South Africa: Failure and Success in Public Services

TOM LODGE is a politics professor at the University of Limerick in Ireland. He is a member of an Irish-Aid funded research team based at Limerick and universities in South Africa, Uganda and Tanzania that is looking at the ways in which African public administrations cope with the HIV/AIDS pandemic".

One of the best ways to assess how well a government is performing is the degree to which it meets the needs of its citizens. Most African governments invest their largest budgetary allocations on health and education. South Africa is unusual in the degree to which it also spends on social welfare: only a few African countries can afford the payment for universal pensions and the other entitlements which keep around a third of the South African population dependent upon state grants. But if we want to compare South African state effectiveness with the capacity of other African states, looking at education and health is probably fair and certainly illuminating, particularly as comparisons about quality don't always correlate with relative resource endowment. Within South Africa, contrasting the outcomes and quality of public provisions for education and health also offers its own insights about the reasons of why successes and failures happen.

In this article, two brief overviews of public education and of public health respectively will show, on the one hand, a system that has been failing citizens badly and, on the other hand, public provisions that despite their shortcomings have obtained real gains. The last part of this article will make the case that the main reason for the comparative failure of South African schools and the relative success of South African health services is political.

Public Education

Opposition party politicians often claim that South Africa's system of public education is close to being the worst in the world. It's a view that was confirmed recently by a ministerial task team.[1] We know from international comparative data that South Africa's public schooling performs very poorly. For example, an evaluation by the Southern and Eastern African Consortium for Monitoring Education Quality tests grade six students with a standardised set of questions on maths and reading. Out of 15 African countries, South African students' performance was ranked tenth for reading and eighth for maths in 2010.[2] Annual national mathematics assessment by the Department of Basic Education of grade 9 students generated a 13 per cent score for basic competence in 2012. The same year, nearly thirty per cent of children in Grade Six were illiterate and forty per cent didn't have the numeracy that would be expected at this level.

What is striking about the comparisons with other African countries is that South African public education is relatively well resourced. Per capita expenditure is higher than anywhere else in Sub-Saharan Africa except for Botswana and Seychelles. It represents around 6 per cent of GDP – a much higher proportion than in most African countries, and moreover, since 2008, educational expenditure has been rising. Moreover in the last twenty years expenditure increasingly targets poor schools in

poor neighbourhoods, especially recently. The historic racial inequities in per capita public expenditure ended more than a decade ago and in consequence the provision of state-funded teachers in historically white and black schools is the same, though, of course today's middle class schools have recourse to private resources unavailable to poorer schools to pay for additional teachers. In comparison to elsewhere in Africa, South African teachers are better qualified, trained for longer periods, and better paid – much better paid – and their pay has improved sharply, recently. So what we have is a relatively well resourced system performing badly when it is compared to the way schooling functions in much poorer national settings. And if we extend the comparisons internationally the relative picture is even less flattering. In 2012 the World Education Forum found that only 9 out of 142 national systems were working worse than South Africa's.

Resource-related issues do explain some of the difficulties. Last year it was still the case that 23,000 South African public schools didn't have libraries or book collections. It's still the case that nearly a third of Eastern Cape schools lack electrical connections. Rural teachers are generally less well qualified and when tested often have inadequate subject knowledge compared to their urban counterparts. Too many teachers still struggle with junior classes with more than fifty pupils. The point is that, notwithstanding the equalisation of expenditure provision, sharp resource inequities remain. Yes, in general, even very poorly resourced South African schools may be favourably endowed compared to schools in other African countries, but in South African inequity has an especially demoralising impact. Reports of high absentee-ism by teachers, overuse of discretionary leave, especially before and after weekends, and strikes are especially concentrated in the more poorly resourced schools. Reflecting this, overall averages indicate that teachers in historically black schools spend much less time in the classroom than teachers working in former white suburbs.

Secondary school completion rates are rising. Compared to the rest of Africa school enrolment in junior grades is excellent – almost universal.

There have been signals of incremental improvement. Secondary school completion rates are rising. Compared to the rest of Africa school enrolment in junior grades is excellent – almost universal. In the last couple of years testing suggests that maths performance has become a little better among students who remain in school in Grade 9, a reflection of ministerial emphasis on "back to basics", and probably a result of the concerted effort to provide nationally standardised subject workbooks. Fewer students drop out after Grade 9. Improving matriculation results may indicate genuine accomplishment, though experts warn that schools might be weeding out students who might be at risk of failing.[3] And, of course, when we consider the totality of South Africa's public education, one sector within it functions rather well. Keeping in mind the demographic changes experienced in student enrolments in South African universities, those among them that have changed most are performing outstandingly well, well up to international standards of achievements, as global higher education rankings confirm.

So it is not entirely a bleak picture. But given the resources that have been expended and the expectations that exist amongst the vast number of South Africans who still believe that education is the key to their children's future, one would expect clearer and less ambiguous evidence of achievement. And when we contrast the quality in public education with the performance of the public health system, its shortcomings appear all the more pronounced.

Public Health

The great achievement over the last seven years or so in South African public health, has been the halting of the death rate for HIV/AIDS. This is, of course, largely a consequence of a massive growth in the number of South Africans who take antiretroviral medication, around three million today compared to 107,000 in 2005. Much of this medicine is prescribed by public health clinics, 2000 of which now offer the drugs and supply or help to organise the supportive regime that is needed by patients. Virtually all primary health care facilities test for HIV/AIDS: in 2010/2011 about ten million people underwent testing, much of it done by redeployed retired nurses. Infant mortality, up sharply between 1994 and 2003, is now down to 1994 levels as a consequence of treatment and support for pregnant women.

Meanwhile increasingly sophisticated preventative messaging has apparently impacted upon sexual behaviour of younger people and another preventative measure, the provision of circumcision, has expanded very quickly for between 2010 and 2013 more than a million men underwent the operation. Much of this success is attributable to the mobilisation of around 60,000 lay counsellors or Community Health Workers who play a key role in helping to maintain patients' adherence to the treatment regime[4] – the "attrition rate" of fall-off from treatment regimes by patients is at 3 per cent comparatively low. To be sure, the availability of these workers has a lot to do with the relative vitality of community based organisation rather than the quality of the state's efforts to engender such support. But even so they are coordinated in a public programme and paid for with state funded gratuities. Of course this effort has resulted in increasing state health expenditure, up to 13 per cent of the budget in 2013 from around 12 per cent in 2010, and the government has begun to depend substantially on foreign aid, though most AIDS-related spending is and will remain exchequer funded.

Of course this effort has resulted in increasing state health expenditure, up to 13 per cent of the budget in 2013 from around 12 per cent in 2010, and the government has begun to depend substantially on foreign aid, though most AIDS-related spending is and will remain exchequer funded.

In other African countries, the redirection of health services to measures to address the HIV/AIDS pandemic has resulted in the erosion of other kinds of health care, most commonly with respect to antenatal care, supported birth deliveries, and immunizations. The evidence from South Africa indicates that these sorts of services have improved or at least expanded. Since 2005 there have been real increases in per capita health expenditure. Increases in the employment of nurses mean that nurses' patient loads in primary facilities have fallen. Usage of hospital facilities has increased, but despite hospitals coping with more patients, Statistics South Africa's general household surveys testify to falling rates of dissatisfaction with the quality of hospital services.

Public health is still beset by inefficiencies including serious shortcomings in the administration of the HIV/AIDS treatment regime. Both the Eastern Cape and the Free State have had to interrupt treatment because of poor supply management and weak financial controls. Even the most favoured urban hospitals are unable to secure equipment replacements as a consequence of unpaid bills. For instance in 2011, Soweto's Chris Hani Baragwanath owed one supplier R8 million. Overworked and consequently overstressed doctors misdiagnose. Even supply of bed linen and food for patients is hostage to incompetent managers in the provincial government who control contracting and tendering for hospitals. Government investment

in capital expenditure on hospital buildings has little impact upon the routine maladministration of hospital services. In general, the Minister, Aaron Motsoaledi, freely concedes that the poor majority of South Africans encounter hospital facilities that by the kindest definition are certainly "second rate". There is still much that is seriously wrong with South African public health but aggregate statistics on access to services and outputs from these services as well as surveys of citizens' opinions does suggest a general trend in which public health is working better. It's a qualitatively and quantitatively different picture from education.

Why, though?

One reason is surely that the nature of the challenges addressed by each is different. In certain respects, and up to a point, in the case of health, some kinds of improvements can be achieved by comparatively simple engagements between the agency providing the service and the people in need. For example the spread of certain diseases can be checked by immunisations that might only be needed once or a few times only. In other words much can be achieved through improving people's access to health care. Certainly, in the case of HIV/AIDS treatment patient engagement needs to be sustained and regular and supported by monitoring and counselling: not all kinds of public health can be undertaken through one-off encounters. But compared to the long term teaching and learning procedures that are involved in primary and secondary education achieving effective care for many kinds of illness is simpler. Prevention is more complicated and the processes that lead to behavioural change are very comparable with what happens in effective education. But a public health system can register gains in the way that has happened in South Africa while continuing to be weak in many respects.

Achieving comparable aggregate gains in education requires much more thoroughgoing systemic reform. Moreover, there is probably wider disagreement amongst experts in the field as to what is needed.

Achieving comparable aggregate gains in education requires much more thoroughgoing systemic reform. Moreover, there is probably wider disagreement amongst experts in the field as to what is needed. The debate within South African educational circles about the merits or shortcomings of "Outcomes-Based Education" is a good example of this, though now there is general recognition that the curriculum the government launched in 1998 and which it has revised successively since then, in its early versions made very unrealistic assumptions about student willingness and ability to undertake self-directed learning. In any case, too many teachers simply didn't understand how they were expected to teach the new syllabus.

The deeper reason though for the difference in results in education and public health is, surely, political. President Mbeki's efforts to limit the provision of anti-retroviral medication to AIDS patients and his questioning of medical orthodoxy certainly did much harm. One calculation is that if medicine had been prescribed on the same scale that it is made available today when it first became really affordable, in the early 2000's, several hundred thousand lives might have been saved.[5] But Mbeki's efforts to change the government's policy orientation on AIDS had an unintended positive effect. They prompted political mobilisation around the issue, not just through the institutional channels for public participation in policy making but also by extra parliamentary action undertaken by an extraordinarily effective social movement, the Treatment Action Campaign (TAC). Protest and citizen sponsored litigation

helped to reshape policy. Litigation by itself would not have been enough, however. Rather the political theatre supplied by TAC's street-based actions helped to open up the kinds of divisions within the ruling party to ensure that, within the executive, there was the necessary political will to act upon and implement constitutional court judgements. But civic action was important in another way too, because the NGO community also supplied through its own programmes models of how mass "roll-out" of treatment could be managed using community support. Here the pioneering experiences of Medicine Sans Frontieres and the TAC in organising their own treatment programmes in Khayelitsha and Lusikisiki were especially influential.

Rural schools are especially affected by demoralised and undisciplined teachers – who too often have their behaviour sanctioned by a protective and politically well-connected trade union.

This set of impetuses for effective action has been missing in education so far. Not that there haven't been successful instances of protest. The Equal Education movement assembled thousands of school children in a demonstration outside Parliament in February 2011 to back its complaints about the dilapidated state of the basic fabric in Eastern Cape schools – and indeed in response the government agreed to spend more money on repairing and improving buildings. One year later Section 27 took the authorities to court over the delays in supplying workbooks. All that is well and good, and certainly correcting inefficiencies in this kind of resource provision may help make education significantly better. But what is needed in public education is the kind of social engagement on changing its functioning that extends well beyond demonstrations and a few court cases.

Rural schools are especially affected by demoralised and undisciplined teachers – who too often have their behaviour sanctioned by a protective and politically well-connected trade union. School Governing Bodies are supposed to check abuses and malpractice by teachers; in the countryside these function poorly, especially in settings in which many adults are illiterate and easily intimidated by patrimonial displays of authority. In the case of HIV/AIDS treatment, as noted above, models of good practice were developed by NGO's within desperately poor communities. In education, debate about its content and methods rarely moves outside the social circles inhabited by the policy elite and academic specialists.

A final consideration that makes the politics of public education different from health is that a massive expansion of bad education has one key success to its credit. It has facilitated very rapid social mobility. South Africans may score at the bottom of the league tables when it comes to proficiency in reading, writing and arithmetic, but access to secondary and higher levels of education has widened and hence the numbers acquiring the formal qualifications needed for entry into white collar jobs has swollen. In public health, the penalties and costs of inefficiencies are immediate and obvious to everybody: people die. In education, the cost are long term, and hence for politicians easier to ignore.

NOTES

1 Republic of South Africa, Department of Basic Education, The Ministerial task team Report on the National Senior Certificate, Pretoria, 26 May 2014.
2 SACMEQ Policy Issues Series, What are the levels and trends in reading and mathematics achievement, no. 2, September, 2010 (www.sacmeq.org).
3 Republic of South Africa, Department of Basic Education, General Education System Quality Assessment: Country Report, South Africa, UNESCO, October 2013.
4 Helen Schneider et al, H Hlophe and D van Rensburg, 'Community Health Workers and the Response to HIV/AIDS in South Africa: tensions and prospects', Health Policy and Planning, 2008, 23, 3.
5 P Chigwedere etal, 2008, 'Estimating the lost benefits of anti-retroviral drug use in South Africa', Journal of Acquirrf Immunity Deficiency Syndrome, 2008, 49. 4.