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**Kin, Market and State in the Provision
of Care in South Africa**

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Abstract

The provision of financial assistance and personal care in contemporary South Africa entails a distinctive combination of state, market and kin. The state assists financially the deserving poor, but provides little personal care. Better-off people rely increasingly on the market for both income support and care. The poor rely heavily on kin, especially female, maternal kin. The South African case is unlike any of the standard welfare and care regimes identified by Esping-Andersen or his critics.

Introduction

The provision of financial assistance to and personal care¹ for children, the elderly, the sick and disabled, and the unemployed in contemporary South Africa entails a complex and changing mix of state, market and kin. Like many other middle-income countries, the roles played by kin are changing, and the roles of the market are expanding. Like some other middle-income countries, the role of the state is changing, as welfare states are rebuilt to provide more for the poor than for the better off. The specific mix of state, market and kin reflects South Africa's specific colonial history. This article reviews the ways in which the state, the market and kin provide financial assistance and personal care to those people who need these, and locates the specific South African pattern in the broader landscape of welfare and care regimes across the world.

Welfare and care regimes vary in terms of how financial assistance and personal care are provided by the state, the market and kin, as well as in some cases non-government organisations. Esping-Andersen's seminal work (1990) on the 'welfare capitalist' democracies of the global North distinguished between their welfare regimes primarily in terms of the varying extent to which they 'decommodified' their citizens through protecting them against the risk of

¹ In this article, 'financial assistance' refers to financial transfers through, primarily, social assistance programmes; 'care' refers to personal care for children, the elderly and the sick or disabled, through the provision of accommodation or assistance with daily needs such as cooking, shopping, and perhaps even basic mobility.

poverty through either social insurance or social assistance. In later work, Esping-Andersen (1999) expanded the analysis to consider the extent to which states replaced families in providing for children and the elderly. His measures of ‘de-familialisation’ included the proportions of both young children in public day care and the elderly receiving home-help. His analysis thus considered both the financial and the personal dimensions of ‘care’. Although he himself did not make this distinction, it is helpful to use the term ‘welfare regime’ to focus primarily on mechanisms of income support, and ‘care regime’ to focus primarily on the provision of personal care.

For Esping-Andersen, the Nordic social democracies in the second half of the twentieth century represented the gold standard, with the state providing generous and universal income support, child and elderly care. In contrast to the social democracies, the conservative or corporatist welfare regimes of continental Europe decommodified unequally – reproducing class inequalities – and buttressed rather than subverted a largely familial care regime. The Anglo-American ‘liberal’ countries decommodified on a minimal and targeted basis. ‘Defamilialisation’ was considerable, but entailed the transfer of care from the family to the market more than to the state.

The further one moved away from Esping-Andersen’s social democratic ideal, the less compelling his typology became. The countries of Mediterranean Europe challenged his typology due to the much more extensive role of the family in the provision of personal care (Ferrera, 1996, 2005; Naldini, 2003; Bettio and Plantenga, 2004; Lyon and Glucksmann, 2008; Gal, 2010). In this respect, countries such as Spain raised many of the typological challenges raised by middle-income countries across the global South, i.e. countries where state and market provision was expanding but where family or kin remained central to the configuration of care. Gough *et al.* (2004) characterise many or even most welfare regimes in the global South as ‘informal security’ regimes because income security is provided primarily through informal channels outside of both state and market. Unfortunately, little attention has been paid to variation in the precise configurations of care in those middle-income countries where the state and market as well as family or kin play important roles.

South Africa is a distinctive case, in that its welfare and care regimes reflect its particular colonial and post-colonial history. Extensive defamilialisation among the minority white population coexisted with persistent dependence on family and kin among the majority African population. Indeed, under apartheid, public policy was premised on this dualism. Democratisation deracialised public policies, resulting in a pro-poor welfare state, especially in terms of social assistance and increasingly, child care. In some respects, however, the state has

retreated from the direct provision of care, most notably for the elderly and disabled.

Historical background

South Africa's welfare and care regimes bear the impress of the country's colonial past in terms of both imperial British 'liberal' influences on the design of state institutions and policies and the resilience of distinctively African practices and beliefs about extended kinship. Neither public institutions nor social institutions (such as the family) nor cultural beliefs have persisted unchanged, but South Africa's welfare and care regimes reflect their diverse origins.

The development of welfare and care regimes in countries across the world has been shaped by the transnational diffusion of ideas as well as by domestic political, social and economic conditions. In the early twentieth century even the European pioneers of welfare state-building were often well-informed about the few precedent cases. In mid-century, the International Labour Organisation promoted energetically specific models of welfare, a role later taken over by the World Bank. In colonies, ideas and models from the imperial power were often especially important. Territories within the British imperial world were distinctively influenced by the British policies, institutions and left-liberal ideas (and by their Australasian variants). In contexts such as South Africa, the policy and institutional mix reflected a combination of external ideas and models with local or domestic conditions.

In the South African case, the outcome was a welfare and care regime that was thoroughly dichotomised through most of the twentieth century. From the 1920s the South African state began to construct a welfare state for its white (and to a lesser extent coloured) citizens, broadly along British (and Australian) lines, providing publicly-funded social assistance and care for 'deserving' categories of women, children and men who were left poor by the market and their kin. At the same time, the state's African subjects² were excluded from the welfare state and social citizenship as well as from the franchise and political citizenship.

² Racial categories were and are widely used in South Africa. The post-apartheid state distinguishes between white, African, coloured and Indian citizens, replicating the typology used by the apartheid state (although with sometimes different labels). 'Coloured' is a heterogeneous category, comprising non-Bantu indigenous peoples (often referred to as Khoi and San peoples), the descendants of slaves brought from south-east Asia (including 'Malays'), and people with mixed white and African ancestry. Most coloured South Africans live in or around Cape Town. 'Indian' refers to people of South Asian descent. Most Indian South Africans live in or around Durban.

Less advantaged white South Africans were given enormous assistance – in terms of public schooling, public health and psychiatric care, social welfare and social work programmes, as well as labour market and other economic policies – to rise up the economic and social hierarchy. However, few resources were allocated to the needs of the much more disadvantaged African majority of the population, and many apartheid policies in the 1950s and 1960s were designed to push better-off non-white people down the economic and social hierarchy (Seekings and Natrass, 2005; Seekings, 2007).

Repressed by the state, and with little power in economic markets, non-white South Africans relied heavily on kin for personal care and financial support. Apartheid, by dividing African families through the imposition of strict controls over who could live where, served to ensure that many working adults left their children to be raised by the children's grandparents, who they supported through the remittance of a share of their earnings. The state thus undermined parental care for children and relied on the extended family among the African population.

The apartheid project was so successful that, from the 1970s, white South Africans enjoyed massive market advantages and needed less and less the services provided by the welfare state. Risk-pooling and income-smoothing through contributory 'semi-social' insurance schemes expanded, with some regulation from the state, but for the most part run by the private sector. The imperatives of economic growth and political stability pushed the apartheid state towards a slow and partial reallocation of scarce public resources away from white citizens and towards coloured and Indian people, and later African people, especially in urban areas.

The post-apartheid welfare and care regimes

The first democratically-elected government inherited in 1994 a state that retained an extensive set of welfare state services, most of which were in the process of being deracialised and thus reoriented towards the poor. The new democratic state quickly moved to complete this deracialisation with respect to most social programmes, including the public provision of financial assistance. One exception was state care for the elderly, hitherto largely reserved for white people. On this, the state rolled back public provision. The expansion of public welfare for the poor coincided with a decline in kinship-based care and financial assistance. At the same time, 'middle class' white, Indian, coloured and African people continued to abandon public services as they turned to the market for health care and to the semi-marketised top end of the 'public' school system for

the education of their children. The middle class and even working class resorted increasingly to the market for the personal care of both children and the elderly.

The provision of care in post-apartheid South Africa thus comprises extensive but uneven public provision, a probably growing role for market provision, and continuing if diminished kin provision – all combined in different ways for different social and economic groups. Overall, an astonishing volume of care and assistance is needed and given in contemporary South Africa. Approximately three-quarters of the total population of about 50 million people in South Africa require care or financial support of some sort (see Table 1). This figure includes approximately 20 million children (defined here as up to the age of eighteen) and 3 million non-working elderly people (defined here as over the age of sixty years), as well as 1 million men and women of working age (defined here as between the ages of eighteen and sixty years) who are sick (many because of AIDS or tuberculosis) or disabled, and a further 12 million men and women of working age who are not working themselves and remain financially (and often emotionally) dependent on others. Some of these non-working, able-bodied men and women of working age choose not to work. Most, however, are not working because there is no work. Mass, chronic and involuntary unemployment is arguably the most important scourge of post-apartheid South Africa (Seekings and Natrass, 2005). Some – overwhelmingly women – are involved in unpaid domestic or care work that does not qualify as ‘work’ in the official statistics, i.e. they are both financial dependents and care-givers.

Table 1: State, market and kin-provided financial support and care

	Approximate % of total population (and number)	State	Market	Kin
Children (and their caregivers)	40% (20m)	Financial assistance through grants to care-givers and subsidised public health and education, as well as the regulation of child maintenance. Care through: growing support for pre-school child care; the regulation of foster care; and limited residential institutions for children without kin carers.	Care: Widespread market-based provision of child care (and, increasingly, health and education), especially but not only to the rich	Limited financial support through inter-household remittances. Care: Widespread child-raising by grandmothers (and other extended kin), especially in separate households.

Working age, sick and disabled	2% (1m)	Financial assistance through grants to the sick and disabled, and subsidised public health	Financial assistance and thus care through private health care sector (including through health insurance)	Widespread care for AIDS-and TB-sick and disabled adults, especially within households
Non-working, non care-giving, able-bodied adults of working age	24% (12m)	Limited financial support through unemployment insurance and job creation schemes (especially public works programmes)	Financial provision through provident funds	Widespread financial support for unemployed adult dependents, especially within households
Non-working elderly	6% (3m)	Financial assistance through old-age pensions and subsidised public health care.	Financial provision through contributory pensions and savings. Care through commercial care including residential institutions.	Limited financial assistance. Care within and between households

Children

The largest category of people in need of care in South Africa are children. South Africa has a fast-growing population with a low median age.³ The most glaring category of children needing care are those who do not live with either biological parent. In 2009, about 5.5 million children – including almost one in six young children (aged six or less), and almost one in three older children (aged seven to seventeen) did not live with either biological parent (see Table 2) - most lived with a grandmother. A minority of these are double orphans, but most have at least one parent living elsewhere. A tiny proportion (only 1 percent) lived with non-relatives (Hall and Proudlock, 2011: 5).

³ The absolute number of children has, however, fallen. The combination of declining fertility and AIDS-related mortality meant that the cohorts born in the 1990s and 2000s are smaller than the cohort born in the 1980s. This demographic distribution contrasts with most of Africa, where each new cohort is larger than its predecessor.

Table 2: *With whom do children live?*

		Proportion of all children	
		Age 0-6 %	Age 7-17 %
Live with parent(s)	Both	34	31
	Mother only	45	34
	Father only	3	4
	Sub-total	82	69
Not live with either parent	At least one parent alive	17	23
	Neither parent alive	2	8
	Sub-total	18	31
Total		100	100

Source: General Household Survey 2009, own calculations.

Only one in three children live with their biological fathers primarily because of the decline of marriage (and infrequency of long-term cohabitation) (Amoateng, 2004; Posel and Rogin, 2009; Hosegood *et al.*, 2009) but also because of the decoupling of sex and motherhood from marriage. Between 1997 and 2006 there was a steady increase in the number of households headed by women, to almost 40 percent (Posel and Rogin, 2009: 31). Women are, in general, increasingly independent from the father(s) of their children, in terms of finances and accommodation (see Seekings, 2011), and probably emotions as well. This does not mean that women are independent, however. Single mothers rely heavily on agnatic kin, as we shall see further below. Nor does residential separation always mean that fathers fail to play a role in their children's lives. In Cape Town, one in three young people living apart from their fathers reported that they spent time with them (Bray *et al.*, 2010: 81; Morrell, 2006; Montgomery *et al.*, 2006; Townsend *et al.*, 2006; Madhavan *et al.*, 2008; Madhavan and Roy, 2011).

Table 2 indicates something of the diversity of living arrangements and family forms in South Africa. Few people in South Africa live in nuclear families with breadwinner husbands and stay-at-home wives who provide care for their children (Spiegel *et al.*, 1996; Russell, 2003). Families are often 'extended', either vertically (including three generations) or horizontally (including uncles, aunts and cousins). This facilitates child care by kin, for example when mothers are working. A rather old study of childcare arrangements among working African mothers found that almost 40 percent of the women left their children

with adult relatives, particularly grandmothers, and 10 percent left their children with older siblings (Cock *et al.*, 1984). A more recent survey, in 2008, found that parents were almost always deemed to have primary ‘responsibility’ for their children, but non-parental kin played a secondary role in caring for as many as one in two children living with one or both parents, and one-third of all children.⁴

Kin do not suffice, however, despite high unemployment rates. The 1984 study cited above found that 50 percent of working African mothers turned to non-kin for childcare: 9 percent left their children with neighbours, 14 percent with child-minders, and 14 percent in crèches, whilst 6 percent hired other women to care for their young children. Even when women left their children with kin (such as the children’s grandmother), the mother usually had to pay. Overall, almost three quarters of the sample was paying for childcare, while just under a quarter were receiving free childcare (Cock *et al.*, 1984). Historically, children in middle class and elite households were cared for by paid non-kin child-minders, i.e. entirely through the market (see Cock *et al.*, 1984). When defining a ‘living wage’ for white South African men in the 1930s, state officials assumed that even a working-class white family supported by a single (male) breadwinner had to employ a domestic worker. Generations of white children born under apartheid were raised by African or coloured women. In the late twentieth century, paid childcare seems to have become a much more common practice among even those working women who are far from rich. A 2009 survey found that about 30 percent of all children aged 0 to 4 attended some kind of crèche or day care facility.⁵ Commercial crèches have proliferated, but they are often expensive, of unsatisfactory quality, and offer no care at the times of the day (or night) when working people are working or travelling to work (Moore, 2013).

Domestic employment constituted a market in care, but it was a market that was profoundly structured by the state until the end of the twentieth century. The state restricted the kinds of work that African or coloured women could do and regulated when, where and with whom they could live. Since the end of apartheid, formal domestic employment has been subject to a wider battery of regulation, covering (inter alia) minimum wages and conditions of employment

⁴ NIDS wave 1 2008, own calculations. The survey did not make a clear distinction between responsibility and care, so it is difficult to compare these data with the 1984 data. The first question asked was: ‘Who is the main person responsible for making sure that this child is fed, bathed, goes to school if of school going age, helped with homework, taken care of when the child is ill, etc?’. The second question asked was: ‘Who else helps to care for the child?’

⁵ GHS 2009, own calculations.

(Fish, 2006; King, 2007; Ally, 2010). Much paid childcare is informal and unregulated, however.

In the early 2000s the state began to provide more childcare, on educational grounds. It introduced one preschool year at primary school, for five year-olds ('grade R', for Reception), and it provides means-tested subsidies for registered early childhood development centres. But, for children younger than five, and many five and even six year-olds also, childcare is provided through the market or by kin.

Kin support may be a substitute for market provision, but it is underpinned by public provision. The state provides for children not only through subsidised schooling (including grade R) and (to a limited extent) crèches, but also through financial grants to caregivers as well as subsidised public health care, limited social work interventions and a small number of residential institutions. The scale of this pro-child welfare state provision is very unusual, and perhaps even unique, in the global South, in terms of both the proportions of children reached and the expense in relation to GDP.⁶

A small proportion but nonetheless substantial number of children are in court-ordered foster care, and many foster care-givers receive the Foster Care Grant (worth, in 2012-13, R770 or US\$90 per month in December 2012) from the state. The numbers of foster child grants paid rose dramatically in the early 2000s: from about 50,000 in 2002 to about 500,000 by 2010 (Hall and Proudlock, 2011: 2; South Africa, 2012: 85).

Originally intended for neglected and abused children, the Foster Care Grant became a vehicle for assisting poor kin who had fostered children, either because the children had been orphaned – often, recently, because of AIDS – or had been abandoned. The 2005 Children's Act defines a child as 'in need of care and protection' – and hence eligible for a Foster Care Grant – if he or she 'has been abandoned or orphaned and is without visible means of support'. It has been up to the courts to decide what is meant by 'visible means of support' (section 150(1)(a); see Hall and Proudlock, 2011: 2). In 2011, a Children's Court in Gauteng heard the case of a child (identified only as 'SS') whose mother left him with her uncle and aunt (a Mr and Mrs Lamani). His uncle and aunt received a Child Support Grant. When his mother died, the Lamanis applied for a Foster Care Grant, which pays three times as much as the Child

⁶ This is true even if we consider only social assistance programmes. The Bolsa Familia programme in Brazil attracts considerable attention, but its reach (in terms of the proportion of households that benefit) and its cost (in proportion to GDP) are each only about 60 percent of the equivalent figures for the Child Support Grant in South Africa.

Support Grant. The magistrate ruled against them, finding that the purpose of the Foster Care Grant was not income support (Hall and Proudlock, 2011: 6). The judgement was overturned on appeal in the Johannesburg High Court, in August 2012. The High Court found that some kin have a ‘duty of support’: biological and adoptive parents, maternal and paternal grandparents, and siblings. Step-parents have a qualified duty of support. Uncles and aunts and other kin – including the Lamanis – have no duty of support, and are therefore eligible for a Foster Care Grant.⁷

The judgement upheld the Lamanis’ application, but threatened the grants paid to many grandparents. Grandparents are by far the single largest category of Foster Care Grant beneficiaries.⁸

Whilst Foster Care Grants are intended for children who have been fostered formally under a court order, on the recommendation of a social worker, Child Support Grants are paid to any caregiver of a child subject to their having no or modest income. The grant is paid for a large proportion of children living with one or both parents and children living with neither parent. About 20 percent of Child Support Grants paid with respect to children under the age of seven are paid to non-parents, as are 30 percent of grants paid with respect to children between the age of seven and seventeen. In addition, many children are raised by grandmothers who receive the much more generous old-age pension. Although pensions are supposed to support the elderly, and child grants are intended to be for children, in practice pensioners are often caregivers, and children are as likely to benefit from pensions as from child grants.⁹

The generous financial assistance to caregivers through social grants reflects the distinctly European origins of South Africa’s welfare state together with the specific social and economic conditions in South Africa in the late twentieth and early twenty-first centuries. The Child Support Grant has its origins in grants paid under the 1913 Child Protection Act, for the protection of, primarily, poor white children. From 1926, the Minister of Education was empowered to pay modest grants to the mothers, stepmothers and grandmothers of children. Concern heightened over poverty among white South Africans during the Great

⁷ *SS v Presiding Officer of the Children’s Court: District of Krugersdorp and Others* (14/1/4-206/10, A3056/11) [2012] ZAGPJHC 149; 2012 (6) SA 45 (GSJ) (29 August 2012). <http://www.saflii.org/za/cases/ZAGPJHC/2012/149.html>.

⁸ The precise proportion is uncertain, because in many cases the grants were incorrectly attributed to the payee rather than the child, and it is not immediately obvious which child is the supposed beneficiary.

⁹ GHS 2009, own calculations. A study in KwaZulu-Natal in 2002 found that 87 percent of recipients were mothers, and only 10 percent were grandmothers (Case *et al.*, 2005: 472).

Depression. In 1933, a white woman Member of Parliament warned that poor white families

‘constitute a danger to the moral life of this country, a danger to themselves, a danger to our social order, our national character, and, in the end, a danger to our white civilization itself. This is a country that has to take these things into account more than other countries, possibly because of its problems of colour.’

Poor people, she emphasised, must be ‘lifted’ up ‘so that they may not constitute a danger to our white civilization’.¹⁰ A new Children’s Act in 1937 provided for a more generous and extensive programme of maintenance grants for poor children, supplemented with parental or family allowances from 1942. Grants were paid in growing numbers to coloured and Indian families, and even to a small number of African families. The transition to democracy in 1994 made it politically impossible to retain a programme that almost entirely excluded poor African families, but it was fiscally impossible to extend the existing programme to poor African families. The Lund Committee of Child and Family Support recommended, in 1996, that the existing generous but exclusive system be replaced by an inclusive system of Child Support Grants that paid much more modest sums to a much larger number of beneficiaries (Lund, 2008). The new Child Support Grants were introduced from 1998, for children until their seventh birthday. The age limit was steadily raised, eventually to the child’s eighteenth birthday. The result was an explosion in the number of grants paid. By 2012, eleven million children received Child Support Grants, worth (in 2012-13) a modest R280 (about US\$30) per month (South Africa, 2012: 85). The programme redistributed more than 1 percent of GDP to poor families.

The vestiges of a European-style welfare state for children are evident also in the persistence of a small number of publicly-subsidised residential institutions for children. At least 13,000 young people live in more than three hundred ‘child and youth care centres’ registered under the Children’s Act, whilst an unknown but probably large number live in unregistered institutions (Meintjes *et al.*, 2007).

The elderly

The elderly, rather than children, were the focus of the most important pillar of the welfare state constructed for mostly white citizens in the 1920s and 1930s.

¹⁰ Hansard, House of Assembly, 5th June 1933, col. 294-5.

Non-contributory, means-tested old-age pensions were introduced for elderly white (and coloured) men and women in 1929. The motivation, as with support for poor families, was in part to uphold ‘white civilisation’ and a clear racial hierarchy (Seekings, 2007). Pensions were extended to elderly African and Indian men and women in 1944, but white pensioners were paid much more generous pensions than other pensioners. In the 1970s the apartheid state began to reduce racial discrimination in benefits, and finally established parity in 1993, on the eve of the country’s first democratic elections (in 1994). Parity was established at a generous level. The real value of the old-age pension has hardly been changed since 1994. As of mid-2012, the maximum pension payable was R1200 (i.e. about US\$140) per month.

The old-age pension is means-tested, but the income and wealth thresholds area set at a high enough level that only the rich are excluded. The 2009 General Household Survey indicates that almost 80 percent of men and women aged 65 or more received the old-age pension. Women have always been eligible from the age of 60. The age of eligibility for men was reduced from 65 to 60 between 2008 and 2010. Almost three million pensions are paid monthly, redistributing more than 1 percent of GDP.

The rationale for old-age pensions from the 1920s was that working-age adults were often unable to save enough for their old-age. Some poor elderly men and women had no children to turn to for support, whilst many others had children who were unable to support their parents (South Africa, 1927: 9-10). The extension of pensions to African and Indian men and women in the 1940s was motivated in large part by the recognition that neither market nor kin was providing adequately for the elderly (Seekings, 2005). In the 1990s, elderly women pensioners themselves described the government pension as ‘doing the work of our husbands’ or of doing what sons are supposed to do (Møller and Sotshongaye, 1996). Because pensions are set at a generous level – higher than the minimum wage in some sectors, such that some working people’s incomes rise when they retire – pensioners often support their kin rather than vice versa. ‘My family eat this money too’, said one pensioner (quoted in Møller and Sotshongaye, 1996; see also Sagner and Mtati, 1999; Bertrand *et al.*, 2003; Klasen and Woolard, 2009; Bohman *et al.*, 2009).

The combination of old-age pensions and high rates of unemployment is one reason why few elderly people live alone (or with only another elderly person). Three-quarters of elderly people live in households with working-age adults and a small number live in households without any working-age adults but with

children below the age of eighteen years. Only about one in six elderly people lives alone or only with another elderly person.¹¹

The fact that the elderly support financially younger kin does not mean that they are not cared for in other senses by their kin. As anywhere, some elderly people need care. One in six people aged sixty years or older report that they experience at least some difficulty walking, and 6 percent report that they experience at least some difficulty caring for themselves.¹² Bohman *et al.* (2009) argue that cross-generational care is reciprocal in extended African families, with the elderly caring for and being cared by their children and grandchildren. But other studies suggest that support for elderly African men and women is less forthcoming than support by elderly African people (Burman, 1996). Sagner and Mtati (1999) found that most elderly people felt that their adult children were not providing them with the kind of support that they deserved. Indeed, one reason why elderly pensioners shared their pensions with younger kin was that they hoped that their young kin would reciprocate and help them if or when they needed assistance. Without the investment of pension-sharing, Sagner and Mtati were told, kin might turn their back on the elderly. Kinship no longer ensures unconditional care: the provision of financial support and other forms of care is now highly conditional (see also Seekings, 2008; Harper and Seekings, 2010).

Despite the fact that an overwhelming majority of elderly people co-reside with working-age adults, very few adult women and almost no adult men report caring for elderly, sick or disabled members of their households.¹³ There do not appear to be any good data on the extent to which working-age adults care for elderly kin living in other households. Given the prevalence of elderly people co-residing with working-age kin, it is very unlikely that there is a huge amount of care being given to elderly kin living in different households. Overall, household survey data suggest that kin do not spend much time caring for the elderly.

A small proportion of the elderly are cared for through the market, through privately-owned residential institutions. It is unclear what proportion of the elderly live in such institutions, not least because household surveys typically exclude institutions from their sampling frame.

¹¹ NIDS wave 1, own calculations.

¹² GHS 2009, own calculations. NIDS wave 1 asked about more detailed categories of activity. One in three elderly people experience some difficulty doing physical tasks, but very few experienced major difficulty doing activities such as bathing or dressing.

¹³ *Ibid.* Mis-phrasing of the question in the GHS might have resulted in under-reporting of care work.

One aspect of the apartheid-era welfare and care regime did not survive the transition to democracy. Under apartheid, the state provided – both directly, and indirectly via subsidies to churches and NGOs – residential care for elderly white men and women. By 1990, as many as 60,000 elderly white, 3,000 elderly coloured, an unknown but small number of elderly Indian people, and (since 1988, when the first old-age home for African people was built in Soweto) a tiny number of elderly African people were accommodated in state-run or -subsidised old-age homes. The state had already begun to shift responsibility for elderly white people back onto the ‘community’, and justified its neglect of non-white people on the grounds that the ‘races’ had different understandings of responsibility for the elderly (SAIRR, 1988: 439-40; SAIRR, 1990: 312). After 1994, the new democratic state chose not to expand costly public provision for elderly African people. In terms of the 2000 Policy on Ageing and 2006 Older Persons Act, residential care was to be provided only for the (very) ‘frail and dependent’ elderly, who need 24-hour care. Community- and home-based care should provide for the ‘semi-fit’ (Malherbe, 2007). This rollback of publicly provided care contrasted with the expansion of financial assistance by the post-apartheid state.

The sick and disabled

Sick and disabled working-age adults constitute the third category of people widely considered to be deserving of assistance, whether from private or public sources. In South Africa, as in many societies, they are considered deserving because their inability to support themselves through work is due to reasons beyond their control. In the early and mid-twentieth century, South Africa began to develop some of the kinds of public assistance for the sick and disabled that were and are widespread across much of north-west Europe. Social assistance was extended to blind and otherwise disabled white and coloured people in the 1930s, and later extended to African and Indian people. Most non-manual workers were insured against short periods of lost earnings through illness under the state-run Unemployment Insurance Fund. Workers injured whilst working, including on the mines, received some compensation under separate legislation; the dependents of workers killed in the workplace also received some compensation. Whilst the state provided financial assistance, it provided little in the way of direct care, except for mentally disabled citizens.

AIDS increased the number of sick working-age people requiring care at the same time as widespread unemployment inflated the number of adults unable to support themselves. By the 1990s most manual as well as non-manual workers were contributors to the Unemployment Insurance Fund, but most unemployed

people had never contributed or had not contributed enough to render them eligible for health-related income support. In any case, financial assistance was provided for only a short time period. The means-tested, non-contributory disability grant therefore served as the major vehicle for public financial assistance to the sick. In the early 1990s about half a million people received disability grants. The number of beneficiaries grew slowly then, between 2001 and 2004, it doubled, reaching about 5 percent of the total population of working-age adults (South Africa, 2012). When the public health care began to roll out treatment for AIDS, which resulted in many very sick people becoming apparently healthy, the administration of the disability grants became highly controversial (Nattrass, 2007). In at least one very poor neighbourhood, residents complained to the authorities that some grant beneficiaries were not so sick (Kelly, 2012). After 2007, the state tightened access to disability grants, arguing that people needed to take more responsibility themselves.

Despite the growth in the number of disability grant payments, many poor and even not-so-poor South Africans faced huge challenges due to illness. Besides lost earnings, many adults need day care. Richer South Africans can buy care on the market, but poorer people have little choice but to turn to kin. Qualitative research suggests that, in addition to unemployment which produced high dependency rates, AIDS strained the bonds of kinship. Case-studies in both rural and urban areas found that sick kin were often unable to call on distant kin, and the support of siblings even became quite conditional. Mothers were almost the only kin who could be relied on for help, and many people were reluctant to tell their mothers that they were HIV-positive (Neves, 2008a, 2008b; Neves and Du Toit, 2008; Bray, 2009). Elderly women are often the source of care for their adult children as well as grandchildren (especially when orphaned). Kinship-based care is profoundly gendered, and AIDS exacerbated this (Urdang, 2006).

Adult dependents without income of their own

With high unemployment rates, many able-bodied working-age adults are financially dependent, even if they need no day-to-day care. There is almost no financial support for this category of people, who have generally been regarded as undeserving of public support. The Unemployment Insurance Fund and provident funds support some former workers, for short periods. Unemployed, able-bodied, working-age adults constitute the gaping hole in South Africa's social safety net.

Under apartheid, many non-working adults were supported through remittances, often sent by migrant husbands, fathers and brothers working in towns or mines.

The scale of such remittances declined before the end of apartheid, and has continued to decline since the transition to democracy. Between 1993 and 2008 the real value of remittances across the economy increased, but the value of remittances going to the poor declined dramatically. Rather than offsetting inequality in income distribution, the changed pattern of remittances actually contributed to worsening inequality (Leibbrandt *et al.*, 2012).

Without state support, with little or no access to support through the market, and in the context of diminished inter-household remittances, unemployed adults have no choice but to try to attach themselves to kin as their dependents. Where possible, they remain attached to breadwinners. Unemployment therefore traps some people in rural areas and generally delays household formation (Klasen and Woolard, 2009).

Dependence on kin does not come without conflict and stress. Care is negotiated according to what people think is the ‘right thing’ to do in terms of the context and the relationship to the person making claims on them. Grandmothers are more willing to support their grandchildren than their adult children, on the grounds that the latter should be able to support themselves, although allowances are made for the poor job situation. In the ‘normative hierarchy’, support for grandchildren comes before support for adult children. For all kin, however, how deserving any individual is depends on their behaviour as well as their relationship to the carer (Sagner and Mtati, 1999). Quantitative data also suggested that the ‘radius of responsibility’ among African people has shrunk. People might be able to claim on some extended kin, but on fewer kin than in the past, and more conditionally (Harper and Seekings, 2010). Unemployed young men are much more likely than unemployed young women to behave in ways that weaken the claims that they can make on kin. Young men are less likely to contribute to domestic chores (Wittenberg, 2009). This is probably a factor in the apparent difficulty that many young men experience in finding a stable, long-term source of support.

Conceptualising South Africa’s welfare state and care regime

Whilst South Africa has massive unemployment and widespread poverty, it is also a middle-income country with a state that is, in many respects, strong and active. South Africa’s social grant system is not only exceptional in continental Africa, but entails very high expenditure in proportion to GDP relative to other countries across the global South. Through its social assistance programmes, the

South African state reaches about one half of all households, and most poor ones. The state also regulates some aspects of care – including, especially, the foster care of children.

The design of the welfare state and state organization of care has many of the features associated with the ‘liberal’ welfare regimes of the English-speaking advanced capitalist democracies – which is unsurprising, given that many of South Africa’s social programmes were designed on the basis of programmes in Britain, Australia and New Zealand. There is very limited state involvement in risk-pooling, contributory social insurance programmes, and the state’s resources are directed towards means-tested social assistance programmes focused on standard categories of deserving poor. In terms of their design, the state’s social assistance programmes focus on groups of people who cannot provide for themselves through the market. In this sense, the state’s programmes are residual, filling the gap left by the market. The state has encouraged the expansion of market provision, in part to avoid additional fiscal pressures. State policy thus promotes contributory pension plans, contributory health insurance, and private crèches. With respect to childcare, the expansion of the market has been dramatic, with the rapid growth of crèches – at the same time as the expansion of public provision (through Grade R in school).

Unlike the liberal welfare regimes of the global North, however, South Africa’s social assistance programmes have a very wide reach: almost one in three adults and children receives every month a grant of some sort, and about two-thirds of the population lives in a household where someone receives a grant of some sort.¹⁴ Similarly, the proportion of South African children in formal, court-ordered foster care is very high in comparison to other countries. This suggests a welfare regime that is somewhere in between a targeted ‘liberal’ regime and a more inclusive or universal ‘social democratic’ one. Coverage is less than universal (although the government committed itself, in 2013, to removing the means test on the old-age pension, making it universal). Decommmodification has its limits.

South Africa’s welfare and care regimes also rely far more heavily on family and kin than either the classic liberal or social democratic regimes of the global North. Public provision in South Africa does not so much fill the gaps left by the market as fill the gaps left by diminished kin provision. Kin care for children, sometimes in return for modest remuneration, they look after the elderly when necessary and they tend for the sick and disabled. They also bear the primary burden of supporting financially unemployed and other jobless working-age

¹⁴ NIDS wave 1, own calculations.

adults. South Africa's welfare and care regimes thus share some features with some of the family-oriented 'conservative' welfare regimes of Europe, including especially Southern Europe (Ferrera, 1996; Naldini, 2003).

Over the past century, both the depth and breadth of kin provision have declined. This decline has been especially striking with respect to paternal kin, with the decline of patrilineal responsibility. The physical separation of fathers and even mothers from their children, the uncertainty of employment, the inadequacy of wages, and cultural norms that support more fluid roles for adults result in pensioned grandparents – especially maternal grandmothers – providing substantial care-work in many South African families. The extended family has not disappeared, but its roles have changed.

The complexity of South Africa's welfare and care regimes reflect their dualist history. Liberal welfare and care regimes were provided for white South Africans, although they were more closely aligned with the 'wage-earners welfare regimes' of Australia and New Zealand (Castles, 1985), with extensive state intervention in the labour market, than the British model (Seekings and Natrass, 2005). The apartheid state provided little for its African subjects, who relied primarily on kin. The deracialisation of public policies and the decline in kin support in the late twentieth century pushed the welfare regime in a more social democratic direction, but the state retreated from its limited role in care, pushing people into reliance on kin or (increasingly) market. The South African welfare and care regimes have some similarities with the family-oriented Southern European cases. One difference, however, is that the extended family in South Africa remains important whilst having undergone dramatic change. Kin are crucial to care and financial support, but patterns of kin support are very different to historic patterns.

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