



Gastroenterology training in private hospitals: India vs South Africa

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future structure and logistics of training needs. This is required in all subspecialties including gastroenterology, as has been done in India. It is hoped that as a consequence well-trained doctors, similar to those in India, might move to provincial hospitals in rural areas, upgrading the medical services and keeping medical power in South Africa. South Africa should become a model for Sub-Saharan Africa, as India already is for South-East Asia.

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Abstract

In South Africa, nurses and doctors are emigrating in significant numbers. Job satisfaction, safety and ensuring career progression are important in retaining doctors to make a career in Republic of South Africa (RSA). Due to budgetary constraints many hospitals have not been upgraded. Coming home after overseas training seems difficult. In RSA it takes a minimum of 13 years for a young specialist to become registered and 15 years for subspecialists. Career progression, creating more specialist trainees in public and private hospitals and shortening the period of professional training are potential solutions to the problem. India, which has a population of more than 1 billion people, is struggling with similar problems. For the past 10-15 years, private hospitals have assisted in manpower development for medical specialist and subspecialist careers. Currently their private sector trains 60% of their recognised (sub)specialties fellows. A national task force for specialist training in RSA should be instituted. It should discuss, based on the current status and projected specialist and subspecialist personnel requirements, the

INTRODUCTION

In South Africa, the health care system faces a variety of problems. There is an overall shortage and maldistribution of medical doctors and specialists, with remote areas the least well populated. In South Africa nurses and medical doctors are the professional categories that emigrate in the most significant numbers. The impact is felt beyond the emigrating numbers of the highly developed skill base the country loses when they leave. Globally, dissatisfaction with income in developing countries is one of the major causes of doctors leaving public service, going overseas and/or joining private hospitals.

It was reported that increases in salaries of doctors in the public sector in South Africa might lead to a number of private general practitioners returning to the public service^[1]. However, many doctors state that other factors such as job satisfaction, safety, working conditions, and improved career opportunities in medical specialist training are more important to stop the exodus of doctors from South Africa to wealthier and safer countries. Ensuring career progression is another factor suggested to be important in retaining academic specialists and fellows to make a career in South Africa. It is therefore imperative to understand and study which specific factors are responsible for doctors leaving the country^[2-4].

New academic hospitals such as Inkosi Albert Luthuli Central Hospital in Durban (2002), Steve Biko Academic Hospital in Pretoria (2006) and Chris Hani Baragwanath Hospital (2010) in Johannesburg have been built or are in the process of being refurbished in an attempt to equalise the provision of tertiary health care. Due to limited national and provincial budget allocations, many urban regional hospitals have not been upgraded. They, like many of the rural hospitals built in the early and mid 1900s, are in a poor state of repair. The quality of these hospitals' patient and staff accommodation is often inadequate. A so-called "capital works" programme has been implemented by the post-apartheid government to build new clinics and hospitals to improve the physical infrastructure of existing health care facilities, but it is currently short of its targets for the workforce to man these institutions once they are built.

However, public hospitals are not the only health facilities with vacancies for nursing staff and medical doctors, especially medical specialists. Private hospitals in competition with the public hospitals also face the same problems although on a smaller scale.

Medical graduates looking for specialist training in South Africa recognise a lack of opportunities and are often forced to look and sample abroad for skills development. This whets their appetite to deliver high quality specialist care. Yet on return, the lack of facilities even at the top institutes leads to frustration in not being able to utilise their newly acquired specialist skills to the benefit of their own community. Completion of training overseas also makes it difficult for doctors who have become accustomed to life in their new environment to return home once their training has been completed. This "Brain-Drain" problem has been witnessed not only in South Africa but in Sub-Saharan Africa in general^[5].

Subspecialties have been considered a luxury in the past by the Government in South Africa. Due to this point of view there is a lack of structure and funding for training in subspecialties of Internal Medicine. These bars to pursuing a subspecialist career in Republic of South Africa result in a shortage of fellows in Internal Medicine finishing their training^[6,7], and competition for posts from within a common pool allocated to all the medical subspecialties.

One solution to this problem would be to change the training for subspecialties such as cardiology, rheu-

matology, pulmonology and gastroenterology to an Internal Medicine track of 2 years instead of the full (minimum 4 years) training in Internal Medicine currently required. This would negate the need for two sets of professional exams and shorten the training period. A common trunk training system of 2-3 years is the standard in Europe and the USA^[8]. In India such a common trunk is still 3 years.

GASTROENTEROLOGY

The number of gastroenterologists in Europe varies between 1:5000 and 1:58000 of the population^[9]. In 2007 the number of gastroenterologists per 100000 of the population was 3.9 in the USA, 3.48 in France, 2.1 in Australia, 1.41 in the UK and 1.25 in The Netherlands^[9,10]. In South Africa this figure was around 0.12. Comparisons between poor and rich countries are notoriously difficult. However, South Africa is both a third and first world country and has a lot of similarities in this respect with India. The Indian model will be discussed in this article.

Unfortunately, no model has been developed and published in South Africa to calculate the required numbers of medical specialists. The Cuban South African agreement, which was signed over a decade ago, notes that South African policymakers were attracted to the Cuban emphasis on prevention and primary care^[2]. This agreement neglected specialist care for the underprivileged. It seems as if the focus of the government was on training medical doctors for the most basic health care level, instead of understanding which and how many medical specialists and subspecialists are needed in post-apartheid South Africa. There is some evidence that the current basic strategy is failing as the infant mortality rate, a parameter often used to measure quality of health care, has increased since 1994. This is in contrast to Europe, but also to countries like India where great emphasis is placed on specialty and subspecialty training. For instance, additional national training numbers have been awarded to trusts in the UK to help meet the requirements of the European Working Time Directive (EWTD). In addition, expansion in the UK is planned with the recommendation that there should be 2.5 gastroenterologists per 100000 of the population^[11]. In comparison, in South Africa there are less than 0.22 gastroenterologists per 100000 inhabitants. (personal communication, Karin Fenton, SAGES, Cape Town).

GUT FEELING

Most internists learn during the current tubal training programmes in South Africa a "gut-feeling" within 3-4 mo, especially in "tubal gut" gastroenterology. Only sixty-two consultant gastroenterologists are available in public and private hospitals around the country, and of these only 17 consultants in gastroenterology work in Academic Hospitals. Only 6 out of the 8 academic complexes teach internists the subspecialty of gastroenterology. There is a lack of internists in general,

of internists for vacancies in training posts, and a lack of dedicated funding for these trainings posts. There is also a lack of gastroenterologists who focus on hepatology and pancreatobiliary disease. Endoscopic ultrasound, therapeutic endoscopy, transplant immunology and nutritional support have developed considerably over the past decades abroad, but not in academic South Africa. In a rather strange contrast, some private institutions in South Africa have gained considerable expertise in some of these fields with the availability of highly specialised equipment and skilled manpower. The University of the Witwatersrand Donald Gordon Medical Center has started a University driven “private” superspecialist programme involving hepatology and liver transplantation. Specialist trainees in Internal Medicine and Anaesthesiology also rotate through the ICU at this private hospital.

The smallness of the gastroenterology community in South Africa, the total sum of equipment and expertise still available in academic institutions and private practise allows a unique opportunity to join forces for developing more training positions for the projected gastroenterology needs of the country in the decades to follow.

NEW SUBSPECIALTY STRUCTURE PROPOSAL

We would like to propose a new training programme with a common trunk of Internal Medicine for 3 years for (“sub”) specialists in cardiology, pulmonology, rheumatology and gastroenterology. Recruitment to gastroenterology will probably entail 3 years of basic medical training in Internal Medicine. A “Brain-Drain” of young doctors willing to specialise abroad should be prevented by creating training posts in private hospitals. The private hospitals should be incorporated in these programmes, like the private hospitals in countries such as India (DN Reddy: personal communication).

A new “core” curriculum should include basic upper GI endoscopy and colonoscopy and a general GI training over 3 years. Additional clinical and endoscopy training should be organised in the final year, further specialisation in GI-oncology, interventional endoscopy or hepatology should be organised if necessary^[8,10].

PRIVATE HOSPITALS AT “CROSSROADS”

With a government that is moving towards a National Health Insurance (NHI) system in South Africa, private hospitals need to work towards the goals of strengthening the existing health services in the country. The new African National Congress leadership seems more willing to listen to new ideas aimed at improving access and affordability and might move away from the current distrust and negativism that have soured the relationship between the government and private sector. Due to the financial situation in public hospitals, medical education and training are drifting to the private hospitals. Major

strides have been made by private hospital groups in addressing the medical needs of South Africa. The private hospital groups are now collectively training more nurses than government institutions. However, medical specialist training in private has not been officially defined nor is there any government policy to regulate its introduction. South Africa is living in 2 worlds when it comes to health services: those who have and those who have not (personal communication: Netcare CEO, Richard Friedland). It would be interesting to look to countries with a similar background between those who have and have not, like India.

INDIA

India with a population of more than 1 billion people is struggling with similar problems. The Indian government has problems in managing and investing in multi-specialty hospitals. However, banks are encouraged to finance innovations in the private sector. Medical education state secretaries realise that joint ventures will enrich India’s health system, and subsequently poor people who can not get basic services will be helped. India is the most preferred treatment destination in the region due to major factors favouring its health care system. India’s private tertiary care medical institutions, with international accreditations, are among the best in the world. They are extremely well equipped with the latest technology and have excellent training standards.

For the last 10-15 years private hospitals in India assist in training and manpower development for medical specialist, nursing and administrative staff. Private hospitals train around 60% of (sub)specialties in India. To encourage the number of junior doctors aiming for subspecialisation, the National Board of Examinations was constituted. This Board is functioning like a National University “sans Frontiers”, where students are enrolled. These students are trained in smaller well-equipped non-academic hospitals. The fact that liver transplantation is being carried out only in the best private sector hospitals and not even in one academic hospital bears ample testimony to the level of competence at these hospitals^[12]. In the early 1990s, the National Board of Examinations added the subspecialties to its list. Consequently a number of junior doctors moved to smaller cities, thereby upgrading the medical services in many provincial hospitals in rural areas. Up to 5-10 years ago the common trend was that Indian doctors training abroad were reluctant to return to India. This trend is also reversing with the set up of corporate hospitals all over India, which offer state-of-the-art equipment and good salaries for medical doctors.

This initiative was followed in the whole South-East region: since October 2007 the Main Board listed Pacific Healthcare Holdings Ltd., a leading Singapore provider of integrated multidisciplinary specialist healthcare services, organised trainee programmes in South-East Asia, in close cooperation with private hospitals in India.

COMPARISON INDIA-SOUTH AFRICA

South Africa has many similarities with India - a large multicultural, multilingual population and coexisting Public (state-run) and Private Medical Care. The public health care system faces resource constraints just as in India. As such, comparisons between medical specialist training in South Africa and India may lead to ideas for improvement, which may be easily adaptable to local conditions.

Medical education in South Africa

There are eight Medical Schools in South Africa, each attached to one of the provincial universities. Students apply to the school of their choice, and may be called in for an interview depending upon their matriculation results and racial background. There is a restructuring of admission policies to redress racial inequities and train more black doctors.

The young student enters medical school and typically undergoes a 6-year undergraduate training programme. Some years ago the Department of Health in collaboration with Health Professions Council extended internship to 2 years. The argument was that newly graduated doctors lacked skills and extra supervised exposure was needed. A compulsory community service was introduced. Specialist training can be completed in 4 years. Subspecialties require a further 2 years. Cardiology and Gastroenterology introduced abroad require 3-4 years instead of 2 years training^[8]. A shorter common trunk system seems the way forward if the total training period is not to be lengthened.

PROPOSAL FOR SUBSPECIALTY TRAINING PROGRAMME IN PRIVATE HOSPITALS

Differences between training in gastroenterology in USA/Europe *vs* India and South Africa are magnified by the obvious resource gap between Third and First world countries. Private hospitals should aim to identify shortages in specialist training positions and provide flexible funding options, thereby providing incremental growth in medical specialist training capacity in the public health system. This is already common practice in Europe.

The public and private sector have to co-operate in preparing for the increased number of medical trainees seeking training positions in developing countries.

A Task Force for specialist and subspecialty training in South Africa should be instituted to meet the current and future specialist training demands, as has been done in India and Eastern-Europe^[13-15]. Redefining training programmes to train specialists more efficiently would be another goal based on a common trunk system for subspecialties of Surgery and Internal Medicine.

Priority 2010-2015

This "priority specialty group for South Africa" should be

identified by Task Forces for Specialist training in close cooperation with the Colleges of Medicine of South Africa. A working group for this Task Force should be instituted with the following tasks: (1) Analysing the South African medical workforce flow data, identifying the numbers entering and leaving workforces in the public and private spheres; (2) Comparing workforce numbers in South Africa with India/Middle East *vs* Europe/USA; (3) Analysing the presence of specialities in different geographical locations; (4) Defining the minimal required service access in rural areas for the basic medical specialties such as Internal Medicine, Surgery, Neurology, Gynaecology and Paediatrics; (5) Discussing the current system of 13-15 years of training for a young specialist to become registered and look for a shorter medical training period to prevent the Brain Drain; (6) Defining the minimal numbers of trainees for subspecialty training in private hospitals and providing and defining funds for training in those private hospital settings in close cooperation with Academic Hospitals; (7) Acknowledging that the medical specialist trainee workforce is complementary to public hospital service. Therefore expansion of training opportunities outside traditional academic settings in private hospitals should be defined and organized. The Medical Board of the HPCSA should expand its role to control and regulate the quality of training, not only in the Public Hospitals but in the private hospitals and prioritizing disciplines facing immediate workforce shortage or maldistribution around the country especially in remote rural areas; and (8) Development of tertiary referral centres would prevent loss of foreign exchange by keeping private patients in the country instead of leaving and spending their money abroad.

CONCLUSION

Medical specialist training is acknowledged as an essential component of health care delivery systems. South Africa, both a developing and developed country similar to India, has a shortage of medical specialists and subspecialists. It is therefore imperative that a national solution should be developed to address the challenges of maintaining an adequate specialist workforce^[6,16,17].

We acknowledge that the academic medical complexes have been and will continue to be the cornerstone of medical training around the world. Over recent years, it has become evident that clinical training will expand from the traditional settings of public hospitals into private hospitals. India showed us the way in how to develop this, keeping junior doctors in the country and giving them access to proper specialist training. This dual pathway for obtaining (sub)specialty training in India over the last 20 years has resulted in almost double the number of specialist doctors, who are now also working inside the smaller rural hospitals in India. Additionally, the massive increase in medical student numbers underscores the need to increase the capacity to train these students in specializations to prevent further "Brain-Drain".

The complexity of medical specialist training in South Africa requires the cooperation of many stakeholders such as, government agencies, the ministries of health and education, assurance companies, academic hospital complexes, the medical board of the health professions council, CMSA, public and private hospitals, fellows registrars and junior medical doctors. A National Task Force should clarify the necessary resource investments and define accountabilities. A Task Force should co-ordinate and govern, while maintaining appropriate flexibility^[18]. We hope that the Medical Societies and Associations in South Africa will consider this expansion of specialist training into settings beyond the traditional teaching hospital model.

Can future specialist training in South Africa involve both, and possibly partner, the private sector and the public teaching system? South Africa could then become a model for Sub-Saharan Africa, as India already is for the poorer Asian countries.

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