Task substitution: the view of the Australian Medical Association

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ABSTRACT

- Technology, community expectations and an ageing population are driving the need for an expanded health care workforce.
- Doctors embrace task substitution wherever it can be done safely and effectively.
- Task substitution should occur in the context of:
  - team care that synergises the different skills of doctors, nurses and other health professionals
  - doctors retaining their central role
  - increases in the capacity to extend medical services with efficiency gains
  - no loss of patient safety
  - no fragmentation of care
- The growth of task substitution could lead to workforce shortages in other health care areas.
- Public policy on task substitution must take full account of patient preferences and expectations.

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Task substitution, defined as allocating clinical responsibilities to lesser or more narrowly trained health professionals with or without medical supervision, has promised to alleviate the problems attending current health workforce shortages.

New technology, growing community expectations and an ageing population are some of the key forces driving the increased demand for health services and, therefore, driving the need for an expanded health care workforce. There has been an accompanying growth in the numbers and scope of non-physician clinicians in Western countries, from nurse practitioners to acupuncturists.[1]

When Australians get sick, they want to see a doctor. Australian research has shown patients are supportive of general practice nursing, but also have strong views that nurses should not be a substitute for doctors, should not take on diagnostic roles, and should be part of a team with the doctor.[2] So, with the public insisting on highly trained doctors who can help them navigate the health system, who will take responsibility for their care, who are good communicators, and who are flexible about the level of decision making by the patient, doctors will retain their central role.

Despite some workforce shortages and some geographic maldistribution, Australians continue to enjoy one of the best health care systems in the world. For a relatively modest national cost (9.7% of gross domestic product),[3] most Australians have good access to a large number of high quality health services. Value for money is not in question.

There is, of course, room for improvement. There is much to be done in mental health, Aboriginal and Torres Strait Islander health and rural and remote area health more generally. There is scope to further improve the safety of our hospitals. Too many Australians persist unwisely in damaging their health through substance misuse (tobacco, other drugs of dependence and excessive alcohol consumption).

Major challenges loom — for example, the growing obesity of the Australian population and the accompanying epidemic of type 2 diabetes. Too few people have heard and heeded the messages on diet and exercise. The Australian health system report card reads "tries hard, can do better".

So, how can we do better? Is workforce reform the answer? Some seem to think so. The Productivity Commission report on the health workforce has recommended that Australia increase the scope for substituting other health professionals to undertake doctors' tasks[4] — a proposal that has some support from the federal government.

The Productivity Commission proposes that there be funding initiatives to hasten task substitution, criticising the "Limited incentives in MBS [the Medicare Benefits Schedule] for delegation of less complex tasks to less highly qualified, but more cost-effective, health professionals" (page XXXIV). In fact, there is very extensive delegation under the umbrella of the MBS. Of the 236 million services processed by Medicare Australia in the 2004–05 financial year, over 90 million (in the areas of pathology and diagnostic imaging) operate in the "for and on behalf of" framework and engage the services of a large number of paramedical health professionals. Add in optometry, practice nurses and the like, and the total is over 100 million services a year.[5]

Contrary to the implication of the Productivity Commission report — and the overt claims in some of the submissions to it — doctors do not stand in the way of task substitution. It is well embraced wherever it can be done safely. Task substitution is not a new idea, just newly discovered by the Productivity Commission.

From the viewpoint of the Australian Medical Association (AMA), any reforms must improve what doctors and other health professionals do, rather than risk any reduction in standards of care. In advocating reforms such as team-based care in general and hospital practice, the AMA is calling for reforms that synergise the different skills of doctors, nurses and other health professionals, rather than for a competitive regimen of overlapping clinical roles. In doing this, there would be the capacity to extend medical services with efficiency gains, but without the potential loss of safety or fragmentation of care.

Practice nurse funding is a pertinent example. General practitioners foresaw how this could help them meet the needs of their patients. The AMA lobbied for the program. Now it is GPs who are making sure that the program is effective, delivering good outcomes for patients at a modest cost for taxpayers.

The medical profession does not share the Productivity Commission's wide-eyed view of task substitution as a panacea for workforce shortages. Indeed, there are fears that the growth of task substitution could lead to a two-tiered system and increase

workforce shortages in other health areas.[6] For a start, many paramedical professionals are also in short supply. In the absence of well planned measures to address the health workforce shortages, the problems are not solved but simply moved around from one discipline to another, akin to robbing Peter to pay Paul. For example, in the short term the rise in the number of practice nurses is achieved by exacerbating nurse shortages in hospitals and nursing homes.

In all areas, we need comprehensive training and retention policies. Too often, the knee-jerk reaction by governments is to churn out more health care workers without finding out why they are leaving the sector or seeking alternative employment. The Productivity Commission report is very short on detail when it comes to improving health workforce retention.

In many areas of health care, there is strong teamwork by health care professionals. It is well understood that the skills are complementary and that good patient outcomes arise from the quality of the individual contributions and the quality of the teamwork. Excellent communication among members of health care teams is a necessary ingredient. In every team situation, however, it is the doctor who bears the final responsibility, and the doctor who is the natural and appropriate leader of the team.

The Productivity Commission is, of course, an economic research agency. In the language of economics, all health care professionals are scarce and expensive resources. Poor economic outcomes arise when scarce resources are misallocated. To push the envelope on task substitution is to invite *poor* resource allocation. It is not a good use of resources to use health professionals in roles for which they are not trained and not expert. However, issues of safety transcend the economic. When it is not safe for the patient, it is just not on.

At present, there is a dearth of scientific evidence on the economic outcomes of task substitution.[7,8] Claims of cost savings are as yet unsubstantiated. The available evidence suggests that midwife-managed delivery, for example, does not result in a lower rate of intervention.[9]

Arguably, the recent initiatives such as practice nurses have not reduced the need for doctors overall. Rather, they have reduced the level of unmet need for primary care. That is a good outcome, especially in rural and remote areas where practice nurses have been encouraged.

In some areas, there is scope for task substitution. When exploring the scope, patient safety is critical and not some kind of optional extra. Modern health care is very complex and, in some cases, hazardous. The risks can be minimised, but never removed altogether. The medical profession is subject to extensive checks and balances in the quest for minimal risk to patients. The fundamental guiding principle — above all, do no harm — should apply to all the health professions. If other professions seek to take over tasks now undertaken by doctors, then they too must be subject to the same checks and balances as the medical profession.

We should be able to learn from other countries — such as the United Kingdom, which went further than most with task substitution, but has sharply increased the number of doctors working in its National Health Service (a 21% increase between 2000 and 2004[10,11]) and in the country at large, and has increased its undergraduate training (over 30% more medical students compared with 7 years ago).[12]

Any public policy on task substitution that does not take full account of patient preferences and expectations is bound to be seen as a failure and bound to be a failure. When people have any serious health problem, they will want and expect to see a doctor. And so they should. Australia has the wealth to ensure that all our citizens have access to health care. Ultimately, it is a matter of choice.

Competing interests

None identified.

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