Human conditions diagnostic

Introduction

Changes since the birth of constitutional democracy provide the basis for significant shifts and achievements in many areas of human development in South Africa. Yet despite many positive outcomes, social exclusion and alienation persist in poor, economically marginalised communities.

The legacy of racial, economic, gender and spatial exclusion continues to shape human development among South Africa's poor majority. New epidemiological and environmental disasters, and shocks and vulnerabilities arising from the recent global economic crisis, are grafted onto existing inequalities. New risks and vulnerabilities collide with old crises, stretching the resilience and capacities of households and communities to limits that are unsustainable and inhumane. The plight of millions of citizens who cannot overcome disease, who cannot get jobs, who live in squalor and who do not have enough food requires urgent attention.

South Africa's future is being shaped by internal and external factors. Changing global production and trade patterns affect employment and wellbeing in virtually every country. The unfair global trading regime, oil and fuel crises, and changes in information and communications technologies pose many challenges. Within South Africa, extremely high unemployment and underemployment have a particularly severe impact on those under the age of 35. Millions of working-age adults are structurally unemployed and live in households with no income. As a result, a great many South Africans depend on a relatively small number of wage earners, so that most working people live in poverty. The HIV/AIDS pandemic continues to take a tremendous toll. These factors, in combination with internal migration from rural areas to urban centres, and increasing regional labour migration, place pressure on limited social infrastructure and state capabilities to provide essential services.

This chapter analyses social and economic trends that have a significant impact on human development. The diagnosis draws on empirical evidence and research from a wide range of sources.

Overview of the human condition

Social and economic exclusions are both *outcomes* and *causes* of poverty and inequality. Race, class, gender and spatial inequalities combine with new risks and vulnerabilities to reduce the freedoms and opportunities available to the vast majority of South Africa's people. The economic landscape is characterised by rising wage inequality, deep working poverty and skewed distribution of resources.

In this context, is it possible for the majority of the population to achieve an acceptable standard of living? To what extent can this be achieved through a household's own

initiatives, especially private earnings from work or business, or through other means? To what degree must social protection provide a safety net to prevent people from falling into deeper poverty?

Poverty and inequality

Poverty has many dimensions that shape people's lives. Poverty in South Africa is most evident in the lack of opportunities for economically active citizens to earn a wage. Income poverty affects individuals and households in ways that are often degrading and lead to precarious lifestyles. However the linkages between income poverty and deprivations in health care, education and social infrastructure are direct, with devastating consequences for individuals and society. Deprivations in health and education are also linked to a lack of access to other assets such as housing, land, social infrastructure (such as clinics, schools, libraries and cultural resources) and services such as credit facilities. Without access to quality health and education and income-earning opportunities, the lives of the vast majority of the poor wage a daily struggle to simply survive.

Poverty

South Africa does not have a single official poverty line. Government uses US$2 a day or R524 a month per person (in 2008 prices, updated to 2010) as a rough guide. Using this indicator, the proportion of people living below the poverty line was about 53 percent in 1995; the figure subsequently varied, reaching 58 percent in 2001 and declining to 48 percent in 2008. By international standards, this is a very high level of poverty. Poverty among women-headed households is higher than the average and women continue to earn less than men, even though differences in years of education have largely been narrowed. About 61 percent of women live in poverty, and 31 percent live in destitution, compared with 39 percent and 18 percent of men respectively. The decline in poverty since 1995 has been relatively small given rising per capita income, a growing economy and significant social policy interventions (Bhorat & Van der Westhuizen 2011a).

Income inequality

There is good reason to be concerned about rising income inequality. Research by Wilkinson and Pickett (2009) shows that unequal societies tend to do worse on a range of socioeconomic indicators, including life expectancy, mental illness, obesity, educational performance, teenage births, homicides, imprisonment rates, levels of trust and social mobility. Other research shows strong relationships between levels of inequality and violence and crime, as well as the propensity for conflict and civil war (Collier 1998; Sen 2000).

Inequality in South Africa is reflected in the following ways:

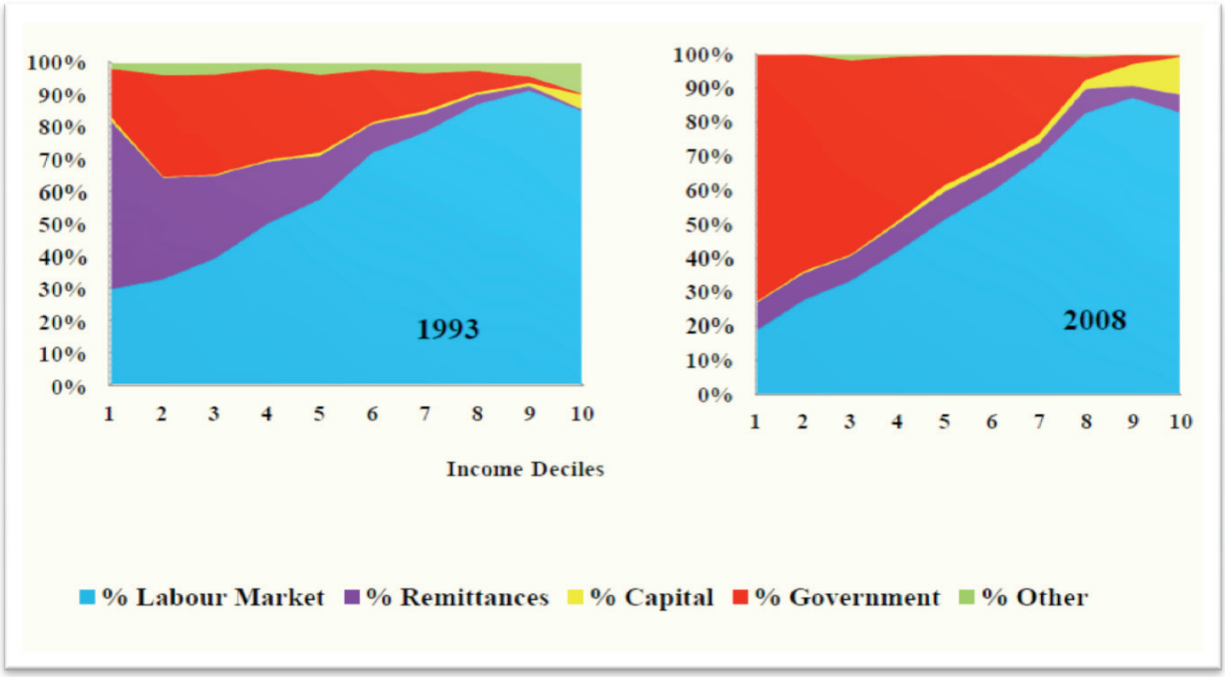
- In 1995, the poorest 20 percent of people earned an average of R1 010 a year (in 2008 prices) and the richest 20 percent earned an average of R44 336 a year. In 2008, the poorest 20 percent of people earned R1 486 a year and the richest 20 percent earned an average of R64 565 a year.
- In 1995, the poorest 20 percent of the population earned just 2.3 percent of national income, while the richest 20 percent earned 72 percent. By 2008, these figures had barely changed, with the poorest earning 2.2 percent of income and the richest earning 70 percent.
- In 1995, median per capita expenditure among Africans was R333 a month compared to whites at R3 443 a month. In 2008, median expenditure per capita for Africans was R454 a month, and for whites R5 668 a month.

- According to the Income and Expenditure Survey, the Gini coefficient, which measures the gap between richest and poorest, increased marginally from about 0.64 to 0.68 between 1995 and 2005. According to the AMPS data, the Gini coefficient has been broadly constant during this period at about 0.67. South Africa remains one of the world's most unequal societies.

Progress in changing the racial profile of earnings is only significant at the top of the income spectrum. The proportion of Africans in the top 20 percent of income earners has increased from 39 percent in 1995 to 48 percent in 2009 (Bhorat & Van der Westhuizen 2011b). Inequality within the African population has increased sharply highlighting the skewed distribution of opportunities (Leibbrandt et al 2010).

Figure 3.1 compares the different sources of income. The graphs chart the declining significance of labour market income (i.e. wages) in the three bottom deciles, which correspond to the poorest sections of the population, and the rapid escalation in the significance of grant income.

Figure 3.1: Income component shares of total income by decile



Source: Leibbrandt et al (2011)

As the figure suggests, poverty for the worst-off sections of the population would be far worse if social assistance grants were removed. A very different redistribution of wealth has taken place from the white corporate sector to the emergent black business sector in the form of black economic empowerment, estimated at R533 billion between 1995 and 2009 (The Presidency 2010).

Income and income inequality trends point to new processes of class development in the wake of apartheid. These trends demonstrate both the rapid growth of a black middle class and elite, and the maintenance, or even expansion, of an impoverished and destitute majority that is excluded from participation in the labour market and subsists on the social grant system.

South Africa has to answer whether this growth path is a desirable and sustainable. If not, what policies can promote a more egalitarian path of growth and human development?

Unemployment and youth marginalisation

Employment is one of the most effective ways of fighting poverty, tackling inequalities and enabling people to improve their quality of life. The lack of jobs is a major cause of poverty and inequality.

Despite the improvement in job creation between 1997 and 2008, unemployment remains very high. Employment increased from 11.1 million in 2001 to 13.6 million in 2008, and declined thereafter as a consequence of the global recession (The Presidency 2009). One of the biggest challenges facing South Africa today is that there is a very small number of working people (41 percent) in the adult population. In addition, earnings from work are low relative to the cost of living. High unemployment results in high dependency ratios, with many people relying on few wage earners. This results in a situation where the majority of working families live near or below the poverty line.

Gender differences in the South African labour market are still pronounced, with male unemployment rates lower, and absorption rates and labour-force participation rates for men higher than those for women. There is also skewed distribution of joblessness by race, with unemployment running at 30.0 percent for African men, 38.7 percent for African women, 4.0 percent for white men and 6.2 percent for white women.

Table 3.1: Unemployment by age group – official definition only (%)

Age cohort	2001	2002	2003	2004	2005	2006	2007	2008
15 – 24	53.4	55.9	55.3	51.8	51.4	50.2	46.9	46.6
25 – 34	34.4	34.1	30.9	29.8	30.3	28.5	25.7	26.2
35 – 44	19.8	21	18.7	18.2	18.2	18.2	14.7	16.6
45 – 54	13.9	16.1	13.5	11.9	13	12.4	11.5	9.3
55 – 65	10.6	10	8.9	7.2	8.3	6.9	6.7	6.5

Source: The Presidency (2009)

The sharpest end of the employment crisis is felt by South Africa's youth. About two-thirds of all unemployed are below the age of 35. Before the 2009–2010 recession, school leavers between the ages of 15 and 24 experienced unemployment rates of about 50 percent, as compared to one-fifth of those between 35 and 44 years. For black youth, this figure was closer to 65 percent. The majority of the job losses in the recession were experienced by those under the age of 30, and with less than a grade 12 education. The social cost of long-term unemployment is staggering: if a young person fails to get a job by the age of 24, they are almost never likely to get full-time formal employment.

South Africa risks having 60 percent of an entire generation of young people live life not having ever held a formal job. This time bomb is the single greatest risk to social stability in South Africa.

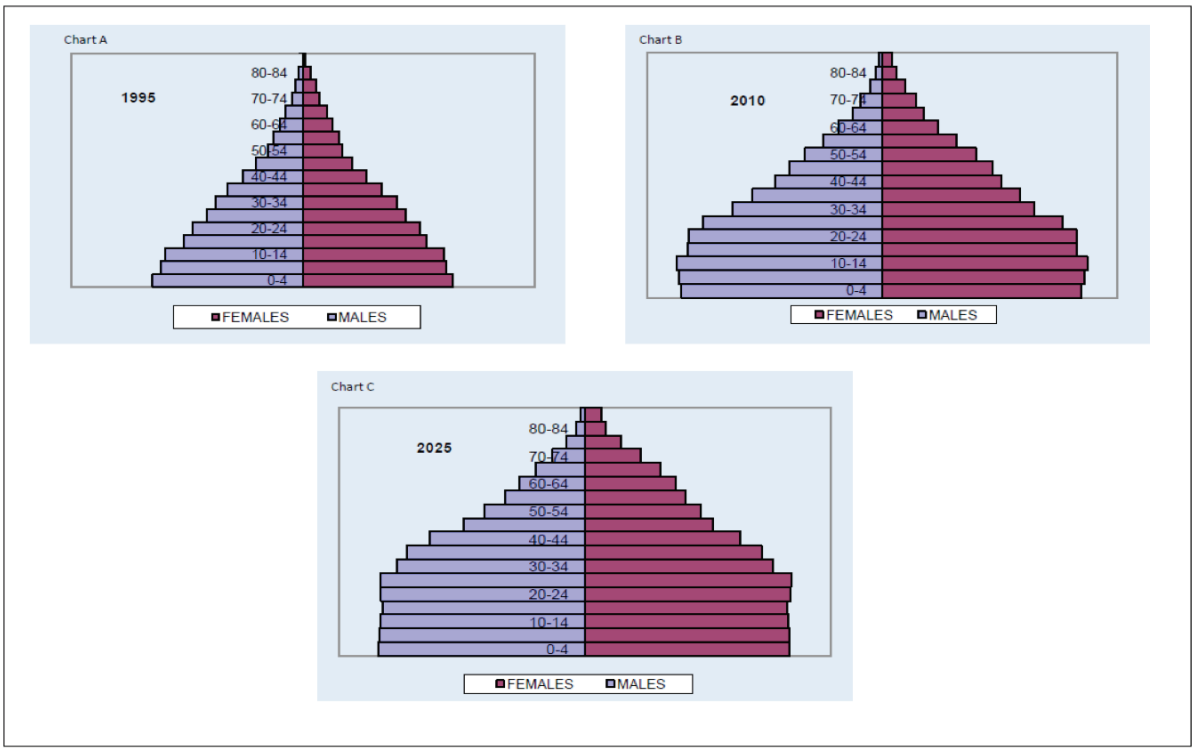
Demographic overview

Three primary demographic trends will inform the planning process. First, South Africa has a very large youth population. Second, the country is moving through this “demographic bulge” and it is expected that population growth will slow. Third, there is a population shift from rural to urban areas.

South Africa is a very young country, with more than two-thirds of the population under 35 and about a third under 15. About 52 percent of the population is female. About 44 percent of people live in two provinces – Gauteng and KwaZulu-Natal – which contain four of the country’s six metros, where the country’s population is concentrated. Given the youthfulness of the population, more careful attention must be paid to the development needs of youth, along with the school to work transition. This should include an analysis of where the youth are concentrated, their skills and educational levels, and how these match job openings.

The South African population grew from 32 million in 1985 to about 50 million in 2010 – an addition of 18 million people over a quarter century. The population is expected to grow more modestly over the next 15 years (Dutkiewicz, 2011). When comparing the population pyramids for the total population (Figure 3.2) it is evident that a profound demographic transition is under way, with a major decline in the proportion of young children. This will contribute to substantial decreases in the rate of population growth over the next 15 years.

Figure 3.2: Trends in the population pyramids for 1995, 2010 and 2025



Source: Dutkiewicz (2011)

Fertility rate measures the number of children, on average, that a woman will have in her lifetime. The fertility rate in South Africa has halved from 4.35 in 1985 to 2.42 in 2010 and is projected to be 2.11 in 2025. In 2025, almost the same number of children will be born, but in a population that is nearly twice the size (Ibid.).

Despite these projections, in the short to medium term young people constitute a significant proportion of the total population, and this must inform the distribution of resources and social services.

Households, communities and social reproduction

The changing structure of households is integral to our understanding of the human condition.

Household trends

Since 1994, broad social changes have affected individual members of households. High levels of migration affect community life in both "sending" and "receiving areas". In sending areas, with the changing profile of migrants, pensioners are left to anchor families and households with very limited income. In some areas of the population structure, there is a "missing middle" as a result of migration and HIV/AIDS.

Another trend that indicates the social transition underway is the change in household size, as shown in Table 3.2. Average household size has declined from 4.6 persons in 1996 to 3.9 in 2007, showing a shift away from extended family households. This varies across the country, with the highest average household size in KwaZulu-Natal (4.6 persons) and the lowest in Gauteng (3.3 persons).

Table 3.2: Trends in household size

Province	1996	2001	2007
Eastern Cape	4.9	4.2	4.1
Free State	4.2	3.6	3.5
Gauteng	3.9	3.2	3.3
KwaZulu-Natal	5.3	4.4	4.6
Limpopo	5.3	4.3	4.3
Mpumalanga	4.9	4.1	3.9
Northern Cape	4.6	3.7	3.7
North West	4.9	3.9	4.0
Western Cape	4.1	3.7	3.8
South Africa	**4.6**	**3.9**	**3.9**

Source: Statistics South Africa: Censuses 1996 & 2001, Community Survey 2007

The types of households, and relations within them, have also changed. The absence of one or both parents is one factor, and with more women becoming income earners, established lines of authority have been unsettled, and decision making and roles of members of households are brought into question. In parts of the country there are growing numbers of orphan-headed households, "skip-generation" households (with one or both parents

missing), single-parent households and children living in care. Institutions such as marriage and family are being challenged and redefined.

Hall and Wright (2010) show that there is a higher proportion of children in rural areas than urban areas. This confirms that working age people tend to migrate to urban areas in search of jobs, leaving children behind. Comparing levels of access to water, sanitation and electricity between adults and children, Hall and Wright find that on average, children's level of access is lower than that enjoyed by adults. Unless this situation is addressed, these young people will remain trapped in poverty.

An estimated 23 percent of all children in South Africa do not live with either of their biological parents. This varies throughout the population: 70 percent of white children live with both their parents, compared with 53 percent for Coloureds and 29 percent for Africans. Many government interventions intended to support children are targeted at parents, guardians and caregivers, and if children live on their own they have very little and usually no social benefits.

Children in households with no adults are vulnerable to crime, especially sexual and other forms of abuse. Other vulnerable groups include women, the aged and people with disability. They are exposed to many types of violence, particularly "interpersonal violence". The absence of functioning social institutions leaves households and communities to bear a disproportionate burden of care.

Communities

There are many variations within South Africa's economically deprived communities. In rural areas, traditional authorities wield an enormous amount of economic and social power and influence the opportunities and choices available to people, especially women. Livelihoods of people living in rural areas are determined by their access to communal lands and resources such as credit. Access to these assets is dependent on the traditional authorities or leaders in these areas. Constitutional democracy has not shifted control over land and other resources in large parts of rural South Africa. Informal and peri-urban areas often have hybrid forms of governance where traditional authorities co-exist with elected municipal governments. Such power relations create complex interactions, and create hierarchies of vested interest and patronage that influence both household and community life. Patriarchy is mediated through access to and control over land and other resources in rural areas.

Low-income townships and residential settlements in urban areas are also not designed to create neighbourhoods of trust, mutual respect and interdependence. The geography of apartheid is still apparent in many of these settlements, which were designed as labour dormitories rather than places to promote integrated human development.

Within these economically fragile communities there are systems of support that test the resilience of its members as people cope with the impacts of HIV/AIDS, interpersonal violence and other social pathologies. Forging new relations based on their everyday struggles to survive youth, civic movements and other grassroots formations are mobilising support to change their conditions. Economic hardship and marginalisation create conditions in which the slightest perceived threat to their fragile security results in violence. This was especially evident during the widespread xenophobic attacks against those who were perceived as foreigners. Issues of community and neighbourhood support systems are crucial to promoting human development.

Social reproduction

Households inculcate values, build social capital and trust, and provide intergenerational support. Typical patterns in the care of the elderly, the care of children and the care of people with disabilities by women no longer apply as more women enter the economy in search of work. Under these circumstances, the unpaid work of women in social reproduction has to be substituted with other social arrangements. Unlike communities with adequate clinics, schools and community centres, economically deprived communities experience the worst forms of neglect and social disintegration in caring for the elderly, the sick and so on.

Decades of labour migration and displacement as a result of apartheid led to the wanton breakdown of family life, and distortions in urban and rural households. Contemporary household types show that male migration to urban areas is matched by female migration, and that social reproduction in South African society is a function of both male and female heads of households. Of particular concern is not the gender of the head of household but rather their age, as a result of the HIV/AIDS pandemic, which has led to more households being headed by orphaned children.

The care and development of people within households and within communities is being eroded. The demands placed on communities in the absence of adequate health care and support services to deal with poverty and HIV/AIDS are beyond their capacities. Such situations spawn new vulnerabilities and risks to young and old, male and female. *Interpersonal violence*, ranked as the second highest cause of morbidity in South Africa, is more prevalent in poor households, as is crime.

Migration

South Africa's major cities have experienced significant population growth since the removal of influx controls, and this trend has accelerated since 1994 as people search for work and better services.

Research suggests a decline in the number of temporary migrants, from about 2 million in 2002 to 1.5 million in 2008, which may mean that more people are migrating permanently (Posel 2010). The profile of migrants has also changed with an increase in the number of female migrants, migrants with higher levels of education and more married people.

The African Centre for Migration Studies (2010) identifies the main forms of vulnerability that migrants face as "risks of unemployment, poor access to services and capital, and insecurity due to collective violence, criminality, and harassment by state representatives". In formal settlements migrants feel excluded because they are not part of the established networks and community structures; while in informal settlements, migrants face significant insecurity as they risk being moved by authorities, which makes it harder to build an asset base, makes their livelihoods more precarious and creates competition for very limited resources and opportunities. Migrants have demonstrated a survivalist capacity under extremely difficult circumstances. Their resilience, creativity and adaptability in instances where formal networks are not accessible is remarkable.

Households and nutrition

Household hunger has fallen dramatically since 2001. In 2002 according to the General Household Survey (Statistics South Africa 2003a), 20 percent of children and 25 percent of adults said that they were hungry "sometimes", "often" or "always". By 2007, 12.2 percent of

children and 10.6 percent of adults said they were hungry. However, malnutrition is widespread. With the exception of folic acid, which helps the body to grow healthy cells and is vital for pregnant women, micronutrient counts have not improved dramatically. Stunting (inadequate growth in height) affects one out of five children, and improved marginally between 1999 and 2005. This is a sign of chronic malnutrition. In 2005, one in 10 children was underweight for their height. Under-nutrition has a major impact on the health of women, particularly the one-third of young women who are HIV positive.

Comprehensive social protection: A response to poverty and inequality

The Constitution places an obligation on government to provide citizens with social security. Social security combines social assistance – usually in the form of government transfers or a social wage – as well as social insurance in the form of work-based or private contributions made through private arrangements. Social protection includes social assistance, social insurance and measures such as livelihood strategies.

South Africa adopted a comprehensive social protection strategy to better address the needs of those living in structural poverty as well as those at risk of falling into deeper poverty. As a strategy it aims to address present needs by raising the incomes of the poorest sections of the population and to enhance future opportunities by ensuring access to education, health care, social welfare services and livelihood options. Such social transfers enable people to develop their capabilities through having access to a minimum standard of living or a social wage. Countries with sound social protection systems are better able to manage risks and vulnerabilities (Taylor 2008).

South Africa has a well established non-contributory social security system that provides social insurance for those who are in paid employment, and those members of society who have access to other forms of income and can make provision against illness, disability or unemployment, retirement and other contingencies. The social security system has gone through extensive reforms since 1994, leading to new and amended legislation to regulate social assistance and social insurance, including medical aid, unemployment insurance and pension fund arrangements. Government has adopted an approach that is consistent with comprehensive social protection and, at a policy level, sees health care, education, work-related benefits, social assistance in the form of cash grants and programmes to address poverty as part of its overall response.

Policy and legislative reforms of social security are matched by significant budget allocations to extend social security in the form of social grants to those who qualify. As a share of GDP, the social assistance programme has grown from 2.9 percent in 2003/04 to 3.5 percent in 2009/10 (The Presidency 2010). The child support grant reaches the largest number of households. Estimates by Leibbrandt et al (2010) suggest that about 2.9 million children who are in need are not receiving the grant. Of these, 2.4 million have never applied for a grant. One of the main reasons cited for not applying for the grant is not having the right documents.

Impact of social grants on household poverty

The available data shows the significant progressive impact of the expanded grant system for households and individuals in the impoverished sectors of the population. If cash transfers were removed, poverty would rise from 54 percent to 60 percent (Leibbrandt et al 2011).

Gains from the extensive reach of social grants, especially the child support grant, are well documented.[1] The gains include at an aggregate level reduced poverty and inequality, as well as improvements in school attendance and hunger reduction. Qualitative research demonstrates that grants enhance reciprocity within households, local investment, trade, household care work and the functioning of informal networks that complement formal social assistance.

When combined with other government cash transfers to children and specific categories of people the impact of South Africa's social grant system reduces the "destitution gap" by 47 percent (Taylor 2008). International studies show that more than half of additional income (such as remittances, government cash transfers and social pensions) is allocated by poor families to increased food consumption (Pinstrup-Andersen & Padya-Lorch 2001, cited in Taylor 2008). The resulting improvements in health and nutrition directly improve wellbeing and productivity.

Long-term planning challenges include ensuring that those young people over 18 years are able to make the transition into work or further education and training and do not fall back on the social assistance system. Growth in social assistance beneficiaries will not outstrip population growth given South Africa's demography. Other challenges include the lack of coverage of adults who are not earning wages and who are under 60 years and exclusions of poor people from income support because of means tests and administrative problems.

Livelihoods and survivalist strategies

Government has rolled out several programmes to create short-term jobs and promote livelihoods among South Africa's poorest sectors. They include:

The expanded public works programme created an estimated 1 million short-term jobs during its first five years (2004/05–2008/09). However, the jobs were of very limited duration and little training was offered. The programme was extended in 2009. Phase 2 aims to create 2 million jobs of short and longer duration by 2014. Much of the programme is centred on municipal infrastructure projects, as well as work in areas such as home-based care and early childhood development.

The community work programme aims to create jobs and incomes in marginalised communities for as long as these are required, and guarantees employment of a minimum of eight days per month at the wage level of R60 per day. Given a lack of state capacity, it is generally rolled out by non-governmental organisations in association with local government. The programme targets 1 000 participants per site and aims for high labour intensity on such socially necessary work as public infrastructure and parks. Government intends to create these projects in every municipality by 2014.

Rural livelihoods. About 2 million people living in the communal land areas of the former Bantustans are involved in some form of subsistence agriculture, with an unknown but much smaller number practising viable smallholder semi-commercial agriculture. About 17 million

[1] For example: (a) Department of Social Development, SASSA and UNICEF (2010), *Child Support Grant Evaluation: Qualitative Research Report*, Pretoria; (b) Financial and Fiscal Commission and UNICEF (2010), Impact of the International Financial Crisis on Child Poverty in South Africa, Pretoria; (c) Department of Social Development and UNICEF (2010), *Vulnerability of Children and poor Families to the Economic Recession of 2008-2009*, Pretoria; (d) Department of Social Development, SASSA and UNICEF (2008), Quantitative Analysis of the Impact of the Child Support Grant, Pretoria; (e) Department of Social Development, SASSA and UNICEF (2008), Qualitative Analysis of the Impact of the Child Support Grant, Pretoria; (f) South African Human Rights Commission and UNICEF (2011), South Africa's Children: A Review of Equity and Child Rights, SAHRC, Pretoria; (g) UNICEF (2010), Discussion Paper on Equity and Child Rights in South Africa, Pretoria.

people live in these areas. Government's land restitution and land reform programmes are targeted in commercial farming areas. Very little attempt has been made to build on the potential for farmworkers, who have the necessary agricultural skills, as beneficiaries of land reform, nor has the potential for urban and peri-urban agriculture been adequately explored.

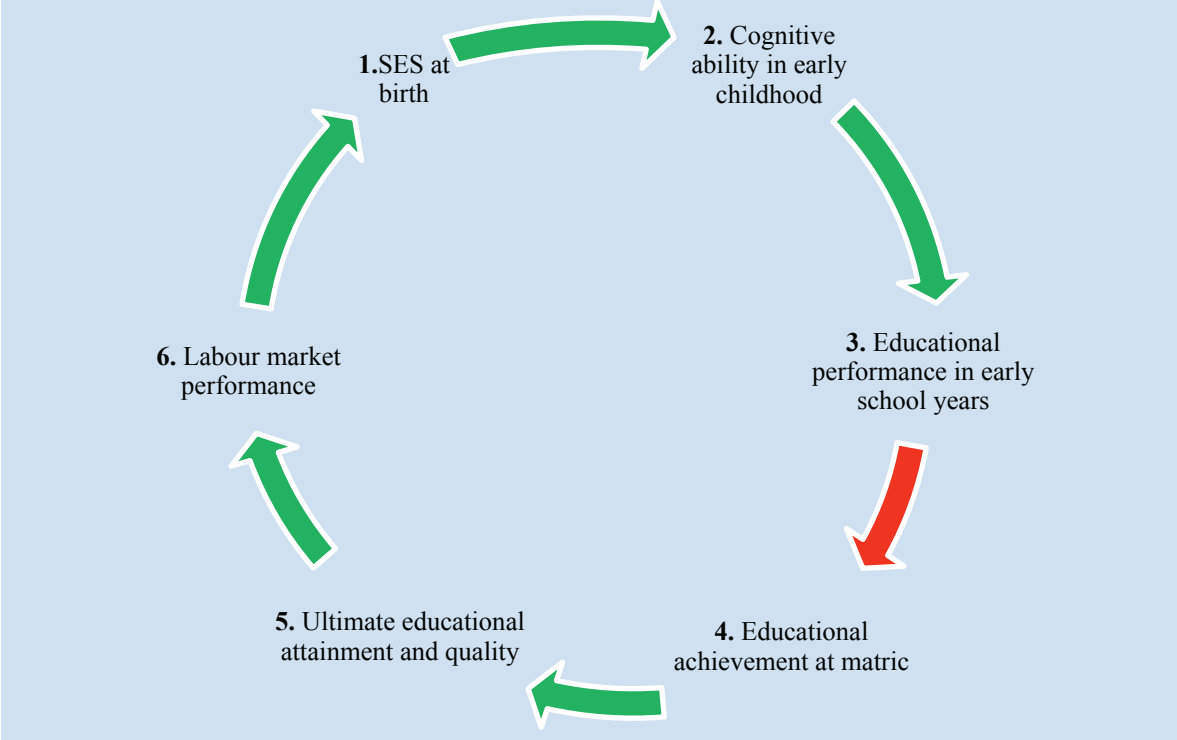
Education and skill development

Education

Education is a key factor in development. Good education provides access to the top end of the labour market and facilitates social mobility, while poor education perpetuates the skills shortage at the top end, causing a wage premium. The large number of low-skilled workers depresses wages at the bottom end. This combination contributes to the exceptionally high level of income inequality in South Africa.

Investment in education is also important in developing responsive and active citizens who can play a role in local governance, community development and other local initiatives.

Figure 3.3: The relationship between education and individual prospects



Source: Van der Berg (2011)

Education is one of the Millennium Development Goals (MDGs) and features prominently in South Africa's Constitution. South Africa has implemented a number of progressive policies to ensure a realisation of the MDGs. This includes compulsory education for children aged seven- to 15-years old or up to Grade 9; the National School Nutrition Programme, which feeds roughly 6 million learners in 18 000 primary schools throughout the country; the introduction of Grade R for children turning five; and exemption from school fees and a no-fee policy for the poorest 40 percent of schools. South Africa has done well in extending access to education and has met MDG targets in this regard.

Education receives the single largest share of total government expenditure. As a proportion of GDP, South Africa's expenditure on education in 2010/11 will be 5.8 percent (R165 billion)

up from 5.1 percent (R105 billion) in 2007/08. National average allocation per learner has also increased from R6 295 in 2005/06 to R11 192 in 2010/11, with the equalisation of per capita government expenditure between races achieved. Differences on expenditure per learner remain between private schools, some public schools that charge school fees and no-fee schools.

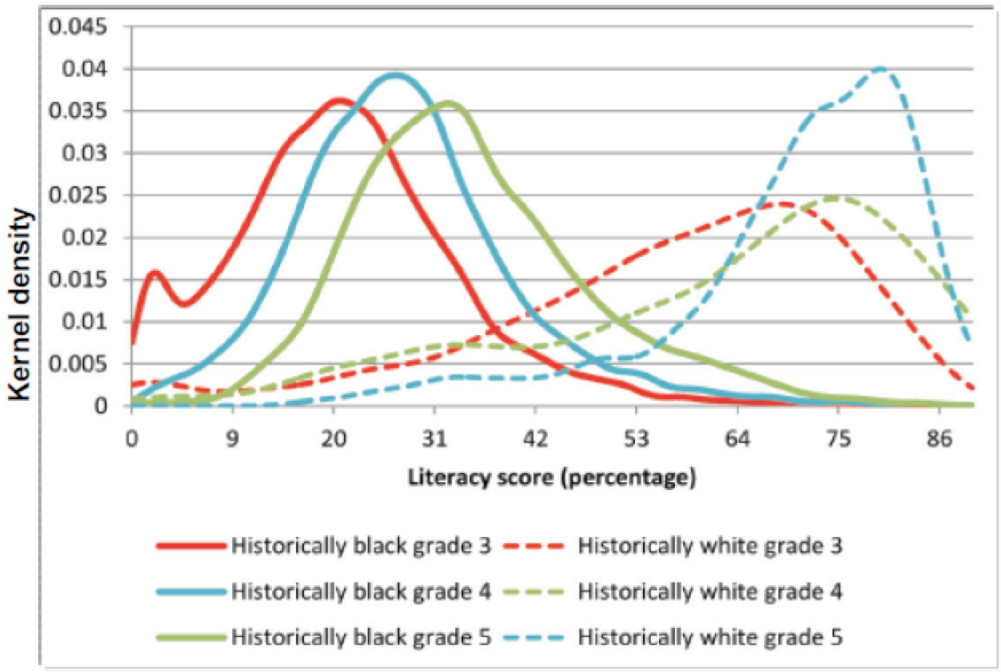
The education system caters for just over 14 million learners, of whom about 12 million are in ordinary schools, with others being in independent schools, further education and training colleges, and public universities. Public schools cater for over 96 percent of all learners in ordinary schools. In 2007, the gross enrolment ratio was 98 percent for grades 1 to 7, suggesting near universal coverage, and 85 percent for grades 8 to 12, reflecting a higher dropout rate before learners complete grade 12.

Although the pass rate of those who sat the matric exam was 67.8 percent in 2010, this hides the fact that only 15 percent achieved an average mark of 40 percent or more. This means that roughly 7 percent of the cohort of children born between 1990 and 1994 achieved the 40 percent or more standard (Department of Basic Education 2011, Sheppard 2009).

The phasing in of a reception year (Grade R) has resulted in a huge increase in the participation rate of five- and six-year olds. In 2007, 80.9 percent of five-year olds were enrolled in an educational institution compared to 45.6 percent in 2001 and only 22.5 percent in 1996 (Taylor et al 2008).

Despite the policy emphasis on education and the significant resources allocated to education, the system is grossly underperforming (Van der Berg 2011). Several comparative studies show that South Africa's educational outcomes are poorer than many poorer countries. Apart from a small minority of black children who attend former white schools and a small minority of schools performing well in largely black areas, the quality of education received by African learners remains poor. Literacy and numeracy test scores are low by African and global standards, despite the fact that government spends about 6 percent of GDP on education and South Africa's teachers are among the highest paid in the world (in purchasing-power parity terms).

Figure 3.4: Reading scores by former school type, 2007



Source: v*an der Berg et al (2010)*

Figure 3.4 shows a distribution of learners' literacy scores by education department before 1994 and by grade. It shows that learners in historically white schools perform better, and that the scores improve with successive years of schooling. In black schools, the learner scores start off lower, and show relatively little improvement between grades 3 and 5.

Learner performance is not solely determined by what happens in school. A child's deductive ability is formed before they enter school. Influencing factors include the presence of both parents in the household, whether parents can read and write, the prevalence of books in the house, adequate nutrition and micronutrient intake, and generally stimulating environments for children.

The physical environment in schools matters. The quality of physical assets at a school level remains highly unequal, though some progress has been made in narrowing the gap. There are still many children who learn in schools without toilets, electricity, desks or chalkboards. In 2009 the number of schools without electricity stood at roughly 2799, 412 schools are entirely mud-structures while 706 schools lacked adequate sanitation.

Post-school learning and training opportunities

About 1 million young people exit the schooling system annually, of whom 65 percent exit without achieving a Grade 12 certificate (JET 2011a). Half of those who exit the schooling system do so after Grade 11, either because they do not enrol in Grade 12 or they fail Grade 12. However, only a small number of those who leave the schooling system enrol in FET colleges or have access to any post-school training. In 2011 only 115 000 enrolled in general vocational programmes in FET colleges. The FET college system is characterised by limited growth in enrolments and poor throughput rates. The net effect of this is that access to post-school education and training is limited for school leavers. The few that access post-school education and training opportunities are not sufficiently prepared for the workplace due to poor quality of education and training provided.

The challenge facing post-school education in South Africa is to find ways to assist the vast majority of school leavers who do not qualify for direct entry into higher education or employment.

Higher education

South Africa's public higher education system consists of 11 universities, 6 comprehensive universities and 6 universities of technology. The full spectrum of opportunities is available across these institutions, from doctoral programmes at universities to career-oriented diplomas at universities of technology. As of July 2009 there were 103 registered and provisionally registered private higher education institutions in South Africa, offering mostly certificate and diploma programmes and bachelor's degrees (12 offered master's level programmes and three doctoral programmes).

The student enrolments in South Africa's public higher education sector increased over the period 2000–2008. Headcount student enrolment total in the public higher education system increased by 242 000 (or 43 percent) and the full-time equivalent enrolment by 152 000 (or 39 percent).[2] In 2008, 86 percent of learners enrolled were in undergraduate programmes, while master's and doctoral enrolment was only 6 percent. Student enrolment has been increasing by an average of 4.6 percent per year, compared with 1.5 percent average annual increases in permanent academic staff, resulting in the full-time equivalent student-to-staff ratio rising from 20:1 to 26:1 between 2000 and 2008. The under-preparedness of many learners entering higher education places demands for support programmes that many universities find increasingly difficult to meet.

The table below shows benchmark graduation rates (set by the National Plan for Higher Education) and rates achieved in 2009.

Table 3.3: Student throughput in higher education

Programme	Benchmark graduation rate	Achieved graduation rate 2009
3-year undergraduate	25%	16%
Masters	33%	19%
Doctorate	20%	13%

Source: Badsha (2011)

Qualifications awarded grew by 6 percent between 2000 and 2009. Yet a cohort study of the 2000 student intake after five years found that 65 000 students were lost from this cohort alone: only 30 percent graduated, and 56 percent had left the original institution without graduating, while 14 percent were still in the system (Badsha 2011). "African graduates as a percentage of all graduates decreased from 58 percent in 2000 to 53 percent in 2008" (JET 2011b: 37), indicating the persistence of the shadow of apartheid in higher education outcomes.

[2] Headcount enrolment is the total number of students registered for any number of courses irrespective of duration and full-time equivalent is a unit to measure students in a way that makes them comparable although they may study a different number of hours per week.

Substantial shifts have occurred in the public higher education system's race and gender profile. The share of African students in headcount enrolments rose from 58 percent in 2000 to 65 percent in 2008, while the proportion of white students fell from 30 percent in 2000 to 21 percent in 2009. The proportion of female students in the system grew from 52 percent in 2000 to 56 percent in 2008.

Race remains a major determinant of the graduation rates. There are some differences between traditional (contact) and distance universities such as UNISA. For contact universities in almost all areas, the black student completion rate is less than half the white student completion rate. The figures are particularly bad for first-generation students, of whom only one in five graduated in regulation time. The difficulties black students and first-generation students have in completing their degrees on time has major implications for social mobility and the effectiveness of the education system.

Despite the significant increases in enrolment a number of challenges remain. Throughput rates have not improved as fast as enrolment rates. The poor quality of the public schools system has transferred the problem to an ill-equipped university system that is failing to cope with the increased number of learners and demands for academic support. The net effect is a system that is not able to produce the number and quality of graduates needed by the economy.

Health

South Africa has more information and data on its health system than most developing countries, and certainly sufficient data to identify shortcomings and failures as a precursor to strengthening health services.

The quadruple burden of disease

The challenge presented by the high burden of disease has been rigorously reviewed in *The Lancet,* which devoted its August 2009 edition to South Africa's health situation. The articles present a picture of a country in the grip of four simultaneous epidemics aptly referred to as the "quadruple burden of disease". The first burden is the HIV/AIDS pandemic; the second is that of injury, both accidental and non-accidental; the third consists of infectious diseases such as tuberculosis, diarrhoea and pneumonia, which interact in vicious negative feedback loops with malnutrition and HIV; and the fourth is the growing incidence of lifestyle diseases related to relative affluence. These burdens are reflected in the morbidity statistics presented in Table 3.4.

Like many middle-income countries, South Africa has to grapple simultaneously with the diseases of poverty and affluence, but the inequalities in access to health care means relatively more is spent on the diseases of affluence than of poverty.

Table 3.4: Leading causes of morbidity and selected risk factors, South Africa 2000 (by Disability Adjusted Life Years)

Rank	Disease, injury or condition	% total DALYs	Rank	Risk factor	% total DALYs
1	HIV/AIDS	30.9	1	Unsafe sex/sexually transmitted infections	31.5
2	Interpersonal violence injury	6.5	2	Interpersonal violence (risk factor)	8.4
3	Tuberculosis	3.7	3	Alcohol harm	7.0
4	Road traffic injury	3.0	4	Tobacco smoking	4.0

5	Diarrhoeal diseases	2.9	5	High BMI (excess body weight)	2.9
6	Lower respiratory infections	2.8	6	Childhood and maternal underweight	2.7
7	Low birth weight	2.6	7	Unsafe water sanitation and hygiene	2.6
8	Asthma	2.2	8	High blood pressure	2.4
9	Stroke	2.2	9	Diabetes (risk factor)	1.6
10	Unipolar depressive disorders	2.0	10	High cholesterol	1.4
11	Ischaemic heart disease	1.8	11	Low fruit and vegetable intake	1.1
12	Protein-energy malnutrition	1.3	12	Physical inactivity	1.1
13	Birth asphyxia and birth trauma	1.2	13	Iron deficiency anaemia	1.1
14	Diabetes mellitus	1.1	14	Vitamin A deficiency	0.7
15	Alcohol dependence	1.0	15	Indoor air pollution	0.4
16	Hearing loss, adult onset	1.0	16	Lead exposure	0.4
17	Cataracts	0.9	17	Urban air pollution	0.3

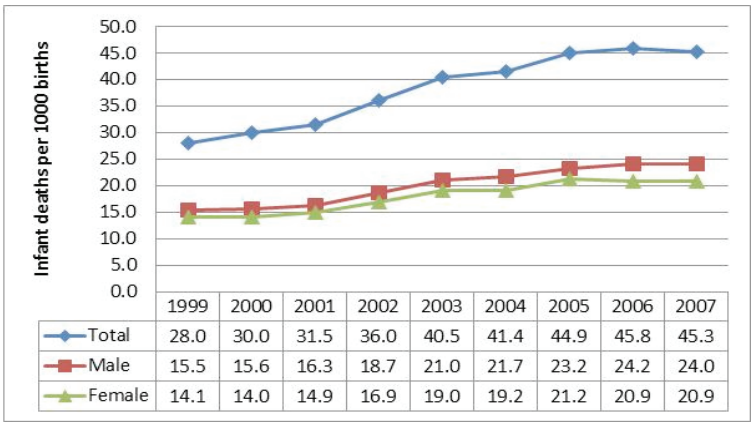
***Source**: The Lancet (August 2009)*

The disability-adjusted life year (DALY) measures the overall disease burden expressed as the number of years lost due to ill-health, disability or early death. Table 3.4 shows the contribution of different factors to a number of years lost in South Africa.

The number of births has been increasing over the past 10 years, but so too has the infant mortality rate. Overall mortality rates in the population have also been growing rapidly – but more quickly for women than for men, with the result that the gap between male and female mortality rates has been narrowing.

Figure 3.5: Births per year 1999 to 2009 and infant mortality ratio per thousand births

Year	Births		
	Total	Male	Female
	1	2	3
1999	951 381	475 985	475 396
2000	962 695	482 170	480 525
2001	946 513	474 134	472 379
2002	956 204	478 656	477 548
2003	948 083	476 091	471 992
2004	999 638	502 474	497 164
2005	1 033 695	519 971	513 724
2006	1 053 863	529 209	524 654
2007	1 027 386	517 002	510 384
2008	1 033 403	519 480	513 923
2009	937 531	471 827	465 704



	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total	28.0	30.0	31.5	36.0	40.5	41.4	44.9	45.8	45.3
Male	15.5	15.6	16.3	18.7	21.0	21.7	23.2	24.2	24.0
Female	14.1	14.0	14.9	16.9	19.0	19.2	21.2	20.9	20.9

Source: Statistics South Africa, Statistical Bulletin Dec 2010

Trends in the disease burden

The rise in total deaths, low life expectancy and high infant mortality are all evidence of a health system in distress. Total deaths in South Africa have increased sharply, with the numbers approximately doubling in the 10 years up to 2008. The increase in mortality can mainly be accounted for by two population groups: young children under five, where the rate doubled, and young adults in the 30-34 age group, where the rate trebled. The increase in under-five mortality reversed gains that had been made during the 1980s and 1990s. The overall increased mortality sharply reduced the median age of death to less than 45 years of age, and to a lower age for females than males.

Figure 3.6: Median age of death

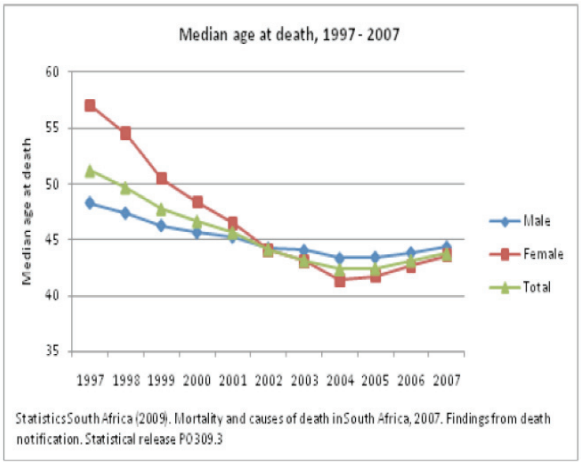


Figure 3.7: Trends in the infant mortality rate

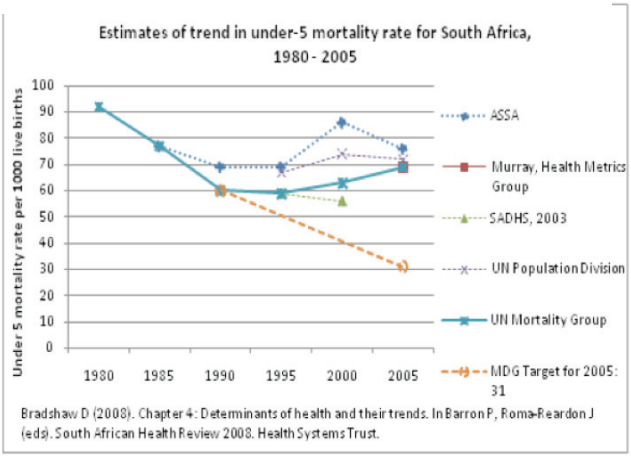
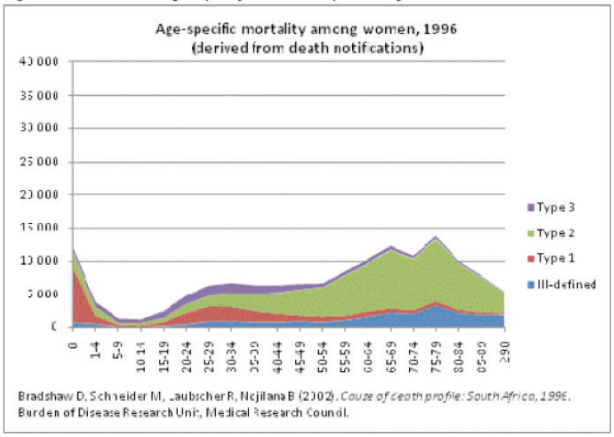
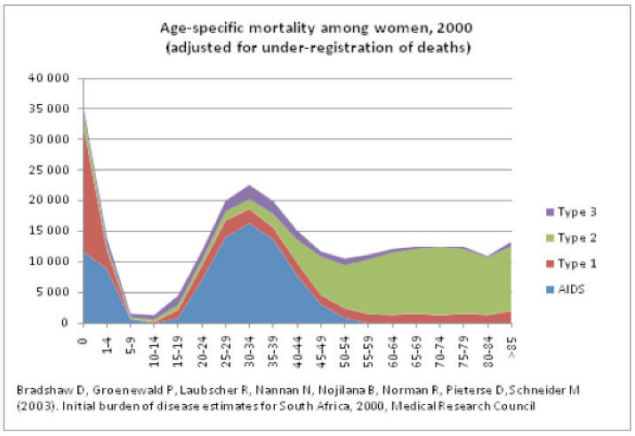


Figure 3.8: Trends in age-specific mortality among women between 1996 and 2000

Note: Type 1 is infectious and poverty-related conditions; Type 2 is non-communicable disease and Type 3 is death from external causes





The changing impact of the disease burden is demonstrated strikingly in the comparison of mortality among women and men in 1996 and 2000. Figure 3.9 contrasts AIDS-related deaths with those for infection, non-communicable disease and injury. There is a dramatic increase in AIDS-related deaths among young adults, which is more marked for women than men. In 1997, 20- to 39-year-old men were 1.6 times more likely to die than women of a similar age, mostly due to fatal injuries. By 2007, 20- to 39-year-old men were marginally (0.95 times) less likely to die than women of the same age (Statistics SA 2009). It is likely that AIDS and HIV-related TB account for the increase in deaths from communicable disease, as well as a considerable part of the non-communicable category.

Figure 3.9: Contribution of three global burdens of disease 1997-2001

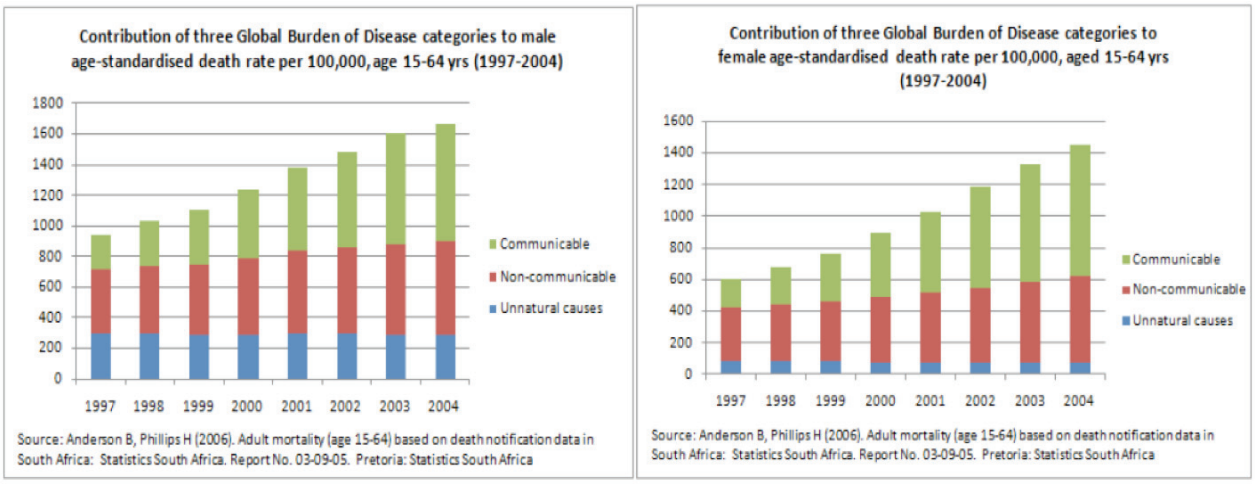
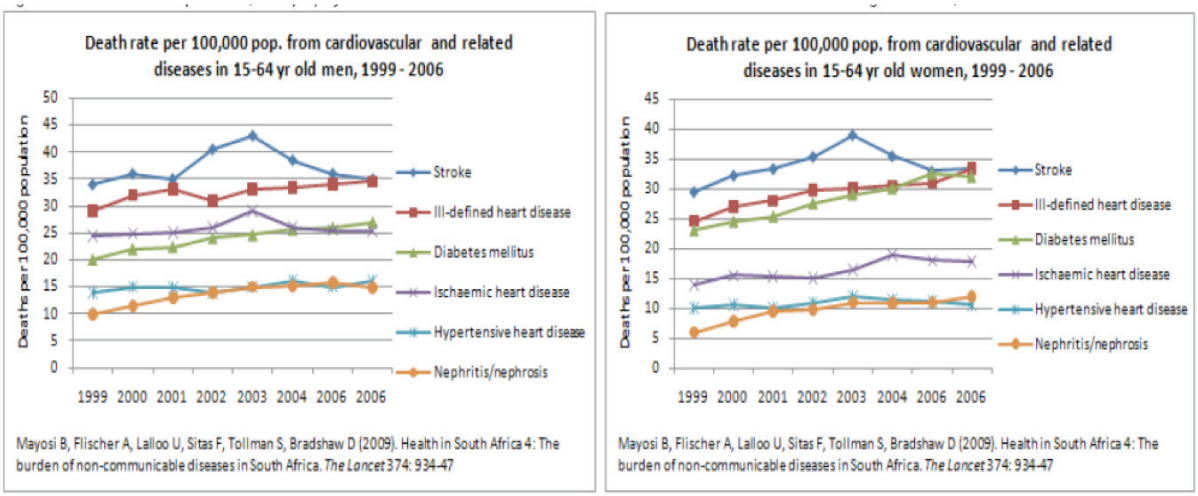


Figure 3.10 shows that, while the number of deaths from unnatural causes remained a significant burden of disease particularly for men between 1997 and 2004, the numbers of deaths in the other two categories both increased logarithmically, most markedly for communicable diseases (4 times), but also for non-communicable diseases (1.5 times).

Figure 3.10: Trends in death rates of non-communicable disease



There was also a similar rise in cardiovascular and related disease mortality from 1999 to 2006, except with stroke which showed a decline from 2003. The significance of this finding is that once mortality due to communicable diseases such as HIV and TB begins to decline, it can be anticipated that cardiovascular diseases will be a growing problem, as they are in most developed countries.

Despite the quadruple burden of disease, in 2010 HIV and AIDS was still likely to account for about 75 percent of premature deaths in South Africa (Bradshaw et al 2003).

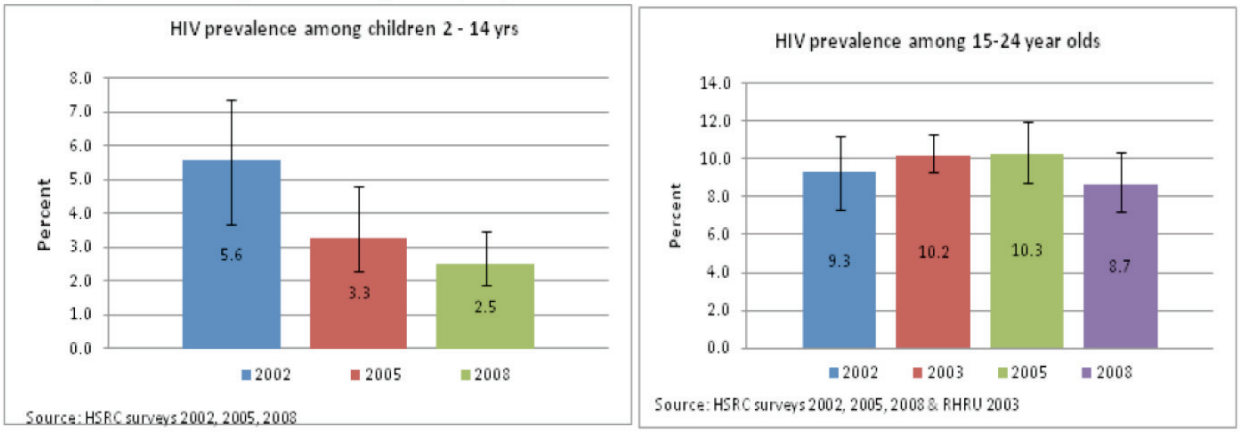
Risk-factor trends

The major risk factors were described in Table 3.4 and include (among the top 10 in order of rank) unsafe sex and sexually transmitted infections, interpersonal violence, alcohol, tobacco, excess body weight, childhood and maternal malnutrition, poor sanitation and hygiene, high blood pressure, the risk of diabetes and high cholesterol.

Unsafe sex and sexually transmitted infections (STIs)

The evidence is that HIV prevalence is dropping in children, adolescents and youth. While the decline in the prevalence in younger age groups is linked to better prevention of mother-to-child transmission, in older age children and youth it is probably due to a change in sexual behaviour. In 2008, 62.4 percent of people over the age of 15 said they used a condom the last time they had sex, compared with 27.3 percent in 2002 (Shisana et al 2009).

Figure 3.11: HIV prevalence in children and youth



Interpersonal violence

Interpersonal violence, particularly among young men, is very high. Seedat et al (2009) estimate that each year about 3.5 million people in South Africa seek medical assistance for non-fatal injuries, of which half are due to interpersonal violence. The overall injury death rate of 157.8 per 100 000 is nearly twice the global average. The rate of homicide of women by intimate partners is six times the global average.

The South African Police Service (2010) reports that there has been a decline in the homicide rate since 2004, but the rate of reported rape and sexual assault has increased by 8.2 percent since 2003. Seedat et al (2009) report that more than 40 percent of men disclose having been physically violent to an intimate partner and 40–50 percent of women have also reported experiencing such violence.

A dominant feature of violence in South Africa is the disproportionate role of young men as both perpetrators and victims. The highest rates for victims of homicide are seen in men aged 15–29 years (184 per 100 000). In some areas, for instance in Cape Town's townships, rates are more than twice this number. Deaths of men from homicide outnumber those of women by more than seven to one.

Traffic injuries constituted 26.7 percent of all deaths due to injury in 2000. South Africa's road traffic mortality rate of 39.7 per 100 000 is estimated to be 26 percent higher than the aggregate for the African region and nearly double the global rate. The National Injury Mortality Surveillance System suggests that almost 16 000 traffic deaths took place on national roads in 2000. This figure is distinctly higher than the number of traffic deaths reported by the Department of Transport, which noted 11 201 deaths in 2001. This is in the same order of magnitude as the number of homicides.

Other risk factors

Other risk factors that contribute to the disease burden include alcohol abuse, which is a factor in over half the fatalities related to violence and traffic accidents, tobacco-smoking and excess body weight.

The Department of Health and the Medical Research Council have shown that nearly one in 10 adult men (8.3 percent) and a quarter (23.3 percent) of adult women was classified as obese in 2003. The high rate of obesity is of particular concern among poorer African women, who are increasingly at risk of cardiovascular disease and diabetes mellitus.

The prevalence of diabetes among all age groups worldwide was estimated to be 2.8 percent in 2000 and predicted to be 4.4 percent by 2030 (Rheeder 2006). Estimates for the prevalence of type 2 diabetes in South Africa vary between 3 percent and 28.7 percent. The greatest prevalence was found in the Indian community of Durban (13 percent) and the elderly Coloured community of Cape Town (28.7 percent). The International Diabetes Federation *Diabetes Atlas* (2008) reports a prevalence figure of 3.4 percent for the 24 million South Africans between the ages of 20 and 79, which is expected to increase to 3.9 percent by 2025.

Wellness

Wellness is a complex constellation of elements ranging from spirituality and self-care to nutrition and exercise. Being well is not simply the converse of being ill. As a result holistic wellness models need to expand beyond a medical remedial focus into a model where individuals take aspirational responsibility for their own wellness.

South Africa's wellness indicators are extremely low. The accumulative effect of low wellness scores on individuals and their families, the economy and society at large are not yet well documented. It has been left to a variety of insurance companies and fitness interest groups to motivate for interventions, alongside some public sector awareness interventions. There is not yet a concerted programme of action around employee wellness and not yet an understanding of the direct impact of absenteeism on productivity.

The impact on the public health system is getting better understood. A growing contributor to the burden of disease in South Africa is the increase epidemic of lifestyle diseases related to relative affluence associated with the epidemiological transition between diseases of poverty and affluence. These include obesity, diabetes, cardio-vascular disease, cancers and a range of challenges to mental health. Tobacco smoking and excess body weight are respectively the fourth and fifth highest risk factors that cause morbidity in South Africa.

Globally, people with chronic disease account for the majority of national health expenditures and approximately 40 percent of total lost work time (PWC & WEF 2008). Chronic disease is placing an increasing burden on health systems, taxes and costs of coverage. This in turn places an increasing burden on organizations and their employees. It is projected that by 2030, the total number of productive years lost in Brazil, South Africa, Russia, China and India will increase 64 percent from 20.6 million in 2000 to 33.7 million in 2030 due to cardiovascular disease alone.

The Medical Research Council (2006) report estimates that 6 million South Africans suffer from hypertension, 4 million have diabetes, 7 million are smokers and 4 million have hyperlipidaemia. It further notes that 46 percent of all South Africans are inactive; 24 percent minimally active and 30 percent are sufficiently active. Hageman (2008) estimates that an obese employee costs a company 42 percent more in paid time off than a normal weight employee and that an employee suffering from depression takes an estimated 5.7 days sick leave per annum due to this condition, costing 65 percent more than a non-depressed employee.

Cape Town based research involving more than 300 000 participants over a five-year period finds that that while there is evidence that incentive programmes assist in getting people to address vaccinations and screening tests, research is less conclusive about the effectiveness of these programmes in addressing more complex behaviors such as unhealthy eating and physical inactivity (Patel et al 2011). The study observed an increase in fitness-related activities over time amongst members of an incentive-based health promotion programme, which was associated with a lower probability of hospital admission and lower hospital costs in the subsequent 2 years.

The Medical Research Council (2006) observation that the country is moving along an epidemiological transition which is driven by the adoption of unhealthy lifestyles, which relate to tobacco use, unhealthy nutrition, and lack of regular aerobic physical activity suggests part of a course of action is a population-wide intervention programme.

Arts and culture

There is a dynamic reinforcing relationship between culture and the arts. The arts can be a way of expressing culture but culture can contribute to the development of the arts and vice versa. The United Nations Declaration of December 2010 identifies the importance of culture as follows:

> "...culture is an essential component of human development, represents a source of identity, innovation and creativity for the individual and the community and (is) an important factor in the fight against poverty, providing for economic growth and ownership of development processes...culture is a source of enrichment and an important contributor to the sustainable development of local communities, peoples and nations, empowering them to play an active and unique role in development initiatives."

In countries such as the United States, the arts sector is a major contributor to GDP, employment and exports. This sector has the potential to play a significant role in the South African economy as well. The Department of Arts, Culture, Science and Technology issued a report in 2006 highlighting the importance of the Creative Industries. The report estimates that 17 percent of all employed people in South Africa are employed in the creative industries, with the sector contributing 3 percent of GDP, on a par with Australia.

The creative industries are important not just for their contribution to the economy. There is an intrinsic priceless value to the human spirit of simple storytelling, song and dance, picture, poem and thought. It might even be that without those that turn rhythm into song, the human spirit would fade (Perkes 2011). The arts are such an integral part of life that sometimes they are taken for granted, yet without nurturing and focussed investment their future is not guaranteed.

Cultural industries are unique in the sense that they are knowledge intensive and involve highly skilled workers on one hand and labour intensive on the other hand. They are also highly differentiated taking the form of Small and Medium Enterprises (SMMEs) and large enterprises. Due to the nature of production value chains in this sector, enterprises and individual artists are linked with close, interlocking but flexible networks of production and service systems (DACST 2006).

A number of factors hamper the growth of the creative industries in South Africa. These include: the perceived desire of locals for international product over local product, divisions

between and within the sectors of the industries, no clear lines of communication between industry and government or between the different genres within the industry, and the lack of a thorough and cohesive skills development programme particularly in arts management and technical skills training.

The problem of lack of skills training starts at the school level. Education in the arts remains relatively nonexistent in South Africa despite the fact that creative and intellectual capital are infinite resources. Many children have no crayons and paper at school let alone music, dance or even simple story telling. Realising the arts contribution to education in other fields, especially the sciences and other innovation outcome pursuits is a way of feeding that innovation (Perkes 2011).

Research points to the need for Talent Clustering - bringing together diverse talent has been shown to accelerate the local rate of economic development. The uniqueness of the arts sector in that creative expression, is at one level essentially an individual concept, and at another level involves a collection of people doing pretty much the same thing (Florida 2006) distinguishes it from other economic or social activity.

Given the current state of affairs, strategic planning in and for the future of creative industries is of paramount importance. In order to catalyse a connected, vibrant and desirable creative industry planning must focus on clarifying, streamlining and consolidating the funding systems in the country; connecting the existing silos within the industry and encouraging a supportive and communicative environment; fostering a sense of ownership of the arts as part of everyday life; and conducting detailed research into the economic impact of the creative industries. There is an urgent need for putting in place mechanisms to harness the power of the arts and culture for human development, fight against poverty and economic development.

Citizen safety

Crime levels are high in South Africa. Violent crime, contact crime and property crime are so common that many South Africans live in fear. When people feel unsafe it makes it harder for them to pursue their personal goals, and to take part in social and economic activity. Feeling unsafe can result from having been a victim of crime, knowing people who have been victims of crime, or hearing crime reported in the community or the media.

A 2010 study by the Centre for Study of Violence and Reconciliation (CSVR) shows that, although violent crimes take place in all settings, it is predominant in metropolitan areas. Major forms of violent crimes identified include: assaults linked to arguments, anger and domestic violence; rape and sexual assault; and robbery and other violent property crime. According to the crime statistics for the period April 2009 to March 2010, the largest number (31.9 percent) of all 2.1 million crimes were contact crimes, followed by property crimes (26.1 percent) and other serious crimes (25.5 percent). Although there has been a decline in murders, the high proportion of contact crimes is bound to raise fears among citizens.

In discussing crime, there is always the danger of focusing too much on policing as a solution. There is no doubt that more visible policing gives citizens a sense of protection, but reducing crime will require a combination of interventions, including those originating from outside the criminal justice system.

The speed with which the police investigate and arrest perpetrators, and how effectively the prosecution is carried out by the criminal justice system, are critical to how safe citizens feel.

The National Prosecution Authority has reported an increase in the percentage of convictions, from 80 percent in 1999/00 to 85.9 percent in 2007/08, and a reduction in the number of cases withdrawn from 414 211 in 2002/03 to 225 407 in 2007/08. However, the high number of cases that are withdrawn affects citizens' confidence in the criminal justice system.

The CSVR study identifies the following factors as sustaining the culture of crime: (1) inequality, poverty, unemployment, social exclusion and marginalisation; (2) perceptions and values relating to violence and crime; (3) the vulnerability of youth, linked to inadequate child rearing and inappropriate socialisation; and (4) weaknesses in the criminal justice system.

The six pillars of violence prevention (WHO 2002, cited in Matzopolous 2011) are: investing in early interventions, increasing positive adult involvement, strengthening communities, challenging social norms that entrench violence, reducing income inequality, and improving criminal justice and social welfare. An effective, integrated strategy is needed to address the pervasive problem of violence.

Main diagnostic on the human condition

Assessing the factors that affect the human condition in South Africa is a complex endeavour. For purposes of this report, the commission has focused on those that we consider to be the overriding factors, with a determining impact on planning scenarios for the future.

Poverty, inequality and issues of distributional justice (unequal resource allocation) remain stubborn features of our landscape. These features are linked to institutional arrangements. It is especially in the interface between local, provincial and national spheres of government, the private sector, the non-profit sector and traditional authorities that we find breakdowns in service delivery, in accountability and in a lack of capacity. Many of these features are influenced by our macro-policy direction and strategies related to the economy, fiscal welfare, occupational welfare, and international processes.

At the operational levels the lack of skilled professional community development workers, health workers, social workers and agricultural extension officers is a problem. Such professionals are essential to ensure that social support systems work at the point of delivery.

Summary of urgent challenges

Below we summarise the main challenges that need to be addressed to improve levels of wellbeing and human development. The national plan to be drafted by the commission will make proposals about how these challenges will be tackled and how interventions will be sequenced.

Improving the quality of education and skills. Education is perhaps where the apartheid legacy casts the longest shadow, because the performance of schools and the quality of learning are influenced by several historical factors. Education systems are large and complex and no single factor can explain performance. Research (JET 2011b; Van der Berg et al 2010; Mourshed et al 2010; Gustafsson 2007) evidence identifies various factors that contribute to the success or failure of education systems:

- Teachers are the backbone of education and no system can function without good teachers. Their motivation, subject knowledge, the amount of time they spend teaching and their level of preparedness are all essential to the functioning of schools and learner achievement.
- Teachers' subject knowledge is also a major issue. There is an urgent need to rethink teacher education and continuous development.
- Time spent on teaching. There is less teaching time in township and rural schools. Chisholm et al (2005) found that teachers in disadvantaged schools spent, on average, 3.5 hours a day teaching compared with 6.5 hours of teaching by their counterparts in former white schools.
- Teacher absenteeism reduces teaching time. A study by Reddy et al (2010) estimates that "between 10 percent and 12 percent of educators are not at school on any day", resulting in between 20 and 24 days of teaching time lost per year by each educator.
- Early childhood education enhances learning ability and outcomes.
- The socioeconomic status of learners, especially the educational background of their parents and whether the child has adequate nutrition, affects learner performance. The same is true of the availability of learning material.
- Learners within the bottom four quintile schools generally receive a significantly poorer quality education relative to those in the highest quintile schools.
- The quality of school leadership is central to educational performance.
- Infrastructure also plays a role in the performance of schools.
- Schools do not adequately prepare young people for higher education and the world of work.
- Higher education is not producing the number of skilled professionals the economy requires.
- Socioeconomic factors affect the performance of learners in higher education, which results in a significantly small number graduating within regulated time.
- The skills development sector, including further education and training colleges, is characterised by high levels of inefficiency resulting in low throughput rates.
- Post-school education and training opportunities are very limited and inaccessible to an estimated 2.8 million young people between the age of 18 and 24.

Prevention and treatment of HIV and AIDS: The new Actuarial Society of Southern Africa model estimates that in 2010, 10.9 percent of the population was infected with HIV. This translates into 5.5 million people, which is marginally lower than the 5.8 million estimated in 2003. Although this suggests an improvement, this large percentage of the population will require long-term treatment.

Prevention of new epidemics: Multi-drug resistant tuberculosis and the extreme drug-resistant TB represent a major public health threat and could significantly contribute to future mortality unless properly controlled. While the prevalence is not accurately known, Department of Health estimates suggest that 6 percent of retreatment cases and 1 percent of new cases are anticipated to have multi-drug-resistant TB – roughly 10 000 cases per year. In most provinces, about 2 percent of isolates show extensive drug resistance, and it may be as much as 5 percent in parts of KwaZulu-Natal. Extreme drug-resistant TB has been identified in all provinces and 60 hospitals in KwaZulu-Natal.

Prevention of alcohol abuse: As discussed earlier, alcohol abuse contributes to both interpersonal violence and road traffic accidents. Apart from reducing the legal blood alcohol limit for drivers from 0.08 to 0.05 mg/dl in 2004, government has been cautious about

regulating the alcohol industry. In 2007 the Department of Health promulgated regulations that require health warnings on alcohol advertising and sales materials. Taxes on alcohol are increased regularly and there have been campaigns against drunk driving. However, there is a lack of a clear and comprehensive policy, without which the existing measures are ineffective.

Distribution of health financing and spending: In 2005/06 health financing came from general taxation (40 percent), medical aid contributions (45 percent) and out-of-pocket payments (14 percent). In general terms health financing in South Africa is progressive, even though healthcare access and outcomes are not. The richest 20 percent of the population contributes three times the proportion of personal income than the poorest 60 percent. Of the contribution by the wealthiest quintile, which amounts to 82 percent of total health care funding, only 45 percent is retained as a benefit, 32 percent being from the private health sector and 13 percent from the public health services. This means that the remaining 55 percent of the contribution by the richest quintile is in effect redistributed to the other quintiles (Health Economics Unit 2009; Ataguba and McIntyre 2009).

The funding per patient in the private sector is significantly higher than in the public sector. Medical aid schemes spend about five times as much per person as the public sector spends on an uninsured person. Despite the progressive nature of healthcare financing, the distribution of benefits is still skewed in favour of the wealthiest quintiles that bear lower burdens of disease (Health Economics Unit 2009). In the private sector, the financing is regressive, with the poorest 20 percent contributing a significantly higher proportion of their income compared to the richest 20 percent. Private medical aid is unaffordable for most South Africans, so membership growth has remained almost static since 1994.

Availability of health personnel in the public sector: One of the challenges in understanding the relative disparity between public and private sectors is that the number of posts and vacancies in government's human resources IT system (PERSAL) is not known with any degree of accuracy for all categories of health professionals. Similarly there is uncertainty in the private sector, where provision is often calculated from registrations with the Health Professions Council, which fails to take into account the large number of professionals who are no longer practising or who have left the country. Also underestimated is the extent to which the uninsured population – estimated at about 7.5 million –make use of private general practitioners. The DBSA (2008) estimates that 32 percent of the population use private general practitioners and 15 percent use private hospitals.

Quality of care: There are many areas of endemic weakness arising from poor quality health care. Harrison (2009) provides examples of some of the critical weaknesses in the quality of care for TB, HIV/AIDS, and maternal and perinatal health. In TB care, for example, the number of smear positive cases proven microscopically to be cured (the cure rate) is only 65 percent, well below the WHO target of 85 percent. Syndromic management of sexually transmitted infections is important for HIV prevention. Some 8.5 million cases of sexually transmitted infections are treated annually, representing a significant high-risk population who should be properly counselled and supplied with condoms as part of effective syndromic management. The fourth *Saving Mothers* report (2005–2007) found that almost 60 percent of maternal deaths were avoidable (National Committee on Confidential Enquiries into Maternal Deaths 2008). The quality of care in district hospitals was particularly bad, with over a third of perinatal deaths being due to avoidable failures (Pattinson 2008).

Operational efficiency: There are serious inefficiencies in the management of the public health system, highlighted by over expenditure by some provinces in the past two financial years. These inefficiencies occur at all levels and many were documented in a health sector audit and review commissioned by the former Minister of Health in 2009. The management and use of district hospitals is a case in point: average length of stay varies across districts from 2.2 days to 8 days, and the bed utilisation rate varies from 50 percent to nearly 90 percent.

Health worker morale: A five-year review of the public health sector conducted in 1999 concluded that morale among health workers was low, especially among nurses. Although nurses ascribed their morale to overwork, this was probably not the main factor: a sense of neglect and lack of support was at the heart of problems of low morale. Subsequent reviews of the health system have tended to reach the same conclusions.

Leadership and innovation: As in education, the quality of leadership in the health system has profound impact on the functioning of the institutions and ultimately on service delivery.

Communities and the state

The complex meshing of problems and agency in poor communities and service delivery institutions implies that:

- Effective government programmes require an active presence of state agents with professional skills at the interface between community and state, and able to access communities, civil society organisations, households and individuals.
- Actively engaging with multifaceted problems in communities and households requires "joined up government" at local level to overcome the silo effect of state structures.
- Civil society organisations, such as non-governmental organisations and churches, may have the necessary skills and flexibility to work consistently with communities and households.

Though there is no substitute for a highly trained and competent professional core in key areas of service delivery, there is scope for experimenting with assigning more routine and administrative tasks currently executed by nurses, doctors, teachers and social workers to other staff who presently have lower skills levels. This would release highly skilled professionals to perform the most critical tasks.

Critical issues

In preparing a national plan for the next 15 years, South Africa needs to debate vigorously and find solutions to key issues facing the country, including:

- Ensuring that economically active but poor citizens can find work that leads them out of income poverty.
- Determining whether the growth path is acceptable or viable, and what other options exist.
- Assessing the degree to which state policy and implementation have been captured by new and old elites.
- Creating a developmental state that can actively facilitate the development of individuals, households and communities, and enhance human capability.

- What is the minimum standard of living that everyone should be able enjoy over the next 15 years?
- Improving nutrition, the quality of education, health outcomes and community safety.
- Finding the appropriate mix of different forms of social assistance and livelihood support.
- Restructuring state institutions and performance.
- Tackling the quadruple burden of epidemics.

Conclusion

South Africa faces many challenges in improving the wellbeing of its people. This chapter has focused on the areas of education, health and social protection, and to a limited extent safety and livelihoods strategies. We have sought to demonstrate the interconnectedness of the factors that affect the human condition. The analysis has shown that the poor performance of education affects people's chances of gaining employment, which in turn affects their level of income, contributes to income inequality, determines health and nutrition status, increases their vulnerability, and contributes to the pervasive culture of crime. This interconnectedness suggests that improving the human condition is best pursued through comprehensive and integrated strategies.

Weaknesses in the various programmes reviewed are not a result of lack of resources. More efficient use of *existing* resources would improve the human condition of many South Africans. For these gains to be realised, greater attention should focus on improving the skills and working conditions of those charged with providing services and leadership, and better management of South Africa's institutions.

In planning for 2025, the National Planning Commission will focus on those areas where improved performance is essential. This could relate to the reallocation of resources in response to new priorities, such as the shifting burden of disease; it could involve reforms to existing measures; or it could involve looking at how existing policies can be implemented more effectively.

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