Personnel development for health in South Africa

By L.Rispel & H. Schneider

The current political changes in South Africa have highlighted the need for more detailed discussion and debate on the structure and financing of a future health and welfare sector, what personnel policies are needed and how the process of transformation will be achieved. In this context, it is important to focus on the development of human resources because the development of a more equitable, accessible and effective health service depends largely on people who are capable and willing to run such a service and also because a large part of any health budget is spent on the training and salaries of personnel, and inefficient use of human resources will result in considerable wastage.

The existing situation

The only available figures of health workers are from the professional registers. A brief look at the numbers of trained health workers in South Africa - approximately 187 500 in 1988 - indicates a relatively rich resource of skilled people. (This figure includes doctors, all categories of nurses, pharmacists, physiotherapists and assistant and supplementary physios, occupational therapists and assistants, psychologists and social workers.)

It is important to note that the professional registers exclude personnel numbers in the TBVC homelands and contain large numbers of health workers who are not practicing their professions or who work part-time. Therefore, the use of these registers as guidelines for human resource planning has been questioned. Nevertheless, on the surface it appears that a post-apartheid health ministry would inherit a favourable situation with regards to the numbers of trained health care personnel.

A number of serious problems, however, exist in the current policies, training, use and management of health workers.

Problems

1. Lack of national health personnel plans and policies for the training, deployment and management of health personnel

The lack of national planning has resulted in personnel development failing to match the health needs of the country:

- training institutions are linked to tertiary hospitals and don't take health care needs of the majority into account.
- no co-ordination between educators and health services as employers of the "graduates".
- fragmentation into different health departments makes coordinated planning and the assessment of health personnel needs difficult. Also, the reallocation of personnel along rational and equitable lines becomes almost impossible. As such, there is no consensus nationally on the relationship between who should provide what kind of care and the resources available for health.
- there are no incentives, career opportunities or regulatory mechanisms ensuring a shift of personnel to less privileged areas.

2. A maldistribution of health workers

It is well known that the deprived areas of South Africa and most areas worldwide (rural and periurban) have considerably lower health worker: population ratio than the more affluent urban areas. In addition, the distribution of health worker to population ratios differ between black and whites.

The problem of maldistribution is compounded by the largely unregulated fee-for-service private health sector which consumes nearly half of the gross health expenditure while serving only 20% of the population.

3. Health workers in the private sector

A large proportion of the country's health personnel (particularly doctors) have become accustomed to a lucrative system of private practice. The private sector has attracted many health workers (par-

ticularly nurses) who are dissatisfied with the working conditions in the public sector.

There will undoubtedly be major resistance to change from the health personnel active in the private sector, who may be concerned about their income levels in a future national health service.

4. Inappropriate training of health personnel

Training is individualistic, curative orientated, with a high reliance on technology. This preparation bears little relation to the challenges faced in the real working situation. For example, nurses are the major providers of primary health care in rural areas, yet their training is hospital-based, curative in orientation and dependent on supervision by doctors.

Professional education also has a strong "hidden" curriculum which creates health workers with attitudes of elitism, domination and control towards individuals and communities - attitudes which are clearly detrimental to the development of comprehensive primary health care.

5. Management of personnel

The current shortage of nurses has been well publicised in the media. Morale in the nursing profession is generally low. This relates directly to working conditions: low salaries, unsociable hours, a rigid hierarchy, little autonomy, poor support structures, sexist practices, poor housing and lack of career mobility and the lack of strong bargaining structures for nurses.

The failure to retain nurses in the public sector has serious implications for a future health service. In addition, a frustrated and burnt out work force does not provide creative, quality care. A discontented, disillusioned workforce will ultimately lead to national health services losing their competitiveness as employers. (Simmonds; 1988)

The majority of present health service managers are politically and professionally conservative. This is compounded by a scarcity of health personnel with suitable managerial and leadership skills.

A. Problems with teamwork

There is little coordination between the separate management structures for nursing and medical staff with top management structures usually reserved for doctors. There are also barriers created by nursing towards other categories of health workers.

The inequalities between nurses and doctors (salaries, power, status and perceived value of work) has given rise to conflict which has until recently been largely ignored and has serious implications for teamwork in PHC.

B. Use of personnel

Much of the health care being provided (particularly in more affluent areas) could be provided by lesser trained people. For example a paediatrician may be consulted for a problem that a mid-level health worker could deal with adequately; normal deliveries performed by obstetricians instead of midwives and so on.

6. The vested interests and power of the professionals

Professionals, particularly doctors are unlikely to relinquish both their political and economic power and status.

Attempts at curriculum reform in medical education has been met with strong resistance from some faculties.

Nursing has been preoccupied with its professional status and will resist changing the curriculum to suit the needs of the communities. As may occur with doctors, the introduction of auxilliaries may also be seen as a threat to their status.

The South African Nursing Association (SANA) and the Medical Association of South Africa (MASA) are likely to resist change and the lack of a strong democratic nursing organisation poses a serious obstacle to change.

Accordingly, care needs to be taken and strategies worked out, not to provoke a crippling resistance to change among those who will actually be implementing new policies.

7. Communities' expectations of health care providers

A wealthy community will not readily accept having to see a Primary Health Care Nurse (PHCN) before a doctor, or even a general practitioner before a specialist. The fact that they may be more articulate in these demands may result in dual standards - village health workers for the deprived rural villages and physicians for affluent urban communities. The problem is compounded by health not being adequately debated on the political agenda in the same way, for example, that education is.

In summary, these are some of the problems which we will face in the process of trying to build a new health service. Realistically, the result is likely to be less than perfect owing to the necessity of mediating the needs of different groups all wanting a particular approach.

Prerequisites for personnel policies to be successful

To achieve a situation of equitable, efficient and effective use of health personnel in this country, the minimum needed would be:

- a political and economic commitment to these principles in the health sector and other social services;
- a process of national coordination in one central structure which:
  - integrates the functions of policy making around personnel (planning, training, deployment, management and evaluation) with policy making in health care generally;
  - is based on non-racialism, democratic participation and the primary health care approach;
  - seeks to be relevant and appropriate to the needs of the communities served;
  - is in line with the economic resources available for health.

Ideas for debate

1. Research and formulation of key policy issues

As a first step, an assessment of health

needs and the availability of economic resources for human resource development in health is needed. As part of this process, there should be wide consultation with communities, the relevant organisations and interest groups involved. Based on this, policies can be determined concerning the types and roles of health workers needed, the training required, the numbers needed and how they need to be distributed.

2. Who should provide PHC ?

Questions that need discussion and debate are whether Community Health Workers (CHW) should be part of the PHC team; to what extent should a cadre of health worker other than a medical practitioner be responsible for providing comprehensive, essential, first contact clinical care. Experiences from countries using other cadres of health workers would be useful for us to learn from.

The appropriate members of the primary health care team should be decided upon, and questions such as whether the health service should be predominantly doctor, nurse or Village Health Worker centred, and how a situation of equality between rural and urban, between rich and poor areas is going to be established, must be answered.

Also needed are structures for the establishment of accountability by health workers towards communities at a local authority level, as well as at a regional and national level.

Progressive groups should then adopt these policies as a united front. Ultimately, the above should result in a coherent national personnel policy which aims to ensure the even distribution of health personnel within the framework of a national health plan.

3. Training of health workers

Principles for training should be: community based and supportive; relevant to health needs and future role; problem orientated and based on progressive adult education principles and should include a PHC orientation.

Certain aspects of education should be multi- and interdisciplinary and should stress aspects of teamwork. Education should also stress accountability to communities.

A national continuing education system should be developed which is implemented regionally and locally and which develops primary health care.

4. Exploration of progressive management systems

The concept of team work should be encouraged. There should be maximum delegation of responsibility and decision making to the health worker teams; equal participation by all in the team; clear role definition, with the leader not necessarily being the doctor or nurse. At the same time the problems of teamwork in primary health care needs to be explored, lessons learnt from the experience of other countries and research needs to be done on managing people in a progressive way.

There is obviously the need for proper working conditions and adequate career structures. There should be incentives for work in unpopular areas, adequate remuneration and clear role definition.

There is a need for a reduction in the salary differentials between different categories of health workers and for strong bargaining structures for health workers, especially nurses.

4. Strengthen progressive organisations

There should be an all out attempt to organise nurses, doctors and other health workers to counter the control of SANA and MASA using a clear programme of action.

At the same time, we should attempt to deepen the contradictions within state and state supportive bodies and perhaps the question of strategic alliances with those who are critical needs to be explored.

5. Lessons from existing experiences in South Africa

There are interesting experiments occurring in the field of human resource development in South Africa. For example, PHCN training and continuing education, village health workers and community rehabilitation worker programmes. They generally function on a small scale, in the face of considerable obstacles. These should be studied more closely to see if they could be generalised to the country as a whole. ❑

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