AIDS, UNEMPLOYMENT AND DISABILITY IN SOUTH AFRICA: THE CASE FOR WELFARE REFORM

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South Africa is facing a dual crisis of AIDS and unemployment.[1] According to the ASSA2002 demographic model, by 2005 19% of adults (and 11% of all South Africans) were HIV-positive. This amounts to a socioeconomic crisis of significant proportions. AIDS undermines the economic security of households by reducing the productivity of (and eventually killing) mainly prime-age adults while simultaneously diverting scarce household resources towards health care. Poor households are especially vulnerable to these shocks.[2,3]

In most of sub-Saharan Africa, where agriculture accounts for a significant portion of employment and output, AIDS has affected the poor mainly through its negative impact on productivity in peasant agriculture.[4] By contrast, South Africa's history of de-agrarianisation and the destruction of peasant farming under apartheid have left the vast majority of households dependent on wage labour.[5] Under these conditions, the negative impact of AIDS is experienced directly through illness-induced retirement from wage-labour, and indirectly through the contraction of employment opportunities (especially unskilled jobs) by firms trying to avoid AIDS-related costs (see Rosen and Simon[6]).

It is particularly tragic that South Africa's AIDS epidemic is occurring at a time when over a third of the labour force is without work (Fig. 1). South Africa's welfare system is premised on full employment: there are means-tested grants for those too old to work (the old age pension of R780 per month) or too young to work (the child grant of R180 per month), and for those who cannot work because they are disabled (the disability grant of R780 per month) – but nothing

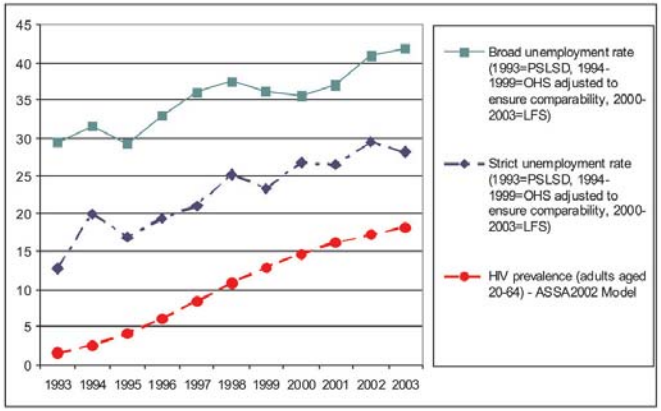

Fig. 1. Unemployment and HIV prevalence in South Africa. Source – Nattrass.[1]

for those who want to work but cannot find it. This 'gap' in the social security net is one of the reasons for the significant correlation between unemployment and poverty. [5,7] It is also, as argued below, a problem for South Africa's recently begun 'rollout' of highly active antiretroviral therapy (HAART).

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Disability grants are available to all 'severely physically and mentally disabled people' older than 18 and younger than 65. The system works according to a 'medical model' which instructs those responsible for recommending patients for disability grants to judge whether they are capable of working – irrespective of whether work is available.[8] People who are in stage 4 of AIDS (i.e. are AIDS-sick) are eligible for the disability grant (as long as they pass a fairly generous means test). Disability grants need to be renewed by medical officers (either every 6 months or every 5 years depending on the grant). Someone on antiretroviral treatment who becomes well enough to work should therefore expect to lose his or her disability grant.[9]

Disability grants are an important source of income for AIDS-affected households in South Africa.[10] Recent survey evidence from Khayelitsha, Cape Town, revealed that 8% of households receive disability grants – and for those households, the grant income comprises 52% of total household income. The cancellation of disability grants therefore has serious implications for household living standards. It also has serious implications for the social position of people living with HIV. Seventy-eight per cent of Khayelitsha respondents agreed with the statement that 'the disability grant helps people with HIV be more accepted by their families'. There is therefore a danger that those who lose their grants and are not able to find work may find themselves experiencing higher levels of stigma.

The loss of disability grant income has the following implications for the HAART rollout:

- Many HAART patients will experience problems purchasing food once their disability grants are cancelled. People on HAART need to eat regular, nutritious meals to enjoy optimal health benefits. Loss of the disability grant could compromise their health status (thereby shortening their lives) and increase their viral loads (thereby rendering them more infectious).
- Those HAART patients who rely on their disability grants to cover costs of transport to the clinics may find it difficult to access their medication on a regular basis.
- Those living in places not yet reached by the rollout, and who have been using their disability grants to pay for HAART treatment through the private sector, will not be able to continue their treatment once the grant is cancelled.
- Some clinicians worry that a significant minority of HAART patients may choose to discontinue their treatment regimens when their disability grants are cancelled so as to become AIDS-sick again in order to qualify for the disability grant once more. However, available evidence suggests that only a small minority of people are likely to consider this course of action.[11] Nevertheless this issue needs monitoring as it could reduce the effectiveness of the rollout and encourage the growth of drug resistance.

POLICY OPTIONS

One response to the potential trade-off between the disability grant and HAART is to remove the grant altogether for HIV-positive people. This would at least remove the perverse incentives described above. However, the cost is that it is discriminatory (because people disabled by AIDS should not be any less entitled to government support than any other disabled person) and cuts away an important income lifeline for poor AIDS-affected households. And, to the extent that lower household income translates into lower food consumption and fewer trips to the clinic, it would undermine the effectiveness of the HAART rollout. To the extent that AIDS is driven by poverty, it could also exacerbate the AIDS epidemic.

An alternative response is to allow HIV-positive people to keep their disability grants – even after their health has been restored. There are two problems with the strategy. The first is that the problem of perverse incentives is not eliminated. Allowing access to the disability grant for people whose health has been restored may even result in some people desiring to become HIV-positive. Although this may sound far-fetched, anecdotal evidence from the Western Cape, the Eastern Cape and KwaZulu-Natal indicates that some people become angry when they test negative – saying that they were hoping to get the grant. In the Eastern Cape, there is a saying that you have 'won the lotto' if you test HIV-positive because it is seen as a ticket to the disability grant. If antiretroviral treatment is regarded (incorrectly) as a 'cure' for HIV, it is possible that some people may desire to become HIV-positive under the mistaken notion that they will be able to get access to the disability grant and obtain antiretroviral treatment.

The second problem with allowing HIV-positive people to keep their disability grants even when their health has been restored through HAART is a moral one: why should they be privileged over other people who may be equally needy, but HIV-negative? Put this way, the immediate question that poses itself is: why not introduce a basic income grant (BIG) for all? There is a range of arguments, both moral and economic, in favour of a BIG in general (see e.g. Van Parys[12]) and for South Africa in particular (see e.g. Standing and Samson[13]). The perverse incentives associated with removal of the disability grant amounts to one more argument in its favour.

A BIG would need to be at a much lower level (probably in the region of R100 - 200) than the R780 maximum grant for the disabled. Households that lose the disability grant as a consequence of antiretroviral treatment will at least have some financial cushioning resulting from the fact that they, and each household member, has a BIG. This may help prevent

people on HAART from being tempted to stop adhering to their treatment regimens in order to get the disability grant reinstated.

If a BIG is introduced for all people – say at R100 a month – what is the appropriate level of payment for the disability grant? Given that so much of the disability grant was used to support the household (rather than just the individual), there is an argument for a significantly reduced disability grant to individuals once a BIG is introduced for all members of the household. For example, in a five-person household, household income would be the same if one disability grant was available at R780 or if a BIG was available for all (at R100 each), and a disability grant was available at R280 to the individual. The loss of a disability grant as a result of HAART would thus result only in the loss of R280 a month. However, given the necessity to support transport costs to and from the clinic, and to ensure that people on HAART have adequate nutrition, there is a case to be made to introduce a new grant for those who are unemployed and on chronic medication. Such a grant should probably be in the region of about R100. This means that someone on HAART would get the BIG (R100) plus the supplementary grant (R100). Their loss of income as a consequence of going on HAART would thus only be from R380 to R200.

THE COST OF INTRODUCING A BIG AND A LARGE-SCALE HAART ROLLOUT

The introduction of a BIG of R100 a month could contribute substantially to reducing poverty and inequality in South Africa (e.g. Bhorat[14]). This is why the Taylor Committee report[15] on comprehensive welfare reform argued in its favour. According to Le Roux,[16] a BIG could be financed by a 7.3 percentage point increase in value-added tax (VAT) and a 50% increase in excise and fuel taxes. This proposal is broad-based and redistributive: those who spend more than R1 000 a month end up paying more in consumption taxes than they benefit from the R100 BIG.

Earlier costing exercises using 2001 prices suggested that a full-scale rollout would require an extra 1.4 – 3.2% of GDP per year.[3,17] The estimate deliberately assumed no rationing in the public sector and (following the ASSA2000 Interventions Model) a rollout to 90% of those who need treatment. It was thus a high social benefit, high-cost scenario and as such was the most expensive of the available South African costing studies (see review in Boulle *et al.*[18]). The recent decline in drug prices has made this argument all the more compelling. It would now cost between 0.9% and 2.6% of GDP (depending on the level of hospital care for HIV-positive people) to provide a full-scale national HAART rollout.[17] If we take the mid-point estimate, this could be funded by raising VAT by 4 percentage points.

Taken together with Le Roux's estimates of the necessary tax increase to finance a BIG, South Africa would need to raise tax revenue by an equivalent of a 12 percentage point increase in VAT to finance a BIG *and* implement a national AIDS prevention and treatment intervention for all who need it.

This, of course, is a significant increase in taxation. Is this feasible? There is no exact technical answer to this question, as different societies tolerate different levels of taxation, and at different times. Welfare expenditure as a proportion of GDP has risen with economic development, and in times of crisis (such as war) citizens have accepted large increases in taxation as legitimate.[19] The notion of what is and is not 'affordable' therefore varies according to the social and economic context. Given the scale of the unemployment problem and the AIDS epidemic, it is possible that reasonable South Africans might agree to an increase in taxation to deal with it. Whether one appeals to Rawlsian logic to protect the lives and livelihoods of the poor – or to more radical left libertarian ideas of providing each citizen with a social dividend as a basic right – the issue ultimately boils down to whether reasonable people can tolerate living in a society that forces people living with AIDS to choose between income and health.

Finally, it is important to note that even if a BIG and an acceptable AIDS prevention and treatment intervention were to be introduced, far more needs to be done to address the problem of unemployment and poverty in South Africa. A BIG of R100 a month is very small: it amounts to one-tenth of average African per capita income, and to one-twentieth of average per capita income in South Africa. Addressing poverty through other means – most notably by encouraging labour-intensive growth – must therefore be an integral part of any solution.

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