THE COST AND FINANCING OF PHCW TRAINING SCHEMES: SOME INITIAL THOUGHTS

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This session is addressed to three important questions. What is the cost of training a primary health care worker (PHCW)? What are the aggregate recurrent expenditure implications for the budget of a PHCW training scheme? How is the burden of this expenditure to be financed? These questions can only be answered once a host of many other fundamental policy issues have been resolved.

For example, to evaluate the cost of training of a PHCW, the policymaker must initially decide on the role that the PHCW is expected to play in the community and in the preventive and curative health care systems. If the PHCW is to simply provide first-aid, the training requirements, and the costs entailed are likely to be very different, and presumably much more limited, than if the PHCW is expected to be the first point in the medical referral process, providing initial diagnosis, prescribing drugs and possibly referring a patient to a health center or hospital outpatient clinic. Is the PHCW also expected to be a source of guidance to families on preventive health actions? Again, this increases the length and depth of training required, and thus the associated costs. Is the PHCW expected to operate in a vacuum or will there be a regular procedure whereby his village or urban block is visited by a more experienced health worker or physician? If there is ongoing supervision of the PHCW, one might be able to design a less comprehensive training program initially, since there will be some opportunity for "learning by doing and guidance" as the PHCW works with and observes the physician.

The nature of the supervisory process and the number of opportunities for the PHCW to obtain some feedback on his or her performance will also dictate the frequency of the need for "refresher courses" or further training. One must presume that the type of person likely to be a PHCW, particularly in the rural areas, is someone of limited education--no more than a secondary level. One must also assume that there are limits to the amount of information which can be taught such a person, retained and effectively applied in the field, particularly if there is to be only limited ongoing supervision. This suggest that the requirements for training will not end after an initial 10 or 20-week course, but that there will be a need for some subsequent training, both in strengthening previous skills and learning new ones.

A critical dynamic factor shaping the magnitude of training is the need for the PHCW to be successful. This may seem obvious, but in most countries they are indeed new creatures on the health care scene. They neither possess the longstanding training via ancestry and apprenticeship of the traditional practitioner nor the credentials of the modern sector physician. To gain acceptance within the community, they will have to

seem as an acceptable and relevant alternative to the traditional practitioner or to a trip to a health clinic. Proximity is not a sufficient attraction. This implies that the community will have to perceive that the PHCW has received sufficient training in the skills he or she is expected to deliver, and this also will be a factor dictating the character and cost of the training received.

The above considerations determine the length of the training process for any individual PHCW, imply something about what types of skills must be imparted during the training process, and suggest the frequency and duration of periodic refresher courses. Three other factors will critically affect the expenditure requirements associated with the training component of such a program. First, a critical policy issue is the desired density of such PHCW staff within the community. This determines the magnitude of the total enrollment that will be necessary to provide the requisite number of PHCW for the country. Should there be one PHCW for every 100 families? 500 families? 1000 families?

Second, some estimate must be made of the anticipated wastage rate of PHCWs, both in a short and medium term sense. Not all PHCWs will complete the training program. One must similarly anticipate that many PHCWs will either stop their "practice" or aspire to further higher training in the medical system. This will necessitate new streams of enrollment into the PHCW system. Third, the cost of training will be critically affected by the type of training program designed. One can imagine the courses being provided in a well-constructed building near a modern hospital, with small laboratory facilities; one can also imagine their provision in a small rural classroom with a limited number of medical teaching staff. While not fully substitutable, one can envision the temptation of the profession to mimic costly and perhaps inappropriate standards of training.

In summary, the toal recurrent expenditure on training will depend on:

1. the number of new enrollees;

2. the number of enrollees in "refresher" courses;

3. the length of the initial and refesher courses, respectively;

4. the technological standard of training; and

5. the "wastage" rate of enrollees.

Given the uncertainty about the decision parameters discussed above, the newness of the PHCW concept and the lack of experience with their functioning, it is difficult to estimate the expenditure requirements in absolute terms. One can hypothesize that we are not dealing with a particularly expensive form of training, relative to the cost of training most other medical personnel for which the government has responsibility. It will presumably require the organization of a training center with dormitories in some centralized location, with some access to a rural-oriented primary care facility (or urban-oriented if one is considering urban PHCW).

How would such an operation be financed? There are several obvious alternatives: (1) directly financed out of the government budget, (2) financed by the PHCW participants themselves, (3) financing by the communities from which the PHCWs are coming and (4) external financing, either from private or foreign governmental sources. In the few countries where this has been tried, the first alternative appears as the chosen approach. In the Chinese case during the Cultural Revolution, medical staff were effectively diverted and sent out to the rural area to train the so-called barefoot doctor cadres. Subsequent to that, the provinces or counties provided the resources for training.

In most countries, there is considerable competition for recurrent resources among ministries and within the health ministry itself. Yet the cost of this type of training program is not likely to be very significant compared to the overall budget of a Health Ministry. For example, in Kenya, the total cost of health training is only approximately 6.5 percent of the total Health Ministry budget, and if one focuses solely on the cost of paramedical training, the share of the budget is likely to be far lower. If the introduction of a PHCW is viewed as an important element in the elaboration of the health system of a country, the budgetary financing of the training program should not be that excessive a problem. External financing for such training is also likely in terms of the initial capital costs and the increased willingness of donors to finance start-up recurrent costs.

A more critical issue is how the services of the PHCW will be financed on an on-going, recurrent basis. Will this be an additional layer of the health system to be financed out of the Health Ministry budget? Will the PHCWs be volunteer workers? Will they be able to charge a fee for services? Will they be financed by the individual communities, as is the experience in China? These are perhaps the more important questions.