FINANCIAL AND FISCAL COMMISSION

For an Equitable Sharing of National Revenue

Submission for the

DIVISION OF REVENUE

2021/2022

FINANCIAL AND FISCAL COMMISSION

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Submission for the 2021/22 Division of Revenue

24 July 2020

Financial and Fiscal Commission

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Acronyms

AGBIS	Agricultural Business Chamber
AGSA	Auditor-General of South Africa
CDU	Chronic Dispensing Unit
COGTA	Department of Cooperative Governance and Traditional Affairs
CUP	Contracting Units for Primary Health Care
CYCW	Community and Youth Care Workers
DBE	Department of Basic Education
DHMO	District Health Management Offices
DOH	Department of Health
DPME	Department of Planning, Monitoring and Evaluation
DSD	Department of Social Development
DTC	Davis Tax Committee
DTP	Diagnosis and Treatment Pairs
ECD	Early Childhood Development
ELRC	Education Labour Relations Council
EMS	Emergency Medical Services
FFC	Financial and Fiscal Commission
GDP	Gross Domestic Product
IGFR	Intergovernmental Fiscal Relations
IGR	Intergovernmental Relations
IMF	International Monetary Fund
LOGIS	Logistical Information System
MECs	Members of the Executive Council
MTEF	Medium Term Expenditure Framework
NDP	National Development Plan
NGO	Non-governmental Organisation
NHI	National Health Insurance
NNSSF	National Norms and Standards for School Funding
NPC	National Planning Commission
PERSAL	Personal and Salary System
PES	Provincial Equitable Share
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMB	Prescribed Minimum Benefits
SALGA	South African Local Government Association
SARB	South African Reserve Bank
SDGs	Sustainable Development Goals
SIAS	Screening, Identification, Assessment and Support
STATSSA	Statistics South Africa
TERS	Temporary Employer/Employee Relief Scheme
UIF	Unemployment Insurance Fund
WHO	World Health Organisation

Foreword

When the Covid-19 pandemic arrived, South Africa's economy was already in recession, the country's sovereign rating was about to be downgraded to sub-investment level, poverty was deepening and unemployment was escalating. Covid-19 and the subsequent lockdown have worsened an already precarious socio-economic situation. In response, South Africa's national and subnational governments are reprioritising expenditure, mobilising resources, repurposing economic and social infrastructure spending, providing support to market industries, and implementing monetary and macro fiscal policy measures. Although the economy is gradually re-opening, the pandemic has increased fiscal and social vulnerabilities. Therefore, it is important to examine all the economic and social interventions being pursued and to determine a clear economic path for South Africa going forward. The impact of the pandemic has highlighted the need for a sustainable financing framework for developmental social services.

Under the theme of ***"Sustainable Financing of Social and Economic Infrastructure and Services"***, this Submission begins the conversation about the implications of Covid-19 for public finances. The most immediate impact on the macro-economic and fiscal framework is the substantial overall increase in government spending on health care and social protection, in particular for the most vulnerable of society. Therefore, in light of the current human, health and economic crisis levels, the Submission begins with an overview of South Africa's pre-Covid-19 economic structure and a brief analysis of economic data for the first quarter of 2020. It then considers the fiscal implications of Covid-19, and looks at agriculture and food security, and the catalytic role of municipal services of water, electricity and sanitation.

Among the structural weaknesses exposed by the Covid-19 pandemic are the imbalances within the health care system. To this end, and given South Africa's human development index, the Commission seeks to address structural challenges of health care financing, by proposing an evidence-based approach to pricing and costing health care, and reviewing the implications of the legislative reform for ensuring universal access of health care through the National Health Insurance (NHI) Bill of 2019 in South Africa. Lastly, the Commission examines the challenges that already exist in public family and community welfare services, which are targeted at the most vulnerable and yet are inadequately funded, in particular early childhood development and inclusive education.

To enable the delivery of the services described above, spending responsibilities are devolved from national to sub-national governments. Yet, despite the decentralised expenditure responsibilities, fiscal powers remain at the national sphere of government with provincial governments almost wholly dependent on national revenue transfers. This contributes to increasing funding gaps, between the delivery mandates and the funding available from both national transfers and own revenues. South Africa has an elaborate intergovernmental fiscal relations (IGFR) system that is meant to facilitate cooperative and coherent service delivery but, as the Submission shows, numerous systemic/institutional challenges hamper the healthy functioning of the IGFR system.

The Commission's role is to ensure that, through the provision of evidence-based research and advice, its Recommendations will contribute to a healthy and sustainably functioning IGFR system. These Recommendations are contained in the annual Submission for the Division of Revenue, which is tabled months before the Minister of Finance's budget announcement. Currently, the Minister of Finance, on behalf of the executive branch, provides the official national government response to the Commission's Submission and Recommendations (as contained in Annexure W1 of the Budget Review). However, year on year members of the various legislatures (Parliament and the nine provincial legislatures) and the

South African Local Government Association (SALGA) enquire and express concerns about the impact of the Commission's Recommendations. The Commission is of the view that the legislative branch of government (the National Assembly and the National Council of Provinces) should determine, through its own processes, the value of the Commission's research and Recommendations. This would complement the current Executive branch's process and assist the Commission in assessing the impact of its annual Recommendations, which are aimed at developing an equitable, efficient and sustainable IGFR system.

The Commission would like to express its gratitude to all its stakeholders for the invaluable inputs provided during the preparation of this Submission.

For and on behalf of the Commission

Professor Daniel Plaatjies
Chairperson
24 July 2020

We, the Commissioners, hereby submit the Financial and Fiscal Commission's Recommendations for the 2021/22 Division of Revenue in accordance with the obligations placed upon us by the Constitution of the Republic of South Africa.

Professor Daniel Plaatjies, Chairperson
Professor Lourens Erasmus
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Professor Michael Sachs, Deputy Chairperson (Term commenced 26 May 2020)
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24 July 2020

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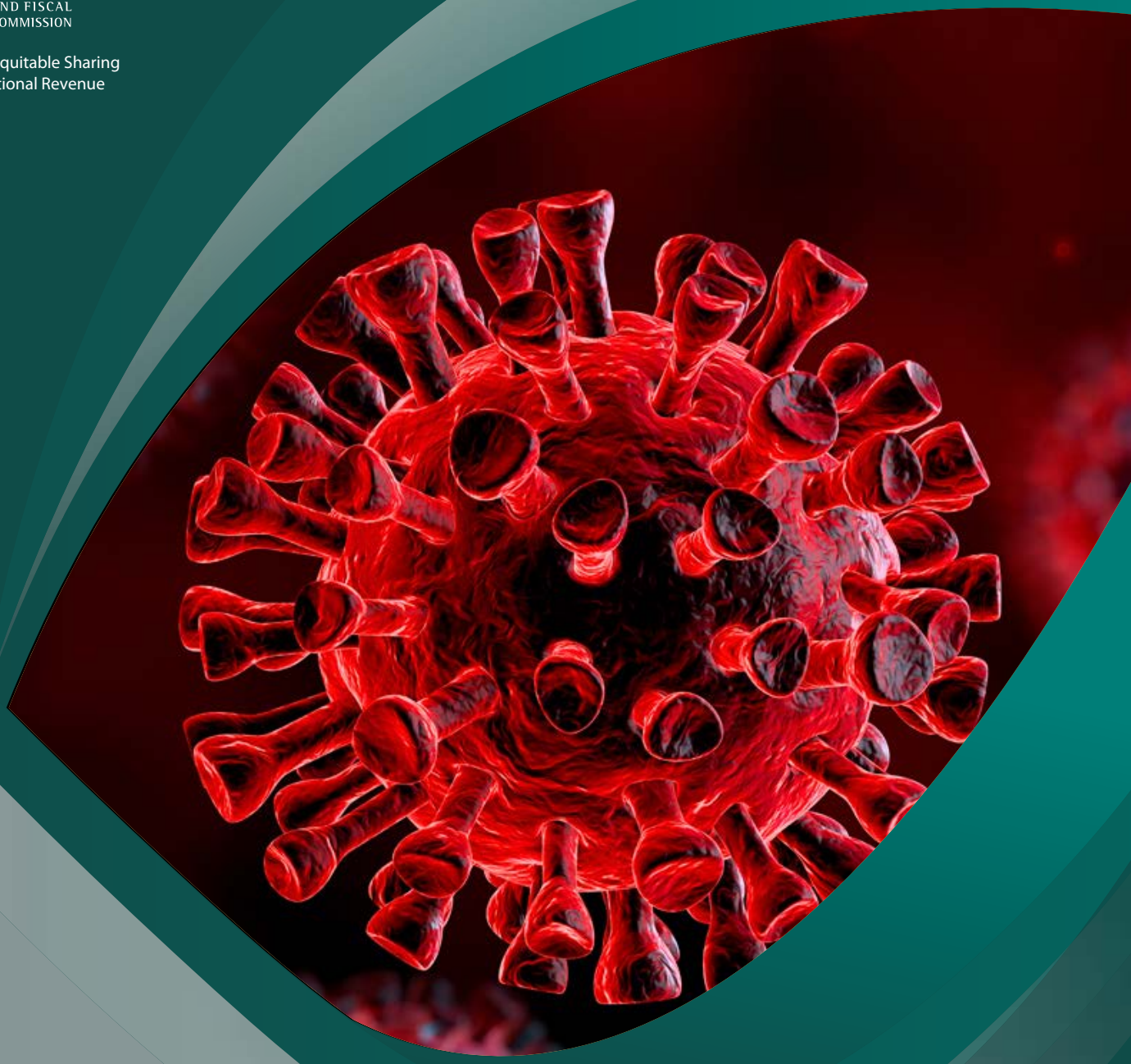

Chapter 1
Introduction

Chapter 1: Introduction

The theme of this Submission is ***"Sustainable Financing of Social and Economic Infrastructure and Services",*** reflecting the need for South Africa's growing social and economic service delivery obligations to be sustainably financed within the context of seemingly deteriorating socio- and macro-economic conditions and, in particular, a weakening fiscal position. The Submission provides a review of the IGFR structures and instruments for social services, with the aim of ensuring that obligations across the relevant spheres are adequately and sustainably funded and delivered. The pre-Covid-19 subdued economic growth outlook and the impact of the pandemic's outbreak have heightened fiscal risks and social vulnerabilities, and brought into sharp focus the need for a sustainable financing framework for developmental social services, such as health, education, and family and community welfare services.

The 2021/22 Submission is tabled against the backdrop of an uncertain and deteriorating economic environment. Challenges facing the economy include long-standing structural weaknesses (the low growth trap), power supply shortages and the Covid-19 induced economic shutdown. In 2019, the economy grew by 0.2% and is expected to shrink by 7% in 2020. This poor growth trajectory will push more South Africans into poverty and unemployment, and exacerbate inequality. Low income earners are expected to bear the brunt of the depression, as their income diminishes at an accelerated pace. Therefore, government will need to cushion the impact of Covid-19 with a range of economic and social relief instruments.

The extent to which government is able to respond to these economic crises and social vulnerabilities depends in part on the institutional arrangements for the delivery of social services. In South Africa, social services are part of the socio-economic rights contained in the Bill of Rights and include education, health, welfare services and housing, as outlined in Schedule 4 (Part A) of the Constitution. The IGFR system plays a crucial role in facilitating the delivery of social services, which are an important part of developmental interventions for eradicating poverty and reducing inequality and unemployment. The Constitution spells out the arrangements for delivering social services and assigns various revenue and expenditure powers to different government spheres and departments. However, institutional arrangements for social services are fraught with multiple challenges, which hinder effective delivery and are likely to undermine sustainable financing and overall fiscal health. Some of these challenges stem from the legislation underpinning IGFR relations, while some reflect coordination failures, and others are related more broadly to funding and poor performance.

The Covid-19 pandemic is putting the health care system under immense pressure and exposing the inherent structural imbalances and weaknesses. The extent of socio-economic inequalities, within a two-tiered (public and private) health care system, makes South Africa's health system particularly vulnerable. The cost of delivering primary health care services needs to be aligned with the provincial expenditure needs or responsibilities, especially given the ongoing perceptions of underfunding within the public health care system and the stark resource inequities between the public and private health care systems. This issue is pertinent in the context of the Covid-19 pandemic, as many of the small-scale primary health care (PHC) clinics are not adequately equipped and capacitated to deal with a viral outbreak, which could potentially put pressure on other parts of the public health-care system. A demand-based costing framework was used to extrapolate the pricing and costing of health care provision, and the results suggest that the PHC package as prescribed by the Health (DOH) is inadequate to meet the demand for health care.

Performance challenges in respect of social services are acutely evident in three areas of government intervention: family and community welfare services, early childhood development (ECD) education, and inclusive education. The Covid-19 pandemic and the subsequent national lockdown may have amplified the hardships faced by the poor and vulnerable, but these challenges are longstanding. Many South African families are dealing with the multiple challenges of poverty, unemployment, HIV/Aids, substance abuse, crime and gender-based violence, child abuse and neglect, and the disintegration of the family unit (DSD, 2019). The unequal access to quality social services, including health care and education, is often visible along income and racial lines, For instance, large numbers of mainly poor and vulnerable children do not have access to quality ECD and special needs education. Several factors compromise the delivery of social services, including the inability to translate legislative and policy imperatives into tangible outputs, substantive funding gaps and the lack of a culture for joint planning and implementation. The prioritisation of social services needs urgent attention, as they provide the building blocks for protecting, nurturing and activating vulnerable people and human capital, and thus reducing poverty and inequality.

Since the outbreak of Covid-19 in South Africa, government has responded with a package of economic and social relief measures, to mitigate against the impact of Covid-19 and the attendant lockdown. These range from a R200-billion business loan guarantee scheme, to a R40-billion unemployment insurance fund (UIF) temporary employer/employee relief scheme (TERS), a supplementary health budget allocation of R20-billion, and a temporary (six months) social grant increase that includes a special Covid-19 unemployment grant of R350 per month. Although the provision of relief to households is comparatively robust and redistributive, the increase in social grants falls far short of the income lost by low-income families, especially as the increase is scheduled to lapse after six months.

Government will need to maintain a delicate balancing act, of stabilising public finances and ensuring sustainable delivery of quality social services, as South Africa's economy is likely to remain fragile, with continued high joblessness and depressed local demand. In addition, national and local revenues are expected to decline sharply as a result of the lockdown and subsequent slow recovery. However, to improve socio-economic development, South Africa will require more than a package of economic and social relief measures; it will require a comprehensive growth and reconstruction programme.

The Submission comprises five chapters. **Chapter 1 provides the context**, with an overview of the fiscal impact and response to Covid-19, and some of the intergovernmental challenges and financing gaps. It highlights the importance of prioritising social services to improve socio-economic development.

Chapter 2 reviews the IGFR system through the prism of social services, looking at the structural, functional and operational facilitators and impediments to financing and delivering social services, as critical functions of provincial governments.

Chapter 3 reflects on the implications of Covid-19 for socio-economic development, and the choice of a future economic path for South Africa, proposing that agriculture offers an opportunity not only to kickstart growth but also to ensure food security.

Chapter 4 is about the sustainable financing of South Africa's health care system and National Health Insurance (NHI). After assessing the value offered by three major packages of health care (PHC, prescribed minimum benefits (PMB) and the proposed demand-based (Pareto) health care package), the chapter examines the NHI reform in the context of legislative and intergovernmental fiscal requirements, and discusses four critical success factors needed to achieve the unification of health care access through the NHI.

Chapter 5 assesses the main challenges to delivering family and community welfare services through a developmental approach, with an emphasis on ECD and inclusive education. It looks at the bottlenecks affecting ECD education, examines the role of the state in light of recent reforms to expand compulsory ECD services and shift responsibility for the function, and evaluates government's progress in rolling out inclusive education.

Recommendations

Below are the Commission's Recommendations for the 2021/22 Division of Revenue:

With respect to IGFR in the context of social services, the Commission makes the following Recommendations:

1. The national departments responsible for key concurrent social functions, especially education and health, must revise their respective enabling or subordinate legislation, to ensure that the roles and responsibilities for various subfunctions or activities within a function are clearly detailed and linked to the accountability framework, i.e. performance management.

2. The national health and education sector departments (including National Treasury and the Department of Cooperative Governance and Traditional Affairs) responsible for operationalising intergovernmental relations (IGR) must invest in financial and human resource capacity to conduct IGR conscientiously and emphasise the values of trust and cooperative governance.

3. The national basic education and health sector departments should reintroduce the outcomes-based performance agreements, as a means of clarifying the lines of accountability between national and provincial executive authorities and all parties supporting the achievement of sector priorities, as per the outcomes approach to monitoring and evaluation introduced in 2009 and the Commission's Recommendations made in its Submission for the Division of Revenue 2014/15.

4. Provincial education departments should incorporate data collection in respect of both eligible and actual learners in ECD, youth vocational training, adult basic education and special needs education within the existing reporting framework, and be required to measure administrator-to-learner and computer-to-learner efficiency ratios.

5. The annual national assessments for Grades 3, 6 and 9, as a means of standardising the assessment of primary and secondary school literacy and numeracy outcomes, should be reviewed and strengthened with new measures of digital literacy, sustainable development knowledge, and existing assessments of life skills in respect of sexual and reproductive health.

6. The district health services directorates of provincial health ministries should measure progress and set annual targets on: clinic leadership and management, health information material disseminated, diagnostic tests and medications issued, municipal utility provision at clinics and district hospitals and computer and medical equipment secured. This is especially urgent in light of the Covid-19 pandemic, which should be used as an opportunity to conduct an audit of health information systems across provinces, so that they can be configured to enable the collection of the required data and entrench measurement and targeting systems.

7. The DOH and Statistics South Africa (Stats SA) must conduct regular demographic and health surveys on official causes of death. These surveys should aim to measure the causes of mortality and morbidity (including the most prevalent communicable and non-communicable diseases, sources of injury, malnutrition, drug abuse, pollution, homicide and suicide) for each province and ideally municipal area.

8. Government should consider balancing the current benefit of the simplicity in the PES formula with a move towards improving the distribution of the overall formula by acknowledging the higher costs of providing services to vulnerable groups and the greater demand for services from certain demographic groups. The proportional distribution mechanism should remain in the PES, but higher weights should be considered for funding vulnerable groups in determining education and health components. This would not result in a change of the overall pool available for education and health, but rather acknowledge and explicitly fund provinces that face greater needs for education and health services given their socio-demographic profiles. This can be achieved as follows:

    a) In the education component, differentiate the school-age population by gender, income and location, and apply a higher weighting for funds for the vulnerable groups. This should be applied also to the data on learner enrolment.
    b) The output sub-component of the health component should differentiate between gender and age of the person using the health service. Higher weights for funding should be applied to persons over the age of 65, women aged between 15 and 49 and children below 5, than for males aged between 5 and 65.
    c) The respective weightings for specific groups should be determined by government and informed by consultations with the respective provinces.
    d) The poverty component in the current PES formula should be updated with the latest income and expenditure data from the 2014/15 Living Conditions Survey undertaken by Stats SA.

9. The departments of basic education and health should urgently pursue efforts to cost the current norms developed in education and health care. This should be done by incorporating the reporting of the costs of specific inputs in the delivery of provincial services through current provincial reporting formats. This would constitute the implementation of a "bottom-up" approach to costing. Government should also use the methods outlined in this report to calculate cost estimates of specific norms and standards. These cost estimates should initially be used to determine provincial expenditure or under-expenditure performance and, in the long term, be considered for incorporation into the PES formula.

With respect to economic and social development in the context of Covid-19, the Commission makes the following Recommendations:

1. The Minister of Finance should develop (and execute) a clear, coherent and comprehensive macroeconomic framework that is in line with the president's economic and social support response package to Covid-19. The Minister should consider the position taken in the Government document, "Towards an Economic Strategy for South Africa", to strengthen the continuity, consistency and credibility of the economic and fiscal stance. These policy positions should be clearly represented in monetary figures, in the 2021/22 Appropriation Bill and Division of Revenue Bill for implementation in the forthcoming Money Bills as per section 77 of the Constitution.

2. After reviewing the economic situation leading up to the Covid-19 crisis, the Commission is convinced that a fundamental structural transformation of the economy is inevitable. Therefore, the ministers of finance, of economic development and trade and industry, and of labour should jointly address the economic barriers, social inequality, and societal polarisation by adopting a localised product value chain approach. The expression of this approach should be found in the incentive grants frameworks of both provincial and local conditional grants, as hard conditions to permit procurement of goods only if they are made or assembled locally within the South African borders, to stimulate the domestic economy and encourage job growth while taking international trade agreements into account.

3. The Commission argues that, with the right infrastructural and financial support from the state, emerging farmers can be catalysts for local economic development and growth with the added benefits of food security in facing the Covid-19 crisis. Hence, the Minister of Finance and the Minister of Cooperative Governance and Traditional Affairs should use reprioritised, consolidated funds to establish an indirect grant and task team for basic services and local economic development. The reprioritisation should be clearly stated in the money Bills over the 2021 medium term expenditure framework (MTEF).

With respect to the sustainable financing of South Africa's health care system and NHI, the Commission makes the following Recommendations:

1. The ministers of health and finance should prioritise the development of an integrated national information system of patient and doctor registries with real-time data, to inform health care financing and provisioning decisions using the demand-based costing methodology. The funding of this data system should be pronounced in the 2021/22 Division of Revenue Bill and Appropriation Bill, completed by 2022/23 for roll-out in 2023/24, testing in 2024/25 and stabilising in 2025/26.

2. The Minister of Health must re-examine the prescribed PHC package based on the needs of the people, refocusing from informing, promoting, identifying, facilitating and educating activities to providing health care services. This should be supported by reprioritisation from within the current baseline allocation of Programme 4: Primary Health Care to ensure that care is available to those who come into primary health care facilities in need of medical attention and curative treatments.

3. The ministers of health and finance must ensure that an enabling policy and legislative framework, aligned among the spheres of government, is put in place with due regard to setting norms and standards, and is enforced with proper oversight by the established technical committees. The Minister of Finance should include these deliberations in Annexure W1 of the Division of Revenue Bill with implications on the Bill, as well as the Budget Review document.

4. The Minister of Health should examine and eradicate the inefficiencies of wastages, corruption and leakages that result from the disparity of the two-tiered (private and public) health care system. In particular, procurement decisions of health care goods and services should be made by consulting health professionals and workers with the necessary expertise and professional integrity. A portion of the department's budget should be set aside for establishing a technical committee of health professionals to decide on purchasing and procuring facilities, instruments, and medicines.

With respect to vulnerability and access to quality and inclusive social services, the Commission makes the following Recommendations:

1. The Department of Social Development (DSD) should lead the development of a three-year progressive realisation sector plan to ensure the establishment of interventions that proactively strengthen and stabilise at-risk families and communities.

2. Based on emerging local evidence, the DSD should consider establishing a holistic package of family interventions that combines income support with targeted family care interventions.

3. The DSD should conduct a nation-wide audit and mapping of ECD services being rendered.

4. Together with relevant stakeholders, the DSD should lead the finalisation of legislation for ECD together with a fully costed, time-bound implementation plan.

5. Government should take urgent steps to strengthen funding for ECD in South Africa. Particular priority should be given to funding all non-profit, non-centre based ECD programmes serving quintiles 1 to 3. Related to this, the process and requirements for registration should be simplified, and specific and appropriate registration requirements for non-centre-based ECD programmes should be finalised with haste.

6. Government should ensure further targeted support to non-profit ECD programmes in quintiles 1 to 3 focusing on infrastructure upgrades, to enable these centres to register and receive subsidies, and for funding for basic early education equipment, which will enhance the early learning programme and prepare young children for formal schooling from Grade R to Grade 12, and beyond, into tertiary training.

7. The departments of basic education, social development and higher education and training should prioritise the upskilling of existing ECD practitioners and develop a plan to professionalise the ECD career path, with a comprehensive and harmonised professional development system.

8. Alongside finalising legislation to underpin the roll-out of inclusive education, the DBE should take the lead in developing a public sector detailed, time-bound and costed implementation plan that promotes awareness of what inclusive education entails.

9. As a matter of priority, the DBE together with relevant stakeholders, need to determine the extent of learners with special educational needs. This will assist in ensuring more evidence-based policy-making and implementation. The assessment should be aligned to the 10 domains of support identified in the Education White Paper 6 and all three levels of support.

10. To support the implementation of inclusive education in South Africa, the DBE must spearhead the development of a holistic funding framework to ensure a uniform approach to funding learners with special educational needs, irrespective of the type of school they attend.

11. The DBE must take steps to adjust reporting in order to allow for disaggregation of funding and performance information related to the roll-out of inclusive education.

12. With respect to inclusive education, the DBE and the Department of Higher Education and Training must prioritise the development of teacher capacity at higher education level and as part of ongoing professional development initiatives.

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Chapter 2

Intergovernmental Fiscal System in the Context of Social Services

Chapter 2: Intergovernmental Fiscal System in the Context of Social Services

2.1 Introduction

South Africa's IGFR system plays a crucial role in facilitating the delivery of social services, which are an important part of developmental interventions for eradicating poverty and reducing inequality and unemployment. In South Africa, social services are part of the socio-economic rights contained in the Bill of Rights and include education, health, welfare services and housing, as outlined in Schedule 4 (Part A) of the Constitution. The Constitution spells out the arrangements for delivering social services, with the various powers and functions assigned to the different government spheres and departments. Some of these powers and functions are exclusive, meaning that only one of the spheres is responsible for setting policies, funding and implementation, while others are concurrent, meaning they are shared among the different spheres of government.

Social services are classified as concurrent national and provincial functions. The generally established practice for concurrent functions, both in law and application, is that national government formulates policies, determines regulatory frameworks, sets the norms and standards, provides the requisite funding and oversees implementation, while provinces are responsible for implementation, in line with the nationally determined frameworks with oversight through the provincial legislature.

National government also has control over the major taxing powers. Therefore, the Constitution addresses the fiscal imbalance and potential abuse or lack of power that may result from centralised revenue powers but highly decentralised expenditure responsibilities. Sections 214 and 227 specify that each sphere of government is entitled to an equitable share of nationally raised revenue. The provincial equitable share (PES) is an unconditional transfer to ensure that provinces have sufficient resources to meet their constitutional obligations. In addition, Chapter 3 establishes that IGR are based on the principles of cooperative governance and consultative governance. The IGFR framework is largely concerned with the division of legislative, revenue and expenditure powers and with facilitating cooperative governance.

Coordinating the governance and delivery of concurrent social services is fraught with multiple challenges. These include a contested policy space, a lack of delivery norms and standards, the perceptions of underfunding, budget gaming[1], national government interference in provincial affairs and judicial involvement in spelling out policy parameters, as well as capacity deficiencies and vague delivery outputs and outcomes. There are also structural tensions between the spending/delivery agents (the provinces) and the suppliers of funds (national government). Most of these tensions relate to the pace and quality of service delivery and the need for value for money given the limited resources available. There is a growing perception and evidence that several challenges are compromising the quality of public health care services in South Africa, resulting in the loss of public trust in the system (Maphumulo and Bhengu, 2019). Similarly, South Africa's educational achievements are poor by almost any international metric due to factors unrelated to funding, such as limited subject knowledge, socio-economic status, history, race and language (Mlachila and Moeletsi, 2019).

1 This refers to the manipulation of information in order to disguise budget difficulties or attract additional funding.

The tensions are the result of both weaknesses in the design of IGFR institutional architecture and a misunderstanding of the execution of concurrent functions. In particular, the perceived or otherwise misalignment of provincial budgets and national priorities, which occurs when provinces are (perceived as) not adequately funding national policy priorities from their equitable share allocations. The Constitution advocates uniformity or equality in the distribution and provision of services across all provinces. National government is responsible for ensuring provinces are funded to deliver national priorities while adhering to the minimum norms and standards. However, provinces contend that, as a semi-autonomous sphere of government, they should not be subjected to wholesale national policy imperatives, as their budgets reflect the competing needs applicable to their specific circumstances. They argue that they should have some discretion in how to allocate their unconditional share of nationally raised revenue to concurrent functions. This view intrinsically recognises provinces as an executive and legislative authority that can take decisions independently through qualified institutions. The lack of intergovernmental consensus on delivery responsibilities and performance leads to overreaching by national departments, which either take over provincial functions and control the funding, or simply pass the buck to provinces when resources are unavailable or inadequate. Similarly, provinces often abuse the system by deviating from national policy requirements on the grounds of ambiguity, autonomy or underfunding. When such intergovernmental tensions arise, service delivery is adversely affected.

These tensions raise questions about the effectiveness of intergovernmental forums, which were established to facilitate cooperation and coordination across sector departments responsible for concurrent functions. The disagreements, about allocations, national priorities and adherence to norms and standards, suggest weak and fragmented consultation and coordination.

The accountability chain for concurrent functions is somewhat nebulous, and accountability arrangements are not clearly defined between the Presidency, Parliament, legislatures, premiers, ministers and members of the executive council (MECs). These accountability ambiguities remain, despite government adopting an outcomes approach to monitoring and evaluation, which covers key outcomes that a collective of ministries are responsible for implementing. The approach attempts to align government planning, budgeting, activities, reporting and accountability for shared outcomes, by introducing new institutional mechanisms, such as performance agreements, sector delivery agreements and delivery forums. The president signs performance agreements with ministers and intergovernmental protocols with provincial premiers, which outline outcomes for a specific sector, input activities and output measures.

What is missing is a framework that clarifies institutional and funding arrangements and responsibilities for concurrent social services. Currently, it is unclear if the national ministers should be held accountable for performance or delivery failures when the resources are transferred directly to provinces (which by law are accountable to provincial legislatures). Similarly, subnational governments are adamant that they cannot be held directly accountable for slow delivery when they are deprived of the resources necessary to meet the ambitious policies set by national government. Without greater clarity, South Africa will continue to achieve unsatisfactory health and education outcomes and to have intergovernmental complaints.

A way of mediating the interests and arguments of different spheres is to measure outputs (spending efficiency) and outcomes (policy effectiveness). However, this requires a mechanism that links the inputs required to deliver social services outputs to the resources allocated to provinces. In 2001, the Commission proposed such a mechanism, which was never implemented due to data shortages.

The absence of costed norms in the current funding allocation mechanism for social services also means that government is unable to link resource allocations to delivery norms and standards and outcomes – and, more importantly, to evaluate if it is progressively realising socio-economic rights as required by the Constitution.

The chapter analyses the IGFR for social services in South Africa, with an emphasis on the governance, delivery and funding challenges within the health and education sectors. After describing the legislative institutional framework underpinning concurrent functions and some of the main IGFR challenges for delivering social services, the chapter reviews the education and health performance data available for measuring outputs and outcome measures. The costed norms approach is then revisited, based on the data available and current norms and standards. In concluding, the chapter draws upon previous recommendations of the Commission, that ongoing reforms of the PES should consider other pillars of the decentralisation system, especially clarifying the "own" vs. "delegated" responsibilities with respect to concurrent functions.

2.2 Research Methodology

The study used a combination of qualitative and quantitative research. A descriptive account of the legislative institutional framework underpinning concurrent functions and the underlying challenges was followed because the problem of concurrent functions has not been fully researched in South Africa's IGR system. It is followed by a detailed review of the coverage, duration, frequency and regularity of education and health performance data, and a data audit of costed norms data requirements compared to available data sources to enable the possible implementation of the formula.

2.3 IGFR Challenges for Social Services

The challenges that affect the effective functioning of IGFR for social services include a lack of legislative clarity, weak IGFR coordination and participation, and the perception of underfunding and of performance capacity.

2.3.1 Legislative Challenges

The main challenge is the lack of clarity over whether concurrent functions constitute a voluntary (own) or a mandatory (delegated) responsibility for provinces. The Constitution provides for both the national government and the provinces to have authority over – and be responsible for – the concurrent functions listed in the Schedule 4 (Murray, 2009). The national Parliament (section 44) and provincial legislatures (section 104) have the authority to legislate on matters listed in Schedule 4 (concurrent functions), while the national executive (section 85) and provincial executive (section 125) have the power to implement such legislation. In addition, section 125 limits the executive authority of the provinces to implement national policies but also obliges national government to ensure that provinces deliver basic services. However, there are no definitive criteria for measuring provincial capacity to implement national policies. This lack of standard measures of administrative capacity and continuous assessment leads to disputes when delivering concurrent services, especially when undertaking section 100 interventions or determining the nature of fiscal transfers to provinces.

In December 2011, these deficiencies became apparent when national government intervened in the financial and administrative affairs of several provincial departments (including health and education) in Gauteng, Free State and Limpopo provinces. National government placed the affected provinces under the different levels of intervention as provided for in the Public Finance Management Act (PFMA) of 1999

without regard to the varying severity of fiscal management challenges. In Gauteng, the intervention was undertaken in terms of section 6(2)(f)–(g) of the PFMA, while the Free State intervention was in accordance with section 100(1)(a) of the Constitution. These were interventions that required national government to issue directives on necessary corrective steps and were less intrusive than the Limpopo intervention. Initiated in terms of section 100(1)(b) of the Constitution, "the Limpopo intervention entailed an effective takeover of the powers and functions of aspects of the provincial administration for a specified period" (FFC, 2012: 4). In reviewing these interventions, the Commission made recommendations for addressing the regulatory, structural, incentives and capacity challenges hampering effective intervention (ibid).

Notwithstanding the limitations placed on provinces to comply with national policy, provinces have also not updated their subordinate legislation to keep up with the changing education and health environment, particularly legislating province-specific delivery norms and standards in the absence of national policy directives.

2.3.2 Coordination Challenges

Deep concerns remain about the ability of IGR structures to foster coordination, good governance and improved delivery. Both national and provincial national departments of education and health are increasingly frustrated with the workings of the IGR and IGFR systems.[2]

For the national government departments:

- There is no point in developing policies aimed at achieving certain outcomes (especially equity and equal opportunities) if they cannot be implemented because provincial budgets do not allocate sufficient resources to these priorities.
- Provincial executives, sector departments and provincial treasuries are not doing enough to ensure that intergovernmental agreements are adhered to.
- Provinces tend to prioritise projects that have different redistributive and redress impact to national priorities, especially when funds are "siphoned-off" from allocations for national priorities to fund the provincial priorities.
- National government cannot be held accountable for delivering services where it does not control the budgets.

For provinces:

- National and provincial priorities are not different and always find expression in provincial budgets. Any differences relate only to the emphasis each sphere places on a particular priority.
- Provinces should determine appropriate funding levels for national priorities in relation to concurrent functions, as they are closer to "the action", and are better able to understand local needs and to assess the capacity of departments to absorb resources. Also, policy priorities are rarely costed before being finalised, which fuels perceptions of underfunding by provincial sector departments.
- The current funding mechanisms (vertical and horizontal divisions, and conditional grants) do not take into account provincial economic development needs, while the current budget process does not provide sufficient room for spending priorities outside of social services.
- The growing phenomenon of earmarking allocations reduces provincial expenditure discretion.

2 These views were expressed in various technical committees of finance and other meetings.

A diagnosis of the entire IGR framework relating to policy-making and budgeting highlights the following challenges.

- The high level of concurrency and large number of interdependent government spheres and departments lead to fragmentation and generate high administration and coordination costs.
- The nature and quality of the IGFR consultations appear inconsistent with the spirit of cooperative governance. During the priority-setting process, national priorities take precedence, which reinforces the view that provinces are the implementing agents of national government, not semi-autonomous spheres of government.
- IGR forums[3] have limited scope to ensure the alignment of policy and budgets for concurrent functions because of the conventional line-function culture of planning, budgeting and implementation, which rewards individual performance. These forums and committees also have their own specific gaps (information asymmetry, unilateralism, and competition) and largely respond to an imperfect process, as it filters down the budgeting process.
- National government makes wrong assumptions about the capacity of provinces to assimilate and customise national policies to their circumstances. These policies are sometimes not well articulated and costed to ensure seamless implementation.

Provinces are represented in all political and official decision-making structures, and provinces and national government should play an equal role in setting policy priorities and influencing the division of revenue. However, disquiet over the sharing of responsibilities for concurrent functions continues and is a direct result of the IGFR design needed to operationalise concurrent functions, i.e. how the share of own-revenue and expenditure responsibilities are assigned to provincial departments (Rodriguez-Acosta, 2016).

2.3.3 Funding Challenges

The main challenge is the perceptions of underfunding or vertical fiscal imbalance. Evidence from provincial submissions made at various forums, especially budget hearings, and the implementation of various programmes (such as oncology services in KwaZulu-Natal) suggest that social services experience serious budget shortfalls (FFC, 2014; 2018). Reasons for these shortfalls range from a misalignment of revenue and expenditure responsibilities, to incremental budget decision-making, the lack of (or poor) costing of policies, high service delivery norms and standards, incremental budget decisions and rapid growth in expenditure (Arnett, 2012). In the education sector, a particular costing challenge is that education departments reach an agreement with labour unions about post-provisioning norms (number of posts to be filled in the next financial year) during September, but only finalise their budgets in March. As a result, the budget for personnel costs is misaligned, which affects the sector's overall performance.

The second challenge is that the primary goal of the equitable share allocated to provinces for social services is unclear, and so the transfers have many objectives – to equalise, distribute, or redistribute public funds to the subnational governments. In some ways, the PES plays the role of an "equalisation grant" found in many other systems of decentralised finance, but it is also the main source of vertical fiscal imbalance.

The frictions and misunderstandings between government spheres are likely to increase until a standard methodology (or a widely accepted principle) is in place for estimating the expenditure needs of provinces based on their assigned education and health responsibilities. In the meantime, subnational governments will continue to argue that the current level of financing is inadequate, while national government will continue to argue that the current level of financing is more than adequate for the responsibilities assigned to provinces.

3 These include heads of departments (HOD) forums, the Technical Committee on Finance, Joint MINMECs, Presidential Coordinating Committee (PCC), extended Cabinet and Budget Council

2.3.4 Performance Challenges

The lack of norms and standards is a long-standing challenge, despite national government's constitutional requirement to ensure uniform access to basic services. It leads to variations in allocations and service quality across provinces, and causes intergovernmental fiscal disputes and unnecessary legal battles. Civil society groups are increasingly approaching the courts of law to ask them to pronounce on policies, which has serious implications for the budget and allocation framework. For instance, the Bhisho High Court ordered the Minister of Education to promulgate and fund norms and standards for school infrastructure as required by the South African Schools Act,[4] while the Free State High Court ordered the provincial DSD to review its policy on funding non-governmental organisations (NGOs) because it lacked a fair, equitable and transparent method for determining the amount of own funding contribution required from the NGO to fulfil state obligations.[5] These two judgments underscore the need to set minimum delivery and funding norms and standards that take into account macro-economic and fiscal constraints.

Another challenge is that provinces do not fully comply with norms and standards that are in place. This points to weak cooperative governance and a lack of enforcement by national government due to inertia, weak oversight and the complex system of intergovernmental accountability.

2.4 Output and Outcome Measures for Social Services

Basic education and health care are two of the most important social services provided by governments. The United Nations has set 12 sustainable development goals (SDGs) for 2030 with indicators and outcomes. SDG4: "Quality education" includes primary and secondary school literacy and numeracy, ECD and vocational training, as well as input indicators related to school infrastructure, scholar funding and teacher training. (Unesco, 2018). SDG3: "Good health and wellbeing" includes reducing maternal and infant deaths, as well as premature mortality from communicable and non-communicable diseases, aiming for universal access to sexual and reproductive health care, and health risk insurance, as well as cross-cutting input measures such as research into medications and vaccines and health worker training (WHO, 2018). These indicators provide a starting point for measuring education and health outcomes for South Africa. A review of South Africa's education and health performance data reveals the following:

- Between 10 and 20 years of data is available to calculate learner : educator ratios in South Africa. The data for primary and secondary schooling is available at national and provincial level, while the data for ECD, youth vocational training and special needs education for the disabled is available only at national level.
- Five years of data is available to measure learner support material, school nutrition, scholar transport, school infrastructure and utilities inputs and spending per learner at both national and provincial levels.
- Insufficient credible data is available for measuring the efficiency of health services (i.e. for calculating per patient spending and cost), such as patient numbers, profiles and care in provincial clinics, hospitals, emergency, mental health, palliative and disabled care facilities. The time series is too short for health worker and professional numbers.

4 *Equal Education and Another v Minister of Basic Education and Others* (276/2016) [2018] ZAECBHC 6; [2018] 3 All SA 705 (ECB); 2018 (9) BCLR 1130 (ECB); 2019 (1) SA 421 (ECB) (19 July 2018)

5 *National Association of Welfare Organisations and Non-Governmental Organisations and Others v Member of the Executive Council for Social Development , Free State and Others* (1719/2010) [2014] ZAFSHC 127 (28 August 2014)

An international comparison suggests that South Africa has 44% of the capacity required to measure educational performance and 32% of that needed to measure health performance (FFC, 2020). Tables 2.1 and 2.2 show the extent of data gaps in the health and education sectors.

Table 2.1: SA health output data available for performance evaluation – beneficiaries

Performance indicator	WHO time series	DOH strategic plan and APP time series	DOH reported at provincial level	DPME reporting time series	DPME reported at provincial level
Outputs – eligible vs actual recipients – with errors of exclusion and inclusion					
Patient age profile	No	No	No	No	No
Patient gender profile	No	No	No	No	No
Clinical care patients	Yes – eligible 2010, 2013 No – actual	Targets set 2015–2019	Yes – 1998, 2003, 2016	No	No
Hospital care patients	Yes – eligible 2010, 2013 No – actual	No	No	No	No
Emergency care patients	No	No	No	No	No
Mental health care patients	Yes – 2000, 2015	Yes – Targets set 2013–2019	No	No	No
Palliative care patients	No	No	No	No	No
Disabled patients	No	Yes – eligible 1998, 2003, 2016 Targets set – actual 2019	Yes – eligible 1998, 2003, 2016 No – actual	No	No
Outputs – Governance					
Health insurance coverage (SDG 3.8)	Yes – incidence of catastrophic out-of-pocket spending 2000, 2005, 2010, 2015	Yes – data 1998, 2003, 2016 Targets set 2014– 2019	Yes – data 1998, 2003, 2016	No	No
Health worker qualifications (SDG 3.12)	No	Yes –Targets set 2008– 2019	No	No	No
Health emergency preparedness (SDG 3.d)	New target	Yes – Targets set 2014– 2019	No	No	No

Source: DOH (1998, 2003, 2016a, 2016b, 2019a, 2019b), DPME (2019), WHO (2019)

Table 2.2: SA educational output data available for performance evaluation

Performance indicator	Unesco time series	DBE strategic plan and APP time series	Reported at provincial level by DBE	DPME reporting time series	Reported at provincial level by DPME
Outputs – eligible vs actual recipients – with errors of exclusion and inclusion					
Primary school learners	Eligible - Yes Actual – Yes 2010–2019 Errors of inclusion 2010–2019	Eligible – Yes Actual – Yes 2002–2018 Errors of inclusion 2002–2018	Yes – errors of exclusion 2002–2017 No – errors of inclusion	Eligible – No Actual – Yes 2002–2018 No	No
Secondary school learners	Eligible – Yes Actual – Yes 2010–2019 Errors of inclusion 2010–2019	Eligible - Yes Actual – Yes 2002–2018 Errors of inclusion 2002–2018	Yes – errors of exclusion 2002-2017 No – errors of inclusion	Eligible – No Actual – Yes 2002–2018 No	No
ECD learners (SDG 4.2)	Eligible – Yes Actual – Yes 2010–2019	Eligible – Yes Actual – Yes 2002–2018	No	Eligible – Yes Actual – Yes 2002–2017	No
Youth vocational training learners (SDG 4.3)	Eligible – N Actual – Yes 2010–2019	Eligible – No Actual – Yes 2007–2018	No	Yes 2007–2017	No
Learners experiencing violence (SDG 4.A.2)	Yes 2017–2019	Yes 2017	No	No	No
Disabled learners	No	Eligible - Yes Actual – Yes 2002–2018	Eligible – Yes Actual – Yes 2015	No	No
Gender profile of learners (SDG 4.5.3)	Eligible – Yes Actual – Yes 2010-2019	Actual – Yes 2002-2018	Actual – Yes 2002-2018	Actual – Yes 2002–2018	Actual – Yes 2002–2018
Socio-economic status of learners(SDG 4.5.3)	Eligible – Yes Actual – No 2010–2019	Actual – Yes 2002–2018	No	No	No
Teacher training & funding (SDG 4.C)	Yes 2010–2019	Yes 2013, 2017	Yes 2013	No	No

Source: DBE (2019), DPME (2019), Unesco (2018)

2.5 Revisiting the Costed Norms Approach

As concerns grow about the efficiency and effectiveness of provinces, and the asymmetric quality of services provided across the country, the ability to evaluate the performance of provincial resource allocation and provincial outcomes becomes even more relevant. In 2001/02, the Commission proposed a costed norms approach for allocating the PES, which was subsequently rejected by national government because, at the time, much of the data required to operationalise the formulas was lacking. Since then, no attempt has been made to review the costed norms formula or to assess its applicability to the current IGFR environment. The costed norms approach was designed to enable all provinces to achieve the national standards of basic services, while retaining their autonomy to design programmes in ways that suit their particular circumstances (FFC, 2001). It also ensured that each province would have the appropriate level of funding to provide basic services to all members of its constituency according to the norms and standards that are affordable within the national fiscal framework. More importantly, the costed norms approach explicitly accounted for regional differences in cost drivers.

Without costed norms in the current PES allocation, the government is unable to link resource allocations to delivery norms and standards and outcomes – and, more importantly, to evaluate the progress in realising socio-economic rights as required by the Constitution. However, many of the variables required to implement a costed norms approach are now available, thanks to improved provincial financial and non-financial reporting, and further research into provincial services costing, outputs and outcomes. Great strides have been made in collecting provincial level financial and non-financial data, particularly by National Treasury, Stats SA and the respective sector departments.

2.5.1 Data Audit

The original data requirements of the costed norms formula included the initial service "norms" proposed by the Commission to operationalise the formula in the face of a lack of data at the time. In 2001, legislated or stipulated policy norms and standards for education and health care did not exist, and so the Commission had proposed certain service standards. As Table 2.3 shows, not all the data required for the costed norms approach is available.

Table 2.3: Data availability for operationalising the costed norms approach

Variables	Availability
Education Component	
Poor primary school learners in urban areas per province	Partial
Poor primary school learners in rural areas per province	Partial
Non-poor primary school learners in urban areas per province	Partial
Non-poor primary school learners in rural areas per province	Partial
Poor secondary school learners in urban areas per province	Partial
Poor secondary school learners in rural areas per province	Partial
Non-poor school learners in urban areas per province	Partial
Non-poor school learners in rural areas per province	Partial
Number of special school learners per province	Yes
Number of inappropriate aged ordinary primary school learners per province	No
Learner-educator ratio for primary school – urban rural	No
Learner-educator ratio for secondary school – urban rural	No
Number of primary school teachers per province	Yes
Number of secondary school teachers per province	Yes
Average/total remuneration of primary school teachers per province	No
Average/total remuneration of secondary school teachers per province	No
Average/total remuneration of special school teachers per province	No
Average/total administrative expenditure of primary ordinary school (non-personnel spending) per province	No
Average/total administrative expenditure of secondary ordinary school per province	No
Average/total administrative expenditure of special school per province	No
Average/total books and supplies of primary ordinary school per province	No
Average/total books and supplies of secondary ordinary school per province	No
Average/total books and supplies of special school per province	No
Health component	
Total number of males between the ages of 5 and 65 in poor and non-poor households per province	Partial
Total number of women between the ages of 5 and 15 in poor and non-poor house-holds per province	Partial
Women between the ages of 50 and 65 in poor and non-poor households per province	Partial
Children under the age of 5 in poor and non-poor households per province	Partial
Women between the ages of 15 and 49 in poor and non-poor households per province	Partial
The aged over 65 in poor and non-poor households per province	Partial
Poverty rate per province	Yes
National average poverty rate	Yes
Total/average costs of indirect services (clinic transport and administration) per province	No
Total/average cost of delivering primary health care per province	No
Total/average cost of delivering secondary health care per province	No

Source: Commission compilation (2020)

2.5.2 Norms and Standards

The education sector does not have norms and standards that consider holistically all aspects of educating learners through primary and secondary schooling. Norms and standards exist for educators, school infrastructure and school funding. They are also available for school posts (through the post-provisioning norms) but are not standardised across provinces and are generally unaffordable (ELRC, 2018). Of relevance to the costed norms approach is the National Norms and Standards for School Funding (NNSSF), which was introduced in 1998. The aim of the NNSSF is to address the historical resources gap between rich and poor schools and to ensure that non-personnel resources are distributed equitably across different types of schools. The NNSSF sets out the financial responsibilities of the state and general public in relation to public ordinary and independent schools; outlines average adequacy benchmarks; provides predetermined funding targets for learners of different socio-economic status; and regulates school fee exemptions requirements and the general governance of public ordinary schools (DBE, 2006).

In the health sector, the national DOH has produced legislation and policy that give a benchmark of the range and quality of primary health services to which ordinary South Africans are entitled. The "Primary Health Care Package for South Africa" defines a "norm" as the statistical normative rate of provision and a "standard" as a statement about a desired and acceptable level of health care (DOH, 2001). It gives provinces direction for allocating resources against the backdrop of a set of primary health care norms and standards, but without cost estimates. The consequence of trying to meet these norms and standards in the absence of cost estimates is that provinces are likely to overspend (on compensation of employees), to defer essential goods and services or infrastructure spending to accruals, or to provide inefficient services (FFC, 2019).

2.5.3 The Costed Norms Approach and the PES

The costed norms approach is a benchmark for the appropriate funding of provinces, given its comprehensive formula with relatively allocative efficiency. Internationally, several funding mechanisms use both demand and supply side factors in the form of costing services (Brodjonegro and Martinez-Vazquez, 2015; Gordon and Vegas, 2005; World Bank, 2001). In South Africa, although progress has been made in collecting provincial data, costing data remains elusive. The lack of data means that not all aspects of the Commission's original costed norms formula can be implemented. Education and health norms and standards have been developed, but they are not comprehensive (i.e. covering all aspects of education and health), and none have been costed.

Provincial financial reporting focuses on overall expenditures, rather than on identifying specific input costs. Yet the use of costing methodologies is the best way to ascertain the costs of service delivery and is not as expensive as collecting costs directly. There are methods for estimating service costs that can be replicated in the South African provincial context.

The current PES is largely a demand-driven allocation model that is simple and appropriate in a data-constrained environment, and its flexible formula allows additional data to be incorporated. However, the PES assumes considerable uniformity among provinces and demand factors and does not differentiate between the different costs and burdens placed on provincial services by different demographic groups. This suggests that the current PES formula is relatively allocatively inefficient and that the current distribution of the PES could be significantly improved by incorporating certain aspects of the costed norms model into the PES formula. The research confirms that data is available to differentiate the population by gender and poverty profile, which are factors that affect service demand and the costs of providing such services. For instance, differentiating the school-age population by gender, income and location, and applying a higher

weighting to funds for vulnerable groups in the education component, and by gender and age for persons using health services. Incorporating such aspects into the current PES would improve the distribution of allocations and the overall allocative efficiency of the formula.

2.6 Conclusion

This chapter examined the IGFR challenges that affect the delivery of social services in South Africa, in particular education and health care services. Social services are a crucial part of developmental interventions aimed at eradicating poverty and reducing inequality and unemployment. They account for the lion's share of the national budget and are of considerable interest to the political authorities, the legislature and the general public. The IGFR arrangements affect the delivery of social services, which are delivered concurrently by national and provincial government. National government is responsible for making policy, setting national norms and standards and providing the requisite funding, while provinces implement the policies in accordance with national legislation. Although the Constitution provides a guiding framework to facilitate the smooth running of the IGFR among spheres of government, concurrent functions and powers are invariably susceptible to intergovernmental tensions and disagreements.

Several long-standing challenges affect the effective functioning of IGFR for social services. They include the lack of legislative clarity over whether provincial concurrent functions constitute "own" (make decisions with complete autonomy) or "delegated" (comply with national mandates) responsibilities. Another challenge is the weak coordination and participation in IGFR, and the quality of provincial representation and the capacity of national government to oversee effective IGR is questionable.[6] Tensions arise because of the ubiquitous perception of underfunding that is fuelled by the inability of the social sectors to cost their expenditure needs. The result is ongoing debates about the inability of national government to fund new policy priorities versus the performance capacity of provinces. Yet currently no system is in place to measure outputs (spending efficiency) and outcomes (policy effectiveness).

A costed norms approach enables inputs to be linked to resources and allocations to delivery outcomes. Currently, the costed norms approach cannot be implemented fully because of insufficient data and the lack of a proper costing of education and health norms and standards. However, thanks to developments in data collection and costing methods and the current design of the PES formula, certain elements of the costed norms approach could be incorporated into the current PES formula, to improve the relative distribution of allocations.

2.7 Recommendations

With respect to IGFR in the context of social services, the Commission makes the following Recommendations:

On improving IGFR for social services:

1. *The national departments responsible for key concurrent social functions, especially education and health, must revise their respective enabling or subordinate legislation, to ensure that the roles and responsibilities for various subfunctions or activities within a function are clearly detailed and linked to the accountability framework, i.e. performance management.*

6 By way of observation, provinces often register their dissatisfaction regarding fiscal matters discussed and agreed to at IGFR forums with the Commission, even when they may have numerous opportunities to make representations at the forums. This is partly attributable to lack of common position on matters that affect provinces differently.

2. *The national health and education sector departments (including National Treasury and the Department of Cooperative Governance and Traditional Affairs) responsible for operationalising IGR must invest in financial and human resource capacity to conduct IGR conscientiously and emphasise the values of trust and cooperative governance.*

These recommendations address the long-standing problem of ambiguities in the division of responsibilities between national and provincial departments responsible for a function. The execution of concurrent responsibilities involves several subfunctions and activities that need to be clearly delineated within the existing legislation and policy framework. The legislative framework and the outcomes-based performance agreements should include the circumstances or conditions under which provinces can deviate from national norms and standards.

3. *The national basic education and health sector departments should reintroduce the outcomes-based performance agreements, as a means of clarifying the lines of accountability between national and provincial executive authorities and all parties supporting the achievement of sector priorities, as per the outcomes approach to monitoring and evaluation introduced in 2009 and the Commission's Recommendations made in its Submission for the Division of Revenue 2014/15.*

There is a seemingly growing disquiet with the effectiveness of IGFR forums in fostering cooperative governance and consensus on policy and budgetary matters affecting sectoral delivery mandates. Additional human and financial resource capacity will ensure that IGFR forums are held as regularly as required, accommodate provincial governments and enable the discussions to be filtered throughout the budgeting process.

On improving education and health performance reporting:

4. *Provincial education departments should incorporate data collection in respect of both eligible and actual learners in ECD, youth vocational training, adult basic education and special needs education within the existing reporting framework, and be required to measure administrator-to-learner and computer-to-learner efficiency ratios.*

5. *The annual national assessments for Grades 3, 6 and 9, as a means of standardising the assessment of primary and secondary school literacy and numeracy outcomes, should be reviewed and strengthened with new measures of digital literacy, sustainable development knowledge, and existing assessments of life skills in respect of sexual and reproductive health.*

6. *The district health services directorates of provincial health ministries should measure progress and set annual targets on: clinic leadership and management, health information material disseminated, diagnostic tests and medications issued, municipal utility provision at clinics and district hospitals and computer and medical equipment secured. This is especially urgent in light of the Covid-19 pandemic, which should be used as an opportunity to conduct an audit of health information systems across provinces, so that they can be configured to enable the collection of the required data and entrench measurement and targeting systems.*

7. *The DOH and Stats SA must conduct regular demographic and health surveys on official causes of death. These surveys should aim to measure the causes of mortality and morbidity (including the most prevalent communicable and non-communicable diseases, sources of injury, malnutrition, drug abuse, pollution, homicide and suicide) for each province and ideally municipal area.*

The study highlighted the inadequacy of the current education and health performance reporting on inputs, outputs and outcomes. This makes it to difficult to ascertain value for money, and is inconsistent with other internationally recognised comprehensive measures of health and education performance. These recommendations seek to ensure that performance reporting covers all aspects of health and education delivery, with a particular emphasis on non-financial performance indicators and broader outcomes.

On improving the funding mechanism and linkage between inputs and outcomes:

8. *Government should consider balancing the current benefit of the simplicity in the PES formula with a move towards improving the distribution of the overall formula by acknowledging the higher costs of providing services to vulnerable groups and the greater demand for services from certain demographic groups. The proportional distribution mechanism should remain in the PES, but higher weights should be considered for funding vulnerable groups in determining education and health components. This would not result in a change of the overall pool available for education and health, but rather acknowledge and explicitly fund provinces that face greater needs for education and health services given their socio-demographic profiles. This can be achieved as follows:*

    a) *In the education component, differentiate the school-age population by gender, income and location, and apply a higher weighting for funds for the vulnerable groups. This should be applied also to the data on learner enrolment.*
    b) *The output sub-component of the health component should differentiate between gender and age of the person using the health service. Higher weights for funding should be applied to persons over the age of 65, women aged between 15 and 49 and children below 5, than for males aged between 5 and 65.*
    c) *The respective weightings for specific groups should be determined by government and informed by consultations with the respective provinces.*
    d) *The poverty component in the current PES formula should be updated with the latest income and expenditure data from the 2014/15 Living Conditions Survey undertaken by Stats SA.*

The Commission initially proposed costed norms and standards as a means of improving the link between funding allocated to provinces and their expenditure responsibilities. The PES is a key provincial funding instrument, but in its current form makes superficial linkage between funding and need using selected demographic indicators. Therefore, the allocation mechanism needs to be reviewed to incorporate additional education and health care indicators, based on availability, in order to improve redistribution.

9. *The departments of basic education and health should urgently pursue efforts to cost the current norms developed in education and health care. This should be done by incorporating the reporting of the costs of specific inputs in the delivery of provincial services through current provincial reporting formats. This would constitute the implementation of a "bottom-up" approach to costing. Government should also use the methods outlined in this report to calculate cost estimates of specific norms and standards. These cost estimates should initially be used to determine provincial expenditure or under-expenditure performance and, in the long term, be considered for incorporation into the PES formula.*

An overwhelming view is that national policies are seldom costed and, therefore, passed onto provinces for implementation without adequate funding. The lack of costing not only makes it difficult to determine the actual cost of services delivery relative to the available funding but also results in budget gaming and passing of the buck when delivery failures occur. Therefore, the costing of policy needs to be institutionalised, with, in the short term, determining funding requirements for new policies and provincial expenditure performance against national average costs, and, in the long term, facilitating the implementation of the costed norm funding approach.

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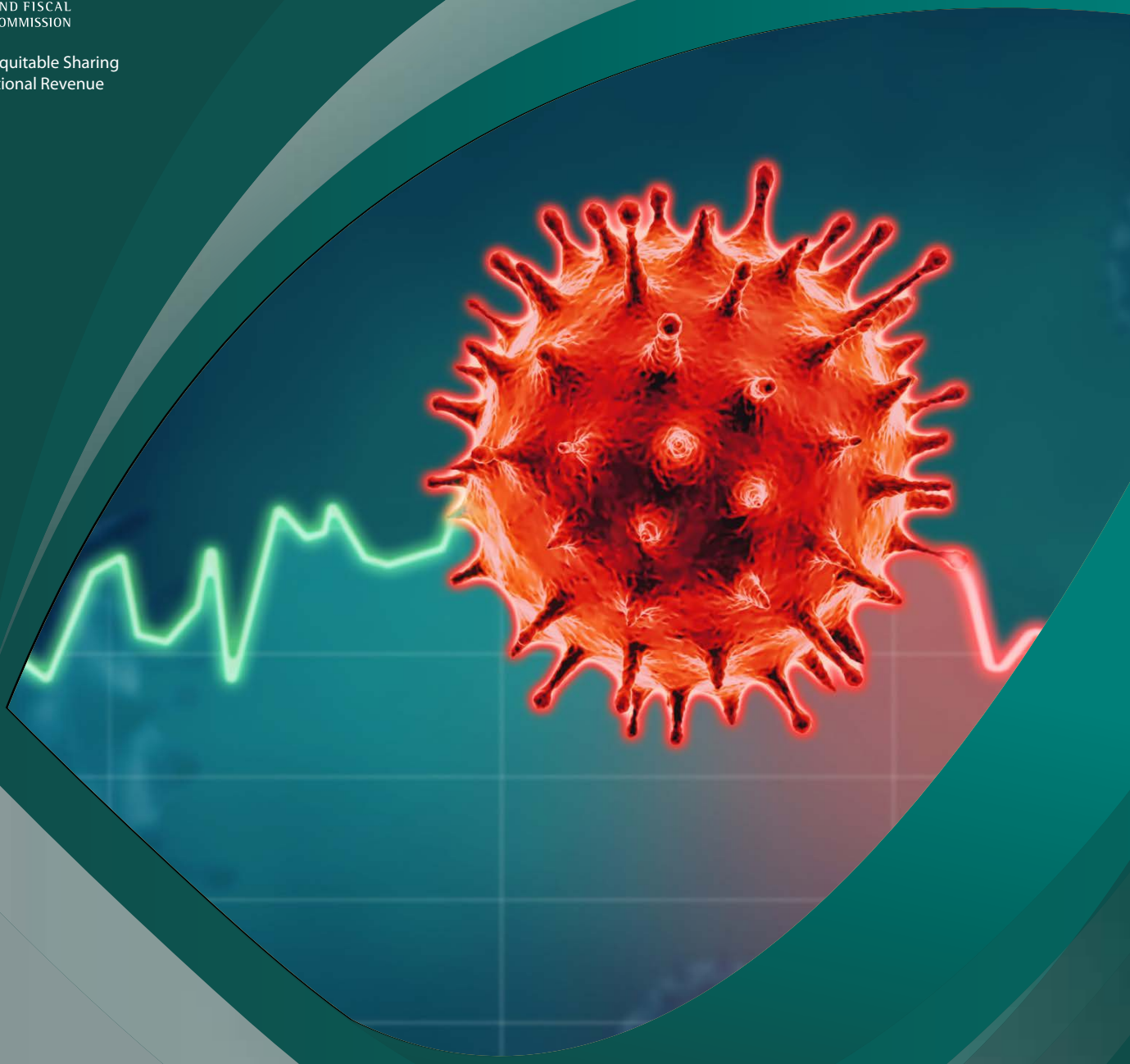


Chapter 3

Economic and Social Development in the Context of Covid-19

Chapter 3: Economic and Social Development in the Context of Covid-19

3.1 Introduction

The Covid-19 pandemic has caused an unprecedented health crisis in both advanced and developing economies. At the time of the outbreak, South Africa was already grappling with a long-term economic deceleration, a recession, a soaring debt level and the persistent socio-economic challenges of poverty, inequality and unemployment. The country's sovereign credit rating had been downgraded to sub-investment grade,[7] which caused a surge in the cost of borrowing, thereby limiting the monetary and fiscal manoeuvrability to stimulate the economy and support social development. Indeed, despite monetary expansions by the South African Reserve Bank (SARB), the first quarter of 2020 marked the third consecutive decline (of -2%) in gross domestic product (GDP), and the official unemployment rate increased to an all-time high of 30.1% (Stats SA, 2020c). Government is faced with the difficult task of balancing the new spending requirements on health care and social support with preserving people's lives and livelihoods, while maintaining fiscal and economic sustainability.

This chapter is divided into three parts. The first part examines the market context as a backdrop to understanding the socio-economic impacts of Covid-19 public health crisis on South Africa. After an overview on South Africa's pre-Covid-19 economic structure, the economic data from the first quarter of 2020 is analysed. The second part considers the fiscal implications of Covid-19, to inform the reprioritisation of the budget towards future economic and fiscal paths for the country, while the final part focuses on issues of agriculture and food security for local development, and the need for municipal services of water, electricity and sanitation. The intent of this chapter is to stimulate a new discourse for a cogent recovery plan, with economic, fiscal and institutional relevance and significance, to invigorate the development of South Africa.

3.2 Research Methodology

Both empirical descriptive and policy analysis research methods are used. Quantitative data is used as the basis for qualitative understanding and interpretations of policies and implications. The economic and fiscal data is drawn primarily from the SARB, Stats SA and National Treasury, rating agencies and international financial institutions, such as the World Bank and the International Monetary Fund (IMF). However, it should be noted that data and information are continuously being produced, as the Covid-19 pandemic is an ongoing event. In particular, while some of the main metros have made presentations on their revenue and expenditure analysis to the Portfolio Committee for the Department of Cooperative Governance and Traditional Affairs (COGTA), not all the provinces have published supplementary budgets in response to Covid-19. To examine local government and food security issues, interviews were conducted across three spheres of government, as well as with representatives of industry organisations, five commercial farmers, 30 emerging farmers and three agri-businesses.

7 Standard & Poor's credit rating for South Africa was adjusted to BB- at 30 April 2020. Fitch's to BB at 3 April 2020 and Moody's to Ba1 at 27 March 2020.

3.3 The Socio-economic Context of Covid-19

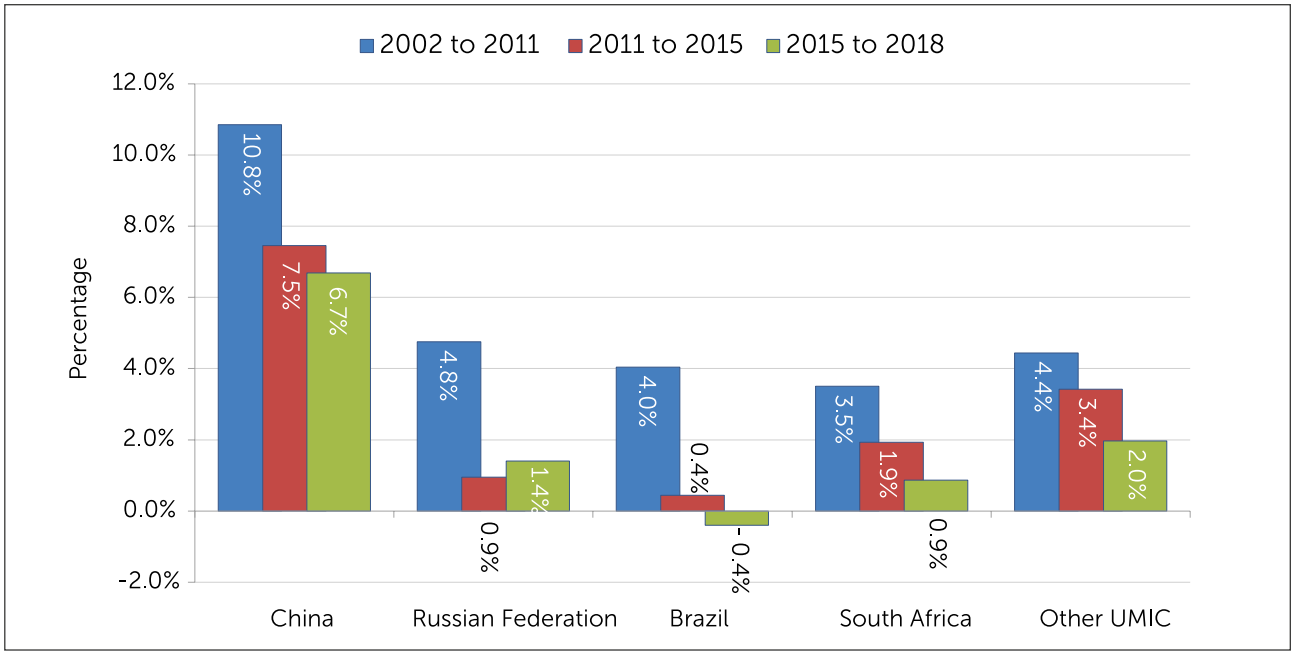
Prior to the Covid-19 outbreak, the South African economy was already characterised by structural fragilities, with declining long-run growth rate averages since 1960.[8] From 1994, the democratic transition ushered in an era of relatively stable economic growth, buoyed by the commodity price boom that favoured financial developments and mining exports. However, other economic sectors declined, due to faltering productivity, growing external dependency, market fragmentation, monopolisation and barriers, which led to fewer inclusive job opportunities.[9] The growth of labour force entrants far outstripped the employment absorption of the market, resulting in a substantial cohort of unemployed individuals (particularly black, unskilled, semi-skilled and graduate youth), unable to find and retain work and receive stable income.

Economic growth in South Africa remains inextricably bound to the fate of mining exports, which account for over half of the country's exports. Along with the end of the commodity price boom and the economic downturn that followed the 2008/09 global financial crisis, various domestic factors added to the pressure on South Africa's growth (Moody's, 2020):

- A more expensive and unreliable supply of electricity from 2008, as a result of institutional failure at the Eskom power utility company.
- Climate change, with more frequent droughts and flooding affecting agriculture and tourism.
- State capture and worsening corruption across the economic landscape, increasing the costs of key infrastructure and services, and discouraging investment.
- Unaddressed structural issues, such as labour market rigidities and uncertainty over property rights generated by the planned land reform.

These domestic and international factors together led to the deteriorating growth and prospect of growth in South Africa relative to other upper-middle income economies (Figure 3.1).

Figure 3.1: South Africa's average annual GDP growth compared to other upper middle-income economies (2002–2018)



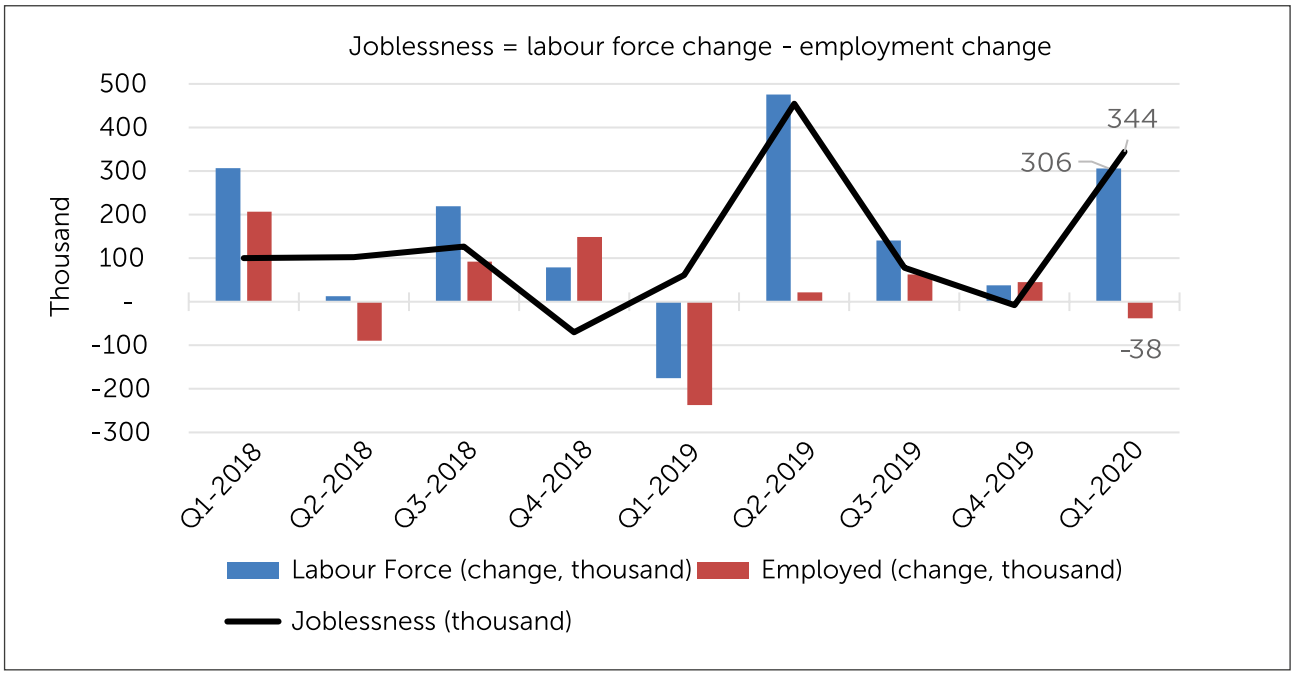
Source: Commission's calculations (2020), based on World Bank, World Development Indicators databases

8 See Figure 3.7 in Appendix
9 See Figure 3.8 in Appendix

During the first quarter of 2020, with the onset of Covid-19, South Africa's economy deteriorated further, as mining and manufacturing activities contracted by an annualised rate of 21.5% and 8.5% respectively (Stats SA, 2020c). The impact of Covid-19 will be the most devastating shock for South Africa's economy in over half a century. As Figure 3.2 shows, during the first quarter of 2020, 38 000 jobs were lost, and 306 000 new entrants were unable to find jobs in the labour market, resulting in total unemployment increasing by 344 000, to 7.07 million unemployed individuals, or an alarming unemployment rate of 30.1% (ibid).

For the average South African, the lockdown resulted in extraordinary hardships in the form of mass layoffs, salary sacrifices, the closure of most informal enterprises, and liquidity challenges in formal businesses. The effects were especially destructive for small producers and business owners whose profit margins are tight and who have little if any reserved savings or adequate insurance. In April 2020, under Level 5 lockdown, only around a third of employees were expected to work, with this figure climbing to about a half of employees under Level 4. Under the extended Level 3 lockdown, the only industries that remain closed are places of entertainment, bars and clubs, although restaurants and personal services must operate through a delivery system.[10]

Figure 3.2: Changes in employment and joblessness (Q1 2018–Q1 2020)



Source: Stats SA (2020c) and Commission's calculations (2020)

The lack of inclusive growth and labour absorption entrenched the disparity between those who can earn a living and those entrapped by poverty, and the current Covid-19 pandemic merely serves to highlight the stark inequalities and inequity of access. Two main root causes underlie the persistently high levels of joblessness and inequality in South Africa: the economic system inherited from the apartheid era, and the over-dependence on commodity-based industries

Apartheid's economic legacy: The destruction of a free market system under the apartheid rule left the country without inclusive, labour-absorbent industries and ease of capital for development. Unlike other economies, which progressed through the stages of inclusive industrial development and involved most of its working-age population across the skills spectrum, South African industries matured and industrialised without sharing the benefits with many people. As a result, even in post-1994 democracy,

10 Government Notices No. 608: Amendment of Regulations issued in terms of section 27(2) of the Disaster Management Act, 2002.

industries were unable to generate inclusive jobs on a large scale. This was exacerbated by policy missteps and ill-conceived regulations, such as the premature trade liberalisation that decimated the clothing industry, an ineffective Competition Commission, and the lack of attention to the critical technology, telecommunications and energy sectors.

Dependence on commodity-based industries: In the late 2010s, South Africa's main competitive industries were found in the concentrated markets of mining and refineries, whose productivity largely depends on commodity price movements, not input factors of labour. Although other industries, such as auto assembly and machineries, financial services and food, make up a share of exports with indirect job creation benefits, only food seemed able to generate employment directly on a large scale. Overall, the terms of trade[11] for economic growth are decidedly unfavourable towards South Africa, especially for items such as electronic appliances, mineral fuels and a wide range of consumer goods manufactured in China.

Reaching a consensus on policy priorities is difficult, due to the deep inequalities and social polarisation in South Africa, but is a process that government must undertake. Without a consensus on an economic path forward, the inconsistent implementation of policies witnessed in the recent decade will be repeated. The government has to navigate between the demands of its citizens, who want real change in the economy and their livelihoods, and the business sector, which prefers minimal disruption, risks and costs from economic restructuring. Furthermore, within each of these camps, major factions often disagree with each other, making the renegotiation of structural change to the economy near impossible. The most noticeable cases are in agriculture (emerging versus commercial farmers), manufacturing (exporters versus importers), the financial sector (in terms of borrowing rates) and mining (the mining charter). These divisions frequently shape and complicate the debates between government departments and agencies.

Notwithstanding these divisions, the state has also failed to function effectively according to its mandate. For example, to deliver a quality basic education and vocational training system, and to provide incentives for financing economic restructuring. For decades, state-owned enterprises, such as Eskom and the Land Bank, have been mired in corruption and mismanagement, without any checks and balances until it is all too late. In local government, municipalities have failed to provide water, electricity and security to under-serviced township areas, while the lack of access to finance and markets has inhibited small business development.

In sum, the democratic state has failed to diversify the economy from the inherited concentrated, fragmented and dependent market; and to eradicate the roots of structural joblessness and social inequality for inclusive development. The Covid-19 pandemic is not only a major shock to the economy, affecting industries and the value-chain and production processes, but it has also created a new form of economic divide: the digital divide, between those who could continue working through the digital platform and those who could not. **South Africa's response to this crisis can be either to try and return to business as usual (which no longer exists) or to grasp the reality and opportunity to leverage the crisis and effect structural change in the economy.** This decision will require discussions among government, organised labour, and the private sector, with meaningful engagements on labour and capital comparative advantages, the distribution of productive ownerships, as well as the profile and character of the economy.

11 The OECD defines terms of trade as the ratio between the index of export prices and the index of import prices. If the export prices increase more than the import prices, a country has a positive terms of trade, as for the same amount of exports, it can purchase more imports https://data.oecd.org/trade/terms-of-trade.htm

3.4 The Financial and Fiscal Context

Continued dependency and barriers, coupled with a polarised, unequal society pose significant challenges for implementing fiscal policy and transforming the economy. Post-1994, the government's contradictory approach replicated the post-colonial experience of most African countries. On the one hand, it sought to mitigate inequalities by expanding services and transfers to poor households, but on the other hand, it avoided raising taxes on established businesses in the name of promoting investment. Although the successful broadening of the tax base through the corporate tax system and administration resulted in an improved tax-to-GDP ratio and an increased tax yield, the eroding tax base and profit shifting, coupled with corruption in the recent decade, undermined growth and progress on development.

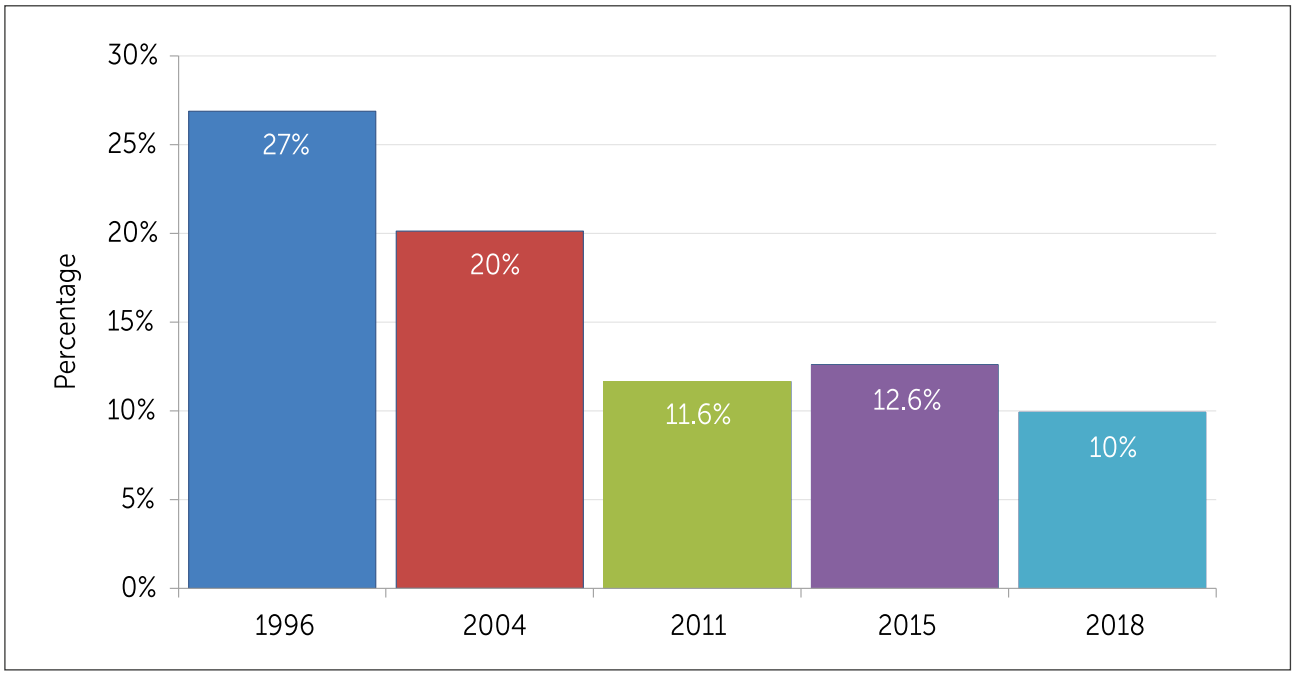
The Covid-19 pandemic arrived when South Africa was facing a fiscal crisis due to slow economic and revenue growth and escalating needs for social spending, such as the social grant system, housing, health and education. The monetary system remains conservatively responsive, not draconian, as the SARB has cut interest rates to address the challenges from the pandemic, and loosened some restrictions on bank lending. A bold intervention was SARB's recent purchase of government bonds on secondary markets, which eased liquidity constraints and had the fortuitous impact of boosting long-term bonds. Some bank guarantee schemes have been put in place to boost liquidity flows, although at the cost of some prudent regulations.

In 2003, social grants were the main source of income for more than a fifth (29.9%) of all households. By 2010, almost half (44.3%) of all households were receiving at least one form of social grant. (Stats SA, 2019) Before the introduction of the Covid-19 grant, child support grants accounted for two-thirds of all social grants, reaching 12.8 million beneficiaries, while the old-age and disability grants were paid to 4.7 million beneficiaries in total (National Treasury, 2020). However, no grant was sufficient to lift families out of the poverty trap: the old age and disability grants were twice the amount of the poverty line[12], while the child grant was half the poverty line until it was increased in response to Covid-19, and the new Covid-19 grant was just over a third of the poverty line for an individual.

Over the past 25 years, the expansion of government services to low-income communities has improved the living conditions for the majority of South Africans. Between 1996 and 2018, the share of households where people went hungry at least sometimes fell from over one in four to one in ten (Figure 3.3). Even with the slowing economy from 2015, the share of households suffering from hunger remained essentially stable. The Covid-19 crisis has undoubtedly worsened food insecurity, but the full scale and impact will only be determined when the data becomes available in 2021.

12 The national poverty lines were constructed using the cost-of-basic-needs approach which links welfare to the consumption of goods and services. The lines contain both food and non-food components of household consumption expenditure. See Stats SA (2019) for details on the various poverty lines.

Figure 3.3: Households where people went hungry at least sometimes (1996–2018)



Source: Stats SA household surveys

Government efforts to improve conditions for low-income communities and households were constrained by the weight it gave to avoiding liberal fiscal policy positions. For instance, the levies for the UIF and Compensation Fund were excessive compared to their claims. The result was an accumulation of large surpluses, which in 2019 amounted to R160-billion at the UIF and R65-billion at the Compensation Fund. Yet these surpluses were invested almost exclusively in listed companies and government bonds, rather than used to promote economic unification between the employed and the unemployed.

3.4.1 Covid-19 and the Budget

The Covid-19 pandemic had two short-term effects on the budget: (i) increased expenditure on health care and public health measures, as well as relief for households that lost and/or decreased their livelihoods; (ii) slashed revenues for the national government and for municipalities that historically raise a significant share of their budgets from rates and services. The main Covid-19-related measures include the following.

1. Health care, mostly to expand hospital capacity in terms of both physical equipment and staff.

2. Public health activities, covering:

    - Mass communication on how to prevent transmission.
    - Identifying and isolating new cases, which in turn rely principally on screening and contact tracing, testing and provision of quarantine facilities where required.
    - Measures to enable people to avoid transmission especially in dense settlements that share facilities such as water and toilets
    - Enforcement of restrictions designed to limit transmission, which range from the lockdown measures in April to health and safety inspections as economic and educational activities resume.

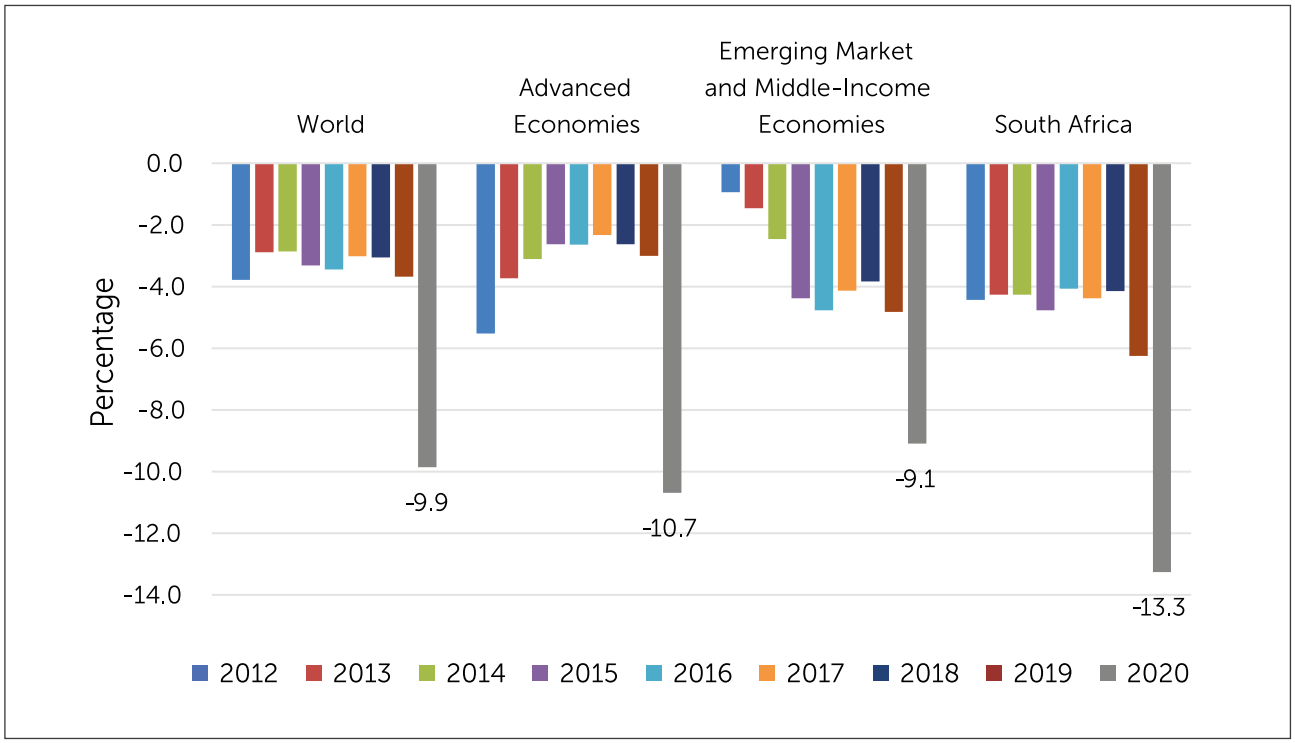
3. Alleviation of economic distress and promoting recovery in response to the national and global depression that has resulted from the pandemic, including:

    - Limiting retrenchments by assisting businesses that could not function normally to pay wages.
    - Support for households that lost informal or business incomes.
    - Support for businesses to avoid dissolution during the lockdown.

4. Longer term, establishing an economic stimulus to kick-start demand.

The IMF (2020) projects that in 2020, the world fiscal deficit as a percentage of GDP will rise to 9.9% because of fiscal measures taken in response to Covid-19 (Figure 3.4). South Africa's fiscal deficit as percentage of GDP is projected to rise to 13.3% in 2020, from 6.3% in 2019.

Figure 3.4: General government fiscal balance as percentage of GDP (2012–2020)



Source: IMF (2020)

In the supplementary budget of 2020/21 tabled on 24 June 2020, the initial adjustments show that government is maintaining its spending and increasing transfers to poor households but without matching increased revenue. The result is a rapid increase in the deficit and accumulation of fiscal debt and debt servicing costs. The higher government debt has major implications for the economy and society at large, especially for an economy with a sub-investment grade and rising cost of borrowing.

3.4.2 Impact Across the Three Spheres

The scope for funding and servicing the new demands due to Covid-19 is significantly different across regions and government spheres. For instance, the main metro areas and some secondary cities have a much higher incidence of Covid-19 than the rest of the country. However, compared to rural, impoverished regions, these cities are more capable of financing new demands from own revenue. In addition, although the main responsibility for delivering health care falls to provincial governments, some larger municipalities provide local clinics and health services.

The new demands in the budget are accompanied by new mandates for health departments across the three spheres, with all departments now responsible for communications and identifying and isolating new cases (Table 3.1).

Table 3.1: Responsibilities for public health measures across government spheres

	National	Provincial	Municipal
Communication	The DOH with the Government Communication and Information System (GCIS), provide national communication framework and media	Provincial health departments provide communication in health facilities and support community communication	Municipal health departments (if exists) provide communication at community level
Identifying and isolating new cases	The DOH develops testing and quarantine strategy, procures testing materials for public sector and maintains public testing labs	Provincial health departments determine criteria for access to tests, manage screening through community health workers, and manage tracing systems and quarantine facilities	Municipal health departments (if exists) assist in identifying cases and ensuring access to quarantine where required, ensure staffing of local clinics (which may require additional costs given high absenteeism)

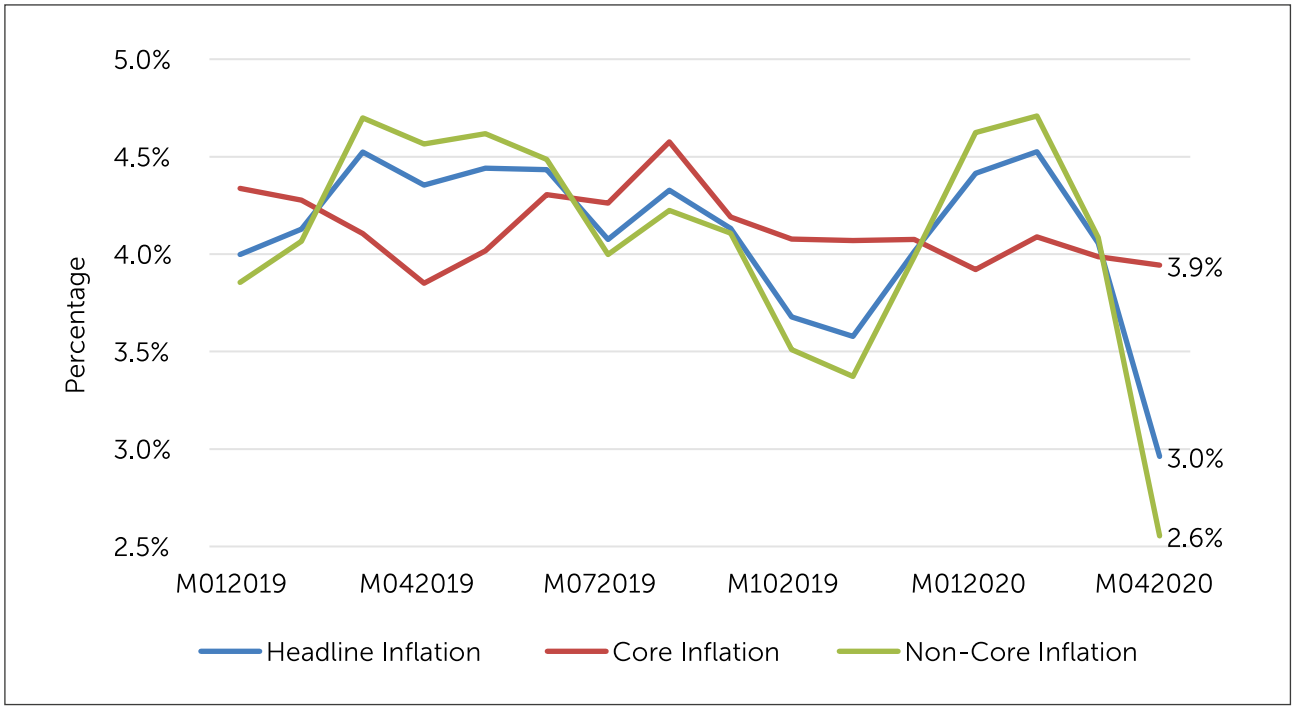
Source: Commission's compilation (2020)

3.5 Food Security, Agricultural Economy and Local Development

The real impacts of Covid-19 on the economy and food security are still emerging, but preliminary data from Stats SA (2020b)[13] shows that in the first six weeks of the lockdown, the number of respondents who reported receiving no income tripled, from 5.2% before the lockdown to 15.4% by the sixth week. Some price markers suggest that the increased cost of essential goods relative to non-essential goods is having a disproportionate impact on the poor, with the cost increases potentially driven by panic-buying, hoarding or localised supply disruptions, compounded with the depreciating currency and increasing cost of logistics. Headline inflation was at 3% (the lower end of the target range, indicating stable prices), due to the sharp decline in economic activities and transactions, whereas core inflation was at 3.9% (Stats SA, 2020a). Core inflation includes essential items of food, non-alcoholic beverages, clothing and footwear, housing and utilities, health, public transport, communication and education, which are necessities for the poor.

13 Online web-based surveys undertaken by Stats SA. Data collection for Wave 2 occurred during the sixth week of the national lockdown between 29 April and 6 May 2020.

Figure 3.5: Financial stability and core inflation



Source: Stats SA (2020b) and Commission's calculations (2020)

South Africa has 96 841 000 hectares (ha) of agricultural land, which is 79.83% of its total land area. Of this land, 12 500 000ha are arable, suitable for growing crops, while permanent cropland makes up 0.34% of the total land mass. Yet only 1.66% (or 1 599 808ha) of land is under irrigation,[14] which suggests that the South African agricultural sector has not realised its full potential for economic growth and productivity.

South Africa's high levels of irradiation also offer an enormous opportunity for renewable energy for industrial growth in rural areas. Renewable energy could provide South Africa with a comparative competitive advantage globally, as European countries are giving preference to carbon-efficient products, and global renewable energy companies are seeking viable projects in which to invest.

Compared to other economic sectors, agriculture has been relatively insulated from the effects of Covid-19 because its operations were allowed to continue as essential services, except for items such as wool, mohair, alcoholic beverages, tobacco and cotton whose sales and exports were prohibited. The sector was particularly affected by the closure of interlinking sectors such as hospitality, restaurants, and food outlets.

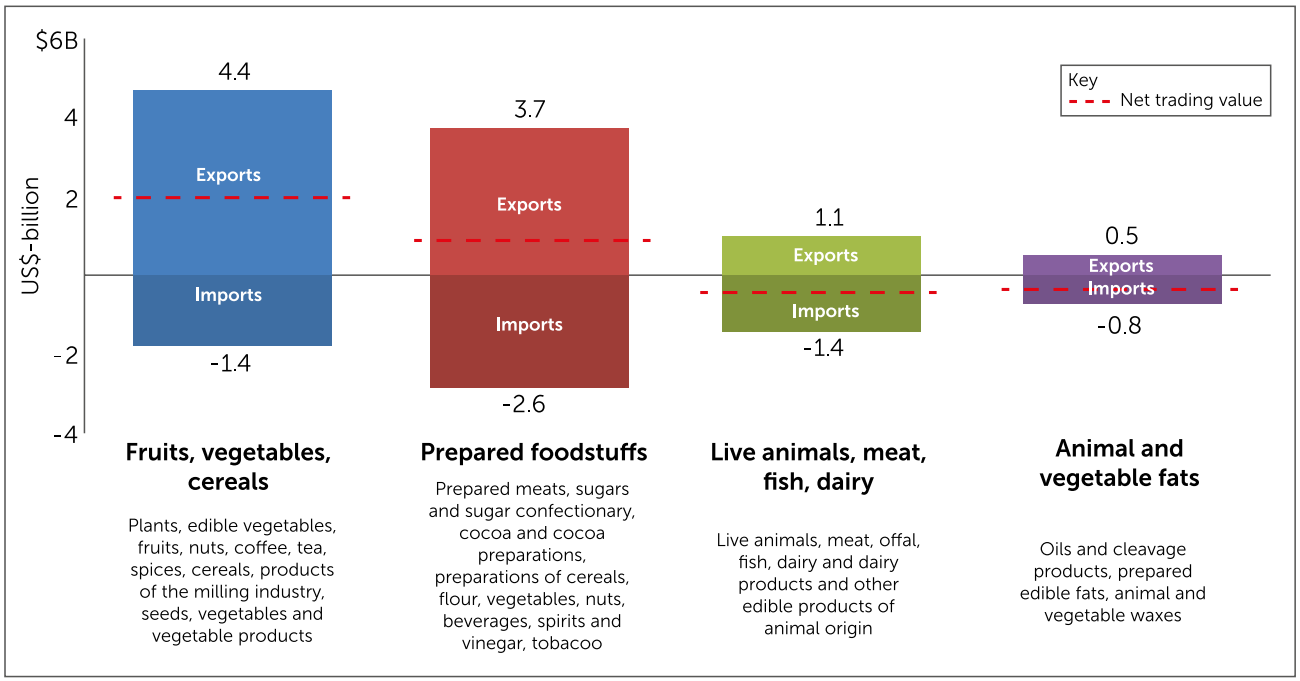
Overall, the net farm income, which is a measure of profitability, remained stagnant, but the producer price index of agricultural goods increased, suggesting future potential growth for demand. This increase was largely due to three factors:

- The agricultural sector learned of its competitive advantage to grow high value export crops (e.g. pecan nuts).
- South Africa's commercial farmers have invested in technology-driven precision farming,[15] which resulted in higher yields per hectare, improved productivity and reduced the cost of inputs.
- Research and development in the commercial sector has resulted in agribusinesses developing their own cultivars, based on geographical locations and soils. These cultivars have been scientifically engineered to produce better yields with less water.

14 World Bank Open Data (2020)
15 Precision farming is a method of farming where the exact quantities of nutrients and water are scientifically calculated to minimise any wastage

South Africa is part of the competitive global agricultural economy, exporting 49% of its produce in value. Europe is the country's dominant export destination market for agricultural products, administered by the SADC-EU Economic Partnership Agreement. In 2019, South Africa recorded agricultural trade exports of almost US$10-billion and a positive agricultural trade balance of US$3.2-billion, making agriculture one of the largest contributors for foreign exchange earnings (Figure 3.6).

Figure 3.6: South African agricultural imports vs exports (2019)



Source: Agbis (2020)

South Africa has a clear comparative advantage in citrus fruit, cotton, pome fruit (e.g. apples and pears), Rooibos and nuts, and opportunities exist for the processing of primary agricultural products for export. However, to unlock the full potential of the agricultural economy and land, South Africa must address the inherited dual structure of the agricultural sector. Like other sectors in South Africa, the agricultural sector is affected by the legacy of apartheid, which manifests in an economy where a small group of advanced, highly-mechanised, first-world commercial farmers with economies of scale in the formal agricultural economy exist alongside a large group of emerging, subsistence farmers located in the informal community. The barrier to converging growth between the two economies is the skewed distribution of productive assets, especially land. White farmers account for 90% of the value added and own 86% of the agricultural land and water, whereas black farmers live and farm on the margins.

3.5.1 Local Government's Role in Local Development

The Covid-19 pandemic has catapulted the municipalities to the forefront, in terms of providing services, not only health services but also basic services of water, sanitation and electricity. The lockdown has reduced the commercial and industrial consumption of bulk services, which in turn, has reduced the municipal revenue, while the closing down of businesses has led to property devaluation, which affects the collection of rates and taxes. At the same time, the general loss of income and rise in unemployment have led to an increase in the number of indigent households. And people's rights to access basic services, such as food, water and electricity, as per section 27 of the Constitution are non-negotiable for maintaining a minimal standard of living and survival.

Municipalities need to mobilise local economic development through basic infrastructure, and to harness the value of productivity using its most valuable natural resource: land. Central to the success of this endeavour is the municipality's ability to deliver on its constitutional mandate to provide essential services of electricity, water, refuse, sanitation and infrastructure. In the same vein, provinces must fulfil their functions,[16] to facilitate economic stimulation through localising procurement and production where possible, and expediting social infrastructure projects through provincial resources.

3.6 Conclusion

The Covid-19 pandemic is expected to be the most devastating shock for South Africa's economy in over half a century and has already resulted in extraordinary hardships for the average South African. Prior to the Covid-19 outbreak, South Africa's economy was structurally fragile and characterised by inequalities and high unemployment, as new labour force entrants far outstrip the market's ability to absorb them. The roots of the high levels of joblessness and inequality lie in the economic system inherited from the apartheid era and the continued over-dependence on commodity-based industries. Since 1994, the state has failed to diversify the economy and to eradicate the roots of structural joblessness and inequality. During the same period, government services have improved the living conditions of the majority of South Africans, and social grants (in some form or another) support almost 44.3% of households, but the tax base has not grown. The result of these and other (domestic and international) factors is a rising deficit, which has been aggravated by the impact of Covid-19. With the increased expenditure and slashed revenues resulting from Covid-19, South Africa's fiscal deficit is projected to rise from 6.3% of GDP in 2019 to 13.3% of GDP in 2020.

Although the real impacts of Covid-19 on the economy and food security are not yet known, preliminary data shows that the poor are being disproportionately affected by increased prices on essential items, including food. South Africa's government faces the difficult task of balancing the additional spending needs, as a result of Covid-19, while maintaining fiscal and economic sustainability.

Government's interventions to date have fallen far short of the magnitude by which Covid-19 has shifted the South African economy. This is because these interventions lack a clear and coherent economic vision, supported by concomitant budgetary support and strategy to bring about clear fiscal actions. Much of the planning for build programmes remains identical to the original business plans and proposals, and so appears set to propagate the problems experienced in the past without understanding first the economic and fiscal context for devising future strategies for growth. Although the Covid-19 social grant relief to households has proven to be comparatively robust, it still falls far short of the loss in income that is affecting household consumption patterns, especially for low-income families. Ultimately, the choice is to revert to business as usual with the same economic and social construct that has deepened after more than 25 years of democracy, or to leverage the Covid-19 crisis, which offers an opportunity to effect structural change in the economy.

16 As listed in Schedule 4 and Schedule 5, per section 104 of the Constitution

3.7 Recommendations

With respect to economic and social development in the context of Covid-19, the Commission makes the following Recommendations:

1. *The Minister of Finance should develop (and execute) a clear, coherent and comprehensive macroeconomic framework that is in line with the president's economic and social support response package to Covid-19. The Minister should consider the position taken in the Government document, "Towards an Economic Strategy for South Africa", to strengthen the continuity, consistency and credibility of the economic and fiscal stance. These policy positions should be clearly represented in monetary figures, in the 2021/22 Appropriation Bill and Division of Revenue Bill for implementation in the forthcoming Money Bills as per section 77 of the Constitution.*

The fiscal credibility of the South African government is under threat, due to inconsistencies and ambiguities of the budget relative to the economic and fiscal positions taken by the government and its president. The country needs a clear strategy for growth, supported in relevant money Bills for proper execution of the envisaged macroeconomic framework. The macroeconomic framework should be based on clear economic and social principles and policy decisions, derived from robust engagements with both private and public sectors of the economy.

2. *After reviewing the economic situation leading up to the Covid-19 crisis, the Commission is convinced that a fundamental structural transformation of the economy is inevitable. Therefore, the ministers of finance, of economic development and trade and industry, and of labour should jointly address the economic barriers, social inequality, and societal polarisation by adopting a localised product value chain approach. The expression of this approach should be found in the incentive grants frameworks of both provincial and local conditional grants, as hard conditions to permit procurement of goods only if they are made or assembled locally within the South African borders, to stimulate the domestic economy and encourage job growth while taking international trade agreements into account.*

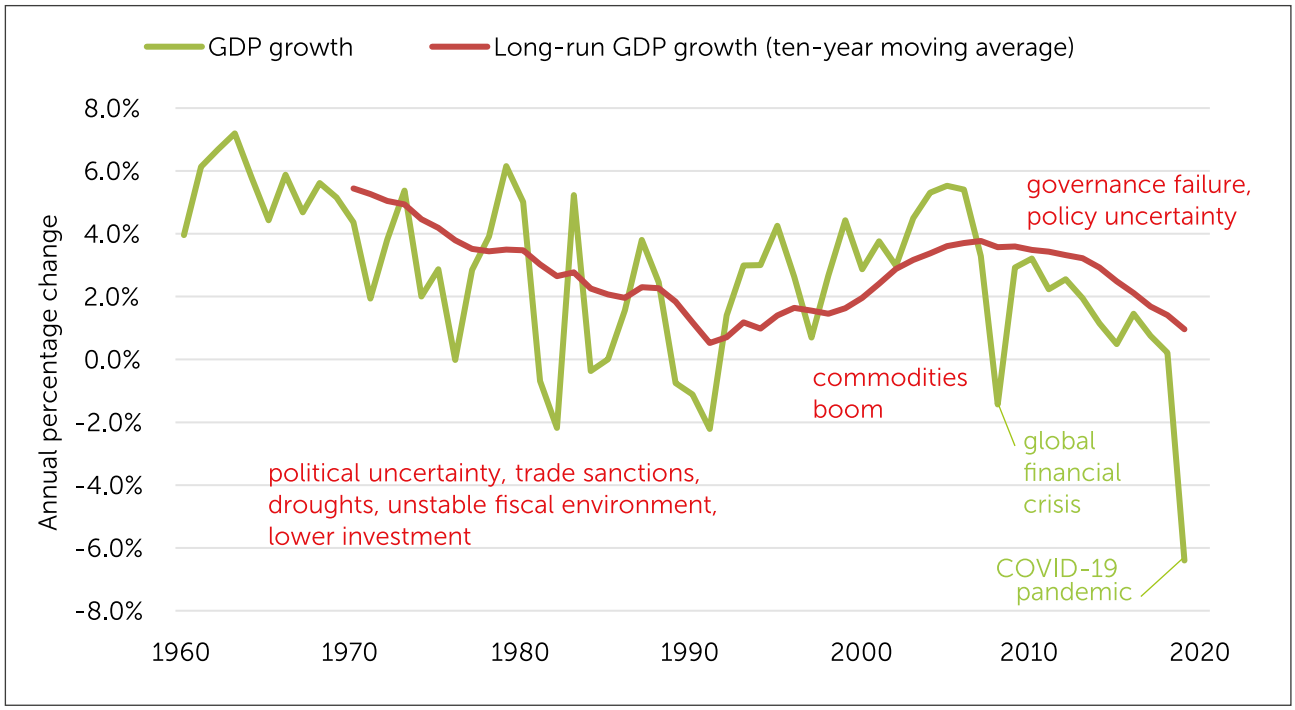
The purpose of a product value chain approach is to stimulate market-led production investments in strategically identified products in the industrial value chains, so that the existing market dependency, fragmentation and concentration are removed. The adoption of this approach will also provide the opportunity to test the power of the intergovernmental fiscal instruments to correct market failures towards the first welfare theorem and pareto efficiency.

3. *The Commission argues that, with the right infrastructural and financial support from the state, emerging farmers can be catalysts for local economic development and growth with the added benefits of food security in facing the Covid-19 crisis. Hence, the Minister of Finance and the Minister of Cooperative Governance and Traditional Affairs should use reprioritised, consolidated funds to establish an indirect grant and task team for basic services and local economic development. The reprioritisation should be clearly stated in the money Bills over the 2021 medium term expenditure framework (MTEF).*

The Auditor-General confirmed that the state of financial and fiscal sustainability, governance and service delivery functions in municipalities is faltering (AGSA, 2020). The Commission's view is that food security, the economic impact of Covid-19 and local government are interrelated, which suggests the urgent need to establish indigenous agricultural ecosystems through local government for economic growth. The fiscal resources of conditional grants should be mobilised to create an inclusive capital indirect grant that serves the interest of both the public and private sectors. For example, a grant sponsored incubation and blended financing strategy, whereby the local government ensures the access to basic infrastructure and private sector provides financial resources for black, emerging farmers, thereby stimulating the production of food for food security, and growing the agricultural economy and revenue for the local government.

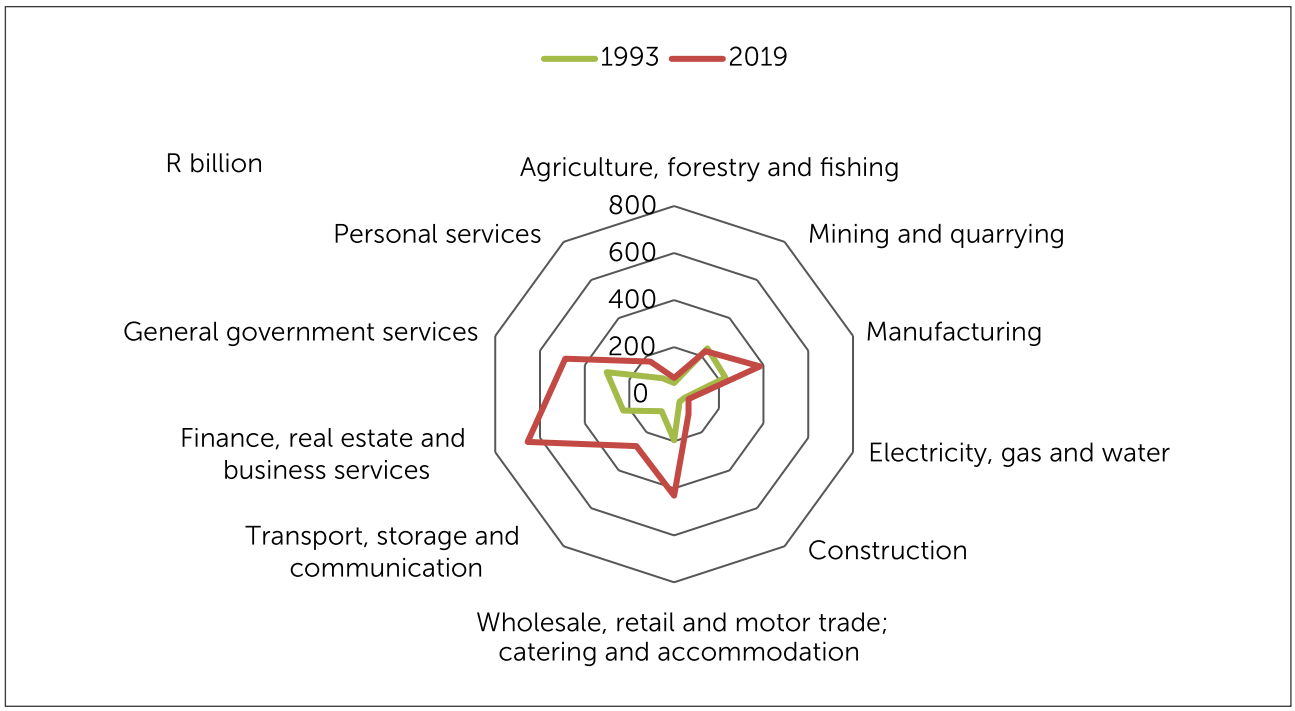
Appendix

Figure 3.7: South Africa's economic performance (1960–2020)



Source: SARB (2020), Commission's compilation (2020)

Figure 3.8: Gross domestic product by industry in 1993 and 2019



Source: Stats SA (2020), Commission's calculations (2020)

FINANCIAL AND FISCAL COMMISSION

For an Equitable Sharing of National Revenue

Chapter 4

Sustainable Financing of South Africa's Public Health Care System and National Health Insurance

Chapter 4: Sustainable Financing of South Africa's Public Health Care System and National Health Insurance

4.1 Introduction

South Africa's public health care system is under strain, with an ever-increasing demand for health services and staff, equipment and financial resources. Health spending accounts for 8.11% of gross domestic product and 13.34% of general government expenditure (World Bank, 2020), which is high relative to the average spend of upper-middle income countries. The Constitution (section 27) guarantees socio-economic rights, including the right to access to health care for all. Yet more than 25 years after the establishment of the democratic state, the failure to implement a unifying system of financing for universal health care access has entrenched a two-tiered health care market system: public health care, financed by the government through the tax system; and private health care, financed through medical schemes and the patient's own pocket. Private health care in South Africa is characterised by high costs due to misalignment of pricing and coverage relative to demand, resulting in barriers to access (Competition Commission, 2019).

The highly contagious, Covid-19 pandemic, sweeping across the globe, has stunned the health care systems of many nations, irrespective of income, wealth, socio-economic status, and financing structure. With millions of confirmed cases, health care systems around the world are overwhelmed, and their structural imbalances and weaknesses have been exposed. South Africa's health system is among the most vulnerable, given the country's extreme socio-economic inequality and two-tiered health care system. Faced with this unprecedented challenge, the need has never been greater for examining the fiscal, structural and legislative requirements for ensuring sustainable and affordable universal access to quality health care services through the National Health Insurance Bill of 2019 [B 11-2019] in South Africa.

The chapter comprises two parts. The first part analyses the pricing of three major health care packages (the PHC package, PMBs and the proposed demand-based (Pareto) health care package), in order to assess the value of health care services covered. The second part examines the NHI reform in the context of the legislative and intergovernmental fiscal requirements and discusses four critical success factors that are needed to achieve the unification of health care access through the NHI: an aligned policy and legislative framework, capacitated and consistent IGR arrangements, determined funding requirements and funding sources for the NHI, and defined comprehensive benefits for NHI beneficiaries. The chapter's intent is that its research findings will be used to support the unification of health care access through the NHI financing reform, thereby enabling all South Africans, irrespective of race, gender and socio-economic status, to have the same needs and rights to universal health care access.

4.2 Research Methodology

The empirical pricing and costing of health care were analysed using a quantitative method. The financial datasets and patient output (non-financial) datasets were merged at the sub-departmental level of the hospital's servicing units to derive the health care output-cost mapping. The health care output-cost mapping was then used to evaluate the value of three health care packages: The PHC, PMBs and proposed demand-based (Pareto) health care packages. The data was taken from the Western Cape's consolidated

database of health facilities for the 2018/19 financial year, which includes both financial and non-financial information (such as patients admitted, inpatient days). It should be noted that the only sub-departmental data available was for central hospitals (Groote Schuur, Tygerberg and Red Cross), regional hospitals (George, Mowbray, New Somerset, Paarl and Worcester) and psychiatric hospitals (Alexandra, Lentegeur, Stikland and Valkenberg). The unit cost was derived by dividing the cost of servicing patient health at the sub-department level over the number of patient visits. Therefore, the derived efficiency proxy is *Rand per patient visit per year (inpatient or outpatient)*. See Appendix A for data issues and variable challenges encountered when pricing and costing health care services.

The 2019 NHI Bill, aspects of the NHI White Paper and the 2018 NHI Bill were examined using a qualitative approach, with the aim of identifying potential functional and structural opportunities and constraints of the 2019 NHI Bill, to provide insights into its implementation.

4.3 Costing and Pricing of Health Care Packages

4.3.1 The Primary Health Care Package

With the PHC package, the DOH establishes a set of primary health care services with norms and standards for the whole country (see Appendix B). The defined services are mainly limited to preventative care and health education, as most curative services are rendered by hospitals through the referral system. The PHC package comprises three components: health promotion and disease prevention; treatment, care and support; and environmental health services.

Health Promotion and Disease Prevention cover general health safety, occupational and oral health, facilitating maternal care, child health (including basic screening), accessing social grants, and supporting patients with chronic diseases. For this component, PHC facilities should provide screening and basic immunisation for mothers and children, and screening of eye and mental health. For communicable and non-communicable diseases, PHC facilities can provide rudimentary testing for HIV, tuberculosis, cancer[17] and Chemoprophylaxis for selected diseases, e.g. malaria.

Treatment, Care and Support focus mostly on identifying common health problems and providing general, rehabilitative support to injuries, including eye, speech, ear and oral health.[18] Most ailments requiring actual curative treatments are referred to the next level of care, while palliative care is limited to controlling distressing symptoms. For this component, PHC facilities should be able to manage minor ailments and illnesses, and provide integrated management of childhood illnesses and contraceptives. The extent of emergency care that can be provided will depend on the facility's resources and competency.[19]

Environmental Health Services provide information and education on healthy living environments and hygiene practices. For this component, PHC facilities should have proper sanitation, clean water, food and adequate ventilation for airborne infection control.

The cost of PHC as prescribed in the package was calculated to be R2,198 per patient, per visit, per year (inpatient or outpatient). It assumes that a patient's exposure to PHC needs is proportional to the number of patient visits recorded at hospitals in the Western Cape province.

17 Pap smear, breast examination or mammogram, prostate specific antigen.
18 Provision of spectacles, hearing aids, basic dental; basic assistive devices including prostheses.
19 Basic emergency obstetric care, respiratory emergencies, cardiac emergencies, diabetic emergencies, allergic emergencies, suspected poisoning, trauma, bleeding, simple burns, injuries and trauma of limbs (excluding fractures), post exposure prophylaxis for HIV and emergency contraception.

4.3.2 Prescribed Minimum Benefits

The Medical Schemes Act (No. 131 of 1998) defines PMBs as the minimum health services that all medical aid scheme members have access to, regardless of the benefit option selected.[20] The aim of having PMBs as regulations to the Medical Schemes Act is:

- To avoid individuals losing their medical scheme cover in the event of serious illness, resulting in the risk of unfunded utilisation of public hospitals.
- To encourage improved efficiency in the allocation of private and public health care resources.

Ultimately, the aim is to ensure the health and well-being of members of medical aids by setting a benefit or coverage "floor" that all medical schemes must comply with. In other words, medical schemes must cover the costs related to the diagnosis, treatment and care of any emergency medical condition, a limited set of 270 medical conditions defined in the diagnosis treatment pairs (DTP), and 25 chronic conditions defined in the chronic disease list. A DTP links a specific diagnosis to a specific treatment and, therefore, broadly indicates how each of the medical conditions should be treated. The treatment and care of conditions should be based on affordability. If there is a disagreement over the treatment of a specific patient case, the public sector standards (also called practice and protocols) are applied, including chronic medicine and medication for conditions such as HIV-infection and menopausal management. The 270 conditions that qualify for PMB cover are diagnosis-specific and divided into 15 broad categories, as shown in Table 4.1.

Table 4.1: Prescribed minimum benefits categories

PMB Category	Example
Brain and nervous system	Stroke
Eye	Glaucoma
Ear, nose, mouth, and throat	Cancer of oral cavity, pharynx, nose, ear, and larynx
Respiratory system	Pneumonia
Heart and vasculature (blood vessels)	Heart attacks
Gastro-intestinal system	Appendicitis
Liver, pancreas, and spleen	Gallstones with cholecystitis
Musculoskeletal system (muscles and bones); trauma NOS	Fracture of the hip
Skin and breast	Treatable breast cancer
Endocrine, metabolic, and nutritional	Disorders of the parathyroid gland
Urinary and male genital system	End-stage kidney disease
Female reproductive system	Cancer of the cervix, ovaries, and uterus
Pregnancy and childbirth	Antenatal and obstetric care requiring hospitalisation, including delivery
Haematological, infectious, and miscellaneous systemic conditions	HIV/Aids and TB
Mental illness	Schizophrenia
Chronic conditions	Asthma, diabetes, epilepsy, hypothyroidism, schizophrenia, glaucoma, hypertension

Source: Medical Scheme Act (No. 131 of 1998) Regulations GNR.1262 – 20 October 1999 as amended and Council for Medical Schemes

20 Section 67(1)(g) of the Medical Schemes Act

Table 4.2 shows the 25 chronic conditions defined in the chronic disease list.

Table 4.2: Chronic disease list

Addison's disease	Crohn's disease	Hypothyroidism
Asthma	Diabetes insipidus	Multiple sclerosis
Bipolar mood disorder	Diabetes mellitus types 1 & 2	Parkinson's disease
Bronchiectasis	Dysrhythmias	Rheumatoid arthritis
Cardiac failure	Epilepsy	Schizophrenia
Cardiomyopathy	Glaucoma	Systemic lupus erythematosus
Chronic obstructive pulmonary disorder	Haemophilia	Ulcerative colitis
Chronic renal disease	Hyperlipidaemia	
Coronary artery disease	Hypertension	

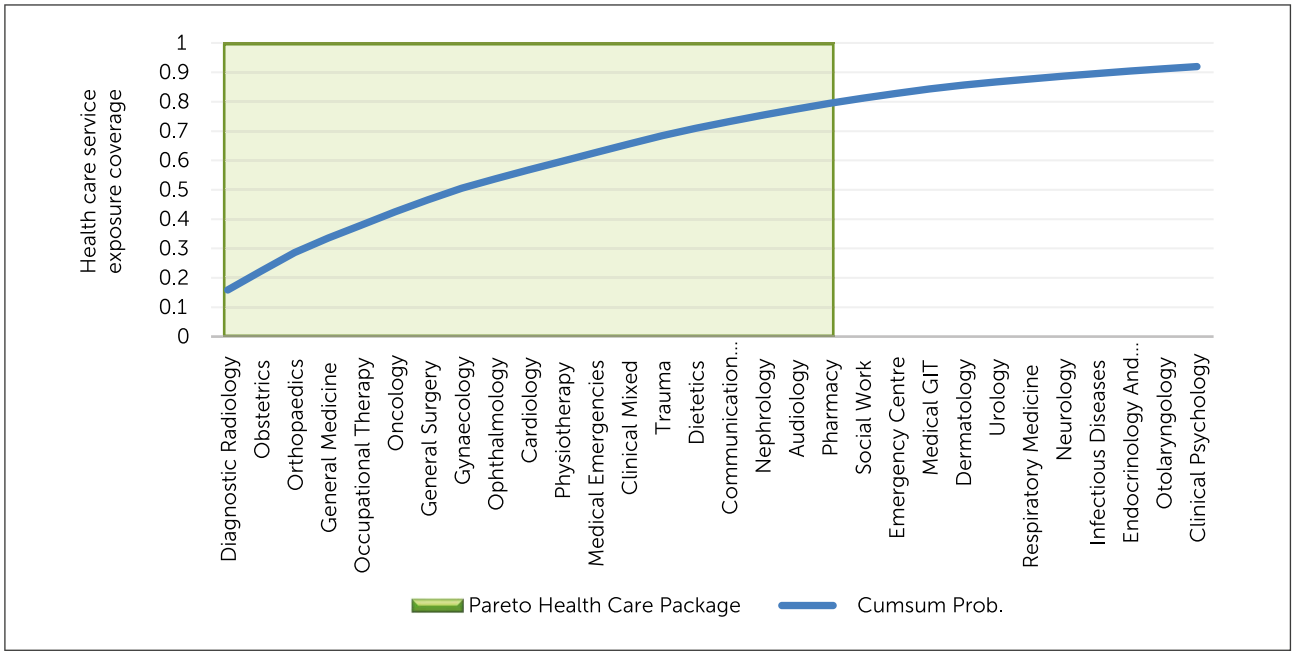
Source: Medical Scheme Act (No. 131 of 1998) Regulations GNR.1262 – 20 October 1999 as amended and Council for Medical Schemes

As PMBs are directly linked to the diagnosis, any exclusions or circumstances (e.g. travel costs and examinations for insurance purposes) that are not compensated by medical schemes do not apply, irrespective of how the condition was contracted. In other words, the doctor should look only at the symptoms and not at any other factors, such as how the injury or condition was contracted. Once the diagnosis has been made, the appropriate treatment and care is decided upon, as well as where the patient should receive the treatment, i.e. at a hospital, as an outpatient or at a doctor's rooms.

4.3.3 Demand-based (Pareto) Health Care Package

A demand-based (Pareto) health care package is estimated using the derived unit costing of health care services mapping, based on the 80-20 rule on the probability of patient visits (Figure 4.1). The horizontal axis with coloured area indicates the sub-departments, ranked in descending order, that are covered under this package.

Figure 4.1: Demand-based Pareto health care package



Source: Commission's calculation from consolidated data (2020)

Table 4.3 presents the three health care packages, based on one patient, one visit per year, without knowing the extent of health care required.

Table 4.3: Costing and pricing of health care packages

	PHC package	PMBs	Pareto health care package
Estimated cost per patient visit per year (2019 prices)	R2,198	R19,764	R12,969
Health care service exposure coverage (%)	27.3%	80.6%	80.0%
Coverage of health care services	• Health promotion and disease prevention • Treatment, care and support • Environmental health services	• PMBs • Chronic disease list	• Diagnostic radiology • Obstetrics • Orthopaedics • General medicine • Occupational therapy • Oncology • General surgery • Gynaecology • Ophthalmology • Cardiology • Physiotherapy • Medical emergencies • Clinical mixed • Trauma • Dietetics • Communication pathology • Nephrology • Audiology • Pharmacy

Source: Commission's calculations (2020)

As Table 4.3 shows, the PHC package costs R2,198 but only covers 27.3% of the health care services, and the actual or curative treatment is minimum. The PMBs and Pareto health care package offer similar coverage (80.6% and 80% respectively) but have different costs, with the Pareto health care package costing R12,969 or 65.6% less than PMBs, which cost R19,764 for inpatients or outpatients. These results were achieved using the same approach and assumptions of costing for all three health care packages. Thus the Pareto health care package, acting as a proof of concept, demonstrates that a highly efficient health care package can be derived by using a simple demand-based costing approach, with data information for output-cost mapping. Naturally, as better and more reliable costing with outputs data is collected, this costing approach can be used as a basis for deciding the extent of coverage and benefits of more effective and efficient health packages.

4.4 Critical Success Factors for NHI Reform

The health care financing reform of the NHI is crucial in order to bridge the gap between public and private health care in South Africa and achieve sustainable, affordable universal health care. The four critical success factors for NHI reform are an aligned policy and legislative framework across spheres of government; capacitated institutions with clearly defined roles and responsibilities, supported by a consistent IGR framework; determined funding requirements and funding sources for NHI; and defined, sufficiently comprehensive benefits, i.e. conditions covered by the NHI.

4.4.1 Aligned Policy and Legislative Framework

The NHI Bill creates a broad enabling framework for the introduction of NHI. However, the Bill relegates to regulations crucial components that will determine the cost and pace of implementation, such as the nature and scope of benefits to be covered by the NHI Fund. Furthermore, the legislative reforms required to ensure a consistent legislative framework have not yet been determined, which could delay implementation of the NHI Act. Although section 59 makes provision for the Act, once passed by Parliament, to take effect on a date fixed by presidential proclamation,[21] the Act cannot be implemented until other laws have been passed or amended, as section 3(4) states: "The Act does not in any way amend, change or affect the funding and functions of any organs of state in respect of health care services until legislation contemplated in sections 77 and 214, read with section 227, of the Constitution and any other relevant legislations have been enacted or amended".

The Constitution (section 239) defines an "organ of State" as government departments and "any other functionary or institution", which would include the NHI Fund and other entities vested with public powers and functions in terms of the NHI Bill, such as district health management offices (DHMOs) and contracting units for PHC. Therefore, any provision of the Bill, which in any way amends, changes or affects the funding and functions of any of these organs of State, is in effect suspended until the conditions of section 3(4) have been met. Most of the Bill's provisions fall within the broad scope of this suspensive condition, and so the NHI Act would effectively be suspended even after its presidential proclamation. To meet the two suspensive conditions contained in section 3(4) of the NHI Bill, the following legislation needs to be enacted:

- The legislation contemplated in section 77 of the Constitution relating to money bills,[22] and section 214[23] of the annual Division of Revenue Act, read with section 227 of the Constitution, which entitles provincial and local government to their share of national revenue.
- "Any other relevant legislation", which creates substantial scope for interpretive dispute and is a catch-all condition because no detail is given on the legislation being contemplated or the specific outcomes of those legislative changes.

The Transitional Arrangements in the Bill does provide some indication of the legislation being contemplated. Section 57(4)(h) includes a list of the legislative reforms that must be initiated in Phase 1 (2017–2022), but the Bill is unclear about amendments to other Acts. For instance, the Medical Schemes Act was not amended by the NHI Bill but by a separate amendment Bill published on the day that the NHI Bill (2018) was gazetted. In addition, several Acts are listed as legislation requiring changes (in section 57) but are not amended by the NHI Bill,[24] whereas other Acts are amended in section 58 but are not included in the list in section 57.[25] Section 57 also refers to "other relevant Acts" (previously "various Provincial Health Acts") that require changes without specifying the legislation. Hence many other laws are "relevant" to NHI and so potentially fall within the ambit and scope of the suspensive condition provided for in section 3(4) of the NHI Bill.

21 Or on different dates for different provisions of the Act, as per section 57.
22 Section 77 Bill is a Money Bill if it-
(a) appropriates money;
(b) imposes national taxes, levies, duties or surcharges;
(c) abolishes or reduces, or grants exemptions from, any national taxes, levies, duties, or surcharges; or
(d) authorises direct charges against the National Revenue Fund, except a Bill envisaged in section 214 authorising direct charges.
23 These are Acts which must provide for:
(a) the equitable division of revenue raised nationally among the national, provincial, and local spheres of government;
(b) the determination of each province's equitable share of the provincial share of that revenue; and
(c) any other allocations to provinces, local government, or municipalities from the national government's share of that revenue, and any conditions on which those allocations may be made.
24 The Mental Health Care Act (No. 17 of 2002), the Traditional Health Practitioners Act (No. 22 of 2007), the Dental Technicians Act (No. 19 of 1979), the Medicines and Related Substances Act (No. 101 of 1965) and the Nursing Act (No. 33 of 2005).
25 The Compensation for Occupational Injuries and Diseases Act (No. 130 of 1993), the Competition Act (No. 89 of 1998), the Correctional Services Act (No. 111 of 1998) and the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008).

The objective of aligning the legislative framework to support the NHI is clear, but the practical application of this provision is extremely problematic. If the Bill were to be passed unchanged, protracted legal dispute would undoubtedly delay the Act, as a result of interpretive difficulties over whether the suspensive conditions in section 3(4) of the Bill have been met. This is a most undesirable outcome and can be avoided in two ways:

- By specifying clearly and unambiguously the legislative outcomes that must be in place in order to fulfil the suspensive conditions for the operation of the Bill.
- Preferably, by making the necessary amendments to all the laws listed in the Bill.

The magnitude and complexity of this task should not be underestimated. Schedule 4 of the Constitution lists "health services" as a concurrent national and provincial function, which means that both national and provincial legislation will need to be aligned in order to revise the distribution of powers and functions between the spheres of government. Alternatively, in the event of a conflict of laws between provincial and national legislation, a determination will need to be made through the intergovernmental dispute resolution process or judicial determination as to which laws prevail, applying the provisions of section 146(2) of the Constitution.

The only, and arduous, option is to follow the necessary intergovernmental processes and align the legislation in the different government spheres, in order to create an appropriate legislative framework to enable the NHI's implementation. Using a technical shortcut, such as section 32(2)[26] of the NHI Bill, might enable legislation to be passed through Parliament but has the potential to delay significantly the legislation's implementation in the long term.

4.4.2 Capacitated and Consistent IGR Arrangements

The NHI Bill provides a reasonably clear framework for establishing the NHI Fund as a legal entity,[27] vested with the necessary powers to enable it to perform its functions.[28] Where difficulties arise are in the coherence of the framework for intergovernmental and fiscal arrangements to support the implementation of NHI. The IGFR system was identified as a challenge in the 2017 White Paper on National Health Insurance (South Africa, 2017: 16):

> Inequity in health care financing and fragmentation are worsened by the health financing system and the system of intergovernmental functions and fiscal relations. The South African health system is underpinned by a financing system that is based on the Intergovernmental Fiscal Relations (IGFR) system. The IGFR system is faced with an institutionalised and structural form of fiscal imbalance because of vertical fiscal federalism and other factors that impact on intergovernmental fiscal relations.

Weak accountability and leadership systems, and the failure to optimise costs and "availability of medical products and technologies" are attributed in part to the "semi-federal public sector" (ibid: 14, 12). In light of this concern about the impact of the IGR system on effective health system functioning, the White Paper envisages that NHI will "necessitate massive reorganisation of the current health care system" (ibid: 3). The most significant changes to intergovernmental functions and powers and associated fiscal flows, as proposed by the NHI Bill, relate to the management and control of hospitals and district health services.

26 Section 32(2) states "Subject to the transitional provisions provided for in section 57, the Minister may introduce in Parliament proposed amendments to the National Health Act for the purpose of centralising the funding of health care services as required by this Act."

27 Although some confusion arises between section 9, which establishes the NHI fund as "an autonomous public entity, as contained in Schedule 3A to the Public Finance Management Act", and section 2, which states the purpose of the Act is "to establish and maintain a National Health Insurance Fund in the Republic funded through mandatory prepayment".

28 Importantly, the fund must establish an Office of Health Products Procurement, which sets parameters for the public procurement of health-related products. More specifically, the Office is responsible for centralising and coordinating the public procurement of health-related products, including but not limited to medicines, medical devices and equipment.

Management and Control of Hospitals

The National Development Plan (NDP) highlighted the negative impact on health service delivery of centralised hospital budgets and supply chain management at the provincial level, noting that "delivery of health services and care for patients takes place at health facilities, yet managers lack the powers to manage effectively" (NPC, 2012: 332). The White Paper's policy response is to make central hospitals "semi-autonomous" and decentralise management functions and responsibilities to hospitals (South Africa, 2017: 33). Similarly, managers of "district, regional, tertiary and specialised hospitals" would have greater decision-making powers, including "delegations on the management of human resources, finance and supply chain/procurement" (ibid: 34).

The NHI Bill provides for this decentralisation in two main ways:

- By amending the National Health Act, removing the function to "control and manage the cost and financing of public health establishments and public health agencies" from provincial health departments.[29]
- By providing for direct contracting between the NHI Fund and all hospitals (district, specialised, regional, provincial and central), and direct payment from the NHI Fund to the contracted hospitals,[30] including accredited private health care service providers.[31]

With these changes, the provincial department will no longer control and manage the cost and financing of the health facilities, as funding for providing services will be paid directly to the hospitals.

Of note is the changes made between the 2018 and 2019 versions of the NHI Bill regarding the role of provincial departments of health. The 2018 version states that the "functions of a provincial department responsible for health in the province in question shall be to provide health services which the Fund would purchase",[32] while the 2019 version notes that "the functions of a provincial Department must be amended to comply with the purpose and provisions of this Act, subject to the provisions of section 57".[33] The role and responsibilities of provincial departments in providing health services in hospitals (excluding central hospitals, which will move to the national government) thus become unclear, especially as the NHI Bill leaves "the legal relationship between the Fund and the various categories of health establishments, health care service providers or suppliers as provided for in the National Health Act"[34] up to the minister to make in regulations.

Management and Control of District Health Services

After the transition to democracy, the health system was reformed based on establishing a district health system, whereby the country is divided into health districts, i.e. health is planned, organised and managed at the district level (Health Systems Trust, 2001). For the NDP, "the district health system embodies a decentralised, area-based, people-centred approach to health care" (NPC, 2012: 331), while the White Paper for the Transformation of the Health System in South Africa (South Africa, 1997: 12) states that:

> The mission of a provincial health department, as mandated by the Constitution of South Africa within the framework of national policies, strategies and guidelines, is to promote and monitor the health of the people in the province, and develop and support a caring and effective provincial health system, through the establishment of a province-wide district health system (DHS) based on the principles of primary health care (PHC).

29 Section 25(2)(k) of the National Health Act, deleted by section 59 read with Schedule to the NHI Bill.
30 Sections 35 and 38 of the NHI Bill.
31 Section 37(2)(b), (g) and (h).
32 Section 35(2)
33 Section 32(3)
34 Section 55(1)(a)

The NHI Bill strengthens management at a district level in the following ways.

- It amends the National Health Act (No. 61 of 2003) to establish DHMOs as the primary management authorities, with extensive responsibilities and "considerable powers to manage, facilitate, support and coordinate the provision[35] of primary health care services for personal health care services and non-personal health services[36] at the district level in compliance with national policy guidelines and relevant law".[37]
- It provides for the establishment of contracting units for primary health care (CUPs), as the organisational unit with which the NHI Fund contracts for the provision of primary health care services within a specified geographical area.[38]
- It amends the powers and functions of district health councils and provincial health departments, with associated changes to the funding flow.

The NHI Bill has amended the powers and functions of provincial health departments, through changes to the National Health Act:

- Deleting the function of provincial health departments to facilitate and promote the provision of comprehensive primary health services and community hospital services in section 25(2).
- Amending paragraphs (n) and (t) of section 25(2):[39]

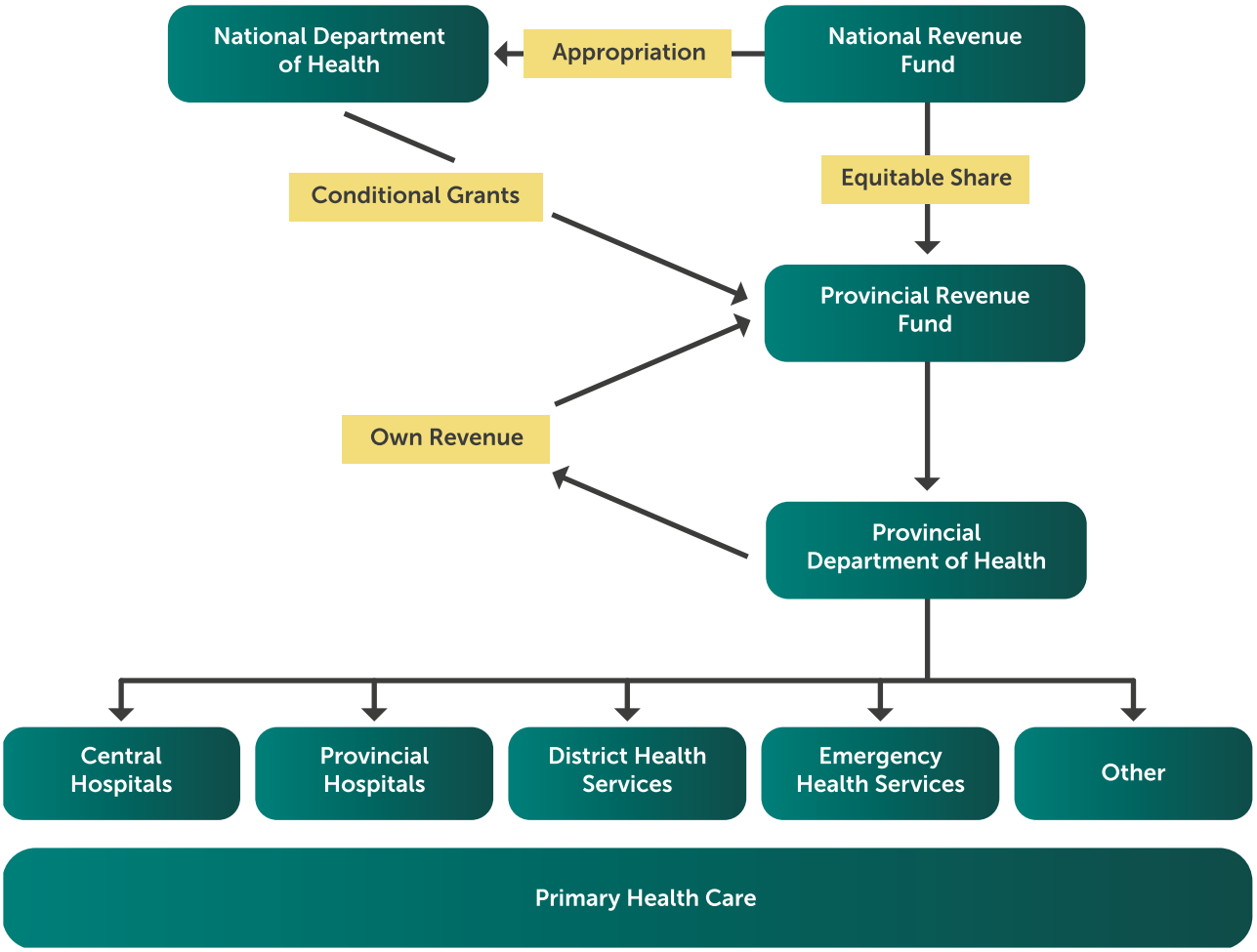
> (n) assist the District Health Management Office in controlling [control] the quality of all health services and facilities.
> (t) together with the District Health Management Office promote community participation in the planning, provision, and evaluation of health services.

Therefore, contrary to the 2018 NHI Bill, in the 2019 NHI Bill, most powers and interactions will be between the national department and the DHMOs in terms of providing primary health care services,[40] and the national department will fund DHMOs (as national government components) in terms of section 31A of the National Health Act.[41] At the same time, district health councils no longer have the responsibility to "ensure co-ordination of planning, budgeting, provisioning and monitoring of all health services that affect residents of the health district for which the council was established."[42]

The shift in functions also entails a significant shift in funding flows. As Figure 4.2 shows, currently provincial government receives the majority of its funding from the national fiscus, mainly through the PES, as well as conditional grants,[43] with a miniscule of funding from provincial own revenue.[44] Provincial health funds are spent on various programmes, with district health services accounting for 46.1% of total expenditure in 2016/17 (Davén et al., 2018).

35 Importantly, the DHMO will be responsible for controlling the quality of all health services and facilities with assistance from the provincial departments in managing the contracted health care providers.
36 Personal health services are delivered individually and are services of a therapeutic or rehabilitative nature. Non-personal health services are actions applied either to collectives (e.g. mass health education) or to the non-human components of the environment (e.g. basic sanitation) (Adams et al., 2002).
37 Section 36 of the NHI Bill: 31A of the National Health Act, to be inserted by section 58 read with the Schedule to the NHI Bill. In the 2018 version of the NHI Bill, the DHMOs were established to engage mainly with the NHI Fund.
38 Section 37 of the NHI Bill.
39 Underlining means insertion and parentheses means deletion.
40 It is worth noting that in "Section 9. Parliamentary Procedure" of the Memorandum on the Objects of the National Health Insurance Bill (2019), the NHI Bill refers to section 76 of the Constitution, which contains the parliamentary procedure for ordinary Bills affecting provinces. More specifically, in terms of section 76(3), a Bill must be dealt with in accordance with the procedure established by either section 76(1) or section 76(2) if it falls within a functional area listed in Schedule 4
41 Section 36 of the NHI Bill; 31A of the National Health Act, to be inserted by section 58 read with the Schedule to the NHI Bill. The DHMOs were originally established to engage mainly with the NHI Fund in the 2018 version of the NHI Bill. See Appendix C for more details.
42 Deletion of section 31(3)(b) of the National Health Act, in terms of section 53 read with the Schedule to the NHI Bill.
43 It is worth noting that the PES cannot be allocated on a sectorial basis, as it is a weighted-share, formula-based approach of horizontal division that is calculated as a lump sum.
44 It should be noted that provincial own revenue is miniscule in comparison to national transfers, determined by the Uniform Patient Fee Schedule, published regularly by the national DOH. The health patient fees revenue collected is surrendered to the provincial revenue fund as per the PFMA unless it is within the department's budget or granted through the revenue retention process.

Figure 4.2: Current funding flows for health services*



Source: Commission's own compilation (2020)

Figure 4.3 illustrates revised funding flows proposed in the NHI Bill, which explicitly states that hospitals (central, provincial, regional, specialised and district) will be paid directly from the NHI Fund. It is assumed that funds transferred to CUPs will also come from the NHI Fund.[45] Emergency medical services will be "reimbursed on the basis of a capped case-based fee with adjustments made for case severity, where necessary", whereas public ambulance services will be reimbursed from the PES.[46] DHMOs are assumed to be funded via the DOH, as their establishment falls within the remit of the department.[47]

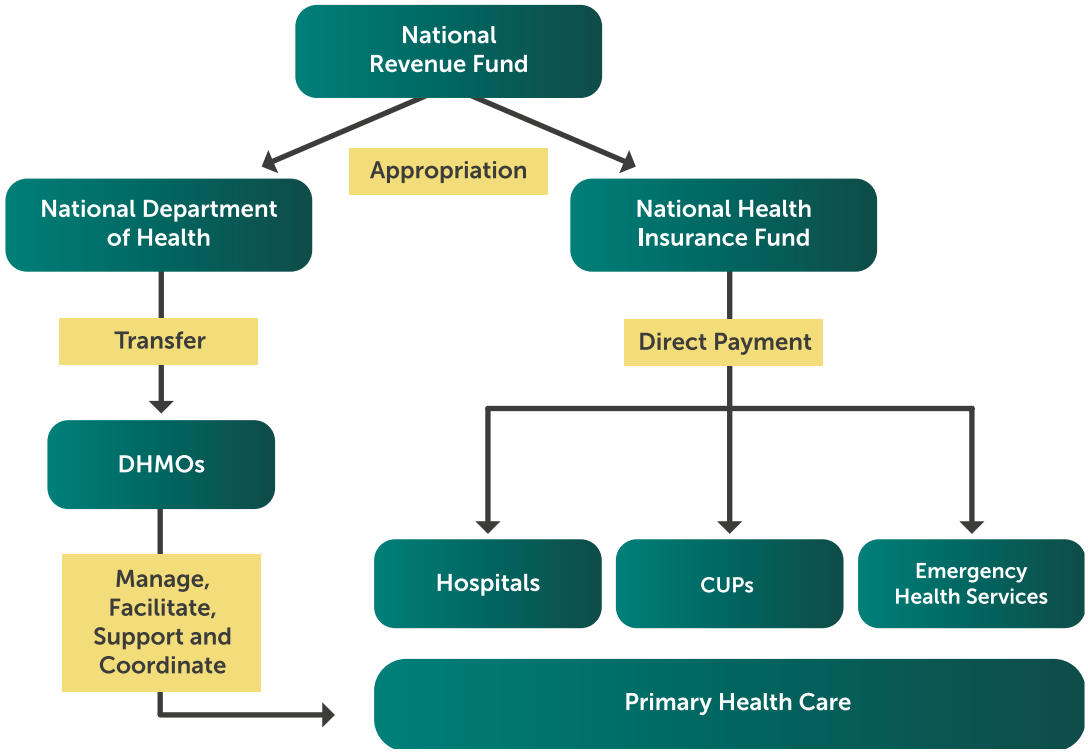
* *Excludes municipal health services*

45 Section 35(3) states "Funds for primary health care services must be transferred to Contracting Units for Primary Health Care at the sub-district level as outlined in section 37."

46 Section 35(4). As a specified Schedule 5 Part A service, the Ambulance Service is reimbursed through PES; otherwise, it would have been dealt with like all other health services.

47 Section 32(2)(c)

Figure 4.3: Proposed revised funding flows for health services



Source: Commission's own compilation (2020)

The NHI Bill envisages the decentralisation of powers and functions, and reorganisation of functions and funding flows, in order to promote greater accountability in the health system. Provincial government is the most affected sphere of government, as the management and oversight of district health services will no longer be their responsibility but will be vested in DHMOs, which will be national government components. Funding for the provision and management of health services will also effectively bypass provincial health departments, as the NHI Fund will pay hospitals and other health service providers directly. This direct payment by the NHI Fund to health care providers for health services creates some difficulty from a constitutional perspective. In terms of the NHI, the provision of health services remains a function of provincial health departments, but according to sections 227(1)(a) and 213(3) of the Constitution, provinces are entitled to an equitable share of national revenue, which is a direct charge against the National Revenue Fund rather than an appropriation by an Act of Parliament.

South Africa's semi-federal structure provides no easy answers. The solution does not lie in simply improving the wording of the legislation, which will always be open to legal challenges that, even if unsuccessful, will delay implementation for years, but rather in resolving these issues through consensus-building and strong intergovernmental coordinating structures.

4.4.3 Determined Funding Requirements and Funding Sources for NHI

Possibly the most contentious issue about the NHI relates to its cost and affordability. The desirability of the intended outcomes of NHI is not debatable, but affordability is a key concern because of its potential risk both to the economy and to achieving a fair and just health system for all.

The White Paper provided "illustrative projections", rather than "the actual expenditure commitments that will occur from the phased implementation of NHI" (South Africa, 2017: 41). The Davis Tax Committee, which the Minister of Finance established in 2013 to look into the tax system and its role in supporting inclusive, sustainable development, evaluated the 2015 NHI White Paper and concluded: "Given the current costing parameters outlined in the White Paper, ***the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth***" (DTC, 2017: 44).

The NHI Bill does not provide the information necessary for estimating costs, and leaves key costing considerations to be made through regulations. These include the scope and nature of health service benefits and programmes and the extent to which they must be funded.[48] Furthermore, understanding the cost implications of the reconfiguration of powers and functions of the various spheres of government (such as asset and staff transfers) is still some way off.

The NHI Bill also does not provide any further clarity on the tax structure reforms that will be necessary to support the implementation of NHI, apart from specifying that the NHI Fund's income would include *inter alia* money appropriated by Parliament, and that the Minister of Health must, in consultation with the Minister of Finance, annually determine the budget and allocation of revenue of the Fund.[49]

However, the NHI Bill does take steps towards integrating medical benefits currently reimbursed through the Compensation Fund for Occupational Injuries and Diseases Act (No. 130 of 1993), the Occupational Diseases in Mines and Works Act (No. 78 of 1973) and the Road Accident Fund Act (No. 56 of 1996). It provides for the amendment of these pieces of legislation to remove compensation for medical benefits,[50] on the assumption that medical benefits would be available through the NHI for those in need of care.

Given the above, decisions on the timing and scope of NHI implementation will inevitably need to be made under a shadow of uncertainty on its projected costs. Therefore, during the transitional implementation phases,[51] the focus must be on reducing this uncertainty, so that the required policy decisions are as informed as possible. An equally important consideration for containing costs is that implementation proceeds at an optimal pace and sequencing, so as to avoid undesirable delays that result in undue financial burdens on households. For example, existing medical scheme beneficiaries paying for NHI through increased taxes but not enrolled in the NHI because of system or coverage constraints.

To avoid delays or cost escalations, what is needed is a clearer roadmap, accompanied by a detailed logical framework with performance indicators for the implementation period.

4.4.4 Defined Comprehensive Benefits for NHI Beneficiaries

As mentioned earlier, the NHI Bill enables the Minister of Health to publish regulations on the "scope and nature of health service benefits and programmes and the manner in and the extent to which they must be funded". It also provides for the establishment of a benefits advisory committee to guide decision-making around benefits.[52] The transitional arrangements make provision for a ministerial advisory committee on health care benefits for NHI to be a precursor to the benefits advisory committee, and to advise the Minister on a process of priority-setting to inform the fund's decision-making processes in determining the benefits to be covered.[53]

48 In terms of section 25(5)(c), the Benefits Advisory Committee must determine the health service benefits, in consultation with the Minister and board.
49 Section 49 of NHI Bill
50 Section 58 read with the Schedule to the Bill.
51 Section 57 of the NHI Bill speaks of the transitional arrangements in terms of phases.
52 In terms of section 25(5)(c), the Benefits Advisory Committee must determine the health service benefits, in consultation with the Minister and board.
53 Section 57 of the NHI Bill

Given the significant concerns around the NHI's affordability and achieving its intended impact, it would be appropriate for the government to be more prescriptive on the criteria that the benefits advisory committee should take into account when making its recommendations/determinations. In determining these criteria, consideration should also be given to the Davis Tax Committee's recommendation of a "fiscal rule to link NHI spending with the availability of fiscal resources" (DTC, 2017).

4.5 Conclusion

The onset of the Covid-19 pandemic has brought into sharp focus the issue of sustainable health financing for efficient, effective and quality universal access of health. South Africa's health system is under strain and health spending is high. After 25 years of democracy, instead of universal health care as envisaged in the Constitution, the country has entrenched a two-tiered health care system, where public health care is financed through taxes, while private health care is financed through medical schemes and is characterised by high costs. The Covid-19 pandemic has highlighted the vulnerability of South Africa's health care system and the importance of sustainable and affordable universal access to quality health care.

Three main health care packages were costed using data from the Western Cape: PHC, PMBs and Pareto-based health care package. The cost analysis found the current PHC package covers less than a third of the health care services for one patient making one visit per year (without knowing the extent of health care required). It also focuses on information, promotion, screening, facilitation and education purposes, whereas in actual care the package's aim is to stabilise patients (including emergencies) and manage minor ailments. Most cases that require more sophisticated laboratory testing and/or medical treatments need to be conducted at hospitals through the referral system. This issue is pertinent in the context of the Covid-19 pandemic, as many of these small-scale PHC clinics are not equipped or capacitated enough to deal with a viral outbreak, thus potentially becoming points of contagion to increase the spread of the disease. A Pareto health care package can offer a same level of coverage as PMBs but at 65.6% of the cost. The research showed that a cost-effective health care package can be derived through a simple demand-based costing approach and, with better and more reliable costing and output data, more efficient packages will be possible.

Four critical success factors were identified for enabling the NHI Reform: an appropriate legislative framework, a strong and consistent IGR framework, a clear funding roadmap, and criteria for benefits covered by the NHI. Arriving at an aligned policy and legislative framework across spheres of government would mean following the necessary intergovernmental processes and aligning legislation in the different government spheres. To achieve capacitated institutions with clearly defined roles and responsibilities, supported by a consistent IGR framework, involves more than simply improving how the legislation is worded. Resolving issues would require consensus-building and strong intergovernmental coordinating structures. In addition, to avoid delays and cost escalations, a clear NHI implementation roadmap would include the funding requirements and sources, and performance indicators. Lastly, criteria would prescribe the conditions covered by the NHI, to ensure the benefits are sufficiently comprehensive. The gap between the public and private sector health care in South Africa must be bridged, and to this end the Commission supports the health care financing reform of the NHI towards universal health care.

4.6 Recommendations

With respect to the sustainable financing of South Africa's health care system and NHI, the Commission makes the following Recommendations:

On improving data to guide health care financing decisions:

1. *The ministers of health and finance should prioritise the development of an integrated national information system of patient and doctor registries with real-time data, to inform health care financing and provisioning decisions using the demand-based costing methodology. The funding of this data system should be pronounced in the 2021/22 Division of Revenue Bill and Appropriation Bill, completed by 2022/23 for roll-out in 2023/24, testing in 2024/25 and stabilising in 2025/26.*

Health care financing decisions should be informed and guided by empirical data for delivering health care goods and services. The Commission's research shows the potential of using a simple, needs-based costing framework for health care services, and the need for the administrative information systems to be scaled up nationally, to measure and monitor the pricing and costing of health care services. Once the system is established, the data information and costing methodology could be used to inform decisions about financing the public health care system, to ensure that funding is adequate, appropriate and sustainable.

On refocusing the public health care system:

2. *The Minister of Health must re-examine the prescribed PHC package based on the needs of the people, refocusing from informing, promoting, identifying, facilitating and educating activities to providing health care services. This should be supported by reprioritisation from within the current baseline allocation of Programme 4: Primary Health Care to ensure that care is available to those who come into primary health care facilities in need of medical attention and curative treatments.*

Although the Commission recognises the importance of preventative services within PHC, it is concerned about the appropriateness of the current PHC package, which focuses too much on preventative services instead of on curative actions and treatments. This takes into account the fact that the majority of the health care facilities and infrastructure are under-resourced, which means that the majority of cases, even if they fall under PHC are, in any case, referred to hospitals for proper testing and treatments.

3. *The ministers of health and finance must ensure that an enabling policy and legislative framework, aligned among the spheres of government, is put in place with due regard to setting norms and standards, and is enforced with proper oversight by the established technical committees. The Minister of Finance should include these deliberations in Annexure W1 of the Division of Revenue Bill with implications on the Bill, as well as the Budget Review document.*

Section 3(4) of the NHI Bill states that the NHI Act does not in any way amend, change, or affect the funding and functions of any organs of state. According to section 239 of the Constitution, an organ of State includes not only government departments but would include the NHI Fund itself, as entities vested with public powers and functions in terms of the NHI Bill. Therefore, the operation of any provision of the Bill, which in any way amends, changes or affects the funding and functions of any of these organs of State is in effect suspended until the suspensive condition provided for in section 3(4) of the NHI Bill has been fulfilled.

4. *The Minister of Health should examine and eradicate the inefficiencies of wastages, corruption and leakages that result from the disparity of the two-tiered (private and public) health care system. In particular, procurement decisions of health care goods and services should be made by consulting health professionals and workers with the necessary expertise and professional integrity. A portion of the department's budget should be set aside for establishing a technical committee of health professionals to decide on purchasing and procuring facilities, instruments, and medicines.*

The Commission's visits to state hospitals and clinics confirmed the Auditor-General's findings that stock control by certain provincial administrations is compromised by technical deficiencies, resulting in wastages, corruption and leakages of expensive stocks and medicines. The procurement of health care equipment, instruments, medicines and procedures should be based on expertise and the integrity of health care professionals. Qualified health experts or pharmacists should run the supply chain management of medicines, so that health practitioners can take their rightful place in the health care value chain. To that end, the NHI Bill 2019 proposes a decentralised structure for taking decisions about supply chain management, pharmacy, human capital specialities and stock purchasing managed by experts at the facilities, while the relevant committee sets the standards, norms and practices as guidelines. However, decentralisation could mean corruption, inter-institutional weaknesses and lapses causing leakages. Therefore, a committee of experts should be established for pharmaceutical purchasing and procurement of medicines.

Appendix A: Data Issues and Variable Challenges for Pricing and Costing of Health Care Services

The data is taken from the Western Cape's consolidated database of financial information, measured in nominal South African rand spent in health facilities for the 2018/19 financial year. It includes the JAC[54] data for pharmacy stock ordering and stock visibility; the chronic dispensing unit (CDU) that monitors the collection of medicines by chronic patients; the Logistical Information System (LOGIS) for the supply chain management; the National Health Laboratory Service data; the Personal and Salary System (PERSAL); SYSPRO, which is a system used by central hospitals for supply chain and asset management; and data from the Western Province Blood Transfusion Service. The database also includes non-financial information, i.e. detailed statistics on number of patients admitted, the length of stay as day patients or inpatient days,[55] and the number of patients discharged, transferred or died, as the number of patients separated by each sub-department in the facility.

As the dataset only differentiates between shared or individual wards and does not contribute valuable information for the quantitative analysis in this chapter, the most detailed and useful level of non-financial information is divided at the sub-department level, where this costing analysis is conducted. Unfortunately, at this sub-department level, only data for central hospitals (Groote Schuur, Tygerberg and Red Cross), regional hospitals (George, Mowbray, New Somerset, Paarl and Worcester) and psychiatric hospitals (Alexandra, Lentegeur, Stikland and Valkenberg) of the province are available for analysis. Nevertheless, the costing approach is useful as a proof of concept, as the hope is to expand the empirical analysis and costing approach to include all hospitals, clinics, and health centres country-wide into a costed-norm approach of evaluating health care through pricing and costing.

To derive unit costing, a simple division of the cost of servicing patient health at the sub-department level over the patient output unit is utilised. This simple approach essentially joins the financial data with the non-financial, service-related data, as it measures how much resource is being spent per patient output as a representation of the cost-efficiency of health care services. Two performance indicators were considered for the denominator of the unit costing calculation: the patient day equivalent and the number of patient visits. Since the data was only able to consistently provide the number of patient visits for both inpatient care units and outpatient units, this chapter focuses on the number of patient visits as its denominator of choice. The derived efficiency proxy as cost over the performance data of patient visits is thus defined as *Rand per patient visit per year (inpatient or outpatient)*.[56]

54 JAC is a pharmacy dispensing and stock control information system and program.
55 Patient day equivalent combines the number of inpatients, plus half the number of day patients plus one third of emergency outpatient visits as recorded in the District Health Information Software.
56 Since the data is for the 2018/19 financial year only, and the purpose of unit costing is to extrapolate and compare the cross-sectional, unit measure of cost, there is no need to adjust for inflation in this cross-sectional study of the cost for health care.

Appendix B: Primary Health Care Package

HEALTH PROMOTION AND DISEASE PREVENTION
COMMUNITY-BASED SERVICES
Promotion of healthy lifestyles
Provision of information on healthy lifestyles
Provision of information on the consequences of risky sexual behaviour, tobacco use and substance abuse
Community campaigns promoting healthy behaviours, including physical activities
Provision of information on safe food preparation, storage, and handling, including hand washing
Provision of information on healthy diets, food choices, eating behaviours and health risks associated with poor diets
Referral of patients with signs of malnutrition
Maternal and women's health
Facilitate access to social grants, health, and social services
Facilitate access to key services e.g. ANC, HIV and TB screening and care in pregnancy, contraception and family planning, TOP, and cervical screening
Assistance with registration of births and deaths
Support for postnatal care and breast feeding
Child health
Ensure that all children have a "Road to Health" booklet and that caregivers are aware of the uses the card
Facilitate access to social grants, health, and social services
Facilitate access to key services e.g. immunisation, growth and development monitoring, Vitamin A supplementation and deworming
Screening of learners for health barriers to learning
Provide information on symptoms of common childhood illnesses, including diarrhoea and pneumonia and basic management of these illnesses for example preparation of ORS
Chronic disease management
Adherence support to patients with chronic diseases
Occupational health
Ensure the workplaces are safe and promote health
Promote the establishment of workplace wellness programmes
Recognise and referrals for work related injuries and diseases
Oral health
Provision of information and education on oral health
HEALTH FACILITIES
Promotion of healthy lifestyles
Provision of information on healthy lifestyles: consequences of risky sexual behaviour, tobacco use and substance abuse; healthy diets, food choices, eating behaviours and health risks associated with poor diets; and physical activity
Provision of information on safe food preparation, storage, and handling, including hand washing

Maternal health
Information on nutrition and maintenance of a healthy diet throughout pregnancy
Pre-natal supplementation
Information and preparation for birth, new-born care, breast feeding, and emergency preparedness
Tetanus immunisation
Assistance with registration of births and deaths
Post-partum family planning advice and provision of contraceptives
Child health
Use of the "Road to Health" booklet as the child's passport to health
Expanded immunisation programme
Information on infant and young child feeding practices
Screening and monitoring of new-borns for development impairment and genetic disorders
Routine growth monitoring)
Screening and monitoring for early childhood developmental delay and impairment
Screening and monitoring for sensory development (hearing and vision)
Referral to appropriate facility if necessary
Referral to specialised education centres if necessary
Communicable and non-communicable diseases
Provision of information on the prevention of communicable and non- communicable diseases
Information on early treatment seeking behaviour
Screening for hypertension and diabetes
HIV counselling and testing (HCT) and provider-initiated counselling and testing (PICT)
Screening and testing for tuberculosis
Weight monitoring/screening (obesity and underweight)
Screening for cancer (pap smear, breast examination or mammogram, prostate specific antigen)
Chemoprophylaxis for selected diseases e.g. malaria
Mental health
Screening for common mental health problems including trauma, abuse, depression, anxiety, substance/ alcohol abuse
Oral health
Provision of information and education on oral health and promotion of good oral hygiene
Eye health
Screening for refractive error, eye disease, external ocular infections, presbyopia, trauma to the eye
Screening for major ocular diseases
Occupational health
Provision of information on the promotion of occupational health
Provision of information on specific occupational health problems

TREATMENT, CARE and SUPPORT
COMMUNITY-BASED SERVICES
Acute care
Identification, support, and management of common health problems
Referral for further treatment where necessary
Communicable and non-communicable Diseases
Identification, support, and management of common health problems
Information on the recognition of severe illness
Psychosocial support
Provision of an integrated approach to adherence support for patients on chronic medication
Refer and facilitate access to treatment where necessary
Provision of information, education, and support for appropriate home care
Referral for further treatment where necessary
Violence and injuries
Identification and first aid management of common injuries
Facilitated access to sexual assault services
Psychosocial support and post-trauma counselling
Mental health and substance abuse
Identification and referral to mental health services
Provision of basic counselling for people requiring psychosocial support
Adherence support for patients on medication for psychiatric conditions
Eye health
Support in accessing / using eye health related care/services
Follow up for patients with vision, eye health problems, or suspected eye health problems
Facilitate access to rehabilitation and low vision care
Speech and ear health
Support in accessing / using ear health related care/services
Follow up for patients with hearing, ear health problems, or suspected ear health problems
Facilitate access to rehabilitation and speech and hearing impairment care
Oral health
Identification of need for curative treatment and referral to oral health services
Rehabilitation
Identification of disabilities and people needing services and support
Education and advice on independent living and participation in activities of livelihood and social integration
Referral and facilitated access to health and social services
Facilitated access to medical consumables and assistive devices
Follow up and support for rehabilitative patients at home
Psychosocial support

Palliative
Palliative care to control distressing symptoms
Back-referral to hospital for management of an acute reversible event
Referral to sub-acute care facility for management of distressing symptoms or family respite
Information with regard to self-care, family care and palliative care
Psychosocial services
HEALTH FACILITIES
Sexual and reproductive health
Provision of information and education on sexual and reproductive health
Provision of the full range of contraceptive methods
Antenatal care and deliveries
Provision of basic antenatal care
Referral for delivery or provision of delivery services in designated CHCs
Acute care minor ailments
Diagnosis of minor ailments and illnesses
Treatment and management of minor ailments and illnesses based on facility and provider competency, including integrated management of childhood illnesses
Referral to nearest appropriate and adequately equipped facility if further investigation and/or admission needed
Referral to specialist or higher level of care if needed
Advice on prognosis and medication
Emergency care
Immediate stabilisation of medical emergency
Treatment of burns and simple injuries
Preparation for urgent referral of serious trauma
Referral and transport to nearest appropriate and adequately equipped facility for treatment of severe trauma
CHC should provide in addition to the above:
Management of acute psychiatric cases and referral
Care of trauma of limbs (excluding fractures)
Care of medical conditions which can be stabilised within 24 hours
Immediate management of emergencies
Basic emergency obstetric care
Respiratory / cardiac emergencies
Diabetic emergencies
Allergic emergencies
Suspected poisoning
Trauma
Bleeding

Communicable and non-communicable Diseases
Screening and assessment of risk factors and co-morbidities
Diagnosis of communicable and non-communicable diseases
Initiation of treatment
Management of complications
Follow up and monitoring of treatment adherence
Violence and injuries
Management of trauma patients
Post sexual assault services, including post exposure prophylaxis for HIV, emergency contraception
Psychosocial support, post trauma counselling
Mental health and substance abuse
Screening, diagnosis, and treatment
Individual, group and family therapy
Referrals and facilitated access to higher levels of mental health services when needed
Eye health
Refraction services
Provision of spectacles and/or low vision devices to those in need.
Treatment of eye disease and trauma
Follow up care after diagnosis and/or ocular surgery
Referral to appropriate eye services
Speech and aural health
Screening for speech and hearing defects
Provision of hearing aids
Referral to appropriate audiology and speech related care/services
Follow up for patients with hearing, ear health problems, or suspected ear health problems
Facilitate access to rehabilitation and speech and hearing impairment services
Oral health
Basic curative services, including relief of pain and infection control
First aid for dento-alveolar trauma
Palliative drug therapy for acute oral infections
Dental treatment (CHCs)
Referral of complicated cases to the nearest hospital
Rehabilitation
Screening, assessment, and early detection
Rehabilitation management plans
Basic assistive devices, including wheelchairs, walking aids, hearing aids, prostheses
Mobility and orientation training for blind children
Counselling and/or education (psychosocial rehabilitation)
Referral for further care when necessary

Palliative
Identification of patients requiring palliative care
Individualised palliative care management plan
Provision of palliative care according to the care plan
Referrals for symptom management
Referrals to palliative care specialist
Referrals for counselling for emotional support, spiritual or bereavement care
Information & education to patient and family
Referrals to home-based and community based palliative care services

ENVIRONMENTAL HEALTH SERVICES
COMMUNITY-BASED SERVICES
Provision of information and education on healthy living environments, including good hygiene practices
Information on water purification and the dangers of unsafe water use
Information on safe food handling practices at household level
Information on environmentally sound and safe management of waste at household level
Information on the safe handling and disposal of hazardous substances at trade and household level
HEALTH FACILITIES
Provision of information on healthy living environments
Provision of proper sanitation in health facilities
Provision of clean water in health facilities Monitoring of food handling practices in health facilities
Ensure proper ventilation of health facilities for airborne infection control

Appendix C: Proposed Functions of Provincial Health Departments, DHMOs, CUPs and District Health Councils in Relation to District Health Services

DHMOs

- Facilitate, coordinate, and manage the provision of primary health care services at the district level
- Develop district health care plans in support of the district health system
- Liaise with provincial and municipal health authorities
- Identify certifies and accredited public and private health care providers at primary care facilities that are suitable to receive funding for services within the relevant district
- Interact with community representatives through District Health Councils
- Coordinate and manage the functioning of the streams of PHC within the district, including district specialist support teams, primary health care teams and agents and school health services
- Provide information on the disease profile in a district that would inform the design of the health service benefits for that district
- Improve access to health care services in a district at appropriate levels of care at health care facilities and in the community
- Ensure that the user referral system is functional, including the transportation of users between the different levels of care and between public and private facilities accredited by the fund
- Facilitate the accreditation of health care providers, health establishments and suppliers at the district level, including municipal clinics
- Facilitate, coordinate, and manage the provision of non-personal public health care programmes level
- Liaise with, and report monthly to the national office of the NHI Fund

CUPs

Assist the NHI Fund to:

- Identify health care service needs in terms of the demographic and epidemiological profile of a sub-district
- Identify certified and accredited public and private health care providers at primary care facilities
- Monitor contracts entered with certified and accredited health care providers, health establishments and suppliers
- Monitor the disbursement of funds to health care providers, health establishments and suppliers
- Access information on the disease profile in a district that would inform the design of the health service benefits for that district
- Improve access to health care services in a sub-district at appropriate levels of health care facilities and in the community
- Ensure that the user referral system is functional, including the transportation of users between the different levels of care and between public and private facilities accredited by the Fund
- Issue certificates of accreditation to health care providers, health establishments and suppliers
- Facilitate the integration of public and private health care services within the district
- Resolve complaints from users

District Health Councils

- Promote co-operative governance
- Advise the MECs, through the Provincial Health Councils, and the municipal council and DHMO, regarding health or health services in the district

FINANCIAL AND FISCAL COMMISSION

For an Equitable Sharing of National Revenue

Chapter 5

Putting the Last First: Vulnerability and Access to Quality and Inclusive Social Services

Chapter 5: Putting the Last First: Vulnerability and Access to Quality and Inclusive Social Services

5.1 Introduction

The right of all individuals to a minimum level of social protection is acknowledged across the 2030 SDGs. In low and middle income countries, social protection is equated with interventions aimed at addressing poverty and vulnerability. In South Africa, the social protection system includes the provision of social assistance, access to free basic services, social insurance, income support for the working age poor, social relief and social welfare services. Governments generally subsidise social services for poorer households, so access is free for indigent households whereas higher income households pay tariffs or levies to access the services. This implies variations in the access and quality of social services along income and, in South Africa, racial lines. For example, higher income groups are able to access private, well-resourced schools, while the majority of South Africans attend public schools. Similar dynamics apply to health care and social welfare services.

Many South African families are dealing with the multiple challenges of poverty, unemployment, HIV/Aids, substance abuse, crime and gender-based violence, child abuse and neglect, and the disintegration of the family unit (DSD, 2019). In addition, large numbers of mainly poor and vulnerable children are unable to access quality ECD and special needs education. While the Covid-19 pandemic and subsequent national lockdown may have amplified the hardships faced by the poor and vulnerable, these challenges are longstanding.

This chapter takes a broad focus on family and community welfare services. After assessing the main challenges that hamper a more developmental approach in delivering family and community welfare services, the chapter hones in on two very specific examples of family and community welfare services: ECD and inclusive education. The analysis of ECD examines the bottlenecks affecting ECD education for poor and vulnerable children in South Africa. It also looks at the role of the state in delivering ECD, given the recent reforms to expand compulsory ECD and to shift responsibility for the function, and then evaluates government's progress in rolling out inclusive education. The assertion of this chapter is that well-thought out family and community welfare services enhance the capacity of families to care for their children and to realise their economic, social and other goals. Alongside stable and nurturing families, high-quality education improves children's chances of breaking the chains of intergenerational poverty and inequality, while within education, ECD and inclusive education target the most vulnerable members of society – young children and those with disabilities. The chapter concludes with recommendations on how South Africa can move towards a more appropriate role for government and a more sustainable approach to financing in these three areas, which are crucial for ensuring that the most vulnerable in society receive the necessary services and care.

5.2 Research Methodology

The analysis in this chapter is underpinned by a multipronged methodological approach. This methodology ensured that data was collected through different methods and from a range of stakeholders, which enabled the triangulation of observer, data source and method, to strengthen the richness, depth and reliability of the research.

For the family and community welfare services, key sectoral documents, in particular the White Paper for Social Welfare (South Africa, 1997), the Children's Act (No. 38 of 2005), the White Paper on Families (South Africa, 2013) and the Review of the White Paper (DSD, 2016), were analysed to get an understanding of the current funding and delivery of these services. The financial data (budget and spending) on social welfare spending for 2003/04–2018/19 was sourced from National Treasury, while the key implementation, coordination and other challenges characterising the sector were ascertained through semi-structured telephonic interviews with stakeholders from government and civil society.

Qualitative research was used for the ECD analysis and included: a desktop review of national and international literature, research studies and government documents; eight in-depth interviews with key informants in the ECD field; and a focus group with nine ECD experts to collect in-depth data for analysis.

The inclusive education research relied on a mixture of quantitative and qualitative research, comprising secondary (literature, document and budget review) and primary data (one-on-one interviews and focus group discussions).

5.3 Family and Community Welfare Services

The wellbeing of families should be considered a public good and a key priority for any government. This is because stable and supportive families are a positive influence on the functioning of society, as they contribute towards social cohesion and more stable communities, and are associated with high levels of productivity and low levels of crime, violence and substance abuse (Zeihl, 2003). They also play a crucial role in moulding and caring for a country's future assets: its children.

Yet the majority of families in South Africa, and by extension the communities in which they live, face many pressures that are detailed in the NDP. These include the spatial legacy of apartheid, whereby people live far away from their workplace which limits their amount of family time; high levels of HIV/Aids, orphan-headed households and interpersonal violence (the second highest cause of death in South Africa); and poverty that means families struggle to ensure education and health care for children, the elderly and disabled (NPC, 2012). In response to the apartheid-inherited and existing challenges faced by families and communities, government provides a range of services to families and communities (Figure 5.1).

Figure 5.1: Services provided to families and communities by government

Services to Families and Communities		
Police • Emergency response services • Referral of child abuse cases • Crime prevention	**Social Development** • Social grants • Child protection • Institutional care/partial care facilities • Parent education and support programmes • Adoption • Early childhood development	**Basic Education** • Free education • Provision of teachers, learner support material, infrastructure • School nutrition programme • Special needs education
Justice • Foster care placement • Enforcement of child maintenance • Protection orders • Prosecution of child abuse/ domestic violence	**Health** • Free primary health care • Nutrition education • School health services to public schools • Health and safety standard for partial care and early learning centres	**Home Affairs** • Registration of births, deaths, marriages, divorces
Water and Sanitation • Provision of water an sanitation infrastructure and services to households, schools, hospitals	**Municipalities / Local Government** • Integrated development plans • Provision of basic services and free basic services to indigent households • Emergency services (fire, flood, disaster management)	**Human Settlements** • Subsidised housing • Informal settlements upgrading

Source: Martin et al. (2018)

The focus here is on the services provided by the DSD that relate specifically to care and support to families. Responsibility for these services is shared between the national and provincial departments of social development, which rely heavily on NGOs to assist in delivering services on the ground. Various programmes contribute to the wellbeing of families, such as programmes and services for older persons or victims of violence, while social security grants (although not explicitly considered here) have an important bearing on the wellbeing of families and complement the family programmes. All provincial departments also have the "Care and Services to Families" programme, which is aimed specifically at promoting functional families and preventing vulnerability in families, and is discussed below.

The research identified four issues that affect family and community services.

5.3.1 Disconnect between Policy and Practice

In 1997, the White Paper for Social Welfare introduced the concept of *developmental* social welfare, which required a significant change in the focus and approach within the sector (South Africa, 1997). Prior to the White Paper, government's service delivery model emphasised statutory interventions, such as providing alternative state care and protective services. The White Paper shifted the emphasis to non-statutory services, i.e. preventative and early intervention services, that take a more proactive approach of identifying children, families and communities at risk. The rationale is to move away from intervening *after* a need has arisen, to intervening *before* a need arises, so before abuse, neglect or exploitation happens.

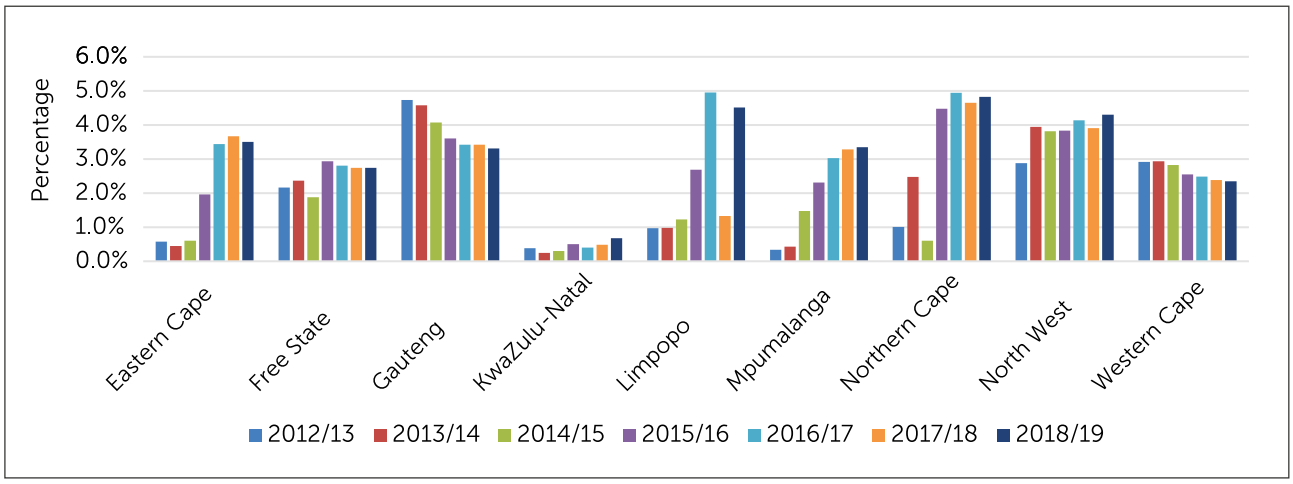
Taking their lead from the 1997 White Paper, all subsequent family and community welfare-related legislation and policies[57] emphasise prevention and early intervention for at-risk individuals, families and

57 For example, the Children's Act (No. 38 of 2005), the Prevention and Treatment of Substance Abuse Act (No. 70 of 2008), the White Paper on Families (2013).

communities. For example, the Children's Act (Clause 146) requires provincial MECs to ensure money is allocated to prevention and early intervention programmes aimed at preventing abuse, neglect and exploitation of children. Such programmes include parenting skills, counselling for children who have suffered trauma, and information on how to access grants and services. However, unfortunately, very few large-scale parenting programmes are being implemented nationally,[58] and none are fully funded by government.

Strengthening families requires integrated interventions, but the provincial "Care and Services to Families" programme is particularly important, as it takes a preventative approach to addressing risks to the functioning of families before they become entrenched. However, provinces attach a low priority to this programme, as shown in their budgetary allocations. Between 2013 and 2019, none of the provinces allocated more than 5% of their total budget to this programme (Figure 5.2). In 2019, provinces allocated an average of 3% of total provincial social development spending (or R533.7-million) to the programme.

Figure 5.2: Provincial allocations for "Care and Services to Families" programme



Source: Commission's compilation from National Treasury database (2019)

Two decades since the promulgation of the White Paper, the shift towards a developmental approach has not happened. Systems for preventative and early intervention services are weak to non-existent, and the sector remains largely untransformed. Therefore, it is perhaps unsurprising that provinces are not prioritising programmes that focus on strengthening families and communities, which are by their nature largely preventative.

5.3.2 Low Prioritisation at Sectoral and Departmental Level

Families and community services are not a high priority at either sectoral or departmental level, as shown by the lack of funding. Provincial budgets do not prioritise social development compared to other sectors, in particular education and health. For example, between 2010/11 and 2017/18, about 95% of total average provincial expenditure was on education (54.6%) and health (41.1%), whereas just 4.3% was allocated to provincial departments of social development, which are responsible for delivering family and community welfare services. This low priority looks set to continue, based on the Commission's analysis of the 2020 Budget Review. Over the next three years, provincial social development budgets are projected to grow by a real annual average of 0.2%. Given the increases in poverty and unemployment, which are key demand drivers in this sector, it is unclear how government will be able to ensure quality and inclusive social welfare services to poor and vulnerable families and communities in South Africa.

58 There are a number of effective parenting programmes in South Africa, such as the Early Learning Resource Unit's Family and Community Motivator programme, and the Foundation for Community Work's Family in Focus Programme, but none of these programmes are offered throughout the country.

The prioritisation of health and education is perhaps unavoidable, in light of the ruling party's election manifesto that is reflected in the Medium Term Strategic Framework, as well as national and provincial budgets. This prioritisation is also entrenched in the PES formula, which consists of six components: education, health, basic, institutional, poverty and economic activity. The poverty component, which is based on income data and attempts to reinforce the redistributive nature of the formula, generally serves as a proxy for social welfare needs per province. It comprises 3% of the total PES allocation (compared to 48% for education and 27% for health). Over the years, unlike other components, the poverty component's share has remained at 3%, despite the increase in population and unemployment numbers, and the expanded mandate/responsibilities of national and provincial social development departments (DSD, 2016). The dilemma is that for social development to be better reflected in the formula requires reliable and robust data, which is lacking in the sector. The approach to funding though is an integral issue that requires a collaborative unpacking by the key social development role-players, so as to ensure that the sector is appropriately prioritised and financed.

The low priority attached to social development in provincial budgets has legal ramifications, in the form of the Nawongo court case[59] which exposed the underfunding of NGOs that deliver welfare services for government. The case revealed a significant funding gap between costs and government transfers, estimated at R3.14 billion (GTAC, 2018). This gap highlights the need to prioritise funding to this sector, as the people who bear the brunt of this lack of funding are the poor and vulnerable.

At departmental level, provincial departments of social development prioritise their limited funding in accordance with the untransformed approach to service delivery, and so "preventive and early intervention services are less likely to be funded than statutory services" (DSD, 2016: 93). This not only inhibits the real transformation of South Africa's poor and vulnerable communities but also does not make economic sense. Prevention and early intervention services are cost effective because they reduce the demand for more costly government services at a later stage, such as alternative care in children's homes, and are an investment in human capital because they provide the space for children to develop to their full potential (Proudlock and Jamieson, 2008: 38). Furthermore, programmes that provide support and care to families and communities increase the gains derived from cash transfers, such as the child support grant (Patel et al., 2019).[60] Given South Africa's well developed social security grant system, the possibility exists to maximise the benefits of government's existing interventions, if they are viewed holistically and not in isolation of each other. This would not only benefit the beneficiaries of these interventions but also ensure the State receives greater value for money.

Notwithstanding the above benefits, the transformation to a more developmental approach is not an "either-or" decision but rather requires a balance between meeting both statutory and developmental obligations. Achieving this balance can be difficult, as statutory interventions are more urgent and immediate than proactive or preventive interventions. The Nawongo court case has also affected the prioritisation of provincial departments of social development. For example, in the Free State, statutory services are now afforded top funding priority. And the stretched provincial social development budgets tend to deprioritise preventive programmes, specifically those related to families. The sector clearly needs additional, new funding and a well-thought out plan to ensure that funding is used to implement developmental programmes. A time-based approach may assist in achieving a better balance, with greater prioritisation of preventive-type programmes. Such an approach views an outcome (for example, a stronger, developmental focus on preventive measures to strengthen families) as a series of outputs (for example, increased allocations for effective, targeted, family-strengthening initiatives) that have different timeframes to achieve each output.

59 *National Association of Welfare Organisations and Non-Governmental Organisations and Others v Member of the Executive Council for Social Development, Free State and Others* (1719/2010) [2014] ZAFSHC 127 (28 August 2014)

60 Known as 'cash and care' interventions, programmes such as the local Sihleng'imizi (meaning "we care for families") Family Programme complement and scale up the positive benefits of the child support grand in South Africa (Patel et al. 2019).

5.3.3 Lack of Reliable Data and Information

The foundation of sound planning and budgeting is reliable data and information. Yet reporting at national and provincial level remains largely manual, as the sector does not have an electronic and integrated reporting system. The result is inefficiencies in the system, and figures/data that cannot be confirmed because no coherent system is in place. In addition, reliable non-financial performance data is needed to be able to assess the quality of services, evaluate impact and make informed decisions on resource allocations.

5.3.4 Insufficient Social Service Professionals

The lack of social service professionals, especially social workers, required to implement family and community welfare services, is not new. As far back as 1997, the White Paper for Social Welfare described the human resource capacity in the welfare field as inadequate to address the social development needs in the country. Despite various measures to address these shortages, including implementing occupation specific dispensations, learnerships for social workers and a conditional grant to fund the employment of social work graduates (from 2016), the sector still does not have sufficient social service professionals. The Covid-19 pandemic has highlighted the need for social workers, and at the time of the national lockdown, the Minister of Social Development indicated the need to recruit an additional 1800 social workers (Mahlati, 2020).

Table 5.1 summarises the factors that affect the demand and supply of social service professionals, such as social workers. While the demand is driven by external socio-economic factors, the largely unattractive internal supply factors may serve to inhibit the number of professionals who are willing to enter into the employ of government.

Table 5.1: Demand and supply factors affecting quantity of social service professionals

Demand Factors		**Supply Factors**	
Internal	External	Internal	External
· Large caseloads and backlogs · Budget constraints	· HIV prevalence · Food insecurity · Challenges affecting the wellbeing of children · Lifestyle concerns (alcohol abuse) · Increased demand for services to older persons and people with disabilities	· Working conditions (low remuneration and staff motivation, related to personal satisfaction and recognition) · Skills and training specific work requirements (driver's licence) · High vacancy rates	· Number of graduates in diversity of social services categories · Gap between practical training of professionals and job requirements · Bursaries, internships and scholarships · Retirement, mortality rates and age profiles of current professionals

Source: DSD (2019)

Exacerbating the situation is the distribution of social workers, which is uneven and does not reflect where the need for services and where the bulk of people are located. Within provinces, the inequalities in the geographic spread of social services professionals are marked: In the Eastern Cape, 75% of all government-employed community and youth care workers (CYCW) are located in Nelson Mandela Metropolitan Municipality, which is home to just 18% of the province's population. Likewise in Limpopo, 75% per cent of CYCWs are employed in the Capricorn district municipality, which accounts for 23% of the population

(DSD, 2016). It should be noted that a proactive approach to interventions, with a focus on preventive and early intervention programmes, could reduce the existing high need, especially for social workers.

5.4 Early Childhood Development

ECD education is considered an essential learning phase and where interventions can have the greatest impact. The first 1000 days of a child's development are particularly important, as the brain is still developing and the child is acquiring social and emotional skills (Berry et al., 2013; Ebrahim et al., 2014). Research has found that attending an ECD programme can have a positive effect on a child's later school readiness, irrespective of their socio-economic status (Ramey and Ramey, 2004), although the effect is heavily dependent on the quality of the ECD programme. For children who miss this window of opportunity, catching up to their peers later in schooling is incredibly costly. Therefore, the important and urgent need for investment into this period of children's development cannot be overstated.

In recent years, South Africa has seen progress in ECD. Government recognises that ECD is integral to reducing poverty and inequality, is aware of the benefits of ECD and has put in place ECD policies and legislation. However, the ECD sector remains fragmented and the inconsistent implementation of ECD policies is a major challenge (South Africa, 2001a). Implementation differs from one province to another and even within provinces, where implementation may vary from municipality to municipality. The differences are not only in how individuals and departments interpret the policies, but also how they implement, at ground level, the regulations and norms and standards derived from the policies.[61] This may well be due to the silo mode of delivery, where each department and government entity works independently from each other, with little coordination across departments (FFC, 2015). In addition, current income streams are inadequate to achieve the required level of ECD provision.

Notwithstanding these challenges, in the 2019 State of the Nation Address, the president announced two years of compulsory ECD and that the Department of Basic Education (DBE) would take over responsibility for ECD from the DSD. The rationale for this shift is that ECD would join Grade R to the formal education system. However, before ECD can move to a higher developmental trajectory, six implementation obstacles need to be addressed.

5.4.1 Lack of Political Will and Prioritisation

In 2015, Cabinet approved the National Integrated ECD Policy (DSD, 2015), which recognises ECD as a universal right of children, a national priority and a public good to which all young children are equally entitled. Its vision is that "[a]ll infants and young children and their families in South Africa live in environments conducive to their optimal development" (ibid: 48). The policy introduces a national integrated and comprehensive ECD system to ensure access to quality ECD that is universally available from conception until the year before children enter formal school, and documents the responsibilities of the South African government. Government's role is to ensure the availability of high-quality, appropriate ECD programmes and resources necessary for "the optimal survival, growth, development and protection of young children to their full potential" (ibid: 24). The policy has three goals with different timelines.

- By 2017, the legal framework, structures, institution arrangements, planning and financing mechanisms would be in place to ensure universal and equitable access to ECD programmes.
- By 2024, essential components of the comprehensive package of ECD programmes would be accessible to all young children and their caregivers.

61 For example, it is far easier for ECD centres to get registered in the Northern Cape than in Gauteng.

- By 2030, a full comprehensive package of ECD programmes would be accessible to all young children and their caregivers.

Although the policy is there, the financial commitment is not. The issue is not that the government does not know its role and the steps to take to achieve the goals of the ECD policy (and those of the NDP). Indeed, South Africa has a high-quality policy that correctly lays out government's role in achieving quality ECD for all children in the country. Rather, the issue is the implementation and financing, which is likely to persist indefinitely because the ECD policy is not legislated. Without the appropriate legislation, government cannot be held legally accountable for achieving the policy's objectives. Achieving this would demand political will and full commitment to implementation by government, the civil sector, the private sector and all relevant stakeholders. However, while it is important and must happen, legislation on its own will not engender greater progress in this sector. To ensure implementation will require a sound performance management framework that incorporates appropriate performance incentives and disincentives and applies to both senior departmental administrators and political leadership.

5.4.2 Need for Greater and Better Targeted Funding

Investing in a child's early years produces clear economic benefits and is the foundation for reducing poverty and inequality in South Africa. Research shows that investing in ECD brings greater returns than investing in later education, such as university. This is because not only are ECD interventions less costly than later investments, which influences the rate of return, but also ECD investments enable children to get more out of subsequent investments (Desmond, et al., 2016). Despite this, adequate funding of ECD is an ongoing problem, with only 1.6% of total education spending allocated to ECD, which equates to roughly 0.29% of gross domestic product (ibid).

Although funding has improved – for instance, between 2007/08 and 2013/14, subsidies for poor children attending registered non-profit ECD centres increased from approximately R122-million to R1.6-billion – it is insufficient and does not reach the poorest and youngest children in need who mostly do not attend registered ECD centres (Berry et al., 2013). The focus is misdirected, with funding going to registered, centre-based programmes, rather than to non-centre, home-based and community-based initiatives (Desmond et al., 2016).[62] A key advantage of non-centre based programmes, particularly home visiting and playgroups, is that they can be more easily adapted to accommodate children with disabilities (ibid). Non-centre based programmes are crucial for those children who are unable to access centre-based interventions due to affordability, geographical positioning, poverty or special needs.

As mentioned, funding is directed to centre-based ECD programmes, which accommodate about a third of children in South Africa, rather than to non-centre-based ECD programmes, where the need is greatest. Non-centre-based ECD programmes are severely under-resourced but find themselves in a Catch-22 situation. To access ECD funding, centres have to register; to be eligible for registration, centres need to achieve a certain standard; but non-centre-based ECD centres lack the financial resources to do the improvements necessary to be eligible for registration and then subsidies. A major part of the challenge is that currently the Children's Act makes no provision for non-centre-based ECD programmes, and so all non-centre programmes have to register as partial care facilities in order to access a subsidy. However, the registration requirements for partial care facilities are the same as for centre-based programmes, despite non-centre based programmes having a fundamental different mode of delivery. Government is missing a very important area of education opportunities for poor and vulnerable young children by not addressing the need for specific and appropriate registration requirements for non-centre-based ECD programmes.

62 Centre-based programmes include Grade R classes in formal schools, as well as crèches, formal playgroups, and pre-primary schools, whereas non-centre-based programmes include informal playgroups, toy-library programmes, mobile ECD outreach programmes, as well as family outreach programmes

5.4.3. Lack of Up-to-date Data

To ensure that services are accessible and delivered equitably, a thorough understanding is required of the number of children, their distribution patterns, the conditions in which they live, and the services that they require (Hall et al., 2017). However, much of the early education data is collected at national level and cannot be analysed at district level; is of poor quality or significantly out of date; and is collected too infrequently, not published, or not collected at all – for instance, data on the *quality* of ECD programmes (ibid). The last complete ECD audit was conducted in 2000. South Africa also does not have an administrative data system for ECD containing the numbers of registered and funded ECD centres and programmes, and the number of children accessing these services (ibid). In brief, the information needed for effective, robust monitoring and planning of programmes is lacking.

5.4.4 Poor Intergovernmental Coordination

Constitutionally, the delivery of ECD straddles numerous departments across all three spheres of government. For example, Schedule 4A of the Constitution lists education and welfare services as concurrent responsibilities of national and provincial government, while Schedule 4B has child-care facilities as a local government responsibility shared with the other two spheres of government. The National Integrated ECD Policy takes its lead from the Constitution and emphasises the integrated and inter-sectoral nature of ECD services.

- Nationally, the departments of social development, basic education and health are responsible for national planning and coordination , and setting national laws, policies, norms and standards and high-level targets.
- Provinces (departments of social development, basic education and health) are responsible for funding and delivering services, as well as registering ECD centres and monitoring and evaluating the compliance of services with norms and standards.
- Municipalities have to ensure the provision of basic services (specifically water and sanitation) and the development of policies and laws governing child-care facilities (harmonised with national policy and legislation). The provincial DSD may also assign the provision of ECD services (registration, regulation and delivery) to municipalities that are deemed to have capacity.

The National Integrated ECD Policy is similar to models in other countries (New Zealand, Finland and Chile), in calling for government to play a strong coordinating role in the provision of ECD. Governments should set standards for the early development of young children, provide funding, fund training opportunities for ECD workers, support community ECD initiatives, assist children with special educational needs and their families, and establish an environment for planning and coordinating programmes.

Given the integrated nature of ECD services, strong management and coordination across different government departments and spheres are needed. However, government's leadership, management, and coordination abilities are lacking.[63] Instead of being streamlined, ECD delivery is complicated and often haphazard, with different departments at different levels of government working in a particularly siloed manner. This has been an ongoing challenge in the sector. What is required is a central coordinating body within government in order to address the weak management, coordination and integration of ECD services, across numerous departments and all spheres of government. The National Integrated ECD Policy makes provision for such a body, in the form of an inter-ministerial committee. The national departments have established an inter-ministerial committee (of various ministers), to coordinate responsibility for ECD leadership, and an inter-departmental committee (of officials) has been set up to focus on implementation issues.

63 This view was raised in the interviews conducted for this report but has also been documented in previous research reports, for example: Richter et al. (2012) and Viviers et al. (2013).

However, IGR forums have limited scope to ensure alignment due to the conventional line function culture of planning, budgeting and implementation and the reward system for individual performance.[64] The Constitution's assigning of responsibilities to specific departments/spheres may further limit the power of intergovernmental forums and exacerbate poor coordination.

5.4.5 Shift of ECD from DSD to DBE

In February 2019, President Cyril Ramaphosa announced government's intention to move the responsibility for ECD from the DSD to the DBE, to join Grade R and the formal education system. This shift includes the introduction of a second compulsory year of pre-school education ("Grade RR"). Before these reforms are fully implemented, various concerns need to be resolved. These include the following.

- The "educationalisation" of early learning could come at a loss of "learning through play", which is how young children learn most effectively, i.e. when they are able to immerse themselves in an experience, which is something that happens during play. This is already the case for many Grade R programmes, where 5–6-year-old children sit at desks all day, working on worksheets, and receiving formal lessons. Taking the same approach with the 4–5 age cohort in Grade RR would run contrary to national and international research.
- The readiness of the schooling system to implement a compulsory Grade RR. The inclusion of Grade RR at ordinary schools would require 33 000 additional teachers and 33 000 classrooms to accommodate the additional 4–5 year olds. The implications for school infrastructure would be massive, as younger children have different needs to older children. For example, installing toilets for younger children, the staffing structure and the nature of the school classroom would need to be reconsidered.
- The financial implications of universalising two compulsory years of ECD education will be enormous, both in set-up costs and ongoingly, particularly because making these years compulsory will require government to cover those children whose families cannot afford to pay fees.

Government would also need to rethink institutional arrangements, resource allocation and funding models, as the ECD budget would need a huge funding injection. Other concerns are around the livelihoods of the owners and educators of community-based ECD centres, and what would happen to non-centre-based ECD programmes.

5.4.6 Lack of Qualified ECD Teachers

As mentioned, adding another year of compulsory early education will require many more trained teachers for 4–5 year olds. Furthermore, many of the teachers currently working in ECD centres are not trained – it is estimated that only 39.2% of ECD teachers in South Africa have an ECD qualification (Ashley-Cooper et al., 2019). The quality of teacher-child interactions is the main predictor of quality for an ECD programme (Biersteker, 2017), and without this quality, ECD programmes do not (and cannot) achieve the positive child outcomes promised by ECD (Ashley-Cooper et al., 2019). Unfortunately, a large proportion of ECD practitioners are not adequately trained, and thus able to optimise learning opportunities.[65] Therefore, existing ECD practitioners will need to be upskilled, and the ECD career path will need to be professionalised, with a comprehensive and harmonised professional development system that would include recognition of prior learning.

64 This is discussed further in Chapter 2.
65 It is obviously possible that untrained ECD teachers are still able to offer high quality teaching and ECD programmes, but this is not often the case if the teacher has received no ECD skills training whatsoever.

5.5 Inclusive Education

Ensuring access to safe, quality education for children with disabilities is central to building an inclusive education system. In South Africa, the right to basic and further education is entrenched in section 29 of the Constitution. Read together with section 9, the right to education includes access to quality education for learners living with disabilities. In 2001, the Education White Paper 6 (South Africa, 2001b) provided the policy framework for introducing inclusive education in South Africa. Unfortunately, the equitable provision of quality inclusive education for learning with special needs remains a significant challenge.

5.5.1 Extent of Learners with Special Education Needs

Historically, special needs education tended to focus on those who were disabled, needed high-level support in dedicated facilities, or could not function in the mainstream education system. White Paper 6 (South Africa, 2001b) presents a wider definition of special needs education that covers 10 domains of specialisation (Figure 5.3). It recognises that many learners require some form of support throughout their schooling careers, and that this support may range from low-intensive to high-intensive, and be on a permanent or a temporary basis. This has substantially broadened the scope of special needs education, and requires that learners with special needs be accommodated suitably and adequately in an inclusive education system.

Despite some uncertainty around the exact numbers, the DBE estimated that approximately 597 953 children with disabilities are not accounted for in the school system (DBE, 2015). Accurate information is needed on the number of learners with special needs and the type of special needs intervention required, based on the White Paper's expanded scope. Many stakeholders[66] feel strongly that the socio-economic data gathered by bodies such as Stats SA does not reflect the reality of the need. For example, data on children with disabilities aged 0-4 years was not included in Census 2011.

Figure 5.3: Domains of special needs education

<table>
<tr><td>1. Vision
(blind, low vision or partial sightedness, deaf-blindness)</td><td>2. Hearing
(deaf, hard of hearing, deaf and hearing impaired)</td><td>3. Motor
(partial or total loss of function of a body part, usually a limb or limbs)</td><td>4. Communication
(little or no functional speech requiring augmentative and alternative communication) – cross-cutting</td></tr>
<tr><td colspan="2">5. Learning and cognition
(moderate, severe and profound intellectual disability or learning disabilities)</td><td colspan="2">6. Neurological and neuro-developmental impairments
(including epilepsy, cerebral palsy, attention deficit hyperactivity disorder, specific learning disabilities, traumatic brain injury, foetal alcohol syndrome and autism spectrum disorder)</td></tr>
<tr><td>7. Health
(including mental health) – cross-cutting</td><td>8. Behaviour and social skills</td><td>9. Skills and vocational education and training / technical occupational</td><td>10. Multiple and complex needs and developmental support</td></tr>
</table>

Source: Commission's compilation derived from DBE (2018) and INS [Sa]

66 See Appendix A for list of stakeholders interviewed.

5.5.2 Policy Process and Emphasis

Two decades ago, in 2001, the Education White Paper 6 was published, setting out the levels of support that should be offered to learners with special needs across the different types of schools in South Africa (Table 5.2). Since then, no legislation regarding inclusive education has been enacted to give effect to government's policy aspirations. Although the White Paper's vision is for an inclusive education and training system, its major focus tends to be on "special needs education". This conflation of special needs education and inclusive education, coupled with an incomplete policy process, has maintained the "ordinary school" vs "special needs school" dichotomy that was established in the South African Schools Act (No. 84 of 1996). As a result, the funding model adopted tends to focus disproportionately on special needs education and schools, with fewer resources being provided to public ordinary schools to promote inclusive education.

Table 5.2: Implementing inclusive education

Ordinary Schools	Full-service Schools	Special Needs Schools	Special Care Centres
Low level of support	Moderate level of support	High level of support	Learners with severe and profound intellectual disabilities

Source: DBE (2001b)

5.5.3 Lack of Funding for Special Needs

The lack of legislation has stunted the development of a specific funding approach and framework for holistically financing inclusive education. The national norms and standards for school funding apply to learners with special needs who are based in public ordinary schools, but no equivalent norms and standards exist for learners with special needs at public special needs schools. Firm legislation and regulations on inclusive education are needed to ensure uniform funding of all learners with special needs, irrespective of the type of school they attend. Unicef outlines three key funding models to determine funding for students with disabilities (Dedman, 2014):

(i) The input or per-capita model: Funding formulae are based on the number of students with special educational needs, and larger per-capita amounts may be specified for factors such as age, location, disability status. Funding follows the student and so encourages local schools to accept children with disabilities because the local school does not have to worry about funding learners with special education needs.

(ii) Resource-based model: Funding is based on services provided, and so in this decentralised funding model, municipalities decide on how to use the special-needs education funds and on the degree of funding.

(iii) Output-based model: Funding is tied to student achievement scores. This model is not widely used because the sanctions for low student performance tend to penalise schools for circumstances beyond their control and encourages segregation by incentivising referral of students to special education programmes

The literature suggests that the funding model for special needs education is moving from a segregated and output-based system towards a flexible, decentralised per-capita model. South Africa's funding model for inclusive education seems to follow a cost-of-services approach, whereas a hybrid model, which also includes provision for budgeting based on costs per learner, may be more appropriate.

5.5.4 Lack of Data on Inclusive Education

The availability, accuracy and quality of financial data on inclusive education is a challenge. There is no way of telling what is being spent on supporting learners with disabilities in public ordinary schools. One of greatest difficulties in reporting and monitoring is separating what is spent on public special needs schools from what is spent on building the capacity of public ordinary schools to include learners with disabilities. This opaque reporting, combined with unreliable data on the extent of needs, undermines the planning, budgeting, performance management and oversight of the implementation of inclusive education.

5.5.5 Teacher Training in Special Needs Education

Ongoing teacher training is needed to assist in determining the need for special needs education. Post-provisioning norms are implemented in line with the various Acts[67] and are used by government to determine the number of teachers to allocate to each school, based on: the number of learners, the number of learners with special educational needs, the number of grades catered for, and the subjects offered. To ensure that more teachers are available for learners with special needs, a relatively higher weighting is given to learners with disabilities. Learners must be assessed in terms of the 2014 Policy on Screening, Identification, Assessment and Support (SIAS), which represents a major reform and innovation. The policy aims to guide officials and teachers in assessing not only for intrinsic factors in the child, but to also examine (environmental) barriers to learning and development. In theory, weightings allocated to learners with special educational needs should ensure that a school can appoint more teachers to accommodate these learners. However, in practice, "the DBE is failing to assess learners who have been identified as requiring special needs education. Without the proper assessment, schools are unable to adapt their post provisioning to reflect the educator needs of their learners" (Sephton, 2017: 258). Systematic training of teachers has been taking place in all provinces, but despite some progress, the SIAS policy is not yet implemented universally.

5.6 Conclusion

This chapter provides an overview of key challenges that inhibit access to quality and inclusive family and community welfare services, and ECD and inclusive education. Basic but essential ingredients for service delivery are lacking across all three sectors. At the one end, transformative policy and legislative requirements are not being translated into delivery on the ground, which implies poor political leadership. At the other end, laudable policies are in place but not the legislation needed to allocate mandate and ensure responsibility and accountability. The lack of accurate data is common across all three sectors and, after 26 years of democracy, is an indictment on both government and those who conduct oversight over government. All three sectors also require a significant injection of additional funding. A common thread across all three sectors is the need for departments and spheres of government to adopt a coordinated, integrated approach to service delivery, but achieving this type of coordinated approach has proven an elusive goal in South Africa (as Chapter 2 discusses). The lack of these essential ingredients have contributed to the lack of transformation seen across poor and vulnerable communities in South Africa. Consequently, these communities continue to be characterised by an array of preventable social pathologies, including gender-based violence, child abuse, gangsterism and substance abuse, and their children continue to be locked into inter-generational poverty and inequality. The economic rationale for allocating public resources to these three areas of government intervention is clear. These sectors are the building blocks for protecting, nurturing and activating South Africa's people and human capital, and thus reducing poverty and inequality. Therefore, the lack of prioritisation of these sectors requires urgent attention. The recommendations that follow highlight the strong and urgent need for policy and funding

67 Employment of Educators Act (No. 76 of 1998), the South African Schools Act (No. 84 of 1996) and the Labour Relations Act (No. 66 of 1995).

priority, and offer proposals for ensuring evidence-based planning, budgeting and decision-making within a legal framework that allocates responsibility and accountability.

5.7 Recommendations

With respect to vulnerability and access to quality and inclusive social services, the Commission makes the following Recommendations:

On family and community welfare services:

1. *The DSD should lead the development of a three-year progressive realisation sector plan to ensure the establishment of interventions that proactively strengthen and stabilise at-risk families and communities.*

For real transformation to happen in poor communities across South Africa, services aimed at strengthening families and communities need to be scaled up and aligned to where the need exists. Prioritising funding towards such interventions should be logical, given that support and programmes aimed at strengthening families and communities result in positive outcomes. The national DSD and its nine provincial counterparts should together establish a sector prioritisation plan to guide the allocation of resources, which focuses on coordinated service delivery interventions over the next five years and which targets, in the first instance, the most at-risk communities in South Africa. Given the increasing levels of unemployment and need across society, urgent action is crucial. In line with the district development model outlined in the president's 2020 State of the Nation Address, the prioritisation should be detailed down to the district level. In addition, service delivery progress should be spatially referenced and reported across the 44 district municipalities.

2. *Based on emerging local evidence, the DSD should consider establishing a holistic package of family interventions that combines income support with targeted family care interventions.*

In this regard, the Sihleng'imizi programme[68] illustrates the potential to scale up the impact of the child support grant by pairing it with a family-strengthening intervention. Such an approach not only leads to increased benefits for recipients but also provides value for money, as greater gains are derived from existing interventions through strategic alignment or pairing.

On ECD:

3. *The DSD should conduct a nation-wide audit and mapping of ECD services being rendered.*

Data is critical in order to reach all children in need, to provide essential services and high quality ECD programming by trained ECD practitioners. Therefore, a full and updated nation-wide audit and mapping of ECD programmes should be conducted. The audit should include all ECD centres (registered and non-registered) and all non-centre-based programmes, in order to be able to assess the kinds of delivery models being carried out, and the numbers being reached.

68 "Sihleng'imizi" is a South African adaption of the SAFE Children Family Programme, developed by the Families and Communities Research Group, School of Social Service Administration, University of Chicago, USA. The programme is a community-based family strengthening intervention for child support grant beneficiaries and their families to improve child well-being. The study was carried out through a partnership between the National Research Foundation, the University of Johannesburg, the City of Johannesburg and Unicef South Africa.

4. *Together with relevant stakeholders, the DSD should lead the finalisation of legislation for ECD together with a fully costed, time-bound implementation plan.*

The National Integrated ECD Policy provides a considered, evidence-based strategy for a holistic package of ECD programming for young children in South Africa. It should be translated into legislation, which details the roles and responsibilities of departments and key roleplayers in the sector and, importantly, includes the implications of the proposed shift of ECD from social development to basic education. Along with finalising ECD legislation, an explicit implementation plan is required that states government's specific targets, the steps to be taken by each role-player to reach these targets, and the budget to be allocated to each step/area of functioning. The roles of government should be considered carefully, and options explored for government to play less of a role in the actual provision of ECD services and, instead, to focus more on coordination, monitoring impact and funding.

5. *Government should take urgent steps to strengthen funding for ECD in South Africa. Particular priority should be given to funding all non-profit, non-centre based ECD programmes serving quintiles 1 to 3. Related to this, the process and requirements for registration should be simplified, and specific and appropriate registration requirements for non-centre-based ECD programmes should be finalised with haste.*

If government wants to make a significant impact and ensure broader and more equitable access to ECD, it must recognise and fund non-centre-based ECD programmes. Non-centre-based ECD programmes play an important role and include toy libraries, day mothers, play groups, parent education and family outreach programmes. Coupled with more and better targeted funding, obstacles to registering non-centre based ECD centres should be removed.

6. *Government should ensure further targeted support to non-profit ECD programmes in quintiles 1 to 3 focusing on infrastructure upgrades, to enable these centres to register and receive subsidies, and for funding for basic early education equipment, which will enhance the early learning programme and prepare young children for formal schooling from Grade R to Grade 12, and beyond, into tertiary training.*

The former will enable more ECD centres to register and be subsidised, while the latter will enhance the early learning programme and prepare young children for formal schooling from Grade R to Grade 12, and beyond, into tertiary training.

7. *The departments of basic education, social development and higher education and training should prioritise the upskilling of existing ECD practitioners and develop a plan to professionalise the ECD career path, with a comprehensive and harmonised professional development system.*

ECD teachers are part of the backbone of the ECD sector. Given that the main predictor of quality for an ECD programme is the quality of teacher-child interactions, government should work together to increase the number of new and existing ECD teachers with appropriate ECD qualifications.

On special needs education:

8. *Alongside finalising legislation to underpin the roll-out of inclusive education, the DBE should take the lead in developing a public sector detailed, time-bound and costed implementation plan that promotes awareness of what inclusive education entails.*

Linked to this, an evaluation of the White Paper should be undertaken, to systematically review implementation progress thus far, and to inform context-sensitive future planning and implementation, which builds on learning about what works and what does not work. The DBE should develop a standardised set of core indicators for implementing inclusive education across all provinces, so that the implementation of inclusive education can be measured and monitored in a systematic manner.

9. *As a matter of priority, the DBE together with relevant stakeholders, need to determine the extent of learners with special educational needs. This will assist in ensuring more evidence-based policy-making and implementation. The assessment should be aligned to the 10 domains of support identified in the Education White Paper 6 and all three levels of support.*

To carry out this needs assessment, the DBE should set up a reference group of key stakeholders, to ensure the participation and contribution of role-players from within and outside of government. The extent of the need cannot be determined only by census data and will require the contribution of all role-players who have access to data and/or are able to generate data. Stats SA should be a key partner in conducting this needs assessment, and in particular amend the domains of disability in the census questionnaires, to ensure better alignment of census data with the 10 domains of support identified in the White Paper.

10. *To support the implementation of inclusive education in South Africa, the DBE must spearhead the development of a holistic funding framework to ensure a uniform approach to funding learners with special educational needs, irrespective of the type of school they attend.*

This will address the existing approach of funding learners with special needs differently based on the type of school they attend. The merits of a hybrid approach to funding, which combines considerations around the cost of rolling out programmes alongside specific learner needs, should be further investigated.

11. *The DBE must take steps to adjust reporting in order to allow for disaggregation of funding and performance information related to the roll-out of inclusive education.*

Budget structures should be revised to ensure that inclusive education budgets are aligned to the type of facilities available in an inclusive education system, namely: public ordinary schools, full-service schools, special needs schools and special care centres.

12. *With respect to inclusive education, the DBE and the Department of Higher Education and Training must prioritise the development of teacher capacity at higher education level and as part of ongoing professional development initiatives.*

Teacher training in higher education facilities must be aligned, to ensure that new teachers are fully competent to implement inclusive education in the classroom. This is a key lever for change, and should be prioritised. Similarly, ongoing professional teacher development should take place, and training in implementing the SIAS policy should be extended to all teachers, with a particular emphasis on those from poorer and/or more rural schools.

For an Equitable Sharing
of National Revenue

FINANCIAL
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of National Revenue

Conclusion

Conclusion

This *Submission for the Division of Revenue 2021/22* focuses on the challenges confronting the delivery of social services in South Africa. Apart from shedding light on these challenges, the ultimate aim is to make recommendations that will assist in unblocking delivery. The research undertook a sectoral assessment that looked at three critical areas of social spending: health care, family and community welfare services, and education, specifically ECD and inclusive education. Complementing the sectoral focus, Chapter 2 provides an institutional dimension to the analysis, by examining the IGR system that underpins the delivery of these services.

With South Africa in the midst of the Covid-19 pandemic, which has exacerbated an already constrained economic environment, the country's recovery must be based on a firm foundation and learn from the past. Governments can use various mechanisms to spur the much-needed growth. They can try and influence economic growth through expansionary fiscal or monetary policy (for example, cutting taxes and/or interest rates), or can spend on items that increase productive capacity. The Commission's 2010/11 Submission noted that, in countries facing high unemployment and poverty, and lagging behind the technological frontier, governments should invest significantly in infrastructure, which has the capability to enhance productivity and economic growth. Prospects for growth can be enhanced through investment in certain sectors, such as education, skills development, health care, or agriculture which, as this Submission suggests, could be both a catalyst for growth and a way of strengthening food security. The Commission believes that, for South Africa to improve socio-economic development, in particular for the poor, a comprehensive growth and reconstruction programme is needed that goes beyond economic and social relief measures.

The Commission's interrogation of these issues is not new. Social services – and indeed some of the very same challenges – have been the subject of past annual submissions and Recommendations. The difference, this time, is the Covid-19 pandemic, which has laid bare the existing inequalities that hamper access and quality services to the poor and vulnerable.

Relevance and Reiteration of Past Recommendations by the Commission

As mentioned, many of the Commission's past Recommendations are still relevant today. This highlights the longstanding nature of some of the challenges confronting the IGFR and delivery of social services in South Africa. For over a decade, the Commission's submissions have contained common threads that are echoed in the 2021/22 Submission. For instance, the need to fund community-based ECD facilities, the importance of establishing and costing norms and standards, and the lack of data available in the health and education sectors.

Submission for the DoR	Recommendations
2016/17 Chapter 5: Fiscal Arrangements for Financing Early Childhood Development Infrastructure	To address inequities in ECD quality standards and service levels, government should provide a full or partial capital subsidy for **constructing and/or upgrading community and non-profit-ECD facilities**, through the municipal infrastructure conditional grant. The funding will facilitate compliance with the required infrastructure norms and standards and ensure that municipalities invest in ECD.
2014/15 Chapter 2: Economic and Social Value of Social Grants	National Treasury should provide advice to departments and agencies working with children on developing **major cross-portfolio initiatives aimed at eliminating child poverty**. The existing range of child poverty measures are scattered across many agencies and should be nested within a new unified outcomes framework of related agencies because of synergies with related programmes.
2014/15 Chapter 9: Effective Intergovernmental Planning and Budgeting for Better Outcomes	National Treasury and the DPME should reform the budget process in order to reconcile the collective responsibility for delivery agreement outcomes and the individual department-focused budget-bidding process by: • Realigning the budget process along service delivery agreements, so the **focus is on outcomes, rather than the current sectoral, individual institutional approach**. • **Directly linking resource allocation to realistic, measurable and few performance targets** per outcome. Programme expenditure reviews must be undertaken at the end of each targeting period
2012/13 Chapter 6: Budget Analysis and Exploration of Issues to Increase Performance in Basic Education and Health	Government, through input and output norms and standards, should take reasonable measures to **give effect to the inclusive education of intellectually disabled children**. These norms should indicate human, physical, administrative and regulatory resources provided by government dedicated to achieving targets for inclusive education
2012/13 Chapter 6: Budget Analysis and Exploration of Issues to Increase Performance in Basic Education and Health	Government should extend its ongoing efforts to **reform health fiscal frameworks,** including: • Review funding for HIV/AIDS, opportunistic and other infectious diseases through regularly assessing usage costs for chronic disease services, to inform resource allocations in public sector health care system. • Institutionalise a budget process that forces provincial health budgets to be based on estimations of health care needs of users and holds provincial governments accountable for the underfunding of hospitals and clinics • Re-examine the distribution of resources between different levels of care without weakening the role played by tertiary hospitals, but also strengthening the role of PHC in the health system.
2010/11 Chapter 4: Performance of Public Hospitals	Government must develop **norms and standards to address issues in relation to the public hospital system**, to close the legislative policy gap that exists despite the provisions of the National Health Act (2004) and current norms guiding the PHC system. These issues include specifying minimum service requirements; establishing minimum input norms, a workable quality assurance framework, and a transparent reporting system; identifying governance requirements, establishing governance norms and standards and a strategic planning framework that outlines the medium-/long-term vision of the hospital system, expressed in terms that are implementable and auditable. Also needed is mix of hard (codified by legislation) and soft (guidelines to aid departments) norms and standards.

Submission for the DoR	Recommendations
2009/10 Chapter 2: The Financing of Health Care	That greater emphasis be placed on **improving the quality of service provided at clinics and funding the maintenance of existing PHC facilities**.
2009/10 Chapter 8: Performance Monitoring Framework	That **health statistics for vulnerable groups be collected and improved**, using the South African Statistical Quality Assurance Framework. These statistics include the proportion of women with access to antenatal care; the availability, affordability and accessibility of health facilities for TB, HIV and Aids; and data concerning children, older persons and persons with disabilities.
2006/07 Chapter 2: Financing Social Welfare Services through the Provincial Equitable Share	That specific consideration be given to **allocating funds to social welfare services in the PES.**

Source: Commission's compilation from Submissions for the DoR (2005, 2008, 2009, 2011, 2013, 2015)

Looking to the Future

The Commission recognises that the repercussions of the Covid-19 pandemic will reverberate for years to come. Although the 2021/22 Submission provides some preliminary evidence on the socio-economic implications of Covid-19, it is concluded while the pandemic continues to spread across the country and cause unprecedented damage both to the economy and people's livelihoods. Chapter 3 offers some initial advice on what is required as South Africa pivots towards recovery from the pandemic, but the present Submission could not fully capture the full impact of this evolving disaster.

For its next Submission – for the 2022/23 Division of Revenue – the Commission intends to provide a comprehensive assessment of the socio-economic effects of the coronavirus pandemic, under the theme: "The effects of Covid-19 and the changing architecture of subnational government financing in South Africa". The Submission will examine in more detail the effects of Covid-19 and how it has influenced changes in subnational IGFR, under four broad themes: (i) the macroeconomic impact of the pandemic, (ii) the implications of the pandemic on provincial service delivery, (iii) the implications of the pandemic on local government finances and service delivery, and (iv) the responsiveness of intergovernmental fiscal instruments to innovation, migration and gender inequalities.

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