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 (July 2016)

Summary and recommendations of a working paper

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.

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

[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

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.

Full report available on www.rhap.org.za or by email to Mafoko@rhap.org.za