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New distribution of work tasks between groups of staff in municipal health care.

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SUMMARY

Aim, main research questions and design

This report was carried out on behalf of KS, by researchers from the Uni Research Rokkan Center in Bergen. The study gives insight into the potential for using new distribution of work tasks as a systematic measure, in order to meet the forthcoming needs and challenges of the municipal health care sector in Norway. Further, it has been an ambition to aid KS in increasing the possibilities for a more knowledge based task shifting policy. New distribution of work tasks is used in this study as a broad term, referring to processes where tasks are shifted from one group of staff to another. The task shifts studied are products of planned processes as well as more ad hoc solutions to acute challenges.

The study analyzes how tasks are solved in Norwegian municipalities today and focuses upon services provided for older people in their own homes and in nursing homes. We identify which tasks can be shifted, and how, and what measures are needed to create a new distribution of tasks.

The study has an explorative focus, as little research has been carried out in Norway on these topics. In particular, there are very few earlier studies of task shifting and new professions in municipal health care**.** The design has three parts: 1. An mapping of academic publications, governmental reports and other publications on task shift and new professions in health care, both internationally and nationally. 2. Interviews with key stakeholders and representatives from health government and associations to gain insights in central national processes and roles of stakeholders. 3. An in-depth study of seven Norwegian municipalities, based on qualitative interviews and document analysis.

Literature on task shifting internationally and in Norway

There is a limited amount of international studies evaluating task shift and implementation of new professions like Advanced Nurse Practitioners (ANP). Several studies carried out in European countries, as well as in the United States and Canada, indicate increased patient satisfaction when tasks are carried out by new professions like ANP, in comparison to traditional task distribution. Regarding cost- benefit of such changes in task distribution, the findings are less clear. International reports point to a

range of factors facilitating new task distribution and development of new professions, in particular decentralizing of services and tasks, financial systems, professional autonomy and new knowledge. It is important to note that there may be internal variations between countries and organizations regarding professional autonomy, and also that varying contextual factors may limit possibilities for direct translation of solutions and measures.

Nordic countries have to a varying extent established advanced nurse education. During the last decade, task shifting has been tried out in hospitals in Finland, Sweden and Denmark. Finland has formalized ANP education, and legalized systems for authorization schemes. Finnish ANPs carry out tasks in local health care, in close cooperation with physicians. In Sweden, ANP education was tested out from around 2002, and new educations for ANP are now being established. Reports from Denmark aiming at inspiring increased flexibility in the organizing of local health services, in particular for older people, have stated that focus on patient flow, quality and multi - professional cooperation in organizing of services may strengthen the basis for task shifting.

A few Norwegian studies have analyzed task shifting in specialized hospital care, underlining that projects anchored in local needs and based upon participation from employees are most likely to succeed. As in some international studies, Norwegian reports also underline that task shifting projects may arouse conflicts and ambiguities among professional groups. Until recently, very few publications have analyzed task shifting in local health services. During the last decade, Norwegian government and labor market, associations have increased their attention towards task shifting as a tool for achieving better and more efficient service provision.

Planning, recruitment and education of staff

The Norwegian Health Staff Act and the Municipal Health Care Act provide Norwegian municipalities with a broad autonomy for composing staff and organize services in accordance with local needs and demands. Our analysis showed that health service managers in the seven municipalities studied, only to a small extent use the possibilities of open recruitment and free composition of staff. Interviews indicated that local managers saw a strong need for skilled health care staff and specialized knowledge. Strategic planning of service organization, staff and division of labor occurred to a varying extent in the seven municipalities. Task shifting was not an explicit focus in any of the competence and health service plans. Most of the municipalities provided education of own staff through courses.

How are tasks distributed in local health service?

Our analysis shows that strategic use of task shifting is very limited in the municipalities studied. There are, however, a range of service innovations and adaptations in the organization of services that facilitate new division of tasks between groups of staff. Vertical and horizontal task shift occur as part of coping with new tasks or technology, lack of staff and specific competence or the financial situation of the services. Vertical task shift in the form of delegation of tasks to staff with lower educational level is very

common, and regarded important for service deliveries in all seven municipalities. Delegation of tasks is in use both as a strategic measure and as an adaptation to contextual factors.

Parallel to an overall tendency to specialize competence and tasks, rather than asking for a broader competence, the municipalities use several kinds of what we have labelled "planning for flexibility", that may facilitate task shift. This includes planning for coordination, multi - professional teams and organizing of services in common units and also many places under the same roof.

Our study has identified several concrete tasks that are distributed in different ways in different services and municipalities, and tasks where responsibilities overlap between different groups of staff. The most prominent are handling of pharmaceuticals, communication with patients and relatives, documentation, handling of various kinds of medical equipment, and procedures related to nutrition, care and rehabilitation.

Some of these tasks may be possible to take care of by a range of staff members if proper training is provided for. For some of these tasks, a particular formal education is necessary. We find that staff members are given varying degrees of training and education by their employer, and this may influence the quality of services.

Measures to facilitate a new distribution of tasks

The report suggests a range of measures that can be taken to facilitate task shift as a strategic devise and at the same time secure a qualitatively good service.

Several central government projects aiming at increasing municipal health staff competence have been launched. The report finds a potential for increasing municipal leaders` awareness of such available measures and the possibilities for support through state projects and tools.

Delegation of tasks and competence development without thorough planning may reduce quality of services. The development of municipal plans for competence and health care services are crucial to increase implementation of task shift as a strategic tool in health care.

There is a potential for a more systematic training and work place education in order to qualify staff to carry out the necessary tasks. We suggest both national training and certification systems as well as evaluation of existing educations. Changes in funding systems may open up for a more flexible distribution of tasks. Employers should also be more aware of their responsibilities for providing more systematic qualification for staff.

Vertical task shifts happen to some extent occasionally, as a response to immediate changes in work force or tasks. An important challenge is to secure enough practicing of specific procedures for part-time workers and when delegation is used unsystematically. Planning and training may strengthen quality of services.

There is great potential for more systematic use of the competence that health care workers have, and in particular for a more systematic task shift from nurses and physiotherapists to health care workers.

How to support more systematic task shifting?

National institutional frames like legal systems, financing of services and educational systems may open or limit the possibilities for task shift between groups of staff. On the other hand, it is important to underline that the existence of legal frames or financial support does not imply that task shifts actually happen. Local government and service managers have to a great extent the necessary frames for developing more systematic task shifting, but it is limited to what extent such measures are actually taken in the municipalities. Knowledge of the frames and incorporation of such measures into both national and local planning among managers and staff is needed to strengthen the possibilities for using task shift as a health care service measure. New distribution of tasks is facilitated if the changes are based on local needs and in collaboration with staff and their associations.

Variations in size, geographical factors, access to the right competence and economical resources between Norwegian municipalities provide different premises for using task shift as a tool for securing better health care services. It is therefore important to consider such local variations when developing and implementing plans for a more systematic use of task shifting between groups of staff in Norwegian municipal health care.