North-South Health Services Conference

Working Together for Better Health Services

Includes the proceedings of a conference held on Thursday 28 June 2001 in Dublin, addressed by Micheál Martin T.D. Minister for Health and Children and Bairbre de Brún MLA, Minister for Health, Social Services and Public Safety

Health Services
National Partnership Forum

CONGRESS
WORKING FOR PROGRESS
IRISH CONGRESS OF TRADE UNIONS

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Preface

Health Services North and South are widely acknowledged as being in crisis and facing radical change. Both health systems are failing to produce the outcomes needed for a modern and inclusive economy – despite everyone working in them doing the best they can.

Health inequality on all the recognised dimensions is significant and getting worse. Long years of under spending and under investment are coming home to roost. Crumbling buildings symbolise the damaged humanity of those receiving and delivering services. Change is in the air, and it is in this context that people at every level need to be engaged and respected. So, what can be done?

- What can be the contribution of partnership models and workplace initiatives that strengthen the links between those delivering health services and those using them?
- What investment and retraining, North and South, is needed to support likely change?
- How do we develop and optimise current patterns of skills development, qualification routes and options for convergence and transferability?

These were the themes and questions addressed at a North-South conference ***'Working Together for Better Health Services'*** that took place on 28th June 2001.

Organised with the support and encouragement of Ministers for Health, Bairbre de Brún MLA and Micheál Martin TD, the conference examined options with regard to the development of joint initiatives on new models of education, training and accreditation for health service staff, both North and South.

The conference proceedings are detailed in this report. It brings together expert perspectives, practical wisdom from health service providers working towards partnership, and delegate contributions through participation in workshops.

At the conference we saw what the reality of genuine partnership has achieved in major institutions, and how this can be taken forward as the essential element of a strategy. The results of our workshops and the endorsements of what we are doing from ministers, can give us the springboard for a better future.

Inez McCormack
President, ICTU

Matt Merrigan
Health Service National Partnership Forum

Keynote Addresses

Micheál Martin T.D.
Minister for Health and Children

"Your agenda provides scope for highlighting opportunities for developing a North/South dimension to healthcare as we strive to find new ways of working together and moving forward for the good of all our people".

I am delighted to be here with you today and would like to thank the Irish Congress of Trade Unions and the Health Services National Partnership Forum for inviting me to address you. The opportunity conferences such as this offers key players in our health services to network and share ideas is invaluable. I am confident you will find today's proceedings informative and stimulating.

North - South Context

Your agenda provides scope for highlighting opportunities for developing a North/South dimension to healthcare as we strive to find new ways of working together and moving forward for the good of all our people.

As Ministers for Health, Minister Bairbre de Brún and I share a mission - it is shared also by health professionals, administrators and service providers in both parts of the island; it is to ensure that health policies are geared to bringing about the conditions necessary to achieve improved access to health services and optimal levels of health for the whole population. The success we can achieve in our mission will be dictated in no small way by the degree of co-operation on a North/South basis that we can bring to bear.

Both of our Departments are currently working to develop new health strategies which will provide a focus and opportunity to take stock and plan for the future; a future which I earnestly hope will bring further and better opportunities for joint co-operation and action between the two administrations North and South.

Before the signing of the Good Friday Agreement over three years ago, there had been a considerable, if relatively quiet, North/South dimension in the health area down through the years. Good relations had always existed between the service providers along the border area and a spirit of co-operation and helpfulness had always been in evidence. A cross-border flow of health personnel undertaking training and clinical placements had also been a regular feature. This was due to the all-island nature of the Royal Colleges of physicians and surgeons and some of the specialist organisations. In addition, good relations had been developed and cemented in recent years through conferences and similar events.

Now, in the post-Good Friday Agreement era, we have at our disposal the necessary tools to enable us to gear up to a higher and more sustained level of contact and focused action. Foremost among these tools, as far as health is concerned, is the North South Ministerial Council. Regrettably, for political reasons that you will be aware of, Minister de Brún and I have not been in a position to meet in the NSMC since last July. I certainly look forward, as I know does the Minister, to being able to resume our collaboration through the Council at the earliest possible date.

Disease, it has often been said, does not recognise borders and on an island so small as our own, this is indeed the case. We share common problems notably the same top three causes of death - coronary heart disease, cancer and respiratory disease. It makes good sense that we should strive for common solutions and joint approaches to tackling these diseases.

Two new cross-border bodies have come into existence since the Good Friday Agreement which are proving to be invaluable resources in the health area and certainly have the potential to help us in our search for common solutions and joint approaches to problem solving. The Institute of Public Health is based in Dublin and the Centre for Cross Border Studies is based in Armagh. In the past few weeks, both have produced valuable reports focusing on key cross border issues.

The Centre's report on Cross Border Co-operation in Health Services in Ireland points out not only the areas of co-operation, but identifies certain obstacles to co-operation setting us the challenge of tackling them. The Institute's latest report is on all-island mortality data and is titled *Inequalities in Mortality*. As I have already mentioned, we share the top three causes of mortality. The report leaves us in no doubt that there is considerable scope for greater North South co-operation for public health.

In recent years, the Co-operation and Working Together (CAWT) initiative has been playing a significant role in establishing partnerships in various aspects of health care through its member Boards and Trusts. CAWT will have an increasing role in developing the North South health agenda through its hands-on method of Working Together.

National Health Strategy

I have already referred to the work that is ongoing in my Department on developing a new National Health Strategy. To ensure a very wide input into the new Strategy, I embarked on a wide consultation process. The first plenary session of the Health Strategy National Consultative Forum took place on the 23rd of April and the second will take place on the 10th and 11th of July.

The Forum comprises a wide range of service providers, staff representatives and academic experts. It is one of a number of strands of consultation. I know many of you are involved in this process. My hope is that this level of research and consultation will ensure that the Strategy is one which is informed by a wide variety of views and which the public, providers, services users and staff will have ownership of for the future.

The 1994 Health Strategy adopted the principles of equity, quality of services and accountability. Undoubtedly, these are principles which we will be staying with in any new Strategy. However, I believe it is vital to develop a system which is "people-centred". This means having a service that is planned and delivered on the basis of the best interests and the needs of patients, clients and their families. It may mean changing the way we deliver services. It certainly means giving clearer information to the public about their entitlement and, for health professionals, continuing to improve openness in their dealings generally, with patients or clients.

There has been a major investment in the health services during this Government's term of office with funding doubling from £2.5 billion in 1997 to £5 billion this year. However, an examination of how much we spend and how we spend it will have to be an important part of developing a strategy for health for the future.

We all know that the staffing shortages in the health system are probably the single biggest potential obstacle to addressing the current service deficiencies. I believe that developing the "people" resource in the system will promote better quality services; give existing health personnel greater motivation and job satisfaction; and make the public service a more attractive place to work.

It is increasingly obvious that there is a need for a more integrated approach to both policy formulation and implementation. This has implications for everyone working in the health services. We will need improved communication, openness to new ways of doing things and a willingness to embrace change. The driving force behind this approach brings us back to the principles I outlined earlier, in particular the idea of a "people-centred" health service.

The job of making sure that everyone living in Ireland has the best possible health is a big challenge for a lot of people and agencies. It is also a challenge for each of us personally, because every day we make choices that affect our health. I attach the greatest priority to making the necessary changes to our health care system to further improve people's health and quality of life.

Partnership

The development of the new Strategy has been greatly helped by the Partnership structures established by the National Partnership Forum. Partnership facilitators have played a key role in the consultation process at local level within the health services.

This is very much in keeping with the partnership approach which is about developing an active relationship with flows in both directions. It is about developing joint objectives in an atmosphere of co-operation and trust. It is about participation and consultation. Ultimately, it is about the delivery of a patient-focused quality Health Service reflecting the needs of the client. In this context, I look forward to the major conference which the National Partnership Forum is organising for the Autumn to lay out its work programme for the next two years or so.

The theme of today's conference reflects the title of our Partnership Programme - Working Together for a Better Health Service. It makes perfect sense for us to look at partnership in a North - South context.

Partnership in Action - Beaumont and Royal Hospitals

The joint project between Beaumont and the Royal Hospitals which will be outlined later this morning is, therefore, very interesting and innovative.

I know that a good working relationship has existed at a professional level between Beaumont Hospital and the Royal Hospitals for many years. With the commencement of formal Health Services Partnership activity down here last year, an initiative was taken by the two hospitals to explore practical applications of partnership that would bring together management, trade unions and staff to work on issues that would add value for patients, practitioners and partners.

I understand that joint groups are working on the development of projects in a wide variety of areas - Human Resources, Infection Control, Bed Capacity and Utilisation, Trauma Management/ Telemedicine, and Joint Fundraising - with a view to projects beginning in September next.

I look forward to hearing more about this exciting development.

Developing Skills and Qualifications

I have already referred to the effects of staff shortages and the connection between developing the "people" resource and better quality services. My Department has taken a proactive approach to the issue of workforce planning and a number of initiatives are underway. However, while increasing the number of training places is very necessary, we cannot train professionals overnight. It is also of crucial importance that we ensure professionals are enabled to focus on their professional role - this is important for the professions and the services alike.

Skill-mix

The issue of skill-mix within the health and social care professions is one which is only now being addressed. The Expert Group reports on both the Health Professions and the Medical Laboratory Technicians recommend the introduction of a grade of assistant. The role of this grade will be to complement that of the therapist and technician - it will not be a replacement for these grades. Initial discussions have begun with the relevant trade unions in relation to the creation of this new grade.

Under the auspices of the National Social Work Forum, the parties are examining the core role of the Social Worker and working to ensure that the high level of professional training given to our Social Workers is reflected in the tasks assigned to them. A workload management study for the profession is being undertaken and this study will also examine the issue of skill-mix.

Nursing

In the nursing area, implementation of a clinical career pathway leading from registration to clinical specialisation and to advanced practice is well under way.

The National Council for the Professional Development of Nursing and Midwifery is working closely with the regional Nursing and Midwifery Planning and Development Units to encourage the development of specialist posts based on identified service and patient need. This is a very welcome development and one of benefit to the nursing and midwifery profession and to our health services.

Effective Utilisation of Professional Skills of Nurses and Midwives

This brings me to two very important recommendations of the Commission on Nursing relating to the effective utilisation of the professional skills of nurses and midwives. One recommendation was that the Department of Health and Children, health service providers and nursing organisations examine opportunities for increased use of healthcare assistants and other non-nursing staff. The second was that the development of appropriate systems to determine nursing staffing levels be examined.

A Working Group, representative of nursing unions and health service employers as well as my Department, was established last year to address these recommendations. The Working Group has completed its work relating to the first of these tasks. Its report is being prepared for publication at present.

The Working Group is recommending that the grade of healthcare assistant/maternity care assistant be introduced as a member of the healthcare team to assist and support the nursing and midwifery function. The report explores the complementary roles of care assistants and nurses and midwives, examines issues related to delegation and integration of the healthcare assistant to the care team and makes recommendations related to the education and training of healthcare assistants.

The report's recommendations are based on the premise that the nursing and midwifery function must remain the preserve of nurses and midwives. For my part I am convinced that nurses and midwives should be allowed focus on their professional nursing and midwifery duties.

A separate group, representative of nursing and non-nursing organisations, was also convened earlier this year to establish standard criteria for the education and training of healthcare assistants as recommended by the Commission on Nursing.

This group has endorsed the Working Group's recommendation that the National Council for Vocational Awards (NCVA) training programme for healthcare assistants should be the preparation required for employment as a healthcare assistant. As evidence of the importance I attach to this issue, a start is already being made on implementation. The NCVA programme will be piloted in Autumn 2001 as recommended by the Working Group.

This is a very welcome development and will, I am sure, be supported by all nurses, midwives and healthcare assistants. It marks a genuine step forward for the nursing and midwifery profession, for healthcare assistants and for the health service as a whole.

Cross-border mobility

We are beginning to think more and more of cross-border co-operation as a possible solution to workforce issues.

In the nursing area, the University of Ulster, the Irish Nurses Organisation and my department have co-operated in the development of a Postgraduate Diploma in Education for Nurses and Midwives to help address the nurse teacher shortages down here. My Department is also grant-aiding State Enrolled Nurses who wish to upskill themselves to work as registered nurses in our health services. At the moment, SENs must travel to the North or Britain for such programmes. It has not proved possible to date to run such conversion courses here. This is an area that I hope to discuss further with Minister de Brún.

Work on North/South co-operation regarding the training of social workers has been ongoing for some time now and good progress is being made. In 1998, the National Social Work Qualifications Board and its counterpart in Northern Ireland, the Council for the Education and Training of Social Workers (CCETSW) produced a joint report, outlining the qualifications structure in the two jurisdictions.

Building on this, there has been formal liaison between the staff and board members of the two bodies, aimed at enhancing social work mobility between the two jurisdictions.

One of the projects undertaken by the two agencies involved identifying the knowledge that a social worker who trained in Northern Ireland would need to practice in the Republic, and vice versa. Areas identified included domestic law, social policy and organisation of social services. This first phase of the project culminated in a one-day seminar last November, with participants from North and South, as well as from other countries.

Phase 2 of this project involves the development of a "Social Work Mobility Study and Resource Pack" as a tool to aid cross-border mobility. It will deal with information on the issues identified as crucial in Phase 1 of the project and will provide a very practical guide to allow social workers to move between North and South.

I am hopeful that the contributions from the key speakers today and the workshops to follow will provide further inspiration for mutually beneficial cross border developments in the areas of skills development.

Conclusion

I will now conclude by thanking Inez McCormack for initiating this conference. Unfortunately, I cannot stay with you for the rest of the day as I must be in Leinster House for question time in the Dáil.

I look forward, however, to receiving a report of the proceedings here today and firm proposals, arising from your deliberations, for a North-South partnership approach aimed at enhancing the quality of our health services to the benefit of the people who deliver those services and the people who use those services.

Bairbre de Brún, MLA
Minister for Health, Social Services and Public Safety (NI)

"I believe that by working together across boundaries and throughout the island of Ireland, we can move towards making services that fully reflect the needs of their users a reality. I am delighted that you are addressing these issues in your conference today."

I am very pleased to be able to join you today at this important conference.

At the outset, I would like to emphasise my determination to make sure that our health services fully meet and evolve with the requirements of the 21st century.

The past few years have been a time of great change in Ireland. With the establishment of new political institutions here it has brought us new challenges but also new opportunities.

We have for the first time our own local administration and it is our responsibility to ensure that the developments we take forward fully reflect the needs of our service users across all aspects of health and social care, address the pressing need for better health outcomes and carry a particular focus on reducing inequalities across our society.

The health service is clearly a particularly complex organisation comprising many different professional specialisms. Our challenge is to align professional and technical developments across the spectrum of services the HPSS covers, with the needs identified by the services users – that is everyone throughout society.

I will work to ensure that the public are given a real say in the development of our services and that those who provide public services are accountable for their actions.

I want to see Ireland at the forefront of health and social care provision. But I am well aware that this task will be neither easy nor straightforward.

I welcome the opportunity today's conference gives us to look at how we engage the public in decisions about their own care, and how we can support each other in taking forward the development of our services throughout the island of Ireland.

So, how do we translate our aspiration for service development into practical reality?

Our starting point has to be involvement. By involving our service users directly in assessing how well our services are responding to their requirements, we can develop services which best meet their needs, rather than services which we **think** will meet those needs.

A number of new ideas for directly involving local people in reaching decisions about their own health and social care have been introduced over the past few years. These include initiatives such as focus groups, consultative meetings with relevant organisations and survey questionnaires. These all contribute to giving service users an active voice in shaping services.

Despite this sort of development, I recognise that there is a general public view that they have too little say in making decisions about their future.

I am committed to empowering the public to play a meaningful part in the planning, delivery and evaluation of services. I want our health service to be open and accountable to the public.

For us to achieve this, I would offer some fundamental principles on which we must build.

Firstly, we must listen. We must listen to the views of the users of our services, and to their relatives and carers. We must listen whether these views reflect satisfaction or dissatisfaction with our service provision.

We must take complaints seriously and work with users to build improvements into the service we provide. And effective handling of complaints must continue to form part of our quality agenda.

Secondly, we must work to ensure that equality underpins how we involve the public. We must ensure that people throughout our society have a voice in shaping our services.

We must work to ensure that the commitment to equality set out in our Programme for Government in the North has a real and meaningful effect in how we deliver and develop our services.

Thirdly, we need to empower individuals and communities. We must work to ensure that they are well informed about proposed service developments. By increasing their knowledge we can help people improve their approach to their own health and enhance their ability to contribute to service planning.

Fourthly we need a focus on human resources. We must involve the workforce at every level in the process of change. Our health workforce has a high level of existing and latent skills. The challenge for the future is to bring about change while seeking to offer security of employment, linked to lifelong learning and skills development. We need strategic workforce planning for the future and it is only right that we should be prepared to look at training and retraining models to enable people to move into areas they have felt excluded from in the past. It requires us to bring to fruition the work we have started in pay and conditions. Getting this process right will make a major contribution to the progress of equality.

And finally, we must ensure accountability. Clear and effective lines of accountability are crucial to our service.

We must build on our framework for assessing performance and we must ensure participation from a wide range of people – service users, Health and Social Services Councils, public representatives and community and voluntary organisations.

Many people throughout the Health and Personal Social Services are working hard to develop this agenda. I would also like to emphasise that we have much to gain by working together not just across the service in the North of Ireland but also through joining with colleagues from throughout the island of Ireland to develop ever improving ways of enhancing our services. And indeed there are many examples of good work already being done.

One example is the co-operation which exists between the Board for Nursing, Midwifery and Health Visiting and An Bord Altranais. These organisations have maintained close working relations over many years. Planned approaches to working together, are reviewed and rolled forward annually. This is based on a shared vision of both Boards, which encompasses a commitment to working together to enhance the standards of practice and education on the island as a whole.

Another example, at a more local level, is the Senior Management and Ward Manager Development Programmes involving staff from the Craigavon Area Hospital Trust and the North Eastern Health Board, which are based on a spirit of working together to better understand healthcare delivery in the North and South of Ireland.

And being launched at this conference is the range of partnership initiatives being developed by the Royal and Beaumont Hospitals which build on the strengths of each organisation's internal partnership arrangements. This model of working can help to inform us all in meeting the challenges of user needs and workforce development we all face.

In conclusion, much work has already been done to develop partnership working between my Department and HPSS organisations, between staff and management within those organisations, and between service providers and service users. I have also given examples of co-operation and working together North and South. We cannot however afford to be complacent. There is much more we can do to develop partnerships at all levels.

I believe that by working together across boundaries and throughout the island of Ireland, we can move towards making services that fully reflect the needs of their users a reality. I am delighted that you are addressing these issues in your conference today. I look forward to hearing the outcomes of your discussions and any recommendations which emerge about how best this important work can be taken forward together North and South.

I wish you all a successful day. Thank you.

Working Together for Better Health Services

An Irish Perspective

Employment Trends and the Health Services

Gerard Hughes
Economic and Social Research Institute

Gerard Hughes is a Research Professor at the Economic and Social Research Institute (ESRI), Dublin and a Visiting Professor at the Department of Economics, University College, Cork. His research interests are in the fields of labour economics, social policy and public finance. He has recently been involved in research for the Government's Expert Group on Future Skills Needs, and has acted as a consultant to the OECD and the European Commission on occupational forecasting and migration projects.

FÁS/ESRI OCCUPATIONAL FORECASTING MODEL[1]

Introduction

The FÁS/ESRI occupational forecasting model provides information on changes over time in the pattern of employment for broadly defined sectors and occupations covering the whole labour force and medium-term forecasts of expected changes in employment in the future. This information is used by FÁS, the Training and Employment Authority, as an input into planning the kind of training which should be provided to respond to the economy's changing skill requirements.

It is also used by the government to plan its employment and education policies and by business, commercial and trade union interests to take account of broad changes in the occupational structure of employment in organising their activities and in responding to expected changes in particular labour markets.

In this paper the information provided by the FÁS/ESRI model will be used to discuss general sectoral and occupational employment trends in the period 1991-97, to look at employment prospects in the period 1997-2005, and to consider employment developments in these periods for the major occupational groups and sub-groups in which the majority of health service workers are employed.

1 *The description of the FÁS/ESRI occupational forecasting model in this section is based on material in Hughes, McCormick, Sexton (2000).*

As the conference is concerned with the health services North and South it would be desirable to present comparative information on health services employment in Northern Ireland and the Republic of Ireland.

Unfortunately, this is not possible because the agencies, such as the OECD and Eurostat, which provide internationally comparable data on human resources in the health services, do not publish information for Northern Ireland.

Occupational Projection Method

The primary sources of information on the structure of employment by occupation and industry for Ireland are the Census of Population, the Labour Force Survey and the Quarterly National Household Survey.

Figure 1 provides a graphical representation of the FÁS/ESRI Occupational Forecasting Model. On the left hand side it shows the various steps involved in developing the sectoral projections while on the right hand side it shows the analysis and forecasts of occupational change within industries.

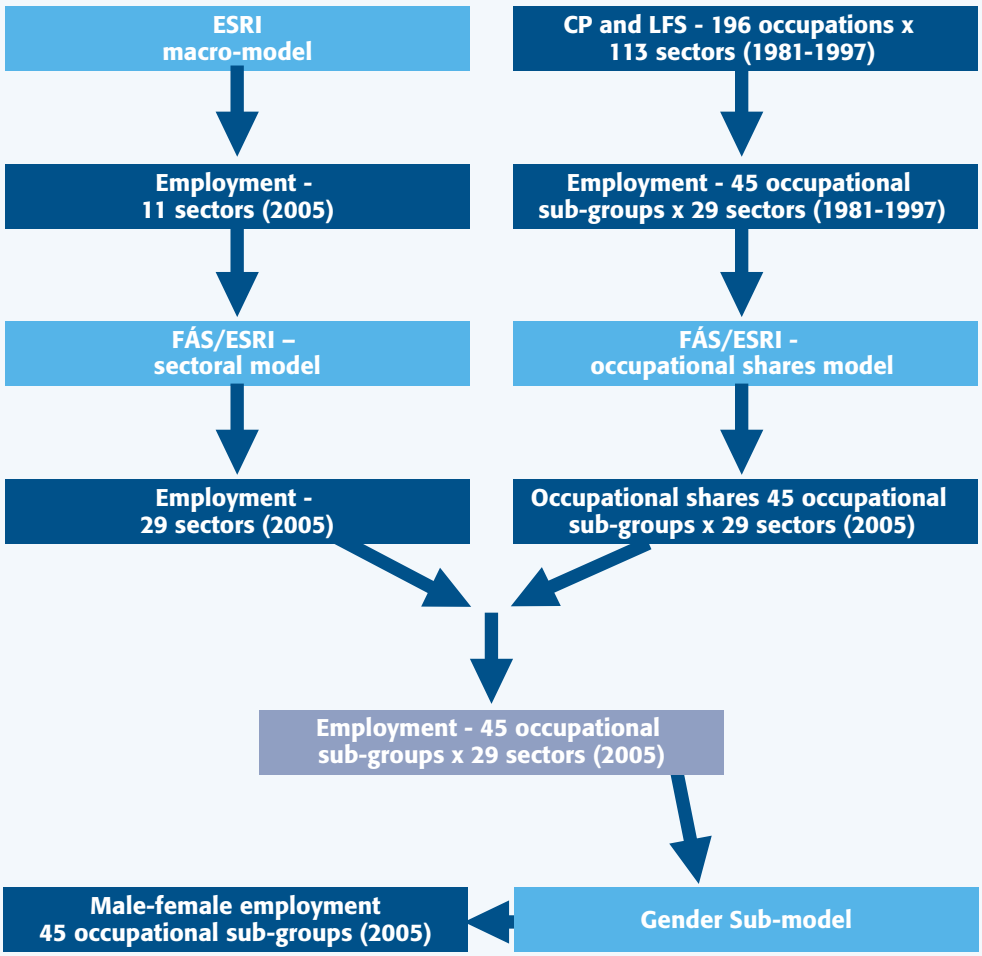
In the middle it shows how the forecasts of employment by sector and occupational shares are linked to provide occupational employment projections for the year 2005. At the bottom the flowchart shows how a sub-model is used to disaggregate employment in each occupation by gender.

Briefly, the basic approach adopted involves the use of an extended range of sectoral employment forecasts for the target year (in this instance 2005) derived from the ESRI macro-economic model and the calculation of projected occupational distributions within these sectors which take account both of past trends and expectations as to how occupational patterns are likely to develop over the forecast period.

As part of the work in producing the periodic *Medium-Term Reviews* (MTRs) the ESRI macro-economic model is used to provide sectoral employment forecasts for eleven major groups. However, for the purposes of compiling occupational projections, these are disaggregated on an estimated basis to provide employment forecasts for a wider range of 29 more detailed sectoral categories.

This is done by analysing past relationships over a retrospective period between the eleven original MTR sectors and the more disaggregated sub-sectors into which these are sub-divided.

Figure 1: *FÁS/ESRI Occupational Forecasting Model*



CP = Census of Population; LFS - Labour Force Survey

Represents model or sub model

Represents data input or output 29

With regard to analysing occupational shares within industries, the basic data used for this purpose have been taken from the 1981 and 1986 Censuses of Population and from the annual Labour Force Surveys over the period from 1989 to 1997.

These sources were used to produce detailed and consistent employment data classified simultaneously by occupation and industry for selected years over the period referred to. The number of sectoral and occupational categories used extended to 113 industries and 196 occupations. These were subsequently aggregated to provide matrices showing employment in 29 industrial sectors and 45 occupational categories.

The male-female classifications of the occupational projections are obtained by means of a gender sub-model. This involves the projection of past trends for the share of female employment in different occupations, taking into account the changing nature of these trends over time.

Major Occupational Groups, Occupational Sub-Groups and Health Service Workers

It will be evident from this description that the FÁS/ESRI occupational forecasting model refers to broadly defined occupational groups and sub-groups and not to specific occupations. In geographic terms it is similar to a map which provides information on regions, cities within regions, but not streets within cities.

Thus, almost all of those working in the health services are included in occupational sub-groups within the model's professional, associate professional, and personal service major occupational groups. The relevant sub-groups are: health professionals, health associate professionals, and other personal service workers.

At the next level down Table 1 shows that the sub-groups in which health workers are concentrated are composed of individual occupations such as doctors and dentists, nurses, and hospital orderlies. The FÁS/ESRI model does not provide information at the level of individual occupation groups as it is focused on developments at the level of occupational sub-groups and major groups.

The data in Table 1 shows that three-quarters of the health professionals sub-group are doctors, just over 85 per cent of the health associate professionals sub-group are nurses, and over one-third of the other personal service workers sub-group are hospital orderlies and dental nurses. The great majority of health service workers are, therefore, encompassed by these three occupational sub-groups.

Table 1 *Employment of Health Service Workers by Occupation in Professional, Associate Professional, and Other Personal Service Groups in 1997*

Group		Sub-group		Occupation	
Prof. Occ.	162,600	Health	11,600	Bacteriologists	0
				Medical practitioners	8,700
				Dentists	1,200
				Pharmacists & dispensers	1,600
		Education	62,800		
		Eng. and science	25,200		
		Business/fin./legal	33,000		
		Religious	7,500		
		Other	22,500		
Associate prof.	83,300	Health	48,000	Dental/orthopaedic/optical	2,000
				Health inspectors	400
				Nurses	41,400
				Opticians etc.	4,200
		Eng. and science	27,800		
		Other	7,400		
Personal service	112,600	Catering	31,600		
		Domestic servants & cleaners	40,200		
		Other personal service	37,700	Livestock workers (non-farm)	900
				Housekeepers/matrons in institutions	300
				Laundry/dry cleaning workers	2,700
				Barbers and hairdressers	11,200
				Hospital orderlies and dental nurses	13,800
				Broadcasting operators	600
				Other service workers	7,200
				Photographers/cameramen	1,100
		Occupation unstated	3,100		

LONG-TERM EMPLOYMENT TRENDS AND PAST AND FUTURE EMPLOYMENT BY SECTOR AND OCCUPATION

Employment and Unemployment in Ireland 1951-2005

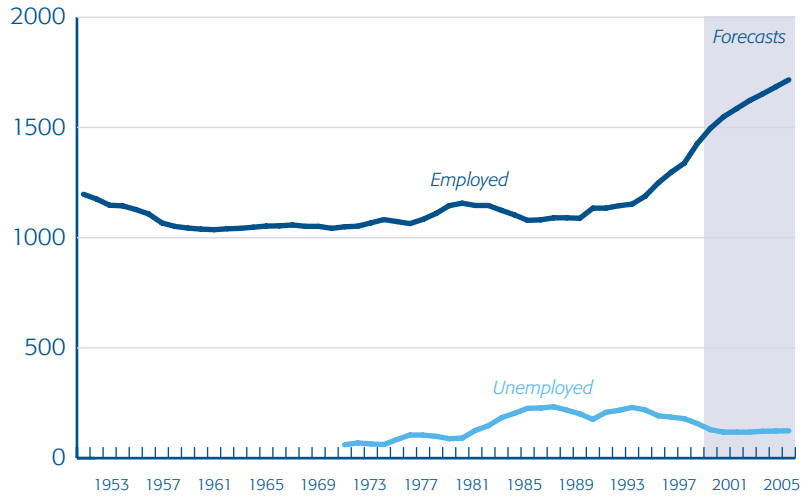
The history of employment and unemployment in Ireland over the last half century is shown in Figure 2. In 1951 about 1.2 million people were employed. Throughout the 1950s employment fell at an alarming rate and emigration soared – an experience encapsulated in the phrase "the vanishing Irish" which was widely used at the time.

The low point was reached in 1961 when there were 160,000 less people at work than there had been a decade earlier. The 1960s were a time of full employment and prosperity in many Western countries which led to many changes in social attitudes.

In Ireland there was virtually no growth in employment with only 13,000 more people at work in 1971 than there had been in 1961. Unemployment in 1971 stood at 61,000 and even though employment grew by around 100,000 during the 1970s it did not grow fast enough to absorb the natural increase in the working age population. Consequently unemployment doubled to 126,000 in 1981. In the 1980s there was no growth in employment and the number unemployed increased by two-thirds to 208,000.

In the early 1990s the actions taken to get economic growth going gradually resulted in a barely perceptible increase in employment of 18,000 between 1991 and 1993 and unemployment reached its peak level of 230,000. Between 1993 and 1996 the number employed increased by almost 50,000 each year and unemployment fell back to 186,000. From 1996 to date over 250,000 jobs have been created and unemployment has fallen to around 120,000.

Figure 2: *Employment and Unemployment in Ireland, 1951-1999 and Forecasts to 2005*

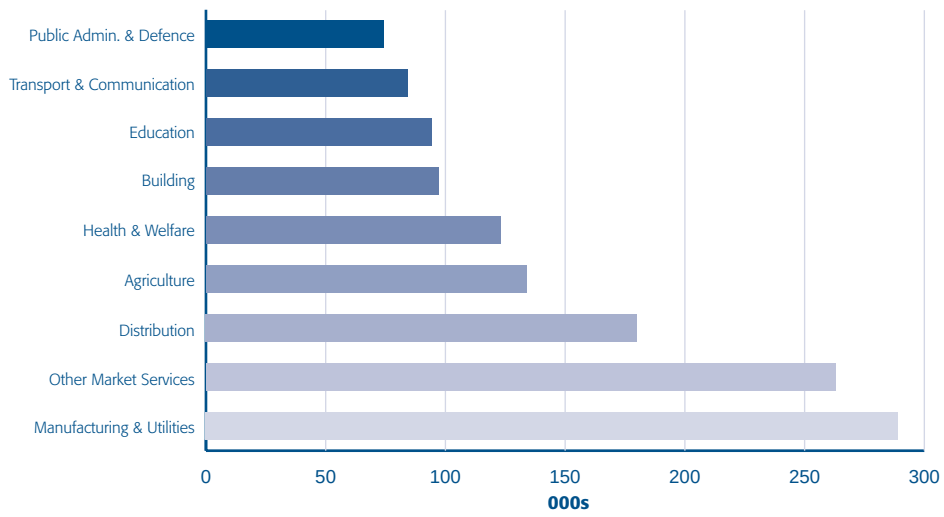


The latest medium-term forecasts from the ESRI suggest that another 170,000 jobs will be added in the period up to 2005 and that unemployment will continue to fall. This means that over the period 1997-2005 employment is projected to grow by over 3 per cent per year and that 378,000 new jobs should be created.

Sectoral Trends 1991-97 and 1997-2005

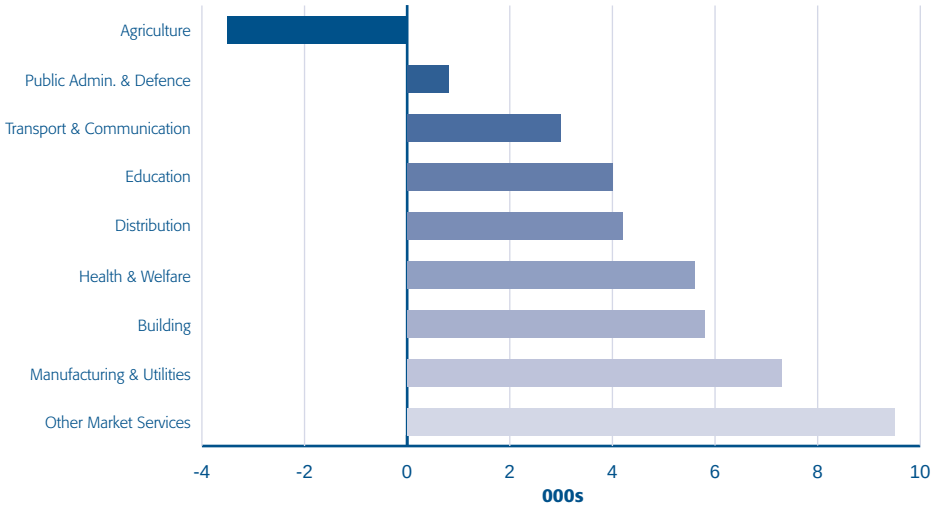
Employment in the health and welfare sector in 1997 is shown in Figure 3. It is a significant employer with 123,000 people working in the sector compared with a total of 1,338,000 in the economy as a whole. It accounts for about nine per cent of total employment and is about the same size as agriculture, which employs 134,000, and larger than education, which employs 94,000 workers.

Figure 3: *Employment by Sector, 1997*



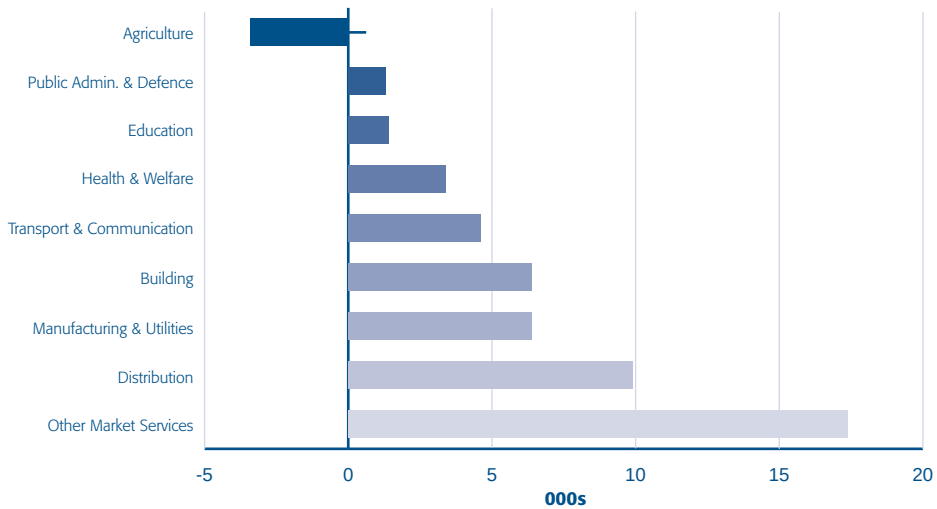
During the period 1991-97 there was strong growth in employment in the health and welfare sector. Figure 4 shows that the number of new jobs in the sector increased each year by 5,500 so that over the whole period there were 33,000 more people employed at the end than at the beginning. In percentage terms over one-third more people were working in the sector in 1997 than in 1991. The annual number of jobs created in the health and welfare sector during the 1990s exceeded the number created in distribution, education, transport and communications, public administration and defence, and agriculture. Only other market services, manufacturing and utilities, and building and construction had a larger number of new jobs each year.

Figure 4: *Annual Change in Employment by Sector, 1991-1997*



In the period 1997-2005 employment growth in the health and welfare sector is expected to be slower than in the period 1991-97 (see Figure 5). The FÁS/ESRI model projects that employment growth in health and welfare in the period up to 2005 will be about 3,400 per year, or about 2,000 less than in the earlier period. Nevertheless, 27,000 more people are expected to be working in the sector in 2005 than in 1997 and the annual number of jobs created is likely to exceed the number created in education and public administration and defence.

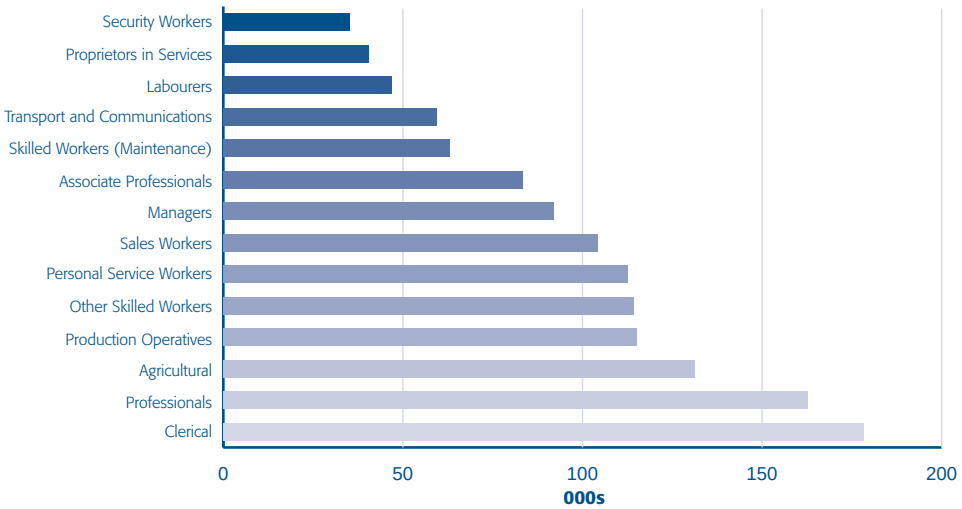
Figure 5: *Forecast of Annual Change in Employment by Sector*



Major Occupational Group Trends 1991-97

Employment by occupation group in 1997 is shown in Figure 6. The professional occupation group is the second largest employer after clerical occupations. It employs 163,000 workers compared with 178,000 in clerical occupations. Personal service occupations, which include a significant number of health workers, employ 113,000 people and associate professional occupations employ 83,000 persons.

Figure 6: *Employment by Major Occupation Group*



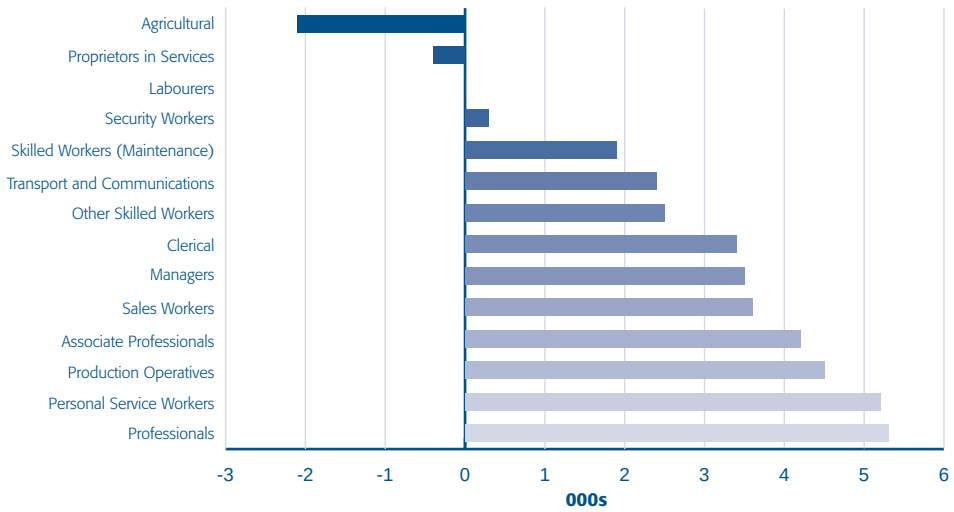
The changes which have occurred in the structure of employment by occupational group over the period 1991-97 are presented in Figure 7. It shows that the largest absolute losses in occupational employment occurred in agricultural occupations.

In 1997 there were nearly 13,000 less persons employed in these occupations than there were in 1991 - this represents a decline of almost 9 per cent in a 6 year period in the total number employed in occupations connected with agriculture. The largest increases in employment in absolute terms occurred in, professional and personal service occupations.

Over 5,000 new jobs were created each year for professional workers during the period 1991-97 and employment grew by almost a quarter from 131,000 in 1991 to 163,000 in 1997. Growth in jobs for personal service workers was about the same with more than 5,000 new jobs each year.

Consequently, employment in these occupations grew by almost 40 per cent from 81,000 in 1991 to 113,000 in 1997. Associate professional occupations also experienced strong growth in this period with more than 4,000 new jobs being added each year. Consequently, employment in these occupations grew by over 40 per cent from 58,000 in 1991 to 83,000 in 1997.

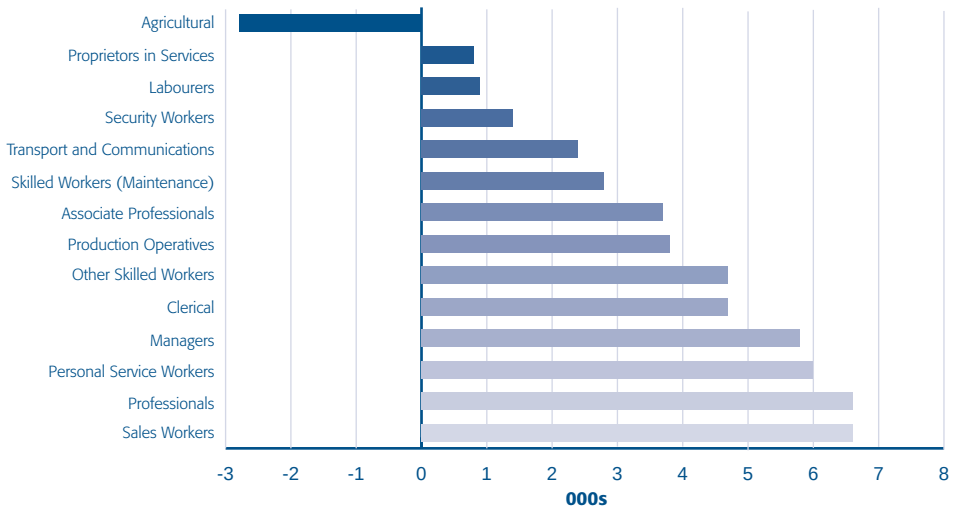
Figure 7: *Annual Change in Employment by Major Occupation Group, 1991-97*



Major Occupational Group Forecasts 1997-2005

Figure 8 shows that the annual change in employment in professional and personal service occupations is likely to be greater in the period 1997-05 than in the period 1991-97 with 6,600 new jobs projected each year for professionals during the forecasting period compared with around 5,000 each year in the earlier period.

Figure 8: *Forecast of Annual Change in Employment by Major Occupation Group, 1997-05*



Almost 6,000 new jobs are projected each year for personal service workers compared with 5,000 annually during the period 1991-97. Employment growth in associate professional occupations is expected to be about the same in the medium-term future, 3,900 per year, as it was, 4,100 per year, during the recent past.

OCCUPATIONAL SUB-GROUPS EMPLOYING HEALTH SERVICE WORKERS

Employment Change in Professional, Associate Professional, and Other Personal Service Occupations 1991-97

It was shown in Table 1 that there are a number of occupational sub-groups within the professional, associate professional, and personal service major occupational groups which employ significant numbers of health service workers.

In the remainder of the paper we will focus on past and future employment trends for health service workers in these sub-groups. Employment of health service workers accounts for the bulk of employment in the relevant professional and associate professional occupational sub-groups and for a significant part of employment in the other personal service workers sub-group.

Figure 9 shows that the health professionals group employs 11,600 people and that it is one of the smaller sub-groups employing professional people.

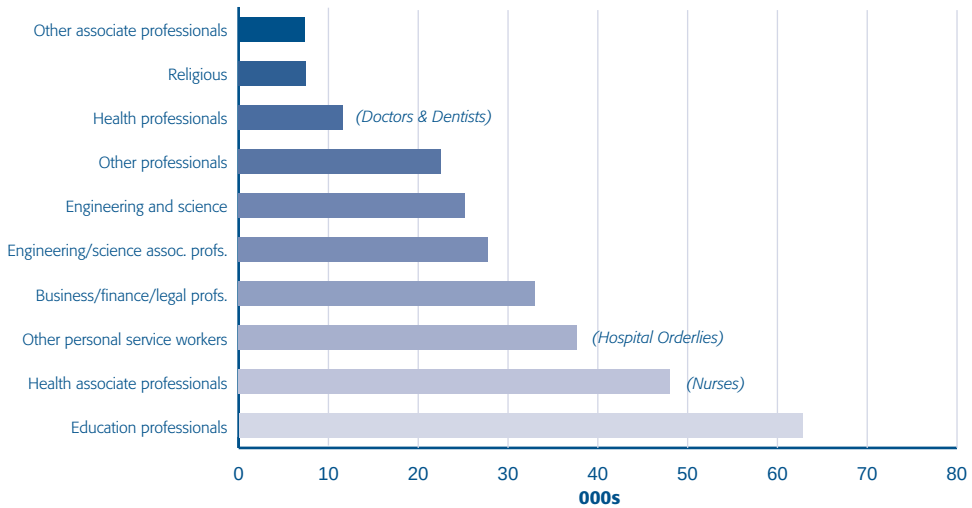
Professional employment is dominated by education occupations, which provide 63,000 jobs, and business, finance, and legal occupations, which provide 33,000 jobs.

The health associate professional and other personal service occupations employ far more people than the health professionals sub-group. Associate health professional occupations employ 48,000 people.

Almost 90 per cent of them are nurses and the remainder are dental, orthopaedic, and optical workers.

Other personal service occupations provided jobs for almost 38,000 workers of which over a third are hospital orderlies and dental nurses.

Figure 9: *Employment of Health Service Workers and Professional, Associate Professional and Other Personal Service Workers, 1997*



Figures 10 and 11 show that taking the period 1991-97 as a whole, all of the professional sub-groups except religious professions showed significant employment gains. The largest absolute increase was among education professionals, who grew by over 2,000 per year.

The most rapid growth rate, however, was among other associate professionals, whose numbers grew by over 8 per cent per year, from 4,500 in 1991 to 7,400 in 1997.

Employment of professionals and associate professionals in engineering and science was also strong with growth rates of 8 per cent per year adding about 1,500 jobs each year during the period 1991-97.

The number of health associate professionals in employment increased by around 2,000 or about 5 per cent per year.

Growth in employment in other personal service occupations, which includes hospital orderlies, was more modest with a growth rate of over 3 per cent adding about 1,200 jobs each year.

The growth in employment of health professionals during the period 1991-97 was below average relative to other professions with just 200 jobs being added each year.

Figure 10: *Annual Change in Employment of Professional, Associate Professional, and Other Personal Service Workers, 1991-97*

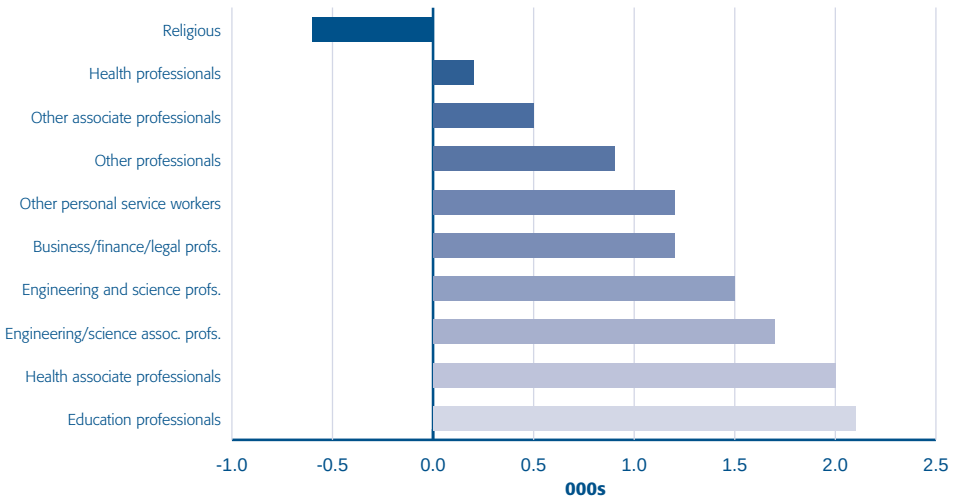
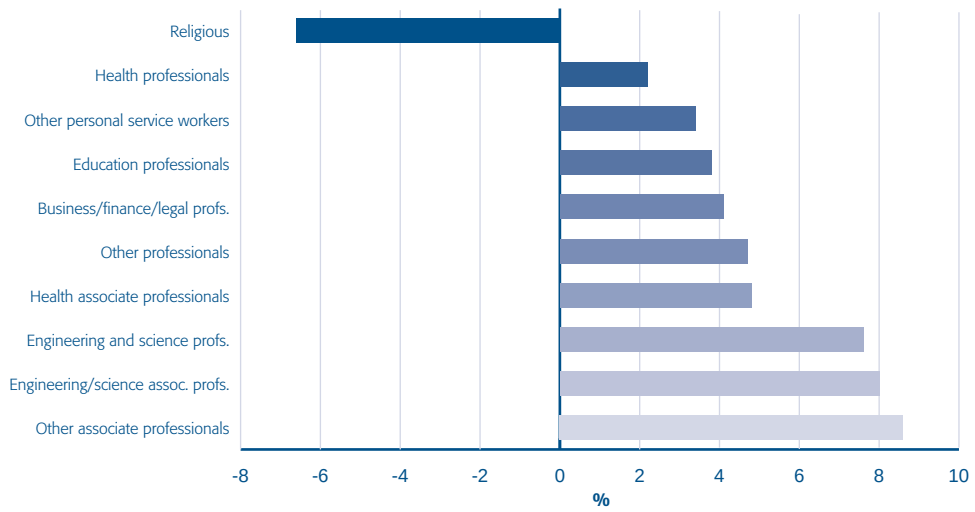


Figure 11: *Annual Percentage Change in Employment of Professional, Associate Professional, and Other Personal Service Workers, 1991-97*



Forecasts of Employment Change in Professional, Associate Professional, and Other Personal Service Occupations 1997-2005

The absolute and percentage changes projected for professional, associate professional and other personal service occupation sub-groups are shown in Figures 12 and 13. In absolute terms, the fastest employment growth is projected for engineering and science professionals and associate professionals and business, finance and legal professionals.

Employment in these three groups is likely to increase by around 2,000 to 2,500 jobs per year. Jobs for other personal service workers should increase by about 1,500 per year while employment of health associate professionals and health professionals should increase by 700 and 400 per year respectively.

Compared with the earlier period these projections suggest that the annual growth in jobs for health professionals should double in the period 1997-2005 while it should increase by a quarter for other personal service workers.

However, employment growth for health associate professionals is expected to slow from 2,000 per year in the period 1991-97 to 700 per year in the period 1997-05.

Figure 12: *Annual Change in Employment of Professional, Associate Professional, and Other Personal Service Workers, 1997-05*

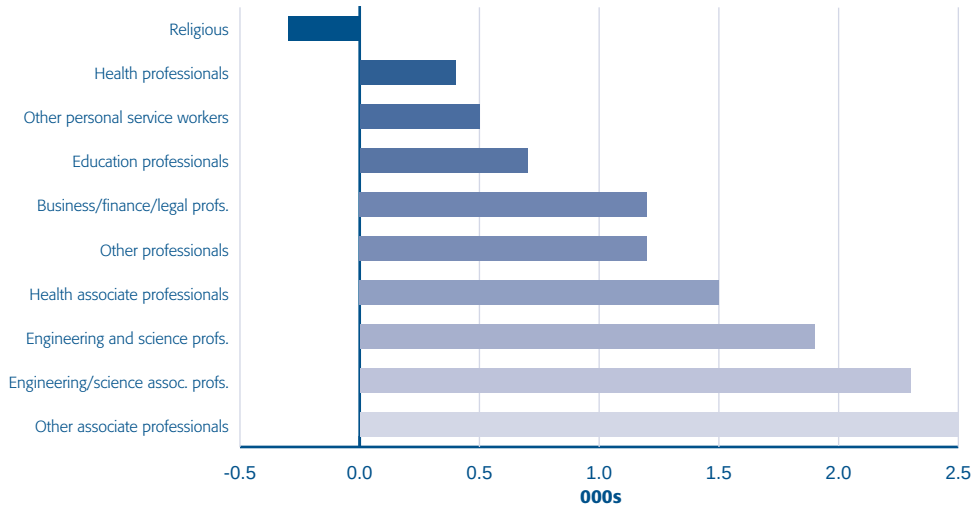
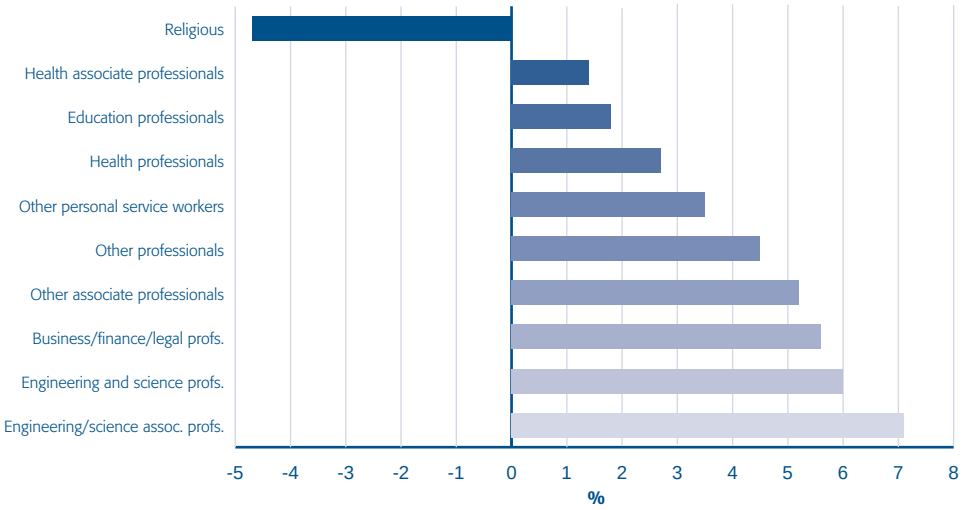


Figure 13: *Annual Percentage Change in Employment of Professional, Associate Professional, and Other Personal Service Workers, 1997-05*



In percentage terms little change is projected for the annual growth rate for other personal service workers, around 3.5 per cent in both periods, while for health professionals the growth rate is expected to increase from 2.2 per cent to 2.7 per cent.

For health associate professionals the annual growth rate is projected to fall from 4.8 per cent per year in the period 1991-97 to 1.4 per cent in the period 1997-2005.

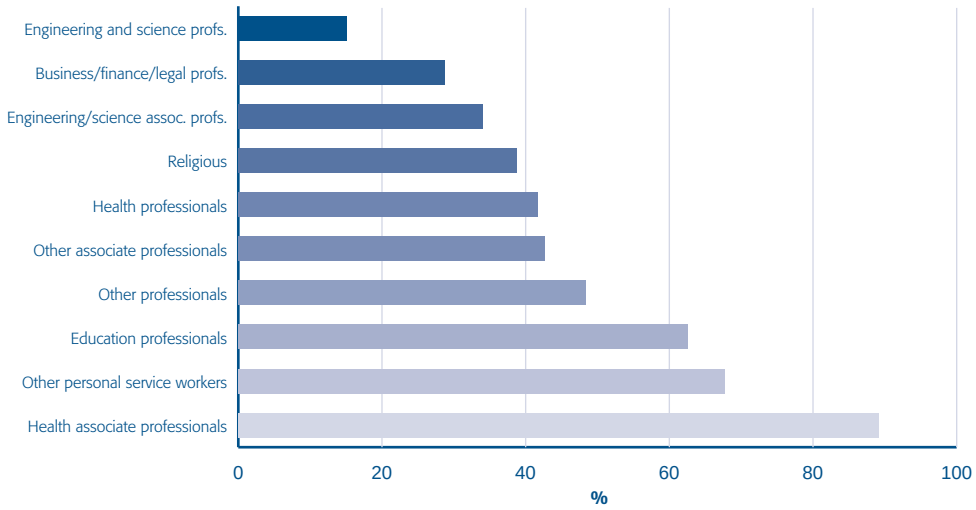
Distribution by sex

Figure 14 shows the female share of employment of professional, associate professional and other personal service workers in 1997.

The health associate professionals group in which the majority of nurses are employed consists almost entirely of women workers. Very nearly 90 per cent of those employed in this group were women.

Women workers are also over represented in the other personal service workers group with two-thirds of those at work being female. Women workers are under represented in the health professionals group as considerably less than half of those at work are female.

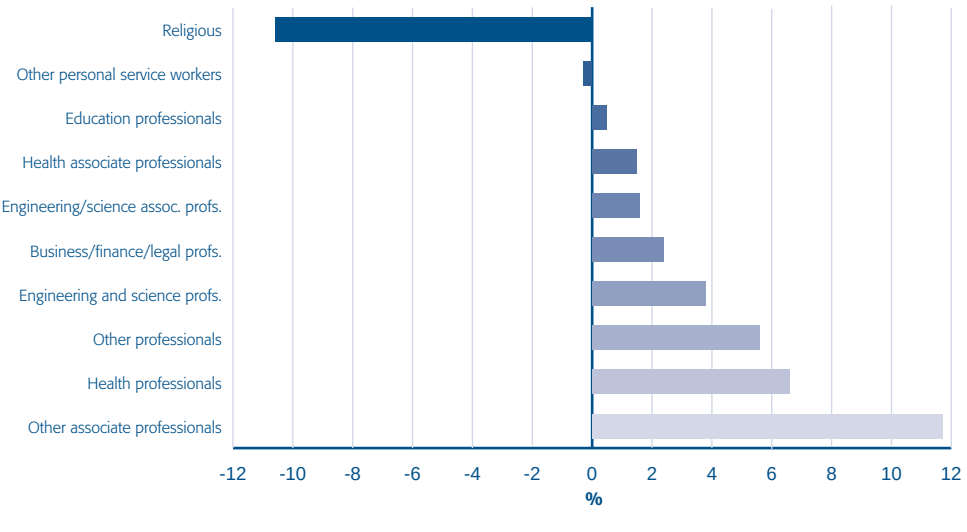
Figure 14: *Female Share of Employment of Professional, Associate Professional and Other Personal Service Workers, 1997*



Forecasts in Figure 15 of underlying trends suggest that women's share of employment is expected to increase in nearly all professional and associate professional sub-groups The major exception is the religious occupations where the female share is projected to fall by more than 10 percentage points between 1997 and 2005 from around 40 per cent to less than 30 per cent. For health workers the female share of employment is likely to increase quite strongly for health professionals by almost six percentage points from 42 per cent in 1997 to 48 per cent in 2005.

For health associate professionals the female share is set to increase by over one percentage point from 89 per cent in 1997 to 90.5 per cent in 2005. For other personal service workers the female share is projected to remain more or less the same.

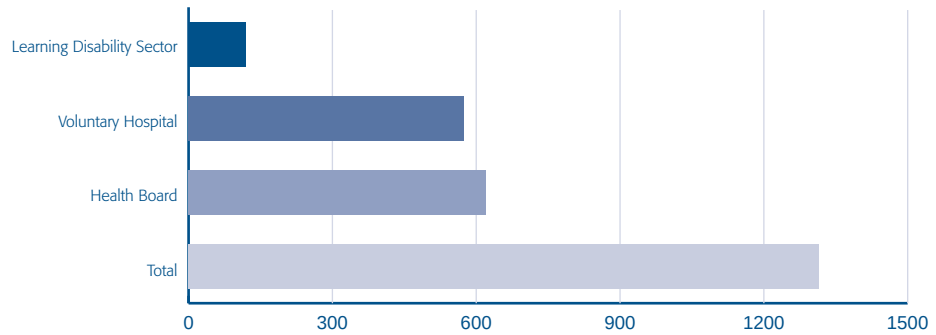
Figure 15: *Change in Female Share of Employment of Professional, Associate Professional and Other Personal Service Workers, 1997-2005*



Vacancies for Nurses

Strong growth in employment in the 1990s has led to the emergence of vacancies across a wide range of occupations. Specific information relating to vacancies for nurses is available from the *National Survey of Nursing Resources* carried out by the Health Service Employers Agency (2001)[2]. Figure 16 shows that there were about 1,300 vacancies for nurses on 31 January 2001. Almost half of the vacancies were in Health Board hospitals, over 40 per cent were in voluntary hospitals and about 10 per cent were in the learning disability sector.

Figure 16: *Vacancies for Nurses by Sector, January 2001*



One way of judging if these vacancies pose a serious problem is to consider the vacancy rates for nurses with those for other professional groups. This is done in Figure 17.

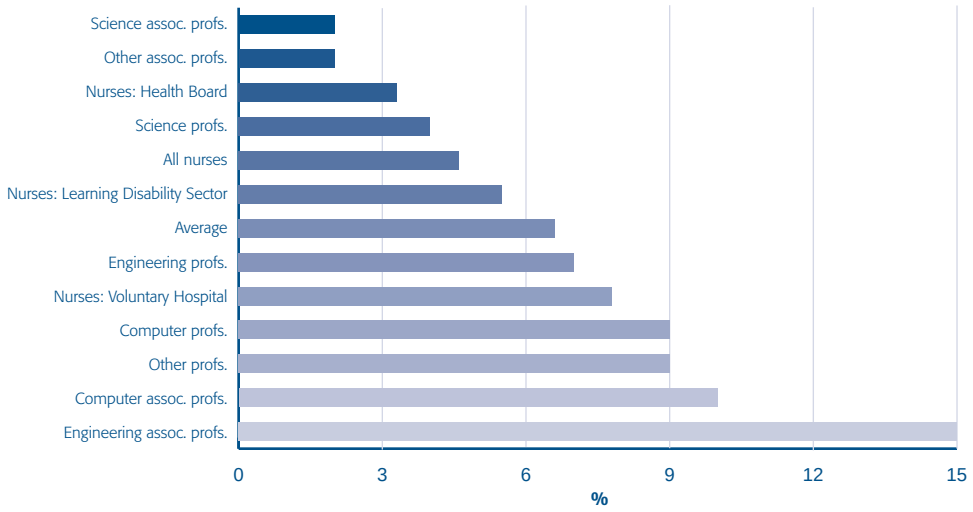
It shows that the vacancy rate for nurses as a group is significant at around 4.5 per cent but less than the average of 6.5 per cent for the professional and associate professional groups with which they are comparable. However, there is considerable variation across sectors in the vacancy rates for nurses. The problem is greatest in the Voluntary Hospitals where nearly 8 per cent of the posts available are unfilled and least acute in the Health Board Hospitals where only around 3 per cent of the posts are vacant. The differences in vacancy rates for hospitals appear to primarily reflect a regional problem rather than one relating to the type of hospital.

The majority of Voluntary Hospitals are located in Dublin while most of the Health Board Hospitals are located elsewhere[3]. The existence of a significant number of vacancies for nurses clearly causes problems for management and staff within the health service. The existing nurses have to work more intensively and to do overtime to meet the urgent demand for patient care and health managers have to spend more of their time juggling work schedules, arranging for agency nurses and recruiting nurses from outside the country.

2 I am grateful to Martin McDonald, Project Manager, Health Service Employers Agency for providing me with the results of the March 2001 survey.

3 I am indebted to Martin McDonald for this information.

Figure 17: *Vacancy Rates for Professionals and Associate Professionals in 2000 and for Nurses by Sector in January 2001*



SOME POLICY ISSUES FOR HEALTH SERVICE RECRUITMENT

Responses to Skill Shortages

The evidence presented in this paper shows that there was strong growth in the demand for health service workers in the 1990s, particularly for nurses and hospital orderlies. Although overall employment growth is likely to be somewhat slower in the period 1997-05, the employment prospects for other personal service workers and health professionals are expected to be better than during the 1990s while prospects for health associate professionals including nurses are likely to be moderate although not as good as during the 1990s.

The continuing strong growth expected in the demand for health service workers means that health service employers are likely to face increasingly tight labour markets in the future at the same time as the demand for health services is increasing due to rising incomes, ageing of the population, and increases in the number of patients being treated in hospitals as the average length of stay falls.

These changes combined with the need to reduce waiting lists and demands for more flexible working arrangements pose a number of challenges for the organisation, training and recruitment of health workers The specific issues which arise in connection with the organisation and training of health service workers are dealt with in the Report of the Commission on Nursing (1998) and the Report of the Forum on Medical Manpower (2001). I will confine what I have to say, therefore, to general issues relating to the recruitment of health workers in a rapidly changing environment and the need to provide training to upgrade the skills of the existing health service workforce.

Recruitment from Traditional Sources

Over the next ten years there will be a decrease in the number of school leavers, the traditional source of supply for nursing and other health occupations, due to the fall in the birth rate in the 1980s. At the same time competition from the expanding services sector will make it more difficult

to recruit people for health service jobs. While entry-level rates of pay need to be competitive to attract new entrants, other factors such as career prospects, the provision of training, and the image of the health services all have a role to play in attracting recruits.

Actions which could be considered to ensure a continuing supply of recruits to the health services include; developing closer links with careers officers in schools, making training courses more attractive, having realistic timescales for career advancement, and advertising campaigns to promote careers in nursing and caring.

Recruitment from Non-Traditional Sources

There are four main non-traditional sources of recruitment for the health service – men, older women, registered nurses who have withdrawn from the labour force, and health workers trained abroad. Let us consider each of these sources of labour supply in turn:

1. **Male Workers:** As we have seen almost 90 per cent of health associate professionals and nearly 70 per cent of other personal service workers are women. On the face of it, therefore, there should be considerable scope for increasing recruitment of male workers in the health services. However, the fact that since 1981 the female share of employment in health associate professional occupations has increased from 86 per cent to 89 per cent in 1997 suggests that social, cultural, and economic factors have all played a part in preventing an increase in the proportion of male workers employed in the health services. Consideration ought to be given to how these factors could be changed to make working in the health services more attractive for men.

2. **Older Women:** In the past large numbers of those who applied to study nursing were unable to get into nursing because of a lack of places. Hence, there is a pool of older women who have expressed an interest in working in the health services which could be tapped as a source of supply. However, health service employers will have to compete with other employers in recruiting from this source of labour supply. Energy and imagination will be required to increase the recruitment of older women into the health services and particular attention will need to be paid to flexible hours during training and employment, the provision of childcare for pre-school and school-going children, and the availability of part-time employment and job-sharing.

3. **Registered Nurses not in the Labour Force:** A comparison of the number of nurses registered with An Bord Altranais (the Nursing Board) with figures from the Labour Force Survey on the number of nurses at work indicates that about a quarter of those registered are not at work.

   Some of these may be Irish nurses living or working abroad but the great majority appear to be nurses who have withdrawn from the labour force for family related reasons. It may be possible to attract many of them back into nursing by 'keep in touch' schemes in the organisations they worked for, and the provision of 'return to nursing' courses, flexible working hours and childcare facilities.

   With regard to the recruitment of older women and nurses who have withdrawn from the labour force, the agreement last year between health service management and trade unions on flexible working arrangements is a very welcome development. Over 8,000 people in the health services, of whom the majority are nurses, work on a job sharing basis. In the past they had to work either full-time or half-time to retain their permanent status. Under the flexible working scheme they "can be employed on a permanent basis to work any contracted hours above a minimum of 8 hours per week on average", as the Health Service Employers Agency (2001) notes.

The sponsorship by the Alliance of Nursing Unions of an Additional Voluntary Contribution Scheme for pensions is also very welcome. It allows nurses who have taken time out of nursing for family or other reasons who have gaps in their pension contribution record to buy cover for the years when they were missing. To date about 7,000 people have taken advantage of the AVC scheme for nurses (see report by Niall Brady, Sunday Tribune, 24 June, 2001).

4. In the past recruitment of **nurses from abroad** was very rare. In recent years, however, it has emerged as a source of labour supply for the health services. Information from the Health Service Employers Agency (2001) survey shows that overseas recruitment accounted for about a quarter of all recruitment in the year up to the end of January 2001. Figure 18 shows that of the 4,200 nurses recruited almost 1,100 or just over a quarter came from abroad. It also shows that there is considerable variability by sector in the percentage of nurses recruited from outside the country.

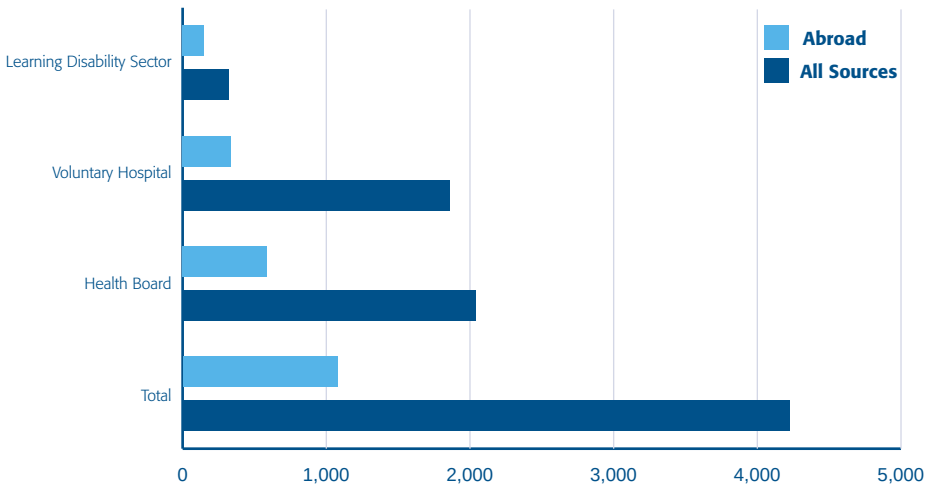
   The learning disability sector recruited about half of its new entrants from abroad, Health Board hospitals recruited about 30 per cent of their new staff from outside the country, and 20 per cent of the nurses recruited by the Voluntary Hospitals came from abroad.

   It is clear, therefore, that recruitment from abroad is an important source of labour supply for Irish hospitals. In recruiting health workers abroad Ireland faces strong competition from other countries.

   We need, therefore, to ensure that the application and validation procedures for securing a job in Ireland are helpful and efficient, that overseas workers are aware that they have the same rights as Irish workers, that those who come here are helped to find suitable accommodation and that they are provided with information which will help them to adjust to living and working in Ireland. We need also to be sensitive to the fact that some of the countries from which we may be recruiting have their own pressing requirements for health workers.

   If we recruit in such countries consideration ought to be given to how we can make the process mutually advantageous by, for example, providing access for overseas nurses to training in Ireland in particular specialities which would enable those who return to their own country to do so with a higher level of skill than they had when they left.

Figure 18: *Recruitment of Nurses from All Sources and Abroad by Sector, Year Ending January 2001*



Training

In a national survey carried out by the ESRI last year employers were asked to consider the overall skills needed to keep their companies running effectively and to say if the need for skills in the average worker is falling, rising, or remaining the same. Almost 40 per cent of employers said skill levels are increasing, 57 per cent said they were static, and 3 per cent said they were decreasing (see Williams, Blackwell, and Hughes, 2001).

The main reason given by firms for increasing skill levels is advances in or the introduction of new technology, equipment, and processes. Although the health services were not included in this survey I suspect that the responses from health service employers would be similar as the development of medical technology and new types of medical care are in the forefront of technological change.

New entrants into medical and nursing courses will be adequately trained in the use of these technologies but the existing workforce may not be, without proper provision being made for on-the-job and off-the job training courses. We now have an opportunity to upgrade the skills of health service workers whose initial training took place some time ago. If we fail to take this opportunity and to respond to the challenges posed by the increasing demand for health service staff we may find that the binding constraint on the development of the health services will be inability to recruit sufficient staff and to upgrade the skills of the existing staff.

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An American Perspective

Experiences of the New York SEIU/Health Industry Project

Deborah King
1199/League Employment, Training and Job Security Program

Deborah King is Executive Director of the 1199/League Employment, Training and Job Security Program, which covers 150,000 healthcare workers and almost 300 employers in the New York Metropolitan Area. She has served in both Union staff and elected positions and has extensive experience in collective bargaining and partnership projects. She lived and worked in Ireland for five years during which time she developed and taught courses on a variety of labour subjects.

PROBLEMS OF HEALTHCARE SYSTEMS

The problems of healthcare systems are the same in many countries. These include:

- not enough financial resources;
- people with inadequate coverage;
- escalating costs due to new technology and medicines;
- increased acuity of patients and longer lives;
- not enough staff with skills to meet demands (leading to more options for women who have traditionally been caregivers);
- hierarchical relationships instead of teamwork, which is itself hampered by class, gender and racial issues;
- professional associations and union divisions;
- little coordination of service delivery between various health sectors and between health care providers and community organisations, schools, churches, etc.; and
- advanced technology coupled with loss of caring.

NORWEGIAN EXPERIENCE

- In Norway the most cost effective programs are correlated with high worker morale.
- Worker satisfaction and patient satisfaction are linked.
- Lowest recidivism was with coordination between community and healthcare institutions.
- Best outcomes were associated with a holistic approach to the patient.

THE NEW YORK PROJECT

- The New York Project serves the not-for-profit healthcare sector. It is different in many respects from the public sector, but with many similarities.
- The project involves union and management at industry, institution and department level, developing innovative solutions to issues.
- Funding comes from collective bargaining and government grants.

The project has three key parts which fit together to make a whole

1. Workforce development/lifelong learning/career ladders

This is the first and oldest part of the collaboration. It was started in 1969, but has greatly expanded in the last 5 years.

(a) Training programs cover almost 200,000 health workers across all health sectors

- This includes home care, long term care (nursing homes), ambulatory care clinics and acute care hospitals.
- It includes most classifications of health workers from home helps, clerical staff, registered nurses, social workers, therapists and technicians (not doctors).

(b) It provides upgrading of workforce/career mobility

- Thousands of health workers have been trained
- Programs provide career mobility for service and clerical workers to move into nursing and other health care careers.
- Professionals are supported in earning advanced degrees and continuing education credits (BSN, nurse practitioners, certifications, etc.).

(c) It provides quality, accessible education for working adults

- Partners with the public universities to develop new programs to accommodate the needs of workers.
- Develops worker friendly programs, including:
  - re-entry to education programs;
  - part-time and onsite programs;
  - distance learning;
  - credit for life experience;
  - articulation between various degree programs;
  - provision of childcare; and
  - scholarship for full-time study.

(d) Examples of some programs include:

- critical care nursing for med-surg nurses which give credit towards the BSN;

- fast track pharmacist training for "at-risk" lab technicians;
- licensed Practical Nurse to Registered Nurse programs which give credit for vocational school training;
- short courses for foreign language, medical interpretation, team building, customer service and computer skills;
- English as a second language, high school diploma and college entrance preparation courses, tutoring and other support, pre-LPN and RN programs; and
- A Bronx Training Centre (convenient location, childcare, full range of programs).

2. Employment Security Program

- This project covers hospital and nursing home sector.
- It is financed by employer contributions.
- Almost 200 employers accept joint responsibility for the employment security of over 100,000 workers.
- Employers agree if positions are eliminated at any participating employer, other employers will give any redundant worker priority placement rights.
- Workers get supplemental unemployment, health and re-training benefits for up to two years.

3. Labour Management Program

- This project involves crisis interventions at financially distressed hospitals.
- Facilitation is aimed at reducing worker and resident injuries or changing the workplace culture.
- It involves full blown strategic alliances in which the union and management work together as business partners.
- It provides interest based problem solving training and facilitation (being used widely on registered nurse staffing and professional issues).
- A health educational campaign used over l5 million dollars to educate the public about the need for health care for all residents of New York State.
  - This was raised from increases in the tobacco tax in New York State to provide health care coverage for one million low income people who previously were uninsured.
- The program will continue until we achieve coverage for all.

SUMMARY

- Quality healthcare is needed by all people.
- Healthcare management and the workers who deliver the services can meet the complex challenges by working together.
- We must address labour shortages and the increasing need for highly skilled health care workers due to new technology, increased patient acuity, etc.
- We must envision and implement quality care.
- Teamwork and cooperation between health sectors is essential.
- We must improve working conditions including worker input into job system design.
- We must win public support for much needed resources.

A UK Perspective

Jonathan Swallow
Swallow Consulting

Jonathan Swallow consults across public services to improve service outcomes by the extensive involvement of employees and service users. He is currently working with a number of UK NHS Trusts on the implementation of the National Plan for Health. He is also developing strategies with a range of public sector bodies and unions to respond to the UK Government's Best Value initiatives.

UK CONTEXT

Funding

- It is now widely acknowledged that the failure to match EU levels of health funding as a proportion of GDP must be remedied. This is a top down commitment from the Prime Minister himself.

Targeted Growth

- The NHS Plan for England targets growth and investment in healthcare funding against a set of performance measures on treatment and waiting times, and quantified inputs of additional health care workers.

Outcomes

- The Plan, while recognising variation and inequality in outcomes for health, fails to link inputs and performance measures to better outcomes for health.
- Over the last 20-30 years those of us committed to defending the principle of free and equal health care at the point of use have to acknowledge that we have not spoken up loudly enough about outcomes that fall short of best practice.

Equality

- From 1979-1997 the working assumption of the then government seemed to be that the poor health of people in deprivation was their own fault.
- The publication in 1998 of the Acheson Report on UK Health inequality and the ongoing work on health action zones at least represents a start in putting the causes and remedies of inequality on the agenda.

Variations

- A key concern of New Labour has been the wide variations in waiting times, mortality and prescribing patterns in different areas, often poverty linked.
- The focus of the National Institute for Clinical Excellence and the Commission for Health Improvement is now on systematically identifying best performance and performance failure.

NHS Plan

- The NHS Plan is a stakeholder document which commits key players in the health service to raising performance to match key performance targets in return for investment.
- Signatories include UNISON, RCN, and the BMA. Whatever the arguments on process and funding approaches, it reflects a collective responsibility to get things right.

Workplace Structures

- After the fragmentation of local bargaining and remuneration through creating Trusts, and progressing contracting out, there is now a welcome recognition of the stored up equality issues through the Agenda for Change process, and the move towards bargaining which is more integrated if not yet single table.
- This may not be enough to resolve a legacy of Equal pay and Equal Value cases which may overwhelm NHS budgets.
- The ingenuity with which employers discriminate against women and defend that discrimination continues to appal.

Initiatives/Training

- There are significant new training initiatives particularly for nursing and in primary care.
- The NHS Plan and the Labour manifesto taken together imply basic NVQ2 qualifications for all support workers; individual learning accounts of £300; and a distance learning University of the NHS to allow progression from domestic or porter to Chief Executive. All of this awaits a reality test!

Partnership

- Partnership as a way of improving health services is relatively undeveloped in the workplace, and often focuses on single issues such as health and safety.
- There is little evidence of the active involvement of users. Health organisations often involve themselves in diffuse multi-agency partnerships whose impact is increasingly being challenged.

NORTHERN IRELAND CONTEXT

Funding/Barnett Formula

- Historically, the Barnett funding mechanism for NI has been used to say that existing levels of funding are higher than those in the rest of the UK, and that consequently new initiatives will only be funded at lower levels.
- The Hayes report recently released identifies that trends in spending in Scotland within the next 2/3 years will leave NI significantly disadvantaged in comparison.

Outcomes

- NI remains the coronary capital of western Europe. Survival rates for some common cancers are worse that those of Poland and Latvia.
- Everyone within the system is clearly doing their best. It is the system that is not delivering.

Equality/Section 75

- There is now a Working Group on Health Equality sponsored by the NI Executive, with UNISON participating in the group and acting as the voice of civil society.
- UNISON has also integrated the disparate literature on health inequality in NI into a comprehensive analysis over all dimensions of health inequality
- The statutory duty for equality under section 75 of the 1998 NI Act will increasingly be used both inside and outside the health service to challenge unequal outcomes and employment.

NHS Plan?

- NI has seen for health and a number of other Ministries an echo of the New Labour syndrome of responding to problems with reactive reviews.
- To date there has been no attempt to look at the entire health system in terms of performance targets, outcomes and related investment over time as in the English NHS Plan model.

Hayes

- The recently published Hayes Review of Acute Services has burst the banks of its terms of reference to look at a whole range of primary and community care issues.
- It also targets improvement in resources and outcomes against EU funding levels.
- It is profoundly challenging to the NI Executive because it demonstrates funding requirements that are not covered in devolved budgets.

Hayes/Workforce

- Hayes rightly identifies the need for workforce planning to meet the changes it anticipates, particularly in the balance of acute to community care.
- It is radical in virtually abolishing the junior doctor model.
- It suffers from an acute failure of vision in neglecting the issues for support workers.

Human Resources Strategy/Fragmentation

- The fragmentation of bargaining created by Trusts is being slowly and painfully addressed through the development of a joint management/trade union human resources strategy.
- The recommendations of Hayes, if implemented, will require fragmentation and inequality to be dealt with in the context of the significantly larger employers.

Partnership Models

- Several NI Trusts have developed partnerships with Trade Unions and users as a model for improving support services and homecare services.
- Significant gains in pay, conditions, and new working practices with a framework of fairness and equality have now been achieved within one major Trust, and more will follow.

CORE TRENDS

Acute Restructuring

- There is a clear trend linked to technology and new forms of surgical intervention which takes acute facilities towards almost a hi-tech factory model of meeting health needs.
- The paradigm of 2/3 weeks recovery while being 'bought the grapes' is on the way out.

Acute/Community Shift

- A health prevention focus is increasingly being used across all jurisdictions to justify raising community investment and GP working outputs to minimise pressure on acute services.

Technologies

- Technologies such as telemedicine and expert IT systems are increasingly being used to support the delivery of services in remote areas.

Up-skilling

- The professionalisation of nursing in community and acute care is leading to new structures of work to support nurse led delivery through, for example, health care assistants and ward assistants.
- There is also a recognition of the critical role support workers play as part of the health care team.

Expectations

- Expectations for the performance of healthcare systems have risen dramatically.
- Sometimes this is out of a genuine frustration with delivery failures, sometimes from a false consumerism encouraged by governments.

Performance/Delivery

- The focus in future will be on consistent performance, raising performance, and measuring outcomes.
- All these trends have significant implications for the future shape and skill levels of the health and community workforce.

PEOPLE AT WORK

Definitions

- We need to develop the widest definition that includes all those working to promote health.
- In the North, this will mean recognising the substantial contribution of the community and voluntary sectors, and the activity of the private sector in community and residential care.

Expectations

- Many health workers have given up on the possibility of real change after years of underfunding and neglect.
- Once belief in the reality of change that is coming in all jurisdictions is established, there will be a clear demand for full participation in the changes to come. Governments and managements that neglect this contribution to change will do so at their peril.

Histories

- Where there has been open involvement and partnership, change can be addressed.
- Where there has been exclusion and denial of the contribution health workers can bring, change will need major clearing of the ground first.

Fears

- There will be major fears of change, particularly if it challenges existing roles and demarcations without a framework to give people security in the face of change.

Users/User Links

- The process of change has to value the input of those working in the system as well as the voice of users and carers.
- Equal respect for both these voices will be essential to sustain long term continuous improvement.

Support for Change

- Partnership and involvement are the only proven ways of delivering the level of change in health care systems now likely in both jurisdictions.
- Top down managerial styles, and attempts to exclude a passive workforce from the change process will not work.

ACTION

Comprehensive Base Line

- To take forward effective workforce projects in both jurisdictions a comprehensive baseline of current resources, systems, qualifications and workforce structures will be essential.
- This baseline will enable change to be modelled and evaluated.

Change/Security Issue

- The model will need to strengthen readiness for change by promoting security at work.
- People standing around waiting to be made redundant are not going to deliver the high expectations and outcomes that are now targeted, and will be damaged in their self esteem and health.

Partnership Model

- The partnership model at the level of government and the workplace North and South will clearly need to be strengthened to respond to the changes ahead.

Needs Analysis

- An effective baseline will allow changes in delivery and their impact to be accurately assessed against the current composition of the workforces.

Stakeholder Support

- The objective has to be a workforce strategy that commands the widest stakeholder support as part of a 'plan' approach, and the full integration of such a strategy into reshaping health care delivery.

Public/Private Consistency

- A North/South approach to this cannot be simply restricted to public sector workers and professionals now that there is significant private sector involvement.
- It has to engage the private sector in coming on board for better delivery of services.

Equality Focus

- A strategy must incorporate a systematic analysis of promoting equality and reducing inequality marching not only the legislative contexts of both jurisdictions but the commitments employers and trade unions have made and now have to be seen to live up to.

North/South Learning

- There are clearly not only significant opportunities for joint learning and a partnership approach, but also possibilities of convergence of qualifications and competencies reflected in initiatives already underway.
- While the mechanics of change North and South may be different, the core trends identified above generate a similar analysis of workforce structures and workforce development.

Partnership in Action

A Presentation on the experience of Beaumont and the Royal Hospitals

BEAUMONT HOSPITAL
Mary Tynan - INO & Joint Chair, Beaumont Hospital Partnership Steering Committee
Marie Keane - Director of Nursing, Beaumont Hospital

About Beaumont Hospital

- Beaumont Hospital is a North Dublin Acute Hospital, opened in 1987.
- It has 620 beds and 2,500 staff with a catchment area of 250,000 people.
- It is a University Teaching Hospital (RCSI) and is the National Centre for Cochlear Implantation, Neurosurgery and Renal Transplantation.

Partnership in Beaumont Hospital

- Beaumont Hospital is a pilot site for partnership under the Health Services National Partnership Forum initiative.
- An initial partnership meeting took place in June 2000 and training followed in July 2000 and February 2001.
- We are just completing our first year of the pilot phase.
- There is a Partnership Steering Committee of 14 people - with 7 Management and 7 Union nominees.
- The Steering Committee meets monthly - with Local Partnership working Groups (LPWGs) working and reporting on agreed projects.
- The importance of people is paramount.

Beaumont Hospital Initial Partnership Projects

- Communications project - some major initiatives have taken place.
- Public Transport project - involving patients, staff and visitors.
- Staff Facilities project - a number of new arrangements, e.g. garden.
- Departmental projects being developed in A&E, Records and Theatre.
- North/South projects are also being developed with the Royal Hospitals.
- National Projects and National Health Strategy.

THE ROYAL HOSPITALS
Evan Bates - Development Director, The Royal Hospitals

About the Royal Hospitals

- The Royal is an Acute General Hospital providing local and regional services, clinical education, training and research.
- It employs 6,000 staff and has 10% of Regional Expenditure.

Partnership at the Royal Hospitals

- Priorities include equality, human relations, human rights and social need.
- Recognises the importance of collaboration in providing health care including:
  - partnership with staff and representatives;
  - equal opportunities;
  - joint negotiation and consultative committee;
  - regional partnership initiatives; and
  - Best Value projects.

North/South Partnership Projects

- Partnership initiation agreement between management and trade unions in Beaumont Hospital and the Royal Hospitals.
- Three conferences/workshops to date in November 2000, February 2001 and June 2001.
- Agreement to work on five project areas.

1. ***Infection Control Project***
   - The impact of cleaning regimes on environmental reservoirs of antimicrobial resistant bacteria, such as M.R.S.A.
   - Multidisciplinary approach involving management, unions, staff and patients.
   - Benchmarking with best practice.
   - Project near operational stage.
2. ***Bed capacity and utilisation***
   - Data analysis - North & South.
   - Multi-disciplinary groups.
   - Exchanges between A&E Departments and ICUs.
   - Review procedures - best practice.
   - Benchmarking.
   - Apply measures to improve systems.

3. *Trauma – Telemedicine*

- Clinical Education via Remote Links.
- Collaborative learning.
- Exchanges of best practice.
- North/South Trauma Database.
- Training rotation.
- Development of North-South standards in software and transmission of imaging data.

4. *Joint Fundraising*

- Co-operative venture involving both hospitals in innovative fundraising activities.
- Strategic objectives outlined.
- Both domestic and North America.
- Funding to support Medical Research Programmes.

5. *Human Resources Project*

- Three elements involving management, trade unions and staff, North & South.

Partnership Development

- *Exchanges and joint work on practical projects - e.g.*
- *Best Value – Facilities.*
- *Key Skills.*
- *Joint workshops on the practical experience of partnership in action and the learning from best practice.*

Management Development

- *Middle managers.*
- *Administrative, Paramedic & Nursing.*
- *Multidisciplinary groups- 360° Feedback.*
- *North-South shadowing exchanges.*
- *Personal Development Plans.*
- *Pilot programme in November.*

Professional Development

- *Partnership in Learning and professional development between Neurosurgical Nursing in both units.*
- *Objectives.*
- *Structure.*
- *Practical Development.*
- *Education.*

- *Research.*
- *Neurosciences Benchmarking Club.*
- *Exchange programme between units.*
- *Establish Irish Neuro Nurses Forum.*
- *Examine Nursing Research Opportunities.*
- *Scale of the project.*
- *Funding, resources and costs.*
- *Evaluation issues: Achievement of objectives, Staff satisfaction questionnaire, Change in practice.*

Partnership Development

- Best Value Projects.
- Trade Union Perspective.

Next steps

- Secure funding and resources.
- Move to implementation stage.
- Invest in training and development.
- Build competence and confidence in the partnership process.

A Trade Union Perspective – Vinty Donaldson, UNISON

"As a trade Unionist who has lived through some bitter conflict in the health service over the past fifteen years I admit I was sceptical when Patricia McKeown, our lead negotiator, offered partnership to the employer.

Partnership was still at a very primitive stage in the North and in the health service. I think most Trusts and the Department were taken aback when we formed it over three years ago.

None of it was easy. We had to move from conflict to joint working. We had to convince our own members (on our side) and the Trust had to convince its own managers and Board (on its side) that there was something in it for us all.

The stakes were high. We wanted to keep privatisation out, to bring real equality in, to tackle low pay and to provide a better service.

It has been hard work, but it has worked. The reason it did, is because we became equal partners . Partnership won't work if one or some of the partners are treated as less than equal. It also doesn't work unless 'partners' are supported with training and back up.

We have achieved major change. Our members have benefited and for the first time have been really involved. The Trust has benefited and most of all patients and the public have benefited. We also have clear understanding that partnership doesn't mean we always have to agree – but we have formed new relationships.

Something that was a clear and most important demand from our members was the need for their skills to be recognised and for them to have access to new skills and development.

We were excited when Debbie King came to Belfast about a year ago to speak of her project. There was widespread interest from public employers and trade unions. Unfortunately, the assembly was suspended at the time (lets hope she's made it this time around).

Today we have endorsement from both Ministers and that can only be for the good of patients, public, workers and both health services."

Workshop Session

Six workshops focused on a number of key issues relating to the initiative.

NEW MODELS FOR EDUCATION/TRAINING

Q.1 What would be the advantages, or disadvantages in developing common educational qualifications and training standards North and South in the Health Services?

Q.2 What steps need to be taken in developing standard North/South qualifications?

- Obvious advantages are standardisation of qualifications, leading to greater mobility between health agencies and across borders; higher levels of education also means gains for both staff and patients.
- Obstacles will be legislation and registration, leading to one-way traffic; loss of professional power and control, and the overlooking of staff already bypassed in current training systems.
- In order for the initiative to be successful, there needs to be political buy-in to it.
- Committed funding and comprehensive communications are also necessary.

RETHINKING FUNDING/QUALITY

Q.3 Should we pilot the North/South Health project in a limited number of specific areas, or go for an all-embracing North/South initiative?

Q.4 Should this initiative be funded directly by both Health Departments or should EU funding be sought?

Q.5 What Quality/Evaluation systems should be put in place?

- The general feeling at this workshop was that a wide project including all health areas should be initiated.
- This could address areas of concern common to both North & South: labour shortages and educational levels, etc.
- It was agreed that E.U., Cross Border and local/departmental funding should be sought.
- It is obvious that there should be clear, specific and time-driven objectives for the project.
- Evaluation of progress, both at local and national (North/South) level, should be continuous.

RETHINKING WORK BOUNDARIES

Q.6 Do we include all groups or levels of Health Service Staff within the scope of the North/South Initiative or do we prioritise Groups?

Q.7 Should we identify potential areas of work/skill mix and pilot them?

Q.8 Do we establish a North/South Skills Exchange Programme and how will it work?

- All grades/groups should be included in the project.
- Potential areas of work/skill mix should be identified and piloted, but not before commitment to the project was secured from all the parties involved.
- Pilot projects should compliment existing jobs and include structured career development.
- The idea of a skills exchange programme was received positively, however, this can only work on a voluntary basis with suitable support arrangements and reporting structures.

CHALLENGES/OPPORTUNITIES

Q.9 What do we see as the main challenges to starting up the North/South project?

Q.10 What are the likely benefits that will arise out of the North/South project?

Q.11 Are there legislative or other changes to be made to allow for recognition of common qualifications and how will they be addressed.

- There will be challenges to the initiative in the form of resources, lack of existing research in the area, staff shortages and temporary registration fees.
- There are benefits for both patients and staff if the initiative is successful. These include improved staff morale, job satisfaction and prospects; for patients, improved healthcare and health status.
- To allow movement between North and South, conflicting legislation must be researched and resolved. In addition, any European law allusions should be examined.

RESOURCES: HUMAN & FINANCIAL

Q.12 What scale of activity do we envisage in the North/South project and will people be available to participate?

Q.13 Will the North/South project require full-time organisation and facilitation?

Q.14 What sort of budget will be required to carry out research, development, implementation and evaluation phases?

- The scale of activity for the initiative will ultimately depend on the funding available. If it is piecemeal funding then an incremental approach will be indicated. However, if significant funds are available, a strategic wide-ranging approach will be permissible.
- With a strategic approach comes the need for full-time organisation, facilitation and budgeting. This budgeting must include all the key phases of this type of project: research, development, implementation and evaluation.
- Without commitment to the release of personnel (where required) and a general culture shift, the initiative will not succeed.
- The long-term benefits of the project have the potential to outweigh any initial costs.

FUTURE AGENDA

Q.15 What can partnership contribute to these initiatives.

Q.16 What timeframe are we looking at for completing the Full Project?

Q.17 Are there distinct phases required to ensure the success of the project?

Q.18 Will there be a need for a Joint Steering Committee?

- Partnership can contribute greatly to the initiative. The non-confrontational and all-inclusive methods employed in Partnership working, provide huge potential to remove existing barriers to change in this area.
- To ensure the success of the initiative, there are distinct phases that must take place:
  - *There must be a local understanding of Partnership; communications and networking, recruitment, research and delivery must all form part of the overall framework.*
  - *The need for a joint steering group to structure the initiative was emphasised by all workshop groups.*

Next Steps

At the conference a draft proposal was agreed on the scope of the North-South health project, and a number of guiding principles were established. It was also agreed to develop a Joint Steering Group; to source funding at a number of levels; to establish an evaluation group; and to develop a core strategic framework.

DRAFT PROPOSAL TO CONFERENCE ON THE SCOPE OF A NORTH-SOUTH HEALTH PROJECT – JUNE 2001

1. Construct a definition of 'employed health worker' that matches the circumstances (and realities) of both jurisdictions. In particular, carefully map the boundaries between those employed in community care tasks and informal care/the work of carers.

   (The above is essential to ensure that there is not an artificial focus on 'state' employees as compared with those in the 'third sector').

2. Using the above definition and boundary, construct a 'what we know - don't know' baseline incorporating the following;

   - Number of employees against a set of sector definitions (e.g. state funded/charitable/private) that as far as possible have common validity in both jurisdictions. Highlight any differences of interpretation.
   - Number of employees by (broad) job categories, per sector, across sectors and per jurisdiction. Again, seek consistency of definition, and highlight variances.
   - Develop estimates of labour costs on the sectoral/job classification model as set out above. Highlight only obvious differences in remuneration and labour market positioning.
   - Map the comparative structures of qualification (non-qualification), and statutory legislation for professional development.
   - Identify current assumptions on:
     - Skills & latent skills
     - Training levels, training priorities, training gaps and funding for training

     } Sectoral/jobs classification model per jurisdiction
   - Assess known employment and user inequalities against all factors in the workplace/ in relation to both jurisdictions.
   - Research current levels of 'partnership' activity at employer/union levels, and where relevant the incorporation of users and stakeholders into models of health partnership working.

3. Construct a 'what needs to be done' model of how both systems will need to be restructured to achieve best practice health and health inequality outcomes.

4. Evaluate the impact of such a model on all the baseline factors in (2), with particular emphasis on:

   - Likely labour/skills surpluses.

- Likely labour/skills shortages.
- Continuing skills and labour strategies.
- Priorities in both jurisdictions for training and qualification initiatives.
- Opportunities for training and qualification convergence and justification of value added to employment and health outcomes.
- Broad estimates of initial and ongoing costs to support labour market restructuring, and sources of funding.

GUIDING PRINCIPLES

1. Recognition of fundamental change in health services North and South.
2. Working together in an all inclusive partnership model reflecting the need for better health outcomes, major reductions in health inequality, and maximising the workforce contribution to these objectives.
3. Linking new thinking on career development to new patterns of health service delivery.
4. Using partnership to involve and release the contribution of employees to change.
5. Generating a strategic agenda for prioritising partnership and change projects and sharing learning.
6. Developing individual projects within a framework based on strategic assessment of change and the workplace impact of change.
7. Building capacity for workforce support for patient and equality focused care.
8. Recognition of how workers in the health care systems contribute to health outcomes.
9. Identification and continuous improvement and promotion of lifelong learning strategies linked to new models of healthcare.
10. Supporting convergence and validation of qualifications North and South in conjunction with existing professional initiatives.
11. Incorporating equality and human resources best practice and legislation into frameworks for change.

JOINT STEERING GROUP

- It was agreed to develop a Joint Steering Group.
- The group should consist of 14/16 people to include equal representation, North and South, from respective Departments of Health, management/employers and ICTU. Relevant stakeholder groups should also have representation.

FUNDING AND SUPPORT ACTIONS

- It was agreed to source funding at a number of levels:
  - Northern Ireland - Department of Health, Department of Education, Department of Enterprise, Trade and Investment
  - Republic of Ireland – Department of Health and Children, Department of Education and Science
  - European Structural Funds
  - IFI/AFI/TSER
- It was agreed to explore a range of placements and short term development opportunities, for example, utilising Lancaster CEOs in support of the project.

EVALUATION

- It was agreed that evaluation should start from day one with an evaluation group of four people to include:
  - Gerard Hughes - Economic and Social Research Institute, Dublin;
  - Deborah King -1199/League Employment, Training and Job Security Program, New York;
  - Jonathan Swallow - Swallow Consulting
  - Patricia Brand - King's Fund.

CORE STRATEGIC FRAMEWORK FOR PROJECT

- Research based baseline North and South.
- Focus groups on likely directions of change and impact of change across the health and community workforce.
- Prioritisation of consequent projects.
- Sustaining core costs for disseminating and mainstreaming projects.

The Conference was attended by participants from the following organisations

1199 Programme, New York, USA
Adelaide and Meath Hospital (incorporating the NCH), Tallaght, Co Dublin
Armagh & Dungannon Trust (NI)
Baggot Street Community Hospital, Dublin
Ballymun Health Centre, Dublin
Beaumont Hospital, Dublin
Belfast City Hospital
Chartered Society of Physiotherapy
Department of Health and Children
Department of Health, Social Services and Public Safety (NI)
East Coast Area Health Board (ECAHB)
Eastern Regional Health Authority (ERHA)
Economic & Social Research Institute (ESRI)
Health Services National Partnership Forum (HSNPF)
Irish Municiple, Public and Civil Trade Union (IMPACT)
Irish Congress of Trade Unions (ICTU)
Irish Nurses Organisation (INO)
John O'Dowd Consultants, Co Meath
Midland Health Board (MHB)
National Rehabilitation Board (NRB)
North Eastern Health Board (NEHB)
Northern Ireland Public Service Alliance (NIPSA)
Our Lady's Hospital for Sick Children, Crumlin, Dublin
Psychiatric Nurses Association (PNA)
Royal College of Midwives
Royal College of Nursing
Royal Hospital, Donnybrook, Dublin
Royal Hospitals Trust (NI)
Service, Industrial, Professional and Technical Union (SIPTU)
South Eastern Health Board (SEHB)
Southern Health Board (SHB)
St. Columcille's Hospital, Loughlinstown, Co. Dublin
St. Ita's Hospital, Portrane
St. Vincents University Hospital, Elm Park, Dublin
Swallow Consulting (UK)
The Coombe Women's Hospital, Dublin
UNISON (NI)