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MIDLEVEL MEDICAL WORKER PROGRAMME

To the editor: The debate on the issue of midlevel medical workers is important. I confess that I have doubts about the planned midlevel medical worker. I am not sure this is the best solution for the problems of health care in rural areas in South Africa. It seems like an admission of defeat. I am very concerned about the rate at which the programme is being pushed, without the intense thought and negotiation around it that there should be, and without us exploring different solutions to the problems. I am also concerned about the possibility of third rate care being delivered to rural citizens.

At the same time I recognise there is a gap which needs to be filled in some way. This gap is in rural district hospitals which struggle along in continual crisis, with never a hope of recruiting or retaining enough doctors. I am also aware that the plan to introduce midlevel medical workers has come from the highest level of government. If it is going to happen then I think it is important to be involved. To fight what is inevitable will mean being labeled as obstructionist and will deprive us of the opportunity to influence the process and the outcome.

It is important that these workers are placed in district hospitals as their prime area of functioning. I propose the name of clinical assistant for such a worker, emphasising their place as assistants to doctors and their primary clinical role. I do not think that the process of training primary health care nurses for clinics should be stopped as they play an important role, a role that should be reinforced and supported by doctors and particularly family physicians.

The question of whether these assistants will be trained for specific units (e.g. for theatre as anaesthetic assistants, or for the emergency unit as a kind of paramedic) or will be trained as generalists needs to be addressed. One of the problems I have with the current therapy assistant programmes is that these are discipline-specific, whereas the district hospital context is much more generalist and non-disciplinary, and team work is important.

I think the context of training is important and the approach of problem- and patient-based learning is appropriate. As much of the training time as possible should be spent in district hospitals.

The assistant must have a clearly prescribed range of skills, which can be built on for specific contexts, and be given specific tasks in support of hospital doctors, mainly in terms of procedures, but also assist with consultations and ward rounds under supervision. The assistant must be a good recogniser of patterns, must know how to deal with uncertainty, and must have clear guidelines and protocols to follow.

It is vital to get input from other members of the team. Community and primary health care nurses are very concerned about discussions regarding midlevel medical workers.

To implement the proposal, additional money must be allocated from the National Treasury. The Department of Health has historically always implemented new programmes on existing budgets, creating major problems. The ARV roll out is one of the first where this does not apply, but even in that regard the plan requires much more money than Treasury has allocated. Programmes such as free treatment for the disabled, free treatment for children and pregnant women, abolition of fees in clinics, additional immunizations, etc, were largely implemented without any increase in budget or special allocation of funding in each case. These were all good programmes but they have placed extra burdens on the resources at the hospital and district levels, with negative consequences.

Additional training resources also need to be allocated to this. The provincial departments of health cannot expect this to be done under the present budgeting frameworks and the present conditional grant structures.

It is important to get this programme right, even if it takes valuable time. I would hate to see training being set up only to be abandoned after a few years, as is happening with the community rehabilitation worker programme. The proposal to implement this very quickly, selecting the first students in September 2004, is totally unrealistic. If this process is worth doing, it is worth doing properly. I hope then we can achieve a midlevel medical worker programme that best fits our context and our needs.

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