POST BUDGET ANALYSIS

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

RHAP's submission problematizes that social spending such as spending on health, education and human settlements is vulnerable to issues of fiscal space arising out of fiscal risks emanating from State Owned Entities. It emphasizes the importance of protecting this spending in order to protect the most vulnerable groups (including those living in rural areas) who rely on it. It is important that social spending is protected not only after crises have been prioritised, but while dealing with crises. To buffer the rural poor from some of the impacts of a weak economy and promote health equity, RHAP recommends that a rural adjuster is included in budgeting guidelines that National Treasury issues to Provinces. An important discussion that is missing from the public discourse is assessment of fiscal space for social spending. Fiscal space analyses are a useful input into health financing reforms and strategies. In light of this context of issues of fiscal space, RHAP's submission highlights studies on fiscal space for health.

INTRODUCTION

This submission provides analysis relating to Budget 2020, as tabled on 26 February 2020 by the Minister of Finance.

The context in which this submission is made is one of weak growth, record high unemployment, a growing budget deficit, rising public debt and the fastest growing area of expenditure being debt service costs.

RHAP's submission assesses some of the ways in which the approach to Division of Revenue replicates pre-existing inequities and problematizes that social spending such as spending on health, education and human settlements is vulnerable to issues of fiscal space arising out of fiscal risks emanating from State Owned Entities.

In November 2019, the International Monetary Fund, in its mission concluding statement on its 2019 Article IV Mission to South Africa noted that "South Africa's undeniable economic potential remains largely untapped and the recent economic performance points to rising risks". Three key challenges that the IMF highlighted were (1) persistently weak economic growth, (2) deteriorating fiscal and government debt, and (3) major difficulties in the operations of state-owned enterprises (SOEs). The IMF noted that the economy has been left with high and rising debt, low growth, and limited fiscal space to respond to shocks. The concluding remarks contained views on how to reinvigorate economic performance and restore fiscal discipline. The IMF's remarks entailed that fiscal consolidation of about 3 percent of GDP is needed, mainly expenditure-based but supported by tax administration improvements. The IMF's remarks also recommended that these expenditure-based rationalizations will need to focus on compensation costs and transfers to SOEs. The IMF continued that "efforts are also needed to improve spending efficiency, particularly on education and health, to deliver better quality public service".

In June 2019, the IMF completed a study on social spending—defined as social protection, health and education spending— which it regards as a key policy lever for promoting inclusive growth, addressing inequality, protecting vulnerable groups during structural change and adjustment, smoothing consumption over the life-cycle, and stabilizing demand during economic shocks.

RHAP highlights these remarks of the IMF and the IMF's study on social spending, because we are concerned that the IMF's advice that expenditure-based rationalizations will need to focus on

compensation costs have been heeded, while the advice that transfers to SOEs be reduced is not feasible in the MTEF as there is a need to address the issues at Eskom and other SOEs. Therefore, instead, spending reductions came from conditional grants for provinces and municipalities and particularly from human settlements (R14.6 billion), health (R3.9 billion), education (R5.2 billion), transport (R13.2 billion) and municipal infrastructure (R2.8 billion). It is less clear how Treasury and the Departments of Education and Health intend to 'improve spending efficiency, particularly on education and health, to deliver better quality public service'.

South Africa is a signatory to the International Covenant on Economic, Social and Cultural Rights. In an open letter on 16 May 2012, addressed by the Chairperson of the Committee on Economic, Social and Cultural Rights to States parties to the International Covenant on Economic, Social and Cultural Rights, the Committee, the Chairperson wrote to highlight that the Covenant provides important guideposts which can help States parties to adopt appropriate policies that deal with the economic downturn while respecting economic, social and cultural rights. RHAP wishes to remind the Appropriations Committees and National Treasury to reference the covenant, which South Africa ratified. The letter deals specifically with the protection of the Covenant rights in the context of the economic and financial crisis.

THE RIGHT TO HEALTH

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.

We reiterate that it is important that the Appropriations Committees and National Treasury recognize the need to protect this spending in order to protect the most vulnerable groups (including those living in rural areas) who rely on it. It is important that social spending is protected not only after crises have been prioritised, but while dealing with crises. We emphasize this, because some of the measures Treasury proposes may not be achieved and we are concerned

that the tough decisions that people will have borne the brunt of to fund a fix that may not work, will serve to further deject citizens.

Whereas Equal Education's analysis revealed that education spending will not be growing in real terms this year, RHAP is relieved that the overall health spending is at least growing. However, we join Section27 in raising a concern that the proposed 5.1 percent average annual increase in nominal terms over the medium term is not linked to the rising cost of health care, and will therefore put access to quality public healthcare at risk.

The proposed reductions to the overall wage bill is creating uncertainty among public servants who need to deliver services. It remains to be seen as to whether National Treasury and unions, who have responded with anger to Treasury's announcement of a need to review the public servant wage agreement will be able to reach a new agreement. Therefore, there is a significant unknown on the horizon. As to how the state will deal with the budget deficit remains to be worked out, which means that fiscal space is an important issue to continue to monitor.

In light of this context of issues of fiscal space, RHAP's submission highlights selected studies on tax compliance to offer potential recommendations to improve revenue collection.

After the 2019 Medium-Term Budget Policy Statement, Rural Health Advocacy Project chose to do a gendered analysis to emphasize our commitment to an inclusive society that prioritizes gender equality. In this submission we continue to emphasize that rural women particularly are faced with inequities when trying to access healthcare while living in remote rural areas and should be protected.

We make this submission with the conviction that as economist, Thomas Piketty says "In all human societies, health and education have an intrinsic value: the ability to enjoy years of good health, like the ability to acquire knowledge and culture, is one of the fundamental purposes of civilization."

DIVISION OF REVENUE

South Africa collects revenues nationally which are then distributed equitably between the spheres of government. The largest share of around half of the revenue (49.2% for 2020/21) is transferred to national department functions. The next biggest share is transferred to provinces (42.2% for 2020/21) in the form of unconditional provincial equitable share. The smallest portion goes to local government, which for 2020/21 will be 8.6%.

While we recognize the redistributive effect of intergovernmental transfer, the use of per capita is not necessarily a good measure to illustrate advances in intra provincial inequity. The social services such as health and education funded through the provincial equitable share are particularly human resource intensive.

RHAP notes that Treasury has said that the ongoing review of equitable share formula is examining costs of rural services. This is potentially good news for bringing about greater health equity.

THE IMPACT OF FISCAL SPACE ON SOCIAL SPENDING

The World Health Organisation (WHO, 2020a) notes that “fiscal space is commonly defined as the budgetary room that allows a government to provide resources for public purposes without undermining fiscal sustainability.”

The crises in State Owned Entities whose audit outcomes are worsening, are taking away from social spending. It is critical that State Owned Entities stop hemorrhaging money to corruption and then coming to the Treasury for bail outs to repay their debts that were guaranteed, while they were ignoring the conditions that National Treasury set for the loan guarantees. This is taking away from areas of spending such as health, education, transport and housing. This is how issues of fiscal space arising largely out of needing to bail out State Owned Entities are putting these

areas of spending under pressure. RHAP therefore welcomes what the Minister of Finance had to say in his speech about getting corruption and wasteful expenditure under control.

Energy supply issues are part of what is constraining the economy, causing disruptions in businesses and in turn dampening revenue collection levels. RHAP is therefore pragmatic about the need for these issues to be addressed. The rampant corruption and state capture at Eskom cannot continue.

RHAP notes that there were baseline adjustments to certain areas of social spending including health spending. There was a R3.9 billion net decrease to the health budget mainly due to the reduction in the national health insurance indirect grant and a reduction in the HIV, TB, malaria and community outreach grant.

The International Labour Organisation (ILO, 2019) says that “a social protection floor is essential in order to secure basic human rights, such as access to health care and education, decent old age living conditions, protection against work injuries or illnesses and provisions in case of unemployment and other precarious situations”.

In 2014, the United Nations Development Programme (UNDP) undertook a study on Social Protection in Africa, which was a Review of Potential Contribution and Impact on Poverty Reduction. The authors, UNDP Economic Advisor South Africa, Babatunde Omilola and Senior Researcher, Sheshangai Kaniki, outline that social protection interventions typically encompass measures to provide adequate housing and nutrition, ensure access to education and health and promote social inclusion and political stability. The UNDP review included looking at the “contribution of social protection in addressing various dimensions of social and gender-based exclusion, inequalities and vulnerabilities over the long term” (Omilola & Kaniki, 2014:2). The authors found that:

- Social transfers have contributed to lower inequality in South Africa. The Gini coefficient is 7 percentage points lower as a result of the social transfer programme.
- Cash transfers have reduced the poverty gap by 48% in South Africa.
- The old age pension in South Africa reduces the country’s overall poverty gap by 21% and by 54% for households with older people.
- There is a growing body of evidence demonstrating that social protection programmes are successful in reducing poverty, improving nutrition, school attendance and access to health services.

The UNDP points out that gender and HIV/AIDS are highly correlated with poverty, vulnerability and exclusion in Africa (Omilola & Kaniki, 2014:24). South African household surveys show that households headed by women are more likely to be poor. The authors (Omilola & Kaniki, 2014: 24) note four reasons for women-headed households having 48% probability of being poor compared to a 28% probability for a household headed by a male being likely to be poor, namely: "(1) female-headed households are more likely to be in rural areas were poverty is concentrated, (2) female-headed households tend to have fewer adults of working age, (3) female unemployment rates are higher and (4) there is a gap between male and female wages."

Given the evidence that social protection measures lower inequality and reduce poverty, it is important that social protection measures are not eroded, especially in light of the extreme extent of poverty, unemployment and inequality in South Africa and even more so when economic performance is weak. Rural women are particularly vulnerable to the impacts of poverty as noted by the UNDP. RHAP therefore reiterates previous recommendations to the Appropriations Committees that budgets need to be rural proofed. To do so, a rural adjuster can be included in budgeting guidelines that National Treasury issues to Provinces.

A rural adjuster 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.

RHAP notes that in the Medium Term Expenditure Framework guidelines for 2020 (National Treasury, 2020:7) departments are directed to report on these budget lenses: "For analyses purposes, a department must indicate the percentage of its budget currently spent on women, persons with disabilities, youth, pro-rural, pro-poor activities." It is encouraging that this is in the Medium Term Expenditure Framework, however, in the Estimates of National Expenditure, there

does not appear to be any inclusion of this information. For these lenses to be reported on, National Treasury will need to go further and include indicators to report on in the templates that departments use and/or work with the Department of Monitoring and Evaluation to request that Departments include performance indicators related to these lenses in their Annual Performance Plans.

The National Health Insurance if correctly implemented can deliver significant benefits, but a poorly funded and implemented NHI could further erode already weak public capacity. In this respect we are cautiously optimistic with measures in this budget that support the strengthening the public sector capacity to deliver the NHI.

An important discussion that is missing from the public discourse is how fiscal space is impacting on health allocations and consequently on health care delivery. Fiscal space analyses are a useful input into health financing reforms and strategies.

The concept of fiscal space has been extended to 'fiscal space for health' and referenced and studied particularly since the introduction of the Millenium Development Goals. In 2016, the World Health Organisation undertook a study assessing fiscal space for health expansion in low-and-middle income countries. South Africa was among 35 countries included in the study. The WHO study looked at earmarked funds as a source of revenue to create fiscal space for health.

Earmarked funds are revenue generated from a tax or group of taxes and set aside as designated for a specific purpose (Barroy, Sparkes & Dale, 2016:10). For example, to fund National Health Insurance, countries may consider revenues from public health taxes, social health insurance contributions/payroll taxes, and other indirect taxes sources, such as natural resources or mobile phones. The WHO found that while there are few studies on earmarking, most of the studies that do exist find that there is limited potential for creating additional fiscal space for health in this manner. They also highlight that it is important to separate health objectives such as reducing behaviours that are harmful to health from the generation of revenue for health, as these measures have more value in deterring unhealthy behaviour than generating revenue (Barroy, Sparkes & Dale, 2016:10). However, the WHO did explore public health taxes (such as tobacco, alcohol and sugar tax) as a source of revenue for health. The WHO concluded that for South Africa, there is scope to explore increased taxation on alcohol, as well as sugary and fatty products (Barroy, Sparkes & Dale, 2016:11).

A strong public sector service delivery platform augmented by contracting private sector capacity can have significant cost differences to a model where services are contracted out.

The importance of strong primary health care services cannot be highlighted enough. The World Health Organisation explains that “primary health care is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing” (WHO, 2020).

RHAP agrees with the Minister of Finance that “for a fast-growing economy we need to make sure our children are well educated, our people are healthy and our money is invested properly.” Health care should not be considered a drain on public finances, but rather, it is an investment in the wellbeing of citizens. Access to health care is also more than an input into the country’s economic potential, it is a right enshrined in the Constitution.

RHAP welcomes that R55.6 million has been reprioritised to the Department of Health to strengthen its capacity to implement the NHI. A team convened by the Presidency developed a National Quality Health Improvement Plan to ensure that the quality of healthcare facilities is improved in order that they be accredited for NHI. R25 million has been reprioritized for this. This is further welcome news.

RHAP is however, concerned that government should communicate about NHI in a manner that is responsible. Government is creating expectations that are 15 years away, speaking about a desired future state rather than addressing the current state, thereby creating an expectation gap that may frustrate citizens.

Important questions to be asking are:

- There is considerable inequity between provinces as well as within provinces which is not fully addressed in the Provincial Equitable Share formula when the horizontal division is done. How can this be addressed?
- As the delivery of health care services is primarily a provincial function how will we ensure that provinces have the necessary support to ensure that cost containment measures don't compromise already weak health systems?

SPENDING ON HEALTH CARE

Average nominal growth in health spending for 2020/21 to 2022/23 is 5.1%. Treasury has noted that the slower growth in spending on health, learning and culture, and peace and security reflects the effect of lower compensation growth.

RHAP notes that the non-personal services component has been allocated R2.2 billion over the next three years. This allocation will support the strengthening of the health system in preparation for national health insurance. Achieving integrated IT systems are an important enabler that would support the success of the NHI. The R2.2 billion allocation over the next three years is intended to "ensure that, by 2022/23, 54 million patients are registered on the national health insurance beneficiary registry, 4.5 million patients are registered to collect chronic medicines at their pick-up point of choice, and 3 830 facilities electronically report on medicines stock through the national stock surveillance system" (National Treasury, 2020:269). We note that by 2018/19 the Department of Health was reporting that 39.8 million individuals were already registered on the NHI patient beneficiary registry. This is reflected in the performance indicators below. If this is correct, it is a huge achievement, particularly because the NHI Bill outlines that biometrics are required. RHAP would like clarification as to whether this is correct, because when patients are not registered on a system, it can exclude them from receiving care, which is more than a simple administrative issue. It is also a rights issue.

Selected performance indicators

Table 18.1 Performance indicators by programme and related priority

Indicator	Programme	MTSF priority	Past			Current	Projections		
			2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Total number of individuals registered on the national health insurance patient beneficiary registry	National Health Insurance	Priority 2: Education, skills and health	–[1]	20.7 million	39.8 million	40 million	46 million	49 million	54 million
Total number of health facilities reporting stock availability at the national surveillance centre	National Health Insurance		3 349	3 492	3 598	3 725	3 765	3 790	3 830
Total number of patients registered to receive medicines through the centralised chronic medicine dispensing and distribution system	National Health Insurance		1.3 million	2.2 million	2.5 million	3.2 million	3.5 million	4 million	4.5 million
Total clients remaining on antiretroviral treatment in the public sector at the end of the year	Communicable and Non-communicable Diseases		3.8 million	4.1 million	4.6 million	5.8 million	6.1 million	6.3 million	6.5 million

Source: National Treasury, Estimates of National Expenditure

RHAP welcomes that the Department of Health and National Treasury are working on strategies to accelerate delivery of health infrastructure projects. This represents an opportunity to address the infrastructure inequality trap. 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.

RHAP submits that the infrastructure inequality gap needs to be addressed as part of the state's Constitutional obligations and its commitment to health equity. RHAP therefore recommends 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 the infrastructure inequality gap.

There have been a number of changes to the conditional grants related to the health sector. RHAP welcomes that in the presentation to the Finance Committees following the public hearings, National Treasury said that together with the Department of Health, they would review health conditional grants system to ensure alignment to NHI and improve delivery. And that National Treasury said that "Development components to assist rural provinces added in 2 grants in 2020".

HUMAN RESOURCES FOR HEALTH

In August 2019, in response to a Parliamentary question about the shortage of doctors and nurses in hospitals, Health Minister, Dr Zweli Mkhize, said that the primary reason for the shortage was due to a lack of additional funding in the health sector budget to meet the increasing demand for health services (News24. 2019).

RHAP was therefore glad to hear Minister Mboweni saying that once fiscal consolidation measures have been implemented, the state will focus on hiring in important areas such as education, police, and health care. And that this will mean that hiring can be done in a strategic

manner ensuring a better match of skills with opportunities. We are cognizant that these fiscal consolidation measures may not be achievable, but will continue to do research in the area of human resources for health, as the filling of shortages in the health care system will support improved services.

To strengthen Primary Health Care services, Human Resources for Health shortages of 80 000 primary health care workers needed to be filled by 2025. Consistent availability of medicines and well-functioning infrastructure will also strengthen health care service delivery. Primary Healthcare is weak and referrals are an area where improvement can be made. The referral pathway can be shortened. Achieving all of these improvements requires significant investment.

Human resource moratoria, also referred to as the 'freezing of posts' has become an increasingly common occurrence within the public health system. RHAP wishes to draw attention to the causes, consequences and possible responses to the implementation of moratoria on the filling of posts within the health system.

Even though there are several contributing factors that result in the implementation of moratoria on the filling of posts, evidence suggests that the cause is primarily budgetary. While provincial health expenditure has more than doubled in real terms over the last decade, slow economic growth has meant that government revenue is becoming increasingly constrained. Health budgets are increasingly unable to keep pace with cost increases that continue to outstrip inflation.

Substantial real increases to the Compensation of Employees (CoE) budget item has often

been cited as the primary culprit for costs in the health system outpacing budgetary increases. While this is true to some extent, poor planning has meant that little has been done to prepare the health system for the implementation of austerity measures.

Provincial departments have managed budgetary pressures by shifting money between budget items and overspending on CoE in the hope that they will receive additional funding in future to account for overspending. In the absence of 'bailouts' from the Treasury, this overspending has contributed to growing accruals and a growing budget deficit that must be recovered from future budgets without necessary adjustments being made for this expenditure.

In recent years and in an effort to control overspending, provincial departments of health and treasuries have started implementing staffing moratoria. This has either been done officially

(including memos and instructions on the filling of posts) or unofficially through repeated delays in making appointments.

The effect of this is that it is having catastrophic consequences for health care, particularly for rural health settings. These consequences include diminished capacity to deliver services; poor supervision of existing staff; weakened support processes (e.g. procurement); additional strain being put on already overburdened staff; and consequently, overburdened staff leaving the public service deepening the crisis.

We argue that a blanket approach to the implementation of moratoria on the filling of posts is a significant threat to the right to have access to health care as provided for in the Constitution and that such an approach acts contrary to the principles of administrative justice.

There is a need to ensure that the impact of spending reductions on frontline service delivery is minimised. In an April 2016 roundtable with the National Department of Health, the Treasury and rural health partners we revised guidelines developed by the RHAP and other rural health stakeholders in November 2015, which sets out an approach to identifying critical posts that extends beyond frontline-posts. These revised guidelines are:

1. The National Department of Health in collaboration with the Treasury should provide guidance through policy on how provinces are expected to protect critical posts at times of spending reductions. This should include:
   - Input by health and partners, in particular around definition of critical.
   - Principles of transparency and consultation, which should include transparency on savings in managerial/admin positions versus frontline health professionals, and an escalation procedure in the event that provinces do not implement the guidelines.
   - A national plan regarding communication and distribution to provinces as well timeframes for the release of the guidelines.
   - Some standardization in implementation: what is required from people; who is responsible for what.

2. Adequate consideration should be given to inhospitable and underserved areas so as to ensure disadvantaged communities are not further marginalised in their access to health

care. This includes but is not limited to rural health contexts for their unique characteristics and challenges.

3. It is national policy to use normative guides “WISN” where available (currently for clinics and CHCs) to identify the minimum posts to be filled.
   - While doing so, facilities must ensure adequate data, which is not limited to headcount and other utilization data. Population data must be used to include unmet need, as alluded to in section 6 of the WISN normative guidelines. In the event that current staffing levels are less than the minimum “WISN” norms, additional staffing is to be advocated for by the facility. In the event that no funding is available for such additional staffing, the facility needs to identify the critical health posts to be prioritized, as guided by the national guidelines.

4. Critical posts need to be defined locally and these can include health professionals and support staff. The purpose is not to define which categories of staff are to be considered critical. Instead the consequences on patient care should be the determining factor on deciding whether post A in facility B is critical under the given circumstances. Here critical posts are simply defined as those that potentially have catastrophic consequences for service delivery if they remain unfilled.

   Here key underlying principles in defining critical include:

   - The protection of frontline health professionals
   - The protection of services to the poor and the marginalised - who have the least option of services
   - Provincially: the more rural the more protection
   - District level: the more rural districts the more protection

5. Districts are expected to develop costed HR plans but this does not happen; if such plans are in place it can help District Managers to identify priority posts at times of staffing

moratoria. The National and Provincial Departments of Health must ensure Districts have such plans in place. Treasury should provide support in the costing of the HR plans.

6. Decision–making on cost-saving and cost-cutting must be made at the district level by giving districts the amount to be saved and allowing the district to decide.
   - These decisions must be supported by guidelines on defining critical posts and must be informed by the Promotion of Administrative Justice (PAJA) principles of evidence-based decision-making, rationality and proportionality to give effect to the constitutional duty of Government to progressively realise the right to health.

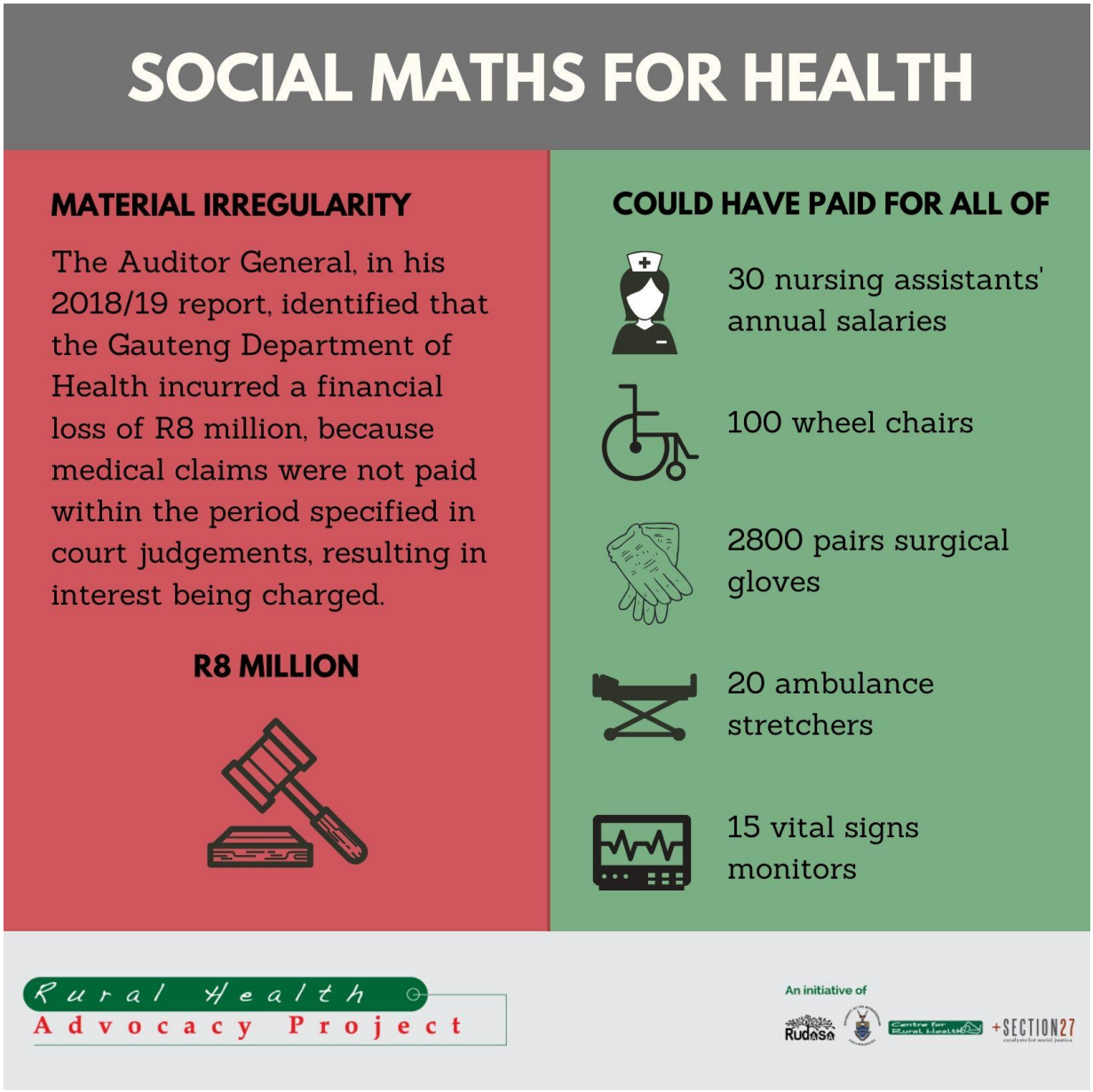
7. Corruption and unauthorized expenditure should be performance managed instead of punishing all managers and districts by withdrawing their delegations of authorities for the transgressions of others. This would mean that provincial departments and institutions should be held accountable for performance management.

IMPROVING EFFICIENCY

RHAP welcomes that the National Treasury and the Department of Planning, Monitoring and Evaluation will undertake a new round of expenditure reviews to identify cost savings and improve efficiency.

Medical malpractice claims and litigation has increased to the extent that National Treasury reported that medico-legal claims payments totalled R2 billion. The Auditor General started implementing the new audit category of Material Irregularity in 2018/19. Sixteen national and provincial government auditees were identified for implementation of the process. Material financial losses were identified for several departments including the Gauteng Provincial Department of Health. In the graphic below, RHAP uses social maths to highlight what could have been bought using R8 million, which was wasted on interest on medico-legal claims after claims were not paid within the time period specified in court judgements. If this is what could have been bought with R8 million, imagine what R2 billion could have bought instead.

Social maths is an approach to translating seemingly complex statistics, financial information and other data into information that is interesting and accessible to activists, journalists and the public. Social maths is more than simplifying language and turning in to graphs though. Social maths is about placing this information in context and communicating it in ways that people can relate to. RHAP recommends that civil society, the Auditor General and National Treasury can partner on a social maths campaign that promotes a more effective spend of public finances and good governance.



RECOMMENDATIONS

RHAP offers the following recommendations:

1. That the Appropriations Committees engage the Parliamentary Budget Office and Fiscal and Financial Commission about research on the fiscal space to implement to the NHI.
2. That the Appropriations Committees engage the National Treasury about making the actuarial models and costing studies on the NHI available.
3. That a rural adjuster is included in budgeting guidelines that National Treasury issues to Provinces.
4. 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 the infrastructure inequality gap.
5. The National Department of Health in collaboration with the Treasury should provide guidance through policy on how provinces are expected to protect critical posts at times of spending reductions.

CONCLUSION

RHAP's submission has problematized that social spending such as spending on health, education and human settlements is vulnerable to issues of fiscal space arising out of fiscal risks emanating from State Owned Entities. It specifically highlights the issue of fiscal space for health for further deliberation. In light of this context of issues of fiscal space, RHAP's submission highlights studies on fiscal space for health. Rural Health Advocacy Project thanks the Appropriations Committees for the opportunity to make a written submission.

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