Human resources for health and universal health coverage: progress, complexities and contestations

Human resources for health (HRH) are critical to the achievement of universal health coverage reforms. Drawing on theories of the health labour market, this chapter highlights the progress, complexities and contestations pertaining to HRH since publication of the last South African Health Review.

Positive HRH developments during the review period include: government’s commitment to developing HRH norms and standards; confirmation of a relatively strong health professional regulatory framework that provides a foundation for reforms; the publication of a major study on health professions education; and embryonic initiatives to develop HRH strategic plans linked to universal health coverage.

Major gaps and weaknesses in the current HRH foundation must be addressed to ensure a high-quality health system and the success of the proposed national health insurance (NHI) reforms. These weaknesses include: insufficient stewardship of HRH planning across the entire healthcare system; lack of a national integrated HRH information system, and inadequate information on overall HRH supply to address historical inequities between urban and rural areas and the public and private health sectors; gaps, and at times failures, in HRH governance; fragmentation, weak coordination and suboptimal governance of health sciences education; and poor and ineffective operational management across all types of health facilities and provincial health departments, with rural provinces worse off than their urban counterparts.

Key recommendations include enhancing HRH technical capacity and expertise in the National Department of Health to provide strategic leadership and support for the entire health system; recruitment of public servants with the right skills, competencies, ethos and values; and the equitable allocation of resources to rural and/or underserved areas.
Introduction

Since the launch of the 20th edition of the South African Health Review (SAHR) in August 2017, the Life Esidimeni catastrophe, or more accurately the Gauteng Mental Health Marathon Project (GMHMP), has dominated the health media headlines. At face value, the GMHMP centres on human rights violations and the lack of compassion and care for vulnerable individuals with mental illness, in the context of a largely dysfunctional and unaccountable provincial healthcare system. However, the GMHMP is also a case study of human resources for health (HRH) governance, albeit a tragic one, showing the criticality of HRH to resilient healthcare systems, and universal health coverage (UHC).

This chapter highlights the progress, complexities and contestations pertaining to HRH for UHC and high-quality health systems in South Africa. We used theories of the health labour market and inputs from a HRH consultative workshop in April 2018 to review key HRH developments since publication of the 2017 SAHR. Sources of data include published annual reports and policy documents or statements by national and provincial health departments; reports by the Auditor-General of South Africa (AGSA); the Competition Commission Health Market Inquiry; the inspection report of the Office of Health Standards Compliance (OHSC); the GMHMP arbitration award; and relevant published studies or reports from advocacy organisations.

The chapter begins by introducing the conceptual framework used to assess HRH progress, complexities and contestations in the key domains of demand, supply, health professional education, HRH governance, and HRH management. The chapter concludes with key recommendations on HRH to ensure a high-quality health system and to move closer to the goal of UHC expressed in the National Health Insurance (NHI) Bill of South Africa.

Conceptual framework for analysis

There is global recognition that HRH respond to policy and institutional changes, as well as to external forces, with increasing scholarly focus on the economic factors that affect the nature and size of the global HRH crisis. A health labour market (Figure 1) is defined as “a dynamic system comprising two distinct but closely related economic forces: the supply of health workers and the demand for such workers, whose actions are shaped by a country’s institutions and regulations.”

Figure 1: Conceptual framework of the health labour market

![Conceptual framework of the health labour market](source: Adapted from Soucat et al., 2013)
Progress, complexities and contestations

Need and demand for HRH

South Africa ranks among the top five countries in the Africa region in terms of density of physicians and nursing and midwifery personnel per 1 000 population. However, there are several reports of acute staff shortages in the public health sector in general, and in rural and underserved areas in particular. Hence the question as to the number and categories of health professionals needed in South Africa is a vexed one, influenced by the definition of need, the skills mix and scope of practice of different categories of health workers, resource availability, and the methodological approach used to determine need.

A positive aspect is that the National Department of Health (NDoH) has set a strategic goal of developing and implementing health workforce staffing norms and standards for health facilities, using the Workload Indicators of Staffing Need (WISN) method. The WISN, developed by the World Health Organization (WHO), is based on a health worker’s workload, with activity (time) standards applied for each workload component. The tool assesses workload pressures on health workers in health facilities and determines the number of each category of health worker needed to cope with the facility workload. WISN is applicable to government, non-governmental organisations (NGOs) and private health facilities.

In 2017, the NDoH reported that the activity standards for district hospitals had been completed. However, the NDoH was unable to meet its target of approving HRH norms for district and specialised hospitals due to the unavailability of data on district hospital service activities. Failure to meet the target of HRH norms for district and specialised hospitals in turn affected the development of HRH norms for regional, tertiary and central hospitals.

Furthermore, the WISN approach seems to be the only method adopted by the NDoH for HRH planning, but it has several limitations. These limitations include dependence on the accuracy of annual service statistics used to assess workloads; possible over-reporting of annual service statistics; inability to differentiate when the same activity is performed by two different staff categories; and insufficient consideration of the unique circumstances and HRH needs in rural areas. In line with proposals from some health economists, it may be more appropriate to use a combination of integrated needs-based HRH planning methods. These methods should include consideration of: demographic and epidemiological changes; impact of health policies on service delivery; quality and equity; prioritisation of underserved areas; workforce and health expenditure; level of services; and the productivity of healthcare workers.

South Africa has some way to go in HRH planning across the entire healthcare system. Thus far, the NDoH has focused on the public health sector for the determination of norms and standards, and excluded the private health sector where the majority of highly skilled healthcare providers are located. Although the planned NHI system may correct suboptimal HRH stewardship across the health system, the current NHI Bill contains insufficient detail on this critical issue.

Supply of HRH

The supply of HRH is essential for UHC and for the successful implementation of NHI. A detailed overview of different categories of health personnel is provided elsewhere in this edition of the SAHR, using a combination of the government personnel salary administration (PERSA) system and the databases of health professional councils. However, HRH information systems remain underdeveloped and under-utilised. Data exclude information on environmental health officers, nurses, doctors and other categories of health workers employed by municipalities. Comprehensive information is lacking on the numbers of practising health workers in the country due to limited information in the health professional council databases. Many health professionals maintain their registration even though they may have emigrated or no longer practise their profession. Updated and accurate information is also lacking on the maldistribution of healthcare personnel between urban and rural areas, between the public and private healthcare sectors, and within provinces. Nonetheless, in 2015, 56.3% of all general practitioners and 73.3% of all nurses worked in the public sector, while only 35.8% of medical specialists and less than one-third of dentists worked in the public sector. This maldistribution is exacerbated by the scarcity of posts for dentists and rehabilitation therapists in the public health sector.

The main issues of contestation regarding HRH supply are summarised in Table 1.

<table>
<thead>
<tr>
<th>Table 1: Contestations of HRH supply in South Africa, 2017/18</th>
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<tbody>
<tr>
<td>Lack of a national integrated HRH system that ensures standardised data collection and analysis.</td>
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<tr>
<td>Inadequate information on overall HRH supply: size, composition and/or deployment.</td>
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<tr>
<td>Lack of data harmonisation across health professional councils.</td>
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<td>Disjuncture between the increased production of medical graduates and the ability of public sector health facilities to absorb interns.</td>
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<tr>
<td>Difficulties in placement of community service health professionals, exacerbated by a reluctance of new graduates to go to rural areas, funding constraints, and freezing of posts.</td>
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<tr>
<td>Policy uncertainty on mid-level and community health workers, including their scope of practice, position in the healthcare system and relationships with other health professionals.</td>
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<tr>
<td>Maldistribution of health workers between public and private health sectors, and between urban and rural areas.</td>
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Sources: Day et al., 2018; Rural Health Advocacy Project, 2018; Academy of Science of South Africa, 2018; Competition Commission of South Africa, 2018.

Training and education

The supply and quality of health workers are determined largely by the pre-service education of health professionals. A significant positive development during the period under review was the release of the consensus study by the Academy of Science of South Africa (ASSAf) on health professional education. The ASSAf study provides evidence-based information and recommendations on the transformation of health professional education in South Africa to ensure improved population health. The key findings and recommendations of the ASSAf study are shown in Table 2.
Table 2: Key findings and recommendations of the Academy of Science of South Africa consensus study on health professions education, 2018

**Major findings**

- South Africa is renowned for healthcare professional education and training excellence, but this is constrained by fragmentation, weak coordination and poor governance.
- Around R12 billion is spent annually in South Africa on health sciences education, through multiple fragmented funding streams and departments.
- There is inefficient use of resources, with shortfalls in the quantity, quality and relevance of healthcare professional education and training for the health needs of the country.
- Barriers to health professional student selection and success include: variation in quality of schooling; inequities in career guidance and access to information; inequities in availability of staff, finance, and facilities at universities to conduct selection processes and academic monitoring, assistance and follow-up; lack of resources and time to develop and perform psychometric tests on select students.
- Current experience of internship may undermine the vision and intention of undergraduate health professional education.
- Although service demands have outweighed learning in the community service programme, most community service professionals report positive professional growth and development.

**Main recommendations**

Student selection should be reconceptualised using a broader set of criteria than those currently in use. Selection and training should be oriented towards addressing inequity and meeting the needs of the most underserved, through supporting a primary health care focus and increasing the supply of healthcare professionals to rural areas.

Public sector academic institutions need to be strengthened to scale up the production of healthcare professionals.

Professional bodies should ensure that their information systems reflect sufficient details on practice location to allow adequate health workforce planning.

The clinical training platform should be expanded to include both public and private healthcare facilities.

Universities should take responsibility for education and professional development from the undergraduate years through to internship and community service.

Inter-professional education and collaborative practice should be developed and implemented in health professional education.

Governance of health sciences funding should be enhanced by strengthening the capacity and accelerating the momentum of the Joint Health Science Education Committee.

Human resource planning, resource allocation and budgeting need to be improved.

Source: ASSAf, 2018

**HRH governance**

The WHO defines governance as the “existence of strategic policy frameworks, combined with effective oversight, coalition building, regulation, attention to systems design, and accountability”. In concert with this definition, Kaplan et al. have defined eight HRH governance principles: strategic vision, accountability, information, transparency, efficiency, equity/fairness, responsiveness, and citizen voice and participation.

Education and training and scope of health professional practice are well regulated in South Africa, which is positive. During the period under review, the South African Nursing Council (SANC) appointed a new registrar, and improved communication with members through an electronic newsletter that commenced in March 2018. However, the planned phasing out of legacy nursing qualifications has been postponed yet again, which will have grave consequences for the future production of nurses. This is because the Minister of Higher Education and Training issued a notice that no training can be provided by nursing colleges beyond 2019 unless they are registered as higher education institutions. Further, there is no published annual report for the 2016/17 financial year to provide an overview of the SANC’s progress and achievements against its legislative mandate. The postponement of critical nursing education reforms, the lack of a detailed annual report, and delays in the appointment of the new Nursing Council reflect gaps in governance and lack of prioritisation of nurses and nursing. This is of concern given the numerical dominance of nurses and their importance to the healthcare system.

The Health Professions Council of South Africa (HPCSA) has published a 2016/17 annual report, but remains without a permanent registrar. A 2015 Ministerial Task Team on the HPCSA found numerous systemic and complex problems, including mismanagement and poor governance, erosion of confidence in the HPCSA, and administrative irregularities. Three years later, the Health Market Inquiry found that despite the important role of the HPCSA, gaps remain in governance of health professionals under its jurisdiction, leading to unintended negative consequences such as lack of innovation and poor cost containment. Furthermore, the Inquiry found that the HPCSA lacks the capacity to enforce ethical rules and to deal speedily with complaints, thereby falling short of a core criterion of a regulatory body.

South Africa’s five-year strategic plans on HRH and nursing education, training and practice expired during 2017. Although there are moves afoot to review performance on both strategic plans, development of new strategic plans has been hampered by lack of technical capacity, and instability in senior management responsible for HRH. Two new HRH chief directors have been appointed in the NDDoH in the space of one year. As pointed out earlier, South Africa lacks a national integrated HRH information system and the NDDoH should be the custodian of this. This situation is exacerbated by gaps in the information provided by the health professions councils.

During the review period, extensive and disruptive industrial action on the part of health workers in Gauteng, Limpopo and North West provinces collided with dysfunctional and weak public healthcare systems. The reported reasons for the industrial action ranged from failure to pay performance bonuses to allegations of corrupt provincial administrations. The industrial action in the three provinces served to highlight a complex and overlapping set of problems, including inadequate or poor implementation of dispute resolution mechanisms provided for in the Labour Relations Act, poor management of health-worker grievances, failure to finalise the minimum service level agreement in the central bargaining council, and inadequate performance management. These problems impact ultimately on the right of people to access healthcare services, and lead to avoidable deaths and further weakening of a fragile healthcare system.

Both the GMHMP catastrophe and industrial action by health workers highlighted additional fault lines in HRH governance (Table 3). In the case of the GMHMP, some health professionals honoured their professional and ethical codes of conduct. At the same time, the GMHMP demonstrated that institutional and professional mechanisms failed to prevent the tragedy, and that this was exacerbated by lack of accountability on the part of public health officials at all levels of the health system.
Table 3: HRH governance fault lines in the Gauteng Mental Health Marathon Project, South Africa, 2017

**Fault lines**

| Inadequate planning, with insufficient preparation and rushed implementation. |
| Failure of accountability at all levels of the healthcare system, including inadequate explanations as to why the GMHMP was initiated and what happened. |
| No mechanisms for independent oversight, monitoring, review and audit. |
| Some health professionals violated the Constitution and other laws, as well as their professional code of ethics, thus showing disregard for the rights of the patients and their families. |
| Both SANC and the HPCSA failed in their mandate to protect the public: there was lack of proactive investigation into the transgression of ethical codes once the facts on the professionals concerned were in the public domain. |


HRH management

HRH management refers to institutional and behavioural ways of making decisions on a range of issues, such as staff recruitment, selection and retention, employee discipline, and employment termination. An effective HRH manager "motivates health workers to perform by aligning their goals with those of the organisation and narrowing the gap between an employee’s ability and performance".

The 2016/17 inspection report by the Office of Health Standards Compliance (OHSC), the independent quality-of-care regulator, highlights suboptimal performance in the ‘operational management’ domain in all nine provinces (Figure 2). This domain measures compliance with national core standards, notably the ability of a health facility to provide safe and effective patient care through effective management of human resources, finances, assets and consumables, and records and information on the provision of scheduled services.

Although Gauteng, KwaZulu-Natal and the Western Cape obtained higher scores than the more rural provinces, their average scores were lower than 70%, demonstrating poor operational management of facilities inspected.

Figure 3 shows the average national operational management scores for hospitals, community health centres (CHCs) and clinics inspected during the review period.

Figure 3: Average national performance scores for operational management by facility type, South Africa, 2016/17

Overall, the average performance scores for hospitals were marginally higher than those for CHCs and clinics, but were very low at 41%. This means that one in every two hospitals inspected during 2016/17 met the national core standards for operational management.
The poor operational management scores across facility types and the nine provincial health departments are of concern, as evidence suggests that effective operational management is correlated positively with health worker retention and performance.\(^3\)

The ASSAf consensus study on health professional education compared the number of graduates for selected professions, over a given period, with the increase in number of new appointments in the public sector.\(^19\) The approach has limitations as it does not track individual graduates but compares graduate output with total new appointments in the public sector in a given year, irrespective of when such graduates qualified.\(^19\) In addition, there are a limited number of public sector posts for rehabilitation therapists, and these graduates have little option but to move to the private sector following their community service. Nevertheless, the comparisons between graduate output and public sector increase suggest poor retention or absorption of newly graduating health professionals in the public health sector (Table 4).\(^19\)

**Conclusion and recommendations**

There have been several positive HRH developments during the review period: government’s commitment to developing HRH norms and standards; existence of health professions regulators that provide a foundation for essential HRH reforms; publication of the ASSAf consensus study on health professional education, which contains detailed recommendations; and embryonic initiatives to develop HRH strategic plans linked to UHC.

Five major gaps and/or weaknesses in the current HRH foundation must be addressed to ensure high-quality health systems and the success of NHI reforms. These gaps/weaknesses are:

- Failures in governance at all levels of the healthcare system and healthcare facilities, as well as on the part of health professions regulators.
- Insufficient stewardship of HRH planning across the entire healthcare system.
- Lack of a national integrated HRH information system, including inadequate information on overall HRH supply to address historical inequities between urban and rural areas and the public and private health sectors.
- Fragmentation, weak coordination and suboptimal governance of health sciences education, contributing to the inefficient use of resources and shortfalls in the quantity, quality and relevance of healthcare professional education and training.
- Poor operational management at health facility level, across type of facility and provincial health department, with rural provinces worse off than their urban counterparts.

Ensuring adequate HRH is a critical requirement in achieving global UHC goals.\(^2,8\) The success of the proposed NHI in South Africa will depend on addressing the identified HRH weaknesses and on strategic investment in the people who enable healthy communities and high-performance health systems. Deeper health labour market analyses are required to understand the economic forces affecting the supply and demand of the health workforce.

We therefore recommend the following HRH strategies:

**Enhance HRH technical capacity and expertise in the NDoH**

Improving the capacity of national HRH staff to develop, lead and implement HRH policies and strategies is critical on the road to achieving UHC. Capacity is required at both the individual and institutional level, involving both additional staff and advanced analytic skills.\(^36\) We therefore recommend the following:

- A mapping exercise should be conducted to assess the capacity needs of the national HRH staff on all eight governance elements of strategic vision, accountability, information, transparency, efficiency, equity/fairness, responsiveness, and citizen voice and participation. In addition to training, ongoing coaching and mentoring should be done to facilitate ownership, strengthen skills transfer, and build institutional memory overtime. Relevant indicators should be developed to monitor and evaluate the success of this initiative. For sustainability purposes, efforts should be made to ensure leadership stability.

**Recruit public servants with the right skills, competencies, ethos and values**

Recruitment and selection of people with the right skills and competencies are critical to the success of the NHI reforms. In many LMICs including South Africa, recruitment and selection processes are often influenced by political interference, nepotism and corruption rather than merit or having the correct values.\(^37,38\) The following recommendations should be considered:

- More professional and objective selection systems and processes need to be developed and applied.\(^37\)
- More innovative strategies are required to select health workers with values that include a commitment to public service, health equity, working in under-served areas, honesty and integrity.

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### Table 4: Comparison between graduate output and public-sector increase in number of health profession graduates appointed in the South African public health sector, 2002–2010

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Graduate output (n)</th>
<th>Public sector increase (n)</th>
<th>Retention gap (n)</th>
<th>Retention gap (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine</td>
<td>11 700</td>
<td>4 403</td>
<td>7 297</td>
<td>62.4</td>
</tr>
<tr>
<td>Dentistry</td>
<td>2 140</td>
<td>248</td>
<td>1 892</td>
<td>88.4</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>3 645</td>
<td>1 960</td>
<td>1 685</td>
<td>46.2</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2 934</td>
<td>497</td>
<td>2 437</td>
<td>83.1</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>1 827</td>
<td>410</td>
<td>1 417</td>
<td>77.6</td>
</tr>
<tr>
<td>Speech-language pathology and audiology</td>
<td>1 413</td>
<td>265</td>
<td>1 148</td>
<td>81.2</td>
</tr>
<tr>
<td>Dietetics</td>
<td>657</td>
<td>502</td>
<td>155</td>
<td>23.6</td>
</tr>
</tbody>
</table>

Source: ASSAf, 2018.\(^19\)
More staff with public health competencies should be employed, including competencies in health promotion and protection, disease prevention, epidemiology, monitoring and evaluation, and strategic management.

**Improve performance management system**

Better outcomes can be achieved by improving the performance of the health workers we already have. Specific recommendations are:

- A review should be done of the performance management system and its implementation to improve the link between staff performance, organisational performance and health outcomes.

In other settings, the implementation of performance-related remuneration systems has been recommended to promote the achievement of UHC. Rewards for team-based performance and the achievement of clear performance outcomes could be considered in South Africa.

Management capabilities in the public sector should be enhanced to address employees’ discontentment with their poor working conditions and wages in order to reduce the impact of employees’ strikes on the delivery of health services. This will encourage professionalism, respect and improved relationships between management and employees.

**Increase allocation of HRH in rural and/or underserved areas**

Achieving universal access to quality health care for all citizens implies that historical inequities in HRH allocation and distribution should be addressed to improve coverage. Despite the government’s commitment to health equity, little progress has been made in changing the way in which financial resources are allocated to ensure distribution according to the relative need for health services.\(^39,40\) We therefore recommend the following:

- Increase capacity of health service managers from poorer, rural provinces to understand different spending options to enable the optimal use and management of resources allocated. This can be done by ensuring that appropriate structures and processes are in place and that relevant training and ongoing support are provided.

- Strategies for attracting more dedicated health professionals to work in rural and underserved areas are required. These may include a combination of financial and non-financial interventions such as creating positive practice environments, improving opportunities for professional advancement, and supportive supervision.\(^41\)

**Immediate Priorities**

The immediate short-term priorities for HRH in South Africa are to:

- Develop an updated HRH strategic plan, with a clear monitoring and evaluation framework.

- Engage with the ASSAf study recommendations and incorporate urgent recommendations into the updated HRH strategic plan.

- Explore the development of an integrated HRH information system that optimises existing systems and that harmonises data from professional councils.

- Develop norms and standards for the entire healthcare system, in consultation with all relevant stakeholders, and aligned with the proposed NHI reforms.

- Provide stewardship of both the public and private health sectors through appropriate and accountable governance structures.

- Ensure regulatory enforcement and oversight of health professions councils, especially SANC and the HPCSA.

- Address the uncertainty and gaps in policy with regard to mid-level health workers and community health workers [see chapter 7],\(^42\) and integrate solutions into the updated HRH plan.

- Monitor implementation of legislation and key policies in provincial health departments.
References


40 McIntyre D, Ataguba J. Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge. Cape Town: Health Economics Unit, Cape Town; n/d.
