

The Standing Committee of European Doctors (CPME) represents national medical associations across Europe. We are committed to contributing the medical profession's point of view to EU and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues.

Policy on the optimisation of the healthcare workforce

Recommendations

- Key to improving health service performance and efficiency is a well-resourced and motivated workforce. Access to facilities and equipment, adequate staffing levels and safe working conditions and the deployment of user friendly eHealth solutions can help improve the delivery of quality, safe, efficient, equitable and accessible healthcare.
- The concept of optimisation in terms of redefining teams and skill mix and the use of digital technologies including but not limited to AI must not be driven by cost-containment but by improvement to quality of care and patient outcomes and efficient allocation of resources.
- Reducing unnecessary administrative and bureaucratic workload should be a core optimisation objective, to protect doctors' well-being and ensure that clinical time is devoted to patient care.
- Task shifting must not replace long-term investment in safe staffing, training, and working conditions. Task shifting is the name now given to a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications.
- National authorities must work together with the medical profession, regulators and healthcare professional representative bodies to safeguard medical standards and professional responsibilities through retaining physician-led care. Multi-disciplinary teams, coordinated by a physician, should be viewed as the gold standard.
- Ethical principles and a clearly defined safe scope of practice are essential to defining good practice when non-physician healthcare staff take on new tasks.

- CPME opposes physician substitution by inadequately trained roles that compromise quality of care continuity and safety.
- CPME highlights the risks of relying on digital tools and AI to address workforce shortages, and underlines that validated tools can support rather than replace clinical expertise.
- CPME advocates for transparent, inclusive policy-making processes where doctors are fully consulted and engaged.

Introduction

Recruitment and retention of doctors is increasingly insufficient to meet growing demand for healthcare. An ageing population and increasingly complex care requirements have outstripped available resources, while the declining attractiveness of the medical profession and its consequent increase in attrition threaten the right to healthcare and the commitment to universal health coverage for all Europeans. Internationally, this perspective is reflected in the WHO Framework for Action on the Health and Care Workforce¹, where among its five pillars, the promotion of workforce optimisation, redefining teams and skill mix and the use of digital solutions with a focus on improving performance and efficiency is increasingly positioned as a core principle of healthcare reform.

Key to optimising healthcare performance is a well-resourced and motivated workforce: Doctors must be provided with the equipment and facilities to deliver safe and effective care. Difficulties in accessing diagnostics, inpatient beds, clinic and operating theatre space cause on-going backlogs to patient care.

Adequate staffing levels and safe working conditions will help reduce risk of burnout, support recruitment and retention and reduce the risk of patient safety incidents. Insufficient staffing of multi-disciplinary teams, allied health care professionals as well as administrative staff, all place additional burdens on existing employees.

Investment in electronic health care records and other automated systems can help reduce errors and repetition and reduce the administrative burden. Systems must be user friendly and fit for purpose in a busy clinical environment.

With a view to improving the outcomes and stabilising health systems, the concept of 'optimisation' of health services in terms of redefining teams and skill mix and the use of digital technology including AI, aims to offer a coherent framework. European Doctors, across patient-facing and non-patient-facing roles, are committed to delivering the high quality safe care within available resources and in the context of evolving technologies. The efforts to optimise healthcare services must be guided first and foremost by patients' rights, effective prevention where possible, clinical benefit, and ethical standards, and the concept of physician-led teams.

¹ WHO (2023) [Framework for action on the health and care workforce in the WHO European Region 2023-2030](#)

Without appropriate safeguards, the concept risks being reduced to narrow short-term efficiency measures that may be invalid proxy measures for better health outcomes that undermine medical standards and erode patient trust.

Productivity

CPME cautions against applying narrow industrial concepts of productivity to healthcare. Productivity is a measure of how much output is produced as a measure of input, but fails to take into account individual needs, patient preferences and social circumstances, and focuses on a very narrow set of inputs and outputs.² Improving efficiency, on the other hand, is about maximising value for money in terms of the resources spent to improve quality of care and population health outcomes.³

‘Prudent Healthcare’ versus ‘Low Value Care’

CPME emphasises the importance of prioritising ‘prudent healthcare’, a concept that better aligns with the principles of clinical appropriateness, quality, and patient safety, rather than relying on the potentially misleading notion of ‘low value care.’ Publications have implied that spending on healthcare provided by highly qualified professionals is wasteful if the care could also be provided by persons with a lower qualification. From this rationale, healthcare services which are considered as not being cost-effective can be referred to as ‘low value care’. CPME warns against use of this definition as it is misleading and such framings risk being misused to justify unsafe substitution of medical expertise. While the term ‘low value care’ may be used in certain contexts such as to describe care based on outdated clinical guidelines, CPME cautions against its broader use where it may be interpreted primarily through a cost or qualification lens. CPME considers that the concept of ‘prudent healthcare’⁴ more appropriately captures the objectives of clinical appropriateness, quality, and patient safety, and therefore does not recommend the use of the term ‘low value care’.

² Cylus J, Papanicolas I and Smith PC, Identifying the causes of inefficiencies in health systems, *Eurohealth Measuring Efficiency in Healthcare* 2017; 23(2).

³ *Eurohealth Measuring Efficiency in Healthcare* 2017; 23(2).

⁴ The four principles of prudent healthcare are: (1) Achieve better health and wellbeing with the public, patients and professionals as equal partners through co-production, (2) Provide care for those with greatest health needs first, making effective use of all skills and resource, (3) Only do what is needed – no more, no less – and to do no harm and (4) Reduce inappropriate variation using evidence-based practice consistently and transparently. Buss P., Howson, H., O’Neill, C., & Berwick, D. (2022). ‘Values to value’ for recovery and renewal: prudent healthcare the key to transforming the health and care system. *Journal of the Royal Society of Medicine*, 115(12), <https://doi.org/10.1177/01410768221142026>

Task Shifting

The term ‘task shifting’ is used to describe a situation where a task normally performed by a doctor 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.⁵ While in task delegation, responsibility remains with the treating doctor, in task shifting, responsibility is transferred from the doctor to another health professional, and can have the potential to come with risk of decreasing the quality of patient care if not carried out appropriately. Discussions on how to make more effective use of healthcare professionals’ competencies have also considered the concept of ‘task sharing’, which is the rational redistribution of responsibilities among health workforce teams. Specific tasks or roles are shared, where appropriate, to less specialised health workers to use the available personnel efficiently. It should be accompanied by appropriate measures in terms of education, supervision, management support, licensing, regulation, and remuneration.⁶ Any such redistribution of tasks interacts with the concept of scope of practice (SOP), which refers to the limits of all a healthcare professional’s knowledge, skills, and experience, reflecting all tasks and activities undertaken within the context of a healthcare professional’s role.⁷

While task shifting has traditionally been associated with low and middle income countries facing significant shortages of resources and qualified professionals⁸, where it was often justified as the only alternative to providing no care at all, similar arguments are now increasingly being made in Europe in response to shortages and uneven distribution of doctors. In rural and underserved areas in particular, task shifting is often presented as a way to maintain access to care. CPME cautions that such measures cannot replace comprehensive workforce planning and investment to ensure adequate and equitable supply of doctors across all regions. Task shifting has also become a feature of European and international health policy agendas more broadly, where it is framed as part of wider efforts to optimise service delivery.⁹ Several EU countries have pursued task shifting initiatives as part of broader health system reforms. This evolution raises critical questions about roles, competence, accountability, and the limits of delegation and shifting in medical care.

Transfer of tasks can help optimise resources if safely designed and properly implemented to allow doctors to focus more on patient care and tasks that specifically require their expertise.

⁵ [World Medical Association Statement on Scope of Practice, Task Sharing and Task Shifting](#) (2025)

⁶ WHO (2021). Health Workforce-related terminology: Terminology work carried out by the WHO Language department at the request of the Health Workforce Department. <https://www.who.int/publications/m/item/health-workforce-terminology>

⁷ [World Medical Association Statement on Scope of Practice, Task Sharing and Task Shifting from the Medical Profession](#) (2025)

⁸ [Expert Panel on effective ways of investing in Health \(EXPH\). Task Shifting and health system design](#). (2019)

⁹ [Bucharest Declaration on Health and Care Workforce](#) (2023)

CPME underlines that legislators should consult and seek consent of the medical profession when considering the safe transfer of activities traditionally reserved for doctors to other health professionals. Within a healthcare facility, decisions concerning the distribution of tasks should, where possible, involve the broader healthcare team.¹⁰ The involvement of doctors in the leadership and evaluation of task delegation, task sharing, and task shifting initiatives is essential in ensuring their proper and safe implementation, maintaining patient safety and quality of care. Doctors cannot be legally responsible for tasks, assessments or actions over which they have no oversight or control.

It remains essential to distinguish task shifting, delegation, and sharing from interprofessional collaboration. Interprofessional collaboration is defined as collaboration between healthcare professionals who are licensed/regulated, highly educated, insured, adhere to strict codes of ethics and work within their domain of competence. Investment in interprofessional collaboration should be pursued to strengthen teamwork and ensure that the complementary expertise of regulated healthcare professionals is mobilised in support of, not in replacement of, medical care.

CPME therefore concludes that:

- Task shifting, sharing, and delegation can only be implemented under structured and formal arrangements that prioritise patient safety, safeguard professional accountability, and uphold the quality of care and principles of doctor-led care.
- It is crucial to define and enforce a scope of practice supported by adequate training and qualifications which are subject to quality control.
- Its use must be justified by a demonstrable service need and restricted to tasks that are appropriate to transfer and ensure that time freed for doctors is dedicated to patient care rather than administrative or ancillary duties.
- Legal responsibility and final accountability must be explicitly defined, with clear supervision and escalation pathways in place. These arrangements must be explicitly clarified and understood by all members of the care team.
- Professionals to whom new tasks are assigned must have the necessary training, competence, and recognition within their scope of practice.
- The effects of task shifting should be evaluated systematically, both through research and using qualitative parameters, and adjusted if necessary.
- European policy-makers should also be guided by existing international frameworks, such as the World Medical Association's (WMA) Statement on Scope of Practice, Task Sharing

¹⁰ [CPME Policy on Health Workforce](#) (2021)

and Task Shifting, which emphasises the need for formal structures clear accountability, and safeguards for patient safety.¹¹

- Task shifting must not be treated as a substitute for training and employing sufficient numbers of doctors and other healthcare professionals. Workforce planning should look beyond the number of tasks delivered and also assess their quality and safety.
- Task shifting must not overlook its impact on doctors, who carry increased responsibilities for supervision, training, and managing complications. As a result these duties require time and resources and must not come at the expense of junior doctors' training opportunities or patient safety.¹²

Emerging Professions

Similar challenges arise in discussions on emerging professions, where new roles must be carefully defined to support rather than replace doctors. The emergence of such professions has often followed major shifts in health systems, including changes in disease patterns, advances in medical technology, and evolving professional norms. These developments have launched a discussion for new skills and functions, giving rise to specialised roles intended to support efficiency and address increasingly complex patient needs. Properly integrated, such professions may contribute to relieving doctors of routine tasks, for example through support in processing patient data or undertaking administrative work, thereby enabling doctors to dedicate more time to direct patient care.

However, recent developments raise concerns. In several countries, the introduction of non-physician practitioners such as physician associates or physician assistants has coincided with efforts to compensate for medical workforce shortages. In the United Kingdom, 'physician associates' have sometimes been deployed to cover gaps in medical rotas without sufficient recognition of their more limited training and without providing doctors with the training, time, and clarity needed for appropriate supervision. Such practices risk lowering standards of care, compromising patient safety, and creating additional pressures on supervising doctors. CPME firmly supports its UK colleagues in opposing the substitution of physicians by physician associates / assistants.¹³

To ensure that new professions contribute positively to healthcare delivery, CPME concludes that:

¹¹ [World Medical Association Statement on Scope of Practice, Task Sharing and Task Shifting from the Medical Profession](#) (2025)

¹² [CPME policy on the impact of task shifting on doctors in training](#) (2011)

¹³ [CPME Statement on doctors' right to strike and physician substitution](#) (2023)

- It is essential that their roles and responsibilities are clearly defined with unambiguous professional titles.
- Non-physician practitioners should not be permitted to see, examine, diagnose, or treat undifferentiated patients independently.
- Enhanced roles, credentialing, or training for non-physician practitioners do not diminish the hands-on learning opportunities of resident doctors and medical students.
- Adequate guidance, training, and resources are provided to doctors to support effective supervision.
- New professions must be regulated and there must be clear rules on liability and supervision.

Digital Technologies and AI

Digital tools cannot replace the need for safe staffing levels and sufficient numbers of trained doctors. CPME concludes:

- It should be a clear principle that AI is not deployed to replace or to compete with health professionals nor to diminish patient autonomy and shared decision-making.
- Doctors need to be strongly involved in the design, monitoring, governance and application of AI within healthcare.
- AI cannot substitute for doctors in addressing Europe's health workforce crisis. While digital tools may streamline administrative tasks or provide analytical support, they cannot manage undifferentiated patients, assume responsibility for complex clinical judgments, or carry professional accountability for outcomes.
- The shortages facing European health systems stem from a lack of trained and available professionals, not from a lack of technology. Relying on AI as a workforce replacement risks unsafe care, erosion of trust, and further fragmentation.

In addition, the safe and effective deployment of digital technologies requires appropriate safeguards and implementation conditions:

- Digital technologies must only be implemented with realistic expectations regarding their impact on efficiency and workload, and supported by proper integration into clinical workflows, adequate training, and ongoing evaluation.
- The digital transformation of healthcare must not exacerbate inequalities in access to care; vulnerable populations must be protected from exclusion due to limited digital literacy or access to technology.

Therefore, AI should be understood as a tool that complements the work of doctors and their teams by freeing time for direct patient care and safeguarding the quality and safety of services.¹⁴

¹⁴ [CPME Policy on the deployment of AI in Healthcare \(2024\)](#)