

LETTER TO THE EDITOR

Private practice (RWOPS) and overtime for state-employed specialists

Over the past few years, RWOPS (Remuneration for Work Outside the Public Service) has been blamed for much of the failure of service delivery in public hospitals with allegations that doctors spend more time in their private practices than performing their duties in state hospitals. The reality is that RWOPS has been one of the main factors retaining specialists and their valuable skills in the decaying public hospital system, and that withdrawal or curtailment of RWOPS will potentially cripple the public health system at secondary and tertiary levels.

Limited Private Practice (LPP) for state-employed specialists was introduced in 1994 to compensate for the poor salaries paid by government, at a time when the country was unable to afford appropriate salary increases. Around the same time, a Fixed Overtime Allowance replaced the Professional Allowance previously paid to professionals in the public service in recognition of their higher qualifications and irregular working hours. In 2001 the LPP system was modified and re-named 'Remuneration for Work Outside the Public Service' or RWOPS.

From the beginning the concept of private practice was a necessary evil. It was evil because it was open to blatant exploitation by some participants, but necessary because it was the only way to keep competent specialists working in the unsatisfactory conditions of the public health system. Recently, dissatisfaction with RWOPS at national and provincial government level has led to it being labelled as fraudulent, with the possibility of it being severely limited or banned. The questions are whether conditions in the public service have improved to the extent that RWOPS can be dispensed with, and what the implications might be if it were stopped.

The **arguments in favour of RWOPS being continued** are professional and financial:

1. Government considers that the Occupational Specific Dispensation (OSD) has removed the need for additional income for specialists; in fact OSD has not brought state salaries anywhere near the income of private specialists. This is aggravated by failure to award deserved promotions and bonuses to many specialists in state hospitals. Their careers have stalled with no hope of further progress and no incentive to continue working for the State.
2. Academic/provincial practice is too restricted to allow surgeons to grow in their speciality. The collapse of the state hospital system with inadequate beds and theatre time, combined with obsolete equipment and under-funding for implants and procedures, all cause enormous frustration among our specialists. This dissatisfaction is relieved by private work, allowing them to continue to work in the public service. The skills so acquired are fed back into the state system to the benefit of patients and trainees.
3. The spectrum of procedures we can perform in academic/state practice is inadequate for training registrars in modern surgery. We need access to the private sector for registrar-training opportunities.
4. Without RWOPS, no expenses such as congress and professional society fees, books, travel, etc., are tax deductible for a state-employed specialist. SARS' position is that the employer is responsible for these costs, many of which are essential to gain the CPD points needed to maintain registration with the HPCSA, a prerequisite for state employment. However the Department of Health is not prepared to finance these expenses.
5. Income from private work is taxed at the maximum rate, at present 40%. So the RWOPS specialist subsidises his own state salary to a significant extent by the tax he pays. With the tax on RWOPS income of R1.87 million/year a senior specialist will repay his own after-tax salary, including overtime, and his services to the state cost the Government nothing.
6. RWOPS specialists offer a valuable service to the community, usually in cooperation with their private colleagues; obvious examples are unusual skills such as transplant surgery or the after-hours orthopaedic trauma service in private hospitals which is often run largely by academic specialists.

If RWOPS is stopped or curtailed there will predictably be a mass exodus from the Public Service, with a further decline in the already abysmal standard of health care for the majority of this country's population. Equally important would be the threat to our training centres at a time when the government accepts the need to dramatically increase our numbers of pre- and post-graduate medical trainees.

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Less attention has been paid to the **implications for the private sector**:

1. Competition for already inadequate private hospital facilities and beds by specialists leaving the state for private practice will put the private hospital groups in a position where they can dictate their own terms for access to their limited facilities.
2. Competition for work when there is pressure to reduce medical costs will diminish specialists' bargaining power with the medical schemes about appropriate tariffs.
3. The result is that private specialists will lose their independence, being forced into managed health care systems and the potential compromise of professional standards. We shall lose our voice in the decision-making levels of health care, being relegated to the status of employees participating only by courtesy of the administrators of hospital and funding groups.
4. Many specialists will simply emigrate. Inevitably they will be the younger and most employable people – the specialists we can least afford to lose. The pool of specialists is already ageing, and within a decade the country may well be left without a corps of experienced specialists, leaders and teachers.
5. It may not be paranoid to see this as the first step towards a privatised National Health Insurance system with lucrative contracts awarded to private sector managed health care. It is unlikely that the State can afford to rebuild the hospitals and service systems it has allowed to collapse; investment by private hospital groups would be an obvious solution, and if doctors could be forced into working in these hospitals for financial reasons, staffing problems would also be solved. I believe medicine should be a socially responsible profession, but realistically it has also become a business; if so, doctors should be able to compete for their rewards on equal terms and not be dominated by other commercial interests, namely the private hospitals and medical aid groups.

Clearly abolition of RWOPS could easily cause irreversible damage to all levels of health delivery and training in this country. It is in the interests of all specialist groups to support the retention of RWOPS, or to suggest practical alternatives to keep specialists in state hospitals.

The biggest single problem in the present form of RWOPS is the difficulty in controlling the amount of private practice performed by a specialist, and there are many **areas of uncertainty** about this issue.

1. Should RWOPS be time-based, or should it be unrestricted provided the quality of service provided to the State is satisfactory irrespective of hours worked? In other words is the specialist being paid a salary for his time or for a defined service?

2. Where should RWOPS be performed? If capacity or conditions in public hospitals are inadequate, can RWOPS be denied? If RWOPS is practised in private hospitals, how can it be controlled?
3. How should each doctor be monitored and by whom?
4. What would be appropriate penalties for exceeding agreed limits of practice?
5. Would specialists accept employment in 5/8 posts or sessions with unlimited RWOPS outside these hours, and would this provide an adequate service level?
6. RWOPS and overtime may be seen as conflicting commitments. Would specialists be prepared to choose one of two options: overtime payment with no RWOPS or alternatively being allowed RWOPS while still providing an unpaid after-hours service?
7. Would it not be easiest to simply cap earnings from RWOPS and let SARS be the monitor?

It is vital that the Department of Health debates these and related aspects with the specialist groups, and not attempt to impose a unilateral decision which will certainly be challenged legally. Government must understand that any authoritarian curtailment of RWOPS will probably lead to a mass exodus of specialists, and the collapse of the state hospital and training systems.

It is encouraging that SAMA has already started to prepare itself for negotiations, and I believe that every doctor should be a member of our legal trade union, and not just our specialist associations.

In the long term, the whole question of specialist services in public hospitals needs to be reviewed.

It must be remembered that although financial gain from RWOPS is important, it is far from the only issue for most state-employed doctors. RWOPS also provides enormous personal and professional satisfaction that is sadly lacking in the overloaded, under-resourced public hospitals, and could provide valuable training opportunities for registrars. Academic and secondary hospitals urgently need improved financing and revitalisation programmes to make a public service career more attractive to specialists. South Africa should perhaps consider a system like New Zealand's, where all specialists are in private practice, but also work part-time for the State.

Should RWOPS be stopped, realistic financial compensation would be needed – say 50% of salary – guaranteed to be increased annually in line with the Reference Price List or its replacement. This, of course, would bring us back to the original reason for RWOPS, and would still not improve the unsatisfactory working conditions of a public service specialist.

Until conditions in the public service improve, RWOPS remains a necessary evil. But it must be better controlled and used for teaching.

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