

# **NURSES' PERCEPTIONS OF THE IMPLEMENTATION OF OCCUPATIONAL SPECIFIC DISPENSATION AT TWO DISTRICT HOSPITALS IN THE GAUTENG PROVINCE OF SOUTH AFRICA**

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## **ABSTRACT**

This paper explores nurses' perceptions of the implementation of occupational specific dispensation (OSD) at two selected district hospitals in the Gauteng province of South Africa. At each hospital, in-depth interviews were conducted with key informants that included the chief executive officer, nursing service manager, human resource manager, and trade union shop steward (n=8). Day duty nurses (n=27), who were permanently employed, completed questionnaires after informed consent had been obtained. Both the interview schedule and questionnaire focused on the OSD policy and its implementation.

Key informants and nurses were of the opinion that the OSD resulted in nurses' salary improvements and facilitated the hospitals' ability to attract nurses with specialised skills. However, 72.0% of day duty nurses indicated that the OSD had been implemented unfairly, 54.1% that OSD demoralised them and 58.3% that OSD adversely affected the relationships between management and nurses. Only 24.0% of the nurses agreed that communication around OSD was good, and 22.7% agreed that OSD improved service delivery.

The participating nurses had both positive and negative perceptions about the OSD implementation. Recommendations include: clear communication to ensure the same understanding of the policy; involvement of front-line nurses; training to ensure uniform interpretation and implementation; and improved monitoring and evaluation of the OSD implementation.

**Keywords:** health human resources, health policy, occupational specific dispensation, nurses' remuneration in South Africa

## **INTRODUCTION AND BACKGROUND INFORMATION**

The health system in South Africa experiences challenges of health work force production, recruitment and retention (DOH, 2011:10). A holistic and innovative approach towards strengthening human resources for health is critical for the improved performance of the health system (DOH, 2011:11). Significant policy developments during the last decade included the development of an overall human resource development strategy, various training and capacity building initiatives, community service for health professionals, infrastructure upgrading and the implementation of various financial incentives (DOH, 2006 & 2010).

During 2007, the South African government implemented Occupational Specific Dispensation (OSD), a financial incentive that enabled the introduction of new salary scales for identified occupations in the public sector (PHSDSBC, 2007:2). The OSD policy aimed to attract and retain employees, thereby improving service delivery in the public sector (DPSA, 2007:1; PHSDSBC,2007:1). The OSD policy defines the remuneration structure, frequency of pay progression, grade progression opportunities, career pathing, recognition of appropriate experience, required levels of performance, and translation measures of identified occupations (DPSA,2007:1; PHSDSBC,2007:1). The OSD implementation commenced with the nursing sector.

## **PROBLEM STATEMENT**

A 2009 review of health system performance reported inadequate planning prior to the introduction of the OSD, resulting in variations of and inconsistencies in the policy implementation across the nine South African provinces (Integrated Support Teams, 2009:9).

## **STUDY OBJECTIVES**

The study objectives were to

- explore key informants' and nurses' understanding of the OSD policy
- determine nurses' perceptions of how the OSD policy influenced remuneration, hospital service delivery, relationships between management and nurses and relationships among different categories of nurses
- assess nurses' perceptions about the OSD implementation and
- obtain nurses' recommendations for improving policy implementation.

## **DEFINITIONS OF KEY TERMS**

**Human resources** simply individuals who make up the workforce of an organisation.

**Health policy** embraces courses of action that affect institutions, organisations, services, and funding arrangements of the health care system (Buse et al., 2005: 6).

**Nurses** are persons registered in terms of the Nursing Act No 50 of 2005 to practise nursing and/or midwifery in South Africa.

**Occupational specific dispensation (OSD)** entails a revised salary structure unique to each identified occupation in the public service of South Africa.

## **RESEARCH METHODOLOGY**

### **Ethical considerations**

The University of the Witwatersrand Human Research Ethics Committee, the relevant health authorities and the hospitals' chief executive officers granted permission to conduct the study.

### **Conceptual framework**

This study focused on the context, content, actors and process of the development and implementation of the OSD policy. The 'Walt/Gilson Health Policy Triangle' was used as the framework of analysis (Buse et al., 2005:8). The triangle focuses on understanding the forces and factors that influence why and how policies are initiated, formulated, and implemented and consists of four aspects: context, content, actors and process (Buse et al., 2005:8). Context refers to 'systemic factors—political, social and economic- impacting on health policy' (Buse et al., 2005:11). Content relates to the specific nature and design of policies, the interaction between these policies and other institutional changes, and the implementation guidelines. Actors are about the people or organisations involved in health policy changes, the roles of these policy actors and how they use their power in taking forward, blocking or challenging policy implementation. Process is concerned with the way in which policies are identified, formulated and implemented (Buse et al., 2005:9-15).

### **Study setting**

The study was conducted in Gauteng, a predominantly urban province and the economic powerhouse of South Africa, with a population of around 10 million (20.0% of the

South African population) (Statistics South Africa, 2011:3). During 2010, two out of ten Gauteng district hospitals with 150 and 144 beds respectively, were selected purposively for the study.

### **Study participants and data collection**

The research team reviewed relevant government documents, media releases and hospital policy directives in order to understand the context and content of the OSD (DPSA, 2007:2; PHSDSBC, 2007:1). To gain insight into actors and processes of the OSD implementation, the population of interest comprised hospital managers, trade union shop stewards and all nurses working at the two selected hospitals. Data were collected from 20 December 2010 until 20 January 2011.

A combination of qualitative and quantitative methods was used for the study. All study participants signed consent forms after receiving a study information sheet. Confidentiality and anonymity were maintained because no institution or person's name was entered on any completed questionnaire and the interviews were numbered. The collected data were kept locked up and protected with a secure password on the computer. The raw data will be destroyed two years after publication of all the study findings.

At each hospital, key informants included the chief executive officer, nursing service manager, human resource manager and trade union shop steward. These persons were interviewed using semi-structured interviews, comprising the key informants of the study. In the qualitative component, trustworthiness was addressed through pre-testing of the interview schedule, digital recording of the interviews, verbatim transcription, and independent verification of the interview content. The questions focused on the background and context of OSD for nurses; implementation of OSD at the particular hospital; successes of the OSD implementation; challenges experienced; and recommendations for improving OSD implementation. Each digitally recorded interview lasted about 45 minutes, and was transcribed verbatim. All interviews were done by one interviewer, while a second person took detailed notes during each interview and wrote a synopsis. In total, eight key informant interviews were conducted.

In each district hospital, all day duty nurses, who were permanently employed, and working in the hospital's emergency division and in-patient wards, were requested to complete a pre-tested, self-administered questionnaire, specifically designed for the study. The questionnaire contained sections on demographic information, 11 statements on the OSD policy using a seven point Likert scale, and five open-ended questions on their understanding of the OSD, benefits and challenges of the OSD policy, and whether OSD could have been implemented differently.

## **Data management and analysis**

The key informant interviews and the nurses' responses to open-ended questions were analysed, using thematic content analysis (Anderson, 2007:1). The first step in the analysis was to examine words and phrases without preconceived notions or classifications. The language used by each participant was then examined in light of the following questions:

- What was the understanding of the OSD, its rationale and goals?
- How did people view their involvement in policy implementation?
- What was the experience (both positive and negative) with the OSD policy implementation?

The information was then analysed for emerging themes and subsequently grouped into thematic categories in line with the health policy triangle, namely context, content, actors and process.

The information from the self-administered questionnaires was analysed using Stata version 10. Given the small sample size, only descriptive analyses were done. The three categories of slightly agree, agree and strongly agree were combined into one category called 'agree'. Similarly, the three categories of slightly disagree, disagree and strongly disagree were combined into one category called 'disagree'. The data from the qualitative interviews, the nurses' questionnaires and the analysis of the OSD policy documents and hospital circulars were triangulated to arrive at the findings reported in this paper.

## **RESULTS**

### **Demographic characteristics**

Out of 32 nurses, 27 completed questionnaires at the two district hospitals (12 in district hospital 1; 15 in district hospital 2), resulting in a response rate of 84.3%. Most respondents (88.9%; n=24) were females and 62.9% (n=17) had completed the four-year nursing courses. The mean age of participants was 43, ranging from 26 to 60.

### **The policy context of OSD**

The OSD was part of ongoing government efforts to recruit and retain health care professionals in the public sector through specific policy interventions (DOH, 2006; DPSA, 2007:2). There was intense lobbying by organised labour, particularly by the Democratic Nursing Organisation of South Africa (DENOSA), for improved

remuneration. The OSD agreement followed a protracted public servants' strike during 2007 (Gray, 2007:18-20).

The eight key informants were knowledgeable about the rationale and goals of OSD, and indicated that the policy intended to facilitate recruitment and retention of scarce nursing skills, improve remuneration, and recognise work experience and specialised qualifications, as illustrated by the following comments:

*“Prior to the OSD, there was a lot of what was called brain drain where nurses were leaving the public service to go either private or overseas. OSD was actually a strategy to attract the skills back to the public service and to retain the skills.”*

*“I think the goal of [the] OSD policy was to improve the salary packages for nurses... it was to create a career path for nurses, to give recognition to certain qualifications within nursing, and to also create opportunities for further development within the nursing ranks and to attract and retain nurses.”*

In contrast, front-line nurses' responses revealed insufficient understanding of the OSD aims, and misperceptions, as revealed by the following quotes:

*“This tool was supposed to acknowledge nurses for their hard work and dedication by giving them incentives, but it was just a rip off.”*

*“Occupation specific dispensing [sic] which applies only to professional nurses working in specific units or has a speciality as post-basic qualification.”*

### **OSD policy content**

The OSD for all categories of nurses came into effect in July 2007, and was applicable to nurses employed at government departments of health, education or correctional services. The key elements of the policy included:

- definitions of each occupation's scope, with centrally determined grading structures (work levels and job descriptions) and competency requirements per post/grade level in order to ensure consistent application between provinces/departments
- unique salary structures addressing the specific requirements of the occupations, with stipulated percentage increments between notches to encourage nurses to continue in clinical practice, rather than move into a supervisory positions in order to earn higher salaries
- pay progression system, as part of the career pathing model that allows for a 3% increment every two years, provided that employees comply with the qualifying criteria

- career pathing by means of grade progression at production levels. However, the career progression is not an automatic salary increase, but dependent on above average performance, qualifications and experience
- dual career path allowing professional nurses to progress to higher levels and earn higher salaries when entering specialised clinical fields (oncology, intensive care) without moving into management posts
- consolidation of scarce skills allowances payable to professional nurses working in oncology, intensive care and operating theatre
- salary recognition that allows the appointment of employees from outside the public service on higher notches/levels, taking account of relevant experience (DPSA, 2007:1).

The policy directive stipulates that, although nurses' salaries will not be reduced on translation to the OSDs, no general salary increase is implied nor will all nurses get the same financial benefit with the OSD implementation. The 22-page directive, with eight annexures, also contains guidance on post and salary structures; translation to different OSDs; translation of professional nurses not in possession of prescribed qualifications, but who have been working in the area for a long period; organisational structures; promotion; pay progression; job grading; and implementation phases (DPSA, 2007:1&3).

### **Policy actors**

Numerous actors were involved in the OSD policy development and implementation. These include national government ministries (public service and administration; health; treasury); provincial departments of health, including health facilities; DENOSA and health trade unions. The main policy implementers were management teams at hospitals. Following the OSD bargaining council agreement, the DPSA was the custodian of the OSD policy and developed implementation guidelines (DPSA, 2007:3). The Department of Health and DENOSA were perceived to be the main policy actors, as shown by the following verbatim quotes:

*"I think the Department [of Health] nationally together with the labour structures because basically the two were in a position to meet and consultation was done from initiation until implementation".*

*"DENOSA had more influence, because they understood the dynamics of nursing in terms of qualifications".*

However, key informants reported that there was insufficient consultation with them on the OSD policy development. All key informants at the two district hospitals indicated that they did not take part in the OSD policy development, and none had seen a prior

draft of the policy for submitting inputs. Nonetheless, the key informants indicated active involvement with the actual implementation of the policy, using the DPSA guidelines and departmental circulars.

### **Perceived positive aspects of OSD implementation**

The three main perceived OSD benefits that emerged from the key informants were salary improvements, the ability to recruit nurses with specialised skills and staff retention. Most key informants indicated that the salary improvements were one of the main benefits of the OSD policy:

*“We often say money is not the motivator but it is so. The key factor is that people were earning a lot of money [through OSD] and their salaries were matching with inflation, I think the key factor was the salary increase”.*

This finding was supported by the findings obtained from the questionnaires completed by nurses at the two participating hospitals: 56.0% (n=14) agreed that ‘OSD improved my salary’ and 56.0% (n=14) agreed that ‘OSD is a good policy’ (see table 1). Nurses’ responses to the open-ended questions concerning OSD benefits revealed that some received significantly higher salaries or had been adjusted upwards from a perceived low-income base.

Key informants also indicated that the OSD improved the hospital’s ability to attract nurses with specialised skills, such as critical care nursing, when they stated:

*“We were able to attract experienced people from abroad and basically they were excited when they saw the salary scales. Also from the private sector, we were able to attract people from speciality areas.”*

*“I think OSD has worked in attracting those specialities that we didn’t have. It helped in keeping a lot of specialised nurses in the clinical area – [nurses are] not opting to go for managerial positions.”*

### **Perceived negative aspects of OSD implementation**

The perceived negative aspects of OSD related to policy design (including the eligibility criteria of OSD), but primarily to implementation (misinterpretation of the policy, erroneous or outstanding payments), leading to unintended consequences (unhappiness among nurses who did not benefit or whose posts were incorrectly translated). One key informant commented:

*“OSD has been implemented and there was a lot of excitement in terms of recruitment and retention of staff but in district hospitals there are still wounds that are not*

*healing. The nursing manager of the district hospital is earning the same salary as area managers.”*

Key informants reported that challenges related to the different interpretations of the policy, particularly around the so-called ‘grandfather clause’, recognising nurses without formal speciality qualifications, but who had worked within the speciality area at the time of OSD policy implementation (DPSA,2007:4; PHSDSBC,2007:3). This recognition resulted in their translation at an entry salary level of the speciality, as illustrated by the following quotations:

“It [OSD implementation] was not 100% smooth....there were errors where people were either overpaid or underpaid. There was a lot of misinterpretation of those clauses [in the OSD policy]. Sometimes, when we compared with other institutions, we would find that the whole document was interpreted differently.”

*“The unhappiness was around the understanding of OSD.... you find that the grandfather clause- not everybody understood it the same way as the document is saying”.*

*“Implementation in Gauteng was a challenge. We had grievances with implementation. For example, within this hospital our infection control nurse was at level 7 [of the salary scale] and in level 2 regional hospitals, the infection control nurse was at level 8 [of the salary scale]. The initial circular that was given to us was saying the clinical coordinator [for infection control] that needs to be translated must be at level 8, but that caused disparity and we had grievances around that.”*

The key informants’ interviews suggest that erroneous or outstanding payments were problematic aspects of implementation, leading to unhappiness among nurses:

*“People who were overpaid were not happy to pay back the money because it was thousands and they had already spent it. It was not pleasant for them to pay back.”*

*“You see every translation has a monetary value attached to it. The longer your service, the more money you would get on translation. Managers were fighting for recognition of their experience because recognition of experience goes with money and they were only translated into a management salary bracket without recognition of their experience and years of service because of the nature of the resolution itself, so that caused dissatisfaction amongst managers.”*

The nurses had negative perceptions of OSD implementation: 72.0% (n=18) of nurses agreed that the OSD was unfairly implemented; 54.2% (n=13) agreed that the OSD demoralised them and 58.3% (n=14) agreed that OSD adversely affected the relationships between management and nurses (see table 1).

**Table 1:** Nurses' perceptions of the implementation of the OSD policy

Statement	Strongly disagree n (%)	Disagree n (%)	Disagree slightly n (%)	Neither disagree nor agree n (%)	Agree slightly n (%)	Agree n (%)	Strongly agree n (%)
OSD improved my salary n=25	5(20.0%)	6 (24.0%)			6(24.0%)	6(24.0%)	2(8.0%)
Unions influence on OSD was helpful n=25	6(24.0%)	4(16.0%)	3(12.0%)	3(12.0%)	1(4.0%)	8(32.0%)	
OSD demoralised nurses n=24	4(16.7%)	5(20.8%)		2(8.3%)	2(8.3%)	5(20.8%)	6(25.0%)
OSD adversely affected the relationship between management and nurses n=24	2(8.3%)	2(8.3%)	3(12.5%)	3(12.5%)		8(33.3%)	6(25.0%)
Communication about OSD was good n=25	9(36.0%)	7(28.0%)	1(4.0%)	2(8.0%)	3(12.0%)	3(12.0%)	
OSD improved service delivery in the hospital n=22	6(27.3%)	4(18.2%)	2(9.1%)	5(22.7%)	3 (13.6%)		2 (9.1%)
Management asked nurses for their views on OSD n=24	11(45.8%)	6(25.0%)	1(4.2%)	2(8.3%)		4(16.7%)	
OSD was unfairly implemented n=25	2(8.0%)	1(4.0%)	2(8.0%)	2(8.0%)	1(4.0%)	5(20.0%)	12(48.0%)
OSD favoured professional nurses n= 24	4(16.7%)	3(12.5%)	1(4.2%)	2(8.3%)	1(4.2%)	6(25.0%)	7(29.1%)
Enrolled and auxiliary nurses benefited from OSD n= 24	5(20.8%)	5(20.8%)	3(12.5%)		4(16.7%)	6(25%)	1(4.2%)
OSD is a good policy n=25	4(16.0%)	1(4.0%)	1(4.0%)	5(20.0%)	2(8.0%)	5(20.0%)	7(28.0%)

Similar themes of misinterpretation of the OSD policy, perceived unfairness, or poor implementation emerged from nurses' responses to open-ended questions, as shown by the following responses:

*"There was misunderstanding of the OSD document e.g. the grandfather clause on implementation. Casualty [the emergency division] didn't qualify according to management, but the whole maternity ward qualified. The reason given was that this hospital is a district hospital"*

*"People did not get the same amount of money; even if they are in the same position and have the same years of experience. Others did not get it at all- in some cases people working in the same department, doing the same duties- one got it the other person did not."*

*"There was favouritism- people favoured were taken to speciality wards. Even if they don't have specialities, they got money, and you with the speciality being stationed in general wards got nothing."*

Only 24.0% (n=6) of nurses agreed that there was good communication around OSD, while 16.7% (n=4) agreed that nurses' views were elicited about OSD implementation. Only 22.7% (n=5) agreed that OSD improved service delivery in the hospital.

The responses to open-ended questions suggest that the policy implementation caused divisions within the nursing profession, and that there was general unhappiness because professional nurses were the primary beneficiaries of OSD. These financial benefits were higher if professional nurses had specialised skills (such as critical care nursing). In the survey 58.3% (n=14) of nurses agreed that OSD favoured professional nurses. Nurses said, in response to an open-ended question concerning the OSD implementation at their hospitals:

*"OSD only caused injustice and further confusion among the nursing community".*

*"I know we differ according to our rank but truly speaking professional nurses benefited a lot, may be ten times more than other [categories of] nurses".*

A key informant commented as follows on the perceived division within nursing:

*"In terms of recognition of experience of [nursing] managers, that's a burning issue which could have been done differently. The gaps between the salaries of enrolled nurses, auxiliary nurses and professional nurses could have been done differently; the recognition of enrolled nurses performing duties in speciality areas could have been done differently".*

Unintended consequences of the policy, included difficulties with the rotation of nurses:

*“Previously when you have a gap in a certain [clinical] area you could just move nurses around but now after OSD you have to be very cautious in terms of movement because there is money involved. You have to consider whether you are going to be paying people according to the speciality area that you are putting them in.”*

## **DISCUSSION**

The analysis of OSD policy implementation is important because the remuneration of health workers affects their motivation, performance and morale and the ability of employers to attract and retain staff (Bärnighausen et al., 2010:1; McCoy et al., 2008: 78). Policy analysis is useful for informing the implementation of the same policy among different groups of beneficiaries or in different, but comparable settings (Morestin et al., 2010:3), or to make judgements about the generalisability of the findings, given contextual factors (Rychetnik et al., 2002:119).

This study found that the key informants and the nurses at the two hospitals viewed the OSD policy positively as it resulted in nurses' salary improvements and facilitated the hospitals' abilities to attract and retain nurses with specialised skills. This is important as low salaries are de-motivating to health workers (Willis-Shattuck et al., 2008:5) and the introduction of financial incentives has been shown to improve the retention of health workers in rural areas (Bärnighausen et al., 2010:1).

Notwithstanding the positive aspects of OSD for improving nurses' remuneration, recruitment and retention, several implementation weaknesses were evident. These relate to different interpretations of policy guidelines, perceived unfairness of implementation, and insufficient communication between policy-makers and implementers of the OSD guidelines. Unintended consequences of OSD policy implementation included feelings of demoralisation among frontline nurses, perceptions of adverse relationships between management and nurses, and among different categories of nurses.

This study supports existing evidence on the gap between policy and implementation (Gilson et al., 2008:749; Hanney et al., 2003:2; Pick et al., 2008:166). In the case of South Africa, the challenges of health policy implementation are widely recognised, ranging from frontline nurses' perceptions of the implementation of the Public Finance Management Act (Penn-Kekana et al., 2004:i73 ), through to the implementation and perceived effectiveness of a rural allowance policy in hospitals in the North West Province of South Africa (Ditlopo et al., 2011:s85). Similar to this study, these local studies have found that new policies have had unintended negative consequences, including undermining the quality of care; staff dissatisfaction; and divisiveness among different categories of staff (Ditlopo et al., 2011:s86; Penn-Kekana et al., 2004:i74).

Although the DPSA in South Africa drafted a detailed set of OSD implementation guidelines, some complex clauses (such as the grandfather clause) were interpreted in different ways by local managers and did not take into account the nuances of staffing structures and grading levels at different hospitals. There appeared to be insufficient consultation of local management teams to provide feedback about the guidelines, a top-down approach to the formulation and implementation of the policy, insufficient training, and inadequate monitoring during OSD implementation.

## **CONCLUSION**

The OSD implementation, despite detailed policy guidelines, lead to different interpretations of these guidelines and unintended negative consequences. However, the OSD enabled hospitals to attract and retain nurses with specialised qualifications in intensive care, operating theatre and oncology.

## **RECOMMENDATIONS**

The involvement of nurses in policy development and implementation is important to avoid misinterpretations that could lead to perceptions of unfairness. Recommendations for policy improvements include:

- clear communication to ensure that everyone has the same understanding of the policy
- consultation and involvement of front-line nurses in policy-making
- extensive, standardised training for implementers to ensure uniform interpretation
- fairness in the application of policy criteria and
- improved monitoring and evaluation.

## **LIMITATIONS**

Although this study provides valuable insights into the views of front-line nurses on OSD policy implementation, these perspectives are inevitably influenced by the respondents' viewpoints at the time of the interviews. The study was conducted in two district hospitals in one province, so the findings cannot be generalised to other district hospitals, or to other provinces, in South Africa.

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