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PERSONAL VIEW

Rural hospital focus: accommodation

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ABSTRACT

Rural and Remote Health is committed to the task of providing a freely accessible, international, peer-reviewed evidence base for rural and remote health practice. Inherent in this aim is a recognition of the universal nature of rural health issues that transcends both regional interests and local culture. While RRH is already publishing peer-reviewed material, the Editorial Board believes many articles of potential worth are largely inaccessible due to their primary publication in small-circulation, paper-based journals whose readership is geographically limited. In order to augment our already comprehensive, international evidence base, the RRH Editorial Board has decided to republish, with permission, selected articles from such journals. This will also give worthwhile small-circulation articles the wide audience only a web-based journal can offer. The RRH editorial team encourages journal users to nominate similar, suitable articles from their own world region. This article 'Rural hospital focus: accommodation', is third in our series. It first appeared in *South African Family Practice* 2000; 22 (7), and is reproduced here in its original form, with kind permission of both publisher and author, prominent South African rural doctor, Professor Ian Couper. 'Rural hospital focus' was the title of the SAFP column which presented this article.

In this column, I have looked at two of the three main issues that I believe to be critical in most rural hospitals. This month I focus on the third, viz. accommodation. Once again, I am raising issues for debate and discussion, and invite responses.

People outside of rural hospitals usually have little understanding of why accommodation is needed, let alone some of the difficulties relating to the allocation of housing. Doctors working in rural hospitals, however, often experience accommodation issues as one of the most

common causes of tension and unhappiness, possibly second only to call rosters!

Why is accommodation needed in the first place? Why is the rural hospital different? There are a number of reasons. Firstly, in order to work in a rural hospital, in nearly all cases doctors are required to relocate themselves. It is not simply a matter of changing jobs - by their very nature, rural hospitals are away from areas which doctors usually live in. Secondly, unless the rural hospital is near an established town there is seldom accommodation - to rent or buy - in the local community. Housing of any sort is usually very difficult to obtain and in tribal areas outsiders cannot buy land. Even where towns are nearby, the overtime call roster may make it difficult for doctors to stay elsewhere. And those rare local graduates returning to serve their own communities often do not wish to live in the community because of the excessive demands placed on them by family and friends. Thirdly, most rural doctors are short-term workers who have no interest in, or incentive to, obtaining their own accommodation. Finally, many rural doctors as we well know are foreign graduates, whose insecurity about ongoing employment makes them very reluctant to consider alternatives.

Note that I am not advocating living in a hospital compound as the best model, only describing what is the practice. Doctors who have made the effort to live in the communities they serve have usually found this to be a very rewarding and fulfilling experience which enhances their ability to meet the needs of the people.

So, we have agreed that doctors need accommodation. This is the easy part. How does one allocate this? Almost every rural hospital I know has too little accommodation. The housing is also often old and in need of repair. The types of units available vary from large old mission houses to flatlets to rooms in 'nurses homes'. It is difficult to decide who gets what. If seniority is the basis for allocation, how are families dealt with? A doctor's family is often the critical factor in determining how long he or she will stay. If the family is unhappy - and accommodation is very often the key factor in this - the doctor will leave, no matter how personally fulfilling the job is, making utilitarian approaches to housing allocation very short-sighted.

One major complication is that it is not only doctors who need accommodation. Most of the professional staff of a rural hospital are not local people and need accommodation. It is easy enough to establish the principle that local residents do not get housing (even though they often demand it and are most aggrieved when they do not get it). But how does one decide whether a house should be allocated to a doctor, a matron, a therapist or a laboratory technologist? In some hospitals, housing units are allocated to specific sections and there can be no movement in this - so that much needed houses even stand empty because posts are vacant in particular sections. This approach does reduce conflict but does not help the shortage of space. In other hospitals there is flexibility, and the needs and situation of each staff member requesting accommodation is taken into account. This allows for more creative and functional usage of space, but does produce conflict as staff question why a colleague is given a particular house or room.

There is no doubt in my mind that the Department of Health should put budgetary resources into building accommodation units, but the types of units should be locally appropriate (not designed in Pretoria!) and there should be a clear local policy framework in each hospital for allocating these units.

Related to accommodation, one provision of the Public Service regulations which is prejudicial towards rural doctors is the non-payment of housing subsidies for houses that are not being lived in. Because doctors often cannot and usually do not wish to purchase houses in rural areas, there should be support given to them to buy houses in cities. This would be an incentive that would encourage rural doctors by giving them the security of a place to go to when they move on.

The need for accommodation will no doubt increase, as more categories of health professionals are required to do community service, filling long-vacant posts. One can only

wonder if there is any strategy that exists in the provincial departments of health to ensure that there will be the accommodation needed. Prefabricated units and mobile homes are only short-term solutions, as they deteriorate quickly. One solution would be to provide funds to rural hospitals to enable them to use local builders and materials to develop appropriate housing units. However, arguments of standards, aesthetics and ongoing maintenance are usually raised in terms of this.

I believe, though, that the problem of staffing rural hospitals cannot be adequately addressed if the question of housing is not considered.

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