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## **WMA Resolution on Task Shifting from the Medical Profession**

*Adopted by the WMA General Assembly, New Delhi, India, October 2009*

In health care, the term "Task Shifting" is used to describe a situation where a task normally performed by a physician is transferred to a health professional with a different or lower level of education and training, or to a person specifically trained to perform a limited task only, without having a formal health education. Task shifting occurs both in countries facing shortages of physicians and those not facing shortages.

A major factor leading to task shifting is the shortage of qualified workers resulting from migration or other factors. In countries facing a critical shortage of physicians, task shifting may be used to train alternate health care workers or laypersons to perform tasks generally considered to be within the purview of the medical profession. The rationale behind the transferring of these tasks is that the alternative would be no service to those in need. In such countries, task shifting is aimed at improving the health of extremely vulnerable populations, mostly to address current shortages of healthcare professionals or tackle specific health issues such as HIV. In countries with the most extreme shortage of physicians, new cadres of health care workers have been established. However, those persons taking over physicians' tasks lack the broad education and training of physicians and must perform their tasks according to protocols, but without the knowledge, experience and professional judgement required to make proper decisions when complications arise or other deviations occur. This may be appropriate in countries where the alternative to task shifting is no care at all but should not be extended to countries with different circumstances.

In countries not facing a critical shortage of physicians, task shifting may occur for various reasons: social, economic, and professional, sometimes under the guise of efficiency, savings or other unproven claims. It may be spurred, or, conversely, impeded, by professions seeking to expand or protect their traditional domain. It may be initiated by health authorities, by alternate health care workers and sometimes by

physicians themselves. It may be facilitated by the advancement of medical technology, which standardizes the performance and interpretation of certain tasks, therefore allowing them to be performed by non-physicians or technical assistants instead of physicians. This has typically been done in close collaboration with the medical profession. However, it must be recognized that medicine can never be viewed solely as a technical discipline.

Task shifting may occur within an already existing medical team, resulting in a reshuffling of the roles and functions performed by the members of such a team. It may also create new types of personnel whose function is to assist other health professionals, specifically physicians, as well as personnel trained to independently perform specific tasks.

Although task shifting may be useful in certain situations, and may sometimes improve the level of patient care, it carries with it significant risks. First and foremost among these is the risk of decreased quality of patient care, particularly if medical judgment and decision making is transferred. In addition to the fact that the patient may be cared for by a lesser trained health care worker, there are specific quality issues involved, including reduced patient-physician contact, fragmented and inefficient service, lack of proper follow up, incorrect diagnosis and treatment and inability to deal with complications.

In addition, task shifting which deploys assistive personnel may actually increase the demand on physicians. Physicians will have increasing responsibilities as trainers and supervisors, diverting scarce time from their many other tasks such as direct patient care. They may also have increased professional and/or legal responsibility for the care given by health care workers under their supervision.

The World Medical Association expresses particular apprehension over the fact that task shifting is often initiated by health authorities, without consultation with physicians and their professional representative associations.

## **RECOMMENDATIONS**

Therefore, the World Medical Association recommends the following guidelines:

1. Quality and continuity of care and patient safety must never be compromised and should be the basis for all reforms and legislation dealing with task shifting.
2. When tasks are shifted away from physicians, physicians and their professional representative associations should be consulted and closely involved from the beginning in all aspects concerning the implementation of task shifting, especially in the reform of legislations and regulations. Physicians might themselves consider initiating and training a new cadre of assistants under their supervision and in accordance with principles of safety and proper patient care.
3. Quality assurance standards and treatment protocols must be defined, developed and supervised by physicians. Credentialing systems should be devised and implemented alongside the implementation of task shifting in order to ensure quality of care. Tasks that should be performed only by physicians must be clearly defined. Specifically, the role of diagnosis and prescribing should be carefully studied.
4. In countries with a critical shortage of physicians, task shifting should be viewed as an interim strategy with a clearly formulated exit strategy. However, where conditions in a specific country make it likely that it will be implemented for the longer term, a strategy of sustainability must be implemented.
5. Task shifting should not replace the development of sustainable, fully functioning health care systems. Assistive workers should not be employed at the expense of unemployed and underemployed health care professionals. Task shifting also should not

replace the education and training of physicians and other health care professionals. The aspiration should be to train and employ more skilled workers rather than shifting tasks to less skilled workers.

6. Task shifting should not be undertaken or viewed solely as a cost saving measure as the economic benefits of task shifting remain unsubstantiated and because cost driven measures are unlikely to produce quality results in the best interest of patients. Credible analysis of the economic benefits of task shifting should be conducted in order to measure health outcomes, cost effectiveness and productivity.

7. Task shifting should be complemented with incentives for the retention of health professionals such as an increase of health professionals' salaries and improvement of working conditions.

8. The reasons underlying the need for task shifting differ from country to country and therefore solutions appropriate for one country cannot be automatically adopted by others.

9. The effect of task shifting on the overall functioning of health systems remains unclear. Assessments should be made of the impact of task shifting on patient and health outcomes as well as on efficiency and effectiveness of health care delivery. In particular, when task shifting occurs in response to specific health issues, such as HIV, regular assessment and monitoring should be conducted of the entire health system. Such work is essential in order to ensure that these programs are improving the health of patients.

10. Task shifting must be studied and assessed independently and not under the auspices of those designated to perform or finance task shifting measures.

11. Task shifting is only one response to the health workforce shortage. Other methods, such as collaborative practice or a team/partner approach, should be developed in parallel and viewed as the gold standard. Task shifting should not replace the development of mutually supportive, interactive health care teams, coordinated by a physician, where each member can make his or her unique contribution to the care being provided.

12. In order for collaborative practice to succeed, training in leadership and teamwork must be improved. There must also be a clear understanding of what each person is trained for and capable of doing, clear understanding of responsibilities and a defined, uniformly accepted use of terminology.

13. Task shifting should be preceded by a systematic review, analysis and discussion of the potential needs, costs and benefits. It should not be instituted solely as a reaction to other developments in the health care system.

14. Research must be conducted in order to identify successful training models. Work will need to be aligned to various models currently in existence. Research should also focus on the collection and sharing of information, evidence and outcomes. Research and analysis must be comprehensive and physicians must be part of the process.

15. When appropriate, National Medical Associations should collaborate with associations of other health care professionals in setting the framework for task shifting. The WMA 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.