GTAC
Analyse
Assess
Activate
Strategic & Technical Advisory

National Treasury
REPUBLIC OF SOUTH AFRICA

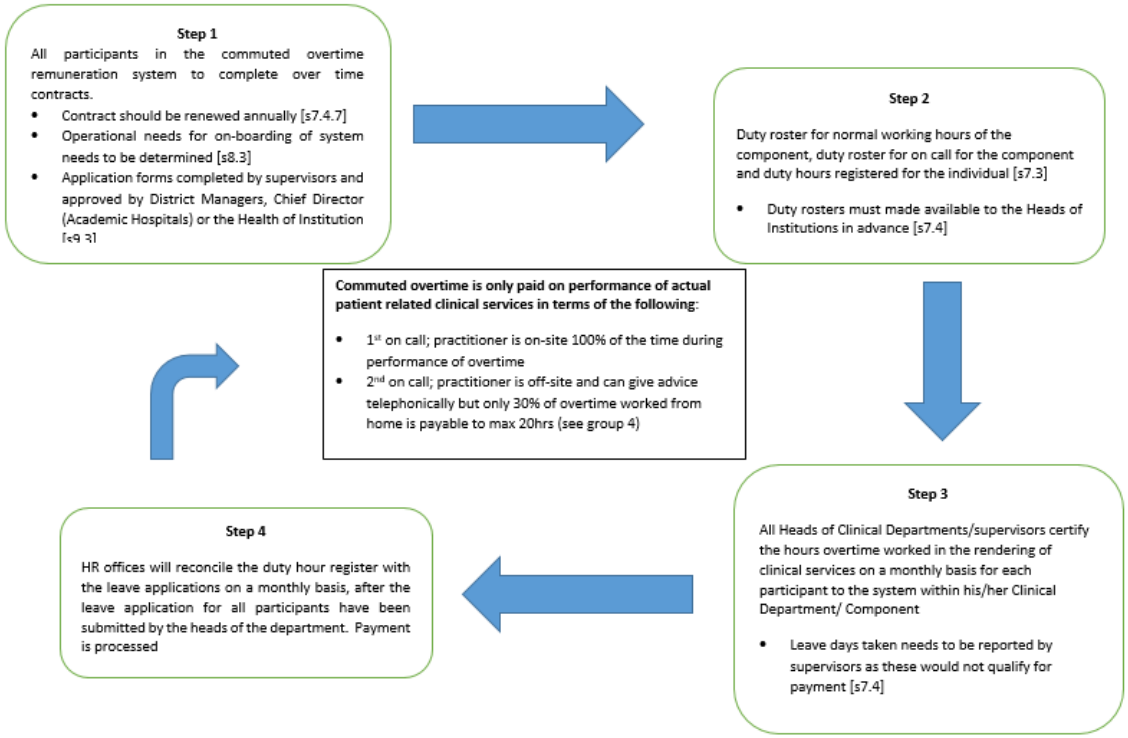
SAVINGS@WORK

GOVERNMENT SPENDING REVIEWS CONFERENCE

Topic: Health Overtime
Name: Refiloe/ Noxolo

Brief on National Policy on Commuted Overtime for Clinical Staff

- **Key policy characteristics guiding implementation**
  - Grouping based on expected workload
  - On-boarding process



Groupings	How it works
Group 1	May claim for actual hours overtime worked where such duties are needed, as applicable to other categories of staff in terms of PSCBC Resolution 3 of 1999
Group 2	Overtime remuneration is payable at a fixed tariff equal to 8 hours per week at 1.3 of the applicable hourly tariff
Group 3	Overtime remuneration is payable at a fixed tariff equal to 16 hours per week at 1.3 of the applicable hourly tariff
Group 4	Overtime remuneration is payable at a fixed tariff equal to 16 hours per week at 1.3 of the hourly tariff plus actual hours worked in excess of the limit of 20 hours at the applicable overtime tariff as per PSCBC Resolution 3 of 1999

- **Shortcomings**:
  - Preloaded as part of "normal package"
  - Renewable/ amendable only annually
- **The policy has two main mechanisms:**
  - Introduction of a 1.3 times normal hourly tariff and not 1.5 times normal hourly tariff
  - Capping the hours payable based on a grouping system that aligns to specific needs at facility level.

What led to the need to regulate the overtime system?

- Combination of rapid increase in workload and low throughput of medical officers (i.e. achieve more with less)
- “Normal overtime” grew large and progressively started to show signs of being unsustainable (e.g. GT spending significant, although perhaps partly due to inflow of workload from other provinces etc.)
- Medical officers and facility managers take advantage of the system (an attempt to discourage).
- Achieve more with less (policy sought to essentially “purchase” additional medical officer hours at cheaper rate).
  - Did policy achieve objective?

Objective of spending review

Grand problem: cost-effectiveness of the policy not immediately clear when looking only at overtime spending before and after implementation of the policy.

Sub-issues

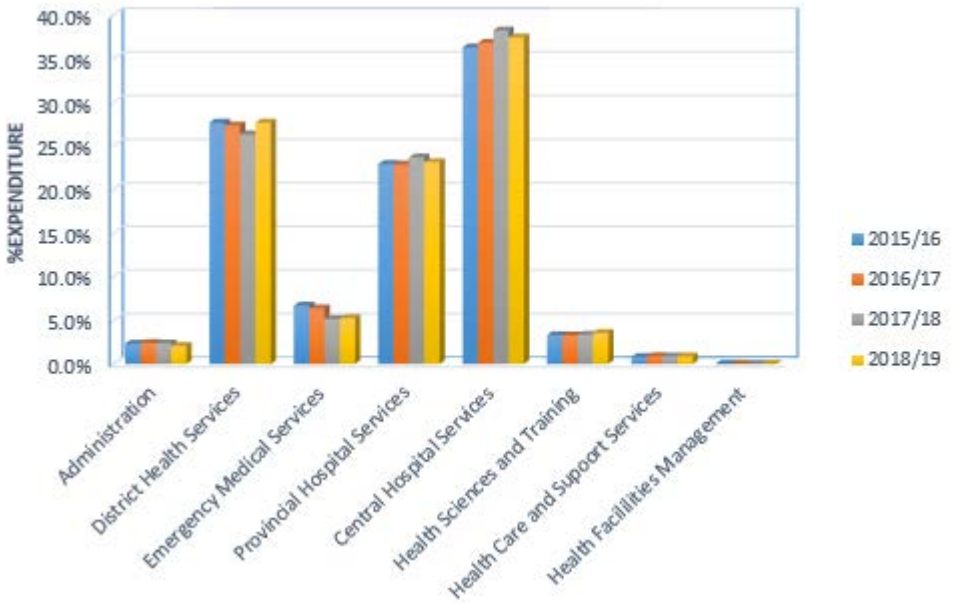
- Certain aspects of the commuted overtime policy are rigid. Not clear how abrupt workload changes would be accommodated (a).
- No national guidelines on the determination of clinical need for overtime capacity at facility level (b).
- No clear trade-offs between capacity obtained through the commuted overtime system versus additional appointments (c).

Objectives of review

- Determine differences in overtime spending across provinces by level of care.
- Link overtime to workload for comparative purposes.
- Quantify the trade-off between capacity obtained through overtime and additional appointments.

What are the differences in overtime spending across provinces by level of care?

Programme name	2015/16	2016/17	2017/18	2018/19
Administration	2.3%	2.4%	2.4%	2.1%
District Health Services	27.7%	27.3%	26.3%	27.7%
Emergency Medical Services	6.7%	6.4%	5.2%	5.3%
Provincial Hospital Services	22.9%	22.9%	23.7%	23.1%
Central Hospital Services	36.3%	36.8%	38.2%	37.4%
Health Sciences and Training	3.3%	3.3%	3.4%	3.6%
Health Care and Support Services	0.8%	0.9%	0.9%	0.8%
Health Facilities Management	0.0%	0.0%	0.0%	0.0%



- Majority of spending in clinical programmes
- Central hospital services largest share:
  - Consistent with the skills shortage narrative
  - General complexity of cases
- **Quick win**: Although small and not regulated by Commuted Overtime Policy, probably worth regulating Administration more closely (Rxx spent in 2018/19)

What are the linkages of overtime to workload?

Indicators used for budget efficiency:

- ***Deviation from norm (overtime spending)***
  - ➢ indicates extent to which a respective province's overtime spending deviates from the national average overtime spending.
  - ➢ *Negative result indicates that a province's spending lies below the national average and the opposite applies for a positive result.*
- ***Deviation from norm (overtime per PDE)***
  - ➢ indicates the extent to which a province's expenditure per PDE deviates from the national average overtime spending PDE.
  - ➢ negative result indicates that a province's spending lies below the national average and the opposite applies for a positive result

❖ ***Both indicators used together for colour coding system used.***

Data used:

- Patient Day Equivalent (PDE); hospital workload data as proxy for service demand.
- Persal data (data may underestimate/overestimate in some areas as provinces may follow different approaches to recording)

Rating code system legend

Colour code	Assignment	Implications
High inefficiency	If province is above national average for both indicators	If this coding is assigned, the respective province needs to consider employing additional staff for the given programme. The trade-off model (which has been developed) will support in this.
Medium inefficiency	If province is above national average for one of the indicators	If this coding is assigned, the respective province needs to consider employing additional staff for the given programme. The trade-off model (which has been developed) will support in this.
Moderate	If province below national average for both indicators	Although this is seen as positive, the province may want to review reasons for this and determine whether service delivery is not-compromised.

What are the linkages of overtime to workload?

....continued

Province	District hospitals			Prov hospitals			Central hospitals			Rating (based on 2018/19)		
	2018/19	2017/18	2016/17	2018/19	2017/18	2016/17	2018/19	2017/18	2016/17	District	Provincial	Central
Eastern Cape												
PDE	1 511 399	1 706 494	1 732 042	906 558	1 467 680	1 475 109	780 997	1 002 756	1 013 760			
Overtime spending	4 318 831	4 307 607	6 571 593	16 031 401	15 705 034	18 948 900	669 088	209 912	285 892			
Deviation from norm (Overtime spending)	**63.1%**	**79.9%**	**161.5%**	**375.2%**	**403.1%**	**332.9%**	**-46.4%**	**-81.3%**	**-72.5%**			
Deviation from norm (overtime per PDE)	**-23.0%**	**-49.6%**	**4.9%**	**201.0%**	**268.4%**	**87.5%**	**-96.4%**	**-97.0%**	**-98.1%**			
Free State												
PDE	1 511 399	1 706 494	1 732 042	567 049	528 467	530 201	457 033	451 643	459 372			
Overtime spending	27 673	51 963	7 291	-	-	-	-	-	-			
Deviation from norm (Overtime spending)	**-99.0%**	**-97.8%**	**-99.7%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**		*	*
Deviation from norm (overtime per PDE)	**-99.5%**	**-99.4%**	**-99.9%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**			
Gauteng												
PDE	775 495	475 469	972 115	2 961 620	1 983 112	2 830 985	3 466 659	3 372 685	3 365 555			
Overtime spending	2 766 764	2 531 714	2 503 303	79 178	65 153	66 752	31 183	64 453	59 133			
Deviation from norm (Overtime spending)	**4%**	**6%**	**0%**	**-98%**	**-98%**	**-98%**	**-98%**	**-94%**	**-94%**			
Deviation from norm (overtime per PDE)	**-3.9%**	**6.3%**	**-28.8%**	**-99.5%**	**-98.9%**	**-99.7%**	**-100.0%**	**-99.7%**	**-99.9%**			
KwaZulu Natal												
PDE	2 574 973	1 328 461	2 600 167	3 386 620	1 995 238	3 241 746	1 141 898	910 628	1 255 551			
Overtime spending	522 192	2 325 220	819 978	58 838	27 015	-	134 400	112 737	45 317			
Deviation from norm (Overtime spending)	**-80.3%**	**-2.9%**	**-67.4%**	**-98.3%**	**-99.1%**	**-100.0%**	**-89.2%**	**-89.9%**	**-95.6%**			
Deviation from norm (overtime per PDE)	**-94.5%**	**-65.0%**	**-91.3%**	**-99.7%**	**-99.5%**	**-100.0%**	**-99.5%**	**-98.3%**	**-99.8%**			
Limpopo												

What are the linkages of overtime to workload?

….continued

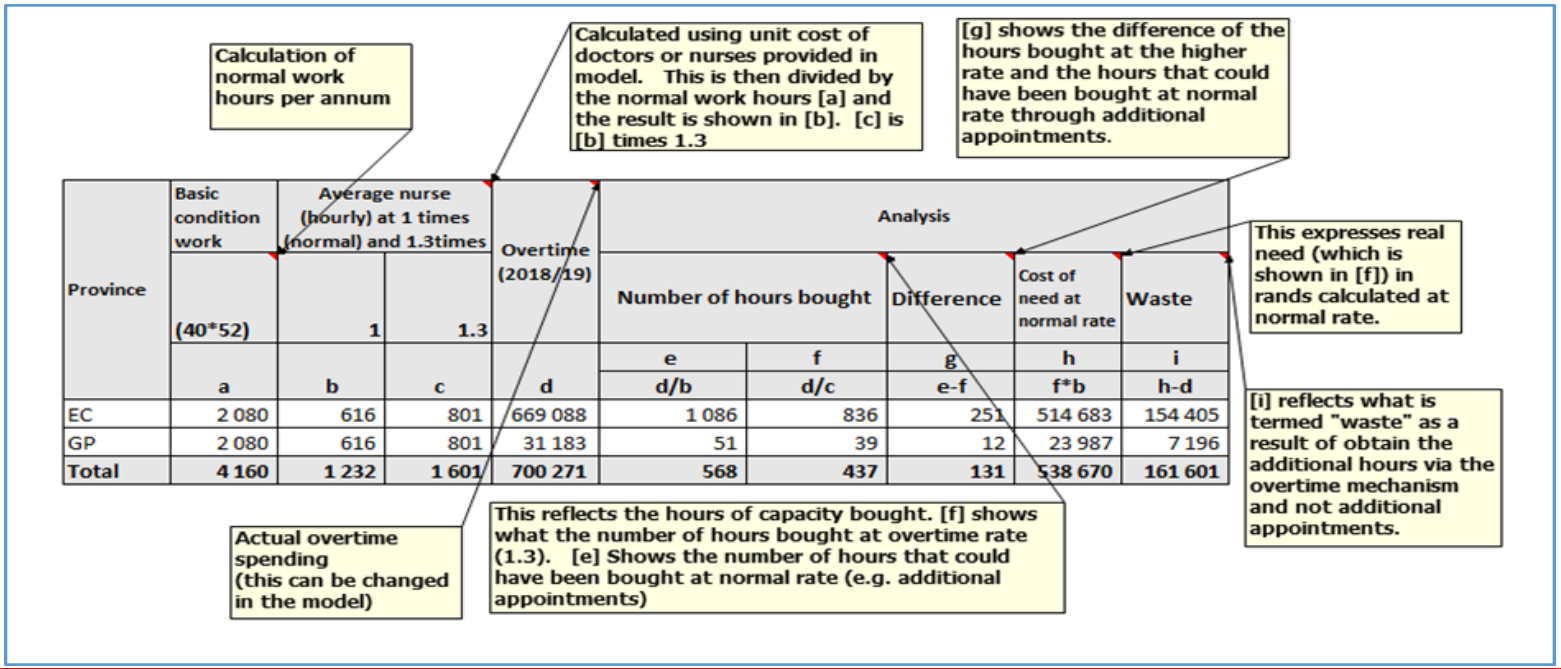
Mpumalanga												
PDE	1 232 637	335 178	1 262 405	627 025	489 376	674 419	37 809	49 500	58 739			
Overtime spending	2 041 310	2 348 180	4 478 338	3 227 269	3 068 705	6 221 217	2 565 943	2 705 483	3 331 987			
Deviation from norm (Overtime spending)	**-23%**	**-2%**	**78%**	**-4%**	**-2%**	**42%**	**105%**	**142%**	**221%**			
Deviation from norm (overtime per PDE)	**-55.4%**	**39.9%**	**-1.9%**	**-12.4%**	**115.9%**	**34.6%**	**182.4%**	**671.2%**	**275.8%**			
Northern Cape												
PDE	195 450	109 439	197 463	308 253	-	320 323	38 620	-	42 846			
Overtime spending	1 151 876	520 039	1 713 398	6 760 897	6 401 449	11 582 885	4 077 432	3 496 199	3 316 639			
Deviation from norm (Overtime spending)	**-56%**	**-78%**	**-32%**	**100%**	**105%**	**165%**	**226%**	**212%**	**219%**			
Deviation from norm (overtime per PDE)	**58.8%**	**-5.1%**	**140.0%**	**273.3%**	**-100.0%**	**427.7%**	**339.4%**	**-100.0%**	**412.8%**			
North West												
PDE	405 911	268 770	443 223	376 115	240 381	714 337	74 840	881 771	1 774 441			
Overtime spending	6 195 451	5 023 538	5 838 105	2 278 811	1 827 081	2 024 510	2 918 603	2 955 225	2 280 765			
Deviation from norm (Overtime spending)	**134.0%**	**109.8%**	**132.3%**	**-32.5%**	**-41.5%**	**-53.7%**	**133.7%**	**163.8%**	**119.6%**			
Deviation from norm (overtime per PDE)	**311%**	**273%**	**264%**	**3%**	**162%**	**-59%**	**62%**	**-53%**	**-91%**			
Western Cape												
PDE	421 926	586 902	1 366 830	376 115	240 381	714 337	74 840	881 771	1 774 441			
Overtime spending	203 218	588 071	350 956	-	804	22 846	2 172	5 647	-			
Deviation from norm (Overtime spending)	**-92%**	**-75%**	**-86%**	**-100%**	**-100%**	**-99%**	**-100%**	**-99%**	**-100%**			
Deviation from norm (overtime per PDE)	**-87.0%**	**-80.0%**	**-92.9%**	**-100.0%**	**-99.9%**	**-99.5%**	**-99.9%**	**-99.9%**	**-100.0%**		*	
National												
Average overtime to total	2 647 892	2 393 919	2 513 206	3 373 680	3 121 402	4 377 291	1 248 869	1 120 238	1 038 667			
Average exp per PDE	3.71	5.01	3.62	5.87	2.90	6.85	24.03	7.09	15.09			

* - data not available for rating

What are the trade-offs between capacity obtained through overtime and additional appointments?

- Model used for trade-off calculation.
- NB: can be customized by user, particularly given data challenges.

Model mechanics



Province	Basic condition work	Average nurse (hourly) at 1 times (normal) and 1.3times		Overtime (2018/19)	Analysis				
					Number of hours bought		Difference	Cost of need at normal rate	Waste
	(40*52)	1	1.3						
	a	b	c	d	e d/b	f d/c	g e-f	h f*b	i h-d
EC	2 080	616	801	669 088	1 086	836	251	514 683	154 405
GP	2 080	616	801	31 183	51	39	12	23 987	7 196
Total	**4 160**	**1 232**	**1 601**	**700 271**	**568**	**437**	**131**	**538 670**	**161 601**

What are the trade-offs between capacity obtained through overtime and additional appointments?

Trade-off: hours of additional capacity purchased at overtime rate versus normal rate per hour

i. Based on the overtime spending (R322.5m) for doctors for district hospitals; 1 703 405 hours were bought at 1.3 times the normal rate.
ii. Further, the rands spent on overtime could have bought 2 214 426 hours at normal hourly rate.
iii. If we assume that the hours bought using overtime (1 703 405) are reflective of the real additional capacity, only R248.1m would have been spent to obtain the same capacity through additional appointments.
iv. The difference (R74.4m) between R322.5m and the R248.1m in [i] is what is termed as "waste" in this review.

Level of care	Basic condition work	Average (hourly) at 1 times (normal) and 1.3times (overtime)		Overtime (2018/19)	Analysis				
	(40*52)	1	1.3		(overtime/1)	overtime/1.3)	Difference	Cost of need at normal rate	Waste
	a	b	c	d	e d/b	f (real need) d/c	g e-f	h f*b	i h-d
District	**2 080**	**381**	**495**	**415 698 826**	**2 729 660**	**2 099 739**	**629 922**	**319 768 328**	**95 930 498**
Doctors	2 080	616	801	23 831 032	38 691	29 763	8 929	18 331 563	5 499 469
Nurses	2 080	146	189	391 867 794	2 690 969	2 069 976	620 993	301 436 765	90 431 029
Provincial	**2 080**	**381**	**495**	**278 343 311**	**1 752 185**	**1 347 834**	**404 350**	**214 110 239**	**64 233 072**
Doctors	2 080	616	801	30 363 123	49 297	37 921	11 376	23 356 248	7 006 874
Nurses	2 080	146	189	247 980 188	1 702 888	1 309 914	392 974	190 753 991	57 226 197
Central	**2 080**	**381**	**495**	**333 711 858**	**2 232 675**	**1 717 442**	**515 233**	**256 701 429**	**77 010 429**
Doctors	2 080	616	801	11 239 817	18 249	14 037	4 211	8 646 013	2 593 804
Nurses	2 080	146	189	322 472 041	2 214 426	1 703 405	511 021	248 055 417	74 416 625
Total sector	**2 080**	**381**	**495**	**1 027 753 995**	**6 714 519**	**5 165 015**	**1 549 504**	**790 579 996**	**237 173 999**

Summary

Pocket issue	Issue no.	Finding	Recommendation
Policy is not entirely responsive to workload (e.g. participation is annual and renewable annually). If headcount happens to be increased in a given year, all those benefiting from overtime will continue to do so for remainder of said year.	a	Although savings can be immediately realised from allowing termination and re-entry to participation at any period within a given year. It is important to note that the policy, which was hugely contested by organised labour, is already a compromise by both employer and health professionals. For instance, commuted overtime is calculated on 1.3 times the normal hourly rate as opposed to the legislated 1.5 times (based on conditions of services).	• More work to done on viability of amending current policy and assess the extent to which changes would be implementable given the strong-hold unions have. • Perhaps benchmarking South African overtime practices to other countries. This will require expanding the efficiency analysis beyond the country.
No national guidelines on the determination of clinical need for overtime capacity at facility level is provided. This is entirely left to the discretion of facility managers, which leaves room for abuse and impacts monitoring capability as there would be no objective benchmark available.	b	Since supervisors and clinical heads are required to use own discretion in determining need for participation in overtime, there is no uniformity in the approval process. It is likely that participation is more than what is required as, based on discussions with a clinician, and overtime seems to be largely considered part of the package.	• National Department of Health will need to consider the development of some kind of norms to guide facilities.

Summary

....continued

There seems to be little consideration to the trade-off between capacity obtained through the commuted overtime system versus additional appointments.	**c**	**The summary table from the cost model, shows that in 2018/19, the sector has spent R237.2 million more than what could have spent if the capacity was obtained through appointment of additional staff. R95.9 million in district hospitals, R64.2 million in provincial hospitals and R77 million in central hospitals.**	• **Provinces, particularly those in the red or amber categories in table 11 and 12, will need to carefully assess the trade-off and decide if still prudent to continue with the overtime route. The cost model allows for customisation of the unit cost in order to make the analysis more sensitive to the specific provincial context**

Risks

- Basic Conditions of Employment Act/ Labour Relations Act
  - Organised labour bargaining process
  - Commuted overtime already a negotiated "stretch" — **a.**
- S40 of Constitution (government spheres)
  - Difficult for national government to enforce policy as it pertains to detail of provincial budget processes etc. — **b.**
- Additional appointments must be made very careful and take into account facility level information.
- Sessional appointments probably better option but note abuse of system similar to RWOPs. — **c.**

Topic: Commuted Overtime Health

Thank you