PRIMARY CARE CLINICIANS A MEDICAL MANPOWER OPTION

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SOME DEFINITIONS

PCC, PHCN and HE

A primary care clinician (PCC) will be a medical service provider with clinical skills who will be registered with the Medical and Dental Professional Board [MDPB] of the Health Professions Council of South Africa [HPCSA] to provide primary medical care only.

A primary health care nurse (PHCN) is a nurse trained in clinical skills who provides a medical service and is registered with the South African Nursing Council.

A health educator (HE) will be a health worker registered with the HPCSA trained to educate lay people about health and disease and to assist in patient care.

The problem

- a shortage of appropriately trained and competent medical service providers in primary [first contact] medical care in the:
  - public sector in urban and rural areas
  - private sector in poor and rural areas
- the current primary care paradigm
- limited economic resources

How to correct the shortage of medical service providers in primary medical care in the public and private sectors

more of the same within the current paradigm

OR

a different community oriented paradigm with

two new categories of medical service providers and

no PHCNs or nurses as medical service providers

The current position - I
primary care in the public sector

medical service providers:

- doctors and PHCNs
- where neither are available
  - other nurses and midwives [not trained in medical care]
  - environmental health officers, community health workers

assistants: other nurses, interpreters, ...

<u>doctors act as supervisors and consultants</u>

process: first come, first served - “NEXT”
no or limited continuity of care
sequential service with many Qs
no family or community commitment

The current position - II
polyclinics in the private sector

medical service providers:

- doctors
- PHCNs and registered nurses [not trained in medical care*]

assistants: other nurses, midwives, interpreters, ...

doctors act as supervisors and consultants

process: first come, first served - "NEXT"
no or limited continuity of care
sequential service with many Qs
no family or community commitment

* not acceptable in law

The current position - III
single or group private practice

medical service providers:

- doctors

assistants: nurses, interpreters, receptionists, …

usual or best practice:

- patients seen by appointment
- continuity of care
- family commitment
- optional home visits
- no community involvement

Dispensing - current position

- public sector - hospital-based polyclinics

  urban: semi-retired pharmacists and pharmacy assistants
  rural: pharmacy assistants and lay workers

- public sector - other clinics

  urban and rural: assistant nurses and medical care providers

- private sector practices and clinics

  urban private practice: independent pharmacists mostly
  rural private practice: dispensing doctors mostly
  group practices: independent pharmacists, dispensing doctors or in-house pharmacists

An alternative in both sectors of primary medical care

medical care providers:

- primary care clinicians and doctors*

other service providers:

- midwives
- health educators

<u>working as a team - no assistants</u>

process: continuity of care
one-stop unified comprehensive service
family and community commitment

* dispensing by medical care providers unless pharmacist accessible

Continuity of personal care, one-stop service and team-work

These medical service providers “could share administrative, computing, prescribing, audit, and educational support with each other within primary care [service units] but would offer a more personal and individual service. The evidence is that patients prefer this kind of organisation and would probably have better medical outcomes from it.”

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Doctors not a medium to long-term human resource option - I

new graduates:

- there are not enough training institutions for medical students in the country
- academic entry criteria are high
- the training period + internship is very long
- the course is too expensive for most applicants and for the country as a whole

Doctors not a medium to long-term human resource option - II

SAn registered medical practitioners:

- poor response to past appeals
- unwilling to work in under-served areas
- licensing* private practice may be unconstitutional

in addition:

- there will not be enough doctors
- specialisation and emigration are attractive and feasible alternate options

* government proposal to force doctors to practice in under-served areas – not implemented

Doctors not a medium to long-term human resource option - III

foreign-born and foreign-trained doctors:

- there will not be enough of them
- they may be inappropriately trained
- registration with the HPCSA may be difficult
- some will be unfamiliar with local culture and language/s
- some would have to become South African citizens
- restricting these doctors to primary care in under-served areas may not be sustainable nor constitutional
- relationships with other countries, whose medical graduates South Africa could be poaching, would be compromised

PHCNs not a medium to long-term option

No more PHCNs should be trained because:

- registered nurses should not be removed from nursing
- there is already a shortage of nurses in the country
- the pool of recruits to nursing is small and shrinking
- the basic training and experience of nurses is not appropriate to medical practice
- the total period of training of old-type PHCNs is too long
- fast-track trained new-type PHCNs may not be competent to function independently and safely
- either way the training of PHCNs is not standardised
- PHCNs are registered as nurses but act as doctors
- PHCNs are not formally accountable for their actions

Other nurses NOT a medium to long-term option

It is inappropriate and may be dangerous to use registered nurses who are not PHCNs and who are not trained in medical skills as medical practitioners. Using unregistered nurses is even more so.

Nurses are trained to be nurses. They should not be trained in one discipline (nursing) to be used in another discipline (medicine).

Other categories of “health” professionals/workers also not a medium to long-term option

The use of pharmacists, environmental health officers, homeopaths, community health workers, and other “health” professionals/workers who are not doctors as medical practitioners cannot be a medium or long-term solution.

The reservations on foreign doctor recruits apply also to medical auxiliaries* from other countries.

* This presentation was prepared before SA started training its first medical auxiliaries: clinical associates who work with in-patients

PCCs could be a medium to long-term human resource option

This new category of <u>medical</u> service provider, provisionally called a Primary Care Clinician [PCC], could be trained and deployed to meet the medium and long-term need for primary medical care personnel. This is further discussed here.

Role of PCCs

they would function only at the personal primary first contact care level

- to protect health and prevent disease
- to cure disease where possible
- to control disease where cure is not possible
- to promote convalescence and rehabilitation
- to reduce pain and distress
- to provide first aid and emergency care

Scope of practice of PCCs - I

- attend to personal medical needs (medically examine, diagnose, perform tests, and treat)
- work in out-patient settings and on house-calls
- care for patients suffering from uncomplicated common conditions
- prescribe and dispense medicines
- perform minor surgical procedures appropriate to an out-patient setting
- monitor normal pregnancy
- act as gate-keepers for doctors, therapists, and other “health/disease” service providers
- participate in developing community programmes

Scope of practice of PCCs - II

Primary care clinicians will <u>NOT</u>:

- work in an in-patient setting
- care for patients with complicated conditions
- perform abortions or assist in birthing [deliveries]

Non-medical PCC competencies

- understanding people and society*
- language and numeracy
- collecting and evaluating data
- communication and patient counselling
- nutrition, dietetics and home budgeting
- achieving and maintaining their own health

* social and family dynamics, the psychology and sociology of sexuality, violence and substance abuse, the social and economic determinants of health and disease

Medical PCC competencies

- first aid and emergency care
- health promotion and protection
- diagnosing and treating common conditions
- performing, ordering, and interpreting special tests
- prescribing and dispensing medicines
- referring patients to other levels of care
  and to other disciplines

Non-medical curriculum

- English language and mathematics
- social anthropology and local history
- medical sociology, demography, and ecology
- epidemiology, biostatistics, and medical informatics
- nutrition, dietetics and home economics
- psychology and sociology of violence and substance abuse
- family dynamics and parenting
- counselling and communication skills
- administration and management
- medical ethics and law
- physical fitness training and relaxation techniques

Medical curriculum

- first aid and emergency care
- anatomy, physiology and pathology
- pharmacology and drug supply management
- medical care of common diseases and mental disorders
- infant, child and adolescent growth and development
- genetics and sexuality
- contraception and midwifery
- geriatric care
- environmental and occupational health
- intermediate medical technology
- selected surgical procedures
- dental health and hygiene
- psychotherapy and physiotherapy

Examples of common conditions that would be managed by PCCs

acute conditions:

respiratory tract infections, gastro-enteritis, intestinal parasitic infestations, dyspepsia, STDs, other genito-urinary tract infections, conjunctivitis, skin infections, locally endemic infections such as malaria, joint and muscle strain, minor cuts and abrasions, ...

chronic conditions:

asthma and chronic bronchitis, diabetes mellitus, epilepsy, hypertension, obesity, under-nutrition, osteo-arthritis, PTB, AIDS, substance abuse, depression, chronic psychoses, mental retardation, and dementia, ...

Training of PCCs

- entry criteria: English language proficiency and a grade 12 certificate
- selection criteria: academic, social, and personal
- course duration: 3 years full-time
- curriculum: scientific, experiential, outcomes-based, and community-oriented
- training sites:
  - theoretical: medical schools
  - practical: accredited rural and urban service sites
    qualification: bachelor degree
- internship: 1 year

PCC student recruitment

becoming a primary care clinician could be an option for any person who:

- specifically wants to be a primary care clinician and not a nurse or a doctor
- wants to become a doctor but
  - cannot afford to do so
  - has not complied with academic admission criteria
  - does not get a study placement: (more applicants than posts)

PCC student selection

selective recruitment to direct post-graduate deployment to areas in need

- applicants from under-served areas to be preferentially recruited
- sponsorship, bursaries and social contracts from the state, the community, NGOs, and the private sector to be conditional on post-graduate placement in pre-selected areas

Re-grading of PHCNs to PCC status

- PHCN training to be discontinued
- PHCNs to have the option to continue in their current discipline or to re-grade to PCC status provided that they meet prescribed standards in respect of:
  - professional qualifications
  - recognised prior learning
  - duration, content, and relevance of experience
  - the successful completion of bridging courses and challenge examinations

Re-grading of other health professional to PCC status

- pharmacists
- environmental health officers
- medical auxiliaries or assistants

also to have the option to re-grade to PCC status provided that they meet the same prescribed standards as PHCNs

Registration of PCCs

PCCs will be registered with the Medical and Dental Professional Board [MDPB] of the Health Professional Council of South Africa [HPCSA].

PCCs will therefore be eligible for membership of the South African Medical Association [SAMA] and the Medical Protection Society [MPS] and will be able to benefit from the same support and protection as doctors.

Career development

within primary care:

specialisation with diplomas for example in:

- paediatrics
- reproductive health
- mental health
- occupational health

beyond primary care:

- MB BCh	medical practitioner
- MPH	Master in Public Health

Job opportunities

- public and private health centres and clinics
- public hospital primary care “polyclinics”
- private primary care practices

Effect of PCCs on doctors

GPs' income will not be unduly affected

in the public sector because:

- PCCs will only work in primary care and nowhere else
- PCCs will not attend to patients with complicated conditions

in the private sector because:

- there are more than enough patients for both GPs and PCCs
- GPs derive much of their income from services which PCCs are not allowed to provide such as in-patient care, deliveries, and surgery

medical specialists may benefit from having

- a larger pool of referring medical service providers
- possibly more selective and appropriate referrals

Other effects of PCCs on health professionals

- less pressure on nurses to become PHCNs
- more nurses to remain in nursing
- more doctors and nurses to provide medical and nursing care resulting in:
  - less work-strain and burn-out
  - job satisfaction and high morale
  - fewer resignations and premature retirements

General effects of PCCs

in the public medical sector

- more medical service providers
- shorter waiting time for patients
- more time for consultation and care
- a new service paradigm with continuity of care and one-stop service as a viable organisational option

in the private medical sector

- more primary medical care providers
- another polyclinic organisational option

in the country as a whole

- possibly an improvement in the quality of medical care
- a lower doctor and nurse emigration rate (financial and brain drain)
- an extra and affordable career option

Economic advantages of PCCs

- PCCs cheaper to train than doctors and PHCNs
  - shorter training period
  - practical training in primary care and not in hospitals
  - almost two (RN + PCC) for the price of one (PHCN)
- PCCs longer potential working life than PHCNs
  - because they will be younger on graduation
- nurses will not be lost to PHCN ranks
- PCCs less attractive to poachers than doctors
- PCCs may be more cost-effective than PHCNs or doctors in both the public and private sectors

Other advantages of PCCs - I

When many PCCs have been trained, the shortage of skilled medical service providers would be reduced resulting hopefully in:

- an appropriate patient-load
- less work strain
- enough time to spend with each patient
- job satisfaction
- high work-place morale
- low human resource attrition

Other advantages of PCCs - II

because their qualifications will be accredited, they will be obliged to:

- maintain high standards
- follow a strict code of professional ethics
- comply with CPD requirements as a condition of continued registration with the MDPB
- account formally for their acts and omissions

Other advantages of PCCs - III

because their status and scope of practice will be defined and recognised, there could be:

- a good reciprocal relationship with other health professionals
- explicitly defined remuneration packages within the public sector
- career development and a career ladder
- job opportunities

What happens if the motivation is accepted

- preparation of detailed recommendations
- acceptance of these recommendations
- passage of enabling legislation
- establishment of training infra-structures
- implementation of training with little delay
- creation of posts
- employment of trained PCCs

Why little delay

- medical student curricula could be easily and quickly adapted to PCC specifications
- existing training institutions and primary care treatment facilities can be used for training
- the cost of implementation is not prohibitive*
- there are many potential recruits
- there are PHCNs and other health professionals interested to re-grade to PCC status

* PCC students need less space, equipment and money than medical students

Short-term doctor options - I

voluntarily relocated doctors if

- causes of low uptake in the public sector are removed or reduced:
  - poor working conditions
  - inadequate remuneration
  - inefficient referral networks
  - insufficient academic and specialist support
  - poor communication services
  - inadequate transport facilities for patients and staff
  - inhospitable living conditions
  - limited recreational and entertainment facilities
- incentives for employment in the public sector are provided:
  - flexi-time and part-time employment
  - hospitable working hours
  - good child care and schooling facilities
  - subsidised, dedicated, and safe transport at, to and from work
  - opportunities for in-service CPD

also apply to private doctors in under-served areas

Short-term doctor options - II

medical conscripts

- before qualification
  - as a requirement for a bursary
- recently qualified medical practitioners
  - as part of community service
- registered medical practitioners
  - as a CPD or licensing requirement
- applicants for specialist registration
  - as a requirement for registration
- foreign-trained SAn doctors
  - as a requirement for registration
- immigrant doctors
  - as a requirement for citizenship

Short-term doctor options - III
other medical practitioners

- breast-feeding female doctors
- other parenting doctors
- retired and retrenched doctors
- temporary foreign recruits

PHCNs as a short-term option

voluntarily relocated or conscripted:

- currently employed and non-practising old-type PHCNs
- registered nurses who have successfully completed a fast-track training course in primary medical care, provided that:
  - they undertake to upgrade to PCC status
  - their training and practice is HPCSA sanctioned

all relocations and conscription to be conditional on:

- improvements in working and living conditions
- specific and appropriate incentives
- removal of causes of current alienation of PHCNs, especially
  - very high work-load and responsibility
  - remuneration not commensurate with training and duties

Other health professionals as possible short-term options

- pharmacists
- environmental health officers
- medical auxiliaries or assistants*

should be offered the same opportunities for fast-track training as registered nurses before being allowed to serve as primary medical care providers - with the same provisos

registered and unregistered nurses are deliberately excluded

* foreign trained

Interim standards and control

An interim body within the HPCSA should be established

- to regulate in the short-term the scope of practice, training, registration and practice of medical service providers who are not registered with the MDPB
- to address some of the causes of the current disaffection experienced by PHCNs
  - problems with annual licensing and practice authorisation
  - inadequate protection against medical malpractice litigation
  - legal limitations to the right to prescribe medicine
  - legal limitations to the right to practice in the private sector

ADDENDUM*

lay and professional health educators can reduce the burden of disease and alleviate the medical human resource shortage by:

- promoting and protecting health
- preventing disease
- empowering people to self-manage some diseases and disabilities
- diagnosing and treating some common conditions
- facilitating the appropriate use of medical services

* Effie Schultz only

Other roles of health educators in primary care

- child growth monitoring and immunisation
- dressing wounds, performing selected tests
- dispensing of OTC medicine
- supervising prescribed drug treatment
- counselling, exercise monitoring
- family diagnosis, home nursing
- personal care of the elderly and disabled
- epi-demography