South Africa needs more doctors and dentists

The debate on the staffing of South Africa's health care system is old, and the issues have changed very little over the past 30 years. It may seem incredible that, with so much debate over such a protracted period, there's so little improvement in human resources for health in the country. What more can one add to the discussion than to lament our collective failure? Why is it that other developing countries with far lower per capita GDP have such radically better indicators of health?

The Reynders Committee[1] in 1980 reported to the Regional Health Organisation for Southern Africa (RHOSA) (members: Gazankulu, Lebowa, Kangwane, KwaNdebele, QwaQwa, Transkei, Bophuthatswana, Venda, Ciskei, SWA/Namibia) the difficulties being experienced by the members in recruiting doctors and other health professionals and in keeping them, once recruited. Of the 16 reasons documented for these difficulties, plus a further 3 for nurses, only 2 have been addressed, and 1 has fallen away with the end of military conscription.

The Browne Commission,[2] appointed in 1980 and concluded in 1986, found that there was 'excessive fragmentation of control over health services and a lack of policy direction, resulting in a misallocation of resources, duplication of services and poor communication between the various tiers.' Regarding personnel, the commission reported on maldistribution, dominance by whites, large percentages of qualified nurses not actively nursing, student nurse numbers declining, overworked staff and inaccurate manpower statistics.

There is apparently poor conversion of recommendations into action. Perhaps the starting point in the debate is a failure to fully appreciate that South Africa is a developing country with a subset of developed communities – and not a developed country. Professionals, policy makers and legislators by and large live in the developed subset and exhibit an overwhelmingly unrealistic view of 'need'. This is pervasive in society and partly to blame for service delivery protests. It is time for professionals to accept that the country cannot afford all of the professionals that we 'need', based on the frequently quoted developed world benchmarks. The human resource for health (HRH) model for South Africa needs not only realistic thinking but also highly pro-active implementation. The country needs deliberate and aggressive development of task-shifting, task-sharing, introduction of other categories of personnel, focus on prevention programmes, and real care at clinic level – as opposed to the esoteric debates that we still hear about primary health care. As far back as 1986, the Browne Commission recommended that 'nobody should do a job that a person with a lower qualification could do equally well'.

So in planning the 'doctor requirements' for the future, there is a need to recognise a more diverse set of professionals than doctors alone. Likewise, planning the range of specialties and the numbers of specialists should match the population and burden of disease variables. Human Resource for Health planning also depends on the availability of supporting infrastructure (theatres, hospitals, etc.) and all staff required to support the team. There have been attempts in the national Department of Health to design appropriate models[3] that consider these many variables, but there has never been consultation and joint problem-solving with professional associations who are best placed to understand the issues. The conclusions of departmental modelling, and of work done by the Colleges of Medicine[4], point to a deficiency in graduate numbers and, by implication, in training opportunities. Yet there are still 8 health sciences faculties, and their collective output has not grown to even keep pace with population growth. Already in 1984, the de Villiers Report[5] presented recommendations for investigating the possibility of further facilities for medical and dental training. This committee also recommended that professional councils should give urgent attention to recruitment, training, salary structures and status of nurses and supplementary health personnel. The same problems continue to plague the health system today.

There has not been systematic and prolonged, deliberate policy evolution and implementation, even for the public service. It is neither necessary nor advisable to embark on massive policy upheaval all at once, but a multi-year policy roll-out is essential. Some elements of a potential policy have been implemented. In the public sector, which is the foundation for training centralised intern placement, community service and occupational specific dispensation (OSD) have been implemented, mostly not well. However, other elements have not been implemented or have been very poorly managed, and opportunities missed. Policy on foreign recruitment is dogmatic and retrogressive,[6] OSD failed to differentiate rural (and other inhospitable) settings from urban and, in fact, area allowances have disappeared. Failure to provide sufficient accommodation plus the policy on 'market-related rental' of official housing in isolated rural areas has a negative effect on the ability to recruit and retain professionals. Only very recently have registrar numbers increased, but without sufficiently understanding specialist needs. The CMSA has done considerable work on this matter. Lastly, the debate continues as to whether the private sector negatively influences the availability of public skills capacity. In raw numbers, this has not been convincingly proved. However, if interns and community service and registrar doctors are removed from the public sector figures, it is clear that experienced and skilled practitioners are more abundant in the private sector. Policy and action on collaboration of the sectors lacks creativity and remains clouded by suspicion on both sides.

The cause of the human resource deficiency is frequently stated as financial shortage. However, it is difficult to make this case. Following the dawn of the democratic era in 1994 health services suffered major structural adjustment and budgeting challenges together with a shift to fiscal federalism. The Health Minister and national Department of Health have no control at all over health budgets. These are determined at provincial level from 'provincial equitable shares' distributed by an act of parliament annually on the advice of National Treasury.[7] Salaries and benefits are negotiated centrally and prescribed for the entire public sector by the Department of Public Service and Administration after conclusion of Bargaining Chamber agreements. In an attempt to protect tertiary care and professional teaching and training (and other special health sector needs), National Treasury proposed several 'conditional grants'. The 'tertiary services grant' (TSG) and 'health professionals teaching and training grant' (HPTDG) were implemented for this reason. However, more than a decade later, there is still debate over, and individual provincial interpretation of, both grants. No province can report on spending of either grant or on compliance with any condition. Academics, together with the education authorities, concerned by the failure of the grants to protect teaching and training, have motivated to National Treasury to introduce a further grant in the education vote.

One more attempt to steer the design of the health sector and, indirectly its human resource capacity, is the introduction of the concept of a 'certificate of need' and the more recent Office for Health Standards Compliance (OHSC).[8]

The bottom line, however, remains that facilities, other infrastructure and equipment, while essential to health services, cannot replace a competent, appropriately skilled and motivated

workforce. A comprehensive long-term human resource plan, managed with transparency and inclusiveness, is long overdue and a *sine qua* non for a successful national health service.

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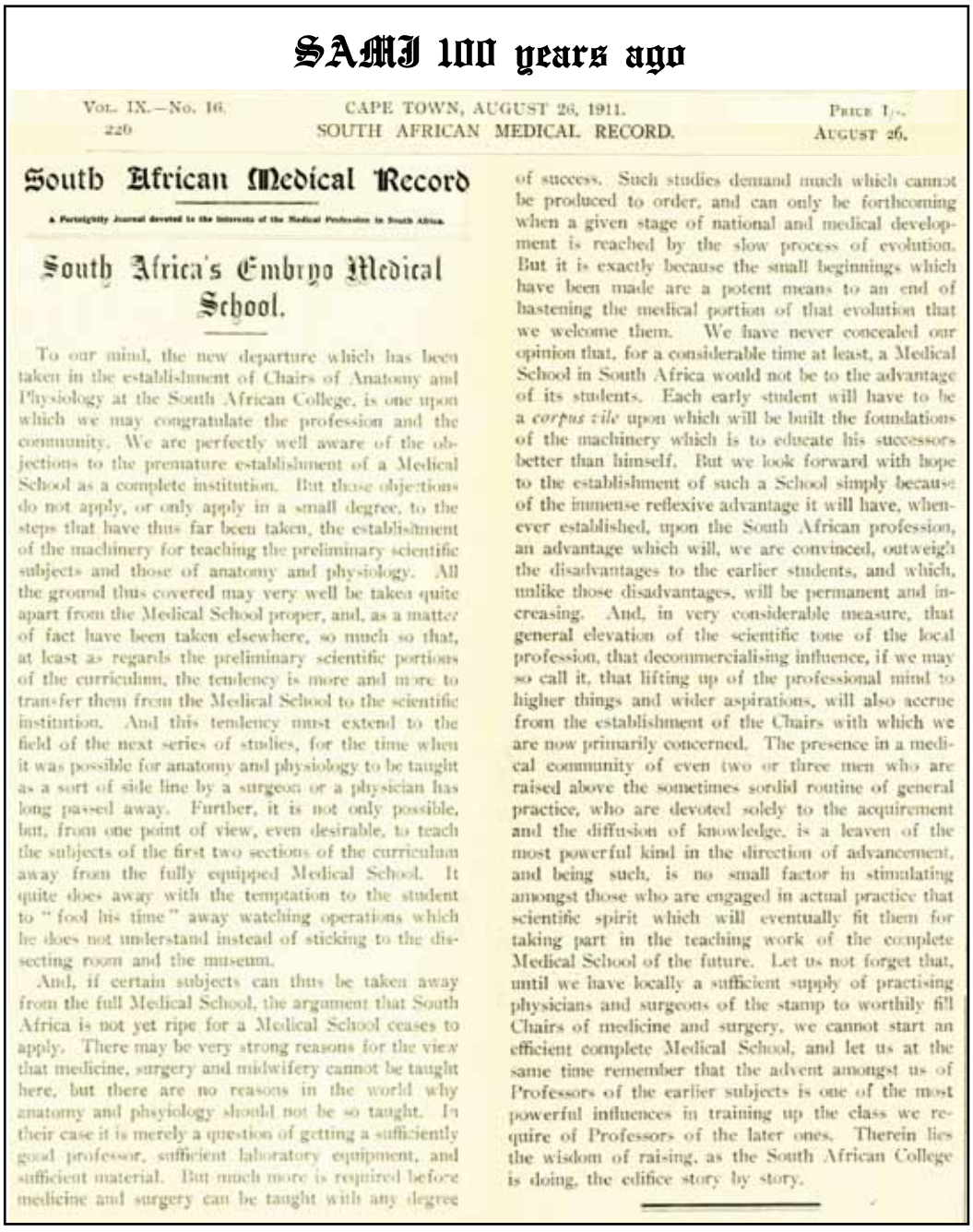
SAMJ 100 years ago



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South Africa's Embryo Medical School.

To our mind, the new departure which has been taken in the establishment of Chairs of Anatomy and Physiology at the South African College, is one upon which we may congratulate the profession and the community. We are perfectly well aware of the objections to the premature establishment of a Medical School as a complete institution. But those objections do not apply, or only apply in a small degree, to the steps that have thus far been taken, the establishment of the machinery for teaching the preliminary scientific subjects and those of anatomy and physiology. All the ground thus covered may very well be taken quite apart from the Medical School proper, and, as a matter of fact have been taken elsewhere, so much so that, at least as regards the preliminary scientific portions of the curriculum, the tendency is more and more to transfer them from the Medical School to the scientific institution. And this tendency must extend to the field of the next series of studies, for the time when it was possible for anatomy and physiology to be taught as a sort of side line by a surgeon or a physician has long passed away. Further, it is not only possible, but, from one point of view, even desirable, to teach the subjects of the first two sections of the curriculum away from the fully equipped Medical School. It quite does away with the temptation to the student to "fool his time" away watching operations which he does not understand instead of sticking to the dissecting room and the museum.

And, if certain subjects can thus be taken away from the full Medical School, the argument that South Africa is not yet ripe for a Medical School ceases to apply. There may be very strong reasons for the view that medicine, surgery and midwifery cannot be taught here, but there are no reasons in the world why anatomy and physiology should not be so taught. In their case it is merely a question of getting a sufficiently good professor, sufficient laboratory equipment, and sufficient material. But much more is required before medicine and surgery can be taught with any degree of success. Such studies demand much which cannot be produced to order, and can only be forthcoming when a given stage of national and medical development is reached by the slow process of evolution. But it is exactly because the small beginnings which have been made are a potent means to an end of hastening the medical portion of that evolution that we welcome them. We have never concealed our opinion that, for a considerable time at least, a Medical School in South Africa would not be to the advantage of its students. Each early student will have to be a *corpus vile* upon which will be built the foundations of the machinery which is to educate his successors better than himself. But we look forward with hope to the establishment of such a School simply because of the immense reflexive advantage it will have, whenever established, upon the South African profession, an advantage which will, we are convinced, outweigh the disadvantages to the earlier students, and which, unlike those disadvantages, will be permanent and increasing. And, in very considerable measure, that general elevation of the scientific tone of the local profession, that decommercialising influence, if we may so call it, that lifting up of the professional mind to higher things and wider aspirations, will also accrue from the establishment of the Chairs with which we are now primarily concerned. The presence in a medical community of even two or three men who are raised above the sometimes sordid routine of general practice, who are devoted solely to the acquirement and the diffusion of knowledge, is a leaven of the most powerful kind in the direction of advancement, and being such, is no small factor in stimulating amongst those who are engaged in actual practice that scientific spirit which will eventually fit them for taking part in the teaching work of the complete Medical School of the future. Let us not forget that, until we have locally a sufficient supply of practising physicians and surgeons of the stamp to worthily fill Chairs of medicine and surgery, we cannot start an efficient complete Medical School, and let us at the same time remember that the advent amongst us of Professors of the earlier subjects is one of the most powerful influences in training up the class we require of Professors of the later ones. Therein lies the wisdom of raising, as the South African College is doing, the edifice story by story.