Macro

Budget Brief 2021
Preface

This budget brief is one of five that explores the extent to which the national budget and social services sector budgets addresses the needs of children under 18 in South Africa. For the 2021 Budget Brief series, three budget briefs are devoted to an analysis of progress in equity over the last decade (national, basic education, and social development), while two briefs are thematic contributions in the areas of prevention and early intervention in social development and child nutrition, as a cross-cutting issue for children.
Key messages and recommendations

The South African economy declined by 7.3% in 2020. This result and the decline in Gross Domestic Product (GDP) per person of 8.3% necessitated prudent use of government resources and a stern commitment to protect the social wage for children.

Over the 2021 MTEF, government budgets will be cut at a rate of 5.2% annually. None of the mainstay social services sector departments escaped budget cuts with Social Protection predicted to decline at almost 6% in real terms over the MTEF, while the Basic Education and Health functions are being trimmed by 3.9 and 4.3% respectively, over the same period.

Benefit incidence analyses show that Early Childhood Development (ECD) services for children aged 0-4 have doubled their national participation rates (from 17% in 2010 to 35% in 2019). Public clinics have a high participation rate among poor children and an overall utilisation rate of 77%. Public hospitals, due to their core mandates, are predictably used less frequently by children, especially poor children; and had a much lower national participation rate (7.0% in 2019); and, public school access for 7-17-year olds operates at scale (91% in 2019).

The general expansion in ECD for children aged 0-4 was good for all income groups. While the poorest quintile achieved a national participation rate of 9.2% in 2010, by 2019, more than 32% of eligible young children in that income group took part in some form of ECD services. Black African children’s participation rates increased from 17% in 2010 to 35% in 2019, while the participation rate for Coloured children grew from 15% in 2010 to 26% in 2019. Almost 60% of young White children had access to public or private ECD in 2019.
The Child Support Grant and the Care Dependency Grant showed strong real annual growth over the last decade and grew at more than 4% annually every year in the period 2010-2019. The largest access gains were achieved by the Child Support Grant, which grew from a 29% household base in 2010 to a 35% household base; receiving at least one Child Support Grant per family in 2019.

Public school per learner spending remained stagnant during the last decade, while provisions for primary healthcare for children grew at an impressive rate of 4.2% annually over the period 2010-2019. The benefit incidence analysis also showed a larger proportion of White learners exiting the public school system: in 2015, only 73% of eligible 7–17-year-old White children participated in the public schooling system, and that number was further whittled down to 66% in 2019. A similar trend was observed for learners from higher income groupings.

The present budget cuts present a real threat to the equity gains made over the last decade. In the context of government departments’ general challenge to maximise the use of resources, the immediate future for social service spending for children appears bleak.

In view of the need to sustain the equity gains and to address the concomitant quality challenge for public services, the national and provincial governments are encouraged to:

I. Recognise that each child service is unique, has different equity and quality challenges, and all governments must engineer a policy and financing response which is commensurate with children’s most immediate needs.

II. Carefully weigh the balance between expanding the grant base (extensive margins) and increasing the monetary value of the Child Support Grant (intensive margins) to bring such spending in line with the country’s Food Poverty Line.

III. Sustain investments in public clinics, which are used heavily by poorer children, while simultaneously working on efforts to improve the reach and quality of primary healthcare services for children, especially in rural areas.

IV. Re-think the stagnant growth in per learner spending in public schools and focus additional investments in quality learner support materials and teacher-centred quality interventions.
Section 1: Macro and Socioeconomic Context

MACRO TRENDS

South Africa’s real Gross Domestic Product (GDP) per capita of R55,000 in 2019 is hardly different from its comparable level in 2009, namely R53,000 (see Figure 1). In fact, between 2014 and 2019, the economy hardly got out of first gear and consistently achieved real negative GDP per capita growth rates. The health pandemic in 2020 did not help matters in any way and reduced the country’s GDP per capita by more than 8%.

National survey data shows that the country’s households did experience positive income gains between 2010 and 2015 (Figure 2a, b and c). What is encouraging are the positive gains for the poorest proportion of the population, and it is likely that the extension of the Child Support Grant (CSG) would have played some part in the elevated incomes for poorer households. The data also shows clearly that households in the middle of the income distribution did reasonably well.

The same good news does not extend to household consumption over the corresponding period. Between 2010 and 2015, most households experienced negative consumption rates and it would appear as if the decline was more severe for richer households. There are, however, large fluctuations in the consumption patterns for the poorest 20% of households, in that some managed to maintain their consumption between these two periods, while others experienced relatively large declines. The extent of the decline in consumption is more severe for rural households as opposed to their urban counterparts. The poorest rural households were in a considerably weaker position between 2010 and 2015 (see Figure 2c).

There is some evidence that national survey data under-represents the true extent of private household consumption. While there is a steady growth depicted in the national account data in Figure 3, the inflation-adjusted numbers suggest a population that has not been able to significantly increase its consumption levels. There is some correspondence, therefore, between national survey data and the country’s official national accounts. For the period 2016-2020, no significant real hikes can be observed in the data, and the pandemic shock of 2020, forced private household consumption levels back to their 2015 and 2016 levels.

Figure 1: Nominal and real GDP per capita and real change in GDP per capita, 2009 to 2020


ii. Yu (2012) provided a detailed treatment of the extent to which national survey income and expenditure match up to the national accounts data published by the South African Reserve Bank and presented evidence of various surveys, some of which capture income/consumption better than others etc. See Yu (2012) University of Stellebosch’s doctoral Dissertation Using household surveys for deriving labour market, poverty, and inequality trends in South Africa.
FIGURE 2A: Real growth of (per capita) household income between 2010 and 2015 (In constant FY2010 Rands)
Source: Income and Expenditure Survey 2010 and Living Conditions Survey 2014-15 (Own calculations)

FIGURE 2B: Real growth of (per capita) household consumption between 2010 and 2015, urban areas (In constant FY2010 Rands)
Source: Income and Expenditure Survey 2010 and Living Conditions Survey 2014-15 (Own calculations)
Note: The graph refers to growth in household expenditure per capita for urban households

FIGURE 2C: Real growth of (per capita) household consumption between 2010 and 2015, rural areas (In constant FY2010 Rands)
Source: Income and Expenditure Survey 2010 and Living Conditions Survey 2014-15 (Own calculations)
Note: The graph refers to growth in household expenditure per capita for rural households

FIGURE 3: Private household consumption expenditure, 2010 to 2020 (inflation-adjusted values)
Note: The 2010 to 2019 data are from the SARB, while the 2020 data point is from the World Bank

iii. This curve, known as the Growth Incidence Curve, is defined by the World Bank in the following manner: “...captures graphically the annualized growth rate of per capita income for every percentile of the income distribution between two points in time.” https://www.worldbank.org/en/topic/poverty/lac-equity-lab/economic-growth/growth-incidence-curve#:~:text=The%20Growth%20Incidence%20Curve%20(GIC,be-tween%20two%20points%20in%20time

iv. From the World Bank Data Indicator site, the following definition of private consumption expenditure: “...includes purchases and fees to governments to obtain permits and licenses. Here, household consumption expenditure includes the expenditures of non-profit institutions serving households, even when reported separately by the country.” See https://data.worldbank.org/indicator/NE.CON.PRVT.KD.ZG?locations=ZA
SOCIAL DEVELOPMENT TRENDS

Between 2016 and 2019, roughly one in every four households that contain children ran out of money to buy food according to a national survey data (see Figure 4). Over the same period, households that do not contain children experienced relatively high levels of cash shortages to buy food, but the percentages are still substantially lower than households with children in them. It is not clear whether the dip observed in the 2019 data is an artifact of the data collection processes in 2019, or whether this reveals a real reduction in this indicator, prior to the start of the COVID-19 health pandemic.

The NIDS-CRAM real-time survey data shows that household and child hunger levels have improved since the early days of the lockdown, where 23% of households and 15% of children reportedly went hungry (see Figure 5). The latest data suggest that household hunger levels hover at around 17%, while child hunger levels are sitting at 14%. These still represent high levels of food deprivation and will have severe consequences for the well-being of families and children if not mitigated immediately.

Children are consistently poorer than the rest of the population, due to the overall status of the household head (female-headed households) and because poor children tend to live in larger households with minimal incomes. Figures 6a and 6b show that 41% of children were likely to be food-poor in 2019 (versus 36% in the general population), while if one uses the inflation-adjusted upper-bound poverty line, then roughly 69% of children were poor versus a 60% poverty rate in the broader population.

**FIGURE 4:** Households’ ability to feed children, 2016-2019

*Source: General Household Surveys, 2016-2019 (Own calculations)*

*Note: The survey question reads “Did your household run out of money to buy food during the past 12 months?”*

**FIGURE 5:** Food insecurity and hunger in the NIDS-CRAM data (wave 1-5)

*Source: Van der Berg et al, 2021: 3v*

**FIGURE 6A** Inflation-adjusted food poverty lines, 2016-2019vii

**FIGURE 6B** Inflation-adjusted upper bound poverty lines, 2016-2019vii

*Source: General Household Surveys, 2016-2019 (Own calculations)*

*Note: The GHS’s household income variable contains lots of missing, zero, and unspecified incomes. In instances where no economic activity was indicated, household income was set to zero. However, unspecified incomes are likely to represent the incomes of richer households, and hence the estimates above might be upwardly biasedvi.*

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v. The question that was used in the NIDS-CRAM study to assess hunger levels for households is “In the last 7 days, has anyone in your household gone hungry because there wasn’t enough food?” whereas the child hunger question was phrased as “In the past 7 days, has any child in your household gone hungry because there wasn’t enough food?”


vii. The inflation-adjusted food poverty lines for South Africa were 2016 (R498), 2017 (R531), 2018 (R547), and 2019 (R561)


ix. The inflation-adjusted upper bound poverty line for the same period was 2016 (R1,077), 2017 (R1,138), 2018 (R1,183), and 2019 (R1,227)
Section 2: Government’s Budget Framework 2021 MTEF

The government’s consolidated budget is projected to decline at a real average annual rate of 5.2% (inclusive of debt service costs) and by 3.4% (exclusive of debt service costs). This represents a huge knock for the social sectors. The Social Development function is projected to shed 6.0% on average over the 2021 MTEF, while the Health and Basic Education functions decline at 4.3% and 2.5% respectively, over the same period (please see note on difference between the Budget Review and more detailed sector analyses). This is bad news for children’s services, because of the magnitude of the cuts and the extended period over which budgets cuts will continue to be made.

The concerted effort to reduce the wage bill explains the largest percentage of the planned budget cuts over the medium-term. When the Budget was released in February 2021, the government expected to reduce the consolidated wage bill by more than R300 billion over the 2021 MTEF. Subsequent wage negotiations and agreements in 2021 would have reduced the extent of that proposed saving. This may lead to further cuts in non-personnel and capital budgets, which are disastrous for key children’s services.

FIGURE 7: Consolidated government expenditure framework\(\text{x}^\text{x}\), FY2020 to FY2023 (in constant FY2020 Rands)

Source: Budget Review 2021 (own calculations)

Note: In the disaggregated and detailed analyses of basic education and social development spending, spending on basic education is projected to decline at 3.9% on average, whereas for social development (more restrictive than social protection), the planned reduction is 5.7% on average over the next three years (please consult the sector-specific budget briefs).

\(\text{x}\): Consolidated government spending includes provisions on the contingency reserve over the MTEF and allocations to public entities that are connected to departmental votes, but excludes debt service costs. This expenditure aggregate provides a more reliable indication of the total resources that are devoted to service delivery. This definition differs from our 2017 Budget series where we had excluded public entities from total consolidated government spending.

\(\text{xi}\): The numbers for basic education and social development are likely to be different compared to the more detailed sector analyses done in the sector-specific budget briefs.
The net effect of the large reductions is that for the first time in decades, child grants will not be benchmarked to the country’s prevailing consumer price inflation rate. The CSG is predicted to decline in real terms by approximately 7.0% over the MTEF, while the CFG and the CDG are projected to decline by 14.5% and 1.3%, respectively over the same period. The Old Age Grant is the only social grant that is predicted to sustain a small real average increase (0.3%) over the 2021 MTEF, even though it also takes a negative knock in FY2021.

In basic education, the provision for the national school nutrition programme is maintained, but this programme will grow by less than 1% in real terms over the 2021 MTEF. Surprising, however, is the strong real gains on the Education Infrastructure Grant (EIG), which is projected to grow by more than 9% on average over the next three years. Due to the labour-intensive nature of basic education and health, both sectors are projected to have significant cuts made to their respective wage bills.

The Budget Review 2021 noted that reductions in the health sector, focusing on compensation spending, are likely to be in excess of R50 billion over the next three years. In addition, health departments have been requested to prioritise efficiency savings.

<table>
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<th>FY 2022</th>
<th>FY 2023</th>
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<td>-20,562</td>
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**TABLE 1: Baseline reductions by economic classification over the 2021 MTEF period**

Source: Adapted from the Budget Review 2021

A strong real gain on the EIG is projected to grow by more than 9% on average over the next three years. Due to the labour-intensive nature of basic education and health, both sectors are projected to have significant cuts made to their respective wage bills.

Cuts in social service sector budgets have become the norm and will continue over the 2021 MTEF. Non-interest government spending is projected to decline at 3.4% annually for the next three years, while overall government spending is trimmed by more than 5% in real terms annually.

The planned reductions are focused on the government’s wage bill (R303 billion planned to be slashed), while provincial conditional grants and the significant reductions in social grant payments make up the largest portion of the remaining baseline reductions.

Departments’ operational budgets continue to be cut, thus raising questions about the viability of implementation, especially in programmes that serve children.

Spending on Basic Education will be reduced by 3.9% annually, while corresponding spending on Health and Social Protection is projected to decline at 4.3% and 5.9% annually.

**Takeaways**

- Cuts in social service sector budgets have become the norm and will continue over the 2021 MTEF.
- Non-interest government spending is projected to decline at 3.4% annually for the next three years, while overall government spending is trimmed by more than 5% in real terms annually.
- The planned reductions are focused on the government’s wage bill (R303 billion planned to be slashed), while provincial conditional grants and the significant reductions in social grant payments make up the largest portion of the remaining baseline reductions.
- Departments’ operational budgets continue to be cut, thus raising questions about the viability of implementation, especially in programmes that serve children.
Section 3: Progress in Equity for Children, 2010 to 2019

EVOLUTION IN PER REAL CAPITA SPENDING RATES ON CHILDREN’S SERVICES AND PROGRAMMES

During the last decade, per learner spending on public ordinary schools was maintained, whereas per child spending on the primary healthcare programme grew on average by 4.2%, inclusive of inflationary changes. The settled nature of the public ordinary school programme explains, in part, the stable spending, but investment in basic education did not enjoy the same level of prioritisation over the last decade. The graph also looks at the level of spending during the last decade and the rate at which spending grew in respect of the three child grants. The level of spending on the CSG was almost 50% higher than the corresponding figure in 2010, and a positive rate of growth (assuming no disruptions to spending) of 4.4% is expected on average over the ten-year period. A similar positive level and rate of growth was achieved for the CDG, while the CFG, due to policy changes, declined at an annual rate of 3.4% over the same period.

CHILDREN AND HOUSEHOLDS AND THEIR RATES OF PARTICIPATION IN CRITICAL SOCIAL SERVICES

Over the last decade, interesting and varied patterns of access to children’s services emerged. For public schools, the most affluent children were progressively less represented in public schools (migration to independent schools etc.), whereas children in affluent households have had a much larger share of access to (presumably private) ECD facilities. Notwithstanding this fact, the general expansion in ECD services meant that children in poorer households were also beginning to stake a claim on public and private ECD education.

Access to public hospitals (likely to be in the large metro areas) was dominated by children in richer households, whereas children in poor households enjoyed and maintained a disproportionate level of access to public clinics.

The national participation rates for public and private ECD grew from 17.6% in 2010 to 35% in 2019 (Figure 10). Children in the poorest quintile

FIGURE 8: Evolution in per capita spending rate on public schools, primary healthcare, and the three child grants: FY2010-FY2019 (In constant FY2010 Rands)


xii. This Budget Brief used both simple average growth rates (to establish whether the inflation-adjusted level of spending is higher/lower in later years) and a compound average growth rate (to establish the idealized rate at which spending would have grown over a ten-year period, ignoring all fluctuations etc.).

xiii. In this Budget Brief, the benefit incidence approach used focuses on frequencies. The more detailed sectoral briefs will monetise the access to services and calculate the distribution of fiscal benefits. “Shares of services” refers to weighted actual use/access to a service for a group (income, population, province etc.) over the weighted total pool of actual use/access to a service. “Rate of participation” refers to weighted actual use/access to a service for a group (income, population, province etc.) over the weighted total number of potential users of that service. Shares are consequently equal to 100 and rates of participation cannot exceed 1 (proportion) or 100 (percentage). The benefit incidence analyses were performed with the Distributive Analysis Stata Package (or DASP, version 2.3, 2013: A. Araar and J.Y. Duclos).

xv. The General Household Survey (2010, 2015, and 2019) was used to perform the benefit incidence analysis for public hospitals and clinics. It asked the question; “If anyone in this household becomes ill and decides to seek medical help, where do they usually go first?” The estimates from the GHS and the more detailed income and consumption surveys were not that different. For example, using the Living Conditions Survey 2015, public hospital utilisation rates for children were estimated as 5.3% versus 6.7% in the GHS 2015, whereas public clinics had a utilisation rate of 76% in the LCS and 77% in the GHS 2015.
improved their rate of participation from 9.7% in 2010 to 18.2% in 2015, whereas this group achieved a participation rate of 32% in 2019. This expansion in access to ECD for eligible children between the ages of 0 and 4 happened across all quintiles, which is indicative of a general expansion in access to public and private ECD services for very young children. Children between the ages of 0 and 17 have a high participation rate for attending public clinics (77.4% in 2019), and poorer children have participation rates that vary from 76% to 90%. The situation is reversed for public hospitals, where children have much lower participation rates overall, even though the more affluent children participate more in accessing public hospital services.xiv

White children between the ages of 7 and 17 have become less represented in the public schooling sector; declining from a 73% representation in 2015 to 66% in 2019. According to the 2019 data, Indian children are also less represented in public schools, whereas rates of participation for Black African and Coloured children have remained roughly the same over the corresponding period. White children between the ages of 0 and 4 have a relatively high participation rate in public and private ECD, growing from 36% in 2010 to 58% in 2019. However, Black African children in the same age grouping doubled their rates of participation in ECD, growing from 17% in 2010 to 35% in 2019. Black African and Coloured children have high participation rates for public clinics, ranging from 82% for Black African children in 2019, while roughly 55% of Coloured children had access to the same services in 2019.

**FIGURE 9**: Shares by income groups for public schools**, ECD, public hospitals and clinics: 2010-2019


Note: Hospitals and clinics refer exclusively to public facilities and ECD examines the 0-4 age grouping.

**FIGURE 10**: Rates of participation by income groups for public schools, ECD, public hospitals and clinics: 2010-2019


Note: Hospitals and clinics refer exclusively to public facilities and only the national participation rates per sector are labelled.

xiv The General Household Survey (2010, 2015, and 2019) was used to perform the benefit incidence analysis for public hospitals and clinics. It asked the question: “If anyone in this household becomes ill and decides to seek medical help, where do they usually go first?” The estimates from the GHS and the more detailed income and consumption surveys were not that different. For example, using the Living Conditions Survey 2015, public hospital utilisation rates for children were estimated as 5.3% versus 6.7% in the GHS 2015, whereas public clinics had a utilisation rate of 76% in the LCS and 77% in the GHS 2015.

xv The benefit incidence analysis was defined for child services in the following manner: Public school (attendance at a public school for a child between the ages of 7 and 17); ECD (attendance at an ECD institution for children between the ages of 0-4, inclusive of public and private ECD institutions); public hospitals and clinics (utilisation of any of these public facilities for children between the ages of 0-17). The population for schools was defined for the cohort 7-17 (and not 5-17); for ECD it was 0-4; and for public hospitals and clinics, it was children under the age of 18. Stata 13.1 was used as the general statistical package and the Distributive Analysis Stata Package (DASP, version 2.3) was run inside the Stata computing environment, to perform the benefit incidence analyses (focusing on frequencies).
COMPARING THE DISTRIBUTION OF ACCESS TO SERVICES FOR CHILDREN WITH THE DISTRIBUTION OF HOUSEHOLD INCOME

Children’s access to public clinics can be described as “absolutely progressive”, suggesting that poorer children enjoy a much larger share of this service compared to their richer counterparts. This appears to be the case for all three years represented in the panel to the right, even though the extent of that progressiveness was somewhat muted in the 2019 data. The pattern for public hospitals is more complex and although there was a degree of progressiveness to this service in 2015 and 2019; in both these years, the resultant concentration index was not statistically significant. Evidence that we shared around shares and rates of participation suggested that richer households make more use of this service, even though it is more progressively distributed than household income. Furthermore, apart from a strong negative index value achieved in 2010, for both 2015 and 2019, the concentration index for this variable appears negligible (see Figures 12a, b and c).

Public schools have been strongly progressive over the last decade and the reduced concentration index value for this variable in 2019 may reflect more on the quality of the data, rather than any real changes in access patterns to this service. Although access to public and private ECD can be described as relatively progressive in 2010 and 2015, the index value is negligible and in both instances is not statistically significant (see Table 3).

Earlier in the text, we commented on the large expansion drive in ECD provisioning, and the 2019 results appear to suggest that there were positive distributional effects as well. Although the ECD service has a statistically significant value in 2019, the concentration curve shows clearly that poorer children (especially in quintile 1) do not yet capture their full shares as expected.

Households that receive at least one CSG increased from 29% in 2010 to 35% in 2019. Household receipt of the CDG appear stable over the last decade ranging from 0.9% in 2010 to 0.6% in 2019. At least 1.0% of households appeared to have received the CFG in 2019, down from the corresponding figure of 1.5% in 2015 (see Figure 14).

FIGURE 11: Rates of participation by population groups for public schools, ECD, public hospitals and clinics: 2010-2019

FIGURE 14: Percentage of households that have received at least one child grant (Child Support Grant, Child Foster Grant, and Child Dependency Grant) in 2010, 2015, and 2019
**TABLE 2:** Gini and concentration indices for public hospitals and clinics in 2010, 2015, and 2019

Source: General Household Survey 2010, 2015, and 2019 (own calculations)

* Statistically significant at the 5% level

<table>
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<tr>
<th>Variable</th>
<th>2010</th>
<th>2015</th>
<th>2019</th>
</tr>
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<td>Per capita income (Gini coefficient)</td>
<td>*0.60</td>
<td>*0.64</td>
<td>*0.63</td>
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<tr>
<td>Public hospitals concentration indices</td>
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</tr>
<tr>
<td>Public clinics concentration indices</td>
<td>*-0.26</td>
<td>*-0.26</td>
<td>*-0.17</td>
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**TABLE 3:** Gini and concentration indices for public schools and ECD in 2010, 2015, and 2019


* Statistically significant at the 5% level

<table>
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<tr>
<th>Variable</th>
<th>2010</th>
<th>2015</th>
<th>2019</th>
</tr>
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<tbody>
<tr>
<td>Per capita income (Gini coefficient)</td>
<td>*0.68</td>
<td>*0.66</td>
<td>*0.63</td>
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<td>ECD concentration indices</td>
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<tr>
<td>Public schools concentration indices</td>
<td>*-0.18</td>
<td>*-0.20</td>
<td>*-0.11</td>
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xvi. The Gini index is a measure of inequality that examines the distribution of household income whereas the concentration index measures the distribution of access to services. Both inequality measures use an ordering variable such as per capita income and “apportions” income or access to services to the various income percentiles/deciles/quintiles etc.
Section 4: Equity for Children in the Last Decade: How Far Are We?

“EQUITY”: ITS DIFFERENT AND VARIED MEANINGS OVER TIME

Given the vastly different configurations, approaches and development in services and programmes that target children, poverty and budget data mean different things for different sectors. Public schools and the CSG (to a lesser extent) are arguably operating at scale, and equity will be less interpreted as “access” to services, but other dimensions of equity and quality will be invoked. In the case of public schools, equality and the quality of outcomes have been pushed to the foreground of policy debates, but academic and policy research that highlights quality issues has not yet made inroads as much as was expected.

Access to public schools and clinics proved more favourable for poorer children, and while public and private ECD is still dominated by children from richer households, children in poorer households are starting to catch up, at least in terms of access.

White learner numbers have dwindled in public schools and Indian learners are following suit.

Public hospitals appear to be used more by children who are in urban areas and who are from more affluent households. This may reflect the strong urban bias in the location of large and quality public hospitals.

The government has succeeded in extending the CSG to more households: in 2010, one in three households was a CSG household, and by 2019, 35 per cent of households received at least one CSG.

There is no rallying and coherent plan for the advancement of quality in schooling that affects the poorest of the poor.

The Child Support Grant has reached high levels of penetration and although there are still grounds for further expansion, equity could be tackled in two main ways. One, all eligible children should receive the grant, thus bringing the service up to the same level as public primary and secondary schools. Two, there is a strong argument for engaging the child grant on the intensive margins: raising the cash grant to at least the level of the country’s official food poverty line.

For ECD, “equity” still signifies an expansion of access for young children, especially in the poorest communities. While the recent gains of the sector are undeniable, the private ECD sector plays a significant part in expanding access, but it is important that the public sector continues to expand not only access, but that it also considers quality programming and interventions at the same time. If the latter is not given sufficient attention, then ECD programming risks reproducing the same unequal patterns as public primary and secondary schooling.
In primary healthcare, “equity” points to the strong participation patterns of poorer children in this service due in part to where most poor children are located (rural areas) and the greater efficiency gains associated with a service that is within easier reach of local communities. To sustain these gains, more public clinics should be made available, medicines should be available, and the necessary staff should be in place to provide much-needed services. At the same time, policy and government intervention should aim at improving the overall quality and efficiency of the service.

THE LIKELY IMPACT OF BUDGET CUTS ON PROGRESS IN EQUITY AND QUALITY IN CHILDREN’S SERVICES AND PROGRAMME

While budget cuts are likely to be implemented over a longer time horizon, it will have negative impacts for both the quality and equity agenda in delivering services to children. In summary:

• Public school interventions require the continuation of quality learner support materials and finding innovative ways of supporting the teaching process and teachers in the classroom. Budget cuts threaten to stop experimentation because there is not much money available for “untried” interventions.

• Budget cuts could lead to the halting of engaging the Child Support Grant on both the extensive margins (no serious incentive to add new beneficiaries rapidly to the system), and the intensive margins (affordability means that the monetary value of the CSG will remain unchanged).

• Continued ECD expansion requires not only a bricks and mortar approach, but it requires the education authorities to grapple with the issue of providing for children who are from disadvantaged backgrounds with a suite of interventions that would remediate some of their cognitive and socio-economic disadvantages. This includes quality ECD practitioners, the continuation of a dedicated school nutrition programme, quality health interventions, and a concerted attempt to reduce the unpredictable and violent environments within which many children operate.

• For the public hospitals and clinic services, to take their part in a future National Health Insurance (NHI) system, the system requires dedicated changes to improve their overall quality. If public clinics and hospitals enter the NHI equation in better shape, it could have serious implications for the pricing model and affordability of providing services to millions of South Africans. Budget cuts could delay the process of modernising and improving the quality of services of these public institutions.

To protect the value of services to children during a period of budget cuts requires innovation and efficiency in delivering services. Extant evidence paints a bleak picture of government departments’ ability to maximise the use of resources.

Takeaways

Continued budget cuts threaten both progress in equity and the quality agenda in basic education and public health.

After a decade of policy reform and implementation, child services and programmes require different type of interventions to consolidate and improve their overall efficiency, equity, and quality.

The range of much-needed interventions such as quality in schools and health delivery, extending child grants while raising the value of the Child Support Grant, and extending the benefits of public clinics to more communities, is dependent on stable financing flows.

Despite the plea for improved efficiency, extant evidence paints a bleak picture of the ability of government departments to maximise resources and obtain much-needed additional benefits for their core beneficiaries.


xviii. Between 2010 and 2014, the National Treasury used a Financial Management Capability Maturity Model (FMCMM) to assess the financial maturity of departments. By 2014, most national departments were moving closer to the compliance level (level 3), but this also means that the higher-level objectives of public financial management (effective and efficient use of scarce resources) were barely in sight. This was the same scenario for provincial governments where the bulk of children’s services and programmes are located. See the National Assembly “Question for Written Reply” 21 February 2014. http://www.treasury.gov.za/publications/other/MinAnsw/2014/Reply%20to%20PQ%20191%20[NW197E].pdf