# Health Personnel
## New Categories, Training and Redistribution

***William Pick***

*A number of commissions at the conference focussed on health personnel. Some commissions, such as Redistribution and New Categories of Health Personnel, Support and Reorientation of Health Personnel and Labour Relations in the Public Health Sector, debated issues relevant to a wide range of health workers. Others, such as Community Health Workers and Traditional Healers, concentrated on specific categories of health providers.*

*In general, the commissions addressed two central concerns. Firstly, health personnel must provide a relevant service, appropriate to South Africa's needs. Currently, personnel are concentrated in urban, middle class, predominantly white areas and provide mainly curative services. There is a shortage of personnel who are able to provide primary health care (PHC). A significant proportion of personnel have an unprofessional manner and a lack of respect for patients. There is a need to reorientate and train existing personnel, to inculcate a philosophy of public service and provide a good understanding of the primary health care approach. A redistribution of health workers to underserviced areas has to take place and new categories of health personnel have to be established, in order to provide comprehensive PHC.*

*The second concern addressed by the commissions is that the health sector must provide acceptable working conditions for health workers. At present, large numbers of health workers are unhappy and demoralised. Health workers need support and appropriate training. There should be greater career mobility and there is a need for democratic and representative professional bodies. Furthermore, health workers in the public sector are still denied their basic labour rights. The Labour Relations Act must be extended to all public servants. Health workers must have the right to freedom of association and to bargain over salaries, benefits and conditions of service. They must have access to dispute resolution mechanisms and have the right to strike.*

*In the following article, William Pick outlines the discussion and debate that took place in one of the commissions on personnel, namely Redistribution and New Categories of Personnel.*

The participants in this commission were from a wide range of backgrounds, including community development workers, community health worker trainees and a wide a range of health worker professionals. The commission was set the task of looking at two topics, namely new categories of health personnel and redistribution of health personnel.

## Limitations of Existing Personnel

Discussion on the first topic started with an examination of existing categories of health personnel. The group of participants generated a list of categories. This includes nurses, physiotherapists, physiotherapy assistants, community health workers (CHWs), occupational therapists, dental therapists, dentists, rehabilitation assistants, health inspectors and doctors. The deficiencies of this conventional range of health personnel was discussed.

The main problems which were identified include a lack of appropriate training for health personnel; insensitivity and 'unfriendliness' of health personnel towards patients; inaccessibility of health personnel, especially due to inability to afford private sector care; and a lack of transport to health facilities.

## Doctors and PHC Teams

There was a lot of debate about the role and power of doctors in health care. A question was raised as to whether doctors are an essential part of health care teams and, more specifically, whether they are needed to play management roles. Consensus was reached that this should not necessarily be the case. Moreover, at the level of primary health care, adequate intervention in terms of health care delivery can occur without necessarily involving doctors.

## Going Beyond Conventional Categories

The plight of rural communities with no access to potable water and sanitation was discussed at great length. In view of the lack of environmental health, particularly in rural communities, participants identified the need for environmental health workers.

The need for health promotion and its neglect in the current South African health care system led to a high priority being accorded to a new category of health worker - the health promoter or advocate. The group was, however, mindful of the danger of providing new categories of health personnel that may not be sufficiently trained to meet the needs of communities. The need for

adequate training was emphasised.

The inappropriate training of existing categories of health personnel led to a discussion on the need to provide additional skills to health workers who are in the frontline of patient care. The group highlighted the need for training in management and primary clinical skills. Management skills, such as planning, financing, administrative and evaluation skills, need to be developed to manage the health system, especially at district level. Skills in primary clinical care need to be developed amongst existing personnel such as nurses. It was also suggested that a new category of personnel - the medical assistant - should be introduced to provide clinical care at the primary level.

The need for health workers trained in occupational health and the improvement of the skills of existing categories of health workers in occupational health was brought to the commission's attention by one speaker. After much discussion, the group agreed that this need could not be overlooked.

The constant breakdown of essential equipment in hospitals with no local expertise for repairing this equipment was also discussed. This led to the proposal that a special category of technicians be trained.

The discussions were permeated by the need to see health as much broader than illness and disease. This is reflected, for example, in the types of new categories which were discussed, as well as the aspects of training which were stressed by the group.

## Compulsory Service

The second topic, redistribution of health personnel, was discussed in terms of the glaring inequalities in health personnel provision that exist between urban and rural; rich and poor; and private and public sectors.

The discussion on the need to redistribute existing health personnel, especially the so-called professional categories, ranged from the provision of incentives to more coercive measures. Coercive measures suggested by this commission include a form of compulsory service for health workers in underserved areas. It was argued, however, that such compulsory service should not be restricted to medical professionals, who might view this as a form of punishment. Compulsory service should also include other categories of health workers, such as health inspectors and environmental health workers. It was felt that the concept of compulsory service should not affect long established practices, but should concern newly qualified people. Compulsory service in underdeveloped areas should be linked to training and state provision of bursaries. Students should, for example, have to repay their state subsidies if they refuse to do such compulsory service.

Personnel: change the curricula, compulsory service, or both?
*Photo: Ismail Vawda*

## Zimbabwe and the Importance of Incentives

It was clear that attempts to move health personnel from urban to rural areas and other under-served communities has been largely unsuccessful worldwide. The participants suggested a close look at the reasons for this failure and the Zimbabwean experience was cited as a compelling lesson for South Africa.

This experience shows that, even where there is an attempt to reorientate the curricula of medical education in a way which satisfies the need for personnel in less developed areas, medical personnel will remain reluctant to go to these areas if salaries and other incentives in urban areas are far better than in these areas. The extent of hostility amongst medical personnel towards serving in rural areas was seen in 1988 in a strike by junior doctors refusing to serve in poorer areas. With the background of this experience, the need to provide favourable working conditions for health personnel in under-served areas was identified as central to correcting the existing imbalances.

## A Few Words on Process

Initially, discussion was dominated by certain participants, but more and more participants articulated their views as time went by. It was quite a large group and this accounted for the initial unevenness of discussion. Taking this into account, the commission completed its tasks admirably.

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