

NEW PERSPECTIVES ON AN OLD PROBLEM

- Recruitment and Retention of Health Professionals in Rural Areas

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The definition of insanity is to keep doing the same thing over and over, and expect something different to happen.

In a 1971 article in the Lancet, Dr Julian Tudor-Hart coined the “inverse care law”, which notes that the fewest health professionals are found where they are needed the most, and vice-versa. Clinicians operate largely in a problem-solving mindset – the daily work of seeing patients presenting with one or other clinical problem means that we tend to deal with all issues in the same way. And so it is that, confronted by the problem of recruiting and retaining staff, we immediately look for solutions. We recruit others from overseas, we advocate for better conditions of service, we encourage young matriculants into the profession, we find sponsorships for those who need them, and shepherd them through medical school, hoping that one or two of them will return to fill our places when we are tired and worn out, and have moved on. But beyond our well-intentioned efforts to stem the tide, there are powerful forces in operation. You see, when all you have is a hammer, it is remarkable how many things start to look like nails. In the next 20 minutes I would like to put our hammers down for a little while, as it were, and look around at what’s happening around us and to us, in a broader perspective.

I want you to imagine that you have 7 different pairs of glasses in front of you, each of which is a different shape and size and strength. If you are my age, then this represents a part of the real situation with regard to reading glasses, which I keep leaving all over the place, so I have to have 6 or 7 pairs, otherwise I can’t read a thing.

The problem-solving fix-it paradigm is our default mode – essentially technician in approach, it is close to the biomedical paradigm. It is limited in effect, and does not change anything in the longer term.

Let’s try a different pair of glasses.

An Historical and Political Perspective

Now if I put on my bifocals here, then I can look through historical and political lenses simultaneously. Imagine a historian in 50 years' time – the year 2057 – documenting the history of rural health in SA. They might note that Rudasa members were merely actors in a particular period of history which had its own momentum in this country, starting with **Traditional healers** in rural areas, then the **Missionaries** setting up clinics and hospitals, the establishment of **medical schools**, and only later those for training black doctors, followed by the era of the Apartheid **homelands** and the difficulty of recruitment once the missionaries disappeared. Then the impact of **HIV and AIDS**, the New **democratic government** from 94, and the **Moratorium** on recruitment from Africa and developing countries, the introduction of **community service**,I could go on.

And here we are at the **11th conference of Rudasa**, poised at a tipping point in history !

We can't change history, but we can influence this direction intentionally through joint effort. And that's why I use the bifocals on history and politics, because whether we like it or not, we have more and more of a political role to play in advocating for the health of rural people. Witness the huge and direct impact that the current political leadership, and the lack of it, has on the health of South Africans, for example the recent shenanigans of the Minister, which is diverting attention away from the real issues which we face in the frontline.

Economics

Now if I put on my accounting spectacles, and start to look at the world in purely financial terms, there are obviously huge forces at play. Doctors will go wherever you want them to – even to the most inhospitable and dangerous places on earth – if you pay them enough. One chap we met works for 2 months each year in some God-forsaken ice-bound oil station in northern Alaska, and on what he earns is able to finance travelling around the world for the remaining 10 months of the year. So, you could say, it's all about money. Hennie Groenewald suggested that I say something about the effect of the **rural allowances**. Some research I did with a group of medical students showed that the rural allowance has made a difference to choices that health professionals make with regard to where they practice – it definitely influences about a third of people to change their site of work. When we asked them how much would make them change where they practiced, a majority of nurses and doctors said that R50 000 per annum would do.

But on the negative side, there are financial forces at play attracting health professionals very strongly away from rural areas, and into urban areas, private practice and overseas, as we all know. Whether we like it or not, we are mere pawns in a global market place, where health care and health professionals are mere **commodities** that can be bought and sold. In this paradigm, every doctor

has a price. So open your eyes to the competition – in the private sector, they want good doctors who are clinically competent and reliable, and they will pay you handsomely. And what of the global economy ? Well, you may have heard of something called **GATS**, which stands for the General Agreement on Trade and Services. Basically it is a worldwide agreement that we should all trade fairly and not protect our own economies, and make trade easier between countries, so that goods and services can be exchanged without restrictions or import duties. And guess what ? Doctors' skills are part of the Services in GATS – they want to liberalize exchange of the skills we have, produced at great cost locally in our medical schools, and make it easier for whoever has the money to buy the services that they need.

So what do we do about this one ? There is not much we can do to influence global economics, but we can continue to lobby for rural allowances and conditions of service such as accommodation that operate in the opposite direction to the flow of resources from public to private, from rural to urban, from SA to overseas. In other words, use economics to reverse the inverse care law. It can be very effective, but the problem is that we may not be able to afford it in this country on a sustainable basis.

So, maybe we should try a different set of spectacles.

The Legal perspective

Let's look at the issue of maldistribution using a legal lens.

Look at what the AIDS Law Project has done in conjunction with the TAC with regard to access to anti-retrovirals. But what about access to other health services by rural people ? If Rudasa raised the funds to hire 4 or 5 lawyers, to take on a few cases of litigation over poor quality of care, or the unfair distribution of resources, we might make a lot of progress on recruitment and retention of professional staff in rural areas. Using the SA constitution as a guide, it may well be possible to make a case for a human rights approach to rural health, and force the actual implementation of many of the nice policies and grand rhetoric of the politicians and senior managers in government, so that real changes are seen in our hospitals and clinics. If recruitment and retention of staff is the major limiting factor in the ARV rollout, then the availability of accommodation is just as much a constitutional issue as the availability of the drugs themselves, which the TAC took to court.

A quick tut on human rights and health: The “**Core**” human rights are constructed around the 3 principles of

- Freedom
- Dignity, and
- Equality or fairness

The development of a human rights approach to health issues started after the Second World War with the **Universal Declaration of Human Rights** in 1948, which stated that “Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care”. In 1966, the **International Covenant on Economic, Social and Cultural Rights** confirmed “... the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Then the **Convention on the Rights of the Child** in 1989 stated in Article 24: “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall **strive to ensure** that no child is deprived of his or her right of access to such health care services.” Section 27 of our **South African Constitution** states that “Everyone has the right to have **access** to health care services, including reproductive health care”, and that “The State must take reasonable legislative and other measures, within its available resources, to achieve the **progressive realization** of each of these rights.” This means that the government can still argue that there are not enough resources to guarantee access for everyone, and this is a convenient loophole. Except in the case of children, where these rights are less negotiable.

So we could conceivably assist a team of lawyers to take up a few key cases in the courts, to push the boundaries of access to health care in rural areas, particularly on behalf of children. Issues such as the need for birth certificates before children can access ARVs is a specific example that needed to be challenged. But the lack of health professionals in rural areas, and the consequent denial of access by rural people to a reasonable quality of health care, is a more general issue that could be tackled, as the SA Human Rights Commission has recently started to do with their Public Inquiry into the right to have access to health care services. We look forward to their report with anticipation.

Class & Race & Gender

[DARK GLASSES!] These are my PW Botha glasses. And I can't see anything very clearly through them.

There is no doubt that race plays a huge role in the distribution of medical practitioners around the country, but there is also evidence that this is changing.

We are obsessed by race in South Africa, and the whole meaning of transformation has become synonymous with racial correctness and so-called equity (although no-one can accurately define what they exactly mean by equity), rather than a genuine concern for dignity, fairness and freedom.

But what about class ? There are no South African studies to back this up, but social class definitely plays an important role in determining where medical practitioners choose to practice. John Tumbo's study of rural origin of students in SA medical schools shows that around 20% of SA medical students are currently of rural origin. If this is a proxy for social class, then we have some work to do to make our medical graduates more representative of the communities that they will serve.

in the BMJ in 2004, two British studies showed that there were massive disparities in medical school admissions by social class, mainly because pupils from working class backgrounds see medical school as distant, unreal, and culturally alien.

In the first study, researchers found that white and black pupils from the highest social class (social class I) were between 30 and 100 times more likely to gain a place at medical school than those from the poorest social classes (social classes IV and V). The findings of this study suggest that many able and ambitious pupils from poor backgrounds are not achieving their potential.

A second study looked at the reasons for these differences. Focus groups were conducted with high ability pupils aged 14-16 years from different backgrounds in six secondary schools in London, and found striking differences by socioeconomic status. Pupils from lower socioeconomic groups held stereotyped and superficial perceptions of doctors, saw medical school as culturally alien and geared towards "posh" students. They greatly underestimated their own chances of gaining a place and staying the course. Whilst they saw medicine as having potential financial rewards in the distant future, they perceived prohibitive personal risk in the more immediate term. In contrast, pupils from affluent backgrounds viewed medicine as one of a menu of challenging career options with intrinsic rewards such as personal fulfilment and achievement.

How could we address the issue of social class as it affects recruitment and retention ? Through the selection policies of the medical schools. We need to understand the complex social and psychological issues in the South African situation, by undertaking appropriate research, into the internal and external barriers that black students from rural backgrounds face in considering medicine as a career.

But more than this is needed – also a marketing, motivational programme that helps high school learners from rural and underprivileged backgrounds see their potential, and start to realize their dreams. The Friends of Mosvold scholarship scheme has shown how this can be done, and a number of other student-lead initiatives are doing similar work.

Let's look at it from another perspective

Psychology / Motivation

I often ask students what **motivated** them to get into medical school. And I get some stock responses – money, status, family pressure, interest in science or biology. But every medical student has some sense of wanting to be helpful or of service to their community or their patients. Even the most mercenary students, who explicitly want to make a lot of money and drive a fancy car, have some degree of altruism or humanitarian values. If you think about it, opting to study and practice medicine has an intrinsic value built-in: every patient is by definition ill, and being ill makes one vulnerable, marginalized even, by one's illness. So we commit ourselves to the care of a vulnerable, marginalized sector of society. While some choose to exploit the misfortunes of others, and make personal profit from others' miseries, I believe that in Rudasa the **values** that set us apart are those that implicitly commit us to the care of rural communities who are amongst the most poor and marginalized in South African society. During the apartheid years, I always said that the worst effects of the system, the sump, the ultimate impact, could be seen in the childrens' ward of a rural hospital in a so-called homeland. These are the most vulnerable of the most vulnerable, and they are the most powerful indicator of the effectiveness of our health system in correcting the gross inequities of the past. I am sorry to say that I don't think much has actually changed in these terms over the past 13 years – with HIV and AIDS it may even be worse.

The person who taught me the most when we worked at Bethesda Hospital was a quadriplegic man called Frans Gumbi, who had fallen off his bicycle and broken his neck a few years before we got there. And he was a pathetic sight – barely able to move his arms, emaciated, and with constant urinary infections and recurrent bedsores. But he was always, always grateful and pleased to see us, greeted us with a wide smile, and bore his suffering with an extraordinary dignity. Being unable to cough, he died eventually of TB, but he left with me a lesson in the power of outward vulnerability, to transform our responses from fear and rejection, to care and commitment.

There is a value system that in the past was labelled as "**Vocation**". The sense of a calling is what lead the missionaries a century ago to establish most of the rural hospitals in SA in the first place. We still talk about "Vocational training" as a particular type of post-graduate apprenticeship.

In the new era, now that the old-style "**missionary era**" is over, we need to retain that sense of calling, or at least a vision for one's career that involves serving the poor and marginalized. It is a precious thing, whatever you call it, and it is altogether too easily lost, drowned out by the clamour for status or money or privilege as we climb the career ladder. So, I would argue that when we talk about retention, we consider not just the retention of staff geographically, but also the retention of the values that got us into this life path into the first place.

How could we go about it, ?

Help to develop a sense of vocation – for everyone, not just those whose motivations are explicitly religious. It means nurturing in students and young doctors that sense of accountability and **social responsibility** that is in everyone, (even if it is difficult to see sometimes). It means being the role models, and exposing younger doctors to the role models, who live and work with these values visibly. And helping younger graduates to **plan their careers** appropriately.

What does this mean for Rudasa ? Why are we so often able to “punch above our weight” as it were ? Why do people in government listen to us (even if it is lip-service) ? Why do the corporates, at the other end of the spectrum, also take us seriously and want to give us money out of their social investment portfolios ?

I think it’s not that we are as important as all that, but because we represent something important, that we symbolize and stand for a value system that everyone tacitly acknowledges is just, in an unjust and unfair world.

And so I think it is entirely appropriate that our first strategic priority, from our meeting at Bulungula 2 years ago, is to inspire scholars, students, other doctors, government officials and specialists to consider the needs of the rural people whom we seek to serve.

Education

Finally, an educational paradigm, which in my view, brings a lot of these things together. Ian has spoken about the **rural pipeline**. If we move the pipeline into an educational framework, then we start to think about recruitment as a process that starts at high school, not one that starts after completion of community service. If we start recruiting our professional staff for rural areas from our local high schools, we will probably do quite a few things differently, including supporting those students through their studies and ensuring that they return.

There are established theories and concepts of education broadly termed “**critical pedagogy**” – a theory of teaching and learning that takes the issue of power as a central component. Writers like Paulo Freire and more recently, Henri Giroux talk about most educational processes being essentially **reproductive**, when teachers seek to replicate in their students the same set of knowledge, skills and attitudes as their own. By contrast, critical pedagogy is essentially “**transformative**”, in that students and teachers are encouraged through the process to challenge and push the boundaries, not taking their teachers’ word on everything, and to transform not only themselves but also the society and context in which they function. It is a very radical movement, that would see teachers and even doctors as “transformative intellectuals” ? Have you ever thought of yourself

in that way ? Maybe we do actually transform the lives of the individual patients we interact with – certainly with ARVs now we do. But transform society ? But why not ? We are not politicians, I hear you mutter - leave that to the TAC.

But we are among the intellectuals of this country: most doctors were top of their classes in matric. The medics of the University of Natal (black section) were the intellectual powerhouse of the struggle, Steve Biko included. So where are we now ? Have we lost our minds ?

I would suggest that we have stopped thinking in a critical way: we have been seduced and blunted by the medical system, which gives us a status way beyond our due, and turns health care (including our own work) into a commodity which can be bought and sold to the highest bidder (usually a foreign one).

What about a “**rural pedagogy**” ? What about a theory of teaching that values the principles of rural life, draws on it for perspective, and offers it as something useful for others ? The 1997 World Rural Health Conference took this as its theme. I believe that we as rural doctors have something incredibly valuable to offer to the medical community at large, and that is a unique perspective on relationships and systems that are manageable within a circumscribed community, that facilitates a health-focused rather than a disease-focused approach to health care.

Conclusion

I am saying that we have to look at the bigger picture - we can't keep banging on at the recruitment and retention problem with the same old instruments, and expect a different result.

So what are the take-home messages ?

- As Rudasa we should consider using legal means to advocate for the rights to health of our rural people.
- Think about Recruitment as a longer term process beginning with selection to medical schools
- We should pay attention to retention, not just in the geographic sense but also in the motivational sense of retaining the values that inspire us.
- Education, as a transformative process instead of Training as a reproductive process, is a unifying concept.
- We need to be involved in critical debate, challenging the status quo, activism and lobbying.
- And finally, don't forget that there are 3 R's – recruitment, retention and return. The RHI is working on that one – getting South African doctors to return from their wanderings around the northern hemisphere, back to where they can make a difference.

I hope that I have introduced a broader understanding of the issues in terms of the ways in which we think of them, which will stimulate rural doctors and others to consider more creative ways of engaging with the issues of recruitment and retention in rural areas, so as to bring new networks and strategies to bear on this old and apparently intractable problem.

And now it's OVER TO YOU !