



## Human Resource Plan - What does South Africa need?

In the eleventh year of our democracy, the Department of Health still has no clear Human Resource Plan in place. In 2004 RuDASA and other stakeholders had been invited to meetings. At the time the Minister of Health announced that the plan would be made public for comment by March 2005, then end of June 2005 ... We are still waiting.

While we are waiting, most rural and urban hospitals and clinics are in dire need of staff. Care of the vulnerable section of our population who cannot afford private health care is compromised due to staff shortages. The ARV roll-out is far behind its targets. The "3 by 5" progress report released by the World Health Organisation revealed that South Africa had fallen short of its target by a staggering 866 000 patients<sup>1</sup>.

It has been said that we do not really have too few health professionals in the country, they are just maldistributed<sup>2</sup>. Only 33.8% of doctors and 44% of professional nurses work in the public sector that serves 80% of the population. One only has to look at the distribution of public sector doctors by province, to get an idea of the maldistribution between more rural and more urbanised provinces<sup>3</sup>. The WHO minimum standard is 1 doctor per 5000 people, or 20 per 100 000<sup>4</sup>. Just to add some perspective, in Lesotho there are an estimated 5.4 doctors / 100 000 and the DRC 6.9 / 100 000<sup>4</sup>.

What would we like to see in the Human Resource Plan? Firstly, the plan needs to look at every section of the pipeline producing health workers. It starts with high school and the selection of students. Research has shown that rural origin medical students are three times more likely to choose a career in rural practice than their urban counterparts<sup>5</sup>. A best practice example is the Mosvold project, where the sub-district selects local students according to their projected HR needs and assists them during their training in return for a commitment of working in the sub-district after qualification<sup>6</sup>.

There are serious concerns about the decrease in the number of nurses currently produced in South Africa which is much less than the demand and projected need. The Pick report<sup>7</sup> did not see nursing as a problem area, but the recent migration of nurses has led to shortages in almost all health facilities. Migration tends to happen from rural to urban, from public to private and from local to developed countries. Once again it is the most marginalised – poor rural people – who suffer most due to these shortages. The closure of rural nursing schools in favour of centralised nursing training, has certainly contributed to the problem.

A clear recruitment and retention strategy needs to be part of any Human Resource Plan. Several factors need to be taken into consideration. Remuneration is not the only factor, as shown by research done after the introduction of the new rural allowances<sup>8</sup>. Addressing working conditions can go a long way in attracting and retaining staff. Hermann Reuter, (Rural doctor of the year 2004) emphasises that the Department of Health should look after staff (working and living conditions) if they want them to stay. At their hospital in Lusikisiki several nurses live in shacks outside the hospital grounds because there is inadequate nursing accommodation. For those who walk home to the village at night, there are the risks of rape and mugging.

Secondly, the HR plan needs to take into consideration the

impact of the increased number of women doctors produced. More than 50% of medical students are female. A recent four-nation study of women in medicine<sup>9</sup> concluded that "Workforce planners should anticipate larger increases in physician full-time equivalencies than previously expected because of the increased number of women in practice and their tendency to work fewer hours and to be in part-time practice". Women doctors are still expected to carry a greater weight of household chores and family responsibilities compared to male doctors; tend to prefer practising in urban areas and reduce working hours when they have children. In Australia women doctors are estimated to have a working life that approximates 60% of that of male doctors<sup>10</sup>. In South Africa about one third of women doctors work only part-time<sup>11</sup>. To take that into consideration, the number of doctors trained will have to be increased.

Thirdly, it is hoped that the HR plan will address the scope of practice of different categories of staff. Planning of the curriculum for the training of medical assistants is still taking place, but the Department of Health hopes for such training to start in 2006. This midlevel worker is envisaged to practice at district hospital level, by assisting doctors with practical procedures<sup>12</sup>. It has been agreed that their scope of practice will be different from that of primary health care nurses. Planning will have to ensure that there are posts in place for this new category of staff when they qualify. We would also like to see a clear role for the Family Physician in the district, to ensure the recognition of our speciality.

Dr Percy Mahlati, Director of Human Resources at the Department of Health has been reported saying that that once minister Tshabalala-Msimang has signed off the plan, public consultations would begin. The department expected only two months of consultation which would include written submissions on the document and targeted one-on-one meetings<sup>13</sup>. Our Academy-FAMEC-RuDASA network will have to ensure that our voices are heard during the consultation process.

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The Department of Health has published the HR plan since this article was written (see item on page 9), but SAFP believes it still to be relevant, bringing out the main issues at hand. Readers can now judge whether the plan has actually addressed these issues adequately

### References

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