A Note on Personnel

by Helen Rees

Central to the current debate around the role of Primary Health Care (PHC) in a future health service is the question of what kind of personnel are required to provide such a service? This article briefly raises some questions relating to the role of PHC nurses and general practitioners (GPs) as providers of PHC.

Introduction

There is a broad range of opinion which supports the development of Primary Health Care (PHC) services in South Africa. Both the government and the ANC, amongst others, have expressed their support for PHC. Before an effective PHC service can be developed, certain questions about the kind of personnel required to deliver such a service need to be answered.

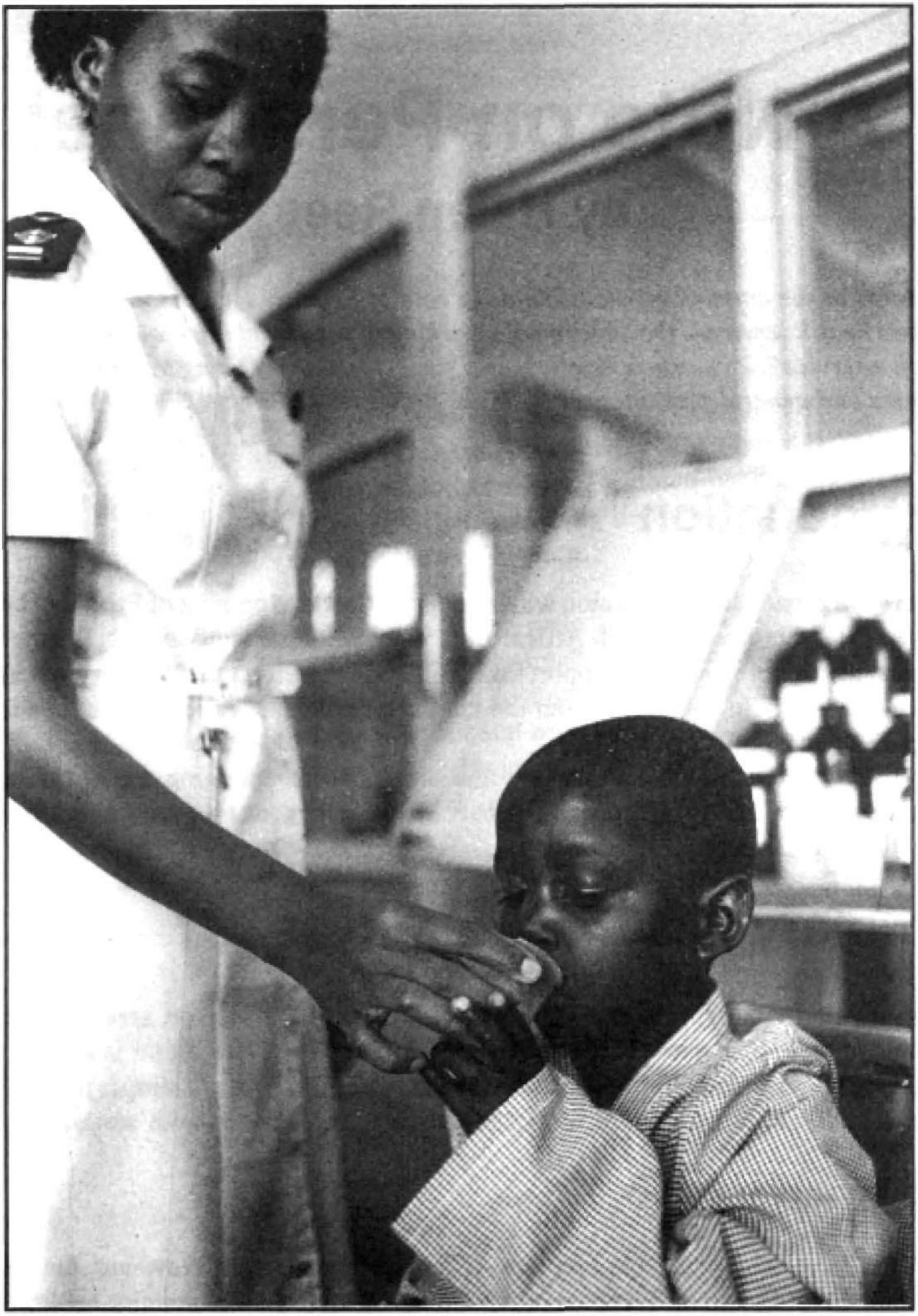
This article briefly focuses on some aspects of the emerging debate on health personnel. Its aim is to raise questions that need to be looked at before we can develop a national PHC policy.

Primary health care nurses

It is a shared assumption that PHC services, particularly in rural areas, would be provided by PHC nurses (PHCNs). The exact role of the PHC doctor is less clearly defined, but one model proposes changing the PHC doctor from a simple provider of clinical care, into that of clinical consultant, manager, and research worker.

Content of training

PHCNs have been practising in South Africa for several years. However, the nature of their training varies. Some centres train PHCNs with a community health bias, whereas, others train them primarily as PHC clinicians (that is, examining patients, making diagnoses and providing treatment) in the belief that this is the major service



What is the role of the Primary Health Care Nurse? Photo: Medico Health Project

they provide once they are practising.

In their most recent recommendations the South African Nursing Council has weighted the PHC training heavily towards community health skills with very little emphasis on clinical skills. They imply that nurses require little training to develop the necessary skills after their basic nurse training to allow them to work as clinicians. Some people involved in the training of PHCNs would argue that PHCNs are, in fact, family practitioners and not community health specialists and that their training should be orientated towards the discipline of family health rather than community health.

This then raises the first question: what is the present role of PHCNs, and what training would best support this role?

Support structures for PHCNs

Apart from the problems of the content of PHCN training, there are also problems for them in terms of support structures. Their job has no prospect of promotion unless they move back to the traditional nursing hierarchy. They are neither nurse nor doctor, although still subject to nursing structures. The result is that there is often conflict between PHCNs and their nursing peers and conflict with their nursing superiors.

On the other side, there is professional rivalry between PHCNs and PHC doctors. Doctors feel threatened by the movement of PHCNs into their territory, and increasingly uncertain of what their role as a doctor ought to be. If the role of the two professionals is similar, then why should doctors get paid so much more than PHCNs?

Cost benefit

To add to this confusion, is the question of cost benefit. When PHCNs were first trained, the aim was to have a PHC practitioner who was locally based and trained, and who would be cheaper to train and more effective than a doctor. Whilst the former point is often true for PHCNs, the latter two points may not be. A primary health care nurse has 3 years of basic nurse training, after 1 year of midwifery and a final year of PHC training.

With basic nursing training expanding to 4 years, PHCN training will become 6 years in length, and hence very expensive, although still cheaper than a doctor's training. Secondly, PHCNs often work more slowly than doctors and have to refer more cases for second opinions. This means that in terms of cost, a PHCN consultation is potentially more expensive than one with a doctor, as was recently shown in a study done at Diepkloof Clinic in Soweto.

A different type of PHC clinician?

With all these problems attached to PHCNs as the model of a mid level health worker, some people are now suggesting that it may be better to train a different type of PHC clinician. Community members could be given a 3 year community based training in both family medicine and community medicine skills. This would qualify them as a PHC clinicians, with a career option that would later allow them to qualify, if they wanted to, as doctors. Much more research has to be done into the role of the PHCN before we can assume that they are the model health workers for a future PHC service.

General Practitioners

When we talk of future health services and the development of a multi-disciplinary health training, we include in that team a PHC doctor. But where do we find these doctors, and what training do they need?

In addition, those who are motivating for the expansion of PHC services need to be more specific about what will happen to the private sector and, in particular, to general practitioners (GPs).

We have 7 000 - 9 000 doctors practising as "generalists" in South Africa, who are thought to give about 12 million consultations every year. Although drug companies may know where all these GPs are, the progressive health sector and probably the government does not know much about this work force. We don't know where they are, what functions they fulfil, what their skills are, or whether they would be interested in joining a multi-disciplinary health team.

More and more doctors are choosing private general practice as a career option. We need to look carefully at the reasons for this and at the nature of the service they are providing to the community. The image of a GP is that of a high income earning doctor, with a large patient load. In some cases, this is a fair assessment. Some doctors choose to go into private practice because they believe that they will be able to give a better quality of care to patients than can be given in a public sector, renown for bureaucracy, long queues and lack of continuity.

Some people argue that GPs are serving the `first world' component of the population. This is only partially true. Although GPs over cater for the urban areas, many work in peri-urban and rural areas. Many of their consultations are to "cash" patients (that is, poorer, non-medical aid patients). As PHC clinicians, GPs have also become aware of the PHC team approach, and of the limitations of their predominant

curative practices. Financially, GPs are feeling the squeeze. Medical aids are increasingly in conflict with GPs over their remuneration. Dispensing may become prohibited for many urban GPs, and this would eat into their profits.

Under these circumstances increasing numbers of GPs may be interested in integrating their practices into a comprehensive state run PHC model. Can we afford to ignore GPs? The state certainly couldn't afford to provide services for 12 million consultations per annum and at the same time cannot ignore 8 000 skilled health workers working in the field.

Finally, do we really know what kind of health service is acceptable to South Africans? It seems that many people prefer to spend more money and see a "special doctor" rather than seeing a PHCN in a clinic. Is our intention to develop a `third world' nurse based service, whilst allowing a `first world' or doctor based service to continue in parallel. Isn't this just more of the fragmentation that we are all so keen to escape from? And how does this challenge an oft held view that health care begins and ends with doctors?

Before committing ourselves to a model for PHC services in SA we first need to have a better understanding of what is happening in presently in health services. The feasibility, costs, and potential impact of any model put forward must be assessed. Decisions about a PHC model should not be made by politicians and community health specialists alone. The debate must be broadened to include all PHC clinicians, and the communities they serve.

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