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Skills Mix: Future Health Policy and Workforce Planning in Primary Care

Patrick Redmond

The Department of Health strategy document, Primary Care: A New Direction, proposed primary care as the "team-based approach to service provision which will help to build capacity in primary care and contribute to sustainable health and social development"[1]. This strategy envisioned the establishment of a network of primary care centres staffed with GPs, nurses, physiotherapists, and social workers amongst many other health professionals.

The successful implementation of universal primary care in Ireland is dependent on a number of factors, not least capacity and workforce planning. Concerns regarding the age, gender and working patterns of general practitioners have been expressed. Younger GPs indicate a preference for shorter working hours and earlier retirement. Female GPs tend to work a shorter working week compared to male GPs (although this may be shifting amongst younger GPs). In addition the GP per population ratio (52/100,000) is lower than other European countries (France 164/100,000), appreciating that this does not allow for structurally different health systems and role definitions[2]. It is projected that the growing number of older patients, retiring GPs and the increasing feminization and part time nature of general practice will lead to a gap between supply and demand if even the current low ratio of GPs per capita is to be maintained[3]. In addition the introduction of universal access has been projected will remove the artificially low attendance of some patients to primary care and increase attendance by 17%[3]. Finally it is accepted that the enhanced nature of primary health care, incorporating chronic disease management will require far more GPs than are currently working in the system.

A number of interventions have been suggested to combat this projected dearth in GP manpower; increased training numbers, recruitment from abroad and incentivizing delayed retirement. These solutions suffer from problems in relation to 'lead in time' delay, significant investment costs, and ethical concerns regarding migratory workers. Indeed a recently established code of practice by the WHO has encouraged regulating the supply of HCPs in a sustainable way to avoid denuding poorer areas of the world of expensively trained HCPs[4]. An alternative solution is the concept of task shifting in which substitution allows nurses to assume some of the roles of GPs. Teljeur et al modeled the planned workforce requirements in primary care and suggested nurse substitution as a possible medium term solution[5].

Key distinctions to be made in defining the enhanced role possible for nurses include whether nurses supplement (complement services already offered by GPs) or substitute (assume a role currently performed by GPs). Role enhancement allows nurse to remain within their scope of practice while adding to their capacity by learning new skills (e.g. prescribing) and assuming additional responsibilities. Examples include screening, health promotion, disease monitoring and secondary prevention. This is considered a vertical progression professionally and doesn't impinge upon other professionals' remit[6]. Additional benefits may accrue in terms of positive impact on staff retention, enthusiasm and job satisfaction. Potential downsides to role enhancement include inter-professional confusion, rivalry and lack of clarity about responsibilities as well as problems around appropriate recognition of enhanced status with regard to remuneration and experience levels. Role enlargement describes the expansion of a professional's skill set horizontally; while skills learnt remain relatively generic they may cross several disciplines (e.g. a nurse providing health promotion advice whilst undertaking a medication review and devising a care plan).

Richardson et al suggested nurses could substitute in 25-70% of the work undertaken by doctors[7]. Specific to primary care, these include the routine management of diabetes, heart disease and health promotion. It is speculated the enhanced role offered by nurses would allow GPs to focus on 'doctor only' tasks. Research has suggested nurse led care has no negative impact on health outcomes with reports of greater patient satisfaction and compliance, however they did report longer consultations with more investigations ordered[8]. While patients report similar levels of satisfaction with both nurses and doctors they tended to prefer nurses for more chronic, routine, or educational issues and doctors for what was perceived to be more "difficult" problems[9]. While nurses may be less expensive to train the cost saving is eroded by longer consultations, more investigations ordered, increased repeat visits, and a shorter lifetime participation in the actual workforce by nurses. In addition concerns have been expressed in terms of reduced productivity due to lack of autonomy to act independently[6].

The shift in workload to nurse led activity will bring its own challenges. Nurse to patient ratios, shown to have a direct correlation with quality of care will need to be agreed. The benefits derived from multidisciplinary teams are not the panacea often proclaimed and can have mixed results in terms of patient outcomes[10]. The ideal 'staff mix' between different professionals, levels of experience and specialization, junior and senior staff will also require research to determine the best "blend" of personnel. The potential for deskilling or a perception of disenfranchisement of current GPs as they shift in to more "clinical leadership" roles is also possible.

Organizational change will necessitate appropriate governance structures to recognize and support the development of clinical autonomy amongst nurses; appropriate oversight as well as commitment to CPD will also be necessary. Successful implementation of skills mix will also be aided by the commitment of the regulatory bodies and legislators to this new face of general practice. Opportunities also exist for common training pathways and desegregation of the traditionally separate routes of education received by different HCPs. Stakeholders (unions, individual HCPs etc) will have a major impact on whether a skills mix policy will be successfully implemented. Recognition of the valuable insight to be gained from these "ground level" actors necessitates the adoption of a bottom up approach in devising and implementing any policy successfully. Primary care is very much on the agenda in this political cycle, and the dearth of manpower with considered solutions has been articulated, issues remain about whether politically the paradigm shift in nurses' roles in the Irish health system is acceptable to the many interested parties.

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References

1. Department of Health and Children. Quality and Fairness: A health system for you. Dublin, Ireland; 2001.
2. Thomas S, Normand C, Smith S. Social health insurance: Further options for Ireland. Dublin, Ireland; 2008.
3. A quantitative tool for workforce planning in healthcare: example simulations. FAS Dublin, Ireland; 2009.
4. Taylor AL, Hwenda L, Larsen B-I, Daulaire N. Stemming the brain drain--a WHO global code of practice on international recruitment of health personnel. The New England Journal of Medicine. 2011 Dec 22; 365:2348–51.
5. Teljeur C, Thomas S, O'Kelly FD, O'Dowd T. General practitioner workforce planning: assessment of four policy directions. BMC health services research. 2010 Jan; 10:148.
6. Dubois C-A, Singh D. From staff-mix to skill-mix and beyond: towards a systemic approach to health workforce management. Human Resources for Health. 2009 Jan; 7:87.
7. Richardson G, Maynard A, Cullum N, Kindig D. Skill mix changes: substitution or service development? Health policy. 1998 Aug; 45:119–32.
8. Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care. Cochrane database of systematic reviews. 2005 Apr 18;(2):CD001271.
9. Laurant MGH, Hermens RPMG, Braspenning CC, Akkermans RP, Grol RPTM. An overview of patients' preference for and satisfaction with care provided by general practitioners and nurse practitioners. Journal of Clinical Nursing. 2008; 17:2690–8.
10. Aigner MJ, Drew S, Phipps J. A comparative study of nursing home resident outcomes between care provided by nurse practitioners/physicians versus physicians only. Journal of the American Medical Directors Association. 5:16–23.

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Other References

No Other References

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