Confederation of Medical Associations in Asia and Oceania

CMAAO Statement on Task Shifting (Tokyo Statement)

Adopted by the 27th CMAAO General Assembly, Taipei, Taiwan, R.O.C., November 2011[*1]

PREAMBLE

Task shifting approach was proposed by the World Health Organization (WHO) in 2006 as a key contribution to address serious shortage of workforces in countries where HIV/AIDS are taking the greatest toll. Task shifting in this context involves "rational redistribution of tasks among health workforce teams" and describes a "process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications."[*2]

These practices have existed for many years, but WHO's plan to increase access to HIV services inspired discussion regarding it in earnest. WHO's desire to extend task shifting to essential services other than HIV services is controversial.

Controversy regarding task shifting is its impact and efficacy on patient safety and quality of care. Task shifting occurs both in countries facing shortages of physicians and those not facing shortages. Task shifting should not be considered as cost-saving measure at any time.

Paying attention on this controversy and focusing on transferring of tasks from physicians to other health professionals, WMA adopted a resolution on task shifting at the General Assembly in New Delhi, India, October 2009. According to WMA resolution on task shifting from the medical profession, task shifting is used to describe the 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. WMA resolution on task shifting clearly states the following points:

- The quality of care and patient safety should never be compromised
- Physicians and national medical associations (NMAs) should be involved in the discussion and decision-making of task shifting throughout the whole process.
- Task shifting should be viewed as a short-term measure with clear exit strategy in principle and it should not replace fully functioning healthcare system, nor education and training of physicians and other healthcare professionals.
- Task shifting should not be viewed solely as cost saving measures as such approach is not likely to produce quality results in patients' best interests.
- Task shifting must be assessed and evaluated independently and other methods such as collaborative practices and team approach should be developed.

Health care systems need to be considered according to cultural background and social

*1 This statement was originally adopted as the CMAAO Tokyo Statement on Task Shifting by the CMAAO ad-hoc committee meeting held in Tokyo, Japan in March 2011.
*2 WHO, Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines, 2008.

capacity. Task shifting principles and strategy should be approached from this context and representatives of CMAAO members agreed to develop a resolution on task shifting which reflects the situations of the region.

Considering the above mentioned circumstances, the representatives of CMAAO members attending the CMAAO ad-hoc committee meeting on task shifting hereby recommend the following:

RECOMMENDATIONS

1. Under any circumstances, patient safety should not be compromised. Task shifting should be applied only under specific instance of severe medical workforce shortages or emergency situation.
2. Whenever possible, preference should be given to team work and task delegation. In terms of task delegation, specified medical tasks are performed by other health professionals or community health workers under direction and supervision of physicians.
3. NMAs should be closely consulted in the whole process of preparation and implementation of any kind of task shifting. Appropriate training programs regarding task shifting should be achieved with the involvement of NMAs with the establishment of appropriate clinical guidelines.
4. Even in the case of task shifting for addressing workforce shortage, transferring of tasks should be restricted to skill-related practices and should not be extended to knowledge-intensive practices such as diagnosis and prescription. It must be acknowledged that a health worker who is not fully trained as a medical practitioner cannot bring the full range of scientifically based skills to patient care.
5. Governments should not depend on task shifting as a long-term strategy even in emergency or inevitable situations where otherwise it means no treatment at all for patients due to critical shortage of medical workforce. Task shifting is only a tentative alternative to a shortage of medical workforce and it should be implemented with a clear exit strategy. Task shifting should not be extended to other health services beyond specified emergency situations.
6. In the interest of patient safety and quality of care, task shifting approach should not be seen as the final solution to address medical workforce shortages. Strategies for recruitment and retention of medical workforces are important pillars of fully functioning health care system. Governments should develop policies for retention including strategies on physician migration and positive practice environment for physicians.
7. Governments should not view task shifting as a cost saving measure. Governments should make every effort to establish fully functioning health care systems based on stable provision of skilled medical workforces.
8. Implementation of universal coverage of health care would be the best way to enhance access to medical services and strengthen the health care system.