**Towards Substantial Reform for Rural Health: Submission to the Standing Committee on Finance in response 2018 Fiscal Framework**

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**Project**

The Rural Health Advocacy project is a public interest advocacy group whose vision is the realisation of the right to health of rural communities. While all South Africans enjoy the right to quality health services rural communities face significant challenges in accessing this right. Working with a network of partners the RHAP advocates for rural proofed strategies that consider the varied implementation contexts.

In considering the context of rural health, it is important to understand that pre-existing deprivation and vulnerability affects the impact of policy implementation. Former homeland areas, all rural, are the most deprived in South Africa in terms of the social determinants of health. This broader context affects the ability of people to access healthcare and attain good health. Historical neglect of the rural areas, poor roads and access to facilities, high unemployment, food insecurity, and school drop-out rates are examples of the broader context affecting health outcomes. A socially just response to healthcare would take cognizance of these factors and would seek to avoid further blows to people’s capabilities to live healthy lives. Failing this will result in a continued underinvestment in rural health which in turn will result in the widening of poverty and inequality.

Accordingly, RHAP is concerned by the fiscal framework proposed by National Treasury in the 2018 budget. We are concerned that the revenue raising proposals and the harsh austerity measures beyond deepening poverty and inequality will result in narrowing of access to healthcare for already deprived rural communities.

**The Fiscal Framework**

In the tabling of the 2018 National Budget, Minister Gigaba provided a set of revenues raising and an accompanying expenditure proposals that seeks to guide the implementation of the government program the next three years. The fiscal framework, summarizes the various inputs and outputs that government has considered in the tabling of the budget. Included are a number of tax proposals and austerity spending measures that if implemented have the potential to significantly impact on the ability of rural communities to access quality health services. [[1]](#footnote-1)

**1% Increase in VAT**

We are concerned that the proposed 1% increase in value added tax if implemented has the potential to reduce the real disposable income of poor communitiesand there is considerable danger that this will increase poverty and inequality. While we acknowledge that these risks are somewhat mitigated by a 1,5 % real increase in grants as well the existing of zero rating of 19 food items, the proposal will negatively impact rural households. We fully support a submission by the civil society coalition in response to the increase agree with the reasons presented below. [[2]](#footnote-2)

1. **Zero-rated goods do not necessarily make up the majority of low-income household’s food consumption needs**. The Pietermaritzburg Association for Community Social Action(PACSA) tracks a basket of goods consumed most commonly by the poor. In June 2015 only 45% of the rand value of this basket was zero-rated.[[3]](#footnote-3)
2. **The current basket of zero-rated goods is not, in all cases, optimally targeted**. For example, zero-rating on frozen vegetables and “basic” fresh vegetables benefit the poor but zero-rating on more expensive fresh vegetables does not, while canned vegetables, consumed by the poor, are not zero-rated.[[4]](#footnote-4)
3. **The current basket of zero-rated goods excludes a number of goods consumed heavily by the poor**, for example, white flour, canned beans, margarine, chicken, polony, candles, and soap.
4. **Food consumption patterns matter and food and fuel price rises can push low-income households *away* from zero-rated items**. PACSA shows that as food prices rise and households drop nutritious food from the plate, they substitute these with relatively cheaper fats, salts and sugars that are not zero-rated. Further, as some zero-rated items (like dry beans) have longer cooking times, a rise in fuel prices can shift consumption away from these.[[5]](#footnote-5)

**Increase Fuel Levy**

 We are further concerned by the proposed increase in the fuel levy as well on the carbon tax on motor vehicles. Transport costs are a significant input cost and we believe that these taxes in addition to increase in tax will further reduce the real disposable income of the poor as well as contribute to greater ill health amongst rural communities by deepening inequality of access the reasons for this include:

1. Rural Communities cover large geographical areas, accompanied by small population densities and resultant diseconomies of scale leads to higher prices
2. In the absence of planned patient transport, rural communities have to incur significant out of pocket costs to access health. Increased transport costs will impact on the health seeking behavior of rural communities as communities’ delay or opt out of essential health care.
3. Transport is a key input cost in health care delivery particularly in rural settings, as facilities are often further apart and could have a negatively impact on the health sector procurement.

We call on parliament to call on national treasury, national department of health and their provincial colleagues to investigate measures to minimise the impact of increased transport costs. Measures should include increased investments planned patient transport, improved efficacy of emergency medical services. Further inputs on the impact on transport costs on health can be found in RHAP’s working paper [[6]](#footnote-6)

**Revenue Forecasts**

Included in the budget review are a number of risks could impact on the forecasts. Firstly, there is an assumption on the back of increased business confidence. There is little consideration of the impact of increased consumption taxes on overall economic performance in forecasting further economic growth over the forecast period.

Secondly, despite the revenue measures proposed as well as expenditure savings forecast as well as the reintroduction of fiscal consolidation measures the risk of a further sovereign ratings downgrade remain. If this occurs national treasury projects that economic growth may be revised downward by as much as 50%. Greater consideration should be given to the impact of missed forecasts on budget execution.

We call on parliament to call on national treasury to provide details on the risk mitigation strategies in place to ensure that social expenditure is not negatively impacted by changes in the economic outlook.

**Division of Revenue**

The division of revenue bill proposes a number of reductions in the expenditure ceilings of national and provincial departments. In total a further R 86 billion in expenditure savings is forecasted these are in addition to the R 30 billion in savings forecasted from reductions in the cost of employment budgets. While there is a recognition of the need to improve the efficacy of spending by departments it is not entirely clear what measures are in place to ensure that the reductions in expenditure ceilings do not lead to irrational approaches to cost saving as department attempt to stay within their respective expenditure ceilings.

**The provincial equitable share**

While the equitable share allocations of national income are maintained (National 48%, Provincial 43% and Local Government 9%) the reduction of expenditure ceilings places significant risk to budget expenditure. Additionally, as RHAP has previously argued that while there is significant transparency into the processes as to how equitable share allocations are arrived at, provinces have significant discretion in the manner as how resources are ultimately allocated.

In the case of the health budget the introduction of additional revenue raised from amendments to the medical aid tax credits are welcomed as well as measures to improve efficacy of spending on a number of direct conditional grants particularly the health facility revitalization grant which has underperformed are welcomed. However, given that front line health services are funded from the provincial equitable share proposals to reduce transfer to provinces over the medium term is particularly concerning. This means that allocations for district health services, which include district hospitals, community health centres, primary health care clinics as well community outreach services, which are funded directly through provincial budgets. This is problematic insofar as provinces, when receiving a lump sum allocation for the provision of basic services, have significant discretion as to how much is eventually allocated to health services. In a presentation to the portfolio committee on Health in October 2017, the Minister of Health presented findings of the ministerial task team that investigated service delivery in public health facilities across the country. The findings paint a very bleak picture, and confirmed anecdotal reports of chronic understaffing exacerbated by continued freezing of critical health posts, poor financial management resulting underinvestment in health infrastructure, as well as abuse of government procurement systems. These findings place serious doubt on the ability of provinces to meet their responsibility in providing quality health services.[[7]](#footnote-7)

**The Human Resources for Health (HRH) crisis**

The National Department of Health confirmed to a joint sitting of the Parliamentary Committees of Health and Finance that confirmed over 40000 vacancies in the health service across all provinces. So, even though there are no additional cuts to the cost of employment, the failure of the budget to specifically address the retention and protection of critical frontline health posts is concerning. The lack of clear guidelines in the managing the impact of austerity measures is problematic. The impact of irrational approaches to staff cuts were documented in a  [report](http://rhap.org.za/wp-content/uploads/2017/04/Cutting-Human-Resources-for-Health-Who-Pays-RHAP-2017.pdf) developed by RHAP that showed both the gravity and the complexity of the HRH crisis for rural communities in South Africa. [[8]](#footnote-8)

While many of the challenges described affect health services at all levels including in urban and peri-urban areas, it is clear that rural South Africans are uniquely vulnerable to the effects of staffing cuts, and are disproportionately affected by them. We argue that poor access to quality healthcare for impoverished communities plays a critical role in the vicious cycle of illness and poverty. Disability has also been shown to play a rapidly increasing role in the (ill) health of our people, and it is imperative that health services are staffed and equipped to address this. So, as we consider a public-sector wage bill and how best to manage this, we need to be reminded that the essential role that skilled and committed health workers play in the health system.

**Financial Management**

While we are appreciative of governments attempts to improve the efficiency of its spending, we believe that by simply reducing expenditure ceilings without careful consideration of the impact thereof may be pennywise but pound foolish. The proposed reduction of R1.4 billion in equitable share allocations without a consideration of priority needs is concerning. Accompanied by the introduction of further expenditure ceilings with regards to goods and services could have disastrous effects on already underserved rural communities.

RHAP has consistently called for health budgets to consider the particular implementation context of rural health, which is characterized by large geographical areas with low population densities. Despite the fact that there are fewer people to serve, the context in fact increases the cost of delivering care. Budget items such as planned patient transport, outreach campaigns, as well as the considerable out of pocket expenses incurred when accessing services, require careful consideration. Further monitoring should be implemented as to the management of non-negotiable expenses such as medicines, patient food, and cleaning materials to protect the system from abuse. The continued growth of over R20 billion in unfunded expenditure needs to be better managed to ensure that abuse does not continue to undermine service delivery.[[9]](#footnote-9)

**National Health Insurance**

The establishment of the transitional NHI fund, and the planned introduction of the NHI bill are welcomed. However, the initial allocation of a mere R700 million as opposed to the forecasted R25 billion is disappointing. While initially, the transitional fund was targeted at a set of priority health programs such as maternal and child health, young people, the elderly, and people living with disabilities, the limited funding has resulted in the priority has been limited to referrals for optometry and audiology services emanating from screening in the school health program. Similarly, the planned strengthening of community mental health services under the fund is welcomed. We urge that in the roll out of this program, populations who currently suffer the worst access to health services, most notably rural populations, must be prioritized

**Expansion of the HIV/AIDS TB Conditional Grant**

We welcome the additional R1 billion made available to the program over the next 3 years. The rapid expansion of treatment has contributed significantly to the improvements in life expectancy as well as maternal and child health outcomes. However, we are concerned by the varying implementation successes. In the Eastern Cape, a mostly rural province, there are currently over 700000 people living with HIV, with only 400 000 people currently on treatment. This represents a significant treatment gap and well short of the targeted 90 % coverage.

The proposed housing of an integrated community health worker program within this grant is welcomed. However, the current allocation of R1,4 billion per annum is grossly inadequate to fully fund a comprehensive community health worker program. Given the importance of community health workers in ward based outreach teams we urge that rural communities that currently enjoy limited access to health are prioritised.

In conclusion, thank you for your consideration our request and we look forward to the opportunity to present to our concerns to the committee.

1. National Treasury, ‘Budget Review 2018’ (Government of the Republic of South Africa, 21 February 2018), http://www.treasury.gov.za/documents/national%20budget/2015/review/FullReview.pdf. [↑](#footnote-ref-1)
2. Gilad Isaacs, Civil Society Submission to the portfolio committee on finance in response to the 2018 Fiscal Framework, 26February 2018 [↑](#footnote-ref-2)
3. Ada Jansen, Elizabeth Stoltz, and Derek Yu, ‘Improving the Targeting of Zero-Rated Basic Foodstuffs under Value Added Tax (VAT) in South Africa - An Exploratory Analysis’, Working Papers (Stellenbosch University, Department of Economics, 2012), https://ideas.repec.org/p/sza/wpaper/wpapers159.html. [↑](#footnote-ref-3)
4. PACSA, PACSA Food Price Barometer (Pietermaritzburg Agency for Community Social Action, October 2018). [↑](#footnote-ref-4)
5. [↑](#footnote-ref-5)
6. RHAP,” The role and impact of transport on rural communities accessing the state health care system is South Africa, Johannesburg, March 2013.’ http://www.rhap.org.za/wp-content/uploads/2014/02/RHAP-Position-Paper\_THE-ROLE-AND-IMPACT-OF-TRANSPORT-ON-RURAL-COMMUNITIES-ACCESSING-THE-STATE-HEALTH-CARE-SYSTEM-IN-SOUTH-AFRICA.pdf [↑](#footnote-ref-6)
7. [↑](#footnote-ref-7)
8. RHAP, “Cutting HRH, Who Pays; A Eastern Cape Case Study,” Johannesburg, November 2016 /http://rhap.org.za/wp-content/uploads/2017/04/Cutting-Human-Resources-for-Health-Who-Pays-RHAP-2017.pdf [↑](#footnote-ref-8)
9. NDOH , ‘Presentation to the Portfolio Committee on Health “, Cape Town, 22 March 2017 [↑](#footnote-ref-9)