way staff work in the future and to ensure that training and education reflect the changing role of NHS workers.

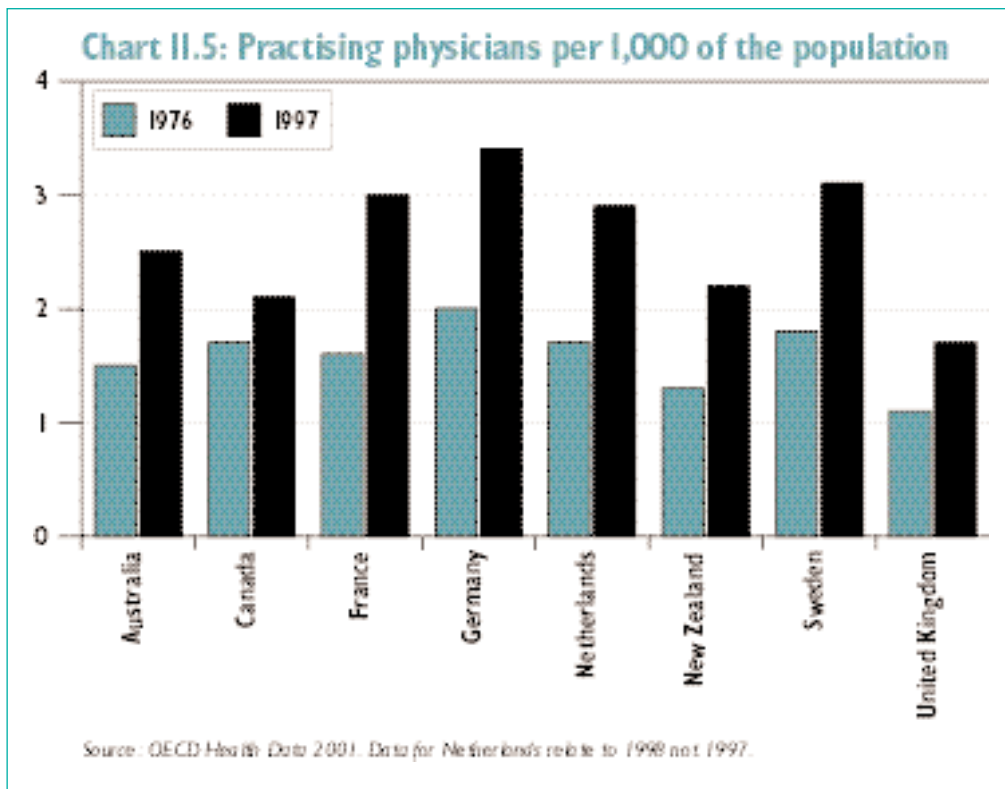
Staff numbers in 20 years' time

11.17 The UK currently employs fewer doctors and nurses per head than most European countries, at 1.7 doctors and 4.5 nurses per thousand of the population in 1997. Charts 11.4 and 11.5 compare the number of doctors and nurses in the UK over the last 20 years against the seven principal comparator countries examined for this Review. The UK now has substantially fewer doctors and nurses per head of population than any of these other countries⁵.



⁵ These data are based on the number of fully, qualified registered nurses and exclude the health visitors. The exclusion of health visitors means that there is an underestimate of the nursing workforce in the UK.

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11.18 Although numbers in the UK have increased, they have not increased at the same rate as in other countries. For nurses, in particular, the UK's relative position has been declining as other countries have expanded their nursing workforce at a much faster pace. Over the last 20 years, the number of nurses in the UK has increased by less than 20 per cent compared to a 65 per cent increase across the seven principal comparator countries. Since the NHS was founded, the UK has operated a system of central control of the annual intake into UK medical schools. The slower rate of growth in the number of doctors and nurses in the UK reflects conservative estimates of the future demand for doctors and cut backs in nurse training in the 1980s.

11.19 The number of staff alone is not a guide to the quality and efficiency of a country's health service; that depends on the skills of the staff, the structures within which they are employed and motivated and the other resources, particularly technology, which support them. But numbers are important and undoubtedly act as a constraint on the achievements of the health service.

11.20 The NHS Plan set out targets for the NHS workforce in England by 2004 of:

- 7,500 more consultants;
- 2,000 more GPs;
- 20,000 extra nurses; and
- over 6,500 extra professionals allied to medicine.

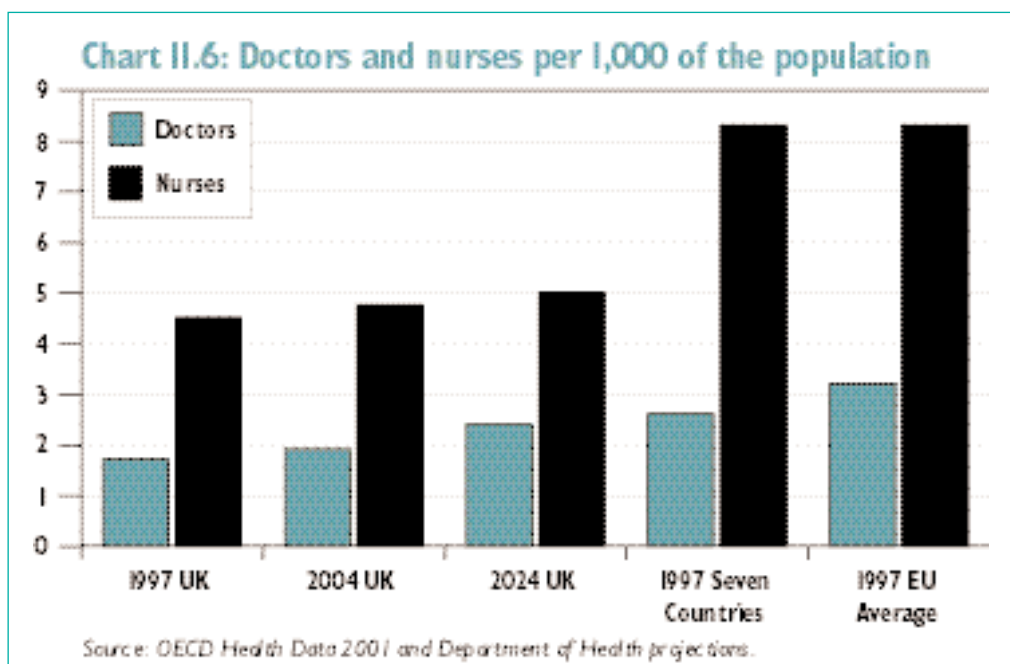
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Overall, this means that over 20 per cent more doctors will be employed in the NHS in England in 2004 than in 1997. Over the same period the number of nurses will increase by over 10 per cent.

11.21 Alongside this, the Government has put in place a significant expansion in the number of doctors, nurses and other health professionals in training. As a result, the number of doctors, nurses and other health professionals will continue to increase substantially beyond 2004. The expansion in training places means that, in 20 years' time, assuming similar wastage rates to today, there will be:

- 30,000 extra specialist doctors and GPs, a 50 per cent increase on top of the expansion outlined in the NHS plan;
- 24,000 extra nurses and midwives, a 7 per cent increase on top of the expansion outlined in the NHS plan;
- 94,000 extra qualified scientific, technical and therapy workers, an 80 per cent increase on top of the expansion outlined in the NHS plan.

Taken together, these represent a total increase in the qualified clinical workforce of just under 150,000 people. Chart 11.6 shows how the increases in the doctors and nurses would affect the number per thousand of population. The UK would still be below the average 1997 figures across the EU⁶. The gap will be much greater for nurses than for doctors.



⁶ OECD data related to the number of practising doctors on each country, but at least two countries figures are the total number of qualified doctors.

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11.22 Differences in the organisation and efficiency of different countries health care systems mean that there is scope for large variations in the productivity of doctors and nurses in different countries. For example, countries with fee-for-service reimbursement systems and no primary care gatekeeper, are more likely to experience over utilisation of health care. As a result there is no evidence that the UK should match the EU average number of doctors or nurses per head of population. To decide on the 'right' level of staffing for the UK, it is also necessary to consider the scope for changes in the skill mix and productivity of the UK's health care workforce.

11.23 The workforce expansion set out in the NHS Plan and expansion of training places mean that in the future, the health service will have:

- a smaller proportion of qualified nurses and midwives in the overall clinical workforce, possibly reducing from 61 per cent of the clinical workforce to only 51 per cent unless further increases in training are implemented. Nursing growth is forecast to slow after 2005 because of higher levels of retirement. A further increase in numbers of nurses and midwives in training of 20 per cent beyond the 2003-04 target, if achievable, could produce an additional increase in the workforce of around 44,000 in 20 years' time;
- more highly-skilled doctors, current plans will mean that qualified specialist doctors and general practitioners will increase from around half of the medical workforce to two-thirds; and
- more consultant-provided services with junior doctors responsible for considerably less patient care. This will result from a combination of factors including the growth in the number of consultants, implementation of the Working Time Directive and reform of doctor training;
- a significant growth in the number of nursing and midwifery consultant and practitioner roles and further development of nurse and midwife-led services. Similar developments are likely to take place for other non-medical professions; and
- an expansion in the health care assistant (HCA) workforce to offset the relatively slow growth in the qualified nursing and midwifery workforce. This may pull existing or potential staff away from the social care workforce.

The health service pay bill in 20 years' time

11.24 The rate of growth in the NHS pay bill over the next two decades will depend on the rate of earnings growth for individual staff groups, changes in the mix

of skills and the degree of any productivity gains from the many sources apparently available.

11.25 The starting point for pay assumptions is the expected increase in earnings across the economy as a whole. In real terms, over the long run, these should reflect the rate of growth in whole economy labour productivity. The long-term Treasury projections are currently based on a trend rate of growth in labour productivity of around 2 per cent a year. The question for the Review is: are there any reasons to believe that pay growth or productivity gains in the health service will diverge significantly from this? The main reasons for health service pay to diverge would be if:

- the NHS was competing for a pool of skills where economy wide pay increases were higher than this; and
- there was a large mismatch between the demand for suitably skilled health care workers and their supply.

The long lead-in times for training means that an excess demand would be reflected in recruitment and retention problems leading to higher pay.

11.26 If more than the required number of workers were trained, excess supply would probably be manifested by low participation rates in the health sector and lower pressure on wages. Medical and nurse unemployment or underemployment would incur the opportunity cost of excess investment in human capital but it may be that training more people than might be required would be less costly and less risky than training too few.

Recruitment and retention in the next 20 years

11.27 In order to consider the potential for a significant mismatch between the demand for, and supply of, workers in the health service, the Review is examining the following issues:

- how the growth in the number of skilled staff which the Department of Health and NHS has put in train compares with likely demand over the next 20 years;
- whether it is likely to be possible to continue to draw on doctors, nurses and other professionals from overseas; and
- whether the demands for skilled labour from other parts of the labour market will make it more difficult to recruit and retain staff.

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International migration

11.28 The UK has a long tradition of employing health care workers from overseas and this trend is gaining momentum in social care. Overseas staff have been drawn from Europe and the rest of the world.

11.29 The European Investment Bank has reviewed the expected trends in medical employment in the EU over the next 20 years. For this Review, it has examined the implications of these European changes for the UK⁷. The key findings are:

- in the short term there is an excess supply of doctors across Europe; 8 per cent of doctors across Europe are currently unemployed. National unemployment rates for doctors vary from 0–24 per cent. The main countries with excess supply are Italy, Germany, Spain, Austria and the Netherlands;
- in 20 years' time, the position in the current EU–15 is likely to be very different. Many of the countries with excess supply have declining overall workforces due to demographic changes and they are cutting back on the numbers of doctors in initial training. As a result, the overall surplus of doctors is likely to have been eliminated; and
- it is not clear what impact EU enlargement would have, if the EU grows to 28 countries, its population will increase by an additional 170 million people. Many of these countries have an excess supply of doctors – particularly the former Soviet countries of Estonia, Lithuania and Latvia. Income differences between these countries and the UK may make employment within the UK health service very attractive. However, most of their excess supply is in hospital-based specialists and there is very little excess supply of primary care physicians.

Wider trends in labour market

11.30 The Institute for Employment Research (IER) at the University of Warwick have undertaken work for the Review to look at how the demand and supply of skilled labour is likely to change over the next 10 years. This will help the Review to assess how difficult it might be for the health service to recruit and retain a particular number and mix of staff in the future. Some of the key points from the IER work are:

- the number of young people will continue to fall but this will be more than offset by further increases in participation in higher education. Meeting the Government's participation target and a

⁷ Jennett N (2001), Medical employment in the EU in 2022 – Implications for the UK, in Health Trends Review: Proceedings of a conference held at the Barbican Centre, London on 18 and 19 October 2001, HM Treasury, November 2001.

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continuation of recent trends in net migration could result in an annual increase of over 300,000 newly qualified entrants to the workforce a year at NVQ⁸ levels 4 and 5 over the next 10 years;

- those with NVQ level 4 and 5 qualifications as their highest qualification are projected to increase substantially as a share of the total workforce over the next decade. The numbers of those with NVQ level 3 as their highest qualification is projected to fall in both absolute and share terms making it more difficult than in the past to recruit good candidates at that level;
- graduates are expected to take the majority of all new jobs for higher level occupations. Demand is projected to grow particularly rapidly for those with social science degrees, although there is also likely to be high demand for science and vocational subjects. The public sector may face increasing competition for those with higher level qualifications; and
- projecting the likely balance between demand and supply is sensitive to the assumptions used. But on the basis of recent trends in the take-up of those with higher level qualifications into employment and supply meeting Government educational participation targets, the IER projections suggest that demand and supply for workers at NVQ levels 4 and 5 may be broadly in line with each other over the period. Within the total there might be a shortfall at postgraduate level and some surplus at first degree level. The projections make no assumptions about how the labour market would adjust to particular demand-supply imbalances.

11.31 The movement of staff between health and social care settings, especially in primary care, will be affected not only by wider trends in the labour market but also by the direct comparison between pay and conditions between the NHS and social care providers.

Productivity

11.32 In order to assess the overall rate of increase in the pay bill over the next 20 years the Review also needs to consider the scope for improvements in the productivity of the workforce. Productivity improvements could come mainly from:

- increasing the effectiveness and efficiency of the work of individual staff groups, using new and existing technologies better, greatly improved information and communication technology (ICT) and processes which enable the whole health care system to be considered at national and local levels; and
- changing skill mix.

⁸ NVQ level 5 relates in this work to higher degrees. NVQ level 4 includes first degrees and equivalent, higher education below degree level, HNC BTEC, RSA Higher and nursing and teaching qualifications. NVQ level 3 includes A level and equivalent, GNVQ advanced, ONC and BTEC National.

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11.33 The historic trend in the hospital and community health service has been for labour productivity to increase by an average of 2 per cent a year i.e. in line with the trend for the economy as a whole. This figure should be treated with caution as there are significant problems in measuring labour productivity in the NHS to ensure that quality of care rather than just the volume of activity is properly taken into account. There is the further problem of aggregating the volumes of many very different types of activity.

Productivity – contact time

11.34 A key factor in health care labour productivity is the percentage of time doctors, nurses and health care professionals are able to devote to patient contact. There is a limited amount of evidence available on the allocation of time by health care professionals. The most robust evidence comes from the US which indicates that, on average, less than a third of health care professionals' time is spent with patients⁹. A few micro studies in the UK have replicated the US research and confirm that current rates are similarly low¹⁰. Contributory factors are:

- the amount of time spent on administrative tasks and record keeping; and
- system deficiencies and strict role demarcations which result in task duplication and excess waiting times.

Process redesign, new technologies, more effective use of support staff and much greater flexibility in the roles and responsibilities of different staff groups should all create scope to increase the proportion of time health care professionals spend with their patients. The evidence suggests that patient expectations will be for longer consultations with their doctor as they are better informed and take more responsibility for their health care. This offers scope for significant productivity and/or quality gains, particularly if coupled with improved clinical governance arrangements.

Productivity – patients as co-workers

11.35 The extent to which patients are willing and able to take responsibility for elements of their own health care will have an important influence on the scope for productivity gains in the health service. If patients are able to manage more of their own routine care this will free up the time of skilled health care workers to devote to the more complex needs of patients. In other sectors of the economy technological change has often enabled individuals to take a more active role.

11.36 In the health sector there is also a close link between technology and the scope for patients to take more responsibility for their own health care. Information technologies which provide people with more information are

⁹ Lathrop P (1993), *Restructuring Healthcare: The patient focused paradigm* Jossey-Bass Inc, San Francisco.

¹⁰ Personal Communication, Durrow Consultancy.

obviously important. One of the most important areas for greater partnership between patients and health service staff is the management of chronic conditions. Technological developments are likely to be important in facilitating change in this area. Improvements in home monitoring and self-testing techniques for a range of conditions are an obvious example, potentially capable of releasing staff time for other aspects of patient care.

Productivity – changing the skill mix

11.37 The way the role of health care workers develops over the next 20 years will have a potentially profound effect on the UK's health service. With such a large, specialised and highly skilled workforce it is vital that the health service makes best use of this scarce resource. The Review has drawn together advice and evidence on the possible changes that might occur in the role of health workers over the next 20 years. The sections below set out some of the main trends that the Review has identified. The assumptions which the review makes about the role of health care workers will be a key factor underpinning our assessment of the cost and productivity of the service.

11.38 Changes in skill mix over the past 20 years have added to the cost of health care. Over this period, there has been an increase the proportion of the more highly skilled within the workforce. Over the next 20 years, skill mix changes within the medical profession may continue to be cost additive with the move to an increasingly consultant-provided service, the reduced reliance on junior doctors for much patient care and implementation of the Working Time Directive.

11.39 There is a body of evidence suggesting that there is significant, untapped potential for fundamental changes to the mix of staff providing much health care. The most significant areas seem to be:

- a substantial change in the mix of services provided by doctors and nurses. A review of the existing evidence suggests that between 25 and 70 per cent of doctors' tasks could be undertaken by nurses or other health care professionals¹¹. The evidence suggests that, while maintaining or reducing costs this could improve care outcomes, suggesting scope for improved productivity; and
- much greater use of health care assistants (HCAs) to undertake much of the routine work undertaken by nurses.

11.40 New roles may well emerge, for example:

- 'physician assistants' – registered professionals able to undertake many of the routine tasks currently provided by doctors in primary care, A&E departments and follow-up outpatient appointments;
- 'health care practitioners' – registered health care professional able to span a number of current professional boundaries;

¹¹ Richardson G, Maynard A, Cullum N and Kindig K (1998), Skill mix changes: substitution or service development? *Healthy Policy*, 45 (2):119–132.

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- ‘health care technicians’ – health care workers with a range of skills but not registered; and
- ‘care co-ordinators’ – health or social care workers supporting patients with chronic and major conditions across institutional boundaries.

Skill mix – an ever increasing role for nurses

11.41 Recent developments such as NHS Direct, walk in centres and the emergence of digital health and on-line services mean that patients are accessing primary care services in an increasing variety of ways. This trend is likely to continue over the next two decades. One important aspect of these new services is that many rely heavily on nurse-led services for the first contact in primary care. Within the traditional setting of the GP surgery, nurse-led services are also likely to continue to expand.

11.42 The available evidence supports an expansion of the role of nurse practitioners. Studies suggest that patient safety, drug prescribing rates and satisfaction are just as high with nurse practitioner services. Indeed, in three randomised controlled trials, patient satisfaction was higher with care given by the nurse practitioner^{12, 13, 14}. The nurse practitioner role is different to that of a doctor. Their main focus is on providing minor illness services, triage to assess patients needs, outreach services to communities with poor access to primary care – examples include the homeless and prostitutes – and health education and promotion. In primary care a study found that between 20 and 32 per cent of GPs could be replaced by nurse practitioners¹⁵. If applied in England substituting nurses for doctors at this rate has been estimated to offer potential savings of £300 million a year at 1995 prices¹⁶. Another study suggests that the potential savings from a policy of substituting nurses for doctors are around 10 per cent of total medical costs¹⁷. The extension of nurse prescribing will be one key factor in the speed and rate of change.

¹² Venning et al (2000) Randomised controlled trial comparing cost-effectiveness of general practitioners and nurse practitioners in primary care, *British Medical Journal* 320:1048-53.

¹³ Kinnersley P, Anderson E, Parry K et al (2000), Randomised control trial of nurse practitioner versus general practitioner care for patients requesting same day consultation in primary care *British Medical Journal* 7241, April 15th 1043-1048.

¹⁴ Shum C, Humphreys A, Wheeler D, Cochrane M, Skoda S, Clement S (2000), Nurse management of patients with minor illnesses in general practice: a multi centre randomised control trial *British Medical Journal* 7241, 15th April. 1031-1043.

¹⁵ Lomas J, Stoddart GL (1985) Estimates of the potential impact of nurse practitioners on future requirements for physicians in office-based general practice. *Canadian Journal of Public Health* 76:119-23.

¹⁶ Richardson G, Maynard A (1995) Fewer doctors? More nurses? A review of the knowledge base of doctor – nurses substitution. Centre for Health Economics Discussion Paper 135. University of York.

¹⁷ Denton FT, Gafni A, Spencer BG, Stoddart GL. (1983) Potential Savings from the adoption of nurse practitioners in the Canadian Health Care System, *Socio-Economic Planning Sciences* 17(4):199-209.

- 11.43 The cost impact of a major shift in the balance between GP and nurse practitioners will depend, in part, on the time spent with patients by different staff groups. At present, nurse practitioners tend to spend longer with their patients, indeed this may be part of the reason for the high levels of patient satisfaction¹⁸. This additional time will offset at least some of the savings in terms of staff costs from the development of nurse practitioner services. But, it costs up to seven times as much and at least twice as long to train a GP. This suggests that the overall benefits favour such a shift.
- 11.44 The expansion of the role of nurses in primary care is likely to be mirrored by similar developments in secondary care. In A&E departments, some studies have found that up to 20 per cent of the activities undertaken by junior doctors could be carried out by nurse practitioners¹⁹. As the number of nurse practitioners grow, so will the number of nurse consultants. With these new roles, nurses will be extending their clinical decision-making and leadership responsibilities for example in pre-operative assessment and advice on discharge.
- 11.45 Nursing staff are a highly valuable resource to the health service. Structuring the workforce to ensure effective utilisation of their time and skills in primary and secondary care will be a key challenge. Over the next 20 years the expansion of nurses' role in clinical decision-making and leadership is likely to be accompanied by greater use of HCAs. HCAs are staff who are typically trained to NVQ level 3 and who support nursing staff by undertaking routine clinical work. In primary care, this might include taking blood, blood pressure measurement, routine administration and new patient screening. The HCA role is not new. In practice HCAs have substituted for nurses in a number of ways over a number of years. The NHS workforce plans call for an expansion of their numbers. Increasing the number of HCAs has the potential to deliver significant productivity gains, releasing more of the time of highly skilled nurses allowing them to undertake work for which their specialist skills are vital. The research evidence for HCAs is more limited than for nurse practitioners. But, in a Manchester pilot, employment of an HCA almost eliminated the role of the practice nurses in stock ordering for a primary care practice²⁰.

The changing role of the doctor

- 11.46 A number of important changes are likely to affect the medical workforce over the next 20 years. These include:
- systematic implementation of clinical governance;
 - many more specialists are likely to be located outside hospitals, probably in medical centres or primary care clinics, this is very common in other countries;

¹⁸ Venning et al (2000) op cit.

¹⁹ Greenhalgh and Co. (1994) *The Interface Between Junior Doctors and Nurses*, Greenhalgh Ltd. Macclesfield.

²⁰ Marsden J and Street C (2000), *Health care assistants in primary care, pilot project evaluation*, Report commissioned by the Manchester Health Authority.

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- GPs will have a much greater role in the strategic management of health care. They are increasingly expected to be managers of major health care resources and to be subject to detailed accountability procedures; and
- much more joint working with social care and other related services such as education for children.

11.47 However, perhaps the biggest issue for the medical workforce over the next two decades is the specialist-generalist debate. The last few years have seen a proliferation of subspecialties in hospital medicine. The general physician specialism now includes 25 sub-specialties. A number of forces are pushing medical services towards even greater specialisation; in particular:

- a significant growth in direct access services provided by other health professionals. In addition to nurse practitioners there is likely to be a significant expansion of direct access services for allied health professionals such as occupational therapists and physiotherapists;
- the pace and complexity of technological advance;
- litigation and safety; and
- evidence linking some measures of quality – for example, surgical outcomes – to greater specialisation.

11.48 Against this there is evidence that generic skills are important, particularly in relation to continuity of care and the treatment of people with multiple health problems. With an ageing population, the need to ensure integrated care which addresses patients' health care needs holistically points to a key role for generalists working across the health and social care boundary in delivering quality. GP services are seen by patients and most commentators – both in the UK and in other countries – as a major strength of the health service in the UK. Cross-country studies of health care systems suggest that countries, like the UK, with strong primary care achieve better health outcomes for their populations and are more efficient. The GP's gatekeeper role provides continuity of care and a mechanism to ensure appropriate use of more specialist services.

11.49 Reconciling the move to greater specialisation within medicine and an expansion of direct access services provided by other health care professionals, with the need to maintain the benefits of the GPs traditional gatekeeper role will be a vital challenge for the next 20 years. The outcome is likely to have significant resourcing implications.

11.50 One possible vision of the future is:

- individuals will be responsible for more of their healthcare, either managing minor illnesses without the need of support from health care professionals or, working with health care professionals, taking a more active role in their own treatment;
- a large part of the first and routine contacts between patients and the health service will be provided by nurses and other health and social care professionals in community based settings. The services might cover for example, minor injuries, minor surgical procedures, counselling, laboratory work and care of the elderly. The setting where care would be provided might include the patients' home and health centres or could be in any location via the telephone;
- health care assistants to undertake a large part of the routine work which nurses currently undertake in primary and secondary care;
- GPs will focus on patients with more complex health problems and provide a wider range of diagnostic and treatment services in the community. This will allow more services to move from secondary to primary care;
- GPs will become more specialised. They will work in teams including for example, paediatricians; geriatricians; psychiatrists and geneticists;
- more older people will be supported at home or in intermediate care facilities. Their treatment will be managed by community-based health care specialists;
- major acute hospitals will be focus on providing 24 hour intensive and high dependency care. They will be centres of excellence for tertiary and high tech services. They will be staffed by doctors who are increasingly specialised and act as a centre of care networks; and
- the increase in specialisation will probably continue but all specialists will have a strong general background and will work closely with community physicians to ensure holistic care for patients.

Conclusion

11.51 The health and social care workforce is a key driver of the volume, cost and quality of health care in the UK. As the NHS Plan made clear, the UK has too few doctors, nurses and other health care professionals. A substantial expansion in the numbers is now planned. However, if current trends are allowed to continue there could be a greater increase in the medical workforce than in the nursing workforce. In 20 years, the number of doctors will increase from 1.7 per thousand of population to 2.4 and nurses from 4.5 to 5.0 per thousand of population. It takes a long time to train doctors and nurses so having the right workforce in place in 20 years' time will depend to a large part on decisions taken in this decade.

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- 11.52 Although the number of health care professionals is important for the capacity of the system, arguably the way the workforce is used is even more important.
- 11.53 Straight-line projections of current demand and its implications for the workforce are unlikely to be the best way to assess the future demand for health care workers. It seems likely that there will be major changes in the roles of different groups of workers and considerable scope for the health service to make better use of its most skilled workers. These changes offer the potential to significantly improve the productivity of the health service. Even more fundamentally a significant shift in the balance between professional care and patient's self-care would have far reaching implications for the health and social care workforce.

Questions for consultation

Workforce:

Q11.1 What are the key changes in the roles of health care professionals that are likely to occur over the next two decades, in particular:

- what is the scope for a significant expansion in nurse-led services;
- how will the use of health care assistants change;
- how will the roles of specialist and generalist doctors change; and
- how will partnerships with other professionals, especially social care, change?

Q11.2 Will the current training places give the UK the number and mix of health care professionals it needs?

Q11.3 How can a mismatch between the demand and supply of skilled labour in the health service be avoided? What implications will this have for the cost of the workforce?

Productivity:

Q11.4 What is the scope for significant gains in the productivity of the health care workforce beyond the 2 per cent a year growth which might be expected for the UK workforce as a whole? Will productivity gains be more likely to improve quality and outcomes or to reduce costs and improve efficiency?

Q11.5 What other factors will drive productivity gains and what are the potential barriers to achieving them? Is it skill mix, contact time or other workforce and organisational factors?

Q11.6 What would be the impact of patients becoming much more involved in their own care?

England, Northern Ireland, Scotland and Wales have different health needs reflecting differences in their populations, environments and economies. However, over the next 20 years, the overall impact of the major health trends is likely to be similar across the UK.

This chapter looks at the differences in population composition, health need and economic performance between the four countries. It outlines the current levels of resources, plans and priorities for health. The main points are:

- population profiles and patterns of morbidity vary between the four countries;
- death rates are higher in Northern Ireland, Scotland and Wales than in England, although more health service resources – money, beds and doctors – are available per head;
- providing services to meet local needs such as those of remote and rural areas and dealing with pockets of severe social deprivation create extra demand in Northern Ireland, Scotland and Wales;
- plans for future health services are broadly similar although the organisation of the NHS is diverging;
- Northern Ireland, Scotland and Wales have lower income per head and employment rates than England; and
- the varying needs of the regions within England also need to be considered, as average figures may obscure regional variations.

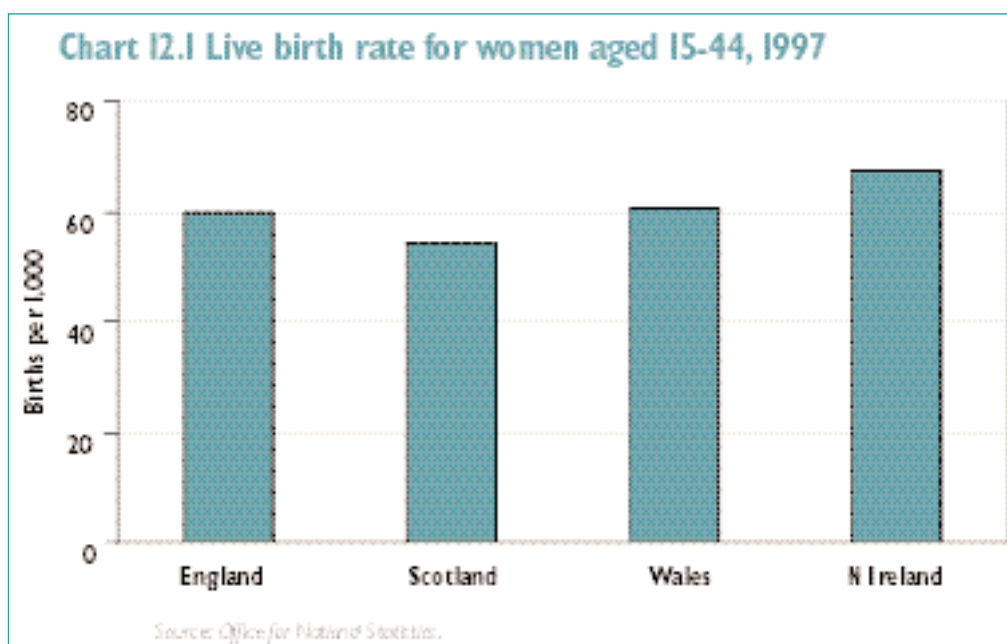
12.1 Health services in England, Northern Ireland, Scotland, and Wales have been managed separately since their inception in 1948. As a result, there are a number of differences in the provision of health services within the UK. In Scotland and Wales, responsibility for health services is now fully devolved and so policy may diverge in future. Patterns of morbidity and exposure to risk factors are not uniform within the UK. Differences may occur in terms of:

- population size and composition;
- mortality and morbidity rates;
- social deprivation;
- major diseases;
- health service resources and expenditure per head;
- economic performance;
- policy and plans; and
- organisation and management.

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Population size and composition

- 12.2 In 1998 the Office for National Statistics (ONS) estimated the population of the UK to be almost 60 million people. The size of the countries within the UK differs markedly. The majority live in England. Scotland has a population of around 5 million, Wales just under 3 million and Northern Ireland, 1.5 million. The age structure of the population varies: Wales has the highest proportion of elderly people with one in six over 65 and one in twelve over 75. Northern Ireland has the youngest population with less than one in eight over the age of 65 and fewer than one in sixteen over the age of 75. England and Scotland have a similar age profile with just under one in seven being over 65.
- 12.3 The central population projection suggests that, over the next two decades, the population of England and Northern Ireland will grow by around 8 per cent and by half that rate in Wales. In Scotland the population is projected to fall by around 1 per cent. Chart 12.1 shows the live birth rate, which is lowest in Scotland and highest in Northern Ireland.



- 12.4 The population aged under 45 is forecast to decline as a percentage of the overall population in all four countries, this decline being particularly steep in Northern Ireland. The 45–64 age group is projected to increase in all counties of the UK, with growth ranging from 2 per cent in Wales to 5 per cent in Northern Ireland. Growth rates in the age groups over 65 are projected to be similar in all four countries.
- 12.5 The distribution of older people and so of health need varies between regions and health areas. In 1999, ONS and General Register figures showed that 18.4 per cent of the population of the South West region of England were over 65, compared with the average for England of 15.6 per cent. In Wales the figure

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was 17.3 per cent, Scotland 15.3 per cent and in Northern Ireland 13 per cent. National averages can mask considerable local variations. For example, in Scotland in 2001 the proportion of the population aged over 65 in Health Board areas varied from 13 per cent to 19 per cent. More importantly, by 2016, the remote and rural areas will have among the highest proportions of older people. The highest need will therefore exist in those areas where it is most difficult to provide services.

Mortality and morbidity

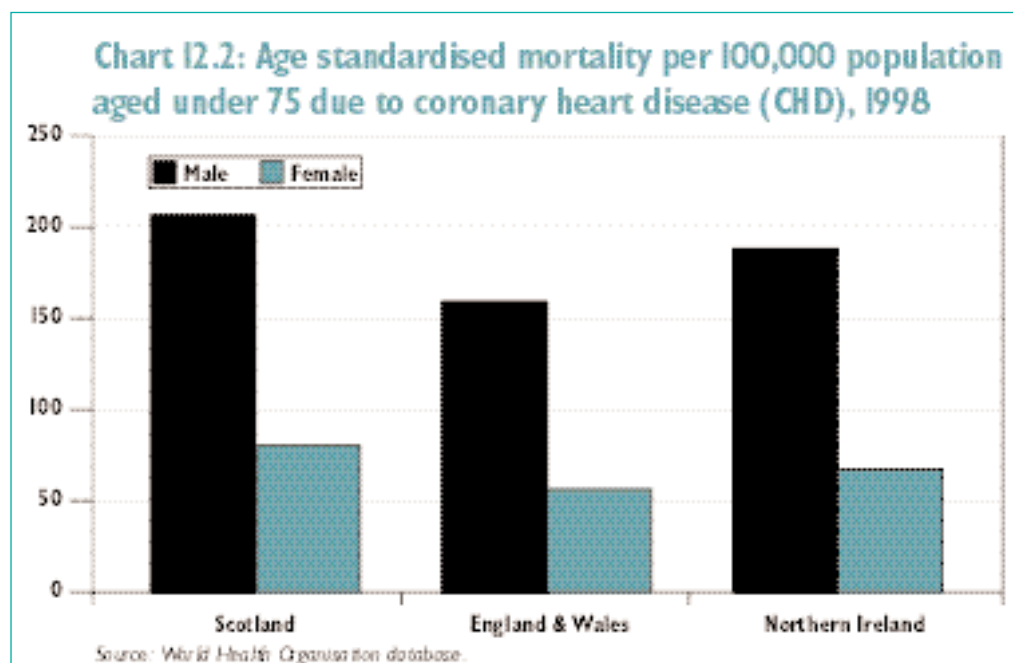
12.6 The crude death rate is highest in Wales, reflecting the relatively high proportion of elderly people. Age-adjusted death rates are higher in Scotland than in the rest of the UK, suggesting poorer health status (see Table 12.1).

Table 12.1: Death rates in each of the countries of the UK

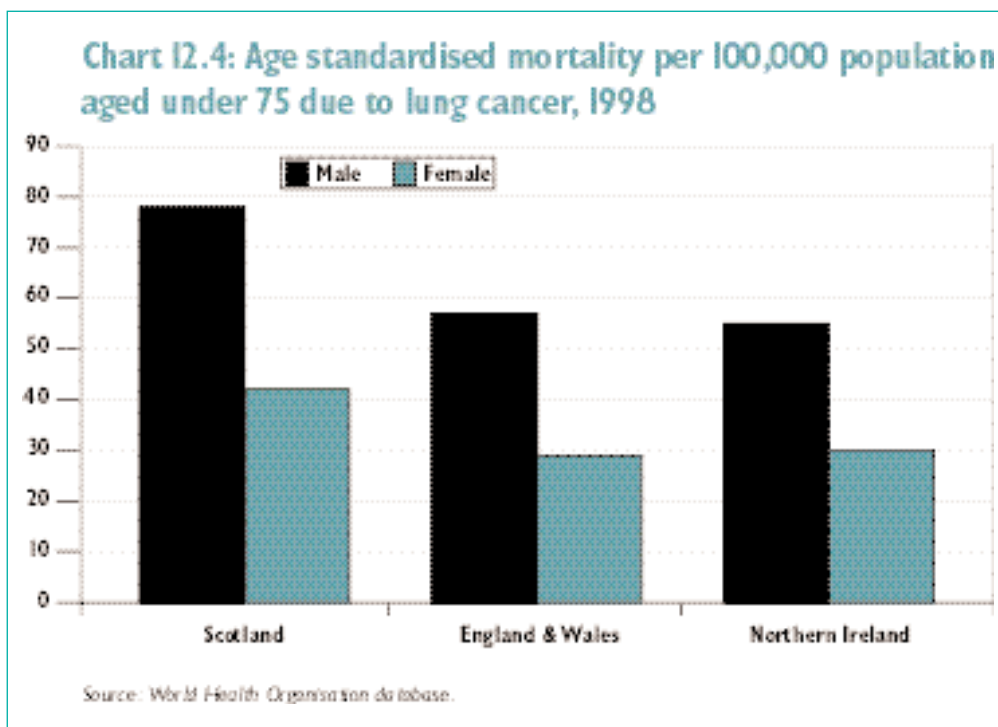
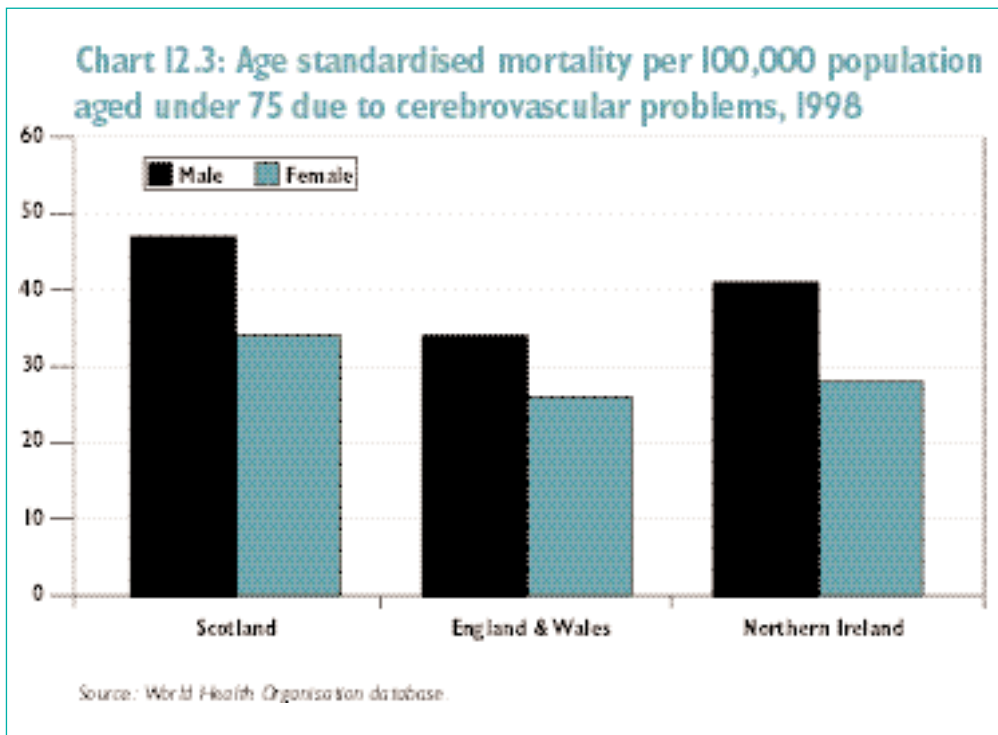
Death rates, 1997 (per 1,000 population)	England	Wales	Scotland	Northern Ireland
Crude death rate	10.3	11.9	11.6	9.0
Age adjusted:				
Males	9.6	10.2	11.5	10.6
Females	10.3	10.8	12.1	11.2

Source: Office for National Statistics, *Regional Trends*.

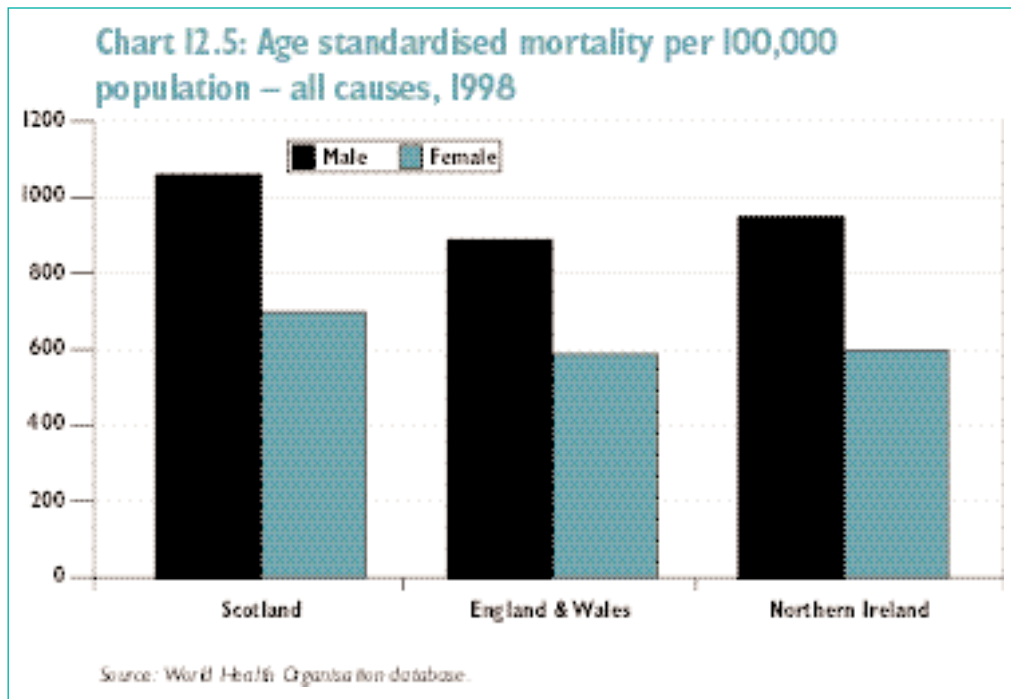
12.7 Infant mortality is similar in all four countries, ranging from 5.3 deaths per 1,000 live births in Scotland to 5.6 in Northern Ireland and 5.9 in both England and Wales. However, a range of other indicators shows that the health status of people in Northern Ireland and Scotland is generally below that for people in England and Wales. Death rates for coronary heart disease (CHD), cerebrovascular disease, lung cancer and overall age standardised mortality rates are all significantly higher (see Charts 12.2 to 12.5). These figures combine England and Wales.



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Social deprivation

- 12.8 The extent of social deprivation differs between countries, between regions within countries and even within very small local areas. Meeting both the needs of people in rural areas and those in pockets of severe urban deprivation is a key challenge for the devolved administrations.
- 12.9 The final report of this Review will explore the implications of the research on social deprivation and resource allocation, such as the Townsend review in Wales, the Arbuthnott review in Scotland and the Targeting Social Need initiative in Northern Ireland. The issues to be addressed include assessing health needs associated with socio-economic disadvantage and approaches to deal with inequalities in health, including estimating the additional cost of providing services in rural and remote areas. The Review needs to address how much of the variation between the countries of the UK is attributable to different levels of social deprivation.

Major diseases

- 12.10 Cancer is a major cause of death throughout the UK: one in four deaths are attributable to the disease. Age-adjusted mortality rates for cancer are higher in Scotland and Northern Ireland than in England or in Wales. In 1997, the mortality rate per 100,000 of the population was 307 in Scotland, 273 in Northern Ireland, 267 in Wales and 260 in England.
- 12.11 CHD is also a UK-wide problem, but prevalence is particularly high in Scotland – 43 per 1,000 men, compared with 39 in Wales and 34 in England.

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12.12 Mental health problems are highly prevalent: 133 women per 1,000 suffered from anxiety or depression in Scotland in 1997, compared with 83 in Wales and 81 in England. Chronic ill health in Great Britain has also increased, particularly among children, with 18 per cent of the under 16s and 62 per cent of those over 65 reporting chronic illness in 1998.

Health service resources

12.13 Clear comparisons of spending on health and social care are difficult due to different definitions and ways of organising health and personal social services. However, spending per head is higher in Northern Ireland, Scotland and Wales than in England, as Table 12.2 shows.

Table 12.2 NHS expenditure in each of the countries of the UK

	England	Wales	Scotland	Northern Ireland	UK
Spend per capita (1998–99)	£740	£822	£904	£819*	£766
Percentage growth since 1975–76	68	75	73	66	70

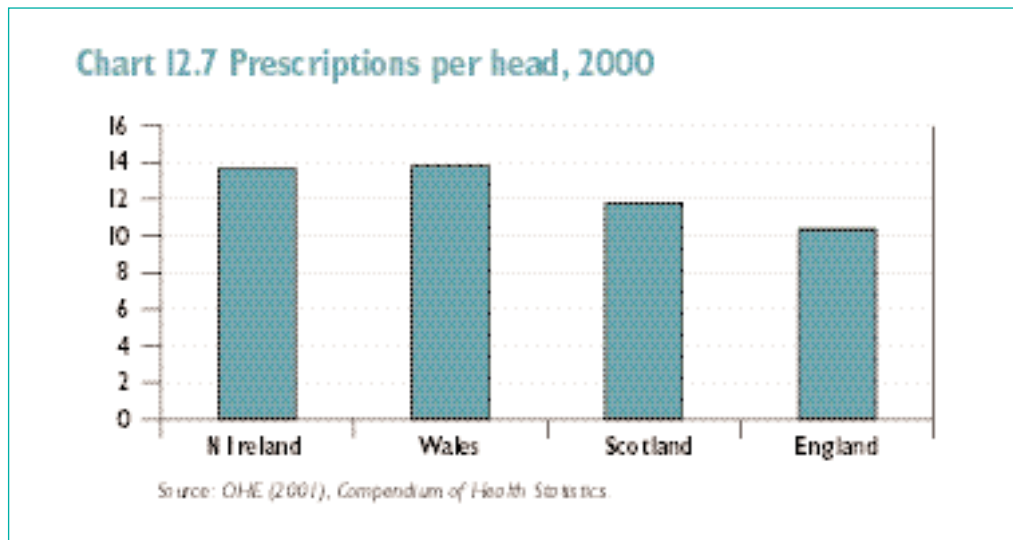
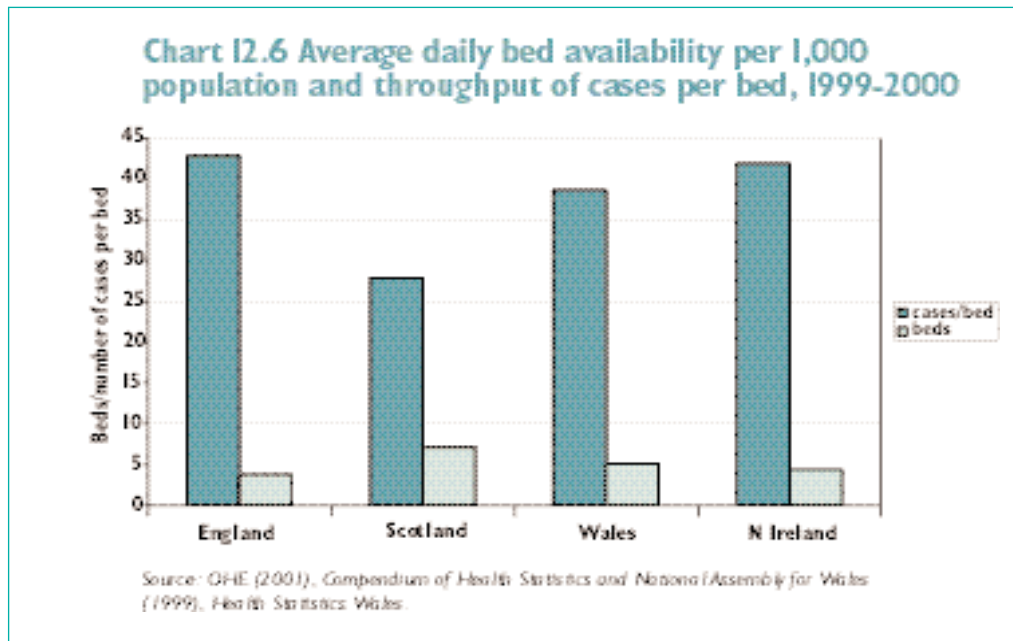
* NHS element of integrated health and personal social services budget.

12.14 The variation in spending per head is reflected in differences in the volume of health resources available within the UK. Northern Ireland, Scotland and Wales have more doctors per head of the population. GP list sizes are smaller in Northern Ireland, Scotland and Wales than in England and prescribing rates per head are higher.

12.15 Chart 12.6 shows that where there are fewest hospital beds (in England) they are used most intensively. Prescriptions per head are highest in Wales and Northern Ireland (13.9 and 13.7 respectively) compared with 11.9 in Scotland and 10.2 in England (see Chart 12.7).

12.16 There are fewer private sector health services in Scotland, Wales and Northern Ireland than in England. The availability of health care is therefore solely the responsibility of the NHS in a number of areas.

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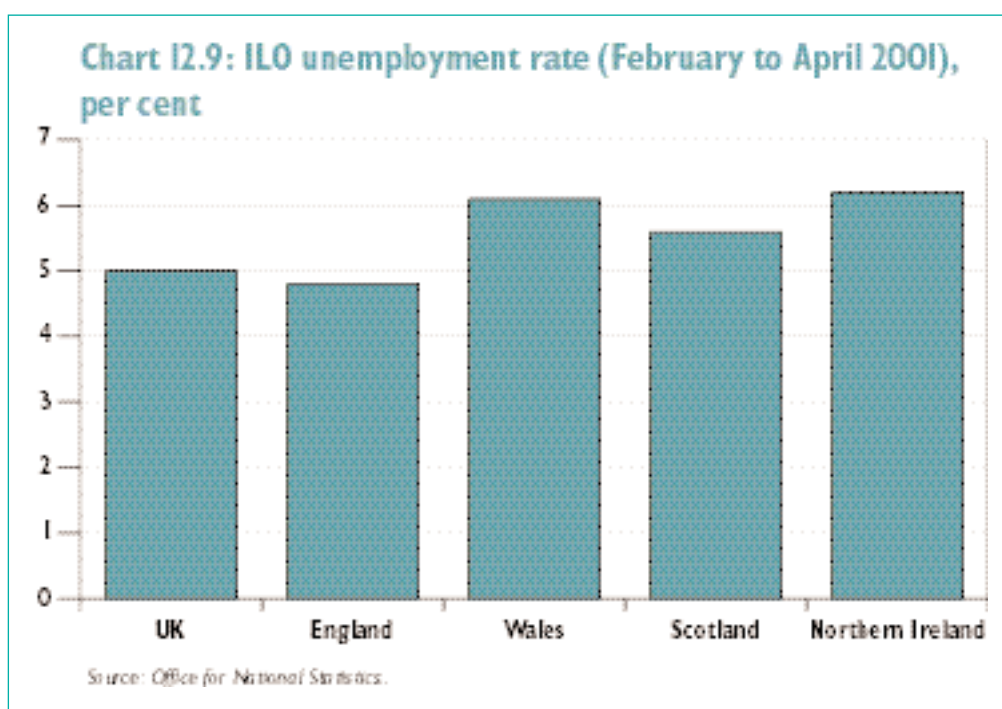
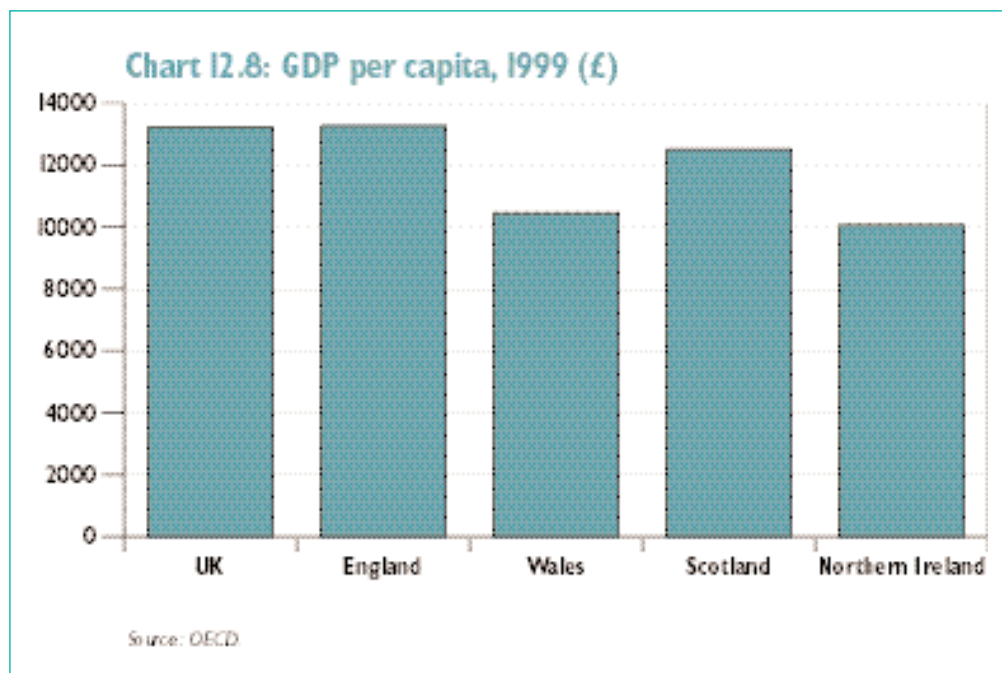
12.17 Plans for future spending envisage major increases in all four countries. Between 1998–99 and 2003–04, health expenditure in England is set to rise from £40 billion to £59 billion in resource terms. In Scotland, NHS expenditure is planned to rise from just under £5 billion in 1998–99 to £7 billion by 2003–04. In Wales, health expenditure will rise from £2.4 billion in 1998–99 to £3.8 billion in 2003–04 in resource terms.

12.18 In Northern Ireland, illustrative figures only are available as the forward budgets have yet to be agreed. However, in resource terms, health services are forecast to grow from £1.4 billion in 1998–99 to £2.02 billion in 2003–04.

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Economic performance

12.19 Income levels, economic growth rates and employment vary significantly between the countries that make up the UK. In 1999, Gross Domestic Product (GDP) per head was £13,278 in England. Income per head in Wales was just 80 per cent of this level. In Northern Ireland it was even lower at just three quarters of the average income in England. The difference with Scotland was narrower – GDP per head was 94 per cent of the level for England (see Chart 12.8).



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12.20 In addition, Chart 12.9 shows that Northern Ireland, Scotland and Wales all have higher levels of unemployment than England. These factors may make demand for health care higher in Northern Ireland, Scotland and Wales.

Policy and plans

12.21 The NHS Plan for England was followed by plans for Scotland and Wales. The policy background is therefore different for each country, although key themes and service priorities are similar. Boxes 12.1 to 12.3 provide some detail.

England

12.22 During the Review's further consultation period discussions will be held in the English Regions to explore the differing characteristics of health and social care across the country. At this stage of the Review, England has been taken as a whole.

Box 12.1: England

The NHS Plan published in July 2000 sets out Government policy for the development of the NHS in England over a 10-year period. Seven key strategies underpin the Plan:

- better prevention;
- better treatment;
- more patient involvement;
- faster, easier access;
- the right care in the right place delivered by the right people;
- a better environment; and
- better use of IT.

Key targets:

- reduce the maximum wait for an outpatient appointment to three months and the maximum wait for inpatient treatment to six months by the end of 2005;
- patients will receive treatment at a time that suits them in accordance with their clinical need: two thirds of all outpatient appointments and inpatient elective admissions will be pre-booked by 2003–04 on the way to 100 per cent pre-booking by 2005;
- guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours by 2004;
- to secure year-on-year improvements in patient satisfaction including standards of cleanliness and food as measured by independently audited surveys; and
- reduce substantially the mortality rates from major killers by 2010; from heart disease by least 40 per cent in people under 75; from cancer by at least 20 per cent in people under 75; and from suicide and undetermined injury by at least 20 per cent.

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Scotland

12.23 While *Our National Health* identifies the same three main clinical priorities as the NHS Plan – cancer, coronary heart disease (CHD) and mental health – the Scottish Plan also highlights older people and children/young people as priority areas. The provision of health and social care in Scotland differs from England because of the need to provide services in remote, island and rural areas. The Remote and Rural Areas Resource Initiative has been set up specifically to develop health care services and support for professional staff. There are also pockets of extensive urban deprivation. There is a less developed private sector than in England and there are varying trends in health-related behaviour – for example, alcohol and drug abuse. A declining rather than growing population – with a higher proportion of retired people and a smaller proportion of younger people in the workforce – will also pose challenges for health care. The distribution of older people will vary significantly between Health Board areas and so the pressure on services will be uneven.

Box 12.2: Scotland

Our National Health: a plan for action, a plan for change was published in December 2000 by the Scottish Executive.

The aims of the plan are:

- redesigning services around the patient;
- a commitment to improving health, not just health care and health services;
- making the NHS a truly national service;
- a joined-up, multi-agency approach; and
- a commitment to modernisation, including investment in staff and facilities.

Selected targets:

- CHD – maximum 12-week wait for angiography from time of seeing a specialist by 2002;
- maximum 24-week wait for surgery or angioplasty from time of angiography by 2002;
- cancer – managed clinical networks by 2002;
- older people – free home care support for four weeks following discharge from hospital;
- £36 million investment in learning disability services; and
- maternity and child health service frameworks to be produced.

Wales

12.24 The geography and organisational structure of the NHS in Wales differentiate it from England and from the rest of the UK. The population has greater needs in some respects, for example, due to the relatively high rate of disability. There are generally high utilization rates for services. Meeting the health care needs of people in remote and rural areas is a particular challenge for Wales. There are also pressures to contend with in providing comprehensive specialised services, as outlined in *Access and Excellence*. There is an active approach to health protection and public health, and there are close links between health and local authorities, which the National Assembly plans to strengthen by establishing Local Health Boards. Sustaining primary care in Wales is a major issue, particularly as utilization and prescription rates are high.

Box 12.3: Wales

Improving health in Wales: A Plan for the NHS with its partners was published in February 2001 by the National Assembly for Wales.

The Plan sets out to:

- improve the quality and effectiveness of health care;
- refocus health services to meet the needs of patients and communities;
- strengthen and develop family health services and extend the range of free services with Assembly funds;
- provide fairer and better hospital services;
- deliver more effective and better joined up services by improved joint working between the NHS, local government and their partners in the community;
- ensure greater participation by patients and the public in the NHS in Wales and a continuing role for Community Health Councils;
- value the staff who work in the service at all levels;
- prevent disease and ill health and help people take more responsibility for their own health by providing better information and support; and
- simplify the administration of the NHS in Wales by strengthening Local Health Groups, abolishing Health Authorities and setting out clear accountabilities at all levels.

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Northern Ireland

- 12.25 In Northern Ireland the *Draft Programme for Government*, February 2001, outlines targets for improved public health, health care and social services, and the *Acute Hospital Strategy* describes a vision of future services. The principles underpinning these plans are broadly similar to the NHS Plan in England: the NHS is to become more patient-centred. Improving health and reducing inequalities is emphasised as well as improving health care, and there is to be an inclusive and joined-up approach between agencies. The overall theme is of a need for investment in staff and facilities, matched by reform in the delivery of services.
- 12.26 The integrated nature of health and personal social services, and the demands of a younger population, differentiate Northern Ireland from the rest of the UK. Deprivation and rurality are also important factors to consider. Waiting lists are currently 50 per cent higher per head in Northern Ireland than in England and the acute hospital sector is under strain. A major statutory driver is equality of opportunity for people regardless of gender, age, marital status, disability, with or without dependants, religious belief, political opinion, racial group or sexual orientation.

Organisation and management

- 12.27 Structures for delivering change vary from country to country. In England there is a national Modernisation Board, with regional and local equivalents. In Wales there is a new All-Wales Health and Well Being Council to oversee implementation of the Plan. However, in Scotland there is no overall board and the emphasis is on local delivery through one unified NHS Board.
- 12.28 In England, *Shifting the Balance of Power* announced that there would be approximately 30 Strategic Health Authorities, working with Primary Care Trusts and NHS Trusts to modernise services. In Wales, the National Assembly will assume direct democratic control of its health responsibilities, health authorities will be abolished and Local Health Groups will in future have responsibilities for commissioning and delivering care. In Scotland, one unified NHS board is being created to form a single system for local health communities. In Northern Ireland, Health and Social Care Systems are the building block for service modernisation.

Conclusion

12.29 There are significant differences in demography, epidemiology, health care provision and funding between the constituent countries of the UK. However initial research suggests that the major trends that are likely to affect health and health care funding by 2020 are broadly similar. During the consultation process, the Review team would welcome any evidence of major divergences which might affect the findings for the UK as a whole.

Questions for consultation

- Q12.1 Are there any health trends that will affect different parts of the UK in different ways which need to be taken into account in the final report?
- Q12.2 How much of the variation between the countries of the UK is attributable to different levels of social deprivation?
- Q12.3 What specific aspects of morbidity and mortality are likely to vary from the UK average in each country?
- Q12.4 What impact, if any, will the differing forms of NHS organisation and management in the four countries of the UK have on resource needs?
- Q12.5 Will diverging population trends require a different approach to health care in England, Scotland, Wales or Northern Ireland?
- Q12.6 How will devolved responsibilities for health and social care affect technology diffusion and workforce development?
- Q12.7 What variations in health need between the English Regions need to be taken into account in the Review?

