The rocky road to rural health

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Summary

Rural health is featuring more prominently on the national agenda in recent times. This article offers a personal review of some aspects of rural health care in South Africa, particularly in terms of human resources, and proposes a way forward.

There have been some important advances in rural health care, such as the implementation of the district health system, the community service and Cuban doctor programmes, the rise of RuDASA and academic initiatives in rural health. Difficulties in the way of improved rural health care include the AIDS burden, the moratorium on the registration of foreign doctors, negative attitudes to non-South African doctors, loss of nursing staff and lack of a coherent approach to human resources in health care.

It is proposed that a coordinated rural health strategy is needed, which might include private-public partnerships, clarification of the role of the doctor in primary care and a team approach to solving the problems.

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INTRODUCTION

Nobody with any knowledge or insight would have suggested that the road to rural health in South Africa would be anything but a long and difficult one. There are many factors involved in moving towards the destination of improved rural health including important development issues such as provision of water, basic sanitation facilities, electricity and the like. However, rural health care and an adequate health care system for rural people is one important ingredient which I wish to focus on.

POSITIVE DEVELOPMENTS

There certainly have been some important positive developments in rural health care in South Africa over the last decade. The focus on primary health care and the development of the district health system with its principles of equity and accessibility are cornerstones of improving health care for rural people. Alongside this, there has been a clear recognition on the part of administrators and politicians alike that there needs to be specific attention paid to rural areas. The introduction of community service, first for doctors, then for dentists and now for other health professions, has made a difference to rural hospitals, many of whom have regular South African medical and other health professional staff they never had before. Important in this has also been the increased number of local South Africans who have returned to their own or similar communities to practice, enabling patients to receive care in their own language. The government to government agreement with Cuba and the recruitment of a significant number of Cuban doctors to work in South Africa has also brought about important benefits. Many hospitals that would have been without doctors previously, are now being staffed with Cuban doctors and important regional hospitals supporting and serving rural areas now have a complement of specialists who were not available before. The recognition by the Department of Health that incentives do play a role in ensuring that professionals go to rural areas has led to the most recent announcement that the rural allowance for doctors will be substantially increased (the details of this are still unclear) and that this will be broadened out to include other health professionals who are in critically short supply in rural areas.

At the same time there has been the development of a clear voice for rural doctors seeking to improve rural health care in South Africa through the establishment of the Rural Doctors Association (RuDASA) eight years ago. It has grown from strength to strength and is increasingly consulted by government, the Health Professions Council of S.A., the S.A. Medical Association and other stakeholders, and regularly draws 150 to 200 people to its annual conferences. (Following a decision made four years ago, the venues for these conferences are always in rural areas). Meeting rural doctors I am frequently encouraged to hear of the excellent service, often unrecognised, being provided in many rural areas, in spite of the circumstances, and the wide range of skills evident in rural hospitals in South Africa.

Another recent development has been the shift of Faculties of Health Sciences towards a specific focus on rural health as an important component of academic training for health

professionals in South Africa. Although the University of Transkei Medical School has had a particular community based focus for a number of years, looking towards developing doctors for rural and underserved areas, it has often received better recognition overseas than it has in South Africa[1]. Now other medical schools have followed suit. The University of Pretoria Faculty of Health Sciences established a Department of Community-based education which, although not solely focused on rural issues, does address these significantly. In 2001, the University of Stellenbosch established the first university Centre for Rural Health (Ukwanda), and the University of Natal established the first academic position in rural health in South Africa in 2002. The University of the Witwatersrand, which has a long history of educational and research activity in rural Limpopo province, appointed the first Chair of Rural Health in South Africa in the same year. What impact these developments have and how much they are examples of tokenism or of real change remains to be seen.

OBSTACLES

Despite these positive developments the obstacles along the road seem to have grown larger and more numerous at the same time. As is the case in almost every part of the health sector the burden of AIDS has increased the work load on rural health professionals and placed extra stress on them in situations where they are really under a lot of pressure. This has not helped staffing. Alongside that, the moratorium on the registration of foreign doctors, which was only finally lifted in November 2000, and the introduction of examinations for all foreign doctors, including those who were previously eligible for full registration, has decreased the number of overseas doctors coming into South Africa to assist. Much of the medical service in rural areas was previously provided by such doctors. The clear message from the Department of Health, until very recently, that they were not interested in employing foreign doctors has also been made known internationally; although this has now changed, it will take a lot of effort and work for the message to be communicated that overseas doctors are welcome again to come and assist in rural areas. Previous contacts and connections have been lost and will need to be re-established.

Alongside this process there was a seemingly xenophobic approach on the part of the Department of Home Affairs, working together with the Department of Health, which made many well qualified African doctors from outside of South Africa feel unwelcome in this country. These doctors provided the backbone of service in rural hospitals and many of them, as soon as they have obtained additional qualifications or been made aware of other opportunities, have moved to countries that have made them feel more welcome, particularly Canada and Australia. This has meant that they have been lost not only to South Africa but also to the continent of Africa as a whole.

Despite the fact that health has been recognised as an important pillar in the government's integrated rural development strategy, there has been no evidence of a clear and co-ordinated rural health care strategy on the part of the Department of Health. The positive developments mentioned above have been piecemeal and there has not been a co-ordinated plan put in place. The latest in these piecemeal approaches has been the announcement by the Minister of Health that her department will be introducing mid-level medical workers (medical assistants) by the end of this year[2]. Many rural doctors, and nurses, are very concerned about this development and believe any such approach should be part of a comprehensive rural health strategy which is discussed with all role players i.e. there needs to be a clear road map for the way ahead.

The outflow of health professionals from the country has continued apace but it has been probably most felt in terms of nursing personnel. In the last few years other countries have suddenly discovered that South African nurses are well trained and suitably skilled, and they have thus been recruited in large numbers, with the attraction of substantial rewards. While this has had an impact on hospitals everywhere, its greatest impact has been on rural hospitals, as nurses have not only left these hospitals to go overseas but have also left these hospitals to replace nurses leaving the urban hospitals. Strategies are being developed to address this, but again these need to be part of a comprehensive plan. It is reported that the Department of Health is in the process of working with the Commonwealth Health Ministers to develop an ethical recruitment code which may go part of the way to addressing this. The lead in terms of this was taken by the fifth World Rural Health Conference in Melbourne in May last year when the Melbourne Manifesto was adopted by the conference. The manifesto is a code for international recruitment of health professionals[3].

However it is not only international recruitment that has affected nursing shortages in rural areas. In at least one instance, that is in KwaZuluNatal, the opening of a large referral hospital in a city has led to an exodus of nurses from rural hospitals. The possibility of this happening in other provinces, particularly for example the Eastern Cape where the new academic hospital in Umtata will shortly be commissioned, is something that is of concern.

WHAT CAN BE DONE?

So what is the way ahead? As mentioned above there needs to be a clear road map. As part of this, I believe there is a need for a clear policy on rural health care in the country. However it cannot simply stop at policy as the country already has many excellent policies in place, which cannot be faulted but which do not get implemented on the ground. There must therefore be a clear strategy, with officials tasked with implementation of the strategy. In order to develop the strategy it is important that all key stakeholders are brought together. Rural doctors, like many others, are very willing to contribute positively to such a process.

One largely untapped resource that exists in many parts of the country is a pool of private general practitioners in small towns and villages. Many general practitioners are feeling the squeeze financially because of medical aid constraints, managed health care, etc. They are looking for opportunities to find additional ways to supplement their

income at the same time as contributing to health care in this country, rather than seeking financially greener pastures outside. Many of them have a history of working part-time in government service or as district surgeons but in more recent years have either been deliberately excluded or excluded themselves because they have not felt able to fit into the new dispensation. This is a tragedy which needs to be addressed. A co-ordinated approach from both sides to bring such doctors back into the system can have a significant impact. Many of these doctors are highly skilled and would play a beneficial role not only in terms of actual patient care but also in terms of support of community service doctors in such situations. Their full incorporation into the district health system would certainly have the potential to move us forward significantly, and would encourage a more co-ordinated approach to common health problems. In a number of places GPs have already taken action such as adopting a local government clinic where they work on a regular basis[4], sometimes voluntarily but more often at a rate that is low enough that it is almost voluntary.

I believe that another area that is critical and needs to be sorted out is the place of the doctor in primary health care in rural areas. It is clear that the doctor has a very strong and important role to play in district hospitals and in secondary care. However, public service doctors have often neglected primary care, causing problems in many instances. It is important that rural doctors and primary health care nurses come together to understand the role that each plays and to develop the concept of a team approach to primary health care. This will ensure that the role of the family physician or experienced rural generalist as an important facilitator and supporter of primary health care is not negated. One of the very positive lessons from Cuba is their model of the family physician, or generalist comprehensive doctor as they call the specialty, who serves as the fundamental cornerstone of primary health care in that country. In our situation, with the important role of primary health care nurses in primary care, this needs to be adjusted but the importance of the family physician in this situation should not be ignored. A clear understanding of this needs to be developed. This may be facilitated by discussions around the Wonca-WHO guidebook *Improving Health Systems*[5].

There are many other issues which need to be addressed such as support of community service doctors, the context and content of training for medical students, the development of vocational training in South Africa, the need for enhanced procedural skills for doctors going to work in rural hospitals, the critical importance of proper hospital management, etc, but all of these should be included in any rural health care strategy plan. While South Africa has its own unique needs and situation we should learn from the experience of the USA and Australia who have developed clear rural health strategies over the last two decades and are well on the way to implementing these. Australia, for example, has reached the point where every faculty of health sciences is required to have a rural clinical school and students are required to spend at least 25% of their time in such schools.

However we also need to learn from Australia and make sure that there is not conflict between rural doctors and family physicians, causing a division which can be exploited by antagonists of both. It is in the interests of family physicians and rural doctors to work together and to have a united vision for the development of rural health care in this country. Indeed, just as family doctors/general practitioners should not separate themselves from rural doctors, so rural doctors should not separate themselves from their health professional colleagues in the rural health team but should stand and work together in seeking to develop a health care strategy for rural people.

THE ROAD AHEAD

The only way that we can make progress in developing this road to rural health and ensuring the major obstacles are cleared is if all role players - doctors in public and private service, other health care professionals, administrators, politicians and rural communities - come together, speak to each other and develop a unified approach, so that we all work in the same direction.

Am I hoping for too much?❐

References

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