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# Nursing, Employment, and Resource Allocation in a Reorganized National Health Service†

*Stephen L. Heasell\**

## INTRODUCTION

The aspiration that nursing will be, ever more fully, both a distinctive professional activity and integral to a comprehensive health care service raises legal issues and professional dilemmas about the allocation of responsibilities in health care. Many of these issues and dilemmas can also be seen as decisions to be made about the allocation of scarce resources for health care: the economic problem. Links of this kind can be expected in every national, regional, and institutional context. The detail of experience, debate, and responses will differ and can be used to inform decisions in each location, especially when considering what appears to be a major transition in contrasting but comparable health care systems.

In Britain in recent years, the debate about what nursing opportunities exist has been played out against the background of changes to the organization and management of health and related services, particularly those involving the National Health Service (NHS).<sup>1</sup> These changes, among many instigated by successive conservative central governments, have been presented prominently as ways to improve “value for money,” which some see as being synonymous with efficiency, in the allocation of resources for health care. What are the prospects of employment for nurses given their aspirations and in the light of these newly emerging features of organization and management? Equally, from the patient’s or the public’s perspective, what are the pros-

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1. For an overview of the reformed NHS, see Stephen L. Heasell, *Economic Aspects of Medical Negligence in the Context of the National Health Service in Britain*, 3 ANNALS HEALTH L. 205, 210-216 (1994).

pects for health care under the contemporary regime for allocating resources for the NHS, given the aspirations of nurses who have hitherto constituted so large a proportion of its workforce?

The paper is organized around a sequence of three interrelated issues. The final issue concerns the prospects for nurses and nursing employment in the NHS. Leading to it is a discussion of possible links between the reformed NHS after 1990 and the notion of rational resource allocation, followed by a focus on prospects for market competition involving the NHS. The sequence has been chosen to reflect an optimism in some quarters that the recent reorganization of management in health care in the United Kingdom will lead, via market competition, to a more rational and appropriate use of nursing and other resources. Those sentiments are subjected to critical review as the paper proceeds.

## I. THE REFORMED NHS AND RATIONAL RESOURCE ALLOCATION

Optimists about prospects in the reformed NHS (post 1990) have tended to present their case in terms of rational resource allocation. In particular, general managers of the various local organizations within the NHS express the prospect of making reasonable choices that establish, given the relevant resource constraints, the best ways to fulfill explicitly desirable outcomes or objectives. (Whatever they may be, the broad rhetoric usually speaks of meeting the health needs of patients irrespective of individual ability to pay.) To quote one NHS manager:

The separation of the purchaser role . . . from that of the provider of health services presents the opportunity for a much more explicit analysis of the health needs of the population and the setting of service specifications to meet those needs. Accompanying the analysis of need must be a rigorous assessment and evaluation of the most effective and economic ways of meeting those needs.<sup>2</sup>

Viewed from such a perspective, nurses or nursing services compose but one set of potential inputs; these inputs can best fulfill explicitly desirable outcomes by implementing reform measures.

Confidence appears to be more equivocal, however, specifically in the *discipline of a competitive market* for NHS health

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2. Chris West, in *POLICY ISSUES IN NURSING 57* (Jane Robinson et al. eds., Milton Keynes/Philadelphia, Open University Press 1992).

care, where health care is regarded as an output of the institution. There are those who seem to doubt that a market and its material incentives—in shorthand, “money”—will induce the appropriate choices to supply care and to employ inputs that have the capability to contribute to the provision of health care.

A recent, though early, survey of NHS managers’ views of the reforms found that:

55% of [District General Managers] believe that “a market is necessary to get the benefits of the purchaser-provider split,” while nearly one-third do not. Clearly therefore a bare majority of DGMs believe that at least the *threat* of competition is necessary to exert leverage, even if, as the case studies show, they do not contemplate moving much business from their main providers.<sup>3</sup>

This mix of managerial responses could be interpreted in several ways. Perhaps the strength of the support for the purchaser/provider split reflects approval mainly for the identification of clear and distinct individual and organizational responsibilities within the NHS. Taken literally, however, the nomination of purchaser and provider, that is, effective demand and supply, seems to imply the role of markets in some form.

It could be, then, that the apparently less emphatic approval of markets by managers reflects, more precisely, an aversion to the risk and rigours of having to compete in the market, an aversion allegedly typical of buyers and sellers at least since Adam Smith articulated it two hundred years ago.

“Working for Patients” was the carefully considered title given to the (in)famous government White Paper that led to the Act of Parliament of 1990 and the reformed NHS.<sup>4</sup> Its rhetoric indicated an attempt to reestablish the principle that employment in the NHS was a means to an end, not an end in itself. This encouraged a conception of the NHS explicitly in terms of a clear distinction between its outputs or outcomes and its inputs (in other words, contributions towards achieving ultimate outcomes, patient care) despite the legendary difficulties in health care of distinguishing in detail between outcomes, inputs, and processes. The reforms were advocated as a set of material incentives—money again—to ensure that achievement of patient-

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3. WENDY RANADE, *A FUTURE FOR THE NHS?* 78 (Harlow/New York, Longman 1994).

4. DEP’T OF HEALTH, GREAT BRITAIN, *WORKING FOR PATIENTS* (White Paper) (CM555, London: HMSO, Jan. 1989).

orientated outcomes took precedence over mere employment of inputs.

The employment of nursing and other resources (both the quantities and how they are to be put to use) would depend, according to the optimistic interpretation of the reforms, predominantly on their contribution to the provision of those health care outputs that are valued sufficiently highly by purchasers such that purchasers offer a price that covers all the input costs of providing them. Demand for health care would drive the supply of health care, which would in turn drive the demand for nursing and other inputs.

Many aspects of these optimists' accounts of the reforms are controversial in the United Kingdom. Inevitably, perceptions of what constitute the appropriate outcomes of the NHS differ, especially when the broad and ambiguous objectives originally set for the NHS are confronted with any notion of scarce resources and difficult choices to be made between individually desirable options.

Pessimists about the reforms identify a fragmentation of the NHS network of services and an insensitivity to the spirit of its original creation. More cynically, some suspect the government, as the instigator of the reforms, of putting in place the means of further constraining the publicly financed resources made available to the NHS. The NHS has always been a live political issue since (and even before) its inception.

Much of the controversy can be summarized by saying that there is a debate about the practical consequences of viewing the organization and management of the NHS in terms of a simplistic version of rational resource allocation: even if the clarity of such an account can be helpful as a framework for thinking through the issues in the abstract, it can also be accompanied by an insensitivity to the subtleties of the health care context, which may result in decisions being made that compromise the quest for rational resource allocation, in any case.

Decision making in the post-1990 NHS relies to a considerable extent on the general manager of each local NHS organization, who may have expertise primarily in management, not in health care. Rational resource allocation implies the availability of appropriate knowledge or information about the actual or potential performance of inputs so that, in principle, the general manager could select, attract, and coordinate the appropriate combinations of inputs to fulfill the desired outcomes.

How possible is it, even technically, to discern best possible or acceptable ways to meet appropriate health care objectives (for example, to identify clinical best practice) so as to choose the best combination of inputs?

Beyond the technical difficulties, do suppliers of inputs themselves (nurses, doctors, others) have enough incentive to identify best practice explicitly? If they feel a need to protect their own self-interest to any extent, or are encouraged to do so in the new contracting culture, is there a temptation to restrict or obscure the explicit dissemination of professional expert information that might be used to their personal disadvantage by managers or others, especially if the effects on desirable health care outcomes for patients are questionable? The issue of clinical freedom is obviously lurking here, but similar concerns may be equally relevant for many professionals.

In addition, if health care is regarded as inputs and outputs, is there a material incentive for all suppliers of so-called "inputs" to portray what they do as being (almost) synonymous with the desirable "outputs" (in other words, that they *do* what the NHS is ultimately there to *achieve*) so that their contribution appears to be indispensable and thus much valued in the market by employers?

In the world of the archetypal competitive market for health care, much of the appropriate information for managers would be contained concisely in the prices being paid under contracts to provide health care and for the supply of nursing or other resources.

In the absence of that archetypal competitive market, the appropriate information is likely to be technically more difficult to assemble in a form so readily usable by managers in decision making. Those who have discretion to decide whether to acquire this explicit information, in the name of rational resource allocation, must judge the expected benefits of additional acquisition (exclusively for themselves or otherwise) against the technical and political costs of doing so.

Some pessimists about the 1990 NHS reforms have equated the pursuit of "rational resource allocation" in health care with a narrow pursuit of efficiency as the dominant criterion of performance and the use of crude market competition to be efficient. Therefore, they reject the reforms *because* they reject narrow efficiency criteria and/or *because* they reject crude market competition.

It does seem far more difficult to specify how alternative criteria such as equity or distributive justice between individuals can be pursued by rational means, and easy to envisage how these criteria might be squashed by rigidities of rationalist systems in practice. If, too, efficiency meant only that each individual would minimize the costs to themselves of providing the minimal service they can persuade clients to tolerate, then few would hold out much hope for the more profound aspirations for the NHS.

However, efficiency in the much broader sense of taking every opportunity to further those aspirations within available resources is bound to be an important criterion of performance in a health service like that in the United Kingdom, which remains effectively constrained by a firm government decision each year about overall levels of public expenditure. Any proportion of national resources made publicly available to the NHS—high or low<sup>5</sup>—is available.

If so, then maximum efficiency in the use of those resources would, almost by definition, help to fulfill more of the possibilities. The identification of what constitutes more and less efficient uses of resources, however, does remain problematic, especially in a politically sensitive public service institution with ambiguous overall objectives.

## II. PROSPECTS FOR MARKET COMPETITION IN THE NHS

There is a debate, even among economists, about whether market competition is always the best way, or even an effective way, to pursue efficient or equitable outcomes.<sup>6</sup> In any case, though, will the NHS promote competition, an expectation that appears to fuel the optimism of many reform optimists?

The archetypal competitive market does not exist in health care anywhere in the real world. Many would argue that this is partly because it would be impractical given the peculiarities of the health care context. Partly, too, it is because many have deliberately rejected the full rigours of the competitive market as a way to allocate resources for health care, often for fear that an unacceptable distribution of beneficial and harmful (or costly) consequences among people might result.

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5. At present, about 5% of annual output is available. OFFICE OF HEALTH ECONOMICS, COMPENDIUM OF HEALTH STATISTICS 2.16, Table 2.5 (8th ed. 1992).

6. See, e.g., GAVIN MOONEY, KEY ISSUES IN HEALTH ECONOMICS ch. 10 (New York/London, Harvester Wheatsheaf 1994).

In some quarters, 1990 was portrayed as the year that saw the instant introduction of the full rigours of a competitive market in NHS health care. This was very far from being the case, although the practice of routinely buying and selling many types of NHS care as outputs in large quantities was genuinely new.

Competition is or could be compromised by a number of distinctive features of the reformed NHS. These features can be considered in terms of the overall network of services/"outputs," local services/"outputs," and the market for "inputs."

The first feature to consider is the continuing role of the government as by far the single largest source of finance for the NHS (more than 90% of the total) and hence of health care in the United Kingdom as a whole.<sup>7</sup> Thus, the government, in effect, is the dominant purchaser of NHS services overall, and, indeed, recent governments have seemed to prefer to employ organizations as their agents to provide the public the services they demand.

The government no longer appears to want the responsibility of directly providing and managing or administering services. There is a wide range of political influence over NHS activities, which comes with dominant purchaser status. The government can insist that local NHS purchasers ensure that particular health policies (for example, the pursuit of the current "Health of the Nation" health improvement targets) are adhered to by themselves or, via contract specification, by NHS providers. The government could also discourage forms of competition, which would lead to politically damaging closures of popularly cherished NHS facilities that fail to secure sufficient contracts to ensure their continuing existence. The ongoing wrangles about the future of services in London offer prominent examples.

A second feature to consider is that the NHS remains by far the single largest source of health care services in the United Kingdom. That fact bestows on the institution as a whole a degree of potential monopoly power in deciding what services it will supply and under what conditions, although this potential power is somewhat reduced by the fragmentation of the structure into individual NHS purchasers and providers with some degree of independence from the centre.

Individual purchasers and providers within the NHS enjoy a degree of potential spatial or local monopoly power. Prominent

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7. RUTH LEVITT & ANDREW WALL, *THE REORGANIZED NATIONAL HEALTH SERVICE* 128 (London/New York, Chapman & Hall 1992).

among NHS purchasers, each District Health Authority (DHA) is granted public funds through the NHS bureaucracy each year, with which it must purchase the access to the health services needed by the resident population within the District's boundaries (currently between about 100,000 and 750,000 people in each DHA). These funds are increasingly being limited to a fixed sum for each head of resident population (weighted capita-tion). At present, at least, there is no market established for trading the exclusive rights to act as the local DHA for any geo-graphical area.

Few other organizations could match locally the total purchas-ing power of a DHA with revenue budgets for 1993/94 ranging from approximately £35 million to £350 million, except perhaps for particular services for particular residents. This concentra-tion of total purchasing power may be further enhanced by the recent merger throughout the NHS of the local DHA with the locally equivalent body for some primary care services, the Fam-ily Health Service Authority, to form what is called a "Health Commission."

There has been some apparently effective competition for DHAs as purchasers from the growing number of fundholding GP (family doctor) practices, now thought to be serving approx-imately one-third of the national population, albeit with wide regional variations. GP purchases of NHS health care, however, are restricted to a limited range of services on behalf of patients on their practice list. Their annual budgets, publicly financed increasingly as a fixed sum for each patient on the list (earmarked within DHA budgets, ironically), are also compara-tively small (typically about £1 million). This is especially so among prospective new entrants to the fundholding scheme, whose list size may only be 7,000 patients strong and who may not receive all the financial support offered by the government to encourage the first wave of entrants in 1991. The more GP fundholders there are, of course, the more possibilities that exist for competitive pressure to develop among themselves.

On the provider side of the NHS quasi market, an NHS Trust may have no effective rivals for the provision of the majority of services they offer. The Trusts may attract a monopoly share of the contracts offered by the local DHA. This is especially possi-ble if patients express a strong wish to receive services locally, as has been the tradition, rather than having to travel far to obtain an arguably more appropriate and timely service.

Another feature of the NHS in recent years is the merging of or cooperation in decision making between individual NHS purchasers or providers, in lieu of competition with each other, to offer or bid for contracts to supply health care. Potential spatial monopoly power of both purchasers and providers has raised the prospect of local bilateral monopolies, in which one local DHA or GP fundholder enters into contracts almost exclusively with a very few large local NHS providers.

There may be opportunities for mutually convenient cooperation between NHS purchasers or providers in these circumstances, releasing the pressure of competition to meet patient needs. A genuine joint attempt to meet these needs by pooling resources could also be possible, and many NHS employees might wish to achieve it. But would the incentives to do so be strong and consistent enough throughout these bodies? The historic fusion of NHS health authorities and organizations providing care, broken only as recently as 1990 (with the reforms), must at least temporarily increase the likelihood of local cooperation—a large number of employees are colleagues of long standing, and a vast array of expertise and other resources *in situ* remain recognizably the same as they were. In addition, the quasi market in United Kingdom health care remains predominantly known as an *internal* market: the main purchasers and the main providers are all within the overall NHS institution with its remaining hierarchical and bureaucratic features, or else are very closely bound to it. By way of illustration, it is intended that contractual disputes between NHS purchasers and NHS providers are to be resolved by the NHS centrally and not through the courts.

Having considered doubts about the extent of competition in providing the outputs of the NHS, we now turn to the so-called “inputs,” especially human resources and particularly nurses.

One relevant feature is that the NHS remains by far the single largest purchaser of inputs, including personnel, for health care in the United Kingdom. The NHS is the single largest employing organization in Europe; three quarters of its total current costs are spent directly on staff pay.<sup>8</sup> This feature bestows on the institution a degree of potential monopoly power as an employer, technically known as factor monopsony, in deciding what inputs to employ under what terms and conditions.

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8. LEVITT & WALL, *supra* note 7, at 268.

A feature to set beside the preceding one is that the medical and nursing professions remain organized in such a way as to present a concentrated source of supply of their labour to the NHS. Prominent organizations include the British Medical Association and the Royal College of Nursing.

To the extent that each professional body presents a common front in negotiations with the NHS on behalf of its members, it retains a degree of potential monopoly power in the supply of services, including entry into the relevant profession itself.

The combination of potential output monopoly and factor monopsony powers of the employer, the NHS, with potential input monopoly power of employees, each professional body, could form an input bilateral monopoly. The result could be a trial of strength between two organizations that have no competitors of similar influence with which to compare their performance; instead, cooperation in decision making between them or, at worst, collusion for their own mutual convenience and not necessarily in the best interests of the ultimate purchaser or recipient of NHS services, could result.

The NHS structures put in place at the government's instigation in the reforms of 1990 allow, in principle, for the possibility of competition or contestability among large numbers of players throughout the system. The likelihood that competition will in fact be heavily compromised stems from the context in which those structures have been introduced, together with the preferences and material incentives of the players to avoid the rigours of full rivalry with each other.

The debate will continue about whether or not the compromises inherent in the large, complex, unprecedented NHS quasi market are an appropriate adaptation of simplistic blueprints for (rational) resource allocation; given the peculiar case of the health care network of services in the United Kingdom, will patients be better off as a result?

### III. PROSPECTS FOR NURSES AND NURSING EMPLOYMENT

In the market for the services of nurses (if regarded as one particular set of potential inputs), there are pressures, via various statutory institutions, to fragment the monolithic bargaining over terms and conditions of employment between the NHS and nationally organized bodies representing groups of employees. The management team of each individual NHS Trust, since 1990 becoming the typical form of provider of NHS hospital and

community services, has wide responsibility for employment bargaining. Hence, the providing organization is not protected as before by the monopoly negotiating power of the central NHS. At the same time, each management team remains potentially vulnerable to the organized medical and nursing professions and to the remaining influence of terms and conditions (some of them statutory ones) agreed to in earlier years.

The general manager of each NHS provider might resent the rigidities, as much as the direct expense, of existing terms, conditions, and job specifications that prevent the manager from attracting precisely the levels and mixes of nursing services thought to best adapt to the local changing circumstances.

There seems to be a material incentive, then, for managers of NHS Trusts to persuade those who are or might be nurses to negotiate their own contracts in an attempt to weaken the potential monopoly power of the large employee bodies. Managers, especially of small NHS providers, might anticipate better chances to attract a versatile, or "flexible," set of nursing inputs at low cost despite having to negotiate an increased number of separate contracts.

The prospect of an imminent decline in the proportion of young female adults in the population can only intensify incentives to attract nontraditional entrants or returners by offering new and more flexible patterns of employment opportunities in nursing and related activities.

In addition, the nursing field, under conventional headings, comprises about one-half of the total workforce of the NHS, which, in the late 1980s at least, employed about one in three females who left school with higher education entry-equivalent qualifications, although up to a third of them did not proceed to nurse registration. Costs of recruiting and retaining nursing services, then, look set to increase either because the bargaining power of nurses will increase as their scarcity increases, masked by general economic recession and household unemployment in recent years, or because of the complications of recruiting from nontraditional sources. It would not be surprising to see parallel attempts by local NHS Trust Managers, as employers with limited budgets, to seek ways to reduce their demands for nursing services; they may also seek alternative sources of supply for services previously performed by NHS nurses. They may try to accomplish this by substituting other types of employee or technical inputs in place of them, with possible consequences for the

quality of services. These strategies, rigorously pursued, might be enough to outweigh the imperfect cohesion of nurses as a bargaining group with some potential monopoly power. The result could be lower salary offers by Trusts for many NHS nurses, perhaps with some promotions and additional payments for enhanced performance, additional responsibilities, or localized or short-term demands, as specified by Trust Managers.

Provision of costly care that is neither formally required of a local NHS budget holder nor would generate an obvious net contribution to the local budget may be reduced. NHS bodies are apparently drawing a distinction between access to health care (particularly with respect to the elderly), about which the NHS certainly has obligations, and access to nonhealth, social care, which may be regarded as being the responsibility of others. Exit by NHS bodies from the provision of what they consider nonhealth, social care can be expected to create some opportunities for the profitable or not-for-profit provision of care by the private sector, with a consequent redirection of opportunities for nursing employment away from the NHS.

Some nurses themselves could benefit from a willingness to consider cost-reducing input substitution in so far as managers will be considering substitutions among *all* their potential inputs. Nurses may be sought as substitutes in place of clinical or other expensive staff services (reinforced at present by the pressures, encouraged to some extent by the government, to reduce the work hours of junior hospital doctors). It is likely, however, that the bargaining power of organizations representing clinical staff will remain at least as strong as that of those representing nurses, so the balance of narrow group advantage may not work in favour of nurses as a group, though some individuals will prosper.

What seems certain is that any demands for an enhanced role available to the entire NHS nursing cohort of the current size, at greatly enhanced levels of pay and conditions, are unlikely to be realized in the near future, given the constraints faced by employers, given their own incentives as built into the post-1990 NHS, and given the sheer proportions of the resources at stake. About one-half million people in the United Kingdom, from a total workforce thought to number about 23 million, are currently employed in nursing in some capacity, costing in total about three times as much as doctors and dentists as a group.

It could be that while the total cohort of NHS employees with the formal title of “nurse” is diminished at the margins, partly because of the exit to the private sector, the distribution of nursing “inputs” within the total NHS cohort stretches. Greater concentrations of both the very highly qualified nurses and those much less qualified than has been the case may be coupled with lower concentrations of those in between. The degree to which some nurses will accept comparatively low pay to inherit some of the traditional responsibilities of doctors and other more senior staff might well affect the balance between these trends.