

Putting Aaron's famous hearing skills to the test

The impending National Health Insurance (NHI) has galvanised both the academic and private sectors into innovative action, as ongoing reports in *Izindaba* show,¹ but among the most recent and exciting developments is the critical mass of medical academics aiming to boost locally appropriate clinical skills via teaching in and among the most deprived communities.²

This is sweetly in harmony with National Health Minister Dr Aaron Motsoaledi's desire to rehabilitate health care facilities in underserved areas most plagued by delivery dysfunction, especially to meet minimum standards for NHI funding accreditation. One of the most obvious ways to do this is to harvest sufficient health care professionals available and committed to rural and underserved community health care – something the combined output of eight campuses, government foreign recruitment and top NGO head-hunting agencies has so far failed to do. The country's most rurally innovative generalist health care educators have banded together and come up with a best-practice recruitment and retention strategy – starting with multi-professional training platforms and student recruitment in and from underserved areas. They toured highly successful rural clinical schools in Australia to see what it takes, tailoring their findings to local conditions and existing pioneering rural teaching programmes. Government must listen, surely?

South Africa needs more doctors

The quality of medical education in South Africa compares well with international standards. However, two papers^{3,4} on the medical and dental staffing of South Africa's health care system describe considerable inadequacies.

In his editorial³ Nicholas Crisp finds it incredible that, with so much debate over such a long period, there's so little improvement in human resources for health in the country. The Reynders Committee in 1980 reported difficulties experienced in recruiting doctors and other health professionals, and in keeping them once recruited. Of the 16 reasons documented for these difficulties only two have been addressed, and one has fallen away with the end of military conscription. The Browne Commission that concluded its task in 1986 found excessive fragmentation of control over health services and lack of policy direction, and personnel problems including maldistribution and declining numbers of nurses. The Browne Commission recommended that 'nobody should do a job that a person with a lower qualification could do equally well'. Already in 1984 the De Villiers Report presented recommendations for investigating the possibility of further facilities for medical and dental training. Crisp concludes that a comprehensive long-term human resource plan, managed with transparency and inclusiveness, is long overdue.

The Colleges of Medicine has initiated a project 'Strengthening Medicine and Specialist Training'. Strachan, Zabow and Van der Spuy report on their research into the number and needs of specialists and sub-specialists in South Africa.⁴ Their study shows that South Africa

has a poor ratio of doctors and dentists per 1 000 population and that many districts have limited or no access to specialist medical or dental services. From 1997 to 2006 there was a significant decline (from 3 782 to 2 928) of specialists and sub-specialists in the public sector. Reasons for the lack of graduates being recruited into the public sector include lack of planning and lack of finance and posts, poor working environment and working conditions, and very limited career prospects. A significant contributor to low retention has been lack of positive reinforcement from the Department of Health. South Africa also needs a reliable database that supplies the numbers of health professionals, and trends in output and retention.

Not meeting South Africa's cataract surgery rates

Cataract is the leading cause of blindness in South Africa, responsible for about 50% of the prevalence of blindness and identified as a national health priority. Cataract surgery is also one of the most cost-effective of all health interventions, and the most cost-effective surgery. Lecuona and Cook⁵ investigated why South Africa's cataract surgery rate (CSR) has failed to reach its targets.

The CSR should be at least 2 000 per million population per year for elimination of cataract blindness. The national CSR rate was planned to increase from 1 000 in 2005 to 2 000 in 2010, but since CSRs have failed to reach targets each year, the national target for 2010 was reduced to 1 500.

The authors conclude that a target CSR of 2 000 per million is achievable in South Africa. In existing surgical units, systems developed in India and Nepal to generate efficiency and high-volume, high-quality, low-cost surgery should be introduced. Additional posts for ophthalmologists, optometrists and ophthalmic nurses should be provided and more medical officer cataract surgeons trained.

Measles in South Africa

Measles ranks as one of the most contagious of all organisms. Reflecting on South Africa's measles outbreak of 2009/2010, Barry Schoub⁶ asks why this infectious disease, which is so easily prevented by a highly effective, safe and inexpensive vaccine, is still such a major cause of morbidity and mortality.

Schoub proposes a plan to manage measles based on the acronym 'MAMI' – measurement, analysis, motivation and implementation.

He concludes that South Africa was a pioneer on the continent in measles vaccination, and should be in a position to be the forerunner in Africa for measles elimination.

JPvN

1. Bateman C. Pre-NHI clean-up: Motsoaledi enlists private sector. *S Afr Med J* 2011;101:438,440,442.
2. Bateman C. Academics appeal to State: 'Help us train where the needs are'. *S Afr Med J*;101:496-500.
3. Crisp N. South Africa needs more doctors and dentists. *S Afr Med J*;101:517-518.
4. Strachan B, Zabow T, Van der Spuy ZM. More doctors and dentists are needed in South Africa. *S Afr Med J*;101:523-528.
5. Lecuona K, Cook C. South Africa's cataract surgery rates – why are we not meeting our targets? *S Afr Med J*;101:510-512.
6. Schoub B. Lessons from the 2009 measles epidemic in South Africa. *S Afr Med J*;101:519.