

The Economics of the UK Health and Social Care Labour Market: How Labour Economics Can Inform Policy toward the Frontline Care Workforce. By Robert Elliott. Oxford University Press, 2024. Pp. xvi, 250. \$50.00. ISBN 978–0–19–888314–2, cloth. (JEL H51, I10, J22, J24, J31, J82, L84)

In *The Economics of the UK Health and Social Care Labour Market*, Robert Elliot brings together concepts from labor economics and applies them to the developments in the UK labor market for the frontline health and social-care workforce in the run up to the COVID-19 pandemic. Here, “frontline” refers those workers providing direct, face-to-face patient care, while social care is support for daily living that is often termed “long-term care” in the United States and elsewhere.

Elliot uses his decades-long experience as an academic economist and an advisor to the UK government, European Commission, and OECD to identify economic theories and models relevant to the frontline health- and social-care labor market. The five economic theories he highlights are net advantages, human capital formation, the production function, labor demand, and labor market equilibrium. Each is then described and explained in chapters 2 to 4 of the book, and then used to frame developments in the markets for frontline care workers in the 2010s—with a particular focus on doctors, nurses, and adult social-care workers.

The author sets himself the ambitious task of both explaining economic concepts to a nontechnical audience in a user-friendly way while remaining relevant to the fast-moving health-care policy space. This would be a challenge during any period. The vast majority of health-care workers (but not social-care workers) in the United Kingdom are employed by the taxpayer-funded National Health Service. New governments can therefore bring changes to pay setting, visa arrangements, organizational structures, and roles and responsibilities. However, since 2020 changes have been more frequent and seismic. The pandemic shook front-line health and care services around the world, while political turbulence led to frequent changes in government: The UK is on its fourth prime minister and sixth secretary of state for health in five years.

It is, therefore, not surprising that the greatest strength of this book is conceptual. Economic theories of the labor market are clearly and explained and supported using diagrammatic figures and data. These are kept at a level of detail that means concepts like

the human capital formation and the elasticity of labor supply remain relevant to most health-care markets. This should be useful for those without economics training, but also provides a valuable reminder for those working in and on the economics of the health-care workforce. Data from the period 2010–2019 are helpful in explaining how these concepts can relate to the real world. The evidence Elliot presents encourages the reader to think more broadly about both research and policy questions. The implications of the dominance of the National Health Service (NHS) as a buyer of health-care (but not social-care) labor supply is discussed in chapter 4, but the book does not aim to provide cross-country comparisons. An informed reader may however find it useful to infer how this differs from their own country's context.

The data and analysis are, however, less useful at providing policymakers with evidence about current workforce challenges, six or more years and one pandemic later. There are also some areas where members of the workforce and readers close to workforce policy may disagree with or question some of Elliot's arguments. For example, in chapter 2 (p. 39) Elliot draws strong distinctions between the outside options and responsiveness to pay of social-care workers and nurses on one side and doctors on the other.¹ Limited evidence is provided to support this distinction. Questions may be raised, as barriers to entry and exit are higher for degree-educated nurses than for social-care workers, who do not typically require formal care qualifications. More recent evidence also contradicts the assertion (p. 41), that having young children does not appear to affect doctors' labor supply. Kelly and Stockton (2022) show that average contracted hours of NHS doctors fall after returning from maternity leave (median length 10 months), with little change

¹ Registered nurses require degree-level qualifications to enter the profession, and have to maintain a certain number of practice hours to remain registered, creating barriers to a temporary exit. Whereas neither apply to social-care workers. The majority of nurses that leave the NHS work as nurses in other settings or in other occupations within health and care (Crawford, Disney, and Emmerson 2015; Shembavnekar and Kelly 2023). Social-care workers move between the sector and a wide range of other low-paid occupations, albeit with a sizeable flow into NHS (Kelly et al. 2022). It therefore seems probable that registered nurses lie somewhere between social-care workers and doctors, in terms of outside options—just as they do in terms of human capital. Social-care workers do however have more in common with nurse support workers, or nursing auxiliaries, who do not have degrees.

over the subsequent five years.

Chapters 5 to 7 concentrate on two issues highly pertinent to workforce policy debates and planning in the United Kingdom and elsewhere: the global market for health- and social-care workers (chapter 5) and pay (chapters 6 and 7). In chapter 5, Elliott describes the long reliance that the United Kingdom has had on recruiting health and care workers from abroad. He provides a useful description of why care workers may come to the United Kingdom and the impact they may have on the UK labor market. The data and evidence do, however, stop too early to pick up the surge in international recruitment of health-care workers, and of hospital doctors and nurses in particular, since 2020 (Barker 2023). There have also been important changes in source countries. Most of the increased inflow of international health workers in the early 2010s was by staff from the European Union, whereas more recent increases, post-2021, are accounted for by health workers from Asia and Africa. This shift coincided with the UK's exit from the EU, but there are multiple potential causes. Nor does Elliott address the out-migration of both UK and overseas-trained health- and social-care workers, a “stepping stone” to other countries, such as Australia and the United States (Bazeer, Kelly, and Buchan 2024).

Chapter 6 presents the theory of pay setting in an easily accessible way, while linking it to the UK health and social care sector. This exemplifies some of the book's greatest strengths. By contrast, chapter 7 raises issues around pay that remain relevant, but does not incorporate more recent post-pandemic experiences, such as a wave of strikes over pay and pensions by NHS hospital doctors, nurses, and ambulance workers from 2022 to 2024. Given the author's international experience, a chapter or section on how and why the UK labor market differs from other selected OECD countries may also have been valuable to both UK and international readers.

The solutions proposed in chapter 8 rest quite heavily on pay increases, but do not factor in the costs or how effective increasing pay might be relative to other measures, such as improving the working environment. These are areas that might be addressed in any future volume.

Overall, the book largely succeeds in its task in explaining economic concepts of the labor market in a readable way. For those working in or researching health care in the

United Kingdom, it provides a useful companion to help think through workforce issues using an economics lens. Recent events in health care and beyond do, however, mean that it is less valuable as a guide to the detail of current policy debates in the United Kingdom, as much has changed since the book was completed. As long as the reader has that in mind, it is a worthwhile addition to any bookshelf.

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