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Abstract

The focus of this chapter is on key human resource issues for district hospitals in 2004. The chapter describes the background of developments in the health system and the National Strategic Review. Human resource issues are considered in relation to 5 key areas:

***The changing policy framework**. The National Health Act has implications for district hospitals which are not yet fully realised. Key areas of development include the implementation of rural and scarce skills allowances, the full implementation of community service, and the launch of the medical assistants programme.*

***Management of district hospitals.** Evidence suggests that district hospital managers are struggling to balance the demands of the system. The Public Finance Management Act and the drive for quality of care, in the face of insufficient skills and inadequate resources are particularly challenging.*

***Recruitment and retention of staff.** The biggest challenge continues to be the recruitment and retention of the appropriate skilled human resources required for district hospital service delivery. Issues around foreign qualified doctors, national and international migration of health professionals and poor morale all impact on this.*

***Education and training of personnel.** Changes in undergraduate and postgraduate training of doctors, and the new two year internship, hold out hope for improved medical staffing in district hospitals in the future. Examples and issues around the skills mix required for district hospitals are discussed.*

***Quality of care.** Human resource issues impact on quality of care. New quality of care initiatives are supported by increased community involvement.*

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resources: **district hospitals**

Introduction

The district hospital plays a pivotal role in the district health system (DHS). It supports primary health care (PHC) services and serves as a gateway to higher levels of specialist care. The district hospital provides a wide range of level-one (generalist) services to in-patients and out-patients, ideally on referral from a community health centre or clinic. Each hospital provides a 24-hour emergency service and an operating theatre. Generalist doctors, covering a range of clinical disciplines, supply these services, supported by nurses.[1]

The role of the generalist doctor in district hospitals is broad. In the absence of specialist support, they are called upon to perform clinical duties ranging from primary care to serious emergencies and surgical operations, as well as administrative, teaching, and public health functions.[2] The unique nature of district hospital practice, and the health needs of the populations they serve, make it imperative that health workers staffing these hospitals receive relevant education and training. Also, appropriate education and training is seen as a key modifying factor in addressing the maldistribution of health workers between urban and rural areas, where most district hospitals are situated.

This chapter explores the following key issues for district hospitals regarding human resources:

- The changing policy framework
- Management of district hospitals
- Recruitment and retention of staff
- Education and training of personnel
- Quality of care.

In order to understand these issues, a number of processes were undertaken, including:

i a search of literature, articles, press releases, documents, etc;

ii a rapid appraisal assessment by means of a telephonic interview with two district hospital managers in each of the provinces, who were asked to describe their key human resource challenges during 2004;

iii an email survey, asking the same question, sent to selected senior hospital doctors including clinical managers in five provinces; and

iv an approach to the national Department of Health (DoH) to provide relevant documents.

Background: the developing health system

The development of an effective and efficient district health system is one of the many efforts of the present government to address the inequities of the past.[3] One of the equity challenges is to address the human resources (HR) differences between rural, peri-urban and urban communities.

There are several initiatives that have been implemented in the public health care system to improve HR distribution. The models used have posed many challenges with the district health systems in rural areas experiencing the majority of the constraints especially around recruitment and retention of personnel.

The celebration of ten years of democracy was an important back-drop to events of 2004 and this review cannot overlook

the achievements of the past ten years. The 2003-2004 DoH Annual Report[4] gives an overview of achievements. Those which relate to HR in district hospitals included the following:

- Launching of the proposed medical assistants programme.
- Bilateral agreements with France regarding management support, and with the UK about migration of health professionals.
- Implementation of the scarce skills and rural allowances for certain health worker categories.
- Augmenting the supply of doctors by getting personnel from Cuba and Iran.
- Launching of the Community Health Workers programme.
- District Hospitals Reporting Strategy.
- Launching of the Hospitals Chief Executive Officer (CEO) Forum.

The Strategic Priorities for the National Health System 2004-2009[4] sets the tone for the next five years.

Unfortunately while the strategies put in place have worked for some district hospitals, others in rural areas are struggling with HR issues. Challenges cited by Managers in District Hospitals include:

- Lack of accommodation.
- Acute shortages of skilled staff, particularly of doctors and professional nurses.
- High turnover of staff.
- High rates of absenteeism related to:
  - demands of the new policies and procedures e.g. implementation of audits in the workplace, increasing numbers of statistics required, a complicated performance management process;
  - low morale; and
  - limited resources.

The Policy Framework

Potentially the most significant policy development was the promulgation of the National Health Act (No. 61 of 2003).[5] Section 48 allows for monitoring the provision, distribution, development, management and utilisation of human resources within the National Health system). The National Health Council is charged with developing policy guidelines that ensure adequate distribution of human resources and provision of appropriately trained staff at all levels of the National Health system. By implication this should have a significant impact on district hospitals, especially in rural areas, as there is a clear legal provision to ensure that there is appropriate distribution of health service providers and health workers at all levels.

Section 49 states that the Minister must determine guidelines to enable provincial departments to implement programmes for the appropriate distribution of health care providers and health workers. It remains to be seen how this might impact on district hospitals.

Also of significance is Section 51 which states that the Minister may establish academic health complexes which can consist of one or more health establishments at all levels of the National Health System including peripheral facilities. This clearly indicates that district hospitals can form part of academic health complexes and be involved in the education and training of health care personnel. This process is yet to be fully defined but has started in some places with the establishment of academic district hospitals within a number of cities where new teaching hospitals have been built and old tertiary hospitals have become district hospitals. Examples include the Wentworth Hospital in Durban and the Umtata General Hospital in Umtata, where these district hospitals are being run by Departments of Family Medicine as part of academic training. The principle of joint appointments of doctors between the provincial departments of health and the relevant university is in place, and requires implementation by provincial departments of health and their university counterparts. Amongst other things, this has the potential to assist in the retention of doctors because of career pathing.

"Another challenge is the career pathing in a district hospital. Family medicine and the role of the FM 'specialist' in the district hospital does give a way forward for people." (Clinical Manager, KwaZulu-Natal).

In July 2004 the DoH released its document Strategic Priorities for the National Health System 2004-2009.[6] Although the document contains little specific to district hospitals, the strengthening of human resource management and the increase in the number of hospitals in the revitalisation programme (up to 25% of hospitals by 2009), will have a positive impact on district hospitals.

In the previous Health Sector Strategic Framework 1999-2004[4] there were three issues that impacted on HR in district hospitals viz. mid-level medical workers, community service and rural and scarce skill allowances.

Mid-level medical worker (medical assistant) programme. According to the Minister of Health, the intention is not to draw medical assistants from existing professional health care workers but rather for the community to be involved in identifying those people who after training will plough back into their communities.[7] Most of the work of these medical assistants will be in district hospitals. For more details consult chapter 11 in this Review.

Community service. This has been an important strategy to address the shortage of health workers, particularly in rural areas and has had a positive impact on staffing in district hospitals. A number of these hospitals have medical, dental and / or therapy staff for the first time in many years. Issues around the lack of supervision and support, long term HR development and post structures for community service professionals who wish to stay remain problematic.

Whilst many community service doctors report a good experience, problems related to support, accommodation and training cause few to stay in the public service after their year of community service.[8] Active recruitment strategies of these community service professionals are often non-existent at hospital or provincial level. As a result many go overseas or into private practice.

"What tends to happen is that the bulk of OPD work is done by the junior doctors and medical officers and there is a real missed opportunity when it comes to building up the strength and capacity of the middle group of doctors (MOs and SMOs) by not encouraging community service doctors to stay on…. Proper exit interviewing does not happen i.e. 'how can we encourage you to stay? … Unfortunately before their first year as medical officers, the DoH decides that it is not necessary to approach them to offer them jobs, while the UK does make the effort to contact them and of course they go. I don't think the DoH can complain about this until they start to lift a finger to at least try and tempt them to stay on – e.g. each Province could send out a letter to each community service doctor offering them jobs, explaining the rural allowances, accommodation, sights etc. and telling them how to go about applying…" (SEHDASA[a] representative).

This is in contrast to what is happening in developed countries where aggressive recruitment strategies are used, such that many of the developing countries fulfil their labour needs. This supports the theory that developing countries make migration easy by training personnel to suit the needs of developed country settings.[9]

Rural and scarce skills allowances. This key strategy to recruit and retain health workers was implemented in March 2004. This was in line with recommendations of the World Health Report, 2003,[10] which suggests paying differently by reviewing non-financial benefits and also considering opportunities for rotation to rural areas. Whilst these allowances are a step in the right direction, and apparently do lead to changes in career plans,[11] there are other issues that need to be addressed such as job satisfaction, working conditions, further training, and career opportunities.[11]

a Senior Hospital Doctors Association of South Africa.

Table 1: Summary of rural and scarce skills allowances

Scarce skills allowance	
15% of basic Salary	Medical and Dental Specialists, Dentists, Medical doctors, Pharmacists, Pharmacologists
10% of basic salary	Dental technicians, Psychologists, Dieticians & Nutritionists, Occupational therapists, Physiotherapists, Radiographers, Speech therapists
	Professional nurses with qualifications in: • Operating theatre technique • Critical care (intensive care) • Oncology
Rural allowance	**Percentages**
ISRDS Nodes	22% Doctors & Dentists 17% Therapists, Pharmacists & Dental Technicians 12% Professional nurses
PSCBC designated rural areas	18% Doctors & Dentists 12% Therapists, Pharmacists & Dental technicians 8% Professional nurses
Other inhospitable areas	To be determined by the Provincial Head of Health, depending on availability of funds, from within provincial budgets

Source: PHWSBC Resolution No. 2 of 2004[12]

Differences in implementation of the allowances have led to fragmentation, inefficiency and inequity in terms of salaries paid out by different districts.

"There have also been complaints from personnel in rural areas who do not qualify for either scarce skills or rural allowance" (Hospital Manager, KwaZulu-Natal).

As predicted,[13] this poses another HR challenge.

A number of hospital managers in rural areas indicated that their institutions do not qualify for the rural allowance due to the allocation being based on outdated lists of rural hospitals.

"The major HR challenge we are faced with is recruitment and retention of staff; there is no response to our adverts to the extent that we have to consider people at the lower end of the scale for a senior position. We are a farming community, there is nothing appealing about our area: we should qualify for rural allowance" (Hospital Manager, Free State).

The effectiveness of these allowances remains questionable. Research by Reid[11] indicated that there were other more important factors in retaining staff.

"Money isn't everything – especially to rural doctors – leave is much more of an attraction i.e. generous study leave, unpaid leave." (PMO, Limpopo).

This was confirmed by a hospital manager:

"The rural allowance doesn't seem to motivate nurses to stay." (Hospital Manager, KwaZulu-Natal).

Another issue is the question of why primary care nurse practitioners, a skilled group in short supply, were not included in the scarce skills categories.

A policy for the Norms and Standards for District Hospitals exists but has not yet been officially endorsed and launched. This policy has major implications for the level of skills and training needed in rural hospitals and the skills mix.

Management issues

During 2004, the issue of the management of district hospitals surfaced frequently. A cadre of hospital managers has come into the system who do not necessarily understand the intricacies of the health care system and who have often not been trained or equipped to recognise or deal with crises in HR. When critical staff shortages occur, they are seldom addressed immediately or as a priority. This has had a significant impact on recruitment and retention of staff and the creation of a positive work environment which produces job satisfaction. In many instances posts are not filled simply due to a lack of active recruitment, the slow appointment process, and little understanding of the processes needed to recruit professional staff in short supply.

"Persuading the management that we had to put up the money to employ more senior doctors was also a bit of up hill. Direct competition with filling administrative posts!" (Medical Manager, KwaZulu-Natal).

"The things that caused the crisis was complete slackness of HR management to recognise the crisis coming (even though it was spelled out to them a number of times as early as 9 months before it happened) and then the difficulty to recruit in the crisis. It seems that HR practitioners do not know how to attract staff - they can 'put out an ad' - and that is how far it goes - they don't seem to know how to recruit - i.e. actively get people to apply and be employed. So it often falls on already overburdened [medical managers] to do the recruiting as well" (Medical Manager, KwaZulu-Natal).

Many managers have no understanding of critical levels of staff for services to run, and no guidelines exist from national or provincial departments of health.

"When the crisis happened, what was also difficult was that management did little to make the crisis easier - there was little understanding of what could be done with how many doctors - when the casualty service should be stopped or when it was no longer feasible or safe to do caesarean sections." (Medical Manager, KwaZulu-Natal).

The focus of management in district hospitals has been on controlling overspending and conforming to the Public Finance Management Act. There is also a tendency to conduct hospital reviews by examining statistics rather than broader quality of care issues and this impacts on the way that HR are seen. The percentage of posts filled, especially in those with key skills is not generally seen as an important indicator of care. In addition, many health professionals, especially doctors, have become alienated from management. This has affected the understanding of a team approach to health care.

A number of commendable initiatives to address the lack of capacity in management have been launched, with provinces putting managers through specially designed courses, supporting them to do district hospital management training programmes and commissioning development of specific tools for district hospital managers, e.g. the HST / North West Province Guidebook for District Hospital Managers.[14] A bilateral agreement signed with France will see an extensive hospital management training programme being inaugurated over the next year.

Managers often find it difficult to introduce the many changes they have had to effect. There has thus been a tendency in the health system to focus on hard issues such as the legal framework, organograms, financing and technical skills development rather than some of the soft issues such as management styles, communication, relationships and problem solving approaches.[15]

"From management there seems to be little understanding of how staff can be supported in fulfilling their roles better. A lot of management is to instruct and to control and little listening or supporting is happening. The actual people delivering the service are poorly informed about strategic direction or intention of the service" (Medical Manager, KwaZulu-Natal).

"Even if you successfully introduce and effect changes, to the extent of saving the department some money, the glory is not yours until it is acknowledged by the national provincial hospital" (Hospital Manager, Northern Cape).

The focus on the hard issues may also be at the expense of HR development. Managers in district hospitals cite personnel shortages as the most critical factor affecting delivery of quality services:

"I do not have a clinical manager, finance manager." (Hospital Manager, Northern Cape).

"I have two admin assistants instead of four. ... I only have one clerking officer" (Hospital Manager, KwaZulu-Natal).

Despite these problems, there remain examples of district hospitals that are functioning well and serve as a model to others.[16] There is ample opportunity for visionary leaders and competent managers to make a success of human resource management despite the constraints and challenges within which they operate. Such management teams should be commended and rewarded, and used as examples for others to follow.

Case Study: Manne Dipico District Hospital

Colesberg Hospital, renamed the Manne Dipico District Hospital, was a 35 bed hospital, but is now a Level 1 hospital with 45 beds. It is one of the hospitals that has benefited from the Hospital Revitalisation Programme. The Hospital Manager was affected by the hardware focus in the health system, but has managed to turn things around. Instead of complaining about and struggling with the issue of staff shortages, the Hospital Manager made provision for all the professional nurses to acquire theatre skills. Through this initiative the manager saved on overtime costs as staff are no longer on call for extended hours. As part of quality improvement initiatives, the Hospital Manager assisted all staff, including the general assistants, in acquiring basic computer skills. This has allowed them to provide a quality service all around in terms of attending to community queries. Other initiatives include arranging 20 learnerships for auxiliary nurses and training of staff on an ongoing basis in trauma skills, with Medicity Clinic. This is an example of public-private collaboration. The problem of absenteeism was addressed via unions and staff meetings. There has been a turnaround; staff members are happier and more cooperative. Batho Pele, the vision and mission of the hospital as well as having community interests at heart are holding Colesberg's hospital and its people together. MinMEC has decided to use the hospital in benchmarking exercises for managers of other hospitals.

Recruitment and retention of staff

The biggest challenge facing district hospitals, undoubtedly, is securing personnel in rural areas. Some of the district hospitals currently have staff shortages of 50%. This results in existing staff having difficulty in fulfilling their duties, high levels of absenteeism, and low levels of morale.

The introduction of new policy changes are adding to the burden as staff do not have time to adjust and cope with the ever changing environment.[17] These staff require a specific retention strategy to keep them in service and reduce their sense of being overwhelmed and alienated. It has been suggested that in order to achieve a positive result, recruitment issues should be addressed separately from retention issues.[18]

"Most of the frustrations are due to fewer doctors having to serve a large population with no rest. When one is on call you sometimes spend the whole night seeing patients who could not be finished during the day due to fewer doctors. Clinics are not visited regularly by doctors, therefore patients flock to the hospital ... 7 doctors left the hospital because they could not take it any more." (Clinical Manager, Limpopo).

Although neither the national nor provincial departments of health have produced a clear recruitment and retention strategy for skilled staff, various proposals are under debate or are already being implemented.

There is a debate around the role of foreign qualified professionals. The new Deputy Director General of Human Resources, Dr Percy Mahlathi stated that he believes the answer must come from within South Africa.[19]

However, foreign qualified doctors, including the Cuban doctors' initiative, have had a positive impact on rural district hospitals. This programme has now been stopped.[b] The resulting non-replacement of Cuban doctors has already had a very significant impact on district hospitals and on regional hospitals in terms of medical staffing. The importance of this is that for many district hospitals their support came from Cuban specialists at regional hospitals and the absence of these doctors is causing serious lack of support for district hospitals.

On the other hand medical staffing in district hospitals will benefit over the next few years by getting South Africans trained in Cuba. Under the Cuba-SA agreement, 57 medical students completed their training and have qualified as doctors since the agreement was signed in 1997. They are being acclimatised to the South African environment within 5 of the 8 SA medical schools.[20]

In February 2004 the Health Professions Council of South Africa (HPCSA) and DoH team followed on a ministerial delegation to Iran and recruited a number of doctors to work in district hospitals in the provinces of Limpopo, Mpumalanga and North West.[21] However, by the end of 2004 the first group of Iranian doctors had yet to arrive.

Also in 2004 the Medical and Dental Professional Board of the HPCSA launched a concerted effort to smooth out the registration process of foreign qualified doctors. This has led to a small increase in the number of foreign qualified doctors coming in.

The DoH policy against employment of doctors from developing countries, and specifically from Africa, although ethically and morally defensible, also influences rural hospitals:

"Major HR challenges for 2004 have been the recruitment and retention of doctors. South African doctors usually never want to work in this rural remote area. The DoH policies on recruitment of doctors from developing countries make it practically impossible to recruit from such countries." (Clinical Manager, North West).

"The employment of foreign graduates has been very difficult but we made it in the end with four doctors." (Clinical Manager, KwaZulu-Natal).

At the same time the outward migration of South African doctors has continued unabated. Community service has not stopped doctors from leaving after the year to spend time overseas. Many of these, when they do return, do so often to tertiary hospitals for specialisation rather than to rural district hospitals.

Even more significant has been the ongoing loss of professional nurses abroad as well as to new hospitals such as the Nelson Mandela Hospital in Umtata and the Chief Albert Luthuli Memorial Hospital in Durban. This has led to the loss of key senior nurses in district hospitals, representing a potentially more serious crisis than the loss of doctors. Such migration has if anything, been exacerbated by the exclusion from the scarce skills allowances of all but a few specialised categories of nurses, who would not commonly be found in district hospitals.

It is uncertain what impact the proposed extension of community service to professional nurses may have on this. The lesson from other categories appears to be that it may do nothing for the retention of staff though it may help fill posts in the short term.

b Personal communication, Office of International Health Liaison.

The roll-out of antiretroviral drugs has meant great competition for the professionals who are needed for this programme. There have been numerous advertisements for doctors, professional nurses, pharmacists and dieticians. The advertisements have attracted existing HR out of the general pool of public sector health workers, rather than bringing new people into the system.

According to a PERSAL report, vacant public health posts in 2003 were expressed at an overall 31.1% for the whole of SA. The table below gives a break down by province. (Adapted from Padarath et al.[13])

Table 2: Vacant Public Sector Health Posts, 2003

Province	Percent Vacancies
Mpumalanga	67.4
Free State	40.7
North West	33.0
Gauteng	31.9
Eastern Cape	28.4
Northern Cape	27.3
KwaZulu-Natal	24.5
Western Cape	13.8
Limpopo	13.4

Source: SAHR: 2003/04

The DoH 2004-2009 Strategic Priorities Report[4] states that only 40% of PHC facilities have nurses trained specifically in PHC. This impacts on the workload of district hospitals. Only 30% of clinics are visited by a doctor at least once a week.[4] This is indicative of the shortage of doctors in district hospitals, because these doctors prioritise hospital activities over those of clinics when they are understaffed.[22] The Strategic Priorities Report accepts that there has been lower than planned levels of production of doctors but migration is also blamed for the shortage which affects all district facilities.[4]

The private sector is also experiencing the effects of poaching of health care workers by developed countries which continuously offer lucrative deals to SA nursing staff;[23] the private sector in turn recruits staff from the public sector, exacerbating the problem.

In many districts, and notably in Limpopo Province, doctors from the private sector have been enticed back into the public sector, taking up positions in district hospitals, by offers of appointments at higher levels with commensurate salaries. In other areas, private general practitioners (GPs) are playing a major role in keeping district hospitals running through sessional appointments. However, in other areas there has been no such rapprochement, with mutual suspicion being common, and private GPs still feel marginalised and excluded. Further initiatives to develop this collaboration in all rural parts of the country have the potential to bring much relief.

One commonly cited cause of staff shortages is the environment. A typical rural district in the Eastern Cape, in one of the most disadvantaged areas in SA faces challenges due to lack of infrastructure and electricity. Accommodation problems are being exacerbated by the need to house community service professionals and additional senior managers.

The accommodation problem is such that hospitals which are short of staff will not recruit simply because they do not have sufficient accommodation.

"One major challenge for 2004 has been where to house all the new managers. And as 2005 began where all the community service health professionals might find a bed?" (Clinical Manager, KwaZulu-Natal).

"We are finding we are getting more staff especially paramedical staff but we are struggling to accommodate them - we are basically at the point where we don't want more staff as it is such a nightmare trying to accommodate them.... although we have lots of empty posts we are getting a flood of paramedical people (radiographers, pharmacists, OTs, physios, optometrists, social workers etc) and dozens of new managers in newly created posts who are taking up accommodation that was usually used by doctors." (SEHDASA representative).

Education and training

Attention to education and training of doctors for district hospital practice has only received focused attention in the last few years. In this section recent trends in education and training for district hospitals are discussed. This section also provides an overview of important principles underlying these trends as this subject has not been covered in previous South African Health Reviews. While this section focuses on doctors, the key issues relate to all health professionals in district hospitals.

Undergraduate training

Preparation for district hospital practice should already feature in selection procedures. A recent South African study confirmed the international literature demonstrating rural origin as the single most significant predictor of rural practice. It was found that a third of graduates from rural origin return to rural practice, compared to between five and 13% of urban origin graduates.[24] The Friends of Mosvold Scholarship Scheme provides a scholarship scheme for prospective students in health sciences from the surrounding communities. The scheme negotiates with teaching institutions for the placement of these students, provides vacation and elective training experiences in the hospital, and contractually binds these students to serve at Ingwavuma Hospital after completion of their studies.[25] Another pilot scheme, the Wits Initiative for Rural Health Education (WIRHE), based on the same principles, has been developed in two districts in 2 other provinces, viz. Bophirima district in North West and Bohlabelo district in Limpopo.[25]

Changing the medical school curriculum by providing appropriate theoretical and practical education and training will prepare future doctors to understand and be able to address the needs of communities. A community-oriented curriculum and practical rotations in the district health system throughout the continuum of undergraduate training (versus once-off rotations) is a prerequisite. Students reported that experience in a rural clinic changed their vision about themselves and their future careers as well as the difficulties and frustrations of an inadequate health service.[26]

There is often a gap between the lofty mission statements of Health Science Faculties and the actual outcomes of its graduates.[27] The HPCSA for example, issued guidelines for medical undergraduate education in 1999 emphasising community-based education. To what extent these guidelines are actually implemented in curricula, and the extent to which they influence the educational outcomes in terms of graduates' contributions to the health system, is unknown.[27] There has been some progress in curricula change in the 8 faculties of health sciences but the kind of curriculum envisaged by the HPCSA is still a long way off.[27]

Internship

The institution of a two-year internship by the HPCSA in 2005/06 will for the first time include a mandatory family medicine rotation. This will assist considerably in preparing interns for district hospital practice. The internship year is rich in opportunities for development for district hospital practice, with the emphasis on acquiring skills and demonstrating confidence.

One of the challenges facing a newly qualified doctor is the addition of practical skills to theoretical knowledge. A study performed in a large district hospital in the North West province demonstrated that young doctors gain sufficient experience while working in a district hospital under appropriate supervision to develop confidence in their ability to manage the majority of common conditions encountered. However, it is an area of concern that South African interns expressed a lack of confidence in their ability to administer a general anaesthetic at the end of their internship year, despite a two-week obligatory anaesthetic rotation under supervision.[28]

Postgraduate education and training

In SA, structured postgraduate education and training for generalist practice has been the responsibility of the academic Departments of Family Medicine. These courses, which have in the past mainly focused on primary health care, have been challenged to include extensive procedural training to prepare practitioners for district hospital practice.

In 2003, the Medical and Dental Professions Board decided that family medicine will be the clinical discipline for district and rural health.[29] This makes family medicine postgraduate training an integral part of district health care and facilitates the structured training of practitioners delivering the district hospital package of service. The Family Medicine Education Consortium (FaMEC), which comprises all 8 academic Family Medicine departments, is developing this as part of structured family medicine training. The district hospital is regarded as an integral part of the DHS and the training is set up to prepare doctors to function in the community

as well as the district hospital. Pilot training complexes throughout the country, including underserved rural and urban areas, have been developing during 2004. This training will have a positive impact on service as well as integration of postgraduate training into district hospitals.

Continuing professional development

Rural doctors commonly use continuing professional development (CPD) activities readily available to them, e.g. journal reading, visits by pharmaceutical representatives, attending evening lectures sponsored by the pharmaceutical industry.[30] It is questionable whether these activities will make a difference to practice patterns and patient outcomes as they are largely inappropriate and ineffective educational formats. [31]

The HPCSA formed a central CPD committee in 2004 for its 12 Professional Boards to develop a new CPD system. Proposals for the new system include a wider variety of activities which will make CPD more accessible for rural practitioners.

In-service learning under supervision in the district hospital has been found to be the best method for maintaining and updating knowledge and skills.[32] For in-service learning to be effective there needs to be continued employment of experienced doctors in district hospitals who can provide supervision. Rotations in secondary hospitals were found to be particularly useful to learn about procedural skills. The role of specialists in updating doctors for district hospital practice appeared to be limited to outreach visits. These are only beneficial if the specialist understands the district hospital context and provides relevant and appropriate training.[32]

The implementation of updating programmes for district hospitals is complex. A number of variables affect the process, e.g. a tradition of passive learning, working conditions, and the absence of a learning environment.[31,33]

"Another challenge has been to develop appropriate skills at the hospital without having the luxury of sending people away for long periods of time. The on-the-job learning only goes so far if the learning process is not supported and the 'quantum leaps' of learning are not facilitated." (Medical Manager, KwaZulu-Natal).

A collaborative project for the maintenance of competence for district hospital doctors in the Western Cape Province was set up in 2004 between the Provincial Health Department and the Universities of Stellenbosch and Cape Town. This project aims to implement an in-service learning model in district hospitals that will facilitate skills development and maintenance.

Staff development is affected by recruitment and retention strategies and staff shortages, especially of professional nurses. For example, in some district hospitals there is training of staff nurses to qualify as professional nurses. However, it is difficult to retain these staff.

"As soon as they have served their two year contract they leave for either the bright lights of the city or emigrate to the UK". (District Hospital Manager in KwaZulu-Natal).

Skills mix

The optimal skills mix for district hospitals to address the health needs of their communities will vary depending on local health problems, disease patterns, identified priorities and available resources. Context is also vital:

"Another challenge for me is the differing perception in city hospitals and rural hospitals on what constitutes competence." (Clinical Manager, KwaZulu-Natal).

Nevertheless, training for an appropriate skills mix can be guided by the package of services that needs to be rendered in district hospitals. District hospitals provide health services up to level one hospital services in four areas namely out-patients, in-patient, emergency and trauma, and outreach and support services. In order to efficiently render these services the skills mix in district hospital should include a health team comprising a range of health professionals and support staff. These include, amongst others, generalist medical officers up to the level of specialist family physician, pharmacists, health therapists, clinical nurse practitioners, theatre nurse practitioners as well as the usual support staff such as administration and cleaning. Table 3 provides a summary of the skills mix needed in district hospitals.[c]

Given the wide scope of services to be provided in district hospitals, it is not always possible for an individual to be able to attain and maintain all of these skills. It is therefore important that HR planning for a particular hospital should take into account the required versus the available skills mix. For example, if neonatal care is identified as a gap in the team, plans should be made for someone to gain these skills; if anaesthetics is the strength of only one person, plans should be made to transfer these skills within the team.

Any skills development process needs to be done within the broader HR needs of an institution.

"The broader issues around the HR challenges relate to relationships and context as well as numbers and the skills." (Clinical Manager, KwaZulu-Natal).

It is important that skills are viewed broadly:

"Another thing I think is a skill that is lacking, is patient centredness, skill in managing patients with chronic disease and an interest and insight into the context of the illness." (Clinical Manager, KwaZulu-Natal).

c With acknowledgement to the Western Cape Health Department.

Table 3: Guidance to Skills Mix for District Hospitals[32]

Out-reach and Support to PHC	General Out-patient Department (OPD)	Emergency and Trauma Services	In-patient Services
Training ✧ In-service training / Vocational training ✧ Continuing professional development ✧ Formal education and training **Clinical Services rendered by -** Medical Officers Pharmacists Health therapists	**Level of Skills** Generalist Medical Officer up to the level of Family Physician **Curative:** **Acute and Non-Acute** ✧ Direct or referrals from general practice and PHC platform ✧ Evaluation and treatment support to patients with chronic illness referred by PHC platform ✧ Stabilising patients before discharge to clinics ✧ Management of patients referred from regional and tertiary hospitals **Promotive / Preventive** ✧ In areas where PHC services are not available ✧ Opportunistic (e.g. immuni-sation) **Rehabilitative** ✧ At level of health therapists ✧ Including - - Occupational Health and Safety - Pathology: - Forensic - Clinical	**Level of Skills** Same as for OPD, plus need for additional emergency care training at appropriate level for needs of district hospitals **Services** ✧ Point of entry services or referrals ✧ 24-hour services in dedicated area ✧ Preferably separate dedicated areas for trauma and other emergencies ✧ Stabilisation or referral of common and / or life threatening conditions up to level of a Diploma in Primary Emergency Care ✧ Minimum services to be rendered: - Trauma - Medical & surgical emergencies - Psychiatric emergencies (NOTE: seclusion & sedation) - Clinical forensic emergencies - Injuries on duty (Compensation for Occupational Injuries and Diseases Act)	**Level of skills** Generalist Medical Officer who can provide comprehensive management of all conditions as defined under “Services” **Services** ✧ Internal medicine - Acute - Chronic (range defined by protocol) ✧ Surgery (emergency and cold). As a minimum, the following procedures will be available: - Appendicectomy - Caesarean Sections / Ectopic - Non-compound fractures ✧ Anaesthetics ✧ Woman’s Health Termination of pregnancy Sterilisation ✧ Paediatrics ✧ Psychiatry Management of suicidal patient / 72-hour assessment period ✧ Rehabilitation

Source: de Villiers: 2004

Quality health care

A major factor in quality of care is that many valuable new quality improvement activities have been introduced. However, these require additional human resources. This places even more pressure on the small group of available skilled professionals and further affects their morale.

"There is increased expectation of what should happen, what committees should exist, without any additional resources being made available. EAP, Health and Safety, clinical audits, QA, etc., all are terribly important, but if your pool of nurses and doctors is limited, it becomes a real burden and certainly does not fulfil its function." (Medical Manager, KwaZulu-Natal).

Many issues around supervision of staff, including health professionals, surfaced during the year. While performance agreements have been implemented, there are still reports of hospitals in which no doctors can be found in the afternoon, where various categories of health professionals run private practices while in full-time employ, and where lunch and tea breaks extend way beyond the set times. Lack of team-work, with a sense of mutual responsibility and commitment, is an important contributor to this. As long as Batho Pele remains nothing more than a poster on a hospital wall, quality of care cannot be achieved. Amongst other things, more formalised supervision of all categories of staff, including professionals, is required to address these issues.

An important element in primary health care is the support that the district hospital needs to provide to surrounding clinics and to the community. This requires a commitment from hospital staff (and management) to look beyond their walls and to view their responsibilities in a broader light. This may require reorientation and training to achieve.

The launch of the 40 000 community health workers (CHWs) project for PHC clinics, can also make a positive contribution to this process.[34] The CHWs facilitate and support community involvement in hospitals, including partnership at facility board level. Most district hospital managers interviewed have a positive outlook towards the symbiotic relationship between the hospital boards, as governing bodies for the district hospitals, and community members. The constitution allows for community representatives such as izinduna and amakhosi to provide the required feedback to the community.[d] This supports the view that community members in rural areas should be active participants in the planning, implementation, monitoring and evaluation of any developments in their communities.[35]

Conclusions and recommendations

The urgent development and implementation of a National HR Policy and Strategy with a particular focus on district hospitals is critical.

The following elements must be addressed by this policy:

- Recruitment and retention of professional staff for district hospital service, particularly doctors and nurses.
- Clear guidelines for district hospital managers regarding the role and importance of skilled professionals, minimum numbers for services required, and approaches to dealing with crises in staffing.
- Appropriate, ongoing training and support of hospital managers, including balancing the demands of financial management with service delivery needs and appropriate quality of care measures.
- The development of district hospitals as training sites, as part of the academic health complexes envisaged in the National Health Act. Focused postgraduate training of family physicians, primary health care nurse training, and the training of a new cadre of medical assistants must be facilitated by partnerships between service providers and training institutions.
- The implementation of the medical assistant programme to support and strengthen district hospitals.
- The revision of the rural and scarce skills allowances to include additional nursing categories and the standardisation of definitions of rural hospitals across provinces.

d Hospital managers, KwaZulu-Natal and Eastern Cape.

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Working in the third poorest district in South Africa and close to the poorest town has posed many challenges for Dr Will Mapham, but at the same time he describes it as an enriching and rewarding experience.

"A hot shower would go a long way. After a day in the hospital you are often covered in blood and you can't even wash yourself properly. It can get you down every now and again."

After graduating from the University of Cape Town, Mapham found himself doing his community service in Madwaleni, the Mbashe district of the Eastern Cape, about 45 minutes drive along a "bumpy dirt road" from Elliotdale.

"The area around the hospital is scattered with huts and subsistence farms. The people are very friendly and welcoming. Mbashe district is the birth place of Nelson Mandela, Thabo Mbeki and Bantu Holomisa – there must be something in the water," Mapham quips.

Mapham often asks himself why he is staying. He lives in a small flatlet with no hot water, and he works long hours with not much professional support. However, he is drawn to the lifestyle. "I can canoe down the river or surf on the weekend or explore the beautiful inland," he says.

"I always vowed that I would work in a rural area," says Mapham, who declined the opportunity of studying in Edinburgh, opting to return home and study at home.

Mapham acknowledges that the scope for professional development is very limited although the province will pay for doctors to undertake various courses. The every day challenges are immense.

Health Journalist, Health-e

a Doctor

Will Mapham

of Madwaleni, Mbashe district of the Eastern Cape

"A woman arrived with her face chopped off by a panga. She had no nose, no cheeks and her upper lip was gone. They had refused to take her at Umtata Hospital, so I spent three hours trying to sew her up even though I was not vaguely qualified. Luckily it seems to have gone well."

He relays a story of how he was forced to practice plastic surgery although his skills were almost non-existent.

After completing his community service Mapham informed the authorities that he was keen to remain at the hospital. However, bureaucratic red tape saw him having to work for two months without pay until his posting was approved.

He welcomes the rural allowance, but wishes he could be paid for the many hours of overtime he put in.

"The Transkei has been written off so it is very easy to make a difference. I would not be able to make this kind of impact anywhere else," says Mapham.

The nurses he works with are "incredible", he adds.

"You couldn't work with nicer people. They really do their best for their community."

Mapham and another doctor (there are four), have managed to organise a high speed internet connection at the hospital, a move that has enabled them to enroll for Masters courses.

What would make him stay? "A hot shower would go a long way. After a day in the hospital you are often covered in blood and you can't even wash yourself properly. It can get you down every now and again."

"In four years we could be specialists, out here you really have to solve problems yourself."