

HUMAN RESOURCES FOR HEALTH

**A STRATEGIC FRAMEWORK FOR THE
HUMAN RESOURCES FOR HEALTH PLAN**

Draft for Discussion



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ABBREVIATIONS

HR	Human Resources
HRD	Human Resource Development
HRH	Human Resources for Health
HRM	Human Resource Management
HRP	Human Resources Planning
JLI	Joint Learning Initiative
MINMEC	Forum of Minister and Health Members of Executive Councils in the Provinces (Forum now termed National Health Council)
MTEF	Medium Term Expenditure Framework
NDOH	National Department of Health
NHIS	National Health Information System
NQF	National Qualifications Framework
NSDS	National Skills Development Strategy
OECD	Organisation for Economic Cooperation and Development
PHRC	Provincial Health Restructuring Committee
SAQA	South African Qualifications Framework
SGB	Standards Generating Body
WHO	World Health Organization
WISN	Workload Indicators for Staffing Needs

¹ DEFINITION OF CONCEPTS

Human resources for health (HRH - synonyms are health manpower, health personnel, or health workforce) refer to persons engaged in any capacity in the production and delivery of health services. These persons may be paid or volunteer, with or without formal training for their functions, and in the public or private sector. HRH encompass “all individuals engaged in the promotion, protection, or improvement of population health, including clinical and non-clinical workers.” (JLI, 2004)

Human resources development (HRD), as applied to human resources for health (HRH), includes the planning, production, and management of health personnel.

Human resources planning “...is the process of estimating the number of persons and the kinds of knowledge, skills, and attitudes they need to achieve predetermined health targets and ultimately health status objectives.” (WHO, 1978) Over the years this function has been broadened to include that of formulating human resources policy, in which the word ‘policy’ refers to statements made by relevant authorities that are intended to guide the allocation of resources and effort. Health services and human resources policies are key instruments for implementing decisions affecting the delivery of health care.

Human resources production refers to “...all aspects related to the basic and post-basic education and training of the health labour force. Although it is one of the central aspects of the health manpower (development) process, it is not under the health system's sole control” (WHO, 1978). The production system includes all the educational and training institutions, which are increasingly a joint responsibility of service and educational institutions.

Human resources management has been defined as the “mobilization, motivation, development, and fulfilment of human beings in and through work” (WHO, 1978). It “...covers all matters related to the employment, use, deployment and motivation of all categories of health workers, and largely determines the productivity, and therefore the coverage, of the health services system and its capacity to retain staff.” Management also encompasses programmes for in-service and continuing professional education, as well as evaluation.

Occupations and occupational categories refer to a set of functions, requiring a specific combination of knowledge and abilities, and associated with a specific title, for example, doctor, nurse, laboratory technician, sanitarian.

¹ WHO monograph, *Health Manpower Planning: Principles, Methods, Issues*, Hall, TL, and Mejia, A., eds: WHO, 1978 (www.hrtoolkit.forumone.com)

EXECUTIVE SUMMARY

Introduction:

South Africa faces the most intricate human resource challenges characteristic of health systems in many other countries. Ensuring an adequate human resource pool for the staffing of especially the public health sector is a major task that is complicated by many global and disease burden challenges. Even though the private health sector is not experiencing the same pressures to the same degree, maldistribution within this sector is a serious challenge.

Developing a human resource plan for health is very high on the agenda of the National Department of Health. It is globally recognized that a focused human resource strategy backed up by an appropriate implementation plan is a critical ingredient of positive change in health care. Success in this area helps create a positive image and an environment conducive for health care to flourish. Equity, efficiency and effectiveness of the health system depend on the two elements – a visionary strategy and a focused plan being appropriately developed and implemented.

Context:

The Department is mandated by both the Constitution of the Republic of South Africa and the National Health Act to deliver health services to South African society. This means ensuring provision of adequate human resources to enable the health system to deliver on that mandate. At the national health summit held on 2 – 3 December 2004 the Department of Health promised that a strategic framework for the human resource plan will be ready for consultation purposes in 2005. This document presents this strategic framework with the expectation that all stakeholders will contribute positively to the process.

The conceptualisation process started with a review of the work that has previously been done in an attempt to address the human resource challenges to health. Critical to this approach was a rapid appraisal of the work done by Professor William Pick and getting the views of a number of people that had given input to that process. The Pick Report (2001) said in its introduction said: *“In order to give expression to the Primary Health Care (PHC) approach, the vehicle through which basic health care will be made accessible to all, the Department is committed to ensuring, through proper planning, that a continuous supply of, suitably qualified, competent human resources will be available to staff primary, secondary and tertiary health facilities”*.

In addition to the legislative and constitutional mandate to provide good quality health services to the nation, the 2001 National Human Resource Strategy provides the context for developing a human resource plan.

Approach to Developing the HRH Plan

The Department’s Drafting Team used the WHO HR Toolkit (2004) as a basis in drafting this framework. The framework is drafted such that it will be easy to finalise

the plan once stakeholders have supplied the department with their inputs. This consultation document has therefore been framed in such a way that it already takes the form of a national human resource plan. The purpose of the National Human Resource Plan for Health is to guide the development of Provincial HR plans and also serve as a reference point for the private health sector. It will also have the major role of guiding education and training institutions in the production of human resources for health for the national health system.

Initial consultation proved very useful in broadly scoping the work and identifying the initial gaps that need to be addressed. Many stakeholders have made available some data and information that has also been used in crafting the strategic framework presented in this document.

Specific issues addressed:

Stewardship for Health Care – The question of who takes responsibility for the performance of the health system is an issue firmly addressed by the World Health Organisation in its World Health Report 2000. We address this issue in detail and identify certain activities that the department has to do to ensure that government firmly fulfils this responsibility.

Approach to defining Norms and Standards – Over many years it has been a practice to declare norms and standards at national level when dealing with human resources for health. While there is no denying that HR planning is impossible without a certain amount of standardisation and benchmarking, there has been a growing realisation of a need to develop context-sensitive workload indicators. The drafting team has taken a different approach and proposes a provincial approach to determining staff ratios. This is done bearing in mind the complexity of the country's health care system. The department anticipates that this will generate a lot of positive debate and possibly lead to a new unique approach to dealing with the health workload demands.

Strategic Framework for HR Plan – This document puts forward a strategic framework that identifies guiding principles, strategic objectives and broad activities to act as an anchor of the HRH Plan. The view taken here is that the national plan should act as a reference framework that each stakeholder would utilise in developing its own plans. The broad activities mentioned would therefore not have time schedules attached to them. These activities are organised in such a manner that they speak to the national department, provincial departments, health science education institutions and private health sector bodies etc. Each of these bodies would be expected to further identify sub-activities as part of implementation and attach definite timeframes to these.

Scan of Policy and Legislation – It is important to note that although a concrete Human Resource Plan for Health has not been in place, there are several policies and legislation that served as guidance in the HRH field. This scan was done as part of a rapid analysis of the status of various HRH issues as proposed by the WHO Toolkit for Human Resources. *Majors Pillars of HRH Plan* – The following are pillars that form an overarching framework of the HRH Plan. These are areas that are deemed a foundation for a robust HRH Plan for South Africa. It therefore necessitates that

major investments are made in these areas to ensure the long-term sustainability of planning, developing and managing human resources for health.

The Six-Point Action Strategy Plan - The department has decided to draft and publish a shorter version document that identifies certain activities in the short-term that need urgent attention. These activities directly link to the guiding principles and strategic objectives of Chapter 4 of this document. The purpose is to make sure that work starts immediately in addressing issues that need attention even before a final plan is adopted.

Summary Of Guiding Principles And Associated Strategic Objectives For The HR Plan

Guiding Principle	Strategic Objective
i X Stewardship for Health Care lies with the National Department of Health	Provision of leadership through guidance of the Public and the Private Health Sectors
	Defining a vision and developing an over-arching National Human Resource Plan
	Establishing shared values and base with provinces on issues of HR planning, management and development
	Establishment of reliable monitoring and evaluation systems
	High level investment and resource allocation decisions
	Management of regulatory environment and oversight function
	Development of partnerships spanning all formations in the health sector
j X South Africa's role in international health issues contributing to leadership, scientific advances and global health professions is critical	Influencing global HR research and production
	Promotion of cooperation between the South African Health System and other health systems regionally and internationally
	Influencing and directing international aid towards the country's capacity development priorities
	Exerting influence through advocacy in international forums
	Understanding and influencing global HR market trends
kX Planning and development of human resources linked to the needs and demands of the health system must be strengthened	Application of HRH research and knowledge to advance the health system as a whole
	Alignment of training and education resources to the health system needs

Guiding Principle		Strategic Objective
l X	The optimal balance, equitable distribution and use of skilled health professionals to promote access to health services must be developed	Provision of human resources to render adequate, accessible and appropriate services in rural and other under-serviced areas
		Development of incentive systems for health service provision in under-serviced areas
		Balancing health worker categories, align and synergised scopes of practice
mX	South Africans must enjoy a reliable supply of skilled and competent health professionals for self-sufficiency	Ensuring regular and up-to-date projection of national and regional HR needs in line with identified priorities
		Set up mechanisms and structures for the periodic/regular projection of health worker needs and subsequent adjustment of plans
nX	South Africa's contribution in the short to medium term to the global health market must be managed such that it contributes to skills development of health professionals	Optimisation of the bilateral agreements that South Africa enters into with various countries
oX	Health workers must have the capacity and skills to render accessible, appropriate, high quality care at all levels	Provision of initial and continuing education and training that meets the identified health needs of the country by training institutions
		Provision of high quality and appropriate experiential learning
		Establishment of skills monitoring and assessment systems
		Promotion of life-long learning and research-based practice among all health workers
pX	Work environments should be conducive for good management practice to maximize the potential for the health work force to deliver quality health services	Creating a culture of valuing all workers

In order for the plan to be on the pulse in addressing HR challenges faced by the country, stakeholder participation in reviewing this document and proposals made is strongly encouraged. The gulf between the public and private health sectors needs to be reduced and the plan must be geared towards the attainment of national goals. There is also an absolute need for the health system to possess credible data and information on human resources for health so that the health department as a whole can plan better.

Stakeholders seeking to contribute to the process are particularly requested to cover the following in their submissions:

- ⌘ Identify the gaps – i.e. what has not been covered that you feel is critical to include in this framework?
- ⌘ Concrete suggestion/s on how such gaps can be addressed
- ⌘ What kind of resources do you think will be needed to address this gap?

Implementation of the National Human Resources for Health Plan

It is critical that the Human Resource Plan once adopted gets implemented as a matter of urgency. All stakeholders who have a part to play therefore have to ensure close interaction so that milestones are achieved in a seamless manner.

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Chapter 1

Human Resource for Health: A Strategic Plan

- 1.1 Introduction
- 1.2 Rationale and Objectives
- 1.3 Process and Approach
 - 1.3.1 Assumptions
 - 1.3.2 Consultation

CHAPTER 1: A HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN

1.1 Introduction:

The field of Human Resources for Health has gained immense international prominence with human resource planning being viewed as a critical activity within the broader sectoral planning activity. Despite health being a human right issue, most countries struggle with provision of health services. Generally, the health sector presents the most intricate challenges to all countries in the world. High up on the list of challenges is ensuring an adequate human resource pool for the staffing of the public sector; a task that is complicated by many global and disease burden challenges. The National Department of Health has grappled with these issues, and produced a Draft Strategic Framework for the Human Resources for Health Plan.

The document is divided into 4 chapters. The first chapter provides the rationale and objectives that underpin the Plan and outlines the process followed in developing the framework. Chapter 2 is a rapid appraisal and analysis of Human Resources in the S.A. health care system and highlights the status of HRH policy and planning in the country. Chapter 3 flags the major HRH challenges that the SA health care system faces, which the Plan will seek to address. The proposed elements of the Plan, elaborated upon through a set of strategic objectives are presented in Chapter 4.

1.2 Rationale and objectives

The purpose of developing a National Human Resource for Health plan is to put in place a national guideline for human resource policy and planning spanning the whole health system. Human resource planning is essential for any organization to ensure that its human resources are capable of meeting its operational objectives. This planning ensures that an organization obtains the (right) quality and (adequate) quantity of staff it requires; makes the optimum use of its human resources; is able to anticipate and manage surpluses and shortages of staff; and develops a multi-skilled, representative and flexible workforce, which enables the organization to adapt rapidly to a changing operational environment.

The plan will serve as a guide / reference for province specific HR Plans and will provide managers with the guiding tools to recruit, develop appropriate retention strategies, and plan further development of strategies to address challenges faced in implementation of the plan. The finalised plan will also contain a template that will be helpful in reporting of progress made with implementation of activities aimed at realizing the broad strategic objectives of the national health system.

1.3 Process and Approach

The Department's Human Resource Branch spearheaded the development of the Strategic Framework for the HRH Plan, however the content of the plan reflects collective thinking of a wide range of stakeholders who were consulted extensively throughout the process.

1.3.1 Assumptions

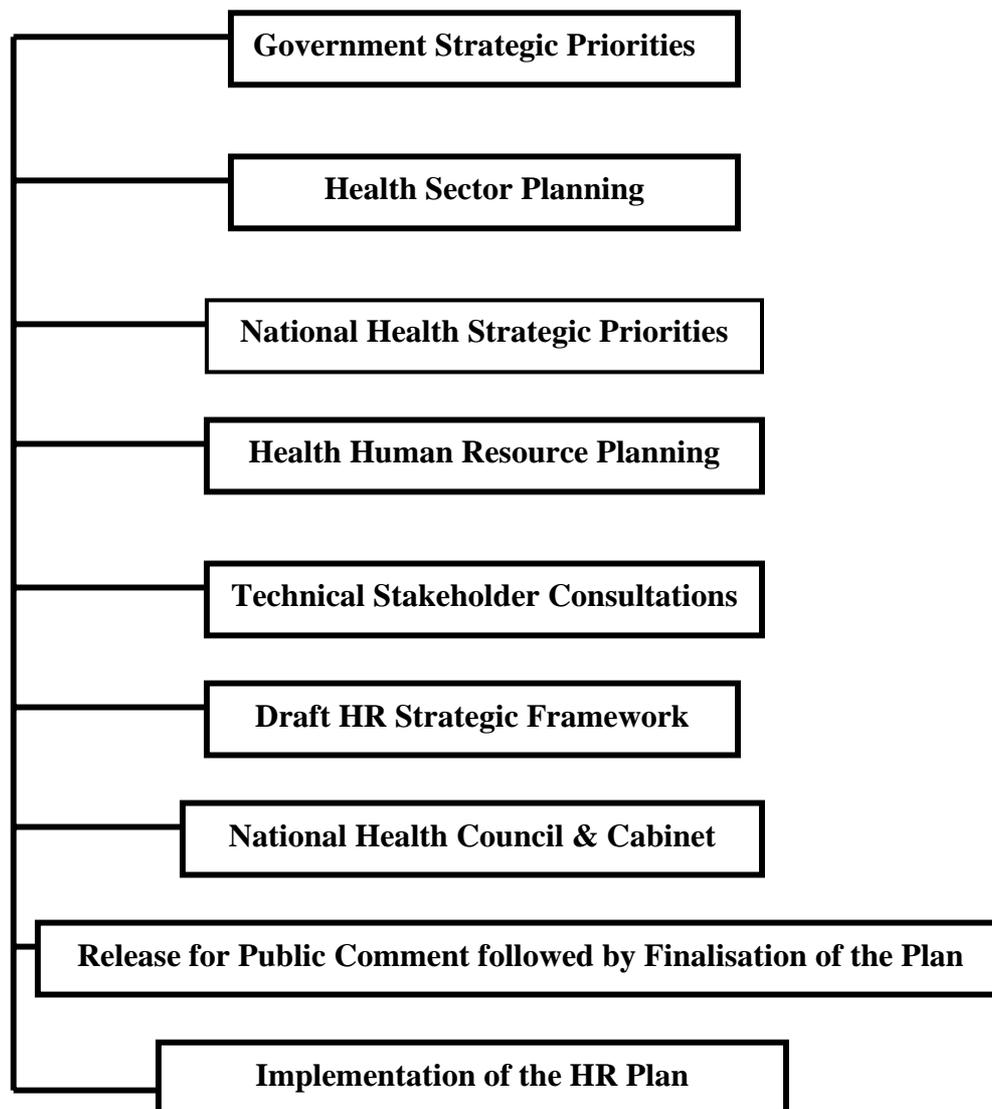
In developing the framework the following assumptions were made:

- ⌘ That the South African Human Resource for Health plan is a critical element for the realisation of the national health strategic priorities
- ⌘ That both the public and private health urgently need the plan to guide them in strengthening planning, development and management of the health system
- ⌘ That the country has the necessary financial resources to implement the national human resource plan

1.3.2 Consultation Process

In view of the assumptions made above, the department embarked on a process of developing a human resource plan starting with a strategic framework as represented in the model below (Figure 1).

Figure 1: Linkage of Consultation Process to wider Health Planning



Chapter 2

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

- 2.1 Introduction
- 2.2 The Context of HR for Health in South Africa
 - 2.2.1 Structural Organisation of the SA Health System
 - 2.2.2 Population demographics and HR Specific Statistics
 - 2.2.3 Policies and Legislation
- 2.3 A Review of Achievements and Trends
 - 2.3.1 HR Related Achievements Post 1994
 - 2.3.2 Health Financing and Expenditure
 - 2.3.3 Summary of Trends Impacting on Human Resources for Health

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 answer the following key question:

‘What are the gaps in the existing knowledge and practice in the HRH field?’

This review was guided by the following objectives:

- ⌘ To determine what information we have, what has already been done and what information is needed for the development of a National 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 determination 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 Organization 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 has two major components – the public and the private health sectors. It is therefore necessary that overall planning for the health system incorporate both sectors.

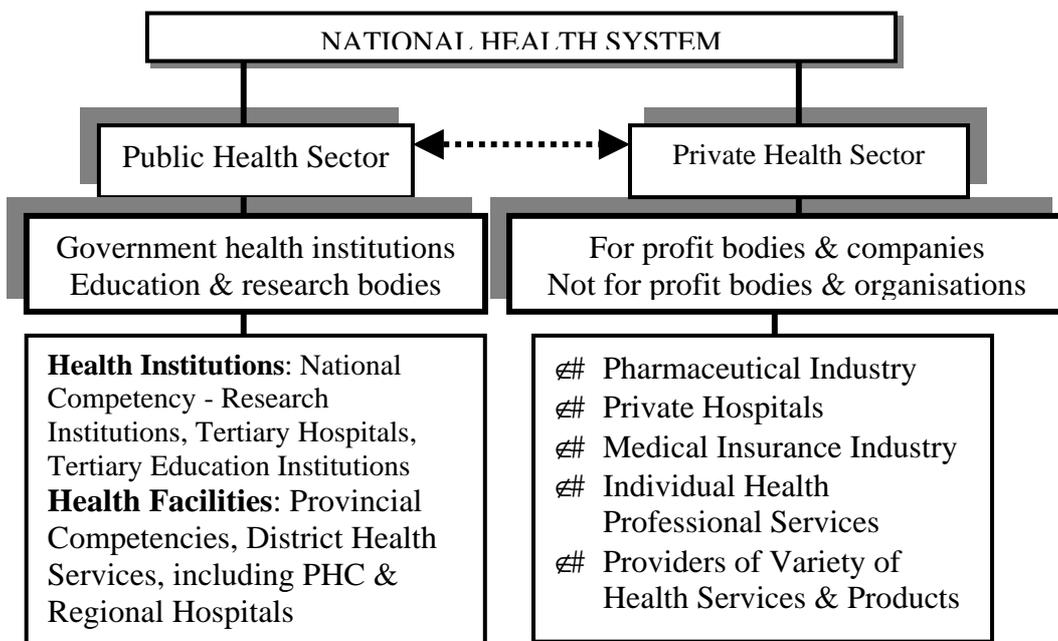


Figure 1: Macro Organisation of the National Health System

2.2.2 Population Demographics and HR Specific Statistics

Population growth and related demographics in addition to other health drivers have an important role in the planning of human resources for health.

With urbanization on the increase, the health system faces a challenge of attracting health professionals to rural areas. The 20 to 30 year age group is the target group for recruitment either to careers in health sciences or for work in the health sector. Almost all health education and training institutions are located in urban areas and this has an influence on choices of employment by young professionals. Recruitment strategies therefore have to extend to pre-higher education student life whilst recognizing the urge for young people including those from rural communities to experience urban life as well as international travel and experience.

Table 1 below gives a summary of population distribution by province with the most populous provinces being KwaZulu-Natal with 9.4 million people, followed by Gauteng with 8.8 million and Eastern Cape with 6.4 million people. The Northern Cape province is the least populated province with just over 800 000 million people. The table also indicates the number of health professionals (sampled) working in the public health facilities in the provinces. With the majority of provinces being more rural in nature and the challenge of staffing health facilities in these areas, new strategies have to be employed to engage health professionals who operate specifically at primary health care level in the private health sector to also provide services in the public health facilities.

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

Province	Population	Professional Nurses	Medical Practitioners (excl. Specialists)	Pharmacists
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

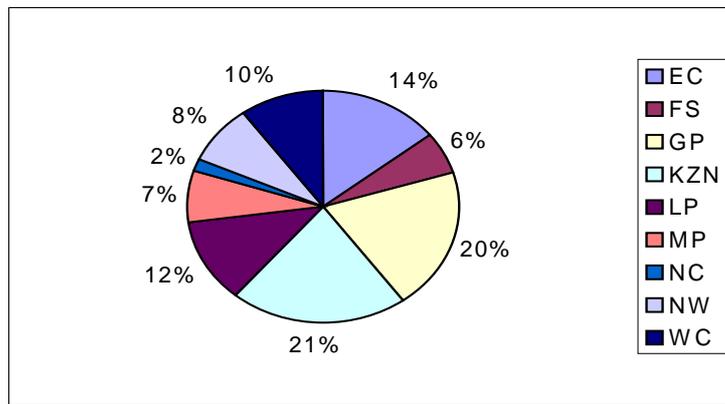
Sources: Statistics South Africa, 2003. Census in Brief: 2001

Data source on health professionals: Vulindlela

(Extracted from PERSAL 07 March 2005)

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

Figure 3: Distribution of the population of South Africa by province, 2001



Source: Statistics South Africa. 2003. Census in Brief

2.2.3. Policies and Legislation

The White Paper on Transformation of the Health System introduced a number of changes post-1994 to address a number of system challenges. A number of these changes have a direct relevance to HRH. Overall the countries' policies on human resources take on 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.

Policies / Legislation Addressing Health Systems Development

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:

- š Strengthen HR Planning function
- š Strengthen HR function with view to retention and capacity building, in the context of the labour market, changing skills requirements and contribution of higher education institutions
- š Improve quality of work experience and physical work environment
- š Attend to conditions of service of professionals to attract and retain them in the public service

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 health sector transformation. It established a number of important principles to guide human resource planning, production and management:

- €# 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 strategy 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.

Human Resource Development Strategy for South Africa– DPSA

The Human Resource Strategy concept was adopted 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 situation between what education institutions (generally responsible for human resource production) produce and what the labour market needs.

Within the Health sector a number of learner-ships have been developed in the field of nursing and memoranda of understanding have been entered into regarding management and implementation of learner-ships whose qualification include those of professionals. However, the Department of Education does not have systems for registering providers of further education and training (FET). As a result this aspect of education (in health) cannot be regulated.

Consequently there is lack of coordination between the SETA, Further Education and Training (FET) and the Health Sector regarding training of the health workforce. Partly this problem is due to lack of capacity within the FET management to regulate provision of learner-ships falling within the FET band.

Some of the manifestations of this disjuncture are the confusion around training and subsequent employment opportunities. The health ancillary training programmes are the case in point where providers offer training on ancillary programme and some market these as an entry requirement for a nursing qualification.. This practice has created confusion around career progression for the nurse professionals and community based health workers. Regulation of FET needs to be prioritised in order to facilitate the implementation of mid-level worker health care programmes without subjecting prospective candidates to exploitation by some unscrupulous services providers.

National Health Act

The Act provides framework legislation for the health sector. With regards to the HRD, the Act introduces a *National Health Council*, charged, among other things, to develop “policy and guidelines for, and monitor the provision, distribution, development, management and utilization of, human resources in the national health system”. Given the problems around 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 including:

- ⌘ Ensure that resources are made available for education and training of personnel to meet human resource requirement for the health system
- ⌘ Create new categories of health personnel to meet the requirements of the health system;
- ⌘ Addressing the skills shortages through various measures, including the recruitment of foreign health professionals;
- ⌘ Development of 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.

Policies / Legislation Addressing Human Resource Development

The main objective of the HRD policies / legislation is to facilitate the attainment and to make available, a health workforce that has the requisite skills and competencies and correct orientation for the development agenda of the country. These have to be supplied in sufficient quantities for each level of care in the health system.

The Government's commitment to improve the quality of education and training finds expression in a range of policy and legislative framework 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 legislation provides for learner-ships that lead to recognised qualifications and establishes new ways of financing skills development through a National Skills Fund.

White Paper of Public Service Training and Education (WPPSTE, 1998)

Training and development is one factor regarded as key for Public Service to succeed in its mandate of providing effective and efficient service delivery. The White paper provides a policy framework of the Governments' 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)

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 the Department of Education. This is a critical 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 critical 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 specialized sector. Knowledge and skills acquired are specific to the practice of healing diseases and illnesses to patients thus a direct impact on life and death matters.

There is currently no coherent relationship at inter-sectoral policy level between the Departments of Education, Health and Labour relating to higher education. Issues of transformation that are fundamental to HR production and therefore provision of services to underserved areas remain largely unattended to as there is no policy coordination between Health and Education. Transformation of health science faculties is therefore left to the willingness or otherwise of these institutions to embark upon it.

Policy on Internship

The policy of internship ensures 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 done on internship show that these professionals are exposed to heavy workloads sometimes without the necessary supervision and support. This adds to factors contributing to alienation to work in rural areas upon completion of mandatory internship. This is consonant with Reid's findings where skills gaps, attitudes, lack of supervision and poor conditions of service were identified as areas needing improvement. Reid (2002)

Policy on Continuing Professional Education

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

National Skills Development Act, 1999

The overall objective is to revolutionize skills development by advancing the culture of excellence in skills development and life long 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 of skills acquired through these learnerships to future career prospects of the youth receiving the skills training.

Policies/Legislation Addressing Health Service Delivery

Scarce Skills & Rural Allowance Policy Framework

The DPSA provided all government departments with this policy as a guide to develop and implement departmental scarce skills policies. This framework contextualised the problems being experienced with scarce skills employees in the Public Service 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 sufficient (perhaps even an excess supply) pool of skills from which to draw its human resources.

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

Policy on Commuted Overtime for Medical and Dental Practitioners

This policy was developed and implemented to compensate medical and dental health professionals for the work overload 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 making it a permanent fixture of their remuneration. This unintended consequence serves to boost or compensate the salary challenge that these professionals experience.

Policy on Recruitment, Employment and Support of Foreign Health Professionals

The policy on the recruitment and employment of health professionals from abroad seeks to restrict the recruitment and employment of health professionals seeking work in South Africa. Health professionals with relevant qualifications and skills obtained in foreign countries that meet the minimum requirements of training and education of health professionals in SA are restricted to providing a service in the public health sector (DoH, November, 2002). The challenge in this area is how to ensure a seamless relationship between this policy and the HR development policies that should ensure HRH production sufficient to supply for the country's needs.

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 equitable distribution of newly qualified doctors in underserved communities.

Despite the introduction of CS, staffing of the most rural hospitals remains a problem, and hospitals in remote rural areas remain without doctors, due to the fact that Community Service Professionals (CSPs) can choose the area of their placement. Reid (2002) suggests a renewed look at 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 many CSPs described their experience as positive with hindsight, few were willing to change their career plans based on the experience (specifically obtained from the underserved rural areas) to seek employment in urban health facilities or even go out of 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".

The other challenge is that upon completion of community service there is no guarantee of employment due to either lack of posts or professionals being kept at the same salary level as when they were doing community service

While community service provides short-term solutions to staffing problems in underserved areas development of a long-term retention strategy is required.

The continued problems indicate to some extent that these policy interventions are not comprehensively addressing the HR issues confronting the health sector. They create more challenges during implementation as they are subject to different interpretations. An over-arching strategy or plan to address issues of transformation of health institutions, deployment and equitable distribution of health professionals, adequate training both in quantity and quality etc must be developed and this must be informed by service delivery needs. Policies addressing recruitment and retention of health professionals including the issue of adequate remuneration for health professionals are critical so as to be able to recruit and retain skilled and competent health 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: 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, “*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 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 then include the following:

- €# Amalgamation of historically fragmented staff establishments (those of former national, provincial and homeland governments) into integrated human resource establishments for the provinces.
- €# Decentralization through the introduction of the District Health System devolving authority to districts; albeit the outstanding challenge of integrating provincial and local authority staff into combined district health establishments;
- €# 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;
- €# Deliberate shift in emphasis, mainly through the reprioritization of budgets, and resources towards 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 8.5% of GDP in the year 2003/4. This is relatively high by international standards and exceeds that in the majority of countries of a similar level of economic development. However, health status indicators (such as infant and maternal mortality) in South Africa are far worse than that in 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 heavily one of a lack of financial resources but rather a great need to use the existing resources more efficiently and equitably.

2.3.3 Summary Of Trends Impacting On Human Resources For Health

A number of trends, national and global, 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 complication 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 health problems e.g. obesity
<i>Political</i>	<ul style="list-style-type: none"> ⚡ The health system is increasingly being influenced by global health systems developments ⚡ There is pressure to expand the scopes of practice for various health professionals ⚡ Migration to overseas countries is leading to higher level skills being acquired by professionals of trained at lower levels as they do work left by those who emigrate
<i>Economic</i>	<ul style="list-style-type: none"> ⚡ The Private Health Sector is playing an influential role in provision of health services ⚡ There is marked increase in professional migration from the public to the private health sector ⚡ There is increased cost of care driven by technology and economic other factors ⚡ There is shrinkage of budgets for financing the public health programmes and services ⚡ Migration of health professionals is increasing
<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 ⚡ 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 to skills development ⚡ Participation in Continuing Professional Development being requirement for some professionals ⚡ Stricter control of numbers enrolling for university programmes being imposed by 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 number of students from SADC enrolling in SA institutions

CHAPTER 3:
HUMAN RESOURCE ISSUES
FOR NATIONAL DEBATE

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CHAPTER 3: HUMAN RESOURCE ISSUES FOR NATIONAL DEBATE

3.1 Current topical HR Issues

3.1.1 Existing Skills Mix and Key Competencies

The matter of skills mix remains a challenge in the South African health system. The nursing profession provides a perfect example of the challenges around this issue and is thus used as the tracer profession to tease out the inherent challenges. A number of nurses were trained in PHC. However, while a review of 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 reside with skills that are not necessarily applied where they should. 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 get 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 in the area of skills mix in the form of the new funding formula for higher education institutions (DoE 2004), which places more emphasis in rewarding postgraduate than undergraduate offerings. This in turn creates a major challenge of reconciling the service delivery needs with funding of production e.g. institutions would be better rewarded for producing a PhD rather than a Graduate. This seems 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 appropriate skills mix required implementing the District Health System (Pick 2001).

3.1.2 Distribution of staff

A number of strategies are being implemented in an effort to attract and distribute health personnel in underserved and rural areas. These include the following:

- ⌘ Recruiting doctors from other countries,
- ⌘ Introduction of community services for health professionals; and
- ⌘ Provision of scarce skills and rural allowance.

While provision of an allowance for personnel providing skills classified as scarce in the Public Service is a public sector wide strategy, its effectiveness in attracting and retaining health workers in underserved areas has not yet been assessed.

The short-term trend shows a slight decline in 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 personnel distribution 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 through ratio statements often described as norms and standards. These ratios are typically linked to population or disease. However, these norms and standards have significant shortcomings and have led to a new approach to determine the staffing levels.

Norms and standards have been developed for a number of areas, most notably PHC facilities and district hospitals. However, norms and standards, as well as staffing establishments, only gain validity in the context of service packages or requirements at different levels of care. It is for this reason that there is debate as to the feasibility and efficiency of present norms and standards and staffing establishments.

The potential impact of an increased use of auxiliaries/mid-level workers particularly at primary level on staffing establishments has not been reviewed. In relation to this two aspects will require consideration: how will the introduction of auxiliaries impact on the skills requirements and workloads of professionals, and what will be the supervision requirements demanded of professionals. Already, HIV services (excluding ARVs) have dramatically altered services rendered at primary care, but also at secondary and tertiary care levels (Lehmann and Zulu, 2004; DoH, 2003). Other changes in the disease profile, such as the increasing prominence of diseases of life style with further change the picture and approach to determining staffing needs.

Closely linked to the issue of norms and standards is the question of workloads. Daviaud (2004) 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 needed and valuable in human resource planning activities, they hide the fact that health care delivery in South Africa takes place in enormously complex and diverse socio-economic contexts and conditions and that transformation (integration and decentralisation) of services is far from complete. 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 quite fundamentally determined by dramatic structural differences.

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

Population-based approaches state a ratio of health cadre in relation to a population. A critical review of this approach highlights the general and non-specific nature of using this approach because the demographic element of disease or illness burden is obscured. For example, two facilities within one demographic area can have 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 that population ratios inadequately address include:

- ⊘ Physical barriers such as mountains and rivers
- ⊘ Population movements for example urbanization or migration due to draught
- ⊘ Shift 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 become a negative political and advocacy tool. For example, in the absence of official ratios some organizations 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 production centres.

Developing New Methods

Hornby (1998) developed an instrument for WHO called the Workload Indicators for Staffing Needs (WISN). WISN “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 does not have the *disadvantages of population-based ratios*. Health administrators have been turning their attention to... *issues such as...* the optimal deployment of staff, particularly to rural areas; the equitable deployment of staff in accordance with the demands actually experienced; and the optimal determination of staff categories...

Ideally one would want to determine the optimal:

- ⊘ 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;
- ⊘ 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 according to local conditions (morbidity, access, attitudes) and not 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 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 *achieve the aforementioned* should be:

- ⌘ Simple to operate, using data which is already collected and available;
- ⌘ Simple 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. finance, planning, personnel administration;
- ⌘ Realistic, so that the results will offer practical targets for budgeting and resource allocation.

The major question is whether the WISN Method is the most appropriate method or not for the South African National Health System.

3.1.4 Education, Training And Skills Development For HRH Personnel

Production of Health Professionals

It is evident that compared to other African countries, South Africa has large numbers of staff available. However, national figures hide dramatic geographical differences as well as differences between the public and the private sector. Vacancy rates are a good indication of this. Furthermore, needs are both changing and increasing, due to particularly changing disease profiles. This therefore means that the training of health professionals must keep up with all the trends that impact on health care especially the changing disease profiles and global HR trends. Annexure 1 gives more detail through showing distribution of sample health professional categories trained in the South African education institutions from 1999 to 2002.

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 (Table 2).

Table3: *Growth in the South African Nursing Council Register and Roll of Nurses for Period 1998-2003*

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

Source: South African Nursing Council

The production of nurses (the three basic categories) as reflected on the South African Nursing Council register for the period 1998 to 2003 indicates that there is fluctuation in the growth of nurses that are registered and enrolled to practise nursing in South Africa. There has been a growth of 5 704 in the number of professional nurses and 831 enrolled nurses. There has been a decline of 2517 in the number of nursing auxiliaries. The total growth in the number of nurses is 4 018.

The growth trend over the last 6 years in the register and roll of nurses is of serious concern as this growth is not in keeping with the growth in the population of the same period. Furthermore with the increased demands and the reliance of the health service on the profession of nursing within the health care delivery system has increased considerably during this period due to the emphasis on primary health care and the increasing diseases of lifestyle in addition to communicable diseases like HIV infection and AIDS. The declining number of nursing auxiliaries is also an area of concern. It is evident from the statistics that over the past 6 years there has been a decline of 2 517 in the number of nursing auxiliaries on the roll.

The South African Nursing Council (SANC) in the absence of unified training programme has put in place a two-year bridging programme that allows enrolled nurses and nursing auxiliaries to register as professional nurses. While this programme assists with the advancement of the careers of enrolled nurses and nursing auxiliaries, it does have a negative impact on the number of these categories of nurses. It is important as part of human resource planning to ensure that there are always sufficient numbers of new enrolled nurses and nursing auxiliaries to replace those that are advancing their careers. The South African Nursing Council has to review, once the new scope of practice is finalised, the education and training programme. This should most probably result in the phasing out of the Bridging Programme (*Personal communication with SANC*).

In the determination of the skills mix required for implementation of comprehensive primary health care it is important to note that professional nurses who have completed a bridging programme are primarily trained to practice as general nurses and are not trained in midwifery, community health and mental health. These professional nurses are only registered with the SANC to practice as general nurses and this limits their ability to practise in primary health care settings where nurses are required to practise comprehensively.

The number of professional nurses that trained at universities during the 5-year period was 2 391. It is evident from Table 3 that the number of professional nurses trained at universities although low is consistent with no drastic decline in the number trained over the 6 years. It also important to ensure that there are nurses who are educated to follow academic and research careers in nursing.

TABLE 3: Professional Nurses Trained at Universities for Period 1998 to 2003							
Province	1998	1999	2000	2001	2002	2003	TOTAL Per Province
Limpopo	6	8	9	11	47	59	130
North West	38	35	154	76	48	54	405
Mpumulanga	0	0	0	0	0	0	0
Gauteng	106	89	63	82	95	89	524
Free State	80	59	60	75	46	47	367
KwaZulu Natal	44	51	56	46	39	41	277
Northern Cape	0	0	0	0	0	0	0
Western Cape	67	74	44	59	52	80	376
Eastern Cape	40	35	22	59	73	83	312
TOTAL	381	351	553	408	400	453	2391

Source: SANC 2004

The above analysis indicates the importance of comprehensive HR planning including taking into consideration the unintended consequences of policy.

3.1.5 Introduction of New Health Worker Cadres

The introduction of new cadres of health professionals or 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 much discussed.

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 has been under discussion for a number of years, but finality has not yet been reached on these. More recently active steps have been taken to introduce a mid-level cadre in the medical field – the medical assistant.

Re-vitalisation of the Community Health Worker Programme

The term “Community Health Worker” (CHW) embraces a variety of community health aides who are selected, trained 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“.

3.1.6 Management Of Training, Formal Education, Staff Development Including In –Service 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 level of learning institutions: Nursing Schools, Nursing Colleges and Institutions of Higher Learning. There are concerns about management of nursing education in each of these sectors. Each is briefly presented below:

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) (entry requirement is enrolment as a nurse)

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 Department of Education has not yet finalized the requirements for the registration of Further Education and Training providers and this registration has been deferred to December 2005. This deferment has had an impact on ensuring that all Further Education and Training providers comply with a set of minimum requirements and adhere to the quality standards set for such providers.

The impact of the above has been that there has been an influx of private providers that are providing education and training that do not lead to the attainment of a qualification or a unit standard that is registered on the National Qualification Framework. As a result of this there are providers providing training in non-nursing courses but these courses have a bearing on health care e.g. home based care, health worker training. “Pre-nursing” Learners undergoing such training are either misled to believe or are under the false impression that on completion of such training they will be entitled to practice as nurses.

The providers offering these health care courses mentioned above often have links with an approved nursing school and have 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 nor approved by the SANC.

A joint strategy for resolving this issue is indicated and partnership between all role players i.e. the Departments of Health, Education, South African Qualifications Authority Health and Welfare SETA is vital. 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.

Nursing Colleges

Currently nursing colleges exist in both the public and private sector with the majority of the colleges found in the public sector. In the public sector the colleges are part of the health care delivery administrative structures and the role and function in these structures is often blurred. There is a need to clarify the roles of the various bodies responsible for nursing education.

Universities and Universities of Technology

Over the years institutions of higher learning have been able to align their training programmes with health services needs. However the funding formula applicable to higher education institutions have compelled institutions for higher learning to focus on providing postgraduate degrees as opposed to undergraduate degrees.

3.1.7 HRH Management

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 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 others, poor coordination of communication and activities between different departments, 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".

3.1.8 Migration of Key Health Professionals

Migration of health personnel, also dubbed the *brain drain*, from rural to urban areas, but 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. Reliable figures are hard to come by and invariably controversial. 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):

	Practitioners²	Nurses/midwives	Other health professionals³	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

If one considers that 11,332 doctors and 41,617 nurses were working in the public sector in South Africa in 2001 (Doherty and Joffe, 2003), the above figures are very considerable and worrying, all the more since indications are that the trend is escalating. 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 are 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.

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

³ Including assistants

“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 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 while South Africa is losing health professionals, it is also a recipient. 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 due to changes in recruitment policies of the department and changes to the Immigration Act.

3.1.9 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 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 equitable distribution of personnel whilst being cost-effective. To achieve this 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 not much systematic and published engagement with issues of HRIS. The Department of Health will shortly introduce new HR Information System, which will address requirements as identified in a number of WHO documents.

3.2 SUMMARY OF OUTSTANDING HR BUSINESS

Despite the health system achievements in a number of areas, human resources have remained a major area of weakness that has not been addressed successfully. Some compounding factors include migration of the skilled and most experienced health professionals, especially in the medical and nursing fields, to wealthy health systems, changing disease profile, socio-cultural challenges, a 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 one 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 health human resources based on what they perceive is needed or in many cases dictated to by financial constraints.

Over the past few years a number of mid-level health worker categories were introduced to the health system mostly with the aim of limiting their practice to the

public health sector. A number of questions have arisen in relation to HR workforce planning e.g. proportion of say dental therapists that must be trained to the number of dentists. Other questions are for example the relationship between various health professional categories, focus of production investment and balance that needs to be maintained within the health workforce.

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

Summary Of Agenda Items

Below is a list of topics identified in the text, which may require additional research or information gathering. They have been extracted from the main text for easy reference purposes.

New Health Worker Cadres

Information gaps exist with regard to future projections of staff availability. A need exists to conduct an age analysis of the present workforce, and particularly nurses, to enable succession planning. Furthermore, staffing needs will need to be reviewed against the background of the impact of the introduction of new cadres on nursing (e.g. mid-level workers), the revision of scopes of practice and the subsequent review of staffing establishments. This includes the development of different staffing scenarios and projections and their economic feasibility.

Norms And Standards/ Staffing Establishments

The debate on this means that for planning purposes norms and standards and staffing establishments have to be live documents, which require on-going revision to accommodate changing needs. At present there undoubtedly is a need for a revision with a particular focus on: a) *the changing disease burden*; b) *structural changes*; and c) *the impact of new cadres*, in particular auxiliaries.

Continuing Professional Development

The impact of Continuing Professional Development programmes for health professionals has to be evaluated to ascertain the efficacy of the programmes to meet continuing education needs of the country and value in lieu of investment made.

Availability and Distribution

Although much focus in the past few years has rightfully been on the development of the District Health System and Primary Health Care, the health sector clearly has to

retain strong and well-functioning hospitals. An assessment of the HR situation in hospitals has to be part of a comprehensive situational analysis.

Staffing Workloads

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

Skills Development

A comprehensive and textured skills analysis for different programmes and fields within the health sector followed by systematised education programmes (both initial and continuing education), appropriately funded through skills development funding and organised by the SETA, is a key HR strategy.

Re-Vitalisation of the Community Health Worker Debate

The role of community- and home-based health workers and their organisational and structural accommodation in relation to the health services has to be pursued as a matter of urgency, given the dramatic increase in need for chronic and palliative care.

Funding of Health Education and Training

The issue of funding for health professions education as well as the inter-relationship between different levels of health professions education needs to be urgently attended to as a measure to improve the efficiency and efficacy of training in the health sector.

Strengthening Interface Between Departments of Health And Education

The introduction of the *National Health Council* through the National Health Act, imposes certain responsibilities and introduces some opportunities to firmly address human resource issues as provided for in the Act.

Rethinking Academic Health Complexes Towards Primary Health Care

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

Nursing Education Reform

An elaborate inter-sectoral strategy for resolving issues in nursing education is indicated driven by a solid partnership between the Department of Health, Department of Education, South African Nursing Council, South African Qualifications Authority and the Health and Welfare SETA. The review of the nursing education and training

being done by the Nursing Standards Generating Body has paved the way to finally transform nursing education and streamline qualifications in this profession.

Special Allowances for Retention of Health Professionals

Evidently, a close monitoring and evaluation of the impact of these allowances is imperative, specifically as financial incentives to motivate workers to work in under-serviced areas remains a much-debated measure. Without a doubt, however, in itself the recently introduced allowances will not be sufficient to attract and retain staff. They have to be embedded in a package of initiatives aimed at improving conditions of service.

Organisation Structures And Functionality For Managing HRH

A review of the functionality and capacity of HRH structures and organisations at national and provincial level might contribute to improving the functioning of HRH planning and management across all levels.

Career Progression Of Key Cadres

While there is considerable public debate about the career progression and limitations of career progression for certain cadres, in particular nurses and lower-level cadres, there needs to be better systematic work in this area. As career progression is an important contributing factor to career choices, a review of career trajectories and options may well contribute to enlarging the pool of health professionals in future.

Impact Assessment of HRH Planning

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

Conclusion

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

Chapter 4

MAJOR PILLARS OF THE NATIONAL HUMAN RESOURCE PLAN FOR HEALTH

- 4.1 Human Resources Vision and Mission**
- 4.2 Concept of the Stewardship Role of Government for Health Care**
- 4.3 Strategic Pillars of the National Human Resource Plan for Health**
 - 4.3.1 Human Resource Policy and Planning**
 - 4.3.2 Human Resource Production**
 - 4.3.3 HRH Management / Leadership**
 - 4.3.4 HR Information System**
 - 4.3.5 Health Education Institutions**
 - 4.3.6 HRH Research**
 - 4.3.7 Monitoring and Evaluation**
- 4.4 Strategic Objectives & Supporting Activities**
- 4.5 Action Strategy Plan**

Chapter 4:

Major Pillars Of The National Human Resource Plan For Health

This chapter deals with the issue of developing a national agenda on human resources for health based on a shared vision and therefore commitment to the mission of providing adequately for the country. The purpose of developing a vision specific for human resources is to ensure that all strategies and activities related to the HR plan are directly linked to the overall vision of the national Department of Health, which is: *‘An accessible, caring and high quality health system’*.

The vision for human resources is therefore *‘to provide skilled human resources for health care adequate to care for all South Africa’*.

Its mission is *‘to provide leadership for the planning, development and management of human resources for health to improve the health care delivery system by focussing on access, equity, efficiency, capacity, quality and sustainability’*.

4.1 Concept of Stewardship Role of Government for Healthcare

By definition stewardship is the assumption of responsibility for the welfare of society. The concept of stewardship is the *“mantle under which operate all of the progressive causes human rights, conservation, economic welfare, government reform and oversight, education, health care, disaster relief, animal welfare, mental health, peace”*. The best example of a steward is a government because it comes into being through elections where it pledges to be a steward for the whole nation. Stewardship is therefore an institution in perpetuity, which results in cumulative gains resulting from collective actions by individuals mostly driven by altruistic motives.

Governments should [therefore] be the “stewards” of their national resources, maintaining and improving them for the benefit of their populations (WHO 2000). For a health system, stewardship relates to the extent to which government takes responsibility for the provision of health services to all its citizens. This means being ultimately responsible for both the public and private health sectors because good stewardship denotes good governance. Stewardship to include the private health sector certainly becomes contested territory simply because there is a perception that there is no direct investment by government in developing infrastructure or staffing the private sector. It is worthy to note that government provides virtually all the education and training for health practitioners in the private sector. It therefore invests directly in the staffing of the private sector.

If the country is to succeed in planning appropriately and ensure good performance of its health system, the issue of stewardship should be clearly understood by all concerned. It is an issue of how the leadership in both sub-sectors relates and takes collective responsibility for the performance of the health system. As WHO notes, the health of the people must always be a national priority: government responsibility for it is continuous and permanent thus Ministries of Health must take on a large part of the stewardship of health systems (WHO, 2000).

“Health policies and strategies need to cover the private provision of services and private financing, as well as state funding and activities. Only in this way can health systems, as a whole be oriented towards achieving goals that are in the public interest. Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. At an international level, stewardship means influencing global research and production to meet health goals. It also means providing an evidence base to guide countries’ efforts to improve the performance of their health systems”.

For government to ensure good stewardship, it is necessary that in its human resource policy and planning the private health sector is regarded as an integral part of the health systems, that has to continuously plan and execute its plans in support of the national health system’s strategic goals. Stewardship also calls for developing solid social partnerships spanning all formations in the health sector including communities who are invariably the recipients of the public goods over which government exercises control, offers guidance or promotes. The resources referred to here form part of our national pool of resources, be they in the public or private health sectors.

Viewed from a broader perspective, stewardship is also a responsibility for purchasers and providers of health services who must ensure that as much health [value] as possible results from their spending (WHO 2000). In terms of effective stewardship, the key role of government is one of oversight and trusteeship. This should always translate to provision of good quality health services to the whole population.

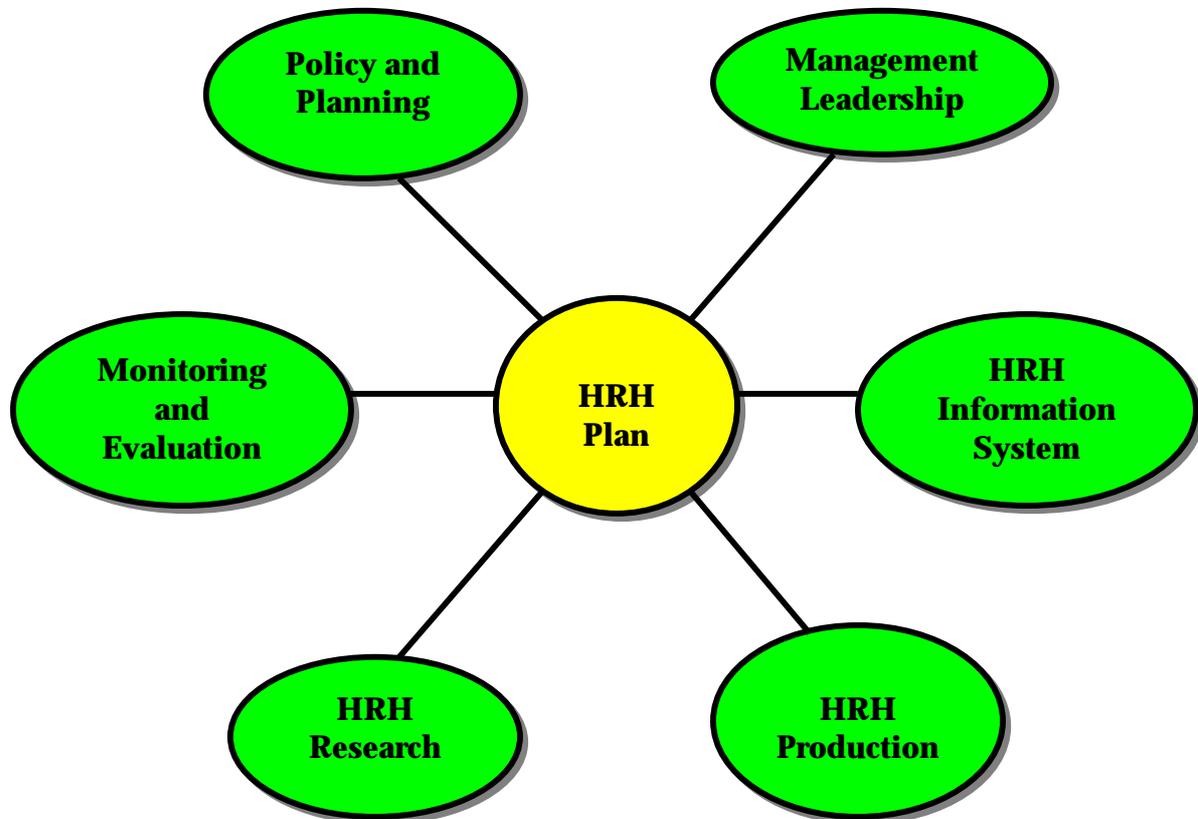
National health priorities therefore have to be premised on the understanding that strategies for implementation will give effect to the active demonstration of good stewardship by all concerned. The draft framework identifies stewardship as an important element of the National Human Resources for Health debate to emphasise the need for a good understanding of the responsibilities that the State has of health care. These responsibilities are also embedded in the health legislation.

- ⌘ The NHA of 2003 emphasizes the stewardship role of the National Department of Health in the development of the health system.
- ⌘ Section 48 of the NHA requires the National Health Council to develop policy and guidelines for, and monitor the provision, distribution, development, management and utilization of, human resources within the national health system.
- ⌘ Section 49 stipulates that the Minister, with the concurrence of the National Health Council must determine guidelines to enable provincial department and district health councils to implement programmes for the appropriate distribution of health care providers and health workers.
- ⌘ Section 52 empowers the Minister to make regulations regarding human resources within the national health system.

The following pillars of the HRH Plan have been identified within this context.

4.2 Major Pillars of the National Human Resource Plan for Health

These pillars are identified so that the national health system can focus in each area, making strategic investment decisions to ensure the robust development of the system.



4.2.1 Human Resource Policy and Planning:

This pillar is linked to and addresses health systems priorities with specific reference to planning and production of human resources for health. Policy and Planning at national level should cascade to the provincial and district health levels to ensure a seamless application.

4.2.2 Human Resource Production

This second pillar addresses issues related to education and training of all cadres of health professionals. It covers policies on HRH production namely admissions, funding of health higher education, and transformation issues. Policies on skills development for HRH personnel are an important aspect and in the case of health professionals, this is a joint responsibility of the Department of Health and the Health Professional Statutory Councils e.g. Continuing Professional Development for various professional cadres. The presence of education institutions committed to advancing the national interests through production of a skilled competent health workforce is also an important aspect. Advances in health sciences are naturally led by the professions who continuously seek innovative ways of improving health care and pursue excellence.

4.2.3 HRH Management / Leadership (Capacity Development)

The third pillar is the presence of policies and programmes to nurture and promote good quality leadership for the health sector spanning the public and the private sectors. These programmes are geared towards developing the leadership committed to ensuring realisation of positive health outcomes for South Africans.

4.2.4 HR Information System

A comprehensive HR information system is an essential pillar for a health system. It enables management to use the data and resultant information for futuristic planning in addition to its use as a management tool. The complexity of the health system requires that this pillar be developed and managed appropriately to be a standard for good health management.

4.2.5 HRH research

The World Health Organisation acknowledges that human resources play a vital role in determining good health outcomes. To maintain a secure future in terms of planning, it is absolutely necessary that a culture and capacity to research human resources within the National Department of Health.

4.2.6 Monitoring and Evaluation (programmes for HRH improvement)

Human Resources is a form of labour market characterised by those countries that produce a good product and make it available on the international market, experiencing the effects of normal markets namely those with financial resources being able to purchase the skills. Due to the costly nature of human resource production in health, it is imperative that good monitoring and evaluation systems for health human resources are put in place

Based on the pillars described above, a framework of guiding principles has been developed. Its purpose is to define precisely how the pillars will be anchored. This means describing in detail what principles will guide the plan, what strategic objectives are being pursued and the kind of activities that are necessary to implement the HRH plan.

STRATEGIC FRAMEWORK FOR THE NATIONAL HUMAN RESOURCES FOR HEALTH PLAN

The country's human resource plan is guided by the following principles:

- Guiding Principle 1:** Stewardship for health care lies with the National Department of Health
- Guiding Principle 2:** South Africa's role in international health issues contributing to leadership, scientific advances and global health professions is critical
- Guiding Principle 3:** Planning and development of human resources linked to the needs and demands of the health system must be strengthened
- Guiding Principle 4:** The optimal balance, equitable distribution and use of skilled health professionals to promote access to health services must be developed
- Guiding Principle 5:** South Africans must enjoy a reliable supply of skilled and competent health professionals for self-sufficiency
- Guiding Principle 6:** South Africa's contribution in the short to medium term to the global health market must be managed such that it contributes to skills development of health professionals
- Guiding Principle 7:** Health workers must have the capacity and appropriate skills to render accessible, appropriate, high quality care at all levels
- Guiding Principle 8:** Work environments must be conducive for good management practice to maximize the potential for the health work force to deliver good quality health services

These guiding principles are backed up by a set of strategic objectives linked to broad activities for implementation. These activities are broad and are of such a nature that each stakeholder will be able to further develop them into concrete action plans.

Listed in the next pages are 8 guiding principles that form the foundation of the Human Resources for Health Plan.

GUIDING PRINCIPLE 1:

Stewardship for Health Care lies with the National Department of Health

Strategic Objective 1.1

Provision of leadership through guidance of the Public and the Private Health Sectors

Supporting Activities to Objective 1.1

Promoting leadership development

- Identifying appropriate formal training programmes
- Establish mechanisms and opportunities for local and international exchange programmes
- Strengthening health specific management programmes and expand to include the Private sector

Strengthening of Government's capacity to exercise stewardship

- Targeted recruiting of specific skills to the public health sector
- Set up programmes to develop technical expertise in priority areas

Promoting good governance

- Jointly setting up a national training programme on governance with the private health sector and higher education institutions
- Development of clear guidelines for governance of health facilities

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
<p>Development of national standards for health management training</p> <p>National Department of Health (with PHRC oversight) jointly with accredited Private Health Sector bodies to develop and adopt the standard</p> <p>Range of accredited health management programmes linked to twinning between public and private health sectors</p>	<p>Development of the programmes by January 2006</p> <p>Agreement with accredited private health bodies to gain access to their Training Institutes and facilitate training to start in 2006</p> <p>Agreement on trainee placement in public and private facilities during training period (for exposure)</p>

Strategic Objective 1.2

Defining a vision and developing an over-arching National Human Resource Plan

Supporting Activities to Objective 1.2

Engaging with all stakeholders in the refinement of the National Human Resource Plan

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Development of a national common agenda for human resources in health through discussion and agreement on the strategic framework	Commitment of all role-players through developing or modifying own HR plans based on the national strategic framework by 2006

Strategic Objective 1.3

Establishing shared values and base with provinces on issues of HR planning, management and development

Supporting Activities to Objective 1.3

Sharing of best practice with and across provinces and the private health sector on HR policy development, planning and management

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Identification and agreement on best practice between the public and private health sectors	Regular interaction (e.g. at least three times per annum) between representative bodies at provincial level

Strategic Objective 1.4

Establishment of reliable monitoring and evaluation systems

Supporting Activities to Objective 1.4

Setting up of mechanisms for regular monitoring of policy implementation
Development of performance indicators for implementation of the Plan

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Sharing of expertise and technology where necessary for appropriate monitoring and evaluation systems	Agreement on performance indicators and monitoring of implementation

Strategic Objective 1.5

High-level investment and resource allocation decisions

Supporting Activity to Objective 1.5

Joint inter-sectoral planning with other HRD related Ministries to ensure growth of the health sector

Matching of education and training to the national health needs

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Agreement on strategic areas of high level investment in human resource development	Departments of Health, Education, Finance and DPSA agree on a plan and specify implementation timetable

Strategic Objective 1.6

Management of regulatory environment and oversight function

Supporting Activities to Objective 1.6

Consistent evaluation of the impact of regulations in the context of emerging trends in health

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Engagement of role-players in assessment of need and/or strengthening of regulatory environment impacting on human resources	Define HR research agenda and commission joint research projects (where necessary) to assess impact

Strategic Objective 1.7

Development of partnerships spanning all formations in the health sector

Supporting Activities to Objective 1.7

Regular interaction with stakeholders for information sharing and setting up joint projects where necessary

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Development of a strong stakeholder management policy by the Departments of Health	Setting up and operationalisation of the National Consultative Forum and Adhoc Interaction (based on need) at national and provincial level

GUIDING PRINCIPLE 2:

South Africa's role in international health issues contributing to leadership, scientific advances and global health professions is critical

Strategic Objective 2.1

Influencing global HR research and production

Supporting Activities to Objective 2.1

Enhancement of relevant country's HR capacity

Interaction with international health systems on new trends in production of human resources

Facilitation of contact between SA Research and education institutions with counterparts internationally

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Identifying credible international organisations and institutions active in the area of HR research	Develop a policy of facilitating interaction through the country's foreign policy activities Share best SA practice on HR research specifically with WHO

Strategic Objective 2.2

Promotion of cooperation between the South African Health System and other health systems regionally and internationally

Supporting Activities to Objective 2.2

Designing of MOU agreements such that they are in line with the strategic focus of the SA health system

Establishment of technical level contact to support the relationship at Ministerial level

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Setting up of close ties between administrative leadership to complement the political ties where indicated	Each MOU to have identifiable projects or programmes for implementation; informed by the country's needs as articulated in the national strategic plans

Strategic Objective 2.3

Influencing and directing international aid towards the country's capacity development priorities

Supporting Activities to Objective 2.3

Establishment of a framework for management and focusing of donor funding towards priority capacity building programmes

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
International donor funding to be structured such that it targets developmental needs as identified by SA	Donor coordination structures at both national and provincial levels to have common set of priorities in line with national strategic plans

Strategic Objective 2.4

Exerting influence through advocacy in international forums

Supporting Activities to Objective 2.4

Strategic placement of South Africans in influential positions within the multi-lateral organizations

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Identify strategic positions for advancement of South African influence drawing people from both public and private health sectors	Constantly identify and advocate for South Africans to gain positions of influence in multilateral organisations through primary appointments or secondments

Strategic Objective 2.5

Understanding and influencing global HR market trends

Supporting Activities to Objective 2.5

Development of expertise to analyse market trends, policy and research trends in HRH

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Setting up close working relations with other bodies like StatsSA to build capacity to play role in HR market research	National department to set up an internal HR research capacity by the end of 2005

GUIDING PRINCIPLE 3

Planning and development of human resources linked to the needs and demands of the health system must be strengthened

Strategic Objective 3.1

Application of HRH research and knowledge to advance the health system as a whole

Supporting Activities to Objective 3.1

Setting of a National Health Human Resources research agenda

Implementation of a comprehensive Health Human Resources information management system

Knowledge management to create an evidence-base for planning in line with identified priorities

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Public Health Sector, supported by the Private Health Sector setting up a national HR research agenda to address challenges e.g. migration.	Creating a HR knowledge management unit within the national department to act as a resource for the national health system

Strategic Objective 3.2

Alignment of training and education resources to the health system needs

Supporting Activities to Objective 3.2

Collective management of resources for the production of Health Human Resources to address the national health demands

Integration of training and education into all levels of the health system to ensure that training platforms are structured and resourced to reflect priorities of service delivery

Implementation of a competency-based framework to inform personal developments plans

Alignment of workplace skills development resources to the needs of the health system

Alignment and prioritisation of study grant schemes to benefit the health system needs

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
<p>Common approach to training and education of health professionals</p> <p>Ensuring that there is close relationship between supply and demand in education</p> <p>Alignment of skills development with health system needs</p> <p>Modification of study bursary contracts to ensure pay-back is linked to providing service in areas of need</p>	<p>Agreement on targets (numbers) to be achieved over a specific period of time</p> <p>Strengthening of intersectoral planning between the Departments of Health and Education in relation to the national institutional planning</p> <p>Annual planning between the Department of Health and health training institutions to match needs with training</p> <p>Provincial Departments of Health must amend bursary contracts to remove the option of paying back in monetary terms.</p>

GUIDING PRINCIPLE 4

The optimal balance, equitable distribution and use of skilled health professionals to promote access to health services must be developed

Strategic Objective 4.1

Provision of human resources to render adequate, accessible and appropriate services in rural and other under-serviced areas

Supporting Activities to Objective 4.1

Revisit recruitment criteria for health science students to earmark students from rural and under-serviced areas

Exploration of international experiences with recruitment schemes aimed at addressing mal-distribution

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Recruitment of students from rural and under-serviced areas	State bursary contracts and financial aid must focus on students from disadvantaged areas

Strategic Objective 4.2

Development of incentive systems for health service provision in under-serviced areas

Supporting Activities to Objective 4.2

Addressing appropriate placement of health workers

Continue the development financial and non-financial incentive schemes

Facilitate collaboration of stakeholders in developing incentive schemes

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Recruiting experienced staff to work in under-resourced areas	Modification of recruitment strategies to target appropriately experienced health professionals Develop mechanisms of retention of staff to complement financial incentives

Strategic Objective 4.3

Balancing health worker categories, align and synergise scopes of practice

Supporting Activities to Objective 4.3

Address placement and supervision of health professionals in community service

Take stock of status and recent developments in the introduction of new and restructuring of existing health worker categories

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Provision of adequate supervision of community service health professionals	Recruiting experienced General Practitioners to provide supervision and mentorship to young doctors

GUIDING PRINCIPLE 5

South Africans must enjoy a reliable supply of skilled and competent health professionals for self-sufficiency

Strategic Objective 5.1

Ensuring regular and up-to-date projection of national and regional HR needs in line with identified priorities

Supporting Activities to Objective 5.1

Revisiting staffing balances and scopes of practice to ensure correct skills mix, alignment and synergy between different staffing categories at different levels of service

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Ensuring that health professionals are produced in sufficient numbers for the national health system	Re-evaluation of production of health professionals over an Medium Term Strategic Framework period to link with the MTEF budgeting cycles

Strategic Objective 5.2

Set up mechanisms and structures for the periodic/regular projection of health worker needs and subsequent adjustment of plans

Supporting Activities to Objective 5.2

Review of existing and develop new context-specific norms and standards for staffing at facilities at all levels of care

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Setting up a system at provincial level for detection of pending staff shortages to inform short-term HR Plan modifications	Ensure that HR Information System has good HR Intelligence at all levels with provinces linked 24 hours a day to the national office. Engage relevant structures on the process of determining / reviewing norms and standards for staffing at all levels of care

GUIDING PRINCIPLE 6

South Africa's contribution in the short to medium term to the global health market must be managed such that it contributes to skills development of health professionals

Strategic Objective 6.1

Optimisation of the bilateral agreements that South Africa enters into with various countries

Supporting Activities to Objective 6.2

Establishing mechanisms to manage the HR aspects of the Memoranda Of Understanding

Entering into agreements for possible placement of South Africans in institutions that will enable them to acquire new skills

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Modelling bilateral agreements to benefit the country in the global human resource market	Public and private health sectors must develop a mechanism to recruit internationally skills most needed by the country
Placement of South Africans in international institutions in positions of a strategic nature for acquiring skills needed by the country	National Department of Health must play an active role in influencing employment or election of South Africans to identified strategic institutions

GUIDING PRINCIPLE 7

Health workers must have the capacity and skills to render accessible, appropriate, high quality care at all levels

Strategic Objective 7.1

Provision of initial and continuing education and training that meets the identified health needs of the country by training institutions

Supporting Activities to Objective 7.1

Assessment of training institution's ability to offer adequate and appropriate initial and continuing education programs (teaching capacity, enrolment capacity; losses during training)

Establishment of structures to facilitate joint decision-making and oversight between the Department of Health and Department of Education on matters of health professional education and training

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Ensuring that skills development is commensurate with the needs to provide good quality health services	Departments of Health and Education must regularly assess the exit competencies in health training institutions and the Department of Health must regularly assess the quality of skills training for health approved by the HWSETA

Strategic Objective 7.2

Provision of high quality and appropriate experiential learning

Supporting Activities to Objective 7.2

Identification and strengthening of sites of good practice to be developed as learning sites at all levels of the service

Monitoring the roles of service providers in rendering on-site health workers training

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Gearing the work place to provide good continuing professional development and experiential learning	Ensuring that in-service training providers are properly accredited and evaluated on a regular basis

Strategic Objective 7.3

Establishment of skills monitoring and assessment systems

Supporting Activities to Objective 7.3

Strengthening of programmes and tools for continuous assessment and monitoring of existing skills levels in the health workforce

Improvement and decentralisation of structures for the continuous implementation of skills assessment

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Skills monitoring and assessment systems must be standardised nationally	Provincial departments of health must set up the systems and regularly assess their efficacy

Strategic Objective 7.4

Promotion of life-long learning and research-based practice among all health workers

Supporting Activities to Objective 7.4

Development of applied research skills, which enable reflective practice and proactive problem solving

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Organising resources to encourage and support the development of a research based culture to improve quality of services	Department of Health to set up relationship with the private health sector to encourage research-based practice in identified facilities

GUIDING PRINCIPLE 8

Work environments should be conducive for good management practice to maximize the potential for the health work force to deliver quality health services

Strategic Objective 8.1

Creating a culture of valuing all workers

Supporting Activities to Objective 8.1

Development and implementation of cross-government initiatives that promote a healthy and safe work environment

Development and implementation of targeted initiatives in health to promote a positive and supportive work environment

Putting in place balanced financial and non-financial incentives

Ensuring a developmental performance management system that acknowledges excellence

Promotion of life long learning amongst all health workers

<i>Planning Issue/s</i>	<i>Implementation Issue/s</i>
Continued development of health sector managers to develop a caring value-laden culture	National Department of Health must engage with private health sector institutions to harmonise the development programmes

ACTION STRATEGY PLAN

It is realised that an HR Plan is a medium to long-term activity and that a short-term programme for the first phase implementation should be developed. The following action strategy plan identifies those areas for immediate action as a prelude to the full implementation of the National Human Resource Plan once it has been adopted.

	Action Strategy	Action Point
1	Improve Human Resources for Health Production and Supply	<ul style="list-style-type: none"> a. Review capacity of health education and training institutions b. Promote health sciences as careers of choice to students so as to increase student numbers and significantly increase outputs at higher education institutions c. Mobilise resources to focus on mid-level health workers e.g. medical assistant training programme d. Remove obstacles to nurses rejoining public health service e. Harmonisation and increased production of Community Health Workers f. Finalisation of the review of the nursing qualifications being done by the Nursing SGB
2	Improve work-life experience of health workers	<ul style="list-style-type: none"> a. Research and develop new remuneration structure for health professionals b. Revitalise health infrastructure and improve physical environment at health facilities to improve health outcomes
3	Strengthen National Human Resource Databank	HR Information Systems development and positioning of HR databank to achieve following functions: <ul style="list-style-type: none"> a. Analysis of supply and demand to ensure accurate forward projections for planning b. Provide up-to-date HR data for the HR Information Management c. Identify gaps for planning d. Provide information in relation to number of professionals in training, areas of skills development, practice locations etc
4	Improve Management Training	Accelerated training of middle managers

CONCLUSION:

In order for the plan to be on the pulse in addressing HR challenges faced by the country, stakeholder participation in reviewing the proposals made is strongly encouraged. Proper planning is critical in addressing the national human resource challenges. There is therefore absolute need for the health system to possess credible data and information on human resources for health spanning both the public and private health sectors. The gulf between the public and private health sectors needs to be reduced and the HRH plan must be geared towards the attainment of national goals.

Stakeholders seeking to contribute to the process are particularly requested to cover the following in their written submissions:

- ⌘ Identify the gaps – i.e. what has not been covered that you feel is critical to include in this framework?
- ⌘ Concrete suggestion/s on how such gaps can be addressed
- ⌘ What kind of resources do you think will be needed to address such gap/s?

To complement the process of engaging stakeholders in the manner proposed above, the department will proactively engage with various groups of key stakeholders to obtain more specific feedback on aspects of this strategic framework. This will be in addition to the written submissions that are mandatory as a form of comment to this document.

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APPENDIX 1:

Headcount of students enrolled for Medicine, Dentistry, Pharmacy and All Health Sciences 1996 to 2002

Year	Medicine			Dentistry			Pharmacy			Total			All Health Science Universities
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	
1996													27530
1997													27026
1998													28000
1999													25142
African	1017	1245	2262	155	162	317	304	257	561	1476	1664	3140	
Coloured	214	229	443	44	52	96	24	10	34	282	291	573	
Indian	597	671	1268	71	91	162	354	162	516	1022	924	1946	
White	1776	1551	3327	238	282	520	677	218	895	2691	2051	4742	
Unknown							1	0	1	1	0	1	
	3604	3696	7300	508	587	1095	1360	647	2007	5472	4930	10402	
2000													30945
African	1287	1517	2804	164	146	310	371	294	665	1822	1957	3779	
Coloured	266	226	492	41	48	89	32	12	44	339	286	625	
Indian	875	783	1658	71	80	151	321	122	443	1267	985	2252	
White	1759	1465	3224	236	266	502	648	201	849	2643	1932	4575	
Unknown							0	0					
	4187	3991	8178	512	540	1052	1372	629	2001	6071	5160	11231	
2001													32107
African	1528	1694	3222	167	149	316	435	302	737	2130	2145	4275	
Coloured	309	246	555	40	49	89	36	12	48	385	307	692	
Indian	874	767	1641	70	73	143	331	97	428	1275	937	2212	
White	1748	1392	3140	241	262	503	652	189	841	2641	1843	4484	
Unknown			0										
	4459	4099	8558	518	533	1051	1454	600	2054	6431	5232	11663	
2002													34445
African	1605	1722	3327	186	150	336	497	345	842	2288	2217	4505	
Coloured	336	231	567	61	61	122	42	19	61	439	311	750	
Indian	861	690	1551	88	74	162	332	94	426	1281	858	2139	
White	1734	1295	3029	231	217	448	699	202	901	2664	1714	4378	
Unknown			0	2									
	4536	3938	8474	568	502	1070	1570	660	2230	6672	5100	11772	

Source: National Department of Education 2004

Graduates for Medicine, Dentistry, Pharmacy and All Health Sciences 1996 to 2002

Year	Medicine			Dentistry			Pharmacy			Total			All Health Science Universities
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	
1996													5066
1997													5355
1998													5699
1999													4943
African	126	196	322	33	31	64	43	33	76	202	260	462	
Coloured	26	35	61	8	9	17	2	2	4	36	46	82	
Indian	88	102	190	16	21	37	73	42	115	177	165	342	
White	321	301	622	43	43	86	181	52	233	545	396	941	
Unknown							1	0	1	1	0	1	
	561	634	1195	100	104	204	300	129	429	961	867	1828	
2000													6057
African	112	181	293	30	20	50	49	40	89	191	241	432	
Coloured	30	23	53	7	6	13	5	0	5	42	29	71	
Indian	118	101	219	14	15	29	74	42	116	206	158	364	
White	294	272	566	37	43	80	169	53	222	500	368	868	
Unknown								0					
	554	577	1131	88	84	172	297	135	432	939	796	1735	
2001													6342
African	187	163	350	23	20	43	42	23	65	252	206	458	
Coloured	31	36	67	7	6	13	3	1	4	41	43	84	
Indian	119	128	247	11	20	31	76	25	101	206	173	379	
White	284	281	565	54	73	127	114	35	149	452	389	841	
Unknown			0										
	621	608	1229	95	119	214	235	84	319	951	811	1762	
2002													6007
African	176	218	394	15	20	35	70	54	124	261	292	553	
Coloured	36	40	76	4	6	10	2	1	3	42	47	89	
Indian	105	136	241	13	10	23	65	17	82	183	163	346	
White	277	224	501	35	48	83	139	37	176	451	309	760	
Unknown			0										
	594	618	1212	67	84	151	276	109	385	937	811	1748	

Source: National Department of Education 2004

**% Graduates of Enrolments for Medicine, Dentistry, Pharmacy and All Health Sciences
1996 to 2002**

Year	Medicine			Dentistry			Pharmacy			Total			All Health Sc. Universities
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	
1996													18.4
1997													19.8
1998													20.4
1999													19.7
African	12.4	15.7	14.2	21.3	19.1	20.2	14.1	12.8	13.5	13.7	15.6	14.7	
Coloured	12.1	15.3	13.8	18.2	17.3	17.7	8.3	20.0	11.8	12.8	15.8	14.3	
Indian	14.7	15.2	15.0	22.5	23.1	22.8	20.6	25.9	22.3	17.3	17.9	17.6	
White	18.1	19.4	18.7	18.1	15.2	16.5	26.7	23.9	26.0	20.3	19.3	19.8	
Unknown							100.0			100.0		100.0	
	15.6	17.2	16.4	19.7	17.7	18.6	22.1	19.9	21.4	17.6	17.6	17.6	
2000													19.6
African	8.7	11.9	10.4	18.3	13.7	16.1	13.2	13.6	13.4	10.5	12.3	11.4	
Coloured	11.3	10.2	10.8	17.1	12.5	14.6	15.6	0.0	11.4	12.4	10.1	11.4	
Indian	13.5	12.9	13.2	19.7	18.8	19.2	23.1	34.4	26.2	16.3	16.0	16.2	
White	16.7	18.6	17.6	15.7	16.2	15.9	26.1	26.4	26.1	18.9	19.0	19.0	
Unknown													
	13.2	14.5	13.8	17.2	15.6	16.3	21.6	21.5	21.6	15.5	15.4	15.4	
2001													19.8
African	12.2	9.6	10.9	13.8	13.4	13.6	9.7	7.6	8.8	11.8	9.6	10.7	
Coloured	10.0	14.6	12.1	17.5	12.2	14.6	8.3	8.3	8.3	10.6	14.0	12.1	
Indian	13.6	16.7	15.1	15.7	27.4	21.7	23.0	25.8	23.6	16.2	18.5	17.1	
White	16.2	20.2	18.0	22.4	27.9	25.2	17.5	18.5	17.7	17.1	21.1	18.8	
Unknown													
	13.9	14.8	14.4	18.3	22.3	20.4	16.2	14.0	15.5	14.8	15.5	15.1	
2002													17.4
African	11.0	12.7	11.8	8.1	13.3	10.4	14.1	15.7	14.7	11.4	13.2	12.3	
Coloured	10.7	17.3	13.4	6.6	9.8	8.2	4.8	5.3	4.9	9.6	15.1	11.9	
Indian	12.2	19.7	15.5	14.8	13.5	14.2	19.6	18.1	19.2	14.3	19.0	16.2	
White	16.0	17.3	16.5	15.2	22.1	18.5	19.9	18.3	19.5	16.9	18.0	17.4	
Unknown													
	13.1	15.7	14.3	11.8	16.7	14.1	17.6	16.5	17.3	14.0	15.9	14.8	

Source: National Department of Education 2004

APPENDIX 2

OVERVIEW & METHODOLOGY FOR GROUP DISCUSSIONS

National Consultative Workshop November 2004

