ECONSTOR
Make Your Publications Visible.

A Service of
ZBW
Leibniz-Informationszentrum Wirtschaft
Leibniz Information Centre for Economics

Ulriksen, Marianne S.; Plagerson, Sophie

Working Paper

Political and institutional drivers of social security policy in South Africa

UNRISD Working Paper, No. 2017-12

Provided in Cooperation with:
United Nations Research Institute for Social Development (UNRISD), Geneva

Suggested Citation: Ulriksen, Marianne S.; Plagerson, Sophie (2017) : Political and institutional drivers of social security policy in South Africa, UNRISD Working Paper, No. 2017-12, United Nations Research Institute for Social Development (UNRISD), Geneva

This Version is available at:
https://hdl.handle.net/10419/186091

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.

If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.

WWW.ECONSTOR.EU

Mitglied der Leibniz-Gemeinschaft

United Nations Research Institute for Social Development

CENTRE FOR SOCIAL DEVELOPMENT IN AFRICA
A RESEARCH CENTRE PURSUING KNOWLEDGE, APPLICATION AND INNOVATION

UNIVERSITY OF JOHANNESBURG

Working Paper 2017-12

Political and Institutional Drivers of Social Security Policy in South Africa

Marianne S. Ulriksen and Sophie Plagerson

prepared for the UNRISD project
New Directions in Social Policy:
Alternatives from and for the Global South

December 2017

UNRISD Working Papers are posted online
to stimulate discussion and critical comment.

The United Nations Research Institute for Social Development (UNRISD) is an autonomous research institute within the UN system that undertakes multidisciplinary research and policy analysis on the social dimensions of contemporary development issues. Through our work we aim to ensure that social equity, inclusion and justice are central to development thinking, policy and practice.

UNRISD, Palais des Nations
1211 Geneva 10, Switzerland

Tel: +41 (0)22 9173020
Fax: +41 (0)22 9170650
info@unrisd.org
www.unrisd.org

The Centre for Social Development in Africa (CSDA) at the University of Johannesburg was established in 2004 and is dedicated to basic, applied and strategic research in social development and developmental welfare. The CSDA aims to positively influence development issues in the Southern African region by contributing to debates on social policy, improvements in service delivery and the expansion of knowledge through cutting-edge research.

CSDA, University of Johannesburg
PO Box 524, Auckland Park 2006, South Africa

Tel: +27 11 559-1904
csdainfo@uj.ac.za
www.uj.ac.za/faculties/humanities/csda

Copyright © United Nations Research Institute for Social Development

This is not a formal UNRISD publication. The responsibility for opinions expressed in signed studies rests solely with their author(s), and availability on the UNRISD website (www.unrisd.org) does not constitute an endorsement by UNRISD of the opinions expressed in them. No publication or distribution of these papers is permitted without the prior authorization of the author(s), except for personal use.

Introduction to Working Papers for New Directions in Social Policy: Alternatives from and for the Global South

This paper is part of a series of outputs from the research project New Directions in Social Policy: Alternatives from and for the Global South.

The project examines the emergence, nature and effectiveness of recent developments in social policy in emerging economies and developing countries. The purpose is to understand whether these are fundamentally new approaches to social policy or welfare systems which could offer alternative solutions to the critical development challenges facing low- and middle-income countries in the 21st century. This research aims to shed light on the policy options and choices of emerging/developing countries; how economic, social, political and institutional arrangements can be designed to achieve better social outcomes given the challenges of the contemporary development context; how the values and norms of human rights, equity, sustainability and social justice can be operationalized through "new" social policies; and how experiences, knowledge and learning about innovative approaches can be shared among countries in the South. For further information on the project visit www.unrisd.org/ndsp.

This project is funded by the Swedish International Development Cooperation Agency (Sida).

Working Papers for New Directions in Social Policy: Alternatives from and for the Global South

Moving towards Redistributive and Transformative Social Security? Gendered Social and Economic Outcomes in South Africa
Sophie Plagerson, Tessa Hochfeld and Lauren Stuart, December 2017

The Controversial Brazilian Welfare Regime
Lena Lavinas, Denise Gentil and Barbara Cobo, November 2017

The Rise of Homegrown Ideas and Grassroots Voices: New Directions in Social Policy in Rwanda
Chika Ezeanya-Esiobu, May 2017

The Development of Indonesian Social Policy in the Context of Overseas Development Aid
Brook Wilmsen, Alexandra Kaasch and Mulyadi Sumarto, March 2017

Universalizing Elementary Education in India: Achievements and Challenges
John Harriss, February 2017

Contents

List of Tables iii
Acronyms iv
Abstract ..... **Error! Bookmark not defined.**
1. Introduction 1
2. Theoretical Framework and Methods 1
2.1 Interests: Policy preferences and power resources 2
2.2 Institutions: Vested interests and path dependence 3
2.3 Ideas as policy justification 3
2.4 Methods and structure of analysis 4
3. Social Security in South Africa: Overview and Case Selection 5
4. Social Cash Transfers 7
4.1 The Child Support Grant 8
4.2 Incremental changes to social grants 11
4.3 The Basic Income Grant 12
4.4 The social cash transfer paradigm 13
5. National Health Insurance 14
5.1 Major proposals for health reform (up to 2007): Repeatedly proposed but not implemented 15
5.2 The development of multiple institutional structures 17
5.3 The NHI: Current drivers and hindrances to progress, 2007-2017 20
The African National Congress Party conference in 2007 as a turning point 20
State departments, party politics and electoral appeal 21
Allies and critics: Trade unions, opposition parties and private sector stakeholders 22
5.4 The NHI: Holding institutions and interests in tension 24
6. Conclusion: Comparing Political and Institutional Drivers in Social Assistance and Social Insurance 25
7. References 28

List of Tables

Table 1. Public Health Expenditure (as percent of GDP) and Health Outcomes in Selected Countries 15
Table 2. Comparison of Private and Public Health Indicators 18
Table 3. Comparing Political and Institutional Drivers of the Two Case Studies 26

Acronyms

ANC	African National Congress
BIG	Basic Income Grant
BRICS	Brazil, Russia, India, China and South Africa
COSATU	Congress of South African Trade Unions
CSG	Child Support Grant
ECD	Early childhood development
GEMS	Government Employees Medical Scheme
NEHAWU	National Education Health and Allied Workers Union
NHI	National Health Insurance
SASSA	South African Social Security Agency
SMG	State Maintenance Grant
UIF	Unemployment Insurance Fund
UNRISD	United Nations Research Institute for Social Development
ZAR	South African Rand

Abstract

This paper provides an analysis of political and institutional drivers that shape social policy in South Africa with a specific focus on social security. As elsewhere in the Global South, South Africa has a quite extensive social assistance framework, whereas social insurance is limited and inadequate. This is contrary to the experiences of the Global North, where social insurance has been the primary social security mechanism with social assistance playing a more marginal role. In order to explore the contrasting developments within social security policy, we focus our analysis on two case studies with varying policy outcomes: 1) the social cash transfer system, which is well established; and 2) the National Health Insurance (NHI) scheme, a recent policy, which has suffered several delays.

Building on the power resource and historical institutionalism approaches, we explore how different actors seek to assert their policy preferences, and how current institutional arrangements shape actors' interests and their ability to influence policy reforms. The two cases reveal interesting differences that can explain the success of social cash transfer expansion and the sluggish progress (to date) to introduce national health insurance. While the latter has strong vested interests against reform, even though there is consensus on the need for a national health insurance scheme, the former has had no strong opponents and subsequent incremental expansions have benefited from well-established institutional arrangements, positive research evidence and civil society advocacy and litigation. Moreover, the introduction of a health insurance scheme is relatively more complex (politically, institutionally and technically), compared to expanding an already existing social cash transfer programme. In our analysis, we also explore the different ideational narratives related to the two types of policies. Social cash transfers have legitimacy as a policy addressing the needs of the most vulnerable, which are defined to be the elderly, young and people living with disabilities, but not able-bodied adults. In the case of health insurance, ideological narratives are pitted against each other: the concept of health as a common good against health as a commodity, and market-oriented strategies for delivery against state-centric approaches.

1. Introduction

This paper contributes to the South African case study in the UNRISD research project New Directions in Social Policy: Alternatives from and for the Global South, through an analysis of political and institutional drivers that shape social policy with a specific focus on social security. As elsewhere in the Global South, South Africa has a quite extensive social assistance framework, whereas social insurance is limited and inadequate. This is contrary to the experiences of the Global North, where social insurance has been the primary social security mechanism with social assistance playing a more marginal role. In order to explore the contrasting developments within social security policy, we focus our analysis on two case studies with varying policy outcomes: 1) the social cash transfer system, which is well established; and 2) the National Health Insurance (NHI) scheme, a recent policy, which has suffered several delays.

Building on the power resource and historical institutionalism approaches, we explore how different actors seek to assert their policy preferences, and how current institutional arrangements shape actors' interests and their ability to influence policy reforms. The two cases reveal interesting differences that can explain the success of social cash transfer expansion and the sluggish progress (to date) to introduce national health insurance. While the latter has strong vested interests against reform, even though there is consensus on the need for a national health insurance scheme, the former has had no strong opponents and subsequent incremental expansions have benefited from well-established institutional arrangements, positive research evidence and civil society advocacy and litigation. Moreover, the introduction of a health insurance scheme is relatively more complex (politically, institutionally and technically), compared to expanding an already existing social cash transfer programme. In our analysis, we also explore the different ideational narratives related to the two types of policies. Social cash transfers have legitimacy as a policy addressing the needs of the most vulnerable, which are defined to be the elderly, young and people living with disabilities, but not able-bodied adults. In the case of health insurance, ideological narratives are pitted against each other: the concept of health as a common good against health as a commodity, and market-oriented strategies for delivery against state-centric approaches.

The paper is structured as follows: in the next section, we outline the theoretical framework and our approach to the analysis. In Section 3, we provide an overview of the social security system in South Africa. Sections 4 and 5 include the analyses of the social cash transfer system and the health insurance scheme respectively. Section 6 concludes by way of comparing the two cases.

2. Theoretical Framework and Methods

In this paper, we are interested in exploring the causes underlying the diverging experiences of social security reforms in South Africa. In the social policy literature, scholars often refer to the five I's in order to explain social policy development across countries. These are industrialization, international influence, interests, institutions and ideas (Gough and Therborn 2010). Industrialization is a structural explanation; it refers to the changes in economic production that cause the population to move from (subsistence) farming to wage labour and how consequently an increased pressure for public social security measures is created. Countries in the Global South have not experienced the path of industrialization that led to the early welfare policy initiatives in the Global North. Hence, although economic structural conditions certainly shape social

policy demands (Haggard and Kaufman 2008), industrialization as an explanatory factor has limited relevance for our purposes.

In contrast to industrialization, international influence on social policy has been a strong determining factor in specifying the social policy paths taken in many countries in the South, where international organizations have played prominent roles in defining policy priorities and designs (Deacon et al. 1997; O'Brien 2002). South Africa is an exception in this regard, as the international influence has been much more limited. During apartheid, South Africa was isolated internationally and even with the transformation to democracy in 1994, the international community has had a relatively limited influence on policymaking. Of course, South Africa's international standing and economic credibility affect policymakers, but international agencies assert little direct influence—donor funding only accounts for a very small part of South Africa's national budget and policymaking continues to be a predominantly domestic affair.[1]

Thus, in this paper we focus on interests, institutions and ideas. We understand these three explanatory factors to be endogenous and to be interrelated in the way they shape a specific social policy path. In order to structure our analysis of social security policy development in South Africa, we outline a theoretical framework in the following, which specifically draws from—and builds on—the power resource approach and historical institutionalism, both established theories within the social policy literature.

2.1 Interests: Policy preferences and power resources

In the classical power resource approach, the emphasis was on the specific interests and bargaining power of labour unions vis-à-vis the capitalist business sector and their respective political parties (Korpi 1983). The argument is that actors' policy preferences are shaped by their socioeconomic interests. Low-income groups and the organizations representing them (trade unions, civil society organizations) tend to prefer redistributive social policies, whereas the wealthy and the business sector prefer social policy frameworks that are the least costly to them. The position of the government in turn depends on which social and economic actors are their primary constituencies.

Although the power resource approach has its roots in the Northern welfare regime literature, a power resource analysis is also applicable in the Global South and relevant actors can as well include other domestic stakeholders such as the rural population and civil society (Haggard and Kaufman 2008; Ulriksen 2012). Thus, to understand the role of interests in defining social policy development, we need as a first step to explore the policy preferences of a variety of state actors (such as different governmental ministries and departments) and non-state actors in the political, social and economic spheres (Mkandawire 2004).

In Section 2.2, we explain how policy preferences are not only shaped by socioeconomic interests but also by current institutional arrangements. Nevertheless, policy preference is one thing to bring to policy negotiations, another is bargaining power. The power resource approach emphasizes how social policy outcomes will tend to reflect the policy preferences of those actors in a stronger bargaining position (Esping-Andersen 1996; Korpi and Palme 2003). Hence, for instance, the ability of trade unions to push for social policies favourable to them depends on their ability to mobilize and gather wide support

[1] For instance, with respect to the development of the Child Support Grant programme as discussed in Section 4.1, the international community partly supported the involvement of international experts. This kind of influence is indirect as international experts merely provide inputs to the policy recommendations developed by the domestically based committee, and the actually policy discussions sits with the cabinet (Lund 2008). Furthermore, the social grants are fully funded by domestic tax revenue (RSA 2017a).

(Korpi 1983). One aspect of a strong bargaining position therefore relates to the ability to mobilize. However, although there may be preferences for or against policy reform, mobilization may not always occur due to the collective action problem: if potential beneficiaries or contributors constitute a vast and diverse group and the potential benefits/costs are either small or diffuse, mobilization is not so likely. Mobilization is much more likely if the costs/benefits are higher and target a smaller group within which actors can easily identify each other as carrying similar interests (Olson 2003; Garay 2007).

Combining the collective action perspective with a view of the (economic, social and political) resources that different actors have can help to further distinguish between the power resources of different actors. Resourceful, mobilized and therefore often powerful actors in politics often include the private sector and trade unions (although their power resources vis-à-vis each other and the government can vary significantly), whereas labour market outsiders (informal workers, the unemployed, sick, old and vulnerable) have few resources, are poorly organized and, therefore, have limited influence on policy (Ulriksen 2016). The latter groups may have some support from civil society organizations, who may be able to direct some pressure on government. Also within the governing political system, it is useful to distinguish between the different resources and bargaining power of various institutions. For instance, it can also be assumed that the Ministry of Finance—in its central position as carrier of the purse—tends to hold a specifically strong position vis-à-vis other ministries. In our analyses, we explore to what extent the various stakeholders are able to assert their policy preferences for policy (non-)reform.

2.2 Institutions: Vested interests and path dependence

Historical institutionalism emphasizes how interests are not only formed by socioeconomic positions but also by the already established institutional arrangements where actors "adjust their strategies to accommodate [a] prevailing pattern" (Thelen 1999: 385).

Current institutional arrangements (including both specific institutions as well as policy frameworks) in themselves create vested interests that in turn affect policy preferences. For instance, an implementing institution/agency may not initially have a specific policy preference, but once it has the main responsibility of implementing a certain policy—and its status relies on this—the institution will have an interest in maintaining and possibly increasing the importance of that policy. Similarly, beneficiaries of a policy—be it low-income groups receiving a cash transfer or high-income groups benefiting from tax subsidies—will gain a vested interest in that policy as they would not want to lose the benefit. They may not initially have asked for the benefit, but once the policy is in place it is difficult to reverse. This situation has important implications for the likelihood of introducing policy reforms. Although a new or reformed policy may likely be to the advantage of some groups, the potential beneficiaries may not be aware of policy discussions and so may not mobilize. Conversely, actors with vested interests in a policy will oppose efforts at major reforms that threaten such interests (Pierson 1994; Moe 2015). Thus, while institutional change is possible, institutions tend to create positive feedbacks, which reinforce the recurrence of a particular policy pattern, also referred to as path dependency (Pierson 2000).

2.3 Ideas as policy justification

Policymaking is a messy affair (Lund 2008), which includes a range of actors who each in their own way and to different ability will attempt to affect policy change—or more often, policy stability (Pierson 1994) —that suits their interests and preferences. Political

parties in government may represent specific organized interests, but typically, ruling governing parties tend to encompass a broad range of interests. This means that the overall policy framework is less likely to be coherent and ideationally consistent and social policies will instead contain a range of specific—maybe even contradictory—characteristics reflecting the nature of negotiation, bargaining and incremental influence that different groups assert into the policy process, both at the time of policy reform and during the subsequent implementation phase.

Yet ideas matter. Ideas can be regarded as an external factor that travel across countries through diffusion, but we treat here ideas as an endogenous factor as we want to explore how the government uses different ideas to justify policy reform or non-reform. Specifically, we focus on the way that the government justifies specific social security policy decisions with reference to a variety of principles, such as for instance, economic principles of affordability and/or moral principles of helping the neediest (Plagerson and Ulriksen 2016). We do not necessarily expect the government to be consistent in its ideological formulations—both because policymaking, as explained, is a complicated process entailing compromise and adjustments, but also because the normative foundation of specific social policies may be seen to differ. For instance, social assistance is often viewed to provide some basic income to the most vulnerable and thereby referring to an idea of need, whereas social insurance by its nature carries an idea of equity where reward equals contribution (Devereux 2016). Thus, in our analysis, we explore how ideas are used to define the government's conceptualization of the purposes of social security. We see such justification of social security policy choices to contribute to our main quest of the UNRISD project, which is to define South Africa's overall social policy paradigm.

2.4 Methods and structure of analysis

In exploring the political and institutional drivers of social security in South Africa, we focus on the two contrasting cases of social cash transfers and national health insurance, as introduced and explained in the next section. In analysing these two cases, we utilize both primary and secondary data, such as government policy documents, historical narratives of policy development, interviews with key stakeholders and academic research and accounts. In the following, we explain how we structure the case analyses.
Keeping in mind the theoretical framework, we explore how different political, economic and social actors in South Africa in different ways and at different times have sought to assert their preferences with respect to social security policies. We pay attention to the policy decision phase, which may lead to both policy reforms and non-reforms, and we explore the implementation phase, which may cause incremental policy adjustments. This is important, as it is likely that actors have differing ability to influence policy at these different phases. In exploring different points of the policy process, we are conscious of how current institutional arrangements shape actors' interests and ability to influence policy. As will become clear, certain actors have much stronger influence in defining policy choices up front, but still, other actors can change policy on the margins, which also, in the end, can define the overall social policy path. Finally, we extract the ideas put forward in justifying government policy and in the concluding section, where we compare the two cases, we seek to illuminate the social justice paradigm of South Africa's social security framework—as it has developed in practice and as it is defined by its main stakeholders.

3. Social Security in South Africa: Overview and Case Selection

According to the ILO-led *Recommendations concerning National Floors of Social Protection Adoption*, the route to building a comprehensive social security system has both horizontal and vertical dimensions. The aim of the horizontal dimension is to guarantee access to essential health care and minimum income security for all, whereas the vertical dimension is designed to progressively ensure higher levels of income protection through the provision and regulation of social security benefits and voluntary insurance schemes (ILO 2012). Thus, the ideal social security system would ensure access to health care and income security for all through adequate provisions of social assistance (in cash or kind) and social insurance (covering incidences of income loss in events such as unemployment, old age and sickness).

Like many other countries in the Global South, South Africa has a social security system that provides relatively wide coverage of social assistance (called social grants in South Africa), on the one side, and which has a narrow coverage of social insurance, on the other. In fact, one could say that South Africa is an extreme case as this dualistic system is characterized by an extensive and quite generous system of social cash transfers (albeit still with limits as explained below) and a particularly minimal system of social insurance compared to other middle-income countries like Brazil and Argentina (Seekings 2008).

The African National Congress (ANC)-led government of 1994 inherited a fairly well developed welfare state for a middle-income country (Seekings 2015). Social assistance already included an old age social pension, disability grant, care dependency grant, foster care grant and a state maintenance grant. During the apartheid era, grant payments had been differentiated according to race so that Whites received higher payments than Indians and Coloured, and black Africans received the lowest amount. These differences were gradually equalized during the last two decades of the apartheid regime and parity in payments were in place by 1993. At this point, there were about 2.5 million grant recipients in South Africa and the tax-funded, non-contributory social grants system cost the government about 2 percent of GDP (van der Berg 1997; Devereux 2007).

It has been noted that when the ANC came to power in 1994, it not only took over an already well-established social cash transfer system, it also had much less financial leeway to address deep-set inequalities than what it anticipated (Van der Berg 2014). Nevertheless, the expenditure and coverage of social grants have increased tremendously in the past two decades. There are now about 17 million grant recipients (about one third of the population) and expenditures to the administration and payment of social grants cost 3.2 percent of GDP (RSA 2017a). The social grants already in place in 1993 have continued to exist. The only exception is that the State Maintenance Grant (SMG) was replaced by the Child Support Grant (CSG) in 1997. In the case study of social cash transfers in Section 4, we explore in more detail the political and institutional drivers related to this reform process.

In terms of both coverage and spending, South Africa has one of the most extensive social assistance systems in Africa. As of April 2017, older persons and people living with disabilities receive ZAR 1650 (USD 120) per month in social grants from the state. The CSG is at ZAR 380 (USD 28) much less generous but in terms of coverage, it is the largest single cash transfer programme on the continent (WB 2015, RSA 2017a). However, the social grants system is also being criticized for being mere “tokens” that are oriented to fit a neoliberal economic approach rather than to meet the needs of the society (Bond

2014). Critics argue that the system is a "spray-gun approach" that still "misses many people who are in dire straits" (Marais 2011: 243).

Thus, although the social assistance system significantly mitigates poverty among the older persons, people with disability and children, there are no provisions for able-bodied adults of working age (Seekings 2008). In the early 2000s, following the recommendations of the Taylor Committee (DSD 2002), the option of introducing a Basic Income Grant (BIG) to all adult citizens was part of policy negotiations. However, the BIG did not gain foothold in government and as of yet, there are still no social grants that directly target the able-bodied working age population. This policy non-reform will also be analysed in Section 4.

Many South Africans of working age (and their dependents) are also not covered by any social insurance schemes. The country does not have any publicly financed contributory retirement system or national health insurance; instead, South Africans rely on contributory and voluntary retirement funds and medical schemes. There is an Unemployment Insurance Fund (UIF), which is financed by labour and business, but the UIF has a limited reach. The existing insurance schemes are generally linked to formal employment, which excludes many South Africans given high levels of unemployment and an increase in informal and contract-based employment[2].

The social insurance system is highly unequal and regressive in that it benefits only a small section of the population, and primarily those with already high incomes. Thus, the Unemployment Insurance Fund is limited to formal sector employees and domestic workers, and it is estimated that only about 5 percent of the unemployed population benefit from the UIF. Pensions and provident funds are also limited to private sector and government employees. Just over 2 million pensioners are estimated to benefit from these funds and the yearly pay out of benefits are projected to equivalent about 5 percent of GDP (Woolard et al. 2011; Seekings 2008); a striking difference to the over 16 million benefiting from social grants at a cost of 3.2 percent of GDP as mentioned above.

Equally, access to health services is very unevenly distributed. Of the current health spending of 8.8 percent of GDP, 4.6 percent accounts for private health provision covering 17 percent of the population (8.8 million beneficiaries, including 3.9 million members typically in formal employment and their dependants). The remaining 4.2 percent of GDP spending on health services caters for 87 per cent of the population, representing 42 million citizens who are at the mercy of a deteriorating public health system, and are mostly on low incomes or unemployed. There are 83 medical schemes in South Africa and the country's spending on medical schemes is six times higher than in OECD countries (Council for Medical Schemes 2016, Lorenzoni and Roubal 2015). In addition, the contrast in implementation is stark: for instance, approximately USD 1,753 per capita is presently spent on private patients compared to USD 327 spent on public patients […] "[and w]hile there is approximately one GP for every 540 beneficiaries in the private sector, the ratio is one GP to 4,000 patients in the public system" (Surender 2017: 325).

A national health insurance scheme that could combine the well-resourced private health sector with the dilapidated public sector could provide more coherent and complete health service provisions (Seekings 2013), and already in 1995, the ANC government presented plans to develop such a system. However, the plans stalled and a green paper was only presented by the Department of Health in 2011 (RSA 2011), which in turn was only

[2] Barchiesi 2007; Lund 2002; Woolard et al. 2011; Devereux 2011

developed into an official white paper by December 2015 and revised in 2017 (RSA 2015, RSA 2017b). Thus, over a 20-year period, the government has been unable to provide a policy for developing a health insurance system that would equalize access to health care. This case of delayed reform with respect to a national health insurance scheme is the topic of the second case study, which is analysed in Section 5.

To sum up, since 1994, social assistance coverage has increased substantially whereas there has been only little progress in expanding social insurance, particular with respect to social health insurance (Woolard et al. 2011). To understand these contrasting developments, we explore in the following the political and institutional drivers that have shaped reforms and non-reforms in the social cash transfer and the health insurance systems respectively in post-apartheid South Africa.

4. Social Cash Transfers

In this chapter, we analyse three specific policy processes related to the social grants system in post-apartheid South Africa: the introduction of the CSG, the rejection of the proposal to introduce a Basic Income Grant (BIG), and the incremental changes to social grants more generally, particularly after 1998 when the CSG was introduced. We end the chapter with a discussion of the ideas that underline these developments.

Following the analytical framework as presented in Section 2, we explore how policy preferences and power resources, in combination with institutional vested interests, have formed social assistance policies in South Africa, and we discuss the ideas that have been used to justify policy decisions. Specifically, we discuss how it came to be a “yes” for the CSG and its gradual expansion, and a “no” for the BIG. Our analysis as presented in Sections 4.1, 4.2, 4.3, and 4.4 lead us to highlight the following findings:

Although, the ANC government is the final policy decision making body, the ANC is not a uniform actor and is also subject to influence by economic and social actors outside the government (as is also evident in the case of National Health Insurance). In the examples of policy (non-) reform, trade unions and the business sector have not been able, or willing, to assert much direct influence. Although unions were part of the BIG campaign, their vested interests were in the end not with ‘labour-market outsiders’ who were to be the main beneficiaries of the BIG; and when the CSG was introduced the reception among unions was primarily critical.

The business sector for its part has not attached much importance (and certainly has had limited vested interests) in social grants - as long as they target the deserving poor and are not too costly. This is in line with the Ministry of Finance, which played a mainly restrictive role in advocating for financial constraints and thus influenced the policy experts to propose a more limiting child grant than they would have wished. Scepticism of social grants is prevalent within the ANC government. Nevertheless, the CSG and the social grants system also had champions within Government, particularly in the Ministry of Social Development (formerly Ministry of Welfare), who could draw on the mood of post-apartheid reconstruction and need for redistribution as well as the empirical evidence of the positive impacts of other social grants in South Africa and beyond.

Civil society organizations mobilized, not in favour of the CSG—at least not initially—but against the removal of the SMG. Civil society also mobilized to promote the BIG but they have not been able to assert sufficient pressure for the government to introduce this policy. This is in line with the theoretical expectations that highlight how mobilization is

easier in cases where benefits are lost and the targeted group easily defined. Nevertheless, through the subsequent implementation of the CSG and the continuance of other social grants, civil society organizations have played an important role in extending coverage. The implementation of social grants has also been improved and coverage increased through the establishment of SASSA (South African Social Security Agency), which also partly has to do with this institution's drive to fulfil its stated objectives. These changes on the "margins" of the policy design have been instrumental in further expanding the role of social grants so that they have become the most central part of South Africa's social security system; and it is one of the areas where the ANC government can claim to be successful.

Yet, despite the acclaim of social cash transfers, the ANC government maintains a sceptical view of the grants. This is in line with the underlying idea that the main objective of social transfers is to address the needs of the most vulnerable *only*. The able-bodied working age population is not defined as vulnerable and hence a line is drawn with respect to social cash transfers as something to benefit only the young, old and disabled. Employment is viewed as the primary income security solution for the adult population, despite high structural unemployment and a large informal sector, and government strategies related to employment being limited to facilitating economic growth and some public works initiatives (Plagerson et al. 2017 (forthcoming)).

4.1 The Child Support Grant

Social cash transfers to children were minimal in the mid-1990s. The large majority of the about 2.5 million grant beneficiaries were pensioners and people living with disabilities, and only 12 percent of the budget for social transfers went to child grants. There were three grants directed at children: the Foster Care Grant for children who were placed with foster parents through a court order; the Child Dependency Grant, which was given to caregivers of severely disabled children; and the SMG (Woolard et al. 2011).

The SMG was available to a parent or guardian living with a child under 18 years. The grant was means-tested and the applicant had to prove that she[3] had attempted to obtain private maintenance from the partner. The grant was given only if fulfilling a range of conditions including that the parent/guardian was unmarried, widowed or separated and had been deserted by the spouse for more than six months. The grant included both a parent and a child allowance (of ZAR 410 and ZAR 127 respectively), and the child allowance was payable for up to two children.[4] In the early 1990s, about 200,000 women received the SMG (Lund 2008).

The racial and spatial distribution of the SMG was highly unequal, which had to do with the very uneven administration of the SMG across the different welfare departments. Particularly, the under-resourced welfare administrations covering the black African population were mostly unable to identify and pay potential beneficiaries, or were not even aware of the SMG. The SMG therefore went disproportionately to coloured and Indian women and although the SMG recipients were poor, there were large numbers of even poorer, primarily African women and children who did not receive any assistance. The SMG was also deemed inappropriate for the South African context as it was modelled on an idea of a nuclear family of formal marriage where the father was employed in the labour market and the main bread-winner (Woolard et al. 2011; Lund 2008).

[3] From 1992 it could also be a he, as men were then included as possible beneficiaries as well (Lund 2008).
[4] Before 1992 for up to four children.

Early in 1995, the national welfare ministry and the provincial welfare departments discussed the future of the SMG. In line with the impetus of the time to address racial inequalities in policy and administration, calculations were made to estimate the costs of awarding the SMG to all women and children in South Africa who qualified according to the rules. The estimated costs came to roughly ZAR 12 billion per year, which was about the same already being spent on the annual health budget. Largely driven by these calculations, the Ministry and provincial departments considered to terminate the SMG with immediate effect (Lund 2008). According to Francie Lund:

> There was very little understanding inside the government of the role played by the SMG, or of the consequences of stopping it. The new politicians, and the old officials, had some understanding of the importance of the role of the pensions for elderly and disabled people in general poverty, especially in rural areas. In contrast, the provinces in which poverty was worst were precisely those in which the SMG had either not been administered at all, or had been patchily administered (Lund 2008: 17).

Nevertheless, with the timely and proactive intervention[5] of Francie Lund and some other experts on social welfare, it was agreed not to terminate the SMG outright, and instead do an investigation into the issues of child and family maintenance. The Lund Committee for Child and Family Support was set up in late 1995, it had its first full meeting early February 1996, met for the last time in August that year and subsequently presented its recommendations. The Committee recommended to phase out the SMG over a five-year period (later changed to four years) and instead introduce a means-tested Child Support Grant of ZAR 75 for children 0-6 years of age, to be paid to the caregiver of the child. The recommendation of introducing a new grant was based on substantial evidence of the positive impacts of cash transfers and was counter-posed against other policy alternatives targeting children. The grant was also seen to be administratively feasible as it followed similar structures to additional social grants (Lund 2008). Yet the Committee's policy recommendations were less extensive than they would have wished for, as they needed to be in line with prevailing dominant policy interests within the government, as we discuss in the following.

In Francie Lund's seminal and detailed narrative of the events around the Lund Committee and the decision to recommend the CSG, it is clear how decisive the Ministry of Finance was in defining the scope and character of the grant. As Chair of the Committee, Francie Lund was advised by the Deputy Minister of Finance, Alec Erwin, to "take the existence of the fiscal constraint seriously and to 'redistribute within the existing envelope'. […] any recommendation for policy reform that did not take this seriously would itself not be taken seriously" (Lund 2008: 90). Consequently, although the Committee members were strongly convinced (based on substantial evidence both in South Africa and internationally) of the value of cash transfers and preferred "more rather than less", a pragmatic approach was taken out of fear of losing the support of the Treasury and Ministry of Finance who at times acted in "arrogant", "stingy and punitive" ways (Lund 2008: 93, 95). The recommendations were therefore within the budget of ZAR 1.2 billion otherwise allocated to the SMG.

The Committee faced ideological restrictions as well. For instance, the Committee members wanted to call the child cash transfer a "benefit", rather than a "grant", which was flatly refused. Furthermore, it was made clear to the Committee that a universal grant

[5] This is our interpretation of the events as documented and explained by stakeholders.

(not means-tested) was out of the question. Francie Lund is not convinced that this specific policy design feature was really based on concerns of resource constraints:

> The resistance to universal benefits clearly has its roots in something other than arguments of logic or efficiency and, in this case, affordability. Means testing stands for something deeply felt, about distinguishing between the different categories of people in poverty, the "deserving" and the "non-deserving" (Lund 2008: 87).

Looking beyond the government, the initial reactions to the Committee's recommendations were negative. Civil society organizations primarily reacted to the proposal to phase out the SMG and protested strongly on behalf of the SMG beneficiaries who would lose their benefits and most likely face poverty (Lund 2008). Trade unions also criticized the work of the Committee, which with its references to budget constraints, was seen as part of the government's loathed Growth, Employment and Redistribution economic strategy.[6] It does not appear that the unions engaged themselves deeper with the issues other than on this abstract level, probably as cash transfers to children is not the primary interest of their members (Barchiesi 2007; Seekings 2013). Parliamentarians were also primarily negative: "the majority of responses to the idea of opting for a new cash transfer for children were extremely conservative, so much so that I was seriously taken aback" (Lund 2008: 103). This resistance related to still commonly held views within the ANC, in the business sector and across the general public that grants create perverse incentives, although this is not supported by research (Everatt 2008).

Still, the Cabinet was intent on going ahead with the child grant, probably because it had already committed itself to such a possibility and as the Lund Committee presented an easily workable solution that fitted existing structures of the welfare system and was within the resource envelope given. Moreover, towards the end of the policy development process, a number of events involving the Welfare Minister, academics, bureaucrats and civil society substantially increased the final budget allocation of the CSG. The Cabinet had decided that child grant beneficiaries should be between 0-6 years, which came to be understood as through to a child's seventh birthday, although it could just as well have meant that the grant should end once a child turned 6 years. Civil society organizations, supported by some academics, managed to push the Minister to agree to raise the level of the CSG from ZAR 75 to ZAR 100 a month.[7] And, finally, the Minister of Welfare, Geraldine Fraser-Moleketi, became a political champion of this policy reform and she directed that the number of children to benefit from the grant be raised to three million (instead of 1.5 million) and that the take-up rate should be sped up (Devereux 2011; Lund 2008). The grant was introduced March 1998, and although the initial take-up was slow with only 150,000 children benefiting from a CSG in 2000, the numbers rose sharply thereafter with more than 9 million children benefiting in 2009 and more than 12 million by the end of 2015 (Woolard et al. 2011; RSA 2016). The massive expansion in social grant coverage, primarily of the CSG but also for other grants, is the topic of the next section.

[6] The Growth, Employment and Redistribution strategy of 1996 privileged public spending constraint and budget deficit containment (Barchiesi 2007).

[7] From USD 21 to USD 28 according to exchange rate ratings for 1995. The CSG is currently equivalent to only USD 27 (see Section 3), which is due to the weakening of the South African Rand from ZAR 3.6 per USD 1 in 1995 to ZAR 13.4 per USD 1 in 2017 (http://www.xe.com/currencytables/?from=ZAR&date=1995-11-16, accessed 9 July 2012).

4.2 Incremental changes to social grants

The Child Support Grant received a lukewarm welcome when it was introduced in 1998 as explained above. This nevertheless changed as a Senior Official in the SASSA explains:

> [I]n the first six years of its implementation the Child Support Grant grew in popularity and there was widespread support from all sectors of society for its extension to older children. In 2003 it was extended to children under 9 years, in 2004 to children under 11 years, in 2005 to children under 14 years and in 2008 incrementally to children under the age of 18 (Naicker 2016: 212).

The extensions in age eligibility were largely achieved through advocacy and campaigns by civil society organizations (Devereux 2011), and the "shrewd leadership" of the Minister of Social Development (1999-2009), Zola Skweyiya. Through the commissioning of research, the Minister was able to provide evidence of the positive impacts of the grants on income poverty and to refute as unfounded many of the objections and myths of the grant related to encouraging teenage pregnancy and discouraging labour market participation (Seekings 2015).

Other developments related to institutional arrangements and civil society activity have led to additional changes to the CSG and other grants, which have had an upward positive effect on both the coverage and uptake of grants. SASSA was established in 2006 to centralize the implementation of the grants system and thereby improve the effectiveness and efficiency of the pay-out of social grants. Bringing together the previously disjointed welfare sector was paramount for an effective and consistent implementation of social cash transfer policies (Plagerson and Ulriksen 2017). SASSA as an implementing institution has also highlighted various inconsistencies in policy that has led to improvements in implementation, such as the paradox in policy that 16-year-olds can receive a grant as a caregiver but then are excluded to receive a grant as a child (Naicker 2016). Furthermore, civil society organizations have played a critical role through evidence-based advocacy in improving implementation by highlighting inconsistency and incompetency in the pay-out of the grants, which caused SASSA to both simplify and perfect its procedures, for instance by allowing documentation other than ID books and birth certificates to apply for social grants (Devereux 2011).

Civil society organizations have also at times used litigation and court cases to extend social grant coverage. Thus, a court case by four men (in short called *Roberts*) challenged the constitutional eligibility of paying social pensions to women at the age of 60 but only to men at the age of 65. They were successful in this effort and consequently increased the pool of elderly people eligible for a social pension (Seekings 2008, Plagerson and Ulriksen 2017). The final extension of the Child Support Grant to up to 18 years of age was also prompted by a court case (*Mahlangu*) in which the applicant argued that children up to 18 years had a constitutional right to income support. The government conceded to this claim before the case was heard in High Court and amended the age limit (Seekings and Matisonn 2012). Another example is the extension of social grants to permanent residents and refugees in South Africa, which again were based on court cases (*Khosa* and *Scalabrini Centre*), and which again led the government to widen the coverage of social grants (Devereux 2011; Plagerson and Ulriksen 2017).

These incremental changes to social grants, led by implementing agencies and civil society organizations, have thus increased the uptake of social grants tremendously. As

mentioned earlier, the social cash transfer system is one of the ANC government's "main claims to fame" and there is a substantial pool of scholarly research highlighting the many positive effects that social grants have for the well-being (broadly understood) of poor beneficiaries and their dependents (see for instance Plagerson and Ulriksen 2015 for a review). Yet this does not imply an altogether positive attitude of the ANC government towards social grants as discussed in the following sections. The incremental expansion has also had a number of unintended and not outright positive consequences. Thus, the Lund Committee was in favour of a policy that focused primarily on early childhood development (ECD) and would therefore have preferred progressive increases in government budgets to focus on strengthening the support to the ECD sector rather than to expand the grant to older children (Lund 2008). The CSG has led to a primary focus "of supplementing existing household income rather than responding to the basic needs of children" (Naicker 2016). There is a danger that social grants become a quick fix solution in which a small monetary payment is supposed to address a complexity of problems that would rather have required a holistic approach, such as with the debate to extent the CSG to young adults between 18 and 23 of years in order to address youth unemployment.

4.3 The Basic Income Grant

In 2000, the government appointed the so-called Taylor Committee, formally named the Committee of Inquiry into a Comprehensive System of Social Security for South Africa. The Committee was appointed to investigate, recommend and budget on an integrated set of policies related to social security, including social cash transfers, retirement schemes, unemployment insurance and health care financing (Plagerson and Ulriksen 2017; Barchiesi 2007). In relation to social cash transfers, the Committee recommended a gradual introduction of a Basic Income Grant (BIG), which would pay a modest cash transfer of ZAR 100 to all South Africans. The BIG was estimated to cost about 4 percent of GDP (DSD 2002; Seekings and Matisonn 2012).

Trade unions (including the three major union federations of Congress of South African Trade Unions (COSATU), the National Council of Trade Unions, and the Federation of Salaried Staff Associations) already in late 1998 flagged the idea of a basic income grant for poor South Africans, particularly the unemployed. In the early 2000s, the unions together with churches and other civil society organizations joined in the Basic Income Grant Coalition, which with the Taylor Committee's recommendations in the back, sought to assert pressure on the government to pursue this policy reform. However, by 2005 the coalition had faltered due to failing commitments of the trade unions, lack of strong mobilization by civil society organizations and strong opposition to the idea within the ANC government (Seekings and Matisonn 2012; Barchiesi 2007).

In opposition to the apartheid regime and in the immediate post-apartheid era, the trade unions led collective action in support of redistribution of wealth and power. However, given a growing membership base among workers in the better-paid formal sector, the trade unions in South Africa increasingly had "little or no presence among the growing number of poor people outside the formal economy" (Friedman 2012: 86). Instead, although the unions might have been ideologically sympathetic to the poor, the original social activism of trade unions fighting for social and economic justice declined. Their own narrow interests related to securing decent employment conditions and to increasing salary levels in the formal sector came to dominate. This in turn implied that their commitment to the cause of a basic income grant primarily benefiting the working poor

in the informal sectors was not been in their immediate sphere of interest[8]. In addition, although established unions such as COSATU did wield considerable political power, for instance in influencing leadership change in the ANC, "organized labour has generally been more successful in blocking unwelcome reform that in winning its demands for further reforms" (Seekings 2013: 24).[9]

Without the trade unions, civil society organizations were "unable to play the role once played by unions and […] they are not equipped to lead an effective campaign for the redistribution of power and resources" (Friedman 2012: 86). The BIG campaign also met particularly strong opposition within the ANC government. Although the BIG was rejected with references to it being unaffordable, scholars argue that the primary reasons for the government to reject the BIG is because it does not fit their philosophy of social security provision for the able-bodied working age population. Certainly other and more expensive programmes, including the National Health Insurance, have been on the table (Everatt 2008; Seekings 2013).

Opposition to the BIG relates to the idea that grants for able-bodied adults would just become hand-outs and that adults should instead enjoy the rewards of work (Seekings 2015). Speaking of the events around the BIG campaign and of ANC's own policy resolutions, Barchiesi puts it like this:

> [The ANC] placed a major emphasis on the creation of short-term employment in the form of public work programmes for the sake of "pride and self-reliance of communities". The praise of volunteerism as self-sacrifice, responsibility and renunciation of financial reward was far more prominent in the ruling party's public discourse […] than redistribution of resources and universal social grants (Barchiesi 2007: 547).

The idea of a grant for able-bodied adults were thus too far a push for the government. Although public works programmes are in place (Plagerson et al. 2017), the government has generally been unable to address the deep-set structural unemployment problem and consequently to develop alternative policies that could provide income security for the working poor (Barchiesi 2007, Ulriksen 2016).

4.4 The social cash transfer paradigm

> [O]ne of the signal features of post-Apartheid politics and policy has been the nearly universal agreement that poverty is an important problem—and the willingness to do something about it (Du Toit 2012: 1).

There can be no doubt that the ANC government has been at pains to reduce poverty, but the government has also been criticized for only being concerned with ameliorating the worst effects of poverty rather than seeking to eradicate it through structural transformation (Barchiesi 2007; Du Toit 2012). In seeking to understand the ideas driving the government in its social policy formulations, it is important to remember the ANC itself contains many different factions with differing views on poverty and the role of social assistance herein. As Everatt explains:

> Broad brush strokes are unavoidable, but one side promotes an all-out war on poverty with a heavy social welfare emphasis, and looks to social grants (if

[8] Seekings 2013; Southall 2004; Beresford 2012; Seekings and Nattrass 2002
[9] Though as we argue in the NHI case study, the fracturing and weakening of the trade union movement in recent years has led to a reduced political influence and mounting pressure to recover representation of low income workers.

> not a full welfare state) and a more interventionist 'developmental state' to back up the fight. This set of views has the support of COSATU and the SACP [South African Communist Party], the churches, and some elements of civil society. The other side, including senior government officials, business and much of the media, emphasises 'the dignity of work' as the primary anti-apartheid intervention and deploys supply-side interventions to try and coax the market to function appropriately (Everatt 2008: 30).

Thus, within the ANC alliance itself there are opposing views where some feel that the party has sold out to a "neoliberal" agenda working against the poor, whereas others emphasize the necessary move towards a cross-class alliance in which the poor benefit from social policy. However, even those sceptical of social grants recognize the continued importance of providing social benefits to poor voters and consequently acknowledge the need to safeguard the social grants system from cuts (Seekings and Nattrass 2005).

Yet, in the government's actual approach to social assistance (in policy choices and justifications), it also becomes evident that the main aim of social grants is to address the needs of the most vulnerable. Once social grants are proposed to move beyond the so-defined vulnerable—either by suggesting that the CSG be made universal or to introduce a BIG benefiting able-bodied adults—a line has been drawn. Justifications of not going beyond the so-defined vulnerable groups relate to economic principles of affordability, but beneath this is an uneasiness with providing non-contributory cash transfers to the able-bodied, working age population. In this sense, one could argue that the social assistance paradigm is based on a principle to help the neediest, but not to tackle structural transformation.

As Weible and Leisering puts it: "The aim of the social grants is poverty reduction, but the grants are only about *alleviating* rather than eradicating poverty" (Weible and Leisering 2012: 225). In this framework, it has become important to define who are the most vulnerable and needy, which has consequently evolved around the concept of "desert", and as the social grants system has developed the "deserving" are the elderly, children and people living with disabilities. Able-bodied adults on the other hand are not "deserving" of social grants (Seekings 2008).

There may be a notion that the ANC government cares less about poor, able-bodied adults given its unwillingness to target them through social grants and a general inability to address structural unemployment. However, the characteristics of social assistance in South Africa may also have to do with social grants being regarded as a means to address the needs of the most vulnerable. Other social security policies may better meet the demands of the working population, such as a national health insurance scheme, which is the topic in the next chapter.

5. National Health Insurance

Current National Health Insurance (NHI) plans provide a platform for the analysis of evolving relationships and bargaining between the private, public, labour and non-state sectors in the area of social security reform. As in many countries, national and pilot initiatives underway to move towards universal health coverage are being negotiated amidst strong competing interests (Yi et al. 2017; Surender 2017). The radical NHI framework envisages the integration of the current two-tier health system, in which well-resourced private service providers and a poorly-resourced public sector have previously operated largely independently. South Africa has poor health care outcomes relative to its

endowment of health care resources and investment in health compared to other countries of comparable level of development (see Table 1). The NHI proposals aim to overcome the widening inequalities in health care provision, inequities in the distribution of human resources, the inadequacies in the public health sector and the escalating costs of the private sector (RSA 2011; 2017b). The NHI aims to deliver a "health care financing system that is designed to pool funds to actively purchase and provide access to quality, affordable personal health care services for all South Africans based on their health needs, irrespective of their socioeconomic status" (RSA 2017b: 3).

Table 1. Public Health Expenditure (as percent of GDP) and Health Outcomes in Selected Countries

	Child malnutrition	Mortality rate				Deaths due to TB	Life expectancy at age 60	Physicians	Total health expenditure	Public health expenditure
	(percent stunted under age 5)	Infant (per 1000 live births)	Under-5 (per 1000 live births)	Female (per 1000 adults)	Male (per 1000 adults)	(per 100000 people)	(years)	(per 10000 people)	(percent of GDP)	(percent of total health expenditure)
Brazil	7.1	14.6	16.4	93	194	2.6	21.3	18.9	8.3	46
China	9.4	9.2	10.7	72	98	2.8	19.4	19.4	5.5	56
India	38.7	37.9	47.7	145	217	17.0	17.7	7.0	4.7	30
Kenya	26.0	35.5	49.4	251	296	21.0	17.8	2.0	5.7	39
Russia	—	8.2	9.6	—	—	11.0	18.4	43.1	7.1	52
South Africa	23.9	33.6	40.5	419	464	44.0	16.1	7.8	8.8	48

Source: Global Health Observatory 2017; WHO 2017a.

Established trade unions are strongly supportive of proposals to establish the NHI system. Objections expressed by the private sector, including health service providers, health professionals, pro-market think-tanks, pharmaceutical companies and insurance companies are focusing on weaknesses in state capacity to manage health services structures[10].

This case study analysis outlines how several radical health reform proposals have been abandoned over the past decades, and how instead gradual developments have led to the present inelastic institutional configuration of parallel health systems. In the absence of a universally trusted lead institution, processes of negotiation between stakeholders have struggled to overcome ideological, professional and technocratic differences. The multiple positions held in tension by the state are shown to both explain and limit the progress of health policy reform.

5.1 Major proposals for health reform (up to 2007): Repeatedly proposed but not implemented

The historical trajectory of reform in the health sector in South Africa is somewhat disjointed and several milestones can be identified over the past century. Sweeping proposals have succumbed to accidental and somewhat reactive policy changes (discussed in Section 5.2), resulting in small incremental developments rather than anticipated radical reforms. In the twentieth century there were several windows of opportunity for the consolidation of health services and the introduction of health financing reform: through the 1928 Commission of Old Age Pension and National Insurance; the 1941 Collie's Committee of Inquiry into National Health Insurance; the

[10] Surender 2017; Seekings 2013; Mayosi et al. 2012

1943 African Claims that proposed equal treatment in the scheme of Social Security; the National Health Services Commission of 1943, headed by Henry Gluckman (a Member of Parliament in the incumbent United Party); and the Freedom Charter as adopted by the Congress of the People in 1955 (Mayosi et al. 2012; RSA 2017b).

The most prominent proposal was developed by the Gluckman National Health Services Commission, which advocated for a nationalized, non-discriminatory and tax-funded health care service for all inhabitants (van Niekerk 2012). It sought to respond to institutional fragmentation, namely the devolution of authority to the provincial level, as well as the recognized need to address the inequitable distribution of health benefits (both issues that are also faced by the current NHI). The promotion of benefits for all was not solely motivated by liberal values of equality but also rooted in the circumstances of the time, whereby demands for cheap labour posed challenges to attempts to keep the population racially segregated, and strengthened an instrumental rationale for a healthy workforce.

The proposal enjoyed wide-ranging support from trade unions, health professionals, the ANC and several other groups (Freund 2012). Yet despite the climate of a certain degree of willingness for compromise and negotiation between stakeholders (including for example health professionals), institutional obstacles and political resistance censured the proposals from advancing. Normatively, this early proposal crystallized the ideological tussle, which has subsequently fundamentally shaped the direction of health policy. Furthermore, as we show, it illustrates how the clash of values was also mediated by other contextually-determined ideals. The Gluckman proposal promoted the notion of health as a common good, to be underwritten by the collective responsibility of the state, which was countered with the prevailing understanding of health as a private commodity and as the personal responsibility of individuals (van Niekerk 2012).

The recommendations for an inclusive health insurance policy was not endorsed by the government at that time. This was not primarily because the government opposed the abstract notion of health as a social right, but because even liberal policy at the time excluded the extension of these rights to the African population, preferring a paternalistic as opposed to a citizenship-based approach, which addressed symptoms rather than the roots of inequalities. Thus, under the increasingly segregated policy framework, even notions of common public good were interpreted as categorical (applying only to certain race-determined groups) rather than universal. Since the proposals were conceptualized as a direct attempt to inclusively address the health and welfare needs of Africans, they were rejected, as incongruous with the policy of the time. Further reasons cited were the expense involved, and the preservation of the status quo with regard to the provincial oversight of various aspects of health system administration (Freund 2012; Marks 2014). The proposed advances were abandoned entirely following the change of government when the Nationalist Party came to power in 1948, rejecting all of the Gluckman Commission's recommendations (Makgatho 2015) followed by four decades of dormancy on radical health reform (McIntyre and Van den Heever 2007).

The advent of a democratic era for South Africa in 1994 ushered in another window of opportunity for moving towards a mandatory health insurance scheme, a time characterized by a spirit of social solidarity and a potential willingness to accept relatively large cross-subsidies (McIntyre and Van den Heever 2007). The rhetoric of radical reform was revived at this time. In its 1994 National Health Plan for South Africa, the ANC outlined a plan to transform the health system in order to "redress social and economic injustices", particularly the "harmful effects of apartheid health care" (ANC 1994: 1). The

Health Plan recommended an investigation of a possible National Health Insurance and the most vulnerable groups were identified as a priority in the allocation of resources. The Constitution legally guaranteed all citizens the right to access to health care, to be realized progressively within the government's capability (RSA 1996).

The decade that followed was punctuated by repeated calls and proposals for an overhaul of the health sector. Major proposals have included the Committee of Enquiry on National Health Insurance in 1995, the Taylor Committee of Inquiry into Comprehensive Social Security in 2002, and the Ministerial Task Team for Implementing Social Health Insurance in 2002. Yet despite the growth and consolidation of public health services, wide provincial disparities remained and little progress was made towards the implementation of universal health coverage (McIntyre and van den Heever 2007).

As in the case of the Gluckman proposals, these delays may be explained by the interaction between ideological tenets and the context into which they were received. As the previous case study on social grants showed, the ANC has traditionally encompassed a broad range of positions, in particular with regard to how markets should be constituted and their role in service provision. Overall, in the early transition period, social democratic discourses which favoured redistributive interventions dominated. However, these declined in the early 2000s, as the government committed itself to increased fiscal discipline and as the limits to state capacity became increasingly evident. The human resources crisis in the public health sector was compounded in this period by the state's reluctance to respond through treatment and prevention measures to the AIDS epidemic (Seekings and Nattrass 2015).

This section has highlighted the mismatch between radical policy proposals for health reform and their lack of implementation. In contrast, the next section describes the historical development of the current complex and fragmented institutional landscape, to explain how institutional allegiances have shaped competing policy preferences, and acted as a brake to the drivers of policy reform. Yet despite the challenges, the NHI has achieved a more advanced stage to date than its previous counterparts, primarily because of the achievement of a moderate alignment between state departments. Section 5.3 explores the disparity between the significant progress towards universal health coverage since 2007 with a strong statist and rights-based dimension and the persistent climate of doubt and misgivings that characterize the engagement of several stakeholders, whose buy-in may determine the success in implementing the NHI (Ruiters et al. 2012).

5.2 The development of multiple institutional structures

In contrast with conspicuous calls for radical health reform, a slower process has over time dramatically shaped the current institutional landscape, which has in turn exacerbated the contested environment, but also provided opportunities for gradually pushing the NHI forward. At present, South Africa is characterized by multiple parallel institutional health care systems, dominated by the public and private health sectors. The public sector is a state-owned system designed to provide open access health care. Clinics provide services for free, while public hospitals charge fees for their services, though these are largely small nominal fees, tiered according to patients' ability to pay. The private sector is a network of private entities including insurance companies (such as medical aids), health care providers and suppliers of consumables and technology (for example pharmaceutical companies) (Makgatho 2015). Non-profit organizations and traditional healers also belong to the private sector, but are not the main focus of this discussion.

Table 2. Comparison of Private and Public Health Indicators

	Public health sector	Private health sector
Health expenditure as percent of GDP (2014)[11]	4.2	4.6
Percent of Total Health expenditure (2014)	48	52
Health Expenditure per capita (2014)	USD 327	USD 1753
Percent of population served	83	17
Percent of total bed capacity	74	26
Percent of medical specialists	45	55
Geographical focus	Urban/Rural	Urban
Out-of-Pocket payments	ZAR 451 million	ZAR 20.7 billion
Tax subsidies[12]	N/A	ZAR 15.9 billion

Sources: WHO 2017b; Lorenzoni et al. 2015; RSA 2017b.

In 2014, the private sector provided healthcare to 17 percent of the population primarily through medical insurance schemes, and represented over 50 percent of total health expenditure. The public sector provides health care for the remaining 83 percent of the population (Table 2). The private healthcare system is typically regarded as a provider of better quality of care compared to the public system (Hassim et al. 2007). However, private healthcare services are very costly (even by international standards) and only accessible to middle and high-income earners (Lorenzoni et al. 2015). As a result, the overburdened and under-resourced public sector caters for the population who cannot afford the private healthcare (Hassim et al. 2007; Mayosi et al. 2012). Access to the public sector remains limited by availability of facilities (especially in rural areas), distance to facilities and cost of public and emergency transport (Surender 2017).

The NHI is now seeking to integrate these vastly different and internally complex systems with evident challenges. As narrated in the following, a gradual historical progression going back to the early 1990s explains the developments that have resulted in the current multi-institutional configuration.

By the early 1900s, health was largely treated as a private responsibility, to be funded through out-of-pocket payments. The state health sector only emerged reactively in response to an outbreak of influenza. Public services remained focused on meeting the needs of the poor rather than on providing services for the general population, with wage earners required to pay for the use of public hospital services. Thus, the private sector largely evolved in a policy vacuum as a response to the need for insurance in the absence of access to free public services for income earners (van den Heever 2012). Large private firms established social security-type schemes as a response to their employees' welfare, establishing early medical insurance prototypes, which evolved into an important alternative health care funding vehicle for income earners (van den Heever 2012).

Subsequently, insurance firms developed similar services externally for smaller firms, creating an option for non-employer-based schemes. In the decade before the end of apartheid, commercially-driven reforms in legislation enabled the proliferation of smaller insurance schemes. By 1990, South Africa had over 240 registered medical schemes. Like the private insurance industry, private hospitals also emerged to fill a gap, providing services previously offered by state or mission hospitals. A migration of health care

[12] The amount represents 12 percent of gross income from medical scheme contributions

practitioners from the state hospitals towards the more lucrative private services stimulated the growth of the private hospital business, creating inequities in access, because of their geographic distribution in affluent areas (Makgatho 2015; van den Heever 2012).

In the period after 1994, efforts by the incoming ANC government to reverse some of the previous legislative amendments that allowed rampant commercialization of the private sector, and to introduce greater regulation, were not sufficient to reduce the hegemony of the private sector, as the state pursued uneven agendas, with a dual concern for maintaining market freedoms as well as achieving health equity outcomes. Indeed, the private sector grew rapidly, followed by a period of consolidation and mergers (Dambisya and Mokgoatsane 2012, in Surender 2017). Ruiters et al. argue that in many ways the state supported its growth:

> After 1994, the government's tacit support for the commercialization of health services was evident from the declining expenditure on public health, allowing the establishment and promotion of private hospitals, the growth of medical aid schemes and diagnostic and treatment centres, the consolidation and growth of pharmaceutical retail chains, as well as tax rebates for private health insurance and finally, the proliferation of public-private partnerships in hospitals. (Ruiters et al. 2012: 37)

The growth of the public sector has compensated for the gaps left by the private sector, but lacked the reform momentum envisaged by the radical proposals outlined earlier. Despite major efforts to integrate the fragmented health system under the National Department of Health and to reprioritize resources to the primary care level, it has struggled to overcome the inherited legacy of geographical and racial disparities and to ensure access to quality health care and improved health outcomes for the majority of the population (Surender 2017; RSA 2012).

Overall, the current institutional landscape is now dominated by more than one health systems colossus. In each case ideological commitments are deeply enmeshed and hard to disentangle from competing "technical" strategies for funding, pooling risk, purchasing and providing health care. Taken as a whole, the health system falls far short in provision of equitable access to needed, effective health care. The poorest groups have lower rates of health service use and derive fewer benefits from use of health care, despite the burden of ill health being far greater on these groups (Marten et al. 2014: 2168).

While the health systems are often portrayed as independent, significant linkages exist between them. Firstly, all health care professionals in the public and private sector are trained in the public system, at public expense. Secondly, full-time public sector employees often work part-time in the private sector. Thirdly, the public system supports the private sector indirectly through tax benefits given to individuals and companies for medical aid contributions (Hassim et al. 2007). Fourthly, the state also has a medical aid scheme for its employees, the Government Employees Medical Scheme (GEMS) that covers government employees' private health care needs. Lastly, medical aid beneficiaries whose capped benefits run out, often fall back onto the public system for their health care needs.

These linkages demonstrate interdependence between the systems, but have not been viewed as creating a platform for dynamic and mutually advantageous integration.

Instead, these factors have been underplayed or accentuated in the tussle to demonstrate institutional superiority.

In summary, a historical progression has enabled a formidable private health care sector to emerge out of a policy vacuum, and an embattled public sector to develop with ongoing challenges with under-resourcing, poor infrastructure and human resource shortages. From an institutional perspective, this has created a less elastic and more charged environment, compared for example to the context into which the Gluckman proposal was introduced. There is a natural resistance to compromise institutional allegiances and well-established structures, leading to a seeming structural stand-off between private and public sectors. Yet this is nuanced by the fluidity of represented interests, political and pragmatic considerations and the need for negotiation that are outlined in the next section.

5.3 The NHI: Current drivers and hindrances to progress, 2007-2017

Despite the incrementally developed complex divide as well as interaction between the private and public health provisions, there has been significant progress towards the realization of the NHI. This section highlights a turning point in the NHI trajectory, and the ongoing developments in stakeholder relations as key to understanding the direction and uneven progress to date.

The African National Congress Party conference in 2007 as a turning point

In 2007, the fifty-second annual national conference of the ruling party, the ANC, marked a critical juncture. A change in leadership was accompanied by a reaffirmation of a solidaristic commitment to the implementation of the NHI as an equitable goal to be pursued, that could address the mounting disease burden and the extreme pressure on public health facilities and staff (Mayosi and Benatar 2014; Ruiters and van Niekerk 2012). In 2009, a Ministerial Advisory Committee (comprising members from labour, academia, insurance providers, health economics and public policy) was introduced to advise the Minister on policy, legislation and implementation of the NHI. A National Health Insurance Green Paper was published in 2011, proposing a gradual 14 year roll-out plan from 2012-2026 (RSA 2011). After the launch of the Green Paper, over 100 submissions were made to the National Department of Health by medical scheme administrators, labour, the pharmaceutical industry, professional associations for various occupations, statutory bodies, government departments, academia and civil society (Matsoso and Fryatt 2013). Pilot programmes were initiated in 11 selected health districts throughout the country (prioritizing primary health care strengthening, standardization of services and health workforce development) and the Office of Health Standards Compliance was established to monitor health service quality norms and standards in public health care (NDOH 2015; Mayosi et al. 2012). The NHI White Paper was published in 2015, and its revised version in 2017 (RSA 2017b; RSA 2015).

This progress is remarkable, especially in the light of the historical trajectory outlined in previous sections. Yet the realization of the NHI continues to be contentious, as in other countries attempting similar far-reaching reforms (Yi et al. 2017). This is not surprising given the range of stakeholders and the breadth of commercial, professional, institutional and ideological interests that are affected by the NHI. Several factors explain the headway made so far despite resistance and/or scepticism from several stakeholders.

State departments, party politics and electoral appeal

Following the resolutions by the ANC in 2007 to push for implementation of the NHI, there has been a high level of endorsement from different arms of the state. The Department of Health has taken the lead in championing the NHI as a channel for universal access to health, bolstered too by the support for universal health coverage by international institutions such as the World Health Organization (WHO 2010). The Minister of Health, Aaron Motsoaledi (2009–present) has been a staunch advocate for the initiative, defending the statist view driven by equity concerns. He has articulated the need for health resources to be distributed according to need, seeking to dissolve the concentration of health care services according to wealth hubs. Importantly, the Finance Minister, Trevor Manuel, acknowledged the NHI in the 2009 budget speech, signaling the institutionalization of the NHI agenda (Manuel 2009). In 2011 and in 2012, the subsequent Finance Minister, Pravin Gordhan, announced substantial budget allocations for NHI-related projects so to pave the way for NHI implementation, and NHI budget considerations have featured in all subsequent budget speeches (Gordhan 2011, Gordhan 2012). Furthermore, momentum has been sustained by the public commitment of central government, with the President, Jacob Zuma, identifying NHI activities as a priority in seven out of nine State of the Nation addresses between 2009-2017[13]. Politically, the hegemonic role played by the ANC, whose dominance has remained unthreatened since 1994, has meant that it does not suffer the restrictions typically faced by political parties in multiparty democracies to operate within short-term political cycles. This has increased its confidence to tackle a radical and long-term shift such as the NHI, but has also meant that there have been fewer political incentives to push for a difficult reform when the position of power is relatively secure. However, as the electoral margins decrease, the popular support for the NHI may serve to accelerate implementation plans in the run-up to the ANC party election in December 2017 and a national election in 2019 (Bonorchis and Kew 2017; Hlophe 2013).

Despite the electoral appeal, broad alignment across the government and within the ANC does not however imply uniform support, either ideologically or in terms of delivery and financing mechanisms. The Ministry of Finance has trodden a cautious path with regard to the NHI, seeking to avoid alienating private stakeholders and defending the need for accurate actuarial costings (Ruiters et al. 2012). Rather than a social rights approach, the Ministry of Finance has underlined the instrumental value of a healthier workforce (Surender 2017). Media reports were quick to point out the conspicuous absence of National Treasury representatives at the release of the 2015 NHI White Paper (Business Day 2015). The Finance and Fiscal Commission (FFC), a constitutional body charged with overseeing the financial arrangements between different spheres of government, expressed concern at the policy uncertainty around the roll out of the NHI, and governmental resource allocation across national, provincial and district levels (Kahn 2016).

The NHI has not been affected by the same divisions within the government around employment-related issues that have characterized debates concerning social grants. Indeed the relationship between the NHI and productivity is characterized as positive, through improvements to the health of the workforce and increases in labour participation rates (Coovadia 2013). The equity basis on which the decommodification of health has been argued has superseded potential concerns around the need to "deserve" health benefits. Rights-based approaches are also viewed as a mechanism to overcome the linkage between employment and access to private medical aids that excludes the working

[13] Zuma 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017

poor and unemployed. Furthermore, the design of the NHI requires mandatory payments for those who can afford them on a sliding scale, thus circumventing fears of dependency (RSA 2017b).

Particularly with regard to the involvement of the private sector, divided opinions coexist across the ANC and the state regarding the relative merits of public versus private mechanisms and opportunities for private-public partnerships in health care delivery. Over time, consensus within government has (reluctantly) shifted towards accepting the contracting of private health practitioners and the involvement of private insurers in providing complementary services, though the exact arrangements have not been specified[14].

Dissent within the ruling party and between state departments is amplified by the complexity of the implementation and operational aspects of the NHI reform, and may explain the slow progress and ongoing lack of detail that has characterized successive policy iterations. The mixed findings concerning resulting from audits of pilot schemes and evaluations have also fueled the arguments of both sceptics and proponents of NHI reforms (NDOH 2015, Blaauw and Lagarde 2015).

Allies and critics: Trade unions, opposition parties and private sector stakeholders

Support for the NHI has been vociferously endorsed by several (though not all) trade unions as a means for transforming the health system. The positions held by trade unions have evolved in response to the internal fragmentation of the movement in recent years. The stance put forward by two large and politically influential trade unions—the COSATU and the National Education Health and Allied Workers Union (NEHAWU)—has shifted over time, as other trade unions have emerged unencumbered by historical political affiliations which have divided public sector worker affiliations. In 2002, COSATU and NEHAWU's response to health reform proposals articulated in the Taylor report (which also advocated for the BIG) was qualified by demands that mandatory contributions should not entail higher costs for low-income workers, and that funding streams which disproportionately affect the poor, such as value-added tax, should not be considered (Hlophe 2013). Latterly, COSATU's active endorsement for the NHI has emphasized a preference for redistributive policy options that favour the socio-economically disadvantaged, and a wholesale rejection of profit-driven entities in health care provision (Pamla 2015).

From different perspectives, trade unions have become more critical of the government's position on the NHI. On the one hand, the Federation of Unions of South Africa has objected to the absorption of current medical aids for public sector workers (such as the GEMS*)* into the universal NHI system (Gon 2017). On the other hand, COSATU has been outspoken against concessions the government has made to private sector involvement in the NHI roll-out, and the South African Federation of Trade Unions has been disparaging of the slow progress in implementing the NHI. Other civil society organizations, for example the Treatment Action Campaign[15], have supported the need for reform of the health sector, and advocated for greater levels of public engagement around the proposals, since there has been little mobilization of citizens, so far unaffected by the reforms, around the goals and significance NHI (Ruiters et al. 2012; Nkosi 2014).

[14] Hlophe 2013; Surender 2017; RSA 2017b

[15] The Treatment Action Campaign (TAC) is an NGO that engages in monitoring, advocacy and campaigning within the health system to ensure that every person with HIV has access to quality comprehensive prevention, treatment, care and support services.

Outright opposition has been expressed by the Democratic Alliance opposition party, which has rejected the premise that the commercialization of the private sector is to blame for the inequities in access to health. Pointing instead to the maladministration of the public sector, the party has not recognized the NHI as a plausible solution. Pro-market think-tanks, such as the Free Market Foundation, have vociferously opposed the NHI and fueled concerns in the media and among middle-class tax-payers about the feasibility and desirability of the NHI (Surender 2017; Marten et al. 2014).

Medical insurance schemes, pharmaceutical companies and private health care providers have trodden carefully in seeking to defend their professional and institutional interests. Stakeholders with different vested interests have aligned themselves according to the private/public institutional divide that dominates health care in South Africa, but have also sought to straddle this gulf to achieve their individual aims. Strong political and institutional drivers have met with both active and passive resistance from groups set to be disadvantaged by the reform. Several hospital companies and insurers have expressed support for the vision of universal access represented by the NHI as a means to improving coverage, health outcomes and reducing injurious health expenditure for the poor (Surender 2017; Ruiters et al. 2012). However, they have also resisted the notion of the state-led NHI as a magic bullet for overcoming health care challenges and expressed concern at the lack of detail contained in policy documents (Bonorchis and Kew 2017). Preferring a "stewardship" role for the public sector, the private sector has identified its own managerial effectiveness and efficiency as a basis for expanding its services and making them affordable to a larger proportion of the population (van Niekerk 2012).

Bargaining positions draw on the private sector's sway over health care providers and infrastructure. Normative and pragmatic differences are played out in complex debates about the appropriate goals of reform and the best mix of financing and service delivery mechanisms. Despite broad agreement around the diagnostics contained within policy documents, objections have centred around the ambiguities (on financing, risk pooling, purchasing and provision of health care) contained in the documents, around the perceived lack of capacity for the public sector to deliver on its proposed role, the affordability of the scheme and the predicted disadvantages that would be experienced by current private sector providers and beneficiaries (Ruiters et al. 2012). A reactive wait-and-see approach has been common with expressions of hostility and criticism of the White Paper (Makgatho 2015). Responses to the White Paper by representatives of the largest medical aid firm in South Africa have been quoted in the press: "it's premature to comment on the role of medical schemes within the NHI context because it depends on clarification of several critical elements of the proposal, which are not dealt with in detail in the NHI white paper" (Malan and Green 2016). Thus, unease and protective attitudes have been expressed. These responses are in line with a cautious approach that seeks to keep distance from a potentially unfavourable policy but also to keep options open, and to maintain a platform for negotiations.

The support and compliance of health professionals has been identified as a crucial factor in realizing the NHI[16]. The state has stepped up efforts to court their support. However, pilot schemes to attract private general practitioners into public sector services have had only moderate success (Blaauw and Lagarde 2015). A survey of doctors' attitudes found that both private sector and public sector doctors were dubious that the implementation of National Health Insurance would improve the delivery of health care in South Africa, but also identified incentives that could improve retention rates (van der Spuy et al. 2017). Within the public sector, workers have anticipated some reduction in workload. Within

[16] Rispel and Barron 2012; Surender 2017; Marten et al. 2014

the private sector, workers have moved to defend their interests in line with their institutional allegiances. The South African Private Practitioners Forum has been outspoken in its criticism of the NHI White Paper and criticized the selective nature of consultative processes (Surender 2017). Despite medical professional bodies having demonstrated their ability in the past to block reform and defend its interests, signs of mobilization among private clinicians and institutions in favour of the NHI policy are present but perhaps limited by the fragmented nature of the health care professions. Engagement has been more reactive than proactive, seeking to block rather than shape reform (Surender 2017).

Overall, several factors explain the contrast between the adamant progression of policy documents, and the concurrent stilted and unenthusiastic processes of consultation, and how these bargaining processes have been overshadowed by perceptions of hostility and mistrust. Ideologically, there is a shared recognition of the need for health reform. Pragmatically, negotiations preceding and following the release of the White Paper highlight the recognized interdependence of the various stakeholders, and the private sector's need to carve out an advantageous role within the NHI framework, and the public sector's need to draw on (at least in the short term) private health care human resources. Nonetheless, in spite of extensive consultation with stakeholders, the White Paper has not been welcomed as representative of and responsive to broad stakeholder interests or of lessons learned from the pilot stages. Concerns raised by stakeholders have not been responded to sufficiently to allay the fears of pharmaceutical companies, insurance and health providers, whose wait-and-see approach is designed to mitigate risks to vested interests. The divided positions within the state have maintained a fragile balance but have not secured a trusted space to accommodate robust negotiations. Combined, these factors explain both the milestones reached to date by the NHI and the considerable delays it has experienced and continues to experience.

5.4 The NHI: Holding institutions and interests in tension

This case study has outlined the historical developments that have shaped the institutional configuration in health care and the web of interests that act as a backdrop for the current state of the NHI, a complex and ambitious policy reform that needs to navigate the multiple interests involved in its effective delivery.

A well-established skyline with multiple institutional systems has emerged organically from incremental amendments to legislation and unregulated developments in the private sector, despite repeated attempts at radical reform. While the prospect of integrating these systems is now recognized as necessary by the majority of stakeholders, there is no universally-trusted lead institution with the gravitas required to steer the complex integration process with buy-in from all actors involved. The state has assumed this role nonetheless, and the strong statist dimension and articulation of equity values of the NHI is unique even in the recent South African policy developments.

In line with the oppositional stance between private and public sectors, the private sector has been perceived to respond defensively, rather than in a conciliatory manner, seeking to block reform rather than engage in shaping reform. Under the surface, the web of interests is more nuanced and less polarized. Common ideological aims, and mutual interdependencies have been acknowledged by different actors, yet these have not succeeded in overcoming institutional allegiances and disagreements between competing interests regarding the extent to which the state should assume responsibility for health service provision.

Multiple interests and positions have been held in tension by the state, with little internal settlement, involving a balancing act between responding to demands for social equity in line with its mandate, and pressure to follow a macroeconomic path that would enable growth, and give weight to fiscal feasibility. The different positions held in tension by the state can be seen both as enabling the progress achieved to date (for example the publication of the White Paper) without total alienation of commercial and professional stakeholders, while also allowing the state to be seen as representing the interests of the majority and civil society. Yet the lack of alignment and integrated representation of interests can also be seen as a major factor explaining the sluggish progress towards implementing the NHI vision. The tussle between these factors will determine the course and speed of the NHI moving forward, and whether this radical reform can succeed where its predecessors have not.

6. Conclusion: Comparing Political and Institutional Drivers in Social Assistance and Social Insurance

> As employment did not absorb the previously disadvantaged Africans into the formal sector, the expansion of social assistance built up a lifeline to reduce their deepest poverty. This in turn might have displaced the expansion of social insurance, especially in the health field, from the policy agenda, where there has been hardly any progress despite concrete proposals on the table since 1995. (Woolard et al. 2011: 375).

The contrasting developments of social assistance and social insurance in South Africa are quite striking. Where the social cash transfer has expanded tremendously in post-apartheid South Africa, the development of a national health insurance scheme has stalled with only a very recent endorsement of the White Paper and beginning pilot projects. There is no doubt that the ANC government has seen the expansion of social grants as a way to address deep deprivation among vulnerable groups. However, our analysis of the NHI case does not indicate that the focus on social assistance has taken away attention from addressing the problems in the health sector, as otherwise implied in the above quote.

Instead, the comparison of the two cases reveals how political, economic and social actors—each with their own policy preferences, power resources and vested interests—have both enabled and blocked policy reforms (see summary of the cases in Table 3). It is clear from the analyses, that policy reforms are not introduced in a vacuum. Instead, policies are presented into institutional contexts in which there are already vested interests that to some extent lock policy negotiations and subsequent policy development to follow a certain path. In the case of the NHI, a strong private medical sector and a myriad of service providers developed in the absence of a coherent national health insurance system. And although there has been agreement with the overall idea of health as a common good, the existing institutional arrangements have been enormously difficult to break as institutions with vested interests have sought to maintain their raison d'être. The institutional arrangements of the social assistance system have been less complicated with fewer and not very resourceful vested interests against them. The introduction of the CSG furthermore followed in line with existing social assistance scheme, which made its introduction relatively smooth.

Table 3. Comparing Political and Institutional Drivers of the Two Case Studies

	Social cash transfers	Health insurance
Actors (power resource, policy preference, vested interests)		
Government	Wants to address poverty, but ambivalent view on social grants. Ministry of Finance: strong position, advocates resource constraint. Ministry of Social Development: less powerful, champion of social grants, gains strength as evidence proves positive impacts.	Wants to address health inequality, ambiguous in relationship with private sector (critical but needs buy-in). Ministry of Finance: supportive of NHI as instrumental for the economy through wealthier workforce, Cautious on affordability. Ministry of Health: supportive of NHI on basis of equity principles.
Implementing institutions	SASSA: implementing agency, has an interest in successful implementation and expansion.	Implementing institutions: multiple and interdependent institutions with contradictory support for NHI vis-à-vis private sector advocated alternatives.
Trade unions	Strong political influence. Although sympathy to the poor, trade unions have no vested interests in social grants.	Strong political influence, and strongly supportive of the NHI, despite possible conflicts of interests given government medical aids for employees.
Civil society	Difficult to mobilize to promote policy, easier to mobilize against policy removal. No strong influence in policy decisions, but influences policy on the "margins" in the implementation phase. Represents beneficiaries (who are otherwise poorly organized).	Strongly supportive of NHI but muted voice. Little public participation.
Private sector	Strong political influence, no vested interests in social grants.	Very strong vested interests against, particularly in private medical sector. Limited mobilization and little visible influence on policy design, wait and see approach prevails. Buy-in needed so strong power of veto.
Ideas	Social justice view: prioritize those who have the least. Competing political ideas: rights versus dependency. Resource constraint as a value.	Social justice view: offering the same to everyone. Health as a common good. Competing political ideas: rights versus co-responsibility. Efficiency as a value.
Policy concept	Address the needs of the most vulnerable (elderly, disabled, young).	Seeks to provide quality health services for all South Africans, irrespective of whether they are employed or not.
Policy outcome[1]	Existing policies in place, new type added; coverage gradually extended.	White Paper published in Dec 2015 and revised in 2017. Pilot programmes under way.

1) Refer to actual policy in place, not the impact that the policy may have on e.g. well-being

Yet the analyses of the two cases also show that reforms are possible despite vested interests. Continuous negotiations and compromises (for instance between private and public sector health providers, and trade unions and business) may carve the way for policy frameworks that might not be as coherent and ideal as wished by some, but that might instead be politically feasible and implementable. Budgetary restrictions may also cause policy designers to suggest less far-reaching policies than they might have wished. This is the case with the CSG, where the Lund Committee would have preferred the grant to be universal rather than means-tested and where the suggested eligibility criteria and amount of the benefit fitted the "resource envelope" directed by the Ministry of Finance. The final policy framework is therefore often compromise documents that seek to meet a variety of interests. Moreover, once a policy is in place, there is room for further adjustments on the margins, which is the case with social grants where coverage has continued to expand, in large part also due to civil society pressure.

Ideational justifications feature in policy negotiations and a broad variety of notions flourish: "rights", "co-responsibility", "dependency", "common good for all", "support for the neediest", "affordability", "efficiency", to name a few. The two cases reveal some interesting differences in ideational foundations, where there seems to be general agreement that health is a common good to be offered to all, whereas social assistance is strictly to be targeted to vulnerable and deserving groups. Thus, what might appear as a contradiction in the government's approach to social policy may rather be a reflection of the varying perceived aims of different types of social policies.

7. References

ANC (African National Congress). 1994. *A National Health Plan for South Africa, 30 May 1994*. Johannesburg: African National Congress.

Barchiesi, F. 2007. "South African Debates on the Basic Income Grant: Wage Labour and the Post-Apartheid Social Policy." *Journal of Southern African Studies* 33 (3):561-75.

Beresford, A. 2012. "Organised Labour and the Politics of Class Formation in Post-Apartheid South Africa." *Review of African Political Economy* 39 (134):569-89.

Blaauw, D., and M. Lagarde. 2015. *Uptake of Public Sector Sessional Contracts by Private General Practitioners in South Africa*: Resilient and Responsive Health Systems (RESYST).

Bond, P. 2014. "'Talk Left, Walk Right' in South African Social Policy: Tokenistic Extension of State Welfare versus Bottom-up Commoning of Services." SoBED Seminar Febuary 2014.

Bonorchis, R., and J. Kew. 2017. "How South Africa Stumbles on Health Care for All. 17 July 2017. https://www.bloomberg.com/news/articles/2017-07-27/how-south-africa-stumbles-on-health-care-for-all-quicktake-q-a."

Business Day. 2015. "No Remedy in NHI White Paper," 17 December 2015. https://doctorsportal.mediclinic.co.za/News.aspx?Period=Dec2015."

Coovadia, A. 2013. *Funding NHI: A Spoonful of Sugar? An Economic Analysis of the NHI*. South Africa: KPMG.

Council for Medical Schemes. 2016. *Council for Medical Schemes Annual Report 2015/16*. Pretoria: Council for Medical Schemes.

Deacon, B., M. Hulse, and P. Stubbs. 1997. *Global Social Policy: International Organizations and the Future of Welfare*. London: Thousand Oaks.

Devereux, S. 2007. "Social Pensions in Southern Africa in the Twentieth Century." *Journal of Southern African Studies* 33 (3):539-60.

Devereux, S. 2011. "Social Protection in South Africa: Exceptional or Exceptionalism?" *Canadian Journal of Development Studies/Revue Canadienne d'études du Développement* 32 (4):414-425.

Devereux, S. 2016. "Is Targeting Ethical? ." *Global Social Policy* 16 (2):166-181.

DSD. 2002. *Transforming the Present - Protecting the Future: Consolidated Report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa*. Pretoria: Department of Social Development.

Du Toit, A. 2012. *The Trouble with Poverty: Reflections on South Africa's Post-Apartheid Anti-Poverty Consensus. Working paper 22*. UWC Belville: PLAAS.

Esping-Andersen, G. 1996. *Welfare States in Transition: Social Security in a Global Economy*. London: SAGE.

Everatt, D. 2008. "The Undeserving Poor: Poverty and the Politics of Service Delivery in the Poorest Nodes of South Africa." *Politikon* 35 (3):293-319.

Freund, B. 2012. "The South African Developmental State and the First Attempt to Create a National Health System: Another Look at the Gluckman Commission of 1942–1944. ." *South African Historical Journal* 64 (2):170-186.

Friedman, S. 2012. "Beyond the Fringe? South African Social Movements and the Politics of Redistribution." *Review of African Political Economy* 39 (131):85-100.

Garay, C. 2007. "Social Policy and Collective Action: Unemployed Workers, Community Associations, and Protest in Argentina." *Politics & Society* 35 (2):301-28.

Global Health Observatory. 2017. *ANNEX B Tables of Health Statistics by Country, WHO Region and Globally, http://www.who.int/gho/publications/world_health_statistics/2017/EN_WHS2017_AnnexB.pdf?ua=1 (Accessed 15 August 2017).*

Gon, S. 2017. "The End of COSATU's Hegemony?" 14 June 2017, *PoliticsWeb http://www.politicsweb.co.za/news-and-analysis/the-end-of-cosatus-hegemony*.

Gordhan, P. 2012. *Budget Speech*. 22 February 2012. Cape Town: National Treasury."

———. 2011. *Budget Speech*. 23 February 2011. Cape Town: National Treasury.

Gough, I., and G. Therborn. 2010. "The Global Future of Welfare States." In *Oxford Handbook of the Welfare State*, edited by F. Castles, 741-58. Oxford: Oxford University Press.

Haggard, S., and R. Kaufman. 2008. *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe*. Princeton: Princeton University Press.

Hassim, A., M. Heywood, and J. Berger. 2007. "The Private Health Care Sector." In *Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-Apartheid South Africa*, 162-199.

Hlophe, S. 2013. *How Have Stakeholders' Interests Shaped the National Health Insurance in South Africa? An Evaluation of NHI: Stakeholder Analysis from 2002 to 2013. Department of Political Studies, University of Cape Town*.

ILO, (International Labour Organization). 2012. *Social Security to All: The Strategy of the International Labour Organization : Building Social Protection Floors and Comprehensive Social Security Systems*. Geneva: International Labour Organization.

Kahn, T. 2016. "Finance Commission Seeks Clarity on NHI Fiscal Effects across Government Levels", 6 April 2016, Business Day Live http://www.bdlive.co.za/national/health/2016/04/06/finance-commission-seeks-clarity-on-nhi-fiscal-effects-across-government-levels."

Korpi, W. 1983. *The Democratic Class Struggle*. London ; Boston: Routledge & K. Paul.

Korpi, W. and J. Palme. 2003. "New Politics and Class Politics in the Context of Austerity and Globalization: Welfare State Regress in 18 Countries 1975-1995." *American Political Science Review* 97:426-46.

Lorenzoni, L. , and T. Roubal. 2015. *International Comparison of South African Private Hospitals Price Levels OECD Health Working Papers, No. 85*. Paris: OECD Publishing.

Lund, F. 2002. "Social Security and the Changing Labour Market: Access for Non-standard and Informal Workers in South Africa." *Social Dynamics* 28 (2):177-206.

Lund, F. 2008. *Changing Social Policy. The Child Support Grant in South Africa.* Cape Town: Human Sciences Research Council.

Makgatho, A. 2015. *Making Sense of Stakeholder Responses to Impending Major Policy Reform in the Private Healthcare Sector*. Masters Thesis. Johannesburg: Gordon Institute of Business Science, University of Pretoria.

Malan, M. , and A. Green. 2016. "Motsoaledi Strikes Sack at NHI Critics", 22 January 2016, Bhekisisa http://bhekisisa.org/article/2016-01-21-motsoaledi-strikes-back-at-nhi-critics.

Manuel, T. 2009. *Budget Speech*. 11 February 2009. Cape Town: National Treasury.

Marais, H. 2011. *South Africa Pushed to the Limit: The Political Economy of Change*. Claremont: UCT Press.

Marks, S. 2014. "Reflections on the 1944 National Health Services Commission A Response to Bill Freund and Anne Digby on the Gluckman Commission." *African Historical Journal* 66:169-187.

Marten, R., D. McIntyre, C. Travassos, S. Shishkin, W. Longde, S. Reddy, and J. Vega. 2014. "An Assessment of Progress towards Universal Health Coverage in Brazil, Russia, India, China, and South Africa (BRICS)." *Lancet* 384:2164-2171.

Matsoso, M., and R. Fryatt. 2013. "National Health Insurance: The First 18 Months." *South African Medical Journal*, 103 (3):156-158.

Mayosi, B., and S. Benatar. 2014. "Health and Health Care in South Africa - 20 Years after Mandela." *N Engl J Med* 371:1344-1353.

Mayosi, B., J. Lawn, A. van Niekerk, D. Bradshaw, S. Karim, and H. Coovadia. 2012. "Health in South Africa: Changes and Challenges since 2009." *Lancet* 380 (9858):2029-43.

McIntyre, D., and A. Van den Heever. 2007. "Social or National Health Insurance." In *South African Health Review 2007*, edited by S. Harrison, R. Bhana and A. Ntuli. Durban: Health Systems Trust.

Mkandawire, T. . 2004. "Social Policy in a Development Context: Introduction." In *Social Policy in a Development Context*, edited by T. Mkandawire, 1-33. New York: Palgrave Macmillan.

Moe, T. 2015. "Vested Interests and Political Institutions." *Political Science Quarterly* 130 (2):277-318.

Naicker, P. 2016. "The Developmental Paradox: Examples from the Child Support Grant in South Africa." *Global Social Policy* 16 (2):212-14.

NDOH. 2015. *Status of NHI Pilot Districts. 12 Month Progress Report*. Pretoria: National Department of Health.

Nkosi, Z. 2014. *Narrowing the Health Gap for Greater Equity in Health Outcomes: The Discourse around the NHI System in South Africa*. Pretoria: UNISA.

O'Brien, R. 2002. "Organizational Politics, Multilateral Economic Organizations and Social Policy." *Global Social Policy* 2 (2):141-61.

Olson, M. 2003. *The Logic of Collective Action: Public Goods and the Theory of Groups.* Cambridge, Mass.: Harvard University Press.

Pamla, S. . 2015. "COSATU Welcomes the Release of the National Health Insurance.", 14 December 2015 White paper Congress of South African Trade Unions (COSATU) http://www.cosatu.org.za/show.php?ID=11229.

Pierson, P. 1994. *Dismantling the Welfare State?: Reagan, Thatcher, and the Politics of Retrenchment*. Cambridge, England: Cambridge University Press.

———. 2000. "Increasing Returns, Path Dependence, and the Study of Politics." *The American Political Science Review* 94 (2):251.

Plagerson, S., T. Hochfeld, L. Stuart, and P. Patel. 2017 (forthcoming). *Gendered Social and Economic Outcomes of Social Security in South Africa: Are they Redistributive and Transformative?* Geneva: United Nations Research Institute for Social Development.

Plagerson, S., and M. Ulriksen. 2015. *Cash Transfer Programmes, Poverty Reduction and Economic Empowerment of Women in South Africa. GED Working Paper no. 4/2015*. Geneva: Gender, Equality and Diversity Branch, Conditions of Work and Equality Department & Social Protection Department, International Labour Office.

———. 2017. *Assessing the Realisation of Socio-economic Rights: the Right to Social Security*. Johannesburg: Foundation for Human Rights.

Plagerson, S., and M.S. Ulriksen. 2016. "Can Social Protection Address Both Poverty and Inequality in Principle and Practice?" *Global Social Policy* 16 (2):182-200.

Rispel, L., and P. Barron. 2012. "Valuing Human Resources: Key to the Success of a National Health Insurance System." *Development Southern Africa* 29 (3):616-620.

RSA, (Republic of South Africa). 1996. *Constitution of the Republic of Africa. No 108 of 1996.* Pretoria: Republic of South Africa.

———. 2011. *Green Paper 2011. National Health Insurance in South Africa*. Pretoria: National Department of Health.

———. 2012. *Human Resources for Health South Africa, HRH Strategy for the Health Sector: 2012/13-2016/17*. Pretoria: National Department of Health.

———. 2015. *White Paper 2015. National Health Insurance for South Africa. Towards Universal Health Coverage*. Pretoria: National Department of Health.

———. 2016. *Budget Review 2016*. Pretoria: National Treasury.

———. 2017a. *Budget Review 2017*. Pretoria: National Treasury.

———. 2017b. *White Paper 2017. National Health Insurance for South Africa. Towards Universal Health Coverage*. Pretoria: National Department of Health.

Ruiters, G. , and R. van Niekerk. 2012. "Inequality and Health Systems in Context " In *Universal Health Care in Southern Africa*, edited by G. Ruiters and R. van Niekerk, 1-18 Scottsville: University of KwaZulu-Natal Press.

Ruiters, G., S. Shamu, and R. van Niekerk. 2012. "Competing Policy Choices and the Debate on National Health Insurance in South Africa." In *Universal Health Care in Southern Africa*, edited by G. Ruiters and R. van Niekerk, 21-40. Scottsville: University of KwaZulu-Natal Press.

Seekings, J. 2008. "Deserving Individuals and Groups: The Post-Apartheid State's Justification of the Shape of South Africa's System of Social Assistance." *Transformation: Critical Perspectives on Southern Africa* 68 (1):28-52.

———. 2013. *Democracy, Poverty and Inclusive Growth in South Africa since 1994. CSSR Working Paper No. 321. Available at http://www.cssr.uct.ac.za/sites/cssr.uct.ac.za/files/WP%20321.pdf, accessed on 31 December 2014*. Cape Town: Centre for Social Science Research, University of Cape Town.

———. 2015. *The 'Developmental' and 'Welfare' State in South Africa: Lessons for the Southern African Region. CSSR Working Paper No. 358*. Cape Town: CSSR, University of Cape Town.

Seekings, J., and H. Matisonn. 2012. "South Africa: The Continuing Politics of Basic Income." In *Basic Income Worldwide*, edited by M. Murray and C. Pateman. Palgrave Macmillan.

Seekings, J., and N.. Nattrass. 2002. "Class, Distribution and Redistribution in Post-Apartheid South Africa." *Transformation: Critical Perspectives on Southern Africa* 50 (1):1-30.

———. 2005. *Class, Race, and Inequality in South Africa*. New Haven and London: Yale University Press.

———. 2015. *Policy, Politics and Poverty in South Africa*. UK: Palgrave Macmillan.

Southall, R. 2004. "Political Change and the Black Middle Class in Democratic South Africa." *Canadian Journal of African Studies* 38 (3):521-42.

Surender, R. 2017. "The Drivers of Universal Health Care in South Africa: the Role of Ideas, Actors and Institutions " In *Towards Universal Health Care in Emerging Economies. Social policy in a Development Context*, edited by I. Yi. Basingstoke: Palgrave Macmillan.

Thelen, K. 1999. "Historical Institutionalism in Comparative Politics." *Annual Review of Political Science* 2:369-404.

Ulriksen, M.S. 2012. "Welfare Policy Expansion in Botswana and Mauritius: Explaining the Causes of Different Welfare Regime Paths." *Comparative Political Studies* 45 (12):1483-1509.

———. "The Politics of Inequality in Botswana and South Africa." In *Poverty and Inequality in Middle Income Countries: Policy Achievements, Political Obstacles*, edited by E. Braathen, J. May, M.S. Ulriksen and G. Wright, 104-22. London: Zed Books.

van den Heever, A. 2012. *Review of Competition in the South African Healthcare System*. Johannesburg, South Africa.

van der Berg, S. 1997. "South African Social Security under Apartheid and Beyond." *Development Southern Africa* 14 (4):481-503.

———. 2014. "Inequality, Poverty and Prospects for Redistribution." *Development Southern Africa* 31 (2):197-218.

van der Spuy, Z., T. Zabow, and A. Good. 2017. "Money isn't Everything - CMSA Doctor Survey Shows Some Noteworthy Results." *SAMJ* 107 (7):550-551.

van Niekerk, R. 2012. "The Historical Roots of a National Health System in South Africa." In *Universal Health Care in Southern Africa*, edited by G. Ruiters and R. van Niekerk, 41-54. Scottsville: University of KwaZulu-Natal Press.

WB, (World Bank). 2015. *The State of Social Safety Nets 2015*. Washington, DC: World Bank.

Weible, K., and L. Leisering. 2012. "South Africa's System of Social Cash Transfers: Assessing Its Social Quality." In *Sozialpolitik in Globaler Perspektive: Asien, Afrika und Lateinamerika*, edited by H. Burchardt, A. Tittor and N. Weinmann. Frankfurt/New York: Campus.

WHO (World Health Organization). 2010. *Health Systems Financing: the Path to Universal Coverage*. Geneva: World Health Organization.

———. 2017a. *Global Health Data Repository, http://apps.who.int/gho/data/view.main.HEALTHEXPRATIOCHN?lang=en (Accessed 17 August 2017).*

———. 2017b. "Global Health Expenditure database http://data.worldbank.org/indicator/SH.XPD.PRIV.ZS?locations=ZA (Accessed 14 August 2017)."

Woolard, I, K. Harttgen, and S. Klasen. 2011. "The History and Impact of Social Security in South Africa: Experiences and Lessons." *Canadian Journal of Development Studies/Revue canadienne d'études du développement*, 32 (4):357-380.

Yi, I., L. Koechlein, and A. de Negri Filho. 2017. "Introduction: The Universalization of Health Care in Emerging Economies." In *Social Policy in a Development Context*, edited by I. Yi. Basingstoke: Palgrave Macmillan.

Zuma, J. 2009. *State of the Nation Address. 3 June 2009.* Cape Town: The Presidency.

———. 2010. *State of the Nation Address. 11 February 2010.* Cape Town: The Presidency.

———. 2011. *State of the Nation Address. 10 February 2011*. Cape Town: The Presidency.

———. 2013. *State of the Nation Address. 14 February 2013.* Cape Town: The Presidency.

———. 2014. *State of the Nation Address. 13 February 2014*. Cape Town: The Presidency.

———. 2015. *State of the Nation Address. 12 February 2015*. Cape Town: The Presidency.

———. 2016. *State of the Nation Address. 11 February 2016*. Cape Town: The Presidency.

———. 2017. *State of the Nation Address. 9 February 2017*. Cape Town: The Presidency.