



## PRIVATE INPUT IGNORED IN RURAL AND SCARCE SKILLS INCENTIVES



Professors Ian Couper and Steve Reid.

Research on the government's latest rural allowances reveals that they may have influenced 27% of qualifying health workers to stay where they are, but that creating job satisfaction and opportunities for career advancement are far stronger incentives.

Two leading rural health academics, Professors Steve Reid and Ian Couper, warned against merely 'throwing money at the problem without proper evaluation'. When combined with the 9 months' back pay and a scarce skills allowance, the new incentive package meant a kick-off bonus of R20 000 for some.

Most glaringly absent from the incentive package are distance education facilities, acknowledgment of GP session work and appropriate training for senior hospital and district health managers.

Reid, Chair of Rural Medicine at the Nelson Mandela Medical School in Durban, conducted the latest research and tempers his findings by highlighting the inherent

'methodological' problems he encountered. He believes the scarce skills allowance and the back pay (increases were back-dated to July last year) may well have skewed his findings to display a 'far more positive response' than actually exists.

'I deliberately waited for 2 months after the actual increases (until May) to try and offset that, but the study does suggest that the rural allowance may be having some effect,' he said.

He sampled 20% of health care professionals working in rural institutions, most of them nurses. The 27% who said they would reconsider changing their site of practice in the light of the rural allowance represents a drop of 3% on a similar survey done among mainly doctors when the first rural allowance incentives came into effect.

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Reid told *Izindaba* that the biggest issue was providing career advancement and professional development 'without having to get them out of their jobs and into the city to get ahead'. He stressed that educational institutions could not afford to pay for effective distance learning.

Both he and Couper, Chair of Rural Health at Witwatersrand University, emphatically agreed that upgraded hospital management capacity would also be a major contribution to rural health worker retention. Couper said

the new government policy of chief executive officers running hospitals on business lines often made life difficult for doctors and nurses whose primary focus was on the proper care and management of patients.

'I don't blame the government because that's what the public finance management act demands, but there are a lot of inadequately trained managers and far too few actual leaders,' observed Couper.

A CEO who was totally focused on his bottom line would tend to see doctors mainly as an expense and shy away from advertising posts or recruiting them. Poor administration resulting in, for example, some workers not being paid for several months could also sabotage any cash incentives.

One example of the chasm between official policy and hands-on reality is that of Dr Helen Daniel, a foreign qualified medical officer at Manguzi District Hospital near Hluhluwe in KwaZulu-Natal. She has worked unpaid for the first 3 of 9 months she has been there.

The Briton, who struggled for 6 months to get registered and for 4 months to obtain a work permit (in spite of qualifying for fast-tracking), then found herself denied R35 000 in overtime because Manguzi hospital, a head office senior decreed, was 'over-budget'. Her initial non-payment was blamed on new computer systems being installed at the Empangeni DOH offices.

Two months after arriving at Manguzi, Daniel's quarters were burgled and her wallet stolen. Fellow doctors clubbed together to keep her from having to pack up and return home. 'It's been an interesting introduction,' quipped a stoical Daniel, who at least qualifies for the new incentives.



Couper called for the scarce skills incentive to be broadened to include primary health care trained nurses. At present it only applies to critical care, oncology and theatre nurses. 'The entire focus of the system is supposed to be on primary health care, yet these nurses don't even get a clinic allowance any more,' he said.

Also deserving of the scarce skills allowance were advanced midwives, many of whom ran rural hospital labour wards because of the shortage of doctors. Couper said the country's perinatal and maternal mortality statistics cried out for urgent intervention. Such a skills incentive would go a long way to alleviating the crisis. He cited North West Province, where the majority of primary health caregivers in clinics are untrained and those with training move to a hospital 'the moment an opportunity arises'.

Both experts noted that the rural and scarce skills allowance details were thrashed out in the public sector bargaining chamber after input from the Rural Doctors Association of South Africa (Rudasa), although Rudasa was not consulted on subsequent detail.

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While the public bargaining sector framework excludes them from benefiting from either the rural or scarce skills allowances, a significant number keep district hospitals and clinics afloat

and enhance the overall public health care delivery network.



*Dr Percy Mahlali, Deputy Director of Human Resources in the national health department.*

Dr Jenny Nash has served at the far-flung Mseleni Hospital with a catchment of 85 000 people near Sordwana Bay for the past 7 years. About to complete her Master's degree in family medicine, Nash has 2 children, aged 1 year and 2 years 6 months, is married to Stephen, an engineer, and works officially from 7am to noon (five-eighths).

One of three Senior Medical Officers (although she does the work of a Principal Medical Officer), Nash supervises the maternity and female surgical wards, co-ordinates the TB and PMTCT clinics, supervises the main hospital antiretroviral site (there are eight district sites), co-ordinates the clinic nurses and supervises the University of Pretoria medical students' obstetrics rural block. She does most of her statistical and roster and protocol work after hours.

She nets just over R6 000 a month.

Nash worked full-time until July 2002 when she elected to start a family, going

onto the five-eighths shift. In February this year she received a rural 'disallowance' slip, docking R11 500 from her pay. 'It seems that they suddenly realised I was no longer eligible – and the next month it was deducted again. I was clueless until I read about the five-eighths and scarce skills not being included and put two and two together,' she said.

Nash says there must be scores of doctors in her situation who could be incentivised. 'They'd get far more for their money if they had three people working part-time instead of one full-time. Everyone has their special interest. If government could attract part-timers into public sector posts as well as in rural areas it would boost work morale and delivery'.

She doubted that cash incentives would 'make or break' women in her situation but said it could 'well encourage them to carry on or make them feel appreciated'. She stressed that long-term doctors did not 'come out of the woodwork'.

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'You really feel the crunch at the beginning of the year. Suddenly you have six new doctors; nobody knows how to do caesars, minor procedures, where to find things, OPD, where to refer – you have to cover the whole time.'

Dr Hoffie Conradie, a specialist family physician in Worcester, says GPs are a 'dying breed in rural towns'. Two years ago he was the only full-time doctor in Dordrecht, Eastern Cape.





Conradie says full-time doctors also have to be relieved sometime. He strongly believes the rural incentive should also apply to private specialists.

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'Worcester is 100 km from Cape Town but we struggle to get specialists and we're desperately in need of another full-time surgeon and have place for two specialists in each specialty.' The lack of rural specialists had a negative knock-on effect in the vital training and supervision of community service doctors and interns.

Responding, Dr Percy Mahlati, Deputy Director of Human Resources in the national health department and former SAMA CEO, said it was too early to effectively evaluate the government's rural incentive policy. He said the impact of professional mobility would only be felt after 2 - 3 years. He said that Reid's finding that money was not a primary incentive made good sense. 'If you couple money with conditions of service, facilities and professional development, I think it would take 2 - 3 years to see if the rural incentives are working or not,' he said. His department had also told cabinet that it was 'too early' to properly evaluate.

Foreign qualified professionals were 'very fond' of the rural allowance,

whereas for locals the scarce skills allowance was more popular.

Asked what evaluation plans were in place, Mahlati quoted President Mbeki emphasising government capacity building at the September Local Government Association conference, and said plans were afoot to 'strengthen internal monitoring and evaluation capacity'.

On business-oriented hospital management, he said what was required was a balance between health care expertise and mechanisms to develop competency needs indicators. Key issues identified at the recent launch of the public hospital CEO forum, were training and experience needs, and minimum standards.

Mahlati stressed that government had a major hospital revitalisation programme, 'looking at HR, equipment, you name it – the effects of working in a debilitated hospital cannot be underestimated,' he conceded.

He cited the recent upgrading of Kimberley Hospital and its ancillary facilities, the new Nelson Mandela Academic Hospital in Umtata, the new Nkosi Albert Luthuli Tertiary Hospital in Durban and the upgrading of the Mary Theresa District Hospital near Mount Frere. All were now attracting health care professionals.

Distance education however was a statutory council function, not a government one. 'We put in the infrastructure and then leave it up to the professionals to do continuing education and linking up for procedures.' So far government had 28 telemedicine sites in place.

The DOH was in discussions with the Democratic Nurses' Organisation (Denosa) and the Nursing Council in

order to 'critically evaluate' the various nursing categories 'so we can ensure we remunerate properly'.

'I'm not sure that the scarce skills allowance is the answer here – we're in the early stages of discussion. Broadly speaking it will depend on these discussions.'

Specialisation in nursing created new challenges and difficulties in singling out categories. Short-term measures, especially with nurses, were not the answer. 'We may end up with people saying the whole nursing profession is a scarce skill,' he observed.

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Mahlati said he was 'in dialogue' with SAMA, the Colleges of Medicines, the Health Professions Council and the Committee of Deans of Health Sciences Faculties to address the education and training that vitally underpinned all service provision. 'We're trying to develop a HR plan where all these groups will be represented. The reality is that the gap between the public and private sector has to be narrowed significantly – not all is well in the private sector, not because of transformation legislation but because of market issues,' he added.

**Chris Bateman**