REPUBLIC OF SOUTH AFRICA

OPERATION PHAKISA
planning | implementation | growth

Ideal Clinic Realisation and Maintenance

Human Resources for Health

Lab Report
November 2014

Executive summary and status of work

- The public primary healthcare system in South Africa is currently ridden by several issues:
  - There is a **personnel shortage of both clinical and non-clinical staff** ranging from 3% to 84% of missing input: there are currently 46,000 vacancies in the human resources nationwide database
  - This shortfall is further accentuated by a **sub optimal distribution of the existing resources**: it is likely that a redistribution of staff will reduce this shortage, allowing for an optimization of the current budget
  - Going forward, **the shortage is only likely to increase** given:
    - a **higher demand** from the requirements of the **Ideal Clinic delivery model**
    - **low numbers of health** and clinical studies **graduates** (~1,200 doctors graduate each year)
- The already constrained resources are even more challenged by a **mismatch of the existing capabilities and workload** and a poor management of training schedules
- The above mentioned issues arise in **an environment that fails to incentivize the desired behavior**, which leads to:
  - an overall lack of motivation
  - high attrition rates (35% attrition rate for pharmacists in Gauteng)

Contents

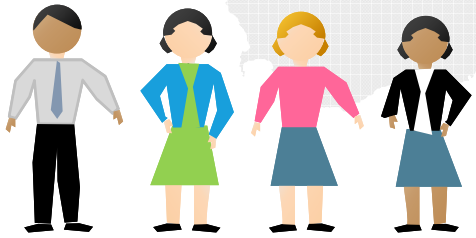
The South African health system covers over 50 million people across 9 provinces and is attended to by over 100,000 nurses and doctors

USD 7.4bn
in government funding in 2014

~40,000
doctors[1]

~3,100 public health clinics

~64,000
nurses[1]



Over **50** million
patients across the country

An estimated 80% of doctors and nurses work in the private sector

1 Doctors and nurses comprise all those registered with Health Professions Council South Africa and South African Nursing Council. It is estimated that less than half work in the public sector, the remainder are in private practice

SOURCE: Health Systems Trust; Local Government website; World Health Organisation, Business Monitor International

21% of clinics have no manager

47% of clinics had no visits from doctors

On average, it takes 4.5 months to fill a post in the public service

79% of clinics have no information management staff

41% of South African health workers are actively seeking employment elsewhere

Nurse vacancy rates go as high as **68%**

Nearly 30% of surveyed nurses have engaged in moonlighting

SOURCE: National health facilities baseline audit, 2012; Blaaw, Global Health Action, 2013;
Prof. Rispel, Study on nurses moonlighting, 2014; SA institute of race relations 2013; DPSA, Report to parliamentary committee 2010

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These issues can be articulated along three main areas of focus

1 Supply & demand

- Currently, the system faces a current shortage of personnel accentuated by a sub optimal distribution of existing resources
- This shortage is only likely to increase given:
  - the requirements of the Ideal Clinic service delivery model
  - low numbers of health and clinical studies graduates

2 Capabilities & skill set

- The already constrained resources are even more challenged by a mismatch of the existing capabilities and the workload

3 Incentives & behavior

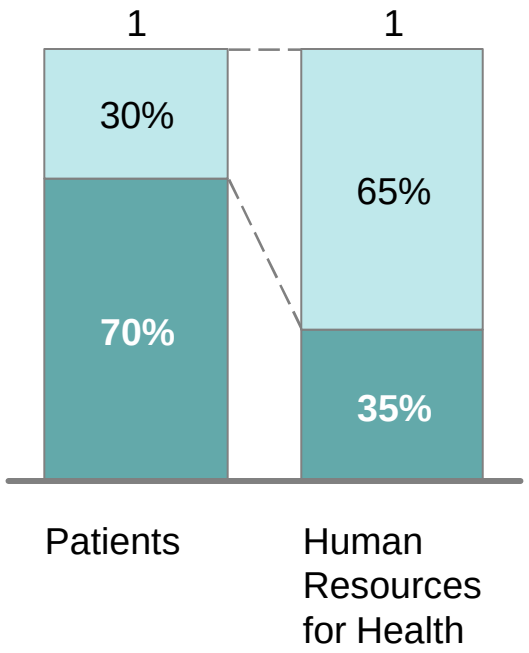
- The above mentioned issues are amplified by an environment that fails in incentivizing the desired behavior, which leads to:
  - an overall lack of motivation
  - high attrition rates
- These undermine the system even further, transforming it into a vicious circle

Although ~70% of South Africans depend on public health, only 35% of the country's human resources are public

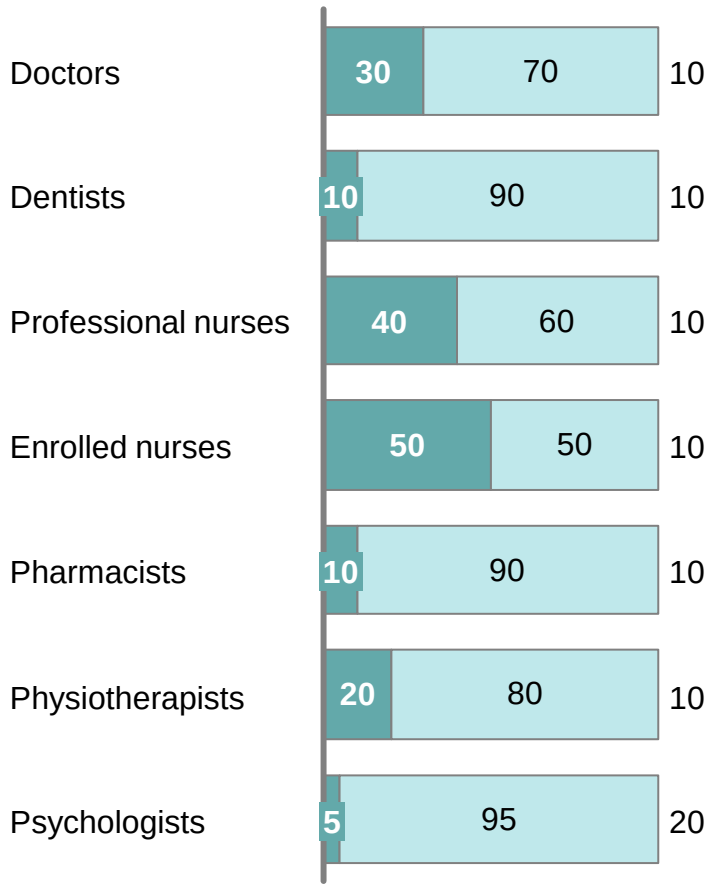
The human resources for the PHC system in South Africa…

Distribution of patients, health professionals

Percentage of patients, health specialists



… are particularly constrained

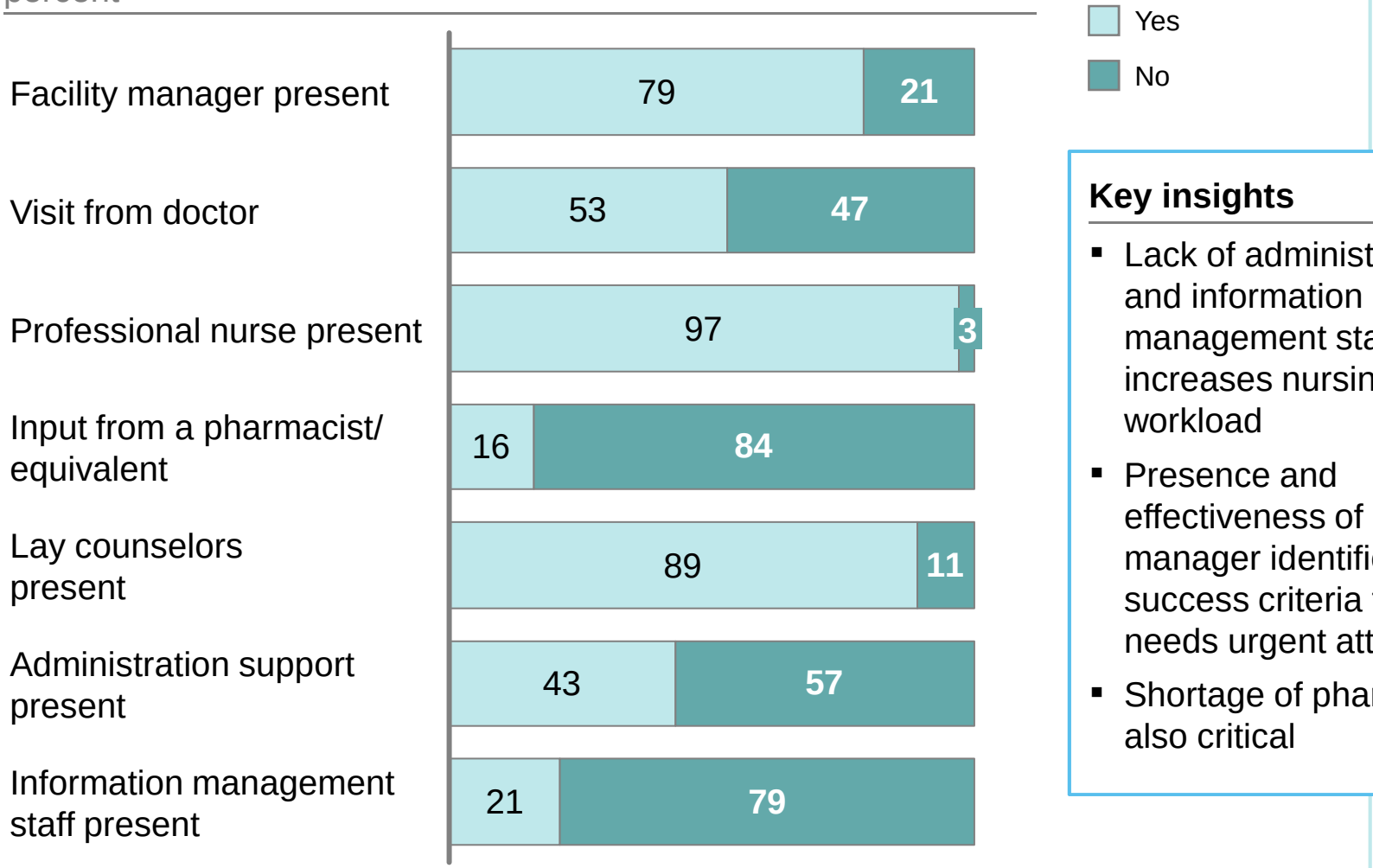


SOURCE: SA Health Review 2008, HST

This leads to some critical staff shortages in primary health clinics

Availability of staff at 3,075 clinics across South Africa

percent



Key insights

- Lack of administrative and information management staff increases nursing staff's workload
- Presence and effectiveness of facility manager identified as key success criteria for IDCs needs urgent attention
- Shortage of pharmacists also critical

SOURCE: National Health Facilities Baseline Audit 2012

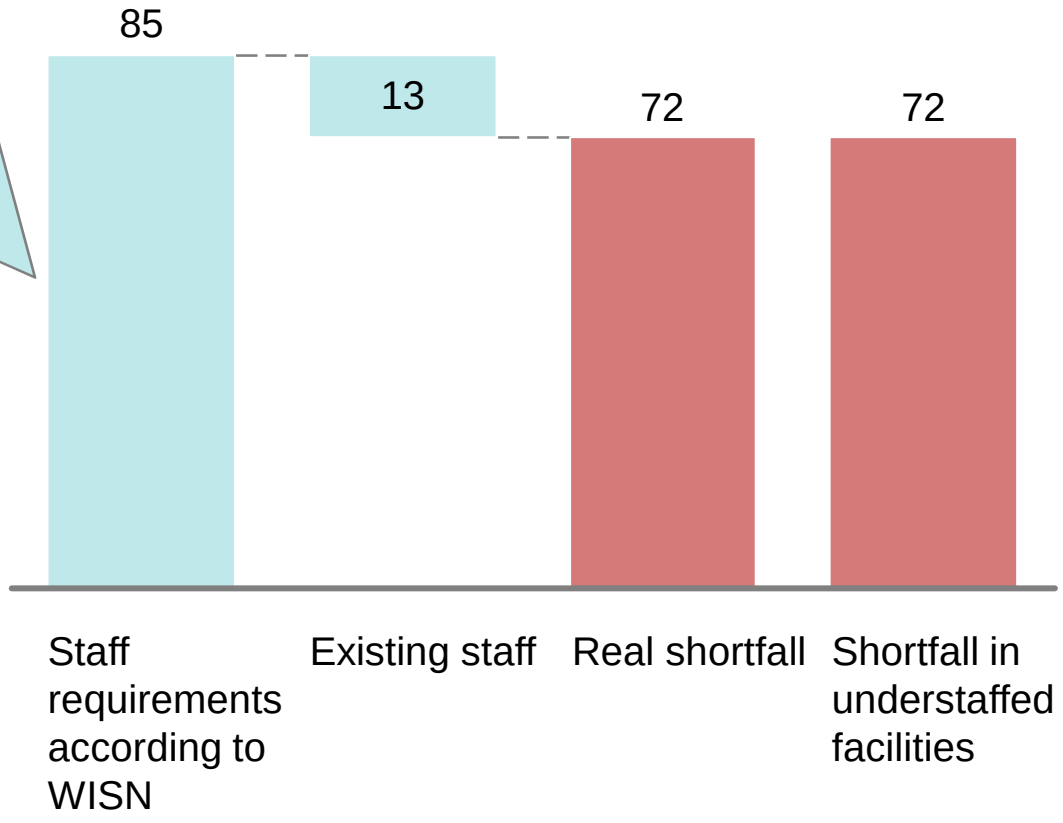
The shortages in the system are due both to a lack of professionals … (1/2)

A pilot assessment with the WISN tool was conducted in over 90 facilities to estimate the real requirements in terms of human resources

Distribution of pharmacy assistants across 63 primary healthcare clinics assessed with the WISN tool – No. of Pharmacy assistants

WISN PILOT STUDY

The total demand according to WISN could be underestimated given that it is based on headcount: it does not take into account the unattended patients at the clinic



The current shortfall in understaffed facilities is equal to the difference between the requirements of the current service delivery model and the existing staff

SOURCE: WISN assessment – 63 facilities

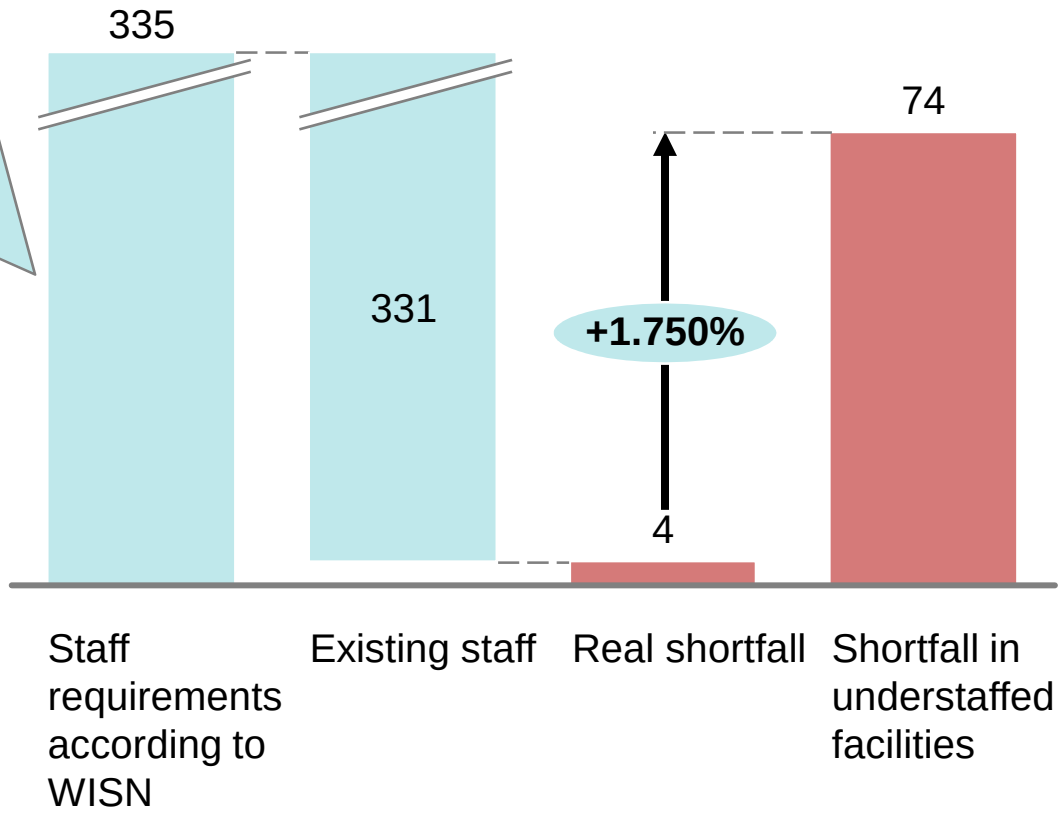
… and to an inequitable distribution of the existing human resources (2/2)

A pilot assessment with the WISN tool was conducted in over 90 facilities to estimate the real requirements in terms of human resources

Distribution of Professional nurses[1] across 63 primary healthcare clinics assessed with the WISN tool – No. of Professional nurses

WISN PILOT STUDY

The total demand according to WISN could be underestimated given that it is based on headcount: it does not take into account the unattended patients at the clinic



The current shortfall in understaffed facilities is over 1,000 times higher than the difference between the requirements of the current service delivery model and the existing staff

1 The position "professional nurse" comprises: professional nurses, clinical nurse practitioners, public health nurses, and registered nurses

SOURCE: WISN assessment – 63 facilities

Distribution and requirements of staff across 63 primary healthcare facilities (1/3)

X% Inequitable distribution
X% Average shortage
X% Strong shortage

Cadres	Staff requirements according to WISN[1]	Existing staff	Real shortage[2]	Shortage in understaffed facilities	Need for personnel[3]
Operational Manager[4]	▪ 64	▪ 35	▪ 28	▪ 28	100%
Health Promoter	▪ 16	▪ 13	▪ 3	▪ 7	43%
Medical Officer	▪ 19	▪ 10	▪ 9	▪ 13	69%
Enrolled Nurse	▪ 359	▪ 82	▪ 277	▪ 350	79%
Cleaner	▪ 137	▪ 59	▪ 78	▪ 82	95%

1 Personnel required according to the current delivery model of service packages as estimated per the WISN tool
2 Shortage calculated as staff requirements according to WISN minus existing staff
3 Real shortage/shortage in understaffed facilities
4 Working hypothesis of one operational manager per clinic – to be revised
SOURCE: WISN assessment of 71 primary healthcare clinics

Distribution and requirements of staff across 63 primary healthcare facilities (1/3)

X% Inequitable distribution
X% Average shortage
X% Strong shortage

WISN ASSESSMENT

Cadres	Staff requirements according to WISN[1]	Existing staff	Real shortage[2]	Shortage in understaffed facilities	Need for personnel[3]
Lay counselor	▪ 63	▪ 41	▪ 22	▪ 48	46%
Admin Clerk	▪ 101	▪ 44	▪ 57	▪ 92	62%
Data capturer	▪ 106	▪ 19	▪ 87	▪ 101	86%
Groundsman	▪ 70	▪ 27	▪ 43	▪ 56	76%

1 Personnel required according to the current delivery model of service packages as estimated per the WISN tool
2 Shortage calculated as staff requirements according to WISN minus existing staff
3 Real shortage/shortage in understaffed facilities
SOURCE: WISN assessment of 71 primary healthcare clinics

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In order to extrapolate the results from the pilot WISN assessment to the 3,507 primary healthcare clinics nationwide and size the gap between supply and demand, the following methodology was used

What we did

- ✓ Identify workload per facility (2012 data for 3,093 facilities)
- ✓ Determine the facility requirements for clinic, per cadre, according to the norm, for 11 cadres
- ✓ Estimate total system's requirements for 3,093 clinics and prorate for 3,507 clinics
- ✓ Determine the estimated lack of staff (based on statistics on shortages from the 2012 baseline)
- ✓ Determine the "real shortage" of staff (total demand minus existing staff)

What we did not do

- ✗ Conduct a WISN assessment of all 3,507 facilities
- ✗ Estimate burden of disease per clinic
- ✗ Verify the existing staff with all 3,507 facilities
- ✗ Assess the amount of existing staff based on PERSAL

To meet current demands and achieve Ideal Clinic status for the 3,507 primary healthcare facilities, additional human resources are necessary

HIGHLY PRELIMINARY

Cadres[1]	PHC needs[2]	Lack of staff[3]	Gap to current delivery model[4] (+/- 20% range)	Gap to ideal clinic delivery model
Operational Managers	▪ 3,400	▪ 21%	▪ 550 - 850	***Assessment of the needs of the Ideal Clinic model in progress***
Medical Officer	▪ 1,700	▪ 47%	▪ 650 - 960	
Professional Nurses	▪ 17,200	▪ 3%	▪ 400 - 600	
Pharmacist's Assistant	▪ 6,800	▪ 84%	▪ 4,500 – 6,800	
Lay Counsellors	▪ 6,800	▪ 11%	▪ 600 - 900	
Data Capturer	▪ 10,350	▪ 79%	▪ 6,500 – 9,800	
Administrative Clerk	▪ 10,350	▪ 57%	▪ 4,700 – 7,000	

PLEASE NOTE

- This information is based on existing data, the quality of which is sub optimal and could be enhanced
- The Human Resources for Health workstream strongly advices to perform, and fast-track, a nationwide WISN assessment to have an accurate depiction of the system's needs

1,2 Nationwide PHC needs for cadres with defined WISN ratios extrapolated on the basis of available information on headcount and opening hours for 3,093 facilities; 3 Lack of staff based on National Baseline Audit, assumed homogeneous throughout clinics; 4 Gap to current delivery model according to lack of staff and estimated PHC needs (+/- 20% range)

SOURCE: WISN norms, Headcount/Opening hours of 3,093 facilities (2012), National Health Facilities Baseline Audit (2012)

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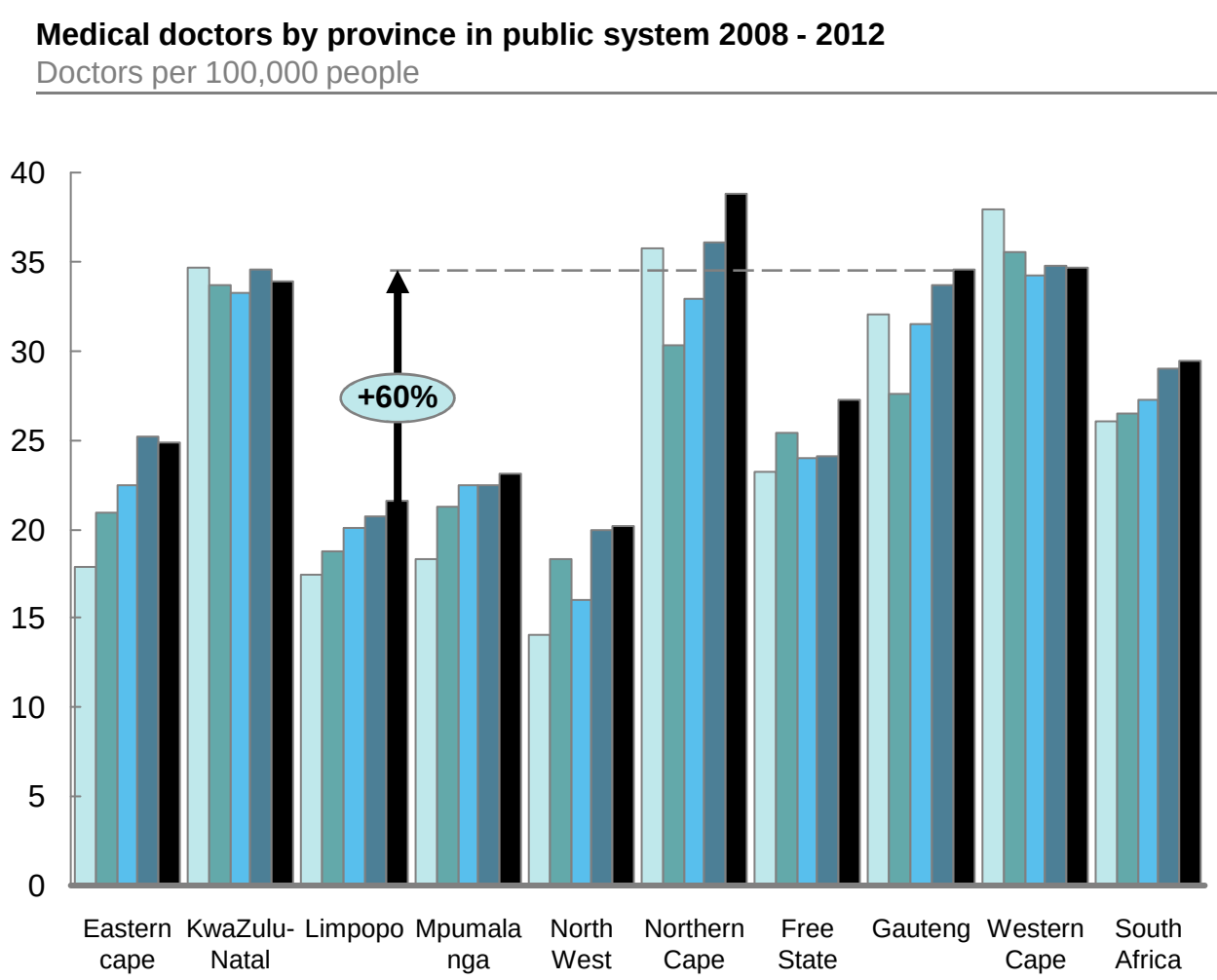
The shortage is especially important along the rural urban divide: for example, medical doctors are more scarce in rural provinces

Medical doctors by province in public system 2008 - 2012

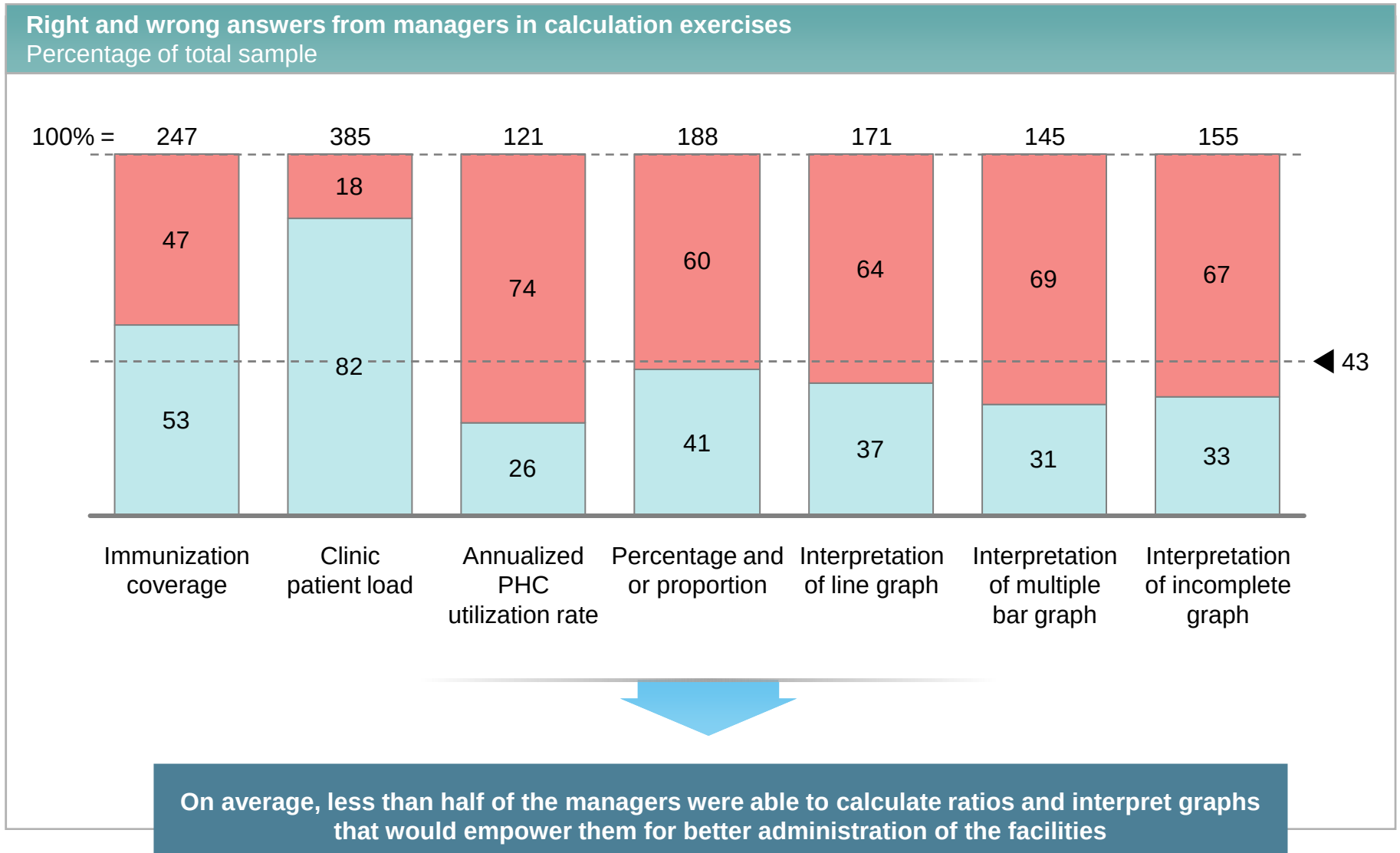
Doctors per 100,000 people



- Although numbers have been increasing across provinces, medical doctors are still more scarce in rural provinces than in urban provinces
- This could mirror difficulties in retaining staff deployed to those areas

SOURCE: RUDASA

Managers lack the numerical competencies necessary for an effective administration of facilities



On average, less than half of the managers were able to calculate ratios and interpret graphs that would empower them for better administration of the facilities

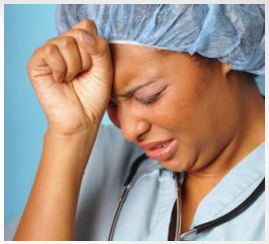
SOURCE: HST - HSR Unit and Change Management Group

Staff shortages appear to be a drain on both the facility managers and other staff members

"We're very short staffed. Our cleaner is on leave so the municipality sent people but I have no control over them"

"I tell my nurses to hang in there…They're overworked because we're so short staffed"

"Two of my nurses are currently off on training so it puts a strain on the rest of the team"



SOURCE: Interviews at the facilities, Lean operations diagnostic, team analysis

These challenges were made apparent by the reality on the ground

Insights and quotes from clinic visits

	Description	Implications (problem)
Clinics can be over or understaffed	▪ Staffing is more or less the same yet the workload is different (i.e., one clinic sees twice as many patients) ***"We need more nurses"***	▪ Staffing is not matched up to workload/demand
Communica-tion structures are inefficient	▪ There is no clear communication line between clinic managers and central level ***''Ask us how to run the clinic instead of imposing"***	▪ Clinic managers cannot optimize decisions due to missing information ▪ There are no feedback mechanism on quality of information (and thus no way to improve information)
System fragmentation hinders best management practices	▪ The nurses can be employed by either the municipality or the province but report to a municipality employed clinic manger ▪ Provincialization of municipal clinics has not been completed	▪ Work conditions are not the same amongst workers performing the same tasks ▪ Clinic mangers do not have full control of staff which undermines leadership ▪ There are inconsistencies in policy application and operations (PMDS, discipline, etc.)
Accountability and sound work split is low	▪ Absence of an approved organogram ***"I do not know" (answer given by staff member when asked about the clinic's organogram)***	▪ There is lack of proper HR planning and budgeting.

SOURCE: Clinic visits – October 13th and 14th 2014

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These challenges were made apparent by the reality on the ground

Insights and quotes from clinic visits

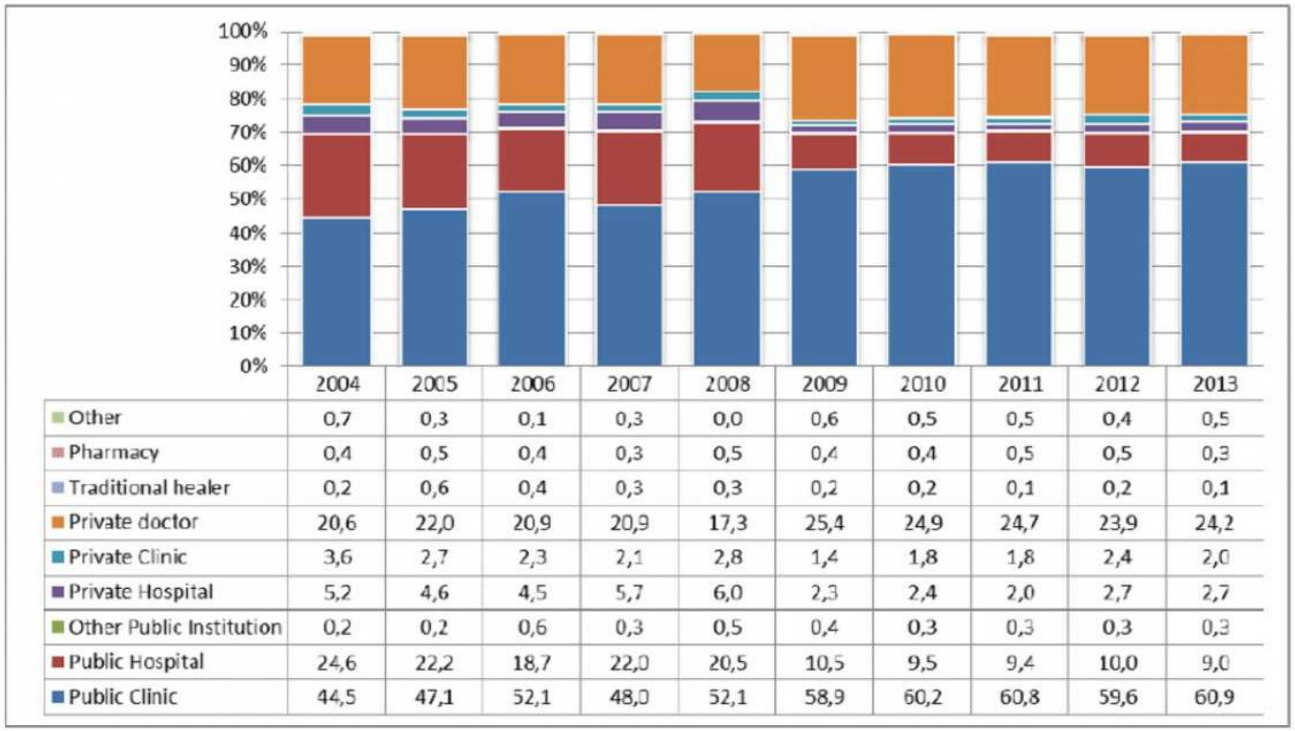
	Description	Implications (problem)
Skill mix is not always optimal	▪ Absence of pharmacist assistant ▪ Pharmaceutical services are performed by clinic managers	▪ Professional nurses are overloaded with pharmaceutical services hindering service delivery
Trainings are not need-driven	▪ Formal training is arranged by the central office	▪ Training requirements are not addressed as per institutional need.
Continuity of external contracts is not ensured	▪ Clinics rely on contract workers for support services (e.g. for security personnel)	▪ Continuity of the services beyond the contract periods is uncertain which may compromise service delivery due to an increase in workload ▪ Safety of staff and clients at risk when security personnel not resourced

SOURCE: Clinic visits – October 13th and 14th 2014

With patients being redirected from public hospitals into clinics to move towards a culture of prevention…

Type of facility consulted first by households when members fall ill or get injured

Distribution, percentage, 2004 - 2013



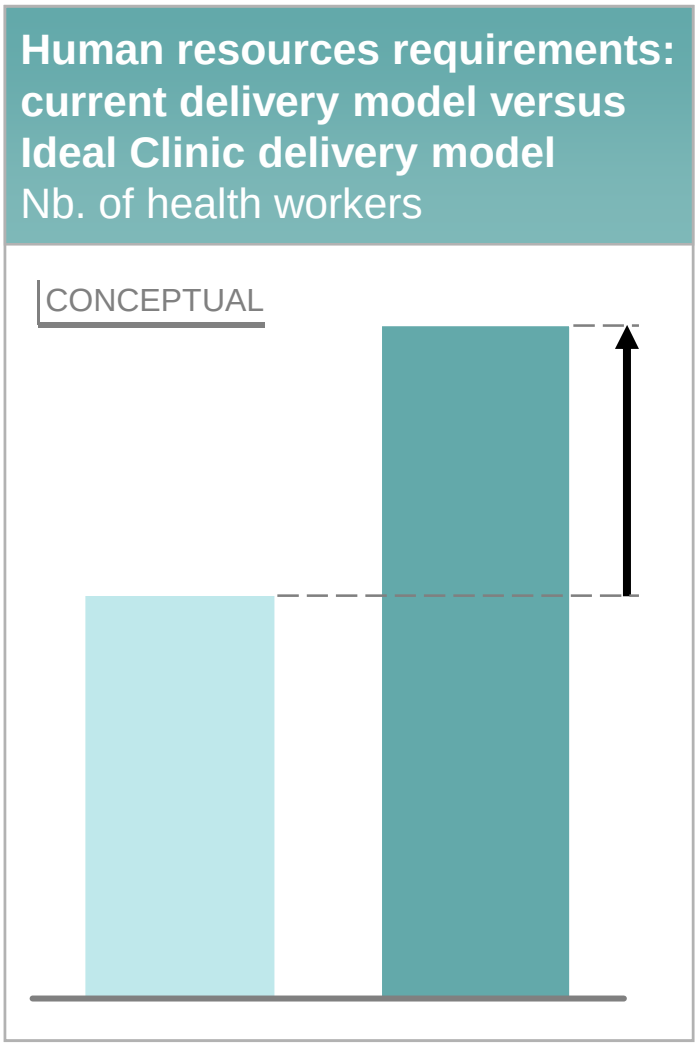
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Other	0,7	0,3	0,1	0,3	0,0	0,6	0,5	0,5	0,4	0,5
Pharmacy	0,4	0,5	0,4	0,3	0,5	0,4	0,4	0,5	0,5	0,3
Traditional healer	0,2	0,6	0,4	0,3	0,3	0,2	0,2	0,1	0,2	0,1
Private doctor	20,6	22,0	20,9	20,9	17,3	25,4	24,9	24,7	23,9	24,2
Private Clinic	3,6	2,7	2,3	2,1	2,8	1,4	1,8	1,8	2,4	2,0
Private Hospital	5,2	4,6	4,5	5,7	6,0	2,3	2,4	2,0	2,7	2,7
Other Public Institution	0,2	0,2	0,6	0,3	0,5	0,4	0,3	0,3	0,3	0,3
Public Hospital	24,6	22,2	18,7	22,0	20,5	10,5	9,5	9,4	10,0	9,0
Public Clinic	44,5	47,1	52,1	48,0	52,1	58,9	60,2	60,8	59,6	60,9

- As demand is being redirected from hospitals into the primary healthcare facilities, the public sector's resources will be further and further stressed

SOURCE: StatsSA general Household Survey 2013 – Health

…and the implementation of the Ideal Clinic model of services delivery, it becomes critical to optimize the management of human resources in the primary healthcare system

Human resources requirements: current delivery model versus Ideal Clinic delivery model
Nb. of health workers



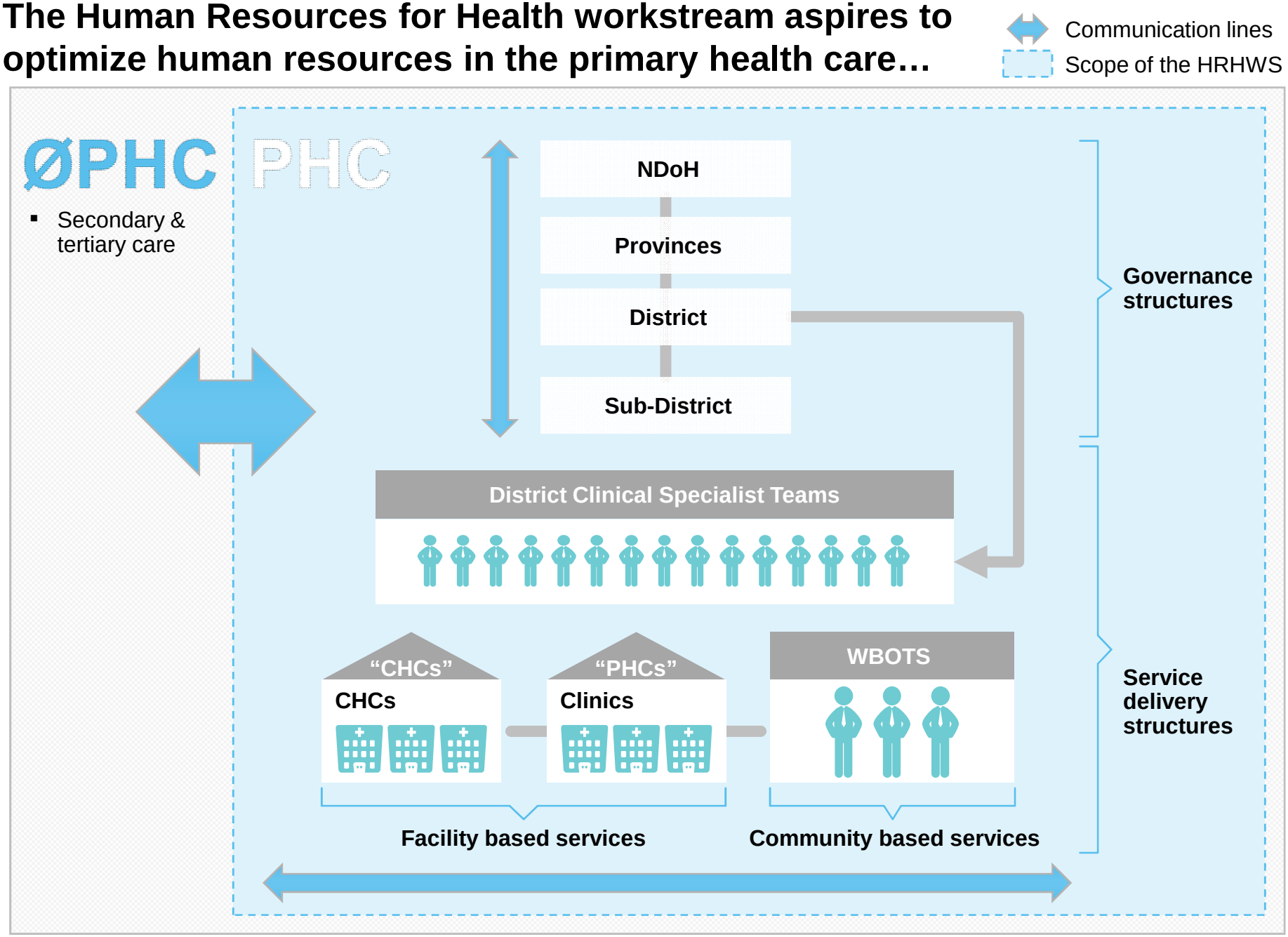
- The model of service delivery designed for the Ideal Clinic realization and maintenance will drive the existing demand up
- This means that the number of posts to be filled will increase between 2014 and 2018

Contents

- Context and case for change
- **Aspirations**
- Issues and root causes
- Solutions and Initiatives

ASPIRATIONS

The Human Resources for Health workstream aspires to optimize human resources in the primary health care…



ASPIRATIONS

… by focusing its efforts around the three main areas identified

	Aspiration	Target
1 **Supply & demand** 	▪ Matching supply of health professionals to demand ▪ Balancing existing resources in the service delivery platform ▪ Increasing productivity ▪ Coordinating partner efforts through the NHI	▪ Nb. of facilities at norm – 100% by 2018/2019 ▪ Coordination of all partner efforts by 2018/2019
2 **Capabilities & skill set** 	▪ Ensuring that all workers have the skills to effectively deliver required services	▪ Nb. of properly skilled workers – 100% by 2018/2019
3 **Incentives & behavior** 	▪ Transforming the public Primary Healthcare System into the employer of choice	▪ Increase staff satisfaction ▪ Increase retention rates ▪ Attract new employees ▪ Improve patient experience

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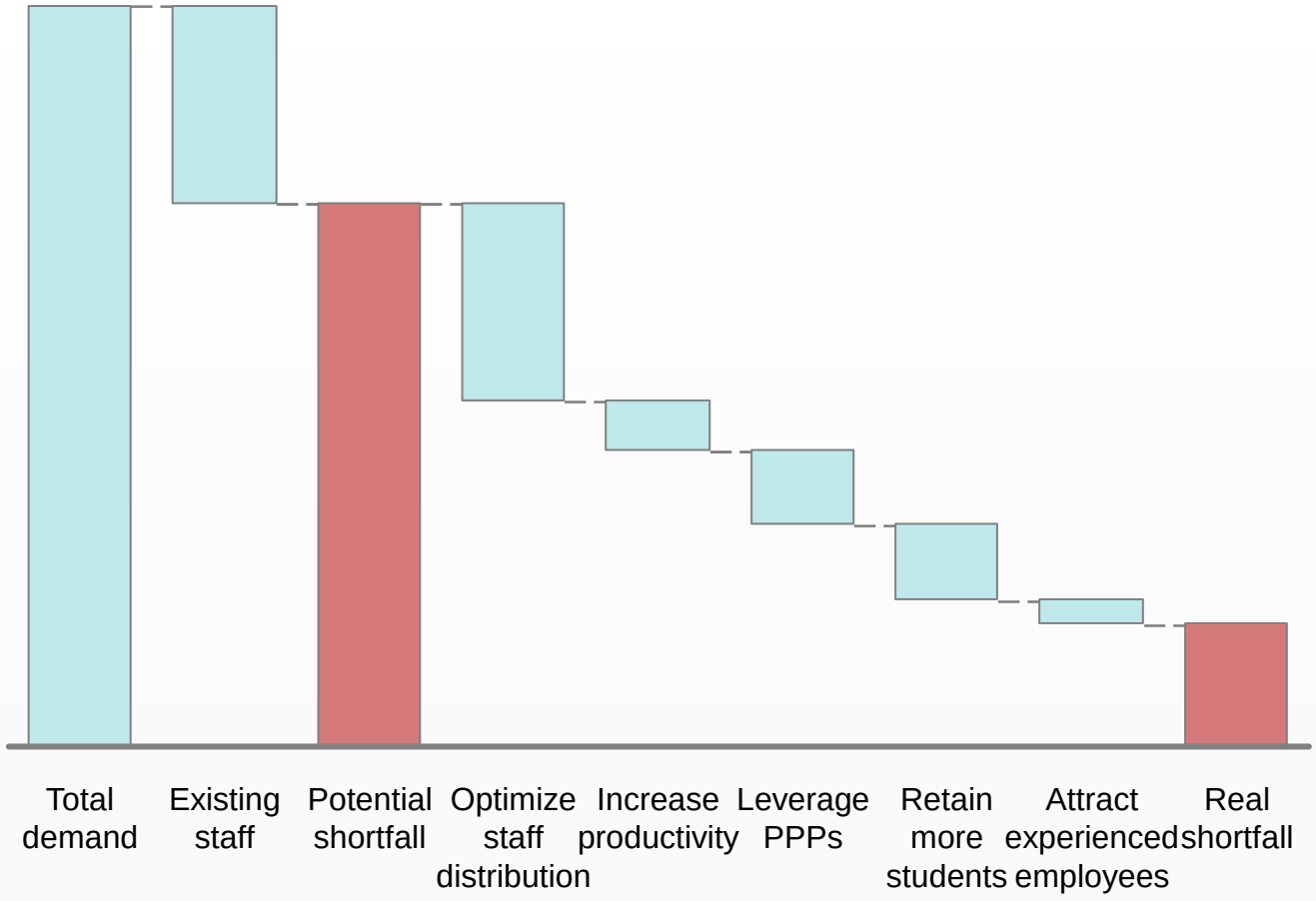
ASPIRATIONS

1 To ensure that no patient goes home unattended we can pull several levers

Health workers in the PHC system

CONCEPTUAL



- By pulling all the possible levers, the potential shortfall narrows

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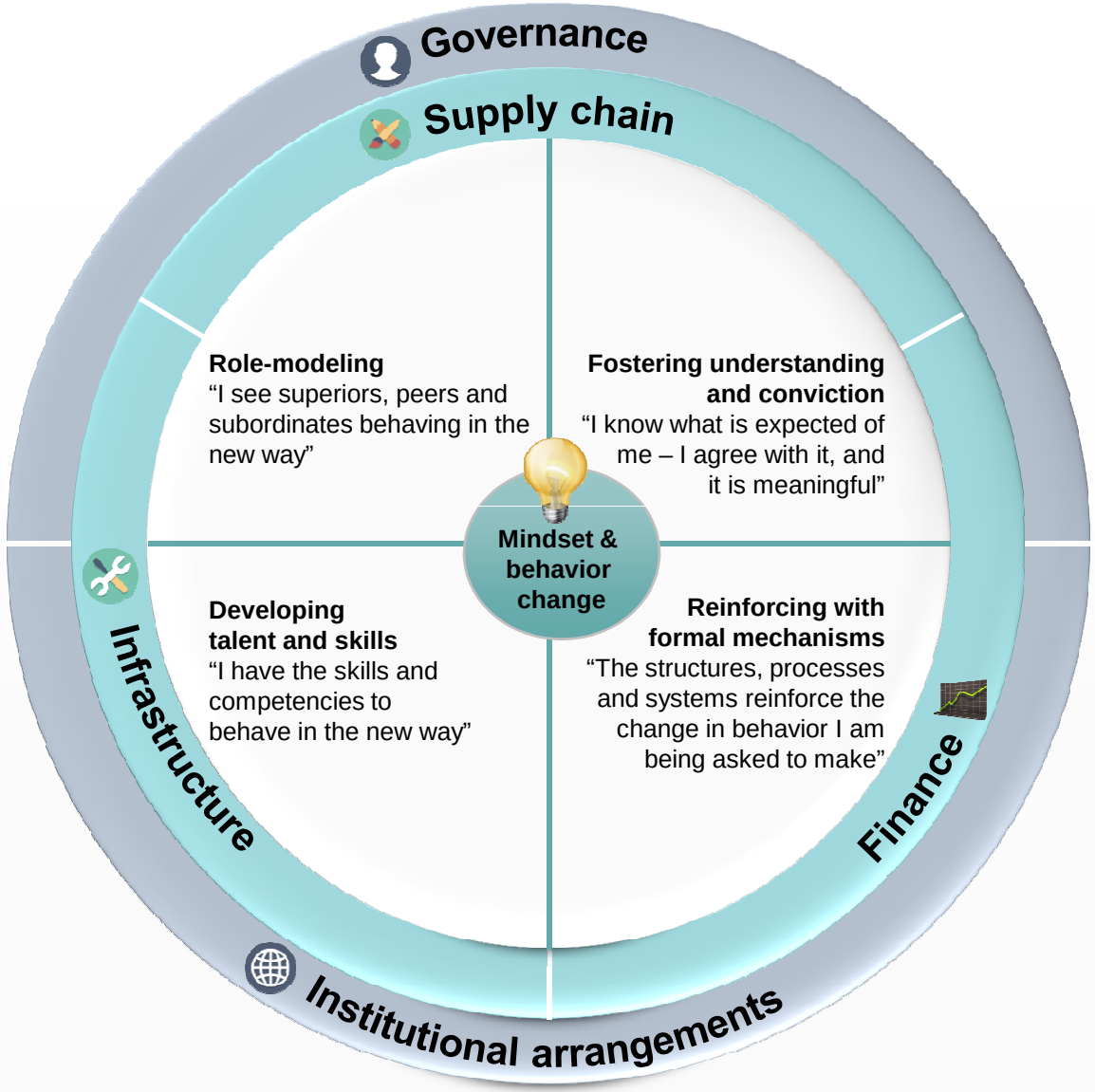
ASPIRATIONS

2 3 …and drive our health workers to perform at their best



- By taking a system wide approach to implement change management we will be able to sustain improved performance over time

WHAT WE WILL BRING TO THE TABLE

The Human Resources for Health workstream will ensure that...

No patient goes home unattended due to a lack of staff

No employee feels that going the extra mile is not worthwhile

All workers are engaged and ready to perform at their best

No post will remain vacant due to inefficient recruitment processes

No clinical professional is overburdened with administrative tasks

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ISSUES AND ROOT CAUSES

The primary healthcare system is crippled by specific HR issues

		Issues	Root causes
1 Supply & demand	We do not have enough people	▪ There are currently ~46,000 vacancies in the primary healthcare system	▪ We are not being efficient – Available and budgeted posts are not rapidly filled: on average, it takes 4.5 months to fill a post in the public service – Top down HR planning does not make the most of frontline input: managers are not empowered as decision makers in the system – We are not coordinating our efforts as the information flows from clinic to district, but not the other way around
	We are not distributing them optimally	▪ ~80% of the facilities are either understaffed or overstaffed	
	We are not preparing for the future	▪ There is a mismatch between the health profession students and the growth of the demand for clinical services	
2 Capabilities & skill set	We are not training on the right topics at the right time	▪ Health workers are fleeing rural areas ▪ Facility managers are performing poorly ▪ Orientation and induction are not systematically provided	▪ Health professionals are not prepared to face rural conditions or leadership roles ▪ Trainings are not optimally scheduled
3 Incentives & behavior	We are not walking the talk	▪ Professional etiquette (uniforms, politeness, etc.) is not observed ▪ Workers do not always benefit from Employee Wellness Packages	▪ Management is stalling important policy approval due to inefficient processes ▪ Moreover, it is perceived as irrelevant and is not role modeled across the organization: we are not enhancing the sense of responsibility or belonging ▪ There are no consequences for non-compliance with professional etiquette or other undesired behavior ▪ PMDS are poorly implemented
	We are not promoting the desired behavior	▪ 41% of health workers are actively seeking employment elsewhere ▪ Nearly 30% of nurses have engaged in moonlighting	

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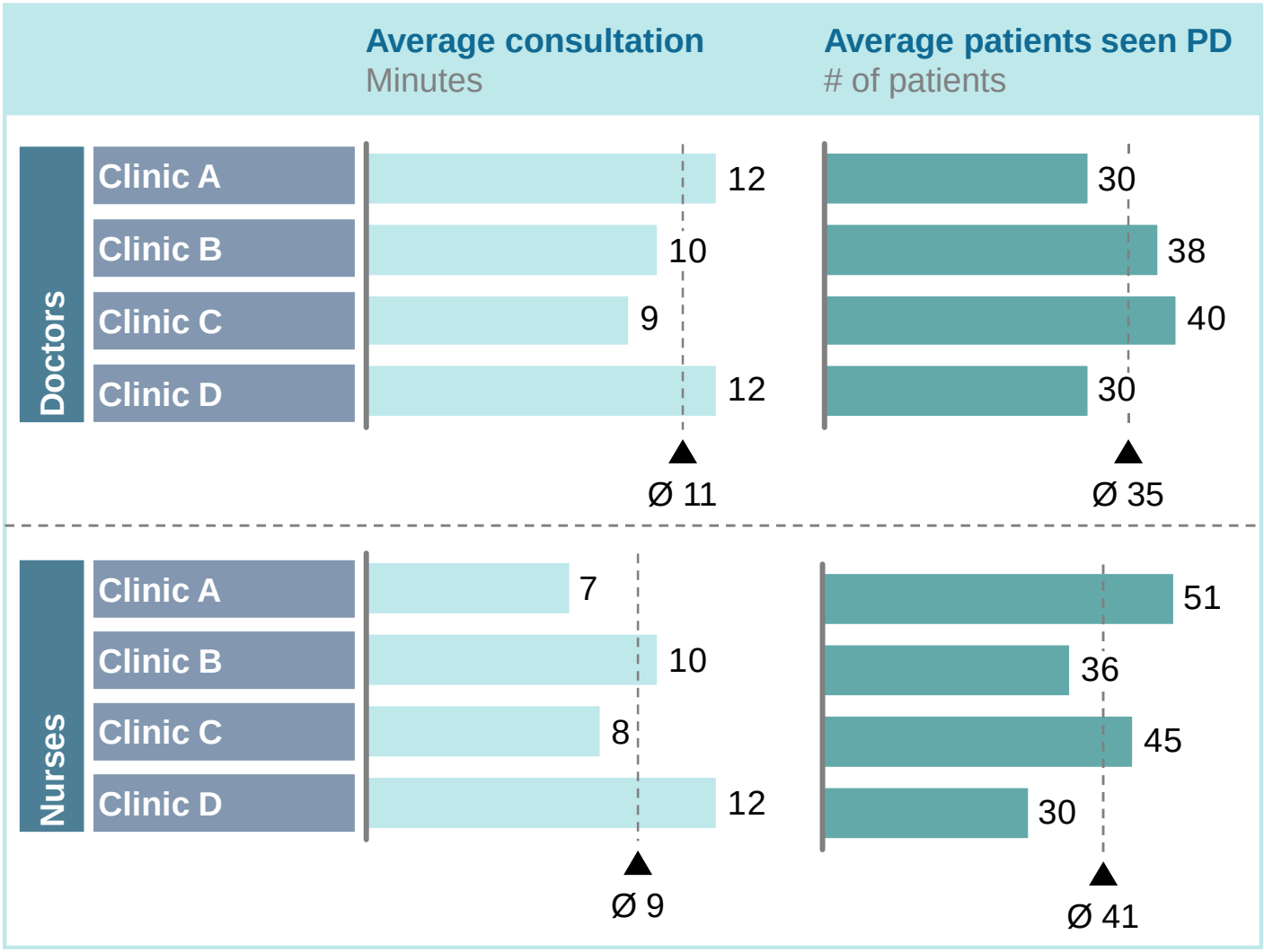
The inequitable distribution of personnel translates into high variability in productivity levels across clinics



Insights

- Poor capacity planning has resulted in **inconsistent productivity**
- Patients in over-burdened clinics have **below average face time with doctors and nurses**
- **Quality of care may be compromised** by overstretching practitioners capacity

1 Based on OPE

SOURCE: Gauteng Health QA, team analysis, Lean Operations diagnostic

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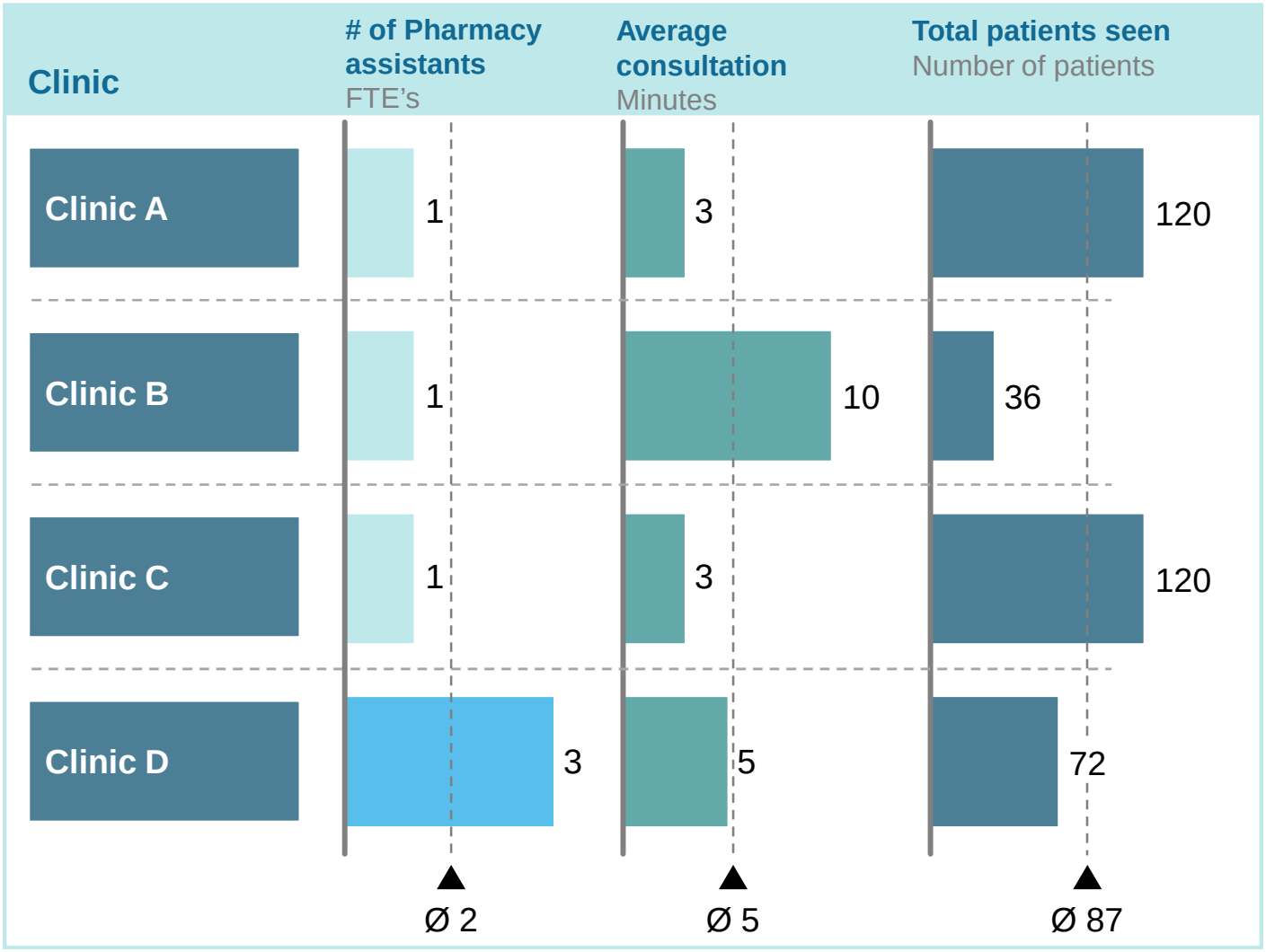
ISSUES AND ROOT CAUSES - SUPPLY AND DEMAND

For example, the shortage of pharmacy assistants translates into high variability of workload across clinics

Includes general workers



Insights

- According to the 2012 baseline audit, only 16% of clinics had input from a pharmacist
  - Pharmacists at Clinics B and D appear to be under-utilized
  - Pharmacists in Clinics A and C are seeing >35 patients per day above the average

1 Excludes General Workers deployed to Pharmacy

SOURCE: Gauteng Health QA, Diagnostic on lean operations, team analysis

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ISSUES AND ROOT CAUSES - SUPPLY AND DEMAND

Recruitment processes are slow and inefficient

	Working days
Identify the need to fill a post and prepare the request	1
Identify funds for advertising and filling of the posts	1
Identify the approval and availability of posts in the st	1
If there are no posts approved, request for the creation	5
Receive the request and compile a submission to be approv	15
Forward the approved document to Line/Programme Managers	2
Identify shotlisting and interview panel members and conf	1
Prepare a submission for approval to advertise the post,	10
Receive the approval, prepare the advert and place an adv	3
Receive and register application forms	20
Profile application forms	1
Shortlisting	3
Interview identified candidates through the utilisation o	1
Screening of the recommended candidates	3
Prepare submission for approval of the appointment of the	10
Prepare appointment letters for successful candidates and	2
Inform successful and unsuccessful candidates interviewed	1
Receive response from the appointed candidate and Inform	2
Prepare logistics such as office, office furniture and eq	2
The appointed candidate assume duty on the agreed date an	1
Line/Programme Manager receive the candidate and orientat	1
Total	86

It could take close to 4.5 months for a worker to be at the clinic

SOURCE: Lab analysis, questionnaire

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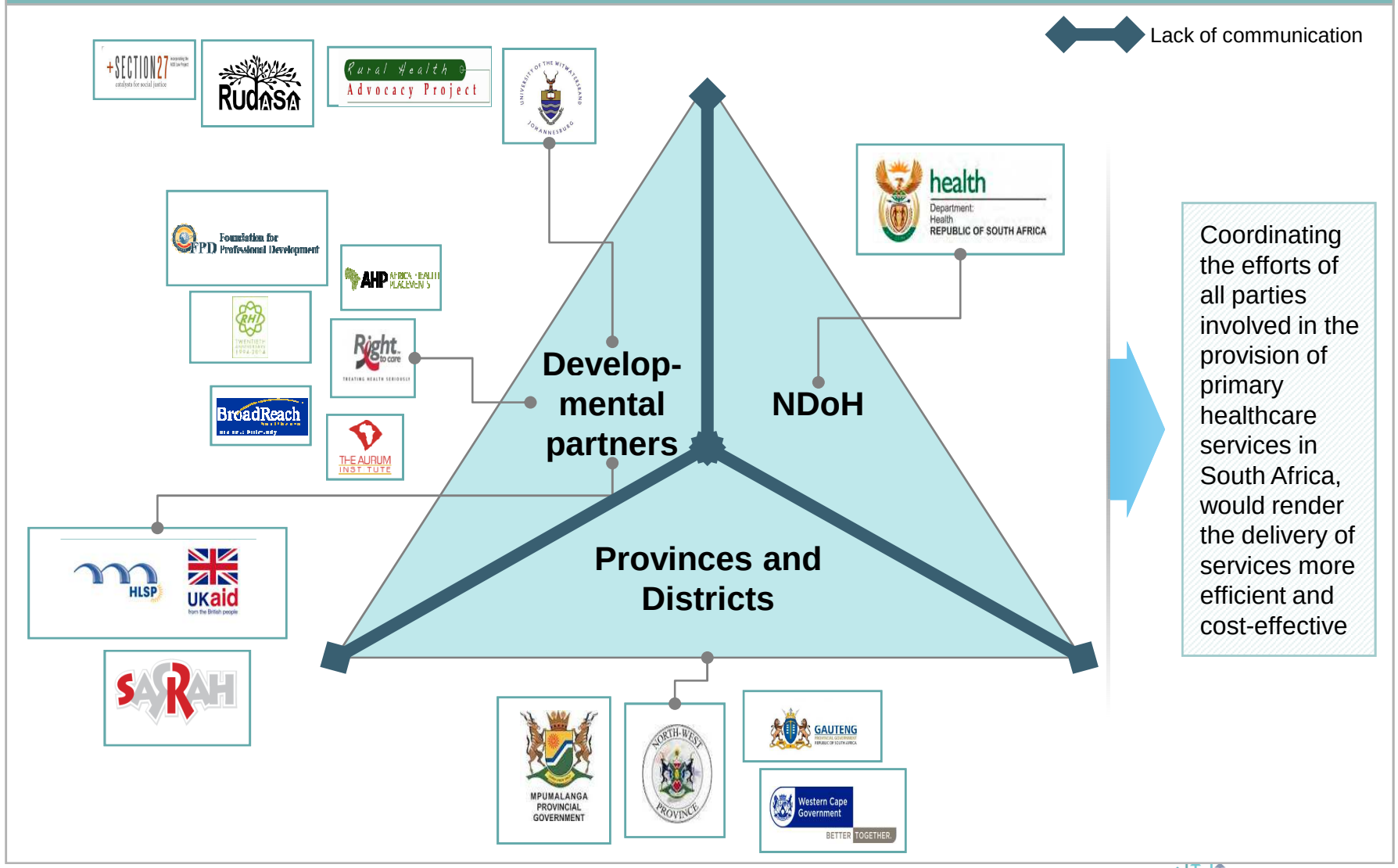
ISSUES AND ROOT CAUSES - SUPPLY AND DEMAND

Efforts from partners ara not always best coordinated

Currently the efforts from group of developmental partners, the NDoH and Provinces and Districts are not optimally coordinated, which might lead to a duplication of efforts



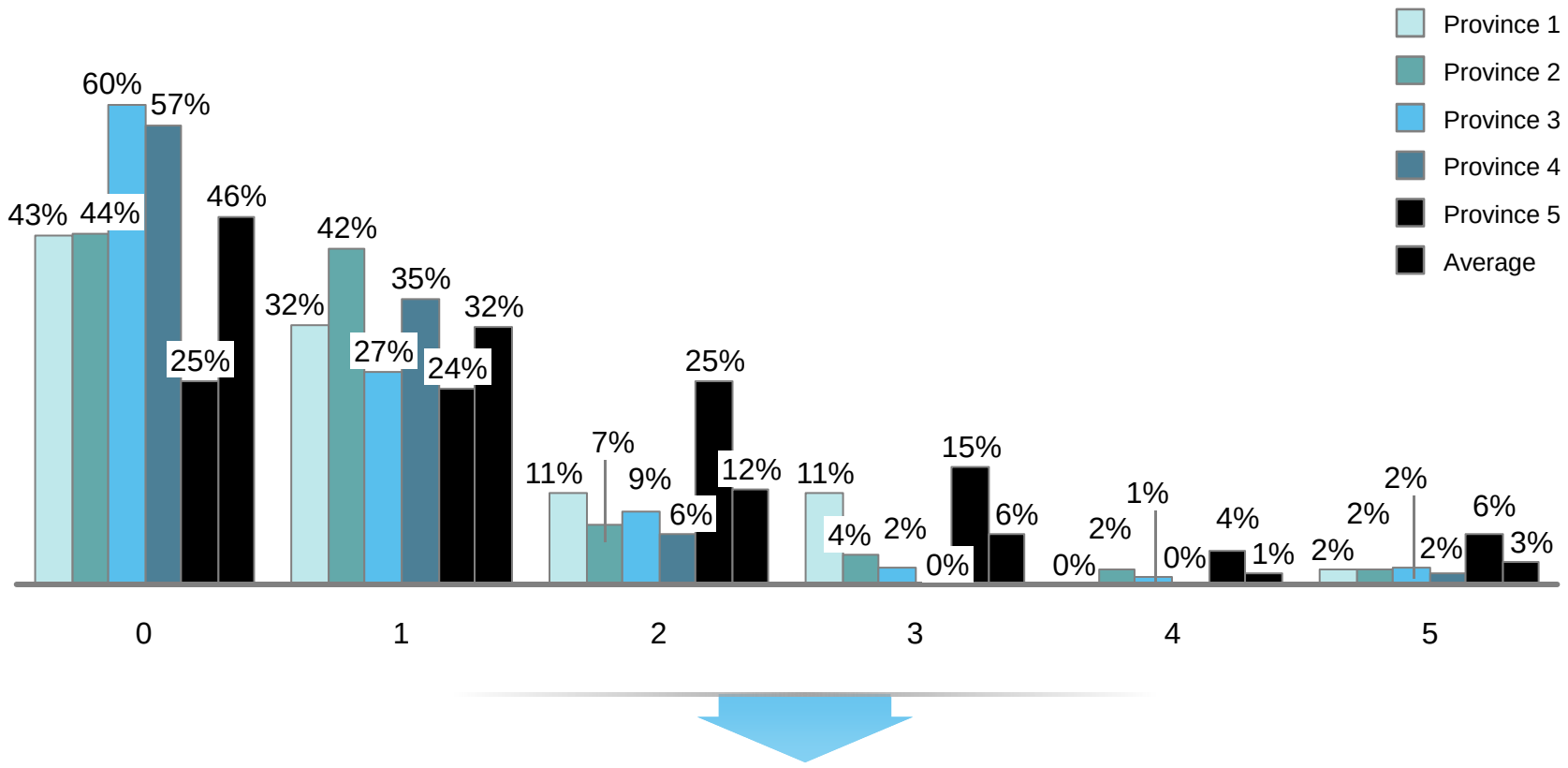
SOURCE: Lab analysis

Contents

- Context and case for change
- Aspirations
- **Issues and root causes**
  - Supply & Demand
  - **Capabilities & skill sets**
  - Behaviour & incentives
- Solutions and Initiatives

Training is not provided systematically…

Number of training sessions in the past five years
Frequency (% of total)



Nearly half of the managers interviewed had not attended a training session in the past five years

SOURCE: HST - HSR Unit and Change Management Group

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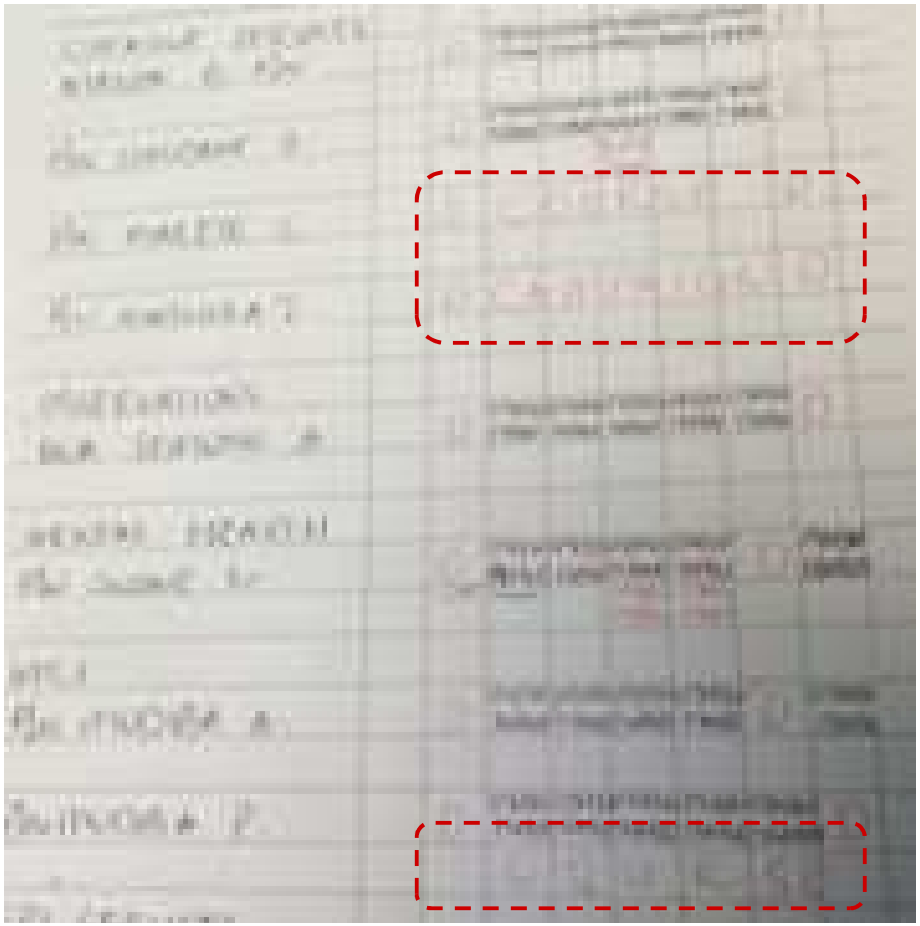
… and when it does if actually affects the good functioning of the facility: the lack of frontline input from management prevents a smooth and effective training process

Staff log in Clinic C



- **Three of ten nurses** were **off site** on **training** or **campaigns** for week in question
- Majority of training conducted **at district level** – limited scope for training to be moved to lower peak times of the day

SOURCE: Clinic staff logs, interviews, Lean Operations diagnostic

Contents

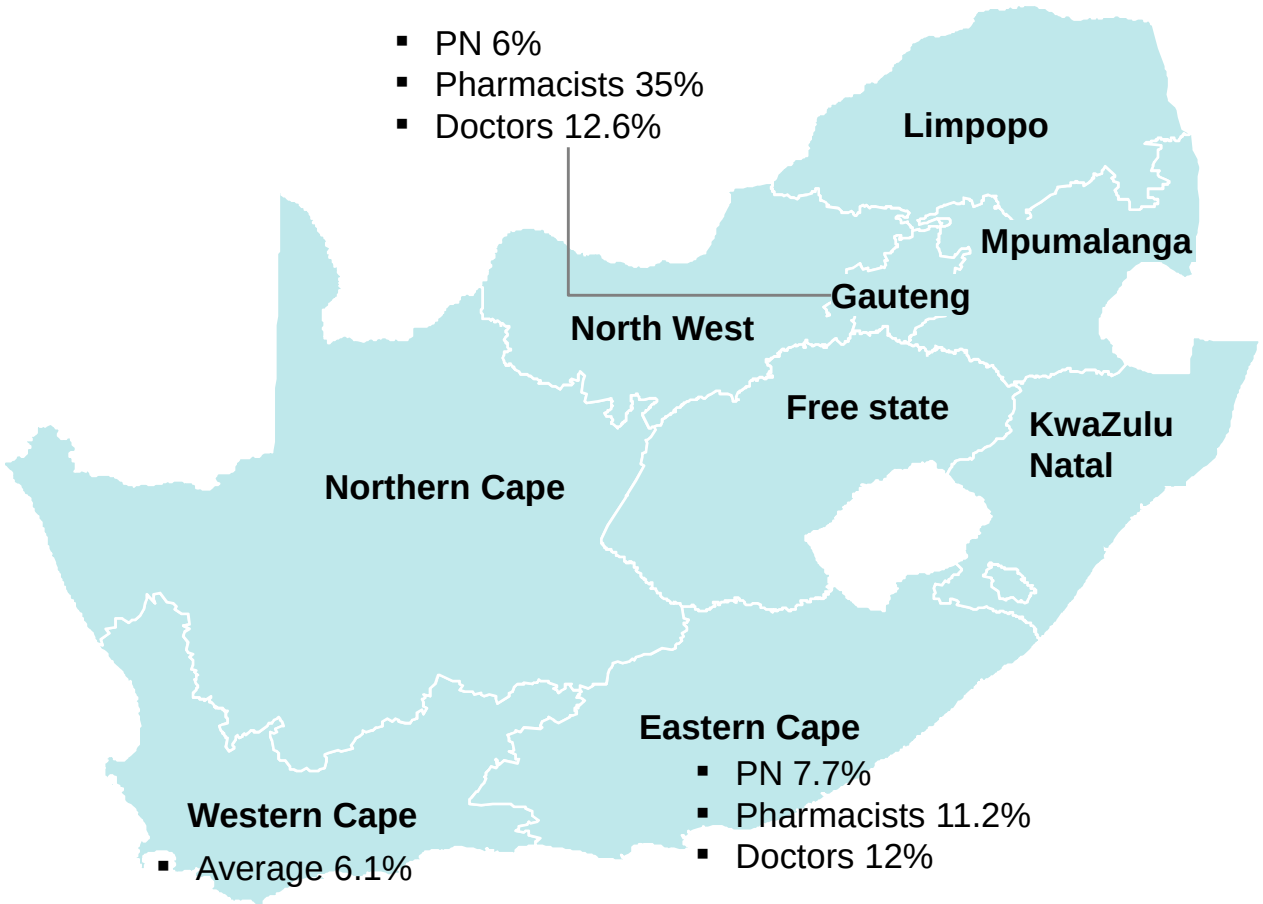
In addition to the personnel shortages, the existing staff does not benefit from a working environment conducting to the best outcomes

Sources of frustration related to HR issues	Impact on medical staff	Root causes
Lack of communication and role modeling	▪ Clinic staff becomes 'frustrated' and 'confused', feels lack of ownership over new processes: *"like if I came to your house and re-arranged your furniture"* ▪ Clinic staff unsure if executing on changes correctly	▪ Lack of 'change story' from NDoH ▪ Lack of buy-in from clinic managers ▪ Disconnect between provincial and national support systems ▪ No feedback or validation from those issuing changes
Burden of non-medical work	▪ Medical staff becomes demoralized (particularly when forced to do jobs like cleaning), feels this takes them away from patient care	▪ Vacancies in administrative roles ▪ Poor accountability in areas like reception ▪ Poor management skills amongst administrative team leaders
Lack of tangible benefit for doing well	▪ Little evidence of reward for "going the extra mile" leaves nurses demorallized and disincentivized	▪ Lack of evidence based KPIs (not tracked at individual level) ▪ Inconsistent PDMS scores, which are highly subjective ▪ Sporadic bonus payouts

Source of risk when nurses practice beyond limit of their licenses (e.g., acting for pharmacist)

SOURCE: Client focus groups, team analysis, Lean Operations diagnostic

The primary healthcare public system suffers from high attrition rates, especially in rural areas



Despite a difference in attrition rates throughout the provinces, the incentive package is homogenous nationwide

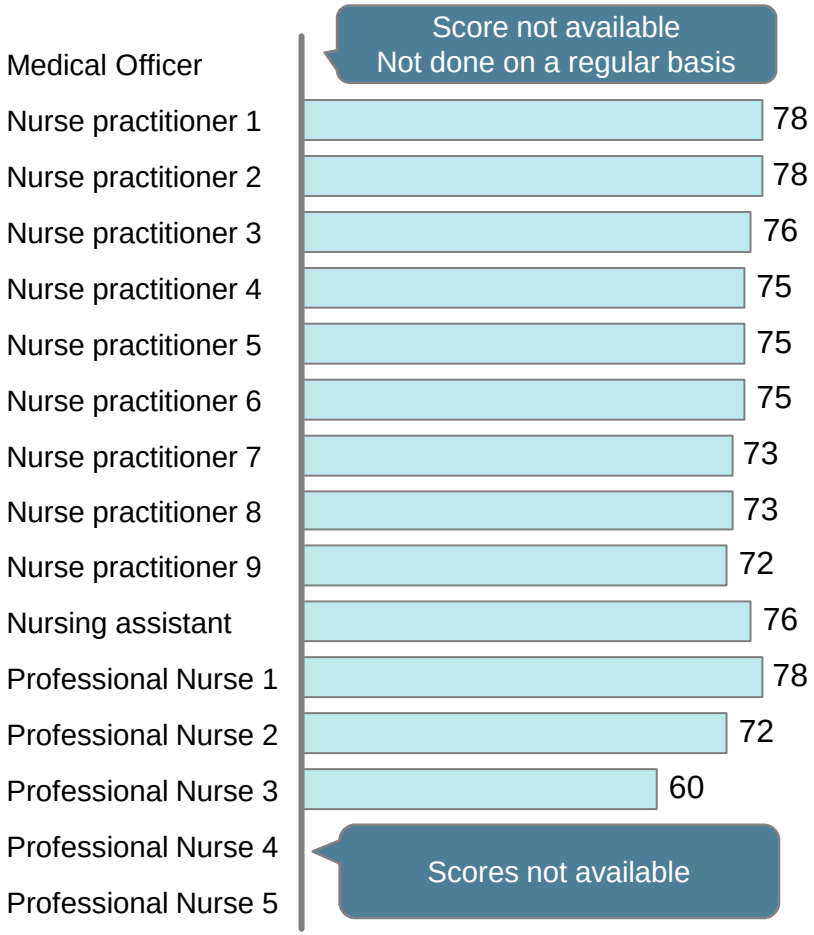
SOURCE: TBD

The performance management and development system is not rigorously implemented

The uniformly high (versus bell-shaped) scores of a facility reveal that the PMDS is not being rigorously implemented

Sample of scores for medical staff within one facility

Score out of 100



- **Discrepancy between impressions of clinic managers and medical staff:**

  Clinic manager: "There is a benefit to high performers. Nurses with high PDMS scores get promoted"
  Nurses: "Your evaluation isn't linked to promotion. It's not fact based, it depends on who is doing it – it's hard to prove that you gone the extra mile and move from a three to a four"

- **Doctors are not evaluated regularly and there is little tangible incentive to perform well**:

  Doctor: "No one does [performance management] for me – the professor never comes here… I do the best I can for patients, there is no bonus"

- **KPIs aren't always under influence of nurses**:

  Nurse: "If you're on TB [rotation], what you do now will only show in a year; you can't show progress when you're evaluated"

SOURCE: PDMS data from Gauteng Health QA, nurse focus groups, team analysis, Lean Operations diagnostic

Contents

INITIATIVES OVERVIEW

To ensure that no patient goes home unattended, and that our health workers are at their best, the workstream developed 14 initiatives which were prioritized into 3 categories

Initiatives that can be successfully implemented within the current "*business as usual*" context have been deprioritized from the ICRM Lab program

	Breakthroughs *"Must win"*	**Major delivery fixes** *"Effective execution"*	***"Business as usual"***
Supply & Demand	1 Ensure optimal redistribution of employees from overstaffed to understaffed facilities 2 Streamline recruitment process (no more than 3 months) 3 Contract GPs and other skills from the private sector 4 Identify and protect (ring-fence) funding for non-negotiable cadres	5 Ensure equitable implementation of community service policy to support under-resourced areas 6 #BringBackOurProfessionals: A campaign aimed at getting back into the primary health care system specific employees: – South African health professionals working overseas – Retired clinical employees	10 Get more health students in school and in the NDoH and expand state to state agreements to increase education capacity and recruit foreign professionals
Change manage-ment		7 Empower facility managers through training and decentralization 8 Task shifting and task sharing 9 Upskilling of non clinical staff: Provide basic emergency triage and customer focus training to all non-clinical employees	11 #Walk the talk: campaign to secure adherence to the change management framework 12 The Health Academy: an institutional link between the NDoH and the DoE 13 Improve the Performance Management Systems 14 Ensure implementation of Employee Wellness Programs

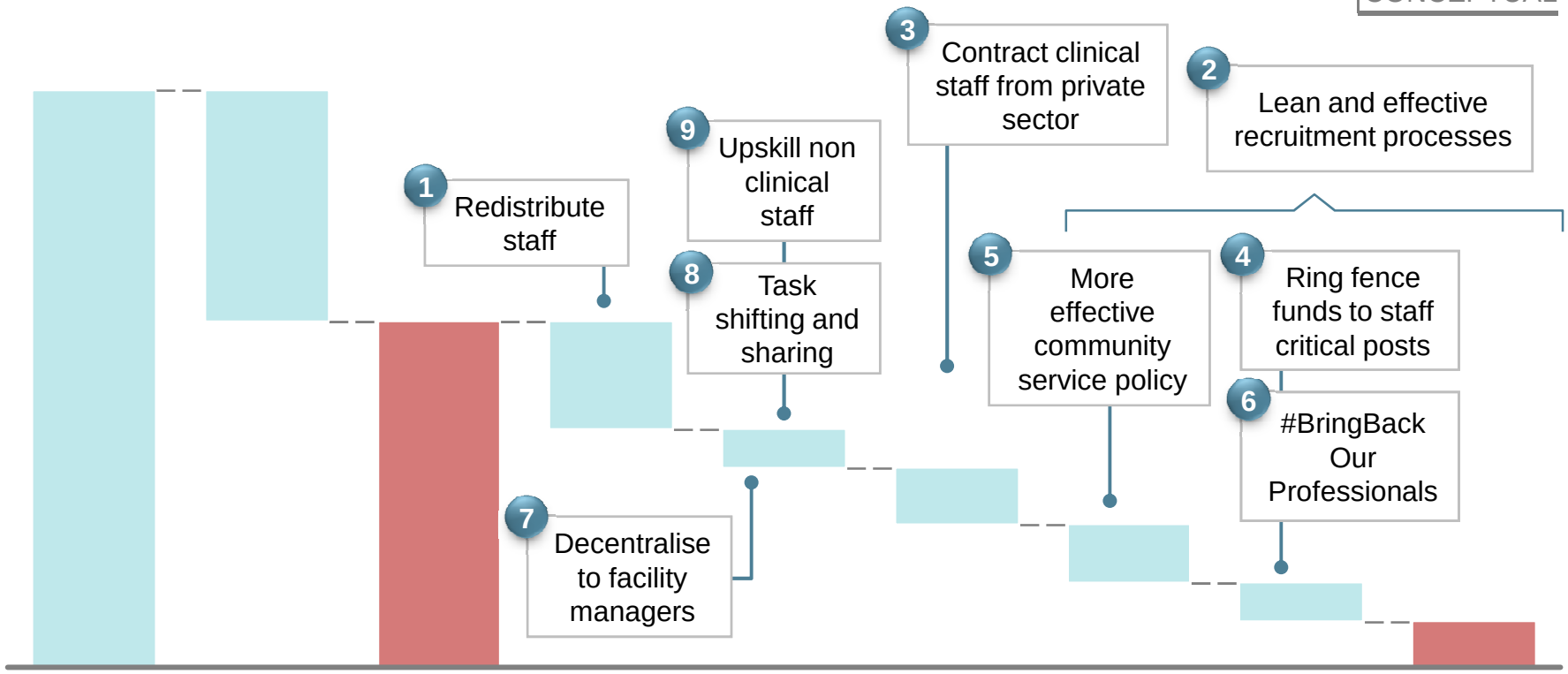
SOURCE: Lab analysis

INITIATIVES OVERVIEW

The workstream developed three feet implementation plans to drive breakthrough and major delivery fixes initiatives

Health workers in the primary healthcare

CONCEPTUAL



Long term initiatives will increase the number of health professionals trained

Contents

REDISTRIBUTION OF EMPLOYEES

1 Optimal redistribution of employees

Objective:
Develop an agreement that will ensure the optimal redistribution of employees from overstaffed to understaffed facilities

Case for change

Currently, the clinical staff is not evenly distributed throughout the country, there are ~6% understaff facilities while 26% of facilities is actually overstaffed, according to WISN standards. The divide is mostly articulated along urban vs. rural areas

Initiative details/steps

1. **Implement reallocation**
   1. Assess 3,507 facilities according to WISN methodology to accurately determine number of overstaffed, understaffed facilities and number of employees potentially concerned
   2. Make business case for number of workers to be redistributed
   3. Formulate policy in concert with all relevant stakeholders
      1. Agree redistribution conditions with organized labor
      2. Mobilize resources required to implement redistribution
   4. Coordinate and implement policy
2. **Design of enablers for sustainability of optimal allocation of staff**
   1. Create IT tool to constantly report staffing levels and needs
   2. Coordinate with private partnerships to ensure optimal distribution of staff

Redistribute workers from overstaffed to understaffed clinics

Owner

- National Department of Health

Key stakeholders identified

- Provincial/Districts and Facility Managers for Health Departments
- Organized Labor
- Employees

Required resources

Investment (ZAR):

People:

Other resources:

Level of implementation

Clinics (PHCs and CHCs)

Level of implementation

- Start date: 2015
- End Date: 2018

SOURCE: Lab analysis

OPERATION PHAKISA

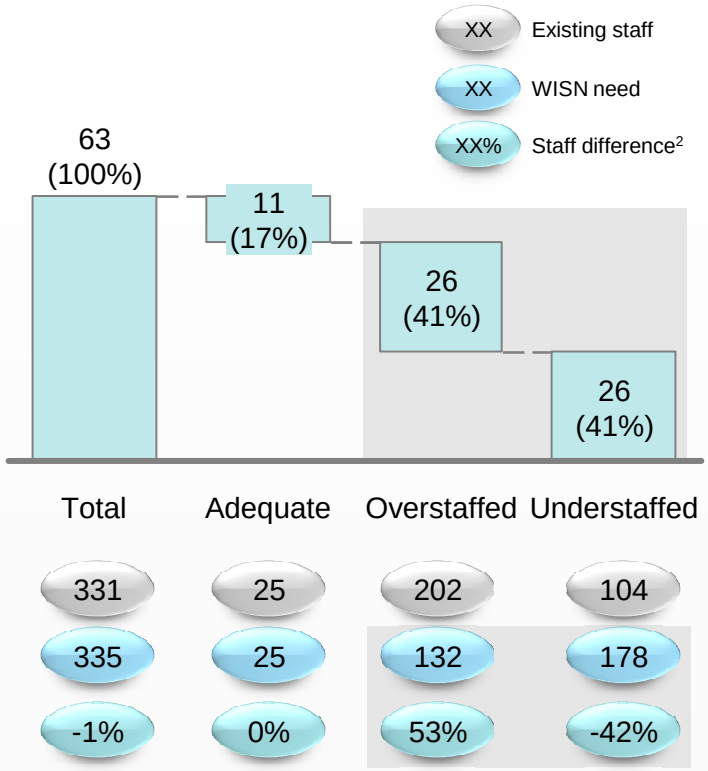
REDISTRIBUTION OF EMPLOYEES

1 Redistributing the staff surplus will help alleviate existing shortages

Over 80% of the clinics are either over or understaffed by ~50% of their real needs

Number of PHC facilities according to the need and availability of professional nurses[1]

No. of PHCs (% of total)



We estimate that redistribution of 20% of the existing staff could alleviate shortages

Redistribution steps and model

Suggested approach

Country wide redistribution

- Employees are redistributed across the country to better leverage the existing staff to fill existing vacancies
- The compensation package for redeployed workers will be most expensive as incentives have to compensate for moving across provinces

Province wide

- Employees are redistributed only within their province: the optimization of the existing staff is lower
- The compensation package for redeployed workers is smaller

District wide

- Employees are redistributed within their district: the level of optimization is lowest
- The compensation package for redeployed workers is smallest

Steps of redistribution		Estimated timeframe
1.	Assess all 3,507 facilities according to WISN[1] and estimate margins of error	2015
2.	Define a comprehensive incentive package for concerned employees and assess related costs	2015 October – December
3.	Determine policy in consultation with relevant stakeholders	2016 January – March
4.	Design and roll out plan with input from bargaining council	2016 - 2017 March - July

1 Adjusted to the needs of the current service delivery model 2 Ratio calculated as (existing staff – WISN need)/ WISN need 3 Adjusted to the needs of the new service delivery model

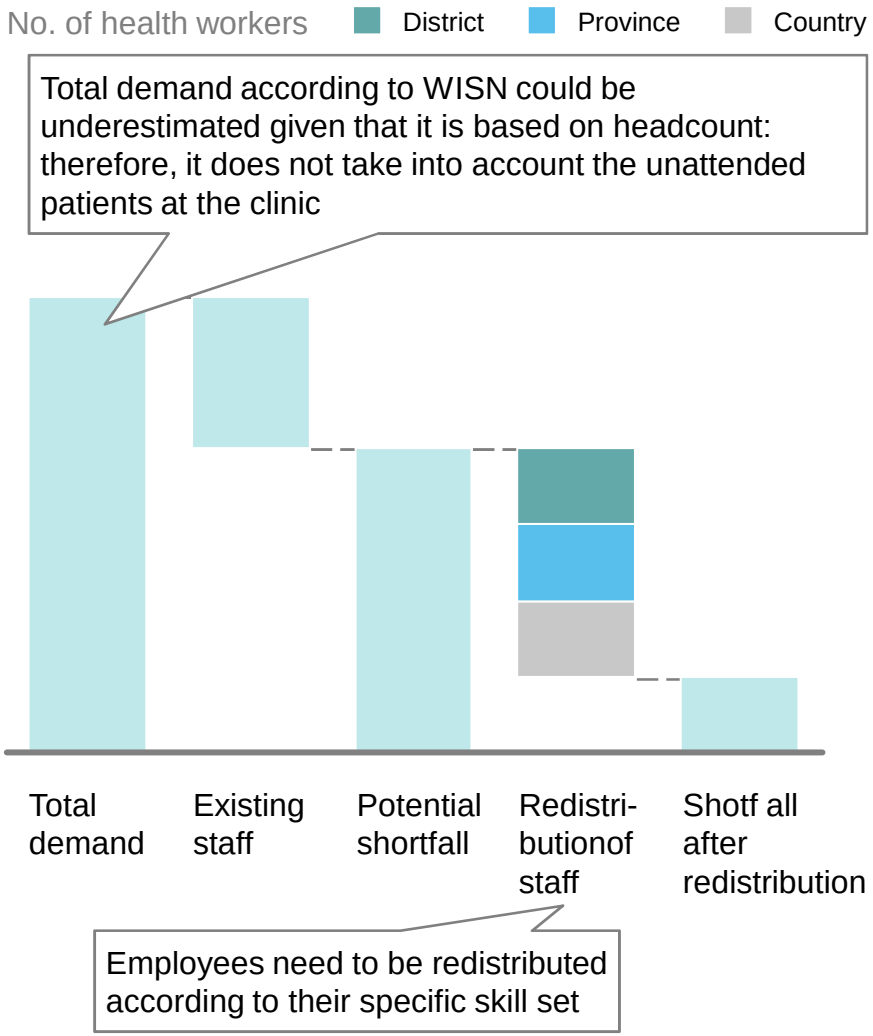
SOURCE: WISN user manual and preliminary results, lab analysis

OPERATION PHAKISA

1 The effectiveness of the staff redistribution will depend on the flexibility of the relocation process

CONCEPTUAL

Health workers in primary health care clinics



Redistribution hypothesis

H_0: Country wide

- Employees are redistributed across the country to better leverage the existing staff to fill existing vacancies
- The compensation package for redeployed workers will be more expensive as incentives have to be larger to move beyond district/provinces

H_1: Province wide

- Employees are redistributed only within their province
- The compensation package for redeployed workers is smaller than in H0
- The level of optimization of the redistribution might be lesser

H_2: District wide

- Employees are redistributed only within their district
- The compensation package for redeployed workers is smallest
- The level of optimization is also smaller than the previous options

SOURCE: Lab analysis

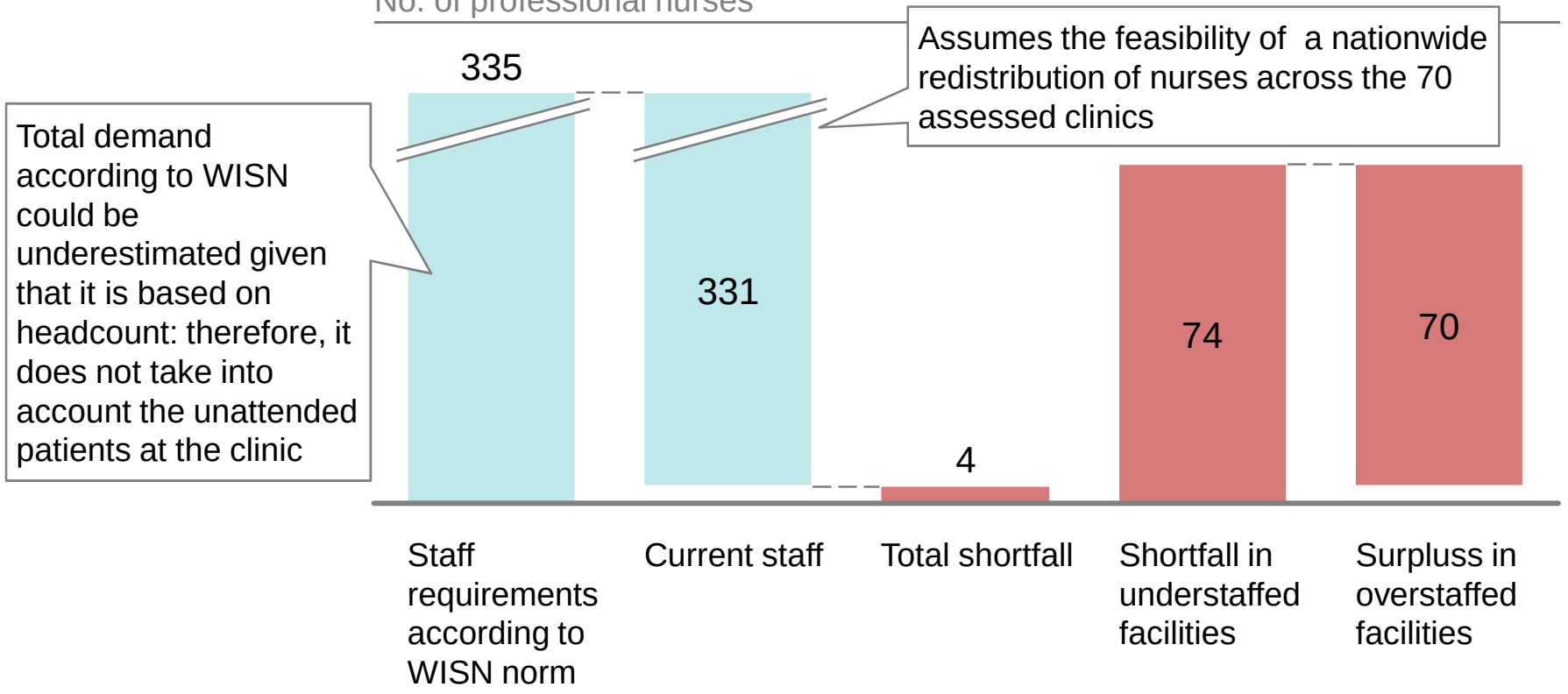
REDISTRIBUTION OF EMPLOYEES

1 Redistributing 20% of the professional nurses from the PHC clinics assessed with the WISN tool could help alleviate the staff shortage

Distribution of professional nurses[1] in 63 PHC clinics

ILLUSTRATIVE

No. of professional nurses



Assumes the feasibility of a nationwide redistribution of nurses across the 70 assessed clinics

Total demand according to WISN could be underestimated given that it is based on headcount: therefore, it does not take into account the unattended patients at the clinic

Percentage of current staff

100% | 22% | 21%

Most impactful hypothesis
The real shortage would be within a range according to the flexibility (cf. previous page)

1 The position "nurse" groups assistant nurse, clinical nurse practitioner, dispenser enrolled nurse, professional nurse, public health nurse, registered nurse, staff nurse

SOURCE: WISN assessment – 63 facilities

REDISTRIBUTION OF EMPLOYEES

1 Steps of the staff redistribution

Organized Labour
NDoH
National Treasury
DPSA
PSCBC
Provincial Bargaining Council
National Bargaining Council

Prioritize volunteers
Based on current requests of transfer/cross transfer

- Assess 3,507 facilities according to WISN methodology to determine number of overstaffed, understaffed facilities and number of employees potentially concerned by a redistribution of staff
- Make business case for optimal number of workers to be redistributed
- Determine incentives package for relocation
- Formulate policy in consultation with all stakeholders
  - Consultation and agreement on redistribution conditions and incentive package with organised labour
- Mobilise the financial and material resources required to implement redistribution

Design roll out plan
- Align with provincial Bargaining Council for better coordination and implementation
- National Bargaining Council to develop the Resolution/Agree ment that will result into Policy on Staff Relocation

Redistribute concerned employees
- Joint operation with provincial Bargaining Council and National Bargaining Council (for better coordination and implementation)

Remuneration and allowances must be maintained or increased. Rural Allowance should be widened to accommodate Enrolled Nurses and Pharmacist Assistants with post basic qualification

The clinics must be well resourced to promote a conducive working environment and be attractive to health personnel

Design enablers for sustainability of optimal allocation of staff
- Create IT tool to constantly report staffing levels through WISN going forward
- Coordinate with private partnerships to ensure optimal distribution of staff

SOURCE: Lab analysis

OPERATION PHAKISA

2 Streamlining recruitment processes

Objective: Streamline recruitment processes to 3 months

Initiative concept/details/highlights

Currently, HRH recruitment is centralised and the function doesn't lie with the Facility Manager.

The recruitment doesn't include Facility Managers and Labour Organisations and not e-technology enabled but paper based which prolongs the process in terms of a high number of signatory levels.

What the HR Lab would want to achieve

1. Allow the process of recruitment and appointment of HRH to be decentralised to the facility level.
2. Analyse the availability of posts as per WISN norms
   - Determine the norms set for the facility
   - Identify the workload per facility
   - Determine the facility benchmark norm for each cadre
   - Determine the variance between existing staff, and the facility norm
3. Analyse the gap in terms of scares skills shortage per facility needs through WISN process (i.e. non-negotiable staff)
4. Reduce the time period for filling identified and prioritised posts to shorten the recruitment process.
5. Improve HR appointment process through the implementation of e-technology

Owner

- National Department of Health

Key stakeholders identified

- Provincial Health departments
- Facility Managers
  - Recruitment Agencies
- Organised labour
  - Electronic& paper-based Media Houses
  - Professional Bodies

Required resources

- Investment (USD): Budget

Implementation timeframe

- Start date:2015
- End Date: 2018

Key milestones

- 2015: Process Decentralisation
- 2018: Recruitment finalised within 3 months

SOURCE: Lab analysis

2 Streamlining recruitment processes

Objective: Streamline recruitment processes to 3 months

What the HR Lab would want to achieve

5. Use different ways of post advertisement including walk-in application process at facility level and

- Re-enforce the policy on direct appointment for incumbents with appropriate competencies in terms of facility needs.
- Head hunt appropriate incumbents through Professional Councils websites, University Career Centers, Recruitment Agencies within a month of identifying the need
- Advertise positions internally through intranet and externally through local, regional and national radios and newspapers, online, Professional Councils websites, University Career Centers, Recruitment Agencies, etc. Use media, e.g. local, regional and national newspaper and radio, recruitment agencies, intranet, internet, etc.

7. Interview identified candidates through the utilisation of Tele-communication or face to face.

8. Inform successful and unsuccessful candidates interviewed through e-mails, telephone, SMS, etc.

To ensure the recruitment and appointment of successful incumbents within three (3) months by 2018

Owner

- National Department of Health

Key stakeholders identified

- Provincial Health departments
- Facility Managers
- Recruitment Agencies
- Organised labour
- Electronic& paper-based Media Houses
- Professional Bodies

Required resources

- Investment (USD): Budget

Implementation timeframe

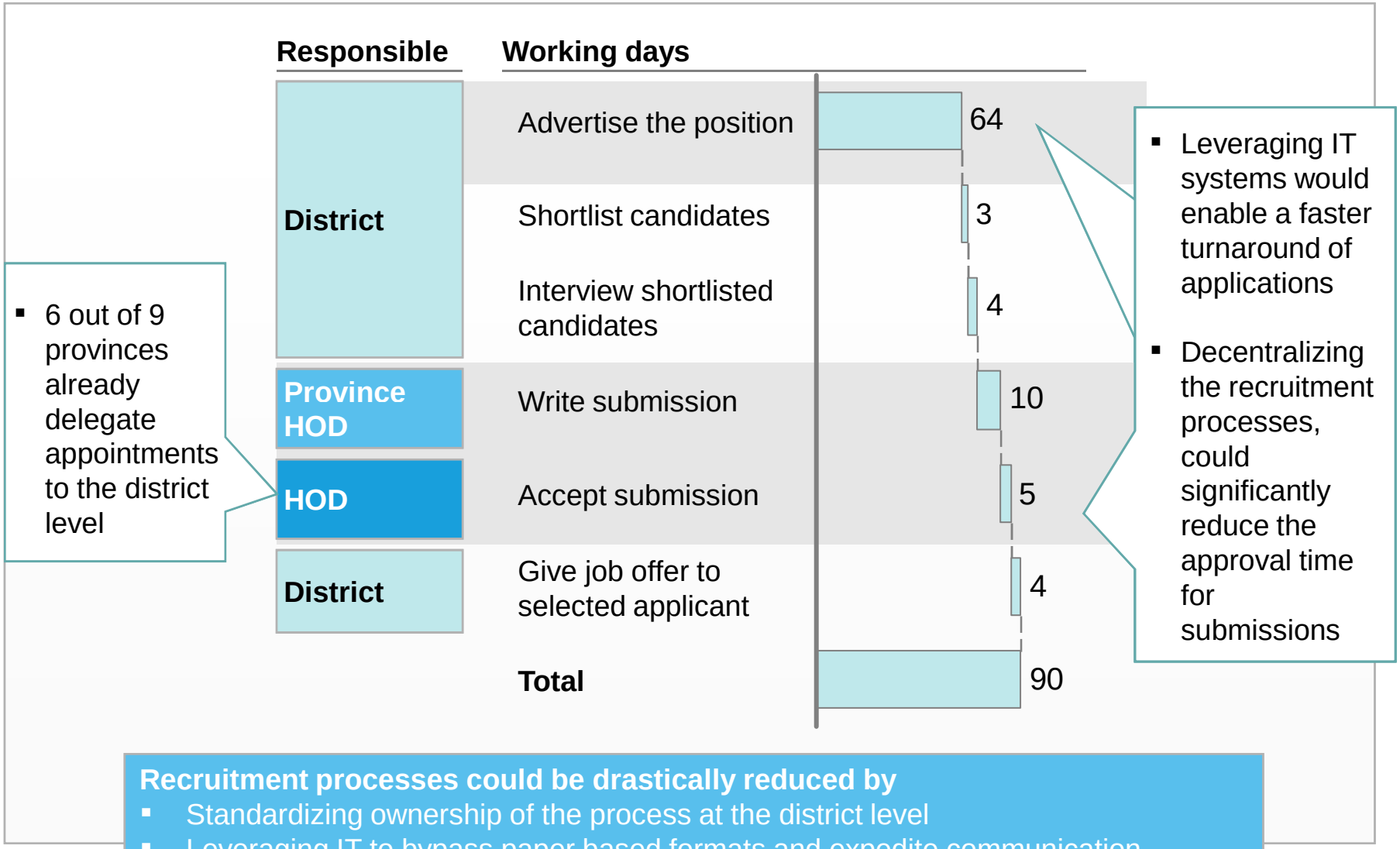
- Start date:2015
- End Date: 2018

Key milestones

- 2015: Process Decentralisation
- 2018: Recruitment finalised within 3 months

SOURCE: Lab analysis

2 Streamlining recruitment processes down to 3 months will ensure that we actually hire the experienced employees and retain the students



Recruitment processes could be drastically reduced by

- Standardizing ownership of the process at the district level
- Leveraging IT to bypass paper based formats and expedite communication
- Standards would have to be established to maintain quality of recruitees

CONTRACT FROM PRIVATE SECTOR

3 Contracting clinical staff for the most deprived areas will help to bridge the gap between supply and demand

Objective: Increase the number of healthcare professionals in the primary care public system by contracting private sector workers and coordinate the existing efforts from developmental partners so as to avoid duplication of tasks

Concept

- According to the 2012 baseline audit of the PHC system, 84% of clinics did not receive any input from pharmacists & pharmacist assistants[1] and 47% of clinics did not have visits from doctors
- By leveraging the human resources from the private sector we can partially address the shortage of critical skills

Steps

In order to leverage private sector resources, the following steps will have to be taken:

- Conduct a **pilot** to leverage **private GPs** and **refine best practices**
  - Assess the number of private GPs required and specific skill mix
  - Optimize contracting guidelines (standardize fees, consultation hours) and syndicate with developmental partners
  - Ensure completion and monitoring of pilot in NHI districts
  - Evaluate pilot and incorporate findings onto contracting strategy
- **Roll out pilot to allied health professions** (e.g. pharmacists)
  - Assess the number of private professionals required per profession
  - Engage with developmental partners to contract the required staff

All 3,500 clinics should have: + **Visits from doctors** + **Pharmacy assistants**

Owner

- NDOH - HR

Key stakeholders identified

- Professional Organizations & Unions

Estimate of required resources

- Financial resources (ZAR): GP's R 388.00 p/h; Assistants 160K p/a
- Human resources: Doctors & pharmacists

Level of implementation

- Start date: 2015/2016

SOURCE: Lab analysis

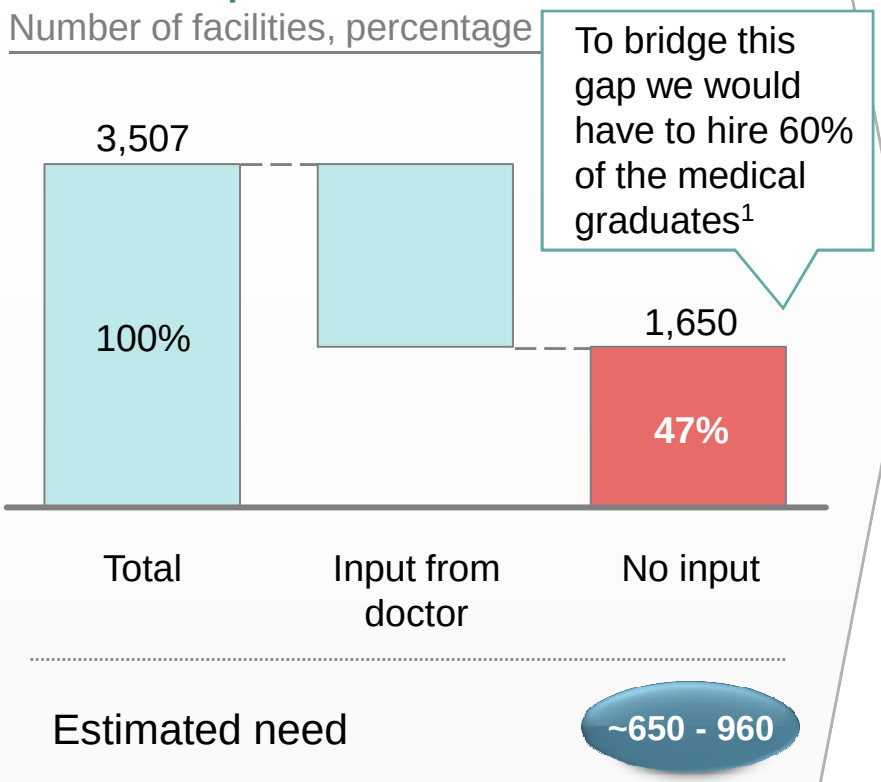
CONTRACT FROM PRIVATE SECTOR

3 Contracting private general practitioners and other health workers could be a fast way to address the scarcity in the PHC system

Almost 50% of the clinics in the country do not have doctor visits

PHCs in the public service

Number of facilities, percentage



Developing partners could assist in securing access to a GP for all South Africans

1. Fast track the current GP contracting pilot being conducted by the FPD
2. Assess the number of private GPs required and specific skill mix for the remaining 43 non pilot districts
3. Optimize the contracting guidelines (standardize fees, consultation hours) and syndicate with developmental partners
4. Contract required number of GPs
5. Extract best practices from findings of GP contracting and incorporate into strategy for other health professionals

1 Assuming a service package with one doctor per clinic

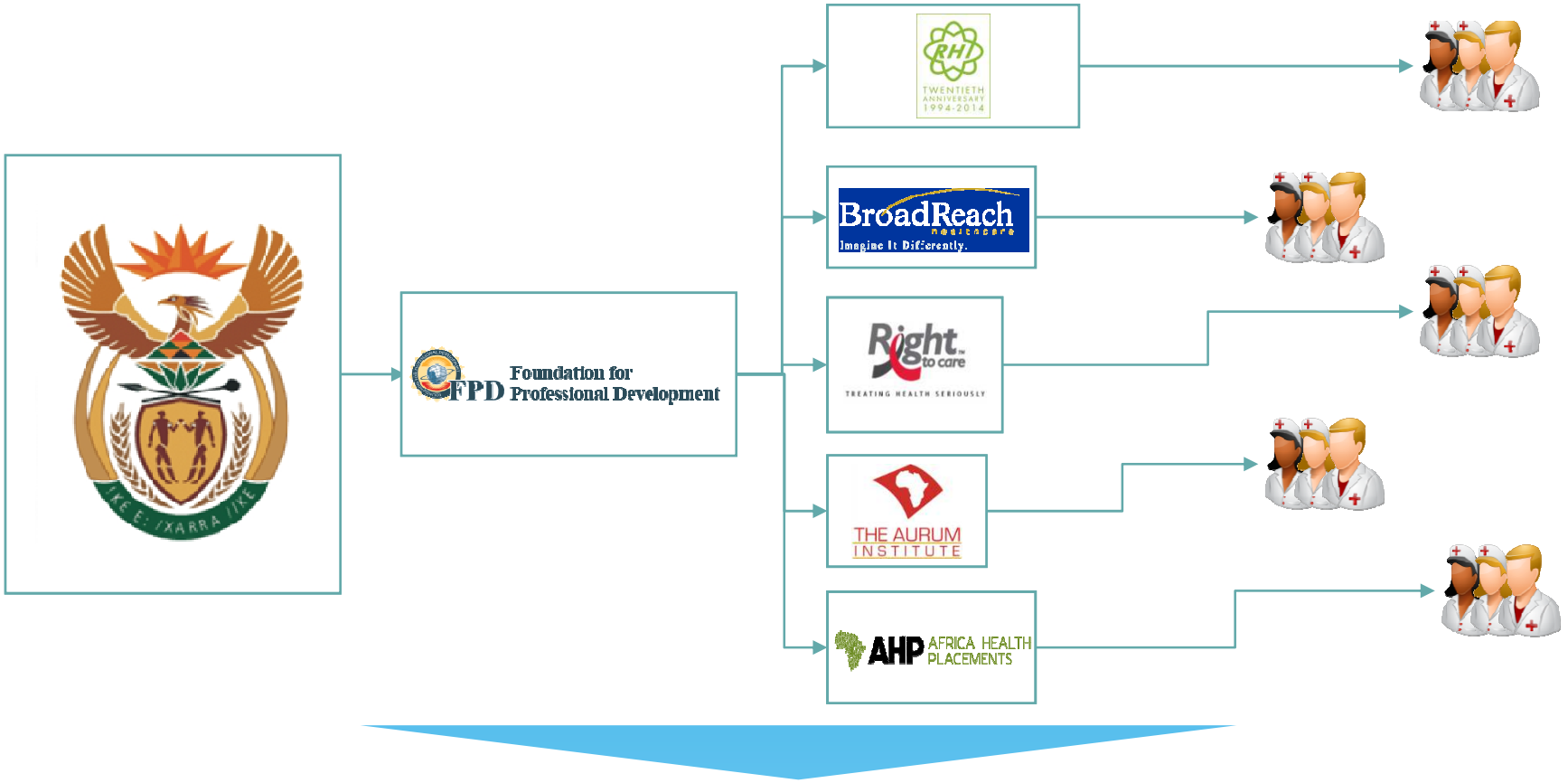
SOURCE: Lab analysis, IPAF, 2012 Baseline Assessment

OPERATION PHAKISA

CONTRACT FROM PRIVATE SECTOR

3 By leveraging developmental partners to assist its contracting efforts, the NDoH can efficiently multiply its reach to health professionals

NOT EXHAUSTIVE



- Mediating the contracting process entails coordinating the efforts of the developmental partners in order to ensure an equitable and efficient distribution of the human resources deployed
- To increase efficiency and secure coverage of rural areas, an attractive incentive package has to be in place (e.g. accommodation package, transportation compensation)

SOURCE: Lab analysis

NON NEGOTIABLE STAFF FUNDING

4 Ensure Funds for non-negotiable staff

Objective: Ensure that 100% of the primary healthcare clinics have minimum non clinical staff to function adequately

Idea

- 21% of clinics have no manager
- Due to lack of funds posts were not filled
- Some of the posts were abolished as they were not filled for over a year
- Although filling of clinical post was prioritized above support staff but there were still clinical posts that could not be filled
- Some of the posts were abolished because they were unfunded
- On the other hand the system has “ghost workers” that are receiving a salary but are not working

Steps

- Clean up the Persal database and work towards linking it to the department of Home Affairs to keep it updated
- Identify existing vacant posts in the clinics
- Where there are no vacant posts request for funding and creation
- Cost the filling of posts
- Request the budget from treasury for creation and filling
- Appoint the minimum for every clinic for the Support staff
- Determine the number of staff according to the WISN staffing norms

Owner:

- District Managers

Key stakeholders identified:

- National and Provincial Treasury

Required resources

Funds for the filling of posts including support staff

People: Number of Security Guards

Other resources: TBD

Level of implementation

- District and Province and Facility

Implementation timeframe

- Start date: 2014/11/ 31
- End Date: 2014/11/21

NON NEGOTIABLE STAFF FUNDING

4 It is necessary to ring fence the funding of 5 key support posts in clinics to ensure that the facilities will be fully functional to deliver health services

	Situation today	Minimum requirements per facility	Needs No. of employees
Facility Manager	▪ 21% of clinics have no manager	▪ 1 manager for larger facilities ▪ Smaller PHCs can potentially share one manager	Up to 550-850
Pharmacist's assistant	▪ 84% of clinics lacked pharmacists	▪ 1 Pharmacist's assistant or Pharmacy technician	4,500 to 6,800
Data capturer	▪ 79 % had no information staff	▪ 1 data capturing clerk	6,500 to 9,800
Security officer and cleaner	▪ 24% of the 63 facilities assessed through WISN had no cleaner	▪ 3 Security officers[1] ▪ 1 Cleaner	14,000

Proposed steps

1. Clean up the PERSAL database and work towards linking it to the department of Home Affairs to keep updated
2. Determine an accurate number of staff required according to results from a nationwide WISN assessment
3. Identify existing vacant posts in the clinics and cost them
4. Where there are no vacant posts request for funding and creation from Treasury
5. Recruit and appoint the non-negotiable cadres for every clinic

1 It is assumed that, by 2018, all security personnel will be either in-house or outsourced after the expiry of the current outsourcing contract

SOURCE: National Facilities Baseline audit (2012), Lab analysis

OPERATION PHAKISA

4 Ring-fencing will be enforced through directives at province and sub-district level

Initiative also conducted by the Financial Management workstream

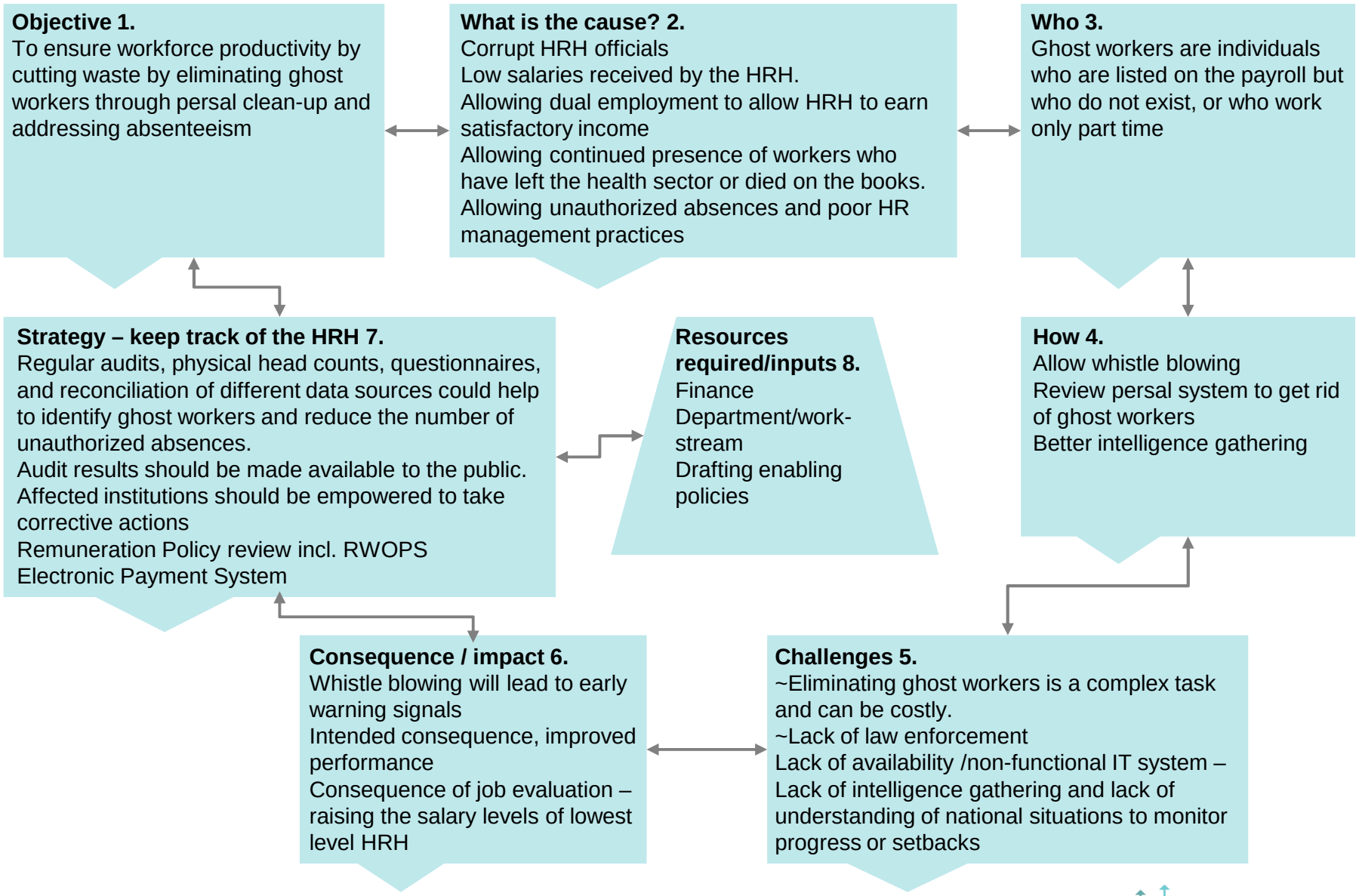
Province	▪ CFO enforces that budget office is not allowed to shift away from non-negotiables during the financial year
Sub-district	▪ Sub-district manager approves facility shifts only within non-negotiables or to non-negotiables
Facility	▪ Facility manager given full visibility on budget, and is allowed to shift funds but not from non-negotiable to other categories

Ring-fencing implies that funds can be shifted to non-negotiables, but never away from non-negotiables

SOURCE: Estimates of Provincial Revenue and Expenditure 2013 / 14 financial year

NON NEGOTIABLE STAFF FUNDING

4 Persal clean up: remove "ghost workers" from payroll



SOURCE: Lab analysis

OPERATION PHAKISA

NON NEGOTIABLE STAFF FUNDING

4 It is necessary to ring fence the funding of 5 key support posts in clinics to ensure that the facilities will be fully functional to deliver health services

	Situation today	Minimum requirements	Rationale
Facility Manager	▪ 21% of clinics have no manager	▪ 1 Facility manager per facility ▪ Working hypothesis to be refined according to the size of the facility	▪ The presence of the facility manager in the clinic ensures leadership at facility level for the workforce to feel valued and supported
Pharmacy assistant	▪ 84% of clinics lacked input from pharmacists	▪ 1 Pharmacy assistant	▪ Shortage of dispensers
Data capturer	▪ 79 % had no information staff	▪ 1 data capturing clerk	▪ An insufficient number of data capturers compromises data integrity ▪ This can lead to a poor understanding of the situation of the clinics, compromising in turn a sound HR planning strategy
Security officer and cleaner	▪ Patient Safety and Security has the lowest score in the rating by the National Health Baseline Audit	▪ 3 Security officers[1] ▪ 1 Cleaner	▪ The safety and security of staff and patients are of utmost important for delivery of services

1 It is assumed that, by 2018, all security personnel will be either in-house or outsourced after the expiry of the current outsourcing contract

SOURCE: National Facilities Baseline audit (2012), Lab analysis

NON NEGOTIABLE STAFF FUNDING

4 There are a number of vacancies in supporting roles (admin, maintenance and security)

ILLUSTRATIVE

	Admin/ general	Maintenance/ security	Nurses	Doctors
Clinic A	1 vacancy (of 1 post)	1 vacancy (of 1 post)		
Clinic B				
Clinic C	2 vacancies (of 2 posts)		2 vacancies (of 37 posts)	1 vacancy (of 3 posts)
Clinic D	Data not available			

Vacancy

No vacancy

Insights

- Shortages of administrative staff results in admin work being shifted to non-administrative staff

SOURCE: Gauteng Health QA, Lean Operations diagnostic, team analysis

OPERATION PHAKISA

NON NEGOTIABLE STAFF FUNDING

4 Estimated financial resources that will have to be ring-fences to ensure full functionality of the 3,507 ideal clinics

PRELIMINARY

Staff	Goal By 2018 Number of extra employees (%)	Annual wage[3] R'000	Total Cost Rm	2015-16 Rm	2016-17 Rm	2017-18 Rm
Facility Manager[1]	736 (21%)	350	260	87	87	87
Security Officer[2]	10,500 (100%)	90	945	0[2]	473	473
Pharmacist Assistant	2,950 (84%)	122	360	120	120	120
Data Capturer	2,800 (79%)	103	290	97	97	97
Cleaner	3,507 (100%)	87	305	0[2]	152	152
Total	20,493		**2,160**	**304**	**929**	**929**

NB: Figures might not add up given rounding of estimations

1 Working hypothesis to be refined: One facility manager per clinic

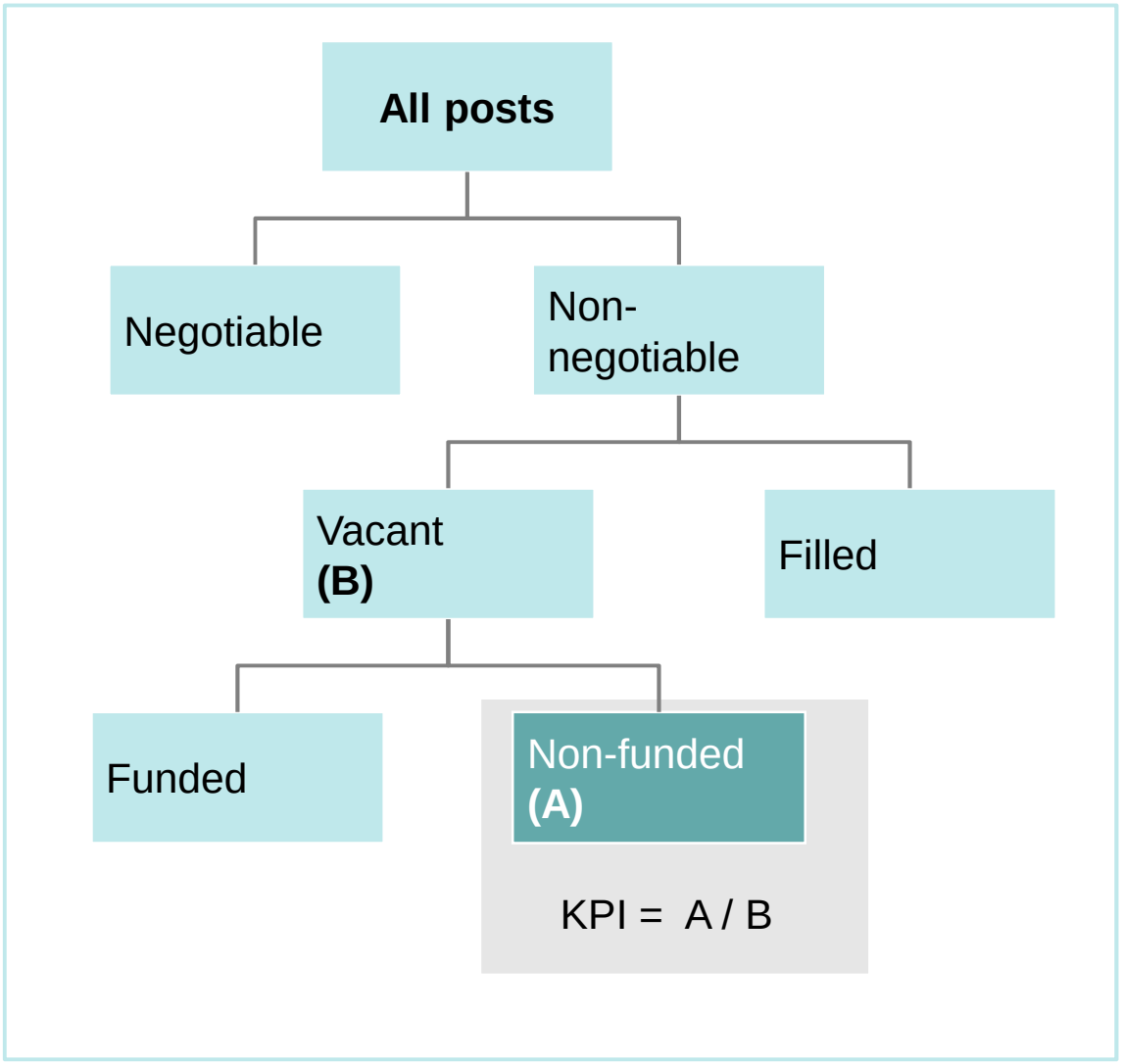
2 It is assumed that, by 2018, all security and cleaning personnel will be either in-house or outsourced after the expiry of the current outsourcing contract

3 Annual wages as stated in the COLA

SOURCE: Lab analysis

OPERATION PHAKISA

Initiative 4: Ring fencing funding for non-negotiable posts



SOURCE: Team analysis

Contents

COMMUNITY SERVICE

5 An effective community health service policy

Objective: To develop a more effective community service policy to alleviate HRH shortage in under-served areas for optimal health outcome

Initiative concept/details/highlights

Currently there is no standardized policy in the country between the professions and between the provinces. The existing policies cannot effectively address the distribution of health professionals to the under-served areas. According to the HRH strategy, South Africa will need ~2,800 doctors and 3,160 professional nurses by 2015/16

What the HR Lab would want to achieve

- Find all existing policies
- Establish the current distribution of community Health Service professionals across the country
- Compare the policies to find gaps
- Obtain the original policy framework for the introduction of Community service to identify gaps in all existing policies
- Obtain literature on Community Services in other countries
- Prepare recommendations for the formulation of a standard community Health Service

To have an equitable/proportional distribution of all community service health professionals across the country by 2018

Owner

- Department of Health

Key stakeholders identified

- Provincial Health departments
- Health professionals statutory bodies; (SANC)
- Organised labour
- Nursing schools/colleges

Required resources

- Investment (USD): Budget

Implementation timeframe

- Start date:2015
- End Date: 2018

Key milestones

- 2015: Policy formulation
- 2016: Policy implementation

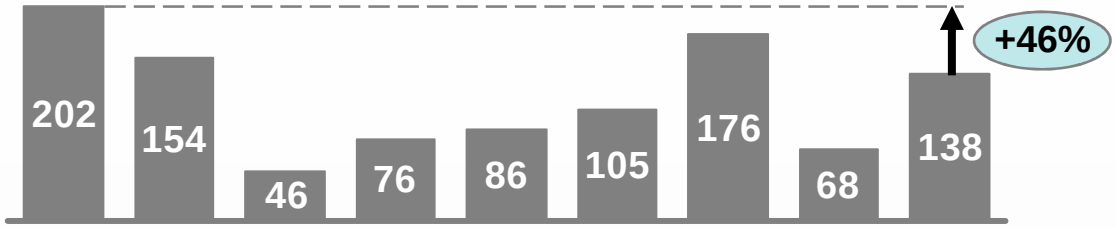
SOURCE: Lab analysis

OPERATION PHAKISA

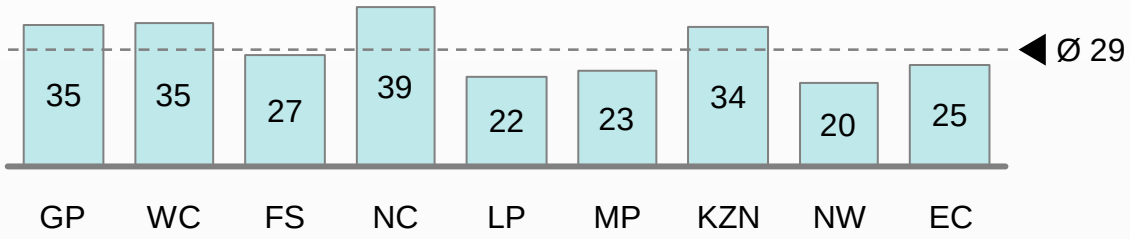
5 Developing a more effective community service policy and practices will supply more clinical practitioners to rural areas

Community service professionals are not equitably distributed across provinces

No. of community service professionals per province of deployment



No. of medical doctors per 100,000 inhabitants



- Some provinces are receiving fewer community service professionals than others despite having a lower ratio of medical doctors per 100,000 inhabitants

How we plan to achieve it

1. Review policy to:
   - Prioritize underserved areas when budgeting for community service posts
   - Distribute HRH (allocate according to facility needs and not individual preferences)
2. Create more placement posts in underserved areas
3. Incorporate incentives in the current policy to motivate community service professionals in underserved areas to accept a permanent position
   - Transport subsidy
   - Wi-Fi/internet
   - Flexi-hours
   - Training and conferences

SOURCE: South African Health Review 2013/2014

COMMUNITY SERVICE

5 There are best practices when it comes to drafting a sound community service policy

Good planning	Prospective and proactive planning around the 3 steps of the process is key for a successful program ▪ Assignment ▪ Placement ▪ Fulfilment The individuals should be trained in procedures relevant to working in a rural area
Transparency and clarity	▪ A clear understanding of the rationale and requirements is key: health professionals need to have a clear understanding of the rationale for their assignment and a clear set of expectations ▪ Clarity of intent and consistency of implementation on the following are key: – Rationale for the assignment – Duration of assignment – Decision making processes around the assignment – Role of the host community in the selection process
Support	▪ Benefits provided to the health worker must be clearly defined: – Pay – Housing – Continuing education – Clinical backup or supervision ▪ Sending doctors to remote areas with little support may place doctors in the periphery, but the absence of assistance is likely to result in clinicians abandoning their site, or function ineffectively

It is possible to benchmark off international best practices: In Norway each graduate is assigned a random number called in order. The graduate has six hours to choose a post location from those still available[1]

This system allows each graduate to know his/her chance of gaining a choice post location

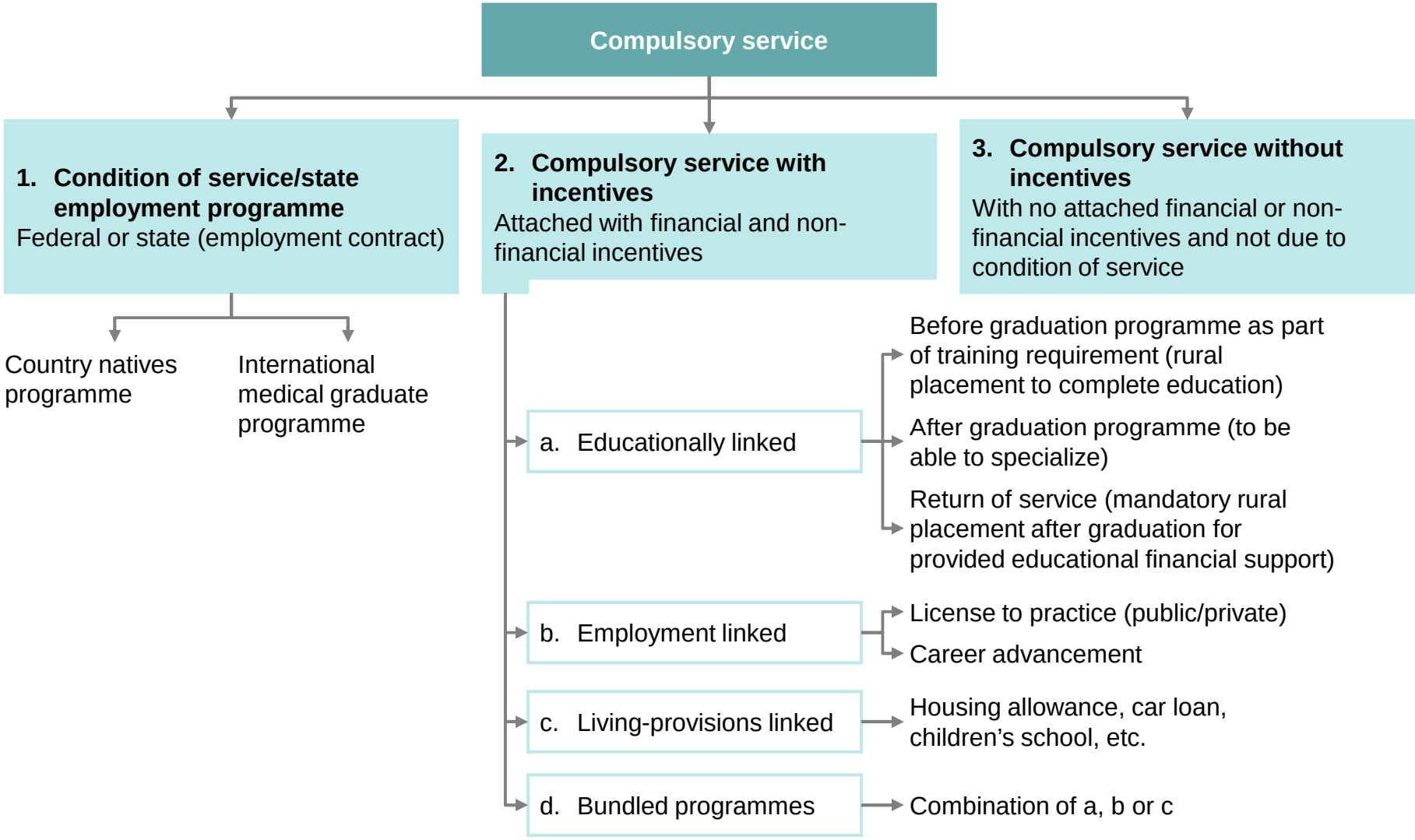
1 Except under extreme circumstances (i.e. severe illness in the immediate family), no swapping of assigned locations is permitted

SOURCE: WHO - Compulsory service programmes for recruiting health workers in remote and rural areas: do they work?

OPERATION PHAKISA

COMMUNITY SERVICE

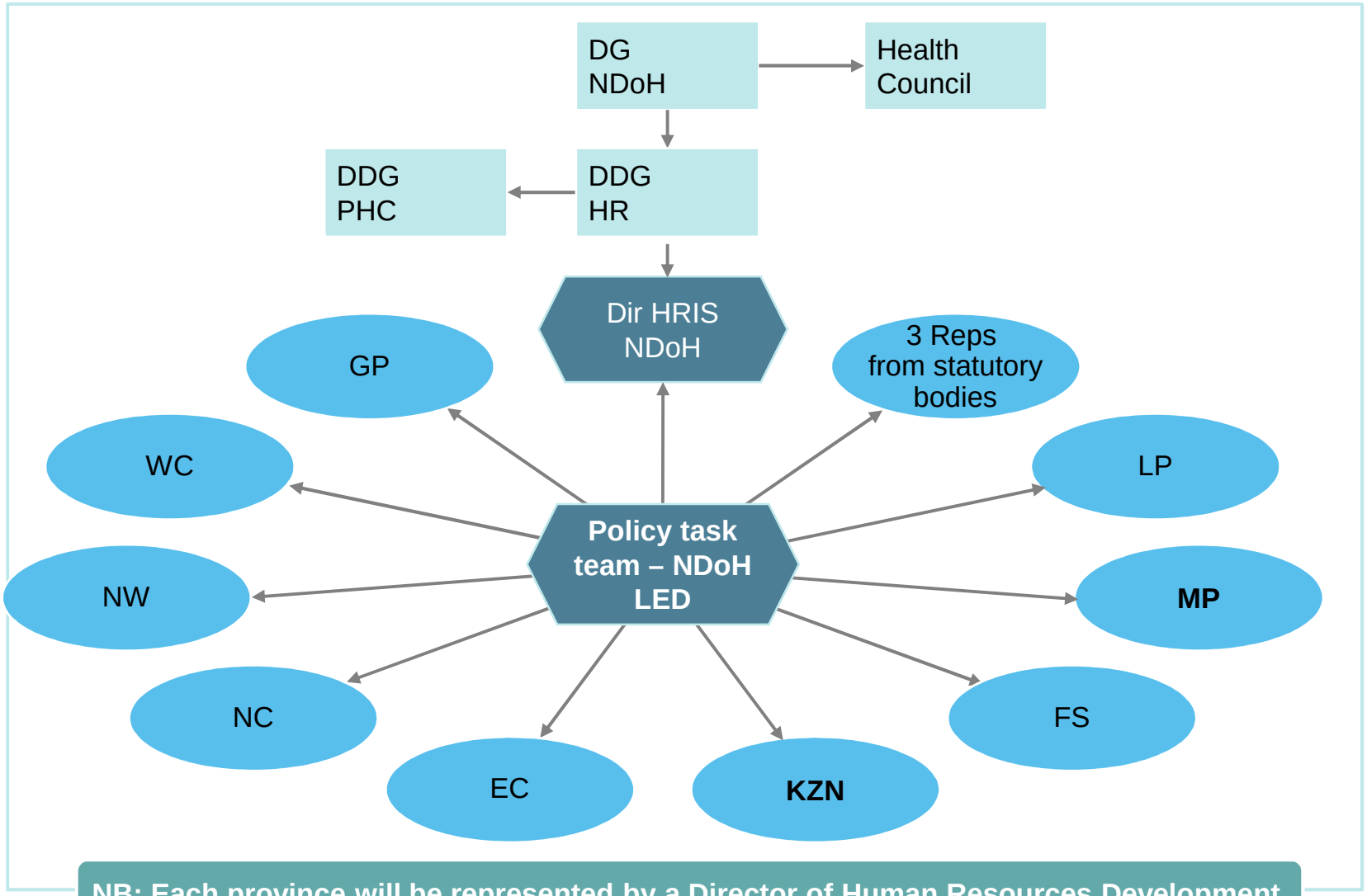
5 Compulsory service programmes can be classified in three groups



SOURCE: WHO - Compulsory service programmes for recruiting health workers in remote and rural areas: do they work?

OPERATION PHAKISA

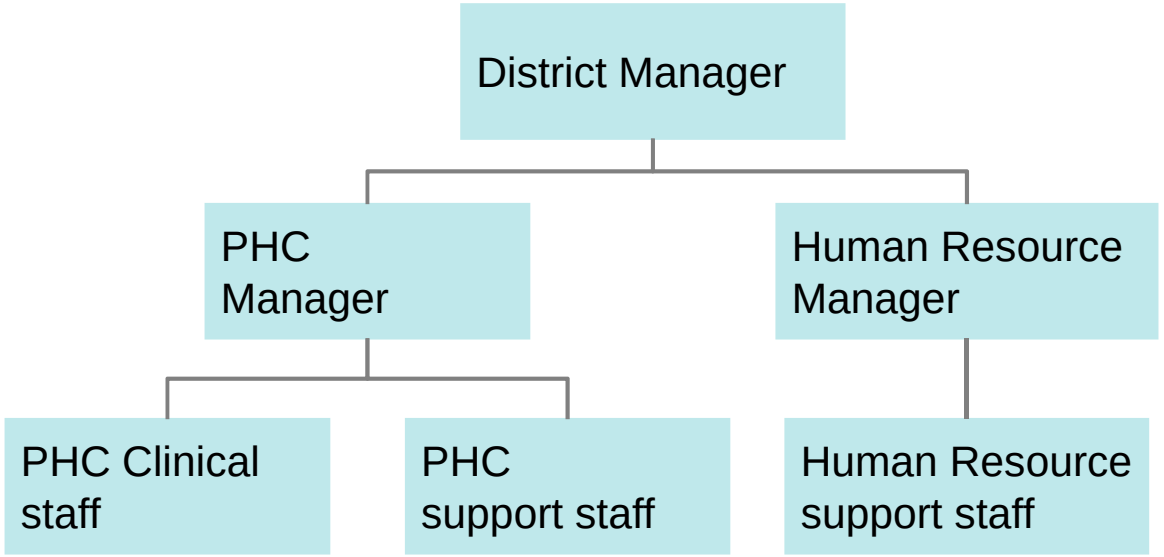
5 Community Service Policy Task Team



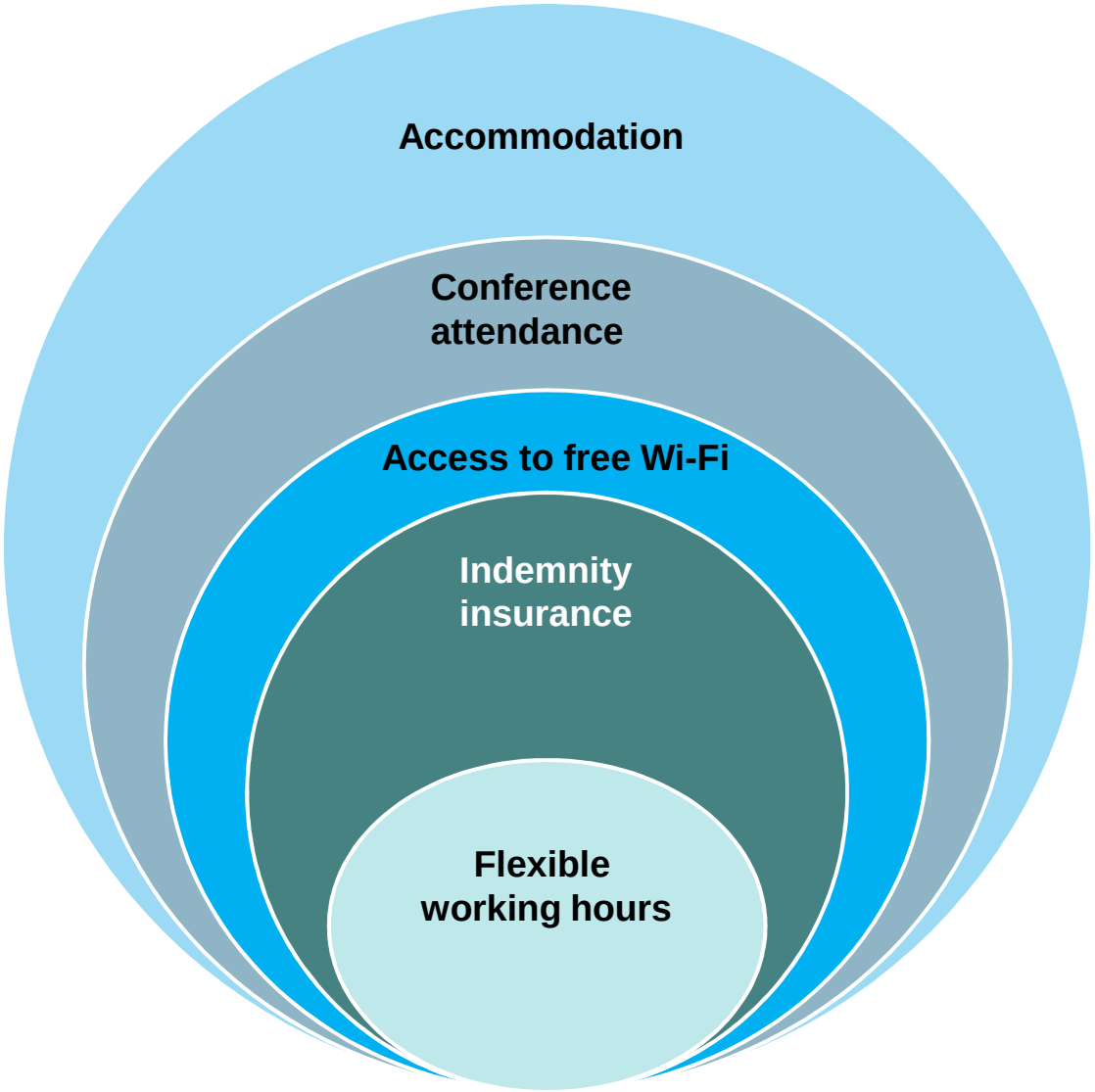
NB: Each province will be represented by a Director of Human Resources Development

5 Target groups for the new Community Service Policy

- Facility managers (3,507 managers)
- Human Resource Managers & staff (156 managers)
- PHC personnel (Clinical staff at 3,507 facilities)
- District Managers (Managers at 52 districts)
- Sub-District Managers (208 managers)
- **Approximately ~11 000 people to be trained.**



5 Proposed incentives for community service professionals in PHC facilities



6 #BringBackOurHealthWorkers

Objective: Carrying out a communications campaign to recruit South African trained workers currently living abroad, retired health professionals and clinical workers outside the medical field back into the public health sector to help match the supply of clinical workers to the existing demand

Develop strategies to increase the return of health professionals who have left the profession

A Quick wins to bring back professionals ASAP

- **Launch of the #BringBackOurHealthWorkers campaign**
- Partner with International Marketing Council and the Homecoming Revolution campaign
  1. Communications campaign
  2. Time constrained financial incentives (tax exemption for a limited period)

B Implement NDoH Monitoring structure

Implement a HR Observatory structure within NDoH to baseline and monitor continuously push & pull factors (Ensure Health Systems strengthening through an integrated HRM information management system in partnership with WHO by adopting HR Observatory system for use in SA with financial support from PEPFA and further support from DIRCO and Home Affairs to monitor migration patterns)

1. **Carry out an accurate, detailed analysis of the current situation and needs**
2. **Refine mix of incentives based on determined needs (type and number of professionals and motivation of those professionals to leave)**

Owner

- NDoH, Provincial Health Departments, District Offices

Key stakeholders identified

- DPSA, DoL, DIRCO, HA, DHET, WHO, SARS
- DIRCO, International Marketing Council
- Organised Labour
- Professional Councils
- Association of Retired Nurses

Required resources

- Funding to be made available to fill the 46000 vacant posts X one nurses unit costs per category

Implementation timeframe

- Start date: 2015
- End Date: 2018

Key milestones

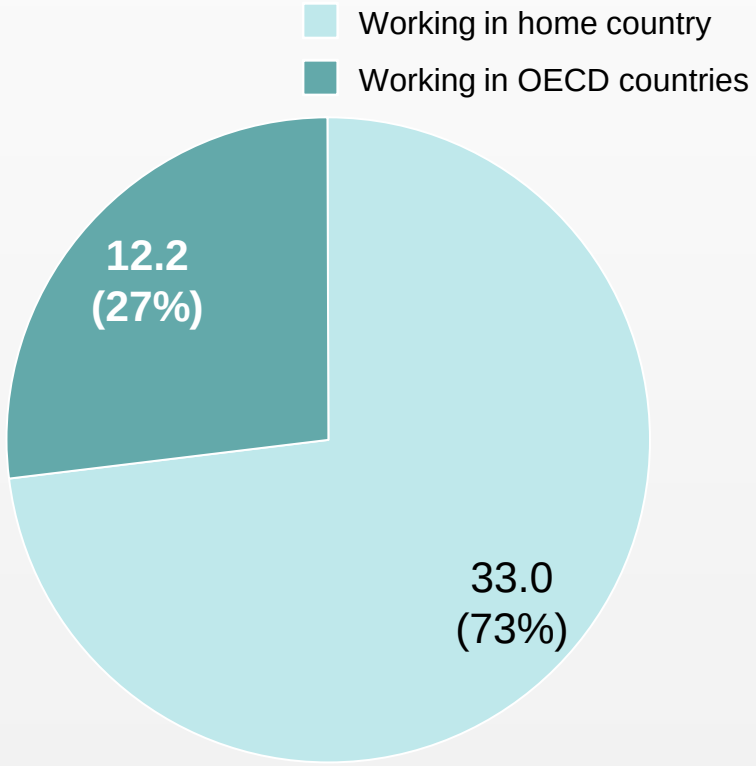
- 2015/16: Launch international #BringBackOur HealthWorkers communications campaign
- 2015/16: Implement HR observatory unit to monitor trends, coordinate campaign leveraging WHO Observatory system

SOURCE: Lab analysis

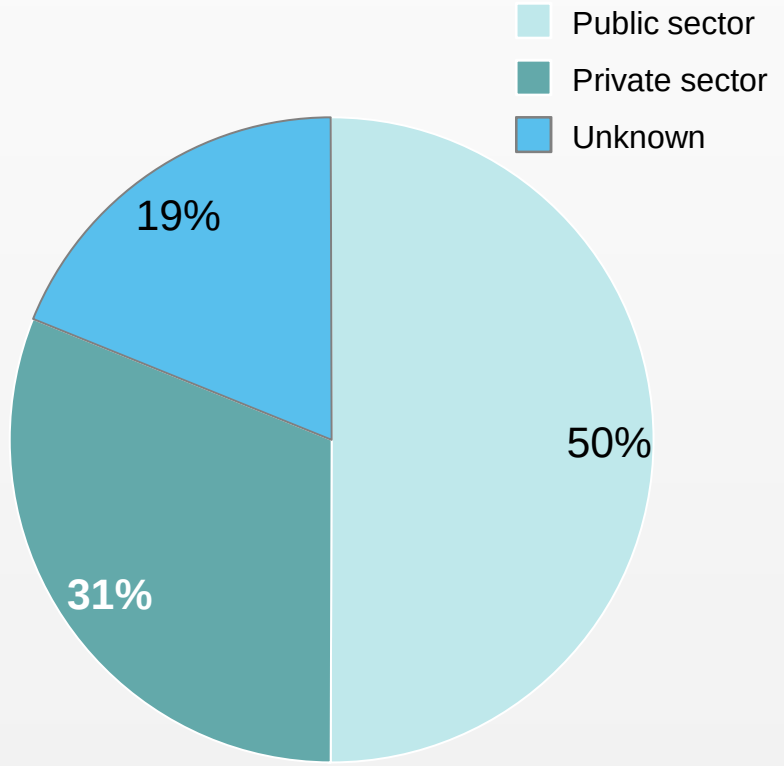
#BRINGBACKOURHEALTHWORKERS

6 Almost a third of South African trained doctors work outside the country, and of the ones in the country, 20% are outside the profession

Doctors trained in South Africa working in OECD countries[1]
Thousands of health workers, percentage



General practitioners in South Africa per sector of practice
Percentage of health workers



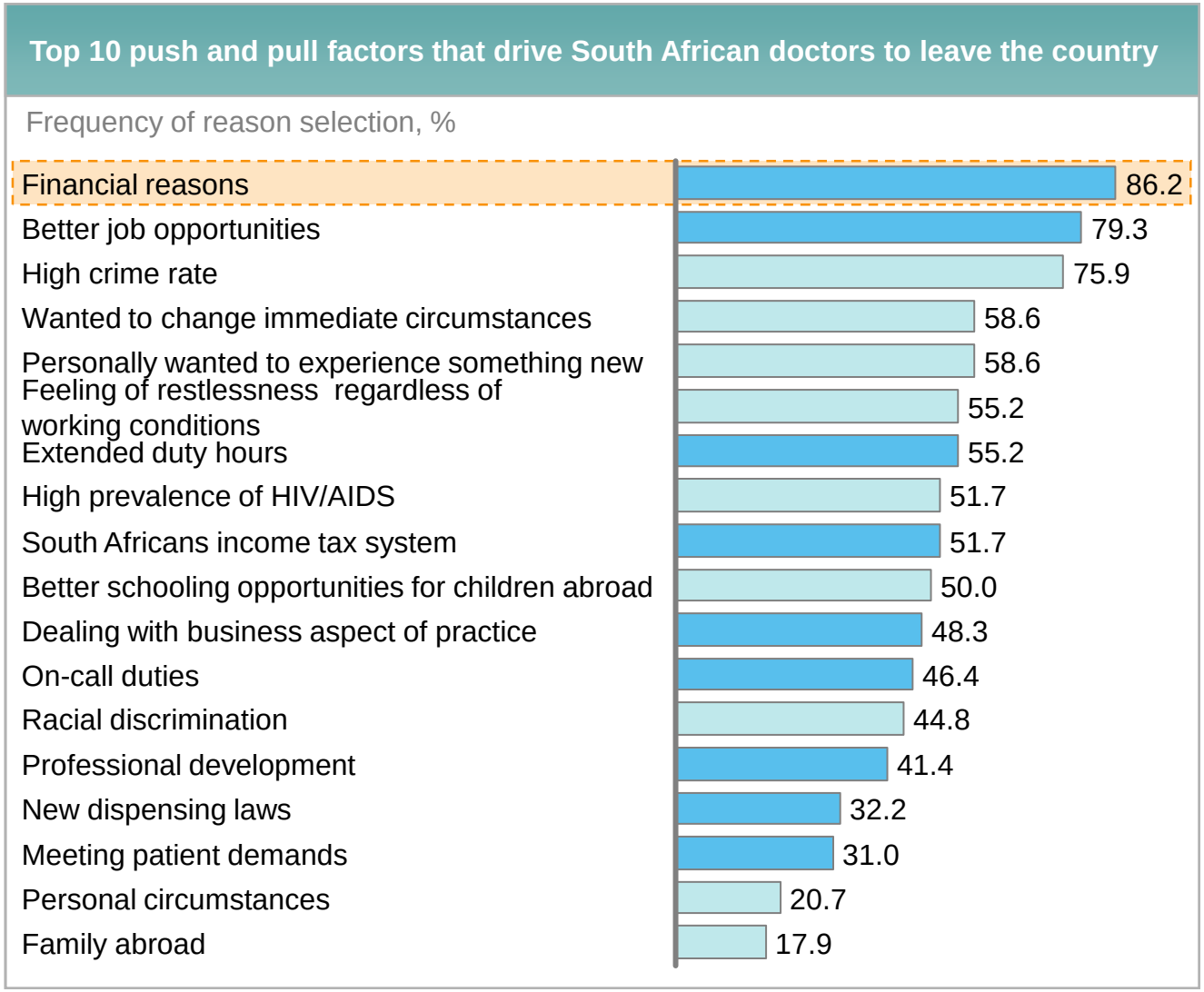
1 Doctors - Australia, Canada, Finland, France, Germany, Portugal, United Kingdom, USA

SOURCE: WHO (2006:100), Econex for the South SAPPF and HealthMan (2012)

OPERATION PHAKISA

#BRINGBACKOURHEALTHWORKERS

6 In order to revert the flee of South African doctors from the country it is necessary to align the incentives with their drivers



Beyond reach of NDoH

Within reach of NDoH

- The NDoH can actually have an impact on 9 out of the 18 reasons quoted
- This would create the opportunity of designing a wide incentive package tailored to the concerns of these professionals in order to bring back the South African health workers

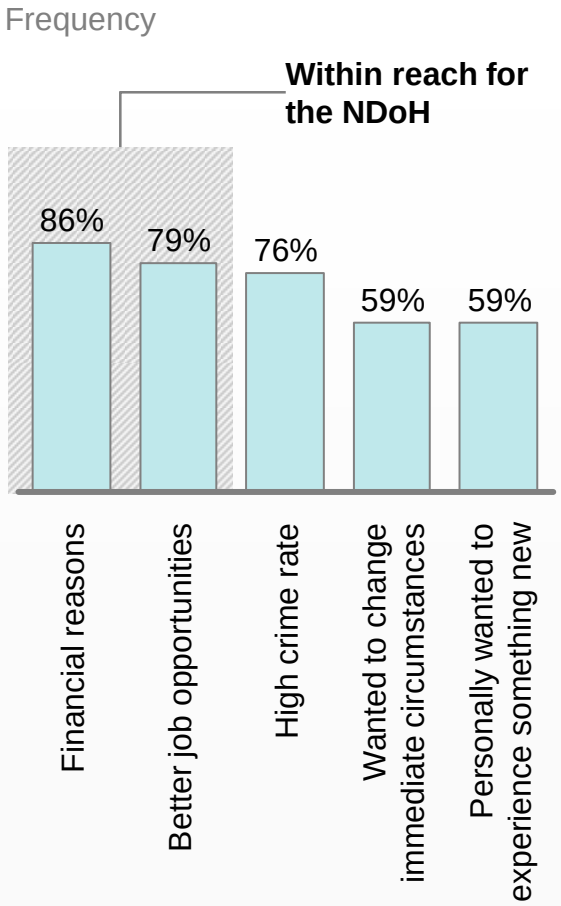
SOURCE: NDoH HRH Strategy, 2012

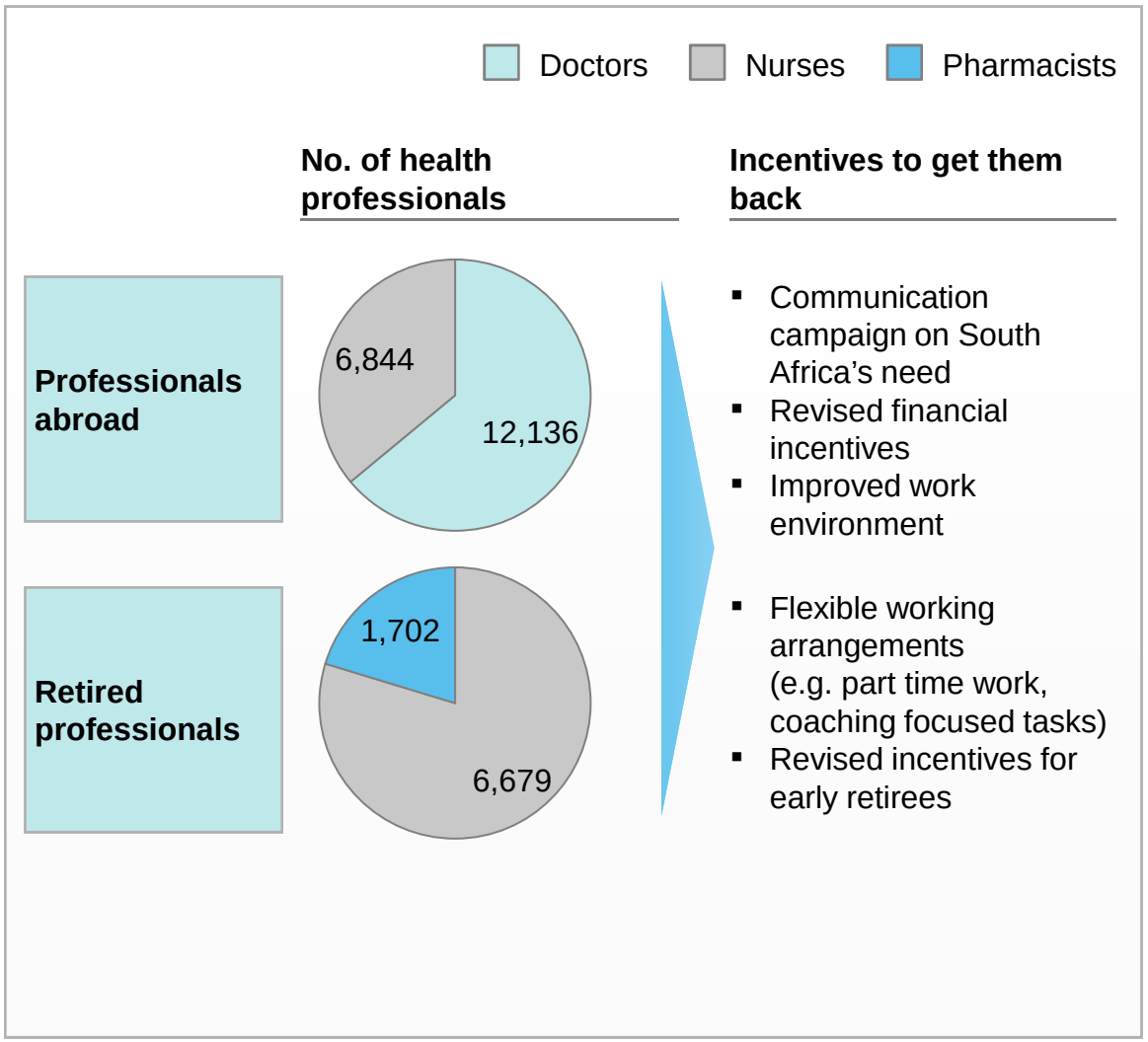
OPERATION PHAKISA

#BRINGBACKOURHEALTHWORKERS

6 #BringBackOurProfessionals aspires to getting health workers back in the PHC system

Top 5 factors that drive South African GPs out of the country





1 Needs according to the current service delivery model: Total WISN need x lack of staff ratios
Professional nurses: ~500, Pharmacy assistants: ~5,000, Doctors: ~700

SOURCE: HRH strategy plans (from professional councils), National Health Facilities Baseline Audit 2012, Lab analysis

OPERATION PHAKISA

6 #BringBackOurHealthWorkers will focus on communicating the reasons to join the PHC system and secure the incentives

	Description	Measures to undertake
Communication 	▪ Carry out an awareness campaign advocating the need for South African doctors to come back to the primary health care system – **Fact based** communication (e.g. 47% of clinics had no doctor visits, improvement on working conditions) – **Patriotic resonance** (e.g. communication based on patriotic duty) – **Incentives to join the PHC system** (e.g. communication on tax exemption policy for returning workers from overseas)	▪ Engage DIRCO & International Marketing Council (IMC)
Other incentives 	▪ A multi-benefits package in line with the concerns and ambitions of the health professionals that we want back in the system: – Acknowledge and credit time spent working outside the country for returning health professionals and entry point salary is important – Part-time employment for retired personnel – Improved opportunities for professional development training	▪ Secure cabinet approval ▪ Syndicate with relevant stakeholders

SOURCE: Lab analysis

7 Empower managers through training and decentralisation of key responsibility

Objective: Empower facility managers on defined set of skills and competencies to empower them to better perform their current tasks and enable them to undertake higher responsibilities

Initiative concept/details/highlights:

Facility managers in clinics lack the required skills that are stipulated in the DPSA Leadership, Development and Management framework. This is further confirmed in the research conducted by the Health Systems Trust (HST). Facility managers need to be trained to do the required management tasks and before having any decentralization

Training

The training would be based around the competencies identified by the HST (planning, budgeting, organising, communicating, leading and controlling, analysing, and community assessment, planning and implementation) to specifically enhance the following competencies:

a. Project management
b. Financial management
c. Stakeholder management
d. People management (HR)

All 3,507 facility managers will be equipped with leadership and management skills which will result in better planning , timeous appointments of staff and procurement of services and resources.

Owner:

- South African Government
- Department of Health

Key stakeholders identified:

- DPSA NSG
- HST
- DHET and training Institutions
- NGOs
- National school of Governance

Required resources

- Funding
- Training materials

Implementation timeframe

- Start date: 2014
- End Date: 2017

Key milestones

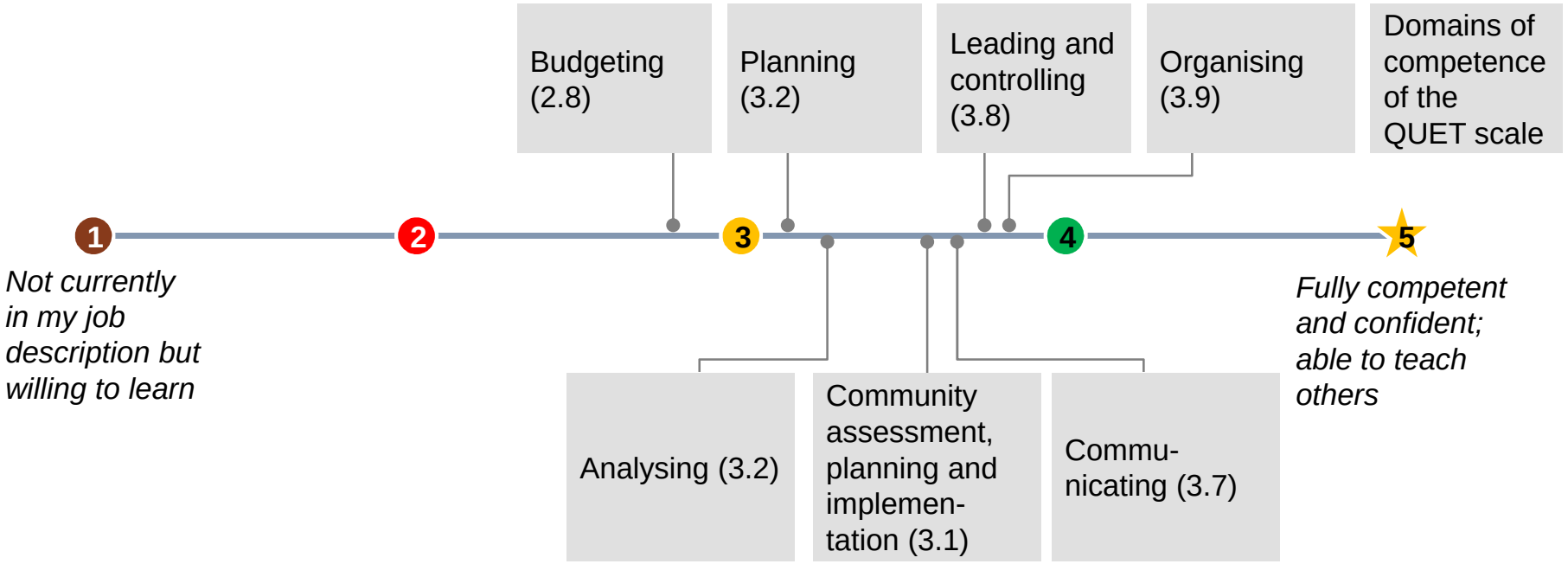
- Training – 2015
- Decentralization of functions - 2016

SOURCE: Lab analysis

7 Training of facility managers is key to strengthen their engagement and empower them to secure leaner processes

Self-assessment of facility managers

Average score in each component



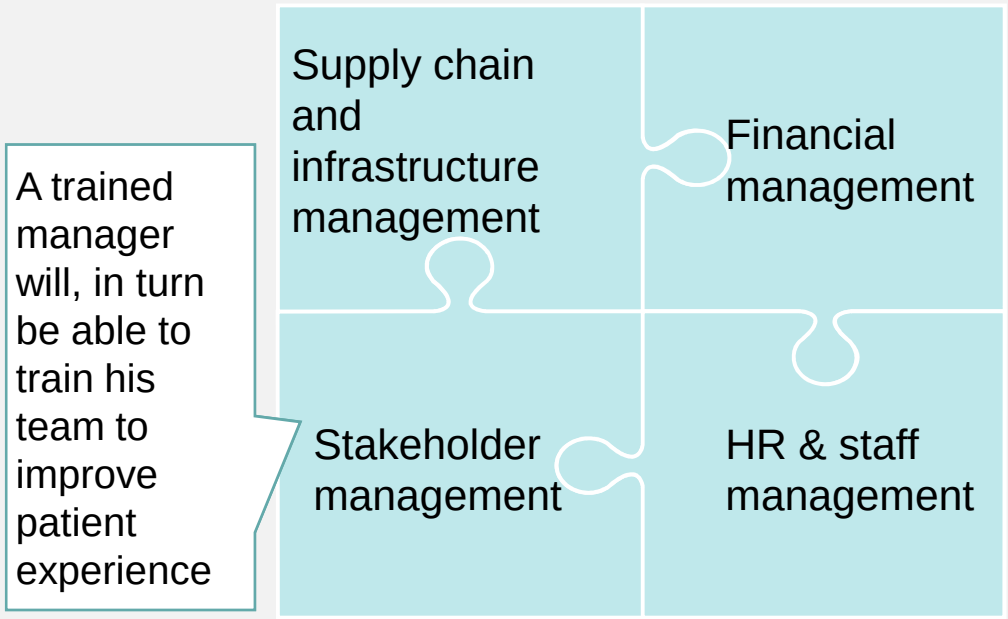
- Facility managers scored
  - better for organizing, leading and controlling and communicating
  - worse on planning, budgeting, analyzing and community assessment, planning and implementation
- Overall, clinic managers scored worse than other managers of the sample
- There was a tendency to overscore themselves, however, there is a linear relationship between the level of confidence and the scores

SOURCE: HST facility manager competency assessment, 2014; QUEST sub-scale

EMPOWERING MANAGERS

7 Empower facility managers through training and decentralization of key responsibilities

Managers will be trained around 4 key competencies



The training could be delivered through various platforms:

- Mobile and online training
- In person/"classroom" (leveraging clinic accelerator teams that will be on the field)
- On the job

Decentralization support

Key processes will be decentralized to facility managers. To accompany this we will foster:

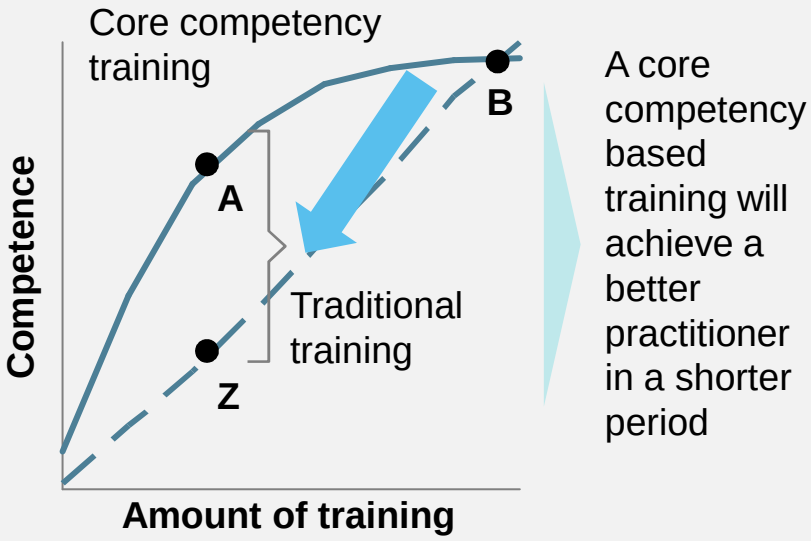
- **Transmission of knowledge** by informally appointing a deputy facility manager in the clinic to ensure transfer of knowledge
- **Sharing of best practices and enhanced sense of belonging** by creating a peer network for clinic managers to communicate and reach out in case of need

SOURCE: Lab analysis

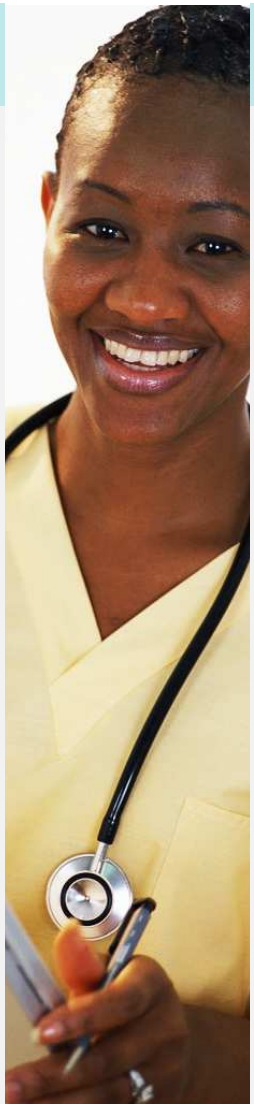
7 Empower facility managers through training and decentralization of key responsibilities

Managers will be trained around 4 core competencies

- Project management
- Financial management
- Stakeholder management
- People management



A core competency based training will achieve a better practitioner in a shorter period



Decentralization and support

- **Ensure transmission of knowledge:** Informal designation of a deputy facility manager to ensure knowledge transfer
- **Decentralize powers**
  - Selected financial decision making processes (i.e. managers will be involved at key points during the planning and budgeting cycle)
  - Selected HR functions:
    - Replacement of operational staff
    - Recruitment processes (receive and assess applications)
    - Monitor and use WISN tool
    - Deal with disciplinary issues
- **Share best practices and enhance sense of belonging**
  - Create peer network for clinic managers to share best practices, and reach out in case of need

SOURCE: Lab analysis

TASK SHIFTING

8 Amend job descriptions

Objective: To review job descriptions in the facilities and sub-districts in order to ensure that the roles and responsibilities are clearly defined, the areas of accountability are identified and that the descriptions are flexible enough to allow for task shifting/sharing

Initiative concept/details/highlights:

Eliminate inconsistency in the job profiles, skills requirement, roles and responsibilities and limit in scope of accountability

Detail job profiling for the following categories

- District manager
- Sub district manager
- Operational Managers
  (Facility manager, CHC Manager, PHC Manager)
- Assistant Manager (for the facilities)
- Program managers
- Out reach team leader

Establish job content per staff category

Identification the gaps within the current work force and job load – as per WISN – in order to motivate for task shifting / task sharing

Increase in amount of time spent with the patient by doctors and nurses
Increase in number of patients seen per day

Owner:

- National Department of Health

Key stakeholders identified:

- NDOH office of the DDG
- DPSA
- Organized Labor
- PPPS(HST)
- Organizational Design Unit

Required resources

Investment (ZAR):

Funding required to enlarge competency assessments & job profile study currently in progress by HST

Level of implementation

- District , Sub District & Facility Levels

Implementation timeframe

- Start date:2015
- End Date:2018

SOURCE: Lab analysis

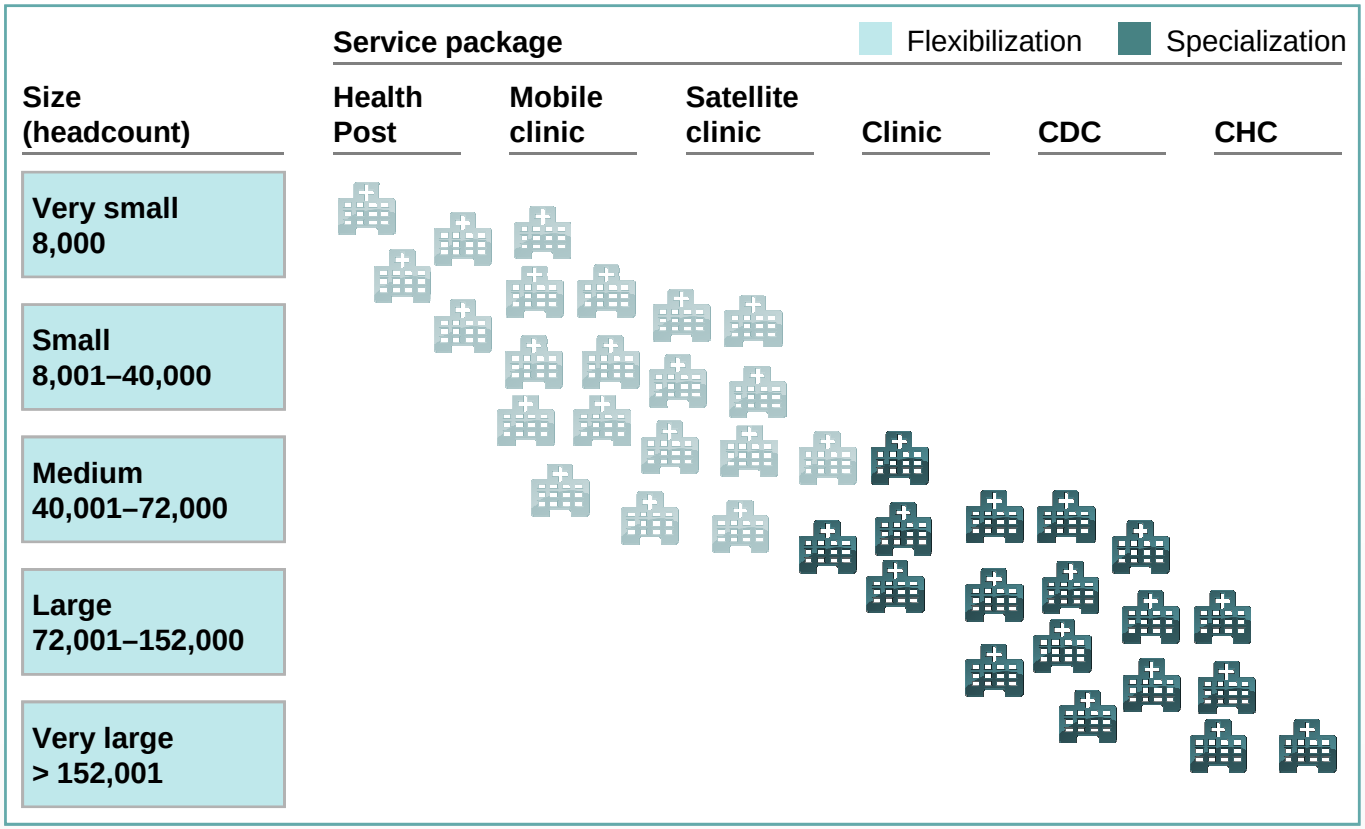
OPERATION PHAKISA

TASK SHIFTING

8 Enable task shifting for larger facilities and task sharing for smaller facilities

Task shifting and sharing could help to both increase productivity and optimize expenditures

- Facilities can be categorized according to their size and the service package delivered



- Workers in **bigger, more complex facilities** could **shift task** from one another **to specialize**
- Workers in **smaller facilities** with **less services** can **share tasks**

How we plan to implement it

1. Identify key tasks within:
   - Patient Care that could be delegated to Ward Based Outreach / junior clinical staff / volunteers
   - Administration that could be delegated to clerks, data capturers and other administrative
   - Management which could be delegated to team leaders
2. Identify cross-skilling opportunities
3. Get buy-in and agreement on assignment of tasks
4. Deliver training and build capabilities within group to whom tasks are transferred

OPERATION PHAKISA

TASK SHIFTING

8 Task transfer can increase face to face clinical care of doctors and nurses

Key activities

- Identify key tasks within:
  - Patient Care that could be delegated to Ward Based Outreach / junior clinical staff / volunteers
  - Administration that could be delegated to clerks / data capturers / general workers
  - Management which could be delegated to team leaders
- Identify cross-skilling opportunities
- Get buy-in and agreement on assignment of tasks
- Deliver training and build capabilities within group to whom tasks are transferred

Prerequisites for success

- Availability of baseline for performance indicators
- Strong clinic management and leadership
- Willingness from clinic staff to transfer and take on tasks
- Capacity within team for capability building
- Strong labour relations
- District support and involvement during and after implementation to ensure sustainability and roll out to other three clinics

Outputs

Physical outputs

- Revised role description
- Potential increase in admin staff (e.g., data capturers)

Results

- Increase in amount of time spent with the patient by doctors and nurses
- Increase in number of patients seen per day

Performance indicators

- Time spent on patient care by nurses
- Time spent on patient care by doctors
- Number of patients seen per day by nurses
- Number of patients seen per day by doctors

SOURCE: Lab analysis, Lean Operations diagnsotic

OPERATION PHAKISA

9 Upskilling non-clinical staff

Objective: Non-clinical health workers should be trained on observing clinical emergencies and on customer care to increase productivity in clinics and sense of belonging to reduce attrition

Provide induction and customer care training to non-clinical staff in facilities.
The achieved impact will be:

- Coordination of staff within the clinic to improve patient experience and productivity
- Sense of belonging and responsibility, awareness of employees
- Ripple effect of promoting health within the community

Steps

1. Design training methodology and estimated total cost
   - Determine the target group and number (~31,600)
     - Non clinical service flow line staff from 3,507 clinics will include:
       - security guards
       - grounds men,
       - queue marshals
       - admin clerks
       - datacapturers
   - Adapt NQF Level 2 framework course materials aiming at multi-skilling non-clinical staff (health care advocates) on basic health care and prioritizing emergencies such as (basic first aid/ basic life support, ability to observe the need for emergency assistance and ability to identify key symptoms of the burden of disease in the community)
   - Determine the schedules of training for all target workers
   - Identify the training institution and facilitators, preferably the proposed health academy
   - Syndicate with people running “Walk the talk” to ensure communication of “Health advocates Program” (i.e. basic induction sessions, posters, manager communication)
   - Determine sources of financing:
     - Contracting accredited service providers through the health academy/RTC;
     - Leveraging developmental partners (PPP)
2. Implementing the trainings
   - Pilot it in NHI Ideal clinic districts
     - Plan enrolment
     - Secure monitoring (staff satisfaction, patient satisfaction)
   - Roll off

Owner

- NDoH – HR - HRD

Key stakeholders identified

- DOH (training needs ass-target group and number confirmed)
- Accredited service providers (NGO/Private)
- **Content**
  - SAQA (NLRD- national learner record data base)
  - Quality councils (QCTO)
  - Health & Welfare SETA
- **Implementation**
  - Districts
  - Employees
  - Organized labour
- **Funding**
  - Custodian of training (DHET)
  - Developmental partners

Required resources

- R157 800 000 = R 5,000 X 31,600 (targeted staff)
- Venues for training and Transport (not included in the cost)

Implementation timeframe

- Start date: Jan 2015
- End Date: NA

SOURCE: Lab analysis

UPSKILLING NON CLINICAL STAFF

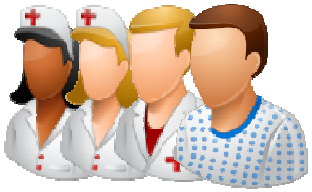
9 Training non-clinical facility workers will pave the way for a “health awareness” culture in South Africa

Providing basic health and customer focus training to over 31,000 non-clinical workers of the primary healthcare system would ripple into several spheres of influence

Individual worker

- Raise awareness on health issues
- Enhance sense of belonging, understanding how the pieces of the puzzle fit together
- Develop sense of responsibility leading to delivering better service

Staff

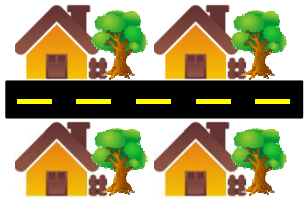


- Enhance the coordination between clinical and non-clinical staff driving productivity increases through fast-tracking
- Ensure a better split of tasks

Facility

- Improve approach to addressing the burden of disease, which contributes to an improved patient experience

Community



- Create ripples of awareness in the community: Health Advocates can recognize signs of alarm or emergency
- Promote healthier lifestyles

SOURCE: Lab analysis

OPERATION PHAKISA

9 The impact of this initiative would go beyond the primary care facilities as the trained staff bring the knowledge to their communities

Over 30,000 non-clinical workers would be empowered

Target population

Non clinical service flow line staff:
- security guards
- grounds men
- queue marshals
- admin clerks
- Data capturers
- all other non-clinical staff[1]

Content

- Provide basic health promotion training:
  - Ability to observe the need for emergency fast-tracking
  - Ability to identify key symptoms of the burden of disease in the community
- Provide customer care training
- The workers can progress in their trainings up to a NQF-Level 2. This enables them to qualify for further studies

- Estimated cost: ~ R160MM (R 5,000 X 31,600)
- Possible sources of financing:
  - Contracting accredited service providers
  - Leveraging developmental partners (PPP)

The impact of this initiative can potentially ripple down beyond the clinic

- Assuming a potential area of influence of 5 people per non-clinical health worker, the initiative could ripple down to ~150,000 South Africans

1 Category levels ranging level one to five

SOURCE: Lab anaysis, The National HIV Counselling and Testing campaign strategy

UPSKILLING NON CLINICAL STAFF

9 In order to optimize training of supporting staff, the training given will not a full clinical training but will incorporate some elements of customer focus training

What it is	What it is not
✓ Training on the principles of Batho-Pele	✗ Patient care and clinical treatment
✓ Training on customer care to improve ▪ communication skills ▪ listening skills ▪ Compliance to etiquette	✗ Patient counseling
✓ Training on emergency triage to fast-track patients in case of urgency and understanding immediate patient needs	✗ Aditionnal tasks to existing ones

SOURCE: Lab analysis

9 Elements for training of non-clinical staff

- Focus on Batho Pele principles
- Tailor training courses to fit non-clinical staff
- Training to be provided in all 11 languages as needed by the trainees
- Face to face training with a facilitator
- Role playing training and clinic simulation
- Practical training
- Participants to be tested on knowledge and competences
- Participants to be given certificates of attendance and completion
- Participants to be given a take home manual after training (preferably on video or graphics depending on content)

Contents

GET MORE HEALTH STUDENTS INTO SCHOOL AND IN THE NDoH

10 Initiative: Retain more students

Objective: Increase the Medicine, pharmacy and nursing students intake to increase output of medical professionals

To ensure efficient HRH supply and conversion of health students to Public Service as an employer of choice

Analysis

- Use survey to understand final year students' aspirations/plans
- Review bursary conditions to ensure conversion to public service on completion of the bursary holders' studies.
- Track pipeline students on a regular basis

Student financial support and communication to ensure health student uptake and conversion to Public service.

- Get more students into NDoH careers via a revised bursary system and support during training period
- Communicate NDoH value proposition to students by advising that:
  - State be employer of choice
  - Duty to the country
  - Leverage role model and high profile workers
- Rural prioritization will assist when increasing number of student intake through revised bursary system

Steps

- Vigorously recruit school leaving students to follow health related studies as their field of choice
- Avoid potential dropouts through counselling, monitoring and financial support.
- Provide academic support to those who could not complete their studies within the required period.
- Increase number of graduates from disadvantaged areas and community service professionals serving in the Public Service after completion
- Increase commitment of professionals in the Public Service from current 50% to at least 80% of the total graduates per year

Owner

- NDoH

Key stakeholders identified:

- Accredited service providers (NGO/Private)
- SAQA (NLRD- national learner record data base)
- Quality councils (QCTO)
- Custodian of training (DHET)
- Health & Welfare SETA (funding)
- Department of Basic Education

Required resources

- Infrastructure
- Funding

Implementation timeframe

- Start date: January 2015
- End Date: January 2019

Key milestones

SOURCE: Lab analysis

OPERATION PHAKISA

10 Expand bilateral agreements between countries to recruit foreign workforce

Objective: To increase the number of foreign workforce and optimize health services in the country

Initiative concept/details/highlights

- The current bilateral agreements are limited to fewer countries (Cuba and Tunisia) thus restraining the recruitment of Health Professionals apart from Medical Officers, however the country needs more Health Workers not limited to Medical Officers. Health professional such as Pharmacists and other Allied Health Professionals are in short supply and the extension of bilateral agreements to other countries will alleviate the problem.
- It is recommended that the country expands bilateral agreements to more countries and extend the agreement to include other Health Professionals in order to ensure the adequate supply of health professionals into the country.

The overall impact and target is to have more bilateral agreements with other countries in order to recruit an increased number of foreign health professionals work force into the country

Owner

- South African Government
- Department of Health

Key stakeholders identified

- Provincial Health departments.
- Foreign/Outside countries.
- Xxx
- xxx

Required resources

- Investment (USD):

Implementation timeframe

- Start date:
- End Date:

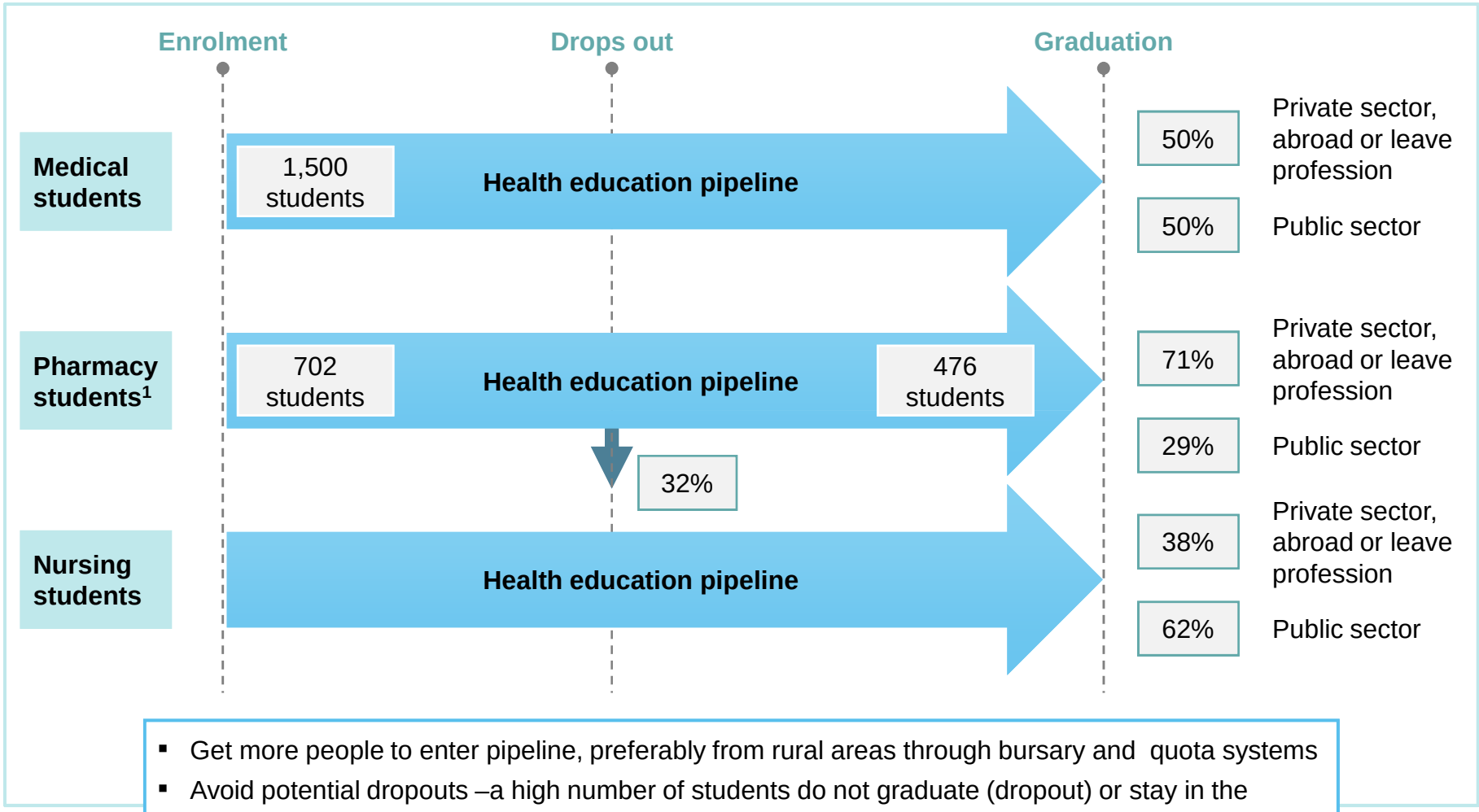
Key milestones

- 2015: Negotiation with other countries.
- 2016: Bilateral agreements.

SOURCE: Lab analysis

GET MORE HEALTH STUDENTS INTO SCHOOL AND IN THE NDoH

10 The NDoH can accompany health student's through their studies (e.g. providing financial support) to ensure conversion to the public service



- Get more people to enter pipeline, preferably from rural areas through bursary and quota systems
- Avoid potential dropouts –a high number of students do not graduate (dropout) or stay in the system longer that required— through counselling, monitoring and financial support
- NDoH target for doctors: 2,400 new doctors per year by 2014/15

1 Students enrolled to become pharmacists

SOURCE: Lab analysis

OPERATION PHAKISA

11 #WalkTheTalk

Build awareness and engagement in the change process by having all members of the walk the Talk campaign for the Ideal Clinic Realization

Initiative concept/details/highlights

Carry out a communications campaign to build awareness and engagement in the change process by having all members of the walk the Talk campaign for the Ideal Clinic Realization

1. Ensure commitment to implementation

2. Ensure that the knowledge translation takes place

3. Carry out joint problem solving

4. Ensure continuous communication strategy from senior management

5. Establish informal coalition with other agents (stakeholders that will be to capacity building)

6. Celebrate successes – 1% performance incentive for best performing clinic

7. Role Modeling

Owner:

- National Department of Health

Key stakeholders identified:

- Provincial/Districts and Facility Managers for Health Departments
- Organized Labour
- Employees
- Civil society – NPOs , Community

Required resources

- People: Supply chain & service delivery
- Other resources: Posters , digital messages at Provincial , District , Sub District offices and at Clinics; Facilitators , Venues for training , catering , transport ;

Total Uniform Costs per Nurse per annum: R2025 @ 131.770 Nurses = R266,834.250 country wide

Level of implementation

- Clinic/sub-district/district/provincial/national?
- Community

Implementation timeframe

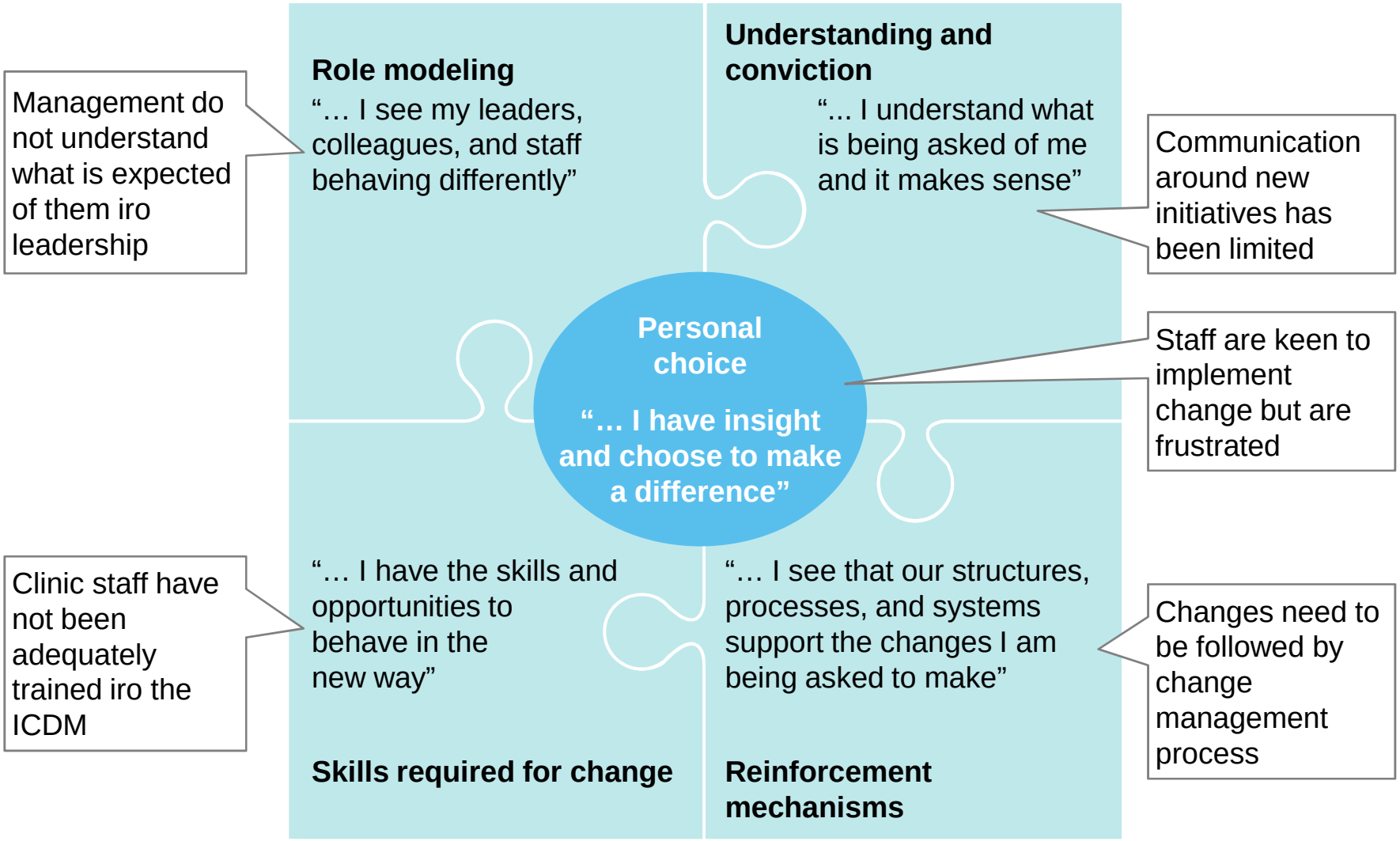
- Start date:2015
- End Date:2018

SOURCE: Lab analysis

#WALKTHETALK

11 The prerequisites for change are generally lacking in most clinics

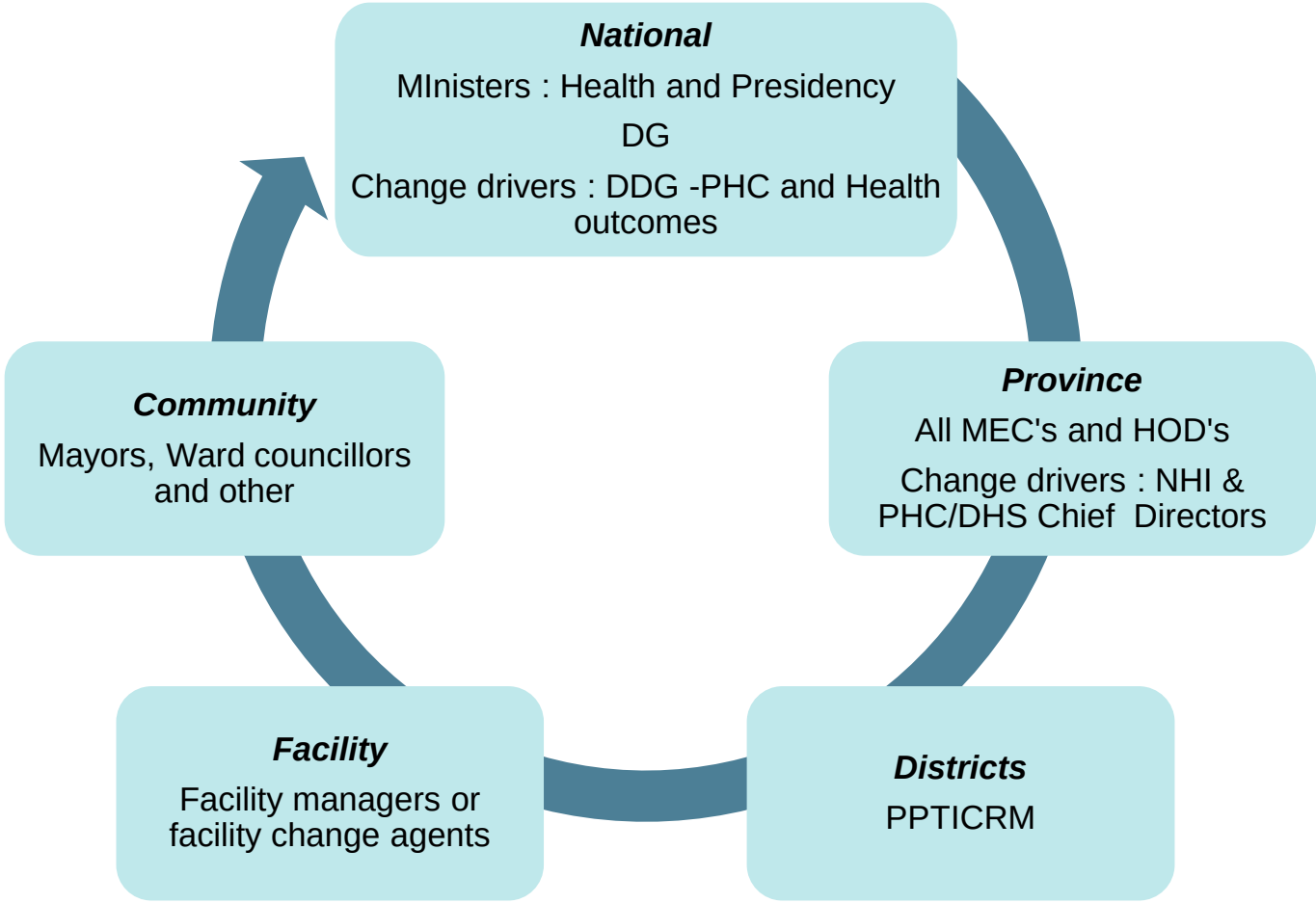
CORE FRAMEWORK



SOURCE: Lab analysis

#WALKTHETALK

11 Everyone, from the NDoH, to the personnel in the facilities and in the community needs to be engaged in the change management process



SOURCE: The Change management Plan Storyline Ms. N Jacobs, Lab analysis

OPERATION PHAKISA

#WALKTHETALK

11 Several elements from communication to performance management will have to be aligned in order for the employees to embrace the change

Ensure that the knowledge translation happens	Ensure that the knowledge translation takes place through: ▪ Mentorship & coaching ▪ Continuous repetitive training programs at service delivery points ▪ Information sharing sessions ▪ Provincial workshops
Carry out joint problem solving	▪ Establish data elements that will monitor the change progress ▪ Monitor progress through feedback reports
Ensure continuous communication	Ensure continuous communication from senior management via: ▪ Newsletter publications – from Districts , Provincial offices, & NDOH ▪ Digital messaging – at Provincial , District , Sub District & Clinics ▪ Posters ▪ Emailing
Celebrate successes	Assign performance-based incentives for best performing facilities

Impact of ensuring change

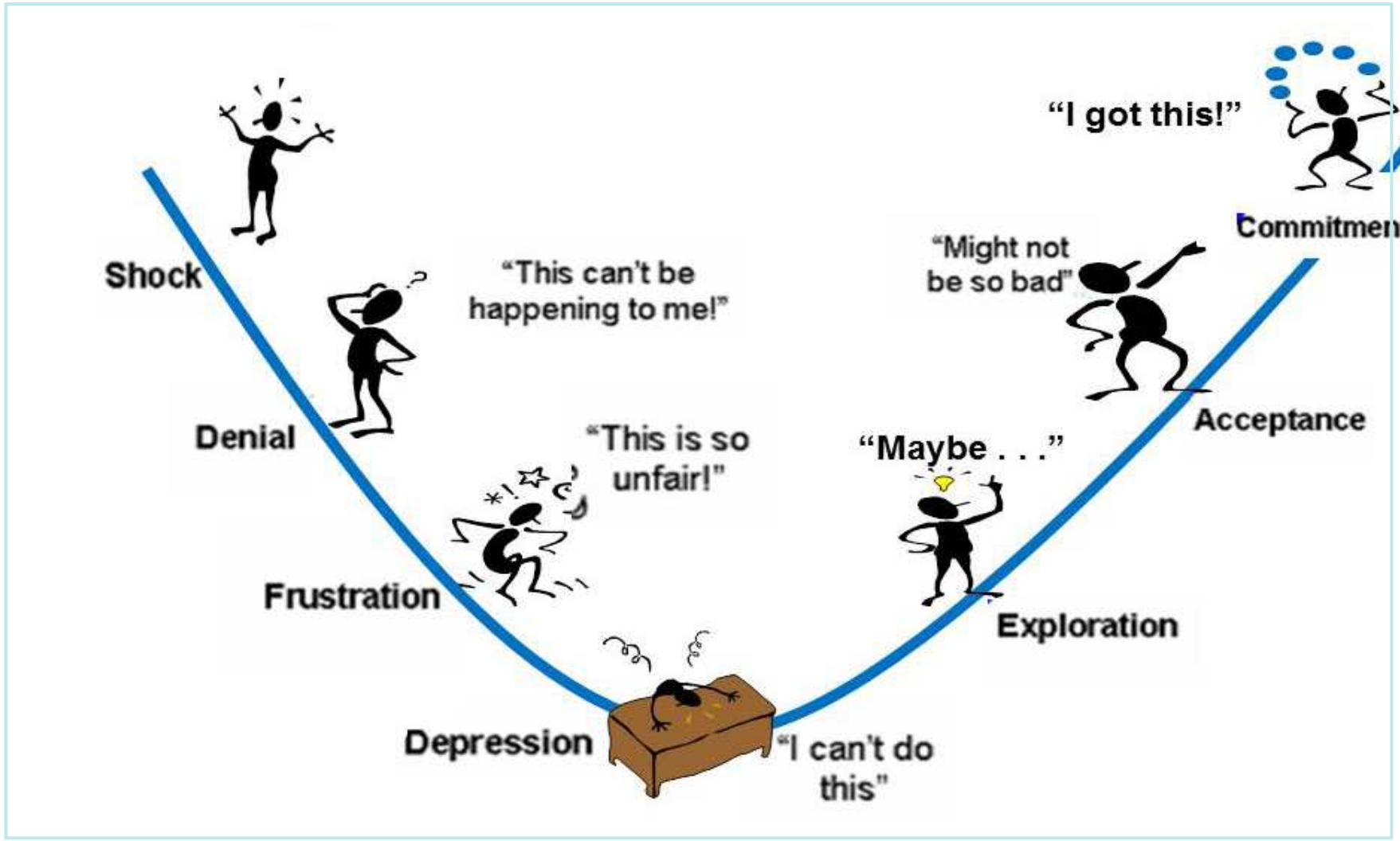
- Improved staff attitude and thus patient experience
- Increased staff satisfaction, retention rates, attraction rates
- Compliance to dress code
- Transparency of organograms and job descriptions

SOURCE: Lab analysis

OPERATION PHAKISA

#WALKTHETALK

11 Employees are likely to go through the stages of personal change



SOURCE: Personal Change Management Model - Jo Mc Dermott: 4 Nov 2012

OPERATION PHAKISA

#WALKTHETALK

11 Process of change

UNFREEZE	CHANGE	RE FREEZE (the Kurt Lewin Model)
What needs to change? ▪ Survey the current status; ▪ Understand why it needs to happens; ▪ Ensure senior management buy in; ▪ Stakeholder analysis + stakeholder management and other key persons.  	**Create a need for change** ▪ Have a vision and strategy; ▪ Communicate to all stakeholders with reasons why? ▪ Describe the benefits ; ▪ Prepare everybody for the change; ▪ Dispel rumors; ▪ Answer any problems; ▪ Deal with any problems; ▪ Empower and involve everybody in the team; ▪ Identified quick wins. **Signs of excepting change** ▪ A stable organizational structure or chart; ▪ Consistent job descriptions'; ▪ Communication strategy in place; ▪ Institutionalization of the changes; ▪ Synchronization of daily activities; ▪ Confidence and comfort with the changes;	1. **Anchor the changes into organization culture** ▪ Identifying what supported the change ▪ Identify barriers to change; 2. **Ensure the buy in to leadership;** ▪ Document progress; ▪ Establish a feedback system in the organization; ▪ Adapt the organizational structure if necessary; 3. **Provide support and training.** 4. **Establish M&E Tools to monitor the progress.** 5. **Celebrate the success.**

SOURCE: The Change management Model, Kurt Lewin

OPERATION PHAKISA

12 Health Academy

Objective: To provide coordinated training to keep health professionals abreast of the latest information, clinical updates, policy and soft skills for other health care workers

Structure

- One main Centre – Health Centre for Excellence- which will have a training facility
- Convert the Regional Training Centre's into Center's of Excellence for skills training (52- one in each district)

Model

- Capacity Building
- Dissemination of education
- Synergies with education institutions
- Research center

Implementation

- Building
- Education staff
- Resourcing the building with a library and other material (guide on storage and departments)

Monitoring and Evaluation

- Assess the needs and strengthen the surveillance
- Evaluate real life effectiveness of the training programs

Owner

- NDoH
- Department of education

Key stakeholders identified:

- DOH & (private sector BPM) (training needs ass)
- NGO'S (train with/without funding)
- Universities/DHET(standards/
- Private Provider
- SAQA (NLRD- national learner record data base)
- Quality councils (QCTO/ CHE)
- Syndication- IS/SD/FIN)

Required resources

- Investment (ZAR):

Implementation timeframe

- Start date: Jan 2015
- End Date: April 2016

Key milestones

- Mr. Cook and Ms. Mbane input
- Dr Carter to Present
- Confirmation of RTC center
- Evidence of the model

SOURCE: Lab analysis

12 Health Academy

Current situation

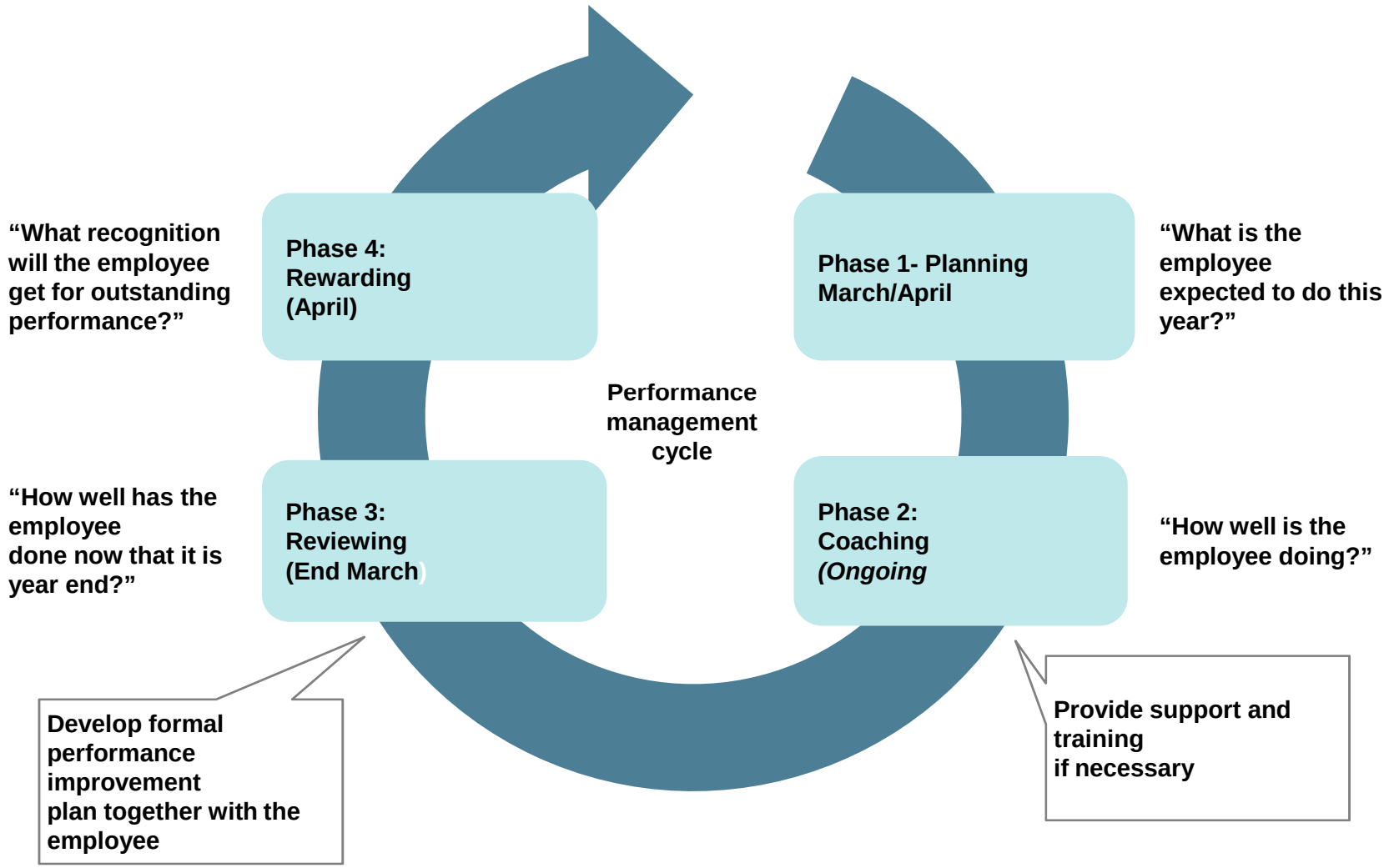
- No well-coordinated training institution or central center in the country targets the non-clinical training staff
- Staffing skills component not meeting the needs of the sector
- Currently we have limited number of health professionals graduating and joining Public Service
- Student intake specifically from rural areas are low and most do not complete their studies
- Fewer graduates joined Public Service beyond their community service period

Situation with Health Academy

- There is specialist institution in the country that houses programmes under one roof that targets at a range of clinical staff professionals and non clinical staff that particulary focus on addressing the countries disease burden and other immediate training shortage demands
  - Appropriately skilled staff
- Better service
- Improved productivity
- Efficiency and effectiveness
- Increased retention
- Improved public image

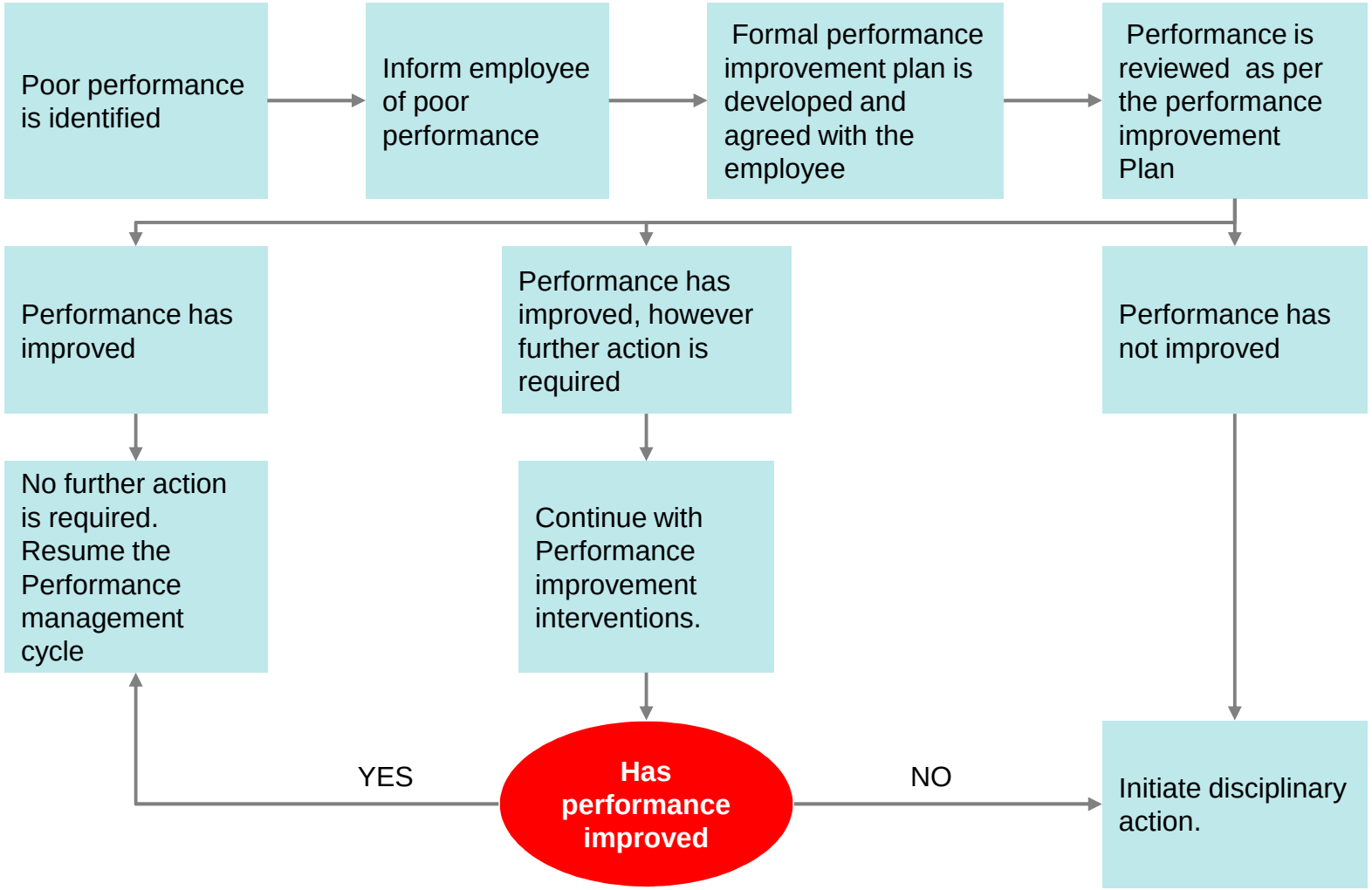
SOURCE: Lab analysis

13 Facility managers can use the performance management cycle to monitor the performance of their employees



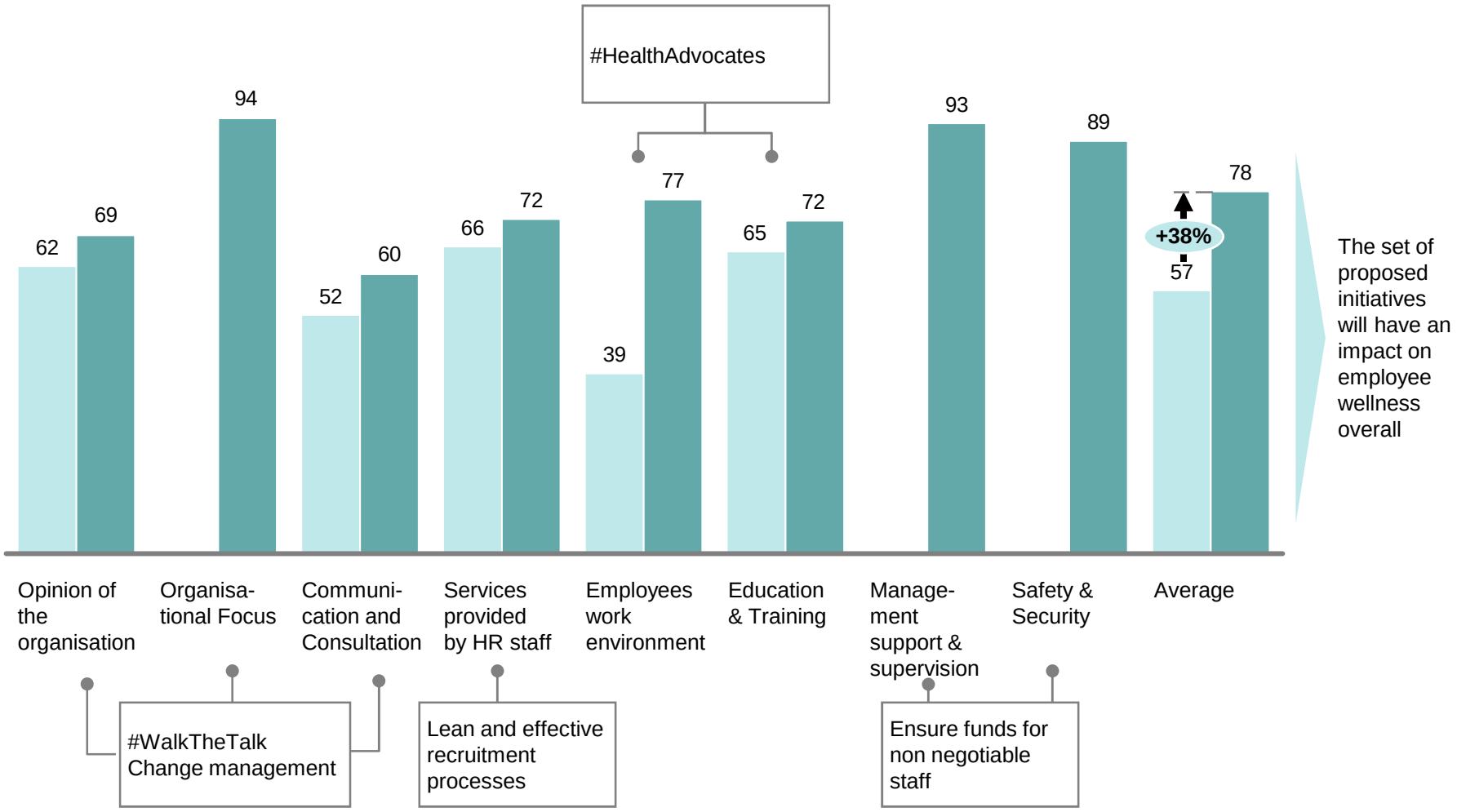
SOURCE: Lab analysis

13 Should poor performance be identified, they will be given the tools to address it



SOURCE: Lab analysis

14 Despite a satisfaction increase, it is necessary to ensure a series of employee welness measures to transform the PHC system into the employer of choice



SOURCE: Western Cape Report, KZN report, National Core Standards

OPERATION PHAKISA

14 Employee Wellness Programs

Objective: Ensure that there is a management system in place to improve Employee Safety, Health and Wellness

Develop management systems to improve employee safety, health and wellness with a view of ensuring job satisfaction

- **Steps**
  - Conduct baseline staff satisfaction studies
  - Determine the staffing requirements to implement Health and Wellness programs (psychologists, etc)
  - Develop a strategy to improve staff satisfaction and employee morale
  - Review DPSA policy framework on employee wellness
  - Develop systems to improve workplace security and personal safety
  - Introduce programs and systems to reduce the risk of contracting communicable diseases (e.g. TB)
  - Re-launching a fitness campaign

Bring a positive Image of the Clinic Staff

Owner:

NDoH, Provincial Department of Health, District Management, Facility Managers

Key stakeholders identified:

- Organised Labour
- Professional Councils

Required resources

- Funding for proposed initiatives

Implementation timeframe

- Start date: 2015
- End Date: 2018

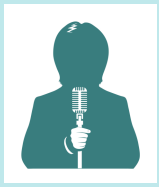
Key milestones

- Follow up on the staff satisfaction survey conducted in 2015

SOURCE: Lab analysis

14 Steps to roll out employee wellness programme

1. **DPSA to issue directive on the implementation of EWP**
2. **Provinces to develop policies for EWP**
3. **Fund the EWP programme**
4. **Awareness campaign**



Provinces
Districts
Facilites

5. **Monitor and evaluate**

Happy & productive workforce

SOURCE: Lab analysis

Contents

- Context and case for change
- Aspirations
- Issues and root causes
- **Solutions and Initiatives**
  - Initiative overview and prioritization
  - Initiative details
  - **Budget of prioritized initiatives**
  - 1,000 feet plans

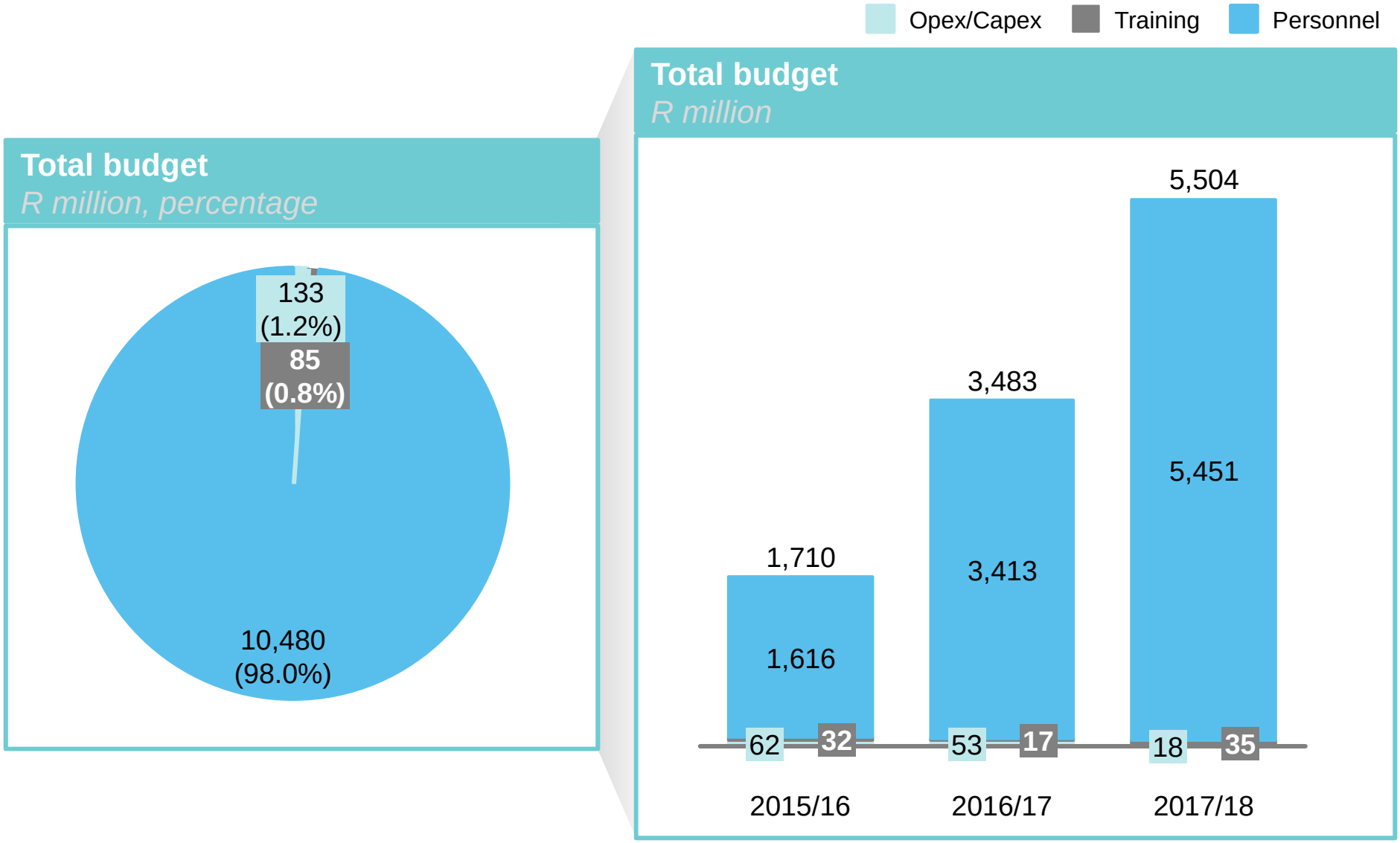
Detailed initiative budget – Human Resources for Health

Total additional budget, R thousands

		2015/16			2016/17			2017/18			
Initia-tives	Initiative Description	Capex/ Opex	Training	Personnel	Capex/ Opex	Training	Personnel	Capex/ Opex	Training	Personnel	TOTAL
1	Redistribution of staff				R 4,280						**R 4,280**
3	Contracting clinical personnel					R 11,212			R 11,212		**R 22,425**
4	Ring fencing budget for non negotiables					R 6,243			R 6,243,100		**R 12,486**
5	Review community service policy	R 150	R 14,300		R 52						**R 14,502**
6	Bring back our workers campaign	R 62,060			R 48,120			R 18,144			**R 128,324**
7	Empower Managers		R 17,543								**R 17,543**
9	Upskill non-clinical staff				R 50				R 18,000		**R 18,050**
	Filling the "personnel gap"			R 1,616,073			R 3,413,146			R 5,450,691	**R 10,479,911**
		R 62,210	**R 31,842**	**R 1,616,073**	**R 52,502**	**R 17,455**	**R 3,413,146**	**R 18,144**	**R 35,455,540**	**R 5,450,691**	**R 10,697,521**

OPERATION PHAKISA

Budget overview – Human Resources for Health



Contents

- Context and case for change
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  - Budget of prioritized initiatives
  - **1,000 feet plans**

1,000 FEET PLAN

1 Redistribution of employees from overstaffed to understaffed facilities

	2015-2016	2016-2017	2017-2018
Main activities	▪ Implementate WISN ▪ Measure of estimate for Staffing Need ▪ Consultation with affected employees and organized labor	▪ Determine the Staffing Needs per clinic (assess 3,507 facilities) according to WISN methodology ▪ Define and formulate the redistribution Policy with all stakeholders	▪ Mobilize the financial and material resources for human capital and infrastructure ▪ Engage stakeholders in redistribution/re-allocation of employees ▪ Coordinate and implement the policy with stakeholders
Targets/ milestones	▪ Obtain clear understanding of the staffing needs within primary care level clinics	▪ Appointment of deputy managers	▪ Distribute the staff taking in account the ideal distribution of resources and in the smoother possible way

SOURCE: Lab analysis

OPERATION PHAKISA

1,000 FEET PLAN

2 Streamline recruitment processes

1,000-feet plan

	2015-2016	2016-2017	2017-2018
Main activities	▪ Develop a regulatory policy and framework to ensure quicker turnaround times and equitable processes ▪ Develop detailed recruitment plan with targets and align different areas within the HR department ▪ Head hunt through Professional Councils websites	▪ Build an online recruitment platform ▪ Advertise positions internally externally ▪ Implement e-technology for monitoring of pipeline volumes and enabling facility managers to have a say in recruitment issues	▪ Ensure and enforce continuous recruitment and appointment of incumbents within 3 months
Targets/ milestones	▪ Ensure basic utilization of e-technology enablement in the recruitment and appointment of personnel	▪ Ensure availability of e-technology infrastructure ▪ Ensure the utilisation of e-technology enablement in the recruitment and appointment of personnel	

SOURCE: Lab analysis

OPERATION PHAKISA

1,000 FEET PLAN

3 Contracting GPs and other skills from the private sector

	2015-2016	2016-2017	2017-2018
Main activities	▪ Assess the number of private GPs required and specific skill mix ▪ Optimize contracting guidelines (standardize fees, consultation hours) and syndicate with developmental partners ▪ Ensure completion and monitoring of pilot in NHI districts ▪ Evaluate pilot and incorporate findings onto contracting strategy	▪ Define and adapt contracting strategy based on pilot findings ▪ Assess the number of private professionals required per profession ▪ Engage with developmental partners to contract the required staff ▪ Recruit and contract local GP's & pharmacists to be trained and employed in their home towns/ local areas	▪ Leverage private sector resources on the remaining unsatisfied demand on primary care clinics ▪ Define attractive incentive packages to increase efficiency and secure coverage of rural areas
Targets/ milestones	▪ Finish and evaluate first initiative pilot	▪ Roll out pilot to allied health professions	▪ Reduce the gap between offer and demand

SOURCE: Lab analysis

OPERATION PHAKISA

1,000 FEET PLAN

4 Ensure Funds for non-negotiable staff

	2015-2016	2016-2017	2017-2018
Main activities	▪ Identify existing vacant posts in the clinics ▪ Where there are no vacant posts request for funding and creation; cost the filling of posts ▪ Request the budget from treasury for creation and filling ▪ Appoint the minimum for every clinic for the Support staff ▪ Determine the number of staff according to the WISN staffing norms	▪ Review accorded amounts of budget ▪ Analyze existing offer and demand and evaluate the required budget for next year	▪ Nationwide evaluation for the required staff in all the clinics
Targets/ milestones	▪ Assure required budget for the long term implementation of the initiative	▪ Determine additional needs of personnel	▪ Ensure that 100% of the primary healthcare clinics have the minimum required staff to function adequately

SOURCE: Lab analysis

OPERATION PHAKISA

1,000 FEET PLAN

5 Community service

	2015-2016	2016-2017	2017-2018
Main activities	▪ Review current policies on Community Service for all Health workers for the ideal clinic(SA) ▪ Review all International policies for health care workers required in the ideal clinic to benchmark aging them ▪ Establish a Community Service Policy Development Task Team ▪ Develop first draft policy on Community Service ▪ Consult internally (DOH) and externally (all other stake holders) ▪ Develop final draft based on the consultation inputs from stake holders.	▪ Capacity Development on the policy (for individuals, organization, and the Sub district	▪ Operational plan for the Community Service Policy developed and implemented
Targets/ milestones	▪ Cost the Draft Policy and develop the policy implementation and M&E tools		▪ Equitably distributed Health Workers on Community Serrvie

SOURCE: Lab analysis

OPERATION PHAKISA

1,000 FEET PLAN

6 #BringBackOurProfessionals

	2015-2016	2016-2017	2017-2018
Main activities	▪ Launch of the #BringBackOurHealthWorkers campaign ▪ Partner with International Marketing Council ▪ Carry out an accurate, detailed analysis of the current situation and needs ▪ Refine mix of incentives based on determined needs (type and number of professionals and motivation of those professionals to leave)	▪ Evaluate professional evolution, and define continuous goals for the team ▪ Define strategies for low penetrated segments	▪ 2nd year evaluation to the professionals attracted
Targets/ milestones	▪ Start bringing professionals, quick wins to bring back professionals ASAP		

SOURCE: Lab analysis

OPERATION PHAKISA

1,000 FEET PLAN

7 Empower facility managers

	2015-2016	2016-2017	2017-2018
Main activities	▪ Access key information from HST research ▪ Consider recommendations to be applied (DPSA) ▪ Approve organogram ▪ Access basic indicators and develop initiative's baseline	▪ Appoint deputy facility managers in all clinics ▪ Develop adequate information systems that enable personnel to perform their functions correctly	▪ Create a forum for managers to share best practices ▪ Commitment within the lab to conclude the organogram/organizational structure at facility, sub district and district levels ▪ Follow-up existing facility managers to understand if proper training has been offered
Targets/ milestones	▪ Training of 3,507 facility managers	▪ Ensure transmission of knowledge through deputy managers ▪ Secure continuous information flow	▪ Assess and train facility managers (continuously)

SOURCE: Lab analysis

OPERATION PHAKISA

1,000 FEET PLAN

8 Task shifting and sharing

	2015-2016	2016-2017	2017-2018
Main activities	▪ Review and revise current job descriptions ▪ Syndicate with unionized labour and reach consensus over new contracts ▪ Create title for “Job Deputy Manager” and related responisibilites (without creating aditional post, “deputy facility manager is a title to ensure transfer of skills, not a function)	▪ Ensure that organograms in clinics countrywide have a skills mix that aligns with amended job profiles ▪ Monitor performance indicators	
Targets/ milestones	▪ Amendment and revision of all job profiles/functions	▪ 3,507 with upgraded job profiles	

SOURCE: Lab analysis

OPERATION PHAKISA

1,000 FEET PLAN

9 Upskilling non clinical staff

	2015-2016	2016-2017	2017-2018
Main activities	▪ Determine the target group and number (~31,600) – Non clinical service flow line staff from 3,507 clinics will include: ▫ security guards ▫ grounds men, ▫ queue marshals ▫ admin clerks ▫ datacapturers ▫ all other staff category levels ranging from level 1-5 ▪ Identify training and estimated total cost ▪ Identify the service provider/s ▪ Enrolment of identified group	▪ Continuous coaching and mentoring of the trained staff as per diseases burden and per clinic environment and set up needs	▪ Continuous monitoring of the application of customer care service principles through quality assurance processes. e.g customer care feedback tools ▪ Evaluation through self evaluation tests, focus groups, in-depth interviews etc,
Targets/ milestones	▪ Improved customer care, patient experience, image of the service points and health sector as a whole	▪ Maintenance of improved customer care	▪ Informed interventions

SOURCE: Lab analysis

OPERATION PHAKISA

Back-up

OPERATION PHAKISA

BACKUP

The Human Resources for Health workstream has addressed the following key questions

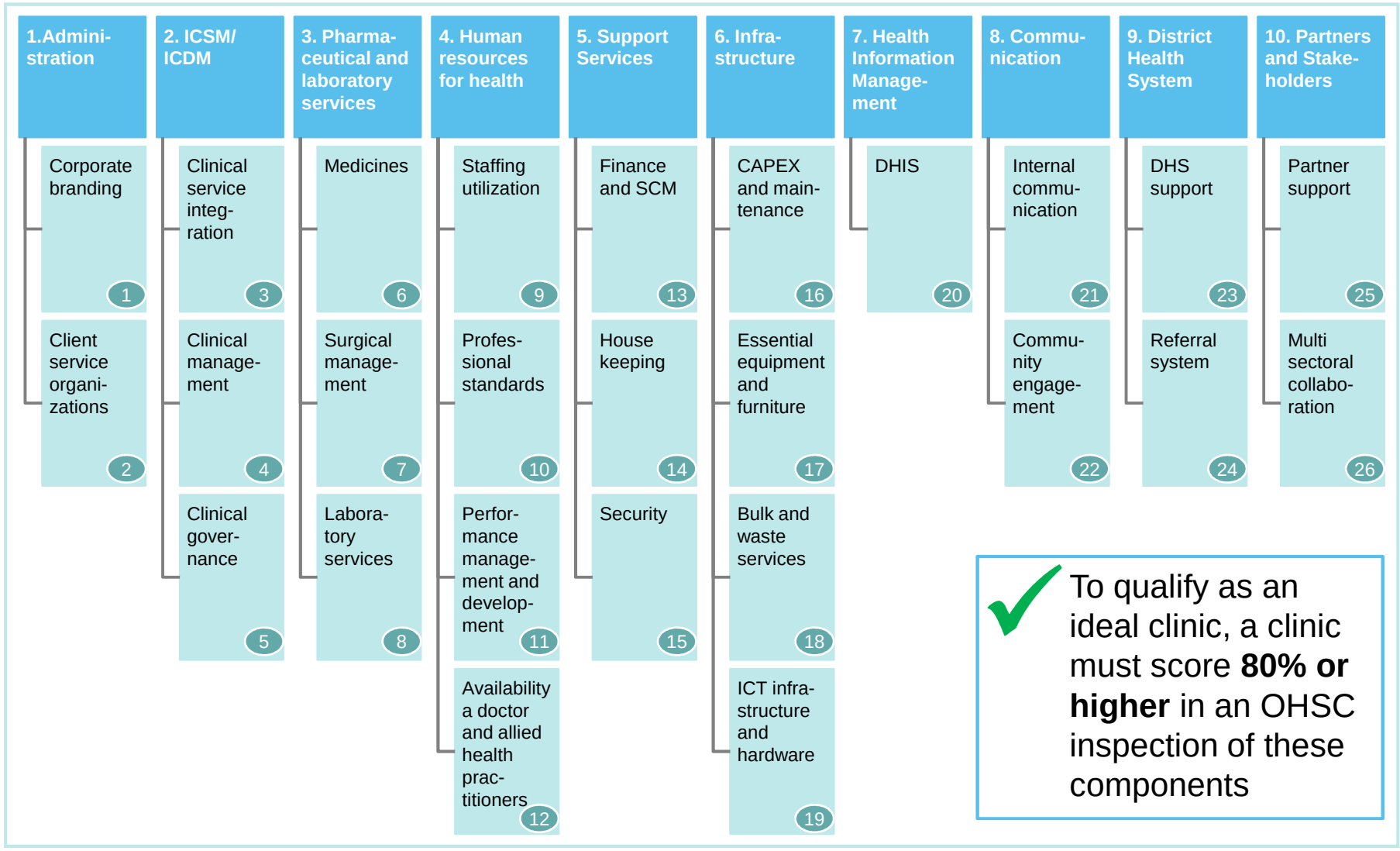
Key questions

- How to quickly and effectively implement the WISN tool across the 3,507 clinics in order to optimize the staffing numbers and training needs?
- How to best utilize clinical associates in order to achieve optimal skill mix?
- How to ensure a sufficient supply of health professionals and prevent those in the pipeline from being lost to the South African health system? And how to best leverage private sector resources?
- How to ensure an equitable distribution and retention of clinicians in both rural and urban communities? And how to fast-track recruitment and ensure retention of non-clinical personnel in both rural and urban areas?
- How to empower facility managers to accurately identify skill gaps amongst employees and timely bridge them properly? How to empower district staff to optimize monitoring processes and planning?
- How to ensure that the roles and responsibilities of managers in both clinics and districts are clearly defined and uniform across the facilities? And how to ensure compliance to their tasks?
- How to build and sustain the required skills, in a timely manner, for all health workers to be able to properly perform their tasks?
- How to enable and train workers to properly deliver health services (e.g. all health workers with uniforms and name tags)?
- How to establish an effective framework to monitor and ensure a positive staff attitude? And how to ensure staff satisfaction?
- Determine whether to employ or outsource support services (security, cleaning, etc.) to ensure continuity of services. And how to ensure the effectiveness of the service from an HR perspective?

SOURCE: Lab analysis

BACKUP

Ideal Clinics will have 10 components which break down into [26] sub-components and [196] elements that detail the exact requirements



SOURCE: NDoH Ideal Clinic Status Realization Tool

OPERATION PHAKISA

BACKUP

ANALYSIS TO BE PERFORMED

To estimate the new service model demand, the 3,507 PHC have to be classified per their size and the service package delivered

Number of facilities

Size (headcount) \ Service package	Health Post	Mobile clinic	Satellite clinic	Clinic	CDC	CHC	Total
Very small 8,000	✕	✕	✕	✕	✕	✕	✕
Small 8,001–40,000	✕	✕	✕	✕	✕	✕	✕
Medium 40,001–72,000	✕	✕	✕	✕	✕	✕	✕
Large 72,001–152,000	✕	✕	✕	✕	✕	✕	✕
Very large > 152,001	✕	✕	✕	✕	✕	✕	✕
Total	✕	✕	✕	✕	✕	✕	✕

SOURCE: Team analysis

OPERATION PHAKISA

BACKUP

Organisation chart for each typology

Cadre needed? – If so, how many HRH?

ANALYSIS TO BE PERFORMED

✓ Needed ✗ Not needed

Clinical staff		Non Clinical
Core cadres	***Visiting cadres***	***Core cadres***
Operational manager	Doctor	Administrative officer
Professional nurse	Health promoters	
Clinical associates	Dieticians	Administrative clerk
Staff nurse (Enrolled nurse)	Nutritionist	
Nursing assistant	Social worker	Data capturer
Dental therapist	Radiographer	
Oral hygienist	Physiotherapist	Groundsman
Pharmacist	Environmental health	
Pharmacy assistants	Specialist audio	Security guard
Pharmacy technician	Advanced midwife	
Lay counselors	Dental assistant	Cleaner
	Pharmacist	
	Lab (NHLS)	Queue manager
	Medical officer	
	Optometrist	