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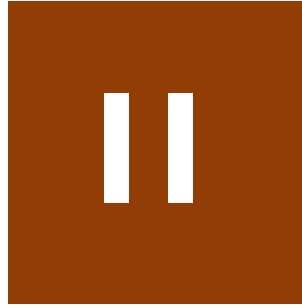
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mid-level

Authors

Abstract

This chapter discusses the need for mid-level workers. It compares the recommendations regarding mid-level workers of the Pick Report on Human Resources (2001) with the current situation. It then gives an overview of developments on a range of mid-level health workers and makes some recommendations regarding these.

health workers in South Africa

not an easy option

Introduction

The role and usefulness of mid-level workers is a topic of diverse opinion and disagreement. 'What is this animal?' is an unfortunate question often heard in discussions on the topic.

Medical assistants (MA) played an important role in the health care of South Africans (e.g. in Tanzania) during the armed struggle. In the ANC camps a system of medical assistants and referrals to the few doctors developed. This system contributed to health care.¹ During this time a debate took place in South Africa (SA) on how to address the shortage of doctors in the neglected rural areas² and a MA cadre was proposed by rural doctors.³ In the prevailing separate development ideology, allied to the strong antagonistic position taken by the nursing profession, this idea was shelved. It was replaced by a separate medical school for blacks to address the shortage of doctors.⁴⁻⁶

In developed countries like the USA, mid-level medical workers in the form of physician assistants are interdependent, semiautonomous clinicians practising in partnership with physicians.^{7,8} They are capable of giving care comparable to that of physicians and share improved access to health care for populations in rural, inner city, and other medically under-served areas. A similar system has been proposed in the United Kingdom.⁸

In African developing countries, various models of substitutions have been used. The documentation and evaluation of these experiences is quite limited. However, the general perception of the use of substitutes for doctors has been quite positive. They have been a stabilising factor in health services and rural and peri-urban deprived communities have had better access in countries like

Tanzania where clinical officers continue to be the backbone of human resource for health.^{9,10}

A quote from a review of substitute workers in Africa indicates why mid-level workers are on the agenda.

"Substitute Health workers, especially as used for doctors, professional nurses, pharmacists, laboratory technologists, radiologists,...is clearly an essential option for African countries. Even richer countries such as South Africa and Botswana, are experiencing quite high emigration rates and indeed are considering the introduction of Medical Assistants into their health systems, especially for rural health services. Special effort needs to be made to build up this aspect of the workforce into the formidable force..."⁹

Mid-level health workers seems to reflect the realities of developing countries and are able to respond to local needs and resources.^{11,12}

The Pick Report

The Pick Report of 2001 is the one policy document about Human Resource (HR) Planning that communicates an official opinion about HR planning in SA.¹³ In this report the Primary Health Care (PHC) package is taken as a point of departure for planning human resource provision for SA.

The report recommends that the scope of practice be defined for each professional group in order to reduce overlap between these groups. It proposes a narrower defining of the scopes of practice of professional groups but a broadening of the scope of practice of 'lower levels' of

health workers. This is different from an approach to have a more focused, narrower scope of practice for mid-level workers where a limited number of skills can be taught and practised adequately. It is more difficult for a person with less training to render services over a wide range of activities compared to a person trained for very specific tasks of a routine nature.

The report states that cooperation between professionals, professional councils and labour unions is necessary, but it contains very little if anything about teamwork and a team approach. Table 1 contains more details.

	Pick Report Recommendations	Situation in 2005
Nursing	<ul style="list-style-type: none"> ✧ Expand the scope of practice of the enrolled nursing assistant including immunisation and the administering of prescribed medicine. ✧ Enrolled nursing assistant and enrolled nurse training be increased and not phased out. ✧ The enrolled nurse / nursing assistant: professional nurse ratio increased to 2:1. 	<ul style="list-style-type: none"> ✧ According to the statistics from the Nursing Council, the number of enrolled nursing assistants declined steadily from around 52 000 in 1996 to 45 000 in 2002. In the last two years there has been an increase and by 2004 there were around 51 000 enrolled nursing assistants.¹⁴ ✧ The ratio of nursing assistant to professional nurse is 1:2. ✧ The scope of practice of the enrolled nursing assistant is being reviewed by the Nursing Council. In the new draft regulations that would follow on a new Nursing Act, the enrolled nursing assistant will be able to function independently and take responsibility and be accountable for his or her own actions.
Dental / Oral Health	<ul style="list-style-type: none"> ✧ Single dental auxiliary be created. ✧ Expanding the scope of practice of the dental therapist by caring for wounds, place sutures and place pre-activated orthodontic appliances. 	<ul style="list-style-type: none"> ✧ The single category dental auxiliary has not materialised and no action seems to be happening in that regard. ✧ There are 418 dental therapists registered with the Health Professions Council of South Africa (HPCSA) but only 137 are employed in the public service. There are 314 posts in the public service.^{15,16} ✧ No changes in the scope of practice of the dental therapist are being planned.
Pharmacy	<ul style="list-style-type: none"> ✧ Expand the role of the pharmacist assistant to include the dispensing of medicine. 	<ul style="list-style-type: none"> ✧ Pharmacy legislation has provided for 2 categories of pharmacist's assistants – basic and post basic level ✧ An appropriate scope of practice has been developed for each cadre. ✧ Training and assessments are carried out in practice sites approved by the Pharmacy Council. ✧ Accredited private providers now cater for all such training in SA. ✧ There are currently 3 063 pharmacist's assistants or learner assistants registered with the Pharmacy Council. They work in private and public sector.
Radiography	<ul style="list-style-type: none"> ✧ Service provided by nurse radiographers or mid-level health workers (radiography assistants). 	<ul style="list-style-type: none"> ✧ 270 Assistant radiographers are registered with HPCSA.¹⁵
Multi Skilled Mid-level Worker	<ul style="list-style-type: none"> ✧ A new category of multi-skilled mid-level health care worker to be created. ✧ Report does not mention the community rehabilitation worker as a mid-level worker. 	<ul style="list-style-type: none"> ✧ The community health worker developments can be regarded as the development of a multi skilled mid-level worker. ✧ The programme to train and provide a multi skilled rehabilitation worker (viz the Community Rehabilitation Worker) has been stopped in favour of discipline specific rehabilitation workers (e.g. physiotherapy technicians) namely occupational, speech and physiotherapy technicians. These programmes have failed to materialise.

Source: Pick Report, Department of Health; 2001.

Table 2: Registration numbers of mid-level health workers and professionals¹⁴⁻¹⁶

Mid-level category	Number registered	Professional category	Number registered	Ratio Mid-level : Professional
Enrolled Nursing Assistant	47 431	Registered Nurse	96 715	1:2
Dental Therapist	418	Dentist	4 492	1:3
Oral Hygienist	924			
Occupational Therapy Assistant	525	Occupational Therapist	2 781	1:5
Physiotherapy Assistant	274	Physiotherapist	4 716	1:17
Supplementary Diagnostic Radiographer	270	Radiographer	5 161	1:19
Community Speech and Hearing Worker	42	Speech therapist and audiologist	1 394	1:29
Speech Therapy Assistant	6			
Registered Counsellor	61	Psychologist	5 668	1:92

Source: SANC: 2004; HPCSA: 2005; DoH 2004.

There is a wide variation in the ratio of mid-level workers to professionals. These are highlighted in Table 2. The range is from 1:2 in nursing to 1:92 in psychology. Pharmacists and associated mid-level worker are discussed separately in chapter 12 of this Review.

Current and proposed mid-level health worker categories

As shown in Tables 1 and 2 there are a wide variety of mid-level health workers in SA. The next section reviews some of the different types of mid-level health workers.

Community Rehabilitation Workers

In 1988 it was decided that there was a need for a multi-skilled mid-level rehabilitation worker. In collaboration between Occupational Therapy, Physiotherapy and Speech Therapy, university departments and the DoH, a two year pilot project trained around 170 Community Rehabilitation workers to work at the community level.

Despite the successes of the programme and ongoing consultation between professional groups, DoH, communities and clients the training was stopped in 2003. The Professional Boards felt that a discipline specific mid-level worker should replace the Community Rehabilitation Worker and provision has now been made for separate mid-level workers in Occupational Therapy, Physiotherapy and Speech and Hearing Therapy. Some of the reasons for this decision include:

- Professional protectionism and a lack of willingness to share skills across disciplines.
- The difficulty of registering a worker with multidisciplinary skills and deciding which professional group should take responsibility for his / her supervision.
- Lack of recognition of the need for assistance at the community level where people with disabilities are unable to get rehabilitation support.
- Lack of clarity from the DoH regarding the existence of and categories of mid-level workers.
- The separate boards in HPCSA for occupational therapy, speech therapy and physiotherapy.

This will probably result in a deterioration of rehabilitation services to the rural people where the programme operated.^a

Occupational Therapy mid-level workers

Following the discontinuation of the generic Community Rehabilitation Worker programme in favour of a discipline specific mid-level worker, the Occupational Therapy and Medical Orthotics / Prosthetics Board of the HPCSA (OT Board) developed a comprehensive approach to the mid-level worker in occupational therapy. The OT Board decided on the creation of two levels of workers. These are the Occupational Therapy Auxiliary Worker (OTA) and the Occupational Therapy Technician (OTT). Registration as an OTA requires one-year of training while the OTT involves a

^a Personal communication Majorie Concha.

two-year training course. Both can work in the private, public or NGO sectors.¹⁷

Some concerns of the OT Board included:

- The limited availability of supervisors and the implications of limited or lack of supervision for service provision to patients.
- The apparent limited training of occupational therapy students to equip them to supervise effectively, and subsequent limited supervisory skills.
- The limited awareness of occupational therapy practitioners of rules and guidelines for supervision of OTA / OTTs.

These concerns were translated into a comprehensive set of policy documents that spelt out the details of:¹⁸⁻²²

- Policy
- Scopes of practice
- Core skills
- Supervision
- Guidelines and responsibilities

Specific points of interest from these documents include:

- The policy allows for the mid-level worker to assist the professional therapist under supervision.
- The training is based on **discipline-specific** basic and advanced knowledge and skills (70%), **community development** and **community based rehabilitation** (20%), as well as certain **generic skills** (10%).

The principle of career path development of OTAs and OTTs into the full OT degree course training is supported. However, in practice this is not possible under the current curriculum structure.

The new two-year courses for OTTs have not yet commenced. This is partly because funding is not available and partly because there is no clarity as to where the courses will be offered. One way to fund the courses is through learnerships from the Health and Welfare Service Sector Education Training Authority (HWSETA)

- The scope of practice spells out in detail the differences between the OTAs, OTTs, Community Rehabilitation Workers and the fully qualified OT.
- The supervision of mid-level workers is described in detail and includes close supervision (face-to-face), routine supervision once a week and general supervision once a month. Ways to train occupational therapists for supervision and guidelines for when supervision is

not available are described. The relationship between therapist and assistant is often difficult and the detailed description of supervision assists in this relationship.

- The responsibilities of employers regarding mid-level workers are described.

The documents produced by the OT Board were circulated. Following this, a workshop and talks with DoH were planned in 2004, these did not materialise.^{23,24} The discussions between the different rehabilitation boards did not produce results and they were unable to make progress.

There is long-standing unhappiness amongst OT assistants, relating to the perception that they do much of the work without recognition and appropriate remuneration.

Assistants who trained as multi purpose workers are now frustrated because they are being pushed back into discipline based work. Frustration also results from supervision by community service therapists who have very little experience in running rehabilitation services, especially in rural areas.

Despite good and thorough documentation of the process to create a mid-level OT worker, poor communication between the OT Board, the DoH, training institutions and employment agencies, the outcome has not been positive. Successful training courses were stopped and have not yet been replaced. Differences in opinion about the need and place of mid-level workers in rehabilitation between key stakeholders contributed to the situation. A future strategy would have to address issues of posts, post levels, career structures and the funding of training. It is hoped that the awaited human resource plan of the DoH will address these issues.

Physiotherapy mid-level workers

There are 274 registered Physiotherapy Assistants.¹⁵ The Professional Board for Physiotherapy, Biokinetics and Podiatry of the HPCSA is discussing the creation of a physiotherapy technician register. These technicians would have a two-year training and they would function under supervision of a physiotherapist. The University of the Witwatersrand developed a one-year Diploma course in Therapy Assistance in order to upgrade Physiotherapy Assistants to Technicians, qualifying with a two-year training programme. However in 2003, the Minister of Education resolved that qualifications leading to an undergraduate Diploma or Certificate would no longer be presented by Universities and had to be offered by the Institutes of Technology (previously known as Technikons). The Institutes of Technology did not regard this to be viable as the students had to be in posts and large

numbers of students had to be trained at a time in order to be cost-effective.²⁵

The Professional Board planned to meet with the DoH to discuss the creation of Physiotherapy Technician posts as well as the training and upgrading of physiotherapy assistants to physiotherapy technicians. At the time of writing, there is no indication of when this will happen.

Mid-level Worker in Speech and Hearing Therapy

There are 42 Community Speech and Hearing Workers and 6 Speech Therapy assistants registered with the HPCSA,¹⁵ while 362 posts for Community Speech and Hearing Workers exist in the public service.¹⁶ No training courses are registered with HPCSA for these categories, but the Board for Speech and Hearing Therapy is working on unit standards for the training of speech therapy assistants. The Board acknowledge the need for speech therapy assistants but is hesitant to develop the structured training before there is clarity about posts. They plan to discuss this with the DoH.

Environmental Health Assistants

The Board for Environmental Health developed draft regulations for the creation of a category of Environmental Health Assistants. This is aimed at registering people who already work as assistants in the field. No training for this category exists at the moment.

Mid-level Worker for Psychology: Registered Counsellor

The mid-level worker for Psychology has been identified as a registered counsellor. The Professional Board of Psychology of the HPCSA developed a framework for the Education, Training and Registration of a Registered Counsellor. The scope of practice refers to "more formalised, structured and short term interventions at primary care / prevention levels."²⁶ In the document the core competencies of registered psychologists as well as registered counsellors are described. The differences between the two categories are related to:

- The depth of assessment, screening, diagnosis and intervention.
- Referral expertise where the registered counsellor refers to primary care practitioners in health and workplace and to psychologists while the psychologists refer to practitioners at primary, secondary and tertiary levels. Another difference is that psychologists can design full intervention programmes while registered counsellors can only design sections of an intervention programme.

Training programmes are registered with the Board at a wide range of universities. The first students, 25 at the University of Pretoria, completed their training in 2002. The training programmes are presented in a number of departments including Industrial Psychology Education.

The regulations for registered counsellors were published in December 2003.²⁷ The regulations state that registered counsellors can only work in the public or NGO sector despite the initial concept and planning being that these practitioners would function in both the public and private sector. Not all the practice areas are applicable to public and NGO services (e.g. sport counselling). In addition no posts have been created for this category of mid-level worker in the public service. That means that people who have completed training cannot find employment. A group of students who completed their studies have now initiated court action against the HPCSA, the university and the DoH. The apparent reason is that expectations were created about a career and employment and that did not materialise.

A large amount of work was done by the Board for Psychology, 23 training institutions and hundreds of students. However, the programme has been interrupted because those who have passed the course can only function in the public or NGO sectors as no posts were created in the public service.

The four-year university training for the status of a mid-level worker with limited practice is a concern. This contrast with professional nursing and degrees in therapy where a four-year degree would give someone an independent profession.

Mid-level Worker in Dentistry

Dental Therapists have been trained since 1975 at the Medical University of Southern Africa (MEDUNSA), University of Durban Westville (now the University of KwaZulu-Natal – Westville Campus) and the University of the Western Cape. The aim was to train dental workers for rural and under-served areas. MEDUNSA used to produce 35 Dental Therapists per year and University of Durban Westville 10 per year. Since 2003 MEDUNSA has reduced the intake to 15 students per year.

The initial aim of the programme was to increase rural people's access to oral health. From the start of the programme there were insufficient posts in the public service and the then Medical and Dental Council allowed dental therapists to work in private practice. This resulted in competition between dentists and dental therapists and concerns about

the quality of care provided by dental therapists in private practice.

Many of the dental therapists who did not get jobs drifted to the urban areas. A study in a 2003 found that close to 80% of dental therapists live in urban areas; 70% of them went on to become dentists; and several of them went into health management positions.^b

The situation became more difficult with compulsory community service for dentists. Newly qualified dentists work in rural areas in the country and there is more pressure on the availability of posts.

At the moment only 137 of the 418 dental therapists are in public dental service.^{15,16}

A separate board in the HPCSA was created for the dental therapists and oral hygienists. That means that two different boards in the HPCSA regulate oral health. There are discussions between the two boards to look at collaboration and the possible creation of a single board for oral health.

Many students in dental therapy want to become dentists but usually do not have the required matric grades to qualify for the dentistry dental course. When they are admitted into the full dentistry course after working as dental therapists, they have performed well. With the present integrated course in dentistry, dental therapists have to start the dentist course in the first year which makes their overall training long and expensive.

These developments contributed to the decision at MEDUNSA to reduce the number of dental therapist students from 35 to 15 per year.

Oral Hygienists

Oral hygienists complete a two-year diploma course and work in the public and private sector. There are 924 registered at the HPCSA.

Ophthalmologist Assistants

An interesting situation exists in ophthalmology where lay workers have functioned as assistants to ophthalmologists for many years. These assistants work under supervision of the ophthalmologists. Since 1992, the Ophthalmology Society of SA (OSSA) has developed courses for these workers.

The following prerequisites exist for the training:

- Matric school qualification

- At least three years full time work with an ophthalmologist in a clinic or consulting rooms.

The training is done by the Pretoria Eye Institute on behalf of the Ophthalmology Society of South Africa. The theory is offered as distance learning and the learners do the practical aspects of the course whilst working with an ophthalmologist.

Level I and II courses exist and a level III course has been developed. Since 1994, a total of 302 candidates completed Level I and 170 completed Level II courses. The multidisciplinary team and teamwork is addressed in the course. These courses have been reviewed by the Optometry Board in the HPSCA but were not approved, as there are concerns that the scope of practice of these assistants overlaps with that of optometrists. A meeting between course organisers and the DoH is planned to discuss the situation.

The ophthalmologist assistant is an example of an apparently successful mid-level medical worker that fits into the multi-disciplinary team, makes an important contribution to patient care and where the training is well established. It is also an example of a mid-level worker that functions in a limited but well-defined field.

Emergency Care Workers

Emergency care workers are an example of a successful development of mid-level health care programme.

The training time of emergency practitioners are as follows:

- Basic ambulance assistants: 4 weeks
- Ambulance Emergency Assistants: 6 months
- Paramedics: 9-12 months

Further training is via a National Diploma (three years) and a B Tech degree (four years), but these do not change the registration category of the worker.

These practitioners function well in private and public services and fit in well into emergency care teams. They play a critical role in the development and management of emergency services.

Mid-level Medical Workers: Medical Assistants From 2000 to 2005

No specific mention is made about mid-level medical workers in the Pick report. In December 2002 MinMec (now called the National Health Council) took a decision that mid-level medical workers should be developed for SA. This decision was confirmed on 8 January 2004.

^b Personal communication: T Gugushe, Dean - Faculty of Dentistry MEDUNSA; 2005.

In July 2003 a delegation from the DoH and HPCSA visited Tanzania and USA to look at mid-level medical workers in those countries. The reports following these visits suggested that a mid-level medical worker programme in SA would work but that it needed to be developed uniquely for SA.²⁸

A task team from DoH consulted various stakeholders in 2004 about the implementation of a mid-level medical worker programme and the Minister of Health launched the programme at a conference in March 2004. The conference served as a consultation with stakeholders and was well attended by all the medical schools, several statutory councils, professional organisations, departments of health and speakers from USA and Tanzania. The conclusion from the conference was that the work must continue. The first task was to finalise the scope of practice and develop a national curriculum and training programme. Human resource planning and funding for the programme needed attention. A further meeting was held in November 2004 to discuss the scope of practice.

The Madibeng Centre for Research is doing a rapid appraisal of the task gap and common conditions in district hospitals in SA for the DoH. This study should inform the scope of practice, curriculum and courses for medical assistants in district hospitals in SA.

When the discussions started in 2003, there was widespread opposition to the concept of a medical assistant. Subsequently many role players in the statutory boards, medical faculties, health services and professional organisations now actively support the concept. This has created a situation where a programme can now be developed with much more acceptance and collaboration from key stakeholders.

There are a number of issues regarding the medical assistant where there is a high degree of consensus. These include:

- ▶ The name of the mid-level medical worker is to be a Medical Assistant. This name communicates clearly that this health worker will assist medical doctors and that they will not work independently.
- ▶ MAs to be developed to assist doctors in district hospitals in rural and urban areas. Primary Health Care Nurses function in district clinics and health centres as clinicians. Keeping MAs in district hospitals will avoid overlap and uncertainty with PHC nurses.
- ▶ The MA will work closely in a team with the doctor, under supervision of the doctor and will not replace the doctor as an independent worker. There are too few doctors in district hospitals and the workload is too high. A well trained MA working with the doctor

in the district hospital can be very effective and relieve both the doctor and the nurses from routine procedural work.

- ▶ MAs should be trained in Family Medicine Training complexes linked to medical schools. Medical schools already have the infrastructure to do the training needed for MAs. Family Medicine Training Complexes are being developed throughout the country in under-served urban and rural areas. These training complexes develop the capacity to do undergraduate, intern and postgraduate and PHC nurse training in primary care and district health and will be able to incorporate MA training.
- ▶ Regulation of MAs to be at the HPCSA via the Medical and Dental Professions Board.

A team from the Family Medicine Education Consortium (FaMEC) is presently working with DoH to develop the academic aspects of the programme including the curriculum and a training programme. Other teams are looking at management issues, stakeholder liaison and implementation of the programme.

Issues related to mid-level workers

There are a number of generic issues related to mid-level workers.

Level of training

Training ranges from four weeks for ambulance assistants to a four-year university course for registered counsellors. If the level of training is too high, it creates too small a gap between the mid-level worker and the professional and causes difficulties in terms of scope of practice, competition and remuneration (e.g. Dental Therapy and Psychology).

If the level of training is too high, a person would rather do the full professional training. If the training is too brief, the person cannot really provide a useful service.

Working while training

The nature of work of mid-level workers is mostly about assisting with practical skills. Working while in training is important to ensure appropriate skills learning and teamwork. The programmes where the learner works actively whilst training, (e.g. pharmacy, ophthalmologist assistant) appear to be the most successful.

Critical difference at level of clinical reasoning

The most complex part of the task of a professional is clinical reasoning, which includes the assessment of the patient or a situation and the decision about intervention. This can be regarded as a critical difference between a mid-level worker and a professional.

Career and training laddering

Career laddering is an important issue due to the South African Qualification Authority (SAQA) approach, but in practice it does not seem to work.

Acceptance from professionals

A certain amount of acceptance from the professions involved is critical for a successful mid-level programme. There is resistance from professional groups to mid-level workers, either from the same professional group (doctors for medical assistants) or from related professions (e.g. optometry for ophthalmology assistants, nursing for medical assistants). A wide enough gap between the assistant and the professional helps in this regard and replacement of a professional by a mid-level worker creates difficulties. Clearly defining the scopes of practice goes some way to address resistance, but teamwork and relationship issues are important to address the concerns of professionals and work out effective ways of care.

Teamwork and relationship between mid-level worker and professional

Teamwork is critical for functional health teams. It is even more important where mid-level workers are concerned. The only programme where teamwork and team issues are addressed specifically is in the ophthalmologist assistant programme.

In the USA, there is a clear defined relationship between physician assistants and the doctors they work with, as well their interdependence. Physician assistants are taught about teamwork and communication.⁷

Supervision

The relationship between the mid-level worker and the professional is only described in terms of supervision. In the Occupational Therapy documents this is spelt out clearly and it assists in the relationship. Supervision can be seen as a way of control and taking responsibility. It can also be a way to satisfy the professional lobby and to protect the profession. Supervision, to be functional, should also be

worked out in terms of teamwork, guidance and mentoring. The level of supervision and what to do when a supervisor is not available also needs attention.

Scope of practice

Scope of practice, differences between scopes of practice and supervision are used as a way to describe and regulate mid-level workers.

Mentorship, guidance and flexibility

Mentorship, guidance and flexibility are important aspects of functioning between mid-level workers and professionals. Very little evidence of these was found in this review and it clearly needs more emphasis.

Replacement or assistant

Is the mid-level worker there to replace the professional in areas where it is difficult to get professionals to work, or are they assistants to professionals who work in these difficult areas? This question is fundamental and requires answering.

Generalist vs focused routine tasks

The approach to have a general mid-level worker replacing various professionals in areas of need is different from a focused approach where the mid-level workers are taught to assist the professional with specific routine tasks. Generalist skills are complex and require the ability to function with a large amount of uncertainty while doing a limited number of routine repetitive tasks is easier and needs less training. The latter is more appropriate for mid-level workers.

Employment and remuneration

The creation of employment possibilities and posts is critical. Trying to limit mid-level workers to the public service creates problems. Mid-level workers function in public, private and NGO sectors. Synergy between these sectors enhances the chances of success. (e.g. pharmacy and ophthalmology assistants). Currently there are large difference in the post levels and remuneration among mid-level workers in different disciplines.

Funding of training

Funding mechanisms for training need to be clearly worked out to enable appropriate training. Possible sources of funding include the HWSETA and the Department of

Education.

Qualifications

The nature of training is often at a technical level and diplomas and certificates are often the appropriate qualifications. When training is best done at university, the issue of a diploma qualification at university level creates a stumbling block. It is important that mid-level workers and professionals learn together and the issue of qualification should not lead to separate training.

Synergy between role players

Complete synergy is needed between the HPCSA, DoH, Department of Education, employers and training institutions to ensure success. This seems to be absent in many of the programmes.

Build on existing and emerging processes

Effective programmes often emerge from existing processes rather than major preplanning and regulation which can lead to problems around implementation. A developmental approach with slow progression, multiple levels, review and adaptation can be considered in the development of mid-level worker programmes (e.g. the pharmacist's assistant).

Absence of evidence about impact of mid-level workers

There are no examples of studies that attempt to assess and document the impact of mid-level workers in health care delivery in SA. Work in this regard, especially the effect on equity and improved quality of care, is needed to justify the resources spent on programmes. Well designed and well funded studies are needed.

Recommendations

It is proposed that the DoH commissions a comprehensive audit of existing programmes including successes and failures.

A National Framework can then be developed with input from stakeholders including the departments of Health, Education and Labour; private, public and NGO service providers; universities and statutory councils; professional bodies, labour unions and functioning mid-level workers and professionals. This should fit into the National Human Resources for Health Plan. Individual mid-level programmes can then be developed further from the present realities, the

proposed framework and taking all the issues described above into account.

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