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Integration of health assistants into interdisciplinary teams

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Abstract--The global healthcare landscape is facing significant challenges, including a shortage of primary care physicians alongside a rising demand for services. This has led to the implementation of team-based primary care models, which emphasize collaborative practice among a diverse range of healthcare professionals, such as nurse practitioners, registered nurses, and other clinical staff. The primary aim of this work is to provide an overview of the education, tasks, and remuneration of nurses and other primary care team members. By utilizing a framework of team organization that spans the care continuum, this study seeks to identify and compare the skill mix, education and training, responsibilities, and compensation of health professionals working within primary care. The research emphasizes the transition from ‘task delegation’ to a more collaborative ‘team care’ approach, recognizing the barriers posed by traditional role concepts, legal frameworks, and reimbursement systems. The findings reveal that nurses generally serve as the primary non-physician healthcare professionals collaborating with doctors across most countries assessed. However, the types and roles of nurses and other allied health professionals differ widely. The introduction of more allied health professionals and support workers, such as medical assistants, is becoming more common in primary care settings. A clearer definition of each team member's role could facilitate better shared responsibilities and enhance patient care. The shift toward optimized team-based care in primary care is a global trend that has the potential to sustain access and improve the quality-of-care delivery.

Keywords--Healthcare Assistants, Collaboration, Interdisciplinary Teams, Patient Support, Training and Development.

1. Introduction

Primary care systems worldwide are confronted with the quandary of reducing physician personnel in parallel with the growing need for treatment. The supply of medical graduates pursuing primary care specializations including general internal medicine, family medicine, or geriatrics is declining both in the United States (US) (1) and globally (2). Quantitatively, the number of patients and the requests for care are significantly rising (3-5). Transformations in health systems in some nations can lead to a rise in demand. Specifically, the Care Act of 2010 in the United States extended healthcare coverage to a large number of persons who did not have health insurance by 2014. This expansion resulted in a further rise in the need for primary care services (3). Given these advancements, the conventional notion of the 'lone-doctor-with-helpers paradigm' may create significant challenges in terms of accessing quality primary care (6).

Addressing these issues, the medical field is becoming more diverse by including non-physician medical professionals including physician assistants, nurse practitioners, and additional clinical employees (7). The worldwide observation of this evolution reveals variations in the skill mix of the primary care workforce and the pace of advancement in delivering primary care as a team across different countries (8-10).

The objective of this article is to examine the competencies, educational background, training, responsibilities, and compensation of healthcare professionals in primary care settings. We analyze and contrast health professionals and provide an evaluation of worldwide patterns in the evolving skill composition of the medical profession.

2. Healthcare Practitioners Classifications

Discrepancies in terminology and designations used to refer to non-physician health practitioners across various countries impede worldwide comparability. Thus, this study categorizes health professionals based on the care continuum framework introduced by Almgren (11). Based on the difficulty of responsibilities and resource allocation, this system categorizes health professionals into five different areas of care delivery. These areas range from general practitioners, who handle all clinical cases, to nursing assistants or assistants, who handle simple well-defined tasks such as urine analysis or phlebotomy.

3. Methods

This article presents the skill mixture in the workforce for primary care estimated using a MEDLINE, Scopus, PubMed, and Web of Science search conducted in 2009 to 2018, using the terms 'primary care', 'workforce', 'mix'. Each respective national expert, namely the author, determined the placement of the doctors on Kernick's continuum. Using this paradigm, it is possible to compare and contrast non-physician health workers in primary care across different nations. However, it is important to note that this structure is restricted by its emphasis on medical responsibility. Detailed analysis of the labor force and challenges in each nation

was based on scientific publications, policy reports from local governments (which involve websites), and personal interaction if additional data was required.

4. Occupational Composition in the Global Setting

The decline in the number and working hours of medical professionals may be attributed to many factors, such as a growing number of female doctors prioritizing maintaining a work-life balance and choosing to opt for fewer hours or just part-time. Contrarily, the number of patients and the need for treatment consistently rise. In light of this scenario, nations have established medical teams with varying skill compositions. Although our article has mostly focused on conventional primary care practices, which constitute the predominant part of the service in most nations, it is important to note that alternative primary care services, such as nurse-led walk-in facilities, also showcase a shift in the composition of skilled professionals, with an increasing number of non-physician practitioners.

Nevertheless, it remains true that in all of these nations, the sheer number of doctors employed in primary care surpasses the total amount of non-physician healthcare practitioners. As the level of complexity in medical duties diminishes, the compensation of health professionals also tends to drop. Despite the shown ability of nursing professionals and medical assistants to provide a minimum of 60% of office-based medical care (12), the total number of nurse professionals or medical assistants employed in primary care remains low in the majority of nations. The reason for this may be attributed to many issues, such as demanding training prerequisites and much lower remuneration in comparison to comparable roles in other fields and primary care doctors (13).

Innovations are required to address the complexity of medical care in the twenty-first-century workforce, to reduce the burden for primary care doctors (14). An essential component of this innovation is the transfer of responsibilities from doctors to non-physician healthcare personnel. Task shifting necessitates both the willingness of doctors to relinquish assigned responsibilities and the capability and aptitude of non-physician health providers to carry out these activities. The delegation of tasks from physicians to non-physician health workers has generated two significant issues: compromised patient safety and quality of treatment and reduced continuity of care. The current body of evidence substantiating each of these issues is insufficient. Contrary to that, many studies have shown that the quality of treatment provided by non-physician health professionals such as nurse practitioners is not worse than that of doctors (15,16). Nevertheless, there is a lack of substantial data about the quality and safety of care provided by practicing nurse auxiliary personnel (17-19). Implementing protocol-based treatment, such as establishing standing orders for prescriptions fill, may more effectively support job shifting by addressing challenges arising from insufficient education and a dearth of legal responsibility (6).

Incorporating more members into care teams heightens the likelihood of compromising the continuity of care if defined as 'consistently seeing the same healthcare professional every time'. Nevertheless, the use of electronic health

records that are accessible to all members of the team can somewhat mitigate the possible negative consequences of having more healthcare professionals present for each patient (7). Indeed, the concept of assigning responsibilities to non-physician health workers has been progressively replaced by initiatives to establish 'care teams' in all the nations being examined. However, although there is a pressing need for further efforts to encourage team formation in all nations, the first step helped by this overview is to develop an understanding and appreciation of the roles of each team member.

5. Conclusion

The optimal distribution of responsibility for patient care among various members of the healthcare team can be achieved by ensuring adequate training, timely and comprehensive sharing of information among all team members, and equitable reimbursement plans for services offered by non-physician medical practitioners. Although benefits should be evaluated about national or regional laws and regulations, this study offers valuable information on many changes in the skill mix. This information may be used to formulate plans aimed at preserving the availability of primary care and ensuring the provision of high-quality care. Therefore, nations may gain knowledge from global experiences as long as they recognize the specific circumstances of the skill combination discussed in this research.

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دمج المساعدين الصحيين في فرق متعددة التخصصات الملخص

تواجه المشهد الصحي العالمي تحديات كبيرة، بما في ذلك نقص أطباء الرعاية الأولية إلى جانب ارتفاع الطلب على الخدمات. وقد أدى ذلك إلى تنفيذ نماذج الرعاية الأولية القائمة على الفريق، التي تركز على الممارسة التعاونية بين مجموعة متنوعة من المحترفين الصحيين، مثل الممارسين المررضين، والمررضين المسجلين، وغيرهم من الطاقم السريري. الهدف الرئيسي من هذا العمل هو تقديم نظرة عامة عن التعليم والمهام والتعويضات للمرضين وأعضاء فريق الرعاية الأولية الآخرين. من خلال استخدام إطار عمل لتنظيم الفريق يمتد عبر نطاق الرعاية، يسعى هذا البحث إلى تحديد ومقارنة مزيج المهارات والتعليم والتدريب والمسؤوليات والتعويض للمهنيين الصحيين العاملين ضمن الرعاية الأولية. تؤكد الأبحاث على الانتقال من "تفويض المهام" إلى نهج أكثر تعاونًا يُعرف بـ "رعاية الفريق"، مع الاعتراف بالعوائق التي تفرضها المفاهيم التقليدية للدور والأطر القانونية وأنظمة التعويض. تكشف النتائج أن المررضين عمومًا هم أبرز غير الأطباء المهنيين الصحيين الذين يتعاونون مع الأطباء في معظم البلدان التي تم تقييمها. ومع ذلك، تختلف الأنواع والأدوار للمرضين وغيرهم من المهنيين الصحيين المساعدين اختلافًا كبيرًا. أصبح إدخال المزيد من المهنيين الصحيين المساعدين والعمال الداعمين، مثل المساعدين الطبيين، أكثر شيوعًا في إعدادات الرعاية الأولية. يمكن أن يسهل التعريف الواضح بدور كل عضو في الفريق تحسين المسؤوليات المشتركة وتعزيز رعاية المرضى. إن الانتقال نحو رعاية قائمة على الفريق الأمثل في الرعاية الأولية هو اتجاه عالمي لديه إمكانية الحفاظ على الوصول وتحسين جودة تقديم الرعاية.