



Task shifting in the public health sector – what is the evidence?

To the Editor: We read your editorial of May 2008¹ on task shifting in the public sector with great interest. With the chronic shortage of health professionals in the public health sector in South Africa and other countries in sub-Saharan Africa, task shifting is a very attractive strategy. This is especially true in the context of HIV/AIDS, which poses a significant threat to social security and food supplies in sub-Saharan Africa. While the rational use of effective antiretroviral (ARV) medication has changed the course of the disease in well-resourced countries, the same is not true for resource-poor countries in sub-Saharan Africa, where a critical shortage of skilled health workers has limited the provision of life-saving ARV drugs to a large proportion of those who need them.² However, moving specific tasks from highly specialised health workers to less specialised ones in our resource-poor health care systems should be based on solid scientific evidence.³

We searched Medline, EMBASE and The Cochrane Library, and found three systematic reviews that assessed the effectiveness of doctor-nurse substitution in the provision of care at the primary level.⁴⁻⁶ These reviews synthesised currently available randomised controlled trials (RCTs) and controlled before-and-after studies, and found that unselected patients (coming to either primary care facilities or emergency departments) were more satisfied with care from a nurse than from a doctor; but there were no appreciable differences between doctors and nurses in patient health outcomes, the care process, resource utilisation or cost. These systematic reviews provide the scientific basis for task shifting at the primary care level. However, the studies included in these systematic reviews were conducted in high-income countries in Western Europe and North America and did not provide



good-quality evidence of the economic results of substituting nurses for doctors. While systematic reviews of the effects of interventions are valuable for making good health care decisions, they are not sufficient. Policymakers who wish to institute programmes for moving the tasks of highly qualified workers to those with shorter training would need to consider local conditions, needs, values, costs and the availability of resources. Such changes to the delivery of care should be preceded (or accompanied) by standardised protocols, appropriate training, regular supportive supervision, and meaningful career development opportunities. However, given the complexity of ARV drugs and the highly specialised nature of care for HIV/AIDS patients, the need exists for a systematic review of the evidence for the effectiveness of nurse-led management of HIV/AIDS patients.⁷ Should the evidence be lacking, policymakers need to consider programmatic shifts in HIV/AIDS care to be evaluated in the context of RCTs.

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