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# Trading off Income and Health?: AIDS and the Disability Grant in South Africa

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## Abstract

Despite high levels of unemployment, South Africa's welfare system is premised on full employment: only those who are too young, too old or too sick to work qualify for social assistance. A government committee recently recommended the introduction of a universal Basic Income Grant (BIG) to address this hole in the welfare net. Now that highly active antiretroviral therapy (HAART) is being rolled out through the public health sector for people sick with AIDS, the case for a BIG is even more compelling. People sick with AIDS qualify for a disability grant. The HAART rollout offers them the chance of restored health – but it comes at the cost of losing the disability grant because they will be deemed well enough to work. Given South Africa's high unemployment rates, many will not be able to find work, and hence will face a trade-off between health (taking HAART) and income (keeping the disability grant). This could undermine adherence to HAART and/or reduce the effectiveness of the treatment by compromising the nutritional status of patients, thereby facilitating the growth of drug-resistant HIV. Introducing a BIG could help resolve this unintended tension between health and welfare policy.

## Introduction

South African social policy is exceptional in three respects. First, there is a generous non-contributory old age pension that, together with a progressive income tax structure, reduces inequality by more than anywhere else in the developing world (Seekings, 2002: 5). Second, despite the existence of high unemployment rates (of between 28 and 42 per cent, depending on the measure) the welfare system is premised on full employment (Nattrass and Seekings, 1997): there are no grants for the unemployed.<sup>1</sup> Social assistance is provided only for those too old to work (the pension), too young to work (the child support grant) or too sick/disabled to work (the disability grant). In an effort to plug this large 'hole' in the welfare net, a recent government committee recommended the introduction of a universal Basic Income Grant (BIG) for all South Africans (Taylor Committee, 2002). Although this was not accepted by government, it sparked a strong social movement in favour of a BIG (Matisonn and Seekings,

2003). That a BIG is firmly on the policy agenda at all is the third characteristic that sets South African social policy apart from other countries.

This article argues that the AIDS pandemic is making the need for welfare reform all the more pressing – not only because of the relationship between HIV prevalence and poverty, but also because of an unintended conflict between welfare and health policy now that highly active antiretroviral therapy (HAART) is being provided through the public health system. People sick with AIDS qualify for a disability grant. The HAART roll-out offers them the chance of restored health, but it comes at the cost of losing the disability grant because they will be deemed well enough to work. Given South Africa's high unemployment rates, many will not be able to find work, and hence will face a trade-off between health (taking HAART) and income (keeping the disability grant). This could reduce proper adherence to HAART and/or reduce the effectiveness of the treatment by compromising the nutritional status of patients, thereby facilitating the growth of drug-resistant HIV. Introducing a BIG could help resolve this tension between health and welfare policy.

### **AIDS, poverty and unemployment in South Africa**

AIDS is a very serious problem in South Africa. According to the government's antenatal survey, over a quarter of pregnant women who attend government clinics are HIV-positive. Using this and other demographic data such as deaths by age, gender and race, South Africa's premier demographic model (ASSA2002)<sup>2</sup> estimates that 18.7 per cent of adults between the ages of 20–64, and 10.8 per cent of the total population, were HIV-positive in 2004. Such projections from the ASSA2002 model can be treated with confidence because they accord with South African death data, and (as shown in Figure 1) are consistent with data from the antenatal survey and a 2001 national household survey of HIV prevalence (Shisana and Simbayi, 2002).

The AIDS pandemic amounts to a socio-economic 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 medical expenditure. This has been especially problematic for poor African households in South Africa (see Booysen, 2002, and evidence cited in Nattrass, 2004b). As can be seen in Table 1, HIV prevalence is highest among South Africa's majority African population, which also has the highest rate of unemployment and the lowest per capita income of all the racial groups. This connection between low income and HIV prevalence has been found elsewhere in Africa (Stillwaggon, 2002).

In most of Sub-Saharan Africa, where agriculture accounts for a significant portion of employment and output, AIDS has affected the poor mainly through

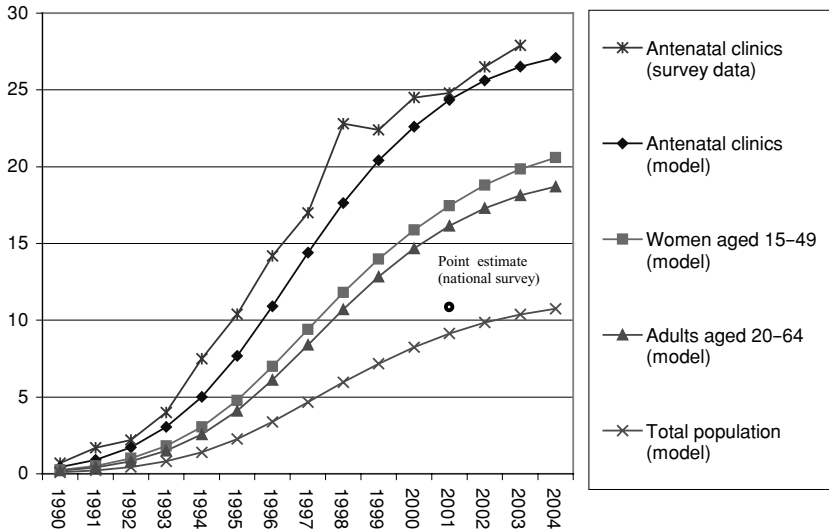


Figure 1. HIV prevalence in South Africa (% of population that is HIV-positive).

Source: ASSA2002 Demographic Model; Department of Health (2004), Shisana and Simbayi (2002).

TABLE 1. HIV prevalence and unemployment rates in South Africa.

	African	Coloured	Indian	White	Total
Adult HIV Prevalence 20–64 (2004)	23.3%	3.9%	3.1%	2.4%	18.7%
Strict unemployment rate (Sept 03)	33.7%	21.5%	16.9%	5.2%	28.2%
Broad unemployment rate (Sept 03)	48.8%	29.4%	20.7%	7.6%	41.8%
Share of total population in 2004	78.1%	9.0%	2.6%	10.2%	100%
(ASSA 2002 model). <i>N</i> = 45.9 million					
Population share of national income (2000)*	40%	9.0%	5.0%	46.0%	100%
GDP per capita (2002) NB: \$1 = R6.5	R12,800	R25,000	R48,000	R113,000	R25,000

Source: South African Labour Force Survey September 2003 (Statistical News Release Po210, 25 March 2004, Pretoria), ASSA2002 Demographic model (available on [www.assa.org.za](http://www.assa.org.za)).

\* Calculated by Murray Leibbrandt using revised weights on the 2000 Income and Expenditure Survey by StatsSA.

its negative impact on productivity in peasant agriculture (IFAD, 2001). 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. 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, 2002; Nattrass, 2003).

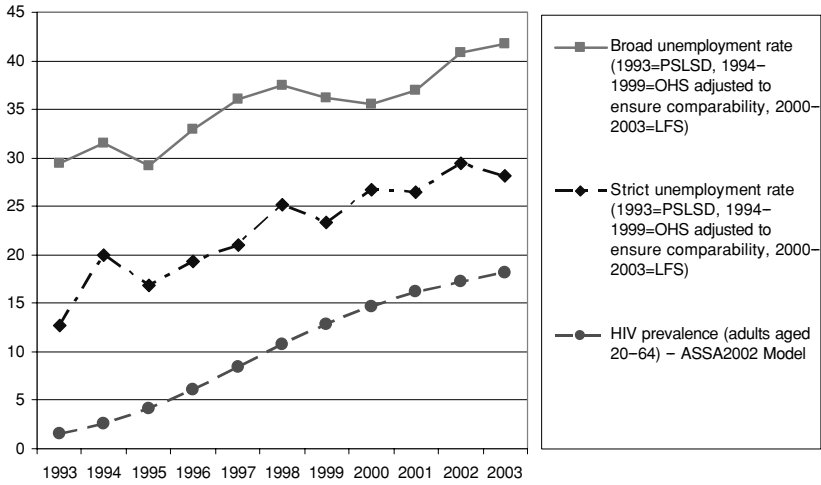


Figure 2. Unemployment and HIV prevalence in South Africa.

Sources: Klasen and Woolard (1999: 11); CSS, Statistical News Release P0317, 10, 13 August 1998; Statistics South Africa, Statistical News Release P0317, 18 May 2000; Statistical News Release P0317 31 July 2000; Statistical News Release, P0210, September 2002; Statistical News Release, P0210, 25 March 2004; the ASSA2002 demographic model. Following Klasen and Woolard (1999) the data have been adjusted to account for differences in survey design between years mainly to deal with the exclusion and incorporation of migrant hostels in the sampling frame (see Natrass, 2000). OHS: October Household Survey. PSLSD: Project for Statistics on Living Standards and Development. LFS: Labour Force Survey.

It is particularly tragic that South Africa's AIDS epidemic took off at a time when the unemployment rate was high and rising by any measure (see Figure 2).<sup>3</sup> According to the September 2003 Labour Force Survey, the official (strict) rate of unemployment (which includes only those without work who are also actively seeking it), was 28.2 per cent. If those who say they want work but are not looking for it are also included among the ranks of the measured unemployed (the broad definition), then the rate rises to 41.8 per cent. As there is no significant social insurance available for able-bodied unemployed adults of working age, loss of employment (or failure to find it) has a major impact on household living standards (Leibbrandt *et al.*, 2000; Seekings, 2000; Seekings and Natrass, forthcoming, Seekings 2003b). Households without wage-earners are thus forced to rely on remittances from friends and relatives living elsewhere, and on those receiving pensions, child support grants or disability grants.

### Welfare, AIDS and disability in South Africa

The South African government faces significant fiscal exposure to the AIDS epidemic through the welfare system. A government means-tested disability grant of a maximum of R740 a month (about US\$115) in 2004 is available to

all 'severely physically and mentally disabled people' older than 18 and younger than 65. Grants can be temporary (six months) or permanent (and these usually have to be reviewed every five years). The Social Assistance Act of 1992 (amended in 2001) clarified the rules for awarding disability grants in general, but makes no mention of HIV/AIDS. It simply defines a disabled person as someone: 'who has attained the prescribed age and is, owing to his or her physical or mental disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him or her to provide for his or her maintenance' (Section 1).

This 'medical model' of disability effectively instructs those responsible for recommending patients for disability grants to judge whether they are capable of working – irrespective of whether work is available (Simchowitz, 2004). Welfare payments in South Africa are administered at provincial level (although moves are afoot to consolidate these payments at national level through the new National Social Security Agency). Different provinces use different means of assessing disability, with some relying on evaluation by the district surgeon or medical officers, and others on an 'assessment panel'. Assessment panels (comprising *inter alia* social service officers, nurses, social workers and community members) were made possible by the 2001 amendment to the Social Assistance Act. They were designed to ensure that people had access to disability grants in rural and other areas where medical officers were in short supply (Simchowitz, 2004).

Some provinces, such as the Western Cape, opted not to introduce assessment panels, but rather to continue insisting on the use of medical officers to assess disability. The Western Cape is the only province to have laid out clear criteria for when a person with AIDS should be considered sick enough not to be able to work. The rule is that the individual should be either in Clinical Stage 4 of AIDS or have a CD4 cell count of less than 200.<sup>4</sup> In other provinces, the clinical criteria for assessing AIDS-related disability remain obscure, and it is left up to the judgement of individual medical officers.

If we take the Western Cape guidelines as the rule for eligibility for the disability grant, then according to the ASSA2002 demographic model (which projects the number of people in different stages of AIDS) about 340,000 people would meet the clinical criteria for the grant in 2004.<sup>5</sup> Not all of these individuals would, however, necessarily qualify for the grant because in addition to medical criteria, successful applicants have to be able to provide identity documents and proof of income and assets. Only those who cannot work and have an income from other sources of less than R1,502 and assets of less than R266,400 are able to obtain the full grant (Simchowitz, 2004).<sup>6</sup> However, as this is a fairly generous upper income limit (it is one and a half times the average African per capita income, and twice the old age pension and minimum wage for domestic workers) it is probably safe to assume that the great majority of those who are clinically eligible would also pass the means test. Furthermore, it appears that as

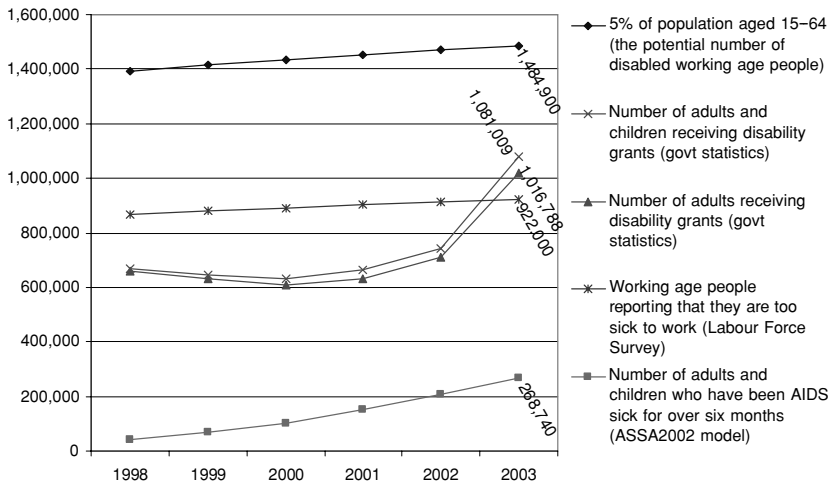


Figure 3. Trends in the number of disability grant recipients.

Sources: South African Labour Force Survey September 2003 (Statistical News Release Po210, 25 March 2004, Pretoria), ASSA2002 Demographic model (available on [www.assa.org.za](http://www.assa.org.za)). Ministry of Finance (2002, 2003, 2005). NB: The number of working age people too sick to work was derived from the Labour Force Survey of September 2003 and extrapolated as a percentage of the population for the preceding years.

is the case with the old age pension, there is little administrative capacity to check whether a person receiving a disability grant is actually working or has a non-earned income of less than the stipulated amount. A recent survey of patients on HAART in Cape Town revealed that 22 per cent of those receiving the disability grant also reported being employed (Coetzee and Natrass, 2004). This suggests that the medical officer's assessment of disability (rather than the means test) is key to obtaining a disability grant.

Figure 3 presents trends in the number of actual disability grant recipients and in the estimated number of people who would clinically qualify for a disability grant as a result of being in Stage 4 of AIDS and who have been AIDS-sick for six months or more (to account for the time it takes between applying for a disability grant and actually receiving one). Means-tested disability grants are available for adults (who are not in receipt of the old age pension), and for children up to age 18 (the grant for children is known as the 'care dependency grant' rather than the disability grant). Figure 3 shows that most disability grants go to adults, although the number of disability grants for children has been rising faster (as evidenced by the widening gap between the number of disability grants for adults and the number of grants for adults plus children).

It is unclear to what extent the disability grant actually reaches the disabled people who need it in South Africa because the number of disabled people is unknown. According to a recent government inquiry into social security in South

Africa, 5 per cent of developing country populations are severely or moderately disabled (Taylor Committee, 2002: 101). If this is the case, then South Africa is likely to have had about one and half million disabled people of working age in 2003. This is one and a half times as many people as the number of adults actually receiving disability grants (see Figure 3). However, as this includes the moderately disabled who may well be able to work, and hence should not qualify for the disability grant, an alternative way of estimating potential grant recipients is to use the number of people enumerated by labour force surveys who say that they are too sick or disabled to work. According to the September 2003 Labour Force Survey, about 922,000 people fell into this category – that is, just under 100,000 less than the number of people actually receiving disability grants that year. This implies that either the Labour Force Survey is a very poor way of measuring disability, or that more people are obtaining access to the disability grant than should be the case (according to existing criteria).

It was only as a result of the sharp increase (of 45 per cent) in the number of disability grants awarded in 2003 that the number of disability grant recipients rose above the number of disabled people as estimated by the Labour Force Survey (see Figure 3). Disability grants going to adults as a percentage of adults reporting that they were too sick to work rose from 68 per cent in 2000, to 70 per cent in 2001, and then to 78 per cent in 2002 followed by a massive 110 per cent in 2003.

There are five plausible reasons for the dramatic increase in 2003. The first was the introduction of assessment panels in the Northern Cape and the Eastern Cape. Such panels appear to have adopted a broader notion of disability than the medical model – thus resulting in a sharp increase in grants awarded (Simchowitz, 2004). Fearing further dramatic growth in the disability grants, these pilot assessment panel projects were subsequently cancelled. The second reason for the sharp increase in disability grants was as a result of a court order (in the Mashishi case) instructing government to reinstate all temporary grants that had been cancelled because the government had failed to notify the recipients appropriately. These grants were subsequently cancelled in 2004, with the result that the expected number of disability grant recipients in 2004 is likely to be lower than that for 2003. Third, the AIDS pandemic is reaching its mature stages in South Africa with the consequence that more illness and death are being experienced. This is clearly placing upward pressure on the numbers of adults and children qualifying for the disability grant. Fourth, the National Treasury has highlighted the possibility of fraud and misuse of the grant as one of the reasons for the sharp increase in grant recipients (Cape Times, 2 September 2004). Finally, a grants awareness campaign (operated by an NGO grouping called ‘The Alliance for Children’s Entitlement to Social Security’ in collaboration with government) was conducted in 2003, which may well have resulted in increased take-up rates of all grants (Insideout, 2004).

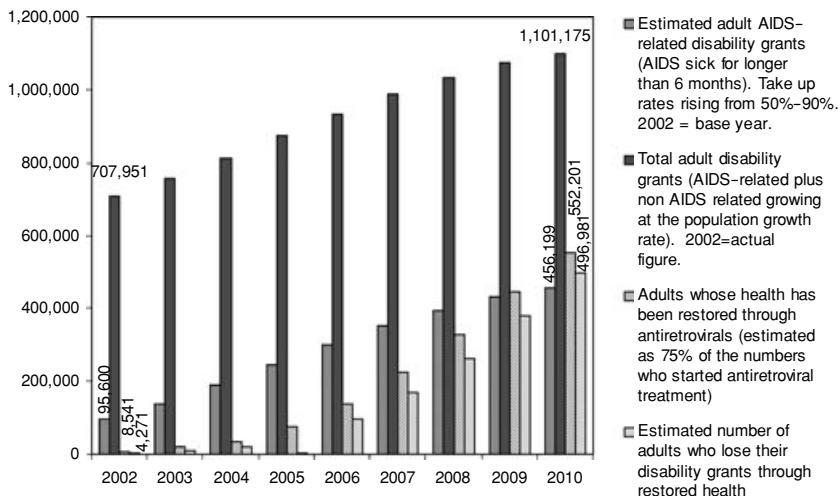


Figure 4. Projected numbers of adult disability grant recipients.

Sources: Intergovernmental Fiscal Review (Treasury, 2003); ASSA2002 demographic model.

If we assume that only half of those who were AIDS sick for longer than six months actually received a disability grant, then 13.5 per cent of the total number of disability grants actually awarded in 2002 would have been to AIDS-sick adults. If we assume that take-up rates by AIDS-sick adults rises steadily from 50 per cent in 2002 to 90 per cent in 2010, and that the number of non-AIDS-related disability grants rises at the same rate as the population, then the number of disability grant recipients will rise at an average annual compound growth rate of 22 per cent. In 2010, 1.1 million will be receiving disability grants (see Figure 4). This will cost the state R9.3 billion in 2002 prices.<sup>7</sup> (Note that these estimates use 2002 as the base in order to avoid the possibly distorting impact of the 2003 increases.) This would require an increase of 75 per cent in the budget allocated to disability grants, which in turn would require an increase in 18 per cent to the budget allocated for all transfer payments.<sup>8</sup>

### The impact of highly active antiretroviral therapy (HAART)

The figures for the number of disability grants in Figure 4 were derived from the ASSA2002 model on the assumption that take-up rates for the grant would rise from 50 per cent to 90 per cent over the period. It is, however, important to note that this take-up rate refers only to those who are AIDS-sick, that is, who are displaying AIDS related symptoms. In the ASSA2002 demographic model, the AIDS sick comprise those in Stage 4 (that is, those displaying AIDS-related symptoms who are not yet on HAART) and 25 per cent of those who started HAART.<sup>9</sup> Figure 4 plots the numbers of people who have had their health restored by HAART and who (given our assumptions about take-up rates for the disability

TABLE 2. Selected output from the ASSA2002 model (with and without the government's slow HAART rollout).

	Without the HAART rollout	With the HAART rollout
Life expectancy at birth in 2010	46.3	50.0
Infant mortality rate in 2010	52 per 1,000 live births	45 per 1,000 live births
New adult HIV infections (2000–2010)	5,536,028	5,454,468
Cumulative AIDS deaths (2000–2010)	3,553,562	3,119,249
HIV Prevalence (2010)	10.6%	11.3%
New AIDS sick cases (2010)	504,432	503,718
Total AIDS sick cases (2010)	864,370	663,470

Source: ASSA2002 Demographic Model.

grant) are thus likely to have lost their disability grants as a result. The figure shows that the number of people still alive who are likely to have lost their disability grant as a consequence of HAART rises from just over 4,000 in 2002 to just under half a million in 2010.

The ASSA2002 demographic model includes a set of assumptions about the roll-out and effectiveness of various AIDS-policy interventions ranging from voluntary counselling and testing, to mother-to-child-transmission prevention and providing HAART for adults.<sup>10</sup> Given the government's current slow roll-out of HAART (less than 29,000 people are currently on HAART compared to an estimated half a million people who need it), the ASSA2002 demographic model assumes that the HAART roll-out will increase steadily, but will reach only 50 per cent of Africans who need it by 2009 – and then remain at that level.<sup>11</sup>

Despite this limited roll-out, the model predicts that HAART will have a major impact on life expectancy. This is partly because HIV-positive people on HAART live longer. As can be seen from Table 2, over half a million deaths would be averted between 2000 and 2010 as a consequence of adding a HAART roll-out to the existing suite of policy interventions including mother-to-child-transmission prevention, voluntary counselling and testing, the management of sexually transmitted diseases and so on. (The number of deaths averted, of course, explains why HIV prevalence rises in the population once HAART is rolled out.) But the increase in life expectancy is also because many fewer people get infected in a scenario in which HAART is rolled out.

The fact that a treatment programme is likely to *prevent* many new HIV infections often comes as a surprise to those who hear it for the first time. Surely, they ask, if people with HIV are living longer, they have more time to pass on the virus? While it is certainly the case that people on HAART live longer and continue to have sex, they are living with substantially reduced (if not undetectable) viral loads – and hence are less infectious. Drawing on medical evidence, the ASSA2002 model assumes that an HIV-positive person on HAART

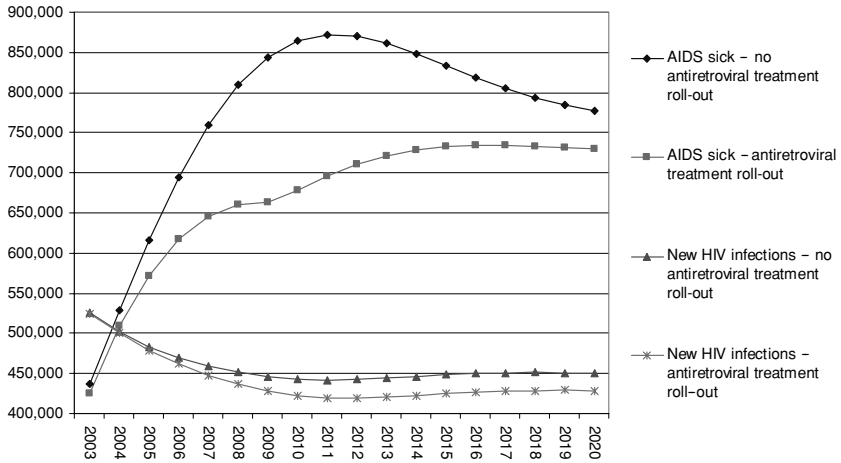


Figure 5. The number of AIDS sick and number of new HIV infections with and without the government's slow HAART rollout.

Source: The ASSA2002 demographic model.

is substantially less infectious over their life-time than they would be if they died earlier and with a higher viral load in the last few years of their lives. This, together with a small positive impact associated with the voluntary counselling and testing programme associated with the HAART roll-out, is why the model predicts that there will be over 80,000 fewer adult HIV infections by 2010 if HAART was rolled out at the current (slow) pace, than would be the case if it was not.

Figure 5 plots the trend over time in the number of AIDS sick cases and the number of new HIV infections with and without a HAART roll-out. The top two lines track the number of AIDS sick cases. It shows that in the absence of a HAART roll-out, the number of AIDS sick cases rises steeply, and then falls after 2011. This reflects the gradual burning out of the epidemic as people die from AIDS. By contrast, the number of AIDS cases flattens as the antiretroviral roll-out takes place, and then rises. This is a product of the assumption in the model that HAART delays the onset of terminal AIDS illness rather than prevents it entirely.<sup>12</sup> The bottom two lines track the number of new HIV infections over time with and without a HAART roll-out. It shows that there are significant and sustained benefits in terms of HIV infections averted as a consequence of rolling out treatment. Fewer HIV infections and fewer AIDS-sick cases translate into lower hospitalisation costs for government. This 'cost savings' aspect of the roll-out substantially reduces the net health costs faced by government (that is, the direct cost of the intervention plus AIDS-related hospital costs). Where relatively high levels of hospital care are provided for people living with AIDS, the government is likely to spend fewer resources implementing a large-scale roll-out than would be the case if it did not (Nattrass, 2004b; Nattrass and Geffen, 2004).

### **The potential trade-off between disability grants and HAART**

The discussion so far assumes that HAART is an unambiguous benefit for people living with AIDS. However, this may not be the case for those who as a result of their illness obtained access to a disability grant, and who subsequently stand to lose it as a result of restored health. Disability grants need to be renewed by medical officers (either every six months or five years depending on the grant (Simchowitz, 2004)). Someone on HAART who becomes well enough to work should thus expect to lose their disability grants.

Disability grants can be an important source of income for AIDS-affected households in South Africa (Coetzee and Natrass, 2004). Survey evidence from Khayelitsha, Cape Town, reveals that for those households receiving a disability grant income, the grant comprises between 41–49 per cent of total household income (*ibid*). The importance of disability grant income was illustrated by a respondent said ‘I love this HIV’ because of the grant. She explained her choice of words as follows:

Yes I like this HIV/AIDS because we have grants to support us. . . . Before I was staying with my mother and father and sister, they didn’t work. Maybe I was taking three to four days without food. People discriminated against me and no one come in the house. The only thing that was helping was my grandmother’s pension. We were surviving on that money. Concerning the illness, our lives are changed completely. (cited in Natrass, 2004b: 95)

The notion that someone might ‘love this HIV’ seems shocking. But it is understandable (albeit in a terrible way) when one considers the desperate circumstances that households can find themselves when they lack access to an income earner. The advent of a disability grant, as was clearly the case for the respondent quoted above, can be a major life-line for the entire family. The threat of its removal as a result of HAART is thus serious indeed. If the data from Khayelitsha are anything to go by, they suggests that average household income could fall by a third if a disability grant is lost through restored health.

It is, of course, possible that some of those individuals who lose their disability grant through restored health will in fact find a job – thereby contributing to an increase in household income. Panel data are necessary to answer this question. In this respect, we do have information on the changes experienced by 104 HAART patients during their first year of treatment. This limited data set shows a significant rise in labour force participation as a consequence of treatment. However, as more people moved from the ranks of non-labour force participants to the searching unemployed than moved into the ranks of the employed, the unemployment rate actually rose (see Table 3).

It is worth noting, however, that not only was the sample limited to one particular African township, but the changes in employment over time were strongly influenced by the fact that this was the first cohort of Africans in South Africa to receive HAART. People from this group were thus in demand as AIDS

TABLE 3. Changes in labour force participation for the 104 HAART patients for whom we have a year's worth of data).

	At the start of the programme (base line)	After one year on HAART
Employed	44 (42.3%)	55 (52.9%)
Searching unemployed	25 (24.1%)	33 (31.7%)
Non-labour force participants	35 (33.7%)	16 (15.4%)
Total	104 (100%)	104 (100%)
	Pearson's $\chi^2 = 9.4041$ (pr = .009)	
Unemployment rate (strict)	36.2%	37.5%
Labour force participation rate (strict)	66.4%	84.6%
Employment rate	42.3%	52.9%

Source: Coetzee and Natrass (2004).

treatment advocates (for NGOs like the Treatment Action Campaign) and as lay counsellors. One thus cannot expect that subsequent cohorts of antiretroviral patients will experience similarly good employment opportunities once their health is restored. It is safer to assume that most of these people will become unemployed and that their household incomes will fall as a result of the loss of the disability grant.

Given such a scenario, it is possible that a small but significant proportion may opt to discontinue HAART so as to become AIDS-sick again in order to qualify once more for the disability grant – and then once it is reinstated, go back onto treatment (and when the grant expires once more, repeat the cycle). Besides the negative impact on the health of the individual, such possible behaviour will dramatically increase the growth of drug-resistant strains of the HI virus, thereby rendering the entire antiretroviral roll-out less effective. Put differently, the more that people switch from being on and off HAART, the greater the numbers of AIDS sick, and the greater the number of new HIV infections. In other words, the outcomes depicted in Figure 5 would look more and more like the no HAART roll-out and less and less like the scenario that included the HAART roll-out. The rate at which the shift takes place depends on how many people choose to yo-yo between the disability grant and HAART, the rate at which resistant strains of HIV develop, and the extent to which such resistant strains spread through the population.

### **Towards a basic income grant**

One response to the potential trade-off between disability grant and HAART is to remove the grant altogether for HIV-positive people. This would at least remove the perverse incentives described above. The cost, however, 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 life-line for poor AIDS-affected households. And, to the extent that lower household income translates into lower food expenditure, it may also adversely affect the nutritional status of people on HAART, thereby reducing the effectiveness of the treatment roll-out via a different route. Furthermore, to the extent that AIDS is driven by poverty, this could also exacerbate the AIDS epidemic.

An alternative response is to allow HIV-positive people to maintain 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 result in some people desiring to become HIV-positive. Although this may sound far-fetched, there is anecdotal evidence from the Western Cape, the Eastern Cape and KwaZulu-Natal indicating that some people become angry when they test negative, saying that they were hoping to get the grant.<sup>13</sup> 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.<sup>14</sup> If HAART is regarded (incorrectly) as a 'cure' for HIV, then 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 HAART.

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 whom 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? A BIG would need to be at a much lower level (probably in the region of R100–R200) than the R740 maximum grant for the disabled (as of 2004). Those households who lose the disability grant as a consequence of HAART will be 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? If the payment to disabled people was to remain at its 2004 level, then if someone gets a disability grant on top of the BIG, it could fall by R100, to R640. This means that if a person loses the disability grant as a result of going on HAART, they would still have R100 a month BIG to help them get by. It is, however, possible that for some very poor individuals on HAART, the gap between the disability grant and the BIG may still be large enough to encourage them to stop taking HAART in order to restore the grant. If so, then there is a case for reducing the value of the disability grant and/or raising the value of the BIG.

There is a range of arguments, both moral and economic in favour of a BIG in general (see, for example, Van Parys, 2001) and for South Africa in particular

(see, for example, Standing and Samson, 2003). This is not the place to review these arguments, or the arguments against the introduction of a BIG. The point is simply that, given the context of the AIDS and the perverse incentives associated with the removal of the disability grant, this amounts to one more argument in favour of the introduction of a BIG.

Previous research and financial simulations have shown that even a modest BIG of R100 per month for all South Africans could contribute substantially to reducing poverty and inequality in South Africa (for example, Bhorat, 2002). This is why the recent 'Taylor Committee' report on comprehensive welfare reform argued in favour of a BIG (Taylor Committee, 2002). According to Le Roux (2003), a BIG could be financed by a 7.3 per cent increase in value-added tax (VAT) and a 50 per cent 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.

In earlier work, I estimated that implementing a full-scale AIDS prevention and treatment intervention which provided HAART to all those who needed it (that is, with a rapid roll-out and no rationing of HAART), would require an increase in resources equivalent to raising VAT by between 3 and 7 percentage points depending on what level of care is provided to those suffering from AIDS-related illness (Nattrass, 2004b).<sup>15</sup> Given the subsequent dramatic decrease in the price of HAART – the first line triple therapy treatment regimen dropped by 72 per cent between November 2003 and June 2004 – the revenue which would need to be raised would now probably require an increase of between 1.9 and 5.7 percentage points on VAT (Nattrass and Geffen, 2004). If we take the mid-point estimate and add it to Le Roux's estimate of a necessary tax increases to finance a BIG, then it would appear that 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 (Seekings, 2003a). The notion of what is and is not 'affordable' thus 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 so as 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 – thus must be an integral part of any solution.

### Notes

- 1 Workers who contribute to the Unemployment Insurance Fund (UIF) can draw income support for up to 36 weeks. However, fewer than 10 per cent of workers are covered by this fund.
- 2 The ASSA2002 model was developed by Rob Dorrington, Leigh Johnson and others for the Actuarial Society of South Africa. It is available on [www.assa.org.za](http://www.assa.org.za).
- 3 See Natrass (2000) for a discussion of measurement issues concerning South African unemployment rates in the 1990s. The Labour Force Surveys from 2000 onwards use standard international classifications for unemployment, with the strict rate of unemployment (that is, comprising only active job-seekers) being adopted as the official unemployment rate. If those who say they want work but are not actively seeking it are included in the definition, then a higher 'broad' unemployment rate can be calculated. Both measures of unemployment are high by international standards and have been rising steadily since 1990.
- 4 Clinical Stage 4 of AIDS is the final stage of AIDS. The diagnosis of Stage 4 is determined by a set of clinical criteria including the patient manifesting AIDS-related opportunistic infections (such as thrush in the mouth and throat). A person in Stage 4 of AIDS also usually (but not always) has a CD 4 cell count of less than 200.
- 5 This is equal to the total number of AIDS sick estimated each year minus half the number of new AIDS sick to take into account the approximate six-month delay between applying for and receiving a disability grant.
- 6 For married individuals, they have to show that their joint income is less than R2,782 and that their joint assets are less than R532,800 (*ibid*).
- 7 This is broadly consistent with Simkins's earlier estimate (using different data and a different demographic model) that the number of disability grants will rise to 1,237,000 in 2010 and that the annual cost to government will rise to R9.5 billion as a result (2003: 9).
- 8 The total disbursed by provincial governments for all transfer payments (that is, including the old age pension, disability grants, care-dependency grants, foster care grants etc) in 2001/02 was R21.5 billion (Ministry of Finance, 2004: 97). Of this, R5.3 billion (25 per cent) was for disability grants. This amounted to just under 2 per cent of total government expenditure: that is, about half a percent of GDP.
- 9 The model includes a category for those who started but then stopped HAART. Twenty-five per cent of these people are also estimated to be AIDS-sick. Note that the demographic model assumes that once a person stops taking HAART, their risk of mortality rises to that of people in Stage 4 (AIDS sick) and hence they do not live very long once they are off treatment.
- 10 For a discussion of these attributes of the ASSA model, see Natrass (2004b).

- 11 Roll-out rates are assumed to be much higher for whites and Asians, because their income and employment rates are higher, and hence they are able to access HAART through the private sector.
- 12 Technically, what the model does is assume an increase in the median term to death of between four and five years for those who take HAART.
- 13 Reported by social workers and peer counsellors.
- 14 Correspondence with a journalist in the area.
- 15 The money could of course be raised through income tax rather than VAT. The discussion about taxation is presented here in terms of VAT simply to keep the argument simple.

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