



Mid-level workers: high-level bungling?

It came by decree. Without adequate consultation and against advice from the key health workers' organisations, the National Department of Health (DoH) has ordered that there will be mid-level health workers, also sometimes referred to as Clinical Assistants and, more recently, Clinical Associates (CAs). The training is scheduled to start in January 2007. Why this move? The ostensible reasons are that there is a big hole out there in health delivery services, there are insufficient (or unwilling) nurses and doctors to fill the void, and mid-level workers have been shown to be ideal to fill the gap. What should we make of this?

Let's firstly take the title 'mid-level' worker. This must mean that the person trained fits in somewhere between existing professions, and in this case can reasonably only be interpreted as slotting in between doctors and nurses. The problem is that nursing covers a range of levels, and at their higher levels of qualifications and experience nurses equate and even exceed the competence levels of doctors in specific fields. It would be highly problematic to insert another category somehow *between* the two to justify their 'mid' status. Relationships between the existing professions are reasonably stable and comfortable, but with the addition of this cadre it is likely that professional boundaries, status and pay will be heavily disputed.

What evidence for CAs?

The USA has a group of health care workers that may be defined as 'mid-level' and to all accounts function well as physicians' assistants and even as independent practitioners. The USA's physician numbers are approaching one million for a population of 300 million. Their annual *health care expenditure* per person considerably exceeds annual *earnings per person* in South Africa. Nevertheless, globally the USA does not fare well in terms of the health of their people for the money spent.

Other models of CAs may be found in Africa. In the early 60s, while on holiday in the Caprivi, I was given my first glimpse of *Trypanosoma protozoa*, which is transmitted to humans by the tsetse fly and causes sleeping sickness, by an orderly with little training other than being skilled at identifying these organisms on blood smears. Later during the same visit on the shores of Lake Tanganyika, I watched operations being performed under anaesthetics administered by an orderly who had learned the basic anaesthetic techniques. Two years ago it was my privilege as a member of a team organised by the World Health Organization to evaluate the education of health care workers in Malawi, including doctors, nurses and 'clinical officers'. The latter train in a 3-year programme to work in specific disciplines, such as radiography and orthopaedics. Three points are of note concerning Africa. Firstly, South African health care expenditure per person exceeds the per capita incomes of several countries close to us and we have proportionately

vastly more health care professionals. Secondly, these CAs are generally trained with a focus on a narrow area as described. Thirdly, they tend to become displaced as doctors and others move into their regions.

Another example of extending the reach of professionals is to train 'community care workers' such as the highly successful programmes developed by the Hospice Palliative Care Association of South Africa. Such workers are each able to provide palliative care services to some 10 - 15 patients in their homes, and in turn an appropriately qualified nurse supervises 10 - 15 of them. However, the flawed vision of the DoH is that persons who have attended such short courses focused on specific needs can be used for all-purpose services.

It is clearly possible to train different levels of health care workers. However, the extrapolation of educational offerings from other countries with vastly differing financial and human resource realities, even given local modifications, is seriously flawed.

Where to place them?

The greatest need is in the rural areas. But can CAs work independently? Recent moves imply that they will perform their tasks under supervision of a doctor. But doctors are not present in those areas – ask any community service doctor who battles to get adequate (or any) supervision in larger facilities. Dental therapists were originally envisaged to fulfil the dental equivalent of CAs, but they are in practice in the cities and have their own professional council, and there are constant scope-of-practice boundaries issues between them and dentists. Hardly a promising example!

Curriculum clues

The curriculum provides the best clues for the future of CAs, and it is not promising. Their training period must be short, otherwise doctors or other health care professionals would be duplicated, so it is to be a 3-year university degree. The DoH has hopelessly optimistic views of the knowledge and skills that can be acquired during this period. The training is not geared for skills in a particular discipline and the course is supposed to produce an all-purpose generalist practitioner capable of functioning in all fields. Compare this with physiotherapists, occupational therapists, speech and hearing therapists, etc., who have 4-year studies to adequately prepare them for practice in their respective narrower fields. Doctors cannot achieve overall competence in their much longer courses, hence the 2-year, double-dose internship and continuous studies thereafter.

The description of the CAs' proposed educational process is laced with the current correct jargon. The curriculum is to



be integrated vertically and horizontally. It will be problem based. It will not be tainted by the presence of tertiary services academics, as it will take place at district health complexes. Those who have been involved in the development of curricula of this sort will attest to the need for considerable expertise and resources. The latter are notably absent from these facilities, which are repeatedly reported as having poor facilities and serious staff shortages.

It is envisaged that the CAs will perform a wide range of diagnostic and therapeutic tasks when let loose upon the public. A few samples: Assessing and initiating emergency treatment of acute psychosis, IUCD insertion, abortion, lymph node biopsy, bone marrow aspiration, bladder catheterisation, lumbar puncture, setting of fractures, draining of anal haematomas (I cannot recall seeing one in many years of general practice – and what about the dangers of incising a malignancy instead?), paracentesis, incision and draining quinsy, cricothyroidotomy, pleural tap, blood transfusion, spinal anaesthesia, etc. Within the curriculum it is also intended to provide a pharmacy council-approved course to qualify them for dispensing, thus pipping doctors to this post.

A recurring theme of health care curricula is the problem of overload. Students will positively stagger under the proposed CA programme.

Nursing

When they require care, patients tell us that it is nurses who rank most highly. They are highly skilled and their services are crucial to achieve good health services. However, the WHO has identified serious shortages of nurses in Africa, with brain-drain to developed economies affecting their ranks disproportionately more seriously than other health care professionals. South Africa too has a haemorrhaging nursing service, but we have added to our woes by diminishing training facilities. We therefore have leakage from the top and insufficient replenishing of their numbers. But the nursing exodus is accelerated by lack of appreciation, poor pay and the appalling state of our public health facilities.

Positive actions?

When faced with the sins of omission of the DoH in their refusal to treat patients with HIV/AIDS, civil society, including the Treatment Action Campaign, doctors and other health care professionals, religious groups, trades unions and others

stood up to challenge this – and prevailed. Civil society is not as informed, and does not feel as affected by acts of commission by the DoH, such as the proposed introduction of CAs and the more recent grab for control of the various health professions councils. These nevertheless have serious potential consequences for the professions and for the public they serve. We must not shirk our responsibility to clearly articulate our concerns and if necessary oppose them vigorously.

In determining the world's greatest companies in terms of accountability, *Fortune*¹ uses a scoring system of six categories. The first two are:

- Stakeholder engagement. Does the company engage in dialogue with people who have an interest in, or may be affected by, or may affect, its business?
- Governance. Do senior executives and the advisory board consider stakeholder issues when setting strategy and formulating corporate policy?

The Minister of Health has lacked in terms of these criteria and the medical profession has felt distinctly sidelined. Happily there are promising signs of changes to apply such values by members of the DoH and others in government that are most welcome and require our fullest support and engagement.

While opposed to the introduction of the CA health worker category, SAMA has expressed its wish to be involved in the development of the programme to ensure the best outcome. However, a much better solution would be for the DoH to hear the evidence and genuine concerns of the professions and to pull the plug on this exercise.

HIV/AIDS apart, the most difficult health care issues facing South Africa are the poor state of the public health care facilities and the nursing crisis. Our efforts and resources should be geared towards addressing these. They cannot be escaped by introducing an educationally flawed new health worker category to solve the problems. This is more likely to aggravate them!

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1. Demos T. *Fortune* 2006; 154: 62-66.