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**Rural Health Advocacy Project Submission on the Medium Term Budget Policy Statement 2015: More bad news for human resources for health**

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**Summary and recommendations**

This submission is made to the Portfolio Committee on Finance on the 2015 Medium Term Budget Policy Statement tabled in Parliament on 20 October 2015. The Rural Health Advocacy Project’s interest in the MTBPS emerges out of its work on health care financing and rural health. While our financing work covers a broad range of financing issues including equity, efficiency and effectiveness of expenditure in rural health care contexts, this submission narrows its focus to the impact that budget policy decisions could have on access to human resources for health within the public system.

Over the last two years the RHAP has witnessed an increasing occurrence of staffing moratoria or the freezing of posts being implemented at the provincial level. While there are several contributing factors that result in such action, in our view the issue is primarily budgetary.

While provincial health expenditure has more than doubled in real terms over the last decade several budgetary pressures have emerged that could potentially have catastrophic consequences for service delivery. These primarily relate to the fact that even though health expenditure increases beyond inflation each year, substantially higher than inflation increases to the compensation of employees and a substantial increase in the number of administrative and policy level posts, often at the expense of service delivery posts, has meant that budgets are often insufficient to sustain current staffing levels.

Provincial departments have traditionally managed these pressures by securing adjustments to CoE budgets during the MTBPS or shifting funds from other areas of the budget such as goods and services. This action has contributed to growing accruals where goods and services expenditure has not been adjusted to account for shifts within spending priorities. These accruals have contributed to a hidden deficit that must be recovered from current expenditure without necessary budget adjustments being made. This simply results in the deepening of the crisis.

In an effort to control overspending and cost pressures that emerge from higher than inflation increases to CoE, provincial departments of health and treasuries have started implementing staffing moratoria or the freezing of posts. 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. In response the MTBPS explicitly states “The revised MTEF provides no funds to expand public sector employment over the next three years…and some departments may need to reduce their establishment”

Our concern is that that should these austerity measures continue in the way that they have been implemented in some departments over the last two years, there will be catastrophic consequences for health care. These 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.

Appreciating that it may not be possible in the immediate future to simply allocate more funds to address the shortfall we argue that the Constitution and other administrative justice laws demand that any action that is taken is reasonable and does not have any catastrophic consequences for the right to have access to health care.

We therefore recommend that, at a minimum the following action is taken:

* 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
  2. 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
  3. Districts are expected to develop costed recruitment 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 treasury should play an active role in ensure this happens and should provide some guidance on how financial aspects should be addressed
  4. 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 based on PAJA principles of rationality, proportionality and the over-arching constitutional right to progressively realise the right to health, not to stagnate and not to deteriorate
  5. Corruption and unauthorised expenditures should be performance managed instead of punishing all managers and districts by withdrawing their authorities for the transgressions of others
  6. Government need to provide guidance for Treasuries on how to exercise their discretion in protecting health rights where the treasury directly intervenes in the business of health administration

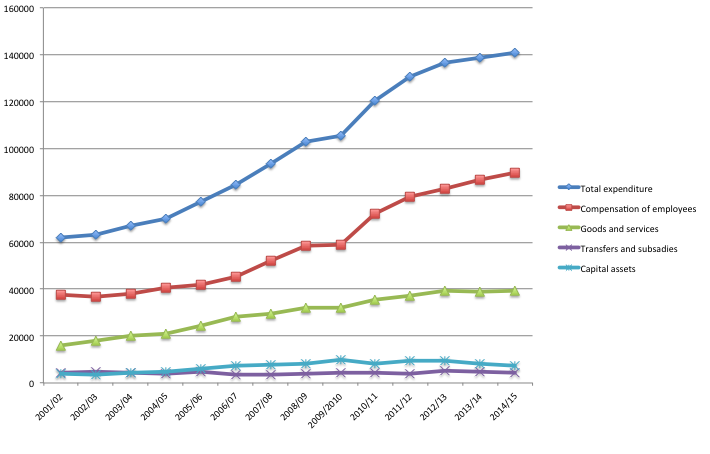
**Introduction**

1. 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. The RHAP welcomes the opportunity to make a submission to the Portfolio Committee on Finance on the 2015 Medium Term Budget Policy Statement, which was tabled before Parliament on Wednesday 20 October 2015, the Minister of Finance, Mr Nhalnhla Nene.
3. Our interest in the MTBPS 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 these 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, underspending, and the mismanagement of funds continues to compromise care in many rural settings on health care.
4. 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 input on the MTBPS, 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.
5. The availability of human resources for health is a particularly vexing issue in rural contexts in South Africa. 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 rural and urban areas. About 60% of the nurses and 40% of the doctors serve 85% of the population using the public health sector. Vacancy rates are the worst in rural provinces, with the three most rural provinces having the lowest doctor-to-patient ratios. 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.
6. In this submission the RHAP wishes to draw the committees attention to a particularly troubling trend developing within most provincial departments of health that has potentially catastrophic consequences for service delivery to 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 have been made aware of official moratoria being implemented in the North West, Eastern Cape, Western Cape (limited) 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 for 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.
7. 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.
8. In this submission we (1) briefly outline the systemic causes of budgetary pressures that have lead to the implementation of moratoria; (2) How the current MTBPS indicates that the situation is likely to become more severe over the MTEF; (3) A brief discussion of the consequences of blanket moratoria on human resources for health, particularly in rural contexts; and (4) a few recommendations for actions that could be taken to mitigate some of the most severe consequences of such moratoria.

The budgetary origins of the current crisis

1. 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). 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).
2. 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 here have been average real increases to goods and services and capital assets of 5% and 2% in real terms respectively (Graph 1).

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



1. 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%.
2. 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:
   1. Wages in the public sector have continued to increase beyond inflation each year. Between x and y public sector wages have increased by x% above inflation year on year…
   2. In contrast, there has been a substantial 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”

The problem of a growing public sector administration at the expense of service delivery cadres is not limited to health though and is one which is widespread throughout the public service. The 2015 MTBPS 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.”

In contrast

“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”

1. 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.
2. Based on our own research we found that in the past 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.
3. 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.
4. 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.
   1. 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.
5. 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…
   1. In the North Wes, for example, a memorandum dated 24 November 2014 from the department’s Chief Financial Officer (CFO) announced:
      1. Total embargo on all appointments
      2. Total embargo on normal maintenance of physical infrastructure
      3. Total embargo on purchase of equipment
6. 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

MTBPS 2015 and a deepening HR crisis

1. On Wednesday 20 October 2015, the Minister of Finance, Mr Nhalnhla Nene, presented the Medium Term Budget Policy Statement (MTBPS)[[1]](#footnote-1) 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.
2. 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 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”.
3. Practically this means the implementation of further austerity measures that seem to inevitably lead to further staffing moretoria. 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 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)

1. 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.
2. 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 remains unclear what measures will be taken to avoid catastrophic consequences, especially as they relate to departments being able to fill critical posts within health system

Impact of poorly managed staffing moratoria

1. Based on a recent rapid assessment of the impact of staffing moratoria and the freezing of posts on provincial health systems, 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 staffs 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

Recommendations: Protecting critical posts in times of austerity

1. Appreciating 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.
2. Section 27 of the South African Constitution (Act 106 of 1996) affords everyone the “right to have access to health care services” and while this right is to some extent limited to “within available resources” the constitution is explicit that it is the government’s duty to ensure that every measure, including legislative measures, are taken to ensure that this right is realised. This implicitly includes an obligation to identify ways to prevent catastrophic consequences of the freezing of critical posts.
3. The law provides good guidance to provincial Treasuries and Departments of Health on the government’s obligations in this regard. Section33 of the Constitutions prescribes that everyone has the right to administrative action that is lawful, reasonable and procedurally fair, while Section 195 confirms the democratic values and principles enshrined in the Constitution that should govern public administration including:

• Efficient, economic and effective use of resources

• Public administration that is development-oriented

1. The Public Administration Justice Act (PAJA) gives further direction to these Constitutional principles. It defines “Administrative action” as “a decision taken or failure to take a decision by an organ of state when exercising public power which adversely affects the rights of any person and has a direct, external legal effect.”
2. Here administrative action will be unfair “unless it is reasonable” and that in turn means the action must be rational and proportional. In the case of the freezing of posts, decision-makers need to consider whether the decision enables the maximum realisation of the right of access to health care services within available budget. For an action to be rational it needs to be supported by evidence and it needs to further the purpose for which it was made. For an action to be proportional it “must not be disproportionately onerous in effect” - in other words, the impact of the decision needs to be considered.
3. For reasonable decision making in the case of the freezing of posts, Government - Health and Treasury representatives in this case - need to assess the extent of the budgetary shortfall and identify what decision should be made on the basis of what would be fair administrative action. In terms of evidence the key questions that must be answered is will the proposed decision achieve its aims, which must be the maximum realisation of the right of access to health care services within available budget or will the decision be too onerous to justify its outcome.
4. At a workshop held at the most recent Public Health Association Conference (PHASA) in Durban on 8 October 2015 the developing crisis in human resources for health due to staffing moratoria and frozen posts was discussed. Stakeholders from civil society, provincial treasuries and health system representatives from the national, provincial and district levels identified the following actions as essential to protecting critical posts. Our recommendations here emerge out of this process and are 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
   2. 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
   3. Districts are expected to develop costed recruitment 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 treasury should play an active role in ensure this happens and should provide some guidance on how financial aspects should be addressed
   4. 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 based on PAJA principles of rationality, proportionality and the over-arching constitutional right to progressively realise the right to health, not to stagnate and not to deteriorate
   5. Corruption and unauthorised expenditures should be performance managed instead of punishing all managers and districts by withdrawing their authorities for the transgressions of others
   6. Government need to provide guidance for Treasuries on how to exercise their discretion in protecting health rights where the treasury directly intervenes in the business of health administration

[ENDS]

1. 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. [↑](#footnote-ref-1)