

RECRUITMENT AND RETAINMENT OF STAFF IN **Rural Areas**

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Central to any attempts to strengthen management in rural areas is the necessity to recruit suitable personnel and to retain them long enough to provide some continuity. There is a striking difference between rural health districts in which there has been some permanence of management and those in which there has been a rapid turnover. This problem has been the subject of considerable study in Australia and in Canada, and in this country has been studied by at least three commissions whose reports have been totally ignored by the central health authorities.

It has been said that only missionaries, mercenaries and madmen will voluntarily seek a career in a remote area. Present remunerative packages certainly exclude mercenaries, except perhaps for doctors coming from Eastern Europe and third world countries, and the character and motivation of the missionaries has changed markedly in the past few years.

This paper attempts to identify some of the factors which encourage or discourage doctors from working in underdeveloped regions.

1. Lack of a Career Structure

- Even with the best motivation in the world it is virtually impossible to envisage a career in a rural area without considerable personal sacrifice. Current salary scales only allow advancement to the rank of Principle Medical Officer and in the case of specialists to Senior Specialist, no matter how long one has been in the service. In the case of medical administrators the highest possible rank is Senior Medical Superintendent with a salary equivalent to a junior specialist in provincial hospitals!
- No fringe benefits. Apart from a "territorial allowance" which varies from time to time and is

not pensionable, rural doctors do not benefit from housing allowances, sabbatical leave and transport allowances. Study leave and attendance at congresses is very difficult to obtain.

- No recognition for additional qualifications. There is thus no incentive for further study other than self motivated continuing education. As part of an employment package a compulsory planned continuing education programme would go a long way to making a career in a remote area more attractive.

2. Inappropriate Training

• *Undergraduate*

1. Selection of students. In Australia and Canada it was found that students selected from rural backgrounds tended to return to rural areas. In this country most medical students come from an affluent urban milieu and have, as role-models, well remunerated specialists.
2. There is insufficient exposure in current curricula to rural practice and in most of our Medical Schools the teaching is organ and disease orientated.

• *Postgraduate*

- The training of specialists in the traditional clinical disciplines is becoming more and more compartmentalised which makes them more and more inappropriate and indeed irrelevant in regions where a wide spectrum of skills is required. Highly trained specialists rapidly become frustrated in a setting in which they cannot use their highly developed skills. In an understandable attempt to improve the situation and in the mistaken belief that more high tech equipment will ameliorate their service, they make demands for more equipment, often inappropriate and always expensive. The result is that scarce resources are diverted from

Primary Health Care and suitable Secondary Level activities to satisfy the personal needs of the specialist.

• **Specific Appropriate Training**

Vocational Training Programmes. Departments of Family Health at some of our Universities and the Academy of Family Practice currently run Vocational Training Programmes for Family Practitioners which go a long way to improving the skills of rural practitioners. However, they do not address the need for technical skills and do nothing to improve the career structures of rural practitioners.

“The Rural Medicine Specialist”.

The concept of a doctor trained specifically to work in remote regions was first proposed in 1989 and since then many academics and rural doctors have shown an interest in the idea.

Apart from a training which would enable a doctor with limited access to specialist support to be able to manage such diverse conditions as Caesarean sections, abdominal emergencies, compound fractures and other trauma, prostatectomies and tonsillectomies as well as anaesthetics and acute and common medical and paediatric conditions; such training should also open up a whole career structure. This implies that the training should be at least equivalent to the training of a specialist (four years or more) and should be registrable with the South African Medical and Dental Council as a specialist and so gain access to the salary scale of the specialist rank. Unfortunately, there is still much resistance to the concept, not least of all from the super-specialists who see this as a threat and an encroachment into their little empires.

• **The “Need to Specialise”**

There are many young graduates who are prepared to work in a rural area, but because of their training, after a few years leave to go and specialise. Once trained in a speciality they find it difficult or impossible to return to a Primary Health Care situation as their skills have become inappropriate.

3. Spouse Satisfaction

Nowadays both partners are often professionals in their own right. Unless both can find jobs in the same rural facility, the non-medical partner becomes dissatisfied with household chores. It has been suggested to the Minister of Health that additional unspecified posts should be created on the establishment of rural hospitals. Spouses could be appointed into these posts and allocated duties in which they could be productive in their own fields. Thus a teacher could start a class for longterm patients, an accountant could institute improved accounting procedures and an architect could design health or community facilities. Alternatively, their services could be farmed out to local private enterprises. The total cost of a few extra posts, which may often be vacant, would certainly not be exorbitant.

A career in rural practice demands considerable personal sacrifice

4. Schooling for Children

In places far from adequate schools, the time for a health worker's children to go to school is one of the most important reasons for relocation. Various suggestions have been made to the Minister ranging from the reintroduction of the “farm school” concept, to the payment of a subsidy/bursary to cover boarding fees and transport and to the provision of “bussing” to take children to school.

5. Academic Isolation.

The “need to specialise” is not only seen as a way to improve one's career but also to improve one's skills and intellect. Specific Continued Medical Education (CME) programmes would help to reduce the isolation. In British Columbia a rotation programme has been introduced to allow doctors in remote areas to rotate with Family Medicine registrars at the University of BC in Vancouver. Planned short-term attachments to clinical units in tertiary institutions would, in addition to updating the knowledge of the rural doctor, also expose academicians to the problems of remote communities.

6. Bureaucratic Problems

- Long delays in appointing new candidates mean that suitable appointees are lost as they cannot wait for six months or more for their appointments to be approved. Requests for Head Office to advertise vacant posts are often ignored causing further delays.
- It takes many months for salaries of new appointees to be adjusted to the correct notch. In the mean time incumbents have to either make do with no salary or a provisional payment on the lowest notch.
- It is the rule, rather than the exception, for salary deductions and additional allowances to be incorrect. In one instance it took two years to correct errors in an officer's salary!

Satisfaction of feeling they are doing something really useful

7. Poor Working Conditions

Inadequate equipment, few or no library facilities and scarce opportunities for specialist consultations, all make a career in a remote area more unattractive.

8. The Role of Foreign Graduates

There has been much debate in recent years on the influence and desirability of doctors trained in other countries. It is a fact of life that health services in rural areas in many third world countries depend on expatriates. In South Africa, the history of Mission Hospitals is rich with examples of highly successful contributions from foreigners. More recently there has been an invasion of doctors from Eastern Europe, Asia and Africa some of whom are excellent. However, many have inadequate professional skills, a poor work ethic and doubtful motivations.

9. Positive Aspects

Many health professionals who have worked for some time in rural areas talk of the satisfaction of feeling they are doing something really useful, of the joys of living in the country, of not being part

of the rat race, of dealing with people rather than organs and diseases and bits of paper, of the pleasure of being able to work from home and of the satisfaction and challenge of covering a wide spectrum of clinical conditions and community problems.

There are fortunately enough health professionals in all the disciplines who believe that the positive aspects outweigh the difficulties and problems to assure at least a nucleus of workers in the less privileged regions to maintain an effective service even if inadequate at times.

Some suggestions to attract and keep Health Workers in remote regions:

- Recruit more medical students from rural areas.
- Decentralise Management

to basic Health Districts.

- Create attractive career structures for all health workers including specific appropriate training, possibilities of promotion to higher grades for long term appointees and compulsory subsidised CME.
- Institute perks for permanent staff such as sabbatical leave, long service awards (not a certificate signed by the deputy minister), housing subsidies even for those occupying official dwellings and possibly improved pension benefits.
- Improve links with academia.
- Pay more attention to the wellbeing of families including spouse satisfaction and schooling.

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