Alison Leary: The healthcare workforce should be shaped by outcomes, rather than outputs

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It’s time to think more radically about the way we plan the healthcare workforce, says Alison Leary

The current “workforce crisis” in the NHS is not a new phenomenon and we are seeing this become a growing challenge across the professions. In a recent report, for example, a number of think tanks predicted that there will be a shortfall of 108 000 full time equivalent registered nurses in 10 years if current trends continue.

We can reach for some obvious solutions: improve staff working conditions and pay, incentivise low occupancy roles, and streamline the process of immigration into shortage occupations. These measures would go some way to ameliorating current staffing problems, but perhaps it’s time to think more radically about the way we plan the healthcare workforce.

Healthcare workforce planners have tended to concentrate on supply—how many of XYZ can we train or afford, and the estimates for the workforce numbers we need seem to come primarily from the acute sector. This supply side approach has some distinct disadvantages. It doesn’t inform us of what types of workers or attributes are needed to meet demand. Healthcare demand itself is poorly understood and very few attempts have been made to model it. It seems to be put in the “too difficult” box and we stick with what we know.

Sticking with what we have always done might explain why the healthcare workforce is modelled in a similar way to a service industry from the 1970s, using principles that were abandoned long ago by other sectors undertaking complex, safety critical work outside of healthcare. The idea that people are vessels for technical skills and that work is a series of timed, deliverable tasks without regard to situation, risk, or human factors is a fairly entrenched one in healthcare. Yet this is not the case in other industries, which go further in understanding the work, the workforce, and the workforce’s relationship with outcomes and safety.

Classic, reductionist approaches to the division of labour in clinical work can be seen in most healthcare services nowadays. Consequently, when we see healthcare initiatives or programmes that return to holism, they are lauded for their novelty.

This thinking is even reflected in the commissioning of services, which commissions the delivery of tasks, not the delivery of care to people or better health outcomes. This approach is appealing because of its apparent simplification of a complex phenomenon and because productivity can be measured by the number of tasks accomplished rather than the outcomes achieved.

The reality is that such reductionist, efficiency based approaches are likely to underestimate workload in complex, high risk work because the relationships between the workforce and outcomes are complex. This has resulted in a narrow focus on healthcare as a series of tasks to be completed, rather than the delivery of person centred care. This kind of reductionism is also associated with workforce dissatisfaction because it can be dehumanising. The nature of clinical work is people oriented; it is not focused on simple deliverable products.

The idea that healthcare work is simply tasks also perpetuates the fairly pernicious idea of task shifting between groups of workers. It reinforces the concept that there is a simple hierarchy of skills with an associated hierarchy of value. All that is required, therefore, to meet demand is to “upskill” other workforces to close the gap.

Yet this line of thinking assigns false value—it asserts that the performance of the most technical and demanding work is the most valuable, even when it might not be the work required to actually meet demand in many situations. By default it devalues the complex work that professionals other than doctors perform, which might be just as essential to managing risk or preventing harm. The examples we see that are perceived as lower value skills include case management, which stops people falling through gaps; psychosocial care or symptom control, which alleviates distress; and what is often termed “basic” care, for example washing or feeding vulnerable and acutely unwell patients. Without context this work is seen as low skilled, yet it is not and its absence is catastrophic. This simplistic task shifting approach can also cause problems with workplace relationships and jurisdiction when it manifests in a group claiming certain tasks as “theirs,” which then becomes a source of workplace conflict.

With the pursuit of increased productivity, it seems that the link between the purpose of healthcare work and the planning of the workforce has been lost. It appears that the purpose of workers is to deliver work rather than achieve better outcomes for patients. This is akin to an airline completing take-off but not really worrying if they land.

Healthcare is a human activity delivered by humans. Trying to model skills, task delivery, or any other abstraction of the work is unlikely to meet with success. Instead, we need to put more effort into understanding demand and risk. We need to look at what a healthcare workforce needs to deliver care to the populations they serve and design a workforce driven by that demand. And we need the courage to let go of activity as the primary measure of success in health, and instead consider outcomes for patients and workers when we think about workforce planning.

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