Mid-level providers online forum

Digest of day 1 (nomenclature and definition)

Responses by Helen de Pinho

Thank you to all those who have contributed to what is turning into an extremely rich discussion. The strength of these dialogues is that it brings together people working at international level who seek to bring much needed clarity to the issue of mid-level providers, with those people working closely on the ground who experience firsthand what it means to be a mid-level provider working at the frontline.

Reflecting on the discussion so far a couple of issues emerge:

1. **Why do we need consensus around the definition of mid-level providers?**

   There is a growing movement for countries to strengthen and/or initiate the use of mid-level providers to increase access to care. This is evident in local human resource strategy documents through to global documents such as the Kampala Declaration and Agenda for Global Action and the Addis Ababa Call to Action on Human Resource for Maternal and Newborn Survival.

   In many countries, mid-level providers already function at the forefront of health care provision in health facilities in both developed and developing countries. In the absence of an encompassing definition that spans countries and continents, it is difficult for these providers to organize globally, advocate for their profession or even just be appropriately counted and included in routine surveys—a critical step towards recognition and professional visibility.

   And, for very pragmatic reasons, some consensus around this definition is needed given that the term “mid-level providers” is already widely used in the literature—both grey and peer reviewed.

2. **Use of the ISCO-2008 classification.**

   From the discussions, it is evident that the ISCO-2008 provides a mechanism for mapping the various cadres of mid-level providers that exist in countries. This classification is based on a distinction between health professionals—who include those who are direct providers of curative, preventive and promotive care, and health associate professionals—who perform the tasks necessary to support diagnosis and treatment of illness. Its utility is in providing a means to aggregate data and information regardless of national variations in training requirements, regulations and nomenclature.

   This said, we must be sensitive to the variations in nomenclature that do exist amongst countries, and respectful of the roles that these mid-level providers play in delivering care, often in the most remote areas of these countries.

   We are not proposing that countries change the names of their current cadres, but suggest countries make use the classification afforded by ISCO-2008 to map their cadres against that classification, enabling comparison across countries.
3. Towards a working definition of mid-level providers.

It is evident from the discussions as to who is NOT considered a mid-level provider, and while it is never satisfactory to define anyone in the negative, perhaps we could very tentatively and sensitively draw some boundaries around this group of mid-level providers and say that they are neither doctors, nor community health workers and neither nurses acting under direct supervision or standing orders of others nor health associates who only provide a supportive role to those who directly engaged in curative and preventive care.

Such a definition is really not ideal. Perhaps more helpful, and also arising from the discussion is a definition of mid-level provider that encompasses the following elements:

A health provider who:

a. Is trained, authorized and regulated to work autonomously AND
b. Who receives post school leaving pre-service training at higher education institution for at least a total of 2-3 years AND
c. Whose scope of practice includes (but not restricted to) being able to diagnose, manage and treat illness, disease and impairments (including perform surgery where appropriately trained), as well as engage in preventive and promotive care.

That a definition is needed is evident, but let us not lose sight of the fact that behind this definition are the mid-level providers, without whom millions of people would be denied their basic human right to access health care.

Thank you.
Neeru Gupta (WHO, Switzerland) points to the fact that the ISCO 2008 revision groups health workers into two major sub-groups: "health professionals" and "health associate professionals". The former have longer training, higher level of competencies, and skills in diagnosis and treatment; the latter includes staff who perform technical and practical tasks in a supporting role. In addition there are "personal care workers", who perform simpler tasks of a routine nature. Gupta concludes: "In sum, I do not believe there is a simple definition to "mid-level health worker" limited to a single occupational category from either ISCO or other available frameworks. But I do believe ISCO provides a solid foundation for countries and stakeholders to map their national information according to tasks and duties of health workers."

Manish Kumar (IntraHealth International, India) agrees on the need to have a common understanding of MLP based on their function, and points to inadequacies in the ILO definition, as it is excessively focused on curative/clinical care.

Apenisa Ratu agrees on the need to have a common definition, but reports that the ILO one does not entirely apply to the reality of her country.

Kenneth Wind Andersen cautions against an approach that defines mid-level health workers in negative terms, i.e. according to what they are not.

Sarasivathy Eddiah concurs that training, scope of practice and degree of autonomy are the criteria according to which MLP should be defined.

Susan Studeaker (nurse-midwife, The Women’s Center at Mainland Medical Center, USA and Nicaragua) points to the wide variations in competencies across different types of MLP, making reference to the multiple nursing cadres in the American health care system, and suggests that there should be a consensus on definitions, so as to have clarity with policy makers, managers, funders and patients. She finds that the categories suggested by Neeru Gupta - "health professional" and "health associate professionals" - provide a clearer framework than the term "mid level provider".

Dian Marandola (Pediatric Nurse Practitioner and Public Health Nurse) suggests that developing definitions should be based on the Core Competencies framework. http://www.phf.org/link/corecompetencies.htm

Abdurahman Ali, (Chief Executive Officer Ethiopian Nurses Association, Ethiopia) agrees on the need for a common definition, and suggests that this should be the basis for standardization of scope of practice and identification of minimal educational requirements of health providers, and nurses in particular. The absence of standards and regulatory frameworks negatively impact on the effectiveness and perceptions of nurses’ work. Mr Ali agrees that nurses fall within the parameters of the ILO definition of paramedical practitioners, but dislikes the term as it may undermine relations among health care providers and negatively impact on team work.

Ahmad H Nawafleh (Jordan) agrees on the need for a common definition to clarify and simplify things for academics and researchers.
I read with interest the background statement on nomenclature and definition of mid-level health workers. Thank you Helen. But I feel I must respond to the statement "MLP are known variously as health officers, clinical officers, assistant medical officers, técnicos de cirurgia, physician assistants, nurse practitioners, nurse clinicians, or more generally as non-physician clinicians... [which are included in the] International Standard Classification of Occupations 08 (ISCO) (2009 ) [under] a category of health professionals called Paramedical practitioners."

In fact, the ISCO-2008 revision categories most health workers under two broad categories (known as “sub-major groups”): health professionals and health associate professionals. Health professionals may be broadly defined as those who study, advise on or provide preventive, curative, rehabilitative and promotional health services based on an extensive body of theoretical and factual knowledge in diagnosis and treatment of disease and other health problems. They may conduct research on human disorders and illnesses and ways of treating them, and supervise other workers. In this category we find (at the more disaggregated minor group level): medical doctors, nursing professionals (including nurse practitioners, clinical nurses and related), midwifery professionals, paramedical practitioners (including clinical officers, surgical technicians and related), and others such as dentists, pharmacists and traditional medicine professionals.

Health associate professionals, on the other hand, may be broadly defined as those who perform technical and practical tasks to support diagnosis and treatment of illness, disease, injuries and impairments, and to support implementation of health care, treatment and referral plans usually established by medical, nursing and other health professionals. Under ISCO-2008, this includes, for instance, radiographers, biomedical laboratory technicians, assistant nurses, assistant midwives, community health workers and others.

One main factor differentiating these two groups is the assumed skill level required to fulfill the tasks and duties of jobs. Occupations at the health professional level usually require knowledge and skills obtained as the result of study at a higher educational institution for a period of 3–6 years leading to the award of a first degree or higher qualification. At the associate professional level, appropriate formal qualifications are often an essential requirement for entry to these occupations, but in some cases relevant work experience and prolonged on-the-job training may substitute for the formal education.

In any case, the intent of ISCO is to offer a system for classifying and aggregating occupational information obtained by means of administrative records, population censuses and other statistical surveys, regardless of national variations in training requirements, regulations and nomenclature.

I may also add that, in many countries, a large number of health service providers fall...
into another category, known under ISCO as "personal care workers in health services" - including nursing aides, orderlies and others who provide direct personal care services in health care and residential settings, assist with health care procedures, and perform a variety of other tasks of a simple and routine nature for the provision of health services. These occupations typically do not require extensive health care knowledge and training.

Moreover, there are many other categories of workers who do not provide patient care services directly but are essential to effective health systems performance, such as health service managers, medical supplies procurement officers, computer technicians, ambulance drivers, and many others. An advantage to the ISCO classification is that, since it covers all branches of national economies, it can be used as a tool for consistent reporting across all of these categories within and across countries and over time.

In sum, I do not believe there is a simple definition to "mid-level health worker" limited to a single occupational category from either ISCO or other available frameworks. But I do believe ISCO provides a solid foundation for countries and stakeholders to map their national information according to tasks and duties of health workers at various skill levels and skill specializations to enhance comparability of findings and in a form which can be useful for research, decision-making and action-oriented activities.

Neeru Gupta
Statistician, Health Workforce Information and Governance
Department of Human Resources for Health
World Health Organization
Switzerland

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I think it is important to develop a common understanding of who MLP’s are based on their functions. This should be broad enough to meet the context specific needs of different countries and regions.

ILO definition is helpful but is again limiting the MLP functions to medical practices and procedures. It does not take into account health education and health promotion activities performed by mid-level providers.

Manish Kumar
Technical Advisor
Vistaar Project,
IntraHealth International, Inc,
New Delhi India

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Very thorough explanation, Neeru.
Thanks much,
Pat
1. Is it necessary to develop a consensus around the definition of mid-level providers? Why?

I believe it is necessary to develop consensus around the definition of mid-level providers, or any health care professional cadre for that matter, because of the global interest in HRH today. We have to be referring to the same issues and have some level of agreement to the type of workers we are discussing.

2. Does the ILO definition of a paramedical practitioner (reported in the initial statement) adequately capture the work of the mid-level provider?

Not really because paramedical practitioners in my country also refers to all other health care workers apart from Medical doctors. That includes dentistry, radiography, physiotherapy, Pharmacists, medical laboratory technicians, but not nurses. Sometimes it also includes those workers who work with the ambulance and NGOs workers who take care of emergency health issues.

Apenisa Ratu

Isn’t it tempting with a title like “Mid-Level Health Workers” to categorize and put the two words “Mid-Level” and “Health Workers” into their two boxes and trying to define them vis-à-vis what is not mid-level and what is not a health worker?

We are all workers, responsible for our own and others health; and hence, we are all managers. Perhaps, the best perspective, which could aid you in grasping these two concepts, viewed as “Mid-Level Health Workers”, is to make sense of why you should love your neighbour and then in a given societal context codify what to do and how (epistemological perspective).

Kenneth Wind Andersen

1. Is it necessary to develop a consensus around the definition of mid-level providers? Why?

I agree that it is necessary to define mid-level providers by their level of training, scope of practice and degree of autonomy in their practice. It is necessary to provide a clear line of authority and responsibility between top level management and the lower level providers.
2. Does the ILO definition of a paramedical practitioner (reported in the initial statement) adequately capture the work of the mid-level provider?

It does not really capture the work of the mid-level providers as there need to be an in-depth discussion of their qualifications and outline the work performed.

Sarasivathy Eddiah

1. Is it necessary to develop a consensus around the definition of mid-level providers? Why?

I am a "mid-level provider" in 2 ways: as a Women's Healthcare NP and as a Nurse-Midwife. I think that there should be consensus about the definition of a mid-level provider as well as an understanding that we may reach the level of a mid-level in a variety of different ways and that we may practice in a variety of different fields and settings. We have specific sets of similar skills (such as physical exam, diagnostic, treatment, etc) but may go on to develop more/different advanced skills.

I think that one of the major problems in health care, even within a specific country or setting, is that our professions (with the probable exception of medical doctors and dentists) are not readily understood by the general population, patients, and even those in the health professions. In nursing in the US, we have LPN/LVNs, RNs, nurse practitioners, nurse-midwives, nurse clinicians, nurse associates, clinical nurse specialists— with variable requirements for education, licensure, and job tasks. Add to this list: medical aides, nurses aides, medication aides, etc. and "nursing" begins to be seen as a very confusing occupation. Across countries, this becomes even more difficult but, very important; the people we serve, those with whom we work and collaborate, governments, and funding sources should understand who we are.

2. Does the ILO definition of a paramedical practitioner (reported in the initial statement) adequately capture the work of the mid-level provider?

I generally think of mid-level providers in terms of the ISCO definition, especially with regard to the identified education, level of autonomy and supervision, and duties. I do not usually think of health educators, surgical techs, etc as mid-level providers because of the issues mentioned above. However, I have seen auxillary nurses and community health workers competently perform these skills in Central America.

It appears from the posts that other people view MLP as encompassing these fields. After reading Dr Gupta's post, I find that the categories of health professionals and health associate professionals are categories that may provide a better understanding. How are we defining MLP for this conversation?

Thank you.
http://www.phf.org/link/corecompetencies.htm

As many may know, The Core Competencies for Public Health Professionals are a set of skills desirable for the broad practice of public health. They reflect the characteristics that staff of public health organizations (collectively) may want to possess as they work to protect and promote health in the community. The Core Competencies are designed to serve as a starting point for academic and practice organizations to understand, assess, and meet training and workforce needs. Has the structure of competencies been applied to defining the roles and responsibilities for mid level providers. If not, this may prove to be a useful approach to defining roles rather than by titles.

Thank you for this important discussion

Dian Marandola APRN, MSN, MPH
Pediatric Nurse Practitioner and Public Health Nurse

Many thanks for creating this very relevant forum to share experiences and learn from each other to contribute to HRH agenda at national, regional and international level. Please see my response to the questions below.

1. Is it necessary to develop a consensus around the definition of mid-level providers? Why?

I would suggest standard definition, if such labelling is relevant for policy, planning and revitalising HR like nurses. I would rather suggest defining MLP should follow standardization of scope of practice of health providers including nurses. As in our case in Ethiopia I feel scope of practice of each category is not clearly defined in any form for the professional themselves and the public at large. Yes nurses substitute medical doctors in their absence and remote areas for many years, but their contribution is not acknowledged in most cases. This practice is not legally back up, regulation exercises are incomplete, practices would almost seemed traditional, not updated as per the demands of the health care. More over, definition of MLP would take in consideration, minimum educational preparation and complex of responsibility at local context.

2. Does the ILO definition of a paramedical practitioner (reported in the initial statement) adequately capture the work of the mid-level provider?
Nurses falls in this category. Nurses in Ethiopia undergo minimum of two years and above duration of training in recognized nursing schools as accredited by ministry of education, Diploma, degree, etc. There is no nursing body like nursing board, nursing council as the case in other countries responsible to regulate the profession and determine standard of training and scope of practice, advice the HRH policy with respect to nursing in the country.

But, I would not agree with the terminology paramedical to describe nurses and other providers. For me the word is not polite, it undermines health care intervention as team work and, undermines relationship between the different health providers.

Abdurahman Ali, MPH(C), BSCN, Dedu, RN
Chief Executive Officer
Ethiopian Nurses Association

1. Is it necessary to develop a consensus around the definition of mid-level providers? Why?

Mid-level providers is not common for people in the field therefore it is necessary to develop a definition. this phrase probably is required because there are several professions that need to be collapsed under one name to make it more simple at least for researchers and academics.

Ahmad H Nawafleh
Jordan