



OPINION

Rural health and transformation in South Africa

S J Reid

The 10th Annual Conference on Rural Health organised by the Rural Doctors' Association of Southern Africa, to be held on 10 and 11 August 2006 in Empangeni, marks a significant moment in the development of the concept and practice of rural health in this country. Previously a somewhat vague idea, which everyone felt they intrinsically understood as being medical practice outside of urban areas, rural health is becoming increasingly better understood, and is demanding more attention particularly within the academic disciplines of family medicine and public health, as well as within the public health services. The Rural Doctors' Association itself, although a relatively small voluntary organisation, frequently 'punches above its weight' in terms of input to policy and practice, and it is salient to ask why this is so.

What do we actually mean when we talk of 'rural' in the South African environment? A precise geographical definition is difficult, because the notion of 'rural', like that of beauty, is somewhat in the eye of the beholder. There is in 2006 no agreed definition of 'rural' in South Africa, and this causes confusion. Different bodies have defined it differently – for example Statistics South Africa used to classify areas proclaimed as municipalities as urban, and everything else as rural. However, all parts of South Africa now fall within a municipality and most municipalities include areas that are to some degree 'rural'. The Department of Health has awarded the 'rural allowance' to personnel working in certain named hospitals, some of which are even in urban areas, based on a so-called 'inhospitality' index. On the other hand the President's office identified 13 'rural nodes' for the purpose of accelerated multi-sectoral development, based on different criteria again. In many developed countries 'rural health' becomes synonymous with 'agricultural health', concerned with issues such as pesticide poisoning and farm injuries, but this would be appropriate only to some commercial farm areas in this country.

In South Africa, however, we know that a vast burden of disease is carried by our rural citizens, a legacy of the 'homeland' system of division and deprivation perpetrated by the previous government, and compounded by the poverty

and unemployment endemic in these areas. In South Africa, 52% of the total population, and 75% of poor South Africans, live in rural areas. According to financial research group Eighty20, 60% of households where individuals were living on less than R20 a day were in rural areas, meaning that 1.3 million rural households were unable to meet their daily food needs. And so we come to an understanding of 'rural health' in our context that addresses the issues of poverty and inequity, and consequently has a strong element of social justice, social responsibility and advocacy, beyond the technical definitions of distance and geography. We speak of 'rural and under-served' areas in the same breath, to denote a commitment to the marginalised and disenfranchised, the rural poor. And access to quality health services, both preventive and curative, becomes the single biggest issue, if not the defining issue, in rural health.

The burden of poverty and ill-health in rural areas is made all the more difficult by the continued operation of Tudor-Hart's so-called 'Inverse Care law', which states that: 'The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources.'¹

Basically, the fewest doctors, nurses and other health professionals are found where they are needed the most, and vice versa. And this is promoted internationally by increasing globalisation, and specifically by the General Agreement on Trade and Services (GATS). So the exodus of young and not-so-young doctors and professional nurses overseas is not just the result of personal choice, but an expression of the balance between 'push' and 'pull' factors in a global context.

The democratic government has done much to try to counteract this maldistribution, with some evidence of success – the import of Cuban doctors, raising of public service salaries, compulsory community service for health professionals, and the rural and scarce skills allowances.² Unfortunately, private general practitioners have been largely marginalised rather than included by the district health system, and are not as involved as originally envisaged. There is no doubt that the introduction of the compulsory year of community service has made a difference to the staffing of rural hospitals – indeed, some have become totally dependent on them – but they generally do not stay in the public service. If community service is an effective

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recruitment strategy, the challenge is staff retention in areas of need, particularly senior personnel with experience.

Rural health practitioners face particular challenges that demand a specific and wide-ranging set of skills, and the ability to work in a team. It is the domain of the all-round generalist at the district level of care, for whom the principles of primary health care and family medicine provide the most appropriate conceptual frameworks. 'Any patient, with any problem, at any time, anywhere' is a definition that captures the flavour of rural practice, for both medical and nurse practitioners.³ But beyond the individual patient who presents for care, there is also the need and responsibility always to regard one's area of practice as a 'population at risk' by extending access to care to those who do not come, or cannot afford to come.⁴ This population-based approach demands the skills of public health in addition to the traditional clinical skills. So the rural practitioner, nurse or doctor therefore needs, for example, to be as familiar with emergency care of a patient with a snakebite as with community planning for a water and sanitation scheme. This broad scope of practice is the exciting and challenging attraction of rural practice.

So what has been achieved in rural health in South Africa in the past 10 years? It is safe to say that rural health has developed into a significant issue during this time, in line with the Department of Health's vision in which all South Africans have access to affordable, good-quality health care. The extension of information and communication technology to rural areas in the past decade has made a significant difference to the sense of isolation and marginalisation that used to characterise rural health services. Healthlink, a project of the Health Systems Trust, set up the e-mail discussion group 'mailadoc', which makes it possible for rural practitioners to obtain answers to clinical problems from urban specialists as well as rural colleagues. The Rural Doctors' Association, formed in 1995, has grown in membership and hosts a popular annual conference. The association has addressed a number of issues of importance to rural doctors and addresses rural health policy issues at national level. The Southern African Academy of Family Practice/Primary Care has played a major supportive role for rural doctors, including the hosting of the 2nd WONCA World Rural Health Conference in Durban in 1997. More recently, the Rural Health Initiative of the Academy has been successful in supporting numerous educational and community-based projects in rural areas, as well as the

recruitment of doctors to rural hospitals. The overwhelming tide of terminal AIDS care is starting to be counterbalanced by the hope inspired by patients getting better on antiretrovirals in many rural hospitals. Centres of Rural Health have been established at three different universities together with dedicated academic posts, and a number of decentralised campuses have been developed, to expose students to the realities of rural health care early in their training. The results of these efforts will only be realised over the next decade, when our young graduates make their career choices, based on their experiences and perceptions of the relative advantages of pursuing their careers in South Africa versus overseas, in the public sector versus private practice, or in rural versus urban areas.

Despite these apparent advances, the health of our rural citizens leaves much to be desired, and there is a long way to go. A true primary health care approach has not been implemented in South Africa, and we still operate a largely medical model of health care that is more curative than preventive or promotive in orientation, without real community involvement. The rural health networks that do exist are mostly doctor-driven, and a team approach involving all stakeholders in health, including traditional leaders and healers, is the rare exception rather than the norm. Rural areas are largely 'out of sight and out of mind' of the politicians and the media, but the extent to which we care and provide for those who are unable to care for themselves remains a measure of our development as a nation. Unfortunately there is no valid mechanism for measuring progress towards equity across the urban-rural divide – at present we rely on anecdote and case studies. So, for example, the accessibility and quality of care available to an elderly disabled woman living in a rural area will remain a valid measurement of our progress towards a more just, fair and civilised society, until a more objective measurement is developed. This will be an indicator of real transformation, beyond race or skin colour, towards a just and fair society that gives extra attention and resources to those who need them the most.

1. Tudor Hart J. The inverse care law. *Lancet* 1971; i: 405-412.
2. Reid SJ. Monitoring the effect of the new rural allowance for health professionals. Health Systems Trust, Durban, 2004. <http://www.hst.org.za/publications/643> (last accessed 16 July 2006).
3. Pistorius CJ, Pistorius CWL. *Family Practice Management*. 1st ed. Pretoria: Haum Tertiary, 1990.
4. Gruen RL, Pearson SD, Brennan TA. Physician-citizens – public roles and professional obligations. *JAMA* 2004; 291(1): 94-98.