Altruism or perverse incentive?

To the Editor: Discovery's offer to invest R100 million to train medical specialists over the next decade should not be seen as altruistic.

At the risk of much criticism, I must say that it is a carefully thought-out business plan. It is an ingenious way of training their 'own' service providers – an attempt to get compliant specialists.

Dare I say that it is a cunning perverse incentive? What is the difference between a pharmaceutical company sponsoring attendance at an overseas course (regarded as a perverse incentive) and Discovery funding the training of specialists (of course they know that these doctors will be beholden to Discovery – it must surely influence one's medical judgement). Sincere education grants should go to universities or societies for distribution to needy prospective doctors.

Of course, the irony is that the fund cannot meet the present fee demands of the medical profession, but hey, there is R100 million available for training doctors!

One wonders whether the fund members (the real beneficiaries of the fund) were consulted about the distribution of the monies. I am sure they would rather see payment made for ailments currently not covered by their medical aid because of 'insufficient funds'. Just think how many now non-MPBs could benefit from R10 million a year.

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Mid-level workers: high-level bungling?

To the Editor: Your recent editorial refers.[1]

There are numerous problematic statements in this diatribe. However, I wish to make only two points.

First, in the supposedly extensive opposition cited, the voice of rural doctors is not heard. As the professional group probably most affected, one would expect the opinion of rural doctors to be important and their views to be included, especially in a piece on consultation (or lack thereof), but this was not the case. In fact, rural doctors have generally welcomed the move towards introducing mid-level workers. The latter can play a vital role in assisting with or performing many procedures that are time-consuming for the overburdened rural doctor and out of scope of the nurses (equally overburdened) who often land up doing them, in supporting doctors in emergency care and in facilitating care of the large numbers of patients in rural hospitals, steadily increasing with the AIDS epidemic.

Secondly, a case is made for training specialised health workers for very specific needs. However, a rural hospital is generalist in nature and function. There is limited scope for specialists in any field. It is highly problematic to have workers who can only perform a limited range of tasks – how many different workers must one then have in a hospital, and what should they do when they are finished their set tasks? Take for example a rural hospital that has 2 operating days a week – what does the anaesthetic assistant do for the rest of the week? On the other hand, a pluri-potential mid-level worker can then be further trained for specific functions, remaining available to do general duties in between. Thus, using the same example, he or she could assist with anaesthetics twice a week, and work in the emergency unit on the other days.

There may be problems with the proposed clinical associate programme, but they are an important part of the solution to the workforce crisis in rural hospitals, described elsewhere in the same issue of the *Journal*.[2]

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1. Van Niekerk JP. Mid-level workers: high-level bungling? *S Afr Med J* 2006; 96: 1209-1211.
2. Bateman C. Rural health care delivery set to collapse. *S Afr Med J* 2006; 96: 1219-1226.

To the Editor: Your editorial 'Mid-level workers: high level bungling'[1] refers.

Thank you for addressing this important and complex issue. This letter mainly addresses the concept of a mid-level worker and the allegation that the clinical associate programme is being implemented without adequate consultation.

Mid-level workers in health care are a well-known entity used in much of the world, and are specifically addressed in the Pick report on Human Resources for Health in South Africa.[2] There is a whole range of mid-level workers in different health professions, e.g. enrolled nursing assistant in nursing, pharmacist assistant in pharmacy, registered counsellor in psychology, therapist assistant or technologist in occupational therapy, physiotherapy and speech therapy, and dental therapist and oral hygienist in dentistry. A mid-level worker refers to a worker who functions at a mid-level *within* a profession, and not between professions as suggested by the editorial. Clinical associates will therefore not fall 'between' a doctor and a nurse (a statement that in itself conveys a hierarchical understanding of the relationship between a doctor and a nurse, instead of seeing them as health professionals with different, albeit complementary, roles within the health team).

Physician assistants in the USA do not work independently. Each one is registered with a physician under whose

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