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TASK-SHIFTING IN HEALTH CARE SETTINGS

DESK REVIEW

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TASK-SHIFTING IN HEALTH CARE SETTINGS

Task-shifting has been a popular option in dealing with HIV prevention, treatment, and palliative care. Task-shifting offers patients the option of high-quality care with easier access to their communities, at lower cost. The main challenges to implementation include adequate and sustainable training, support and pay for staff in new roles, the integration of new members into health care teams, and the compliance of regulatory bodies.

In a review of 84 published studies in Africa evaluating the effectiveness of task-shifting from medical staff to lower level cadres for HIV care and treatment (Callaghan, Ford, and Schneider 2010), the authors found that in the areas of efficiency and access to antiretroviral therapy (ART) and counseling, shifting services from doctors to nurses resulted in better services. Quality of care and using viral suppression, adherence, toxicity, and death as indicators were as good in nurse-treatment programs as in doctor-treatment programs. Home-based care, treatment support, and other extra-clinical services provided by lay health workers (LHWs) have been shown to be effective.

Evidence consistently shows that delegation of tasks, whether from doctors to nonphysician clinicians, including nurses, from nurses to nursing assistants or aides or to nonprofessional or LHWs and patients, can lead to improvements in access, coverage, and quality of health services at comparable or lower cost than traditional delivery models. The authors of the review article “Task Shifting: The Answer to the Human Resources Crisis in Africa?” also make the case that task-shifting, in order to be effective, requires a comprehensive and integrated reconfiguration of health teams, changed scopes of practice and regulatory frameworks, and enhanced training infrastructure, as well as availability of reliable medium- to long-term funding, with time frames of 20 to 30 years instead of 3 to 5 years (Lehman et al. 2009).

A review of the use of LHWs for support of directly observed treatment short-course patients has found a beneficial effect compared to use of institutional support for tuberculosis treatment, but that “there is little evidence available regarding the effectiveness of LHWs in substituting for health professionals or the effectiveness of alternative training strategies for LHWs” (Lewin et al. 2006).

A study in Zambia demonstrated that when HIV testing and counseling was shifted from health care workers to LHWs, service quality did not decline (Sanjana et al. 2009).

In a review article of task-shifting HIV care and treatment tasks to LHWs or community health workers (CHWs) in Africa (Hermann et al. 2009), the authors establish a list of several criteria for successful CHW programs for ART:

- Selection and motivation: There is wide agreement that CHWs should be selected on the basis of their motivation to serve the community in which they will be working.
- Initial training: Training for unskilled health workers is crucial, and its length and content depend on prior knowledge, tasks, and roles to be fulfilled by the future CHWs. Training should

be practically oriented and not consist of transferring disease-specific knowledge alone, but also communication and counseling skills.

- Simple guidelines and standardized protocols: The use of protocols and standard guidelines is increasingly being recognized as an important tool for quality assurance in most health professions. In Bangladesh, for example, CHWs who follow simple and standardized protocols for acute respiratory disease control are performing to standard.
- Supervision, support, and relationship with the formal health services: Supervision and other forms of support, such as supplies, are widely acknowledged in the literature as crucial for the continued quality of service provision by CHWs. Only good supervision, together with adequate material support, will enable CHWs to function.
- Adequate remuneration/career structure: The initial idea of the CHW assumed the existence of a pool of willing volunteers, but lack of payment has emerged as an important cause of CHW attrition. Some evidence suggests that the possibility of professional development is an important motivating factor for CHWs, possibly improving retention.
- Political support and a regulatory framework: For national CHW programs, it is necessary to develop regulatory frameworks that demarcate the boundaries between CHWs and the professional health cadres and provide protection for patients and health care workers.
- Alignment with broader health system strengthening: CHWs are not a remedy for weak health systems. Health systems must assure a number of functions, such as clinical care, uninterrupted supply, training and supervision, monitoring and evaluation, etc.

A study of CHWs who were recruited to improve newborn care in Bangladesh found that respondents were motivated primarily by a desire for self-development, to improve community health, and for utilization of free time. The most common factors cited for continuing as a CHW were financial incentives, feeling needed by the community, and the value of the CHW position in securing future career advancement. CHWs who left the program cited heavy workload, night visits, working outside of one's home area, familial opposition, and dissatisfaction with pay (Rahman et al. 2010). While demographic characteristics may be similar for community volunteers in India, personal and community barriers to working with patients living with HIV may be greater than working with newborns.

In a review article by Dubois and Singh (2009), the authors review the main approaches to and limitations of conventional health care personnel deployment. "Health care organizations have a range of options for ensuring a richer staff-mix:

- Increasing the number of personnel
- Higher ratios of qualified workers
- Higher ratios of senior staff members
- Multidisciplinary teams

Despite conflicting findings and the need for further research, a number of studies and systematic reviews suggest that a richer staff-mix may be associated with better outcomes and fewer adverse events for patients. The evidence, however, is highly limited by practical limitations and methodological shortcomings. While many studies have reported positive impacts from enriching

staff-mix, they do not offer clear guidance about ideal thresholds in terms of personnel/patient ratios or the proportion of different categories of staff members on teams” (Dubois and Singh 2009).

The authors of this article reviewed the recent literature documenting the idea of changing the focus of human resource management from appropriate staff-mix to appropriate skill-mix. Two types of general interventions—those aimed at skill development and those aimed at skill flexibility—have been tested:

“Wider perspectives, which focus on how human resources can be differently managed either through skill development or skill flexibility, go some way towards conceptualizing personnel use in the dynamic and constantly evolving realm of health care. In order to be fully effective, policy-makers, managers, and practitioners need to consider the organizational factors that affect how staff members work. The evidence suggests that no matter which workers are employed or what their roles are, it is only by tackling organizational issues that a fully efficient and effective workforce can be generated” (Dubois and Singh 2009).

Changing roles and increasing role flexibility for health care workers requires changes in the institutional and legal systems that govern health care workers, which must change professional incentives, facilitate work between and within cadres, enhance the performance of multidisciplinary teams, and ensure that the best qualified staff are providing care.

In addressing HIV care and treatment specifically, the World Health Organization’s public health approach to task-shifting “promotes sharing of clinical management responsibilities to the lowest relevant cadre and into the community, a vital step for chronic disease management and the shift to long-term treatment and care. The most important task shift is to the patient: sustaining effective chronic HIV care with ART needs substantial patient involvement in managing their own illness, adhering to treatment, responding to side effects, and preventing transmission to others” (Gilks et al. 2006).

SUMMARY

A summary of key points is as follows:

- Nonphysician health care workers are able, with careful training and supervision, to deliver equal, and sometimes better, results than doctors. There is now considerable evidence regarding the possibility of shifting HIV tasks from professionals or midlevel workers to LHWs or CHWs.
- While task-shifting certain activities to community health is effective, there are several criteria that accompany delegation of tasks to CHWs.
- While task-shifting can be effective, it requires changes to the health system and regulatory framework that need decades and serious financial commitments to implement.
- Task-shifting can be conceptualized as a change from staff-mix to skill-mix, but new approaches to evaluating the skill-mix needed to provide high-quality care are required and should include legal and institutional regulatory changes to be effective.

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