

CHAPTER 2

**HUMAN RESOURCES IN THE SOUTH AFRICAN HEALTH CARE
SYSTEM: A RAPID APPRAISAL**

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CHAPTER 2: A RAPID APPRAISAL OF HUMAN RESOURCES IN THE SOUTH AFRICAN HEALTH SYSTEM

2.1 INTRODUCTION

Development of the HRH Plan was partly informed by a rapid, desktop appraisal of the HR situation in the country. The desktop review sought to provide a description and analysis of the human resources for health situation in the country – thereby provide a platform upon which a Plan would be developed.

This review was guided by the following objectives:

- To appraise the information that was already available, which would help in the development of the HRH Plan
- To identify gaps where additional research or information collection may be necessary to provide a complete picture of the HRH situation in the country
- To contribute to the identification of the elements of the pillars of the HRH plan

2.2 THE CONTEXT OF HR FOR HEALTH IN SOUTH AFRICA

2.2.1 Structural Organisation of the SA Health System

The following diagram illustrates the structural organisation of the national health system. Emphasis should be placed on the fact that it contains two major components – the public and the private health sectors. It is therefore necessary that overall planning for the health system incorporate both sectors.

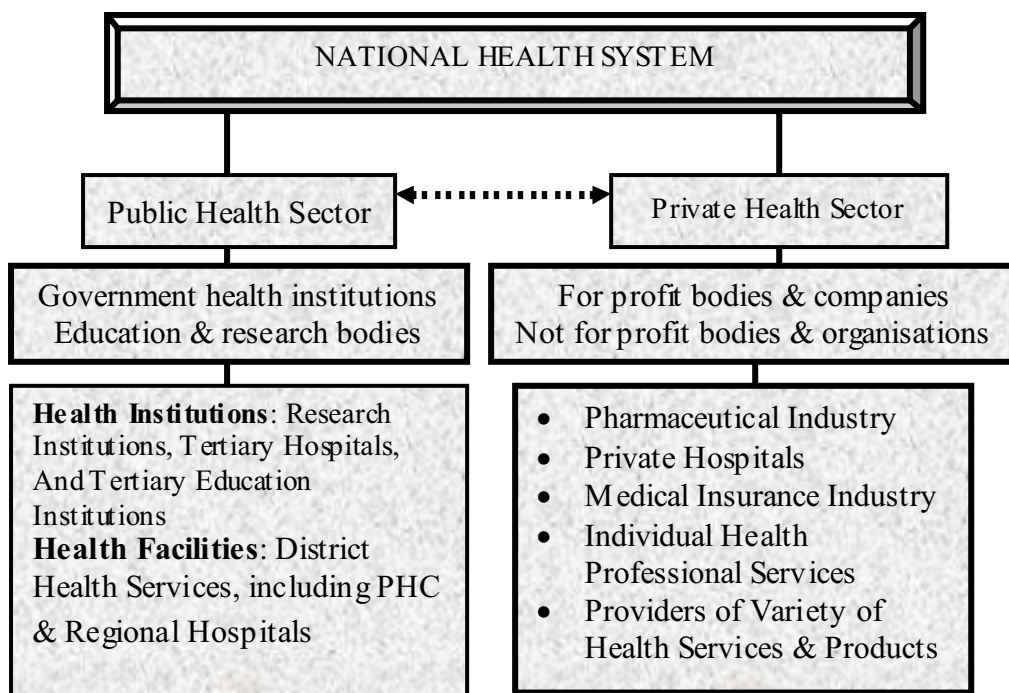


Figure 2: Macro Organisation of the National Health System

2.2.2 Population Demographics and HR Specific Statistics

Population growth and related demographics in addition to other health drivers play an important role in the planning of human resources for health. With urbanisation on the increase, the health system faces the task of attracting health professionals to rural and other under-served areas. The location of almost all health education and training institutions in urban areas influences the choices made regarding their employment by young professionals. Even though provinces have tended to focus on providing study assistance to students from rural communities, there are conflicting views concerning whether this strategy ensures that such students willingly return to work in their communities after graduation.

Of concern is the challenge of attracting prospective students to the health sciences. Recruitment strategies therefore have to extend to pre-higher education student life, whilst recognising the urge for young people, including those from rural communities, to experience urban life as well as international travel and experience. Utilising the size of the population in rural areas as a basis for argument, it is clear that the availability of health professionals in provinces with large rural communities is a serious issue.

Table 1 below offers a summary of population distribution by province, also indicating the number of health professionals (*nurses, doctors and pharmacists used for illustration only*) working in the public health facilities in the provinces. With the majority of provinces being more rural in nature and bearing in mind the challenge of staffing health facilities in these areas, new strategies need to be employed at provincial level so as to encourage health professionals who operate specifically at primary health care level in the private health sector also to provide services in the public health facilities.

Vital to this approach is an increased and sustained level of production of health professionals over a period of time. Such strategies will include most of the professional categories, in order to avoid gaps in planning that ultimately affect service delivery seriously and negatively.

Table 1: Population by province; 2001 (compared to nurses, medical practitioners and pharmacists in the public health facilities March 2005)

Province	Population ¹	Professional Nurses ²	Medical Practitioners (excl. Specialists) ²	Pharmacists ²
KwaZulu-Natal	9 426 017	9380	1916	374
Gauteng	8 837 178	6997	1582	240
Eastern Cape	6 436 763	6370	866	201
Limpopo	5 273 642	5612	657	142
Western Cape	4 524 335	3824	1139	246
North West	3 669 349	3040	403	105
Mpumalanga	3 122 990	2725	536	115
Free State	2 706 775	3475	445	102
Northern Cape	822 727	950	240	36
South Africa	44 819 778	42373	7784	1561

¹**Sources:** Statistics South Africa, 2003. Census in Brief: 2001

²**Data source on health professionals:** Vulindlela

(Extracted from PERSAL 07 March 2005)

The comparison above is made only for illustrative purposes, indicating the spread of a sample of health professionals in the provinces.

2.2.3 Policies / Legislation Addressing Health Systems Development

Most countries in the world are facing an increase in the burden of disease and the challenge of adjusting their health systems to cope. Complicating this is the phenomenon of migration of health personnel, negatively affecting mainly the developing countries. Reviewing the trends in the production of South African health professionals and reversing them is obligatory. By so doing the country should be able to reassess not only the need for training but also the way in which its health workforce is trained. Overall, various pieces of legislation impact on human resources generally, with some being more specific to health. The White Paper on the Transformation of the Health System introduced a number of changes post-1994 in order to address a number of system challenges. A number of these changes are directly relevant to HRH. In general the country's policies on human resources adopt a developmental approach and focus on making an investment in areas that seek to improve the health status of citizens, thereby affording all a chance to participate in development initiatives.

2.2.3.1 Government's Programme of Action on Human Resources

The government's Programme of Action on Human Resources provides a link to HRH by pronouncing on the following priorities:

- Strengthening the HR Planning function
- Strengthening the HR function with a view to retention and capacity building, in the context of the labour market, of changing skills requirements and of the contribution of higher education institutions
- Improving the quality of the work experience and the physical work environment

- Attending to the conditions of service of professionals in order to attract them to and retain them in the public service

2.2.3.2 White Paper for the Transformation of the Health System

The 1997 White Paper for the Transformation of the Health System in South Africa came to be the first pivotal policy document guiding transformation in the health sector. It established a number of important principles to guide human resource planning, production and management, covering the following:

- A national framework for the training and development of health personnel will be established.
- The skills, experiences and expertise of all health personnel should be used optimally to ensure maximum coverage and cost-effectiveness.
- Health personnel should be distributed throughout the country in an equitable manner.
- Education and training programmes should be aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve.
- Particular emphasis should be placed on training personnel for the provision of effective primary health care.
- New policies and strategies for human resource development should address priority education and training needs.
- The experience of people using the health system should be one of caring and compassion.
- Management authority should be decentralised to the provincial and district levels to allow for a greater degree of autonomy.
- Health service managers should be supported in acquiring the skills required to manage a decentralised health service.
- A participative, democratic management style and management by objectives should be engendered.
- Effective evaluation techniques and procedures should be introduced to assess management efficiency at all levels of the health services.
- The clinical skills of health workers should be upgraded.
- The skills of managers at all levels should be developed, if substantive health reform is to be sustained.
- Institutional capacity to support human resource planning and management should be developed.
- Research capacity focusing on essential health research strategies should be implemented to support health sector development.
- Affirmative action policies should be aimed at transforming the public health services into a non-racial, non-sexist organisation.
- The personnel profile of the health system should reflect broadly the composition of the relevant labour market at all organisational levels.

Following this groundbreaking policy document, the Health Sector Strategic Framework 1999-2004 and the 2004 Strategic Priorities for the National Health System 2004-2009 were published by the National Department of Health, highlighting human resource development as a priority area.

2.2.3.3 Human Resource Development Strategy for South Africa– DPSA

The Human Resource Strategy concept was adopted in order to support a holistic approach to Human Resource training and development in the public sector.

The strategy is underpinned by a set of institutional arrangements, including Sector Education and Training Authorities, aimed at ensuring coordination in the implementation of the strategy. It also seeks to address what the HSRC (2003) refers to as “*several HRD problems, [that] are expressions of highly contradictory and disconnected interactions between institutions ...*”. This statement describes the gap between what education institutions (generally responsible for human resource production) generate and what the labour market needs.

Within the health sector a number of learnerships have been developed in the field of nursing, and memoranda of understanding have been entered into regarding the management and implementation of learnerships, which are monitored by SETAs. All learnerships are accredited by the SAQA, abide by the National Qualifications Framework and have accredited service providers that offer the courses/training. At the end of a learnership a learner receives a qualification that represents accredited unit standards. The DoE maintains a Private Higher Education Chief Directorate responsible for the registration of institutions, including FET institutions.

There is however a lack of coordination between the SETA, Further Education and Training (FET) and the health sector regarding the training of the health workforce. This problem should be proactively addressed by means of high-level interaction between the Departments of Health and Education to ensure improved management and regulation of the provision of learnerships falling within the FET band.

2.2.3.4 National Health Act No. 61 of 2003

This Act provides a framework of legislation for the health sector. With regard to the HRD, the Act introduces a *National Health Council*, charged, among other tasks, with developing “*policy and guidelines for, and monitor[ing] the provision, distribution, development, management and utilisation of, human resources in the national health system*”. Given the problems surrounding inequitable distribution of staff, training and development, this legislation enables the Council to develop strategies for dealing with issues within their mandate.

The Act also provides for the establishment of *the Forum of Statutory Health Professional Councils* with wide ranging stakeholder representation, charged with overseeing policies and performance with regard to health professionals, and advising the Minister on relevant matters. Finally the Act establishes *Academic Health Complexes* consisting, very importantly, of health establishments at all levels of the national health system as well as educational institutions. Regulations relating to human resources include:

- Ensuring that resources are made available for the education and training of personnel to meet the human resource requirements of the health system
- Creating new categories of health personnel to meet these requirements;
- Addressing the skills shortages by means of various measures, including the recruitment of foreign health professionals;
- Developing appropriate recruitment and retention strategies;

- Ensuring that capacity exists within the different levels of the national health system to adequately and appropriately plan, produce and manage human resources.

2.2.4 Policies / Legislation Addressing Human Resource Development

The Government's commitment to improve the quality of education and training finds expression in a range of policy and legislative frameworks developed since 1994. At a broad level, these include the South African Qualifications Authority Act (SAQA) Act, 1995; the Skills Development Act, 1998; the Skills Development Levies Act, 1999. These pieces of legislation introduce new institutional frameworks to determine and implement national, sector and workplace skills development strategies. The main objective of the HRD policies / legislation is to facilitate the training and provision of a health workforce that possesses the requisite skills and competencies and exhibits the correct orientation for the development agenda of the country.

2.2.4.1 *White Paper for Public Service Training and Education (WPPSTE, 1998)*

Training and development is a factor regarded as a key for the Public Service to succeed in its mandate of providing effective and efficient service delivery. The White Paper provides a policy framework regarding the Government's commitment to invest in training and development as one of the strategies for enabling public servants to provide effective and efficient service delivery. (WPPSTE, 1998)

2.2.4.2 *Policy on Higher Education*

The National Department of Education is the custodian of higher education and as such the higher education institutions in health are accountable primarily to this Department. This is an essential field because "*higher education has a critical and central role to play in contributing to the development of an information society in South Africa both in terms of skills development and research*" (National Plan for Higher Education 2001). The Human Sciences Research Council (HSRC) further noted that higher education has a key role to play in contributing towards high-level human resources development (HSRC 2003). The challenge in this area relates to the fact that health is a specialised sector. The knowledge and skills acquired are specific to the practice of healing patients and thus impact directly on matters of life and death.

There are currently efforts at ensuring a coherent relationship at inter-sectoral policy level between the Departments of Education, Health and Labour relating to higher education and skills development relevant to the health sector. Issues of transformation that are fundamental to HR production and therefore to the provision of services in under-served areas must be tackled through enhanced policy coordination and implementation between Health and Education.

2.2.4.3 *Policy on Internship*

The policy of internship ensures the supervised training of certain designated newly qualified health professionals before they can register for independent practice. Although the aim is not to get extra pairs of hands to do the work where there are shortages, studies on internship show that these professionals are in fact exposed to heavy workloads, sometimes without the necessary supervision and support. This adds to the factors contributing to the disinclination to work in rural areas upon completion of the mandatory internship. This is consonant with Reid's

findings (Reid 2002) where skills gaps, attitudes, lack of supervision and poor conditions of service were identified as areas needing improvement.

2.2.4.4 *Policy on Continuing Professional Development*

In 1999 the Forum of Statutory Health Councils established a *Continuing Professional Development* Programme. This introduced the principle that all registered health professionals must update their skills on an ongoing basis by means of a range of professional development activities, including organisational activities, self- and group study, publications, teaching and the acquisition of additional qualifications.

2.2.4.5 *National Skills Development Act, 1999*

The overall objective is to revolutionise skills development by advancing the culture of excellence in skills development and lifelong learning. The Act aims to promote skills development by encouraging various government departments and agencies to establish learnerships so that the unemployed youth can gain some work exposure. Although a major step forward, this policy is not necessarily aligned to overall health policy in terms of expanding the skills base in health care. There is no demonstrable link between the skills acquired through these learnerships and the future career prospects of the youth receiving the skills training.

2.2.5 *Policies/Legislation Addressing Health Service Delivery*

2.2.5.1 *Scarce Skills & Rural Allowance Policy Framework*

The DPSA provided all government departments with this policy as a guide to developing and implementing their departmental scarce skills policies. This framework contextualised the problems being experienced in the Public Service, concerning employees with scarce skills, in relation to the open labour market and it details possible strategies, which departments may adopt. These strategies are aimed at ensuring that in the long term the State as the employer, possesses an adequate (perhaps even an excess) supply of skills from which to draw its human resources.

The challenge for the health sector is that owing to the poor salaries being paid to the health professionals in addition to high workloads, many such professionals in various categories, backed by the labour unions, are demanding that they be included in the scarce skills categories. There also exists no structured relationship between this policy framework and other retention strategies, especially non-financial incentives, to retain health professionals within the public health service.

2.2.5.2 *Policy on Commuted Overtime for Medical and Dental Practitioners*

This policy was developed and implemented to compensate medical and dental health professionals in the public sector for the overtime they are required to do outside their normal working hours. The challenge, however, has been the ability of departmental management at facility level to manage its implementation, leading to some professionals making it a permanent fixture of their remuneration. For the practitioner doing commuted overtime on a semi-permanent basis serves to boost the salary earned even though it is not supposed to be a permanent fixture of one's salary.

2.2.5.3 *Policy on Recruitment, Employment and Support of Foreign Health Professionals*

This policy seeks to restrict health professionals, hailing from other developing countries, from seeking permanent employment work in South Africa. This policy emanated from the Ministers of Health in the SADC region and is aimed at ensuring that South Africa does not participate in the brain drain taking place in fellow developing countries. The policy encourages the setting up of government-to-government agreements with the purpose of better control of the movement of health professionals. Where such recruitment takes place, the health professionals with relevant qualifications and skills obtained in foreign countries that meet the minimum requirements for the training and education of health professionals in SA are restricted to providing a service in the public health sector (NDoH, November, 2002). The challenge in this area is to ensure that a seamless relationship exists between this policy and the HR development policies that are aimed at HRH production sufficient to meet the country's needs. The recruitment of foreign skills will therefore serve to complement existing ones or be directed towards areas of strategic growth where South Africans may not have enough capacity for example, in some areas of research.

2.2.5.4 *Policy on Community Service by Health Professionals*

The policy on community service (CS) by health professionals came into operation in 1996 and medical doctors were the first to be required to do community service. This policy is aimed at ensuring that in addition to young health professionals providing services in needy areas, there is to a certain extent an equitable distribution of newly qualified doctors in under-served communities.

Despite the introduction of CS, the staffing of most rural hospitals remains a problem, and hospitals in remote rural areas still lack doctors, owing to the fact that Community Service Professionals (CSP's) can choose the area of their placement. Reid (2002) suggests a renewed consideration of strategies to attract and retain professionals in rural areas, including targeted recruitment of students from rural areas, and increased exposure of students to rural practice during their training.

Although with hindsight many CSP's described their experience as positive, few were willing to change their career plans (based on the experience specifically obtained in rural areas) to seek employment in urban health facilities or even to practise outside the public health service. However, "*around 20% of CS doctors would voluntarily consider working in a rural or under-served area in the future, a cohort that could potentially fill the staffing needs of these hospitals, given the right incentives. However, only 13% of pharmacists and 6% of dentists shared these career plans*". (Reid 2002)

Another problem is that upon completion of community service there is no guarantee of employment, owing either to lack of posts or to professionals being kept at the same salary level as when they were doing community service. All these and other issues such as living conditions, particularly in health facilities situated in rural areas, call for a constant evaluation of the policy. While community service provides short-term solutions to staffing problems in under-served areas, the development of a long-term retention strategy is necessary.

The continued problems indicate to some extent that these policy interventions are not comprehensively addressing the HR issues confronting the health sector. They create further

challenges during implementation as they are subject to different interpretations. An overarching strategy or plan to address issues of the transformation of health institutions, the deployment and equitable distribution of health professionals, adequate training both in quantity and quality, and the like, must be developed and informed by the needs regarding health service delivery. Policies addressing recruitment and retention of health professionals, including the issue of adequate remuneration for such professionals, must be re-appraised so as to be able to recruit and retain skilled and competent professionals in the public health service and in the country.

2.3 A Review of Achievements and Trends

HRH before 1994 shared the same features as the rest of the health system that prevailed at that time: it was characterised by fragmentation along racial, gender and class lines and a hospital-based, bio-medical approach to health service delivery. In the early 1940s the *National Health Services Commission (Gluckman Commission)* concluded that, “*the services were not organised on a national basis, they were not in conformity with the modern conception of health; and they were not available to all sections of the people of the Union*” (SAHR, chapter 4, 1995). It further concluded that “*a national health service cannot be planned, still less can it be carried into effect – without taking into account the numbers of medical and other necessary personnel available now and in the near future*”. “*Availability [and, one might want to add, capacity] of personnel, not finance, is the absolute limiting factor*” (Pick, 1995).

Until 1994, 14 separate national departments were responsible for rendering health care to the South African population, with the resulting racial inequalities reflecting those of society as a whole. As Pick pointed out (1995), “*the development of human resources for health in South Africa needs to be seen more broadly in the context of the development of human resources capacity of the nation. Inequality in the human resource situation in South Africa is extreme*”.

2.3.1 HR Related Achievements Post-1994

Some of the human resource milestones achieved in this regard since 1994 include the following:

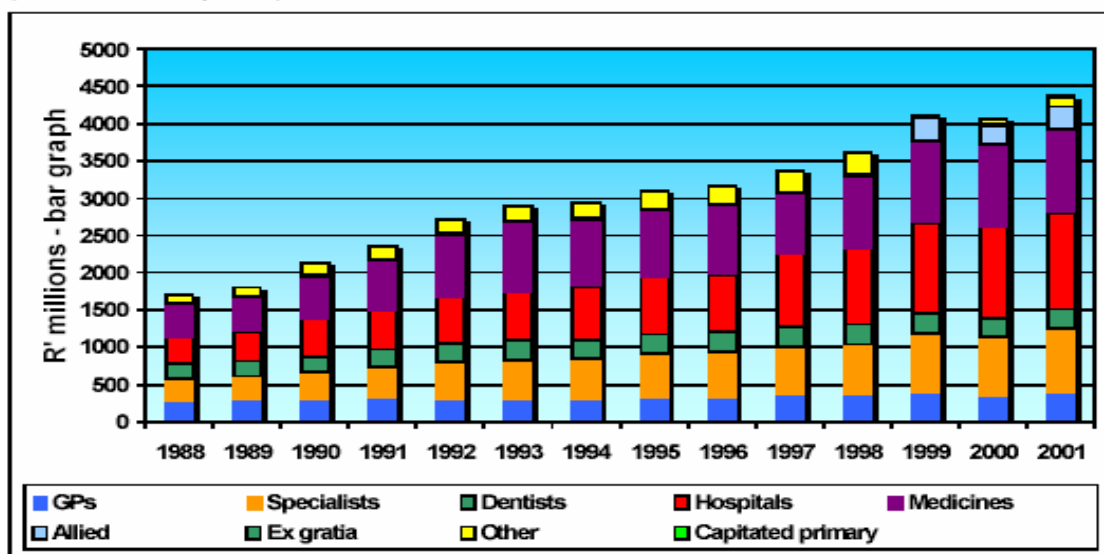
- Amalgamation of historically fragmented staff establishments (those of the former national, provincial and homeland governments) into integrated human resource establishments for the provinces.
- Decentralisation through the introduction of the District Health System, devolving authority to districts; however the challenge of integrating provincial and local authority staff into combined district health establishments still remains;
- Transformation of statutory health councils that are mandated by an Act of Parliament to regulate the health professions;
- Founding of training schools for an increasingly diverse set of health professions;
- A deliberate shift in emphasis, mainly through the reprioritisation of budgets and resources to focus on primary health care with concomitant downsizing of sophisticated curative and tertiary care.

2.3.2 Health Care Financing and Expenditure

Health care expenditure in South Africa was approximately R107 billion in 2003/04. This is equivalent to 8.7% of GDP in that year which is relatively high by international standards; it exceeds that in the majority of countries of a similar level of economic development and similar to that in many high-income countries (e.g. UK). Private sector contribution as a share of GDP is 5.2% catering for a population of 7 million people, whilst public sector share is 3.5% providing for 35 million people. However, health status indicators (such as infant and maternal mortality) in South Africa are far worse than those of other upper-middle income countries. There is, therefore, a strong basis for arguing that the key challenge facing the South African health sector is not one of a lack of resources but rather a great need to use the existing resources including human capital more efficiently and equitably. More than 38% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the national, provincial and local Departments of Health), while 62% flows via private intermediaries. In relation to the original sources of finance, the vast majority of funds flowing through public sector financing intermediaries are funded through nationally collected general tax and other revenues; over R1 billion arises from local government rates, taxes and other local revenues, while provincial revenues are smaller. Most of the funds flowing through private intermediaries are attributable to households; in addition to their direct out-of-pocket payments, households contribute significant amounts to medical schemes. From the provider perspective, about 39% of all health care expenditure occurs on public sector providers and 61% on private sector providers.

Public spending on human resources is in excess of 65% of the health sector's annual budget. This is only limited to the employment situation and does not include the amount spent in supporting production of health professionals through the Departments of Health in the form of bursaries and through the National Department of Education through subsidies given to students. The expenditure experienced in the private sector as shown in the graph below indicates how resources spent in educating some health professional groups rapidly flow out to the private health sector with little or no return investment to the public health sector.

Figure 1: Real per capita claims cost changes in medical schemes from 1988 to 2001 (constant 2001 prices)



[Source: Council for Medical Schemes' Annual Financial Statements of medical schemes]

2.4 Summary Of Trends Impacting On Human Resources For Health

A number of trends, national and global, which directly contribute to the human resource challenges in the health sector have emerged or increased in impact since the adoption of the Pick Report. These trends are presented in this document as challenge statements:

Trend	Description – examples
<i>Disease</i>	<ul style="list-style-type: none"> • Re-emergence of certain diseases e.g. cholera • Persistence of some diseases e.g. tuberculosis • Further complications of certain diseases e.g. Multi-Drug Resistant Tuberculosis • Emergence of new diseases e.g. HIV • Increase in the prevalence of chronic diseases e.g. diabetes • Challenges of certain lifestyle health problems e.g. obesity
<i>Political</i>	<ul style="list-style-type: none"> • The health system is increasingly being influenced by developments in global health systems • There is pressure to expand the scopes of practice for various health professionals and create new categories/cadres of health professionals • Migration to overseas countries is leading to higher level skills being acquired by professionals initially trained at lower levels as they are required to do the work of those who emigrate
<i>Economic</i>	<ul style="list-style-type: none"> • The private health sector is playing an influential role in the provision of health services • There is a marked increase in professional migration from the public to the private health sector • Increased costs of care are evident, driven by technology and other economic factors • Budgets for financing public health programmes and services are shrinking • Migration of health professionals is increasing

Summary Of Trends Impacting On Human Resources For Health (continued)

Trend	Description – examples
<i>Social</i>	<ul style="list-style-type: none"> • High expectations by South Africans that the health system will cater for their health needs • Increasing recognition / awareness of patients' rights, leading to higher expectations • Increasing recognition of indigenous traditional health practices • Increased migration of health professionals • Greater focus on issues of quality of care • More health professionals required to do community service
<i>Technology</i>	<ul style="list-style-type: none"> • New technology in health care in the form of improved diagnostic equipment, Tele-Medicine, Information Communication Technologies etc • Technology and knowledge driven improved skills and competencies, resulting in new roles for various disciplines
<i>Education</i>	<ul style="list-style-type: none"> • Advent of tele-education services as a means for skills development • Participation in Continuing Professional Development being required for some professionals • Stricter control of the numbers of students enrolling for university programmes being imposed by the Department of Education • Increased role of Sector Education and Training Authorities in skills development • Mergers of higher education institutions likely to impact on production outputs • Globalisation, manifesting in local education institutions twinning with overseas education institutions • Increased numbers of students from SADC enrolling in SA institutions

Table 2: Summary of trends impacting on HRH

Conclusion:

These trends contribute to several issues that are discussed in the following chapter as these collectively provide a measure of the country's ability to provide good quality health services to its citizens.