



Generalists, specialists or others?

The National Department of Health is flirting with the possibility of introducing 'mid-level' health care practitioners into South Africa. Presumably the idea is to address the paucity of practitioners in the rural areas and to reduce health care costs. Also considered by the Department has been the appropriate ratio between medical generalists and specialists, with thoughts about reducing the numbers of specialists. Elsewhere in the world these matters have been the subject of much debate, planning and policy, with results that often fail to deliver appropriately. In the USA specialists make up over 80% of the medical workforce, while the reverse applies in South Africa — is there an appropriate ratio, and if so how is it determined? And is there a place for mid-level health care workers?

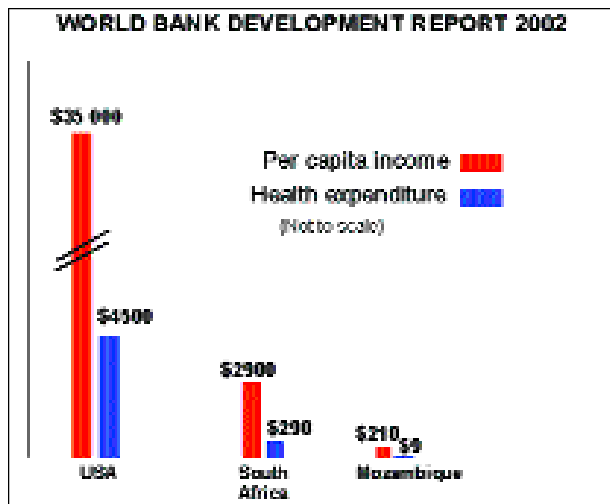
Of primary importance in determining any medical manpower is the financial capacity of the country to carry the costs of the personnel. The training of specialists is lengthy and costly. Specialist services are more expensive and invariably require specialised facilities, equipment and supplies, which add further to costs. Because of these factors and in order to reduce unit costs, specialists must process a large number of patients or procedures and therefore tend to be confined to large towns or cities. The rural areas are thus deprived of specialists — but also of health care workers at all levels!

The specific disease patterns of countries play an equally important part in determining the makeup, education and distribution of health care personnel. South Africa has disease patterns associated with poor countries, including malnutrition, infectious diseases, high maternal and infant mortality and trauma. It also has the burden of diseases of developed countries, including those influenced by lifestyles, and of ageing. Further factors influencing health care manpower are management and infrastructure capacity and emigration.

Rationalising (usually a euphemism for rationing) of medical manpower, as for health care services, is complex and cannot be solved by simple sums. The approach proposed for the rationing of antiretroviral therapy for HIV/AIDS in South Africa by Kenyon *et al.* in the January 2003 SAMJ could perhaps be adapted for the rationalisation of manpower. They address factors such as the number of persons to be served, the types of services to be offered, the budgets required for such services — these to be related to the total spending on care and prevention, which in turn must be related to other health and social spending and their allocative implications.

The importance of financial capacity is evident from the sobering facts provided in the World Bank Development Report 2002 and the WHO World Health Report 2002, which were used to make guided biopsies that graphically illustrate global disparities (see figure).

Using the specialty of ophthalmology to illustrate the theme further: for every 4 million people, Mozambique has 1 ophthalmologist, South Africa has 25 and the USA 200! And to develop the ophthalmological theme further, the 5 main causes of blindness in sub-Saharan Africa are cataract, glaucoma,



onchocerciasis (river blindness), keratomalacia (caused by vitamin A deficiency) and trachoma (chlamydial infection). The latter 3 must be dealt with by good primary health care and public health measures. Cataracts and glaucoma require specific skills, but not necessarily those of an ophthalmologist, as clinical officers who do not have a medical qualification have been successfully trained to deal with them.

Our diagnosis confirms our surmise, namely that there is a direct relationship between the financial capacity of a country and the proportion of specialists. Resource-restricted countries may provide skills to meet their specific health care needs by training other categories such as clinical officers or medical assistants. But specialists are required to train such categories and to provide a higher level of care. As illustrated by the number of ophthalmologists in Mozambique, the emigration of just one specialist could have a devastating impact.

There is evidence that systems failure rather than inappropriate health care training bedevils South Africa's health care. Dabbling in potential new job categories when it is unclear what could be provided that is not already within the scope of nurses and doctors, further stretches our organisational and educational capacity. We would be better served by concentrating on improving the health care systems and the training and retention of existing categories of health care personnel. This includes specialists, whose reduction without good supporting evidence is ill advised.

Any medical expertise lost results in the dumbing down of our health care services.

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