How golden policies lead to mud delivery – and how silver should become the new gold.

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There is a general perception amongst academics, government officials, non-governmental organisations (NGOs) and the South African public at large that as a country we have good policies, but that we implement these policies poorly (1). In fact, one of the fundamental issues that we need to address as a country is to try to understand why, despite good policies, adequate amounts of money and more skilled workers than in most parts of Africa, South Africa performs so badly (especially in health and education) when compared to other African countries. The tendency of policy makers is to blame downstream factors, such as general lack of capacity , "lazy managers" or "obstructive clinicians", which to some extent is reflected in the research (2).

But my job today is to describe to you what it is like being at the rural coalface. Though I have loved working in a rural hospital for the past six years, it has also been one of the toughest periods in my life. Working in rural medicine is a bit like sitting on a rollercoaster: a combination of enormous challenge and reward, feeling exhausted and exasperated and then inspired and invigorated, seeing dignity and strength in patients, but also sadness and unnecessary suffering and death. One always feels stretched and one often feels as if one is hanging on by one's fingertips. The rural idyll is something that might be experienced on weekends off, but the reality of the working week is that on the whole one is extremely busy and constantly rationing care and doing the best one can with the resources available.

It therefore might come as no surprise to the reader that at the coalface "policies" are more often seen as a hindrance than a help to the delivery of health care. Policies or programmes are often imposed from above, with no consultation and with little understanding of realities on the ground. There is usually poor data collection and feedback, lots of time-consuming and unnecessary paperwork and a focus on irrelevant aspects of care with the neglect of critical aspects. I need to make clear that good, realistic and helpful policies are greatly appreciated by most clinicians working at primary care level, as they improve care and the health of our patients (for example the new antiretroviral treatment guidelines).

But there are also many examples of policies and programmes that aim for an unrealistic gold standard (with its unnecessary and unhelpful complexity) and which, as a result, undermine the provision of good healthcare to as large a population as possible.

The first example of this is the new Road to Health Booklet. Although an extremely well-intentioned document, it is completely unrealistic to expect a busy primary care nurse to use this tool properly. It appears as if the designers of the document have never set foot in a packed rural (or township) immunization clinic, or tried to fill in the booklet with 60 screaming babies requiring injections in the waiting room outside. A year after it was introduced in our area, we still find that critical data such as

mother's HIV status and type of prevention-of-mother to child transmission (PMTCT) treatment provided is left out, whilst on the old, much simpler Road to Health Card, this was filled out really well.

Another example of where aiming for gold results in mud delivery is the District Health Information System (DHIS), a tool with so many parameters and different indicators that it is not actually possible to fill it out correctly unless each clinic has several dedicated data capturers with computers and technical support. As a result, much of the data is literally made up (I have seen it happen with my own eyes) and results in very poor quality data. At a recent meeting in my district, for example, several clinics had a higher than 120% coverage for measles vaccination. Yet managers and health planners scratch their heads and wonder why we get such poor quality data and complain that overloaded nurses at the coalface must just fill the data sheets out correctly. The DHIS needs to be simplified drastically, and nurses on the ground must get regular feedback on certain critical indicators that truly reflect improved care.

Many people balk at the idea of not aiming for a "gold standard" at a policy level – surely we must at least aim for the stars even if this isn't really achievable?
Firstly, I would like to argue that we have ample evidence of how aiming for gold actually undermines the provision of care at grassroots level, and that we instead need to focus on simplicity and doing the basics really well. This would result in the biggest health impact on the greatest number of people.

Secondly, I think that we need to be cognisant of our limitations in terms of both human and financial resources in South Africa and recognise that we do not have the capacity to achieve gold right now, although it may be possible to aim for gold 20-30 years from now.

In the health sector we should be working within a framework of clear, straightforward priorities, aiming for what is achievable (silver?) and doing the basics extremely well, with simple monitoring and clear feedback to all healthcare workers. I would like to argue that a policy cannot be labelled as "good" unless it is implementable. We need to recognise that putting policy together is the beginning of a long process. Policymakers need to be involved in drawing up implementation strategies, and government must support policy implementation through adequate finances and capacitating and empowering managers to manage the changes that will be required when policy is implemented.

Let me end with a final plea from the coalface that those of you who write policy use the following as your guiding principle: good health policies make things better and easier on the ground and result in improved patient care.

Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.

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