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Task Delegation Versus Task Shifting in the Indonesian Health Service

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Prior to 2001, the Indonesian government conducted several programs to enchance the quality of health services at health centers [1]. One of these initiatives was to improve the skill of nurses and midwives in providing health services by using the Clinical Algorithms (CAs). A CA is a step-by-step problem-solving procedure for clinical services that guides nurses/midwives to arrive at a diagnosis and treatment. The Indonesian government provides CAs because doctors are used in managerial roles at government health centers. As a result nurses and midwives must provide most of the health services. For that reason, the Indonesian Medical Association (IMA) and the Indonesian Nurse Association (INA), in collaboration with the Ministry of Health and Social Welfare and with the support of the World Bank, developed 15 CAs for nurses and midwives to implement in government health centers to improve the quality of services.

After the CAs were developed, the IMA supported the program by issuing a letter of agreement for the nurses and midwives to conduct some restricted medical activities [2]. Through that letter, nurses and midwives had the authority to diagnose and treat patients using the CAs for 15 symptoms of diseases, i.e.: running nose and cough, fever >4 days, fever <5 days, hearing problem, itching of skin, rash on the skin, vaginal discharge, eye redness, diarrhoea, nausea and vomiting, muscle and joint ache, vaginal bleeding, headache, burning during urination, sore throat, epigastric pain, and difficulty in breathing. The IMA letter of agreement meant that certain elements of doctors' authority could be formally delegated to nurses and midwives. Of course, the letter of agreement also had terms and conditions for nurses and midwives to follow when conducting the doctor's job. First, the authority to diagnose and treat using CA guidelines applied only in government health centers during working hours. Second, the tasks delegated were given by the government health center doctor to the government health center nurses and midwives only. Third, the scope of tasks delegated was restricted to CAs with written guidelines. Lastly, the task delegation required nurses and midwives fully record all procedures in patients' medical records.

Task delegation to be Task Shifting

In the beginning, there were no major problems in task delegation or implementing the CA guidelines. For five years, from 2001 until 2005, the program and relationship between doctors and nurses/midwives was

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WMA

run well. By the end of 2005, however, the situation was out of control. The conditions in the letter of agreement allowing nurses and midwives to conduct these restricted medical activities were not properly met by nurses in one province of Indonesia. At that time, Indonesia had 33 provinces and the doctors In Central Java province, the second largest province in terms of total population, launched a protest to the IMA central executive board. They insisted the IMA Central Executive Board revise the letter of agreement [3].

The main reason for the protest was that the condition of the relationship between doctors and nurses/midwives had become chaotic, especially in Boyolali district, where the Health Authority of Central Java Province established the Village Health Clinic (VHC) [4]. The VHC was basically a community health service effort with the nurses/midwives serving independently as health service officers. It was very different from the spirit of the letter of agreement that allowed the nurses/midwives to conduct diagnoses and treatment in government health centers only. The conflict occurred between general practitioners and nurses/midwives in Boyolali when nurses/midwives campaigned to the community that they could conduct the doctor's job because they were trained as well as a doctor using CA guidelines, which were recognized by IMA. nurses/midwives also felt secure doing the doctor's job since the VHC was a formal institution licensed by the Central Java Health Office. Task delegation evolved to task shifting at that time.

Cancelled Task Shifting

As a result, the Boyolali District IMA Branch office asked the IMA Central Executive Board to take immediate action [5]. Since data showed that the total number of doctors in Central Java was relatively high in proportion to the population, and transportation was generally available if there was a need to find a doctor in another village, the need for task delegation in Central Java seemed less imperative. Fortunately, previous to that situation occurring in October 2004, the Indonesian Parliament and Government had enacted the Medical Practice Law (Law No. 29/2004) [6] which states, in articles 73 & 77, that any person who intentionally assumes the identity of a registered doctor, or provides the impression to the public that he or she is a registered doctor, shall be punished with imprisonment of 5 (five) years or a fine of not more Rp 150.000.000. With this law in place, the Indonesian Medical Association finally cancelled the letter of agreement.

After the IMA cancelled the letter of agreement, there was a need to find a way to meet health services needs when there were no doctors in a particular area. Therefore, the Indonesian Medical Association sent recommendation letter on task delegation in 2008 [7]. In this letter, the IMA recommended that doctors delegate medical authority to nurses/midwives in remote areas with the following terms and conditions: the delegation mechanism includes accountability measures; the criteria of service is very clear; the time frame is restricted; only selected doctors in the area can delegate authority to nurses/midwives; medical authority to be delegated is clear; there is a limited list of drugs that can be dispensed by nurses/midwives; and nurses/midwives can perform these tasks in government health facilities only [8].

The main difference between the prior letter of agreement and the new letter of recommendation is in the scope of collaboration. In the letter of agreement, the Ministry of Health collaborated with the IMA Central Executive Board directly. The terms and conditions of collaboration were very general and it was difficult to control their implementation. In the letter of recommendation, the IMA Central Executive Board did not collaborate directly with the Ministry of Health but instead gave full authority to IMA Branch offices at district levels to decide on collaboration with the district health office. The collaboration really depends on how severe the shortage of doctors in that area is and requires that doctors in that district accept the concept of delegating their medical authority. The IMA Central Executive Board was involved minimally only in determining the guidelines.

Lessons Learned

The World Medical Association describes "Task Shifting" as a 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 (World Medical Association) [9]. Within the World Health Organization (WHO), task shifting is a term that involves the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health [10].

Regardless of the differences between the WMA and WHO definition, the fact is that the Indonesian Medical Association formerly supported shifting some physicians' tasks to nurses and midwives, as communicated through the letter of agreement. But, given the deteriorated professional relationship among physicians and nurses/midwives, and the IMA's assessment that the implementation of task shifting could be dangerous for patients, the Indonesian Medical Association cancelled the letter of agreement.

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History of Georgia, Georgian Medicine and Medea

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Georgia

Georgia is situated in the South Caucasus, on the southern foothills of the Greater Caucasus mountain range. There is a short border with Turkey to the south-west and a western coastline on the Black Sea. The northern border with the Russian Federation follows the axis of the Greater Caucasus. To the south lies Armenia and, to the south-east, Azerbaijan.

Georgia has a rich history thanks to its strategic location. Ionian Greeks colonized this area in the 6th century BC. At this time the western region of what is now Georgia was known as Kolkhida and the eastern region as Iberia. In the 4th century BC Georgia was united into a single kingdom, with Mtskheta as its capital.

Christianity was introduced in the 4th century AD. The Persian and Byzantine empires dominated the area until the Arab conquest in the 7th century. The region then came under control of the Seljuk Turks in the 11th century before their foray into Anatolia. A period of unification and independence in the 12th century, under King David IV, was swept aside by the Turco-Mongol invasion in the 13th century. Between the return of Timur's army to central Asia and the 18th century, control of Georgia oscillated between the Persian and Ottoman empires. A short-lived Georgian kingdom was proclaimed in the mid-18th century, followed soon after by annexation by the Russian Empire. Initially, in 1783, this took the form of control of the kingdom's foreign affairs.

In 1801, with the abdication of the last Georgian king, Georgia was fully incorporated into the Russian Empire. After the Russian Revolution, in 1917, Georgia briefly became an independent republic. This independence was short-lived, lasting only until 1921, when it was incorporated into the Union of Soviet Socialist Republics (USSR), where it remained for the following 70 years.

During the Soviet era, Georgia was a relatively prosperous republic, supplying USSR with produce and services and exerting con-