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TITLE: PUBLIC HOSPITAL EMPLOYEES' EXPERIENCES OF WORKING UNDER AUSTERITY IN THE EASTERN CAPE PROVINCE, SOUTH AFRICA.

NOXOLO MADELA

STUDENT NO: 886656

SUPERVISORS

PROF. JANE GOUDGE AND DR THANDUXOLO FANA

(CENTRE FOR HEALTH POLICY, UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG)

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DECLARATION

I, Noxolo Madela declare that this research report is my own, unaided work. It is being submitted for the degree of Master of Public Health (Health Systems and Policy) at the University of the Witwatersrand, Johannesburg and has not been submitted before for any degree or examination at any other University.

(Signature of Candidate)

03 October 2024

DEDICATION

My dear grandmother, Beatrice Biyela, may have left this world in 2018, but her spirit lives on as my guardian angel. Her love and guidance continue to inspire and comfort me, even in her absence.

ABSTRACT

Introduction: In the aftermath of the 2008 worldwide economic downturn and, more recently, the COVID-19 pandemic, many nations have gone through a phase of austerity, often enacted via cost-containment strategies and budget cuts. Despite South Africa's attempts to safeguard expenditures for social services like healthcare and education, the public healthcare system has encountered several obstacles, partly due to reduced budgets and centrally controlled expenditures.

Aim: The aim of this study is to explore the perceptions and experiences of public hospital employees of the impact of austerity on their well-being and the delivery of healthcare services.

Methods: This study is a qualitative secondary analysis of data collected from two public hospitals in South Africa. The dataset comprises 22 interview transcripts and 4 focus group transcripts, featuring responses from clinical staff, non-clinical staff, and senior management. Both the facilities and participants were selected through a combination of purposive and convenience sampling techniques. This study used an interpretative epistemological approach for the analysis to explore and obtain an in-depth understanding of health workers' experiences of working under austerity.

Results: The results show that the most immediate consequence of cost containment has been staff shortages, increased workload, burnout, absenteeism, and reduced quality of patient care. The approach adopted for cost containment, which involved centralisation decisions on expenditure, has been criticized for its ineffectiveness. It failed to address the urgent needs of facilities and was not representative of them. The problem was further compounded by poor financial management, misclassification of hospitals and medico-legal claims against the state, which have only worsened the effects of austerity.

Conclusion: Austerity measures have negatively affected the well-being of healthcare workers and healthcare service delivery. The findings highlight the need for strategies that can enhance hospitals' resilience through strengthening leadership and management.

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To my babies Okuhlekodwa and Olethukhanyo, my "why?" I am grateful for their understanding and support during the times when I had to be away from home to complete this task.

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LIST OF ABBREVIATIONS

AGSA	Auditor General South Africa
CEO	Chief Executive Officer
EU	European Commission
HREC	Human Research Ethics Committee
GDP	Gross Domestic Product
IMF	International Monetary Fund
OECD	Organisation for Economic Co-operation and Development
MTEF	Medium Term Expenditure Framework
NT	National Treasury
SANAC	South African Nursing Council
WHO	World Health Organization

DEFINITIONS

Accruals	Expenses for goods and services that have been received but not yet paid for.
Austerity	A mechanism used to respond to economic constraints through fiscal consolidation with measures such as cost containment and budget reductions
Provincial Equitable Share Formula	"A formula which is used to distribute nationally raised government revenue over the nine provinces. It composes of six components from which a weighted average is calculated based on elements such as population, disease burden etc"(1)
Medium Term Expenditure framework	"a structured approach to integrating fiscal policy and budgeting over a multi-year horizon" (2)
Transversal term contract	"a centrally facilitated contract with one or more suppliers for the supply of goods and services over a period"(3)
Zero-base budgeting	This is a budgeting technique in which expenditure for future years is scrutinised and justified extensive methodologies such as spending reviews. This is done with an aim to eliminate unnecessary costs and inefficiencies(4).

CHAPTER ONE: INTRODUCTION

This chapter offers a comprehensive overview of the study background, starting with an explanation of austerity and its implementation in various countries, including South Africa. It then presents the problem statement, which forms the core foundation of the study. Additionally, the chapter provides a brief justification for the research, leading into the study's aim and objectives.

1.1 Background

The economic recession that occurred globally in 2008 put public services, including healthcare systems, of many countries in a precarious position (5-7). In response to low economic growth and fiscal deficits, several governments implemented austerity measures to curb public expenditure and reduce debts (5, 8). Austerity is generally defined as a mechanism used to respond to economic constraints through fiscal consolidation. It involves reducing public expenditures, increasing taxation and out of pocket expenditure on public goods to reduce state debt and contain public expenditure during the periods of economic stagnation (5, 9). Austerity necessitates the closure of programmes and/or projects and delays in implementation of new ones (10, 11). The severity, content, duration and impact of these vary across nations (6, 8, 12).

South Africa faced fiscal constraints following the global economic crisis of 2008. The country's revenue declined, and Gross Domestic Product (GDP) contracted, while social demands increased, leading to significant changes in the fiscal framework. In 2009, the country had a deficit and for the first time in 17 years the state was in recession(13). The deficit of 7.3% was funded through borrowing to offset the revenue shortfalls and ensure that social services expenditure demands were met (13). As shown in the 2010 Budget Review by the National Treasury, during this time, about R13.4 billion was reprioritised within provincial budgets towards government's priorities such as health and education(14).

Although the country had sought to protect public spending in some critical areas (as mentioned above) with hope of the economy recovering, budget reductions were

implemented in 2013/14 (15) (16). Additionally, in October 2013, the National Treasury (NT) issued cost containment guidelines after the Cabinet's decision that all departments and government institutions must implement measures to curtail operational expenditure and prevent unnecessary spending (17).These measures included limiting expenditure on travel, consultants, catering and events(17).

Provinces like Eastern Cape developed a framework for cost containment in 2014/15, which was set to control spending in freezing appointments of administrative staff, entertainment, travel and subsistence, venues and facilities. Task teams were formed to streamline the implementation of the cost containment guidelines under the supervision of the office of the premier(18). In the 2016 MTEF, the province introduced more cost containment measures, which included centralising recruitment and managing the wage bill by cutting personnel costs (19).

Again in 2020/21 there was a sharp decline in the economy and this required a fiscal response to stabilise debt-to-GDP ratio and keeping up with public expenditure (20). Implications of this in the budget manifested in Budget 2021, there was approved budget reductions of R307.8 billion over three years (from 2021/22 to 2023/24) to avoid further borrowing (21). Health's share of these reductions amounted to R50.3 billion across provinces, between 2021/22 and 2023/224(21). However, later, provinces tabled their budgets post national budget and these showed reductions for R76.4 billion in the same period (22). In 2023, the NT issued another set of guidelines which extended cost containment to freezing of posts, issuing of circulars prohibiting advertising, filling and appointment of non-clinical post and non-payment of staff benefits (23-26).

Economic crises can lead to reduced health budgets and austerity measures, which often result in poorer health outcomes due to limited access to medical supplies and services (27). The way health systems deal with economic crises has a significant impact on maintaining good health outcomes (28). The OECD has emphasized the importance of investigating the long-term effects of the economic crisis and austerity measures on healthcare services (28). As health professionals play a central role in providing healthcare, it is necessary to study the impact of these measures on them. This can help determine what measures work and what could potentially harm the health system. By doing so, we can recommend better ways to implement cost

containment measures that have minimal impact on service delivery and the well-being of health workers.

1.2 Problem statement

The implementation of austerity measures in South Africa to tackle the low economic growth and high debt levels has had a negative impact on the country's service delivery programmes. The changes in the budget emanating from budget reductions and reprioritisation have caused uncertainty in sustainability of programmes and improving inputs for service delivery in the health sector. In addition, limited studies have been conducted to investigate the effect of austerity on healthcare service delivery and health workers (29). It is crucial to recognize the significance of having sufficient financial resources to ensure that the necessary inputs for service delivery are available. Therefore, there is a need to comprehend how changes to budget formulation and execution, including austerity measures, impact these resources. At the centre of this issue are the health workers, who are the ones responsible on the forefront of healthcare service delivery.

1.3 Justification

For a very long time the impact of austerity has been hard to assess due to lack of relevant data (29). Noting the continuing economic recession in South Africa and the impact which COVID-19 had on the economy (21), fiscal constraints can be expected to intensify over the next few years to contain the country’s level of debt against its GDP (debt-GDP ratio). Healthcare workers play a crucial role in the delivery of healthcare services (30), this entails that they are also at the forefront in receiving the direct effects of austerity. It is important that potential risks to their functionality are explored which would enable effective development of strategies to potentially minimise the effects of austerity as it relates to healthcare worker experiences and potentially healthcare service delivery.

1.4 Research question.

What are the perceptions and experiences of public hospital employees on the impact of austerity on employee wellbeing and the delivery of healthcare services in the Eastern Cape public hospitals?

1.5 Aim

The aim of the study was to explore public hospital employees' perceptions and experiences of the impact of austerity on employee wellbeing and the delivery of healthcare services.

1.6 Objectives

1. To describe the measures used to implement austerity in two public hospitals in the Eastern Cape Province, South Africa.
2. To describe health care workers' perceptions of the impact of austerity on their physical, emotional and mental health well-being
3. To describe managers' and health care workers' perceptions of the impact of austerity on the quality delivery of healthcare services
4. To describe the challenges of the health system accentuating the effects of austerity

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter aims to provide an in-depth exploration of the existing literature on the topic of the study to ensure that the research is well-grounded. There is a significant amount of literature on austerity measures across the globe, particularly in Europe, where the impact of the 2008 global recession on country economies and healthcare systems has been extensively documented(31). The impact of austerity on health workers has not been studied widely in South Africa, however. While conducting the literature review, I was only able to find international studies on the experiences of health workers working under austerity, and its effect on the quality of healthcare provided and only one study conducted in South Africa. The chapter will trace the global outlook on austerity and its effects on the health system. Additionally, the South African economic context leading to implementation of austerity measures in will be presented.

This chapter will further draw on some literature on the South African health system and how it is financed, while highlighting some of the challenges it faces. This is done to give a reader an extended understanding of the importance of this study and the challenges that underpin its focus. Additionally, the chapter explores the WHO building blocks and the systems thinking approach, illustrating how different aspects of the health system interact and impact its functionality.

2.2 Global outlook: Austerity and its effects on the health system around the globe

In 2008, the European member states experienced a financial crisis which has resulted from a sovereign-debt crisis (10). The European Commission supported the call to invoke austerity measures as suggested by various policy makers to address national debt across Europe. In collaboration with the European Central bank and the International Monetary Fund (IMF), the European commission established the Troika which was a structure developed to monitor countries in severe economic crisis, particularly those receiving loans from the EU, and the IMF (32). Troika imposed austerity measures in 2010 and countries had to implement these in order

to quality for bailouts (32-34). From this economic trajectory, many of the European member states have implemented severe austerity measures and reduced public expenditure immensely. Consequently, in most European countries, growth in health expenditure per capita declined in real terms (adjusted for inflation) in 2010, from a steady trend of 4.6% between the years 2000 and 2009 to 0.6% in 2010 (34).

Greece reduced its public health expenditure from 9.8% of the GDP pre 2008 crisis to 6% of GDP post-crisis (34). This change in public health expenditure in Greece was realised in 2012 when there was a “25% reduction spending on medical services and goods through price-volume agreements and 15% reduction in hospital costs” (8). The budget reductions in the health sector resulted in expenditure reductions in prevention and treatment programmes, including HIV prevention programme for the vulnerable groups which saw a decline in condom distribution (35). In addition to this, while demand for healthcare services was increasing during the time, staff members were overwhelmed with high workloads and rural areas were disproportionately affected with shortages of medicines and medical equipment (35). Other countries that applied austerity measures such as Italy, Ireland, Estonia, Portugal and Latvia had an increase in unmet healthcare need (32). Other studies conducted in these countries found that the austerity policy was associated with a reduction in access to healthcare (34, 36).

Literature also presents that countries such as Slovenia, United Kingdom, Romania and Ireland have reduced expenditure on compensation of employees through reduced wages, freezing of posts and non-filling of vacant posts(37-39). The effects of austerity have also been directly felt by the users of the public health systems as user charges have been instituted as part of austerity. Structural reforms have also happened due to economic downturn, such as closure or merging of facilities, reconfiguration of healthcare services and greater focus on primary health care services(5, 40).

2.3 Impact of austerity measures on delivery of quality health care and health workforce

Quality of care is multifaceted and can be explored from different perspectives e.g., patient, healthcare providers and policy makers. For this paper quality of care is discussed from the perspective of health workers.

Quality healthcare has been defined by the World Health Organization (WHO) as a "the degree to which health services for individuals increase the probability of desired health outcomes" (41). Quality care has also been defined as care that is provided to achieve optimal health outcomes through measurement of patient welfare (42). It is worth noting that healthcare service delivery is influenced by various factors during the process of its provision. One may mention that adequate staffing, availability of medical supplies, functional equipment are some of the key elements required to ensure provision of quality care. There is growing interest in defining quality of care according to a) *effectiveness* of healthcare services, b) *safety* for people whom care is intended for and c) it being *responsive* to the needs, values and preferences of individuals (41).

The Institute of Medicine Committee on Quality of Care in America presented quality of care as an interaction between patients, healthcare providers and inputs for care and how these translate into quality healthcare (43). Aligned to the definition by the WHO, the committee states that health care services should be effective, evidence based and used in accordance to need, not underutilised or over utilised (43).

Since the economic crisis in 2008, there has been growing interest in how austerity has impacted the quality of healthcare services (44). Understanding how health systems respond to the economic crises is important in improving and maintaining health outcomes (28). Limited studies have been done in this area to ascertain the impact of austerity on the quality of services, particularly from the perspective of health workers (45). However, evidence suggests that implementation of austerity in different countries have impacted the processes of service delivery thereby affecting quality of care provided by clinicians to patients. In the five studies conducted in three jurisdictions of Australia i.e. South Australia, New Wales Victoria, Tasmania and New Zealand, there was an indication of a significant relationship between lack

of equipment and poor patient care delivered, resulting from budget shortfalls due to budget cuts (46), and these have direct effect on the quality of services provided.

A study conducted in Portugal has revealed negative effects of austerity measures on healthcare services (44). The study found that some healthcare professionals reported shortages in drugs, denial of innovative treatments, lack of equipment, and administrative intrusion in medical decision-making during the period of austerity(44). Although this study did not investigate the effects on health outcomes, it did ascertain that there was a negative impact on quality of care.

In the United Kingdom, research provides evidence that austerity has contributed to a deteriorating public health system, especially for children and this is mainly from the budget cuts effected in public services leading to poor health outcomes (36, 47). From these studies it is evident that austerity measures can significantly undermine the quality of care delivered by healthcare professionals. This situation emphasizes the urgent need for a more nuanced understanding and effective management of health systems, particularly during economic downturns. By recognizing and addressing these challenges, policymakers can better safeguard the integrity and efficiency of healthcare services, ensuring that economic constraints do not compromise patient care.

In South Africa, there was a study done in KwaZulu Natal province which sought to ascertain the “impact of staffing moratoria on the delivery of quality of health care” (48). One of the findings was that the moratoria resulted in increased absenteeism due to high workloads and low staff morale. Low staff numbers due to unfilled posts and absenteeism caused delays in the delivery of services, resulting in long queues and less satisfaction of patients. One of the respondents also mentioned that it has been a challenge for the hospital to implement quality improvement initiatives because of inadequate staff levels (48). It was also found that moratorium on staffing resulted in medical error as inexperienced staff undertook duties beyond their scope of training and practice to offset the gap of staff shortages in different areas (48). This further deteriorated quality of care provided to patients.

In a study done in Zimbabwe, halting of filling vacant position in health facilities was highly associated with increased poor health outcomes, particularly for children (49), a proxy to poor quality care.

The impact of austerity measures on public services has been a subject of intense debate, particularly concerning their effects on health systems. Austerity has been blamed for affecting functioning of health systems and human resource is one of the significant inputs to the delivery of healthcare which have suffered the consequences (29, 50, 51). A study conducted in the UK highlighted the economic and social dimensions of austerity which create unconducive working conditions for healthcare workers (52). In this study, it is said that, during the periods of austerity, healthcare workers find themselves battling with moral distress. is distress arises because healthcare workers, despite having the professional knowledge and the desire to provide the best care for their patients, often lack the necessary resources or capacity to do so (53). As a result, healthcare workers may find themselves in situations where they have to act in ways that are unethical, contradict their values and beliefs, leading to a loss of integrity and a sense of moral conflict (54). This essentially means that austerity is not only a risk factor for patients receiving adequate care but it also has potential to undermine professionalism in healthcare (52).

From an interpretive perspective, it is essential to understand that the moral distress experienced by healthcare workers is not merely a byproduct of economic constraints but also a reflection of systemic issues within the healthcare infrastructure. The inability to provide adequate care due to resource limitations can lead to a sense of professional inadequacy and ethical conflict. This highlights the need for policymakers to consider the broader implications of austerity measures on the well-being of healthcare professionals and the overall quality of patient care

Kentikelenis and Stubbs (51), highlight the probable impact of austerity in health systems as he posits that “austerity policies have been linked to a so-called ‘medical brain drain’, as staff migrate to the Global North in search of better employment opportunities”. According to Mudallal and Protoghese (55, 56), the association between poor health comes resulting from poor well-being of the health workers in the workplace is mostly due to the high workloads, poor working conditions and burnout. Burnout has been described by Maslach and others (57) as a “psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity.” One interesting aspect of burnout, especially for those in

service-oriented roles, is the development of depersonalization. This refers to the negative and cynical attitudes that can arise towards clients, and it has been widely documented to be prevalent in the healthcare industry (55, 57).

2.4 South African economic context leading to austerity.

Austerity measures in LMICs often lead to significant cuts in health budgets. This reduction in funding affects the availability of essential medical supplies, infrastructure, and healthcare personnel (58). Economic crises exacerbate existing health disparities in LMICs. Vulnerable populations, including the poor and rural communities, face greater barriers to accessing healthcare services (59). Many LMICs rely heavily on international aid and external funding for their health systems. Austerity measures can reduce this external support, further straining the already limited resources (60). This is particularly critical in instances where co-financing policies guard funding allocations to countries.

South Africa has experienced significant health budget cuts due to austerity measures, impacting the quality and availability of healthcare services. South Africa is grappling with an escalating fiscal crisis. Over the past decade, persistent austerity measures have significantly diminished the quality and effectiveness of public services, which are crucial for the majority of South Africans1. Despite these prolonged austerity efforts, the country remains far from achieving fiscal consolidation. This ongoing situation is progressively undermining the state's fiscal capacity, hindering its ability to leverage fiscal policies effectively (61)(62). Similar trends are observed in other LMICs, where austerity measures have led to deteriorating health systems and outcomes (58).

Since the 2008 crisis, South Africa has been incurring a budget deficit, which amounted to 6.25% of the GDP in 2019/20 (4). Austerity has intensified in South Africa especially since 2012/13 due to the deteriorating economy, rising deficit, issues of corruption, rise in budget pressures (e.g., increase in medico-legal claims, accruals and escalating wage bill), inefficiencies and rising state debt. In response to these, budget reductions have been implemented across the board, including the health sector (24, 63-65). Considering potential and prevalent implications for public services and the overall well-being of the population, moving forward, it is crucial for

South Africa to not only focus on fiscal consolidation but also to implement structural reforms that address the root causes of inefficiencies and corruption. This dual approach could help stabilize the economy and create a more sustainable fiscal environment.

The impact of these changes in public expenditure, including health, has been immense. Before 2012/13, the public health expenditure growth had been between 8.5 and 10.5% per year in real terms until 2012/2013 when there was a significant drop in the health budget to 1.8% from 2012/13 to 2019/20 (16). In addition, over the period 2016/2017 to 2019/20 the provincial health budgets per capita uninsured declined by 3.5% in real terms (2019/20 prices) (66) .

The slow growth in provincial health budget per capita indicates the pressures in the fiscus and provincial treasuries. This is also exacerbated by medical inflation, which normally exceeds headline inflation, which is not considered in the budget formulation process(67). Therefore, a low real growth could pose a risk in sustaining optimal health expenditure, resulting in the rise of accruals. The situation continued to deteriorate in the 2021 Medium Term Expenditure Framework (MTEF), health budgets grew at an average annual rate of 2.5% (in nominal terms) and at -1.7% in real terms from R227.1 billion in 2020/21 to R216.1 billion in 2023/24. The Eastern Cape budget decreased by an average annual rate of -4.9% in real terms (2021/22 prices) (21). Over the 2024 MTEF, the health budget only grows by an annual average of 3.4% in nominal terms, this is also below the projected annual average consumer-price index inflation of 4.7% over the same period (68).

To streamline service delivery processes and cut costs, the sector implemented certain strategies. Amongst others, these included centralisalisation of medicines procurement, development of transversal tenders for equipment and other medical supplies. The health sector also identified certain essential items, which they referred to as "non-negotiables," to protect them from budget cuts. These essential items include medicines, medical supplies, laboratory services, and food supplies(69).

The austerity measures are reversing the country’s efforts towards improved financing of the health system. The provinces are faced with difficult choices, having

to ‘triage’ spending areas e.g., having to decide whether investing in infrastructure is worth more than hiring more personnel or procuring medicines (51). The country is caught in-between protecting public finances while reducing spending to deal with the deficit rapidly. Furthermore, some of the reforms in financial management have included centralisation of decision making in budget planning and expenditure (70). Evidence suggests that continued centralisation of decision making will potentially have a negative impact in the optimal functioning of the health system(70).

2.5 South African health system and its financing

The National Health Act provides a description of the responsibilities of the three spheres of government regarding the public health system (71). The National Department of Health is the custodian of the health policy and therefore is responsible for providing policy direction, coordination and oversight on the delivery of healthcare services (67, 71); provincial departments of health are responsible for the provision of health care services. In provinces, healthcare services are delivered through hospitals and primary healthcare facilities (clinics, Community Health Centres, mobile clinics and Ward Based Primary Health Care Outreach Teams). In addition, in some provinces the delivery of primary health care service is supported by local government (with some level of revenue injection of local government) (72).

Figure 1.1 below shows the flow of funds to the health system in South Africa. Private health providers are mostly funded by medical schemes with members receiving subsidies through medical tax credits, an incentive by the government to support those not using public health facilities. There are also individuals who opt to pay out-of-pocket and can afford these services. Individuals who do not have medical insurance or whose insurance does not cover certain services often pay directly for healthcare services. These payments can include costs for consultations, treatments, medications, and hospital stays (73). This dual system of funding through medical schemes and out-of-pocket payments sustains the operations of ensures that private health provider. Moreover, medical schemes significantly contribute to the financing of the private health system, with members receiving subsidies through medical tax credits. Public health services are mostly financed through taxes which make up more than 90% of public health expenditure and partly

through donor funding which only makes up about 4.8% (22, 73). A minor proportion of the funding is gathered through direct, out-of-pocket payments. This approach is particularly applicable to hospitals that employ a Uniform Patient Fee Schedule (UPFS). The UPFS ensures a consistent application of fees charged to patients, which are set based on the health means test (74). Medical schemes also pay public health providers in cases where services were offered to a patient that is insured but was treated in a public health facility. The funds raised nationally through tax collections of various categories including VAT (also pay by private providers on medical services), personal income taxes, sin taxes etc are distributed across the three spheres of government i.e., national, provincial and local government (75). As healthcare services are delivered largely by the provinces, the provinces receive a lion's share of the health budget, about 92% as from 2015/16 up to 2020/21(22). Provincial government revenue is made up of transfers from the National Revenue Fund (about 97%) (65), made through the Provincial Equitable Share formula[1] and revenue generated by provinces (20).

The National Department of health also administers transfers to provinces through conditional grants to support specific health programmes (e.g. National Tertiary Services and HIV response)(20, 22). Each province has the discretion to decide on the final budget for each department, irrespective of what the National Treasury would have determined in the equitable share formula for each sector. This decision-making process is rigorous and may be influenced by the political agenda.(20). The provincial treasuries make transfers to the provincial departments of health, who then distribute the funds to health facilities in accordance with the delegation of powers for procurement, project management, management of employees etc

[1] Provincial equitable Share formula "is used to distribute nationally raised government revenue over the nine provinces. The formula composes of six components from which a weighted average is calculated". The weighted average is an indication of the provincial needs, taking into account different demographic factors that affect service delivery in provinces1. Parliamentary Monitoring Group. Report on Provincial Equitable Share: Budget Committee. In: Parliament, editor. 2021..

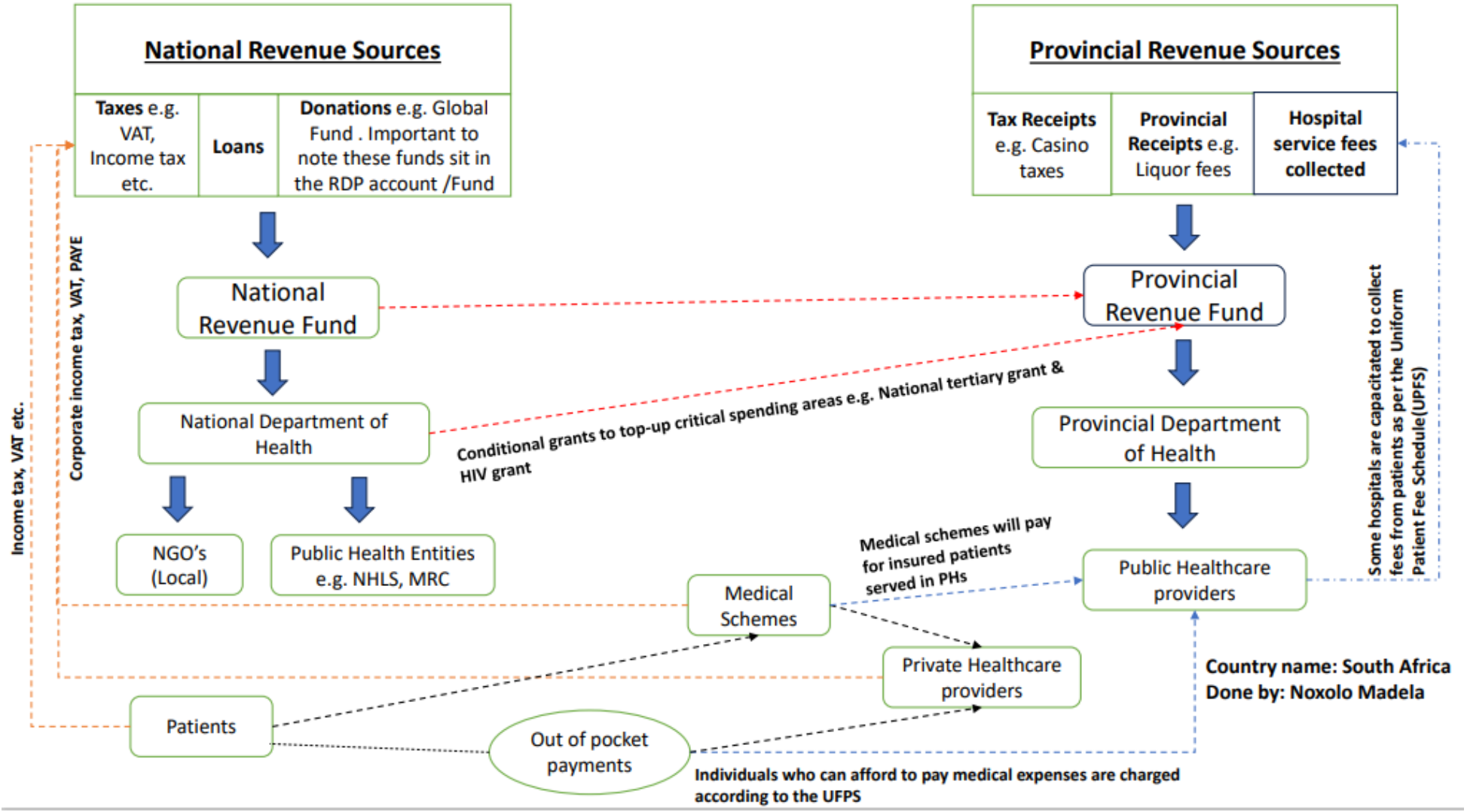

Figure 2.1: Flow of funds from the National Revenue Fund to the Health System

Source: author drawing from (75) (69)(65)

2.5.1 Budgeting in South Africa

Budget formulation in South Africa is consultative process that involves multiple levels of government and other stakeholders to ensure transparency and accountability in the budgeting process. These stakeholders include National Treasury, Provincial Treasuries, Technical Committee on Finance, Budget Council, Ministers' Committee on the Budget and other government constituents (76). The country uses incremental budgeting, which is largely embedded in historical budgets and uses the consumer price index to maintain the purchasing power of previous allocations (77). The South African budget is set over a three-year cycle under the medium-term expenditure framework, with the 2 outer years subject to change. The assumption is that programmes will require a similar level of budget over the years and the aim is to just keep up with inflation (77). Many authors have criticised this type of budgeting and National Treasury has also shared that this type of budgeting "only focuses changes at the margins of spending rather than at the core and does not guarantee efficiency in the allocation of resources and generates inertia" (77). While this may enable predictability and give some surety on sustainability of programmes, this is only favourable in a stable economy. The disadvantages as laid out by National Treasury are one of the reasons the country is looking into introducing zero-based budgeting(4).

2.5.2 Health expenditure

Prior 2019/20 expenditure trends in health showed average growth of 1.7% real growth per annum (from 2015/16 to 2019/20). This level of growth indicated pressures in the health sector budget as it did not keep up with the inflationary increases (67). The growth in spending has been influenced by many factors including population growth (1.6% on average from 2015/16 to 2019/20), medical inflation and exchange rate fluctuations (not accounted for in the budget formulation) which largely affect goods and services spending on medicines and medical supplies (20,78). It is worth noting that while spending has increased from 2015/16 to 2019/20, masked in this spending is overspending which emanated from medicines and medical supplies (22), due to the factors already mentioned earlier. As a result, the sector had a considerable rise in accruals, which are service providers' unpaid bills, these increased from R10.2 billion in 2015/16 to R 15.3 billion in 2020/21,

representing 17% of the sector's 2021-22 budget (excluding compensation of employees) 8). These unpaid bills indicate immense pressure on the health budgets, poor financial administration and are a threat to service delivery.

The issue of accruals varies across provinces, with Eastern Cape having the largest share almost every year, the province uses most of its budget to settle unpaid bills from a previous year (69,78). This results in the province always planning healthcare service delivery on a lower budget, which then compels stringent measures in controlling expenditure through prioritising main essential activities (79). Sachs and others (78) suggest that a solution to this recurring problem may be to provide additional allocations to baseline of departments to address the current quantum and deal with part of the initial cause of this problem which was inadequate funding of the sector. However, Sachs et al (78) also argue that there is also an eminent need to enhance financial management and financial controls through improved management and systems. These are also some of the views expressed in the Presidential Health Compact of 2018 (78,79). Effective management systems can ensure that the additional funds are utilized efficiently and transparently, thereby addressing both the symptoms and root causes of the problem. This also highlights the necessity of a comprehensive strategy that combines financial inputs with robust management practices.

During 2021, the Minister of Finance tabled a budget which was concerning for expenditure programmes, as expenditure was reduced by R50.3 billion over the 2021 Medium Term Expenditure Framework – which is over 3 years(21). These reductions were mostly effected on compensation of employees. However, due to additional allocation to fight the COVID-19 pandemic, the health budget increased substantially, making up 16% of government's total expenditure. Changes then came about in budget 2023, where the country saw a sharp decline in the health budget, with a nominal average annual growth of 1.8% from R210.9 billion in 2019/20 to R226.4 billion in 2023/24 (22). This is post COVID-19 once-off allocations and budget reductions emanating from the economic downturn due to the pandemic.

The country continues to fight issues of corruption and mismanagement of funds (fruitless and wasteful expenditure), underspending, contingent liabilities emanating

from medico-legal claims and irregular expenditure[2] etc. (4, 78). Concerning the latter, in 2020, the provincial departments of health had a total of R60 billion of irregular expenditure (78). This total may be inclusive of expenditure that could be condoned but necessary steps were not taken e.g. providing motivation on spending that could not have been avoided and was necessary for service delivery. It may also be an indication of failures of the department to hold officials accountable and recover some of these funds due to deficiencies in the management and administration of public finances and lack of credible instruments and structures for accountability (78).

Additionally, the South African health system faces numerous unresolved challenges. Among these, medico-legal claims and the impact of COVID-19 are critical issues that need to be reviewed. Understanding these factors is essential to gaining perspective on the broader challenges that hinder the successful adaptation to austerity measures.

2.6 Other challenges in the public health system

The South African health system, although functional, continues to face several challenges. As may be a common issue across health systems in different countries, South Africa continues to face the challenges of inadequate staffing in health facilities. This problem is more prevalent in rural provinces, Gilson (72) states that more rural provinces are disproportionately affected with urbanised provinces having a better supply of a range of health practitioners (general and specialised). There are many factors that have aggravated this situation, including brain drain and migration (81). The reasons for migration of skilled health workers in South Africa, described as both push and pull factors, have been studied widely (82-83). Push factors are factors that drive outward migration such as low remuneration, poor working conditions, narrow career development pathways, high workloads in part due to high disease burden (83). Pull factors are those factors that draw inward migration to

[2] Irregular expenditure – this is expenditure incurred "in contravention of or that is not in accordance with a requirement of any legislation (e.g. the Public Finance Management Act), applicable to public sector procurement". Irregular expenditure may indicate poor financial management and inability to comply with the set legislation. Expenditure classified as irregular during the audit may be condoned for various valid reasons, for instance, where it can be proved that there was no negligence and no misuse of funds.

those countries which would be preferred by the health workers migrating from South Africa. These include, for instance, vacant positions, better working conditions, better living conditions, and higher remuneration (82-83).

Austerity has exacerbated the push factors including increased workload for remaining staff, reduced quality of care, and reduced access to health care services.

2.6.1 Medico legal claims

One of the biggest threats in the South African health budgets has been the medico-legal contingent liability. There are growing concerns around the increasing number of claims in recent years. Extensive research has been conducted on the primary reasons behind the increasing number of medico-legal claims. The South African Law Reform Commission, which is also exploring ways to manage this problem through legislative amendments has published several papers on this issue in South Africa (84). There are numerous factors contributing to this rise in claims such as poor quality of services in health facilities which also result from inadequate resources such as personnel, equipment, medical supplies and shortage of medicines (84). However, some authors have argued that while resources and quality are sub-optimal in health facilities, this increase may not be solely explained by this and negligence (85). It is said that law firms have also been targeting the health sector, immorally advertising and encouraging the public to pursue litigation in cases where a person may have adverse events emanating from healthcare (85-86). This has gone as far as lawyers illegally working with health officials to get access to the files leaving the state defenceless (22).

While the rise of these claims is largely a health care issue, due to poor quality of health care service delivery, it has also become a burden to the fiscus, becoming a financial matter (88). Medico-legal claims increased by over 50 per cent between 2014/15 and 2015/16 with the notable increase in four provinces i.e. Eastern Cape, Gauteng, KwaZulu Natal and Limpopo (69). Wishnia and Goudge (63), show that in 2019/20, government spent 1.9% of its hospital budget in settling medico-legal claims, of which Eastern Cape had a largest share, spending 5.6% of its hospitals budget on the payments. This is also in-line with the fact that Eastern Cape's medico-legal claims contingent liability has been the highest in the country from

R24.2 billion in 2017/18 to R36.8 billion in 2019/20 (22, 69, 88). From the beginning of 2020/21 financial year, the whole country made payments towards medico-legal claims to an estimated R1.6 billion of which approximately R870 million was paid by the Eastern Cape (89).

A noteworthy fact is that settlement of medico-legal claims is funded by service delivery budgets, reducing funding for service delivery programs (78, 88). For instance, much of Eastern Cape's expenditure on medico-legal claims pay-outs has been reprioritised from non-compensation budget line items such as equipment, medical supplies, medicines, and the consequence is higher accruals (78).

Prinsen (86) states that lack of availability of essential tools of trade for health care professionals and understaffing are a huge risk for continued clinical errors. He further states although it is inappropriate for health professionals to be expected to deliver services under such circumstances, they are still expected to perform their duties (86). This indicates a probable vicious cycle of poor quality of care and malpractice which is detrimental to the patients and overall achievement of good health outcomes. Addressing this issue requires strategic interventions dedicated to deal with the root causes as mentioned.

2.6.2 The status quo post-COVID19 pandemic[3]

The COVID-19 pandemic severely affected the South African health system, and its consequences are still evident in various aspects of the system. One of the main problems, as cited by many countries, was the interruption of healthcare services delivery, including HIV and TB-related services, maternal and child health, and many others (73, 90,91). Beyond this, South Africa was already faced with budgetary constraints and the health sector was affected. The budget reductions introduced in 2019, which deepened in 2021, hit the sector quite badly and this was further exacerbated by the pandemic. While there were baseline additions of around R21

[3] The selection of these factors was primarily informed by a review of the literature and prior knowledge. The inclusion of austerity measures post-COVID-19 aims to provide a forward-looking perspective on challenges arising from the pandemic's impact on public health funding and resources, which exacerbated the situation observed in 2019. Given that the secondary analysis is done post-COVID-19, it seemed pertinent to reflect on recent developments in health systems, particularly regarding challenges affecting health financing in the era of austerity.

billion in 2020/21 and 2021/22, these only focused on COVID-19 response related interventions and had no impact on other service delivery programmes(22). In the 2021 report by Auditor General South Africa (AGSA) it was posited that:

> "The sector's financial health situation is also concerning, given its critical role in ensuring that South Africans have access to quality healthcare, and this threatens its ability to achieve overall targets by 2030. **The covid-19 pandemic aggravated the pressure of the situation**, as the sector had to use its limited budget to expand its current activities to include measures to deal with the pandemic." (88)

The impact of the COVID-19 pandemic on the economy has made it difficult to maintain adequate levels of spending in health. The 2024 Budget review shows that the situation is worsening, with shortfalls in central budget revenue expected to reach R46.3 billion in 2023/24, and a total of R113.5 billion by 2024/25 and 2025/26. This is primarily due to poor economic growth and a decline in corporate and net value-added tax. Unfortunately, South Africa has not yet developed any fiscal interventions or approaches to facilitate recovery while protecting spending in critical areas such as health (48).

Given the previously discussed issues indicating significant problems within the health system, influenced by various external and internal factors, this study aims to conceptualize the impact of austerity on the health system as experienced by health workers. Utilizing the WHO building blocks framework through a systems thinking approach, as proposed by Savigny (92), is crucial. In the context of South Africa, the application of this framework is particularly pertinent. The country's ongoing fiscal challenges and austerity measures have profoundly impacted its health system, underscoring the need for a systems thinking approach to review and understand issues. By examining the intricate relationships between health financing, workforce, governance, and service delivery, stakeholders can better understand how financial constraints affect overall quality healthcare. This holistic perspective is essential for identifying root causes of inefficiencies and developing strategies to enhance the resilience and responsiveness of South Africa's health system.

2.7 WHO health system building blocks.

The World Health Organization developed a framework of the health systems building blocks with an intent to help guide countries in strengthening health systems. It emphasizes the importance of identifying and addressing gaps to ensure systems are both responsive and resilient. The six critical areas outlined by the WHO—health financing, workforce, leadership and governance, service delivery, medical products, vaccines, and technologies, and information systems—are interconnected and mutually influential (93). This interplay is crucial; it is not the individual components but their synergy that forms a cohesive health system, indicating a systems thinking approach.

According to Savigny and others (92) “systems thinking is an approach to problem solving those views “problems” as part of a wider, dynamic system”. Systems thinking goes beyond merely responding to current outcomes or events; it requires a profound comprehension of the connections, relationships, interactions, and behaviours among the components that define the whole system (92). By applying a systems thinking approach, one can discern that issues within the health system are rarely isolated; they often stem from complex interactions within the system's network. Understanding the dynamics of health financing, particularly public health budgets and implementation in South Africa, for instance, can shed light on its impact across the system, aiding in pinpointing root causes of problems and fostering resilience.

This study narrows its focus to three of these building blocks—health workforce, service delivery, and leadership and governance—to delve deeper into their interrelations and influence on the health system. Through this framework the WHO establishes different key indicators and outcomes to leverage on potential advantages of a harmonised approach to health systems strengthening and monitoring, including increased efficiencies. Leadership/governance and health information systems are cross cutting but provide basis for overall policy direction and regulation of the other building blocks. Savigny and others (92) state that the building blocks are not a holistic representation of systems, but it is the interaction of these blocks and how one affects the other that convert these blocks into a system. As a result, a health system may be understood through interaction of these blocks.

Viewing these blocks from a lens of systems thinking then enables one to understand that one problem in the health system is not exclusive but may have been influenced by many other parts of it and every outcome in the health systems results from interaction of various components of the system. Noting the research question for this study, it then becomes essential to understand how austerity (which affects health financing) affects the other parts of the system. Consequently, this would aid in addressing the root causes of problems and possibly building resilience within different components of the health system.

While the study employs a system-wide lens to the enquiry, the focus will be more specifically of the three building blocks, namely, health workforce, service delivery and leadership and governance, more details are discussed below. This framework is deemed useful and important in guiding policy makers on what key areas, and content within those areas, should be addressed and managed to strengthen the health system (29). These elements are essential in building a resilient health system. For the purposes of this study, the focus will only be on the four of the elements. These are discussed below as follows:

2.7.1 Medical products, vaccines, and technologies.

This building block focuses on ensuring that medical products, vaccines, and other technologies are of high quality, safe, effective, and cost-efficient (93). A well-functioning system guarantees equitable access to these essential items. Disruptions in the supply of medicines, vaccines, and supplies can demotivate workers, affecting their presence and performance (93). This highlights the interconnectedness of health system components, where a failure in one area impacts the overall functionality and effectiveness of the entire system.

2.7.2 Information systems

Information systems play a crucial role in the health sector by enabling responsive and evidence-based planning. Their impact is significantly enhanced when supported by a robust human resources component. These systems are vital for decision-making and data storage, helping to track trends and changes in population

needs over time. They also allow for the monitoring of what strategies are effective and which are not, facilitating better planning within the health system. This building block intersects with all other components of the health system.

The key functions of health information systems include (93):

a) Data Generation: Collecting relevant health data.
b) Compilation: Organizing and storing the collected data.
c) Analysis and Synthesis: Interpreting the data to identify trends and insights.
d) Communication: Sharing the findings with relevant stakeholders.
e) Use: Applying the insights to improve health outcomes and system efficiency.

By integrating these functions, health information systems ensure that health planning and responses are both informed and effective.

2.7.3 Health financing

This building block focuses on securing adequate funding for healthcare services, ensuring that individuals can access care without facing financial hardship. It is crucial for maintaining and enhancing human welfare. Without sufficient financial resources, it would be impossible to employ enough healthcare workers, procure necessary medicines and medical supplies, or implement health information systems. This component involves the mobilization, accumulation, and allocation of funds to meet the population's healthcare needs.

2.7.4 Health workforce

The World Health Organization states that the way in which countries can develop health policies and strategies and achieve goals and objectives set, is through possession of skills, knowledge and adequate deployment of personnel entrusted with managing the health system and delivering of healthcare services (93). The health workforce is defined in this framework as all those people appointed whose primary intent is to contribute to the enhancement of the health systems. These include clinical staff such as nurses, doctors, pharmacists, dentists, and other personnel involved in the delivery of services. In management and support staff these would include cleaners, security guards, finance managers, kitchen staff and

policy makers (93). The availability of adequately trained personnel in required numbers is essential for delivering health services and achieving universal health coverage.

Personnel headcount declined by 8 293 between 2011/12 and 2019/20 in the South African health sector (69). Much has been said in the media about delayed filling of posts and lack of clear strategies in dealing personnel shortfalls (69). Satisfaction and motivation of nurses on the job is important in the management of health systems and delivery of healthcare services as evidence has linked this to the quality of patient care and health outcomes (94). Studies conducted by McHugh et al (87) (95) and Kutney –Lee et al (12) established a significant relationship between the nurses' work environment and patient quality of care, as the study found that dissatisfaction of nurses was associated with low quality of care experienced by the patients. Since this study focuses on health workers' experiences and perceptions during times of austerity, this aspect is crucial to our research. Additionally, comprehending the role and significance of health workers is important in exploring the participants' issues in-depth and finding solutions to address some of these issues.

2.7.5 Service delivery.

This component presents the immediate outputs of the inputs in the health system. These outputs are influenced by various health policies that guide the direction of the healthcare workforce, financing, medicines, and supplies to ensure that quality healthcare is provided to the covered population (93). The correct mix and efficient use of these inputs have potential to derive good health outcomes (29). The successful delivery of healthcare services also depends on the accessibility of the service, such as the proximity of the services, adequate infrastructure, and availability of the services in the benefits package, with no barriers of cost and language (93).

Budget cuts are at the core of austerity measures, which can lead to changes in how services are delivered in the healthcare sector. This can result in revised benefits packages, reduced staff, and limited procurement of medicines and medical supplies. All these changes have the potential to affect access to healthcare services

and the quality of care provided. This study aims to investigate the impact of austerity measures on service delivery as perceived by healthcare workers. The main argument in this building block is that the successful delivery of healthcare services, which depends on the efficient use of inputs and accessibility, is significantly impacted by austerity measures.

2.7.6 Leadership and governance

This element cross-cuts all other elements as it is focused on policy regulation of all other elements in the health system and it is also closely linked to accountability (93). According to Ferrinho et al (30), “Involve ensuring that policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability.” Important in this element is also accountability. Borghi and Brown (96) state that an accountable health system is one that has structures of procedural quality, effective management of stakeholders, quality of outputs and assumed responsibility of oversight in health planning and delivery of services. The WHO presents that an accountable health system should be measured against i. Delegation and/or understanding of how services should be supplies ii. Adequate financing to ensure resources are mobilised efficiently for the delivery of services iii. Enforcement of performance management for staff iv. Performance management of supply of services and 5. Monitoring and evaluation of performance (93, 96). Some authors have suggested that effective and successful introduction of change in an organization requires leadership that will foster proper planning and organising to ensure that all parties involved cope better with the renewed ways of working and initiatives (97). During this time, leaders should be invested in monitoring the operations of an organisation under renewed circumstances, have risk mitigation measures in place and continuously provide guidance to employees on how to manoeuvre different aspects of change (97). Failure to do so has negative implications for the institutions/s.

Leadership and governance as the cornerstone of policy making and implementation of health programmes create an enabling environment for other elements of the health system to thrive. Development and continued execution of cohesive policies for health systems strengthening is essential in the control and management of

known diseases and future pandemics (50). In the current study the experiences of management during the time of austerity are important to understand as well as interactions of management and staff. This brings questions of whether there is strong leadership and governance which keep the health system resilient despite the financial challenges; the extent to which health policies and operations have been impacted and the response thereof. The featured components of this element help to identify the strengths and weaknesses of the leadership and management in health. Leaders and managers have significant roles in managing people, programmes and finances, guiding policy changes and implementation, and setting the direction of service delivery. Their guidance and response to employees during reforms in the mentioned areas have far-reaching implications. It is important to note that different policies and legislation may govern each of these building blocks, and achieving universal health requires multi-sectoral efforts (98).

Leadership and governance are crucial for maintaining a resilient health system during times of austerity. Amongst many other things effective leadership may involves a) overseeing organizational operations under renewed circumstances b) Implementing measures to mitigate risks c) Continuously guiding employees on how to navigate changes. As part of fulfilling the aim of this study it is important to examine whether strong leadership and governance can keep the health system resilient despite financial challenges. Based on the findings one may highlight the importance of leadership in managing people, programs, and finances during austerity.

The WHO health systems building blocks have been identified as fit for this study because of its comprehensiveness and link to systems thinking framework by de Savigny. These six building blocks represent the essential attributes of a health system, and the framework demonstrates how integrating these blocks can bolster the health system (99). By examining these holistically, we can identify strengths, weaknesses and gaps (99) and managing the interactions between them can ensure that the system functions equitably and efficiently.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

Research methodology is one of the very important elements of research and provides an approach through which research may be undertaken (100). This chapter presents the methodology applied in carrying out this research study which is a secondary analysis from a primary study which was conducted in 2019. The subject of the primary study was focused on governance, management and effects of human resources policies and practices during the periods of austerity in public hospitals in South Africa. The data collected was qualitative data and respondents included nurses, allied healthcare professionals, general workers (i.e. cleaners, kitchen staff), administrators, shop stewards as well as senior and middle management staff. Following the primary study, the researcher (TF) identified themes that emerged beyond the original research scope. Consequently, a secondary analysis was recommended for further exploration of the data in this regard. Hence this secondary analysis focused on the health workers' experiences of working under austerity.

This chapter will begin by detailing the research design employed in both studies, which is a qualitative paradigm. Furthermore, this chapter describes the study setting, study population, sampling methods, data collection, positionality of the researcher and ethical considerations of the primary study, and the data management, analysis, and credibility of the secondary study.

3.2 Study design.

3.2.1 Qualitative inquiry

The primary study employed a qualitative inquiry with a case study design. According to Berwits (101) qualitative research is used to capture the data exhaustively through the application of rigorous research techniques to analyse complex data conveyed through language and behaviour in a natural setting. Tenny and Brannan (102) explain the strengths of qualitative research as "its ability to explain processes and patterns of human behaviour which can be difficult to quantify". This would include studies that seek to understand the experiences,

behaviours and attitudes of a population of interest which are often difficult to understand from a quantitative perspective (103). Qualitative research may ask open-ended questions (102) (104) and requires investing time and applying techniques that help in organisation and making sense of data. The qualitative approach in this study enabled a deeper understanding of various measures imposed to implement austerity and how these have affected the well-being of health workers and quality of healthcare services. Cresswell (105) states that one of the key reasons for conducting qualitative research is that it can be exploratory, in that it may enable the researcher to explore much about what has not been studied vastly instead of just describing the phenomena.

The research design for this study was exploratory in that it is flexible and adaptive, allowing one to explore various dimensions of the topic as new information emerged during data analysis (106). Looking into how the participants perceived and experience working under austerity, providing what naturally occurs in the health facilities. This study also provided new insights and identified areas for further research, rather than just describing existing conditions. This outcome is typical of exploratory studies.

Below is a further breakdown of the employed study design in the primary study and secondary analysis.

3.2.2 Primary study

Qualitative methods with a case study design were employed to understand the perspectives of public hospital workers, the context, and the challenges they faced. The purpose of the primary study was to examine governance, management and effects of human resources policies and practices during the periods of austerity in public hospitals in South Africa.

3.2.3 Secondary study

This qualitative study employs an interpretivist epistemology, viewing knowledge as a social construct shaped by multiple perspectives and diverse meanings. It sought to understand an individual's perception of reality, which is seen as an interpretation

rather than an absolute definition (107). The study conducts secondary thematic analysis on 22 interview and 4 focus groups transcripts collected from a previous case study conducted in 2019.This study used an interpretative epistemological approach for the analysis to explore and obtain an in-depth understanding of health workers' experiences of austerity (108). An interpretive epistemological approach is about understanding contexts and experiences around the phenomena of interest from different perspectives (i.e. from individual actors), with an intent to analyse and account for shared meanings (108). This approach was relevant because the primary researcher (TF) sought to understand the processes of austerity and the experiences of health workers working under austerity. This design enabled exploration of health workers' experiences of working under austerity as data collected from the primary study discovered that several interviewed health workers and managers shared their feelings and views about the implementation of austerity measures.

3.3 Study setting.

The primary study was conducted in the Eastern Cape province in South Africa, a predominantly rural province with high levels of poverty. In the latest census (2022), this province is ranked fourth in the most populated provinces in SA with over 85% of the population being African black, 7.6% coloured, 5.6% white and less than 0.5% Indian/Asian (109) .The province is also characterised by a widespread burden of disease which is compounded by an ailing public health system, including, instability in leadership at different levels, inadequate financial resources, poor financial management and dilapidated health infrastructure (110).

This secondary analysis study used data collected in two of three public hospitals included in the primary study. Given the large data set, comparing two hospitals instead of three made it more manageable and allowed for a more in-depth analysis for the master's research study. Hospital A is classified as a specialised provincial tuberculosis referral hospital it has 350 beds and a staff establishment of 200 employees (both clinical and non-clinical). The hospital had faced challenges in its management, within 5 years the hospital changed its Chief Executive Officers (CEO) three times causing instability in leadership and management. Hospital C is classified as a district hospital in the province, although at the national level it is

classified as a regional hospital. It has 200 beds and 600 staff members. This hospital seemed to have stability in its management and at the time its CEO had been in the role for 4 years including the Finance Manager. Both these hospitals are wholly governed and funded by the government through taxes and other public sources of revenue.

3.4 Study population.

In the primary study, the study population consisted of 800 employees from the two public hospitals; 200 employees were from hospital A and the other 600 employees from hospital C. The staff included both clinical and non-clinical employees.

3.5 Sampling methods

In the primary study, a combination of purposive and convenience sampling was used to select the facilities. In purposive sampling, participants were selected based on their knowledge and experience about the study phenomenon (111). Managers were selected using this technique because of their responsibility in the management of operations in the hospitals and their involvement in decision-making. Managers that were interviewed included Chief Executive Officers, Clinical Operational managers in nursing, Deputy Director Human Resources, Chief Medical Officer, Patient Administration, Operations Finance and Area Managers in nursing, Assistant Director: Human Resources Management. The primary researcher (TF) used convenience sampling to select participants as and when these individuals were available and willing to participate without any systematic technique for selection (112) these included nurses, kitchen staff, general staff, administrators, nursing managers, human resources management staff.

3.6 Data collection

Data was collected through in-depth interviews and focus groups with public hospital staff members from April to September 2019. The primary researcher (TF) conducted in-depth interviews with management staff, clinical staff, administrators, and shop stewards in each hospital. Focus groups were conducted with clinical and non-clinical staff, as detailed in Appendices A, B, and C. To minimize group effect, one-on-one in-depth interviews were conducted with one person from each focus

group. This technique ensured data triangulation, covering similar themes in both interviews and focus groups.

The interviews and focus group discussions were audio-recorded to ensure accurate data capture and later transcribed verbatim for coding. Interviews were conducted in the participant's preferred language and transcribed into English. They took place in private spaces within the hospitals, such as unused consulting rooms, to ensure confidentiality. Information sheets and consent forms for both audio recording and interviews were provided.

In two hospitals, the primary researcher (TF) conducted 22 interviews (10 in Hospital A and 12 in Hospital C) with staff, management, and shop stewards. Additionally, 4 focus group discussions were held in each hospital with healthcare workers and support staff.

All 22 interviews and data from all focus group discussions were included in secondary data analysis to ensure that the researcher gets in-depth descriptions of the phenomena from the participants. The interviews were only conducted with participants who agreed to sign the informed consent forms. The interviews were audiotaped, and field notes were taken during the proceedings of the interview.

3.6.1 Content of data collected.

It should be noted that while the primary study focused on governance and management in hospitals, the interview questions were aligned with this focus. However, participants had much to say about austerity and its related effects. The data revealed unexpected findings about austerity, leading to the publication of an article titled "*Austerity, resilience and the management of actors in public hospitals: a qualitative study from South Africa*" (113). Another article "*Managing under austerity: A qualitative study of management-union relations during attempts to cut labour costs in three South African public hospitals"* (114)*,* has also been published.

During the primary study, the effects of austerity measures on health workers were observed. This was largely due to the qualitative approach, which utilized open-ended questions, allowing participants to express themselves beyond the initial queries. Consequently, additional themes emerged that were not originally intended to be part of the primary study.

Since qualitative research does not occur in a controlled environment and often involves open-ended questions (103), the emergence of themes or concepts outside the study's initial parameters is inevitable. This phenomenon is advantageous as it broadens the scope of data exploration and continuously contributes to knowledge generation.

3.7 Data management and analysis

Data collected from the interviews and focus groups, i.e., transcripts, in the primary study, was securely stored in Word files on a password-protected computer. The same was done in the current study. Only the primary researcher (TF), secondary researcher and the supervisor have access to the recordings and the data. The data will be destroyed after 5 years if the study findings are not published and two years if published.

3.7.1 Thematic analysis in the secondary analysis

Braun and Clarke (115) define a thematic analysis as "a method for identifying, analysing and reporting patterns (themes) within the data." Thematic analysis is renowned for its flexibility which allows for a fairly unlimiting manner through which a researcher could explore and organise data. In this secondary study, the researcher (NM) used a combination of the deductive and inductive analysis approach. The deductive approach is theory-driven as themes are predetermined and data is linked to the developed themes (115, 116). Inductive analysis is described as a systematic approach which is not theory-driven but is data-driven, meaning that the raw data is used to develop themes for analysis (117, 118). Both these approaches involved detailed reading and review of raw data to develop themes which were used to interpret the data (118). Appendix A shows some of the work done during the analysis is attached at the end of the report. The steps that guided the application of inductive approach are as follows:

> "a) initial reading of the text data; b) identification of specific text segments; c) labelling the segments of the text to create categories; d) reducing overlap and redundancy among categories; and e) creating a model incorporating most important categories" (117).

In using the deductive approach, the researcher (NM) used the research objectives and some pre-conceptions of the research which stemmed from the reviewed literature to develop themes. Data was then linked to these themes.
The combination of these approaches assists in enabling generation of unexpected emerging themes (inductive) while also supporting fixed themes developed through theoretical basis (deductive). The researcher (NM) combined both approaches to ensure a thorough review and analysis of the data, especially since this is a secondary study where context matters the most. The following indicates a breakdown of the mentioned steps combining both approaches applied in this secondary analysis:

Step 1: the researcher (NM) read the transcripts repeatedly to familiarise herself with the data and to ascertain whether it contained data sought for the study and if it made sense to undertake a secondary analysis. This was the step where the researcher (NM) identified the variables of interest for the secondary analysis. In this step, the researcher (NM) could understand more deeply the context of austerity which was essential in interpreting the data correctly.

Step 2: The process of extracting what was relevant to the broader aim of the secondary analysis began when the researcher (NM) created a document for each hospital and extracted the data from transcripts as is. Enough time was given to go through the transcript line-by-line paying attention to details and making sense of what was asked by the interviewer and the response of the interviewee.

Step 3: The researcher (NM) used manual coding after creating a model of categories that will determine the themes under which data was be analysed. The researcher (NM) then developed topics aligned to the research objectives, at this point the focus was on trying to understand if the research question would be addressed through this data. These details were presented in a tabular format which placed each data segment against the developed topic and the hospital from which it was extracted. As the process unfolded new themes were emerging new topics were then developed, and data was allocated accordingly.

Step 4: the texts extracted from the data were then organised to ensure coherence and clear transition within the topic and from one topic to the next.

3.8 Data validation and credibility

Audio recordings of individual and focus group interviews were transcribed by the primary researcher (TF). This ensured the quality of the data, as the tapes might have been difficult to hear. During data collection in the primary study, the researcher employed both person triangulation, comparing perspectives from management and staff on similar topics; and *method triangulation* by comparing data from the focus groups and individual interviews. These triangulation methods were utilized to ensure the validity of the study findings.

To improve the credibility of the study, during data analysis in the secondary analysis I also used data source triangulation – analysing data on the same topic collected through different means from different participants (119). This was done to check if the views expressed by participants were moving in the same direction. So as the researcher (NM) was synthesising data from the two methods used to collect the data (i.e., FGs and IDI interviews), similarities were identified, and this had a positive impact on the study results.

I kept a reflective journal and used a password-protected computer drive to store all the work done during data coding. This ensured that I had an audit trail, thereby enabling me to retrieve data easily and improve credibility.

3.9 Positionality

I work as a Budget Analyst for Health in the National Treasury of South Africa for the past four years. During this period, I have gained extensive knowledge and experience in health financing in South Africa, including national and provincial budgeting, as well as monitoring of health department expenditure. My awareness of various facets of austerity in the country and her interest in understanding its impact on health workers have further influenced her research. My expertise in the sector and its financing has allowed me to have a better understanding of pertinent issues

covered in this research such as austerity, financial management issues, and economic constraints. This has helped me to interpret the data effectively and break down complex jargon expressed by participants and existing literature in a way that is easy to understand. Furthermore, while my position may have been subconsciously influenced interpretation of the data, potential bias was managed through reflexivity. I have also continually reflected on my preconceived assumptions about the impact of austerity, which helped to ensure that my interpretations are grounded in the data rather than my personal beliefs.

My experience in conducting this study has given me a unique perspective on the subject. Going forward, these insights will provide a valuable contribution to the ongoing discussion surrounding health financing and austerity in South Africa. The knowledge gained from conducting this study will also help in communicating effectively with stakeholders regarding the concept of austerity and its implications for health workers and healthcare service delivery.

3.10 Ethical considerations

Ethics approval for the study has been obtained from the Human Research Ethics Committee (HREC) at the University of the Witwatersrand [Ethics certificate number: M220830 MED22-08-008]. Access to the data is limited to the supervisors and researchers (TF and NM) involved in the primary and secondary studies. The primary data is stored for five years electronically in a password-protected computer and the student will do the same for the secondary data analysis. In the primary study anonymity was ensured through the consent form which clearly outlined the protection of confidentiality for all participants e.g. the study does not refer to the participants with their provided names.

CHAPTER FOUR: RESULTS

4.1 Introduction

The previous chapter introduced the methodology applied in this research study, highlighting both the limitations and the key aspects of the primary study. This provided an engaging overview of the study's nature, evoking the reader's interest in exploring the findings. This chapter presents the findings obtained from the secondary analysis, aligning them with the research objectives. It enables an assessment of the researcher's success in gathering data pertinent to the study's objectives. The findings from the participants are presented under five themes: a) Measures used to implement austerity in public hospitals in the Eastern Cape Province; b) Institutional challenges with the cost containment measures; c) Perceived impact of austerity on the delivery of healthcare services; d) The challenges of the health system accentuating the impact of austerity; e) Perceived impact of austerity on their physical, emotional and mental health well-being.

4.2 Measures used to implement austerity in public hospitals in the Eastern Cape Province

The provincial department of health, in compliance with the cost-containment measures instituted by the provincial treasury, introduced a committee to manage and oversee the implementation of cost-containment measures: *"In 2015 there came a circular which introduced cost containment measures and established the District Cost Containment Committee (DCC) and Provincial Cost Containment Committee (PCCC)"* (CEO Hosp C). The composition of the PCC includes "General Manager: Financial Services, General Manager: Budgeting and Director Human Resources". Due to the decentralised nature of the health system *"there was also an introduction of institutional/facility cost containment committee"* (Financial Manager Hosp. C). This is the level where most facility work related to expenditure planning and implementation begins as delegated by the head office. The spread of committees across different levels is set to streamline the process and to ensure that key parties involved form part of the decision-making: *"We submit our facility expenditure requests, sit with our staff here at the institution and then get approved by the*

district, and then from the district office the matters are taken to the head office where the PCC sits and make final approval" (Financial Manager – Hosp: C).

While the cost containment implementation structure is set to look at overall spending in health, the focus is more on some cost drivers in spending: *"This cost containment structure is mainly for compensation of employees, but it also sits for everything even goods and services"* (Human resource practitioner – Hosp A). "*With HR recruitment, the CEO cannot appoint nursing and medical officer staff, she can submit for post advertisement at head office but whoever is going to be recommended must go through the approval process. So, they have delegated some of the functions to the CEO at the district office but when it comes to HR, it must go to the PCCC*" (CEO Hosp C). Decisions related to procurement of goods and services, capital assets and human resource appointments are only made upon approval by the PCCC. *"At times this takes more than 30 days*" (Finance Manager Hosp C).

4.3 Institutional challenges with the cost containment measures.

Since the introduction of cost containment measures and the administration thereof, there have been numerous challenges. Some included the extended periods to replace posts. One of the managers explained by saying:

> *"If you could compare the organization now and before 2010/2011 when delegations were decentralized, the filling of replacement posts was never an issue. It was possible to fill them within 3 months because our CEO and DM had delegations, now it is the opposite. Look for instance, travel and subsistence claims can no longer be processed by CEOs, everything is controlled at Head Office, and it must go to PCCC" (*ASD Human Resources Manager: Hosp A)*.*

It appeared that some of the staff were not satisfied with the composition of the PCCC. They cited that the lack of, for instance, district managers resulted in limited appreciation of the contextual issues that were encountered at district level. One of the staff noted as follows: *"the disadvantage of the introduction of the PCCC is that people that sit and make decisions in this structure do not know or understand what is happening at a grassroots level. By grassroots I mean hospital or facility level.*

There are no District managers in that structure" (Human resource practitioner – Hosp A). The manager continued to explain how the limited structure of the Committee resulted in the lack of understanding of hospital priorities and the required skills mix. This reportedly had consequences on the quality of care. They described this as follows:

"It seems like the people who sit in that structure do not really know the priorities in the hospital. For the past 8 years, we have not had a dietician, no infection control person. This is a big problem for a TB hospital, and no health and safety officer yet there is an expectation of good quality outcomes. The hospital is contravening health and safety laws. We were recently told that there is no money, and the post was not funded" (Human resource practitioner – Hosp A). Although the process of approving spending and projects begins at the facility level, one of the staff members at the facility level expressed frustration that the final decisions (i.e., at PCCC) are made without participation of the facility: "*We are not physically present to elaborate to the committee as to why. You must forward a paper, and, on that basis, they approve it or not. So, we are not physically there in the meetings to motivate, and they don't even invite you to present your cases or posts*" (Human Resources Practitioner Hosp C).

The cost containment measures implemented to control healthcare service expenditure may have long-term effects. Despite budgetary challenges, healthcare facilities must provide necessary services to the population. However, this approach is unsustainable and often leads to budget overspending. Consequently, overspending in one year is carried forward into the next, compounding the problem. A CEO from one of the hospitals said: *"Every year we have a shortfall with the budget, especially with for the laboratory services, National Health Laboratory Service; and we have accruals every year. Despite budget increases, the accruals regress the budget" (CEO Hosp C).* The issue of accruals was also raised by a clinical manager as a problem in budget planning: "*by the beginning of a new financial year, we are now paying the accruals of the previous year. It happens all the time, and I do not know how we can overcome this problem, but it is a continuous problem"* (Area manager: Medical Department Hosp C).

The facilities are expected to do more with less while the cost drivers continue to escalate. The burden of disease and high unemployment rate (which increases the proportion of the uninsured population) are some of the challenges that are imminent and put pressure on the health system: *"… most of the population in this area is unemployed and this is also a threat to public health because this comes with all the diseases that are related to poverty and unemployment" (*Area manager: Medical department Hosp C).

The financial strain on healthcare facilities is intensified by the need to allocate funds for medico-legal cases and attorney fees. These medico-legal claims partly stem from staff's poor performance due to inadequate resources, long hours worked by core staff such as nurses and doctors, and the widespread shortage of both clinical and non-clinical personnel. Some of the managers commented on how cost-containment measures adversely affect staff placement. They noted as follows: "*The money for positions is used to settle the medico-legal cases and to pay an attorney. What causes medico-legal cases is negligence from staff. But it is expected especially as the core staff (nurses and doctors) are working long hours and there is a shortage across the spectrum (clinical and non-clinical)*" (Human Resources Manager, Hosp A).

4.4 Perceived impact of austerity on the delivery of healthcare services

The effects of the decisions by the PCCC have resulted in staff reductions in health facilities, which is detrimental to the delivery of healthcare: "*The cost containment committees affect service delivery because now we are short staffed and that is causing the problem because when people get tired, they just take leave or just become sick*" (Hosp A – Professional Nurse). The Human Resources Manager further alluded to the effects of staff shortages: "*despite the prescripts of the South African Nursing Council (SANC) on duties and responsibilities and norms and standards of different nursing categories, the shortages of staff have led to pure non-compliance with those, hence opportunity for medical negligence"*. The shortages of staff increased workload and result in poorer quality care: "*We only have three doctors in this hospital and all 3 are responsible for 227 patients who are in the hospital as well as +- 600 patients that are outside. We are supposed to review our*

patients every month until they finish the course of their treatment. The doctors are supposed to go and monitor/ review the patients at the clinics, but they are unable to do this due to the shortage of staff" (CEO Hosp A).

The staff shortages are not only in the medical department but in other administrative areas such as supply chain management: "*The shortage of equipment also revolves around the human resource. For instance, procurement of equipment and other goods and services is done by the supply chain management personnel but there are few staff members, and this causes delays in procurement. Look now we are waiting for our medical equipment"* (Area Manager: Nursing Hosp A).

In response to shortages in essential items, officials explained their strategy of seeking assistance from other institutions to maintain hospital operations. One manager said: "*If we don't have something we will ask from other institutions like for instance food items. We ask from other institutions to assist us and then we give back when we get our order"* (Finance Manager Hosp C).

The delays in procurement are impacting timely and optimal patient care: *"Each patient needs to have an ECG done because the treatment that they receive affects the functioning of the heart. However, to buy these resources, we must go through many channels for consideration by the PCCC. By the time the committee responds, we would have accumulated a large backlog of patients requiring the use of this machine"* (CEO Hosp A). Some staff members would sometimes resort to using their finances to support patients where the facility is unable to do things in time: "*Sometimes we have to use our own money to secure the resources because we don't want our patients to suffer. We are here to save lives while we are waiting to get approval for the orders"* (CEO Hosp A).

4.5 The challenges of the health system accentuating the impact of austerity

Decision-making for final budget allocation is not determined by the facility. The Kitchen Manager at Hospital A highlighted concerns about the resource allocation decisions made by Head Office and their impact on patient nutrition: *"Head Office decides how much they allocate and where. Sometimes you will not understand why*

they allocate more for eggs which get served less than other essential foods such as meat. This affects nutritional requirements for patients" (Kitchen Manager Hosp A). Hospitals are legally classified according to the level of care provided and this informs resource allocation: "Improper *classification of hospitals is a huge challenge. This hospital is gazetted as a regional hospital but recognized as a district hospital within the province… this affects the hospital's budget and staffing"* (CEO Hosp C).

Misclassification of hospitals was found to be one of the aspects that intensifies the negative impact of austerity. In discussing the challenges faced by the healthcare system, one staff member highlighted the limitations of the current staffing structure and the potential benefits of a proposed organogram: "*The current organogram has 3 posts of doctors while these are not enough for the services that we provide; HR cannot do anything to adjust the organogram. HR can only appoint people when the province has decided to improve the organogram by adding more posts. There is an organogram, that they proposed and which we hope one day it will be implemented. In this organogram, we will have 8 doctors including the clinic manager. This organogram will be good for us because it will enable us to do our outreach work without interruptions. If we had more doctors, our outcomes would be much better*" (CEO Hosp A).

Cost containment measures seem to be preventing the hospital from collecting its own revenue because resources are limited to enable revenue collection activities: The Assistant Director of Public Administration (Hospital C) mentioned that "*The hospital has a high utilisation rate but the available resources i.e., computers and staff, for patient administration, are not enough and this causes delays in processing patient data including billing. As a result, revenue collection gets limited due to issues in the system.*

When resources are tight, helping others is harder: *"There is also a lack of teamwork between ward clerks and patient clerks and this is exacerbated by operational managers because the operational managers do not want to share the resources, especially those obtained through donations, they will hold fast to the staff and limit their work to certain responsibilities e.g. writing minutes for the doctors*" (Assistant Director: Public administration Hosp C). In discussing the challenges faced by the hospital, one staff member highlighted the issues with patient referrals

and collaboration with other facilities: "*Our hospital is supposed to be dealing strictly with XDR and complicated cases of MDR. Cases that fall out of this category must go to our sister hospitals. We work well with other facilities except Mpilweni Hospitals where they always turn patients away and send them to us. Some clinics refer patients to us when they are supposed to refer them to the other facilities*" (CEO Hosp A).

An occupational therapist expressed concern around prioritisation in health budgeting: "*There seems to be prioritisation of infrastructure more than clinical matters e.g. shortage of nurses and doctors. It is as if there is no effort put into procuring the medical staff, the ECG machine, and those kinds of things needed to render patient care. I find that again in lots of the decisions that are made, it's about infrastructure or about what we look like on the outside, very little about the quality of the patient care. The doctor can struggle without some equipment*" (Occupational Therapist Hosp A).

The CEO from another hospital expressed frustration with the PCCC: "*The policy says that posts must be filled in within 6 months and that is not happening. That is frustrating because if you don't have the staff to do the work it is frustrating everybody. And I feel that preferences are given to regional and tertiary hospitals because there are high-level posts that are being filled in those areas*" (CEO Hosp C).

4.6 Perceived impact of austerity on their physical, emotional and mental health well-being

The shortage of staff has meant that employees take up other tasks outside of their role: "*There are shortages in kitchen staff, there have been no replacements of exiting staff. Staff are tired because they are overworked. As a result, other staff members from admin and nursing would be assisting in the kitchen, basically taking up on duties that are not theirs*" (Area manager: maternity Hosp C). The Area Manager in the medical department also has similar experiences to share of nurses having to fill gaps in other areas: "*If there is no general assistant (GA) that day, it does not mean patients must not eat, it does not mean that you are going to walk over vomitus. A nurse needs to work in a clean environment; therefore, the nurse*

must take the mop and mop up because you will be told there are no cleaners". She further added *"Sometimes there are no porters to take corpses to the mortuary and the nurses have to do that, and we get blamed for not doing the job diligently or properly. For instance, we were not taught about handling corpses in nursing school we were just taught how to wrap the body. And now we must answer if something goes wrong*" (Area Manager: Medical Department Hosp C).

One of the representatives of PAWUSA, a labour union, reiterated this by stating that *"The shortage of staff is a major problem because it affects productivity, as a result they don't work. You may overwork someone, and on the third day, they may take sick leave, you, see? One person is doing the work for 2 or 3 people"* (PAWUSA secretary – Union Hosp C).

The implementation of austerity measures affects the optimal functionality of staff in delivering services: "*The PCC prolongs the process of filling vacancies and now we have to work with fewer staff. The staff get tired, and they take leave or just become sick. It is also bringing out the negative attitudes, especially with the nursing staff.*" (Human Resources Clerk Hosp A).

The Area Manager of the medicine department explained how the high workloads affect the physical well-being of staff: "*The staff gets burned out, absenteeism becomes a problem, a lot of staff has back aches, the nurses have back aches. Now we can see the cause. It comes from the fact that they must do it all"* (*Area Manager: Medicine department: Hospital A*). The support staff are frustrated with the high workload and is worried about their health: "*Sometimes we wish we could just pack our bags and leave. That is why the absenteeism rate is high because you just feel fed up with this pressure. When we started working here, we were told to take care of ourselves and manage stress because we are in an environment that caters for patients infected with XDR TB which is highly contagious. But now it is the amount of work that is stressing us, and we are concerned because they said stress has the potential to weaken the immune system which means we could be infected easily*" (Cleaner 1 Hosp A).

Another cleaner also expressed devastation: "*I have a chronic condition. I did not have a chronic condition when I started here. I have a wound that is not healing. The doctors say I must work light duty, but I do not work light duty because of the*

workload. I am working in a big ward alone" (Cleaner 2 Hosp A). Explaining the extent of work pressure in the ward, one of the nurses stated: "*We do not manage at all. Especially in New Block with a high number of patients. I mean the patient ratio [is meant to be] 10 patients per nurse. Here is double. I am sure it is 25 patients per nurse at night because there are 50 patients" (Professional Nurse 1 Hosp A).*

One of the nurses added it also affects their career development: "*We are not exposed to courses or workshops that are given in the country because we always have to be in the facility as there is shortage of staff*" (Professional Nurse 2 Hosp A).

One of the clinical managers was proud of the nurses who continued to show up at work under the circumstances: "Working in the m*edical department is very stressful and physically tiring but despite the challenges and difficulties that we face, what keeps us motivated is the fact that we made an oath to serve patients. I find that nurses are mostly criticized and everything that goes wrong in the hospital the nurses are to blame, and we are never too good to provide the services. This pressure may easily cause nurses to be demotivated and have negative attitudes. As a manager you must have skills to be able to motivate your staff" (Area Manager: Medical Department Hosp C).*

Managers are putting effort into lifting staff morale and building a healthy working environment: "*Every month, or every second month we have meetings, with the staff and I tell them that it is your meeting, it is your platform to express how you feel and how you think things should be and so on. You encourage that they can speak and have a platform where they can just debrief*" (Area manager: Medical Department Hosp C). Another manager at a different hospital also expressed efforts made to support the staff: "*We try to boost the self-esteem of the nurses, provide more guidance with the professional ethics and the nursing itself because the morale is very low. So, we have done team building events to build and encourage the team*" (Operational Manager XDR Hosp A).

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This study explored the perceptions and experiences of public hospital employees regarding the impact of austerity on their wellbeing and the delivery of healthcare services. The findings indicate that cost-cutting strategies have influenced the delivery of services, compelling employees to adapt to changes such as staff shortages and resource constraints. Despite employees becoming accustomed to the new operational methods, which involve managing substantial workloads, it has exerted significant stress on their wellbeing and impacted the provision of healthcare services. This chapter serves as the culmination of this research study, where the various threads of research are woven together. It synthesizes the comprehensive review of literature, the results derived from rigorous analysis, and the researcher's insightful conclusions drawn from various findings. It aims to provide a coherent narrative that not only encapsulates the essence of the research but also offers meaningful interpretations and implications of the study. The ensuing discourse will delve into these aspects, shedding light on the significance of the research findings in the broader context of the field. This process will further elucidate the my contributions to the existing body of knowledge and highlight limitation which provide potential avenues for future research (as will be presented in Chapter 7 as implications for future research).

The discussion chapter of the thesis is structured into several key themes. It begins with an examination of centralisation and cost containment in the South African health system, analysing how these strategies have been implemented and their overall effectiveness. Following this, the chapter explores the perceived impact of austerity measures on health workers' physical, emotional, and mental well-being, providing insights into the challenges faced by these professionals. The next section delves into the perceived impact of austerity on the delivery of healthcare services, discussing how budget cuts and resource constraints have affected service quality and accessibility. Finally, the chapter addresses the limitations of the study, acknowledging any constraints encountered during the research and suggesting areas for future investigation.

5.2 Centralisation and cost containment in the South African health system

In South Africa, the process of cost containment has been largely led by National Treasury as instructed by cabinet. The guidelines issued by NT in 2013/14, sought to guide all government institutions in interpreting and applying the instruction to contain operational costs and eliminate non-essential expenditures (26). Since this instruction came from the national sphere of government, provinces exercised discretion in implementing these. The Eastern Cape provincial treasury decided to develop a framework for cost containment and establish a provincial cost containment committee which then centralised decision making associated with expenditure in all departments including the department of health.

Centralisation of expenditure was then the modality through which austerity measures were implemented. This study found that this meant a change in delegation of powers to health managers for procurement and approval of some types of expenditure. One of the managers mentioned that the filling of replacement posts used to be delegated to the CEO of the hospital and the process of filling vacancies was quicker than it is now. The centralisation of decision making on expenditure has changed this working arrangement, making it difficult for managers to make decisions timeously and as they see fit for the facility. There is a general view that decentralised decision-making in health systems enables rapid decision making and favours efficient functionality of the system (120). Rubio further argue that decentralisation results in greater experimentation and innovation in the delivery of healthcare services which would inadvertently result in efficient operations (120).

Much criticism of the approach applied in executing the instruction note by NT has been expressed by some of the participants in this study. One of the participants mentioned that there is poor representation of facilities in the provincial cost containment committee, final decisions are made without input from facility managers. As a result, some decisions are made without clear understanding of the probable impact on operations of the hospital and on the delivery of healthcare services holistically. This finding lends support to a study conducted by Wishnia and Goudge (63), which found that centralisation of expenditure decisions proved to be

ineffective as some managers felt that the decision makers at head office were not well equipped or versed in matters concerning the entire health system. This is also consistent with the views of Ogundaini and others (121) who mention that one of the key reasons for decentralisation of decision making in health systems is that local decision makers are better informed about the health needs of the populations they serve, and the most essential inputs required to deliver those services on high demand. Taking this power away from facilities without a strategic approach that considers a bottom-up approach in decision making, may be problematic for optimal functionality of the facilities and attainment of good health outcomes. Centralisation in Canadian health systems in the three provinces has not yielded the results hoped for. Scarffe et al, (122) observed that centralization of services often fails due to a lack of empirical evidence supporting the new interventions. This can lead to failure of the strategies implemented. For example, in 2008, the Alberta province in Canada centralized all its health services administratively and fiscally. However, this strategy was later abandoned and reverted to decentralization since it proved to be disadvantageous (122).

Oates et al (123) argues that decentralisation of decision making in the health system could result in efficiency gains essential for improved health outcomes, particularly if decentralisation complements quality of inputs and these are responsive to the needs of the population. This aligns with the WHO building blocks, particularly in enhancing service delivery, health workforce distribution, and health information systems by making them more responsive to local needs. However, it is important to also note that there are instances when centralisation is necessary to enforce uniformity and standardisation in implementation. For example, when centralisation happened in three provinces in Canada, the goal was to achieve cost savings and to ensure consistent oversight on quality health care delivery. This reflects the systems thinking approach by de Savigny, which emphasizes the need for strategic, context-specific interventions that balance decentralization and centralization to meet the needs of facilities without disadvantaging any institution. Effective centralisation in such cases should be accompanied by strategic interventions which are context-specific to ensure that the needs of facilities are met and well catered for, and that no institution or facility is benefiting at the expense of the other.

5.3 Perceived impact of austerity on health workers' physical, emotional and mental health well-being

Health workers are continuously exposed to various diseases and are under pressure to deliver high-quality health care. Therefore, it is essential that they work in an environment that is conducive to their well-being. If a health system fails to take care of its workers, it can negatively impact the system's ability to function optimally and respond to the needs of the population. This aligns with the WHO building blocks, particularly in enhancing the health workforce and service delivery by ensuring a supportive work environment. Unfortunately, health workers often bear the brunt of challenges faced by facilities and other factors beyond their control. Protoghese and others (56) state that health workers are at an increased risk of experiencing stress in the workplace, burnout as well as both physical and mental illnesses. Healthcare workers face various challenges due to cost-containment measures implemented in their facilities, as highlighted in the previous chapter. These challenges include staff shortages, resulting in an increased workload for present staff. The recruitment process, which must go through the PCC, causes delays and sometimes posts are not refilled. This further exacerbates the workload of existing staff, causing burnout and increased rates of absenteeism.

Healthcare facilities need to address these challenges and find solutions to ensure a safe and healthy work environment for their staff. Owens and others (51) suggest that the poor working conditions under austerity pose significant risk to health workers. It is evident that the change in economics and health financing requires a shift in health policy. It is no longer viable to operate as though there have been no changes in health financing arrangements, especially considering the dire consequences that result from austerity measures.

In this study, the staff also felt that management was being oblivious to the working conditions, particularly high workload, and not prioritising their health. One of the cleaners mentioned although they were informed to manage their stress levels and take care of themselves because of the environment they work in, management has not taken care of them. The workers are more susceptible to contracting TB or other contagious illness because of high stress level which they feel compromises their immune system to fight infections.

One of the participants expressed concern that the some of the key posts, for instance, dietician, infection control professional, and health and safety officer, had not been filled. Noting the importance of the mentioned personnel, their absence poses a risk to the safety of health care workers. Tuberculosis is a widely known occupational hazard for health workers (124-126) and health workers are more exposed to TB compared to the rest of the population. The risk is higher when nurses see many TB positive patients in the health care facility and can be reduced by implementing infection control measures (127). Deficiencies in infection control interventions is a huge concern and a lack of such may lead to more problems of health workers contracting the disease.

A study conducted in South Africa by Tudor (125) found that there was poor management and implementation of infection control in one of the facilities due to lack of personnel responsible for this, and proper implementation of occupational health practices was more prevalent in hospitals with personnel dedicated to ensuring implementation of such practices. This highlights the importance of the WHO building blocks in ensuring adequate health workforce and service delivery, and the systems thinking approach by de Savigny in addressing these challenges through strategic, context-specific interventions that considers different aspects of the system. A productive health workforce also requires a conducive work environment with the necessary tools of trade to deliver optimal healthcare services to the population in need.

5.4 Perceived impact of austerity on the delivery of healthcare services

As discussed in the previous section, the dissatisfaction of health workers, having to do more with less, lack of resources in some instances compounded by the increased workload has potential to affect the performance outcomes of the facility. While the main purpose for implementation of austerity measures was to curb public expenditure with an aim to reduce debt, the consequences of this are multifaceted. In this study staff shortages, were highly associated with the implementation of cost containment measures. This is because great attention was placed on controlling compensation of employee’s expenditure (COE) to contain the wage bill which

makes up a lion's share of the health expenditure (78). It is worth noting that while expenditure on health workers' takes up a large share of spending, health workers are also a backbone for a functioning health system. The World Health Organization provides that universal health coverage is highly dependent on the right skills mix of health personnel in required numbers (93). The reduction in health workers has direct impact of service delivery and health outcomes. The WHO states that universal health coverage relies on the right skills mix of health personnel in required numbers (93). Therefore, the reduction in health workers directly impacts service delivery and health outcomes, highlighting the need for a balanced approach to health financing and policy.

There is a growing interest in investing more on lay health workers as a solution for low health personnel numbers (104). The South African human resources for health strategy 2030 acknowledged that considering fiscal constraints, there is a need for exploration of other models of service delivery which embraces more use of mid-level workers such as assistant medical officers and physician assistants (128). This would also include task-shifting and strengthened community health worker programme.

The effect of absenteeism is multi-fold and may sometimes involve disruption of services delivery. This finding is consistent with what was discussed in the study conducted by Ndebele who found that moratoria on staff recruitment resulted in increased absenteeism due to high workloads and low staff morale. This further caused delays in the delivery of services resulting in poor patient satisfaction (47).

It is important to note that the reduction in staff because of the halt in filling vacancies occurred at a time when South Africa was already experiencing shortages of nursing and medical personnel, especially in rural areas. In 2010, there were approximately 81,925 vacancies in different nursing categories within the South African public sector (129). This is partly due to the ongoing challenge of training and retaining healthcare professionals (130). Since the introduction of the hiring freeze and centralization of personnel recruitment, the shortage has worsened. This raises concerns about the long-term viability of the health system in meeting the healthcare needs of the population and doing so in a timely manner without compromising the quality of care.

This is also supported by another finding that increased workloads for nurses have brought about negative attitudes, a big threat to patients' safety. A study conducted in South Africa by Ntlabezo et al (131) found that when there are staff shortages, the level of motivation of nurses was the main factor influencing whether quality care continues to be provided. This is in line with the views of Lagarde et al (132) who mention that the issues of poor-quality care and clinical errors emanate largely from demotivation of health care workers.

Demotivation of staff is usually fuelled by poor working conditions due to inadequate infrastructure and lack of equipment (27). The responses of nurses to austerity in Australia and New Zealand (45) have gone beyond looking out for their needs and satisfaction but have been concerned with lobbying for improved staffing levels and patient care equipment and increased workload with no compensation. Over and above this, management's failure to protect workers from performing duties beyond their scope and sometimes without necessary tools has also led to medical errors and exploitation of health workers.

Furthermore, this may partially explain the rise in medico legal claims against the state, as also posited by Prinsen (86) who argues that unavailability of resources for healthcare service delivery signals a risk for clinical errors. De Hert (133) also brings another dimension to this, stating that burnout of health workers is strongly linked to suboptimal patient care which would mostly lead to medical errors with high potential increased malpractice and litigation. Highlighting the depth of consequences of high workloads, Nakweenda and others (134) mention that quality patient care remains at risk, with the possibility of increased infections, neglection of patients which may accelerate conditions of critically ill patients. Because of this, the health system is exposed to a vicious cycle of clinical errors and poor health outcomes, which carries a profound negative impact on the sustainability of health budgets, henceforth delays in improving the functionality of the health system (134).

Additionally, Owens and others (52) state that while healthcare professionals should be held accountable for their actions and poor performance, but their assessment should be considered under the working conditions they operate in. This means that it is not only the healthcare professionals in the frontline that should be held accountable but also those in management as well as policy makers as they are also

ethically bound to ensure working environment that are enabling for the healthcare workers to perform their duties efficiently and effectively. The issue of non-budgeting for medico legal claims wherein service delivery budgets are then used to make settlements came up in this study as also discussed by Sachs and others (78).

The problem of staff shortages has resulted in blurring of roles, this was mostly reported by nurses. In most instances they find themselves having to do work that is outside their scope of practice. One of the nurses made an example that they sometimes must do the porters' job, taking corpse to the mortuary and this is a risky task because they were never trained to undertake this type of work. These results are consistent with the findings from a study conducted by Oshodi (135) in Southeast of England, who found that nurses were frustrated with having to do tasks outside their scope of practice. It was further stated that taking up these tasks hinders them from providing adequate care to patients.

There appears to be a lack of collegial support among staff, which makes it difficult to deal with the problems collectively as a team. The poor coordination between ward clerks and patient clerks is problematic and indicates lack of teamwork, with some managers even refusing to share resources especially those obtained through donations. This may be an indication of lack of understanding among workers of the values shared by the organization. Intervention by human resources and management is essential in building a strong workforce which is cognisant of the pertinent issues in the facility and how to better manage these issues for the sake of service delivery.

Centralizing decision-making in budgeting and expenditure introduces complexities that hinder effective management and leadership at the facility level. This centralization has stripped facility managers of powers such as making staff appointments. Management strategies like task-sharing, intended to address staffing shortages, are perceived by workers as exploitative. The primary study found in Hospitals A and C, the lack of collaboration among management hindered the development of resilience capacity, leading to increased tensions and a decline in organizational performance (113).

5.5 Limitations

- While several managers expressed frustration with the current situation with austerity, there was no indication of what management and leadership had attempted to do to try and influence the head office in as far as it relates to making decisions that are favourable to the performance outcomes of the facility.
- Even though austerity measures have been implemented nationwide, the way different provinces implement the NT instruction notes on cost containment can vary. This is because the fiscal positions of the provinces differ significantly, with some provinces having larger revenue sources, while others, particularly in land provinces, face limitations. Therefore, the findings of this study may not be applicable or generalised to all public hospitals. For example, in the district health barometer for 2022/23, there is visible variation in district hospital expenditure per capita across provinces and within provinces (i.e. districts) (136). This highlights the need for further research to be conducted in this area.
- Another limitation of this study is the absence of validation methods such as cross-referencing different sources, member checking (returning new analysis to participants), or expert checking. Implementing these methods would have significantly strengthened the study. However, these approaches were not undertaken due to constraints in time and resources.

CHAPTER SIX: CONCLUSION

6.1 Conclusion

The purpose of implementing cost containment measures is to reduce government spending and lower its debt. While this fiscal strategy might work to some extent, it has become evident from this study that the correct implementation of these measures is crucial to avoid adverse effects on the health system and the population's health. The study focused on the experiences and perceptions of health workers under austerity and their perception of the impact of austerity on healthcare service delivery and their well-being.

The results of the study indicate that austerity measures have negatively affected hospital operations, mainly due to a shortage of staff, leading to increased workload, work stress, and a decline in service delivery. It is essential to recognize that the healthcare system is under immense strain, with rising patient complaints about inefficient service delivery and unequal access. This pressure is exacerbated by the worsening economic situation, and the absence of strategic interventions to mitigate the impacts of austerity measures. It appears that by studying austerity in healthcare systems, we can develop more effective strategies to ensure that healthcare remains accessible, high-quality, and sustainable, even in times of economic hardship.

Earlier, health outcomes were presented as a tangible measure of quality care, while healthcare workers' perceptions provide an important case on this, there is a need for an empirical study to be conducted to ascertain causality between austerity and quality care in the South African context, in hospital settings. The role of management and leadership in the hospitals in managing the impacts of austerity as it affects quality of care was not immediately clear.

It is essential to reconsider the roles, values, and professional ethics of health workers amidst ongoing economic instability affecting public service financing which has impact on functionality of health workers. The current situation of financial constraints resulting from austerity, as outlined in this study, offers a chance for the healthcare industry to reassess and enhance its human resources, along with the professional values and ethics of healthcare workers. This can be achieved through various measures, such as regular ethics training health professionals (helping them

to navigate difficult decisions and reinforce importance of ethical behaviour), increasing the number of health professionals and introducing shift working arrangements instead of overtime to prevent burnout. These steps are crucial not only for protecting healthcare workers but also, for safeguarding the rights and needs of healthcare users.

CHAPTER SEVEN: RECOMMENDATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

The recommendations and implications for future research presented in this chapter aim to address the challenges identified in the study. By focusing on strategic interventions, professional ethics, staff motivation, balanced health financing, alternative service delivery models, and improved leadership and communication, these recommendations seek to provide comprehensive solutions to enhance the effectiveness and sustainability of the South African health system. These insights not only offer practical guidance for policymakers and practitioners but also highlight critical areas for further investigation, ensuring that future research continues to build on the findings of this study and contributes to the ongoing improvement of healthcare delivery.

7.1 Recommendations

Table 7.1: recommendations based on study conclusions/findings

Study conclusions/findings	Recommendation
• The effects of the decisions by the PCCC have resulted in staff reductions in health facilities, which is detrimental to the delivery of healthcare: "*The cost containment committees affect service delivery because now we are short staffed and that is causing the problem because when people* get tired, they just take leave or just become sick" (Hosp A – Professional Nurse). The Human Resources Manager further alluded to the effects of staff shortages: "*despite the prescripts of the South African Nursing Council (SANC) on duties and responsibilities and norms and standards of different nursing categories, the shortages of staff have led to pure non-compliance with those, hence opportunity for medical negligence*".	• Implementation of moratoria on staffing needs to be accompanied by strategic interventions to counter the effect of staff shortages. This should be accompanied by a training curriculum, task shifting and reviving the service delivery platform which is enabling for such practices.
	• For the immediate future, it is crucial for management and policy professionals in the health human resources field to prioritize professional ethics in times of fiscal restraint. This may involve the revitalization of values and ethics via training, taking into account the dynamic economic and political context in public finance that impacts healthcare workers.
• **Staff Shortages and Role Blurring**: The problem of staff shortages has resulted in blurring of roles; this was mostly reported by nurses. In most	• Develop a staffing plan, under the ambit of cost containment, which considers the context of facilities. This includes factors such as disease

instances they find themselves having to do work that is outside their scope of practice. One of the nurses made an example that they sometimes must do the porters' job, taking corpse to the mortuary and this is a risky task because they were never trained to undertake this type of work. • There appears to be a **lack of collegial support** among staff, which makes it difficult to deal with the problems collectively as a team.	burden, population coverage, and types of services delivered. The aim is to prioritize critical areas of healthcare service delivery while also prioritizing the wellbeing of healthcare workers to ensure a high standard of care in medical facilities.
• The reduction in health workers has direct impact of service delivery and health outcomes. The WHO states that universal health coverage relies on the right skills mix of health personnel in required numbers (93). Therefore, the reduction in health workers directly impacts service delivery and health outcomes, highlighting the need for a balanced approach to health financing and policy. • An occupational therapist expressed concern around prioritisation in health budgeting: "There seems to be prioritisation of infrastructure more than clinical matters e.g. shortage of nurses and doctors. It is as if there is no effort put into procuring the medical staff, the ECG machine, and those kinds of things needed to render patient care.	• Noting the constrained fiscal environment with poor economic outcomes, there is an immediate need to investigate the service delivery model and how it can be amended to fit the extent of availability of resources. Furthermore, this also requires extensive process of prioritisation of available resources to meet the immediate needs of user as deemed by the health professional. • The above point also leads one into thinking about general prioritisation of interventions and public health programmes with an aim of achieving efficiencies without potentially affecting health outcomes. This could be done through different approaches e.g., Health Technology Assessments and various economic evaluations of different interventions. This recommendation is also in line with one of the interventions implemented by some countries to make health systems more resilient to budget reduction as presented by Stuckler (35). Perhaps there could be some efficiency gains that could also aid in dealing with the impact of austerity.
• Leaders and managers have significant roles in managing people, programmes and finances, guiding policy changes and implementation, and setting the direction of service delivery. Their guidance and response to employees during reforms in the mentioned areas have far-reaching implications.	• There is a need for improving leadership and management in the department and health facilities to ensure that competent people are placed in positions and that there is better communication with the head office to influence decision making at the PCC level. Additionally, management should take responsibility for providing strategic direction in dealing with the challenges that arise from the implementation of cost-containment measures.

• It appeared that some of the staff were not satisfied with the composition of the PCCC. They cited that the lack of, for instance, district managers resulted in limited appreciation of the contextual issues that were encountered at district level. One of the staff noted as follows: "the disadvantage of the introduction of the PCCC is that people that sit and make decisions in this structure do not know or understand what is happening at a grassroots level. By grassroots I mean hospital or facility level. There are no District managers in that structure" (Human resource practitioner – Hosp A).	• The above requires empowerment of facility leadership and management by the head office. Facility management structure needs to be trusted.

7.2 Implications for future research

- Future studies should also examine how organizational culture, management strategies, and leadership styles have either alleviated or perpetuated the impact of austerity on staff. Additionally, these studies could explore the role of employee engagement, communication practices, and support systems in mitigating the negative effects of austerity measures. This comprehensive approach would provide a deeper understanding of the factors influencing staff well-being and the overall effectiveness of austerity policies.
- While workers in this study offer insights into the effects of these measures on healthcare service quality, future research could focus on the direct impact on service delivery from the patients' perspective, including an assessment of health outcomes.
- Further studies are required to replicate this study and assess whether similar results hold in other provinces where financial management issues are less prevalent. One would then be able to deduce the degree to which austerity measures have impacted the health system in the country.
- The study's claim that austerity is associated with poor service delivery quality should be viewed cautiously, despite indicators such as the unavailability of medical supplies and staff shortages which affect patient care. Establishing a causal relationship between austerity measures and quality care by measuring actual health outcomes would have been intriguing, but this was not the study's aim. Future research could benefit from delving deeper into this area.

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APPENDIX A: thematic analysis

Research objective	Theme	Quote	Participant ID
A. To describe the measures used to implement austerity in two public hospitals in the Eastern Cape Province, South Africa.	The Provincial Cost Containment Committee (PCCC) as a vehicle to implementing austerity	1. "There is a costs containment committee that sits in the facility, then there is a district costs containment then provincial costs containment committee. So we submit our staff requests, sit with our staff here at the institution and then get approved by the district, and then from the district taken to the head office. HR appointments and procurement of items are only made upon approval by the PCCC. At times this takes more than 30 days".	Financial Manager – Hosp: C
		2. "On Monday the Institutional/Facility Cost Containment Committee (ICCC) sits, then on Tuesday the District Costs Containment Committee (DCCC) sits and everything presented here is taken to Head Office the Provincial Costs Containment Committee (PCCC) which is supposed to sit weekly on Wednesday. The PCC makes the final decision on recommendations from other committees."	Human resource practitioner – Hosp A
		3. In terms of the composition of the PCCC structure, it is general manager: financial Services, general manager: budgeting and Director Human Resources.	Human resource practitioner – Hosp A
		4. "This cost containment structure is mainly for compensation of employees but it also sits for everything even goods and services. But the disadvantage of introduction of this PCCC is that people that sit and make decisions in this PCCC do not know or understand what is happening at grassroots level, by grassroots I mean hospital or facility level. There are no District Managers in that structure".	Human resource practitioner – Hosp A
	Description and application of austerity measures	5. "In 2015 there came a circular with constraint measures when the PCC and DCC was introduced. Part of that was not to pay bonuses through PMDS and look at other ways of acknowledging people which is not really working. Sending people on courses and other types of ways that is mentioned in the policy that you can give.	CEO – Hosp C
		6. The policy says that posts must be filled in within 6 months and that is not happening. That is frustrating because if you don't have the staff to do the work it is frustrating everybody. And I feel that preferences are given to	CEO Hosp C

		regional and tertiary hospitals because there are high level posts that are being filled in those areas"	
		7. With HR recruitment, the CEO cannot appoint nursing and medical officers staff, she can submit for post advertisement at head office but whoever is going to be recommended must go through the approval process. So they have delegated some of the functions to the CEO at the district office but when it comes to HR, it must go to the PCCC.	CEO Hosp C
		8. Delegation of powers to CEOs for staff recruitment is partial. You do the processes but the final approval is at head office This includes all types of posts i.e. promotional and filling of vacancies, all of these must be advertised at head office".	CEO – Hosp C
	Institutional challenges with the implementation of austerity measures	9. If you could compare the organization now and before 2010/2011 when delegations were decentralized**, t**he filling of replacement posts was never an issue. It was possible to fill them within a period of 3 months because our CEO and DM had delegations, now it is the opposite. Look for instance, travel and subsistence claims can no longer be processed by CEOs, everything is controlled at Head Office and it has to go to PCCC.	ASD Human resources Manager: Hosp A
		10. The challenge that we have is with the budget. Every year we have a shortfall with the budget, especially with the NHLS lab services, we have accruals every year. Despite budget increases, the accruals regress the budget.	CEO – Hosp C
		11. We are not physically present to elaborate to the committee as to why, you must forward a paper and on that basis they accept it or not, approve it or not approve. So we are not physically there in the meetings to motivate and they don't even invite you to present your cases or posts so we are basically in the hands of,	HR Hosp C
		12. "…then it comes with unemployment because most of the people living in those areas are unemployed. It comes with all the diseases that are related to poverty and unemployment".	Area manager: Medical department Hosp C

		13. "And unfortunately, by the beginning of a new financial year, we are now paying the accruals of the previous year. It happens all the time, and I do not know how we can overcome this problem, but it is a continuous problem". 14. There is a general increase in population in area because of people moving in and out but that doesn't speak to the budgeting. That is a problem, and that is our biggest problem".	Area manager: Medical department Hosp C
B. To describe health care workers' perceptions of the impact of austerity on their physical, emotional and mental health well-being	Effects of the austerity measures on human resources and staff wellbeing	1. "The PCC prolongs the process of filling of vacancies and this affects service delivery because now we have to work with short staff. The staff also gets tired and they take leave or just become sick. It is also bringing out the negative attitudes especially with the nursing staff, they are under staffed, but they are trying their best and people get sick."	Human Resource Clerk – Hosp A
		2. The shortage of staff is a major problem because it affects productivity, as a result of the effect on the productivity they don't work. You may overwork someone, on the third day, they may take sick leave, you see?" One person is doing the work for 2 or 3 people	PAWUSA secretary – Union Hosp C
		3. The staff gets burned out, absenteeism becomes a problem, a lot of staff has back aches, the nurses have back aches. We can see now the cause, it comes from the fact that they have to do it all.	Area manager : medicine department Hosp A
		4. "There is shortage of staff so much that sometimes there is 1 person working which means that you can just end up cleaning only the high care not the other wards. Sometimes we wish we could just pack our bags and leave. 5. That is why the absenteeism comes in because you just feel fed up of this pressure. And here in this hospital they say we are working in the XDR we can't have stress because when you are stressed your immune system goes down and then you are infected quickly. 6. I have a chronic condition. I did not have a chronic condition when I started here. I have a wound that is not healing. The doctors say I must work light duty but I do not work light duty because of the workload. I am working in a big ward alone.	Cleaners Hosp A
		7. We do not manage at all. Especially in New Block with high number of patients. I mean the patient ration to the nurse is 10 patients per nurse. Here is double. I am sure it is 25 patients per nurse at night because there are 50 patients	Professional Nurse Hosp A

		8. We are not exposed to courses or workshops that are given in the country because we always have to be in the facility as there is shortage of staff.	Focus group, professional nurse, Hosp A
		9. There are shortages in kitchen staff, even those that have left, there have been no replacements, existing staff is tired because of being overworked. As a result other staff members from admin and nursing would be assisting in the kitchen, basically taking up on duties that are not theirs. 10. If there is no general assistant (GA) that day, it does not mean patients must not eat, it does not mean that you are going to walk over vomitus. It is important as a nurse to work in a clean environment, therefore the nurse has to take the mop and mop up because you will be told there are no GA's. So the nurse will play the role of a GA. The nurse will have to dish up and wash the dishes because the patients must eat. You will find that the nurses are abused to be honest. Nurses are even doing porters' job. 11. Sometimes there are no porters to take corpses to the mortuary and the nurses have to do that, and we get blamed for not doing the job diligently or properly. For instance, we were not taught about handling of corpses in nursing school we were just taught how to wrap the body. And now we must answer	Area manager: maternity Hosp C Area manager: Medical department Hosp C
		12. Despite the challenges and difficulties that we face, what keeps us motivated is the fact that we made an oath to serve patients. I find that nurses are mostly criticized and everything that goes wrong in the hospital the nurses are to blame, and we are never too good to provide the services. Like I said now, if a patient falls where was the nurse, if there is no linen what has the nurse done, if there is no food then the nurse has failed. We get a lot of criticism; you would expect nurses to be really demotivated and have negative attitudes. As a manager you have to have skills to be able to motivate your staff. Medical department for example is a very stressful and physically tiring department, it is not easy to work in medical department. 13. Every month, or every second month we have meetings, with the staff and I tell them that it is your meeting, it is your platform to express how you feel and how you think things should be and so on. You encourage that they can speak and have a platform whe"re they talk about how they feel and how things should be done.	Area Manager: Medical department Area manager: Maternity Hosp C

		14. In nursing we tried to boost self-esteem in the nursing, the professional ethics, the nursing itself because the morale is very low. So we have done team building events to build encourage the team	Operational manager XDR: Hosp A
C To describe managers' and health care workers' perceptions of the impact of austerity on the delivery of healthcare services	Impact of austerity on the quality delivery of healthcare services	1. The process of cost containment committees affects service delivery because now we have to work with short staff and that is causing the problem because when people get tired they just take leave or just become sick."	Human Resource practitioner – Hosp A – Professional Nurse
		2. "It seems like the people who sit in that structure do not really know the priorities in the hospital. For the past 8 years we do not have a Dietician, no Infection Control person (this is a big problem for a TB hospital) and no Health and Safety Officer yet there is an expectation of good quality outcomes. It is not possible to achieve such good outcomes with some key personnel missing. The hospital is also contravening health and safety laws. We were recently told that there is no money and the post was not funded".	HRM- Hosp A
		3. "Each patient needs to have an ECG done because the treatment that they receive affects the functioning of the heart. However, in order to buy these resources, we have to go through many channels for consideration by the PCCC. By the time the committee responds, we would have accumulated a large backlog of patients requiring the use of this machine".	CEO – Hosp: A
		4. **"**Sometimes we have to use our own money to secure the resources because we don't want our patients to suffer and we are here to save lives while we are waiting to get approval for the orders".	CEO – Hosp: A
		5. "The shortage of equipment also revolves around the human resource. For instance, procurement of equipment and other goods and service is done by the supply chain management personnel but there is a few staff members and this causes delays in procurement. Look now we are waiting for our medical equipment".	Area manager: nursing Hosp A
		6. "…If we don't have something we will ask from other institutions like for instance food items we ask from other institutions to assist us and then we give back when we get our own order".	Financial management Hosp C
		7. "…We must pay our suppliers within 30 days and we used to be able to pay our suppliers on time, but now , we must get PCC approval from Head Office and only then we can be able to pay our suppliers"	Finance manager – Hosp C

		8. "There seems to be poor prioritisation of spending areas… here at the department we don't have a wheelchair ramp at the entrance. So when we have the patients on the wheel chair they struggle to get in here. For the past 5 years I have put on the requisition for the wheelchair ramp. Every year it gets put at the bottom of the list, by the operations manager, he is doing the tender; he decides what tender is going to be done.mm	Occupational Therapist Hosp A
		9. "We have staff shortages of doctors, nurses as well as in the procurement and finance department. We only have three doctors in this hospital and all 3 are responsible for 227 patients who are in the hospital as well as +- 600 patients that are outside. We are supposed to review our patients every month until they finish the course of their treatment. The doctors are supposed to go and monitor/ review the patients at the clinics, but they are unable to do this due to the shortage of staff.	CEO – Hosp A
To describe the pitfalls of the health system accentuating the impact of austerity	The pitfalls of the health system accentuating the impact of austerity	1. There seems to be prioritisation of infrastructure more than clinical matter e.g., shortage of nurses and doctors. 2. "It is as if there is no effort in procuring the medical staff, the ECG machine, and those kinds of things needed to render patient care. I find that again in lots of the decisions that are made, it's about infrastructure or about what we look on the outside, very little about the quality of the patient care. The doctor can struggle without some equipment".	Occupational Therapist Hosp A
		3. "Budget is getting better but it is not allocated effectively. Head Office decides how much they allocate and where. Sometimes you will not understand they will put the lot of money in eggs, which get served less than other essential foods such as meat. This affects nutritional requirements for patients".	Kitchen manager: Hosp A
		4. " improper classification of hospitals is a huge challenge. This hospital is gazetted as a regional hospital but recognized as a district hospital with in the province… this affects the hospital's budget and staffing".	Hosp CEO – Hosp C

		5. "the current organogram has 3 posts of doctors while these are not enough for the services that we provide; HR cannot do anything to adjust the organogram. HR can only appoint people when the province has decided to improve the organogram by adding more posts. There is an organogram, that they proposed and which we hope one day it will be implemented. In this organogram, we will have 8 doctors including the clinic manager. This organogram will be good for us because it will enable us to do our outreach work without interruptions. If we had more doctors, our outcomes would be much better"	CEO – Hosp A
		6. The hospital has a high utilisation rate but the available resources i.e., computers and personnels , for patient administration are not enough and this causes delays in processing patient data including billing. As a result revenue collection gets limited due to issues in the system. The ward clerks are also not playing their part. They think or assume that it is the duties of patient clerks whereas we should be working as a team. These divisions in the team are also created by operational managers because the operational managers do not want to share the resources, especially those obtained through donations, they will hold fast to the staff and limit their work to certain responsibilities e.g. writing minutes for the doctors. What about- there are many challenges that we are facing, which we should be discussing, so that we are able to streamline whatever that needs to happen.	ASD: Public Administrator – Hosp:C
		7. **"**Our hospital is supposed to be dealing strictly with XDR and complicated cases of MDR. Cases that fall out of this category have to go to our sister hospitals. We work well with other facilities except Mpilweni Hospitals where they always turn patients away and send them to us. Some clinics refer patients to us when they are actually supposed to refer them to the other facilities. 8. "The head office knows about this issue because one hospital reported the matter. They informed them that at Empilweni they do not admit patients after three. Head office came and spoke to them and they denied everything. When the department came to supervise them they changed their behaviour and when they left they reverted back to their old ways"	CEO – Hosp A

		9. "The money for positions is used to settle the Medico legal cases and to pay attorney. What causes medico-legal cases is negligence from staff. But it is expected especially the core staff (nurses and doctors) are working long hours and there is shortage across the spectrum (clinical and non-clinical). 10. Despite the prescripts of the SANC on duties and responsibilities and norms and standards of different nursing categories, the shortages of staff has led to pure non-compliance with those, hence opportunity for medical negligence	HRM –Hosp A

APPENDIX B: Plagiarism declaration form

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

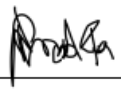
PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Noxolo Madela (Student number: 886656) am a student registered for the degree of Master of Public Health in the academic year 2024.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature:  Date: 15 March 2024

APPENDIX C: Turnitin report

Final research report nm 22.03.24.docx

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The Centre for Health Policy

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

25th March 2024

Subject: Noxolo Madela Turnitin Report

This is to confirm that I have checked the detailed Turnitn report for Noxolo Madela's MPH research report, and can confirm that the high similarity index of 14% does not constitute plagiarism

Sincerely,

Jane Goudge

Jane Goudge
Professor
Centre for Health Policy
School of Public Health
University of the Witwatersrand
Johannesburg, South Africa

APPENDIX D: Research ethics clearance certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Miss Noxolo Madela

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M220830 MED22-08-008

NAME: (Principal Investigator)	Miss Noxolo Madela
DEPARTMENT:	School of Public Health
PROJECT TITLE:	Public hospital employees' experiences of working under austerity in the Eastern Cape Province, South Africa.
DATE CONSIDERED:	26/08/2022
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Prof Jane Goudge and Dr Thanduxolo Fana
APPROVED BY:	Dr C Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	15/09/2022

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 301, Third floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed August and will therefore be due in the month of August each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES