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Task Shifting in the Netherlands

Summary

Over the past few years there has been an ongoing discussion in the Netherlands about shifting tasks from physicians to nurses (preferably specialized nurses). According to the Dutch government, such task shifting could be a way of solving the capacity problem in healthcare. Now, new legislation is on its way to making this possible. The legislation will enable physician assistants and nurse practitioners to perform certain medical health checks and procedures independently. The RDMA has been positive about the proposals, but also critical of their substance.

1. Introduction

In the coming years, finding qualified professionals for the healthcare sector is set to become a growing problem in the Netherlands. Several studies have shown that a shortage of professionals is to be expected.[1] There are two trends contributing to this development. The first is the overall decrease in the size of the workforce. Following de-

1 Netherlands Bureau for economic Policy Analysis (Centraal Planbureau), Derks, W., P. Hoevens, L.E.M. Klinkers: Structurele bevolkingsdaling, een urgente nieuwe invalshoek voor beleidsmakers, The Hague 2006. www.cpb.nl

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cades of growth, the Dutch population is moving towards a decline, which is likely to result in a smaller pool of professionals. The second trend is the growing demand for healthcare as a result of demographic, technological and socio-cultural developments, and not least because of the aging population and increasing number of people with chronic disorders. Faced with these developments, healthcare capacity will be unable to meet the expanding demand. If nothing changes, we will be seeing more and longer waiting lists, a risk of declining quality of care, and upward pressure on incomes.[2] The accessibility and affordability of healthcare will therefore come under increasing pressure.

Under the Dutch constitution, the government is required to promote public health.[3] This constitutional provision places an obligation on the government to ensure the accessibility, affordability and quality of healthcare.

Accordingly, the government must provide sufficient resources for care providers to deliver quality care. It also implies that the government must adequately supervise the quality of healthcare. These requirements have been elaborated in Dutch healthcare legislation, including the Quality of Health Care Institutions Act[4] (QHCI Act) and the Individual Healthcare Professions Act (IHCP Act)[5].

Both acts provide a few general standards, with broad outlines that leave room for self-regulation, but nothing more. As such, they place great responsibility on healthcare professionals and health institutions to ensure the delivery of appropriate and high-quality care.

Aiming to ensure the future accessibility and affordability of care and thus honour its constitutional obligation, the Dutch government introduced a bill amending current Dutch legislation on healthcare professions by making task shifting possible.

According to the government, task shifting is one of the ways in which the capacity problem in Dutch healthcare could be solved. In 2009, the World Medical Association (WMA) drew up a 'Resolution on Task Shifting from the Medical Profession'.[6] And in 2010 the Standing Committee of European Doctors (CPME) introduced the Policy on Task Shifting.[7] The question now is to what extent the new Dutch legislation on task shifting may actually go beyond the WMA Resolution or the CPME Policy.

This article gives an overview of the way in which task shifting is being introduced into the Dutch legal system. To this end, I first provide a detailed definition of task shifting and describe the positions that the WMA and CPME have taken on task shifting. Next, I describe the current Dutch laws governing healthcare professions and the new legislation being introduced to facilitate task shifting. The article ends with a discussion and conclusion.

2. Definitions and positions on task shifting

Definitions

In the WMA's 2009 'Resolution on Task Shifting from the Medical Profession' 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. This definition is also used by the CPME's Policy on Task Shifting. The definition often used in the Netherlands is: 'The structural redistribution of tasks between different professions to ensure effective use of skills and capacity'.[8]

Unlike in job differentiation, task shifting does not entail the redistribution of tasks between jobs. Rather, tasks are distributed over entire professions or occupational groups, which gain direct authorization to perform a given task. In the present context it entails assessing the need for the task, followed by its actual performance, both of which are carried out independently. A case in point is shifting tasks from a doctor to a nurse.

Another term commonly used in this context is *task delegation*. The difference between *task shifting* and *task delegation* is that the former refers to the predetermined structural allocation of tasks to a new profession. That task can subsequently be independently performed by the profession to which it has newly been assigned. In the case of task delegation, by contrast, the task is formally allocated to a professional practitioner who can decide in any given situation to delegate that task to another practitioner. Under the current Dutch system so called reserved procedures, as described in section 3, qualify for task delegation but not for task shifting.

WMA and CPME positions on task shifting

In its Resolution, the WMA expresses that although task shifting may be useful in certain situations, and may sometimes improve the level of patient care, it can also be risky. First and foremost the WMA signals the risk of decreased quality of patient care,

2 Parliamentary Papers II 2009/2010, 32 261, no. 3, p. 3.

3 Section 22 of the Dutch Constitution (*Grondwet*).

4 *Kwaliteitswet zorginstellingen.*

5 *Wet op de beroepen in de individuele gezondheidszorg.*

6 WMA 'Resolution on Task Shifting from the Medical Profession', Delhi, October 2009.

7 Comité Permanent Des Médicins Européens (CPME), CPME Policy on Task Shifting, 2010/128.

8 Parliamentary Papers II 2009/2010, 32 261, no. 3, p. 2.

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particularly if medical judgment and decision-making is transferred. According to the WMA, beyond the fact that the patient may be cared for by a healthcare worker with less training, there are other specific quality issues involved, including reduced patient-physician contact, fragmented and inefficient service, lack of proper follow up, incorrect diagnosis and treatment, and inability of the less-qualified practitioner to deal with complications.

In addition, the WMA signals that task shifting that deploys assistive personnel may actually increase demand on physicians. Physicians will have increased responsibility as trainers and supervisors, diverting scarce time away 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 healthcare workers under their supervision. The WMA expresses particular concern about the fact that task shifting is often initiated by health authorities, without consultation with physicians and their professional representative associations.[9] As part of its efforts to address these issues, the WMA has drawn up fifteen recommendations on task shifting, the first of which states that the 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.

The CPME endorses the WMA resolution.[10] It points out that the shifting of some tasks may facilitate better use of manpower and resources, free up valuable time for physicians and therefore contribute to better care for patients, provided it is done with due care. However, it goes on to stipulate that, in the interests of patient safety, responsibility for diagnoses and therapeutic decisions cannot be divided and always remains with the doctor.

3. Current Dutch legal situation

The Dutch Individual Healthcare Professions Act (IHCP Act) seeks to monitor and promote the quality of professional care by providing regulations for a number of occupations devoted to individual healthcare. Individual healthcare comprises in particular the performance of any procedure that directly affects an individual person and serves to promote or maintain that person's health. The law further seeks to protect patients from incompetent and negligent treatment care.

One of the provisions laid down to achieve this aim is the rule defining what are known as 'reserved procedures' (*voorbehouden handelingen*). Effectively, these are certain medical procedures that only legally designated professionals are allowed to perform independently. Prior to the IHCP Act, the Netherlands had a blanket prohibition on the performance of medical procedures by anyone other than a physician.

That prohibition was revoked when the IHCP Act took effect in 1997. Since then, anyone may perform medical procedures. The general consensus was that patients should be given the freedom to seek out aid and assistance for their own health situation where and as they saw fit.[11]

However, the prohibition was not revoked entirely, the exception being the rule in respect of reserved procedures. The Act specifies a number of procedures that may only be carried out by designated professionals. These procedures are deemed to pose a considerable risk to the health of the patient if performed by anyone who is not qualified.

The reserved procedures specified in the Act are:[12]

- surgical procedures;
- obstetric procedures;
- catheterizations and endoscopies;
- punctures and injections;
- general anaesthesia;
- procedures involving the use of radioactive substances and ionizing radiation;
- cardioversion;
- defibrillation;
- electroconvulsive therapy;
- lithotripsy;
- artificial insemination;
- prescribing medication.

Reserved procedures may be carried out by two groups of professionals: those with direct authorization (*zelfstandig bevoegd*) and those who perform the procedure on the order of someone else with direct authorization (task delegation). Physicians have the authority to perform all categories of reserved procedures.

Dentists and midwives do for some procedures. This authority entitles them to perform reserved procedures in their own name, implying responsibility for the diagnosis and decision to perform a specific procedure. They are only authorized to act to the extent that they deem themselves competent to perform the procedure.

Reserved procedures can also be carried out by others on the order of a professional with direct authorization. Issuing such an order is subject to certain conditions. Most important is that both the person giving the order and the person receiving it are confident that the latter is in fact competent to perform the procedure. Where necessary, the practitioner in question must give instructions, supervise the performance of the procedure and be on hand to intervene. In 2001, the Dutch Ministry of Health, Welfare and Sport issued a brochure on the IHCP Act in English. For further informa-

9 WMA 'Resolution on Task Shifting from the Medical Profession', Delhi, October 2009.

10 Comité Permanent Des Médicins Européens (CPME), CPME Policy on Task Shifting, 2010/128.

11 Parliamentary Papers II 1985/1986, 19 522, no. 3, p. 1.

12 Section 36 of the IHCP Act.

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tion about the IHCP Act, please refer to this brochure.[13]

Under the current laws, nurses, nurse practitioners[14] and physician assistants are not permitted to perform reserved procedures under their own authority; they may only do so on the orders of a physician.

4. New legislation on task shifting

The shifting of tasks between practitioners is a dynamic and continuous process. Tasks that were once the exclusive preserve of physicians can now be carried out by other professions. Often, this redistribution of tasks is a natural and gradual process, acquiring structural permanence in due time.

Many routine medical procedures that are now performed by doctors could equally be performed by specially trained professionals such as nurse practitioners and physician assistants. This re-division of tasks would enable doctors to spend more time on more complex medical matters directly related to their specializations.

Various studies have been conducted in the Netherlands over the past few years to investigate the effects, and possible effects, of task shifting.[15] These studies have shown that task shifting in general can contribute to improving the quality, continuity and efficiency of care. A report published by the Dutch Council for Public Health and Health Care[16] reveals that task shifting is being driven by a wide range of interests. In most cases it is a combination of factors, such as the desire to establish a rational breakdown of jobs and operational processes, knowledge-building within and the emancipation of professional fields, capacity shortages in one or more occupational groups, and technological developments.[17]

Seeking to ensure the accessibility and affordability of care, the Dutch government introduced a bill in December 2009 to legalize task shifting. The bill is necessary because the current statutory regulations, as described in section 3, offer no scope for task shifting.

Specifically, it provides that, by way of a trial, subordinate legislation may grant direct authority to assess and perform reserved procedures to professions that do not currently have such authority. The trial can run for a maximum of five years. If the amendment is ultimately approved and task shifting enacted, the minister will therefore have to draw up subordinate legislation specifying the professions – new or existing – in question, along with the requisite training for those professions and which reserved procedures may be performed directly.

The new provision will therefore also serve to grant authorities to the professions of physician assistant and nurse practitioner. It is in this context that two orders in council were recently (May 2011) submitted to the Upper and Lower Chambers of the Dutch parliament, granting direct authority to the aforementioned professions to perform certain reserved procedures – as specified in the decisions. The new element in these decisions is that they allocate direct authority to perform *both* the medical health check and the procedure.

The direct authority granted by the bill is limited in scope, with restrictions regarding training, personal competence and the specialization in which the practitioner is permitted to work. Under the IHCP Act, each occupational group in the medical sector is linked with a distinct area of expertise, and it is only within their own general area that practitioners can operate.

In addition, the provision is restricted to include only procedures that are of limited complexity, routine in nature and subject to manageable risks, and will further be subject to national guidelines, standards and protocols derived from these. According to the explanatory notes to the decision, these protocols will be reflecting the cooperative relationships between nurse practitioners and the other disciplines with whom they work.

As is the case under the current statutory regime, a nurse practitioner or physician assistant will only be authorized to perform the designated reserved procedure within the designated parameters if he or she is, in fact, qualified to do so. Once these practitioners have direct authority to perform reserved procedures, they will also, in turn, have the inherent authority to instruct other care workers to carry out those same reserved procedures.

If the trial period shows this form of task shifting to be effective, the next step would be definitive recognition of the designated occupational groups. The proposed regulations recommend that the trial be subject to an evaluation focusing on, among other things, the consequences of task shifting on the quality of actual care.

5. Discussion

The bill paving the way to task shifting has met with mixed responses in the Neth-

13 Ministry of Health, Welfare and Sport, The Individual Health Care Professions Act, The international publication series on Health, Welfare and Sport, no. 10, *http://english.minvws.nl/en/*.

14 In Dutch: Verpleegkundig Specialist.

15 For instance: 'Task Shifting proven to be beneficial for quality of healthcare', Inspectorate for Health Care, *Staat van de gezondheidszorg*, 2007, december 2007, and 'Taskshifting in healthcare', Health Counsel, December 2008.

16 *Raad voor de Volksgezondheid & Zorg*. The Dutch Health Counsel and the Dutch Council for Public Health and Healthcare are (independent) advisory bodies to the Dutch Government.

17 Council for Public Health and Health Care, Task shifting in healthcare, 2002. www.RVZ.net.

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erlands. The associations for nursing professions and for physician assistants have welcomed the bill, echoing the minister of Health, Welfare and Sport's position that task shifting will be the key to resolving impending healthcare capacity problems.[18]

The Royal Dutch Medical Association (RDMA) has been positive about the spirit of the proposals, but also critical of their substance. Recognizing that task shifting could offer advantages for the quality of care, provided certain conditions are met, the association had previously already advocated the allocation of new authorizations to practitioners by means of experimental trials.

However, like the international physicians' associations, the RDMA is concerned about the risks involved. Task shifting will lead to a rise in the number of people caring for each individual patient, for example. If it is to be effective, there need to be clear, definitive and transparent agreements between all involved care workers regarding the tasks and the associated responsibilities and authorizations. The RDMA considers it vital that the proposed statutory regulations and resulting subordinate legislation eliminate these risks as much as possible. That has yet to happen.[19]

In fact, it is debatable whether the new legislation would even comply with the first recommendation of the WMA Resolution, which states, as mentioned above, that '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'.

In a letter addressed to the Upper and Lower Chambers of Dutch parliament, the RDMA emphasized the need for greater clarity on the scope of the authorization.

In addition, the RDMA stated that it sees the delegation of reserved procedures to new categories of practitioners as going a step too far, resulting in a confused view of who is supposed to do what and thereby putting the quality of care at an increased risk. Moreover, many of the existing medical guidelines contain no provisions that would allow for task shifting, prompting questions as to their validity in the new situation.

A coordinated effort to prepare the necessary treatment protocol—involving the new professions and guided by physicians—is therefore one of the first steps that would need to be taken.

The minister in charge has indicated that the bill should enter into effect as soon as possible after its acceptance by the Upper Chamber. It is essential that occupational groups affected by task shifting are jointly involved in the subsequent defining of the basic statutory framework in order to ensure that task shifting does, in fact, make a real contribution to the quality of care.

Equally vital, according to the RDMA, are the quality of cooperation between the occupational groups involved in the actual implementation of task shifting and their sharing of responsibility for the provision of good care.

It further recommends conducting a thorough evaluation after the first five years of the trial in order to come to a well-founded decision regarding the definitive statutory enactment of task shifting.

The RDMA notes that the new legislation does not comply with the strict CPME Policy on Task Shifting, which states that responsibility for diagnoses and therapeutic decisions cannot be divided and always remains with the physician.

6. Conclusion

Over the coming years the Netherlands will be facing a growing shortage of care workers, even as demand continues to rise. If nothing changes, the resulting problems could be huge. Task shifting is being held up as a possible solution. The introduction of an amendment to the existing legislation would make it possible to grant direct authorization to certain professions to perform specific medical health checks and procedures on a limited trial basis.

The RDMA has been positive about the proposals, but has serious, enduring concerns related to their substance. It feels that the conditions under which task shifting is to be introduced fail to provide the necessary degree of clarity about its scope and limits. And without that foundation of clarity, there is no firm guarantee of the quality of care. Guaranteeing quality will require that new treatment protocols be drawn up under the supervision of physicians. Finally, all of the occupational groups involved in the implementation of task shifting must be able to work together effectively. A subsequent evaluation of that implementation within the Dutch system should demonstrate whether task shifting can in fact lead to measurable improvement. Then – and only then – can the trial make way for definitive legislation. It is debatable whether the new legislation would comply with the WMA's resolution and the CPME Policy on Task Shifting.

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18 The Verpleegkundigen & Verzorgenden Nederland (V&VN) and the Nederlandse Associatie Physician Assistant (NAPA).

19 A.C. Hendriks, D.Y.A. van Meersbergen, 'Afspraken nodig over taakherschikking', Medisch Contact, 4 March 2011, nr . 9, p. 555-557. www.medischcontact.nl or www.KNMG.nl