UNIVERSITY OF KWAZULU-NATAL

Implications and possible responses to the effects of staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal

by

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DECLARATION

I **Nduduzo Comfort Ndebele** declare that:

I. The research reported in this dissertation, except where otherwise indicated, is my original research.

II. II. This dissertation has not been submitted for any other degree or examination at any other University. III. This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

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1. Their words have been re-written but the general information attributed to them has been referenced.

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V. This dissertation does not contain text, graphics or tables copied from the Internet, unless specifically acknowledged, and the source being detailed in the dissertation and in the references section.

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"With God, nothing is impossible" – Luke 1:37

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DEDICATION

Despite the fact that PhD studies are an individual effort, this could not have been achieved was it not for the unconditional support, encouragement and love of my late grandmother Rosemary Maphumulo who departed recently. This thesis is dedicated to her, *May your loving soul rest in peace Gogo*. I also dedicate this thesis to my two boys, Olwethu and Mpilenhle Ndebele.

GLOSSARY OF ABBREVIATIONS AND ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
ANC:	African National Congress
ART:	Antiretroviral
CEO:	Chief Executive Officer
COE:	Cost of Employment
CMD:	Case Management Department
DOH:	Department of Health
DPME:	Department of Planning, Monitoring and Evaluation
DPSA:	Department of Public Service and Administration
EU:	European Union
FD:	Finance Department
GDP:	Gross Domestic Product
HIV:	Human Immunodeficiency Virus
HRM:	Human Resource Management
HRMD:	Human Resources Management Department
HRH:	Human Resources for Health
HOD:	Head of Department
ICU:	Intensive Care Unit
IMF:	International Monetary Fund
KZN:	KwaZulu-Natal
KZNDOH:	KwaZulu-Natal Department of Health
MDG:	Millennium Development Goal
MEC:	Member of Executive Committee
MED:	Monitoring and Evaluation Department
MPT:	Manpower Planning Theory
MTBPS:	Medium:Term Budget Policy Statement
MTEF:	Medium Term Expenditure Framework
MSPAMD:	Medical Services and Professional Allied to the Med. Dep.

NGO:	Non-Government Organisation
NHLS:	National Health Laboratory Services
NPM:	New Public Management
NPS:	New Public Service
NRF:	National Research Foundation
NSD:	Nursing Services Department
NTH:	Ngwelezana Tertiary Hospital
OCEO:	Office of the Chief Executive Officer
OSD:	Occupation Specific Dispensation
PDE:	Patient Daily Expenditure
PHASA:	Professional Hunter’s Association of South Africa
PHC:	Primary Health Care
PhD:	Philosophical Doctor
PRO:	Public Relations Officer
PSC:	Public Service Commission
RBIZ:	Richards Bay Industrial Zone
RHAP:	Rural Health Advocacy Project
SA:	South Africa
SANBS:	South African National Blood Services
SMD:	Systems Management Department
SPSS:	Statistical Package for Social Sciences
US:	United States
USA:	United States of America
UNICEF:	United Nations Children's Fund
WPBTS:	Western Province Blood Transfusion Services
WHO:	World Health Organisation

ABSTRACT

The government is committed to improving the health system by providing universal coverage to all South Africans as articulated in national health policies. The biggest threats facing the health sector today are the shortage of well-trained healthcare workers, the increasing costs and demand for healthcare services. The global crisis of 2008/2009 forced the government to implement cost-cutting measures to reduce public expenditure and resolve budgetary pressures, including in the health sector. The study aimed to examine the implications and possible responses to staffing moratoria, implemented as an austerity measure, on the organisational performance of a public hospital – Ngwelezana Tertiary Hospital in KwaZulu-Natal. The objectives of the study were to examine the impact of staffing moratoria on healthcare service delivery; assess the working conditions and the challenges faced by healthcare workers; and discuss the effect of task-shifting on healthcare service delivery at the hospital. The study employed a mixed-method design in order to yield both quantitative and qualitative data. The quantitative approach was dominant in this study, where a sequential embedded mixed method design was adopted as the most appropriate cross-sectional survey method. The survey yielded a total of 177 respondents. The qualitative approach provided rich information on the perceptions of nine [9] key informants who were interviewed regarding staffing moratoria. Quantitative data was analysed using descriptive statistics, Chi-square tests of association and the Cramer's V test whilst qualitative data was analysed using thematic analysis. The results show that staffing moratoria at Ngwelezana Hospital resulted in severe staff shortages and the deterioration of working conditions as a result of excessive working hours, job enlargement, limited personal development opportunities, increased administrative and housekeeping burdens on professionals, employee burnout and stress. It also promoted distrust between employees and management that furthered job dissatisfaction at the workplace. Whilst task-shifting was adopted to address staff shortages, delays in serving patients, long waiting periods for patients, increased risks of error and patient mortality was observed. Task-shifting presented its own challenges such as legal and professional risks and staff morale issues. The study proposed a framework that empowers hospitals to implement staffing moratoria based on the supply and demand of labour in order to manage staffing budgets. The study, recommends that staffing moratoria should be supported by a decentralised multi-

dimensional approach in planning and implementation to ensure a collective consultative process that involves all relevant stakeholders.

Keywords: staffing moratoria, healthcare workers, budgets, healthcare services, task-shifting.

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CHAPTER ONE: STUDY ORIENTATION

1.1 Introduction

In September 2015, the KwaZulu-Natal (KZN) Department of Health implemented a moratorium restricting the filling of vacant posts within public medical facilities as part of its cost-cutting measures (Circular No. PT (12) of 2015/2016 of 15 September 2015). This was followed by another circular, this time from the national Department of Public Service and Administration (DPSA) also announcing the freezing of posts in the public services sector including health services (Public Service Vacancy Circular No 08 of 2016). The KZN Department of Health followed up on the latter with another circular (KZN DoH HRM Circular No. 18/2016) all restricting the free recruitment of public healthcare workers.

As stated by the KZN Provincial Treasury, the aim behind the implementation of such cost-cutting measures were to ensure efficiency savings, prioritising spending on service delivery, and cutting down on wasteful expenditure (Magagula, 2016). Thus, moratoria that affected the hiring of staff at public health facilities were put in place and have been regulating the employment of healthcare workers in KZN public health institutions to date. Ngwelezana Tertiary Hospital (NTH) is one such facility that operates under these moratoria and this study uses a case study of this hospital to investigate staff and organisational performance at this facility. In addition, the study examines the effectiveness of task-shifting which has been informally adopted by Ngwelezana Tertiary Hospital as an attempt to optimise operational efficiency through the redistribution of duties and responsibilities across available human resources to cope with the staffing moratoria. Thus, the capacity of NTH staff to provide service excellence in healthcare to the public as mandated by the Constitution of South Africa of 1996 will be examined as a function of cost-cutting measures, particularly staffing moratoria, and of task-shifting strategies from the perspective of the healthcare workers.

1.2 Background

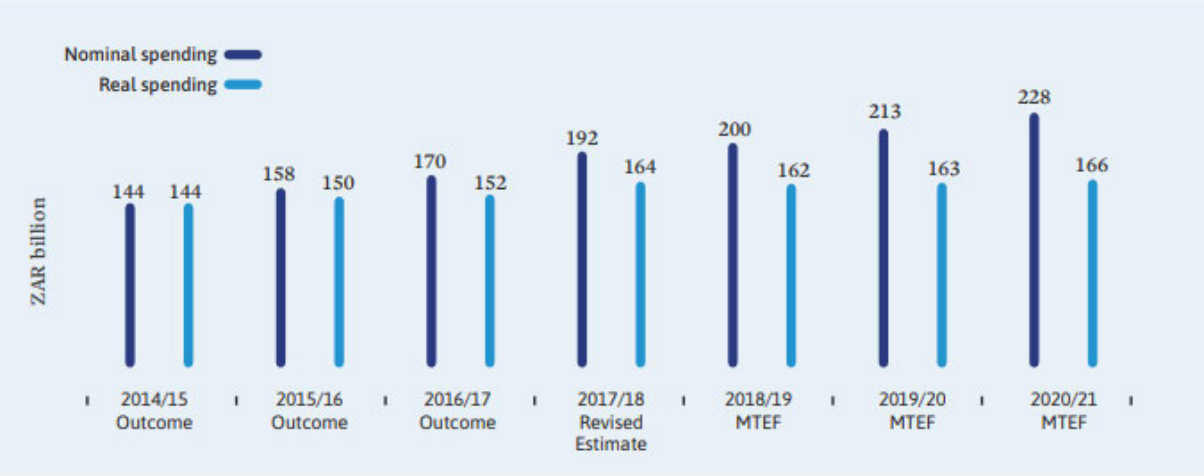
In 1994, the new democratic South Africa inherited a greatly disjointed, inequitable health system from the apartheid regime (Van Rensburg, 2014; Maphumulo and Bhengu, 2019). Upon attaining democracy, a new constitution was introduced with, among others, the goal to reduce inequality including unequal access to services like healthcare as a basic right. The South African Constitution provides for the right to healthcare services access (Constitution, 1996). In addition, the ANC-led government accepted a Primary Health Care (PHC) philosophy aimed at community development as well as promoting community participation in planning, provision, control and monitoring of healthcare services (Ataguba and McIntyre, 2018). Such a philosophy was aimed to ensure that constitutionally mandated health services expectations are developed and fostered.

Presently, South Africa is transitioning the healthcare system to facilitate universal health coverage (UHC) by instituting a program of national health insurance (NHI) (SA Government, 2020). The NHI program is an extensive shift in policy which will require an enormous restructuring of the present public and private health care system (SA Government, 2020). Although this is a great initiative from the government, however, it raises some concerns as to where the government will pool funds to finance this initiative with the already high expenditure on healthcare (Belcheri et al., 2017). and with the current staff shortages (Limbani et al., 2019) facing the public healthcare system.

In the past years, various factors have influenced South Africa's extent to fully deliver upon its constitutional obligation to offer an excellent healthcare service to everyone (Young, 2016; Kama, 2017; Maphumulo and Bhengu, 2019). Perhaps the most notable of these factors has been the availability of adequate financial resources to fund the public healthcare system so that it can be the pillar upon which equal access to healthcare is supported and achieved (Doherty, Kirigia, Okoli, Chuma, Ezumah, Ichoku et al., 2018). Economic challenges, particularly slow economic growth, increasing public debt, decreasing business confidence, and exposure to global economic shocks have resulted in scenarios where the government is not able to fund all public expenditure demands, including healthcare capital and operational expenditure (Belcheri et al., 2017). There are, however, views from certain quarters that funding challenges in the public healthcare systems are attributable to inefficient

use of resources in the public health sector, corruption, and mismanagement (Rispel, De Jager and Fonn, 2016). Regardless of the source of these problems, a notable and catastrophic symptom has been an underfunded public healthcare system that fails to meet the growing demands of South African society. Figure 2.1 below shows the growth in nominal and real public health expenditure for South Africa between 2014 and 2015.

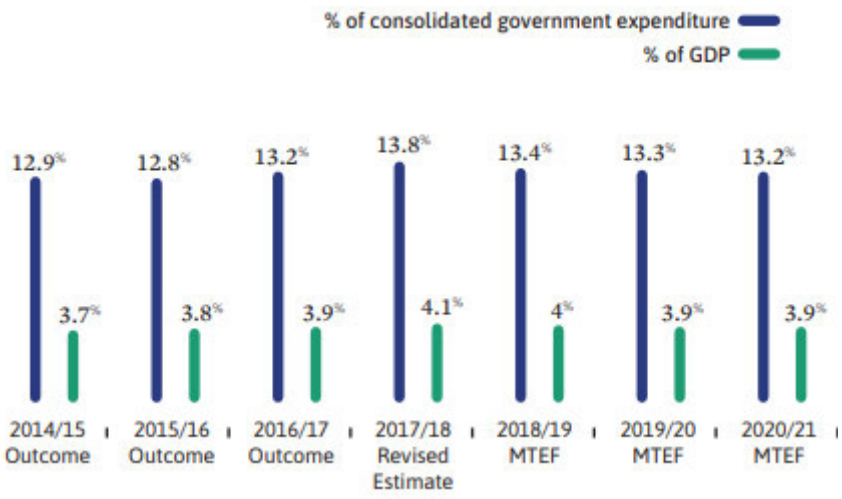
Figure 1.1: Nominal and real public health expenditure for South Africa 2014-2020



Source: UNICEF (2019)

In the above graph, it can be noted that inflation-adjusted or real expenditure on public health has remained almost static between 2017 and 2020. The nominal expenditure has, however, continued to rise, increasing from R144b in 2014 to a projected R228b in 2020, representing a 58% growth. In real terms, public health expenditure grew from R144bn in 2014 to a projected R166b in 2020, a 15.3% growth. This points to a decline in government expenditure in inflation-adjusted terms, which confirms that the public sector health budget has not been growing at a pace that enables the public system to keep up with inflationary pressures. Another graph below also indicates stagnant growth in funding made to the public health sector.

Figure 1.2: Public health expenditure as a percentage of government expenditure and GDP



Source: UNICEF (2020)

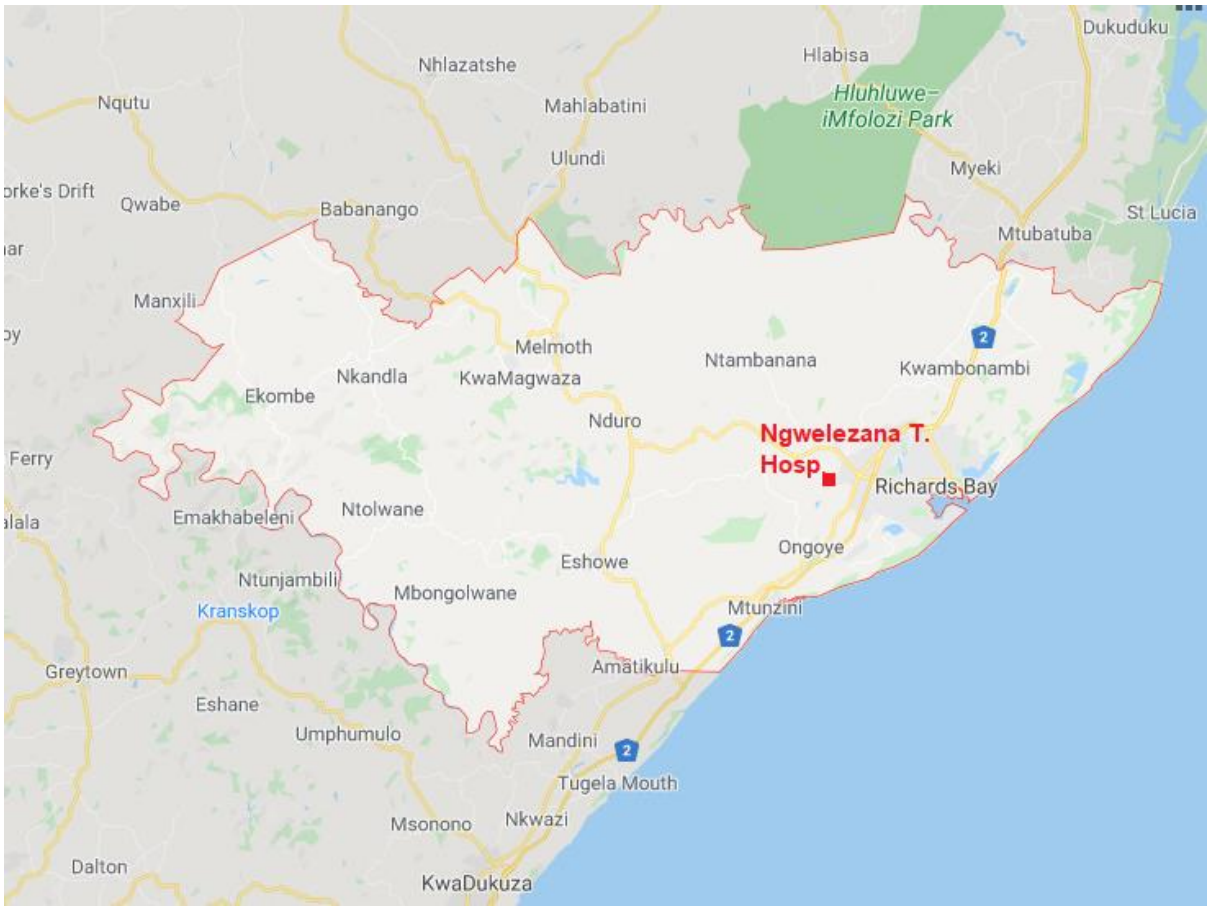
Figure 1.2 above shows that the public health budget ranged between 3.7% and 3.9% of gross domestic product (GDP) from 2014 to projected 2020. This gives the picture that government funding of the public health sector had been consistent. However, GDP at both inflation-adjusted and nominal values has been on a decline in the period under review. This points to a truth that the value of funding has also been decreasing over the period from 2014 to 2020. Thus, the public health system is confronted with a real challenge of declining funding during a period where more and more people are depending on it as a result of increasing unemployment (Belcheri et al.,2017).

It is against this background of decreasing government funding to the public health sector that the KwaZulu-Natal Department of Health together with the KwaZulu Natal Provincial Treasury implemented a moratorium restricting the filling of vacant posts.

1.3 Research study Area

This study was undertaken at Ngwelezana Tertiary Hospital. The hospital is in the King Cetshwayo Health District precinct. It is situated in eMpangeni in the North Coast Region, KwaZulu-Natal Province in the Ngwelezana community which is about 5km from Empangeni town (KZN Department of Health, 2020). The map below shows the geographical position of this hospital.

Figure 1.3: Location of Ngwelezana Tertiary Hospital



Source: Google Maps (2020)

The population in King Cetshwayo District consists of approximately 982 726 residents, under six local authority areas (COGTA, 2020). The King Cetshwayo public health system has seven hospitals under it to cater to this population (KZN Department of Health, 2020). These consist of one tertiary hospital and six district hospitals. The district hospitals are Eshowe Hospital, Catherine Booth Hospital, Queen Nandi Memorial Hospital, Ekombe Hospital, Mbongolwane Hospital, Nkandla Hospital and St Mary's KwaMagwaza Hospital; while Ngwelezana Tertiary Hospital is the tertiary facility (COGTA, 2020; KZN Department of Health, 2020). It also has 57 fixed clinics and one community healthcare centre. Ngwelezana Tertiary Hospital also serves 14 mobile clinics that have 66 mobile stopping points. Six local municipality clinics are also found in the district (KZN Department of Health, 2020).

Ngwelezana Tertiary Hospital was chosen as a focal institution for this study because in uMhlathuze it serves as the only facility in the sub-district rendering regional, district

and tertiary healthcare services (COGTA, 2020; KZN Department of Health, 2020). It is a 554-bedded hospital. Additionally, as a component of the Kwa-ZuluNatal Department of Health (KZNDoH) infrastructure renewal programme, the hospital has recently completed the construction of a surgical building with three storeys accomodating 192 hospital beds. As a referral hospital for tertiary and secondary care, Ngwelezana Tertiary Hospital services 18 hospitals in Region IV (KZN Department of Health, 2020). Ngwelezana Tertiary Hospital has eight interdependent components under it which have different respective functions and below is a brief description of these components (KZN Department of Health, 2020).

1.4 Departments within Ngwelezana Tertiary Hospital

This section outlines the departments within NTH and briefly discusses the main functions carried out in each department. To add, these are the departments from which most of the study's sample originate.

a) Human Resources Department

The role of this department is to offer human resource management services, specifically human resource training, planning and development services, labour relations, as well as employees' wellness services. The department also deals with recruitment and selection services of the hospital and clinics under NTH.

b) Medical Management Department

This department provides surgical and orthopaedic services to NTH. The department also provides anaesthetic, high care and intensive care unit (ICU) services, as well as internal medicine, neurology, ophthalmology, ENT, urological and PAMS services. It also supports the hospital with psychological, radiological, emergency medicine, and family medicine services.

c) Professions allied to Medical Department

This department provides social work, psychological, physiotherapy, occupational therapy, dietetic, pharmacy and optometry services to the hospital. Other professions allied to medical component include speech therapy and audiology services, administrative support, diagnostic imagining, clinical technology, speech therapy and audiology.

d) Nursing Department

This department provides tertiary, regional, and district nursing services to the community. They provide orthopaedic, critical care, and emergency medical services, theatre and central sterile and supply services, surgical and ophthalmological nursing, medical, psychiatric, and tuberculosis management services. Additionally, the nursing department provides administrative nursing support services.

e) Finance Management Department

This department provides budget management services, financial accounting services and supply chain management services to NTH. The units within the finance management department are budget management services, financial accounting, supply chain management, expenditure control, as well as financial analysis and revenue services.

f) Systems Management Department

This is one of the largest departments within the hospital providing a wide variety of functions. One of the functions is to provide patient administration and mortuary, engineering management, auxiliary, and maintenance services. It also provides safety and waste management services to the hospital.

g) The Chief Executive's Office

The main purpose of this office is to provide monitoring and evaluation services to NTH. It also provides infection prevention and control services, quality management services as well as the management of information services.

1.4.1 Categories of public hospitals under King Cetshwayo Health District

The staffing moratorium circular by the KZN Department of Health was not only directed at NTH, but to all other government healthcare facilities in the Province. The information below highlights various hospital types in King Cetshwayo Health District.

a) Regional hospitals

A regional hospital is a hospital that operates throughout a 24-hour day, and its departments of healthcare are internal medicine, obstetrics and gynaecology, general surgery and also paediatrics. It must be a hospital that provides healthcare service in

one or more of these specialities: (i) psychiatry; (ii) orthopaedics; (iii) diagnostic radiology and (iv) anaesthetics.

Support and outreach for a regional hospital are provided by a tertiary hospital and a regional hospital accommodates beds between 200 and 800 (Government gazette No. 35101, 2012:5). King Cetshwayo Health District has one regional hospital, namely Queen Nandi Memorial Hospital (KZN Department of Health, 2020).

b) District Hospitals

District hospitals fall into three categories, namely large, medium, and small district hospitals. It is a hospital that serves a distinct populace in a health district and offers support to primary health care facilities. District hospitals also provide healthcare throughout the 24-hour day. They are manned by general practitioners and nurse practitioners. Service provision in district hospitals encompasses primary healthcare, ambulatory healthcare, in-patient care and emergency medical service. Regional Hospitals provide outreach and support to district hospitals through their specialist services (Government Gazette No. 35101, 2012:4). A district hospital only provides a limited number of specialist services. The district hospitals under King Cetshwayo Health District are EKombe Hospital, Catherine Booth Hospital, Mbongolwane Hospital, Eshowe Hospital, St Mary's KwaMagwaza Hospital and Nkandla Hospital.

c) Tertiary Hospitals

According to the Government Gazette No. 35101, 2012:5, tertiary hospitals are facilities that offer specialised services offered by regional hospitals but also provide intensive care services that are supervised by a specialist intensivist. Tertiary hospitals are training service providers for healthcare professionals. Their catchment is nationwide in contrast to regional hospitals which are limited to provinces they operate from. With regards to bed capacity, tertiary hospitals have between 400 and 800 beds.

1.5 Problem statement

The problem at hand is that while there is a need to understand how staffing moratoria implemented at NTH are affecting this health facility's ability and capacity to offer service excellence in healthcare to the population, where there is no known empirical data that facilitates this need. It was noted earlier that this hospital plays a critical role

as the main referral centre for a population of close to a million residents. It, therefore, plays a significant part in the healthcare system of the King Cetshwayo District Municipality. Any strategic changes, including the moratorium in question, that affects the quantity and quality of its staff and has the potential to influence staff morale and motivation is worth studying, owing to the fact that the large population of the district could be exposed to health risks. These risks include lack of access to healthcare services, poor service quality that not only infringes upon the residents' rights to healthcare under the Constitution but exposes them to high mortality and morbidity risks.

Luthuli (2009) and Mathaba et al. (2013) note how the public sector needs to give health seekers their money's worth by enhancing service quality that encompasses adequate access, customer satisfaction and effective service outcomes. In providing these services, the sector must remain efficient and economic (Mathaba, 2013). A client-centred approach where quality healthcare service is provided without overstretching meagre state resources is required. This has stimulated a need to find new maintainable approaches that may ensure better client experience of care and health outcomes at a lower price (Fourie, 2011). Nonetheless, such austerity measures may have negative effects such as the shortage of healthcare workers in hospitals. An inadequate supply of healthcare personnel and support staff in care facilities could compromise the quality of healthcare that patients receive from these health facilities (Chipeta, 2014).

Whilst economic challenges facing South Africa are a reality that has to be acknowledged, and while such a reality affects public services funding, it is critical to find a balance between scarce health sector funding and the need to provide quality healthcare services through a committed and motivated healthcare team and resources. Such a balance would be critical in ensuring that the interests of the public sector healthcare workers and the public, both being the major affected parties of the moratoria are considered. However, finding such a balance of such conflicting objectives requires adequate, empirical and situational evidence that can be used to back proposed recommendations, if any. This study makes note of the fact that such empirical evidence that specifically reviews the matter from an NTH perspective is almost non-existent. The study, therefore, researches the effects of the moratorium at NTH for the purpose of understanding how the balance between austerity and service

quality (especially as a function of staff morale and organisational performance) can be approached.

1.6 Study aim and objectives

The study aimed to investigate the implications and possible responses to the effects of staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal. This was in response to one such moratorium passed by the KwaZulu-Natal Provincial Treasury in September 2015.

1.6.1 Study objectives

The main objective of this study are:

- To examine the impact of staffing moratoria on healthcare service delivery at Ngwelezana Tertiary Hospital.
- To ascertain the factors that have led to the implementation of cost-cutting measures and staffing moratoria at the Ngwelezana Tertiary Hospital.
- To assess the current working conditions and the challenges faced by healthcare workers under staffing moratoria at the Ngwelezana Tertiary Hospital.
- To measure the extent to which task-shifting has been able to address the issue of staff shortages at the Ngwelezana Tertiary Hospital.
- To develop a framework for guiding government departments on the development and implementation of staffing moratoria in KZN.

1.6.2 Research Questions

From the research objectives, the research questions formulated were as follows:

- What impact do staffing moratoria have on healthcare service delivery at the Ngwelezana Tertiary Hospital?
- What are the factors that led to the implementation of cost-cutting measures and staffing moratoria at the Ngwelezana Tertiary Hospital?

- What are the current working conditions and challenges that are faced by the healthcare workers under staffing moratoria at the Ngwelezana Tertiary Hospital?
- To what extent has task-shifting been able to address the issue of staff shortages at the Ngwelezana Tertiary Hospital?
- What framework can guide KZN Department of Health in the development and implementation of staffing moratoria in the province?

1.7 Significance and contribution of the study

The research is important in providing the much-needed empirical evidence on staffing moratoria and their effects on Ngwelezana Tertiary Hospital and in the process, highlighting how other KZN public health system entities may be affected as well. The study is therefore important because it is a descriptive and prescriptive resource for on the effects of staffing moratoria in the public health system on society, beginning with the affected workers. The researcher, therefore, hopes the study will play a critical role in informing public policy on staff-directed cost-cutting measures in public hospitals in KZN, especially NTH, where it was undertaken. This is an empirical study carried out within the confines of an affected and interested institution.

From a practice paradigm, the study will identify some of the challenges that healthcare workers encounter as a result of cost-cutting measures and freezing of posts, which has subsequently resulted in shortages of staff, noting how these challenges affect the working conditions of healthcare workers on their respective divisions within the hospital. The study also identifies the factors that have led to cost-cutting measures in the Department of Health through the opinions of managers that will take part in this study. It also brings awareness to the public on how policy change and the changes in the management at national level affects the functionality of hospitals at regional level under the KZN Department of Health.

It is interesting that the moratorium was put in place at a time that staffing challenges were noted as a major problem in South Africa's public health services, including in KZN. The country suffers from shortages of qualified medical professionals due to the limited capacity of the country's institutions to churn out the number of graduates that meets industry demand of medical professionals (Van Rensburg, 2014; Voget, 2017; Maphumulo and Bhengu, 2019). To make matters worse, there has been a strong

tendency of the few professionals serving the public sector to move into the private sector and to relocate to other countries (Heywood, 2014; Veld and Van De Voorde, 2014; Manyisa and van Aswegen, 2017). The study, therefore, among other things, wanted to investigate how the public sector medical staff fared, given a moratorium occurring in an environment that was already overstretched in terms of the supply of skilled personnel. Thus it also took an occupational conditions interest of healthcare workers as employees. In this regard, it was important in highlighting the social, psychological, and physical impact of moratorium-related change on their working lives.

The research will also provide possible solutions to manage the impact of budget cuts on public health staffing. Thus, it is of remedial importance to major public health management issues. The recommendations of this study will assist the Department of Health and other government departments affected by the freezing of posts in managing the current human resources situation to plan on how alternative mechanisms to ease challenges that come with such freezes can be implemented.

The study is significant from a theoretical background as well. It observes how the New Public Management theory, whose precepts presumably guide government action in attempting to bring economic efficiency and commercial custom in the public service applies to the staffing moratoria and the general cost-cutting measure. The study also evaluates other theories and models applied within the public health system context including the World Health Organisation's task-shifting framework. In studying these theories in relation to the situation in the KZN Department of Health and Ngwelezana Tertiary Hospital as one of the affected institutions, the study scrutinised current paradigms in South Africa's funding of public health. Testing application of theory into practice spurs academic and professional researchers to critically evaluate such theories and paradigms with an aspect of improving such theoretical foundations so that they can relate more to the real world.

The study will therefore have descriptive, informative and remedial importance on subject matter relating to staffing moratoria at NTH, although its findings will also be applicable to other South African public health facilities as well. It is therefore important to the wellbeing of South Africans who depend on the public health institution in question and others as well. Its academic and empirical contributions will help to build

a South Africa with a resilient health system that is able to meet its constitutional mandates of providing the public with access to quality healthcare services while also taking cognisance of budgetary constraints and the impact of budget-related policies on healthcare human resources that are at the cornerstone of quality healthcare services.

1.8 Definition of terms

Cost-cutting measures – these are any policy-related measures that have the objective of reducing operational and capital costs.

Staffing moratoria – is a process stopping or suspending the recruitment of posts in an institution, usually to reduce costs relating to compensation of employees or staff.

Healthcare workers – are defined as all employees working in any health facility providing healthcare services including administrative staff and support staff. These employees are not limited to employees rendering medical services.

1.9 The research structure

Chapter One (Orientation): this chapter gives an introduction and concentrates on providing contextual, background information of the phenomenon being explored, the problem statement, as well as the aims, objectives and contributions of the study to the social sciences, public administration and public healthcare disciplines.

Chapter Two (Review of the Literature): focuses contextualisation of cost-cutting measures and staffing moratoria and their impact on the delivery of healthcare services. The chapter subsequently borrowed international literature on the implementation of cost-cutting measures and its impact in selected European countries in which the South African health sector can learn lessons from. The chapter concludes by examining the extent to which task-shifting has been able to address staff shortages in the health sector.

Chapter Three: This chapter focuses on the experiences of other countries that have attempted to contain public expenditure through staff freezes and other methods.

Chapter Four (Theory Chapter): the chapter provides the research's conceptual framework, namely the New Public Management (NPM) theory. The chapter also

includes the Manpower Planning Theory (MPT), which reviews staffing moratoria as public health staffing policies emanating from external economic, political and social realms outside individual medical facilities and lastly, the chapter looks into the Game Theory, which deals with the procedure of decision-making and the involvement of other stakeholders from Department of Health.

Chapter Five (Methodology): the chapter outlines and clarifies the research methods and processes followed including the research approach and instruments used as well as how data was analyzed.

Chapter Six and Chapter Seven (Data Analysis and Interpretation): Chapter Six, presents the first data analysis chapter, covers aspects on the understanding of staffing moratoria and their impact on the delivery of healthcare services at NTH, challenges that freezing of posts had on staff members. These issues were reconciled with the theories underpinning the study. Chapter Seven also dealt with data analysis relating to task-shifting, the magnitude is has been implemented to address staff shortages in the KZN Department of Health, its challenges and opportunities. Concluding this chapter is a framework for the implementation of staffing moratoria and sub-framework for managing task-shifting in the KZN Department of Health.

Chapter Eight (Conclusion and Recommendation Chapter): this chapter combines every chapter of the dissertation and shows how the study has achieved the goal of the research. It includes conclusions of the study, recommendations, limitations, as well as issues for further research.

1.10 Conclusion

Chapter One focused on the orientation of this study and identified the research problem as; the lack of research that addresses the implementation of cost-cutting measure particularly staffing moratoria, its impact on organisational performance and the delivery of healthcare services, and it challenges to healthcare workers under the KwaZulu-Natal Department of Health' Ngwelezana Tertiary Hospital. The study placed the cost-cutting measures within the public health care system as a function of deteriorating economic conditions and declining fiscal support, both factors prompting the need to attain greater cost efficiency within the public health system as a result. Drawing from various sources, the chapter hinted that cost-cutting through staffing

moratoria and the goal to provide quality healthcare services may be conflicting goals that needed to be delicately balanced. The chapter also put the staff of NTH as the units of analysis for the study. The chapter ended by outlining the structure of the research report which will be divided into eight chapters. The next chapter presents a detailed discussion on staffing moratoria, task-shifting, employee and organisational performance.

CHAPTER TWO: CONCEPTUALIZATION OF STAFFING MORATORIA

2.1 Introduction

The South African Constitution Act (108 of 1996) accords healthcare as a right to all persons and the government has been working tirelessly to enhance the performance of the healthcare system. However, there are indications that the greatest risk to achieving equity in accessing healthcare services, particularly, in rural areas, is not adequate healthcare workers not being keen on “going to rural health facilities”. Rather, it is having adequate funds to make appointments for those keen to work in those rural health facilities. Financing healthcare workers is a costly affair that the health departments are currently faced with. National and provincial treasuries, as well as health departments, are tasked to sought judicious and appropriate solutions that aim to realise all out benefits of accessibility to healthcare within their budgets

After the first chapter highlighted the background and objectives of this study, this chapter seeks to conceptualise the defined problem, which in this case is staffing moratoria in the KwaZulu-Natal Department of Health and its effects on organisational performance. It also seeks to highlight the current situation with regard to this particular problem. The study objectives are:

- to define and understand the concept of staffing moratoria in the context of this study;
- to discuss the lessons that South African can learn from European Union members’ states on cost-cutting;
- to discuss the implementation of austerity measures in African union members’ states;
- to discuss the implementation of austerity measures in South African public sector;
- to discuss the implementation of austerity measures in KwaZulu-Natal;
- to identify and discuss factors that lead to cost-cutting measures in KwaZulu-Natal Health Department; and
- to discuss task-shifting as a strategy to address staff shortages in the Health System.

2.2 Understanding the concept of staffing moratoria

To understand staffing moratoria, the two words that make up this term will first be defined independently and from a general perspective. Different authors define staffing differently. For instance, Stretton (2015) defines it as the process of selecting and developing people to work towards the achievement of organisational goals. Caruth et al. (2008) define staffing differently, namely as a procedure of regulating personnel requirements in an organisation and obtaining adequate numbers of trained persons to fulfil these requirements. Staffing, also referred to as recruiting is a multifaceted attempt entailing numerous different responsibilities starting from analysing the work to appraising work performance (Kapur, 2018; Pahos and Galanaki, 2018). It also encompasses tasks from interviewing persons for a job, to progressing their careers and from contracting to ending employment (Caruth et al., 2008). To perform staffing responsibilities appropriately, organisational employees entrusted with the work should have the lawful knowledge and the mental, and situational background of where staffing will take place (Caruth et al., 2008).

Moratoria, singular - moratorium, according to Oxford Advanced Learner's Dictionary (2015), is defined as a temporary stopping of an activity, especially by official agreement (Oxford, 2015). It is also defined as a ban or delay in a general, business, organisation or institutional sense. Furthermore, the term is also described as a lawfully approved duration of postponement in the presentation of a lawful compulsion or the compensation of a liability or an interval prescribed by someone in charge. Thus, the term is generally associated with an indefinite or temporary ban on an activity by an official authority.

Putting these two words together in the study context and purpose, staffing moratoria is a process whereby an organisation decides to temporarily prohibit, delay employment, or ban the process of filling of posts. This practice takes place for several reasons, for instance, when a business or organisation is not performing well financially and decides to discontinue employment. It is also important to mention that the terms 'staffing moratoria' and 'freezing of posts' will be used interchangeably in this study. Staffing moratoria or freezing of posts are part of cost-cutting measures that that was implemented by the South Africa National Treasury in the Department of Health in an attempt to relieve budget pressures. As highlighted earlier, the research's

key goal is the effect of such freezing of posts on organisational performance in public healthcare service delivery.

2.3 Staffing moratoria and organisational performance in public healthcare facilities

Organisational performance, broadly described as the organisation's capability to meet its goals and objectives, cannot be distanced from staffing and human resource-related changes like staffing moratoria (Ipsos-MRIB, 2014). The public healthcare sector takes up significant portions of national budgets and as such, internal and external stakeholders are greatly concerned about how they perform (Abolhallaje et al.,2012). Another important factor behind the increased focus on the performance of public healthcare facilities is their effect on public health (Badahori et al.,2011). Poorly evaluated or unevaluated healthcare systems pose a risk to the public (Rahimi et al. 2016). At the same time, public healthcare facilities with effective performance evaluation systems are in a better position to promote quality healthcare provision (Badahori et al., 2011). This is because performance evaluation enables managers and policymakers to quickly identify challenges and to address this in time before they become major disruptions to service provision (Goshtasebi et al.,2009). Performance evaluation in these facilities is therefore crucial in assessing current performance as well is in mapping strategies for future performance (Markic, 2014). This section reviews the concept of organisational performance in relation to internally and externally imposed changes to organisational structures.

2.3.1 Service quality in public healthcare facilities

Quality measurement has become one of the major indicators of public healthcare facility performance (Sauerman, 2015). Healthcare quality was described and classified in numerous and various ways. Baker (2001) identified six constructs that can be used as public healthcare quality measurement dimensions. These are safety, effectiveness, customer focus, time sensitivity, equitability in sustainability. Hasa (2017) discusses the same dimensions except for sustainability. Safety refers to the degree to which facility users are protected from harm emanating from within the facility. Effectiveness refers to the extent to which services provided to patients bring about desired outcomes (Baker, 2001). Customer focus is concerned with the extent to which service and processes in the facility are patient-centric (Baker, 2001; Hasa,

2017). Time sensitivity relates to the extent that staff within the facility are conscious of the need to serve patience in time (Baker, 2001). Equitability relates to the provision of healthcare services to all health-seeking groups while sustainability relates to the system's ability to consistently provide a defined service standard given the resources limitations (Cohen et al.,2017). Key performance indicators relating to the six dimensions above can help to identify the overall performance level of public healthcare facilities.

2.3.2 Key performance indicators in public healthcare facilities

Organisational performance is often assessed using the key performance indicator approach (KPI). KPIs can be defined as critical indicators whose execution affects the overall realisation of organisational goals (Markic, 2014). Within the medical fraternity the use of key performance indicators to assist the performance of individuals, teams in the organisation as a whole is a common practice.

Sauerman (2016) assist that before KPIs can be used to assist performance and objective performance evaluation system needs to be put in place. Such a system can enhance the usefulness of KPI's in indicating actual organisational performance this is targeted or desired performance. Sauerman (2016) emphasizes that objective KPIs should ensure organisational accountability, individual responsibility and should guide an organisation in crafting strategies and programs aimed at directing performance towards the desired end (Wu, 2015). Key performance indicators assist in resource allocation, quality management and in overall decision-making (Wu, 2015). They enable a healthcare facility to benchmark its performance against others. They also facilitate inter-organisational performance comparison (Markic, 2014).

During and after organisational change, KPIs can help to detect if the implemented changes are helping the organisation move towards these objectives (Rahimi et al., 2017). This makes KPIs an important aspect of change management (Markic, 2014). During change, KPIs help to gauge if the change is having the desired effects or if there is a need for adjusting the change process. KPIs also support or justify budgetary changes during transformation as they provide objective reasons for increases or decreases in organisational spending.

Despite the above benefits, Markic, (2014), Khalifa and Khalid (2015) and Wu (2015) believe that KPIs come with certain disadvantages. Firstly, they may lack objectivity

and therefore produce results or outcomes that may not be meaningful in affecting policy changes. Secondly, KPIs do not identify cause and effect relationships but simply point out that performance targets have not been met. They, therefore, lack the problem-identification aspect required of effective performance management systems (Markic, 2014). Thirdly, they can easily be influenced by political decision-making in organisations. Different stakeholder groups may emphasize certain KPI's even though these may not effectively measure organisational performance (Khalifa and Khalid, 2015). Despite their strong appeal and common use in hospitals, it is important to take caution of the potential weaknesses of KPIs in individual and organisational evaluation (Khalifa and Khalid, 2015). Wu (2015), therefore, recommends the use of tested and proven methodology's in performance evaluation and suggest that performance measurement should be taken as a multi-dimensional approach that incorporates all important indicators of organisational performance. This is to ensure that the final result of organisational performance is comprehensive and assists managers in planning and in implementing corrective action (Wu, 2015). Khalifa and Khalid (2015) recommend that hospitals should test KPIs and validate them against other data sources before use as a way of enhancing their reliability.

2.3.2.1 Types of performance indicators

Public hospitals are not profit-making entities and this to an extent creates performance evaluation challenges (Markic, 2014). Profit-making entities in the private sector rely on returns on investments and other profitability indicators to gauge their performance (Pourmohammadi et al., 2018). Market share growth is also used to determine performance in private healthcare facilities (Markic, 2014). Markic (2014) identifies three broad categories of performance indicators used assessment of public healthcare facilities and systems. Outcome indicators measure the extent to which an organisation is achieving long-term predetermined goals and objectives. Process indicators assess the extent to which a public healthcare facility can implement and follow through on required operational and strategic processes. Finally impact indicators assess the effect that a public healthcare facility's intervention is having on its internal and external stakeholders, including staff and the communities it serves (Markic, 2014; Pourmohammadi et al., 2018).

Cohen et al. (2017) also mention that indicators can be classified as process-based or as time-based. The former assesses the effectiveness of a facilities processes in

delivering targeted goals and the latter assesses the extent to which facility outcomes are delivered on time (Cohen et al., 2017). Hasa (2017) groups public healthcare facility performance indicators into three categories. The first category consists of process measures with the mortality in the morbidity rates being core indicators of a facilities effectiveness also discussed as paramount by Maphumulo and Bhengu (2018). The second group relates to patient safety KPIs and the third to patient satisfaction (Hasa, 2017). Bahmei et al. (2017) and Hasa (2017) state that internationally facilities are moving towards patient-reported outcomes and away from process-related, internal outcomes. The voice of the patient is therefore becoming more important in the determination of service quality.

Khalifa and Khalid (2015) also assert that KPIs in a hospital set-up can be classified by management levels. Operational KPIs measure performance on daily tasks such as bed occupancy, daily discharges and so on. Tactical KPIs measure strategy and programme implementation success while strategic KPIs measure long-term hospital strategic performance (Khalifa and Khalid, 2015). Going back to the staffing moratoria subject matter, job freezes fall in the tactical KPIs section. This is in consideration of the view that hospitals mainly play an implementation role with the formulation role having been done at the governmental level. Hospitals have a role of translating staffing moratoria into a reality that meets the government's cost-cutting aspirations.

Rahimi et al (2017) utilised the balanced scorecard approach for discussing key performance indicators of a public healthcare facility. Their research captured four dimensions of the balanced scorecard and related these to public healthcare facility KPIs. These were the financial dimension, internal processes, employee-related factors and the customer dimension. This section uses a similar balanced scorecard approach to discuss four key dimensions of healthcare-related KPIs.

a) Financial indicators

The financial position of a public healthcare facility is an important indicator of how well the organisation is performing (Okwo and Marire, 2012). Several financial indicators have been identified in the literature. These include facility revenue, facilities expenditures and surpluses. More specific indicators include patients costs per day or per engagement and management accounting ratios such as staff costs as a percentage of revenue, operational costs as a percentage of revenue and payment

defaults is a percentage of total costs and revenue (Rahimi et al., 2017). Financial performance indicators are important for assessing efficiency levels in the use of financial resources (Schuur et al., 2013). Underutilization and overuse of financial resources put public healthcare facilities at the risk of delivering poor services to communities. In the case of resources underutilization, facilities may be holding back on essential services and deliverables to its employees end to the public (Schuur et al.,2013). At the same time, overutilization of financial resources create deficits that can cripple operations in public healthcare facilities which may also fail to meet their financial obligations. Employee-related costs are of major interests to this study. These are costs relating to total salaries, wages and allowances that facilities pay out monthly. Staff freezes have generally been motivated by the perception or reality that employment costs in the sector are too high for the efficient financial operation of healthcare facilities (Dieleman et al.(2012).

In the literature, some sources assert that costs and quality are positively correlated (Cohen et al., 2017). It is argued that to increase service quality in public healthcare facilities, operational costs as well as capital expenses must also increase (Schuur et al., 2013). Schuur et al. (2013) point out that because financial resources are limited and patients always demand high-quality service a delicate balance between cost and quality must be struck. Hasa (2017) notes that in most instances the goal is to increase healthcare quality while reducing costs. The above views present a moral dilemma on whether the need to save money should be put as a higher priority over providing quality healthcare services.

The financial dimension of public healthcare facility performance also produces conflicting perspectives among different stakeholders. Hasa (2017) states that healthcare funders are more concerned with the financial and cost aspect of service delivery. On the contrary hospital, teams focus more on the quality aspect of performance. Regulators are also concerned with quality compliance in facilities. Thus, healthcare funders may view a facility that is succeeding in saving costs and or in increasing revenue as performing better than one that is incurring high costs but is providing better quality service (Hasa, 2017). Pourmohammadi et al. (2018) and Wu (2015) warn that focusing too much on one KPI, in this case, the financial aspect of public healthcare performance can result in poor decision-making as other various factors also determine overall healthcare facility performance. Thus, when

governments assess the performance of the public healthcare system they should consider various dimensions including service quality, health services accessibility, among others, in addition to financial performance.

b) Internal processes

Internal processes as key performance indicators, measure the outcomes and effects of internal operations in a public healthcare facility (Rahimi et al., 2017). There are many internal process indicators for healthcare facilities (Raeisi et al.,2012). The commonest one is the mortality rate which is the percentage of persons admitted to a healthcare facility who die (Khalifa and Khalid, 2015). Other indicators that assess the efficiency and effectiveness of internal processes as discussed by Rahimi et al (2017) are listed below:

- mean duration of stay
- bed occupation percentage
- internal infection rates
- facility readmission rate
- number of internal accidents per given period
- procedural errors on patients per given period
- medication errors
- patient injuries due to staff negligence
- number of patient complaints
- time spent before getting service
- patients' service cancellations

Indicators can give a guideline on the quality of service that patients are getting from a facility (Raeisi et al.,2012). For instance, a high readmission rate per given period indicates treatment ineffectiveness (Khalifa and Khalid, 2015). The importance of different indicators is influenced by facility-specific issues (Iravani et al.,2012). For example, in some facilities, accident-related indicators may become important owing to the rising number of complaints from patients.

c) Staff-related indicators

Organisational performance within a public healthcare facility can be assessed from a staff-related perspective. This focuses on the general views of employees on their

satisfaction with working for the facility. Rahimi et al (2017) list over 10 employee-related factors including:

- Employee turnover rate
- Employee satisfaction rate
- Employee absenteeism rate

Staff related indicators also include training and development indicators (Wu, 2015) that include total training expenditure on staff (Rahimi et al.,2017). Expectations are that workers satisfied with their jobs and their working situation will exhibit a low employee turnover, a low absenteeism rate and a high satisfaction rate.

d) The customer dimension of public healthcare performance

The customer dimension captures the reviews and experiences of patients who visit and make use of public healthcare facilities (Koumpouros et al., 2013). KPIs of interest under the customer dimension include patient satisfaction rate with services and the number of complaints from patients. It also captures the experiences of other stakeholders who may not be patients but who are interested or affected parties of the facility (Rahimi et al.,2017). Koumpouros et al. (2013) believe that the customer dimension of performance evaluation and customer-related KPI's are very important considering that organisations exist to serve customers.

2.4 Perceptions of staffing moratoria and employee morale

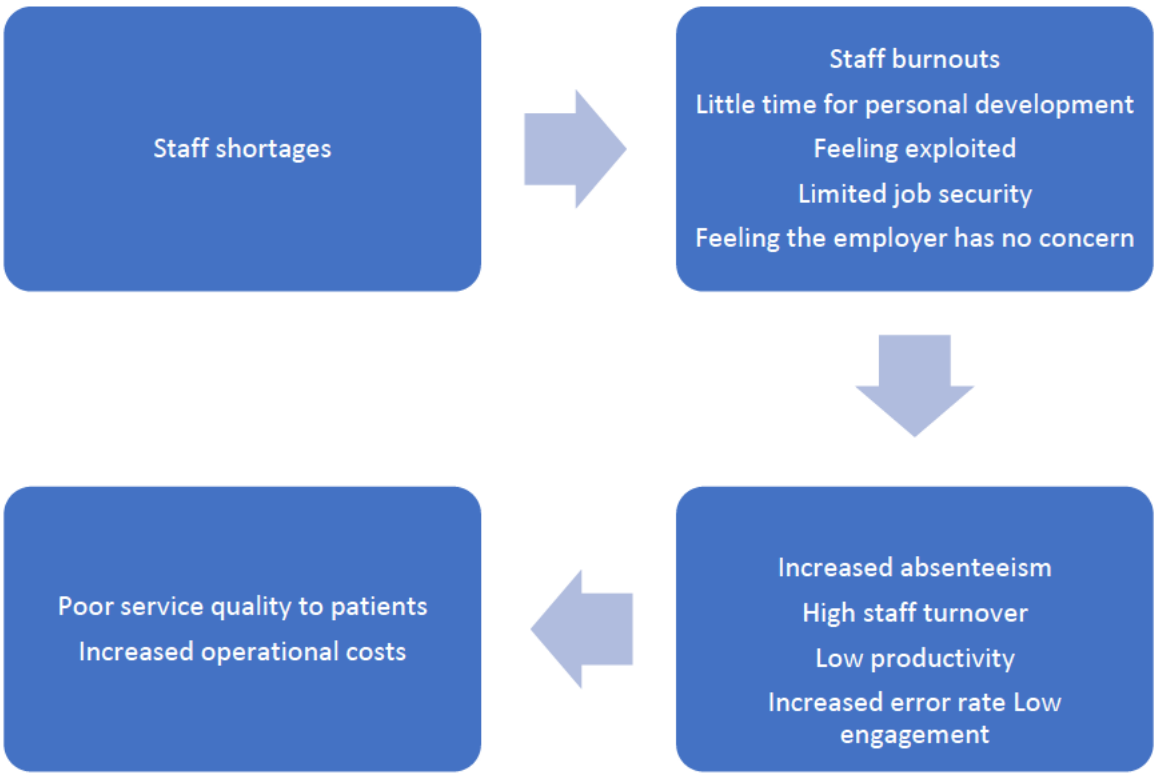
The World Health Organisation (WHO) categorises health personnel as the health system's greatest input, whose performance depends on their capabilities and self-confidence (Frenk, 2010). Healthcare workers, as stakeholders in the public healthcare system, hold varying views on the reasons behind the freezing of posts as well as behind austerity measures and their impact on society. A study by Osaro and Chima (2014) revealed that staff freezes were associated with decreasing employee morale and productivity, as well as reduced healthcare quality. Larson (2017) states that in the healthcare sector, staff morale is a critical variable of service quality. The same author goes on to states that patient quality care and patient satisfaction was directly affected by staffing challenges that included low staff morale and motivation. Larson (2017) advises that for this reason, healthcare facilities should never be understaffed. According to Parke (2016) morale determines the level of engagement

of staff members. Low morale came with severe cost implications associated with firing and rehiring workers, absenteeism, errors, and low productivity (Parke, 2016).

In a study conducted in Malawi, Chipeta (2014) found that staff shortages had a severe impact on workforce morale. Like Osaro and Chima (2014), Chipeta notes that healthcare with low morale do not put their best efforts forward, and this results in dissatisfaction among poorly attended patients. Chipeta (2014) goes on to mention that low work morale reduced public healthcare facilities staff retention capacities as workers opted to find jobs elsewhere. Low staff morale also decreased staff engagement and commitment to the health sector and created a situation where employees had dual careers (Chipeta, 2014).

Figure 2.1 below summarises the general relationships between staffing moratoria and its risks of understaffing, staff morale and service quality.

Figure 2.1: Staffing moratoria, staffing levels and service quality



Source: Compiled by the researcher using various sources

The quality of service will suffer as a consequence of increased absenteeism, rate at which staff is being renewed, decreased productivity and high incident or error rates that are a result low staff morale (Chipeta, 2014; Kaplan and Haas, 2014; Parke, 2016; Larson, 2017). As stated by Parke (2016), overall operational costs may actually increase in the process. The following section looks at the challenges that affect public healthcare worker's morale in South Africa.

2.4.1 South African public healthcare sector working conditions

Recruitment freezes in the healthcare sector occur in a background characterised by difficult and challenging working conditions for healthcare workers. Also, such changes either add to or ameliorate these challenges. The working condition of healthcare workers especially those in the public sector remains an issue of major concern in the developing world and among developed countries alike. In South Africa, public healthcare workers face many challenges some of them being well-documented and others not. This section discusses some of these challenges. Employees' working conditions can be defined as situations and circumstances that an employee directly encounters as they interact with the roles and responsibilities of their job (Massay and Blystad, 2011). Conditions of work are also described as work situational factors that affect an employees execution of their duties (Manyisa, 2015). Scholars above take the working environment to include both psychological and physical factors that affect how one does their job.

2.4.1.1 High and unbalanced workloads

A problem in South African public healthcare facilities is that employees at all levels are subjected to heavier than normal workloads (Maphumulo and Bhengu, 2019). Every employee has a maximum capacity of work they can do without burning out. Any load above this maximum can cause physical and emotional exhaustion that affect employee productivity (Holden et al., 2011). A workload is also defined as the volume of work an employee can handle, is a function of available work resources, their physical situation, time allocated for the work and the nature of the work (Holden et al., 2011). Too much work that is allocated to an employee without adequate support resources and completion time will likely constitute a heavy workload (Manyisa and van Aswegen, 2017).

Heavy and unbalanced workloads are associated with the public healthcare system's slow reaction to changes in service demands particularly population growth, new disease burdens and the migration of skilled healthcare professionals (Maphumulo and Bhengu, 2019). These changes put pressure on the medical healthcare system and if governments do not respond through providing adequate human resources and material resources there is a risk that remaining healthcare workers will bear the burden of an under-resourced system. In the public healthcare system, employees who on average have more than normal workloads tend to report more personal health and emotional problems than those with comparatively smaller workloads (Al-Momani, 2008). Tomic and Tomic (2008) pointed out that employees who wake with workloads they cannot manage were more prone to musculoskeletal disorders, hypertension, diabetes, depression and other challenging physical and psychological health condition (Lockley et al., 2007; Manyisa and van Aswegen, 2017).

Adverse effects of heavy workloads eventually trickle down to the patient in the form of poor service. Burnt-out employees are often blamed for being uninvolved and uncaring towards patients (Manyisa and van Aswegen, 2017). Burnt-out employees in the healthcare sector therefore increase the quantity of the workforce and not the quality (Manyisa and van Aswegen, 2017).

2.4.1.2 Long working hours

Another problem associated with resource shortages in public healthcare facilities is that of employees being subjected to longer than normal working hours (Sauerman, 2016). While public healthcare facilities have normal working hour schedules on paper, it is different in reality (Manyisa and van Aswegen, 2017). There are reports of healthcare professionals working 16-hour shifts. Longer than normal working hours affect one's abilities to concentrate on their tasks increasing medical accidents. Additionally, employees subjected to long working hours are likely to be physically tired such that their productivity goes down. They fail to serve patients in the required time limits. Also, employees subjected to longer than normal working hours are prone to physical and psychological problems including musculoskeletal pain and depression. Osaro and Chima (2014) also found that staff freezes resulted in healthcare workers working very long hours, with little opportunities for personal growth. Stress and burnouts among staff resulted in increased absenteeism and burnouts (Osaro and Chima, 2014; Chipeta, 2014; Young, 2016). A study by Lockley

et al., (2007) notes how healthcare workers working abnormally lengthy shifts are more likely to face social and family problems than their peers with normal working hours. Lockley et al. (2007) specifically point at divorces and other marital problems as well as dysfunctionality within families as family cohesion is adversely affected by the physical and psychological unavailability of family members due to work commitments.

2.4.1.3 Lack of adequate work resources

Healthcare workers need adequate equipment and materials to effectively do their job. Due to various reasons that include budgetary restrictions and poor administrative systems employees often find themselves in situations where they do not have the necessary resources needed for completing particular tasks (Chassin and Loeb, 2013). Increasing hospital admissions, in general, have resulted in increased usage of public health facilities resulting in current resource allocations falling short of the needed quantities (Van Rensburg, 2014). In addition to the shortage of work equipment and material, healthcare workers experience shortages of basic resources required by patients including bedding, feeding equipment among others (Mokota et al.,2011). As alluded to earlier, employees require specific resources for them two effectively handled their work. In the absence of lifting equipment, for example, healthcare workers are sometimes forced to intervene manually thereby increasing their workload. Within the South African scenario, Manyisa and van Aswegen (2017) to some extent also blame hospital administration for resources management citing examples of theft of facility consumables by staff due to poor controls. Mokota et al. (2011) suggest that resource shortages were so intense that professionals chose to live for the private sector.

2.4.1.4 Skills shortages

Contrary to views that skills shortages are a problem for developing countries Rouleau et al. (2012) found that even developed countries like Canada and the USA face similar challenges albeit in different proportions. Skills shortages expose patients to high mortality rates. Skills shortages also affect the training and development of the next generation of healthcare professionals as experienced healthcare professionals who are important in passing on practical knowledge to trainees may not be readily available (Walsh et al., 2010). Munga et al. (2012) highlight how some countries like Tanzania have been forced to adopt task shifting is a coping mechanism for skills

shortages. This puts the lives of patients at risk as they are attended to by unqualified persons.

In South Africa, skills healthcare sector skills shortages have been attributed to high attrition rates versus low recruitment and training rates (Veld & Van De Voorde, 2014). Low retention rates in the public healthcare sector are associated with the previously discussed problems that include unsafe working conditions, heavy and abnormal workloads, lack of career development opportunities, poor leadership among others (Mokota et al.,2011). The private sector remains the employer of first preference for most medical practitioners in South Africa (Van Rensburg, 2014). The local public healthcare sector, due to the myriad of problems highlighted is generally a lowly preferred employer. Thus, addressing the current public sector challenges could solve some of the skills challenges.

2.4.1.5 Poor relationships with leaders, supervisors

Workplace conflict and poor relationships between public healthcare workers and their peers, as well as this superiors, is a serious yet less discussed problem (Higazee, 2015). Workplace conflict includes cases of bullying, violence, discrimination and unfair and disrespectful treatment from both superiors and peers. Fusheini et al. (2017) assert that poor conflict resolution end management among public healthcare managers result in continued friction and abuse within work teams. Work conflict is also associated with general problems faced by public healthcare facility workers including limited opportunities for growth and working with inadequate resources (Cunniff & Mostert 2012). Competition for limited resources (CIPD, 2018) as well as different perceptions relating to the interpretation of operating standards and procedures also enhance conflict. Additionally, conflict is sometimes exacerbated by managers who may be trying to impose upon workers who feel that they already have too many duties (Rispel and Penn-Kekana, 2015). Thus heavy workloads and long working hours may fuel conflict between managers and non-managers in public healthcare facilities.

The result of unresolved relationship conflicts is low job satisfaction for affected employees and consequentially poor service delivery to patients. It is also reported that unresolved conflict results in increased absenteeism and staff turnover ratios (Fusheini et al.,2017).

2.5 Staff Moratoria and Employee Engagement

Staff freezes affect employees' levels of engagement as well as performance within an organisation (Akinduro and Farinmade, 2016). As such, it is important to assess the dynamics between staff engagement and personal as well as organisational performance within the public healthcare sector. According to Allen-Short (2019), employee engagement is one of the most studied disciplines in the fields of organisational development and organisational psychology. The term "employee engagement" was initially conceived and described by Kahn (1990) as:

> *"The harnessing of organisational members selves to their work roles (and) in engagement, people employ and express themselves physically, cognitively and emotionally during role performances."*

A common is that employee engagement should is a winning scenario for all (employee and employers) (Macey and Schneider, 2008).

2.5.1 Types of Employee Engagement

Three levels of engagement are generally discussed in the literature. Employees can be engaged, disengaged or actively disengaged. These three levels are briefly discussed below. Engaged employees are the kind of employees that are required for the optimal achievement of organisational goals (Zondo, 2020). These are workers who exert themselves passionately and have a deep connection to the organisation. They drive and foster innovation, perform their activities at high levels every day at the same time looking for means and ways to improve themselves and the organisation as a whole (Lowe, 2012; Osborne and Hammond, 2017).

Disengaged workers are not happy in their jobs and show their displeasure as they go about their duties (Osborne and Hammond, 2017). The disengaged employees come and leave work on time, they take their breaks as appropriate, never undertake or volunteer for additional projects or work. Without passion or innovation, these workers neither oblige to the organisation's direction nor work against it (Zondo, 2020). These employees may have been actively engaged personnel at one period, however somewhere during the way, they became disengaged because of particular matters like lack of promotion, perceived pay inequality, job dislike, or poor relations with immediate supervisors and senior management (Saks, 2011). In comparison to the disengaged workers, they do not add value to the organisation nor are they concerned

with the success of the organisation. Within the healthcare sector, Lowe (2012) perceive them as posing a risk to service quality and patients' health.

Koerner (2006) define actively disengaged employees as disgruntled workers whose negative attitudes and action harm others. Due to their dissatisfaction, the actively disengaged employees fail to achieve anything and they influence others to be less productive. Actively disengaged workers are described as employees who persevere with their job as a means of obtaining a salary. Actively disengaged employees and unproductive workers usually complain about their work and aim to demoralize others by sharing and spreading their unhappiness to other employees (Catalado, 2011). For organisations to succeed they should aim to get rid of these disengaged employees since they lack creativity and show little passion for their jobs, they might end up de-moralizing the engaged employees (Cataldo, 2011). Some scholars, like Lowe (2012), however, suggest that organisations should seek to actively re-engage this group. Lowe (2012) makes this suggestion with the caution that skills shortages in the healthcare sector make it precarious for organisations to lose employees. Osborne and Hammond (2017) believe that in the healthcare sector, actively disengaged workers can provide crucial feedback on how working conditions and the organisational environment can be improved.

2.5.2 Drivers of employee engagement

Researchers have proposed several engagement drivers. Markos and Sridevi (2010) highlight that several studies have sought to point out factors that result in employee engagement with some proposing models to highlight employee engagement-disengagement implications for managers. A common classification of employee engagement drivers is the financial-non-financial incentive divide (Markos & Sridevi, 2010). Financial incentives are monetary benefits that include salaries, bonuses and allowances. Non-financial benefits are intangibles associated with affecting the positive feelings and perceptions of employees. These include recognition, a positive working environment, satisfying jobs and roles and good relationships with others (Pillay & Singh, 2018).

Aon Hewitt (2014) divides employee engagement drivers into six categories, these are; leadership, brand, performance, the basics, company practices and the work. Almost similarly, Lowe (2012) uses organisational characteristics, leadership,

supervision work colleagues and teams, job characteristics and personal development as core constructs of employee engagement. An employee is more likely to be engaged if they have positive experiences on the above factors. On the contrary, employees, who have negative experiences with these factors are likely to be disengaged or actively disengaged from their work (Gibbons and Schutt, 2010). In reality, however, employees will exist at different points and levels of satisfaction with one or more what are the factors (Gibbons and Schutt 2010: Lowe, 2012; Osborne and Hammond, 2017). What this entails is that individual employee engagement in an organisation may be a challenge to measure. At the same time, however, it is possible to determine a general level of engagement and satisfaction of the team using surveys that capture the general rather than individual mood in the workforce.

2.5.2.1 Job characteristics

The dimension of job characteristics encompasses factors together with aspects that empower an employee to effectively carry out their duties without getting worn out in the process (Gibbons and Schutt 2010; Lowe, 2012). These factors include the ability to decide how one can complete one's tasks, the clarity of goals and objectives associated with one's work, the appropriateness of working hours as well as the flexibility of work schedules (Pillay and Singh, 2018). The job characteristics dimension of employee engagement also considers whether one has got necessary resources to conduct one's work and also whether one gets the necessary recognition for work well done (Gibbons and Schutt 2010; Lowe, 2012). Lowe (2012) also believes that job characteristics dimension is the most important or employee engagement dimensions.

2.5.2.2 Personal training and development

The personal development dimension of employee engagement captures employees need to progress in their careers (Lowe, 2012). Employees are concerned about whether they will be able to progress in the organisation and whether they will be able to get new skills and education that enable them to realize their personal progress goals (Osborne and Hammond, 2017). Most employees generally expect their organisations to play a part in their training and development including through providing opportunities to learn and to attend training courses and enabling them to make use of their newly acquired skills (Korzynski, 2013). This also includes availing them time to develop themselves (Osborne and Hammond, 2017). Thus, if employees feel that the working environment does not support their personal growth there is the

risk that they might get disengaged from duty (Zondo, 2020). Training and career development are important elements that should be considered in empowering workers (Kehoe and Wright, 2013). Training improves service quality and employee satisfaction therefore simultaneously achieves service quality end employment engagement goals (Kehoe and Wright, 2013).

2.5.2.3 Team dynamics and interpersonal relationships

Employees place value on their relationship with work colleagues and superiors (Mone and London, 2018). Osborne and Hammond (2017) discuss the importance of interpersonal relationships in the determination of employee engagement in organisations. Lowe (2012) captures interpersonal relationships under the work teams dimension. Work teams where employees assist each other in dealing with everyday work problems promote employee engagement. In the healthcare sector, this is very important considering that most employees work in teams (Kouzes and Posner,2012). A study by May (2004) concluded on how associations at work affect job significance and employee engagement. Mone and London (2018) found that people who have more satisfying interpersonal interactions with their fellow workers perceived their work to be more interesting.

Other positive team attributes that promote employee engagement include tolerance for diversity, respectfulness, consultative and communicative attitudes. Team size is also important and employees value teams that have enough staff members to handle given workloads (Lowe, 2012). Alagaraja and Shuck (2015) also state that employee engagement was best facilitated by an organisation's ability to manage alignment across relationship levels: personal, team and organisational.

2.5.2.4 Leadership and supervision

In Lowe's employee engagement classification, there are two leadership dimensions. The first one relates to the employee's immediate supervisor in the second one to the general healthcare facility leadership. Osborne and Hammond (2017) found that employees can leave their jobs as a result of being frustrated by their immediate supervisors. Employees expect supervisors to treat them with fairness provide adequate feedback on their performance and to assist in employee career progress. Employees also expect a leadership team that understands the organisation's

objectives and that is concerned about their working conditions (Lowe, 2012). Leaders are also expected to appreciate the value that is created by employees (Lowe, 2012).

2.5.2.5 The organisational dimension of employee engagement

Another dimension of employee engagement is the organisational aspect. Employees from organisations whose goals and objectives are clear and well communicated are likely to be more engaged in their work in comparison to employees from organisations without clear goals (Farndale, 2015). An organisation should be viewed as a safe place to work from and should instil employees with a sense of pride and belonging (Lowe, 2012). Organisations that empower workers to participate in making decisions also support enhanced employee engagement (Farndale, 2015). The policies of the company, processes, systems and frameworks also determine the extent of staff member are engagement (Anitha, 2014). Scholars have found that good organisational principles and processes are critical for worker engagement and the ultimate fulfilment of organisational objectives (Abrecht et al.,2015; Pillay and Singh, 2018). Significant processes and policies encompass reasonable staffing, choosing employees and non-rigid employment practices (Abrecht et al.,2015).

2.5.2.6 The financial aspect of employee engagement

There is a potential benefit in investigating the effectiveness of remuneration systems for the performance of employees (Anitha, 2014). This is because of the findings that financial factors also influence employee engagement (Farndale, 2015). Employee retention literature discusses the extent to which salary levels increase staff turnover. There is evidence that shows that employers offering better packages have on average lower staff turnovers than those who offer little remuneration to employees (Farndale, 2015). Raising salary levels can lead to greater job satisfaction where workers are already content and actively engaged (Dhir and Shukula, 2018). Compensation must, therefore, be supplemented by other factors that improve employee engagement (Dhir and Shukula, 2018).

Kazimoto (2016), however, argues that money was not always a major driver of employee performance despite the overemphasis it received from managers. Markos and Sridevi (2010) assert that both monetary and non-monetary benefits and incentives are important in keeping employees engaged and in motivating employees to perform. The next subsection discusses how employee engagement affects

organisational performance within the medical healthcare sector and in organisations in general.

2.6 Employee Engagement and Organisational Performance

Several scholars assert how employee engagement influences how a company performs (Markos and Sridevi, 2010; Kadiresan et al.,2015). Kadiresan et al. (2015) state that the more employees are engaged, the better the organisation realizes positive productivity, profitability, security and customer loyalty outcomes. Devi (2017) shares the same opinion and adds that organisations could improve organisational functions by employing engagement as a strategic tool. Wellins and Bernthal (2015) state how worker output, service excellence and efficient input utilisation are enhanced by positive work environments. Muthike (2016) further found out that if an organisation wants to enhance its effectiveness, it is critical for it to regularly review employee performance focusing also on identifying and addressing employee engagement levels. Involving them could help ensure that employees are highly motivated and engaged. Muthike (2016) believes that any organisation, public or private, could be defined in terms of how effectively it uses its resources, including human resources, to achieve the desired outcomes. Muthike (2016) also comments that, unlike other organisational resources, people have different needs. This means that each organisation's leadership must identify and acknowledge such different needs, particularly through its human resources management systems. The alignment of organisational needs with employee needs facilitates employee engagement (Muthike, 2016).

The Ontario Hospital Association devised its own model to assess employee engagement together with its effect on organisational outcomes including quality of service after conducting a study involving 10 000 members. This model titled 'The quality healthcare workplace model' is shown below:

Figure 2.2: The quality healthcare workplace model

Source: Lowe (2012)

According to the model in figure 2.2 above, there are three major components of employee engagement. These are inputs, processes and outputs. The inputs of employee engagement also referred to as drivers are a positive work environment, attractive and acceptable job characteristics and adequate organisational support for employees. If the three core drivers of employee engagement are available in an organisation, there is positive individual performance among medical and non-medical staff. Additionally, if these drivers are available employees experience a healthy work-life relationship and feel safe at work ultimately leading to an enjoyable working environment. The results of employee engagement emanating from positive drivers spillover into organisational performance. Most importantly organisations are capacitated to deliver quality services to patients. Secondly, they will be able to attract

and hold on to the essential and critical services required in delivering care. Finally, they will benefit from a very productive workforce that has lower operating costs. The Ontario model resonates with the findings and views from several scholars whose work was discussed above including Lowe (2012), Wellins and Bernthal (2015) and Pillay and Singh (2018). The model, however, offers a more comprehensive link between employee engagement drivers and public healthcare facility performance.

The Ontario model is very important to this section because it addresses the issue of employee engagement from a healthcare employee platform. The model also connects individual performance as affected by various organisational factors to organisational performance. It encourages the scrutinization of organisational change processes like staffing moratoria and task shifting in terms of how they affect engagement drivers, individual outcomes and finally organisational objectives like the efficient delivery of quality healthcare services.

2.7 Staffing moratoria and task redistribution

Staffing moratoria results in significant changes in staff components and consequentially in the distribution of tasks and responsibility amongst employees. This section looks at the redistribution of tasks associated with staff freezes. It excludes task-shifting which is a delegation of more responsibility to lower-level workers as this has been discussed in detail in another section.

Generally, the jobs of professional healthcare workers include an element of administration. There is a general perception among scholars that this administrative component should constitute a small proportion of one's duties (Kudo et al.,2012; Rao et al., 2016). However, there seems to be a growing concern over the increasing administrative burdens on professional healthcare workers across the world mostly as a result of different forms of staff restructurings (Oetelaar et al.,2016; Erickson et al. (2017). Kudo et al. (2012) report on how healthcare professionals spend a significant amount of time on housekeeping and general administrative duties. In most cases, these duties are not recognized as part of their roles and responsibilities. They are also not considered an increase in workload on the part of professionals (Oetelaar et al.,2016).

In a survey on the English public healthcare system, Storey et al. (2008) found that 61% of nurses felt overburdened by administrative and house-keeping work and low

support for such administrative services. This was associated with employee burnouts, increased absenteeism and low staff retention (Storey et al., 2009). In South Africa, Delobelle et al. (2011) also found that work content affects job satisfaction level, performance and consequentially service quality amongst primary healthcare workers. Primary healthcare workers who were not satisfied with the content of their work had low job satisfaction levels and would probably leave the profession (Delobelle et al., 2011). In the US, Rao et al. (2016) found that physicians believed that they spent far too much time on administrative rather than clinical functions and this impacted on their capability to offer an excellent patient service and also lowered their satisfaction with the content of their work. Kudo et al. (2012) came up with a similar conclusion on the Japanese public healthcare sector.

Increasing administrative burden within public healthcare facilities can be attributed to many factors including understaffing within the administrative function and poor planning (Rao et al., 2016). Some administrative functions especially those of a housekeeping nature are seen as a downgrade of what health professionals are expected to do (Singh et al., 2019). General recommendations on these include increasing administrative and housekeeping staff components. Erickson et al. (2017) believe that public healthcare systems must streamline administrative tasks to increase a practitioner's execution of clinical tasks. The Nursing Times (2012) comments that an increase in housekeeping staff frees more time for healthcare professionals, increasing their effort and concentration on patients. The Nursing Times (2012) also associated an increase in housekeeping team numbers with an increase in clinicians' morale. Erickson et al. (2017), however, warn that some administrative tasks are necessary in the provision of quality healthcare services. Some administrative functions are naturally related to certain clinical functions and in some cases, these are best performed by healthcare workers (Rao et al., 2016). Erickson et al. (2017) recommend a multi-stakeholder approach in relieving clinicians of administrative burdens and also encourage the use of modern technologies in this process.

As highlighted in the KZN Department of Health's staffing moratoria directive, seemingly less significant roles like housekeeping were not to be given any priorities when hiring staff. The above studies point out that such a decision may negatively impact excellent service provisions as professionals end up taking housekeeping

chores. The number of hours they get to spend on patients gets reduced and patients are not served on time.

2.8 Staffing moratoria and healthcare service delivery costs

The dilemma in today's healthcare facilities centres on how to improve quality care to patients while at the same time reducing ever-increasing staffing costs (Larson, 2017). Healthcare facilities should therefore avoid being overstaffed as this wastes limited financial resources. At the same time, they should not be understaffed, as this affects service quality (Larson, 2017; Lifecare, 2020). Lifecare (2020) argues that freezing labour posts and understaffing medical facilities does not cut costs at all. In fact, costs may go up due to the unprecedented effects of low staff morale and the need to get auxiliary staff to support core staff. Kaplan and Haas (2014) agree with this notion and also state that while cost-cutting might have immediate effects on financial reports, it has long term negative effects on organisational performance. They note some common mistakes that healthcare facilities make on cutting staffing costs. These include:

- Cutting costs on non-clinicians without evaluating how this affects the productivity of clinicians. For example, a clinician's productivity can be reduced if they now have to focus on administrative duties previously handled by a hospital clerk.
- Cutting costs without doing due diligence on the effects and impact that this has on the medical facility and its stakeholders.
- Cost-cutting without any analytical assessment of the actual budgets.
- Attempting to maximise the number of patients that clinicians can handle without consideration of healthcare quality.

For these reasons, cost-cutting through staff freezes and staff cuts often fail. The risks of such failures are often felt by patients who end up receiving poor quality service and the employees who feel overworked and demotivated (Kaplan and Haas, 2014; Larson, 2017).

2.9 Staffing moratoria, maladministration and corruption

Some sources see staff freezes as an outcome of financial mismanagement in healthcare facilities. In a petition to the Parliamentary Monitoring Group (2018),

mismanagement and maladministration were cited as precursors to poor human resource planning and policy management at Khayelitsha Hospital. Staff freezes at the facility were out of proportion, even under the precepts of the known staffing moratoria (PMG, 2018). Due to poor administration, hospital management did not consider the exceptionalities of the community, particularly its large demand for public healthcare services. Mismanagement of public resources also created pressures on funding systems. One of the ways through which such pressures have been revealed is through cutting healthcare budgets, including through staff freezes. Molelekwa and Sehoai (2017) report that hospitals in Gauteng often run out of funds due to misuse, in certain instances failing to pay staff their salaries. This situation is antecedent to staff cuts and staff freezes as facilities attempt to compensate for illicit budget deficits through cutting costs. In the same vein, Veld and Van De Voorde (2014) and Maphumulo and Bhengu (2019) suggest that mismanagement in public healthcare facilities in South Africa might have played a bigger role than expected on the deterioration of financial health, which is an antecedent factor of job cuts and freezes.

There are some views that the financial challenges that lead to decisions by staff freezes and other cost-cutting measures in the public healthcare sector stemming directly from corruption. The findings by Rispel, Jager and Finn (2015) are indicative of corruption challenges in South Africa's health system. They revealed predispositions to corruption as; choosing agents, absence of a mechanism to see corrupt activities and lack of consequence for corrupt persons. They then recommend that strategies to decrease corruption should encompass political willpower to get rid of corruption in healthcare, enforcement of laws from government, relevant systems, the participation of members of the public and advocating for public officer bearers accountability (Rispel et al, 2015). Flowing from the assertion above by Rispel et al. (2015) on corruption being one of the factors contributing to the problems affecting the South African healthcare sector. Lewis et al. (2006), as well as Holmberg and Rothstein (2011), argue that reinforcing authority structures and decreasing corruption are universally recognised as important interventions for enhancing health outputs, to attain Millennium Development Goals, and other communal and progression objectives (Lewis et al. 2006).

2.10 The impact of staffing moratoria on healthcare access

The implementation of staffing moratoria is hard-hitting for poor rural patients on the ground and has catastrophic consequences for healthcare, particularly in rural health settings (Young, 2016; PSC,2018). Provincial treasuries and health departments are encouraged to find reasonable responses to staffing moratoria within available budgets (Ferrinho et al.,2012). The three most rural provinces in South Africa have the lowest doctor to patient ratios with the worst vacancy rates. RHAP, (2015) states that for the rural clients, the results are numerous and can result in death. The impact on healthcare and the consequences include amongst others:

- poor health care service with negative consequences– a high number of grievances
- poor healthcare output– impacting chronic patient retention in treatment;
- increased duration for receiving treatment– resulting in people not seeking treatment;
- inadequate supervision and failure to follow protocols and procedures
- increased turnaround time in responding to emergencies and
- Non-compliance with national standards of care and management of chronic illnesses

These are amongst other challenges that rural health hospitals are facing as a result of staffing moratoria (RHAP, 2015). The next section discusses staffing moratoria as a change management view.

2.11 Staffing moratoria: a change management view

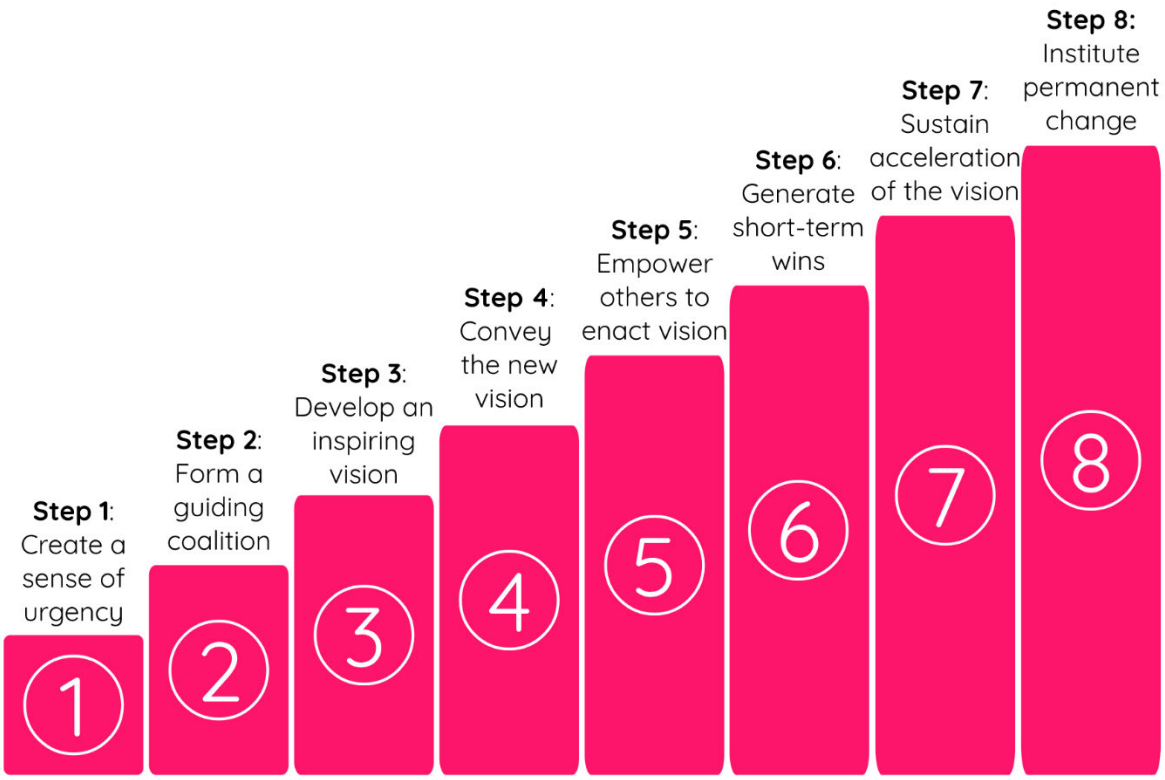
Staffing moratoria can be viewed from a change management perspective as it involves significant transformations in staffing volumes relationships and structures (Lv and Zhang,2017). This section looks at staffing moratoria from a public administration change management perspective.

It is argued that there are two types of change - a change that is necessary and change that is perceived to be unnecessary (Kouzes et al.,2016). Unnecessary change involves transformations that will not add to the achievements of the goals and objectives of the healthcare system (Lv and Zhang, 2017). Necessary change, on the contrary, is expected to bring about positive outcomes to healthcare systems (Kouzes

et al., 2016). Employees and other stakeholders are less inclined to participate in change perceived to be unnecessary (Eckert et al.,2016). At the same time even when change is sometimes necessary, there is also a risk that employees may not be inclined to participate in it. This is because change is seen as disruptive, uncertain and requiring a lot of effort from employees (Donnelly and Kirk 2015; Eckert et al.,2016).

There are various change management models in the literature. Lv and Zhang (2017) assert that Kotter's change model can be successfully used to implement change in the public healthcare sector.

Figure 2.3: The eight stages of Kotter's change management model:



Source: https://www.businessballs.com/change-management/8-step-change-model-kotter/

Using Kotter's model as discussed by Kotter (1997), Shore (2014) and Lv and Zhang (2017) the first step in implementing change is to create urgency. This involves justifying why change is needed and why it is needed immediately (Shore, 2014). This

stage also helps to rationalize the necessity of change to employees and other stakeholders (Shore, 2014, Aziz, 2017 and Lv and Zhang, 2017). The second stage involves building a coalition that will spearhead the change. This involves identifying and engaging internal and external stakeholders who will be able to implement and guide the change process (Shore, 2014, Aziz, 2017 and Lv and Zhang, 2017). Internal stakeholders from across all departments and professions can increase the level of buy-in then the proposed change can have.

The third stage involves the development of a vision for the change, focusing on why this would be good for the organisation. The fifth stage involves communicating the developed vision for change while the fifth stage involves empowering staff to participate in the change. This could involve training, retraining and extensive engagements meant to make staff aware of the proposed change (Shore, 2014, Aziz, 2017 and Lv and Zhang, 2017). The sixth stage involves generating short-term wins and the seventh and eighth steps consolidating such wins and making change a core part of the system (Shore, 2014, Aziz, 2017 and Lv and Zhang, 2017). The above steps are seen as necessary because they guide against haphazard change implementation that in the end may not have any buy-in from employees. They also improve the quality of change as they emphasize the rationalization of change to involved stakeholders (Kotter, 1997; Shore, 2014).

The World Health Organisation (2000) cites five key qualities that healthcare system change processes should encompass. These are:

- change should be systematic and must be evidence-based
- change formulation and implementation process should be inclusive taking into account all concerned stakeholders
- change should be supported by highly responsive leadership
- change should be supported by effective communication that is simple and understandable to or parties involved
- change should be transparent and open in the drivers of change should indicate the possible risks and dangers of coming change.

The above guidelines and Kotter's model emphasize the importance of inclusivity, openness and communication in change management.

The role that leadership plays during change cannot be underestimated. Lv and Zhang (2017) discuss the concept of collective leadership during change. In collective leadership, all leaders whose units or entities are affected by change work together to bring about coordinated and well-supported change that meets the objectives of the whole system (Eckert et al.,2016). Change is associated with great uncertainty and fear (Shore, 2014; Eckert et al.,2016). After implementation, some of the greatest concerns are the failure to adapt to change and resistance to it (Shore, 2014; Donnelly and Kirk 2015). Collective leadership of a transformational nature and style will be needed to engage employees, address their fears and concerns and motivate them towards reaching change goals (Lv and Zhang (2017).

Byers (2015) believes that effective leaders can manage change even under a severe lack of organisational support. This is necessary for the public healthcare sector where policymakers and policy implementers are distanced creating the risks that most formulated policies are not strategically supported (Byers, 2015). Leaders in the public healthcare sector need to balance policies on paper with the reality on the ground. This requires leaders who can lead from the front (Maynard-Moody & Musheno, 2012). The above scholars suggest that in the public healthcare system poorly supported change is a common reality that challenged more from managers and leaders.

2.12 The public healthcare system in South Africa

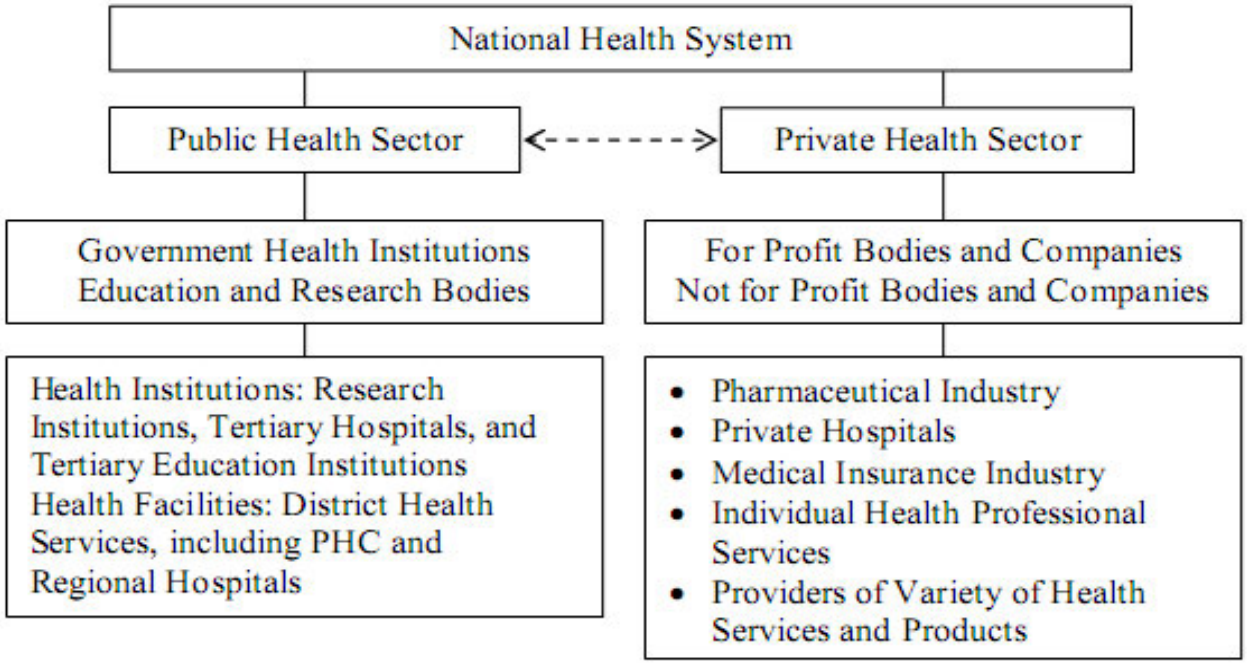
South Africa's historical background paved way for an unequal society negatively impacting on black Africans (Delobelle, 2013; Young, 2016). Albeit attempts by the government to rectify the historical inequalities, improvements have been minimal with little progress in attaining the health Millenium Development Goals. Ineqaulities also exist between the urban and rural communities adding to the load of the poorly capitalised public health system (Delobelle, 2013).

Delobelle (2013) posits that South Africa's health system can be defined as "pluralistic", comprising of a partially privatised and partially socialised system. The black Africans are mostly served by the large public health sector with service offerings ranging from primary health care to tertiary services in government-owned facilities. In contrast, the private sector provides service in state-of-the-art facilities for a minority with health insurance or those affording the service.

The public healthcare system is stretched and under-resourced in some rural places (Eager et al.,2019). The budgetary portion for health is approximately 40% and this provides for 71% of the population in need of healthcare and as a result, resources are constrained (Nkonki, 2019). In contrast, the private healthcare system is commercialised serving the middle class and the upper class comprising 27% of the population. Due to better wages and well-resourced health facilities, the private sector is more attractive to healthcare workers (Young, 2016). Spending on healthcare in the private sector surpasses spending in the public sector resulting in inequality of access to quality services for the majority black Africans (Shisana 2001; Nkonki, 2019). The authors also note that as a result, the majority black Africans miss chances of prevention and care services with fatal consequences.

Thus, the South African healthcare is a bipartite system - the public, and private sectors. In addition to the private-public facility gap, the healthcare sector in South Africa is unequally apportioned along the following lines: rural and urban, poor and rich and lastly government-dependent and medical insurance-dependent and these divisions have racial connotations (Rensburg, 2014). South Africa's attempt to achieve sustainable development goals will continue to be hampered by the inequitable distribution of professional healthcare workers between the public and private health systems (Rensburg, 2014).

Figure 2.4.Organisation of South Africa's Health System



Source: Department of Health (2006)

Public health institutions are overstretched with more people from rural areas dependent on them than private health institutions resulting in disparities to access healthcare services between the urban and rural communities disadvantaging the poor in rural areas.

2.13 Government expenditure during fiscal constraints and slow economic growth.

The period between 2007 and 2008 marked a period of "the global financial crises", a global recession then followed in 2009. As a result, there was a rise in expenditure by governments with lowered income, resulting in South Africa undergoing slump in economic growth with the consequence of constrains in the fiscus (Belcheri, et al., 2017; Eagar, Rensburg and Versteeg-Mojanaga, 2019). After the 2008 economic slump, the economy's growth did not quickly improve as projected and in reaction to this, the South African government presented measures to contain costs, decrease public spending growth and reprioritise expenditure from 2011 and 2012. Part of cost-containment was the freezing of posts in all government departments resulting in severe shortages in healthcare employees (Belcheri et al., 2017; Eager et al., 2019).

Pollitt and Bouckaert (2004) posit that the effects of the global economy are a critical contextual variable in the country's administrative restructuring. As noted, and in confirmation with Pollitt and Bouckaert's (2004) view the South African National Treasury response to high public expenditure was a moratorium effective the 1st of April 2016 which read in part:

> appointments for non-critical vacant posts will be blocked on government's payroll system, pending the submission of revised human resource plans. Positions for nurses, doctors…and other critical posts will be excluded from the lock, which is aimed at administrative and managerial personnel (2016/17 National Budget Review, 2016: 5).

Bardill (2000) asserts that the restructuring of the South African public sector was impacted by increasing worldwide competitiveness, the effects of World Bank/IMF structural adjustment programmes, a developing world economic crises which were not improving and central government development plans that failed. Thus, the impact of global economic performance intertwined with increasing government expenditures versus low revenue reveals itself to be one of the major root causes of public healthcare staffing challenges.

2.14 Cost-cutting measures in KwaZulu-Natal Department of Health

Presently, staffing moratoria have developed into a norm that is done formally through circulars and memos giving the direction of implementation and informally through habitual postponements in filling empty positions despite the availability of candidates**.** When staffing moratoria are formally implemented the Finance MEC and Premier must give their approval for vacancies to be filled for the current financial period. The KZNDoH Human Resource Management Circular No. 18 of 2016 issued on 09 March 2016, states that the following posts were considered critical, and may not be frozen:

> **EMRS emergency care officers:** Emergency care officer, Paramedic
>
> **Manager: Chief Executive Officer:** Chief Executive Officer
>
> **Medical Officers:** Clinical managers, Senior Clinical Manager**,** Manager: Medical Services: Non-Clinical**,** Medical Officer**,** Medical Officer (Community service and Intern)

Medical specialist: Head Clinical Department**,** Head Clinical Unit**,** Medical Specialist (Sub-Speciality) and Medical Specialist

Nurse professional: Professional Nurse (Community Service, Speciality and General Nursing)**,** Clinical Programme Coordinator**,** Clinical Nurse Practitioner**,** Operational Manager Nursing (General)**,** Assistant Manager Nursing (Head Nursing Service)**,** Assistant Manager Nursing Area**,** Deputy Manager Nursing (level 1 and 2 Hospital)**,** Operational Manager Nursing (Primary High Care and Speciality Unit) and Assistant Manager Nursing (Primary High Care and Speciality Unit)

Pharmacist: Manager Pharmaceutical Services, Manager Pharmaceutical Services Assistant, Pharmaceutical Policy Specialist, Pharmacist (Community Service), Pharmacist and Pharmacy Supervisor

Radiographer: Assistant Director Radiography, Chief Radiographer**,** Diagnostic Radiographer (Community Service)**,** Radiation Oncology Radiographer, Radiographer**,** Supplementary Diagnostic Radiographer and Ultrasound Radiographer.

According to the Circular, institutional heads were directed to proceed with the recruitment process when the above-mentioned posts become vacant and were also cautioned to practice objectivity and be conscious of the financial constraints affecting all government structures as they apply for the filling of critical vacancies (KZN DoH HRM Circular No. 18/2016). The minister of health further announced twenty non-negotiable budget areas which are; “medicines, laboratory services, HIV, AIDS and TB, infection control including cleaning, blood services, medical waste management, the supply of medical sundries, child health services, food, registrars, specialists at the district level, laundry, security, vaccination, infrastructure maintenance, pilot district services, maintenance of standards and norms and reproductive health services”.

During an earlier Durban conference for Professional Hunter’s Association of South Africa (PHASA) held on the 8th of October 2015, with the Office of the Health Standards and Compliance, NDoH, Treasury Department of the North West and district and provincial managers in attendance, resolutions set were;

> 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 in deciding whether post-A in facility B is critical under the given circumstances (Versteeg-Mojanaga and Eagar, 2015: 5).

This policy has been the subject of criticism by health workers and community members, as recipients of healthcare services, due to its consequences on service delivery in healthcare facilities. The Standing Committee on Appropriations on the 2016 Medium-Term Budget Policy Statement (MTBPS) made recommendations after the identification of programmes most likely to be affected by implementing the budget. According to the Standing Committee:

> The Minister of Finance should ensure that the National Treasury, in partnership with the Department of Planning, Monitoring and Evaluation (DPME), develops systems and mechanisms targeted at identifying those programmes and spending areas that are most at risk with regards to budget execution. The committee should receive submissions of these programmes after identification.

Furthermore, the Standing Committee provided guidelines on how to minimise human resources expenses without an impact on the quality of service:

> The Minister of Finance should ensure that the National Treasury, in partnership with the Department of Public Service and Administration (DPSA) and the DPME, develops comprehensive cost-containment guidelines targeted at national and provincial departments of education and health, ensuring that posts for critical staff are protected in relation to service-delivery requirements, payroll management is effective, and that all districts have costed human resource plans and innovative methodologies to contain costs without compromising service delivery.

Thus, there are strong views from other public healthcare stakeholders that feasible cost-cutting alternatives that exclude the freezing of staff posts can be found.

2.14.1 Factors that lead to cost-cutting measures in the KwaZulu-Natal Health Department

Despite numerous aspects that led to implementing of the staffing moratoria in the KZNDoH, there is proof that the main reason was a budget constrain (Rural Health Advocacy Project, 2015).

The implementation of cost-cutting measures in the KZN Department of Health can be traced back to 2009, when the KwaZulu-Natal Treasury announced that it has placed a moratorium on the filling of all posts in all departments, with effect from 29 October 2009. The Human Resource Management Circular no. 153/2009 titled "*Moratorium on the freezing of post"* further states that all vacant posts that have been advertised and interviews conducted, but the appointment letter has not been issued are also frozen. In determining the root cause of the implementation of stringent cost-cutting measures, the provincial treasury in KZN stated how the expected excessive spending at the end of the year would warrant a provincial recovery plan authorised by the cabinet to decrease the overspending levels.

The corporate communication issued by Mbangwa (2008) further mentions that the department of health has previously highlighted to the provincial treasury the necessity to revise the yearly budget apportionment for the department. This also put the department under significant pressure after failure to revise the allocation. For the 2007 to 2008 financial year, the department spent R14.959 billion which was in excess by R1.034 million from the allocated R13.925 billion. The R14.959 billion departmental expenditure for the 2007/08 financial year was accounted for as follows:

- R730 million was over-spent in worker remuneration and R637 million for services and products. The department spent approximately R1 billion on nursing remuneration adjustments in line with the Occupation Specific Dispensation (OSD) after protest from public servants was resolved by that nursing compensation should be effected from the 1st of July 2007.
- Despite spending about R1 billion compensating nursing services, R237 had been apportioned for the execution of the OSD. Consequently, R441 million was overspent. Auditing was done which showed incidences of over-compensation totalling R28 million. The R28 million spent on overcompensation is presently being paid back in line with regulation.

- R220 million was added for compensation adjustment of 1.5% which translated to R298 million, the R78 million shortfall for this adjustment was not received to finance staff benefits.
- R250 million was added to fill in vacant nursing positions, this catered for 250 nurses at R80 000 each annually.

In the 2007/08 hearings for the expenditure committee with the national and provincial treasury in attendance, the DoH described the budget constraints they had experienced. Furthermore, written communication was delivered to provincial treasury describing the sections with the greatest necessity. In addition, similar communication was given to KZN Committee on Finance and Economic Development, who resolved that Provincial Treasury should convene with the department to help with financing and review budget constraints (Mbangwa, 2008).

Budget pressures emanated from the 2009/10 budget year, where certain departments, including the health department, had over-expenditures thereby part 34(2) of the "Public Finance Management Act" was to be implemented. The department affected included amongst others Vote 5: Education, Vote 7: Health and Vote 12, these departments saw their budget being reduced to allow compensation for overspending. The second charge did not, however, affect the health department. The cabinet approved a provincial recovery plan implemented from October 2009. An amount of R2.065 billion was projected to be collected with the buy-in of all departments in the province. Furthermore, the plan contained a list of cost-cutting measures which departments need to adhere to, in order to reduce the projected overspending.

Cost-cutting measures as implemented in 2009 include:

- Staffing moratoria
- Suspension of asset acquisition
- Only critical training internally should be implemented
- Travel abroad was streamlined
- meals during meetings were halted
- Control of mileage on vehicles
- Officers to travel in teams;
- Unnecessary trips prohibited

- Prohibition of private conferencing facilities
- Restrictions on air travel
- Team building and Christmas gatherings halted
- Limitation on accommodation overnight;
- performance bonuses halted
- no promotional merchandise to be bought;
- cash-in-lieu of leave ceased
- Restrictions on overtime and
- revision of telecommunications expenditure

These cost-cutting measures, according to the researcher in this study, appear to have failed to resolve budget pressures in the KZN Department of Health, noting that in September 2015, the department went on to introduce more austerity measures including the expansion of the staffing moratorium. Table 2.1 below shows the vacancy-related figures from 2005 to 2016.

Table 2.1: Filled vacancies in provincial health departments 2006–2016

Year	Filled posts (n)	Actual mean unit cost (R)	Amount spent on remuneration (Rand per filled post) (%)	Filled posts (%)	Mean unit cost (Rand per filled post) (%)	Actual spending on remuneration (Rand million) (%)
2005/06	228 789	201 285	46 052	2.7	2.2	5.0
2006/07	237 887	208 011	49 483	4.0	3.3	7.5
2007/08	255 091	218 615	55 767	7.2	5.1	12.7
2008/09	265 856	234 080	62 232	4.2	7.1	11.6
2009/10	271 971	250 837	68 220	2.3	7.2	9.6
2010/11	284 191	271 638	77 197	4.5	8.3	13.2
2011/12	308 813	272 601	84 183	8.7	0.4	9.0
2012/13	314 636	277 161	87 205	1.9	1.7	3.6
2013/14	303 631	299 501	90 938	-3.5	8.1	4.3
2014/15	306 784	304 359	93 373	1.0	1.6	2.7
2015/16	309 367	312 598	96 707	0.8	2.7	3.6

Adapted: National Treasury: Medium Term Budget Policy Statement (2016)

From 2012 to 2013 the number of vacancies filled in the provinces has been decreasing by 0.5% after a high of 314 636 in 2012 and 2013 (National Treasury, 2016). Worker remuneration is the greatest part of a provincial Department of Health's budget and as a whole, this portion from all provinces is a centre of attention during this period of cost-cutting (National Treasury, 2015). Table 2.1 above shows filled posts from 2005/6 financial year to 2015/16 financial, an average cost per filled post and real expenditure on compensation for these posts and the annual changes in compensation for these posts. In 2009/10 (2.3%) to 2015/16 (0,8 %), there is a decrease in the number of posts filled, yet there was a huge increase in the expenditure on compensation for these posts.

Rispel et al. (2015) mention that the budget portion from provincial health for worker remuneration rose from 54% to 64% from 2005/6 to 2014/15. These authors added that over-spending because of high inflation, salary increments, cumulative accruals, uncontrolled corruption, and a notable decline in government income together imply the absence of any fiscal room for remuneration (Rispel et al., 2015). The intention of decreasing the budget allocation was to ensure reasonable salary payments and quality service provision in alignment with the country's financial constraints.

According to RHAP (2015), over the last decade, spending in health at the provincial level has increased twofold in a period of low economic progress resulting in increased constraints on the government's income. Budgetary allocation for health is not matching the rising costs which are above inflation rates (Rural Health Advocacy Project, 2015). The National Treasury in the "Medium Term Budget Policy Statement" mentions that the revised "Medium Term Expenditure Framework" (MTEF) did not provide for funds for the expansion of public sector employment for three years. Departments that had plans to expand their headcount had to delay them. Other public facilities have to cut down on the existing number of people employed (Rural Health Advocacy Project, 2015).

2.15 Alternatives and best practices to staffing moratoria

In the literature, some scholars point out potential alternatives to staffing moratoria in the healthcare sector. The Becker's Review (2020) states that instead of laying off healthcare workers or freezing staffing positions, facilities should enhance the way they manage other costs. The review proposes that healthcare facilities ought to install

systems that objectively evaluate labour costs and that identify wastage of resources. Additionally, they should hire the appropriate personnel with required expertise as this reduces the need to duplicate resources. Poorly skilled persons often require much more support and guidance and this increases supervision-related costs. Finally, medical facilities need to keep other operational costs in check through effective cost management systems (Becker's Review, 2020). Similarly, Osaro and Chima (2014) believe that any staff cuts or staff freezes must be a result of objective, evidence-based research that outlines the effects of freezes on costs, quality care, and employee behaviour.

Prior to any changes in workforce composition, healthcare management should establish service standards and benchmarks that include the number of professionals required per patient, average and standard patient consultation hours, among others. This will enable them to assess whether decreasing or increasing staffing will have a negative consequence of healthcare services (Becker's Review, 2020). Larson (2017) proposes the use of predictive analytics that help to forecast service demand in relation to staffing needs. Predictive analytics can predict overstaffing and understaffing in the future and give medical facilities ample time to adjust human resources plans accordingly (Larson, 2017).

From the literature, it is apparent that the freezing of healthcare posts requires a delicate balancing act of quality and costs (Prince, 2017). Burke and Ryan (2014) argue that the relationship between costs and quality is complex and mediated by many unknown factors. They conclude that in the US public healthcare system, an increase in cost does not necessarily translate into an improvement in healthcare quality. Additionally, a reduction of costs does not always mean that healthcare quality will decrease. It was therefore critical to assess institution-specific factors that governed this relationship between cost and quality and make decisions based on such assessments in order to address situation-specific issues that can arise as a result of cutting costs (Burke and Ryan, 2014).

2.16 Task-shifting as a method to solve health personnel shortages

Recently, the worldwide "human resources for health" (HRH) problem has increased finding a suitable resolution has increased, as a result, several research resources are available on this matter. It is therefore of paramount importance to discuss briefly the

concept of task-shifting in this research's background and in relation to the crisis of HRH. The global human resource shortage in healthcare is widespread. According to the WHO (2019), globally there is a perennial inadequacy of skilled healthcare personnel at a time when there is an elevated need for their services. WHO projects that worldwide, a total of 9 million healthcare workers is required if Sustainable Development Goal 3 is to be met by 2030. By 2030, 18 million healthcare workers will also be required to meet global demand (WHO, 2019). This demand is under-developed and developing countries (WHO, 2019). These shortages in human resource for health have given the construct and implementation of task-shifting urgent eminence.

There is no solitary reason for the HRH crises. There is inadequate training and recruitment of persons in public health facilities. Moreover, in South Africa, the workforce crisis is due to the fact that cost-cutting measures are implemented to meet budget pressures despite a substantial upsurge in the demand. In addition, there is an unequal distribution of expert health personnel with the majority in urban communities and employed in the private sector, instead of the public sector. Several terminate employment because of impoverished employment situations and poor remuneration and join the private sector. Emigration overseas also depletes the public sector workforce (WHO, 2016).

The World Health Organisation (2008) provides a comprehensive definition of HRH, described as persons involved in activities intended to improve health (viz. medical and non-medical employees within the health sector). This definition includes persons involved in health promotion and preservation together with persons diagnosing and providing treatment. Further encompassed in the definition are managers and support staff, who provide services indirectly and help make the system function effectively and efficiently (WHO, 2008).

Emdin and Milson (2012) indicate that task-shifting partly originated from the management of HIV especially in low to middle-income countries where inadequate health personnel in the public sector had increased work pressure. Currently, research has indicated task-shifting models facilitate improved service excellence, cheaper and reaches larger numbers of patients than physician-centred models (Callagham, Ford and Schneider, 2010). According to Lehmann, Van Damme, Barten, and Sanders

(2009) in the past the assigning a job between workers was known as substitution and represents an old practice. Lehmann et al. (2009) state that for several decades the practice of substitution has been utilised for emergencies as a strategy to ensure adequate care for primary and secondary facilities. Substitution has spanned numerous countries as a means of cost reduction and improving service excellence. It has also been used to increase staffing levels in understaffed rural facilities (Lehmann et al., 2009; Baine et al., 2018). These advantages from task shifting have spurned the increased attention it has received as an answer to enabling accessibility of health service to the public. Task-shifting strategies are aligned to the basic values of equity, access and quality in health service (Baine et al., 2018).

WHO advocates and approves task shifting, which is used interchangeably with task-sharing. It is described as:

> …the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health (WHO, 2008:2).

There is a crucial difference between task shifting and task sharing, the latter denotes a cooperative method that levels the tiered framework of a “physician centred” theory (Emdin and Millson, 2012). Contained in the construct of task-sharing is the notion that similar jobs are done the various healthcare personnel, that is procedures are carried out collaboratively and accountability is mutual (Petersen et al., 2012; Emdin and Millson, 2012). In both task-shifting and task-sharing, two broad groups of participants can be identified. In the first instance, non-clinicians or administrative staff within medical systems can be given additional roles and responsibilities formerly reserved for clinicians. In the second instance, community health workers who are not part of the healthcare facility can take up clinical roles and responsibilities as if they were employed by the healthcare facility (Cliff et al., 2010; Smith et al., 2014).

Task-shifting illustrates how tasks which have conventionally been within the sole domain of specialists should be done by other healthcare workers who do not have the specialised training (Emdin and Millson, 2012). Lehmann et al. (2009) suggest that task shifting needs thorough consideration of the organisation, structuring, and sourcing of care services (Lehmann et al., 2009). They further concluded that while

task-shifting was motivated by the need to curb the HIV epidemic it has the likelihood to capacitate countries to construct systems they can maintain, which have equity and can provide monetary value, as countries progress towards attaining “health for all”. Task-shifting signifies abandonment from the conventional healthcare service delivery strategies which were dependent on specialists and can contribute to increasing accessibility, particularly for marginalised communities.

2.16.1 Opportunities for task-shifting

Studies on the feasibility of task-shifting were done during the ’70s and ’80s in the Democratic Republic of the Congo as there were inadequately trained healthcare personnel warranting the utilisation of support staff in healthcare. Task-shifting was reportedly associated with increased health access as a benefit. Doctors were freer to apply their expertise to complicated cases as they had more time. Several patients noted the advantage of accessing care services within their localities instead of distant hospitals. A study conducted within Mozambique, it was concluded that respondents held positive views on task-shifting because it resulted in quicker and efficient service at medical and healthcare facilities. It freed doctors from less critical activities enabling them to focus on more critical cases and it increased overall healthcare accessibility (Rustagi et al.,2015).

On a financial front, task-shifting is seen by some as a solution to fiscal resources challenges. For instance, Jacob, McKenna and D'Amore (2015) believe that it is costlier for governments to engage and train nurses and doctors than auxiliary healthcare employees, this is despite that auxiliary healthcare workers when experienced and skilled have improved patient outcomes justifying their employment instead of trained personnel.

In 2006, the WHO launched a task-shifting project in seven developing countries, specifically; Zambia, Ethiopia, Malawi, Namibia, Uganda, Haiti and Rwanda. The task-shifting method was hailed for supporting HIV management efforts in these countries. In Uganda, task-shifting forms the basis for administering antiretroviral therapy (ART) (Baine, et al., 2018). The doctor-patient ratio in Uganda is 1:22 000, and a shortage of healthcare workers is estimated at 80%. As a result, numerous tasks which were done by doctors are now performed by Ugandan nurses. Examples of these responsibilities

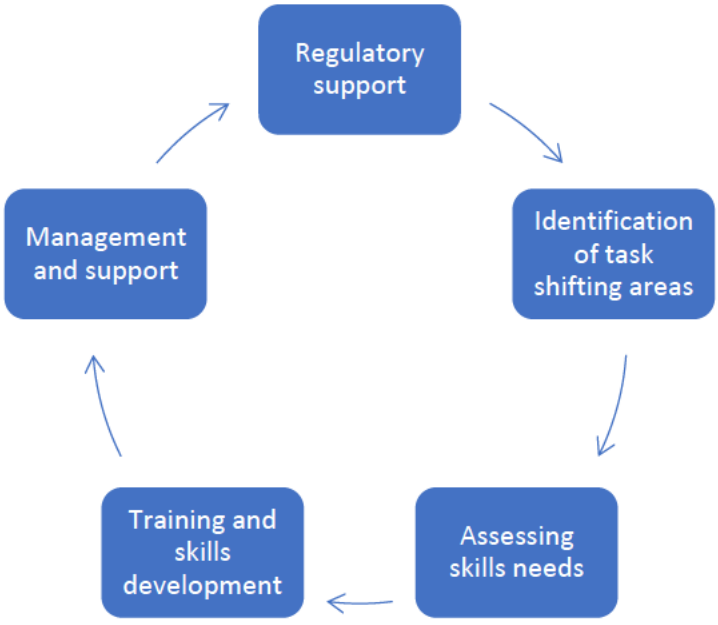
are ART management inclusive of opportunistic infection (OI) treatment (Baine, et al., 2018).

The United Kingdom has also experienced task shifting. It has been suggested that people in these developed countries show greater satisfaction when service is provided by a nurse practitioner than a doctor and this is attributed to improved interactive skills in nursing in comparison to doctors. The adoption of task-shifting has also been noted in Australia and the United States of America, where tasks are shifted from trained personnel to untrained members of the public. Many people with chronic illnesses are given patient education to manage their illnesses daily. The health outcomes of the patients are much more positive and they require a lesser amount of service (WHO,2006).

2.16.2 Task shifting steps and processes

Deller et al. (2015) studied over twenty sources from between 2005 to 2011 and came up with a stepwise set off key success factors in the implementation of task shifting. Figure 2.5 shows these factors:

Figure 2.5: Key task shifting factors



Source: Deller et al., (2015)

Developing a regulatory framework that supports task shifting is presented as an important factor without which task shifting cannot proceed. This involves setting task shifting as a process within national legislation (Callaghan et al., 2010). This also means that providers of task shifting services are recognized within health professional structures and bodies (Callaghan et al., 2010). Without adequate regulation, there is a risk that government monitoring of task shifting, as well as the implementation sustainability measures associated with it, may not be of any legal effect (Dambisya & Matinhure, 2012). This may also result in increased resistance to the process of task shifting by other stakeholders especially considering that some groups may feel that their professional territory has been infringed upon (Baine and Kasangaki, 2014; Deller et al., 2015). Regulation also means that standards that control risks implemented in that important policy to give means is well is procedural manuals for task shifting are made available (Dambisya & Matinhure, 2012). They also suggest the popularization of any new task shifting policies to ensure that policymakers, employees and other stakeholders share a common understanding of task shifting. Baine and Kasangaki, (2014) caution that healthcare professionals and policymakers were a potential threat to task shifting because of their resistance to it but Rustagi et al.,(2015) believes that greater involvement of all key stakeholders of task shifting reduced conflict and resistance.

2.16.2.1 Identification of task shifting areas

Not all services that are provided by clinicians can be physically and successfully task shifted (Deller et al.,2015). It is therefore important to identify areas in which task shifting can be effectively implemented and within the regulatory framework (Baine and Kasangaki, 2014). The task identification stage is important in that it guides the levels of skills that will be required discussed in the next subsection.

2.16.2.2 Skills determination

The skills determination process involves the identification and quantification off skills and expertise that will be required amongst the human resources to be tasked shifted. The identified skills need to be standardized and certified to enhance service consistency (WHO, 2014). Deller et al. (2015) and Limbani et al. (2019) view this stage as very important because it also attempts to prevent potential skills versus services mismatches that may result from poorly- planned task shifting.

2.16.2.3 Skills development

Once the required skills have been identified the next step will be to develop these skills. This involves training, mentoring, in-service learning, demonstrations and additional types of skills development that may be necessary for developing a given level of knowledge and expertise. Deller et al. (2015) advise that supervisors, administrators and clinicians responsible for supervising task shifted employees must also be trained. This is to enhance their capacity to manage task shifting resources so that they perform according to set standards and procedures (Brentlinger et al., 2010; Limbani et al., 2019). Mdege et al.,(2013) recommend training must be a continuous process to enable the scaling of task shifting in line with healthcare system needs.

2.16.2.4 Management and support

The final stage in task shifting implementation is management and support. According to Deller et al. (2015) support involves the following:

- Giving adequate supervision, guidance, and monitoring to task-shifted personnel
- Ensuring fair remuneration to task-shifted employees
- Providing technical and material resources required by task-shifted employees for them to do their jobs effectively
- Linking them to a referral system through which they can quickly escalate complicated medical and health conditions

Deller et al. (2015) assert that referral systems are more important in cases where task shifted resources work from communities that are far from public healthcare facilities. Limbani et al. (2019) comment that the task shifting management process must focus on conflict resolution among co-workers. This was because of different levels of acceptance that the process had among different skills cohorts. They further assert that effective management and employee acceptance can result in a well-functioning task shifting regime that improves the operationality of the public healthcare sector.

Overall, Lumbani et al's (2019) study conducted in South Africa showed that task shifting helped to increase healthcare access among hypertension patients. Spedding et al.(2020) also assert that task shifting has helped in increasing support for South African mental health patients. These findings agree with the conclusion that task

shifting could be a potential solution to healthcare staff shortages provided various contextual factors, among them the five discussed by Deller at al.,(2015), are taken into account.

2.16.3 Key considerations in implementing task-shifting

It must be noted that research indicates that task-shifting is An important method to cope with inadequate HRH, hence, where its practise should be in structures that have enough controls for the healthcare personnel and patients (Smith et al., 2014). To achieve this there must be laws and or policies that facilitate and control task shifting (WHO, 2006:6). In some government health institutions, certain duties are limited to certain health workers and cannot be performed by other workers. Despite task-shifting being allowed in several countries, there in the South African context, legislative protection is not accorded to personnel performing beyond their practice scope. In addition, formalised control for nurse management of ART (ART53), is absent or a practice scope for auxiliary personnel. Despite section 56(6) of the South African Nursing Act (33 of 2005) permitting ART prescription by nurses, the non-existence of authorisation from the South African Nursing Council is concerning.

For task-shifting to be implemented smoothly and to yield the desired outcomes, checks and balances are essential to avoid conflict with the systems already in place. WHO (2006:7), warns countries practising task-shifting as an imperative solution to health personnel inadequacies, in situations where service needs supersede regulation procedures which are sluggish and burdensome. In Ethiopia and Malawi, the state of affairs has become urgent as such creating an impetus to assist in the creation of an innovative facilitating environment. The governments in both countries have removed the legislative and controlling statutes on doctors only prescribing ART (WHO, 2006). In other parts of the country, task shifting occurs outside the legislative structures because statutory instruments do not outline tasks to be performed and the person performing them, or due to task-shifting occurring beyond public facilities like in not-for-profit organisations.

Padmanathan and De Silva (2013) reviewed the possibility and adequacy of task-shifting for mental healthcare in developing and under-developed countries among patients and healthcare providers. Their findings warn about perceiving task-shifting as the absolute answer to staff shortages. These authors highlight many critical

aspects for consideration if task shifting will be suitable and possible. The factors encompass, paying attention to the degree of distress of workers, individual worker perceptions of ability, how other cadres in the workforce accept benefits given to retain staff (Padmanathan and De Silva, 2013). If practised in a healthcare system that is overwhelmed and not functional, in solitary task-shifting will not enhance service excellence and effectiveness (Smith, et al., 2014; Crowley and Mayers, 2015).

2.16.4 Challenges of task-shifting in response to staffing moratoria

Several African countries, including South Africa, support staff, auxiliary staff and community health workers take up responsibilities and provide interventions lawfully preserved for middle to higher graded personnel because of staff shortages (Buchan and Dal-Poz, 2002; Baine et al., 2018). This practice is recognised out of formal lines and seldomly reported and disregarded in planning HRH.

In South Africa, task-shifting is being implemented informally and haphazardly, without health legislation and policies supporting its implementation (CrowleyI and MayersII, 2015). For task-shifting to do well, structures and personnel backing are needed. In highlighting the challenges in the implementation of task-shifting, Lund and Flisher (2009) caution that however creative and operative task-shifting methods are in decreasing the mental health interventions difference professional services will continue to be needed. Kakuma et al. (2011) also mention that although the goal of task-shifting is to decrease expenses, and expand inputs, WHO issues a stern warning on reliance on task-shifting as the only solution to staff shortages. Also, the WHO notes the need to implement measures to improve the number of healthcare personnel (Kakuma et al., 2011). At the same time, task-sharing is most successful if one or more professionals is coordinating and managing task-shifting (Goodrich and Kilbourne, 2013). This does not resolve the human resource for health crisis especially in South African health departments, where specialised doctors and nurses have left health facilities.

The South African College of Applied Psychology (2018) cautions that a problem impeding the utilisation of task shifting in mental health care is fear associated with the provision of care below acceptable standards. Nevertheless, there are indications that

auxiliary staff and members of the public can be taught to provide efficient mental health interventions for most disorders (South African College of Applied Psychology, 2018).

Fears that were associated with task-shifting were that most persons enrolled in the programme were not given adequate training to provide sufficient levels of care to patients. In addition to this little or no training situation, they were also poorly supervised. Overall, this translated into increased risk for patients (Rustagi et al., 2015). Smith et al. (2014) cite cases from Malawi where task-shifting participants lacked a clear understanding of their roles, due to lack of adequate guidance and poor delegation processes. Smith et al. (2014) cite that communities were notably frustrated by the fact that they did not understand the limits of the roles and responsibilities of task-shifting workers. Philip and Chaturvedi (2018) identify four concerns or challenges associated with task-shifting. These are ethical concerns relating to the passing of responsibilities to less qualified cadres; legal concerns associated with laws and regulations that restrict medical practices to professionals; systemic concerns associated with poor policy and strategy management; and training concerns. If task-shifting is to be successful, these concerns needed addressing.

Rustagi et al. (2015) found that there were risks of power conflicts between clinicians and assistants enrolled in task-shifting programmes. These could emanate from poorly structured roles and responsibilities between the two groups. Rustagi et al. (2015) further comment that any structural challenges in the clinician-assistant relationship would affect service excellence offered to the society negatively. A study by Baine et al. (2018) hints that conflict can also exist when qualified clinicians begin to believe that their professions were being encroached upon by unqualified persons. A study by Bocoum et al. (2013) also mentioned protectionism as a hindrance the success of task-shifting. Professionals protecting their domains are less likely to support the recruited task-shifting cadres leading to their disorientation.

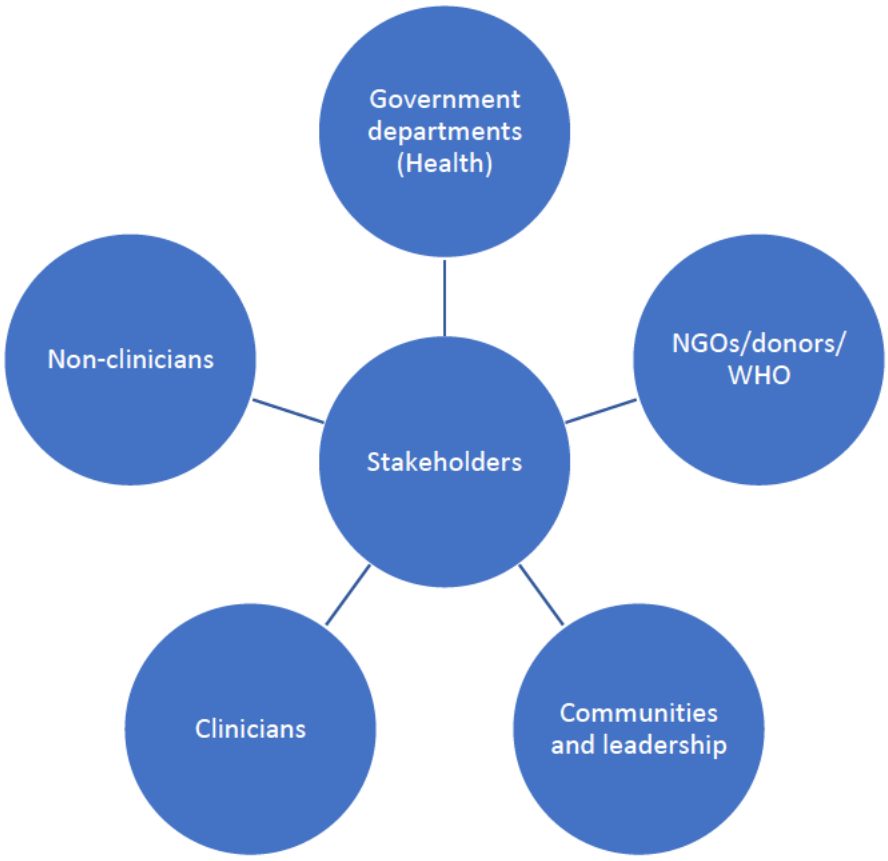
Some studies also show that the cadres recruited for task-shifting sometimes do not perform as effectively as envisaged. Walsh et al. (2010) point out that the assistants are often exposed to high volumes of work, often with little supervision and assistance from professional healthcare workers. This exposed them to burnouts that impeded their ability to provide quality service. Traore et al. (2011) state that task-shifting cadres

do not always have a clear career path, which serves to undermine motivation and reduce job satisfaction. Nabudere et al. (2010) argue that task-shifting cadres are likely to feel insecure about their positions, because most lacked a legal backing for their new roles, while Bocoum et al. (2013) believe that because they often get little benefit from their jobs, their turnover was considerably high. These factors, as noted, impeded the ability of task-shifting cadres to effectively contribute to the betterment of the health crisis. Bocuum et al. (2013) therefore propose judging the effectiveness of task-shifting cadres, while considering the context in which they worked.

2.16.5 Roleplayers in the implementation of task-shifting

Several key players need to be incorporated in the formulation and practising of task-shifting. Rustagi et al. (2015) believe that task-shifting is only effective where there is consensus among the wide group of role players involved. For this reason, consultation and engagement with various interest groups is critical for the success of task-shifting. Figure 2.5 below shows the stakeholder groups that should be considered.

Figure 2.6: Task-shifting stakeholders



Source : Smith et al. (2014) ; Rustagi et al. (2015)

WHO leads on guidelines on the adoption of task-shifting particularly with regards to controlling structures, backup management and monitoring, and evaluation guidelines. However, the World Health Organisation alone can never succeed without allowing the involvement of the councils that regulate the professions making decisions on task-shifting. Regulatory bodies that are also important roles players in task-shifting include the Health Professions Council of South Africa (HPCSA), South African Nursing Council (SANC), South African Pharmacy Council (SAPC), Allied Health Professions Council of South Africa (AHPCSA) and Traditional Health Practitioner Council (THPC). Direction and assurance from management bodies also play an important role to solve problems. Smith et al. (2014) conclude that task-shifting works effectively when the NDoH leads the plan and approach development of the process in consultation with NGOs and other healthcare sector stakeholders. This creates a common understanding of the process and also makes it easier to co-ordinate task-shifting programmes across different healthcare facilities (Smith et al. 2014).

WHO initiated guidance on task shifting 11 years ago (WHO, 2006). The guidelines where particular in the framework of HIV management. The current times may be ideal to revise the WHO guidelines to incorporate other healthcare services that are presently problematic, especially the human resource crisis for health to ensure the optimum provision of healthcare including HIV-related services (Crowley and Mayers, 2015).

2.16.6 Task shifting: the Mozambican experience

Within Southern Africa, Mozambique is one of the most cited countries when it comes to task shifting. Mozambique introduced task shifting as a coping mechanism for high public healthcare services demand versus significantly low human resources capacity (Government of Mozambique, 2005). Mozambique has one of the lowest ratios of health care professionals per given persons. In 2014 the WHO reported a ratio of 4 healthcare professionals for every 10,000 Mozambicans (WHO, 2014). This was by far one of the lowest considering that WHO's recommendation stands at 23 health care professionals for every 10,000 people (WHO, 2014) This was, however, an

improvement compared to the 1.43 per 10 000 persons reported in 2004 when the government first mooted introducing task shifting (Government of Mozambique, 2005). Like most countries in Africa Mozambique was hardly hit by the HIV/AIDS pandemic. The country's depleted public healthcare system found itself unable to cope with increasing demand for services. This demand was even higher in the very poor rural communities that dominate Mozambique (Brentlinger et al., 2010).

In 2006 the Mozambican government introduced training for physicians assistants to help with the implementation of ART distribution processes (Sher et al., 2009). This group received two and a half years of training instead of the usual five years for medical doctors. They were recruited after completing the 10th grade and upon successful completion of training, they received further two-week training in dealing with HIV/AIDS ART prescribing and monitoring (Brentlinger, et al., 2010). Their direct responsibilities, therefore, included prescribing ARTs and attending to pregnancy-related HIV/AIDS matters, activities formally reserved for medical doctors and senior nursing staff (Rustagi et al., 2015).

2.16.6.1 Effects of task-shifting on public healthcare challenges

In 2010, the Mozambican government suspended task shifting and implemented a retraining process for physicians' technicians. This was after an initial evaluation of the training process given to physician's technicians as well as their performance in the field was conducted (Brentlinger et al., 2010). Brentlinger et al. (2010) note that only 10 of all observed patient-professional interactions involving the physicians' technicians went according to set guidelines. They point out at poor training procedures in the absence of task shifting best practices as a major challenge that Mozambique's initial training and deployment of physicians' technicians faced. Another challenge that task shifting processes were exposed were limited supervision and were at risk of failing to manage any complications that resulted from their efforts (Rustagi et al.,2014). On the other hand, scholars note that the programme has had its successes (Deller et al., 2015). The Mozambican task shifting approach was associated with increased access to healthcare among rural populations, reduction of waiting periods for service, reduction of work burden for medical doctors and increased patient, post-treatment monitoring (Rustagi et al., 2014). It has also increased the public healthcare sector's counselling and testing capacities (Deller et al.,2015).

The key success factors in task shifting as drawn from Brentlinger et al. (2010), Ferrinho's et al's (2012) Rustagi et al's (2014) studies are that adequate, well-regulated training and supervision must be provided to cadres recruited for tasks shifting and without that the process poses a severe risk to the public. Rustagi et al (2014) add that task shifting must be implemented in consultation with all key stakeholders including communities. They cite the buy-in of medical doctors whose jobs were to be task shifted as being crucial since they provide the overall monitoring and supervision of the process. Without the buy-in of internal staff, task-shifted resources ran the risk of being rejected and isolated. Importantly, Rustagi et al (2014) point out that resistance to task shifting can be expected even when resources are scarce and therefore encourage greater co-operation among stakeholders.

2.17 Conclusion

Healthcare services offered rely on an adequate number of healthcare personnel, capabilities of the health workers, their deployment and their leadership. This chapter discussed staffing moratoria from a South African, as well as an international perspective. It further investigated the matter of task-shifting as a tool to solve the problem of inadequate personnel in health. Generally, the findings point to staffing moratoria as having a negative impact on personnel motivation and the quality of service in the sector. On the subject of task-shifting, the literature revealed the existence of a multiplicity of both negative and positive views on the process. Some sources noted task-shifting as the answer to inadequate staff, while others reported it to be a source of risk to patients who might be exposed to poorly trained personnel. The next chapter looks healthcare sector cost-cutting experiences of four countries – Greece, Zimbabwe, Ireland and Uganda.

CHAPTER THREE: HEALTHCARE COST CONTAINMENT: SELECTED COUNTRIES' EXPERIENCES

3.1 Introduction

Cost-cutting measures in the public healthcare sector have been implemented in other countries as well as a response to different factors and crises. Countries in the European Union (EU) saw recessionary conditions due to the global economic crisis with Greece, Ireland, Spain, and Portugal being most impacted (Mavridis, 2018). The EU crisis health budget decreases and the implementation of financial efficacy-aimed initiatives in the public sector (Jimie, 2010). Zimbabwe and Uganda also implemented public healthcare cost-cutting measures that included recruitment freezes. In this chapter, experiences from four countries that implemented staff recruitment freezes as part of cost-containment measures, namely Greece, Ireland, Zimbabwe and Uganda are brought to the fore.

3.2 Healthcare cost containment in selected countries

3.2.1 International countries (Greece and Ireland)

3.2.1.1 Greece

Like South Africa, Greece implemented staffing moratoria as a way of managing public healthcare costs. This section discusses staffing moratoria in Greece starting with the origins of the problems that resulted in this decision. In 2008 the global economy was plunged into crisis, later officially referred to as the 2008 global economic crisis (Xanthakis, 2020). The crisis started in the United States of America with the collapse of Lehman Brothers (Igan et al.,2019). Loss of value in the United States real estate market resulted in an enhanced and unsustainable decline in asset portfolio values in the financial sector (McKibbin and Stoeckel, 2009). This decline resulted in illiquidity in the financial markets as investors struggled to liquidate their fixed assets before further losses of value. This illiquidity and the state of panic spread across the world as global banks that were exposed to United States banks also feared to be caught in the impending crisis (Igan et al.,2019).

Before the global economic crisis, the European economy was performing comparatively fine (Ozturk et al.,2015) However, the Greek economy seems to have been an exception. Even before Europe was hit by the effects of the crisis, Greek was

already struggling with high domestic debt, high international borrowings, and low economic growth (Ozturk et al.,2015). Like South Africa (Belcheri et al.,2017), Greece then suffered low economic downgrades from rating agencies as a result of increasing economic risks. The cost of borrowing for both the government and the private sector went up significantly with interest rates rising from slightly below 6% to over 12% in less than six months in 2009 (Economou et al.,2017). During the same time, Greece's budget deficit shot up room 6% of GDP to close to 16% (Petmesidou, 2019). Greece tested the firstfruits of economic recovery in 2018 when it recorded an unemployment rate of 19%. The country is not yet fully recovered and still owes the troika debts that are 180% of its annual GDP (Petmesidou, 2019).

As the challenges persisted Greece was caught up in the European debt crisis (Ozturk et al.,2015). This was a severe near bankruptcy scenario with some European countries, as result of the global economic crisis and other underlying internal economic challenges failed to honour their obligations to private entities, central banks in multilateral lending parties (Kouretas, 2012). Countries hard-hit by the debt crisis included Portugal, Spain, Iceland and Cyprus (Ozturk et al.,2015). The European Central Bank (ECB), the International Monetary Fund (IMF) were forced to intervene in Greece and the other affected countries (Petmesidou, 2019). The ECB established the European Financial Stabilisation Mechanism (EFSM), later taken over by the European Stability Mechanism (ESM) as part of continental economic recovery processes (Petmesidou, 2019). Greece benefited from these mechanisms through low-interest loans offered for budgetary and stability support purposes (Petmesidou, 2019). In 2010, Greece received 110 billion euros as part of a bailout agreement from the troika (Economou et al.,2014).

While other countries affected by the European debt crisis recovered fairly quickly, Greece needed more time to recover given the depth of the challenges created by poor economic performance exacerbated by the debt crisis (Petmesidou, 2019). By 2015, Greece had entered its fifth year of economic recession. This is despite all the implementation of various structural economic changes by the trio (the International Monetary Fund, The European Commission and the European Central Bank). Greece was put under severe pressure to reform the public sector, which was a major driver of high government expenditure by the troika (Economou et al, 2014).

Despite the above-discussed interventions, Greece continuously failed to meet the Troika's targets on revenue growth as well as public expenditure cuts. With further disbursements of the bailout agreement being conditional upon on the meeting of periodic economic targets, Greece was forced into a period of severe austerity (Matsaganis, 2012). These public budget cuts eventually spilt into the public healthcare sector.

3.2.1.2 The pre-crisis public health situation

Even before the economic and debt crisis, Greece's public healthcare system faced some structural problems. The Greek health system had failed to evolve with modernity like most public healthcare systems in the European Union (Economou, 2010; Bolton et al.,2018). Economou et al. (2014) put bureaucracy and extensive centralisation as a major underlying challenge of the Greek health system. The system suffered from both fiscal and administrative centralisation with public healthcare entities having little or autonomy to innovate to meet service demand changes of the growing population. In addition to excessive centralization, there was poor planning attributed to a lack of skilled management staff and poor management systems (Yvantopoulos and Yvantopoulos, 2015; Petmesidou, 2019). Poor planning poor coordination in lack of expertise resulted in the inefficient allocation of already scarce resources (Petmesidou, 2019). This included the poor distribution of personnel across facilities. The other challenges that the system was facing as discussed by Economou et al.(2014) include:

- Lack of adequate strategies to serve sparsely distributed populations
- poor and costly referral systems between primary and major healthcare facilities
- Unequal access to healthcare facilities and services
- Poor public healthcare funding structures
- Poor adoption of health management technologies and systems

These challenges persisted for decades as there was noticeable resistance for change even when feasible proposals were consistently being made (Bolton et al., 2018). Unlike South Africa, Greece had a national health fund whose function was to provide payment for healthcare services rendered to citizens (Bolton et al.,2018). Petmesidou

(2019) notes that this fund was poorly managed in coordinated and its inefficient operations resulted in it accumulating large debts. Its liquid resources were not adequate to immediately cover costs incurred by the public healthcare system on citizens' health.

The above challenges occurred during a period in which public healthcare expenses in Greece were rising (Eurostat, 2013). The OECD (2013) states that between 2005 to 2008, Greece's public healthcare expenditure increased from 9.7 billion euros to 14.6 billion euros. Eurostat (2013) assert that healthcare cost increases in Greece were much higher than the European Union averages. this was blamed on poor cost containment in public hospitals and other facilities, full control over the allocation of resources in the same facilities and increasing government subsidies to public health facilities as a result of non-payment by health insurance funds (Eurostat, 2013). Kaitelidou et al. (2012) and Polyzos et al. (2013) blame systemic abuses by healthcare practitioners, health insurance funds and pharmaceutical companies for increases experienced in Greece's public healthcare budgets. They list the following abuses:

- Medical aid reimbursement distortions and frauds
- Abuse of poor referral systems to refer patients for unnecessary procedures
- Over-prescription of drugs by doctors and other practitioners

Thus, even before the global economic crisis system weaknesses were taking a toll on the vulnerable public healthcare system, the healthcare system had been subjected to severe abuses that put healthcare costs out of proportion.

3.2.1.3 Public health policy changes in response to the crisis

Greece implemented various changes in an attempt to cab increasing public healthcare costs. Some of these changes are listed below (Economou et al., 2014):

- Increase in hospital fees for non-vulnerable groups
- Increase in prescription fees for non-vulnerable groups
- Increased cost-sharing for prescribed medicines between medical aids and hospitals
- Creation of a generic drug list for use in public hospitals
- Establishing a body to monitor reimbursements to practitioners under the national health insurance structures

- E-prescription systems were introduced to curb prescription abuses
- Maximum drug reimbursement prices were set
- Establishment of a regional body to monitor and approve procurement decisions
- Merging clinics and hospitals to reduce operational costs

The above measures were targeted at reducing public healthcare operational costs and the incidents of abuse that were rampant as a result of poor operational controls within the public healthcare system. These were also meant to curtail abuses that occurred when publicly insured patients visited private practitioners (Polyzos et al.,2013).

3.2.1.4 Accounting reforms

The Greek government, on the realization that some of the large cost incurred in healthcare was due to parties abusing poor accounting systems, implemented major public accounting reforms (Polyzos et al.,2013). This was aimed at increasing oversight of health expenditure as well as enhancing the accountability of the sector. The introduced changes included (OECD, 2013):

- regular publication of public health budgets and audited financial reports
- Information for all pending payments and details of the payments was to become available publicly one in monthly basis
- Major early accumulating arrears were to be reported in parliament
- The adoption of e-health technologies that enabled the central management of transactions including prescriptions and referrals
- strengthening of price monitoring mechanisms for public procurement to control over pricing risks

Various levels of success were noted in the implementation of the above (Polyzos et al.,2013) with e-health related milestones being reported as the most difficult to realise (OECD, 2013).

3.2.1.5 Staffing-related changes

The Greek government also sought to reduce operational costs in the public healthcare sector by changing its human resources policies (Kaitelidou et al.,2012). The first major policies involved the reduction of the public healthcare services employment costs bill. In January 2010 the Minister of Health in Greece pronounced

a 12% salary cut for all employees in the public healthcare sector (Economou et al.,2014). In June of the same year, another 8% salary cut was applied across the board for government healthcare workers. Performance bonuses and special allowances for healthcare workers were also removed or frozen (Economou, et al., 2014).

In 2011, the Greek Ministry of Health imposed a staffing moratorium on the hiring of doctors in public hospitals, clinics and other facilities (Petmesidou, 2019). This was based on the presumption that Greece had an above optimum number of doctors. No freeze was imposed on nursing staff as it was indicated that there way fewer nurses than needed in the country (OECD, 2013). There were further reductions in public healthcare staff owing to a new regulation against the renewal of expired fixed-term employment contracts for healthcare workers (Petmesidou, 2019). Another staffing moratorium was imposed on the replacement of retired personnel. Only 20% of the retired staff would be replaced across the board. Additional staff reductions came through voluntary retirements for older workers (Economou et al.,2014).

3.2.1.6 Outcomes of the public healthcare system reforms

It is acknowledged that the changes that were implemented in the Greek healthcare system did contribute to a reduction in operational costs. Tsavalias (2013) reports that between 2009 and 2011 a total expenditure cut of 680 million euro was realised. However, other quality indicators suffered in the process.

Starting with service quality, there are views that healthcare quality suffered as a result of declining staffing levels (Tsavalias, 2013; Boulountza, 2018: Petmesidou, 2019). As alluded to earlier, when Greece entered the financial crisis, it already had major shortages of nurses (Petmesidou, 2019). With less staff being hired, available staff had to do the work of doctors whose numbers were reduced (Katharakis et al.,2013). Petmesidou (2019) asserts that the government's mood to hire nurses went down even though there were no moratoria for their group. There were reported cases of hospital wards failing to operate because of these shortages (Petmesidou, 2019).

As the Greek crisis continued, the demand for public healthcare services increased (Boulountza, 2018). Low-income and uninsured citizens begin to rely on the public healthcare system having migrated from private healthcare insurance schemes. Thus,

the reduction of employees employed by the Ministry of Health occurred simultaneously with increases in service demand. For instance, between 2009 and 2010, the number of public hospital admissions in the country went up by 26% while there was an 18% increase in the number of surgical procedures carried out in public hospitals between 2010 and 2011 (Economou et al., 2014). Inequalities in access to healthcare services also increased in Greece (Zavras et al.,2012). Most people without health insurance were relegated to poorly staffed, under-equipped facilities (Chantzaras et al., 2018).

There are reports that waiting periods for services increased fourfold in some facilities (Economou et al.,2014). Additionally, patients intending to undergo surgery and other specialist treatments were subjected to longer waiting periods than before (Boulountza, 2018). At the same time, it is noted that readmissions as a result of incomplete treatment increased (Tsavalias, 2013).

In an attempt to enhance quality promised many changes in the healthcare sector, the Minister of Health introduced some quality-focused procedures. these included:

- the establishment of quality management units for each public hospital
- compulsory client satisfaction surveys
- the establishment of a board that certifies public healthcare quality systems

Two studies carried out during the crisis (Katharakis et al.,2013; Tsavalias, 2013) show that while some hospitals were able to reduce operational costs, they were not able to increase their efficiency scores. A few (less than 28%) were able to increase efficiency scores while also cutting costs. Most efficiencies that were obtained were not directly related to patient healthcare but were directed at non-core operational activities like procurement and accounting (Chantzaras et al., 2018). Indeed, there are views that the procurement changes that were done by the Greek government could resemble best practices in public healthcare procurement. These included the use of auctioning and extensive publication in public government procurement transaction to enhance transparency and efficiency (Economou et al, 2014) but they were budgetary rather than medical improvements (Bolton et al.,2018).

3.2.1.7 Lessons for South Africa

South Africa and Greece were affected by the global economic crisis of 2008. Both countries felt the consequences of the crisis on their populations and in public expenditures although in different proportions. Both countries suffered economic downgrades, increases in unemployment levels, increases in inequality and increases in government debt as well as declines in economic growth (Belcheri et al, 2017; Petmesidou, 2019). Both countries targeted increased austerity in public healthcare spending as one of the ways of managing public expenditure and national debt.

Based on the reviewed literature South Africa can learn the following from the Greek experience:

- Improper procurement policies can be a major drain on government revenue and if left unchecked can severely cost the public and its access to quality healthcare. It is therefore critical to review the public healthcare sector and general government procurement policies to identify loopholes in gaps that are used for rent-seeking costing the government a lot of money that would otherwise have been directed towards public healthcare services.
- In periods of economic decline, governments should be aware that reducing public sector healthcare resources (including human resources) create a severe risk of low health access and access to poor-quality healthcare. This is because during periods of economic decline more and more people rely on the public healthcare system as private medical insurance schemes may become too costly for most.
- Operational efficiency in public healthcare facilities does not always mirror public health goals. For example, while Greece's procurement systems and budgeting structures improved from deficits, this did not mirror any improvement in the public's access to quality healthcare. South Africa must ensure that financial goals and objectives crafted in consideration with health objectives and success can only be claimed if fiscal objectives are met without resulting in the deterioration of public healthcare services.
- South Africa should consider having a national public health insurance scheme like Greece, although it should be well-coordinated, structured and better-

managed. The scheme would help to increase investment in public healthcare resulting in better healthcare services without the need to cut important jobs.

In conclusion, the case with Greece is an interesting one. Greece underwent one of the biggest and most challenging economic crises in modern-day Europe. The crisis teaches the importance of sustaining a robust public healthcare system that is well staffed with qualified practitioners. In times of crisis and low economic growth, the public relies more on the public healthcare system. The risks of unequal access also increase especially amongst the already vulnerable economic groups.

3.2.2 Ireland

Due to the 2008 global economic crises, In 2009, Ireland had a GDP shrinkage of 7%, which represented the largest and longest shrinkage external to the Balkan states (Keegan et al., 2013). This resulted in the Irish government cutting the health expenditure regularly as they tried to narrow the margin created by the decline in income (Keegan et al., 2013). Arie (2013) and Williams and Thomas (2017) assert that the decrease in budget in all health departments left the health system on edge. In March 2009, the Irish Government introduced a moratorium on recruitment through the policy document *"Future health, A Strategic Framework for Reform of the Health Service 2012-2015".* Additionally, the staffing moratorium in Ireland was succeeded by a focussed and non-forced programme for early retirement which resulted in at least 1600 non-clinical staff leave the public healthcare sector. Overall, public service employee numbers fell from a peak of more than 320,000 in 2008 to a low of 288,200 in the fourth quarter of 2013. Public service recruitment decreased at a slower pace than in than the private from 2008 to 2011 (Public Health Service, 2016).

Williams and Thomas (2017) conducted a study to assess the Irish government's health department managed with the government's cutting on expenditure measures. Though the government policy of budget cuts forced substantial Human Resource for Health changes, Williams and Thomas (2017) concluded by noting achievements had been made in the objectives of the programme to grow the number of "frontline" workers simultaneously decreasing the number of supportive employees and safeguarding the particular officials. Furthermore, government policy on budget cuts was able to produce financial savings as intended but on the other hand, it failed. This

was because of the need to hire more expensive temporary staff due to the shortages caused by the moratorium (Williams and Thomas, 2017).

Before Williams and Thomas' (2017) study, MacDermott and Stone (2013) conducted a study titled *"Death by a thousand cuts"*. This study evaluated the effects of the application of an all-encompassing public service job cuts. The authors concluded that staffing moratoria decreased service excellence and accessibility and in the long run the moratoria impaired public facilities. MacDermott and Stone (2013) also concluded that a high staff turnover resulted in the loss of organisational memory and impacted skills base which worsened the unavailability of skills. The Irish Health Services staff survey conducted in 2014 also revealed that cuts in staffing intensely affected staff morale. The survey also revealed that overall employees future outlook was gloomy and they were not satisfied with the government as an employer and also felt that the health system in Ireland did not prioritise patient care (Williams and Thomas, 2017).

Also, MacDermott and Stone (2013) caution that staff moratoria in Ireland were likely the utmost harmful ways to rationalising due to these being unselective and minimising the capacity of institutions to reorganise and add new skills. Such strategies also place an additional burden of the structure needlessly (Williams and Thomas, 2017).

3.3 African countries (Zimbabwe and Uganda)

3.3.1 Zimbabwe

Zimbabwe experienced one of the most protracted economic crisis in the history of Africa. One of the crisis' major effects was felt on the already struggling public healthcare sector that experienced severe administrative and capital cost-cutting. The crisis in Zimbabwe is argued to have stemmed from poor economic management as well as misrule under the then President Robert Mugabe who ruled the country for 37 years from the time it gained its freedom from Britain.

Noyes (2019) outlines the various factors that resulted in the crisis. These include:

- Corruption and maladministration

- Macroeconomic mismanagement under the International Monetary Fund (IMF) and World Bank-recommended Economic Structural Adjustment Programme (ESAP)
- General increases in fruitless government borrowing and spending
- Zimbabwe's financially unprepared participation in the Democratic Republic of the Congo civil war in aid of one of the contesting parties led by Laurent Kabila

The impact of the above factors severely hit the Zimbabwean economy and population hard resulting in a strong resurgence of mass discontent and opposition politics. Prior, the Zimbabwean ruling party – ZANU-PF had experienced very insignificant political opposition especially after its merger with a major political party, the Zimbabwe African People's Union (PF-ZAPU) in 1987. Increased opposition politics came with increased political repression (Chipere, 2020). In 1999, after the loss of a popular vote on a political referendum, the Zimbabwean government embarked on an ad hoc land redistribution process as a means of gaining ground ahead of the 2000 national elections (Noyes, 2019). Many researchers and political sources put this as the major event that put Zimbabwe's economic recovery prospects at severe risk (Kairiza, 2010; Noyes, 2019; Chipere, 2020).

The political and economic crises continued with ZANU-PF's alleged election rigging that denied the country prospects of economic recovery (Chipere, 2020). Between 1998, the year that the major economic impact of the DRC war was felt, the country's GDP fell from -0.8% to -6%. Inflation rose from 47% to 231,150,889% while money supply grew from 26% to 66659% (Kairiza, 2010). After allegations of further election rigging in 2008, a national unity government brokered by the Southern African Development Committee came into effect.

3.3.2 The health sector under crisis

From 2008, Zimbabwe experienced relative economic recovery under a coalition government. The country dollarized reducing inflation to single-digit figures almost overnight (Kairiza, 2010). However, this came with challenges of its own. The government struggled to raise enough revenue to support its fiscal needs within a dollarized environment as it could no longer print money (Noyes, 2019). The public healthcare sector suffered from this challenge as government spending on employment costs was putting a severe strain on the national budget (Haley et

al.,2017). The public healthcare sector continued to face major challenges including poor funding, understaffing especially in rural areas, human resources flight, unequal access to healthcare, infrastructure deterioration and a generally low capacity to react to challenges imposed on it by the HIV/AIDS pandemic (Chirwa et al.,2014; Haley et al., 2017; Mangundu et al.,2020). Chirwa et al. (2014) further assert that while the country had formulated a Human Resources for Health (HRH) policy aimed at attracting, retaining and redistributing qualified healthcare workers to address the above challenges, there was little political will to fully implement it.

Before 1997, healthcare workers in Zimbabwe had full mobility. They had the choice to look for employment anywhere upon the completion of government-funded training programmes (Mashange et al., 2019). Between 2007 and 2010 bonding was introduced as a process to force healthcare cadres to stay in the public healthcare system for a time equal to their duration of training as a way of avoiding human resources flight. This temporarily resulted in a system overwhelmed by unexperienced healthcare workers as professionals not bound by the government were free to move (Mashange et al., 2019). Bonding was lifted in 2010 as the Ministry of Health and Child Welfare (MOHCW) was no longer able to place all recruits into positions owing to staff freezes. The MOHCW had to approach the Ministry of Finance with any new staffing proposals and only upon approval would professionals be hired (Mashange et al., 2019).

Initially, on the onset of the crisis in 1997, no staff freezes were imposed on the public healthcare sector despite such being implemented across the public sector. The major argument was that Zimbabwe had already lost many professional healthcare workers to European countries as well as to South Africa (Chirwa et al., 2014; Haley et al., 2017). However, in 2010, staffing freezes were eventually imposed in the sector as well. All recruitment in the healthcare sector had to get individual approval from the Ministry of Finance and due to bureaucracy, this process took over six months to complete (Chirwa et al.,2014). As reported by Dieleman et al. (2010), the staffing moratoria was implemented in a background characterized by staff shortages. In 2010, Zimbabwe required 43,254 public healthcare workers across the board but only had 36,477 giving a 16% deficit (Dieleman et al.,2010).

According to Haley et al. (2017), hiring bottlenecks that were created as a means of controlling healthcare workers employment costs resulted in a lower than minimum replacement rate. This rate, which was higher than the attrition rate created staffing shortages in all facilities albeit rural ones were more severely affected. Research by Mangundu et al. (2020) shows that, in rural communities, most nurses experienced fatigue and burnouts as a result of being overburdened by work. Rural healthcare facilities took longer to get approvals for new staff, a fact that made them even more prone to understaffing challenges (Mashange et al., 2019).

3.3.3 The impact of staffing moratoria in Zimbabwe

The Zimbabwean public healthcare system has been severely affected by staffing moratoria. Chirwa et al. (2014), Haley at al. (2017) and Mangundu et al. (2020) assert that the provision of quality healthcare services to the public has been greatly compromised. Haley et al. (2017) highlight that key health indicators, including the child mortality rate, have deteriorated. Rural communities were resorting to the use of traditional healers and other unorthodox practitioners putting their health at risk (Mangundu et al., 2020). UNICEF (2018) report that Zimbabwe's public health sector is grossly understaffed with a ratio of 10 healthcare workers per 10,000 people versus the WHO-recommended minimum ratio of 23 per 10,000 people. The poor health care access resulting from this scenario has been mostly felt by vulnerable socio-economic groups including women and children (UNICEF, 2018). While the government has been able to reduce employment costs significantly, this reduction is not being channelled towards public health key infrastructure and other operational costs (UNICEF, 2018). This has resulted in a depleted public health care system that also suffers from poor material resourcing (Mangundu et al.,2020).

Dieleman et al.,(2012) found that the decreases in the public healthcare's employment numbers and the increases in vacancy rates occurred within a background of increasing service demand. They cite increases in births in public facilities by 23% between 2008 and 2011 as well as increases in patients on antiretroviral therapies (ART). This resonates with Economou et al's view (2014) that during economic crises, the public tended to rely more on public healthcare, making it an unwise decision to curb public healthcare expenditure.

Staffing moratoria also affected the morale of healthcare workers in the Zimbabwean public sector (Dieleman et al.,2012; Chirwa et al.,2014). Increased workload put severely strained available resources resulting in some leaving the sector. With no replacements being allowed, unless authorized directly by the Ministry of Finance's Treasury Department, this also worsened staffing shortages (Dieleman et al.,2012). Mashange et al. (2019) point at the impact of forced transfers that healthcare workers were subjected to as a source of demotivation and increased staff turnover amongst qualified professionals. In 2006, Human Services Regulations imposed that in a bid to ensure efficient distribution of available resources, employees could be moved to any part of the country for an undetermined period. Any refusal to such a transfer was considered an employment contract breach that could lead to dismissal (Government of Zimbabwe, 2006).

Concluding on Zimbabwe, the country still operates a heavily centralized public health care system where expenditure in staffing at determined at a national level. UNICEF recommends that the country should find other ways to fund its public health care system without compromising access in quality as is the case (UNICEF, 2018). UNICEF further comments that the country needed to improve its resources allocation structures while balancing between the need to reduce employment costs and the need to also reduce human resources gaps in the public healthcare system (UNICEF, 2018). There have also been strong recommendations from various stakeholders for the government to remove staffing moratoria in the public healthcare system (Mangundu et al.,2020).

3.4 Uganda

In 2012, the Ugandan Ministry of Health implemented a staffing moratorium that has been in existence to this day. The reasons cited for this move were that the government was failing to cope with a rising wage bill for the health sector (Parliament of Uganda, 2020). Critics have spoken loudly against the moratorium as it exposed Uganda's 40 million people to health access risks. The Ugandan version of the moratorium prohibits the creation of new positions and hiring of new staff, except to replace those lost through attrition (Walubiri, 2012). The moratorium has been considered ill-placed, as it came into effect when maternal and infant mortality rates were noted to be significantly high (Walubiri, 2012).

Lack of funding is characteristic of several African health systems (Seidman and Atun, 2017). This lack of funding is the major reason behind staffing moratoria in Africa (Ferrinho et al. 2012; Limbani et al.,2019). In Uganda for instance, the health workforce is way below the recommended lowest numbers. One of the main causes of such healthcare worker shortages in Uganda is the inadequate recruitment of healthcare employees. There are qualified health personnel not in employment and cannot be incorporated into the public health system due to budgetary constraints (Baine and Kasangaki, 2014).

Kaseje (2006) mentions that a suitable, strong and maintainable framework for development in the operations of the health system is necessary to oppose the deteriorating pattern in health and progression and disrupt the circle of impoverishment and sickness in Africa (Kaseje, 2006). Kaseje (2006) concludes by noting how the deteriorating indicators of the health position in Africa require a new introspection at how health systems are structured and the way health systems tackle intricate underlying ways that fall outside the official health department (Kaseje, 2006; Okyere et al. (2017). This, in the views of the researcher, includes assessing strategies and policies that affect the supply of public healthcare workers for their contribution to the achievement of health goals.

Lessons from around the world highlight that when rationalising is poorly planned and implemented in a disorderly manner it will probably be detrimental. Outcomes from a study conducted by Belcheri, Davéni, Kolliparai, Maharajii, Mansvelderiii and Gaarekwei (2017) on health expenditure in a period of poor economic growth and financial restrictions highlighted areas of weakness in methods used to tackle financial challenges. Inadequate ways to detect and classify as important the replacement of important empty positions was identified to be one of the major weakness in staff restructuring exercises (Rawat, 2015; Belcheri et al.,2017). Belcheri et al. (2017) also revealed that inadequacies and services below standard formations should be sought so that the usage of inputs can be maximally reorganised. Furthermore, inequalities of allocation of qualified health workers are still in existence and this needs to be managed as part of public service healthcare restructuring. For instance, some public

healthcare facilities with a large amount of work have very little staff in contrast to comparatively vacant facilities (Belcheri et al., 2017).

3.5 Conclusion

In the above countries, governments implemented staffing moratoria aimed at curbing high or rising public healthcare employment costs in response to fiscal pressures. In all the cases four common lessons can be drawn. Firstly, recruitment freezes negatively affected the public healthcare sector's ability to deliver quality services. Secondly, they resulted in an overworked, demoralised and poorly engaged staff compliment. Thirdly, they affected the socio-economically vulnerable groups more and these included rural communities, children and the poor. Finally, they intensified staffing challenges as professional healthcare workers were forced to leave work due to poor working conditions. The next chapter discusses the theoretical framework relating to the study's subject matters.

CHAPTER FOUR: THEORETICAL FRAMEWORK

4.1 Introduction

This chapter will focus on theories that relate to cost-cutting, staffing, and task-shifting, respectively. These are new public management theory, the manpower planning theory, and the game theory. New public management (NPM) is of central interest for the theoretical framework of this study. These theories were selected because they contribute towards the theoretical understanding of the reasons, processes, and impact of the staffing moratoria in the delivery of healthcare services in the KZN Department of Health. A theoretical framework is vital in a research study because it forms the foundation, structure of the research and the direction through which research must follow.

4.2 New Public Management Theory

The first movement of New Public (NPM) started between the end of the ’70s and the start of the ’80s. The persons who pioneered the practice of NPM started in the United Kingdom governed by Margeret Thatcher, together with local government in the United States of America (USA), which had been severely impacted by the economic downturn and protests on excise duty (Gruening, 2001). The 80s’, transition movers, especially monetary burdens drove several Western countries to pay attention to enabling competitiveness of the public service, and public officials to respond to the needs of the population by providing their money’s worth, options to choose from and openness (Kalimullah, Alam and Nour, 2012). This change was then termed, “new public management” (NPM) by scholars, and this terminology was also subsequently adopted in New Zealand and Australia, respectively.

The NPM signifies a union of economic models (transaction cost theory, principal-agent theory and public choice theory), managerialism, and an assortment of methods used in administration in the private sector which have been initiated in public servicer (Uwizeyimana and Maphunye, 2014; Robinson, 2015). Upon its appearance, NPM turned into the force of public service facility management with dual characteristics, the first is the division of policy-making from implementation and the second is how crucial the administration influenced by the private sector is (Kalimullah, Alam and Nour, 2012). The main aim of NPM was to enhance service excellence in the public sector, decrease public spending, increase the efficacy of public services and ensure

the application of policy is operative (Twizeyimana and Maphunye, 2014; Robinson, 2015).

Gruening, (2001) cautioned that the NPM was a mix of values that seemed to fit the then situation of the 1980s and that seemed to solve administrative problems of that time. Gruening (2001) further states that it was unlikely to remain applicable as a paradigm in the future. Kalimullah, Alam and Nour, (2012) describe NPM as having been a form of 'hype' rather than a theory of 'substance', and that nothing has really changed since its implementation. They further allude that the model has negatively affected the quality of government services and is not achieving in its main goal to decrease expenses (Kalimullah, Alam and Nour, 2012).

The NPM, which is also known as the Reinventing Government, has both undisputed as well as debatable characteristics:

Table 4.1: Features of New Public Management

Undisputed features	Arguable features
Expenditure cuts	Fiscal and spending controls
Vouchers	Controlled decentralisation
Accountability	Enhanced policy assessment
Performance measurement	Enhanced legislation
Commercialisation	Rationalisation or streaming of administrative structures
	Democratisation

Adapted from Gruening (2001)

Table 4.1 above shows budget cuts as one of the undisputed characteristics of NPM. Mathiasen (1999) in shortening the OECD notes the NPM targeted harnessing an output centred way of working in a decentralised public service that featured:

a) Emphasis on output with regards to service excellence, efficacy and efficiency
b) The changing of a very central ranked framework through decentralising administration functions such that resolutions on sharing resources and providing service are closer to care facilities which enable suggestions from service users

c) The freedom to investigate other options to guide offers to the public and control that could produce better cost-efficient strategy outputs
d) An increased emphasis on effectiveness in the service offered by public service encompassing the setting up of output goals, the formation of situations in and with the public service facilities
e) The firming of policy abilities at the core to guide the transition of the government and enable its responsiveness to outside transitions and different welfares routinely, freely and cheaply

The NPM as such is associated with the idea of restructuring the public service (Dickinson, 2016). Re-structuring is a way of thinking in an administration that looks towards changing procedure which public facilities function so that efficacy, efficiency and competitiveness are enhanced (Gumede and Dipholo, 2014). Also, it requires a transformation in the framework of public facilities, their working environment, administrative function and factors that provide backup to the new enterprise (Lapuente and VandeWalle, 2020). Furthermore, it entails customer focussed, direction motivated service excellence improvement and a democratic management style utilising inputs in unconventional methods to increase efficacy and efficiency

4.2.1 Classical public administration schools

As a public administration paradigm and theory, the New Public Management succeeded in various other theories. Because these older paradigms have influenced the NPM, it is critical to discuss these. The old public administration also referred to as the classical public administration theory or model borrowed a lot from Weberian principles of efficiency (Robinson, 2015). Its focus was on the efficient and effective management of public resources given the complexity of emerging government and public administration structures. According to McCourt (2013), the main characteristics of this model where:

- separation of responsibility between political offices in administrative and management offices in government
- the regulation of public administration processes and systems to ensure greater uniformity of standards
- the appointment of personnel based on merit and qualification

- the separation of public sector resources from individual resources

Most of the above principles found their way into the New Public Management out of the need to diminish the powers of patronage that were prevalent in the administration of public resources in 19th century Europe (Dickinson, 2016). Royalty-based public administration systems failed to separate the state from ruling classes and were marred with cases of nepotism based appointments that negatively affected the operations of the public administration systems (Robinson, 2015). At the core of these features are the chain of command and centralization aspects also referred to as the bureaucratic aspect of administration (Du Toit and Van Der Waldt, 2017). Robinson (2015: 5) states that the old public management operated based on "command and control" principle. Centralization and bureaucracy were considered necessary and almost indispensable as they enabled the public administration system to control decision making and resources allocation (Roll, 2014).

4.2.2 NPM theory: Centralisation versus decentralization of public healthcare decision-making

As highlighted above a distinguishing feature of the old or classical public administration schools was the issue of power and authority centralisation. While the NPM is associated with the decentralisation of governance and public services (Cinar et al., 2013; Lapuente and de Walle, 2020), the debate on whether public services are more efficiently managed under a centralised or decentralised system continues in the literature and practice (Vartola et al., 2010). Staffing moratoria as implemented by the KZN Department of Health reflect the centralization of government decision-making in some aspects of public healthcare management as broadly discussed in theories linked to the old public administration. Centralization runs from national government departments to provincial governments and finally, to individual public healthcare facilities like Ngwelezana Tertiary Hospital. With this observation in mind, this section reviews the literature on the centralization and decentralization of decision-making in public healthcare facilities in South Africa and the world at large. The section starts by defining decentralization and centralization in goes on to discuss the advantages and disadvantages of each.

Decentralization has been defined is the distribution of power and authority to lower units of governance and administration from a previously centralized power system

(Kettunen, 2015). Decentralization gives more power and authority to lower governance levels to plan their operations and make critical decisions on how they run their jurisdictions (Kuhlmann and Wollmann, 2014). It involves the restructuring of power relations and giving more power to lower administrative units to make decisions. In contrast, under a centralized system decision are made by a single unit of command that then cascades them downwards in a bureaucratic manner (Martinez-Vazquez et al, 2015). Within the discussed public healthcare set up, provincial health departments hold most decision making powers with individual public healthcare facilities having to look up to the department four authority and permission as well is approvals to make sometimes even day-to-day decisions. The debate that goes on is whether decision-making in a decentralized public healthcare system would work better and provide more efficient results than in a centralized one (Adhikari, 2017).

There are several forms of decentralization. Delegation is a form of decentralisation that involves the transfer of power and authority to lower administrative and managerial levels (Rechel et al., 2018). Delegation is an inter-organisational form of decentralization (Adhikari, 2017; Rechel et al., 2018). In the case of Ngwelezana Tertiary Hospital, delegation would involve management giving more power and authority to frontline staff. Deconcentration is another form of decentralisation and unlike delegation, power and authority are distributed to a lower administrative level rather than to individuals (Prianto et al., 2014). In a public healthcare facility set up deconcentration gives more power to departments to make decisions that directly affect them (Prianto et al.,2014).

Rechel et al (2018) assert that centralization and decentralisation decisions can be taken on a micro-scale, meso-scale and macro scale. On a micro-scale, the decentralisation-centralisation debate is focused on power and authority relationships associated with the conduction of day-to-day operations any public healthcare facility. This involves daily decisions like staff duty rotations, housekeeping quality and daily admissions among other things. Decentralisation at the meso-scale relates to the implementation of organisational policies (Rechel et al., 2018). At the meso scale, organisations are said to be decentralized if they have enough authority to formulate, implement and evaluate their own policies (Rechel et al., 2018). At the macro scale, focus is placed on managing government-level, national health policies. Government departments are fully decentralized when they have the autonomy to make decisions

independently (Prianto et al., 2014). Delegation of authority to a public healthcare facility occurs across the micro in the meso levels. If decentralized, a public healthcare facility will have greater autonomy to implement policies at a micro and meso levels without having to resort to a central authority for approvals (Martinez-Vazquez et al, 2015). It, however, still needs to operate in line with and in compliance with national public health policy structures. At the meso level, and within a decentralized setup, a public health facility can make decisions on who to hire and is also able to make financially independent decisions (Prianto et al., 2014). Hendricks et al. (2014) and Maphumulo and Bhengu (2019) believe that South Africa has a decentralised healthcare system where the national government has given provincial health departments power and oversight over provincial healthcare systems. However, they do not discuss the decentralisation of power and authority to individual public healthcare facilities.

Decentralisation can also be classified on the basis of the key functions for which power and authority have been passed down to lower levels of government. Fiscal decentralisation refers to the passing down of more power and authority to lower levels to plan and manage their revenues and expenditures (Martinez-Vazquez et al, 2015). Administrative decentralisation is the redistribution of power and authority relating to administrative decisions to lower levels of government (Lidstörm, 2007; Prianto, 2014). The degree to which an entity is physically decentralized can be measured using the percentage of revenue that it can keep in control (Adhikari, 2017). It can also be measured by the types of expenses that it can incur without having to resort to high levels of government for approval. Rechel et al. (2018) assert that a fully fiscally decentralized system would have total control of its revenue and expenses. This is arguably a very rare case in the public sector globally and locally (Martinez-Vazquez et al, 2015). Both fiscal decentralisation and administrative decentralisation can be fully passed down two public sector entities including public healthcare facilities (Adhikari, 2017).

4.2.2.1 The advantages of decentralisation

There are several advantages of decentralisation discussed in public administration and public healthcare management literature. Adhikari (2017) believes that decentralisation improves the quality of public healthcare service by enabling

decisions to be made by the most affected and the most involved entities. The other advantages of decentralisation are discussed below:

a) Efficient problem solving

Decentralization is associated with increased efficiency in decision-making. Under a decentralized system, decisions are made close to the source of the problem (Kuhlmann and Wollmann, 2014; Olum, 2014). The source of the problem vividly provides most data that is required in assessing the extent of the problem, its features and characteristics as well as potential and alternative solutions to it (Harris, 2019). Administrators at the source of the problem observe the manifestation of the problem first-hand and can interact directly with stakeholders interested in or affected by the problem. This is different from high-end political offices and centralized executive administrators who get to hear of the problem from reports submitted to them and from secondary sources. This advantage that administrators at the source of the problem have is critical in crafting acceptable decisions that take into account most facets of the problem at hand (Olum, 2014; Harris, 2019). It must also be noted that in centralized systems administrators deal with more than one public healthcare facility at a time. this may affect their ability to effectively scrutinize the intricate details every challenge presented to them by individual public healthcare facilities (Kuhlmann and Wollmann, 2014). Under a decentralized system, administrators are only concerned about the problems that are going on in their facility and therefore have a lot of time to focus and concentrate on them (Olum, 2014). This enhances the quality of decisions made as part of a solution to a problem (Rechel et al, 2018).

b) Quick decision-making

A major criticism levelled against centralization is its bureaucratic structures and tendencies that result in slow decision-making. In centralized systems, there are several layers and levels of government that stand between the decision-makers and those affected by the decision (Cinar et al.,2013). On the contrary in a decentralized system decision are made internally or at least close to the situation (Olum, 2014: Adhikari, 2017). This expedites decision-making critical for emergencies associated with the public healthcare system (Rechel et al, 2018). Because programme planning and implementation are hinged upon the ability to make decisions (Kuhlmann and

Wollmann, 2014), the ability to decide quicker facilitates quicker and more effective programme implementation in response to healthcare needs.

c) Increased accountability

There are views that accountability and responsibility increase when a system is decentralized. With fewer accountability layers it is easy to identify who is responsible for given actions (Adhikari, 2017). Managers in public healthcare facilities become accountable for challenges, resources and other pertinent matters as they take on most of the responsibilities in the facility (Rechel et al.,2018). Thus blaming the government for anything that goes wrong within a public healthcare facility ceases to be an option. The OECD (2019) asserts that under current arrangements, public healthcare facilities and government departments have shared responsibilities in decision-making albeit power and authority are more skewed towards the government. This tends to reduce accountability on budgets and policies as it is not always easy to identify the main power behind the decision (OECD, 2019). Once a system is decentralized, the shared responsibility aspect of decision-making is minimized or falls away making it easier for the public to challenge for accountability from public healthcare facilities (Rechel et al.,2018).

d) Improved resource management

Scholars like Olum (2014), Adhikari (2017) and Rechel et al. (2018) believe that decentralization improves resources allocation. In public economics, two types of resources management efficiency are usually discussed (Sow, 2015). These are allocative efficiency and technical efficiency. Allocative efficiency refers to a systems ability to effectively match resources demand to resources needs, in other words, to direct resources to where they are needed most and where they would have an optimum benefit (Sow, 2015). For instance, under a decentralized system, a public healthcare facility would be authorised to hire health professionals and administrative staff that would have the highest impact on the delivery of quality healthcare services without having to adhere to quotas imposed by a central authority (Adhikari, 2017). Technical efficiency relates to the output obtained from a given set of inputs. Technical efficiency as argued also improves under a decentralized system (Adhikari, 2017). This is attributed to better decision making in the ability to make quicker and more responsive decisions (Adhikari, 2017).

e) Equity in the provision of healthcare services

Decentralisation brings governance to the people and is therefore an appropriate mode for addressing inequalities in healthcare service access (Alves et al. 2013). The localization of decision-making enhances public healthcare facilities capacity to meet service needs and the requirements of otherwise marginalized groups (Olum, 2014). Centralized systems have been blamed for failing to take into account local differences and inequalities when making decisions (Abimbola et al.,2014). Groups that are easily marginalized by centralization include rural poor. With inequality being a major issue in South Africa and with the rural-to-urban divide being an area of concern in the provision of services, decentralized systems as argued, are in a better position to come up with policies and programs that take consideration of marginalised groups whose attention can escape central authorities provision (Hendricks et al.,2016). Adhikari (2017) also opines that decentralization encourages community participation programs leading to healthier communities. Decentralization can help to fight inequality by enabling a need-based resource allocation approach albeit the success could depend on pre-existing conditions (Sumah et al.,2016). Some communities may require more intensive resource interventions due to poverty while other communities may need special types of resources that cannot be easily identified by central systems. Decentralized system can, therefore, better help ensure that communities are not marginalized further by providing resources that enhance equality in healthcare provision (Hendricks et al.,2016).

f) Employee satisfaction

Decentralized systems encourage greater employee engagement. When employees feel empowered to make decisions that affect them, they are more likely to commit to those decisions in comparison to decisions imposed by an external office (Zoghi and Mohr, 2011). Additionally, employee grievances and issues are quickly heard and addressed in a decentralized system compared to a centralized one. Employees who are geographically distanced from head offices can easily feel neglected is management may seem to be less in touch with their issues (Abimbola et al., 2015). Decentralization also empowers employees with greater responsibilities, a factor that increases their job satisfaction (Kisumbe and Mashala, 2020). Additionally, decentralized systems avail more decision-making skills development opportunities to

their employees (Zoghi and Mohr, 2011). Gartenstein (2019) argues that overall, decentralisation creates a participative working environment that reduces staff turnover and increases employee productivity.

g) Innovation and adaptivity

If individual public healthcare facilities are given the autonomy to manage their internal processes, including budgeting and human resources, they develop a better capacity to innovate and to come up with solutions that best address local problems (Cinar et al., 2013; Abimbola, 2019). Public healthcare facilities do not face similar problems all the time. Even when they do they face these problems in different magnitudes. Localized responses are usually necessary to find solutions to current and emerging problems (Abimbola, 2019). When public healthcare facilities always have to wait for and rely on is centralized authority like a provincial health department for decisions and solutions, their capacity and motivation to craft internal solutions are restricted (Adhikari, 2017). This, in the long run, hampers their effectiveness to contribute towards the attainment of local and national health objectives.

4.2.2.2 Disadvantages of decentralization/advantages of centralization

Despite the above advantages, not all scholars agree that a decentralized public healthcare system works better for the public good than a centralized one. While some scholars and authorities advocate for decentralisation within the public health system, others point out the disadvantages that are associated with the process. Global governance is bureaucratic by nature consisting of various layers that eventually report to a single entity. It is also argued that even in decentralized systems there is a certain degree of centralization. It is, therefore, a debate of how centralized or decentralized a government system is rather than of whether centralization exists or not. Centralization is associated with bureaucracy with some sources seeing no difference between the two.

It is argued that decentralization results in the loss of policy coordination in government (Surender, 2014). Public healthcare facilities are instruments that are used as a central part of the government's policy of improving and promoting health. With decentralization, government departments can lose oversight of public healthcare facilities to the detriment of public sector health goals (Surender, 2014). Local health policies can be promoted ahead of broader and more encompassing national policies.

However, there are also arguments that coordination can only be lost if the decentralized process itself is poorly managed. Even under decentralized systems, government departments remain in charge of overall policy implementation and public healthcare facilities remain accountable to government departments on broader policy issues (Rechel et al.,2014).

Some scholars believe that decentralization can result in wastefulness due to the duplication of resources across facilities. For instance, each independent facility may require a different set of structures and functional units that could otherwise be singularly provided by a centralized system. This disadvantage may not fully apply to South Africa considering that most tertiary public healthcare facilities like Ngwelazana in question already have fully functional structures and departments that are not shared with others through the KZN Department of Health. The issue of contention however is that these departments are not fully empowered to make all decisions relating to the hiring of staff and budgetary resources allocations. The next section discusses public service reform in South Africa. The country made various efforts to transform from a centralised bureaucracy as a way of enhancing governance efficiency.

4.2.3 New Public Management reforms in the South African context

During apartheid, the South African public sector worked in isolation from transitions happening around the world in terms of Public Sector Reform (Thornhill, 2008; Cameron, 2009). The public administration paradigm of the apartheid regime strongly resembled the classical public administration approach characterised by heavy bureaucratic and command-based control of the public sector (Vyas-Doorgapersad, 2011). The advent of democracy in 1994 generally coincided with the transformational era from the traditional public administration approaches to NPM. Vyas-Doorgapersad (2011) comments that during this time, there were pressures from the Bretton Woods institutions for African economies to open up and liberalise. Most countries, among them Zimbabwe, Zambia, and Ghana had inherited command-based economic systems that naturally resonated with the bureaucracies of the traditional public administration paradigm. The pressure to liberalise also came with the demands to reform the public sector into a more independent, efficient, and economically rational entity (Vyas-Doorgapersad, 2011). Additionally, there were pressures for the new government to come up with a public administration system that resembled inclusion

and that was able to respond to the previously neglected needs of the non-white section of the population (Ramogonyane and Jarbandham, 2018).

The initial state paper dealing with public service reform was “The White Paper on the Transformation of the Public Service South Africa” (Carstens and Thornhill, 2000). Policy changes proposed in the paper pointed towards a more liberal public administration paradigm that resembled the NPM (Ramogonyane and Jarbandham, 2018). Heywood (2013) asserts that the NPM was suitable for South Africa at that time because the new government did not have the full capacity to provide services without the support of the private sector. The private sector, which was consulted as a client played a crucial role in enhancing the government’s policy execution capacity (Heywood, 2013).

There are still views that in South Africa, values of the NPM were not carried out without bias resulting failure. The top-ranking public officials were poorly trained and their appointment had been based on political or ethnical affiliation, therefore, they were unable to appreciate the basic values of the NPM (Chipkin and Lipietz 2012; Muthien 2013). Several scholars on public service, therefore, concluded that South Africa did not have a sound theory of public service restructuring and administration (Chipkin and Lipietz 2012; Muthien 2013). The above views suggest that NPM-related changes that resulted in staffing moratoria in the KZN Department of Health might themselves have been based on principles that were not adequately infused into the public service. If this was indeed the case, it would be expected that the staffing moratoria would also have unintended consequences on the systems they were trying to improve.

4.2.4 Factors influencing New Public Management reforms in Africa

In this section, common NPM issues affecting African countries are briefly discussed. These issues include reasons behind NPM implementation attempts and failure causes.

a) Economic/ fiscal crises

NPM was adopted by developing countries out of the expectation that its elevated focus on government economic efficiency my uplift them from their economic challenges (Brinkerhoff and Brinkerhoff, 2015). The prevalence of economic crisis is one of the most influential factors facing most African countries including South Africa.

Although many countries have grown economically, slow economic growth and poverty are in abundance and there is worry about inflation, national debt and the extent of public spending in relation to dwindling government revenue and the higher rates of offering services to the public. These fears on financial issues have resulted in NPM changes including critiquing of the part the state plays in administering the country economics and the supply of services (Hope, 2001; Ribakula, 2014). This is also evident in South Africa where an increase in state spending particularly in the health department has resulted in the implementation of cost-cutting measures which are parts of NPM reforms and principles (Rubakula, 2014). Scholars like Brinkerhoff and Brinkerhoff (2015) are sceptical of the NPM's efficacy amidst severe economic problems and also believe post-NPM paradigms are needed for developing countries.

b) Malfunctioning and Unstable political order

The dysfunctional and political instability in Africa has led to a necessity of transitioning public administration to build fundamental structures of governing, create facilities that are non-authoritarian and enhance and create a civil society and restructure relations with the public (Hope, 2001; Ribakula, 2014). As such this entails going to the utilisation of methods of public administration that back the legislation and open and responsible governments together with a foreseeable legislative structure with regulations acknowledged beforehand and dependable, impartial justice system. (Hope, 2001). Brinkerhoff and Brinkerhoff (2015) suggest that other post-NPM paradigms might work better in this regard arguing that the NPM was never suitable for developing economies that had not fully established stable forms of governance.

c) Complex Institutional Mechanisms

In many African governments, it is challenging to effectively operationalise NPM concept and guidelines due to the complexities in traditional institutional mechanisms (Ribakula, 2014; Brinkerhoff and Brinkerhoff, 2015). The NPM goes against the traditional, centralised, bureaucratic cultures that have become entrenched in African public administration system and in some cases has been met with resistance by the public sector (Islam, 2015). Evidently, In South Africa, despite the needs to move towards a more decentralised public administration approach, the effects of entrenched bureaucracy can be observed in the fiscal centralisation of public healthcare spending. In other countries too, complex traditional governance structures are proving a challenge to quickly transform (Ingrams et al.,2020). Also, social, political

and economic stakeholder to public administration generally hold a “cultural” view of how government structures should work and in most cases, they tend to see bureaucracy and centralisation as the status quo of governance (Ingrams et al., 2020) Thus public reforms towards the NPM have been concluded on paper with the reality showing the persistence of bureaucratic mechanisms.

4.2.5 New Public Management and Batho Pele principles

The Batho Pele principles are those core values that prescribe how the public service entities must deliver their services to the public. There are eight of these principles. There are also common views the Batho Pele principles are a direct response to the NPM (Mothamaha and Govender, 2014; Venter, 2018). Venter (2018:13) states that *“*From the above, the core principles of New Public Management (NPM) seem evident within the principles of Batho Pele.”

This study takes the eight Batho Pele principles as part of the NPM paradigm that forms the theoretical concept of interest. Out of the need to improve on service delivery efficiency and to treat residents and citizens as clients who benefited fully from the value of their money, the following eight principles were crafted. Below is an extract of the eight Batho Pele principles from The White Paper on Transforming Public Service Delivery (1997):

> *BP1: Consultation*
> *Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered.*
>
> *BP2: Service Standards*
> *Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect.*
>
> *BP3: Access*
> *All citizens should have equal access to the services to which they are entitled.*
>
> *BP4: Courtesy*

Citizens should be treated with courtesy and consideration.

BP5: Information
Citizens should be given full, accurate information about the public services they are entitled to receive.

BP6: Openness and transparency
Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge.

BP7: Redress
If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response.

BP8: Value for money
Public services should be provided economically and efficiently in order to give citizens the best possible value for money.

In the researcher's view, all of the eight principles apply to the KZN DoH staff freezes and task-shifting contexts. Mostly, communities that rely on Ngwelazana Tertiary Hospital, as expected under Batho Pele, ought to receive quality healthcare service from the facility. Any changes that affect service standards and the principles violate the Batho Pele principles. These principles were set to be performance indicators and monitoring mechanism in health facilities. Generally, there are views that the application of Batho Pele principles has deteriorated as a result of staffing moratoria in public healthcare facilities. Such views are broadly discussed in the Public Service Commission's report entitled: *Investigation into Health Care Facilities in Kwazulu-Natal: A Special Focus on Professional Ethics* (PSC, 2018).

4.2.6 The relevance of the theory to the study

In the context of this study, the researcher is under the impression that the freezing of posts by the KZN Provincial Treasury in the KZN Department of Health was done with the need to cut costs and increase efficiency as advocated by NPM proponents. The

staffing moratoria in the province, as well as the task-shifting agenda that followed, are associated with the following NPM principles as discussed by Gruening (2001), Osborne (2006), Ramogoyane and Jarbandham (2018):

- reduction of government expenditure;
- increasing operational efficiency of government units and departments;
- rationalisation of administrative structures;
- increased monitoring and evaluation of public expenditure; and
- adoption of private-sector principles (of economic efficiency) in the public sector.

Staffing moratoria were targeted at ensuring that there was minimal wastage of human resources yet ensuring that service delivery is not compromised. The available human resources were conceived to be deployed in areas and positions where they would be most efficient. As noted, one of the areas of inefficiency within the public sector, in comparison to the private sector, was that of human resource duplication and lack of accountability on the deployment of the same resources. Through controlling wastage, and in a quest for efficiency, the department hoped to saved money on employment costs, while getting the best out of the existing resources similar to the private sector.

The researcher believes that the government envisaged the following scenario: cut and control the hiring of staff; increase the efficiency of current resources and improve service quality. This view is corroborated by some sources pointing to the public services sector as being full of duplication of roles and responsibilities. Nonetheless, not all the characteristics of the moratoria are aligned with the principles of NPM theory. For instance, NPM is associated with the decentralisation of public sector decision-making as a way of enhancing efficiency (Osborne, 2006; Robinson, 2015). The moratoria, on the other hand, took more of a centralised approach, where the KZN Department of Health made decisions solely on what posts to freeze in hospitals and other medical and healthcare facilities. This particular element of staffing moratoria relates to the traditional public administration approaches characterised by bureaucracy and centralisation. The weaknesses of such approaches are that they create situations where decisions are made by individuals who not with the situation on the ground, and additionally, who are not quickly and easily accessible for recourse or appeal.

4.2.7 Criticism of the New Public Management

Some scholars have come up with a list of criticisms on the applicability and effectiveness of the NPM as a public administration paradigm. Savoie (2002) and Singh (2003) assert that the model has errors due to private sector administration practises being seldom applied to the public sector. They argue that it is unsuitable for public service as the public service has intricate goals and a complex network of accountability and an unstable political climate than the private sector (Savoie, 2002, Singh, 2003). Islam (2015) supports the argument noting it is perilous in utilising theories for private enterprises for public service due to variations in their backgrounds. Cheung and Lee (1995) assert that the flexibility in the private sector is more in comparison to the public and that this limited flexibility, mostly felt in decision-making, reduces the effectiveness of NPM in government.

Another criticism of the NPM model is that its originates from a few affluent countries where the theory cannot be applied from their situation to less affluent states due to incompatible situational characteristics like politics and practices (Minogue, 2001a). Furthermore, Polidano (1999) adds that NPM is unsuitable for developing states because leadership in those states (i.e. South Africa) do not have the pre-requisite proficiency and possess undependable information communication technology mechanisms (Polidano, 1999). Developing states do not have the inputs and management capability to adopt complex NPM changes. Developing states often retain central administrations and this creates a burden for subjective corrupt practices (World Bank, 1997).

Finally, Peyton (2009) points out that a major flaw of the NPM is the existence of potential conflicts between or among its values. Peyton mentions healthcare service quality and financial costs reduction as goals that are almost always in conflict. For quality healthcare to be afforded to poor communities, increased funding outside economic efficiency parameters is usually required. Lapuente and Van de Walle (2020) also note that under NPM, public-centric values such as equity and equal access to services (including health) may be jeopardised when financial considerations are prioritised ahead of community needs. This view resonates well with this study, as it investigates both. The financial or cost control aspect primarily came from Treasury, while the health goals or outcomes rest with the KZN Department

of Health (KZN, 2006). These values are both important, although their importance may not necessarily be perceived as the same to both departments.

In view of the above criticisms, there is greater advocacy for the New Public Service (NPS) paradigm. The NPS, as argued, puts people ahead of any economic decision including those decisions that are aimed at enhancing public service efficiency (Robinson, 2015; Rustag et al.,2015). Thus, as far as decisions between economic efficiency and public healthcare access are concerned, the NPS advocate the prioritisation of the public (Osborne, 2010). This is because NPS proponents point to the NPM's excessive focus on economic efficiency, as guided by private sector principles, as its major downfall. Because of this downfall, it fails to serve the needs of poor communities.

4.3 The Manpower Planning Theory (MPT)

The Manpower Planning Theory, as discussed in this section, is quite an old work. However, it has a very strong appeal on the matters under discussion hence its inclusion among the theories of interest to the study. This view is motivated by Hurst's (2015) arguments that old theories can improve society's understanding of contemporary challenges.

Manpower planning stems from the collection of workforce statistics from the census in Rome right through to the counting of slaves and 18th-century population census (Morton, 1969). Furthermore, Geisler (1976:229) posits that, in the 20th century, the emphasis in workforce planning was on the employee who had output every hour for increasing efficiency and the necessity to enhance production and to initiate increased impartiality to human resources policies. In the 60s, the prevailing view of manpower planning was that industries forecasted their needs, recognised loopholes from what was necessary and what they had. Workforce planners structured the hiring, selecting and deployment of new workers, met the training and capacity building needs and forecast the appropriate elevations and transferences.

In the 80s, human resource planning, the workers need for involvement in decision making, impacting their work increased. In the '90s constructs which were not clear were; work sharing, decreased working hours, flexible time, a major restructuring of jobs and job habits, work structure, work improvement, complete service administration and enterprise procedure restructuring. Manpower planning also refers

to the procedure involving predicting, constructing and guiding through which a company makes sure that it has adequate human resources and the appropriate person at the appropriate place, timeously performing the job which they are most financially valuable (Geisler,1967). Thus, manpower planning entails forecasting tomorrow's personnel needs and constructing workforce plans for the execution of the projects.

Wickstrom (1981) notes that manpower planning comprises a sequence of actions viz:

(a) Predicting workforce need for the future through either statistical analysis of patterns in the economic situation and sector progress or judging from approximations on the basis of a particular plan of the institution;

(b) Drawing up a list of the current workforce and evaluating the degree to which personnel are fully occupied;

(c) Expecting workforce challenges by forecasting current staff into the future needs to ascertain their sufficiency in terms of quality and quantity; and

(d) structuring the required schemes of necessities, choosing, training and capacity building, utilisation, transference, elevation, motivations and remuneration to make sure that tomorrow's workforce needs are adequately catered for.

4.3.1 Conceptualising Manpower Planning Theory

Manpower planning differs from human resource planning, it focuses both on the qualitative and quantitative aspects. Thus, Obojo, (2012) described manpower planning as the procedure through which an institution makes sure that it has adequate personnel and the appropriate persons at the appropriate position timeously performing the work they are most financially valuable for. Hence, according to Stain (1981), manpower planning is a method for acquiring, using, enhancing and conserving the institutions' personnel. Its objectives are to harmonise the requirement for the obtainability of various forms of workers.

Coleman (1980) has defined manpower planning as the procedure of ascertaining workforce needs and the ways of fulfilling these needs to enable implementation of the composite institutional plan.

Gardon McBeath (1979), notes that manpower planning entails two phases. The first phase focusses on the intricate planning of workforce needs for all forms and grades of workers through the duration of implementation. The second phase focusses on the planning of workforce resources to offer the institution the appropriate persons from every resource to fulfil the planned needs.

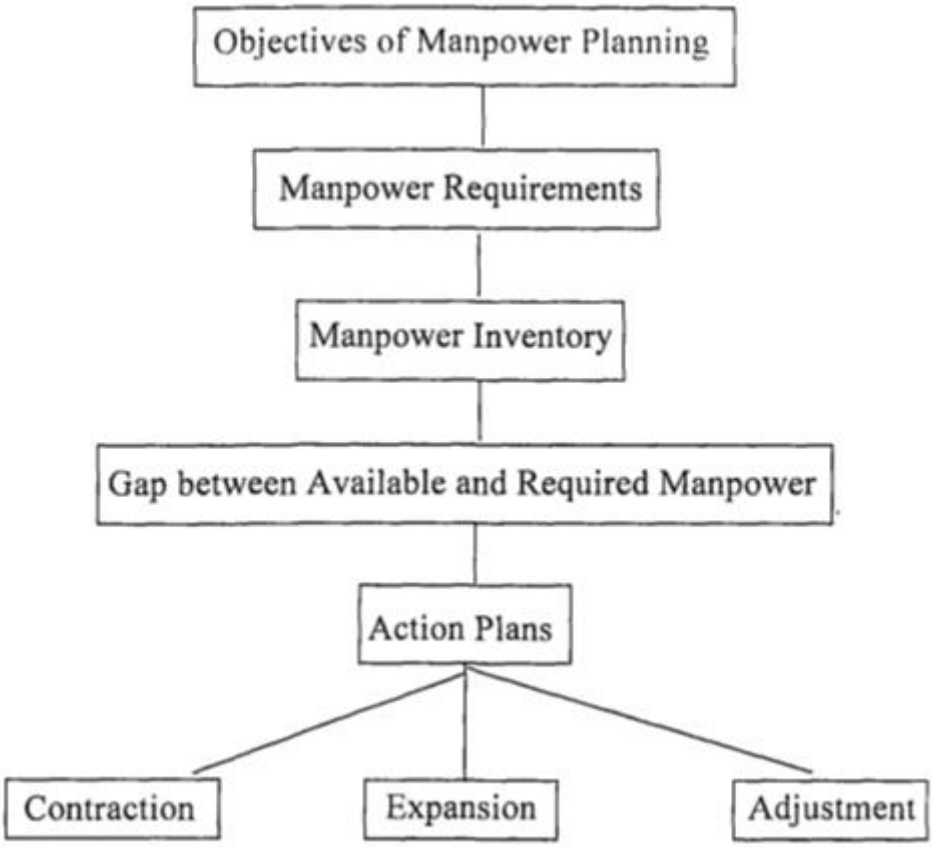
Manpower planning is a way of getting ready for tomorrow's contingencies, approximating the likelihood of their happening and ascertaining what should be implemented in time, is and as it happens. It is actually a means of controlling and operating the future by minimising unpredictability. Manpower planning needs anticipation, perseverance and consciousness of what is taking place and what is probably going to occur which impacts the lifetime of the business. Thus it is clear from the above definition that manpower planning comprises of predicting tomorrow's workforce needs and developing workforce plans of execution of these predictions. This planning has to be flexible. It is open to changes, restructuring and amendments in line with the need of the institution's transitions.

In an institution properly managed administration is informed about its workforce. Information on its workforce must be availed particularly regarding hiring and staff changes including information about their wellbeing. Proper personnel planning and progression build manpower that will probably achieve.

4.3.2 The Manpower Planning Process

The manpower planning process starts with planning. The Manpower planning also referred to human resource planning considers matching all jobs and individuals in future. The organisation can achieve this by taking systematic manpower planning. The process of manpower planning involves deliberation of numerous stages with appropriate inputs before human resource needs being met and at the other end, the recognition of the source that provided the needs, considering the challenges on the other hand. Various phases in personnel planning are illustrated in Figure 4.1:

Figure 4.1: The manpower planning process



Source: Coleman (1970)

a) **Objectives of manpower planning**: The main goal of manpower planning is one of suiting worker skills to organisational needs with a focus on tomorrow and not the current situation.

b) **Forecasting the Manpower Requirements:** Approximating the forthcoming numbers and quality of personnel needed. Many situational aspects impact on this estimation. These encompass enterprise predictions, extension and development, strategy and framework transitions, administration viewpoints, state guidelines, produce and person abilities combination and opposing factors. Prediction is needed for different causes like;

   i) the possibilities of overall economic enterprise circles like price increases, salaries and rates impact on long and short term plans of institutions

   ii) business enlargement after development comprises utilisation of personnel and reassignment of amenities all which require planning of personnel

   iii) transformation in administration viewpoints and direction skills

iv) usually transformations in the number and quality of produce or service need a transformation in the institutional framework. Plans need to be created for this reason too.

h) **Human Resource Inventory or Forecasting Supply of Human Resources:** It is approximated of the quantity and types of personnel which can be anticipated to form an institution's manpower in a period in future. It is founded on the meticulous evaluation of an institution's present sources, including deliberation of worker turnover. Investigating sources entails current personnel, inside and outside supply sources. Internal sources include transfers, promotions and demotions.

   A workforce record assists in ascertaining and assessing the amount and quality of personnel inside an institution. It shows what is available in terms of workforce and what is anticipated in forthcoming times. It also shows the likely gaps in contrast to the needs of extending and forthcoming framework of the institution. After the current personnel are evaluated the probable transformation that will happen can be approximated. Possible personnel losses can occur through employees resigning, discharge, fatalities, firing, layoffs, demotions, elevations, sickness, service out of the organisation and absenteeism. Likewise, more personnel can come through hiring, elevations demotions, transferences, secondment of consultants and addition of abilities through training.

i) **Identification of Gap Between Available and Required Human Resources:** Once an organisation's human resources requirements and supply are forecast, the two must be compared. Contrasting like this will show an excess or shortfall of personnel in forthcoming times. Such comparison helps so that open positions are replaced by appropriate workers timeously

j) **Action Plans:** After identification of the human resources shortfall plans can be made to cover these shortfalls. Plans to cover the excess human resources can be transfers, promotions, demotions and retrenchment etc. Shortfalls may be covered by new choices, elevations, demotions, transfers, and training etc.

4.3.3 Need for Manpower Planning

Manpower planning is a way of being ready for forthcoming contingencies approximating likelihood of their happening and ascertaining what should, can, could be done, at what time, if s they come up. It is a means of controlling and operating the forthcoming by minimising unpredictability. Manpower planning needs anticipation, perseverance and consciousness of what is going and what is likely to happen which impacts the business. This is an intricate job due to the way of our transitioning situation (Johnston, Meridith and Winter, 1968).

Manpower planning signifies a trial to be ready for the forthcoming times. It gives us the knowledge about what we currently have so that organisations adapt sufficiently to unexpected transitions in aspects like technology changes, new business opportunities and pressure from politics and the economy.

In relation to the downsizing of the workforce, it can provide an accurate illustration of the number of people needed to finish a particular job in a set duration. It is utilised to attain basic expansion of a business. It can calculate the right man at the right cost by capability development. It targets at right position, the right person at the right work. As such manpower planning is a necessity to ensure maximum utilisation of the most important input there is; which is the workforce to the achievement of the institution.

4.3.4 Relevance of the manpower theory to the study

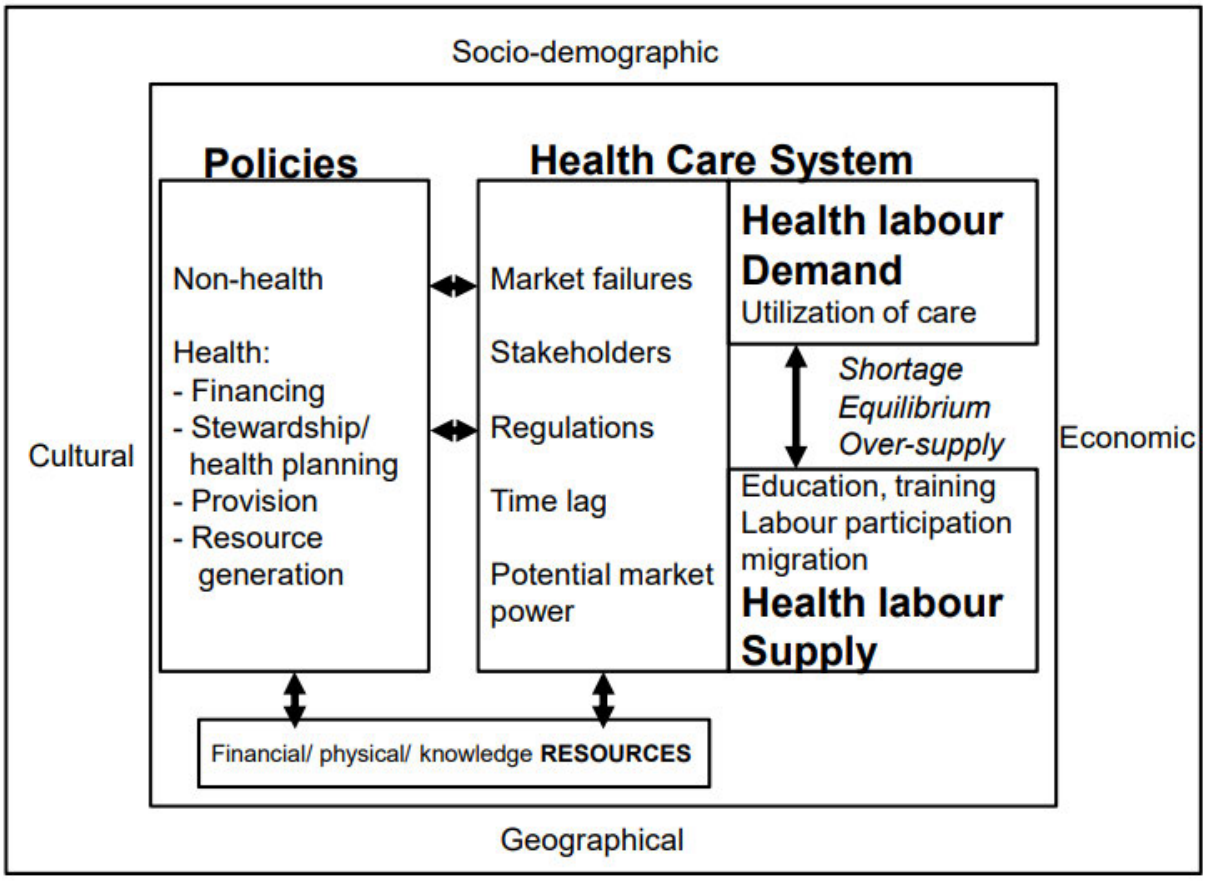
The manpower planning theory (MPT) is associated with the works of Makridakis and Hidon (1979). The MPT is one of the major models applied by the World Health Organisation in the forecasting of healthcare labour demand and supply (Smits et al. 2010). The theory is based on the premise that health management systems, which might be as small as a single medical facility to the national health system at large, have a set of predetermined objectives (WHO, 2010). These objectives require the formulation and implementation of strategies that ensure that there is an equilibrium between demand and supply of healthcare labour. This equilibrium can be current, as when health authorities plan to meet occurring health needs and objectives. The equilibrium can also be planned for the future and in this case forecasting the supply and demand needs of health care workers, based on foreseen future dynamics becomes necessary (Smits et al.2010). Parma et al. (2013) further expand on this to add that manpower planning, in theory, focuses on three aspects: providing the right

number of employees with the right skills, and expertise at the right time and place. Such a provision is what enhances organisations ability to meet their objectives.

In the theory, if the supply of labour is below the equilibrium. supply is less than demand, and there is a risk that set health objectives will not be met. At the same time, an oversupply of labour will result in the wastage of scarce resources. Thus, it is critical to ensure that there is an equilibrium position where the supply of healthcare labour is just equal to demand.

The theory, as expounded by Smits et al. (2010) considers the policies that eventually affect the demand and supply of healthcare staff to be both internal and external. Internal factors are those that originate within the health facility or health system and are to an extent under the control of the system. External factors, on the other hand, originate from outside the system but have far-reaching effects on the supply and demand for labour in the healthcare system. The model below by Zurn et al. (2004) as cited in Smits et al. (2010) attempts to elucidate the relationship between these factors further.

Figure: 4.2: Demand and Supply health labour model



Source: Adapted from Smits et al (2010)

The above model treats the labour supply scenario within a health system as external being a function of economic, cultural, geographical, and socio-demographic factors. Most significantly, the interaction of these factors attracts health and non-health policies and strategies that affect labour supply and demand. Zurn et al. (2004) assert that the external environment challenges and issues affect health financing and the provision of resources to this sector. For instance, increases in the population may call for an increase in healthcare budgets if public health objectives are to be met. However, economic conditions, such as institutional and national budget deficits, may make this impossible. The overall effect of responding to the external environment through health and non-health policies is what determines if health goals are eventually met (Zurn et al. 2004; Smits et al. 2010).

In the model put forth by Zurn et al., five factors determine the effectiveness of policies implemented to align labour and supply conditions to meet health strategy objectives. These are briefly discussed below: market failures refer to the potential inabilities of

the health care workers to freely and competitively move within the labour market as a result of information asymmetries and bureaucratic rigidities. Stakeholders also affect the effectiveness of attempts to align demand and supply conditions. Zurn et al. point to unionised labour, professional association, the public as interested parties whose support or opposition may affect the attempts by governmental authorities to align labour demand and supply in the health sector. The authors discuss time lags that occur between the time a realisation that there is a need to change policies to equilibrate supply and demand of labour as another factor that determines policy effectiveness in aligning demand and supply of labour. They state that in the health sector, it takes time to train, retrain, register, and licence professionals needed to balance labour figures. The longer it takes, the longer it will address non-equilibrium in the healthcare labour market. Furthermore, regulations on qualifications, licence, hiring practices will also affect the equilibrium creating process (Zurn et al. 2004; Smits et al. 2010). The following section will focus on Game theory as a third theory underpinning the study.

4.4 The Game Theory

Having discussed the new public management thinking above and its origin, the researcher sees a link between new public management and game theory that in the public sector decisions rests in the hands of public managers as it is the case in the current study, where a decision to implement cost-cutting measures was taken by the national treasury and the management in the NDoH yet the outcomes of those decisions do not directly affect public managers.

The Game Theory explores situations of dispute or conflicting cases, the relations among the persons and their resolutions. According to Bonanno (2018), the field of game theory was initiated at the beginning of the 20th century by Ernst Zermelo (1913) and John von Neumman (1928). The innovation was highlighted by John Van Neuman and Oscar Morgensten's publication, "*Theory of Games and Economic Behavior*", (1944). This was succeeded by crucial work by John Nash between 1950 and 1951 and Lloyd Shapley (1953). Bonanno (2018) further expressed that game theory impacted on the progression of many parts of economics. Eventually, the influence of game theory expanded to other parts of the social sciences and beyond the social sciences to fields like technology and biology.

4.4.1 Game theory defined

Nie et al. (2014) define the game theory as the official research on how to make a decision whereby many stakeholders make selections that probably impact the welfare of other stakeholders. Sihlobo, (2012) attests that the game theory has been criticized in several disciplines of social sciences from its elevation to eminence at least 50 years back (Lim, 1999). The game theory is applicable in several types of research where there is competition, where the problems are known as games and the respondents are known as players. A player is described by Osborne (2002) as a person or cluster of people who decide. Sihlobo (2012) further delineate the expectations of the game theory by noting that players make beliefs on the basis of analysis of what other will probably do, choose an appropriate answer based on those beliefs and modify their answers and beliefs until there is an equilibrium. Dobbins et al.(2017) reiterated that these expectations are periodically violated, implying that not everyone acts reasonably in trying circumstances

Osborne and Rubinstein (1994) noted that the fundamental expectation that drives the game theory is that those who make decisions are reasonable and they do so methodically. However, Gryzl et al. (2019) accentuate that expectations at times are violated implying that not all players act reasonably in intricate circumstances. Munoz-Garcia and Toro-Gonzalez (2016) further state that those who make decisions are conscious of their choices and choose their activities purposefully after a procedure of enhancement. Constructs of the Game theory are applicable every time the activities of many agents depend on the activities of each other (Wang, 2016). Kerk (n.d.) notes that a game is a circumstance where there are two or more players. In addition, Turocy and von Gryzl et al., (2019) notes that a game with a single-player is problematic in decision making. The agents may be persons, several people, institutions or a collection of the aforementioned (Munoz-Garcia and Toro-Gonzalez, 2016). The constructs of the game theory give a “language” to make a framework analysis and comprehend methodical situations. (Wang, 2016).

Conventionally, the game theory has emphasized on relations between complex, intellects who are reasonable. For instance, Robert Aumann defines game theory as follows:

> *"Briefly put, game and economic theory are concerned with the interactive behavior of Homo rationalis – rational man. Homo rationalis is the species that always acts both purposefully and logically, has well-defined goals, is motivated solely by the desire to approach these goals as closely as possible, and has the calculating ability required to do so."* (Aumann, 1985, p. 35.)

Dixit and Skeath (2004) argue that game theory satisfies two key assumptions: common knowledge and rationality. Common knowledge assumes both players can deduce what the other will do contingent on each player's move, that is each player knows the consequences of each action, knows that both know it, knows that both know it, etc (Wang, 2016; Dobbins et al.,2017). This assumption is particularly evident in trust version of the game, which insists on its maximum transparency. Rationality assumes that the players are instrumentally rational in the sense that they will always choose strategies that maximize their pay-offs, relative to their knowledge and beliefs about benefits and harms of each chosen strategy (Nie et al.,2014; Gryzl et al., 2019).

4.4.2 Essential ingredients of the game theory

According to Malhotra (2012) every game has got three distinct components. These are:

- Some decisions have to be made in each game and players are responsible for this
- Some strategies are available to implement decisions
- Some outcomes are anticipated for each game (decisions and strategies applied)

Furthermore, Game theory consists of six elements, namely the game, the players, the strategy, the pay-off, the information and the equilibrium (Nie et al.,2014; Gryzl et al., 2019).

Game: The implementation of the staffing moratoria

Players: KZN DoH, Department of Treasury, healthcare employees, communities

Strategy: Resolving budget pressures and decreasing expenditure facing the department health

Pay-off: Cut and control hiring of staff, increase the efficiency of current resources, improve service quality

Information set: Circular on the implementation of staffing moratoria from the premier's office, necessitated the decision to implement freezing of posts

Equilibrium: An outcome where two goals are achieved: an austerity goal driven by the Department of Treasury that brought staffing moratoria and the public healthcare goals of the KZN Department of Health

Game theory is generally divided into two branches, which are non-cooperative and cooperative game theory (Munoz-Garcia and Toro-Gonzalez, 2016). Lim (1999) further clarified that whether a game is cooperative and non-cooperative would depend on whether the players can communicate with one another. According to Peters (2015), the non-cooperative game theory focuses on strategic choices resulting from interaction among competing players, each player chooses its strategy independently for improving its utility. Wang (2016) suggested that non-cooperative game theory specifically means, this branch of game theory explicitly represents the process in which players make choices out of their own interest. Christiansen (2013) further suggested that in the model of non-cooperative game theory the details of the ordering and timing of players' choices are crucial in determining the outcome of a game. While the non-cooperative game theory focuses on competitive scenarios, cooperative game theory provides analytical tools to study the behaviour of rational players when they cooperate (Peters, 2015). The main focus of cooperative games describes the formation of cooperating groups of players that can strengthen the players' positions in a game. Munoz-Garcia and Toro-Gonzalez (2016) view cooperative game theory concepts as sets of payoff combinations that satisfy both individual and group rationality. As one example of how cooperative game theory can naturally be applied in situations arising in political science or international relations, where concepts like power are most important (Turocy and von Stengel, 2001).

4.4.3 The relevance of the game theory in this study

The use of game theory in this study arrives at policy decision making regarding the formulation and implementation of staffing moratoria in the KZN Department of Health.

In the game theory, changes or strategic moves by one or many of the players can offset the existing equilibria; in the case of this study, standard expectations between the employer and employee. Game theory is useful for identifying conditions under which individual stakeholders in a collective action problem interact in more cooperative ways and the best interest of the collective. Azevedo et al. (2011) believe that when applying game theory to the labour markets, the common rationalisations that bind employers and employees are working conditions, and remuneration. The decisions and actions of the management in the Department of Health to introduce workplace reforms in KZN healthcare facilities potentially affect the interest of other players, which in this case, are the employees in the KZN Department of Health. Decisions in the Department of Health pertaining to the managing and functioning of the institutions are taken at the national and provincial levels, regardless of the impact and outcome of these decisions in health facilities at regional level.

The theory suggests that the staffing moratoria were and is a multi-stakeholder game that needs to accommodate the needs of different players to come at an equilibrium that optimises the pay-offs of all the players. It, therefore, motivates the researcher to challenge the suitability of the centralised approaches that were used in implementing staffing moratoria. Furthermore, the researcher believes that if game theory is applied early it can yield better payoffs and tangible solutions to public health issues. Using game theory to model public health problems is not different from using it to model any other type of problem or decision-making scenario.

4.5 Conclusion

This chapter discussed several theories pertinent to this study. The new public management theory, manpower planning theory, and the game theory all contribute towards the theoretical understanding of the reasons, processes, and impact of the staffing moratoria in the delivery of healthcare services in KZN. Under NPM theory, staffing moratoria were associated with the need to cut costs and increase efficiency in a manner that resembles how the private sector entities operate. Under the manpower planning theory, staffing moratoria were reviewed in line with the management of supply and demand of healthcare employees with the view to achieving an equilibrium position where there were neither shortages nor excesses of staff. Finally, under game theory, staffing moratoria were conceived of as a “game”

involving several stakeholders, among them the Department of Health, Treasury, the employees and communities. The next chapter outlines and discusses the methods and processes that were followed in further investigating the subject matter under study.

CHAPTER FIVE: RESEARCH METHODOLOGY

5.1 Introduction

The purpose of this study was to assess the implications of, and the possible responses to staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in the King Cetshwayo Health District. The study also aimed to identify and propose a suitable framework that can be applied in managing staffing moratoria at the hospital. This chapter focuses on the research methods and processes applied to assist in reaching the study's objectives. It further presents the philosophy underpinning this study. In the chapter, the research design, research population and sample, data collection and analysis procedures applied in the study are also discussed. The chapter ends with a brief review of the research ethics that guided the study.

5.2 What is research?

Research is a systematic process of collecting, analysing, interpreting and presenting data to produce new knowledge and/or to add to existing knowledge about phenomena (Kumar, 2014). Research is generally about generating knowledge or adding knowledge to assist in knowing. In this regard, Jurgen Habermas gives three distinct ways of generating knowledge based on what he calls cognitive interests, which differ from individual to individual (Du Plooy-Cilliers, 2014). As per Du Plooy-Cilliers (2014), cognitive interests are namely, technical, practical and emancipatory and "the word 'cognitive' refers to the mental processes of knowing things." Habermas believed that there are three ways of knowing, depending on what you want to know, and he further identified three cognitive interests which closely correspond to three common research paradigms. These are given in the table below:

Table 5.1: Habermas' three Cognitive Interests

Empirical-analytical	The *empirical-analytical* sciences are empirical and technical, and their aim is to find (cause and effect) relationships hence this type of science is closely related to positivism.
Historical-hermeneutic	The *historical-hermeneutic* (or hermeneutic-phenomenological) sciences are practical, and their aim is in-depth understating of phenomenon hence this type of science is related to Interpretivism.
Critically oriented	The *critically oriented* sciences are emancipator and related to critical realism hence it aims to empower people through knowledge.

Source: Du Plooy-Cilliers (2014:21).

The cognitive interest of the researcher ultimately influences: "…the aims or goals of research, or the reasons for doing research; what are considered worthwhile phenomena for research; what research methods should be used; and what is considered knowledge" (Du Plooy-Cilliers, 2014:21).

This study followed an, empirical-analytical scientific view to understand and assess the impact of freezing of posts in the KZN Department of Health (*effects*) and challenges facing healthcare workers in the provision of healthcare services. The researcher wanted to appreciate the factors leading to the implementation of staffing moratoria as well as how these have affected organisational performance and service delivery.

5.3 Types of Research

In academia, research is basically broken down into two categories, which are basic/pure research and applied research which leads to different purposes, requiring different levels of control and precision (Davis, 2014). Davis (2014) defines pure research as studies that are conducted to add to existing knowledge. Pure research is sometimes referred to as basic or fundamental research and deals with questions that are intellectually challenging to the researcher but may or may not have practical applications at the present time or in the future. Pure or basic research seeks an extension of knowledge. It is not necessarily problem-oriented. On the other hand, Kumar (2011) defined it as being focused on:

> "…the development, examination, verification and refinement of research methods, procedure or techniques or tools that form the body of research methodology" (Kumar, 2011:10).

Applied research is research with findings that can be applied to solve social problems of immediate concern (Krueger and Casey, 2014). It is problem oriented because research is carried out to solve specific problems about which decisions must be reached. While Davis (2014) views applied research as more challenging in the social sciences especially when conducted within a qualitative approach, he defines it as:

> "An investigation to investigate practical issues in order to find solutions that can be implemented in practice" (Davis, 2014:75).

This study was conducted using an applied research approach with the need to understand the implications of, and the possible responses to staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital and to find solutions on how organisational performance challenges, if any, could be managed. Its practical recommendations include a framework on how staffing moratoria should be managed at the hospital.

5.4 Research Paradigms or Philosophies

A paradigm is defined as a general view through which society attempts to understand and explain a phenomenon (Saunders et al., 2014). It has also been defined as "a philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated" (Merriam-Webster, 2020:1). In research, paradigms guide the researcher's philosophical perspective on how the study can best be approached to provide results that are meaningful in answering posed research questions. Thus research methods, research designs, approaches and processes, may all stem from the research paradigm that research holds in relation to the generation of information (Kumar, 2014).

5.4.1 Positivism and interpretivism

While many research paradigms exist in the literature, the commonly discussed are positivism, interpretivism and pragmatism. Positivism is a view that is strongly associated with research in the natural sciences and is the oldest of the three.

Positivists believe that research should, at all costs, produce results that are highly objective (Babbie, 2016). This means that for a given phenomenon being researched, the outcomes should be narrowed down to a single, correct answer or conclusion (Bryman & Bell, 2015). This conclusion is expected to remain consistent if similar research procedures are applied under the same conditions (Kumar, 2014). Positivists, therefore, advocate for research methods that enhance the precision of results as well as the use of large, representative and unbiased samples (Beaudry & Miller, 2016). Positivists are associated with quantitative research methods that also advocate for validity and reliability (Gray, 2017).

Interpretivists on the other hand, believe that research findings should be subjective enough to accommodate the different realities that research subjects exist in (Beaudry and Miller, 2016; Ryan, 2018). Interpretivists query the application of natural science methods and principles in social research or research involving human beings as respondents (Ryan, 2018). Unlike natural phenomenon, human beings are social beings and are, therefore, diverse. Research methodologies, according to interpretivists, should cater for human diversity. Social research is considered reliable if it is flexible enough to support subjective, often inconsistent views that may depend on the research's natural settings as well as the interactive roles of the researcher (Creswell, 2014; Babbie, 2016). In interpretivism, researchers are therefore, not independent co-ordinators of a study but participants as well. Interpretivism is associated with qualitative research methods (Kumar, 2014).

5.4.2 Ontology, epistemology and axiology

In addition to positivist-interpretivist debates, there are also varying philosophical views on what constitutes reality and knowledge. Ontology is the philosophical view that questions the nature of reality while epistemology questions the nature of knowledge through which reality is understood (Saunders et al.,2014). In research, epistemology, as a philosophy is important in that it guides a researcher to identify acceptable knowledge within a discipline (Saunders et al.,2014). In this study, data generated through qualitative and quantitative methods can be used to construct acceptable knowledge as is custom within policy-related studies. On an ontological platform, there are views that social reality is external to social actors (objectivism) and contrasting views that social actors do construct and are part of reality or subjectivism (Blaikie & Priest, 2017).

Ontological and epistemological views cut across the positivist and interpretivist paradigms (Beaudry & Miller, 2016). There is, therefore, an ontological positivist view, an epistemological positivist view as well as ontological and epistemological interpretivist views (Blaikie & Priest, 2017). The researcher believed that reality is both external to social actors, i.e. some phenomenon is generally objective and also that some reality is subjective. The staffing moratoria, for instance, represents an objective truth, or a reality that exists within the case of interest as substantiated by various policy documents and sources cited in the study. However, the manner in which individual actors interpret that reality and are affected by it differ. These differences may be affected by time and place (Yin, 2014). Thus it is possible that at some point a respondent may believe that the freezing of posts at the hospital was a positive move and another time that it was a bad move with negative consequences on service delivery. Thus, in answering the research questions, the researcher attempted to accommodate approaches that take both the subjective and objective ontological views, while at the same time meeting the epistemological demands of policy research.

Another philosophical approach that influences research choices is axiology. Axiology refers to the values that researchers place in their study (Saunders et al.,2014). Axiology affects the epistemological and ontological, as well as the positivist and interpretivist views that a researcher adopts (Given, 2008). If a researcher values objective views existing outside social actors, they are most likely to follow positivist world views.

5.4.3 Pragmatism

While the debates between positivists and interpretivists, ontologists and epistemologists suggest mutual exclusivity in research method choices, pragmatism is a more recent view that notes that research choices and methods can be made from a combination of philosophies (Kumar, 2014; Yin, 2014). Pragmatists believe that the best philosophical view to a study stems directly from the research question the study aims to answer (Saunders et al.,2014). Kaushik and Walsh (2019) assert that pragmatists believe in the interpretivist views that social reality is constructed by social actors through experiences and the formation of belief and perceptions associated with those experiences. At the same time, they accept that within those subjective social experiences, objective truths that are realities that are held and supported by

wider populations also exist. These are best extracted objectively (Kaushik and Walsh, 2019). Thus, reality and knowledge can be embedded in both subjective and objective views held by society (Babbie, 2016; Ryan, 2018).

Going by the above views, researchers can use any research method that can extract both, or either subjective and objective realities and still attain the epistemological power to make acceptable research conclusions (Kumar, 2014; Blaikie and Priest, 2017).This study was strongly guided by a pragmatist view and therefore applied both qualitative and quantitative research methods.

Going back to the research questions, all the research questions could be answered from both a wider and objective organisational perspective and from an individualistic subjective and objective viewpoints. The first research question for instance (What impact does staffing moratoria have on healthcare service delivery at the Ngwelezana Tertiary Hospital?) had the capacity to provide epistemologically acceptable answers from both what individual employees perceive to be the impact of the moratoria on healthcare service delivery and what the statistics from collected data points out to be objective truths.

5.5 Research methodology

Research methods are generally guided by research paradigms discussed above. According to Walliman (2011), research methodology encompasses the techniques and tools that allow the researcher to collect, sort and analyse data so as to come to a conclusion. As a result, a research methodology is thus a systematic, theoretical analysis of the methods applied to a field of study and generally it encompasses concepts that inform the designs which may be qualitative or quantitative strategies for data collection and analysis. Research methodology plays an important role in the implementation of a study and accordingly assists in the achievement of research objectives. Research methodology comprise methods, techniques and procedures that are employed in the process of implementing the research project or research plan (Braun and Clarke, 2014). It also necessitates a reflection on the planning, structuring and execution of the research in order to comply with the demands of truth, objectivity and validity (Babbie, 2016).

5.5.1 Research Design

Research design refers to the decisions that the researcher makes to execute the chosen methodology. A research design is necessary to execute any research study. It is the framework of how the researcher intends to carry out the research study and provide answers to research questions (Kumar, 2014). Additionally, Cooper and Schindler (2003) state that a research design outlines the direction the research will follow, taking into account different tools used when designing data collection instruments (Cooper and Schindler, 2003).

Common research designs that are used in social research include descriptive, exploratory, explanatory, experimental, and participative designs (Kumar, 2014; Babbie, 2016). This study applied an exploratory research design that was used in a qualitative study set-up and a descriptive study that was supported by quantitative methods. In an exploratory research design, the broad aim of data collection, analysis and interpretation is enhance the understanding on an phenomenon that is poorly understood, new or less studied (Saunders, et al., 2014). In the context of this research, an exploratory research design was motivated by the lack of any previous studies that examined staffing moratoria and task-shifting from a Ngwelezana Tertiary Hospital perspective. As a mixed study, it also applied a descriptive research design. This design supports research whose aim includes the description of known phenomenon. A descriptive design was applicable because there was a need to describe: the issues under study in terms of what they were; how they affected the relevant stakeholders; who were the affected parties; and why they were affected by the phenomenon in this way (Babbie, 2016; Beaudry and Miller, 2016). A descriptive design was also applicable because some elements of the research agenda, including the reasons behind staffing moratoria, were well known although they had never been described from a Ngwelezana Tertiary Hospital perspective.

5.6 Research Strategies

Saunders, Lewis and Thornhill (2015) discuss various research strategies that can be used in the collection of data for a study. In their view, a research strategy serves to guide the efficient collection and analysis of data leading to reliable and valid conclusions. They identify seven research strategies, namely, experimental, survey, action research, archival research, ethnography, grounded theory and case studies

Experimental research is used to test hypothesis on cause and effect relationships between or among variables (Walker, 2010; Goos and Meintrup, 2016). It makes use of test and control groups or candidates to compare and contrast outcomes after a treatment has been administered to test groups. A survey strategy involves the collection of data by asking groups of interest to respond to administered questions (Blaikie & Priest, 2017). The precepts behind using a survey strategy is the belief that populations and samples of interest have the capacity to provide insights that can be used in answering research questions (Bryman & Bell, 2015). Saunders et al. (2014) also discuss ethnography as a research strategy that relies on natural observed and experienced social phenomenon to answer research questions. It relies less on any methodological data collection tools making use of the researcher's felt and observed experiences as s/he interacts with the sample of interest. Action research involves the participation of a researcher in bringing about targeted change in the research setting (Saunders et. al.,2014).

These strategies can be used in different appropriate research designs. Some scholars, however, among them Kumar (2014) and Babbie (2016) do not put any distinction between a research strategy and a research design. For instance, Kumar classifies an experiment as a research design alongside surveys. This study takes Saunders et al.'s approach and distinguishes the two. Thus, a survey is classified as a strategy rather than a design.

5.6.1 The case study strategy

Of interest to this study is the case study strategy because the research was conducted as a case study of a selected hospital. The case study strategy embedded a survey strategy as well as an exploratory research design. The next subsection discusses the concept and the practice of a case study strategy. Yin (2014) defines a case study as an empirical, positivist research strategy that makes use of a case, which could be an event, a place, a person or an organisation to better understand a phenomenon of interest. Saunders et al. (2014:592), define it as a "Research strategy that involves the empirical investigation of a particular contemporary phenomenon within its real-life context, using multiple sources of evidence." Like Yin (2014), they point to the real-life or naturalistic aspect of a case study. Harrison et. al. (2017) also add that case studies are associated with the need to understand complex

phenomenon using various research designs and sub-strategies. Like Yin (2014), many scholars associate case studies with the collection of in-depth, highly informative data from a clearly defined case within a given period. Harrison, Birks, Franklin and Mills (2017), thus, assert that case studies are bound by time and space.

This study utilised a case study approach because of the need to understand how an organisation, as a case, was affected by a specified phenomenon in a more holistic and naturalistic way. A case study approach was also selected out of the need to come up with more detailed results that can be used in policy implementation (Saunders et al., 2015). Several scholars, among them Cresswell (2014) and Yin (2014), opine that because case studies are highly specific to the uniqueness of the case of interest, involve the collection of more holistic and in-depth data and use various designs and strategies, they are more likely to generate research recommendations that can be applied in real life situations. Thus, a case study approach was also driven by the applied research aspect of the study.

5.6.1.1 Types of case studies

Three types of case studies can be identified (Mills, Durepos and Wiebe. 2010). These are the intrinsic case study, the instrumental case study and the collective case study. Intrinsic case studies involve the study of a unique phenomenon, where the case itself is taken to be the phenomenon (Given, 2008; Mills et al., 2010). For instance, a case that exhibits very different and divergent patterns from what is taken to be the norm can be investigated in order to understand the factors behind its uniqueness (Obeng, 2015). An instrumental case study, on the other hand focuses on what is happening inside a case rather than the case itself (Mills et al., 2010; Bryman and Bell, 2015). When more than a single case is studied with the aim of understanding the same phenomenon, this is referred to as a collective case study (Obeng, 2015).

This study focused on what is happening inside Ngwelezana Tertiary Hospital as a case of reference and studied only one case. It, therefore, applied an instrumental case study approach where the events and ocurrences inside the hospital are the phenomenon of interest. An instrumental case study is important when there is a need to empirically study complex phenomenon in a case for the purposes of drawing practical recommendations (Bryman & Bell, 2015). Yin (2014), therefore, associates it

with evaluation research processes that aim to understand the actual performance of a case versus the desired or targeted performance.

Case studies can also be classified by the methods used in conducting an inquiry. Mono-method case studies use a single research method in an attempt to meet research objectives. Mono or single method case studies are generally qualitative in nature because of their naturalstic setting and empirical subjectivity concerns (Yin, 2014). Cook and Kamalodeen (2019) state that mixed method case studies make use of both qualitative and quantitative studies in an attempt to benefit from the advantages that these methods bring. Thus, they seek to be subjective enough to respresent the uniqueness of research participants yet objective enough to support reliable and acceptable conclusions (Creswell, 2014). As a mixed methods case study, this study was able to represent the participants unique views and was also able to extract conclusions that can be inferred to the whole study population – Ngwelezana Tertairy Hospital.

5.6.1.2 Case selection and representativeness

An important theme in case study discourse is the selection of a case. There are different views on whether or not a case needs to be representative enough to generate results that can be applied to other related cases. For instance, in this study, this debate would centre on whether the data generated from Ngwelezana Tertiary Hospital could produce conclusions that can be generalized to other tertiary hospitals in the province. Yin (2014) suggests that the naturalistic part of a case study may make it difficult to generalize the results it generates to other contexts. The generalisability of findings, should therefore, not be the main objective behind conducting a case study. On the other hand, Obeng (2015) asserts that case studies can be representative and can produce results that can be generalized to other contexts. Obeng (2015) emphasizes that case studies must therefore be selected with representativeness in mind. This study adopted a more or less balanced approach where it foresaw the results, conclusions and recommendations of the study as being highly applicable to Ngwelezana Tertiary Hospital although they can be generalized to other hospitals to different extents. This is because the phenomenon of interest, despite being studied from Ngwelezana Tertiary Hospital, occurred to all other public

hospitals in the province. At the same time, it takes a cautious view that some aspects of the results may differ according the hospital-specific dynamics.

5.7 Research Methods

There are three common methods applied in social research – qualitative, quantitative, and mixed methods. Qualitative methods make use of text and images and voice to answer research questions while quantitative methods mainly rely on the use of numbers (Kumar, 2014). From healthcare workers' perspectives, qualitative research is considered person-centred, because it involves human experiences such as interactions between medical doctors, nurses, administrative personnel, and other healthcare workers from other components within the hospital; hence, the study seek their views, feelings, emotions, and experiences about the central phenomenon being investigated, which in this case is the impact of freezing of posts in the KZN Department of Health.

Quantitative research is captured by Leedy and Ormrod (2010) and Kumar (2014) as possessing the characteristics of highly formal defined structures that allow inflexibility and rigidity. The purpose of using quantitative research approach in this study is to best analyse the quantitative data (shape of numbers, figures, charts and/or tables). The purpose of using it in social science research is to get data that can be generalised to a wider population; data and conclusions that have a greater level of reliability and validity; and data that is standardised enough to facilitate comparisons across cases (Wagner & Gillespie, 2018).

The researcher in this study employed a mixed-method strategy. A mixed-methods study makes use of more than one type of research methods, usually qualitative and quantitative methods (Bryman & Bell, 2015). The purpose for using qualitative research approach is to focus on understanding social phenomena from the individual's perspectives (Beaudry & Miller, 2016). Mixed-methods research is described by some scholars as being notably pragmatic in the sense that it combines the advantages of both qualitative and quantitative studies at the same time, removing the weaknesses associated with each method (Babbie, 2016). For instance, qualitative research is associated with low reliability, because it does not use scientific sampling, data collection, and analysis procedures. Its flexibility of approaches from one case to the next makes it difficult to standardise results and come with a unified, quantifiable

conclusion (Saunders, et al., 2014). On the other hand, quantitative research methods lack the flexibility to gain deeper insights into situations (Gray, 2017). Using mixed methods, the research was able to harness on the strengths of both methods. It was able to explore the deeper insights into the matter under study and at the end to infer its findings to the broader population of staff at the hospital.

5.7.1 Reasons for choosing methodological triangulation design

Mixed studies are linked to the process of triangulation. Methodological triangulation involves comparing and contrasting outcomes from different methods as way of coming up with a conclusion that is no tainted by any methodological weaknesses. Mixed-methods research, also known as methodological triangulation, involves collecting, analysing, and integrating (or mixing) quantitative and qualitative research (and data) in a single study or a longitudinal program of inquiry. The purpose of this form of research is that both qualitative and quantitative research, in combination, provide a better understanding of a research problem or issue than either research approach alone. Johnson and Onwuegbuzie (2004) cited in Vosloo, (2014) state that the aim behind combining qualitative and quantitative approaches in one study is to ensure that the methods are able to complement each other in a way that ensures the validity of research. This view is supported by Nau (1995:1, cited in Vosloo, 2014:322) who suggest that blending quantitative and qualitative methods of research can produce a final product, which can highlight the significant contributions of both. In the research context, the final product referred to a framework that will help the department of health to overcome moratorium-related challenges. Through the application of mixed methods, the study was able to reach multiple and diverse permanent healthcare workers, both senior and junior, so as to establish their attitudes and perceptions of the topic (Vosloo, 2014).

One of the limitations of using mixed methods in a single study is that more time and resources are needed to collect/analyse both quantitative and qualitative data. Furthermore, the researcher may not have expertise in both quantitative and qualitative methodologies, as these both involve complex procedures (Kumar, 2014; Saunders et al., 2014; Babbie, 2016). Lastly, mixing methods may be viewed as combining incompatible epistemologies.

5.7.2 Inductive versus deductive approaches

Within qualitative, quantitative and mixed research methods, a research can be framed as deductive or inductive (Creswell, 2014; Gray, 2017). A study is deductive if its broad aim is to test whether given theoretical or conceptual views are applicable to the study's findings. A study is inductive if it aims to develop or identify theories and conceptual views from the data. Thus, a deductive approach focuses on theory-testing and an inductive approach on theory-building (Gray, 2017). Research scholars also associate inductive and deductive reasoning with the philosophical views discussed earlier. Deductive reasoning, with its demand for strict procedure to test the truthfulness and applicability of existing theories and hypothesis, heavily relies on positivist views associated with quantitative research methods (Scheurich, 2014; Sahajan, 2014). Deductive reasoning is asociated with interpretive paradigms and qualitative research methods (Kumar, 2014; Gray, 2017).

This study had both a deductive and an inductive aim. On the deductive front, the study sought to deduce whether current theories can explain the status quo at Ngwelezana Tertiary Hospital. The New Public Management (NPM) was taken as the study's main theoretical framework. There was, therefore, a need to test and assess, if at all the NPM theory can be applied to the study. At the same time, there was a need to develop a theoretical framework that could guide the implementation of staff freezes in the future, implying an inductive approach.

5.8 Population and Sampling process

A research population is the set of all research candidates that meet defined research eligibility criteria (Gray, 2017). The population for this study comprised of all permanently employed healthcare workers currently working at Ngwelezana Tertiary Hospital under the KZN Department of Health. The study also selected executive members at Ngwelezana Tertiary Hospital, the KZN Department of Health head office, and King Cetshwayo Health District.

The study used both non-probability and probability sampling methods to select the qualitative and quantitative research samples. In non-probability sampling, unlike in probability sampling, every unit of the population does not get an equal chance of

participation in the investigation (Babbie, 2016; Gray, 2017). This study adopted a purposive sampling technique to recruit participants (Blaikie & Priest, 2017). Purposive sampling is one of the most common sampling techniques for qualitative designs (Macket al., 2005) and is very popular among researchers in the social sciences (Guare and Barrios, 2006). Furthermore, on the quantitative side the study used stratified sampling technique to select samples. Respondents were selected based on their different components in the hospital.

5.8.1 Availability of participants

A major challenge noted in academic research is the failure to access the population of interest due to restrictions, lack of interest from participants, among others (Saunders et al.,2014). The researcher applied to the gatekeepers of Ngwelezana Tertiary Hospital through the office of the chief executive officer and of King Cetshwayo Health District through the office of the district manager as well as from KZN Department of Health through the office of the health research and knowledge manager. Permissions to access participants were granted in all the above cases (Please see attached annexures E, F and G). The researcher was also granted an ethical clearance certificate from University of KwaZulu Natal Humanities and Social Sciences Research Ethics Committee (see annexure C) to obtain information from the targeted population.

5.9 Research Sample

A sample can be defined as a group of relatively smaller number of candidates selected from a population for investigation purpose (Alvi, 2016). The members of the sample are called participants. Dawson (2002) further define a sample as a number of people or subjects that are considered to be manageable to take part in a research study (Dawson, 2002). Target population refers to all the members who meet the particular criterion specified for a research investigation by (Alvi, 2016). In social research, Babbie (2008) in Mthuli (2018) argues, there is no limit to whom or what can be studied. The units of analysis can be either individuals, groups or organisations such as corporations, church congregations, colleges and academic departments or supermarkets. Ngwelezana Tertiary Hospital as a healthcare facility providing healthcare services under KZN Department of Health was considered the unit of study.

5.9.1 The eligibility criteria

Eligibility criteria describe the characteristics that participants in the population must have in order to qualify to participate in the study (Mbokani, 2009). The eligibility criteria in this study were that the participants:

a) Must be permanently employed in the KZN Department of Health and at Ngwelezana Tertiary Hospital

b) Must have working experience of at least six months within the KZN Department of Health

c) Must be a healthcare worker who is interested in contributing and participating in this study.

The whole sample that was eventually drafted met the three requirements above.

5.9.2 Sample size

Mthuli (2018) defines sample size as the number of candidates or units that participate in an inquiry. The study adopted both quantitative and qualitative designs and a non-experimental strategy to fulfil its purpose. On the qualitative side, data was collected with a survey questionnaire. The targeted population were healthcare workers employed at Ngwelezana Tertiary Hospital deployed in different components within the hospital.

This study adopted a probability sampling strategy and used Yamanes (1967:886) simplified sampling formula to calculate sample size, which is:

$$n = \frac{N}{1 + (N)(e)^2}$$

N = Population
e = Margin of Error
n = Sample size

A stratified sampling technique was employed and 292 survey questionnaires were distributed at Ngwelezana Tertiary Hospital amongst healthcare workers. The sampling process is presented below.

Figure 5.1: Determining sample size process for Ngwelezana Tertiary Hospital:

$$n = \frac{N}{1 + (N)(e)^2}$$

$$n = \frac{1084}{1 + (1084)(0.05)^2}$$

$$n = \frac{1084}{1 + (1084)\ (0.0025)}$$

$$n = \frac{1084}{3{,}71}$$

N = 292,18

The sample size is 292 healthcare workers.

Figure 5.1: illustrates the formula used to determine the required sample size that would be a representation of Ngwelezana Tertiary Hospital population and allow the researcher to generalize about the population. The research sought to have a 95% confidence level and an expected error margin of 5%. Figure 4.1 above shows that the required sample size was 292 from a population of 1084 healthcare workers employed at Ngwelezana Tertiary Hospital. The researcher administered the survey questionnaires amongst permanently employed healthcare workers with working experience of above six months and who were willing to participates in the study.

Out of 292 sample size required for this study, only 177 healthcare workers who were willing to participate and participated in this study. Due to unforeseen problems during the data collection process such as unwillingness to participate in the study because of prevailing staff shortages facing the hospital and the high demand of healthcare services on the patients' side, the author did not reach the required 292 sample size. By not reaching the required sample size, the author was aware that generalization was not possible. However, with the use of the actual 177 sample which represented all components within Ngwelezana Tertiary Hospital (see Table 4.2 below), the author was able to profile the 177 healthcare workers based on the data collected from them.

On the qualitative side, data was collected using interviews. Non probability sampling strategy was employed. Nine respondents were key informants who participated in in-

depth interviews. The key informants were made up of senior and executive managers who were involved in staffing moratoria and human resources decision-making. In this study, the selection of the nine sampled respondents was made on the basis of the researcher's subjective judgement. Under this judgement, purposive sampling was guided by the availability of the participant, the willingness to participate and the ability to effectively participate and the positions respondents hold which made them knowledge holders.

Table 5.2: The sample distribution of departments at Ngwelezana Tertiary Hospital

Department	**Surveys**	**Interviews**
Finance department	11	1
Human Resources Management Department	15	1
Medical Services and Professional Allied to the Med. Dep.	23	1
Systems Management department	22	1
Case Management Department	2	-
Monitoring and evaluation Department	1	1
Nursing Services Department	92	1
Office of the Chief Executive Officer	-	1
Other, (Please specify)	10	-
I prefer not to say	1	-
External interviewees	-	2
Total	**177**	**9**

Adapted: Approved Ngwelezana Tertiary Hospital organogram (2014)

5.10 Data collection

The study made use of both primary and secondary data. The management of these two types of data is discussed in this section.

5.10.1 Secondary Data

Secondary data is data that was collected by other researchers, sometimes for reasons other than research, such as office statistics, books, administrative records or other accounts kept routinely by organisations (Saunders et al, 2009). Secondary data can be generally understood as data that is existing and has not been collected by the researcher and it can encompass a whole variety of empirical forms. There are many such sources these may include, official government documents, company reports, trusted media publications and Department of Higher Education and Training (DHET) accredited published academic research (Harris, 2001). In this study, sources such as Department of Higher Education and Training (DHET) accredited academic journals and non-academic journals, books, official government reports, policy documents, trusted newspaper articles and internet sources were used in the study as secondary data. The use of these documents assisted in constructing the background, identifying the problem that needed researching and the literature review as well as theoretical framework of the study.

5.10.2 Primary data

Primary data is collected by the researcher directly for the purposes of meeting the defined research objectives (Creswell, 2014). According to Hox and Boeije (2005) in Mthuli (2018), primary data is collected for the explicit research problem at hand, using processes that fit the research problem best. Primary qualitative data can be collected through in-depth interviews, observations and focus groups (Mack et al., 2005). In this study, qualitative primary data was collected using in-depth interviews and quantitative primary data was collected through the use of survey questionnaires.

Studying people's experiences in contemporary organisations can be done in various ways, such as examining personal and institutional documents, through observation, by utilising survey questionnaires or by examining existing literature (Seidman, 2006). In this regard, the goal of this research was to understand the meaning the people involved in the delivery of healthcare services at Ngwelezana Tertiary hospital under KZN Department of Health make of their experiences thus, interviewing and

distributing of survey questionnaires provided a necessary but costly and timely avenue of inquiry (Hox and Boeije, 2005; Seidman, 2006). In addition, the use of primary data was to ensure that the data collected helped to understand the problem and assisted in "the operationalization of the theoretical constructs, the research design, and data collection strategy which could be tailored to the research questions" (Hox and Boeije, 2005: 594).

5.11 Data Collection Tools

The quality of research depends to a large extent on the quality of the data collection tools (Babbie, 2016). The researcher used structured questionnaires and conducted semi-structured interview schedules as data collection tools in this study. Questionnaires contained closed questions, as well as open-ended questions that enabled respondents to use their own words in responses. Some of the close-ended questions include non-comparative scales. These questions list a series of attributes of an object that are assigned numerical values that range from favourable to unfavourable, and from agree to disagree (McDaniel and Gates, 2001).

5.11.1 The survey questionnaire

Survey questionnaires were used because of their advantages and suitability for the study, namely their ability to collect a large quantity of data relatively quickly, their user-friendliness, their promotion of respondent anonymity, their applicability in field research, and their ease of use (Kumar, 2014; Babbie, 2016, Gray, 2017). Their disadvantages were noted as their potential to confuse participants if poorly constructed, and the limited ability to support in-depth discussion (Saunders et al.2015). The first weakness above was addressed through pilot-testing the questionnaire for ambiguity.

Interviews offered the advantage of being able to collect rich data that reflected the perceptions and emotions of participants (Beaudry and Miller, 2016; Gray, 2017). They also offered the research the flexibility to fine-tune questions to meet the response patterns and narratives of different participants (Saunders et al., 2015). Their noted disadvantages were that they take away the element of anonymity from the research process (Babbie, 2016). The researcher believes that interviewees, in particular instances, hold back sensitive information due to the fact that their identities

are known. Guarantees were, however, given that all the data from the interviews would be used for academic purposes only and will be held in confidence.

5.11.1.1 Survey Questionnaire design

According to Fowler (2014), a good survey questionnaire is one that is clear and well-defined in terms of what it is trying to measure. In this study, the survey questionnaire was carefully designed in accordance with the study's objectives as stated in Chapter One. When the questionnaire was developed, great care was taken to ensure that its wording was clear, simple, and easy to comprehend, without compromising the objectives of the study. The pre-test/pilot study also played a significant role in ensuring that the questionnaire was appropriate, and to guard against ambiguity and unclear questions.

The self-administered survey questionnaire was designed in a way that ensured that participants did not encounter problems when completing it. Survey questionnaires in this study were divided into two: one for supervisors at Ngwelezana Tertiary Hospital, and the second for junior staff members at the same hospital. Both survey questionnaires were appropriately short (six pages and took 15-20 minutes or less to complete). The survey questionnaire was also clear and self-explanatory, and accompanied by instructions. Preceding the distribution of questionnaires, the researcher clearly explained the purpose of the study, the length of the questionnaire, details of the researcher, and how the results from the questionnaires will be used. Both questionnaires were coded, meaning all questions were numbered, answers were provided participants chose answers which were most suitable for them.

5.11.1.2 Survey Questionnaire format

The survey questionnaire was designed to meet the objectives of the study. Section B and C of the questionnaire made use of the Likert scale questions to collect data (Questions 2.2, 2.9, 2.10, 3.1, 3.2, 3.3). The reason behind using this type of scale was its power in measuring the strength of participants perceptions on given statements (Babbie, 2016). Neuman (2011) asserts that the use of scales in a questionnaire is imperative as it can give the researcher more information about a variable and expand the quality of measurement. The rating scale measures used in the questionnaire were 1 = strongly agree; 2 = agree; 3 = strongly disagree; 4 =

disagree; 5 = uncertain/ not sure; and 6 = I don't know (questions 2.2, 3.1 and 3.2) Other rating measures used in the questionnaire were 1 = has significantly improved; 2 = has slightly improved; 3 = has remained the same; 4 = has slightly deteriorated; 5 = has significantly deteriorated; 6 = not sure (question 2.10); and 1 = extremely positive; 2 = positive; 3 = unchanged/neutral; 4 = negative; 5 = extremely negative; and 6 = not sure (Question 2.9).

According to Bertram (2007), some of the strengths of the Likert scale are that it is easy to construct, it produces a dependable scale, and, on the part of participants, it is simple to understand and complete. However, it does have a few weaknesses among them the observation that it is biased towards central tendencies, is prone to social desirability biases (Bertram, 2007; Creswell, 2014).

5.11.1.3 Survey Questionnaire layout

Questionnaires were used as a data collection instrument in this study. In the developmet of the questionnares, the reseracher ensured that the wording of the questionnare was clear, simple and easy to understand withouth compromising the objectives of the study. The survey questionnaires were delivered by hand to the respondents. Survey questionnaires involve respondents reading the question, interpreting what is expected, and then writing down the answers; where in some other cases, respondents were asked for clarity when they didn't understand the question.

The survey questionnaire was divided into four sections and represented the five objectives of the study (refer to annexure A). Section A covered questions pertaining employment particulars such as departments employees working under, occupation, direct components, number of years worked, and the highest level of study. This section aimed to determine how staffing moratoria affect these variables; this section aimed at answering objective one of the study.

Section B focuses on the possible causes of staffing moratoria in the KZN Department of Health, with questions in the form of the Likert scale, where respondents express their responses in terms of level categories, this section aims to answer objective two and three of this study. Section C focuses on the issue of task-shifting and possible solutions to staffing moratoria with questions aimed to answer objective four and five of the study. The last section dealt with additional comments regarding the study, this

section aimed to allow participants to provide to allude on any additional information pertaining the study in a form of open-ended questions on issues relating to staffing moratoria, task-shifting and possible solutions to the challenges brought by staffing moratoria. Section A, B, and C contained closed-ended questions where participants were provided answers to choose from, theirs was to choose answers which are most suitable to them.

Table 5.3 Questionnaire items answering the empirical objectives

Research Objectives	**Items**
The impact of staffing moratoria on healthcare services	A1 and B2
Factors that have led to the implementation of staffing moratoria	B2.4 -
Current working conditions and challenges faced by healthcare workers because of staffing moratoria	B2.7 – 2.12
Task-shifting in addressing staffing moratoria challenges	C3.2 – 3.3
Best practices to be used in order to address staffing moratoria in the KZN Department of Health	C3.1

Adapted from: Ndebele (2016, p60)

5.11.2 Interviews

There are three types of interviews: structured, semi-structured and unstructured interviews (Kumar, 2014). In a qualitative research design, interviewing as a means of data collection is common in the social sciences because such allows the researcher to interact with the respondents either in person or over the telephone. The interviewer can explain matters that are not clear and observe the behaviour of the interviewee (Luna-Reyes and Andersen, 2003). This is also asserted by Seidman (2006) who agree that interviewing is a basic mode of inquiry in qualitative designs that makes meaning of people's experiences and is one of the best tools for attaining an in-depth understanding of the lived experiences of research participants.

This study used semi-structured interviews. In semi-structured interviews, the researcher makes use of a research schedule that has similar basic questions for all interviewees (Bryman & Bell, 2015). However, additional questions are asked to interviewees depending on how they respond to the basic questions (Sahajan, 2014). The main role of the interviewer was to guide the dialog and remain neutral so that the remarks of the participants were not biased by the behavior of the interviewer and to clear confusion before the interview was concluded (Beaudry & Miller, 2016). In total, the researcher conducted nine (9) interviews.

Semi-structured interviews were conducted from 26 September 2019 to 04 November 2019. Interviews were conducted during respondents' convenient times. Appointments were made with respondents prior to the interviews. The interviews lasted between 45 minutes to 1 hour 30 minutes. The use of key informants ensured that very rich and in-depth information was obtained, because the researcher was in a position to repeat some questions, rephrase them and also to clarify some issues that were raised by the interviewees (Ndlovu, 2009). Below is a brief discussion of the interview guide used by the researcher when conducting interviews in this study.

5.11.3 In-depth interview guide

This study employed a methodological triangulation where two methods of data collection were used in one study, namely questionnaire and interview. An in-depth interview is less structured, but more intense and probing, in comparison with other methods of data gathering, such as questionnaires (Creswell, 2014; Gray, 2017). The intention with an in-depth interview is to collect rich, detailed data, while giving individual attention to the interviewee (Babbie, 2016). The interview schedule consisted of a list of questions derived from the objectives of the study. It was categorised into 6 sections (A, B, C, D, E and F) that are in line with the objectives of this study. Section A included questions that focuses on the understanding of staffing moratoria by participants, this section of the schedule addressed objective one of this study. Section B consisted of questions that focused on the factors that led to the implementation of staffing moratoria. This section of the interview schedule addressed objective two of the study. Section C consisted of questions that focused on the impact of staffing moratoria on the delivery of healthcare in the KZN Department of Health, this section addressed objective two of the study. Section D and E consisted of

questions that focused on opportunities and challenges of staffing moratoria, respectively. The last section F examine task-shifting to address staffing moratoria, this section of the interview schedule addressed objective four and five of the study.

The use of interviews in the present study permitted the interviewer an opportunity to probe and cross-examine the interviewees concerning the marketing strategies that the destination marketing organisation has employed under turbulent and inflationary conditions. The interviewer also had the opportunity to control the discussion and thereby concentrate on the major areas under review (Malhotra and Birks, 2003:61).

5.12 Pilot Study Testing

In a pilot study, the researcher simulates the main study using fewer people in a group that resembles the targeted population. According to Lancaster (2005:137), "a pilot study is conducted to detect weaknesses in the design and research instrument, it is an informal investigation, which serves as a guide for the formal study."

Sekaran and Bougie (2010) state that the purpose of a pilot study is to:

- determine how long the data collection process will take;
- enable the researcher to assess the validity of the research instrument and to confirm that the data collected addresses the objectives and the hypotheses of the study;
- save time, money, and energy if problems are corrected before the main distribution; and
- help identify the weakness or pitfalls of the study at an early stage so that corrective measures can be taken timeously.

The pilot study was conducted by the researcher for two weeks (08 August 2019 – 23 August 2019). It involved distribution of questionnaires and conducting interviews to relevant healthcare employees. Participants who participated in a pilot study included nurses, medical interns and community services, administrative staff members working in the KZN Department of Health and at Ngwelezana Tertiary Hospital. Another group of five academics also assisted with the pilot test and the review of the instruments. Questionnaires were pre-tested on 30 respondents of the targeted population and it was found that some questions were ambiguous and unclear. Two

interviews were also conducted as part of the pilot study. Two senior managers in the hospital participated on the pilot interviews. This enabled the researcher to revise the research instruments and make corrections where necessary. Some corrective adjustments and changes were made after the pilot study was conducted.

The following significant matters were identified and agreed upon:

- the questions were deemed lengthy and an excessive amount of time was taken to fill them;
- because of the length of the questionnaire, participants suggested that the researcher include closed questions and provide answers for participants to choose from;
- in terms of interviews, participants suggested that the researcher categorise questions according to the objectives of the study as well as in themes to create coherence of the interviews; and
- the questions in the interviews were noted to be too many and some needed rephrasing.

Based on the feedback received from the pilot study changes, the necessary changes were undertaken so as to both the structured questionnaire and the semi-structured interview schedule.

5.13 Data Collection Procedures

This study relied more on the primary data (perceptions, opinions and observations) from the targeted population (permanent healthcare workers) in order to achieve its objectives. In terms of questionnaire distribution, the researcher liaised with the head of departments on arrangements to distribute questionnaires in their respective subcomponents, units, and wards. The researcher was allowed to directly go to wards and units to provide a brief narrative of what the study entails and what was expected from the participants as they answer the questionnaires.

5.14 Data Processing and Analysis

Data preparation is the process of extracting data from data collection tools (questionnaires and interviews) so that it can be read and manipulated by the software that is used. Qualitative data collected from the survey was captured in Statistical

Package for Social Sciences (SPSS) Version 17 for further analysis after the questionnaires had been edited and validated. The study also made used of thematic analysis after the questions were edited and validated from the interviews. The data were edited to check for omissions and consistency of responses in order to ensure the integrity of the data and wholesomeness of the questionnaire and interview schedule. The following categories of data analysis were undertaken.

5.14.1 Frequency analysis

Frequency analysis involves the counting of observations of interest, tallying, and comparing them to determine response patterns (Warner, 2013). In this study, frequencies were extensively used to determine the commonest responses per questions. In Likert scale questions and statements, like those used in the questionnaire, the commonest responses (modes) are important in concluding on how respondents perceive a phenomenon (Warner, 2013; Sabo and Boone, 2016).

5.14.2 The mean

Mean scores were also used to determine the average view of the sample on phenomenon of interest. Unlike frequencies that are aimed at showing the number of respondents selecting a particular response, means give a single score for all the possible responses in a Likert scale question or statement. They therefore make it possible to compare means across different statements (Walker, 2010; Sabo and Boone, 2016). Means were used alongside standard deviations whose purpose is to measure the level of variation in mean.

5.14.3 Skewness and kurtosis

Kurtosis and skewness are measures used to assess the distribution of data (Wagner & Gillespie, 2018). A skewness between -1.5 and 1.5with a kurtosis between -2 to 2 were used to guide whether responses in a statement were normally distributed and could therefore be reliably analysed using a mean (Wagner & Gillespie, 2018). Skewness and kurtosis, like the standard deviation, were therefore important in ensuring that data can be reliably analysed using mean scores.

5.14.4 Chi-square tests of association

Chi-square tests of independence and association test, whether or not there is an association between or variables of interest. An association indicates that the variables of interest do not respond or relate to each other in a random way, but that a pattern can be found between them (Elliott and Woodward, 2012; Wielsen, 2019). In this study, chi-square tests of association were used to test whether identified variables, where management level and department were associated with respondents' perceptions on the causes and results of staffing moratoria as well as task-shifting at Ngwelezana Tertiary Hospital.

In chi-square tests, different p-values can be set to determine a level of confidence at which an association between variables is determined (Goos & Meintrup, 2016). This study used a p-value of 0.05 to determine association. All chi-square statistics with a significance level below 5% were therefore taken as indicating a statistically significant association between selected variables. Chi-square tests with a p-value above 0.05 meant that different groups (e.g. managers and subordinates) perceived the same phenomenon in a similar manner.

The chi-square test of association was appropriate for the study, mostly because it addresses the needs of the research questions; specifically, the ability to assess if there were associations and therefore relationships between variables. The data collected was categorical in nature and therefore met a major requirement of the chi-square tests of association (Nisbet et al., 2017; Akoglu, 2018).

5.14.5 Cramer's V test

Cramer's V test is a measure of the size effect of a statistically significant association (Wielsen, 2019). The test is done after a chi-square test has identified a statistically significant association between selected variables and there is a need to find out how strong this association is (Warner, 2013). Cramer's V test values range from 0.00 to 1.00. The table below interprets the values of the tests as applied in the study:

Table 5.4: Cramer's V test interpretation

Cramer's V	Interpretation
> 0.25	Very strong
> 0.15	Strong
> 0.10	Moderate
> 0.05	Weak
> 0	No or very weak

Source: Akoglu (2018)

A Cramer's V test statistic above 0.25 implies that there is a strong association between the selected variables (Akoglu, 2018). An association between variables indicates the existence of a general relationship between the two. Like correlations, associations do not mean that there is causation between the variables of interest, but just to point out that the two tend to vary in a systematic pattern that suggests a relationship between them (Wielsen, 2019).

5.14.6 Thematic analysis

Thematic analysis is a qualitative data analysis process, where research questions are answered by way of themes and sub-themes. Thematic analysis has also been defined as a process that classifies data into independent but related clusters that help to give meaning to a given mass of data (Guest et al., 2011; Ezzy, 2013).

Braun, Clarke and Terry (2012) list six stages involved in thematic analysis. These are:

- familiarisation with the data;
- identification and establishment of initial codes;
- extracting themes from established codes;
- reviewing and revising the codes and themes;

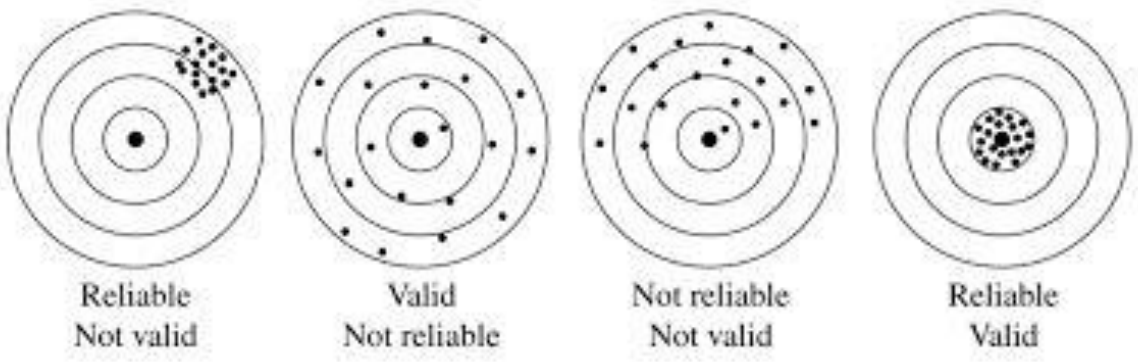
- finalisation of the themes; and
- report presentation.

The above steps guided the use of thematic analysis. The extraction of themes was guided by both open and closed coding processes. With open coding, the researcher looked for any codes relevant in answering research questions from the transcribed data. With closed coding, the researcher attempted to identify themes that were related to the topics that were discussed in the questionnaires as a way of getting data that could be used for triangulation processes.

5.15 Reliability and validity of the data collection instruments

Reliability and validity are the hallmarks of good measurement and are key to evaluating the authenticity of research findings (Babbie, 2016). In order for the results to be trustworthy, it is important for the data to be reliable and for the measuring instruments to be valid (Bryman & Bell, 2015). In quantitative research, therefore, output quality is measured using the concepts of validity and reliability (Saunders et al.,2015) Validity refers to the extent to which the measurement produced by a particular instrument is free from both systematic and random error (Diamantopoulos and Schlegelmilch, 2002). Reliability, on the other hand, refers to the degree to which a study yields consistent results if repeated (Babbie, 2016). For a study to be of acceptable quality, it must simultaneously possess validity and reliability as qualities.

Figure 5.2: Validity versus reliability



Source: Ruel, Wagner and Gillipsie (2016)

The centre of each circle represents the aims of the research and the concentric circles inside the number of times the study is carried out (Ruel et al., 2016). A valid and reliable study will meet the aims of the study every time it is conducted. A study that is reliable but not valid will not meet the research objectives, although it will produce consistent results with every repetition (first circle on the right). A study that is valid but not reliable will meet the research aim at the first instance and will produce different results any other time it is conducted again.

To ensure validity, the researcher relied on the literature to identify key concepts associated with the research aims (Babbie, 2016). These concepts and issues were thoroughly scrutinised and guided the construction of research questions that would enable the attainment of research aims. To ensure reliability, the researcher ensured that the data collection tools used in the study were thoroughly tested (Saunders, et al., 2014). Additionally, the researcher was guided by a series of research textbooks and journals in selecting the sample and in using the right data analysis techniques. Finally, the researcher relied on the triangulation of results as a way of enhancing the validity of research results (Babbie, 2016). The researcher also documented all the research procedures applied in the study to ensure that checks for both reliability and validity can be independently carried out.

5.15.1 Trustworthiness

According to Krefting (1991) trustworthiness in qualitative research like this study, is the ability to present data findings and results in a sound, credible and objective manner. Qualitative researchers use different criteria to determine trustworthiness. This could be through credibility, transferability, dependability or confirmability of the researcher findings (Koonin, 2014:258-259). Since this study was qualitative, unlike quantitative research that seeks to generalize results to a broader population, it sought to promote understanding of the phenomena, in a specific context (Koonin, 2014). Hence trustworthiness was supported by the transparency of the research process (Dawson, 2002), which was upheld by the audio recordings of the interviews (Mack et al., 2005), because the recordings and transcribed data can be used to ensure confirmability and can therefore support the findings and interpretation of the researcher (Koonin, 2014).

5.15.2 Data triangulation

In this study, both qualitative and quantitative methods were utilised hence a mixed data was collected. The study used a method of triangulating of data were both qualitative data and quantitative data sets were analysed and merged at the end to provide one comprehensive meaning/understanding of the data.

5.16 Ethical Considerations

Research involving human participants and the collection and/or study of data derived from human participants normally requires ethical approval to ensure that the research conforms with general ethical principles and standards of conducting inquiries (Kumar, 2014). Kumar (2014) further defines research ethics as a set of norms and standards that guides the research process. Saunders et al. (2014) defines the same as the rights and obligations that the researcher holds towards the research participant. While there are many research ethics and ethical guidelines, the principal research ethics are:

- the right of informed consent;
- the right voluntary participation/non-participation;
- the right to confidentiality, and anonymity; and

- the right to protection from harm.

In the study, the participants were duly informed of the aims and purpose of the study, the kind of information it would collect, and how this information would be used. In the same consent letter, the participants were also informed of their other rights. They were free to choose to participate of not to participate in the study without any penalty befalling them if they chose not to be part of it. They were also free to withdraw from the study at any given time and were also informed that their identities will be concealed in the study. The study did not carry known risks of physical or psychological harm. Participants were however protected from potential legal harm that might come as a result of providing organisational information to an unauthorized third party. Therefore, the researcher applied for and was granted approval to collect data from the targeted institutions (Ngwelezana Tertiary Hospital, King Cetshwayo Health District and KwaZulu Natal Department of health Head Office) as well as the Ethical Clearance Certificate issued by the University of KwaZulu-Natal Ethics Committee.

5.17 Conclusion

This chapter introduced the methodology that was applied in this study. It highlighted the important instruments for data collection and the way the researcher went about administering the data collection and analysis processes. The study used mixed methods research processes as a way of minimising the individual weaknesses of both qualitative and quantitative research methods as well as for triangulating results for greater validity. Data was analysed using descriptive statistics, chi-square tests of association and thematic analysis. The next chapter presents and discusses the findings of the study.

CHAPTER SIX: THE IMPACT OF STAFFING MORATORIA ON HEALTH SERVICE DELIVERY AT NGWELEZANA TERTIARY HOSPITAL

6.1 Introduction

This chapter aims to present and discuss the findings of the study. This chapter looks at the impact of staffing moratoria on healthcare service delivery in the KZN Department of Health using the case of Ngwelezana Tertiary Hospital. The chapter is divided into ten sections. The first section of the chapter describes the sample in terms of its size, departments of work, years of experience and sample's level of study. Other following sections in the chapter cover views on the reasons and purposes of staffing moratoria; changes in the number of non-managers under supervision during staffing moratoria; the impact and challenges of staff shortages on healthcare services and service delivery at Ngwelezana Tertiary Hospital; the impact of moratoria on staff duties at Ngwelezana Tertiary Hospital; the challenges as a result of staffing moratoria; the effects of staffing moratoria on Batho Pele principles and Chi-square tests of associations. Finally, the chapter relates the findings of the study to theories pertinent to health sector staffing moratoria and healthcare human resources.

6.2 Sample description of the study

The study, being of a mixed-method approach, made use of two samples, viz. a quantitative study sample from which a survey was used to collect data, and a qualitative data sample, where interviews were used to gather data. This section briefly describes these two samples, respectively.

6.2.1 Population and sample size of the study

Table 6.1 below shows data on population size, and the targeted sample versus the achieved sample of the survey.

Table 6.1: Survey population and sample

Description	Number	%
Total Population	1084	100%
Target sample size	292	27%
Achieved sample	177	16%

Source: Surveyed respondents (2019)

Table 6.1 above shows that out of a population of 1084 healthcare workers permanently employed at Ngwelezana Tertiary Hospital, the study targeted 292 respondents intending to include over 25% of the population into the sample. However, out of the 292 targeted respondents, only 177 responded and this represented 16% of the population of healthcare workers employed at Ngwelezana Tertiary Hospital.

Additionally, the qualitative data sample targeted seven executives/heads of departments from Ngwelezana Tertiary Hospital representing all departments. One executive from King Cetshwayo Health District and one from the KZN Department of were also interviews making a total of nine interviewees. The qualitative data sample was therefore inclusive of all the heads of departments or their deputies/proxies at the hospital.

The executives' actual titles or positions will not be revealed in the analysis and discussion of the results. This is in line with the study's ethical considerations on anonymity and confidentiality. Significantly, executive and senior officials had very informative views on the subject matter under discussion adding to the depth of the study's findings. Table 6.2 below shows the two sample groups highlighted above.

Table 6.2: Sample size by department

Department	**Surveys**	**Interviews**
Finance Department	11	1
Human Resources Management Department	15	1
Medical Services and Professional Allied to the Med. Dep.	23	1
Systems Management Department	22	1
Case Management Department	2	-
Monitoring and Evaluation Department	1	1
Nursing Services Department	92	1
Office of the Chief Executive Officer	-	1
Other, (Please specify)	10	-
I prefer not to say	1	-
External interviewees	-	2
Total	**177**	**9**

Source: Surveyed respondents (2019)

6.2.2 Sample distribution by department and management level

Table 6.3 shows the sample distribution by hospital department. Only seven departments were included in the study.

Table 6.3: Percentage distribution of respondents per department

Variables and response categories		Seniors/supervisors		Junior	
		N	%	N	%
Department	Finance Department	4	12.9	7	4.8
	Human Resources Management Department	6	19.4	9	6.2
	Medical Services and Professional Allied to the Med. Dep.	6	19.4	17	11.6
	Systems Management department	7	22.6	15	10.3
	Case Management Department	0	0	2	1.4
	Monitoring and Evaluation Department	1	3.2	0	0
	Nursing Services Department	6	19.4	86	58.9
	Other, (Please specify)	1	3.2	9	6.2
	I prefer not to say	0	0	1	.7
	Total	**31**	**100.0**	**146**	**100.0**

Source: Surveyed respondents (2019)

Table 5.3 above shows that in total, 31 respondents who participated in this study were in senior/supervisory positions and 146 were junior staff members. The inclusion of both seniors/supervisors and juniors' in the sample was purposefully done to enhance the study's ability to provide a balanced view from supervisors and junior staff members on the issue of staffing moratoria, and its impact on the delivery of healthcare services at NTH. The Nursing Department had the most supervisors at the hospital and the highest number of respondents represented in the sample. In the study population, 59% of staff at Ngwelezana work in the Nursing Department and in the sample, 62.4% of respondents were nurses thus reflecting the representativeness of the sample by the department. The second-largest represented department in this study was the Systems Department, with a sample of 22.6 % supervisors and 10% for

junior staff members. The systems department is one of the largest departments within the hospital providing a wide variety of functions. These functions include patient administration and mortuary, engineering management, auxiliary, and maintenance services. It also provides safety and waste management services to the hospital. The department with the least representation was the Monitoring and Evaluation Department with only 3.2% overall representation. The Monitoring and Evaluation Department is located within the Office of the Chief Executive Officer. It plays an oversight role to all the departments at Ngwelezana Tertiary Hospital.

6.2.3 Sample distribution by work experience

Table 6.4 below shows the distribution of the sample by work experience. The interviewees' years of experience were not collected during the interviews.

Table 6.4: Percentage distribution of respondents according to work experience

	Managers		Non-managers		Total	
	N	%	N	%	N	%
0-5	8	25.8	60	41.1	68	38%
6-10	11	35.5	41	28.1	52	29%
11-15	7	22.6	23	15.8	30	17%
16-20	0	0	6	4.1	6	3%
21-25	2	6.5	5	3.4	7	4%
26-30	1	3.2	9	6.2	10	6%
31 and longer	2	6.5	2	1.4	4	2%
Total	**31**	**100.0**	**146**	**100.0**	**177**	**100%**

Source: Surveyed respondents (2020)

Table 6.4 above shows that in total, 38% of the study sample had five years or less of work experience, 29% between 6 and 10 years of experience and 17% between 11 and 15 years. Therefore, it can be concluded that 62% of the sample had over 5 years of experience. From this observation, it can be implied that most of the respondents had experience in working within both staffing moratoria and non-staffing moratoria conditions over the years as the staffing moratoria were implemented in September 2015. They were therefore in a position to provide comparative views of the pre and post-moratoria periods.

Additionally, 74.2% of the managers, compared to 59.8% of non-managers had over five years of experience. These results, therefore, show that proportionally more managers have been on service to experience the changing human resources hiring regimes in the health sector and at NTH. Overall, the respondents in this study judging from work experience, had the ability to give insightful views and experiences based on their long stay at NTH and in the KZN Department of Health.

6.3 Distribution of respondents' level of education

Table 6.5 below shows the respondent's levels of education. It also cross-tabulates educational level with managerial level. No data was collected on the interviewees' regarding their levels of education for anonymity purposes.

Table 6.5: Percentage distribution per level of education

Level of education	Managers		Non-managers		Total	
	N	%	N	%	N	%
Primary schooling	0	0	0	0	0	0
Secondary Schooling	0	0	13	8.9	13	7,3%
Tertiary Schooling (Higher Certificate)	7	22.6	42	28.8	49	27,7%
Tertiary Schooling (National Diploma)	8	25.8	61	41.8	69	39,0%
Tertiary Schooling (Bachelor's Degree)	10	32.3	19	13.0	29	16,4%
Tertiary (Honours degree, Postgrad Diploma/Certificate)	6	19.4	11	7.5	17	9,6%
Total	31	100.0	146	100.0	177	100 %

Source: Surveyed respondents (2019)

Table 6.5 above shows that most respondents in this study (39%) had a national diploma as their highest qualification, followed by 27.7% who had a higher certificate, and 16.4% who had a bachelor's degree. The majority of respondents held a qualification higher than a secondary school certificate. Most non-managers (41.8%) had a national diploma while most managers (32.3%) had a bachelor's degree. The highest qualification levels reported in the sample were in the tertiary education category (honours degree, postgraduate diploma/certificate). From all the respondents, no respondents indicated having either master's or a doctoral degree, and interestingly, there was no respondent with primary schooling who participated in this study. This, therefore, implies that the sample was dominated by professionally

qualified respondents and it also denotes that respondents had the capacity to operate professionally. Based on the results shown in Table 6.5, it can be implied that challenges faced by the sample (discussed later) were therefore not a result of low levels of education, since most respondents were professionally qualified employees.

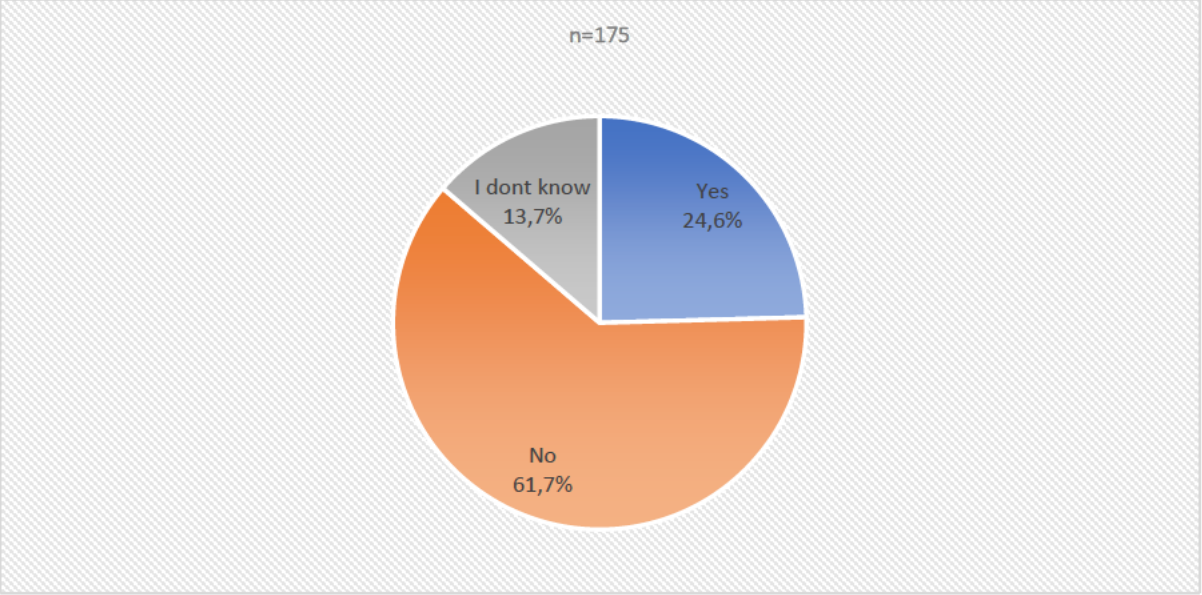
6.4 Perceived reasons behind the implementation of staffing moratoria

This section shows data analysis results relating to the samples' perceived reasons behind the implementation of staffing moratoria, as well as its purpose. It starts by assessing the proportion of the sample that was consulted about staffing moratoria prior to its implementation.

6.4.1 The level of consultation in the implementation of staffing moratoria

Figure 6.1 below shows the respondents responses as to whether they were consulted before the implementation of staffing moratoria at Ngwelezana Tertiary Hospital. This question aimed to evaluate the level of communication and consultation between the KZN Department of Health, the hospital and staff.

Figure 6.1: Level of consultation in the implementation of staffing moratoria



Source: Surveyed respondents (2019)

Figure 6.1 above shows that amongst 175 respondents who responded to the question, 61.7% (108) said that they were never consulted prior to the implementation of staffing moratoria, and the interviewees also confirmed the view that most

respondents were not consulted before the implementation of staffing moratoria. All of the nine respondents interviewed shared that staffing moratoria came in as a memorandum/circular from the Officer of the Premier without any previous discussions being done. The evidence from interviews, which are cited verbatim throughout, shows that executives themselves could therefore not consult their subordinates, given that the decisions on staffing moratoria, as communicated in the memo, were already finalised.

One respondent expressed that:

> *"…here at Ngwelezana, it is just an institution of the department as a whole so the decision making is at a higher level it is at provincial level okay, so unfortunately at this level we receive only what is given to us after decisions have been taken at a higher level…"* **(Respondent 4)**

This was also asserted by another respondent who reiterated that:

> "*There was no consultation. I think it is important that I give the background. The moratorium was put in place by the KZN premier's office for all the public service departments, be it agriculture, health, education; so basically, I don't think there were preparations to that end because when it came it came as a surprise"* **(Respondent 7)**

In the survey, another 24.6% of the surveyed respondents indicated that they had been consulted, and 13.7% were not sure. This indicates that more employees, therefore, believed that they were not consulted in comparison to those who were consulted.

Interestingly, one interviewee revealed that consultation does take place in the KZN DOH on other matters where hospital CEOs are part of the review team that sits quarterly discuss critical matters. When asked whether CEOs were invited and consulted in the staffing moratoria decision-making processes, one respondent said that:

> "*We do. But if there is no money what is the involvement going to do we ask them what? It's nice the whole concept works if you have extra money. But if you fail to reprioritise services that's not what finance should do…*" **(Respondent 3)**

The respondent further reiterated that:

> "*Yes, we have every quarter we do a review. We can continuously expect that one time we have gone to them and we call them in and discuss at the office and one budget analyst is monitoring one or two districts. We go through together monitoring them. But in the beginning, I did it all by myself but they also go through this. They prepare and I highlight the issue and when there are too many facilities we call and rope in here. So, we get the picture in the facilities sitting with posts with goods and services and all the pressures our routine is formal per quarter so this we can do every six months and proper. So, the second and third quarters I call all the three districts and the finance managers this time into this..."* **(Respondent 3)**

When the respondents were asked whether their input was included in deciding the criteria to determine which posts were critical and which ones were not, one respondent stated that:

> "*No, in fact, we have been arguing about that. We have been pleading that certain posts should be reviewed. Okay, we were not consulted or our inputs were not invited. But our argument is what is critical at Ngwelezana Tertiary Hospital is not critical at other hospitals. So the criticality of the post should then depend on the individual institution but till today that approach has not been taken into consideration*." **(Respondent 7)**

When they were further asked if they made any submissions regarding the determination of critical and non-critical posts to the KZN Department of Health head office. The respondent further reiterated that:

> "*We have done quite a number of submissions to that effect but unfortunately none of them has seen the light of day*." **(Respondent 7)**

The above findings both from the survey questionnaires and the interviews, reveal that consultation and involvement do take place in the KZN Department of Health albeit in different extents. However, in the case of the staffing moratoria, there was not much consideration of the hospital heads views. Consultation processes were also done on an executive level that excluded lower-level staff from participating.

The contentious issue that arises from the findings of the study is poor communication mechanisms and lack of dissemination of information from managers of the hospital to healthcare workers.

While most respondents reported that they were not consulted in the planning and implementation of staffing moratoria, this then suggests that their views and contributions on how the hospital could map the way forward in response to staffing moratoria were not considered. Moreover, based on the interviews it seems as if most respondents were therefore informed, rather than consulted on the new changes at NTH regarding the implementation of staffing moratoria.

The above results on consultation and involvement of relevant stakeholders in the decision-making highlights the levels of centralisation in the KZN Department of Health in contrast to the principles of the New Public Management Theory. The NPM is associated with decentralisation of public sector decision-making as a way of enhancing efficiency in the delivery of healthcare services (Robinson, 2015). The views from the executives above highlight the fact that there is still limited fiscal decentralisation in the management of public health care facilities. As discussed by Martinez-Vazquez et al. (2015), within a fiscally decentralizased system, facilties can come up with their own staffing policies to manage the financial consequences thereof.

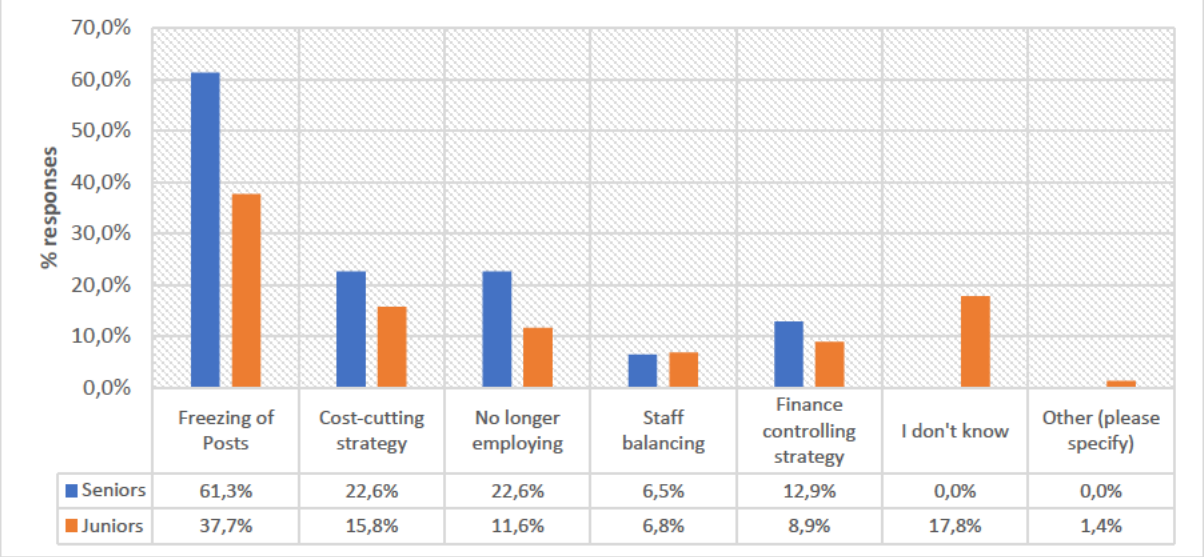
In the above findings, the advantages of decentralized decision-making as discussed in the literature are strongly highlighted. For instance, the view that hospitals that are affected by the changes do not get to make the decisions resulting in outcomes that do not serve the unique interests of local communities is discussed by Respondent 7. Fiscal and administrative decentralization, as argued by Cinar et al.,(2013), Olum (2014) and Adhikari (2017) facilitate the making of decisions that effectively apply to different staffing scenarios. Another disadvantage of highly centralized decision-making noted above is the slow reaction to challenges as highlighted by Respondent 7. The bureaucratic processes slowness affects the efficient operationability of affected lower level layers as asserted by (Kuhlmann and Wollmann, 2014) who also believe that decentralised systems, because of their proximity to a problem, are quick to respond.

Overall, the above findings show that staffing moratoria took more of a centralised approach where the KZN Department of Health solely, made decisions on what posts to freeze in hospitals and other medical and healthcare facilities without involving healthcare workers. The weaknesses of such approaches are that they create situations were decisions are made by individuals who not very akin to the situation on the ground and additionally, who are not quickly and easily accessible for recourse or appeal. The Department of Health needs to consider decentralised decision making to accommodate health care workers on the ground who are faced with challenges that arises from these decisions.

6.4.2 Perceived understanding of staffing moratoria at Ngwelezana Tertiary Hospital

Figure 6.2 below shows what managers and non-managers within the hospital understand about staffing moratoria and its implementation at Ngwelezana Tertiary Hospital.

Figure 6.2: Perceived understanding of staffing moratoria



	Freezing of Posts	Cost-cutting strategy	No longer employing	Staff balancing	Finance controlling strategy	I don't know	Other (please specify)
Seniors	61,3%	22,6%	22,6%	6,5%	12,9%	0,0%	0,0%
Juniors	37,7%	15,8%	11,6%	6,8%	8,9%	17,8%	1,4%

Source: Surveyed respondents (2019)

Figure 6.2 above shows that both managers and junior staff members believed the moratoria were about the freezing of posts, although there were more managers who believed in this compared to junior staff members (61.3% versus 37.7%). Among the managers, 22.6% associated staffing moratoria with cost-cutting in the department of health, compared to 15.8% non-managers. Interestingly, the results above show that

17.8% junior staff members indicated having no knowledge about what the staffing moratoria is all about, which then raises the question as to the level of communication and involvement in the decision-making process. Overall, both managers and junior staff members at Ngwelezana Tertiary Hospital perceived staffing moratoria as a post-freezing process and a cost-cutting process.

In the semi-structured interviews, interviewees shared a common perspective on what the moratorium was about. They viewed it as the KZN Health Department's way of cutting staff costs through freezing of non-essential, non-medical posts as a response to low budgetary support. The interviewees, being at head or senior level in the hospitals, held views that were directly informed by the memorandum from the Office of the Premier on the matter.

One respondent stated that:

> "…*it is because of the financial crises that South Africa is currently facing. There has to be limiting the government purse in terms of employees and for that there was a moratorium placed in 2015 to freeze all posts in the Department."* **(Respondent 1)**

Another respondent believed that:

> "*Moratoria are basically putting a stop or freezing of vacant posts, with the intention of not filling them for that particular period where the moratoria is effective. Meaning basically to put a stop on recruitment of vacant posts*." **(Respondent 7)**

The above views associate the moratorium with two main things: freezing of posts and cutting costs. The results above resonate with the literature where the views closely resemble the objectives of staffing moratoria in health systems that tend to place a focus on the management and reduction of costs (Holm-Peterson, 2017). The views resonate with the KZN DoH HRM Circular No 18/2016 that communicated the process and agenda of the moratorium. The freezing of non-critical costs with the view to cut costs amidst the department's financial woes was clearly communicated in the moratorium. The view by the Rural Health Advocacy Project (2015) that the major reason behind the freezing of posts was budgetary is strongly captured in the sample

as well. A similar view was discussed by National Treasury (2015) when it cited staff costs as a significant portion of public service budgets. The third view that the moratorium meant that the Department was no longer employing staff somehow represents an erroneous view on the part of both managers and non-managers. This is not surprising in centralised decision-making where the probability that some lower organisational levels may fail to fully understand the rationale behind decisions being made (Adhikari, 2017; Abimbola, 2019). Furthermore, this strongly relates to the views that there was limited consultation in the process.

6.5 The perceived purpose behind staffing moratoria at NTH

Table 6.6 below shows responses to the question regarding the purpose behind the implementation of staffing moratoria at Ngwelezana Tertiary Hospital. The responses were recorded using a Likert scale and respondents were offered a choice of six coded responses namely 'strongly agree', 'agree', 'strongly disagree', 'disagree', 'uncertain or not sure' and 'I don't know'. Below are the results.

Table 6.6: Perceived purpose behind staffing moratoria

Perception/View	N	SA	A	SD	D	U/U	IDK
To minimise employee numbers in the hospital	146	24,0%	28,8%	11,0%	13,7%	10,3%	12,3%
A strategy to cut-cost in the hospital in general	154	30,5%	32,5%	14,3%	7,1%	9,1%	6,5%
It is a strategy to reduce employment costs in the hospital	146	30,8%	28,1%	8,9%	10,3%	13,0%	8,9%
It is a strategy to control the recruitment of staff in the hospital	142	19,7%	28,2%	6,3%	19,0%	14,1%	12,7%
It is a management punishment to the hospital staff	143	16,8%	13,3%	14,7%	27,3%	10,5%	17,5%
It a response to low budget allocations by government	145	35,9%	29,0%	10,3%	6,9%	8,3%	9,7%
It is a measure to curb irregular expenditure	142	16,2%	31,7%	13,4%	9,9%	11,3%	17,6%

It is a measure to reduce corruption and resources abuse	141	14,2%	29,8%	13,5%	17,7%	9,2%	15,6%

Source: Surveyed respondents (2019)

In the above findings on the perceived purpose of staffing moratoria, 35.9% strongly agreed and 29% agreed that staffing moratoria were a response to low budget allocations by government. All the interviewees acknowledged that they have witnessed reduce budgetary allocations to the provincial public health sectors over the years, thereby confirming the views in the survey.

One respondent stated that:

> "…*reduced hospital cost of employment (COE) budgets came as a result of national treasury cutting the health budget in some years, leading the provincial treasury to do the same in response to national strategy*." **(Respondent 7)**

The disjuncture is asserted by another respondent who expressed that:

> *"The pressure to stay within budgets resulted in the hospital not hiring both critical and non-critical staff. The moratorium negatively affected the hiring of professional medical staff as well albeit this was an unintended consequence*." **(Respondent 6)**

Furthermore, the results also revealed that 30.8% strongly agreed that the moratorium was a strategy to cut-cost in the hospital in general. As stated earlier, the respondents in the interviews also commonly shared the same view with most respondents from the survey. The interviewees, however, stated that many other means had been implemented to reduce expenditure, including delays in capital projects, limiting administrative costs and staffing moratoria.

The results from the survey also revealed a response to the perception that staffing moratoria were a form of punishment on hospital staff. As shown, 27.3% disagreed; followed by 17.8% who did not understand it as a form of punishment. At the same time, 16,8% and 13,3% of the respondents strongly agreed and agreed that staffing moratoria were put in place to punish staff. Thus, a considerable percentage of respondents associated the moratorium with a sinister agenda from management. This shows that there was a lack of trust regarding the reasons behind the moratorium

amongst the respondents. This could also be traced back to the responses that there was very little or no consultation and involvement of staff on the decision to implement staffing moratoria. When interviewed, none of the executives associated staffing moratoria with any sinister agenda to punish staff at the hospital. The above views strongly suggest a lack of trust between managers and non-managers. As discussed by Krot and Lewicka (2012), lack of trust can emanate from poor intra-organisational relationships. Poor communication within centralised systems can also jeopardise trust (Krot and Lewicka, 2012) and as highlighted earlier most employees stated that there was not much communication about the staffing moratoria.

Figure 6.3 above also shows that 31.7% of the respondents agreed, and 16.2% strongly agreed that the moratorium was a measure to curb irregular expenditure. This view implies that over half of the survey respondents saw the moratorium to be a result of poor financial management at the hospital or at provincial levels. The respondents in the interviews perceived staffing moratoria as a spending controlling strategy that will ensure that the KZN Department of Health does not overspend. Nevertheless, when the issue of over-expenditure was further interrogated, it was found that overspending was mostly on the compensation of employees. This was asserted by a respondent who stated that:

> "*The staffing moratoria were a response to overspending, and this overspending was done at provincial department level rather than at the hospital."* (**Respondent 3)**

Respondents in the interviews noted that the provincial Health Department reduced budgetary support in response to the need to curb over-expenditure. Most funding was being directed to non-critical activities that, overall, drained the department of much-needed financial resources. It was believed that reduced funding would result in increased financial management efficiency. Therefore, it seems as if reducing budgets has not been successful in curbing overspending. Generally, the results above are in line with Magagula (2016), who asserts that the aim behind the implementation of these cost-cutting measures were to ensure efficiency savings, prioritise spending on service delivery, and cut down on wasteful expenditure (Magagula, 2016). Rispel et al. (2015) also discuss the problem involving irregular expenditure in an environment

where budgetary allocations to the health sector were not increasing significantly. Irregular expenditures under such a scenario exposed the health system to ineffectiveness, as it risked failing to deliver its mandate of public provision of services.

Finally, the results above in Figure 5.3 show responses to whether there was a perception that the moratorium was a measure instituted to reduce corruption and resources abuse, where 29.8% agreed, and 14.2% strongly agreed. This view suggests that a considerable percentage of supervisors and junior staff members saw staffing moratoria as a response that had nothing to do with budgetary issues but with the poor ethical issues within both the public health management system at the hospital and across the province.

In the semi-structured interviews, however, only one interviewee hinted that corruption had cost the provincial health department lots of money forcing it to cut costs elsewhere as a way of offsetting losses. This was discussed by a respondent who stated that:

> *"Put a freeze on corruption because that has taken a lot of money from the department. Deal with the issue of incompetency and cadre deployment."* **(Respondent 7)**

The same respondent further stressed that:

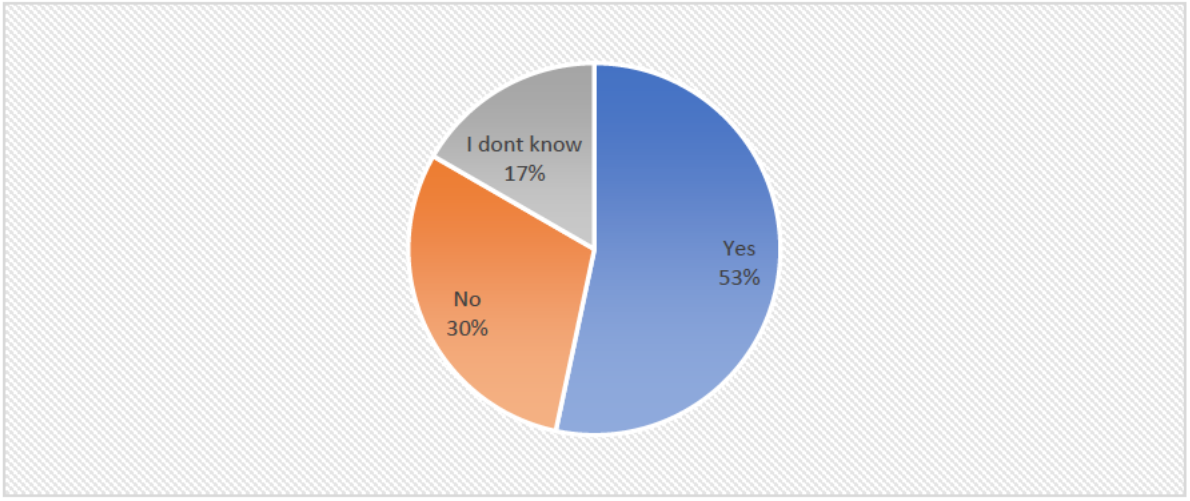
> "*Corruption was a result of persons favoured by political parties being deployed in the provincial public health management system.*
>
> *…Yes that is how it is. Secondly, for me we have been part of the department you consider a lot of things, another contributing factor would be the mismanagement of the budget. When the budget was available there was a mismanagement of the budget, by the time we woke up, there was a lot of money which had been eroded through irregular and fruitless expenditure and I think the Auditor General (AG) reports for the subsequent years will reveal how much money has gone to fruitless expenditure and unauthorised expenditure."* **(Respondent 7)**

The above results disagree with Rispel et al. (2015), who do not share the view that a staffing moratorium was a meaningful solution for corrupt activities, although they acknowledged the rampant degree of corruption within the South African public health sector. These authors do not believe that moratoria were put in place to stop corruption and share a view that they are mainly a response to fiscal challenges, specifically the scarcity of funds. Contrary to that, Molelekwa and Sehoai (2017) report that hospitals in Gauteng often run out of funds due to misuse, in certain instances failing to pay salaries to staff. Veld and Van De Voorde (2014) and Maphumulo and Bhengu (2019) also believe that mismanagement in public healthcare facilities in South Africa might have played a bigger role than expected on the deterioration of financial health, which is an antecedent factor of job cuts and freezes. Thus, the view that corruption has got something to do with the staffing moratoria also finds its justification in the literature.

6.6 Changes in the number of subordinates under supervision during staffing moratoria

Figure 6.3 below shows responses to a question on whether the number of subordinates that managers working at Ngwelezana Tertiary Hospital had have changed (decreased or increased) as a result of staffing moratoria.

Figure 6.3: Changes in the number of non-managers during staffing moratoria



Source: Surveyed respondents (2019)

Of the 31 managers who responded to the question, 53% agreed that there had been a change in staff under their supervision, while 30% disagreed. All the managers who

responded “yes”, further elucidated that the moratorium had resulted in staff shortages in response to the question: ‘*In your own view, has the staffing moratoria at Ngwelezana Tertiary Hospital had any impact on staff shortages?*’ whose results are shown below:

Table: 6.7 Impact of staffing moratoria on staff shortages

In your own view, has the staffing moratoria at Ngwelezana Tertiary Hospital had any impact on staff shortages?

Response	N	Frequency	Percent
Yes, It has resulted in staff shortages.	31	31	100%
No, it has not resulted in staff shortages.	31	0	0%
I’m not sure.	31	0	0%
Other (Please specify)	31	0	0%

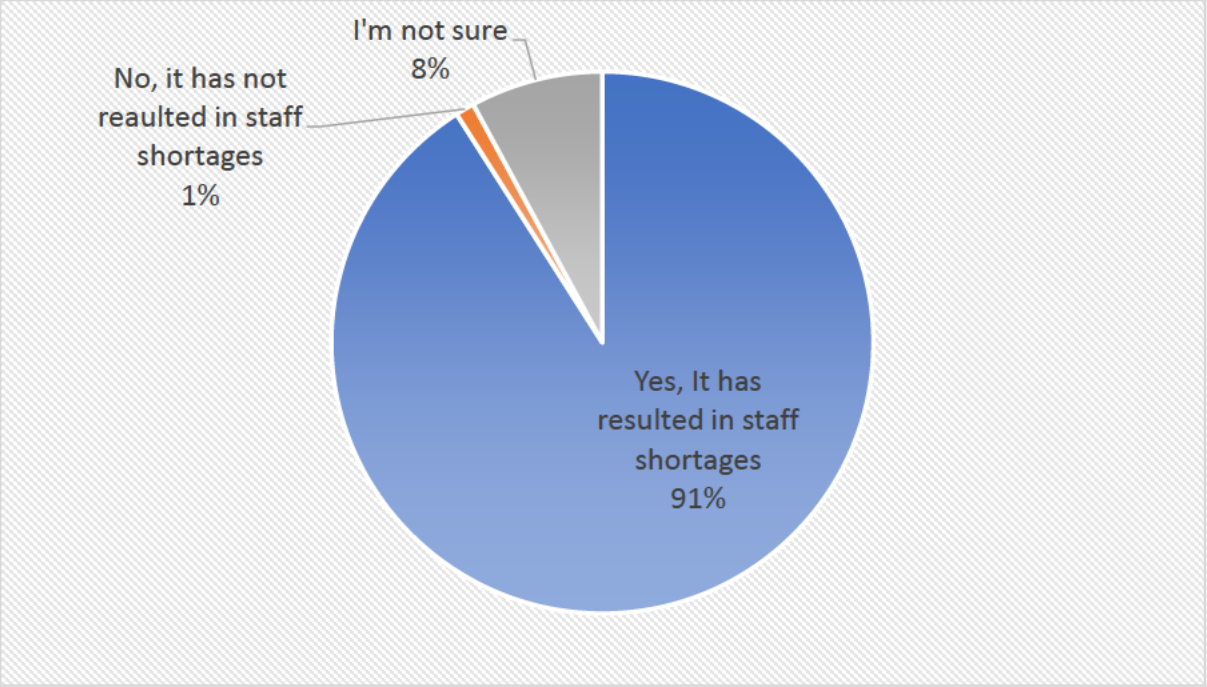
Source: Surveyed respondents (2019)

The above responses show that staffing moratoria had resulted in a total reduction of staff under all the managers surveyed. Respondents in the interviews expressed that they had to take additional roles and responsibilities in response to the diminished number of employees. They further discussed that staff numbers had gone down within the hospital and across the provincial public health system at large, indicating that the decline in staff numbers was a widely acknowledged outcome of staffing moratoria. Further questions were asked to assess the impact of staff shortages at the hospital and these are shown in the next subsection.

6.6.1 The perceived impact of staffing moratoria on staff shortages

Figure 6.4 below shows responses to statements on the impact of staffing moratoria on staff shortages.

Figure 6.4: The impact of staffing moratoria on staff shortages



Source: Surveyed respondents (2019)

As shown above, out of 177 respondents, 91% were of the view that staffing moratoria had resulted in staff shortages. Another 8% were not sure, and 1% believed that it had not resulted in staff shortages. Staffing moratoria were therefore seen as a major cause of staff shortages at the hospital by the majority of the respondents.

In the interviews, respondents expressed that while previous policy announcements on cost-cutting measures were meant to affect non-critical staff members, excluding specialized nurses and doctors, it was instead affecting all staff. Respondents further expressed that staffing moratoria affected even the critical staff, with respondents citing the shortage of doctors, nurses, and other specialised medical staff. This shortage was worsened by the fact that medical staff were resorting to doing non-medical jobs in order to compensate for shortages of administrative staff. This was worsened by the fact that even before the moratorium, there were already shortages of critical staff within the hospital.

This was asserted by a respondent who expressed that:

> *"…Staff shortages have resulted in the closure of certain services, for example, the office of the PRO because it is only one post for PRO so if you don't have*

that one individual so literally the office is closed. So, it leads to closure of certain critical services which are not supposed to be closed…" **(Respondent 7)**

Outside the study, shortages in critical medical staff can be explained by the labour dynamics of the South African health industry. Rawat (2015) explains that even outside moratoria, South Africa generally has health staffing gaps, emanating from low training capacity of medical professionals versus high demand for such professionals. Rawat (2015) cites the *Human Resources for Health South Africa: Strategy for the Health Sector 2012/13-2016/17* as a national strategy that was formulated before the 2016 moratoria as an attempt to decrease staff shortages in the public health sector. Thus, some of the discussed views on staff shortages emanate from beyond the moratoria, although interviewed respondents vehemently believed that the moratoria had added to these challenges. These views are in agreement with the perceptions of the interviews that the moratorium worsened an already existing problem of critical skills shortages.

The above findings on the implementation of staffing moratoria in public health care systems that are already suffering from staff shortages resemble findings from the Greek (Economou et al., 2014), Zimbabwean (Dieleman et al.,2012) and Irish (MacDermott and Stone, 2013) case studies covered in chapter 3. In all these countries staff freezes were implemented even when there were policy-acknowledged deficiencies in public healthcare staffing. Zimbabwe continued with its staffing moratorium even when it had 10 public health care workers for every 10,000 persons compared to the required 23 health care workers for every 10,000 persons (UNICEF, 2018). Greece had the lowest ratio of nurses per population in the European Union (Economou et al.,2014). Like in South Africa, these labour shortage dynamics were overshadowed by the need to manage costs. Such findings appear to suggest that countries sometimes prioritized budgetary performance over public health.

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Going back to theory, the findings on the impact of staffing moratoria on staff shortages go against the precepts of the Manpower Planning Theory associated with the works of Makridakis and Hidon (1979). The theory advocate for the balance in the demand and supply of labour where organisations (in this case Ngwelezana Tertiary Hospital)

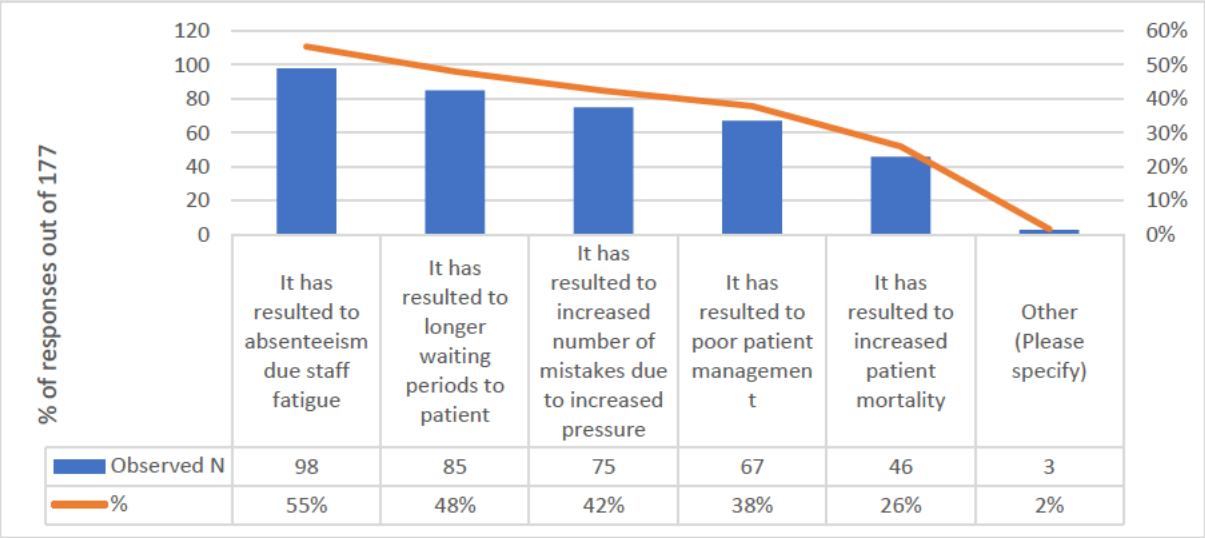
should ensure that it has the right number of people and the right kind of people at the right place and the right time, doing things for which they are economically most useful (Smits et al.,2010; Parma et al.,2013). As stipulated in the theory, South Africa does have clear public health goals and objectives also guided by the Batho Pele principles as they apply to public healthcare (PSC, 2018). However, unlike with the theory, and as hinted from the findings, there has been poor manpower preparation for these goals as well as the principles, leading to staff shortages.

Furthermore, manpower planning is a means of preparing for future contingencies, estimating the likelihood of their occurrence and determining what should and can be done, when, if, and as they arise (Makridakis et al.,2009; Parma et al.,2013). It challenges the organisation to forecast future resources demands in response to change (Makridakis et al.,2009). This aspect might have been missed by the health department. Findings have revealed that the implementation of staffing moratoria created an imbalance in the supply of labour in the hospital where more healthcare workers were leaving worsening the already prevailing problem of staff shortages in the KZN DOH and from a manpower planning theory perspective and this points to poor planning on the part of the provincial health department. A balance in the demand and supply of labour is of paramount importance in ensuring and preparing for contingencies and is also important in rationalising labour-affecting decisions such as staffing moratoria.

6.7 The impact and challenges of staff shortages on healthcare services and service delivery at Ngwelezana Tertiary Hospital

This section presents data analysis results relating to the perceived impact of staff shortages at Ngwelezana Tertiary Hospital. It also looks at the challenges that the two samples associated with the staffing moratoria. Figure 6.6 shows the respondents' responses to the statement: '*Impact of staff shortages on healthcare services and services in the hospital.'*

Figure 6.5: Impact of staff shortages on healthcare services and services in the hospital



Source: Surveyed respondents (2019)

On the above statements, respondents were free to select as many responses as necessary to convey their view regarding the impact of staff shortages on healthcare services. Responses were absenteeism, waiting periods, risks of medical errors, patients' management, patients' mortality and other (respondent to specify).

6.7.1 Absenteeism and fatigue

Out of all the 177 respondents, 98 (55%) believed that the moratoria had resulted in absenteeism due to staff fatigue. Among the respondents: 85 (48%) believed that it had resulted in longer waiting periods for patients; 75 (42%) that it had increased mistakes among practitioners due to increased work pressure; 67 (38%) that it resulted in poor patient management; and 46 (26%) that it had resulted in increased patient mortality.

In the interviews, absenteeism, as a result of staffing moratoria were discussed at length by the respondents. There were two broad reasons behind absenteeism in staff. These were low staff morale, as well as fatigue. The respondents in the interviews further stated that it was also morally difficult to impose heavy disciplinary penalties on employees as the employees would sometimes be exhausted as a result of the extra work they had to do.

This is highlighted in the below response:

"There is growing misconduct cases because of absenteeism. People are tired. Negligence people did not do what was expected of them. **(Respondent 7)**

Belita et al. (2013) found absenteeism to be associated with overburdening workloads, as well as unfavourable working condition perceptions. Their study reviewed over 1000 studies that had been done on absenteeism as a problem, with their area of focus being Sub-Saharan Africa. Their findings strongly resonated with the views from the interviews and the survey. Among the respondents in the interviews, the view that absenteeism is not always voluntary is captured by the interviewees. Belita et al. (2013) also discuss similar views, classifying absenteeism into voluntary and involuntary forms.

However, the respondents mostly pointed at voluntary absenteeism (following from Belita et al.) as the Hospital's core challenge. Healthcare workers simply chose not to come to work due to low morale and being overworked. Nyathi and Jooste (2008) also found workload-driven voluntary absenteeism to be a common problem in hospitals in the Limpopo Province, which resonates with the findings in this study.

In a study held on two children's hospitals in Ireland, Farelly (2011) noted that in contrast to the expectation that a staff freeze at the hospitals was going to cause increased absenteeism, absenteeism levels went down post a staffing moratorium. This is opposite to the findings of this study, where a moratorium resulted in increased absenteeism. Farelly further discusses the causes of this being the observation that with too small a staff complement, any unnecessary absenteeism from duty would have far-reaching negative effects on the health delivery system at the hospitals. Again, this also stands in contrast to the findings of this study where it emerged that there was an increase in absenteeism despite the perceptions of staff shortages.

6.7.2 Waiting periods for patients at NTH

The interviewees also discussed long waiting periods to which patients were being subjected. Respondents in the interviews believed that staff shortages as a result of the moratoria were responsible for patients getting service late. In the interviews, these delays were described as being both administrative and medical. On the administrative side, patients waited for long hours to get their paperwork and files processed due to fewer administrative staff than is required. On the medical side, treatment was also

delayed as a result of an overwhelmed medical team that had to content with administrative tasks as well.

To this regard, one respondent said that:

> *"…So, one; it is staff shortages, two; delay in curative and rehabilitation of patients' extension of hospital length of stay and bed occupancy rates will always be full remember people are not being discharged and bed occupancy is always high or full."* **(Respondent 7)**

The findings above are very comparable to conclusions from previous studies. In its report, the RHAP (2015) outlined that staffing moratoria in public health systems negatively affected the speed at which services are rendered to the public. Because of fewer than optimum staff, medical facilities were not able to provide services to patients timeously. The comparatively large volumes of patients that frequent public health facilities, when combined with low staffing levels. created the risk of delayed treatment that could worsen patients' medical situations (RHAP, 2015). Going by a view by Maphumulo and Bhengu (2019) that delayed assistance to patients indicates efficiency and effectiveness-related failures on a medical facility, the moratoria, due to its negative impact on the speed at which patients are assisted, was some cause of concern at the hospital. Maphumulo and Bhengu also suggest that without adequate staffing, it was a challenge for hospitals to implement meaningful quality improvement programmes.

An Important point raised in the findings is that of shortages in administrative staff resulting in clinical staff taking on administrative duties. According to Oetelaar et al. (2016) and Erickson et al. (2017), there is an optimum ratio of clinical versus administrative staff required in healthcare facilities. Excessive administrative duties reduce clinicians' times to focus on patients as there to contend with administrative duties as well (Kudo et al.,2012; Rao et al., 2016). This not only results in delayed service delivery but can also result in increased errors as clinicians will be focusing one too many things instead of concentrating on treating the patient (Oetelaar et al., 2016).

In previous studies, Storey et al. (2009) and Singh et al. (2019) found that heavy administrative burden of clinicians negatively affected their morale as it was perceived as a sign of low management concern. It also resulted in increased workloads that

burnt-out employees causing high absenteeism rates. These studies' findings strong resonate with the above discussions by the interviewees. An important lesson to be drawn is that the administrative staff directly influence the efficiency and effectiveness of medical and clinical staff by offering critical support services. These are the employees who are easily targeted during staffing moratoria with a little concern for the impact that this would have on medical teams.

6.7.3 Risks of medical errors at NTH

In the survey, 20% of the respondents believed the moratoria had increased mistakes among practitioners, due to increased work pressure. The interviewees corroborate this view, pointing out that the risks of delivering erroneous services to patients had increased in frequency, alongside the risks of litigation for negligence, also referred to as medico-legal cases.

In the interviews, the errors were as a result of both low staff morale, and dealing with increased pressure from too much work. Another section attributed the errors to inexperienced personnel taking duties beyond their training as a stopgap measure to offset staff shortages. These views agree with the conclusions by the World Health Organisations that excessive work and the staff's psychological state, as well as skill and experience, are major factors associated with medication errors in medical facilities (WHO,2016). In another study, Mathaba's (2013) also found that moratoria can put the lives of patients at risk due to errors and this view is similar to this study's findings.

Notably, one respondent refuted that the staffing moratoria increased the number of patient incidents and litigations for negligent service, as healthcare workers overstretch themselves to provide the necessary care.

The respondent stressed that:

> *"I cannot say that there are too many cases of patient incidence because I might say there are only a few cases even though they are short-staffed. There are those nurses we overstretch."* **(Respondent 6)**

Furthermore, the issue of litigation claims as a result of medical errors was also highlighted:

"The second one is that money supposed to be saved by the department from not employing might as well go to the increasing medico-legal cases. Meaning that the department is now being sued millions for medico-legal cases. Definitely, if there are staff shortages the service output will be of poor quality and our constitution allows people to sue the state when there are issues of malpractice." **(Respondent 7)**

Another respondent also stated that:

"The increased risk of medical-legal claims, litigation mistakes because of understaffing but there is a difference between being short-staffed and being critical, below a certain staffing level at which errors do happen. In the system, medical risks are increasing and that may probably not be seen now but only after one or two years when people open the claims. The trust in government and healthcare system will be rapidly eroded..." **(Respondent 3)**

This view also resonates with the survey's findings on increasing errors as a result of staffing moratoria. In the survey, a small number of respondents pointed out that staffing moratoria were not a cause of medication errors at the hospital although this number was not negligible. Therefore, from the results above the Department of Health will invite a situation where its quest to decrease expenditure is unachievable because of increasing litigation claims that are caused by medical errors due to staff shortages.

In the literature, several scholars believe that medical errors are in critical indicator of the quality of health care services offered by an institution as highlighted in the interviewees' views. Iravani et al. (2012), Raeisi et al. (2012) and Rahimi et al.(2017) identify hospital or medical facility accidents as internal process measures that show the effectiveness of staff in handling their responsibilities. Like Respondent 3, these scholars also believe that increasing accidents will erode the trust that users put in a healthcare facility.

6.7.4 Increases in patient mortality at NTH

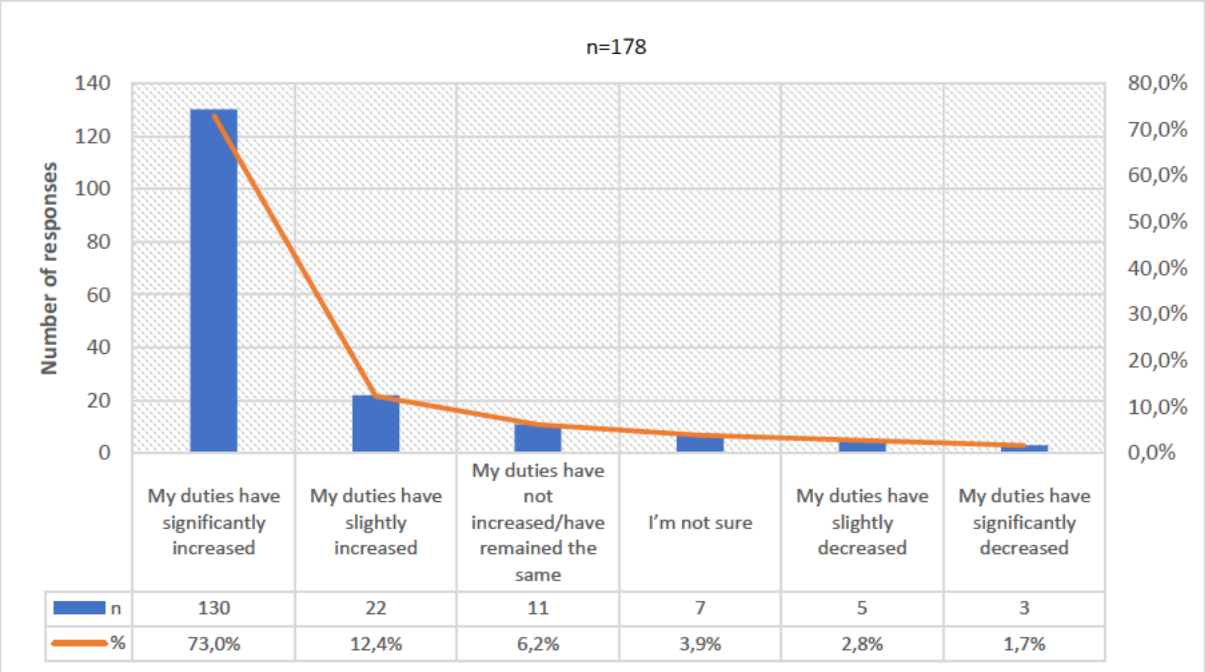
In the survey, 26% of the respondents associated the moratoria with an increase in patient mortality at Ngwelezana Tertiary Hospital. Two interviewees were of the view that the moratorium compromised the lives of patients. Thus, the view that moratoria were associated with a significant increase in mortality rates was held by a small, but considerable proportion of the sample.

In comparison to other studies, El-Khatib and Ritcher (2009) discussed how the staffing moratoria in the health sector created a high mortality rate risk among patients. This view resonates with the findings from this study. As stated by El-Khatib and Ritcher (2009), under moratoria, public health facilities tend to focus more on reducing and meeting staffing budgets rather than on providing quality healthcare, thereby putting the lives of patients at risk. El-Khatib and Ritcher (2009) views are therefore shared by part of the sample in this study. Iravani et al. (2012), Raeisi et al. (2012) and Rahimi et al.(2017) also put mortality rates as a major indicator of healthcare facility efficiency and effectiveness in delivering services to the public. In the Zimbabwean case study, the freezing of posts in the public healthcare system was also associated with increased child mortality rates (Haley, 2017). This shows the importance of maintaining an adequately sized and skilled staff complement in public hospitals in preserving lives.

6.8 Impact of moratoria on staff duties at Ngwelezana Tertiary Hospital

Figure 6.6 below shows managers' and non-managers' responses on the impact of staffing shortages on their duties.

Figure 6.6: Impact of staffing shortages on duties as a manager/non-manager



Source: Surveyed respondents (2019)

Figure 6.6 above shows that the majority of the sample (73%) believed that their duties had significantly increased as a result of the moratoria. Another 12.4% believed that their duties had slightly increased after the moratoria. Only 1.7% said that their duties had decreased as a result of the moratoria. The moratoria had, therefore, resulted in an increase of duties, from the respondents' points of view.

The survey did not collect data on the types of additional duties that the sample took. Interviewees, however, shed more light on these. The view that staffing moratoria had resulted in an increase in staff duties is widely discussed in the interviews, with all except one interviewee confirming this. The respondents in the interviews elaborated that two classes of duty-increase can be identified. The first one is the general increase in the duties and responsibilities that a healthcare worker was employed to do. For instance, nurses tended to take care of more patients than they used to. The second type of duty increase included healthcare workers taking administrative and housekeeping duties outside their contracts. A common example given was that of nursing staff doing hospital cleaning work, as well as grooming patients.

The overall view that the duties and responsibilities of staff had increased was discussed under various sub-topics above. Only a small part of the respondents asserted that they had experienced a decline in activity in their jobs. In a survey to assess the effects of the 2008-2014 staffing moratoria in Ireland (The Health Services Employee Survey, 2014), 37% of the surveyed healthcare workers showed that they were overburdened by heavy workloads as a result of freezing of posts. This is much lower than the 73% highlighted in this study. Comparatively, the staff at Ngwelezana are more burdened by the effects of staffing moratoria. Both studies, however, share the view that staffing moratoria increase staff duties beyond what is formally documented in their contracts.

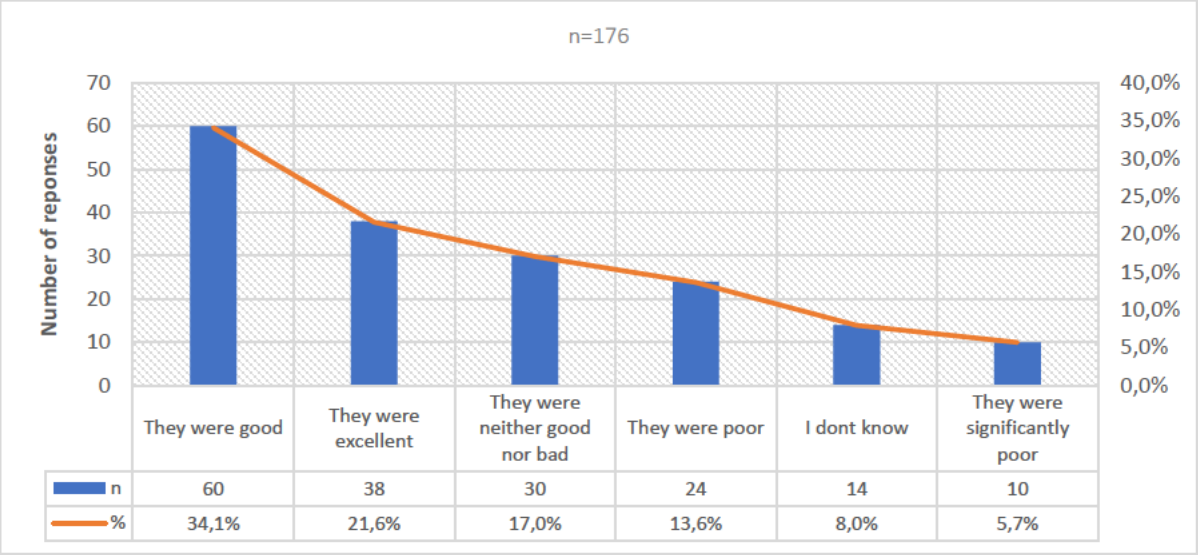
While the issue of increasing administrative burden has already been discussed in an earlier section, this section discusses the effects of additional housekeeping duties that staff particularly nursing staff are subjected to due to staff shortages. Kudo et al. (2012) state that increasing housekeeping functions within clinical roles was a major source of demoralisation for professionals. Storey et al. (2009) assert that professionals felt downgraded and unsupported and this increased their turnover and absenteeism. Delobelle et al. (2011) also linked doing unexpected roles with a decline

in job satisfaction, cautioning that work content quality was critical in maintaining a motivated team. The findings clearly show that healthcare professionals were more demoralised by off-contract, housekeeping duties as discussed by some scholars above.

6.9 Working conditions before staffing moratoria at Ngwelezana Tertiary Hospital

The survey and the interviews probed the working conditions that the respondents were subjected to prior to the implementation of the moratorium. Figure 6.7 shows the sample's responses to a statement on working conditions under your supervisor before staffing moratoria.

Figure 6.7: Working conditions under your supervisors before staffing moratoria

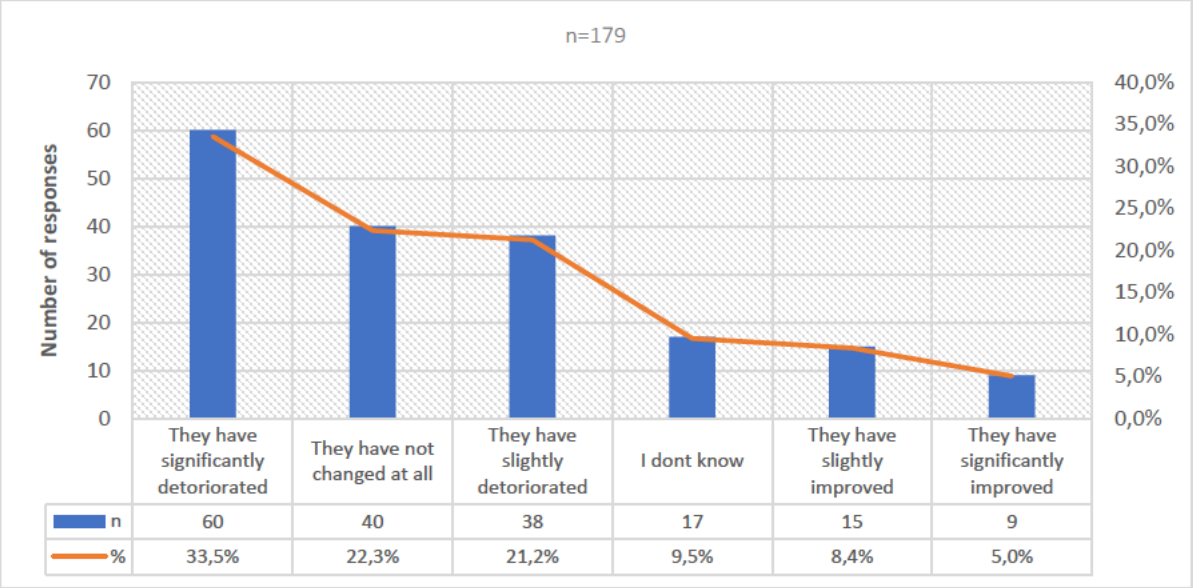


Source: Surveyed respondents (2019)

As shown in Figure 6.7 above, 34.1% of the respondents believed that their working conditions before the moratoria were good, while 21.6% believed that they were excellent. Only 5.7% believed that the working conditions before the moratoria were significantly poor.

The respondents were also asked to choose a response that best describes working conditions after the moratoria.

Figure 6.8: Working conditions in your department since staffing moratoria



Source: Surveyed respondents (2019)

After the implementation of staffing moratoria at Ngwelezana Tertiary Hospital, 33.5% believed that working conditions have significantly deteriorated, while 22.3% believed that they had not changed at all.

In the interviews, respondents expressed that working conditions after the implementation of staffing moratoria had declined significantly. Before the moratorium, as expressed in the interviews, employees concentrated on their contractual duties. For instance, nurses did not have to clean the wards as a result of shortages of cleaning staff. They were also able to share their work with other colleagues if they felt overburdened. They also relied on nursing aids to clean and bath patients. After the moratorium, they took care of the cleaning work as well. As a result, they were always fatigued by their work. Staff shortages compounded by absenteeism make their work difficult.

The same factors responsible for absenteeism, namely low staff morale and larger than manageable workloads, were also behind the deterioration of working conditions. As in the survey, most respondents believed that the working conditions they experienced before the moratoria were more positive compared to the current conditions.

The respondents in the interviews were also able to outline the workers' grievances and concerns in detail. From the interviews, the reasons behind the perceived deterioration of working conditions are shown below:

Table 6.8: The reasons behind the perceived deterioration of working conditions

Grievance	Example
Working with little or no rest	On a daily basis, nurses fail to take lunch breaks: in the long-term most staff were being denied annual leave.
Working longer than expected hours	Staff did not always take mandatory breaks resulting in increased working hours.
Being delegated too much work to handle	Staff had to cover for absent staff and frozen posts, this included being delegated lower tasks and also being task-shifted to higher-level tasks.
Doing work that was not on one's job description	Nurses and other clinicians taking administrative duties and duties of general hands such as cleaning and bathing patients.
Feeling exploited by the situation	Workers who task shift felt that they were not compensated to meet the added skills levels; staff felt they were paid at the same rates like hospitals where staffing levels.

Source: Interviewed respondents (2019)

The perceived deterioration of relationships among departments (discussed later) was also another factor that negatively affected the working environment conditions. With the exception of the feeling of being exploited, all the other factors were noted as being behind low job satisfaction and the perception that the working environment was harsh by Irish healthcare workers (Ipsos-MRIB, 2014). There were therefore similarities between the grievances that the sample had and those that Irish healthcare workers had with a moratorium to freeze non-critical posts in the Irish public healthcare system.

In a study conducted in Ireland, Williams and Thomas (2017) concluded that the moratoria on medical staff hiring introduced in that country between 2008 and 2014 as part of austerity measures, despite recording some successes on curbing expenditure came with a notable deterioration in working conditions as perceived by healthcare workers. Comparing the Irish situation to the that of Ngwelezana, fewer Irish workers were dissatisfied with the working conditions emanating from the 2008-2014 moratoria, with 47% of the sample being unhappy with their working conditions compared to 54.7% in the study (33.5%+21.2%).

6.10 Challenges faced by healthcare workers as a result of staffing moratoria

Table 6.9 below shows responses on the challenges that are faced by employees as a result of the implementation of freezing of posts. The responses were recorded using a Likert scale, and respondents were offered a choice of six coded responses, namely 'extremely positive', 'positive', 'unchanged/neutral', 'negative', 'extremely negative' and 'not sure' as discussed in the methodology presented in Chapter 4. Below are the results.

Table 6.9: Challenges faced by healthcare workers under staffing moratoria

Perceptions/ Views	*N*	*Extremely positive*	*Positive*	*Unchanged /Neutral*	*Negative*	*Extremely negative*	*Not sure*
Challenges as a results of staffing moratoria. Staff morale	174	1,1%	6,9%	9,2%	56,9%	17,2%	8,6%
Personal development among staff	174	1,7%	10,9%	13,8%	47,7%	17,2%	8,6%
Staff retention	173	2,3%	5,2%	16,2%	48,0%	15,0%	13,3%
employee-employee relationships	172	1,2%	4,7%	5,2%	54,7%	31,4%	2,9%
employee-management relationships	170	0,6%	2,9%	3,5%	45,3%	45,9%	1,8%

Source: Surveyed respondents (2019)

6.10.1 Staff morale

As shown in Table 6.9 above, the most popular response for staff morale as a challenge after the moratoria were “negative”, which occurred with a 56.9% frequency. Low staff morale has widely been discussed in the document as a major unintended outcome of the moratorium.

Respondents in the interviews expressed that the moratorium had lowered the morale of the workforce across all the hospital departments. Interviewees associated deteriorating working conditions with low worker morale. Furthermore, job satisfaction was reported to have declined to levels where most employees preferred not to work for the Department. In the interviews, when asked how has staffing moratoria affected staff morale, One respondent alluded that:

> *“It’s horrible….it forces people to leave to move away, just to do something different. who wants to work in a situation where every time there is underfunding nothing possible etc especially in the wards. I know in the wards especially in busy hospitals where they don’t have enough staff and they can’t get any it’s horrible.”* **(Respondent 3)**

Another respondent further expressed that:

> *“Unfortunately this is a very thorny issue in the hospital because we are talking about human beings who have overstretched themselves now it means as a manager you have to be with them at all times and sympathise with them for them like to boost their morale for example if I can take you to the wards you will be surprised to see how people are working, there are some of them walking on foot. You see ladies like to walk in high heels now they are walking on foot because they are up and down they can’t sit down.”* **(Respondent 4)**

Low morale as a result of the high workload manifested itself in the form of poor conduct, increased tension and unhealthy relationships within work teams. Further to that, the increasing numbers of work-related errors and absenteeism pose a regular challenge for management who have to decide whether to discipline staff or to make compromises considering that staff were overstretched.

As discussed in the literature, according to Frenk (2010), the World Health Organisation (WHO) cites human resources as being the most critical input of a

healthcare system and stresses that the performance of this resource is strongly influenced by the levels of morale (Frenk, 2010). The respondents in this study strongly shared a similar view. Like Frenk (2010), the respondents associated low staff morale with a discharge of potentially low-quality healthcare services that may put society at risk.

The issue of staff morale has been raised by Larson (2017) and Parke (2016) who expressed concerns regarding staff morale in the literature stating that staff morale plays a critical role in quality service while the latter state that low morale results to severe cost implications which are associated with firing and rehiring workers due to absenteeism, errors, and low productivity. While low staff morale negatively affects the productivity of healthcare workers, it further affects patients where poor quality healthcare services are being rendered.

Low morale as a concept can also be looked at from an employee engagement perspective. As stated in the literature there are three levels of employee engagement: actively engaged, disengaged and actively disengaged (Cataldo, 2011). the general behaviour of employees at the hospital point to a disengaged group. The employees exhibit the characteristics that are associated with disengagement including high absenteeism rates, high staff turnovers and general detachment from duty (Saks, 2011; Lowe, 2012). Thus, the issues discussed by staff should be considered important indicators that should be addressed in a bid to restore the majority of the employees to an actively engaged state.

6.10.2 Personal development of staff members at NTH

For the purposes of personal development, the most popular response was also “negative” as rated by 47.7% of the sample. Two interviewees discussed personal development challenges that came as a result of the moratorium. Before the moratorium, it was possible to temporarily relieve staff of their duties so they could go for career development training. The interviewee stated that as a result of the moratorium, they would not be able to send more than two people for training at once because of staff shortages. In the past, they could afford to send about 10 nurses for career path development at a time. The interviewee linked low motivation among staff to the existence of very little personal growth opportunities amongst some of the professionals at the hospitals as a result of the moratorium. Working long hours and

fatigue also impeded staff from taking personal development programmes. Staff were therefore denied the opportunity to grow as a result. Contrary to this study, RHAP (2016) asserted that moratoria could encourage training and development as processes to ease the current burden of overworked professionals in the local public health system, but cautioned that trained resources could easily leave as a result of low morale factors.

Lack of training and development opportunities was also discussed as a cause of disengagement among employees in various sources from the literature. Employees commit to organisations with personal goals to endeavour and grow (Kehoe and Wright, 2013; Korzynski, 2013; Osborne and Hammond, 2017). If opportunities for growth are not available, employees generally become less actively engaged in their jobs (Korzynski, 2013). This reduces their contribution to organisational performance (Osborne and Hammond, 2017).

6.10.3 Staff retention at NTH

The most frequent response to how the sample felt about staff retention changes as a result of the moratoria was “negative”, with a 48% frequency. In the interviews, four interviewees stated that they were trying their best to motivate employees to remain at the hospital. However, they all indicated that the staff retention strategy had been weakened by the moratoria due to the uncertainties surrounding it. Overall, there was the view that the hospital’s capacity to retain staff had deteriorated and this implies that it was at risk of losing key staff, further worsening staffing challenges.

The issue of staff retention was stressed by some of the respondents, who highlighted that strategies that the hospital was using were no longer effective in the presence of staffing moratoria.

On this matter, one respondent stated that:

> *“I will be honest mainly our staff retention strategy even in the past before the moratorium it was mainly making sure that employees are happy to be with the hospital. Like those who need accommodation, training opportunities and career path development... So basically the implementation of the moratorium has also impacted negatively on staff retention of staff meaning there is little the hospital can do…* **(Respondent 7)**

The respondent further reiterated that:

> *"So I don't think we can have any retention strategy that actually works to keep staff except for the moratorium because it has actually become a retention strategy. Because people are now scared to leave because chances of finding employment are very slim so you have people staying longer. Not because they are happy but because there are no other options, "like I am one of them"* **(Respondent 7)**

The above results raise interesting concerns. Management at the hospital has run out of staff retention strategies because of staffing moratoria. Staffing moratoria have become a retention strategy, in that staff members are scared to leave their current healthcare facilities with fears of not getting employment elsewhere. This was because the freezing of posts was a national issue that did not only affect Ngwelezana Tertiary Hospital. Again, this finding points at a disengaged staff compliment that would leave if it got an opportunity to do so as stated by Osborne and Hammond (2017).

The findings from the study also resonate with the arguments by MacDermott and Stone (2013) that low staff morale is strongly associated with low staff retention. As morale goes down in public health facilities, more and more personnel consider leaving for the private sector as well as for other countries (Frenk, 2010). MacDermott and Stone (2013) further elucidate the risks of low staff retention, such as substantial losses of institutional knowledge and skills. Poor working conditions, low staff morale and dissatisfaction results in staff members leaving the hospital. Given that there are always concerns that the public sector was losing key staff to the private sector and that South Africa was losing key health resources to the developed world, there is need to relook staffing moratoria from a staff retention perspective.

6.10.4 Manager-to-employee relationships at NTH

In the survey, most respondents (45.9%) also held an extremely negative view on employee-to-management relationships. Interviewees revealed that managers were being viewed as the drivers of staffing moratoria, and were therefore to blame for all the problems associated with it. This was regardless of the fact that managers themselves did not have much of a say in its implementation. Furthermore, it was also revealed that relationships had soured because of the need to discipline staff for

absenteeism created tensions as staff believed they had genuine reasons (fatigue) to be absent from duty without notice.

This is evident by a respondent who expressed that:

> *So, there is a growing number of misconduct cases which most of them in terms of employee wellness is compromised and there is little that can be done (except to discipline employees)…"* **(Respondent 7)**

In relation to the view that managers were seen as uncaring, the respondent further said that:

> *"…One big challenge is that some people, when they look at me, they see a manager who is difficult and not supportive to their needs and its even worse when they come and cry at my office…"* **(Respondent 7)**
>
> *"…You look at a person and at the end of the day after he has mentioned all those challenges you have to tell the person, 'unfortunately there is nothing I can do.' So you can actually see even on their faces the level of disappointment and others take it personally"* **(Respondent 7)**

Thus, the freezing of posts, to some extent, was perceived to have brought divisions between managers and non-managers and resulted in poor team relationships at the hospital with some employees believing that managers were uncaring and not doing enough and with managers being seen as too punitive of staff working under difficult circumstances.

In a study designed to explore nursing managers working conditions in Gauteng and the Free State, Munyewende and Rispel (2014) found that poor relationships between managers and their subordinates were associated with lack of trust between these groups. Non-managers mostly felt that managers were behind moratoria. They also found that pressure from staffing moratorium where non-managers felt over pressured by their superiors was a source of contention in these poor relationships. This study produced a similar finding on the matter of mutual trust, and according to Munyewende and Rispel's view, this scenario was not sustainable, as it affected staff motivation and the quality of service delivered. As stated by Osborne and Hammond (2017), if employees believe their managers to be distanced and uncaring, there is a risk that

they may become less engaged to duty and less committed to work towards organisational objectives.

6.10.5 Employee-to-employee relationships at NTH

According to the study results, most respondents (54.7%) held a negative view on the state of employee-to-employee relations that came as a result of the moratorium. In the interviews, the relationships between employees were not widely discussed. It however, came out that disagreements over human resources allocations were a major contention across departments as well as among personnel. Also, the sharing and coordination of heavy workloads created tensions as units attempted to carry less of the overburden caused by staff shortages. One respondent mimicked common arguments that affected both interdepartmental and personal relationships:

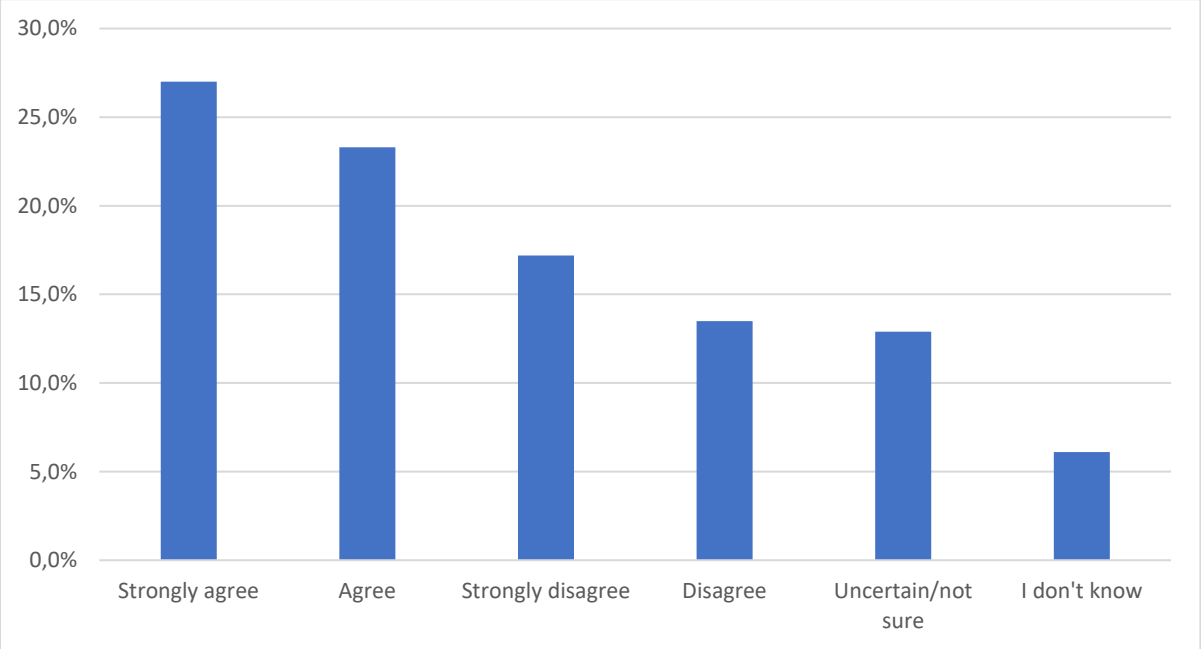
> *"They sat HR does not want to give us posts and even when doctors see their patients when the ward is full, but they want to admit new patients and they can't because other patients have not been discharged; then there is another tension between therapeutic and allied staff or medical staff, because they are seen as an obstacle to rendering services..."* ***(Respondent 6)***

In the literature, there are findings that constrained working conditions especially those characterized by staff shortages can create tension among staff and these resonate with the above views. Alagaraja and Shuck (2015) assert that employee engagement was best facilitated when there was alignment across personal, team and organisational relationships, a thing that seems absent in the organisation. Also, Mone and London (2018) take positive interpersonal relationships to be a precedent of job satisfaction and like in the study suggest that tension reduces employee satisfaction with their jobs. This overall shows the various facets of the impact of staffing moratoria on individuals. Staffing moratoria did not only affect organisations at a departmental level but also affected employee relations on a personal level.

6.11 Impact of staffing moratoria on rural communities

The respondents also rated their perceptions on the statement: *staffing moratoria severely affected facilities that are situated in rural areas more than those in urban areas.*

Figure 6.9: staffing moratoria severely affected facilities that are situated in rural areas more than those in urban areas.



Source: Surveyed respondents (2019)

Out of 163 respondents, 27% strongly agreed with the statement and 23.3% simply agreed with it. This is in comparison to 13.5% who strongly disagreed and 12.9% who disagreed with the same statement. Half of the respondents, therefore, believed that services in rural areas were more adversely affected by the moratoria than those in urban areas.

While the interviewed sample did not dwell on the comparative effects of the moratoria in urban versus rural set-ups, several studies have. A study by Hoyler et al. (2014) described the South African healthcare system as being overstretched in terms of professional staffing. Additionally, rural communities were more disadvantaged by staff shortages, as fewer professionals were willing to work there. This increased inequitable access to health between rural and urban communities. Hoyler et al. and Delobelle (2013) also describe any measure that affects staff availability to have a greater impact on such rural communities than urban ones. RHAP (2017) asserts that staffing moratoria within rural set-ups should be stopped as most rural facilities were already underresourced. RHAP (2017) recommends that more funds should be directed towards the public healthcare sector to avoid staff freezes that were implemented as austerity measures. Furthermore, in rural communities, task-shifting

as a measure to alleviate staff shortages was more common and regular compared to urban communities. This view generally agrees with the findings above, where more than half the sample perceived the moratoria as having a larger negative impact in rural communities than in urban ones.

6.12 Effects of staffing moratoria on Batho Pele Principles

Table 6.10 shows the respondents' overall rating of how the eight Batho Pele principles applicable to service delivery at the hospital have been affected. Mean scores were used for the ratings and the kurtosis and skewness between -1.5 and 1.5 were used to determine whether the responses were normally distributed to be reliably analysed using the mean.

Table 6.10: The impact of staffing moratoria on the Batho Pele principles

	N	Missing	Mean	Median	Mode	SD	Skew	Kurt
Batho Pele principles, Consultations to patients	171	6	4	4	4	1,39	-0,27	-0,5
Service standards to patients	166	11	3,9	4	4	1,38	-0,31	-0,61
Accessibility/access to service by patients	164	13	3,6	4	4	1,41	-0,14	-0,66
Courtesy to patients	164	13	3,8	4	4	1,35	-0,18	-0,66
The free dissemination of information to patients	164	13	3,9	4	4	1,43	-0,14	-0,85
Openness and transparency of services	164	13	3,7	4	4	1,44	-0,14	-0,77
Redress to patients complains	164	13	3,7	4	4	1,44	-0,06	-0,91
Value for money to paying patients	165	12	4,1	4	4	1,41	-0,24	-0,89

Source: Surveyed respondents (2019)

The mean scores for the eight Batho Pele principles ranged from 3.6 (sd=1.44) to 4.1(sd=1.41). This ranged correspondent with the "has slightly deteriorated" response. The highest mean was on *value for money* as a principle (mean=4.1sd=1.41) indicating that the respondents, overall held this principle as having deteriorated much more than the others. It was followed by *consultation to patients* (mean=4, sd=1.39);

service standards to patients (mean=3.9, sd=1.38). The general view was therefore that the moratoria had resulted in a deterioration on the application of the Batho Pele principles. Thus, in an attempt to improve service quality and customer engagement under the new public management precepts, value to clients has ironically decreased.

The views that the application of Batho Pele principles had deteriorated as a result of the moratoria, to an extent resonates with the findings that the Public Service Commission (PSC, 2018) in its report entitled: *Investigation into Health Care Facilities in Kwazulu-Natal: A Special Focus on Professional Ethics.* The report indicated that in KZN tertiary hospitals, blanket approaches to moratoria had negatively affected the professional and ethical deliverance of duty among staff. Generally, the violation of all Batho Pele principles was most likely taking place in situations where healthcare workers were not supportive of human resources rationalisation programmes like the moratoria. The report asserts that this state-of-affairs was a result of the unintentional failure of the system to deliver on the principles due to the negative effects of rationalisation and low commitment of staff. The report, however, did not individually discuss the effects of the moratoria on each of the seven principles as attempted by this study.

In another study, James and Miza (2015) investigated the perceptions of nurses on the application of Batho Pele principles in South African public hospitals and found that the efficient execution of Batho Pele principles is compromised by the planning and implementation of strategies that affect human resources. While James and Miza (2018) did not directly refer to moratoria in their study, they concluded that poor planning that eventually affected staff commitment resulted in a low commitment in staff to work towards attaining the principles. In the same study (James and Miza, 2015), it was also concluded that human and material resource constraints made it difficult for them to achieve the goals of the Batho Pele principles. From the sample, it can be noted that the respondents perceived staff shortages as an obstacle to the delivery of quality healthcare services in a similar manner as that discussed in James and Miza's findings.

Low staff morale, regardless of its causes, resulted in the poor application of Batho Pele principles as found by Mtshali (2018). Demotivated staff generally lack the commitment to ensure that the eight principles are realised. Mtshali (2018) made this

conclusion, which agrees with the views from this study, from a study done at Umphumulo Public Hospital, also in the KwaZulu-Natal Province.

These results on the application of the Batho Pele principles can be further assessed from a New Public Management theory perspective. The Batho Pele Principles are a direct response to the NPM (Mothamaha and Govender, 2014; Venter, 2018). Venter (2018:13) states that:

> *"the core principles of New Public Management (NPM) seem evident within the principles of Batho Pele."*

In the researcher's view, all of the eight principles apply to the KZN, DoH staff freezes and task shifting contexts. Mostly, communities that rely on Ngwelazana Tertiary Hospital, as expected under Batho Pele, should get quality healthcare service from the facility. Any changes that affect service standards and the principles violate the Batho Pele Principles and this can be viewed as a failure of the NPM-induced changes in bringing effective and efficient services.

6.13 Chi-square tests of associations

This section presents results of Chi-square tests of association between selected variables. Cramer's V tests were used to measure the strength of these associations and were interpreted using the parameters shown in the table below.

Table 6.11: Interpretation table for Cramer's V scores

Cramer's V score	p-value	Interpretation
>0.25	>0.05	Very strong
>0.15	>0.05	Strong
>0.10	>0.05	Moderate
>0.05	>0.05	Weak
>0.00	>0.05	No association

Source: Akoglu (2018)

Only statistically significant associations were discussed in this subsection.

6.13.1 Association between management level and perceptions on the moratoria

Table 6.12 below shows the results of the test of association: management level and perceptions on the moratoria.

Table 6.12: Management level and perception on the purpose of staffing moratoria

		N	Mean	Std. D.	Chi-Square	Sig.	Cramer's V	Sig.
Purpose of staffing moratoria is to minimise employee numbers in the hospital	Non-managers	140	2.99	1.67	13,3	0,02	0,302	0,02
	Managers	6	1.83	2.04				
	Total	146	2.95	1.71				
It is strategy to cut-cost in the hospital in general	Non-managers	145	2.60	1.53	15,6	0,00	0,318	0,00
	Managers	9	1.11	.33				
	Total	154	2.51	1.53				
It is a strategy to reduce employment costs in the hospital	Non-managers	140	2.81	1.7	14,04	0,02	0,31	0,02
	Managers	6	1.00	.000				
	Total	146	2.73	1.7				

Source: Surveyed respondents (2019)

The results above show that there were statistically significant associations between management level and the view that the moratoria's ultimate purpose was to reduce employee numbers at the hospital ($p<0.05$). This association was interpreted as very strong with a Cramer's V of 0.302 which is >0.25. There were statistically significant associations between management level, and the view was that the moratoria were a strategy to generally cut costs in the Hospital ($p<0.05$). This association was interpreted as very strong with a Cramer's V of 0.318($p<0.05$), which is >0.25. There were statistically significant associations between management level and the view that the moratoria were a strategy to reduce employment costs in the hospital ($p<0.05$). This association was interpreted as very strong, with a Cramer's V of 0.31($p<0.05$), which is >0.25.

In all the three sets of associations, non-managers held a stronger conviction that the moratoria's ultimate purpose was to minimise employee and general costs at the hospital. No studies that explored the association between management level and perceptions on staffing moratoria in the health sector locally or internationally could be

found. In the interviews, the interviewees, who were managerial, however, held stronger views that freezing of posts was a cost-cutting measure. Thus, while both groups held common views, these views appeared to be stronger on the part of the non-managers.

6.13.2 Association between perceptions on the moratoria and department

Table 6.13 below shows the results of the test of association between perceptions on the moratoria, and the department from which one worked.

Table 6.13: Association between perceived purpose of the moratoria and department

Statement	Department	N	Mean	Std. Dev.	Chi-Square	Sig.	Cramer's V	Sig.
Purpose of staffing moratoria. To minimise employee numbers in the hospital.	FD	5	1.80	.837	65,40	0,00	0,30	0,00
	HRMD	9	3.22	1.093				
	MSPAM	14	3.50	1.698				
	SMD	19	2.16	1.864				
	NSD	87	3.05	1.711				
	Other	9	2.56	1.667				
A strategy to cut costs in the hospital in general.	FD	9	1.89	.782	50,10	0,05	0,23	0,05
	HRMD	13	2.31	1.316				
	MSPAM	17	2.65	1.730				
	SMD	16	1.62	1.147				
	NSD	87	2.71	1.554				
	Other	9	2.56	1.740				
It is a managerial punishment to the hospital staff.	FD	4	1.75	.500	62,60	0,00	0,27	0,00
	HRMD	10	2.60	1.174				
	MSPAM	16	3.44	1.590				
	SMD	15	4.53	1.125				
	NSD	86	3.63	1.743				
	Other	9	2.89	1.691				
It a response to low budget allocations by government.	FD	6	1.50	.548	74,10	0,00	0,32	0,00
	HRMD	9	2.67	1.323				
	MSPAM	16	2.50	1.592				
	SMD	16	2.44	1.590				
	NSD	86	2.57	1.773				
	Other	9	2.22	1.641				

Use a Likert Scale1 – 6, 1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree and 5 = uncertain/ not sure, 6 = I don't know

Chi-square tests of association showed a statistically significant association between department and the statement: *The purpose of staffing moratoria were to minimise employee numbers in the hospital.* In the above table, it is shown that respondents from the NSD were, on average, leaning towards the “strongly disagree” option than the other groups, while the MSPAMD respondents were mostly leaning towards the “strongly disagree” response. Respondents from the FD mostly agreed with the statement. These differences were all statistically significant, with a Cramer’s V of 0.30 ($p<0.05$) indicating a strong association between department and the response to the statement.

Chi-square tests of association showed a statistically significant association between department and the statement: *Purpose of staffing moratoria - A strategy to cut-cost in the hospital in general ($X^2=50.1$, $p<0.05$).* FD and SMD respondents had the highest levels of agreeability with the statement, while NSD respondents, on average, leaned towards the strongly disagree option, followed by MSPAM respondents. The Cramer’s V tests showed that the association between department and the statement was strong (Cramer’s V=0.23, $p<0.05$). Respondents were therefore likely to choose a certain response based on the department in which they worked. This further shows that respondents from different departments perceived the purpose of the moratoria differently.

Chi-square tests of association showed a statistically significant association between department and the statement: *Purpose of staffing moratoria - It is a management punishment to the hospital staff ($X^2=62.6$, $p<0.05$).* Based on mean scores shown above, HRMD respondents were most likely to “strongly disagree” with this statement compared to other respondents. FD respondents generally agreed with the statement while NSD respondents disagreed with it. Cramer’s V tests showed that the association between department and this statement was strong (Cramer’s V=0.27. $p<0.05$).

Chi-square tests showed a statistically significant association between department and the statement *It is a response to low budget allocations by government*. FD respondents were most likely to agree that staffing moratoria were a response to low budget allocations by government compared to other groups. HRMD respondents, on average, were mostly strongly disagreeable with the statement. The association

between department and purpose of this statement was generally strong (Cramer's V=0.32, p<0.05).

6.13.3 Association between working conditions perceptions and department

Table 6.14 below shows the results of the test of association between perceptions on working conditions and the department one worked from.

Table 6.14: Test of association between management level and perceptions on working conditions

		N	Mean	Std. D.	Chi-Square	Sig.	Cramer's V	Sig.
Challenges as a result of staffing moratoria. Staff morale	Non-managers	144	4.06	1.066	23,1	0,01	0,364	0
	Managers	30	4.23	.817				
	Total	174	4.09	1.027				
Personal development among staff	Non-managers	145	3.92	1.202	29,3	0	0,41	0
	Managers	29	4.00	.535				
	Total	174	3.94	1.118				
Staff retention	Non-managers	144	4.28	2.535	30,2	0,00	0,418	0,00
	Managers	29	3.97	.680				
	Total	173	4.23	2.331				
Unhealthy employee-employee relationships	Non-managers	144	4.22	.925	24,93	0,00	0,381	0,00
	Managers	28	4.07	.378				
	Total	172	4.19	.861				
Unhealthy employee-management relationships	Non-managers	142	4.44	.812	37,7	0,00	0,471	0,00
	Managers	28	4.07	.378				
	Total	170	4.38	.770				

1 Extremely positive, 2 Positive, 3 Unchanged/Neutral, 4Negative, 5 Extremely negative, 6 Not sure

As shown above, when associating managerial level by perception, managers were more negative on staff morale compared to non-managers (X^2=23.1, p<0.05). This association was very strong with a Cramer's V of .364 (p<0.05).

Managers were also associated with greater negativity than non-managers on the perception of how the moratoria had affected personal staff development. This

association, with a Chi-square of 29.3 ($p<0.05$) was rated as very strong with a Cramer's V of 0.41($P<0.05$).

Table 6.15: Test of association between department and perceptions on working condition

Statement	Department	N	Mean	Std. Dev.	Chi-Square	Sig.	Cramer's V	Sig.
Impact of staffing shortages on duties as a Manager	FD	10	1.20	.422	122,7	0,00	0,341	0,00
	HRMD	15	2.67	3.830				
	MSPAM	23	2.00	1.243				
	SMD	22	1.36	1.136				
	NSD	92	1.63	1.636				
	Other	10	2.50	2.068				
	Total	176	1.78	1.834				
Working conditions in your department since staffing moratoria	FD	10	4.30	1.252	94,1	0,00	0,277	0,00
	HRMD	15	3.87	1.307				
	MSPAM	23	4.17	2.387				
	SMD	21	4.29	.956				
	NSD	92	4.26	4.489				
	Other	10	3.50	1.900				
	Total	175	4.71	5.540				
Unhealthy employee-employee relationships	FD	9	3.78	.667	64,6	0,01	0,274	0,01
	HRMD	15	4.00	.756				
	MSPAM	22	3.77	1.270				
	SMD	21	4.33	.483				
	NSD	92	4.32	.769				
	Other	10	4.60	.966				
	Total	172	4.19	.861				
Unhealthy employee-management relationships	FD	9	4.11	.333	70,1	0,00	0,287	0,00
	HRMD	15	4.07	.458				
	MSPAM	20	3.80	1.152				
	SMD	21	4.33	.658				
	NSD	92	4.54	.686				
	Other	10	4.90	.738				
	Total	170	4.38	.770				

Source: Surveyed respondents (2019)

Table 6.15 above shows that there was a statistically significant association between department and the statements on the impact of staffing shortages on one's duties as a manager ($X^2=122.7$, $p<0.05$). On average, FD, SMD and NSD respondents were

inclined towards the option: *"My duties have significantly increased",* while HRMD respondents were inclined towards the view that their duties had not increased. A Cramer's V of 3.41($p<0.05$) shows that this association was very strong, with managers from different departments being affected by work pressure differently.

There was also a statistically significant association between department and the statement*, working conditions in your department since staffing moratoria* ($X^2=94.1$, $p<0.05$). With higher mean scores indicating deterioration of working conditions. FD, SMD and NSD respondents recorded higher levels of deterioration to working conditions after the moratorium compared to respondents from other units. A Cramer's V of .277 ($p<0.05$) indicated that this association was strong.

In relation to the association between *unhealthy employee-employee relationships,* as a factor, and department, there was a significant Chi-square ($X^2=64.6$, $p<0.05$). This association was classified as strong (Cramer's V=.271, $p<0.05$) with higher mean scores being observed in NSD, MSD and the "Other" groupings. Respondents from these groups were the most negative and strongly believed that there had been a deterioration in employee-to-employee relationships as a result of the moratoria.

The tests for association between department and the statement, *unhealthy employee-management relationships was also statistically significant ($X^2=70.1$, $p<0.05$)* with higher mean scores (indicating more negative perceptions) in the NSD, MSD and "Other" departments. These groups experienced more negativity in employee-to-management relationships than others.

The associations between department and perceptions on relationships between working relations are also highlighted. For instance, in response to the question*, 'does staffing moratoria cause tensions or bad relationships between you and your staff members in the department of health?'* managers responded that it did not, while others held the opposite view that it had resulted in the deterioration of manager-employee relationships.

One respondent asserted this by stating that:

> *"Not really no. It was because it's not new not anymore. Because everybody is aware of the financial situation and I don't have extra money and that is not a shared type of issue, we are all aware of the pressures altogether and if we*

don't take the right type of decision we know that one will just go from bad to worse" **(Respondent 3)**

And another respondent gave a different view:

"A lot because they feel we are not doing anything. They don't believe we have written to the head office we have motivated for posts. They feel it's all good with us" **(Respondent 7)**

This hints at the fact that relationships between management and employees had been affected differently across the departments as highlighted by the statistically significant associations discussed above.

6.13.4 Chi-square non-significant associations

Non-significant Chi-square tests of associations indicated that respondents from different departments did not respond to statements in ways that showed any systematic differences or patterns. Differences across departments were therefore random. This could mean that respondents from different departments did not experience or perceive staffing moratoria issues differently. All the impact and challenges that came as a result of staffing moratoria affected different department uniquely.

6.14 Discussion on the emerging issues

Overall, the findings on the causes behind staffing moratoria as well as its effects resonate well with the Manpower Planning Theory (MPT) as discussed by Smits et al. (2010) and expounded in Zurn et al.'s (2004) model cited in Chapter 4. Starting with the model by Zurn et al., staffing moratoria are public health staffing policies emanating from external economic, political, and social realms outside individual medical facilities such as Ngwelezana Tertiary Hospital. Their effects are felt on how they eventually affect the supply and demand of the right quality of labour. In the study, the interpretation that staffing moratoria had offset the labour and supply equilibrium of skilled medical staff is commonly shared by both managers and their non-managers respectively. As noted in the model, economic decisions filter into the health sector through both health and non-health policy changes. In the Ngwelezana Tertiary Hospital context, decisions by the KZN Provincial Treasury and the KZN Department of Health on the need to cut staffing costs resulted in a staffing moratoria which then

resulted in the worsening of skilled labour shortages at the hospital. Under the MPT, the hospital's ability to supply the right quality of professionals in the right quantities and the right times was compromised. As noted, this compromise resulted in the failure of the facility to fully practice Batho Pele principles that are used to assess service delivery quality in the health sector. As a result, members of the community who receive healthcare services at Ngwelezana Tertiary Hospital during the period where staffing moratoria were implemented were negatively affected.

The findings also reflect the views that the New Public Management's (NPM) focus on cost efficiencies rather than quality services can result in unintended negative consequences on employees and the quality of service being rendered. Staffing moratoria and other cost-cutting measures aimed at making government more financially efficient under the auspices of NPM philosophies and views can invite policies that can save money at the expense of quality service. Simone (2014) studied the NPM within the French public health system context, reaching similar findings in the observation that under the NPM, underlying health system objectives including the provision of quality services at an affordable cost and greater accessibility can be compromised by the need to meet budgetary allocations. Thus, meeting budget requirements becomes more important than meeting the actual health system deliverables (Singh, 2003). This view is highlighted by respondents who felt that staffing moratoria, as a cost-cutting measure, had negatively affected the delivery of quality health care to communities that depend on Ngwalezana Tertiary Hospital.

The findings from the study also puts the centralization-decentralisation argument to the fore. Regardless of the fact that the NPM unlike its predecessors the classical old public administration schools emphasizes on decentralisation as a more suitable administration model for delivering efficient and effective public services (Robinson, 2015) the effects of intense centralization are widely seen in staffing moratoria decisions. The advantages of decentralisation include empowering administrators to deploy resources to where they are most needed (Adhikari 2017; Kuhlmann and Wollmann, 2014). With decentralisation resoruce allocation decisions are made by the affected groups, in this case this case management and staff at Ngwelezana Tertiary Hospital. Decentralisation also facilitates more equitable service access and works well when poor and rural groups that are easily marginalised by bureaucracies are also among services users (Olum, 2014: Rechel et al., 2018). In the case of

Ngwelezana Tertiary Hospital, fiscal centralization of staffing budgets and administrative centralization of hiring processes have resulted in shortages of staff, overworked, less-engaged staff and overall, the delivery of poor quality services that are below Batho Pele expectations.

Decentralisation within an NPM framework also suggests the failure of the provincial government to fully operate within that paradigm. Challenges of governments and governmental units failing to adapt to NPM principles are not uncommon (Lapuente and Walle, 2020). In the Ngwelezana Tertiary Hospital context, under a purely NPM approach, the researcher opines that the marketisation of public services is impossible owing to high hospital-user poverty rates. Thus, elements of classical administration schools on the control and command of resources might have been necessary, albeit to a lesser extent. Fiscal and adiministrative decentralisation are still feasible as they improve both allocative and technical efficiency in resource allocation, even under traditional public administration philosophies.

Evidence of classical administration theories are strongly evident in the limited consultations and the slow reactions of the provincial health department to the staffing problems that are regularly communicated to it. These serve as evidence of bureaucratic tendencies (Lapuente and Walle, 2020).

Coming back to the staffing issues, as stated by O'Donnell, Allan and Peetz (1999), the need for cost efficiency and other financial objectives results in overworked, thinly-spread public service employees, who are lowly motivated and get little satisfaction from their jobs. All these features are discussed in the interviews with managers and executives from Ngwelezana Tertiary Hospital and are also reflected in the questionnaire survey responses. The failure of staffing moratoria to result in more satisfied employees, judging by the low scores on whether it had resulted in the attainment of the eight Batho Pele principles, is another indication that the NPM may not apply as effectively to some public service areas, due to different objectives, as argued by Savoie (2002) and Singh (2003). The perception that the NPM often fails to apply in scenarios where economics of price, demand, and supply may fail to hold is also highlighted by the perception that rural communities relying on Ngwelezana Tertiary Hospital suffer more than other urban and comparatively affluent communities in terms of accessing quality healthcare delivered by qualified professionals.

6.15 Conclusions

In this chapter, data analysis results showed that the staffing moratoria affecting Ngwelezana Tertiary Hospital were associated with strategies to cut labour costs in an environment characterised by declining funding versus increasing healthcare service demand. However, there is a strong agreement that staffing moratoria intended to curb the hiring of non-essential staff at the facility, has had a severe negative impact on the supply of essential health care workers at the hospital as well. Various administrative and operational gaps left by the non-replacement of so-called non-essential staff as well as due to high staff turnovers from disillusioned staff, have resulted in unmanageable workloads on the part of professional healthcare workers. Failure to cope with the effects of these staffing changes that include long working hours, heavy workloads, poor relations with colleagues, limited staff development opportunities and increasing administrative and housekeeping burdens has resulted in a disengaged team. Thus the process has had severe unintended effects on the supply of medical professionals at the hospital as well as their commitment to fully discharge their duties. The next chapter presents data analysis results on the possible solutions to staffing moratoria among them task-shifting, as discussed by the study's respondents.

CHAPTER SEVEN: CHALLENGES AND OPPORTUNITIES FOR IMPLEMENTING STAFFING MORATORIA AT NGWELEZANA TERTIARY HOSPITAL

7.1 Introduction

This chapter is a continuation of the previous data analysis chapter. It presents data analysis results from statements and questions relating to the possible solution to moratorium-related challenges. This chapter aims to answer two study research questions:

- To what extent has task-shifting been able to address staff shortages in the department of health? and
- What are possible solutions to the issue of staffing moratoria in the KwaZulu Natal Department of Health?

It builds upon the perception that some measures can be put in place to assist the moratorium-associated challenges as well as general staff shortage issues discussed in the previous chapter. The chapter contains sections on solutions to staffing moratoria, task-shifting as a possible solution to staffing moratoria; associations between task-shifting perceptions and department as well as management level. The chapter ends with a discussion of major theories relating to task-shifting focusing on how the theories apply to the findings of the study.

7.2 Perceived solutions to staffing moratoria in the KZN Department of Health

Table 7.1. below show respondents' perceptions on the possible solutions to staffing moratoria-related challenges. The responses were recorded using a Likert scale and respondents were offered a choice of six coded responses namely 'strongly agree', 'agree', 'strongly disagree', 'disagree', 'uncertain or not sure' and 'I don't know' as discussed in the methodology chapter.

Table 7.1: Perceptions on possible solutions to staffing moratoria in the KZN Department of Health

Perception/view	Strongly agree	Agree	Strongly disagreed	Disagree	Uncertain / not sure	I don't know	N
It should not form part of cost-cutting. measures in the Department of Health.	58,7%	26,2%	4,7%	2,9%	2,9%	4,7%	172

National Treasury must increase budget allocation for the Department of Health.	66,5%	24,1%	1,8%	1,8%	1,8%	3,5%	170
Posts must be unfrozen in all health facilities under the Department of Health.	64,5%	21,9%	3,6%	0,6%	3,0%	6,5%	169
Hospitals must be granted autonomy to define and decide on which posts they consider critical.	50,6%	25,0%	6,0%	6,5%	5,4%	6,5%	168
The department should continue to freeze posts and fill in exceptional circumstances.	7,1%	2,4%	43,5%	33,9%	4,2%	8,9%	168
Providing more space for university students who require in-service training to fill the gap caused by the human resource health crisis.	34,7%	22,8%	11,4%	12,6%	11,4%	7,2%	167
Decisions-making on cost-saving and cost-cutting must be made at district level.	30,5%	21,6%	9,6%	12,0%	14,4%	12,0 %	167
Salary increases must not increase beyond inflation.	12,7%	11,4%	16,9%	29,5%	15,7%	13,9 %	166

Source: Surveyed respondents (2019)

The results above show that the most popular response for the first four solutions was “strongly agree”. These were: staffing moratoria should not form part of cost-cutting measures in the Department of Health (58,7%); National Treasury must increase budget allocation for the Department of Health (66,5%); posts must be unfrozen in all health facilities under the Department of Health; (64,5%) and hospitals must be granted the autonomy to define and decide on which posts they consider critical with a 50,6% frequency. Below is a brief discussion of the perceived solutions to staffing moratoria in the KZN Department of Health.

7.2.1 Increase budget allocation for the KZN Department of Health

In the survey, 66.5% of the respondents strongly agreed, and 24.1% agreed that National Treasury must increase budget allocation for the Department of Health. In the interviews, managers pointed out that the moratoria should not be used as a solution

for budgetary deficiencies in the health sector. One interviewee further clarified that due to financial problems in the sector, the budget was too small to cater for all its demands, with labour being only one of these. The interviewees, therefore, held a view that staffing moratoria were not the best way of cutting costs within the public health sector and also believed that cost-cutting should be left to individual health facilities who can manage the process better, without causing staffing shortages. Furthermore, interviewees also revealed how staffing moratoria had affected their duties, stating that it has disturbed hospital budget management as the Office of the Premier treats hospitals as the department rather than individual health facilities. One respondent stated that:

> "*For me, the department should put in place a minimal staffing level per institution and enforce that so that the institution utilises the minimal staffing levels enforced*." **(Respondent 1)**

The above view shows that rather than capping staffing levels or setting maximum cut-offs, the opposite should be done, with staffing benchmarks being based on a minimum number of employees required to effectively operate various functions within public healthcare facilities. Employees' calls for an increased budget are not in solitude. Viranna (2020) commented on the generally insufficient budgets that the province's public healthcare got from the government. Viranna (2020) further comments that the provincial treasury has to scavenge for funds to support healthcare systems while the Department of Health ended up coming with staffing moratoria. The solution was, therefore, the reprioritization of public healthcare in national and provincial budgeting rather than freezing posts in already understaffed facilities

7.2.2 Filling in of post in the health facilities under the KZN Department of Health

The results from the survey showed a strong view that posts must be unfrozen in all health facilities under the Department of Health, with 64,5% and 21,9% of respondents strongly agreeing, and agreeing, respectively. While executives in the interviewees acknowledged financial challenges in the economy, like most of the respondents in the quantitative tests, they believed that other solutions besides the moratoria ought to be sought. This was because of the negative consequences it had on both staff and patients. The views that staffing moratoria ought to be reversed and more funding

should be allocated to the health sector resonate with the recommendations by RHAP (2016), who asserted that the current budgetary levels were too low to support South Africa's national health objectives. Under the moratorium, efficient resource use was measured by staying below the budget, even if this meant failing to maintain optimum staffing levels (RHAP, 2016). Under the proposed measure of efficiency, this will mean attaining the best possible health objectives with a given budget (RHAP, 2016). Like the interviewees in the study, El-Khatib and Ritcher (2009) also recommended the removal of the moratoria, arguing that they could derail the achievement of important health goals in South Africa.

Furthermore, 43,5% strongly disagreed, and 33,9% agreed that the Department should continue to freeze posts and filling then in only under exceptional circumstances. The respondents in the interviews also did not agree with the view that the Department ought to continue with the moratorium. As already highlighted, they perceived it as a reason behind the shortages of both critical medical staff and support staff. Respondents further expressed that staffing moratoria had failed in ensuring that the hospitals have adequate critical staff, even though it was established to curb excess expenditure on non-critical public healthcare staff.

Further results showed that, in total, 75.6% of the survey respondents were agreeable (with 50.6% strongly agreeing and 25% agreeing) that hospitals must be granted the autonomy to define and decide on which posts they consider critical. The respondents in the interviewees also expressed that hospitals are better able to decide on the posts that needed to be frozen as well as on posts that needed to be left unaffected by staffing moratoria.

This was asserted by a respondent who expressed that:

> *"…We have been pleading that certain posts should be reviewed. Okay we were not consulted or our inputs were not invited. But our argument is what is critical at Ngwelezana is not critical at other hospitals. So the criticality of the post should then depend on the individual institution but till today that approach has not been taken into consideration…"* **(Respondent 7)**

Another respondent emphasised that:

"We were not informed of the criteria, but as I think they thought of the patients. Because if you look at the people that are employed they are directly involved in patient care." **(Respondent 5)**

Thus, based on the above results, hospitals were viewed as being in a better position to define critical and non-critical job openings, depending on their specific staffing needs.

The above findings are also in line with the principles of New Public Management Theory which advocates for decentralisation of decision-making in the public sector. Allowing hospitals at regional level to determine and categorise which posts are critical and non-critical according to hospital individual needs. New Public Management theory believes that decentralising decision making promotes efficiency in the delivery of services in government (McCourt, 2013; Lapuente and Walle, 2020).

7.2.3 In-service trainees as a short-term solution to the problem of staff shortages

In the survey, 34.7% of the respondents strongly agreed with the view that providing more space for university students in need of in-service training to fill the gap caused by the human resource health crisis, could help to ease staffing shortages. Another 22.8% agreed with the same view. However, respondents in the interviews expressed that getting the assistance of students who were training as healthcare staff from tertiary institutions as a short-term solution to the problem of staff shortages, as this would not fully relieve the hospital of staff shortages. Overall, a significant proportion of the sample (57.5%) believed that the above suggestion could work as a solution to current staffing challenges. A study by Bola et al. (2015) confirms that interns can help in reducing the work burden in public healthcare facilities. However, they assert that interns perform well when workloads and working hours are well-managed and effective supervision is provided. Where heavy unsupervised workloads are dumped on interns their contribution towards patient care tends to become a risk.

7.2.4 Decisions-making on cost-saving and cost-cutting must be made at District level

The results from the survey showed that 30.5% and 21.6% of respondents respectively strongly agreed and agreed that decisions-making on cost-saving and cost-cutting must be made at district level. Most survey respondents agreed with the view that

districts must be empowered to do their cost rationing, and therefore, direct funding to areas they felt were critical. This suggests that they did not see the current arrangements where national and provincial health departments and treasuries were responsible for making budgets for District public health facilities. Moreover, this further suggests that districts have a better understanding of local health demands and that they were in a better position to allocate funds, including employment costs, to hospitals more efficiently.

In the literature, the centralised budget and funding systems practised in South African hospitals are also queried. Rosman (2017), like the respondents cited above, believe that decentralisation of the management structures and authority from provincial health departments to actual health facilities can improve resource management and efficiency. Rosman asserts that if hospitals are autonomous, decisions will be made by persons who are directly involved in the day-to-day running of each facility, where this would improve both the speed at which decisions are made and their quality.

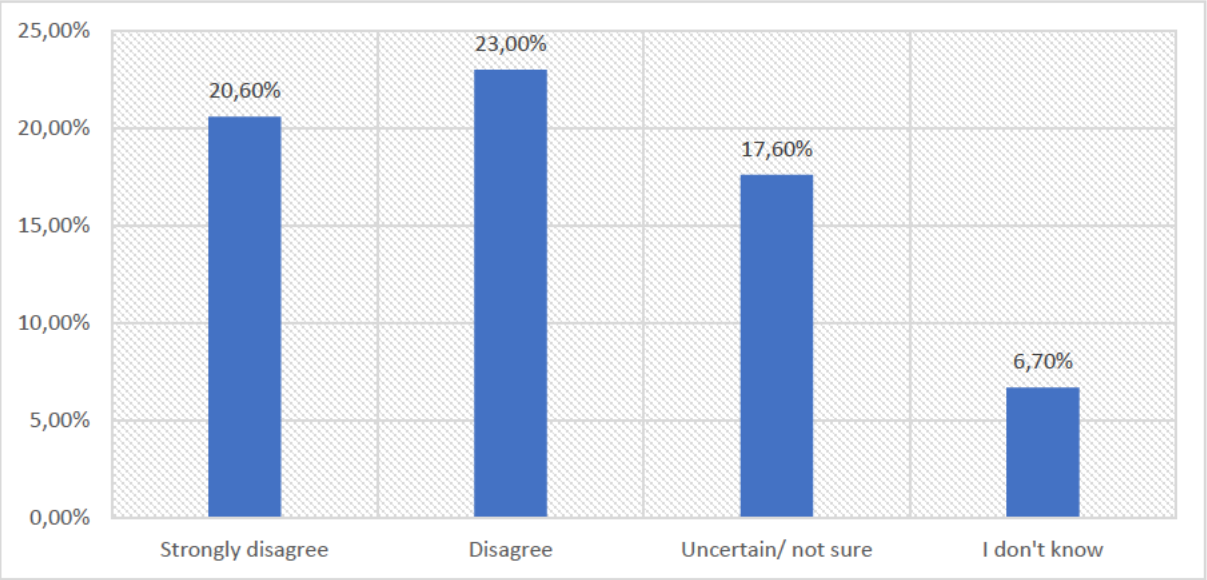
7.3 Task-shifting as a possible solution to staffing moratoria in the KZN Department of Health

This section presents results on the study participants' responses to statements relating to task-shifting as a phenomenon of staffing moratoria and staff shortages in the KZN Department of Health as they affect Ngwelezana Tertiary Hospital.

7.3.1 Task-shifting and training in the KZN Department of Health

Figure 7.1 shows respondents' perceptions of task-shifting as a response to staff shortages in the hospital. The responses were recorded using a Likert scale and respondents were offered a choice of six coded responses, namely: 'strongly agree', 'agree', 'strongly disagree', 'disagree', 'uncertain or not sure', and 'I don't know'. Below are the results.

Figure 7.1: Task-shifting has assisted in increasing health worker training capacity at Ngwelezana Tertiary Hospital



Source: Surveyed respondents (2019)

This statement was presented to assess if task-shifting had resulted in more training opportunities, a feature that would possibly result in fewer staff shortages in the future. Amongst the respondents, 23% disagreed that task-shifting has assisted in increasing health worker training capacity at Ngwelezana Tertiary Hospital, while another 20.6% strongly disagreed with the same statement.

While the hospital had embraced internship programmes and in-service training as a way of increasing staff capacity, these were not long-term enough to fully alleviate skills shortages at the hospital. Personnel trained under the moratoria and task-shifting arrangements were not there to permanently augment the hospitals' staff numbers.

In the literature, several studies conflict on the question of whether task-shifting is a solution for staffing shortages in the healthcare sector. For instance, Fulton et al. (2011) see it as a solution to shortages of qualified healthcare professionals in sub-Saharan Africa. On the other hand, Okyere et al. (2017) doubt the effectiveness of task-shifting as a stop-gap measure for the shortages of professionals in the same Sub-Saharan context. The respondents' views mostly align with those of Okyere et al. (2017), who, like the respondents, doubt the effectiveness or non-effectiveness of task-shifting, just like many studies exemplified above.

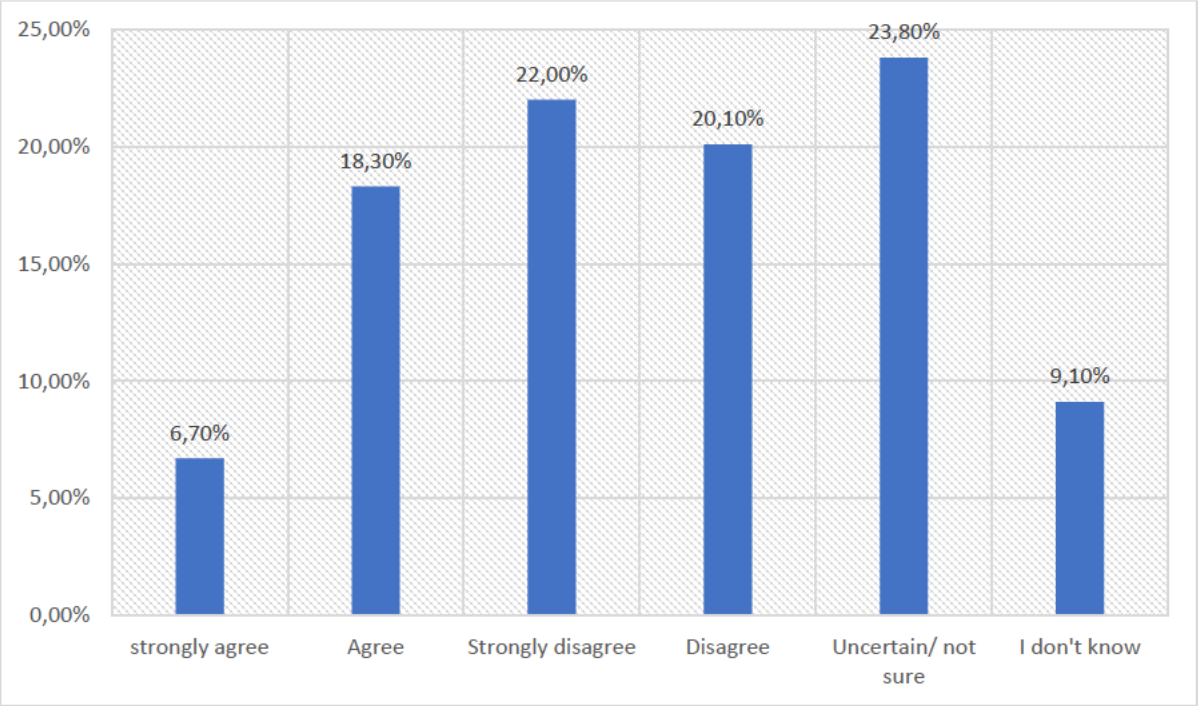
The above results on task shifting as a strategy for healthcare staff shortages concurs with the Manpower Planning Theory. The theory consists of projecting future manpower requirements and developing manpower plans for implementation of the projections. This planning cannot be rigid or static. It is amenable to modification, review and adjustments in accordance with the need of an organisation or the changing circumstances. Similar to this study, healthcare workers at NTH have made adjustments by implementing task shifting in accordance with the changing circumstances caused by freezing of posts and staff shortages facing the department of health in the KZN province. Shifting of tasks from lower level staff to experienced workers is one of the requirements of the MPT which requires the formulation and implementation of strategies that ensure that there is an equilibrium between demand and supply of healthcare labour.

In the theory, if supply of labour is below the equilibrium. supply is less than demand, there is a risk that set health objectives will not be met. At the same time, an oversupply of labour will result in a wastage of scarce resources. Thus is critical to ensure that there is an equilibrium position where supply of healthcare labour is just equal to demand. In the present study, findings suggest that there was no equilibrium between the supply and demand of healthcare workers. Low supply resulted in the shifting of task amongst the available healthcare workers to ensure that the NTH objectives of providing healthcare services to the community was achieved. Although, healthcare services were rendered through the use of task shifting, however, there were challenges facing healthcare workers associated with shifting of tasks.

7.3.2 Shifting tasks to shorter-period trained workers in the Health Department

Figure 7.2 shows the survey respondents' response to the statement: *the shift of specific tasks from highly qualified health workers to shorter-period trained health workers has resulted in the efficient use of the available human resources.*

Figure 7.2: The shift of specific tasks from highly qualified health workers to shorter-period trained health workers



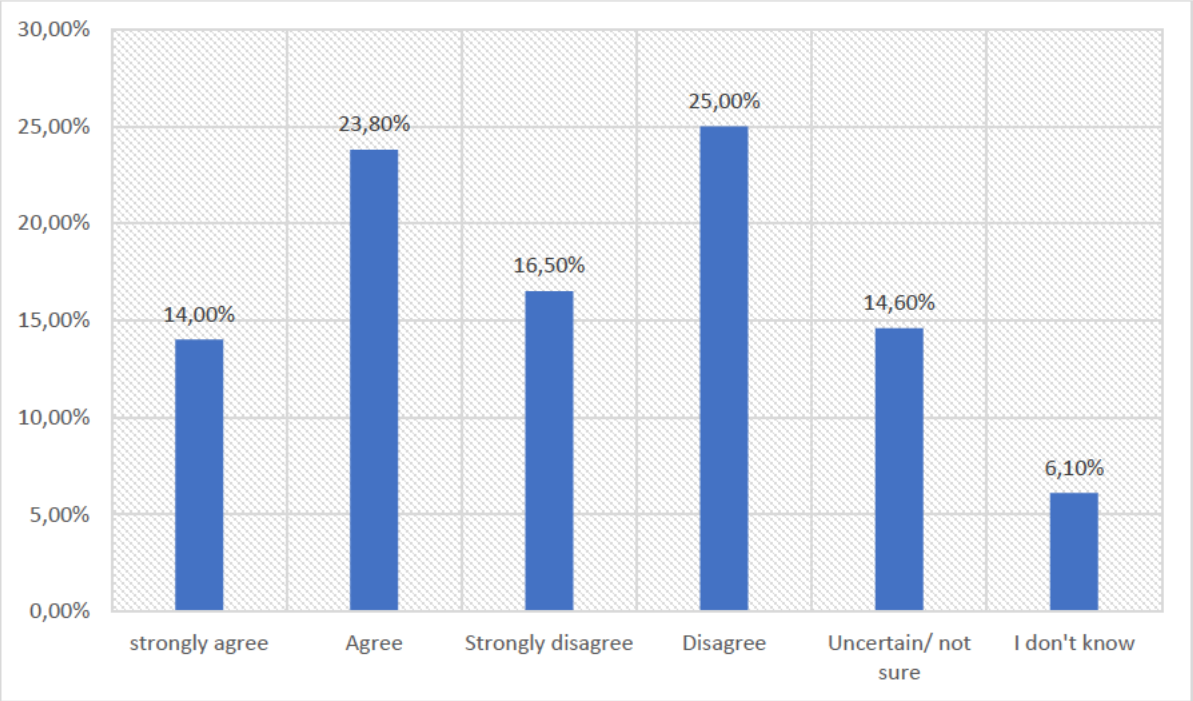
Source: Surveyed respondents (2019)

Figure 7.1 above shows that out of 177, 22% strongly disagreed and 20,1% disagreed that the shifting of specific tasks from highly qualified health workers to shorter-period trained health workers had resulted in the efficient use of the available human resources. This is in comparison to 13,9% who strongly agreed, and 18,2% who agreed with the statement. More respondents disagreed with the statement than those who agreed with it indicating that the shifting of specific tasks from highly qualified health workers to shorter-period trained health workers was not seen as a solution by most of the staff.

7.3.3 Task-shifting and staff shortages in the Department of Health

Figure 7.3 below shows responses to the statement, *Task-shifting has addressed staff shortages in the Department of Health.*

Figure 7.3: Task-shifting has addressed staff shortages in the department of health



Source: Surveyed respondents (2019)

Figure 7.3 above shows that out of 177 respondents, 16.5% strongly disagreed and 25,0% disagreed with the view that task-shifting had addressed staff shortages in the Department of Health. This is in comparison to 14% who strongly agreed and 23.8% who agreed with the statement. More respondents disagreed with the statement compared to those who were in agreement with it.

In the interviews, respondents expressed that task-shifting did not alleviate staff shortages at the hospital. This was because of professional body regulations, as well as the inability to task-shift due to training and experiential factors. Because a specific number of professionals is always required to maintain professionalism in a hospital like Ngwelezana, task-shifting will not help in cases where such a minimum number of professionals is not hired. This was because task-shifting personnel were needed to support professionals. Thus, task-shifting was not regarded as a solution to the staffing problems at the hospital, despite acknowledgements that it played a part in alleviating the same shortages.

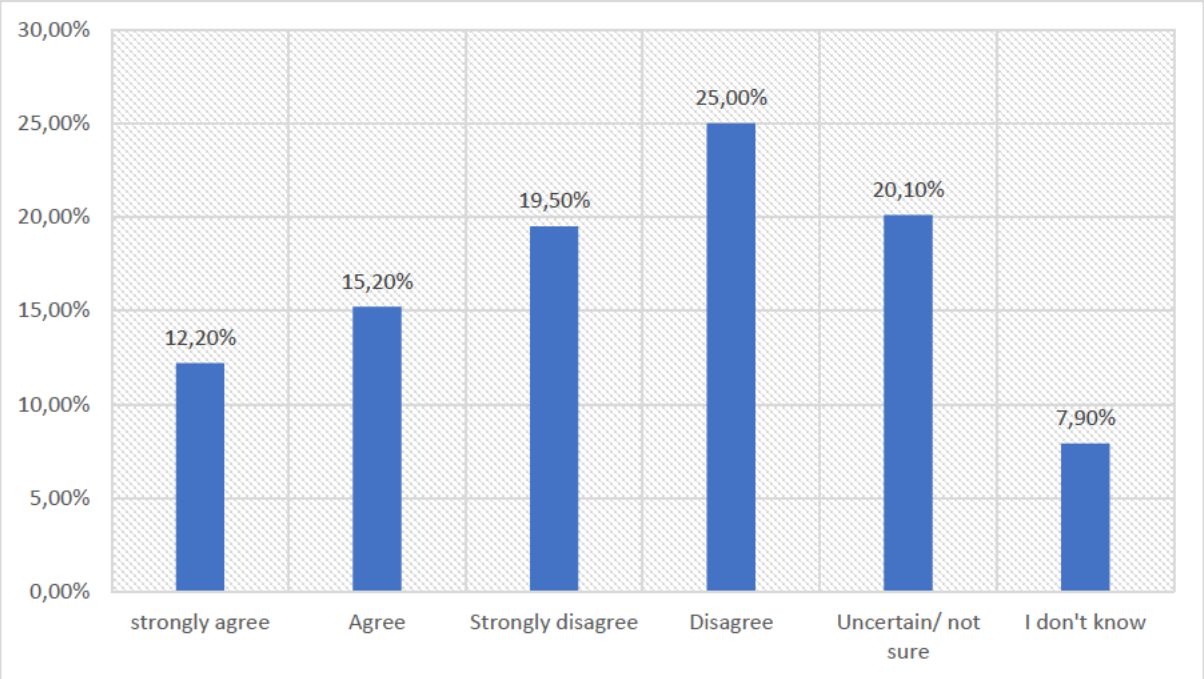
A few studies have been conducted in African countries on the effects of task-shifting on the shortages of health professionals. One by Okyere et al. (2017) found that there

were mixed perceptions on the effectiveness of task-shifting in reducing labour shortages in the health sector. Like in the study, Okyere et al. (2017) concluded that some tasks could not be easily shifted, given the levels of expertise they demanded. This view is shared by one respondent in the interview who indicated that through task-shifting, efficiency and effectiveness that comes with skill and specialisation can be lost if hastily trained or oriented staff are introduced as a solution to labour shortages. Okyere et al. (2017) also concluded that for task-shifting to have a meaningful effect, health facilities must have adequate, co-ordinated training regimes that support skills development in employees to be task-shifted.

7.3.4 Task-shifting as a solution to staff exodus in the Department of Health

Figure 7.4 shows the sample's response to the statement*: task-shifting has reduced work overload caused by the exodus of staff to greener pastures.*

Figure 7.4: Task-shifting has reduced work overload caused by the exodus of staff to greener pastures



Source: Surveyed respondents (2019)

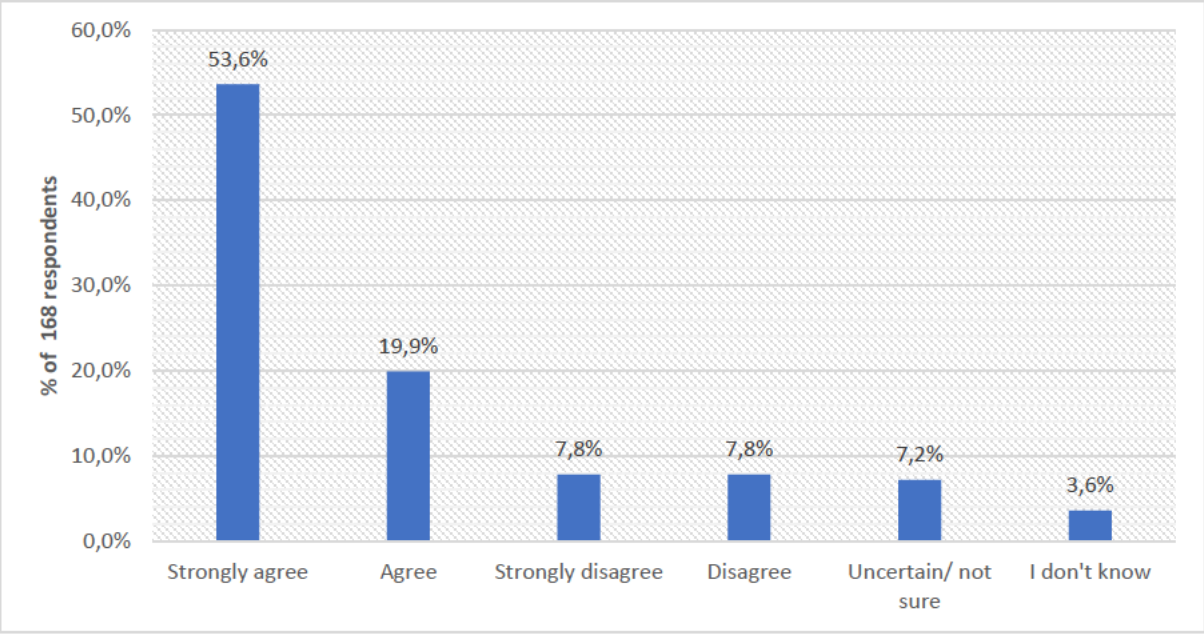
Figure 7.4 shows that from 164 respondents, 25% disagreed, and 19.5% strongly disagreed that task-shifting had reduced work overload caused by the exodus to greener pastures compared to 12,2% who strongly agreed and 15,2% who simply agreed with the statement. One interviewee noted that task-shifting minimally resolves

the problem of staff shortages, where the respondent notes that sometimes, the task cannot be shifted.

7.3.5 Task-shifting and workloads

Figure 7.5 below shows the respondents' responses to the statement*: task-shifting has resulted in staff burn-out and work overloads.*

Figure 7.5: Task-shifting has resulted in staff burn-out and work overloads



Source: Surveyed respondents (2019)

Figure 7.5 above shows that out of 166, 53.6% strongly agreed with the statement, while another 19.9% disagreed with it. Generally, the sample shared the view that task-shifting, as a process, had resulted in staff feeling overworked and burnt out.

The interviewees, like the survey respondents, generally asserted staff was burnt-out regardless of task-shifting. They, therefore, dismissed any views that task-shifting was a solution to prevent medical staff from being overworked.

One respondent expressed that:

> *"I don't think task shifting served the purpose because of a lot of discrepancies and then people are working overtime because there is not enough staff, people are getting sick, prolonged sickness due to workload."* **(Respondent 8)**

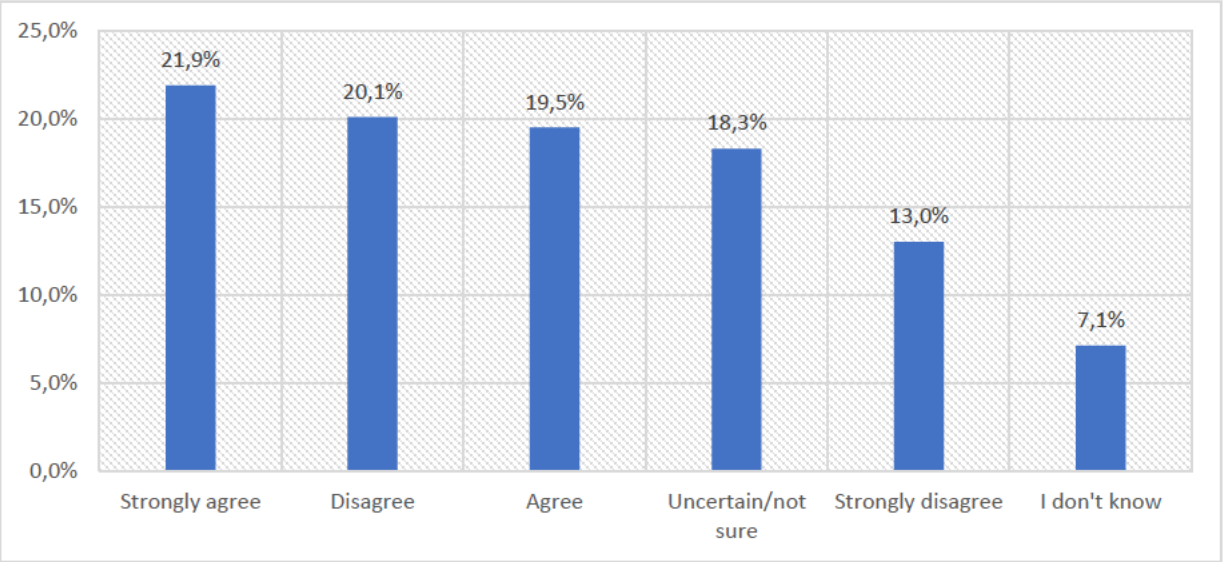
The above view was commonly shared by all except two interviewees, one of whom held a view that their section was not heavily affected by the moratoria in the first place. Thus, the common view from both samples was that there were inadequacies to task-shifting as a solution to the moratoria-induced staff shortages.

Similar to the findings of this study, Ferrinho et al. (2012) also found that task-shifting was strongly associated with work overload. Their study attributed the heavy workloads to multitasking in an attempt to cover gaps created by staff shortages and additional supervisory and oversight functions that professional healthcare workers needed to exercise over non-specialised staff. In the cited study, absenteeism was also discussed as a factor that worsened workloads on the professionals who would be at work. As a result of burn-outs, and sometimes as a result of training regimes that required the attendance of personnel under task-shifting arrangements, nurses had to bear the brunt of carrying out too many responsibilities to compensate for missing staff. This study by Ferrinho et al. strongly relates to the findings from Ngwelezana on the issue of burn-out resulting from task-shifting.

At the same time, several studies point at task shifting as a solution to understaffing and work overloads in public healthcare facilities. Studies carried out in Mozambique show that after task shifting was implemented medical professionals had more time to concentrate on their core duties (WHO, 2014; Rustagi et al., 2015). Even in South Africa, Lumbani et al. (2019) found that task shifting helped to increase healthcare access among hypertension patients while freeing overworked professionals. Spedding et al. (2020) found that task shifting has helped in increasing support to mental health patients in South Africa as it provides more human resources to tackle large work volumes that would otherwise be a burden to a few available professionals.

7.3.6 Task-shifting as a solution to staff shortages in rural health facilities

Figure 7.6: Task-shifting as a solution to staff shortages in rural health facilities



Source: Surveyed respondents (2019)

Figure 7.6 shows that out of 168 respondents, 21.9% and 19.5% strongly agreed and agreed (respectively) that task-shifting has supported or encouraged the implementation and continuation of staffing moratoria, with 20.1% disagreeing and 13% strongly disagreeing with the same view. The results show that most respondents believed that task-shifting had elevated the moratoria although there was also a comparatively sizeable number that did not agree with this. The view that the presence of task shifting as a potential solution to staff shortages has encouraged the department not to replace staff suggests mistrust and disgruntlement over the process.

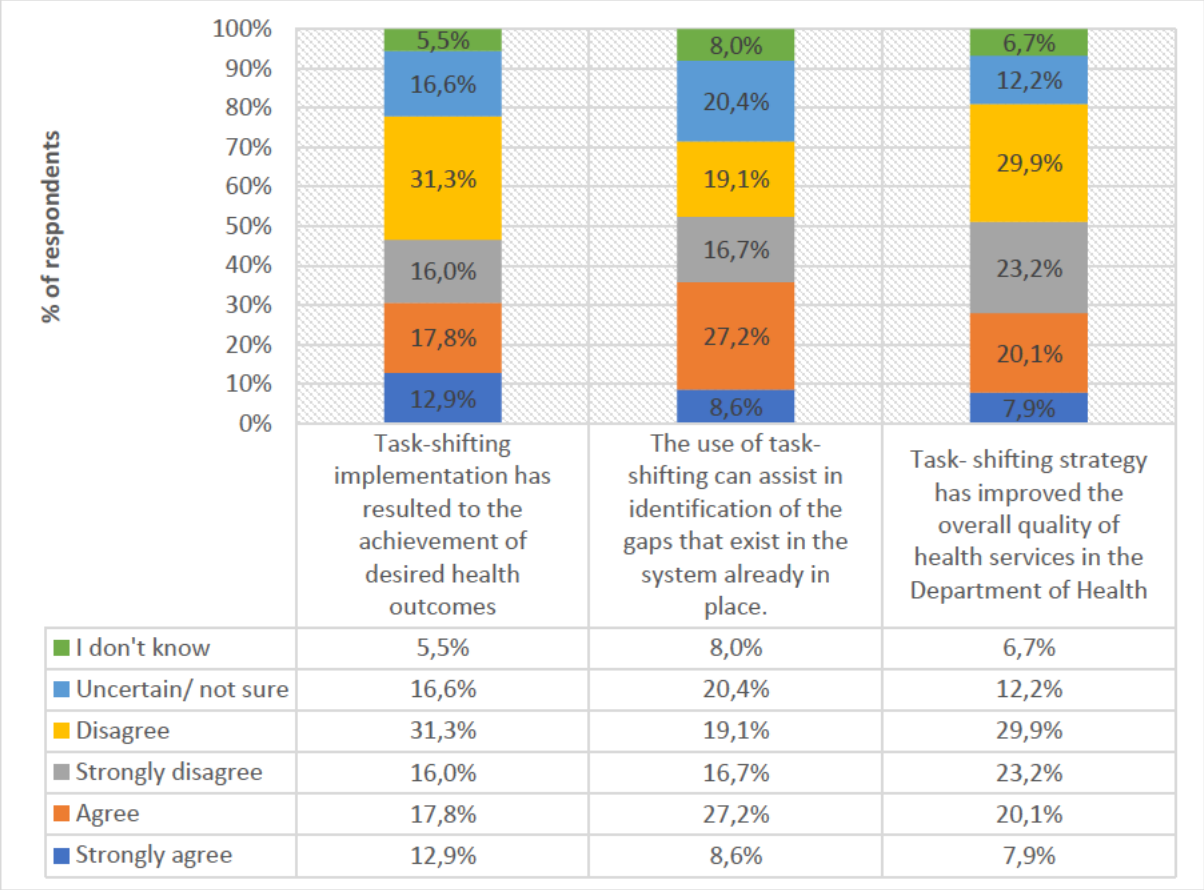
In the literature, there is a stronger view that task shifting should not be a justification for the downsizing of healthcare professionals. Task shifting is mostly viewed as a stop-gap measure that is meant to provide support to professional healthcare workers working under high-pressure and low-resourced conditions (Vaughan, 2015). Vaughan (2015), Polus et al. (2015) and Siedman and Atum (2017) believe that task shifting can reduce public healthcare costs but do not recommend its elevation ahead of hiring skilled staff.

7.3.7 Task-shifting as a public health strategy

Figure 7.7 below provided statements where respondents had to share their perception on task-shifting as a public health strategy. The responses were recorded

using a Likert scale, and were offered a choice of six coded responses, namely: 'strongly agree', 'agree', 'strongly disagree', 'disagree', 'uncertain or not sure' and 'I don't know'. Below are the results from three statements on the efficacy of task shifting in the Department of Health in specific reference to Ngwelezana Tertiary Hospital.

Figure 7.7: Perceptions on task-shifting as a strategy to address staff shortages



	Task-shifting implementation has resulted to the achievement of desired health outcomes	The use of task-shifting can assist in identification of the gaps that exist in the system already in place.	Task- shifting strategy has improved the overall quality of health services in the Department of Health
I don't know	5,5%	8,0%	6,7%
Uncertain/ not sure	16,6%	20,4%	12,2%
Disagree	31,3%	19,1%	29,9%
Strongly disagree	16,0%	16,7%	23,2%
Agree	17,8%	27,2%	20,1%
Strongly agree	12,9%	8,6%	7,9%

Source: Surveyed respondents (2019)

Figure 7.7 above shows that out of 163 respondents, 31.3% disagreed and 16.6% strongly disagreed that *task-shifting implementation has resulted in the achievement of desired health outcomes,* compared to 17.8% who agreed and 12.9% who strongly agreed with the same statement. More respondents, therefore, did not believe that task-shifting had resulted in the achievement of desired health outcomes.

Figure 7.7 also shows that out of 177 respondents, 19.1% disagreed and 16.7% strongly disagreed that *the use of task-shifting can assist in the identification of the gaps that exist in the system already in place*. Comparatively, 27.2% agreed and 8.6%

strongly agreed with the statement. In the above statement, there were almost balanced views on whether task-shifting can assist in achieving the above.

Most respondents, however, did not agree that the *task-shifting strategy has improved the overall quality of health services in the Department of Health*. Out of 164, 29.9% disagreed that a task-shifting strategy has improved the overall quality of health services in the Department of Health, while 23.2% strongly disagreed.

The above statements generally queried the effectiveness of task-shifting as part of health policy at a more external level. Health policies generally target increased access to health at budgeted costs. The sample was equally split on whether task-shifting had effectively contributed towards the attainment of health objectives. Most respondents expressed doubt over whether quality access to health had improved as a goal, while a sizeable number argued otherwise. Scenarios were a large proportion of the sample disputed the effectiveness of task-shifting, while a smaller proportion believed it worked were also produced in studies by Ferrinho et al. (2012). Ferrinho et al. also expressed the view that because task-shifting takes managers from their quality oversight duties and puts them on the frontline, the overall quality of the healthcare system can be put at risk as a result of task-shifting.

In different studies, Fulton (2012), Vaughan (2015), Polus et al. (2015) and Siedman and Atum (2017) task-shifting was perceived as a solution that enables the facilities to enhance healthcare quality amidst staffing shortages. The authors argue that task-shifting can create an efficient mix between labour availability and affordability; factors that can enhance the delivery of services to larger, poorer populations. Studies in South Africa and Mozambique also validate task shifting as a credible solution for staff shortages.

The respondents in the interviews also painted a gloomy picture of the abilities of task-shifting. The respondents expressed that the issue of task-shifting does not resolve the problem of staff shortages, due to the fact that the scope of practice for nursing limits their ability to shift tasks. The response to the question “to what extent has task-shifting been able to address the issue of staff shortage?’, is outlined below.

It was noted that the issue of task-shifting minimally resolves the challenge of staff shortage. Task-shifting among the exempted posts in medical and nursing minimally resolved the issue of staff shortages, because they were limited by their scope of

practice. Within those categories of exempted posts, not all employees would shift tasks, due to the limitations of their scope of practice. Oykere (2017) and the European Commission (2019) discussed the same issue, wherein one's areas of practice and specialty can inhibit a person from effectively serving in a different capacity.

The executives in the interviews went on further to discuss the reasons why task-shifting might not be working as intended in reducing staff shortages. There were views that staff generally resisted task-shifting, where one interviewee associated such resistance to strong unionised labour in the health sector:

> *"On that there is this issue, there are our stakeholders and they are organised labour, and the staff is dependent on organised labour, so it's not easy to take a person and work wherever. You have to make him or her understand because once they report the matter to organised labour it seems as if he was not aware, he doesn't care about this Moratorium."* **(Respondent 4)**

In its 2019 report entitled *Task-shifting and Health System Design: Report of the Expert Panel on Effective Ways of Investing in Health (EXPH),* The European Commission noted that trade unions were a major force behind the resistance of task-shifting, especially in Italy and France. The unions argued that task-shifting exposed patients to risks and encroached the professions of their members. In this study, the role of trade unions is discussed as important in driving the success of task-shifting. In the study, it is noted that unions were highly reluctant to support the process, although some of their members did.

7.4 Association between task-shifting perceptions and department

Table 7.2 below shows the results of the test of association between perceptions on task-shifting and the Department from which one worked.

Table 7.2: Association between department and task-shifting perceptions

Statement	Department	N	Mean	Std. Dev.	Chi-Square	Sig.	Cramer's V	Sig.
Task-shifting implementation has resulted in the achievement of desired health outcomes	FD	10	2.80	1.398	70,5	0,02	0,294	0,02
	HRMD	13	3.00	1.291				
	MSPAM	19	3.58	1.610				
	SMD	15	3.60	1.682				
	NSD	92	3.46	1.362				
	Other	10	3.00	1.764				
Task-shifting has addressed staff shortages in the Department of Health	FD	10	3.10	1.197	68,3	0	0,289	
	HRMD	13	3.38	1.805				
	MSPAM	19	3.63	1.461				
	SMD	16	3.19	1.471				
	NSD	92	3.14	1.434				
	Other	10	2.90	1.969				
Task- shifting strategy has improved the overall quality of health services in the Department of Health	FD	10	3.30	.675	60,2	0,02	0,271	0,02
	HRMD	13	3.46	1.330				
	MSPAM	19	3.53	1.307				
	SMD	16	2.94	.854				
	NSD	92	3.42	1.393				
	Other	10	3.30	1.947				
Task-shifting has assisted in reducing expenditure on employee compensation	FD	10	2.40	1.506	79,3	0,03	0,28	0,03
	HRMD	14	3.29	1.326				
	MSPAM	21	4.10	.944				
	SMD	18	3.33	1.534				
	NSD	92	3.72	1.865				
	Other	10	3.80	1.814				

Use a Likert Scale1 – 6, 1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree and 5 = I don't know, 6 = I refuse to answer

Table 7.2 above indicate that there was a statistically significant association between the statement *task-shifting has addressed staff shortages in the Department of Health* and department (X^2=68.3, p<0.05). MSPAM respondents, on average, were more negative regarding this statement when compared to the other groups. FD respondents had been, on average more inclined to agree with this statement. The association was strong (Cramer's V=0.294, p<0,05).

Chi-square tests showed a statistically significant association between respondents' departments and the statement *task-shifting strategy has improved the overall quality of health services in the Department of Health* (X^2=60.2, p<0.05). *FD, HMRD and NSD respondents on average, leaned towards the strongly disagreed option in comparison to the other groups.* Cramer's V tests showed a strong association between department and this factor (Cramer's V=0.271, p<0.05).

There was also a statistically significant association between the statement *task-shifting implementation has resulted in the achievement of desired health outcomes* and department (X2=70.5, p<0.05). NSD respondents, on average, strongly disagreed with the statement *task-shifting implementation has resulted in the achievement of desired health outcomes.* FD respondents had been, on average more inclined to agree with this statement. The association was strong (Cramer's V=0.294, p<0,05).

The Chi-square between the statement, task-shifting has assisted in reducing expenditure on employee compensation and department was 79.3(p<0.05). FD respondents were more inclined towards the "strongly agree" response compared to other groups. HRMD respondents, on average, strongly disagreed with the statement while NSD respondents agreed. The tested associations had a Cramer's V of 0.28(p<0.05). and were therefore strong.

7.5 Management level and perceptions on task-shifting

Chi-square test of association between management level (non-managers versus managers) and perceptions on task-shifting were all statistically insignificant (p>0.05). The statements tested for this association are shown in Table 6.3 below.

Table 7.3: Statistically insignificant Chi-squares

Statement	x p-value
The issue of task-shifting, Task-shifting has assisted in elevating staffing moratoria at Ngwelezana Tertiary Hospital.	p>0,05
Task-shifting has resulted in staff burn-outs and work overloads.	p>0,05
Task-shifting has assisted in increasing the capacity of training for health workers at Ngwelezana Tertiary Hospital.	p>0,05
Task-shifting implementation has resulted in the achievement of desired health outcomes.	p>0,05
The use of task-shifting can assist in the identification of the gaps that exist in the system already in place.	p>0,05
The shift of specific tasks from highly qualified health workers to shorter-period trained health workers has resulted in the efficient use of the available human resources.	p>0,05
Task-shifting has addressed staff shortages in the Department of Health.	p>0,05
Legal and regulatory restrictions has limited the implementation of task-shifting in the Department of Health.	p>0,05
Task-shifting strategy has improved the overall quality of health services in the Department of Health.	p>0,05
Staffing moratoria severely affected facilities that are situated in rural areas more than those in urban areas.	p>0,05
Task-shifting has reduced work overload caused by the exodus of professional staff to greener pastures.	p>0,05

Source: Surveyed respondents (2019)

The table above shows that there were no statistically significant differences between how managers and their subordinates responded to the following statements. On the issue of task-shifting: *task-shifting has assisted in elevating staffing moratoria at Ngwelezana Tertiary Hospital*, and *task-shifting has resulted in staff burn-outs and work overloads*. With regards to the first statement, 20.9% of the respondents strongly agreed, and 18.6% agreed. With regards to the second statement, 25% of the respondents disagreed, and 19.5% strongly disagreed. Importantly, there were no

statistically significant differences between how managers or their subordinates responded to the statement. Thus, managers and their subordinates shared the same sentiment on these statements.

The managers and non-managers also did not show statistically significant differences on the following statements, *namely that task-shifting had: assisted in increasing the capacity of training for health workers at the hospital* (disagree 23%, strongly disagree 20.6%); *resulted in the achievement of desired health outcomes* (disagree 23%, strongly disagree 20.6%) and *assisted in the identification of the gaps that exist in the system* (disagree 19.1%, strongly disagree 16.7%).

Likewise, managers and non-managers did not have statistically significant differences regarding their perceptions of how task-shifting had: *assisted in the shifting of specific tasks from highly qualified health workers to shorter-period trained health workers resulting in the efficient use of the available human resources* (uncertain 23.8%, strongly disagree 22%); or *addressed staff shortages in the Department of Health.*

Other non-significant differences were observed on the following statements: *Legal and regulatory restrictions have limited the implementation of task-shifting in the Department of Health* (disagree 25%, uncertain 23.8%); *had improved the overall quality of health services in the Department of Health* (29.9% disagree, 23.2% strongly disagree); and *had reduced work overload caused by the exodus of professionals to greener pastures* (25% disagree, 20.1% uncertain). It can be noted that the modal responses in the above statements were ‘strongly disagree’ and ‘disagree’. Thus, both managers and non-managers tended to disagree or strongly disagree in a manner that did not differ. The managers and non-managers also did not show statistically significant differences in how they responded to the statement: *staffing moratoria severely affected facilities that are situated in rural areas more than those in urban areas*, where the modal response was ‘strongly disagree’ followed by uncertainty.

The results show that the two groups shared similar views that task-shifting was not as beneficial as intended, and was not a total solution to the staffing challenges caused by staffing moratoria. They also shared a common view that rural areas were hardest hit by the staff shortages that came with the moratorium. This further indicates that the perceived ineffectiveness of task-shifting, as a solution to staff shortages was not a

management problem and was certainly not a non-management problem but a challenge that affected both groups.

The above findings on insignificant chi-squares to some extent go against the findings by Ferrinho et al. (2012) who reported that managers and non-managers were affected differently by task-shifting. In the study by Ferrinho et al. (2012) conducted in Zambia and Mozambique, staff of different levels showed distinct experiences and therefore perceptions on task-shifting as a solution to healthcare staff shortages. Ferrinho et al. report that in the Mozambican setting, where managers felt the burden of task-shifting the most, considering that they were the ones accountable for poor service delivery in facilities.

This occurrence did not amuse most managers, as they also remain answerable to challenges that may occur as a result of losing oversight non-specialised healthcare workers (Ferrinho et al. 2012). In the same study, care providers held negative perceptions of task-shifting, although their perceptions were not as strong as those of managers. Support staff generally viewed task-shifting as a positive move in their careers, and were, therefore, more pleased and motivated by this development.

7.6 Towards a process for improving health service delivery at Ngwelezana Tertiary Hospital

In this section, challenges on the implementation of task shifting at Ngwelezana Tertiary Hospital under the guidance of the KZN Department of Health are discussed. The researcher notes that task shifting, despite being labelled ineffective could work for the hospital if contextual issues are addressed. The above conclusion stems from the finding that the implementation of task shifting in the hospital faced an element of resistance from workers and the unions. This resistance is hinted to be behind some of the perceived failures of task shifting and findings that are generally in contrast with those that note it to be a possible solution to staff shortages in the public healthcare industry.

Deller et al. (2015), like this study, also found that task shifting can be resisted by groups fearful that their professional territory could be encroached by non-professionals. Also, similar to the findings of this study, Deller et al. (2015) also noted that It is difficult to implement task shifting without a clear regulatory framework that among other things addresses the risks in fears of task shifting. Baine and Kasangaki,

(2014), Rustagi et al.,(2015) and Seidman and Atun (2017) are among the many scholars who believe that for task shifting to work effectively, several internal and external factors needed to be addressed. These factors include training, supervision, stakeholder buy-ins and already-mentioned regulatory changes.

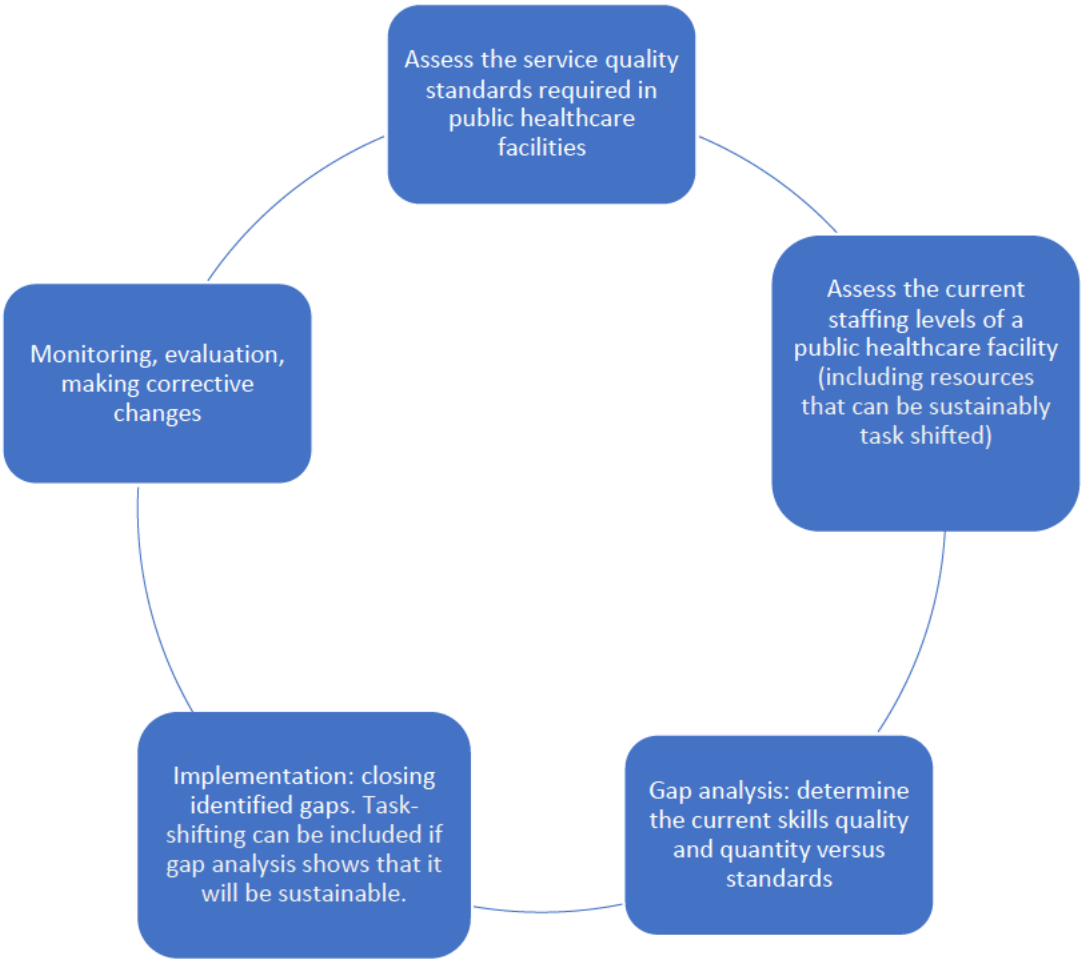
In the literature, Kotter's change management theory was discussed from a task shifting context. Task shifting was seen as an aspect of organisational change that could be managed using various change management concepts. Looking at task shifting as a change management issue and drawing upon Kotter's change management process as discussed by Shore (2014) and Lv and Zhang (2017), firstly there was a need to justify why task shifting was a necessity to the hospital and why it was immediately needed. Secondly, the department's leadership and hospital management needed to establish a multi-stakeholder coalition that would guide the development and implementation of task shifting protocol. This coalition would work towards implementing and instituting acceptable change.

Deller et al (2015) identified five key factors that organisations implementing task shifting needed to carefully consider. These factors are that task shifting must be based on a formal regulatory framework, a systematic identification of tasks that needed to be shifted, skills assessment, skills development and the management of task shifted resources. The World Health Organisation also advised on how major changes within public healthcare systems should be principled. WHO's guidelines put evidence-based and objective needs assessment as a critical process when implementing changes like both staffing moratoria and task shifting. WHO (2000), like Rustagi et al.(2014) encourages a multi-stakeholder approach that involves all parties concerned, an aspect that seems to be lacking in the Ngwelezana Tertiary Hospital approach. WHO (2000) also lists effective leadership and communication as crucial for the success of planned change. From the empirical study, evidence of poor relations between management and staff as well as poor communication and consultation are rampant in the survey scores and interview narratives. Finally, WHO (2000) states that change should be transparent and open in the drivers of change should indicate the possible risks and dangers of coming change. The above change prerequisites are not very evident in the Ngwelezana Tertiary Hospital case. The following section presents a skills management framework proposed from the study.

7.6.1 Framework for managing skills availability

This study proposes a five-step process in correcting and managing staff skills availability. The proposed process is based on the recommendation that staffing moratoria, as currently applied, is not a sustainable solution to public health challenges and should therefore be changed and be implemented more inclusively. Public healthcare facilities should be empowered to manage skills supply and demand gaps versus allocated budgets. However, in doing so, there is a need for them to be fully accountable of health personnel budgets they incur. The goal of this proposed process is to guide the development of policies and strategies that ensure that at any given time, a public hospital will have the right quality and quantity of critical and non-critical human resources. The process proposes steps to objectively determine the minimum number of professionals required to ensure that public healthcare facilities meet their clinical standards and the *Batho Pele* principles.

Figure 7.8: Proposed process for improving health services



Source: Author's own construction (2020)

The above proposed process borrows from gap analysis processes. It attempts to balance between conflicting interests of cost-cutting within government versus service delivery as is discussed in the sections below.

Step 1: Assess the service quality standards required in public healthcare facilities

This step involves engaging stakeholders including medical staff, non-medical staff, union representatives, facility executives, community representatives among others in the identification and assessments of service delivery standards in a public healthcare facility. At this stage, data can be collected using performance appraisal reports, surveys, interviews, and internal documents such as strategies and policies. Standards that should be considered include:

- number of professionals per number of patients;
- the sustainability of task-shifting (availability of task-shifting staff, resistance and challenges to the process);
- facility capacity (number of patients per category that can be handled per unit of time);
- mortality rates;
- service turnaround times;
- rates and frequencies of medical errors;
- Department of Health standards for facilities of certain classes; and
- general community expectations.

The above indicators are discussed as important organisational performance indicators in healthcare facilities by various scholars including Markic (2014), Khalifa and Khalid (2015) and Wu (2015).

From a community stakeholder perspective, Batho Pele principles listed below will be used as standards, where a facility determines the degree or level to which it would meet each of the eight principles:

- consultations with patients;
- service standards for patients;

- accessibility/access to service by patients;
- courtesy to patients;
- the free dissemination of information to patients;
- openness and transparency of services;
- redress to patients complaints; and
- value for money to paying patients.

Data on this must be collected from the communities that use the facilities and can be collected through the use of short post-service evaluations through questionnaires.

The first stage of the framework takes WHO's (2000) guideline that public healthcare change must be guided by objective and inclusive information and evidence. It also takes Kotter's change management model in relation to building coalitions that will ensure the urgency. inclusivity and acceptability of change.

Step 2: Assess the current staffing levels of a public healthcare facility

The second step of the proposed process is consultative and data gathering in nature. Before implementing staffing moratoria, it is important to assess the current supply versus demand of critical and non-critical staff within a public medical facility. The first step of the assessment will require the input of individual public health facilities that will:

- perform a skills audit of available skills in the facility;
- assess the adequacy of these skills in meeting set health indicators and goals, including number of doctors and professionals per 10 000 persons;
- determine whether there is a shortfall or surplus of resources;
- determine whether and how task-shifting can be effectively deployed as part of the skills deficit gap; and
- present budget scenarios required to maintain a skills demand and supply equilibrium (the position where the number of skills available is equal to the number of skills needed).

For the skills audit to be effective, minimum skills standards and standards on staff sizes in medical facilities need to be set. This standard setting exercise should be

based on research output and should be administered by an external health skills consultant to avoid internal biases.

The logic behind this step is that if there is already a shortage of staff at a hospital, imposing a moratorium would not be necessary, as it would further worsen the staff shortages burden a hospital will be going through. However, if there is an oversupply of staff, restrictions on hiring additional staff may be justifiably imposed on skills classes that are reported to be in excess supply.

At the same time, if there is a deficit in human resources, the potential impact of task-shifting in alleviating this deficit should be objectively assessed. While task-shifting is discussed as part of the solution to skills deficits in the healthcare sector, this step ensures that institution-specific factors are taken into account. This skills audit should assess the feasibility of task-shifting, including:

- the availability of staff that can be effectively shifted without compromising service standards;
- the legal implications of task-shifting certain staff and how they are to be managed;
- the management of common task-shifting risks, including improper training and supervision; and
- the potential impact of task-shifting on team morale and how negative impacts of morale can be managed.

The skills audit process should also ascertain the minimum number of critical and non-critical staff required to support a given number of critical medical staff in a bid to meet the established public health indicators and standards within a public health facility. The skills audit will also guide public health authorities to set a minimum number of non-critical staff that is required to efficiently support a facility based on the work demands determined in the first step, as well as the involvement of non-critical staff in offsetting the work-burden of critical staff. The logic behind this step is that some so-called non-critical staff may be directly involved in critical work, including under task-shifting or other staff development arrangements. As noted in the empirical study, freezing their posts without considering this will result in staff shortages among the critical staff they support.

The second step takes the MPT's objective manpower planning aspects into consideration. It also considers Deller et al's (2015) advise that task shifting, as a process, should be implemented upon assessing the capacity and readiness of the available staff to be shifted.

Step 3: Gap analysis: Determine the current skills quality and quantity versus public health facility standards

The third step includes assessing the identified skills quality and quantity gaps versus required clinical standards or public health facility standards. Theoretically, such standards will be linkable to the eight *Batho Pele* principles within public health establishments. At this stage, a public health facility should be able to answer the following questions:

- are the current skills adequate to meet clinical standards?
- are the current skills adequate to meet Batho Pele principles?
- what are the factors that are affecting the realisation of set standards?

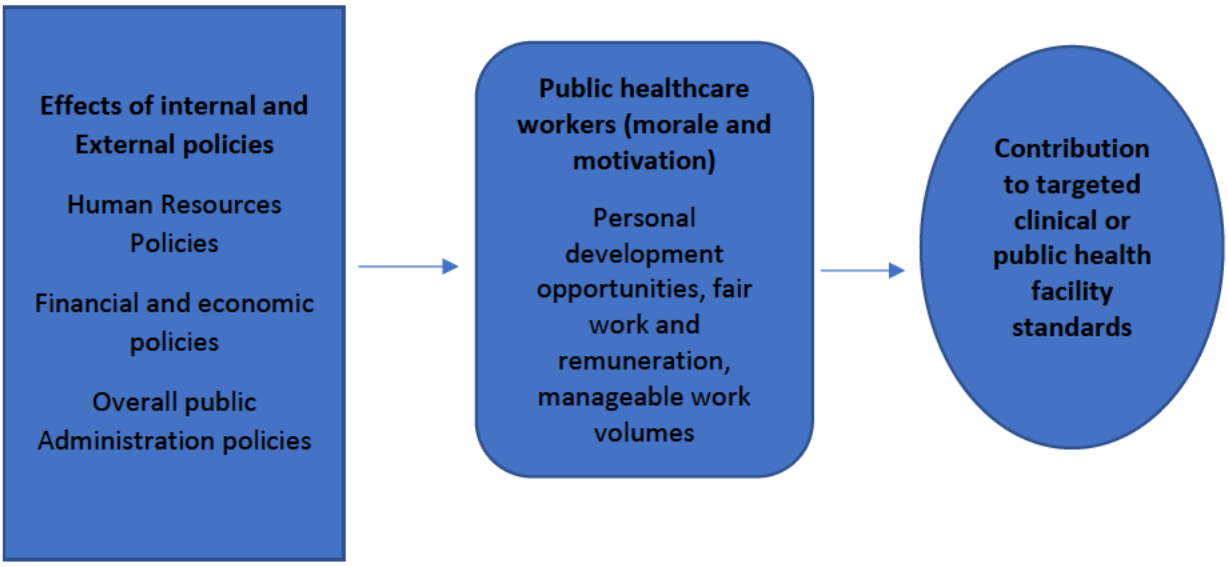
a) Skills volumes

The results of the assessment will show whether the skills quantities are adequate to meet required standards. This involves the quantification of available skills in numbers and noting the gap between the actual and the desired skills quantities.

b) Skills quality

This level is proposed based on the findings that skilled staff's engagement to perform depends on other motivational and work environment factors. It is premised on the findings that the ability of public healthcare staff to perform optimally is influenced by morale, which is a function of policies and factors from the work environment, in this case, the staffing moratoria. An analysis of staff's morale level should therefore be performed using surveys, interviews and focus groups. This stage therefore provides data on the commitment and capacity of the skilled resources to work towards set standards, *Batho Pele* included. This is illustrated below:

Figure 7.9: Internal and external policies' effect of public health standards



Source: Author's own construction (2020)

The above illustration is part of the gap analysis stage that utilises findings from this study as a guide to frame investigative questions to determine if skills quality issues, especially staff morale, are fine-tuned to contribute towards the realisation of public health goals at the hospital. It challenges the gap analysis process to take an inclusive and comprehensive approach that looks beyond the internal facets of the Hospital.

This stage is important in assessing how the current state of human resources, including issues of staff morale, motivation and commitment also affect the achievements of standards within a public health facility, as shown in the above illustration. In addition, it also assesses the extent to which internal strategic issues, including financial policies, organisational structure, and stakeholders affect the quality of skills. The stage is motivated by the findings from the study that showed that it was not only the numbers of professionals that determined service quality standards but also the state of the professionals, including their engagement and commitment to duty as a function of staff morale.

Step 4: Implementation of flexible staffing moratoria: Closing identified gaps

The fourth stage is the first stage in the actual crafting of policies and strategies that are aimed at closing gaps on the skills quantity and skills quality. The solutions proposed will depend on the output from the data gathering exercises and analysis above, namely the skills audit and the assessments of standards. As noted in the

study, moratoria-related gaps are caused by both internal factors such as overall public administration policies, and internal factors relating to how individual medical facilities respond to broad government policy.

a) Skills quantity gaps

In the long-term, public health facilities will need to address shortages in skills through the hiring and training of personnel. In the short-term, as highlighted in the findings of the study, temporary skills support arrangements including task shifting, internships, and in-service trainees can be applied although with the acknowledgement that these are just short-term measures necessary to support services standards during the personnel gap adjustment periods.

b) Skills quality gaps

Skills quality gaps noted in the study include low morale in personnel that will also need to be addressed through implementing the measures that are necessary in creating a pleasant working environment. Important aspects that the study found and that public health facilities should consider include:

- employee-to-management relationships;
- employee-to-employee relationships;
- working and rest hours;
- opportunities for personal development;
- fair remuneration for excess hours worked; and
- acknowledgement of out-of-contract roles and responsibilities.

c) Setting a budget

This involves coming up with a budget that supports the staff required to ensure that the facility meets its service goals. The proposed process, as shown above, proposes that a budget should come after, rather than before, the determination of staffing needs. That way, facilities are not forced to cut-off important positions in response to budgetary constraints.

The budgeting step involves balancing the considerations of the various stakeholders, including the medical staff, whose work burden might be affected by the reduction in the numbers of non-critical staff. The proposed process proposes a “flexible

moratorium" that is implemented from within each individual facility, taking the facility-specific labour supply and demand dynamics.

Step 5: Monitoring, evaluation, making corrective changes

Finally, the implemented policies will need to be monitored and evaluated to ensure that goals and targets on staff morale, personnel adequacy, and budget uses among others are met. From a service perspective, Batho Pele principles can be used as one of the monitoring guidelines. In the long-term, it must be expected that the set clinical standards may change. Personnel-related issues are also expected to change. This prompts the conducting of baseline data collection activities discussed regularly, for instance once every year. For this reason, this proposed process is presented in a cyclical form. This will ensure the changing of budgetary allocation in response to changing employment and community needs.

It can be noted that the proposed process hinges upon four principles: objectivity, consultation, health prioritisation, decentralisation and continuous improvement. Starting with objectivity, all decisions on cutting or expanding of staff, as well as the impact of these decisions, must be objectively determined through reliable applied research and evaluation processes. This reduces the risk of arbitrary decisions that include imposing moratoria on systems that may already be struggling with staffing shortages. The whole process is highly consultative. This is because inputs for decisions on the process include data from multiple external and internal stakeholders. these groups must be consulted to ensure that the implementation of this process, unlike staffing moratoria, faces little resistance. Thirdly, the proposed process attempts to reconcile the conflict between economics and health by prioritising health goals in situations where economic reasoning clash with objectively drawn health-related conclusion like the need to increase medical professionals in public healthcare facilities. As a principle, decentralisation would empower public healthcare facilities, but would mean varying levels of power in managing staff budgets. Finally, the process accommodates the fact that there will be a constant need for adjusting the budgeting and health planning processes, given the dynamism in society.

The proposed steps above resonate with NPM principles on the efficient and effective use of public resources as they ensure neither an understaffed nor overstaffed scenario in public healthcare facilities. NPM principles are further reinforced by the

use of objective assessments in making public sector decisions that promote the efficient allocation of resources (Robinson, 2015). The precepts of the MPT are strongly evident in the forecasting and planning of manpower quality and quantity needed to meet predetermined organisational theory. The stages also accommodate WHO's guidelines on organisational change processes in the public healthcare sector specifically:

- Change should be systematic and should be based on the results of objective research
- Change formulation and implementation process should be inclusive taking into account all concerned stakeholders
- Change should be supported by highly responsive leadership
- Change should be supported by effective, simple communication
- Change should be transparent and open in the drivers of change should indicate the possible risks and dangers of coming change.

Given the wide empirical and secondary source consultations done in crafting the above framework, the researcher believes it could be of much use to the public healthcare sector in South Africa.

7.7 Conclusion

In the chapter, it was evident that most respondents believed that better budgeting mechanisms including the decentralisation of budgeting processes could be implemented to reverse the skills shortages that came about as a result of the moratorium. Task-shifting was also widely discussed as having no major impact on staff shortages, with respondents further associating this with even more problems, particularly burn-out amongst staff, legal and professional risks, and staff morale issues. However, there was also evidence that some negative views on task shifting stemmed from resistance to the process.

Health professionals are forced to engage in task-shifting, with most professionals taking on lower-level tasks, although scenarios of personnel taking higher-level responsibilities were also reported. Personnel were therefore shifting up and down, depending on the situation resulting in an overworked, poorly motivated staff. Task-shifting, as a proposed solution of the moratoria, has not been a very successful

remedy to staff shortages emanating from the moratoria. Staff at all levels, including executives, still shared a common view that the ultimate solution to staffing problems lay in the reversal of the moratoria, and in empowering public healthcare facilities more autonomy in hiring necessary staff.

Finally, the chapter presented a process on the development and implementation of personnel management strategies and health personnel budgets in public health facilities. The construction of this proposed process was based on the findings of this study, and on the literature reviewed. The aim of this process is to guide the development of policies and strategies in the KZN Department of Health and the health sector at large, that ensure that at any given time, a public hospital will have the right quality and quantity of critical and non-critical human resources at a determined budgetary provision. The next chapter provides conclusions and recommendations that are based on the objectives that were outlined in the first chapter of this study.

CHAPTER EIGHT: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

The study aimed to investigate the implications and possible responses to the effects of staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal. In the previous two chapters, data collected for the study were analysed and discussed. This chapter provides conclusions on these findings. The chapter also provides recommendations on how to address staffing moratoria challenges in the Department of Health. The chapter concludes with the limitations of the study and a brief overview of areas for further research. The study had five research questions, and these were:

- What impact does staffing moratoria have on healthcare service delivery at the Ngwelezana Tertiary Hospital?
- What are the factors that led to the implementation of cost-cutting measures and staffing moratoria at the Ngwelezana Tertiary Hospital?
- What are the current working conditions and challenges that are faced by the healthcare workers under staffing moratoria at the Ngwelezana Tertiary Hospital?
- To what extent has task-shifting been able to address the issue of staff shortages at the Ngwelezana Tertiary Hospital?
- What framework can guide the KZN Department of Health in the implementation of staffing moratoria in the province?

The next section summarises the findings relating to the above research questions.

8.2 Summary of major findings

Overall, both survey and interview respondents at Ngwelezana Tertiary Hospital perceived staffing moratoria as a post-freezing and a cost-cutting process. A considerable percentage of respondents saw staffing moratoria as a response that had nothing to do with budgetary issues but with the poor ethical issues within the public health management system both at the hospital and across the province. Despite the implementation of the moratoria, most respondents believed that budget reduction and the curtailing of overspending, as objectives, had not been met by the KZN Department of Health.

The direct impact of the staffing moratoria were a total reduction of staff in all departments, at all levels and among both medical and non-medical professions at NTH. It emerged that managers and non-managers, as well as medical and non-medical staff, were taking additional roles and responsibilities in response to the diminished number of employees because of staffing moratoria.

The freezing of posts at NTH has negatively affected staff morale and in turn, staff engagement levels. Most respondents believed that staffing moratoria had resulted in absenteeism, due to staff fatigue. The study found that working conditions before staffing moratoria were perceived to be much better, and comparably pleasant than working conditions after the implementation of staffing moratoria. The common grievances of healthcare workers in this study were working with little or no rest, working longer than expected hours, being delegated too much work to handle, doing work that was not on one's job description and feeling exploited by the situation. Staffing moratoria also had a negative impact on staff retention, staff development (as employees did not have time to attend studies or training) and had caused a deterioration in the relationship between managerial and non-managerial teams.

Furthermore, staffing moratoria were blamed for poor and deteriorating service at Ngwelezana Tertiary Hospital. They had resulted in longer waiting periods for patients, increased mistakes among healthcare workers due to increased work pressure, poor patient management and increased patient mortality. Moreover, staffing moratoria had a negative impact on the achievement of all the Batho Pele principles at Ngwelezana Tertiary Hospital with value for money, consultation to patients, service standards, and dissemination of information being classified as the most affected. Thus, in an attempt to improve service quality and customer engagement under the New Public Management precepts, value to clients has ironically gone down.

From the results, the most common perceptions on possible solutions to staffing moratoria were that: they should not form part of cost-cutting measures in the Department of Health; the National Treasury must increase budget allocation for the Department of Health; posts must be unfrozen in all health facilities under the

Department of Health, and hospitals must be granted the autonomy to define and decide on which posts they consider critical.

With regards to task-shifting as a possible solution to staffing moratoria and staff shortages, the common views were that task-shifting had not increased the hospitals' training capacity. Most of the study's participants also did not believe that the shift of specific tasks from highly qualified healthcare workers to shorter-period trained healthcare workers has resulted in the efficient use of the available human resources. There were more employees and managers in this study who believed that task-shifting had not addressed staff shortages in the Department of Health than those who believed that it had. Also, more participants believed that task-shifting had not relieved them of work overload and had actually resulted in employee burnouts. Thus task-shifting was not perceived to be a tangible solution or even a stopgap measure for the skills quality and quantity challenges that came with the implementation of the moratoria. At the same time, it was noted that resistance to task shifting had affected its potential as a solution to staff shortages at the hospital.

8.3 Review of research objectives

This section summarises the findings relating to the study's research questions.

8.3.1 To examine the impact of staffing moratoria on healthcare service delivery at Ngwelezana Tertiary Hospital

The results of this study revealed that staffing moratoria had a negative impact on all Batho Pele principles, especially value for money, service delivery, and information provision. It also increased mortality rates and medical incident risks. Service delivery at Ngwelezana Tertiary Hospital had therefore suffered since the implementation of staffing moratoria. This finding is not new to broader public health research, as scholars like RHAP (2015) and Maphumulo and Bhengu (2019) have reported similar results. Also, case studies of Greece, Zimbabwe and Ireland share similar conclusions on the deterioration of service standards as a result of healthcare staff recruitment freezes. The moratorium in the freezing of posts, therefore, is a high-risk trade-off between service quality and cost-cutting. The trade-off is however felt by the district's socio-economically vulnerable groups that cannot afford other health access alternatives. With rural communities being already vulnerable to health risks due to

inequality and poverty, staffing moratoria adds another challenge and burden to such communities.

8.3.2 To ascertain the factors that have led to the implementation of cost-cutting measures and staffing moratoria at the Ngwelezana Tertiary Hospital

From the participants' perspective, cost-cutting measures and staffing moratoria were a response to the need for more conservative budgets given the decreasing levels of funding in the National Department of Health. Some shared the view that staffing moratoria were a response to poor financial management, rather than declining budgetary support for the public health sector. While the participants mostly shared the view that staffing moratoria were a direct response of government austerity, the existence of doubtful views to this suggests mistrust between the provincial government and its health sector employees, as well as the need for dialogue and engagement as a way of establishing a commonly-shared view of the moratorium as well as the way forward.

In the literature, staffing moratoria were mostly a result of increasing government austerity in response to economic challenges. In the case of Greece, the global economic crisis of 2008 and the European debt crisis that followed resulted in near bankruptcy for the government (Economou et al.,2014). The Greek government was forced to cut public sector expenditure including employment costs resulting in staff freezes. Similarly, Zimbabwe introduced staff freezes in the public healthcare sector in response to severe and protracted macroeconomic challenges (Mashange et al., 2019).

8.3.3 To assess the current working conditions and the challenges faced by healthcare workers under staffing moratoria in the KZN Department of Health

The current working conditions at NTH were characterised by low morale, high absenteeism, poor internal relationships, and low staff retention. Staff development was also compromised due to high work pressure. The above negative perceptions were commonly held across different departments and between managers and non-managers, indicating how entrenched they were in their respective departments within the hospital.

Respondents in the interviews also expressed the view that working conditions after the implementation of staffing moratoria had declined significantly. Before the moratorium, as expressed in the interviews, employees concentrated on their contractual duties. For instance, nurses did not have to clean the wards as a result of shortages of cleaning staff. They were also able to share their work with other colleagues if they felt overburdened. After the moratorium, they took care of housekeeping as well as administrative duties as well. This was associated with increasing fatigues and burn-outs. Staff shortages were further compounded by absenteeism. The same factors responsible for absenteeism namely low staff morale and larger than manageable workloads were also behind the deterioration of working conditions. Employees generally exhibited disengaged behaviour.

The above findings do not come as a surprise as the literature is awash with findings of how overburdening at work can result in low morale leading to work resentment (Nyathi and Jooste, 2008; Belita et al., 2013). Low staff morale among healthcare workers is associated with poor health service delivery, and this compromises the public health sector's ability to meet public health outcomes.

8.3.4 To measure the extent to which task-shifting has been able to address the issue of staff shortages in the KZN Department of Health

Respondents discussed the training of healthcare workers in the interviews. While the hospital had embraced internship programs and in-service training as a way of increasing staff capacity, these were not long-term enough to fully alleviate skills shortages. Personnel trained under task shifting arrangements were not there to permanently augment the hospitals' staff numbers.

Overall, results showed that task-shifting was not a solution to staffing moratoria and staff shortages facing NTH as the results have revealed that challenges continued to occur, even when task-shifting was in place. Task-shifting has been informally practised at NTH since the freezing of posts due to the ongoing staff shortages facing the hospital. At the same time, the results pointed at poor buy-ins and resistance from employees as a reason behind the hospital's poor task shifting performance suggesting the need for systematic change management processes in its implementation. In the literature, some sources like Polus et al. (2015), Vaughan (2015), Seidman and Atun, (2017) found task-shifting to be a tangible solution for

medical staff shortages in contrast to this study. This leads to the conclusion that task-shifting was not a universal solution to staffing challenges, as it may not work in some environments and that facility-specific contextual factors needed to be taken into account when implementing task shifting processes.

8.4 To develop a framework for guiding government departments on the development and implementation of staffing moratoria in KZN

It is evident that consequences associated with implementing cost-cutting measures, in particular, the freezing of posts, are a result of lack of engagement and involvement of relevant stakeholders in decision making processes by the management at NTH the KZN Department of Health. As echoed by the results of the study, the KZN Department of Health, together with the KZN Treasury, failed to communicate properly and to consult and involve managers in health facilities in the planning and implementation of recruitment freezes in the KZN Province. As a result, the study has developed a framework using results and the literature reviewed to guide government departments on the implementation of staffing moratoria in KwaZulu-Natal (in Chapter 7). The framework provides a step-by-step approach to the planning and implementation of moratoria in hospitals, but only in cases where assessments show overstaffing. The framework will advise NTH and all health facilities under the KZN Department of Health on how to manage staff shortages while ensuring the provision of quality healthcare services.

8.5 Conclusion

To conclude on the above objectives, staffing moratoria have had negative consequences on service delivery through adversely affecting healthcare workers' morale and engagement. The strong negative sentiments from the healthcare workers from all departments within NTH suggest that the staffing moratoria have not achieved a sustainable balance between financial management and public health service quality. Task-shifting, which has been reinforced as a stop-gap measure to staffing challenges has further compounded the low work morale among healthcare workers, indicating a need for more plausible solutions, including the removal of staffing moratoria altogether. It is notable from the results of the study that two competing goals are involved: an austerity goal driven by the Department of Treasury that brought the moratorium, and the public healthcare goals of the KZN Department of Health.

Healthcare workers are caught between conflicting goals, and together with the public that receives compromised service quality, become victims of this conflict.

Going back to the theoretical framework of the study, the objectives above point to the weaknesses of the New Public Management as a public administration paradigm in the healthcare sector. The NPM places focus on the commercialisation of services as a way of attaining government efficiency, and this can be linked to its strong reliance on economic rationality theories (Osborne, 2010; Basheka, 2012; Msomi et al., 2018). The results also point to the conflicting goals with the NPM paradigm, in this case, quality healthcare service versus austerity. It can be argued that both objectives are important, and as highlighted above, need to be balanced, taking consideration of the circumstances of the communities that rely on public services that are provided by public healthcare workers in question. Consultative and participatory governance approaches like the New Public Governance (Robinson, 2015) place such participation at the top of the agenda after noting that in its attempts to enhance market and economic-based efficiency, the NPM had neglected the participation of public service stakeholders like communities and public service workers (Runya et al.,2015).

8.6 Recommendations

In reference to the findings of this study, several recommendations are made. The study underscores the value of creating an optimum balance between national government objectives and provincial government needs, removal or easing of the staffing moratoria, institution-based implementation strategy, consultative approach, communication of initiatives, and job performance and patients' satisfaction.

a) Creating an optimum balance between national government objectives and provincial government needs

The results of the study have shown that there are two competing goals involved: an austerity goal driven by the Department of Treasury that brought staffing moratoria and the public healthcare goals of the KZN Department of Health. Healthcare workers are caught in between conflicting goals and together with the public that receives compromised service quality are victims of this conflict.

Therefore, provincial governments needed to strike a balance between conflicting objectives that can adversely effect on service delivery, in this case, the delivery of healthcare services. There is a need for re-engagement between the Provincial

Treasury and Health Department to establish optimum cost-cutting strategies that will not have an adverse effect on healthcare workers' ability to provide constitutionally mandated health services to communities.

b) Institution-based implementation strategy

A staffing level analysis on individual hospitals is required in order to achieve a balanced demand and supply of labour in health facilities. Individual hospitals ought to be given the autonomy to implement or not to implement staffing moratoria depending on their specific labour supply-demand situations and staffing budgets. This will also allow them autonomy to determine which posts they consider critical, and which ones are non-critical *in individual hospitals.* A situational analysis will also prevent a blanket approach in the implementation of freezing of posts in the KZN DOH, rather allowing individual hospitals to determine their needs in terms of staffing levels according to their priority.

c) Collective consultative approach and decentralization of decision-making

The study recommends a new and accommodative approach in the development and implementation of government strategies and policies such as staffing moratoria. The approach should be based on a collective consultative process involving, all relevant stakeholders in the KZN Department of Health, including community members, policymakers, healthcare workers (medical and non-medical) and hospital executives members. This would also send a positive message to staff, who are reported to be exploited by the situation and would increase buy-ins to relief measures such as task shifting.

The study further recommends the decentralization of public health sector decision-making to enhance efficiency. The current approach of the KZN DOH uses centralized decision-making processes where healthcare workers are informed rather than involved in decisions, create a situation where decisions are made by individuals who are not in touch with the situation on the ground, and additionally, who are not quickly and easily accessible for recourse or appeal.

d) Consider multi-skilling to improve performance under staffing moratoria

As revealed, the implementation of cost-cutting measures in the KZN Department of Health was done without proper consultation, and hence no adequate training or retraining of healthcare workers was done. The study recommends adequate training

and retraining of healthcare workers to equip them with skills to improve performance and adapt to the changes that came as a result of staffing moratoria.

e) Regular employee and patient satisfaction surveys

Furthermore, job performance can also be improved by the use of regular employee satisfaction surveys. As argued by Osborne and Hammond (2017) disengaged employees can be re-engaged and employee feedback is crucial for this to happen. Patients' satisfaction surveys could also be conducted by the KZN DOH to monitor the quality of healthcare services and patient satisfaction levels and to ensure that healthcare services are rendered in accordance with Batho Pele principles and internal indicators. These surveys will assist the department in improving employees' job performance, and to ensure patients service satisfaction. Service quality, rather than cost, must be used as indicators of public health facilities efficiency.

f) More systematic implementation of task shifting

The KZN DOH should work towards a regulatory and procedural framework that guides the implementation of task shifting. Adequate skilling in change management processes should help in minimising resistance and aligning task shifting to broader facility processes. Additionally, task shifting should not be used as an excuse for not engaging highly skilled healthcare professionals but as a relief measure necessary for reducing the impact of staff shortages in public healthcare facilities.

8.7 Areas for further research

This section recommends further studies that can be carried out to enhance knowledge on subject matters covered in this research.

- The study proposed process on the development and implementation of personnel management strategies and health personnel budgets in public health facilities, therefore further studies could be done to test the applicability of the proposed process of the implementation of staffing moratoria in health facilities taking place under the mandate of the Department of Health.
- Further studies on the effects of task-shifting on healthcare workers in other facilities under the KZN Department of Health should be undertaken.
- There is also a need to research community perceptions on service delivery and healthcare services to determine the quality and level of satisfaction with

the healthcare services being rendered since the implementation of staffing moratoria.

- Finally, a study on how government departments and units can collaborate towards the development of non-conflicting and more aligned goals and objectives on public health and public finance are also needed. This study could take a best-practices approach, aimed at identifying the most optimum standards of co-operation among governmental units.

8.8 Concluding remarks

This study provided a clear picture of the consequences of cost-cutting strategies that are implemented without proper planning, engagement and involvement of relevant stakeholders in the Department of Health. These compromise service quality putting communities at risk. This study contributes to the literature and the body of knowledge as the impact of cost-cutting measures, particularly the freezing of posts, is largely ignored and under-researched in the academic discourse. There are few peer-reviewed journal articles found, and the study relied largely on government policy documents and Department of Health directives and circulars relating to the topic. Additionally, the study advanced the debate on the weaknesses of the current NPM in dealing with public healthcare service delivery in vulnerable communities, as well as challenges that emanate from potentially conflicting provincial government goals, in this case, health and austerity. The study further contributed a framework for guiding government departments in the implementation of staffing moratoria in stringent cases where it is evident that such staffing moratoria will not adversely affect public healthcare workers' working conditions and public healthcare service delivery. Finally, the study emphasises that staff freezes are generally associated with severe economic crises. Looking at the Greek, Irish and Zimbabwean cases, governments resort to staffing moratoria in response to record, globally talked-about economic challenges like near bankruptcy, multi-digit inflation and shocking economic decline figures. Moderate economic challenges like those associated with the local economy do not offer good justification for such stringent measures. The government is therefore recommended to reconsider the need for staffing moratoria in the public healthcare system.

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ANNEXURE A

QUESTIONNAIRE SCHEDULE: JUNIOR STAFF MEMBERS

STUDY ON STAFFING MORATORIA IN THE DEPARTMENT OF HEALTH

Thank you once again for participating in this study. Please be assured that data collected from this study shall only be used for the purpose of completing the study the above topic. You are encouraged to provide as honest and frank answers as possible. Information collected herein will be held in confidence and your name will not appear against your responses. You are also free to withdraw your participation from this study at any time without any consequence to you.

SECTION A
EMPLOYMENT PARTICULARS

1.1 State the department which you are working under:

1	Finance Department	
2	Human Resource Management Department	
3	Medical services department and Professions Allied to the Medical Department	
4	Systems Management department	
5	Case Management Department	
6	Monitoring and evaluation Department	
7	The Office of the Chief Executive Officer	
8	Nursing Services Department	
9	Other, (Please specify)	
10	I prefer not to say	

1.2 What is your occupation at Ngwelezana Tertiary Hospital?

……

1.3 Please indicate your direct department/section in the hospital (**e.g Internal Medicine, HRD, Stores, Transport etc…**)

……

1.4 For how long have you been working at Ngwelezana Tertiary Hospital?

0 – 5 years	
6 – 10 years	
11 -15 years	
16- 20 years	
21- 5 years	
26- 30 years	
31 years and longer	

1.5 Please indicate your highest level of study:

Primary schooling	
Secondary schooling	
Tertiary Schooling (Higher Certificate)	
Tertiary Schooling (National Diploma)	
Tertiary Schooling (Bachelor's Degree)	
Tertiary Schooling (Honours degree, Postgraduate Diploma, Postgraduate Certificate)	
Tertiary Schooling (Master's degree)	
Tertiary Schooling (Doctoral degree)	
Other (please specify)	

SECTION B

POSSIBLE CAUSES OF STAFFING MORATORIA IN THE KZN DEPARTMENT OF HEALTH

2.1 To the best of your knowledge, what do you understand about staffing moratoria?

[Please tick any answer(s) most suitable for you]

1	Freezing of posts	
2	Cost-cutting strategy	

3	No longer employing	
4	Staff balancing	
5	Finance controlling strategy	
6	I don't know	
7	Other (Please specify)	

2.2 What was the purpose behind the implementation of staffing moratoria at Ngwelezana Tertiary Ngwelezana? [Please tick any answer(s) most suitable to you] **Use a Likert Scale1 – 6, 1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree and 5 = uncertain/ not sure, 6 = I don't know**

	Items	1	2	3	4	5	6
1	To minimise employee numbers in the hospital.						
2	A strategy to cut-cost in the hospital in general.						
3	It is a strategy to reduce employment costs in the hospital.						
3	It is a strategy to control the recruitment of staff in the hospital.						
4	It is a management punishment to the hospital staff.						
5	It a response to low budget allocations by government.						
6	It is a measure to curb irregular expenditure.						
7	It is a measure to reduce corruption and resources abuse.						
8	Other (Please specify)						

2.3 In your own view, has staffing moratoria at Ngwelezana Tertiary Hospital had any impact on staff shortages?

1	Yes, it has resulted in staff shortages .	
2	No, it is has not resulted in staff shortages.	
3	I'm not sure.	
4	Other (Please specify)	

2.4 If your answer to the above question was **YES,** what is the impact of these staff shortages on healthcare services and services in the hospital? **[Please tick any answer(s) most suitable to you]**

1	It has resulted to increased patient mortality.	
2	It has resulted to absenteeism due staff fatigue.	
3	It has resulted to longer waiting periods to patient.	
4	It has resulted to poor patient management.	
5	It has resulted to increased number of mistakes due to increased pressure.	
6	I don't know.	
7	Other (Please specify)	

2.5 How has the impact of staffing moratoria affected your duties**? [Please tick any answer(s) most suitable to you]**

1	My duties have significantly increased.	
2	My duties have slightly increased.	
3	My duties have not increased/have remained the same.	
4	My duties have slightly decreased.	
5	My duties have significantly decreased.	
6	I'm not sure.	

2.7 How would you best describe the situation in your direct department/section in terms of working conditions **since** the implementation of staffing moratoria in September 2015 to-date? **[please indicate by ticking answer(s) most suitable to you below]**

1	They have significantly improved.	
2	They have slightly improved.	
3	They have not changed at all.	
4	They have slightly deteriorated.	

5	They have significantly deteriorated.	
6	I don't know.	

2.8 How would you best describe the situation in your direct department/section in terms of working conditions **before** the implementation of staffing moratoria in September 2015 to the date of your appointment? **[please indicate by ticking answer(s) most suitable to you below]**

1	They were excellent.	
2	They were good.	
3	They were neither good nor bad.	
4	They were poor.	
5	They were significantly poor.	
6	I don't know.	

2.9 In your component, can you rate the following in relation to the results of staffing moratoria? **[please indicate by ticking answer(s) most suitable to you below]**: Please use Likert scale provided: **1= Extremely positive, 2=Positive, 3=Unchanged/Neutral, 4=Negative, 5=Extremely negative, 6=Not sure**

	Items	1	2	3	4	5	6
1	Staff morale						
2	Personal development among staff						
3	Staff retention						
5	Employee-employee relationships						
6	Employee-management relationships						
8	None of the above						

2.10 Can you rate how the following Batho Pele principles have changed after the implementation of the moratoria: Please use the following **Likert scale: 1=Has significantly improved, 2=Has slightly improved, 3=Has remained the same, 4=Has slightly deteriorated, 5=Has significantly deteriorated, 6=Not sure**

		1	2	3	4	5	6

1	Consultation with patients						
2	Service standards for patients						
3	Accessibility/access to service by patients						
4	Courtesy to patients						
5	The free dissemination of information to patients						
6	Openness and transparency of services						
7	Redress to patients complains						
8	Value for money for paying patients						

2.11 Were you consulted before, regarding the implementation of staffing moratoria at Ngwelezana Hospital?

1	Yes	
2	No	
3	I don't know	

2.12 If your answer in 2.11 above was **Yes**, how were you consulted, **[please indicate by ticking answer(s) most suitable to you below]**

1	Through departmental circulars	
2	Through word-of-mouth	
3	Workers called a formal meeting	
4	Management called a formal meeting	
5	It was announced on national TV	
6	It was announced on national newspaper	
7	I know nothing about it	
8	Other (Please specify)	

SECTION C

POSSIBLE SOLUTIONS TO STAFFING MORATORIA

3.1 What do you think can be the best solution(s) to staffing moratoria? Use a Likert Scale1 – 6, **1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree and 5 = uncertain/ not sure, 6 = I don't know**

Possible solutions to staffing moratoria

	Items	1	2	3	4	5	6
1	Staffing moratoria should not form part of cost-cutting measures in the Department of Health.						
2	National Treasury must increase budget allocation for the Department of Health.						
3	Posts must be unfrozen in all health facilities under the Department of Health.						
4	Hospitals must be granted autonomy to define and decide on which posts they consider critical.						
5	The department should continue to freeze post and fill in exceptional circumstances.						
6	Providing more space for university students who require in-service training to fill the gap that has been caused by human resource health crisis.						
7	Decisions-making on cost-saving and cost-cutting must be made at district level.						
8	Salary increases must not increase beyond inflation.						

3.2 What are your views regarding the issue of task-shifting? Use a Likert Scale1 – 6, **1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree and 5 = I don't know, 6 = I refuse to answer**

Task-shifting as a response to staff shortages in the Department of Health

	Items	1	2	3	4	5	6
1	Task-shifting has assisted in elevating staffing moratoria at Ngwelezana Tertiary Hospital.						
2	Task-shifting has resulted in staff burn-outs and work overloads.						
3	Task-shifting has assisted in increasing capacity of training for health workers at Ngwelezana Tertiary Hospital						

4	Task-shifting implementation has resulted to the achievement of desired health outcomes.						
5	The use of task-shifting can assist in identification of the gaps that exist in the system already in place.						
6	The shift of specific tasks from highly qualified health workers to shorter-period trained health workers has resulted to the efficient use of the available human resources.						
7	Task-shifting has addressed staff shortages in the department of health.						
8	Legal and regulatory restrictions has limited the implementation of task-shifting in the Department of Health						
9	Task-shifting has assisted in chronic shortages of health workers.						
10	Task-shifting strategy has improved the overall quality of health services in the Department of Health						
11	Staffing moratoria severely affected facilities that are situated in rural areas more than those in urban areas.						
12	Task-shifting has reduced work overload caused by exodus to greener pastures.						

3.3 What are your views regarding the opportunities that task-shifting bring in the department of health? Use a Likert Scale1 – 6, **1 = strongly agree, 2 = agree, 3 = strongly disagree, 4 = disagree and 5 = I don't know, 6 = I refuse to answer**

Task-shifting opportunities in the Department of Health

	Items	**1**	**2**	**3**	**4**	**5**	**6**
1	Task-shifting has assisted in reducing expenditure on employee compensation.						
2	Task-shifting strategy has brought promotion opportunities to health workers performing extra duties.						

3	Task-shifting has resulted in a better spread of benefits amongst health workers.						

SECTION D

ADDITIONAL COMMENTS

5.1 Please provide any additional comments or remarks, if you have, regarding staffing moratoria in the Department of Health.

……

……

5.2 Please provide any additional comments or remarks, if you have, regarding task-shifting in the Department of Health.

……

…… ……

5.3 Do you have any other solutions that can be of help in managing staff-related costs and other costs at Ngwelezana Tertiary Hospital.

……

……

……

…….

Thank you for your participation.

ANNEXURE B

QUESTIONNAIRE SCHEDULE: SUPERVISORS STAFF MEMBERS

STUDY ON STAFFING MORATORIA IN THE DEPARTMENT OF HEALTH

Thank you once again for participating in this study. Please be assured that data collected from this study shall only be used for the purpose of completing the study

the above topic. You are encouraged to provide as honest and frank answers as possible. Information collected herein will be held in confidence and your name will not appear against your responses. You are also free to withdraw your participation from this study at any time without any consequence to you.

SECTION A

EMPLOYMENT PARTICULARS (SUPERVISORS)

1.3 State the department which you are supervising under:

1	Finance Department	
2	Human Resource Management Department	
3	Medical services department and Professions Allied to Medical Department	
4	Systems Management department	
5	Case Management Department	
6	Monitoring and evaluation Department	
7	The Office of the Chief Executive Officer	
8	Nursing Services Department	
9	Other, (Please specify)	
10	I prefer not to say	

1.4 What is your occupation at Ngwelezana Tertiary Hospital?

……

1.3 Please indicate your direct department/section in the hospital (**e.g. Internal Medicine, HRD, Stores, Transport etc.**)

……..

1.4 For how long have you been working at Ngwelezana Tertiary Hospital?

0 – 5 years	
6 – 10 years	
11 –15 years	
16 – 20 years	
21 – 25 years	

26 –30 years	
31 years and longer	

1.5 Please indicate your highest level of study:

Primary schooling	
Secondary schooling	
Tertiary schooling (Higher Certificate)	
Tertiary schooling (National Diploma)	
Tertiary schooling (Bachelor's Degree)	
Tertiary schooling (Honours degree, Postgraduate Diploma, Postgraduate Certificate)	
Tertiary schooling (Master's degree)	
Tertiary schooling (Doctoral degree)	
Other (please specify)	

1.6 How many employees under your supervision?

…….

1.7 Has this number changed or increased recently?

1	Yes	
2	No	
3	I don't know	

1.8 If the answer above was "Yes", Please explain why below.

……

……

SECTION B

POSSIBLE CAUSES OF STAFFING MORATORIA IN THE KZN DEPARTMENT OF HEALTH

2.1 To the best of your knowledge, what do you understand about the term or process of staffing moratoria? [Please tick any answer(s) most suitable for you]

1	Freezing of posts	
2	Cost-cutting strategy	
3	No longer employing	
4	Staff balancing	
5	Finance controlling strategy	
6	I don't know	
7	Other (Please specify)	

2.2 What was the purpose behind the implementation of staffing moratoria at Ngwelezana Tertiary Ngwelezana? [Please tick any answer(s) most suitable to you]

1	To minimise employee numbers in the hospital.						
2	A strategy to cut-cost in the hospital in general.						
3	It is a strategy to reduce employment costs in the hospital.						
3	It is a strategy to control the recruitment of staff in the hospital.						
4	It is a management punishment to the hospital staff.						
5	It a response to low budget allocations by government.						
6	It is a measure to curb irregular expenditure.						
7	It is a measure to reduce corruption and resources abuse.						
8	Other (Please specify)						

2.3 In your own view, has the staffing moratoria at Ngwelezana Tertiary Hospital had any impact on staff shortages?

1	Yes, it has resulted in staff shortages.	
2	No, it has not resulted in staff shortages.	
3	I'm not sure.	
4	Other (Please specify)	

2.4 If your answer to the above question was **YES**, what is the impact of these staff shortages on healthcare services and services in the hospital? [Please tick any answer(s) most suitable to you]

1	It has resulted to increased patient mortality.	
2	It has resulted to absenteeism due to staff fatigue.	
3	It has resulted to longer waiting periods for patients.	
4	It has resulted to poor patient management.	
5	It has resulted to increased number of mistakes due to increased pressure.	
6	I don't know.	
7	Other (Please specify)	

2.5 How has the impact of staffing moratoria affected your duties as a supervisor? [Please tick any answer(s) most suitable to you]

1	My duties have significantly increased.	
2	My duties have slightly increased.	
3	My duties have not increased/have remained the same.	
4	My duties have slightly decreased.	
5	My duties have significantly decreased.	
6	I'm not sure.	

2.6 How would you best describe the situation in the direct department/section under your supervision in terms of working conditions **since** the implementation of staffing moratoria in September 2015 to-date? [please indicate by ticking answer(s) most suitable to you below]

1	They have significantly improved.	
2	They have slightly improved.	
3	They have not changed at all.	
4	They have slightly deteriorated.	
5	They have significantly deteriorated.	
6	I don't know.	

2.7 How would you best describe the situation in the direct department/section under your supervision in terms of working conditions **before** the implementation of staffing moratoria in September 2015 to the date of your appointment? [please indicate by ticking answer(s) most suitable to you below]

1	They were excellent.	
2	They were good.	
3	They were neither good nor bad.	
4	They were poor.	
5	They were significantly poor.	
6	I don't know.	

2.8 As a supervisor in your component, what challenges do you encounter as results of staffing moratoria? [please indicate by ticking answer(s) most suitable to you below]

1	Poor staff morale.	
2	Personal development among staff.	
3	Staff retention.	
5	Unhealthy employee-employee relationships.	
6	Unhealthy employee-management relationships.	
8	None of the above (please specify)	

2.9 Can you rate how the following Batho Pele principles have changed after the implementation of staffing moratoria: Please used the following **Likert scale: 1 has significantly improved; 2 has slightly improved; 3 has remained the same; 4 has slightly deteriorated; 5 has significantly deteriorated; 6 not sure.**

	Items	1	2	3	4	5	6
1	Consultation with patients						
2	Service standards to patients						
3	Accessibility/access to service by patients						
3	Courtesy to patients						
4	The free dissemination of information to patients						

5	Openness and transparency of services						
6	Redress to patients complains						
7	Value for money to paying patients						

2.10 Were you consulted before, regarding the implementation of staffing moratoria at Ngwelezana Hospital?

1	Yes	
2	No	
3	I don't know	

2.11 If your answer in 2.10 above was **Yes**, how were you consulted, [please indicate by ticking answer(s) most suitable to you below]

1	Through departmental circulars	
2	Through word-of-mouth	
3	Workers called a formal meeting	
4	Management called a formal meeting	
5	Publicly announced on national TV	
6	Publicly announced in a national newspaper	
7	I know nothing about it	
8	Other (Please specify)	

SECTION C
POSSIBLE SOLUTIONS TO STAFFING MORATORIA

3.1 What do you think can be the best solution(s) to staffing moratoria? Use a Likert Scale1 – 6: **1 = strongly agree; 2 = agree; 3 = strongly disagree; 4 = disagree and 5 = uncertain/ not sure; 6 = I don't know**

Possible solutions to staffing moratoria

	Items	1	2	3	4	5	6
1	Staffing moratoria should not form part of austerity measures in the Department of Health.						
2	National Treasury must increase budget allocation for the Department of Health.						
3	Posts must be unfrozen in all health facilities under the Department of Health.						
4	Hospitals must be granted autonomy to define and decide on which posts they consider critical.						
5	The department should continue to freeze post and fill in exceptional circumstances.						
6	Providing more space for university students who require in-service training to fill the gap that has been caused by human resource health crisis.						
7	Decisions-making on cost-saving and cost-cutting must be made at district level.						
8	Salary increases must not increase beyond inflation.						

3.2 What are your views regarding the issue of task-shifting? Use a Likert Scale1 – 6, **1 = strongly agree; 2 = agree; 3 = strongly disagree; 4 = disagree; and 5 = I don't know; 6 = I refuse to answer.**

Task-shifting as a response to staff shortages in the Department of Health

	Items	1	2	3	4	5	6
1	Task-shifting has assisted in elevating staffing moratoria at Ngwelezana Tertiary Hospital.						
2	Task-shifting has resulted in staff burn-outs and work overloads.						
3	Task-shifting has assisted in increasing capacity of training for health workers at Ngwelezana Tertiary Hospital.						

4	Task-shifting implementation has resulted to the achievement of desired health outcomes.						
5	The use of task-shifting can assist in identification of the gaps that exist in the system already in place.						
6	The shift of specific tasks from highly qualified health workers to shorter-period trained health workers has resulted to the efficient use of the available human resources.						
7	Task-shifting has addressed staff shortages in the department of health.						
8	Legal and regulatory restrictions has limited the implementation of task-shifting in the Department of Health.						
9	Task-shifting has assisted in chronic shortages of health workers.						
10	Task-shifting strategy has improved the overall quality of health services in the Department of Health						
11	Staffing moratoria severely affected facilities that are situated in rural areas more than those in urban areas.						
12	Task-shifting has reduced work overload caused by exodus to greener pastures.						

3.3 What are your views regarding the opportunities that task-shifting bring in the department of health? Use a Likert Scale1 – 6, **1 = strongly agree; 2 = agree; 3 = strongly disagree; 4 = disagree; and 5 = I don't know; 6 = I refuse to answer.**

Task-shifting opportunities in the Department of Health

	Items	**1**	**2**	**3**	**4**	**5**	**6**
1	Task-shifting has assisted in reducing expenditure on employee compensation.						
2	Task-shifting strategy has brought promotion opportunities to health workers performing extra duties.						

3	Task-shifting has resulted in a better spread of benefits amongst health workers.						

SECTION E
ADDITIONAL COMMENTS

5.1 Please provide any additional comments or remarks, if you have, regarding staffing moratoria in the Department of Health.

……

……

5.2 Please provide any additional comments or remarks, if you have, regarding task-shifting in the Department of Health.

……

……

5.3 Do you have any other solutions that can be of help in managing staff-related costs and other costs at Ngwelezana Tertiary Hospital.

……

……

……

…….

Thank you for your participation.

ANNEXURE C

INTERVIEW SCHEDULE (EXECUTIVE MEMBERS)

STUDY ON STAFFING MORATORIA IN THE DEPARTMENT OF HEALTH

Section A: Understanding of staffing moratoria

- To the best of your knowledge, what do you understand about staffing moratoria?

- What was your level of consultation and involvement in the implementation of cost-cutting measures, in particular, freezing of posts at Ngwelezana Tertiary Hospital?
- What was the criteria used to determine posts to be considered as critical and those that are non-critical in the KZN Department of Health?
- What was your level of involvement in determining critical posts and non-critical posts at Ngwelezana Tertiary Hospital?

Section B: Reasons for effecting staffing moratoria

- What the factors that have led to the implementation of cost-cutting measures and freezing of posts in KZN Province?
- What was the purpose of implementing staffing moratoria in the department of health?
- Did the implementation of staffing moratoria achieve it purpose at Ngwelezana Tertiary Hospital?
- How has the impact of staffing moratoria affected your duties as the member of the Executive at Ngwelezana Tertiary Hospital?

Section C: Impact of staffing moratoria on service delivery

- What is the impact of staffing moratoria on service delivery at Ngwelezana Tertiary Hospital and in the KZN Department of Health?
- What is the effect of staffing moratoria on services delivery and healthcare services at Ngwelezana Tertiary hospital?
- How do you think staffing moratoria affected staff morale?
- What is the impact of staff shortages on healthcare services and service delivery in the hospital?
- What is the impact of staffing moratoria on the hospital budget?
- What are your retention staff strategies for the health workers?

Section D: Opportunities for using staffing moratoria

- What benefits can the department of health receive from implementation of staffing moratoria?
- What do you think can be the best solution(s) to staffing moratoria?

Section E: Challenges on effecting staffing moratoria

- As a supervisor at Ngwelezana Tertiary Hospital, what challenges have you faced in the implementation of staffing moratoria?
- Do you think the challenges faced by healthcare workers are different to other hospitals?
- Is the KZN Department of Health and provincial government aware of these challenges?
- How would you best describe the situation in the component under your supervision in terms of working conditions since the implementation of staffing moratoria in September 2015 to-date?
- How would you best describe the situation in the component under your supervision in terms of working conditions before the implementation of staffing moratoria in September 2015 to the date of your appointment?
- Does staffing moratoria cause tensions and unhealthy relationship between staff members in your department?

Section F: Task-shifting to address staffing moratoria

- To what extent has task-shifting been able to address the issue of staff shortages in the Department of Health?
- Did task-shifting address staff shortages at Ngwelezana Tertiary Hospital?
- What strategies did you use to ensure efficient service delivery under staffing moratoria?
- What is the effect of task-shifting on service delivery?
- What are your views regarding the opportunities that task-shifting bring in the department of health?
- Does staffing moratoria have the same effect on different departments within the hospital? Please explain.
- What is the effect of staffing moratoria on critical posts?
- What is the institutional contingency plan for freezing of posts and staff shortages?

ANNEXURE D

ETHICAL CLEARANCE

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

21 September 2018

Mr Nduduzo Comfort Ndebele 210554970
School of Social Sciences
Howard College Campus

Dear Mr Ndebele

Protocol Reference Number : HSS/0807/018D
Project title: Implications and possible responses to effecting staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal

Full Approval – Expedited Application

In response to your application received 7 June 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

[redacted]

Dr Ronicka Mudaly (Deputy Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Dr Loram Ndlovu
cc Academic Leader Research: Professor Maheshwari Naidu
cc School Administrator: Mr N Memela

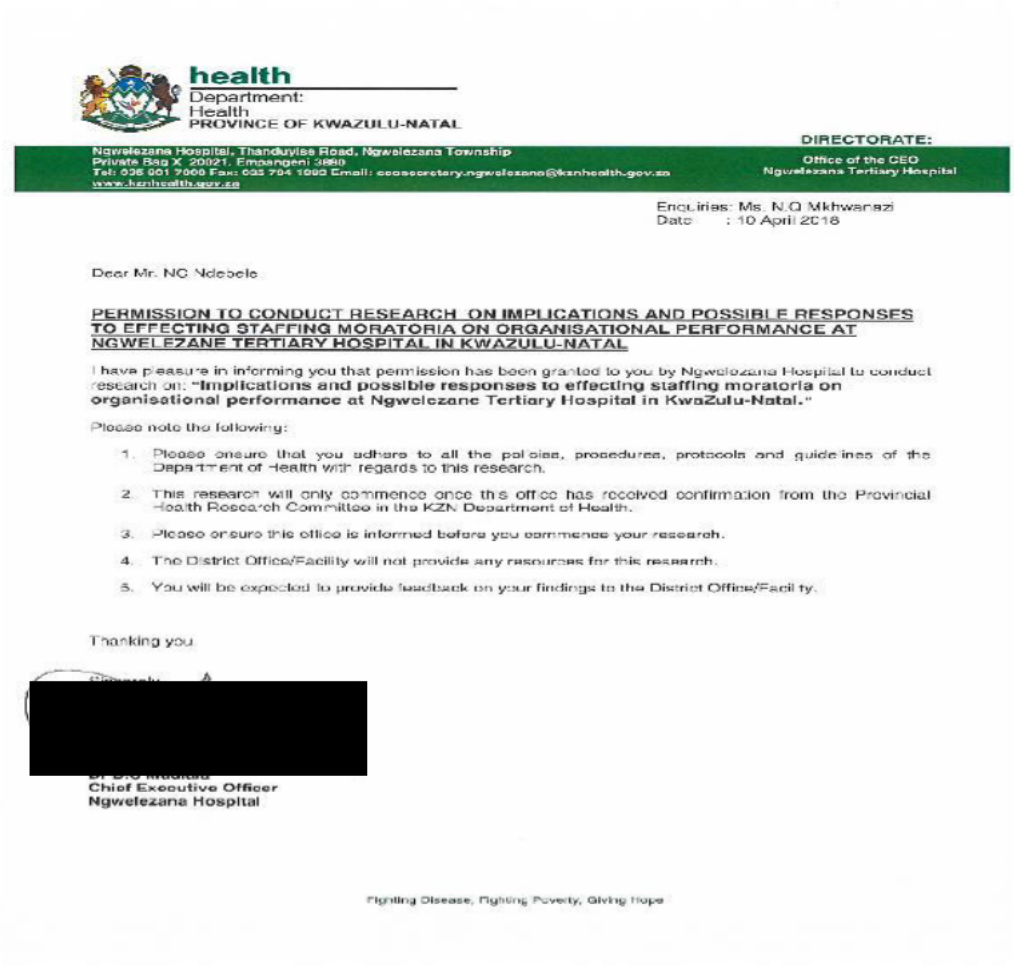
Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0)31 260 3587/8350/4557 Facsimile: +27 (0)31 260 4609 Email: [redacted]
Website: [redacted]

1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Foundation Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

ANNEXURE E

GATEKEEPERS LETTER: NGWELEZANA TERTIARY HOSPITAL



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Ngwelezana Hospital, Thanduyise Road, Ngwelezana Township
Private Bag X 20021, Empangeni 3880
Tel: 035 901 7000 Fax: 035 794 1000 Email: ceosecretary.ngwelezana@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
Office of the CEO
Ngwelezana Tertiary Hospital

Enquiries: Ms. N.O Mkhwanazi
Date : 10 April 2018

Dear Mr. NC Ndebele

PERMISSION TO CONDUCT RESEARCH ON IMPLICATIONS AND POSSIBLE RESPONSES TO EFFECTING STAFFING MORATORIA ON ORGANISATIONAL PERFORMANCE AT NGWELEZANE TERTIARY HOSPITAL IN KWAZULU-NATAL

I have pleasure in informing you that permission has been granted to you by Ngwelezana Hospital to conduct research on: **"Implications and possible responses to effecting staffing moratoria on organisational performance at Ngwelezane Tertiary Hospital in KwaZulu-Natal."**

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. The District Office/Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office/Facility.

Thanking you

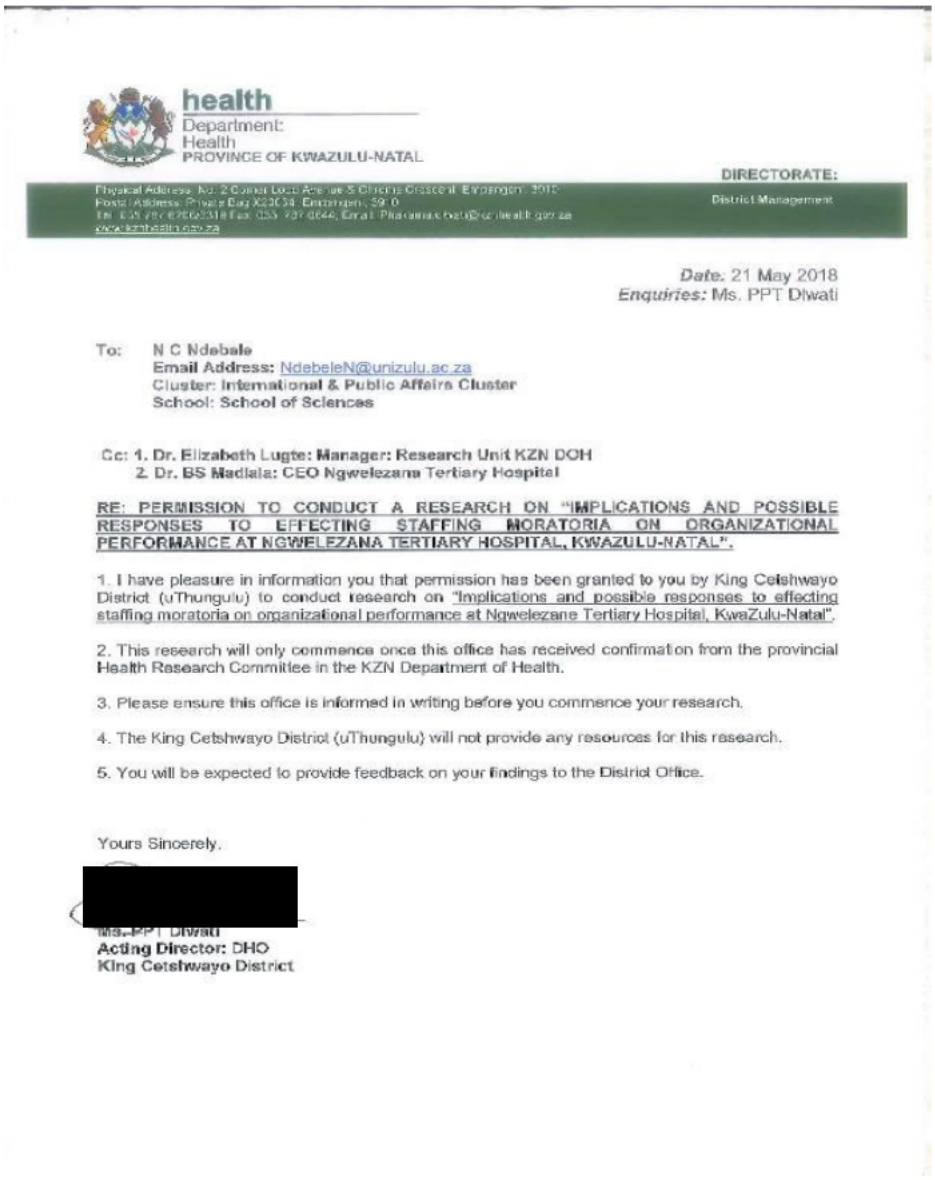
[redacted]

Dr. [redacted]
Chief Executive Officer
Ngwelezana Hospital

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE E

GATE KEEPER'S LETTER: KING CETSHWAYO HEALTH DISTRICT



health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
District Management

Physical Address: No. 2 Cornet Louis Arenue & Cheetah Crescent, Empangeni, 3910
Postal Address: Private Bag X23034, Empangeni, 3910
Tel: (035) 797 6700/6318 Fax: (035) 797 6644, Email: Pharmacy.hod@kz.health.gov.za
www.kzndoh.gov.za

Date: 21 May 2018
Enquiries: Ms. PPT Diwati

To: **N C Ndebele**
Email Address: NdebeleN@unizulu.ac.za
Cluster: International & Public Affairs Cluster
School: School of Sciences

Cc: **1. Dr. Elizabeth Lugte: Manager: Research Unit KZN DOH**
2. Dr. BS Madlala: CEO Ngwelezana Tertiary Hospital

RE: PERMISSION TO CONDUCT A RESEARCH ON "IMPLICATIONS AND POSSIBLE RESPONSES TO EFFECTING STAFFING MORATORIA ON ORGANIZATIONAL PERFORMANCE AT NGWELEZANA TERTIARY HOSPITAL, KWAZULU-NATAL".

1. I have pleasure in information you that permission has been granted to you by King Cetshwayo District (uThungulu) to conduct research on "Implications and possible responses to effecting staffing moratoria on organizational performance at Ngwelezane Tertiary Hospital, KwaZulu-Natal".

2. This research will only commence once this office has received confirmation from the provincial Health Research Committee in the KZN Department of Health.

3. Please ensure this office is informed in writing before you commence your research.

4. The King Cetshwayo District (uThungulu) will not provide any resources for this research.

5. You will be expected to provide feedback on your findings to the District Office.

Yours Sincerely.

[redacted]

Ms. PPT Diwati
Acting Director: DHO
King Cetshwayo District

ANNEXURE F

KWAZULU NATAL DEPARTMENT OF HEALTH APPROVAL LETTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele Street
Private Bag X9051, Pmb, 3200
Tel: 033 395 2639/2640/3120 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management (HRKM)

Reference: HRKM093/18
KZ_201802_063

28 August 2018

Dear Mr N C Ndebele
(UKZN)

Subject: Approval of a Research Proposal

1. The research proposal titled 'Implications and possible responses to effecting staffing moratoria on organizational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby approved for research to be undertaken at King Cetshwayo District and Ngwelezana Hospital.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facilities before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms C Khumalo on 033-395 3189.

Yours Sincerely

[redacted]
Dr E Lutge
Chairperson, Health Research Committee
Date: 30/08/18

Igniting Liveses, Igniting Poverty, Living Hope

ANNEXURE G

CONSENT FORMS (INTERVIEWS)

This page is to be retained by researcher

Information Sheet for participants

UNIVERSITY OF KWAZULU-NATAL

School of Social Sciences

Doctor of Social Sciences Research Project

Researcher: Mr. Nduduzo C. Ndebele (083 479 1156)

Supervisor: Prof. J. Ndlovu (031-260 7503)

Research Office: Ms. P. Ximba (031-2603587)

Greetings,

My name is Nduduzo C. Ndebele from University of KwaZulu-Natal. My contact details cell number 0834791156 and my email address is ndebelecomfort@gmail.com

You are being invited to consider participating in a study that involves research. The aim and purpose of this research is to investigate the **"Implications and possible responses to the effects of staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal"**. The study is expected to include Ngwelezanana Tertiary Hospital executive members, staff from King Cetshwayo Health District and from the KZN Department of Health Head Office. It will involve collecting data through interviews. The duration of your participation if you choose to participate and remain in the study is expected to be 45 minutes to 1 hour 30 minutes for interviews.

The study does not include any risk to participants. We hope that the study will create the following benefits which will assist the participants to understand the impact of freezing of posts, its challenges and possible measures or guidelines that can be used to assist the Department of Health in the development and implementation of strategies such as staffing moratoria in the future. The study does not have any participants who are currently on treatment for any health conditions.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number: HSS/0807/0180). In the event of any problems or concerns/questions you may contact my supervisor Professor J. Ndlovu at 031-260 7503 and 078 646 3971 or the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban 4000 KwaZulu-Natal, SOUTH AFRICA
Tel: +27 31 2604557- Fax: +27 31 2604609
Email: HSSREC@ukzn.ac.za

Your participation in the study is voluntary and by participating, you are granting the researcher permission to use your responses. You may refuse to participate or withdraw from the study at any time with no negative consequence. There will be no monetary gain from participating in the study. Your anonymity will be maintained by the researcher and the School of Social Sciences and your responses will not be used for any purposes outside of this study.

All data, both electronic and hard copy, will be securely stored during the study and archived for 5 years. After this time, all data will be destroyed.

If you have any questions or concerns about participating in the study, please contact me or my research supervisor at the numbers listed above.

Sincerely,

Nduduzo C. Ndebele

Informed Consent Form

UNIVERSITY OF KWAZULU-NATAL

School of Social Sciences

Doctor of Social Sciences Research Project

Researcher: Mr. Nduduzo C. Ndebele (083 479 1156)

Supervisor: Prof. J. Ndlovu (031-260 7503)

Research Office: Ms. P. Ximba (031-2603587)

CONSENT TO PARTICIPATE

I (Name) have been informed about the study entitled **"Implications and possible responses to the effects of staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal"** by **Nduduzo C. Ndebele**

I understand the purpose and procedures of the study which are as follows.

- To examine the impact of staffing moratoria on healthcare service delivery at Ngwelezana Tertiary Hospital.
- To ascertain the factors that have led to the implementation of cost-cutting measures and staffing moratoria at the Ngwelezana Tertiary Hospital.
- To assess the current working conditions and the challenges faced by healthcare workers under staffing moratoria at the Ngwelezana Tertiary Hospital.
- To measure the extent to which task-shifting has been able to address the issue of staff shortages at the Ngwelezana Tertiary Hospital.
- To propose best practises that could be used to address staffing moratoria challenges in the Department of Health and to contribute to the body of knowledge in this field by developing a framework for guiding government departments on the development and implementation of strategies in KZN.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 0834791156.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable
I hereby provide consent to:
Audio-record my interview / focus group discussion YES / NO

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**
(Where applicable)

ANNEXURE H

CONSENT FORMS (QUESTIONNAIRE)

Information Sheet for participants

UNIVERSITY OF KWAZULU-NATAL

School of Social Sciences

Doctor of Social Sciences Research Project

Researcher: Mr. Nduduzo C. Ndebele (083 479 1156)

Supervisor: Prof. J. Ndlovu (031-260 7503)

Research Office: Ms. P. Ximba (031-2603587)

Greetings,

My name is Nduduzo C. Ndebele from University of KwaZulu-Natal. My contact details cell number 0834791156 and my email address is ndebelecomfort@gmail.com

You are being invited to consider participating in a study that involves research. The aim and purpose of this research is to investigate the **"Implications and possible responses to the effects of staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal"**. The study is expected to include healthcare workers at Ngwelezanana Tertiary Hospital. It will involve collecting data through distribution of questionnaires. The duration of your participation if you choose to participate and remain in the study is expected to be 10-20 minutes for questionnaires.

The study does not include any risk to participants. We hope that the study will create the following benefits which will assist the participants to understand the impact of freezing of posts, its challenges and possible measures or guidelines that can be used to assist the Department of Health in the development and implementation of strategies such as staffing moratoria in the future. The study does not have any participants who are currently on treatment for any health conditions.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number: HSS/0807/0180).

In the event of any problems or concerns/questions you may contact my supervisor Professor J Ndlovu at 031-260 7503 and 078 646 3971 or the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban 4000 KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Your participation in the study is voluntary and by participating, you are granting the researcher permission to use your responses. You may refuse to participate or withdraw from the study at any time with no negative consequence. There will be no monetary gain from participating in the study. Your anonymity will be maintained by the researcher and the School of Social Sciences and your responses will not be used for any purposes outside of this study.

All data, both electronic and hard copy, will be securely stored during the study and archived for 5 years. After this time, all data will be destroyed.
If you have any questions or concerns about participating in the study, please contact me or my research supervisor at the numbers listed above.

Sincerely,
Nduduzo C. Ndebele

Informed Consent Form

UNIVERSITY OF KWAZULU-NATAL

School of Social Sciences

Doctor of Social Sciences Research Project

Researcher: Mr. Nduduzo C. Ndebele (083 479 1156)

Supervisor: Prof. J. Ndlovu (031-260 7503)

Research Office: Ms. P. Ximba (031-2603587)

CONSENT TO PARTICIPATE

I (Name) have been informed about the study entitled **"Implications and possible responses to the effects of staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal"** by **Nduduzo C. Ndebele**

I understand the purpose and procedures of the study which are as follows.

- To examine the impact of staffing moratoria on healthcare service delivery at Ngwelezana Tertiary Hospital.
- To ascertain the factors that have led to the implementation of cost-cutting measures and staffing moratoria at the Ngwelezana Tertiary Hospital.
- To assess the current working conditions and the challenges faced by healthcare workers under staffing moratoria at the Ngwelezana Tertiary Hospital.
- To measure the extent to which task-shifting has been able to address the issue of staff shortages at the Ngwelezana Tertiary Hospital.
- To propose best practises that could be used to address staffing moratoria challenges in the Department of Health and to contribute to the body of knowledge in this field by developing a framework for guiding government departments on the development and implementation of strategies in KZN.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 0834791156.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
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Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: +27 31 2604557 - Fax: +27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable
I hereby provide consent to:
Audio-record my interview / focus group discussion YES / NO

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**
(Where applicable)

ANNEXURE I

EDITOR'S LETTER

GENEVIEVE WOOD
P.O. BOX 511 WITS 2050 | 0616387159

EDITING CERTIFICATE
LANGUAGE EDITING SERVICES

Date: 2020/7/18

This serves to confirm that the document entitled:

Implications and possible responses to affecting staffing moratoria on organisational performance at Ngwelezana Tertiary Hospital in KwaZulu-Natal
by
Nduduzo Comfort Ndebele
(210554970)

has been language edited on behalf of its author, with recommendations for improvement.

Genevieve Wood
PhD candidate
Wits University

ANNEXURE J

TURNITIN REPORT