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RESEARCH REPORT 3

The Provision of Care by Non-Household Institutions

South Africa

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ACRONYMS

ABET	Adult Basic Education and Training
AIDS	Acquired immunodeficiency syndrome
ANC	African National Congress
ART	Anti retroviral therapy
BCEA	Basic Conditions of Employment Act
CDG	Care Dependency Grant
CSG	Child Support Grant
DG	Disability Grant
DLA	Department of Land Affairs
EAP	Employee Assistance Programme
EEA	Employment Equity Act
ECD	Early Childhood Development
EPWP	Expanded Public Works Programme
FCG	Foster Care Grant
GDP	Gross Domestic Product
HBC	Home-based care
HCBC	Home- and community-based care
HIV	Human immunodeficiency virus
NGO	Non-governmental organization
NPO	Non-profit organization
NSFAS	National Student Financial Aid Scheme
NSNP	National Schools Nutrition Programme
OECD	Organisation for Economic Cooperation and Development
OAP	Old Age Pension
OSD	Occupation-specific dispensation
OVC	Orphans and other vulnerable children
PLWHA	People living with HIV/ AIDS
SASSA	South African Social Security Agency
SEPPI	Socio Economic Study of the Persistence of Poverty and Inequality
SMG	State Maintenance Grant
SNA	System of National Accounts
TUS	Time Use Survey
UIF	Unemployment Insurance Fund
VCT	Voluntary counselling and testing
WO	Welfare organization

INTRODUCTION: RESEARCH REPORT THREE IN CONTEXT

The first report on the research in South Africa (Budlender and Lund 2007) gave an overview of the country, characteristics of poverty and inequality and the main policy changes over the time of transition. It gave socio-demographic trends and, in particular, characteristics of household composition, fertility and mortality. The second research report (Budlender 2007) used the 2000 Time Use Survey to estimate the value in time and money of unpaid care work, and used this information for comparisons with the value of paid care work, all paid work, GDP, and taxation.

This third research report focuses on the provision of care by non-household institutions, in particular by the state, the private sector, and the organized social sector. It uses this to assess the nature and dynamics of 'the care diamond', and to reflect on central concepts in welfare regime theory. It starts with an overview of social policy provision, and in particular the policy changes that happened in the transition from apartheid to democracy. Section Two gives a short summary of main findings of the analysis of the Time Use Survey (TUS) which covered household care work. Section Three then describes provision of money, services and in-kind benefits, by non-household institutions – the state, private sector, private formal welfare sector, and informal organisations. In line with the overall focus of the South African project, the focus is on care for children and for elderly people (and not on those with disabilities), and in this section we approach social provision targeted at and through three generations: children, working-age adults, and older people. The concluding segment of Section Three looks at the interaction between these different providers and programmes. The final Section Four of the paper, on 'the care diamond', attempts to draw some generalizations, identify paradoxes and contradictions, and raise questions for further discussion and analysis.

SECTION ONE - THE SOCIAL POLICY REGIME

GENERAL CHARACTER

It is difficult to classify South Africa according to conventional welfare regime analysis. Sitting at the south of the continent, the country is the economic giant in the region, comparatively well resourced and stable. The way in which apartheid policies were overlaid on to the existing racist colonial policies means that the resources were and still are very unevenly distributed. Economic and social policies were, for more than a century, driven by the ideological imperatives of racial separation and racially separated capitalist accumulation. Some social policies were imported from Great Britain and were used to bolster the stability and well being of the minority white population. Mostly, responsibility for social provision for the population that was not white – the African, coloured and Indian population in apartheid terms – were left to that racial population to deal with. This was especially the case for welfare for Africans. Significant forms of provision however, such as some employee benefits, and cash transfers for elderly people, were available to the whole population, and have become a part of indigenous social policy.

This paper seeks to understand the present regime of social provision by institutions outside the household as it impacts on paid and unpaid care. We will see that South Africa presents what may be a unique mixture of aspects of different welfare regimes. The attempts during the political transition in the 1990s to provide more inclusive and more racially equitable policies gave way to more emphasis on fee-paying and private provision such as had characterized the provision in the past, and were then faced also with the challenges presented by the HIV/ AIDS pandemic.

The paper takes the beginning of the twentieth century, under the Union government, as the beginning of the period of codified policies for public health provision, education, and some limited

worker-related social benefits. Regardless of the type of provision there is an overriding feature, that of racial discrimination. The overarching political goal was the preservation of white minority interests; this worked in harmony with the economic policies of racial capitalism. Social policies were subservient to these macro-political purposes, and were in fact not clearly articulated.

There was a flurry of activity in social policy in the 1940s, influenced by and taking advantage of opportunities offered by the Second World War to build a new 'national project'. The Gluckman Committee of Enquiry into health strongly recommended a universal primary health care system for all South Africans, regardless of race; a series of social security conferences and committees went far down the road to recommending a Beveridge-like welfare state system, building on the existing patchy system of family allowances and pensions for elderly people. These progressive and inclusive initiatives were lost in the political battle that resulted in the election to government of the Nationalist Party. This party spent the next decade concertedly passing legislation that would entrench white rule and privilege (van Niekerk 2003).

Some social policies were prescribed only for the white population. Some were for white, coloured and Indian people, but at different levels of provision. All services were biased towards urban areas, except that the Calvinist churches took a special interest in reaching white Afrikaans- speaking people in rural areas as well. Underpinning and justifying apartheid ideology was a conservative Christian Calvinism which rationalized white supremacy under the idea of sovereignty for separate groups, but with the white 'nation' or '*volk*' as dominant. Embedded within this, and at the heart of understanding the dynamics of care, was an ideal of family structure and family life, in which men were breadwinners, while women tended the hearth, kitchen and children, and in which there was a strong but narrow role for volunteerism, for 'helping one's own'. There was, however, extensive provision, within the church and within organised welfare (much of which itself took place under the umbrella of the church), to protect those individuals who had no families of their own to protect them.

Again, it is impossible to understand the particular nature of apartheid without appreciating how, when the Nationalist Party captured state power in 1948, it deliberately used the state apparatus as a vast employment project for its own supporters, building up a largely Afrikaans-speaking civil service. It also used the resources of the state to create a battery of social provision for the white population in general. This included education bursaries, subsidies to private welfare organizations, massive public works programmes for poor white people, and residential institutions with comprehensive facilities for dysfunctional white families. The state was used to change the life chances of working class white people. This history presents the opportunity to explore for a non-northern country a much-neglected aspect of Esping-Andersen's work, which is how the development of the welfare regime at the level of *providers* of welfare is a creator of social stratification.

For example a government may decide to change the shape of professional health providers in the public health sector, subsidizing the training and recruitment of many primary health care workers, rather than registered nurses with the four year degree training. Over time, this state support will mould class formation among the providers. A good example of this comes from the South Africa. Shula Marks, in *Divided Sisterhood*, showed how the nursing profession in South Africa was an exceptionally important avenue for upward class mobility for African women, and later for Afrikaner women, from the end of the nineteenth and beginning of the twentieth centuries (Marks, 1994). Esping-Andersen's and others' main emphasis, however, has been on the influence of welfare provision on social stratification with respect to recipients' access to and exclusion from provision.

Significant elements of apartheid policy were the enforced racial segregation of residential areas in the cities; the 'export' to the bantustans of some eight million of the black population, with the accompanying idea that those in the bantustans would largely bear responsibility for their own care needs; the introduction of education and training policies that would consign those not white to inferior or no opportunities for their personal skills development. These spatial borders were regulated, allowing into the 'white cities' those who had registered employment. Not least among these were the tens of thousands of domestic workers, mostly women, who managed to negotiate their way through the complex and hostile labour pass system, and left their own families to assume multiple care responsibilities in mostly white households – a significant form of care service provisioning through the market with the complicity of the state. On white farms, the female spouses of African agricultural labourers were typically employed as domestic workers, with the financial lives of their families totally dependent on their white employers.

A hallmark of the colonial then apartheid policies was the dispossession of land, the removal of millions of black South Africans from their land, and thus the removal of opportunity to make a living. The white minority of 13 percent of the population came to own or control 87 percent of the land. The challenge to land reform is enormous, as it is to employment creation in isolated ex-Bantustan areas in which markets were systematically underdeveloped. Land reform is proceeding very slowly. The Department of Land Affairs (DLA) has, as Walker (2003) points out, a high commitment to gender equity, but there have been weaknesses implementing the programme. More recently, also, there has been a shift in policy orientation within the DLA from the earlier gender mainstreaming approach, to viewing women as one of several 'vulnerable groups'.

In the apartheid era, social policies were residual and stratified, with the additional stratification feature of racial differentiation. The central government in Pretoria retained political control over the important sectors of health, education and welfare. Particularly in welfare services there was room for some variation in service provision across the racially segregated administrations. The provision of pensions and grants, however, was a measure set at national level. It was legislated by Pretoria, and had to be guaranteed by Pretoria even if implemented through the four provinces and ten bantustans. It was this feature of the apartheid era that laid the basis for the relatively extensive non-contributory provision of cash transfers. The difference in age eligibility, with women being eligible five years earlier than men, was introduced early on, and continued into the apartheid era and beyond.

Work-related social benefits fell under nationally determined labour legislation, and applied only to those in formal employment with a recognizable employer. The benefits were racially discriminatory in scope and level. African worker rights in terms of organising were severely restricted. At around the beginning of the 1970s organized labour started becoming the predominant force in the internal political movement against apartheid, with social wage issues such as pensions benefits being part of that struggle.

Towards the end of the 1980s policy work for 'the new South Africa' started in earnest. Those engaged had to move increasingly 'from protest to reconstruction', from how to get rid of the old to how to build the new. The guiding pattern for new policies came from the 1954 Freedom Charter, which identified aspirations for the new order, with a strong emphasis on free health, education, housing and welfare for all, and inclusive participation in policy development. It would be fair to say that, although women's voice and rights had high salience, gendered demands were largely subordinated to overall political demands for political rights. The different social sectors worked at different paces and with different purposes: health, already a politically powerful sector, drew early on substantial local and international technical expertise. This formed the basis on which the first post-apartheid health minister was able to tackle controversial issues such as primary health care, abortion, generic drugs, and community service that impact on care provision and women's health.

She was strikingly unable or unwilling, however, to tackle HIV/ AIDS policies. The welfare sector took more time over policy development, building consensus over the move to developmental social welfare. This slower process and lesser sense of urgency might itself be a gendered issue.

The new South African constitution now laid the template for all policies, including social policies. The 1997 Constitution states that there will be no discrimination on grounds of race, gender, marital status, ethnic origin, sexual orientation, age, disability, or culture. It includes a wide range of socio-economic rights - a healthy environment, access to land, education, health care services, sufficient food and water, social security, among others.

The policy trend on all social fronts was towards redressing racial inequities in provision, and towards inclusiveness. However while the policy rhetoric is towards inclusiveness, many obstacles have presented themselves. In the fifteen years since 1994, the leaders of the African National Congress (ANC) have, through the adoption of specific macro-economic policies, reneged on many of the commitments to responding rapidly to the level of poverty, inequality and unemployment.

This particular history means that South Africa is difficult to classify as 'a regime' and this will be one of the themes of the paper. We pose questions as to whether Esping- Andersen's welfare regime classification, and the many modifications of it that have subsequently been developed (such as Gough et al, 2004) can travel to 'the south' in general. Specifically, South Africa's history of colonized industrial development; the nature of the labour market and employment which was moulded to suit the needs of racialised capitalism; the shape of family life that preceded and then was moulded by colonialism and subsequently apartheid; the way in which relative to whites, black people got little provision, yet some social services, especially means tested cash transfers, penetrated deep into rural areas, suggests that South Africa may need to be flagged as a special case.

KEY COMPONENTS OF THE SOCIAL POLICY REGIME

There is variation between countries and regions in how 'social policy' is defined, and in how the sectoral terms are used. In the South African parliament and cabinet, the 'social cluster' is defined to include health, education, social development (which includes social welfare services and social assistance), and transport. In the South African budget, on the other hand, the following are listed under 'social services': health, education, social development, labour, arts-and-culture, and sports-and-recreation. In the Organisation for Economic Cooperation and Development (OECD) countries, social policy is more narrowly confined to health, education and welfare, though nd sometimes includes housing.

In this care project, we confine ourselves to those services that are most clearly related to care: health, education, and social welfare, the latter of which includes personal social services (including subsidies to institutional care), and social assistance in the form of cash transfers to individuals. Sometimes we include infrastructural provision, such as water and electricity, which clearly and directly affect care work.

Social spending over the years since 1994 showed a clear increase in the absolute amounts spent on health, education, and social welfare (of which the largest amount by far goes to social assistance grants), but with the amount spent on social assistance rising in proportion to that spent on the others. By 2007/08 the three main items of social spending constituted 13.2 percent of GDP, up from the 10 percent of 1997/08 ten years before (Budlender and Lund 2007: 12).

Social expenditure requires a state strong enough to raise revenue, and a tax base (or donors) wealthy enough to pay. Since 1994 the South African government has used its command of the fiscus as a redistributive tool. Using household income and expenditure data for 2005/06, the official statistical body claims that:

> The Gini coefficient based on disposable income (from work and social grants) for the whole country was 0.72. … If social grants and taxes were excluded, the Gini coefficient for the whole country would be 0.80 rather than 0.72, i.e. the reduction of inequality through redistributive policies reduces the Gini coefficient by 8 percentage points. (StatsSA 2008: 3)

The task of this section is to provide a broad summary of sectoral policies, as a backdrop to the more detailed analysis of care-related policies and provision that forms the bulk of Section Three.

1.2.1 Health

The Freedom Charter called for 'Free Health Care for All', and indeed even during the apartheid regime it was possible for all citizens to get free health care in the public health system, though given the dearth of services in rural areas, they were in fact expensive to access, because of transport costs. The new health policy – the White Paper and then the National Health Act – expressly committed government to health equity goals, where the health services would be an integral part of the national commitment to addressing poverty and inequality. The old mix of public and private provision has persisted, however, and while a few South Africans have access to very good private services, the majority endure an inadequate and shabby public service, despite some real improvements.

Public health expenditure increased from 1.8 percent of GDP in 1995 to 4.3 percent in 2005, and some of this was in response to the rising demands for health services caused by the rapidly increasing HIV/ AIDS rates. There is a large variation between provinces in the per capita amount spent on health, between for example the Western Cape's R812 and poorer Limpopo's R321. There is also inequitable spending between the private and public health sectors; in 2003/04 medical schemes spent R8,800 per beneficiary compared to the public sector's spending of R1,050 per person who was not health-insured (Chetty 2007: 18, 19).

In the public sphere, there is free primary health care for all, with specialized services for children under six years old and pregnant mothers; there has been significant expansion of facilities to rural areas; the district health system, meant to further the idea of integrated local-level services, has been introduced, with primary facilities for preventive and elementary curative care as first port of call, and upward referrals to tertiary facilities for more serious health problems. Abortion has been legalized; smoking has been strictly regulated; generic drugs have been introduced, giving more people access to more affordable medicines. Government policy on HIV/ AIDS has been a catastrophic confusion, and this will be discussed in more detail later.

In the private traditional healing and medicine sector, path-breaking work has been done in incorporating and regulating the work of traditional healers. These healers work with a knowledge base that is directly at odds with that of allopathic ('western') medicine; for certain illnesses, especially those with a psychological dimension, traditional healers may be more effective providing a cure. In the formal 'western' private sector, there have been moves to include formerly excluded branches such as chiropractors and homeopathic medicine. On the whole though, the private sector is dominated by western medical interests, intertwined with the global pharmaceutical and medical equipment and insurance industries. The large private health insurance industry covers decreasing numbers of people. Benefits have become unaffordable to private citizens, and fewer

people are in the types of formal employment that carry health service benefits (this theme will be dealt with in more detail later).

Ironically, under apartheid a large and very competent body of health professionals was developed. For black women, nursing was one of the earliest professions they could train for, and get formal secure employment. The bantustan governments then offered opportunities for career development. The last two decades have seen a marked increase in emigration of skilled health personnel. Major reasons cited for emigration are poor working conditions, higher salaries offered elsewhere, the impact of HIV/ AIDS on working conditions, and the high crime rate. At the same time other countries in southern Africa lose their skilled health professionals to South Africa. The global movements of care workers, and the resulting care gains and deficits, will be a focus of the fourth South African research report.

Increasing numbers of PLWHAs are now on anti-retroviral therapy (ART) through the private and public health services. In 2007, over 370,000 of the estimated 890,000 people who needed it were receiving ART, 78 percent of whom were receiving it through the public health services. This will have a number of care-related impacts. There will be fewer orphans and sick adults to be cared for (though some will need intermittent care while on treatment). Some adults and children who would otherwise have died will continue to be available to participate in caring. There will be decreased household expenditure on equipment for caring, but there may be additional expenditure on the cost of ART itself, for those procuring it privately. There will likely be a strong impact on the morale of health carers, and the people they care for get healthier, and have hope for the future. This is likely to be important as well in the motivation of the many home-based carers who are themselves PLWHAs. The focus on treatment through ART may, however, displace some of the policy attention that might have otherwise started being given to the care of those who are seriously ill.

Overall, South Africa's health policy picture is uneven – it contains much that is progressive, and much that is inclusive of women's health needs. Given the amount of money that has been spent, much too little has been achieved in retaining staff, promoting better working conditions, addressing HIV/ AIDS, and protecting the standards of health services. Also, policy documents are on the whole strikingly ungendered. There are very good economists working in health, but there is little awareness of the links between paid and unpaid health care work, or of gender and the labour market.

1.2.2 Education

There are similarities in trends in policy and provision between the health and the education sectors in the years since 1990. As in health, the education sector tackled the racialised institutional fragmentation, moving from the 18 racially separate departments to a unified national department, and nine provincial ones. As in health, education first promised 'free education for all', but then introduced policy components that have meant that inequalities have endured and even got worse. As in health, it has not been the shortage of resources that has been the problem – the amount of money that has been spent should easily have achieved more than has been achieved. There has been a real increase in spending per learner over the years since transition. Education spending as a percentage of GDP has shown a slight decrease, from 6.4 percent in 1997/98 to 5.5 percent in 2007/08.

The idea of fee-paying was introduced in the 1995 White Paper on Education and Training, and then institutionalized in the 1996 South African Schools Act, and the 1998 National Norms and Standards for School Funding. The Act specifies that no learner should be turned away from school because of inability to pay. In effect, however, already-privileged schools attracting elite children of all races have used fees to attract additional teachers, and better resources, while poorer (mostly

African) schools are unable to raise fees from parents, are located in communities where there is not much scope for fund-raising, and cannot attract good teachers. Children receiving the Child Support Grant are automatically exempted from paying fees. In very poor schools, almost all school children up to the age of 15 were thus supposed to be exempted – leaving little scope for collecting fees (Raab, 2008). In 2007, school fees were abolished in the lowest two quintiles of schools. Schools in the second best-off quintile are still very poor, and find it difficult to collect fees from parents (ibid.).

South Africa's relatively high enrolment figures at primary school level have persisted, for both girls and for boys. There is nine years of compulsory schooling, and no child is supposed to be excluded because they cannot pay (more on this later). The quality of education is very low, with South Africa being placed last on international tests of school performance. There is a low rate of labour absorption after school, with average age of first employment being late in the twenties, so that such knowledge and skills that were learned, are eroded.

While girls' attendance rates at school are high, girls are particularly vulnerable to gender-based abuse and violence while at school, with teachers abusing their positions of authority. There are also high rates of teenage pregnancy, with many school girls dropping out of school to have the baby, but then unusually, many also returning to continue their education after about the baby has been born..

Historically non-whites were excluded from most tertiary education (and this made nursing and teaching, through non-university colleges, attractive professions for women who were not white). Tertiary education has been deracialised and nominally open to all. However, excluding mechanisms make tertiary education the privilege of only a few. There are high fees, and the costs of universities increase at above inflation whereas the subsidy does not. A National Student Financial Aid Scheme (NSFAS) was established in 1996, based on the Tertiary Education Fund of South Africa which operated during the apartheid era. In 2005 NSFAS awarded loans for tertiary education amounting to R1.2 billion, to 120 000 students, of whom just over half were women, and 90 percent were African (NSFAS website). However, in order to target available resources, NSFAS excludes middle class children, who may yet find the costs of education beyond their reach.

In the 1980s there was an active lobby for the provision of facilities for early childhood education. ECD and ABET (Adult Basic Education and Training) were the Cinderellas within the education sector, and they needed a strong lobby from outside government, in this case NGO service providers. The policy debates were along the expected lines of 'width versus depth': Should the focus be on a more or less adequate level of care for many children, cared for by a large cadre of women with little formal training? Or should the focus be on using the ECD field to train fewer women at a much higher level of skills, with the emphasis on proper preparation of children for school readiness. The sector was divided on this issue, but nevertheless succeeded in getting ECD on the national policy agenda. This was supported when Nelson Mandela announced his "First Call for Children' almost immediately after he became President. After a promising start, ECD got caught between the institutional cracks of education, health and welfare, and has only recently been re-claimed as an important component of overall development programmes. Data will be given on the extent of service provision later in this report, as will the government's programme of employment creation for (mostly) women, within the ECD field.

Overall, the lack of progress in the quality of education shows remarkable path dependency with the apartheid past, with 'deep continuities' between the past and present (Chisholm, 2005; Fiske and Ladd, 2004). Learners are not being appropriately equipped for the labour market, and for the fact that increasing numbers of them will have to make their own work, rather than expect to find a ready-made job.

1.2.3 Welfare services

In the past, the welfare sector had two categories, which were termed social security, and social services or welfare services. In South Africa, as distinct from other countries, the welfare services were broadly defined as 'what social workers do'. Services were delivered through partnerships between the state and private welfare organizations (WOs), now more often called non-profit organisations (NPOs), working in a range of fields of service: child and family care, the elderly, physical and mental disability, substance abuse, rehabilitation of offenders. Within social work training there have been specialisations such as psychiatric, youth, medical and school social work.

The state provided some limited direct services, such as the removal from their families of children being neglected and abused, institutions for children and mentally ill people, and emergency relief. The subsidies to private NPOs were used to bias welfare allocations towards white welfare, in urban areas, and for white elderly people. There were few NPOs in rural bantustan areas. In both urban and rural areas there were, however, informal associations that provided welfare services.

In the transition to democracy, and starting in the late 1980s, organisations in the welfare sector started advocating for a shift towards what was first called 'developmental social welfare', and now more commonly called 'social development'. This marked a significant shift in conceptual orientation away from curative care to a more preventive, developmental and community-based approach that encourages self-reliance and independence. The vision is worthy, and the government has continued to provide financial support to a more inclusive range of NPOs, and made the process of regulation easier. The rhetoric of 'community care', however, obscures the fact that funds are cut back on the very services (such as institutional care for elderly and for those with psychiatric problems) which provided much-needed support for those who cannot live independently and relieve the burden on the (largely female) household members who must otherwise provide or buy in care.

South Africa has a relatively small body of social workers, with about 12,000 being registered, about nine in ten of whom are women. The profession itself is responsible for resisting a broader based training for multiple types of workers, some of whom could assist directly with building modest community-based systems for support to carers. Social work salaries are low, but are much higher in the public than the private welfare sector. Social workers move to government where arguably many are less effective than they would have been in non-government service; many of the brightest go to other careers in the corporate and philanthropic world.

1.2.4 Social security and social assistance

South Africa has a mixture of both private and public social security and social assistance measures. These will be a main theme of Section Three and are summarized here.

People with formal employment must make contributions to a core set of social security funds. Unemployment insurance, which includes maternity benefits, is funded through contributions from workers and employers, and has been expanded to include domestic workers and agricultural workers. Self-employed people who can afford it can buy private work-related insurance which covers interruption to income. A national health insurance scheme has been proposed for well over a decade, but has still not been introduced by government.

There is a state fund for the compensation of work-related injury and death. Improved legislation in the early 1990s led to a more rational and fair system, but it covers progressively fewer workers (as

increasing numbers of workers are contractualised and/or casualized). With regard to savings for retirement, formal workers may contribute to a pension or provident fund. The self-employed who can afford it can access the private insurance industry, with schemes available that link health insurance and retirement savings.

The non-contributory social assistance programme reaches about one quarter of all South Africans directly, and indirectly benefits many millions of others in their households. These means tested benefits are targeted to children, people with disabilities, and elderly people, and are largely unconditional grants. There is also state provision for disaster relief.

As noted by many, including the committee ('the Taylor Committee') that was set up to investigate a comprehensive system (Department of Social Development 2002 these schemes taken together are substantial in size and scope, but still leave many categories of people both poor and uncovered.

1.2.5 Other care-related social policy components

Most care of individuals takes places in people's private homes, and it makes a great deal of difference to the ability to care, and to the costs of care, as to whether private homes have access to decent shelter, water, sanitation, fuel and electricity, and affordable transport (to service nodes and markets). Across all of these areas, the pattern is similar: the apartheid era was marked by a steep inequality of provision, with residential areas for whites being overprovided, and those for others, and particularly for the African population, having limited services.

The years since 1994 have seen substantial new provision. While income poverty has not decreased, many more poor people now have access to basic services. Local government plays a key role in this provision, more so than in regard to the other major programmes such as health and social services that will be covered in Section Three. There is much variation between municipalities in terms of their resources, and in terms of whether they have introduced and implemented pro-poor infrastructural and service provision policies. Outside of the main metropolitan areas, the majority of municipalities are poor, with many in debt. Infrastructural services are a municipal, not provincial, responsibility, and with no or little additional support from national level, poor municipalities do not have the local revenue base to raise funds to provide better services to poor citizens. These decisions have a direct impact on the well being of the poor.

1.2.6 Care-related personnel

Those providing care are distributed over a range of occupations and occupational statuses. The professional tier is well-defined and well-regulated. In 'the helping professions' in South Africa – in health, education and welfare – women outnumber men. The professionals are in both public and private sectors (and the dynamic movements between public and private are dealt with later in this report, as well as in the RR4. The care work of the professionals is supplemented by growing numbers of para-professionals, and also by the work of volunteers, both paid and unpaid.

Some general trends in care-related provision can be noted. First, there is a large public service in South Africa (government is the biggest single employer). Second, jobs in this sector are relatively secure, with good benefits, and the public sector is an extremely important source of security and indeed independence for many professional women such as teachers, nurses, social workers, and related care workers. Third, public sector employees are well organized, and in 2007 showed their ability to paralyse the country's schools and health services through a strike. This led to an Occupation Specific Dispensation (OSD) for teachers and social workers, that will lead to much improved pay levels.

Fourth, during the late 1980s and the 1990s, and as part of the progressive primary health care movement, some of the care professionals themselves undertook to move towards a more accessible, community-based mode of operating, which would have direct implications for care work. This was perhaps specially pronounced in the move to Community Based Rehabilitation Work, involving physio-, occupational- and speech-therapists attempting to expand their work to rural areas and poor urban areas.

Fifth, and associated HIV/ AIDS related needs for more care work, there are renewed calls for auxiliary workers and volunteer work. This work, paid and unpaid, is overwhelmingly done by poorer women.

A brief visit to dynamics within the social work profession illustrates some of the public/ private trends in provision. Social workers are employed in government, in industry, or in the NPO sector, with very few in private self-employed practice. Government subsidises social workers in NPOs, but the latter get very much lower salaries than those in government service. At the same time, the treasury acknowledged that in 2005/06, about 60 percent of the money allocated to social welfare services in the provinces went to NPOs, but these NPOs were running more than 90 percent of welfare facilities, and seeing more than 60 percent of welfare clients (PBER 2005/06: Chapter 6). Furthermore, many of the services being rendered by the NPOs were statutory, that is, they were legally mandated processes for the protection of people who were in fact in the care of the state. So here we see lower paid women workers, doing care work in the private sector, themselves also galvanizing a great deal of unpaid voluntary work from mostly poor women, and doing work that is fundamentally the state's work to do. A large part of the work of the managers of the NPOs goes into additional fund-raising, rather than practising their professional skills. While there has been some recovery of capital spending on welfare recently (PBER 2005/06: 62), there are simply not enough welfare facilities, and those that exist are highly unequally distributed.

Social work has now been declared a scarce skill, and pay levels will be improved. Government is developing a recruitment strategy to encourage more students to take up social work, through more scholarships for professional study, and a retention strategy to stem the numbers who leave clinical practice, and who emigrate. The social work profession itself is not active in articulating a gendered analysis of the links between unpaid care work, and their own care work; what gets volubly expressed is how all the work being done on getting grants for women, children and the elderly detracts from their own ability to practise their profession. In her recent textbook for social workers, Leila Patel (2005) identifies a range of roles for social workers – including advocacy, brokering, mediating, and collecting evidence - that could help them bridge the distance between their clients' need for care, and need for cash.

1.3 ANALYTICAL THREADS

The 1995 South African Constitution defined for the first time rights and entitlements for all South Africans. The basic rights were accorded, as well as an array of social or socio-economic rights. Children have access to a specific array of rights as well.

South Africa is a capitalist society, and very few people make independent livings from the land. Most people thus have to have a cash income. Market-related work gives some people access to cash. Many who work do not earn enough to do more than simply survive – certainly not enough to accumulate assets sustainably and securely. About two fifths of the population is not recognisably employed, and earns no or little and intermittent cash income. The size of the informal sector, and the numbers of people working informally, is relatively small, most likely directly due to the legal constraints placed on Africans during the apartheid era to make their own work off the land, while

at the same time having own land confiscated, or being resettled away from their own land. By the time deregulation of the over-regulated business sector took place (in about 1990) the formal sector was already large. As Imraan Valodia suggests, the informal economy may be so small *because* the formal is so large (Valodia, personal communication). Social assistance grants give about one quarter of the population access to some cash; the amount is not enough to get by on for most beneficiaries. Families, sometimes with complex and and non-nuclear structures, help support those who do not earn an income or receive a grant.

It is hard to forge a use for Esping-Andersen's idea of 'decommodification', meaning the lack of individual dependence on the market (Jensen 2008: 157), in this context. Perhaps decommodification could only have resonated so strongly as a concept in a post-industrial societies, where the idea and practicality of the welfare state is taken for granted, so that it is reasonable even to posit, as did Esping-Andersen and others since, that people could have an existence independent of the market, or choose to be emancipated from the market.

A larger problem is that the the concepts of 'the market' and of work and employment, from Marshall through Titmuss and on to Esping-Andersen and those since, are grounded in a conception of the formal labour market, where people 'get employment' (rather than make work) with a recognisable employer, and the employment relationship is covered by a contract, and that contracts binds the employer and the workers to rights and responsibilities, and part of the employers' responsibility is to the social wage. The worker's family – spouse and children – are eligible for a large part of the social benefits, and this covers parts of care work as well. This template is not applicable to employment conditions for most workers in most countries of 'the south'.

The concept of 'defamilization' is likewise awkward, if it is taken to mean the ability of individuals to be independent of family, and to mean that women and men can choose between market work and household work (as in Orloff 1993). Just as 'decommodification' rests on a certain interpretation of the metaphor of the market, so it seems that 'defamilization' assumes a move away from an assumed family form, that is, a modern nuclear family form. Juliana Martinez-Franzoni has attempted to integrate more complex family forms in her analysis of defamilialisation in Latin America (Martinez-Franzoni 2007: 41). South Africa is an extreme example of a society with fractured families, households in which structures are complex, fluid, with wide boundaries and definitions as to what constitutes 'my family', 'my brother', and 'my aunt'. A shared family name, or clan name, carries recognition of a person with the same name as 'family'. This might determine in really important ways who can be counted on as carers, as well as who will be counted as or assumed to be carers.

A particularly valuable theoretical contribution of Esping-Andersen was his insight that the process of providing social benefits itself is a constitutive process of social stratification. The obvious way in which it does this is that welfare interventions may have redistributive outcomes, and mould class formation. The less obvious way, and one which we would like to integrate into the South Africa analysis, is that the state makes commitments as a provider of welfare. It provides directly itself through the employment for example of nurses and social workers, and indirectly through its regulation of the private providers. Price-setting for the caring professionals then itself is a mechanism for constituting social classes. Given that most of these professionals are women this is a site where the state intersects powerfully with gender and class.

SECTION TWO – THE SIGNIFICANCE OF WITHIN HOUSEHOLD UNPAID CARE TO TOTAL CARE PROVISIONING – A REPRISE

The second research report used data from the 2000 South African Time Use Survey (TUS) to estimate the significance of unpaid care work, relative to paid work, paid care work, and relative to macro-measures such as the GDP, the size of personal and general taxation and other variables (Budlender 2007). The focus of this third report is on the non-household pillars of care provision, but we summarise here the major findings from the TUS as a reminder both of the importance of this household care, and also so that we can figure it into the discussion about the interaction between different forms of provision.

There are three System of National Accounts (SNA) related categories in the TUS: first, activities that fall within the SNA production boundary ('SNA' in the table); second, those within the general production boundary, but outside the SNA production boundary, that is, unpaid care work ('ExtSNA'); and third, non-productive activities ('Non-prod'). The first section of the table shows the *mean population time* when averaged across the whole population, and uses the 24-hour minute. The second section, the *participation rate*, shows the percentage of the whole population – men and women – who actually did each these three categories of activities. Then the third section, *mean actor time*, indicates the amount of time in minutes spent by those who actually did these activities. The age group covered is 15 to 64 years.

Table 1
Mean minutes per day by SNA-related category and sex, 24-hour minute

With regard to SNA work, Table 1 shows that men are more likely (56 percent) than women (44 percent) to participate in SNA work. Men also spend much longer than women on SNA work – a mean time of 234 and 143 minutes respectively. Conversely, with regard to unpaid care work, the 'ExtSNA' column shows that women are much more likely than men to participate in unpaid care work, 95 percent compared to 73 percent; also, women spend far longer – 246 minutes per day - on this unpaid care work, than men, who spend 89 minutes on it. The mean actor time column shows that, of those who do participate, women spend fully twice as long as men at unpaid care work, 259 and 123 minutes respectively. If both types of work – SNA and extended SNA – are added together, women tend to spend more time working than men.

Three categories of work make up unpaid care work, that is, household maintenance ('housework' in the table), care of persons in the household ('person care') and community services and help to other households ('comm care'). Table 2 shows the mean amount of time, in minutes per day, spent by men and by women on each of these categories.

Table 2
Mean minutes spent per day by categories of unpaid care work and sex

The most striking thing about Table 2 is that most people do not spend time on person care – 93 percent of men, and 65 percent of women. Household maintenance accounts for by far the largest amount of time spent on unpaid care work; and women who do such work (mean actor time) spend about twice the amount of time as do men on both household maintenance and person care (241 and 137 minutes for women compared to men's 123 and 74 minutes). All the above was expected. Men spend more time than women on community care, both in terms of mean population time (7 percent compared to 4 percent) and in terms of mean actor time (176 minutes compared to women's 139 minutes). It should be remembered that 'community care' is broadly defined to include, for example, attendance at community meetings.

The second research report (Budlender 2007) suggested that there was less variability for men compared to women in respect of unpaid care work – men appeared to do a fairly consistently low amount of unpaid care work, whereas women showed much higher variability and thus inequality in

contribution. What are the variables that may influence these gender differences? Table 3 confirms the relative lack of variability in time spent by men compared to women.

Table 3
Percentage of population time spent by men and women on unpaid care work by economic activity status, income, and household composition

Looking at economic activity status, both men and women who are unemployed spend more time on unpaid care work than those who are employed or not economically active, and the 24 percent for women is particularly striking. This theme will be returned later. Personal income levels make very little difference to the time spent by women or men on unpaid care work. Women with higher household incomes spend somewhat less time – 17 percent of the time of those with household incomes less than R400 per month compared to 13 percent where household income is over R1800 month. Presumably, the better-off can buy in care. Of the three variables chosen for comparison here, women in nearly all cases spend between two and a half to over three times more of their time on unpaid care work than men. It is only in household composition that the difference between men and women in the percentage of time spent on unpaid care work is closer to a multiple of two than of three, for men who live in an adult-only household (6 percent), and men who live in a household that contains adults and an older person (7 percent) compared to women's 12 percent and 15 percent respectively.

The TUS survey data was then used to compare the value of unpaid care work with a number of macro measures, in order to give an idea of the size of the care economy relative to other parts of the economy. Using data from the 2000 LFS, Budlender's calculations drew on median earnings of all employed people (employees, self-employed and own account), and applied the average earnings approach and the generalist approach. Here we present the comparative findings relative first to the GDP, and second to government spending on care-related personnel. (Full details of methods used and the theory behind them, are in Budlender 2007: 29 and following.)

First, unpaid care work as a whole was worth 30.4 percent (R269.7 billion) of the total GDP, when the sex-disaggregated median wage of all employees was used, and 10.9 percent (R96.7 billion) using the median wage of domestic workers. It should be noted that there was no minimum wage for domestic workers in 2000, and they are historically a very low paid group of mostly women. The above estimates were for unpaid care work as a whole. Using the narrower category of person care, this form of unpaid care work contributed between 1.4 percent and 3.7 percent of the GDP. For both comparisons the contribution of women is larger than that of men, even though each hour of women's work is accorded a lower value than an hour of men's work when using the median wage of all employees.

Second, in estimating the comparative value of paid and unpaid care work, Budlender compared the estimations of the value of unpaid care work with data on government expenditure on care-related personnel (in health, education and welfare). The value of unpaid care work as a whole was more than four times the amount of government expenditure on care personnel. Using the narrow category of person care, still unpaid care work was valued at half of the value of government social services.

In sum, then, the household provision of unpaid care work is significant in size; is done more by women than by men; women's participation is more variable than that for men, but unemployed women are more likely than employed and not economically active women, and than men as a whole, to do unpaid care work. This unpaid household- based care work has been relatively invisible and uncounted. A theme of this and other South African research reports is that the HIV/

AIDS epidemic requires us to make this work more visible if the gains women have already made are to be protected.

SECTION THREE: NON-HOUSEHOLD INSTITUTIONS PRODUCING THE WELFARE/ CARE MIX

This section covers the non-household institutions – state, market, formal and informal non-governmental agencies – involved in providing care. It covers major policies and provisions, and trends in provision since 1994; eligibility and implementation; and what is known about the impacts on care work, for beneficiaries and for providers. The paper describes the dynamics of the public/ private mix of provision. It also considers new pressures on providers and beneficiaries resulting from HIV/ AIDS.

In line with the analysis of the TUS data in the second research report (Budlender 2007), this section is structured, and the material approached, more or less through a three-generation lens: the children, the working-age generation (and parents), and older people (and grandparents). The picture is complicated by AIDS – children are cared for, but are also carers. Likewise, elderly people have caring needs, but for decades have been required to be carers as well, and now more so with the presence of AIDS. Adults of working age are most seriously affected by AIDS, and have increased needs for care.

This section brings forward some of the main characteristics of South African society described in the first research report (Budlender and Lund 2007): the high levels of largely racially-determined poverty and inequality; declining fertility but rising morbidity and mortality rates; the relatively weak relationship between fertility and marriage. The society has complex household composition, where only one third of households fit the 'nuclear family' model of two generations of parents and children; nearly one half (46 percent) of households have no adult married people in them (adults being defined as those over 18, and 'married' includes those cohabiting but not formally married (Budlender's calculations using General Household Survey of 2006); and at least one fifth of households comprise three generations. Of major importance also are the very high rates of unemployment and underemployment.

3.1 MONETARY AND SOCIAL SECURITY BENEFITS

South Africa has a relatively extensive system of contributory social security and non-contributory social assistance benefits. The system was inherited from and modelled on the British system of provision, and then parts of it adapted and moulded by the apartheid government. Contributory benefits (for example health coverage, insurance against work-related injuries and death, and maternity benefits) were attached to formal employment, and favoured those earning higher incomes. Non-contributory pensions for elderly white and coloured people were introduced in 1928, and later extended to the Indian and African population as well. In April 2008 they were being received by 12.4 million people, or about one quarter of the population. This spending is estimated to constitute 4.6 percent of GDP in 2008/09 – a significant commitment from the state. The evidence for links between these cash transfers and care is dealt with under each type of transfer, and then synthesized in the final section.

The levels of benefits, and the procedures followed, were racially discriminatory (for a summary of the situation at 1990, see Lund 1993). Schemes came to include pensions for elderly people, grants for those with disabilities, and a state maintenance grant for women and their children who could not support themselves. Anticipating the political change that was to come, the apartheid

government equalized the pensions and grants by 1993, the year before the democratic elections. Since then, the main reform has been the phasing out of the State Maintenance Grant (SMG), and the introduction of the Child Support Grant (CSG). In the field of contributory benefits, changes in the labour market, and changes in the insurance industry associated with the spread of AIDS, mean that fewer people get work-related insurance and other benefits.

Table 4 shows the numbers of social grants beneficiaries over the years 1997 to 2007 for the main types of grants. In this section we focus on the CSG and the Foster Care Grant (FCG), for children, and the Old Age Pension (OAP) for elderly people.

Table 4:
Social grants beneficiary numbers in 1997, 2002 and 2007, and maximum value of grants, 2007, in rand/ month

The table shows the large increase in numbers overall, with most of the increase in numbers since 2007 taken up by the CSG (awarded at a much lower amount than the other main grants – R200 compared to R870 per month in 2007). Also reflected in the table is the phasing out of the SMG which happened between 1998 and 2001, and which will be discussed later. The table shows the large increase in the Care Dependency Grant (CDG), paid to adult caregivers of severely impaired children, and shows also the doubling of numbers of adult recipients of the Disability Grant (DG). Disability is not covered in this paper, except tangentially, but it should be noted how vital these grants are in supporting people with disabilities and their caregivers (Swartz and Schneider 2006; Johannsmeier 2007). At least part of the increase in both these grants reflects the fact that they are sometimes awarded to those with AIDS.

Finally, the OAP for elderly people shows a steady upward increase in numbers. Age of eligibility is 60 for women and 65 for men. When the age is equalized downwards (as announced by government in March 2008) so that men also receive it at 60, there will be a slightly larger than usual increase in OAP numbers.

The table indicates some substantial shifts. Historically, by far the largest share of the social grants budget went to elderly people, followed by those with disabilities, and a very small portion went to child and family care. Now, the CSG has meant first a budgetary swing towards children, through the younger women who are their caregivers. The CSG was introduced in 1998. This cash transfer replaced the old State Maintenance Grant (SMG), which was being awarded to about 400 000 mainly coloured and Indian women and children, at a much higher rate. There was widespread controversy, especially in the welfare sector and within human rights advocacy groups, because of the loss of the SMG, as over the lack of consultation in the policy development process. Nevertheless, within ten years the CSG was reaching ten million mainly African children, in both rural and urban areas. The Constitution had re-written the map of how state resources had to be allocated in the new South Africa, and the policy was passed just as the damaging conservative macro-economic policy was taking hold. An important outcome has been that spending on grants now goes to more younger women, the primary care givers of the young CSG beneficiaries.

A mainstay of the provision of welfare in South Africa, in the apartheid era and since the transition to democracy, has been the partnership between the state and non-profit private welfare organisations, or NPOs. This partnership is structured around the provision of a subsidy to registered organisations. Under apartheid this subsidy was used to drive racially separated services, and procedures for registration were cumbersome. Since 1994, registration has been made easier, and a much more varied array of organisations get support, although registration certainly does not guarantee funding.

Table 5:
Numbers of non-profit organisations in care-related categories on the government data-base in the provinces of Gauteng, KwaZulu-Natal and Limpopo, 2007

Table 5 presents figures for 2007 for three provinces, to show patterns of registered NPOs in three different provinces. Gauteng, which contains the Johannesburg industrial complex, has relatively low poverty rates and is almost entirely urban. KwaZulu-Natal is the most populous province, containing about one fifth of the population, is about equally urban and rural, and has a high incidence of deprivation. Limpopo is small, very rural, and very poor. From the data, categories were selected that are most likely to involve care activities: social services (mostly the more traditional and formal WOs; economic, social and community development services, which include community and neighbourhood associations, large numbers of whom are likely to be doing care-related activities; HIV/ AIDS; and religious congregations and associations – again, to qualify for registration, they must have listed welfare/ care activities in their motivation. Excluded, and put under the residual category 'other' in the table, were primary and secondary school facilities (though some of these might have been for school aftercare); sports; recreation clubs; and many others that could be doing care activities.

The first thing to note is simply the extent to which there is a procedure for registering extensive numbers of organisations. The table shows the difference between the provinces in terms of the numbers of organisations receiving support, which reflects the higher levels of organization in for example the province of Gauteng, with greater ability to tackle the registration procedures, and perhaps also that organisations that are national are likely to have their head offices there. The social services form the largest single category receiving support, in terms of numbers of organisations reached. In the early 1990s, they would have completely dominated the picture; the language of 'economic, social and community development' was not then in South Africa; and there would have been very little organizing around HIV/ AIDS, at that early stage in the epidemic.

The table does not show how many of these registered actually received support from government, or from other sources. In one of the three provinces shown, KwaZulu-Natal, in 2007/08 the budget reflects R313 million was allocated by government to NPOs, projected to rise to R600 million by 2010/11. The child care and protection category was by far the largest in terms of support received.

3.1.1 **Cash to facilitate care of children**

Monetary and social security benefits targeted at support for children include state provision, private parental provision, and private organizational provision. (Services, as opposed to cash support, will be dealt with later.)

3.1.1.1 State provision

Three grants focus on the care of children: the CSG, FCG, and CDG, and we deal with the first two of these. The SMG had been payable to women, in their capacity as partner and as mothers, when they had been widowed, abandoned, or their partner/ the father had been committed to state institutional care and was unable to earn an income. It was phased out between 1998 and 2001 and replaced by the CSG.

Child Support Grant
The CSG was introduced in 1998 as a *poverty-oriented* policy measure, designed to reach children in very poor households. It is means tested in respect of income, and payable to the primary care giver (not necessarily the biological mother or father) of young children. Eligibility was initially for children up to their seventh year; since then this has been extended to children up to their fifteenth

birthday (due to be achieved in January 2009). Introduced at an amount of R100 per child per month, and had risen to R230 per month at the end of 2008. A cash amount is paid monthly, via banks, post offices and most commonly through a mobile grant delivery system for which South Africa has become very well known.

With regard to coverage, by 2008 the grant reached eight million children. The vast majority of applicants are women, the majority of whom are the biological mothers, the rest being largely grandmothers or other older relatives. Increasing numbers of fathers have recently being applying. Different modeling produces somewhat different estimates, and the ongoing extension of the age of eligibility makes assessment difficult, but it appears that well over 80 percent of eligible children are getting the grant. This is a good performance in delivery, but there are still substantial administrative and bureaucratic hurdles, the means test levels have not been changed over time to reflect inflation (though the finance minister undertook in his 2008 budget speech that it would be changed), so more applicants are excluded. There are isolated pockets of the country where the grant seems not to penetrate at all. Other critical gaps in coverage are that children who are not in the care of an adult cannot access it, and two vulnerable groups of children who are thereby excluded are children in child-headed households, and children who live on the streets.

Early studies of this new form of provision concentrated on barriers to getting the grant, in particular the difficulties of getting the requisite identity cards; the costliness of applying (including the means testing process); the gendered vulnerability of women applicants in a largely male governance apparatus. Increasingly, as the administrative system settles down, studies are turning to assessment of impact. The CSG is well targeted to rural areas, and to those in poverty (Case et al 2005). Studies show the grant acting as a small but useful supplement to the household budget. With regard to impacts, grant recipients stay in school for longer (Case and Ardington forthcoming); one study in KwaZulu-Natal finds that it has beneficial effects on children's nutritional status (measured in height-for-age) (Aguerro et al 2005). Both of these outcomes should contribute to longer term improvements in the life chances of children.

With regard to the impact on work and care, the grant amount is very small, and the grant has been introduced only recently. It would thus be difficult to find measurable effects on paid work, either in terms of the caregiver using the grant to seek for work, or to hire someone else to care for the child while she seeks work. Aguerro et al (2005) cautiously estimate that the CSG will increase the life-time earnings of children receiving the CSG, after they have stopped receiving the CSG, because of their enhanced ability to find work which should be a result of their increased school attendance.

Foster Care Grant

Most industrialised countries have strictly regulated policies about the protection of children who are deemed to be in need of care through the death of a parent, or through neglect or outright abandonment. Typically, countries have two different processes. First, a policy of foster care provides for the immediate and notionally short term placing of children in protection of a suitable adult(s), and the foster parent(s) are given some of the rights of a biological parent. Second, a policy of adoption enables children to become the permanent legal children of adoptive parents, who take over all the rights of parents. Neither of these policies is necessarily an anti-poverty measure. Both of them require the actions of the courts, as changing the status of the relationship between children-and-parents is such a serious issue, and the best interests of the child must be taken into account.

South Africa's foster care policy originated in the first half of the last century, and was strictly regulated, requiring interventions of social workers and the courts, and resulting in a cash grant being awarded to foster parents, for up to a maximum of six foster children per foster parent(s). FCGs were effectively only granted to the coloured, Indian and white population, with Africans

being largely excluded. African people who knew about and sought out foster parent status were largely excluded through a combination of mechanisms, such as the policy not being implemented in the bantustans areas; social workers acting to exclude black people; and perceptions (without legal basis) that the grant was 'not for Africans'.

With regard to coverage, Table 4 showed the tenfold increase in the number of FCG awards between 1997 and 2007, from just over 40 000, to just over 400 000. The pressure on the grant is related to the AIDS epidemic, as well as to the harmonization of the formerly racially fragmented welfare system since 1994. In 2008 the monthly amount paid was R620 per child.

Not much is known of the impact on a child of the change in status to becoming a foster child. Without a doubt the grant enables the care, within a family context, of children who would otherwise be in worse care, or in overcrowded institutions, or out on the streets.

School fee exemption

In the transition to democracy, the government announced that there would be a policy of free schooling for a minimum of nine years. This was rapidly modified to a policy whereby schools could charge fees, but that no child should be excluded from schooling because he or she could not afford the fees. A school fee exemption policy was meant to cater for this, and a later provision said that all children in receipt of grants (such as the CSG and the FCG) were automatically excluded from paying fees.

The school fee subsidy is paid by government directly to schools, for children in the state's care, most of whom are grant-receiving, and a few in children's homes. The subsidy was R564 million in 2005/06 and was projected to rise to R1.05 million in 2010/11. In general however the fee exemption policy has been unevenly implemented, and acknowledged to be a failure. In the whole of the largely poor Umkhanyakude Magisterial District in rural KwaZulu-Natal, not one school was found to be applying fee exemptions (Anne Case, personal communication, Africa Centre survey data). In other parts of the province, interviews in poorer households revealed that there were sympathetic school principals who, rather than excluding children because of their lack of fees, would allow mothers or other households members to do unpaid work at the school – for example cooking and cleaning – in lieu of fees. In all such cases, the people doing this work were women (unpublished data, Socio-Economic Persistence of Poverty and Inequality Project, University of KwaZulu-Natal).

Since 2006 the government has moved towards a policy where schools serving poorer areas as a whole, rather than individual pupils within schools, qualify for exemption, and furthermore, poorer schools qualify for additional financial support from government. The implementation and outcome of this new dispensation is not yet known.

It should also be noted that surveys continually find that the fee component of schooling costs is large, but is not the only one. Much is also spent on school uniforms, transport, and other school maintenance costs, such as cleaning materials. These costs are generally not well picked up in quantitative household surveys.

3.1.1.2 Private parental provision

Family policy in South Africa in the past was constructed, as in many societies, on the idea of a nuclear family with legally married spouses, and family welfare services were designed to prevent the breakdown of marriages. Where separation happened, fathers (and rarely mothers) would be forced to pay for the support of their former spouse and children (up to four legitimate children). Gradually during the 1960s and 1970s the State Maintenance Grant (SMG) was expanded to include

single parents (those never married) with a ceiling of two children regardless of their legitimate status.

The private maintenance system was designed in such a way as to make women vulnerable in trying to trace the father and prove both his employment status and the amount that he earned. (This is quite unlike the situation in the United Kingdom, for example, where a welfare agency acts as a third party between the two contesting parties.) This made women so vulnerable that many turned to the state SMG (which had been designed for situations where there was an absent male breadwinner0 rather than track their former partners down, especially in light of high levels of gender-based violence.

The new Maintenance Act No. 99 of 1998 is a much improved piece of legislation. It makes provision for maintenance orders to be issued by default if the respondent does not attend the court hearing. Investigating officers can track down defaulters (this used to be the responsibility of the woman), and additional maintenance clerks and legal interns have been allocated. Maintenance money can be deducted directly from the salary of the (father) parent. Different types of maintenance officers have been introduced, as well as training for them.

When it comes to determining the amount of money to be paid by the father, there has been and still is little consistent procedure. Many men are unwilling to pay, but at the same time many others are not employed or are employed at very low wages, and cannot pay, even though they may be willing. Maintenance is still not a priority in the over-stretched court system.

The impacts of this system of private parental financial support on household well-being, the care of children specifically, and women's paid and unpaid work, is at this point little documented or known. How many women (and men) receive this form of support? What amounts are received, and how do these amounts relate to the real costs of caring for children? What is the relationship between this support and the other parent's (nearly always the woman's) paid work? Do domestic workers provide some child care, and are they partly paid through the maintenance allowance? What other forms of income do parents have? How do their working hours affect their ability to care for the children? A significant research programme addressing these and related questions is needed.

3.1.1.3 Private organizational provision (monetary and social security benefits)

As will be discussed in a later section, numbers of welfare organizations and other NGOs provide services to children. Many of these organizations themselves receive a subsidy from government for part of their work, and this subsidy may cover the greater proportion of their costs. Doubtless some of these agencies on occasion give direct monetary support, such as in times of acute disaster or distress, to individuals. On the whole though this is not part of routine formal service provision, which is covered in 3.2.

3.1.1.4 Individual giving

Urban South Africa has a tradition of Saturday street collections for charities, informal choirs singing outside people's houses and collecting donations, and sometimes giving to charities is institutionalized through employing institutions. A survey of South Africans' giving patterns (Everatt and Solanki 2008) found that in the month preceding the survey over half (54 percent) of the nationwide sample of respondents had given money to a 'charity or other cause', with the mean amount given to an organization being R27 (R29 for men and R26 for women). Extrapolating from the sample to the general population, this would mean that R930 million rand a month was given to organized charities or religious bodies, or to individual poor people. About a third (31 percent) of

the sample gave goods, food or clothes to the same. Just less than a fifth (17 percent) had volunteered their time, with women having volunteered 2.2 hours in the previous month compared to men's 1.7 hours. It is not possible to estimate accurately the proportions of the giving in this survey that went to the categories of children and the elderly who are the main focus of this paper, nor how much of this went to care-related support. Everatt and Solanki (2008: 58) present data that say that 18 percent and 15 percent of the giving of goods, food and clothes were identified as going to the aged and to children respectively, but larger categories such as 'to religious causes' and 'to the poor' scored 60 percent and 31 percent respectively, and these may support care-related programmes for children and the elderly as well.

3.1.1.5 Summarised themes for later discussion

Some themes have emerged in this sub-section which will be picked up in discussion in Section 4:

- There has been a shift towards more state monetary support for children, and for young mothers.
- There has been greater policy focus on father's financial responsibilities, though this does not receive the same high profile media attention as the state grants.
- The extent of state support is good relative to other developing countries, but is still small, and does not help people out of poverty.
- There is substantial private individual giving, some of which has been captured in surveys, and presumably there is a lot more that is not captured.

3.1.2 Benefits for working-age adults

South Africa's work-related social benefits were introduced early in the last century and at first benefited mostly white people, in the formal workforce. Union struggles especially since the 1970s led to a solid set of worker benefits that began to reach black workers as well, though with inadequate levels of payment. New labour legislation in the early 1990s did much to improve the basic conditions of employment for those in formal wage employment, and importantly, domestic workers (most of whom are women) and agricultural workers were incorporated into employment-related social provision. South Africa is a signatory to the ILO Convention 156 of 1981, on Workers with Family Responsibilities.

3.1.2.1 Access to and conditions of employment

The 1997 Basic Conditions of Employment Act, amended by the Basic Conditions of Employment Amendment No. 11 of 2002 (both will be referred to here as the BCEA) stipulates a core of essential rights. These include the prohibition of employment of children under the age of 15; a limit to the amount of overtime that can be worked; formulae for additional payment for overtime work and work on Sundays and public holidays; and procedures for the termination of employment. There is a minimum of 15 days of annual paid leave.

Paid sick leave is allowed for one day out of 26 days worked, or six weeks in any 36 month cycle of employment. Pregnant women are entitled to four consecutive months of maternity leave (domestic workers who work less than 24 hours a week for an employer – as many do - are excluded from this entitlement). A new policy provision in this act is family responsibility leave: the employee (male or female) is entitled to three days paid leave in the event of a child being born or being sick. It is also applicable in the event of the death of a broadly defined set of people: the employee's spouse/ partner, parent, adoptive parent, grandparent, child, adoptive child, grandchild or sibling. This accommodates the complexity of kin relationships and responsibilities in South Africa, and of HIV/ AIDS deaths.

A companion law to the BCEA is the Employment Equity Act No. 55 of 1998 (EEA) that was designed to address and redress apartheid's racial discrimination, as well as discrimination against women and against people with disabilities. Women are a designated group, and included in the many grounds on which it is illegal to discriminate (such as race, ethnicity, culture, religious belief) with regard to employment are gender, marital status, pregnancy and sexual orientation.

3.1.2.2 Contributory health insurance/ medical aids

People who are formally employed in firms of a certain size may contribute to a health insurance scheme. A large insurance industry has grown up around such schemes, and the schemes entrench the inequality in access to quality health services that is the worst feature of the public/ private mix of provision.

Table 6: Trends in medical aid (employment-related health insurance) coverage, men and women, 2000 and 2006, percentages

Table 6 draws from LFS 2000 and 2006 data showing trends in coverage of employment-related health insurance, and includes both domestic workers and state employees. The table shows a slight decline in the numbers who were not covered over this period. The most striking fact is the high numbers who are working but who are not covered through their work – around seven out of ten workers. When those in government employment are disaggregated (not shown in the table), numbers with any medical aid coverage declined from 44 percent in 2000 to 32 percent in 2006 (showing even lower coverage in the non-state sector). Taking the public and private sectors together, the numbers of both men and women who got coverage for themselves only (as opposed to for themselves and dependents) nearly halved over the two periods.

A number of factors work against an egalitarian system. First, within those who are in formal and permanent employment, there is a huge difference in coverage by medical aid schemes according to income: only 7 percent of those with incomes of less than R1000 a month, are covered, compared to 97 percent of those earning more than R8000 a month (Adams et al 2007: 114). Second, McLeod's study (Department of Social Development 2007) suggested that employers are changing the way that they provide health care, and are passing the risk of escalating costs (partially attributed to HIV/ AIDS) onto employees. Third, the government is the largest single employer in South Africa, and civil servants belong to medical schemes, and are free to purchase their health care in the private health sector. As with non-governmental medical aids schemes, employee contributions are tax-deductible, that is, they reduce government revenue. Tax resources are thus supporting the very expensive private medical aids schemes (McIntyre and Thiede 2007: 45). These authors estimate that in 2000 the government spent twelve times more for medical scheme cover per civil servant than it spent on funding public sector health services per person (ibid).

While there has been an increase in numbers of health insurance providers, the numbers of people able to purchase medical aids has not increased, and insurance schemes themselves are facing increased risks because of AIDS. There are checks and balances: in a recent court case, a scheme was prevented from restructuring in such a way that it would not have been classified as a medical aid scheme (it was trying to pass on costs to clients); schemes are required to provide a minimum set of benefits (many were limiting the range of services offered); there have been attempts by government to limit cherry-picking. But the health industry is a powerful group. Government itself, in allowing civil servants to use tax-deductible parts of salary to purchase private care, has invidiously blurred the private-public boundary.

There is a strong gendered dynamic at work here that relates to care. Many of the government employees are women, and many of these are in the helping or caring professions. Their jobs are

secure. Their medical scheme will cover a number of their direct family members (spouse and children) which will enable these members to buy care as well.

3.1.2.3 Contributory unemployment insurance, including maternity and paternity benefits

The Unemployment Insurance Fund (UIF) covers workers, mostly those in formal employment, providing income support to workers and their dependants in the case of unemployment, illness, maternity, child adoption, and death of the workers. State employees have always been excluded as their continuing employment is pretty well guaranteed, with severance packages if they do lose their jobs. Until recently revenue came from contributions from employers, employees, and the government through the Department of Labour. The fund was financially unsustainable for a number of reasons, including the exclusion of high income earners, and mismanagement. Furthermore, women employees were directly disadvantaged by the linkage of maternity benefits with unemployment benefits. In other words, a female employee who had accumulated paid time against unemployment, had to use that time for maternity leave – whereas all of a man's accumulated unemployment time goes to support for when he is unemployed.

Under recent reforms, contributions are now made only by employers and employees, who each contribute 1 percent of the value of the workers' earnings. Coverage has been extended to include domestic workers and agricultural workers. Although many poorer informal workers (among whom disproportionately more women) are still excluded (as are state employees), reforms have on the whole been in a progressive direction, in terms of both gender and class. In particular:

- The inclusion of high income workers mean the scheme is financially sustainable because of contributions of richer workers.
- Payouts are based on previous earnings, but with the formula set such that a higher percentage is paid out to lower earners.
- There are some one million domestic workers in South Africa, the vast majority of whom are women, and poorly paid, and they now have access to the UIF. There has been a higher than anticipated signing up of domestic workers into the UIF.
- The delinking of maternity benefits and the unemployment component means that men contributors are now carrying at least part of the reproductive burden borne by women (Budlender 2007a: 16).

Informal workers and the unemployed are excluded from these benefits. These women and men do however get access to free reproductive health care services provided by the state.

3.1.2.4 Compensation for work-related disability and death

Formal workers are members of compensation funds, funded by employers, which insure against work-related disability, occupational disease, widow's and dependants' benefits in the case of work-related death, and funding for the rehabilitation of disabled workers. There are two separate funds, one for the mining industry, the other for all other industries. They are state funds and employers contribute according to the calculated risk of the industry they operate in. The compensation funds 'insure' the employers, as they avoid employees making personal claims.

A number of basic questions still need to be pursued. What is the gender breakdown in the payouts of workers compensation? This does not appear in the official reports. With regard to widow benefits, how many married women get benefits when their spouses die? How many men and women get work-related pension benefits for permanent disability? Within workers compensation, how much of the payments go to the lawyers and the medical professions, compared to the amount that goes direct to beneficiaries?

3.1.2.5 Summarised themes for later discussion

- Progressive legislation regarding basic conditions of employment and equality of opportunity in employment has been introduced, and this legislation covers more categories of workers, including insecure and poorly paid workers such as domestic workers (mostly women) and agricultural workers.
- An array of work-related social benefits are included in the above.
- A large industry has been created around health insurance, with regressive dynamics in the public/ private mix.
- HIV/ AIDS is placing stress on the work-related benefits.
- The schemes themselves are more or less adequate. The biggest problem is that they cover so few working people, being restricted to those in formal employment.

3.1.3 Elderly people

3.1.3.1 Work-related provision

In 2004/05, of the total South African population of 47 million, about 12.3 million were employed, and about 5.9 million of these were active retirement fund members (National Treasury 2008: 100, data from Genesis Analytics 2007, for data for 2004/05). About three quarters of the formally employed, and about half of all those employed, were members of a provident or pension fund (ibid). This private retirement industry is an important segment of the economy, with investments amounting to more than R600 billion, and providing for some of the support needs of working people in their later years.

Women are less likely than men to be direct contributors, as they are less in formal employment. Many women are nevertheless beneficiaries, as the legal partners of their contributing men.

One key problem with this system is that, as in many European countries, the employer's contribution is not portable when a person changes jobs, with the employee thus losing the employer's contribution to the entitlement; if jobs are changed often, the employee loses employers' contributions repeatedly. Another significant problem is there is not enough oversight of this industry – the Taylor Committee cited as main problems that it was controlled by 'powerful vested interests' with 'limited regulatory capacity' (Department of Social Development 2002: 97). In the health sector, the Council on Medical Schemes has a good grasp on the industry. In this retirement sector, by contrast, the Pensions Registrar is not an expert on the industry, and governing bodies have not been experts either. Finally, it is generally acknowledged that there are too many small and unsustainable funds.

On the whole these schemes provide relatively good coverage for those in higher paid and formal jobs. There is some good provision for low paid members through bargaining council schemes, but limited numbers are covered and some of the schemes are at risk.
Poorer informally and unemployed men and women who wish to save for their later years find formal and informal savings mechanisms very expensive, as well as unreliable. Many rely on the state old age pension for support.

3.1.3.2 State provision

One of the first measures of state social assistance in the twentieth century was the pension for elderly people (still colloquially called the OAP – the Old Age Pension). This is a non-contributory grant, means tested on income and assets, from general revenue. Women have been eligible from the age of 60, and men from 65; in 2008 it was announced that age eligibility will be equalized at 60

years old. It was introduced for the white and coloured population in 1928 (Devereux 2007), gradually widening in scope until it included the whole population, in about 1960. The OAP is supplemented by a small War Veterans Pension for South Africans who fought in certain specified wars; the amount is small, and there is a declining number of beneficiaries (Table 4 shows there were only 2340 in 2007), and little more will be said of this, save that it clearly was awarded almost exclusively to men.

During the apartheid years there was extreme racial discrimination in the levels of the OAP, and in administrative procedures (see Lund 1993 for a summary of the position just before the political transition). In the mid 1980s the level of the grant, in rands, was pegged at a ratio of 10: 5: 1 rands for white: coloured and Indian: African people. Transaction costs for people in rural areas were generally higher. Nevertheless, as early as the 1980s this grant had measurable effects on poverty, and started overtaking the migrant remittance, in rural areas, as a source of income support. Noticeably, it had pronounced gendered dynamics (Ardington and Lund 1995). The grant did not depend on a previous employment record. Women drew the grant earlier and lived longer; early evidence showed that pension money received by elderly women was more likely to be spent on items 'good for the children and for the household' than pension money received by men. Racial disparities in amounts and procedures were removed in 1993.

In April 2007 there were approximately 2.2 million beneficiaries, each receiving R870 per month (about 4 dollars a day). It is estimated that take up of this grant is well over 80 percent, and may be as high as 90 percent. It is well targeted for poverty, to women, and to rural areas. Any system of this size is bound to be open to some level of abuse. Extensive research on this shows the abuse to be present but limited; that officials are nearly always involved in setting up the fraud; and that it makes a difference whether the minister involved is either party to the abuse (for example Abe Williams in 1995) or is intent on catching the abusers (for example present minister Zola Skweyiya).

In the 1980s, the pensions were delivered by the state and its organs (such as the Post Office). Gradually this was outsourced to private firms who created mobile delivery systems which reached far into rural areas. In the last five years, the state has created a new agency, the South African Social Security Agency (SASSA), in order to address some of the lack of capacity in some of the poorer provincial governments, and in the interests of transparent and efficient management, and better service to clients. SASSA's performance has not yet been evaluated.

A great deal of research has been done by South African and foreign scholars on the OAP, with convergence in the findings of much of the research – convergence between quantitative surveys of different sorts; between qualitative studies; and between quantitative and qualitative work. Much of this has a direct relationship with care (Lund 2002). With regard, first, to the effects for elderly people themselves, studies quote elderly people and especially women as talking about the enhanced security and dignity that this regular monthly income brings to them. They talk about it giving them a right to be in the household, and how they have decision-making rights about how that money is spent (which leads to the effects noted below).

With regard, second, to the effects of the pensions on household members' well-being, where pensions are pooled in households (a common practice) they have positive effects on the nutritional status of household members in general (Case, 2004). There is clear evidence also that pension money is spent on schooling for younger household members, and that younger girls stay in senior school for significantly longer when they are living with a pension-receiving grandmother (Case and Menendez, 2006). They play a significant and important role in day-to-day subsistence and in helping households through crises (Schatz and Ogunmefun 2007).

Third, a body of research has investigated the relationship between pensions and the labour market behaviour of households in pension-receiving households. One study (Bertrand et al 2004) found that when a pension came into a rural household, it meant that prime age men in that household were more likely to leave their work. Given the very high rates of unemployment in South Africa, and the lengths men (and women) go to in order to get work, this seemed in fact to be unlikely. A reanalysis of the data (Posel et al 2006) found an intriguing result. When pensions came into households in which there were elderly women, it increased the likelihood that a younger mother in that household would become a labour migrant. What is not yet known is whether it is the older woman driving this decision ("there is more reliable money in the household now, so leave your child with me, and see if you can get a job and send money back"), or the younger mother ("I feel better now about leaving my young child with my mother, and I will go and see if I can get a job so as to earn something for my child"). This finding has recently been confirmed in data from a more recent survey (Ardington et al forthcoming).

3.1.3.3 Monetary provision from private formal and informal welfare organisations

Numbers of formal and informal organisations and associations focus on care of elderly people, and their work will be discussed in relation to service provision, in 3.2 later on. It is reasonable to suggest that these entities give some money directly to elderly people, but it is quite impossible to estimate the size of this giving, as compared to the cost of the service provision. It probably occurs seasonally (such as on major religious dates); fairly substantially through religious donations; irregularly; and more in urban than in rural areas.

3.1.3.4 Summarised themes for later discussion

- Most people in formal employment have retirement schemes of some sort; the problem is that so many South Africans are unemployed, or informally employed.
- Apartheid locked non-working people into the bantustans, very often in extended families.
- When pensions were extended to the black population in the 1970s and 1980s, they penetrated deep into rural areas.
- Where pensions are pooled in households, their positive effects on household members are more pronounced when the for pensioner is a woman.
- It is possible that younger people cluster around older people – pensions may be associated with refamilizing, rather than defamilizing.
- The state pensions play a significant role in securing the position of older people in households, and in enabling them to provide care for younger household members

3.2 SOCIAL CARE SERVICES AND BENEFITS IN KIND

The last section dealt with direct monetary provision to beneficiaries, from the state to citizens, or from the employer to worker, as part of the wage package. Table 5 at the beginning of 3.1 showed that the state registers and supports an array of NPOs, and many of these do work related to care. Most of this is in the form of services, and is not direct financial support. This section deals with such services and benefits in kind, which are more difficult to deal with according to separate categories. First, in their nature they are more difficult to enumerate; second, the state plays a role in the subsidy and regulation of private provision, so there is much interaction across boundaries; third, the line between formal and informal provision is not easy to draw, and neither is it static.

3.2.1 Children

Section 28 of the South African Constitution says that 'every child has the right … (b) to family care or parental care, or to appropriate alternative care when removed from the family environment; (c) to social services; and (d) to be protected from maltreatment, neglect, abuse or degradation'. Children are also guaranteed rights to 'an adequate standard of living', in addition to access to social security.

3.2.1.1 State programmes

A number of programmes for children are delivered through the school system. A significant one is the National School Nutrition Programme (NSNP), introduced soon after the 1994 elections. The intention is that school children in poor areas should receive a morning meal or snack on the school premises; another goal was that it should stimulate local enterprises and employment in the production of food. It rapidly reached some five million learners in about 16,000 schools (Kallmann 2005). It has not been adequately evaluated in terms of its effects on nutritional status, effects on schooling, or on its employment-creating effects for local women (Budlender and Lund 2007).

Some schools provide after-care services, where children can stay at school after hours, and this should enable parents especially mothers to work. Some schools also offer school social work services, where social workers are called in to counsel children presenting with special problems. The latter service is available only in more elite schools.

For children in the pre-school years, South Africa has had an active formal and informal ECD sector. There has been some limited government support in the past in the form of subsidies, while at the same time government imposed strict regulations that required costly facilities.

The 1994 paper on Reconstruction and Development integrated ECD (as well as Adult Basic Education and Training - ABET) into the education sector. Shortly after 1994, however, ECD was shifted institutionally from education to the welfare ministry which had little past experience of the ECD field. In 2001, two important initiatives served to place ECD back on the policy agenda – the national audit of ECD services (Department of Education 2001), and the *White Paper 5 on Early Childhood Education* (Department of Education 2001a), both from the department of education. These documents gave hard data on the extent of under-provisioning and unequal provisioning of ECD facilities between provinces, and between this provision for very young children, and for children in higher school grades. Wildeman and Nomdo (2004: 35) estimated that in 2003/04 the average spending per ECD learner was R390, compared to R4243 for primary and secondary education spending. KwaZulu-Natal and Limpopo were spending R100 per ECD learner, compared to the North West province's R1400.

There has been an extension of ECD facilities, and budget allocations have increased. The annual General Household Survey captures a steady increase in the percentage of children between two and six years old who are 'attending educational institutions', from 22 percent in 2002 to 32 percent in 2007 (calculations by Debbie Budlender). However, as Wildeman and Nomdo (2002) point out, there is a national framework but it is ignored by provinces (where implementation takes place); there is no legal framework; undue attention has been paid to the establishment of the reception year (Grade R) inside schools, thereby firmly linking ECD to the idea of school-based learning, rather than a wider approach to child development and care. All of these combine to reinforce the old apartheid patterns of exclusion of those living in rural areas and in informal settlements.

This public sector support to the NPOs in the ECD field has for a long time been supplemented on two sides. First, there is formalized fee-paying pre-school care, with formal built facilities, clear

registration procedures and regulations regarding the facilities provided. Their fee structures mean they are attended mostly by middle class children. There are also innumerable informal facilities in poorer people's private homes and backyards, largely invisible, but readily apparent to any field worker in urban townships and informal settlements. Fees are charged, but when they cannot be paid, then exchanges are entered into, or payments deferred.

More recently, there is a third source of provisioning, the ECD component of the expanded public works programme (EPWP). That will be a special focus of 3.3.1 below.

3.2.1.2 Private formal welfare provision

South Africa has a long tradition of formal welfare organisations, and especially in the coloured, Indian and white areas. Many have their origins in religious groups. In the 1960s and 1970s the apartheid government used the subsidies to drive racially segregated services. They have received different forms of subsidy, for services such as placement in institutional care, prevention of abuse, family counseling, facilities for disabled children, and drug prevention and treatment.

It is usual to make the distinction between institutional care (for example children's homes which receive a subsidy of about R1,000 per child per month), and the personal social services rendered through welfare organisations (where for example the salaries of social workers in the child welfare field are subsidized by government).

With the increasing rate of AIDS-related orphanhood in South Africa, questions are raised as to the most appropriate places for the care of children, in terms of the best interests of the child. As a general rule, it is better for children to be cared for in a private family, and it is also a less expensive form of care. Nevertheless different lobby groups are advocating for more institutional care, in a variety of types of children's homes, and for cluster foster care. Yet others promote the retention of children in private family care through trying to extend the Foster Care Grant, and also through trying to introduce an adoption allowance to facilitate the permanent integration into a family orphans or other vulnerable children.

South Africa has an array of specialist child and family care organizations. The conventional child welfare societies are found in all towns of any size, usually receive the largest proportion of provincial welfare subsidies compared to the other fields of service, and social workers offer diverse statutory and counseling services. Examples of more specialist organisations are ACESS (Access of Children to Economic and Social Security), a national network of child-related organisations that seeks to influence child policy, and advocate greater access to entitlements, which will enable their better care and support. Ntataise ('to lead a young child by the hand') is a relatively large organization in the pre-school field that assists poor women in rural areas to establish ECD programmes in their communities. In 2006 it worked through more than a thousand ECD facilities, in seven of the nine provinces, reaching some 60,000 children, and training about 1,600 ECD practitioners (Ntataise 2006).

3.2.1.3 Private informal provision

In addition to the above examples of formal and visible organisationsare the thousands of grassroots, community-based organizations, some of which are unregistered and unsubsidized, that provide care and support to children. In the last decade the government welfare department has made the legislation and regulations pertaining to their registration and support more inclusive and progressive, and many more have been registered. However large numbers of informal organisations remain outside this form of support, and their work has to focus increasingly on care needs and deficits created by HIV/ AIDS.

Measures relating to working age adults

Compared to northern industrialized countries, South Africa does not have a well-developed set of social services for employees. Some firms, especially larger ones, offer health services on site. Some industries have Employee Assistance Programmes (EAPs) in which social workers are employed for early detection and referral of social problems (and in particular, of alcohol abuse). Assessments of the magnitude and effectiveness of these programmes appear not to be available. To the extent that they are effective in treating alcohol abuse, they will have an affect on care work, in so far as the worker will continue to earn an income, rather than lose a job, and will require less care.

Partly as a result of union intervention, some firms give time off for health and safety related education, and increasingly for sessions to do with HIV/ AIDS. In 2003 government circulated guidelines to employers about AIDS and the workplace. A national study of more than 100 companies, conducted by the South African Business Coalition in HIV/ AIDS, found that some sectors had a relatively high proportion of firms with an AIDS policy. In the finance sector, which ranked highest, 80 percent had a policy, and services included awareness-raising, VCT, and care, support and treatment, with more than 30 percent of firms in this sector offering ART as well. Worrying, though, was that in a sector such as construction, which possibly has a higher turnover of less skilled workers, there was a much lower prevalence of AIDS policies and services (Adams et al 2007: 112). The more effectively firms participate robustly in programmes that fight HIV/ AIDS, the less will be the care burden on those who will come to care for those affected, and the less will be the income shocks associated with eventual loss of employment.

3.2.2 Elderly people

For a large part of the last century South Africa's welfare services for whites were biased towards services for elderly people. The apartheid government gave large subsidies to those providing institutional care for the elderly, though the private welfare organisations who ran these homes had to raise additional funds to cover costs. Specialised organisations for the aged ran a range of non-residential services as well, such as meals on wheels, home visiting programmes, and recreational programmes. Over time, welfare organisations for coloured and Indian people were also established, as also later for African people. Political settlement meant that international NGOs such as HelpAge International established a presence in the country as well.

On the formal health front the hospice movement has been an important provider of care to elderly people with terminal illnesses; its beds are increasingly under pressure from younger people with AIDS.

During the 1990s government policy moved explicitly to reduce drastically the number of residential institutions for elderly people, on grounds both of cost and of inappropriateness to the new model of social development, preferring that elderly people live an independent life in the community as far as possible. The government sold off much of the valuable residential stock that it had built up through subsidy. At least some of this was then bought up by private firms and individuals to convert to high quality care facilities for well off people. This exacerbates the problem of care for those who cannot afford to buy it – with implications for the women family members of the elderly who need care.

It is not possible to estimate the numbers of informal support groups and associations, many of which are organized around religion, and in which much of the care work is done by women in for example Jewish, Muslim and Christian (traditional African and mainstream) associations.

3.2.4 Summarised themes for later discussion

- The care–related services are harder to enumerate and evaluate than are the direct monetary benefits. It is more difficult to demonstrate the effectiveness of money spent on care services, relative for example to cash transfers, and this will impact on the ability to argue for more resources to be allocated to care services.
- South Africa has a long history of formal provision of welfare care and services to children and to the elderly. This has been biased towards services for whites in urban areas, but there were substantial services for the whole urban population as well, with community centres for elderly people in township areas, extensive (but not adequate) child welfare organisations in especially Indian and coloured areas.
- This formal provision was subsidized in the past, and since the transition to democracy, the subsidies have been extended to a more inclusive array of organizations, at the same time as there has been a move away from support for formal residential care, and towards other forms of community-based care.
- There is little service provision for people of working age, through the workplace; provision is restricted to those in formal employment.

3.3 THE INTERACTION BETWEEN FORMS OF PROVISION

Dealing with the forms of provision according to the categories above means that the very thing we are after – the dynamics of care – can slip through the cracks that come with categorisation. To address this problem, this section will illustrate the interaction between different programmes and how they impact on care.

3.3.1 A public works programme for child care and women's employment

The field of ECD had a relatively high profile at the political transition, but rapidly lost because of other priorities in education, and then received renewed attention in 2004 with the announcement of the Expanded Public Works Programme (EPWP). This had two programmes in the social sector, ECD, and Home- and Community-Based Care (HCBC). The EPWPs require targeting of women (60 percent) youth aged 18 to 24 (20 percent), and people with disabilities (2 percent). More recently the EPWP has shifted the target for women to 45 or 40 percent.

South Africa appears to be the only country in the world that has taken on social provision, in addition to physical infrastructure, as the focus of national public works programmes. In India, the new National Rural Employment Guarantee Act (NREGA) includes the provision of child care facilities, but as a service to those doing manual construction work on the programmes. In the South African ECD-EPWP, the government aims to achieve a number of goals at once: improve child care, provide employment opportunities for women in the programmes, and promote the professional development of women working in the child care field. The government notes that the programme 'can free parents and other adult carers to take up opportunities for education and employment' (Department of Social Development 2006: 12). In pursuing these goals, which explicitly relate to care work, the ECD-EPWP is intended to have a poverty-reducing effect (Department of Social Development 2006: 12).

The ECD-EPWP is relatively new, the statistics provided about it are dubious in their reliability, and implementation has been much slower than planned (Budlender and Parenzee 2007 give an assessment of early problems). Nevertheless, it is an interesting example of promoting interaction between public and private provision. The government relies on the extensive network of existing

non-profit organisations in the ECD field, some of which receive some government subsidy, and in which it is estimated that only about 10 percent of educators are qualified. The state subsidises learnerships in these ECD organisations. Learnerships are part of a new system of promoting training opportunities in the private sector, and should enable the ECD organisations to hire more staff, or provide opportunities for skills development to existing staff.

There are fewer existing ECD organisations in the rural areas where the needs are the greatest, both in terms of the absence of facilities, and of the lack of employment for women (Berg 2007). The level of skill – and especially the level of mathematical ability - needed to qualify for a learnership excludes many people. Initial government figures and projections were based on a completely unrealistic assessment of what caring for children involves – for example, they estimated one ECD educator per 50 children! Budlender and Parenzee (2007) critique the ECD-EPWP on a number of grounds, not least because it favours employment of younger women rather than the older ones who have traditionally been involved in informal child care provision at community level.

Nevertheless it will be worth following the progress of this programme, which at first is concentrating on site-based provision, in other words to specialised community-based facilities, but plans to go on to support home-based ECD provision, in other words, where ECD facilitators provide training and support to women who, using their own homes, offer a paid care service to a limited number of children. Its potential importance is the combination of developing better care and school preparation for children, combined with employment creation for women, and all being run through non-governmental organisations, with government support. The programme makes visible two important questions: how seriously is children's development taken? And how seriously will this type of work opportunity for women be taken, as reflected in the levels of pay.

3.3.2 AIDS and 'the welfare mix'

The HIV/ AIDS epidemic in South Africa has alarming implications for the demands on paid and unpaid care work. There was a completely inconsistent approach to HIV/ AIDS around the transition. The first national AIDS policy appeared in 2001, and this has been followed by further policies and plans developed around the idea of a 'continuum of care' from home-based care to care in tertiary health facilities (Budlender 2006; Hunter 2005). The focus has increasingly turned to a policy of home- and community-based care (HCBC). At first this was argued for in terms of providing a better quality of life for individuals when cared for in their own homes; this shows little understanding of the realities of care work. As time has gone by, the policy statements acknowledge that the demands AIDS is making on hospital beds is too great, and that HCBC has to supplement this health service.

Nina Hunter describes the way in which the rationale used for the HCBC programmes changed as the AIDS crisis deepened (Hunter 2005: 3 – 5). Her qualitative study of how the care policy works in practice in KwaZulu-Natal province shows how poorer households in which AIDS-illness was present were excluded from the services of the HCBCs for a number of reasons. Sometimes the family caregivers did not want the HCBC to know there was AIDS present, because of the stigma surrounding it; sometimes the family caregivers had heard the HCBC workers could give little assistance, so did not bother to ask. On the other hand, some family caregivers had found the service helpful and encouraging. HCBC workers themselves talked about the difficulty of providing care when there were no materials such as gloves to provide safe care with, and found it very difficult to provide counselling which directed people towards the health services, but families were too poor to get the transport to the health services (Hunter 2005: 26 – 30).

Home based care is delivered in different ways: some interventions fall under health and some under the welfare departments; some HCBC workers are employed directly by the state, and in

other programmes the state (usually at provincial level) routes its subsidies for HCBC workers through welfare or health NPOs; some of the home based care work is done entirely independently of the state, often through religious organizations. The hospice movement shows how support is garnered from a number of sources. It receives some state subsidy, raises its own funds through effective campaigns, uses unpaid volunteers to supplement its own professional staff, and to do community outreach work, and receives bequests from the estates of those they care for at the end of their lives.
Akintola's study comparing what 'community care' means in South Africa and in Uganda showed that in poorly-resourced Uganda, community-based volunteer care givers receive active support from the health services. In better-off South Africa, community care tends to mean volunteers, some of whom are paid a stipend, but receive little state support for their demanding work (Akintola 2004).

Hunter confirms the fear that in South Africa, 'home-based care could become home-based neglect' (Hunter 2005: 39). She insists that HCBC is not preventive or curative care: it has been (in the absence of ART being available) care for the definitely dying (2005: 38). Showing how stigma and poverty act as barriers to care provision, she concludes that:

> It is evident that the burden of care provision is falling at the household level, and almost entirely upon individual female family caregivers … (who) are undertaking nursing work and domestic work with little, if any, training, guidance or support in this environment for other stakeholders, as outlined in the (government's) care guidelines (Hunter 2005: 38).

The state itself, at national level, has supported the private sector by providing guidelines for industry. Industrial sectors in turn have developed, to a greater or lesser extent, their own policies and services, as described in earlier in this paper, including VCT facilities, and some even providing ARTs to their workers. Firms experience greater absenteeism, not only through the sickness of the workers themselves, but also through workers being absent because caring for sick family members, and for funerals. The self-employed in small businesses are very hard-hit by illness, with one study finding that the majority had to close their businesses the last time they had been ill (Lund and Ardington 2005).

In an interview with a retrenched worker in northern KwaZulu-Natal, the man describes how he and his wife planned to use his substantial retrenchment money to secure greater land use for farming; all of the money went, however, on trying to purchase a cure for AIDS for his oldest daughter (unpublished interview data, SEPPI project, University of KwaZulu-Natal). At pension paydays where the elderly are given their public OAPs, private insurance firms are there like vultures, selling private insurance.

In its financial support to NGOs the state contributes further to care. In its monetary allocations to grants to individuals – importantly the grants to children and adults with disabilities, to elderly people, and to children - it ensures that poorer individuals are able to care or be cared for better than otherwise. Individuals themselves are engaged in giving to charitable and religious organisations, some of which provide AIDS-related care services.

Increasingly, external funding is playing a role in providing resources to address HIV/ AIDS. Huge resources have been made available for clinical trials of vaccines and of microbicides. All of these are important, and the research on female contraceptives does attempt to address gendered power relationships in determining sexual choices. Mostly this research does not take into account the carer needs, or the social context, of those with HIV/ AIDS. Now, new funding from the Gates Foundation is going to see the AIDS research and care agenda determined to an even greater extent

by non-South African sources. There could be a good side to this, given the hapless performance of the internal AIDS policy process, so long as the voice of carers and of women can be heard.

Finally, domestic workers – the approximately one million low paid workers, nearly all women – are an important part of the overall picture of care in the context of HIV/ AIDS. They provide care for children, the sick, and elderly in many middle and upper class households, and may even have 'retarded' the development of public services for young children and the elderly (a point suggested by Shahra Razavi). Domestic workers are themselves affected and infected by HIV/ AIDS. They are largely employed by women (the husband or male partner may formally be the employer in the sense of paying the wage, but the wife or female partner is generally the person in closer contact with the domestic worker). They are employed in the private domain of the home. Domestic workers form one of the three occupational groups that are the focus of the South African RR4, together with the home-based care workers, and nurses.

SECTION FOUR – THE 'CARE DIAMOND'

South Africa contains contradictions. What looked like policy coherence – crass racism and underprovision to blacks – under the apartheid regime, contained within it the basis of a system of welfare provision that the new democratic government built upon, a good example of path dependency. At the same time, in the new dispensation, the initial policy coherence of pro-poor, state-driven intervention rapidly gave way to an approach that contained greater elements of a private-public mix, and a dilution of the initial pro-poor policies. Through the South African lens we see a country from which skilled health professionals emigrate to richer countries, but which also receives skilled health professionals from other countries. We see women in very secure (though not necessarily well-paid) employment in care-related jobs in the civil service, but at their most precarious when in informal employment, or when not in employment at all. We see social assistance provision that has been extended to include millions more women as beneficiaries, but the elderly pension has to stretch to feed unemployed younger household members who cannot get access to unemployment benefits, because they have never been in formal employment, and nor are many likely ever to be.

Out of this contradictory and complex picture, the paper attempts to draw some generalizations, and raises some questions for further discussion.

Welfare regime classification

Esping-Andersen's initial classification of welfare regimes differentiated between social democratic, conservative/ corporatist, and liberal types in terms of their main aims and outcomes, whether the focus was on redistribution and equality (social democratic), or cross class solidarity (social democratic), or dualism and differentiation (liberal, and conservative/ corporatist). His basic typology has been amended and refined, including by him, but the broad types are still useable.

South Africa's social spending on social security is redistributive, and would hence be called social democratic. This paper noted that it has been estimated that the social grants and taxes reduce inequality by 8 percentage points (StatsSA 2008: 3). However, the means test used to identify eligible beneficiaries are characteristic of the differentiation that is typical of the liberal and conservative/ corporatist regimes. The paper has given examples from the health and education sectors showing how the mix of private and public policies has led to dualism and differentiation in provision, with good quality services for the better-off, and very poor services for the rest. Within the health sector, McIntyre and Thiede rightly argue that it is in the dynamics of the public-private health sector mix that the key challenges lie:

> The most significant challenge facing the South African health system is to address the inefficient and inequitable distribution of resources between the public and private health care sectors relative to the population served by each. (McIntyre and Thiede 2007: 44)

They calculated that about R9,500 was spent per person on those belonging to medical schemes, who comprise less than 15 percent of the population, compared to the government's spending of R1,300 for those dependent on the public sector – nearly two thirds (64 percent of the population). In this paper an attempt was made to elaborate this rather simple component of the public/ private mix, and see how different forms of provision interact with each other, and across generations, and what this implies for care

The social security component of welfare has elements of the liberal regime in the matrix, in that it offers 'stigmatising subsistence level grants to those unable to participate in the market' (Orloff 1993: 210). However it is unusual in the extent of these benefits relative to the surrounding region (some of which countries had a similar colonial history). Yet South Africa offers very little support to its care workers and volunteers, compared to a country such as Uganda that has much fewer resources to allocate (Akintola 2004; Budlender 2006).

Jensen (2008) makes the important point that the welfare regime literature tends to 'read off' state spending on health, and on grants, as indicators of the extent of welfare provision. He and others argue that social care services are a better indicator. In the preparation of this paper, it has been more difficult to capture and estimate the extent of these care services, let alone their effectiveness. And this has been clear in work with the welfare sector in South Africa over the last two decades. It is much easier to argue, to the state, for money for grants, than it is to argue for say community-based geriatric services, or shelters for abused women, or payment for family members who are homebased caregivers – the vast majority of whom are women.

Gendered trends in care and in provision

This paper has identified the strong gendered trends in care. The analysis of South Africa time use data (Budlender 2007) showed that women do more unpaid work, and the next research report will look in more detail at certain occupational groups that do care work. Many more women than men are involved in volunteer work, and the care-related public works programmes are designed to include more women.

In the last fifteen years, women have formed a greater share of beneficiaries of state grants. For a long time women comprised a greater proportion of those receiving OAPs, and more recently, the huge increase in women beneficiaries is largely attributed to the new CSGs being awarded to primary caregivers – who are overwhelmingly women. More women have recently been included in contributory work-related benefits such as the UIF.

A large body of research has now shown that women are better spenders of welfare money than are men, in the sense of more money being spent on things such as health, education and food for the family when it comes through women beneficiaries – and this has a short term and longer term impact on care needs.

The old SMG was scarcely accessible to African people, especially those in rural areas. It was based on an outmoded and indeed European notion of family life that was out of touch with both modern reality, and traditional African reality (Lund 2008). It has been argued (Goldblatt 2005) that the SMG was the only grant in South Africa's welfare history that went to women as women/ partners of men (though part of the SMG claim was by virtue of their being mothers as well). From another perspective, the shift towards the 'follow the child via the primary care giver' could be seen as more flexible and appropriate, and not linked to women having to show proof of their relationship to men.

The idea of the primary care giver was intended to depart decisively with the old SMG system where, to get the grant, the woman had to prove her relationship to the father of the child. With the CSG, little is yet known about the gendered dynamics in the decision about who applies for the grant (Lund 2006), nor of the inter-generational dynamics between older and younger women in the household, in cases where decisions have to be made between mothers and daughters, and between mothers and daughters-in-law (in rural African households, the latter is often a tense and hostile relationship with the daughter-in-law being in a very disadvantaged position). Little is known yet about the effects of the CSG on the younger primary caregivers' visibility and position in the local community. The demographic composition of the crowds at grant payout days has completely changed, with so many more young women now present, in addition to the elderly people and people with disabilities.

Children and older people: rights, laws, resources and services

In this recent period of rapid transition, the South African social policy field has faced immense challenges: the Constitution and bill of rights set the framework for rights, policies had to be developed, legislation changed, regulations approved, resources allocated, staff trained and administrative procedures for implementation set in place for the delivery of services.

With regard to both children and older people, the constitution guarantees their access to rights, and new specific legislation has been passed to ensure that these rights are effected. The Children's Act 38 of 2005, and the Children's Amendment Act 2007, have been passed after years of campaigning and lobbying by child rights groups. These reforms took a lot longer to be achieved than did the policy regarding the introduction of the CSG. The new Act says that the state *must* provide for children's rights to family and alternative care, social services, and protection against abuse and neglect. It identifies a broad array of services that must be developed for children, including a continuum of facilities from support for care in own private home, to cluster foster care, to residential care.

Conrad Barberton (2006) developed a method for costing out the implementation of these services for children, according to full cost and partial cost scenarios. He noted that the budget for child care did not get anywhere the real costs of implementing the old Children's Act, and would certainly fall hopelessly short of being able to implement the envisaged legislation. Budlender and Proudlock (2008) more recently state that new allocations, in response to the legislation, appear promising, with increases each year well above inflation – but are still nowhere near the amounts necessary to fulfil even the government's own limited implementation plan.

The Older Persons Act 13 of 2006 proposes the development of norms and standards for quality of services, and promotes the idea of community-based services what will be regulated by government. Older people are seen only as *people needing care*; nothing in this legislation acknowledges the role they play as *people providing care*.

In order to bolster support for continuation of state spending on grants, a lot of effort has gone into demonstrating how the grant for elderly people buys a lot of care and support for the broader household in which the older person lives, and enables the older person to provide care. The evidence is robust and well-grounded. There have however been two unintended effects of this policy smudge. First, the emphasis on household-wide positive effects has detracted attention from the fact that the grant is actually intended for the older persons themselves. Second, in some way this has led to a different form of commodification, which may be expressed as: "The older people get grants, so then we don't have to worry about their other care needs or about other forms of service."

The spending on grants may take the focus off the need for services; the grants themselves can buy only a few 'services'; and there may thus be 'arrested development' of services that might otherwise have been forthcoming, in the absence of grants. The outstanding work done on costing out the Children's Act, noted above, needs to be pursued for the Older Persons Act as well.

Social policy and the family: the past in the present

Women's economic dependence on men was inscribed in Beveridge's welfare state model. Esping-Andersen's continued the blindness to gender, and to the family/ household as an active economic contributor to the welfare regime, in his work. A body of work has tried to address these gaps, notably that by Orloff (1993), Pascall and Lewis (2004) and a body of work by Jane Lewis (see for example Lewis 2007). These scholars link changes in welfare provision to changes in the labour market, and chart the move from the model of the male-breadwinner families, to dual-earner families, and beyond, as women and men move into and out of the labour force. Their work acknowledges the move (especially of women) to part-time work, the reconciliation between part time work and child care, and the commodification of many care services.

The extension of the European Union has brought with it a rash of new comparative work on social policy. As Mahon (2001) points out, however, there has too little dialogue between the (largely) quantitative statistical analysts of large data bases, who are too gender-blind, and whose notion of work is too constricted, and the feminist analysts who may understand the burden of women's paid and unpaid work more clearly, but who have not drawn sufficiently from the data bases that are available.

Many of these analyses merging from the north are extremely helpful to the understanding of policy development further south. But we need to scrutinize very carefully the assumptions about family formation and the labour market that even the progressives and feminists from the north have. More than a century of migrant labour policies tore African families apart, and removed people from access to the main means of production which was land. In the 1960s, families of African, Indian and coloured people were smashed through residential resettlement policies. Ironically the labour policies and bantustan policy were overlaid on the traditional extended family form, and many older people continue to live with their children and grandchildren. This presents real challenges to the analysis of the relationship between social policies and family formation. For example, a number of scholars have tried to explore the relationship between the pension for older people and household formation. The pension for elderly people has for the last 40 or so years been of such economic importance to poor households that it has become embedded in the economic dynamics of households, and has affected the role and status of older people, enabling them to be cared for, and to care for others. It is easy enough to demonstrate that there are more young children and more unemployed young people living in households in which there are pensioners, but it is difficult to capture the process. And research has shown that the receipt of an OAP by an older woman is associated with a younger mother in the household leaving young children in the older woman's care, in order to look for work. But to try and establish, as some analysts have, that 'pension goes up, more children arrive', simply shows no understanding of the complex processes by which people in different statuses in households make decisions about and respond to changing access to resources.

Another example of challenges to understanding the influence of welfare provision concerns the FCG. This grant enables tens of thousands of children to be cared for in a family context. When foster parents move to adopt a child, they lose the FCG, and do not get a settling in adoption allowance as is the case in some countries. This might act as an incentive to keep children in this less permanent, less familialised foster status. With regard to the CSG, research has shown that the grant has a positive effect on nutritional status and school attendance, but we do not know about its

effects on family formation, nor about how decisions get made inside the household as to who will apply as the primary caregiver on the child's behalf.

The paper has repeatedly pointed to the effect of AIDS on family life and on who needs care and who provides care. Through her study of women street traders in Warwick Junction in Durban, May Chazan (2008) reminds us that grandmothers were carers for a long period preceding AIDS because of the apartheid policies of migrant labour. The elderly, many impoverished and ill themselves, are now having new AIDS-related care burdens thrust upon them:

> While they are doing what they have always done – caretaking – they have become increasingly stretched. They are supporting growing numbers on shrinking incomes. Many are not yet eligible for pensions and are resorting to taxing work to feed their families. Their wellbeing is at stake, both emotionally and physically. They are, in many ways, the invisible, unpaid and unrecognized, and yet they are the pillars of their families and communities. (Chazan forthcoming: 12)

This is an interesting example of historical continuity in the role of older people. With regard to men, in the last few years some greater attention has been given to the role of fathers, and the problematic notions of masculinity that led to such appalling levels of gender-based violence, and so little financial responsibility by fathers for children. The reformed private parental maintenance provisions should bring more financial support from more fathers; the new parental responsibility provisions for those with formal work includes fathers, and men. At the same time, though, and directly related to HIV/ AIDS, we see the introduction of reactionary traditional practices such as public virginity testing of young girls (with boys' and men's sexual behaviour being completely obscured), and calls to moral rearmament. The flag of 'African culture' can unfortunately be used to excuse the continuation of gendered forms of oppression in the private domain of families (Ratele 2007).

Commodification and the growth of informal work

Many of the critiques surrounding Esping-Andersen's initial and subsequent work (Esping-Andersen 1990, 1999) have been directed towards the lack of gendered analysis, and blindness to unpaid female household labour in the provision of care. Esping-Andersen himself has acknowledged gendered criticisms. Applying his analysis to countries that are not advanced industrialized states, however, reveals further problems with the generalisability of his and others' welfare regime analysis with regard to the labour market.

The analysis operates too much out of binary propositions: people have a job/ do not have job; participate in the labour market/ do not participate in the labour market. Ann Orloff (1993: 313) for example, poses the problem as 'women choose between work, and being in the household'. She properly argues for the incorporation of unpaid care work as work, but she and others do not see that home is the place of paid care work for many women. It is assumed that 'employment' is something that exists in the form of a recognisable 'job', with an employer; or as registered self-employment. It does not matter how often authors protest that 'of course the reality is more complex than this': the basic assumptions permeate the analysis. Rather, the analysis needs to integrate work and household, and paid work and care work. Increasing numbers of people now work in 'atypical places' such as public streets and in their own homes. Chen et al (2005: 64) identify the specific risks attached to specific atypical places of work. It is widely accepted that one of the benefits noted by women who work from home is the fact they can reconcile the need to earn an income with the need to look after children or elderly people. It is also clear that this multi-tasking affects their levels of productivity and hence incomes earned.

Decommodification is framed as the extent to which people can live independently of the market – with independence being enabled by the extent of state provision. For many women and rural people, labour was not commodified in the first place. Young urban people may be active consumers, may complete school, and yet cannot get into the labour market to 'get commodified'. An analysis is needed that takes into account the informalization of work under globalization. Increasing numbers of people who work cannot contribute to social funds such as unemployment or health insurance, or savings for retirement through work, and thus will get no social benefits through work. It is necessary to understand more about what drives the process of informalization, and the ways in which this process affects the care-related sectors.

Stratification and the welfare state

Welfare regimes mould stratification in society through two main paths: through the way in which social provision or the lack thereof affects the well-being and life chances first of the *beneficiaries or consumers* of services, and second of the *service providers*. More analytical attention has been given to the first group than the second.

Under apartheid, the National Party deliberately used the state to shore up the poor white population, both as beneficiaries and as providers of services. In one generation, Afrikaans-speaking people were provided with the wherewithal to get out of poverty, to urbanise, and to access tertiary education. The apartheid state also offered avenues for upward mobility to many people who were not white, and especially in the helping professions such as teaching, nursing and social work, in all of which there are a majority of women. Currently, the demographic transformation of the public service has meant further opportunities for black mobility.

The service providers in state employment, or in employment subsidized by the state, themselves are constitutive of one portion – and a very large portion in South Africa – of the labour force, with changes in occupational differentiation depending on policy decisions about the structure of the health and welfare sectors, for example. And, as happened in 2007, the massive public sector strike brought the country to a standstill, and resulted in significant pay increases to the caring professions – nurses, teachers, social workers – in which largely women are employed. In addition to the overall salary increases, the government committed to introducing OSDs for, among others, teachers, nurses and social workers – all occupations that directly relate to care, and are heavily female-dominated. The broader significance of the strike was that for the first time since 1994, the ANC government could not automatically accept its supremacy in the alliance, including organized labour, that brought it to power. How organized labour lends its support will have an influence on social policies to come, and not least in the future of the campaign for a basic income grant for all South Africans, for which labour has given support in the past.

There are differences between the care-related sectors in the movement between public and private sector employment. In health, the private sector pays better and has better working conditions; the public sector loses staff to the private sector, and the private sector in turn loses some when skilled personnel emigrate, either temporarily or permanently. In the welfare sector, on the other hand, the private welfare organizations pay much smaller social work salaries than the government salaries, and there is a serious turnover of staff as people move to government service. Recent salary increases have been substantial, and a further round of increases, following the 2007 public service strike, have been announced. The wage difference between public and private remains, however, as the provinces limit the amount of subsidy awarded to the private welfare organisations (a five percent increase in the case of KwaZulu-Natal, which does not even keep up with inflation). The fourth research report in this series will provide the opportunity to take this aspect of the analytical work further.

Policy actors and influencers

Under apartheid, social policy making was centralized at the level of the national state, totally undemocratic, and largely dominated by white men, through a suite of professional councils. In the years leading to the transition, in all of the major caring professions – medical, nursing, teaching, social work – progressive practitioners and academics set up alternative professional bodies, such as for example the National Medical and Dental Association, the Democratic Nurses Organisation of South Africa, Concerned Social Workers of South Africa, and the South African Democratic Teachers Union. These were on the whole aligned with the ANC in the mass democratic movement, and on the whole they all stood for a strong role for the state, free services, and racial equality in services.

With the political settlement, councils and professional bodies have once again unified. They determine definitions, they regulate practice, they set price frameworks, and they influence the private/ public boundaries. Some have set up structures for broader professional and public consultation on policy issues. On the whole, though, opportunities for policy participation have again narrowed – one case study of how this participation narrowed around the introduction of the CSG is given in Lund (2008: 97 - 105).

There is a difference in power and influence between sectors within the social policy clusters, which does not relate directly to the size of the budgets they control. Health appears to have a dominant influence, and this might be related to size of its own private sector and the influence of major health industries such as insurance and pharmaceuticals, and the high status of the medical profession relative to teachers and social workers,

CONCLUSION: ISSUES FOR FURTHER DISCUSSION

In general, this paper supports the position of Pascall and Lewis (2004: 385) that:

> … unless care is underpinned with public services, gender equality will belong to the better off.

They argue this with reference to 'a wider Europe', and there is no reason why this should be different for countries in the south as well. Women carry a disproportionate load of care responsibilities, and a combination of labour market changes, privatization of health services, higher salaries for social workers in the public compared to the private sector, and AIDS, will stretch women's unpaid care burden even further. The possibility exists that the positive allocation of resources to grants, which is shown to buy in a lot of care and support, will displace space needed to promote other and additional care services. On the other hand, the expansion of ART services will certainly alleviate some of the need for care, in health facilities and in people's private homes. The paper has warned, however, that ART provision may detract attention from the continuing importance of support for care work.

This UNRISD project uses countries as the point of entry, the nation state as the main unit of analysis. This mirrors the work done in the analysis of policy regimes. Two important spaces are consequently missing – the local and the international, and both are missing from this paper. With the growth of cities and the urbanization of the world, there is a need systematically to consider the municipal level, and how cities differ in what they do in terms of the provision of infrastructure – such as water, electricity, roads, sanitation – that we know affects *both* the ability of people to provide care, and the ability of poorer people to earn incomes in informal work in their own homes or in very local spaces.

With regard to the international level, what role do international relationships play in welfare state restructuring and formation? It has been important for South Africa to be a signatory to the international conventions on rights of children and women. However it would be interesting to do a systematic study of influences on South African policy development by international institutions. An interesting current example is the attempt by the World Bank and others to place conditionality on the South African CSG, while at the same time this unconditional CSG is being used by the African Union initiative on social policy to argue for greater allocations to be made for cash transfers.

Finally, it is common place to cite 'lack of capacity' of states as a barrier to delivery of services. Lack of state capacity is not the main problem in health and welfare provision in South Africa. Once there is a direction, the state has shown its ability to roll out services, and examples in this paper are, in health, the numbers of people receiving ART over a short period, mostly in the public health system, and, in welfare, the delivery of CSGs to more than eight million children in less than ten years, some of them in remote rural areas. There is healthy revenue-raising ability, a budget surplus (for now), and government services that can reach poor areas. South Africans have gained the rights of citizenship, and the rights to political participation. The Constitution gives certain guarantees to socio-economic rights. We need a government that will pay attention to governing and to getting more services to poorer people.

TABLES

Table 1 Mean minutes per day by SNA-related category and sex, 24-hour minute

	Mean population time			Participation rate			Mean actor time		
	SNA	ExtSNA	Non-prod	SNA	ExtSNA	Non-prod	SNA	ExtSNA	Non-prod
Male	234	89	1116	56%	73%	100%	420	123	1116
Female	143	246	1052	44%	95%	100%	324	259	1052
Total	185	173	1081	49%	84%	100%	375	205	1082

Table 2 Mean minutes spent per day by categories of unpaid work and sex

	Mean population time			Participation rate			Mean actor time		
	House-work	Person care	Comm Care	House -work	Person care	Comm care	House-work	Person care	Comm care
Male	86	5	7	70%	7%	4%	123	74	176
Female	225	48	4	94%	35%	3%	241	137	139
Total	160	28	5	83%	22%	3%	194	128	158

Table 3
Percentage of population time spent by men and women on unpaid care work by economic activity status, income, and household composition

	Male	Female
Economic activity status		
Employed	6	15
Unemployed	8	24
NEA	5	14
Personal income (monthly, rands)		
No income	5	15
1 – 500	6	16
501 – 1000	6	15
1000+	5	13
Household composition		
Child + adult	5	16
Child + adult + older person	5	14
Adult	6	12
Adult + older person	7	15

Table 4
South African social grant beneficiary numbers in 1997, 2002 and 2007, and maximum value of grants, 2007, in Rand/month

Type of grant	April 1997	April 2002	April 2007	Max Value 07
Child Support Grant	-	1 907 774	7 863 841	200
Foster Care Grant	41 865	95 216	400 503	620
Care Dependency Grant	2 895	34 978	98 631	870
State Maintenance Grant				
Child Allowance	209 658	-	-	
Parent Allowance	152 973	-	-	
Grant-in-Aid	10 082	10 332	-	200?
Disability Grant	732 322	694 232	1 422 808	870
Old Age Pension	1 737 682	1 903 042	2 195 018	870
War Veteran's Pension	12 047	5 266	1 931	890
TOTAL	2 899 524	4 650 840	11 983 141	

Sources: Budget Review April 1997: 65; Budget Review April 2002: 57; Budget Review 2008: 96

Table 5:
Numbers of non-profit organisations in care-related categories on the government data-base in the provinces of Gauteng, KwaZulu-Natal and Limpopo, 2007

	Gauteng	**KZN**	**Limpopo**
Social services	4165	2217	1269
Economic, social and community development	2068	1754	1002
HIV/ AIDS	798	705	314
Religious associations	2245	1002	285
Sub-total	9275	5678	2870
Other	6052	3333	2273
Total	15327	9011	5143

Table 6: Trends in medical aid (employment-related health insurance) coverage, men and women, 2000 and 2006, percentages

	M		F	
	2000 N= 5182740	2006 N= 6006724	2000 N= 3948595	2006 N= 4302371
Yes, for self only	12	7	12	7
Yes, for self and dependents	16	19	13	17
No, because covered by someone else	-	4	-	5
No, no medical aid benefit	69	68	74	70
Don't know	2	1	2	1
Unspecified	1	0	1	0
TOTAL	100	100	100	100

Sources: LFS 2000, 2006; raw numbers

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