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Commuted Overtime performed by Medical Doctors

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SECTOR: HEALTH

PUBLIC EXPENDITURE AND POLICY ANALYSIS

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GOVERNMENT SPENDING REVIEWS

Common lessons: Commuted Overtime performed by Medical Doctors

Introduction

Government spending has been on an unsustainable path for the past 15 years, as revenues have decreased and consolidated spending has increased, at some point this unsustainable trajectory needs to be altered. One of the main drivers of the increased spending is the compensation of government employees (CoE), which is a large component of government spending that contributed to around 60% of overall spending across all 9 provinces.

This is especially relevant in provincial governments, where provincial CoE as a proportion of total spending has increased from 56% in 2006 to 60% in 2020. Even though the growth of the wage bill in isolation may not be an issue, the fact that it has increased faster on average (10% pa) than total spending by provincial governments (9.5% pa), in a period where growth in the economy and government revenue has stagnated, that is an issue.

To slow down the unsustainable growth in CoE, several methods to decrease CoE are being analysed to identify whether it would have any significant effect on the reduction of the public wage bill, while not negatively affecting the service delivery goals that provincial governments have. One of the possible methods to reduce provincial government CoE is to decrease overtime expenditure, more specifically commuted overtime in the health departments across the country.

Two spending reviews were carried out by officials as part of Spending Review training presented by the PEPA unit in GTAC:

- "Provincial Health Departments: Commuted overtime" by Refiloe Thokoa and Noxolo Madela from National Treasury in 2020.
- "Commuted Overtime: cost-effectiveness and efficiency in addressing capacity constraints in health facilities through fixed overtime allowances" by S Damon, C Minter, S Seya and E Brand from the Western Cape Provincial Treasury in 2022.

The two reviews considered the cost efficiency of the commuted overtime policy and identified inefficiencies caused by a mismatch of supply of overtime capacity and workload due to annual contracting. The NT Spending Review costed the implications of procuring capacity from outside at a lower rate.

This report aims to update, verify, provide additional analysis and extract common lessons from the two spending reviews. The following questions are considered:

- How much do we spend on commuted overtime per annum and at what pace is this amount growing? Is the growth sustainable?

- What proportion of total compensation of employees (CoE) is spent on commuted overtime in Provincial Health Departments, and is the proportion growing?
- What are the main causes of higher than inflation growth in commuted overtime expenditure? Is the growth in commuted overtime caused by the growth in recipients of this allowance or has the unit cost grown in real terms?
- What is the contribution of commuted overtime to doctors' salaries? Do all doctors perform commuted overtime and how many hours per week do they typically spend on commuted overtime? Do the data suggest abuse of the system by individuals?
- How does the service delivered during overtime periods (nights and weekends) compare to normal hours in terms of doctors on duty (paid)?
- How well do we cover the target population in terms of doctors per uninsured population? Do we have an over or under-supply of doctors performing commuted overtime?

These aspects are considered after a brief description of the policy guiding commuted overtime.

Commuted Overtime Policy

Policy documentation on commuted overtime is not readily available on the NdoH website, in draft form and undated. It seems from media reports that there have been unsuccessful attempts to revise the existing (1999) policy. This report is based on the national policy "National Policy: Commuted Overtime for Medical Officers" (not dated) which is in draft form (extracted from SAMA website on the link https://www.samedical.org/file/74). Another undated version entitled "National Policy on Commuted Overtime for Medical & Dental Personnel" is available on SAMA's website at the link https://www.samedical.org/cmsuploader/viewFile/256. The titles of the two draft policies suggest that they are different at least concerning the target groups. References are made to a policy which dates to 1999, but which could not be located on the NDoH of DPSA websites.

Provinces seem to have a degree of autonomy in the implementation of the national policy. Internet searches yielded a draft policy of KZN Health dated 2015 on the link Policy On Commuted Overtime For Medical And Dental Personnel For The Kwazulu-Natal Department Of Health (Samedical.Org) which differs slightly from the draft national policy.

The only formal reference found is in "The determination on working time in the Public Service" made by the Minister of Public Service and Administration annually. The most recent determination states that the *status quo*, prior to July 2007, regarding the payment of

commuted overtime in the Health and Welfare sector remains the same. (See Determination on Working Hours in the PS (dpsa.gov.za).)

According to the draft policy "National Policy: Commuted Overtime for Medical Officers", commuted overtime was introduced for full-time medical officers, registrars and superintendents who are rendering actual clinical, patient-related services where the continuous need for overtime duties in a medical facility is necessary to provide health services. The policy exists to increase the capacity in public health facilities, in addition to, addressing the scarcity of skills in these fields.

It is a flexible system that averages overtime hours worked by an eligible official who provides regular overtime services monthly. Commuted overtime, like a basic salary, is paid in monthly instalments together with the basic salary and the overtime these officials receive is a fixed amount, based on the average agreed-upon amount of clinical overtime these officials perform each month. Therefore, commuted overtime can essentially be explained as the preloading of overtime and aims to limit the total overtime payable at any given time.

HR managers at the respective health facilities are responsible for controlling the efficiency and effectiveness of commuted overtime in their facilities. One of their main responsibilities is to create a roster for officials at different facilities for 1st and 2nd on-call responsibilities. 1st on-call is when an official is on-site and all of these hours are classified as commuted overtime hours. Furthermore, 2nd on-call is when an official is performing duties off-site, and these hours are captured as 30% of commuted overtime hours. Furthermore, commuted overtime is only payable to officials who are on 1st and 2nd on-call duty.

There are 4 groups into which officials who are eligible for commuted overtime can be a part of, which are determined by the average number of hours of overtime they complete during a week. Table 1 includes information about the different groups.

Table 1: Commuted Overtime Groups

Group	Hours of Overtime Worked	Policy
Group 1:	Between 0 and 4 hours of overtime are completed each week.	May claim for actual hours of overtime worked as applicable to other categories of staff in terms of PSCBC Resolution 3 of 1999.
Group 2:	Between 5 and 12 hours of overtime are completed each week (average can't be less than 8 hours per week).	Overtime remuneration is payable at a fixed rate of 1.3 times the applicable hourly tariff for 8 hours per week.
Group 3:	Between 13 and 20 hours of overtime are completed each week (the average can't be less than 16 hours per week).	Overtime remuneration is payable at a fixed rate of 1.3 times the applicable hourly tariff for 16 hours per week.
Group 4:	More than 20 hours of overtime are completed each week.	Overtime remuneration is payable at a fixed rate of 1.3 times the applicable hourly tariff for 16 hours per week, plus the excess hours above 20 hours per week at the applicable overtime tariffs as per the PSCBC Resolution 3 of 1999.

Source: https://www.samedical.org/file/74

The implementation of the policy can be traced by considering payments of the commuted overtime allowance to medical doctors using PERSAL data. PERSAL payment records are very detailed, allowing commuted overtime expenditure and its recipients to be isolated from other remuneration expenditure and other occupations. Unit costs are calculated accurately as well as estimates of the number of hours worked per doctor. This can be done over a period to analyse growth patterns.

Data used in this analysis

This report analyses commuted overtime paid to medical doctors (Key Scale Table code 267 on PERSAL) in Provincial Departments of Health over twelve financial years 2010/11 to

2021/22. There are six overtime categories on PERSAL. Commuted overtime is captured under the allowance code 0353: “Fixed overtime (dentists/medical/other personnel)”.

- *The National Treasury Spending review analyses overtime, no distinction is made between overtime and commuted overtime. Nurses’ overtime is included in the analysis, while the commuted overtime policy only applies to medical doctors. The period covered by NT is 2016/17 to 2018/19.*
- *The Western Cape Spending Review provides overtime and commuted overtime for WC Health between 2017/18 and 2020/21. The expenditure could be verified and is aligned with this report.*

Commuted overtime expenditure, its growth over the past 12 years and its share of total CoE are considered for all provincial departments of health grouped to assess the impact of the policy on CoE. This can be repeated at the provincial level and compared to the national totals.

Commuted overtime expenditure trends

Table 2 provides commuted overtime expenditure within the perspective of total overtime and total Compensation of Employees in provincial departments of Health for *all personnel*.

Table 2: Health departments expenditure on Commuted Overtime (all personnel)

Year	**Commuted overtime (R bn)**	**Total Overtime (R bn)**	**Total CoE (R bn)**	**Comm overtime as % of CoE**
2010	2.44	3.42	59.78	4.1%
2011	2.80	3.98	69.15	4.1%
2012	3.13	4.37	74.93	4.2%
2013	3.49	4.80	82.34	4.2%
2014	3.88	5.30	89.42	4.3%
2015	4.23	5.65	96.44	4.4%
2016	4.67	6.41	105.66	4.4%
2017	5.09	6.98	113.11	4.5%
2018	5.52	7.35	122.63	4.5%
2019	6.06	8.30	132.35	4.6%
2020	6.52	9.23	139.39	4.7%
2021	6.90	9.90	150.28	4.6%
CAGR 2010 to 2021	**9.9%**	**10.2%**	**8.7%**	

Findings:

- Health departments spent **R 6.9 bn** on commuted overtime in 2021, which was 4.6% of total provincial health CoE in 2021.
- Commuted overtime expenditure grew faster than total CoE (9.9% vs 8.7% on average), and consequently, the share of commuted overtime in total CoE increased from 4.1% in 2010 to 4.6% in 2021.
- Total provincial health overtime was R9.9 bn in 2021. Around 70% of the total overtime in provincial health is commuted overtime.
- Other categories of overtime (the remaining 30%) grew faster than commuted overtime in provincial health departments.
- The effect of COVID is suggested considering the growth in total CoE between 2020 and 2021 and by the slightly higher share of commuted overtime in 2020, even though we see the net effect of COVID and the wage freeze, which occurred simultaneously.

- *The NT Spending Review disaggregates overtime expenditure by programme, hospital type and province from 2016/17 to 2018/19. Not clear if it is total overtime or commuted overtime. The numbers in the NT Spending Review do not correspond to PERSAL data. As an example, EC Health Overtime on PERSAL in 2018 is R743 952 500. The comparable number for the three hospital types in EC in the report is R 21 019 320.*
- *The NT Spending Review provides overtime as a percentage of total Health CoE, but the percentage is way too low. The national average is given as 1.3% in 2018. In this report, commuted overtime in 2018 is three times the number (4.5% of total CoE).*
- *The WC report expresses both overtime and commuted overtime as a percentage of CoE (4.4% and 3.4% in 2020) which is comparable to this report. It also considers commuted overtime as a percentage of total overtime (78.5% in 2020), which is aligned with this analysis. The expenditure could be verified and is aligned with this report.*

Growth in the number of doctors performing commuted overtime has had a significant effect on expenditure growth.

<u>The effect of personnel growth on commuted overtime expenditure</u>

Table 3 provides the growth trajectories of the number of full-time equivalent (FTE) doctors and total personnel in Provincial Departments of Health.

Table 3: Personnel growth in Provincial Health departments (thousands)

	Doctors FTE ('000)	Total FTE ('000)	Doctors as % of total
2010	17.3	300.3	5.7%
2011	18.4	319.4	5.8%
2012	19.3	325.6	5.9%
2013	20.2	337.1	6.0%
2014	21.1	340.9	6.2%
2015	21.5	342.2	6.3%
2016	23.8	340.7	7.0%
2017	24.3	336.1	7.2%
2018	24.8	335.8	7.4%
2019	25.9	359.9	7.2%
2020	27.6	380.4	7.3%
2021	28.9	392.2	7.4%
CAGR 2010 to 2021	**4.8%**	**2.5%**	

Findings:

- The number of FTEs employed in Provincial Health has grown by 2.5% per year on average between 2010 and 2021.
- The number of Full-time equivalent doctors has grown faster than other occupations in Health, at 4.8% per year, changing the staff composition from 5.7% doctors in 2010 to 7.4% in 2021.

Nevertheless, Doctors still make up a relatively small percentage of total personnel in Provincial Health departments (7.4% in 2021). However, they receive a significant proportion of total CoE across provincial departments of Health, in 2021, doctors received around 22% of total CoE.

- *The NT Spending Review gives full-time equivalents for all health personnel (not specifically doctors). Furthermore, the total health personnel numbers are lower than PERSAL FTEs:*

Health personnel ('000) FTE

Year	*NT*	*PERSAL*
2016	*314*	*341*
2017	*315*	*336*
2018	*325*	*336*

- *The WC report spending review provides FTE personnel per programme and per occupation.*

Drivers of commuted overtime expenditure growth

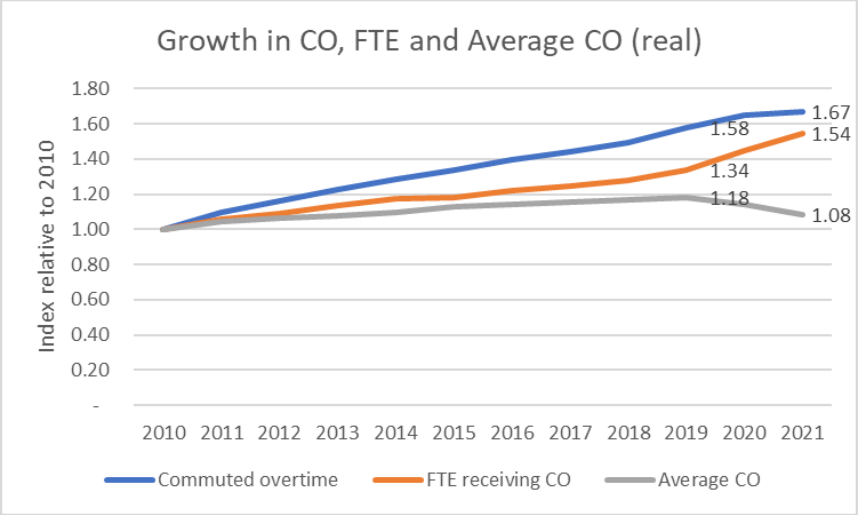
Commuted overtime expenditure growth is the result of a combination of growth in the number of recipients and average commuted overtime per recipient. In this paragraph, the expenditure per FTE recipient is considered (in real terms). Furthermore, the contributions of growth in commuted overtime per FTE and growth in recipients are compared.

Methods that can be implemented to slow down growth in commuted overtime include managing the number of recipients and reducing real growth in the commuted overtime per recipient. Any remuneration policy which affects the salary notch of doctors (e.g. annual cost of living adjustments (COLA) and accelerated progression) will automatically affect commuted overtime expenditure as commuted overtime rates are based on an officials notch.

Table 4: Real growth in commuted overtime (CO), FTE receiving commuted overtime and average commuted overtime (doctors only)

	Commuted Overtime (CO) (R bn) Real 2020	**FTE doctors receiving CO**	**Average annual CO (R'000) Real 2020**
2010	3.94	13 368	295
2011	4.34	14 088	308
2012	4.58	14 606	313
2013	4.83	15 173	318
2014	5.07	15 674	323
2015	5.28	15 825	333
2016	5.50	16 278	338

	Commuted Overtime (CO) (R bn) Real 2020	FTE doctors receiving CO	Average annual CO (R'000) Real 2020
2017	5.69	16 677	341
2018	5.90	17 069	345
2019	6.22	17 861	348
2020	6.51	19 321	337
2021	6.59	20 633	319
CAGR 2010 - 19	**5.2%**	**3.3%**	**1.9%**
Growth 2010 - 19	**57.7%**	**33.6%**	**18.0%**
CAGR 2010 to 21	**4.8%**	**4.0%**	**0.7%**
Growth 2010 - 21	**67.0%**	**54.3%**	**8.2%**



Findings

- Commuted overtime per FTE was R319 000 per annum in 2021. It grew from R295 000 in 2010 at a rate of 1.9% per year in real terms.
- Between 2010 and 2019 real commuted overtime expenditure increased by 58%. The strongest driver of this growth is the increase in the number of doctors who received

commuted overtime (34%), while the average real commuted overtime earned per FTE doctor also increased (18%).

- The increase in doctors contributed *double* as much as the increase in real average commuted overtime to overall commuted overtime expenditure growth between 2010 and 2019.
- The growth in real average commuted overtime mirrors the growth in real basic salaries of doctors, which saw persistent above inflation annual increases up to 2019.
- In 2020 and 2021 the average real commuted overtime per doctor decreased due to the wage bill freeze and possibly a different composition of doctors performing commuted overtime. But the possible savings were absorbed by a sharp increase in the FTEs performing commuted overtime due to Covid demands.
- It seems that the additional demands due to Covid in 2020 and 2021 were covered by increasing the number of doctors claiming commuted overtime, rather than increasing the doctor's commuted overtime hours. Could this be a benefit of pre-loading commuted overtime contractually as per the policy?

- *The NT Spending Review based unit costs on all personnel and is therefore much lower than commuted overtime per recipient used in this report. Unit cost per FTE was R25 000 in 2018 in NT Spending Review while commuted overtime per FTE recipient in this report was R319 000 per year in 2021.*
- *The WC Spending Review considers recipients of commuted overtime per occupation and bases the unit cost on the recipients. The commuted overtime per FTE was R 332 000 in 2021, which aligns with the figure in this report (Table 4).*

The next section considers trends in the demand for commuted overtime. It can be argued that the growth in the number of doctors in public health is a response to a low base stock of doctors compared to international standards and the simultaneous and persistent growth in the uninsured population which increases the demand for health services.

Demand for commuted overtime

The number of Doctors, the size of the uninsured population and the coverage of doctors are compared in Table 5.

Table 5: Doctors per uninsured population

	Doctors FTE (000's)	**Uninsured population (millions)[1]**	**Uninsured population per FTE Doctor**	**FTE Doctors per 1 000 uninsured population**
2010	17.3	42.46	2 461	0.41
2011	18.4	43.30	2 347	0.43
2012	19.3	43.68	2 258	0.44
2013	20.2	44.86	2 219	0.45
2014	21.1	45.66	2 165	0.46
2015	21.5	46.52	2 161	0.46
2016	23.8	47.31	1 988	0.50
2017	24.3	48.18	1 979	0.51
2018	24.8	48.96	1 975	0.51
2019	25.9	49.74	1 924	0.52
2020	27.6	50.48	1 828	0.55
2021	28.9	50.91	1 761	0.57
CAGR 2010 to 2021	**4.8%**	**1.7%**		

Findings

- The uninsured population grew from 42.5 million in 2010 at an average rate of 1.7% p.a. to 50.9 million in 2021. Therefore, the demand for commuted overtime also grew over the period.
- The coverage of doctors per uninsured capita improved between 2010 and 2021, from 0.41 per 1000 population to 0.57 in 2021.
- Even though the of doctors per uninsured capita has improved (0.57 per 1000 uninsured population) it is still low by international standards. (World average was 1.8 in 2017 – but included doctors working in the private sector).

[1] Source: Health Systems Trust

- *The NT Spending Review measures workload as patient day equivalent (PDE). Overtime expenditure per PDE per province and hospital type is compared to the national average to indicate over and underspending. Average overtime expenditure per PDE varied from year to year and across hospital types, the highest was 24.03 in central hospitals in 2018 - units of measurement not indicated. The numbers are highly variable and no conclusions were made.*
- *The WC Spending Review provides PDE and commuted overtime per PDE. The number of doctors per uninsured population is not covered in the WC report.*

Changes to the commuted overtime policy will have a significant effect on the remuneration of a key occupational group in the health system. Table 4 shows that doctors received an average of R337 000 per year commuted overtime in 2020, which was just under 21% of their total compensation. An analysis of PERSAL payments at the personal level provides insight into the implementation of the policy with regards to aspects such as the participation of doctors, units claimed, etc.

Contribution of commuted overtime to doctors' remuneration

The contribution of commuted overtime to the salaries of medical doctors is considered in this section.

Table 6: Commuted overtime as a component of medical OSD (Key Scale 267) CoE

Year	Commuted overtime doctors (R bn)	Total Overtime doctors (R bn)	Total CoE doctors (R bn)	Comm overtime as % of doctors CoE	Overtime as % of doctors CoE	Comm overtime as % of Overtime for doctors	Doctors Commuted Overtime relative to total prov CoE
2010	2.42	2.54	11.21	21.5%	22.7%	95.0%	4.0%
2011	2.79	2.95	13.09	21.3%	22.5%	94.5%	4.0%
2012	3.11	3.27	14.66	21.2%	22.3%	95.1%	4.1%
2013	3.47	3.60	16.39	21.2%	22.0%	96.3%	4.2%
2014	3.86	3.98	18.31	21.1%	21.7%	97.1%	4.3%
2015	4.21	4.32	20.05	21.0%	21.5%	97.3%	4.4%
2016	4.66	4.78	22.95	20.3%	20.8%	97.4%	4.4%
2017	5.08	5.20	25.05	20.3%	20.8%	97.6%	4.5%
2018	5.51	5.61	27.14	20.3%	20.7%	98.1%	4.5%
2019	6.05	6.16	29.60	20.4%	20.8%	98.1%	4.6%
2020	6.51	6.64	31.60	20.6%	21.0%	97.9%	4.7%

Year	Commuted overtime doctors (R bn)	Total Overtime doctors (R bn)	Total CoE doctors (R bn)	Comm overtime as % of doctors CoE	Overtime as % of doctors CoE	Comm overtime as % of Overtime for doctors	Doctors Commuted Overtime relative to total prov CoE
2021	6.88	7.02	33.69	20.4%	20.8%	98.1%	4.6%
CAGR 2010 to 2021	**10.0%**	**9.7%**	**10.5%**				

Findings:

- Overtime contributes significantly to doctors' salaries. Around 21% of doctors' remuneration is overtime (all categories), most of which (98%) is commuted overtime.
- 71% of total overtime in Health departments was disbursed to doctors in 2021 (Table 2 and Table 6).

Table 7: Doctors participating in Commuted Overtime (thousands)

	Doctors perf CO ('000 FTE)	Doctors total ('000 FTE)	Doctors perf CO ('000 headcounts)	Doctors total ('000 headcounts)	% Doctors perf CO (headcounts)
2010	13.4	17.3	16.7	21.1	79.3%
2011	14.1	18.4	17.6	22.3	78.9%
2012	14.6	19.3	18.2	23.2	78.4%
2013	15.2	20.2	18.8	24.3	77.4%
2014	15.7	21.1	19.4	25.1	77.0%
2015	15.8	21.5	19.8	25.9	76.5%
2016	16.3	23.8	20.4	28.4	71.6%
2017	16.7	24.3	20.9	29.1	71.7%
2018	17.1	24.8	21.6	30.0	71.9%
2019	17.9	25.9	23.0	31.6	72.8%
2020	19.3	27.6	24.6	33.4	73.5%
2021	20.6	28.9	26.3	35.2	74.9%
CAGR 2010 to 2021	**4.0%**	**4.8%**	**4.2%**	**4.7%**	

Findings:

- Not all doctors participated in commuted overtime. In 2021 75% of doctors received commuted overtime remuneration.
- The participation rate has dropped from 79% in 2010 to 72% in 2018, after which it climbed to 75%, probably because of COVID demands.

Table 8: Distribution of annual commuted overtime amounts received by all full-time doctors who performed commuted overtime in 2021

	Percentiles (R per annum)		Smallest (R per annum)
1%	140 992		6 179
5%	188 805		6 183
10%	188 805		6 754
25%	255 810		13 521
50%	312 272		

			Largest (R per annum)
75%	416 420		913 055
90%	490 522		926 744
95%	552 568		952 918
99%	667 359		954 759
Number of doctors	16 493		
Mean	336 463		
Std. Dev.	118 701		

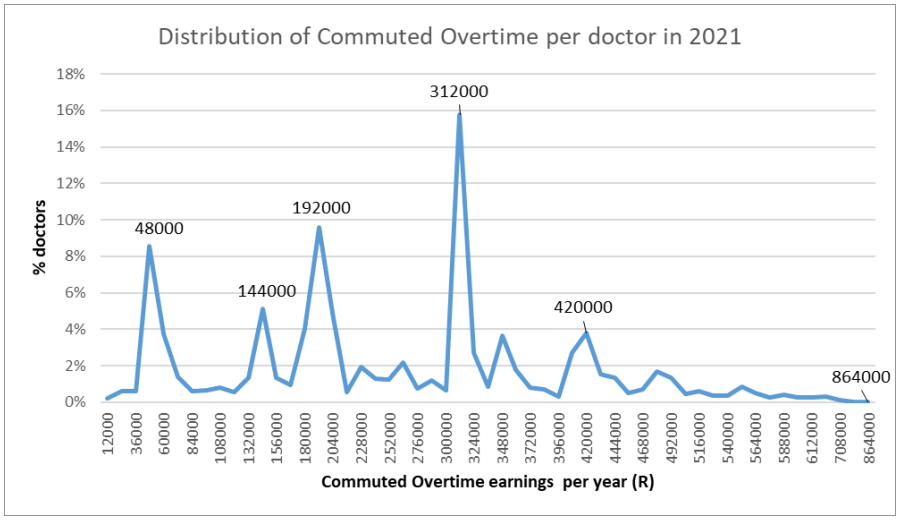


Figure 1: Commuted overtime per doctor in 2021 (Rand)

Figure 1 and Figure 2 provide the distributions of commuted overtime per doctor and the hours remunerated at a rate of 1.3 times the basic salary. The calculation is done at the individual level by calculating the hourly rate based on the notch[2]. The total annual expenditure on commuted overtime for the person is divided by the hourly rate, to give the number of hours commuted overtime for the year. This is then divided by 52 to get the number of hours per week.

[2] Hourly rate = (Basic annual salary/365 x 7)/40
Hourly CO rate=Hourly rate x 1.3
Estimated annual hours=Total annual CO/(Hourly CO rate)

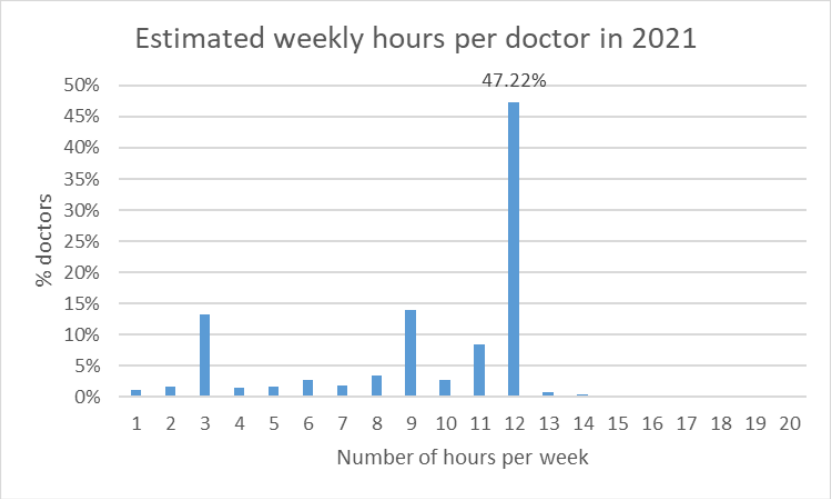


Figure 2: Hours commuted overtime per week per doctor in 2021

Findings

- Most doctors who participated in commuted overtime were remunerated for 12 hours per week at the commuted overtime rate (see Group 2 in Table 1: Commuted Overtime Groups).
- Commuted overtime per doctor in 2021 ranged from +- R 140 000 to R670 000 with a few outliers. Outliers could be actual payments or data issues such as delayed payments.
- The overall coverage of overtime hours is low considering that most doctors cover, in addition to their 40 normal hours, 12 additional hours per week or 9% (12/128) of weekly overtime hours. (Assuming a week is divided into 40 normal and 128 overtime hours.) Given that not all doctors participate (75% in 2021, see

- Table 7), the overall coverage during overtime hours is even lower than 9%. Assuming that 75% of doctors participate, this coverage drops to below 7%. In other words, during overtime, one doctor is representing 14 doctors. This needs to be compared with the actual workload during overtime periods and it needs to be investigated what the average after-hours workload requirement is to ascertain whether we are procuring too many or too few hours of commuted overtime.

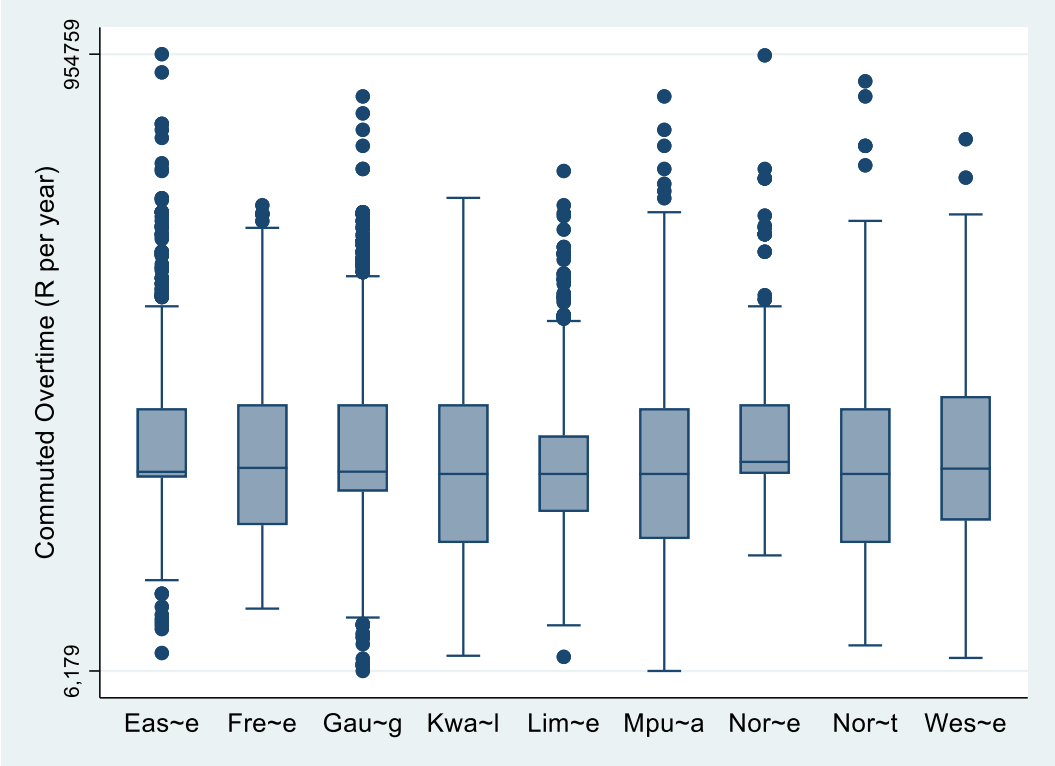
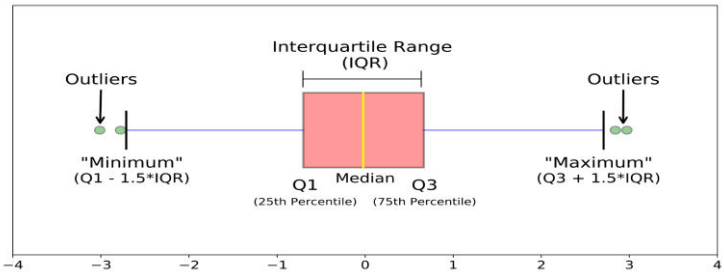


Figure 3: Distribution of commuted overtime per province in 2021 [3]

Provinces' distributions of commuted overtime payments per person for 2021 are compared in Figure 3. The hours per week can be estimated based on the hourly rate of a doctor and the commuted overtime paid and Figure 4 provides a comparison of the provinces based on the weekly hours per doctor in 2021. Most doctors performed 12 hours per week as Figure 4

[3] Interpretation of Boxplot:



indicates. Additionally, the maximum number of hours was one individual who performed 20 hours per week on average for the whole year in the Free State.

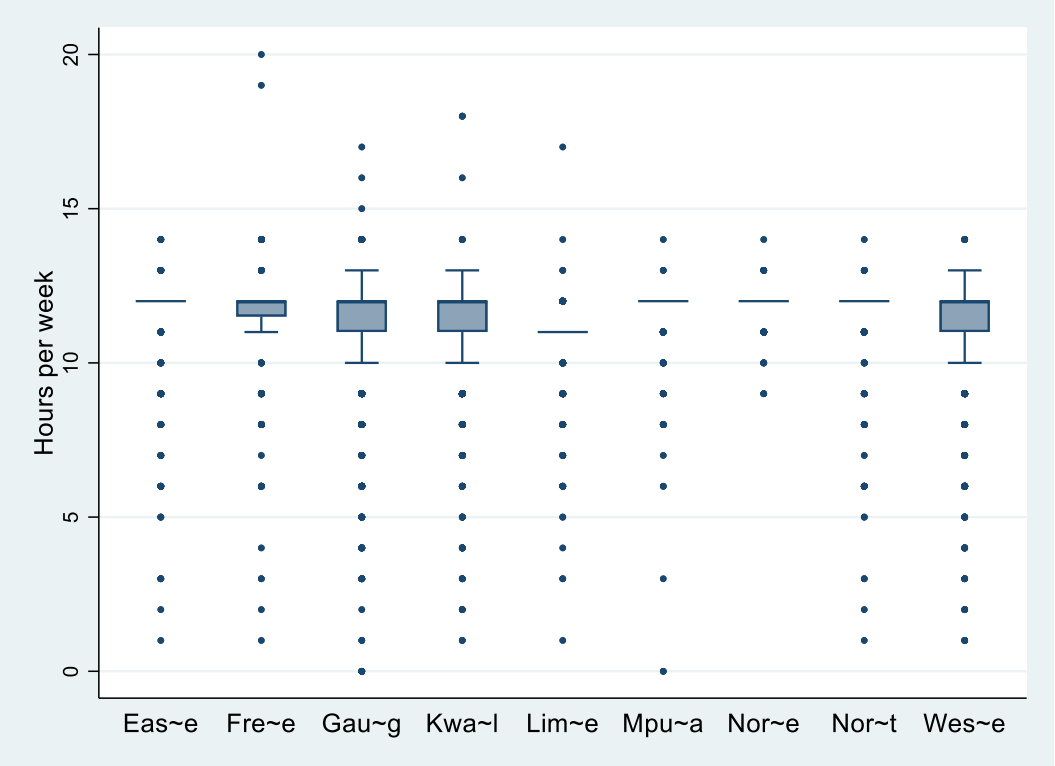


Figure 4: Distribution of hours per week commuted overtime per doctor per province

Findings:

- Most provinces had outliers, with the highest payments per person associated with the Eastern Cape and Northern Cape.
- Eastern Cape, Northern Cape and Gauteng's distributions are positively skewed, which indicates that the top 50% earnings are much more variable and dispersed than the bottom 50%. This is due to provincial differences in the mix of basic salaries of doctors performing commuted overtime.
- Except for Limpopo Province at 11 hours, all provinces' median hours of overtime per doctor per week is 12.
- Comparing Figure 3 and Figure 4 shows that the composition of doctors providing commuted overtime is different across provinces. In some provinces, more senior doctors (on higher notches) are performing more commuted overtime compared to other provinces.
- There is no evidence of doctors being paid more than the maximum allowed by the policy (20 hours per week) in any province.

- *The distribution of commuted overtime per doctor or hours commuted overtime per doctor is not analysed in the NT Spending Review.*
- *The WC Spending Review provides the distribution of the number of hours commuted overtime per facility. According to the table, the majority of doctors performed 16 hours of overtime per week, which is different from the 12 hours found in this report using PERSAL data. The source of the facility data in the WC report is not specified.*

Conclusions

- The strongest contributor to commuted overtime expenditure growth between 2010 and 2021 was the expansion of the number of doctors in the health system. Even with the expansion, the number of doctors per 1000 uninsured population is still low by international standards. Stabilising or slowing down the growth in the number of doctors will slow the growth in commuted overtime expenditure. But that will come at the cost of reduced service delivery.
- Reducing the number of doctors performing commuted overtime may not be an option, given that the number of doctors in public health is low by international standards and that overtime coverage seems to be low relative to normal hours. The current approach to spread the overtime workload over many doctors and limiting the number of hours per doctor as per the policy may be the best approach.
- The coverage of doctors after hours seems to be low considering that doctors typically perform 12 out of the 128 night and weekend hours overtime per week. Given that 75% doctors performed overtime, it can be shown that the coverage during after hours is 7%: in other words, 1 doctor is representing 14 doctors after hours. This needs to be compared with the actual workload during overtime to ascertain whether we are procuring too many or too few hours of commuted overtime.
- The commuted overtime policy seemed to have been robust enough to handle additional demands during the COVID pandemic. The data suggests that doctors performed commuted overtime within their contracts. Increased spending on commuted overtime was for the appointment of additional doctors under the same policy.
- Commuted overtime expenditure growth is directly related to growth in the basic salaries of the recipients. Lower annual COLA and fewer progressions and promotions will slow down commuted overtime expenditure growth.
- No evidence of excessive claims was detected in the 2021 PERSAL data.

- The NT spending review considered the effect of lowering the commuted overtime hourly rate from 1.3 times the normal rate to the normal rate by appointing additional doctors to perform commuted overtime at the normal rate. The assumption that doctors would be available at the proposed normal rate may not be realistic, also considering that the commuted overtime factor of 1.3 is already lower than the factors 1.5 and 2 used for other overtime categories in the public service.

- *Both reviews recommend a closer link between the need at the facility level and the contracts entered into (the development of a national norm).*
- *Both reviews recommend closer monitoring of the performance at facility level. This will increase the efficiency of the current spending.*

Recommendations

1) Finalise and publish the commuted overtime policy.
2) The impact of COLA and progression on commuted overtime should be understood and managed.
3) Consider adding a norm for the provision of commuted overtime capacity based on a suitable measure of overtime workload, e.g. PDE or uninsured population.
4) Use PERSAL payment data to annually screen excessive claims and do enquiries/ audits to prevent misuse of the system.
5) Ensure that facility managers monitor the performance of commuted overtime.

Annexure 1: Comparison of three studies

Below is a brief comparison of the three studies on commuted overtime.

Table 9: Comparison of three studies on Commuted Overtime

	NT 2020	**WC 2021**	**PEPA**
Data sources	BAS, Persal. (PDE data source no cited)	BAS, Persal, facility data (source not provided – internal?) (PDE data source no cited)	BAS, Persal, Health Systems Trust

	NT 2020	WC 2021	PEPA
Spatial coverage	All Provincial Health depts	WC Health	All Provincial Health depts
Time coverage	Mostly 2016 to 2018	2017 to 2020	2010 to 2021
Commuted overtime considered	No	Yes	Yes
Lowest level of analysis	Province, Programme, hospital type, occupation	Facility (also programme and staff grouping)	Analysis at the individual level, aggregated
Study group	All health personnel, doctors, nurses	Medical doctors and dentists	Medical OSD which includes medical doctors and dentists
Workload considered	Yes, PDE	Yes, PDE	Uninsured population
Objective	*This spending review seeks to*: • Determine differences in overtime spending across provinces by level of care • Link overtime to workload for comparative purposes • Quantify the trade-off between capacity obtained	This expenditure review aims to determine differences in overtime spending across the Western Cape districts (sub-districts) by taking the following into account: • Types of hospitals by level of care including other programmes. • Linking commuted overtime	Review other work on commuted overtime Update/expand work – longer timelines, all provinces) Common findings (are the numbers the same, do we arrive at same results)

	NT 2020	WC 2021	PEPA
	through overtime and additional appointments.	spending for districts/ hospitals/ clinical programmes to workload for comparison. • Establish a norm in terms of commuted overtime per Patient Day Equivalent (PDE)/ staff member/ per district. • Comparison across districts, facilities, staff categories - reasons for deviations. • Establish if demand for services align to the number of overtime hours. • Identify the level of	

	NT 2020	WC 2021	PEPA
		care, clinical services which has the highest demand. • Quantify the trade-off between capacity obtained through overtime and additional appointments.	
Methodology	Unit cost spread over all personnel	Unit costs per recipient	Unit costs per recipient Some calc at indiv level, then aggregated
Recommendations	Service can be provided at cheaper rate by reducing factor to 1 from 1.3 of basic salary. Amount to be saved includes nurses, which is incorrect.	Optimising in terms of a closer link between supply and demand. (Develop norms and standards). Improving return on investment by comparing actual hours worked to claimed hours.	Finalise CO policy CO growth could be curtailed by 1. Reducing/stabilising doctors' basic salary growth (reduced COLA, fewer progressions and promotions) 2. Stabilise growth in doctors numbers

Annexure 2: National Policy: Commuted Overtime for Medical Officers

Table of context

NATIONAL POLICY ON COMMUTED OVERTIME FOR MEDICAL OFFICERS

1. PREAMBLE

1.1 Disparities in the existing Provincial Policies on Commuted Overtime and inconsistencies in the application of commuted overtime administration are leading to excessive expenditure and compromised patient care within the public health sector.

1.2 It is therefore essential to develop a National policy ("policy") that is adopted and applied uniformly throughout the country, to ensure that there is transparency, fairness and consistency.

1.3 The fundamental purpose of this policy is to regulate the consideration and application of Commuted Overtime by Medical Officers in the public health sector.

2. POLICY PURPOSE

2.1 The purpose of this policy is to provide a comprehensive framework within which Medical Officers in the public health sector may perform Commuted Overtime in the public service. The policy further regulates management of the commuted overtime system for Medical Officers and alleviates practical challenges through the prescribed monitoring and control measures.

2.2 The policy on commuted overtime for medical officers seeks to guide the dispensation, whilst ensuring that the employing authorities stay on top of matters to prevent abuse thereof.

2.3 The fundamental tenets of this policy are dependent on the ability of the Department of Health to meets its human resource needs in the Public Health Sector in the short, medium and long term.

3. SCOPE OF APPLICABILITY

3.1 Scope of applicability

The commuted overtime system is applicable to:

3.1.1 All full-time Medical Officers employed in a permanent or temporary capacity who are rendering actual clinical, patient related services on an organized basis within a health facility may participate in the commuted overtime system where, on a continuous basis, the need exists for the rendering of such overtime duties.

3.1.2 A medical officer who has entered into and fulfils the requirements of a commuted overtime contract.

Exclusions:

3.1.3 The commuted overtime system is however not applicable to Part-time medical doctors who are employed for less than 40 hours per week as well as sessional medical officers.

3.1.4 The commuted overtime system is not applicable to other qualified health professionals employed in the public sector. Overtime remuneration for such health professionals will be dealt with in terms of the general overtime policy in terms of Resolution 3 of 1999 of the Public Service Coordinating Bargaining Council (PSCBC).

4. REGULATIONS

The performance of Commuted Overtime is regulated by:

4.1. Public Service Act, 1994;

4.2 Public Service Regulations, 2001;

4.3 Basic Conditions of Employment Act, 1997;

4.4 Public Finance Management Act, 1999;

4.5 Treasury Regulations;

4.6 Health Professions Act, 1974;

4.7 Labour Relations Act, 1995; and

4.8 Related Public Service Coordination Bargaining Council Resolutions.

5. GLOSSARY OF TERMS/DEFINITIONS

For the purpose of this policy the following definitions apply:

"Medical Officers" means a qualified health professional who has complied with all tertiary studies that have allowed him/her to successfully register with the Health Professions Council of South Africa as such;

"Normal hours of work" means the first 40 hours of work per week that a medical officer is scheduled to work in accordance with a duty roster;

"Commuted overtime" means hours of work additional to the total number of normal hours of work required by the employer to render a health service within a health facility in terms of operational needs. It should be only duty in excess of the normal prescribed working hours and authorized by the relevant delegated authority;

"Commuted overtime system" is a flexible system averaging the overtime hours worked to accommodate medical doctor who perform scheduled overtime on a regular basis over a 4-week period;

"On-site or 1st On-call" means a medical officer is within the health facility for the full duration of the commuted overtime hours. On-site sometimes is referred to as 1st On-Call. The medical officer must be available within minutes in the clinical area as and when needed. There should not be a delay period in the availability of the doctor. These hours are classified as actual commuted overtime hours;

"Off-Site or 2nd On-call" means a medical officer is off-site and is rostered for 2nd call in order to be available to render clinical advice with regard to patient care:

-This could be advise rendered telephonically in which case 30% of the time spent at home (off-site) will be classified as actual commuted overtime hours. To a maximum of 20 hours, thereafter the medical officer must be remunerated according to the normal overtime policy.

-Should the medical officers have to come in to the health facility to attend to clinical duties, all hours spent on-site during 2nd call will be classified as actual commuted overtime hours.

“Chief Executive Officer (CEO)” means a Hospital or Facility Manager that is not directly responsible for the management of clinical services.

“Clinical Manager” means a Clinical Medical Manager who is directly responsible for the management and control of clinical services rendered by medical officers and health professionals;

“Manager: Medical Services” means a hospital and or facility manager who is also directly responsible for the management and control of clinical services rendered by medical officers and health professionals;

"Sessional employee" means a person who is remunerated by the department when he/she renders service for a fixed number of hours per week;

"Standby" means being available during a specific period which is outside one’s normal working hours to render service should the need arise;

6. POLICY PROVISIONS

6.1 Effect of Organization and Establishment Control

6.1.1 Medical officers do not in general partake in shift work where staff members involved in operational areas working hours need to be extended due to operational needs, the working hours per day and per week can be adjusted based on service delivery needs . As a result of this, the filling of posts will only reduce the need for overtime hours during normal hours of work, i.e. between 07:00 to 16:00. After hours, i.e. from 16:00 to 07:00, will always necessitate the rendering of overtime duties.

6.2 Payment of commuted overtime during periods of leave

6.2.1 Commuted overtime is payable to medical officers who participate in the commuted overtime system for periods of annual leave within each calendar year (i.e. from 1 January of a year to 31 December of that year) on the following basis:

6.2.1.1 22 working days in respect of employees with less than 10 years' service;

6.2.1.2 30 working days in respect of employees with more than 10 years of service;

6.2.2 Commuted overtime will not be paid during sabbatical-, shop steward- and maternity leave. Provision must be made to ensure that the amount of commuted overtime payable per month is decreased on a pro-rata basis in cases where such absences occur during the course of a month. However, commuted overtime is paid during periods of exam preparation leave, family responsibility, pre-natal if employee was not scheduled to work and individual did meet his/her commuted overtime commitments.

6.2.3 With due regard to absences in respect of periods of sick leave where the individual is not in a position to fulfil his/her commuted overtime contractual obligation during a specific month, the commuted overtime rate must be reduced on a pro-rata basis.

6.2.4 No reduction of commuted overtime must however take place in cases where an individual for the reasons as set out hereunder is able to fulfil his/her commuted overtime-contractual obligation during a specific month:

6.2.4.1 With regard to short periods of sick leave and family responsibility leave, where an individual is absent on the day(s) where he/she is not rostered to perform after-hour duties.

6.2.4.2 With regard to periods of sick leave where the individual is rostered to perform after-hour duties, but is able to meet his/her after-hour commitment by interchanging (swopping) his/her after-hour duties with other doctors in a specific month. This arrangement must be

approved by the supervisor (Clinical Manager). The supervisor (Clinical Manager) must certify on the Z1(a) (leave form) that the commuted overtime commitment for the sick leave period was worked in.

6.2.5 Carry over of commuted overtime hours: Medical Officers are not allowed to carry over their rostered after-hour commitment for a specific 4-week period to the following 4-week period to avoid the reduction of commuted overtime remuneration in the specific period where they were not able to meet their rostered overtime commitment in respect of that specific 4-week period due to absence on sick leave or family responsibility leave.

6.3 Suspension

6.3.1 Commuted overtime remuneration is not payable in cases where employees have been suspended from duty with full emoluments. In view of the fact that commuted overtime does not form part of the salary packages of medical personnel, it is not payable to employees during periods of suspension from duty with full emoluments.

6.4 Training and research

6.4.1 The payment of commuted overtime remuneration is limited to the rendering of actual patient related clinical services as needed by the Department of Health and therefore is not applicable to any academic/ training or research functions.

6.4.2 With regard to employees appointed on public service conditions of employment (Joint Staff Appointments) at academic/psychiatric institutions in terms of the Joint Agreement, the time spent by such personnel on teaching and research may not be included in overtime calculations. The aforesaid employees may spend time to a maximum of 14 hours per week on teaching and research activities. These activities must be included in the normal official 40-hour workweek core service (i.e. the normal 40 hour workweek may consist of a minimum of 26 clinical service hours and a maximum of 14 hours teaching/research activities).

6.4.3 Time spent by registrars in receiving formal training/teaching is regarded as on duty, whilst time spent on own study should not be taken into account.

6.5 Standby duty

6.5.1 In terms of the measures set out in the Collective Agreement on overtime (PSCBC Resolution 3 of 1999), an employee may only be paid overtime remuneration for work performed in addition to his/her contracted hours of work (i.e. 40 normal official hours per week).

6.5.2 Periods of on-call are not regarded as standby duty according to the standby duty measures applicable to the rest of public service employees.

7. PERIODIC REVIEW AND CONTROL MEASURES

7.1 In terms of the Public Finance Management Act, the Head of Department as Accounting Officer must ensure that he/she implements and maintains effective and efficient systems of financial and risk management and internal control measures. With due regard to the above, the commuted overtime system as part of a remuneration system is therefore subject to periodic review in order to reduce the risk of irregular expenditure and/or financial misconduct.

7.2 It will be necessary for all participants in the commuted overtime remuneration system to complete commuted overtime contracts.

7.3 The following mechanisms should be implemented to manage, monitor and control the payment of commuted overtime efficiently:

7.3.1 Normal working hours' duty roster of the component

7.3.2 On call duty roster of the component

7.3.3 Duty hours' register of the individual

7.4 To further reduce the risk, the following control measures will apply:

7.4.1 Duty rosters must be made available to the Heads of Institutions in advance. The duty roster must indicate the normal official duties required in the component and another on call roster must indicate the individuals who are scheduled to be on-site (1st call) and off-site (2nd call).

7.4.2 The Heads of Institutions/ Clinical Managers/ Heads of Clinical Units will verify the overtime worked by participants in the commuted overtime system in accordance with their record of 4-weekly duty hours and the relevant duty roster and duty hours register of the component's clinical service delivery.

7.4.3 All Heads of Clinical Departments/supervisors will certify the hours overtime worked in the rendering of clinical services on a 4-weekly basis for each participant to the system within his/her Clinical Department/ Component. Furthermore, the said Clinical Head/supervisor will also indicate all leave taken during the 4-week period by each participant.

7.4.4 It is the responsibility of the Head of a Clinical Department/supervisor to submit all applications for leave approved by him/her directly to the staff office of the institution. Heads of Institutions/ Clinical Managers/ Heads of Clinical Units will reconcile the duty hour register with the leave applications on a monthly basis.

7.4.5 The Head of Department, as Accounting Officer, may on instruction request audits of the commuted overtime system within institutions from time to time, to monitor the compliance of medical staff to the commuted overtime system and the conditions of the contract in accordance with the duty rosters.

7.4.6 Commuted overtime can only be earned when performing actual patient related clinical services at the workplace. This can either be on-site (1st on call) or off-site (2nd on call) and that is duties performed additional to the normal 40 working hours.

7.4.6.1 Notwithstanding the afore-mentioned, if the medical officer is off-site and is rostered for 2nd on call, 30% of the time spent at home (off-site) will be classified as actual commuted overtime hours. To a maximum of 20 hours, thereafter the medical officer must be remunerated according to the normal overtime policy.

7.4.6.2 Should a medical officer who is rostered for 2nd on call have to come in to the health facility to attend to clinical duties, all hours spent on-site during 2nd on call will be classified as actual commuted overtime hours.

7.4.7 All commuted overtime contracts of medical officers will be reviewed annually on an individual basis by the responsible Heads of Institutions/Clinical Managers in collaboration with the Heads of Clinical Departments, in terms of the existing operational need for such overtime work. Furthermore, all renewed contracts will be authorized by the Head of the Department of Health or his/her delegate (current delegation is with the CEO).

7.5 It must be emphasized that, in terms of the commuted overtime contract, the Heads of Clinical Departments/supervisors will take responsibility and accountability should any malpractice be identified with the compliance to the conditions and practices of the system. In this regard cognizance should be taken of Section 81(1)(b) of the Public Finance Management Act in the event of authorizing expenditure for overtime not performed.

7.6 Heads of Institutions as well as Heads of Clinical Departments/supervisors are instructed to ensure that the above control measures are implemented and maintained effectively.

7.7 When medical officers change from one work sphere to another or from one rank to another, they will have to complete a new contract because of changed circumstances. It must be accepted that such changes might result in a reduction in the commuted overtime rate, e.g. appointment of a medical doctor to CEO/ Manager: Medical Services/ Clinical Manager position.

7.8 The continued need for additional overtime hours should be reviewed when vacant posts are filled.

7.9 It is the duty of Heads of Departments to ensure that persons who make themselves part of fraudulent practices with regard to overtime, are dealt with in terms of the relevant disciplinary measures.

7.10 Medical Officers working in a capacity/rank identified to participate in the commuted overtime system, must, before the commuted overtime remuneration is payable to him/her, sign an undertaking in which he/she undertakes to accept that the payment of the applicable commuted overtime rates be terminated:

7.10.1 on transfer/promotion to a post/rank not identified to participate in the dispensation; and

7.10.2 where the establishment position is favourable to such an extent that the need for overtime on a commuted basis expires.

7.11 Commuted overtime payment terminates:

7.11.1 where the recipient is transferred/promoted to a post/rank not identified to participate in the dispensation;

7.11.2 where the establishment position is favourable to such an extent that the need for overtime on a commuted basis expires;

7.11.3 where the incumbent of a post of supervisor is not directly linked to the supervision and management of clinical medical services.

7.12 The commuted overtime tariffs are fixed and must not be taken into account when:

7.12.1 any benefits/payments are determined which are derived from/based on basic salary; and

7.12.2 officers and employees are classified according to their salaries, for purposes of granting any service benefit, payment of housing allowance, overtime remuneration and any allowance, etc.

7.13 Commuted overtime is payable, as is basic salary, in installments over a period of a year together with basic salary and where a reduced/increased basic salary is payable on a pro rata basis, for whatever reason, the commuted overtime tariff must be reduced/increased in the same ratio.

8. COMPULSORY OVERTIME AND REFUSAL TO WORK OVERTIME

8.1 In terms of the Basic Conditions of Employment Act, 1997, an employer may not require or allow an employee to work overtime except by an agreement. This agreement may be an agreement between the employer and an individual employee or it may be a collective agreement.

8.2 The collective agreement regulating overtime in the Public Service (PSCBC Resolution No. 3 of 1999, Part VII) specifically stipulates that the definition of overtime in the relevant agreement refers to work in excess of hours of work per week or 4-week period that an employee has contracted to perform. With due regard to the foregoing an employee in the Public Service cannot be compelled to work overtime. The commuted overtime system which was consulted with organized labour is based on the same principles.

8.3 In terms of the commuted overtime system, medical officers engaged in actual patient related clinical work on an organized basis, may participate in the aforesaid system provided that the operational need exists for the rendering of overtime duties and on the understanding that the individual fulfills the requirements as set out in the relevant commuted overtime contract. The contract only becomes effective once both parties have signed it. It is therefore clear that full-time medical officers do not automatically qualify for participation in the commuted overtime system, that participation is voluntary, that the hours overtime to be performed are per mutual agreement and that participation is subject to the terms and conditions as set out in the contract. Therefore should an individual not be prepared to apply for participation in the scheme, the terms and conditions of the relevant system does not apply to him/her and the employer cannot expect such a person to perform overtime under normal circumstances.

8.4 In terms of current legislation, an employer may only expect an employee to work in excess of normal working hours in exceptional circumstances such as in cases of emergency, and not due to other factors such as personnel turnover, etc. The employer is also not in a position to compel an employee to perform overtime duties in cases where no agreement on the performance of such overtime duties exists between the employer and the employee. In the case of a medical officer, the commuted overtime contract constitutes such an agreement. Although the foregoing has the effect that existing medical personnel will be acting fully within their rights to refuse to work non-contractual overtime, it has been held in court that an employer may dismiss an employee who persistently and unreasonably refuses to work overtime as required by the employer due to operational needs.

8.5 In order to accommodate the Department's specific need regarding overtime hours needed and with due regard to the fact that it is the prerogative of the Department to determine

the conditions attached to employment within the parameters of the regulatory framework (i.e. Public Service Act, 1994 (as amended), Labour Relations Act, 1995 (as amended), the Public Service Regulations, 2001, and Collective Agreements), the opinion is held that institutional heads should, based on operational requirements, determine before advertising and filling of posts whether or not it will be required of the successful candidate to perform overtime duties on an organized basis. In cases where the successful candidate will be expected to perform overtime duties on an ongoing, organized basis due to the nature of the post, this issue must be specified in the advertisement, be included in the job description and clearly stipulated in the relevant employment contract. In such instances the successful candidate will be fully aware of the fact that he/she will be required to perform overtime duties and by applying and accepting such an appointment on the terms stipulated, the successful candidate is obligated to perform overtime duties. In these cases the employer has the right to call in overtime in terms of the contract of employment and refusal by an employee to perform contractual overtime will constitute a disciplinary offence.

8.6 With due regard to the aforesaid it is advisable that the number of overtime hours needed per institution be managed as follows:

8.6.1 Heads of Institutions must determine their actual clinical, patient related hourly overtime need (operational requirements) per week, preferably over a 12-month period. Once the overall need has been established, the actual number of overtime hours required per week must be allocated to the filled posts of medical personnel (as applicable) on an individual basis. With the aforementioned information at hand the institutional head, on identifying the need for the filling of a vacant post in the above-mentioned group, will be aware whether or not the post incumbent will be required to perform overtime duties or whether the overtime already allocated to filled posts can be reduced. In the latter instance the current commuted overtime contracts of existing employees will have to be revised or cancelled and new contracts entered into. Record of this exercise must be kept on file as it, inter alia, could serve as documented proof should a dispute arise pertaining to whether or not the requirement of the employer for the rendering of overtime duties in respect of a specific post incumbent was based on operational requirements.

8.6.2 In cases where there is a need for the performance of overtime duties at an institution and certain existing medical personnel at such an institution are not prepared to perform overtime duties (i.e. not prepared to voluntarily participate in the commuted overtime system or are no longer prepared to continue with the performance of overtime duties as contracted for and cancel their existing commuted overtime contracts), their discharge in terms of section 17(2)(c) of the Public Service Act, 1994 (as amended) may be considered. Before proceeding with the termination of services in terms of the aforementioned section, the following process should be followed. It is important to note with regard to the actions as set out hereunder, that the employee must be afforded the opportunity to be represented by his/her union representative:

8.6.2.1 Consultation process:

8.6.2.1.1 Request the relevant employee in writing to perform the required number of hours overtime duties per week based on the operational requirements of the institution involved. In the request elaborate on the negative impact on the work situation (i.e. the effect on service delivery to patients and his/her co-workers) should the employee not be prepared to perform the required overtime duties. Request the employee to respond in writing within a specified period of time whether or not he/she is willing to perform the required overtime duties and should he/she not be prepared to perform such duties, to submit reasons.

8.6.2.1.2 Should the employee respond negatively to the written request, inform the employee (if verbally, follow up in writing) of the fact that his/her refusal to perform overtime duties has a detrimental effect on service delivery to patients and that his/her action cannot be accommodated in the work situation of the institution concerned. Furthermore, the employee must be informed that the head of institution has no other option but to seek an alternative position in another component in the same hospital or at another institution for the employee in question where it is not a requirement to render overtime duties (i.e. relocate by means of transfer mechanism). Also inform the employee that should it not be possible to secure a transfer to another position under the control of the Department of Health, the head of institution has no other alternative but to request a termination of service in terms of section 17(2)(c) of the Public Service Act, 1994 (as amended).

8.6.2.2 Actions to secure other employment:

8.6.2.2.1 Approach (in writing) the higher level authority (Regional Director/Chief Director), explain the problem and request them to indicate whether it is possible to accommodate the employee in question in a suitable position at any of the institutions under their control. Upon receipt of the response, inform the employee concerned whether or not he/she can be accommodated elsewhere. Where applicable, execute the necessary transfer actions.

8.6.2.3 Termination of services:

8.6.2.2.2 In cases where it is not possible to accommodate the employee elsewhere, such an employee must be informed that every endeavor was made to secure alternative employment but without any success. Furthermore, that due to the foregoing and the fact that the continuous employment of the individual at the relevant institution negatively impacts on the operational requirements of the employer due to his/her refusal to perform the required overtime duties, the employer has no option but to request the termination of service in terms of section 17(2)(c) of the Public Service Act, 1994 (as amended). The employee must be given the opportunity to respond within a reasonable time and such response must be thoroughly considered before the final recommendation is made for the termination of service.

9. CATEGORIES OF OVERTIME REMUNERATION

9.1 The commuted overtime system makes provision for four categories of overtime remuneration. The purpose is to make provision for a flexible system in order to accommodate medical officers who do not perform overtime on a regular basis, as well as those employees who regularly perform overtime duties.

9.2 The four categories are as follows:

Group 1 0-4 hours per week May claim for actual hours overtime worked where such duties are needed, as applicable to other categories of staff in terms of PSCBC Resolution 3 of 1999

Group 2 5-12 hours per week

(average of overtime worked may not be less than 8 hours per week) Overtime remuneration is payable at a fixed tariff equal to 8 hours per week at 1.3 of the applicable hourly tariff

Group 3 13-20 hours per week

(average of overtime hours worked may not be less than 16 hours per week) Overtime remuneration is payable at a fixed tariff equal to 16 hours per week at 1.3 of the applicable hourly tariff

Group 4 >20 hours per week Overtime remuneration is payable at a fixed tariff equal to 16 hours per week at 1.3 of the hourly tariff plus actual hours worked in excess of the limit of 20 hours at the applicable overtime tariff as per PSCBC Resolution 3 of 1999

9.3 Group 1

As indicated above, the measures contained in PSCBC Resolution 3 of 1999 are applicable provided that the control measures as set out in the aforementioned agreements are adhered to. Application forms and time sheets in respect of such claims must be completed by the relevant supervisors and submitted to the delegated authority for evaluation and approval (currently District Managers, Chief Director (Academic Hospitals), or Head of Institution). The commuted overtime contract is not applicable to medical officers who resort under Group 1. In general, a maximum of 4 hours overtime remuneration is applicable to Group 1. This may only be exceeded in exceptional circumstances.

9.4 Groups 2 and 3

Medical Officers who wish to participate in the commuted overtime system as indicated in Groups 2 and 3 must complete the commuted overtime contract. The Head of Clinical Department is responsible for verifying the contract as measured against the need for overtime services in their clinical departments. Heads of Institutions are responsible for the approval of individual contracts and are accountable to the Auditor-General for the effective control of the overtime system. District Managers/Chief Directors of Academic Hospitals are regarded as Heads of Institutions in cases where Manager: Medical Services wish to participate in the commuted overtime system. Should it be required of these personnel to perform overtime work in excess of 20 hours per week, they must be compensated in terms of the provisions as set out for Group 4.

9.5 Group 4

9.5.1 With regard to individuals in Group 4, Heads of Institutions are urged to limit the need for overtime duties in excess of 20 hours per week. Claims and the subsequent payment for hours worked in excess of 20 hours per week shall under normal circumstances be limited to a maximum of 32 hours per week in accordance with the measures of Public Service Regulations, Part V, D2. This limit may only be exceeded in exceptional, fully motivated circumstances, e.g. in cases where an individual is compelled to perform additional overtime duties as the result of severe staff shortages or in a crisis situation. Claims in respect of every hour worked in excess of 20 hours to a maximum of 32 hours will be administered in terms of the measures and criteria as contained in Chapter VII of Resolution 3 of 1999. These claims must be accompanied by the prescribed application forms and time sheets, and must be duly completed by the relevant supervisor to be submitted to the delegated authority on a 4-weekly basis for evaluation and approval. The claims must be supported by a written motivation, with due consideration to compliance with the normal official 40 hour workweek.

9.5.2 All medical officers (including those who participate in the commuted overtime system at their own institutions) who are willing to perform additional duties at other hospitals, community health centres and primary health care clinics may perform such duties. Such personnel may claim for actual hours overtime duties performed at the relevant institutions at the prescribed rates as set out in Chapter VII of Resolution 3 of 1999 on the condition that the criteria as mentioned in the afore-mentioned paragraph are adhered to and provided that the Head of the employing institution is in agreement with the arrangements.

9.6 With regard to personnel in the occupational classes of Specialist, Head of Clinical Units and Head of Clinical Departments, as well as Manager: Medical Services, the following restrictions are placed on the maximum number of hours overtime which are payable according to commuted rates.

9.6.1 Managers: Medical Services and Senior Manager: Medical Services:

9.6.1.1 Managers: Medical Services and Senior Manager: Medical Services, who render clinical services in excess of the 12 hours commuted overtime per week, may apply for inclusion in Group 3 in order to provide relief where there is a need for clinical services.

9.6.1.2 If a Manager: Medical Services applies to partake in Group 3, the Group 2 (8 hours) contract lapses. Medical staff may only partake in one commuted overtime contract during a specific period.

9.6.2 Head of Clinical Units and Head of Clinical Departments:

12 Hours per week.

10. SPECIFIC PROVISIONS

10.1 The payment of the commuted overtime rates is only payable to medical officers, registrars, specialists and medical managers. (OSD terminology should be used in terms of post classes.)

10.2 The Clinical Manager who is the supervisor of clinical services will qualify for commuted overtime.

10.4 Dentists:

10.4.1 Dentists do not partake in the Commuted Overtime system. If due to operational requirements, there is a need for dentists to perform overtime, normal overtime measures will apply. There has to be an approved monthly overtime roster for dentists linked to a specific hospital/institution.

10. 4.2 A standby allowance (or as may be determined) is paid for the days that the dentist is on call.

10.4.3 Actual time worked is recorded in the register every time the dentist is called to the hospital for clinical work.

11. APPROVED AND AUTHORIZED BY THE NATIONAL HEALTH COUNCIL

_____

Signature: NHC Chairperson

Minister of Health

-oOo-

Annexure 3: Spending Review National Treasury 2020

national treasury
Department:
National Treasury
REPUBLIC OF SOUTH AFRICA

[DOCUMENT TITLE]

Provincial Health Departments: [Document subtitle]

REFILOE THOKOA, NOOLO MADELA

1. Executive summary/ overview of issue

The apparent need, within applicable legislation, to increase hours of medical professionals in facilities is seen in the level of overtime spending. These increased hours can be obtained through additional appointments or by increasing the work hours of staff already in the system beyond the traditional 40 hour week. For the latter, section 10 of the Basic Condition of Employment Act applies and stipulates that an hour worked overtime, should be remunerated at a rate no less than 1.5 times the normal hourly rate.

It appears, based on spending on overtime that most provinces have opted for paying overtime as opposed to appointing additional staff. This is a comparatively expensive option due to the legislation in this area.

It is against this backdrop that the National Health Council (NHC) led by the National Department of Health (NDOH), whose Minister is the chairperson of the council, recognised the need to regulate the overtime system to ensure its sustainability. Requiring staff to work overtime appears to be the preferred approach to obtaining additional capacity. The only way government can get staff to work overtime, at a cheaper rate is through agreement with employees or organised labour. To deal with this, the National Policy on Commuted Overtime for Medical Officers (that is, all professionals registered with the Health Professions Council of South Africa) was developed.

In the policy, appointment of additional staff is not recommended as they are seen to usually work during normal work time, between 7:00 to 16:00, but little thought was given to sessional doctors (i.e. the opposite of Remunerative Work outside Public Service) if we accept that it is unusual for permanent appointees to work the 8 hours from the period 16:00 to 7:00. Commuted overtime is essentially the preloading of overtime and aims to cap the total overtime payable at any given time.

The policy has two main mechanisms:

- Introduction of a 1.3 times normal hourly tariff and not 1.5 times normal hourly tariff
- Capping the hours payable based on a grouping system that aligns to specific needs at facility level.

2. Problem statement

The following problems have been identified with the current policy:

(a) Nurses and doctors, in terms of the commuted overtime policy, are required to participate on an annual basis if need has been determined. The overtime requirement is based on estimated workloads for the year and the total over time awarded does not vary with changes to workload during the year.

(b) There are no national guidelines on the determination of clinical need for overtime capacity at facility level. This is at the discretion of facility managers and open to abuse as there are no benchmarks that can be used for the monitoring the implementation of the policy.

(c) There seems to be little consideration to the trade-off between capacity obtained through the commuted overtime system versus sessional appointments.

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

2.1. Aims and objectives

This spending review seeks to:

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

3. Programme beneficiaries

The programme is designed to ensure increased capacity at public health facilities, its beneficiaries are therefore the uninsured population. The table below summarises the estimated number of uninsured population (mid-year population estimates less CMS number of beneficiaries on medical aids). This however is still slightly underestimated as some medical aid options do not provide comprehensive cover or provides only limited cover requiring beneficiaries to access public healthcare at some point.

Table 1: Uninsured population estimation

Province	2019	2020	2021	2022
Eastern Cape	6 086 014	6 091 079	6 097 052	6 097 250
Free State	2 451 032	2 462 739	2 473 478	2 484 713
Gauteng	11 792 005	12 100 650	12 402 905	12 707 575
Kwazulu Natal	9 983 016	10 099 806	10 215 017	10 329 285
Limpopo	5 524 876	5 569 482	5 615 572	5 654 835
Mpumalanga	4 052 333	4 118 294	4 182 282	4 244 627
Northern Cape	1 074 023	1 088 311	1 101 618	1 114 520
North West	3 519 914	3 579 820	3 636 662	3 694 198
Western Cape	5 241 444	5 346 035	5 448 259	5 553 008
Total	**49 724 657**	**50 456 215**	**51 172 845**	**51 880 010**

4. Key policies, laws, regulation and informal practices

The main guiding policies and legislation for the healthcare sector are:

i. Constitution

Chapter 2, Section 27 of the bill of rights states that, (1) Everyone has the right to have access to— (a) *health care services*, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance

ii. National Health Act, which draws chapter 2 of the constitution

Chapter 3 states the general functions of the National Department of Health:

> Section 21 (1) The Director General must (a) ensure the implementation of the national health policy and (b) issue guidelines for the implementation of the national health policy.
>
> (2) The director general must in accordance with the national policy […] (k) facilitate and promote the provision of health care services for the management, prevention and control of communicable and non-communicable diseases; and (l) co-ordinate health services rendered by the national department of health with health services rendered by the provinces and provide such additional health services as may be necessary to establish comprehensive national health system.
>
> (3) 22(1) National health council, MOH and HODs/MECs etc. The National Health Council must advise the Minister on- (a) policy concerning any matter that will protect, promote, improve and maintain the health of the population,

Chapter 4 states the responsibilities of the provincial department of health:

> 25 (1) The relevant member of the executive council must ensure the implementation of the national health policy, norms, standards in the provinces.
>
> (2) The head of the provincial department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province […] (f) plan, co-ordinate and monitor health services and must evaluate the rendering of health services (O) provide health services contemplated by specific provincial health service programmes.

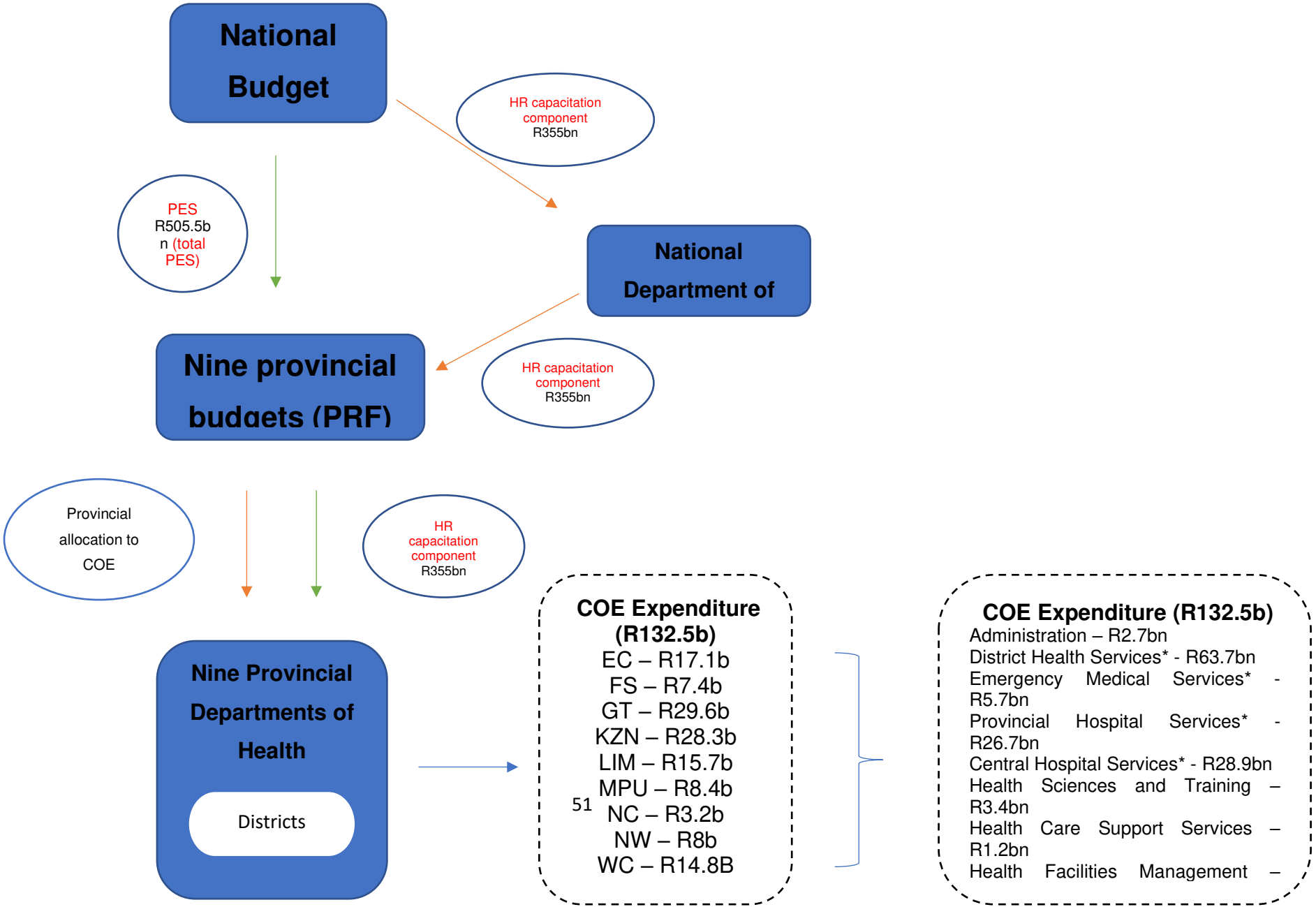
Table 2 below provides summary of specific policy, regulations relating to commuted overtime

Table 2: summary of applicable policy/regulations on commuted overtime

Policy/regulation	Key aspects
Basic Conditions of Employment Act	• Overtime is discretionary (more than 40 hours a week cannot be forced) • Remuneration at no less than 1.5 times normal hourly rate [s10(2)] • However, Act empowers employer to, upon agreement with employees, require that they work more than normal work time and; (i) pay an employee no less than normal hourly work rate but also grant 30 minutes time-off and (ii) or remunerate overtime at 90 minutes time-off [s10(3a+b)]

	• S9(1) 45 hour work week
Labour Relations Act	• In the public sector, employees are represented by organised labour, which through the PSCBC can enter into agreement with employer, was formed in terms of Labour Relations Act [s35]. • Therefore agreement with PSBC important
Public Finance Management Act	• The PMFA is applicable to all levels of government • Accounting authorities are specifically entrusted to ensure effective, efficient and transparent systems of financial and risk management and internal control [s38(a)] (e.g. ensure that overtime policy not abused) • Financial misconduct stipulation [s81] empowers employer to take action in cases where overtime has not been worked but authorised, by facilities CEO, clinical heads and supervisors.
Public Service Act	• Employees can be disciplined within confines the act and their services may be terminated in terms of s17 (2) if necessary.
Division of revenue Act	• The Division of Revenue Act allocates the nationally raised revenue across the spheres of Government each year. It determines the allocations to each province, both of the provincial equitable share and the conditional grants. The grant frameworks provide the rules for how conditional grants are managed and spent. • There is a specific grant framework for Human Resource Capacitation component, it is meant to support provinces to augment compensation budget for clinical staff

5. Flow of funds for provincial COE (with 2019/20 amounts)



6. Description of process

Step 1

All participants in the commuted overtime remuneration system to complete over time contracts.

- Contract should be renewed annually [s7.4.7]
- Operational needs for on-boarding of system needs to be determined [s8.3]
- Application forms completed by supervisors and approved by District Managers, Chief

Step 2

Duty roster for normal working hours of the component, duty roster for on call for the component and duty hours registered for the individual [s7.3]

Commuted overtime is only paid on performance of actual patient related clinical services in terms of the following:

- 1st on call; practitioner is on-site 100% of the time during performance of overtime
- 2nd on call; practitioner is off-site and can give advice telephonically but only 30% of overtime worked from

Step 3

All Heads of Clinical Departments/supervisors certify the hours overtime worked in the rendering of clinical services on a monthly basis for each participant to the system within his/her Clinical Department/ Component

- Leave days taken needs to be reported by supervisors as these would not qualify for

Step 4

HR offices will reconcile the duty hour register with the leave applications on a monthly basis, after the leave application for all participants have been submitted by the heads of the

6.1. Notes on commuted overtime

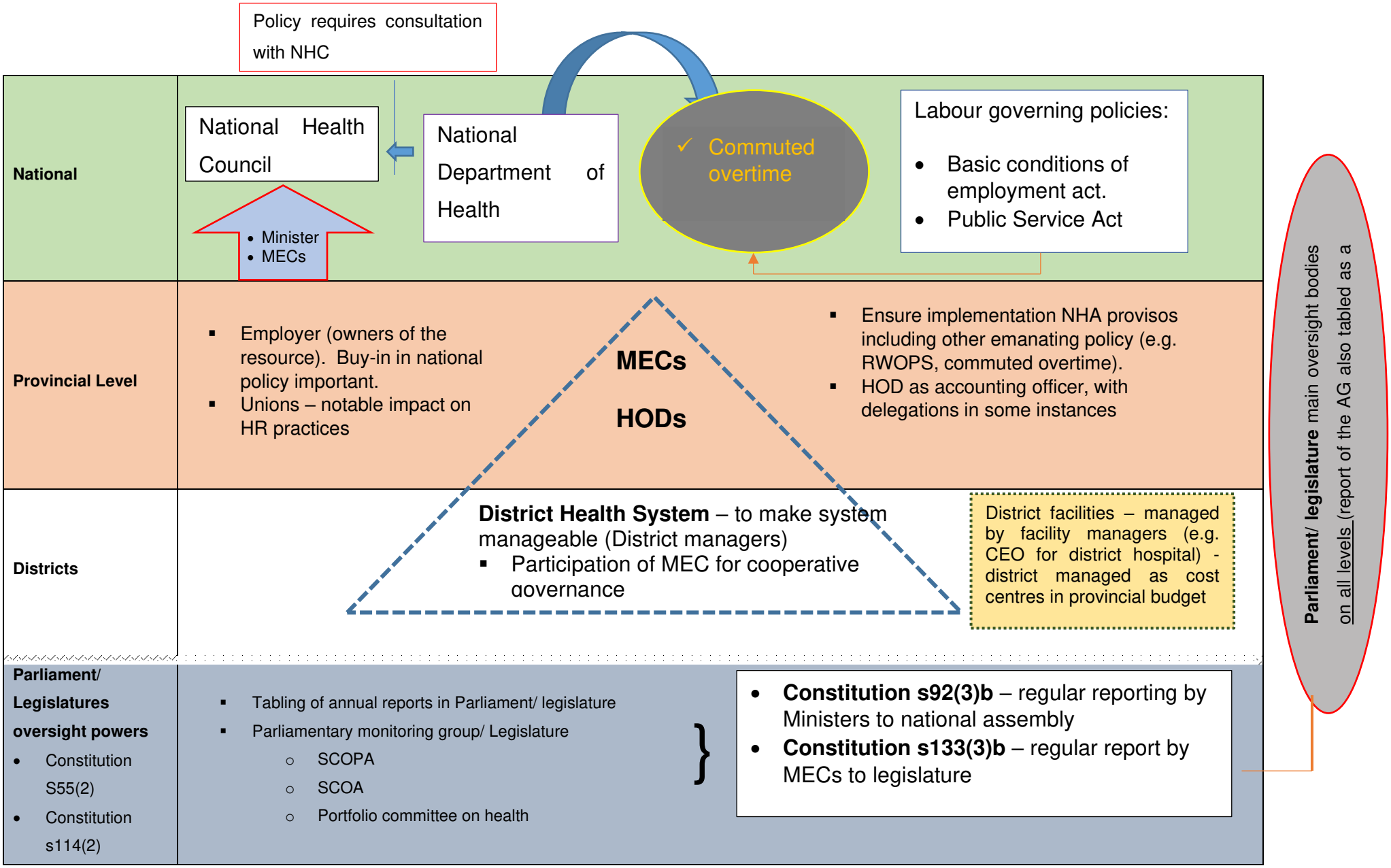
a) Commuted overtime is based on a grouping system as discussed in table 4 below. Operational managers, as identified in the process flow, would need to determine operational for additional capacity and classify employees accordingly.

Table 3: overtime group

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

b) Payment of commuted overtime during periods of leave: Commuted overtime is payable to medical personnel who participate in the commuted overtime system for periods of annual leave within each financial year (i.e. from 1 April of a year to 31 March of that year) on the following basis:

- 22 working days in respect of employees with less than 10 years' service;
- 26 working days in respect of employees with more than 10 years' service;
- 28 working days in respect of employees appointed as public servants prior to 1 January 1966 as well as former provincial employees appointed prior to 1 January 1978.


Policy requires consultation with NHC
National
National Health Council
National Department of Health
Minister
MECs
✓ Commuted overtime
Labour governing policies:
Basic conditions of employment act.
Public Service Act
Provincial Level
Employer (owners of the resource). Buy-in in national policy important.
Unions – notable impact on HR practices
MECs
HODs
Ensure implementation NHA provisos including other emanating policy (e.g. RWOPS, commuted overtime).
HOD as accounting officer, with delegations in some instances
Districts
District Health System – to make system manageable (District managers)
Participation of MEC for cooperative governance
District facilities – managed by facility managers (e.g. CEO for district hospital) - district managed as cost centres in provincial budget
Parliament/ Legislatures oversight powers
Constitution S55(2)
Constitution s114(2)
Tabling of annual reports in Parliament/ legislature
Parliamentary monitoring group/ Legislature
SCOPA
SCOA
Portfolio committee on health
Constitution s92(3)b – regular reporting by Ministers to national assembly
Constitution s133(3)b – regular report by MECs to legislature
Parliament/ legislature main oversight bodies on all levels (report of the AG also tabled as a

8. Expenditure analysis

The expenditure analysis includes the following set of analyses:

a) *COE baseline analysis*; this is done to highlight the
   - (i) importance of COE to as main cost driver and
   - (ii) to determine provinces whose COE budget are at risk of "crowding-out" funding for goods and services and capital assets.

Generally COE budgets above 65% of total budget are considered problematic by the sector at large (this view is based on information obtained from various cost-centre managers in the sector).

b) *Unit cost analysis across all programmes for the sector*; this is to assess whether COE is largely centred on actual healthcare delivery programmes. Findings will be used to make immediate recommendations to the National Department of Health, if necessary, should it be found that spending is not centred on these programmes.

c) *Zooming in on overtime*; similar to the purpose of the unit cost analysis referred to in (b), the first part of "zooming in on overtime" provides a spread of overtime for the sector by programme. This is done to determine where analysis of overtime should focus given the proportion of overtime spending by programme. The highest spending programmes on overtime were District Health Services, Provincial Hospital Services and Central Hospital Services.

d) *Overtime spending per full-time equivalent (FTE)*; the overtime spending by programme is illustrated in the context of the number of employees. A national average is then used to determine programmes where overtime is high. If any "non-direct service delivery" programmes appear as above the national average, this would suggest a need to look into the application of overtime in the given programme.

e) *Admin programme spending on overtime*; during the data analysis stage, overtime spending of +R70 million was noted on the Administration programme. An analysis was done to determine provinces where most of this spending is seen.

f) Workload and overtime analysis; an attempt is made, using a rating system, to determine comparative efficiency in the application of overtime.

a) COE sector baseline

Table 4: Total COE by province (R' million)

Province	Audited outcome			2019/20 (revised estimate)	2020/21	2021/22	2022/23	2016/17 - 2019/20	2019/20 - 2022/23
	2016/17	2017/18	2018/19						
Eastern Cape	13,454	14,559	15,981	17,130	18,348	19,352	20,371	8.4%	5.9%
Free State	5,815	6,263	6,679	7,420	7,961	8,431	8,882	8.5%	6.2%
Gauteng	23,290	25,085	26,902	29,633	33,265	36,444	38,175	8.4%	8.8%
Kwa-Zulu Natal	23,355	24,615	26,336	28,349	30,750	31,912	33,508	6.7%	5.7%
Limpopo	12,218	12,979	14,199	15,662	16,127	17,168	17,993	8.6%	4.7%
Mpumalanga	6,687	7,217	7,663	8,410	9,390	10,007	10,510	7.9%	7.7%
Northern Cape	2,322	2,572	2,864	3,157	3,375	3,598	3,771	10.8%	6.1%
North West	6,051	6,412	7,166	8,035	8,553	8,838	9,263	9.9%	4.9%
Western Cape	11,834	12,660	13,515	14,774	15,793	16,653	17,426	7.7%	5.7%
Tot	**105,026**	**112,362**	**121,306**	**132,570**	**143,562**	**152,403**	**159,899**	**8.1%**	6.4%
Prov total	**166,062**	**180,836**	**195,477**	**213,492**	**224,881**	**239,695**	**252,141**	**8.7%**	5.7%
% share of COE to total prov allocation								**Average COE proportion (20/21 to 22/23)**	**Ranking based on average 20/21-22/24**
Limpopo	71.0%	70.6%	72.0%	72.7%	72.8%	72.7%	72.4%	72.6%	**1**
Eastern Cape	65.6%	65.4%	65.3%	64.9%	69.5%	69.7%	70.4%	69.9%	**2**
Free State	`	63.9%	65.2%	65.8%	66.6%	66.4%	66.7%	66.6%	**3**
Kwa-Zulu	63.1%	61.7%	61.9%	62.8%	64.0%	62.7%	62.8%	63.1%	4
North West	62.0%	62.2%	62.3%	61.2%	64.8%	62.0%	61.2%	62.6%	5
Northern Cape	53.1%	56.3%	58.7%	58.0%	60.3%	60.3%	60.3%	60.3%	6
Mpumalanga	63.2%	59.7%	58.7%	58.9%	60.3%	60.2%	60.1%	60.2%	7
Gauteng	62.2%	59.7%	58.5%	57.8%	59.7%	60.7%	60.0%	60.1%	8
Western Cape	58.9%	58.9%	58.7%	59.2%	60.2%	59.9%	59.9%	60.0%	9
Tot	**63%**	**62%**	**62%**	**62%**	**64%**	**64%**	**63%**	**63.6%**	

Overall, the proportion of COE expenditure has remained relatively stable ranging between 62% on the lower side to 64% on the higher for the respective years between 2016/17 and 2022/23 averaging 63% for the period. Since there are no national norms for appropriate COE to total spending ratio, the national average ratio of 63.6% from the period 21/22 to 22/23 is used to identify provinces which seem to have high COE expenditure.

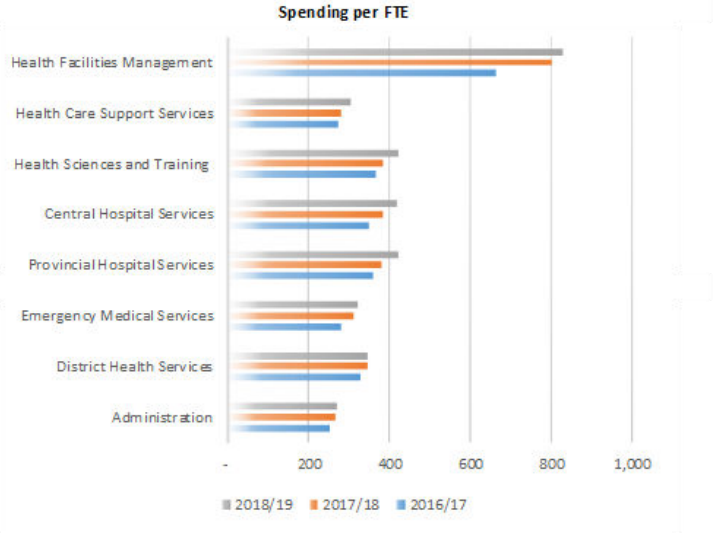
If personnel budgets are not appropriately managed, there is real risk that this COE will effectively crowd-out funding for "tools of trade" such as medicine and medical supplies. The following three provinces had the highest proportion of COE to total health spending:

- Limpopo came out top and is 9% above national average for period
- Eastern Cape is the second highest and is 6.3% above the national average for the period
- Free-State is the third highest and is 3% above the national average for the period

b) Unit cost analysis across programmes

Table 5: spending per FTE by programme

R000's	2016/17	2017/18	2018/19	2019/20		
	Outcomes			Main appropriation	Adjusted appropriation	Revised estimate
Administration	2,280,558	2,372,259	2,480,441	2,928,677	2,766,559	2,692,665
District Health Services	49,250,646	52,479,224	57,080,629	63,443,935	63,532,006	63,688,683
Emergency Medical Services	4,284,253	4,758,415	5,030,817	5,329,058	5,251,415	5,379,945
Provincial Hospital Services	22,192,660	23,608,701	25,595,125	27,855,703	27,281,343	26,979,525
Central Hospital Services	22,841,076	24,852,326	26,591,681	27,840,981	28,424,529	28,953,138
Health Sciences and Training	3,074,119	3,079,684	3,164,064	3,676,187	3,715,418	3,373,822
Health Care Support Services	929,108	994,612	1,115,763	1,253,050	1,233,954	1,205,030
Health Facilities Management	173,324	216,970	247,066	340,777	302,313	297,268
Total	**105,025,744**	**112,362,191**	**121,305,586**	**132,668,368**	**132,507,537**	**132,570,076**
FTE (headcount) per programme						
Administration	9,085	8,943	9,250			
District Health Services	150,626	152,423	164,930			
Emergency Medical Services	15,370	15,351	15,584			
Provincial Hospital Services	61,869	61,879	60,780			
Central Hospital Services	65,097	64,837	63,474			
Health Sciences and Training	8,389	7,993	7,485			
Health Care Support Services	3,402	3,543	3,678			
Health Facilities Management	261	270	297			
Total FTE	**314,097**	**315,238**	**325,478**			
Spending per FTE (headcount)						
Administration	251	265	268			
District Health Services	327	344	346			
Emergency Medical Services	279	310	323			
Provincial Hospital Services	359	382	421			
Central Hospital Services	351	383	419			
Health Sciences and Training	366	385	423			
Health Care Support Services	273	281	303			
Health Facilities Management	665	804	832			
Total FTE per capita	**334**	**356**	**373**			



Spending per FTE increase as the level of care increases, which is expected. Of the three clinical programmes, district health services has the lowest spending, followed by provincial hospital services and then closely followed by central hospital services. There is high spending per FTE in some non-clinical programmes particularly Health Facilities Management. This may be due to high salaries paid to infrastructure/ construction specialists.

Furthermore, the following are observed:

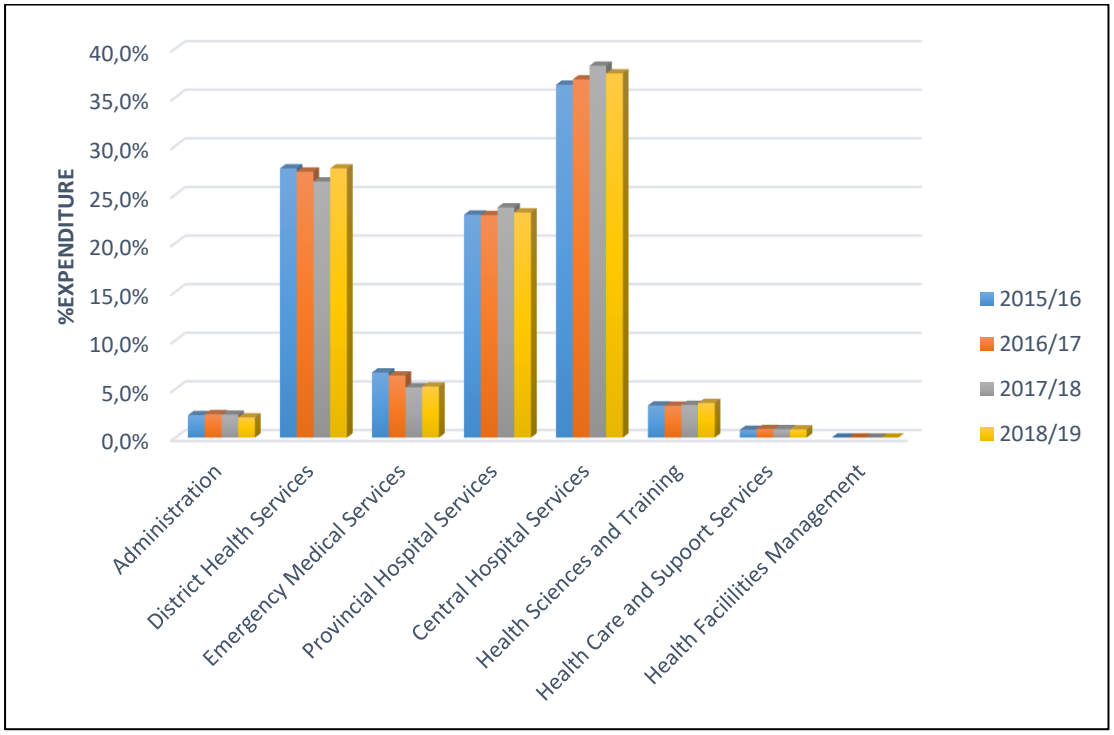
- Broadly, staff complement by programme largely supports a preventative approach to health care as the majority of headcount in district health services.
- The data supports the view that the cost per FTE at district health services level are lowest (only looking at COE but noting that this the largest cost-driver)., A formalised referral system, as with community health services delivered by community healthcare workers, becomes even more important in a universal health coverage discussion as this would be affordable at a primary healthcare level.

c) Zooming in on overtime

Table 6: Proportion overtime spending by programme

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

Figure 1: Proportion overtime spending by programme as in table 6



Overall, majority of spending on overtime is in the clinical programmes starting with Central Hospital Services, District Health Services and then Provincial Hospital Services. This is aligned with expectations, however Administration should ideally have no overtime spending as it is not a clinical programme or directly involved in services (e.g. as would be the case with health facilities which manages infrastructure in the province). Overtime in administration therefore assessed in this report.

d) Overtime spending per FTE

Table 7: Overtime spending per FTE (R'000)

Programme name (R'000)	**2016/17**	**2017/18**	**2018/19**
Administration	18	19	18
District Health Services	13	12	14
Emergency Medical Services	29*	24*	28*
Provincial Hospital Services	26*	28*	31*
Central Hospital Services	39*	42*	48*
Health Sciences and Training	27*	30*	39*
Health Care and Support Services	18	18	19
Health Facilities Management	1	0	1
Total	**22**	**23**	**25**

* *Values above national average*

As the case with total COE spending per full-time equivalent (FTE), overtime spending per FTE on the three clinical programmes that are the focus in this review and emergency services, are the highest. Overtime spending in Health Sciences and Training features is comparatively larger and warrants an investigation in a follow up review.

e) Admin programme spending on overtime

Table 8 shows the overtime spending as a proportion of total COE. This is done for each province using its overtime and total provincial COE data. The national average represents the total overtime as a proportion of total COE for the sector.

Table 8: Admin overtime

Overtime spending as a percent of total health COE by provinces						
Province	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Eastern Cape	4.0%*	1.0%	0.8%	1.4%*	0.8%	0.9%
Free State	0.2%	0.1%	0.4%	0.5%	0.1%	1.4%*
Gauteng	1.7%	1.5%	2.6%	3.1%*	3.3%*	3.8%*
KwaZulu-Natal	0.3%	0.3%	0.2%	0.2%	0.2%	0.4%
Limpopo Province	2.5%*	3.8%*	3.5%*	3.0%*	1.9%*	1.4%
Mpumalanga	6.1%*	11.8%*	5.8%*	1.5%*	0.2%	0.8%
North West	0.2%	0.1%	0.3%	0.8%	0.6%	1.4%*
Northern Cape	0.7%	1.5%	0.6%	0.9%	1.1%*	1.4%*
Western Cape	0.7%	0.4%	0.4%	0.4%	0.4%	0.5%
National Average	**1.8%**	**2.3%**	**1.6%**	**1.3%**	**1.0%**	**1.3%**

f) Workload and overtime analysis

In this section, an attempt is made to easily highlight provinces which are not efficient in the management of overtime (also taking into workload data). The national average is used as benchmark

i. For the analysis, the following data was used:

- Patient Day Equivalent (PDE); hospital workload data as proxy for service demand.
- Persal data was used to obtain (i) overtime spending by hospital level type and province. It is noted that data may underestimate/overestimate in some areas as provinces may follow different approaches to recording employees against budget programmes.

ii. The following indicators, using data described above, were used to rate the budget efficiency on use of overtime.

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

iii. The colour code rating system; a rating system was developed so that it is easy to identity provinces which were which above the national average. This system uses the two indicator described in (b) above. The colour codes are assigned as explained in table 9.

Table 9: Explanation of colour codes

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

iv. The rating system was applied for doctors as shown in table 10 and for nurses in table 11.

For tables 10 and 11:

Deviation from norm (overtime spending) – this represents the extent to which a province's overtime spending exceed national average overtime spending and is expressed as percentage.

Deviation from norm (overtime per PDE) – this is similar to the measure above but focuses on overtime spending per PDE.

Table 10: Workload and overtime analysis (doctors) (next page)

Province	District hospitals			Prov hospitals			Central hospitals			Rating (based on 2018/19)		
	2018/19	2017/18	2016/17	2018/19	2017/18	2016/17	2018/19	2017/18	2016/17	District	Provincial	Central
Eastern Cape												
PDE	1 511 399	1 706 494	1 732 042	906 558	1 467 680	1 475 109	780 997	1 002 756	1 013 760			
Overtime spending	4 318 831	4 307 607	6 571 593	16 031 401	15 705 034	18 948 900	669 088	209 912	285 892			
Deviation from norm (Overtime spending)	**63.1%**	**79.9%**	**161.5%**	**375.2%**	**403.1%**	**332.9%**	**-46.4%**	**-81.3%**	**-72.5%**			
Deviation from norm (overtime per PDE)	**-23.0%**	**-49.6%**	**4.9%**	**201.0%**	**268.4%**	**87.5%**	**-96.4%**	**-97.0%**	**-98.1%**			
Free State												
PDE	1 511 399	1 706 494	1 732 042	567 049	528 467	530 201	457 033	451 643	459 372			
Overtime spending	27 673	51 963	7 291	-	-	-	-	-	-			
Deviation from norm (Overtime spending)	**-99.0%**	**-97.8%**	**-99.7%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**		*	*
Deviation from norm (overtime per PDE)	**-99.5%**	**-99.4%**	**-99.9%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**	**-100.0%**			
Gauteng												
PDE	775 495	475 469	972 115	2 961 620	1 983 112	2 830 985	3 466 659	3 372 685	3 365 555			
Overtime spending	2 766 764	2 531 714	2 503 303	79 178	65 153	66 752	31 183	64 453	59 133			
Deviation from norm (Overtime spending)	**4%**	**6%**	**0%**	**-98%**	**-98%**	**-98%**	**-98%**	**-94%**	**-94%**			
Deviation from norm (overtime per PDE)	**-3.9%**	**6.3%**	**-28.8%**	**-99.5%**	**-98.9%**	**-99.7%**	**-100.0%**	**-99.7%**	**-99.9%**			
KwaZulu Natal												
PDE	2 574 973	1 328 461	2 600 167	3 386 620	1 995 238	3 241 746	1 141 898	910 628	1 255 551			
Overtime spending	522 192	2 325 220	819 978	58 838	27 015	-	134 400	112 737	45 317			
Deviation from norm (Overtime spending)	**-80.3%**	**-2.9%**	**-67.4%**	**-98.3%**	**-99.1%**	**-100.0%**	**-89.2%**	**-89.9%**	**-95.6%**			
Deviation from norm (overtime per PDE)	**-94.5%**	**-65.0%**	**-91.3%**	**-99.7%**	**-99.5%**	**-100.0%**	**-99.5%**	**-98.3%**	**-99.8%**			
Limpopo												
PDE	1 902 921	966 802	1 662 461	959 941	657 404	960 091	298 953	98 308	293 042			
Overtime spending	6 603 717	3 848 942	335 896	1 926 729	997 377	528 506	840 996	532 483	28 274			
Deviation from norm (Overtime spending)	**149.4%**	**60.8%**	**-86.6%**	**-42.9%**	**-68.0%**	**-87.9%**	**-32.7%**	**-52.5%**	**-97.3%**			
Deviation from norm (overtime per PDE)	**-6.5%**	**-20.5%**	**-94.4%**	**-65.8%**	**-47.8%**	**-92.0%**	**-88.3%**	**-23.6%**	**-99.4%**			
Mpumalanga												
PDE	1 232 637	335 178	1 262 405	627 025	489 376	674 419	37 809	49 500	58 739			
Overtime spending	2 041 310	2 348 180	4 478 338	3 227 269	3 068 705	6 221 217	2 565 943	2 705 483	3 331 987			
Deviation from norm (Overtime spending)	**-23%**	**-2%**	**78%**	**-4%**	**-2%**	**42%**	**105%**	**142%**	**221%**			
Deviation from norm (overtime per PDE)	**-55.4%**	**39.9%**	**-1.9%**	**-12.4%**	**115.9%**	**34.6%**	**182.4%**	**671.2%**	**275.8%**			
Northern Cape												
PDE	195 450	109 439	197 463	308 253	-	320 323	38 620	-	42 846			
Overtime spending	1 151 876	520 039	1 713 398	6 760 897	6 401 449	11 582 885	4 077 432	3 496 199	3 316 639			
Deviation from norm (Overtime spending)	**-56%**	**-78%**	**-32%**	**100%**	**105%**	**165%**	**226%**	**212%**	**219%**			
Deviation from norm (overtime per PDE)	**58.8%**	**-5.1%**	**140.0%**	**273.3%**	**-100.0%**	**427.7%**	**339.4%**	**-100.0%**	**412.8%**			
North West												
PDE	405 911	268 770	443 223	376 115	240 381	714 337	74 840	881 771	1 774 441			
Overtime spending	6 195 451	5 023 538	5 838 105	2 278 811	1 827 081	2 024 510	2 918 603	2 955 225	2 280 765			
Deviation from norm (Overtime spending)	**134.0%**	**109.8%**	**132.3%**	**-32.5%**	**-41.5%**	**-53.7%**	**133.7%**	**163.8%**	**119.6%**			
Deviation from norm (overtime per PDE)	**311%**	**273%**	**264%**	**3%**	**162%**	**-59%**	**62%**	**-53%**	**-91%**			
Western Cape												
PDE	421 926	586 902	1 366 830	376 115	240 381	714 337	74 840	881 771	1 774 441			
Overtime spending	203 218	588 071	350 956	-	804	22 846	2 172	5 647	-			
Deviation from norm (Overtime spending)	**-92%**	**-75%**	**-86%**	**-100%**	**-100%**	**-99%**	**-100%**	**-99%**	**-100%**		*	
Deviation from norm (overtime per PDE)	**-87.0%**	**-80.0%**	**-92.9%**	**-100.0%**	**-99.9%**	**-99.5%**	**-99.9%**	**-99.9%**	**-100.0%**			
National												
Average overtime to total	2 647 892	2 393 919	2 513 206	3 373 680	3 121 402	4 377 291	1 248 869	1 120 238	1 038 667			
Average exp per PDE	3.71	5.01	3.62	5.87	2.90	6.85	24.03	7.09	15.09			

* - data not available for rating

Table 11: Workload and overtime analysis (nurses)

Province	District hospitals			Prov hospitals			Central hospitals			Rating (based on 2018/19)		
	2018/19	2017/18	2016/17	2018/19	2017/18	2016/17	2018/19	2017/18	2016/17	District	Provincial	Central
Eastern Cape												
PDE	1 511 399	1 706 494	1 732 042	906 558	1 467 680	1 475 109	780 997	1 002 756	1 013 760			
Overtime spending	16 141 618	13 972 691	13 191 938	27 973 514	24 901 615	15 606 226	22 633 624	23 086 202	19 583 143			
Deviation from norm (Overtime spending)	**-55.8%**	**-52.9%**	**-52.7%**	**-10.2%**	**1.6%**	**-13.7%**	**-33.2%**	**-8.5%**	**-12.6%**			
Deviation from norm (overtime per PDE)	**-71.0%**	**-82.3%**	**-67.7%**	**-19.7%**	**-58.5%**	**-39.0%**	**-83.2%**	**-69.6%**	**-57.4%**			
Free State												
PDE	1 511 399	1 706 494	1 732 042	567 049	528 467	530 201	457 033	451 643	459 372			
Overtime spending	11 383 168	8 617 569	7 183 712	8 353 324	7 225 270	6 824 512	14 205 127	9 414 104	6 957 515			
Deviation from norm (Overtime spending)	**-68.8%**	**-70.9%**	**-74.3%**	**-73.2%**	**-70.5%**	**-62.3%**	**-58.1%**	**-62.7%**	**-68.9%**			
Deviation from norm (overtime per PDE)	**-79.5%**	**-89.1%**	**-82.4%**	**-61.7%**	**-66.6%**	**-25.8%**	**-82.0%**	**-72.4%**	**-66.6%**			
Gauteng												
PDE	775 495	475 469	972 115	2 961 620	1 983 112	2 830 985	3 466 659	3 372 685	3 365 555			
Overtime spending	65 740 649	48 737 348	42 584 530	84 861 336	66 868 876	51 847 243	158 363 620	104 833 734	85 823 186			
Deviation from norm (Overtime spending)	**80%**	**64%**	**53%**	**173%**	**173%**	**187%**	**367%**	**316%**	**283%**			
Deviation from norm (overtime per PDE)	**130.3%**	**121.9%**	**85.8%**	**-25.5%**	**-17.5%**	**5.6%**	**-73.5%**	**-58.9%**	**-43.7%**			
KwaZulu Natal												
PDE	2 574 973	1 328 461	2 600 167	3 386 620	1 995 238	3 241 746	1 141 898	910 628	1 255 551			
Overtime spending	10 725 488	9 722 743	8 641 442	6 894 994	2 805 663	3 210 574	9 154 849	7 409 739	5 785 263			
Deviation from norm (Overtime spending)	**-70.6%**	**-67.2%**	**-69.0%**	**-77.9%**	**-88.6%**	**-82.2%**	**-73.0%**	**-70.6%**	**-74.2%**			
Deviation from norm (overtime per PDE)	**-88.7%**	**-84.2%**	**-85.9%**	**-94.7%**	**-96.6%**	**-94.3%**	**-95.3%**	**-89.2%**	**-89.8%**			
Limpopo												
PDE	1 902 921	966 802	1 662 461	959 941	657 404	960 091	298 953	98 308	293 042			
Overtime spending	161 870 313	134 230 173	133 551 717	49 682 480	40 573 481	30 218 944	26 666 943	16 127 870	21 615 939			
Deviation from norm (Overtime spending)	**343.1%**	**352.6%**	**378.6%**	**59.6%**	**65.5%**	**67.1%**	**-21.3%**	**-36.1%**	**-3.5%**			
Deviation from norm (overtime per PDE)	**131.1%**	**200.5%**	**240.6%**	**34.6%**	**51.0%**	**81.4%**	**-48.2%**	**116.9%**	**62.7%**			
Mpumalanga												
PDE	1 232 637	335 178	1 262 405	627 025	489 376	674 419	37 809	49 500	58 739			
Overtime spending	15 367 071	13 600 817	8 103 898	51 847 243	36 969 355	20 886 837	24 933 046	18 910 038	12 119 323			
Deviation from norm (Overtime spending)	**-58%**	**-54%**	**-71%**	**67%**	**51%**	**16%**	**-26%**	**-25%**	**-46%**			
Deviation from norm (overtime per PDE)	**-66.1%**	**-12.2%**	**-72.8%**	**115.1%**	**84.8%**	**78.5%**	**282.7%**	**405.2%**	**355.2%**			
Northern Cape												
PDE	195 450	109 439	197 463	308 253	-	320 323	38 620	-	42 846			
Overtime spending	4 441 159	2 667 279	4 626 039	1 277 297	1 659 771	1 831 453	2 783 845	1 873 655	1 548 043			
Deviation from norm (Overtime spending)	**-88%**	**-91%**	**-83%**	**-96%**	**-93%**	**-90%**	**-92%**	**-93%**	**-93%**			
Deviation from norm (overtime per PDE)	**-38.3%**	**-47.2%**	**-0.7%**	**-89.2%**	**-100.0%**	**-67.0%**	**-58.2%**	**-100.0%**	**-20.3%**			
North West												
PDE	405 911	268 770	443 223	376 115	240 381	714 337	74 840	881 771	1 774 441			
Overtime spending	19 381 611	14 197 171	12 360 114	30 952 935	22 667 978	18 074 908	22 802 949	19 097 125	15 722 959			
Deviation from norm (Overtime spending)	**-46.9%**	**-52.1%**	**-55.7%**	**-0.6%**	**-7.5%**	**0.0%**	**-32.7%**	**-24.3%**	**-29.8%**			
Deviation from norm (overtime per PDE)	**30%**	**14%**	**18%**	**114%**	**131%**	**46%**	**77%**	**-71%**	**-80%**			
Western Cape												
PDE	421 926	586 902	1 366 830	376 115	240 381	714 337	74 840	881 771	1 774 441			
Overtime spending	23 702 619	21 201 032	20 897 305	18 359 829	16 980 236	14 223 833	23 329 866	26 271 224	32 470 385			
Deviation from norm (Overtime spending)	**-35%**	**-29%**	**-25%**	**-41%**	**-31%**	**-21%**	**-31%**	**4%**	**45%**			
Deviation from norm (overtime per PDE)	**52.6%**	**-21.8%**	**-35.2%**	**27.0%**	**72.8%**	**14.8%**	**80.9%**	**-60.6%**	**-59.6%**			
National												
Average overtime to total	**36 528 188**	**29 660 758**	**27 904 522**	**31 133 661**	**24 516 916**	**18 080 503**	**33 874 874**	**25 224 855**	**22 402 862**			
Average exp per PDE	**36.8**	**46.2**	**23.6**	**38.4**	**40.9**	**17.3**	**172.3**	**75.6**	**45.3**			

9. Costing

An attempt is made to quantify losses to health sector as a result of obtaining additional capacity through commuted overtime as opposed to appointments.

9.1. Assumptions

a) Unit cost

The accompanying model allows provinces to further customise unit costs; for the purpose of this review the average unit cost was calculated as shown in tables 12 and 13 below. The *min* is the lowest salary notch as per 2018/19 DPSA salary scales and the max is the highest salary notch within a given category (doctors and nurses were used).

Table 12: unit cost calculation for doctors

	Occupation	Cost	Average	Final used
Min	Medical officer grade 1	821 205	1 091 786	1 281 125
Max	Medical offcer grade 3	1 362 366		
Min	Medical specialist grade 1	1 106 040	1 470 465	
Man	Medical specialist grade 2	1 834 890		

Table 13: unit cost calculation for nurses

	Occupation	Cost	Average	Final used
Min	Staff nurse grade 1	171 381	234 603	302 897
Max	Staff nurse grade 3	297 825		
Min	Professional nurse 1	256 905	371 190	
Man	Professional nurse 3	485 475		

Note:

The average min and max notches for both medical offers and medical specialists was used to obtain the unit cost of the doctor (R1.281m) and similarly for nursing using staff nurses and professional nurse (R302 897). This was done as it difficult to separate overtime spending on medical officers versus specialists, and staff nurses versus professional nurses. However, this shortcoming is addressed through the cost model as it allows provinces/users to simply update the unit cost and perhaps spending for a newer year. The model would then use this inform to quantify the trade-off between additional appointments and continued payment of overtime.

b) Hourly rate

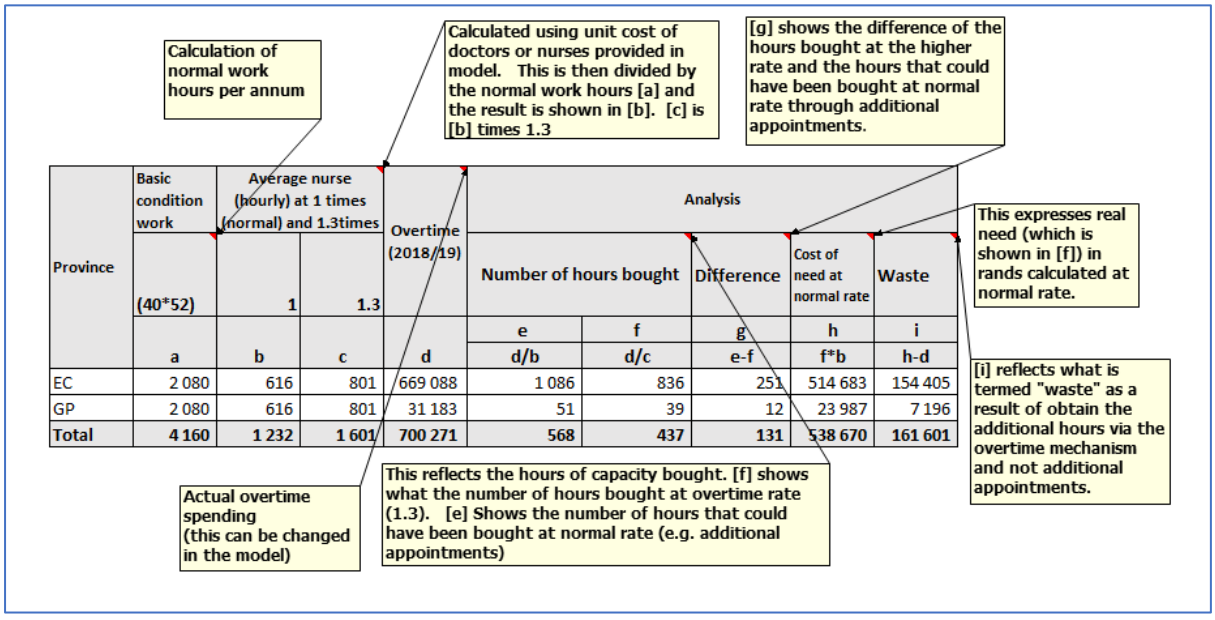
The following assumptions underpin the hourly rate estimation in the model:

- Normal work hours per unit per annum; 2080 hours (40 hour work week in line with the basic conditions of employment act and commuted overtime policy)
- Overtime hours are remunerated at 1.3 times the normal hourly rate in line with commuted overtime policy
- Overtime spending is assumed to reflect the real need for additional capacity (which will be expressed in hours)
- The 0.3 of the 1.3 times overtime rate is assumed to be the wastage

9.2. Mechanics of the model

The mechanics of the model are shown in the result table below – see sheet “mechanics of model”

Figure 2: Explanation of mechanics



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

9.3. Results of model

a) Doctors

Table 14: Trade-off scenario for doctors – district hospitals

Province	Basic condition work	Average nurse (hourly) at 1 times (normal) and 1.3times (overtime)		Overtime (2018/19)	Analysis				
	(40*52)	1	1.3		(overtime/1)	overtime/1.3)	Difference	Cost of need at normal rate	Waste
					e	f (real need)	g	h	i
	a	b	c	d	d/b	d/c	e-f	f*b	h-d
EC	2 080.0	615.9	800.70	4 318 831	7 012	5 394	1 618	3 322 178	996 653
FS	2 080.0	615.9	800.70	27 673	45	35	10	21 287	6 386
GT	2 080.0	615.9	800.70	2 766 764	4 492	3 455	1 037	2 128 280	638 484
KZN	2 080.0	615.9	800.70	522 192	848	652	196	401 686	120 506
LP	2 080.0	615.9	800.70	6 603 717	10 722	8 247	2 474	5 079 782	1 523 935
MP	2 080.0	615.9	800.70	2 041 310	3 314	2 549	765	1 570 239	471 072
NC	2 080.0	615.9	800.70	1 151 876	1 870	1 439	432	886 058	265 817
NW	2 080.0	615.9	800.70	6 195 451	10 059	7 738	2 321	4 765 732	1 429 719
WC	2 080.0	615.9	800.70	203 218	330	254	76	156 321	46 896
Total	**2 080**	**616**	**801**	**23 831 032**	**38 691**	**29 763**	**8 929**	**18 331 563**	**5 499 469**

*Missing data for WC, provinces will be asked to update numbers before the 15 Sept.

- Based on the overtime spending (R23.8m) for doctors for district hospitals; 29 763 hours were bought at 1.3 times the normal rate.
- Further, the rands spent on overtime could have bought 38 691 hours at normal hourly rate.
- If we assume that the hours bought using overtime (29 763) are reflective of the real additional capacity, only R18.3m would have been spent to obtain the same capacity through additional appointments.
- The difference (R5.5m) between R23.8m and the R18.3m in [i] is what is termed as "waste" in this review.

Table 15: Trade-off scenario for doctors – provincial hospitals

Province	Basic condition work	Average nurse (hourly) at 1 times (normal) and 1.3times (overtime)		Overtime (2018/19)	Analysis				
	(40*52)	1	1.3		(overtime/1)	overtime/1.3)	Difference	Cost of need at normal rate	Waste
					e	f (real need)	g	h	i
	a	b	c	d	d/b	d/c	e-f	f*b	h-d
EC	2 080.0	615.9	800.70	16 031 401	26 028	20 022	6 006	12 331 847	3 699 554
GP	2 080.0	615.9	800.70	79 178	129	99	30	60 906	18 272
KZN	2 080.0	615.9	800.70	58 838	96	73	22	45 260	13 578
LP	2 080.0	615.9	800.70	1 926 729	3 128	2 406	722	1 482 099	444 630
MP	2 080.0	615.9	800.70	3 227 269	5 240	4 031	1 209	2 482 514	744 754
NW	2 080.0	615.9	800.70	6 760 897	10 977	8 444	2 533	5 200 690	1 560 207
NC	2 080.0	615.9	800.70	2 278 811	3 700	2 846	854	1 752 931	525 879
WC	2 080.0	615.9	800.70	-	-	-	-	-	-
Total	**2 080.0**	**615.9**	**800.7**	**30 363 123**	**49 297**	**37 921**	**11 376**	**23 356 248**	**7 006 874**

*Missing data for FS, WC. GT, KZN need to be verified. Provinces will be asked to update numbers before the 15 Sept.

- Based on the overtime spending (R30.4m) for doctors for district hospitals; 37 921 hours were bought at 1.3 times the normal rate.
- Further, the rands spent on overtime could have bought 49 297 hours at normal hourly rate.
- If we assume that the hours bought using overtime (37 921) are reflective of the real additional capacity, only R23.43m would have been spent to obtain the same capacity through additional appointments.
- The difference (R7m) between R30.4m and the R23.4m in [i] is what is termed as "waste" in this review.

Table 16: Trade-off scenario for doctors – central hospitals

Province	Basic condition work	Average nurse (hourly) at 1 times (normal) and 1.3times (overtime)		Overtime (2018/19)	Analysis				
	(40*52)	1	1.3		(overtime/1)	overtime/1.3)	Difference	Cost of need at normal rate	Waste
	a	b	c	d	e d/b	f (real need) d/c	g e-f	h f*b	i h-d
EC	2 080	616	801	669 088	1 086	836	251	514 683	154 405
GP	2 080	616	801	31 183	51	39	12	23 987	7 196
FS	2 080	616	801	134 400	218	168	50	103 385	31 015
LP	2 080	616	801	840 996	1 365	1 050	315	646 920	194 076
MP	2 080	616	801	2 565 943	4 166	3 205	961	1 973 802	592 141
NC	2 080	616	801	4 077 432	6 620	5 092	1 528	3 136 486	940 946
NW	2 080	616	801	2 918 603	4 739	3 645	1 094	2 245 079	673 524
WC	2 080	616	801	2 172	4	3	1	1 671	501
Total	**2 080**	**616**	**801**	**11 239 817**	**18 249**	**14 037**	**4 211**	**8 646 013**	**2 593 804**

*Missing data for FS, WC. GT, KZN need to be verified. Provinces will be asked to update numbers before the 15 Sept.

- Based on the overtime spending (R11.2m) for doctors for district hospitals; 14 037 hours were bought at 1.3 times the normal rate.
- Further, the rands spent on overtime could have bought 18 249 hours at normal hourly rate.
- If we assume that the hours bought using overtime (14 037) are reflective of the real additional capacity, only R8.6m would have been spent to obtain the same capacity through additional appointments.
- The difference (R2.6m) between 11.2m and the R8.6m in [i] is what is termed as "waste" in this review.

b) Nurses

Table 17: Trade-off scenario for nurses – district hospitals

Province	Basic condition work	Average nurse (hourly) at 1 times (normal) and 1.3times (overtime)		Overtime (2018/19)	Analysis				
	(40*52)	1	1.3		(overtime/1)	overtime/1.3	Difference	Cost of need at normal rate	Waste
					e	f (real need)	g	h	i
	a	b	c	d	d/b	d/c	e-f	f*b	h-d
EC	2 080	146	189	16 141 618	110 845	85 265	25 580	12 416 629	3 724 989
FS	2 080	146	189	11 383 168	78 169	60 130	18 039	8 756 283	2 626 885
GT	2 080	146	189	65 740 649	451 443	347 264	104 179	50 569 730	15 170 919
KZN	2 080	146	189	10 725 488	73 652	56 656	16 997	8 250 375	2 475 113
LM	2 080	146	189	161 870 313	1 111 569	855 053	256 516	124 515 625	37 354 688
MP	2 080	146	189	43 358 010	297 741	229 031	68 709	33 352 315	10 005 695
NW	2 080	146	189	32 511 499	223 258	171 737	51 521	25 008 845	7 502 654
NC	2 080	146	189	6 070 985	41 690	32 069	9 621	4 669 989	1 400 997
WC	2 080	146	189	44 066 065	302 603	232 772	69 831	33 896 973	10 169 092
Total	**2 080**	**146**	**189**	**391 867 794**	**2 690 969**	**2 069 976**	**620 993**	**301 436 765**	**90 431 029**

- Based on the overtime spending (R391.9m) for doctors for district hospitals; 2 069 976 hours were bought at 1.3 times the normal rate.
- Further, the rands spent on overtime could have bought 2 630 969 hours at normal hourly rate.
- If we assume that the hours bought using overtime (2 069 969) are reflective of the real additional capacity, only R301.4m would have been spent to obtain the same capacity through additional appointments.
- The difference (R90.4m) between R391.9m and the R301.4m in [i] is what is termed as “waste” in this review.

Table 18: Trade-off scenario for nurses – provincial hospitals

Province	Basic condition work	Average nurse (hourly) at 1 times (normal) and 1.3times (overtime)		Overtime (2018/19)	Analysis				
	(40*52)	1	1.3		(overtime/1)	overtime/1.3	Difference	Cost of need at normal rate	Waste
					e	f (real need)	g	h	i
	a	b	c	d	d/b	d/c	e-f	f*b	h-d
EC	2 080	146	189	27 973 514	192 095	147 765	44 330	21 518 088	6 455 426
FS	2 080	146	189	8 353 324	57 363	44 125	13 238	6 425 634	1 927 690
GT	2 080	146	189	84 861 336	582 746	448 266	134 480	65 277 951	19 583 385
KZN	2 080	146	189	6 894 994	47 348	36 422	10 926	5 303 841	1 591 152
LM	2 080	146	189	49 682 480	341 171	262 439	78 732	38 217 293	11 465 188
MP	2 080	146	189	18 215 679	125 088	96 221	28 866	14 012 060	4 203 618
NW	2 080	146	189	25 928 705	178 053	136 964	41 089	19 945 158	5 983 547
NC	2 080	146	189	2 839 955	19 502	15 002	4 500	2 184 580	655 374
WC	2 080	146	189	23 230 200	159 523	122 710	36 813	17 869 385	5 360 815
Total	**2 080**	**146**	**189**	**247 980 188**	**1 702 888**	**1 309 914**	**392 974**	**190 753 991**	**57 226 197**

- Based on the overtime spending (R247.9m) for doctors for district hospitals; 1 309 914 hours were bought at 1.3 times the normal rate.
- Further, the rands spent on overtime could have bought 1 702 888 hours at normal hourly rate.

- If we assume that the hours bought using overtime (1 309 914) are reflective of the real additional capacity, only R190.8m would have been spent to obtain the same capacity through additional appointments.
- The difference (R57.2m) between R391.9m and the R301.4m in [i] is what is termed as “waste” in this review.

Table 19: Trade-off scenario for nurses – central hospitals

Province	Basic condition work	Average nurse (hourly) at 1 times (normal) and 1.3times (overtime)		Overtime (2018/19)	Analysis				
	(40*52)	1	1.3		(overtime/1)	overtime/1.3	Difference	Cost of need at normal rate	Waste
					e	f (real need)	g	h	i
	a	b	c	d	d/b	d/c	e-f	f*b	h-d
EC	2 080	146	189	22 633 624	155 426	119 558	35 867	17 410 480	5 223 144
FS	2 080	146	189	14 205 127	97 547	75 036	22 511	10 927 020	3 278 106
GT	2 080	146	189	158 363 620	1 087 488	836 529	250 959	121 818 169	36 545 451
KZN	2 080	146	189	9 154 849	62 867	48 359	14 508	7 042 191	2 112 657
LM	2 080	146	189	26 666 943	183 123	140 864	42 259	20 513 033	6 153 910
MP	2 080	146	189	20 610 144	141 531	108 870	32 661	15 853 957	4 756 187
NW	2 080	146	189	31 272 941	214 752	165 194	49 558	24 056 108	7 216 832
NC	2 080	146	189	9 044 541	62 109	47 776	14 333	6 957 339	2 087 202
WC	2 080	146	189	30 520 253	209 584	161 218	48 365	23 477 118	7 043 135
Total	**2 080**	**146**	**189**	**322 472 041**	**2 214 426**	**1 703 405**	**511 021**	**248 055 417**	**74 416 625**

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

9.4. Summary of findings from model

The model also has a summary sheet, which provides the overall savings for the country by level of care. The analysis shows that overall, R237.2m has been wasted in the sector as a result of the choice of obtaining capacity through the overtime system

Table 20: summary of results from model

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

10. Bringing it all together

The following table brings together the work done in the review. Although this spending review shows that it is cheaper to obtain capacity through appointments as opposed to overtime, it is important note that the sector can probably only realise this in a phased manner (this assuming that buy-in to the proposal will be obtained). In the interim, the advancement of the overtime policy and its application are still important. It is for this reason that recommendations relating to issue a, b, c and d.

Table 21: Summary and final recommendations

Pocket issue	Issue no.	Finding	Recommendation
Policy is not entirely responsive to workload (e.g. participation is annual and renewable annually). If headcount happens to be increased in a given year, all those benefiting from overtime will continue to do so for remainder of said year.	a	Although savings can be immediately realised from allowing termination and re-entry to participation at any period within a given year. It is important to note that the policy, which was hugely contested by organised labour, is already a compromise by both employer and health professionals. For instance, commuted overtime is calculated on 1.3 times the normal hourly rate as opposed to the legislated 1.5 times (based on conditions of services).	• More work to done on viability of amending current policy and assess the extent to which changes would be implementable given the strong-hold unions have. • Perhaps benchmarking South African overtime practices to other countries. This will require expanding the efficiency analysis beyond the country.

No national guidelines on the determination of clinical need for overtime capacity at facility level is provided. This is entirely left to the discretion of facility managers, which leaves room for abuse and impacts monitoring capability as there would be no objective benchmark available.	b	Since supervisors and clinical heads are required to use own discretion in determining need for participation in overtime, there is no uniformity in the approval process. It is likely that participation is more than what is required as, based on discussions with a clinician, and overtime seems to be largely considered part of the package.	• National Department of Health will need to consider the development of some kind of norms to guide facilities. •

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

Annexure 4: Spending Review Western Cape Treasury

Commuted Overtime: cost effectiveness and efficiency in addressing capacity constraints in health facilities through fixed overtime allowances

Expenditure review on Commuted Overtime

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Departments: Provincial Treasury

Designations: Expenditure analyst, Economist, State Accountant

Date: 25 February 2022

Version: 01

Executive Summary

Capacity constraints in public health care services was and remains a concern for government, while the demand of government services such as health continues to increase. The country averages 7 doctors per 10 000 people which is below norm when compared to other upper middle-income countries like Brazil which has 23 doctors per 10 000. Capacity constraints are especially prevalent in the public health sector which 80 out 100 SA citizens depend on for health care services. The rising demand for health care services has been further exacerbated by the impact of COVID-19 pandemic, as more citizens have accessed public health care facilities for treatment.

While responding to COVID 19, the Western Cape Department of Health had to deescalate non-core services such as immunisations, HIV&TB testing & treatment, maternal routine checks, and elective surgeries. This has created a significant backlog to the public health system. COVID-19 is expected to become epidemic and should be mainstreamed as such, going forward. This means, more pressure / workload for the public health system going forward.

Commuted Overtime was a mechanism introduced by National Government to facilitate the workload pressures within provincial health departments – by increasing the number of hours worked per Doctor based on the specific health care facility work load requirements.

Main findings

- Actual hours worked could not be compared to actuals to what is permissible per grouping.
- Medical staff with the same rank description is more or less in the same grouping, which in most cases tends to be 16 fixed hours paid commuted overtime allowance. Hence there is no scope to improve on that.
- There are no opportunities for savings by ensuring that staff are assigned to the right grouping. However, to validate this, a comparison of the actual hours worked, and the permissible hours needs to be done.

Recommendations

Further work to be undertaken due to time and capacity constraints, the following should be investigated further:

- Actual hours worked per staff member vs hours paid per staff member (sample of specific health facilities to be identified).
- Linking commuted overtime spending for districts/ hospitals/ clinical programmes to workload for comparison.
- Establish a norm in terms of commuted overtime per Patient Day Equivalent (PDE)/ staff member/ per district.
- Comparison across districts, facilities - reasons for deviations.
- Establish if demand for services align to the number of overtime hours.
- Identify the level of care, clinical services which has the highest demand.
- Quantify the trade-off between capacity obtained through overtime and additional appointments

Implications

- Further analysis must be done, based on recommendations.
- More information needed – i.e., actual hours worked per facility.
- Sample of health facilities to be surveyed.

CONTENTS

1. Introduction

2. 2.1 Background

The Western Cape's (WC) population is expected to grow at 2 per cent per year, mainly due to inward migration and fertility rates. The Western Cape Infant Mortality Rate[4] (IMR) decreased from 17.0 in 2017 to 16.6 live births in 2018, and net in -migration was estimated 852 992 for the period 2016 - 2021. The province remains attractive due to the economic opportunities available for many South Africans (with the population growing on average by 2 per cent). As a result of this rapid increase in the population growth, the demand for health care services is expected to increase.

While demand for health services has risen, the capacity to deliver has not kept pace. The country averages 7 doctors per 10 000 people which is below norm when compared to other upper middle-income countries like Brazil which has 23 doctors per 10 000. Capacity constraints are especially prevalent in the public health sector which 80 out 100 SA citizens depend on for health care services. The province faces continued pressure in Emergency Medical Services (EMS) pressure related to alcohol abuse which augments the weekend patient load in accident and trauma centres.

At the same time, the province faces a quadruple burden of disease with four severe epidemics – maternal health, new-born and child health; HIV/AIDS and tuberculosis (TB); non-communicable diseases; and violence and injury. The leading causes of deaths in the Western Cape were diabetes mellitus (7.6 per cent), followed by ischaemic heart diseases (6.1 per cent) and cardiovascular diseases (5.9 per cent) in 2018.

Capacity constraints on public health care services has been further exacerbated by the impact of COVID-19 pandemic, as more citizens have accessed public health care facilities for treatment. The Western Cape Department of Health had to deescalate non-core services such as immunisations, HIV&TB testing & treatment, maternal routine checks, and elective surgeries. This has created a significant backlog to the public health system. COVID-19 is

[4] The infant mortality rate is the number of infant deaths for every 1,000 live births.

expected to become epidemic and should be mainstreamed as such, going forward. This means, more pressure / work load for the public health system going forward.

In response to the capacity challenges within the province, the Western Cape Government instituted a policy of commuted overtime since 2013 to date. Commuted overtime refers to all hours of work that are additional to the total number of prescribed work hours that a health establishment requires a health professional to render a service. This policy exists to increase capacity in public health facilities, given workload and the increase in the uninsured population and burden of disease. Commuted overtime aims to also address scarcity of skills and budget constraints in rural districts that limits additional staff appointments.

Commuted overtime is the preloading of overtime and aims to cap the total overtime payable at any given time. The expenditure review will aim to determine the cost-effectiveness of commuted overtime:

- by examining the differences in overtime spending across provincial health facilities by level of care including other programmes, such as maternal routine checks, childhood immunisations, HIV& TB testing and treatment;
- linking overtime spending of clinical programmes to workload for comparison; and
- establishing the trade-off of alternative options (e.g., additional appointments).

2.2 Purpose of this spending review

Commuted overtime was designed to ensure increased capacity at public health facilities, as its beneficiaries are mostly the uninsured population. The table below summarises the estimated number of uninsured population (mid-year population estimates less CMS number of beneficiaries on medical aids). This is still slightly underestimated as some medical aid options do not provide comprehensive cover or provides only limited cover requiring beneficiaries to access public healthcare at some point.

This expenditure review aims to determine differences in overtime spending across the Western Cape districts (sub-districts) by taking the following into account:

- Types of hospitals by level of care including other programmes.

- Linking commuted overtime spending for districts/ hospitals/ clinical programmes to workload for comparison.
- Establish a norm in terms of commuted overtime per Patient Day Equivalent (PDE)/ staff member/ per district.
- Comparison across districts, facilities, staff categories - reasons for deviations.
- Establish if demand for services align to the number of overtime hours.
- Identify the level of care, clinical services which has the highest demand.
- Quantify the trade-off between capacity obtained through overtime and additional appointments.

3. Policy and Institutional Information

3.1 Legislation and policy

Commuted overtime as a response mechanism is affected by the following legislation and regulations outlined in the table below.

Table 1: Policy / regulation related to commuted overtime

Policy/regulation	Key aspects
National Health Act 61 of 2003	Provides a framework for a structured uniform health system within the country, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith e.g., • Provision of provincial health services, and general functions of provincial department. • Regulations relating to human resources.

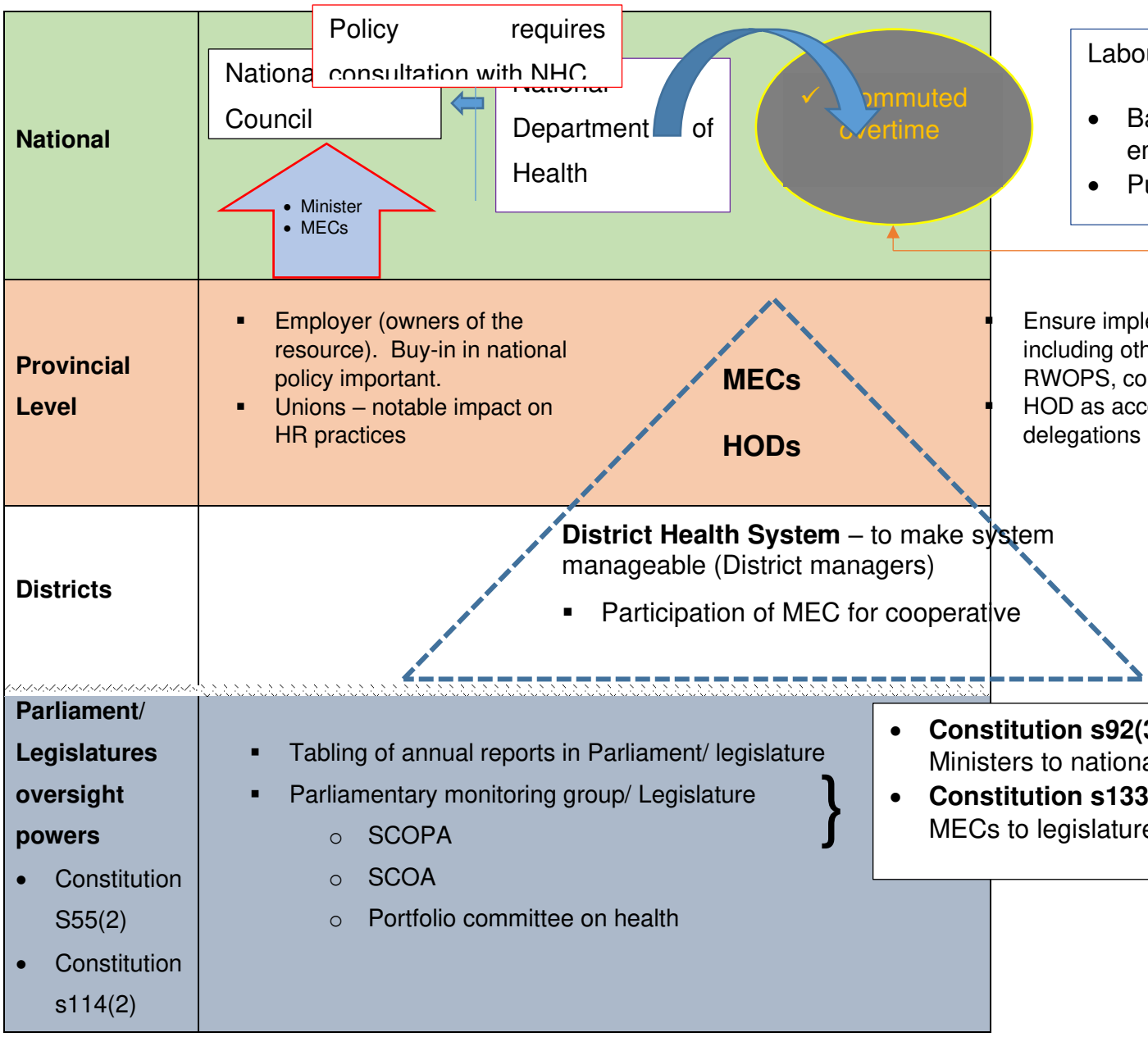
Labour Relations Act	In terms of Labour Relations Act [s35].public sector employees are represented by organised labour, which through the PSCBC can enter into agreements with the employer.
Public Finance Management Act	The PMFA is applicable to all levels of government Accounting authorities are specifically entrusted to ensure effective, efficient and transparent systems of financial and risk management and internal control [s38(a)] (e.g. ensure that overtime policy not abused) Financial misconduct stipulation [s81] empowers the employer to take action in cases where overtime has not been worked but authorised, by facilities CEO, clinical heads and supervisors.

The national health legislation and regulations mandates the provincial department of health to deliver health care services on behalf of the national government. The National health Act states that provinces must ensure the implementation of national health policy, norms and standards, as well as human resource planning in accordance with the health requirements in the province. Commuted overtime is a human resource instrument that is in line the health care provision mandate of the province.

4. Institutional arrangements

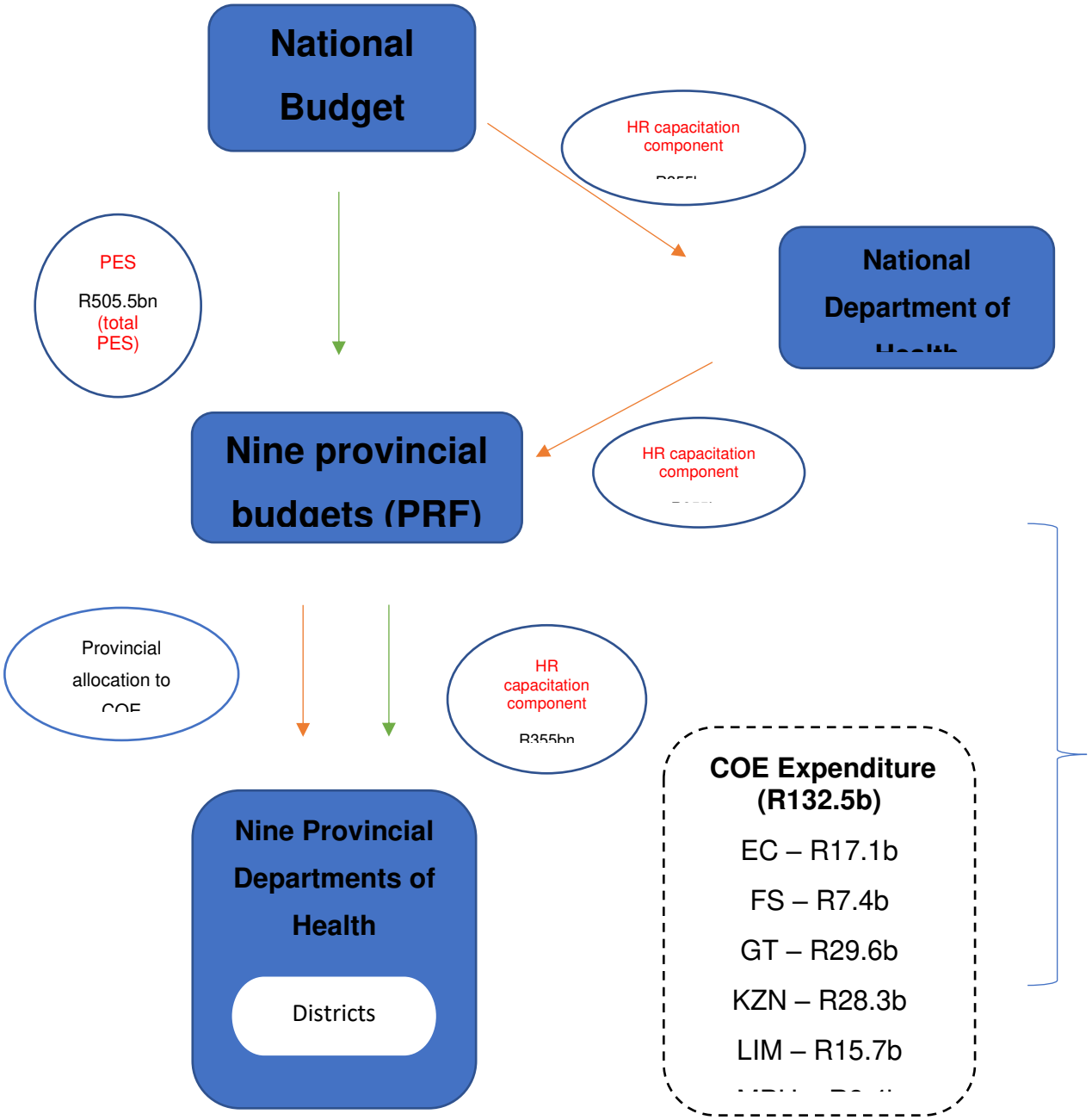
The Department of Health started implementing the commuted overtime policy from 2013.

a) Institutional framework


National
Policy requires consultation with NHC
National Council
Department of Health
Minister
MECs
Commuted overtime
Provincial Level
Employer (owners of the resource). Buy-in in national policy important.
Unions – notable impact on HR practices
MECs
HODs
Districts
District Health System – to make system manageable (District managers)
Participation of MEC for cooperative
Parliament/ Legislatures oversight powers
Constitution S55(2)
Constitution s114(2)
Tabling of annual reports in Parliament/ legislature
Parliamentary monitoring group/ Legislature
SCOPA
SCOA
Portfolio committee on health
Constitution s92(3
Ministers to nationa
Constitution s133
MECs to legislature

5. 4.1 Flow of funds

Figure 5: Flow of funds for provincial COE (with 2019/20 amounts)



Delivery Processes and Logical Frameworks

6. 5.1 Process maps

The National Department of Health developed this policy to regulate the management of the commuted overtime system for medical personnel including its practical challenges, i.e.,human resource capacity challenges. Specific monitoring and control measures are prescribed for provincial departments. The National and provincial process of commuted overtime is outlined in the diagram below.

Policy requires consultation with NHC

a) Description of Process (National)

Step 1

All participants in the commuted overtime remuneration system to enter into over time contracts.

- Contract should be renewed annually [s7.4.7]
- Operational needs for on-boarding of system needs to be determined [s8.3]
- Application forms completed by supervisors and approved by District Managers, Chief Director (Academic Hospitals) or the Health

Duty roster fo component, d component an individual [s7.3

Commuted overtime is only paid on performance of actual patient related clinical services in terms of the following:

- 1st on call; practitioner is on-site 100% of the time during performance of overtime
- 2nd on call; practitioner is off-site and can give advice telephonically but only 30% of overtime worked from

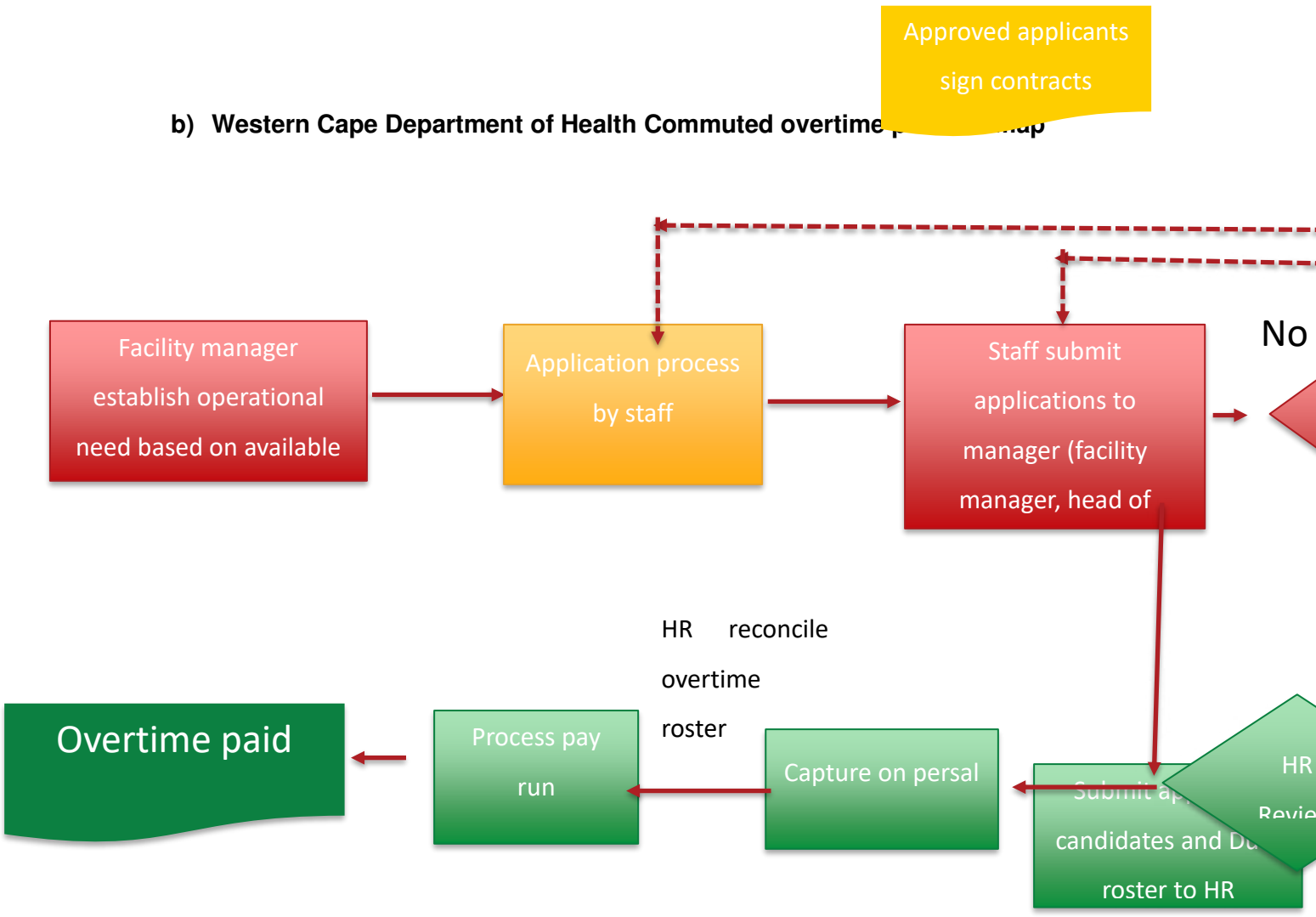
Step 4

HR offices will reconcile the duty hour register with the leave applications on a monthly basis, after the leave application for all participants have been submitted by the heads of the

All Heads o certify the ho of clinical se participant to Department/

- Leave da supervis

b) Western Cape Department of Health Commuted overtime p[illegible]ap



5.2 Component description *Commuted overtime system:*

Annual contractual agreements are established with relevant medical and dental practitioners, which is based on a uniform system of commuted overtime for certain minimum of hours worked, more than 40 hours per week. Payments related to this system is limited to a commuted overtime rate equivalent to 8-, 12- or 16-hours overtime at 4/3 x basic salary. The categories for committed overtime are as follows:

Group 1:

- Individuals who do not participate in the commuted overtime remuneration system – these individuals will claim overtime through the standard overtime remuneration system.

Group 2:

Working 5 to 13 hours per week (average of not less than 8 hours per week)	Commuted overtime remuneration at a commuted overtime rate equivalent to 8 hours per week.

Group 3:

Working 13 to 20 hours per week (average of not less than 16 hours per week)	Commuted overtime remuneration at commute rate equivalent to 16 hours per week.
Post classes head clinical unit and head of clinical department	Commuted overtime remuneration at commute rate equivalent to 12 hours per week.

Occupational class: Manager: Medical Services

Manager: Medical services	Commuted overtime remuneration at commute rate equivalent to 8 hours per week.

Manager: Medical services only when rendering actual clinical duties	Commuted overtime remuneration at commute rate equivalent to 16 hours per week.

Committed overtime is payable to medical and dental personnel who participate in the commuted overtime system during their annual (vacation) leave within each calendar year (1 January to 31 December of that year).

Commuted overtime is not payable during sabbatical leave, in respect of absence on leave without pay, on special leave or maternity leave. Commuted overtime rate is reduced when such instances / absences occur.

Commuted overtime is paid if sick leave is taken, family responsibility leave and special leave for studying purposes (prep and exam). In such instances the commuted overtime rate will be reduced on a pro-rata basis. Carry-over of rostered after-hour commitments to another month is not allowed.

HR managers ensure that control measures are in place to monitor monthly submission of verification forms and duty rosters for all medical staff who are paid commuted overtime. A control sheet is used by personnel to complete their overtime hours and submits to clinical heads. Clinical heads must ensure that hours are indicated for all medical staff prior submitting the documents to HR.

- Duty rosters must be made available to heads of institutions in advance. The duty roster must indicate the normal 40-hour duties required in the component. A separate on call roster must indicate the individuals who are scheduled to be 1st call and 2nd call.
- Overtime is only payable if performing duties related to actual patient clinical services at the workplace. This can be 1st on call (on site) or overtime duties performed additional to the normal 40 working hours.
- If medical practitioner is off-site and is rostered for 2nd on call, 30% of the time spent at home (off site) will be classified as commuted overtime hours. The same principle will apply to individuals who are scheduled to be 1st on call (off-site).

- Should a medical practitioner who is rostered for 2nd on call have to go into a health facility to attend to clinical duties, all hours spent on-site during 2nd call will be classified as actual commuted overtime hours.
- All commuted overtime contracts of medical and dental staff will be reviewed annually on an individual basis by the responsible chief directorates in collaboration with the heads of clinical departments, in terms of existing operational need for such overtime work. All renewed contracts will be authorised by the head of the department of health or his/her delegate.

Performance Analysis

The data that was analysed to understand the efficacy of the commuted overtime policy was as follows:

- Salary information per staff member (those eligible for commuted overtime).
- Staff head counts - medical Drs/ dentists per facility, type of facility and per occupational category.
- Hospital data: Patient Day Equivalent (PDE), Bed Utiisation Rate (BUR), Average Length of Stay (ALS), nr of beds per clinical category.
- Standard Operating Procedure (SOPs) / departmental policy – commuted overtime (for process map: differentiate if between facility types).

The following performance indicators were developed:

- Percentage of Overtime spend per programme
- Commuted Overtime per headcount/ FTEs
- Commuted Overtime spent per PDE (workload)
- Commuted Overtime per Staff Grouping
- Commuted Overtime per Facility

Expenditure Observations

Table 2 Aggregate Compensation of Employees, Agency Staff and Medical Contractors Expenditure

R'000	2017/2018	2018/2019	2019/2020	2020/2021	Total
Total WC Health Expenditure	21,496,056	23,043,593	24,773,271	26,963,540	93,040,991
Total CoE	12,660,391	13,515,392	14,758,597	15,338,438	56,272,818
% CoE of Total Exp	59%	59%	60%	57%	60%
Agency Staff	350,149	363,870	393,693	439,549	1,547,261
Medical Contractors	328,766	266,037	265,612	346,600	1,207,014
Total HR Capacity Expenditure	13,339,306	14,145,299	15,417,902	16,124,586	59,027,093
% Total HR Capacity Expenditure of Total Exp	62%	61%	62%	60%	63%

Between 2017/18 and 2020/21 financial years, the Department spent at least 60 per cent of its total annual expenditure on Compensation of Employees (CoE), while the percentage of total HR capacity (adding agency staff and medical contactors) amounted to 63 per cent of total expenditure. There was was a jump expenditure on agency staff and medical contractors from 2019/20 to 2020/21 financial – marking the response to the start of the COVID-19 pandemic. The 2020/21 financial year also saw a decrease in the share of CoE of total expenditure, which is related to the increased expenditure on Goods and Services in response to the COVID-19 pandemic. This includes spending on personal protective equipment (PPE), testing (laboratory services), agency staff, oxygen, etc.

Table 3 WC Department of Health: Compensation of Employees per Programme

Total CoE	2017/2018	2018/2019	2019/2020	2020/2021	Total
1. ADMINISTRATION	322,898	340,271	359,156	369,241	1,391,566
2. DISTRICT HEALTH SERVICES	4,685,005	5,032,114	5,533,601	5,915,546	21,166,266
3. EMERGENCY MEDICAL SERVICES	632,175	672,280	720,603	729,515	2,754,574
4. PROVINCIAL HOSPITAL SERVICE	2,454,090	2,612,953	2,857,385	2,925,263	10,849,690
5. CENTRAL HOSPITAL SERVICES	4,126,084	4,379,069	4,760,853	4,847,072	18,113,078
6. HEALTH SCIENCES & TRAINING	121,959	137,403	153,558	158,014	570,934
7. HEALTH CARE SUPPORT SERVICES	270,754	291,195	318,383	336,147	1,216,479
8. HEALTH FACILITIES MANAGEMENT	47,425	50,107	55,059	57,639	210,230
Total CoE	**12,660,391**	**13,515,392**	**14,758,597**	**15,338,438**	**56,272,818**
% Share of Total CoE per Programme	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**Total**
1. ADMINISTRATION	2.6%	2.5%	2.4%	2.4%	2.5%
2. DISTRICT HEALTH SERVICES	37.0%	37.2%	37.5%	38.6%	37.6%
3. EMERGENCY MEDICAL SERVICES	5.0%	5.0%	4.9%	4.8%	4.9%
4. PROVINCIAL HOSPITAL SERVICE	19.4%	19.3%	19.4%	19.1%	19.3%
5. CENTRAL HOSPITAL SERVICES	32.6%	32.4%	32.3%	31.6%	32.2%
6. HEALTH SCIENCES & TRAINING	1.0%	1.0%	1.0%	1.0%	1.0%
7. HEALTH CARE SUPPORT SERVICES	2.1%	2.2%	2.2%	2.2%	2.2%
8. HEALTH FACILITIES MANAGEMENT	0.4%	0.4%	0.4%	0.4%	0.4%
Total CoE	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
CoE: Programme 2, 4 and 5	**11,265,179**	**12,024,136**	**13,151,839**	**13,687,881**	**50,129,034**
% Share Programme 2,4 and 5	**89%**	**89%**	**89%**	**89%**	**89%**

Table 3 above highlights that the bulk of CoE expenditure occurs in the big service delivery programmes (i.e., District Health, Provincial Hospital Services, and Central Hospital Services). Together, these three programmes account for 89 per cent of the total annual CoE expenditure in the Department.

Table 4 Total overtime (normal and commuted overtime)

WC Health	2017/2018	2018/2019	2019/2020	2020/2021	Total
All Overtime	975,879	1,005,372	1,152,101	1,241,303	4,374,655
Total WC Health Expenditure	21,496,056	23,043,593	24,773,271	26,963,540	96,276,460
% Total Overtime of Total Expenditure	4.5%	4.4%	4.7%	4.6%	4.5%
Total CoE	22,659,808	24,247,897	26,151,991	28,444,379	101,504,074
% Total Overtime of Total CoE	4.3%	4.1%	4.4%	4.4%	4.3%
Total Communted Overtime	759,649	827,362	923,091	974,008	3,484,110
% Comm Overtime of Total Exp	3.5%	3.6%	3.7%	3.6%	3.6%
% Comm Overtime of Total Overtime	77.8%	82.3%	80.1%	78.5%	79.6%
% Comm Overtime of Total CoE	3.4%	3.4%	3.5%	3.4%	3.4%
Patient Day Equivalent (PDEs)	3,985,072	4,122,624	4,132,520	3,510,405	15,750,621
Communted Overtime per PDE	0.19	0.20	0.22	0.28	0.22

- The Department spent approximately 4.5 per cent of their total annual expenditure on paying staff to work overtime.
- Total overtime makes up 4.3 per cent of total Compensation of Employees on average each year reviewed.
- Commuted overtime constitutes the bulk of the total overtime paid at 80 per cent of total overtime paid each year.

Table 5 Total Overtime per Programme

Programme	2017/2018	2018/2019	2019/2020	2020/2021	Total
1. ADMINISTRATION	901	1,114	2,451	1,366	5,832
2. DISTRICT HEALTH SERVICES	273,579	276,677	322,480	379,562	1,252,298
3. EMERGENCY MEDICAL SERVICES	38,889	30,855	42,731	36,918	149,393
4. PROVINCIAL HOSPITAL SERVICE	186,268	195,684	224,285	236,661	842,899
5. CENTRAL HOSPITAL SERVICES	452,820	476,330	532,194	554,453	2,015,796
6. HEALTH SCIENCES & TRAINING	1,604	3,248	2,333	2,875	10,061
7. HEALTH CARE SUPPORT SERVICES	21,756	21,434	25,558	29,212	97,960
8. HEALTH FACILITIES MANAGEMENT	63	30	69	256	417
Total Overtime	**975,879**	**1,005,372**	**1,152,101**	**1,241,303**	**4,374,655**
% Share of Total CoE per Programme	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**Total**
1. ADMINISTRATION	0.1%	0.1%	0.2%	0.1%	0.1%
2. DISTRICT HEALTH SERVICES	28.0%	27.5%	28.0%	30.6%	28.6%
3. EMERGENCY MEDICAL SERVICES	4.0%	3.1%	3.7%	3.0%	3.4%
4. PROVINCIAL HOSPITAL SERVICE	19.1%	19.5%	19.5%	19.1%	19.3%
5. CENTRAL HOSPITAL SERVICES	46.4%	47.4%	46.2%	44.7%	46.1%
6. HEALTH SCIENCES & TRAINING	0.2%	0.3%	0.2%	0.2%	0.2%
7. HEALTH CARE SUPPORT SERVICES	2.2%	2.1%	2.2%	2.4%	2.2%
8. HEALTH FACILITIES MANAGEMENT	0.0%	0.0%	0.0%	0.0%	0.0%
Total Overtime	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Overtime: Programme 2, 4 and 5	**912,667**	**948,691**	**1,078,958**	**1,170,676**	**4,110,992**
% Share Programme 2,4 and 5	**94%**	**94%**	**94%**	**94%**	**94%**

As expected, the bulk of overtime is paid to staff in the three service delivery programmes as highlighted in table 5 above. These programmes account for 94 per cent of all overtime paid.

Table 6 Commuted Overtime (CO) per Programme

Programme	2017/2018	2018/2019	2019/2020	2020/2021	Total
1. ADMINISTRATION		80,342	109,851	214,019	404,212
2. DISTRICT HEALTH SERVICES	199,497,878	218,600,199	250,675,592	281,590,338	950,364,006
3. EMERGENCY MEDICAL SERVICES	3,448,612	3,308,733	2,947,110	3,204,536	12,908,991
4. PROVINCIAL HOSPITAL SERVICE	153,103,735	166,744,676	187,485,101	195,439,242	702,772,755
5. CENTRAL HOSPITAL SERVICES	390,520,925	423,295,481	466,209,535	477,299,590	1,757,325,530
6. HEALTH SCIENCES & TRAINING	305,888	2,074,974	326,794	165,329	2,872,985
7. HEALTH CARE SUPPORT SERVICES	12,771,920	13,258,056	15,337,023	16,094,471	57,461,470
Grand Total	**759,648,958**	**827,362,460**	**923,091,005**	**974,007,525**	**3,484,109,949**
% Year-on-Year increase		**8.9%**	**11.6%**	**5.5%**	
Overtime: Programme 2, 4 and 5	**743,122,539**	**808,640,355**	**904,370,228**	**954,329,170**	**3,410,462,292**
% Share Programme 2,4 and 5	**97.8%**	**97.7%**	**98.0%**	**98.0%**	**97.9%**

The table above shows CO expenditure per programme. On average, 97.9 per cent of CO is paid to staff in the three programmes highlighted.

Table 7 Commuted Overtime Expenditure per FTE

Full Time Equivalents (FTEs)	2017/2018	2018/2019	2019/2020	2020/2021	Total
1. ADMINISTRATION		0	0	2	2
2. DISTRICT HEALTH SERVICES	715	744	820	921	3,201
3. EMERGENCY MEDICAL SERVICES	8	7	6	7	27
4. PROVINCIAL HOSPITAL SERVICE	489	513	567	607	2,176
5. CENTRAL HOSPITAL SERVICES	1,192	1,223	1,319	1,360	5,094
6. HEALTH SCIENCES & TRAINING	2	12	2	1	16
7. HEALTH CARE SUPPORT SERVICES	32	31	35	36	134
Total	**2,438**	**2,530**	**2,749**	**2,933**	**10,649**
CO per Full Time Equivalents (FTEs)	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**	**Total**
1. ADMINISTRATION		241,026	263,642	142,680	179,650
2. DISTRICT HEALTH SERVICES	278,856	293,916	305,640	305,661	296,935
3. EMERGENCY MEDICAL SERVICES	449,819	467,115	498,103	493,006	475,178
4. PROVINCIAL HOSPITAL SERVICE	313,363	325,091	330,662	321,931	323,027
5. CENTRAL HOSPITAL SERVICES	327,550	346,042	353,546	350,999	344,979
6. HEALTH SCIENCES & TRAINING	166,848	179,134	217,862	247,993	184,363
7. HEALTH CARE SUPPORT SERVICES	400,165	427,679	439,246	451,247	430,423
Total	**311,630**	**327,032**	**335,842**	**332,142**	**327,187**

Although the three big service delivery programmes has the bulk of FTEs, Programme 3: Emergency Medical Services is the most costly in terms of Commuted overtime paid per FTE at R475 178 per FTE when compared to other programmes' CO spending.

Table 8 Commuted Overtime per Staff Grouping

Grouping	2017/2018	2018/2019	2019/2020	2020/2021	Total
Cleaners in offices workshops hospitals etc.	-	-	-	11	11
Dentists	5,833	5,371	4,499	3,663	19,365
Managers	-	242	1,026	1,323	2,591
Medical doctors	753,651	821,749	917,392	968,949	3,461,740
Pharmaceutical and Related Professionals	165	-	175	-	340
Social science and related professionals	-	-	-	62	62
Total	**759,649**	**827,362**	**923,091**	**974,008**	**3,484,110**
% Share of Total Commuted Overtime					
Cleaners in offices workshops hospitals etc.	0.0%	0.0%	0.0%	0.0%	0.0%
Dentists	0.8%	0.6%	0.5%	0.4%	0.6%
Managers	0.0%	0.0%	0.1%	0.1%	0.1%
Medical doctors	99.2%	99.3%	99.4%	99.5%	99.4%
Pharmaceutical and Related Professionals	0.0%	0.0%	0.0%	0.0%	0.0%
Social science and related professionals	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Commuted Overtime per FTE					
Cleaners in offices workshops hospitals etc.				45,914	45,914
Dentists	295,339	322,275	333,230	298,981	311,506
Managers		363,576	410,286	396,793	398,576
Medical doctors	311,791	327,053	335,785	332,240	327,251
Pharmaceutical and Related Professionals	220,304		349,580		272,014
Social science and related professionals				247,993	247,993
Total	**311,630**	**327,032**	**335,842**	**332,142**	**327,187**

- Medical doctors are paid the majority of commuted overtime at 99.4 per cent of the total CO expenditure.
- The management grouping is the most expensive in terms CO per FTE when compared to other category groupings.

Table 9 Commuted Overtime per Facility

Year	2020				
Grouping	0	4	8	12	16
GROOTE SCHUUR HSP	41	0	7	31	722
TYGERBERG HOSPITAL	4	0	10	29	745
RED CROSS HOSPITAL	6	3	5	11	181
GF JOOSTE HOSPITAL	6	0	1	1	193
SOMERSET HOSPITAL	4	0	3	5	160
PAARL HOSPITAL	4	0	5	8	149
GEORGE HOSPITAL	7	0	4	7	143
WORCESTER HOSPITAL	3	0	14	8	135
KHAYELITSHA DHS	3	0	0	0	135
KARL BREMER HSP	5	0	2	0	130
DAY HOSPITALS	2	0	22	0	100
VICTORIA HOSPITAL	7	0	0	0	109
CD: MDHS NTSS1: CHC	11	0	9	0	70
HELDERBERG HOSPITAL	1	0	1	0	72
DEPT OF HEALTH	7	0	3	0	63
MOWBRAY MATERN HOSP	4	0	2	0	52
KESS: CHC	0	0	8	0	37
DIR: FPS	0	0	0	6	34
LENTEGEUR	5	0	0	8	26
BEAUFORT WEST HSP	9	0	0	0	27
EERSTE RIVER HOSP.	0	0	6	0	28
VALKENBURG HOSPITAL	5	0	0	2	25
STIKLAND HOSPITAL	2	0	1	1	25
CALEDON HOSPITAL	3	0	0	0	25
KNYSNA HOSPITAL	1	0	0	0	24
MOSSEL BAY HOSPITAL	3	0	1	0	20
CERES HOSPITAL	2	0	0	0	21
OUDTSHOORN HOSPITAL	0	0	2	1	20
WESFLEUR HOSPITAL	1	0	0	0	21
SWARTLAND HOSPITAL	0	0	2	0	19
DENTAL SERVICES	0	0	6	0	14
HERMANUS HOSPITAL	0	0	2	0	18
VREDENBURG HOSPITAL	1	0	0	0	19
RD :W-COAST/WINELAND	6	0	1	0	12
STELLENBOSCH HSP	3	0	1	0	15
SOUTH CAPE TB CENTRE	9	0	2	0	6
FALSE BAY	0	0	2	0	14
ROBERTSON HOSPITAL	0	0	0	0	12
C/WINELANDS TB CENTR	1	0	7	0	3
TC NEWMAN	0	0	8	0	3
WCRC	1	0	7	0	3
BERGRIVER SUBDISTRIC	0	0	0	0	10
RIVERSDAL HOSPITAL	0	0	0	0	10
ALEXANDRA HOSPITAL	3	0	0	0	6
BROOKLYN CHEST HSP	0	0	5	0	4
CITRUSDAL HOSPITAL	3	0	0	0	6
MONTAGU HOSPITAL	1	0	0	0	8
VREDENDAL HOSPITAL	8	0	0	0	1
EMERGENCY ME	0	0	0	2	6
BREDASDORP HOSPITAL	0	0	0	0	6
RD : S-CAPE/KAROO	1	0	1	1	3
SWELLENDAM HOSPITAL	0	0	0	0	6
LAINGSBURG HOSPITAL	2	0	0	0	2
WINELANDS DISTRICT	0	0	4	0	0
KESS OFFICE	0	0	0	0	3
OVERBERG DISTRICT	0	0	2	0	1
LADISMITH HOSPITAL	0	0	0	0	2
RD: WC REG OFFICE	0	0	1	0	1
Grand Total	181	3	156	121	3441
Total across all groupings for the year	3902				

The table above shows that staff across health facilities are contracted in the 16 hour commuted overtime grouping. Although the table reflects 2020/21 data, the same distribution was found across the years analysed.

Options analysis

Given that we did not have the actual hours worked we could not compare actuals to what is permissible per grouping. Checking for variation in the proportion of staff by rank and facility within each grouping was done. However, despite the odd outliers everyone with the same rank description is more or less in the same grouping, which in most cases tends to be 16. Hence there is no scope to improve on that.

A hypothetical consideration is to move those in group 16 to group 12[5] and calculate the possible savings (i.e., 25% reduction in payments). However, such a consideration does not taking into account any operational requirements and may just be impractical. Given that most facilities have staff in the same rank description in the same grouping, there is also no grounds for arguing for this option.

Therefore, it can be concluded that there are no opportunities for savings by ensuring that staff are assigned to the right grouping. However, to validate this, a comparison of the actual hours worked, and the permissible hours needs to be done.

Recommendations

Further work to be undertaken due to time and capacity constraints, the following should be investigated further:

- Actual hours worked per staff member vs hours paid per staff member (sample of specific health facilities to be identified). Sample of overtime registers per staff member.

[5] Refer to notebook in appendices

- Linking commuted overtime spending for districts/ hospitals/ clinical programmes to workload for comparison.
- Establish a norm in terms of commuted overtime per Patient Day Equivalent (PDE)/ staff member/ per district.
- Comparison across districts, facilities - reasons for deviations.
- Establish if demand for services align to the number of overtime hours.
- Identify the level of care, clinical services which has the highest demand.
- Quantify the trade-off between capacity obtained through overtime and additional appointments.

Actions

- No current actions to taken forward. Further work to be conducted of actual vs fixed hours paid to find any possible savings.

Appendices

1. **Overtime analysis table**