An Assessment of the Remunerative Work Outside Public Sector Policy at the Johannesburg Hospital

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A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand in partial fulfillment of the requirements for the degree of

Masters of Public Health
Johannesburg, 2007

DECLARATION

I, Farzana Khan, declare that this research report is my own work. It is being submitted for the degree of Masters of Public Health in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other university.

DEDICATION

I dedicate this work to my family who were with me throughout the life of this project.

ABSTRACT

Good infrastructure and equitable distribution of resources are critical factors in securing equal health care access to all. Poverty, food production and distribution, water, sanitation, housing, environmental protection and education all impact on health (Lee and Mills, 1983). Despite the multi-dimensional determinants of health and healthcare, one of the most noticeable challenges facing the health care system is that of human resources. Health care systems cannot function optimally without sufficient levels and adequate distribution of health care personnel. Brain drain in South Africa is one of the critical areas of concern according to the Health Minister (Poggenpoel, 2004). Recruitment and retention of health care workers within public health institutions is still one of the most critical challenges facing South Africa. Poor working conditions; limited consumable resources and mismanagement of facilities aggravate the problem of shortage of skilled health care personnel.

Limited private practice (LPP) is seen as one of the many mechanisms to retain health care personnel. Limited Private Practice or moonlighting allows for government or state employees to perform private duties within certain time parameters. LPP is common in many developing countries, including South Africa. This study focuses on the health professionals engaging in limited private practice in South Africa. Remunerative Work Outside Public Sector (RWOPS) is potentially an alternative term used for LPP in South Africa.

The study focuses on the evolutionary process of the RWOPS policy and explores the attitudes and perceptions of the health professionals and management at the Johannesburg Hospital with regards to the RWOPS policy. Policy documents, press releases, international studies and official documents collected through searches on the world-wide-web have provided the bases for the evolutionary process of the study. The perception and attitudes were determined through a self-administered structured questionnaire. Participants were randomly selected from a list obtained from the Johannesburg Hospital Human Resource personnel. Some participants were selected using snowball sampling. A total of forty two questionnaires were handed out to the respective participants with feedback from thirty five participants. The questionnaire compromised of closed and open ended questions. The sample population consisted of the following participants:

- Nursing personnel (these included nurses at all levels, professional nurses, senior nurses, chief nurses as well as representatives from DENOSA)
- Doctors (all levels registrars, senior registrars, Head Of Department's, consultants and reps from SAMA)
- Management (the CEO and some human resource personnel responsible for processing the RWOPS applications)
- Allied Health Professionals (all levels of physiotherapists, occupational therapists, pharmacists and the speech and hearing therapists)

The results are presented graphically. The data was thematically analyzed allowing the researcher to identify the role of the key actors in the implementation process. The Walt and Gilson (1994) model was used to analyze and assess the RWOPS policy.

A pilot study was conducted to determine if the validity and reliability of the questionnaire in determining the role, attitudes and perceptions of these key actors with regards to the RWOPS policy. The pilot study was included in the actual sample population. Management n=2; doctors n=11; nurses n=15 and allied health n=7 were the total number of respondents.

Most individuals felt that a shortage of human resource was the most critical challenge. Most participants are not familiar with the RWOPS policy even though seventy seven percent of the participants answered yes to being familiar with the policy. The expectation from many participants was for them to receive substantial financial incentives through the policy. This relates the lack of knowledge on the policy terms. Participants also felt that certain professions and individuals benefited the most from the RWOPS resulting in animosity amongst health care workers at the Johannesburg Hospital. The questionnaires indicated that there was minimal input from all the relevant key actors. This lack of consultation with all relevant actors or perhaps a miscommunication amongst the relevant players may have contributed to the abuse of this policy.

ACKNOWLEDGEMENTS

I would like to thank my supervisor, Haroon Wadee for his continued support and critical judgment, my mentor Professor Shan Naidoo, for his continued support and advice and my dear work colleagues Drummond Goven and Richard Masoetsa for their patience and support through this masters programme.

My loving and very supportive husband, Faisal Hoosen, for his continued drive and patience. My loving and dearest daughter, Ammarah for her patience.

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CHAPTER ONE

1.1 INTRODUCTION

1.1.1 Background

A nation's development is conditioned by its culture, climate, and historical background. Governments attempt to ensure that all efforts are directed in achieving the national objectives and strategies within the health sector (Lee and Mills, 1983). Leon and Mabope (2005) explain that it is the role of the government to provide stewardship in the utilization of national resources to benefit the health needs of the entire population ensuring it is equitable, efficient and accessible. Governments in developing countries are faced with the challenge of ensuring there are sufficient resources such as: Staff, equipment, consumables, infrastructure and community support. Hence the critical shortage of skilled health care personnel within the public sector is crucial in delivering quality health care, and governments in developing countries need to devise mechanisms in ensuring these skills are retained within the public health sector.

Maldistribution of health personnel, poor infrastructure and inequitable distribution of resources impact on service delivery and compromise quality care. A shortage of skilled health professionals has been labeled as the most critical problem encountered in public hospitals. According to the World Health Report (2006) the main reasons for the decrease in the health work force are migration, risk of violence, illness or deaths, and change of status. Figure 1 outlines these exit routes of the health work force.

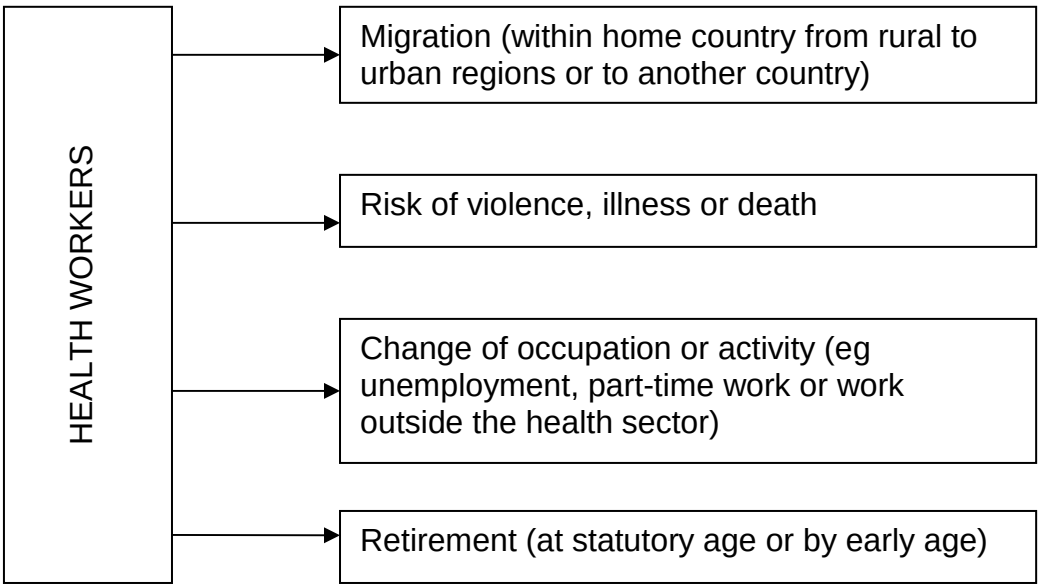

Figure 1 The typical exit routes of the health work force

Exit routes for Health Workers explaining the possible shortage of health care personnel (World Health Report, 2006)

Dual practice or limited private practice (LPP) may be interpreted as health professionals skilled with multiple specialties that engage in activities outside the health sector and health professionals engaging in public and private work (Ferrinho, Van Lerberghe, Fronteira, Hipolito and Biscaia, 2004). LPP or *moonlighting* refers to the process whereby health practitioners employed by the government or state are contractually allowed to perform private duties within certain time frames. LPP is potentially one of the many mechanisms to retain health care personnel.

The participation of public doctors in LPP in developing countries is expanding in a much unregulated manner. Unregulated *moonlighting* can have detrimental effects on public sector institutions, because it has the potential to drain valuable resources from the public health care system. For instance, doctors may spend more time on private sector activity, whilst receiving public sector remuneration for much-needed public sector duties. There are financial and non-financial incentives in regulating and implementing dual jobs for health care personnel, explains Gruen, Anwar, Begum, Killingsworth and Normand (2002). This will ensure stricter measures are in place and facilitate the monitoring of activities of health care personnel.

It is important to retain health professionals within the country and more so within the public sector (Wadee, Gilson & McIntyre, 2004). South African policy debates around LPP have emerged in an attempt to retain health care personnel within the public sector. In South Africa this is made possible through legalized incentive schemes, such as the Remunerative Work Outside Public Sector (RWOPS) policy.

LPP is widespread in many developing countries with similar encounters to that experienced in South Africa. This study focuses on the health professionals that are employed in the public sector but engage in private work in South Africa. Remunerative Work Outside Public Sector (RWOPS) is an alternative term used for limited private practice in South Africa. It is against this background that the study was conceived.

1.2 AIMS

The aim of this study is to explore the evolution of the RWOPS policy in Gauteng and gain insight on the attitudes and perceptions of healthcare professionals and management staff involved in implementing the RWOPS policy at the Johannesburg Hospital.

1.3 STUDY OBJECTIVES

- To assess the evolution of the RWOPS policy that is implemented at the Johannesburg Hospital
- To explore the attitudes and perceptions of health professionals and management at the Johannesburg Hospital with regards to RWOPS

1.4 JUSTIFICATION

The attitudes and perceptions of doctors concerning the RWOPS policy have not been fully-explored in South Africa. The attitudes and perceptions of other health care professionals and the administrative staff have to date not been explored. This study intends to explore these issues to shed light on factors that may impact on the successful implementation of the policy.

At the 2001 National Health Summit (Department of Health, 2001) the need for an evaluation surrounding the policy on remunerative work outside public sector was highlighted, in lieu of a constructive partnership between the public and private sectors in achieving an equitable and accessible health care system in South Africa.

CHAPTER TWO

LITERATURE REVIEW

Equal access to health care is seen as a right of every individual and recognized by the World Health Organization in the Declaration of Alma Ata (World Health Organization as cited in Lee and Mills, 1983). The South African National Health Policy is based on the Declaration of Alma Ata *Health for All* (Andrew and Pillay, 2005). The South African National Health system is based on the District Health system approach using primary health care as a vehicle in improving access to health care.

It is the responsibility of the Department of Health to promote health and wellness in South Africa (Burger, 2005/2006). It is the role of the government to commit itself in providing the relevant infrastructure and resources in providing health care to the people of its country. One of the ten priorities for 2004-2009 as outlined by President Mbeki emphasizes *Human resource planning, development and management* (Andrew and Pillay, 2005) in an effort to achieve the Millenium Development Goals (MDGs). The South African National Health Act of 2003 provides the framework for the South African Health Care system, which is also enshrined in the constitution (Gray, Govender, Gengiah and Singh, 2005). Chapter one of the South African National Health Act outlines the roles and responsibilities of health care providers and users.

The National Health Department is responsible for the formulation of health policies and legislation; the appropriate allocation and utilization of health

resources; co-ordination of health information and monitoring national health goals; regulation between the various health levels and regulating the public and private sectors. The Provincial Health Department is responsible for the rendering of health service, formulating and implementing Provincial Health polices to meet the demands of the National Department of Health and co-ordination of funding and financial management of District Health authorities. The Primary Health Care providers are solely responsible to meet the health demands of the communities by offering health services.

Chapter seven of the National Health Act explains it is the responsibility of the National Health Council to take the necessary steps in human resource recruitment and allocation. The National Health Council includes (National Health Act, 2004):

- The minister of Health (or a nominee)
- Deputy minister of Health
- Relevant members of the executive councils
- One municipality councilor
- Director-general and Deputy director-general of national department of health
- Head of each provincial department
- One employee of national organization
- Head of South African Military Health Services

However, escalating costs along with lower public health budgets, emergence of AIDS, prevalence of chronic diseases coupled with persisting communicable

diseases, demoralized staff and emerging drug resistance to diseases are some of the issues undermining health systems development.

Health care personnel are defined as all professionals providing health services in terms of any law, including the Allied Health Professions Act, Health Professions Act, Nursing Act, Pharmacy Act and Dental Technicians Act (Gray, et al., 2005). Health workers are individuals whose job involves protecting and improving the health of their communities (Gray and Pillay, 2006).

Health personnel are crucial in ensuring the delivery of health services. There are still major challenges facing the national health system in attracting health personnel to the rural areas. The National Health Act, 2003 compels the National Health Council to develop such policies and guidelines to ensure the availability and distribution of human resource personnel within the health care system. The scarce skills and rural allowance was introduced to attract health care personnel to these areas. The introduction of limited private practice was another such initiative to attract health personnel to work in the public sector.

Dual job holding, *moonlighting* or LPP is defined as a situation where public health workers engage in private practice or work in other facilities to supplement their income (Jumpa et al., 2003). Health care professionals engage in extended hours in dual practice, charge informal fees, stay absent to attend to patients at their private clinics and some also refer public hospital patients to their private clinics (Ferrinho et al., 2004). This abuse of public health facilities compromises service delivery because the shortage of health personnel is perpetuated. It poses a threat

to quality health care because it disrupts and hinders the day to day functioning of the health care system.

Berman and Cuizon (2004) explain it is best to investigate the underlying causes and the regulatory mechanisms in place, which contribute to dual practice or LPP. There are various endogenous and exogenous factors that influence the migration of health care personnel. Endogenous factors include low remuneration rates, unrealistic work demands due to a lack of adequate human resource planning, work associated risks, poor infrastructure and poor working conditions. Exogenous factors include political insecurity, taxation laws, and increased crime (Padarath, 2003/2004). These factors result in the depleting number of health care personnel in the public health institutions.

Doctors that are employed by the state may also practice privately to supplement their income since their salaries from the public sector are low (Bian et al., 2003 & Ferrrinho et al., 2004). The discrepancies in salaries earned seem to be the most important factor driving health care personnel to engage in private work. Marq (cited by Berman and Cuizon, 2004) explains that it is becoming increasingly difficult for practitioners to engage in public work exclusively because of the vast gap that exists between the salaries earned. Berman and Cuizon (2004) explain that the following are the main reasons why public practitioners engage in dual practice:

- Professional motivation to increase private patient numbers
- Potential to increase earnings and
- Opportunity for self development.

It is evident that dual practice is widespread in many developing countries (just cite some of many references here). Most countries report similar experiences with health care personnel that engage in dual practice. In Zambia, Indonesia, Poland, Mexico and Spain senior doctors are officially permitted to engage in private work, but there is anecdotal evidence that junior doctors and paramedical staff are also practicing at private institutions, (Gonalez, 2002 and Berman and Cuizon, 2004).

Doctors in Kenya are permitted to apply for permission to engage in dual practice; however there are no control mechanisms in place to monitor such practices. The governments of India, Bangladesh, Peru and Egypt have adopted an agreeable attitude towards dual practice because it helps retain staff within the public hospitals and rural areas, (Berman and Cuizon, 2004 and Jumpa et al., 2003).

The French government permits private practice with a restriction on the fee that may be charged, (Gonalez, 2002). Berman and Cuizon (2004) highlight that the Egyptian health ministry has guaranteed medical graduates a job in any of the public institutions, including education and defense, upon completion of their medical studies to retain skilled personnel within the public sector. The remuneration for such practices is paid according to the level of training obtained. In the United Kingdom doctors are allowed LPP under contracts with the National Health Service or NHS (Gonalez, 2002).

Dual practice is mooted as a possible systems solution to the poor availability of limited resources (Jan, Bian, Jumpa, Meng, Nyazema, Prakongsai and Mills,

2005). South African health care personnel have experienced similar encounters and share similar sentiments. LPP instead of dual practice was offered to health care personnel to address these various issues. Poor regulation and a lack of monitoring have lead to the abuse of working hours and neglect of patients visiting public hospitals. This caused the Department of Health to abolish LPP and regulate it by introducing a new policy. Limited private practice ended in January 2000 and Remunerative Work Outside Public Sector (RWOPS) system was implemented to facilitate management and control (Moorman, 2001).

RWOPS is not limited to any professional level like other countries. Instead the policy allows for all contractual government employees the opportunity to apply for permission from the relevant institution to engage in such practice. The application for permission from the relevant institution where individuals are employed allows for management to control and regulate the practice session thereby ensuring there is always adequate supply of staff. There are no mechanisms in place to monitor the exact amount of time spent in RWOPS neither the usage of state equipment for private use. The South African government does not impose any restrictions on the fee charged like the French Government because in 2004 the Competition Commission ruled that representative bodies of funders and providers could not set tariffs. In this vacuum the National Department of Health (NDoH) has implemented the National Health Reference Price (NHRPL) which is merely a reference price and not a regulated fee.

RWOPS has encountered many problems since its implementation (Public Service Commission, 2004). Staff employed at the Pretoria and Johannesburg academic

hospitals explained that apart from the above mentioned reasons, senior management took very long to process the relevant administrative forms for RWOPS and they faced a lack of commitment from the management at their respective institutions. These complaints indicate the frustration most doctors and nursing staff are facing. According to doctors it is frustrations such as these that force them to cheat the system. (Health-e-guest, 2005).

In South Africa doctors are permitted to engage in private work, however, they are dissatisfied with the working hours stipulated in their contracts. *"Most of us reject the option of limited private practice (RWOPS) because our work is demanding and leaves no time for private practice*," Health-e-guest (2005). These complaints are not unique to the two above mentioned institutions. The doctors working in the Western Cape public hospitals complained that they do not have the time to engage in private practice because of the long durations spent in the public facilities. The health care workers also highlighted the overtime they worked, the salaries earned were not compatible and that they spent less quality time with their families.

2.1 Human Resource Challenges facing the South African health care system

The South African health care system has both a public and private sector. South Africa has major inequities between the public and private health care sectors, (Schneider and Gilson, 2001) such as salaries, working conditions and staff incentives. These factors entice many health care personnel to work in the private sector. Public hospital services account for the major portion of public health expenditure, (Boulle, Blecher and Burn, 2000), yet the public hospitals are unable to retain the skilled health care personnel.

Approximately 80% of the South African population is dependent on the public sector, yet health resources are concentrated in the private sector. The private sector caters for only 20% of the population aggravating the already inequitable distribution, (Doherty, 2002). The degree and pressure of maldistribution of skilled personnel within the private sector is existent but it is not the same as that of the public sector (National Department of Health, 2006).

Budgetary restraints and increasing inflation make it difficult to allocate adequate resources to the social sectors (Cooper Weil, Alicbusan, Wilson, Reich and Bradley, 1990). The inequitable resource distribution within the public health sector is very limiting, frustrating staff and further impacting on the healthcare services available to the population. Accessibility to health services is affected and quality of care is compromised. The South African Health Charter acknowledges that

human resources are critical to ensuring there that the health services are accessible to all (Department of Health, 2005/06).

Padarath (2003/2004) explains that health personnel are the most significant component of any health care system. The shortage of skilled health care personnel is one of the most significant constraints preventing developing countries from reaching the millennium development goals (Smith and Henderson-Andrade, 2006). Brain drain in South Africa is one of the two critical areas of concern tabled by the Health Minister in the budget brief 2004. The crisis does not only involve the movement of health personnel from South Africa to other countries but also within the country from the public to private sectors (Poggenpoel, 2004).

The most noticeable challenges facing the health care system is that of human resources. The inability to recruit and retain skilled staff within the public health sector (Berman and Cuizon, 2004 and Andrew and Pillay, 2005), compromises service delivery. Poor working conditions; such as poor salaries, long working hours due to staff shortages, limited consumable resources and mismanagement of facilities drive health care personnel to seek better opportunities (Pick, Doherty and Joffe, 2002). Doctors have argued that salaries earned in the public sector are very low. They have been supplementing their incomes by attending to private patients while working at public institutions.

If the skills are not retained and maintained it compromises service delivery as it limits accessibility to health care. Andrew and Pillay (2005) explain that provinces

are also hindered in service delivery because of inequitable resource distribution and a backlog in infrastructure. The ratio of adequately trained health care personnel to communities is poor. This has resulted in long waiting times, frustrated patients and poor quality health care. The discussion paper on public-private interactions discussed at the 2001 National Health Summit identifies the shortage of staff as one of the factors that is currently impacting and hindering the delivery of quality health care to all South Africans, (Department of Health, 2001).

There is increasing concern vis-à-vis the impact of HIV/AIDS on healthcare workers, (Veriava, 2005), because of the high and burden placed upon the already-stretched staffing levels. The skills development levy intended to address staff shortages by training additional health personnel to supplement the high numbers of absenteeism. There is no evidence to show that this levy has been utilized for training additional health personnel.

The fixed salary provided by government provides little incentive to improve the performance of doctors and health workers (Gruen, et al., 2002). The earning capacity offered within the private sector for specialist services are more attractive and lucrative hence there is a migration of skilled professionals to the private sector, leaving the public sector short staffed. This increases the inequity and inefficiency of the public health care system. Salaries and the service conditions of these health care personnel need to be critically evaluated to ensure retention of skilled staff shortages.

The South African health care system faces one of the most intricate human resource shortages. This is further impacted by global demands and disease patterns (NDoH, 2006). The retention of skilled health care personnel still remains the most difficult challenge facing public health institutions. The health charter explains that annual targets need to be set for recruiting, training and retaining of health care personnel (Department of Health, 2005/2006). Gauteng has proportionately spent more money on public health services per capita than any other province, yet the public hospitals have reported to be in crisis (IDASA Budget Brief, 1999). The increase demand placed on the provincial health care system as a result of mass migration of population groups into Gauteng. The health budgets do not cater for such 'spill over'.

Table one displays the total percentage allocated to the Gauteng Province for health and science training; this is a proportion of the total health budget. This table shows the commitment from Department of Health to increase training in the health sector. The proportion allocated from 2001 to 2006/2007 has steadily increased.

Table 1 The Percentage allocated to Gauteng for training of health personnel

	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
Gauteng Province	0.8%	1.4%	1.6%	2.0%	2.1%	2.2%	2.2%

(Provincial Budget Statemets, 2004 as cited by Poggenpoel, 2004)

Table 2 outlines the number of posts available within the public sector in Gauteng Province for the period 2001 to 2003. The table shows the need and demand for Gauteng Province to train additional health care personnel from the period of 2000/2001 to 2006/2007. The percentage to cater for additional training has increased in this period.

Table 2 The total number of health professional posts in the public sector 2001 to 2003

	2001 public sector	**2002 public sector**	**2003 public sector**	**2003 public sector filled**
Gauteng Province	42, 899	43,148	32, 873	22,375

(Poggenpoel, 2004)

The table highlights the decreasing number of posts available within the province indicating more posts are being filled within the public sector in Gauteng Province. Gauteng Province has increased the budget for training more health care personnel. Despite health care posts being filled (Table 2) and an effort to train more health care personnel (Table 1), Gauteng Province is still experiencing a shortage of health care personnel. A possible explanation is that more staff are employed and reflected on the system but not available to do their duties because of the time spent in RWOPS.

Boulle, Blecher, and Burn (2000) explain that hospital managers are still facing the frustrations of filling vacant posts. Hospital managers are responsible for the

upgrade in salaries for the health care personnel to ensure retention of the currently employed staff, they need to budget for small benefits, like tea and sandwiches, to promote a more comfortable environment, they need to budget for targeted incentives such as rural allowances, scarce skills allowance and housing subsidies to attract health personnel (National Department of Health, 2003).

To ensure economic development the social, health and welfare status of the population is critical. Governments need to employ appropriate mechanisms that address the needs of the staff to encourage staff retention within the respective sectors. The South African government acknowledges that the quality of health services is dependant on the availability and the work ethic of the health care personnel. RWOPS has been developed to allow health professionals to increase their earning potential whilst in the employ of the government. This is an attempt to retain the relevant skills within the public sector. The RWOPS policy offers guidelines as to the processes public health care personnel need to follow to engage in RWOPS.

2.2 CONTENT OF THE RWOPS POLICY

The Gauteng Department of Health has devised guidelines on RWOPS to prevent the abuse and corruption to public health institutions. Key features of these guidelines are

- All provincial employees may apply to do remunerative work outside the public Sector (RWOPS).
- Only legal and fair administrative criteria will be taken into account when deciding whether to grant or refuse to perform RWOPS.
- Permission to perform RWOPS must be applied for in advance, and RWOPS may be performed only once approval has been obtained.
- Details of the kind of employment that an employee proposes to participate in must be provided on the prescribed application form.
- RWOPS shall in no way interfere with an employee's duties for the province in terms of time or content.
- Permission to perform RWOPS will be considered only if the proposed employment takes place entirely outside an individual's official working hours of employment for the State/a province.
- The proposed employment must in no way result in a conflict of interest between the province and such employment.
- The employment/province has the prerogative to decide when an employee is required for duty, based on service requirements, on a contract and/ or on the law relevant to the public sector. Thus an individual is employed to render a service as required by the province and the institution concerned,

and may not redefine his/her working hours to satisfy his/her wish to perform RWOPS.

- The core hours required for the occupational class of medical practitioner, (as distinct from overtime) including all ranks and specialties, are between 07:00/ 08:00 and 16:30/ 15:30, from Mondays to Fridays. These core hours reflect the pattern of practice in most disciplines, and coincide with the time when all the support staff and other resources required for efficient patient care are in places and functioning at optimal level. The core attendance hours refers to the service and academic activities. Core hours in individual departments/ units may be slightly restructured to accommodate service requirements, staffing levels and academic timetable.
- Certain sections, such as casualty, may require a different pattern, but the above constitutes core hours or attendance for full time medical practitioners, and is determined by current practice, service requirements and/ or a separate overtime system.
- Doctors will need to demonstrate that their team members are capable of caring for their patients when they are not on duty in the public sector. Such proof will ensure that both the public sector patients treated during core hours, as well as private patients treated in terms of RWOPS, will receive optimum care, without being compromised.
- Overtime/ after hours duties are governed by the Policy on Commuted Overtime.
- RWOPS may not be performed while utilizing state health facilities. Exceptions will be made only in special circumstances and will be based on factors that do not impact negatively on the overall provincial health care

goals and service delivery to the poor. The province retains the right to define the circumstances under which exceptions would apply.

- Should an individual who is employed by the province wish to perform RWOPS during the time he/ she has been contracted to work for the State, the following would apply:
    - Permission may be refused, or
    - An employee may apply to be employed for fewer hours per week or month. Such an arrangement will enable RWOPS, if approved, to be performed outside the hours for which he/ she was contracted, e.g. on a five-eighths or on a sessional appointment basis.
    - Option (b) of the guidelines is applicable if the health institution at which an individual is employed agrees to the request for a change in the nature of the individual's appointment, based on the service requirements, to maintain relations with a university (joint appointments), and to generate additional income during the time they are not be contractible to the province. This option is considered both fair and reasonable. While providing the flexibility that is customary in order other large organizations, it will prevent the re-occurrence of some of the problems encountered in limited private practice.
- Should a full time employee who does *not* have permission to perform RWOPS indeed perform such work, it would constitute a breach of his/ her terms of employment, even if such work is performed outside normal working hours.

- An employee who absents himself/ herself from their place of employment during working hours to perform RWOPS will be guilty of fraud and will be dealt with accordingly.
- Permission for RWOPS may be granted for a 12-month period. Approval must be obtained or reapplied for after the approved period has expired.
- Compliance will be monitored and non-compliance may result in withdrawal of the permission for RWOPS prior to the expiry if a 12- month period (a monitoring form must be completed monthly by each area supervisor).
- In addition to the (possible) withdrawal of permission, the normal and established progressive disciplinary procedures will apply.
- All completed application forms should be submitted by the third Monday of each month.
- Applications will be considered by central RWOPS committee in the last week of each month.
- The Superintendent-General or his designate will grant approval for RWOPS.
- Both an individual's supervisor and institutional manager must recommend the application and must agree to monitor compliance with the core hours before an application will be considered by the Central RWOPS Committee.
- Each manager will be responsible for submitting monthly reports on all staff members who perform RWOPS. These reports will be monitored by the Gauteng Health Department.

(Public Service Commission, 2004):

The RWOPS policy was introduced to allow personnel employed by the public sector the opportunity to supplement their incomes while in the employment of the state. The above policy does not discriminate against any profession. Instead it is open to all provincial contract personnel. This regulated policy requires all provincial health workers to formally apply for permission to engage in private practice work. The application for RWOPS is granted for a one year period provided that the time spent on private work was outside the public duty times, (Moorman, 2001).

The policy stipulates that application must be submitted to the RWOPS committee but does not outline which individuals should constitute this committee. If the committee comprises of mostly health care personnel it leaves room for abuse as they would be the individuals applying to perform the RWOPS.

The policy states that the managers from the respective sectors are responsible to grant permission for practitioners to engage in RWOPS and they are responsible for the monitoring and evaluating the progress of the hours engaged in RWOPS. These reports are to be submitted by the institution manager to the department of health.

2.3 KEY ACTORS INFLUENCING THE RWOPS POLICY

Macroeconomic and microeconomic policies impact on the health of developing countries (Cooper, Weil et al., 1990). These include balance-of-payments deficit, inflation and government budgetary deficits, privatization of public enterprises, a shift towards market oriented systems and rapid economic growth. These are often in collaboration with the World Bank and other international lenders (Cooper Weil et al., 1990). The World Bank, multinational companies and donor agencies affect health policies all over the world (Walt, 1994). Politicians and bureaucrats are the key policy makers and they are influenced by international actors.

The political stability is crucial in ensuring the economy of the country remains stable. It is the role of the government to manage the economy to ensure that the allocation of limited resources can satisfy the needs and demands of the people (Lee and Mills, 1983). The state is involved in the financing, planning and managing the services in the country. The restructuring of public expenditure as part of the economic adjustments may affect health because of the vulnerability of the social sectors to cuts in government spending (Cooper Weil et. al., 1990).

Governments are centrally involved in health regulation and provision (Walt, 1994). In South Africa the National Department of Health is mainly responsible for the governing of policy and monitoring of the national health system, and the provincial health departments are more concerned with the delivery within specified frameworks as outlined by National department of health, (Poggenpeol, 2004). Developing a human resource plan for health is high priority for the national

department of health (NDOH, 2006), as the critical shortage of skilled staff and the maldistribution of staff has an immense impact on the delivery of health services. This outlines the importance making the situation of retention of skilled personnel a high politics priority. In recognition of this priority the National Department of Health has produced a Strategic Plan for Human Resources (NDoH, 2006) to lay the policy foundation to begin to tackle the human resource challenges plaguing the country.

Countries that have a public and private health sector encounter the common problem of having doctors work in both sectors. Gonzalez (2002) explains that the complex relationship between these two sectors is conflicting and can create a conflict of interests for doctors working in both sectors at the same time. There is room for abuse in the public sector. Consumable resources from the public sector are at the disposal of health professionals doing both private and public work. Furthermore, if no monitoring is in place, hours may be claimed from the public sector whilst actually spent in private consulting rooms.

There is the potential for constructive engagement between the public and private health care sectors in striving towards an equitable, efficient and quality health care system in South Africa, (DoH, 2001). The possibility of such engagements also has the potential to undermine the public health care system therefore it is imperative that principles and guidelines are set in accordance with the visions and missions of the National health care system.

The implementation of the RWOPS policy offers government the opportunity to recruit health personnel to work in public health care areas. Health personnel are allowed to engage in private practice but still be in the employment of the government offering their services at public hospitals. They also have the opportunity to increase their knowledge, skills and expertise in their respective fields by being exposed to a variety of patients visiting state hospitals. However, the appropriate monitoring mechanisms must be in place to prevent abuse of the system.

Government has an important role in enabling Public-Private Interactions (PPIs) to encourage a healthy and effective work environment. Folateng is one such interaction. Folateng is a network of private wards that have been set up within the public hospitals, in Gauteng, to attract private patients to use the public hospitals and to generate income within the respective institutions. One of the objectives in establishing the Folateng unit was to retain doctors and other health professionals in the public sector. Folateng is a private unit functioning within a public hospital. Presently health professionals are allowed to see to private patients outside their normal hours and admit them into private hospitals. The Folateng unit allows health professionals to increase their income through RWOPS within the public sector, and it increases the income generating capacity for the public institution (DPSA, 2002).

An investigation regarding the RWOPS hours was undertaken in two of Gauteng's Provincial hospitals, (Pretoria Academic and Johannesburg General) following complaints from nursing staff about the abuse of hours, no prior approval to

engage in private practice and theft of state assets for use in private practices (Public Service Commission, 2004). This investigation was conducted in the form of a questionnaire which included HR staff, Chief Executive Officers, Hospital Advisory Committees, Health Professions Council of South Africa, South African Nursing Council and senior management from the Gauteng Department of Health.

A report following the investigation was presented to the health portfolio committee for endorsement. A health stakeholders workshop was held to engage with the various stakeholders within the province. This workshop was conducted in accordance with Gauteng Provincial Legislature's constitution to encourage public participation by engaging with the key actors involved in the decision making process, (Gauteng Legislature, 2005).

The key participants present at the workshop included the following:

- Democratic Nurses Organisation of South Africa (DENOSA)
- National Education Health and Allied Workers Union (NEHAWU)
- Hospital Personnel Association of South Africa (HOSPERSA)
- South African Medical Association (SAMA)
- South African Nursing Council (SANC)
- Wits Medical School
- Tshwane University of Technology
- Afrox
- Medi-Clinic
- Netcare
- Garankuwa Nursing College

- Public Service Commission (PSC) consisting of members from Parliament, Executive, National and Provincial Departments

The report found the following:

- Abuse of official working hours
- Abuse of sick leave
- Abuse of full paid leave to work in other state hospitals
- Salaries are not competitive
- Influx of doctors and nurses from Eastern Cape, Kwa-Zulu Natal, Limpopo and Mpumalanga and Free State to work in Gauteng hospitals

The general consensus regarding RWOPS from all stakeholders included:

- Poor remuneration for public health personnel
- Delays in processing RWOPS applications
- Poor conditions of service: shortage of staff, equipment etc
- Abuse of state property
- Poor management and control of RWOPS
- Difficulty in separating core working hours, overtime and RWOPS
- Discrepancies in management of the different health care personnel
- Delayed payment for overtime
- No flexibility within the health care system
- Low morale amongst all health care personnel

Schneider and Gilson (2001) explain that the quality management systems are weak or absent within the health care system. Managers at all levels seem to

focus on balancing the budgets and less concerned with the lack of quality of care. The most common reasons for poor services rendered at public institutions have been attributed to the poor work environments, rigid management structures and procedures, poor incentives and remuneration packages and limited resources.

The following factors have been outlined as the key areas that warrant urgent attention to achieve efficient and accessible quality care at public health institutions: addressing the workplace culture; encourage ethical practice; train and educate the different disciplines; establish routine monitoring and evaluation systems, and create quality management systems.

2.4 POLICY ANALYSIS

Development policies are designed to encourage economic growth and improve infrastructure, services, commerce and community development. This can sometimes create or exacerbate the health problems of industrialization (Cooper Weil, et al., 1990). Policy analysis is established in industrialized countries but seriously lacking in the developing countries, (Walt and Gilson, 1994), where health transformation is most prevalent.

Kingdon (1984) as cited by Walt (1994) states that policy formulation includes the following process:

1. Setting of the agenda
2. Specification of alternatives from which a choice is to be made

3. An authoritative choice among those specified alternatives and
4. The implementation of the decision

Hogwood and Gunn (cited by Walt, 1994) states that policy formulation includes:

1. Deciding to decide (issue search and agenda setting
2. Deciding how to decide (issue filtration)
3. Issue definition
4. Forecasting
5. Setting of objectives and priorities
6. Options analysis
7. Policy implementation, monitoring and control
8. Evaluation and review
9. Policy maintenance, succession or termination

Models for policy analysis and formulation have certain common characteristics. Whichever approach is used it is important to recognize that it is a COMPLEX process and not just a linear procedure. Critical attention should be paid to context and the buy in of the key actors because this is crucial for successful implementation. Walt and Gilson (1994) explain that a simple analytical model incorporating the concepts of content, context, process and key actors assists policy-makers in reform and implementation.

Policies vary and the type of policy influences political behavior. Walt (1994) explains that it is best to categorize policies into high and low politics. High politics

involve those policies where the *maintenance of core values- including national self preservation- and long term objective of the state (Evans and Newnham, 1992 as cited in Walt 1994),* are critical. Low politics policy is one that *is not seen as involving fundamental or key questions related to a state's national interests, or those of important and significant groups within the state (Evans and Newnham, 1992 as cited in Walt 1994).* Participation may be weak or non-existent in high politics and the potential for participation often exists in low politics (Walt, 1994). Hence RWOPS it is a high politics policy because of the minimal or limited participation from key actors in the formulation of the policy.

The political system of a country provides the framework which determines the participation of people in that country; it encourages or discourages participation (Walt, 1994). In Cuba health is perceived as a right of all citizens and the social structures were geared for equal access. In South Africa, prior to 1994, the disenfranchised majority black population experiences poor access to healthcare services. Citizens of any country share an interest in their health and it is in the national interest that the resources available for health are spent effectively (Lee and Mills, 1983), and in the post-1994 political transition in South Africa one witnesses an attempt to tackle the structural entrenched health system inequities.

Participation in policy making may be direct or indirect (Walt, 1994). According to Walt (1994) direct participation involves ways in which the people try to influence the course of policy face to face by means through lobby groups. And indirect participation occurs through influencing the selection of government representatives and policies they are likely to pursue by means of campaigning

and voting for a particular party or candidate. RWOPS participation involved the direct means because the different individuals representing the health professional were asked for their input. Whether these suggestions were incorporated into the actual implementation phase of RWOPS is questionable.

CHAPTER THREE

3.1 Methodology

3.1.1. Research Design

This is a descriptive as well as explorative study. According to Babbie (1995) a study is explorative when the researcher is researching a new topic of interest or if the study has never been conducted before. This study is explorative given the dearth of studies of RWOPS in South Africa and in Johannesburg Hospital specifically. Descriptive studies describe situations and events (Babbie, 1995). The assessment of the evolution of the RWOPS policy makes it a descriptive study.

The RWOPS policy will be analyzed using the policy analysis framework proposed by Walt and Gilson, (1994). The framework outlines the role of content, context and key actors in policy development and implementation. This framework allows for the triangulation across the data sources through the thematic guidance needed in analyzing data from multiple sources. This approach allows for a rich understanding of the complexities of both policy development and implementation, by providing the theoretical and conceptual foundation with which to unveil policy dynamics – in this instance – that of RWOPS in a tertiary hospital setting.

This study does not seek to provide ultimate conclusions on the policy implementation, but aims to highlight areas for future research. In addition, given that the policy has only been implemented recently there is inadequate data to

fully assess policy impact to date. This also partly explains why there are few studies on the policy in question.

Forty-two questionnaires were handed out to participants but due to the sensitivity surrounding the study many declined to participate. A total of thirty-five agreed to complete the questionnaire but some did not want to state their professions as they were afraid of being discriminated by their superiors, despite reassurances that all information was confidential.

3.2 Data Collection

3.2.1 Data Sources

Policy documents, press releases, international studies and official documents collected through searches on the world-wide-web have provided the bases for the content and context of the RWOPS policy. The questionnaire was to determine the role of key actors with regards to the RWOPS policy.

The perception and attitudes were determined through a self-administered structured questionnaire (appendix II). The questionnaire, subject information sheet and consent form (appendix I) were distributed to the participants. The participants were randomly selected from a list obtained from the Johannesburg Hospital Human Resource personnel. Some participants were selected using snowball sampling. A total of forty two questionnaires were handed out to the respective participants. Only thirty five personnel participated in the study. The sample population consisted of the following participants:

- Nursing personnel (these included nurses at all levels, professional nurses, senior nurses, chief nurses as well as representatives from DENOSA)
- Doctors (all levels registrars, senior registrars, HOD's, consultants and reps from SAMA)
- Management (the CEO and some human resource personnel responsible for processing the RWOPS applications)
- Allied Health Professionals (all levels of physiotherapists, occupational therapists, pharmacists and the speech and hearing therapists)

3.2.2 Data Measurement and Analysis

The questionnaire was self administered. Closed and open ended questions wee used in the questionnaire. Closed ended questions allow for uniformity and are easily processed whereas open ended questions ask the respondents for their own answer (Babbie, 1995). The Likert Scale allows for an unambiguous response and allows the researcher to explore the strength of the statement (Babbie, 1995) it is also a type of closed ended question. Hence the Likert scale was adopted to gain an understanding of the perceptions and attitudes of the participants. Open ended questions allow for further clarity and further exploration on the themes during analysis of the data.

The data from the questionnaire has been computed and summarized using MS excel. The results are presented using tables and graphs. The following themes were used to analyze the questionnaire data:

- Understanding of the Human Resource challenges within the health care system and at the Johannesburg Hospital
- Awareness of the RWOPS policy
- Awareness of the RWOPS policy development process
- Awareness of the RWOPS policy implementation process at Johannesburg Hospital
- Perceptions of the strengths of the RWOPS policy
- Perceptions of the weaknesses of the RWOPS policy
- Perceptions of the challenges for successful implementation
- Perceptions of the main beneficiaries of the RWOPS policy

The themes outlined above allowed the researcher to identify the role of the key actors in the implementation process. It is important to note that the graphs are only representative of the percentage that participated in the study and is not generalisable.

The summarized data using the above-mentioned themes highlights the role of the key actors. The policy documents, press releases, international studies and official documents allowed the researcher to explore the content and context of this policy, allowing for triangulation across the data sources.

The Walt and Gilson (1994) model was used to analyze and assess the RWOPS policy. The Walt and Gilson framework (1994) involves the triangulation between of the content, context and process of a policy revolving around actors. Walt and

Gilson (1994) explain that the use of such models enables policy makers and researchers to understand the process of health reform providing more effective implementation processes. Figure 2 outlines the triangle framework.

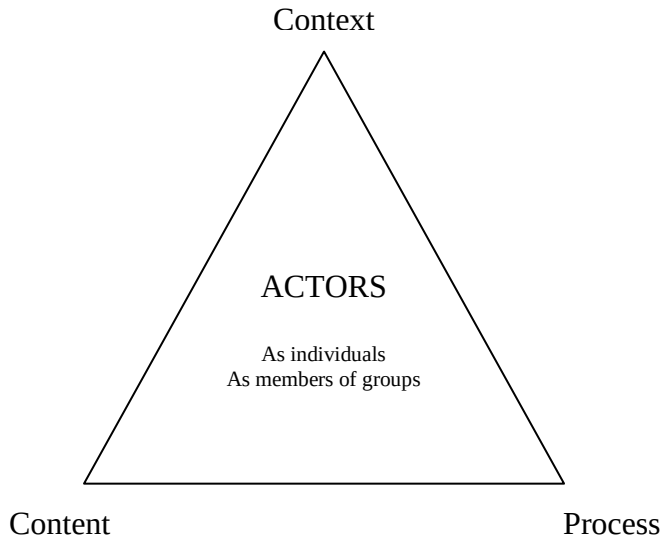

Figure 2 Model for Health Policy Analysis (Walt and Gilson, 1994)

The above model shows that policies cannot concentrate on the content alone. It is a dynamic ongoing process incorporating the content, context involving the key *actors*. Walt and Gilson (1994) explain this model incorporates the interrelationships between these dimensions. The *actors* are influenced by the *context* in which they live or work both at a macro and micro level. The *context* in turn is shaped by the political stability of the country, socialist ideologies, historical experiences and culture. The *content* of the policy usually reflects some or all of the above influences and speaks primarily to the policy design.

The *content* of a policy is set to manage factors within a particular *context*. In other words a policy is usually introduced to bring about a set of norms for standard behavior so that key *actors* may understand and act in accordance with the policy. The *content* of every policy is always unique to the demands and *context* in which it is introduced at that particular time.

Context is the environment that results in the introduction of a policy. It is influenced by the political approach of the governing body at that time. The cultural and political history has a marked influence on the ideologies that are introduced in a particular policy.

The actors involve all that are party to the implementation and will be directly affected by the policy. The input of these actors greatly influences the success of any policy because of the impact it has in their daily duties.

The *process* incorporates the actual content of the policy meeting the needs within that environment mooted by the actors within that environment. At regular intervals an assessment of the situation is essential. A continuation of this triangle is critical to ensure the success of any policy.

A pilot study was conducted to determine if the validity and reliability of the questionnaire in determining the role, attitudes and perceptions of these key actors with regards to the RWOPS policy. The comments made from the pilot study were minor grammar corrections with no significance consequences on the expected

outcomes of the study. The pilot study was included in the actual sample population due to the poor response from the participants.

3.2.3 Limitations

- There was limited response from participants because of fear of intimidation from senior staff personnel.
- The availability of some of the health care personnel to complete the questionnaire.
- Participants were not familiar with the content of the RWOPS policy despite them answering yes to being familiar with the policy.
- Some junior nursing staff declined from answering the questionnaire because they felt they were not competent enough to complete it.

CHAPTER FOUR

4.1 RESULTS

This chapter merely presents the results from the questionnaire. The critical reflection and analysis will unfold in Chapter 5

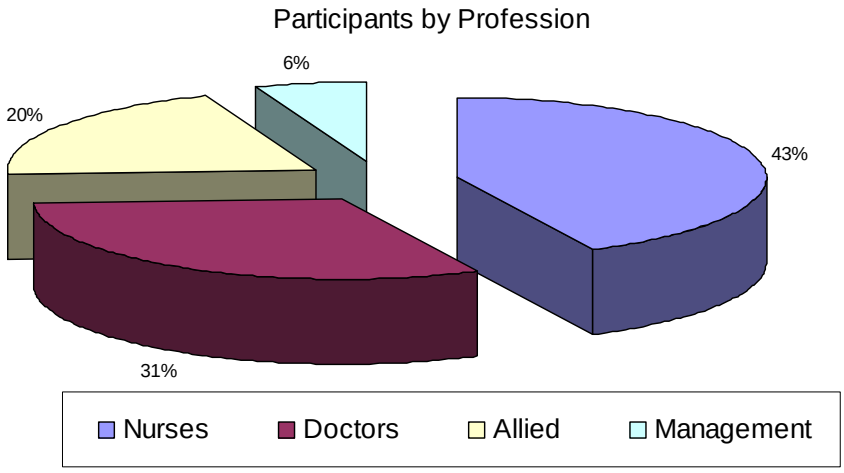

Figure 3 Participants by Profession

(Management n=2; doctors n=11; nurses n=15 and allied health n=7)

The above figure is a representation of the different categories of staff at the Johannesburg Hospital that participated in the study. These included nurses, doctors, allied and management. The nurses incorporated all nursing levels, ranging form nursing assistance to chief nursing sisters. The doctors that participated involved the registrars and professors from the different medical

disciplines. The allied medical personnel covered individuals from the fields of physiotherapy, pharmacy, occupational therapy and speech and hearing therapy. Management had representation form the CEO and one for the human resources department.

Question one sought to investigate the human resource challenges facing the Johannesburg Hospital. The results are summarized in figure 4.

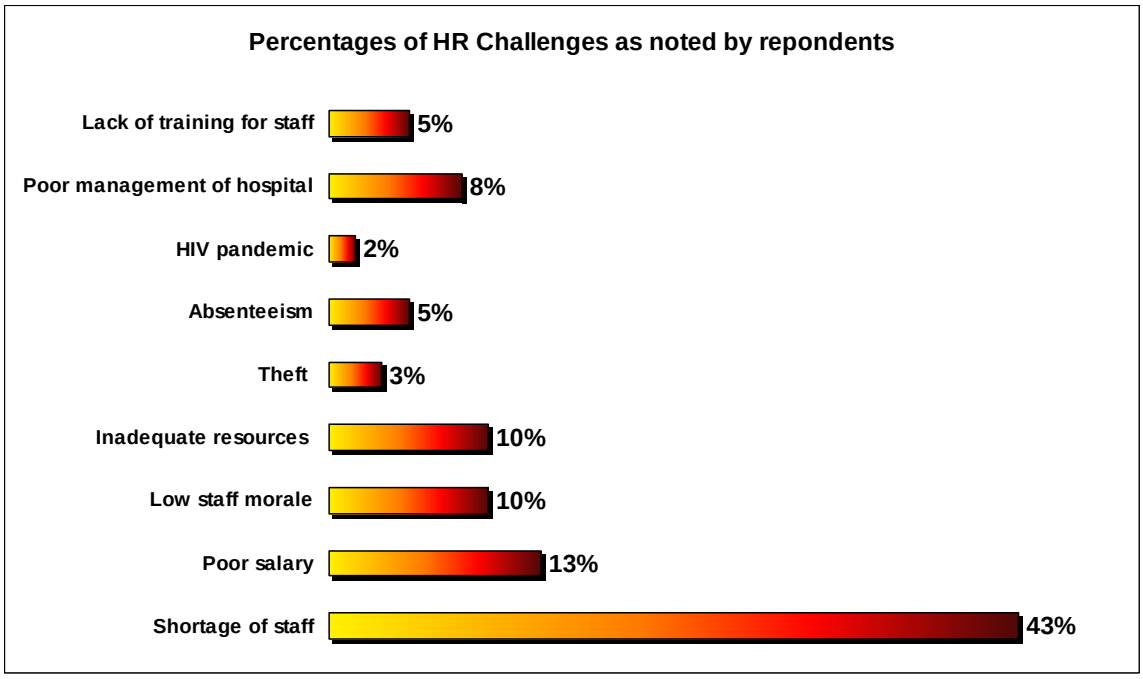

Figure 4 Percentage of HR challenges as noted by respondents
(Management n=2; doctors n=11; nurses n=15 and allied health n=7)

Figure 4 is a summary of the responses to the human resource challenges experienced at the Johannesburg Hospital. These graphs offer an understanding of the human resource challenges. Most of the participants felt that the shortage of human resource personnel was the most critical challenge facing the

Johannesburg Hospital. Only two percent felt that the HIV pandemic was a challenge to human resources at the hospital. Figures 5 - 14 is profession specific to the summarized responses in figure 4.

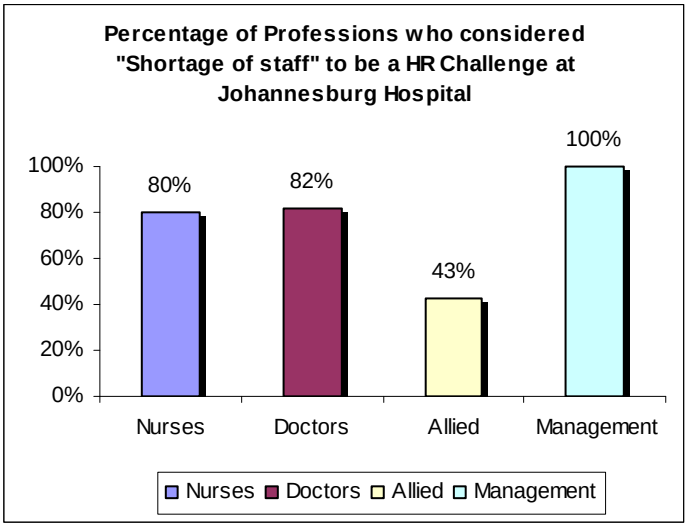

Figure 5 Percentage of Professions who considered Shortage of staff to be an HR challenge at Johannesburg Hospital
(Management n=2; doctors n=9; nurses n=12 and allied health n=3)

The above figure is a distribution of the percentage of professions that felt staff shortages is a critical human resource problem that the Johannesburg Hospital is facing.

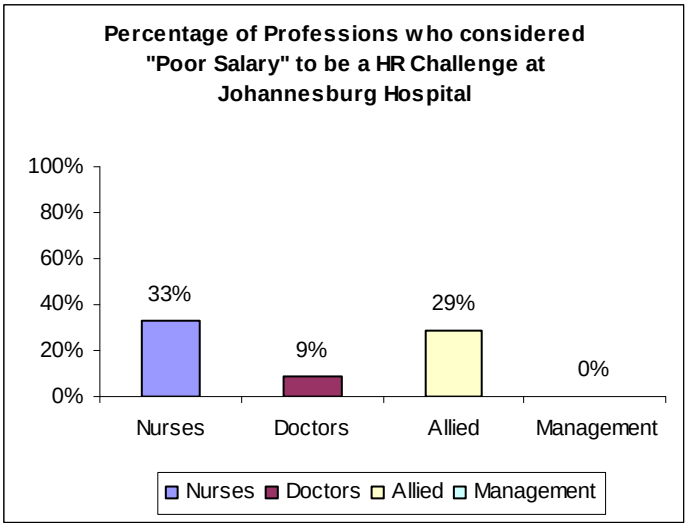

Figure 6 Percentage of Professions who considered Poor Salary to be an HR challenge at Johannesburg Hospital

(Doctors n=1; nurses n=5 and allied health n=2)

Figure 6 is a distribution of the percentage of professions that felt poor salaries is a problem that the Johannesburg Hospital. The allied medical staff were the majority that felt the salaries is an issue facing the Johannesburg hospital. There was no response to this question from either of the management participants.

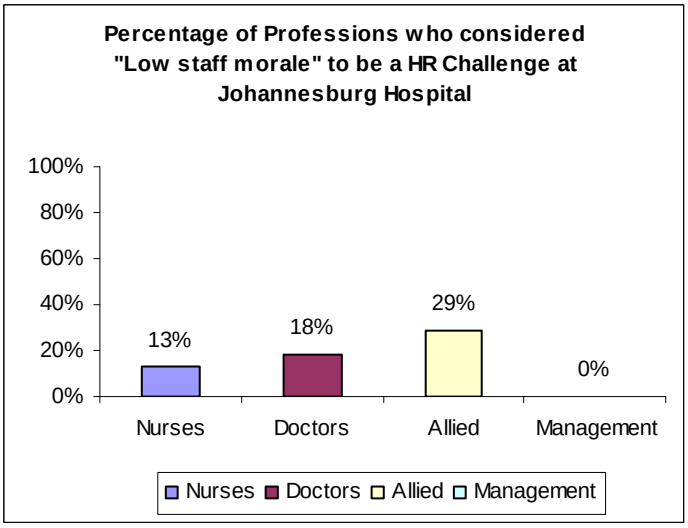

Figure 7 Percentage of professions who considered Low Staff Morale to be an HR challenge at Johannesburg Hospital
(Doctors n=2; nurses n=2 and allied health n=2)

The above figure highlights the percentage of professions that felt poor there is poor staff morale at the Johannesburg Hospital.

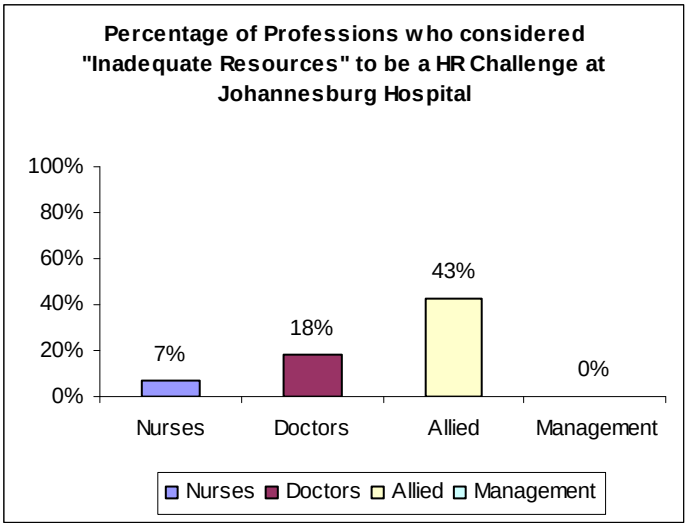

Figure 8 Percentage of Professions who considered Inadequate Resources to be an HR challenge at Johannesburg Hospital
(Doctors n=2; nurses n=1 and allied health n=3)

The above figure is suggestive of the percentage of professions that found inadequate resources affected the Johannesburg Hospital.

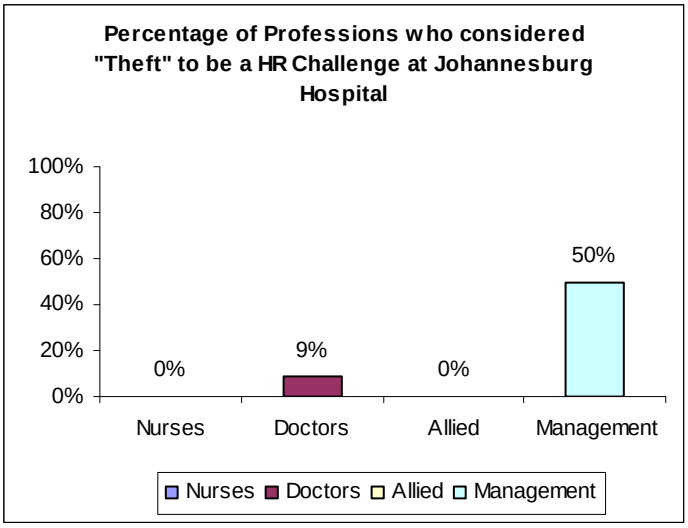

Figure 9 Percentage of Professions who considered Theft to be an HR challenge at Johannesburg Hospital
(Doctors n=1; management n=1 and allied health n=7)

Figure 9 is a distribution of the percentage of professions that found theft of resources to be a challenge at the Johannesburg Hospital.

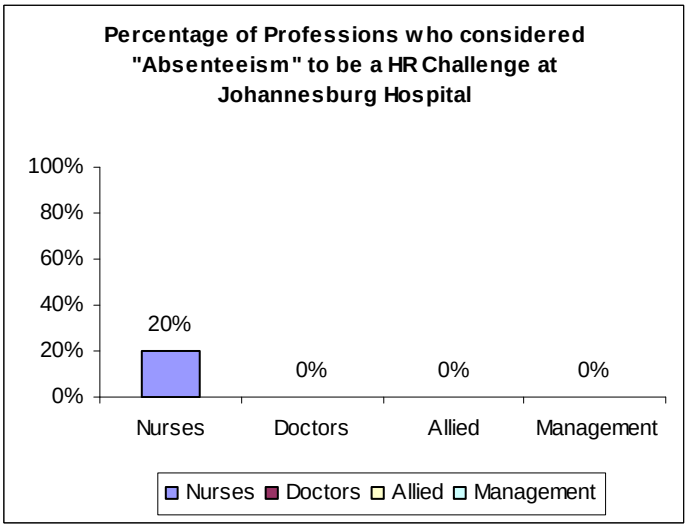

Figure 10 Percentage of Professions who considered Absenteeism to be an HR challenge at Johannesburg Hospital
(Nurses n=3)

Figure 10 signifies the distribution of the percentage of professions that felt absenteeism affected the staff numbers at the Johannesburg Hospital.

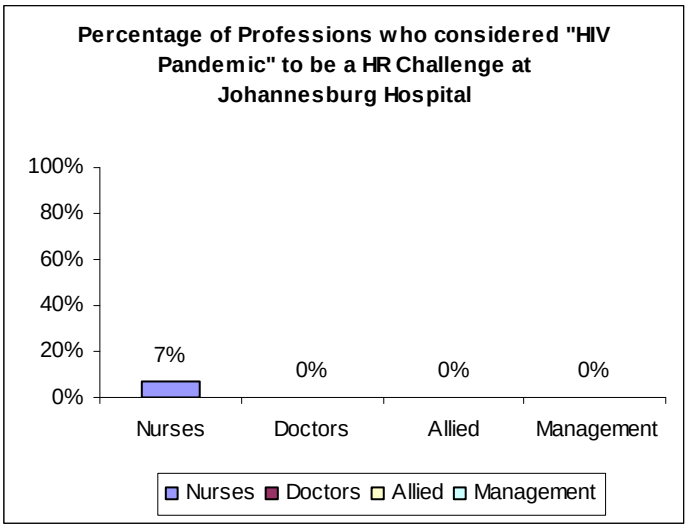

Figure 11 Percentage of Professions who considered HIV Pandemic to be an HR challenge at Johannesburg Hospital
(Nurses n=1)

Figure 11 is a distribution of the percentage of professions that felt the HIV pandemic impacted on the challenges facing the Johannesburg Hospital. Only seven percent of the nursing staff found that HIV is a hindrance to the personnel at the Johannesburg Hospital.

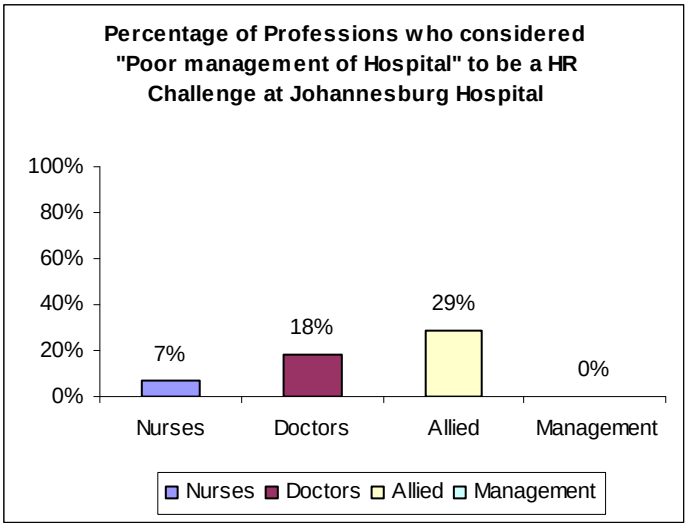

Figure 12 Percentage of Professions who considered Poor Management of Hospital to be an HR challenge at Johannesburg Hospital
(Doctors n=2; nurses n=1 and allied health n=2)

Figure 12 is a distribution of the percentage of professions that felt poor staff morale was a challenge at the Johannesburg Hospital. There was no response to this question from either of the management participants

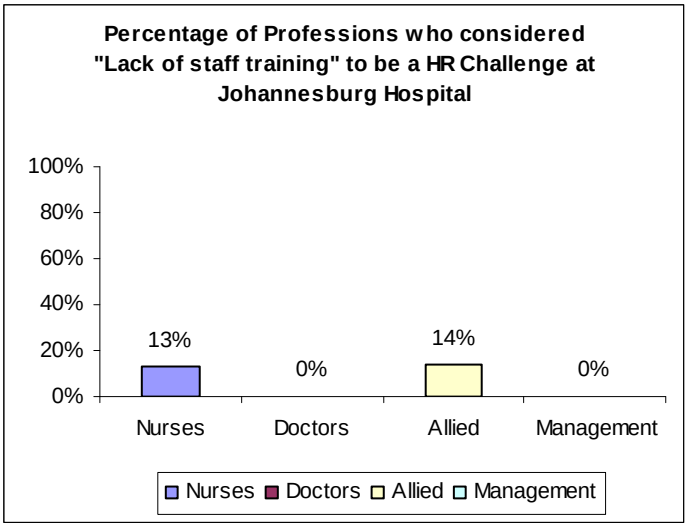

Figure 13 Percentage of Professions who considered Lack of Staff Training to be an HR challenge at Johannesburg Hospital
(Nurses n=2 and allied health n=1)

Figure 13 is a distribution of the percentage of professions that found a lack of staff training was one of the challenges at the Johannesburg Hospital.

Question two attempted to interrogate the familiarity with the RWOPS policy. This question allowed us to determine if the staff at the Johannesburg Hospital were familiar with the RWOPS policy.

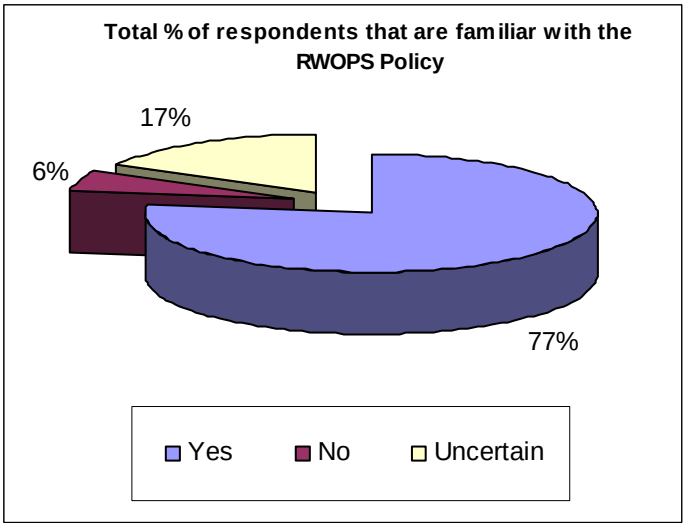

Figure 14 Total % of respondents familiar with the RWOPS policy

Figure 14 represents the summary of these responses. The response rate shows that most personnel that participated in the study were familiar with the policy.

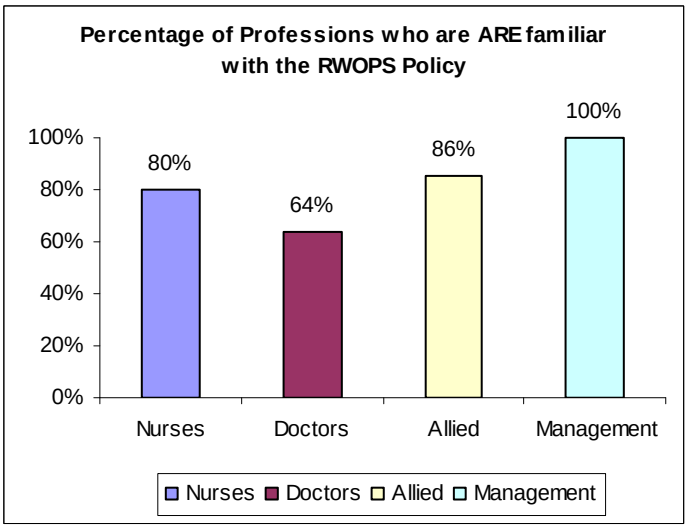

Figure 15 Percentage of professions that ARE familiar with RWOPS policy
(Management n=2; doctors n=11; nurses n=15 and allied health n=7)

Figure 15 highlights the percentage of professionals that are familiar with the RWOPS policy. This graph informs us that most of the participants are familiar with the RWOPS policy.

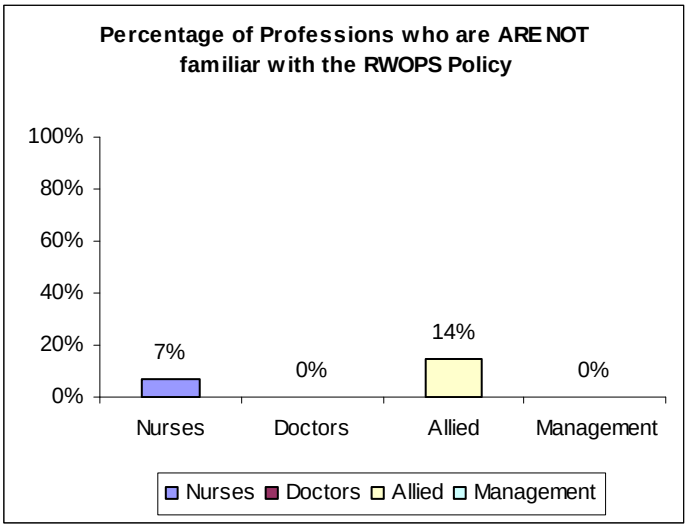

Figure 16 Percentage of Professions that ARE NOT familiar with RWOPS policy
(Nurses n=1 and allied health n=1)

Figure 16 shows the percentage of professionals that are NOT familiar with the RWOPS policy. Only seven percent of the nurses and fourteen percent of the allied medical personnel were not familiar with the policy.

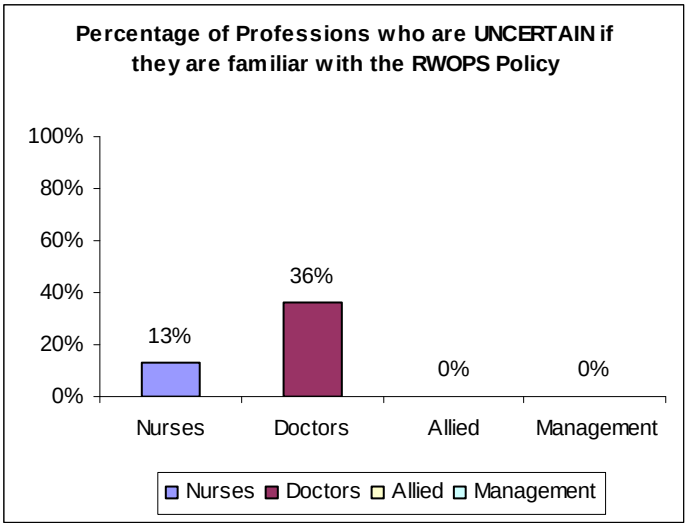

Figure 17 Percentage of Professions that are UNCERTAIN if they are familiar with the RWOPS policy
(Doctors n=4 and nurses n= 2)

Figure 17 provides a sense of those individuals uncertain of what the RWOPS policy is.

Question 3 was presented using a Likert scale where participants were asked to rate specific responses from 1-6, with 1 being the lowest and 6 being the strongest. This question gave insight on human resource challenges, on the awareness of the RWOPS policy, perceptions of the challenges of the policy and on the awareness of the implementation process of the policy at the Johannesburg Hospital.

Table 3 is a summary of the responses from the participants to question three.
N = Total percentage of respondents

Issue/Question	Professional Type	1 Strongly agree	2 Agree	3 Uncertain	4 Disagree	5 Strongly Disagree
3.1 Can the RWOPS policy address the HR challenges at Johannesburg Hospital	Nurses	13%	27%	13%	27%	0%
	Doctors	9%	18%	0%	45%	0%
	Allied	0%	43%	0%	57%	0%
	Management	50%	50%	0%	0%	0%
3.2 Is RWOPS sufficiently adequate to address the HR challenges at the Johannesburg Hospital	Nurses	0%	20%	7%	47%	7%
	Doctors	9%	0%	0%	45%	9%
	Allied	0%	0%	43%	57%	0%
	Management	0%	0%	0%	50%	0%
3.3 RWOPS is a good way of retaining skilled health professionals	Nurses	7%	27%	0%	20%	7%
	Doctors	9%	18%	18%	36%	18%
	Allied	14%	14%	43%	29%	0%
	Management	0%	50%	0%	50%	0%
3.4 The current design of RWOPS at Johannesburg Hospital supports overall service delivery at the hospital	Nurses	13%	27%	13%	27%	0%
	Doctors	9%	9%	18%	27%	9%
	Allied	0%	57%	14%	29%	0%
	Management	0%	0%	0%	50%	50%
3.5 RWOPS has improved service delivery at the Johannesburg Hospital	Nurses	7%	33%	13%	27%	0%
	Doctors	18%	18%	9%	9%	18%
	Allied	0%	14%	43%	43%	0%
	Management	0%	0%	50%	50%	0%

Issue/Question	Professional Type	1 Strongly agree	2 Agree	3 Uncertain	4 Disagree	5 Strongly Disagree
3.6 The hours spent in this public hospital are on par with colleagues working in other public institutions	Nurses	0%	27%	33%	13%	7%
	Doctors	0%	9%	27%	9%	27%
	Allied	14%	14%	43%	29%	0%
	Management	0%	50%	0%	50%	0%
3.7 The RWOPS policy has met my individual expectations	Nurses	0%	27%	13%	33%	7%
	Doctors	9%	27%	0%	9%	18%
	Allied	0%	43%	14%	29%	14%
	Management	0%	0%	0%	0%	50%
3.8 I am satisfied with the way RWOPS currently operates at this institution	Nurses	0%	33%	13%	27%	7%
	Doctors	0%	27%	0%	27%	9%
	Allied	0%	29%	14%	57%	0%
	Management	0%	0%	0%	50%	0%

Question four intended to identify which health care personnel were allowed to perform RWOPS at the Johannesburg hospital. This question offered an understanding of the policy and the implementation process at the Johannesburg Hospital.

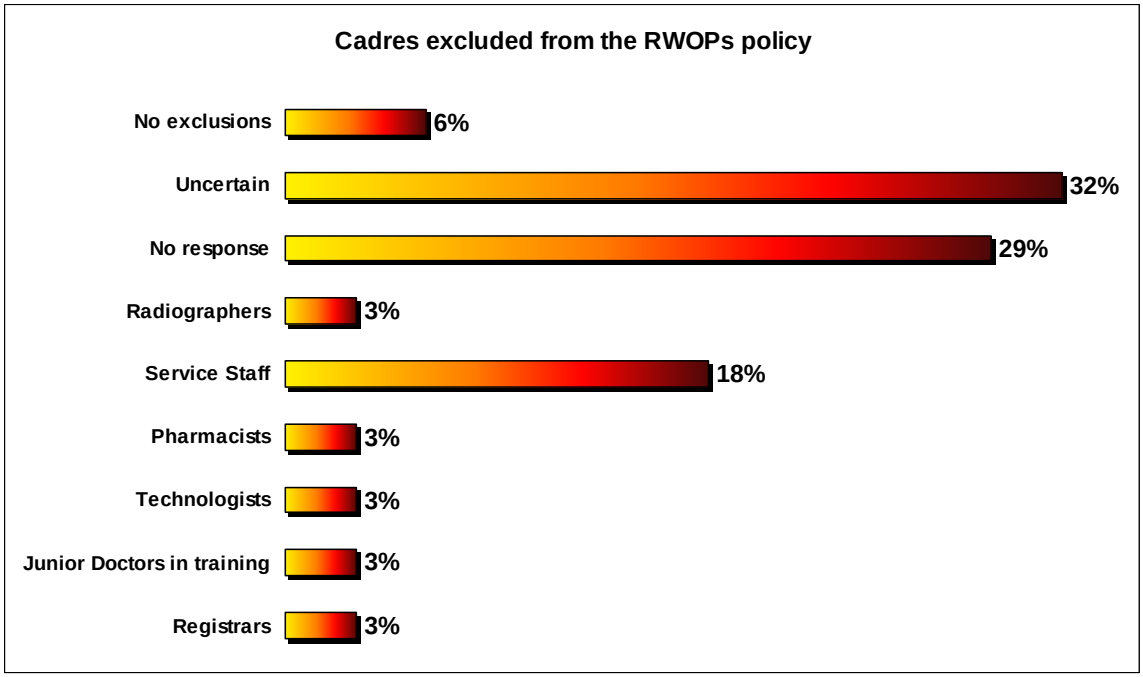

Figure 18 Cadres excluded from the RWOPS policy
(Management n=2; doctors n=11; nurses n=15 and allied health n=7)

Figure 18 is a graphical presentation of the responses to question four. The graph highlights the percentages of staff that are excluded from the RWOPS policy as perceived by the professionals that participated in the study. Thirty-two percent of the participants were uncertain and only six percent were correct in saying that there are no exclusions. This tells us that most of the staff are not familiar with the policy and the implementation process of this policy at the Johannesburg Hospital, despite the high percentage of response to them being familiar with the policy.

Question five investigated how many professionals felt that RWOPS had to be performed at the Johannesburg Hospital Folateng ward. This question also gave insight into the implementation process of the RWOPS policy at the Johannesburg Hospital.

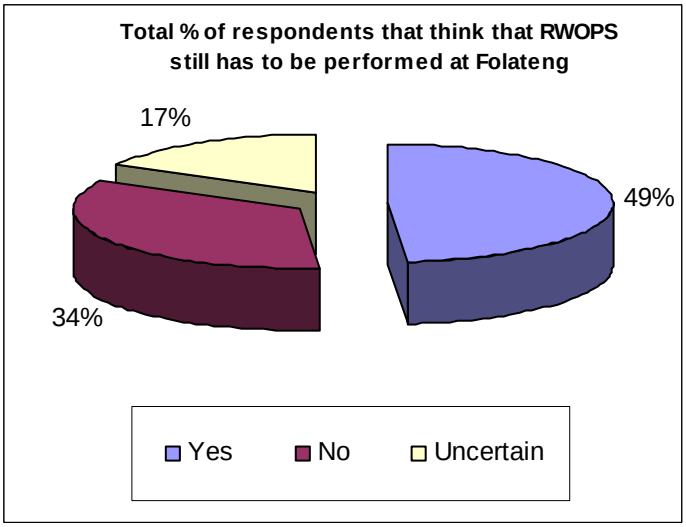

Figure 19 Total % of respondents that think RWOPS has to be performed at Folateng (Management n=2; doctors n=11; nurses n=15 and allied health n=7)

Figure 19 provides the summarized percentage of the health professionals that felt RWOPS had to be performed at the Folateng ward at the Johannesburg hospital. The majority of the participants felt that RWOPS had to be performed at the Folateng ward at the Johannesburg Hospital. This tells us that most of the participants are not familiar with the RWOPS policy and the implementation process at the Johannesburg Hospital.

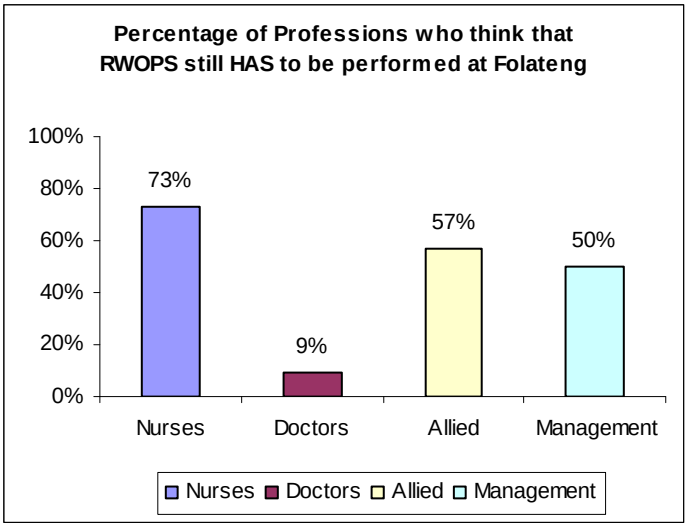

Figure 20 Percentage of Professions who think RWOPS has to be performed at Folateng (Management n=1; doctors n=1; nurses n=11and allied health n=4)

Figure 20 offers the individual professionals that felt the RWOPS had to be performed at the Folateng unit at the Johannesburg hospital. From the total percentage it is the nursing staff that felt RWOPS had to be performed at the Folateng ward of the Johannesburg Hospital, this tells us that they are the group that are least familiar the actual policy and the implementation process at the Johannesburg Hospital.

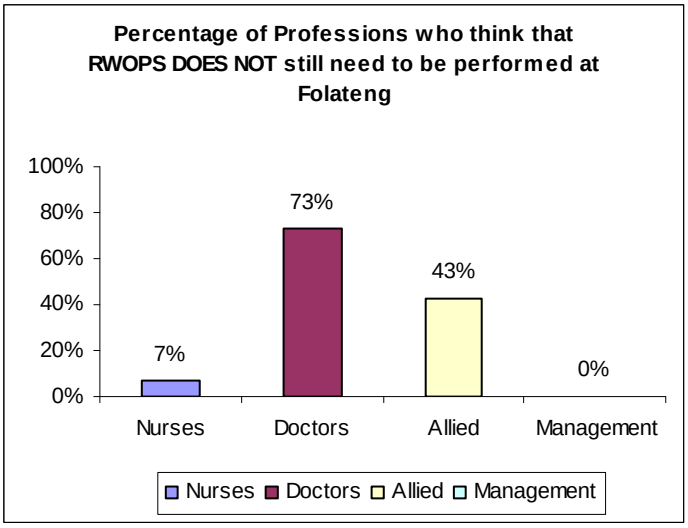

Figure 21 Percentage of Professions who think RWOPS does not have to be performed at Folateng
(Doctors n=8; nurses n=1 and allied health n=3)

Figure 21 highlights that the doctors are most familiar with the RWOPS policy and the implementation process at the Johannesburg Hospital, since RWOPS does not have to be performed at the Folateng ward of the Johannesburg Hospital.

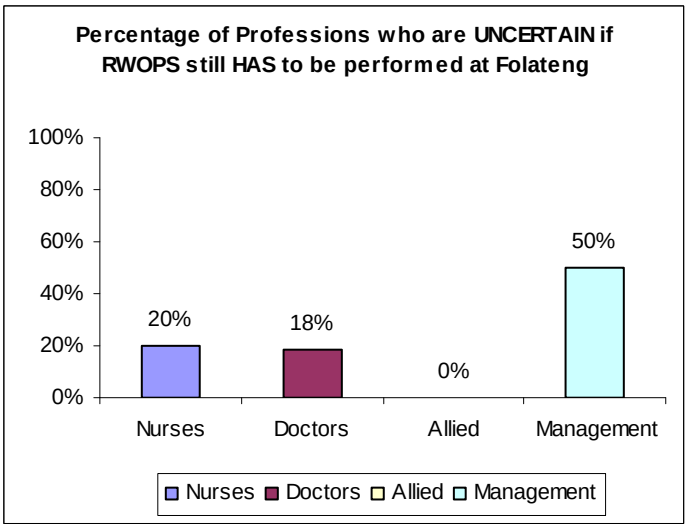

Figure 22 Percentage of Professions who are UNCERTAIN if RWOPS has to be performed at Folateng

(Management n=1; doctors n=1 and nurses n=3)

Figure 22 is the profession specific responses to the staff that were uncertain as to where RWOPS may be performed.

Question six investigated if the staff were consulted during the development of the RWOPS policy. This question explored the challenges for the successful implementation of the policy.

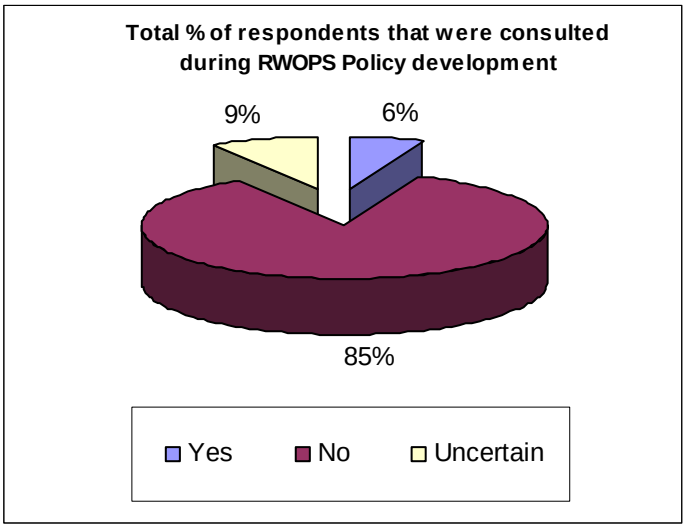

Figure 23 Total % of respondents that were consulted during RWOPS policy development
(Management n=2; doctors n=11; nurses n=15 and allied health n=7)

Figure 23 is the summary of the total distribution to the response in question six. Most participants were stated that they were not consulted during the development of the RWOPS policy.

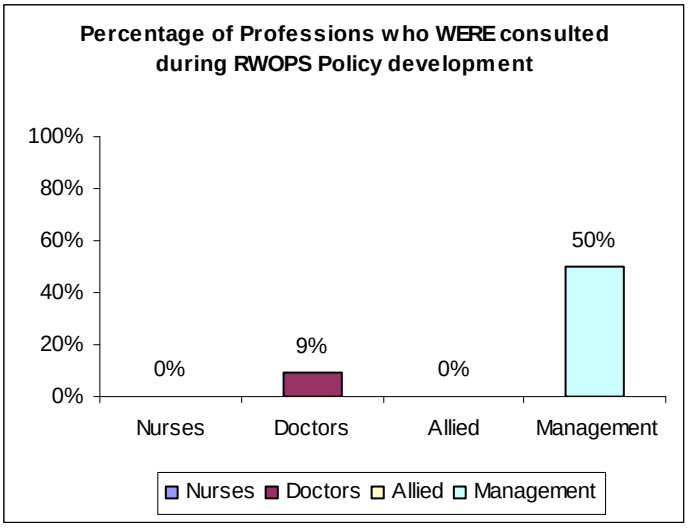

Figure 24 Percentage of Professions who WERE consulted during RWOPS policy development (Management n=1 and doctors n=1)

Figure 24 highlights the professions that felt they WERE consulted during the development of the RWOPS policy. One of the two management participants and only the doctors responded yes to this question. This tells us that not all the actors were consulted during the development of this policy.

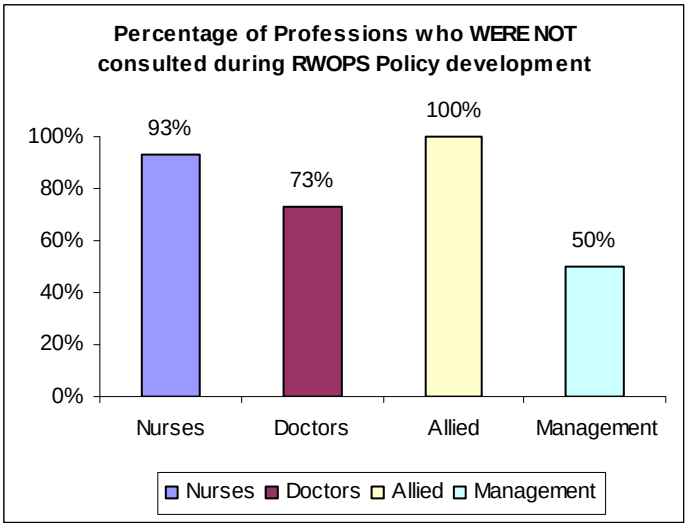

Figure 25 Percentage of Professions who WERE NOT consulted during RWOPS policy development
(Management n=1; doctors n=8; nurses n=14 and allied health n=7)

Figure 25 displays the professionals that WERE NOT consulted during the development of the RWOPS policy. According to this graph most of the participants felt strongly that they were not consulted.

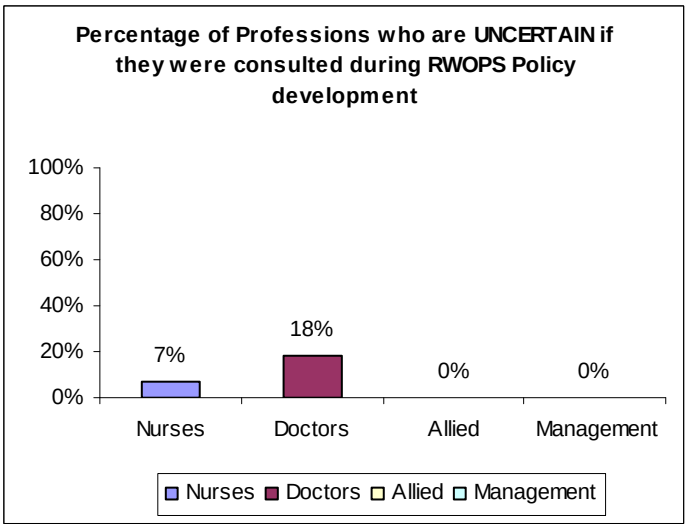

Figure 26 Percentage of Professions who are UNCERTAIN if they were consulted during RWOPS policy development

(Doctors n=1 and nurses n=1)

Figure 26 are the percentages of profession specific responses to those participants that were uncertain if they had been consulted during the development of the RWOPS policy.

International experience highlights several strengths of RWOPS-style policies. A Likert scale was used for question seven to determine the strengths of this policy. Question seven also explored the possible reason for poor implementation of the policy, an understanding of the policy and further insight into the HR challenges at the Johannesburg Hospital. A score of 1 was the weakest and six the strongest.

Table 4 Strengths of the RWOPS Policy
N = total percentage of respondents

Issue	Professional Type	1 Smallest Problem	2	3	4	5	6 Greatest Problem	No response
Retention of scarce skills in public service	Nurses	20%	13%	20%	13%	13%	13%	7%
	Doctors	9%	9%	18%	18%	9%	55%	13%
	Allied	43%	14%	0%	14%	14%	14%	0%
	Management	0%	0%	0%	0%	0%	50%	50%
Improved service delivery due to availability of skilled professionals	Nurses	20%	7%	27%	27%	7%	7%	7%
	Doctors	9%	9%	18%	18%	27%	0%	13%
	Allied	29%	14%	14%	0%	29%	14%	57%
	Management	0%	0%	0%	0%	50%	0%	50%
	Totals							
Improved health-professional morale	Nurses	27%	7%	13%	20%	27%	0%	7%
	Doctors	9%	18%	9%	27%	18%	0%	13%
	Allied	29%	0%	29%	14%	14%	14%	0%
	Management	0%	0%	0%	0%	0%	50%	50%
	Totals							

Issue	Professional Type	1	2	3	4	5	6	No response
		Smallest Problem					Greatest Problem	
Improved remuneration of health professionals	Nurses	27%	7%	27%	13%	7%	13%	7%
	Doctors	9%	0%	0%	45%	9%	18%	13%
	Allied	29%	0%	0%	0%	29%	43%	0%
	Management	0%	0%	0%	0%	0%	50%	50%
	Totals							
Improved patient satisfactions	Nurses	13%	13%	27%	7%	20%	13%	7%
	Doctors	18%	18%	18%	18%	9%	0%	13%
	Allied	29%	43%	14%	0%	14%	0%	0%
	Management	0%	0%	0%	50%	0%	0%	50%
	Totals							
improved investment in services	Nurses	27%	0%	27%	20%	7%	13%	7%
	Doctors	9%	0%	0%	45%	9%	18%	13%
	Allied	29%	0%	0%	0%	29%	43%	0%
	Management	50%	0%	0%	0%	0%	0%	50%
	Totals							
Improved use of existing resources – equipment, space	Nurses	20%	13%	20%	33%	7%	0%	7%
	Doctors	18%	9%	9%	36%	9%	0%	13%
	Allied	14%	14%	43%	0%	14%	14%	0%
	Management	50%	0%	0%	0%	0%	0%	50%
	Totals							
Improved access to health services	Nurses	13%	20%	27%	20%	13%	0%	7%
	Doctors	27%	9%	0%	27%	0%	18%	13%
	Allied	43%	0%	0%	29%	14%	14%	0%
	Management	0%	0%	0%	0%	0	50%	50%
	Totals							

Table 5 Weaknesses of the RWOPS Policy
N = Total percentage of respondents

Issue	Professional Type	1 Smallest Problem	2	3	4	5	6 Greatest Problem	No response
Retention of scarce skills in public service	Nurses	27%	0%	7%	20%	13%	20%	13%
	Doctors	18%	0%	18%	45%	0%	0%	13%
	Allied	14%	14%	14%	14%	14%	0%	29%
	Management	50%	0%	0%	0%	0%	0%	50%
Using public resources to supplement private practice	Nurses	13%	7%	7%	7%	27%	27%	13%
	Doctors	27%	9%	0%	18%	9%	18%	13%
	Allied	14%	0%	57%	0%	14%	0%	29%
	Management	0%	0%	0%	0%	0%	300%	50%
	Totals							
Less time available for public sector care	Nurses	13%	13%	7%	7%	13%	33%	13%
	Doctors	9%	9%	18%	9%	0%	36%	13%
	Allied	14%	14%	0%	14%	14%	14%	29%
	Management	0%	450%	0%	0%	0%	50%	50%
	Totals							
Bias towards private patients – high income/insured patients	Nurses	7%	7%	20%	7%	20%	27%	13%
	Doctors	18%	9%	9%	9%	0%	36%	13%
	Allied	14%	14%	29%	14%	14%	0%	14%
	Management	0%	0%	0%	0%	0%	50%	50%
	Totals							

Question nine investigated if the time allocated for RWOPS was fair to all individuals practicing within the same unit and amongst the different health professionals at the Johannesburg Hospital. This question allowed the researcher to determine the awareness on the implementation process of the policy and possible beneficiaries.

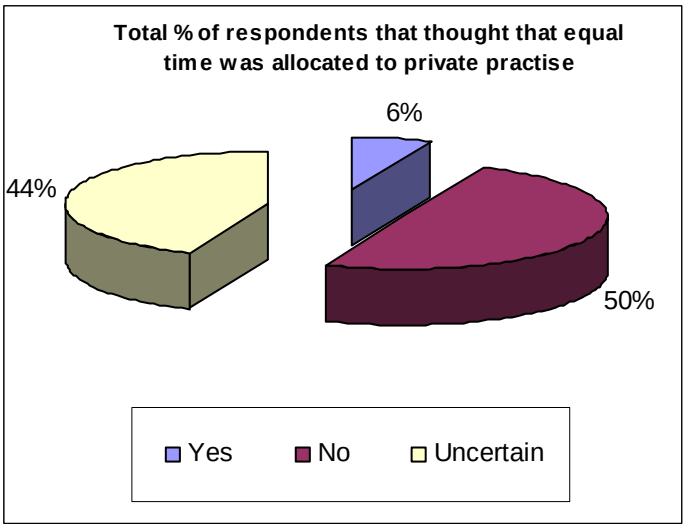

Figure 27 Total % of respondents that thought equal time was allocated to private practice (Management n=2; doctors n=11; nurses n=15 and allied health n=7)

A summary of the total response to the time spent amongst the different health professionals for RWOPS. Majority of the responses felt the time spent in private practice was not on par with the other institutions within the public sector. No specifications were made if the time spent was more or less than other institutions.

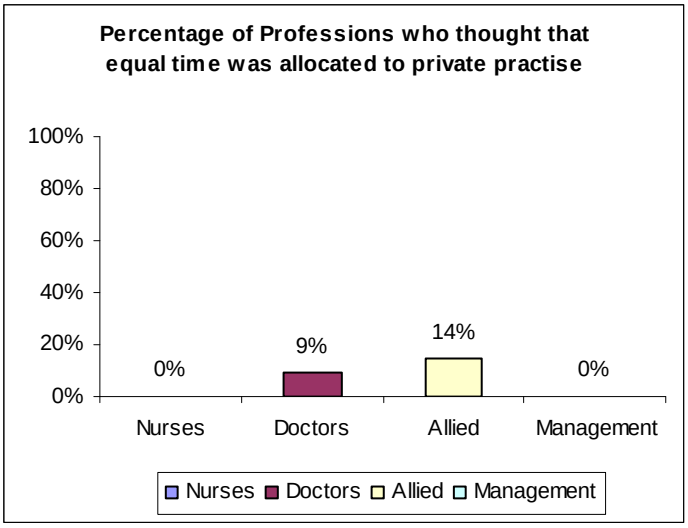

Figure 28 Percentage of Professions who thought that equal time was allocated to private practice (Doctors n=1 and allied health n=1)

Figure 28 is a profession specific response to those that felt equal time had been allocated to all individuals practicing RWOPS. Only 9 and 14 percent of the doctors and allied medical personnel respectively felt there was equal allocated to private practice to colleagues at other institutions.

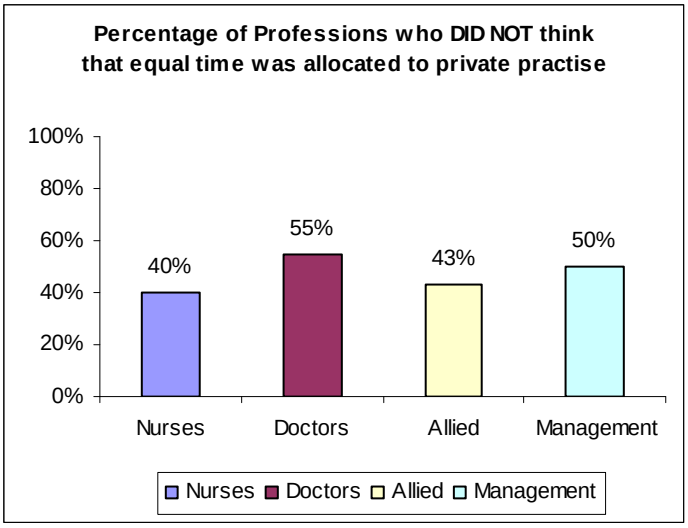

Figure 29 Percentage of Professions who DID NOT think equal time was allocated to private practice
(Management n=1; doctors n=6; nurses n=5 and allied health n=3)

This graph is representative of the professions that felt the equal time had NOT been allocated to all individuals practicing RWOPS at other institutions.

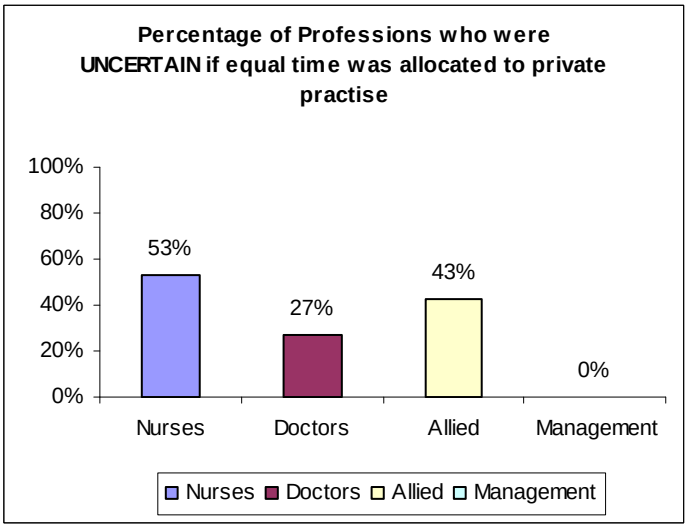

Figure 30 Percentage of Professions who were UNCERTAIN if equal time was allocated to private practice
(Management n=2; doctors n=11; nurses n=15 and allied health n=7)

Figure 30 shows the profession specific response to those that were uncertain to the time allocated to all individuals practicing RWOPS.

Question ten aimed to determine the expectations of the respondents. This question highlights the strengths weaknesses, perceptions for successful implementation and awareness of the policy.

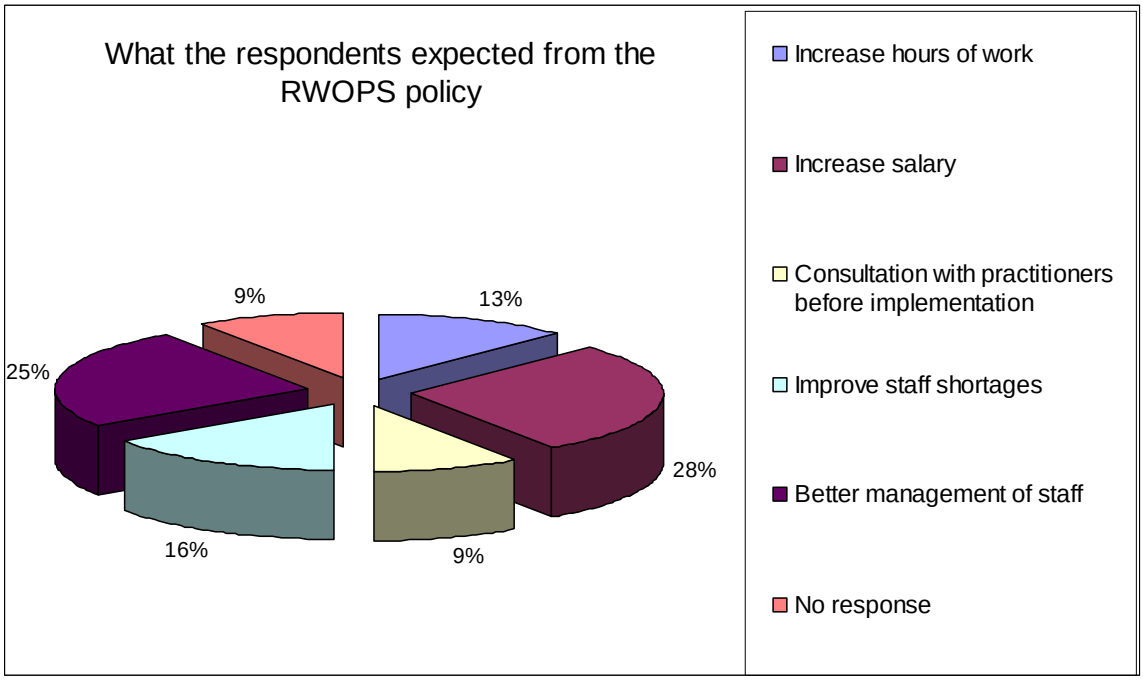

Figure 31 Expectations of respondents from the RWOPS policy
(Management n=2; doctors n=11; nurses n=15 and allied health n=7)

The above graph represents the expectations of the participants with regards to the RWOPS policy. Thirteen percent expected their work hours to increase. Twenty-eight percent expected their salaries to increase. Twenty five percent expected better management and this reinforces an earlier response which affects their morale and shortages of the staff.

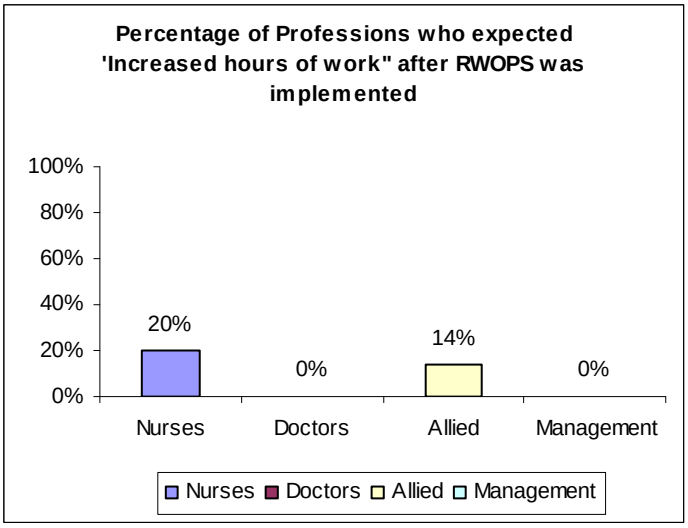

Figure 32 Percentage of professions who expected Increased Hours of Work after RWOPS was implemented
(Nurses n=3 and allied health n=1)

From the thirteen percent that expected their work hours to increase the above figure shows the nursing staff and allied medical personnel were the professions that expected increase in their working hours.

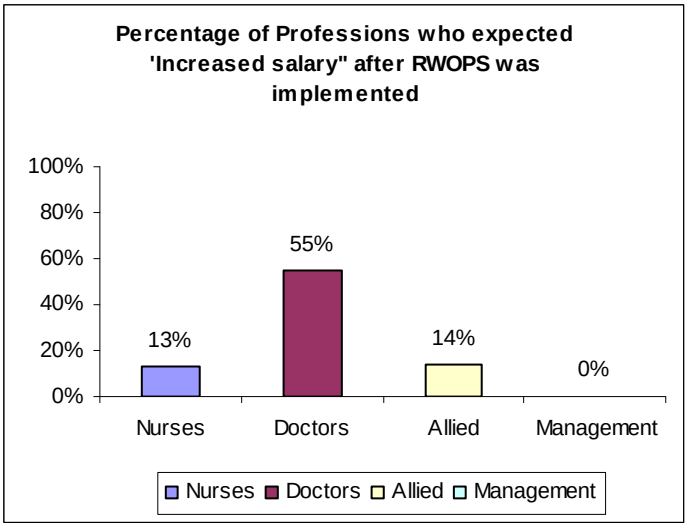

Figure 33 Percentage of Professions who expected Increased Salary after RWOPS was implemented
(Doctors n=6; nurses n=2 and allied health n=1)

From the twenty eight percent that expected an increase their salary after the implementation of the RWOPS policy at the Johannesburg Hospital, fifty five percent of those were the doctors. The doctors did not expect their work time to increase but expected better payment.

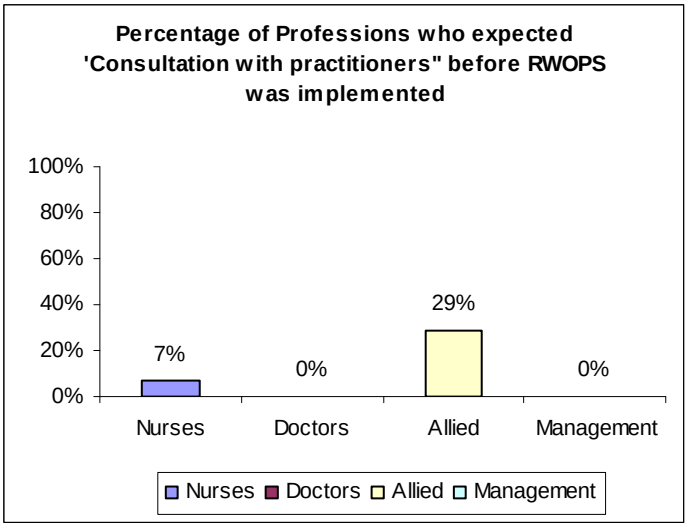

Figure 34 Percentage of professions who expected Consultation with Practitioners before RWOPS was implemented
(Nurses n=1 and allied health n=2)

This figure highlights those that expected to be consulted before the policy had been implemented. Only nine percent expected to be consulted before the policy was implemented and of this nine percent twenty nine percent were allied medical personnel and seven percent were nurses. No doctors felt the need to be consulted however an earlier figure shows that they felt they should have been consulted.

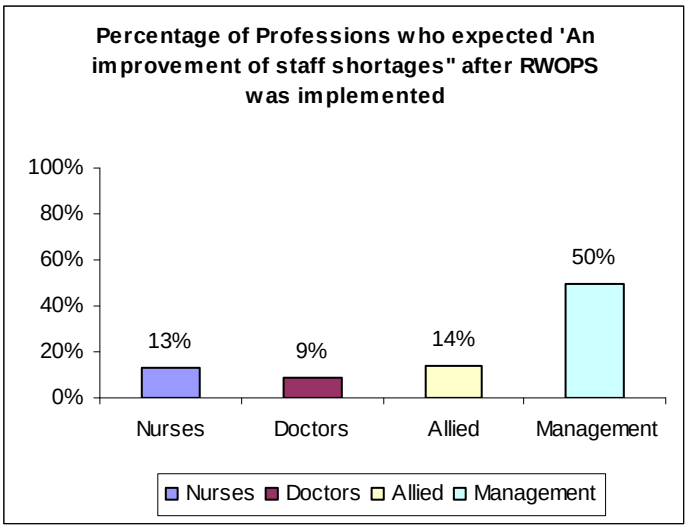

Figure 35 Percentage of Professions who expected An Improvement of Staff shortages after RWOPS was implemented
(Management n=1; doctors n=1; nurses n=2 and allied health n=1)

This figure represents the percentage that expected an improvement in staff shortages. Sixteen percent of the total percentage of participants felt staff shortages should have improved.

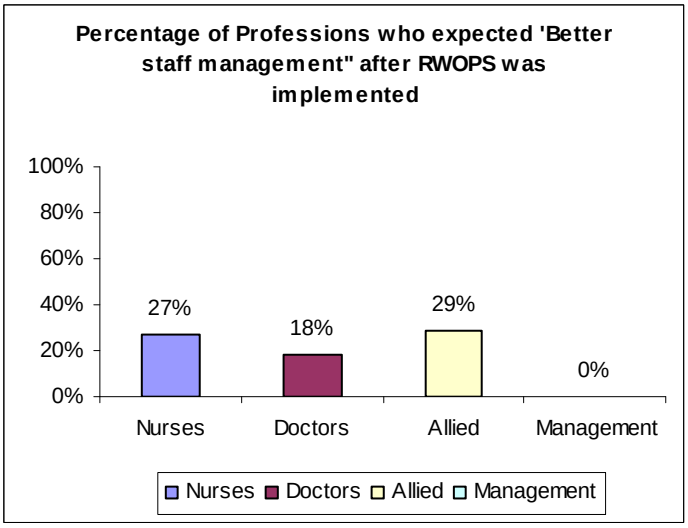

Figure 36 Percentage of Professions who expected Better Staff management after RWOPS was implemented
(Doctors n=2; nurses n=4 and allied health n=2)

The above figure highlights the expectations that staff management would improve after the implementation of the RWOPS policy at the Johannesburg Hospital.

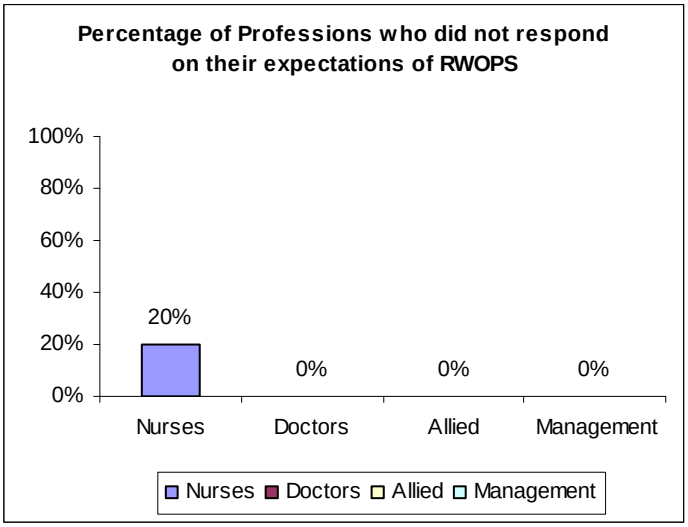

Figure 37 Percentage of Professions who did not respond on their expectations of RWOPS (Nurses n=3)

Figure 37 displays only a percentage of nurses did not respond to this question.

Question eleven asked respondents to suggest ways in which the RWOPS policy could be improved. This question explored the perceptions of the challenges for successful implementation of the RWOPS policy at the Johannesburg Hospital.

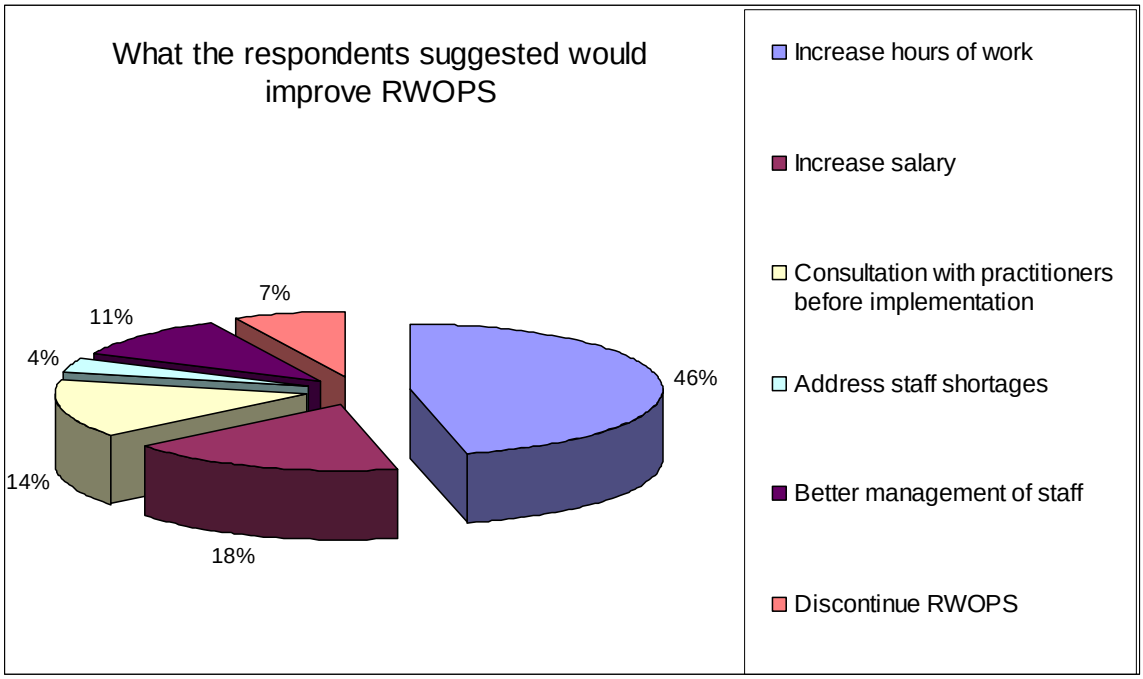

Figure 38 Suggestions form respondents on ways to improve RWOPS
(Management n=2; doctors n=11; nurses n=15 and allied health n=7)

Figure 38 is a summary of the possible improvements that could be made to the RWOPS policy. Forty six percent of the participants felt that the RWOPS hours should be increased and only seven percent felt it should be discontinued. Fourteen percent felt they should have been consulted before the policy was implemented compared to the nine percent response to the expectation from the RWOPS policy.

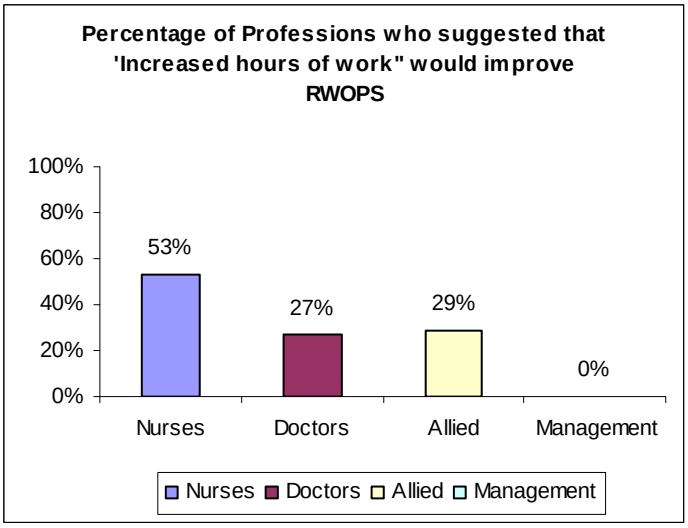

Figure 39 Percentage of Professions who suggested that increase hours of work would improve RWOPS
(Doctors n=3; nurses n=8 and allied health n=2)

The above figure represents the professions that felt there should be an increase in the number of hours for RWOPS. The highest response was from the nursing profession.

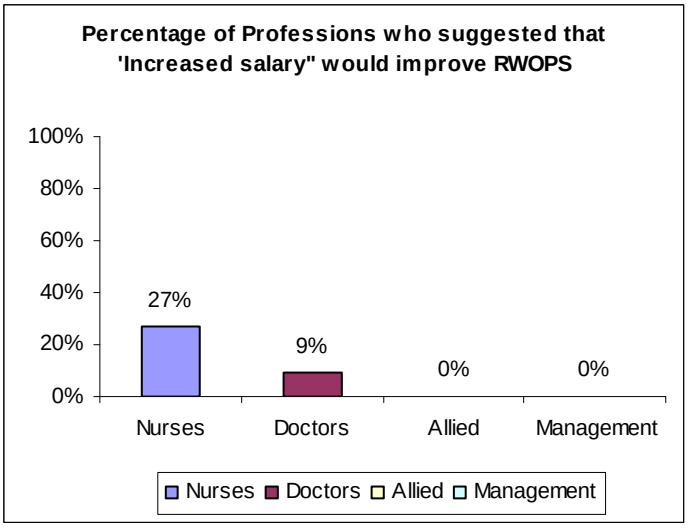

Figure 40 Percentage of Professions who suggested that Increased Salary would improve RWOPS
(Doctors n=1 and nurses n=4)

This figure represents the percentage that felt an increase in the salary for RWOPS was necessary.

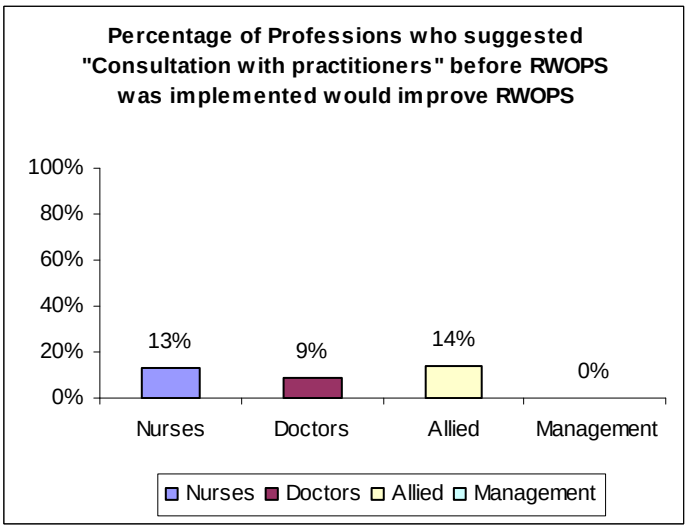

Figure 41 Percentage of Professions who suggested Consultation with practitioners before RWOPS was implemented would have improve RWOPS
(Doctors n=1; nurses n=4 and allied health n=1)

From the fourteen percent that felt if they were consulted it would have improved the policy nine percent are doctors, thirteen percent re nurses and fourteen percent are from the allied medical field.

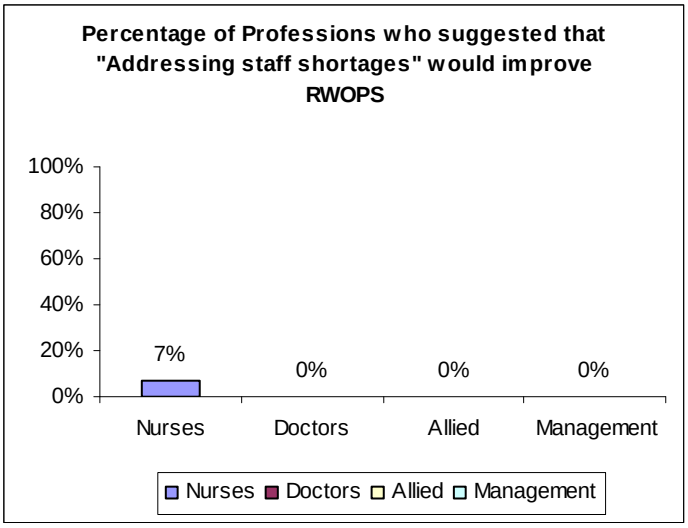

Figure 42 Percentage of Professions who suggested that Addressing Staff Shortages would improve RWOPS
(Nurses n=1)

This figure represents the individuals that suggested staff shortages be improved.

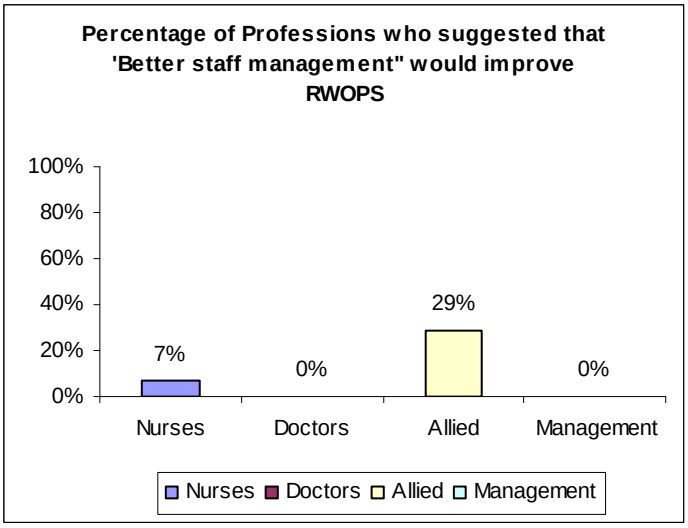

Figure 43 Percentage of Professions who suggested that Better Staff Management would improve RWOPS
(Nurses n=1 and allied health n=2)

This figure shows the percentage of participants that felt there should be better management of the staff to improve the policy.

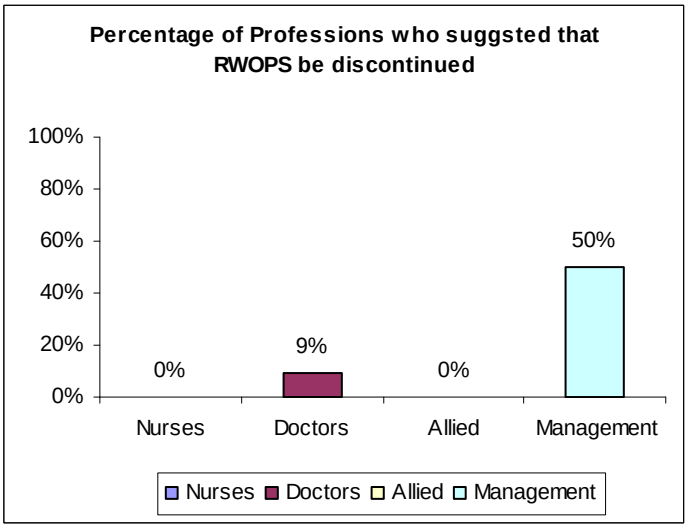

Figure 44 Percentage of Professions who suggested that RWOPS be discontinued
(Management n=1and doctors n=1)

The above figure represents the percentage that felt the RWOPS policy should be discontinued. Fifty percent of the management and nine percent of the doctors felt the RWOPS policy should be discontinued.

CHAPTER FIVE

5. DISCUSSION

The participants had varying views on the RWOPS policy depending on their professional category. The management had different take on many issues when compared to the professional health care personnel. The health professionals have also expressed support for and against the policy depending if they were practicing RWOPS. The questionnaire identified the key human resource challenges experienced at the Johannesburg hospital and determined the knowledge of the policy amongst the staff at the hospital. The eight themes outlined in the methodology, assisted the researcher to gain a better understanding of the perceptions of the actors in relation to the content and context of the RWOPS policy.

5.1 Understanding the Human Resource challenges within the health care system and at the Johannesburg Hospital.

An understanding of the human resource challenges experienced at the Johannesburg Hospital was unpacked through question one which asked participants to identify these challenges. Figures 5 – 13 offer graphical representation of these challenges as understood by the participants in response to question one. Most participants identified the shortage of human resource as the most critical challenge. These findings are consistent with the study conducted by Smith and Henderson (2006) that demonstrates a shortage of skilled health

professionals is one of the most critical constraints in developing countries. However, this does not tie in with Table 2 illustrates that the public posts in Gauteng Hospitals are being filled. Perhaps the staff are spending more time in RWOPS resulting in a shortage of human resources or the “spill over” from other provinces is not appropriately documented. This hampers the planning and budgeting processes for Gauteng province because they do not have the proper statistics.

The participants felt that the HIV pandemic was the least important factor impacting on the human resource challenges at the Johannesburg hospital. This finding was not consistent with an investigation (Veriava, 2005) of high absenteeism due to the HIV/AIDS pandemic. Walt and Gilson (1994) explain that the emergence of HIV/AIDS has impacted on the growing crisis within the health care systems in developing countries, however the participants at the Johannesburg Hospital felt it had a minimal impact on the staffing resources.

The shortage of health care personnel allows us to gain a better understanding off the context in which the RWOPS policy was introduced. Policies are introduced to suit the context and meet the needs of specified content as perceived by certain parties. Whether all parties are consulted on such issues is a different matter.

Table 3, issues 3.1 – 3.8 further explores the HR challenges at the Johannesburg Hospital. These responses were rated by the participants and again the shortage of health care personnel was highlighted as a critical challenge. The participants offered a varied response to the RWOPS policy being able to address the

challenges at the hospital. Management felt that the policy could address the challenges but the medical personnel felt it was not sufficient. The responses from the remaining two groups (doctors and allied medical personnel) of participants varied depending if they were actively engaging in RWOPS or not.

The context refers to the shortage of personnel in the public sector and the content (RWOPS) is the policy developed within this particular context. Published guidelines, the content i.e. the design and objective of the policy, offers the parameters and mechanisms to apply for RWOPS allowing health care professionals the opportunity to increase their earning potential hence attempting to retain the skilled staff within the public sector. The opportunity to supplement their state earned income provides an incentive for scare skilled personnel to stay within the public sector and more so in rural set ups (Berman and Cuizon, 2004). Eisenburg (1986) as sited by Berman and Cuizon (2004) explain that peer acceptance and professional interaction amongst physicians influence them to practice in public hospitals. The public hospitals in Gauteng have been successful in attracting health care personnel (Table 1) but these skills are absent from duty perhaps due to their engagement in RWOPS.

5.2 Awareness of the RWOPS policy at the Johannesburg Hospital

A summary of the responses (Figure 14) to question two which investigated the familiarity of the policy. Most participants are not familiar with the RWOPS policy

even though seventy seven percent (Figure 14) of the participants agreed they were familiar with the RWOPS policy (Figure 15). This is evident in question four which asked, "*Which healthcare professions at Johannesburg Hospital are excluded from RWOPS? (e.g. Physiotherapists)",* to which many of the participants were unaware of the cadres included/excluded. The policy does not specify the exclusion of any personnel from performing RWOPS, instead states that "*ALL provincial staff are entitled to engage in private work*" (Public Service Commission, 2004).

Familiarity to the RWOPS policy is also evident (Figure 19), where participants were asked if RWOPS had to be performed at the Folateng ward at the Johannesburg Hospital. The policy does not stipulate where RWOPS should be performed. This tells us that actors were not consulted in the formulation and implementation processes of the policy. Perhaps another reason why the policy has not managed to satisfy the context in which it was intended. It also reinforces the observation – like the earlier probe vis-à-vis cadres entitled to conduct RWOPS – that personnel are not fully aware of the policy design – that is the content of the policy.

5.3 Awareness of the RWOPS policy development process

The question, "*Were you consulted during the development of the RWOPS policy?"* investigated the consultation during the development process. Graph 6 provides the summary of these responses. 85% of the participants (pg 57) felt they had not been consulted. Figures 24 - 26 provide the profession specific response to being consulted during the developmental stages of the policy.

This suggests that there was limited involvement and hence buy-in from all role players. Many of the health care personnel were clueless to the developmental and implementation of the policy. Walt and Gilson (1994) emphasize the importance of buy in from the key role players for successful implementation of any policy.

The policy alludes to being high politics where government used a top-down approach to implement a policy to address the critical shortage of health care personnel (Evan and Newnham, 1992 as cited in Walt, 1994). However it is a low politics policy because the policy has been implemented from above as though it was a routine 'business as usual' policy. The policy has not fundamentally challenged the legitimacy of the state and has not been a contentious issue of lively debate within the health sector and civil society more broadly. Policy and a top down approach does not mean it is a high politics policy. The policy was developed and implemented with little opposition and resistance. The passive acceptance and 'routine' implementation speaks to the low-politics nature of the

policy - a policy deemed necessary to stem the tide of scarce skilled personnel from the public sector.

5.4 Awareness of the RWOPS policy implementation process at Johannesburg Hospital

The question 7, "*International experience highlights several strengths of RWOPS-style policies"* was presented in the form of a Likert scale to understand the strengths of this policy. The actors suggest that the content is insufficient to address the HR challenges experienced at the Johannesburg Hospital. Thus the content of this policy does not satisfy the context in which it came about. The RWOPS policy was intended to retain skilled personnel within the public sector and according to the actors the content of the policy has not allowed for this to be achieved. There is retention of more skilled staff on paper but the reality is that there is a shortage of health care personnel on duty perhaps due to the engagement in RWOPS.

Question nine, (Figure 27) expresses the awareness of the implementation of the hours spent by different professions for RWOPS thereby also telling us their knowledge on the policy. Figures 28 to 30 offer the views of individual professions responding to question nine.

5.5 Perceptions of the weaknesses of the RWOPS policy

Question eight, "*International experience highlights several problems that emerge from RWOPS-style policies",* was presented in the form of a Likert scale which allowed us to gain a better understanding the weaknesses of the policy. The actors tell us that the content of the policy is inadequate for the context in which it was adopted and intended. It is believed that the combination of private and public work interferes with work performance in the public sector and has a negative effect on the overall functioning of the health care system (Gruen, et al., 2002 & Jumpa, et al., 2003).

There is anecdotal evidence from international studies (Jumpa, et al., 2003 and Jan, et al., 2005) that suggests individual staff members are not mentally alert when performing state duties, because there is no time constraint on the hours engaged in RWOPS. This study highlights similar issues within Johannesburg Hospital. Some staff members have explained that certain individuals engaging in RWOPS work extended hours prior to reporting for state duty leaving them too exhausted to perform basic tasks. These individuals potentially compromise the quality of health care, and it impacts on the staff that needs to assist overtime in such instances. Patient care is also compromised as tired individuals cannot function at their full capacity. This results in the remaining staff having to assist with their duties which exacerbates the human resources crisis.

There is no direct evidence at the Johannesburg Hospital that suggests patients in the public sector are being compromised vis-à-vis quality of care. It may be inferred that the shortage of staff is impacting on individuals within the nursing sector. However, the general perception regarding multiple job holding is that is has a negative impact (Berman and Cuizon, 2004).

Berman and Cuizon (2004) argue that individuals do not change or create these situations but respond to the needs of the available markets and low wage salaries. The need for these services within the private sector provides the opportunity for individuals to accept offers at nominal rates increasing their earning potential. Health care personnel working in the public sector state that a double in their current salary will stop them from practicing in the private sector and engaging in RWOPS (suggestions from questionnaire).

5.6 Perceptions of the challenges for successful implementation

Question ten and eleven allowed the participants to express their expectations and offer possible suggestion to improve the RWOPS policy. These expectations tell us that the majority of actors were not consulted during on the implementation of the policy. Figure 34 indicates the percentage per profession that felt they should have been consulted before the implementation of the policy. This is probably the reason for such discrepancies amongst the different health professional practicing RWOPS.

Health policies wrongly focus on the content of the policy (Walt and Gilson, 1994) ignoring the actors involved at the different levels and the context of the policies. It diverts attention from understanding policy implementation. One of the reasons for the possible failure of the policy was that the buy-in of the actors was not considered. The context surrounding the policy has also had a major role in influencing the outcome given that the public sector still experiences a critical shortage of skilled personnel. Furthermore the RWOPS policy has introduced a negative work attitude amongst the different professional categories that engage in RWOPS and abuse to state property and time. This highlights the importance of consulting with all relevant stakeholders when introducing any new policy.

5.7 Perceptions of the main beneficiaries of the RWOPS policy

RWOPS is offered to all health personnel contracted to the government however, this study has revealed that community service doctors are also engaging in RWOPS, as per certain responses from the health care personnel at the Johannesburg Hospital. The general perception was that doctors and nurses in higher ranks gained the most from RWOPS. These perceptions were gained through the interactions with various participants during data collection. No specific graph or question allows the researcher to validate this perception.

Government employees engaged in multiple jobs see their private work as being either competitive; complementary or a combination of both to their public sector work (Berman and Cuizon, 2004). This research has highlighted that there is abuse of official working hours and requesting of leave with full pay to engage in

private work. This has implications on the quality of service administered at the public institutions since these come secondary to the private work.

The migration of health staff from rural to urban areas causes conflict and unhappiness between the local health workers. Migrant staff work shifts in the private sector and then avail themselves for public services (suggestions from questionnaire). They are often not adequately qualified to work in certain units and very tired because of the long shifts they work (suggestion from questionnaire). This study did not probe the details of these situations but the suggestions in the questionnaire indicate that the local staff blames the RWOPS policy for this situation. Migrant staff apply for leave in their respective provinces and avail themselves to work sessions at Gauteng public hospitals. As contractual staff of the province they have a right to apply for RWOPS and work extra hours to earn additional money. Table two highlights the decrease of in the number of posts from 2001 to 2003 available in the public health sector. On paper this is what is reflected but practically there is still a critical shortage within the public health hospitals perhaps because of the hours spent in RWOPS.

This raises many concerns. Insufficient or no reference check on the employment status of staff results in duplication of services. Two critical questions arise: Is it deliberate because of the shortage of health care personnel? Or are there no mechanisms in place to monitor and validate such information. Either way health information systems need to reflect the number of registered workers within the specific provinces using a more personal approach and not a holistic figure.

FrameWork Analysis

Health care is a highly political issue. It is an important part of the economy, employs a large number of workers and absorbs relatively large amounts of the resources (Walt, 1994). In South Africa this amounts to over 8% of GDP. Government, all levels of health care workers, policy makers and communities should work closely in achieving health for all (Lee and Mills, 1983).

Leichter (cited in Walt, 1994) explains there are critical factors such as structural factors, situational factors, environmental factors and cultural factors that influence policy making. Health policy and its implementation is strongly influenced by macroeconomic factors (Lee and Mills, 1983). Health services absorb a significant proportion of the government expenditures (Lee and Mills, 1983). Whatever factors are prevailing they form the context in which polices are introduced and will determine the success of the policy. However, this cannot be seen in isolation as the key actors are directly influenced by such factors and therefore it is critical to involve them in the process of any policy making and implementation.

Policy analysis allows for comprehensive approaches to health reform instead of focusing on technical matters alone (Walt and Gilson, 1994). It allows for all aspects to be incorporated in ensuring the success of any policy. The political stability of the country influences the content of the policy. This also determines the extent to which key actors may participate in policy making. The type of political system has a marked influence on the nature of participation from various actors (Walt, 1994).

‘All Provincial Employees may apply to do remunerative work outside public sector ‘. Many state employees are not aware that any state employee may engage in RWOPS indicating that all the relevant actors were not consulted and are not aware of the actual policy. This may have resulted in abuse on the part of those individuals familiar with the policy. There is less buy in from some of the relevant actors because they are not familiar with the policy content. This results in frustration on their behalf breeding animosity between the different cadres of professionals and within the same professions working within the hospital. The process in which the context is being implemented is breeding contempt because RWOPS is seen to be favoring the needs of certain health professions.

Health policies often wrongly focus on the content of policies (Walt and Gilson, 1994). Traditional focus on the content results in neglect of actors, process and the context resulting in the ineffective implementation and ultimately failure of the policy. This is evident in the analysis on the awareness of the policy, weaknesses and the challenges facing the successful implementation that the health care personnel were NOT consulted during the development of this policy.

‘The proposed employment must in no way result in a conflict of interest between the province and such employment’. Process is one of the corner stones of the triangle indicating the significance and importance in ensuring the success of any policy. The policy content stipulates there should be not conflict of interest but how is this measured. What mechanisms are in place to ensure that this will not or does not occur. There is no practical way of measuring and determining any

conflict of interest amongst the actors engaging in RWOPS. This again breeds contempt amongst coworkers as they see the RWOPS to be benefiting a few health professions.

‘An individual is employed to render a service required by the province and the institution concerned, and may not redefine his/her working hours to satisfy his/her wishes to perform RWOPS’. The processes to monitor such activities are lacking. The lack of monitoring allows for abuse in RWOPS hours and aggravates the tension amongst the working health professions within the hospital. This indicates that all actors were not consulted because RWOPS seems to be favouring some individuals and certain health professions at the Johannesburg Hospital.

The core working hours are stipulated in the policy, leaving little time for RWOPS. There are no monitoring systems to ensure that health workers are on duty at the recommended times. Colleagues often feel over burdened because they are standing in for individuals performing RWOPS or for individuals that are present but to exhausted to perform because they have just returned from a RWOPS shift. The context in which the process of RWOPS is occurring is having a negative effect toll on the staff at the hospital. The content does not clarify monitoring processes for such activities aggravating the bitterness amongst the health care personnel at the Johannesburg Hospital.

In health many policies fall into the category of low politics (Walt, 1994). This policy was brought about because of the crisis within the health system with regards to the retention of skilled health care personnel within the public sector. It may have been a low politics policy within a high politics setting. Indirect participation of actors through elected representatives (Walt, 1994), may not have been effectively communicated to the majority of individuals. This may have resulted in the limited knowledge and unrealistic expectations from the RWOPS policy.

‘Doctors will need to demonstrate that their team members are capable of caring for their patients when they are not on duty in the public sector’ (Public Service Commission, 2004). The content of the policy does not state how doctors are meant to demonstrate such capabilities. Fair and just decisions cannot be rendered even if such monitoring systems were in place because the doctors are also engaging in RWOPS often with the relevant team members.

‘RWOPS may not be performed while utilizing state health facilities. Exceptions will be made only in special circumstances... ’ (Public Service Commission, 2004). The content allows for abuse of state facilities and encourages ill feelings amongst fellow workers. Who determines the special circumstances are often colleagues from the same profession and individuals that are engaging in such practices. The process of such behaviour empowers certain individuals and illustrates that the RWOPS policy is favourable to these individuals.

This indicates that there was no consultation with all the relevant actors. The context is to retain skilled workers with the public sector. While the policy may have succeeded in retaining the skills on paper, the availability of such skills in attending to state patients must be investigated. The policy has introduced animosity amongst the health care personnel and demoralized many individuals. It has encouraged health personnel to abandon duties from other provinces to be in the employment of the Johannesburg Hospital because of the prospective income it may bring.

The success of any policy is dependant on the content of the policy being appropriate for the context in which the processes occur. It is critical that this occurs with the consultation and buy in of all the key actors to ensure success of the policy, be it direct or indirect participation. Public policy will remain of critical importance and hence governments will continue with the central role of policy making (Walt, 1994).

CHAPTER SIX

6. RECOMMENDATIONS

6.1 HUMAN RESOURCE PERSONNEL

6.1.1. Non-financial incentives:

A nation's most important resource is human resources in the developing process (Becker cited in Lee and Mills, 1983). Investments on basic infrastructure may satisfy the objectives but also serves as an attraction tool to underdeveloped areas. The introduction of appropriate education (schools and tertiary) facilities, recreational facilities for youth, access to health facilities attracts students and this alone has many spill over effects. Literacy is a strong determinant of health status of a community (Grosse 1980 as cited in Lee and Mills, 1983).

Human resource development is the focal point in any developing country. A nation's policy on manpower becomes a crucial component in its developmental process (Lee and Mills, 1983). Government posts offer advanced technology and exposure to a varied patient pattern thus increasing individual abilities. Private practitioners rarely interact at the professional level which may lead to the deterioration of medical skills through a lack of knowledge on current trends, practices and technology. The availability, accessibility of modern technology and peer reviews are incentives offered to medical staff in an academic state environment. State employed physicians enjoy the security benefits but earn less than the average private physician. These are some of the reasons for health

personnel to stay within the public health sector despite the poor remuneration rates.

6.1.2. Financial Incentives

Offer competitive packages that would assist in retaining the health care personnel within the different disciplines. The package does not have to be on par with the private sector but should be close and the offer of non-financial incentives should be attractive.

6.1.3 Review the RWOPS policy

Review the RWOPS policy – to allow for improving mechanisms for monitoring the volume and impact of RWOPS. Such monitoring and evaluation will assist policymakers in determining the value-add of the policy in addressing the deeper structural health system constraints undermining the broader health system goals espoused in the National Health Act of 2003 (Republic of South Africa, 2003).

The policy has encouraged the abuse of public health facilities and hours worked at the public hospitals. Introduce other incentives that will be attractive to the individuals concerned and consult with the relevant key stake holders on what would be beneficial to them. Chawla (cited by Berman and Cuizon, 2004) states that dual job holding will provide an incentive to physicians to perform better in their public duties. However this has been reported as having negative effects on the morale of some staff members and a compromise on the quality of care administered to patients visiting state hospitals.

6.2 APPROPRIATE POLICIES

6.2.1 Human Resource Policy

The National Department of Health has recognized the critical shortage of human resources within the health care sector. The national department of health is responsible for health policy and legislation, the implementation as well as monitoring and evaluating the impact of these policies, with the overall objective in improving accessibility to quality health care services. The department had outlined four priorities for 2000: HIV/AIDS programme; implementing a district health system; finalizing the National Health Bill and developing a National Human Resource plan, (Department of Health, 2000). Government has identified the problem of shortage of health care personnel and this has been finalized in the National Human Resource Plan.

The introduction of a monitoring and evaluating system that will preventing provinces from employing contractual staff from other provinces without sufficient proof of resignation for that particular province. This will limit urban rural migration and help monitor the situation. Perhaps establishing a national data base using the individual HPCSA numbers within the specific professions as a means to allow for a cross referencing.

The National Human Resource Health Plan is to allow for guidance on the human resource policy and planning for the entire health care system in South Africa (National Department of Health, 2006). It aims to ensure there is maximum utilization of the available resources and equitable distribution of these resources.

It is to serve as a reference point for province-specific HR plans providing managers with a framework for recruiting and retention of skilled personnel.

Health auxiliaries and community health volunteers serve as a means of improving the community's access to basic health care (Lee and Mills, 1983). The auxiliary staff serve to supplement the health workers and not replace them in any way instead they operate under the supervision of the health workers. They reduce the shortage of professionally trained health workers in rural areas, they can be trained less expensively than health professionals, they are closer both physically and socially to the people they serve. The basis and strength of such services lies in a cadre of suitably selected and staff (Lee and Mills, 1983).

Primary health care is a strategy employed to place the appropriate health services within the reach of everyone in a way that is effective and equitable to the needs of that population (Lee and Mills, 1983). There is often a lack of knowledge among politicians, government officials, health administrators, which results in inefficient resource allocation. Educating and ensuring the relevant parties are familiar with the necessary procedures in allocating resources to the relevant areas.

CHAPTER SEVEN

7.1 CONCLUSION

The health sector seems to be the most neglected public sector in most developing countries resulting in a growing crisis within health systems (Walt and Gilson, 1994). *Moonlighting* or LPP is a result of many underlying factors. Government's ambitious attempts to develop staff and extensive health care delivery systems within limited and overstretched resources, (Berman and Cuizon, 2004), could compromise on the quality of the current available health care. Dual practice is a cause of many other underlying factors. The type of job and extent of dual practice is profession specific and dependant on individual practices, which is directly influenced by market demands and policy regulations. Berman and Cuizon (2004) explain that the negative impacts of dual practice include, compromised service delivery because of the increased absenteeism; referral of patients to private practice since they become paying patients in the private clinic and opportunity to utilize government resources for personal use. This is evident from the study conducted.

The negative and positive aspects of dual practice have been highlighted; however, most of the evidence presented in developing countries is anecdotal. Berman and Cuizon (2004) explain that it is critical to determine which has a more dominant effect on the provision of quality health care services. There is limited data on the actual positive and negative impacts of dual practice and limited research on the overall impact of the RWOPS policy.

There is no evidence on the impact of the RWOPS policy. The anecdotal evidence from international studies (Jumpa, et al., 2003 and Jan, et al., 2005) and evidence from this research suggests individual staff members are not mentally alert when performing state duties, because there is no monitored time constraint on the hours engaged in RWOPS. This study has also highlighted the animosity that has been introduced between the different health professionals because of the impression of preferential treatment in engaging in RWOPS.

Berman and Cuizon (2004) explain that most countries multiple job holding is widespread; government officials have different view on multiple job holding; efforts to regulate and effectively implement regulations regarding multiple jobs are not enforced and there is limited information on the impact and extent of multiple job holding. This attitude is not unique to South Africa given the nature and sensitivity of this topic many medical personnel are reluctant to assist in recording the activities of RWOPS.

The South African government acknowledges that the quality of health services is dependant on the availability and the work ethic of the health care personnel. The RWOPS policy has attempted to resolve the issue surrounding income but the implementation of this policy has rendered the public sector short on skilled health care personnel. Statistics (Table 2) highlight the decreasing number of posts available meaning more health care professionals are opting to work for the state but the province is still short staffed. The content of the RWOPS policy attempts to

attract health professionals to the public sector but the implementation process of this policy is poor, crippling the quality of care being offered.

More research needs to be conducted nationally on the impact of the RWOPS policy amongst the different sectors of the medical personnel (nursing, physiotherapy, speech therapy etc.). It has been suggested that the nursing staff structure of level of training and competency levels of those engaging in RWOPS at the Folateng be seriously investigated. Most staff agreed that an increase in their current salary will stop them from engaging in private work since the state positions offer security and stability.

Efficiency, effectiveness and equity are critical to the economy of any country, (Lee and Mills, 1983). The allocation of resources to meet the demands of the people requires the input of all the key actors involved within that context. The input of all relevant stakeholders will determine the effectiveness of the policy in the implementation phase. The awareness of the policy content was very poor as noted in the discussion, perhaps due to the lack of consultation during the policy formulation processes.

There is a major problem with the human resource distribution within the South African health care environment. Sourcing and training more staff is not the only solution to facilitate the health needs of the people. The infrastructure to retain and the ability to equally distribute human personnel to the different areas are vitally needed. The roles as outlined in the National Health Act, 2003 (Republic of South Africa, 2003) should be emphasized and the decentralized approach should be

revisited to identify where the broken links. An attempt has been made to resolve the problem of governance by integrating the provincial and municipal services, (Andrew and Pillay, 2005), however this attempt has been facing its own share of problems.

There is more emphasis being placed on shifting from curative based care to integrated community based care. Once new systems are in placed monitoring and evaluation of these systems is critical to ensure government is meeting the needs of the people. These are being addressed though the national health information system (Andrew and Pillay, 2005).

The gravity of human resource challenges is heavily weighing down the pace of health service delivery. Government needs to take serious action and implement systems to monitor the progress of the human resource strategic plan to ensure the effectiveness of this policy.

Appendix I

Information sheet

Good Day,

I, Farzana Khan, a Master of Public Health (MPH) student at the University of Witwatersrand, is conducting a study on the Remunerative Work Outside the Public Sector (RWOPS) at Johannesburg Hospital. I would like to invite you to participate in this study.

Why am I doing this? There have been few studies too date on RWOPS in South Africa. This study seeks to, in an explorative manner; contribute to the body of knowledge on issues facing the health system – human resources for health being one of the major challenges.

What do* I *request from the participants in the study? I expect participants to share knowledge and experience of the policy development and implementation challenges that RWOPS presents to service delivery at Johannesburg Hospital. This involves sharing perceptions of the strengths, weaknesses and challenges the policy poses as a means of exploring whether the policy can in fact contribute towards strengthening the health system. It is hoped that the lessons from Johannesburg Hospital can inform current policy debates as well as open up avenues for further research into the subject. The questionnaire should take 20 minutes to complete.

Are there benefits to the participants? The benefit is not directly targeted towards individual participants, but has wider benefit for policymaking at the level of the hospital and hopefully the South African Health system as a whole.

May participants withdraw from the study? Certainly, you may do this at any time without having to give a reason. Remember that the study is completely voluntary and not taking part in it, or withdrawing from it, carries no penalty of any sort.

What about confidentiality? Permission to conduct this study has been obtained from senior management. Anonymity will be maintained by the use of a code instead of names on the questionnaire sheet and subsequent analysis. Confidentiality will be maintained at all times. By completing the questionnaire you are agreeing to participate in this study.
If you have any queries, more information may be obtained from Farzana Khan at number (011) 406-2469.
If you are happy to participate in the study, kindly complete the questionnaire sheet.

Thank you
Farzana Khan

Appendix II

Demographic information

Gender Male ☐ Female ☐

Occupation _____

QUESTIONNAIRE

1. What are the Human Resource challenges currently facing the Johannesburg Hospital?

_____

_____

_____

_____

2. Are you familiar with the RWOPS policy? (please tick one option)

YES ☐ NO ☐ Uncertain ☐

Only if you have ticked yes, kindly answer the rest of the questions.

3. Kindly tick the most appropriate response.

	Strongly agree	agree	uncertain	disagree	Strongly disagree
Can the RWOPS policy address the HR challenges at Johannesburg Hospital					
Is RWOPS sufficiently adequate to address the HR challenges at Johannesburg Hospital					
RWOPS is a good way of retaining skilled health professionals					

The current design of RWOPS at Johannesburg Hospital supports overall service delivery at the hospital					
RWOPS has improved service delivery at the Johannesburg Hospital					
The hours spent in this public hospital are on par with colleagues working in other public institutions					
The RWOPS policy has met my individual expectations					
I am satisfied with the way RWOPS currently operates at this institution					

4. Which healthcare professions at Johannesburg Hospital are excluded from RWOPS? (e.g. Physiotherapists)

_____

5. Do RWOPS have to be done at Folateng?

YES ☐ NO ☐

6. Were you consulted during the development of the RWOPS policy?

YES ☐ NO ☐

If yes, at what stage of the policy development were you consulted?

_____

7. International experience highlights several strengths of RWOPS-style policies. Rate the key strengths of RWOPS policies from 1 to 6 (fill in a number from 1-6 in each block with 6 being the greatest strength and 1 being the greatest weakness)

Retention of scare skills in public service ☐
Improved service delivery due to availability of skilled professionals ☐
Improved health-professional morale ☐
Improved remuneration of health professionals ☐
Improved patient satisfactions ☐
Improved investment in service delivery – e.g. technology ☐
Improved use of existing resources – equipment, space ☐
Improved access to health services ☐

8. International experience highlights several problems that emerge from RWOPS-style policies. Rate the key weaknesses of RWOPS from 1 to 6 (fill in a number from 1-6 in each block with 6 being the greatest problem and 1 being the smallest problem)

Recruiting public patients to private practice ☐
Using public resources to supplement private practice ☐
Less time available for public sector care ☐
Bias towards private patients – high income/insured patients ☐

9. Is there equal time allocated to private practice amongst the different levels of doctors and other health professionals?

YES ☐ NO ☐ Uncertain ☐

10. What did you expect from the RWOPS policy?

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11. What do you suggest can be done to improve the RWOPS policy?

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12. Additional comments

Appendix III

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Khan

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER M060208**
PROJECT	An Assessment of the Remunerative Work Outside the Public Sector at the Johannesburg Hospital
INVESTIGATORS	Ms F Khan
DEPARTMENT	School of Public Health
DATE CONSIDERED	06.02.24
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 06.05.03 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Mr H Wadee

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

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