Allied health professionals

The contribution of the "non-physician health care provider" is not yet fully recognised. A major conference in Denmark last June tried to set the record straight.

Edmund McTernan and Lee J. Holder

Since the provision of at least minimal primary care services has been a basic objective of the Health for all movement, most efforts have focused on developing a primary care system, structured around community health workers with physician back-up. This basic approach is appropriate in less developed nations, where much of the population have lacked even the most rudimentary health services. In such settings, recent achievements have been impressive. However, "Health for all by the year 2000" is also conceived as a goal for the more developed nations, as a means towards the constant improvement of all mankind's health status. Furthermore, social justice requires that we continue to work for access to more sophisticated health care services in those areas where even the provision of the indigenous, minimally-trained health worker has been a recent step forward.

Most physicians, even those who are practising in primitive and isolated settings, received all or part of their professional training in modern and complex medical centres, such as are now found in most of the major cities of the world. They were typically trained to work in a team, depending upon and interrelating with a wide spectrum of other health care professionals. In addition to nurses, the radiology or x-ray technicians and medical laboratory technologists are probably the most common members of the health care team alongside the physicians. Others include rehabilitation specialists (physiotherapists, occupational therapists, speech therapists and so on), public health workers (such as health educators and sanitarious) and several other categories of health service providers. Some countries have mid-level providers such as physician assistants and nurse practitioners.

While it is certainly true that these non-physician health care providers are often in short supply in developing nations, their gross numbers as partners on the care team are legion in a global context. And since they can typically be educated and trained for service in a much shorter time than the physician, their roles can be adapted to meet new needs and they can be more easily deployed in the service system than physicians.

Medical chauvinism

Many observers feel that a form of medical chauvinism has prevented the optimal use, appreciation, and deployment of the non-physician health worker, to the detriment of total health care. Whatever the reason, the literature and programmes of international public health have certainly largely ignored the existence and value of the non-physician health care provider in recent times. In the April 1987 issue of *World Health*, for instance, devoted entirely to the shortage and maldistribution of health personnel, only one article referred to any of the allied health fields, and that reference was limited to just a few fields!

To begin the process of assessing the current and potential contributions of the non-physician health professional in world health care, and to focus added attention on this huge and complex group of professionals, a first World Congress on Allied Health was held last June at Elsinore (near Copenhagen), Denmark. The term "allied health professionals" was applied during this conference because it had been planned and funded through the efforts of the Washington-based American Society of Allied Health Professionals. (Major funding support was provided by the W. K. Kellogg Foundation.) But since it was recognised that this term is not in common, worldwide use, future Congresses might well use some other designation.

The Congress was structured in such a way as to relate the human resources represented by the many millions of "allied health" workers to the concept and goals of Health for all by the year 2000. It was, in a way, an effort to sensitize these professionals themselves to the Declaration of Alma-Ata and its goals, and to alert world health planners and programmers to the often overlooked contributions which can be made by this immense human resource.

*Maternity visit in an Indian village by a public health worker. Is the contribution of such workers being consistently undervalued?*
Prince Henrik of Denmark extended his patronage to the Congress, and the keynote address was given by Dr. J. E. Asvall, WHO’s Regional Director for Europe. The 231 participants from 21 countries included representatives of more than 100 educational or training institutions, 17 professional associations and 16 governmental agencies.

Speakers addressed the concept of the allied health professional, the need for research by and for non-physician health providers, and aspects of education and training. A select panel fielded questions on a number of regional problems afflicting different regions of the world. More than 120 papers dealt with non-physician health care challenges, programmes and achievements in virtually every corner of the world. There were also a large number of excellent poster presentations.

The Congress identified differences and similarities of problems in developing and industrialised nations. In developing countries, the greatest problems were infectious diseases, environmental factors such as basic sanitation and safe water supply, nutrition, infant and maternal mortality, sexually transmitted diseases, accidents, and health service infrastructure—particularly the need to make services accessible to rural communities.

In the industrialised world, the accent was on diseases associated with lifestyles—tobacco, alcohol and substance abuse, AIDS and sexually transmitted diseases, and accidents. Certain health problems are specific to special population groups, such as the very poor, teen-aged girls and the effects of unwanted pregnancy, and the elderly.

A major priority

Common to both emerging and industrialised nations were environmental concerns, sexually transmitted disease issues (especially AIDS), and the fact that both health facilities and health personnel are unevenly distributed. The need to allocate greater resources to primary care was generally accepted as a major priority issue. The underlying question was whether the human resources grouped under the team “allied health professions” could participate in a significant way in responding to these health care challenges, and add significant impact to needed solutions. The answer was strongly in the affirmative, but many speakers underlined the need for greater attention to be paid to developing and using allied health resources.

This first World Congress on Allied Health concluded that:
- there is inadequate data on supply and demand of allied health personnel. Data currently available focus upon physicians, dentists, pharmacists, nurses and midwives, to the exclusion of other disciplines.
- there is a general lack of manpower planning, and insufficient continuity between and among the planning, education and training, and use and management of human resources.
- there is a need for better recruitment, training and retention of allied health personnel, who deserve better recognition, continuing education opportunities, improved remuneration, and better opportunities for career mobility if they are to stay in effective contribution to the total health.
- This first World Congress on Allied Health—and it will almost certainly be followed by a second—has made its contribution to the goal of Health for all by encouraging millions of non-physician health workers around the world to serve that goal. It has also helped the world’s health planners and administrators to gain a better understanding of, and appreciation for, this great resource. The result, it is to be hoped, will be a new and greater role for non-physician care providers in the health for all movement.