A GENDERED ANALYSIS OF THE MEDIUM TERM BUDGET POLICY STATEMENT WITH A FOCUS ON RURAL HEALTH

SUBMISSION BY THE RURAL HEALTH ADVOCACY PROJECT

TO THE SELECT AND STANDING COMMITTEES ON APPROPRIATIONS

Standing and Select Committees on Appropriations

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EXECUTIVE SUMMARY

An investment in health is an investment in people. Health is not just about treating disease. Good health is an enabler. We are particularly concerned that the revenue raising proposals and harsh austerity measures in the form of expenditure cuts will exacerbate poverty and inequality and retard job creation and economic growth. It is noted that the worsening fiscal position is threatening government's ability to maintain existing levels of service provision and infrastructure investment. After debt-service costs, health is the fastest growing area of spending at a time when reductions in spending are being made. The Medium-Term Budget Policy Statement indicated that the average nominal growth in spending in health over the medium term is 7%. Despite the tough economic and fiscal circumstances, the increase in health care spending offers some opportunities. Health spending has a role to play as a catalyst for inclusive growth. Ensuring that South Africans are healthy means that as a nation we will be better placed to participate in the global economy and prosper. The health sector can be a pathway to employment for youth. This submission's contribution is to advance that investing in health and social infrastructure can offer

short-term stabilisation and long-term growth. While RHAP has taken note of what Treasury has indicated about the National Health Insurance costing, the policy discussions remain underway. With the transition to universal healthcare, government will be investing a significant amount of money in health spending to roll out the National Health Insurance. To manage the transition to universal healthcare, government needs to focus its spending efforts on improving existing facilities and the services offered there. If the transition is managed well, the additional investment can be used to stimulate employment and particularly youth and women's employment in rural areas. This submission offers practical recommendations for how, in the tight fiscal space that exists, the health sector can be an enabler of economic growth. It also offers recommendations for rural-proofing the health budget and ensuring that it is gender-responsive.

INTRODUCTION

This submission provides analysis relating to the Medium-Term Budget Policy Statement 2019 and Adjusted Budget tabled on 30 October by the Minister of Finance. It provides comment on spending priorities and proposed changes to conditional grants for the health sector. It also assesses spending and performance midway through the year by analysing the Adjusted Budget Summary for Vote 16, Health. This includes looking at a gender perspective in reviewing the midyear spending and performance, to provide a gendered analysis with a particular focus on rural health. Rural Health Advocacy Project has chosen to do a gendered analysis to emphasize our commitment to an inclusive society that prioritizes gender equality. We affirm that women's development should be at the centre of public spending. Given the rural health focus of our work, this submission specifically addresses rural women's experiences and the inequities they are faced with when trying to access healthcare while living in remote rural areas.

Despite the tough economic and fiscal circumstances, health spending has a role to play as a catalyst for inclusive growth. Ensuring that South Africans are healthy means that as a nation we will be better placed to participate in the global economy and prosper. The health sector can be a pathway to employment for youth. This submission's contribution is to advance that investing in health and social infrastructure can offer short-term stabilisation and long-term growth.

ACKNOWLEDGING THE CHALLENGES

This year's Medium-Term Budget Policy statement comes at a juncture in which South Africa is beset with multiple pressures. The Minister of Finance presented tough choices and trade offs. South Africa's GDP growth trend has continued to decline, which Treasury attributed to multiple factors, including policy uncertainty, electricity supply shocks, lower investment levels, inefficient State Owned Company investments and poor education outcomes. There was an acknowledgement that the worsening fiscal position is threatening the government's ability to maintain existing levels of service provision and infrastructure investment.

Before the National Planning Commission (NPC) developed the National Development Plan, it undertook a diagnostic study, which outlined South Africa's achievements and shortcomings since 1994 (StatsSA, 2019b:3). StatsSA notes that the Diagnostic Report identified persistent high levels of unemployment, low quality of education provided especially to black South Africans, inadequate and poorly located infrastructure, South Africa's resource-intensive and therefore

environmentally unsustainable growth path, an 'ailing' public health system, an inefficient public service, corruption and a lack of social cohesion as the main challenges that South Africa faces. These challenges remain with us in 2019 and require sustained effort and hard work to address.

In order to deal with the challenges, we need to have frank conversations that acknowledge the challenges and what has not worked to address them. As members of respective constituencies including government, labour, business, academia and civil society, we need to engage in a different kind of conversation in order to take the country forward. Taking increasingly polarized positions will not help us to boost employment, build and maintain infrastructure, improve educational outcomes, bring about universal healthcare or very importantly, set us on a more inclusive economic trajectory. It also won't address corruption or improve the capacity of the public service. It is imperative that we address the challenges we are faced with. We need to move from entrenched positionalities to a meeting of minds on the issues where we can agree, so that solutions can be found. Beyond conversations, we need well-conceived, decisive, and effectively executed actions. Through our work, Rural Health Advocacy Project aims to contribute to creating a more equitable, healthier future. This submission therefore attempts to go beyond pointing out the admittedly tough challenges and registering concern about them. It tries to offer solutions and practical recommendations emanating from an evidence-based understanding.

DEMOGRAPHICS AND RURAL POVERTY

According to Statistics South Africa's Men, Women and Children: Findings of the Living Conditions Survey 2014/15, approximately half (49.2%) of South Africans live below the upper-bound poverty line (of R992 per person per month); and of these, 52 per cent are women. In addition, more than one out of every five adults (20,6%) were living below the food poverty line (of R441 per person per month) in 2015. We cannot be a prosperous nation if the poorest fifth of the population is living below the food poverty line. Very simply, people are not able to work or thrive if they do not eat enough and are nutritionally deprived. It is not an inclusive economy that disregards one fifth of its population.

Statistics South Africa's findings show that across all age cohorts, the poverty headcount is higher for females than males. The findings also reveal that poverty was more concentrated among young adults, especially females.

In 2015, 70,3% of households in South Africa were in urban areas and 29.7% in rural areas. When looking at how the 29.7% households that are in rural areas is comprised in terms of settlement type, 25,7% of all households are from traditional areas and only 4,1% reside in rural formal areas (Stats SA, 2018:8). Households from traditional areas were mainly headed by women (52,0%). The incidence of poverty by settlement type stands out as being high for rural traditional areas. Stats SA found that 67,4% of households residing in traditional areas were living below the Upper Bound Poverty Line and that this particularly affected female headed households, with seven out of every ten (74,8%) of households headed by females in traditional areas living under the upper-bound poverty line (StatsSA, 2018:17).

Table 1: Poverty incidence and poverty share of households by settlement type and sex of the household head (UBPL), 2015

	All households		Male-headed households		Female-headed households	
Settlement type	**Incidence (%)**	**Share (%)**	**Incidence (%)**	**Share (%)**	**Incidence (%)**	**Share (%)**
Urban formal	24,3	36,8	19,6	18,5	32,0	18,3
Urban informal	59,1	14,4	55,7	8,2	64,4	6,2
Traditional	67,4	43,2	59,3	18,3	74,8	25,0
Rural formal	54,4	5,5	48,8	3,4	66,8	2,1
Total	**40,0**	**100,0**	**33,0**	**48,4**	**49,9**	**51,6**

Source: Statistics South Africa. Men, Women and Children: Findings of the Living Conditions Survey 2014/15

In other words, there is a gendered dimension to poverty in that it affects women more acutely than it affects men and its incidence is highest in traditional rural settlements.

Expenditure at the household level also had a gendered dimension, with men having a higher expenditure on average compared to women. The report highlights differences between population groups as being illustrative of the inequality present in South Africa; black Africans on average had expenditure levels four times less than white-headed households (StatsSA, 2018:23).

South Africa remains one of the most unequal countries in the world and, in fact, Statistics South Africa has reported that inequality has increased since the end of apartheid. The Gini coefficient has risen from 0.58 in 1995 to 0.63 in 2015.

In the 10 years from 2008 to 2018, the unemployment rate has increased from 21,5% to almost 28,0%. The results of the Quarterly Labour Force Survey (QLFS) for the second quarter of 2019,

showed that unemployment is worsening, with the official unemployment rate (in terms of the narrow definition) being 29% or 6,7 million unemployed persons. However, the narrow definition masks the full extent of South Africa's unemployment challenge, as it does not consider those in long-term structural unemployment. The percentage of young persons aged 15–24 years who were not in employment, education or training (NEET) is 32,3% (3,3 million). Of the 20,4 million young people aged 15-34 years, 40,3% were not in employment, education or training (NEET).

Poor schooling outcomes affect South African youth and contribute to keeping youth from disadvantaged backgrounds stuck in a poverty trap. To illustrate, just over one million learners entered grade 1 in 2003. Only 49% made it to matric in 2014. 37% passed matric. And only 14% qualified for university entrance (Spaull, 2015). Statistics South Africa outlines that 57,4% of the unemployed are those with an education level of less than matric (Statistics South Africa, 2017). Here the relationship between poor quality educational outcomes and unemployment can be evidenced. Just 8% of youth aged 18 to 24 go to college or university (Branson, Hofmeyer, Papier & Needham, 2015).

Almost 50% of South Africa's population are under 25 (De Lannoy, Leibbrandt & Frame, 2015). But South Africa is not harnessing its demographic dividend. With a higher working-age ratio than dependency ratio, the country should be able to harness the skills and talents of its youthful population to improve its and their economic prospects. For South Africa's rural youth the situation is even more dire with few paths to employment and above average dependency ratios.

The structural issues of the economy, labour market dynamics and poor educational outcomes, however are contributing to growing youth unemployment (Graham, Patel, Chowa, de Vera, Khan, Williams & Mthembu, 2016:8) and impedes the realisation of the benefits of South Africa's demographic dividend. The triple challenges of poverty, inequality and unemployment in South Africa are widely acknowledged. Addressing these trends that are continuing to worsen is imperative.

EMPLOYMENT IN THE HEALTH SECTOR

The Competition Commission's Health Market Inquiry found that private hospital services are a relatively new development which started to grow from the mid-1980s. In 1986 there were a total of 6,125 private hospital beds. By 1998 there were 20,908 beds in 162 private hospitals (an

increase in beds of more than 240%). By 2010, a further 10,000 private beds and 54 hospitals had been added. These changes over time have been accompanied by changes in the distribution of employment in the private and public sectors. The Health Market Inquiry noted that distribution is uneven across categories. In 2015, approximately 56.3% of all general practitioners and 73.3% of all nurses worked in the public sector. However, only 35.8% of medical specialists and fewer than 30% of dentists worked in the public sector. As the table below indicates, there are far fewer health professions to patients in the public sector than in the private sector. This means that there is an inequality in the care received by those who can afford private services versus those who can afford public health services.

Table 2: Estimated public and private sector distribution of key health professionals (2015)

Health Professional	Estimate			% of total			Per 10,000 population		
	Pub	Priv	Total	Pub	Priv	Total	Pub	Priv	Total
General practitioners	11 299	8 768	**20 067**	56.3%	43.7%	**100.0%**	2.4	10.0	**3.7**
Medical specialists	4 233	7 595	**11 827**	35.8%	64.2%	**100.0%**	0.9	8.7	**2.2**
Dental practitioners	1 047	2 523	**3 571**	29.3%	70.7%	**100.0%**	0.2	2.9	**0.6**
Dental specialists	88	310	**398**	22.2%	77.8%	**100.0%**	0.0	0.4	**0.1**
Nurses	109 477	39 904	**149 381**	73.3%	26.7%	**100.0%**	23.7	45.5	**27.2**

Source: Health Market Inquiry compiled from data received from the HPCSA

National Treasury provided compensation data as an annexure to the MTBPS. This data shows compensation spending as a percentage of total spending. Although the percentage of total spending has risen in the health sector, the occupation specific dispensations that saw doctors and nurses being remunerated better were necessary to ensure that skilled personnel are attracted to the professions and specifically to public sector healthcare, where the working conditions are less attractive than in the private sector.

Table 3: Compensation spending as a percentage of total spending

Table B.1 Compensation spending as a percentage of total spending

	2006/07	2018/19	Change[1]
National government	36%	37%	1%
Provincial government	56%	61%	4%
Basic education	79%	79%	0%
Health	54%	62%	8%
Police	70%	80%	10%
Land and rural development	46%	50%	4%
Roads and transport	17%	21%	4%

1. May not balance due to rounding
Source: National Treasury

An impact of budget cuts on health is on the employment conditions of doctors, nurses, specialists and other health personnel. In recent years, tens of thousands of public health posts have been vacant.[1] This is resulting in critical staff shortages and hampering the expansion of health professionals necessary to improve levels of care and prepare the country for the transition to NHI.

The make up of the health workforce is 67% nurses. Close to half of nurses qualify for retirement in the next 10 years . As a country, we need to employ more nurses so that the institutional capacity within the service delivery platform is not compromised.

When examining human resource for health data, the total net gain year on year per profession is around 3.5 %. However, the public service is adding a host of community service professionals each year and then they leave the following year. After completing community service, the country does not absorb the new capacity into the healthcare system with estimates that as much 70% of new capacity is not absorbed.

Community Health Workers, the majority of whom are women, have experienced the brunt of health budget shortfalls and a lack of political prioritisation by working without decent wages or employment benefits. We are concerned that neither the MTBPS nor the adjusted National Health

[1] Russell Rensburg 'What to do about South Africa's unemployed doctors' *Bhekisisa* 21 Feb 2019. Available at: https://bhekisisa.org/article/2019-02-20-budget-speech-2019-unemployed-doctors-health-spending-austerity .

Department budget makes mention of the commitment to spend R1 billion on the implementation of the minimum wage for Community Health Workers.

HEALTH SECTOR AS AN EMPLOYMENT CREATOR AND CATALYST FOR INCLUSIVE GROWTH

In examining how to overcome the significant challenge of youth unemployment in South Africa, the authors of the Siyakha Youth Assets study undertook their study on the premise that "young people have dreams, that they want to study and to work, and that they have a range of assets that could contribute to programme success such as their own ideas, motivations and energies to make a difference in their lives" (Graham, Patel, Chowa, de Vera, Khan, Williams & Mthembu, 2016:9-10). Despite identifying systemic barriers such as dynamics of the labour market, structural problems of the economy and the education system, the authors of the Siyakha Youth Assets study see youth agency as part of the solution (Graham, Patel, Chowa, de Vera, Khan, Williams & Mthembu, 2016:10). They note that youth "are nevertheless motivated to make constructive decisions, use the opportunities available to them and their resources and networks to take appropriate action." Importantly, they do however note that on their own, youth are unlikely to overcome these issues. The Siyakha Youth Assets study is a longitudinal study which looks at programmes that intervene into the youth unemployment challenge at 48 sites nationally. It examines explanations for youth unemployment, provides a review of interventions and provides an overview of pathways to the labour market.

The Medium Term Budget Policy Statement indicated that the average nominal growth in spending on health over the medium term is 7%. Despite the tough economic and fiscal circumstances, the increase in health care spending offers some opportunities. Health spending has a role to play as a catalyst for inclusive growth. Ensuring that South Africans are healthy means that as a nation we will be better placed to participate in the global economy and prosper. The health sector can be a pathway to employment for youth.

This submission's contribution is to advance that the health sector can be linked to pathways to employment for youth. With the transition to universal healthcare, government will be investing a significant amount of money in health spending. If the transition is managed well, the additional

investment being made to realise universal healthcare in South Africa, can be used to stimulate employment and particularly youth and women's employment in rural areas.

While RHAP has taken note of what Treasury has indicated about the National Health Insurance costing, the policy discussions remain underway. The transition to universal healthcare, government will be investing a significant amount of money in health spending to roll out the National Health Insurance. To manage the transition to universal healthcare, government needs to focus its spending efforts on improving existing facilities and the services offered there.

An investment in health is an investment in people. Increased spending on health care will ensure that South Africans are healthy and able to participate in the global economy. In so doing, health spending has an important role to play as a catalyst for inclusive growth.

To do so, South Africa needs to be budgeting in such a way that acknowledges that women are the majority of the population and that South Africa has a youthful population who want to be part of a prosperous future.

RHAP observes that the Jobs Fund has declared R157.225 million unspent for the 2019/20 financial year. The Small Enterprise Finance Agency's small business and innovation fund has declared R300 million unspent. The Community Works Programme has declared R364.99 million unspent for the 2019/20 financial year. Stimulating employment would support the economy by generating greater tax revenue.

RHAP recommends that the Jobs Fund could consider a funding round that focuses on women's employment with the health sector as one of the sectors featured in the funding window.

There is a budget allocation to integrate community health workers into the system. The current focus is on employing around 50 000 community health workers next year. RHAP recommends that employing new community health workers in rural areas should be prioritized and that the Appropriations Committees should request both the National Department of Health and Provincial Departments of Health develop and publish a plan to support their integration into the Primary Healthcare System.

ADDRESSING THE INFRASTRUCTURE INEQUALITY GAP

Historically urban areas have been favoured when it comes to health expenditure. Research has shown that provinces that are the most deprived and with the least developed health systems have historically received the smallest share of healthcare funds. This has been explained as the 'infrastructure inequality trap', where provinces with comparatively well-developed health infrastructure and human resourcing compliments tend to receive a larger share of available resources (Stuckler, Basu & McKee, 2011). There is a tendency for urban areas which have greater absorptive capacity to receive more of the budget to maintain current provision. This means that historical inequities in provision of health care are remaining entrenched.

The Government Technical Advisory Centre, National Treasury commissioned a Performance Expenditure Review on Provincial Health Services. The Performance Expenditure Review which was completed by Deloitte and Touche South Africa in 2018 made use of Provincial Statistics for hospitals and clustered them according to number of beds per hospital and whether the hospital was in a rural or urban area. The information was extracted from the 2016 National Hospital List.

Table 5 - Provincial Statistics by Size and Demographics

Province	Number of Hospitals with <200 beds	Number of Hospitals with >200 <400 beds	Number of Hospitals with >400 <600 beds	Number of Hospitals with >600 beds	Number of Rural Hospitals	Number of Urban Hospitals
Eastern Cape	70	13	4	3	16	74
Free State	25	2	2	2	5	26
Gauteng	7	12	3	12	5	29
KwaZulu-Natal	29	26	11	7	22	51
Limpopo Province	22	12	3	0	9	28
Mpumalanga	20	9	0	0	6	23
North West	13	3	2	2	5	15
Northern Cape	18	0	0	1	5	14
Western Cape	35	13	0	3	10	41
National	**239**	**90**	**25**	**30**	**83**	**301**

Source: Performance & Expenditure Review: Provincial Health Services Revenue Generation

Rural Health Advocacy Project analysed this information further. The 'infrastructure inequality trap' is evident in the spread of the number of hospitals between urban and rural areas, where 78% of hospitals are in urban areas versus 22% in rural areas.

Figure 1: Number of hospitals in urban versus rural areas for South Africa

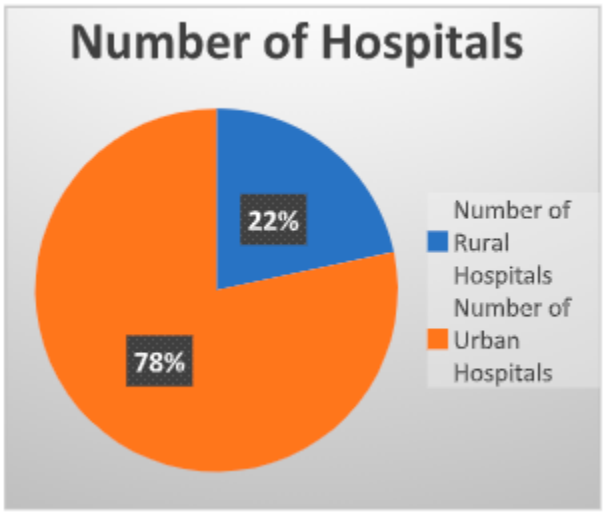
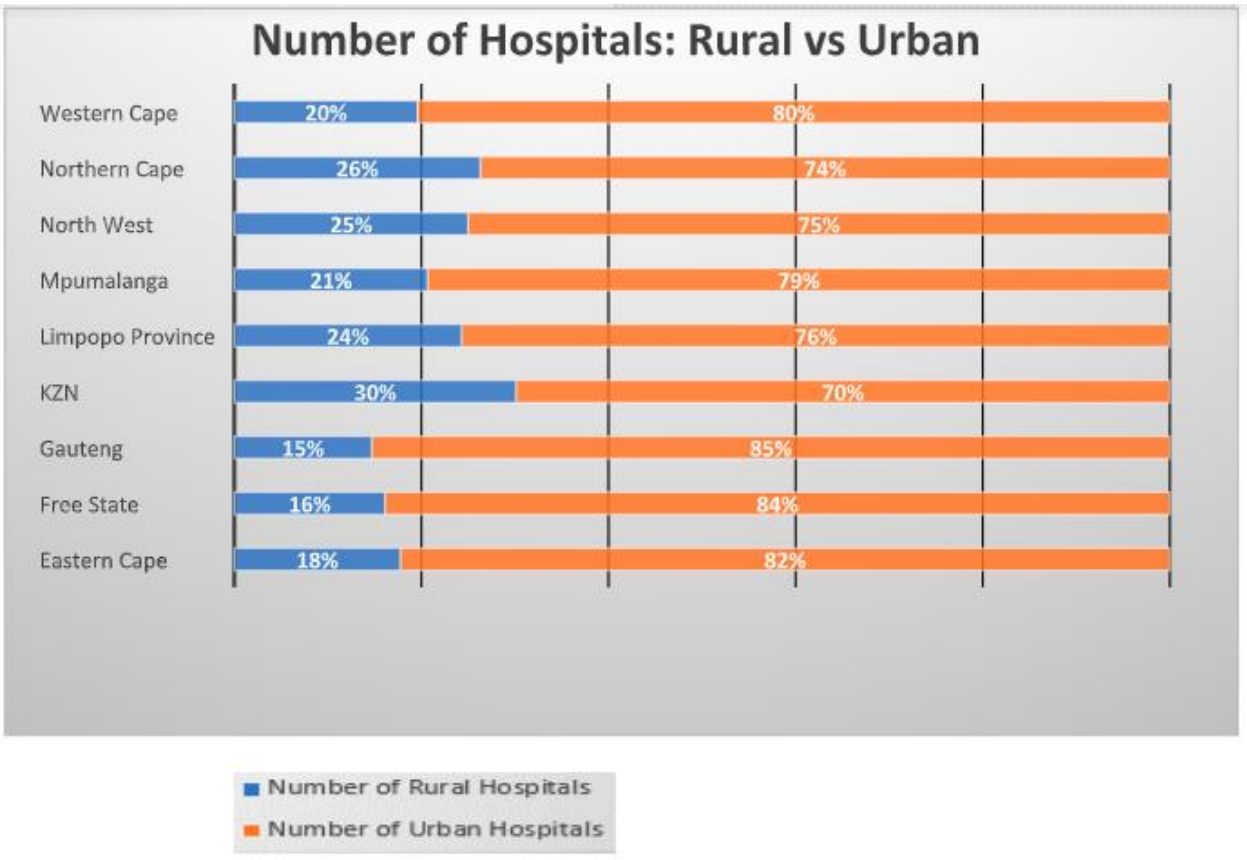


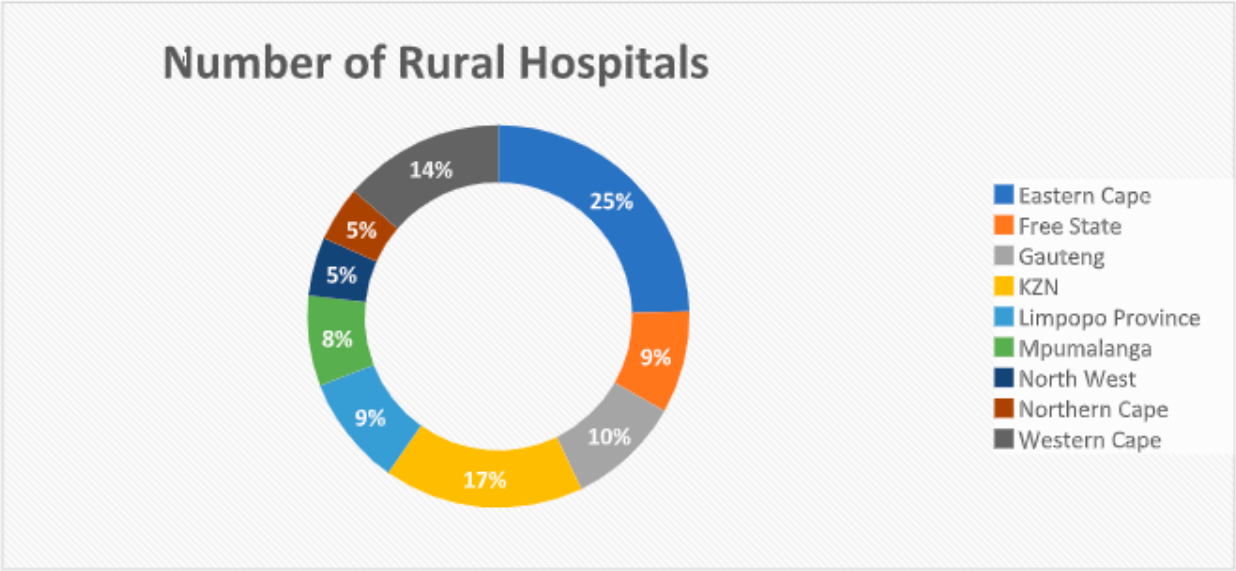
Figure 2 below shows the spread of hospitals per province. KwaZulu Natal, Northern Cape and North West have the greatest proportion of rural hospitals.

Figure 2: number of hospitals rural versus urban, per province



In terms of the number of rural hospitals per province, the highest number of rural hospitals is in the Eastern cape, followed by KwaZulu Natal and Western Cape.

Figure 3: Rural Hospitals per province



The World Health Organisation outlines that equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

Section 27 (1) of the Constitution provides that everyone has the right to have access to— (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. Section 27 (2) of the Constitution says that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. And Section 27 (3) says that no one may be refused emergency medical treatment.

The infrastructure inequality gap needs to be addressed as part of the state's Constitutional obligations and its commitment to health equity.

RURAL-PROOFING THE BUDGET

Rural-proofing may be defined as a process which ensures that all relevant executive policies are examined carefully and objectively to determine whether or not they have a different impact in rural areas from that elsewhere, because of the particular characteristics of rural areas: and where necessary, what policy adjustments might be made to reflect rural needs and in particular to ensure that as far is possible public services are accessible on a fair basis to the rural community (DEFRA, 2002:2). Rural-proofing of budgets involves looking at policy and strategic planning through a rural lens. It asks policy makers and planners to first think about the impact a policy or intervention will have in a rural context and then how that policy or intervention can be designed to ensure that rural populations are treated fairly and enjoy equal opportunities to access services as their urban counterparts.

Rural-proofing of budgets means ensuring that policy changes that affect rural areas and communities are funded equitably and account for the higher costs of implementation in rural areas due to the lower economies of scale.

The RHAP cautions that designing universal “packages of care” are insufficient on their own; these need to be in reach of rural people through sufficient staffing, outreach and dignified referral services. Rural-proofing is not a choice - it is a critical intervention to achieve the goals of NHI and to ensure that ‘rural people’ are not ‘traded off’ against average gains for the higher costs of bringing healthcare in reach of all.

As part of its ‘New Rural Paradigm’ the OECD has advocated for cross-sectoral approaches to rural development that focus on infrastructure, economic development, public service provision and the “valorisation of rural amenities” (natural and cultural) (OECD, 2006).

The implementation of the National Health Insurance as a policy change in the health sector offers some potential for rural-proofing by creating work opportunities while simultaneously ensuring that rural populations gain equal access to services when compared to those living in cities. To gear for the implementation of the NHI, government can focus on ensuring that rural amenities such as clinics and hospitals are upgraded and remain well-maintained. By focusing on rural infrastructure, job opportunities in the construction sector can be created. For the job opportunities to genuinely accrue to rural citizens, a well-designed programme that offers the opportunity to people to receive a high quality training in artisanal skills is required. Bearing in mind that procurement requirements include specific percentages of local content, this will ensure that those

in the areas where the infrastructure projects are undertaken, have the requisite skills to contribute to ensuring that health amenities in their areas are well-built and well-maintained.

WHY A GENDER RESPONSIVE BUDGETING LENS

On 29 and 30 November 2018, a Gender Responsive Planning and Budgeting Summit was held in Gauteng. At this summit, South Africa recommitted itself to Gender Responsive Planning and budgeting. The summit declaration affirmed that "gender-responsive planning, budgeting, monitoring and evaluation and gender auditing is a critical country intervention to improve the quality of life of women and girls in South Africa". Attendees, including government and civil society committed themselves in the declaration to the development and implementation of a Gender-Responsive Planning, Budgeting, Monitoring, Evaluation and Auditing Framework in South Africa[2].

Gender Budgeting, also referred to as Gender Responsive Budgeting (GRB), is a tool that can be applied with the purpose of integrating gender perspectives in the budgeting process (UN Women, 2016). Gender Budgeting is not about designing separate budgets for women, rather as UN Women outlines, it seeks to ensure that the collection and allocation of public resources is carried out in ways that are effective and contribute to advancing gender equality and women's empowerment (Unwomen.org.au, 2019). Oxfam concurs that "it's not about 'budgets for women', instead, a gender-responsive budget is a budget that works for everyone – women, men and, girls and boys – by ensuring gender-equitable distribution of resources and by contributing to equal opportunities for all".

While a facet of gender-responsive budgeting does entail analysing government budgets to assess the effects that allocations have on the different genders, it is about much more than simply providing and analysing sex disaggregated data. When Gender Responsive Budgeting is done well, it results in actual changes in the budget in a manner that ensures that gender equality commitments that government has made are achieved. As Stotsky (2016) highlights "Gender budgeting is an approach to budgeting that can improve it, when fiscal policies and administrative

[2] Declaration of the Gender Responsive Planning and Budgeting Summit. Available at: https://www.gov.za/speeches/declaration-gender-responsive-planning-and-budgeting-summit-1-dec-2018-0000

procedures are structured to address gender inequality … When properly done, one can say that gender budgeting is good budgeting".

Gender responsive budgeting is also not only preoccupied with expenditure. As Sharp and Elson outline "gender responsive budget initiatives are strategies for assessing and changing budgetary processes and policies so that expenditures and revenues reflect the differences and inequalities between women and men in incomes, assets, decision-making power, service needs and social responsibilities for care".

On the revenue side, a Gender Responsive Budget considers the impacts of the manner in which revenue is raised (tax and borrowing choices) from a gender perspective. It also considers how revenues are lost, for example, through illicit financial flows, tax evasion and base erosion & profit shifting. And what the implications of this are. In tight fiscal circumstances, the implications may be in the form of cuts to expenditure to balance the budget. The gender lens serves to be aware that certain areas of expenditure that get cut may particularly support vulnerable groups such as unemployed rural women and children in their care.

On the expenditure side, Gender Responsive Budgeting considers the proportions of budget allocations to specific expenditure areas (such as health, education, social development, debt service costs etc.) and how the expenditure impacts the socioeconomic status and opportunities of women and men as well as the lesbian, gay, bisexual, transgender, queer and/or questioning, intersex and asexual (LGBTQIA) community. It considers how effectively allocations are being spent and their impact from a gender perspective, whether the allocations are sufficient and whether they are made in a manner that closes the gender gap. As Elson observes, it is important to have a sound understanding of the magnitude, trends and effectiveness of targeted expenditures on women and girls to improve the expenditure effectiveness of budgets. Such analysis is also cognizant of the norms and roles associated with men and women, and the relationship between genders and how spending choices may reinforce that in a negative manner. For example, jobs that typically attract women being remunerated at lower rates than jobs that typically attract men.

SPENDING PRIORITIES OVER THE NEXT THREE YEARS

Analysis of Medium-Term Budget Policy Statement

The Medium-Term Budget Policy Statement is an expression of government's fiscal and budget policy position for the Medium Term Expenditure period. It is an indication of the rationale for the budget allocations that will be made when the February budget is tabled and highlights the economic, policy and contextual factors that are informing the choices being made. We note that economic growth estimates are lower than expected and revenue projections have consequently been reduced sharply and that Treasury has highlighted mounting spending pressures led by the public service wage bill and state-owned companies in crisis.

The consolidated fiscal framework presented in MTBPS 2019 revealed that the revised budget deficit is R306.2 billion. To plug the deficit, we note that government is clawing back some of the revenue shortfall through reductions to departmental baselines and slower spending growth in the outer year of the medium-term expenditure framework (MTEF). Spending reductions of R21 billion in 2020/21 and R29 billion in 2021/22 are being made, mostly in the area of goods and services, and transfers. However, additional measures in excess of R150 billion over the next three years, or about R50 billion a year are still needed. The proposed additional measures mostly entail measures relating to the wage bill, which must still be discussed with the unions. In the 2019 budget, the measures relating to the wage bill that were announced were early retirement without penalisation, national macro reorganisation of government, reducing performance bonuses, and freezing of salaries for members of the executive and parliamentarians. These measures did not lead to the savings that National Treasury had hoped for. Therefore, how realistic the latest additional measures are is debatable.

While RHAP is cognisant of the many challenges, we are not convinced that the path that Treasury proposes to restore the public finances to a sustainable position is the best one. Whereas concerns about public debt levels were central in the MTBPS 2019 messaging, we think that job creation did not receive sufficient attention.

Seven out of ten young people are unemployed. Yet, we have the opportunity to make use of a demographic dividend and because many of the factors constraining our growth are endogenous, they are within government’s control to address. Instead of the downward spiral that we are on, there’s a need to invest in a better, more prosperous future. To generate more tax revenue, we advocate that there is a need to boost employment, improve the enabling environment for businesses and focus on social stimulus.

The International Labour Organisation, European Union and Institute for International Labour Studies conducted a review of global fiscal stimulus. Amongst the main findings (2011:2), an evaluation of country efforts revealed that countries that showed relatively better GDP and employment recovery also had implemented bigger stimulus packages as a percent of GDP. Another of the main findings was that "*because of rising government deficits and sky-rocketing public debt, several governments have embarked on fiscal austerity measures to rein in public spending and get the public finances in order. Cutting or reducing certain programmes, while improving fiscal balances in the short run, could undermine the fragile recovery underway. In fact, spending on labour market programmes can help job seekers to find new employment opportunities more rapidly, while at the same time sustaining disposable income and demand – which can help fiscal balances in the long run*".

Instead of looking at social spending as a leakage, it needs to be reframed as an investment in our future. Through effective spending in the health sector, health can be an enabler. A social solidarity fund like National Health Insurance can support people to fully prosper. Infrastructure investment in healthcare facilities can bring jobs to areas where there are no jobs. Health care receives more allocation than economic development. Economic Development is considered a process of structural change that facilitates a sustained rise in the living standards of the population as a whole. We advance that in these constrained times, we need to be innovative and consider that healthcare spending can be put to use in bringing about a more prosperous economy. Investing in a healthy, well-nourished population will raise overall living standards and would ensure that youth are better supported to have good educational outcomes and go on to become an active part of the labour force. Health spending has a role to play as a catalyst for inclusive growth. Investing in health and social infrastructure can also offer short-term stabilisation and long-term growth.

Youth employment opportunities can be created at the same time as simultaneously addressing the 'infrastructure inequality trap' outlined earlier in this submission, which is where provinces with comparatively well-developed health infrastructure and human resourcing compliments tend to receive a larger share of available resources.

In order to address the infrastructure inequality gap, RHAP recommends prioritising improvements to rural infrastructure. A practical manner to do so would be to develop a health infrastructure prioritisation tool that gives a weighted priority to improving rural health

infrastructure first to promote construction jobs in rural areas and to address the infrastructure inequality trap.

RHAP notes that National Treasury included updated cost estimates for National Health Insurance in the 2019 MTBPS. Treasury outlined that originally, NHI costs were projected to increase public health spending from about 4 per cent to 6 per cent of GDP over 15 years, but that given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 are no longer affordable. The MTBPS outlines that the National Treasury assisted the Department of Health to develop an actuarial model with updated fiscal costs and limited policy reforms to strengthen the current healthcare system. The revised model estimates that rolling out NHI would require an additional R33 billion annually from 2025/26. Treasury was also tentative in outlining that the amounts are not budget commitments but indicative cost estimates. RHAP is concerned that the policy reform entailed in the introduction of the National Health Insurance may be undermined through insufficient budget allocation to support its success.

Audit outcomes as a reflection on National and Provincial government spending priorities

While social spending should not be framed as leakage, the leakage that does need to be dealt with decisively is taxpayer money being wasted through corruption instead of being spent on the services it was budgeted to be spent on.

Quantifying the cost of corruption in terms of a figure is not straightforward. RHAP is cognisant that the categories of irregular expenditure, unauthorised expenditure, and fruitless and wasteful expenditure that the Auditor General reports on, added up, do not simply equal money lost to corruption which could have been spent on services. RHAP welcomes the procurement reforms to the Public Audit Act which became effective on 1 April 2019 and which introduced the concept of a material irregularity. If the material irregularity relates to a financial loss, the value will be the loss. For 2018/19, the Auditor General's office implemented the approach with 16 auditees. RHAP notes that a total of 28 material irregularities were identified with R2.81 billion in financial loss in the 2018/19 financial year. Of the material irregularities, the Provincial Department of Human Settlements in Free State had the most material irregularities with 10 being identified and PRASA had 9 material irregularities. In the Health Sector, the Gauteng Provincial Department of Health had 2, the Northern Cape Department of Health had 2 and the KwaZulu Natal Department of

Health had 1. When material irregularities is reported on for all auditees in the future, this procurement reform will provide a more accurate sense of the leakage of public finance that could have been spent on services, but was not. RHAP also welcomes that the new procurement reforms allow the Auditor General to:

- ➢ Refer material irregularities to relevant public bodies for further investigation
- ➢ Take binding remedial action for failure to implement recommendations for material irregularities
- ➢ Issue a certificate of debt for failure to implement remedial action if financial loss was involved

The Auditor General's work provides the most accurate available reflection on the financial health of departments and for 2018/19 indicates that there is much room for improvement. Many Departments are not prioritising a culture of accountable spending of tax payer money to deliver services efficiently and effectively. Efficient, economic and effective use of resources must be promoted as envisioned in section 195 of the Constitution. Examining the Auditor General's Consolidated General Report on national and provincial audit outcomes for 2018/19 provides insight into where improvements must be made in this regard.

RHAP joins Auditor-General, Kimi Makwetu, in expressing concern that the 2018/2019 report shows that there is R62.6 billion in irregular expenditure, which is up by R11.6 billion from the 2017/18 financial year figure of R51 billion in irregular expenditure. The figure could be even higher, because certain contract information could not be obtained from auditees.

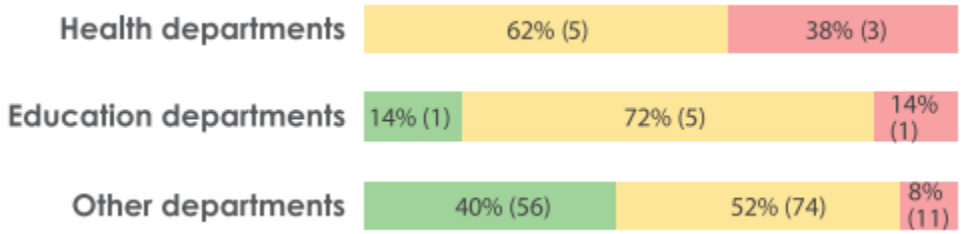
None of the State Owned Entities that the Auditor General audits received a clean audit and the Auditor General has said that the level of irregular expenditure at State Owned Entities is very worrying. The Auditor General notes that the financial health of SOEs remains under significant pressure, with material uncertainties regarding auditees' ability to continue with operations in future without financial assistance at Denel, the South African Broadcasting Corporation, the Petroleum Oil and Gas Corporation of South Africa (a major subsidiary of the Central Energy Fund), South African Express Airways and the South African Post Office is reported. There is also a trend of SOEs not providing their financial statements, preventing the completion of audits. The Auditor General reports that most of the SOEs where audits had not yet been completed are facing going concern challenges.

The Auditor General does not audit all SOEs and reports that the irregular expenditure of the SOEs they did not audit amounted to R57 billion, which included R49,9 billion at Transnet and R6,6 billion at Eskom – these amounts are not included in the irregular expenditure of R62,60 billion. The significant increase in irregular expenditure at these SOEs was due to a drive to clean up past irregularities.

What is also concerning is that instead of outcomes improving, the trend is worsening and there is a trend of the AG's recommendations not being implemented in departments. The Auditor General reported that they again focused on the management and delivery of the key government programmes for water infrastructure development, housing development finance, school infrastructure 12 delivery, expanded public works programme, and district health services (HIV/Aids, TB as well as maternal and child health). The Auditor General notes that there has been little improvement on these programmes, as not all the AG's recommendations have been implemented.

The Auditor General outlines that the financial health of provincial departments of health and education needs urgent intervention to prevent the collapse of these key service delivery departments. In comparison with the other departments, these sectors (particularly the health sector) are in a bad state, as demonstrated below:

Figure 4: Financial Health of Provincial Departments of Health and Education



Source: Auditor General. PFMA report 2018-19: Section 4: Financial Management in Provincial and National Government

In the Medium Term Budget Policy Statement, Treasury notes that Medical legal claims against provincial health departments continue to increase, from R80 billion in 2017/18 to R99 billion in 2018/19. Payments against these claims amounted to R2 billion in 2018/19, compared with R1.5 billion paid out in 2017/18. These claims against the state negatively affect service delivery. The Auditor General calculated the claims as a percentage of next year's budget:

Province	Vulnerable position	Unauthorised expenditure	Deficit	% of cash shortfall funded by next year's operational budget*	Claims as % of next year's budget
Provincial education departments					
Free State	Yes	R280 million	R452 million	82,3	2,4 (R38 million)
Gauteng	No	-	R472 million	0,4	5,8 (R478 million)
KwaZulu-Natal	No	R11,9 million	No deficit	14,5	16,1 (R1 038 million)
Mpumalanga	No	-	No deficit	23,4	7,4 (R205 million)
Northern Cape	No	R18,8 million	No deficit	27,3	7 (R75 million)
North West	No	-	No deficit	2,8	16,3 (R375 million)
Western Cape	No	-	No deficit	0,5	7,7 (R274 million)
Provincial health departments					
Eastern Cape	Yes	R569 million	R3 million	7	366,3 (R29 million)
Free State	Yes	-	R134 million	7,9	68 (R2 511 million)
Gauteng	No	-	R4 281 million	14,7	116,74 (R24 756 million)
KwaZulu-Natal	No	R14 million	R1 347 million	0,3	135 (R20 730 million)
Limpopo	No	-	R1 053 million	0,1	185 (R8 499 million)
Mpumalanga	No	-	R207 million	4,6	182 (R10 091 million)
Northern Cape	No	R22 million	R553 million	8,7	49,1 (R2 107 million)
Western Cape	No	-	No deficit	0	1,4 (R126 million)

*** These departments will start the 2019-20 financial year with part of their budget effectively pre-spent**

Source: Auditor General. PFMA report 2018-19: Section 4: Financial Management in Provincial and National Government

As an example of how the claims negatively affect service delivery, the Auditor General highlighted that for the Mpumalanga Provincial Department of Health:

"The department's budget for claims in 2018-19 amounted to R68-million, but the total claims paid out for the year amounted to R499 million. As a result, vacant positions of chief executive officers and nurses were not filled timeously at some hospitals. The maintenance and purchasing of new ambulances were also affected, which in turn had an impact on the services rendered by hospitals."

As the Auditor General notes, many of the issues in Departments are not new and of more concern, are not being rectified. To illustrate this, as above, unauthorised expenditure was incurred by the Eastern Cape (R569 million), KwaZulu Natal (R14 million) and Northern Cape (R22 million) in the 2018/19 financial year. Each of these provincial departments also incurred unauthorised expenditure in 2017/18 which can be seen in the table below.

Table 6: 2017/18 National and Provincial view

NATIONAL AND PROVINCIAL VIEW

	Irregular (R million)	Unauthorised (R million)	Fruitless and wasteful (R million)
National	R15 744 35% of total 3% of national budget	R584 27% of total 0,2% of national departmental budget	R1 924 78% of total 0,3% of national budget
KwaZulu-Natal	R9 917 22% of total 7% of provincial budget	R509 24% of total 0,4% of provincial departmental budget	R12,3 1% of total < 0,1% of provincial budget
Gauteng	R6 367 14% of total 5% of provincial budget	None	R199 8% of total 0,2% of provincial budget
Free State	R3 860 8% of total 6% of provincial budget	R513 24% of total 1,5% of provincial departmental budget	R16 1% of total < 0,1% of provincial budget
North West	R3 065 7% of total 8% of provincial budget	None	R55,4 2% of total 0,1% of provincial budget

Limpopo	R2 471 5% of total 4% of provincial budget	R193 9% of total 0,3% of provincial departmental budget	R215 9% of total 0,3% of provincial budget
Mpumalanga	R2 218 5% of total 4% of provincial budget	R37 2% of total 0,1% of provincial departmental budget	R2,3 0,1% of total < 0,1% of provincial budget
Northern Cape	R1 050 2% of total 6% of provincial budget	R231 11% of total 1,4% of provincial departmental budget	R6 0,2% of total < 0,1% of provincial budget
Eastern Cape	R860 2% of total 1% of provincial budget	R58 3% of total 0,1% of provincial departmental budget	R23 1% of total < 0,1% of provincial budget
Western Cape	R44 0,1% of total 0,1% of provincial budget	None	R0,2 < 0,1% of total < 0,1% of provincial budget

Expenditure of 5% or higher of the provincial budget is highlighted in red

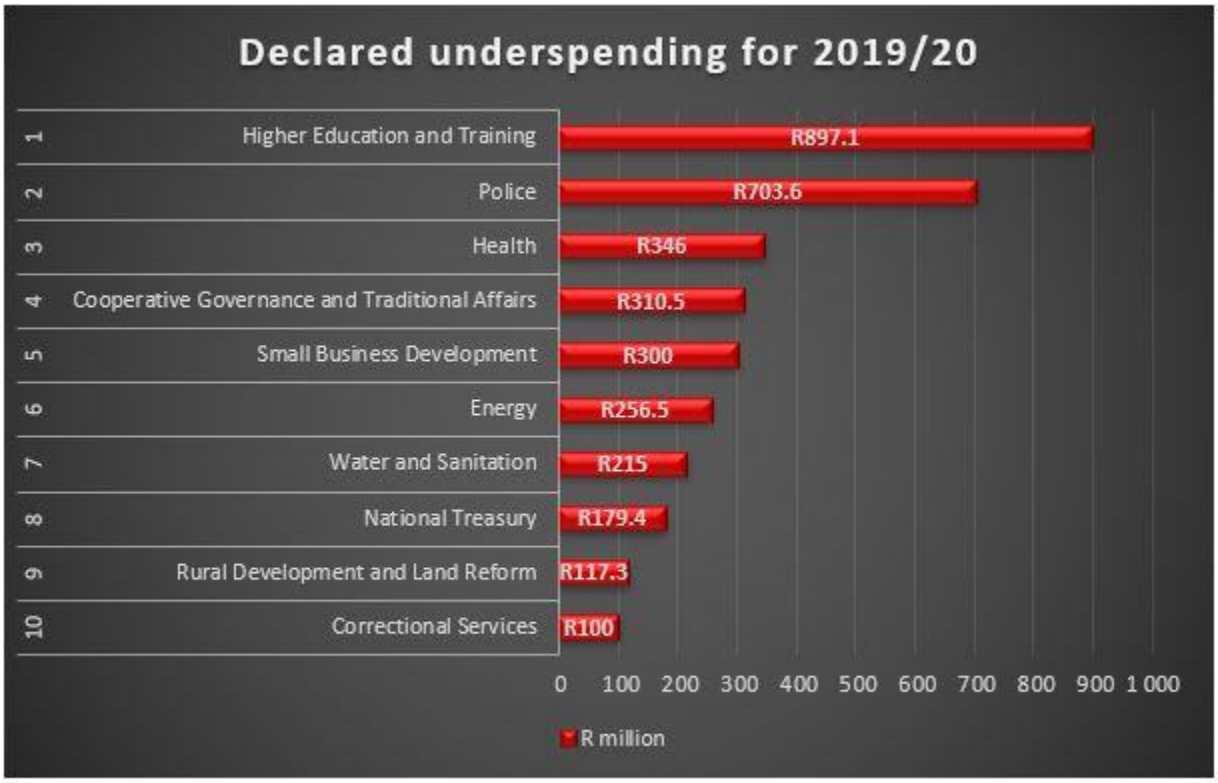
Source: Auditor General's Consolidated General Report on national & provincial audit outcomes: 2017/18

ANALYSIS OF THE ADJUSTED BUDGET FOR HEALTH VOTE

Declared underspending

RHAP notes that this year R3,9 billion was declared unspent halfway through the year. The same time last year, a much smaller amount of R328.8 million was declared unspent. Health was among the departments declaring the greatest amount of underspending, as the figure below shows:

Figure 5: Declared underspending for 2019/2020



Source: National Treasury Adjusted Estimates of National Expenditure 2019

It is noted that R346 million was declared unspent in the 2019/20 Adjusted Budget for health. This was comprised of R230 million from the national health insurance indirect grant: personal services component, R45 million from goods and services, R30 million from the national health insurance indirect grant: health facility revitalisation component, R20 million from compensation of employees, R11 million from the human papillomavirus vaccine grant, and R10 million from the national health insurance indirect grant: non-personal services component (goods and services).

R89,3 million was rolled over. The R89.3 million roll over was for medical equipment in Limpopo. R8.8 million was shifted between votes.

The underspending declared in Programme 3: Communicable and Non-communicable diseases is particularly concerning. Subprogrammes dealing with HIV, AIDS and STIs, Tuberculosis Management, Women's Maternal and Reproductive Health, Child, Youth and School Health and Health Promotion and Nutrition will all be spending less money than initially allocated, now that it has been declared unspent and/or shifted/vired away from the subprogramme.

Programme 3: Communicable and Non-communicable Diseases

Subprogramme	2019/20							
		Adjustments appropriation						
R thousand	Appropriation	Roll-overs	Virements and shifts	Shifts between votes	Declared unspent funds	Other adjustments	Total adjustments appropriation	Adjusted appropriation
Programme Management	5 250	–	100	–	–	–	100	5 350
HIV, AIDS and STIs	22 572 408	–	(103 427)	–	(38 900)	–	(142 327)	22 430 081
Tuberculosis Management	27 748	–	(1 000)	–	–	–	(1 000)	26 748
Women's Maternal and Reproductive Health	20 299	–	(1 800)	–	(1 700)	–	(3 500)	16 799
Child, Youth and School Health	237 608	–	(43 000)	–	(11 000)	–	(54 000)	183 608
Communicable Diseases	24 058	–	–	–	–	–	–	24 058
Non-communicable Diseases	65 702	–	1 900	–	–	–	1 900	67 602
Health Promotion and Nutrition	54 196	–	–	–	(11 300)	–	(11 300)	42 896
Total	**23 007 269**	**–**	**(147 227)**	**–**	**(62 900)**	**–**	**(210 127)**	**22 797 142**
Economic classification								
Current payments	**563 564**	**–**	**(104 436)**	**–**	**(51 900)**	**–**	**(156 336)**	**407 228**
Compensation of employees	167 903	–	(109)	–	(13 000)	–	(13 109)	154 794
Goods and services	395 661	–	(104 327)	–	(38 900)	–	(143 227)	252 434
Transfers and subsidies	**22 443 341**	**–**	**(42 891)**	**–**	**(11 000)**	**–**	**(53 891)**	**22 389 450**
Provinces and municipalities	22 250 195	–	(43 000)	–	(11 000)	–	(54 000)	22 196 195
Departmental agencies and accounts	18 066	–	–	–	–	–	–	18 066
Non-profit institutions	175 080	–	–	–	–	–	–	175 080
Households	–	–	109	–	–	–	109	109
Payments for capital assets	**364**	**–**	**100**	**–**	**–**	**–**	**100**	**464**
Machinery and equipment	364	–	100	–	–	–	100	464
Total	**23 007 269**	**–**	**(147 227)**	**–**	**(62 900)**	**–**	**(210 127)**	**22 797 142**

Source: 2019 Adjusted Estimates of National Expenditure

Performance

The 2019/20 performance target in terms of the number of facilities maintained, repaired and/or refurbished funded by the National Health Insurance indirect grant is 45 facilities for the year. At mid-year, only 7 facilities had been worked on. Disappointingly, R30 million from the national health insurance indirect grant: health facility revitalisation component was declared unspent. While RHAP notes that the Department of Health (NDOH) does anticipate that the remaining health facilities in national health insurance districts will reach completion stage in the second half of the financial year, we are concerned that with the reduced allocation, the quality of the work may be undermined.

It is reported that the department is on track to exceed its target for mother-to-child transmission of HIV, which at the end of August 2019 was 0.68 per cent against the annual target of 0.9 per cent. However, the antiretroviral treatment programme is progressing somewhat slower than anticipated, with 4.8 million clients against a target of 5.8 million. The uptake is particularly slow among children and men, where the coverage is 60 percent and 62 percent respectively,

compared to 72 percent among females. The department intends to intensify efforts to reach the target of 6.1 million total clients on antiretroviral treatment by December 2020. RHAP draws the attention of the Appropriations Committees to these gendered dynamics relating to the uptake of antiretroviral treatment. Communications work could be done to try to address this trend. RHAP recommends that the Appropriations Committees request the department to explain what it plans to do to intensify its efforts to ensure this critical target is met.

It is noted that there are several performance targets where the Department is reporting that it has already exceeded its target. Notably, 1 920 public health care facilities qualify as ideal clinics against a target of 1 800, and the chronic medicines programme has already met its annual target. RHAP also notes that during the first half of 2019/20, the department assessed 30 municipalities for adherence to environmental health norms and standards against an annual target of 31. This performance target is in support of the department's programme to emphasize environmental determinants of health, such as sanitation and food safety monitoring, as part of the delivery of environmental health services by municipalities. RHAP welcomes this performance and congratulates the NDOH.

RHAP also notes that the department has already exceeded its annual target for the number of individuals registered on the national health insurance patient beneficiary registry. Unfortunately, the mid-year performance reporting indicates that protracted negotiations with Gauteng provincial facilities have caused delays in the implementation of the system in additional facilities. These and other challenges that have emerged in the Gauteng health sector require ongoing attention to resolve. It is important that they do get resolved.

On a positive note, the NDoH in partnership with the Department of Science and Technology and the Council for Scientific and Industrial Research (CSIR), developed the Health Patient Registration System (HPRS), which commenced in July 2013[3]. The use of Information Technology that functions well can significantly improve outcomes in the health sector. This intergovernmental cooperation between NDOH, DST and CSIR is commended.

In assessing performance, RHAP has examined more than the performance indicators supplied in the Adjusted Budget, but has also referred to South Africa's Sustainable Development Goal (SDG) report for 2019. SDG 3 is "Ensure healthy lives and promote well-being for all at all ages".

[3] Gov.za. Update on progress and achievements in 2016/17. Available at: https://www.gov.za/issues/health

It seeks to ensure health and well-being for all, at every stage of life. The Goal addresses all major health priorities, including reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage; and access for all to safe, effective, quality and affordable medicines and vaccines. It also calls for more research and development, increased health financing, and strengthened capacity of all countries in health risk reduction and management (UN, 2019).

In South Africa's country report, Statistics South Africa summarizes SDG3 performance (Statistics South Africa. 2019b), outlining that South Africa has made notable progress in reducing the maternal mortality ratio (3.1.1), the under-5 mortality rate (3.2.1), neonatal mortality rate (3.2.2) and the infant mortality rate (3.2.2A1). New HIV infections have also slowed down (3.3.1) and the incidence of tuberculosis has declined (3.3.2). Despite significant progress, the incidence of HIV and tuberculosis remains very high. South Africa is seeing an increase in the harmful use of alcohol (3.5.2).

3.3.1A1: HIV prevalence (additional indicator)	15–24-year-olds: 9.3% (2005), 10.3% (2008), 7.1% (2012), 7.9% (2017)
	15–49-year-olds: 15.6% (2005), 16.2% (2008), 18.8% (2012), 20.6% (2017)
3.3.1A2: The number and percentage of people living with HIV exposed to antiretroviral treatment by age and sex (additional indicator)	Male: 25.7% (2012), 56.3% (2017)
	Female: 34.7% (2012), 65.5% (2017)
3.3.2: Tuberculosis incidence per 100 000 population	981 (2010), 1 003 (2012), 834 (2014), 567 (2017) (unit: incidence per 100 000)

Source: South Africa's Sustainable Development Goal country report

South Africa's SDG report concurs with the Department's performance indicator reporting about women's uptake of antiretroviral treatment being greater than men's uptake. It is worth highlighting the proportion of the population covered by vaccines.

3.b.1: Proportion of the target population covered by all vaccines included in their national programme	DTP: 68.9% (2010), 97.3% (2014), 94.2 (2015), 71.4 (2016), 84.1% (2017)
	Measles: 68.4% (2010), 73.2% (2014), 74.5 (2015), 82.7 (2016), 77.6% (2017)
	Pneumococcal conjugate: 52.1% (2010), 83.9% (2014), 85.2 (2015), 76.0 (2016), 78.8% (2017)
	HPV: 64% (2015), 68.8% (2016), 61.4% (2017)

Source: South Africa's Sustainable Development Goal country report

As is evident above, in 2017, there had been a reversal in terms of the percentage of the target population covered by HPV vaccination. Mid-way through the year, R11 million was declared unspent on the human papillomavirus vaccine grant. HPV is a common sexually transmitted infection. This allocation was to a programme for child, youth and school health communicable diseases. In other words, it is school-going girls who will not be tested due to the declared underspending. HPV can lead to genital warts and cancer. But it is preventable with a vaccine.

Focusing on teenage pregnancy, SDG indicator 3.7.2 provides insight:

3.7.2: Adolescent birth rate (aged 10–14 years; aged 15–19 years)	10–14-year-olds: 1.2 (2010), 1.6 (2013), 1.4 (2015), 64.7 (2016), 0.6 (2017) (unit: per 1 000 females)
	15–19-year-olds: 65 (2010), 73.9 (2013), 64.7 (2015), 55.4 (2016) 46.2 (2017) (unit: per 1 000 females)

Source: South Africa's Sustainable Development Goal country report

Teenage pregnancy can have the effect of preventing girls from completing their schooling and this in turn can stop them from entering the labour market and being economically empowered. If girls have access to family planning, support in the form of social protection and good health care, teenage pregnancy is less disempowering for girls.

In 2016, 75,6% of women of reproductive age have their need for family planning with modern methods satisfied.

3.7.1: Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	75.7% (2016)

Source: South Africa's Sustainable Development Goal country report

As Statistics South Africa notes, South Africa has made notable progress in reducing the maternal mortality ratio (3.1.1), the under-5 mortality rate (3.2.1), neonatal mortality rate (3.2.2) and the infant mortality rate (3.2.2A1).

3.1.1: Maternal mortality ratio	276 (2007), 184 (2011), 121 (2016) (unit: deaths per 100 000 live births)
3.1.2: Proportion of births attended by skilled health personnel	84% (1998), 96.7% (2016)
3.1.2A: Percentage of mothers and children who receive post-natal care either at home or in a facility and within 6 days of delivery (additional indicator)	52.4% (2011), 72.6% (2014), 70.6% (2017)
3.2.1: Under-5 mortality rate	47.7 (2010), 34.7 (2013), 30.2 (2015) (unit: rate per 1 000 live births)
3.2.2: Neonatal mortality rate	19.8 (1998), 21 (2016) (unit: rate per 1 000 live births)
3.2.2A1: Infant mortality rate (additional indicator)	33.4 (2010), 25 (2013), 22.3 (2015) (unit: rate per 1 000 population)
3.2.2A2: Stillbirth rate	21.1 (2014), 21.3 (2015), 20.2 (2016), 20.9 (2017), 20.9 (2018) (unit: rate per 1 000 live births)

Source: South Africa's Sustainable Development Goal country report

The percentage of women who receive post-natal care is an area that can be improved further, particularly in rural areas.

Capacity building

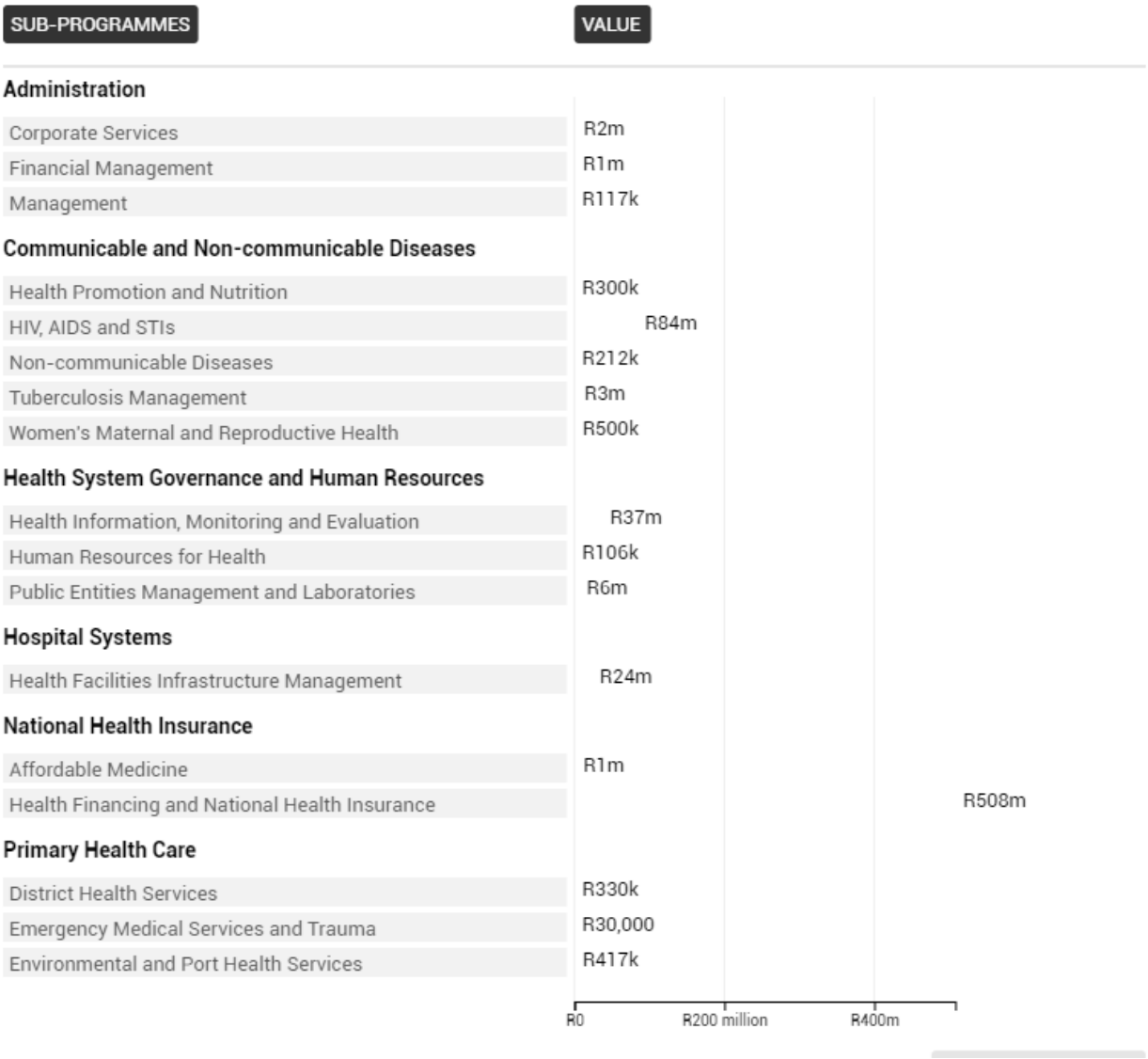
The United Nations Development Programme defines capacity as "the ability to perform functions, solve problems, and achieve objectives" at three levels: individual, institutional and societal (United Nations, 2006).

Building a stable and capable state comprised of professional, ethical public servants committed to delivery of high quality services to citizens requires a deliberate and long-term commitment from government. In debating compensation budgets, there is a need to guard against generalising and vilifying public servants. The state needs to attract talented and committed public servants who see the public sector as an attractive career opportunity.

In order to ensure that departments meet their service delivery targets, they need to have the capacity to spend allocated budgets in an accountable manner while working to meet their performance targets and deliver against norms and standards. RHAP's analysis in this section highlights the relationship between achieving spending priorities stated in government plans and the capacity (human resources) in departments. Correlating the relationships between underspending, service delivery performance and programmes with heavy reliance on consultants and contractors can serve to highlight issues of paucity of internal capacity.

The figure below shows the National Department of Health's consulting spend per sub-programme for 2018/19. There are instances in which it is appropriate to make use of consultants because a Department does not require those skills on an ongoing basis in the form of permanent employees, as the skill is not central to their mandate, however where there is extensive consulting spend and reliance on consultants, a department needs to ask if it is more appropriate to build the capacity internally. Subprogrammes that stand out as having high consulting spend are Health Financing and National Health Insurance; HIV, AIDS and STIs and Health Information, Monitoring and Evaluation.

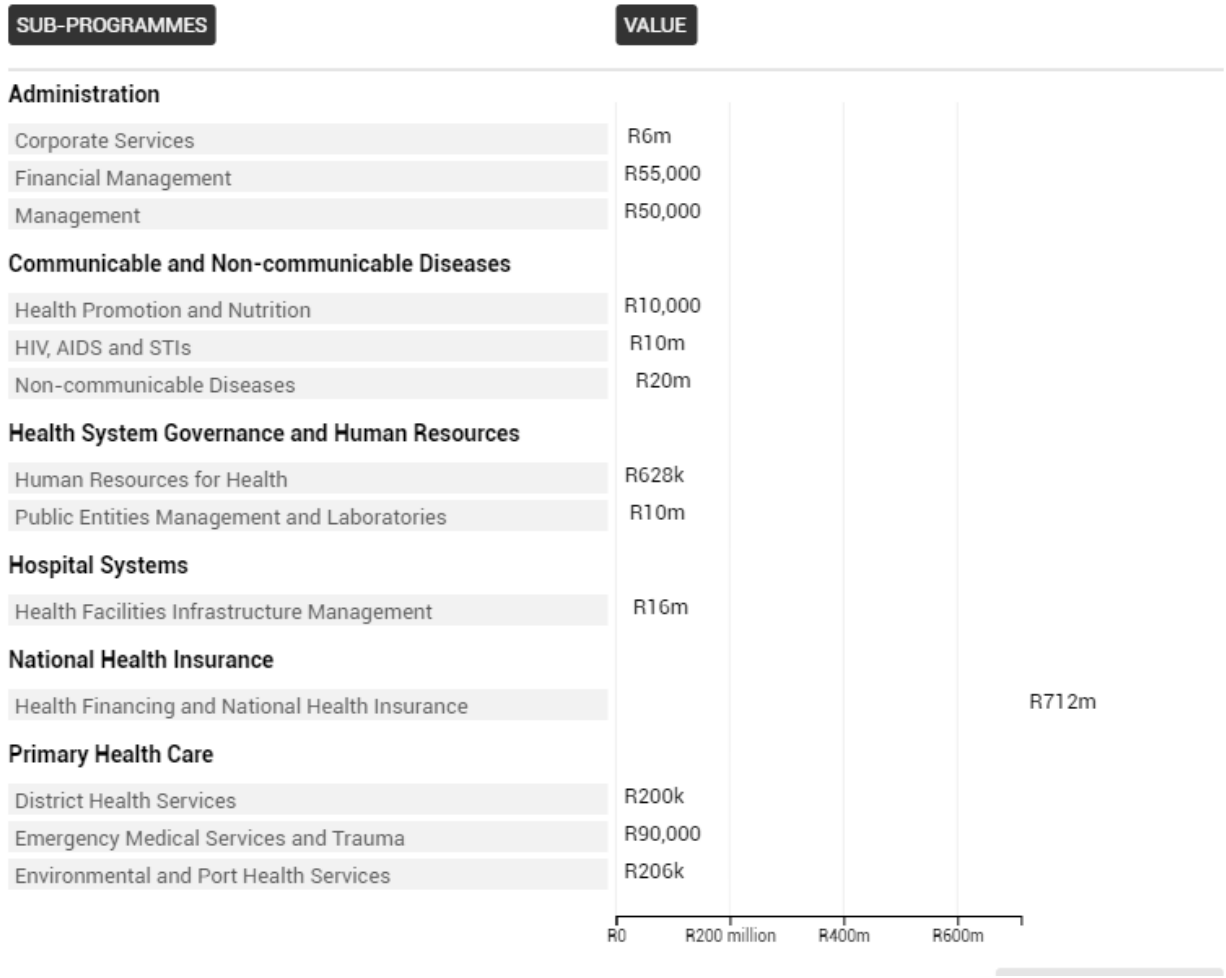
Figure: Budget for Consultants: Business and Advisory Services for 2019/20



Source: Vulekamali Budget Portal

What is notable is a pattern that is fairly similar per sub-programmes for budget for contractors:

Table: Budget for Contractors: Business and Advisory Services for 2019/20



Source: Vulekamali Budget Portal

Health Financing and National Health Insurance; Health Facilities Infrastructure Management; Non-communicable Diseases and HIV, AIDS and STIs have notable amounts of budget for contractors.

In the current environment in which compensation budgets are under pressure and posts are frozen, it can also indicate how distortions are occurring through hiring consultants or contractors instead in order to get around posts being frozen. The issues that arise from this is that the labour rights of those essentially performing the work of government officials are more tenuous and the Department battles to retain such skills.

When looking at the total adjustments per programme, the programmes that are seeing budgeted funds vired/shifted away from them or declared underspending in 2019/20 are communicable and non-communicable diseases and National Health Insurance. These are also where the highest consulting spend in the health sector is going in 2019/20.

Source: Vulekamali Budget Portal

Because NHI is a new policy reform that is being implemented, the Department of Health may not yet have put internal teams in place with experienced officials who are geared to spend allocated budgets and to provide sufficient interface with consultants who are supporting government. RHAP highlights this to illustrate drivers of spending performance are linked to internal capacity. In this case, building the capacity may require hiring additional personnel, but while government is seeking to make savings in compensation budgets, Departments rolling out new policy reforms are likely to resort to making use of consulting services. RHAP recommends that consideration be given to seconding experienced officials already employed within the health sector and who have a successful track record of delivery to the NHI roll out. This could also have the effect of supporting opportunities for succession within stable programmes where those officials have been leading and there are upcoming officials who are seeking to advance their careers and are ready to take on new challenges.

RHAP seeks to highlight that capacity building can look like retaining talent through ensuring opportunities for succession while equipping a department with the capacity to spend allocated budgets to achieve service delivery targets. The planning of human resourcing matched to outcomes that departments seek to achieve is key to successful implementation.

PROPOSED ADJUSTMENTS TO CONDITIONAL GRANTS IN HEALTH SECTOR

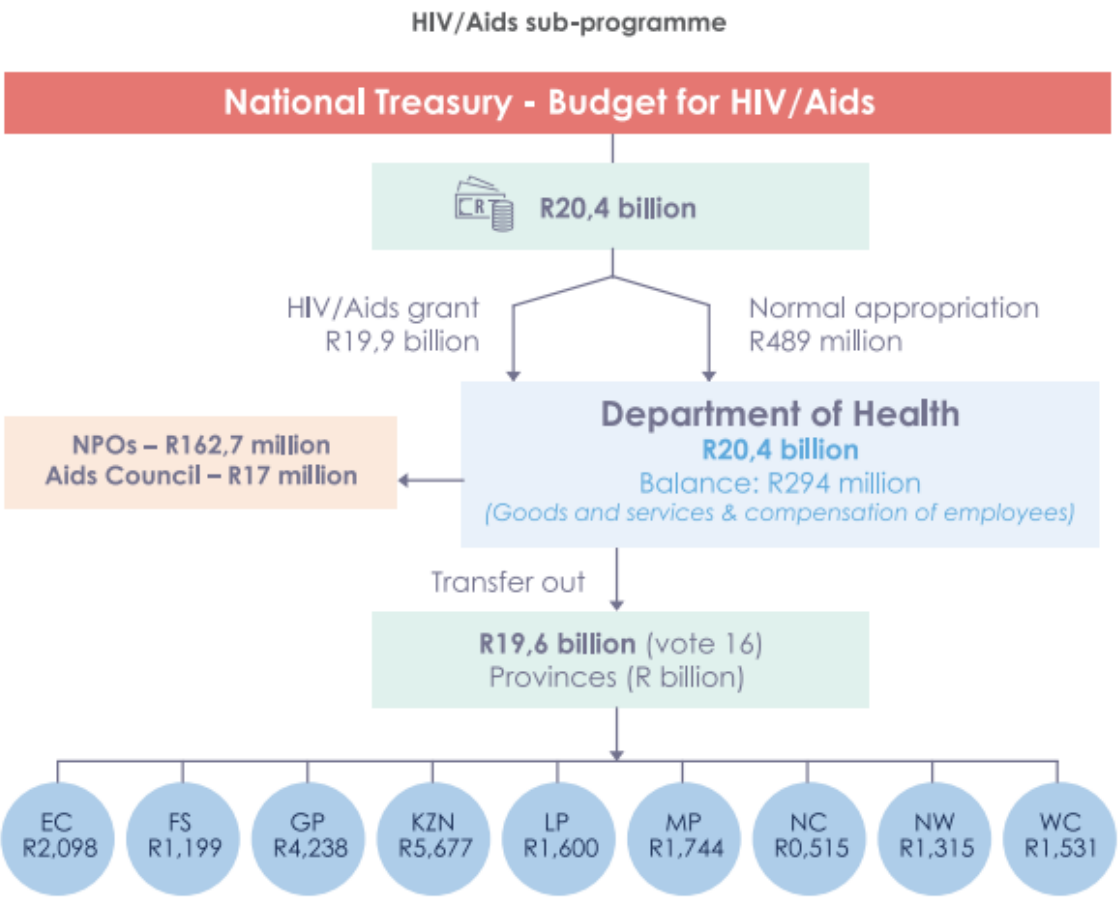
RHAP notes that several changes are proposed to the structure of conditional grants for health over the medium term. As contained in the MTBPS, these are:

- The human papillomavirus vaccination grant will be merged into the HIV, TB, malaria and community outreach grant from 2020/21.
- From 2021/22 new components will be added to the grant for mental health and oncology (funded from a shift from indirect grant).
- From 2020/21, funds for internship and community service posts will be shifted from the human resources capacitation grant to the health professionals training and development grant.
- Provinces will receive a direct grant to contract health professionals in pilot NHI districts - this is currently funded through the NHI indirect grant.
- National Treasury and the Department of Health will develop a strategy to reform health grants prior to implementing NHI.

Given that declared underspending included R230 million from the national health insurance indirect grant: personal services component, R30 million from the national health insurance indirect grant: health facility revitalisation component, R11 million from the human papillomavirus vaccine grant, and R10 million from the national health insurance indirect grant: non-personal services component (goods and services) due to slow spending on these grants it does seem to be indicated that reconsideration is needed. Spending performance is not always an indicator of lack of need, it can indicate a lack of capacity within a department to spend allocated funds. Particularly with a new area of reform such as the implementation of the NHI.

The Auditor General's 2018/19 consolidated report contains a section on the management and delivery of key programmes. The Auditor General's office selected District health services (HIV and Aids, tuberculosis and maternal and child health) as one of the key programmes to audit. The programme's objectives are to reduce the rate of mother-to-child transmissions, increase the life expectancy of people living with HIV, and reduce new infections. In 2018/19, the programme had a budget allocation of R20,7 billion. The auditor general focused on the sub-programme HIV

and Aids for testing, which had a budget allocation of R20,4 billion in 2018/19. The figure below shows this visually.

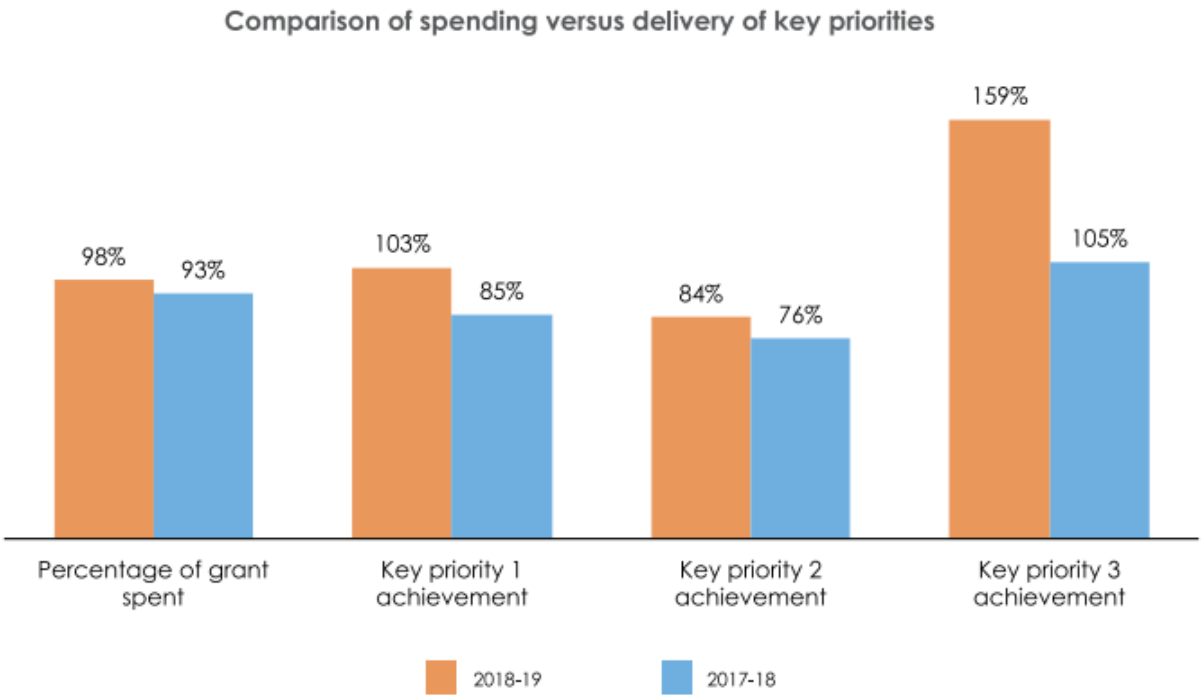


The Auditor General opted to look at the spending on the HIV/Aids Grant and performance against it.

PROGRAMME PERFORMANCE OVER TWO YEARS

Grant spending against actual achievement

The figure below compares the spending of the grant against the budget and indicates the average percentage achievement per key priority for 2017-18 and 2018-19:



RHAP highlights this work by the Auditor General, because the analysis adds value by drawing attention to whether spending performance is positively linked to performance against service delivery targets. A department spending all of its budget, may not be meeting its service delivery performance targets. While another department may have spent 80% of its budget, finding a more cost effective way to meet 100% of its targets. This approach also brings the citizen perspective into focus.

RHAP therefore recommends that the Appropriations Committees engage National Treasury to request that the strategy to reform health grants prior to implementing NHI, entails assessing spending performance against key priorities for the department and includes understanding the driving factors that led to the grants not being able to be spent.

MITIGATING THE EFFECTS OF AUSTERITY

RHAP is particularly concerned that the revenue raising proposals and harsh austerity measures in the form of spending cuts will exacerbate poverty and inequality and retard job creation and economic growth. It is noted that the worsening fiscal position is threatening government's ability to maintain existing levels of service provision and infrastructure investment.

Any cut in health expenditure is gender negative, because women are the biggest users of the healthcare system and in the majority of cases, serve as primary caregivers to dependents, both children and relatives.

For the provision of health care in rural contexts, carefully considered budgets are essential to ensuring sufficient resources are available to deliver on activities and meet objectives. Due to various contextual factors, such as additional expenses associated with transporting goods to hard to reach outlying areas, service delivery in rural settings is often more expensive than urban centres (Heady, 2002). There are also additional costs associated with attracting and keeping health care workers to rural areas. In this instance, added costs may include additional remuneration in the form of a rural allowance or the provision of subsidized accommodation (WHO, 2012). On a per capita basis, service delivery also tends to be more expensive in rural areas because of diseconomies of scale (Heady, 2002). In South Africa, rural areas have been disadvantaged through historical and structural neglect (Stuckler et al, 2011). This means that if social justice and equity are underlying principles in the budget process, which they are, then rural should be given priority when deciding on allocations. To avoid a situation where health systems in rural areas are under-resourced, it is important that rural cost factors are accounted for in budgeting at all levels of the health system. In the context of austerity and spending cuts, where compensation budgets are being examined for savings, it is important not to lose sight of social justice and equity and ignore measures such as those outlined above.

To mitigate the effects of austerity, we advocate that departments and National Treasury need to rural-proof budgets before they are finalized. We recommend that an effective manner to rural proof budgets is to adopt a rural adjuster, that accounts for factors such as diseconomies of scale and the higher unit costs of goods and services in rural settings. A rural adjuster could be included in budgeting guidelines that National Treasury issues to provinces to use when they undertake their budgeting or it could be built in to a resource allocation formula used to determine the proportion of available resources a province or department should receive.

The argument for rural-proofing is compelling, taking into account historical discrimination, high levels of poverty, the added rural costs of healthcare delivery and the Constitutional requirement of progressive realisation of access to healthcare for everyone within available resources. In addition, based on the Promotion of Administrative Justice Act, decisions on resource-allocations must be evidence-based, proportional, equitable and give special consideration to marginalised groups.

It is therefore our position that rural-proofing of policies and budget is not to be considered an option but ought to be a mandatory process in order to equitably protect, promote and advance the rights of rural people to access quality healthcare. Similarly, in the context of austerity, we wish to highlight the framework by the United Nations Human Rights Office of the High Commissioner] to guide the interpretation of the "within available resources" clause (Report on Austerity Measures and Economic and Social Rights, United Nations Human Rights Office of the High Commissioner, 2013). It serves as a useful reference point when considering austerity measures.

1. The existence of a compelling state interest must be demonstrated: this means that states must demonstrate that implementing austerity measures are due to factors beyond their control and cannot be justified by the need for "fiscal discipline" or "savings" (p.16). Consequently, austerity measures should only be implemented if on balance they result in the overall protection of rights.
2. The necessity, reasonableness, temporariness and proportionality of the austerity measures: austerity measures are only justified if they are temporary and if any other course of action would be more detrimental to the realisation of rights.
3. Exhaustion of alternative and less restrictive measures: states must prove that all options have been considered and that less restrictive measures are not feasible. States must, for example, demonstrate that further tax reform aimed at generating additional revenue is not a viable solution.
4. Non-discriminatory nature of the measures adopted: austerity measures cannot be intentionally or unintentionally discriminatory in cause or effect.
5. Protection of a minimum core content of the rights: states must identify and articulate a minimum core of rights that will be protected during the implementation of austerity measures.

6. Genuine participation of affected groups and individuals: states must demonstrate that those who are likely to be most affected by austerity measures are consulted and play a role in identifying interventions that would minimise harm.

The need for rural-proofing to advance equity and the unique and stringent conditions under which austerity measures might be permissible point to the need to protect rural communities from austerity and indeed to prioritise the worst-off in terms of healthcare access. As such, the question is not whether rural-proofing is affordable or not, but *how* to rural-proof within available resources, as a means of achieving greater equity and protecting and expanding access in worst-off areas.

The international literature including work done by the WHO provides guidance with regards to closing the health gap and achieving equity within a context of limited resources. Broadly speaking there are three options to advance access to the healthcare a population needs, which can be considered simultaneously:

1) Increasing the health budget
2) Improving efficiencies
3) Setting priorities

In terms of "priority-setting", in its report "Making fair choices on the path to universal health coverage", the WHO (2014) argues that setting priorities is an inevitable feature of healthcare provision and that trade-offs are unavoidable due to conditions of scarcity. For a society to be considered fair and just, the WHO also argues that priority setting cannot be solely based on crude assessments of cost and efficiency. If priority setting does not have fairness and justice at its core, it is likely to exacerbate inequities in access to care and will deepen inequities in society more broadly.

While every country prioritises services, many only do so implicitly. It is critical to develop explicit criteria for categorising services by priority. The WHO draws attention to three fundamental practical criteria for ethical priority setting and we provide an additional rural lens:

1) Categorise services into priority classes:

The WHO recommends that countries generate lists of health services, and then rank these on the basis of cost-effectiveness. The concept of cost-effectiveness depends crucially on the idea of a benefit. In quantifying the notion of a healthcare benefit, the WHO appeals to the idea of "healthy lifeyears saved", which is an outcome measure that represents both gains in lifeyears and quality of life. Here, it is important that the definition of 'quality' takes into account the rural healthcare context and adequately acknowledges the impact of relatively small interventions on vulnerable rural patients, such as access to cost-effective rehabilitation services which improve people's capabilities to participate in vital tasks and achieve reasonable lifegoals such as having an education, being able to work, and participate in community life.

2) Give priority to the worst off: In addition to cost-effectiveness over a lifetime, ethical prioritisation involves ensuring priority is given to those who are worst off in terms of health status and social determinants (e.g. income, deprivation and other associated factors such as a rural location). This leads directly to the next criteria.

3) Financial risk protection: In addition to deciding on priority services and populations, priority should be given to ensuring financial risk protection. This means removing cost barriers (out-of-pocket expenditure) associated with accessing care and the potentially catastrophic consequences of paying for access. This can be achieved through pre-payment for care and improved risk-pooling. Financial risk-protection is only ethical if it serves to protect the worse off though. So, a fundamental criterion of financial risk-protection is contribution based on ability to pay and access based on need.

The WHO outlines five trade-offs that are not acceptable in priority setting:

1. Expanding coverage for low- or medium-priority services before there is near universal coverage for high-priority services. This includes reducing out-of-pocket payments for low- or medium-priority services before eliminating out-of-pocket payments for high-priority services.
2. Prioritising very costly services whose coverage will provide substantial financial protection when the health benefits are very small compared to the alternative, less expensive services.

3. Expanding coverage for well-off groups before doing so for worse-off groups when the costs and benefits are not vastly different. This includes expanding coverage for those with already high coverage before groups with lower coverage.
4. First including only those with the ability to pay in the universal coverage scheme and not including informal workers and the poor, even if such an approach would be easier.
5. Shifting from out-of-pocket payment toward mandatory prepayment in a way that makes the financing system less progressive.

For decision-makers this may prove a long list of criteria without enough guidance for implementation. The underlying principle for distribution of healthcare resources should be that all people have adequate access to healthcare, starting off with high priority healthcare and expanding to lower priority healthcare. Principles to determine high priority healthcare need to be identified, along a hierarchy of health needs over a lifetime. Such principle would include priority for serious conditions, that are life-threatening or impair functioning with priority for the young. What follows from this is the priority to prevent and treat serious conditions early over more expensive treatment at an advanced stage of illness. Such priority healthcare services should be available to all, regardless of personal circumstances such as place of living or ability to pay. For instance, the reality of rural infants and children not accessing basic healthcare for preventable and treatable conditions is under no circumstances justifiable. In addition, while we can't guarantee rural communities 'equal' ease of access to specialised healthcare services in comparison to their urban counterparts, what we can and must guarantee is timeous detection of need and a functional, affordable and dignified referral pathway to such services concentrated in urban settings.

With regards to the first point of 'increasing the health budget', earlier in this submission we have noted the nominal increase in the health budget. However, it is also evident that rural communities in deprived districts continue to insufficiently benefit from this and remain far behind in terms of equitable healthcare access and healthy living conditions.

In terms of "improving efficiencies", we have pointed at the obvious loss of funds due to the ballooning medico-legal claims. While a complex set of factors have given impetus to the rise in claims, the freezing of posts and understaffing of rural facilities have contributed to avoidable medical errors. Rooted in health system failures, ensuring rural facilities do not drop below a minimum level of staffing is evident, urgent and achievable.

As RHAP we question the continued neglect by the Department of Health to fully embrace the newer cadre of Clinical Associates, who can perform routine tasks of medical doctors at a third of a doctor's salary. However, due to lack of posts, this cadre is now migrating to the private sector and overseas job opportunities. This is a true disgrace, a lost opportunity and particularly saddening given that this cadre consists mostly of young people of disadvantaged backgrounds.

The other obvious area for improved efficiencies is the investment in community health workers, while creating jobs for impoverished persons who in turn are able to help maintain their households with a corresponding positive health impact, community health workers are also known globally for their effective role in preventing illnesses and early detection. While South Africa has spent many years stating its commitment to this cadre and developing a new policy, we are yet to see the large-scale roll-out, with priority to deprived rural areas.

These are two examples that require a financial commitment for more posts (Clinical Associates) and new posts (CHWs) to advance rural health equity within a context of austerity.

RECOMMENDATIONS

- In order to mitigate the effects of austerity on people living in rural settings, particularly women, we recommend a rural adjuster is included in budgeting guidelines that National Treasury issues to Provinces.
- With respect to spending performance against budgeted allocations, the Appropriations Committees give consideration to how newer policy reforms where there is underspending, such as with the NHI, may benefit from a systematic Human Resourcing approach worked out between the relevant sector department and DPSA, that could include seconding experienced officials with proven track records, and which would also support succession of promising upcoming officials within departments.
- Appropriations Committees engage National Treasury to request that the strategy to reform health grants prior to implementing NHI, entails assessing spending performance against key priorities for the department and includes understanding the driving factors that led to underspending on the current grants.
- RHAP recommends that employing new community health workers in rural areas should be prioritized and that the Appropriations Committees should request both the National Department of Health and Provincial Departments of Health develop and publish a plan to support their integration into the Primary Healthcare System.
- That the Appropriations and Finance Committees consider reigniting the Women's Budget Initiative that prepared women and children's budgets.
- The antiretroviral treatment programme is progressing somewhat slower than anticipated, with 4.8 million clients against a target of 5.8 million. The uptake is particularly slow among children and men, compared to women. RHAP recommends that the Appropriations Committees ask the Department of Health what it intends to do to meet the target after declaring underspending in that programme.
- That the Appropriations Committees engage National Treasury to request that all health infrastructure projects being considered are published and the Budget Facility for Infrastructure develop a mechanism to prioritise rural infrastructure in order to address infrastructure inequality gap.

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