COSATU Submission on

Comprehensive Social Security

Submitted to the Taylor Task Team on Social Security, December 2000

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1. Introduction

COSATU welcomes the Committee of Enquiry investigations process aimed at developing a comprehensive social security system. This written submission complements the oral evidence given by COSATU to the Committee on October 10, 2000. This submission paper results from intensive discussions by COSATU and affiliated unions.

According to the ILO, social security is

"…the protection which society provides for its members, through a series of public measures against the economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, employment injury, unemployment, invalidity, old age and death; the provision of medical care; and the provision of subsidies for families with children".(1)

The 1998 Presidential Job Summit underscored the importance of a comprehensive social security system in reducing the impact of unemployment and placing the economy on a higher growth path. A comprehensive social security system, which ensures that no South African lives in dire poverty, is critical to breaking the vicious cycle of poverty. Such a system would combine with other components to ensure an adequate social wage. Basic components would include:

Free basic services: These should help ensure that every South African, irrespective of income or wealth, has the access to minimum services essential forof survival. Basic services must include both the main municipal services – water, housing, transport and electricity – as well as other government services, especially healthcare, education and safety and security. This document focuses particularly on the provision of municipal infrastructure and a proposal for National Health Insurance.

Basic income grant: to ensure a minimum income for all South Africans. Obviously, the key aim is to alleviate poverty. But the grant would also have a broader developmental effect. It would provide a degree of household and community stability, laying the foundations for more productive and skilled communities over time. Moreover, it would ensure that even the poorest households have a little cash, which could contribute to their economic potential.

Existing grants: Old age pension, disability grant, and child support grant. The current system of social grants does not come close to reaching the majority of the unemployed and destitute. Most are old-age pensions and disability grants, although child-support grants should become an important sector in the future. While these grants are important in alleviating particular hardships, they focus on individuals' needs and so may prove unresponsive to households' economic requirements and family dynamics.

Unemployment Insurance: The UIF provides short-term cover for workers who become unemployed, based on compulsory contributions from employers and employees. It does not aim to assist the long-term unemployed. Since it only caters for the formerly employed for a few months, it reaches less than 10 per cent of all unemployed people. Still, proposals are made to

strengthen this mechanism, to increase its coverage, and improve benefits. Despite its limitations, such a reformed system it has an important role to play in lessening the impact of short-run unemployment.

Private provident and pension funds: The retirement industry covers about two thirds of workers in the formal sector. The Pension Fund Act does not compel employers or workers to provide for retirement. The retirement sector is therefore fragmented, inefficient, and expensive. In some sectors, such as sales and catering, thousands of workers are labelled casual and receive no benefits. It is imperative that the law end these practices, to permit these workers to make sufficient provision for their old age. *Note: this section of the submission is not dealt with in this document, but will be submitted to the Committee separately.*

This submission paper first explores the importance of the social wage to ensuring social and economic development. It then analyses the existing systems of various aspects of social security, and. It then proposes threefive key changes to the system – a basic income grant, national health insurance, and a comprehensive strategy for HIV / AIDS, reform of the UIF system, and reform of retirement fund provision. (2) The final section considers the fiscal implications of an effective comprehensive social security system.

2. The developmental importance of the social wage

The vicious cycle of poverty essentially arises where widespread poverty in itself causes slower growth, which aggravates poverty. In these circumstances, the market is effectively not raising living standards. Government intervention is necessary to break the cycle.

The extent of poverty and inequality

As a result of apartheid, South Africa has amongst the most unequal distribution of income in the world, leading to poverty on a mass scale. Inequalities in the distribution of income and wealth are associated with another apartheid legacy – low skills levels for the majority of the population, especially those aged over 30. In 1996, according to Census data analysed by WEFA, the poorest 40 per cent of our population got less than 3 per cent of the national income, while the richest 10 per cent enjoyed over 50 per cent.

Unfortunately, despite some improvements in government services for historically disadvantaged communities, Statistics South Africa finds that income inequality worsened in the past few years. This deepening inequality arises primarily from the loss of formal jobs, which offset improvements in government transfers to the poor in the same period.

Poverty prevents growth

The social damage caused by poverty is obvious in the sufferings of so many millions of our people, who are left to live in shacks and squatter compounds, without adequate water, fuel, education or health care. But poverty also imposes great economic costs.

Poverty slows economic expansion in two ways. On the one hand, it makes households and communities less productive. On the other, it constrains domestic demand.

Poverty causes low productivity by:

1. Reducing access to education and skills,
2. Worsening health,
3. Causing instability and insecurity in families and communities,
4. Increasing the time required for household chores, especially fetching wood and water (The recent survey of child labour by Statistics South Africa found, for instance, that almost one in ten children under 17 must spend over eight hours a week collecting wood and water), and
5. Making it harder for people to locate employment opportunities because they cannot afford transport, obtain access to information on job opportunities, or afford childcare while they search for work. Statistical analysis indicates that higher living standards correlate with more extensive and intensive job search efforts as well as higher rates of finding employment, even when controlling for the effect of remuneration on consumption. (3)

Poverty is associated with lack of access to income-generating assets and skills, as well as low incomes. As a result, the poor are less likely to be self-employed. At the same time, their chances of finding employment in the formal sector have plummeted. Formal employment dropped by about one job in ten in the past three years alone, and around one in five since 1990 with half of the job losses occurring in the past three years alone. The biggest job losses affected unskilled workers in mining, agriculture and the public sector. Semi-skilled workers in manufacturing were also affected. (See Table 1) Largely as a result of these devastating losses of formal jobs, the share of labour in total income dropped from 58 per cent of the national income in 1992 to 56 per cent in 1999.

The fact that job losses mostly affect unskilled workers will certainly aggravate the poverty trap. Workers in these jobs cannot easily find alternative employment, and lack the assets and skills for productive self-employment.

The impact of the shrinkage in employment goes far beyond the workers affected. The poor are more likely to be unemployed; but

transfers from employed people form a critical part of their income. Remittances from workers are one of the most important sources of income for the poorest households. The Poverty and Inequality Report found that in the mid 1990s, the poorest 40 per cent of households received almost 60% of their total income from wage earners: a fifth of their total income from remittances, with two fifths from wages and a fifth from government transfers and pensions. In contrast, for the remaining 60 per cent of households, earnings from work contributed over 70 per cent of total income.

Poverty also limits domestic demand, reducing the incentive to invest. Surveys by Statistics South Africa demonstrate that the single most important obstacle to expanded production is limited demand. This situation means that growth depends excessively on foreign markets, which are typically highly unstable. Furthermore, it means that formal producers have little incentive to increase the production of wage goods – notably food and clothing – for domestic use. As a result, prices remain relatively high and employment low in these industries, aggravating the vicious cycle of poverty.

Finally, the current inequalities destabilise communities and reduce social cohesion, contributing to crime. That, in turn, has a deterrent effect on both foreign and domestic investment, including small-scale enterprise. Reduction in poverty and the consequent stabilisation of communities should assist in controlling this problem.

The benefits of strong measures to bring about greater equality can be illustrated by looking at the economies of South East Asia, the only countries that broke out of underdevelopment in the 20th Century. All these countries, despite their authoritarian rule put great effort into increasing equality in wealth and incomes, through land reform, education, housing programmes, worker ownership and rapid improvements in wages. In contrast, countries in Latin America that, like South Africa, did little to improve equality still face sluggish growth and instability. As far as possible, measures toward equity should be designed in ways that support employment generation, in part by ensuring the poor have greater access to income-generating assets and skills.

Overcoming the poverty trap

Given the extraordinary inequalities left by apartheid, government must play an active role in eliminating poverty, as a key mechanism to kick-starting the economy. Critical instruments include:

6. Income transfers, including a basic income grant, and other forms of social assistance (social insurance such as retirement provision and unemployment insurance is largely financed by the private sector). If well designed, income transfers can provide immediate relief, helping households stabilise and

reducing the effects of deprivation on children and consequently on the future labour force. They should help overcome the delays in rolling out government services.

In addition, the transfer of income to poor households should have some important positive effects on macro-economic trends.

7. It should increase and stabilise domestic demand, especially in rural areas and for wage goods. As these goods are less likely to be imported, it should in the long run assist in kick-starting local industry and reducing the burden on the balance of payments.
8. In the longer term, social assistance can motivate - and actually allow - people to save. Community saving schemes, which cater for lower amounts, can be encouraged and help people to provide back-ups for crises.
9. Provision of housing and infrastructure for poor households. These raise productivity in a variety of ways. Clean water is a critical input for health. Running water and electricity substantially reduce the burden of household labour, which falls predominantly on women and children. As a result, children can more easily get an education and women can undertake income-generating activities. Formal housing helps stabilise communities and families, making them more productive overall.

   In themselves, municipal services are crucial for home-based economic activities, again especially for women. For instance, childcare, cooking, spaza shops and hairdressing are important income-earning activities for women – and all of them are difficult, if not impossible, without water or power.

10. The big social services – education, health and policing – are all critical for improving the productivity of individuals and communities. Education, which must be linked to broader skills development programmes, addresses the skills backlogs left by apartheid, a central obstacle to economic growth in South Africa. Healthcare, including for HIV / AIDS, is crucial to maintain productivity, reduce absenteeism, and avoid the loss of competencies. In particular, for most experienced workers it is cheaper to treat HIV / AIDS with anti-retroviral drugs than to find replacements. Finally, unstable and insecure communities make economic activity impossible. This is apparent, for instance, when crime prevents women from taking on economic activities at night. It also emerges in the problems with maintaining bank outlets in poor communities.

The provision of the social wage must be linked to a strategy of improving the distribution of wealth and economic power. This strategy

must help guide the country onto a new economic growth path that can generate employment on a large scale.

Measures to improve the distribution of wealth overlap substantially with the social wage. They include:

11. The provision of housing and related infrastructure,
12. Education and skills development,
13. Strengthening community and state capital, including making state-owned enterprise more accountable and developing social infrastructure (schools, clinics, police stations, etc.),
14. Land reform and other support for small and micro enterprise,
15. Protection for labour rights and strategies to democratise ownership and decision-making in the formal sector.

It follows from these proposals that, to be effective, a comprehensive social security system must combine various measures and institutional systems. Critically, as a whole, the social wage must ensure:

16. Universality, reaching all the very poor, including those historically marginalised under apartheid, such as people with disabilities in rural areas and domestic, informal, migrant and agricultural workers,
17. Administrative simplicity, which means amongst others avoiding means testing as far as possible,
18. Synergy between free provisions and grants, social (compulsory) insurance, and private provisions, so that the private sector does not effectively undermine public services and systems,
19. Adequate measures to support people with AIDS and those whose families are destroyed by AIDS, and
20. Compatibility with long-run economic and social development.

In sum, measures to address poverty are critical for bringing about sustainable economic growth. Rather than seeing them as counterpoised to or a possible consequence of economic expansion, they form a necessary precondition. As far as possible, these measures should be designed in ways that support employment generation, in part by ensuring the poor have greater access to income-generating assets and skills.

3. Proposals for a social wage

Social security in South Africa currently consists of a combination of social grants, infrastructure and housing provision, social services and private pensions and insurance. Substantial shortcomings emerge in each of these areas. We identify these problems and then attempt to propose ways to address these through a combination of radical

reforms to the existing system, and the introduction of totally new elements which are currently not in existence.

3.1 Income transfers

The system of social grants should ensure a minimum income for all South Africans. The current set up does not come close to reaching that goal. For this reason, COSATU proposes a basic income grant as a critical component in an effective comprehensive social security system. The basic income grant would provide an effective, administratively easy mechanism to substantially raise the income of poor households.

The current system of grants shows three key weaknesses, which mean it does not assist as effectively as possible in breaking the poverty cycle.

First, for historic reasons, only the old-age pension is adequately focused on poor households. The other grants are still disproportionately located in the Northern and Western Cape. Overall, welfare spending per person is not well related to the level of poverty in a province.

Second, old-age pensions and child-care grants account for the bulk of payments. While these grants are important in alleviating hardships, they focus on individuals' needs and so may prove unresponsive to households' economic requirements and family dynamics.

Third, most grants have declined in real terms in recent years, and none of them reach in full the population for which they are designed.

Research conducted for COSATU on existing social grants revealed that over 13,8 million people in the poorest 40% of South Africa's households do not qualify for any social security transfers. (Haarman 1998)

Failure to reach most of the poor

By no means do social grants reach all the poor. As Table 1 shows, there is virtually no relationship between levels of poverty and the extension of social grants. In no province except Gauteng and the Western Cape does the share of the population receiving social grants come close to the share of the population living in poverty.

Table 1. Percentage of population in lowest income quintile compared to social grant recipients

	% of population in lowest income quintile	% of population getting a social grant
Gauteng	5%	5%
Free State	31%	6%
Mpumalanga	17%	7%
North West	24%	7%
Northern Province	26%	7%
KwaZulu Natal	12%	7%
Western Cape	6%	8%
Eastern Cape	32%	9%
Northern Cape	23%	12%

Taken together, the current system of social grants closes the poverty gap – the difference between incomes in the poorest two quintiles and the poverty line – by less than 40 per cent.

In that context, the grants are not targeted exclusively to the poor. Table 2 demonstrates that, as a whole, the existing social grants primarily benefit the poor, with 66 per cent going to the 40 per cent of households with the lowest incomes. Still, a third of social grants benefit people in the top three income quintiles.

Table 2. Distribution of social grants by household income quintile

First Quintile	38%
Second Quintile	28%
Third Quintile	19%
Fourth Quintile	8%
Fifth Quintile	5%
Total	100%

Source: Calculated from, Haarmann (2000) Social Assistance in South Africa: Its potential impact on poverty.

The failure to reach all the poor also emerges from the disparities in the share of beneficiaries and the share of poor people by province. In particular, the provinces in the Cape, that historically benefited disproportionately from social grants because of relatively large White and Coloured populations, continue to have relatively high transfers. As the following table shows, the richest and most urban provinces have a substantially larger share of beneficiaries than of the country's

poor. In contrast, poor and more rural provinces typically have a relatively low share of beneficiaries compared to their poverty.

Table 3. Beneficiaries of welfare grants compared to share in national poverty, 1999/2000

	Number of Beneficiaries	**Percentage of Beneficiaries**	**% of poor ***
Northern Province	334 000	12%	18%
Mpumalanga	186 000	6%	8%
North West	226 000	8%	9%
Free Sate	162 000	6%	6%
Eastern Cape	597 000	21%	22%
KwaZulu Natal	605 000	21%	21%
Northern Cape	100 000	3%	2%
Gauteng	334 000	12%	10%
Western Cape	327 000	11%	4%
Total	2 871 000	100%	100%

* i.e. per cent of poorest quintile of the population living in the province.

Source: Department of Social Development Annual Report 1999 / 2000 and
United Nations Development Programme, South Africa: Transformation for Development (2000)

The Northern Province has the worst take up relative to poverty level, with 18 per cent of the country's poor people but only 12 per cent of its grant recipients. In contrast, the Northern Cape, Gauteng and the Western Cape all receive a larger share of grants than their share in the country's poor. Moreover, while nationally 7 per cent of the population receives a social grant of some kind, the figure for the Northern Cape is around 13 per cent.

As Table 4 shows, three fifths of social grant expenditure goes for the old age pension. Although the pension is targeted by age, not income, most studies show that it is the single most effective measure for reaching poor households. This is because only 0,3 per cent of households in the two poorest quintiles contain only pensioners. In contrast, 30 per cent of

households in these quintiles contain children and working-age adults as well as pensioners. It is not surprising, then, that these transfers constitute a significant share of income for the poor, despite the failure to ensure an adequate link to household needs.

Table 4. Share of welfare expenditure by type of grant, 1999/2000

Type of Grant	% of welfare spending
Care for the Aged	62,0%
Care for the Disabled	24,5%
Child and Family Care	9,1%
Administrative Support	4,1%
Social Relief	0,3%

Source: Department of Social Development, Annual Report 1999 / 2000

The real decline in social grants

Relative to headline inflation, the old age pension and disability grants have dropped by almost 20 per cent. The child grant has not increased since its introduction in 1998, so relative to inflation it has already fallen by a 10 percent.tenth. Compared to the inflation rate for low-income people, which is somewhat higher than the overall CPI, these grants have fallen even more.

Table 5. Changes in the old age pension and disability grant

Year	Amount	Nominal increase	Headline CPI (4)	Increase after inflation
1995/96	R 410	3.8%	7.8%	-4%
1996/97	R 430	4.9%	8.1%	-3.2%
1997/98	R 470	9.3%	7.6%	+1.7%
1998/99	R 490	4.3%	7.7%	-3.4%
1999/00	R 520	6.1%	4.0%	+2.1%
2000/01	R 540	3.8%	5.5%	-1.7%

Source: IDASA

The decline in social grants reflects the fact that the level of the grant is set essentially by the Department of Finance, without a comprehensive investigation in terms of social needs. In that context, two factors have led to cuts: the overall restrictions on the budget, and an inappropriate response to the extension of the grants to the entire population.

Until the transition to democracy, these grants were essentially restricted to a privileged minority. The provision of the grants to Africans led to a very substantial increase in take up, and a corresponding rise in expenditure. Instead of considering the social costs and benefits in a comprehensive fashion, however, it seems that the level of the grant since then has been driven in most years by a desire to cut the real cost to the fiscus.

The latest Medium Term Budget Policy Statement proposes that welfare spending as a whole should grow at 2,2 per cent, just below the rate of growth in the population. Within that amount, however, the Welfare Department proposes to cut the share of spending on social security from 90 per cent to 80 per cent of the budget. This is likely to lead to restrictions in the amount of grants. Ntenga (2000) notes that,

> "The Welfare Department's long-term commitment is to reduce Social Security expenditure to 80 per cent of the expenditure as against the current provincial average of close to 90 per cent. At the end of the current MTEF cycle, provinces overall are still projected to spend 82.5 per cent of their Welfare budgets on social grants."

The rationale for the benchmarks are that if spending on social security is reduced it will release funding for other programmes including for social development (i.e. community development projects, capacity building, assets for the poor and promoting partnerships) and social welfare (e.g. running welfare institutions, frail care and drug-dependency).

These benchmarks are highly problematic. The real problem lies in the narrow restrictions placed on welfare budgets, which means they do not even keep up with population growth. As a result, departments are placed in the untenable position of having to choose between welfare grants and other programmes.

Even given limited resources, COSATU cannot support the prioritisation of developmental welfare and other programmes over income transfers. Other departments may be able to deal with developmental issues; but no one else will provide support for those unable to earn an income due to disability, illness (including HIV) or age. In these circumstances, it is inappropriate to reduce funding for social grants in order to increase spending on other programmes.

Low take up

Low levels of take up for most of the main grants point to difficulties in administering them and effectively favour the more urbanised provinces that typically have more efficient delivery systems. Only the old-age pension reaches more than half of the target population. The disability grant benefits 1,5 per cent of the population, which is substantially lower than most estimates for disability.

A particular concern remains the restricted payment of the Child Support Grant, which was expected to reach three million children in the five years following its initiation in 1998. In the event, the take-up rate for the grant has been very low, particularly in the poorest provides. Thus, Eastern Cape reached only 31 000 of the targeted population of 241 000 for the 1999/2000 financial year. In the same year, KwaZulu Natal reached only 53 000 of a targeted 186 000.

The outsourcing of pension payments is a cause for serous concern in this connection. The complaints raised by the Welfare Department about service providers are unfortunately indicative of standard problems with outsourcing. The state has relinquished its own capacity to provide the service, and does not have the regulatory capacity to ensure adequate services from the private sector.

Conclusion

In sum, the current system of grants represents a critical support for many of the very poor. But it remains inadequate to provide a decisive measure against poverty. For this reason, in the next section we propose a significant shift toward a basic income grant.

3.2 The basic income grant

In light of the difficulties with the existing social grant system and the problems in extending basic services to the poor, COSATU has long called for the introduction of a basic income grant. Obviously, the key aim is to alleviate poverty. But the grant would also have a broader developmental effect. It would provide a degree of household and community stability, laying the foundation for more productive and skilled communities over time. Moreover, it would ensure that even the poorest households have a little cash, which could contribute to their economic potential.

Labour proposed to the Presidential Job Summit a basic income grant of at least R100 a month to all adult South Africans who do not get an old-age pension. Rather than taking on the administrative burden of means testing, the cost would be

retrieved through a progressive increase in taxes on those earning over a specified amount, say R2-3000 a month. While for medium/low income earners, the 'claw back' may leave them in a relatively neutral position (the tax roughly equalling the grant), the solidarity tax would kick in at a specified threshold, and increase progressively as income rises.

The proposed basic income grant has the advantage of giving all households a small but secure minimum income, improving their stability and economic potential. Because it is a flat sum, it is highly progressive. Moreover, it favours large households - which tend to be poorer - as they pool income, and increases the incomes especially of women and younger people.

This document sets out the essence of COSATU's proposal on the basic income grant. It then suggests some of the main variables that could be considered in implementing the grant. Finally, we model the impact on poverty and the costs to the state of one option.

The essence of the basic income grant

The basic income grant would involve a relatively small sum – between R100 and R200 – paid to all individuals, without exception, every month. It aims to overcome the deficiencies of the current social grants, and more broadly in the social wage as a whole. Critical aspects to achieving this end include universal coverage and sustainability.

Universal coverage of individuals is critical for various reasons.

1. It minimises administrative burdens. As the current systems for social grants and municipal services demonstrate, government simply does not have the capacity to utilise means tests efficiently. This is critical, since the welfare administration is already overstretched by the existing grants. Payment through the PostBank could further streamline delivery.
2. Payments to all individuals inherently favours larger households, which tend to be poorer and have greater needs. The options discussed below will modify this effect.
3. Payments to all individuals also benefits women and young people directly. That should increase their power and autonomy within the household economy, which in the long-run should help reduce the abuse of women and children. That in turn is critical for social stability, skills enhancement, limiting the spread of HIV, and ultimately for sustainable social and economic development.

4. A universal grant will reach not only the unemployed but also the working poor, who constitute a very large share of people officially classified as employed. Farm and domestic workers, people trying to eke out a living in the informal sector, and even large sections of the formal sector earn incomes well below the poverty line. To overcome the obstacles poverty poses to social and economic development, it is important to increase their household incomes.
5. Universal coverage reduces the risks associated with the dole – that is, a disincentive to work and stigmatisation. The means tests associated with the dole mean that individuals must choose between income from work and from the grant, which may lead them to relinquish possible income-earning activities.

Universal coverage should help overcome the risk of corruption. Payments would be made with a standard record, for instance in a person's ID book. That would reduce the temptation to bribe officials to obtain access, and make it harder to provide double payments without extensive record keeping. The main difficulty would be to ensure control over the individual's papers, rather than analysing millions of records centrally.

A second critical aspect is ***fiscal and economic sustainability***. This sustainability has two foundations: the proposed financing mechanisms, and the longer-term stimulus to the economy.

Financing mechanisms are discussed in greater depth in the final section of this paper. We propose a combination of increases in the income tax, a small increased in government borrowing, and a more efficient use of government resources through reforms to the Government Employees Pension Fund (GEPF).

More fundamentally, the sustainability of the grant must be seen in a dynamic context. As the grant provides the basis for economic growth in the medium term, the fiscal burden reduces over time relative to the budget and the economy as a whole. In that sense, it represents a critical investment, whose longer-term returns more than justify the short-run costs.

In sum, the basic income grant essentially aims to ensure an adequate social wage by overcoming the weaknesses in public administration and the inappropriate financing systems that bedevil current systems. In the process, it should support systemic changes that are critical to overcoming the poverty trap and initiating sustainable social and economic development.

Options for the basic income grant

Choices in defining a basic income grant revolve around the amount; possible age limitations; the relationship to existing grants; and financing measures. We here consider all but the final dimension, which is analysed in the final section of this paper.

Amount: COSATU proposes that the Commission consider a range of between R100 and R200, rising with inflation (specially, the low-income CPI) over time. This modest amount would be economically sustainable over time, but high enough to make a meaningful difference to people's lives.

For a normal household, with between five and six people, any amount in the proposed range would leave the family below the poverty line. But the grant will support increased income earning by households, both through more productive self-employment and by making it easier for people to obtain skills and employment outside the household. Thus, in the medium term it would provide the basis for all households to reach a decent standard of living.

Eligibility by age*:* A debate has arisen over whether the grant should go to all individuals, or only to adults, for instance over 16 years old. Providing the grant to children will increase the administrative difficulties, since the state would have to determine the main caregiver for the child – typically a mother or grandmother. The child support grant already requires that effort, however. Moreover, failure to provide the grant to all children leads to an unacceptable paradox, where South Africans under seven and over 16 would all receive social assistance – but not the vulnerable group between those ages. For this reason, COSATU proposes that all individuals be eligible.

Relationship to other grants: The basic income grant could be provided as an addition to other grants, or could be offset against them. The critical issue here is whether the existing old-age and disability transfers are considered sufficient to sustain the recipients, or if they should be increased by the amount of the basic income grant. That, in turn, depends on the perspective on cost as well as social needs.

The basic income grant could be paid into people's accounts through the banking system. A reformed and extended Post Office Bank or community banks could be used. This would help to expand much-needed financial infrastructure into rural areas. Such an electronic and automatic transfer is cost effective and requires less administration. Furthermore, recent evidence points to the positive spin-offs of bringing poor people into the formal banking system. Access to and integration into the

system would be a huge advancement for poor people by giving them opportunities to accelerate development.

Modelling the basic income grant

This section models the impact of the basic income grant on the budget and on poverty. We here only consider one option:

- an amount of R100
- provided irrespective of age,
- offset against other grants, so that 33 million individuals are eligible, and
- with complete take up.

The following table displays the impact of the basic income grant on different household compositions by age and income. Two effects stand out:

- a substantial narrowing of the poverty gap for all types of households, and
- a continued bias in grants toward the lowest two quintiles, despite universal coverage. The use of income taxes would make the net impact even more progressive.

Table 6: Effects of the basic income grant at R100, irrespective of age, offset against other grants

	Only children	children & working-age adults	children & pension-able adults	children, working age & pensionable adults	only working age adults	working age & pen-sionable adults	only pen-sionable adults	total
% of people living in the bottom two quintiles:	0.1%	62.8%	1.9%	29.5%	3.8%	1.6%	0.3%	100.0%
For the lowest two quintiles of households:								
Average % of the poverty gap closed by all social grants	80.7%	77.0%	97.5%	90.3%	64.1%	92.8%	100.0%	81.7%
Average	100	102	204	151	106	223	428	121

per capita transfer from all social grants (Rand)								
Average per capita transfer through basic income grant alone (Rand)	77	80	50	66	98	62	-	75
Total annual transfers by BIG (in R millions)	50	26,700	330	6,880	4,970	730	170	39,820
Total annual transfer through all social grants (in R mns) to quintiles of households:								
First quintile	10	8,810	530	6,820	400	470	100	17,140
Second quintile	30	7,720	450	4,730	630	460	190	14,240
Third quintile	20	6,650	270	2,860	900	410	233	11,410
Fourth quintile	10	4,800	80	940	1,430	430	250	7,930
Fifth quintile	-	3,620	10	300	1,760	420	460	6,560
Total annual transfer through all social grants (in R mns) to								
Rural areas	60	15,760	1,070	10,250	1,520	940	440	30,070
Urban areas	4	15,850	260	5,390	3,600	1,240	800	27,160

The average transfer per household rises from by R75 a month, to R121. This is about 60 per cent higher than the current system provides.

Because lower-income households are typically larger, they gain a higher total transfer from the basic income grant. As a result,

the bulk of transfers would continue to benefit the poorest two quintiles of households. Some 55 per cent would go to the bottom two quintiles, and a further 20 per cent to the third quintile. The average per capita transfer in these quintiles would rise from R45 to R120 a month. The transfers are almost evenly split between rural and urban areas, and because of universal coverage are proportional by race.

In this model, which does not give the basic income grant to recipients of existing transfers, the main beneficiaries of the new grant are working age adults and children. Under the current system, 60 per cent of transfers go to pensioners, who make up under 6 per cent of the population. In the proposed system, working age adults would receive 44 per cent of transfers, followed by children with 38 per cent and pensioners with 18 per cent. Pensioners still receive a relatively high share of income because the old-age pension is higher than the basic income grant. This reflects the fact that pensioners will be unlikely to have other sources of income.

It follows from the pattern of benefits that the poverty gap is closed most strongly for households with pensionable adults and, to a lesser extent, children. In these households, the poverty gap would be closed by between 77 per cent and well over 90 per cent - far higher than under the current system of income transfers alone. For the few households that have only pensioners, the current system already closes the poverty gap entirely. The minimum per capita transfer comes to R100 – that is, the basic income grant alone; for three-generation households, who receive old-age pensions as well, it amounts to R151.

The following table indicates the impact on the poverty gap in the lowest three quintiles.

Quintile	**Not in poverty before transfers**	**under the current system: % of households closing the poverty gap by 100%**	**With the basic income grant, % of households closing the poverty gap by:**	
			50 to 90%	**100%**
Lowest	5%	5%	60%	25%
Second lowest	25%	10%	35%	40%
Third lowest	55%	10%	20%	25%

Summary and conclusions

COSATU considers a move toward a basic income grant a decisive step toward breaking the vicious cycle of poverty. Because it is administratively simple, it overcomes the problems we face with the administration of the social wage. As a result, it can reach all the poor, contributing substantially to more equitable incomes and thereby laying the basis for sustained and robust development.

3.3 The Unemployment Insurance Fund (UIF)

The UIF is a form of social insurance aimed at assisting with short-term job losses. While it provides an important form of support for workers between jobs, it is not helpful for the long-term unemployed or the underemployed. This section evaluates proposals to reform the UIF.

The functions of the UIF

By definition, unemployment insurance schemes are designed to provide benefits only to those in a position to pay the contributions. Currently, both employer and employees contribute towards the Unemployment Insurance Fund. In effect, access to benefits is predicated on prior contribution and, by extension, formal employment.

Generally, the aim of the fund is to provide income support during times of unemployment for a defined period. After the period has lapsed, if the individual does not find any income generating activity, she or he will fall through the unemployment safety net. This is a reality for the majority of the unemployedment who were lucky enough to have worked.

For the vast majority of the unemployed who have never held a job, the situation is even more precarious. Moreover, domestic, farm and migrant workers may not join the UIF, although they face particularly unstable employment and often suffer joblessness.

The UIF has historically provided a uniform scale of benefit equal to 45% of the beneficiary's wages when employed. This system favours higher income-earners relative to low-income earners. Moreover, very high income earners and public servants do not belong to the UIF, which reduces its income substantially.

According to the Report of the Task Team on the UIF established by the Ministry of Labour, less than 10 per cent of South Africa's unemployed benefit from the UIF at any point in

time. (5) Most unemployed people are not eligible for UIF benefits because they never held a formal sector job. In addition, UIF benefits are relatively short term, generally lasting no more than six months, and so do not meet the requirements of long-term unemployment.

Furthermore, the UIF is facing a financial crisis. This has two sets of causes. First, the extension of membership to African workers meant that for the UIF now has to meet the needs of workers with a high rate of unemployment. Second, rapid and consistent job losses since 1990 aggravates the situation, as the UIF has to pay even more benefits while its contributors' base is shrinking. For this reason, the Fund has not been financially sustainable and is on the verge of collapse.

In light/view of the high levels of unemployment and job losses prevalent in the economy, it is critically important that the Unemployment Insurance Fund (UIF) be transformed:

12. To provide adequate and accessible benefits, particularly to the most vulnerable low paid workers, and
13. to structure contributions from workers, employers and the state so as to ensure its stability and sustainability.

Government proposals for reform

The Minister of Labour recently unveiled two sets of Bills aimed at reforming unemployment insurance, namely the Unemployment Insurance Bill and the Unemployment Insurance Contributions Bill. These Bills introduce laudable reforms in the existing unemployment insurance system, which will go a long way in addressing some of the problems surrounding the Unemployment Insurance Fund.

Inevitably, reform of the Fund must be linked to the question of a comprehensive social security system. At the centre of the social security debate in South Africa is the need to extend safety nets.

The key progressive changes in the Unemployment Insurance Bill and the Unemployment Contributions Bill are:

14. Introducing a progressive scale of benefits, so that lower-income employees receive a higher share of their wages as benefits than higher ones;
15. Inclusion of higher income earners into the ambit of the UIF;
16. Separation of maternity benefits from unemployment benefits;
17. Extension of the benefit period from six to nine months;

18. Establishment of a database of contributors.

In terms of the Bill, the scale of benefits may vary between 60 per cent for low-income contributors and 38 per cent for higher income-earners. At a certain income level (the 'benefit transition income'), the benefit reaches a minimum percentage of wages. At that point, a fixed sum will be paid irrespective of the former wage level.

Under the new proposals, all workers except public servants, domestic and migrant workers will be included in the UIF. High-income earners contribute at the transition income threshold of R7774 per month, and will benefit at that level. On the other hand, the Bill provides for further investigations into the position of domestic workers. Migrant workers will continue to be excluded. In other words, some of the most vulnerable workers will still be excluded.

The Bill also deals with the current gender discrimination by separating maternity benefits from unemployment benefits. In terms of the new proposal, pregnant women will not jeopardise their unemployment benefits when they draw their maternity benefits. COSATU sought to make maternity benefits automatic and not linked to period of employment to deal with the unintended discrimination against pregnant women. If accepted Tthis would means that maternity benefits wouldill not be proportionate to the period of employment and all women wouldill enjoy similar benefits. In addition, COSATU also argued for payment for six months' maternity leave, rather than the four months provided in the Basic Conditions of Employment Act.

Last, the benefit period has been extended to nine months. This will provide cover for a longer period than is currently the case. The trade-off for extending the period of benefit is the cap placed on credits that can be accrued during a benefit cycle. The maximum credits are equivalent to 238 days within four years.

Proposals for further reforms

The proposed reforms do ensure more fairer benefits and better coverage. But they do not deal adequately with the financial dilemmas facing the UIF. For this reason, COSATU argues strongly for a new financing model. Amongst others, it called for the state to underwrite or subsidise the fund. In addition, we argued that public servants should be included in the Fund, since their relatively stable employment helps spread the risk of joblessness. This initially has been vehemently opposed by government, purely on fiscal grounds. Finally, COSATU argued

for a stronger governance structure for the Fund, giving the Board greater leeway to introduce reforms aimed at efficiency.

The current amendments to the UIF Act do not envisage a shift from a passive labour market policy (i.e. paying benefits to the unemployed) to active labour market policies (i.e. creating conditions conducive to getting the unemployed into work). (6) In part, this results from the belief that the Skills Development Act will deal with the issue of training of the unemployed. The only indication in the current legislation for possible active labour market policies is the powers granted to the Board to advise the Minister on changes to legislation in for far as it impacts on unemployment policy.

In countries where unemployment has been reduced, the reduction has been attributed largely to a shift from passive labour market policies to active labour market policies. Given South Africa's long-term unemployment, it is imperative that active labour market policies are effectively combined with social security measures implemented to prevent, combat and cushion the impact of unemployment. In this connection, retrenchments should be avoided at all costs and, where they are unavoidable, social plan interventions should be implemented.

In order to counteract the effects of long-term unemployment, a more fundamental review of benefits must be undertaken. Benefits should be much higher for the low-income group than the current proposals, for example at 70 per cent of wages. Furthermore, the benefit period should be extended to at least two years. In Germany, by comparison, the benefit is payable from the first day of unemployment for between 78 and 832 days, depending on contribution history and age of the beneficiary. (7)

In the event, the NEDLAC constituencies have agreed to work with the existing system at least for the next two years. After two years, an actuarial assessment of the Fund will be undertaken to ascertain the impact of the new benefit regime on the financial situation of the Fund. Thereafter there will be a discussion regarding the benefits schedule and the contribution rates. Still, a review of measures for the long-term unemployed could be undertaken more urgently. In addition, the basic income grant proposed below will play pivotal role in providing income support for the unemployed once they have exhausted their unemployment benefits.

3.4 Health care

According to the ILO, medical care helps "maintain, restore and improve the health of individuals and helps provide a fit and

efficient workforce, thus affecting productivity and consequently economic growth." (8)

South Africa spends 8,5 per cent of its GDP on health, yet the outcomes – measured for instance by child, infant and maternal mortality and life expectancy – remain worse than found in other middle-income developing countries. The reasons life in part in inequalities in the health system, and in part in the lack of basic infrastructure to ensure clean water and sanitation for many of our people. The HIV pandemic has aggravated the situation.

The two-tier health system

South Africa has a two-tier health system, where those who can afford it can get the best care in the world, while the majority continue to have inadequate services. The private sector serves less than 20 per cent of the population, but absorbs two thirds of total health spending. In contrast, the public health sector serves the majority of our people, but remains under-resourced, resulting in poor quality care.

Of the 40 million inhabitants on South Africa, only a tiny minority (about 7 million, of whom only 9 percent are Africans) have access to private medical scheme cover. This leaves majority of South Africans uninsured and forced to rely on public health services. The annual revenues of the private medical schemes comes to R25 billion a year, about 20 per cent more than the total public health budget.

The public system has experienced major problems due to declining real budgets in recent years. This has worsened the quality of services and inefficiencies in the system. Furthermore, it exposes the public health system to threats of privatisation (mostly in the form of proposals for contracting out, outsourcing, and public-private partnerships) and a spate of hospital closures. In this context, efforts to contain personnel spending in health has led to some understaffing.

Since 1994, government has changed policies to improve access by the poor. The crucial steps were the opening up of all facilities to all races and the provision of free health care for mothers and young children. At the same time, government expanded primary health care. This strategic shift was initially expected to reduce costs for curative care. In the event, it led to higher referrals to hospitals, with a consequent increase in costs there as well. So bad is the situation in some provinces that nurses are seen begging for money to buy food for patients.

In the same period, budgets for health have declined relative to inflation. Between 1996/7 and 1999/2000, provincial health

budgets rose 4 per cent a year, with inflation at 7,7 per cent a year. In other words, in real terms health budgets dropped by over 3,5 per cent a year, or close to 10 per cent in three years. At the same time, the population was growing at over 2 per cent a year. In per capita terms, then, the health budget dropped by 15 per cent over the period.

Although new health care facilities have been constructed in the past six years, 46 per cent (9) did not have an adequate supply of clean water and electricity. Many clinics are being opened without necessary staff or resources. The staff are resentful because they are made to deal with increased patient numbers without the necessary support. (10)

Poor health care has a gender dimension because,

> "Women are more likely to be in need of health care facilities, because of going through the process of child-birth, or due to their vulnerability to domestic and sexual abuse, and physical strains caused by daily chores in rural areas. They are more likely to interact with the health care system in providing care for children and other members of the household."

The two-tier system promotes a maldistribution of resources and wastage, and defeats commitment to a health care for all. It inflates health costs for all South Africans, pushing up the cost of living and employment costs. Yet the majority must still do without adequate health care.

The crisis in the health insurance system

The two-tier system has led to a crisis in the private health insurance system, which has been aggravated by the HIV pandemic. This crisis emerges both in inadequate coverage and in rising costs.

- The present health insurance system (medical aids) has failed to provide insurance coverage for health care services for more than 33 million South Africans. The number of those lacking such coverage grows as more South Africans are thrown out of medical schemes. The result is the "dumping factor" as the uncovered people – typically those seen has having higher risks - end up in the public health sector that is facing fiscal constraints.
- Unnecessary and excessive profits and administrative costs have inflated the cost of health care with the users (mainly medical schemes members) bearing most of the brunt. Employers providing medical schemes have also been severely affected as demonstrated by declining

contributions or premiums. At the same time, where profits drive medical care, it becomes it difficult for health care personnel to provide and users to receive appropriate care.

- The private health care system, rather than complementing the public health system and national health policy, actively weakens the public health care system. It does so in two ways: by shifting the cost of caring for patients with serious illnesses, including HIV, onto the public sector; and by setting up a parallel system of (expensive) private hospitals that diverts potential paying patients from public hospitals.
- Private medical schemes typically require co-payments and deductibles. These requirements endanger the health of poor people who are sick, decrease the use of vital in-patient medical services as much they discourage the use of unnecessary ones, discourage preventive care and are unwieldy and expensive to administer. Increasing co-payments and deductibles have failed to slow down the escalation of costs.

The problems of exclusion in private health care both mirrors the broader social problem in our society. Income inequalities have increased in the 1990s, in particular because of the loss of formal jobs. More and more of the black working class is getting impoverished as their wages decline and their jobs are wiped out by the massive economic restructuring.

Despite attempts by the private sector to introduce the concept and practice of managed care in the 1990s, the crisis in the private health insurance continues to threaten the financial viability of many medical schemes. Managed care was originally conceived in the 1980s in the United States as a response to the rising costs of private health. It was imported to South African private health sector for the same reasons. But experience in the United States now indicates that managed care, because of the orientation toward profits, is unable to address issues of costs and quality. Many of its earlier advocates now publicly admit that for-profit managed care has failed to deliver.

Proposals for Social Health Insurance(11)

Social health insurance, as proposed by government in 1997 and now revived in some quarters, aims to resolve the health crisis by requiring that all people with an adequate income participate in a state-run health insurance scheme. As with the UIF, employers and employees would have to pay a compulsory contribution. Presumably self-employed people, at least in the formal sector (indicated, for instance, by registration for VAT) would also have to contribute.

The insurance scheme would be run by an independent Social Health Insurance Authority, which would be accountable to the Ministry of Health but outside the public service. The Authority would identify insured patients, reimburse hospitals, register members and collect contributions. To obtain the hoped for gains, the authority must keep its administrative costs low.

In this system, private and public health systems would still exist side by side. Individuals who prefer greater benefits that the state provides could continue to pay for private insurance. Private medical schemes would be encouraged to use public-sector hospitals, which would reduce costs for all participants while increasing revenue to the public service.

Public hospitals would be allowed to retain a portion of their revenue from private patients as an incentive to increase collection and improve quality of care. To attract private patients, they might have to establish better conditions to attract private patients; but all patients would benefit from the improvements in resourcing. Practically, this will require a substantial investment in new billing systems, training for personnel and new computer systems.

Proponents argue that this system will bring many advantages. It will reduce the costs for the medical aid schemes; cards issued by the SHI authority will make health care free at point of delivery and therefore there will be no need for the hospital to conduct an instant means test or for the patient to carry cash; and billing and statistics in the public health system will improve, together with the quality of service.

Critique of Social Health Insurance

Proposals for Social Health Insurance centre on increasing resourcing for the public sector health system directly, through the insurance system, and indirectly, through improved use of public hospitals by private patients. Implicitly, then, it identifies the under-resourcing of the public health system as a key problem.

The Social Health Insurance proposal aims to remedy this by making workers pay more and by drawing in some resources from the private sector indirectly, through increased use of public hospitals. That approach ignores the huge diversion of resources to private healthcare. Specifically, it is problematic because:

- Total revenues would come to about R1,5 billion to R3 billion. If used only in the public sector, that would increase funding of the state system only by about 10 per

cent – returning it, at best, to 1996 levels. Given relatively low revenues, the cost of administering the scheme may use of the bulk of the funds collected.

- The basic tenet of the proposal is to make the working poor pay for the very poor. It would levy a flat percentage. That is inherently undesirable, since losing a percent of income means much more to a lower-level worker than to the rich, even if the actual amount is less.
- By leaving private insurance in place, the system leaves untouched a huge amount of resources. What is happening here is that the working poor are made to subsidise the poor and those in the informal sector, while the rich to not contribute proportionately.
- The current proposal does not cater for visits to general practitioners. Yet state clinics and hospitals require huge amounts of time, deterring use – a major obstacle to adequate primary care. That means that those who can afford it will still look to private medical schemes; and the poor will not remain with inadequate care.

The right to health care for all (not only for those who can afford) is entrenched in the constitution. The current public health system is failing a majority of our citizens. It is imperative therefore that it is improved through increased government funding. In turn, that requires that we leverage money into the public health sector and stem the outflow of funds to the private sector as well as the undermining of the private health sector.

A lasting solution therefore requires a basic change of the way we pay for care. For this reason, COSATU has proposed a National Health Insurance systemm, as discussed below.

National Health Insurance

The overall objective is the provision of adequate, quality health care for all. This is critical for an effective comprehensive social security system. Moreover, the right to health care is a fundamental right enshrined in the South African Constitution.

The main features of National Health Insurance

The key difference between Social Health Insurance and National Health Insurance is that the latter requires that, through a transitional period, all health resources be incorporated into the public sector. Payment for health would then take place almost exclusively through a National Health Insurance authority (NHI). It would be financed in part through dedicated taxes that would effectively equal current private health costs. In the medium term, it would permit considerable efficiency gains compared to the current system.

Everyone would be included, without co-payments, in a single national insurance scheme covering all medically necessary services. That includes primary health care, rehabilitative, long-term, home care and mental health services, dental services, occupational health care, prescription drugs and medical supplies, and preventive and public services. With community and labour representatives, the government would determine which services were unnecessary and ineffective, and exclude them from coverage.

The National Health Insurance funds would be publicly administered and tax-financed. A progressive earmarked health-care tax would augment government health spending. Because the tax would replace employee-employer insurance premiums and the portion of out-of-pocket expenditures, they should not increase the cost of health care to the average South African or overall. In the long term, by reducing administration and procurement expenses, the cost of health care should ultimately decline.

An NHI authority would be established to manage the health system. It would draw on the funds raised to fund capital and current expenditure by hospitals, clinics, nursing homes and other health providers, as described in more detail below. Alternative insurance coverage for services included under the NHI would be eliminated, as would patients' co-payments and deductibles. In effect, the NHI would replace the present array of 175 private medical schemes. Initially, it would pay for expanded care out of the administrative savings, without adding new costs to the overall health care budget, and would establish effective mechanisms for long-term cost control.

A single comprehensive insurance coverage would both to ensure equal access to care and minimise complexity and expense of billing and administration. Although the consolidation of purchasing power in the public institution may cause apprehension among some health professionals, the NHI would free them from myriad of administrative intrusions that currently plague the practice of medicine.

Instead of confused and often unjust dictates of insurance companies, a greatly expanded programme of technological assessment and cost-effectiveness would guide decisions about covered services, as well as about the allocation of funds for capital spending, drug formularies and other issues.

Payment for hospital services

Each hospital would receive an annual lump-sum payment to cover all operating expenses --" a global budget". The amount of

this payment will be negotiated with the state NHI programme board and would be based on the past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and other costs, and proposed new and innovative programmes.

Hospitals will not bill for services covered by NHI. No part of the operating budget could be used for hospital expansion, profit, marketing, or major capital purchases or leases. These expenditures will also come from the NHI fund, but monies for them will be appropriated separately. The separate appropriation of funds explicitly designed for capital expenditures would facilitate rational hospital planning.

In countries where NHI has been put into place, this method of hospital payment has been successful in containing costs, minimising bureaucracy, improving distribution of health resources and maintaining the quality of health care. Global perspective budgeting simplifies hospital management and virtually eliminate billing, thus freeing up resources for increased clinical care.

The incentives for hospitals management will be boosted by the Public Finance Management Act [PFMA) and democratic participation in the community hospitals' boards.

Other payments

For patients not using hospitals, the diversity of existing practice arrangements, each with strong proponents, necessitates a pluralistic approach. Under all the three options proposed here, capital purchases and profits would be uncoupled from payments to doctors and other operating costs - a feature that is essential for minimising entrepreneurial incentives, containing costs and facilitating health planning.

To minimise the disruption of existing patterns of care, the NHI would include three payment options for doctors and other practitioners: Fee-For-Service Payment, salaried positions in the institutions receiving global budgets, and salaried positions within group practices receiving per capita (capitation) payments.

Fee-for-service: The NHI payment board and a representative of fee-for-service practitioners would negotiate a simplified, binding fee schedule. Doctors would submit bills to the NHI on a simple form or by computer and would receive extra payment for any bill not paid within 30 days. Payment to doctors would cover only services provided by doctors and their staff. Doctors who

accepted payment from the NHI could bill patients directly only for uncovered services.

Global Budgets: Institutions such as hospitals, clinics, health centres, group practices and medical home-care agencies could elect to receive global budgets for the delivery of outpatient, home care and doctors services, as well as for preventive health care and patient-education programmes. The negotiation process and regulations covering capital expenditures will be similar to those for inpatient hospital services. Doctors employed in such institutions would be salaried.

Capitation: Group practices and other institutions could elect to be paid fees on a per capita basis (capitation) to cover all outpatient services. Doctor's services and medical home-care services could receive a fixed payment for groups practices for the services they provide individuals. The regulations covering the use of payments for capital expenditure and for profits would be similar to those that would apply to hospitals. Capitation fees would not cover inpatient services (except care provided by a doctor), which would be included in hospitals' global budgets. Selective enrolment policies for patients will be prohibited. Patients could leave a health management organisation or other health plan with appropriate notice.

Doctors working in managed-care organisations would be salaried. Financial incentives to doctors based on the managed care organisations' financial performance would be prohibited.

Under the fee-for-service option, doctor's office overhead would be reduced by simplification of billing. The improved coverage would encourage preventive care. In countries like Canada, fee-for-service practice negotiated fee schedules and mandatory assignment (acceptance of the assigned fee as total payment) has proved to be compatible with cost containment, adequate incomes for physicians and staff and a high level of access to and satisfaction with care on the part of patients.

The Canadians have responded to the inflationary potential of fee-for-service payment in various ways:

27. By limiting the number of doctors;
28. By monitoring doctors for billing patterns;
29. By setting overall limits on provincial spending on physician services (thus relying on the profession to police itself); and even
30. By capping the total reimbursement of individual doctors

These regulatory provisions have been made possible (and have not required an extensive bureaucracy) because all

payments come from a single source. Similar measures might be needed in South Africa, although a cap might be required on NHI administration and reimbursement bureaucracy - a restriction, say, to a specified percentage of total costs.

Global budgets for institutional providers would eliminate billing, while providing a predictable and stable source of income. Such funding would encourage the development of preventive health programmes in the community, such as education programmes on HIV / AIDS, whose costs are difficult to attribute and bill to individual patients.

Continuity of care would no longer be disrupted when patients' insurance coverage changed as a result of retirement, retrenchment, or a job change. Incentives for providers receiving capitation payment to skimp on care will be minimised, since unused operating funds would not be devoted to expansion or profit.

An expert panel would establish and regularly update a list of all necessary and useful drugs and outpatient equipment. Suppliers will bill the NHI directly for the wholesale cost, plus a reasonable dispensing fee, of any item in that list that was prescribed by licensed practitioner.

Allocation of capital funds, health planning and return on equity

Funds for the construction or renovation of health facilities and for purchases of major equipment would be appropriated from the NHI budget. The NHI will would pay current owners of for-profit hospitals, nursing homes and clinics reasonable fixed rate of return on existing equity. Since it would fund virtually all new capital investment, it would not be included in calculating the return on equity. Current for-profit providers will be compensated for existing investments. Since new for-profit investment will be barred, the proprietary sector would gradually shrink.

A Transitional Period

Clearly, the establishment of an NHI will require a transitional phase, to avoid unnecessary disruption to health care and economic interests.

In terms of funding in this period, the main aim would be to begin to centralise funding in the NHI so as to initiate efficiency gains. To that end:

- current expenditure by the government on health care, adjusted for inflation, would be paid to and administered by the NHI.
- A health-care tax on employers and employees would equal, overall, current employer and employee contributions to medical schemes. The tax would have a progressive basis, with a lower percentage for low-income employees and small business. Employers obligated by pre-existing contracts to provide health benefits could credit the cost of those benefits toward their NHI tax liability.
- A second health-care tax on income would raise the equivalent of the amount now spend by individual citizens for insurance premiums and out-of-pocket health costs.

Over a few years, private health insurance plans duplicating the coverage of the NHI would be phased out. During this transition period, their revenues would be turned over to NHI after the deduction of a reasonable fee to cover the costs of collecting premiums.

3.5 Meeting the challenge of HIV / AIDS

Situation analyses

Undoubtedly, HIV / AIDS forms the most important health problem facing South Africa. Young women aged 20-30 have the highest prevalence rates, and young women under the age of 20 have the highest percentage increase compared to other age groups in 1998 compared to 1997. This and other data available indicate that HIV has already become a leading cause of death, especially for young people.

HIV / AIDS has public health, economic and social dimensions. The impact on the labour force will likely be severe, since a large proportion of the HIV infected population are young adults, many of them experienced and skilled. This would lead to increased mortality and reduced population and supply of labour. Other effects may include increased absenteeism, early retirement and changes in labour force participation.

The epidemic also has a direct impact on the social security system, since most HIV-positive people require state assistance. Only a relatively small percentage of people living with HIV / AIDS have medical cover, retirement or unemployment support, and few benefit from existing social grants. Yet government services have been rife with claims of discrimination against people who live with HIV / AIDS.

In this submission we would highlight some of the key challenges posed by the HIV epidemic. In the main, COSATU does not suggest separate grants for people living with HIV / AIDS. Rather, existing grants should be targeted to deal with the disease. The scale and extent of the social security implications of HIV / AIDS needs to be documented.

Social Assistance

A number of existing grants can be targeted to support people living with HIV / AIDS, including child support, foster care and disability grants. Rather than establishing a separate grant for people living with HIV / AIDS, government should adopt a conscious strategy of directing existing grants to meet their needs.

COSATU proposes that the Commission conduct a study of the impact of existing grants on people living with HIV / AIDS. On that basis, it should develop a strategy to target existing grants to benefit people living with HIV / AIDS. That could entail rewriting some of the eligibility criteria, improving communication about the availability of grants to HIV-positive people – for instance in connection with counselling – and fast-tracking applications by people with HIV.

Treatment, support and care

A key component in combating HIV / AIDS is effective treatment strategies. Currently there are no effective strategies for treatment in the public sector. Debate has centred on the cost of drugs and the effectiveness of anti-retroviral drugs. COSATU resolutions demand that the public health system urgently develop effective treatment strategies, including obtaining cheaper medication; treatment for opportunistic diseases; treatment for STDs; use of anti-retroviral therapies including, but not restricted to, prevention of mother-to-child-transmission; and a proper infrastructure for counselling. Obviously, the use of anti-retrovirals would involve researching affordable options, which can cost well under R1000 a month.

Government already provides free health care for pregnant women and children under six. This has gone a long way in improving the health status of a vast majority of poor women and children. The general concern is that the existing public health programme for mothers and children does not cover expensive treatment such as treatment for HIV / AIDS. Some of the opportunistic diseases such as TB are covered. The commission should investigate the feasibility of extending the current mother and children programme to cover HIV /AIDS treatment.

It is also critical that government provide condoms on a broader basis. The current budget for condom provision suffices to provide around five condoms per adult South African a year. Yet many adults cannot afford to buy condoms from the private sector. Moreover, in remote rural areas they may not even be available for sale. It is clearly crucial that the government address the shortfall.

Compensation for Occupational Injuries and Diseases

Currently Compensation Legislation does not address HIV / AIDS as an occupational disease. HIV / AIDS is not listed in the Compensation for Occupational Injuries and Diseases Act (COIDA). This means there is no guidance for employers, workers and the Compensation Commissioner on how to deal with HIV / AIDS as an Occupational disease. In recognition of this problem, the Compensation Board has initiated a process to deal with this issue. In addition, a Code of Good Practice on Aspects of HIV / AIDS was introduced by the Department of Labour in terms of the Employment Equity Act. The underlying objective of the Code is proper management of HIV / AIDS in the employment context.

We suggest that the commission engage with the workmen's compensation commissioner, to look at how to deal with the challenge posed by HIV/ AIDS to the Occupational health safety and Compensation regimes, and make specific recommendations on this matter. (12)

Medical aid, life insurance and retirement annuity

Medical and life insurance schemes have generally discriminated against people with HIV. Discrimination takes the form of simple exclusion and/or high premiums that have the same effect. In essence, the companies are attempting to avoid the pooling of risk that justifies insurance in the first place. As a result, individuals must bear the full cost of treatment and disability – a factor that contributes to the loss of many years of life.

The Constitution and the Prevention of Unfair Discrimination and Promotion of Equality Act prohibit unfair discrimination. The Act goes further to impose an obligation on all sectors to adopt positive measures to end discrimination. But the Act does not specify discrimination against people with HIV. Action needs to be proposed to deal with schemes which are violating the Act.

In contrast, the Medical Schemes Act explicitly prohibits discrimination on the basis of HIV / AIDS status. It is imperative that a comprehensive study be conducted to ascertain the

extent to which medical schemes comply with the Act and what types of products they have developed for people with HIV.

Similarly it is important to ascertain the extent to which the retirement and life assurance industry has dealt with the issue of HIV / AIDS. Anecdotal evidence suggests widespread discrimination against people living with HIV / AIDS. For instance, life assurance companies routinely test potential clients for HIV. Because the information is kept confidential between the doctor and the company, it is practically impossible to know whether health status influenced the premiums. Legislative intervention in this area may be necessary to protect people with HIV from unfair and arbitrary discrimination.

In short, COSATU proposes that an audit and /or investigation be conducted in the medical aid, life assurance and retirement industries to ascertain compliance with the Act and the types of products offered to cover HIV / AIDS. Such an investigation should be geared towards formulating practical recommendations including the introduction of legislation to combat discriminatory practices.

3.6 Infrastructure and housing

The provision of free infrastructure and adequate housing form an essential component of an effective anti-poverty strategy. This section considers current developments in terms of tariff policy and the extension of infrastructure and housing. It then outlines some of threats to the provision of basic municipal services and adequate housing to the poor.

Structuring tariffs to ensure services for the poor

The Municipal Systems Bill requires every municipality to ensure basic municipal services free to the poor, either through subsidies or by providing a free minimum amount – the "lifeline tariff." The ANC Local Government Manifesto commits ANC-led local governments to the second option. In addition, the Departments of Water Affairs and Minerals and Energy have proposed a shift to a free lifeline tariff.

COSATU argreues that the best way to provide municipal services to the poor is through the free lifeline tariff, with rising costs per unit for consumption thereafter. This system has various advantages:

- It obviates means testing; the system is self-targeting, because households with enough resources to pay for services will use more than the minimum. In contrast, some towns have relied on "indigent policies," which

provide free services only to households earning under R800 a month. In most cases, because of the difficulty of conducting regular means tests, only a tiny fraction of poor households actually benefit.

- The rising cost per unit above the minimum ensures revenues to cross-subsidise the poor and encourages more prosperous households to conserve on municipal services.
- Where similar systems have been attempted for water supply, in Durban and Hermanus, the result has been increased government revenues with reduced consumption.

The system has two disadvantageslimitations: it does not benefit those who are not yet connected to the basic infrastructure; and in poor regions, especially in towns in the former homelands, the prosperous neighbourhoods may be too small to pay for even the minimum usage by the poor. That means that the system will only ensure services for all if the roll-out of basic infrastructure continues. It also requires continued national subsidies to towns in poor regions.

The commitment of key government departments and the ANC to the extension of infrastructure and to free lifeline tariffs is a major step forward toward ensuring a basic standard for municipal services for poor households. But various factors may make implementation difficult or impossible. The next section considers these issues.

The threats to provision for the poor

The main threat to provision of infrastructure and housing to the poor remains inadequate funding. Most poor households – essentially those in the lowest two income quintiles – cannot afford to pay the full cost of municipal services. They certainly cannot afford the cost of the initial provision of infrastructure. Moreover, their consumption levels may be initially so low that even if they could pay the full cost of their current usage, it would not cover installation costs in a reasonable period..

Taken together, budgets for transport and communication, water and housing declined in real terms by 12,5 per cent between 1996/7 and 1999/2000. That translates into a fall of almost a fifth per capita. In contrast, the latest MTEF proposes that in the coming three years, infrastructure provision should increase substantially per capita. But between R600 million and R1 billion of the annual increase reflects the shift of the cost of electrification fromEskom to the budget, paid for with new taxes on Eskom. Taking this into account, the effective real increase will be around 1 per cent above population growth.

If the budgets for infrastructure do not in fact increase, the risks are that services will be provided at a low level. That would limit the potential improvement in living standards. Moreover, it could mean that services would not suffice to support productive activity. Already, electrification programmes sometimes provide only enough current for lighting, but not enough for cooking or running equipment. That limits the hoped-for improvements in productivity, by reducing fuel collection and cooking time as well as laying a basis for home-based production.

Budget cuts have led to an over-optimistic approach to privatisation of services. These proposals hope to leverage private capital to provide infrastructure. The problem lies in the failure to take into account the reluctance of private companies to service the poor, who cannot pay enough to ensure a normal profit. Indeed, throughout the Third World, privatisation of services has led to improvements in services for the rich, but a decline for the poor. Even if the state provides a subsidy to encourage private providers to supply poor households, it pays the private partner to skimp on services.

Proposals for privatisation include the proposal that electricity production and distribution and telecommunications invite private competitors. Here, the risk is that, in order to compete, the state-owned entity will have to cut such unprofitable activities as extending the infrastructure network to the poor.

The proposals for electricity illustrate the problem. They propose permitting private competition in generating electricity, with direct sale to large-scale users – that is, industry. This is expected to drive down the cost of electricity to business, resulting in reduced cross-subsidisation and an increase of between 22 and 50 per cent in electricity tariffs for households. Moreover, it seems likely to reduce the funds available for electrification, unless government provides a subsidy from the budget. In effect, then, it reduces the revenues from electricity for the state, limiting the funds available for extending and maintaining services for the poor.

In addition to the problem of under-resourcing, institutional and policy factors may limit the effect of current commitments.

- Some communities or local governments may insist on means testing for providing free municipal services, despite the extremely poor track record of that approach.
- The lack of a national strategy to set standards for the free lifeline tariff may lead to regional discrepancies. If richer regions set higher standards, increased rural-urban migration may result.

- Agencies providing municipal and social services do not co-ordinate their activities particularly well. That aggravates the transport difficulties for the poor.
- The current housing policy often locates residential areas far from job opportunities and social and recreational facilities. This increases the cost of commuting, which is aggravated by substantial cuts in the transport budget and the privatisation of municipal transport. The result is not only a higher cost of living for the poor, but a further obstacle for poor people seeking jobs.

Some proposals

To ensure the continued extension of affordable services to the poor, in line with current political commitments, COSATU has called for:

- Adequate funding for housing and infrastructure, as promised by the MTEF, with stronger subsidies where necessary for poor towns and neighbourhoods.
- National guidelines laying out a commitment to free lifeline tariffs for the poor, with adequate levels of service to permit economic activity as well as a substantial improvement in living standards.
- Co-ordination of municipal services through Integrated Development Plans, as required by the Municipal Systems Bill. These plans should ensure the establishment of one-stop shops for government services, where possible.
- As agreed at the Presidential Job Summit, a review of the housing policy to make sure it services the poor by providing adequate shelter as near as possible to employment. Where residential areas are far from jobs, the state must continue to take responsibility for adequate, affordable transport. To achieve that end, government should review its policy on public transport.

Some fiscal implications

Decisive measures to address poverty will require substantial additional expenditure by the state, as well as a review of delivery mechanisms in local government and the parastatals. This would require a reversal of recent economic policies, which have seen a decline in *per capita* spending on the big social services, including welfare, as well as infrastructure. The main new item on the budget would be the basic income grant; but growth would be required in all the relevant functions. Still, simulation with models that take into account the impact on productivity demonstrate that the initial cost is soon offset by more rapid economic growth.

This section first considers the options for funding social security, explaining why COSATU supports an increase in budgetary assistance. It then assesses overall spending on the social wage, which has declined in real terms in the past three years. The third section estimates the requirements of the innovations proposed here, especially the basic income grant, National Health Insurance, increased support for people with HIV, and municipal infrastructure. Finally, we propose ways to fund these requirements that are fiscally and economically sustainable.

4.1 Mechanisms for funding social security

There are three major ways to fund social security:

0. Social assistance: wholly financed through taxes.
1. Social insurance: financed through compulsory contributions to a common fund by employees, employers and sometimes government. This effectively pools the risk across society as a whole.
2. Individual insurance: individuals buy insurance on a voluntary basis.

Unless government provides substantial subsidies to social insurance schemes, they will effectively tax only formal workers. In that case, we will be compelling the poor to pay for the destitute – hardly a solution able to eliminate poverty in the long run. Furthermore, the vast majority of South Africans simply cannot afford private insurance.

In short, given the vast income inequalities in South Africa, the bulk of social security must be funded through the budget. Because taxes are still, overall, progressive, tThis is the only way to ensure that the funding of social security has a progressive incidence.

4.2 Existing expenditure on the social wage

In assessing expenditure trends and needs, we need to take into account both inflation and population growth. Here, we use CPI to deflate expenditure, and set population growth at 2,3 per cent – the rate found in the 1996 census.

We here consider the social wage to consist of social grants, health care and municipal services and housing. All three components have shrunk in real terms over the past three years.

The latest MTEF proposes some growth in the next three years – but overall it will lag behind the expansion in the population. As a result, by 2003/4 it will still be lower in per capita terms than it was in 1996. Unfortunately, the MTBPS figures for

infrastructure do not correspond to those in the 2000 / 1 budget, ruling out a more detailed comparison.

Table 8. Expenditure on main social wage functions, 1996 / 7 to 2000 / 1

	Current R millions		**Change after inflation**	
Sector	**1996/7**	**1999/2000**	**expenditure**	**per capita**
Health	21,300	24,100	-9.3%	-15.3%
Welfare	16,100	20,900	4.2%	-2.7%
Infrastructure & economic services	18,800	20,600	-12.1%	-17.9%
of which:				
Transport communication	8,700	8,800	-18.9%	-24.2%
Water	2,000	2,300	-5.5%	-11.7%
Fuel/energy	600	400	-55.9%	-58.8%
Total budget	*187,700*	*224,500*	*-4.2%*	*-10.5%*
NB: CPI	*104.5*	*130.4*		

Source: Calculated from, Department of Finance, Budget Review 2000

Table 9. MTEF projections for expenditure on main social wage functions, 1999/2000 to 2003/4

	Current R billions		**Average annual change after inflation**	
	1999/2000	**2003/4**	**Total expenditure**	**Per capita**
Health	25	33	1.1%	-1.2%
Welfare	20	27	2.2%	-0.1%
Infrastructure	21	32	4.2%	1.9%
Infrastructure less estimated electrification costs	*21*	*31*	*3.1%*	*0.8%*
total social wage	66	91	2.1%	-0.2%

functions				
Expenditure after interest	167	233	2.0%	-0.3%

Source: Calculated from, Department of Finance, MTBPS, October 2000, using the MTBPS predictions for CPI.

4.3 Funding COSATU proposals

The main additional cost arising from our proposals arises from the basic income grant. The NHI proposal will increase expenditure through the budget, but will not expand spending on health. It merely shifts expenditure from the private sector to the budget. Strategies on HIV / AIDS will add costs for treatment and condoms.

Any effort to cost additions to comprehensive social security must take a dynamic view. To the extent these measures stimulate economic growth, it will generate more resources for the budget, reducing the burden on the economy.

We here first look at the cost of our proposals on the budget, and then consider strategies for funding them in the medium term.

4.3.1 Income transfers

Dr Claudia Haarmann (2000) has estimated the gross cost of the basic income grant modelled here, with full take up by all eligible individuals, at R40 billion. But the actual cost to the state will be reduced by: the actual take up, and the extent to which payments are recouped through the tax system. The implications for taxes are discussed below.

Low take up in the top two quintiles would reduce the total cost without affecting the extent of poverty relief. If none of the people in the fifth quintile and only half of those in the fourth claim the grant, costs would fall to R30 billion. It is likely that take up in the top two income quintiles will be low, since the proposed level of the grant is small from the standpoint of the high-income group. Moreover, the government can make it clear that the grant is primarily aimed at those living in poverty.

In addition to the basic income grant, COSATU proposes that other social grants and welfare services remain at least unchanged in real terms per capita. That means that in the short run, welfare spending must go up by 2,3 per

cent over the inflation rate. In the longer term, of course, the proposed structural change toward greater equality should obviate the need for welfare, leading to some decline.

4.3.2 Infrastructure and housing

Estimates in the Municipal Infrastructure Investment Framework (MIIF) suggest the need to invest R7 billion to R10 billion a year in order to extend decent, although still quite low level, municipal services to all South Africans.

Unfortunately, the budget does not distinguish between maintenance and extension of infrastructures, or indicate how far it will help us achieve the MIIF targets. We need an assessment of the implications for basic municipal services of

3. The MTBPS proposal to increase state spending on infrastructure, and
4. Trends in national subsidies to local government.

4.3.3 National Health Insurance

As noted above, the proposal for National Health Insurance should not lead to a net increase in health costs in the short run. It will, however, increase government spending on by the equivalent of private health expenditure. The equivalent of spending on medical aid schemes alone would increase the public health budget by R25 billion, with an equivalent rise in claims on the NHI. Thus, while the cost of health care to individuals would not increase, the health budget would more than double.

In addition, COSATU proposes that after the NHI is established, the per capita health budget should increase at least at the rate of inflation. That would require a 2,3 per cent increase. Additional costs related to HIV / AIDS are discussed below.

4.3.4 HIV / AIDS

COSATU's proposals for HIV / AIDS would require additional funding for treatment and condoms.

We here only consider anti-retroviral treatment. The cheapest anti-retroviral treatment consists of AZT with some additions; they are not as effective as the top-of-the-line combination, but will still prolong people's lives

and health substantially. In Brazil, which has provided low-end generic anti-retrovirals on a large scale, deaths are down by half, and the rate of infection has dropped.

The treatment costs around R500 to R850 a month. That is, it is not very far off from the old-age pension. It can be justified in terms of the enormous economic benefits of retaining productivity, skills and family breadwinners for longer periods.

If the infection rate is around 20 per cent of the total population, at R500 a month it would cost around R10 billion a year to give the cheapest anti-retroviral treatment to 20 per cent of those infected – which is probably the number with symptoms at any given time. This is probably not a high enough rate of treatment to limit the spread of infection, but would go far to prolonging lives until a better treatment is found.

In addition, to provide every South African adult with two condoms a week will cost around R2 billion, at R1 per condom. That sum should also cover distribution costs.

In short, just providing retrovirals and condoms on a near-adequate scale would cost approximately R12 billion. If not offset by other savings, that would increase the current public health budget by over 50 per cent. In fact, however, the combination of improved health for HIV positive people and reduced spread should lead to savings in treatments for opportunistic diseases, training and productivity. Furthermore, the entire cost of the proposed HIV treatment need not come entirely from the budget. In the short run, as a minimum, individuals should have access to pensions or provident funds to obtain treatment.

We need much more research to assess the probable net impact of the proposed measures on the budget. As an example, we here assume that the net cost will be R9 billion a year – probably an overestimate of the costs in the medium-term.

4.4 Sources of funding

COSATU proposes three sources of funding for improvements in the social wage:

5. Modest increases in progressive taxes, especially the personal income tax,
6. A modest rise in government borrowing, and

7. More efficient use of government expenditure, especially by finding better ways to fund public servants' pensions and reducing military expenditure.

4.4.1 Taxation

At the outset, it should be noted that despite the claims from some quarters, South Africa's tax rates are not high by international standards. Indeed, a careful comparison with similar countries shows that South Africa is actually under-taxed both in comparison to developed and developing countries. Furthermore, a tax-effort analysis point to the possibility of substantial increases in progressive taxes, notably the personal and corporate income tax.

In terms of taxation, COSATU proposes that the Basic Income Grant and the National Health Insurance be paid for through dedicated income taxes.

The health tax would not add to the cost of care to private individuals, although it would permit greater efficiency and cross-subsidisation within the health sector. It would raise tax rates substantially, but would not reduce average disposable income. In the long run, of course, by increasing efficiency, it should permit society as a whole to save on health costs.

For the basic income grant, we propose that the bulk of costs be reclaimed through a progressive surcharge on the income tax – a solidarity tax. This would leave only R15 billion to be met through other means. Under this proposal, while everyone would be eligible for the basic income grant, in the top quintile and for some people in the second quintile, taxes would increase by somewhat more than the amount received. The proportion financed through a net fiscal injection would ultimately be a political choice.

The following table models the impact of a tax averaging 17,5 per cent for the top two quintiles, assuming full take up by all quintiles. It shows the impact by quintile on net benefits from social grants as a whole as well as from the basic income grant.

Table 10. Impact of proposed solidarity tax on net benefits, by quintile, in millions of rand

Total annual income through	Net benefit from all social	Net benefit from basic

	solidarity tax	grants	incomebasic income grant
1. Quintile	20	16,920	10,070
2. Quintile	220	13,940	8,850
3. Quintile	330	11,050	7,660
4. Quintile	1,730	6,200	4,740
5. Quintile	13,920	-7,380	-8,210
Total	15,000	42,050	24,110

Source: Calculated from, Haarmann (2000) Social Assistance in South Africa: Its potential impact on poverty.

In this model, income taxes for the top quintile would rise by 9 per cent. This would mean an increase of 4 per cent in total taxes, which would rise from 25 per cent to 27 per cent of GDP. Tax effort studies by the Economic Policy Research Institute (EPRI) indicate that this is sustainable; COSATU can provide the background research on request.

The proposal from some quarters that a basic income grant be funded through an increase in the VAT is counter-productive. In its current form, the VAT is one of our most regressive taxes. On the one hand, it affects almost all wage goods, so that even the very poor pay VAT on most of their consumption. On the other hand, it does not apply to many kinds of savings, so that the rich effectively do not pay as high an overall rate. Funding the basic income grant through an increase in the VAT would thus fundamentally undermine its ability to relieve poverty. It would take with one hand what it gives with the other.

It seems likely that objections will be raised to any increase in tax rates. In this case, however, the link to a basic income grant should ensure that the benefits outweigh the costs.

To start with, there is a convincing moral argument that the wealthy should show practical solidarity with those who were formerly oppressed and economically marginalized. This aside, they and their businesses would

benefit directly from the greater social cohesion and stability created by a basic income grant.

Investment and economic activity in South Africa is not so much limited by high tax rates as by the instability created through poverty and crime. Given current inequality levels, a stable and secure economy can only be won through greater redistribution. The notion that this should be done by directly paying cash transfers to the people which does not require an expensive structure where the money does not reach the beneficiaries, seems in fact the reason why the basic income grant has been positively mentioned in the business press.

4.4.2 Reallocation of expenditure

Two areas of government expenditure now seem unnecessarily high: military spending and the funding of the GEPF. The first is a political choice. The second is more about how one ensures efficiency.

The GEPF is a defined-benefit fund – that is, employees' benefits are guaranteed. If the GEPF's investments do not return enough to cover retirement costs, they must be met out of the budget. The question is thus which is most beneficial for South Africa in the short run – to invest in the GEPF, or to meet a share of public servants' pensions from the budget. In the event, the evidence is that it would be more efficient to reduce the funding level of the GEPF and turn the funds to developmental uses.

The GEPF is currently 96-per-cent funded. The level of funding has risen extraordinarily quickly since 1996, when it was at 60 per cent. This indicates that the current rate of employer contribution – now at 15 per cent of salaries, or almost R10 billion a year – is too high.

In the light of this situation, a modest reduction in the level of funding could release substantial resources. In one scenario: COSATU proposes therefore that

8. the employer contribution could be reduced to 12 per cent of salaries. That will save a total of R1,5 billion a year; and
9. the funding level could be reduced by 2 per cent, or R3 billion a year, for the next three years, and the funds utilised for once-off investments in infrastructure and housing.

A more substantial reduction in the level of funding, towards a pay as you go system, would obviously release corresponding resources.

4.4.3 Borrowing

Finally, the government could increase the deficit target to, say, 5 per cent. That would release an additional R5 billon. Assessments of the impact of this approach depend largely on the forecasting model used.

Typically, business uses models that incorporate an assumption of crowding out – that is, the higher government spending inevitably reduces private investment, leading to economic stagnation. There is, however, no historical evidence of crowding out in South Africa. On the contrary, virtually all studies show a close positive correlation between government spending, especially on infrastructure, and private investment.

EPRI has developed a model that seeks to take into account the productivity-enhancing effects of poverty alleviation. In this model, increased government spending, if targeted effectively at reducing poverty, is associated with increased economic activity and investment. As a result, the initial increase in the deficit to GDP ratio reverses quite soon, as the economy grows more rapidly.

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Footnotes

1. Social Security, A worker's education guide, ILO pg 4
2. This section of the submission will follow separately.
3. Samson et al (2000) The Macro-economic Implications of Poverty-reducing Income Transfers.
4. Based on projections in the National Budget- considerably lower than the actual inflation level for these years. Thus e g the calculations for real growth/ decrease in pensions in 1999 and 2000 underestimate the effect of inflation in eroding the value of the SOAP.
5. Department of Labour, Task Team Report, 1996. “Unemployment and related coverage issues.”
6. According to the Task Team report 'active measures' generally include placement, labour market information, employment counselling, job search training and small business development functions. These measures are intended to rapidly redeploy labour, and increase skills. The ultimate aim is to match workers and employers or assist the unemployed to 're-enter' the labour market. 'Passive measures' on the other hand are generally seen to include employment benefits, family and maternity allowances, social welfare payments, pensions, wage subsidies and relocation allowances. These measures aim primarily to provide income to support the unemployed, reducing resulting poverty.
7. Task Team Report, p.86.
8. Social Security, A worker's education guide ILO pg 25
9. CSAE survey
10. Child Health Unit and Health Systems Trust in 1996
11. This section answers a question asked by one member of the committee during the public hearings.
12. The Committee also needs to investigate the compensation system of redress for workers who suffered permanent disability before 1977, including domestic workers and other workers who are not included. In 1997 the Parliamentary Portfolio on Labour mandated the Department of Labour to investigate this matter and report back within eighteen months.

- See more at: http://www.cosatu.org.za/show.php?ID=831#sthash.EtI9PpT4.dpuf