EXPLAINING THE ENDURANCE OF POVERTY AND INEQUALITY:

SOCIAL POLICY AND THE SOCIAL DIVISION OF WELFARE IN

THE SOUTH AFRICAN HEALTH SYSTEM

by

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ABSTRACT

This thesis examines the structure and flow of public funding between the public and private sectors in the South African health system and the consequences thereof for the achievement of equity. The conceptual framework used to undertake the analysis derives from Richard Titmuss' core theoretical framework, the Social Division of Welfare. The application of the Social Division of Welfare applied to the South African health care context demonstrates how state resources end up benefitting the non-poor and, as a result, reproduce inequality.

Those who access public institutions such as public health care are assumed to be 'dependent' on the state, whilst those who access private health facilities claim to be 'independent' of the state. However, this thesis shows that these assumptions are flawed. Access to the formal labour market, and subsequently the paying of taxes, authorises one to access state subsidies not available to those who do not. The application of the Social Division of Welfare shows that tax-paying private health care patients benefit considerably from state resources.

This thesis argues that due to cost escalation in the private health sector, a consequence of the commodification of health care, these private health care 'consumers' as well as the private health industry in general are dependent upon state resources. This thesis analyses the role played by the profit motive present in the private health industry and the consequences for equity, quality, access and efficiency in health care provision.

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DECLARATION

I declare that EXPLAINING THE ENDURANCE OF POVERTY AND INEQUALITY: SOCIAL POLICY AND THE SOCIAL DIVISION OF WELFARE IN THE SOUTH AFRICAN HEALTH SYSTEM is my own work and that all sources I have used or quoted have been indicated and acknowledged by means of complete references.

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U DU PLESSIS DATE

SUMMARY

This thesis examines the structure and flow of public funding between the public and private sectors in the South African health system and its consequences for the achievement of equity. The conceptual framework used to undertake the analysis derives from Richard Titmuss' core theoretical framework, the Social Division of Welfare, first presented in 1955 and published in *Essays on 'The Welfare State'* (1958). The Social Division of Welfare is applied to the South African context to demonstrate how state resources intended to alleviate poverty can be re-distributed to benefit the non-poor. Situating the Social Division of Welfare in the South African context is necessary, as it subjects to critical scrutiny the largely pejorative claims about which social groups and classes are the primary beneficiaries of government income maintenance programmes. In order to understand the theoretical framework of Titmuss (1958) and explain its significance for analysing how fiscal resources are distributed between the public and private sectors, it is necessary to understand Titmuss' general approach to the function and aim of social policy.

Chapter 1 introduces the thesis whilst Chapter 2 traces Richard Titmuss' theoretical and conceptual insights with a brief biographical outline in order to situate him in the context of his era. It draws parallels between the significance of his theoretical work in mid-20th century United Kingdom and its relevance to democratic South Africa. The approach is informed by the view that the work of Titmuss is that of a social theorist writing in the academic field of social policy.

Chapter 3 outlines the theoretical and conceptual framework which is used in this thesis. It traces the origins of Titmuss' approach to the concept of solidarity and his interest in the perpetuation of class-based stereotypes through social policy. It then interrogates his ideas on 'value systems' embedded within institutions and apply this to contemporary South African academic discourse on social policy, poverty and "the poor". Finally it sets out the methodological mechanisms of the Social Division of Welfare which is fully explained, applied and analysed in Chapter 5.

Chapter 4 provides some historical examples of social policy measures developed in South Africa which show how particular interest groups shaped the discourse and agenda which

influence social policy. This chapter demonstrates, with reference to Richard Titmuss' conceptual framework, how powerful class interests and the discourse of racism have shaped these policy measures. The changing economic and social patterns in South Africa have brought with it what Titmuss terms a state of 'diswelfare' (Titmuss, 1968). Social policy measures, aimed at ameliorating diswelfare, are shaped by discourses of dominant groups contoured around illness, poverty, class, race and gender. An historical understanding of how the egalitarian intentions of social policy can be undermined by dominant discourses can help to explain how interventions in social policy in the democratic era can be appropriated to serve narrow interests.

Chapter 5 outlines the concept of the Social Division of Welfare in detail and its criticisms. The Social Division of Welfare is then applied to the South African health system, in particular, fiscal resources in and between the public and private health systems. The analysis focuses on the structure and operation of public resource flows towards the private health system.

Chapter 6 examines how the structure of the current health system, in particular the private health system, undermines the principles of equity and accessibility and the goals of efficiency and affordability. It does this by tracing the resource flows in and between government and the two-tier health system from the evidence provided in Chapter 5. It integrates the conceptual insights of the Social Division of Welfare into the larger context of the South African health system and look at the different means by which state resources flow towards the private health system. The chapter then analyses how the interactions between the public and private health systems lead to inequalities in resource flows; away from those who most need them.

Chapter 7 outlines and discusses the argument that the private health system is the source of many of the inequities in health provision in South Africa. This chapter argues that primary health care is neglected in the private health sector which has a detrimental effect on health outcomes in the country. The "hidden" flow of public resources towards the private sector is discussed as well as the concomitant quality of care which is able to be provided in the private sector because of such flows. The migration of doctors and nurses trained through public funds and the unequal geographic distribution of private health care facilities are analysed and the reasons and effects of this is explained. Lastly, the effectiveness of private

health provision with regards to the most pressing health concern in South Africa, HIV/Aids, is interrogated.

Chapter 8 provides a conclusion which discusses the findings of the preceding empirical chapters and relate these to the conceptual framework outlined in Chapter 3 in order to provide an explanation for the tenacity of current problems which beset the health care industry in South Africa despite government commitment to public health care and what may be required to address this.

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LIST OF ACRONYMS

ANC – African National Congress

BMA – British Medical Association

CT (scan) – Computed Tomography

DBSA – Development Bank of Southern Africa

EBITDA – Earnings before interest, taxation, depreciation and amortisation

GCI - Gross Contribution Income

GDP – Gross Domestic Product

GEAR – Growth, Employment and Redistribution

GEMS – Government Employee Medical Scheme

GGE – General Government Expenditure

GP – General Practitioner

HER – Health Expenditure Review

HIV/Aids – Human immunodeficiency virus/Acquired immunodeficiency syndrome

HSRC – Human Science Resource Council

IEA – Institute of Economic Affairs

LSE – London School of Economics

MDG – Millennium Development Goal

MPB – Minimum Prescribed Benefits

MRI (scan) - Magnetic Resonance Imaging

NASA - National AIDS Spending Assessment

NHA – National Health Accounts

NHI – National Health Insurance

NHS – National Health Service

NP – National Party

SABC – South African Broadcasting Corporation

SAHR – South African Health Review

SARS – South African Revenue Service

SDW – Social Division of Welfare

SOAP – State Old Age Pension

StatsSA – Statistics South Africa

STI – Sexually Transmitted Infection

TB - Tuberculosis

TES – Tax Expenditure Subsidy

UK – United Kingdom

USA – United States of America

VAT – Value Added Tax

WHO – World Health Organisation

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CHAPTER 1

INTRODUCTION

During a recent interview following the publishing of the 2011 census results, the ex-finance minister and current head of the National Planning Commission, Minister Trevor Manuel, in responding to the question of why inequality has increased despite considerable redistributive policies, said that South Africa's current developmental trajectory and focus on growth means it is inevitable that in the short term inequality is going to increase (SABC 3 NEWS Interview, 30 October 2012). The relationship between growth and inequality that Minister Manual posits is arguably not self-evident, nor is it universal. Economic growth does not necessarily lead to an increase in inequality, and policies that benefit the well-off do not necessarily contribute to economic growth. Inequalities, and increases in inequalities take different forms and have structural origins in the organisation of capitalist society. Our task is to understand these origins and how the mechanisms which perpetuate inequality work.

This thesis shows that in the realm of social policy, particularly health policy, a considerable amount of financial and other resources flow from the state to the private health system and from the public health system to the private health system. Overall, this is having negative quantifiable and unquantifiable consequences for the public health sector and goes some way to explain the crisis in the public health system. This thesis identifies and quantifies the flow of resources from the state to the private sector and analyse the consequences of this distorted flow of resources.

This empirical evidence is situated within a larger conceptual framework which explains why and how resource flows can be appropriated and re-distributed in favour of the well-off and why they are not visible enough to be exposed to constant public scrutiny. When systems of redistribution from rich to poor are proposed they are always accompanied by much criticism, research and theorisation. Studies are done on the often poor recipients of state benefits, outcomes are speculated upon and unintended consequences are fretted over. It is particularly the latter which shapes criticisms of policies of redistribution. Welfare - it is often argued in the public media, policy documents, by public officials and think tanks - creates dependency;

child support grants encourage teenagers to have children; and if the unemployment grant is set too high – their recipients will refuse to look for work.[1] This discourse resembles to a large extent that of Tony Blair's 'Third Way' in the United Kingdom (Meth 2004: 12-13). As is often thought to be the basis of a 'developmental state', individuals and institutions who hold this view often argue that grants must be linked to incentives to work. See for instance the 2007 ANC National Conference Resolutions document:

> We are building a developmental state and not a welfare state given that in welfare state, dependency is profound. (ANC, 2007)

This is contrasted against the seemingly rational decisions likely to be made by those already rich – if you tax the rich less they are likely to invest in productive activities.

These are class-based value judgments that treat the poor as children in need of guidance and have important consequences for policy formation, implementation and outcomes. This thesis argues that notions such as these legitimate the enrichment of the better off and justify the withdrawal of redistributive measures. These class-based value judgments pass over many of the causes of poverty and inequality in society and assume itself as rational logic. As we shall see, social policy discourses go further than simple justification of the status quo. The argument of this thesis is that class-based stereotypes which emerge from the lack of a critical interrogation of the causes of poverty in South Africa play an important role in legitimating the inequalities in resource flows in, among other spheres, the health sector.

[1] For example see some of the following: Newspaper reports: 'SA becoming a welfare state – SAIRR', News24, January 31, 2011; 'Route to growth lies in tax cuts', *Business Day*, December 23, 2012; 'Begroting: Werk moet geskep word', *Die Burger*, February 23, 2011; Free Market Foundation, Vivian Atud, *Business Day*, Friday February 1, 2013; SAIRR, Nachi Majoe, quoted in Media Release: 'Construction of a Welfare State in Progress', January 31, 2011; Government and party officials: Minister of Agriculture and Land Affairs, Thoko Didiza in *Business Day*, Wednesday August 14, 2002:2; Minister of Finance, Pravin Gordhan in 2011 Budget Speech, 23 Feb 2011; Policy documents: The notion of dependency was particularly popular during the Mbeki administration, see for instance the 51st ANC National Conference Resolutions, December 2002; 52nd ANC National Conference Resolutions, December 2007. Democratic Alliance: Helen Zille, 'Address by the Leader of the Democratic Alliance, on social cohesion, at the National Social Cohesion Summit in Kliptown, Soweto', March, 4, 2012; Speech delivered at Liberal International Congress by Lindiwe Mazibuko, Parliamentary Leader of the Democratic Alliance, 22 October 2012

As Saleem Badat (unpublished paper) so aptly explains, the structure of society and its institutions are deeply informed by the ideas of its members:

> Two kinds of injustice prevail in South Africa. One kind is rooted in beliefs, prejudice, stereotypes, chauvinism, intolerance and fear of the 'other' – whether the 'other' are people of different 'races', social classes, sex, gender, sexual orientation, cultures, religions, languages, or nationalities, or live in specific geographical areas. Its effects are patterns of unjust social inclusion and exclusion, and domination and subordination of particular social groups. The other kind of injustice is deeply woven into the social and economic structures and relations of South African society, which have ossified so as to be thought of as natural and preordained, even though they are, of course, reproduced through human action and agency. These social and economic structures and relations ensure that great privileges and unbounded economic and social opportunities for a small minority coexist with harsh deprivation and an absence of opportunities for the majority; that the country remains one of the most unequal societies in the world in terms of disparities of wealth and income, living conditions and access to education, health and various social services; and that severe race, class, gender, geographical and other inequalities continue to be reproduced.

The theoretical and conceptual framework explores the different value systems which underpin the policy process and traces and outlines the work of Richard Titmuss as he sought to debunk the myths of welfare dependency based on stigmatising class-based stereotypes perpetuated in the British welfare state between 1950 and 1970. For this reason, the work of Richard Titmuss is particularly relevant in analysing the ways in which these taken for granted stereotypes influence social policy discourses and processes as well as their outcomes. Utilising the conceptual framework of the Social Division of Welfare and meticulous empirical research Titmuss demonstrated how institutional and fiscal mechanisms were concealed from analysis by the system of classification of public expenditure. These hidden mechanisms and institutions perpetuated inequality in the welfare state. In other words "inequality… persisted beneath the façade of the welfare state" (Schlesinger, 1966).

The historical work of Andries du Toit (2011a) on traditions of poverty study in South Africa is utilised in order to extend Titmuss' concepts to the South African situation. Du Toit divides the poverty studies discourse in South Africa into three traditions. The

technical/managerial tradition has given rise to a discourse of 'service delivery'. The moralist tradition associated with appealing to the conscience of the middle and upper classes depoliticises the poverty discourse, and, in the process either ignores the systemic causes of poverty or misplaces them. The radical tradition which, in a similar vein to Titmuss' argument around the creation of 'diswelfare', argues that the focus of poverty studies in South Africa should be returned to a focus on the systemic causes of poverty, and as a result, the mechanisms which contribute to increasing inequality.

It is undeniable that the legacy of racist policies formulated and implemented in the colonial, segregation and apartheid era continue to have pervasive structural, socio-economic and political effects with negative psychological and emotional consequences on the everyday lives of working class and poor South Africans. The emergence of poverty and racism and the role of powerful interests in the shaping of South African social provision can be traced to dominant interest groups who shaped discourses on poverty and disease in order to influence policy in their favour. These resulted in intended and unintended, quantifiable and unquantifiable consequences for the working class and marginal social groups.

Just as a particular conception of the hierarchy of races legitimated racist policies, so are particular ideas around poverty and poor people legitimating the continuation of regressive social policies. Policies are analysed to demonstrate how particular ideological reasonings are appropriated by groups to shape discourses which create an image of the poor. This thesis analyses these popular representations and point out how they are based upon a particular understanding of the causes of poverty and disease and how they allow for the process of regressive distribution of resources to occur. Equally important is to investigate the ways in which resources flow away from those who need it; ways which are, as is shown in this thesis, hidden and justified by layers of ideology. Ideologies which were historically fuelled by ideas about race, have more recently made an incomplete shift to ideas about class which continue to haunt South African society.

The ANC government have always placed an emphasis on the notion of solidarity, and they have, in practice, formulated and implemented several policies more or less in line with solidaristic principles. These would include the continuation of the social pension, the National Health Insurance proposals aimed at providing universal health care, as well as a variety of tax-funded grants. Solidaristic social policies are based upon principles of risk-

sharing usually in the form of a social insurance where members of society are equally protected.

As Baldwin (1990: 1) puts it

> Insurance translates the effects of fate, luck and iniquitous social circumstance into the common denominators of cash, kind and services, then reallocates them so that the stricken bear no more than an average burden and those spared assume responsibility for events not directly affecting them.

However, in most of these cases there are institutional divisions between what the poor have access to and what the rich have access to. In South Africa the private health system serves a minority of people capable of affording high cost care. South Africa therefore has a mixed system of health provision where the risk sharing is undermined by institutions of inequality. The decision to implement risk-sharing policies is usually accompanied by some controversy as classes struggle for the preservation of their own interests. It is widely held that cross-class solidarity arises when all classes stand to benefit mutually from a particular policy (see Baldwin, 1990). The gains of equality-producing policies however are often hidden behind layers of ideology, notions of desert, and ideas about the causes of poverty and fears about 'dependency'. And, as Titmuss pointed out, the gains often manifest in the form of externalities which are not easily quantified and are often overlooked (Titmuss, 1970: 243-246).

The psychological and emotional legacy of apartheid coupled with persisting socio-economic differentiation based still almost completely on race is thwarting the emergence of a true cross-race, cross-class solidarity. The consequences of inequality (such as high crime rates, violence and unemployment) are perpetuated in class and race stereotypes in dominant discourses which, in turn, negate the probability for cross-class buy-in to policies based on the principle of social solidarity. Titmuss' work derives from his observations of citizens in the United Kingdom's collective organisational response to the threat of Nazism during the "war years" of the 1940's. From these observations he developed the argument that cross-class social solidarity is an achievable goal and can take an institutional form (such as the British National Health Service) that is supported across classes. Social policy, depending on the principles and values which underpin it, can either contribute to or discourage such cross-class solidarity.

In a country which is still addressing the divisive legacy of apartheid Titmuss' theories on the cohesive or corrosive effects of social policies can provide a unique lens through which to scrutinise contemporary South African social policy. An ethic of solidarity stands in contrast to an each-to-its-own logic which prevails in the South African system of health provision. It leads us to an analysis that focuses on poverty as an independent 'problem', or narrowly focusing on the needs of 'the poorest of the poor'. Social policies based on an ethic of social solidarity however, engage the "problem" of the middle and upper classes and their role in the creation of a society suffused by poverty and inequality. A solidaristic ethic argues that stability in a capitalist society is created by a comprehensive system of risk-sharing and high levels of redistribution in the social sectors. The middle and upper classes therefore have an important role to play in producing the social stability and political conditions which would allow for the legitimation of institutions of mutual risk sharing (such as a universal health service and comprehensive public education) which would positively impact on the quality of life of all citizens across classes.

The argument therefore is that in order to tackle poverty and inequality, the roots of its emergence and perpetuation should be analysed and social policies should be formulated which will reverse or remove these structures. This stands in contrast to the currently pervasive idea that the 'problem' of poverty can be 'addressed' through 'service delivery'. 'Poverty' is often separated from or even displaces inequality. In the process of 'addressing' poverty, the idea of 'pro-poor' policies vindicates those who do not fall in the category of 'poor' and encourages popular stereotypes that contribute to the lack of questioning by the middle and upper classes as to their own role in the production of poverty. The racial origins of class inequalities in South Africa provide a foundation for such stereotypes and render class relations opaque. They will continue to flourish unless these stereotypes are critically engaged with and challenged.

As Richard Tawney argues, and as Titmuss demonstrates in *The Gift Relationship* (1970), the "amenity and dignity and mutual appreciation" between classes (and social groups) is not only an important element in "individual happiness and social well-being", but a fundamental necessity for economic prosperity (Tawney, 1931: 20). So far however a call for solidarity has only ever been employed when convenient and then only as an attempt to dissipate ill-feeling among the working class and unemployed, or to promote philanthropic intentions among the rich and business class. The lack of institutionalised cross-class solidarity means there is no real substance in terms of solidarity to fall back on when times of crises arise.

As Tawney so fittingly observes:

> A nation, like an individual, reaps in the wet what it sows in the fine. It enters a crisis with its habits framed and temper fixed by the normal and permanent set of its policy and institutions. If it reserves its enthusiasm for co-operation to moments when co-operation offers obvious economic advantages, it is likely to discover that the object of its invocations, if not sleeping off dinners at his club, is hunting the shires or on a journey to the Riviera. (Tawney, 1931: 21)

If a more solidaristic society is to be developed, risk-sharing will need to be institutionalised across classes. The argument Tawney makes and Titmuss spent his career exploring was that solidaristic principles are not only socially desirable but when employed in the social services are more efficient than for-profit services such as private health care.

In 1989 public health specialist Max Price predicted that the trend of privatisation in the South African health sector, which was implemented in an attempt to decrease state expenditure, will have the opposite effect. He argued that continued privatisation will have dire consequences for equality of access and primary care; it will create resource problems for the public health system and invert the processes of rational resource allocation (Price, 1989: 128). Chapters 4 and 5, on the Social Division of Welfare applied to state health spending in South Africa, shows that the situation Price predicted has indeed come to pass. The South African health system as a whole is becoming less efficient and more unaffordable. Titmuss' conceptual framework can shed light on why this has happened.

The 'Social Division of Welfare', a conceptual framework devised by Titmuss to show just how well-off Britons benefit from the welfare state and in effect countering the then-emerging argument that the British welfare state was impoverishing the middle classes, is then applied to state resources in the health sector in the South African context. The South African private health system and its patients – often viewed as independent of the state – are showed not only to depend considerably on state subsidisation, but also that private patients receive more state resources than their public counterparts. With the help of Titmuss' framework not only is this shown to be the case, but even more importantly, *how* and *why* this occurs in a country which has embraced the ethos of redistribution through the social services.

The thesis then goes on to analyse how the interactions between the public and private health systems lead to a distortion of resource flows. Drawing from the theorem of Kenneth Arrow (1963) on the presence of uncertainty in the medical care industry and the detrimental consequences it has for efficiency if subjected to market principles, Chapter 5 shows how the mere presence of a private health sector is creating dysfunctions in the public health sector as well as producing unsustainable cost increases which undermine the long term viability of the private sector itself. Thus, privatised health care is not only problematic due to the socially exclusionary manner in which it operates, but also the way in which the overall private system creates a systemic flow of health resources towards the better off. In this way there is arguably a corollary between the deteriorating public health system and the presence of a private health system, however regulated.

Using the theoretical framework of Titmuss coupled with the concepts drawn from throughout the thesis it is interesting to conclude that inequality is not only produced through the chosen economic system operating in industry and the workplace, nor is it, as Trevor Manuel noted, just an unintended and unavoidable consequence of development and economic growth; it can be observed in those state functions whose aims, at the outset, are of equity and redistribution. Their presence therefore persists due to combinations of special interests in the system of 'private' medical provision, institutional continuities and habits, persisting class-based stereotypes due to a lack of their critical interrogation, and an international and persisting trend of focusing on growth and development whilst deferring blame for poverty on poor people.

The Social Division of Welfare points to inequitable spending trends in the health system of South Africa. Spending trends alone do not however explain the reasons for the continuing negative outcomes in health or for the dire state of the public health system. Resource flows follow the particular market mechanisms embodied by the system and if encouraged, can be distorted to enforce inequity. Thus the trajectory of resource flows in South Africa is a derivative of a commodified health system. There are many challenges facing the public and private health systems today and this thesis uncovers how the resource flows in the public and private health systems *contributes* to the current crisis in health care. An analysis and investigation of these trends, along with the historical context of its emergence sheds light on the structural challenges that face health reformers today.

CHAPTER 2

RICHARD TITMUSS AND SOCIAL POLICY

2.1. Introduction

This first section of this chapter provides a historical context to the theoretical framework used in this thesis which is applied through a biographical and historical outline of Richard Titmuss, his work and his conceptual insights in the area of social policy. This is done in order to identify Titmuss' theoretical work and the development of his ideas on social policy as that traditionally associated with a social theorist. It is also to draw parallels between the significance of his theories as applied to mid-20th century Britain and its relevance and application to the problems of health, poverty and inequality in democratic South Africa. The second section traces the origins of his concept of solidarity and its relationship to class stereotypes. It then interrogates the ideas of Titmuss on 'value systems' as they are embedded within institutions. Through this a need for the re-examination of South African social policy discourse is argued. Finally the chapter discusses the methodological mechanisms of the Social Division of Welfare and how it fits into Titmuss' conception of social policy and social institutions. The Social Division of Welfare is fully explained and analysed in Chapter 4.

2.2. Biographical Framework

2.2.1. Early work

Richard Titmuss was a scholar who never received a graduate education. The impact this had on his thinking is often quite apparent. His experience in an insurance office, the consequences of non-transferable pensions, the stigmatisation of the unemployed, and the effect that poverty has on the process of growing up all contributed to his general theory of compensation for what he termed the "diswelfare" of industrialisation (Titmuss, 1968). The lack of a rigid education in a singular discipline arguably contributed to Titmuss' nuanced interdisciplinary approach. Bryan S. Turner argues, in the preface to *From Max Weber: Essays in Sociology* (Turner, 1991, in Gerth and Mills (eds.), 1948: xxiv) that for Marx, capitalism "pushed humanity along the road of modernisation, but at an enormous cost in

terms of individual and collective suffering" whilst for Weber it destroyed the systems of belief which governed 'pre-modern' society. In a similar vein Titmuss explores 'collective suffering' whilst devising new ways, in the form of the social services, which can replace the systems of belief or in his view, the norms, values and principles which bind societies together.

Within the discipline of social policy, Titmuss used the insights of theorists who concerned themselves with the origins or development of capitalism (such as Marx, Weber, and Tawney) as a basis to investigate its effects in terms of structure, responsibility and blame. Similar to Weber (Gerth and Mills (eds), 1948: 34), Titmuss used statistics extensively to point out the underlying economic and social consequences of capitalism[2] . His view then, that poverty in society was a consequence of the processes of social change had a significant impact on the way 'poverty' was framed and policy was formulated in Britain. These two issues, ideology and process, were, for Titmuss, intertwined and he argued that the separation of the two would lead to unintended consequences (Titmuss, 1958; 1968).

As the Chairman of the British Sociological Association from 1959 to 1962, Titmuss was a sociologist, yet as T.H. Marshall points out, what Titmuss was so 'supremely' good at was

> to show how our understanding of social conditions, problems and processes can be immeasurably increased by studies which owe little to theoretical formulae, but a great deal to the purposeful selection of a precisely defined subject and to the meticulous handling of factual data (Marshall, 1973).

Whilst working at Bedfordshire County Fire Insurance Office, he used his spare time to write a series of monographs. His first four books were published during this period, the first being *Poverty and Population* (1938), which argued that the alarming decline of the British population was due to policies which did not protect British citizens effectively. Blaming premature death and the offshoots of unemployment, Titmuss argues that liberal economic theories were failing the country and creating dangerous social consequences for future

[2] In the early 1890s Weber embarked on an extensive survey on the depopulation of rural workers in the East-Elbian region of Germany. He showed how "the real-estate and property interests of Junker capitalism were responsible for the depopulation of the German east" (Gerth and Mills 1948: 34). His extensive use of statistics allowed for the 'economic and social reasons' for the German peasant depopulation of the East-Elbian area and their replacement with cheap foreign labourers to emerge.

generations and that intervention in the increasing poverty and inequality in Britain was imperative.

Titmuss' second book titled *Our Food Problem* (1939) written with F. Le Gros Clark, was about the effects of malnutrition in Britain. He increasingly began to draw from the work and ideas of R.H. Tawney. *Our Food Problem* investigates and reiterates Tawney's argument that 'bad wages produce bad work' (Tawney, 1914, in Reisman, 2004: 774). The possibility of a "lively and vigorous population" (Titmuss and Clark, 1939: 91-92 in Reisman, 2004: 774) was being undermined by malnutrition and vitamin deficiencies which were the result of inequality caused by low wages.

In 1942 he published another co-authored book with his wife, Kathleen Titmuss, titled *Parents Revolt* (1942), which explained the declining birth-rate. Titmuss shared a view that Britain was going through a crisis where the population was not effectively reproducing itself to be able to maintain the current economy as well as sustain the country after the impending war. There were just too few people in Britain and this was due, Titmuss and Titmuss (1942) argue, to the fact that people could not afford the cost of children in Britain, and that British couples were effectively in "revolt" against the system, opting rather for the little security they could manage as married individuals without casting themselves into poverty due to the costs of bringing up children. Absolute deprivation was, in other words, acting as a form of birth control at a time when Britain was in dire need of active citizens (Reisman, 2004: 775).

Birth, Poverty and Wealth (1943) followed soon after and continues with the theme of *Parents Revolt* in that it grapples with the problem of population growth in Britain. During the 1940s in Britain the problem of population growth was a public concern. As the Manchester Guardian stated in 1943, "The future of the race" was being faced with a "menace" of "a low fertility rate among the well-to-do and a declining fertility rate with a high infant mortality among the less favoured classes". Where *Parents Revolt* grappled with the low fertility rate through the lens of obligation, which was viewed as decreasing altruism due to inequality and poverty; using statistics, *Birth, Poverty and Wealth* argued that the population problem could be solved by lowering the infant mortality rate. This is the now familiar Titmussian argument that the increasing gradient of inequality in Britain was having a profound negative effect on the life chances of, not only the survival and productivity of individuals, but that of Britain as a whole. As Maurice Newfield argues, by this time Titmuss had established himself as an expert in statistical analysis (Foreword in Titmuss, 1943).

2.2.2. The war years

Problems of Social Policy (1950), a major study of the social policy reactions of the British government to war time, was a study commissioned by the British Government who wanted a history of the consequences for social policy of World War II recorded. War, Titmuss realised, especially a civilian war on the home front, had the ability to unite people. Seeing the growth of the emergency services and the buy-in from the whole range of classes in Britain, Titmuss concludes that "a shared contingency evokes a collective response" (Reisman, 2004: 776). The notion of solidarity and its subsequent effect on the operation and conscience of societies, which was a common theme in Titmuss' work, now found itself at the centre of his analytic framework. An "inarticulate need… to be a wanted member of society" (Titmuss 1950: 347) became a central theme of Titmuss' work perhaps exactly because he saw first-hand the cohesive effect and effectiveness of its presence during war. Drawing from Tawney, Titmuss saw how the civilian war was able to promote the cohesion among classes that allowed for the relatively smooth adoption of the Beveridge proposals, which exemplified a comprehensive social security system that allowed all British citizens to live above a certain minimum standard.

2.2.3. The emergence of the welfare state in Britain.

Titmuss took the newly instituted Chair of Social Administration, a new discipline established at the London School of Economics in 1950. Titmuss had a profound effect on the shape of the academic discipline of social policy in the mid-1950s, one writer states that his influence was so far reaching that "to say social policy in Britain was to say Richard Titmuss" (Reisman, 2004: 779). The establishment of the British welfare state by the post-war Labour government (1945-1951) attracted criticisms from the right, and anti-welfarist views were becoming increasingly widespread in the ruling Conservative Party. Although the Conservative government did not overturn the institutions of the welfare state such as the National Health Service (NHS), when they came to power in 1951 they subjected it to sustained criticism. In 1956 Titmuss and Brian Abel-Smith, a colleague at the LSE, produced a book in defence of the NHS. Conservative critics mostly argued that the NHS was becoming too expensive and inefficient and Titmuss and Abel-Smith, in *The Cost of the National Health Service* (1956) provided arguments accompanied by empirical data proving that this claim was not valid. Titmuss produced several commissioned case studies (*Social Policies and Population Growth in Mauritius*, 1961 and *The Health Services of Tanganyika*,

1964a), in 1958 several of his lectures and articles were published in *Essays on 'The Welfare State'* (1958) and later, *Commitment to Welfare* (1968). In 1962, in an influential empirical study, *Income Distribution and Social Change* (1962), he demonstrated how, despite the intentions of welfare state redistribution, the middle and upper classes still managed to find fiscal loopholes in the system of welfare provision which enabled them to hold on to their wealth.

2.2.4. Titmuss and the Institute of Economic Affairs (IEA)

The year 1963 was, as Fontaine (2002: 402) writes, the commencement of a period of hostility between Titmuss and a new conservative think tank, the Institute of Economic Affairs (IEA) based in London which would profoundly shape the direction of Titmuss' research. By then several media articles had appeared arguing for the privatisation of health care, mainly written by conservative MP's[3]. But it was the economist D.S. Lees' pamphlet, *Health through Choice*, (1961) that prompted Titmuss to write *Ethics and Economics of Medical Care* (1963)[4]. In *Ethics* Titmuss sought to expose the selective amnesia of the British Medical Association (BMA) which had previously been hostile towards private provision; even calling the competitiveness between private medical practitioners 'evil' (Titmuss, 1963: 17, quoting BMA Report, 1905: 28). By the mid-1960s the BMA had changed their loyalties and was increasingly in favour of the reprivatisation of health care.

Titmuss went on to debunk Lees' claims that somewhere in history a healthy private health care market flourished without third party intervention. He continues that the provision of medical care is not an ordinary commodity that produces, as do other commodities, an environment of expanding choice. Titmuss used extensive empirical data to make the point that the privatised American health system was not working as efficiently as its proponents argued. He then argued that the formula being applied to the American health care system, which was assumed to work efficiently and "produce acceptable allocations of resources"

[3] ''The Social Services – needs and means': analysis by two Conservative MP's', Iain McLeod and Enoch Powell's, *The Social Services – needs and means'*. (*The Times*, 17 January 1952) (They were two Conservative MP's at the Conservative Political Centre), the editorial in the same edition, and John Jewkes and Sylvia Jewkes, *The Genesis of the National Health Service* launched some of the main attacks on the NHS in Britain in the 1950s.

[4] Dr Lees was widely referenced by the American Medical Association (see for instance *New York State Journal of Medicine*, February 15, 1962). He argued that there was "a strange neglect of general economic principles" being applied to health care. His pamphlet, *Health through Choice* (1961), released by the Institute of Economic Affairs in London, is not available thus all references thereof are taken from *Ethics* (Titmuss, 1963), and from Fontaine (2002) who provides extensive information on the relationship between Titmuss and the IEA.

was "singularly inoperative" (Titmuss, 1963: 19). Not long after *Ethics* was published, the economist Kenneth Arrow (1963) wrote a powerful theorem on the role of uncertainty in medical care and the subsequent role that ethics plays in its provision. Although Titmuss had alluded to some of the ethical dimensions of Arrow's argument in previous lectures[5], such an article by a noted economist (he was later to win the Nobel Prize) provided Titmuss with concrete ammunition against the IEA's attacks (Fontaine, 2002: 407).

Arrow's argument is that the particular characteristics of health care provision distort market principles. Arrow argues that the distortions in the medical-care market are due to "the existence of uncertainty in the incidence of disease and in the efficacy of treatment" (Arrow, 1963: 941). Market principles cannot be strictly applied to health care because the characteristics found in health care (such as the general uncertainty of the consumer about their condition) distort the efficiency usually expected in a competitive environment. Titmuss added that the application of market principles to health care produces the kind of physician that cares little for "the welfare of human beings… [and] is generally not inclined to participate in community activities unless these contribute to his income" (Kelly, 1957: 195-6, as quoted in Titmuss, 1963: 17).

At this point, Titmuss touches on a notion of morality and values implied in the specifics of 'care' in 'health care provision'. In *Ethics* Titmuss argues that if doctors come to be seen as 'small businessmen', and they embrace the market system, they would have to "relinquish their role (as Durkheim put it) as 'centers of moral life'" (Titmuss, 1963: 17, quoting Durkheim, 1957: 26). This Titmuss goes on to argue, would have a profound effect on 'trust' in society. His idea that medical care cannot simply be a commodity is argued with empirical evidence that draws attention to the values embedded in social policies. He argues not only for a regard for human life which could diminish with the commodification of medical care, but he also calls for a reconsideration of the importance of what it is exactly that makes us human – the social bond - and whether or not the 'money thinking' which permeates society delegitimises its necessity; equating human beings with mink coats and medical care with washing machine repair have destructive effects on society beyond efficiency and choice.

Titmuss was an unrelenting critic of the emerging right-wing think tanks, notably the IEA which, in essence, was a Tory response to the 'socialist' Fabian Society, founded in 1884.

[5] See Titmuss, 'Sociological and Ethic Aspects of Therapeutics" paper given at Johns Hopkins University in November 1963 (Fontaine 2002: 407) as well as in *Ethics and Economics of Medical Care* (1963)

Titmuss used rigorous empirical evidence to refute their sloppy use of statistics and facts and their disregard for what he considered the damaging unquantifiable consequences of the actions they proposed. In a similar vein to Weber's 'debunking technique', Titmuss revealed how "ideological assertions" are really "false cloaks for less respectable interests"; the so-called "incongruities between verbal assertions and actual intent" (Gerth and Mills (eds.), 1948: 48).

In *Ethics*, Titmuss points out the selectivity in Lees' choice of historical periods in support of his arguments on private health care (Lees, 1961, as cited in Titmuss, 1963: 16-17): "It would seem, therefore, that Dr. Lees' assumption of free market conditions operating without the intervention of third parties has only limited validity in respect of the period before organised Health Insurance in 1911". He goes on to point out Lees' failure to recognise the fundamental differences between objects and service, life-threatening needs and ordinary wants, and the measure of control over costs in the product services and health care (Titmuss, 1963: 18). Titmuss then shows Lees' gross generalisation of the state of health care in the United States of America and therefore his distorted analyses based upon these generalisations (Titmuss, 1963: 18-19). His conclusion is once again that "the American experience does not, therefore, support Dr. Lees' advocacy of transferring hospitals to private ownership on the grounds that such ownership would keep down costs, expose poor performance, redress imbalances and be more sensitive to consumer demands." (Titmuss, 1963: 19)

He then argues that the increasing specialisation in the medical sciences has the effect of increasing self-diagnosis and self-selection on the part of the medical 'consumer'. This has profound effects on quality and cost in terms of time and opportunity (Titmuss, 1963: 20). Moreover, the growing scientific complexity increases 'consumer' ignorance; increasing the need for trust in the doctor-patient relationship – something that is not flourishing within the American free market health system considering the number of malpractice suits compared to Britain. His most forceful argument is against Lees (1961) and the Jewkes' claim (in *The Genesis of the British National Health Service,* 1961) that free market practice in health care will increase choice: "The imbalances and distortions created by private hospital insurance systems often contradict the principles of good medical care and consumer choice" (Titmuss, 1963: 20).

Countering the attack on the newly established welfare state in Britain in the mid-1950s, Titmuss gives two reasons why the British welfare state, which had been established in 1948, came under fire from the right, and increasingly from the middle and upper classes: the promotion in the media and popular discourse of "a decaying, overworked and anxious middle class"[6] and the "image of an all-pervasive Welfare State for the working classes" (Titmuss, 1958: 36). Two popular books, *The English Middle Classes* (1949) and *Professional People* (1952) by Roy Lewis and Angus Maude argued that since the establishment of the welfare state in Britain, the leisure time enjoyed by the middle classes had decreased whilst that of the working classes had increased. Despite its ideological content many British middle and upper class citizens internalised these ideas. Titmuss argues that even if Lewis and Maude's arguments were defensible (which, with the help of the Social Division of Welfare, he pointed out, were not), it would, as a "political frame of reference" manifest in class-based stereotypes, resulting in widening class relationships and legitimating the withdrawal of redistributive policies (Titmuss, 1958: 36-38).

Public health care meant more to Titmuss than merely its ends as equality. With a desire to prove that institutions, and perhaps wider society, operate more efficiently when embedded with a value system of altruism and a common shared citizenship, he embarked on a project that would result in his final and most significant work, *The Gift Relationship* (1970). Titmuss' normative arguments on social solidarity and the universalisation of social policy, apart from being meticulously researched and based on empirical evidence, was constructed with "a sense of purpose" (Reisman, 2004: 781). What made his theories insightful was his unrelenting belief in the transformation of society based on the solidaristic *virtues* inherent in human nature, in contrast to 'liberal' economists' argument that the *vice* of self-interest could act as an 'invisible hand' to regulate society towards a common/utilitarian good. State intervention was a means to an end; Titmuss wanted to institutionalise a particular form of human relations which would manifest in, or exemplify, a caring society.

In this sense he was a reformist, interested, not in Marx's revolution of the proletariat; or in social reform from above, but rather in investing and "engineering camaraderie" amongst classes that would, in engaging and debunking stereotypes and misconceptions about the effects of industrial change, lead to equality (Reisman, 2004: 782). His work can be seen then as a project to build between-class bridges of solidarity that would allow for what he saw

[6] A similar attitude is conveyed in Denney and Riesman's *Creating an Industrial Civilization* (1952). As with Lewis and Maude's book the increase of leisure time for the working class is viewed as undesirable.

as the essential human need to be altruistic and caring towards strangers to emerge - a practical application of Tawney's notion of co-operation[7]. This value system would then *effectively* and *efficiently* govern society. In this sense it is quite obvious that Titmuss drew extensively from writers such as Durkheim, Weber, Marx and Rawls but in a very selective manner. Their ideas are not systematically applied but rather used as insights by Titmuss in developing his theories which would make a significant contribution to social policy as an area of academic study.

In 1966 Titmuss contacted a colleague at the Ministry of Health to obtain data on blood transfusion with the goal of developing further the argument he made in *Ethics* "by applying economic theory to the problems of blood transfusion and the supply of blood for medical care" (Fontaine, 2002; Titmuss, 1966). In *The Gift Relationship* (1970), he argued that the commercialisation of blood donation puts society at risk. The basic argument is that being allowed to sell your blood would lead people with blood related sicknesses such as Hepatitis to lie about their medical history in order to access payment for their blood. He relates the continued wastage and shortage of blood in the commercialised system to very much the same problem: the free donation of blood connected to the 'altruism' principle upon which the health services to a large extent depends is *completely lost* once the 'money principle' is applied. *The Gift Relationship*, taking its evidence from the blood donation system, is a warning of what happens when the negative unquantifiable consequences (economists calls them 'externalities') of increasing commercialism are underestimated not only in the blood transfusion service but also in the social services and perhaps even society as a whole.

2.3. Critics of Titmuss and the Social Division of Welfare

It is necessary in reviewing Titmuss' theories to examine academic criticisms of his approach and ideas. Of his earlier work, critical reviews are mainly positive, indeed, even applauding. *Essays on 'The Welfare State'* (1958) was argued to carry "the mark of genius" by Barbara Wootton, a British sociologist and president of the British Sociological Association at the time (Wootton, 1959). She was particularly impressed with the way Titmuss refuted myths built upon general fears as well as the manipulative use of statistics, in particular the 'gloom' emitted by the Beveridge Report on the age structure of Britain. In a revisit of the key issues

[7] In opposition to the Marxist notion of class struggle, Tawney argues that a fellow-feeling between classes, based on notions of a common humanity can be institutionalized.

brought up by *Income Distribution and Social Change* (1962), A.B. Atkinson calls this "one-man effort… a singular achievement in the field of social inquiry" (Atkinson, 1975: 68).

The demographer Eugene Grebenik makes a point in his review of *Birth, Poverty and Wealth* (1943) which emerges as a theme in reviews of Titmuss' work among those critical of his interdisciplinary approach, particularly among specialists who did not appreciate his seemingly effortless, yet sometimes simplistic crossing of disciplinary boundaries. Grebenik points to weaknesses in Titmuss' argument, particularly where it pertains to unconventional use of statistics or the drawing of morally saturated conclusions. He took a slightly sceptical view of the statistical methods Titmuss employed, arguing that errors derived from this method conveniently worked in favour of the arguments Titmuss presented. Despite this criticism he nonetheless recommends the book "to the expert and layman alike" due to both its "simplicity" as well as the "importance of the results obtained" (Grebenik, 1943: 172). He more or less follows the same argument in his review of *Income Distribution and Social Change* (1962) (Grebenik, 1963). This theme, of pointed criticism followed by an epitaphic description of its importance and the insights it held, came to resemble most criticism of Titmuss' work.

Most of the criticism, reviews, applauds and appraisals were directed at Titmuss' last work, *The Gift Relationship* (1970) (apart from the ones discussed below, see also Pinker 1979; Collard 1978). As Iain McLean and Jo Poulton said, *The Gift Relationship* "is a fierce and emotional book which prompted fierce and emotional reactions on both sides" (McLean and Poulton, 1986: 431).

An interdisciplinary work, drawing from the writings of anthropologists, sociologists and economists, the book evoked far-reaching responses in which this love-hate theme is particularly evident. In *The Gift Relationship* Titmuss cites economists to the likes of Jan de v. Graaf, E.J. Mishan, and S.K. Nath in order to bolster his critique on the inability of economists to measure certain externalities. In other words the Pareto criterion which argues that "any change is better as long as nobody is worse off and at least one person is better off" (as quoted in Fontaine, 2002: 422-423) was impossible to foresee since most effects are unquantifiable, or at least, easy to ignore. One such externality was the loss of altruism, a product, Titmuss argued, of institutionalised gift-giving to strangers in the form of a voluntary blood donation service.

In 1972 Arthur Seldon, a member of the IEA who was in the process of putting together a book of counterarguments to *The Gift Relationship*, mentioned to his co-editor that Titmuss' book was "taken seriously even by economists of the stature of Arrow" (Fontaine, 2002: 427). Among others were Paul A. Samuelson (1971), Alvin W. Gouldner (1971), Nathan Glazer (1971), and it seems the book had even impressed Milton Friedman (Fontaine, 2002: 427). *The Gift Relationship* therefore received quite a bit of attention as most of these economists, and also significant names in other fields, wrote reviews on the book. Kenneth Arrow, perhaps Titmuss' most renowned reviewer found "many faults with it yet ends up with a blessing" (Fontaine, 2002: 427). In his review Arrow sees *The Gift Relationship* to be

> …intended as something of a searchlight to illuminate a much broader landscape: the limits of economic analysis, the rival uses of exchange and gift as modes of allocation, the collective or communitarian possibilities in society as against the tendencies towards individualism. (Arrow, 1972: 343)

When Arrow was asked to write the review he did not know about the effect his own writing had had on Titmuss' ideas about the medical industry (Fontaine, 2002: 434). Nonetheless he recognises the argument made through the use of the blood system as similar to the one he made in 1963 - that particular characteristics of certain 'commodities' may actually thwart the efficiency of the economic market and that "Formal philanthropy has always been a prominent element of all economic systems and has shown no signs of diminution" (Arrow, 1972: 345).

In Arrow's twenty page review he lauds Titmuss for having

> … not rested content with the moral satisfaction of advocating the good but has immersed himself in the detailed factual analysis and speculative thinking needed if good intentions are to become good deeds. (Arrow, 1972: 343)

He also argues that Titmuss book has made it obvious "that the allocation of goods and services is not accomplished entirely by exchange, as standard economic models would hold" (Arrow, 1972: 344). The way government expenditures are organised, as Arrow notes, represent in a way a form of altruism, albeit not a pure one due to the coercion involved in paying taxes. He agrees with Titmuss that a moral justification exists for public social service provision, which also translates into palpable policy prescriptions. The repression of this form of altruism erodes a sense of community, or rather, solidarity. Arrow argues that

this “role of free giving in producing a more humanitarian social order is worth considering” (Arrow, 1972: 346).

Arrow does not however feel that Titmuss provided adequate evidence when he makes the argument that the gains from a purely voluntary system would be ‘*completely lost*’ in the presence of a mixed system where individuals can choose to either donate or sell their blood. He argues that Titmuss came to the conclusion that the United States has a less altruistic society when it comes to blood donation *because* it has a system of paying for blood, but that the argument could as well be that the United States have a system of paying for blood *because* it is a less altruistic society.

Arrow goes on to ask “why should it be that the creation of a market in blood would decrease the altruism embodied in giving blood? I do not find any clear answer in Titmuss” (Arrow, 1972: 351). Singer came to Titmuss’ defence, arguing that this is one of the areas in which “Arrow did not read Titmuss with sufficient care” (Singer, 1973: 312). Singer argues that Arrow’s conception of ‘freedom’ is too narrow for him to understand what Titmuss is arguing. Indeed Titmuss’ choice of using the words ‘rights’ and ‘freedoms’ is likely to allow the reader to fall into the trap of established liberal definitions and ways of thinking. Arrow does see that the incompatibility of the two systems cannot mean more freedom even if they have more choice.

While a voluntary system, Titmuss argues, fosters these attitudes and creates opportunities for their expression, a commercial system would have the opposite effect. The laws of the marketplace discourage altruism. Even if the opportunity to give still existed, the attitude toward giving would no longer be the same. (Singer, 1973: 314)

In other cases where Arrow demands more evidence from Titmuss Singer argues that

> The extent to which it is reasonable to demand conclusive or very strong evidence before a proposition is taken seriously must vary with the nature of the proposition that is being considered. In a case like the comparison of blood supply systems in different countries, where controlled experiments are impossible and the factor under examination can never be isolated from other differences between the systems, it is unreasonable to demand conclusive proof or anything near it. (Singer, 1973: 314)

He goes on to repeat the evidence provided in *The Gift Relationship*, which Arrow argued to be absent, and comes to the conclusion that "once there is some evidence, the onus is on whoever denies this to produce counterevidence" (Singer, 1973: 314). Where Arrow demands a theoretical explanation between the link Titmuss makes between blood wastage and the commercial blood system (Arrow, 1972: 356), Singer counteracts by saying that the strong research outcomes of the extensive interviews Titmuss did in Britain were adequate. These interviews asked questions around why people donate blood[8] and provides clear evidence that free services such as the British NHS " may strengthen feelings of community and mutual interdependence" (Singer, 1973: 317).

As for biases and under-theorised assumptions lacking in evidence, Singer points out that Arrow's principled stand for self-interest as the driver of supply and demand is motivated by his vague assumption and fear that altruism is a scarce resource, one, he argues, "We do not wish to use up recklessly" (Arrow, 1972: 354).

Not long after, Ernie Lightman attempted to address the question asked by Arrow about Titmuss' conclusions. Lightman asks whether

> the observed differences in outcomes – the quantity and quality of blood supplied and its availability to those who are in need – [are] attributable to the national approaches to blood procurement or to a host of other cultural, economic and political factors which distinguish different societies? (Lightman, 1981: 54-55)

Noting the element which underlies most of this work, the question of human nature, he observes that it does not lend itself to empirical testing. In the process of testing motivations of blood donators, Lightman comes to the conclusion that "Social behaviours can apparently be initiated through a favourable context [such as easy access to clinics] but cannot be maintained" (Lightman, 1981: 74). He finds that the reliable blood donors are those who cite their obligation to the community as their fundamental reason for donating blood (Lightman, 1981: 74-75).

Considering the theme which has characterised Titmuss' reviews and critiques it is no surprise that contemporary reviews either of new editions of Titmuss' work or on his general

[8] Singer quotes some of these interviewees which expressed a motive of extreme gratitude as well as altruism. Most of the interviewees spoke about being grateful about what the NHS has done for them, from small things such as surgical shoes to saving their life. In this case they view the donation of blood as a form of 'giving back'. Others pointed to the interdependence of society and that, just as they depend on others, others also depend on them.

contribution to social policy appreciates his vision with the helpful company of hindsight and theoretical and philosophical advances. Robert Pinker, both a lifelong critic and admirer of Titmuss whose ideological loyalties lie at the opposite spectrum than his former Professor, said that Titmuss, in the writing of *The Gift Relationship* "added a new dimension of ideological conflict to the debate about the values, ends and means of social policy" (Pinker, 2006: 10). Alan Deacon has the following to say:

> The enormous influence which he had exercised over the study of social policy in Britain has been almost universally acknowledged. Writing in this *Journal* in 1981, for example, Hilary Rose outlined what she termed the Titmuss Paradigm, and claimed that 'at its height the Titmuss school reigned unchallenged over the construction of social policy' (1981: 484). (Deacon, 1993: 235)

David Donnison argued that Titmuss 'should be reappraised not rejected' (Donnison, 1979: 145). Even in the area of historical studies Kevin Jefferys argues that not only was Titmuss the first to raise the "issue of government policy towards reform", the claims he made about the reasons for the emergence of welfare reforms "have never been entirely displaced" and is rather being affirmed by new writers (Jefferys, 1987: 123).

Ramesh Mishra writes that "The questions and concerns he pursued so passionately are also our questions and concerns today. And the Titmussian legacy remains important" (Mishra, 2002: 787). Mishra does however point to Titmuss' weaknesses and limitations, arguing that "Titmuss did not see the capitalist economy and corporate power in systemic terms" but rather as 'irresponsible' agents (see 'The Irresponsible Society' in *Philosophy of Welfare* (1987) reprinted in Alcock et al (2001)). What we have become aware of between the writing of 'The Irresponsible Society' and now, Mishra argues, is "vast" (Mishra, 2001: 749). Furthermore, Titmuss was a self-described democratic socialist (more accurately, a social democrat), and Mishra asks the question whether, in the post-Cold War world we live in, his solutions are ever implementable?

There are little written critiques on the framework which this thesis employs, the Social Division of Welfare. Pinker (2006: 17) criticises the framework for giving too little attention to the voluntary sector of welfare provision. Moreover, Pinker argues that both occupational and fiscal welfare are "conceptualised largely in negative terms – as institutional obstacles to the creation of a more unified and egalitarian welfare state" (Pinker, 2006: 17). This was arguably however an explicit intention of Titmuss. Pinker also does not indicate what he

deems to be the positive aspects of fiscal and occupational welfare provision. Those who argue that Titmuss does not take into consideration the positive aspects of these forms of welfare provision fail to realise that Titmuss measures the effectiveness of these forms of welfare provision against an image of an already smooth-functioning unitary and universal welfare system, and not that of an unequal status quo.

Titmuss' paper on the Social Division of Welfare was presented in 1955 and published in 1956. Despite "probably" being "the most cited paper in the British literature of social policy and planning" (Sinfield, 1978: 129) and "possibly the most influential piece of work in social administration" (Mann, 2009), a review of the written evidence suggests its analytic potential has not been tapped in social policy to a degree commensurate with its influence as a concept. However, the theory has been applied in a variety of academic contexts. Hilary Rose applied the framework to the gendered division of paid and unpaid labour, presenting a theorisation of a Sexual Division of Welfare (Rose, 1981). More recently Paul Henman and Greg Marston applied the Social Division of Welfare to surveillance practices in Britain which "point to the way in which surveillance, compliance burdens and risk management unevenly operate within society" (Henman and Marston, 2008: 187). Closer to the area of welfare provision Traute Meyer and Paul Bridgen analysed the pension system in Britain with a particular emphasis on class and gender. They come to the conclusion that this form of systemic analysis is very useful in providing the evidence that "class and gender are important predictors of who receives occupational pensions" (Meyer and Bridgen, 2008: 353).

Kirk Mann reappraised Titmuss' essay in 2009, giving examples of how the Social Division of Welfare illuminates inequitable resource flows in countries such as Australia, Britain and the USA. Challenging the same stereotypes scrutinised by Titmuss, he argues such stereotypes "appear to be more entrenched and more frequently asserted by journalists, politicians and academics, than they were fifty years ago" (Mann, 2009). The impact of the Social Division of Welfare can be measured by quantifying the studies which point to just how the rich is able to save through tax subsidies. Fiscal welfare was then a critically new idea which was subsequently termed Tax Expenditure (Alcock et al., 2001: 4).

Sinfield suggested in 1978 that the concept of the Social Division of Welfare become some form of benchmark in the discipline of Social Policy in order to understand the underlying rationale of the different forms of welfare which exist in a country. Furthermore, since the

Social Division of Welfare is linked to the division of labour, each country's divisions will vary. Its application can therefore shed light on the development, form and rationale of social policies in each country. As Sinfield suggests,

> Even within any one society, however, a careful analysis of the distribution of resources, security, status and power through the social division of welfare would help us to understand much more thoroughly the operation of those mechanisms and systems of distribution and redistribution that generate and maintain social, political and economic inequality. (Sinfield, 1978: 132)

This is what this thesis aims to do: to explain how the division of labour constrains access to health provision which is of particular concern in a country such as South Africa with such a high unemployment rate. The Social Division of Welfare might have brought previously "hidden" forms of publicly funded but privately utilised welfare provision to light, but critics have pointed out that it still has left out other invaluable forms of welfare provision. Rose (1981) and Lewis (1997) called for 'informal welfare' which is perhaps even harder to quantify because it embodies unpaid and often taken for granted care given by family members, friends or even strangers.

> Since care is recognised as public welfare when a nurse cares for a sick child in hospital it is clearly a form of welfare when a mother cares for a sick child at home. (Mann, 2009)

This form of welfare provision has a particular impact on women who, due to their traditional carer role, lose out on occupational pension provision due either to low or part time employment during their lifetimes (see Turner et al., 2005). Hilary Rose pointed out that every aspect of the Social Division of Welfare is gendered (Rose, 1981). Another of Titmuss' critics, Anthony Giddens argued that he downplayed politics, power and the state in his analysis (Giddens, 1977).

Titmuss was a Fabian Socialist and for this he was frequently criticised as well, particularly during the Cold War and the battles which raged around these ideologies. Fabians occupied the middle ground between social democracy and Marxism, moving freely between the boundaries of both. Two particularities, however, were constant: "total commitment to the democratic process and unequivocal support for social welfare services" (George and Wilding 1985: 69). Whereas Fabian Socialists believed that freedom is derived from

equality, which can be attained through redistribution. For 'anti-collectivists', as George and Wilding (1985) calls them, freedom, or liberty is thwarted by coercion, of which redistribution is a form. They therefore criticise any policy which takes from some to give to others as a form of arbitrary suppression which would prevent those at the bottom to choose to rise up and 'help themselves'.

Whilst the Fabians believe in "purposeful government action ... to modify the injustices of the private market" the 'reluctant collectivists' are not bent on change, but insist on the regulation of the free market (George and Wilding 1985: 81). Supporters of Keynesianism, Fabians 'foresee' the potential misery that unemployment can create and insist on economic intervention (George and Wilding 1985: 44). On the other end of the scale Marxists have in common with the anti-collectivists a hostility towards the welfare state albeit from a completely different ideological position. Although Marxism consists of a variety of forms and ideas, they all "reject the view that the welfare state is a mechanism for changing capitalism" (George and Wilding 1985: 126). Whilst some Fabians see the welfare state as a marker of the end of capitalism, Ian Gough writing from a Marxist perspective (1979) argued that the welfare state is merely an adaptation of capitalism, albeit one which has produced a set of contradictions. For Marx himself, the welfare state would never be able to "secure 'genuine' individual and social welfare" (Pierson 1991: 9; see also Claus Offe, *Contradiction of the Welfare State*, 1984).

Titmuss and his contemporaries' almost complete focus on structural issues presents a particular stand on agency. As Welshman (2004: 225) argues, Titmuss' thinking was "characterised by a 'denial' of agency". Others have made similar arguments about the discipline of social administration during the 1960s and 1970s (Williams et al., 1999). Due to its inordinate focus on empiricism and application, the work of the period is argued to be "extremely weak in theory" (Bulmer, 1991: 163) and research and policy-making is only ever top-down (Le Grand, 1997). Whilst warning that Titmussian scholars need to be cautious when interpreting Titmuss, Welshman (2004: 243-244) points out that "Titmuss was clearly interested in behaviour over and above his belief in altruism" and where he did not address issues of agency and behaviour he clearly did wrestle with them. Ultimately he was constrained by the paradigm in which he worked since he endeavoured to refute ideologically and pathologically motivated assumptions about welfare recipients which represented a threat to universal welfare provision and cross-class solidarity, whilst attempting to conceptualise the loss or gains in behaviour which followed solidaristic policies.

2.4. Conclusion

Robert Pinker argues that Titmuss' "reputation as one of the great innovators in the social sciences will survive and grow. His achievement will be the subject of continuous review and reappraisal" (Robert Pinker on Reisman, 2001). Titmuss was an interdisciplinary social scientist, policy advisor, prolific author and one of the major shapers of post-WWII British social policy who drew from Fabian socialism in order to create an expedient, responsible and effective Social Service that would effect greater solidarity and dignity in society. With a consistent focus on the theme of altruism which culminated in *The Gift Relationship* (1970) which is, according to David Reisman, "a remarkable attempt to combine factual evidence with moral philosophy" (Reisman 2004: 780) proving, at least in terms of blood donation, that altruism trumps self-seeking behaviour in efficiency and quality. On 6 April 1973 Titmuss died of lung cancer. Perhaps he would have woven all the threads of his thinking into a single web if he had lived longer; nonetheless, his "legacy to social thought" (Reisman 2004: 779) in the dozens of books, publication and lecture notes written by him provides us with a very helpful lens through which to analyse the inner workings of power, values and resource flows in social institutions.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1. Introduction

The following chapter builds on Chapter 2 by providing an in-depth analysis of the theoretical framework which informs the thesis, based on the ideas and concepts of Titmuss. Titmuss' work on institutions can be seen as twofold. The first is an attempt to argue for the inculcation of values into institutions or perhaps more precisely, to show how value systems are reproduced by institutions within the imagination of the society that utilises them and the resultant consequences for the achievement of equality. The second is aimed at revealing and understanding the methods by which the welfare state can be appropriated by dominant classes or work towards the marginalisation of weak individuals or groups. In both senses, Titmuss' theories are particularly relevant to present-day South Africa. In 1994, at a time when there were expectations that inequality, wealth and redistribution would take a central place in policy discourse it was to a large extent captured by dominant 'neo-liberal' thinking (Vale and Jacklin, 2009: 2). Considered currently to be one of the most unequal countries in the world, the government has very little choice but to review the mechanisms of distribution and redistribution in the country.

Titmuss was not only the biggest supporter of the welfare state but also its greatest critic (Alcock et al. (eds.), 2001). He believed in the transformative power of the social services and yet knew that these important institutions can have the opposite effect of their stated aims. Analysing the policy framework and institutions in South Africa using Titmuss' theoretical and conceptual framework can provide valuable insights into whether South African social institutions work towards or against the ends of equality.

As is discussed in detail, one of the aims to which Richard Titmuss' devoted his time was to point out, with the use of empirical evidence, that the commodification of the social services had far reaching negative implications, many of which manifested visibly but were unquantifiable. In a period when the question of private social provision is being debated in

the policy arena, revisiting his arguments could be particularly useful in gaining insight on the reproduction of inequalities in the South African social system.

3.2. Social solidarity

Titmuss argued for the creation of social institutions that embody an ethic of solidarity. This he did, not because solidarity, as an end in itself, is desirable but for far more complex reasons which the influence of R.H. Tawney on his work can reveal. Titmuss drew regularly from the work of Tawney, writing a foreword for the third print of Tawney's seminal work, *Equality* (1931). A reading of *Equality* provides insight into Titmuss' possible aims with regard to his focus on solidarity and the potential role of altruism within institutions.

Tawney argues that in the wake of the abandonment of "the old formula of free competition" and the fervent uptake of "the new formula of combination" (Tawney, 1931: 16-17), the concern with technical accomplishments had led to a pre-occupation with finding solutions to social problems through modifying institutions of economic organisation. Reason, however, even if employed in the service of their own ends, will ultimately lead to the realisation that the problem lies not so much in the deficiency of economic technique, but among the ruins of habits left over from previous dispensations within the sphere of *social relations*.

Put simply, a new system required new social habits if it is to achieve the institutional goals it aims toward. Indeed, the application of a new formula *presupposed* a change in their old habits (Tawney, 1931: 17):

> It is worth while to inquire whether economic efficiency may not be clogged by the presence of conditions which make for social inertia, and whether the path to its attainment may not lie to a less degree than is commonly supposed in the region of machinery and organisation, and to a greater degree in the attempt to create a more humane and flexible social system. (Tawney, 1931: 18)

The most fundamental habit 'clogging' the path to economic change, Tawney argues, is the aristocratic remnants of the belief in inequality (or hierarchy) as the centre that holds society together and, as a result, the irreconcilability of liberty and equality. This appreciation for inequality which permeated during the era of free competition and gained prominence in the era of Tawney's writing (the 1930's), and appeared to be dying as a creed was nonetheless surviving as habit within the structure of institutions and, as a result, in the minds of people (Tawney, 1931: 25). Unless these habits die, Tawney argues, the economic structure cannot

be changed and any new economic formulas would battle to produce the results of their intentions.

A 'rationalisation' of the social structure could manifest in a social equilibrium in society but Tawney warns that co-operation was not an ornament that adorns rhetoric or an occasional call for social composure. It

> is not a piece of ceremonial furniture which can be offered a ritual tribute of formal piety and frigid commendation when the skies are clear, and then be produced to work wonders in allaying pestilence or averting famine… [it lives] in the daily practice[s] of common affairs, or [it] is not alive. (Tawney, 1931: 21)

If a nation decides to throw off the "repulsive" habit of inequality it first and foremost has to develop new habits in order to liberate and strengthen "the ability to make a collective attack upon economic deficiencies" (Tawney, 1931: 22). Co-operation (or solidarity for Titmuss) should be embedded within institutions so that the habits could be unlearned and replaced by new ideas of a common humanity. Thus Tawney's "co-operative effort" becomes Titmuss' solidarity, a fundamental element in the transformation of the new economic system. A success of a system based upon risk-sharing and redistribution will only 'work the miracles' (Tawney, 1931: 17) its proponents say it can if the system of ideas from which it draws is infused within the institutions and attains 'hegemony'.

Infusing institutions with a set of values means the process of 'reasoning out' the 'old values', which in Tawney and Titmuss' case meant the notion of 'Economic Man' and its remnants. Titmuss did this through meticulous empirical research. One of the unconscious consequences of these old 'free competition' ideas causes society "to apply different standards to different sections of the community, as if it were uncertain whether all of them are human in the same sense as ourselves" (Tawney, 1931: 32). Here one can clearly see the impetus of Titmuss' focus on the effects of stereotypes on social policy formation. He saw the ideas of the old system as remnants which form barriers for the emergence of a new economic order.

3.3. Stereotypes and stigma

Britain in the 1940s and 1950s saw a steady stream of writers on social and economic topics "condemning the egalitarian effects of full employment, the reduction of differences in earnings and rewards for work, high progressive taxation, and the 'Welfare State' (Titmuss,

1962: 16). Titmuss distinguished between the welfare state and 'The Welfare State' as he argues that, in Britain as elsewhere, the welfare state (which simply denotes the state's role in promoting the wellbeing of its citizens) had become stereotyped as "an all-pervasive Welfare State for the Working Classes" (Titmuss, 1958: 37). Countering these stereotypes were important since he knew that "what a great many people believed" (Titmuss, 1962: 15) manifested in barriers to the transformation of institutions and profoundly affected the scope of decision-making available to politicians and policy makers. In his application of the Social Division of Welfare, Titmuss reveals that it is not only the poor that benefit from welfare. If social policies are not, as Titmuss believed, formulated around principles of universality, not only will they stigmatise the poor, but they also could benefit the rich. Stigmatisation, alongside an unsystematic reading of poverty, stereotypes of the welfare state and welfare recipients, all contribute towards a breakdown in social solidarity.

Titmuss argued that much of the criticism launched against welfare provision were unfounded in light of the deeper interrogation of common misconceptions and unfounded criticisms launched at the welfare state. Misunderstandings of the "underlying causal processes and political dynamics that underpin structural poverty and entrench inequality" (Du Toit, 2011a: 128) can lead to "irresponsible" policy decisions and have the consequence of legitimising such policy decisions (Titmuss, 1987). They raise the question as to whether the poor 'deserve' welfare benefits or not and whether it is detrimental to the health of the nation to give 'hand-outs' to the poor.

It is, what Tawney (1931: 32) so aptly calls "slipping into the mood of tranquil inhumanity" where it is unquestionable and natural to argue that poor teenage girls would become pregnant to access the child support grant but that middle class girls would not be that irrational or that, if you give money to the rich they will use it productively, whilst doing the same to the poor makes them lazy. Stigma, sometimes attached to welfare programmes, is a consequence of such views. Stigma disqualifies an individual or a group from being fully part of a society (Goffman, 1963). It is built upon notions of difference, either of physical traits, character or actions. Where welfare programmes treat different people differently it is more likely to perpetuate stigma. Stigma, in this way, creates divisions between groups and classes which have negative implications for solidarity.

3.4. The ‘Welfare State’ and ‘diswelfare’

Titmuss’ concept of ‘diswelfare’ is underpinned by the argument that social policy as a discipline and practice needs to take into consideration the structural causes of poverty. If this is not done, social policies are likely to be formulated and implemented based upon prejudiced moral, religious, or causal assumptions, and are most likely to fail or make little difference. Titmuss argued that economic change causes ‘diswelfare’ (Titmuss, 1958: 108; 1968: 63). The poor and the unemployed are thus casualties in society based upon competitive accumulation. If social policy makers take into consideration these structural causes of poverty and inequality it is more likely that policies aimed at compensation of those who experience ‘diswelfare’ will be formulated.

Assumptions about the role and function of social policy and welfare in South Africa operate within a ‘field of meaning’. These fields of meaning can most easily be identified through the use of typologies. Within the discipline of social policy, typologies are applied to measure, analyse and compare the effects of different social policies between states. Esping-Andersen (1990) acknowledges that the typologies in his seminal *Three Worlds of Welfare Capitalism* are derived from the work of Titmuss, who formulated such typologies in order to demonstrate a lack of homogeneity among welfare states, and thus the inapplicability of a stereotype of the “Welfare State’ for the working classes’, as such states varied significantly. Dominating South African social policy is the residualist tradition that associates social policies with safety nets for those who do not have the economic means to act independently in the labour market.

Titmuss’ residual model, which corresponds with Wilensky and Lebeaux’s (1958) model, exemplifies the liberal individualist argument that welfare should be a last resort for those who cannot survive in the market and in its ideal type uses strict means testing principles. The ‘field of meaning’ in which social policies are constructed influences their shape and outcome. Andries du Toit (2011a; 2012) deals with the different ‘fields of meaning’ and their roots in conceptions of poverty; he argues that the ‘radical tradition’ of poverty studies in South Africa should be revived. His radical tradition is consistent with Titmuss’ notion of diswelfare, seeing poverty as a “symptom of deeper, underlying tensions and contradictions in society” (Du Toit, 2011a: 129). Du Toit shows how other, narrow traditions conveniently misdiagnose, and in effect ignore the structural elements of poverty and inequality.

In *Underclass: A History of the Excluded, 1880-2000* (2007), John Welshman argues that "one of the distinctive features of social policy in the post-war period was an almost total focus on structural rather than behavioural factors in the causation of poverty and deprivation. This derived in part from the approach of its dominant figure - Richard Titmuss" (Welshman, 2007: 22). Titmuss argued, as Tawney (1913) and Peter Townsend (1979), that poverty is not a mark of waywardness in individual character. Instead it is an ill-effect of economic and industrial progress and changes affecting certain individuals, families or communities (Titmuss, 1958: 18-24, 108; 1968: 63). Social policies are thus mediums of compensation for these 'disservices' or 'diswelfare' (Titmuss, 1958: 108; 1968: 63). Industrialisation is desired since it brings about economic growth and raises living standards, yet the effects that often accompany these processes can profoundly affect social life. These processes contribute towards the growth of inequality and the most malign manifestation of inequality takes the form of poverty. The presence of poverty in a society has negative consequences for both social and economic growth.

Social change is outpacing the capacity of institutions to change and families, communities and cultures find themselves in a state of crisis. Diswelfare caused by industrialisation, or what Titmuss calls the 'disutilities of progress' are a consequence of the economic development of industrial society but at the expense of a proportion of the population. Welfare is therefore not merely a safety net for the worst-off; it is compensation for the disutilities created by a chosen economic system. A portion of the population should not have to bear, for society as a whole and without compensation, all the ill-effects accompanying capitalist industrialisation, Titmuss argues (1958: 29). And it is the discipline of Social Policy that needs to investigate and form policies of compensation to ameliorate these rapid social changes. The provision of publically provided services such as health and education need to be as flexible as its accompanying economic institutions (Titmuss, 1958: 29). As Tawney pointed out, a focus on individual or cultural qualities will merely obscure these underlying 'systemic' causes (Tawney, 1913).

3.5. Effects of different 'fields of meaning' applied

If economic progress creates diswelfare and welfare provision is there to ameliorate its negative effects, the withdrawal of welfare provision in the name of socially constructed and pejorative stereotypes of what causes poverty, has the effect of legitimating the accumulation of capital and de-legitimating redistribution of wealth to those who bear the brunt of capitalist

industrialisation. If poverty has systemic roots and welfare is compensation for the "illfare" of capitalism, then social policy makers should not start from the misleading distinction of whether or not any individual poor person is 'deserving' or 'undeserving'.

Initially in Britain there was a post-war consensus that poverty has structural causes, however this did not last. The notion of deservedness soon found its way into policy discourse, services were selectivised and anti-poverty measures began to be aimed directly at the poor, in the process bypassing the structural elements and established power structures that fed into increasing poverty. Titmuss explains why the American "War on Poverty", which was urgently launched in 1964, failed and provided little prolonged benefit to the poor (Titmuss, 1968: 128). Despite its complex and extensive structure and its proclamation to target the 'causes' of poverty, these 'causes' were misunderstood and in effect the solutions were misguided: the poor were to be 'targeted' and resources were to be focused on them.

Not only did the poor have to define themselves as 'poor' in order to benefit from this extensive War on Poverty program, but the focus was squarely on giving the 'poor' a 'hand up', teaching them a work ethic, initiative and entrepreneurship. It was believed that the individual lack of these characteristics were the reason why people were poor. Titmuss draws parallels between the Poor Law Act of 1834 and the American War on Poverty of 1964. Whereas the New Poor Law was a deliberate "assault on personal dignity and self-respect" (Titmuss, 1987: 128) and its anticipated success based upon the mechanism of shame, they "both endorsed and legitimated prevailing social values, both believed in redemption through work regardless of whether work was available and both were rooted in pathological explanations of poverty" (Titmuss, 1987: 128). Despite the fact that the War on Poverty rejected the mechanism of shame (the Civil Rights Movement condemned the 'midnight searches' and public humiliation), the selectivity of the program could not bypass the effects of stigma.

3.6. The ideology of means-testing

The aims and rationality of means-testing serve ideological purposes according to Titmuss, who contrasted universal socialist social policies which were "different in their purposes, philosophy and attitudes" (Titmuss, 1987: 132). If social policy is to become more than merely a safety net from complete destitution, it would have to understand and base its formulation and implementation on the structural causes of poverty. Diswelfare, caused by

economic progress, cannot be tackled in a piecemeal way, nor can it tackled by economic policy alone.

3.7. 'Service-delivery' rhetoric

The route by which social institutions become administrative machines follows Weber's notion of rationalisation. The adoption of capitalist logic creates institutions based upon 'rationality'; it promotes rational efficiency, operation, speed, precision and calculation of results (Gerth and Mills, 1948: 49). Weber's process of rationalisation in political structures corresponds with Marx's 'alienation' in economic structures which creates a bureaucratic efficiency based upon specialisation (Gerth and Mills, 1948: 47). The result, for Weber, is depersonalisation and dehumanisation which, he argued, presented barriers to individual freedoms. Rationalisation turns social institutions into rigid administrations focused on 'managing populations'. The discourse within which policy discussions takes place shapes problems and their possible solutions in a language that marginalise critical thought, avoid issues of power and almost completely excludes popular input. Under such circumstances social policy becomes merely a palliative for managing the social consequences of regressive macroeconomic policies.

Vale and Jacklin (2009: 7) argue that "the technicist market discourses that pervade the public sphere and the academy in South Africa express post-apartheid South Africa's incorporation into the logic and exigencies of global neo-liberal capitalism". If we are to 'recover' critical thought or 'generate' a critical vocabulary then, they argue, "we must read them against the dominant discourses that they aim to uncover, subvert and displace". Titmuss attempted to retain within the discipline of Social Policy this form of 'reading against' the discourse that threatened to turn social policy into a narrow administrative task in the service of economic policy. His particular view of the role of social policy and the larger ideological framework within which it operates provides a unique lens for bringing critical social science and social policy together.

3.8. Definitions of poverty

There is a need to revive other, more critical ways of looking at poverty. General poverty discourse in South Africa, heavily influenced by international development discourse has what Andries du Toit calls an '*ambiguous nature*'. There is an opportunity to "engag[e] critically with orthodox theories of economic growth and development… but [it] is happening

patchily" (Du Toit, 2011a: 125). An understanding of the structural nature and source of poverty plays an important part in policy formation and a critical engagement of this kind has, with rare exception, been largely absent among South African policy makers.

Although there is a significant national consensus on the need to address poverty in South Africa and the discourse around it "carries a significant moral charge" (Du Toit, 2011a: 127), the policy proposal and implementation process happens mainly within a sphere of technicist and value-free discourse devoid of ideological and political positions which largely conforms to orthodox international practice. Thus general policy frames the issue of poverty in depoliticised, managerial and modernist terms and participation mainly by experts and 'stakeholders'.

As Du Toit points out, the concept of poverty functions, not so much on its own, but within "a *field* of meaning" (2011a: 129). It is highly contested and contradictory and dependent on "underlying ideological stories about the nature of society, the relationship between suffering, humanity and material lack, and the obligations of citizenship, community membership and solidarity" (Du Toit, 2011a: 129). Noble et al. (2008: 118) points out:

> The concept and definition of poverty in a society is like a mirror-image of the ideals of that society: in conceptualising and defining what is unacceptable in a society we are also saying a great deal about the way we would like things to be.

According to Du Toit there are "three dominant underlying traditions of poverty study in South Africa: firstly, a moral tradition focusing on deservedness and obligation; a technical and managerial discourse of poverty measurement, and lastly a radical tradition that is not so much concerned with understanding the depth of poverty itself, but rather sees it essentially as the symptom of deeper, underlying structural tensions and contradictions in society" (2011a: 125).

A moral as well as a technicist approach toward poverty obscures the 'messy' and contested nature of the notion of poverty itself. Poverty measurement, Du Toit argues, "is not merely a neutral lens for seeing what is out there" (Du Toit, 2011b: 4). The immediate outcome of measuring poverty provides us with knowledge about what poverty itself is and who poor people are, but not what it is that creates poverty. Figuring out the social processes and relationships that creates poverty is much more complicated and "poverty measurement", Du Toit points out, "is very bad at this" (Du Toit, 2011b: 6). Poverty measurement is useful in

its own right, but it "needs to be linked to forms of knowledge that can reveal the state of poverty as a product and aspect of social power relations, that can engage more clearly with its causes, and that can grasp it directly in the context of social processes of impoverishment, distribution, differentiation and enrichment" (Du Toit, 2011b: 6).

One of the reasons why poverty measurement so easily divorces facts of poverty from the reality of its causes is due to its expert nature and the inevitability of human beings being tabled and becoming no more than numbers. This, in effect, renders poverty "value-free, neutral, objective or scientific" (Du Toit, 2011a: 131). In the process the human connection is lost and biased assumptions are made based upon preconceived notions of class and race. Poverty measurement is informed by definitions of poverty, and the definitional process, as Barnes and Wright argue, is beset with 'issues' (Barnes and Wright 2012: 135). Defining poverty inevitably means the "systematic distinction between 'the poor' and 'the non-poor'" (Du Toit, 2011a: 134). Several new approaches in the area of quantitative measurement have allowed for a much more balanced view of poverty to emerge. The "socially perceived necessities approach" argues for a considerable amount of participation in the formulation of a poverty line (Noble et al., 2008, Noble and Wright, 2012a; Noble and Wright, 2012b). Quantitative data on poverty can have far-reaching effects if it addresses the question of 'process', that is "the particular causal pathways and interactions by which access (or deprivation) of particular resources or goods interact with one another and with complex social processes to systematically produce social and economic disempowerment and marginalisation" (Du Toit, 2011a: 136). Wright, Noble and Magasela (2010: 143) provide an exception to the otherwise sterile statistical data when they aim to "contribute to the theoretical debate on the conceptualisation and definition of poverty in South Africa", in the process of formulating living standard levels.

If poverty measurement remains delinked from the social processes that create it, the immediate causes for poverty will be sought in the individual; and any policy formulated to tackle these causes - like the American War on Poverty of 1964, and the subsequent War on Poverty fought in South Africa in the democratic era – is open to failure. And when they do, these measures and policies "play a very useful role in the rather more conservative project of *managing* poverty: constituting both poverty as an issue, and restive poor populations themselves, as objects of knowledge and regulation" (Du Toit, 2011b: 7). This form of managing poverty is now commonly known as 'managerialism'. Managerialism is a focus on public sector 'service delivery' that, in essence, depoliticises poverty and presents it as

something that can be overcome through a process of 'addressing' the legacy of Apartheid through "modernisation and rational global economic integration" (Du Toit, 2011b: 7).

Managerialism operates within the logic of "New Public Management". New Public Management is "a global phenomenon that… represents an attempt to correct the shortcomings of traditional public organisation in efficiency and service-delivery to citizens" (Hood, 2000: 1). The principles upon which this new form of managerialism is based, Hood argues, are now universally acknowledged 'truths' derived from the need to be internationally competitive and an uncritical adoption of "received ideas about institutional design and managerial best practice" (Hood, 2000: 3). The term 'managerialism' points to the adoption of market-orientated practices within the public sector which emphasises "cutting costs and increasing labour productivity and efficiency; … delegation of management responsibilities; and … the development of neo-Taylorian practices such as setting standards and targets, performance measurement and performance related pay designed to create incentives for better performance" (Ruiters, 2006: 119). The first step is usually to adopt customer charters such as the *Batho Pele Guidelines* recently adopted by South African municipalities. Such a practice has consequences on the discourse of poverty in the way that it depoliticises the provision of resources by presenting it in managerial and technicist terms, "deflect[ing] conflict away from political channels into conflicts between customers and service providers" (Ruiters, 2006: 123) and in presenting the people it serves no longer as citizens but as customers and the services they offer as commodities.

This form of consumerist approach, according to Gamble, is a way of "discrediting the social democratic concept of universal citizenship rights" (1988, as quoted in Ruiters 2006: 121). Ruiters points to the fact that Customer Charters have the potential to be progressive if it is formulated and used by the public as tools for participation but that Charters tend to be formulated top-down and "used as managerial tools… against workers and consumers" (Ruiters, 2006: 121-122). The shift from citizen to the customer may also be seen as a hegemonic state project, as a way of hailing people in ways consonant with exchange rationality – all of which transforms to undermine public service ethics. Public service ethics refer to a set of values which include accountability to the political process, acceptance of bureaucratic norms of honesty, professional integrity and a stress on altruistic rather than pure financial motivations from public officials. The ethic in practice becomes an institution that ensures commitment to service and vocation and a willingness to serve beyond contractual obligations.

Managerialism thus argues to have at its core 'value-neutrality' - like consumerism - of treating all people as equals. However, its function in the process of creating consumers out of citizens incorporates a notion of consumerism that not only rewrites the definition of citizenship, but bases its rationale on business ethics that side lines those who are, at the outset, not part of the market-driven process: the poor. It also destroys the ethics inherent in a public service, as Ruiters (2006) mentions, that ensures that a process of provision, not based upon financial input or output is met. Providing public services within a value system such as that employed by the private sector destroys the altruistic motive that is inherent in an egalitarian project and, due to its subordination to technicism, does not address the issue of the causes of poverty.

The moral tradition embodies to a large extent a performative plea for philanthropic action by appealing to the conscience of the middle and upper classes. Without the moral plea however, one could expect little support for the extensive welfare policies in South Africa and the narrow, but deep tax base that funds it. The moral tradition, as much as its focus is on obligation from the rich, so it also expects a certain 'deservingness' from the poor. This is precisely because this tradition does not draw from "any real sociological and analytical understanding of the factors that actually cause and perpetuate poverty" (Du Toit, 2011a: 132). The dark side of this moralist tradition in South Africa is its preoccupation with deservedness, work ethic, the misspending of grants and arguments such as teenage women falling pregnant in order to access the Child Support Grant, which has been completely refuted by extensive evidence (Makiwane, 2010; Neves et al., 2009; Samson et al., 2004; Steele, 2006).

An overt focus on the moral aspects of poverty has the unintended consequence of opening a Pandora's Box of deservedness and obligation which cannot solve the problems of poverty because it does not take into consideration the structural causes of poverty. On the other hand, the technicist tradition of measuring poverty becomes an end in itself rather than a tool for revealing the meta-causes of poverty, the discourse within which it operates can become oppressive and useless. Instead Du Toit provides another framework, which he terms the 'radical tradition' (2011a: 129).

The radical tradition is very similar to what was outlined in the beginning of the section; it is a reorientation of thinking about poverty, a new focus on the flows of resources in society and the economy and the different elements that restrict and control those flows. This form

of poverty thinking cannot ignore the social and psychological aspects of inequality or the dynamics of class. Its focus is on how the relations of power in society and the economy impact upon the people who live in the society.

3.9. The Social Division of Welfare

The Social Division of Welfare provides an analytic framework which goes "beyond a narrow conception of 'welfare' and [makes] visible the relational aspects of welfare and wellbeing" (Henman and Marston, 2008: 190). The different forms of the 'production of wellbeing' are divided into three categories: social, fiscal and occupational welfare. Through his formulation and analysis, not only did Titmuss reveal the complexity of the system of 'welfare production' in society (which he argued followed the same logic as the division of labour); he also revealed how different conceptions of 'need' influenced the methods and divisions among the various forms of provision within this complex system.

The three categories differed only in the administrative method applied in its distribution or the type of institution in which it is found. The category of social welfare (or "public welfare" as Sinfield (1978) suggests it should be called), includes all state provided social services and benefits from the social security system (grants) to public services such as housing, health care and education. Fiscal welfare encompasses all benefits received through the tax system, from credits, allowances to subsidies. Occupational welfare includes all benefits received by the population through their participation in the labour market. This category includes sick pay, maternal leave benefits, occupational pension and medical aid scheme subsidisation or provision, work-based training and meals.

Each category of welfare provision operates within its own field of meaning and which has often been allowed to operate on its own logic i.e. not systemically connected. The subsidisation of medical aid contributions through the means of tax subsidies have the same function as public health provision – it is, in essence, a cash transfer to the individual to support their well-being. However, it is not part of the annual government budgeting process, it is not viewed as part of health expenditure and rarely is it scrutinised – at least not as much as public provision is. The next chapter provides an extensive outline and application of the Social Division of Welfare to the South African health system. For the purposes of this thesis the Social Division of Welfare is adapted to afford the greatest insight into the resource flows in the health sector and limit the analysis to public expenditure. Chapter 5 analyses and extends the insights provided by the framework, incorporating contextual information and

making consequential inferences, to provide us with a clearer picture on the role of resource flows in the current health crisis.

3.10. Conclusion

The Social Division of Welfare casts a critical light on those 'less visible benefits' received by the more 'advantaged members of society', (Henman and Marston, 2008). Titmuss' conceptual understanding of the workings of a complex system of security provision provides us with an insightful analytic framework through which to scrutinise the resource flows in the system of health care. Titmuss formulated the Social Division of Welfare to reinforce his wider theoretical claims about the structure of social security systems and the ideas that inform it. Thus in order to understand his theoretical framework fully and the significance of the conclusions derived from its findings, it is important to understand Titmuss' general outlook on the function and aim of the social services in society which derived from a lifetime of work within the academic field of social policy, direct interaction with the policy making system in Britain after the advent of the welfare state, and his insights on the functioning of society based on the interaction between the social services and the population and the effect these services have on the people that utilise it.

Within this understanding of society and the social services there lies a range of possible interpretations which can contribute to our understanding of the durability of poverty and inequality in South Africa despite government interventions. Even more so it could give us a deeper insight into other prevailing social ills that are often unquantifiable and poorly understood. Tawney's idea that social institutions should be organised in accordance with the type of social and economic structure we wish to engender had a great influence on Titmuss' work. In his analyses of social structures, resource flows, policy discourse and implementation, Titmuss was aware of the significant effect that ideas and values that inform the policy making and implementation process has on its outcome. The Social Division of Welfare ultimately shows that the application of market logic, such as 'reward principles' to welfare provision, has the effect of re-distributing public resource flows towards the middle-class and rich.

Titmuss talks about "the inherent illogicalities and contradictions in the managerial capitalist system as it is developing within the social structure" (Titmuss, 1987: 60); the economic logic behind it might itself seem rational, sober and responsible yet, "in the aggregate", is followed by an uneven distribution of resources and incomes" (Titmuss, 1987: 61). The

"Social Division of Welfare" is utilised to 'aggregate' these resource flows and the next Chapter does so in the area of health care in South Africa. It aims to demonstrate how, in democratic South Africa, the application of market principles in the social services, and particularly in the health sector, reproduces inequality.

CHAPTER 4

THE HISTORICAL ROLE OF POVERTY AND RACISM IN SHAPING SOUTH AFRICAN SOCIAL POLICY

4.1. Introduction

Many of the systemic problems in South Africa's modern health and welfare structures can be traced back to its institutional origins in colonialism. Norms, attitudes and structural processes become ingrained in institutions and in the absence of specific catalysts they become hard to modify or reverse. Furthermore, the interests that shape social policies and institutions impact on public attitudes towards redistribution. In the prevailing context of a racist society, these are among the most significant factors that have shaped the systems of redistribution that democratic South Africa inherited. A key aim is thus to establish a parallel in this chapter between differentiated social policies based on racist stereotypes that emerged out of dominant economic interests in the colonial, segregation and apartheid era and social policies in the democratic era that aim to redress the "diswelfare" of the preceding eras but which continue to perpetuate class based stereotypes of the "deserving and undeserving poor".

The first section of this chapter starts by setting out very briefly the history of inequality and poverty in South Africa since the discovery of diamonds and gold, the forms it took, and the government policies which were implemented as a reaction. An analysis suggests that many of the policies of the time were shaped by the needs of the emerging gold and diamond industry, mediated and maintained by racist ideology, and was a reaction to the changing character of colonialism, imperialism, segregation and apartheid. The racially differentiated reaction of the state towards poverty in black and white communities will be examined, as well as the popular and normative approaches to the phenomenon of poverty that prevailed at the time. The next section then provides an analysis of arguments on the causes of ill-health and poverty, and demonstrates how these were adapted to the economic needs of dominant interests and how evidence has been manipulated in order to justify certain economic, industrial, health and welfare policies.

4.2. Emerging inequality in South Africa

4.2.1. Early inequality and poverty

Colonial rule ended in 1910 with the formation of the Union government ruling over the four separate British colonies. However, by then, the system of racial domination and exclusion, founded on slavery, conquest, expropriation of land, and the recruitment and control of Black labour had been firmly established and continued, along a similar trajectory firstly under the overarching policy which was known as 'segregation', and later, with the coming into power of the National Party in 1948, an even more aggressively repressive, institutionalised version known as 'apartheid'.

A dominant theme which shaped policy during the colonial, segregation and apartheid era was the supply of labour. The first slaves arrived in early 1653 and slavery was abolished in 1833 at a time when there were already hundreds of slaves in the Cape Colony. The problem with the supply of labour increased exponentially with the discovery and production of diamonds in Kimberley in the 1860s and gold on the Witwatersrand in the 1880s (Davenport, 1987). The discovery of diamonds and gold provided the context for the entrenching of racialised inequality. Since the abolition of slavery, wage labour grew rapidly, particularly after the discovery of diamonds. However, even before that pockets of wage labourers worked on wine and wheat farms as well as in towns. Manual labourers on the Kimberley mines consisted mostly of Africans. Several control measures were implemented during this time in order to control labour, one of which was the pass system first instituted in 1872.

The control of labour was important for the accumulation of capital in the mining industry. Along with the creation of a racial hierarchy through the implementation of the 'colour bar', inequality rapidly increased. This hierarchy was legislated in a number of government reports. A 'unified native policy' was set out in the Report of the South African Native Affairs Commission (Lagden, 1903) which provided the basis for the reconciliation of mining and farming interests which received a considerable amount of legislative attention after the creation of the Union. Most of the subsequent policies had their origins in the legislation of the pre-war Colonies and Republics bolstered by the exclusion of the African, Indian and Coloured franchise by the 1910 Constitution, the 1914 Natives Land Act and the Native Urban Areas Act of 1923. Several amendments to these Acts followed in the proceeding decades each of which, in the main, solidified the basis of capital accumulation and racialised

labour exploitation whilst attempting to divide the cheap labour force between the dominant economic interests (mining, farming and later manufacturing).

Whilst commercial farming expanded, a large part of the white population was gradually impoverished due to the inter-war agricultural depression, landlessness, and the movement to cities with little employment. Afrikaner women were incorporated into industries such as garment making, leading to a perceived threat in the popular white imagination to their "virtue" and the "health of the race" (Teppo, 2004: 13). Similarly, due to the decline of the reserve economy and the war-time expansion of urban employment, as well as the chronic lack of housing in the cities, Africans settled in multiracial slums. Fears over the uncontrolled movement of Africans to the urban areas and accompanying racist images of miscegenation between the white and black poor, were exploited by the National Party who won key urban seats in the 1948 elections. The National Party rapidly promulgated racially exclusionary legislation, such as the 1950 Amendment to the Natives (Urban Areas) Act which lead to the systematic removals of Africans, and Coloureds and Indians from slum areas to urban townships (Teppo, 2004: 14).

As international ideas of poverty and structural social problems infiltrated South Africa, these ideas were extended to poor whites, but not poor blacks. Towards the end of the 19th century poor whites were no longer being regarded as "victims of their vices" (Iliffe, 1987: 116) and the Dutch Reformed Church especially took keen interest in solving white poverty. In 1929 the Carnegie Commission (1932) was tasked with an investigation into the 'Poor White Problem'.

One of the defining consequences of the emergence of poverty in the white South African population was that it ushered in an era of welfare provision at a very generous rate, although on a racialised basis. The desire of the state to 'uplift' (*ophef*) 'poor whites', and as a conscious corollary, the hierarchical separation of races, provided a foundation of social provision that laid the foundations for a racially differentiated welfare state (ie a welfare state for whites) that was unmatched in other middle-income countries towards the end of apartheid. What became known as the "Poor White Problem" started grabbing the attention of South Africa in the last decade of the 19th century. The Carnegie Commission on the Poor White Problem in South Africa defined it as such:

> This term is used to denote principally the economic and social retrogression of a considerable part of the white rural (or originally rural) population of our country. (Carnegie, 1932: v)

And "poor whites" were defined:

> As regards their origin, they are persons of European descent who gained (or are still gaining) their livelihood chiefly by farming. (Carnegie, 1932: v)
>
> As regards their economic condition, they constitute a class consisting principally of poor "*bywoners*," hired men on farms, owners of dwarf holdings or of small undivided shares of land, poor settlers, and the growing group of unskilled or poorly trained labourers and workers outside of farming." (Carnegie, 1932: v)

The main driver of white poverty was landlessness, as in the case of black poverty since the colonial era. The effects of the 2nd Anglo-Boer War, poor education, the economic depression of the 1920s, rapid urbanisation and the rise of commercial farming contributed towards increasing poverty everywhere – economic and social change seems to have been the great leveller. Statistics vary, but according to the Carnegie Commission published in 1932 (even before the full effects of the economic depression) poor whites numbered around 300 000 (Carnegie, 1932). Almost a third of Afrikaners lived under the subsistence level by the 1930s.

The solutions to the Poor White Problem were highly successful (for whites) – by the 1950s poor whiteism had almost disappeared. The social engineering functions (discussed in the next section) attached to social, economic and segregationist policies were highly oppressive for both black and white, but economically more so for blacks as it were implemented with a clear focus of differentiation between races. Some external reasons why white poverty was eliminated in South Africa included the post WWII economic boom which provided most of the jobs for poor whites.

The decade before the electoral victory of the National Party in 1948 however signals a few disjunctures. Van Niekerk (2007) explores the context which allowed for inclusive social policies to develop during the 'war years' as well as why these attempts at inclusivity were unsuccessful. Entering the war meant, for the government, a new vulnerability in the form of a "reliance on black economic and political allegiance" (Van Niekerk, 2007: 290), whilst the post-war vision which culminated in the 1941 Atlantic Charter contributed to the context

within which inclusive de-racialised policies were conceived in the segregationist era. Van Niekerk argues that the lack of political rights of the black population meant that such a 'controversial' issue as a cross-race risk-sharing system of universal health care as proposed by the 1944 Gluckman Commission was vulnerable to the political divisions among the white electorate and therefore failed to be implemented. The United Party therefore reneged on pushing such far-reaching social policy reforms through Parliament in the fear that they might alienate their Afrikaans voters (Van Niekerk, 2007: 292). Similarly Baines (2003) argues that United Party Prime Minister Jan Smuts was more likely a pragmatist rather than an ideologue, playing his cards as he needed to in order to remain in power.

4.2.2. Inequality during Apartheid

There is significant continuity between the racially exclusionary policies of the segregationist era and the apartheid era as some writers have pointed out (Baines, 2003; Legassick, 1975; Walshe, 1963; Bunting, 1964). Apartheid is thus seen as a modernisation of the segregationist project through the institution of an elaborate system of domination and control. Legassick provides a detailed outline:

> …*apartheid* has meant an extension to the manufacturing economy of the structure of the gold-mining industry. In the towns, all remnants of African land and property ownership have been removed, and a massive building programme of so-called 'locations' or 'townships' means that the African work force is housed in carefully segregated and police controlled areas that resemble mining compounds on a large scale. All the terms on which Africans could have the right to reside permanently in the towns have been whittled away… (Legassick, 1975: 47)

Others have argued that there is a more complicated relationship between ideology, the mode of production and political practice (Wolpe 1972: 427). Wolpe argues that "The problems of control… are *not*, however, simply or primarily a function of the *demand* for labour-power which is cheap, but crucially a function of the conditions of the production and reproduction of that labour-power" (Wolpe: 1972: 428). Wolpe finds it problematic that writers on the apartheid system have treated racial beliefs "as a force external to, but productive of, distortions in the otherwise rational economic system" (Wolpe 1972: 429). Instead "(R)acial ideology in South Africa must be seen as an ideology which sustains and reproduces capitalist relations of production" (Wolpe 1972: 454). A response to changing social

conditions is responded to by the 'dominant classes' through the lens of particular ideologies which, in turn, produced the policies of both segregation and apartheid (Wolpe 1972: 454).

The coming to power in 1948 of the National Party government saw the implementation of several repressive legislative measures aimed at segregating social groups even further. In 1949 marriage between social groups were prohibited and in 1950 sexual relations between social groups were made illegal. The Group Areas Act of 1950 specified areas as belonging to particular races and controlled movement within it and the Population Registration Act of 1950 introduced racial classification. "The implications for social policy of this battery of exclusionary legislation", Van Niekerk writes, "was that it organised access to social provision such as housing, health and welfare differentially according to race group" (Van Niekerk, 2007: 160). Service provision in townships was poor and social infrastructure was often non-existent - in contrast to white suburbs. Whereas the provision of services in the townships was previously left to local municipal structures, the central state started taking it under its own authority between 1948 and 1974. The police system was increasingly being used to manage influx control and the pass laws were tightened.

Most of the provisions of the 1940s were either cut back or completely abolished. Unemployment insurance to the black population was cut back in 1949. Seasonal or casual African labourers as well as those earning below £182 p.a. were no longer eligible for unemployment insurance (Legassick, 1974: 18). Although the Nationalist government did replace a considerable amount of shacks with houses, it was done in order to facilitate the policing of townships and to remove freehold rights where possible. Apartheid social policies served the capitalist economy by guaranteeing "the 'comparative advantage' of cheapness of labour and ensure the continued reproduction of labour-power in the reserves" (Legassick, 1974: 19).

Despite rapid and sustained economic growth, poverty and inequality increased during the second half of the 20th century due to discriminatory practices, laws and policies which systematically created a flow of resources and capital away from the black population and towards the white population. This facilitated the process which made it possible for 19% of the minority white population to receive 74% of the national income (Legassick, 1975). The white population was able to "enjoy one of the highest standards of living in the world" (Legassick, 1975: 229). "The disparities in actual income [were] matched in the provision of social services", Legassick notes, where "in terms of education, health facilities, housing,

pensions, and recreation whites are served as well as any advanced industrial country and non-whites in grossly inadequate terms" (Legassick, 1975: 229-230). The poverty resultant from this unequal flow of resources is stark and manifested itself in a variety of systemic social problems: low quality education and the colour bar created low economic mobility; the infant mortality rate was amongst the worst globally for countries of comparable resources - up to half the children born in rural areas died before the age of five (United Nations, Unit on Apartheid, 1970). The South African economy was based upon cheap black labour and the outcome of the unequal system of labour was distributed along explicitly racial lines.

The policy of granting autonomy to reserves was also part of the larger aim to transfer welfare costs and obligations to the Bantustan authorities conceived of in the scheme of "Grand Apartheid". The National Party government started placing greater emphasis on increased African wages and with it increasing the responsibility of the employer – as a means to make "Grand Apartheid" affordable and viable. An overview of the taxability of the African population[9] was one of the reasons the government came to this conclusion – since employers did not pay Africans enough for them to get taxed – and therefore 'pay' for their social services – the state transferred some of the obligations of social provision to employers. Also, it was argued that state subsidisation of cheap African labour through the provision of houses, transport and cheap food had led employers to view the State as a source of profit maximisation, which in turn encouraged employers to employ more African labourers at lower cost.

4.2.3. Summary

There is a similarity between the emergence of structural poverty in South Africa and other industrialising countries. Rapidly changing economic and social patterns left many without the means to live and in this context social measures emerged to ameliorate or compensate for the 'diswelfare' caused by industrialisation and rapid social change. The policies which were formulated following the Carnegie investigations into the Poor White Problem reflect a concern for the effects that modernisation had on impoverished whites. However, these policies were used towards the ends, not of equality, but of racial differentiation and domination. These policies were used to "divide, discriminate and compete", as Titmuss

[9] See the debates on the 1958 Native Taxation and Development Act. It showed that "African wages were too low to permit an increase in taxation." (Legassick, 1974: 20)

warned (1964b: 34) in a different context. The impoverished black communities were segregated from white communities and received different measures of welfare. The differential reaction to the different races was done in order to further the interests of the dominant classes and the ideology of racism and severe repression mediated and made their implementation possible.

Both segregation policy and policies aimed at the 'upliftment' of poor whites were used in this project of racial differentiation. The policy of segregation was used, not only to differentiate people by "race" by providing different services, but also to promote and entrench social alienation between social groups. Economic growth during Apartheid was structured to benefit a white minority. The provision of better services and welfare for a small amount of people and low-quality or non-existent provision for the majority fuelled inequality along racial lines and ideas of racial hierarchy reproducing the status quo. These stereotypes and normative conceptions about race and culture played an important role in the emergence and length of Apartheid rule.

4.3. Powerful interests and ideas of poverty and ill health

Policy is directly and indirectly influenced by several external factors. Policy reacts to the way current social ills are perceived and these perceptions are often shaped by dominant interests. This section focuses particularly on the effects of prevailing attitudes towards disease, social problems and poverty. As has been pointed out, "irresponsible" policy decisions are most often fuelled by a misdiagnosis of the "underlying causal processes and political dynamics that underpin structural poverty and entrench inequality" (Du Toit, 2011a: 128). As a British colony, ideas of the 'deserving and undeserving poor' travelled to South Africa from Britain and influenced the way institutions viewed and treated the poor in South Africa. State-initiated sick pauper centres "were deliberately created to punish and stigmatise indigents in accordance with English notions of poor relief prevailing in the nineteenth-century Cape Colony" (Sagner, 2000: 525; see also Iliffe, 1987: 101). In South Africa the processes of urbanisation, industrialisation and increasing landlessness increased poverty among both the white and black population. Yet these racial groups were treated differently when it came to poverty alleviation.

Attempts to systematically eradicate poverty among whites were made to the detriment of the black poor. The presence of white poverty did not fit into the ideology of white superiority and fears of the dangers of racial and cultural miscegenation proliferated. Policies were used

to divide the population of South Africa and it manifested itself most obviously in the policy of segregation. From early on segregation was justified by interested parties through the use of medical theories. According to Iliffe, serious calls for the segregation of races started in the 1880s due to, among other things, several epidemics[10] which were blamed on the influx of Africans into urban centres (Iliffe, 1987: 115).

The progressive view of scientific inquiry in the medical sciences and social inquiry into poverty argued that, as knowledge grows and facts about disease and poverty causation were revealed through experimental inquiry, the application of medicine and poverty alleviation is extended in society. This notion of progressive enlightenment that influences perceptions of illness and poverty fits into a linear model that explains the changes in policy over time (Bernier and Clavier, 2011: 110). The linear model leads us to believe that, as our understanding about causal factors expand; we will make policy judgments based upon empirical knowledge which would, in turn, lead to positive outcomes.

> A linear model assumes the existence of a continuum from research to policy change: authors assume that good data are provided and that good policy decisions should follow accordingly (Bernier and Clavier, 2011: 110)

However, this does not explain how policies have changed dramatically over time, and have taken, as their point of departure, less enlightened views on causal factors; very often *despite* existing knowledge. For instance, the clear focus on poverty and resultant reforms in the United States in the 1960s and 1970s, however flawed, were nonetheless progressive in the way they were influenced by more enlightened views of the structural causes of poverty. They were, however, followed by a conservative reaction which moved away from structural and systemic contexts as their point of departure and the poor were once again victimised.

As Himmelfarb points out in relation to the UK experience, "the tendency to read the [British] past as a progressive movement towards a more enlightened future" is a "fallacy"; a reading of the past more accurately "resembles a pendulum oscillating between extremes of regression and progression, of punitive, repressive policies and generous, melioratory ones" (Himmelfarb, 1984: 6). Thus despite scientific medical progress, regression in the formation of policy is possible. South African intellectuals and policy makers had access to progressive

[10] Smallpox in 1882; Bubonic plague in 1901

international theories, yet many opted for the application of racist notions and chose to ignore the fundamental causal factors of poverty and ill-health.

4.3.1. Early medical racism, segregation and mining capital

This view of the progressivity of medical knowledge has been questioned by several authors who show, in different contexts, how the social and intellectual environment at a given time affects society's views on disease (Rosenberg, 1962; Kuhn, 1970; Starr, 1982; Rosenkrantz, 1972). Rosenberg points out that views on cholera in American society had changed between outbreaks, not due to medical advances (because there were none) but due to developments in American society itself which had shaped the popular outlook on disease; what was at first "a drama of moral choice and spiritual salvation", had become merely "a consequence of man's interaction with his environment" (Rosenberg, 1962: 228).

Packard (1987) makes a similar argument with regards to the way tuberculosis was viewed in South Africa at the turn of the century and how these views affected (or facilitated) the process of policy formation – policies were made which were, to a large extent, in the interest of a white minority social group. Objective evidence about tuberculosis susceptibility played an ambivalent role in policy formation. Wider social, economic and cultural currents within South African society played a more prominent role in determining medical attitudes. Attitudes towards the disease as it affected Africans "reflected changes in the nature of South African society and, more specifically, phases in the development of racial capitalism" (Packard, 1987: 190).

Deacon makes a similar point when she argues that 'scientific racism' was slow to take root in South Africa as doctors in the Cape Colony drew from more universalist and metropolitan medical theories, but 'racist science' abounded with the incorporation of popular racist norms, practices and stereotypes into what was essentially universalist-orientated theories (Deacon, 2000: 194). Early medicine practiced in the North drew from racist scientific theories which were widespread at the turn of the 20th century. However, popular racism at the time, drawing from "well-worn stereotypes" shaped the early medical profession (Rich, 1990: 667). Furthermore, colonial sanitation policies had a massive influence on the way Blacks were treated medically. These policies also fuelled popular racist conceptions which were then written into policy.

Extreme racist stereotypes of Africans as disease-bearing and unhygienic were widespread and justified segregation as a matter of health:

> When bubonic plague struck Cape Town in 1901 the authorities blamed it on 'these uncontrolled Kafir hordes' and implemented a plan to create a segregated African location at Ndabeni near the sewage farm on the Cape Flats 6 kilometres from the city centre. Some 6000-7000 Africans were immediately moved there, many at bayonet-point. (Iliffe, 1987: 115)

Swanson argues that at this time medical officers and public officials were "imbued with the imagery of infectious disease as a societal metaphor", what he calls "the sanitation syndrome" which contributed greatly to the emergent calls, justification and acceptance of segregationist policy (Swanson, 1977: 387). The emergence of segregationist policy in the late 1800s has been argued to be caused by the increasing need for cheap labour and the strong influences of mining capital in early South Africa; segregationist policy provided the mines with cheap labour whilst exporting the miners' health risks and obligations to the reserves (Legassick, 1975, Wolpe, 1972).

As Packard explains, medical assumptions about tuberculosis susceptibility among the black population reflected the change of needs in the mining industry (Packard, 1987: 191-209). In each and every instance the responsibility of the mining industry towards the health of the African population was negated by the way in which medical officials formulated their theories about tuberculosis susceptibility. This was done by blaming the victim for their own poor health by either downplaying the environmental factors (such as overcrowded living arrangements provided by the mines), by deflecting attention away from these factors through an inordinate focus on pathology, or by claiming that the improvement of environmental factors would have no effect on the mortality rate at all. Interesting to note, this did not stop in the 1990s as some writers' show (Trapido et al, 1998; Williams et al, 1998).

At first the high rate of tuberculosis among Africans were blamed on their 'intemperate' living, drawing from early assumptions that blamed European tuberculosis patients along similar lines. As the mortality rate increased Africans were once again blamed for being inexperienced in the 'civilised way of life' and therefore allowing themselves to be more susceptible to the TB virus. The problem of containing TB therefore became an issue of sanitation and housing, but to absolve the mining industry of these responsibilities they opted for sanitary segregation; protecting white mine workers rather than improving living

conditions for all. Furthermore, much was done in the way of teaching Africans to be 'civilised' and the policy of 'acclimatisation' was employed to increase African resistance to the disease. The medical idea that Africans were inexperienced in the ways of the civilised came at a time when there was a labour crisis and the policy of hiring more experienced mine workers was very much in line with the needs of the mines. Segregation on the mines was also a means of controlling Africans in the urban areas. Also, as Packard points out, segregation justified by 'medical' reasons had the effect of creating a group stereotype; previously TB was viewed on individual terms. The consequence was that disease, particularly tuberculosis

> …contributed to a more generalised association of unsanitary behaviour with race. Physical segregation heightened racial consciousness and moved conceptions of the causes of black susceptibility to disease toward a more explicitly racial conceptualisation of the problem. (Packard, 1987: 196)

Shaped by 'well-worn' racist stereotypes, the emerging health and welfare systems became interwoven with segregationist thinking and medical and social misconceptions about race and culture was used to drive policies through.

4.3.2. Early views of the poor

As a British Colony, South Africa inherited many British ideas and norms about poverty and poverty alleviation. Early notions of the poor were caught up in religious rhetoric on holiness and the amelioration thereof, firmly in the hands of the church, implied the dual role of upliftment and spiritual salvation (Himmelfarb, 1984). A large network of charitable societies and church organisations existed in South Africa by the end of the 19th century which was administered by the Provincial Authorities (Pienaar Commission, 1927: 9). They provided a patchwork of poor relief for both the black and white poor. But with the importation of British institutions, so also came with it ideas of poverty that shaped the consciousness of the population and the attitudes towards the poor.

Debates around poor relief at the time symbolised a clash of fears. On the one hand charity and obligation towards the poor was a religious benchmark of morality – a test few were willing to fail. Then there was the fear that poverty alleviation will have as a consequence "the encouragement of idleness" as Benjamin Franklin warned on his visit to England in 1766 (Himmelfarb, 1984: 5). Both these ideas were compatible with religious doctrine as idleness

was considered a product of unrighteousness and hard work a virtue. The solution to this dilemma was often found in identifying between the 'deserving' and the 'undeserving' poor. As poverty alleviation became secularised these debates changed little. State intervention in poverty alleviation became a "test of civilisation" (Himmelfarb, 1984: 4) and particularly in South Africa to differentiate between civilisation and barbarity. The increasing amount of poor whites challenged the notion of white supremacy by providing 'uncomfortable similarities' between white and black people. State intervention, which emerged in South Africa in the early 1900s, was a reaction to the inability of the religious and benevolent institutions to deal with the extent of poverty among the poor whites in South Africa. The Pienaar Commission on Old Age Pensions and National Insurance argued that, instead of providing adequate security the patchwork of small provisions from various sources was "turning the deserving poor into callous and hardened professional beggars" (Pienaar Commission, 1927: 7). Not soon after, the Carnegie Commission (1932) was instructed to report on the causes and suggest solutions to the increasing amount of poor whites in South Africa.

4.3.3. Poor whitism

Teppo (2004) argues that segregation and the provision of white suburbs for poor whites was done with the aim of creating "good whites" – social provision in the form of grants and housing was instituted and formulated to guide and rehabilitate these 'inferior' whites towards becoming 'civilised – thus the solution to the poor white problem was a 'civilising process' (Teppo, 2004: 15-17).

Drawing from the Carnegie Commission's research into the 'poor white problem' it is easy to see the particular attitudes that governed the inquiry. Not only was the notion of poverty situated in dichotomous terms of civilised/white and uncivilised/black, but the investigation into poverty among the poor whites led to the conflation of poverty with degeneration, mental deficiency and inferiority.

4.3.4. The 1930s and 1940s

The 1930s and 1940s presented an era of competing interests and ideas which culminated in an opening up of possibilities. The deteriorating state of the African family made it onto the agenda for two reasons. Firstly, all over the world developed countries were drawing increasingly from social-welfarist thinking which presented a new confidence in the

interventionist state; secondly there was the need for stable African families which would increase their productivity and provide a healthy workforce as well as reduce crime in urban areas (Posel, 2005: 64-65). Tackling African poverty, it was argued, would promote healthy family life and decrease 'urban juvenile Native delinquency'. A particularly conservative form of eugenicist thinking played an important role in shaping the way the state was to tackle the problem of poverty and was perhaps most clearly explicated in the solutions to the poor white problem. The same happened among the African poor as the state attempted to subject the social and economic life of Africans through

> …systemic and comprehensive state intervention... spearheaded by various groupings of liberals, missionaries, academics, urban African leaders, and urban administrators, who found a receptive audience within some state institutions – notably in the Department of Native Affairs through the office of Douglas Smit as Secretary of Native Affairs. (Posel, 2005: 65)

The social reforms of the 1930s and 1940s did not include extending the franchise to Africans, nor political reforms in any manner. Apart from a few progressive thinkers within and outside Parliament representing sections of the liberal white community, who were more open during the war to extending social, political and economic rights to the black population, suggested and enacted social reforms were treated as no more than rhetoric to the population. In the case of black political movements, most notably the African National Congress, who called for the extension of political, civil and social rights in the context of the war against Nazism, there was a disillusion with constitutional methods of change. The Gluckman Commission (Report of Commission on National Health Services, 1944) called for the nationalisation of the health services open to all South Africans regardless of race. However, the "proposals ran aground on vested institutional interests" (Van Niekerk, 2007: 91). The Smit Commission (Report of the Inter-Departmental Committee on the Social, Health and Economic Conditions of Urban Natives, 1942) suggested the abolition of the pass laws and the right to residency in urban areas for all South Africans. Thus although there were moves towards social inclusivity and calls for political inclusivity, most of these were still-born. As Van Niekerk (2007: 74) puts it

> …social policies which attempted to redress the social inequalities experienced by urban Africans had to confront the policy of segregation and the denial of civil,

political and social rights of citizenship to Africans, the major cause of such inequalities.

1948 marks the end of any possibility for progressive reform with the coming to power of the National Party.

4.3.5. Apartheid

Posel (2005) argues that there was indeed a break with the welfare option in 1948 when the National Party came to power, but draws a significant parallel between the political-economic ideologies of the time: the welfarist logic of regulation that is embedded within social democracy was transferred into the National Party doctrine yet used towards "different political and ideological ends" (Posel, 2005: 64). The roots of this thinking were found in the 1930s where parallels were directly drawn between the deterioration of white family life and the continuing poverty which culminated in a call for racially exclusive welfarist policies and a more interventionist state. Posel argues that the perhaps benevolent notion of welfare developing in Europe and North America at the time, and for a few years in South Africa, set the theoretical stage for making "the Apartheid project thinkable" (Posel, 2005: 66).

What made the logic of welfare so easy to shape according to dominant interests was its premise on both the material as well as the normative. In stark contrast to the ideology of liberalism, which puts the 'private' lives of people off limits to the state, communitarian notions calling for the regulation of the economic sphere often justifies the regulation of the social. In this framework taxation itself is an infringement on the private individual's liberal rights and it is all too easy to 'demand' certain forms of behaviour in return for welfare benefits. The material and the normative are, as have been argued in this thesis, closely interlinked. Racism, to the extent that it denies citizenship or even humanity to a particular race can be written into welfare policies as much as it could be written into economic policies. It is perhaps therefore not hard to see how the Nationalist Party could justify a racialised welfare state. As Titmuss (1964b: 34) warned, "welfare can divide, discriminate and compete".

4.4. Conclusion

Policy can be directed by dominant interests in order to ensure the cheapness of labour and the reproduction of cheap labour power. During the last century both economic and social policies were constructed to systematically create a flow of resources and capital away from

the black population and towards the white population. This use of social policies for perpetuating racial exclusion and political domination leads to the oppression and exploitation of excluded individuals and groups. As argued above, capitalism played a leading role in the unequal outcomes of South African society: racist norms were used to shape social policy in the favour of capital. Race was used to justify differential treatment. It is important to recognise the normative facilitating factor in reproducing racial inequality.

South Africa under apartheid demonstrates that shaping social policy towards ends other than equity and equality can lead to entrenched racial and class divisions. The justifications of these policies are based significantly upon conceptions of poverty and disease which are ideological. The argument that early notions of poverty and disease causation which influenced policy were misinformed due to lack of knowledge provides very little insight compared with the explanation that such notions were shaped by dominant interests and racist ideologies of the time. Early colonial racism had a profound effect on the exclusionary shape of institutions and the inequity in state provision. The ingrained culture of racism and apartness in these institutions continued to fuel an ideology that justified continued inequality. It is only when these institutions are radically changed, despite contemporary resistance, will they then create the foundation for an inclusive and solidaristic society. As these notions become the norm they will reproduce themselves just as racism and apartness reproduced itself in Apartheid institutions.

The main aim of this chapter was to demonstrate the complex relationship between dominant political and economic interests, the production of policy and the ideological framework which justifies, maintains and manages reactions to it. The ideas about race upon which apartheid policies were built provided the ideological framework which shaped popular ideas of race and, particularly among the white voting community, was powerful enough to sustain apartheid for almost half a century. And whilst ideas about human nature fuelled by racist considerations have fallen into disrepute (despite the fact that it still enjoys some popularity), similar stereotypes still remain among classes. Just as a particular conception of the hierarchy of races legitimated racist policies so are particular ideas around poverty legitimating the continuation of regressive policies. And as the privilege of one group (in this case the poor white community) was built upon the exclusion of another, so too today, as is seen through the application of the Social Division of Welfare, one class benefits from policies which are meant, on principle, to benefit the worst off. The anti-egalitarian principles which brought the policies into being are also perpetuated within these institutions

and allow these institutions to be sustained ideologically. The complex relationship between dominant political and economic interests, the production of policy and the ideological framework which justifies, maintains and manages reactions to it in post-apartheid South Africa should be subjected to scrutiny, just as those of the apartheid era have been.

CHAPTER 5

THE SOCIAL DIVISION OF WELFARE AND STATE EXPENDITURE ON HEALTH IN SOUTH AFRICA

5.1. Introduction

Richard Titmuss' most influential theoretical framework, the 'Social Division of Welfare', was a critique of many of the assumptions and stereotypes of the 'Welfare State' that prevailed during the 1950s and 1960s in the West. Titmuss formulated a theory which, in dividing up all the benefits received by all citizens demonstrated how the non-poor disproportionately benefit from welfare provision due to their privileged position in the labour market. First presented at the sixth Eleanor Rathbone Memorial Lecture in 1955, 'The Social Division of Welfare: Some Reflections on the Search for Equity' was subsequently published along with a number of other essays that dealt with the role of the social services in a changing society, in his volume *Essays on 'The Welfare State'* (1958).

The Social Division of Welfare is based around the ideas of the theory of the division of labour. The division of labour was developed by Adam Smith who described the increasing specialisation and division in labour in industrial society. General jobs are broken up into specialised tasks and each of these tasks is performed continuously by one individual. This simplification of tasks creates efficiency.

In 1893, when Emile Durkheim wrote *The Division of Labour in Society* the business sector was

> ingeniously following and reflecting in all its shadings the infinite diversity of industrial enterprises; and, while this evolution is realising itself with unpremeditated spontaneity, the economists, examining its causes and appreciating its results, far from condemning or opposing it, uphold it as necessary. They see in it the supreme law of human societies and the condition of their progress". (Durkheim, 1893, English transl., 1965: 39)

This form of division that we now live with in modern society is interdependent and specialised, as almost no single form of labour can exist or operate on its own. Thus Durkheim argued that the more specialised we become; the more socially dependent we also become (Durkheim, 1893, English transl., 1965). Titmuss sees Durkheim's notion of interdependence and solidarity as a way of explaining the emergence of systems of welfare:

> man becomes more aware of what has caused his dependency, and thus more exposed to uncertainty and conflict about the purposes and roles he himself is expected to fulfil. More self-knowledge of the 'man-made' causes of dependency has been reflected in social policies through the greater recognition accorded to individual dependencies and their social origins and effects. It has also influenced the growth of our other categories of welfare. (Titmuss, 1958: 44)

As is explained by the notion of 'diswelfare', the dependencies and insecurities that arise out of modern society are compensated by different forms of welfare. Titmuss hoped that what is generally perceived as welfare would be regarded, not merely as a safety net for the worst-off, but as a universal system of compensation for the disutilities of a chosen economic system. However, what is, according to the Social Division of Welfare, defined as Social Welfare most often takes the form of a safety net for those who cannot procure these forms of security for themselves in a market driven society. Thus there is a free public service for those who *cannot afford* private health care or health insurance. It is an environment such as this that allows for the emergence of other forms of welfare such as occupational and fiscal welfare.

Titmuss divides welfare into three divisions (1958: 42-44):

> social welfare (directly administered services and transfer payments, including the health services, social security payments, housing and education);
>
> fiscal welfare (taxation allowances and deductions from the state); and
>
> occupational welfare (derived from employment and including pensions and occupational health and welfare).

They all have the same functions and they are formulated in recognition of a dependency or need. However, 'fiscal' and 'occupational' welfare tend to benefit the well-off and are not perceived as welfare as understood generally. They are therefore not subjected to the same

criticisms and scrutiny that 'social' welfare is. In Titmuss' view, these divisions were all redistributive; whether progressive, regressive, horizontal or vertical distributions over time, and involved a transfer of resources, in cash or kind, between social groups.

All forms of distribution or 'collective interventions' are essentially the same in the way that they function or what their 'declared aims' are. Their 'declared aims' are usually attempts at equity. Where fiscal and occupational welfare do differ from social welfare is in "organisational division of method, which, in the main, is related to the division of labour in complex, individuated societies" (Titmuss, 1958: 42). They are, partly due to the fact that they are not considered a form of welfare, most often used as a reward or an incentive. The Social Division of Welfare makes it possible to:

> interpret the development of these three systems of social service as separate and distinctive attempts to counter and to compensate for the growth of dependency in modern society. Yet, as at present organised, they are simultaneously enlarging and consolidating the area of social inequality. That is the paradox: the new division of equity which is arising from these separate responses to social change. (Titmuss, 1958: 55)

The South African system of health provision is uniquely suited to the application of Titmuss' framework. The private health system in South Africa is considered an independent system operating outside the rubric or involvement of the state and runs as a market in health care for those who can afford it. The public health system operates as a 'safety net' for those who cannot afford the high costs of private health care. Due to the fact that the private system is viewed as independent of the state, the connection between the failing state system and the private system is not interrogated. Thus, the failings of the public system are either argued to simply be internal issues over efficiency or external policy weaknesses. The Social Division of Welfare can reveal the differentiated relationship between the private and public health systems and provide conceptual insights previously left unexamined or unexplored.

5.2. The Social Division of Welfare in theory

Titmuss argued that redistribution does not necessarily mean a flow of money from rich to poor and that ill-advised policy could have the opposite effect of its initial intentions. Moreover, he demonstrated exactly how this process occurred. Distribution used as an incentive ends up becoming regressive and allows those in an already favourable position to

benefit over the poor or the unemployed. In what he termed 'occupational welfare', benefits are often used as an incentive and reward for good business conduct and success. This slowly turns into a cycle of privilege that "divides loyalties", "nourishes privilege", and "narrows the social conscience" (Titmuss, 1958: 52).

The Social Division of Welfare identifies three categories of welfare expenditure which is different only in its methods of administration and its general conception in society. The first is Social Welfare. Social Welfare would include the grant system and all directly administered services in the area which is generally conceived in South Africa as the social security system and administered by the Department of Social Development. The focus of this thesis, the South African health system, situates Social Welfare as direct state expenditure on public health care.

Fiscal Welfare represents deductions and allowances on taxable income. In the area of health care Fiscal Welfare is represented by medical deductions and more recently, tax credits, provided under the Tax Act No 24 of 2012. What Titmuss describes as "ordinary social expenditure" such as the State Old Age Pension (SOAP) and the public health system flows directly from the central government account. Subsidies and tax relief on income tax, such as the Tax Expenditure Subsidy (TES) that operate in South Africa for those who purchase private health and retirement insurance express a similar purpose – it is the recognition of a dependent need – the adverse effects incurred on an individual's cash flow due to medical or retirement insurance expenditure.

Fiscal welfare also disproportionately benefits the affluent and more successful since it is almost always offered on a sliding scale to tax payers only and the better paid are more likely to be able to afford such amenities. It is perhaps interesting to note that the notion of fiscal welfare was a critically new concept when Titmuss formulated the Social Division of Welfare in 1955. "Economists took the idea over and called it 'tax expenditure' and it is now a fundamental and accepted part of public economics. Governments measure it and have changed their budget and economic statistics to include it" (Alcock et al., 2001: 4). In South Africa the TES is not treated as health expenditure, and it is "not part of the formal annual budget in parliament" (McLeod, 2009: 4). Nonetheless, both public social provision and tax subsidies for private social provision accrue to being, for the individual, a transfer payment.

Government is often fearful of creating a new major spending program such as a universal state pension scheme due to the controversy and stigma attached to such social schemes. In

order to increase the insured population, either in health or retirement, they opt for less controversial ways such as providing tax cuts. In other words, tax subsidies are politically attractive. There are two ways in which tax subsidisation works, the one is through deductions of tax on health or retirement insurance and costs and the other is through tax credits.

Occupational Welfare represents any form of fringe benefit derived from one's position in the labour market. In order to interrogate the flow of public funds to the private sector, this thesis focuses on public resources only. Occupational Welfare therefore includes all health benefits or contributions provided by the state as an employer such as in the case of the Government Employee Medical Scheme (GEMS), as well as any tax subsidies or deductions that arise from employer-sponsored health provision. The government provides a tax subsidy to employers who contribute towards their employees' medical aid payments. In tax terms these contribution qualify as 'fringe benefits', which have a special tax status.

All of these forms of 'welfare' provisions have some purpose and is often used as an incentive for certain behaviour, especially in the case of fiscal and occupational welfare. Bonuses and fringe benefits are given as incentives either to draw specialised employees or improve productivity. Just as tax incentives for foreign investors are provided in the hope for increasing foreign direct investment, so too is the Tax Expenditure Subsidy (TES) used as an incentive for those in the formal economy to purchase a private retirement plan. These forms of welfare provision, as is demonstrated further on, invert the process of redistribution and allow for the well off and secure to benefit from a process which originated to help the insecure.

The reasoning behind tax incentives is most often that the more people who are able to purchase insurance, fewer will need to utilise state facilities and services (Van den Heever, 2007). Van den Heever (2007: 30-31) makes it clear that subsidies "provided through the tax system (TES) is opaque and its true value is therefore hidden from adequate public scrutiny". The multiple character and complexity of the welfare process is obscuring the fact that those whose needs are greatest are being less and less favoured by redistributive functions. Furthermore, the continuous scrutiny which public social provision is subjected to should therefore be extended to the benefits that flow to the middle and upper classes.

It is important to view fiscal and occupational benefits as part of the social security system since public social provision, tax subsidies for private social provision and occupational

benefits accrue to being, for the individual, a transfer payment from the state to support their well-being. This chapter quantifies the different forms of state welfare provision for comparison. It focuses on trends suggested by the data due to the paucity of information and statistics on these resource flows. Despite this drawback, examination and discussion of data trends reveals who benefits from state expenditure and allow for an analysis of the beneficiaries of public health expenditure.

5.3. The Social Division of Welfare in the South African health system

This section applies Titmuss' Social Division of Welfare to the contemporary South African context. It is restricted to state expenditure for health provision (either directly or indirectly). It quantifies, as far as possible, spending in the different categories for comparison. These figures are analysed and compared extensively in the next chapter by integrating them into the larger context of the two-tier health system in South Africa.

5.3.1. Social Welfare

Social Welfare includes all state funds that are spent in the public health sector. This figure can be quantified by looking at the state budget for health care. Public health expenditure for 2011 was around R122 billion, or 4.2 per cent of GDP (Minister of Health, 2011). Total expenditure on health for South Africa in the 2011/12 financial year was 8.6 per cent of GDP. This amounts to about R258.4 billion (National Treasury Budget Review, 2012). According to National Treasury there has been a 4.9% annual real increase in public health spending (National Treasury Budget Review, 2012). The World Health Organization recommends that at least 5 per cent of GDP is spent on health care which means South African expenditure is particularly high, especially for a middle-income country. However, despite this high expenditure South African health outcomes are very poor.

The focus of the thesis is on state resources on health care. There is of course, in both the private and public systems a great amount of spending by individuals. For comparison, 2009/2010 figures are utilised since the latest fiscal figures are only available for these years. This means that the changeover to tax credits cannot be taken into account. Total health expenditure in the public sector for 2009/2010 amounts to R99 billion, including local government revenue from tariffs and rates. R88 billion of that flowed through the provincial departments through block and conditional grants. These funds are used for projects, infrastructure, salaries, equipment and the subsidisation of public health provision. More or

less half of all health spending in South Africa therefore provides benefits for more than 80 per cent of the population.

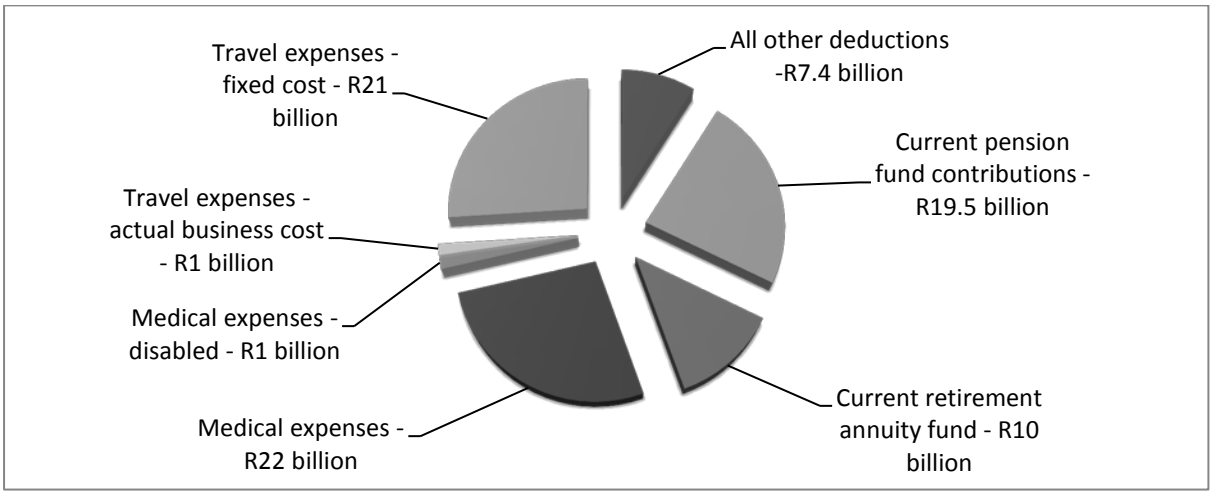
5.3.2. Fiscal Welfare

The tax expenditure subsidy for health deductions is an inherited feature of the apartheid era and "despite 15 years of commissions and reports all arguing for the abolition of the tax break for medical scheme membership, this incentive to join the private sector has been left in place each year" (McLeod, 2009: 6). Due to the fact that it is not part of the formal budget and it is not generally seen as social expenditure, tax legislation such as this "can persist for many years after their purpose has been fulfilled" (McLeod, 2009: 4). As Van den Heever points out with regards to the subsidy for retirement contributions, the subsidy favours those who already have insurance and "effectively provid(es) a financial transfer to beneficiaries" (Van Den Heever, 2007: 18).

5.3.2.1. What is Tax Expenditure?

The notion of 'Tax Expenditure' was coined by Stanley S. Surrey (Wolfman, 1985: 491) long after Titmuss' conception of it as fiscal welfare. Surrey made sense of the concept by explaining it as a formula of government spending on particular groups, but through different mechanisms than direct transfers (Surrey, 1970). Thus, tax expenditure is a transfer of money to individuals or companies through the 'lowering' of their taxes. It has the same goals of direct state spending on social programs, but these goals are accomplished through the tax code. The South African government provides individuals and companies special tax statuses in the form of credits or deductions when they purchase retirement plans for themselves or their employees. The same applies to medical aid. It also provides a tax subsidy for small businesses to grow; for companies to provide learnership programs and to undertake research. The state also subsidises certain basic food items through reductions in Value Added Tax (VAT). Chart 1 indicates the main tax deductions on income tax for 2009 in percentage of total deductions and the actual amount in forgone tax revenue.

Figure 1: Assessed individual taxpayers' deductions, 2009 (National Treasury and SARS, 2001: Figure 2.8)



Tax expenditure is defined as "tax provisions that reduce the amount of tax revenue that could otherwise have been collected" (National Treasury, 2011: 179). It does so through allowances, deductions, deferrals, credits, exemptions or through accelerated depreciation. Since tax expenditure does not go through the normal budgeting process it is often not quantified which has implications for accountability and transparency. In 1994 the Katz Commission (Report of Inquiry into Taxation, 1994) found it impossible to quantify tax expenditure due to lack of data (Stewart, 2012: 8). Since then there has been an increased output of relevant data to quantify and compare the different tax expenditure subsidies in South Africa (Budget Review 2003, 2006, 2011; Tax Statistics, 2008, 2009, 2010, 2011). If tax expenditures are not quantified and published alongside direct government spending programs, government expenditure can never truly be transparent (Swift, 2006).

As a means of measurement, tax expenditures are considered against a benchmark framework which is usually put forward as a position of neutrality and equity, although, depending on the ideology employed, these frameworks differ. The form taxation takes (progressive or regressive) as well as what constitute taxable units, among other things, are what is considered the benchmark income tax structure of the country and "any special departures from those decisions constitute tax expenditures" (Swift, 2006: 4). Tax expenditures are then measured in terms of "estimated loss to the fiscus" (National Treasury, 2011: 180) and done in either one of three ways. The first is through the 'revenue foregone' method which "estimates the tax expenditure by calculating the amount of tax revenue that would have been collected in the absence of the tax expenditure, and assumes that the behavioural response of taxpayers remains unchanged" (National Treasury, 2011: 180).

The 'revenue gain' method calculates "tax revenue that would have been collected in the absence of the tax expenditure, taking into account behavioural responses associated with the removal of a tax expenditure provision" (National Treasury, 2011: 180). The third method is called 'outlay equivalence' where "tax expenditures are measured by estimating the amount of direct government expenditures that would be required to provide the same benefit to taxpayers" (National Treasury, 2011: 180). The first method is the most commonly used since calculating taxpayer behaviour is complex. This chapter utilises the first method to calculate the tax expenditure subsidy for medical spending deductions to tax payers and provide a comparative element by estimating total direct government expenditure on the public health system. This reveals trends on the regressive character of the subsidy.

5.3.2.2. International literature on Tax Expenditure

Tax expenditures provide important economic benefits to those who can claim them. They tend to be a popular measure towards attaining certain goals due to their relative invisibility and because they do not draw as much attention and criticism as public programs. Swift (2006: 2) points out that, especially in low-income countries, tax expenditures are popular among policy makers despite the fact that "the poor do not benefit from tax incentives because their income is usually below the tax thresholds". This he sees as ironic because tax expenditures decrease the revenue governments have to alleviate poverty.

Tax expenditures are regressive when it is applied to a progressive tax rate structure. In their basic formulation they benefit those with high tax brackets more than those with low tax brackets. The other form of state expenditure – direct transfers – can be controlled to favour those it intends to. Wolfman (1985: 493) explains this simply:

> … if a preacher in the 40% bracket is allowed to exclude $10 000 from income, the tax expenditure he receives is $4 000; if a preacher in the 30% bracket excludes the same amount, his subsidy is only $3 000. If instead each receives a direct payment of $10 000 and the receipt is taxable, the lower bracket taxpayer come out ahead, with $7 000 available to him after tax, while the taxpayer in the higher bracket is left with just $6 000. Only when the direct payment is non-taxable would each have the same addition to his consumable resources.

Tax expenditures therefore make progressive taxation less progressive. Particularly in the United States tax expenditures have become a common means of public spending. As Surrey

and McDaniel (1985: 81) argue, “a tax expenditure is a spending program and must therefore be analysed in spending terms”. As a normative tax provision, tax expenditures should be analysed with the same scrutiny as direct public spending.

5.3.2.3. Tax expenditures as incentives

Tax expenditures are sometimes called tax incentives since they are often legislated to change the behaviour of the population in line with social or economic goals. For instance, the government may want to incentivise the purchase of medical aid through the provision of a tax subsidy on medical aid contributions in order to increase coverage of medical aid among the population. The South African government’s policy intentions are to alleviate the burden upon the overcrowded public health system by subsidising the purchase of medical aid (Van den Heever, 2007). Unburdening the public health system, it can then be argued, will mean better quality health care for those who are left in the public system. In this sense the Tax Expenditure Subsidy (TES) on medical aid contributions is a tax incentive. However, TES have been criticised from both the left and the right. It is often argued that they do not change behaviour, especially among the low paid (Littlewood, 1998 in Mann, 2008). Particularly from the right it is argued that tax incentives distort market behaviour.

> In offering the carrot of tax relief/fiscal welfare the government simultaneously appeared to endorse private pensions, subsidised the products and helped to create a ‘sellers market’. (Mann, 2008)

The rationale of incentives was put forward to motivate the introduction of a tax cut on retirement insurance spending in the USA around 2000 to counter the continuous rise in the uninsured population. Gruber and Levitt (2000) used a micro simulation model to measure the impact of tax subsidies on levels of health insurance and came to the conclusion that the subsidy’s ability to do so “remains uncertain and unproven” and that “even very generous tax policies could not cover more than a sizable minority of the uninsured population” (Gruber and Levitt, 2000: 72).

The question is what the consequences of the provision of a TES are for attaining the goal of better quality health care in the public system. Unless Tax Expenditure Subsidies are reconceptualised as a form of government spending (as Surrey (1970) argued) its aims and functions will never be interrogated. Apart from the fact that they are hidden transfers, they are, in the main, erroneously assumed to be costless. This assumption can be linked with

ideas of deservedness and class stereotypes: a state transfer to an upper class citizen does not make this person 'dependent' on the state – however, a state transfer to a lower class citizen could very much have that effect.

5.3.2.4. Tax Expenditures – a safety net for the wealthy?

The TES however also subsidises general medical expenses, which means it is not just an incentive but is used to reduce financial hardship due to high medical expenses. In this way it is also a health care safety net for tax payers. Furthermore, the recognition, by the government, of the adverse effects of high medical costs, points to an important, yet often overlooked fundamental problem within the health system – that of cost escalation in the private health system. The subsidy is playing a fundamental role in alleviating the negative effects for individuals of increasing cost escalation which has, since its inception, been a feature of the private health system.

Not only does the government subsidise the purchase of medical aid, it also has to subsidise the failure of the medical aid industry to provide comprehensive cover for those who utilise it. This need for a subsidy for the richest quintile of the population draws attention to fundamental problems which beset the current private health system. Without medical aid the private health system could not exist. If the justification for a subsidy such as this is to alleviate the burden on the already overcrowded public health system and this intervention comprises an amount up to a fifth of the total health budget it is very important that it should produce the intended results. Furthermore, in order to justify the spending of this amount towards the goal of alleviating the burden on the public health system, all other possible solutions for the deterioration of the public health system and the cost-escalation in the private system need to have been exhausted.

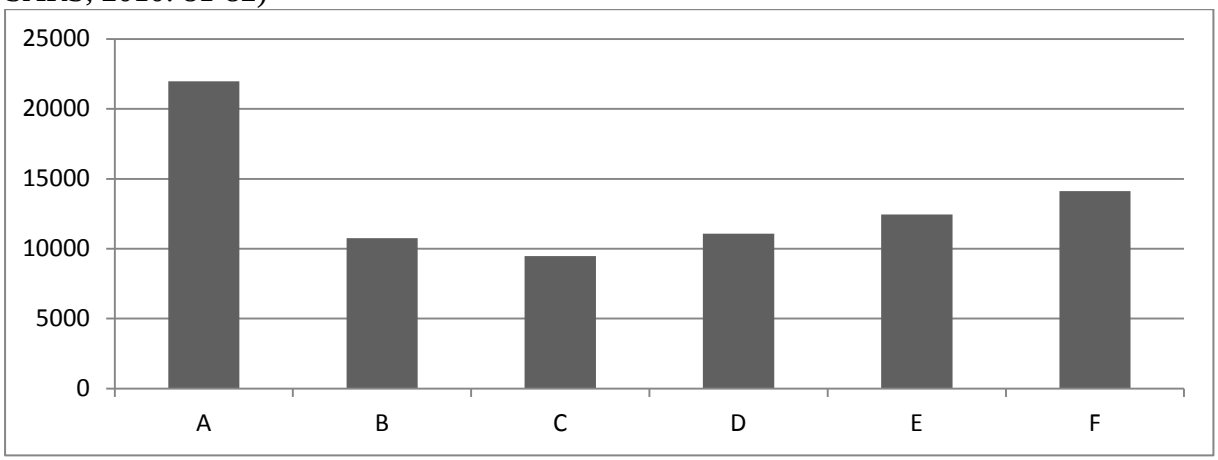
In order to answer this question of whether the TES is the most efficient and effective way of improving public health sector provision, not only does the TES need to be quantified, compared and scrutinised (as is done in this chapter), but the structure of the public health system and the reasons for its low performance need to be analysed within the larger framework of the two-tiered health system (which is done in the next chapter). Also, reasons for the increasing cost-escalation should be analysed and its role in the decreasing health of the overall system should be interrogated. When this is done, the necessity, effectiveness and justification of the TES can be re-evaluated.

5.3.2.5. The Tax Expenditure Subsidy on medical expenses

The TES for medical expenses works on two levels. The first level allows you to claim tax back spent on payments to medical insurance. This is subject to a capped amount that increases with the number of dependents. The second level allows you to add to your claim any further medical expenses which were out-of-pocket and which you could not claim back from your medical aid. You can only claim an amount exceeding 7.5% of your taxable income *after* the first level claims have been deducted. The income tax level is set at different levels for different incomes.

The TES stood at just over R20 billion in 2009. The amount of people who claimed this subsidy equals just over 1.8 million taxpayers. It is of course important to note that these recipients may have dependents; indeed the more dependents the higher the subsidy. The most important thing to note is that 74% of the people who claimed subsidies in 2009 were above the bracket of R100 000 taxable incomes per year. This 1.3 million people together received a medical subsidy of 13.5 billion. The total subsidy divided by its recipients show that public spending in the form of a tax subsidy in medical deductions amounts to just over R10 000 per recipient per year (National Treasury and SARS, 2010: 48,49).

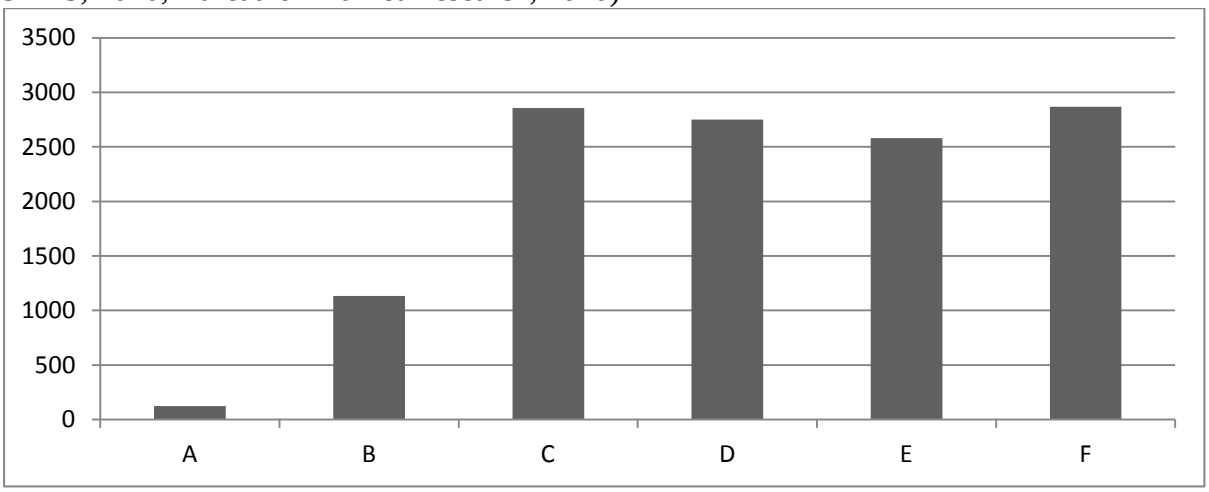
Figure 2: Average TES by income group – current beneficiaries (National Treasury and SARS, 2010: 81-82)



In Chart 2 the subsidy is calculated to show the average amount currently deducted from the taxable income of each income group. Column A refers to taxpayers who had taxable incomes less than R50 000 a year, B to the income tax bracket R50 000 – R100 000; C to R100 000 – R300 000; D to R300 000 to R500 000; E to R500 000 to R750 000 and F to taxpayers earning more than R750 000. Column A includes all registered taxpayers who, in that year, had negative taxable incomes after allowances and deductions. Particularly due to

the fact that all taxpayers with negative incomes for the year fall into group A, regardless of their general class status the tax subsidy seems to benefit the poorest taxpayers and then shows a general regressivity upward. Chart 3 shows just how regressive the subsidy is, mainly due to the fact that it is not offered to those who do not pay tax.

Figure 3: Average TES by income group – total adult population (National Treasury and SARS, 2010; Bureau of Market Research, 2010)



This subsidy is regressive in the way that the benefit is greater the larger your medical scheme payments are. Indeed, "those with the highest incomes benefit the most from tax deductions" (McLeod, 2009: 5). Furthermore, those who do not qualify to pay tax cannot access this subsidy no matter what percentage of their income goes to medical expenses. The capped amount is set quite high to cover most medical scheme fees outright and thus makes most medical scheme payments tax free. Chart 4 shows the total amount of the subsidy since 1995. The dramatic increase in the subsidy pay-out by the government can be explained by rising costs of medical schemes along with an increase in out-of-pocket and co-payments which was facilitated by a gradual increase in the capped amount allowed.

Figure 4: Health TES since 1995 (billions)(National Treasury and SARS, 2008: 58; 2010: 81)

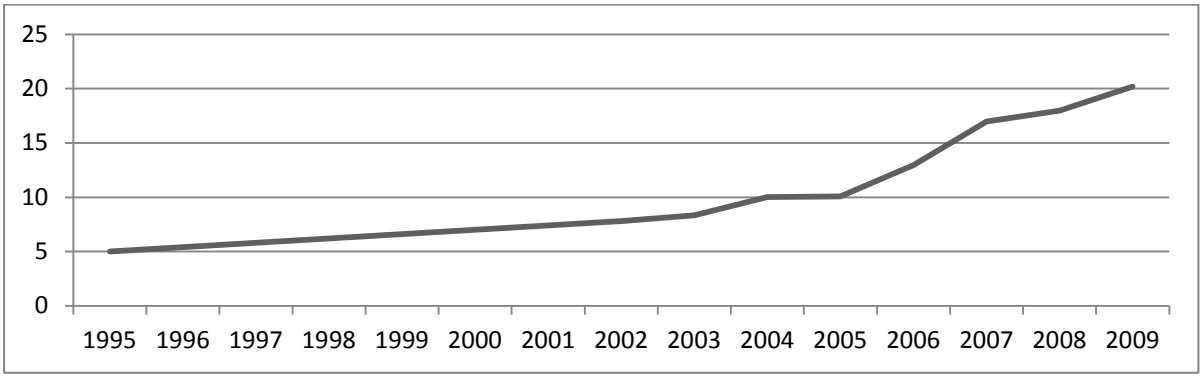


Figure 5: Number of claimants (in millions) of the Health TES (National Treasury and SARS, 2008: 58; 2010: 81)

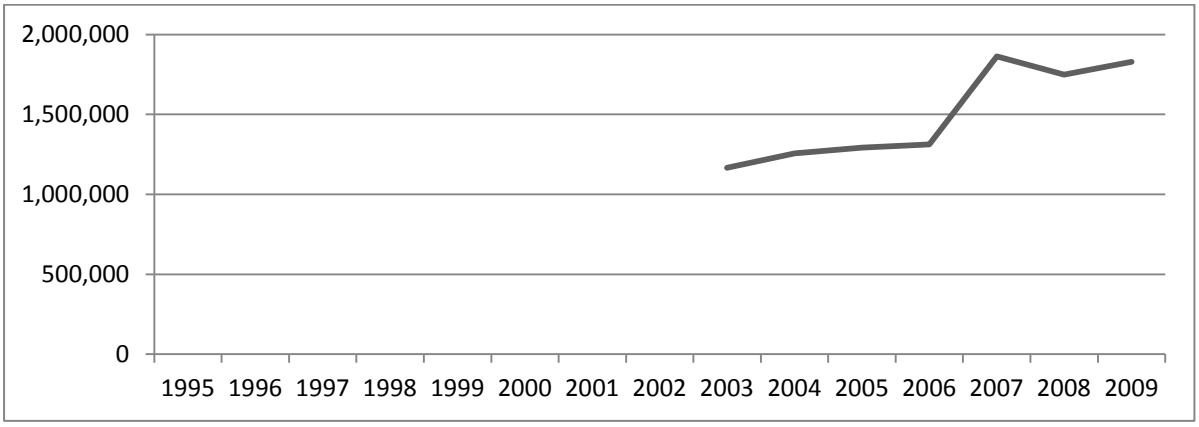


Chart 5 shows a rapid increase in the number of claimants benefiting from tax deductions for medical expenditures between 2006 and 2007. Around 550 000 more beneficiaries claimed the deductions in the 2007 tax year than in the year before. However, after this increase the number of beneficiaries actually decreased yet there is a continuous upward movement in total deductions. This means that the amount of the subsidy increases not just due to an increase of individuals who qualify for it, but also increases with rising medical expenses. It cannot be determined from these statistics whether these expenses were incurred in the private or in the public health sectors. If medical scheme holders utilise the private health system most extensively – and especially if the better off do so disproportionately – it can be deduced that most of the R20.17 billion of tax revenues foregone in 2009 will have subsidised the private health sector.

Until 1 March 2012 the South African tax regime provided medical deductions. This was replaced by medical tax credits. National Treasury recognises the inequitable outcomes of medical deductions:

> While the current deductions regime serves both to provide relief for those taxpayers contributing to medical schemes and protects families against catastrophic health expenditure, it is inequitable in that it affords a greater benefit to higher income taxpayers for necessary services like health, through the effect of the progressive marginal rate structure. (National Treasury, 2011)

Although it is argued that the tax credit will have a more equitable outcome due to the fact that it reduces a taxpayer's liability and not their taxable income and even though it might be

more equitable among taxpaying beneficiaries, it still excludes those who either cannot afford the high medical aid contributions or are non-tax payers. Nonetheless, it is claimed that "the underlying principle behind the proposed change is fairness, and the new system is proposed as a step towards an equitable fiscal contribution" (National Treasury, 2011). As Chart 1 shows, deductions on medical expenses comprised 26.5% of all tax deductions. A similar comparison is worth making in the area of retirement provision, where the tax expenditure subsidy far exceeds the resources spent on the State Old Age Pension[11].

5.3.3. Occupational Welfare

In an analysis of health expenditure inequality in 2003 Wadee et al. pointed out this important fact:

> Over the period of review, government spent twelve times as much per year on subsidising a civil servant to purchase medical aid as it did on funding public provision of care per person dependent on the public sector (Wadee et al., 2003: 13)

Wadee et al. (2003) go on to say that "general tax revenue filters into medical schemes via employer (government) contributions to medical schemes on behalf of civil servants (which amounted to nearly R1.8 billion, or about 16% of the government health budget, in 1992/93). Civil servants and their dependants account for 25% of all medical scheme members." (Wadee et al., 2003: 10) In 2010, R13.1 billion was paid to the scheme in contributions and around R12.5 billion was paid out in claims (GEMS Annual Report, 2010). Members of GEMS can access up to a 75% subsidy paid by the state (GEMS Website). Once again, the form the scheme takes is regressive, with higher paid employees able to access more comprehensive benefits. The Government Employees Medical Scheme (GEMS) has, as its beneficiaries, 3% of the South African population (GEMS, 2010). This represents just under 1.5 million beneficiaries (520 477 principal members).

Figures as to the exact amount of claims paid out to the two health sectors are not available, and utilisation pattern data is not available either, but available information does suggest that very few medical aid holders utilise the public system unless their medical scheme does not cover certain procedures. The cross-tabulation of utilisation and access to medical aid "show

[11] SOAP expenditure in 2009 was around R30 billion (Woolard et al., 2010), whereas the subsidy for retirement annuity and pension fund contributions was around R26 billion (National Treasury and SARS, 2010). This means R30 billion went to the poorest 1.7 million retirees in the country (SASSA, 2009) and R26 billion to just over a million middle to upper class taxpayers.

that those with medical aid were more likely to use private facilities than those without access to medical aid" with 86.4% of medical aid holders opting for private care (Wadee et al., 2003: 21-22). It is therefore safe to assume that most of the R12.5 billion in claims filtered into the private sector.

Another source of state funds flowing to the private health sector which straddles fiscal and occupation welfare provision is that of subsidies for private companies contributing to their employees' medical aid payments. These contributions are fully tax deductible (Wadee et al., 2003: 10) and qualifies as a fringe benefit. In 1994 this subsidy equalled "between R1.5 and R2.6 billion" (Price et al., 1994 in Wadee et al., 2003) being "equivalent to between 10% and 17% of the 1994/95 health budget" (McIntyre, 1997 in Wadee et al., 2003). In 2009 "Medical scheme contributions paid on behalf of employees remains the largest fringe benefit claimed amounting to R6.9 billion" (National Treasury and SARS, 2011: 32). With taxpaying claimants numbering around 990 000, this subsidy works out to be around R7 000 annually per claimant. This is once again state resources flowing towards the private sector.

Occupation welfare provision is also used as an incentive and particularly as an "employee retention and recruitment tool" (Mann, 2008). It plays an important role in providing security; the state plays an important role in either facilitating or subsidising it, yet it is rarely cited in literature dealing with welfare dependency (Mann, 2008). Moreover, there are many fringe benefits provided (on a sliding scale) to employees which also qualify as occupational welfare if judged by their provisional criteria. There is considerable amount of overlap between fiscal and occupational welfare when these fringe benefits are taken into account.

5.4. Analysis and conclusion

The aim of the Social Division of Welfare is to point out that financial resources do not necessarily flow from the rich to the poor and that the middle and upper classes derive a considerable benefit from 'welfare' provision. The analysis of trends in the data shows that indeed, within the health system of South Africa, a considerable amount of state resources flow towards the non-poor.

The Ministerial Task Team on Social Health Insurance (2002) estimated that the Tax Expenditure Subsidy, which amounted to R10.1 billion in 1995, allowed the state to spend R120 per beneficiary per month on medical scheme members whilst only spending R96 per beneficiary per month on those who utilise the public sector. This estimation has increased

exponentially. Currently the figures stands on R11 000 annually per taxpaying claimant, whereas public health spending is estimated at R2 500 per public health sector patient. Over and above that the state spends an aggregated R7 000 per year per civil servant in subsidising their government medical aid bills and even more indirectly, R8 000 per year by providing a subsidy to employers contributing to their employees' medical aid bills.

Although these are rudimentary equations, some of which are fleshed out in the next chapter, the amount that flows to the private sector compared to the amount that flows towards the public sector is significant enough to validate the argument that the non-poor benefits considerably from 'welfare' arrangements. The forms of redistribution that qualifies under fiscal and occupational welfare are not generally considered to be welfare and because they are considered incentives for certain behaviour in private social markets they have the opposite effect of policies aimed at decreasing inequality. Furthermore, due to the fact that they are not considered social spending and therefore not subject to the criticisms launched against social spending, fiscal and occupational welfare expenditure does not get reviewed and their impact evaluated. Thus, even if they do not have a notable effect and do not contribute towards the aims for which they were initially implemented, they nonetheless remain a part of the annual expenditure framework.

In South Africa only 15% of the population are covered by medical insurance (StatsSA, 2011). The dynamics involved in the creation of this form of inequality is caught up in the ideological and structural framework of South Africa. It involves not only the current private/public mix and the tax structure in South Africa, but also depends largely upon the prevailing ideologies that provide a frame of reference for health and tax policy formation. Recently there has been research undertaken on the inequitable outcome of the current South African tax regime. Government proposals are on the table to change the structure through the introduction of tax credits. But there is a very clear recognition that tax legislation reform is only a step towards greater cross-subsidisation. The current tax legislation works to the benefit of the rich since tax relief is based upon percentage of medical expenses. Especially medical benefits provided by employers regressively affect those with a lower income and disproportionately benefit those with a higher income. The same goes for pension benefits.

The main concern it seems of the low rate of medical scheme coverage is that the burden falls upon the already struggling public health sector to service those who cannot afford private medical insurance. The answer to the problem is then sought in tax legislation reform. As

Titmuss points out, occupational and fiscal welfare benefits could have the unintended consequence of increasing inequality since it is based on incentive and reward. In other words, the private health system artificially creates the need for subsidisation of health insurance provision due to the high and escalating costs of private health care provision. Currently the fiscal and occupational welfare provisions are indirectly reproducing inequality, and no matter how reformist they are, they will only alleviate the symptoms of an inequitable system, not transform it.

Through this analysis it has come to light, as in Titmuss words, that stereotypes surrounding welfare provision in South Africa is "either irrelevant or unbalanced" (Titmuss, 1958: 38). In light of this we need to deconstruct the meaning of social policy in South Africa in order to illuminate again what we mean by 'social policies'. The fundamental question then becomes: What are the aims of social policy in South Africa? And what is the role of the social services in South Africa? Misconceptions and stereotypes of policy by the middle classes and well-off has resulted in the emergence of an ideological framework which justifies prevailing inequality and forces attention away from the structural causes of poverty towards the symptoms of poverty. The result is that the public services in South Africa are geared towards alleviating the symptoms of an unequal system and reproducing the status quo.

Considering the high unemployment rate in South Africa, the current system of health provision which is strongly commodified in Esping-Andersen's terms[12], signify potential barriers to the provision of security in these areas to the South African citizenry. If access to quality health care and security in old age remains highly dependent on stable employment in the formal market then a considerable section of South Africa's population will never have access to the fundamental provisions of the Freedom Charter and the Constitution of a system of equitable social security. As this thesis shows, this is not due to a lack of resources, but a structural element of South African security provision system based upon a particular ideological system. This thesis interrogates the assumption that Titmuss makes that welfare as described in the categories of occupational and fiscal welfare promotes inequality in South Africa. In the next chapter this argument is explored more thoroughly.

[12] Esping-Andersen divided states into different regime types. Within each regime type there is a distinctive relationship between the notions of solidarity and distributive justice. The distinctions manifest themselves concretely in differing levels of what Esping-Andersen calls the 'commodification' or 'de-commodification' of human needs and labour power (Esping-Andersen 1990:35). The process of 'decommodification' brings about a situation in which citizens have access to claims of economic and social benefits which does not depend on their labour power.

5.5. Values and the Social Division of Welfare

What is particularly problematic for Titmuss about occupational and fiscal welfare provision is the value system which underpins such redistribution. Indeed, he believed, the actual emergence of such forms of redistribution is built upon a value system that not only misunderstands the systemic roots of poverty but emerges from it. His argument is that such forms of intervention will inevitably lead to exacerbating poverty as opposed to alleviating it. The importance of understanding the real causes of poverty therefore plays a very particular and fundamental role in the process of policy making and that different understandings of poverty are underpinned and distinguishable by different value systems. The privatisation of the social services justifies the application of an ideological framework that works against equality. In this sense, therefore, we need to, as South African citizens and policy makers, be clear on what we believe the aims of social policies should be and what kind of society we want to live in. It will be helpful then to deconstruct the meaning of social policy in South Africa in order to illuminate again what we mean by 'social policies'.

The Social Division of Welfare was formulated in order to disprove stereotypes which were having a detrimental effect, not only on the support of egalitarian policies, but were also creating resentment between classes. The Social Division of Welfare pointed out that indeed the middle and upper classes were benefitting from the social services due to the way these services were appropriated by specific interests and how distribution was skewed over time due to the social services' lack of adequate and equitable adaptation to change. The different systems of welfare, as have been outlined, have each, in their own capacity adapted to particular needs and dependencies in society and are rooted in the differentiated employment status which derives from an unequal labour market. And the fact that it did not do so as a whole has meant that welfare benefits have become skewed in favour of those within the formal market. This has resulted in powerful interests within (especially privatised) social services artificially creating needs, and permitting resources to flow towards ever increasing salaries resulting, in the treating "at a higher standard the symptoms of need rather than in curing or preventing the cause of need" (Titmuss, 1958: 24).

Not only has powerful private interests been allowed to dictate priority, but welfare has been allowed to be shaped by the moral and ethical assumptions of the time. If welfare grants are made to be associated with laziness, lack of intelligence, or inferiority, then, Titmuss argued, the poor could use this to build "an image of their selves" (Titmuss, 1958: 37). Furthermore,

this notion, attached to the fear "that calamity will follow the relaxation of discipline and the mitigation of hardship" (Titmuss, 1958: 37) which welfare represents, invokes a demand for punishment, reprisal and the need to show 'deservingness'.

Particularly in South Africa it is commonly held that welfare creates a dependency on the state. This is a contradictory statement (since the state is there to serve the needs of the populace). Nonetheless, it resonates with the dominant middle-class ideology, which tends to invoke the fear that people will refuse to work once they realise they could sustain a livelihood from social grants. This notion is attached to the common accusation that poor South African teenage women are getting pregnant in order to access the Child Support Grant. These underlying frames of judgments do not just innocently employ the rational logic of a causal chain – they are attached to images and stereotypes of 'the other', or 'the poor'. For R280 a month *your* teenage daughter would not get pregnant, but it is easy to imagine a poor, township-dwelling teenager to do so, since, in the popular middle and upper class imagination, "the other" doesn't tend to reason as they should.

The next chapter looks more closely at the public/private health system of South Africa and comes to the conclusion that the mere presence of market based principles employed in the private health sector is having a detrimental effect on the attempts at equity and equality in the public health sector. There are, in a sense, two ideologies at play in the provision of health care in South Africa and, taking into account the findings of this and the next chapter, the winner, so far, has been the one based upon market principles. This has created a crisis of public health care provision and the majority of the South African population is being very hard hit by the consequences.

CHAPTER 6

RESOURCE FLOWS IN THE CONTEMPORARY SOUTH AFRICAN HEALTH SYSTEM

6.1. Introduction

This chapter aims to analyse the South African public/private health system and the distribution of finances between the government and the two health systems. It shows how the structure of the current health system undermines the goals of equity, efficiency, accessibility and affordability. It does so by tracing the resource flows in and between government and the two-tier health system. The South African health system has been under constant restructuring since 1994 with the aim of securing equity, efficiency, accessibility and affordability (Nadesan-Reddy, 2010: 31). The current public/private system is analysed according to these aims with a particular focus on financial flows. A critical analysis of the flow of resources within the health system is vital to expose existing issues working against these goals. It draws from existing data and sources such as the National Health Accounts, the Health Expenditure Reviews, Household Survey data, National Treasury and South African Revenue Service data as well as from secondary analyses of this data.

A short history of the development of the modern health system and financing intermediaries is provided in order to provide context to the contemporary situation. Since the 1970s South Africa followed a very similar path to many countries affected by the oil crisis of the early 1970s and the ascendency of neo-liberal ideology by privatising the health system and leaving the public health system for those who cannot afford profit-oriented, high cost private health care. The argument of this thesis is that many of the current systemic issues plaguing the South African health system today stems from and is embodied by the move towards the commodification of health care. In this chapter the particularities of the commodification of health care is considered and the connection between the distortion in our own health system and the theoretical arguments against health care as a commodity sheds light on the actual roots of contemporary health inequity.

According to Wadee et al. (2003: 9-10) there are three ways in which government money flows towards the private health sector. Two have already been discussed; the subsidisation of medical scheme contributions (fiscal welfare), the provision of government medical aid that is used in the private sector and the provision of deductions on employer contributed medical aid payments (occupational welfare). Another way in which the government indirectly subsidises the private health sector is through the subsidisation of health professionals training. Every South African-trained health professional that subsequently chooses to find employment in the private sector represents a flow of state expenditure to the private health sector.

A *narrow focus* on state expenditure in the public health system fails to engage the institutional structure of the South African health system i.e. the relationship between public and private health care, and its role in perpetuating inequality. In Chapter 5 the key beneficiaries of government spending in the area of health provision were uncovered with the help of the Social Division of Welfare. A deeper look at the total annual spending patterns within public and private health systems as well as direct government contributions to private health care sheds light on whom the key beneficiaries of government spending really is and how it perpetuates the unequal status quo.

The Social Division of Welfare points to inequitable spending trends in the health system of South Africa. Spending trends alone do not however explain the reasons for the continuing negative outcomes in health or for the dire state of the public health system. Resource flows follow the particular market mechanisms embodied by the system and if encouraged, can be distorted to enforce inequity. Thus the trajectory of resource flows in South Africa is a derivative of a commodified health system. There are many challenges facing the public and private health systems today and this chapter uncovers how the resource flows in the public and private health systems *contributes* to the current crisis in health care. An analysis and investigation of these trends, along with the historical context of its emergence sheds light on the structural challenges that face health reformers today.

Among the many issues that originate from the privatisation of health care is an inevitable favouring of profitable, high-cost curative health provision. Despite the dire need for primary health care, it is crowded out by private, curative-oriented health provision which not only serve only a small percentage of the population, but is also, due to its profit-making orientation, concentrated in urban centres far away from those most in need. This is an

unintended consequence of the privatisation of health care. This thesis aims to show how the privatisation of health care creates a series of institutional problems, most of which can be identified as plaguing the South African health care landscape today.

By dividing state expenditure between Titmuss' social divisions of welfare, the relatively vast inequity and regressive health expenditure, the role of government and the unequal labour market in the process, is revealed. Situating this form of expenditure within the broader framework of the health system of South Africa reveals that the nature of the entire system contributes to and perpetuates continuing inequality in quality health care provision.

6.2. How is a health system funded?

"Total health expenditure" is defined by the World Health Organisation (WHO) as "the sum of general government expenditure on health and private expenditure on health in a given year" (WHO, 2003). Within a health system there is a complex flow of funds. The main source of health expenditure data is provided by National Health Accounts (NHA) which consists of health finance outcome indicators and Health Expenditure Reviews (HER). The collection of health expenditure data dates back to the 1960s when a colleague of Richard Titmuss, Brian Abel-Smith (1963) produced several comparative studies of health expenditure between several countries. The NHA situates health expenditure within a framework of a percentage of Gross Domestic Product (GDP) and describes both the sources of funding as well as its uses.

Since then more and more countries began producing NHAs and demanding reliable expenditure information from both public and private health systems. The methodology was recently standardised for international comparison and currently bases its framework on recommendations from the WHO (2003). For the sake of comparison it is therefore important that methodology and definitions are similar. Thus 'health expenditure' is most commonly defined as:

> "all expenditures for prevention, promotion, rehabilitation, and care; population activities; nutrition; and emergency programs for the specific objective of improving or maintaining health." (Hjortsberg, 2001: 7)

The first HER in South Africa reviewed the years 1992-1993 (McIntyre, 1993). An NHA study for years 1996/7, 1997/98 and 1998/99 for both the private and public health sectors followed (Thomas et al., 2000; Cornell et al., 2001; Doherty et al., 2002). Nadesan-Reddy

(2010) produced a private sector HER for the years 2003-2006. All other years have not been covered.

The quality of NHAs and HERs depends on the reliability and availability of data from Medical Schemes, Income and Expenditure Reviews and General Household Surveys. Often surveys are undertaken to fill the gaps or compensate for inaccuracies in already existing data. Despite this, surveys are generally considered to be inaccurate for obvious reasons. Out-of-pocket expenditure is particularly inaccessible and often grossly underestimated. Furthermore, private health care financing and expenditure data is particularly difficult to obtain (Cornell et al., 2001: 2). Despite these limitations, the NHA, HER and all additional data is valuable since it enables a critical analysis of the systemic flows of finance within the health system and the impact of certain policies on resource flows. The following section clearly sets out the available data produced in order to show the general resource flow trends in the health sector.

Almost all health expenditure reports come to the conclusion that current resource flows in the health system are inequitable. Summarising the 1995 Private Sector Expenditure Review, McIntyre writes that roughly

> … 23% of the South African population benefited from approximately 54% of total health care expenditure in 1992/3. (McIntyre et al., 1995: 133)

In the revision of Public Health Expenditure from 1996-99, Thomas et al (2000: 2) writes that

> It is apparent that corrective action is needed if the public sector is not to slide into inequity and miss its policy objectives. The government needs to find ways of boosting public sector financial resources, focusing on priorities and encouraging redistribution of resources.

The key findings of the Private Sector NHA were that the private sector is consuming not only most of the essential human resources, but is, due to simple supply-side economics, geographically skewed to favour the rich. And despite the fact that the private sector is growing at a remarkable pace

> … population coverage by institutional financing intermediaries has been declining in the late 1990s. This suggests declining ‘value for money’ within the South African private health sector and dependency on public health services,

> particularly in relation to hospital care, for a growing section of the population. (Cornell et al., 2001: vii)

Even the most recent Health Expenditure Review (2003-2006) concluded that

> … both the cost and inequity existing between the public and private sectors increased in the three financial years that were reviewed. (Nadesan-Reddy, 2010: 46)

And

> … there remains a major inequity in the financial distribution of resources between the public and private health care systems.

Thus, despite major reforms, the South African health system remains inequitable 18 years into democracy.

The NHA and HERs take their figures from government income and expenditure surveys, Medical Aid Council annual reports and Household Reviews. With this data it comes to the conclusion that the overall cost drivers include almost every section of the private sector health care provision. For 2003-2006, these were the private hospitals, medical specialists, medicines dispensed from hospitals and administration and broker fees (Nadesan-Reddy, 2010: ii).

The National Health Accounts Project shows that overall health spending in South Africa is very high compared to other middle income countries. Between 1990 and 1997 South African health expenditure as percentage of GDP was averaged at 7.9% (Thomas et al., 2000: 3). In 2002 it had risen to around 8.3% (Nadesan-Reddy, 2010: 29). National Treasury (2011) indicates that in 2011 8.3% of GDP was spent on health care of which 4.1% and 4.2% was spent in the private and public sectors respectively. This is significantly high as the average middle-income country spends about 4.4% of GDP on health care. South Africa's health expenditure to GDP ratio is closer to that of high-income countries.

Spending of government funds on health is averaged at 3.2% of GDP in 2008 and represents "38.6% of total expenditure on health" (Nadesan-Reddy, 2010: 28). The 2007/08 budget allocated R59.2 billion to health in the public sector which constituted 3.1% of GDP and 11.1% of total government expenses (Nadesan-Reddy, 2010: 28). The rest amounts to

expenditure by private individuals either to medical schemes or directly to private or public facilities and practitioners.

The question therefore remains why South Africa has such dire health outcomes. South Africans' life expectancy at birth for 2003 was 48 years. The connection here can be made to the high levels of HIV/AIDS infections in the country. Countries with similar prevalence rates, such as Botswana and Swaziland also spend an above average percentage of their GDP on health and have similar infant mortality and life expectancy rates (WHO, 2012). However, as this chapter shows, only a small percentage of general government expenditure is on HIV/Aids prevention, even less in the private sector, and although it is not an insignificant amount it is not the cost-driver within the health care sector.

6.3. General overview of health care in South Africa

The current challenges in the health system have its origins in the apartheid era. Especially towards the end of apartheid, the National Party (NP) minority white government "began a process of deregulating and privatising health care with little insight into consequences for equity, efficiency and access and the policies of a future democratic government" (Van den Heever, 1998: 281). The NP government implemented discriminatory policies in order to bolster their white electoral base and to enforce ideology.

Corporate capital, particularly the mining houses also had a significant impact on the shape of the South African political economy as well as its social service systems, more so than in other post-colonial countries. The growth of the private health sector was driven "by corporate capital, particularly the mining houses" (Coovadia et al., 2009: 826). Due mainly to government policy of privatisation, for-profit general hospitals expanded greatly between 1988 and 1993 (Coovadia et al., 2009: 826).

The shift towards privatisation in the 1980s mirrored a similar shift within the thinking of advanced capitalist countries during the time (Price, 1989: 122). During the 1940s in South Africa there emerged an increasing interest in the state control of health care exemplified by the Gluckman Commission of 1944 which called for a comprehensive non-racial national health service. Although the recommendations of the commission were accepted in principle they were not implemented and by 1948 with the advent of the NP government the non-racial element of the proposals were discarded. The NP government did however, in line with

international trends, increase its control over the health sector, but, as Price suggests, "in ways not prescribed by the 1944 Commission" (Price, 1989: 122).

Mission hospitals, which serviced the Bantustans, were gradually taken over by the government and handed over to Bantustan administration (Price, 1989: 123). In urban areas the state provided blacks with health care mainly due to concerns over the spread of disease and the maintenance of the health of the massive, yet increasingly expensive workforce (Price, 1989: 123). The broad electoral base consisting of poor whites and farmers played a role in the maintenance of public health provision for whites (Price, 1989: 123). Thus by the 1970s the state still considered itself the custodian of health provision whilst suspicious of private health care, which were at that time, under strict state regulation.

By the late 1970s the Nationalist Government's attitude towards private health care changed dramatically. The Department of Health made it clear that public health care should take second place to private provision by implementing the recommendations of the Commission of Inquiry into Health Services (Browne Commission, 1986). Several policies were implemented to encourage the growth and utilisation of private health care providers. Public sector fees were increased dramatically to encourage the utilisation of private providers and the building of private hospitals was encouraged. By the mid-1980s Medi-Clinic started building a chain of private hospitals (Sunday Express, December 30, 1984, as quoted in Price, 1989: 124). In 1986 the managing director of Medi-Clinic proclaimed that:

> Private hospitals have a great future as the government hands over the medical care of everyone but the indigent to the private sector." (Sunday Times, June 29, 1986 as quoted in Price 1989: 124)

Private health care was, from the outset, exclusionary. Without sufficient numbers of people with medical aid the sector could not survive. Entrepreneurs will only build hospitals where there is a sufficient supply of medical aid holders and will only acquire equipment, employ specialists and do procedures which are covered by medical aid. The private health system could not grow unless there was an increase in the numbers of medical aid holders and at the time the market for whites covered by medical aid was already saturated. This meant the necessary entry into the medical aid market by the middle-class black population. Thus from 1977 there was a push for the gradual increase in the numbers of Africans, Coloureds and Indians covered by medical aid (Price, 1989: 126). This meant that private hospitals were no longer racially segregated. Instead they admitted according to ability to pay.

Price argues that the shift towards privatisation was driven by a desire to decrease state expenditure in the health sector. Though, he argues that the way in which privatisation of the health sector was taking place would eventually increase the costs to the public sector.

> It would in fact aggravate not only the problem of a lack of public finance for health services, but also the problems of rational resource allocation, equality of access to health care, fragmentation and co-ordination of health services, and the appropriate balance between preventive and curative care. (Price, 1989: 128)

The privatisation of the health sector since the late 1970s had particularly significant implications for the advent of democracy. The ANC government, when it came to power in 1994, was confronted with the dilemma of how to overcome the inequalities of the past whilst maintaining the political support of the reformist NP government. The inherited health system consisted of an inequitable centralised and undemocratic framework in which control and implementation was fragmented between the national, provincial, local and the former homelands (Wadee et al., 2003: 5).

Not only was curative (tertiary) and preventative (primary) care provided and administered separately, primary care was marginalised whilst curative care was generously funded. Resources were biased towards former 'white areas' as townships, 'homelands' and informal settlements were "systematically underfunded" (Wadee et al., 2003: 5). By 1991 the private health sector employed half of all South Africa's doctors, almost all dentists, and consumed more than half of all health resources. This was despite the fact that it only served 16% of the entire population (Price, 1994: 50).

Furthermore, medical schemes were facing financial problems and as a result rising costs meant that many beneficiaries were unable to afford the payments (Muller, 1997). In 1993 several amendments to the Medical Schemes Act reinforced the deregulations adopted in the 1980s. This was despite the fact that such policies were criticised widely, "even by the avowedly capitalist agencies of the World Bank" (Muller, 1997: 26).

The reduction in medical scheme holders affected private hospitals which are too expensive for those without medical aid. This opened up an avenue for the emergence of the medical insurance industry which could provide 'top-ups' for those private consumers whose medical aid run out. However, the insurance industry was careful to exclude high-risk patients in

order to insure profits and policies of deregulation allowed them to do so. The result was the 'dumping' of patients on the already overcrowded, underfunded public health sector.

By 1997 the public sector with a budget of R20 billion served 33 million people (82% of the population) (Van den Heever, 1998: 281). The overcrowded public health system, which had been providing free primary care since 1994, still suffered from inequitable access concentrated in urban areas, poor health information systems and bad management (Van den Heever, 1998: 282). Immediately after 1994 there was real increase in health spending but the introduction of GEAR meant that spending could not maintain its parallel with population growth. Since 2002/03 there again has been an increase in the health budget. However, due to the HIV pandemic the real per capita value of this increase has been insignificant (Nadesan-Reddy, 2010: 35). By 2007/08 the health budget stood at R62.7 billion.

6.4. The Public Health Sector

The public health system caters for more than 80% of the population. Public sector hospital care is not free except for those with indigent status and payments are based upon levels of income. Nonetheless, the public service is considerably cheaper since procedures are free of VAT and is subsidised through the health budget. Although the percentage of GDP spent by South Africans on health care is very high compared to other middle income countries, the percentage of General Government Expenditure (GGE) on health is lower than other countries on similar socio-economic levels. Nonetheless, South Africa's GGE on health is still higher than the international average.

Although expenditure on health is high overall and average in the public sector, South Africa's health outcomes are very poor and worsening (Development Bank of South Africa, 2008: 15). The public sector, catering for the majority of the population particularly those whose health status is contributing to the worsening of our health outcomes, it seems, is "underperforming with its given level of expenditure" (DBSA, 2008: 15). A narrow look at public sector spending levels does not explain the low health outcomes of the country. Instead, it is important to look at how the entire health system works together to create low health outcomes in the public health sector.

6.4.1. Spending trends in the public health sector

The public sector is heavily dependent on taxation. The introduction of an NHI could boost resources which means it would be less vulnerable to international financial market volatility

and macro-economic policy (Thomas et al., 2000: 3). Currently however this dependence means the public health sector is frequently plagued by budget cuts such as the falling per capita health spending, the "reversal of redistribution across provinces and limited growth in primary health care expenditure" (Thomas et al., 2000: 2) that occurred between 1997 and 2003.

Between 1992 and 1998 there was a substantial increase in spending in the public health system with particular focus on primary health care. The distribution of funds between the new nine provinces was a lot more equitable. With the introduction of GEAR and the advent of fiscal federalism government expenditure on health as percentage of total health expenditure declined rapidly from 55.9% in 1998 to 33.1% in 2002.

There is some interaction between the two health sectors which could lead to cases where money flows from the private sector to the public sector. This is particularly evident where "private financing funds access to government-owned services for private patients" (Wadee et al 2003: 9), though, this only becomes a useful cross-subsidy if the revenue it generates for the public sector is retained in the public sector. However, "the potential revenue generating capacity of these arrangements for the public sector is limited by the fact that the charges levied for medical scheme members who use public sector hospitals are generally below cost-recovery levels" (Gilson and McIntyre, 2000; 2002, in Wadee et al., 2003: 9-10). This, according to Wadee et al (2003: 10), leads to the subsidisation of the private system by the public system.

The lack of cross-subsidisation between the two systems means that the public health sector is almost completely dependent on public health sector funding. Market trends in health provision leave the public sector vulnerable, and, along with the migration of doctors, nurses and highly trained health personnel to the private sector, the public health sector is in a downward spiral of deterioration that even increased spending has no guarantee of reversing . Due to the fact that the public sector has to adhere to principles of equity and a right to health care it is unable to compete in the health care market.

As the public sector deteriorates so do public perceptions of it which means that more and more people choose to use private health care, even if it presents problems of affordability. This contributes to the already high expenditure as percentage of GDP whilst contributing very little to health outcomes. Most people who opt for private health care are in the middle and upper class income brackets, which mean valuable private income into the public sector

is diminishing. In 1990, around 20% of medical scheme benefits paid to hospitals went to the public sector. In 2004 it stood around 3% (Matsebula and Willie, 2007: 168).

Since 2002 there has been an increase in health spending with current spending patterns at around R100 billion in 2010/2011 (National Treasury, 2012). Despite this, per capita spending in the public health sector has not increased. Most of the increased spending was confined to HIV and AIDS programmes. Since 2005 the District Health Service have benefited from budget increases although public hospitals have not gained much from the increase (DBSA, 2008: 17). Overall unit cost increases shows that since 1998 "the public hospital system has faced a real decline in budget" (DBSA, 2008: 17). The budget increase for the District Health System could soon start showing improvements in health outcomes, but it is still too early to tell.

Despite increases in the budget "as a proportion of total health expenditure, South Africa has one of the lowest levels of government expenditure" (Blecher et al., 2011: 32). This speaks to the inequality in resource allocation in the South African health system and goes some way to explain the low health outcomes in the country.

6.4.2. Financing intermediaries

Public health funds flow through the three tiers of government: national, provincial and local. National Treasury allocates funds according to national priorities in the form of ring-fenced conditional grants (equitable share) and block grants. Conditional grants must be spent on the allocated function (i.e. health, education, social development). Block grants to provincial treasuries and local administration can be used according to their own criteria. Health, education and social development compete for block grant finances. The provincial departments of health then allocate funds to district hospitals, health programmes or clinics. Provincial departments also sometimes contract out services to local departments or subsidise local health projects. Local municipalities often depend on local tariffs and rates for health funds.

The decentralisation of the public health system has been progressing since 1994. This enormous process along with a lack of clarity on roles and responsibility has made implementation of health goals difficult (Local Government and Health Consortium, 2004). Generally, decentralisation is associated with a lack of cross-subsidisation and therefore inequity. In South Africa the particular fragmented and decentralised funding mechanisms in

the health sector is having an effect on equity as have been shown, in 2004, "budgetary allocations between municipalities are inequitable, in that those with least funding have greatest needs... and those with most funding have the least needs" (Local Government and Health Consortium, 2004: 64). Personnel allocations reflect funding and therefore the better-off districts can attract better personnel. Primary health care seems to be generally neglected due to the freedom given to provincial and local departments to allocate funds.

In the financial year 2010/11 the funds allocated to provincial departments amounted to R98 billion (National Treasury, 2012) making the provincial departments of health the largest intermediary. Apart from local revenue collection from tariffs and rates, the public health sector is dependent on tax revenue. As have been mentioned before, this dependence makes the public health sector vulnerable to fluctuating market trends.

6.5. The Private Health Sector

6.5.1. Private Hospitals

Private hospitals play an important role in the South African health system since it has more than 22% of all hospital beds. Despite the fact that it is running around 60-65% capacity (Hospital Association of South Africa, 2010: 7), they alleviate some of the burden on the public sector. The concern is, however, that private hospitals consume the largest component of health spending by medical schemes. Of the R57.6 billion in total medical scheme contributions (Nadesan-Reddy, 2010: 78), R18 billion went to private hospitals (Nadesan-Reddy, 2010: 101, 103). This figure has shown a steep increase in recent years. Available data until 2006 suggests that since 2003 there has been a 30% real increase in benefits paid out to private hospitals. Despite a moratorium placed on the building of private hospitals, there was a 34% increase in the number of for-profit private hospitals (Matsebula and Willie, 2007: 162). This was due to the fact that hospital companies were sidestepping regulations by building wards without other services which would classify them as hospitals (Cornell et al., 2001, in Matsebula and Willie, 2007: 160).

The dominant perception is that public health care is of low quality. Due to this, medical aid holders have increasingly shifted towards using private instead of public hospitals since 1990 (Matsebula and Willie, 2007: 162). More financial resources are flowing towards the private sector than the public sector which in turn contributes to the deterioration of the public sector. There is a dual mechanism contributing towards the increasingly low health outcomes. The public sector is deteriorating due to, among other reasons, the lack of financial and staff

resources, which is increasingly flowing towards the private sector and the inability for the market-driven private sector to contain the rising costliness of private health provision. Both of these reasons are analysed further down.

6.5.2. Financing intermediaries: Medical Schemes

> Health insurance "monetises health"; providing the private health sector "a source of 'effective demand'" (Minister of Health in Daily Dispatch, 30 June 2011, as quoted in Ruiters, 2011: 1).
>
> Medical aid guarantees profit. (Ruiters, 2011: 2)

Medical insurance emerged as a form of risk-sharing which is distinct from accessing universal and free public health. A free public health system, such as the UK National Health Service formed in 1948, uses the tax base as a form of risk-sharing. Resources are provided according to need and indirectly paid for according to means through taxes. In the absence of such an arrangement the middle-class and affluent contract into a medical aid scheme sharing risk among themselves and in order for this medical aid company to stay afloat it risk-rates high risk customers out of the scheme. The uninsured part of the population still needs health care and it falls upon the state to provide for them.

A two-tier system effectively divides the mechanism of risk-sharing in two; to afford an exclusive system the affluent share only among themselves. The uninsured pay out-of-pocket in a public system subsidised by taxes. The section on the public health sector illustrates how finances flow through the public system.

The section which follows discusses funding through medical aid. The first private medical scheme emerged in 1889 and its membership, restricted to the white population, catered mainly for white miners – before that private health care was paid for out-of-pocket. Private hospitals consisted mainly of missionary and mining hospitals, but this changed as for-profit hospitals, driven by government policy influenced by international trends of privatisation, allowed the for-profit health sector to greatly expand from the 1980s (Coovadia et al., 2009: 826). Increasing specialisation and high salaries pulled doctors to the private health sector at the detriment to primary health provision, which was mainly public.

In 1981 77% of the white population was covered by medical aid. The use of the public health system by medical aid customers was high. Only just over a million of the total black

population of over 25 million were covered. Since public hospitals were segregated most of the black insured population utilised private facilities, where they had access, including occupational facilities. With the drive towards privatisation the number of medical aid users increased by just over 1.4 million members between 1981 and 1991. The number of black medical aid holders doubled, but the number of white beneficiaries declined. Together with population growth the number of beneficiaries as a percentage of total population was no more than 1%. By 1995 a total of 17.6% of the South African population had medical aid.

Although numbers differ, the October and General Household Surveys indicate that the number of medical aid *beneficiaries* remained stagnant between 1995 and 2007 (StatsSA, 1995-2007). Between 1994 and 2006 the number of medical aid *members* grew by 20%, but the number of beneficiaries grew at less than half the pace. This trend is "not attributed to real changes in family size but a response to affordability problems in medical schemes" (McLeod and Ramjee, 2007: 50). The sharp increase in medical aid members from 2007 figures onwards is partly due to the introduction of GEMS in 2006. Yet in relation to percentage of population medical scheme coverage has shown a significant decline between 1995 (17.6%) and 2006 (13.7%). The introduction of GEMS brought this figure up to 16% in 2011.

6.6. Hidden resource flows: Subsidies/Tax deductions

The state currently spends 13.6% of general government expenditure funding the public health system. This is through several departments, funds and spheres with the provincial department of health spending the greatest amount. In the financial year 2010/11 this amounted to R109 769 billion (National Treasury, 2012). Although the intermediary through which the largest amount of funds for health flows is the provincial department of health (only since 2008), overall the private system still absorbs more resources than the public system. The public health system caters for just over 82% of the population (42 million people) and the private system is utilised by just over 16% of the population (8 million people).

General health expenditure surveys usually investigate the flow of resources through the two health systems by utilising the data such as provided above. This does not however paint the whole picture. There are other ways in which state funds flow directly to the private sector. This takes the form of subsidies for the purchase of medical aid or of medical expenditure in general as well as providing medical aid to civil servants to access private health care in the

form of occupational health insurance. This was calculated using Richard Titmuss' Social Division of Welfare in the previous chapter.

6.6.1. The subsidisation of health professional training

The South African public health system has a crisis of human resources with regards both staff shortage and retention. The crisis features prominently in media coverage. In these media reports hospital employees are either painted as victims of overwork and staff shortages or as violators of standard good conduct evidenced in the rude manner in which they behave towards patients or refusing patients' treatment. The official opposition party, the Democratic Alliance has focussed on the failure of the ANC government in the delivery of services, with public health provision as a useful example to exploit. They however present a challenge for health reformers who want to promote the NHI since most of these stories lay the blame at the feet of incompetent state machinery.

Due to the failure of public hospitals, public perception and confidence in the state as a vehicle for the provision of services are eroding. The staff shortage crisis, however, has deeper systemic roots going back, once again, to the presence of a private health system that can, at the outset, offer staff better salaries and working conditions. In 1995 McIntyre et al wrote

> Another way in which the state supports the private health sector is by subsidising health worker training. A recent study estimated that the average cost of training a university medical graduate was 66,500 rands in 1992 and that the net government subsidy was 40,200 rands (Bunting, 1994). This refers only to the Department of Education's subsidy to universities, and does not include the substantial indirect medical training costs which are borne by the academic hospitals. The training of all other health personnel is similarly subsidised. There has been a great deal of debate about how to recoup some of the training subsidy of professionals who work in the private sector. Recommendations include providing people with a choice between a period of compulsory public sector service prior to registration for private practice or the full repayment of training costs, possibly through licensing fees. (McIntyre, Bloom, Doherty and Brijlal, 1995: 37)

Without adequately trained and experienced staff, no hospital or clinic can run efficiently. The problem however is that you cannot force an individual to work in the public sector after they have finished their compulsory public sector service work. Another problem is immigration. The state has often had to rely on to foreign trained doctors for service in underserved areas.

Richard Titmuss (Alcock et al. (eds.) 2001: 114) pointed out a very similar trend in the UK in the mid-1900s where the USA actively recruited British doctors trained at the public's expense:

> Since 1949 the United States has absorbed (and to some extent deliberately recruited) the import of a 100 000 doctors, scientists and engineers from developed and developing countries. In about eighteen years the US will have saved some $4,000 million by not having to educate and train, or train fully, this vast quantity of human capital. It has spent more on consumption goods, less on public services. It has taxed itself more lightly while imposing heavier taxation on poorer countries. Estimates have been made that foreign aid to America is as great as or greater than the total of American aid to countries abroad since 1949. Moreover, such estimates leave out of account the social and economic effects in Britain (and much more significantly in the poor countries of the world) of having to train more doctors, scientists and engineers, and of having to pay heavily inflated rewards to prevent American recruitment with all their harmful repercussions on incomes, prices and levels of taxation.

6.7. Conclusion

In each of these cases state funds flows to the private sector. In other words, the state spends a considerable amount of resources in order to bail out the deteriorating public system as well as alleviate the rising costs in the private system. Although the state spends R110 billion on the public sector (including salaries, infrastructure, research and training) to provide health care to 42 million people, it also spends around R40 billion (excluding the subsidies on health professionals) on the private sector to subsidise 8 million people. The per capita state expenditure per South African is therefore just more than R2 600 per person in the public sector and R5 000 per person in the private sector. This is apart from the R115 billion already spent in the private sector.

The reason why these hidden resources arise is due to the structure of the public/private mix and the inability of the state to see the nature in which the commercialisation of health care distorts resource flows. The deterioration of the public health system is an indirect result of the presence of a for-profit health system and the remedial actions of government is merely drawing more resources away from the public health system.

Tax subsidies for the purchase of medical aid as well as other medical costs are an attempt by the state to make private health care more affordable to South Africans. However, the costs to the state of this subsidy will continue to increase with the increase in costs of hospital, specialist and therefore medical scheme benefits. As Chapter 5 has shown, the tax expenditure subsidy for medical benefits has increased dramatically from R5 billion in 1995 to just more than R20 billion in 2009.

The subsidy is in effect support to middle to high income earners to enable them to afford medical aid and resultant non-reimbursed medical spending. Furthermore, due to the fact that it is not part of the formal budget it is not viewed as social expenditure and is not incorporated into general health expenditure surveys. As it is only available to taxpaying individuals, these R20 billion in subsidies benefit an incredibly small minority currently amounting to less than 2 million individuals and their dependents (National Treasury and SARS, 2010).

Tax subsidies can therefore be viewed, not as an attempt to *remedy* a system contributing to an ever-increasing escalation of health costs, but merely to reduce the ultimate negative effect it has on the population. This cannot ever be an answer to the problem of health costs nor can it ever be equitable. It is an incentive for the acquisition of medical aid, yet, like most incentives, it has a very minimal positive impact to society compared to its cost.

CHAPTER 7

THE PUBLIC/PRIVATE MIX OF HEALTH CARE PROVISION AND THE REPRODUCTION OF INEQUALITY

This chapter outlines and summarizes the argument that the private health system is creating many of the inequalities in health provision in South Africa.

7.1. Marginalisation of primary health care

The inordinate focus on curative-oriented health provision has a long history in South Africa. According to the Gluckman Report, by 1944 only 1% of the total of all health spending (state, employer and individual) was on preventive services[13] (Gluckman Commission, 1944: 2). The commission argued that indeed the South African health services were "NOT in conformity with the modern conception of 'Health' – for they are mainly directed not to the promotion and safeguarding of health, but to the cure of ill health." (Gluckman Commission, 1944: 2)

The hospital-centred trajectory in the public service can be attributed to state resource flows: only 11% of state spending went to non-hospital primary health care services by 1994 whereas hospitals consumed 80% of the health care budget. Of the 80%, half went to tertiary level and academic hospitals (Coovadia et al., 2009: 828). Within a public service, state resource flows can be directed by policy. In 1994 the trajectory was changed towards primary health care with the reallocation of resources to primary health care.

In 2008 the World Health Organisation dedicated their annual World Health Report to the promotion of primary health care. The report argues that health sectors all over the world have been slow to channel resources to primary health care and transforming health institutions to accommodate primary health care values. This, the report argues has been due to the "powerful trends" related to commercialised health care. These forces include

[13] This total excluded subsidised housing and subsidised nutrition which accounted for about £3 million state spending.

> a disproportionate focus on specialist hospital care; fragmentation of health systems; and the proliferation of unregulated commercial care. (WHO, 2008: 2)

Primary health care is a more holistic approach to health provision with a greater focus on either promotive, preventive, curative or rehabilitative services, depending on community needs. The goal of primary health care is for people to attain "a level of health that will permit them to lead a socially and economically productive life… at a cost that the community and country can afford to maintain at every stage of their development." (Alma Ata, 1978: Declaration VI). Thus primary health care is focused on community-oriented and non-hospital services, including GPs, pharmacists, dentists etc.

Primary health care is considered to be the major contributor to overall population health. In general, strong primary health care systems reduce the overall need in a country for hospitalisation. Good quality primary health care has also shown to significantly reduce the mortality rate and countries with strong primary health care systems usually have better health outcomes (WHO, 2008: 2-3, 7, and 54). With its particular disease demographics South Africa would benefit considerably from high quality primary health care facilities, particularly ones focused on holistic disease prevention and health promotion.

Primary health care was, and still is, mainly provided by public health institutions. With the deregulation of health care during the 1980's recession, the privatisation of health care immediately led to the rapid expansion of hospital-based curative services. More and more doctors moved away from rural areas to better-paid jobs in the more specialised urban facilities. Preventative service provision declined and the more expensive curative care proved to be a barrier for low-income groups in accessing health care.

Despite the focus on primary health care ushered in by the ANC's election victory in 1994 and its subsequent redistributive changes, the implementation of a people-oriented primary health system is still facing a serious set of obstacles, much of which are connected to the institutional and economic strength of the private, curative-oriented, sector. By 1994 only 11 per cent of health spending was oriented towards primary health care (McIntyre, Bloom, Doherty and Brijlal, 1995: 47). The ANC agenda, set out in the 1994 Health Plan was to substantially change these inherited spending patterns. A centrally administered needs-based resource allocation mechanism was introduced quite speedily as well as the removal of certain public sector fees such as those for children under six and nursing and pregnant women (Gilson et al., 2003: 34). In 1996 all primary care user fees were abolished.

Due to the speed with which these reforms were implemented, public sector capacity was overlooked and this led to many unintended consequences. With the advent of the era of fiscal federalism, the resource allocation mechanism was replaced by provincial block grants distributed by the Department of Finance. This had a negative effect on equitable budgeting; "the initial equity gains achieved through implementation of health resource allocation formulae were reversed by the implementation of provisional block grants after 1996" (Gilson et al., 2003: 36).

Although the geographical re-allocation of resources was a move towards addressing the inequity between primary and tertiary public spending, no action was taken on the improvement of cross-subsidisation between the private and public sectors. This was a goal in the original Health Plan, but the NHI has only recently brought this back onto the policy agenda.

Within for-profit health care there are forces which pull health provision in the direction of specialist hospital care. Curative care is more expensive than primary health care and therefore hospitals will focus on attracting specialists who will bring more income to the facility. One practical example is that the private hospital industry invests in surgical beds over medical beds. Ward fees are the same for all beds. Yet, "the overall cost of a surgical admission is higher due to the use of theatre and surgical items such as the prosthesis" (Matsebula and Willie, 2007: 160).

According to Nadesan-Reddy (2010: 162), the most prevalent condition among medical aid holders is that of hypertension followed by hyperlipidaemia, asthma, diabetes mellitus type 2 and HIV. "Hypertension, hyperlipidaemia and diabetes mellitus type 2 are all strong risk factors for the development of coronary artery disease which is a chronic disease of poor lifestyle management (Nadesan-Reddy, 2010: 162). Although the private sector can provide high quality treatment for these conditions, especially since it has become part of the Minimum Prescribed Benefits (MPBs), (state regulations introduced in 2000) these conditions can be combated, more efficiently through a system of primary health care which focuses on the prevention of such diseases. However, with its current focus on treatment of disease and subsequent marginalisation of primary health care in the private sector, these medical aid holders are done a disservice.

The profit-making incentive in an open health market would therefore direct investment to curative care provision. The WHO argues that health care institutions need to be mobilised

around primary health care values and that the failure to "either counter or substantially modify forces that pull the health sector in other directions, namely: a disproportionate focus on specialist hospital care; fragmentation of health systems; and the proliferation of unregulated commercial care" (WHO, 2008: 4) is the reason for the general failure of countries to meet the MDGs in health care.

7.2. Hidden resource flows to the private health system

As have been pointed out, a considerable amount of state resources flow to the private health system via the tax code. The need for subsidies and incentives to increase the number of medical aid holders are due to escalating cost in the private health industry. The amount of resources which flows through these fiscal and occupational welfare mechanisms are increasing at a relatively rapid pace and will continue to do so if left unexamined. The amount, rudimentarily valued at over R30 billion in the previous chapter represents too large an amount to be allowed to flow to the private health sector without scrutiny. Due to the hidden nature of these subsidies it is important to bring their existence under the spotlight. The existence of these subsidies demonstrates also, as Titmuss attempted to do when he formulated his theory the Social Division of Welfare, that the middle and upper classes benefit disproportionately from welfare spending which is ironic as they are often the most vociferous critics of state expenditure on the poor.

7.3. Quality of Care

It is a common-sense, popular belief that the private health sector provides high quality care in South Africa. This is almost always taken as a given. However, often the inordinate focus on curative-oriented health provision and the general trend to focus on high cost procedures have very negative effects on quality of care. Most problematic however is the lack of data in the area of health outcomes and quality indicators from medical schemes (Council of Medical Schemes, 2001). Despite the fact that they are mandated to do so by the Medical Schemes Act "medical schemes are currently not collecting data that would allow for an accurate evaluation of access to health, cost and quality of healthcare" (Council of Medical Schemes, 2001). Nor do medical aid schemes seem concerned about whether patients are re-admitted for the same problems, for post-operative complications or whether operations themselves are without complications.

Indeed it is acknowledged by the Council that on the contrary data collection by medical schemes is motivated by "cost data than quality and outcomes data" which is evident in the fact that there is a strong emphasis on the collection of data on the administration of high cost items such as MRI and CT scans yet very few bother to collect mortality data (Council of Medical Schemes, 2001).

It is therefore hard to judge whether the private sector is providing adequate quality care which is in line with their high costs. Despite the popular conception that the private health industry provides high quality care this is not always the case in every area of its care provision. A recent study has found that private sector GPs have little knowledge of recent STI developments and more than half of these GPs did not provide up to date information on how to prevent future infections (Stevens et al., 2007: 206). This is one way in which the focus on the curative is having negative outcomes on the general health status of the country. The same study also found that the quality of care received by a patient was highly influenced by their insurance status when patients sought STI treatment:

> STI clients with a medical scheme were 2.64 times more likely to receive effective treatment than cash clients. (Stevens et al., 2007: 206)

People who utilise the private sector are therefore treated differentially merely on the basis of whether they have medical aid or not. The researchers come to the conclusion that the control of STIs among the population "does not appear to be a priority" and as a result it is "undermining national efforts to control STI's especially among the poor" (Stevens et al., 2007: 206).

Private health practitioners and providers are less likely to provide health care services that are in the public interest if it is not in their financial interest. Profit-maximisation is not in the public interest especially where poor people are the main section in need; when it comes to HIV/AIDS and tuberculosis intervention even the private curative services lack sufficient financial incentives to "motivate uniformly high standards in provision" (Stevens et al., 2007: 210). A discussion on the provision of HIV treatment is dealt with further down. Generally however, researchers agree that the private system is not contributing enough to South Africa's most pressing diseases and epidemics.

7.4. Cost-escalation in the private health industry

As have been pointed out in Chapter 2, in 1963 the economist Kenneth Arrow wrote a powerful theorem on 'uncertainty and the welfare economics of medical care' which argued that the particular characteristics of the medical care industry renders it different from the norm which allows systems to operate effectively and efficiently in a competitive model. The first characteristic of the medical care industry that Arrow points out is the nature of demand. The demand for medical care is irregular and unpredictable and "not steady in origin" such as for instance food and clothing (Arrow, 1963: 948). The demand for medical care is usually also accompanied by the "loss or reduction of earning ability" (Arrow, 1963: 949).

Another deviation from the norm is the "expected behaviour of the physician" which is unlike that of a business arrangement since "the product and the activity of production are identical". In other words the consumer cannot 'test' the product and the relationship is highly dependent on trust.

> His (the physician's) behaviour is supposed to be governed by a concern for the customer's welfare which would not be expected of a salesman. In Talcott Parsons' terms, there is a "collectivity-orientation," which distinguishes medicine and other professions from business, where self-interest on the part of participants is the accepted norm. (Arrow, 1963: 949)

Arrow argues further that physicians' behaviour should not be dictated by financial considerations as it would distort the principles which guide the provision of health care.

Particularly pressing is the presence of an 'uncertainty principle' since illness and recovery of human beings are not as certain as the breakdown and servicing of say, a vehicle or a television set. This uncertainty extends to the complicated nature of medical knowledge and the "informational inequality" (Arrow, 1963: 965) between the physician and patient. If the medical industry were to operate according to the norm the patient would know exactly which illness they have and what is needed as a cure. Only then would the patient be able to make a decision in line with competitive market practice.

The medical care industry also deviates from the norms of competitive theory in terms of the governing of supply by net return due to the high cost of training, the subsidisation of training by the state, the restrictions to entry into medical schools, the high earnings of the doctor as

an incentive for entry into the field coupled with the public need and, in effect, interest to training doctors. These disparate departures from the norm make the medical care industry particularly different from the general marketplace.

Arrow also points to problematic trends in pricing practices which results in the deviation from the norm of competitive theory. Discrimination by income could have the unintended consequence of cherry-picking when not regulated. The absence of an ideal competitive environment in health care therefore distorts the outcomes generally expected in a market place. This goes far to explain the problematic issues created by the private health sector of which the most important is cost-escalation and exclusion and attempts to balance the two.

Interest groups within the private sector include the private hospital industry, pharmaceutical companies, doctors and specialists, the medical insurance and the medical scheme industry. Each of these interests puts forward a different scenario as to what is driving cost-escalation and why. In each of these scenarios the protagonist is innocent. What they do have in common is their desire to maintain the private health sector. In most cases the argument is put forward that the imposition, by the state, of regulations, are what is driving costs in the private sector. By imposing regulations to manage risk-rating, they argue, the market mechanisms that would allow medical schemes to keep costs low are thwarted.

The state imposes such regulations in order to insure that more people can access medical aid and therefore private health care. The state also subsidises medical aid users by providing medical tax deductions. Risk-rating is not in the interest of the South African population, or even the medical aid user since many would be excluded. Most of this is due to the fact that health care is not an ordinary commodity that can be withheld from those who cannot afford it. Due to the economic strength of the private hospital and medical aid industry the consumer has very little power to drive costs down.

The question of ethics in health care does not fit into the argument made by proponents of market driven health provision. The choice is therefore between unregulated, highly exclusive private services for a very small part of the population at manageable prices, or regulated, expensive private services for a slightly greater proportion of the population. This is when assuming that state regulation drives cost escalation.

Another argument is that the growing monopoly in private hospital ownership is having an adverse effect on costs in the private sector. Netcare, Medi-Clinic and Life Healthcare own

around 80% of all private hospitals in South Africa. This means that their bargaining power outweighs those of medical schemes. The correlation is made between the trend in hospital consolidation and rapidly increasing costs in hospital care (Matsebula and Willie, 2007: 169). The hospital industry disagrees, citing inflation and regulation as the drivers of hospital costs.

The Council of Medical Schemes (2001) argues that the monopoly practices in the private hospital industry have handed over market power to hospitals thus allowing hospitals to increase their prices without suffering the damage necessarily associated with price increases in a competitive environment due to guaranteed funding from medical schemes. The price increases are shouldered by medical schemes which are then passed on to consumers through levies. Unfortunately the cost is borne by the consumer who can no longer afford medical aid. These patients either start utilising public services or join the swelling numbers of consumers paying out-of-pocket in the private health system.

Apart from quality control (National Health Act 61 of 2003), private hospitals are not regulated. The three monopoly hospital groups were all listed on the Johannesburg Stock Exchange until 2005 when Life Healthcare delisted. Although it is hard to make definite estimates and comparisons:

> Available figures suggest that the private hospital sector is consistently profitable with significantly high rations of operating earnings before interest, taxation, depreciation and amortisation (EBITDA). A seven-year review of the financial performance of both Netcare and Medi-Clinic reveals a consistent trend of growth in earnings. The Competition Tribunal characterises the private hospital industry as having "opaque vertical relationships and a guaranteed source of funding from medical schemes"[14]. (Matsebula and Willie, 2007: 170)

Since hospital admission is out of reach of most South African citizens and would even set an average middle class family back significantly there has been some focus on enhancing bed occupation in private facilities by lower income citizens, although, it seems this has been hampered by the lack of specialists (Matsebula and Willie, 2007: 172). There has not however been an attempt to force private hospitals to lower their prices.

[14] Competition Tribunal, Phodiclinics (pty) Ltd & DJH Defty (Pty) Ltd and Protector Group Medical services (Pty) Ltd & 5 Others. Case no: 122/LM/Dec05, Pretoria 2007. In SAHR 2007: 170.

Another argument is that "the fee-for-service reimbursement mechanism implemented by medical schemes encourage over-servicing" (Matsebula and Willie, 2007: 159). Fee-for-service reimbursement is argued to create the incentive to over-supply (Doherty and McLeod, 2002: 50; see also Arrow, 1963: 953). As was explained earlier, patient ignorance, or what economists refer to as 'uncertainty', allows for health as a 'market good' to be distorted, thus not providing the criteria for optimum competition.

7.5. Migration of doctors and nurses

The low numbers of staff in the public sector presents a major challenge to quality public health provision. There has been significant staff reductions since 1997/98, and possibly prior to this date, although data is not reliable (DBSA, 2008: 19-20).

In 1997 a staff headcount reveals around 251,000 staff members. By 2002 this had declined by around 36,000, and thereafter increased again to 251,000 by 2007/08. Thus from 1997/98 to 2007/8, a period of 11 years, no increases in staff levels had occurred despite a significant increase in the population making use of the public sector and an increased burden of disease resulting from HIV and AIDS.

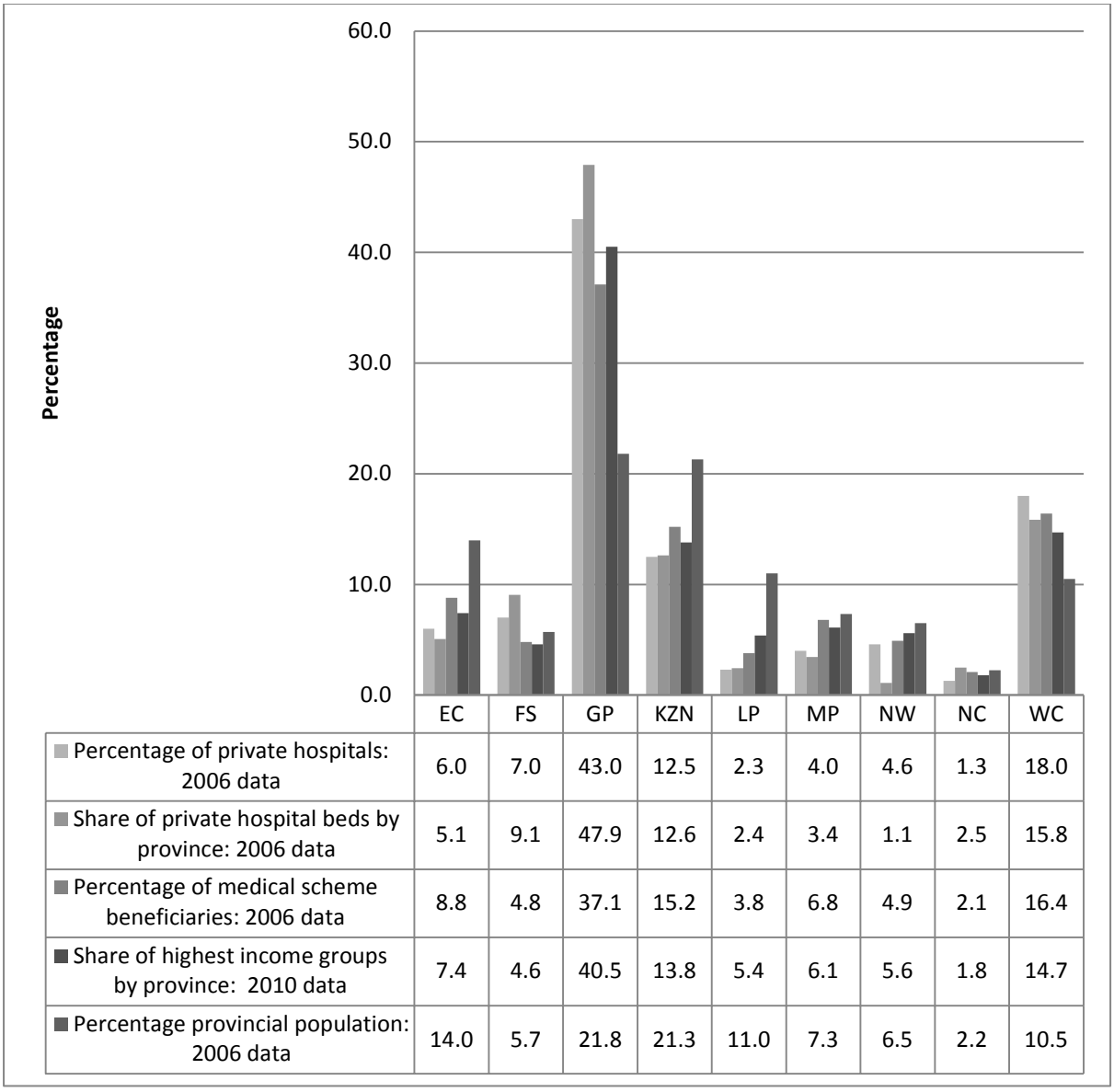
The DBSA report (2008) argues that staff levels fluctuate with budgetary allocations, with fiscal austerity clearly following by staff reductions. One of the reasons why the public sector is short staffed is due to the ability of the private sector to draw trained professional services with larger salaries and better working environments. As have been mentioned, doctor and nurses training is subsidised by the state, and every state subsidised professional who chooses to work in the private sector represents an indirect flow of state resources to the private sector. Furthermore, these invaluable health professionals are not accessible to those who need them most.

7.6. Geographic inequality

For-profit hospital growth is driven by market indicators. They are therefore more likely to concentrate in high-wealth urban areas. Despite the fact that private for-profit hospitals claim that they are not "as dependent on the medical scheme population as is being argued" (Matsebula and Willie, 2007: 162), data shows that private hospitals distribution shows the same patterns as medical aid distribution (See table 1).

Table 1 shows that the distribution of private hospitals does not concur with demand based upon population levels, but rather based upon medical scheme beneficiary levels. Medical scheme beneficiary levels concur with the share of high earners in each province. Therefore, Gauteng and Kwazulu-Natal have equal sized populations; however Gauteng has more than twice the amount of high-income earners and therefore more than twice the amount of medical scheme holders. This explains why there are 95 private hospitals with over 12 000 beds in Gauteng and only 27 private hospitals with a mere 3 400 beds in Kwazulu-Natal (2006 data in Matsebula and Willie, 2007: 161-163).

Table 1: Provincial distribution of private hospitals (Matsebula and Willie, 2007)



	EC	FS	GP	KZN	LP	MP	NW	NC	WC
Percentage of private hospitals: 2006 data	6.0	7.0	43.0	12.5	2.3	4.0	4.6	1.3	18.0
Share of private hospital beds by province: 2006 data	5.1	9.1	47.9	12.6	2.4	3.4	1.1	2.5	15.8
Percentage of medical scheme beneficiaries: 2006 data	8.8	4.8	37.1	15.2	3.8	6.8	4.9	2.1	16.4
Share of highest income groups by province: 2010 data	7.4	4.6	40.5	13.8	5.4	6.1	5.6	1.8	14.7
Percentage provincial population: 2006 data	14.0	5.7	21.8	21.3	11.0	7.3	6.5	2.2	10.5

7.7. HIV treatment

National AIDS Spending Assessment (NASA) reports are compiled by countries, however there is no such report for South Africa. The *South African Health Review* reports that spending on HIV and AIDS is around 0.7% of GDP (2011) and will likely hit the 1% mark soon (Blecher et al., 2011: 32). In 2001 South Africa signed the Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases. This declaration signified the commitment of signatories to commit 15% of their national resources to health care. The HSRC states that in 2003 15% of the total South African government expenditure was dedicated to health care amounting to 3% of GDP. The NHA report of 2003-2006 puts this at 11.1% of total government spending. The Human Science Research Council (HSRC) does recognise that such high spending can be of little use when it is distributed so inequitably and inefficiently.

> Consequently, this apparently adequate level of health spending is not translated very efficiently into health outputs, such as immunisations and antenatal visits, and health outcomes, such as infant and maternal mortality rates. (HSRC Media Brief, 2003, *HIV/AIDS spending in Southern Africa below requirements for prevention, care and treatment*)

It is further stated that two thirds of government spending is awarded to provincial departments in the form of block grants, which is the HIV/AIDS component of equitable share. However, what increases South African health care spending is the 4.1% of GDP spent in the private sector for little more than 16% of the population. The pandemic itself is not the cause for high spending in the private for-profit sector.

Although “the prevalence of HIV appears lower than the national average... among members of medical schemes”, another reason for the low numbers can be that “schemes had restricted access to antiretroviral therapy to dual- and in some cases mono-therapy” (Nadesan-Reddy, 2010: 163). Anti-retroviral therapy has, since 2005, been included in the PMB package which, Nadesan-Reddy argues, would probably lead to an increase in the numbers of medical aid holders reporting HIV treatment. Furthermore, the medical scheme HIV management framework (such as the Disease Management Programme) are not holistically orientated due to its curative focus and therefore these medical aid beneficiaries do not benefit from an integrated framework for the treatment and prevention of HIV-related infections such as TB and STIs (Nadesan-Reddy, 2010: 163).

Even though the Medical Schemes Act (131 of 1998) prescribes a list of PMBs in relation to HIV infection, Stevens et al. (2007) comes to the conclusion that, along with the private sector's curative approach, the problem lies with the lack of "financial incentives among private sector providers to motivate uniformly high standards in provision of care for these priority health conditions" (Stevens et al., 2007: 210). The for-profit private sector, despite the fact that it consumes such a great amount of resources, is not playing a helpful role in controlling infectious disease. This is mainly due to the limited amount of people able to afford private health care and the fact that infectious diseases is most prevalent in low socio-economic circumstances.

7.8. Conclusion

This chapter examines seven areas pertaining to the health sector which is, in some way or another, having a detrimental effect on the health outcomes of South Africa. In each of these areas the presence of a profit motive in the private health sector plays an important role in the creation or continuation of these negative effects. The presence of a profit motive means that services which do not necessarily create high profits are systematically marginalised. These include the provision of primary health care and comprehensive HIV treatment. Private hospitals are built in areas where there are higher concentrations of medical aid holders, i.e. areas where middle and upper class people are concentrated. This bias means rural and poorer areas have little to no access to private health care. Again, this is due to the presence of a profit motive.

The *South African Health Review 2007* asks the pertinent question whether "some of the challenges faced by the public health sector can be laid at the door of an under-regulated private sector?" (Editorial: page viii). The Hospital Association of South Africa disagrees (HASA, 2008: 4) and counters the attack by the SAHR contributors by arguing that the disproportionate spending in the private health sector is inflated by "value-added tax at 14%, the cost of capital, the cost of infrastructure, property rental and the substantial private sector cross-subsidy of pharmaceuticals". However, apart from value-added tax with regards to hospital treatment, the public health budget also caters for the other resources mentioned. The *SAHR* (2007: x) argues that lack of funding plays an important role in the inadequate levels of quality and access which the public sector provides. Low levels of quality health care draw medical aid holders away from the public sector and thus a cycle of deterioration is set in motion. As Wadee et al. (2003: 13) points out:

> …the cost-recovery rate in public facilities is low and decreasing, falling from around 9.2% of public hospital recurrent expenditure in 1992/93 to 2.1% in 1998/99. This is most likely due to a combination of falling use by paying patients and poor management of billing systems.

The intricate flow of resources in and between the state and the two health sectors has been analysed in this thesis. Without a critical interrogation the links between the deterioration of the public sector and the presence of an 'under-regulated private sector' is not apparent, and can easily be argued away, as HASA (2008) attempted to do. The division of the health sector of South Africa into two, one which caters for the well-off and one which caters for the less well-off, quite simply means the division of the risk pool. Cost-recovery in the public sector is thus decreasing due to a lack of paying patients, exacerbated by the fact that medical aid holders are generally charged below cost-recovery rates (Gilson and McIntyre 2000; 2000).

There are mechanisms which can represent resource flows from the private to the public sector. Medical scheme reimbursements for private patients which were treated in the public sector or the leasing of public hospital beds to private providers include some of the more significant ways in which the public sector can obtain private funding (Doherty et al., 2002: 12). But since medical scheme members are charged below cost-recovery levels as Gilson and McIntyre (2000; 2002) pointed out, "these arrangements generate subsidy from the public to the private sector" (Wadee et al., 2003: 9).

The public system therefore remains dependent on general taxation and, as a result, all the vulnerabilities which accompany macro-economic policy, financial market volatility, budget cuts and the like. In the process, the private health system is not contributing in any significant manner to addressing the most pertinent health issues facing the country. This is due to the fact that primary health care is marginalised along with adequate HIV, STI and TB treatments. Apart from this the private sector also excludes those who live in rural areas due to the geographical distribution of private facilities. And where patients without medical aid choose to go to private facilities and pay out-of-pocket, they either incur debilitating financial costs or are unable to receive treatment due to the lack of financial resources.

Each of these 'problems' created in and by the private health sector is due to the presence of the profit motive. And as this chapter has pointed out, the uncertainties which abound in the medical care industry and the deviation from the norms upon which the market operates

creates a variety of distortions which can account for cost-escalation, increasing exclusion, and the diminishing of the ‘care’ principle (Arrow, 1963).

CHAPTER 8

CONCLUSION

Inequality and its consequences are pervasive and prominent features of everyday life in South Africa. What is significant is the reproduction of inequality through social institutions on the basis of access to the formal labour market. This thesis argues that in order to understand and more effectively address the persistence of inequality, policy makers should focus on the mechanisms which reproduce poverty. The work of Richard Titmuss is used as a conceptual framework to explain how social changes are differentially responded to by policy makers who are, in turn, reacting to the interests of powerful stakeholders, hegemonic ideas and persisting stereotypes. Chapter 4 demonstrates how policy decisions were influenced historically by racist ideology and the interests of mining capital. The result was that in the area of health, and particularly mining-related illnesses, views and ideas about causes and cures were continually being rewritten, not only to the benefit of the accumulation of capital in the mining industry but also the wider project of segregation and apartheid.

Notions of the 'deserving and undeserving poor' in South Africa were influenced by debates in the United Kingdom and manifested itself in the differentiated form of social policy aimed at the poor (Sagner, 2000). As capitalism in the mining and agricultural sectors developed and South Africa was industrialised, the social changes which accompanied these processes had profoundly negative effects on a large part of the South African population, in particular the black majority. Policies such as the 1910 Constitution, the 1914 Natives Land Act and the Native Urban Areas Act of 1923 were intended to segregate the races and to dispossess the African population and were in large part fuelled by the racialised form capitalist development took in South Africa. The accumulation of capital and a racist ideology thus worked in tandem. In South Africa the processes of urbanisation, industrialisation and increasing landlessness led to increased poverty amongst both the white and black population. In this context the differential treatment in the application of social policy among races emerged.

Policy interventions for the segregation of the different races, Iliffe (1987) states, emerged around the 1880s although differential treatment preceded along similar lines due to colonial notions of hierarchy as well as slavery and the preoccupation with the supply of labour. The impetus for segregation was rationalised on the basis of several epidemics among the poorer citizens of the Cape Colony. The diagnosis was influenced by these early ideas and blame was laid on the victims themselves, particularly African victims of smallpox and bubonic plague. From very early on ideas about the causes of disease played an important role in shaping policy as well as popular opinion about race. In the analysis of early policy it becomes apparent that these ideas about race and disease were used as justification for certain policy actions (see for instance the Lagden Commission (1903) and the Native Urban Areas Act of 1923 as well as the reactions of the mining industry towards tuberculosis among both black and white miners).

Justified by ideas of racial hierarchy the social policies which emerged as a reaction to increasing poverty resulted in the differential treatment of races and worked in favour of the minority white population as well as capitalist interests. The appropriation of land from the locals as well as the commercialisation of agriculture, along with other social changes associated with rapid industrialisation, led to large numbers of both black and white people moving to urban areas. Slums were segregated to prevent social mixing across social groups and to protect the ideology of white imperialism. The result was that poor whites were materially advantaged through preferential labour policies and differential but redistributive social policies to the detriment of the black population, who were treated either as non-citizens or received racially differentiated benefits. Thus although poor whites were not viewed as "victims of their vices" (Iliffe, 1987: 116), stereotypes of disease ridden and barbarous 'natives' still remained intact.

The solutions to the 'Poor White Problem' therefore played the role of stigmatising poverty as something that should not be associated with being civilised and uplifting poor white people, but in ways which negatively affected the social wellbeing of black people (Teppo, 2004). Although the "war years" of the 1940s under the United Party represented an era of liberal ideas on social policy albeit co-existing with continued labour repression and political disenfranchisement, most of the recommended social policies aimed at ameliorating the social effects of segregation and industrialisation were not implemented. When the National Party was voted into government in 1948 the policy of apartheid rapidly supplanted the liberal impetus which existed in sections of the white intelligentsia. In the health sector the

National Party government continued to manage institutions of health on a racial basis, but gradually ceded control of health institutions for Africans to local Bantustan authorities (including mission hospitals) (Price, 1989). The underdeveloped Bantustans were unable to maintain a fully functioning health system and outside of the Bantustans black South Africans were treated differentially based upon the exclusionary principles and values of apartheid. Access to quality health care was therefore dependent on race and the ability to pay for private health care.

From the 1970s the government followed international trends by pursuing the policy of privatisation (Price, 1989). For-profit general hospitals expanded greatly between 1988 and 1993. Coovadia et al. (2009) argues that established corporate capitalist interests, "particularly the mining houses" drove the policy of privatisation (2009: 826). The drive towards the privatisation of health care was argued to be due to the desire of the state to decrease social spending. Price (1989) argued that it would have the opposite effect. Due to high costs private hospitals were dependent on medical aid beneficiaries and thus could not expand if the pool of medical aid beneficiaries did not as well. This opened up an avenue for the inclusion of the black middle class in the provision of private health care (Price, 1989). The change from public to private health care leading up to the democratic era therefore represents a change from exclusion based upon race to exclusion based upon ability to pay.

The process in which health care came to be a commodity also had several other consequences. This is discussed in a historical setting in Chapter 6 and summarised in Chapter 7. The negative consequences of the privatisation of the health sector includes the marginalisation of primary health care; severe cost escalation; inferior quality care provision in certain areas such as epidemics; the exclusion of a very large part of the population due to high costs and the lack of cross-subsidisation; the unequal geographic distribution of private hospitals; and the distortion of not only human resources but also public health funds. Chapter 5 focuses particularly on the distortion of public health funds through the application of Richard Titmuss' theory of a Social Division of Welfare.

High quality private health care is accessible only to those who can afford it. While those who access public institutions such as public health care are assumed to be 'dependent' on the state, those who access private health facilities are assumed to be 'independent' of the state. However, these connections are not that clear cut. Access to the formal labour market, and subsequently the paying of taxes, authorises one to access subsidies not available to those

who do not. Furthermore, there is a variety of factors which impact upon your access to this subsidy, and these factors all work in a regressive manner. Thus, in essence, the benefits of the subsidy increases the wealthier you are.

Due to cost escalation in the private health sector, medical aid payments have become increasingly costly. Medical aid membership has risen in the last few years only due to the introduction of the Government Employee Medical Scheme (GEMS). GEMS had around 400 000 members and around 1.2 million beneficiaries in 2009 (GEMS, 2010). Overall medical scheme beneficiaries in South Africa has been fluctuating between 6 and 7 million since 1991 (see appendix 1), with new growth showing only in 2005. However, the relation between beneficiary coverage and the growing total population shows that coverage "declined from 17.0% in 1994 to 14.9% in 2005" (StatsSA, 1998b, in McLeod and Ramjee 2007). In 2009 there were just over 5.5 million tax payers and 3.5 million principal members of medical schemes (CMS, 2011). Of these members, 1.8 million accessed the subsidy (National Treasury and SARS, 2010); and as Chapter 5 has shown, access is regressive.

The Gross Contribution Income (GCI) is R84.9 billion for all medical schemes (CMS, 2011: 43) (which exclude out-of-pocket payments). With subsidies which amount to R20 billion (fiscal welfare) and 6.9 billion (occupational welfare), including another R12.5 billion which flows from the government to the private sector through GEMS, as well as the subsidisation of health professionals who migrate to the private sector. The private health sector is thus dependent on subsidies derived through the state through mechanisms such as GEMS. The subsidy which private sector patients receive from the state is, in aggregate, two to three times more than what the average public sector patient receives through the public health budget. This has a number of significant consequences for the reproduction of inequality.

The first consequence is the perpetuation of myths and stereotypes of the "deserving and undeserving poor" which prevail in a highly stratified society such as South Africa. Titmuss' intention with the formulation of the Social Division of Welfare was to demonstrate how the middle and upper classes in the UK were benefitting considerably from the welfare state by dividing all 'welfare' benefits according to administrative method (directly provided public services for the poor, differential fiscal benefits through the system of taxation and occupational benefits through differential positions in the labour market). The social division of welfare demonstrated how the non-poor (middle-class and upper-class) disproportionately benefit from welfare provision due to their privileged position in the labour market. The

application of the Social Division of Welfare to the South African health system reveals a system of class and race-based differentiation in social policy. Rather than being an independent entity operating on market logic, the private health industry in South Africa is demonstrated to be highly dependent on government tax funds through the subsidisation of medical aid to individuals in the form of a Tax Expenditure Subsidy and fringe benefits to employers, the provision of heavily subsidised medical aid to civil servants, and the subsidisation of health professional training. The government indirectly spends more, per person, on the subsidisation of the private health sector than it does on beneficiaries of the public health system. If dependency on the state is measured according to benefits received, or benefits required, private sector patients are very much dependent on the state.

Kirk Mann summarises the significance of the understanding and application of the Social Division of Welfare:

> By telling public welfare recipients that they must do more to avoid dependency, whilst ignoring the dependency of those who can access generous fiscal and occupational welfare provisions, academics, politicians and journalists may reinforce the misleading stereotypes and social divisions. (Mann, 2009)

Because the figures which represent resources flowing to the private system are indirect, not part of the budget and relatively out of sight and they are not the subject of scrutiny. Consequently policies are very often shaped by stereotypes and anecdotes of a feckless "undeserving" poor but which is nonetheless not extended to include discussion of an "undeserving" middle-class. The rhetoric of dependency encourages not only the idea that the poor are lazy but promotes a hegemonic public discourse that welfare provision, in Benjamin Franklin's words, supports "the encouragement of idleness" (Himmelfarb, 1984: 5). These anecdotal but nonetheless neo-liberal ideological views are exacerbated by a concern "that calamity will follow the relaxation of discipline and the mitigation of hardship" (Titmuss, 1958: 37). Ideas such as these have real social consequences however, tending to "[impoverish] political imagination" and "[constrain] the possibilities for social thought and public action" (Katz, 1989: 3). Furthermore, it does what the era of theorists to whom Titmuss belonged feared: it re-enforces class division. Differences in action caused by economic and structural disparities are given prejudicial emotional content by furnishing them with ideological meanings; effectively turning an entire class (or an entire race) into 'the other'.

As Tawney lucidly explained, “One of the regrettable… effects of extreme inequality” is that the middle and upper classes “take for granted” their own “advantages, as though there were nothing in them which could possibly need explanation”, yet become quite “critical of claims to similar advantages advanced by… those who do not yet possess them.” (Tawney 1931: 31-32). This thesis demonstrates that the ‘advantages’ of the middle and upper classes need explanation. Built upon a particular value system which privileges profit over care, the commoditisation of the health system has allowed certain class stereotypes to flourish. The idea that quality health care should be bought, like one does a motor vehicle or a television set, has allowed for the notion of “deservedness” to flourish in the South African health system. Thus, it is assumed in everyday life that those who cannot afford private health care should be content with the diminished quality of health care found in an overburdened public health system. It is these stereotypes which undermine the ability of achieving cross-class solidarity.

In the same way in which the apartheid state could perpetuate a grossly unequal system based upon the hierarchy of races, so too does the logic of capitalism prevail within a highly unequal health system - perpetuated by a hierarchy of classes based on differential access to the labour market. This logic of ‘Economic Man’ allows for the perpetuation of the status quo, continuous unequal resource allocation and undermines prospects for cross-class solidarity. Cross-class solidarity is what social theorists and academic activists such as Richard Tawney, Beatrice and Sidney Webb, Peter Townsend and Richard Titmuss, amongst others, believed would usher in an era of redistribution and equality. The dispelling of myths and stereotypes of classes and the poor, as well as empirically refuting ideological, common-sense views about who the principal beneficiaries of state resources were, would reveal the structural causes of poverty.

As Du Toit (2011a: 129) argues, images of the poor and subsequent reactions to poverty operate within a field of meaning. If poverty is merely seen as a ‘problem’ that can be solved through ‘development’ and economic growth, policy makers are likely to ignore the true causes of poverty in South Africa. Moreover, it is likely to depoliticise poverty discourse through the use of technicist and value-free language, as has been witnessed across other countries. The now popular idea that ‘service-delivery’ is the answer to solving the ‘problem’ of poverty is too simplistic and only reproduces the notion that poverty is an issue removed from wider societal dynamics; that providing services is adequate and there is no

need to remove the structural mechanisms which reproduce inequality between groups of people.

If the concept of poverty is a contested and contradictory one, shaped by "underlying ideological stories about the nature of society, the relationship between suffering, humanity and material lack, and the obligations of citizenship, community membership and solidarity" (Du Toit, 2011a: 129), then South African policy makers should develop a greater awareness of the complexities which beset the process of policy making. Images of the poor, reproduced by political parties and movements and the media, should be constantly interrogated, for they are mere representations, and within middle-class discourses often prejudicial, of those living in poverty.

Policy makers should be aware that poverty is merely a symptom of inequality and that poverty itself cannot be addressed without a focus on its opposite – the accumulation of wealth. Capitalist industrialisation has "pushed humanity along the road of modernisation, but at an enormous cost in terms of individual and collective suffering" (Gerth and Mills, 1948). The modernisation of the South African state alongside racialised policy has historically benefitted a white minority and created a state of 'diswelfare' for the black majority. Furthermore, the form that the accumulation of capital has taken post-1994 has had the same result due to particular policy choices as well as the failure to reform regressive social policies such as tax subsidies largely enjoyed by the middle and upper classes which enables them to access private health care. Thus, poverty, as a corollary effect to the concentration of wealth in the hands of a few, has allowed South Africa to become one of the most unequal countries in the world.

This thesis has illustrated the ways in which public resource flows in health care are directed towards those who are not categorised as poor or needy. These flows are not recorded in a transparent manner in government records because they are not viewed as a contribution to social policy and therefore not subject to scrutiny in the manner that public expenditure on directly provided government services is. Even if a comprehensive non-means tested grant system is established, continuing resource flows from the public to private sector such as those in health will thwart the goal of creating a more egalitarian society based on social solidarity. The South African health system is merely one example in which detailed analysis and scrutiny reveals a regressivity that is contributing to the trend of inequality in the country.

Secondly, the question which needs to be asked is whether the Tax Expenditure Subsidy is attaining its intended goal. The South African government's policy intentions are to alleviate the burden upon the overcrowded public health system by subsidising the purchase of medical aid (Van den Heever, 2007). Chapter 5 interrogates whether or not the TES is the most effective means to this end. The logic of spending up to a quarter of the public health budget on 'unburdening' the public health sector needs to be revised. This is especially since this amount of resources is allocated regressively and excludes the majority of South Africans from accessing it. Even considered on its own terms if the private health sector operates according to a market logic in which competitive behaviour is essential to keeping costs down, not only does medical aid thwart such behaviour, but the provision of a subsidy will create a 'sellers market' (Mann, 2008).

Thirdly, is the commodified form which private health care takes the kind of health care South Africa needs? Chapter 7 summarises some of the problems created when a market mechanism operates within a health system. South Africa, in particular, needs primary health care provision. The World Health Organisation argues that health systems left to their own devices "do not gravitate naturally towards the goals of health for all" (WHO, 2008: 7) and that a renewed focus on primary health care is urgently needed, particularly in Third World countries. Indeed as they point out, commercialised systems tend to fragment, and become hospital and specialist-centred (WHO, 2008: 11). Furthermore, primary health care goals are discarded in systems based upon profit since they tend not to be financially profitable, despite being very beneficial to a country's overall health outcomes. Countries which have invested in re-orienting their health systems towards primary health care have witnessed significant health gains. Oman's under-five mortality rate dropped by 94% since they implemented reforms in the late 1970s (WHO, 2008: 2). With the particular disease demographics of South Africa, this country would benefit considerably from high quality primary health care facilities, particularly ones focused on holistic disease prevention and health promotion. However, as the World Health Report points out, without incredible incentives, private health care facilities are unlikely to reorient themselves toward the values which govern primary health care. It falls therefore squarely on the public sector to provide the necessary primary health care for the entire country.

Data also demonstrates that private hospitals follow concentrations of medical aid membership. This means that large portions of the country, those not marked by relative to high levels of wealth-holders, are left wanting in the distribution of private hospitals. Those

who want to access private care have to incur travel costs in order to access these institutions, over and above the costs of care. But perhaps most importantly is the treatment of South Africa's most prolific disease. As is shown in Chapter 7, medical schemes often restrict antiretroviral, dual and mono-therapy in their packages. And those who do have access to these therapies through medical aid do not benefit from an integrated framework for the treatment and prevention of HIV-related infections such as TB and STIs because the medical scheme HIV management framework (such as the Disease Management Programme) are not holistically orientated due to its curative focus (Nadesan-Reddy, 2010: 163). Stevens et al. (2007:210) lays the blame at the lack of financial incentive for for-profit health institutions to help in controlling infectious diseases such as HIV. The for-profit private sector, despite the fact that it consumes such a great amount of resources, is therefore not making a meaningful contribution to controlling infectious disease in South Africa.

The fourth question that needs to be asked is what role the private health system is playing in the deterioration of the public health system. The exclusive nature of private health provision, due to high costs is having a detrimental effect on the health outcomes of South Africa. As Chapter 7 has pointed out, utilising Kenneth Arrow's theory on the medical care industry and the competitive model (1963), medical care cannot be reduced to an ordinary commodity without significant negative social consequences. An attempt at running it on a profit motive will show various deviations from the norms on which markets operate efficiently. South Africa's total health expenditure is estimated at 8.5% of GDP which is comparatively high for a middle income country (Erasmus and Fitchen, 2010). 3.9% of this is represented by the public health budget leaving the remaining 4.3% to household expenditure on health. As Chapter 6 showed, the Health Expenditure Reviews do not take into account the subsidies which are offered by the state to medical aid holders. Nonetheless, these figures show that the private health sector consumes a large amount of financial resources, considering that it caters for less than a fifth of the population. If the subsidies by the state to compensate for these high costs are removed, the burden of health expenses for those on medical aid could increase beyond their ability to pay.

Due to the fact that the majority of those who are able to pay for health care utilise the private sector, vital resources remain in the private sector without ever flowing through the public system. The public system therefore remains dependent on general taxation and is thus constantly vulnerable to international financial market volatility and macro-economic policy (Thomas et al., 2000: 3). Due to the fact that the South African health system is bi-furcated

by class and race there is very little cross-subsidisation between the public and private system. The continuing decline of spending in the public health sector by the middle-class sector of society plays a significant role in the deterioration of the public sector. This, combined with the lack of cross-subsidisation, the public sector's dependence on general taxation, hidden resource flows from the state to the private sector, and the migration of doctors, nurses and administrative staff to private facilities, who can offer better salaries, all contribute to the continuing deterioration of the public health sector.

If the South African health system, as a whole, is to contribute to the creation of a more equal and overall healthy society and not, as this thesis have shown, to the exacerbation of an already unequal order, health policy makers should review every aspect of the public/private system. If policy makers do not formulate their policies to tackle the structural causes of inequality and poverty, these policies are likely to end up as they have – benefitting the middle and upper classes disproportionately.

The capitalist system has recently found itself in a state of crisis all over the world. In the process it has depended upon state resources to bail it out. Systems working on market logic have needed considerable state regulation, and, as the recent banking crisis in the United States of America has shown, welcomes state intervention. This has become the logic upon which the capitalist system has kept itself afloat. In a very similar way the private health sector in South Africa treasures its 'independence' and boasts about its efficiency and quality, whilst consuming a large amount of state resources.

Not only does the private sector save millions by not training or subsidising the training of their own doctors it depends largely on the state to do so. Without subsidies medical schools are unlikely to attract many students due to the costliness of training doctors. In a sense therefore the private sector is living off the welfare expenditure of the South African state and all who utilise it are highly dependent on the state for these forms of subsidisation. If the subsidies which keep the private sector and all who utilise it afloat exceeds state investment in state sectors, as have been show in this thesis, then perhaps the argument so often made about the poor being dependent on the state should be revised and applied to the middle and upper classes. The challenge for overcoming inequality in South Africa is thus to identify the mechanisms by which poverty is reproduced: which points forcefully to a problem not of the benefits and choices of the poor in society but that of the rich.

BIBLIOGRAPHY

Abel-Smith, B. (1963), *Paying for health services: A study of costs and sources of finance in six countries*, Geneva: WHO.

African National Congress, (2007), 52nd ANC National Conference Resolutions, December 2007, Polokwane, http://www.anc.org.za/show.php?id=2536.

Alcock, P., Glennerster, H., Oakley, A., and Sinfield, A. (eds.) (2001), *Welfare and Wellbeing: Richard Titmuss's contribution to social policy*, Bristol: The Policy Press.

Allsopp, J. (2005), 'Review of *Private Complaints and Public Health: Richard Titmuss and the National Health Service'*, in the *Journal of Social Policy*, Vol.34, Issue 02, April 2005, pp.326-327, Cambridge University Press.

Alma Ata, (1978), Primary health care: report of the International Conference on Primary Health Care, *Alma-Ata, USSR, 6-12 September 1978.*

Arrow, K. J. (1963), 'Uncertainty and the Welfare Economics of Medical Care, in *American Economic Review*, Vol.53, Issue 05, pp.941-973, American Economic Association.

Arrow, K. J. (1972), 'Gifts and Exchanges', in M. Cohen, T. Nagel, & T. Scanlon, *Medicine and Moral Philosophy*, pp.139-158, New Jersey: Princeton University Press.

Atkinson, A.B. (1975), 'Income Distribution and Social Change Revisited', in *Journal of Social Policy*, Volume 4, Issue 01, January 1975, pp.57-68, Cambridge University Press.

Badat, S. (forthcoming), 'Redressing apartheid's legacy of social exclusion: social equity, redress and admission to higher education in South Africa', in *One World, Many Knowledges*: *Dilemmas of Change*, forthcoming book publication.

Baines, G. (2003). 'Revisiting Urban African Policy and the Reforms of the Smuts Government, 1939-1948'. *Workshop on South Africa in the 1940s, South African Research Centre, September 2003.* Kingston.

Baldwin, P. (1990), *The Politics of Social Solidarity: Class Bases of the European Welfare State 1875 - 1975.* Great Britain: Cambridge University Press.

Barnes, H. and Wright, G. (2012) 'Defining child poverty in South Africa using the socially perceived necessities approach', in A. Minujin and S. Nandy (eds.), *Global Child Poverty and Well-Being: Measurement, Concepts, Policy and Action,* Studies in Poverty, Inequality and Social Exclusion Series, pp.135-154, Bristol: Policy Press.

Bernier, N.F. and Clavier, C. (2011), 'Public health policy research: making the case for a political science approach', in *Health Promotion International*, Vol. 26, No. 1, Oxford University Press.

Blecher, M., Kollipara, A., De Jager, P. and Zulu, N. (2011), 'Chapter 3: Health Financing', in *South African Health Review 2011*, pp. 29-48, Durban: Health Systems Trust.

British Medical Association, (1905), 'Report on Contract Practice', in *British Medical Journal*, Supp. July 22, 1905, p.28, BMJ Publishing Group Ltd.

Browne Commission, (1986), *Final Report of the Commission of Inquiry into Health Services*, (RP 67/1986), Pretoria: Government Printer.

Bulmer, M. (1991), 'National contexts for the development of social-policy research: British and American research on poverty and social welfare compared', in P. Wagner, C. Hirschon Weiss, B. Wittrock and H. Wollmann (eds.), *Social Sciences and Modern States: National Experiences and Theoretical Crossroads*, pp.148-67, Cambridge University Press.

Bunting, B.P. (1964), *The Rise of the South African Reich*, London: Penguin.

Bunting, I. (1994), 'Public expenditure on the education and training of medical personnel'. *National Health Expenditure Review*, Technical Paper No. 7, Durban: Health Systems Trust.

Bureau of Market Research, (2010), Press statement to Personal income Estimates for South Africa, 2010, Research Report No.396, Bureau of Market Research.

Carnegie Commission, (1932), *The Poor White Problem in South Africa: Report of the Carnegie Commission: Joint Findings and Recommendations*, Stellenbosch: Ecclesia.

Clark, C. (1954), *Welfare and Taxation*, Catholic Social Guild.

Collard, D. (1978), *Altruism and Economy: A Study in Non-Selfish Economics*, London: Martin Robertson.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D. and McIntyre, D. (2009) 'The health and health system of South Africa: historical roots of current public health challenges', in *The Lancet*, Vol.375, September 5, 2009. Elsevier Ltd.

Cornell, J., Goudge, J., McIntyre, D, and Mbatsha, S. (2001), *National Health Accounts – The Private Sector Report*, March 2001, Pretoria: Department of Health.

Council of Medical Schemes, (2001), *Final Report on Statutory Information Survey: Research and Monitoring*, July 2001.

Davenport, T.R.H. (1987), *South Africa: A Modern History*, 3rd edition, Basingstoke: Macmillan.

Deacon, A. (1993), 'Richard Titmuss: 20 Years On', in *Journal of Social Policy*, Vol.22, Issue 02, April 1993, pp.235-242, Cambridge University Press.

Deacon, H. (2000), 'Racism and Medical Science in South Africa's Cape Colony in the Mid- to Late Nineteenth Century', in *Osiris*, 2nd Series, Vol. 15, pp.190-206, University of Chicago Press.

Development Bank of South Africa, (2008), *A Roadmap for the Reform of the South African Health System*, 10 November 2008.

Doherty, J. and McLeod, H. (2002), 'Chapter 3: Medical Schemes'. In P. Ijumba, A. Ntuli, and P. Barron, *South African Health Review 2002*, pp.41-66, Durban: Health Systems Trust

Doherty, J., Thomas, S. and Muirhead, D. (2002), *Health Financing and Expenditure in Post-Apartheid South Africa 1996/97 – 1998/99. The National Health Accounts Project Consolidated Report.* Health Economics Unit, UCT, Cape Town: Department of Health.

Donnison, D. (1979), 'Social Policy after Titmuss', in *Journal of Social Policy*, Vol.8, Issue 02, April 1979, pp.145-156, Cambridge University Press.

Du Toit, A. (2003), 'Hunger in the Valley of Fruitfulness: globalisation, "social exclusion" and chronic poverty in Ceres, South Africa', Draft paper presented at the conference 'Staying Poor: Chronic Poverty and Development Policy', University of Manchester, 7 to 9 April 2003.

Du Toit, A. (2004), ''Social Exclusion' Discourse and Chronic Poverty: A South African Case Study', in *Development and Change*, Vol.35, Issue 05, pp.987-1010, Blackwell Publishing.

Du Toit, A. (2008), 'Living on the margins: the social dynamics of economic marginalisation', in *Development Southern Africa*, Vol.25, No.2, June, pp.135-150, London: Routledge.

Du Toit, A. (2011a), 'The Proper Subject of Research is Inequality', in B. Maharaj, A. Desai, & P. Bond (eds), *Zuma's own goal: losing South Africa's "war on poverty"*, pp.125-149, Trenton, New Jersey: Africa World Press.

Du Toit, A. (2011b), *Nasruddin's Key: Poverty Measurement and the Government of Marginal Populations*, Working Paper 20, Institute for Poverty, Land and Agrarian Studies, University of the Western Cape, Bellville: UWC.

Du Toit, A. (2012), 'The Trouble with Poverty: Reflections on South Africa's Post-Apartheid Anti-Poverty Consensus', Working Paper 22, Institute for Poverty, Land and Agrarian Studies, University of the Western Cape, Bellville: UWC.

Durkheim, E. (1893), *The Division of Labor in Society, English Edition* (1965), G. Simpson, English Translation, New York: Free Press Macmillan.

Durkheim, E. (1957), *Professional Ethics and Civic Morals*, *English Edition*, Great Britain: Burleigh Press.

Erasmus, M. and Fitchen, E. (2010), *Econex Occasional Note*, November 2010.

Esping-Andersen, G. (1990), *The Three Worlds of Welfare Capitalism*, Cambridge: Polity Press.

Fontaine, P. (2002), 'Blood, Politics and Social Science: Richard Titmuss and the Institute of Economic Affairs, 1957-1973', in *Isis*, Vol. 39, Issue 03, pp.401-434, University of Chicago Press.

Gamble, A. (1988), *Free Economy and the Strong State: The Politics of Thatcherism*, Basingstoke: Macmillan.

George, V. and Wilding, P. (1985), *Ideology and Social Welfare*, London: Routledge.

Gerth, H.H. and Mills, C.W. (eds.), (1948), *From Max Weber: Essays in Sociology*, Great Britain: TJ International Ltd.

Giddens, A. (1977), *Studies in Social and Political Theory*, London: Hutchinson.

Gilson, L. and McIntyre, D. (2000), 'Redressing dis-advantage: Promoting vertical equity within South Africa', in *Health Care Analysis*, Vol.8, pp.235-258, Springer.

Gilson, L. and McIntyre, D. (2002), 'Experiences from South Africa: dealing with a poor health legacy of apartheid', in Whitehead M, Evans T, Diderichsen F and Bhuiya A (eds). *Challenging inequities in health: From ethics to action*, New York: Oxford University Press.

Gilson, L., Doherty, J., Lake, S., McIntyre, D., Mwikisa, C. and Thomas, C. (2003), 'The SAZA study: implementing health financing reform in South Africa and Zambia', in *Health Policy and Planning*, Vol.18, Issue 01, pp.31-46, Oxford University Press.

Glazer, N. (1971), 'Blood', in *The Public Interest*, Number 24, Summer 1971, pp.86-94, National Affairs.

Gluckman Commission, (1944), *Report on the Provision of an Organised National Health Service for all Sections of the Union of South Africa*, Union of South Africa, (U.G.30), Pretoria: Government Printer.

Goffman, E. (1963), *Stigma: Notes on the Management of Spoiled Identity*, England: Penguin Books.

Gough, I. (1979), *The Political Economy of the Welfare State*, London: Macmillan.

Gouldner, A.W. (1971), 'Review of *The Gift Relationship'*, in *New York Times Book Review*, 21 Mar 1971, 76:2-3, 20, The New York Times Company.

Government Employees Medical Scheme, (2010), *Annual Report*. http://www.gems.gov.za/default.aspx?mESVdUJkb8l9G04DJ+aoz16soHtrplOu/zGvqGe06yg=

Government Employees Medical Scheme Website: http://www.gems.gov.za/default.aspx?oMeLCYJThx+ydtQfDMXkfQ

Grebenik, E. (1943), 'Review of *Birth, Poverty and Wealth*', in *Journal of the Royal Statistical Society*, Vol. 106, No. 2, pp.171-172. Royal Statistical Society.

Grebenik, E. (1963), 'Review of *Income Distribution and Social Change', Journal of the Royal Statistical Society*, Series A (General), Vol. 126, No. 1, p.142. Royal Statistical Society.

Gruber, J., and Levitt, L. (2000), 'Tax Subsidies for Health Insurance: Costs and Benefits', in *Health Affairs*, 2000, Vol.19, 1 Feb., pp.72-85, Project HOPE.

Hagenbuch, W. (1958), *Social Economics*, Cambridge: Cambridge University Press.

Henman, P., and Marston, G. (2008), 'The Social Division of Welfare Surveillance' in *Journal of Social Policy*, Vol.37, Issue 02, pp.187-205, Cambridge University Press.

Hickey, S. and Du Toit, A. (2007), *Adverse incorporation, social exclusion and chronic poverty*, CPRC Working Paper 81, Chronic Poverty Research Centre.

Himmelfarb, G. (1984), *The Idea of Poverty: England in the Early Industrial Age*, London: Faber and Faber Ltd.

Hood, C. (2000), 'Paradoxes of public-sector managerialism, old public management and public service bargains'. *International Public Management Journal*, Volume 3, pp.1-22. London: Routledge.

Hjortsberg, C. (2001), *Issue Paper on National Health Accounts – Where are we today?* Stockholm: Swedish International Development Cooperation Agency, (Sida): Department for Democracy and Social Development, Health Division.

Hospital Association of South Africa, (2008), *Private Hospital Review*, http://www.hasa.co.za/documents/detail/98/

Human Sciences Research Council, (2003), Media Brief: *HIV/AIDS spending in Southern Africa below requirements for prevention, care and treatment*, www.hsrc.ac.za/Media_Release-181.phtml

Iliffe, J. (1987), *The African Poor: A History*, Cambridge University Press.

Jefferys, K. (1987), 'British Politics and Social Policy during the Second World War', in *The Historical Journal*, Vol.30, Issue 01, March 1987, pp.123-144, Cambridge University Press.

Jewkes, J., and Jewkes, S. (1961), *The Genesis of the British National Health Service*, University of California: Blackwell.

Katz, B. (1989), *The Undeserving Poor: From the War on Poverty to the War on Welfare*, New York: Pantheon Books.

Katz Commission, (1994), *Third Interim Report of the Commission of Enquiry into Certain Aspects of the Tax Structure of South Africa*. Pretoria: Government Printers.

Kelly, D.L., (1957), *Journal of Medical Education*, Part 2, pp.195-196. Shaheed Beheshti University of Medical Sciences & Health Services.

Kuhn, T. (1970), *The Structure of Scientific Revolutions*, University of Chicago Press.

Lagden Commission, (1903), *Report of the South African Native Affairs Commission*, Cape Times Limited, Government Printers, 1905.

Leatt, A. (2006), 'Child Poverty – Its Meaning and Extent', in J. Movson, K. Hall, C. Smith and M. Shung-King (eds), *South Africa Child Gauge 2006*, Rondebosch: Children's Institute, University of Cape Town.

Lees, D.S. (1961), *Health through Choice*, Institute of Economic Affairs Pamphlet, 1961.

Le Grand, J. (1997), 'Knights, knaves or pawns? Human behaviour and social policy', *Journal of Social Policy*, Vol.26, Issue 2, pp. 146-169, Cambridge University Press.

Legassick, M. (1974), 'Legislation, Ideology and Economy in Post-1948 South Africa', *Journal of Southern African Studies*, Vol.1, Issue 01, pp.5-35, London: Routledge.

Legassick, M. (1975), 'South Africa: Forced Labour, Industrialization, and Racial Differentiation', in Harris, R (ed.), *The Political Economy of Africa*, Boston: Schenkman

Lewis, R., & Maude, A. (1949), *The English Middle Classes*, London: Phoenix House.

Lewis, R., & Maude, A. (1952), *Professional People*, London: Phoenix House.

Lewis, J. (1997), 'Gender and welfare regimes: further thoughts', *Social Politics*, Summer, pp.160–177, Oxford University Press.

Lightman, E.S. (1981), 'Continuity in Social Policy Behaviours: The Case of Voluntary Blood Donorship', in *Journal of Social Policy*, Vol.10, Issue 1, January, pp.53-79, Cambridge University Press.

Littlewood, M. (1998), *How To Create a Competitive Market in Pensions: The International Lessons*, Choice in Welfare Series No. 45, London: IEA.

Macleod, I., & Powell, J. (1949). *The Social Services - Needs and Means*, London: Conservative Political Centre.

Mann, K. (2009), 'Remembering and Rethinking the Social Divisions of Welfare: 50 Years On', in *Journal of Social Policy*, Vol.38, Issue 01, January 2009, Cambridge University Press.

Manuel, T. (2012), SABC News Interview, 30 October 2012.

Marshall, T. H. (1973), 'Richard Titmuss: an appreciation', *British Journal of Sociology*, Vol.24, Issue 02, pp.137-139, London: LSE.

Mbeki, T. (2005), *Address of the President of South Africa, Thabo Mbeki, on the occasion of the Heritage Day celebrations*, Taung, North-West Province, 24 September. www.info.gov. za/speeches/2005/0509261 2 1 5 1004.html

McIntyre, D. (1993), *Health Sector Financing and Expenditure in South Africa*, Health Economic Unit Working Paper No.4, Department of Community Health: University of Cape Town.

McIntyre, D. (1997), *Health care financing and expenditure in South Africa: Towards equity and efficiency in policy making*, PhD Dissertation, Cape Town: UCT.

McIntyre, D., Valentine, N. and Cornell, J. (1995), 'Private sector health care expenditure in South Africa', in *South African Medical Journal*, Vol.85, No 3, March, pp.133-135. Cape Town: Health and Medicine Publishing Group.

McIntyre, D., Bloom, G., Doherty, J. And Brijlal, P. (1995), *Health Expenditure and Finance in South Africa*, Health Systems Trust and World Bank.

McLean, I., and Poulton, J. (1986), 'Good Blood, Bad Blood, and the Market: *The Gift Relationship* Revisited, in *Journal of Public Policy*, Vol.6, Issue 04, October 1986, pp.431- 445, Cambridge University Press.

McLeod, H. (2009), *The Future Role of Private Health Insurance*, Innovative Medicines South Africa, IMSA.

McLeod, H. and Ramjee, S. (2007), 'Chapter 4: Medical Schemes', in *South African Health Review 2007*, pp. 47-70, Durban: Health Systems Trust.

Makiwane, M. (2010), "The Child Support Grant and Teenage Childbearing in South Africa", *Development Southern Africa*, Vol.27. Issue 2, pp. 193-204, Development Bank of Southern Africa.

Matsebula, T. and Willie, M. (2007), 'Private Hospitals', in *South African Health Review 2007*, pp. 159-174, Durban: Health Systems Trust.

Meth, C. (2004), Ideology and social policy: 'handouts' and the spectre of 'dependency', in *Transformation*, No.56. UKZN Press.

Meyer, T. and Bridgen, P. (2008), 'Class, gender and chance: the social division of welfare and occupational pensions in the United Kingdom', in *Ageing and Society,* Vol.28, Issue 03, April 2008, pp.353-381, Cambridge University Press.

Minister of Health, (2011), *National Health Insurance in South Africa*, Policy Paper of Pretoria: Government Gazette, No.34523.

Ministerial Task Team (2004) 'Final recommendations concerning the implementation of Social Health Insurance in South Africa,' *Report 1*. Pretoria: Department of Health.

Mishra, R. (2002), 'Review of Reisman (2001) and Alcock et al (2001)', in Journal *of Social Policy*, Vol.31, Issue 04, pp.747-752, Cambridge University Press.

Muller, M. (1997), 'Overview of what is happening in healthcare in South Africa', *Bilateralism Review*, Vol.2, No.4.

Nadesan-Reddy, N. (2010), *A Health Expenditure Review of the South African Private Health Care Sector from 2003 to 2006*. Thesis submitted for the degree Masters in Medicine in the School of Family and Public Health Medicine, UKZN.

National Treasury, (2003), (2006), (2011), (2012), *Budget Review*, Pretoria: National Treasury.

National Treasury and South African Revenue Service, (2008), (2009), (2010), (2011), *'Tax Statistics: A joint Publication between National Treasury and the South African Revenue Service'*.

Nattrass, N., and Seekings, J. (1997), 'Citizenship and Welfare in South Africa: Deracialisation and inequality in a Labour-Surplus Economy', in *Canadian Journal of African Studies,* Vol.31, No.3, pp.452-481. London: Routledge.

Neves, D. Samson, M., van Niekerk, I.,Hlatshwayo, S. and du Toit, A. (2009), *The Use and Effectiveness of Social Grants in South Africa,* Research report to FinMark Trust.

Noble, M.W.J, Wright, G.C., Magasela, W.K. and Ratcliffe, A. (2008), 'Developing a Democratic Definition of Poverty in South Africa', in *Journal of Poverty*, Vol.11, Issue 4, pp.117-141, Routledge

Noble, M.W.J, and Wright, G.C. (2012a), 'Ring of fire – socially perceived necessities in informal urban settlements in South Africa', in *Policy & Politics* forthcoming, The Policy Press.

Noble, M.W.J, and Wright, G.C. (2012b), 'Does Widespread Lack Undermine the Socially Perceived Necessities Approach to Defining Poverty? Evidence from South Africa', in *Journal of Social Policy*, FirstView Article, August 2012, pp. 1-19, Cambridge University Press.

Offe, C. in Keane, J. (ed), (1984), *Contradictions of the Welfare State,* London: Hutchinson

Packard, R. M. (1987), 'Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand, 1902-1932', *Journal of Southern African Studies,* Vol. 13, No.2, pp.187-208. London: Routledge.

Pienaar Commission, (1927), Union of South Africa, *First Report of the Commission on Old Age Pensions and National Insurance.* Cape Town: UG 21 of 1927.

Pierson, C. (1991), *Beyond the Welfare State*? Cambridge: Polity Press.

Pinker, R. (1979), *The Idea of Welfare*, London: Heinemann.

Pinker, R. (2006), 'From Gift Relationships to Quasi-markets: An Odyssey along the Policy Paths of Altruism and Egoism', in *Social Policy and Administration*, Vol.40, No.1, February 2006, pp.10-25, Blackwell Publishing.

Posel, D. (2005). The Case for a Welfare State: Poverty & the Politics of the Urban African Family in the 1930's & 1940's. In A. Jeeves, & S. Dubow, *South Africa's 1940's: Worlds of Possibilities*, pp. 64-83. Juta.

Price, M. (1989), 'Explaining trends in the privatisation of health services in South Africa', in *Health Policy and Planning,* Vol.4, Issue 2, pp.121-130, Oxford University Press.

Price, M. (1994), 'The Impact of Political Transformation in South Africa on Public/Private Mix Policy Debates', *Health Policy and Planning,* Vol.9, Issue 01, pp.50-62, Oxford University Press.

Price, M., Khunoane, B. and Van den Heever, A. (1994), *Should tax concessions on medical aid contributions be removed? A political-economic analysis*, Johannesburg: Centre for Health Policy, University of the Witwatersrand.

Reisman, D. (2001), *Richard Titmuss: Welfare and Society, 2nd Edition*, Palgrave Manmillan

Reisman, D. (2004), 'Richard Titmuss: Welfare as Good Conduct', in *European Journal of Political Economy,* Vol.20, pp.771-794, Elsevier.

Rich, P. (1990), 'Race, Science and the Legitimisation of White Supremacy in South Africa, 1902-1940', *International Journal of African Historical Studies*, Vol.23, pp.665-86, Boston University Press.

Roberts, F. (1952). *The Cost of Health.* London: Turnstile Press.

Rose, H. (1981), 'Rereading Titmuss: The Sexual Division of Welfare', in *Journal of Social Policy,* Vol.10, Issue 04, October 1981, pp.477-501, Cambridge University Press.

Rosenberg, C. (1962), *The Cholera Years*, University of Chicago Press.

Rosenkrantz, B. (1972), *Public Health and the State, Changing Views in Massachusetts, 1842-1939,* Cambridge: Harvard University Press.

Ruiters, G. (2006), 'New faces of privatisation', in P. Bond, H. Chitonge, & A. Hopfmann (eds.), *The Accumulation of Capital in Southern Africa: Rosa Luxemburg's Contemporary Relevance*, Proceedings of the Rosa Luxemburg Seminar 2006 and the University of KwaZulu-Natal Centre for Civil Society's Colloquium on Economy, Society and Nature, pp. 119-126.

Ruiters, G. (2011), 'Introduction', in G. Ruiters (ed.), *Challenging Commercialised Health Care in Southern Africa: Towards an equity perspective on National Health,* Institute of Social and Economic Research, Rhodes University.

Sagner, A. (2000), Ageing and Social Policy in South Africa: Historical Perspectives with Particular Reference to the Eastern Cape, in *Journal of Southern African Studies,* Volume 26, Number 3, pp.523-553, London: Routledge.

Samson, M., Lee, U., Ndlebe, A., MacQuene, K., Van Niekerk, I., Gandhi, V., Harigaya, T. and Abrahams, C. (2004), *The Social and Economic Impact of South Africa's Social Security System, C*ommissioned by the Economics and Finance Directorate, Ministry of Social Development, South Africa.

Samuelson, P.A. (1971) 'Blood', in *Newsweek,* 13 Sept. 1971, pp. 160–161.

Schlesinger, A. (1966), 'Tawney and Titmuss on the Struggle for Equality', in *Social Work*, Vol.11, January 1966, Oxford University Press.

Sinfield, A. (1978), 'Analyses in the Social Division of Welfare', in *Journal of Social Policy,* Vol.7, Issue 02, April 1978, pp.129-156, Cambridge University Press.

Singer, P. (1981), 'Altruism and Commerce: A Defense of Titmuss against Arrow', in M. Cohen, T. Nagel, & T. Scanlon, *Medicine and Moral Philosophy*, pp. 159-167, New Jersey: Princeton University Press.

Smit Commission, (1942), Union of South Africa, *Report of the Interdepartmental Committee on Social, Health and Economic Conditions of Urban Natives*, GP S 7272, Pretoria: Government Printers.

South African Social Security Agency, (2009), *Annual Report*, Pretoria: SASSA.

Starr, P. (1982), *The Social Transformation of American Medicine,* New Haven: Basic Books.

Statistics South Africa, (1995), (1996), (1997), (1998), (1999), *October Household Survey*, Pretoria: Statistics South Africa.

Statistics South Africa, (1998b), *Mid-year Population Estimates 1991-1998*. Pretoria: Statistics South Africa.

Statistics South Africa, (2002), (2003), (2004), (2005), (2006), (2007), (2009), (2010),

(2012), *General Household Survey*, Pretoria: Statistics South Africa.

Steele, M. (2006).*Report on Incentive Structures of Social Assistance Grants in South Africa.* Kesho Consulting and Business Solutions (Pty) Ltd., Geospace International. Pretoria: Department of Social Development, South Africa.

Stevens, M., Sinanovic, E., Regensberg, L. and Hislop, M. (2007), 'HIV and AIDS, STI and TB in the Private Sector' in *South African Health Review 2007*, Durban: Health Systems Trust.

Stewart, M. (2012), 'Tax Expenditures: Lessons from History and Country Experience', in *Africa Tax Spotlight*, First Quarter, Volume 3. Tax Justice Network.

Sunday Express, December 30, 1984, 'Now Rembrandt sets up a chain of private clinics'.

Sunday Times, Business Times, June 29, 1986, 'Rembrandt values clinics at R170m'.

Surrey, S.S. (1970), 'Federal Income Tax Reform: The varied approaches necessary to replace tax expenditures with direct governmental assistance'. *Harvard Law Review*, Vol.84, No.2, Dec 1970. Harvard Law Review Publishing Association.

Surrey, S.S. and McDaniel, P.R. (1985), *Tax Expenditures*, Cambridge: Harvard University Press.

Swanson, M. (1977), ''The Sanitation Syndrome': Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909', *Journal of African History*, Vol.18, Issue 03, pp.387-410, Cambridge University Press.

Swift, Z.L. (2006), World Bank Policy Research Working Paper 3927, Vanguard, May 2006.

Tawney, R. H. (1913), *Memoranda on Problems of Poverty.* University of London, Ratan Tata Foundation.

Tawney, R.H. (1914), *The Establishment of Minimum Rates in the Chain-Making Industry under the Trade Boards Act of 1909*. G. Bell and Sons, London.

Tawney, R.H. (1931), *Equality*, London: George Allen & Unwin Ltd.

Teppo, A.B. (2004), 'The Making of a Good White: A Historical Ethnography of the Rehabilitation of Poor Whites in a Suburb of Cape Town', Research Series in Anthropology, University of Helsinki, Helsinki University Press.

Local Government and Health Consortium, (2004), *Decentralising Health Services in South Africa: constraints and opportunities - a crosscutting report*, Durban: Health Systems Trust.

Thomas, S., Muirhead, D., Doherty, J., McIntyre, D., Muheki, C. and Dawkinum, D. (2000), *National Health Accounts Project: The Public Sector Report*, Pretoria: Department of Health.

Titmuss, R.M. (1938), *Poverty and Population: A Factual Study of Contemporary Social Waste,* London: Macmillan.

Titmuss, R.M. (1943), *Birth, Poverty and Wealth: a study of infant mortality*, London: Hamish Hamilton Medical Books.

Titmuss, R.M. (1950), *Problems of Social Policy*, London: Longmans, Green and Co Ltd.

Titmuss, R.M. (1958), *Essays on 'The Welfare State'*, London: George Allen and Unwin.

Titmuss, R.M. (1961), *Social Policies and Population Growth in Mauritius,* London: Frank Cass and Co. Ltd.

Titmuss, R.M. (1962), *Income Distribution and Social Change,* London: George Allen and Unwin Ltd.

Titmuss, R.M. (1963), 'Ethics and Economics of Medical Care', in *Medical Care* Vol.1, No.1, pp.16-22, Lippincott Williams & Wilkins

Titmuss, R.M. (1964a), *The Health Services of Tanganyika*, A Report to the Government. London: Pitman Medical.

Titmuss, R.M. (1964b), 'The Limits of the Welfare State', *New Left Review*, Issue 27, Sept/Oct 1964, London: Verso.

Titmuss, R.M. (1966), 'Titmuss to Albertine Winner', 14 April 1966, Series 2, File 260. *Titmuss Papers*.

Titmuss, R.M. (1968), *Commitment to Welfare,* London: George Allen & Unwin Ltd.

Titmuss, R.M. (1970), *The Gift Relationship: From Human Blood to Social Policy*, London: George Allen & Unwin.

Titmuss, R.M. (1987), *The Philosophy of Welfare,* London: George Allen & Unwin Ltd.

Titmuss, R.M. and Abel-Smith, B. (1956), *The Cost of the National Health Service in England and Wales.* Cambridge: Cambridge University Press.

Titmuss, R.M. and Clark, F. Le Gros, (1939), *Our Food Problem,* Penguin Books Ltd.

Titmuss, R.M., and Titmuss, K. (1942), *Parents Revolt,* London: Secker and Warburg.

Townsend, P. (1979), *Poverty in the United Kingdom: A survey of household resources and standards of living*, Harmondsworth: Penguin.

Trapido, A., Mqoqi, NP., Williams, BG. (1998), 'Prevalence of Occupational Lung Disease

in a Random Sample of Former Mineworkers, Libode District, Eastern Cape Province, South Africa', *American Journal of Industrial Medicine*, Vol.34, pp.305-313.

Turner, A., Drake, J. and Hills, J. (The Turner Commission) (2005), *A New Pension Settlement for the Twenty-First Century. The Second Report of the Pensions Commission*, London: The Stationery Office.

UNISA, (2010), *Personal Income Estimates for South Africa*, The Bureau of Market Research (BMR) at the University of South Africa, www.unisa.ac.za/contents/faculties/ems/docs/Press396.pdf

Vale, P., & Jacklin, H. (2009). *Re-imagining the Social in South Africa: Critique, Theory and Post-apartheid Society.* University of Kwazulu-Natal Press.

Van den Heever, A.M. (1998), 'Private Sector Health Reform in South Africa', *Health Economics*, Vol.7, pp.281-289, Elsevier.

Van den Heever, A.M, (2007), *Pension Reform and Old Age Grants in South Africa*, University of Pretoria.

Van Niekerk, R. (2007). Social Policy and Citizenship in South Africa: The development of inclusive, de-racialised social policies in the periods 1939-1961 and 1989-1998. *Unpublished Thesis*.

Wadee, H., Gilson, L., Thiede, M., Okorafor, O., McIntyre, D. (2003) 'Health Care Inequity in South Africa and the Public/Private Mix', Draft paper prepared for the RUIG/UNRISD project on Globalisation, Inequality and Health, September 2003.

Walshe, A.P. (1963), 'The Changing Content of Apartheid', *Review of Politics*, pp.343-61, Cambridge University Press.

Welshman, J. (2004), 'The Unknown Titmuss', in *Journal of Social Policy*, Vol.33, Issue 2, pp. 225-247. Cambridge University Press.

Welshman, J. (2007). *Underclass: A History of the Excluded, 1880-2000.* London: Continuum International Publishing.

Wolpe, H. (1972), 'Capitalism and cheap labour-power in South Africa: from segregation to apartheid', in *Economy & Society*, Vol.1, Issue 04, pp.425–456, London: LSE Academic Publishing.

World Health Organisation, (2013), *National Health Account Indicators*, Geneva, WHO, http://apps.who.int/nha/database/StandardReportList.aspx

World Health Organisation, (2006), World Health Report 2006: Working together for health, *Geneva: WHO.*

World Health Organisation, (2008) *World Health Report 2008: Primary health care – now*

more than ever, Geneva: WHO.

World Health Organisation, 2012, Global Health Expenditure Database. http://apps.who.int/nha/database/StandardReportList.aspx

Williams, C., Campbell, N., Mqoqi, N., Kleinschmidt, I. (1998), 'Occupational health, Occupational Illness: Tuberculosis, Silicosis and HIV on the South African Mines' in Daniel E. Banks and John E. Parker (eds.), *Occupation Lung Disease: An International Perspective*, pp.95-103. London: Chapman & Hall Medical.

Wilensky, H.L. And Lebeaux, C.N. (1958), *Industrial Society and Social Welfare*, New York: The Free Press.

Williams, F., Popay, J. and Oakley, A. (1999), 'Changing paradigms of welfare', in F. Williams, J. Popay and A. Oakley (eds.), *Welfare Research: A Critical Review*, pp. 2-16, London: UCL Press Limited.

Wolfman, B. (1985), 'Tax Expenditures: From Idea to Ideology', in *The Harvard Law Review*, Vol.99, No.2, Dec.1985, pp.491-498, Harvard Law Review Publishing Association.

Woolard, I., Harttgen, K. And Klasen, S. (2010), *The Evolution and Impact of Social Security in South Africa*, Paper prepared for the Conference on "Promoting Resilience through Social Protection in Sub-Saharan Africa", organised by the European Report of Development in Dakar, Senegal, 28-30 June, 2010.

Wootton, B. (1959), Review of *Essays on 'The Welfare State'*, *The British Journal of Sociology*, Vol. 10, No. 2, Jun. 1959, pp.156-158, London: LSE Academic Publishing.

Wright, D. (1971), *The Psychology of Moral Behaviour*, Harmondsworth: Penguin.

Wright, G., Noble, M. and Magasela, W. (2010) 'Towards a democratic definition of poverty: socially perceived necessities in South Africa', in B. Roberts, M. wa Kivilu, and Y.D. Davids (eds.), *South African Social Attitudes 2nd Report: Reflections on the Age of Hope*, Cape Town: Human Sciences Research Council Press, pp.143-166.