HSRC Human Sciences Research Council

policy brief

A WILDSCHUT, A MANAMELA, L HUICHO, Z LASSI AND Z BHUTTA

July 2013

Mid-level providers: The invisible cadre in the provision of human resources for health in southern Africa – policy implications for South Africa

Introduction

South Africa's health system is on the verge of major change. Proposals for a National Health Insurance (NHI) are moving along rapidly towards implementation. In the past, the appropriateness of such a system was the subject of debate amongst health system stakeholders (Department of Science and Technology, DST 2012). Some viewed NHI as an inappropriate system in a country where the current health regime is failing in many respects. Others, while agreeing on the need of such a system, were sceptical of the country's ability to resource the system financially, as well as the impact of the shortages of human resources for health (HRH). The discourse has since shifted to an approach that by and large proposes the NHI to be the future of our National Health System. For now, the focus should be on how to address the current challenges. The South African Department of Health acknowledges that in order to successfully implement NHI in SA, four key interventions need to happen simultaneously, namely:

- a complete transformation of healthcare service provision and delivery;
- the overhaul of the entire healthcare system;
- the radical change of administration and management; and
- the provision of a comprehensive package of care underpinned by a re-engineered primary healthcare system (Department of Health 2011a).

The national discourse around the appropriate system of healthcare provision in South Africa should frame any consideration of health issues at present, however it does not occur in

www.hsrc.ac.za

a vacuum. Globally, health systems' strengthening is recognised as an approach that should underpin any health intervention in a country. It refers to activities and initiatives that improve health systems in ways that will assist in providing more equitable and sustainable health services and outcomes across a country. The World Health Organisation (WHO) asserted that health systems strengthening needs to be a key focus internationally, so that more countries are able to deliver a wider range of health services on a much larger scale than is the case at present (WHO 2008). While the effective and efficient distribution of resources (financial and human) is central to this effort, it appears that '... philanthropy and public funding for global health has typically not targeted workforce development as part of health system strengthening' (Global Health Workforce Alliance, GHWA 2010).

The focus has often been on other, more immediately rectifiable issues. The GHWA recognised that reluctance among funders springs from the complex issues related to HRH, as it requires engagement with a wide array of stakeholders, as well as with complex and contested questions, such as how to most effectively educate, deploy and retain healthcare professionals. We are fortunate in SA that the critical link between HRH and financing appears to be well recognised. In this regard, the Director General of Health in the South African HRH Strategy notes that:

> ...we need to be bold and affirmative and provide solutions with an emphasis on strengthening human resources (to meet service demand) for the immediate future, and medium term. The introduction of new financing mechanisms, such as NHI, will demand a strong human resource capacity for the health sector. (Department of Health 2011b: 7)

This brief argues that the increased training and use of MLPs, as part of a comprehensive medium- to long-term HRH strategy, could be considered such a bold and affirmative solution to the particular challenges faced by the country in efforts to strengthen its health system to effectively support the NHI.

Mid-Level providers (MLPs) have been used in South Africa to help address HRH shortages in nursing, dentistry, pharmaceutical, occupational therapy, physiotherapy, radiography, speech therapy, audiology and psychology professions. Lehmann (2008) notes, that while mid-level nurses have been used for many years, the introduction of other mid-level cadres has been a slow process. With clinical assistants who came from exile being phased out in the early 1990s, the introduction of specific mid-level medical workers/clinical associates to the health system has always been contentious. However, in 2002, the National Health Council took a decision that mid-level medical workers should be developed for South Africa. Consequently, in 2004, the first cohort of 24 mid-level medical workers was admitted for training. At that stage it was acknowledged that posts and career pathways for this cadre were not yet established.

Since then, the state of mid-level providers in the South African context has not yet been comprehensively assessed or followed up on. We argue that their increased training and enhanced use in the medical profession specifically, but also in related health professions, should be put back into considerations around the need to strengthen human resources for healthcare delivery.

Mid-level providers widen access to key health services

Mid-level providers are trained at a higher education institution for two to three years. They are then qualified and regulated to work autonomously to diagnose, manage and treat illness, disease and impairments, as well as to engage in preventive and health-promoting care. The scope of practice of this group of health workers varies significantly across countries, usually responding to a specific need. The contributions these cadres can make to improve the overall health of citizenry

have been extensively documented. They contribute by providing greater access to qualified personnel to serve a wider geographic range, which is a factor strongly correlated to the levels of health of people in a specific area (Campbell & Settle 2010). Any country's strategy that intends to increase health services and strengthen its health systems, in terms of either scope or reach, will need to consider long-, medium- and short-term initiatives that will assist in the increased skilling, re-skilling, up-skilling and retention of health workers. It is thus important for all countries to engage critically with the subject of incorporating different levels of healthcare providers into their health systems.

Task-shifting[1] to mid-level providers is conventionally done in the areas of obstetrics, gynaecology and HIV/AIDs care. Literature and programme evaluations thus emphasise the contribution of MLPs in these areas. It is asserted that they provide particularly in the following areas:

- **Increased access to post-abortion care and emergency obstetric care**: The role of MLPs in providing access to emergency obstetric care (EmOC), post-operative care, post-abortion care (PAC) and reproductive care has been demonstrated (in Tanzania and Mozambique). This collection of services appears to have the greatest potential impact on the reduction of maternal and child mortality, which is a key challenge globally and in SA, as long as training is adequate and clinical protocols are followed.
- **Increased access to HIV/AIDS care**: Task-shifting, specifically for the delivery of HIV/AIDS services in a variety of settings, is increasingly acknowledged as a success. Programmes that rely on nurse- and clinical officer-initiated paediatric antiretroviral therapy showed that task-shifting allowed for dramatically scaled-up roll-out, lowered mortality and lowered defaulting on treatment (Callaghan et al. 2010).

In sum, when adequately supported, MLPs can have an impact on increasing access to a wide range of health services from preventative, clinical and surgical perspectives. Task-shifting is useful and can be a successful policy option to assist in alleviating healthcare provider shortages, skills mix imbalances, and most importantly, to increase access to quality healthcare at a lower cost (Fulton et al. 2011). Our country is facing similar challenges. There are widespread assertions around the shortages of medical practitioners and nurses, the imbalance between the distribution of such human resources across the public and private sectors, and the high costs of training such health workers, to name but a few challenges. This requires serious consideration of the options available to ensure equitable distribution of appropriately skilled health workers. As rightly noted by Lehmann (2008), such a strategy must include not only the accelerated production of professionals, but also of mid-level cadres. However, such strategies are not without challenges.

Taking into consideration the discourse around health systems strengthening nationally and the discussion of the imminent NHI, the authors of this policy brief recommend the scaling up of the training and use of MLPs in the South African health system. For illustration, this brief draws on three African case studies; namely, Tanzania, Mozambique and Zambia, which formed part of a global review of the impact of MLPs on key health outcomes (Bhutta et al. 2013). The data is used to identify critical elements that can contribute to the successful integration of such cadres into health systems. The policy brief considers how South Africa can learn from experiences

1 Task-shifting can be defined as the delegation of some tasks from a more highly qualified health worker to one with lower qualifications.

of other African countries that have used MLPs as a strategy to mitigate country-specific health concerns. It offers an opportunity for the country to reflect on how to set up an integrated HRH system as an important baseline for a strong health system that can support the NHI.

Examples of the use of MLPs in the SADC region

Tanzania: The critical role of communication, recognition and coordination

In Tanzania, two types of medical MLPs predominate in the healthcare service. These are clinical officers (COs) and assistant medical officers (AMOs). Three specific issues challenged the effective use of these cadres:

Clearly communicated scopes of practice are critical

The scopes of practice for different kinds of MLPs, as well as their relation to other health professions, were not clearly communicated or set out. This often led to unclear communication of related policy decisions and the link to requirements of regulatory bodies, training institutions, district level management teams and the HRH professionals themselves. When confusion exists about the scope of practice of health workers in terms of government expectations, regulation or training, these health practitioners may not get the support they need or be in possession of the requisite skills and competencies to provide safe and good quality care (Health Systems Strengthening for Equity, HSSE 2011). Accordingly, this renders the health system ill-prepared to actively and appropriately support, supervise and regulate these cadres in their practice – an essential aspect for their integration. In this regard, Tanzania was not optimally using its MLP cadres to resource the health system.

MLPs need to be recognised for the role they can play in key health interventions

Given the disease profile of Tanzania, where the leading cause of death for children is malaria, and for adults HIV/AIDS, the most pressing health service needs relate to prevention and health education. Such conditions clearly support a more active role for lower-level health workers, who could assist in carrying the preventive and health promoting load, rather than highly qualified medical practitioners. It appears that the role these health workers can play in widening access to HIV/AIDS care is not fully acknowledged and has not been fully capitalised on. The overarching health system policy, One Plan of Tanzania, which outlines strategies aimed at maternal and child mortality reduction, for example, does not explicitly consider the role and training of these cadres (Bhutta et al. 2013).

HRH systems need to be well coordinated

The HRH information system is not well established in Tanzania. Some information is gathered through the health management information system and professional bodies, however, data is very limited for the purposes of informing decision-making and proper planning (Ministry of Health and Social Welfare, Republic of Tanzania 2008). This is exacerbated by the lack of HR information from the private sector and the limited ability and skills to analyse demand and supply in order to inform forecasting. Although supervision and monitoring of the training of MLP cadres is quite extensive, this does not seem to follow through to employment. For example, Tanzania has a board regulating the training of MLP cadres, but has no systems for registering and controlling them as practitioners. Such a gap hampers the structured incorporation of MLPs into the health system.

Mozambique: The importance of coherence and transparency

The Mozambican HRH system presents challenges for the effective use of the main types of medical MLPs in the country, namely: téchnicos de medicina (TMs) and téchnicos de cirurgia (TCs)[2]. The WHO has identified the main obstacles to bettering the Mozambican health system as:

- weaknesses in linkages and coordination between health policies and the wider development sector;
- staffing and systems limitations;
- inadequate resource monitoring systems;
- limited progress in translating global commitments to concrete action within the country; and
- the lack of a multi-sectoral approach to the achievement of health outcomes (WHO 2011).

The system thus struggles with fragmentation, which heavily impacts on the effectiveness of all health system resources and particularly the effective use of available HRH.

These are some recommendations:

Human resources for health systems need to be coherent

The ability to make more positive progress in ensuring the correct numbers and skills mix of HRH in Mozambique is hampered by an underdeveloped HRH system. This is exacerbated by inadequate personnel placement and management and complex processes of career advancement (Ministry of Health, Republic of Mozambique 2010). The capacity to monitor and regulate the HR in the health system is negatively impacted by the lack of coordinated systems of HRH. A Personnel Information System (PIS) was created in 1998, however, the capacity to adequately gather, manage and use this data is limited. The system is also not comprehensive, for instance, it covers all hospitals, but not yet all health centres, health posts or any health workers in the private for profit sector. It is thus important for routine data gathering through the PIS to be strengthened, especially at the most peripheral levels.

Remuneration and career progression pathways have to be transparent

The salary structure of HRH in Mozambique is not very transparent. It differs extensively between types of areas (urban, rural), sectors (public, private), facilities (district, provincial), as well as type of employers (NGO, donor organisation or the government). The salary scales are very complex, with the rate and specific pathway of progression not being well defined. This was identified as a key obstacle in the motivation and retention of MLPs in the country (Bhutta et al. 2013). The provision of possibilities for professional advancement is seen as key in improving the distribution, motivation and retention of MLPs in Mozambique. Unfortunately, unlike Zambia, which has a clear and specified retention policy for HRH, this is not the case in Mozambique. Although MLPs form such a large proportion of the HRH available to provide healthcare services, the factors impacting on their motivation and retention appears to receive little attention.

Zambia: The role of quality HRH data to inform monitoring

The fundamental HRH problems in Zambia that affect the effectiveness of the system are identified as:

2 The TM developed as an entirely new profession to take over many of the clinical roles of doctors, especially in rural areas, whilst the TCs developed from the need for a better surgically trained TM cadre. TCs are also sometimes referred to as surgical technologists, while TMs are sometimes referred to as non-physician clinicians (NPCs).

- A public sector functioning with only half of the required health workforce.
- High levels of internal and external brain drain and increased levels of attrition through deaths, resignations and imbalances in the distribution of health workers between rural and urban areas (Bhutta et al. 2013).

These structural issues were found to impact negatively on the evaluation of the medical MLPs found in the country, namely, the clinical officers (COs).

These are two main recommendations:

MLPs need to be considered and counted in the HRH system

While the country clearly recognises the importance of strengthening pre-service training as a prerequisite for the successful scaling up of HRH, there is no specific mention of what is required for the increased training of MLPs (Ministry of Health, Republic of Zambia 2008). To integrate these cadres more effectively into the Zambian health system, more focus should be placed on gathering and coordinating information on their training and output. In sum, the main problem hampering the planning for MLPs is the lack of information on the numbers, levels and distribution of trained cadres.

MLPs need to be well supported and supervised

Performance evaluation is well established in terms of the education and training programme for COs and medical licentiates (MLs), but this is not true for practitioners. Again, this is a critical gap to be filled if COs and MLs are to enjoy higher status in, and confidence from, Zambian society. Where supervision and monitoring of the quality of programmes does take place, this is not done centrally. Programmes are evaluated internally and disparately by the partners involved and these are available as programme evaluation reports. There is a need for the Ministry of Health to collate and verify this information. This will offer a better perspective of the supply-side context in its consideration of how to respond to the HRH crisis in the country by up-scaling the use of MLPs.

Lessons to be learnt for the incorporation of MLPs in the South African health system

What can South Africa learn from the experiences of their neighbouring African countries?

Within a country context, where severe shortages of health personnel to deliver the critical health services to those in most need has been documented, SA should consider the increased use of MLPs as a viable option for the expansion of health services in support of the implementation of the NHI. While these cadres have important contributions to make in other professions, we argue that the scaling up of medical MLPs, as evaluated in this brief, deserve more concerted attention in South Africa.

The brief has discussed the positive contribution these cadres can make to maternal and child health, as well as to comprehensive HIV/AIDS care. However, as with Tanzania, Mozambique and Zambia, these cadres remain mainly absent from the health discourse in South Africa. This phenomenon is quite common internationally as well, and despite the widespread use of MLPs they are virtually invisible in government policies and strategies (HSSE 2011). It is thus important for SA to firmly put the use of MLPs on the health agenda; however, key aspects need to be in place so that we can avoid some of the difficulties experienced by our neighbouring countries.

Drawing on the issues highlighted, the following recommendations are made:

1. A clearly set out and dedicated policy infrastructure to support the

expansion of these cadres should be put in place.

2 A comprehensive HRH information system that outlines the numbers, levels and distribution of these cadres should be developed. This is essential, not only for the management of MLPs, but to be able to more effectively measure their impact on health outcomes and so build a case for their support and expansion. Here interventions under this new system (NHI) have a role to play in putting the use of MLPs on the national agenda and providing opportunities to embed such cadres in the national health policy discourse.

These recommendations attempt to stimulate debate by proposing a bold HRH policy direction that can support the strengthening of our new NHI enriched South African health system. We expect the implementation of these recommendations to entail extensive engagement between relevant stakeholders, particularly the Department of Health and the Department of Higher Education and Training. However, at this point, most important is the design of the infrastructure and the information systems to support the inclusion of such cadres. Before we can motivate for more targeted interventions, such as increased investment in training, or consider who will manage the information system, these critical building blocks need to be put in place. This will help to ensure that we avoid the difficulties experienced by other countries in trying to incorporate MLPs in their health systems.

References

Bhutta Z, Lassi Z, Wildschut A & Huicho L (2013) *Global experience of mid-level health providers for delivery of health related Millennium Development Goals (MDGs): A global systematic review and 8 country case studies*. Client report commissioned by the Global Health Workforce Alliance of the World Health Organisation

Callaghan M, Ford N & Schneider H (2010) A systematic review of task-shifting for HIV treatment and care in Africa. *Human Resources for Health* 8: 8

Campbell J & Settle D (2010) *Taking forward action on human resources for health in Ethiopia, Kenya, Mozambique and Zambia: Synthesis and measures of success*. The Capacity Project and Integrare, January 2010. Accessed 22 July 2012, http://www.who.int/workforcealliance/knowledge/publications/partner/tfa_synthesis.pdf

Department of Health, Republic of South Africa (2011a) *National health insurance in South Africa*. Policy Paper. Pretoria: Government Printer

Department of Health, Republic of South Africa (2011b) *Human resources for health South Africa 2030: Draft HR strategy for the health sector: 2012/13–2016/17*. Consultation Document V5. Pretoria: Government Printer

DST (Department of Science and Technology), South Africa (2012) *Practical aspects of implementing a single payer National Health Insurance (NHI) universal coverage in South Africa: Experiences from countries*. The 2012 National Health Insurance (NHI) International Science seminar, hosted by the Human Sciences Research Council (HSRC), CSIR Conference Centre, Pretoria (6–7 December)

Fulton B, Scheffler RM, Sparkes SP, Auh EY, Vujicic M et al. (2011) Health workforce skill mix and task shifting in low income countries: A review of recent evidence. *Human Resources for Health* 9: 1

GHWA (Global Health Workforce Alliance) (2010) *Mid-level health providers: a promising resource to achieve the health Millenium Development Goa*ls. Accessed 3 August 2011, http://www.who.int/workforcealliance/en

HSSE (Health Systems Strengthening for Equity) (2011) *The power and*

potential of mid-level providers. Funded by the Irish Aid and the Ministry of Foreign Affairs, Denmark. Accessed August 2011, http://global-health.tcd.ie/research/projects/hsse.php

Lehmann U (2008) *Mid-level health workers – The state of the evidence on programmes, activities, costs and impact on health outcomes: A literature review*. Geneva: World Health Organisation (WHO), Department of Human Resources for Health

Ministry of Health and Social Welfare, United Republic of Tanzania (2008) *Human resource for health: Strategic plan, 2008–2013*. United Republic of Tanzania: Ministry of Health and Social Welfare

Ministry of Health, Republic of Mozambique (2001) *Strategic plan for the health sector (PESS 2001–2005–2010)*. Republic of Mozambique: Ministry of Health

Ministry of Health, Republic of Zambia (2008) *National training operational plan 2008: Field assessments, analysis and scale-up plans for health training institutions*. Republic of Zambia: Ministry of Health

WHO (World Health Organisation) (2008) *Task shifting: Rational redistribution of tasks among health workforce teams: Global recommendations and guidelines*. Work undertaken in collaboration with PEPFAR and UNAIDS

WHO (World Health Organisation) (2011) *Mozambique's health system: Country profile*. Accessed 3 August 2011, http://www.who.int/countries/moz/areas/health_system/en/index.html

Acknowledgments

This policy brief draws on work commissioned by the Global Health Workforce Alliance, a partnership hosted by the World Health Organization, as part of its mandate to implement solutions to the health workforce crisis. The study is a global review of experience of the use of mid-level health workers for the delivery of essential health services.

The authors would like to acknowledge the inputs of Prof Alinah K Segobye, Dr Vijay Reddy and Dr Glenda Kruss on draft versions of this brief.

STUDY AUTHORS

Angelique Wildschut, PhD; Post-doctoral research fellow/research specialist, Education and Skills Development Research Programme, Human Sciences Research Council

Antonia Manamela, BCom; former Masters Intern, Education and Skills Development Research Programme, Human Sciences Research Council

Luis Huicho, MD Dr Med; Professor of Pediatrics at Universidad Nacional Mayor de San Marcos and Universidad Peruana Cayetano Heredia, Peru

Zohra Lassi, MSc; Senior Instructor and Research fellow at Aga Khan University, Pakistan

Zulfigar Bhutta, FCPS, PhD; Professor of Pediatrics and Child Health at Aga Khan University, Pakistan

Enquiries to Dr Angelique Wildschut: awildschut@hsrc.ac.za