Health Policy 119 (2015) 1627–1635

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

The role of governance in implementing task-shifting from physicians to nurses in advanced roles in Europe, U.S., Canada, New Zealand and Australia

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ARTICLE INFO

Article history:
Received 15 May 2015
Received in revised form 9 September 2015
Accepted 11 September 2015

Keywords:
International comparison
Task-shifting
Advanced practice nursing
Nurse practitioners
Physicians
Health workforce
Substitution
Governance

ABSTRACT

Task-shifting from physicians to nurses is increasing worldwide; however, research on how it is governed is scarce. This international study assessed task-shifting governance models and implications on practice, based on a literature scoping review; and a survey with 93 country experts in 39 countries (response rate: 85.3%). Governance was assessed by several indicators, regulation of titles, scope of practice, prescriptive authority, and registration policies. This policy analysis focused on eleven countries with task-shifting at the Advanced Practice Nursing/Nurse Practitioner (APN/NP) level. Governance models ranged from national, decentralized to no regulation, but at the discretion of employers and settings. In countries with national or decentralized regulation, restrictive scope of practice laws were shown as barrier, up-to-date laws as enablers to advanced practice. Countries with decentralized regulation resulted in uneven levels of practice. In countries leaving governance to individual settings, practice variations existed, moreover data availability and role clarity was limited. Policy options include periodic reviews to ensure laws are up to date, minimum harmonization in decentralized contexts, harmonized educational and practice-level requirements to reduce practice variation and ensure quality. From a European Union (EU) perspective, regulation is preferred over non-regulation as a first step toward the recognition of qualifications in countries with similar levels of advanced practice. Countries early on in the process need to be aware that different governance models can influence practice.

1. Introduction

An increasing number of countries in Europe are in the process of introducing skill-mix changes to their health workforces. Task-shifting is one strategy, whereby specific tasks and responsibilities are being shifted, for instance from the medical to the nursing profession [1]. Underlying reasons include physician shortages, limited access to or quality of care, long waiting times, high costs [2]. The effectiveness of task-shifting to specifically trained nurses has been demonstrated [1,3–9]. However, little research has been conducted on the governance and regulatory contexts taking a cross-country comparative design [10–12]. Yet different governance models may have different implications on the implementation of task-shifting in practice.

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http://dx.doi.org/10.1016/j.healthpol.2015.09.002
0168-8510/

1.1. Background on governance and regulation

Governance encompasses the "structures and processes through which policies (formal and informal) are enacted to achieve goals, including legislation, regulation and oversight" [...], hence, it is a framework for formal policy instruments (through laws, bylaws), but also includes informal, non-regulated instruments, such as local governance measures [13]. Regulation, however, refers to legally binding policy instruments and has been defined as government (national or decentralized), setting rules and thereby limiting entry to a profession or a practice, such as by licensing and credentialing specific cadres of health professions, setting standards, limiting or licensing certain practices [14,15]. Regulatory mechanisms can be undertaken by the government(s) itself or may be delegated to a professional body or association in accordance with set laws, referred to as self-regulation [14,15]. Regulation can be executed at different levels: at national, state- or, province-levels. Governments can also choose *not* to regulate, but leaving the governance, including levels and standards of advanced practice to the discretion of the individual settings and providers, e.g. through protocols or collaborative practice agreements between nurses and employers and/or physicians [13,16–19].

Previous studies have assessed barriers and facilitators to task-shifting and cited among others, regulation, professional boundaries, organizational environment and institutional environment as influencing task-shifting in practice [11,12,20]. A systematic review identified six studies where legislation was referred to as a barrier to task-shifting from the medical to the nursing profession [20]. On the contrary, a comprehensive framework suggests five drivers of advanced nursing practice: healthcare needs of the population, education, workforce, practice patterns, and the legal, policy, and economic context [21]. Indeed, regulation has been identified as both, a barrier and a driver of task-shifting [12,19,22], however, not specifying in which contexts.

McCarthy et al. [23] provide a framework on regulatory strengthening in nursing and midwifery. It is based on a review of the regulatory elements recommended by the International Council of Nurses and the World Health Organization, among others. It suggests five overall stages of regulatory strengthening, from no to 'best practice' regulation, the latter defined as regulation in line with global recommendations [23]. The framework, however, was designed for strengthening the regulation of the nursing workforce overall, it did not specify standards on how to regulate Advanced Practice Nurses/Nurse Practitioners (APN/NPs), an umbrella term defined as nurses working in expanded practice, with high levels of independence, expert knowledge, complex decision-making skills and clinical competencies, holding usually a Master's level degree [24].

Research on the governance of task-shifting and specifically, nurses in advanced roles is scarce [10–12,19]. Pulcini et al. [11] used a cross-sectional survey design and showed that 71.9% of 32 countries reported formal recognition of the APN/NP role. However, the study failed to mention which countries had regulations in place and which not. An OECD study [19] suggested that the level of detail of legislation can act as facilitator or barrier. A literature review [10] in 19 countries showed that most countries did not regulate APN/NPs, and few provided full regulation [10]. The study covered a large number of countries, however, it lacked clarity on the selection criteria for country coverage, and how regulation was measured. A survey in 26 countries concluded that there is wide cross-country variation [12]. However, it provided limited information how regulation impacts practice, moreover, it only covered ten countries within the European Union (EU).

To date, no systematic assessment of APN/NPs exists in the EU. Its single market facilitates the movement of professionals, including health professionals in the 28 EU member states, European Economic Area countries and Switzerland. Physicians and most medical specializations are automatically recognized [25,26]. For nurses, however, only the basic nursing qualification is automatically recognized, no nurse specializations or advanced nursing practice [27], which may limit the mobility and skills transfer within the EU.

The objective of this study was to take stock of task-shifting practices with a particular focus on governance models for APN/NPs, based on data from the 2015 International TaskShift2Nurses survey. Two research questions were addressed: how is task-shifting governed in countries with APN/NP practices, and what are the implications of different governance models on the implementation, patient safety, role clarity and the availability of workforce statistics.

A cross-country comparison is relevant for two reasons: first, an increasing number of countries are in the process of implementing APN/NP roles, one of the reasons may be the increasing number of countries that are moving the primary educational level of nurses to the Bachelor's level plus increasing numbers of Master's programs, triggered by the Bologna process in Europe [27–30]. These countries are faced with the policy question of whether and to which extent new, advanced roles of nurses should be regulated. Second, from an EU perspective, due to its free movement principle, the question of regulation is relevant as it may have implications on the mobility of this workforce, the level of skills-transfer and quality of advanced practice when crossing borders.

2. Material and methods

2.1. Literature scoping review

A comprehensive literature scoping review was carried out using Medline, CINAHL, Web of Science, the Cochrane library and google scholar. In addition, the websites of the WHO, OECD, International Council of Nurses, European Federation of Nurses were searched.

2.2. Survey

Data from the international TASK-SHIFT2Nurses Survey 2015 with a focus on primary care, fed into the analysis, in which 93 country experts from 39 countries