Addressing staff shortages in public hospitals: a role for clinical associates?

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Recent news headlines have highlighted the shortage of doctors in public hospitals, especially in disadvantaged areas. There is no doubt that more doctors need to be trained and recruited into the public sector. But are these strategies sufficient to solve the shortage of hospital staff with skills to diagnose patients' problems and implement treatment? How long will it take to fill all the public sector's vacant posts, especially in disadvantaged areas? And how much will it cost?

Developing mid-level health professionals who can complement existing staff is an additional strategy that has been debated since 1994 and incorporated into the government's recent human resources policy (1). Yet progress in the production of mid-level health workers has been slow. Reasons for this are likely to include competing priorities, the practical difficulties associated with setting up and implementing new training programmes, constraints on absorbing new cadres into the existing health system, tensions between different cadres over role definition and working conditions, and the brain drain into the private sector. More fundamentally, concerns remain about whether mid-level workers are the correct choice for our health system (2,3): Will they be supervised adequately?; Will they be able to work well with other professionals?; Will they become a second-best health care option for poor communities?

Drawing on a rapid assessment that has been published in more detail elsewhere (3,4), it is discussed here how the design and early implementation of a new programme to develop South Africa's first mid-level medical health professionals took account of these concerns and realities. Also highlighted are the issues that need to be addressed by government in order to ensure that this new programme has a substantial impact on the quality of care delivered in public hospitals.

Clinical Associates

The new type of mid-level medical professional is called a 'clinical associate.' Clinical associates undergo a three-year Bachelor's degree presently offered by three medical schools (at Walter Sisulu University and the Universities of Pretoria and the Witwatersrand). Training began in 2008 and the first graduates entered the job market in 2011. Participating provincial departments of health (and, more recently, the South African Military Health Services) are integrally involved in the recruitment of students and special efforts are made to identify students from remote and disadvantaged areas. Most training occurs on-site at district hospitals that have been upgraded for training purposes. Training at these sites is overseen by small teams of hospital staff that generally have joint appointments at the partnering university.

Once they graduate, clinical associates are able to do history-taking and physical examinations, deal with emergencies and conduct routine diagnostic and therapeutic procedures. Their competencies are directly related to the typical profile of diseases and conditions at district hospital level. Training focuses on providing students with generalist rather than specialist skills. With time, practising clinical associates could develop more

specialised skills, depending on their interests and the requirements of the facility in which they work.

Unlike clinically-trained Primary Health Care nurses who practise independently, clinical associates are required to work under the direct supervision of a doctor. The intention is that they perform many of the routine tasks that usually consume doctors' time, allowing doctors to focus on more complex tasks. They will also relieve nurses of some of the tasks that they are forced to do, often outside their official scope of practice, because of staff shortages. Thus, clinical associates are not intended to replace doctors or nurses – they are intended to work with them, sharing some of their workload, freeing them to concentrate on the tasks for which they are uniquely qualified.

Further, it takes less time to train a clinical associate than a doctor or a clinically trained nurse. Clinical associates can become very good at what they do because they focus on a specific set of skills that they practice under supervision. They are recruited from rural and disadvantaged communities which should promote retention of new graduates in these areas (5). Health workers like them have made an enormous difference to many health systems around the world, especially in Africa but even in the United States (6).

Way forward

Of course, fully realising this potential depends on how well the concept of a clinical associate is executed in the South African context. A great deal of effort went into the formulation of the concept: the weaknesses and strengths of international and local mid-level worker programmes were analysed and there was extensive consultation with a variety of stakeholders, including doctor and nurse organisations. In Table 1, Doherty *et al* (2013) summarise the resulting features of South Africa's approach that have attempted to respond to international lessons and local stakeholder concerns, especially with respect to scopes of practice and ensuring quality care (4).

Indications are that early implementation of the clinical associate programme has been successful (3,4). Training seems to be of good quality and pass rates are high. It has been reported that new graduates are both competent and confident, and that training facilities appreciate the contributions made by students in alleviating workloads. Importantly, the various stakeholders have cautiously supported the development of the new cadre, at least in the early stages of the programme.

However, a full evaluation of the impact of clinical associates has not yet been conducted and considerable challenges remain. The number of clinical associates produced annually is still too low to achieve the government's minimum target of five clinical associates per district hospital in the near future (1). Expansion of training capacity requires additional funding, teaching staff and training sites. New posts have to be created to absorb emerging graduates, along with recruitment of doctors to ensure adequate supervision. Clear career pathways and improved working conditions are required to retain clinical associates once they have gained experience, just as with other categories of staff. Emerging tensions between different categories of staff around remuneration levels and the boundaries of scopes of practice also need to be dealt with, especially where clinical associates are taking on heavy workloads. The prescribing competencies of clinical associates also need to be addressed: at present the Pharmacy Council does not allow clinical associates to prescribe any drugs which leaves supervising doctors with onerous duties in this regard. Finally, assessing the impact of

clinical associates on the quality of care will soon become a priority, given general concerns about the quality of management and clinical supervision at district hospitals. Without strong action on all these fronts, the strong start made by the clinical associate programme could be undermined.

In conclusion, clinical associates have the potential to bring good quality hospital care closer to communities in a way that is affordable for the country. Along with other initiatives – such as improved hospital management – they could help to strengthen the public sector, and extend its coverage, as envisaged by the National Health Insurance policy.

Table 1: Positive features of the clinical associate programme

FEATURE	POTENTIAL VALUE
Linkage to training and regulation of doctors	
-Training of clinical associates is located within medical schools as a three-year degree course. -Regulation of the cadre is through the Health Professions Council.	-Confers status on the new cadre. -Fosters synergy between clinical associates and doctors who have to work closely together. -Training is quicker and less costly than for a doctor, and there will not be a brain drain overseas as the degree is not recognised internationally. -Enables further post-graduate training which supports career progression.
National curriculum and exam	
-A national curriculum framework guides the courses at different universities. -Students face both a local and national final exam.	-Ensures comparable training and maintains standards. -Allows local flexibility and innovation.
Clearly defined position within the district hospital health care team	
-The clinical associate is conceptualised as part of a collaborative district-level clinical team that includes the doctor working with a primary health care nurse at the clinic and health centre level, and the doctor working with the clinical associate at the district hospital level. -The scope of practice of the clinical associate is tailored to the specific context and needs of the district hospital. -There is an emphasis on generalist skills and flexibility in response to the particular situation of the individual hospital and health worker.	-In tandem with policies to improve district management capacity, supports the development of a particularly weak level of the district health system (i.e. the district hospital) and relieves the workloads of nurses and doctors. -Responds to the patient profile at district hospitals (district hospitals do not have enough patients with complex conditions that warrant full-time specialist clinical associates, such as an anaesthetic assistant). -Clarifies differences in scopes of practice and reporting lines and avoids overlap of roles with Primary Health Care nurses. -Diffuses concerns of other health professionals. -Encourages a sense of belonging to a team. -Creates a ‘pluri-potential’ person who is not locked into specific tasks and is able to adapt to different tasks during their working day and longer-term career.

Rural recruitment and training	
-Students are recruited from rural and other disadvantaged areas. -The bulk of training is in rural facilities.	-Creates a new route of entry into the medical field, especially for students from marginalised communities. -Produces health workers who can communicate with patients in their home language. -Enhances retention in rural areas.
Supervision by doctors	
-Adequate supervision and support is ensured through making the presence of a doctor integral to the functioning of a clinical associate.	-Strengthens quality of care. -Alleviates concerns about the ability of clinical associates to deliver quality care.
Service-based learning	
-Service-based learning. -Creation of District Training Complexes where other categories of health professional can also be trained.	-Provides plenty of opportunities for practical learning. -Allows students to become familiar with local circumstances, the district hospital setting and community in which they will one day work. -Students demonstrate their usefulness to other staff by immediately relieving their workload. -Helps to realise the goal of decentralised, multi-disciplinary training that makes health workers better equipped for, and more responsive to, community needs. -Allows the development of teaching approaches that can be applied to other categories of health professional. -Provides additional motivation and support for staff, improving recruitment and retention.

Source: Adapted from (4).

Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.

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