Analyzing the implementation of the rural allowance in hospitals in North West Province, South Africa

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Abstract  Using a policy analysis framework, we analyzed the implementation and perceived effectiveness of a rural allowance policy and its influence on the motivation and retention of health professionals in rural hospitals in the North West province of South Africa. We conducted 40 in-depth interviews with policymakers, hospital managers, nurses, and doctors at five rural hospitals and found weaknesses in policy design and implementation. These weaknesses included: lack of evidence to guide policy formulation; restricting eligibility for the allowance to doctors and professional nurses; lack of clarity on the definition of rural areas; weak communication; and the absence of a monitoring and evaluation framework. Although the rural allowance was partially effective in the recruitment of health professionals, it has had unintended negative consequences of perceived divisiveness and staff dissatisfaction. Government should take more account of contextual and process factors in policy formulation and implementation so that policies have the intended impact.


Keywords: rural allowance; policy analysis; motivation; retention; health professionals; South Africa

Introduction

Worldwide, there is a shortage of health professionals working in rural areas\textsuperscript{1,2} and this is a major obstacle to achieving the health Millennium
Development Goals and improving health service access. South Africa has more health professionals than neighboring African countries, but it has a severe mal-distribution of personnel between the public and private sectors and between rural and urban areas. In 2004, 46 per cent of the South African population lived in rural areas, yet they were served by only 12 per cent of doctors and 19 per cent of nurses.

The South African government has made several attempts to redress the imbalance of health professionals between rural and urban areas (Table 1), but researchers or government have not evaluated implementation of these policies systematically.

We analyzed the implementation and perceived effectiveness of a rural allowance policy and its influence on the motivation and retention of health professionals in rural hospitals in the North West province of South Africa. The results are part of a larger multi-country project investigating health worker motivation and retention in South Africa, Tanzania, and Malawi. Table 1 summarizes South Africa’s relevant post-apartheid policy initiatives to provide context.

Methods

Conceptual framework

We used the Walt and Gilson policy analysis framework focusing on four related factors critical to understanding public policy-making (Figure 1): actors, policy content, contextual factors, and process.

Study design

We used a multiple descriptive case study design, with complementary methods: document reviews, key informant interviews with policy-makers, and in-depth interviews with hospital managers and with health professionals.

Study setting

We conducted the study in the North West province, a predominantly rural province with a population of 3.2 million (6.4 per cent of the total South African population). We selected five hospitals out of a total
Table 1: Policy initiatives to address mal-distribution between rural and urban settings in South Africa

<table>
<thead>
<tr>
<th>Year</th>
<th>Policy initiative</th>
</tr>
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<tbody>
<tr>
<td>1996</td>
<td>Government recruited first group of Cuban doctors and initiated training of medical doctors in Cuba</td>
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<tr>
<td>1997</td>
<td>Government released White Paper for the transformation of the health system, containing recommendations on equitable health professional distribution</td>
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<tr>
<td>1998</td>
<td>Government introduced community service for doctors and for allied health professionals, making it mandatory for these health professionals to work in under-served areas for a 1-year period</td>
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<tr>
<td>2004</td>
<td>Government introduced a:</td>
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<tr>
<td></td>
<td>• Rural allowance to attract and retain certain health professionals in rural facilities</td>
</tr>
<tr>
<td></td>
<td>• Scarce skills allowance to attract and retain certain categories of health professionals in the public health sector</td>
</tr>
<tr>
<td></td>
<td>Government released a policy on the recruitment and employment of foreign health professionals restricting recruitment to persons with verified qualifications and competencies to work in under-served areas</td>
</tr>
<tr>
<td></td>
<td>Government finalizes a bilateral agreement with Iran to allow Iranian doctors to work in rural South African health facilities</td>
</tr>
<tr>
<td>2005</td>
<td>Government promulgated the National Health Act No. 61 of 2003 with a certificate of need provision for health professionals wishing to establish a private practice to decrease the concentration of health professionals in urban areas. This clause has never been enacted</td>
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<tr>
<td>2005</td>
<td>Commonwealth Ministers of Health signed an agreement regarding the ethical recruitment of health workers</td>
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<tr>
<td>2006</td>
<td>Government releases a National Human Resources for Health Framework to address the critical shortage of health professionals</td>
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<td></td>
<td>Activists developed a Draft Rural Health Strategy for South Africa to improve health services in rural areas in the period 2006–2009</td>
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<tr>
<td>2007</td>
<td>Government signed an agreement to allow recruitment of Tunisian medical practitioners for temporary employment in rural areas</td>
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<tr>
<td>2008</td>
<td>Government released a National Nursing Strategy for South Africa</td>
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<td></td>
<td>Government introduced community service for nurses, making it mandatory for nurses with 4-year diplomas or degrees to work in the public sector and under-served areas for a 1-year period</td>
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<tr>
<td>2008–2010</td>
<td>Government introduced occupation specific dispensation, that is salary categories specific to each occupational category in the health sector</td>
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<tr>
<td>2010</td>
<td>World Health Organization launched a set of recommendations on increasing access to health workers in remote and rural areas through improved retention in Johannesburg, South Africa</td>
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of 30: all three district hospitals participating in a national hospital revitalization programme (the broader study focus), and two other randomly selected hospitals.

**Research instruments and study participants**

The University of the Witwatersrand and the North West Department of Health Research Ethics Committee approved the study, as did hospital managers. All participants signed consent forms after receiving an information sheet.

The study team reviewed relevant National Department of Health policies, including the rural allowance policy to understand its content, along with relevant media releases. We then selected policymakers purposively on the basis of their influence or knowledge about the rural allowance policy process. We used a ‘snowballing’ sampling approach, asking each policy-maker to identify others to
interview. The study team conducted face-to-face key informant interviews with seven policy-makers from national and provincial government and health professional bodies using a semi-structured interview guide derived from the policy framework. We also conducted in-depth interviews with five hospital managers, 22 nurses, and six doctors in the study hospitals. We taped all in-depth interviews and then transcribed them.

Analysis

We conducted a thematic content analysis using the ATLAS.ti software program, using a common coding framework to ensure consistency. Two researchers first independently read six transcripts from different groups of participants and then discussed coding discrepancies until they reached agreement.

Findings

Analyzing the rural allowance policy

Contextual factors

In 2004, near the time of the country’s second democratic elections, the South African government introduced a rural allowance policy to address geographical inequities in health personnel distribution within the country. Although the timing suggests a political motive, one respondent commented on the context of policy implementation:

It was a huge policy problem that we have enormous inequities in the distribution of doctors in rural areas. The reason for the rural allowance is that health workers tend to drift to cities, so countries put in place incentives like rural allowances to try to send most of the health workers to more remote areas. (Policy-Maker 7, National Government)

Policy content

The intention of the rural allowance policy was to attract and retain health professionals to work full-time in public health services in rural, under-served, and other inhospitable areas identified by provincial health departments. Government awarded the rural allowance, a
non-pensionable fixed percentage linked to the annual salary notch\textsuperscript{10} to most categories of health professionals including doctors, dentists, dieticians, pharmacists, psychologists, radiographers, therapists, and professional nurses with 4-year diploma or degree. The policy excluded junior nurses (enrolled nurses with 2 years of training and nursing assistants with 1-year training).

Government paid doctors allowances of 18–22 per cent of their annual salaries, 8–12 per cent for professional nurses, and awarded payments retrospectively to July 2003. We could not determine why policy-makers excluded junior nurses, how they determined the salary percentage additions, or what information they considered to set the allowance scale. Policy-makers, when interviewed, were also unclear on the evidence that guided the rural allowance decisions. One policy-maker commented on the lack of evidence used to inform the development of the rural allowance:

I think there wasn’t proper research done to say what is it that other countries are paying \textit{to} keep their doctors. (Policy-Maker 5, Health Professions Council)

The rural policy called for an annual review of the allowance, notably the percentage allowance and health professional eligibility.

When the rural allowance was introduced, the Department of Health was required to conduct an analysis as part of the agreement. I think it was supposed to be an annual or every third year analysis, I can’t remember the specifics. That would then determine if they needed to roll it out further or extend it. (Policy-Maker 2, National Government)

The Department of Health has not conducted a review nor has it evaluated the effectiveness of the rural allowance:

I can’t say whether rural allowance is effective or not, because we haven’t done research \ldots, I am not sure whether the allowance brought more doctors and health professionals into those areas and secondly if at all they were retained there. (Policy-Maker 2, National Government)
Media releases in 2004 quoted the Minister of Health claiming that the rural allowance would benefit 33,000 full-time health professionals working in designated areas; and that an entry-level medical doctor working in a rural area with an annual salary of R150,000 (US$21,000; $1 = R7) would gain R15,000 (US$2100) per year.11

Government added R500 million (approximately US$71 million) in 2004 and a further R750 million (US$107 million) in 2005 for the implementation of the rural allowance.12 In the absence of evaluations or annual reviews, we do not know how many health professionals benefited from the allowance.

Policy implementation

The interviews with policy-makers and health managers indicated that there were problems with the implementation of the rural allowance policy. At least four policy-makers and all hospital managers reported that the Department of Health failed to implement this policy effectively, leaving information gaps, uncertainty, and room for subjective policy interpretation. Provincial health departments designated ‘rural areas’ without national oversight for consistency within or across provinces. For awarding rural allowances, the provincial Department of Health relied on an outdated list of hospitals that excluded a number of rural institutions:

I think rural allowance was most appropriate but it was not necessarily implemented correctly because the declaration of what is rural depended on the provinces. And the problem is that if you leave any policy to individual interpretation, you’ll actually have a problem. (Policy-Maker 1, National Government)

Communication among hospital managers and health professionals, particularly those in excluded categories, was another weakness:

There was no clear communication to the nursing profession resulting in confusion. And even managers within the health services found it difficult to understand. As a result, when nurses queried whether they are eligible or not, the responses they got were often not helpful. (Policy-Maker 6, Health Professions Council)
Actors and their roles
The key institutional actors included the Department of Health, the National Treasury, the Department of Public Service and Administration (DPSA), representatives from the Public Health and Welfare Sectoral Bargaining Council, and the relevant trade unions. One respondent defined the role of the DPSA:

We as the DPSA assist in dealing with all financial implications and technical implementation. The reason for that is that our own minister [of DPSA] is the person who can determine or approve any allowance in the Department of Health. (Policy-Maker 2, National Government)

Perceived effectiveness of the rural allowance
Figure 2 presents key themes about perceptions of all the respondents on the effectiveness of the rural allowance and links between the policy development and implementation processes.

Partial effectiveness of rural allowance in recruitment
Some hospital managers reported that the rural allowance had been partially effective in attracting health professionals to their

Figure 2: Key themes on the perceived rural allowance effectiveness and linkages with the policy development and implementation processes.
facilities. One commented:

Since our hospital was considered rural and our nurses started getting the rural allowance, we were able to attract more nurses. (Hospital Manager 9, District Hospital)

Other managers argued that the rural allowance was only effective in addressing short-term recruitment needs:

... you give people a rural allowance but salary excites you for the first three to four months. And we know, the more you earn, the more you want ... and that’s basically the challenge, it doesn’t make a sustainable impact. (Hospital Manager 1, District Hospital)

_Rural allowance seen as divisive_

Almost all policy-makers, hospital managers and health professionals (doctors and nurses) consistently perceived the rural allowance to be divisive because it excluded junior nurses. The excluded cadres felt undervalued and dissatisfied, thus affecting team spirit.

The rural allowance is only paid to professional nurses. Enrolled nurses and assistant nurses are not getting a rural allowance ... this causes a lot of conflict because sometimes if you work with a registered nurse, and she wants you to assist her, you say to her: “do your work; you are getting the rural allowance”. (Enrolled Nurse, District Hospital)

Some nurses (professional and junior nurses) felt that equity was compromised in the implementation of the rural allowance:

I feel that the rural allowance is unfair ... It can be better if we were all getting it because personally I feel bad because it looks like some of us are better than others. (Professional Nurse, District Hospital)

All doctors and most of the professional nurses who received the rural allowance indicated that it was low relative to their total salary and felt unhappy that this amount would not be included in the calculation of their retirement pensions.
Remoteness of the area not considered
The implementation of the rural allowance was not linked to the remoteness of rural areas. Health professionals working in deep rural areas received no more than those in semi-rural areas. One hospital manager commented:

The problem with the rural allowance is that what a person gets here [deep rural area], is the same amount that a person gets in Vryburg [rural town]. The semi-rural areas should have a lower percentage than the extremely rural areas. (Hospital Manager 3, District Hospital)

Financial incentives alone are insufficient
Most participants (nurses, doctors, health managers, and policymakers) indicated that financial incentives alone are insufficient to motivate and retain staff.

You can give people a million [rands] but after a year they will go. So the strategy should not only be about money. It is true, money helps but if you have kids that go to school, you won’t come here because there are no good schools. But there are other things that the management can do; they can send people for training. For example, people can be sent to a bigger hospital for six months to enhance their speciality skills. (Doctor, District Hospital)

A doctor in a Regional Hospital commented:

I get a rural allowance; it’s about two thousand rands. For me to get to town just to get a decent meal at a restaurant, I have to travel for about 80 km. There are no recreational facilities here. So you actually spend that money on transport anyway.

Discussion
This study illustrates that good policies with admirable intentions can have reduced impact or even negative consequences because of process and implementation weaknesses. The successful implementation of future retention strategies will require more coordinated effort across
a range of governmental actors. Particular attention needs to be paid to process issues, better communication, use of evidence to inform policy and effective monitoring and evaluation.

Previous reviews of retention strategies found that financial incentives can improve recruitment and retention in the short-term, but long-term impact on retention is less certain.\textsuperscript{13–15} We found unintended negative consequences from design and implementation shortcomings. Our findings contrast with those of Reid\textsuperscript{5} who found that between 28 and 35 per cent of his study population, mainly professional nurses, remained in rural hospitals as a result of the rural allowance. Reid collected data soon after the implementation of the policy and near in time to the large back-dated payouts received by health professionals. Both could have influenced responses. In the absence of before and after studies, evidence on the effectiveness of financial incentives remains inconclusive.\textsuperscript{14}

Some studies found that financial incentives alone are insufficient to motivate and retain health professionals.\textsuperscript{16,17} Some demonstrated that non-financial incentives related to working and housing conditions had greater potential to influence retention.\textsuperscript{18,19} Others recognized that health professionals will always move, often for reasons beyond the influence of any workforce retention programme, no matter how well designed.\textsuperscript{14} Thus, no single measure is likely to improve motivation and retention if other factors are not taken into consideration.

The provincial governments’ efforts to engage and consult with local managers and providers during implementation of the policy were weak, particularly in relation to the exclusion of junior categories of nurses and the differential allowance increases. Central level policy-makers were the key actors driving the overall policy process, suggesting a top–down approach in the formulation of the rural allowance policy.

Policy development should be guided by the best available evidence and every attempt should be made to generate rigorous evidence if novel or untested policies are adopted.\textsuperscript{20} Because respondents perceived the rural allowance to have had limited effect on the motivation and retention, policy-makers should obtain better data on the factors that influence health workers’ location choices in order to develop more appropriate human resource interventions in future.\textsuperscript{21}

Although the rural allowance policy document called for annual reviews, government did not develop a framework to monitor potential
implementation challenges nor evaluate policy impact. The rural allowance is an expensive intervention to have been left without proper evaluation.

Limitations

Our data are valuable as they represent views of those closely involved in formulating the policy or responsible for its implementation, but we recognize that such accounts are inevitably influenced by the respondents’ viewpoints at the time of the event and the interview. Another limitation of the study is that it was only conducted in one province although some aspects of the policy formulation relate to national processes.

Conclusion

The use of financial incentives to motivate and retain health professionals is particularly challenging; limited resources make it difficult to provide allowances to all categories of health professionals, their impact may be short-lived, and they may be inadequate if implemented alone. Retention strategies combining financial and non-financial incentives are likely to be more effective than increased remuneration alone, but these would need to be tailored to individual country contexts.

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