Economic Policy Research Institute
A SECTION 21 COMPANY · Reg. number 1998/09814/08
SANCLARE BUILDING 3rd FLOOR 21 DREYER STREET CLAREMONT 7700 CAPE
TEL: (+27 21) 671-3301 www.epri.org.za FAX: (+27 21) 671

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An Appraisal of the Health and Welfare System and its Reform

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Robert van Niekerk

Economic Policy Research Institute

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ABSTRACT

This paper is concerned with outlining and discussing the institutional, fiscal and legislative frameworks within which the reform of the South African health and welfare system is located. It intends to provide a framework for analysing and developing economic and social policy that can comprehensively address the legacies of the apartheid 'diswelfare' state and the unequal public/private mix of provision. The paper argues that the inherited institutional context within which health and welfare reform occurs has received insufficient attention in attempts to understand the uneven progress of policy implementation.

Following the work of Titmuss (1956) the structure of the labour market is addressed which, in South Africa, differentially shapes access to either private or public health or welfare according to race and income. The focus is on the structure of the private system of health provision to illustrate the scale of the labour market that has influenced access to private and public provision.

The analysis explores the new fiscal and budgeting procedures that determine mechanisms of spending between national, provincial and local government levels to health and welfare. It is argued here amongst other, that the present arrangements have the unintended consequence of undermining the achievement of inter-provincial equity in spending on health and welfare.

Finally a discussion of the re-structuring of the child-maintenance grant is used as a case study to illustrate the tension between fiscal restraint and de-racialisation and the unintended consequences for grant recipients of potentially increased vulnerability.

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Introduction

The following paper is concerned with outlining and discussing the institutional, fiscal and legislative frameworks within which the reform of the South African health and welfare system is located. It intends to provide a framework for analysing and developing economic and social policy that can comprehensively address the legacies of the apartheid 'diswelfare' state and the unequal public/private mix of provision. The paper argues that the inherited institutional context within which health and welfare reform occurs has received insufficient attention in attempts to understand the uneven progress of policy implementation.

The starting point for such an understanding, following the work of Titmuss (1956) is in the structure of the labour market which, in South Africa, differentially shapes access to either private or public health or welfare according to race and income. The focus will in particular be on the structure of the private system of health provision to illustrate the scale and depth of the problem resultant from the racially differentiated structure of the labour market which has influenced access to private (and public) provision.

The analysis will then explore the new fiscal and budgeting procedures that determine mechanisms of spending between national, provincial and local government levels to health and welfare. It is argued here amongst other, that the present arrangements have the unintended consequence of undermining the achievement of inter-provincial equity in spending on health and welfare.

Finally a discussion of the re-structuring of the child-maintenance grant is used as a case study to illustrate the tension between fiscal restraint and de-racialisation and the unintended consequences for grant recipients of potentially increased vulnerability.

Conceptual Framework

The framework used to analyse health and welfare reform in South Africa is derived from the work of Richard Titmuss, a British social policy analyst. Titmuss (1959, 1968, 1974) focuses on *the social division of welfare,* and the social, fiscal and occupational forms of welfare associated with it, locating the development of social policy in the social differentiation which results from the division of labour in capitalist societies.

He discusses the concept of the social division of welfare in terms of three divisions, related to the division of labour in industrialised society. They are social welfare (directly administered services and transfer payments, including the health service, social security payments, housing and education); fiscal welfare (taxation allowances and deductions from the state), and occupational welfare (derived from employment and including pensions and occupational health and welfare). In his view, these divisions were all re-distributive, either progressive, regressive, horizontal or vertical distributions over time, and involve a transfer of resources, in cash or in kind, between social groups. For Titmuss (1968:192-194; 1974) "re-distributive" did not necessarily imply greater equality in resource allocation. For him, the objectives of social policy and the mechanisms used to

effect provision (such as universal provision of health and non-university education) could have unintended consequences. Greater allocations of resources could go to the middle-class as opposed to the working class because of the differential opportunity costs and life-chances available to different social groups. Social services could be responding to "diswelfares" as a consequence of industrialisation and social change (e.g. occupational sicknesses and disabilities, ethnic or religious discrimination against immigrant communities) that caused loss of income. Thus dependence on the state is a compensation for these diswelfares or disservices.

The relevance of the social division of welfare framework lies in the insights it provides to understanding health and welfare reform systemically i.e. as an integrated system of provision rooted in the division of labour. Titmuss' approach thus provides a link between types of welfare provision and the funding and allocative mechanisms used to achieve social policy aims in the context of the political economy of a society. This provides a framework to bridge the relation between public and private forms of provision.

The following section makes observations of the labour market in relation to the social division of welfare in the South African context.

Dualism and the Racialised Labour Market of South Africa

In SA, the institutional conditions and structure of the labour market differentially shapes access to either private or public systems of care according to race and income. This occurs through the employment structure.
Figures[1] for unemployment rate derived from the national October 1994 Household Survey illustrate the historical trend.

Table 1

Social Group	**Unemployment Rate**	
	Expanded Definition	Restricted Definition
	(percentage)	(percentage)
African	41	25
Coloured	23	19
Indian	17	14
White	6	4

(October Household Survey, 1994 in Nattrass, 1997: 253)

[1] The expanded definition of unemployment includes people who express a desire for but are not seeking employment, while the bracketed figure refers to the strict definition of employment which, according to a recent ILO study (Standing et al, 1996), is closer to the international norm (Nattrass, 1997: 253). Nattrass makes the point that the strict definition accords more closely to the much easier employment seeking conditions found in advanced capitalist countries than to a labour surplus economy such as South Africa where actual employment as well employment seeking opportunities are very limited.

Most whites are regularly in formal employment and are able to make provision for private health and occupational social insurance. A higher proportion of Blacks are unemployed or in low-paid or casual jobs. They are thus unable to afford private care and thus forced to rely on public health care and welfare provision. This means that there is less incentive for whites and those members of other social groups who use mainly private care to build up the public care system.

They are able to direct the bulk of funds into the private health care system, which accounts for more than two-thirds of the total national spending on health (public and private) budget for health, but which is only used by one-fifth of the population. The corollary to this is that because whites are the highest relative earners and employed (despite rapid and significant entry of Blacks into public and private management and other high paying jobs) the tax base is also largely concentrated around them. This particular racialised, and class structured form of the division of labour shapes the institutions that condition differential access to health and social welfare in SA. This Titmuss derived framework is thus the critical underpinning for understanding both the particular structure of the system of health and welfare provision in South Africa and strategies aimed at the redress of the residual 'diswelfare' state.

The Structure of the Public/Private Mix of Welfare and Health Provision

The modern public welfare system in South Africa in 1994 consisted firstly of means-tested social security transfers; secondly, institutionalised welfare services and, finally, of limited state supported occupational and unemployment insurance. The state social security transfers consist of old-age pensions, child maintenance grants, foster-care grants, care-dependency grants and disability grants. These grants are modest and employ stringent means tests.

A contributory **Unemployment Insurance Fund (UIF)** was established in 1947 and exists for certain unemployed workers in the formal sector. Benefits are equal to 45 percent of the weekly wage, paid out at the rate of one week for every six weeks contributions made by workers, until a cut-off of 26 weeks pay-out is attained. Employers and workers each contribute 1 percent to the publicly administered UIF. The fund continues to exclude seasonal and domestic workers and those whose income exceed a certain level. Agricultural workers were only included in 1993 (van der Berg, 1997).

Two health insurance funds are administered by the state to cover disease or disability of workers: the occupation-related **Workmen's Compensation Fund** and a **Road Accident Fund**. As these almost exclusively utilise private sector health care providers they might more appropriately be considered part of the private health care industry.

The Workmen's Compensation Fund was established in 1941 to cover employed workers other than mine-workers whose income fell below a certain threshold and who suffered permanent or temporary work related disability, injury or disease. Employers make risk-related contributions to an Accidents Fund against which compensatory withdrawals are

made. The stringent eligibility criteria disqualified many and resulted in the state having to provide Disability Allowances for occupation-related disabilities which should have been the responsibility of employers (van der Berg, 1997).

In addition, the Workmen's Compensation Fund is required by law to indemnify all occupational health expenses and, since the Department of Labour is required to make up the difference between contribution income and expenditure, there is little incentive for Fund managers to control expenditure or stringently enforce premium collection (Soderlund et al, 1998: 38).

Mine-workers were covered separately under the **Occupational Diseases in Mines and Works Act**, which covered both disabilities and industry specific, mainly respiratory diseases. Both of these pieces of legislation were replaced in 1994 by the Compensation for Industrial Injuries and Diseases Act which improved coverage and removed racial discrimination (van der Berg, 1997). The Road Accidents Fund (formerly the Multilateral Motor Vehicle Fund) compulsory insures against disability, medical costs and earning losses resultant from motor vehicle accidents and is funded by a levy on vehicle fuel with the balance made up by the state. Rapid escalation of costs occurs as a result of claims being decided in a court of law after the accident and on the basis of a legal submission done on behalf of clients. The adversarial nature of claims also contributes to the comparatively high legal costs (Soderlund et al, 1998: 39).

Alongside these publicly provided services exists an **occupational social insurance and health care industry** for those with the means to afford such care. The occupational social insurance component comprises occupational retirement insurance funds in the main. Their assets were equal to 73 percent of annual GDP in 1993. These retirement funds cover most industries but with low coverage in agriculture, domestic services, trade, catering and accommodation (van der Berg, 1997).

Civil servant pension funds are covered under these arrangements but, as pointed out by van der Berg (1997), they are politically distinguishable in that they have been used by the state to establish political patronage relationships, to sustain political loyalty and to legitimate the system of "Grand Apartheid" in the pre-1994 period. Their role can be likened to that of the differential welfare provision for civil servants introduced by Bismarck to secure their loyalty to the state and to erode the potential influence of class solidarity with Marxist working-class movements through status differentiation (Esping-Andersen, 1990: 24). The prescribed investment requirements of civil servants pension funds and the ability of civil servants to "buy back" years of service have seriously depleted these pension funds.

Van der Berg (1997) contends that, despite the absence of legal compulsion, these occupational retirement funds should be regarded as social insurance in the more orthodox sense due to the mandatory enrolment in either provident or pension funds required of employees, coupled with the body of agreements and conventions which exist between employees and employers in formal sector employment.

Occupational pension schemes cover an estimated 73 percent of the formally employe although the presence of large-scale unemployment means that only some 40 percent of the workforce is effectively covered (van der Berg, 1997). It thus cannot be considered a national system of social insurance coverage.

Employees and employers each contribute 7,5 percent of wages or salaries to the funds on the basis of the monthly wage and the workers claim benefits upon retirement. The 16 000 retirement funds are circumscribed by regulations under the *Pension Funds Act of 1956.* They provide for a defined contribution scheme (dependent on benefits and returns on investing the funds which are then converted to an annuity for the duration of the beneficiaries lifetime) or on a defined benefit fund (based on a percentage of salary times the number of membership years, which is converted to a monthly pension). Employers are responsible for funding the difference between the obligation and assets of the funds and gain significantly from the departure of employees who leave the bulk of the employers contribution and investment behind (van der Berg, 1997).

Retirement funds are not portable between funds, so employees who leave employment obtain a certain share of the benefits, which is paid out to them and they cannot resume the retirement fund with a new employer. The means tested nature of the state social pension combined with the limited amount of free income which an employee is permitted by the means-test could result in a "poverty trap". This can occur where the existence of private retirement benefits rule out the obtainment of a state pension and the meagre benefits of the private retirement fund (especially if the workers leaves their employment before maturity of the premium is reached) fall's below the monthly amount received in a state pension. Finally, because the present means-test penalises possession of assets, low income workers who enrolled in provident funds opposed to pension funds because the former allowed for lump-sum pay-outs to purchase homes, land or cattle, are now adversely effected (van der Berg, 1997). The cumulative effect is to punish low-income workers for making retirement provisions while protecting the privileged status of high-income workers who do not require state support.

Public health services are provided at national, provincial and local government levels. The national department of health is responsible for determining policy norms, and standards to ensure a functional national health service at all levels of government. It provides services at national level that cannot be provided cost-effectively at lower levels, such as specialised laboratory services and diagnostic, control services for major epidemics and promoting national campaigns for a healthy life-style.

The provincial health departments are responsible for provincial service delivery within national policy, norms and guidelines. The major public services provided are specialised and regional hospital health services, medical emergency services, occupational health services, non-personal health services and specific provincial programmes such as tuberculosis.

At the local level the major health services provided are community hospital health care (non-specialist and non-emergency), health promotion, community level health care such

as nutrition services, appropriate treatment of diseases and injury, mid-wifery, maternal and family planning services, primary environmental health services, mental health services, treatment for chronic diseases, elderly care, oral health services, care of the terminally ill and preventive and promotive services for communicable and non-communicable diseases.

The Structure and Financing of Private Health Care

The restructuring of social policy to provide for the needs of all citizens in South Africa is conditioned fundamentally by the relationship between the public and private sector. The racial and income dualism of the labour market and the manner in which it influences access to private health care has already been mentioned. The following section now discusses the organisation and financing of the various components of private health care in relation to access to public sector health care.

The private health care sector is a more significant sector in human resource and budget terms than the public sector. It is estimated that private finance accounted for 61 percent of all health care expenditure in 1992/93, approximately R18 billion (FFC, 1998: 35). The total health human resource structure, with the exception of nurses, is disproportionately skewed in favour of private health care, accounting for 59 percent of doctors, 93 percent of dentists, 89 percent of pharmacists and an additional 350 000 to 500,000 traditional healers.

Medical-aid schemes, a form of private occupational health, are the most prominent means of accessing private sector health care, and are provided by health insurers regulated under the *Medical Schemes Act of 1969*. These medical schemes are by law, non-profit organisations and are controlled by a board representing their members who employ professional medical scheme administrators to manage claims on a day to day basis. The medical schemes offer variable "packages" of health care services, provided by private general practitioners and hospitals contracted into the medical-aid schemes that provide health care services on a strict fee for service basis. Excluded is only the most sophisticated and expensive specialist care, such as heart transplants that are provided by the public health sector. (Soderlund, 1998:14).

Most medical schemes are employment based. They are organised around an aggregation of employees in industries where mutual welfare arrangements can be developed. The personal income tax system in South Africa permits up to two-thirds of an employers medical scheme contributions remaining tax-deductible. As membership is compulsory for employees there is less chance of only those at high risk securing membership (adverse selection) and costs are thus lower for equivalent risk groups (Soderland, 1998: 12).

Only eighteen percent of the population is covered by such medical-aid schemes however, although the schemes account for nearly 66 percent of all private health care expenditure. The schemes are also indicative of the funding differentials between private

and public health care in general. It is estimated that in 1995 medical-aid schemes spe more than four times as much as the state per head of covered population (Soderlund, et al 1998: 14).

Accessibility to medical schemes is dependent on adequate levels of income to pay contributions. Figures derived from the October Household Survey of 1995 indicate that coverage for those at the bottom quintile (earning under R5000) account for only 11 percent of the 18 percent of the total population who have access to medical aid schemes. Those in the middle quintiles (earning between R5000 - R11000) account for 29 percent of the total population covered. The bulk of medical scheme users are in the top quintile (earning more than R11000 per annum) and account for 60 percent of those covered by medical schemes.

Access to these medical schemes reflects the racialised duality of the labour market whereby those in employment and with the economic means have benefited disproportionately from such schemes. They have predominantly been whites and, to a lesser degree, Coloureds and Indians, particularly public sector workers**.** By 1960, 80 percent of whites had medical scheme cover and thus significantly less need to utilise the public health sector (Soderlund, 1998: 16). This has had a negative impact on the quality of public sector provision.

A striking recent feature is the rapidly increasing coverage of Blacks by medical schemes, accounting for 23-24 percent of those insured in 1990 and 36 percent by 1995 (Soderlund et al, 1998: 18). This suggests that income and class is rapidly becoming stronger factors determining access to private care, than that of race.

Among workers in major industries, 59 percent above the tax threshold of R20 000 are covered by medical aid schemes. The highest percentage coverage is in the finance and business sector (72 percent covered) and lowest in construction (42 percent covered). The new Department of Health has stated its intention to cover, through legislation, those workers at the tax-threshold level (i.e. the level of income which makes them eligible for taxation) with mandatory employer health insurance (Soderlund et al, 1998:18).

The previous government de-regulated medical schemes in 1989. Risk-rating was re-introduced by open funds, which sought to attract younger, healthier members away from the more established closed funds, which did not risk-rate and thus provided for cross-subsidising between younger and older or less healthy members requiring greater levels of health care (Soderlund et al, 1998:18).

The ANC government introduced draft legislation to re-regulate the medical scheme industry to end this practice, in line with proposals contained in the *White Paper for the Transformation of the Health System in South Africa (1996).* The *White Paper* proposed provisions that medical schemes be obliged to continue providing benefits to continuation members (pensioners, widows and widowers), to individuals for a limited

period after becoming unemployed and to end the practice of transferring private patients to public facilities after their medical aid cover became depleted.

A final feature of private health care provision which needs to be considered is direct "out-of pocket" payments. These constitute 23 percent of total public sector health financing, while industry contributes 5,7 percent to total expenditure through occupational health services funded through the Workmen's Compensation Fund (FFC, 1998:35). There is a debate on what proportion of lower income earners use private sector care through "out of pocket" payments. The October Household Survey of 1995 collected information on the relative use of private health care providers by people not covered by medical aid insurance. The Survey

> *…suggests considerable out-of-pocket payment for private health care in lower income groups - for the lowest income quintile less than a quarter of private health care users could have had access to a medical scheme (Soderlund et al 1998: 32).*

According to the Survey, 19 percent of the lowest income quintile of the urban population claimed to have usually used private sector care, while 25 percent seeking care had used the private sector and only 5 percent were covered by a medical aid scheme (Soderlund et al, 1998: 32). The Financial and Fiscal Commission (1998: 35) using data from the SALDRU Survey of 1993, argue that low income patients do not use private sector health care through out of pocket payments in any significant manner. In the SALDRU Survey of 1993, the percentage of those who reported using a private doctor accords closely with the 23 percent of the later October Household Survey (1995). The FCC (1998: 35) make the valid point though that the SALDRU Survey (1993) does not distinguish between district surgeons, who are state employees, and private doctors. Often, many of the district surgeons operate out of the surgeries belonging to the private doctors. There is thus ambiguity about whether the "private medical doctor" is a state or private employee. The major point to be made however is that considerable out of pocket payments are made for private health care by low-earning uninsured groups.

The proposed strategy of the government for covering members of the public who are not able to access public care is to contract out services to private providers. These providers could comprise groups of independent practitioners or non-governmental organisations. In the urban areas, the central thrust of most contracting out reform, is the introduction of competition in the provision of services, while financing is retained in the public domain. It is argued that such reform would address the pervasive inefficiency problems in the public sector while retaining the positive equity effects of the public sector, (*White Paper for the Transformation of the Health System in South Africa: 1996)*

The contracting out proposal resembles the reforms of the NHS in the UK introduced by the *Working for Patients* White Paper of 1989. The NHS reforms meant that the state was to

> *…become primarily only a purchaser of welfare services, with state provision replaced by a system of independent providers competing with one another in internal or 'quasi-markets' (Le Grand et al, 1993: 3)*

In the South African *White Paper* proposal, the conditions for a successful contracting out relationship are listed as: similar level and quality of service provision to be provided in private care as found in public care, sufficient public sector capacity to negotiate and monitor contracts and contracts should not create sustained dependence and lack of capacity in the public sector.

The proposal for contracting out services will need to engage a number of additional issues however if it is to achieve equity. Firstly, asymmetries of information mean that users who would normally use public facilities will not be able to differentiate the quality of care between providers unless the state or other agency regularly monitor the quality of private providers - a large potential administrative and management cost increment to the public health budget.

Secondly, no mention is made of how afford-ability of care is to be differentiated between users in determining appropriate fee schedules - if it is assumed that low-income earners who normally would use public health services, will be "charged" according to public sector rates (the private provider bill to the state for treating "public sector" patients), a mechanism will need to be effected (means-testing for example) to prevent higher-income earners "poaching" services from private providers at these lower public sector rates.

It is also questionable how a competitive market structure is to achieve equity rather than using, for example, a simpler capitation formula which would remunerate private providers according to a defined fee schedule for a pre-determined number of the population. A competitive contracting system is a cash-driven system, which provides incentives for providers who are efficient in driving down costs while, ostensibly, still providing a quality service. This places providers in a contradictory position, which is embedded in applying the market to provision of social care. How can the provider simultaneously meet the needs of the patient for high quality care and be competitive in relation to other private providers, when this care may drain the budget contracted?

The concern raised is of access to the "health market" where planned resource utilisation is supplanted by cash driven supply and demand, and the logic which is to contain costs and maximise returns, as the basis for renewing contracts. These issues are left unaddressed in the government *White Paper.*

The involvement of the private sector, at higher costs, in the provision of basic health services is substantial. Basic health services were determined by the Financial and Fiscal Commission (1998) as comprising general practitioner, dentist and work-based primary care services and medicines (including over-the-counter purchases). It was estimated that these basic health care services accounted for 43% of total private sector health care expenditure amounting to R8 billion in 1992/93. This is not equivalent to the amount of

revenue foregone if the services were provided through the public sector, as the co structure, including its administration, would not be comparable to the services delivered to a broader spectrum of the population using explicit equity formula. It does raise the issue of attraction and retention of revenue by the public sector of private fee-paying patients. This is made starker by the fact that only 2,8 percent of medical scheme spending was on public sector health facilities (Soderlund et al, 1998:19).

The Health *White Paper* proposes intervention in the private sector to expand coverage of patients by this sector through revenue retention and admission of private patients into public hospitals through social health insurance schemes aimed at public sector employees, which would result in public sector employees being bound to use public sector facilities through enrolment in their work-place medical-aid schemes.

Budgetary Arrangements, Governance and Social Policy Implementation

The previous section discussed the structure of the public/private mix of health and welfare provision in relation to concerns of access to either forms of care related to the dualism of the labour market. This section discusses issues of equity in provision of health and welfare services, in the context of constitutional arrangements for budgeting between the three levels of government.

The estimate of government expenditure on health care in 1992/93 was R30 billion, equivalent to 8,5 percent of gross domestic product.
The division between public and private *sources* of expenditure according to the South African Health Review (1995: 89) was as follows:

Table 2

Sources of Expenditure in Health (Public and Private)

Category	Percentage
General Tax Revenue	38
Medical Schemes	40
Out-of-pocket	14
Other	8

The public/private s*pending* division was as follows.

Table 3

Spending Division on Health (Public and Private)

Category	Percentage
Private Health Care	52
Public Health Care	37
Public and Donor funded Capital Projects	1
Research and Training	2
Other	8

Within the public sector 76 percent of funding was accounted for by acute hospitals, with 44 percent of total public funding absorbed by academic and tertiary hospitals. Non-hospital primary level services however composed only 11 percent of expenditure (Makan, et al, SAHR 1996: 73 - 74).

In reality the expenditure pattern in health care was inconsistent with the professed aims and objectives of the new health system as contained in the *White Paper for the Transformation of the Health Service in South Africa (1996) :*

Restructuring the health sector has the following aims:

(i) to unify the fragmented health services at all levels into a comprehensive and integrated NHS;

a) to reduce disparities and inequities in service delivery and increase access to improved and integrated services, based on primary health care principles
b) to mobilise all partners, including the private sector, NGO's and communities in support of an integrated NHS.

The goals and objectives are:

a) to unify the fragmented health services at all levels into a comprehensive and integrated NHS:
b) to re-organise the health system based on primary health care services, with effective referral systems at the primary, secondary and tertiary care levels
c) to promote equity, accessibility and utilisation of health services
d) increase access to integrated health services for all South Africans, focussing on the rural, peri-urban and the aged with an emphasis on vulnerable groups
e) establish health care financing polices to promote greater equity between people living in rural and urban areas, and between people served by the public and private sectors

The achievement of an integrated NHS oriented to primary health care service depends substantially on the re-structuring of funding from tertiary to lower secondary and primary levels of care. The change to more equity in health financing at provincial level occurred in 1994, and in relation to the 1995/96 budget. It was undertaken at national government level through a *Health Functions Committee*, which included representatives of the national and provincial departments of Health, Finance and State Expenditure (McIntyre et al, SAHR, 1999: 33).

The joint determination by the Health and Finance departments of the provincial health allocations for the 1995/96 budget was based on a weighted capitation formula which took account of the need for public health services in the different provinces by the population (*White Paper on Transformation of the Health Services, 1996*). This formula for achievement of equity used variations in per capita provincial spending on health as a proxy for socio-economic status and determines allocations on the basis of equalising these variations.

The task was a complex one: the Western Cape and old PWV (now Gauteng) comprised 26 percent of the population but consumed 45 percent of public health expenditure in 1991/92, the bulk of which was consumed by the tertiary level Academic Health Complexes (McIntyre, 1994: 5). The determination and support for re-structuring funding allocations from the well-resourced to under-resourced of the nine provinces was indicated in the time-frame of five years to achieve weighted per capita equality, requiring substantial changes in the annual provincial budgets (McIntyre et al, 1999, SAHR: 33).

The effects of budgetary re-structuring resulted in a constant or decreased allocation for the well resourced provinces such as the Western Cape and Gauteng (apportioned 12 percent and 21 percent respectively, totalling 33 percent). Total allocations to Gauteng and the Western Cape in the 1995/96 budget represented a decrease of 12 percent from their combined health budgets in 1991/92. Further budgetary decreases over the five year time period it was argued represented a threat to their ability to meet their service commitments (Makan, 1996, SAHR: 77).

When the implications of such a dramatic shift became apparent, involving a 20 percent decrease in the health budget of the well resourced provinces such as the Western Cape, a more cautious approach was adopted while the time-frame was still retained.

It also meant though a substantial increase in expenditure for under-resourced provinces such as Mpumalanga and the Eastern Cape, whose budgets increased by 30 percent and 27 percent respectively (Makan et al, SAHR, 1996: 76). A number of problems were raised with the budgetary structure. These concerned: the accuracy of the base-line population on which per capita weighted averages were based to determine provincial allocations; the inter-provincial service distribution where patients "crossed" service delivery borders to use services in other provinces at a cost to the latter; differences in inter-provincial health morbidity patterns; density of population served between

provinces which impact on infrastructure and service provision cost; and inter-provinci differences in access to and utilisation of health services (Makan et al, 1996, SAHR: 77).

Differences in health status as indicated in morbidity and mortality figures and differential access to health care services between the private and public sectors are arguably more equitable indicators of health need in the South African context.

Per capita spending provides no indication of use of services, as citizens with access to medical aid schemes will very rarely, if ever, use the public sector, other than for infrequent emergency care or specialist care and should thus be removed or proportionally weighted in relation to their potential use of specialist and emergency care.

Secondly, provinces have larger health needs than their total population suggests due to specific health conditions, such as KwaZulu-Natal which has the highest prevalence of HIV and number of AIDS related patients, although this pattern is rapidly changing (McIntyre 1995: 97-99).

With the promulgation on 1 January 1998 of the *Intergovernmental Fiscal Relations Act* a new budgetary system came into effect, which aimed to determine the appropriate share of revenue between the national, provincial and local levels of government (referred to as the vertical division of expenditure) as well as the achievement of inter-provincial equity, known as (the horizontal division of equity). The reasons for the new system related to the weak expenditure control at provincial level, the deficit of which was made the responsibility of the national government and the requirement of co-operative governance over expenditure evaluation, previously done by national government officials. The intention was to establish mechanisms for making provinces more accountable for their expenditure by providing them with greater autonomy over their prioritisation and allocation of functions (such as education, health and welfare) at provincial level for which they would be held accountable for in conjunction with national government.

It was also to overcome problems of "unfunded mandates" the process whereby national government set policy and norms for provincial level service delivery but did not provide sufficient funds for its implementation resulting in either the decline of service delivery or unchecked provincial expenditure to meet commitments which the national government was then required to sustain (FFC, 1996).
The Financial and Fiscal Commission (FFC) replaced the *Health Functions Committee* and was established under Section 199 of the *Constitution* and the *Financial and Fiscal Commission Act* with the task that it should :

> *Render advice and make recommendations to the relevant legislative authorities…regarding the financial and fiscal requirements of the national, provincial and local governments, including - (a) financial and fiscal policies; (b) equitable financial and fiscal allocations to the national provincial and local governments from revenue collected at the national level:..." (FFC, 1997a)*

The FFC responded to some of the criticisms in the formula as applied by the Heal Functions Committee but raised other serious concerns for actual allocations of health and welfare expenditure.

With regard to the vertical division of expenditure the FFC recommended that allocations to national governments should grow more slowly as the constitutional allocation of functions for delivery of services occurred mainly at provincial level, health, welfare and education comprising up to 85 percent of provincial budgets.

With regard to the vertical division concerned with inter-provincial equity, the FFC recommended that total provincial allocations be based on a provincial grants formula. These composed five elements:

(i) a minimum national standards grant for provinces to specifically provide primary and secondary education, and district health care to their residents
(ii) a spillover grant to account for inter-provincial services,
(iii) a fiscal capacity equalisation grant to ensure that the differently resourced provinces have an equalised level of tax raising and retention capacity
(iv) an institutional grant to fund the core of provincial legislatures and finally
(v) a basic grant for enabling provinces to establish and maintain institutions to meet their constitutional obligations according to their own priorities (FFC, 1996a).

The health component of the provincial minimum national standards grant is determined by a combination of demographics, policy and cost. Unlike the previous formula, it separated provincial public users of health services from users covered by medical-aid schemes by apportioning an equity targetted weighting of 3.5 visits to primary level health clinics of the former as opposed to 0.5 percent for the latter (medical scheme users are calculated as averaging public facilities use once in two years as opposed to twice a year for non-medical scheme users, with 3.5 visits per year the provincial target over ten years). These clinic usage percentages are combined for an annual percentage and then used to calculate the 'qualifying population' by dividing this total percentage by the target usage rate. The 'qualifying population' is then multiplied with the estimate of average annual cost of a visit to a primary health care clinic, combined with the cost of secondary level district hospital services (qualifying population x average cost) to arrive at the grant for health. Most recent (1999) changes to the formula was the introduction of a "backlogs" component for underserved provinces which McIntyre et al (2000: 30) contend, has had little impact on overall resource allocation due to the low weighting of 3%. The weighting in favour of vulnerable groups such as the elderly, women and children has also been removed in the new formula.

The advantage of the formula with regards to equity of access is that it separates citizens covered by medical schemes in the private sector from those that are reliant solely on public care. It does not address the concern of differential morbidity and mortality ratios between provinces and the potentially much greater need and thus "qualifying population" of KwaZulu- Natal for example with potentially high HIV and AIDS related

care and contact with health facilities required, or TB treatment patterns such as in the Western Cape with the highest incidence of TB infection globally (SAHR, 1995).

Provincial level determination of per capita weightings also obscures the large intra-provincial differentiation in access to and need for health care, a solution to which requires determination of the formula to be de-centralised to local government level. This is unlikely in the near future given the still unresolved problems with implementing district health boundaries co-terminously with political boundaries at local government level.

As social security is a nationally determined system, all the grant levels are decided upon by the national department in consultation with provincial departments and stakeholders. The provincial departments implement the means-test to arrive at the provincial population eligible for the three categories of grant support for the elderly, disability and child and family support (FFC, 1998). The national government intends to follow the trend in the determination of full provincial accountability for the health budget with welfare, with provinces retaining responsibility for determining their own social security and welfare budgets in the 1998/99 and 2000/01 budget cycles (Department of Finance Budget Review, 1998: 5.21).

The major threat for health and welfare funding represented in the restructuring and introduction of new fiscal arrangements is that they do not entrench funds at provincial level. The provinces are in effect allocated a cumulative bloc grant, including for health and welfare services, which is determined using a formula aimed at achieving inter-provincial equity. Once they "receive" this grant from the national government, provinces are entitled to allocate the bloc grant according to their own provincially determined priorities, alongside the nationally agreed upon norms and standards. A comment by a former national Director-General for Welfare in the new government is instructive as regards the potential effect -

> *Due to shortfalls in the social security budgets, funds for welfare have been used to make up the budget deficits. Welfare services' funds have also been used to fund other provincial programmes and overspending. Consequently government is not always able to meet its statutory commitments, service delivery targets and partnership agreements with its non-governmental partners. This is clearly not a desirable situation (Patel, 1998: 25).*

Macro-Economic Policy (GEAR) and Social Policy

The government unveiled its new economic strategy in 1996 called the Growth, Employment and Re-distribution Programme or GEAR. The GEAR strategy prefaces its

macro-economic policy proposals with a continued commitment to the goals of the RD and the longer term objectives of a

> *competitive fast-growing economy which creates sufficient jobs for all workseekers; a redistribution of income and opportunities in favour of the poor; a society in which sound health, education and other services are available to all; and an environment in which homes are secure and places of work are productive (GEAR, 1996:1)*

The specific strategy enunciated towards its achievement is two-fold: firstly maintaining internal fiscal restraint to rapidly eliminate the government deficit while, simultaneously, re-structuring and re-prioritising the existing national budget to meet social needs. Secondly to implement economic reforms such as lifting exchange controls, restructuring state assets and developing a flexible labour market to facilitate a globally competitive export led growth path that would grow the economy by 6 percent and create 400 000 jobs annually (GEAR, 1996). The specific commitments with regard to fiscal restraint was the reduction of the fiscal deficit to 3 percent of GDP by the year 2000, entailing a significant reduction in government expenditure.
The table below (FFC, 1998: 23) provides a functional classification of the prioritisation of the budget in percentages (figures rounded off and thus not equated with 100).

Table 4

Functional Classification of Expenditure as a Share of Total Government Expenditure

Classification	1983	1985	1990	1995	1998	2000
General Public Services	8	9	9	11	11	12
Defence	14	13	13	8	5	6
Public Order and Safety	6	6	7	9	10	10
Education	18	17	18	20	22	21
Health	10	10	9	9	13	13
Social Security	6	6	6	9	9	9
Housing, Community Services	5	4	4	3	2	2
Fuel and Energy	0.2	0.2	0.2	5	0.2	0.2
Agriculture, Forestry & Fishing	3	4	2	2	2	2
Mining, Manufacturing & Construction	2	3	3	1	0.1	0.1
Transport and Communication	10	7	6	5	4	4
Interest Payments	13	15	12	14	20	19
Other	4	4	6	4	2	2

Source: Budget Review 2000, Department of Finance, pg. 28

These figures show that the largest shift has been towards social expenditure, public services, interest repayments and public order and safety. The share of education, health and welfare increased from 34 percent to 43 percent between 1983 and 2000. The

defence share of the total budget declined from 14 percent to 6 percent. Overall there has been a shift to increased social spending in the new governments budget.

Adelzadeh et al (1996) present a critique of GEAR which argues that GEAR's neo-liberal economic strategy is premised on redistribution through growth, which is incompatible with the demands for redress of inequality and poverty. It addition, he does not anticipate the effects of re-distribution on growth and employment which was the focus of the original, more egalitarian strategy of the RDP base-document in his view. Le Roux (1997: 56) responds however, that although the RDP emphasises greater infrastructural investment to cater for basic needs the GEAR strategy is not solely a trickle-down policy in comparison. Both documents in his view support growth and redistribution as both emphasis social spending priorities in the budget and government intervention to achieve this.

The economic strategy represented by the RDP and GEAR do have an influence on social policy in relation to the level of total government expenditure that is made available for social sectors consequent of the 3 percent fiscal deficit target. The Financial and Fiscal Commission (1998: 21) makes the point that GEAR only achieved a 3 percent growth in GDP in 1996 and thus there would be slower growth in revenue and fewer resources for government spending. In 1999 the real GDP growth rate has fallen to 1.7 percent.

The objective of meeting social needs cannot be judged solely by these criteria. Even if the RDP were fully implemented and a greater rate of government spending was allocated to the social sectors this would not, of itself, suggest that social needs such as health and welfare will be met. A range of legislative, political and governance concerns, inside and outside government, have had a strong influence on social policy, including influences that have not been intended. These factors are more influential arguably in shaping post-apartheid social policy than either the original RDP or GEAR economic strategies per se.

A critical look at taxation is important in terms of the equity aspects of state revenue generation.

State Policy and the Distribution of Taxation

Whether taxation is equitable, according to Biggs (1997: 201) may be evaluated as to whether it achieves vertical and horizontal equity. Horizontal equity refers to citizens who are equally well off shouldering an equal tax burden while vertical equity means that wealthier citizens should pay a proportionally greater proportion of tax. The degree of vertical equity is equivalent to the degree to which redistribution is effected. Examining state welfare spending in the UK, O'Higgins (1985) argues that the share of state social expenditure, including taxation benefits, absorbed by the lower income quintiles needs to be compared with the share of the higher income earning quintiles. This provides a clearer indication of the re-distributive effects of state social expenditure.

The South African system of taxation is composed of direct and indirect taxes broken down as follows:

Table 5

Composition of national Tax Revenue (in rounded off percentages)

Tax Instrument	**Percentage of Total Tax Revenue**			
Direct Taxes	1983/84	1989/90	1994/95	1999/00
Persons and Individuals	30	31	40	43
Mines	10	3	1	1
Companies (other than mines)	17	17	12	11
Other	2	2	1	4
TOTAL	**59**	**53**	**54**	**59**
Indirect Taxes	1983/84	1989/90	1994/95	1999/00
GST/VAT	21	26	26	23
Excise Duties	9	4	5	5
Customs and Imports	7	7	5	3
Fuel Levy	1	6	7	8
Other	3	4	3	2
TOTAL	**41**	**47**	**46**	**41**

Source: Budget Review 2000, Department of Finance (pg. 101).

The figures above indicate that personal income tax accounts for the bulk of state revenue and has increased significantly as the share of state revenue at 39 percent compared to only 16 percent in 1980. The burden of taxation shifting to individuals must be viewed in the larger context of the economic and employment structures of South Africa. The high Black poverty rates and unemployment levels compared to Whites, meant that most of the direct tax burden historically was absorbed by whites. The burden of relative taxation of Blacks and whites is thus more commensurate with their income structures rather than their population number (Poverty and Inequality Report, 1998: 66). The lower rates of taxation found in 1980 could thus be viewed as a real increase in the income of the wealthier, predominantly white population relative to blacks rather than an overall lower, equitable tax rate for the whole population.

Figures for the 1997 tax year suggest that the burden of direct personal taxation remains with the highest income earners, taxpayers in the R100 000 to R200 001 income group accounting for 45 percent of total revenue from income tax and constituting 10 percent of liable taxpayers (Department of Finance, 1998: 9.35).

The rapid decline in taxation of gold mining companies, from 20 percent to 0.41 perce is significant. It not only emphasises the decisive shift in burden of taxation to personal tax and indirect tax on consumers such as VAT. It is also indicative of the powerful position of the mining sector in the South African economy. The source of tax revenue foregone is suggested in Chamber of Mines estimates that it directly *and indirectly* contributed to 18 percent of the Gross Domestic Product in 1994 (Standing et al, 1996: 288). The Department of Finance however placed its recent contribution to a rapidly declined 8,6 percent of GDP, which may account for the need to remove taxation of the gold mining sector, given the decline in the gold price (Department of Finance, 1998: 2.3).

Nevertheless the relative share of taxation between companies and individuals cannot be considered equitable or redistributive on the basis of these figures.

The revenue distribution of the state to the social sectors, referred to as allocable government expenditure, indicates the level of distribution of expenditure between poor and wealthy. The Poverty and Inequality Report (1998: 67) derived the following allocations by quintile based on data for 1993/94 from the Projects for Statistics on Living Standards and Development (PSLSD):

Table 6

Share of allocable expenditure and composition by quintile

SECTOR	QUINTILES				
	poorest	2nd	3rd	4th	5th
	%	%	%	%	%
Agriculture	0	0.1	0	0.2	99.9
Education	15	18	17	21	30
Health	15	18	20	23	24
State Pension	6	22	24	18	30
Total	**13**	**19**	**19**	**21**	**30**

(It needs to be borne in mind that the re-structuring and re-prioritisation of government budgeting is rapidly transforming the above allocable figures as indicated in the *Poverty and Inequality Report*, 1998: 67).

The figures for health and education for 1993/94 demonstrate a similar level of government allocable expenditure for the lowest quintiles at 15 percent. This is half what the richest quintile receives for education at 30 percent and 9 percent less than health expended on the richest quintile.

The share of allocable expenditure on pensions between the poorest and richest quintile more stark, separating the poorest at 6 percent from the riches at 30 percent. These figures should be combined with concessions on medical scheme contributions, since high income earners belonging to the most expensive schemes have the highest marginal tax rates. Figures provided in the Financial and Fiscal Commission Report (1998) indicate that between R1.5 and R2,6 billion is allocated though tax incentives to medical scheme contributions, equivalent to 10-17 percent of the 1994/95 health budget.

Although a far higher proportion of funding is apportioned to the richer quintiles the impact of state social spending is far greater for the poorest quintiles. This is demonstrated in the case of rural areas where the majority of the poor are located. Figures from the Poverty and Inequality Report (1998: 68) indicate that rural citizens received 84 percent of their income from public expenditure benefits, while people in urban and metropolitan areas respectively received 34 percent and 26 percent of their income from public expenditure benefits. This is indicative of the high levels of poverty in rural areas as pointed out in the Poverty and Inequality Report (1998).

It can be argued that revenue distribution on the basis of tax burden is highly redistributive not in total allocations to poorer quintiles (and those located in rural areas in particular) but relative to their positive overall social impact. This is modified by considerations of need, where the poorer income quintiles have a far greater requirement for state support than the wealthier quintiles.

The value added system of tax (VAT) introduced in 1991 can be considered regressive in relation to poorer households. Relatively wealthier quintiles spend progressively less on vital consumption related items such as food and fuel compared to poorer quintiles (Biggs, 1997: 201). In South Africa it is estimated that expenditure on food absorbs 30 percent of the income of poor and low income households, the single largest item. In high income households this accounts for only 10 percent of total income. The other major items of expenditure accounted for in the incomes of low income households were drinks, tobacco, clothing and footwear, energy sources and furniture (Poverty and Inequality Report , 1998: 67).

The burden of VAT by income group for 1994/95 was estimated as follows Poverty and Inequality Report (1998: 67):

Table 7

Distribution of Vat between Income Groups with Percentage of Household Income

	Very Poor	Low Income	Middle Income	High Income	Very High
Total Vat per Household Income	R731	R1719	R4607	R10 151	R16 068
% of Household Income	9%	7%	7%	7%	5%

The regressivity of VAT taxation is evident in the above figures, with a lower percentage of household income taxed for very high income earners compared to the share of household income paid as VAT by for the lowest income earners.

Welfare Reform and the Child Maintenance Grant

The following section illustrates the tension described above between the imperatives of fiscal restraint to cap social spending at 3% of the budget deficit and the imperative on the other de-racialise and extend welfare provision within these fiscal limits.

The new Department of Welfare issued the *White Paper for Social Welfare* in August 1997, aimed at the comprehensive re-structuring of health and welfare. The cornerstone of the new paradigm was described as "developmental social welfare" and the intention as stated in the preamble, was to call upon South Africans to

> *…participate in the development of an equitable, people-centred, democratic and appropriate social welfare system. The goal of developmental social welfare is a humane, peaceful, just and caring society which will uphold welfare rights, facilitate the meeting of basic needs, release people's creative energies, help them achieve their aspirations, build human capacity and self-reliance, and participate fully in all spheres of social, economic and political life. (White Paper for Social Welfare, 1997: 7)*

The goal of the new welfare system aimed to combine the continuation of citizen entitlements to welfare provision on the one hand with the integration of social goals ("build human capacity") with economic goals ("facilitate the meeting of basic needs") on the other.

The *White Paper* provides an acknowledgement however, that a tension exists between the objective of de-racialisation of welfare provision through extending (and thus expanding) the system of social welfare to previously disadvantaged sectors on the one hand and the economic conditions in which this objective is to be achieved on the other:

> *Since resources are limited, trade-offs must be made between investment in economic growth and human resources, and investment in a social safety net. Welfare expenditure will only be able to expand as higher economic growth rates are achieved. The benefits of economic growth, however, should be equitably distributed through raising real per capita income and through social development programmes, which in turn will increase the capacity of individuals and families to meet their own needs. (White Paper, 1997: 11)*

The welfare programme which has most dramatically illustrated this tension in the restructuring of the welfare delivery system under the new government is the new Child Support Grant. This is examined below.

Caught Between De-racialisation and Fiscal Constraints: The New Child Support Grant

The State Maintenance Grant (as the Child Support Grant was formerly known) is a child and family care grant that falls under the social security component of state welfare support, and is one of four types of grant available, the others being for the aged, the disabled and for social relief. Social security expenditure composed 88 percent of the total state allocation to welfare, of which child and family grant related expenditure composed 15 percent. (Lund et al, 1996; *White Paper for Social Welfare*, 1997).
Eligibility for this means-tested State Maintenance Grant was decided on the basis of a divorced, widowed or deserted South African woman demonstrating that she had applied for a Private Maintenance Grant from the father through the magistrates courts to support herself and her child/ren but had failed to secure such support. Other conditions which made her eligible was if her husband was in a state institution, such as a prison or psychiatric hospital and she could not support herself or her family. The State Maintenance Grant was divided between a Parent Grant worth R 410 in May 1995 and a

Child Grant worth R117 per child up to a total of four children (Lund et al, 1996).

Reflecting the system of welfare under the system of apartheid the grant was racialised, with Coloured, Asian and white women receiving the grant while African women were largely excluded in the Republic of South Africa, despite being formally eligible. The grant was not administered in most of the non-independent homelands and "self-governing states". (Report of the Lund Committee on Child and Family Support, 1997).
The cost of the State Maintenance Grant amounted to R 1.2 billion annually in 1995 and reached 394 934 beneficiaries. The fiscal consideration were government estimates that it would cost between R5 billion and R20 billion for the grant to be equalised among all social groups, dependent on the take-up rate of the grant and the level at which the benefit was to be set. (Briefing, Minister for Welfare and Population Development: March 1997).

The de-racialisation imperative stemmed from the fact that in 1990, 48 per 1000 Coloured children received the grant, 40 per 1000 Asian children and 15 per 1000 white children (considered high relative to the comparatively higher standards of living of whites). This was compared to figures indicating that only 2 per 1000 African children received the grant which emphasised the inequitable nature of the grant relative to need among social groups (Report of the Lund Committee on Child and Family Support. 1996: 12).

In response to the high cost and inequitable implications of the State Maintenance Grant, the Ministers Committee for Welfare and Population Development (or Minmec, composed of the Ministry of Welfare and Population Development and the provincial

Members of the Executive Council responsible for welfare and population development charged with co-ordination of policy and implementation issues of mutual concern at national and provincial level, commissioned *the Lund Committee on Child and Family Support* in 1996.

The brief of the Committee was to appraise critically the existing system of state support to children and families, investigate increasing parental financial support through the private maintenance system, explore alternative policy options in relation to social security support for children and families, develop approaches for effective targetting and, finally, provide a report with recommendations. It was given six months to undertake the work and worked as a technical committee given the short time-frame. (Report of the Lund Committee on Child and Family Support, 1996: ii).

The analysis of the Lund Committee contextualised the State Maintenance Grant in relation to the role of such grants in poverty relief, the dynamics of power and resource distribution within poor households, the specificity of the dominant family structure in South Africa and its variation from the nuclear two person family norm and the role of the private maintenance system on parental behaviour and support for child/ren.

The child support grant was considered a necessary instrument to alleviate poverty experienced by women and children and should thus continue to be provided, according to the Lund Committee. This decision was in response to of high overall female unemployment, calculated at a rate of 35 percent (compared with a rate of 26 percent for males), with 50 percent of female headed households calculated as in poverty and with 61 percent of children living in poverty.

The targeting by the State Maintenance Grant of parents within a two person nuclear family structure with a male breadwinner and full male employment (similar to the premises of the Beveridge social security model) was considered at variance with the dominant conditions of the family in South Africa (Report of the Lund Committee on Child and Family Support, 1996: 78).

Apartheid influx control and Group Areas legislation had fragmented African, Asian and Coloured family structures, resulting in a migratory pattern of family life, with parents, most particularly African males, separated for long periods from their children by employment in geographically distant areas.

In addition many poor households are large, with average household size 5,9 compared to only 3,9 among the non-poor according to figures from a 1995 SALDRU National Survey (1995: 12). The households of the poor can also incorporate up to four generations in an extended family. The middle generations (mother and father) in a household may be incomplete or missing altogether due to absenting themselves for periods of various lengths in order to obtain employment (Report of the Lund Committee on Child and Family Support, 1996: 17). The Lund Commission proposed that the new child support grant should be paid to the "primary care giver", the person, on the implied

or express consent of the parent, who had primary responsibility for the child, whether they were directly related to the child or not.

The terms of reference of the Committee included consideration of increasing parental support through the private maintenance system. Prior to obtaining a State Maintenance Grant a woman must demonstrate proof that she has tried to obtain financial support from the father of the child though the judicial or private maintenance system. The enforcement of the private maintenance system is the domain of the Department of Justice (Report of the Lund Committee on Child and Family Support, 1996: 48). The key problems identified by the Lund Committee (1996: 50) with the private maintenance system was, firstly, that the Department of Justice both lacked the human and financial resources to run the system effectively and that the overall lack of status accorded to this area by the justice system re-inforced the poor resource allocation.

Secondly, no statistics on maintenance cases are kept by the Department of Justice. This makes it difficult to assess trends, undertake follow-up work and generally plan a coherent system of private maintenance nationally and provincially with appropriate financial and human resources.

Thirdly, there is no means of enforcing fathers to maintain financial support commitments which contributes to a culture of non-payment and irresponsibility and the magistrates are perceived as unsympathetic to the position of women where fathers can demonstrate that their expenditure exceed their income. An important concern is the fact that high levels of unemployment and poverty result in many fathers not having the financial means for private maintenance (Report of the Lund Committee on Child and Family Support, 1996: 58). The confluence of institutional problems with poverty and unemployment, and the absence of a public and legal culture which can enforce male parental responsibility has undermined the private maintenance system. The result is that a large degree of women circumvent the judicial system in favour of direct state social security support placing a large burden on the state for lack of male familial accountability (Report of the Lund Committee on Child and Family Support, 1996).
The first major recommendation by the Lund Committee (1996: vii) was thus that Parent financial responsibility for children should be promoted through the reform of the private maintenance system.

The objective of the proposal was

> *…to switch the signals which the judicial and welfare maintenance system are giving to parents, particularly fathers. There must be a change in the social climate towards promoting parental financial responsibility, which insists that there is a cost to having children.*
>
> (Report of the Lund Committee on Child and Family Support, 1996:85)

To arrive at what it considered an equitable allocation of child support in the context of constrained fiscal conditions, the Committee modelled different levels of benefit with

total available budgetary resources (R1,2 billion, the approximate amount of the 19[illegible] budget allocation with a possible increase to R1,5 to a total of R2 billion) and various age-cohorts (0-4 years, 0-6 years, 0-9 years).

The final, major recommendation of the Lund Committee was for a means-tested R70 monthly flat rate child support benefit in the age-cohort of 0-9 years, to be paid to the primary care-giver within the household. Conditions for receiving the benefit was that the child should be registered at birth and that the parent should engage in certain primary health care related activities. The Committee also recommended that the new Child Support Benefit should be financed by phasing out the Parental Allowance component of the previous State Maintenance Grant over five years and by not accepting new applicants for the Child Allowance component (Lund Committee Report, 1996: 86).

After deliberation of the Lund Committee Report, the Welfare Minmec forwarded recommendations to the Cabinet in February 1997 on the child support grant. The Minmec proposal was that the child support grant be phased in over a five year period for children in the age co-hort of 0-6 years (and not the 0-9 age cohort recommended by the Lund Committee) with the objective of covering 30% of eligible poor children at a level of R75. The cost was estimated at R2,7 billion in 1996 rands (Department of Welfare, March 1998: 7).

Simultaneously, it was recommended that the State Maintenance Grant be phased out over a five-year period through a reduction in the level of grants by 20% per annum from the 1997 financial year.

The attempt to implement the grant after Cabinet approval resulted in wide-scale public criticism from non-government organisations and trade-union organisations active in the welfare arena. The criticism was directed at what was considered a level of benefit and age-cohort target group that was wholly inadequate for meeting needs. The public submission of the Congress of South African Trade-Unions (COSATU) dated 21 April 1997 on the Child Support Benefit proposal was representative of the position of the non-government sectors who opposed the level and target of the Benefit. The major comments concerned two points.

The first point was a macro-level criticism of the perceived influence on the Lund Committee proposals of government defined fiscal constraints:

> *A problem with the Lund Committee's proposed reform is that the objective of increased equality has been overshadowed by government's self-imposed commitment to reduce the budget deficit by cutting-back on expenditure…. The Lund Committee's recommendations are over-zealous in their attempt to squeeze the new system of child and family support to fit into the constrained fiscal environment. Studies have shown that, if implemented, these proposals will lead to a huge reduction (running into billions of Rands over the next five years) in overall government spending on child and family support. (Cosatu, April 1997)*

The second major criticism related to the take-up rate of the new grant and the amount at which the old State Maintenance Grant was to be withdrawn. The consideration here was that government had miscalculated the rate at which take-up of the entitlement would occur, predicting a rapid take-up by all eligible beneficiaries whereas the likelihood was a much slower take-up by a smaller amount of beneficiaries. The simultaneous reduction in the existing State Maintenance Grant, which was to be phased out at 20 percent per annum over five years, meant effectively that not only would less funds be utilised for the new Child Support Grant than anticipated but that there would be a large overall decline of funds to child and family care.

> Cosatu stated in April 1997 that:
>
> *It probably was not be the intention of the Lund Committee Report that there should be such a reduction in overall expenditure on child and family support. But the test is what effect the recommendations are likely to have in practice. The reduction is as a result of the Committee's over-reaction and miscalculation as to how much support payments had to be reduced by in order to meet the fiscal constraints.*
>
> *This miscalculation is based on the error of assuming that the administrative capacity of the system could be instantly expanded to include support payments to every potentially eligible child, whereas in reality it will take some time to expand the system by extending people's knowledge of the system and government's administrative capacity to those parts of the country where it had never been in operation, especially in the rural areas.*
>
> *Based on this miscalculation (sic), the Lund Committee Report recommends a number of inappropriate (and possibly unnecessary) constraints. For example, it suggests that the system be limited to only the poorest 30 percent of South Africa's children, when it is claimed that nearly 70 percent of poor children under 6 years of age live with a care-giver who earns less than R250 per month and about 83 percent of children live with a care-giver who earns less than R800. Attempts to distinguish the 'poorest' 30 percent in this context are futile and open the system up to arbitrary allocations.*

The imperative for de-racialisation within existing fiscal conditions held sway however in government thinking despite the vocal non-government lobby.

The Minister of Welfare and Population Development, Geraldine Fraser-Moleketi responded to criticisms by saying, firstly, that de-racialisation of the grant was non-negotiable and that it was targeted at the most vulnerable of the child age cohort. It aimed at reaching three million children the majority of whom previously had not been covered by any child support grant. The government secondly was meeting its constitutional commitment to provide basic health and welfare to children by focussing the entire grant on child support where previously two-thirds of the grant had gone to the mother. Thirdly, the grant formed part of a package of government policies aimed at the child, the

other major policy being free maternal and child health (Mail and Guardian, May 1997).

The *Welfare Laws Amendment Act of 1997* and the *Regulations Regarding the Phasing Out of Maintenance Grants in Terms of the Social Assistance Act, 1992 (Act No. 59 of 1992) of 1998* legislated the new arrangements for the child support benefit, with the one concession that the amount of the benefit be increased from R75 to R100.

While illustrative of the tension between fiscal constraint and de-racialisation in government social policy the child maintenance grant also raised concerns indirectly about the "deserving and undeserving poor", albeit in a racial casting.

The drive to de-racialisation of the child support grant subsumed equity of economic means into racial equity. In other words the grant was aimed at covering a much larger group but in a way which would leave previous recipients relatively more impoverished after the grant had taken effect. The unintended irony is that Coloureds and Indian recipients of the previous grant were potentially placed in a more vulnerable position than they had experienced under the previous apartheid government.

It would appear from Lund (1998: 16) that a large degree of ambivalence existed within the Committee initially on whether the grant should be abandoned in its entirety. This was due partly, she alludes, to the fact that all the provincial Members of the Executive Council for Welfare except one were medical doctors and men who did not, and could not, be expected to have had an understanding of the economic role the State Maintenance Grant played in the lives of women.

Thus the basic strategy in this context was:

> *This is an uncertain climate for social security, and there is a lack of popular support for the grants for women. If we devise a plan within the fiscal limits set by GEAR (whose basic message was, come up with a plan within the existing envelope) we are likely to retain the existing budget for family-related social security. If not we'll lose it.* Lund, 1998: 16)

The wider implications of the case of the child support grant relate also to other government support grants, the disability and pension grant. The pension grant has a particular significance in that it performs the role of a supplementary income in poor rural households, a de facto poverty alleviation strategy and effective in terms of coverage,. The figures indicate that the pension grant absorbs approximately 60 percent of the social security budget and is well targeted and highly redistributive. Eighty-nine percent of

households receiving old age pensions are African and two thirds go to rural are (Poverty and Inequality Report: 1998: 123).

The problems raised with the de-racialisation of the pension and disability grant are similar in many ways to that of the child support grant though. The de-racialisation involves involve substantial reductions to the level of the grant, of critical importance to people in poverty who benefit, in order to extend them to a wider social group. What is involved is in fact, an equitable sharing of the burden of poverty among the poor, as extension of the grant occurs at lower levels to a wider group. In addition at these lower levels, the value of the grant and thus the incentive is reduced (in particular for the aged) of accessing the grant. The cost of administration is also increased. This illustrates starkly the problem of extending existing provisions to the majority, the central aim of de-centralisation and ANC through-out the period of the anti-apartheid struggle.

De-racialization then, the emerging evidence suggests, is an ineffective strategy for achieving equity in provision of social security in South Africa.

Conclusion

The above discussion has attempted to provide a framework for analysing health and welfare reform in South Africa which locates reform of the system in the institutional and fiscal conditions which are related to the division of labour. This division of labour has structured provision and access to either private or public systems of care according to race and income to the detriment of the largely black unemployed majority. It has also created a schism in provision between the public and private sectors with the bulk of funding, including human resources, diverted to the private sector. This will need to be addressed if the government imperative of meeting the health and welfare needs of the entire population is to be realised.

The present budgetary arrangements for social spending between national, provincial and local government is undermining the achievement of equity across the provinces. This is due to the subsuming of provincial social expenditure into "block" grants which provinces under the new intergovernmental finance arrangements can spend at their discretion and according to varying provincial government spending priorities. These arrangements will need to be revised in order to more comprehensively "ring-fence" funding to health and welfare and ensure a nationally co-ordinated process of achieving equity.

The case of the child-maintenance grant demonstrates finally that the necessary and non-negotiable imperative for de-racialisation of the system of health and welfare is undermined by the fiscal limits imposed on social spending. This has the unintended consequence of placing previously disadvantaged women in a more vulnerable position due to the lower levels of spending of child maintenance (and even despite inclusion of other new health and welfare benefits). The fiscal limits to social spending need to be

reviewed and increased in the context of the unintended consequences of the prese
spending levels.

Further Investigation/Research with Policy-Related Implications

The central policy related conclusion is that the extension of provision of health and welfare to the historically disadvantaged is dependent on effecting mechanisms which can re-structure the presently unequal public/private mix of provision. This is in order to ensure that the private sector, which controls 61% and more of total annual health expenditure, extends social security coverage to a larger degree of the populace than the privileged 18% of the population allowed for by the present arrangements. Private sector arrangements link access to social security to affordability and employment status which, due to a racialised labour market, effectively excludes the poor, unemployed and low-waged while privileging the high-waged employed.

The second conclusion is that the present distribution of policy determination and implementation powers (based on decentralisation and devolution) between national, provincial and local government has to be fundamentally revised if inter-provincial (as well as intra-provincial) equity objectives are to be met . This is because of the inherited institutional context of delivery, combined with the unintended consequences of changes in fiscal and legislative arrangements.

The final conclusion is that the fiscal deficit target needs to be revised at it retards the achievement of equity in social security provision. The objective of an internally re-distributive budget to increase the relative proportion of budgetary resources to basic social services is limited by the fiscal deficit target which increases the vulnerability of the poor because de-racialisation is privileged over economic equity. The child maintenance grant is used to illustrate this problem.

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