

CHAPTER 3:

CURRENT ISSUES FOR NATIONAL DEBATE

3.1	Current Topical HR Issues	
3.1.1	Existing Skills Mix and Key Competencies	34
3.1.2	Distribution of Staff	35
3.1.3	A Discussion of Norms and Standards	35
3.1.4	Status of Education, Training and Skills Development for HRH Personnel	38
3.1.5	Introduction of New Health Worker Cadres	44
3.1.6	Management of Training, Formal Education, Staff Development & the role of Private Providers	46
3.1.7	HRH Management	47
3.1.8	Migration of Key Health Professionals	48
3.1.9	HRH Information Systems	50
3.2	Summary of Outstanding HR Business	
3.2.1	New Health Worker Cadres	51
3.2.2	Staff Establishments [Norms & Standards]	51
3.2.3	Staffing Workloads	52
3.2.4	Continuing Professional Development	52
3.2.5	Availability and Distribution of Staff	52
3.2.6	Skills Development	53
3.2.7	Introduction of Community Care Givers	53
3.2.8	Funding of Health Education & Training	53
3.2.9	Strengthening Interface: Health & Education	54
3.2.10	Repositioning Academic Health Complexes	54
3.2.11	Strengthening Nursing Services	54
3.2.12	Retention of Health Professionals	54
3.2.13	Organisation and Structures for Managing HRH	54
3.2.14	Career Progression of Key Cadres	55
3.2.15	Impact Assessment of HRH Planning	55
3.2.16	Integration of the Allied Health Professions	55
3.2.17	Critical Skills for the Health System	55

CHAPTER 3:

3.1 CURRENT ISSUES FOR NATIONAL DEBATE

3.1.1 *Existing Skills Mix and Key Competencies*

The matter of the skills mix remains a challenge for the South African health system. The nursing profession provides a perfect example of this issue and is thus used as the tracer profession to tease out the inherent challenges. A number of nurses were trained in Primary Health Care. However, while a review of the records of the SANC reveals that 1033 nurses have been trained in Clinical Nursing Science and Health Assessment, it could not be established whether they are practising as frontline providers within the district health system. The likelihood is that they may have moved to other areas of service delivery and therefore possess skills that are not necessarily applied where they should be. It is worth noting that the system currently does not provide for any material or even professional recognition of clinical nurse practitioners. They do not receive any additional remuneration, for example, in spite of carrying a much greater burden of clinical responsibility than other professional nurses. There is thus no real incentive for these nurses to continue to provide clinical care.

Another challenge also exists regarding the skills mix in the form of the new funding formula for higher education institutions (DoE 2004), which correctly places an emphasis on postgraduate offerings, which can demonstrate relevant competency outputs. This may seem to be in conflict with the recommendation of the Pick report about placing more emphasis on mid-level workers as one of the strategies to deal with the appropriate skills mix required in implementing the District Health System (Pick 2001).

A focus on providing for balanced short-term graduate outputs as well as for future academics, teachers and instructors (postgraduates) is essential to the ability of the country to produce health professionals for self sufficiency. Although the postgraduate output seems to be better rewarded in the formula, it will always tend to constitute a small part of the output while the undergraduate output is predominant in the funding formula. The funding policy therefore attempts to balance the equation in terms of input and output and also to make sure that universities produce enough researchers, scientists and specialists to contribute significantly to health science education and training. More graduates must be produced and encouraged to further their studies, in order to balance the short and long term needs of the health sector as well as other sectors.

Further, enrolment planning proposals seek to cause institutions to focus on improving quality and reducing dropout rates in the programmes offered (these reach 50% altogether over a three year period) and therefore the latter need to be more careful in admitting students, providing support and increasing throughput to graduation. This approach requires rational intra-institutional planning to make sure that those admitted will be given a fair deal as well as rigorously developed support. It is also important to acknowledge that extra capacity will be needed in some areas and that this can be negotiated in terms of what institutions can produce in terms of current resourcing levels and what they may be required to provide in future. The DoH and DoE will need to meet the shortfall in resourcing through various channels.

These Departments have therefore established a close working relationship that will serve to provide leadership in this area.

3.1.2 *Distribution of Staff*

A number of strategies are being implemented in an effort to recruit and distribute health personnel in under-served and rural areas. These include the following:

- Recruiting doctors from other countries to work specifically in under-served areas,
- The introduction of community service for health professionals; and
- The provision of a scarce skills and rural allowance.

While the provision of an allowance for personnel who provide skills classified as scarce in the Public Service is a public sector-wide strategy, its effectiveness in attracting and retaining health workers in under-served areas has not yet been fully assessed. On the contrary, this has generated much debate and discontent among various categories of health professionals.

The short-term trend shows a slight decline in the numbers of key public sector health personnel in the country as a whole. However, there are substantial geographic variations. The two better resourced provinces, Gauteng and Western Cape have seen substantial, and in some cases almost dramatic, declines in public sector personnel, as has KwaZulu-Natal to some extent. There is generally a decrease in the number of professional nurses in most provinces, which threatens the core of health service delivery and needs to be addressed as a matter of urgency. Another source of inequity has been the distribution of personnel by levels of care. While figures are not easily available, Makan's 1998 study of personnel distribution ratios points to stark differences.

3.1.3 *A Discussion on Norms and Standards*

Traditionally, staffing levels have been determined by using ratio statements often described as norms and standards. These ratios are typically linked to population or disease. However, some stakeholders have raised serious concerns about the rigidity of nationally determined norms that sometimes exhibit significant shortcomings. The views expressed have led to a need to debate new approaches to determining staffing levels that objectively take into consideration the conditions the country faces.

Norms and standards have been developed for a number of areas, most notably Primary Health Care facilities and district hospitals. However, norms and standards, as well as staffing, only become valid in the context of service packages or requirements at different levels of care. It is for this reason that debate exists as to the feasibility and efficiency of present norms and standards and staffing criteria.

Closely linked to the issue of norms and standards is the question of workloads. Hornby (1998) used a utilisation-based approach to ascertain workloads as the basis for the development of staffing norms, aimed at assisting "managers to assess or rectify the staff profile in the facilities in the short term". While norms and standards as well as mathematical instruments are undoubtedly necessary and valuable in human

resource planning activities, in South Africa they obscure the fact that health care delivery takes place in enormously complex and diverse socio-economic contexts and conditions. They also conceal the fact that transformation (integration and decentralisation) of health services is far from complete.

3.1.3.1 *Population-Based Norms And Standards: Using Nursing For Illustration Purposes*

Population-based approaches state the ratio of health cadres in relation to a population. A critical review of this method must highlight whether its general and non-specific nature justifies its use as the sole approach. This is because the demographic element of the disease or illness burden becomes obscured. For example, two facilities within one demographic area can exhibit vastly different demands for services. As an illustration, a hospital near a national highway will require more trauma skills than a hospital fifteen kilometers away in the same area.

Factors inadequately addressed by population ratios include:

- Physical barriers such as mountains and rivers
- Population movements, for example urbanisation or migration due to natural factors like drought
- Shifts in disease or illness prevalence
- New service packages
- Poor or defective local infrastructure, for example poor roads or transport

Using blanket ratios creates expectations regarding service standards and undoubtedly becomes a negative political and advocacy tool. For example, in the absence of official ratios some organisations lobby for the introduction of norms and standards to address workload issues for their members. A similar effort can be seen in every cadre and sector of the health system, including educational institutions. The inadequacies of the population-based approach to norms and standards prompted the development at international level of alternative instruments.

3.1.3.2 *Developing New Methods*

It is possible that the country could develop a new approach to determining the staffing of health facilities by modifying the norms approach. It would be very difficult to abandon the population based norms and standards approach in the absence of an effective alternative. Hornby (1998) developed an instrument for WHO called the Workload Indicators for Staffing Needs (WISN), which “sets out all the activities which are necessary in order to design and implement the WISN method in a country”. It was developed to respond to the internationally felt need “to ensure that questions of optimal allocation and deployment of staff can be answered at two levels – at the national/provincial level, so that staff can be allocated or distributed to districts equitably; and at district level, so that staff can be deployed to different locations, services and facilities to best effect”.

Health administrators have long sought a method of calculating health-staffing requirements, which avoids the disadvantages mentioned earlier when dealing with population-based ratios. The optimal deployment of staff, particularly to rural areas;

and the equitable deployment of staff in accordance with the demands actually experienced are two of the issues that should occupy the minds of health administrators.

Ideally one would want to determine the optimal situation to comprise:

- The allocation and deployment of current staff geographically, i.e. allocating staff to provinces, districts, areas within a district, and so on, according to the volume of services which are being delivered and the different types of health staff required to deliver these services;
- The allocation and deployment of current staff functionally, i.e. allocating staff between the different types of health facilities or different health services in the country as a whole, in a province, in a district, in an area, etc, according to the volume of services which are being delivered and the different types of health staff which these services call for;
- Staffing patterns and levels (categories and numbers) in individual health facilities which are appropriate to local conditions (morbidity, access, attitudes), and not only based on national averages (population ratios and standard staffing schedules);
- Staff categories and their activities, i.e. identifying where combining existing staff categories or creating new categories will achieve maximum health impact together with maximum economy.

In order to provide useful information to both medical and non-medical administrators at all levels of the health service in these times of economic stringency and staff shortages, a new technique to achieve the aforementioned should be:

- Simple to operate, using data which is already collected and available;
- Easy to use, so that the results can contribute to staffing decisions at all levels of the health service;
- Technically acceptable, so that health service managers are prepared to use the results in their decisions;
- Comprehensible, so that the results will be accepted by non-clinical managers, e.g. those responsible for finance, planning, personnel administration;
- Realistic, so that the results will offer practical targets for budgeting and resource allocation.

Developing a new method should take into consideration the inequities that exist between the provinces and within the provinces. It is essential that a measure of uniformity is maintained whilst being aware of the danger of promising a supply of health professionals in the face of serious difficulties in recruiting these people, especially for rural areas. Care must also be taken that the supply of health professionals is not perceived as limited to medical doctors, pharmacists and nurses. Other health professionals, like physiotherapists, nutritionists, speech and hearing therapists, radiographers, to name a few, are as important as doctors, nurses and pharmacists.

In developing a new or an improved method all the issues mentioned above must be taken into consideration. It should also be noted that one's workload is not only a question of individual efficiency and productivity, although these are undoubtedly

contributing factors which need to be taken account of, but is quite fundamentally determined by dramatic structural differences within a health system.

3.2 Education, Training And Skills Development For HRH Personnel

3.2.1 *Production of Health Professionals*

It is evident that, compared to other African countries, South Africa has large numbers of staff available. However, national figures conceal serious geographical differences as well as differences between the public and the private health sector. The varying but high vacancy rates in the former are a good indication of this. Furthermore, needs are not only changing but also increasing, owing particularly to changing disease profiles. Hence the training of health professionals must keep abreast of all the trends that impact on health care, especially the changing disease profiles and global human resource trends. The following tables are used here to illustrate the trends in the production of some health professional categories over specified periods.

Production Of Nurses

A review of trends in the production of nurses over a period of 6 years reflects a number of areas of concern in making future projections.

Categories of Nurses	1998	1999	2000	2001	2002	2003	Variance in growth for period 1998 to 2003
Professional Nurses/Midwives	91011	92390	93303	94552	94948	96715	+5704
Enrolled Nurses / Enrolled Midwives	32744	32925	32399	32120	32495	33575	+831
Enrolled Nursing Auxiliaries	49948	47578	45943	45666	45426	47431	-2517
TOTAL	173 703	172 893	171 645	172 938	172 869	177 721	+4018

Table 3: Growth in the South African Nursing Council Register and Roll of Nurses for Period 1998-2003

Source: South African Nursing Council 2004

University Production of Nurses: 1998 to 2003							
<i>Province</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>TOTAL Per Province</i>
<i>Limpopo</i>	6	8	9	11	47	59	130
<i>North West</i>	38	35	154	76	48	54	405
<i>Mpumalanga</i>	0	0	0	0	0	0	0
<i>Gauteng</i>	106	89	63	82	95	89	524
<i>Free State</i>	80	59	60	75	46	47	367
<i>KwaZulu Natal</i>	44	51	56	46	39	41	277
<i>Northern Cape</i>	0	0	0	0	0	0	0
<i>Western Cape</i>	67	74	44	59	52	80	376
<i>Eastern Cape</i>	40	35	22	59	73	83	312
<i>TOTAL</i>	381	351	553	408	400	453	2391

Table 4: University Production of Nurses: 1998 to 2003
Source: SANC 2005

Profession	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Clinical Psychology	88	87	98	99	91	101	114	107	104	111	106
Dentistry	218	247	239	264	278	265	246	262	270	278	278
Dieticians	140	133	165	154	148	185	200	210	189	203	192
Environmental Health Practitioners	406	493	650	626	566	552	500	528	647	613	609
Occupational Therapy	192	220	220	233	262	276	279	293	312	275	332
Pharmacy	403	478	396	565	566	568	640	709	694	605	736
Physiotherapy	205	309	329	389	396	399	403	410	391	373	412
Speech Therapy and Audiology	242	233	220	293	278	262	279	245	307	293	220
Radiotherapy	365	352	368	401	332	359	356	356	412	405	398

Table 5: Admissions: Selected Health Professional Categories 1994 – 2004

[Source: National Department of Health 2005]

Profession	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Clinical Psychology	72	75	88	86	84	101	118	111	99	96	103
Dentistry	95	146	190	168	202	225	221	240	177	202	206
Dieticians	101	123	130	149	141	154	159	155	156	141	135
Environmental Health Practitioners	104	127	147	165	156	169	140	206	246	243	323
Occupational Therapy	167	184	176	213	207	212	201	218	193	227	214
Pharmacy	242	261	291	538	535	697	533	393	449	468	621
Physiotherapy	202	168	206	196	208	241	236	224	253	259	294
Speech Therapy and Audiology	239	230	219	283	230	256	256	230	301	282	210
Radiotherapy	356	348	359	422	332	349	326	346	399	305	368

Table 6: Output: Selected Health Professional Categories 1994 – 2004
[Source: National Department of Health 2005]

Institution	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total
UCT	188	190	182	188	201	183	203	210	201	198	200	200	2344
Free State	140	117	128	100	103	91	90	145	139	150	131	137	1471
MEDUNSA	369	222	182	235	234	180	251	318	199	171	221	239	2821
Natal	123	127	160	149	194	195	199	197	199	211	212	206	2172
Pretoria	235	224	231	208	182	178	207	226	229	222	241	232	2615
Stellenbosch	163	157	172	188	185	204	194	191	201	218	213	222	2308
UNITRA	41	38	62	63	64	72	91	95	108	115	109	105	963
WITS	220	204	254	216	209	220	248	266	168	154	172	206	2537
Total	1479	1279	1371	1347	1372	1323	1483	1382	1276	1285	1327	1341	17231

Table 7: Admissions to medical schools 1994 to 2005

Institution	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total
UCT	167	149	152	147	170	186	132	166	166	164	159	152	2344
Free State	88	87	87	109	117	110	119	124	107	97	111	70	1226
MEDUNSA	123	155	183	249	264	325	247	264	304	326	294	325	3059
Natal	90	109	101	110	104	114	90	116	132	165	179	334	1168
Pretoria	165	173	193	203	217	202	209	214	192	207	196	209	2380
Stellenbosch	157	170	174	158	148	150	145	142	136	186	156	162	1884
UNITRA	18	26	26	29	31	*	26	53	51	62	120	78	520
WITS	202	213	190	228	195	*	195	192	181	188	205	247	2236
Total	1010	1082	1106	1233	1246	1087	1163	1079	1088	1207	1215	1330	14817

Table 8: Outputs at medical schools 1994 – 2005

[Source: National Department of Education 2005]

* Number not obtained

Key Statement on Production of Health Professionals:

The production of health professionals in numbers sufficient to provide health services to South Africans is the key to resolving the chronic human resource challenges.

The reported shortages of health professionals in South Africa appear to contradict the number of higher education institutions that the country possesses. Many reasons have been advanced for the dwindling numbers of health professionals, especially of those working in the public health sector. The question of attending to the production of health professionals is not limited to their numbers but extends to other factors that influence production.

Planning for increased production of health professionals must take into consideration the various factors that can impact on the viability of retaining them within the public health sector. In addition to this the need exists to ensure the maintenance of a balance between and within the professions so that there is a healthy balance in the spread of their numbers. The South African population continues to grow; hence the need to maintain the production of health professionals to care for it. In October 2001 the population was 44,8 million and the mid-2005 estimate now stands at 46,9 million, an increase of about 2,1 million people (Statistics SA 2005). This poses a major challenge to the supply of health services since, even though other resources are important, provision of health professionals is the most critical. The composition of health teams must filter down to the division of numbers at the planning stage. It is important to cater for these factors as they play a major role in whether the country is able to maintain a self-sufficient supply of health personnel or not.

Once again the case of nursing, the profession that PHC services rely on, is illustrative. The South African Nursing Council register for the period 1998 to 2003 indicates that fluctuations occur in the numbers of nurses that are registered and enrolled to practise nursing in South Africa. There has been a growth of 5704 in the number of professional nurses and 831 in that of enrolled nurses. There was also a decline of 2517 in the number of nursing auxiliaries for the same period. The total growth in the number of nurses is 4 018. This trend may start showing signs of reversal as more private nursing schools produce more nursing auxiliaries. However, this must be seen against the background of the number of vacancies for nursing positions reported by the various provinces.

3.2.2 Introduction of New Health Worker Cadres

The introduction of new cadres of health professionals and other para-professionals has been a topic of much debate since the early 1990s. In particular the introduction of a range of mid-level workers, and the role of community-based health workers and their relationship with the national health system, have been discussed extensively.

In general, the introduction of a new health professional category or cadre into a health system invariably has an impact on the existing professions or cadres. An example of this is the introduction of Community Health Workers whose scope of practice overlaps significantly with that of the Enrolled Nursing Assistants.

The implication of any introduction of new categories may be perceived in terms of the following:

- a. Resources for training:
 - Location of training (facilities),
 - Academic staff to offer the training,
 - Funding of training
- b. Scopes of practice (may need to adjust those of the closest existing cadre)
- c. Career paths

It is therefore important that criteria are laid down to guide the process of creating new health categories either at professional or non-professional level. The following general guidelines should be followed before submitting any application for registration with the Department of Education or SA Qualifications Authority.

1. Clear evidence must exist of the health need(s) to be addressed by such a category
2. The need must lie outside the scope of practice of the existing health professional cadre
3. In any case where the scope of practice of the envisaged category will overlap with that of an existing cadre, there must be demonstrable value in allowing this
4. Clear career paths must be identified
5. Agreement must be reached with the National Department of Health about the need to establish such a category

Close collaboration between the Department of Health and Department of Education will greatly assist in narrowing the existing gap.

3.2.2.1 Introduction Of Mid-Level Workers

The first discipline to introduce a mid-level worker has been pharmacy, which has been training pharmacy assistants for the past few years. The introduction of physiotherapy and occupational therapy assistants, as well as the introduction of a mid-level worker in the field of nutrition, have been under discussion for a number of years, but have not yet been finalised. More recently active steps have been taken to introduce a mid-level cadre in the medical field – the medical assistant. Introduction of mid-level workers must be subjected to continuous assessment to ensure that the country does not end up replacing the training of health professionals with that of mid-level workers. A healthy balance must be maintained.

3.2.2.2 Revitalisation of the Community Health Worker Programme

The term “Community Health Worker” (CHW) embraces a variety of community health aides who are selected from, trained in and work in the communities from which they come. The policy documents in the early 1990s, most notably the ANC Health Plan, identified CHW’s as an important resource for PHC implementation. *“They were viewed as catalysts for community development, that could mobilise people around issues such as the need for clean water, sanitation, waste disposal, safe playgrounds and parks. (...) It was envisaged that they would form an integral part of the decentralised health services, and be compensated, either by the Government, or*

the local community” (Friedman, 2002). The *Strategic Priorities for the National Health System 2004 – 2009* specifically list the need to “*strengthen implementation of the CHW programme*”.

3.3 Management of Training, Formal Education, Staff Development including In –Service Training and the Role of Private Providers

In this instance we again use nursing as a tracer profession to illustrate issues in training and staff development. Nursing education is currently located at three levels of learning institutions: Nursing Schools (private sector), Nursing Colleges (public sector) and Higher Education Institutions. Concerns exist about the management of nursing education in each of these sectors. Each is briefly presented below:

3.3.1 Nursing Schools

Nursing schools provide nursing auxiliary and enrolled nurse training programmes, which fall within the Further Education and Training (FET) band. The courses currently provided by the nursing schools are:

- Certificate for Nursing Auxiliary (1-year Course) (FET) (entry requirement standard 8 or equivalent)
- Certificate for Enrolled Nurses (2-year Course) (FET) (entry requirement standard 8 or equivalent)
- Bridging Course (2-year course) (HET) (the entry requirement is enrolment as a nurse)

The fact that entry requirements still refer to a standard 8 means that entry requirements to nursing must be urgently reviewed. All private nursing schools are required in terms of the Higher Education and the Further Education and Training Acts to register as private higher or further education and training providers. Although this registration is a statutory requirement the registration requirements for the FET sector have not yet been finalised. The Departments of Education and Health are now actively discussing how to resolve this aspect and better manage the issue of nurse training. The result will be that of ensuring compliance with a set of minimum requirements and adherence to the quality standards set for private providers.

The achievement of the above goal should assist in managing the influx of private providers who are providing education and training that does not lead to the attainment of a qualification or a unit standard that is registered on the National Qualification Framework. This will also prevent providers who offer training in non-nursing courses to claim that these courses are a route to qualifying as a nurse. “Pre-nursing” learners undergoing such training have either been misled to believe or are under the false impression that on completion of such training they will be entitled to practise as nurses.

The providers offering such courses often maintain links with an approved nursing school and make informal arrangements with these nursing schools (in some cases both institutions are owned by the same persons) for the courses offered by these providers to be made an entry requirement for an approved nursing course.

The institutions themselves create these entry requirements and these are not necessarily in line with the prescribed entry requirements (stipulated in the regulations) for a nursing course. These informal requirements are often not known to nor approved by the SANC.

A joint strategy for resolving this issue is indicated, and the formation of a partnership between all role players, i.e. the Departments of Health, Education, and the South African Qualifications Authority Health and Welfare SETA, is essential. The review of nursing education currently underway by the Nursing Standards Generating Body is an important step towards streamlining the curriculum and qualifications in this profession.

3.3.2 *Colleges of Nursing*

Currently the Colleges of Nursing exist in the public health sector, which means that they are under the control of the Provincial Departments of Health. This basically means that the provinces can exert much influence on the number of nursing professionals that the colleges should produce. Government therefore has a responsibility to investigate all the factors that impact on production, e.g. the availability of physical infrastructure, learning materials, nurse educators and so on, that are critical to the attainment of targets for training.

3.3.3 *Universities and Universities of Technology*

Over the years institutions of higher learning have been attempting to align their training programmes with health services needs. This has always been a tall order, bearing in mind that for a long time there has been no structured interaction between institutions and the Department of Health to establish the type of input needed. Where this interaction existed the relationship challenges brought about by resource constraints have sometimes proved difficult to resolve. The funding formula applicable to higher education institutions also encouraged institutions of higher learning to focus on providing postgraduate degrees as opposed to undergraduate degrees, as the formula favours the production of health professionals at this level. The realignment of nursing qualifications is an important task that the Departments of Health, Education and the SA Nursing Council must conclude as a matter of urgency.

3.4 **HRH Management**

The concern that managers lack the capacity to lead and manage the health sector appropriately is voiced in a number of documents (LGHS, 2004; Leon et al., 2001; Lehmann et al., 2003). The crux of the concerns expressed is summarised in research conducted into the implementation of the *Integrated Nutrition Programme* in Cape Town (Lehmann et al., 2003) and highlights, among other factors, poor coordination of communication and activities between different departments, and the failure to prepare the ground for policy implementation.

The latest *State of the Public Service Report* (2005) reports that “*our public service does not have enough skilled managerial staff*”, elaborating that “*increased decentralisation and delegation of authority relating to human resource management to lower levels have in many instances overloaded managers*”. Other reasons

identified by the State of the Public Service Report, which specifically refers to the health sector, are as follows:

- “Public service professionals (such as doctors and nurses) are paid markedly less than in the private sector while environmental factors and working conditions are not conducive to the retention of such personnel in the public service. Recruitment, succession and career planning, employment equity, reward and recognition and employee relations are important factors that affect the supply of these vital skills.
- The public service recruits personnel from a variety of fields such as medicine, finance and development disciplines amongst others, in addition to the field of public administration. Despite various links between higher education institutions and governments there is still not enough strategic interaction between government and higher education over the supply of skilled personnel”.

3.5 Migration of Key Health Professionals

Migration of health personnel, also dubbed the *brain drain*, partly from rural to urban areas, but more particularly out of the country, has become a hotly debated issue in human resources circles not only in South Africa, but also on the continent of Africa itself. Reliable figures are hard to come by and invariably controversial. For many years before 1994 South Africa constituted a preferred destination for many health professionals, the majority being doctors from the African continent. This situation has however changed since the late 1990’s when a policy of not recruiting from fellow developing African countries was adopted at the SADC Health Ministers level.

A recent OECD study on migration of health professionals presented the following statistics of “South African-born workers practising a medical profession in certain OECD member countries in 2001” (OECD 2003):

	Practitioners ²	Nurses/midwives	Other health professionals ³	Total
Australia	1,114	1,085	1,297	3,496
Canada	1,345	330	685	2,360
New Zealand	555	423	618	1,596
United Kingdom	3,625	2,923	2,451	8,999
United States	2,282	2,083	2,591	6,956
Total	8,921	6,844	7,642	23,407

Table 9: South African-born workers in selected overseas countries

² Doctors, dentists, veterinarians, pharmacists and other diagnostic practitioners

³ Including assistants

If one considers that 11,332 doctors and 41,617 nurses were working in the public sector within South Africa in 2001 (Doherty and Joffe, 2003), the above figures are very substantial and disturbing, all the more since the indications are that the trend has escalated in the past few years. The reasons for the brain drain are much debated. The debate distinguishes between “pull” and “push” factors. The former include those factors that make other countries attractive, such as better wages, easier working conditions and opportunities for professional advancement in foreign countries. The latter comprise factors, which drive staff out of the country. Lack of management and support, work overload, poor working conditions, lack of appropriate skills and emotional burnout are believed to be important factors among these (Lehmann & Sanders, 2002), as are high crime rates and uncertainties about the future.

A recent study of migration in six African countries, conducted by WHO, found that while financial incentives featured prominently, working and living conditions at home were named by the majority of respondents as key reasons for their departure.

“Despite substantial financial incentives, many commentators, including some employee representatives, emphasise that in many cases pay is not the prime motive for leaving the country. Deteriorating working conditions in the public sector is one factor that is frequently mentioned. A significant increase in the workload, due to wider access to healthcare, and the uneven distribution of human resources between the private and public sector, and urban and rural areas, leads health professionals to seek better working conditions. Exposure to AIDS and other endemic infectious diseases, like TB, insecurity resulting from delinquency, the lack of suitable equipment, and social and racial factors, are also cited as difficulties that specifically affect the practice of medicine” (OECD, 2003).

But although South Africa is losing health professionals, the country also used to be a destination for such immigrants. Some 20% of doctors (approximately 6,000) on the South African Medical Register in 1999 were expatriates (Lehmann & Sanders, 2002). There is likely to have been a significant drop in expatriate health professionals over the past few years owing to changes in the recruitment policies of the department and changes to the Immigration Act. In the period 2004 to 2005 the National Department of Health experienced an upsurge in applications to work in this country by health professionals from the African continent. Many of these professionals, mainly doctors and pharmacists, argue that they have been working outside their countries of origin for periods varying from 5 to more than 10 years and therefore do not feel that employment in South Africa will be robbing their own countries of the skills they dearly need.

The existence of a policy not to recruit health professionals from fellow developing countries in the African continent has assisted the department in stemming the internal African brain drain to South Africa. The argument advanced by these health professionals, that they have after all not been providing services to their own countries and therefore feel no obligation to serve them, must constitute part of the assessment of this policy at the level of African Health Ministers.

3.5 HRH Information Systems

HRH planning and management depends very largely on the availability of accurate and timely information. Managers, planners and policy makers need a variety of different kinds of information for effective decision making and planning. The purpose of decisions related to health human resource management is to identify and achieve an appropriate number and mix, and an equitable distribution, of personnel whilst being cost-effective. To achieve this goal there is a need to systematically analyse trends, develop perspectives, define response strategies and develop a coherent plan to address the wide spectrum of issues that impact on the production, retention and distribution of HR in the public health sector.^{i,ii} At this stage there is little systematic and published engagement with issues of HRIS. The Department of Health will, however, shortly introduce a National HR Information System, which will address the requirements identified in a number of WHO documents.

3.6 SUMMARY OF OUTSTANDING HR BUSINESS

Despite the health system achievements in a number of areas, human resources still remain a major area of weakness that has not been addressed successfully. Some compounding factors include the migration of the skilled and most experienced health professionals, especially in the medical and nursing fields, to wealthy health systems, the changing disease profile, socio-cultural issues, and the lack of a developmental approach to human resource planning and management.

It is evident that there are many challenges related to HR management and development. However, the major concern is the production of human resources in sufficient quantities to cater for the country's needs. In the absence of a guideline on HR production, education institutions are producing human resources for health based on what they perceive is needed or which in many cases is dictated by financial constraints or financial prospects for the Institution.

Over the past few years a number of mid-level health worker categories have been introduced to the health system, mostly with the aim of limiting their activities to the public health sector. A number of questions have arisen in relation to HR workforce planning, e.g. the proportion of, say, dental therapists that must be trained to the number of dentists. Other issues comprise for example the relationship between various health professional categories, the focus of investment in production and the balance that needs to be maintained within the health workforce.

Higher education institutions are undergoing major transformation, brought about by the merger of many such institutions. Together with other policies emanating from the National Department of Education there is now a moratorium on creating new qualifications at university level. Funding is also under strain, with institutions having to use alternative methods of raising finance rather than relying on a government subsidy alone. This is a major challenge for the health sector. Lastly, the central question of how health needs are determined and used to inform health education and training has been raised, as has been the case of the evidence for the introduction or creation of new categories so that their creation is not solely based on economic factors.

The following topics require additional research to inform solid policy positions at national level in order to guide the way in which aspects that depend on policy positions will be handled in future.

3.6.1 *New Health Worker Cadres*

Information gaps exist with regard to future projections of staff availability; hence the need to conduct an age, gender, and ethnic group analysis of the present health workforce so as to enable succession planning. Furthermore, staffing needs should be reviewed regularly against the background of the impact of the introduction of new health cadres (e.g. mid-level workers in a particular health professional category), the revision of scopes of practice and the subsequent review of staffing establishments. This includes the development of different staffing scenarios and projections and a determination of their economic feasibility.

This step is necessitated by the impact of the introduction of each new health worker cadre on the health system as a whole. Putting in place a national human resource databank will offer human resource planning a tool to perform this important planning and oversight function.

3.6.2 *Norms And Standards/ Staffing Establishments*

The continuing debate on this issue means that, for planning purposes, norms and standards and staffing establishments must be guided by flexible policies, to allow for revision to accommodate changing needs. At present there is undoubtedly a need for revisions with a particular focus on: a) *the changing disease burden*; b) *structural changes*; and c) *the impact of new cadres*, in particular the mid-level workers.

The South African experience of staffing norms is a mixed one. The freedom of choice of health professionals regarding their work has a direct effect on where they choose to offer their services. Despite the existence of norms and standards for the provision of human resources to all health facilities it has not been possible to adhere to them because of the objective conditions faced by the department in placing health professionals, specifically in rural areas. Moreover the calculation of the staffing norms using a population-based approach fails to take into consideration the existence of the private health sector practitioners. This is due in part to the major gaps that have existed between the two sectors and the poor relations between them over many years. The existence of private health facilities has not been adequately seen and utilised as an additional resource that should complement public health service delivery.

It seems more reasonable to develop staffing norms that will be context specific, as such determinations will take into consideration the disease burden and the most commonly presenting illnesses and conditions for that area; e.g. a particular province may experience certain illnesses more than others.

To ensure the success of this approach and compliance with the commitment continuously improve access to health services, provincial departments or relevant health authorities, assisted by the National Department of Health, will put in place a well functioning referral system operating between the various levels of health care delivery. This should enable better human resource planning and management and

also assist the Department to respond in a reasonable way to the chronic human resource shortages that are now an international phenomenon of health systems. Establishing relationships with the private general practitioners will prove essential at Primary Health Care level. This plan advocates a move, away from individuals contracting for sessional work, to engaging organised practitioner groups. This will aid the management of such contracts and hold the medical professionals represented by that particular organisation collectively responsible for the provision of such services.

3.6.3 *Staffing Workloads*

While there is no denying that HR planning is impossible without a certain amount of declaring norms and benchmarking, more work is required to develop context-sensitive workload indicators as mentioned earlier. Particular attention needs to be given to differences in infrastructure and staffing availability.

An analysis in the Review of the Ten Years of Democracy indicated that one of the major trends in South African society related to the migration of people to urban areas or places where they felt they had a better opportunity to find work. This is a phenomenon, which has long been noticed regarding health professionals. It is therefore vital that recruitment strategies, retention strategies and referral systems take this into consideration. It is increasingly difficult to generalise about the quantum of professionals available to render services even in a Primary Health Care setting. Establishing well functioning responsive referral systems will assist in alleviating the heavy workloads that are often experienced by young, inexperienced staff doing community service in rural areas.

3.6.4 *Continuing Professional Development*

The impact of Continuing Professional Development programmes for health professionals must be evaluated on a five-yearly basis for each of the health professional categories. This is in order to ascertain the efficacy of the programmes in meeting the continuing education needs of the country and their value in terms of the investment made. A direct link to how the system improves the quality of services provided by health professionals should form the basis of assessment and evaluation.

Each health professional group therefore has to ensure that the content of the CPD programmes addresses the gaps or challenges identified in service delivery, either in terms of skills or knowledge. The Health Statutory Councils concerned, in partnership with the National Department of Health, must establish a CPD monitoring system that will enable assessment of compliance and good performance by the practitioners in order to influence the Performance Management Development System as applied in the public health sector.

3.6.5 *Availability and Distribution*

Although much of the focus in the past few years has rightfully fallen on the development of the District Health System and Primary Health Care, the health sector clearly must retain strong and well-functioning hospitals. An assessment of the HR situation in hospitals must therefore form part of a comprehensive situational analysis of staffing.

Technological advances are increasingly influencing the delivery of health care services. Some professional categories can no longer provide good quality services without utilising certain kinds of health technology. The availability of doctors, nurses, dentists, physiotherapists, speech language and audiology practitioners etc is largely influenced by the availability of the tools of their trade.

These factors must be taken into consideration when determining the context sensitive staffing norms and the establishment of referral systems. Basic equipment for use in health care, appropriate for a certain level of health care facility, must be made available, properly maintained and utilised to avoid frustration developing among the staff.

3.6.6 *Skills Development*

A key HR strategy will comprise a comprehensive and textured skills analysis for different programmes and fields within the health sector, followed by organised education programmes (both initial and continuing education), appropriately funded through skills development funding and arranged by the Health and Welfare Sector Education and Training Authorities. The HWSETA plays a major role in the improvement of the skills of health workers spanning all the categories. This is a legislated function, and all contributors to the Skills Levy must be encouraged to apply for funding from the HWSETA so that staff can be sent to participate in skills development programmes. The analysis should therefore also assess the extent to which the HWSETA indirectly contributes to improving the quality of health services.

This analysis will be performed on a five-yearly basis with the assistance of Statutory Health Councils, Professional Associations and Private Health Sector Organisations / Institutions.

3.6.7 *Introduction and Placement of Community Care Givers in the Health System*

The role of community- and home-based health workers and their organisational and structural accommodation in relation to the health services has now been determined. This cadre of health workers is necessitated by the dramatic increase in needs for chronic and palliative care.

3.6.8 *Funding of Health Education and Training*

The issue of funding for the education of health professionals as well as the inter-relationship between different levels of such education constitutes a critical aspect of human resource planning as a measure to improve the efficacy of training in the health sector.

A high level official team has consequently been set up between the National Departments of Health and Education to deal continuously with issues that relate to education and training in the health sciences.

3.6.9 *Strengthening the Interface Between Departments of Health And Education*

The introduction of the *National Health Council* by means of the National Health Act imposes certain responsibilities and introduces a number of opportunities to firmly address human resource issues as provided for in the Act. However, higher education is the field of the National Department of Education, thus necessitating that a high level link is maintained between the two departments. The policy on National Institutional Planning directs institutions to engage in five-year rolling plans, which invariably will affect planning on production of health professionals.

3.6.10 *Repositioning Academic Health Complexes*

In terms of the new legislation, health sciences faculties, in conjunction with the Departments of Health and Education, will now be required to apply their minds to ways in which district hospitals, clinics and community-based settings can be developed as venues for learning in terms of structure, governance, funding and staffing.

3.6.11 *Strengthening Nursing Services*

An elaborate inter-sectoral strategy for resolving issues in nursing education and services is indicated, driven by a solid partnership between the Department of Health, Department of Education, the South African Nursing Council, the South African Qualifications Authority and the Health and Welfare SETA. The review of nursing education and training being carried out by the Nursing Standards Generating Body has paved the way to finally transforming nursing education and streamlining qualifications in this profession.

3.6.12 *Special Allowances for Retention of Health Professionals*

Evidently, a close monitoring and evaluation of the impact of these allowances is imperative, specifically because financial incentives to motivate workers to accept posts in under-serviced areas continue to be a much-debated measure, owing mainly to the selective and limited nature of such allowances. Without a doubt, however, in themselves the recently introduced allowances will not be sufficient to attract and retain staff. They will have to be embedded in a package of initiatives aimed at improving conditions of service.

3.6.13 *Organisational Structures And Functionality For Managing HRH*

A review of the functionality and capacity of HRH structures and organisations at national and provincial level will contribute to improving the functioning of HRH planning and management across all levels. The management and people skills necessary to function effectively, especially at facility level, must be defined and guidelines adopted nationally.

3.6.14 *Career Progression Of Key Cadres*

While considerable public debate is taking place about career progression and limitations in careers as regards certain cadres, in particular nurses and some lower-level cadres, better systematic work regarding sustainable career progression in the public health sector is called for. As career progression is an important factor in career choices, a review of career trajectories and options may well contribute to enlarging the pool of health professionals in future.

3.6.15 *Impact Assessment of HRH Planning*

An HRH Plan is a long-term project that should be dynamic in nature so as to ensure that planning is able to respond to pressures on the health system; thus positively influencing production. It is therefore essential that performance indicators for the impact of HRH planning, development and management are developed. These "Impact Assessments" should become a routine requirement preceding all reforms and initiatives whose aims are to improve the performance of the health system.

3.6.16 *Integration of the Allied Health Professions*

A number of allied health professions e.g. reflexology, aromatherapy, podiatry exist in the South African health system although not prominent within the public health sector. The vast majority of these practitioners are almost exclusively operating in the private health sector. They are however regulated through the Allied Health Professions Council of South Africa. The type of health services that the public health sector offers must guide their participation in the public health sector. Major discussions, guided by national health priorities and policy positions must take place within the provincial setting to determine the possibility of integrating the services offered by the allied health professions in the public health sector.

3.6.17 *Determining the Critical Skills for the Health System*

It is important that beyond the issue of scarce skills the department must establish a mechanism of determining and supplying the skills critical to the successful attainment of the goals of the health system. These may or may not include those that are regarded as scarce. Critical skills may not necessarily be scarce. The notion is based on the importance of the work accruing rather than the number of professionals possessing the skills. An example can be made of epidemiologists, health economists who are both scarce and critical and medical doctors who may not be scarce but are critical to the delivery of health services. Recruitment of critical skills on the international stage must always be complementary to the country's efforts at developing their own.

Conclusion

The possible research agenda items identified above are an addition to the major questions of principles and policy challenges being raised in this document. Instead of providing answers, this framework identifies major pillars that will be vital for the robustness and comprehensiveness of the human resource plan for health. These pillars and the motivation for them are described in the next chapter and are linked to the issues raised in the present chapter.