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CPME draft document on task shifting

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CONCERNING / CONCERNE

CPME WG on task shifting

PURPOSE / OBJET

Discussion

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Task shifting

Task Shifting

First DRAFT, to be discussed within CPME WG on 16 April 2010, Brussels
Rapporteur: Dr Fjeldsted

In October 2009, the World Medical Association (WMA) defined 'Task shifting' as a situation in which a task normally performed by a physician is transferred to another health professional with a different or lower level of education or training, or to a person with specialized education to perform a limited task only, without having a formal education. Task shifting can take place from doctors to pharmacists or nurses, but also from nurses to nurses' aides for example. Usually, decisions are based on evaluation of the tasks and the training.

CPME believes that the basis for task shifting must be patient safety, with the aim to achieve the best possible health care using available resources. Therefore, the responsibility for medical tasks must remain with the doctor even if it is carried out by others.
A policy document on task shifting is needed. The compilation below of documents from CPME, WMA, WHO and the first comments from WG members will help the WG to work towards a CPME policy document.

- **CPME Resolution on Professional Autonomy and Clinical Independence of the Medical Profession in Europe : CPME 2007/003 FINAL**

In June 2009, CPME published a 'Resolution on Professional Autonomy and Clinical Independence of the Medical Profession in Europe' which highlights that the weakening of a doctors' clinical responsibility for patient care is against the interests of the patients, society and third party payers. Results of task shifting might entail reduced trust in treatment, decreased compliance and loss of social trust in health care, as well as increased demands for unnecessary second opinions and diagnostic procedures thus causing further increases in health expenditure. Concluding, the resolution states the right of patients to have a qualified doctor in charge of their care and the doctors' right and duty to be well trained and professionally independent, which require recognition of the medical profession's clearly defined role in the national laws of EU member states and in the present and future planning of health care organizations.

- **Health Professionals statement on task shifting : CPME Info 203-2009**

The World Medical Association (WMA), in cooperation with other important stakeholders (nurses, midwives, dentists, physical therapist, etc.), published a 'Joint Health Professions Statement on Task Shifting' in February 2008. Besides mentioning the advantages of task shifting, such as overcoming shortages of professionals, following concerns are raised:

Decisions should be country-specific and take into account the local service delivery needs, quality and effectiveness factors, efficiency, and include health professionals in decision-making. Moreover, there needs to be a sufficient number of health professionals who can provide selection, training, direction, supervision, and continuing education as well as setting up regulations for assistive personnel and task-shifting. Adequate planning and monitoring is required in order to meet the needs of the patient, but also the assistive personnel shall be ensured to be compensated and benefited equal to a living wage. Moreover, concerns were expressed regarding the increasing demand on health professionals: increased responsibilities as trainers and supervisors, higher numbers will be needed to take care of new patients, and they will be faced with new and more complex health needs which requires more sophisticated analytical, diagnostic, and treatment skills. Nonetheless, task shifting should be viewed in an economic context as well to ensure equal benefits. Furthermore, a distinction is to be made between short-term and long-term task shifting. Short-term as well as program oriented (HIV) task shifting requires regular assessment and monitoring and shall have a stated exit-strategy, whereas long-term task shifting needs to be sustainable. Overall, efforts should be made and supported to increase professional training opportunities, and incentives should be provided for the retention of health professionals. Moreover, it is said that task-shifting shall not replace the development of sustainable, fully functioning health care systems.

- **WMA Resolution on Task Shifting: CPME Info 203-2009**

In October 2009, the WMA published a resolution on Task Shifting from the Medical Profession. In addition to what has been mentioned by the Joint Statement, it further underpins significant risks that task shifting can carry, as e.g.: decreased quality of patient care, reduced patient-physician contact, fragmented and inefficient service, lack of proper follow-up, incorrect diagnosis and treatment, and inability to deal with complications. The focal point is that quality and continuity of care and patient safety must never be jeopardized and should be the basis for all reforms and legislations dealing with task shifting. Another relevant aspect is that there is no one-fits-all solution and the needs of task shifting are different from country to country. Moreover, besides task shifting, there might be different approaches to tackle a shortage of staff, and further methods should be developed in parallel and viewed as the golden standard. The WMA stated that they shall consider establishing a framework for the sharing of information on this topic where members can discuss developments in their countries and their effects on patient care and outcomes.

- **WHO global recommendations and guidelines on Task shifting: rational redistribution of tasks among health workforce teams: CPME Info 090-2010**

In 2008, the World Health Organization (WHO) published a document comprising global recommendations and guidelines on task shifting which propose the adoption or expansion of a task shifting approach as one method of strengthening and expanding the health workforce to rapidly increase access to HIV and other health services. This WHO document

serves to identify and define the key elements which must be in place if the approach is to prove safe, efficient, effective, equitable, and sustainable.
Moreover, the document stresses that task shifting would be best implemented alongside other strategies designed to increase the total number of healthcare workers in all cadres. Task shifting requires significant investment in order to be efficient, but should not be viewed as a substitute for other investments in human resources for health. In total, the document comprises 22 Recommendations which are categorized into five areas: Recommendations on adopting task shifting as a public health initiative; Recommendations on creating an enabling regulatory environment for implementation; Recommendations on ensuring quality of care; Recommendations on ensuring sustainability; Recommendations on the organization of clinical care services.

Comments received from CPME WG :

1) From the Swedish Medical Association :

The basis for task shifting must be patient safety and efforts to achieve the best possible health care using available resources.

- Health care evolves continuously and it is natural that some tasks, that have become routine, are handed over from physicians to other health care professionals.
- We must bear in mind that when more complicated medical assessments are shifted from physicians to other health care professions patient safety might be put at risk.
- Physicians need, during their training, to attain knowledge and skill even regarding relatively uncomplicated treatments/procedures, to ensure that they are able to provide qualified advice and assessments in more complicated cases.
- Many administrative tasks may and should be shifted to from physicians to others.
- Used correctly task shifting may free valuable time for physicians.
- The importance of team work should be emphasized. Deciding which health care professions should be entitled to perform specific tasks is of secondary interest.
- A document from CPME on task shifting therefore should not be overly protective of physicians.

2) From the Danish Medical Association

The Danish health legislation declares that the following procedures are to be performed by authorised doctors:

- Performance of surgical procedures
- Initiation of anæstesia
- Drug prescription
- Use of electrical medical equipment in treatment of patients.

The Danish doctors are however entitled to delegate parts of their assignment to an assistant provided that the assistant has been properly instructed and is certified as a health care professional.

There are however exceptions to the rule of delegation.
Doctors cannot delegate the following tasks:

- The drafting of medical certificates for public use i.e. for instance in criminal cases.
- Drug prescription
- Establishment of time and cause of death, including brain death
- Filling in death certificates
- Decisions concerning end of life prolonging treatment to the dying patient and
- Decisions concerning the use of force in psychiatric care

Furthermore special rules exist for assisting in the field of cosmetic treatment.
Conditions for using an assistant:
The health care professional has to make sure that the assistant has the relevant qualifications
The health care professional must furthermore give clear and precise instructions in carrying out the specific task and must provide relevant supervision.

Examples of delegation from the health care practice in Denmark are:

- nurses performing intrauterine insemination.
- Nurses and midwives performing ultrasound examinations
- Nurses/ performing screening coloscopies.
- Midwifes alone take care of normal pregnancies and deliveries

Conclusion: Task shifting is widespread in Denmark and only imagination and a few legal provisions limit the scope of delegation.