# Human Resources for Health for South Africa: HRH Strategy for the Health Sector 2012/13 - 2016/17

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*This chapter provides the context for development of South Africa's (SA) Human Resources for Health (HRH) Strategy for the Health Sector 2012/13 - 2016/17, a brief description of some of the key trends and challenges for HRH in SA, and the strategic priorities of this strategy.*

*An overview of trends in and challenges for HRH for SA is grouped into three themes in which key issues are highlighted and brief recommendations which informed the HRH strategy are made. These themes are supply of health professionals and equity of access; education, training and research; and the working environment of the health workforce.*

*Eight priorities were identified which form the framework for the HRH strategy: leadership, governance and accountability; health workforce information and health workforce planning; re-engineering of the workforce to meet service needs; upscaling and revitalising education, training and research; creating infrastructure for workforce and service development – Academic Health Complexes and nursing colleges; strengthening and professionalising the management of human resources (HR) and prioritising health workforce needs; ensuring professional, quality care through oversight, regulation and continuing professional development; and improving access to health professionals and health care in rural and remote areas. Each of these are discussed.*

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## Introduction

On 11 October 2011 the Minister of Health (MoH) Dr Aaron Motsoaledi launched the South African Human Resources for Health (HRH) Strategy for the Health Sector 2012/13 - 2016/17 at the Faculty of Health Sciences of the University of the Witwatersrand, and stated:

> Improving human resource planning, development and management is instrumental in the overhaul of the health system. It is a strategic intervention whose activities will contribute significantly to improved health outcomes. Compensation of employees is one of the biggest cost drivers in any institution … Therefore, as the most expensive asset, we have to manage human resources prudently ... this means that the health sector has to be staffed by an appropriately skilled workforce that is able to respond to the burden of disease and citizens' expectations of quality service.[1]

The National Department of Health (NDoH) initiated a process to develop an HRH strategy in May 2011, which included reviewing existing policy, plans and research documents on HRH. Interviews and meetings were held with key informants and stakeholders, the aim being to identify problems and what should be done to strengthen the human resource (HR) capacity of the South African health sector for the immediate, medium- and long-term future.

In his 'Statement of Policy and Commitment' in the opening section of the HRH document, the MoH states that this strategy serves as a guide to action:

> Starting with immediate effect we need to undertake a range of activities, make new policies, develop new programmes, make detailed staffing plans for new service strategies, and manage our health care workforce in ways that motivate them to provide quality health care. These activities need to be undertaken by provincial departments of health, faculties of health sciences, labour organisations, health care managers and professionals … HRH SA strategies need to be developed in all these organisations using the national HRH Strategy as a guide.[1]

The Minister further indicated that the NDoH was committed to a process of consultative engagement to work together to build HR capacity and a working environment to ensure quality health care, emphasizing that:

> Health professionals and health cadres must know that we value and need them. Without their skills, knowledge and caring attitude we cannot build the re-engineered health system we are striving for.[1]

The HRH strategy document provides a strategic framework, a process and infrastructure for developing and implementing effective HR policies in health care. The strategic approach is grounded in a national vision for the population's health which embraces re-engineered primary health care (PHC), strengthened hospital care, health promotion and protection.

## Context of the HRH Strategy for the Health Sector 2012/13 - 2016/17

Workforce planning for the health service is challenging and complex, and visualising and implementing improvements in this arena is influenced by the health, policy, legislative and economic context.

### Health context

South Africa (SA) is experiencing a quadruple disease burden, with health indicators showing a demand for service provision and health workforce development which has to be addressed. Of primary concern is that data indicate that the under-five mortality, infant mortality and maternal mortality rates in SA are unacceptably high and increasing.

The multiple burdens of disease are characterised by the co-existence of diseases associated with underdevelopment, such as diarrhoea and malnutrition, with chronic non-communicable diseases such as diabetes and stroke. These are compounded by a high injury burden and the HIV and AIDS epidemics.[2,3] The extensive and changing burden of disease in SA has implications for HR development and planning. In the short term the priority for the NDoH is to improve maternal and child health. However, health professional training and development must provide for the wide spectrum of conditions which form the disease burden. The aging trend in the population also calls for training and services to meet the needs of older people.

### Policy context

The MoH has signed a Negotiated Service Delivery Agreement "for a long and healthy life for all South Africans" with the President of SA. In this document the MoH and NDoH are committed to four strategic outputs that the health sector must achieve, which are increased life expectancy; decreased maternal and child mortality; combating HIV and AIDS and a decrease in the burden of disease from tuberculosis (TB); and strengthened health system effectiveness.[4]

To address these priorities, the re-engineering of the PHC system and overhauling of the health system are planned. PHC re-engineering will take place according to three main streams to consolidate PHC as the primary mode of healthcare delivery, focusing on prevention of disease and promotion of health.[5] The PHC system will be located in a district-based service delivery model focusing especially on maternal and child mortality. The three main streams are as follows:

➢ *District clinical specialist support teams:* These teams will consist of four specialist clinicians (paediatrician, family physician, obstetrician/gynaecologist and anaesthetist), an advanced midwife, advanced paediatric nurse and advanced PHC nurse, and will be deployed in each district.

➢ *School Health Services:* This programme aims to address basic health issues among school-going children, such as eye care, dental and hearing problems, as well as immunisation programmes. Contraceptive health rights, teenage pregnancy, HIV and AIDS programmes, and issues of drugs and alcohol in school will be part of this initiative.

➤ *Municipal ward-based PHC agents:* This team will be based in a municipal ward and involve about seven PHC workers or PHC agents per ward (six community health workers and a specialist PHC nurse).

The MoH has indicated that improved management of healthcare institutions and health districts will be essential to facilitate re-engineering of PHC, and also announced in 2011 the commissioning of five flagship academic hospitals as part of the process of re-engineering and strengthening the health system and developing balanced capacity for healthcare delivery.

Policy guidelines that inform the HRH priorities for the short to medium-term are informed by the re-engineering of the PHC system. Introduction of new financing mechanisms, such as National Health Insurance (NHI), will also pose service challenges which will demand strong HR capacity in the health sector. The HRH strategy of the NDoH is directed at creating HR capacity for meeting these new health goals and service needs.

Development of the HRH strategy of the NDoH is governed by chapter seven of the National Health Act of 2003.[6] In terms of the Act, the MoH:

➤ may establish Academic Health Complexes (AHCs);

➤ must ensure education and training of the health workforce to meet requirements of the health system, and adequate resources for this purpose;

➤ may create new categories of health workers and ensure sufficient skills, competencies and expertise;

➤ must identify shortages and find ways to fill them through local and foreign recruitment;

➤ must prescribe strategies for and retention of healthcare workers;

➤ must ensure HRH planning development and management structures;

➤ must ensure institutional capacity at national, provincial and district levels to develop and manage HRH;

➤ must ensure clarity on roles and functions of the NDoH, provincial Departments of Health (DoHs) and municipalities with regard to planning, production and management of HRH.

A number of other aspects of legislation impact on management of HRH by the NDoH, including the Higher Education Act 1997,[7] which defines higher education as a national competence of the Department of Higher Education and Training, and the Public Service Act 1994[8] and Labour Relations Act 1995,[9] both of which govern conditions of employment for public servants and remuneration.

The legislative and operational framework of developing and managing HRH for the health sector necessitates a close and on-going working relationship with the relevant ministries.

## Problem statement: Trends and challenges for HRH in SA

The strategy development process involved identifying the trends in and challenges for HRH in SA, which were grouped into three thematic areas, outlined below.

### Supply of health professionals

The first thematic area reviewed the supply of health professionals and equity of access to them. The data showed that from 1997 to 2006 there was stagnation and a decline in public sector clinical posts up to 2002, which then began to change, with a slow growth up to 2010.[1] However, in the past five years there has been a significant increase in public sector personnel expenditure budget due to the Occupation Specific Dispensation (OSD), which increased the salary package for most professional categories. Expenditure increased from R28.7bn to R59.9bn between 2006/07 and 2010/11.[1]

The inequity of access to health professionals per 10 000 members of the population between rural and urban areas and between the public and private sectors has persisted over the past 15 years. For example, Gauteng has 69.23 health professionals per 10 000, compared with the Eastern Cape which has 44.83 per 10 000.[1]

Comparison with several countries showed that SA has a much lower ratio of health professionals per 10 000 population; SA has 5.43 doctors per 10 000, compared with Brazil which has 17.31 doctors per 10 000. In addition, SA has much poorer health outcomes for maternal health and infant mortality than the six comparative countries.

**Table 1:** **Comparative benchmarks for staffing per 10 000 population and health outcomes**

| Indicator | International benchmarks | | | | | | SA current |
|---|---|---|---|---|---|---|---|
| | Brazil | Chile | Costa Rica | Colombia | Thailand | Argentina | |
| Doctors | 17 31 | 15 71 | 20 42 | 19 43 | 8 72 | 31 96 | 5 43 |
| Nurses | 65 59 | 10 45 | 22 19 | 5 83 | 33 21 | 4 87 | 36 1 |
| Pharmacy | 5 81 | 3 72 | 5 34 | 0 | 2 92 | 5 08 | 2 29 |
| Oral health | 13 69 | 7 44 | 4 85 | 8 26 | 1 73 | 9 28 | 1 2 |
| Total | 102 39 | 37 32 | 52 8 | 33 52 | 46 59 | 51 19 | 45 02 |
| MR (per 1 000 live births) | 17 3 | 7 | 9 6 | 16 2 | 12 | 13 | 43 1 |
| MMR (per 100 000 live births) | 75 | 18 2 | 26 7 | 75 6 | 12 2 | 40 | 165 5 |

IMR = infant mortality rate; MMR = maternal mortality rate.

Source: National Department of Health, 2011.[1]

Part of the reason for the low ratio of health professionals per 10 000 for SA is that our country is not retaining the health professionals that it produces. On average, 70% of health science graduates are not retained in the public sector, due in part to unavailability of posts in the public sector.[1]

A significant proportion of community service professionals, who are required to practice for one year in the public sector upon completion of their first degree, either do not report for community service or leave SA soon thereafter due to inhospitable working conditions in the public sector. In 2009, 23.1% of community service doctors indicated in a survey that they are likely to leave SA due to the working conditions in the public sector.[10] This is equivalent to the graduate output of one and a half medical schools leaving the country annually. One-third of the doctors trained in SA are reported to be working outside the country.[11]

Factors reported to affect attrition and migration include the lack of posts in the public sector, HIV and AIDS, working conditions, workload in the public sector, workplace security, relationship with management in the public sector, morale in the workplace, risk of contracting TB, and personal safety. Lifestyle and income were not the most significant factors.[12] Working environment and management relationships are critical factors affecting why health professionals leave the public sector and SA.

Table 2 provides a more comprehensive list of push and pull factors affecting health professionals' choice to migrate. The high level of attrition of health professionals from SA is creating a shortage of health professionals in the country despite the numbers being trained.

**Table 2:    Main push and pull factors in migration and international recruitment of health workers from South Africa**

| Push factors | Pull factors |
| --- | --- |
| Low pay (absolute and/or relative) | Higher pay and opportunities for remittances |
| Poor working conditions | Better working conditions |
| Lack of resources to work effectively | Better resourced health systems |
| Limited career opportunities | Career opportunities |
| Limited educational opportunities | Provision of post basic education |
| mpact of H V and A DS | Political stability |
| Unstable/dangerous working environment | Travel opportunities |
| Economic instability | Aid work |

Source:  Buchan, 2006.[13]

Managing recruitment of foreign-trained health professionals is an important aspect of managing the supply of health professionals. According to the Health Professions Council of SA (HPCSA), in 2010, SA had 3 004 foreign-trained doctors.

## Education, training and research

The second theme reviewed was the education, training and research environment necessary to ensure development of health professionals for the health system. The education and training system for the health sector in SA has not grown sufficiently to meet health needs and system requirements. Trends have been as follows:

➤  output of all health professions has not increased significantly over the past 15 years;

➤  30% of specialist registrar and 75% of sub-specialist accredited HPCSA training posts are unfilled and unfunded;

➤  specialist nursing output has notably declined, leading to reduced capacity for service in tertiary hospitals;

➤  development of specialists in the therapeutic sciences has been limited by budget and lack of public sector posts;

➤  academic clinician posts in all professions have been frozen and required growth in numbers has not taken place, leading to reduced academic capacity for clinical training and research;

➤  training of mid-level workers has not been planned and integrated into the higher education training platform;

➤  financing of health professional development and training has been under review for some time, and requires resolution; and

➤  the infrastructure for clinical training and service development, namely AHCs and nursing colleges, requires management and organisational strengthening.

These trends in the education sector are in part due to a lack of integrated planning between the health and education sectors on development of health professionals in relation to health care needs, and inadequate financing mechanisms for health professional development.

## Working environment

The third theme reviewed was the working environment of the health workforce. It is necessary to ensure a healthcare environment where the health workforce is valued and supported, and has the opportunity to develop while providing high-quality care. A set of interrelated issues, such as job design, performance management, remuneration, employment relationships, physical work environment and equipment, workplace cultures and HR practices, facility workforce planning and career pathing, affect the motivation and abilities of healthcare professionals.

Central to the work environment is the issue of management and leadership in the health sector and healthcare institutions. The MoH has attributed weaknesses evident in the health sector to the weakness of management and leadership at all levels of the health system.

Stakeholders identified abuse of remunerative work outside of the public service (RWOPS), staff turnover and insufficient implementation of performance management systems as affecting the productivity and motivation of health professionals.

A review of the HR and service transformation plans of the provincial DoHs revealed a lack of reliable and comparable information for planning and financing the health workforce.

# HRH Strategy for the Health Sector 2012/13 - 2016/17: Strategic priorities

Based on the review of the problems for HRH in the South African health sector, a vision and strategic priorities were developed.

The vision to implement re-engineered PHC, improve access to health care for all and health outcomes makes it is necessary to develop and employ new professionals and cadres to meet policy and health needs, increase workforce flexibility, improve ways of working and productivity of the existing workforce, improve retention and productivity, and revitalise aspects of education, training and research.

Achieving this requires an organisational infrastructure for education, training and service development – namely, effective and efficient AHCs. It also requires improved management of health professionals and cadres and improvement in their working lives.

Realising the vision of SA's HRH strategy requires firm, accountable and consultative leadership, well informed by information and planning capacity, processes and tools. Most important is Ministerial leadership and leadership of the NDoH to drive the process of change.

The following eight priorities were identified from the problem overview, to form the framework for the HRH strategy:

➢ leadership, governance and accountability;

➢ health workforce information and health workforce planning;

➢ re-engineering of the workforce to meet service needs;

➢ upscaling and revitalising of education, training and research;

➢ creation of the infrastructure for workforce and service development (AHCs and nursing colleges);

➢ strengthen and professionalise the management of HR and prioritise health workforce needs;

➢ ensure professional, quality care through oversight, regulation and continuing professional development; and

➢ improve access to health professionals and health care in rural and remote areas.

Each of these eight strategic priorities will be examined.

## Strategic priority 1: Leadership, governance and accountability

The NDoH is committed to playing a consistent leadership role in workforce planning. It will provide information, direction and oversight for HRH, enable provincial planning and ensure capacity and alignment with national priorities and outcomes. The NDoH will provide the enabling framework to ensure structures and processes for transparency, consultation and accountability in HRH. The NDoH Health Workforce Secretariat will lead the national HRH workforce planning process, with task teams and forums aligned to the eight strategic priorities.

A National Committee on Recruitment and Retention will be formed to develop strategies on recruitment and retention, manage foreign recruitment, and monitor recruitment, migration and retention of HRH. The committee will be tasked with redrafting the policy on foreign recruitment, and will initiate a drive for international recruitment to attract South African health professionals abroad to return, recruit academic clinicians for the short term, recruit foreign doctors for rural areas for the short term, and manage migration of foreign health professionals.

Leadership and management are required across the health workforce and at all levels of the health sector. Development of an NDoH Institute of Leadership and Management in Health Care is proposed; this will detail competency frameworks for leadership and management in the health sector at all levels, define the management qualification framework for job specifications, and design and commission courses for professional and in-service training.

## Strategic priority 2: Intelligence and planning

A significant impediment to current oversight and planning of health professionals for the health system and the anticipated NHI system is absence of an electronic database on health professionals. Health workforce planning systems and processes are also essential to ensuring HRH and impacting on health outcomes. Health professional workforce planning is challenging and involves a range of activities which require a high level of skill.

Box 1 shows some of the key components of health professional workforce planning, while Figure 1 shows the many dimensions of health workforce planning: the links between factors that influence inflow and outflow of health professionals, the link to policy, and interaction between derived demand and supply.

**Box 1:   Key components of health professional workforce planning**

➢ Ongoing provision of data and information on a range of subjects including numbers of health professionals  staffing numbers  training requirements  relevant policy developments

➢ Analysis of future supply and demand  looking at how many and what type of staff are likely to be required in the future  and how many and what type are available

➢ Creation of service plans which detail staffing requirements and link to what staff are available and how the staffing needs should be addressed

➢ Decisions about level of funding and skills available to support health professional workforce planning and how it should be planned and implemented

➢ Commissioning of training and education across all professional categories employed in the health sector

➢ A wide range of health professional development activities  including introduction of new and extended clinical roles and redistribution of staff responsibilities (task sharing and shifting)  increasing productivity  efficiency and quality of patient professional interaction

➢ Negotiation of contracts  including employment and service contracts

Developing the information, processes, systems and capacity for health workforce planning is a priority for the NDoH. Reliable and live information is necessary to inform health workforce planning and management, and the development of a Centre for Health Workforce Intelligence in NDoH is proposed. The Centre will provide intelligence on the health workforce which informs evidence-based workforce planning and development, and empowers leaders to make meaningful and practical decisions on the health workforce to achieve improved health outcomes.

**Figure 1:** Factors influencing health professional workforce supply and demand
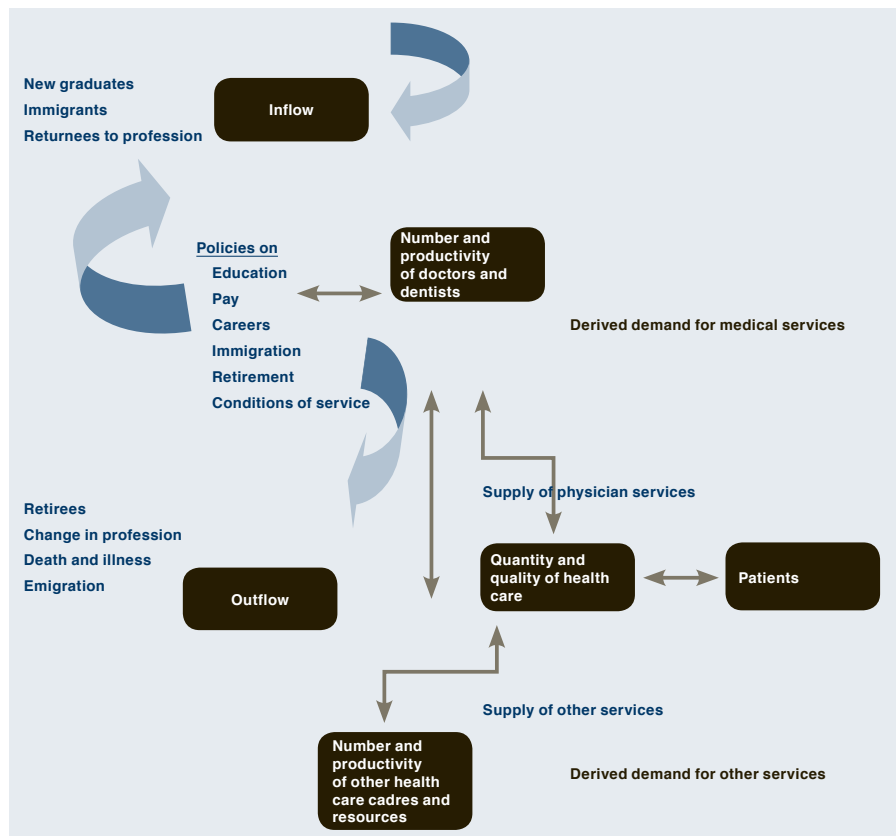


The NDoH Health Workforce Secretariat will develop Provincial Health Workforce Committees and ensure capacity in health workforce planning, integration of national workforce planning initiatives, and information to manage HRH.

## Strategic priority 3:
## A workforce for new service strategies ensuring value for money

The priority of the MoH is re-engineering of PHC and overhauling of the health system. The policy is that the PHC re-engineering will take place in three main streams, which are the district clinical specialist team model, the School Health Programme and the PHC outreach team comprising municipal ward-based PHC agents.

### Training, regulatory and employment implications

To implement the re-engineered PHC model it will be necessary to review and define roles and scopes of practice, task shifting and sharing, new professional categories and new cadres, new team relationships and new health interventions. Re-orientation and reskilling of existing staff will be required as well as training of new categories of staff. Current post structures at district level will need to be reviewed and new post structures created.

### Role of public health specialists and professionals

Public health specialists and public health professionals are going to be required to play a more strategic role in planning and monitoring population health. They are trained to assess the health needs of a community and recommend interventions, determine causes of ill health and disease, strengthen disease surveillance and prevention, develop health strategies and set priorities, evaluate effectiveness

of health care interventions and translate evidence into action, manage resources and provide leadership in community health, monitor and evaluate services, and monitor and evaluate the health of the population. Public health units at district and provincial level are proposed. Most important is the appointment of public health specialists at senior management level in provincial DoHs and development of public health skills and knowledge for the many public health sector managers charged with managing the population's health.

### Strengthening of the hospital sector and five flagship academic central hospitals

Strengthening the hospital sector is also an area for attention, which includes strengthening hospital management and infrastructure as well as ensuring appropriate staffing. The MoH has initiated a process to develop five flagship academic central hospitals which will enhance the tertiary and training sectors of the health system. Academic clinicians and a range of health professionals will be required to strengthen the staffing of these institutions.

### Meeting the workforce needs for NHI

The service delivery model for NHI is in the process of being conceptualised. The first step is the re-engineered PHC model. The detail of the service delivery model will only unfold in a process of stakeholder consultation in the short term and after strengthening of the hospital sector. The HRH strategy project team will need to work closely with the MoH's NHI Advisory Committee to detail HRH requirements as the NHI service model is formulated in detail. Clinical and non-clinical professionals will be required in greater numbers and with different skills and competencies. Essential will

be professionals skilled in management of resources, finance, health economics and clinical information, who will be responsible for facilitating the financing and contracting arrangements required for NHI.

### Contracting with private health professionals and private sector health care providers

Development of an NHI service delivery model is a process which gradually involves all service providers in the public and private sectors. There are significant numbers of health professionals working in the private sector, especially at primary care level and in rehabilitative care, who can be contracted to offer services in the public sector. The shortage of health professionals in SA is in significant part due to maldistribution between the public and private sectors. Contracting arrangements at all levels will be investigated to enhance equity of access to health care.

### Workforce planning for staffing all levels of the health system for NHI

Detailed workforce plans are required for all levels of the health system so that a minimum staffing level is built up and critical posts filled. Posts need to be planned and financed in order to build a balanced healthcare system which can provide a service delivery framework for NHI. In essence, all professional categories require strengthening.

## Strategic priority 4:
## Upscale and revitalise education, training and research

The NDoH is committed to expansion of the numbers of doctors, nurses and other health professionals as well as review of existing practice and productivity. Where appropriate the ways in which staff work will be changed to enhance skills and ensure retention of health professionals. The strategy is to realise the potential of the existing workforce and expand it where necessary. Expansion and recruitment must be carefully planned to avoid the 'boom and bust' scenario, with concurrent activities ensuring a meaningful working environment and funds for employing professionals upon graduation.

Expansion of most categories of the health professions and health cadres is required. Initial modelling on expansion has been undertaken as part of the HRH strategy development process, using the NDoH Health Workforce Planning Model. Higher education institutions and the professions will be encouraged to review these initial proposals and be part of a process of more refined forecast modelling, based on information informed by service plans and the current status and future of the professions.

The transformative role of health professional education for the health system needs to be recognised. In this way education becomes a crucial component of building the future health system.

## Strategic priority 5:
## Academic training and service platform interfaces

Academic Health Complexes and academic medicine have a critical role to play in the health system. The development of strong AHCs is central to development of the health system financed through NHI. Other training platforms, such as nursing, ambulance and provincial training colleges, are also critical to the

development of health professionals. Strengthening health service training platforms is vital to the HRH strategy.

A draft definition of the concept of an AHC in SA is proposed for consideration by stakeholders; AHCs:

➤ may consist of one or more health establishments at all levels of the national health system, including peripheral facilities;

➤ may take different organisational forms;

➤ may include one or more educational institutions working together to educate and train health care professionals at under- and postgraduate level in health promotion, disease prevention, and curative and rehabilitative medicine at primary, secondary and tertiary levels;

➤ have integrated governance and leadership structures that have assumed the role of strategically and operationally managing both healthcare and relevant academic resources;

➤ undertake educational and research activities which increase knowledge and understanding of health and disease;

➤ use knowledge and evidenced-based research as the basis for treating illness and improving health;

➤ design and test new models for improved clinical care, service delivery and improvement of population health; and

➤ advise Government on population health and health care.

A project team appointed by the MoH is proposed to elaborate activities for strengthening of AHCs based on an organisational model which integrates governance and leadership structures to strategically and operationally manage both health care and relevant academic resources.

## Strategic priority 6:
## Professional HR management

Provincial DoHs are responsible for development of HR management strategies and HRH plans, which also must comply with Department of Public Service and Administration (DPSA) requirements. A process of strengthening HR management strategies is proposed as well as alignment of the DPSA HR plan format with health sector-specific requirements. Provincial DoHs are encouraged where appropriate to strengthen the HR management function to address work environment issues that affect the recruitment, retention and careers of health professionals. Provincial DoHs are encouraged to develop HRH strategic plans for 2012/13 - 2016/17 which are aligned with the priorities of the HRH SA strategy for 2012/13 - 2016/17.

An audit of the health workforce in each province is proposed, which specifically should detail health workforce numbers and requirements; structures, policies and procedures which act as barriers to recruitment and retention; and attitudes and perceptions which affect recruitment and retention. A proposal is made to strengthen the role and responsibilities of the HR management function to refine the roles of HR and line managers.

Improved workforce performance is proposed through implement-ation of performance management in healthcare institutions. The abuse of RWOPS and moonlighting is highlighted, and the relevant executive authority encouraged to ensure that the provisions of

the Public Service Act in relation to additional outside work are implemented. A review of the OSD is proposed with a view to ensuring appropriate incentives to retain health professionals' in urban and rural areas.

## Strategic priority 7: Quality professional care

Ensuring quality professional care is an ongoing process which requires strong Statutory Council oversight over professional training and practice, ensuring quality of the clinical training environment for undergraduate and postgraduate health professions. Ongoing professional development linked to health priorities, development of new technologies and new clinical interventions must be ensured. It must also be ensured that the working environment in which health professionals practice is conducive to quality health care, with oversight and firm action on professional malpractice. Guidance and protocols on clinical best practice and evaluation of new clinical interventions for NHI must be provided, with high-level ongoing interaction between the NDoH and the Statutory Councils. The Statutory Councils must be adequately resourced for their functions.

### Licensing of health professional practices

It is recommended that all health professionals must be licensed to practice, re-registration with the relevant council being a relevant criterion. Health professionals should only be allowed to practice in the clinical area for which they are professionally qualified. In addition, the physical facility of the practice must be licensed for the professional and service functions to be performed.

### National Coordinating Centre for Clinical Excellence in Health and Health Care

The development of a health system financed by NHI and setting the objective of providing universal coverage and access to care requires that a similar standard of care should be offered to all. Currently national guidelines exist for priority programmes such as HIV and AIDS and TB, for example. All of the professional associations have guidelines and standards for care in their particular area. In an academic training setting protocols and standards are locally set, but need to become part of national guidelines for best practice. National protocols and guidelines will be required for the NHI services and healthcare interventions. In many cases this will mean coordinating with existing associations and professional groups. Additional resources will be required to develop guidelines and protocols, and provide evidence-based recommendations and standards for quality clinical care.

An NDoH National Coordinating Centre for Clinical Excellence in Health and Health Care will be established. The operations of the Centre will be located at various sites: academic sites of excellence, the Medical Research Council and the NDoH. The central office will provide a coordinating function. It will bring together associations, professional groups, provincial DoHs and the academic community to define and oversee quality professional clinical health care. The Centre will:

➢ provide guidance on new and existing medicines, treatments and procedures, and treating and caring for people with specific diseases and conditions;

➢ make recommendations to the NDoH, provincial DoHs, municipalities and other organisations in the public, private, voluntary and community sectors on how to improve people's health and prevent illness and disease;

➢ advise on cost and effectiveness of medicines, procedures and interventions that will be offered in an NHI healthcare environment;

➢ provide evidence for healthcare interventions and practice;

➢ develop and define the clinical standards of health care that people can expect to receive from services which are part of the NHI package of healthcare delivery;

➢ provide guidance on standards for clinical treatment (or set of clinical procedures) and indicate if they are considered highly effective, cost-effective and safe, as well as being viewed as a positive experience by patients; and

➢ develop a quality and outcomes framework for primary care practitioners and PHC NHI practice.

## Strategic priority 8: Access to health professionals in rural and remote areas

### Special strategy on access to health professionals in rural and remote areas

There has not been a substantial change in access to health professionals in rural and remote areas in the past 15 years, and health outcomes in rural areas have become worse. There is also no history or culture in SA of incorporating rural areas into mainstream health professional training, which is essential in making these sites attractive to future professionals. Most health services do not consider the provision of facilities for students, and there are no faculties yet running mainstream, longer-term rural health placements for students. There is also little understanding on the part of administrative staff of approaches required to recruit and retain health professionals in rural areas, and even sometimes of their value to the health service as having scarce skills. These specific issues indicate the need for a special strategy on access to health professionals in rural and remote areas.

### Special financing mechanisms, staffing norms and other adjustments

The environment for rural health care is very different to that for urban health care, which impacts on strategies and interventions to improve access to HRH in rural areas. Some of the factors which need to be taken into account include the fact that access to health care is generally more difficult, and rural communities face additional economic costs in accessing the health care system. Indirect costs, including transport, are higher for the rural poor.

People living in rural areas are often poor, and the health status of rural communities in SA is generally poorer than communities in urban areas. Also, the consequences for individuals of a failing in the poorly resourced health system are more costly to rectify in rural areas than among the urban poor.

How HR (inputs) is used to achieve desired outcomes (improved health outcomes) is different due to the different circumstances, and may require higher staffing ratios with special skills.

Strategies to overcome these inequities in rural health care need

to be customised and appropriately resourced. This may include a disproportionately high allocation of budget to attract, recruit and retain HRH in the health care sector. Development of facilities and staffing will also be more costly due to adjustments for lack of infrastructure and a generally under-resourced environment.

### Integrated strategy for improved access into rural and remote areas

An integrated strategy is proposed to improve access to health professionals in rural and remote areas, which includes short-term strategies to 'nurture' community service professionals and improve recruitment of foreign and local professionals for rural areas, and an educational strategy based on World Health Organization guidelines for rural and remote areas. It will also include regulatory strategies regarding competencies and scopes of practice for health professionals in rural and remote areas, and financial incentives to attract health professionals to work in rural areas. Personal and professional support will be provided for health professionals working and training in rural and remote areas.

## Conclusion

The NDoH has proposed a strategy for HRH for SA for 2012/13 - 2016/17. The strategy document is a guide to action and requires participation of all stakeholders to make it a 'living' document which enables improvement in HRH. The long-term future of the health sector will be determined by our actions in relation to HRH in the short term, specifically in the next five years.

The NDoH and stakeholders in the health sector have a responsibility to act in a purposeful and considered manner to improve HRH capacity and health outcomes.

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