Rural Health Advocacy Project

Causes, implications and possible responses to the implementation of staffing moratoria in the public health system in South Africa during times of budget austerity

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Summary and recommendations

The purpose of this working paper is to draw attention to the causes, consequences and possible responses to the implementation of moratoria on the filling of posts within the health system. Human resource moratoria, also referred to as the 'freezing of posts' has become an increasingly common occurrence within the public health system over the last two years.

Even though there are several contributing factors that result in the implementation of moratoria on the filling of posts, evidence suggests that the cause is primarily budgetary. While provincial health expenditure has more than doubled in real terms over the last decade, slow economic growth has meant that government revenue is becoming increasingly constrained. Health budgets are increasingly unable to keep pace with cost increases that continue to outstrip inflation.

Substantial real increases to the Compensation of Employees (CoE) budget item has often been cited as the primary culprit for costs in the health system outpacing budgetary increases. While this is true to some extent, poor planning has meant that little has been done to prepare the health system for the implementation of austerity measures.

Provincial departments have managed budgetary pressures by shifting money between budget items and overspending on CoE in the hope that they will receive additional funding in future to account for overspending. In the absence of 'bailouts' from the Treasury, this overspending has contributed to growing accruals and a growing budget deficit that must be recovered from future budgets without necessary adjustments being made for this expenditure.

In recent years and in an effort to control overspending provincial departments of health and treasuries have started implementing staffing moratoria. This has either been done officially (including memos and instructions on the filling of posts) or unofficially through repeated delays in making appointments.

A reading of the 2015 MTBPS reveals that the situation is bound to become far worse over the 2016/17-2018/19 MTEF. Again, while health budgets increase beyond inflation they are insufficient to meet growing cost pressures due to higher than inflationary increases to salaries and goods and services costs.[1]

In this working paper we draw attention to how austerity measures, as they are currently being implemented, are having catastrophic consequences for health care, particularly for rural health settings. These consequences include diminished capacity to deliver services; poor supervision of existing staff; weakened support processes (e.g. procurement); additional strain being put on already overburdened staff; and consequently, overburdened staff leaving the public service deepening the crisis.

[1] Costs of providing health services often increase beyond Consumer Price Inflation because the cost of medicines, medical supplies and other medical services increase beyond inflation each year. Between 2008 and 2011, for example, inflation on medical products was at least 2 percentage points higher than CPI inflation see: http://econex.co.za/wp-content/uploads/2015/03/econex_researchnote_36.pdf

We argue that a blanket approach to the implementation of moratoria on the filling of posts is a significant threat to the right to have access to health care as provided for in the Constitution and that such an approach acts contrary to the principles of administrative justice.

We then present three scenarios that outline different approaches to managing budget austerity and their possible outcomes. The first scenario we discuss is the 'continue on the current path of austerity' approach, which involves the blanket freezing of posts as a cost saving measure. The second scenario we present is the 'finding the money' scenario where additional budget is allocated to account for cost increases. Finally, we present the scenario: "reality check: maximising scarce resources to greatest impact".

Since this working paper there has been some movement on the implementation of a strategy aimed at balancing the need for cost containment in CoE and the need to ensure that the impact of austerity measures on frontline service delivery is minimised. In the 206/17 budget the Treasury notes that while government departments are busy revising human resource plans to include austerity measures, all non-critical posts will be frozen with the exception of front-line posts including teachers, nurses, doctors, police officers and other critical posts.

While this is an important step, we believe that does not go far enough in clarifying the scope of what is critical and may in fact lack the nuance necessary to account for posts that are not 'front-line' but are nonetheless critical. In a recent roundtable (1 April 2016) with the National Department of Health, the Treasury and rural health partners we revised guidelines developed by the RHAP and other rural health stakeholders in November 2015, which sets out and approach to identifying critical posts that extends beyond frontline-posts. These revised guidelines are:

1) **The National Department of Health in collaboration with the Treasury should provide guidance through policy on how provinces are expected to protect critical posts at times of austerity. This should include:**

    - Input by health and partners, in particular around definition of critical.
    - Principles of transparency and consultation, which should include transparency on savings in managerial/admin positions versus frontline health professionals, and an escalation procedure in the event that provinces do not implement the guidelines
    - A national plan regarding communication and distribution to provinces as well timeframes for the release of the guidelines
    - Some standardization in implementation: what is required from people; who is responsible for what.

2) **Adequate consideration should be given to inhospitable and underserved areas so as to ensure disadvantaged communities are not further marginalised in their access to health care. This includes but is not limited to rural health contexts for their unique characteristics and challenges.**

3) **It is national policy to use normative guides "WISN" where available (currently for clinics and CHCs) to identify the minimum posts to be filled.**

    - While doing so, facilities must ensure to adequate data, which is not limited to headcount and other utilization data. Population data must be used to include unmet need, as alluded to in section 6 of the WISN normative guidelines. In the event that current staffing levels are less than the minimum "WISN" norms, additional staffing is to be advocated for by the facility. In the event that no funding is available for such additional staffing, the facility needs to identify the critical health posts to be prioritized, as guided by the national guidelines

4) **Critical posts need to be defined locally and these can include health professionals and support staff. The purpose is not to define which categories of staff are to be considered critical. Instead the consequences on patient care should be the determining factor on deciding whether post A in facility B is critical under the given circumstances. Here critical posts are simply defined as those that potentially have catastrophic consequences for service delivery if they remain unfilled.**

    Here key underlying principles in defining critical include:

    - The protection of frontline health professionals
    - The protection of services to the poor and the marginalised - who have the least option of services
    - Provincially: the more rural the more protection
    - District level: the more rural districts the more protection

5) **Districts are expected to develop costed HR plans but this does not happen; if such plans are in place it can help District Managers to identify priority posts at times of staffing moratoria. The National and Provincial Departments of Health must ensure Districts have such plans in place. Treasury should provide support in the costing of the HR plans.**

6) **Decision–making on cost-saving and cost-cutting must be made at the district level by giving districts the amount to be saved and allowing the district to decide.**

    - These decisions must be supported by guidelines on defining critical posts and must be informed by the Promotion of Administrative Justice (PAJA) principles of evidence-based decision-making, rationality and proportionality to give effect to the constitutional duty of Government to progressively realise the right to health.

7) **Corruption and unauthorized expenditure should be performance managed instead of punishing all managers and districts by withdrawing their delegations of authorities for the transgressions of others. This would mean**

that provincial departments and institutions should be held accountable for performance management.

8) **In the event of a Section100 intervention or when Treasury co-manages a Health Department, there should be an up-front agreement around the prioritization of health needs and clear processes for appointments to occur.**
    - In this even strategies must be put in place to reduce the time it takes to make appointments when there is co-management/S100 intervention to overcome time costs of added layers of decision-making.
    - Process' need to be predictable, as people get frustrated, start intervening etc.

1. Introduction

The Rural Health Advocacy Project was established in 2009 as a partnership initiative between the Rural Doctors Association of Southern Africa (RuDASA), the Wits Centre for Rural Health (WCRH) and SECTION27. Our work revolves around the constitutional right of rural and remote communities to have equitable access to comprehensive, quality health care. Informed by the voices of rural health care workers and communities on the ground, the RHAP aims to facilitate self-advocacy, generate debate, monitor implementation of health policies in rural areas, support pro-equity government interventions, and influence decision-making that is in tune with local rural realities[2].

Our interest in the resourcing of the health system emerges out of the fact that in resource-constrained environments it is critical that available resources are allocated equitably and used efficiently and effectively to achieve the greatest possible impact. There is an added financial cost to provide the same quality service to remote communities and this must be incorporated in the policy, planning and, most importantly, budgeting process. In reality, this added cost factor is often not considered, leading to inequitable financing and ultimately inequitable access to care for rural communities. At the same time there have been weaknesses in how resources are being used: overspending, under spending, and the mismanagement of funds continues to compromise care in many rural settings.

Our work on health care financing covers a broad scope of issues relating to the equitable, efficient and effective distribution and use of resources for rural health. For this working paper, however, our focus will be narrowed to the potential impact current budget policy decisions will have on the recruitment, retention and distribution of human resources for health, with a particular focus on these issues within a rural context.

The availability of human resources for health is a particularly vexing issue in rural contexts in South Africa and is a second core focus of the RHAP's work. Generally, South Africa, as many countries worldwide, is faced with a severe crisis in terms of human resources for health. Inequities exist in the distribution of human resources between the private and public sectors as well as between rural and urban areas. About 60% of the nurses and 40% of the doctors serve the 85% of the population using the public health sector. Vacancy rates are the worst in rural provinces, and the three most rural provinces

[2] For more information on the work of the RHAP visit www.rhap.org.za

have the country's lowest doctor-to-patient ratios[3]. Inequities also exist within rural provinces and districts, with wide variations in staffing levels between facilities leading to inefficient use of scarce health care workers.

In this working document we draw attention to a particularly troubling trend developing within most provincial departments of health, which if not managed properly will have catastrophic consequences for the country's most vulnerable populations. Over the last two financial years we have become increasingly aware of the implementation of moratoria on the hiring of staff to fill vacant posts.

1. In some instances these have been official moratoria where circulars and memos have been distributed to managers within the department indicating a total block on the filling of vacant posts or strict controls on where posts are filled (i.e. posts are only filled in exceptional circumstances). Currently, we are aware of official moratoria being implemented in the North West[4], Eastern Cape[5], KwaZulu-Natal[6], Mpumalanga and Free State provinces.

2. In other instances moratoria are being implemented indirectly or by stealth. In these instances, posts are simply not filled (even where there are candidates) without any clear indication of why appointments are not being made. These posts are either left frozen (i.e. they are PERSAL but cannot be filled) for a long period of time or are eventually abolished from PERSAL all together.

While there are many contributing factors to the implementation of staffing moratoria or the freezing of posts, it is our contention that the primary causes are budgetary.

In this working document we:

1. Briefly outline the systemic causes of budgetary pressures that have lead to the implementation of moratoria;
2. How the current budget documentation indicates that the situation is likely to become more severe over the next three years;
3. Give a brief discussion of the consequences of blanket moratoria on human resources for health, particularly in rural contexts;
4. Present three different scenarios for approaching staffing moratoria; and
5. Offer a few recommendations for actions that could be taken to mitigate some of the most severe consequences of such moratoria.

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[3] Stats on the state of rural health, and health care more generally, in South Africa are available in the RHAP's Rural Health Fact Sheet 2015 available at http://www.rhap.org.za/wp-content/uploads/2015/09/RHAP-Rural-Health-Fact-Sheet-2015-web.pdf

[4] A copy of the NWDoH circular on frozen posts for 2014/15 is available here http://www.rhap.org.za/wp-content/uploads/2015/10/Memo-by-NW-Provincial-Government_Staffing-Moratoria_September-2015.pdf

[5] A copy of the NWDoH circular on frozen posts for 2014/15 is available here http://www.rhap.org.za/wp-content/uploads/2015/10/ECDoH-Circular-Staffing-Moratoria_frozen-posts_-September-2015.docx

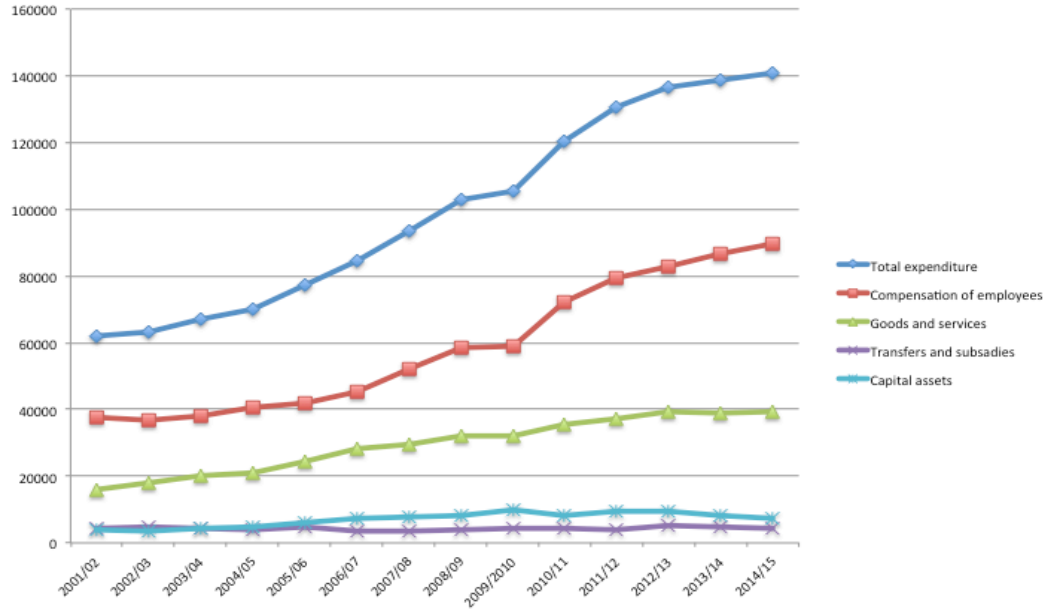
[6] A copy of the KZNDoH circular on frozen posts for 2014/15 is available here http://www.rhap.org.za/kzn-circular-october-2015-motatorium-in-filling-of-posts/

2. The budgetary origins of the current crisis

Over the last 15 years expenditure on health care has increased phenomenally. Since 2001/02 provincial health expenditure has more than doubled in real terms from approximately R60 billion to more than R140 billion in 2014/15 (see Graph 1)[7]. This dramatic increase in expenditure has been driven primarily by increased investment in the response to HIV and AIDS and higher than inflationary increases in the cost of Compensation of Employees (CoE).

Between 2005/06 and 2014/15 expenditure on CoE at the provincial level has increased by on average 8% in real terms year-on-year. Over the same period there have been average real increases to goods and services and capital assets of 5% and 2% in real terms respectively (Graph 1)[8].

Figure 1: Graph1: Provincial Health Expenditure 2001/02-2014/15 (constant process 2014/15)



CoE as a proportion of provincial health expenditure has increased from 54% in 2005/06 to 64% in 2014/15. Over the same period the proportion of provincial health expenditure going to goods and services has declined from 32% to 28% while expenditure on capital assets has declined from 8% to 5%[9].

Increases in CoE have not, however, been driven primarily by an increase in the employment of health care workers. There are two primary factors that have contributed to the dramatic increase:

[7] National Treasury (2015). Provincial Governments Expenditure Review 2011/12-2015/16: Health. Available: http://www.treasury.gov.za/publications/igfr/2015/prov/04.%20Chapter%204%20-%20Health.pdf

[8] National Treasury (2009). Provincial Governments Expenditure Review 2005/06-2011/12: Health. Available: http://www.treasury.gov.za/publications/igfr/2009/prov/04.%20Chapter%204%20-%20Health.pdf

[9] Ibid

1. Wages in the public sector have continued to increase beyond inflation each year.
2. There has been an increase in the number of administrative and management posts. This was clearly articulated in the consolidated Integrated Support team Reports, commissioned by former Minister of Health Barbara Hogan, in 2009. The IST found that:

"Of serious concern is the considerable and continued growth in management and administrative positions across the various provinces, especially in provincial head offices, relative to the growth in health care professional positions"[10]

The trend in the growth of public sector administration at the expense of service delivery cadres has one that has been slowing gradually. The 2015 MTBPS[11]provides the following findings from a recent review on public sector employment undertaken by Treasury:

"In March 2015, national government departments employed 402 748 staff, down from 404 496 in March 2012. This trend has been offset by the expansion of managerial personnel in administrative and policy departments in central government. A recent national treasury review showed that, across 13 departments analysed, 1158 posts were added in the last five years." (p. 30)

At the provincial level the trend does appear to be reversing but not sufficiently to counter the inflationary pressures due to salary increases:

"Provincial staff headcount declined from 923553 in 2012 to 913033 in March 2015, with a decrease of more than 10000 since the start of the current financial year. The changes have not necessarily resulted in smaller compensation budgets, largely due to above inflation wage increases and occupation –specific adjustments" (p.30)

Even though health has seen substantial increases in its budget over the last decade a point has been reached in the last few years where provincial health budgets can no longer keep pace with substantial cost increases and the impact of inefficiencies and irregular expenditure.

Based on our own research we found that in the past years there was a view within provincial departments of health that they could overspend on CoE budgets during the first half of the year and that this overspending would be accommodated in the adjustments budgets.[12]

When adjustments to their CoE budgets were no longer sufficient to accommodate higher than budgeted CoE cost increases, departments have been forced to shift funds from goods and services and capital assets line items to ensure that CoE is covered in full.

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[10] National Department of Health (2010). Consolidated Report of the Integrated Support Team Investigation into Over Expenditure in the Public Health System. Available: http://section27.org.za.dedi47.cpt1.host-h.net/wp-content/uploads/2010/06/Consolidated-IST-Report1.pdf

[11] South African Treasury (2015). Medium Term Budget Policy Statement 2015/16. Available: http://www.treasury.gov.za/documents/mtbps/2015/mtbps/MTBPS%202015%20Full%20Document.pdf

[12] Rural Health Advocacy Project (forthcoming). Budget Mapping: a qualitative and quantitative assessment of budgeting and expenditure for rural health in South Africa.

In many instances departmental spending was not properly adjusted for these shifts and expenditure on goods and services continued as 'normal'. Departments have managed this over expenditure by delaying payments to service providers well beyond government's commitment to pay invoices within 30 days. This has resulted in snowballing accruals, which have to be paid for from future budgets. These budgets then do not adequately account for the need to clear outstanding accruals and so accrual payments are made from budgets that should go toward expenditure in the current financial year. This results in a hidden budget deficit that is not properly managed, which in turn results in further over expenditure and accruals.

Accruals within provincial departments of health are substantial and have reached crisis proportions in several provinces. In 2012/13 accruals totalled R3 billion in the Eastern Cape and R4 billion in Gauteng. By the end of 2014/15 the North West Provincial Department of Health had accruals of R900 million, of which R600 million were for overdue payments.

In the past provincial treasuries have, to some extent, been amenable to 'bailouts' but this is no longer the case. Departments are now being required to implement a number of cost-saving and cost-cutting measures in order to ensure that they remain within budget. These cost cutting measures are widespread and involve every aspect of departmental functioning.

In the North West, for example, a memorandum[13] dated 24 November 2014 from the department's Chief Financial Officer (CFO) announced:

i. Total embargo on all appointments
ii. Total embargo on normal maintenance of physical infrastructure
iii. Total embargo on purchase of equipment

These cost-cutting measures are becoming more pervasive and are being implemented in every province with varying degrees of impact. The concern for us now is that on-going budgetary pressures, if not managed properly will only deepen the crisis, with consequences most acutely felt in poor and largely rural provinces.

3. MTBPS 2015 and Budget 2016/17: a deepening HR crisis

On Wednesday 20 October 2015, the Minister of Finance, Mr Nhlanhla Nene, presented the Medium Term Budget Policy Statement (MTBPS)[14] to Parliament. The tone of this year's MTBPS was particularly troubling and indicates a potential deepening of budget crises already being experienced within key service delivery departments such as health and education.

While expenditure across government will continue to increase by on-average 1.6% above inflation each year over the next three years, poor economic growth and increases to the

[13] http://www.rhap.org.za/wp-content/uploads/2015/10/Memo-by-NW-Provincial-Government_Staffing-Moratoria_September-2015.pdf

[14] The purpose of the MTBPS is to communicate the economic context in which budgeting for service delivery will take place over the next three years. It communicates priorities as well as budgetary constraints that are being considered.

public sector wage bill of 10.1% (more than 2% above inflation) will mean that budgets will remain under severe pressure for the foreseeable future. Service delivery departments are being forced to reprioritise and "do more with less".

Practically this means the implementation of further austerity measures that seem to inevitably lead to further staffing moratoria. The MTBPS states that in order to address the impact of higher than inflation increases to the Compensation of Employees (CoE):

"The revised MTEF provides no funds to expand public sector employment over the next three years. Departments that had planned to expand headcount or fill vacancies need to postpone their plans. Some institutions may need to reduce the number of people they employ." (p.30)

Departments are also being asked to shift funds away from other areas of the budget, such as goods and services and infrastructure to accommodate increases in the CoE that have not been budgeted for.

While the National Treasury has stated that this reprioritisation of budgets will be done in a manner that "avoids any compromises to service delivery", it remained unclear what measures would be taken to avoid catastrophic consequences, especially as they relate to departments being able to fill critical posts within the health system.

In the 2016/17 National Budget Review[15], which outlines spending priorities fro the upcoming year the Treasury did provide some additional detail on measures that would be taken to limit the impact on service delivery from austerity measures aimed at containing the CoE budget item. Recognising that a blanket moratoria on appointments would seriously compromise service delivery in the Budget Review, the Treasury notes that:

"Effective 1 April 2016, appointments for non-critical vacant posts will be blocked on government's payroll system, pending the submission of revised human resource plans. In many cases, these departmental plans will reduce personnel headcounts in administrative and managerial posts, eliminate unnecessary positions and establish a sustainable level of authorised, funded posts. Positions for teachers, nurses, doctors, police officers and other critical posts will be excluded from the lock, which is aimed at administrative and managerial personnel." (p. 5)

This statement indicated that the Treasury had shifted its thinking and was starting a process of identifying critical posts

4. Impact of poorly managed staffing moratoria

[15] Available: http://www.treasury.gov.za/documents/national%20budget/2016/review/FullReview.pdf

Based on a recent rapid assessment by RHAP on the impact of staffing moratoria and the freezing of posts on provincial health systems[16], particularly in rural areas we found the following:

1. Freezing of posts results in critical posts remaining unfilled, which has an obvious consequence for access to care for patients as there are fewer health care providers offering services for a growing demand.

2. If a frozen post results in reduced supervision of junior health care professionals/ workers, then the impact is significant beyond the individual post not being filled. Here the impact involves diminished accountability, skills transfer and support for junior health care professionals.

3. Where frozen posts affect a capacitating component of the service delivery process, such as procurement or financing processes, then the impact is more significant for the bottleneck created. This limits the efficacy of services provided by health care workers.

4. Frozen posts can result in reduced management of health care professionals/ workers as well as other staff diminishing accountability mechanisms and efficient management of scarce resources.

5. If a post is frozen in a facility at which the management is poor, and/or the workload is high, then the impact of the frozen post is felt more acutely, as is the resilience of the health care worker more easily eroded to deal with the consequences.

6. Frozen posts have particularly severe consequences for rural facilities, which are generally already understaffed. When posts remain unfilled other health care workers are required to 'pick-up the slack'. This adds undue pressure on remaining health care workers. This results in a 'domino effect' where staff resign or relocate due to stress. Those newly vacant posts go unfilled, adding an additional burden on staff that remain. This continues until service delivery collapses entirely at a facility.

The following quotes illustrate the impact of frozen posts on patients and health care workers in North West Province alone:

"Maternal and Child services are severely affected, there are not enough nurses, no midwives, and you will find 1 midwife on night duty. It goes against protocol because patients cannot be monitored regularly correctly. This results in maternal deaths". (Doctor)

"The training of Registers has been greatly affected, I try to assist where I can. Our DCST team does not have a Family Physician currently. There are simply no strategies that have been put in place to alleviate these kind of problems." (Doctor)

"There have been no staff appointments in the district ever since the staffing moratorium. Nurses have either resigned or retired. The ones that retired took their pension due to the confusion that if they did

[16] A copy of the RHAP's rapid assessment into frozen posts is available from the RHAP's website

not retire they would not have access to their pension. The Doctors that have left have not been replaced". (Doctor)

"The financial situation has affected us, our staff morale is low. We are no longer being paid for working overtime. This has led nurses to abuse their sick leave days. The nurses prefer to participate in moonlighting because they know that they will not get paid for working overtime. It is difficult because its like your doing work that was supposed to be done by two nurses.

The Clinical staff are really overworked. Because this is a psychiatrist hospital we need psychologists, two psychologists are not enough for all the wards. Patients here need counselling. We are told that there are no posts due to a lack of money." (Nurse)

"Services are affected, you know that we have to comply with the National Core Standards, but we wont be able to because, patient-waiting time has increased. Before if we hard 5 Professional Nurses we would be able to cut down patient waiting time. But now with 3 Professional Nurses they is a definite delay". (Nurse)

"But you know some of the problems that happen are due to burnout that is experienced by doctors and nurses, the shortage of staff is a serious issue. Maybe things will be better in the next financial year but what guarantee do we have". (Doctor)

It is not just patients and coalface healthcare workers who are suffering. We have received reports of senior managers succumbing under the increasing pressures to deliver with less resources. We are aware that in one rural province, 5 senior managers are booked off for stress-related problems.

5. Advancing the right to have access to health care in times of austerity

If we appreciate that there may simply not be sufficient resources to allocate to prevent staffing moratoria it becomes essential that solutions are found that protect critical posts within the health system. Blanket moratoria and the freezing of posts are untenable, unnecessary and possibly unlawful.

6. The legal framework: obligations and tools for decision-making

Section 27 of the Constitution (Act 108 of 1996) affords everyone the "right to have access to health care services", which right must be progressively realised within available resources. The Constitution is explicit that it is the government's duty to ensure that every measure, including legislative measures, is taken to ensure that this right is realised. Given the catastrophic consequences on the health system of the freezing of critical posts, this implicitly includes an obligation to identify ways to prevent the freezing of critical posts.

The right of access to health care services requires that the state goes further than merely stating the right or developing strategies for its realisation. Without implementable plans[17] and budgets attached to those plans, the state's obligations are not met. It is insufficient for the state merely to argue that funds are not available[18] or that a particular priority has not

[17] *Government of the Republic of South Africa & Others v Grootboom & Others* 2000 (11) BCLR 1169 (CC) at [40].
[18] *Rail Commuters Action Group v Transnet Ltd t/a Metrorail* 2005 (2) SA 359 (CC) at [88].

been budgeted for.[19] Finally, if the realisation of rights is dependent on the operation and efficiency of systems, then inefficient budgeting and expenditure is a violation of rights.[20]

In addition to laying out the obligations on the state regarding budgeting for rights, the law provides good guidance on how to take decisions on the allocation of resources in the context of rights.

Section 33 of the Constitution prescribes that everyone has the right to administrative action that is lawful, reasonable and procedurally fair and section 195 of the Constitution provides for public administration governed by democratic values and principles including efficient, economic and effective use of resources.

The administrative law requirement that decisions be reasonable has given rise to jurisprudence on the meaning of reasonableness as it relates to governmental decision-making. For a decision to be considered reasonable, it must be rational and proportional. This means that it must be supported by evidence, it must further the purpose for which it was made, and it must not be disproportionately onerous in effect. In this context, reasonable decision-making on how to apply resources within the health care sector would require an assessment of the maximum available resources that can be made available. The needs of the health care system should be assessed and the extent of the budgetary shortfall established. The impact of possible cuts should be considered, and a decision that ensures maximum realisation of the right with minimum disruption and minimum onerous effects should be taken.

It is difficult to see how a decision to freeze the filling of all posts, including critical posts, and not at the very least to use funding from recently vacated posts to fill human resources vacancies where they are needed for service delivery and the realisation of the right, could be considered a reasonable decision.

The obligations and tools in the Constitution and the law guide decision-making and can be used to ensure an allocation of resources that maximally advances access to health care services.

7. Possible courses of action in dealing with frozen posts: three scenarios

There are a number of ways that the government can approach the management of human resources for health in the current climate of budget austerity. Any course taken will have different costs and trade-offs that must be considered. Below we offer three possible scenarios and how each will impact on both the implementation of moratoria and other areas of service delivery.

7.1 Continue on current path of austerity: we are training for overseas careers and the private sector

The first approach that the government could take to managing austerity is to simply continue with its current course of action. In this scenario provincial departments of health,

[19] *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd and Others* 2012 (2) SA 104 (CC) at [74].
[20] *Glenister v President of the Republic of South Africa & Others* [2008] JOL 22590 at [166] and [189].

with guidance from provincial treasuries, would continue to implement cost-cutting measures that would necessarily include halting the growth in the CoE budget item.

Based on the approach currently being implemented in many provinces this would involve putting a freeze on the filling of vacant posts. Here posts will only be filled in exceptional circumstances, if at all.

Working from the assumptions that salaries will continue to increase beyond inflation each year while health budgets will struggle to keep pace with inflation, stabilising the CoE budget item will *not* equate to stabilising the staffing establishment.

In fact, in this scenario as the Treasury itself suggests in the MTBPS, "Departments that that had planned to expand headcount or fill vacancies need to postpone their plans. Some institutions may need to reduce the number of people they employ" (p.30).

This means that in practice maintaining the current approach to austerity and its focus on managing CoE costs, there will inevitably be a reduction in the number of funded posts in each provincial departments staff establishment—a process that is already underway in some provinces.

There are two broad implications of taking this course of action. The first implication is that there will be a deepening of the current human resources for health crisis emerging in several provinces around the country. The consequences of which are described briefly above and in more detail in the RHAP's rapid assessment of staffing moratoria.

Implications for the health system extend beyond difficulties in managing the filling of posts over the short-term though. Actions taken now could potentially reverse steady progress being made in training and developing human resources for the public system. Plans to expand the intake of students into medical schools and accelerate the production of doctors through the Cuban programme could end up being a fruitless expenditure, whereby we train health care professionals for the private sector or overseas. Why this may sound ludicrous. The analysis above casts serious doubt on whether South Africa will have the funding to absorb these additional graduates.

Data contained within the NDoHs HRH strategy 2012/13-2016/17[21] reveals that South Africa had done well in increasing the number of health care professionals working within the public sector between 2002 and 2010. In that period the number of Medical Practitioners working in public service had increased by 60% or 6.1% on average each year. The number of Professional Nurses in the public system also increased significantly by 35% or 3.9% each year.[22]

While much of the increase in the number of Medical Practitioners could be attributed to the introduction of mandatory community service of two years for all graduates it is an important achievement nonetheless.

[21] National Department of Health (2013). Human Resources for Health Strategy for the Health Sector 2013/14-2016/17. Available http://www.gov.za/sites/www.gov.za/files/hrh_strategy_0.pdf
[22] Ibid, p. 21

Estimates for the period between 2012 and 2014 reveal that total numbers entering the public service will have continued to increase. In the department's HRH Strategy it is estimated that by 2014 approximately 1400 medical school graduates would be entering the public sector for their community service. Due to natural attrition (e.g. doctors retiring) and doctors moving to the private sector, leaving medicine or moving abroad, it was estimated that the total number of doctors working in the public sector would increase by approximately 550 individuals that year.[23]

The number of nurses (all categories) is also estimated to have increased substantially in 2014. Accounting for all forms of attrition, the number of nurses working in the public sector will have increased from 143 000 in 2013 to 148 000 by the end of 2014. This means that approximately an additional 5000 nurses were added to the establishment.[24]

If we assume that trends in training and the number of graduates entering the system remains constant for the foreseeable future then the question emerges: how is the health system going to accommodate graduates for their community service if there is a good chance that provincial health systems will need to reduce the size of their establishments?

The one likelihood is that over the short term, for Medical Practitioners at least, the system will simply not hire any personnel beyond those undertaking their mandatory community service. So space will be made by not replacing staff at senior levels that retire, leave medical service all together, move to the private sector or abroad.

If austerity continues for the medium term, the situation is then likely to become even more complicated when approximately 1000 Cuban trained doctors return annually to the country from 2018 to 2023 to complete their training and undertake their community service. This is over and above the 1400 (at least) South African trained medical students needing to enter the system.[25]

It is important to remember here that these numbers are just for medical practitioners and nurses. They exclude numerous other categories of health care professionals such as physiotherapists, occupational therapists, dentists, pharmacists, and specialists who should also be absorbed into public service.

If the health system continues on the current trajectory of austerity, there may be space to absorb most community service professionals into the system over the short-term and a limited number of professionals from other categories to replace those lost to natural attrition. If, however, austerity continues into 2018, the situation is likely to become even more difficult to manage since the capacity to implement cost savings, gain efficiency in the system and shift resources from non-priorities would have become exhausted. This will mean that even accommodating community service doctors will be virtually impossible.

This brings us to the disconcerting, disillusioning and unacceptable, conclusion that without significant financial increases to the CoE, which is unlikely to happen, many students in South Africa and those in the Cuban programme are being trained to enter the

[23] Ibid, p. 133
[24] Ibid, p. 134
[25] Bateman, C. (2013). Doctor Shortages: Unpacking the 'Cuban Solution'. In the South African Medical Journal. 103 (9): 603-609

private sector, move abroad, for other sectors in the economy, and in some cases unemployment.

The above scenario highlights that we are facing a situation where the problem is no longer one of not being able to find health care professionals to fill vacant posts (even within traditionally difficult rural settings) but rather one of not being able to accommodate increasing numbers of graduates who are available and in many instances desire to work in the public sector

7.2 Find the money: allocating additional resources to fill posts

Another approach could be to give priority to human resources within the health system and identifying ways of allocating resources to fill posts when candidates are available.

There are potentially two ways of achieving this: the first is to sustain the trend in marginal growth in the number of health care professionals seen working in the public sector[26] by identifying ways of sourcing the revenue necessary to accommodate additional remuneration packages.

The NDoH has estimated that if they were to fill all clinical vacancies (identified as the 14 most important categories of clinical personnel) an additional R40 billion (in 2010 terms) would need to be added to the health budget in the public sector.[27]

Even in times where the availability of budget is less of a concern than it is now, filling all vacant posts at once is not possible because of significant cost implications and the fact that the numbers of health care professionals needed are simply not available.

A more plausible option in a version of this scenario where the health system continues to improve access to health care professionals would be to sustain marginal increases in personnel in key categories (Nurses, doctors, OTs, Pharmacists, etc.), which would include increases in some categories of support personnel (e.g. porters, cleaners and procurement).

This option would also have significant cost implications for the health system though. For example, if we assume that approximately 500 additional doctors will enter the public health system each year at an average cost of R859 000[28] per year, then (not accounting for effects of inflation) an additional R430 million would need to be added to the budget each year for doctors alone. Assuming that salaries for doctors keep pace with inflation, but no more, then this number jumps to R450 million for 2016/17.

Even if a decision was made not to expand the clinical establishment within the public health system but rather to keep numbers at their current levels, as things are now, the health system would still need to find ways of increasing allocations for CoE. Excluding the cost of recruitment to replace staff that leave the public service, for 2016/17 the health

[26] The government has been able to increase the number of professionals entering the public service since 2002 by increasing training and introducing mandatory community service for some categories of health care worker

[27] Human Resources For Health Strategy for South Africa 2013/14-2016/17, Annexure A, p.6

[28] Median cost for doctors working in the public sector taken from the HRH Strategy and adjusted for inflation to be represented in todays terms

system will need to increase the CoE budget by R9.5 billion to accommodate the 10% increase in remuneration agreed to for next year alone.[29]

This is more than double the projected increase to the health systems entire budget for that year. This means that if additional resources are not allocated beyond what was projected in the Medium Term Expenditure Framework for 2015/16, funds will need to be shifted from other areas in the budget (e.g. goods & services and infrastructure) in order to sustain current staffing levels.

7.3 Doing things differently: maximising benefits

The above scenarios are either not desirable or realistic under the given circumstances. The current path of sweeping austerity and the implementation of blanket moratoria on the filling of posts in many provinces is untenable. This approach quickly leads to a decline in access to services and the quality of services being delivered. It runs contrary to both the right to have access to health care, enshrined in Section 27 of the Constitution and cannot be considered rational or proportional in terms of legislation such as PAJA.

While identifying ways of bringing additional resources into the public health system should certainly be a priority, especially with regard to promoting greater access and equity in access to care, over the short-term it is a difficult proposition.

In protecting access to health care within the obligations of the Constitution, the National Health Act and Promotion of Administrative Justice Act, it is evident that a different strategy has to be applied. Efficiency in allocating scarce resources is required. Efficiency in this this regard does not mean cost cutting though, it means spending money where greatest benefit will be achieved and where the impact of budget constraints will have the least impact on service delivery.

This would consist of immediate, short term and medium-to-long term solutions.

Importantly the Department's HRH Strategy recognises the threat that austerity poses to service delivery in rural areas through the implementation of blanket moratoria on the appointment of staff and explicitly states that stakeholders should:

"Ensure that provinces do not freeze critical health professional posts in underserved and rural areas as part of hiring moratoria resulting from overspending, through the development of norms for minimum numbers of health professionals for district facilities."[30]

Both the National Department of Health and Treasury have started to engage critically on the protection of critical posts as an interim solution to managing CoE expenditure while limiting its impact on service delivery. As mentioned earlier the Minister of Finance's announcement that frontline posts would be excluded from a freeze is the most public expression of this but it is not the only point of engagement. As part of a process of on-going direct consultation with officials working within the health system at the National

[29] Cost estimates calculated based on projected consolidated health budget allocations contained within the National Budget Review 2015/16, available at: http://www.treasury.gov.za/documents/national%20budget/2015/review/default.aspx

[30] Human Resources For Health Strategy for South Africa 2013/14-2016/17, P. 125

and provincial levels, Treasury officials, health care workers, civil society and rural health partners, the RHAP has been working on and refining a broad set of guidelines that provide a more nuanced approach to identifying and protecting critical posts than the one described by the Minister of Finance.

The most recent version of these guidelines were developed during a round table meeting, which took place on 1 April 2016, of rural partners the NDoH and Treasury on developing effective HRH strategies during times of austerity. At that meeting the agreed to guidelines were given as follows:

1) **The National Department of Health in collaboration with the Treasury should provide guidance through policy on how provinces are expected to protect critical posts at times of austerity. This should include:**

    - Input by health and partners, in particular around definition of critical.
    - Principles of transparency and consultation, which should include transparency on savings in managerial/admin positions versus frontline health professionals, and an escalation procedure in the event that provinces do not implement the guidelines
    - A national plan regarding communication and distribution to provinces as well timeframes for the release of the guidelines
    - Some standardization in implementation: what is required from people; who is responsible for what.

2) **Adequate consideration should be given to inhospitable and underserved areas so as to ensure disadvantaged communities are not further marginalised in their access to health care. This includes but is not limited to rural health contexts for their unique characteristics and challenges.**

3) **It is national policy to use normative guides "WISN" where available (currently for clinics and CHCs) to identify the minimum posts to be filled.**

    - While doing so, facilities must ensure to adequate data, which is not limited to headcount and other utilization data. Population data must be used to include unmet need, as alluded to in section 6 of the WISN normative guidelines. In the event that current staffing levels are less than the minimum "WISN" norms, additional staffing is to be advocated for by the facility. In the event that no funding is available for such additional staffing, the facility needs to identify the critical health posts to be prioritized, as guided by the national guidelines

4) **Critical posts need to be defined locally and these can include health professionals and support staff. The purpose is not to define which categories of staff are to be considered critical. Instead the consequences on patient care should be the determining factor on deciding whether post A in facility B is critical under the given circumstances. Here critical posts are**

simply defined as those that potentially have catastrophic consequences for service delivery if they remain unfilled.

Here key underlying principles in defining critical include:

- The protection of frontline health professionals
- The protection of services to the poor and the marginalised - who have the least option of services
- Provincially: the more rural the more protection
- District level: the more rural districts the more protection

5) **Districts are expected to develop costed HR plans but this does not happen; if such plans are in place it can help District Managers to identify priority posts at times of staffing moratoria. The National and Provincial Departments of Health must ensure Districts have such plans in place. Treasury should provide support in the costing of the HR plans.**

6) **Decision–making on cost-saving and cost-cutting must be made at the district level by giving districts the amount to be saved and allowing the district to decide.**

    - These decisions must be supported by guidelines on defining critical posts and must be informed by the Promotion of Administrative Justice (PAJA) principles of evidence-based decision-making, rationality and proportionality to give effect to the constitutional duty of Government to progressively realise the right to health.

7) **Corruption and unauthorized expenditure should be performance managed instead of punishing all managers and districts by withdrawing their delegations of authorities for the transgressions of others. This would mean that provincial departments and institutions should be held accountable for performance management.**

8) **In the event of a Section100 intervention or when Treasury co-manages a Health Department, there should be an up-front agreement around the prioritization of health needs and clear processes for appointments to occur.**
    - In this even strategies must be put in place to reduce the time it takes to make appointments when there is co-management/S100 intervention to overcome time costs of added layers of decision-making.
    - Process' need to be predictable, as people get frustrated, start intervening etc.

The scare resources available for human resources for health in South Africa must be used to achieve greater equity and the right to access health. Within the tight fiscal climate evidence-based decision-making and efficient use of scarce resources becomes more pertinent than ever. Efficiency in this regard does not mean cost cutting. It means the allocation of resources that maximally advances access to health care services, based on the principles enshrined in the Constitution and PAJA.

[ENDS]

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