

# Task substitution: where to from here?

Niki Ellis, Lynn Robinson and Peter M Brooks

*Meeting future health workforce needs is a challenge for all health professionals*

There now seems little debate that the medical profession needs to accept task substitution as one solution to the health workforce crisis. The contributions in this issue of the Journal from the Royal Australian College of General Practitioners (page 20),<sup>1</sup> Royal Australasian College of Physicians (RACP) (page 23),<sup>2</sup> the Royal Australasian College of Surgeons (page 25)<sup>3</sup> and Australian Medical Association (AMA) (page 27)<sup>4</sup> all acknowledge that reality and express a guarded acceptance of moving in this direction. They correctly emphasise that the overriding issue is the detail of how these strategies should be implemented, always bearing in mind the essential principle that patient care must not be compromised. Collectively, these organisations acknowledge that health care is delivered by a team. Who directs that team is perhaps debatable, although it will in most situations be a medical practitioner. We should, however, acknowledge the recent observations of Sir Graeme Catto, President of the UK General Medical Council:

The exclusivity of medical knowledge and skill is being broken down. Interprofessional learning is now commonplace in medical education and seems likely to increase. Professional boundaries are being blurred as more and more things that were once the sole domain of doctors are being undertaken by other health care professionals. None of us works alone any longer, but in multidisciplinary teams in which we depend upon the expertise of others. This is not a diminution of medicine, but a strengthening of health care. We must acknowledge that, more than ever before, knowledge is available to patients and the public.”<sup>5</sup>

We share the view of the AMA that it is important that health outcomes (slightly different from “health standards”) should not be compromised, but there is little or no evidence that this occurs where task substitution has been introduced. In fact, a Cochrane review of nurse practitioners<sup>6</sup> suggested that outcomes for patients in services delivered by nurse practitioners are the same as or better than those delivered by doctors, and that nurse practitioners are well accepted by patients; however, improvements in cost-effectiveness were not as substantial as expected.

The Productivity Commission report *Australia's health workforce* serves as a blueprint for health workforce reform in Australia and presents task substitution as one plank in tackling what we all acknowledge is a very complex issue.<sup>7</sup> But we need to recognise that the Productivity Commission report is about a lot more than task substitution. Certainly it comes from an economic “direction”, but to suggest that we, the providers of health services, have no economic responsibility is not acceptable in the 21st century. The issue is not principally about saving money — it is about using resources more efficiently to meet rising demand.

The health workforce currently makes up about 11.3% of the total workforce in Australia, and it has been estimated (with feminisation of the health workforce, changing attitudes towards working, the ageing population, chronic disease and increasing community expectations for health) that we may need over 20% of

the total workforce in health-related areas by 2025 if we are to maintain the delivery of services we currently have. Where is this workforce to come from?

To date, four options for meeting increased demand in the future have been identified:

- extending the roles of existing health professionals (eg, nurses and allied health professionals);
- creating new types of health workers (eg, clinical assistants);
- improving efficiency by using information technology more effectively in the health industry;
- placing more emphasis on prevention and health promotion.

Task substitution can involve the creation of new autonomous roles (eg, nurse practitioners) or roles in which non-medical practitioners work under the supervision of someone else (usually a medical practitioner) (ie, delegated care). Supervision may be in person (eg, a clinical assistant working in a primary care setting with a general practitioner) or remote (eg, nurses or physiotherapists running minor illness and injury clinics using video links for medical supervision).

It appears that two very different types of clinical assistant may emerge in Australia:<sup>8</sup> those who work in primary care, and therefore require generalist knowledge, and those who have highly specialised technical skills, such as surgical assistants and endoscopy assistants.

As noted by many of the contributors to this issue of the Journal, moving current health professionals to other parts of the sinking ship will provide very limited gains. It is true that we need more health professionals, but we need to retain them and make use of them optimally.

Implementing task substitution requires a combination of service redesign, using clinical practice improvement methodology, and progressive competency-based training.

Underpinning task substitution is the notion of generic descriptions of health competencies that cross professional boundaries. The UK Skills Escalator<sup>9</sup> is an important example and a potential model for adaptation and testing in Australia.

The Skills Escalator is a nine-level career framework that starts with supporting roles then moves to assistants and senior assistants, assistant practitioners, qualified practitioners, senior or specialist practitioners, advanced practitioners, consultant practitioners and, finally, more senior posts. It provides a wide variety of entry points into health care careers, encourages and recognises lifelong learning and acquisition of new skills, and is used in an environment that seeks both job satisfaction and service efficiencies by “delegating roles, work and responsibilities down the escalator where appropriate”.<sup>9</sup>

The physician assistant (delegated care) model, equivalent to assistant practitioner on the Skills Escalator, seems to have been very successful in the United States<sup>10</sup> and should be considered and tested in the Australian context. Piloting of delegated care models, including the use of clinical assistants, is already being seriously considered by one Australian state health department



and was a major topic of positive debate at a recent annual general meeting of the Australian Society of Urologists. The opportunity is there for the health departments, colleges and universities to work together to identify services that lend themselves to productivity gains through the introduction of delegated care models, define the scope of new practices, develop the curriculum, deliver the learning programs, implement the redesigned services, and evaluate these new models of care delivery.

Introducing delegated models of care is something that can be done now, and its focus on interprofessional care and competency-based training is likely to enhance these emerging trends in health education.

The universities have the opportunity to establish inter-professional educational models at an undergraduate level so that health professionals of all persuasions learn at a very early stage that they are part of a health care team, that each has an important role, and that, in the future, all disciplines will have the potential to play leadership roles.

Meanwhile, we should continue to:

- research and refine techniques to support health workforce innovation;
- explore novel techniques for training and assessing skills, including the use of synthetic environments (such as simulation and skills centres) and community-based environments;
- focus on competency assessment that is truly predictive of performance (as measured by patient safety and outcomes); and
- develop objective, reliable instruments for monitoring performance, safety and quality, especially when task substitution or role extension is newly introduced.

Competencies need to be reassessed as a career progresses. Again, there are major opportunities for the colleges and universities to work together, as is already happening with the development of the Career Medical Officer program by the RACP and the Consortium of Universities for Postgraduate Health Education.

As well as the future of health education, task substitution raises questions about registration and funding mechanisms, as highlighted in the Productivity Commission report. It is obvious that innovations are already occurring in the Australian health system, especially in areas under workforce pressure, from which we could learn — for example, the extended role of nurses and physiotherapists in hospitals with medical shortages.<sup>11</sup> Further experimentation on various models of task substitution through education, service delivery and consumer partnerships would add to our knowledge.

To move the issue of task substitution forward we probably need to move a little further towards accepting loss of “control” of the

system. Like many professions (recall Adam Smith, who observed in 1776 in *The wealth of nations* that all professions tended to form self-interest groups and generally “conspire against the laity”<sup>12</sup>), we still fail to acknowledge that others may be able to do what we do — perhaps even better in some cases. We will need to reorganise the “ego systems”.<sup>13</sup> But what an opportunity! — designing (and testing) a health system that is both patient focused and provider friendly. Surely this is a challenge that all health professions can work together on.

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