Executive summary

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Developments in the redefinition of professional roles

A great deal is expected from the redefinition of professional roles in the health care sector. The assumption is that re-demarcation between existing professions and the creation of new professional groups – non-doctors who are nevertheless competent to perform certain medical procedures – will raise quality standards and lead to more efficient care. Quality and efficiency improvements are needed if the sector is to continue providing appropriate care as demand rises. However, little is yet known about the scientific validity of these expectations.

The uncertainty surrounding the effects of role redefinition was identified as one of the remaining obstacles to change by the Council for Public Health and Health Care (RVZ) in 2002. The other obstacles identified by the Council were uncertainty regarding patient and professional acceptance of change, and legal and financial constraints.

Since 2002, role redefinition has become increasingly commonplace and research has been conducted into its impact. Furthermore, the Minister of Health, Welfare and Sport has indicated a wish to revise the Individual Health Care Professions Act (BIG Act) to afford nurses with certain qualifications the authority to practise autonomously. This would allow nurse practitioners and physician assistants – two examples of new health professionals – to perform minor medical procedures.

In other words, there have been developments in clinical practice and in political circles since the RVZ reported on this matter. It would therefore be useful to establish at this juncture whether role redefinition does indeed have the anticipated benefits. The Health Council has accordingly reviewed the scientific evidence with a view to establishing what is currently known about the effectiveness of role redefinition and about the matters that the RVZ's 2002 report identified as potential obstacles to change.

New information about quality and efficiency

The limited scientific evidence available from the Netherlands and other countries, supplemented by expert opinion, reveals a complex picture. The quality of care hardly ever appears to be adversely affected by the re-allocation of duties or the introduction of a new category of health care professional. Thus, one of the main preconditions for responsible role redefinition is usually met.

There is some evidence to suggest that the quality of care is improved by role redefinition, but the improvement is attributable mainly to better patient supervision and support. Apparently, nurse practitioners and physician assistants, as well as practice assistants and practice support workers who do some of the work traditionally undertaken by GPs, give more attention to such matters. However, role redefinition does not appear to have a beneficial influence on other quality indicators, such as effects on public health.

This implies that the efficiency benefits currently attainable are slight. At present, role redefinition tends to consist mainly of the creation of new health professionals; the re-assignment of duties is much less prominent and there is no redesign of the care process. Furthermore, doctors do not feel that their burden has been significantly alleviated by the changes made to date. It could be that redesign of the process would ultimately result in more efficient care.

Relatively little scientific evidence is available regarding any of these matters, however. Consequently, there is little empirical support for the assumptions on which policy is based.

New information about patient and professional acceptance, legislation and finance

What is known about the other obstacles identified in the RVZ's 2002 report? Patients who have been treated by non-doctors with clearly defined medical responsibilities are largely positive about their experiences. If left to their own devices, however, they are inclined to turn to familiar professionals.

Doctors also appear reluctant to change their ways, despite the scope for responsibly delegating certain tasks. The use of protocols could probably increase interprofessional trust. Again, however, it is likely that more could be achieved by process redesign than by task delegation by individual doctors.

Some of the legal constraints that existed in 2002 have been removed by the proposed changes to the BIG Act. Issues nevertheless remain, because not all care practitioners who undertake medical duties are afforded the appropriate legal authority by the amended Act. This could lead to stricter control. If it is decided that further regulation is required, it is important that a middle path is found: while rules are required to ensure quality and safety, freedom of action is also needed to allow adaptation in the care process.

Little more is known about the financial constraints that the RVZ reported in 2002. The introduction of diagnosis-treatment combinations does not appear to create extra problems, because the combinations do not usually specify which care professional should perform a given treatment.

New focus issues

From the analysis set out above, a number of new issues emerge. First and foremost, role redefinition is currently an extension of the existing, familiar care process, whereas it could be achieved in the context of the redesign of that process. It is conceivable that process redesign could also bring about the desired efficiency gains, without detriment to the quality of care, and possibly to its benefit. However, it is also clear that little is yet known about the likely impact of such changes. Long-term research could help to address this situation.