

CONFERENCE REPORT

Transforming rural health systems through clinical academic leadership: lessons from South Africa

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ABSTRACT

Context: Under-resourced and poorly managed rural health systems challenge the achievement of universal health coverage, and require innovative strategies worldwide to attract healthcare staff to rural areas. One such strategy is rural health training programs for health professionals. In addition, clinical leadership (for all categories of health professional) is a recognised prerequisite for substantial improvements in the quality of care in rural settings.

Issue: Rural health training programs have been slow to develop in low- and middle-income countries (LMICs); and the impact of clinical leadership is under-researched in such settings. A 2012 conference in South Africa, with expert input from South Africa, Canada and Australia, discussed these issues and produced recommendations for change that will also be relevant in other LMICs. The two underpinning principles were that: rural clinical leadership (both academic and non-academic) is essential to developing and expanding rural training programs and improving care in LMICs; and leadership can be learned and should be taught.

Lessons learned: The three main sets of recommendations focused on supporting local rural clinical academic leaders; training health professionals for leadership roles in rural settings; and advancing the clinical academic leadership agenda through advocacy and research. By adopting the detailed recommendations, South Africa and other LMICs could energise management strategies, improve quality of care in rural settings and impact positively on rural health outcomes.

Key words: clinical leadership, human resources, rural academic leadership, training.



Context

Achieving universal health coverage is dependent on skilled and motivated staff working effectively within well-managed and well-resourced health systems^{1,2}. Worldwide, health systems in remote and rural communities fall short of this ideal. In low- and middle-income countries (LMICs), the weaknesses of rural health systems sometimes appear intractable. Innovative solutions are required to galvanise improvements in the quality of care provided to remote communities and address inequities.

In high-income countries, the concept of 'clinical leadership' is gaining traction as a mechanism for achieving substantial improvements in patient safety and quality of care³⁻⁵. This concept acknowledges that health-facility managers have little direct control of day-to-day decisions affecting patient care, and that it is the leadership potential of front-line clinical staff – such as doctors, nurses, allied health professionals and mid-level health workers – that needs to be tapped to achieve transformation⁶⁻⁸. The failure to realise this potential may explain why poor quality care persists in some ostensibly well-resourced facilities in high-income settings⁹.

Clinical staff can lead informally as role models and mentors, or formally through participation in a range of clinical and training initiatives as well as management structures. A cornerstone of the concept is that clinical leaders remain integrally involved in clinical decision-making. This creates a subtle but fundamental shift in management focus from meeting bureaucratic preoccupations to realising patient care objectives, and ensures that leaders have an in-depth understanding of the systems and processes required to support good quality care.

The concept of clinical leadership has relevance to LMICs, especially in remote and rural areas. This is because it offers a way to improve services in poorly resourced facilities. However, some impetus is required to develop clinical leadership. This article is predicated on the assumption that

universities can provide this impetus through the expansion of rural training programs for health professionals. This is because such programs bring with them external clinical academic leaders and other outside resources that immediately benefit the rural services that are used as training sites, including the potential to provide – and model – clinical leadership. In addition, partnering with local clinicians is a practical entry point for longer-term efforts to develop sustainable clinical leadership locally.

While the literature on the features of effective rural training programs in high-income countries is well developed, similar programs are emerging only slowly in LMICs. Further, the literature on how to grow and sustain clinical academic leadership in rural areas is minimal. To initiate debate on these issues a two-day conference was held in Johannesburg, South Africa, in February 2012. Twenty-four South African academics and senior health service staff with expertise in rural health systems development and training gathered at the University of the Witwatersrand as part of a collaboration with Monash University in Australia. Presenting special inputs to the conference were four Australian and Canadian academics integrally involved in running rural training programs in their home countries. A series of small-group discussions with feedback to plenary sessions led to the development of a set of consensus recommendations for further development of rural clinical academic leadership in South Africa.

The purpose of this article is to present these recommendations in order to stimulate further debate and research on how to develop and sustain clinical academic leadership in rural areas of LMICs. 'Rural clinical academic leadership' is defined here as the guidance and role modelling provided by rural academics with respect to improving the quality of health service delivery, achieving clinical governance and protecting patient safety, providing good quality training, conducting relevant research and, more generally, contributing to the social accountability of health services and universities.



Although generated for the South African context, the conference recommendations are relevant to other LMICs and may be of assistance to colleagues from other universities and health services interested in developing transformational rural clinical academic leadership. The challenges of rural health care in South Africa¹⁰ and extreme inequities (public vs private health sectors; among provinces, and urban vs rural) in the country¹¹ result in problems common to many other under-developed settings (Fig1). Indeed, the Australian and Canadian conference participants reflected on the fragility of even their own well-established programs due to dependence on a few key staff.

Further, the experiential or ‘tacit’ knowledge of the policy-makers, program managers and academics on which this article relies is a useful starting point for informing future practice and research, especially given the paucity of more formal evidence¹². Clearly more robust evidence needs to be assembled over time and, accordingly, future research needs are addressed among the recommendations presented in this article.

Issues

Before presenting the recommendations generated by the conference, two underpinning principles are discussed.

A high value should be placed on promoting rural clinical academic leadership

Evidence has accumulated for the positive impact of rural training programs for health professionals on rural health systems in countries such as Australia, Canada and the USA¹³⁻¹⁵. Where curricula have a strong rural focus, and where student health professionals spend a substantial part of their training in rural settings, new graduates are more likely to remain in rural areas. They are also better adapted to meeting the needs of communities and delivering health care in these settings. Retention of health service staff involved in training is improved through the stimulus, support and career paths provided by linkages to an academic institution. As rural

training sites mature, they become well-accepted and supported by local communities who see the presence of students – and of training activities more generally – as vital to the sustainability of their local health services¹⁶.

Thus, effective rural training programs meet multiple objectives: they improve the quality of care provided by both individual students and rural health services, and they improve both the recruitment and retention of health professionals in rural areas. Developing and expanding rural training programs in LMICs is therefore closely linked with developing rural clinical leadership, both academic and non-academic.

However, often the full achievement of these objectives rests on the shoulders of a key set of altruistic, creative and energetic rural clinicians who develop their values and skills locally and have the commitment to drive change, despite numerous obstacles. Conference participants felt, therefore, that it is a priority to implement initiatives to nurture and develop these individuals, in order to both sustain existing rural training initiatives and develop rural clinical leadership on a wider scale. As rural clinical academic leaders have been under-valued in the past (along with rural and generalist practice), this will require strategic direction and collaboration on the part of both health services and universities.

Leadership can be learned and should be taught

Being a good leader is partly about having specific leadership skills and partly about displaying an appropriate leadership ‘style’¹⁷. While some clinicians may appear to be natural leaders, international experience shows that leadership is not a mystical quality but can be observed and learned, in both formal courses and ‘on-the-job’ experience and mentoring¹⁸.

In many countries ‘leadership’ is now acknowledged as a core competency of health professionals¹⁹. It is increasingly offered as a component of faculty development²⁰ and incorporated in undergraduate training courses. Indeed, a key element of the transformative learning advocated for 21st Century medical education is developing leaders who are effective change agents².



Lack of policy coherence: Although a range of policies support the development of universal health coverage and the implementation of the primary healthcare approach, these are not directly linked to the development of rural training programs and clinical leadership, or to budgets for training.

Failing public health systems: Rural health systems are generally weak and suffer from a leadership and management deficit as well as a severe shortage of staff. Working conditions are often poor which impacts negatively on the quality of care as well as staff morale and retention.

Urban bias in health sciences training: Health sciences curricula are urban-based and selection criteria do not favour students of rural origin. Medical students are generally taught by specialists rather than generalists: generalists have low status and this discourages students from embarking on a career in rural health, especially as there are few material benefits. Students only spend short periods of their training in rural areas and the imperative for clinical leadership training is usually not acknowledged. Inter-professional training is under-developed and there is a debilitating hierarchy across and within disciplines that makes good teamwork and leadership in the healthcare setting difficult. The current generation of rural clinical academic leaders is 'greying', raising the prospect of dwindling leadership and training capacity in future years.

Under-developed training roles for public health services: Training is not seen as a core function of health services. The number of training sites is limited and, where training sites exist, services are often underfunded and battle with poor infrastructure and support services. Training is usually not well integrated into service delivery. Accommodation and transport for students are often poor and there are problems supporting distance-based learning (such as providing access to computers and the internet). This means that many rural sites are not ideal for training. Weak management and accountability of health professionals and managers exposes students to negative behaviours and poor quality of care. This can lead to students being put off public service or adopting these negative values themselves, becoming 'corrupted' by their exposure to negative role models. It is difficult for universities to intervene to improve the quality of care because they have no authority over service staff.

Little support for rural trainers: Rural trainers are relatively isolated, geographically and professionally. They receive little professional and administrative support, and are usually not recognised formally as academics. Management and service delivery demands on their time are huge, making it difficult for them to schedule time for academic work as well as continuing professional development.

Figure 1: Challenges to developing rural academic leadership in low- and middle-income countries - the case of South Africa (source: conference deliberations, 2012).

Conference participants concurred, therefore, that another major priority for rural clinical leadership development should be the incorporation of leadership training into education programs for health professionals, with a special emphasis on leadership for rural settings. This is a practical way to begin strengthening clinical leadership, even while acknowledging that leadership development should be a dynamic, multi-stage process that involves a variety of integrated strategies.

Lessons learned

On the basis of these priorities, conference participants generated three main sets of recommendations based on their

collective experience: (i) how better to support local rural clinical academic leaders; (ii) how to train health professionals for leadership roles in rural settings; and (iii) given the paucity of evidence for these interventions, how to advance the clinical academic leadership agenda through advocacy and research.

Supporting rural clinical academic leaders

1. In LMICs, generalism and rural practice should be legitimised and promoted, and rural academics should be provided with opportunities for career advancement through, for example, taking time off to acquire diplomas in specialist areas or complete higher degrees.



2. Rural clinical leaders should be provided with training in academic skills such as curriculum development and assessment, leadership and student support as they often do not have experience in these areas.
3. Rural research units should be established and clinical academic leaders from parent universities and local health services should be involved in this research alongside local rural clinicians, especially when it addresses topics such as promoting the quality of care in rural and primary healthcare settings, or developing rural training programs. This would assist with the widespread issue of rural clinicians finding it difficult to establish a credible research output, especially when entering academia relatively late in their careers. It would also help to avoid the problem of research being done in rural areas without impacting on the subjects of the research.
4. The dissociation of clinical and academic work should be addressed by ensuring rural clinical academic leaders are on joint university and health service posts, and are formally acknowledged for their roles as preceptors. This might be attractive to the health service as it could assist with gaining accreditation of facilities, while a joint agreement is a mechanism for ensuring that the university has influence in ensuring continuous quality improvement. It is important for all parties to be clear about what a joint position means in reality, in order to avoid tensions, and to explore innovative options for optimising the relationship. For example, the university could pay for a service post to alleviate the service burden on the rural academic, or the health service could fund a rural academic's training time through government training grants. There could be a variety of joint positions with some including the expectation of curriculum development and research as well as considerable administrative tasks, and others, at a lower level, only requiring minimal administration and supervision. Rural preceptors should also be

involved in the ongoing life of the university, for example through membership of student selection committees.

5. Rural academics should be supported administratively and protected from unreasonable bureaucratic demands. In resource-constrained environments one can achieve this by creating a hospital education committee that brings together different disciplines and senior hospital managers so that tasks can be shared.

Leadership training for rural settings

1. In LMICs, leadership development should be introduced into the curricula for health professionals as a core component from the first year, with clearly identified core competencies based on review of the literature²¹.
2. Leadership training should address the needs and experience of students, harnessing their extra-curricular activities (such as rural student groups and voluntary work in communities). It should be done in a way that students can apply it to the context in which they are working and learning.
3. Curricula should impart core values and include competencies such as professionalism, emotional intelligence, communication skills, strategies for quality improvement and human resources management. Features of rural clinical leaders that should be fostered include resilience, patient and community advocacy, and the ability to deal with the clinical risk and uncertainty inherent in rural healthcare settings. Training should develop a sense of personal agency among students so they become active in health system transformation²².
4. Leadership training should be for all types of health professional working at all levels in the health service. It should be both taught and modelled during undergraduate and postgraduate training, and thereafter through continuing education, creating a continuum of leadership training. Training should be performed in multidisciplinary teams because many



elements are generic, and learning together also models future interprofessional collaboration. To have a substantial impact, assessment also needs to be inter-disciplinary.

5. Resources should be in place to support leadership training and curriculum development. It would be helpful to draw on the rich international literature and frameworks on leadership, recognising that this experience and underlying theory underpins successful leadership. Partnering with local business schools is a useful strategy but the substantial differences between leadership for business and leadership for rural health systems need to be acknowledged and addressed. Health systems are values-based and have a moral purpose; they are diffuse in nature and the core workforce is largely professional; and 'the means' (delivering health care) is just as important as 'the end' (improving health). It is important, therefore, to adapt leadership training for rural clinicians to the general philosophy of rural health education, as well as the specific context of local health services. Consequently, the predominant models of leadership education for rural clinicians are shared, distributed, multidisciplinary and transformational, rather than directive.
6. Apart from paying attention to the 'formal' curriculum, trainers also need to address the 'informal' curriculum – the unscripted, ad hoc, highly personalised part of the curriculum that students experience and observe – as well as the 'hidden' curriculum – the values transmitted through organisational culture. Both the informal and hidden curricula have a large impact on students as they are very much aware of both²³. If these aspects convey negative messages, students can be deterred from rural practice or inappropriate values (such as dismissive attitudes to disadvantaged patients, poor hygiene control or other unprofessional behaviour) inculcated. Role modelling as part of leadership training becomes very important in this regard.

Need for advocacy and research

1. It is important to advocate for the transformation of rural health services and rural academic leadership in order to ensure that policies are implemented. Strategies could include:
 - building evidence through research collaborations
 - examining how legislation could be used to prompt action
 - mobilising community support
 - interacting with the media (especially regarding 'good news' stories)
 - networking
 - lobbying.
2. Research is important in improving academic rural leadership and producing evidence that will influence the range of stakeholders to support the development of rural clinical leadership. Innovative research methods are required and should include participatory action research, qualitative research, reflective practice and interprofessional collaboration. It is essential to involve rural clinical leaders in research projects. Practical research strategies might be to examine best-practice sites and record the history and experience of clinical academic leaders who are good role models. The over-riding purpose of such research would be to enable health services, academics and communities to collaborate successfully in quality improvement in rural settings. Priority topics identified by participants were as follows:
 - an exploration of the role of government, policy, universities and rural clinical academics in supporting and developing rural clinical academic leadership and training
 - describing and analysing functional district training sites (with a particular emphasis on facilitating and constraining factors)
 - exploring leadership development options in the undergraduate curriculum



- assessing the differences in competency and experience between students and graduates trained in rural and urban settings, including leadership potential
- identifying mechanisms for academic clinical leaders to lead quality improvement in the health services and develop clinical leadership skills in health service staff.

Conclusion

Through their multiple roles and interventions, rural clinical academic leaders can make a vital contribution to the quality and sustainability of health systems, especially in rural areas, ultimately contributing to improved health outcomes for the communities they serve. Developing rural clinical academic leadership is complex and takes time to realise in a meaningful way. Service and training issues are inextricably linked, and the capacity-building of both must be continuous to ensure sustainability. Universities and ministries of health and education should advocate for rural training of health professionals and the development of rural clinical academics as an effective strategy for 'growing' a rural workforce, developing dynamic clinical leadership and strengthening rural health systems.

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