The rural health challenge Retaining doctors in the countryside

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Centre for Rural Health

Outline

- Background to the problem
- International guidelines
- Contextualisation of guidelines in South Africa
  - Lessons from our experience
  - Key national objectives
- Conclusions


SOUTH AFRICA
Capital:
Pretoria, administrative;
Cape Town, legislative and
Bloemfontein, judicial
National capital
Provincial capital
Town, village
Major airport
International boundary
Provincial boundary
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BOTSWANA
ZIMBABWE
MOZAMBIQUE
NAMIBIA
SWAZILAND
LESOTHO
LIMPOPO
NORTH WEST
GAUTENG
MPUMALANGA
FREE STATE
KWAZULU-NATAL
NORTHERN CAPE
EASTERN CAPE
WESTERN CAPE
Gaborone
Polokwane
Musina (Messina)
Pretoria
Johannesburg
Nelspruit
Mafikeng
Klerksdorp
Mbabane
Maputo
Bloemfontein
Kimberley
Maseru
Durban
Cape Town
Port Elizabeth
East London
Port Shepstone
Lüderitz
Oranjemund
Alesander Bay
Port Nolloth
Springbok
Upington
Kenhardt
Karasburg
Keetmanshoop
Hotazel
Sishen
Kroonstad
Welkom
Bethlehem
Ladysmith
Newcastle
Vryheid
Richards Bay
Stanger
Pietermaritzburg
Amanzimtoti
Port St Johns
Umtata
Queenstown
Bhisho
Graaff-Reinet
Middelburg
Aliwal North
De Aar
Carnarvon
Williston
Victoria West
Calvinia
Bitterfontein
Klawer
Vredenburg
Saldanha
Beaufort West
Oudtshoorn
Worcester
Paarl
Stellenbosch
Strand
Heidelberg
George
Knysna
Uitenhage
Grahamstown
Port Alfred
Cape St. Francis
Mossel bay
Cape Agulhas
Cape of Good Hope
Table Bay
False Bay
Saldanha Bay
Saint Helena Bay
Algoa Bay
Great Fish
Great Kei
Sundays
Orange
Limpopo
Olifants
Vaal
Harts
Molopo
Caledon
Buffalo
Drakensberg
Delagoa Bay
Save
Xai-Xai
Barberton
Witbank
Germiston
Krugersdorp
Verseniging
Orkney
Piet Retief
Volksrust
Madadeni
Mkuze
Ulundi
River View
SOUTH ATLANTIC OCEAN
INDIAN OCEAN
0 100 200 300 km
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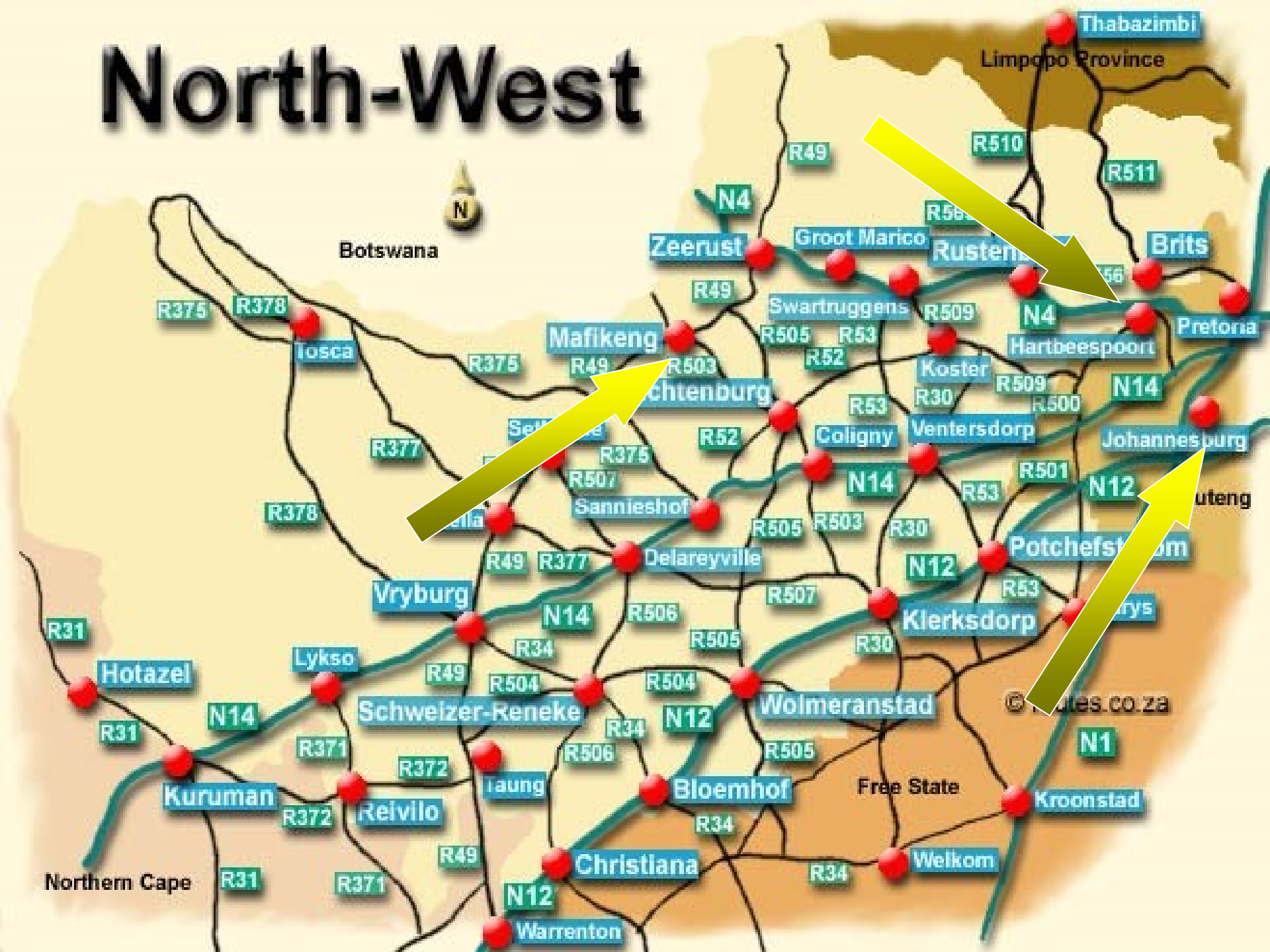
North-West

Thabazimbi
Limpopo Province
R49
R510
R511
Brits
Pretoria
N4
R509
R53
Hartbeespoort
Koster
R30
R500
N14
Ventersdorp
Johannesburg
Coligny
R501
N12
R503
Potchefstroom
Klerksdorp
Kuruman
R372
Reivilo
Bloemhof
Free State
Kroonstad
R34
Christiana
Welkom
Northern Cape
R31
R371
N12
Warrenton
N1


North-West
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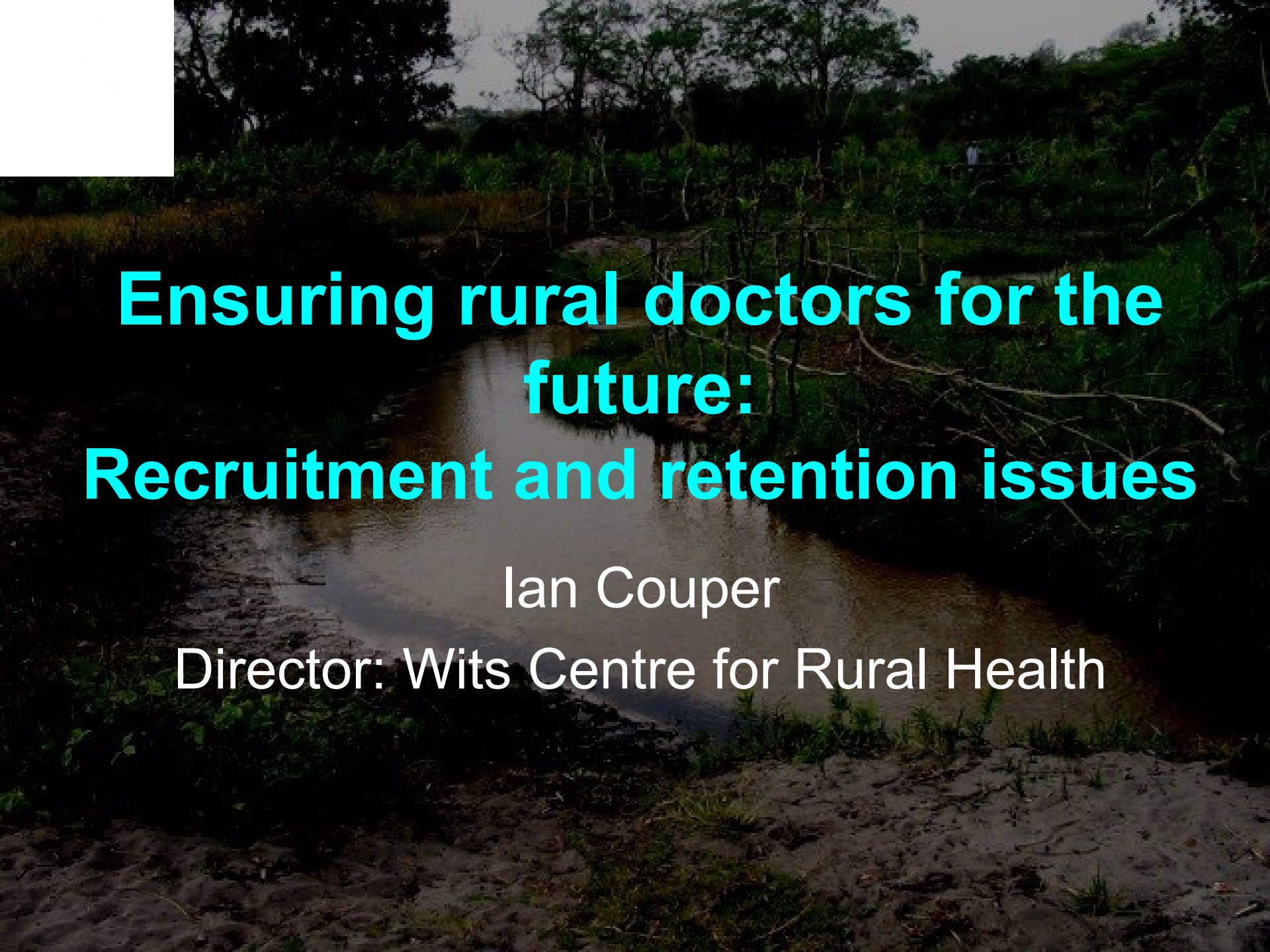


Ensuring rural doctors for the future: Recruitment and retention issues

Ian Couper

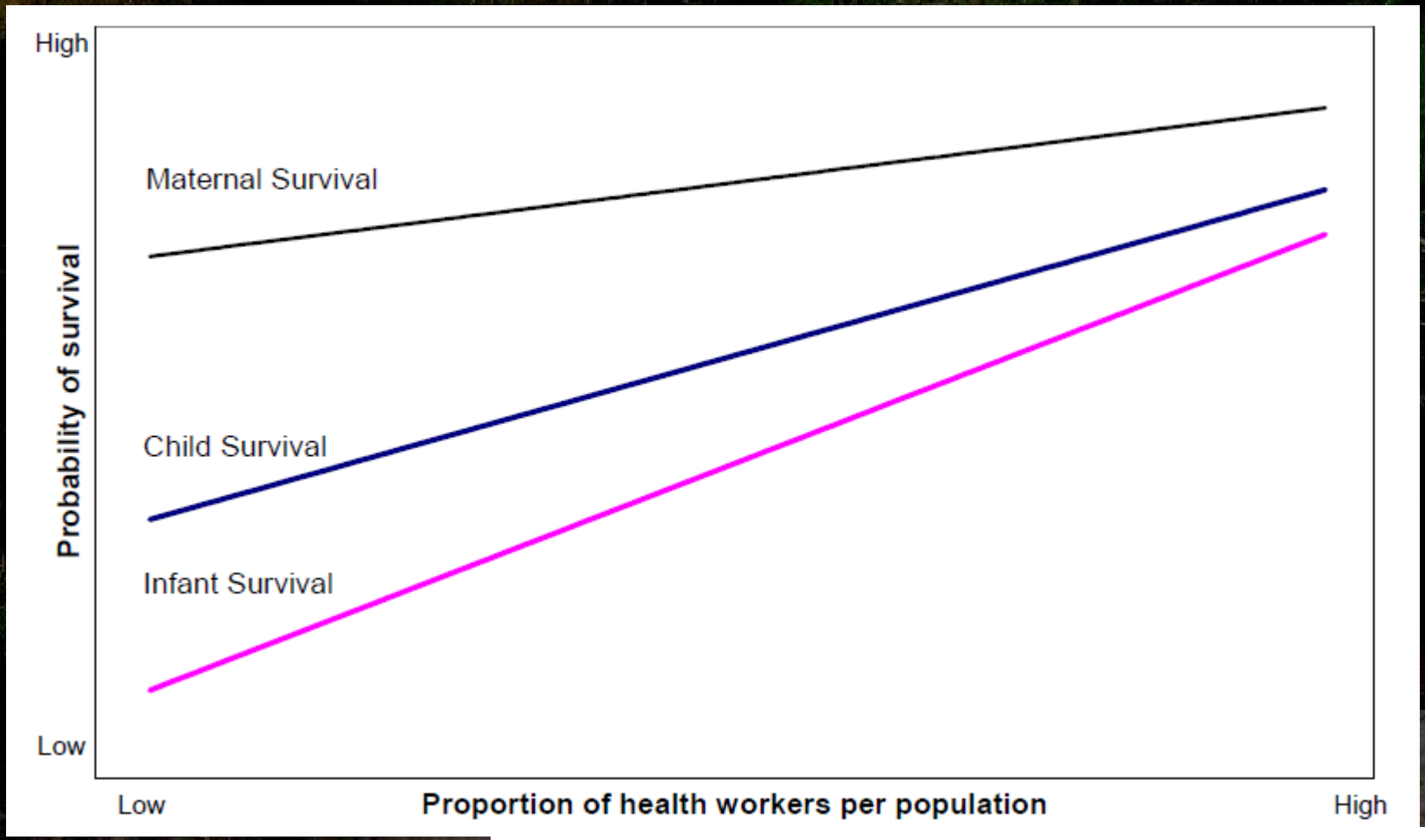
Director: Wits Centre for Rural Health

Can we make a difference?

- NO!

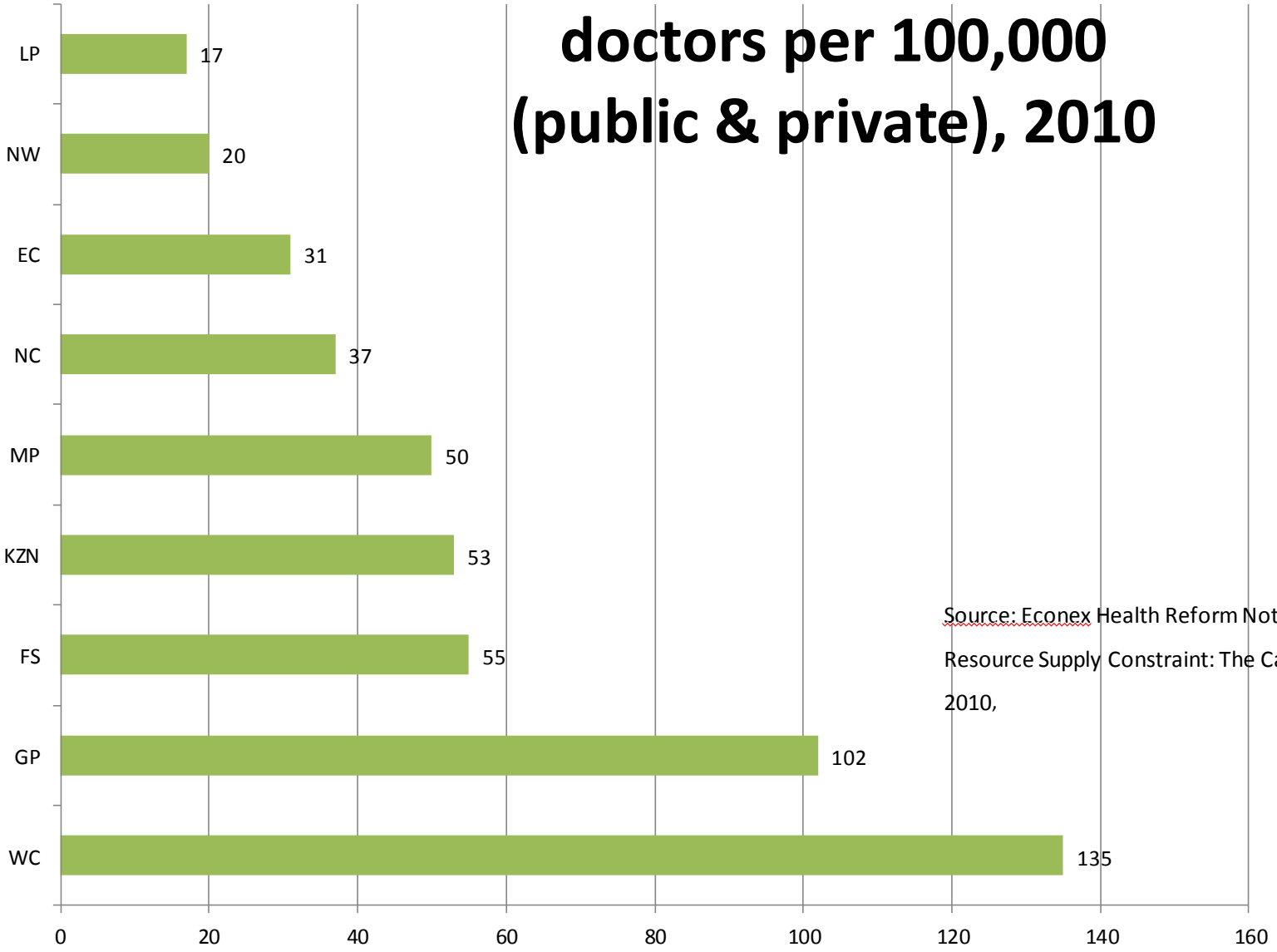
Thank you for coming.

Density of health workers and probability of survival



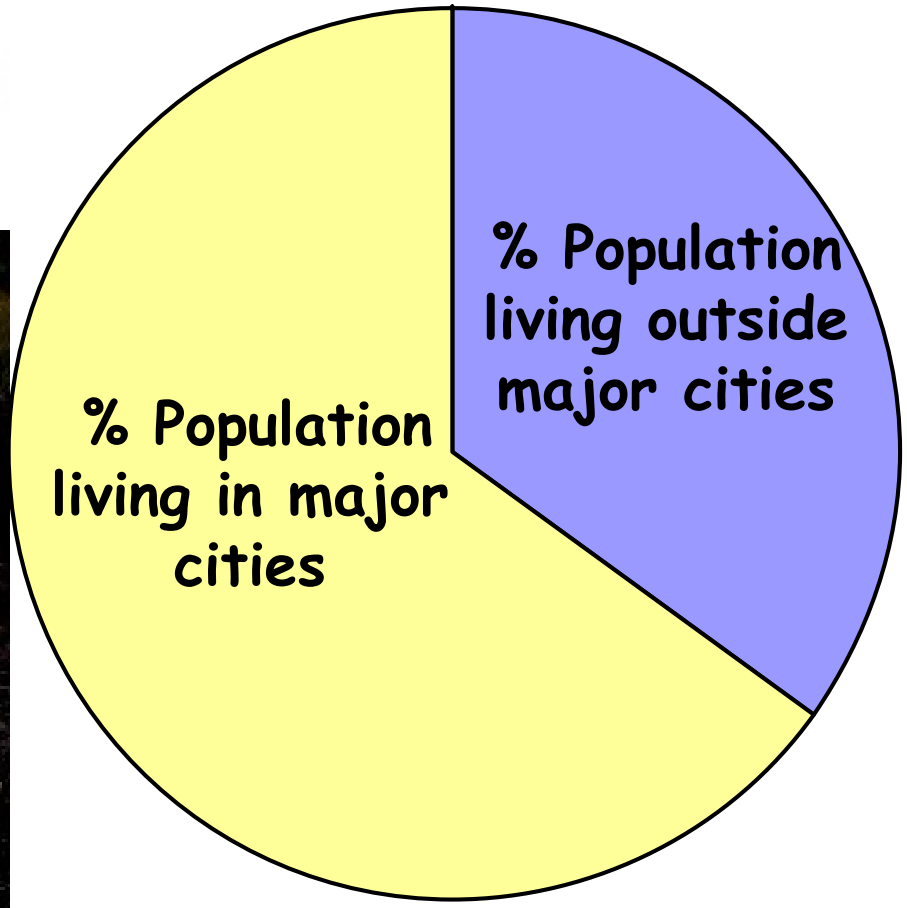
Source: World health report 2

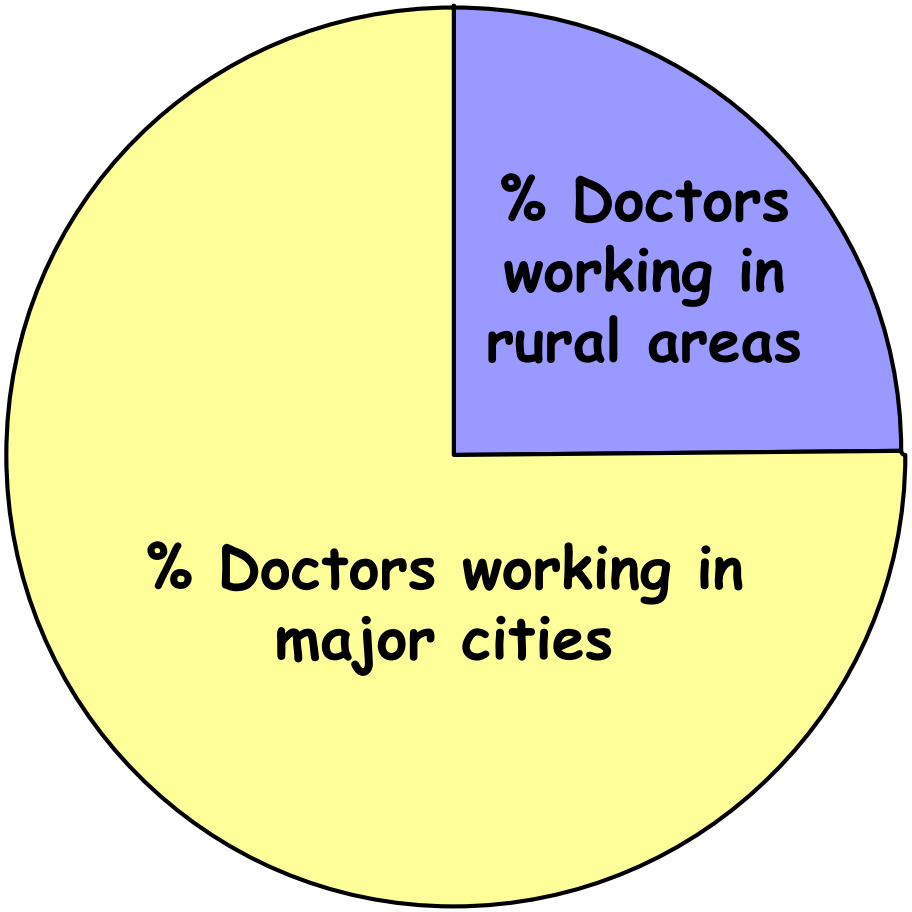
South Africa's regional distribution of doctors per 100,000 (public & private), 2010



Source: Econex Health Reform Note 8. The Human Resource Supply Constraint: The Case of Doctors, 2010,

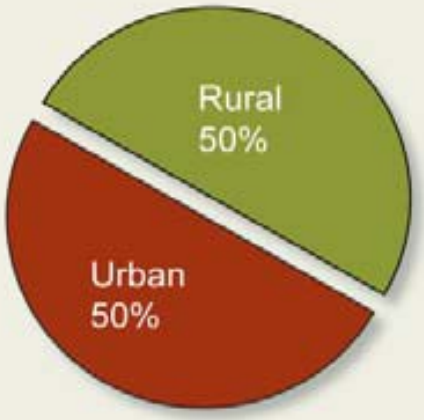
Centre for Rural Health


% Population living outside major cities
% Population living in major cities


% Doctors working in rural areas
% Doctors working in major cities

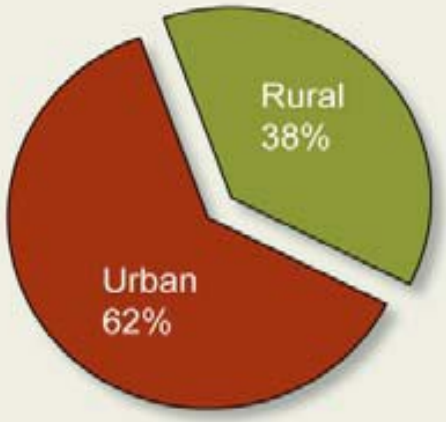
Rural/urban worldwide distribution of physicians, nurses and population

World population

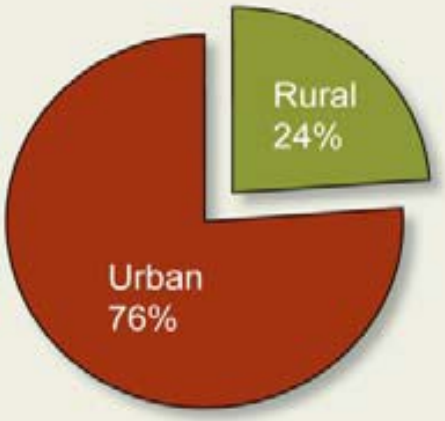


United Nations, *World Urbanization Prospects - The 2007 revision*

Nurses worldwide



Physicians worldwide



World Health Organization, *The World Health Report 2006 - Working together for health*

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Guidelines exist

- WHO Global policy recommendations:

  Increasing access to health workers in remote and rural areas through improved retention

Available at http://www.who.int/hrh/en/

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Development of the guidelines

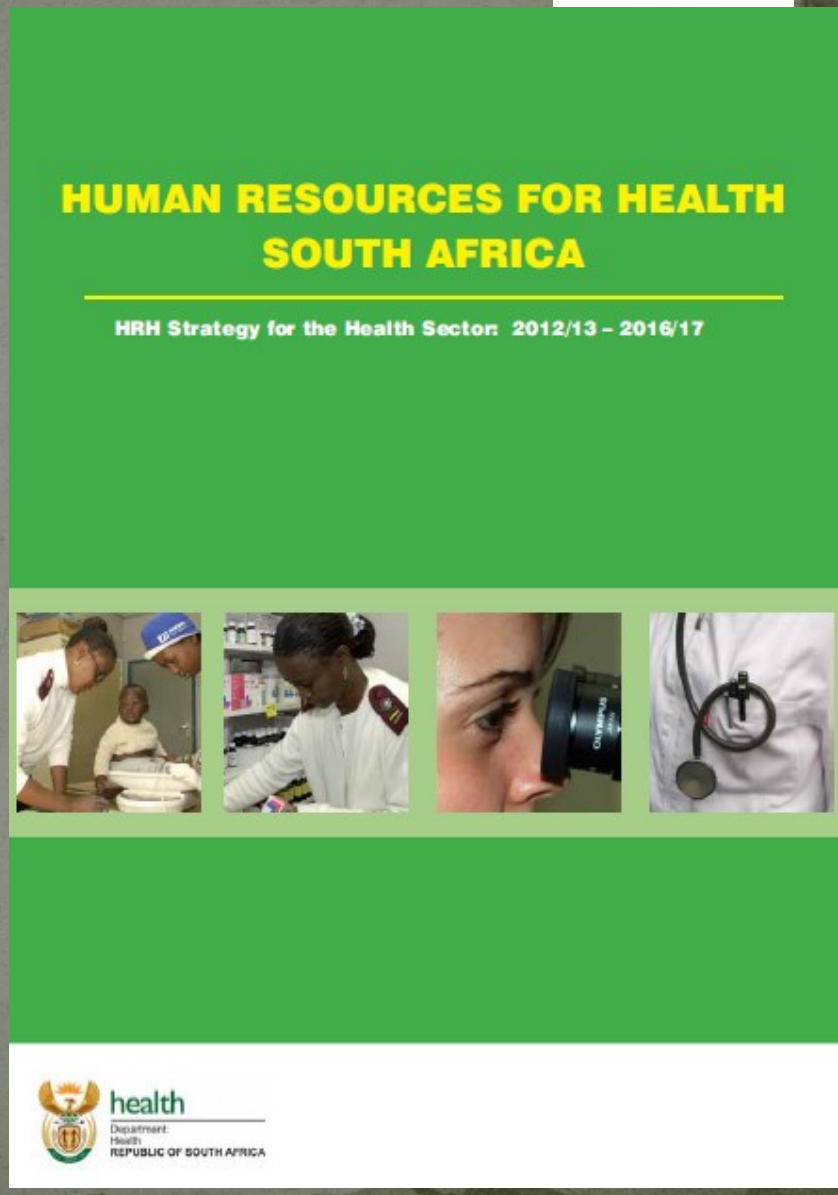
- 2 year process by WHO Expert Panel
- Evidence-based
- Approved by WHO Guidelines Review Committee
- Companion to:
  - WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the Sixty-third World Health Assembly in May 2010

Solutions

- ONE SIZE DOES NOT FIT ALL
- National Human Resources Plans
  - Must take rural and remote health care into account
  - Most include specific rural health strategy
  - Must be based on international evidence

Think global, act local

- Development of South Africa's Human Resources for Health Strategy 2012/13–2016/17 (SA HRH Strategy)
- Role of the Rural Health Advocacy Project (www.rhap.org.za)



Rural Health Advocacy Project

An initiative of

KEY TO A HEALTHY NATION

RHAP is a partnership between Wits Centre for Rural Health, the Rural Doctors Association of Southern Africa and SECTION27. RHAP's vision is "Rural Health - Key to a Healthy Nation". We believe we can only have a healthy nation if rural health care is central to planning and decision-making at national and decentralised levels. The organisational mission of the Rural Health Advocacy Project is "Connecting Practice, Policy and Partners". We aim to be a leading resource in the field of rural health advocacy that facilitates the translation of rural health needs and health care solutions into policy and decision-making.

1. POLICY
2. FINANCING RURAL HEALTH CARE
3. HUMAN RESOURCES FOR RURAL HEALTH
4. IMPLEMENTATION

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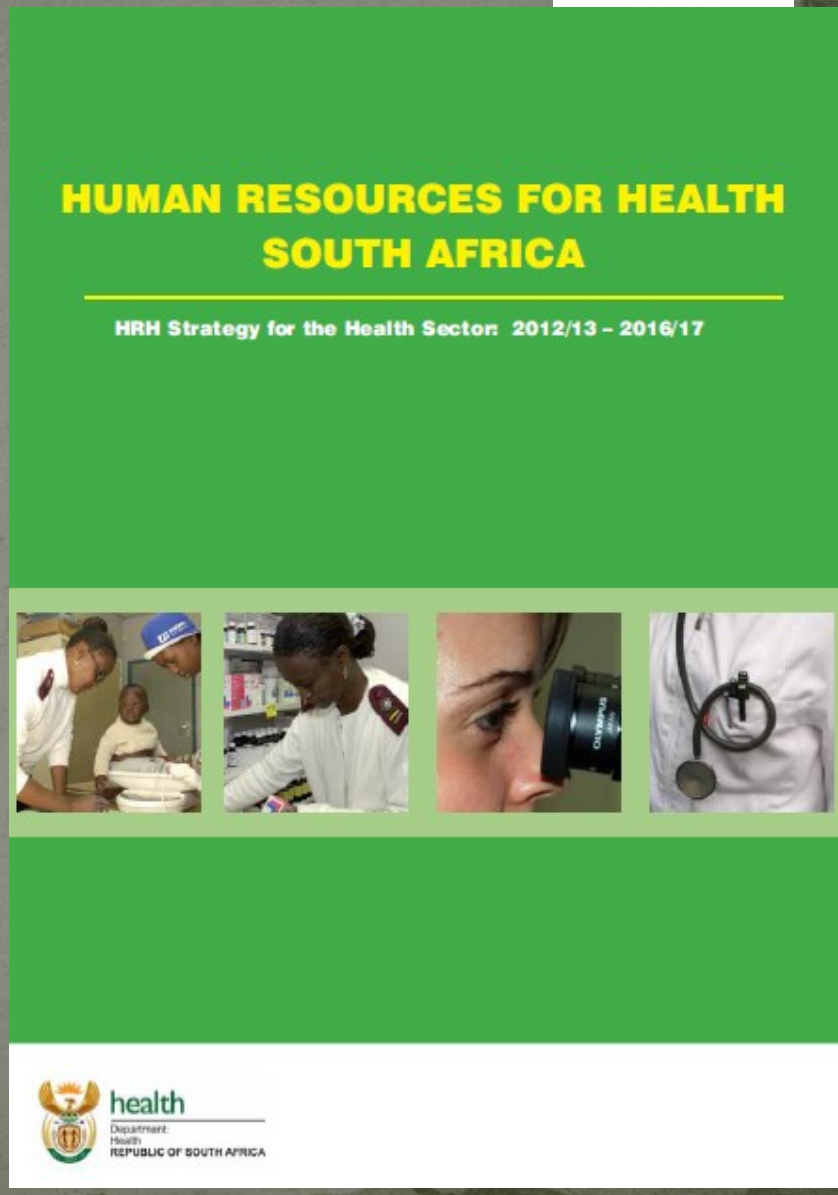
OUR RURAL HRH PARTNERS

LATEST POSTS

JOINT PARTNER PROJECTS

Think global, act local

- Development South Africa's Human Resources for Health Strategy 2012/13–2016/17 (SA HRH Strategy)
- Role of the Rural Health Advocacy Project (www.rhap.org.za)
- 8 sets of recommendations



Strategic objectives

1. LEADERSHIP AND GOVERNANCE
2. INTELLIGENCE AND PLANNING FOR HRH
3. A WORKFORCE FOR NEW SERVICE STRATEGIES
4. UPSCALE AND REVITALISE EDUCATION, TRAINING AND RESEARCH
5. ACADEMIC TRAINING AND SERVICE PLATFORM INTERFACES
6. PROFESSIONAL HUMAN RESOURCE MANAGEMENT
7. QUALITY PROFESSIONAL CARE
8. ACCESS IN RURAL AND REMOTE AREAS

Strategic objective 8: To promote access to health professionals in rural and remote areas

- 8.1: Implement short-term strategies on access to professionals in rural and remote areas
- 8.2: Design and implement an educational strategy based on WHO guidelines for rural and remote areas
- 8.3: Develop regulatory strategies to improve access to health professionals in rural and remote areas and quality of care
- 8.4: Develop financial incentives to attract health professionals to work in rural areas
- 8.5: Provide personal and professional support to health professionals working in and training health professionals in rura

Outcome

- Not OUR plan
  - Critique

Outcome

- Not OUR plan
  - Critique

SUBMISSION

Comment on:

HUMAN RESOURCES FOR HEALTH

SOUTH AFRICA 2030

Prepared by:

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Prof Ian Couper

Wits Centre for Rural Health/Rural Health Advocacy Project

28 September 2011

Centre for Rural Health

Rural Health Advocacy Project

RUDASA

Also endorsed by the UKZN Centre for Rural health and the UCT Primary Health Care Directorate.

Outcome

- Not OUR plan
  - Critique
- Continuing advocacy and lobbying
- The issue of implementation
  - Problematic
  - But it is a basis for action
  - And there has been progress

Buchan J, Couper ID, Tangcharoensathien V, Thepannya K, Jaskiewicz W, Perfilieva G, Dolea C. Early implementation of WHO recommendations for the retention of health workers in remote and rural areas. Bulletin of the WHO. 2013; 91(11):834-40.

Early implementation of WHO recommendations for the retention of health workers in remote and rural areas

James Buchan,[a] Ian D Couper,[b] Viroj Tangcharoensathien,[c] Khampasong Thepannya,[d] Wanda Jaskiewicz,[e] Galina Perfilieva[f] & Carmen Dolea[g]

Abstract The maldistribution of health workers between urban and rural areas is a policy concern in virtually all countries. It prevents equitable access to health services, can contribute to increased health-care costs and underutilization of health professional skills in urban areas, and is a barrier to universal health coverage. To address this long-standing concern, the World Health Organization (WHO) has issued global recommendations to improve the rural recruitment and retention of the health workforce. This paper presents experiences with local and regional adaptation and adoption of WHO recommendations. It highlights challenges and lessons learnt in implementation in two countries – the Lao People's Democratic Republic and South Africa – and provides a broader perspective in two regions – Asia and Europe. At country level, the use of the recommendations facilitated a more structured and focused policy dialogue, which resulted in the development and adoption of more relevant and evidence-based policies. At regional level, the recommendations sparked a more sustained effort for cross-country policy assessment and joint learning. There is a need for impact assessment and evaluation that focus on the links between the rural availability of health workers and universal health coverage. The effects of any health-financing reforms on incentive structures for health workers will also have to be assessed if the central role of more equitably distributed health workers in achieving universal health coverage is to be supported.

Abstracts in عربي, 中文, Français, Русский and Español at the end of each article.

Introduction

Any shortage of health workers can prevent good access to health services and is a barrier to universal coverage. When such shortages are accompanied by an unequal distribution of the workers, their impact can be even more dramatic.

The maldistribution of health workers between urban and rural or remote areas is a concern in virtually all countries. In Senegal, for example, the Dakar region, which is mostly urban, has more than 60% of the country's physicians but only 23% of the total population.[1] In Canada – where 99.8% of the territory is rural – 24% of the population but only 9.3% of the physicians lived in rural areas in 2006.[2] About one half of the world's population lives in rural and remote areas, but this half is served by only one quarter of the world's doctors and by less than one third of the world's nurses.[3]

Lack of access to health workers in rural and remote areas often leads to relatively high mortality rates in such areas. It also leads to rural residents seeking care at urban health facilities and thus to overcrowding – and increased costs – at urban hospitals. The relatively higher levels of staff in urban areas and facilities may lead to the underutilization of skilled personnel, who may then consider emigration.[4]

In 2010, the World Health Organization (WHO) addressed the long-standing problem of the maldistribution of health workers. First, it facilitated intergovernmental negotiations that led to the adoption – by all of WHO's Member States – of a code of practice for the international recruitment of health personnel.[5] Second, it established a global task force to examine the adverse effects of the intra-country relocation of health workers – mainly from rural to urban areas – which then developed 16 evidence-based recommendations for the improved retention of health workers in remote and rural areas (Table 1).[6] Although no systematic approach to collect in-depth information about the implementation of these recommendations has yet been made, this paper provides broad details of progress across two regions, and more specific details of the lessons learnt in using these recommendations in two countries.

Implementing the recommendations

Adaptation to country context

Lao People's Democratic Republic

Health workers in the Lao People's Democratic Republic are concentrated in cities, although more than 70% of the country's population lives in rural areas.[4] In an attempt to correct this maldistribution, the Laotian health ministry began to develop a strategy for the retention of health workers in those areas. This strategy was built, in part, on the national "2020 Health Personnel Development Strategy" and on a governmental decree that established guidelines for implementing financial incentives for rural civil servants.[7] To assess which of WHO's 16 recommendations would be most effective in the Laotian context, the Ministry of Health – in partnership with CapacityPlus and WHO[8] – used a retention survey tool that had been developed from the recommendations[9] to conduct a discrete choice experiment.[10] The results of surveys involving 970 students who were training to become professional health workers and 483 people who were already health workers, indicated that salary levels became less of an issue when a set of other, highly valued incentives, such as promotion and study opportunities, was offered.

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[g] Health Systems Policies and Workforce, World Health Organization, 20 avenue Appia, 1211 Geneva, Switzerland.
Correspondence to Carmen Dolea (e-mail: doleac@who.int).
(Submitted: 10 March 2013 – Revised version received: 31 May 2013 – Accepted: 6 June 2013)

Example

- Lessons from South African and elsewhere

Implement short-term strategies on access to professionals in rural and remote areas

1. Appoint a rural HRH strategy task team
   - First meeting in February 2014
     - Taking a lead
2. Community service

Ensure:

- that allocation is focused on underserved and rural areas
- that they are supported, nurtured and incentivised to stay on in rural sites.

Implement short-term strategies on access to professionals in rural and remote areas

3. Provinces should not freeze critical medical posts in rural areas to deal with overspending
   - Development of norms for minimum numbers of health professionals for district facilities.
4. Revise foreign and local recruitment and retention policies and processes
   - Issues of foreign doctors
     - Necessary in short-term (while working on long-term)
     - Importance of fairness
     - Global code: appropriate implementation

Design and implement an educational strategy based on WHO guidelines for rural and remote areas

1. Development of targeted admission policies by faculties of health sciences
   - Students from rural areas about 2.5-5 times more likely to go rural on graduation

     Wilson NW, Couper ID, De Vries E, Reid S, Fish T, Marais BJ. A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. Rural and Remote Health 9: 1060. (Online), 2009. Available from: http://www.rrh.org.au
   - Government to provide funding for rural student cohorts.
   - Use example of rural scholarship schemes

Rural scholarship schemes

- Wits Initiative for Rural Health Education (WIRHE) scholarship programme
  - Established 2003
  - Partnership with North West province
  - Local relationship and accountability critical
  - Now 55 students in 7 disciplines at 3 universities (Wits, Medunsa, Pretoria)
  - 32 graduates already practicing
  - Provides a model

Design and implement an educational strategy based on WHO guidelines for rural and remote areas

2. Provide funding to enable each faculty of health sciences to:
   - have at least one rural campus
   - locate clinical training opportunities outside of major urban centres.
3. Regulate clinical training, at both undergraduate and postgraduate levels, to ensure that rural clinical exposure is included in all training.
   - Medical schools need to be pushed!

Planning at Wits

- Develop district sites in North West province
  - Increase medical student exposure
  - Accreditation tools
  - Faculty development for trainers
- Faculty decision
  - All health professional students must have some rural exposure
  - Some students should have greater rural exposure
  - Extend academic platform
    - Investigate what other faculties are doing
    - Appoint assistant dean to drive this

Design and implement an educational strategy based on WHO guidelines for rural and remote areas

4. Develop funding formulae to reward faculties that produce health professionals for public service and rural areas.
   - Social accountability
   - Moving towards rating medical schools differently:
     - Staffing the local health services
     - Impact on the MDGs
     - Transformation of the health system

Design and implement an educational strategy based on WHO guidelines for rural and remote areas

5. Ensure that health sciences curricula address priority health needs in the country, including rural health needs.
   - Who determines the curriculum?
   - Who owns the curriculum?
6. Establish a system to support Continuing Professional Development programmes in each rural district
   - Costs
   - Time
   - Relevance

A missing element: New medical schools

- Global consensus: urgent scaling up of training should be core to every country's response to health worker shortages
  - Not enough health workers have been educated, trained and employed in Africa
    - E.g. before 2005, Ethiopia trained 200 doctors per year for 80 million population whereas the United Kingdom trained more than 6,000 doctors for a population of about 60 million; if all doctors trained in Ethiopia in the last 30 years were still working in Ethiopia, there would be about one doctor per 10,000 population, compared to one doctor for about every 450 people in the UK (22.2 per 10 000)
  - South Africa: producing about 1200 doctors per year for 50 million people; the shortfall based on the norms in the HRHSA 3.66 doctors per 10 000 population is over 4 000.
    - NB According to WHO, Brazil has 17.6 doctors per 10 000 population.

A missing element: New medical schools

- An example: Ethiopia
  - Since 2006, moved from 5 to 23 medical schools
  - Increased enrolment from 300 students in 2005 to 2300 in 2012
  - Planning to reach 6000 enrolments
  - Principle: Self-reliance (developed or developing world)

A missing element: New medical schools

- Key issues
  - The nature of the schools
  - The location of the school
- Definition of stupidity …
- Rural medical schools
  - UP Manila SHS, Palo Leyte, Philippines
  - Ateneo de Zamboanga School of Medicine, Philippines
  - Northern Ontario School of Medicine, Canada
  - Memorial University of Newfoundland, Canada
  - James Cook University, Queensland, Australia
  - University of Tromso, Northern Norway
  - Etc, etc.

Develop regulatory strategies to improve access to health professionals in rural and remote areas and quality of care

1. Determine the optimum range of skills required for rural hospitals.
2. Develop mid-level workers to meet these skills needs.
3. Enhance the development and placement of clinical associates
4. Allow for enhanced scopes of practice for health professionals in rural areas to address the skills needed.
5. Provide rural-bonded scholarship schemes managed at a district level

Develop financial incentives to attract health professionals to work in rural areas

1. Develop, use and evaluate financial incentives to attract rural healthcare professionals, including:
   - Revision of the Occupation Specific Dispensation
   - A more focused and targeted rural allowance
   - Sabbatical leave for rural health professionals
   - Opportunities for postgraduate training

Postgraduate training

- Establishment of distance programmes
  - MPH, Postgraduate diplomas
- District-based family medicine training
  - E.g. Registrars (residents) in all 4 districts in North West province, with supervisors co-located and minimal time at central facility
- Specialist training in regional hospitals

Provide personal and professional support to health professionals working in and training health professionals in rural areas

1. Provide personal and professional support to health professionals working in rural areas, specifically:
   - Outreach support from referral hospitals;
   - Improved living conditions, including accommodation
   - A safe and supportive working environment
   - Opportunities for career development and CPD programmes.
2. Provide training to health service managers to enable them to provide appropriate support for and discipline of health professionals in rural areas.

Conclusions

- Improving the distribution of doctors requires a long term plan
  - Politicians don't plan well for the long term
- There are solutions out here …
  - Determine what works in your own context
- We need to learn from each other
  - South African delegation currently in Brazil
- The equity challenge
  - Equality will not produce equity

"It always seems impossible until it's done."

Nelson Rolihlahla Mandela

1918-2013

Thank you

Gracias

Obrigado

Dankie

Siyabonga

Enkosi

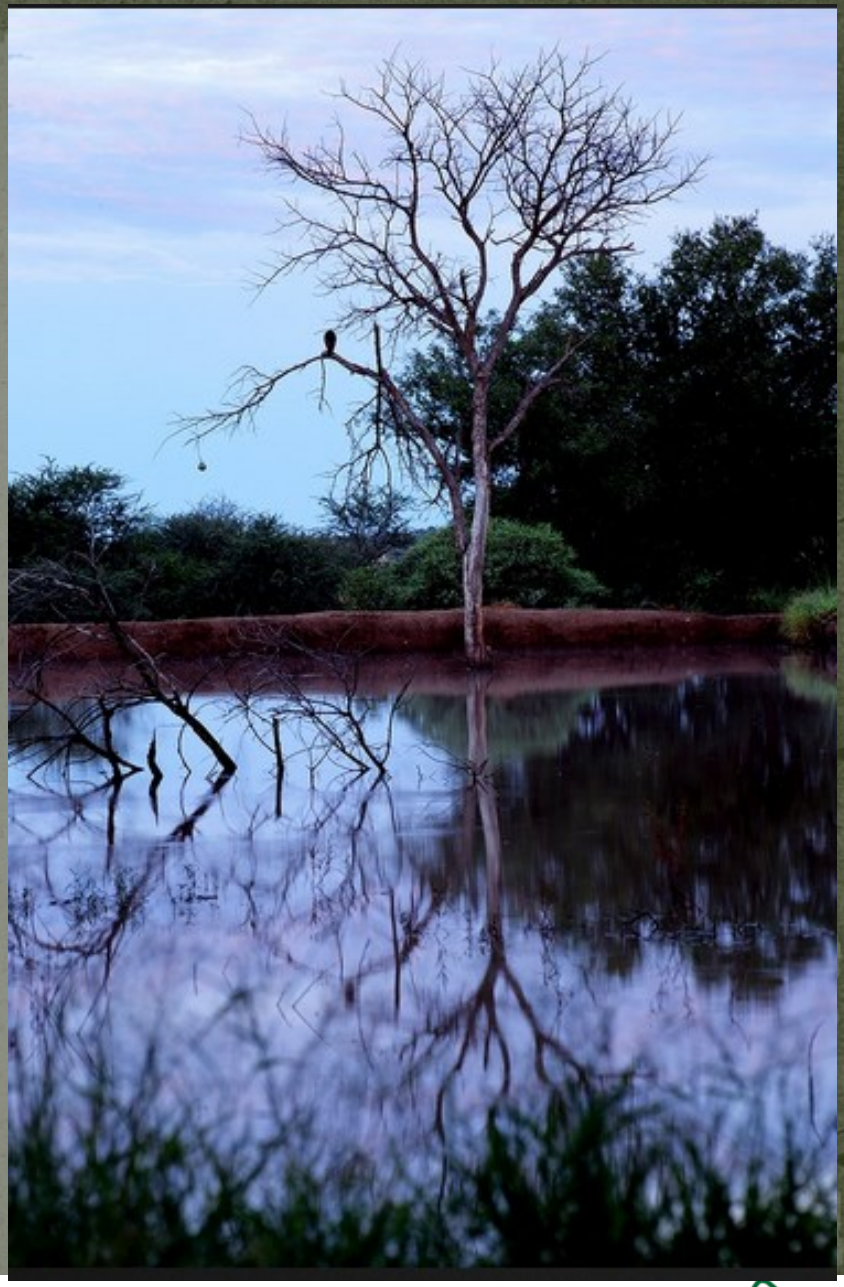
Ngiyathokoza

Ke a leboha

Ke a leboga

INKOMU

Ro livhuwa



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