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Disability and Welfare in South Africa's Era of Unemployment and Aids

Introduction

South Africa's welfare system is exceptional amongst middle-income and developing countries (Seekings, 2005b). It provides generous means-tested non-contributory old-age pensions for the elderly, disability grants for those too ill or incapacitated to work, and child support grants for the care-givers of children. Approximately 10 million social grants are paid out each month, amounting to about 3% of the Gross Domestic Product. But despite this relatively generous level of social assistance, pressure on the welfare system continues to grow – most notably on disability grants which rose from about 600,000 in 2000 to almost 1.3 million in 2004 (see also Nattrass, 2006).

This is in part a consequence of the Aids epidemic. As can be seen in Figure 1, South Africa has one of the highest rates of HIV infection in the world. According to the ASSA2003 demographic model, by 2004, half a million new Aids sick cases were occurring each year.[1] Many of these people were able to access disability grants. A recent analysis of a sample of disability grant files reported that the number of disability grants for people suffering from 'retroviral disease' or who were 'immuno-compromised' rose from 27% in 2001 to 41% in 2003 (CASE, 2005: 63).

However, Aids is not the only reason for the rapid take-up in disability grants. The increase was facilitated by institutional changes to the disability grant system that enabled local decision-makers to respond to growing pressure from citizens to use the disability grant in part as a form of poverty relief. This pressure, in turn, is a consequence of South Africa's high rate of unemployment (see Figures 1 and 2) and the absence of any social security for the unemployed.[2] Unemployment is now the major driver of poverty and inequality (Seekings and Nattrass, 2005) – a situation exacerbated for many by the Aids

[1] The ASSA model can be downloaded from the ASSA website: www.assa.org.za.

[2] There is some social insurance for the unemployed. The Unemployment Insurance Fund (UIF) provides income support for up to 36 weeks for those who have contributed to the fund who subsequently become unemployed. However, typically fewer than 5% of unemployed people receive UIF payments.

epidemic (Nattrass, 2004b). Given that the disability grant is the only social grant available to adults of working age, it is unsurprising that South Africa's dual crisis of unemployment and Aids (see Figure 1) is resulting in a sharp increase in disability grants.

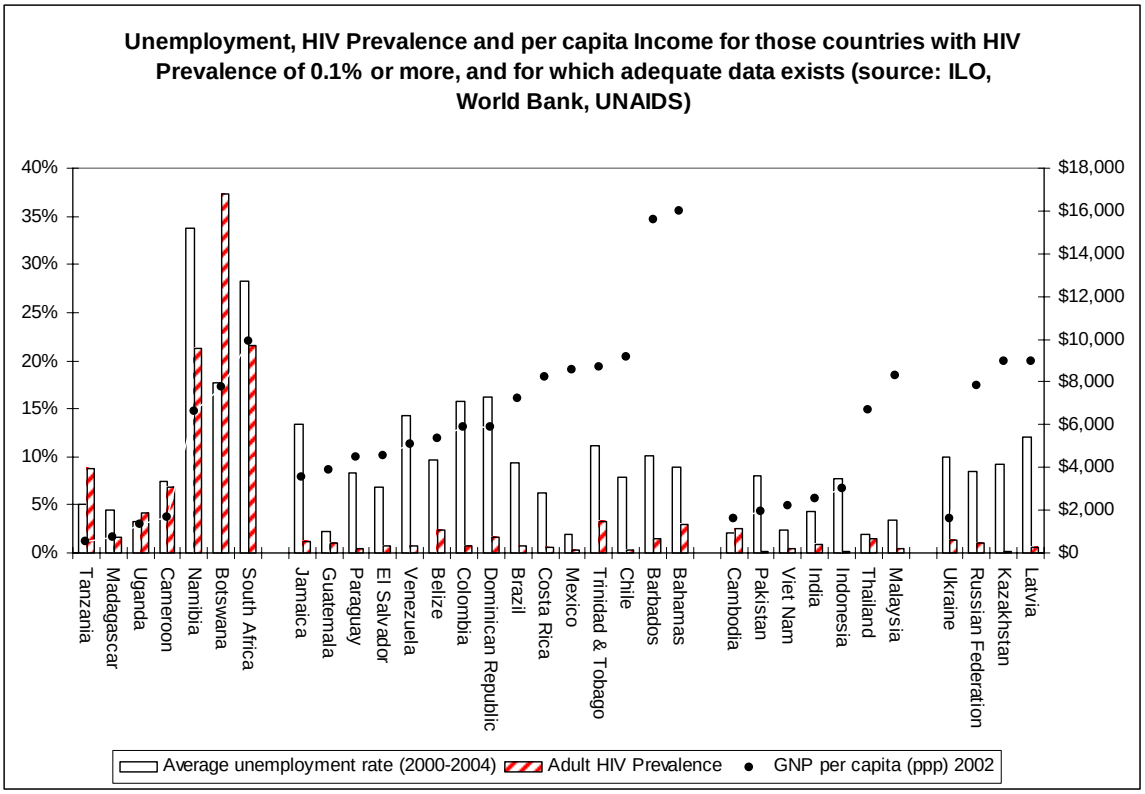

Figure 1: A Comparative Perspective on AIDS and Unemployment

This poses a major challenge for South Africa's welfare system: should it continue to be based on the manifestly incorrect premise that all able bodied adults can support themselves through work; or should it be redesigned to address the large hole in the welfare net through which so many unemployed people are currently falling? This paper argues that in light of the perverse incentives generated by the current system (which leaves many people choosing between income and health), wide-ranging changes are needed to the welfare system. Building on earlier work (Nattrass, 2006), the paper argues that there is growing evidence that current disability policy is creating incentives for people to become and/or remain ill – and that this could be exacerbating the Aids epidemic and undermining the antiretroviral treatment rollout.

There is also evidence of an emerging recognition on the part of local decision-makers of the legitimacy of claims by poor people to improved levels of social security – especially for the unemployed. Recent changes wrought by the national government to tighten up access to the disability grant, thus fly in the face of this emerging discourse of citizens rights. They are therefore likely to be

unpopular and will probably continue to be subverted by local decision-makers wherever possible. Rather than attempting to restrict access to social grants, a case is made for broadening access to the unemployed either by introducing an employment guarantee scheme (to provide jobs directly) or a basic income grant (to provide a minimum, unconditional, income to all citizens).

The Disability Grant System

As specified in the Social Assistance Act (Act 59 of 1992/Act 13 of 2004) individuals are eligible for a disability grant if they pass a means test and if, as a result of mental or physical disability, they are unable to provide for themselves through employment or professional activity. The grant is designed for working-aged adults[3] under the clear expectation that those who are in principle capable of working should not be eligible. According to regulations issued by the national Minister of Social Development, a person is only eligible if the degree of his or her disability makes him or her incapable of entering a labour market. The applicant must not refuse to accept employment which is within his or her capabilities, or to receive treatment which may improve his or her condition. In other words, the grant is not designed to compensate people for their disabilities *per se*, but rather to compensate them for the impact of their disability on earning potential. That people may be able and desire to work, but unable to find it, is irrelevant to the legislation. But it appears not to have been irrelevant for all of those awarding disability grants between 2001 and 2004.

There is evidence that the rapid take-up of disability grants between 2001 and 2004 was facilitated by institutional changes to the grant awarding process and by sympathy on the part of at least some decision-makers towards using the grant to provide poverty-relief for applicants. The 2001 amendment (effective from December 2001) to the Social Assistance Act, empowered provinces to disestablish the role of the Pension Medical Officer (PMO), who previously had evaluated and adjudicated disability grant recommendations made by medical officers (MOs) thereby ensuring a degree of oversight and standardisation to the system. The amendment gave provinces the choice of continuing with the old system, or replacing it with assessment panels (APs), whose members did not necessarily have to be medical doctors, or with a mixture of APs and MOs (see the Appendix for a summary of the different approaches adopted by the provinces). This move in the direction of 'community-based' targeting was

[3] Disabled individuals below the age of 18 are eligible for child support grants (through their care-givers), and those who have reached pensionable age (60 for women, 65 for men) receive the old age pension rather than the disability grant.

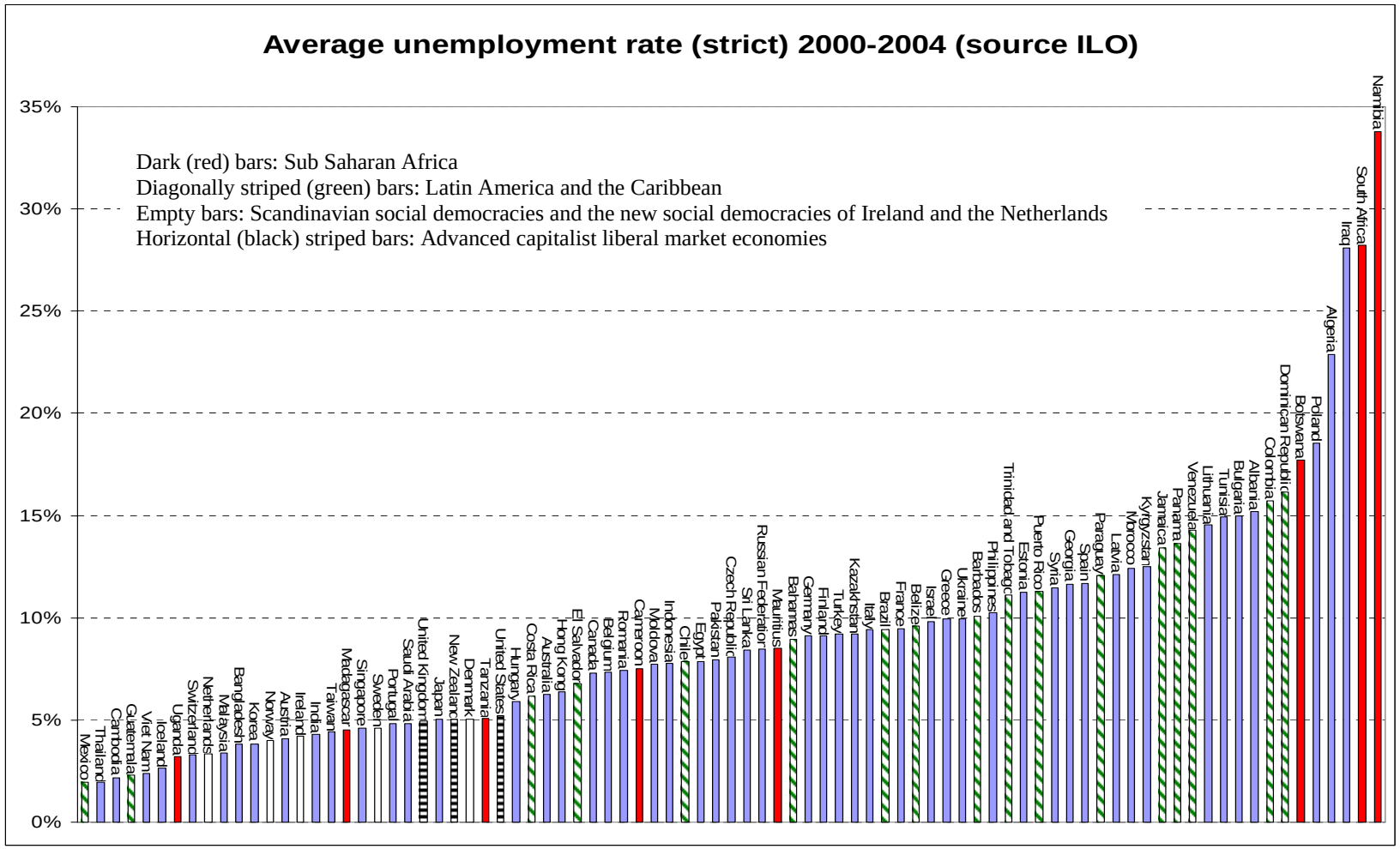

Figure 2: National Strict Unemployment Rates (estimated from broadly comparative national labour force surveys)

consistent with the growing recognition internationally, that given the complexity and high cost of disability targeting, that the community may be in a better position than bureaucrats to determine eligibility.[4] However, it enabled 'social' factors to be introduced into what the legislation envisaged should be a purely 'medical' decision.

In 2004, the national Treasury commissioned a group of researchers from the Community Agency for Social Enquiry (CASE) to determine the reasons behind the sharp increase in disability grants. As part of this project, researchers visited selected sites in all provinces and spoke to a range of officials involved in the assessment and award of disability grants. They reported that poverty and unemployment were the most commonly cited reasons for the increase in the number of grants:

> "The perception that the disability grant is viewed as a form of poverty alleviation by both applicants and some involved in the assessment and approval process was almost universal, although interviewees differed in whether they were sympathetic to this interpretation or not" (CASE, 2005: 92).

The research report includes a set of perceptive quotes and observations on this issue. For example, at Ongoye in KwaZulu-Natal, the clerks argued that poverty is rife in the area and that the disability grant is viewed as '*igrant yokuhlupheka*' or 'the grant for the poor people', both by the general public and some involved in the assessment process. A provincial verification official from Xhariep in the Free State is reported as saying that "The problem is that people seem to think that if I do not have a job, then I can apply for the disability grant so that I can get some money to feed my family" (CASE, 2005: 92). Officials told researchers that APs in KwaZulu-Natal and the North West province were sympathetic to the social plight of people and awarded grants to help them 'maintain themselves'.

This growth in the number of disability grant recipients was not always seen as a problem by officials. A senior official in the Xhariep district office described the introduction of APs as "effective in that many people came into the system and that is an improvement that one would say the department has achieved in terms of bringing services to the people". He did observe, however, that the

[4] See Mitra (2005: 20-21) on international recognition of the complexities and expense of disability targeting, and the advantages that community targeting may bring to the system. Responsibility for disability grants have been devolved to provincial/state level in Canada, and to municipal level in Sweden precisely to ensure that it is tailored to local conditions (Whiteworth *et al*, 2005).

department "did not have enough funds" for this (quoted in CASE, 2005: 93). A similar note was struck by an official from KwaZulu-Natal:

> "The disability grant, as the name indicates, should be based only on disablement. But somehow it becomes a bit difficult to ignore the socio-economic part… because people who are living in rural areas may not be working or do not necessarily have opportunities to work. But we don't necessarily want to change the disability to be a basic income [grant]" (*ibid*: 94).

The above quotes point to the ambiguity experienced by officials involved in the disability grant system at local levels: they see the need for greater social security, yet appreciate that the disability grant may not be the appropriate vehicle for it. At the same time, they appear to recognise (and appreciate) an emerging discourse of access to social grants as a right of citizens and an obligation of the state. According to the CASE report:

> "Interviewees also noted that in the context of high unemployment many people feel that the government has a responsibility to provide them with social assistance and that they are entitled to these grants. In some provinces this was blamed on the government's 'marketing' of the social grants, which leads the public to believe that if they have no income they will be entitled to access assistance from the government. A senior verification official at the Bloemfontein provincial office remarked: 'Is it not that people think [they can get the disability grant] because the government is saying that every person has the right to social security?'" (CASE, 2005: 95).

This emerging interpretation of the rights of citizens to social assistance seems to have been assisted by the expansion of the number of Department of Social Development service points and by various awareness campaigns. As an official from the Northern Cape put it:

> "There are many people who are more aware of their rights. If you look at places like the old homeland states, those people never knew what a grant was. They only knew the old age grant. So as freedom came with education and the bill of rights and the necessary campaigns and imbizos of government, [that] made people to knock on government doors" (quoted in CASE: 2005: 95).

In order to stop the disability grant from becoming a form of poverty alleviation, the CASE report recommended a narrow set of managerial solutions including the adoption of standardised assessment tools and clear uniform eligibility criteria, the simplification of the means test and its enforcement for

every applicant, and better education of frontline staff about the rules of disability grant management (CASE, 2005: 119-20). Such recommendations were consistent with the letter and spirit of many reforms that had already taken place in 2004 to reduce the growth in disability grants. These included the scrapping of APs and/or the sharp curtailment of the discretionary powers of local officials (see the appendix for more detail).

The problem with this policy response is two-fold. Firstly, it does nothing to address the social roots of the growth in disability grants – i.e. unemployment, poverty and Aids. Secondly, it is blind to the complex reasons why many local-level MOs and/or APs, responding to local conditions, awarded large numbers of disability grants as soon as the system provided the flexibility to allow it. Although this resulted in policy variation within the country (something which neither the CASE researchers nor the national Treasury approved of), it had the advantage of being responsive to local conditions and social attitudes. The new measures are thus likely to lack legitimacy and will probably continue to be subverted by sympathetic MOs and other local officials.

A possible response to this would be to tighten the rules yet further and introduce another layer of bureaucrats to check local officials. This, however, could raise costs substantially. For example, in the USA, where successful applicants have to survive a rigorous 'five step disability test', disability payments comprise only 15% of total social security benefit payments, yet account for 45% of the administrative costs (Mitra, 2005: 19-20). Reducing the number of beneficiaries in this way will thus come at the (deadweight) cost of a more bloated bureaucracy whilst doing nothing to address the underlying problem of inadequate social assistance for the unemployed. Furthermore, it will do nothing to address the perverse incentives created by the system for people to become and remain ill/disabled.

Perverse Incentives to Become and Remain Ill or Disabled

Given South Africa's high unemployment rates and relatively generous disability grants, illness has itself become an important source of income (Nattrass, 2006). This reality is reflected in the following quote from a MO in a tuberculosis (TB) clinic in the Western Cape:

> "In my experience, the majority of the patients are really coming mainly because they are unemployed and not so much because of illness. It seems sometimes to me that developing TB is a kind of a

> blessing for some of them, that they now stand a chance of getting a grant" (quoted in CASE, 2005: 93).

The problem with this, of course, is that if illness is a much desired ticket to a grant, then this may well undermine adherence to the treatment required to cure (or manage) the illness. A MO from the Northern Cape complained of precisely this with regard to TB patients: "People won't take their tablets… because they want to stay on the system. Poverty is in such a proportion that people will do things that could kill them to get the grant" (*ibid*).

The same problem is evident with regard to Aids. There are reports that people may be attempting to become HIV-positive in order to get the disability grant (see Nattrass, 2006, Leclerc-Madlala, 2005). The fact that until late 2004, the North-west province allocated disability grants to people simply on the basis of being HIV-positive may have contributed to this problem. Since then, provincial policy towards Aids-related disability grants has been standardising around a medical model which restricts disability grants to those who are Aids-sick (i.e. in the final stages of the illness – usually understood to occur when a patient's CD4 cell count drops below 200 cells per millilitre of blood).[5] This means that being HIV-positive is not enough, people must be deemed to be suffering from Aids. This, in turn, has created incentives for people to become ill. In this regard, a representative of the National Association of People with Aids (NAPWA), has been quoted as saying that HIV-positive people who had not yet become 'sick enough' to qualify for the disability grant start 'neglecting themselves' in order to 'qualify for government grants to put bread on the table'.[6] He went on to argue for job creation for HIV-positive people. This highlights, once again, the growing desperation amongst adults of working age who cannot access social assistance – and the enormous pressure that this is placing on the disability grant as a consequence.

As discussed in Nattrass (2006), this problem is also potentially serious with regard to the antiretroviral (ARV) treatment rollout. ARV treatment has the effect of restoring a person's immune system thereby facilitating a rebound in their CD4 cell counts. As their health improves, they therefore no longer qualify for the disability grant. This is entirely consistent with the underlying premise of South Africa's welfare system – i.e. that only those too sick to work should be provided with social assistance. As the ARV rollout progresses through the country, more and more people will lose their disability grants. It

[5] Leclerc-Madlala reports that a Durban hospital has decided to support applications for disability grants only for those patients whose CD4 counts are below 50 in order to 'stem the rising tide of patients seeking grant certificates' (2005: 6).
[6] Quoted in HIV/Aids News no.126, 15/7/05, available on www.learnscapes.co.za

has been estimated that by 2010, more people will be losing their disability grants through restored health than will be gaining access to them (*ibid*).

This is likely to cause severe economic hardship to households that had previously relied on the grant (*ibid*) as well as undermine the food security and health of people on ARV therapy. According to Dr Khumalo (Rob Ferreira Hospital in Mpumalanga):

> "It does not help that the government takes away the grant once a person becomes better on treatment. Personally, I don't approve because most people on antiretrovirals are poor and they need the grant to survive. With the grant they are able to buy basic food that is necessary to complement antiretroviral treatment. After the twelve month deadline of the grant expires, patients start to become depressed and they start developing side effects to their treatment since most of them have to take their medication on an empty stomach. Without the grant you find that the patient's CD4 counts drop and they start becoming very ill again" (quoted in *Equal Treatment*, December 2005: 11)

Anecdotal evidence from patients and doctors suggests that some individuals may opt to stop adhering to their antiretroviral therapy in order to increase their viral loads and reduce their CD4 cell counts in order to re-qualify for the disability grant (Leclerc-Madlala, 2005; Nattrass, 2006). A recent Aids Consortium meeting of representatives of close to 100 organisations dealing with HIV/Aids from Limpopo and Gauteng highlighted the poverty-alleviating aspect of the disability grant and reported that people were indeed refusing to adhere to antiretroviral therapy "because they are scared that their CD4 count will improve and they will lose the grant" (McCalla-Kay, 2005). The report noted that some people would "rather die of Aids than lose the disability grant" (*ibid*).

That people are considering trading off their health in order to obtain access to a disability grant is an act of terrible desperation. It reflects the enormous problem of poverty and unemployment in a context where the only form of social assistance for able-bodied adults is the disability grant. No wonder, then, that many APs and MOs between 2001 (when greater discretion was facilitated by institutional changes) and late 2004 (when greater controls were imposed in all provinces) felt compelled to consider the socio-economic environment facing disability grant applicants when making their recommendations for disability grants. This was not simply a matter of them adopting a rival 'social' model of disability over the managerially neater (and fiscally cheaper) 'medical' model – it almost certainly also reflects the fact that medical approaches to illness could

not be isolated from the social context. Discussion of policy options needs to be cognisant of this reality.

Towards Policy Reform

All welfare systems are predicated to some extent on the duty of individuals to work, the idea being that welfare should function as a safety net, rather than as an alternative to work. However, welfare systems differ in terms of the level of welfare support and in terms of the policing mechanisms they put in place to ensure that the so-called 'undeserving' do not access social assistance.

In developed economy welfare systems, people of working age are either assisted to find employment, or have access to social security either in the form of income support for the unemployed (or if they are disabled, in the form of disability grants). The underlying assumption is that adults of working age should be productively engaged, and where possible should contribute to social insurance schemes to provide for their own retirement, disability, and periods of unemployment. Social assistance from the state is targeted specifically at those who have been unable to contribute to social insurance schemes or whose benefits from such schemes have proved inadequate (e.g. for long periods of unemployment). Social assistance is typically means-tested and in many countries is increasingly dependent on participation in labour-market programmes designed to improve the employability of grant recipients and to assist them in finding work. This approach has been made easier by buoyant economic conditions in the advanced capitalist countries and by specific labour-market reforms to boost employment.

By contrast, most developing countries do not have such comprehensive welfare nets. Instead, they rely on people being able to earn an income through employment (whether in the formal or informal economy, or in the agrarian sector) and being supported by their kin (Seekings, 2005b). Over the past two decades, urbanisation, de-agrarianisation and a declining capacity to absorb new labour-market entrants into formal employment has posed challenges for many developing country welfare regimes. Some, like Mexico, opted to boost employment through labour-demanding growth strategies (including flexible labour market policies) and by supporting the incomes of the poor through a set of targeted programmes (Whitworth *et al*, 2005: 10-16; Mitra, 2005: 29-30). Others have opted to introduce more 'workfare' oriented policies. Such countries included India, which expanded the Employment Guarantee Scheme (previously limited to Maharashtra) to the entire country (Bagchee, 2005; Seekings, 2005a: 4-6); Ethiopia, where social assistance in the form of food aid is conditional on participation in public works programmes; only those too sick

to work are allocated free food aid (Quisimbing and Yohannes, 2005) and Argentina and South Korea (which introduced massive public works programmes to cope with economic crisis (Seekings 2005a: 5).

In neither the developed nor developing economy welfare regimes do the disabled have an incentive to become or remain disabled. In developed economy welfare regimes people are provided support if they are poor, unemployed and want to work, or too disabled to work (see Figure 3). There is no hole in the welfare net. Most developing countries target the poor in general (rather than the disabled in particular) and place great importance on promoting income-earning opportunities. There is thus no incentive built into these welfare systems for the poor to become disabled, or to prevent themselves from becoming cured of their disabilities. South Africa is one of only a few developing countries that provide a disability grant[7] – but it has done so in a context in which there is little or no support for the unemployed, thus resulting in a set of perverse incentives to become or remain disabled.

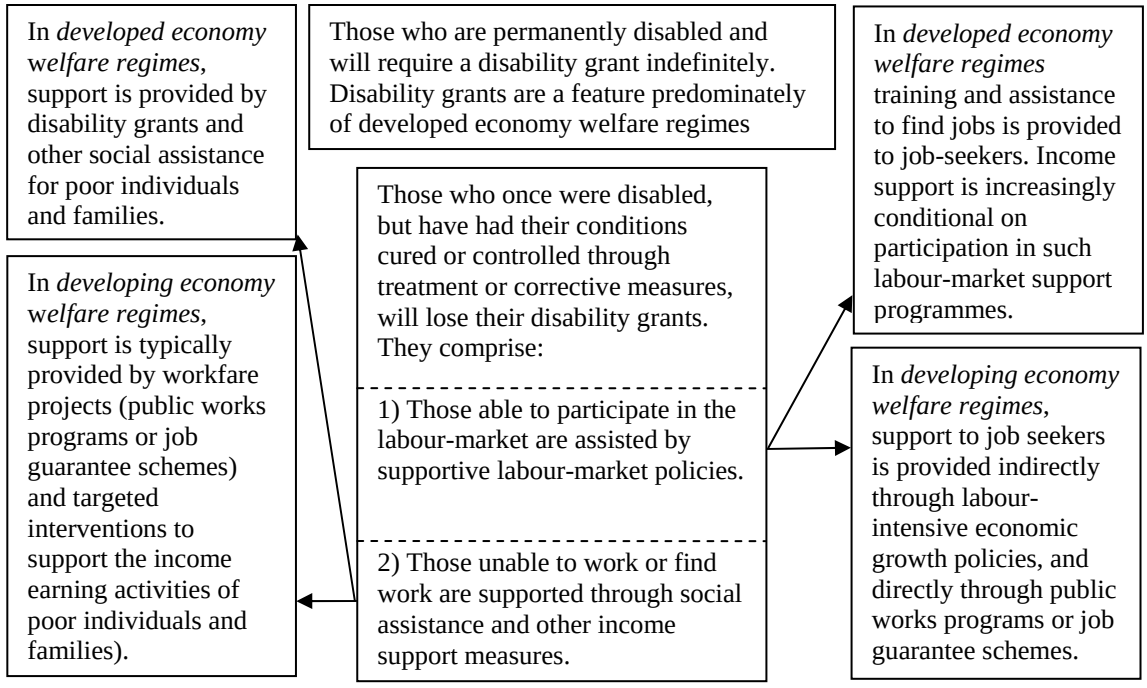

Figure 3: Labour Market Participation and the Disabled Adult

One option is for South Africa to scrap the disability grant system altogether. However this would be unethical and unpopular (as public opinion in South Africa seems to be supportive of the disability grant (Seekings, 2005c)). Another option would be to provide special labour-market programmes for

[7] Others include for example Namibia, Mauritius, Argentina, Barbados, the Bahamas, Brazil, Costa Rica and Bermuda (Mitra, 2005: 16).

those losing their disability grants as a result of restored health (i.e. providing support for a right-ward shift in Figure 3). The state could, for example, introduce specially targeted job creation schemes or provide tax incentives for firms to provide preferential employment for such individuals. The problem with this option is two-fold: it is expensive and administratively complex; and it is unfair. Other unemployed people could justifiably ask why those who had previously benefited from a disability grant are given preferential treatment. Such a situation could exacerbate the existing perverse incentive to become disabled.

Alternatively, the state could improve the left-ward shift options outlined in Figure 3, and provide social support for the previously disabled unemployed. This could, perhaps, take the form of a reduced disability grant for those whose health has improved, but who cannot find a job. In the case of Aids-patients, this could perhaps be called a 'treatment-support grant', which although lower in value to the disability grant, would serve to provide some poverty-relief. But, like the preferential or targeted labour-market support, such policies may be perceived as unfair by those who never had access to the disability grant in the first place. And, once it became known that people with Aids were able to access a disability grant when they were ill, and then a 'treatment support grant' once they were on treatment (and had their health restored), this could exacerbate the perverse incentive to become HIV-positive.

In short, there are compelling reasons for the government to reconsider the structure of the entire welfare system if it is to address the problems currently posed by the disability grant. Crucially, it needs to address the incentive problems posed by the mismatch between the premise of full employment and the reality on the ground.

The most obvious policy response is to boost the rate of job creation. This, however, will not be easy. Despite relatively rapid economic growth since 2000 (the economy is growing at 4.5%, i.e. its fastest since the boom years of the 1960s), unemployment rates have barely changed since 2000.[8] Although there has been some improvement in the rate of job creation since 1995, much of this has is a statistical artefact (resulting from measurement changes) or driven by the expansion of low-earning, low-productivity informal sector activities (Casale *et al* (2004). The fact that the expansion in formal jobs has been so sluggish in response to rapid economic growth indicates that South Africa's long-standing employment problem is likely to remain intractable in the short- to medium-term. This is in part a consequence of South Africa's economic structure, and in part a consequence of resistance on the part of South Africa's

[8] In September 2000 and March 2005, the percentage of the workforce actively seeking employment was 25.4% and 26.5% respectively.

trade unions to labour-market reforms (Nattrass, 2004a; Seekings and Nattrass, 2005).

Employment Guarantee Scheme (EGS)

Another possible response is for the government to deliver jobs directly through an Employment Guarantee Scheme (EGS) such as that in the Indian state of Maharashtra, now recently expanded to the whole of India (see Bagchee, 2005; Pellissary, 2005). Although the South African government supports the idea of 'massive' public works programmes as its preferred policy response to unemployment, this has been more of a rhetorical commitment than a reality. The Community Based Public Works Program of 2002/3 was able to provide only 1% of the number of work days demanded by South Africa's unemployed, and the Expanded Public Works Programme (initiated in April 2004 to improve the labour-intensity of infrastructure provision) is unlikely to do any better.[9]

In short, if public works programmes are to succeed in making a significant dent on unemployment, a major increase in managerial[10] and financial resources is required. However, as is the case with promoting labour-demanding economic growth, this task will remain hampered by wage-setting institutions. Mean wages paid by the Gundu Lashu infrastructural project in the Limpopo province of South Africa are five times higher than that available on the Indian EGS and double the earnings in South African subsistence agriculture (Seekings (2005c) and McCord (2004)). This has resulted in some disruption of local labour markets (81% of workers on the scheme reported giving up or reducing alternative work) and in poor targeting (as only 19% of job opportunities went to previously unemployed individuals). If wages continue to be set at (or close to) industrial sector minima, the number of employment opportunities created will be constrained and poorly targeted at those who need them.

Such institutional constraints on the implementation of an extensive pro-poor public works programme suggest that South Africa may have to address the problem of unemployment and poverty by plugging the hole in the welfare net by other means. This could be done through the introduction of targeted social assistance for the unemployed (a 'dole'). The downside of this proposal is that additional financial and human resources would need to be deployed to manage such a new means-tested grant and to prevent fraudulent claims. This task

[9] See McCord (2003) and McCord and Van Seventer (2004).

[10] Non wage costs of public works programmes are likely to be at least 27% of total expenditure, as has historically been the case in the Maharashtra EGS (Dev, 1995) and possibly as high as 48%, which was the average non-wage cost of the South African public works program implemented between 1992-98 (McCord, 2003: 18).

would be made all the more difficult by the fact that unlike the disability grant (which requires documented assessment of disability) or the old-age pension (which is linked to age as well as income), the labour-market status of people describing themselves as unemployed will be difficult to prove and monitor over time.

A possible solution to this problem would be to go down the route of Indian 'workfare', where the State guarantees each household 100 days of low-wage employment, and if in the unusual event of there being insufficient work opportunities, the state is required to pay the wage as a grant. In the Maharashtra EGS, the grant was never paid but rather its potential claim by villagers petitioning the state for employment to be provided in their area was sufficient to embarrass the state into providing the necessary jobs (Bagchee, 2005). As Bagchee, points out, the system was successful precisely because it was politicised at every level, with villagers expressing voice through village structures which were subsequently successfully channelled to those responsible for providing employment projects on demand.[11] Given South Africa's massive unemployment problem and the major challenges entailed in improving local government structures and providing work opportunities for all, the introduction of an EGS in South Africa would, at least in the short-term, almost certainly result in the payment of a substantial number of grants. This would inevitably result in poor targeting, because it is only once low-wage employment comes on line, that only the very poor (i.e. those prepared to work for low wages) become self-targeted.

What would this cost? As of March 2005, there were 4.3 million unemployed people actively seeking work. The number of unemployed rises to 8.1 if we include in the definition of the unemployed those who say they want work but are not actively seeking it. Let us assume that the government introduces a low-wage employment guarantee scheme paying R20 a day (a wage which is over three times that paid on Indian job guarantee schemes) for a maximum of 100 days a year and that 75% of the active job seekers queue up to demand this work. The total wage bill will amount to R6.45 billion. If we assume that the administrative and managerial costs double the costs of the programme, then the government would have to find an extra total of R12.9 billion a year to fund a job guarantee scheme. If 75% of the broadly defined unemployed demand work, then the costs would rise to R24.3 billion a year. In other words, depending on take-up, the cost of a low-wage job guarantee scheme would cost between 1.1% and 1.8% of GDP, and would require an increase in the tax-take of between 3-7%. Note, however, that if labour-market and economic policy reforms were

[11] Pellissery (2005), however, cautions that the political mobilisation was not always in the best interests of the poor as there was potential for political elites to control access to jobs, and to direct the creation of productive assets through the program to private interests.

implemented to encourage the growth of labour-intensive employment, then the numbers of unemployed will fall, and the number of tax payers would rise, thereby reducing and spreading the tax burden associated with an EGS. And, if the value of existing welfare grants were reduced, this would also reduce the pressure on the fiscus.

A Basic Income Grant (BIG)

The alternative to such a 'workfare' or targeted welfare policy interventions for the unemployed is to opt for a universal, non-conditional BIG that is paid to all citizens. This idea was proposed by the government's Taylor Committee (2002), supported by academics,[12] and promoted by a wide range of civil society organisations 'the BIG coalition'. A BIG has the advantage of being administratively efficient as no means test, nor test of employment status needs to be administered (as would be the case with the introduction of a unemployment-linked social assistance) and nor would additional government resources need to be mobilised to provide employment opportunities for the poor (as would be the case with an EGS). Seekings points out, as the state:

> "already delivers ten million grants every month, increasingly making use of computerized banking technologies. Introducing a basic income grant would double the welfare budget and entail between four and five times as many payments per month, but this challenge would be minor compared to that of implementing massive public works programmes" (2005a: 22).

The downside of a BIG is that the government is opposed to it and public opinion seems to favour the allocation of social assistance to the 'deserving' poor more than it favours universal grants which are seem as being paid to the (undeserving) rich and poor alike (Seekings, 2005c).[13] Of course the introduction of a BIG can be highly targeted and redistributive if linked to a simultaneous increase in value-added tax (VAT) – but this is a complex argument to put across to the average citizen. Le Roux (2003) has shown that a BIG of R100 a month to all citizens would cost R54 billion a year – but that most of this could be 'clawed back' if VAT was increased by 7 percentage points, resulting in a net additional cost of R15 billion a year. His calculations suggest that people who spend less than R1,000 a month will be net beneficiaries of the BIG, and all those rich enough to spend more than R1000 a

[12] See articles in the edited collection by Standing and Samson (2003).

[13] For example, a representative survey of Cape Town found that over 80% of respondents agreed that the government should do more to help the unemployed, but less smaller majorities (less than 60%) supported the introduction of a BIG (Seekings, 2005d: 10).

month will pay more in VAT than they benefit from the BIG. Such a tax-financed BIG would thus be highly redistributive, but would require that VAT rises to the levels found in Kenya and Tanzania. It is also likely to be resisted by those groups (including most unionised workers) whose monthly expenditures exceed R1,000 a month (Matisonn and Seekings, 2003).

Managing Disability in the Context of an EGS or a BIG

Whether South Africa opts for targeted social assistance for the unemployed, or an EGS or a BIG – there is a strong case for addressing the large hole in South Africa's welfare net. Not only will it address the problem of poverty experienced by many unemployed people, but it will help reduce the perverse incentive built into the current system for people to become or remain ill/disabled. However, if the income gap between the disability grant and these new forms of support for the unemployed remains large, then the incentive problem may not disappear altogether.

Table 1 explores the impact of the loss of a disability grant on a hypothetical grant-dependent household. In the current policy context, the loss of a disability grant results in a 100% drop in income for the disability grant recipient, and a 40% decrease in household income. If the loss of the disability grant occurred in the context of an EGS offering R20 a day for 100 days per year to the unemployed (i.e. an average monthly income of R167), then not only would the household be better off to start with, but the drop in personal income for the disability grant recipient would be smaller (R613 as opposed to R780) and household income would fall by only 27.2%. A similar cushioning effect is evident if the loss of the disability grant takes place in the context of a BIG.

In other words, if other forms of social assistance were available to other members of the household in the form of a BIG or an EGS, then the loss of disability grant income is less severe for total household income – and there will thus be less pressure on people to undermine their health in order to access disability grant income. However, the fall in personal income as a consequence of the cancellation of the disability grant is still substantial. This is a consequence of the relatively generous levels of social grants in South Africa.

As South Africa already allocates a much greater share of GDP to social grants than any other middle-income or developing country, consideration should probably be given to reducing the value of existing grants when expanding coverage to repair the hole in the welfare net. Although reducing the value of grants will not be popular because existing grants comprise such an important

share of household income for the poor, if this is accompanied by the introduction of new grants or income opportunities which more than make up for the loss in value of existing grants, then the measure will be easier to sell politically. The final column of Table 1 shows the impact of the loss of a disability grant in the context of an EGS and a 10% reduction in the value of existing social grants. In this scenario, household income falls by 26% as a consequence of the loss of disability grant income, and the disability grant recipient experiences a decline of R535 rather than the R780 which is currently the case. Reducing the value of existing social grants thus has the benefit of freeing up 0.3% of GDP (which could finance between 17% and 27% of the resources needed for an EGS) as well as reducing the trade-off between income and health substantially.

Table 1: The Impact on Household Income of the Cancellation of a Disability Grant

	Current package of social assistance	*With an EGS*	*With a BIG*	*With an EGS and 10% lower value grants*
Disability grant recipient	R 780	R 780	R 780	R 702
Unemployed adult	R 0	R 167	R 100	R 167
Unemployed adult	R 0	R 167	R 100	R 167
Non-labour force participant	R 0	R 0	R 100	R 0
Child of qualifying age for the child support grant	R 180	R 180	R 180	R 162
Child of qualifying age for the child support grant	R 180	R 180	R 180	R 162
Child not of qualifying age for the child support grant	R 0	R 0	R 100	R 0
Old age pensioner	R 780	R 780	R 780	R 702
Total household income	R 1,920	R 2,254	R 2,320	R 2,062
Total household income minus disability grant	R 1,140	R 1,474	R 1,540	R 1,360
New income source for previously disabled individual	R 0	R 167	R 100	R 167
Total household income following the loss of the disability grant	R 1,140	R 1,641	R 1,640	R 1,527
Absolute drop in household income as a result of the loss of a the disability grant	R 780	R 613	R 680	R 535
% drop in household income	40.6%	27.2%	29.3%	25.9%

Note: If a person works 100 days at R20 a day, this amounts to R2,000 a year – i.e. an average of R167 a month.

The discussion so far has sought to address the problem of perverse incentives to become or remain disabled by discussing policies designed to narrow the income differential between the disabled and non-disabled adults. An alternative approach is to address the problem by changing the way that disability grants are administered – especially those for people with long-term chronic conditions which could be managed successfully with treatment.

One could, for example, address the problem of people choosing not to comply with their medication by requiring proof of compliance with treatment regimens. This appears to be the emerging policy stance in the Eastern Cape and the North West Province – see Appendix. However, short of the kind of 'directly observed therapy' (DOT) policy whereby patients have to take their medication in the presence of a witness, treatment adherence is impossible to monitor in any fool-proof manner. Pill counts can be subverted and clinical markers (such as falling CD4 counts in the case of patients with Aids) are not always indicative of non compliance. For example, CD4 counts may fall because the patient stopped taking his or her medication, or they could fall because of emerging drug resistance, thus indicating that the patient needs to change drug regimens. Certainly in the case of antiretroviral treatment, attempts to enforce adherence through coercive measures are likely to be resource-intensive and unlikely to succeed. Addressing the root of the problem – i.e. the need for income on the part of the person on treatment – is almost certainly preferable.

In the scenario sketched in Table 1, a person becoming well enough to work (and hence no longer eligible for the disability grant) at least has the prospects of earning an average of R167 per month through the EGS. Officials managing the EGS should be sensitive to the needs and capacities of people living on antiretroviral treatment (they have to attend clinics regularly and may not be able to perform heavy manual labour) and be required to offer appropriate jobs to people on antiretroviral therapy. If no appropriate jobs are available, then (as would be the case in any job centre which cannot provide work to those demanding it), the applicant for the EGS should be awarded a cash grant equivalent to the average monthly earnings on the programme (R167 in Table 1) until appropriate work can be found.

Conclusion

In sum, there are two ways to address the problems facing South Africa's disability grant system. The first is to adopt a managerial solution by developing stricter guidelines for eligibility. This will probably restrict the numbers of people accessing disability grants (although local officials will no doubt continue to impose local interpretations of the rules). More importantly, it will put a lid on the number of grants (at the cost of considerable hardship for many poor households) and will do nothing to address the perverse incentives associated with the disability grant. This could well undermine the success of the antiretroviral treatment programme and undermine other disease management programmes, such as that for TB.

The second option is to address the root cause of the problem: i.e. repair the hole in South Africa's welfare net. This could be done through the introduction of a grant for the unemployed (a 'dole'), or an EGS or a BIG. The biggest problem with a grant for the unemployed is that it is administratively difficult to determine which individuals are really unemployed – i.e. would be prepared to work if offered a job. An EGS has the advantage of self-targeting the poor unemployed (only those prepared to work at low wages will take advantage of the job opportunities). For this to work, however, wages would need to be low, and there may well be opposition from organised labour to this. Another challenge for the EGS is developing the institutional capacity at local level to provide jobs on demand. A BIG has the advantage of providing universal cover, and is administratively easier. However, the government's opposition to a BIG remains an important obstacle.

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Appendix: Provincial Differences in Disability Grant Policy and Trends

Province (% of total disability grants as of August 2005)	*% of grants awarded by APs (2003)**	*Other Institutional Changes*
Eastern Cape (18.7%)	0%	PMOs stopped in 2001. APs not introduced. Decisions made by MOs alone until April 2004 when a medical assessment unit was introduced and District Medical Officers appointed. Guidelines introduced in August 2004 (person must be significantly impaired and if treatment is available, provide documentary evidence of treatment compliance).
Free State (8.6%)	7%	PMOs stopped in 2001. Continued using MOs with APs (until Sept 2004), now MOs only. No guidelines for HIV/AIDS until late 2004.
Gauteng (12.9%)	0%	PMOs stopped in 2002. Continued using MOs (no APs introduced). Guidelines updated in 2003 to include specific reference to HIV/AIDS (criteria of not being able to work introduced).
KwaZulu-Natal (25.7%)	21%	PMOs stopped in 2001. Parallel use of APs and MOs until 2004 (now MOs only). As of August 2004, MOs have to sign that they are complying with eligibility regulations.
Limpopo (7.6%)	78%	PMOs stopped. As of 2002, a MO does the assessment, the AP (based in hospitals) makes the recommendation, and the Head of Social Security makes the final decision. A person must not be able to compete in the open labour market. People with chronic illness usually given temporary disability grants and reviewed after 12 months.
Mpumulanga (5.4%)	92%	APs work with MOs. Final decision made by PMO or district head. No clear guidelines.
Northern Cape (3.2%)	0%	MOs do the assessment, PMOs make the final decision (as in the past). APs introduced briefly (as part of a pilot) and scrapped
North West (7.5%)	95%	MOs used for assessment, APs make the recommendation and the provincial office makes the final decision. Up to October 2004, just being HIV+ was sufficient for a grant. Now recipients have to be in Stage 3 or 4. People with chronic illness are supposed to be awarded temporary disability grants, to take medication, and be reviewed after 12 months
Western Cape (10.4%	0%	PMOs stopped. Eligibility determined by a MO who decides whether a person is able to work or not. HIV+ people must be in stage 3 or 4. Policy reinforced in several circulars. No APs introduced
Total (100%)	47.4%	

Note: * Calculated from sample of disability grant records (CASE, 2005: 61-64).
Source: Simkins, 2005; CASE, 2005: 19-24, 29, 42, 61-4.

As summarised in the above table, the provinces adopted different approaches, with only two retaining the services of a PMO (the Northern Cape maintained the old system, and Mpumulanga required that either a PMO or an official from the Department of Social Security make the final decision). The other provinces left the award decision to the discretion of MOs or APs. The Eastern Cape, the Western Cape and Gauteng chose not to introduce APs. Others introduced a mixture of APs and MOs (KwaZulu-Natal, Mpumulanga, Free State, Limpopo), but to varying extents. The Free State and Northern Cape piloted the AP system, but discarded it soon thereafter. KwaZulu Natal introduced the AP system widely, but suspended all the APs in August 2004. In Limpopo, APs were located in hospitals and made up of health professionals, in the North West Province and Mpumulanga, they were linked to social security offices. In KwaZulu Natal, which experienced the most rapid growth in the number of disability grants, it appears that APs included a wider variety of community involvement and in the opinion of local officials.

The provinces adopted different approaches to HIV/Aids-related disability. Up until October 2004, the North West province allocated disability grants simply on the basis of being HIV-positive but now requires that people have to be in clinical Stage 3 or 4, that they (like other people with chronic illness) be expected to go for treatment, and that they should only be allocated temporary disability grants that get reviewed after 12 months. Gauteng (from April 2003) and Limpopo require HIV-positive people be too sick to work to qualify – as does the Western Cape (which also requires that people be in stage 3 or 4 of AIDS). The Northern Cape and Mpumulanga have not produced any guidelines on this matter, leaving it up to the relevant MO. Initially, the Eastern Cape left if up to the discretion of MOs, but since August 2004 has produced guidelines requiring that people with chronic illness be significantly impaired and provide documented evidence of treatment compliance (where treatment is available). KwaZulu-Natal similarly introduced guidelines in August 2004.

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