Human resources for health: focusing on people with disabilities

Tom Shakespeare and colleagues (Nov 28, p 1815)[1] suggest that the training of health professionals should become more disability-sensitive than heretofore. This is certainly true, but the most significant challenge in training now facing us is not sensitising conventional health workers, such as doctors and nurses, but training a new cadre of disability and rehabilitation professionals capable of implementing the new and ambitious community-based rehabilitation (CBR) guidelines to be launched this year.

These guidelines will require practitioners to work across disciplines and across health and related sectors (social welfare, employment, education) to address the five major components targeted in the guidelines: health, education, livelihoods, social development, and empowerment. This will require practitioners with a new, and broader, skill set than any profession can currently offer. But in low-income countries, where most people with disabilities live,[2] we already have a chronic shortage of conventionally trained nurses and physicians, with an estimated shortfall in sub-Sahara Africa alone of 800 000 by the target date of the Millennium Development Goals (2015).[3]

However, there is now cumulative and strong evidence for the effectiveness of task shifting to alternative—so-called mid-level or low-level—cadres.[4,5] We call for the development of a new cadre for implementing the new CBR guidelines, but stress that such a cadre, providing a broad skill mix, must have a stronger professional identity, better developed interconnections with other health workers, and a more supportive and motivating work environment than has previously been characteristic of new cadres, in CBR and elsewhere, in low-income countries.

We declare that we have no conflicts of interest.

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HORIZONS-AMI

The 12-month results of HORIZONS-AMI (Oct 3, p 1149)[1] show that, in patients with ST-segment-elevation myocardial infarction (STEMI) undergoing primary percutaneous coronary intervention (PCI), anti-coagulation with bivalirudin reduced net adverse clinical events and major bleeding at 1 year compared with heparin plus a glycoprotein IIb/IIIa inhibitor. The difference, evident almost immediately after the procedure, was due to reduced bleeding with bivalirudin. Very early, but not 12-month, stent thrombosis was increased in the bivalirudin group. Of interest, major adverse cardiac events were lower in those given a 600 mg clopidogrel loading dose than in those given 300 mg, irrespective of antithrombin treatment.[2]

Studies showing a benefit of glycoprotein IIb/IIIa inhibitors in STEMI are from an earlier era, undertaken before the routine administration of thienopyridines in adequate loading doses. Two placebo-controlled trials[3,4] have assessed glycoprotein IIb/IIIa inhibitors in STEMI patients given aspirin and clopidogrel 600 mg. In the 800-patient BRAVE-3 study,[3] abciximab had no beneficial effect on infarct size or clinical outcomes, and in the 400-patient ASSIST trial,[4] eptifibatide did not reduce clinical events.

About 70% of major bleeding after primary PCI is associated with femoral access, and can be largely avoided by intervening via the radial artery.[5] To those of us selectively giving glycoprotein IIb/IIIa inhibitors and routinely using radial access for primary PCI, the benefits of bivalirudin seem modest.

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