Vocational Training Column

KwaZulu Perspective

Talk given by Dr Darryl Hackland, Secretary for Health, KwaZulu, at the Adcock Ingram 'Training the Trainers' Workshop on the 28th September 1985.

"The KwaZulu Department of Health and Welfare has the task of providing health and welfare services to 5,5 million people, of whom, at the present time, over 60% live in rural areas. The health service is delivered to the population through five larger referral hospitals, 21 district rural hospitals, 187 residential clincs and 431 mobile health visiting points.

The present manpower resources are:

	No	Ratio
Specialists	34	
Medical Officers	395 (30 Black)	1 : 12 222
Nurses	8 000	1 : 687
Health Inspectors	30	
Medical Technologists, Radiographers, Physiotherapists and Occupational Therapists	60	
Administrative Staff	600	

The budget allocation for 1985/86 is R198 million. Salaries comprise 70% of this, leaving R60 million or approximately R10 per capita for services.

DEPARTMENTAL POLICY

It is accepted and approved KwaZulu Department of of Health policy that primary care is the nucleus around which the provision of health services revolve. At the very centre of the thinking process — the philosophy of health care — is this word ***primary*** that is not only essential, but paramount. The implications are daunting as to the need to convince the holder of the budget that the allocation of finances must reflect this. Most of the R198 million will be spent on secondary and tertiary hospital curative services. However, there needs to be a turn-about, upside down planning, bottom-up approach.

DELIVERY OF PRIMARY CARE

In speaking of primary care, the broader term of providing comprehensive care to the whole person, and not only 'first contact care', is meant. To enable the Department of health to do this effectively, a team approach has been adopted — the health inspector, the nurse, local community people, other Departments (such as Education, Agriculture, Community Development Doctors. Over the past fifiteen years there has been a gradual but definite move away from the curative approach to medical care. The underserviced areas with regard to health care facilities and health care personnel have had to make the best use of resources available to them. When the ratio of doctor to population is calculated (1 : 12 000), this is an overall ratio for KwaZulu. When the large hospital doctor population is removed, the ratio becomes too horrific to contemplate. But contemplate we must, for we cannot, as health planners and health managers, leave this state of affairs unaddressed. Leaving the number of medical officers at the five referral hospitals, (*viz* 250 who are caring for patients in a secondary and tertiary sense), bound to the walls of a hospital, the remaining 200 are available to care at a district and community level — ratio 1 : 27 500. Is there any wonder then that KwaZulu has looked at the alternatives? Much of the load of primary health care rests on the shoulders of the nursing profession. To that profession we owe a deep debt of gratitude for grasping the problem and providing something of a solution. But is the solution satisfactory? Is it the best that can be achieved? Yes, we do still have to consider the reasons for underserviced areas. On the bookshelves will remain for many years to come David Warner's book entitled 'Where there is no Doctor'.[1] That situation must change. The dilemma is how? How do we plan for the rôle of the doctor in primary care for the future?

— National Health Facilities Plan/Privatisation
— Move of doctors to rural areas by way of the initiative of the SA Academy of Family Practice training.

STEPWISE APPROACH

1. ***The Pretoria Symposium***[2] — addressing the problem of the underserviced areas. It is alarming to learn that, in fact, South Africa is producing enough doctors to meet the need.

700-800/year. 5 "White" medical schools — 4 million population.
100/year. 2 "Black" medical schools — 25 million population.

2. ***Discussions with the Academy*** as to how the KwaZulu Health Service could participate in resolving the dilemma were held. No longer is this a question of 'where there is no doctor' after the initial question we have to ask 'where have all the doctors gone?' (with tribute to Max Bygraves), and consider the response by way of the alternative strategy adopted by KwaZulu of training nurses for the extended rôle in diagnosis and treatment. The decision reached was that this Department would participate in a Vocational Training Programme which would be set up at Edendale Hospital. Facilities would be provided there where the co-operation of the heads of the various departments would be assured.

January 1985 saw the arrival of the first five trainees and the launch of the programme here in Durban a few months later.

3. The next step was that of the extension of the programme into the rural areas — a crucial step. Here planning has to be at its best. Every detail needs to be carefully considered to take this step, small with respect to numbers, but gigantic regarding the implications and in setting the stage for the future of primary care in South Africa. We are now at this crucial point and meeting one of the priority needs of this move — to train the trainees, to equip the mentors to provide the support and training for the future rôle of doctors.

4. A retrospective view over the path already followed, reminded me of the strong opinion expressed by general practitioners at the Durban Conference of the Academy (4th Congress). Here it was said that —

i) Services provided by the State through provision of clinics are ineffective — the only service in many rural areas.
ii) There is no provision made for doctors to operate within the present framework. No incentive to be involved.
iii) Competition exists between the private practitioner and the State service as an outcome of the present policy.
iv) There is no room for the family practitioner to participate in a team approach for the provision of an integrated comprehensive health care service.

THE NEXT STEP

We here in this room, representing the Academy, the University through the Medical Schools, the Medical Association, and Health Administrators, need to stop and take stock.

The questions I ask myself now regarding vocational training, are:

1. Where have we come from?
2. Where are we now?
3. Where do we want to be?
4. How do we get there?
5. How can we be sure we've arrived?

We are at the stage of actually training doctors vocationally to be involved in primary care of the highest standard out there. But have we a clear enough model of what we want the structure of the services to be like really?

I believe that we are in the exciting arena of change within the organization — change that will spell out clearly the rôle of the doctor in the provision of primary care in the at present underserved and poorly doctored areas. For real change to take place in any organization, certain elements have to be present. To my mind these are:

a. Dissatisfaction;
b. a model of what the future should look like;
c. a definite plan of how to achieve the model.

When these elements are present, and only then, will change come about, if the cost of bringing about the change is less than the cost of not changing. Regarding cost, I speak not only of Rands and cents, but the cost to communities, the cost to a nation, a country, if a high standard of health care is not achieved. Considering the above elements in turn, as well as the dissatisfaction with the present situation, I have no doubt.

Dissatisfaction in the positive sense leads to change. We here are perhaps dissatisfied that the medical manpower resource is not being used to best advantage. I am sure that the Academy expresses their dissatisfaction. The Medical Schools at the SAAME workshop (SA Association for Medical Education), by addressing the need to look at a different approach to training of doctors, altering curricula, express dissatisfaction.[3]

Is there sufficient dissatisfaction where it matters, where real change must take place? We need to identify these places and ever heightening dissatisfaction. We must be revolutionary, we must now explore and utilize innovative concepts.

THE MODEL

Have we a model, a structure of what this primary care animal will be out there in the 'tomorrow years'? I'm not sure we have. I certainly have a need to work this out. I would venture to say that we all have the need to a greater or lesser degree. If, in this room, there is a mind into which this model is locked, then it must 'out'.

For KwaZulu the model is taking shape. Appropriately trained primary care practitioners with the skills necessary to meet patient community needs are being trained. Family practitioners will be establishing practices in rural areas. How do we, in this model, provide for the all important interdigitation with the present 'national' health service.[2]

The Plan of how to implement the model depends on the model itself. Having provided the model, the plan can be produced.

Here, being convinced that the course set by the Academy that vocational training is essential in achieving primary health care for all the peoples of South Africa, and considering the cost to be less than it would be if this course is not followed, I make a plea by way of a recommendation to the SA Academy of Family Practice/Primary Care that, together with the architects of change in this country, an acceptable model and plan be provided for the provision of primary care in this our land, South Africa. This primary care must be seen to include an equitable distribution of resources; financial, material and manpower, so that primary care will, in the first instance, address the needs of the seriously disadvantaged in our land.

I place the future of primary care in our hands. Let us not waste the opportunity by creating chaos or despair. Let us continue to be the agents for change.

The KwaZulu motto says: 'Sonqobe Sinanye' — in unity we will succeed. I close by quoting the fifth statement in the Alma Ata Primary Health Care Declaration:[4]

> *'Governments have a responsibility for the **health** of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades (and I include such bodies as our Medical Associations and the Academy) should be the attainment of all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.'*

The torch is now lit. Let us begin to run with it for the night is far spent."

REFERENCES

1. Werner D. Where there is no doctor. London: Macmillin, 1977.
2. Workshop Report. The Role of the Doctor in Primary Health Care. *S Afr Fam Pract* 1983; 4(5): 18.
3. Southern African Association for Medical Education. Report and Recommendations from the Workshop on Dilemmas in Medical Education in Southern Africa. Durban: 1985.
4. International Conference on Primary Health Care — Alma-Ata, USSR: 1982. Geneva: WHO, 1982.