

Human Resources for Health – Challenges and Solutions

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The health-related objectives of the National Development Plan, the health-related outcomes of the South African government’s Programme of Action 2010-2014 and the Ten Point Strategic Plan of the national Department of Health (DoH), particularly the implementation of the National Health Insurance and progress towards health-related Millennium Development Goals, is contingent on a skilled, competent, multi-professional and inter-professional health workforce working synergistically to address the quadruple burden of disease.

It is however evident from Table 1, compiled from the World Health Statistics 2011 (1) and the Human Resources Strategy of the national DoH (2), that health worker (particularly doctors and pharmacists) density/100 000 population is substantially lower in South Africa compared to the vast majority of countries against which South Africa is benchmarked, including the BRIC (Brazil, Russia, India and China) countries. The existing higher education sector is unable to meet the graduate output required by the health sector while foreign recruitment is constrained by current legislation on the registration and practice of foreign healthcare professionals by the Professional Councils and the WHO Global Code of Practice on the International Recruitment of Health Personnel (3). Existing and future health workforce production is not commensurate with the healthcare needs of the country.

Table 1: Average Health Worker Statistics/100 000 population

	Medical Doctors	Nurses	Pharmacists
South Africa 2011	28	293	8
South Africa 2025	36	354	10
Brazil	172	650	54
Russia	431	852	8
India	60	130	52
China	142	138	25
Argentina	316	48	50
Chile	109	63	-
Costa Rica	132	93	53
Colombia	135	55	-
Korea	197	53	12
Singapore	183	590	37
Thailand	30	152	12
Vietnam	122	101	32

While the global agencies and national Departments of Health focus, sometimes exclusively, on the quantitative aspects of the health workforce, a Lancet Commission highlighted curriculum-related qualitative aspects, specifically the failure of existing curricula globally to produce a health workforce that is able to “mobilize knowledge and engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams” (4). The problem statement included the fact that health challenges have outpaced

curriculum reform; fragmented, outdated, static curricula produce ill-equipped health graduates; there are episodic encounters as opposed to a continuum of care; healthcare is hospi-centric as opposed to primary healthcare based; there is narrow technical focus without contextual understanding; there exists a mismatch of competencies and patient/population needs; and there is poor teamwork (4).

These qualitative curriculum-related aspects require collaboration between Universities, the Council for Higher Education’s Higher Education Quality Committee, the DoH and the Education Boards of Professional Councils to develop a shared vision on quality assurance and accreditation in the context of knowledge, skills and competences required of healthcare professionals in the South African healthcare context.

Solutions to barriers related to the quantitative aspect of health workforce production in South Africa are elucidated in Table 2.

Table 2: Solutions to Challenges within Existing and Innovative Paradigms

Challenges	Solutions
Inadequate infrastructure – teaching and learning spaces, skills laboratories, residences.	<ul style="list-style-type: none"> • Infrastructure and Efficiency (I & E) Grant should continue for a defined duration until infrastructural requirements are met (Note 1). • Private Health Sciences higher education and training institutions.
Inadequate clinical teaching and training platform both in available student placement sites as well as the facilities at these sites for non-clinical teaching and learning.	<ul style="list-style-type: none"> • The imminent allocation of the Health Professional Training and Development Grant (HPTDG) to Universities provides an opportunity to re-negotiate joint health education and services agreements with their commensurate teaching platforms and staff establishments (Note 2). • The I & E grant should be used to address the limited/lack of non-clinical teaching and learning spaces. • The existing inter-governmental partnerships such as the South Africa-Cuba partnership for the training of medical doctors should be expanded to priority health professional programmes and refined to place students in English-speaking countries with similar health systems. • Public-private partnerships with the private sector: (a) increasing output by way of private Health Sciences higher education and training institutions and/or (b) accommodating students for mandatory clinical training/experiential learning.
Shortage of clinical supervisors within the clinical teaching and training platform as a result of high vacancy rates and high workloads within public sector student placement sites.	<ul style="list-style-type: none"> • The staffing component of the Clinical Training Grant (CTG) should be continued in perpetuity to address the number of staff required to undertake clinical supervision in fulfilment of the experiential training component requirements mandated by the Professional Councils.

Staff : student ratios mandated by the professional councils are increasingly difficult to effect.	<ul style="list-style-type: none"> • Innovative public-private partnerships/service level agreements with the private health sector/other governments accommodating students for mandatory clinical training/experiential learning.
Limited and dwindling pool of credentialed healthcare professionals pursuing careers in the academic health sciences.	<ul style="list-style-type: none"> • Incentivisation by remuneration packages commensurate with those in the private and now public sector with OSD implementation. • Specific academic health sciences salary scales.
Increased operational costs, particularly transport costs linked to expanded clinical teaching and training platform.	<ul style="list-style-type: none"> • The operational component of the CTG has to be continued in perpetuity to address this.

The Ministries of Health and Higher Education and Training in South Africa should give serious consideration to giving effect to the recommendation on private providers contained in the Green Paper for Post-School Education and Training, specifically, working with vetted private health sciences education providers to strengthen and expand provision in compliance with quality and accreditation requirements in priority and/or scarce skill areas (5).

Notes:

1. The Infrastructure and Efficiency Grant and the Clinical Training Grant are earmarked grants from the Department of Higher Education and Training (DoHET) to Universities to increase graduate output and provide quality clinical training on the DoH clinical training platform
2. The Health Professional Training and Development Grant (HPTDG) is allocated to public health facilities by the DoH to defray the additional costs incurred as a result of the clinical training of undergraduate and postgraduate health sciences students.
3. *Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.*
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