

The future of rural practice – the political perspective



Curriculum Vitae

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“Health is a function of the political process.”

Morley, Rohde and Williams 1983.

Summary

International perspectives are given to illustrate recent interest and research done on the future of primary health care. In South Africa the RDP and its ideals just don't seem to filter down to provincial and district levels because of different political agendas. The essential role of the family physician in bringing about the necessary changes and involving the rural community in primary health care, is described. Recommendations are made regarding future training and education of suitable rural doctors, and their unique role highlighted.

Introduction

The past decade has witnessed increasing interest in several countries especially Australia, Canada, America and more recently South Africa, in addressing the problems of rural and remote health care. Although the provision of adequate health care services and facilities and human and financial resources are important, health system support for rural practice is vital. Appropriately trained and skilled rural general practitioners have been identified as playing pivotal roles in ensuring the delivery of comprehensive, continuous, co-ordinated, integrated and personalised health care. Their role, along with other primary care providers, is seen to be very important in making optimal use of available health resources and appropriate referrals to the intermediate and tertiary levels of care. The role of rural

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The future of rural practice

general practitioners is likely to become even more important if they are able to improve the co-ordination of individual health and community services.¹

Lessons from several country reports illustrate that there is an urgent need to implement strategies to improve rural health services. Recruitment and retention of doctors, education and training for rural practice, the lack of a proper career structure for rural practice and poorly developed infrastructure, have been recurring themes throughout the reports.²⁻⁴ A strong political commitment to equitable socio-economic development and justice in the provision of health care and resources with meaningful decentralisation and community participation at all levels, are the key to the future of rural practice.⁴

AN HISTORICAL PERSPECTIVE

The Australian experience

The concern of rural general practitioners in addressing their problems resulted in the formation of Rural Doctors Associations in all the states. Eventually through a number of local and national initiatives, the Federal and State Health Ministers established an Australian Health Minister's Advisory Council (AHMAC) Rural Health Task Force. In addition, the Federal Health Department funded a National Rural Health Conference organised by the Rural Doctors Association in 1991.

Following the AHMAC Task Force Report and the National Rural Health Conference recommendations, a National Rural Health Strategy was devised. It included recommendations that "all undergraduate professional education programmes should require some appropriate experience" and that "regional hospitals should have a role in undergraduate education". To facilitate these recommendations it proposed

"creation of academic departments in regional centres" which would also create a better "regional focus continuing education allowing rural practitioners a role in education, reducing professional isolation and creating a pool of locums".⁵

The Canadian experience

In 1990 the Canadian Medical Association Board of Directors established the Advisory Panel on the Provision of Medical Services in Underserved Regions⁶ to report on:

1. the nature and extent of deficiencies in the provision of medical services in underserved regions in Canada;
2. the factors that contribute to these deficiencies, and
3. possible strategies to help resolve these deficiencies.

The Barer/Stoddart Report, Commissioned by the Federal/Provincial/Territorial Conference of Ministers of Health, "Toward Integrating Medical Resource Policies for Canada", placed the issue of physicians at the forefront of the discussion and provided a summary of current thinking among health policy experts. Barer and Stoddart reported that geographic maldistribution of physicians emerged as a major concern of all interviewees. Shortages of some specialty services in rural areas were cited as a problem, as was a possible oversupply of general practitioners in some major urban areas.

As background to its deliberations, the Panel for Provision of Medical Services in Underserved Regions considered the various factors that affect health policy environment, existing provincial or territorial incentive programmes and initiatives across Canada related to non urban practice. It also examined trends in the geographical distribution of physicians in Canada. It conducted a national survey of physicians in rural practice and physicians who had

The commitment of RDP is not being filtered down to the district or even provincial levels.

GPs can really raise the standard of health in rural areas.

Poorly developed health policies are hindering progress.

recently left rural practice. In addition, it reviewed the results of a survey of the 16 Canadian Medical Schools regarding their activities to encourage, prepare and support physicians in non urban practice. The panel considered five broad thrusts or strategies to address these problems, viz, incentive programmes, role of medical schools, regionalisation, planning time frame, and community support.

The South African experience

The political commitment of the Government of National Unity to social, economic and political justice is contained in the Reconstruction and Development Programme (RDP) and its health priorities⁷ and in the National Health Plan.⁸ The current problem is that this is not seen to be filtering down to the provincial and district levels. The political processes to achieve this are currently being hotly debated. This process is being slowed down as a result of various political agendas. The transfer of power to the provinces has to be finalised as soon as possible. The District Health System Policy Framework needs to be more fully discussed and debated. At present the local government structures are being developed independently of the districts and the regional district councils which are supposed to include rural and farm areas. The decentralisation process has to take place first for effective delivery of the RDP health priorities.

The experience of developing a rural district health system in the New Hanover district⁹ has highlighted a number of issues that would impact on the future of rural practice:-

1. Family practitioners have an important contribution to make to improve health education, health service and raise the standard of health practice in rural areas. The main obstacles to achieving these lie in poorly developed health poli-

cy for incorporating public health responsibilities into the private sector, lack of incentives, the maldistribution of general practitioners, and the lack of trust in the ability of general practitioners to deliver effective primary health care services. The family practitioners indicated their willingness to become involved if these issues were addressed.

2. Decentralisation or regionalisation is essential for equitable resource allocation.
3. Community involvement in health is essential to address priority issues and build community partnership. Family practitioners can play a vital role in facilitating this process.
4. Multisectoral collaboration is important to address the broader issues of health and development.
5. The problems encountered in coordinating and integrating the previously fragmented service were immense. Many obstacles were encountered, viz, defining the boundaries, deciding on interim government structures, obtaining health ministry support for developing the district health system and implementing RDP health priorities.

Other experiences

1. Rural Health Task Groups have been established in many States in America to investigate the implementation of health strategies for the achievement of optimal health in rural and underserved areas.¹⁰
2. The World Organisation of Family Doctors (WONCA) has established a Working Party on Education and Training for Rural Practice. This committee has completed its report and submitted its final document to the WONCA Council. The recommendations, if adopted by the member countries will have a major impact on the future of rural practice.¹¹
3. Practising Health for All (David Morley, Jon Rohde, and Glen

Decentralisation is essential for equitable resource allocation.

GPs can be facilitators in involving the community in health care.

The future of rural practice

Williams)¹² analyses primary health care (PHC) and rural health programmes in 17 developing countries.

4. Midway Reports of Country Experiences in 15 countries (E Tarimo and A Greese)¹³ describe how the primary health care approach has been adapted to their individual circumstances. The accounts focus on practical experiences in the context of national programmes and policies. They point to the need to develop and improve intersectoral co-operation, infrastructure, and outreach programmes, to ensure effective decentralisation, to make better use of existing resources, to improve information programmes, and to adopt strategies for health promotion.

THE POLITICAL PERSPECTIVES

The disease profiles, the suffering and the demographic decline of rural communities are directly linked to the prevailing socio-economic and political policies and system of government. Country reports of rural communities in Canada, Australia, New Zealand¹⁴ and South Africa¹⁵ have highlighted the plight of rural communities who have suffered deprivation, discrimination and dispossession over many centuries.

The effects on the health of rural communities has been more evident in South Africa where deep scars of inequality in education, health, development and basic service provision exists today. The provision of water, sanitation, housing, electricity, roads, communication and employment are priority issues.¹⁶

Political instability, conflicts, violence and wars, as a result of the struggle for liberation and democracy, have disrupted health services especially in rural and remote areas. The serious consequences for the health of these

people is evident today in Rwanda, Bosnia, Mozambique, Angola, South Africa, South East Asia, Central America and in the Middle East. The foundation for health in these countries will be laid within the framework for democracy. This is the present situation in South Africa as the Government of National Unity implements the Reconstruction and Development Programme (RDP) and its health priorities and socio-economic and health policy frameworks that address the inequalities of the past.¹⁷

The RDP entrenches the political commitment and support for the achievement of optimal health and outlines the minimal standards that should be met nationally, provincially and locally by both the public and private sectors. It aids infrastructure development and creates employment opportunities for at risk communities. Political stability is, therefore, a prerequisite for the future of rural practice.

Several of the above named countries are currently involved in national strategic planning processes that address various inequalities and are attempting to achieve political stability. Experience has shown that the prime objective should be the achievement of a unitary, comprehensive, decentralised primary health care delivery system. The political commitment for the development of such an infrastructure with community involvement and appropriate mechanisms for reorientating medical practice, medical education and medical service to meeting people's needs has been identified as the way forward for the future of rural practice.

It is important that all relevant stakeholders, who have an interest in rural health, consult with each other through a national consultative or advisory committee. There are many people interested in rural health, viz, national, provincial and local government, rural doctors individually and through their

The previously fragmented health service left us with immense problems.

Expose medical students more to rural practice.

Rural health care needs to be well resourced.

professional organisations such as Rural Doctors Associations, Academics, Medical Associations, Colleges, Universities, post graduate committees, and other professional organisations, rural communities and their organisations.¹¹

EDUCATION AND TRAINING FOR RURAL PRACTICE

There is an urgent need to implement strategies to improve rural health services around the world. This will require sufficient numbers of appropriately trained and skilled general practitioners to provide the necessary services. In order to achieve this goal, WONCA recommends:

1. Increasing the number of medical students recruited from rural areas.
2. Substantial exposure to rural practice in the medical undergraduate curriculum.
3. Vocational training programmes which are specific for rural practice.
4. Specific continuing education and professional development programmes which meet the identified needs of rural general practitioners.
5. Appropriate academic positions, professional development and financial support for rural doctor-teachers to encourage rural research and education.
6. Medical schools should take more responsibility to educate appropriately skilled doctors to meet the needs of their general geographic region including underserved areas and should play a key role in providing regional support for health professionals and accessible tertiary health care.
7. Development of appropriate needs based and culturally sensitive rural health care resources with community involvement, regional co-operation and government support.
8. Improved professional and personal/family conditions in rural practice to promote recruitment and retainment of rural doctors.

9. Development and implementation of national rural health strategies with central government support.

THE FUTURE OF RURAL PRACTICE

A number of prerequisites have been identified as essential for the future of rural practice:

1. National health system support for rural practice.^{18, 19} National governments need to develop and implement integrated, comprehensive and effective national rural health strategies to meet the needs for rural practice. This will require the involvement of communities, doctors and other health professionals, hospitals, medical schools, professional organisations and national, provincial, state and local government. The infrastructure for achieving this should be developed first to ensure that rural health is well planned, organised and managed. Rural Health Care should be well resourced. The establishment of a National Rural Health Research Organisation will facilitate this process.
2. Regionalisation and decentralisation of health delivery through the development of district health systems.¹⁹
3. Community involvement and participation in decision making for rural practice.¹⁹
4. Education and training policies that support rural health.¹¹
5. Intersectoral collaboration for effective health delivery.¹⁹
6. The involvement of family practitioners in individual care and in community service planning.²⁰

CONCLUSION

The family practitioner has been identified to play a pivotal role in health care delivery in rural areas. The well trained family practitioner will provide better quality care more cost-effective-

Fundamental changes are needed.

The future of rural practice will depend on recognising the role of the GP.

ly. Not only are they uniquely qualified for the task but represent the most effective means to control unnecessary and untimely use of specialist services. To fulfil this responsibility the family practitioner must be highly competent in patient care and must integrate personal and community health care.¹

To meet the needs of rural practice, fundamental changes must occur in the health care system, in the medical profession, in medical schools and other educational institutions. The family practitioner will be a major agent for change for effective, cost-effective and accessible primary health care of a high standard.

The future of rural practice will therefore depend on recognising the role of the family practitioner in providing optimal health care through appropriate medical education, appropriate medical practice and appropriate medical service.

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