SA HAS NO OVERALL HEALTH STAFF PLAN – HST

Dr Mark Blecher, Director of the Social Sector at the National Treasury.

South Africa lacks a coherent human resources health care plan and piecemeal interventions have failed to impact on the production, retention and distribution of medical professionals, contributing to an overall deterioration in health care services.

This is one of the key conclusions of the Health Systems Trust (HST) in its latest annual *South African Health Review*, a respected 430 page data-driven framework against which the country's progress has widely come to be measured. Giving figures to back this finding, the report says 600 South African doctors are now registered to practise in New Zealand, 1 290 (or 10%) of Canada's hospital-based physicians are South African and about 1 360 (or 6.3%) of Britain's hospital doctors are South African.

The United Kingdom Nursing and Midwifery Council's 2002 figures reveal that 2 114 nurses and midwives from South Africa are registered to practise in the UK. In their human resources chapter, authors and researchers Ashnie Padarath, Antoinette Ntuli and Lee Berthiaume report that between 1989 and 1997 alone, nearly 250 000 skilled personnel left the country for Australia, New Zealand, Canada, the UK and the USA.

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There was 'an urgent need' to systematically analyse trends, develop perspectives and define response strategies and 'generally develop a coherent plan'. The review warns that AIDS-related mortality, burnout and work overload will result in the continued loss of health staff.

Last year 31% of all public sector health posts were vacant with Mpumalanga worst-off at two-thirds of posts empty, Free State at 40% of posts empty and Gauteng with 31% of posts unoccupied. The Western Cape fared best with 14% of empty posts.

HIV/AIDS was reversing the health gains of the past 30 years and almost as many people died of AIDS-related illnesses today as of diseases associated with unhealthy lifestyles.

The private sector's services consumed 58% of total health expenditure and captured a higher proportion of all types of staff, except nurses, than the public sector while catering for less than 20% of the population.

Human resources for health care were undersupplied and understudied in the national Health Department, contributing to staff shortages across the board, with nursing the hardest hit.

Even with nurse recruitment to address the 25% vacancy rate in the public sector, the HST estimates that by 2011 there will be a shortfall of 19 000 nurses.

Community service for 11 different categories of health care workers had achieved 'limited success' in increasing the supply of staff to underserved areas. Students were opting for urban rather than rural placements and the lack of rural supervision resulted in burn-out and a determination to work overseas afterwards, with between 20% and 45% of all community service practitioners planning to do so.

The impact of the inadequate supply and distribution of personnel also hampered the overall functioning of the health system, hitting rural areas hardest. This led to a loss of institutional memory, unmanaged disease burdens and additional costs to households seeking care at higher levels.

A key finding was that the impact of HIV was aggravating staff shortages. Improved health care staff distribution would be 'critical' to the success of plans for providing antiretroviral therapy, it emphasised.

More accurate ways of monitoring migration patterns and distinguishing between temporary and permanent

migration were urgently needed, begging much improved registration and recording. Internal migration between urban and rural could not be separated from 'the larger understanding of migration within and out of the SADC region'.

Introducing rural and scarce skills allowances was a beacon of hope but increasing salaries alone would not necessarily restore the 'sense of purpose' required to make public services function. Developing professional satisfaction, self-realisation, social responsibility and prestige in health care professionals were necessary.

The HST recommended the decentralisation of training institutions, the introduction of recruitment quotas to ensure that the most peripheral areas were represented among medical students and making compulsory rural field experience during medical training.

It pointed to distance learning methods, locum relief schemes to permit rural doctors to take study and recreation leave, respect for and the recognition of the rural doctor as part of a family unit, providing support and incentives for spouses and families, job opportunities for doctors' spouses, improved accommodation and suitable education institutions for doctors' children.

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The HST reiterated the Pick Report finding of revising and re-designing the scopes of practice of many categories of health care workers in the light of the shift to primary health care and noted the DOH's plan to introduce a mid-level health worker category. In the review, Dr Mark Blecher, Director of the Social Sector at the National Treasury and Stephen Thomas of the Health Economics Unit at the University of Cape Town, caution that a real growth of R3 billion in personnel expenditure has masked a reduction of 19 000 unfilled posts. This was largely due to a 28% increase in average wages.

The review identified the global environment facilitating the free movement of health care workers in terms of the General Agreement of Trade and Services (GATS), as a further threat to ensuring an adequate human resource supply. It recommended closer collaboration between the Department of Trade and Industry and the Department of Health to ensure that international trade negotiations did not compromise the country's vision for its health service.

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