Editorial for BJHM

The changing landscape of the UK's healthcare workforce: The role of the Physician Associate

Healthcare is changing internationally. Stimulated by a combination of socio-political, technological, environmental and economic changes, new and extended professional roles are emerging to fill unmet needs across the service and support an existing workforce which is quite simply struggling to meet demand.

This editorial introduces two articles looking at the role of the Physician Associate (PA) in the UK. The first is a scoping review which considers the barriers and facilitators for integrating PAs into the workforce. The second, considers how the widespread introduction of PAs might impact on ways of working, leadership, interprofessional teamworking and collaborative practice.

PAs originated in the US in the 1960s, primarily as a response to workforce shortages, and many original PAs served in the military as medics. Similarly, the rise of PAs in the UK is part of a wider workforce development plan which has introduced the 'medical associate professions', i.e. practitioners who work under a doctor's direction and supervision. These are new roles and have emerged alongside a variety of other new and expanded roles for existing health professionals, including advanced critical care practitioners; advanced scope of practice nurses, physiotherapists, pharmacists, speech and language therapists and occupational therapists (Campaner 2018; Butterworth et al 2017; O'Mahony & Blake 2017; Saxon et al 2014). See Table 1.

Table 1: Primary distinctions between new health worker roles and extended/advanced scope of practice

Rationale for alteration in scope of practice	New health worker roles e.g. Physician Associates; Surgical Care Practitioners	Extended/advanced scope of practice e.g. Advanced Critical Care Practitioners (ACCPs)
Service needs or changes	Designed to meet service needs usually in specific contexts (e.g. ambulatory or primary care).	Designed to meet service needs in specific contexts, or clinical specialties/client groups (e.g. diabetes, dialysis, primary care, perioperative care, eye care, ear care, basic anaesthesia)
Scope of practice	Entirely new roles for which individuals are directly trained, usually	Extended roles can refer to narrow or broad scopes, e.g.

	by completing a Bachelors-level degree and then a postgraduate programme	nurses with prescribing rights or the right to provide advanced care in a specialty or service
Previous qualifications	Often from non-health backgrounds, such as bioscience	Always drawn from existing practitioners, predominantly nurses, but also from other AHPs (e.g. prescribing pharmacists, interventionist radiographers)
Supervisory and reporting relationships	Designed to assist doctors in specific contexts and always perform under medical supervision with the doctor taking responsibility for their practice	Usually autonomous practitioners with a defined scope of practice (and registered as such) and who often work independently in parallel with doctors, referring only to a doctor when needed (e.g. out of hours care)
	Have primarily been developed to support doctors and perform routine tasks whilst under the supervision of a medical practitioner, thus freeing up the doctor to perform more specialised work.	Advanced practitioners are registered and regulated by their professional body / council with a defined scope of practice (e.g. nursing councils)
Training requirements	Formal training programmes and regulatory frameworks exist in some countries, in others the Assistant/Associate roles are not yet formally defined and regulated	Advanced practice roles require postgraduate qualifications

Across the UK, PAs are now working in primary and secondary care with many more in training:

> *'The Physician Associate profession is a growing and evolving one ….there will be just under 600 qualified Physician Associates in the UK by the end of the year [2018] … expected to grow to up to 3,200 by 2020. Physician Associates, in addition to existing members of the healthcare team, are here to add value, capacity and generalist skills to the clinical teams providing care for patients across primary and secondary care'* (Faculty of Physician Associates 2018).

Health Education England plans to have 1000 of these PAs working in primary care by 2020 as part of implementing the General Practice Forward View (https://www.england.nhs.uk/gp/gpfv/) and the Welsh government sees the development of PAs as a key part of its strategy to maintain primary care services. Meanwhile, in secondary care, while no specific targets have been set, the need to diversify the workforce to support hospital services is widely recognised.

Currently, the Royal College of Physicians hosts the Faculty of Physician Associates (FPA), and PAs are regulated via the PA Managed Voluntary Register which requires mandatory regular CPD. This lack of statutory regulation has been seen as a potential risk by all four UK governments. Therefore, the recent announcement by the Department of Health that regulation will soon be in place provides

an important foundation to ensuring that patients receive the highest quality of care from the NHS and is strongly welcomed by all.

It is still too early to fully evaluate the impact of the introduction of PAs into the NHS workforce but the rapid growth of this role reflects an international shift towards a more flexible healthcare workforce to which different countries have taken slightly different approaches.

In 2013, McKimm et al, carried out an international review of expanded and extended health practitioner roles which is a useful open access summary of the various approaches taken to provide a workforce capable of delivering care in various geographic situations with growing health needs and changing demographics. The review highlighted that a range of 'mid-level' healthcare roles is required, and the workforce should comprise a combination of 'traditional' roles (e.g. doctor, nurse, midwife), extended roles for existing registered professionals (e.g. nurses, radiographers, pharmacists) and new roles (e.g. physician associates).

The review found that the latter two types of role can **substitute** for doctors in certain, specific roles or geographical areas as these health workers are generally cheaper due to differences in salary and training costs, and quicker to mobilise due to the shorter duration of their basic and/or post-basic training. Sometimes however, these new roles are **supplementary** and arise from advances in medicine, for example new technologies, procedures and knowledge.

Supporting this, more recently, a systematic review of PAs in secondary care found that, although many studies were observational and methodologies varied in quality, when PAs were compared with doctors there was little or no negative effect on cost or health outcomes (Halter et al 2018). It was also noted that in emergency medicine and trauma and orthopaedics, when PAs were part of the team, positive effects were seen through reduced waiting and process times, equivalent readmission rates and good acceptability by patients and staff.

More research is needed in different settings to fully evaluate comparisons between PAs and the roles for which they might be substituting or supplementing, and the wider impact of introducing PAs into the NHS workforce. However, there is no doubt that over the coming years, the composition and functions of the NHS workforce will change radically. Whilst this has advantages in terms of flexibility and enabling patients to access care more easily, during the transition stages, this may lead to a blurring of role boundaries and some confusion. It will require the existing health workforce and structures to adapt and change to accommodate new ways of working rather than seeing new and extended roles as a threat and challenge.

We hope that these two articles provide some ideas as to how practitioners and managers might work together to smooth these transitions and utilise these new roles most effectively to improve patient care and health outcomes.

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