Perspectives of doctors, nurses and rehabilitation therapists in Gauteng and Mpumalanga provinces' public hospitals on remunerative work outside of the public service

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Background. The remunerative work outside of the public service (RWOPS) policy enables public sector health professionals to engage in multiple job holding (MJH) in South Africa (SA) under specified conditions, but remains controversial. Empirical evidence on health professionals' perspectives on the RWOPS policy stipulations is lacking.

Objective. To examine the perspectives of public sector medical doctors (MDs), professional nurses (PNs) and rehabilitation therapists (RTs) on the RWOPS policy.

Methods. In 2022, public sector MDs, PNs and RTs were surveyed in 14 Gauteng and 15 Mpumalanga province public sector hospitals. In addition to demographic and employment data, the self-administered questionnaire collected information on whether the health professionals had obtained permission for additional jobs, their opinions on RWOPS approval requirements and restrictions and the likelihood that they would leave the public sector if RWOPS was denied. Data analysis was performed using Stata 17. The factors influencing health professionals' perspectives on different aspects of the RWOPS policy were analysed using penalised logistic regression.

Results. A total of 1 397 health professionals completed the survey, for a response rate of 84.3%. Most MDs (61.1%) and RTs (60.5%) supported mandatory RWOPS approval, compared with 41.5% of PNs. Overall, 52.6% of MDs, PNs and RTs engaged in MJH also agreed with mandatory approval. Among those who engaged in MJH, the majority of MDs (84.7%) and RTs (87.4%) had RWOPS permission, compared with only 19.2% of PNs. MDs (odds ratio (OR) 9.9, $p<0.001$) and RTs (OR 30.9, $p<0.001$) were significantly more likely to obtain RWOPS approval than PNs. MDs (OR 2.2, $p<0.001$), RTs (OR 1.5, $p=0.027$), males (OR 1.4, $p=0.039$) and RWOPS participants (OR 2.8, $p=0.030$) were more likely to consider leaving if RWOPS was denied.

Conclusion. Our findings highlight significant variation in obtaining MJH permission among health professionals. The diverse perspectives underscore the need for targeted communication and stakeholder engagement to clarify policy and improve compliance.

Keywords: RWOPS, multiple job holding, dual practice, regulation, health workforce

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Human resources for health challenges, including multiple job holding (MJH) by health professionals, workforce shortages, maldistribution of the workforce and skills mismatches, threaten the achievement of universal health coverage.[1] MJH, also known as dual practice, refers to the simultaneous employment of health professionals in the public and private health sectors, regardless of regulatory provision and/or authorisation.[2]

MJH is shaped by health labour markets, country context and institutional arrangements, with evidence suggesting an increasing prevalence in industrialised countries.[3] In sub-Saharan Africa, low public sector salaries and a disconnect between effort and pay or promotion contribute to healthcare workers' decisions to engage in MJH.[4] Regulation is an important policy lever to balance the possible benefits of MJH with any potential adverse consequences to the health system.[5] However, there are variations in the regulatory approaches of governments to MJH, including full prohibition, allowing MJH with specified restrictions, or the provision of incentives to work exclusively in the public sector.[6]

In South Africa (SA), the Public Service Act of 1994[7] makes provision for remunerative work outside of the public service (RWOPS), defined as any business activity conducted or service provided by an employee outside of their official duties, for which they receive payment.[7] Hence, MJH is permitted for all public sector employees, including those in the health sector, provided that they obtain permission from the relevant authority, service delivery is not adversely affected and RWOPS is conducted outside scheduled working hours.[7,8]

The motivation for the introduction of limited private practice that preceded RWOPS was to increase the retention of public sector medical specialists by allowing them to supplement their government salaries. However, RWOPS has proved a contentious issue in the health system.[9-13] Following a complaint by nurses about absent doctors in 2004, the SA Public Service Commission conducted an enquiry into RWOPS in Gauteng Province. This report documented that most doctors and nurses engaged in RWOPS without approval.[14] A 2012 letter in the *South African Medical Journal* highlighted both the medical profession's non-compliance with, and relative silence on, the potential abuse of the RWOPS policy.[15] The letter unleashed a storm that underscored the wide-ranging perspectives and divided opinions on RWOPS, including the purported benefits,[12,13] the negative consequences for junior doctors, patients and professional ethics[11,16] and the

poor management and monitoring that contribute to RWOPS abuse.[9,10,17,18] The intense RWOPS debates between 2012 and 2017 were followed by updated government directives[7,8] and guidelines[19,20] to support the appropriate management and monitoring of RWOPS in the public sector. Additionally, the SA Medical Association recommended compliance with the RWOPS policy,[21] concerned about the abuse due to poor oversight. The association called for stricter management and enforcement by the National Department of Health. RWOPS was also flagged in the 2019 Presidential Health Compact, which underscored the need for policy revision and mechanisms to 'deter the incumbents' from MJH.[22] Nonetheless, a 2022 newspaper article suggests that RWOPS contestations and abuse remain an enduring problem.[23]

In contrast to medical doctors, the debate on RWOPS among nurses and rehabilitation therapists has been largely absent. The Democratic Nursing Organisation of SA views nursing agencies, the main vehicle for MJH among nurses, as labour brokers that should be banned.[24] A search of the journal archives of the physiotherapy, occupational therapy and speech and hearing therapy professional associations yielded no results on RWOPS.

Notwithstanding the fractured discourse, empirical studies on health professionals and the RWOPS guidelines are lacking. Hence, this study aimed to examine the factors that influence the perspectives of medical doctors, professional nurses and rehabilitation therapists in public hospitals on RWOPS policy and guidelines, thus giving voice to frontline healthcare providers while contributing to the policy discourse on MJH in SA. The research is part of a doctoral study that examines MJH among public sector medical doctors, professional nurses and rehabilitation therapists in Gauteng and Mpumalanga provinces of SA.

Methods

In 2022, a cross-sectional study was conducted in 14 hospitals in Gauteng and 15 hospitals in Mpumalanga provinces.[25] The Human Research Ethics Committee (Medical) of the University of the Witwatersrand in Johannesburg provided ethics approval for the study (ref. no. M210262), and the relevant provincial healthcare authorities also provided study permission. The study population comprised full-time medical doctors, professional nurses and rehabilitation therapists working in public sector hospitals in the two provinces. Details of the sampling approach have been described elsewhere.[25]

Following informed consent, the study participants completed a self-administered questionnaire (SAQ) that collected demographic and employment information, and prevalence, forms and reasons for MJH. The last section of the SAQ focused on RWOPS, examining whether: approval should be required; RWOPS should be restricted to after-hours; there should be limits on RWOPS hours; and respondents would leave the public sector if RWOPS was denied. RWOPS compliance was assessed by asking MJH participants if they had obtained permission from the relevant authority, with an option to provide reasons for lack of MJH permission.

We utilised Stata 17 (StataCorp, USA) and the svy commands to adjust for the cluster sampling design. We computed the frequency of responses and compared them across the different health professional categories. We coded the open-ended responses into categories, and compared their frequencies. Bivariate logistic regression was used to determine which variables influence health professionals' perspectives on RWOPS. We employed Firth's penalised logistic regression method[26] to overcome the challenges of ordinary logistic regression when faced with very low or high proportions for certain professional groups. Unlike ordinary logistic regression, Firth's method uses a penalised maximum likelihood approach to ensure finite and reliable parameter estimates in the presence of such data separation.[27] We used pooled models with appropriate weighting to compare the three health professional groups. The first model identified factors associated with perspectives on RWOPS requirements, the second assessed factors influencing whether health professionals had obtained permission for MJH and the third evaluated factors influencing whether they would leave the public sector if RWOPS was denied.

Results

Sociodemographic characteristics

We obtained a response rate of 84.3%, with 1 397 health professionals completing the survey. The characteristics of the research participants are depicted in Table 1. On average, medical doctors (MDs) were aged 39.9 (standard deviation (SD) 9.7) years, professional nurses (PNs) were 43.7 (SD 10.4) years and rehabilitation therapists (RTs) were 32.3 (SD 8.7) years.[25]

Perspectives on RWOPS

Table 2 presents the results on the perspectives of respondents on RWOPS. Most MDs (61.1%) and RTs (60.5%) agreed that approval should be required before engaging in RWOPS, compared with 41.5% of PNs. Overall, 54.0% of those involved in MJH agreed with this statement, compared with 52.6% of those who had not engaged in MJH. The majority of MDs (74.4%), PNs (79.1%) and RTs (79.8%) agreed that RWOPS should only be allowed after working hours, with little difference between the MJH and non-MJH groups. However, 46.4% of MDs, 41.7% of PNs and 37.5% of RTs agreed that the total number of permissible RWOPS hours should be restricted. Less than a third (31.8%) of those engaged in MJH supported restrictions on permissible RWOPS hours, compared with 45.8% of those in the non-MJH group.

Finally, 46.0% (95% confidence interval (CI) 37.0 - 55.3) of MDs, 21.9% (18.7 - 25.5) of PNs and 32.4% (28.5 - 36.6) of RTs stated that they would leave the public sector if RWOPS was denied. The figure was significantly higher for health professionals engaged in MJH (56.5%, 49.6 - 63.4) compared with those who were not (25.1, 21.9 - 28.4).

Compliance with RWOPS permission requirements

Fig. 1 shows the proportion of health professionals with an additional job who reported obtaining permission to engage in RWOPS. A total of 84.7% (75.0 - 91.1) of MDs, 87.4% (79.3 - 92.6) of RTs and only 19.2% (9.1 - 35.9) of PNs had permission for their additional jobs.

Table 3 depicts the primary reasons for not obtaining RWOPS permission from those health professionals who completed the optional question. Among MDs, the primary reasons were that they did not need permission for work done after-hours (28.9%), and did not require RWOPS permission for the type of additional jobs (13.7%). PNs indicated that they anticipated management refusal upon application (25.3%), or believed that they did not need permission for their after-hours work (20.2%). Among RTs, 28.2% reported that they were still awaiting approval due to a lengthy process, while 23.5% indicated that they had never applied for RWOPS.

Factors influencing health professionals' perspectives on RWOPs regulation

Table 4 shows the results of the logistic regression analysis evaluating the factors associated with health professionals' perspectives on RWOPS. Model 1 covers the perspectives on requiring approval before RWOPS. MDs had 1.83 (1.39 - 2.42) and RTs 2.54 (1.87 - 3.46) higher odds of agreeing that approval should be obtained compared

with PNs. Interestingly, medical specialists had 1.37 (1.04 - 1.80) times the odds of agreeing with approval compared with generalists, and clinical heads of department (HODs) had 1.85 (1.34 - 2.56) greater odds compared with those not in management. Having an additional job reduced the likelihood of supporting approval requirements (0.63 (0.48 - 0.83) compared with those without an additional job.

Model 2 presents the factors influencing health professionals' compliance with the RWOPS policy requirement of obtaining permission before engaging in MJH. MDs had 9.84 (4.19 - 23.09) and RTs had 30.53 (12.24 - 76.13) higher odds of obtaining approval for additional jobs compared with PNs. Medical specialists had 2.23 (1.09 - 4.55) times higher odds of having approval compared with generalists, while being a clinical HOD did not influence compliance significantly. Additionally, MDs and RTs who supported mandatory approval had 2.75 (1.52 - 4.97) times greater odds of having approval compared with PNs.

Finally, model 3 depicts the factors influencing health professionals' opinions on whether they would leave the public sector if RWOPS were denied. MDs were 2.21 (1.62 - 3.02) and RTs were 1.49 (1.05 - 2.12) times more likely to say that they would leave the public sector if RWOPS were not permitted compared with PNs. Male respondents were 1.36 (1.02 - 1.82) times more likely to leave compared with females. In contrast, married professionals (odds ratio (OR) 0.78, 0.59 - 0.97) and clinical HODs (OR 0.51, 0.34 - 0.74) reported a significantly lower chance of leaving if RWOPS was denied. Respondents with current additional jobs had 2.83 (2.13 - 3.75) higher odds of leaving if RWOPS was denied. Conversely, those who supported requiring approval for MJH had lower odds (0.63 (0.49 - 0.81)) of leaving if RWOPS was not permitted, compared with those who did not think approval was necessary.

Discussion

This is one of the first empirical studies to examine and compare the perspectives of public sector MDs, PNs and RTs in SA on the RWOPS policy.

In contrast to PNs, the majority of MDs and RTs supported mandatory RWOPS approval, as legally prescribed. Similarly, most MDs and RTs who engaged in MJH had RWOPS permission, while barely one-fifth of PNs had the necessary permission. Those health professionals who engaged in MJH were less likely to support approval requirements compared with those without an additional job. The study findings illustrate the stark differences in reported compliance with the RWOPS policy requiring permission before engaging in MJH. MDs were nearly 10 times more likely and RTs 31 times more likely to obtain RWOPS approval than PNs. Additionally, MDs and RTs who supported mandatory RWOPS approval were almost three times more likely to have approval compared with PNs.

Table 1. Characteristics of study participants (*N*=1 397)[25]

Characteristic	MDs, *n* (%)*	PNs, *n* (%)*	RTs, *n* (%)*
Total sample	486 (34.8)	571 (40.9)	340 (24.3)
Age, years, mean (SD)	39.9 (9.7)	43.7 (10.4)	32.3 (8.7)
Gender			
Male	265 (54.5)	47 (8.2)	57 (16.8)
Female	217 (44.7)	522 (91.3)	277 (81.5)
Other	4 (0.8)	3 (0.5)	6 (1.8)
Marital status			
Single	154 (31.7)	262 (45.9)	202 (59.4)
Married/living together	302 (62.1)	231 (40.4)	129 (37.9)
Divorced/separated	22 (4.5)	41 (7.2)	5 (1.5)
Widowed	8 (1.7)	37 (6.5)	4 (1.2)
Province			
Gauteng	396 (81.5)	445 (77.9)	242 (71.2)
Mpumalanga	90 (18.5)	126 (22.1)	98 (28.8)
Years of practice, mean (SD)	14.7 (9.0)	10.6 (9.1)	9.1 (7.9)
Speciality†			
No	270 (55.6)	388 (68.0)	n/a
Yes	216 (44.4)	183 (32.0)	n/a
Clinical head of department			
No	426 (87.7)	505 (88.4)	278 (81.8)
Yes	60 (12.3)	66 (11.6)	62 (18.2)
Hospital category			
District	102 (21.0)	147 (25.7)	103 (30.3)
Regional	140 (28.8)	155 (27.1)	79 (23.2)
Tertiary	79 (16.3)	82 (14.4)	46 (13.5)
Central	165 (33.9)	187 (32.8)	112 (33.0)
Multiple job holding			
No	322 (66.3)	522 (91.4)	208 (61.3)
Yes	164 (33.7)	49 (8.6)	132 (38.7)

MD = medical doctor; PN = professional nurse; RT = rehabilitation therapist; SD = standard deviation; n/a = not applicable.
*Unless otherwise indicated.
†Only MDs and PNs can undertake registered specialist training.

These differences across the three groups could reflect variations in professional autonomy that influence MJH forms and reporting structures among the three groups. The same survey found that the most common form of MJH among MDs and RTs was private practice, while PNs engaged in MJH through nursing agencies.[25] MDs and most RTs have more flexible work arrangements compared with PNs, who function within team structures and have less autonomy.[28] PNs may avoid seeking RWOPS approval due to fears of recrimination or scrutiny, which aligns with cited concerns about managers controlling their extended working hours. Although a minority of study participants furnished reasons for not seeking RWOPS approval, the belief that permission was not required for RWOPS after hours or for certain types of work was common across all three professions. Furthermore, the PN perspectives also suggest distrust in the RWOPS approval process and/or managerial objectivity. We could not find similar SA studies with which to compare our findings, while variations in context and MJH regulatory approaches limit comparisons with health professional perspectives in other countries.[6] Nonetheless, a 2002 qualitative study in Bangladesh[29] and a 2007 qualitative study in Peru[30] found that individual health professionals supported more stringent MJH regulations to protect the profession or to ensure quality patient care.

Our study found that the expressed likelihood of leaving the public sector service if RWOPS were denied was higher among MDs, RTs, males and those already engaged in RWOPS, compared with PNs (Table 4). In contrast, MDs and RTs who supported the requisite approval had lower odds of leaving if RWOPS were denied than PNs. These perspectives could relate to the differences in financial incentives among the three professions, as the prevalence of MJH was much higher among MDs and RTs, compared with PNs.[25] As the respondents self-reported the information, we do not know whether the threat of leaving the public sector will materialise. A 2010 study among SA nurses found that intention to leave the public sector was higher among those engaged in MJH compared with those who did not engage in MJH.[31] Nonetheless, the threat of leaving the public sector if RWOPS is denied poses a risk to the retention

Table 2. Respondents' perspectives on RWOPS, by professional group and MJH status

	Professional group, *n* (%)			MJH status, *n* (%)	
RWOPS perspective	**MD, 486 (34.8)**	**PN, 571 (40.9)**	**RT, 340 (24.3)**	**No, 1 052 (75.3)**	**Yes, 345 (24.7)**
Should require prior approval for RWOPS					
No	189 (38.9)	334 (58.5)	134 (39.5)	498 (47.4)	159 (46.1)
Yes	297 (61.1)	237 (41.5)	206 (60.5)	553 (52.6)	186 (53.9)
RWOPS should only be allowed after hours					
No	125 (25.6)	119 (20.9)	69 (20.2)	222 (21.2)	90 (26.1)
Yes	361 (74.4)	452 (79.1)	271 (79.8)	829 (78.8)	255 (73.9)
RWOPS hours should be restricted					
No	260 (53.6)	333 (58.3)	213 (62.5)	570 (54.2)	235 (68.2)
Yes	225 (46.4)	238 (41.7)	127 (37.5)	482 (45.8)	110 (31.8)
Would leave public sector job if RWOPS denied					
No	262 (54.0)	446 (78.1)	230 (67.6)	788 (74.9)	150 (43.5)
Yes	224 (46.0)	125 (21.9)	110 (32.4)	264 (25.1)	195 (56.5)

MJH = multiple job holding (additional job in the preceding 12 months); RWOPS = remunerative work outside of the public service; MD = medical doctor; PN = professional nurse; RT = rehabilitation therapist.

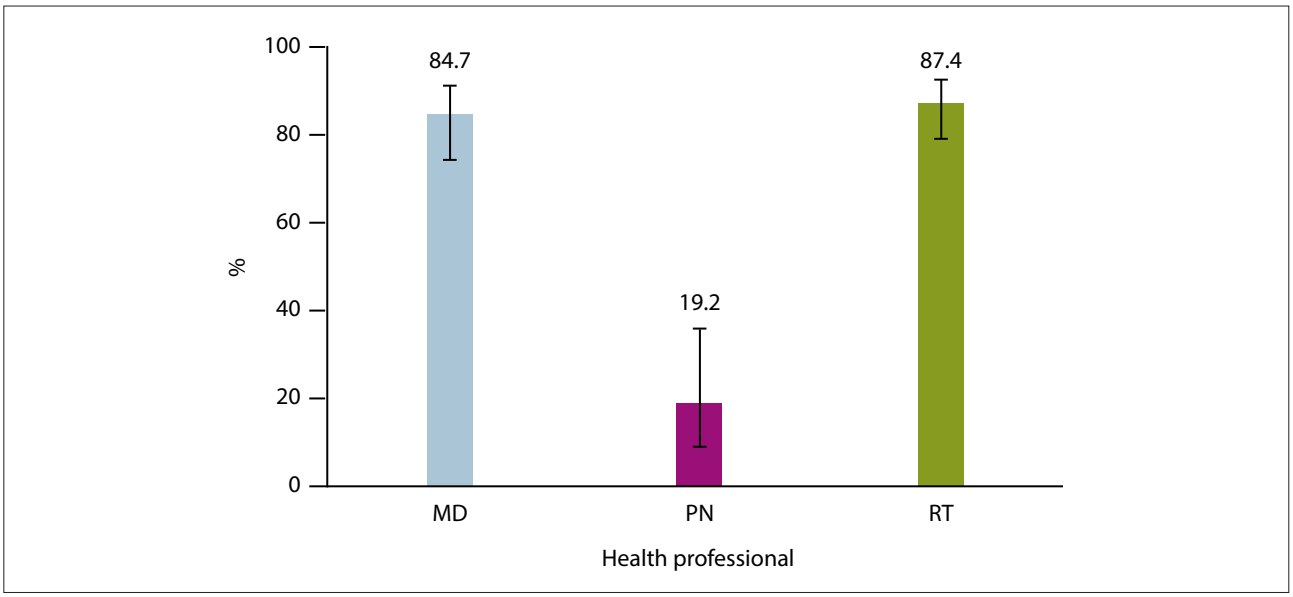

Fig. 1. Health professionals engaged in multiple job holding with remunerative work outside of the public service (RWOPS) approval. Error bars show 95% confidence interval. (MD = medical doctor; PN = professional nurse; RT = rehabilitation therapist.)

Table 3. Listed reasons for doing RWOPS without permission, ranked

MDs	*n* (%)	PNs	*n* (%)	RTs	*n* (%)
1. Permission is not required for RWOPS after hours	7 (28.9)	1. RWOPS will be declined	10 (25.3)	1. Long approval process, awaiting approval	4 (28.2)
2. RWOPS not required for type of work	3 (13.7)	2. Permission is not required for RWOPS after hours	8 (20.2)	2. Never applied for RWOPS	4 (23.5)
3. RWOPS will be declined	3 (12.0)	3. Concerns about managers controlling extended working hours	7 (18.9)	3. RWOPS is not required for type of work	3 (16.7)
4. Never applied for RWOPS	3 (11.8)	4. Long approval process, awaiting approval	3 (7.2)	4. Permission is not required for RWOPS after hours	2 (12.8)
5. RWOPS was declined	2 (6.2)	5. RWOPS is not required for the type of work	2 (5.9)	5. RWOPS will be declined	1 (9.6)
6. Long approval process, awaiting approval	2 (6.0)	6. Never applied for RWOPS	2 (5.0)	6. Concerns about managers controlling extended working hours	1 (5.2)
Other	5 (21.4)	Other	9 (17.5)	7. Unfamiliarity with the RWOPS policy	1 (4.0)
Total	25 (100.0)		41 (100.0)		16 (100.0)

RWOPS = remunerative work outside of the public service.

Table 4. Logistic regression analysis of health professionals' attitudes toward RWOPS

	Model 1: RWOPS approval necessary			Model 2: Had obtained approval			Model 3: Would leave if RWOPS banned		
Variable	**OR**	**95% CI**	***p*-value**	**OR**	**95% CI**	***p*-value**	**OR**	**95% CI**	***p*-value**
Profession									
PN	ref.	ref.	ref.	ref.	ref.	ref.	ref.	ref.	ref.
MD	1.83	1.39 - 2.42	<0.001***	9.84	4.19 - 23.09	<0.001***	2.21	1.62 - 3.02	<0.001***
RT	2.54	1.87 - 3.46	<0.001***	30.53	12.24 - 76.13	<0.001***	1.49	1.05 - 2.12	0.027*
Gender									
Female	ref.	ref.	ref.	-	-	-	ref.	ref.	ref.
Male	0.96	0.73 - 1.26	0.769	0.99	0.53 - 1.86	0.977	1.36	1.02 - 1.82	0.039*
Marital status									
Single†	-	-	-	-	-	-	ref.	ref.	ref.
Married	-	-	-	-	-	-	0.75	0.59 - 0.97	0.030*
Speciality									
No	ref.	ref.	ref.	ref.	ref.	ref.	ref.	ref.	ref.
Yes	1.37	1.04 - 1.80	0.024*	2.23	1.09 - 4.55	0.028*	1.27	0.93 - 1.73	0.129
Clinical HOD									
No	ref.	ref.	ref.	ref.	ref.	ref.	ref.	ref.	ref.
Yes	1.85	1.34 - 2.56	0.014*	0.71	0.31 - 1.62	0.414	0.51	0.34 - 0.74	0.001**
Province									
Mpumalanga	ref.	ref.	ref.	-	-	-	ref.	ref.	ref.
Gauteng	0.94	0.76 - 1.17	0.568				0.96	0.76 - 1.25	0.021
Additional job									
No	ref.	ref.	ref.	-	-	-	ref.	ref.	ref.
Yes	0.63	0.48 - 0.83	0.001**	-	-	-	2.83	2.13 - 3.75	<0.001***
Is approval necessary?									
No	-	-	-	ref.	ref.	ref.	ref.	ref.	ref.
Yes	-	-	-	2.75	1.52 - 4.97	0.001**	0.63	0.49 - 0.81	<0.001***
n	1 397	-	-	321	-	-	1397	-	-
χ^2	63.8	-	-	63.7	-	-	137.9	-	-
p-value	<0.001	-	-	<0.001	-	-	<0.001	-	-

RWOPS = remunerative work outside of the public service; OR = odds ratio; CI = confidence interval; PN = professional nurse; MD = medical doctor; RT = rehabilitation therapist; ref. = reference category; HOD = head of department.
*$p<0.05$.
**$p<0.01$.
***$p<0.001$.
†Single, divorced/separated and widowed combined.
Firth penalised logistic regression. Model 2 only for those engaged in MJH.

of health professionals in the public sector, which has numerous health workforce challenges. Although the question was not phrased as an outright RWOPS ban, a systematic review of MJH regulatory approaches in different countries reported that banning MJH often led to senior skilled MDs migrating to the private sector.[2] Similarly, in SA, public sector medical specialists in Gauteng resigned after threats to ban MJH, while those in Free State Province contested attempts to introduce a ban.[17] Moreover, an SA study[32] found that MDs often did RWOPS without permission, making a ban unlikely to resolve the issue.

Our study found that the majority of MDs, PNs and RTs were against the restriction of RWOPS hours, but indicated a preference for MJH after hours (Table 2). This is encouraging, as a systematic review reported that public sector doctors generally preferred schedules that allowed more time in the private sector.[2] Nonetheless, the support among the majority of RWOPS participants for RWOPS after working hours suggests consideration of patient welfare, ethical conduct and social responsibility.[33]

Study limitations

Our study is limited by its cross-sectional nature and self-reported information from MDs, PNs and RTs, which may have introduced social desirability bias, with health professionals potentially overstating their compliance with written approval or support for the policy. However, the SAQ was designed to minimise this potential bias. Additionally, conducting the study in only two provinces limits the generalisability of the findings to the rest of the country. However, a major methodological strength of the study is the high response rate of 84.3%. The study is novel as it is one of the few comparative studies on health professionals' perspectives on the RWOPS policy, their reported compliance with approval guidelines, their views on the likelihood of leaving the public sector if denied RWOPS and the factors influencing these views.

We have advanced the discourse on the regulation of MJH in SA, with implications for revision and/or refinement of the RWOPS policy and its management in hospitals. Both the 2019 Presidential Health Compact[22] and the 2030 Health Workforce Strategy[34] underscore the need for an RWOPS policy review. Our study findings suggest high levels of reported compliance among MDs and RTs, but very low compliance among PNs, who remain the mainstay of the SA health system. This requires policy and management intervention. Further research is needed on whether the RWOPS approval records for MDs and RTs align with reported approval, and whether health professionals adhere to the approved working hours. Although restrictions of RWOPS hours could be an area for policy adjustment, evidence suggests that consistent monitoring of the existing policy could deter opportunistic behaviour among health professionals.[35] Additionally, our study found that clinical HODs are supportive of the RWOPS policy, and could assist hospital management to monitor and enforce the policy provisions.

All three professions highlighted the long approval process, suggesting the need for streamlined procedures or systems that enhance compliance. The apparent misconceptions about RWOPS approval for all forms of MJH require targeted information and communication campaigns to clarify the RWOPS policy guidelines to all health professionals. Clear, consistent communication using existing Department of Public Service and Administration guidelines[19] and directives[7] is essential for motivating staff, managing resistance and building trust.[36] User-friendly guidelines should be developed by employers and professional associations, and creative strategies employed to reach all health professionals.

Conclusion

Our study has generated new knowledge on the RWOPS policy and the views of medical doctors, professional nurses and rehabilitation therapists. The study has also contributed to the global discourse on MJH and its regulation. The diverse perspectives on RWOPS among health professionals suggest the need for stakeholder engagement and targeted information and communication regarding policy content and compliance. Simultaneously, RWOPS approval systems and improved monitoring should be addressed by the provincial health authorities.

Data availability. Data are available from the authors upon reasonable request.

Declaration. None.

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Author contributions. All authors conceptualised the research project. LR and DB supervised the study. BM developed the first draft of the manuscript. All authors contributed to, reviewed and approved the final manuscript.

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Conflicts of interest. None.

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