SUBMISSION
Made to the Portfolio Committee on Social Development

ON THE REPORT OF THE TAYLOR COMMITTEE OF INQUIRY INTO A COMPREHENSIVE SOCIAL SECURITY SYSTEM FOR SOUTH AFRICA

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INTRODUCTION

The Terms of Reference of the Taylor Committee of Inquiry into a Comprehensive System of Social Security for South Africa (hereafter refer to as the Committee) have a threefold context: the inequities that stem from the apartheid period, secondly the commitment of the government to the goals of poverty elimination, provision of a reasonable income in old age, affordable healthcare and full employment, and thirdly the inadequate and fragmented nature of the delivery of social security benefits to people. The Committee's task was to undertake a review of a broad number of elements relating to social security in order to make recommendations on alternative long-term options as well as practical steps consistent therewith that address immediate needs. The specific areas addressed in the investigation are: the national pensions system, social assistance grants, social assurance schemes, unemployment insurance and health funding and insurance. In doing its work the Committee was required to

examine existing policy processes taking place in respect of specific funds and safety nets, study the core issues of each policy area (eleven core issues are identified), recommend both long and short term future directions and spell out implementation steps and pre-requisites in the form of concrete recommendations.

We welcome the opportunity to make this submission. At the outset we express appreciation for the work of the Committee. Clearly the issues that required attention and exercised the Committee's mind cover a wide area and reach to the heart of the challenges facing the country. Tackling poverty and unemployment in ways that will eventually make a fundamental difference in the individual lives of millions of poor people and improve the overall social and economic fabric of society are difficult in themselves and more so for a developing country. Offering solutions through a comprehensive social protection system requires that the concomitant recommendations be aligned to budget constraints both on the revenue and expenditure sides. Capacity and institutional weaknesses in existing structures have to be carefully assessed and weighed against the value of erecting new institutional frameworks.

Idasa commends and supports the Committee's efforts and main recommendations in principle.
Our comment is offered to support and enhance the recommendations of the Committee, in order that their proposals adequately address institutional capacity issues, are affordable and are practical.

Comprehensive Package of Social Protection Measures
Idasa supports the concept of a comprehensive social protection, as proposed by the Taylor Committee. Such a package should include:
The extension of the Child Support Grant to 18 years, with removal of the means-test,
Improved accessibility to the Disability Grant and the Care Dependency Grant, and to extend eligibility to HIV-positive and symptomatic adults and children,
Some form of income support measure to those currently falling outside of the net,
Access to national health insurance,
Extended, improved and fair social insurance options for persons affected by HIV/Aids.
Free public health services for persons with disabilities and chronic illnesses, including HIV/Aids,
Free ARVs for persons infected with HIV/Aids,
Free, or subsidized, basic services including water, sanitation, refuse

removal and electricity, and housing for low income groups,
Nutritional supplements for persons with disabilities and chronic illnesses, including HIV/Aids,
Emergency relief, either cash or food parcels/ vouchers / supplements.

Social security interventions must occur in conjunction with other development and poverty-alleviating mechanisms, including public works programmes, community development programmes, employment creation as well as infra-structural and service-delivery expansion.

This submission comments specifically on the Committee's recommendations in respect of

Budget allocations to Social Assistance Benefits
The Child Support Grant,
Provisioning for persons affected by HIV/Aids
The Basic Income Grant, and
Administrative issues - the Social Security Agency.

SECTION 1: Budget Allocations to Social Assistance Benefits

Idasa welcomes the increasing allocations to the Social Development Vote.

The 2002 Medium Term Budget Policy Statement targets expenditure increases to social grants. These increases are evident in the growth of the social development proportions 22.99% in 2003/04 to 25.93% over the medium term 2003/04-2005/06.

Social development as a % of total provincial budgets 2002/03-2005/06				
Provinces	**2002/03**	**2003/04**	**2004/05**	**2005/06**
Eastern Cape	27.79	27.69	27.77	29.57
Free State	20.93	22.09	23.26	24.69
Gauteng	16.41	16.86	18.84	21.04
Kwa-Zulu Natal	25.02	24.14	25.95	27.67
Limpopo	22.98	23.30	25.18	26.91
Mpumalanga	20.17	21.59	22.71	23.71
North West	22.20	23.84	25.15	26.54
Northern Cape	25.44	23.52	23.85	24.09
Western Cape	22.74	23.55	24.89	25.31
Total	22.63	22.99	24.36	25.93

Sources: Provincial Budgets 2003.

The graph below indicates the steady increase in nominal allocations to grants between 2001 and 2002.
Source: Guthrie T. 2003. Using SOCPEN data.

Idasa commends and supports the government's commitment to supporting those persons facing social contingencies, through social assistance benefits.

Social Development expenditure by province

The Table below illustrates total Social Development expenditure. The total provincial Social Development budget and expenditure increase by 35.38% and 36.68% in 2001/02-2002/03 respectively. The total Social Development budget was overspent by 7.67% in 2002/03, whereas it was under-spent by 3.27% in 2001/02.

Provincial Social Development spending

Total Social Development Spending	**Real % growth 2001/02-2002/03**		**% of budget spent**		**Contribution to consolidated under-spending**	
	Budget	**Spending**	**2001/02**	**2002/03**	**2001/02**	**2002/03**
	%	*%*	*%*	*%*	*%*	*%*
Eastern Cape	30.97	37.90	95.4	100.5	5.94	-1.60
Free State	43.72	41.94	97.7	96.4	0.95	4.11
Gauteng	32.54	31.30	103.2	102.2	-2.49	-4.53
KwaZulu Natal	38.35	38.92	102.7	103.1	-3.58	-11.30
Limpopo	47.33	44.80	99.1	97.4	0.74	6.11
Mpumalanga	32.70	32.93	97.1	97.3	1.21	3.00
Northern Cape	22.02	30.38	102.5	109.5	-0.46	-4.20
North West	27.54	31.19	99.5	102.3	0.29	-3.21
Western Cape	33.78	32.03	99.0	97.7	0.66	3.95
Total	**35.38**	**36.68**	**99.5**	**100.4**	**3.27**	**-7.67**

Source: Statement of the National and Provincial Governments' Expenditures at 31 March 2002 and 2003, National Treasury; Own calculations

The graph below shows the increases in nominal allocations to each grant.

Source: Guthrie T. 2003. Using SOCPEN data.

On average, the nominal allocations to all the grants has increased by 62% from 2001 to 2003 (according to SOCPEN data). The most drastic increases have occurred for the Child Support Grant (of nearly 250%). The DG also experienced a significant increase in allocation of 82%, and the OAP only 33%, which may be due to the increased amount of the grant, versus increased number of beneficiaries.

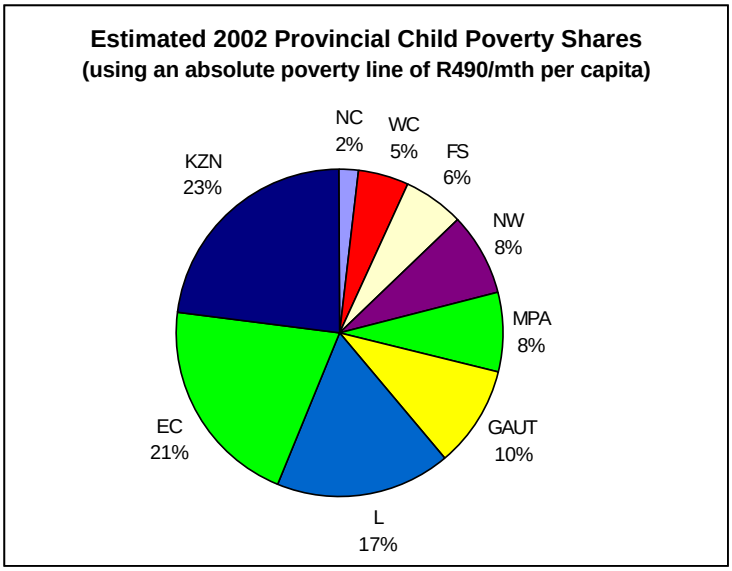
The graph below indicates the increases in allocations to each grant. It can be seen that the Old Age Pension (OAP) and the Disability Grant (DG) still command the greatest amounts. Children, although forming 44% of our population continue to receive the smallest share of the total expenditure on grants. However, this proportion increased from 11% in 2002 to 21% in 2003 (for the 3 child grants).

The graph below compares the proportion of the total social security expenditure for of each grant, where it can be clearly seen that CSG proportion has been steadily increasing while the OAP's proportion has been decreasing. (Source for graphs: Guthrie T. 2003. Using SOCPEN data)

Key points:
The proportion going to the 3 child grants increased from 11% in 2001 to 21% in 2003.
The CSG share of the grant expenditure has doubled from 8% to 16% between 2001 and 2003. The FCG share has increased from 2% to 3% since 2001.The CDG share has also doubled from 1% to 2%
The OAP share has decreased from 66% in 2001 to 53% in 2003.
The DG share has increased slightly from 23% to 26%.
Overall, the allocations to the grants have increased significantly between 2001 and 2003, by 62% on average.
The CSG experienced the largest increase of 250% over the two-year period; the CDG the next largest increase of 117%, which would indicate improved access to children with disabilities.

SECTION 2: The Child Support Grant

Child Poverty in South Africa
Recent child poverty data based on the OHS 1999 survey emphasizes the urgency for improved service delivery of the Child Support Grant. Figure 1 below shows the child poverty shares per province.



Source: October Household Survey (1999), analysis conducted by Woolard reported in Streak 2002.

"It is estimated that in 2002 about 11 million children under 18 years in South Africa are living on less than R200 per month and hence are desperately in need of income support" **(Streak 2002).**

Support for increasing the age of eligibility for the Child Support Grant (CSG) to 18 years
The Committee recommends an immediate change in the eligibility criteria for the child support grant (CSG) to ensure that it is given to all children under 18 years.

Idasa support's this recommendation in light of government's constitutional obligation to deliver the child's right to social assistance, as stated in Section 27 (1)(c):
Everyone has the right to have access to social security, including if they are unable to support themselves and their dependants, appropriate social assistance.
And as set out in s27 (2) and 29:
The state must take reasonable legislative and other measures, within its

available resources, to achieve the progressive realisation of each of these rights.
The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender…age…disability…

Idasa welcomes the recent increase in the age of eligibility for the CSG to 14years, and calls for this to be further extended to 18years.

Despite the change in the age cohort eligibility for the CSG, the gap in provision still remains. In other words, only children under 9 years will benefit from this grant during the current financial year, whereas, children aged 13 years will only have access to the CSG as from financial year 2005/2006. This means that approximately 3 million poor children between the ages 14 to 18 years do not have access to the CSG (ACESS, 2003).

In addition, the income measure in the means test has been unchanged since the inception of the CSG. Hence, the value of income has been eroded by inflation over the last five years. Taking this factor into consideration, it means that the income threshold for gaining access to the grant has been shifting downwards. This means that care givers and their children have had access to less and less real income to be eligible for the CSG.

Concerns to be addressed for the CSG Extension to Children under 18years.

When investigating the delivery of the CSG to children under 7 years the following facts become evident:

Administrative and Capacity Hurdles at Provincial Level
The main obstacles to improving the take up rate of the CSG (for children under 7 years) are:
Physical access to paypoints i.e. poor infrastructure,
Eligible children and primary care givers without any form of identification,
The administrative hurdles created by the means-test, and,
Limited administrative capacity.
Most provinces do not budget for the marketing of the social security grants and hence need to utilise monies from the general communications strategy allocation
There are discrepancies in the manner in which provinces budget for social security grants. Some provinces use growth rates based on historical

growth, while others use sophisticated methodologies.

Idasa recommends increased identification registration: use of existing structures such as schools (for example, during school enrolment, examination times), clinics and faith-based organisations to improve the current take up rate for children under seven years. Efforts to improve administration and physical infrastructure are required, particularly on the part of the Department of Home Affairs.

Adequate resources to personnel and infrastructure must be committed to enable the smooth roll-out of the CSG.

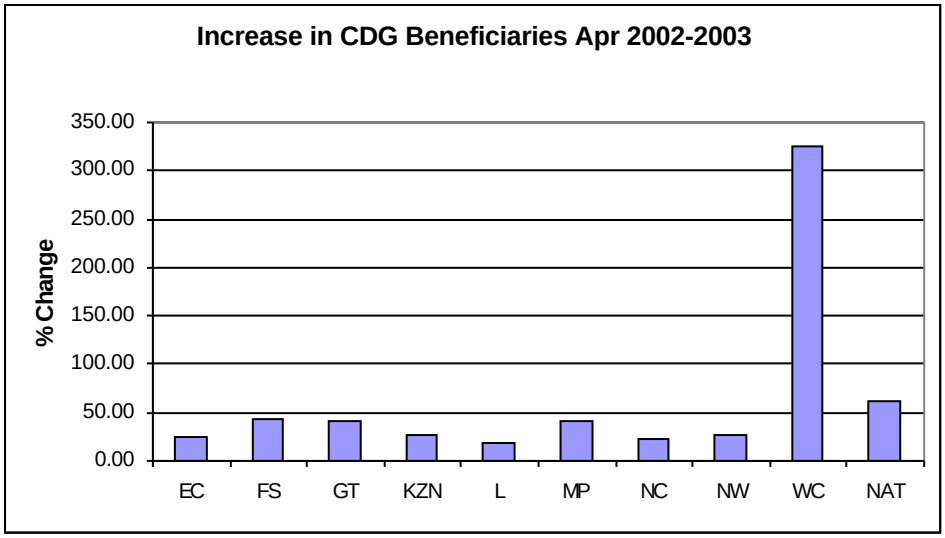
Increasing Uptake Rates

Government has, since 1998, managed to expand access to child social assistance quite rapidly via the three child social assistance programmes, viz. the foster care grant (FCG), the care dependency grant (CDG) and the child support grant (CSG).

The graph below shows the percentage increases in each child grant for the period April 2002 to April 2003, the most significant occurring for the CSG.
Source: Guthrie T. 2003. Using SOCPEN data (30 April 2002&2003).

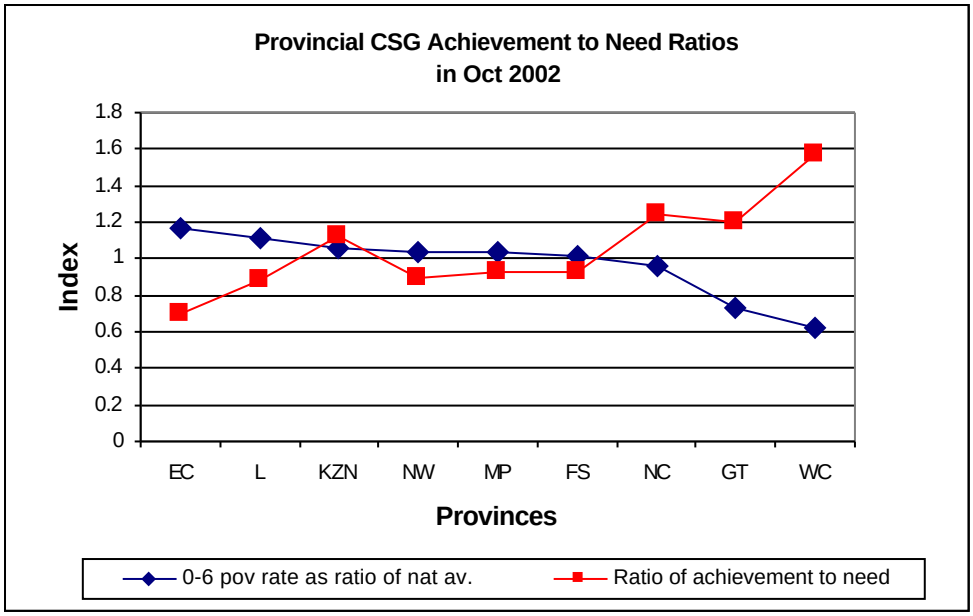
Idasa highly commends the National Department of Social Development for its extensive efforts in the previous year to improve the accessibility to the grants.

The graph below shows the provincial increases in the number of children benefiting from the CSG.



Source: Guthrie T. 2003. Using SOCPEN data (30 April 2002&2003).

Of concern is the "over performance" by wealthier provinces with the smaller child poverty shares. The graph below compares the provincial CSG achievement ratio against the provincial child poverty share ratio (as at Oct 2002). It clearly indicates that the provinces with the greatest need, ie.Eastern Cape, Limpopo and North West, have the lowest uptake rates. While Gauteng and Western Cape, provinces with the lowest child poverty shares, have the highest uptake rates.



Source: Guthrie T. 2002. Children's Institute. **(Using** Streak 2002 poverty analysis of OHS 1999 data and R400/mth poverty line, and Provincial CSG beneficiaries from SOCPEN daily record Oct 2002).

This inequity in access must be addressed for the effective roll-out of the extension of the CSG.

c) Costing and Financing the Extension of the CSG - Prioritisation

The table below presents data for provincial allocations for the expansion of the CSG. The number of child beneficiaries are calculated as at May 26 2003. All provinces have budgeted more than 100% for expanding access of the grant to children aged 7-8 years.

Provinces	Cost of paying current beneficiaries R160/month	Admin costs	Admin cost plus paying beneficiaries R160/month	Amount budgeted for the CSG 2003/04	Amount left for expanding access
Eastern Cape	76916480	3845824	80762304	138289000	57526696
Free State	26126560	1306328	27432888	332617000	305184112
Gauteng	57055840	2852792	59908632	915237000	855328368

KwaZulu Natal	117262560	5863128	123125688	761596000	638470312
Mpumalanga	36527520	1826376	38353896	1386143000	1347789104
Northern Cape	8130400	406520	8536920	433920000	425383080
Limpopo	73101120	3655056	76756176	591149803	514393627
North West	36120960	1806048	37927008	90289000	52361992
Western Cape	33978080	1698904	35676984	556745000	521068016
Total	465219520	23260976	488480496	5205985803	4717505307

Source: Number of beneficiaries, Jeremia Tebeila from the National Department of Social Development. Budget Allocations for 2003/04 supplied by provincial social security departments to Idasa in May 2003 except for the case of Kwa-Zulu Natal where national provincial estimates were used.

Idasa believes that government should have taken a less cautious approach to extending the CSG. It should have made all children age 7-14 eligible for the grant in 2003 and allocated funds (including to build capacity for roll-out) accordingly. The 2003 budget provided an extra R1,1 billion for increasing the threshold to 9 years. The budget also provided for R3,4 billion in 2004/05 to extend the threshold to 11 years and R6,4 billion to extend the threshold to 14 years in 2005/06. This means that an additional R9,8 billion would have been required to extend the CSG immediately to all children up to 14 years. In the 2003 budget tax cuts to the amount of R15 billion were given, with R13,4 billion in the form of personal income tax reductions. Instead of giving tax cuts of that magnitude, government could have financed the extension of the CSG, while still giving some tax relief to low income groups.

Idasa has previously argued that National Treasury could have kept the debt to GDP ratio the same or increased the budget deficit slightly and use the funds for social expenditure. In the 2003/04 budget, National Treasury chose to increase the budget deficit from the figures estimated in 2002 MTBPS from -2,2% to -2,4% in 2003/04 and -2,1% to -2,4% in 2004/05. While we commend this move that is in line with our previous submissions, we feel that National Treasury could have gone ever further in prioritising social spending over deficit reduction. For example Treasury could consider increasing the deficit to cover the additional costs of extending the CSG further to under 18 year-olds. This would cost approximately R5.7 billion at the current R160 per month.

SECTION 3: Social Security for Persons Affected by HIV/Aids

The Taylor Committee's Response to Disability

The Taylor Committee, in its Sub-Committee report on Disability, provides a valuable oversight of the scope and impact of disability in South Africa. It considers the international treaties, as well as the legislative and constitutional imperatives, with regard to provisioning for people with disabilities.

The Sub-Committee concludes:
"Not only is the impact of disability widespread but it is likely to increase for the foreseeable future, this trend has been noted at the international level, where violence and aging populations are driving forces. In sub-Saharan African the situation is considerably worse, due in large part to the project impact of HIV/Aids on the health and well-being of the region. Therefore, not only must we recognise the scope of disability as it affects society, but so too must we recognise the urgent need to put in place measures to address the growing threat of disabling disease"
(Sub-Committee Report. P.359).

The Committee identifies several limitations with regard to social security for people with disabilities, and makes several important recommendations for the extension and improvement of benefits.

Idasa supports the recommendations made by the Committee, particularly the following important 'conceptual shifts':
Social security should be seen not only as poverty alleviating but as measures to promote self-sufficiency and independence, ultimately aiming at societal solidarity, and the full development, equality and participation of persons with disabilities.
A broad definition of disability should be used, with each different scheme adapting this to the purpose and scope of the particular scheme.
Beneficiaries should not be defined according to the disability, but rather the system should measure and respond to their level of need.
Eligibility to the DG should not be based on 'incapacity to work', but rather determined by a needs-based assessment, which would replace the current means-testing.
The extension of the CDG to children with moderate disabilities and to those in special schools or day-care centres, and the removal of 'permanent home care' clause for eligibility for the CDG.
Persons with chronic illnesses, including HIV/AIDS, should also qualify for the disability benefits.

The Taylor Committee's Response to HIV/Aids

Apart from briefly mentioning HIV/Aids in the disability and BIG sections, the Report fails to acknowledge the impact of HIV/Aids, nor deals comprehensively with the need for social security coverage for persons infected and affected by HIV/Aids.

While there is some mention of extending the current Disability Grant to people with chronic illnesses (p404,407 Sub-Committee Report), this is not repeated nor emphasized in the chapter's final recommendations.

Idasa wishes to draw attention to this oversight and provide some additional considerations below.

Extent of the Impact

The HIV/AIDS epidemic is unique in that it hits hardest at the middle sector of the population: adults aged 15-49. According to projections based on the Antenatal Clinic 2000 Survey, 2.5 million women in this age group are infected, and 2.2 million men. The recent HSRC household survey estimates 12.8% of men and 17.7% of women aged 15-49 are HIV positive. Overall prevalence for youths 15-24 years is estimated to be 9.3%; and for adults over 25 years, it is 15.5%. In addition, the HSRC study also reports that 13% of children aged 2-14 years had lost a mother, father or both.

From a social security perspective, the people currently falling through the social security net (ie unemployed persons between 15 and 60 years) are the same population group hardest hit by this epidemic. HIV/AIDS will exacerbate the existing holes in the social security system.

The following section addresses each social assistance grant and asks what part it can play in responding to the needs of households affected by HIV/AIDS.

Limitations with the Current Social Security Provisioning for People infected and affected by HIV/Aids

Idasa's basic message is that the current social security system is not designed to alleviate the impact of HIV/AIDS on families. Thus it may be said that the benefits for persons infected and affected by HIV/Aids are few, fragmented, difficult to access and unfair, limited usually only to those financially able to afford full private medical insurances. Public health services and benefits offer very little. The majority of persons who have developed Aids have no form of income and rely on family members to support and care for them.

Unless they are altered to do so, the current grants (which were not designed to carry this burden) will be stretched and only operate as inefficient and ineffective support to families infected and affected by HIV/AIDS.

We highlight the difficulties inherent in the existing social assistance benefits, namely the Disability Grant, the Care Dependency Grant and the Foster Care Grant, and make recommendations for improved coverage for people infected and affected by HIV/Aids.

The Disability Grant (DG) for Adults with Disabilities
The purpose of the Disability Grant for adults with disabilities is income maintenance for persons who cannot provide for themselves due to the disability. To qualify for a disability grant the applicant has to be over the age of 18 years and have a physical or mental disability of longer than six months duration which renders him or her unfit to provide sufficiently for his or her maintenance.

There is no policy or legislative directive regarding HIV/Aids eligibility, nor for other chronic illnesses, and provinces appear to make use of differing criteria, with some allowing more HIV positive persons to receive the grant. However, there is a tendency to use a very low CD4 count (ALP & TAC 2003). This is problematic firstly because many persons with HIV/Aids may not have CD4 count tests easily available. Secondly, at such a low CD4 count, the person is very ill and in many cases the grant is not processed before the person dies, defeating the purpose of the grant.

Additionally, the person may be fortunate to receive the grant, enabling him/her to access better nutrition, or even to buy ARVs, thus improving dramatically in his/her health. Subsequently he/she looses the benefit, because he or she is no longer 'sufficiently disabled'. This process leads to 'perverse incentives' whereby the person has to choose to remain ill in order to continue receiving the money on which he/she and the family so desperately survives. Similar patterns have been found with TB patients who stop taking their medication, which would cure the illness, in order to maintain the grant.

When considering a costs-benefit analysis, it is important also to bear in mind the saving that would be made by the government in providing free ARVs. Not only would hospital costs be reduced, general economic contributions through the labour force by improved, but importantly, less people would be reaching 'disabling stages' of the illness, and thus fewer relying upon the DG.

Idasa therefore calls for:
Free ARVs as the first priority to all persons infected with HIV/Aids
Extension of the DG to symptomatic HIV positive persons and persons with Aids, at stage 3 or 4 - based on clinical diagnosis, as opposed to CD4 count (as according to ALP & TAC 2003)
Free public health services,
Nutritional supplements and food parcels, and
Further cost benefit analyses of the various options.

The Care Dependency Grant (CDG) for Children with Disabilities
In South Africa the social assistance provisioning for children with disabilities incorporates a cash grant, the Care Dependency Grant (CDG), and free health care to children under six years of age. The CDG targets those children, from 1 to 18 years, with severe physical or intellectual disabilities, requiring and receiving permanent home care. The purpose of the grant was to enable parents to care for their children at home, and thus the tool was intended to capture the child's "need-for-care" by ascertaining the severity of the disability and whether he/she required permanent home care, as an indicator of the child's level of need.

The CDG is limited in its scope and purpose, and suffers from unclear eligibility criteria. The Social Assistance Act (1992) does not define 'severe disability' nor 'permanent home care', leading to subjective interpretation by officers. In addition, by targeting only children with *severe* disabilities in *permanent* home care, it excludes children who may have moderate disabilities but due to their socio-economic situation and under-serviced/ resourced geographical location, these become severe handicaps and their needs are therefore great.

In particular, it also excludes children with chronic illnesses, including HIV/Aids, yet these children have great needs due to the nature of their illness, where frequent hospital visits may be necessary and schooling is constantly disrupted. In these cases, the chronic nature of the medical condition results in a long-term economic burden on the family.

Collaborative discussions with the disability sector have highlighted the call for children who are HIV positive to be allowed immediate access to the CDG, due to the rapid progression of the illness in children. The grant would greatly enhance their nutritional status, and quality and length of life.

Idasa therefore calls for:

Free ARVs as the first priority to all persons infected with HIV/Aids,
The extension of the CDG to all HIV positive children, immediately upon clinical diagnosis (as according to ALP & TAC 2003)
Free public health services,
Nutritional supplements and food parcels.

The Foster Care Grant for Children without Parental Care
The nature and purpose of the FCG is for temporary placements where children are removed from their parents' care, for a variety of reasons. It requires a lengthy court procedure and review every two years. Social workers are currently over-whelmed with time-consuming applications being made by extended family members of children whose parents have dies from HIV/Aids, and who are also suffering the consequences of poverty.

Thus the FCG, which was intended to be a special needs grant, has become a poverty-alleviating grant, similar to the purpose of the CSG. However, the FCG is an inappropriate, costly and ineffectual (reaching only a few of those in need) means of supporting children who have lost their carers through HIV/Aids, or who are being cared for extended family members.

Therefore Idasa suggests that:
All children, thus including those orphaned and made vulnerable by HIV/Aids, would be better reached by the extension of the CSG to *all under 18year-olds* (as according to the Children's Institute, UCT),
However, the CSG amount (being so much lower than the FCG) is insufficient to meet the basic needs of the child, and therefore the CSG amount must be increased,
A universal income support mechanism would greatly enhance the coping strategies of families affected by HIV/Aids,
The FCG should be maintained for its original specialized purpose, for children removed from their parental care,
Subsidized adoptions should be introduced to encourage families to adopt children orphaned by HIV/Aids (as recommended by the SALC in the draft Children's Bill 2003).

The Discrepancies in Amounts of the 3 Child Grants
The difference in amounts of the 3 child grants is problematic, unjust and causes perverse incentives. For example, mothers are being forced to give up their children for fostering by extended family members, so that the family may benefit from the FCG, rather than the much smaller CSG.

The amount of the grant should be determined by its purpose. Thus the CDG is a special needs grant i.e. it is intended to help carers meet the extra needs of their child with a disability. The CSG is an income support measure intended to provide for the basic needs of a child. The FCG was intended to help foster parents provide for the basic needs of the fostered child. Thus the CSG and FCG have similar purposes, and even more so in the context of poverty, they have both become *de facto* poverty grants.

There is therefore no justification for the huge variation in their amounts (R160 vs R470).

Idasa therefore strongly suggests that:
The amounts of the CSG and the FCG be equalized, by increasing significantly the amount of the CSG to adequately cover the basic needs of a child, and
An adoption grant of the same amount be introduced.
An income support measure that would enable every person to have a minimum level of income would further enhance the lives of persons and families affected by HIV/Aids.

Issues Regarding the Provision of Antiretroviral Treatment

Policy incongruity regarding the disability grants in the context of antiretroviral treatment
Currently national policy supports a disability grant being available for people with HIV and WHO clinical stage IV disease (AIDS). In a context where life-extending treatment is not available, it is coherent that the state would provide financial support to those people with AIDS at the time when they are likely to incur the most financial stress as a result of their illness, and also be unable to work due to their disability. Up until now the practice of clinicians has been to expedite the applications for this grant, and to classify the disability as permanent.

Antiretroviral treatment is available in neighbouring countries for less than R500 per month, and the cheapest antiretroviral treatment in the private sector in South Africa is available at a cost not dissimilar to the value of the disability grant. Currently this is being utilised as a mechanism to finance treatment by some patients. At the same time the state is on the brink of announcing a national antiretroviral treatment programme that would see at least 100,000 people on treatment within five years, and probably many more than this. For these patients receiving medicines free of charge, many will have already received disability grants. There are

no guidelines on when a patient no longer qualifies for a grant having responded to antiretroviral treatment, and pilot antiretroviral programmes are already struggling to make sense of what an appropriate response in this context is.

The incongruity is highlighted by the following examples:
patients who have no functional impairment and no employment but are on antiretroviral treatment receive a grant, whilst their neighbours who are also unemployed, but not on treatment receive nothing
patients are funding their own antiretroviral treatment through the disability grant mechanism
patients who have once received a grant after an AIDS diagnosis who then receive antiretroviral treatment could potentially be left to choose between life-saving medicines and a grant if the grant for AIDS were to be non-permanent
the estimates of the cost of antiretroviral treatment could be severely underestimated if in addition to the treatment costs, the state is also funding disability grants for those who already had an AIDS diagnosis at the time of starting treatment (estimated to be 50% of patients initiating treatment)

These examples highlight the policy vacuum in the light of antiretroviral treatment, and illustrate the need for alignment with the national response to HIV/AIDS in the context of life-extending treatment. Policies should support the provision of antiretroviral treatment by channelling resources to funding treatment, whilst providing a universal income support mechanism that both supports adherence to treatment and guards against forcing patients into making difficult choices.

Financing ARV treatment
The funds designated in this budget compare reasonably to some of recent costing studies which have been conducted on financing a government programme to provide anti-retroviral drugs in the public sector. This suggests that financing anti-retrovirals is certainly within the bounds of feasibility. In January 2003 the Aids and Society Research Unit at the University of Cape Town published a study which estimates that a national treatment and prevention plan would cost R1.6 billion in 2003; R5.6 billion in 2005; and rising to R17.1 billion and R20.3 billion in 2010 and 2015 respectively. We can compare their direct cost estimate for the first year to: R1.1 billion sent to the provinces for HIV/AIDS treatment options (via the equitable share), or to the total R1.952 billion we estimate government is already setting aside for HIV/AIDS in this year's budget. Such cursory analysis shows that the ASRU estimate of the direct cost of a national

ARV programme in its first year is **less** than the total amount allocated for HIV/AIDS in this year's national budget.

Based on the modeling exercise by Johnson and Dorrington (2002) of the demographic impact of four AIDS related health interventions, the AIDS and Society Research Unit (ASRU) at the University of Cape Town (January 2003) estimated the total cost of providing antiretroviral treatment to those who need it. The authors of the paper, Nathan Geffen, Nicoli Nattrass, and Chris Raubenheimer, concluded that HAART is expensive, but the net costs to government are significantly lower than the direct costs of providing HAART. This is because people on HAART experience fewer opportunistic infections - thereby saving the government the costs of treatment and hospitalisation. Furthermore, with such a programme in place, the number of new AIDS-related orphans will be reduced, also decreasing costs relating to child-support and orphan care/ foster care grants.

In the event that the Department of Health develops and finalises an anti-retroviral policy in the next 6 months, there are options for mobilising the necessary funds in this financial year. One option would be to appropriate conditional grant funds for this purpose in the Adjustment Estimate tabled in October 2003. Either a new conditional grant-administered by the Department of Health-could be introduced, or funds could be added to the current HIV/AIDS conditional grant for the purposes of providing funds to the provinces for setting up anti-retroviral programmes.

The national budget regularly contains a contingency reserve, which is essentially an amount sliced off the top of the budget and set aside each year for adjustments which are unavoidable or unforeseen at the time of the Budget. In Budget 2003/4 this amount is R3 billion. Launch of an anti-retroviral treatment programme can arguably qualify as unavoidable expenditure or as an "expenditure item not yet included in departmental allocations,"thus justifying utilisation of funds from the contingency reserve.

When the health and treasury task team produces its report on the financial requirements of an ARV programme in the state sector, it will need to not simply address aggregate cost. The task team must also figure out where the funds will be sourced in the budget and what funding mechanisms will be used to transfer funds to the provinces (whom will most likely be responsible for actual implementation).

Absorption capacity. Given that Budget 2003/4 significantly steps up the amount of funds going to the provinces for HIV/AIDS, there are now two critical questions facing us.

1. Extra money for HIV/AIDS was put into the Equitable Share in Budget 2003/4. Will provinces use the additional funds in their equitable share grant to increase their provincial health budgets and boost funding to HIV/AIDS interventions? Or will those funds be diverted to other priorities as identified by individual provinces?

2. Will provinces be able to spend the added funds? Absorption is a real problem-provincial departments are already struggling with capacity in terms of lack of financial management and programme management skills, insufficient staff, or unfilled posts. This issue is not unique to HIV/AIDS but symptomatic of other social sector programmes.

In essence, analysis of Budget 2003/4 suggests that-from a public finance perspective-the main challenge for government's response to HIV/AIDS in the foreseeable future is not going to be lack of financial resources, but the capacity to spend.

SECTION 4: The Basic Income Grant (BIG)

Support in principle for BIG

There are socio-economic advantages to be gained from the introduction of a basic income grant. Moreover there can be little to gainsay the view of the Committee that a universal basic income grant has the potential to fortify the ability of the poor to manage risk thus contributing to socio-economic multiplier effects related to improved household self-reliance, efficiency of social capital and social cohesiveness. The basic income grant will reduce the poverty gap by three-quarters, compared to the present one quarter without the grant, and its positive benefits will be felt at various levels.

The Committee states however that the conditions for the immediate implementation of BIG do not exist, while maintaining the status quo - on the argument of inflexible fiscal constraints - is unacceptable. It is of the view that appropriate capacity and institutional arrangements to ensure effective implementation would first need to be put in place before a comprehensive and integrated medium to long term framework for income support in the form of a BIG. It would take several years to plan, resource and implement the new institutional arrangements and measures. Therefore, rather than advocate the option for immediate implementation of

a comprehensive social protection system, the Committee opts for a two-phased approach towards a comprehensive social protection system, premised on certain immediate steps that the government needs to take.

Idasa commends the committee for recommending income support in the form of a basic income grant to reduce destitution and poverty. This income support is meant to cover gaps in the current social security system and also supports the rights to appropriate social assistance as entrenched in the constitution. The committee's report sees BIG as an extension of the current social security system and does not provide rigorous examination of the relative costs and benefits nor a detailed analysis of how BIG may be administered. We would also have liked the committee to give more detail on the administration of the basic income grant in the light of the introduction of the national social security agency and its potential role in the delivery and administration of the grant. The call for a basic income grant would be supported by rigorous cost-benefit analyses of other poverty-alleviating mechanisms and their impacts.

SECTION 5: Administrative Issues

Social Security Agency
According to the Committee's report, institutions responsible for the delivery of social security suffer from chronic under-performance, the cause of which in the Committee's view is due to poor decentralisation policies. The report calls for an integrated institutional and organizational framework for the provision of social security, and the creation of a national social security board and agency.

The purpose of a social security agency would be to manage social assistance. The agency would also be responsible for determining budget allocations and administering grants.

The move towards a new social security agency is supported by:
the Financial and Fiscal Commission in its 2002 Division of Revenue submission.
Cabinet's approval in principle
Draft social security agency bill to be tabled in Parliament shortly
Allocation of specific funding in the 2003/2004 budget.

Thus in light of the advanced stage of planning for the Agency, Idasa would raise the following concerns and questions for consideration:
The Committee has not made clear what the role of the provinces will be under a nationalized social security regime and how existing provincial

structures for delivery are to be mobilized.

The danger of introducing a new social security model is that it may lead to duplicate functions, especially because its location and accountability mechanisms are not clear. A new agency will have size and expenditure implications. In other words, it will increase the size, in terms of number of people employed and will require more resources to administer.

The introduction of the agency assumes that an audit of current social security institutional arrangements has been undertaken. From the recommendations of the Committee it seems that no such audit was taken because the report calls for a 'review and revision of the organisational framework of institutions governing social security and should focus on clarifying roles and responsibilities'. The establishment of an Agency should have been preceded by an audit of current arrangements, to assess the feasibility or need for a new agency.

Does the Committee's recommendation that under the new social security arrangements 'policy development and determination will remain with the DSD' in effect say anything new in terms of how policy formulation currently happens? Do lead ministries not exercise this prerogative in any case in areas of specific concern and within mechanisms and conventions for inter-ministerial cooperation, consultation and joint effort where this is necessary?

Will a social security agency operate in a different and better way than what presently obtains within existing structures? What guarantees are there that such structures will offer a better service? In what will this added value in service provision consist?

If the work of the agency is to 'operationalize various social security functions outside of the civil service' - what does this mean and what are the exact practical implications of this recommendations? How does giving a national agency within the ambit of the DSD's policy independent legal status with powers to plan, coordinate, budget and execute actually benefit poor beneficiaries in administrative and other new ways?

The agency will be tasked with the function of 'managing the non-contributory social assistance fund', 'determining the budget, and administering the grant.' How long does the Committee envisage it will take to put the requisite mechanisms and systems into place?

Does the creation of a new agency in actual fact boil down to shifting the

same set of problems to yet another platform with meager if any remedial effect?

What will the size be of the infrastructure required for the agency to attend more effectively and efficiently in managing, budgeting and administering the comprehensive social security system? Will social insurance oversight responsibility and acting as an interface for intermediary services not compound the potential for generating the types of problems raised in relation to the provision of social assistance?

Will the DSD and the other lead ministries as well as national treasury eventually not be excessively burdened by the duty to work with as well as exercise performance controls over a huge agency administration with cross-cutting networks and operations at national, provincial and local levels?

Does the Report provide a comprehensive understanding and evaluation of the short, medium and long term operational cost/benefits to be derived from the option of a national board and agency?

The performance and delivery gains of the Agency should be measurable. These should be based on:
client considerations: increased uptake, user-friendliness, ease of access;
operational considerations: distinct savings and cost effectiveness in the administration and provision of services, adequate capacity and effective management systems controls and monitoring mechanisms;
output/outcome considerations: a distinct and observable qualitative improvement and advancement over present systems and operations, customer satisfaction, long-term improvement potential.

CONCLUSION

In conclusion, we commend the Taylor Committee of Inquiry into a Comprehensive Social Security System for South Africa for their thorough and detailed examination of the key problems facing our country, for their accurate evaluation of the existing social security system, and for their important and far-reaching recommendations. These show a commitment to social solidarity, to the reduction of inequity and disparities, to the enhancement of opportunities for all, and overall to the development of South Africa.

Idasa believes in the principle of income support mechanisms for persons in need of support, and therefore we support the Committee's call to extend the current social security coverage. The current system is indeed

fragmented and limited, and in particular, falls far short of providing even minimal support for persons affected and made vulnerable by HIV/Aids, and unemployed adults. There is need for further examination of the most effective means for addressing the current gaps in the social security system.

We also support the Committee's call for a comprehensive package of social protection that would not only include cash transfers, but a whole range of other services and benefits. Importantly, free ARVs should form part of this package. Also required are ongoing development initiatives, poverty-alleviating strategies and employment creation.

We thank the Portfolio Committee for the opportunity to make this submission, and for your commitment to the process. Idasa would wish to contribute further research in order to promote informed debate around the key issues in the development of a comprehensive social security system for South Africa.

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