



## Eating our academic seed corn

Hunger and primitive survival instincts can result in desperation. And desperate people respond desperately. In Zimbabwe empty food shelves in the stores and catastrophic declines in crop production on the farms have contributed to the people plundering the wildlife of the nature reserves and even eating their seed corn. The resulting desolation will take generations to heal. So a human tidal wave from Zimbabwe is engulfing the surrounding countries. What lessons are there for our teaching institutions in South Africa?

There have been unprecedented challenges by senior academic staff in the Western Cape and elsewhere to the continuing erosion of state support to the teaching hospitals. They have correctly drawn attention to the importance of sound secondary and tertiary hospitals in supporting people referred from primary care facilities with complex and serious medical problems. However, a critical component is the decline in the capacity of the remaining academic staff to adequately fulfil their vital role of growing the future crops of health care practitioners. Administrators have persisted in maintaining that all is well despite demonstrable deterioration in services and training.

Consider the key roles that teaching institutions have played in the past and should continue to play if we hope to be a winning nation. They train large numbers of undergraduate and postgraduate health care practitioners. Ideally, they should be staffed by the top experts in the field in order to be at the cutting edge of developments. They should have the capacity to develop new knowledge through research and to evaluate and synthesise existing knowledge in order to apply it most effectively. Capacity building of future generations of people able to recognise important questions and with the tools to answer them are the main objectives of research training through Masters and PhD programmes. Such graduates are pouring out of the successful developing countries while South Africa is falling behind. Trauma is one of South Africa's major health burdens and the large teaching hospitals soak up a disproportionate amount of it, displacing other cases that should be accommodated. Owing to budget cuts it is no longer possible to provide sufficient experience for the specialist staff to retain their expertise, let alone to enable adequate training for registrars. Ten years ago when I was seriously considering re-entering active practice an important determinant in not proceeding was the realisation that, in order to regain clinical skills, I would be competing with registrars for limited practical experience. Their need as budding specialists was certainly greater than mine. Since then the situation has deteriorated further.

One of the arguments for cutting the teaching hospitals is that they are so expensive. When a group of us were

exploring possible models to retain excellence in our teaching hospitals because of budget cuts more than a decade ago, we encountered the shrewd and dynamic head of a successful and high-quality hospital group in Germany who provided some useful insights. When asked what we were concerned about losing we listed such things as renal dialysis, joint replacements, interventional radiology and advanced imaging facilities, heart valve replacements, transplant surgery and radiotherapy. He showed us that the unit costs of such equipment and procedures, at the top of the cost pyramid, on their own were prohibitively expensive. A large hospital needed to have a large supporting base of simpler services that would justify the large staff requirements and the average cost per patient would thereby be significantly diluted. The large supporting base of less complicated patient care and staff has increasingly been diverted from teaching hospitals to secondary and primary facilities elsewhere. This observation is evident when looking at the stripped-down Groote Schuur Hospital. Here average patient costs are high because of the complex nature of cases and procedures and smaller numbers of patients because of budget cuts. In the eyes of some planners such a hospital would seem outrageously expensive in terms of unit costs and deserving of further cuts – a self-fulfilling vicious cycle.

After years of neglect of sufficient funding to maintain the basic infrastructure, let alone keep up with natural growth, major state bodies such as Spoornet and Eskom now require drastic rescue measures to enable them to cope. Spoornet has lost out badly to private road transport, and blackouts have become a depressingly regular symptom of Eskom's declining capacity. The State has recognised this deficiency and has weighed in with big new funding and heavyweight appointments. Unfortunately the same message seems to have escaped the planners responsible for our academic hospitals. The training and practice of medicine, once considered one of the major strategic benefits of the new South Africa, has already been seriously compromised. It is not only the provision of services that is at issue. Like the Zimbabweans, we are eating the seed corn that should produce the new crops of medical and other health care practitioners.

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