



# Social Protection and Disability in South Africa

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This study could not have been undertaken without support from many people who willingly gave up their time to facilitate our visit to South Africa or to be interviewed. We received fantastic support from the South African Social Security Agency (SASSA), in particular Pat Naicker who not only provided us with some great insights but advised us on who to meet while helping set up a wide range of meetings. During our visit to SASSA's office in Western Cape, we were particularly grateful for the help we received from Irmgard Marais and Nomfundo Sasa who arranged for us to visit a range of local offices and disability assessment centres while also offering us their very useful perspectives. We are also highly appreciative of the time that many others, including from government and civil society organisations as well as private citizens, set aside for interviews. As can be appreciated by reading the report, the information we received offered us an in-depth understanding of South Africa's social security system, both its achievements and the challenges it faces. We were particularly impressed by the openness of SASSA and the Department of Social Development and their clear desire to continually improve the delivery of their social security schemes, to further increase their disability inclusivity. We hope that our research and recommendations further strengthen these efforts.

## Executive Summary

South Africa is one of the world's most unequal countries. A high proportion of the population lives on low incomes: around 50 per cent of the population live on less than R.32 (US\$2.50) per day and 65 per cent on less than R.64 (US\$5.00) per day. However, South Africa is one of the highest investors in social protection in Africa and has made significant efforts to include persons with disabilities within the national social protection system.

### *Description of the national population of persons with disability*

Around 3.5 per cent of South Africa's population experience severe functional limitations while 12.2 per cent could be regarded as having at least a moderate disability. Furthermore, around 28 per cent of households have a member with a moderate disability while 9.5 per cent of households include someone with a severe functional limitation. In absolute terms the largest numbers of disabled people are found between the ages of 50-64 years. However, the proportion of disabled people in each age group varies greatly, rising from 4 per cent among those aged 10-14 years to 53 per cent of those aged 85 years or older. In fact, the average age of a person with a disability is 47 years, compared to 34 years among the non-disabled population.

### *Challenges faced by persons with disability across the lifecycle*

Disability has a significant impact on both income and productivity in South Africa. For example, lost earnings have been documented at an average of US\$4,798 per adult with severe depression or anxiety disorder per year (about half of GDP per capita) totalling US\$3.6 billion when aggregated to the national level.

Food poverty rates among households with members with severe functional limitations (44.5 per cent) are significantly higher than among households without a disabled member (29.3 per cent). Further, households with members with severe functional limitations experience a higher food poverty gap than those without a disabled person (19.1 per cent compared to 13.8 per cent). Gender and ethnicity have a significant impact on incomes across households including a person with a severe functional limitation. Households headed by women with at least one member with a severe functional limitation have the lowest average monthly income per capita (pre- and post-transfer) of any group. Households with an African/Black head and a member with a severe functional limitation have incomes of R.905 per month (pre-transfers) compared to R.6,473 per month (pre-transfer) for households with a White head and no disabled members.

Persons with disabilities face challenges across the lifecycle. Children with disabilities face significant challenges. For example, children with disabilities are at higher risk of living in households with inadequate access to water and sanitation and are more likely to live in traditional houses in unplanned settlements with outside toilets and general overcrowding. Access to pre-school education is limited, with just a quarter of 0-6 year olds receiving the Care Dependency Grant attending a crèche or child-minding group. Furthermore, women with disabled children are especially vulnerable to becoming single parents because of the stigma around disability and, in addition, may face exclusion from social and economic activities that could offer support.

Whilst the gap is closing, disabled children are less likely to attend school than non-disabled children, which has significant implications for their rates of literacy. Only 63.9 per cent of young people with severe functional limitations (age 12-17) were attending school compared to 96.1 per cent of young people without disabilities, putting them at a disadvantage as they enter the labour market.

The challenges that disabled people face as children are carried through to later life. Persons with disabilities have much lower personal incomes when compared to non-disabled people, with women particularly disadvantaged. An inability to access work is a major factor explaining poverty.

As people age and become increasingly disabled, there is a link between increasing vulnerability and loss of social status. A lack of capacity to contribute towards sustaining the household can lead to lower social status. This can have an impact on gender roles in households with women (daughters or granddaughters) assuming most responsibility for caring and supporting older family members. Overall there is a significant research gap on the combined impact that disability and old age have on levels of poverty, social exclusion and vulnerability.

### ***Overview of the National Social Security System***

Since the fall of apartheid, South Africa has significantly increased its investment in tax-financed social security schemes with a focus on developing a social security system that addresses key risks faced across the lifecycle. Although social grants in South Africa are regarded as entitlements, they are targeted at those living in poverty and access is determined by a means test. The only exception is the Foster Care Grant, for which no means test is applied. However, to ensure that the social assistance schemes function as entitlements – and, therefore, are available to everyone when eligible – the means test

has been made very simple: applicants only have to sign an affidavit stating their income, which is not verified. In effect, the means test functions as a form of affluence test in that it does not try to identify the poorest but, rather, attempts to exclude the more affluent.

South Africa's social security system is designed to address challenges faced by persons with disability across the lifecycle: there is a Care Dependency Grant for children with disabilities, a Disability Grant for those aged between 18 and 59 years, and an old age pension for those aged 60 years and above. In addition, recipients of the Disability and Old Age Grant can access the Grant-in-Aid programme, which is intended to help them purchase additional support from carers. Persons with disabilities can also access other benefits on an equal basis with others. The only exception is the Child Support Grant which cannot be accessed by children in receipt of the Care Dependency Grant. The rationale for this exclusion is questionable, since both schemes have different objectives: in effect, children with disabilities are being excluded from a scheme that could make an important contribution to their nutrition.

### ***The legislative and policy framework, and governance on disability***

South Africa's social assistance grants are delivered by the South African Social Security Agency (SASSA), a semi-autonomous state agency reporting into the Department for Social Development. Its mandate is "to ensure the provision of comprehensive social security services against vulnerability and poverty within the constitutional and legislative framework". SASSA's head office is in Pretoria, but its management is devolved to regional SASSA offices, which means that there is a degree of inconsistency in how the social grants are delivered. The Ministry of Labour is responsible for the oversight and delivery of social insurance benefits. When SASSA was established, it was intended that it would take over responsibility for all social security benefits in South Africa. However, the transfer of responsibilities from the Ministry of Labour has still not taken place.

South Africa was an early adopter of the UN Convention on the Rights of Persons with Disabilities, which was ratified in 2007. This reflects a commitment to disability equality which is also evident in a relatively progressive constitution. A White Paper on the Rights of Persons with Disabilities was adopted in 2015 although South Africa has no specific disability rights legislation in place. While the Constitution protects the rights of disabled people and mandates that national legislation should not unfairly discriminate against disabled people, the gap in disability rights legislation means that the implementation and monitoring of inclusive legislation is weak.

### ***Evidence on access of persons with disabilities to social grant schemes***

Access to social assistance schemes overall has increased considerably since 1999 when there were 2.5 million beneficiaries, to the current number of 16 million. Much of this increase has been the result of the expansion of the Child Support Grant, which now has just under 12 million beneficiaries, followed by the Old Age Grant with over 3 million recipients. In contrast to the increase in beneficiaries across other programmes, recipients of the Disability Grant have declined by 31 per cent since 2006 as part of a plan to remove people from this scheme who were not regarded as eligible. However, both the Care Dependency and Grant-in-Aid schemes have seen increases, although beneficiary numbers remain low when compared to the likely need.

Overall, 65 per cent of persons with a severe functional limitation and 23 per cent of persons without a disability receive a social grant. This is, in part, likely to be the result of the existence of disability specific schemes and an extensive old age pension. However, it is also due to a policy of equal access of persons with disabilities to mainstream grants, such as the Child Support Grant and the Foster Care Grant. Furthermore, around 80 per cent of persons with a severe disability live in a household receiving at least one social grant, compared to 60 per cent of those households with no disabled members.

However, there are still around 35 per cent of persons with a severe functional limitation not in receipt of a social grant. Some may have been excluded by the means test but, many of those excluded live in extreme poverty. In the third quintile of the population, exclusion of persons with a severe disability reaches around 40 per cent, yet very few in this group should have been excluded by the means test.

### ***Disability assessment mechanisms***

The application processes for the Child Support Grant and Old Age Grant are relatively simple, as an affidavit suffices to prove both assets and income. The application processes for the disability-specific grants are more complex, and lengthier. Applicants need, in effect, to make four visits to institutions including undergoing two medical assessments: first, they need to have a referral letter before they start the pre-application process; then, they have to undergo SASSA's own medical assessment process. Navigating the disability application process is time- and resource-intensive especially when considering that many people will have additional expenses due to their disability.

SASSA currently implements a Disability Management Model, which was introduced in 2007 as a means of standardising the medical assessment process for the Disability Grant,

Care Dependency Grant and Grant-in-Aid. Those wishing to apply for these grants must, as noted above, bring a referral letter from a medical professional, as part of the pre-screening process, which should outline their medical history and the impairment for which they are seeking assessment. On application, the SASSA officer checks the social assistance MIS – known as SOCPEN – to make sure there have been no previous application attempts within the past six months.

During the medical assessment, which follows the application, the medical officer is required to state whether the applicant qualifies for a temporary grant (6-12 months), a permanent grant with review (between 2-5 years), or a permanent grant without need for medical review (although applicants are reviewed every five years to confirm they comply with other conditions, in other words the means test). Medical Officers need to determine the extent to which an applicant is disabled, expressed in terms of a percentage of incapacity. Those identified as experiencing significant impairments are then assessed by the Medical Officer against a series of social factors which include applicants' level of functional independence, education, employment history, age, geographical area and socio-economic factors, and opportunities for referral.

### ***Causes of exclusion of persons disabilities from social grants***

Many of the causes of exclusion of people from disability grants are the result of inadequate human resource capacity within the government of South Africa, in particular in SASSA and the Department of Health (DoH). South Africa's medical system is largely private and the DoH struggles to employ doctors. Yet, assessments for disability benefits have to be undertaken by doctors employed by the state. Given that many persons with disabilities have been treated by private doctors, by not allowing the judgement of private doctors to be used in assessments, a significant burden is placed on the state system which has to repeat assessments that could easily be undertaken by a person's own doctors.

Many Medical Officers undertaking disability assessments do not have adequate training or capacity to undertake them to the required standard. Given the breadth of disability that they have to assess, there are many aspects of disability that go beyond the competence of many general practitioners. SASSA provides training for Medical Officers, but the initial training is only for four hours while only two hours of the training is repeated each year. Moreover, the training is administrative, provided by SASSA staff, and does not teach the Medical Officers how to undertake assessments.



As a result of the lack of capacity among assessors, decisions can be arbitrary, with each Medical Officer applying different criteria. SASSA staff do not monitor the medical assessment itself and focus only on the administrative side of the process. Therefore, they are not familiar with how Medical Officers operate or on what basis they are making their recommendations. Overall, very little time is available for Medical Officers to assess patients: even in a scenario of a maximum of 40 assessments in an 8-hour day, only around 10 minutes would be available for consultations, and that would include the time spent filling in the form.

Furthermore, the need for evidence means that people with more visible impairments or those who are more articulate are more likely to be certified as eligible for the disability-specific grants, as Medical Officers often do not have time to undertake physical examinations and they are often also unable to use medical tests that have been undertaken of the applicants within the medical system. However, the Western Cape has developed its own version of the disability assessment system which is undertaken in collaboration with health facilities. As a result, the assessors are able to access medical records of the applicants, as long as they have been treated within the local health facility.

### ***Impacts of social grants on persons with disability***

South Africa's social security system has significant positive impacts on poverty and inequality. The social security transfers have resulted in a reduction in the national poverty rate from 47.9 per cent to 41.6 per cent – a 13 per cent decrease – while the poverty gap has fallen by 37 per cent. The poverty rate among persons with severe functional limitations has fallen from 71.9 per cent to 59.9 per cent - or a reduction of 16.7 per cent – while the poverty gap is down by 46.8 per cent, a larger impact than on the population as a whole.

The extra cost of disability among households including a person with a severe functional limitation is around 40 per cent of household income. However, the Disability, Care Dependency and Old Age Grants provide only 23 per cent of average household income, which suggests that they are not at a high enough level to compensate for the disability-related costs faced by households with disabled members, never mind having further impacts on household well-being. In fact, approximately 25 per cent of households in receipt of the Disability Grant had experienced hunger in the preceding year (a higher incidence than for the general population) and a third of households receiving the benefit had experienced running out of money to buy food (compared to a fifth of the general population).

### ***Perverse incentives and the disability grant***

There are concerns that the Disability Grant has engendered some perverse incentives linked to the management of chronic illness and employment. Much of the pressure on the Disability Grant comes from people experiencing chronic illness but who are not necessarily disabled. In part, this is the result of the use of community panels for disability assessments in the past when many people with chronic illness were placed on the grant. But, it is also because many people with chronic illnesses are living in extreme poverty and are unable to obtain work: instead, they see the Disability Grant as their only option.

It is difficult to know whether the 'unfit to work' criteria for the Disability Benefit does, in fact, act as a deterrent to employment. Nonetheless, when a comparison is made between recipients and non-recipients of the Disability Grant who have a severe functional limitation and are aged between 18 and 59 years, around 4.2 per cent of recipients were in employment compared to 44 per cent of non-recipients (while 33 per cent of non-recipients are in formal sector employment).

However, perhaps the bigger policy question is why disability benefits are not used to support people into, and during, employment. Given that persons with disabilities face significant additional costs compared to the non-disabled – which makes it more challenging for them to access employment – a case could be made for offering a grant that addresses these additional costs and, therefore, increases their capacity to find and stay in work.

### ***Conclusion***

South Africa is one of the few low- and middle-income countries that has established a lifecycle system of social security transfers for persons with disabilities, potentially enabling support to be accessed by persons with disabilities at any time of their lives. Overall, the social security system has a major positive impact on the lives of persons with disabilities in South Africa.

Nonetheless, there are still a range of challenges to address, if the effectiveness of the social security system in supporting persons with disabilities is to be enhanced. Key issues include: many persons with severe functional limitations face challenges in accessing benefits; children on the Care Dependency Grant are prohibited from accessing the Child Support Grant; the Disability Grant may discourage people from working due to the 'unfit to work' test; and the registration process for the disability benefits is too complex and exclusionary.

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## Acronyms

AIDS	Acquired immune deficiency syndrome
ANC	Africa National Congress
ARV	Antiretroviral
ATM	Automated Teller Machine
CD4	White blood cells that play a major role in protecting your body from infection
CDG	Care Dependency Grant
CSG	Child Support Grant
DFID	Department for International Development
DG	Disability Grant
DoH	Department of Health
DPME	Department of Planning, Monitoring and Evaluation
DPSA	Disabled People South Africa
DSD	Department of Social Development
DWCPD	Department of Women, Children and People with Disabilities
FCG	Foster Care Grant
FSM	Frontline Service Monitoring
GDP	Gross Domestic Product
GHS	General Household Survey
GiA	Grant-in-aid
HIV	Human immunodeficiency syndrome
HRC	Human Rights Commission
ILOSTAT	International Labour Organization database of labour statistics
IMF	International Monetary Fund
INDS	Integrated National Disability Strategy
LBPL	Lower Bound Poverty Line
MIS	Management Information System
NGO	Non-Governmental Organisation
NIDS	National Income Dynamics Study
OAG	Old Age Grant
PMO	Pension Medical Officers
R	Rand (South African Currency)
SA	South Africa
SASL	South African Sign Language
SASSA	South African Social Security Agency
SOCPEN	South Africa's information management system to process social grants
SRD	Social Relief of Distress
UBPL	Upper Bound Poverty Line
UN	United Nations
UN-DESA	United Nations Department of Economic and Social Affairs
UNICEF	United Nations International Children's Emergency Fund
WVG	War Veterans' Grant

# 1 Introduction

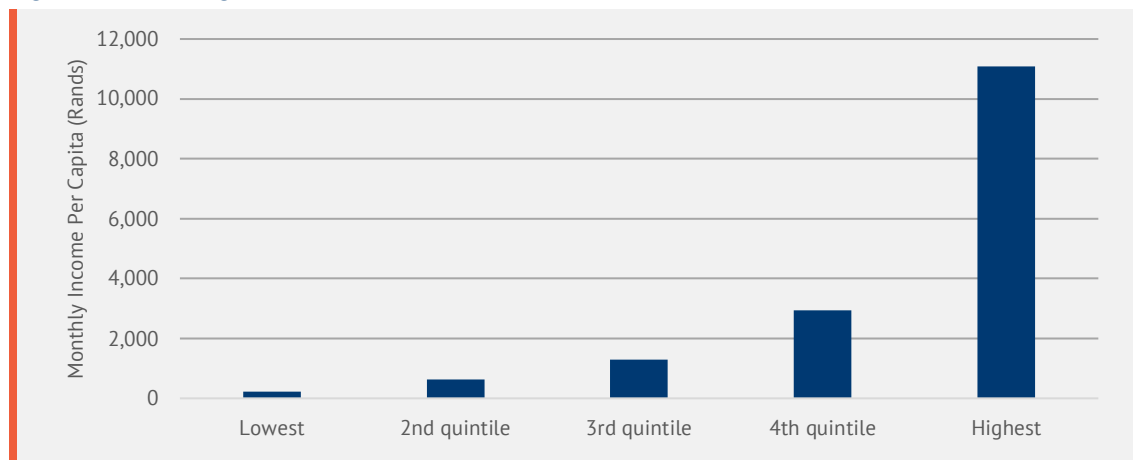
This report comprises one component of the DFID-financed study *Leaving no-one behind: how social protection can help people with disabilities move out of extreme poverty*. It is one of seven country case studies to identify good practice in enabling the inclusion of persons with disabilities in social protection systems and programmes. The research aims to address the gaps in knowledge in the design and delivery of social protection for persons with disabilities and to find examples of good practice that can be used to improve policies and programmes so that social protection in developing countries can become more disability inclusive. The study has been undertaken by Development Pathways.

The report presents findings from a study in South Africa to examine its social protection system and programmes and identify the challenges faced by persons with disabilities in accessing them. It begins by describing the broader economic and social context within South Africa, followed, in sections 2 to 4, by an overview of the population of persons with disabilities in South Africa and the challenges they face throughout each stage of the lifecycle. Sections 5 to 7 provide an overview of South Africa's social security schemes including relevant legislative and policy frameworks. They assess the extent to which persons with functional limitations have access to social security schemes, how disability is assessed in the South African context, and the potential causes of exclusion from social security schemes for persons with disabilities. Section 8 provides evidence of the impacts of social security on poverty and inequality among persons with disabilities in South Africa. Finally, sections 9 to 14 discuss the perverse incentives that are commonly linked to the Disability Grant as well as the linkages between social security and other services for persons with functional limitations.

## 2 The Context

Since its first democratic elections, South Africa has experienced relatively slow economic growth averaging 2.9 per cent from 1993 until 2016.<sup>1</sup> Nonetheless, South Africa is a middle-income country with a GDP per capita higher than other countries in the same region (estimated to be US\$5,074 per capita in 2017).<sup>2</sup> Increased economic prosperity has resulted in an overall reduction in poverty rates, although income inequality is very high: South Africa has one of the highest Gini Coefficients in the world, ranging between 0.66 and 0.70.<sup>3</sup> According to the most recent household survey (GHS) of 2015, the average household monthly income per capita is R.3,237 although, as Figure 2-1 indicates, there are significant differences between those in the deepest poverty and those living in affluence: the average household monthly income per capita in the poorest quintile of the population is R.233 (US\$16 in 2016) which increases to R.2,940 (US\$200 in 2016) in the fourth quintile and R.11,080 (US\$755 in 2016) among the most affluent quintile.

**Figure 2-1: Average household monthly income per capita across wealth quintiles in 2015<sup>4</sup>**



Overall, a high proportion of the population of South Africa lives on low incomes, as illustrated by Figure 2-2. Around 50 per cent of the population are getting by on less than R.32 (US\$2.50) per day and 65 per cent on less than R.64 (US\$5.00) per day. And, as will be explained later, for many people much of their income comes from social grants.

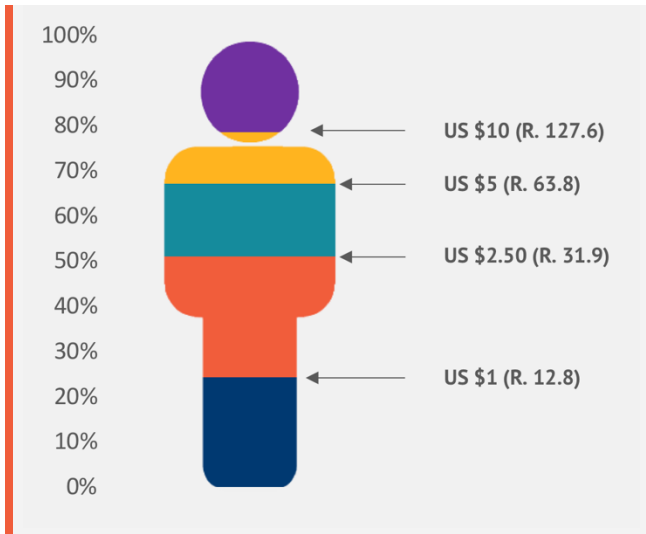
<sup>1</sup> Source: Average GDP growth rate estimated by Trading Economics, at <http://www.tradingeconomics.com/south-africa/gdp-growth>.

<sup>2</sup> Source: Estimate taken from International Monetary Fund World Economic Outlook for October 2017, at <https://www.imf.org/external/pubs/ft/weo/2016/02/weodata/weorept.aspx?pr.x=71&pr.y=15&sy=2014&ey=2021&scsm=1&ssd=1&sort=country&ds=.&br=1&c=199&s=NGDPPC%2CNGDPDPC&grp=0&a=>.

<sup>3</sup> Stats, SA (2014)

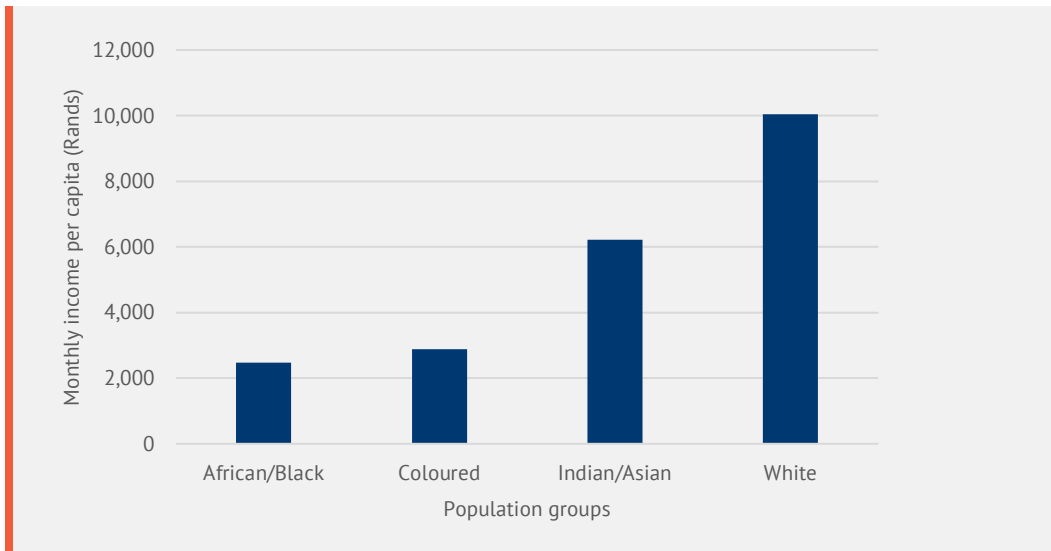
<sup>4</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

**Figure 2-2: Incomes in South Africa<sup>5</sup>**



Income differences are closely related to ethnicity. As Figure 2-3 indicates, the average household monthly income per capita among households with an African/Black head is R.2,467 (US\$168 in 2016), in contrast to R.10,045 (US\$684.3 in 2016) for households with a White head.

**Figure 2-3: Average household monthly income per capita across population groups in 2015<sup>6</sup>**



There is significant depth to poverty in South Africa. Around 28 per cent of the population above the age of 5 years live in food poverty. The food poverty line indicates a minimum food intake equivalent to R.335 per person per month in 2011 values. Moreover, as shown in Figure 2-4, the prevalence of food poverty is particularly high among children and young adolescents: 36 per cent of children aged 5-11 years live in food poverty, in

<sup>5</sup> Source: Secondary analysis of Statistics South Africa’s General Household Survey (GHS) 2015 by Development Pathways

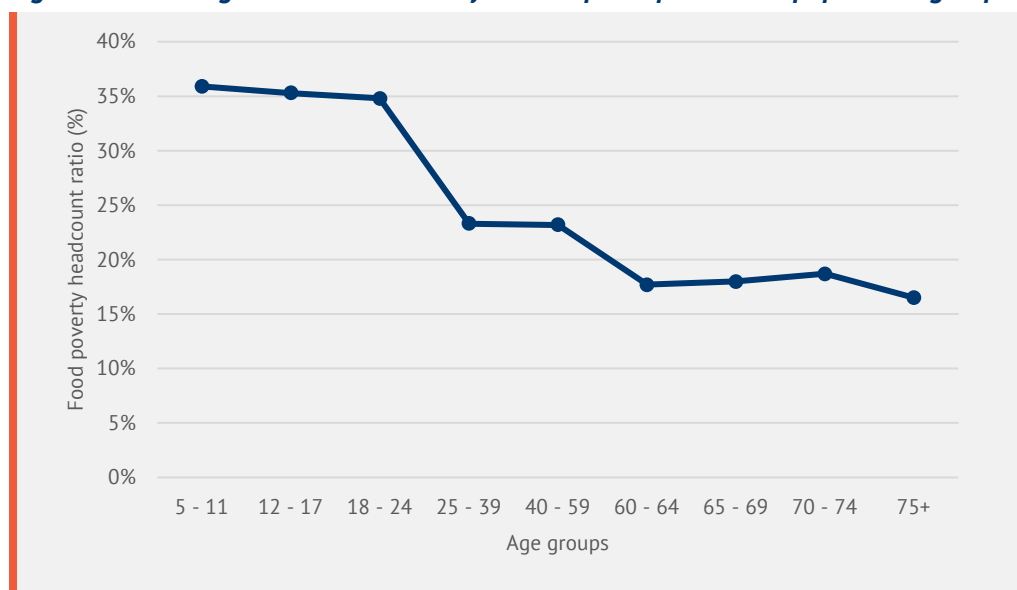
<sup>6</sup> Source: Secondary analysis of Statistics South Africa’s General Household Survey (GHS) 2015 by Development Pathways.



## 2 The Context

contrast to around 23.3 per cent of adults between the ages of 25 and 59. Indeed, according to the National Income Dynamics Study (NIDS) of 2008, 23.9 per cent of children under the age of 5 in South Africa were stunted, a similar level to the much poorer country of Kenya.

**Figure 2-4: Average household monthly income per capita across population groups in 2015<sup>7</sup>**



A common shock faced by people in South Africa is the loss of employment or income, with high unemployment rates creating significant challenges for the population. In 2015, the unemployment rate in South Africa was 25.2 per cent, of which 42.3 per cent faces long term unemployment. Moreover, a large proportion of people are not active in the formal labour market: the labour force participation rate is 54.6 per cent, suggesting that almost half of the working age population is not in the active labour force. Further, a large proportion of young people aged 15-25 are unemployed: their unemployment rate is 50.1 per cent and 30.5 per cent of young people are neither in employment, education or training.<sup>8</sup>

<sup>7</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

<sup>8</sup> Source: Labour statistics taken from ILOSTAT in 2015, at

[https://www.ilo.org/ilostat/faces/oracle/webcenter/portalapp/pagehierarchy/Page21.jspx?\\_afLoop=22605502697211&\\_afWindowMode=0&\\_afWindowId=32wn6oqhc\\_30#1%40%40%3F\\_afWindowId%3D32wn6oqhc\\_30%26\\_afLoop%3D22605502697211%26\\_afWindowMode%3D0%26\\_adf.ctrl-state%3D32wn6oqhc\\_62](https://www.ilo.org/ilostat/faces/oracle/webcenter/portalapp/pagehierarchy/Page21.jspx?_afLoop=22605502697211&_afWindowMode=0&_afWindowId=32wn6oqhc_30#1%40%40%3F_afWindowId%3D32wn6oqhc_30%26_afLoop%3D22605502697211%26_afWindowMode%3D0%26_adf.ctrl-state%3D32wn6oqhc_62).

## 3 Description of the National Population of Persons with Disability

According to the 2011 census, the prevalence rate for disability in South Africa is estimated at 7.5 per cent, a total of 2,870,130 people (age  $\geq 5$  years).<sup>9</sup> In contrast, the GHS 2015 gives a prevalence figure of 3.5 per cent for those with severe functional limitations, while, when 'some difficulty' is used as the measure, the prevalence figure is 12.2 per cent.<sup>10</sup> Furthermore, according to the GHS 2015, around 28 per cent of households have a member who has 'some difficulty' while 9.5 per cent of households include a person with a severe functional limitation. These figures indicate the significance of disability as an issue within South Africa since it directly impacts on a large number of households.

Overall the census reveals there are significantly more disabled women than men (male, 42 per cent; female 58 per cent) and in a higher proportion than the gender difference amongst the non-disabled population (male, 48 per cent; female, 52 per cent). Higher rates of disability among women may partly be the result of women living longer than men and having increased rates of disability in comparison to men as they become older.

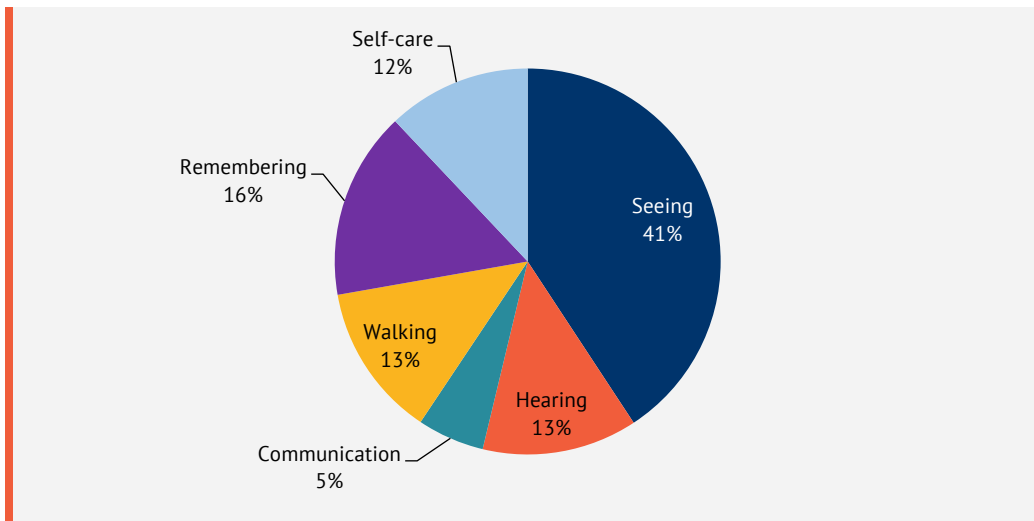
In terms of impairments, as indicated by Figure 3-1, the census provides details on six functional domains and levels of difficulty experienced, indicating that the highest number of persons with functional limitations is found amongst those with seeing difficulties (41 per cent), followed by remembering (16 per cent), walking (13 per cent) and hearing (13 per cent).

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<sup>9</sup> Census 2011: Profile of Persons with Disabilities in South Africa. Statistics South Africa.

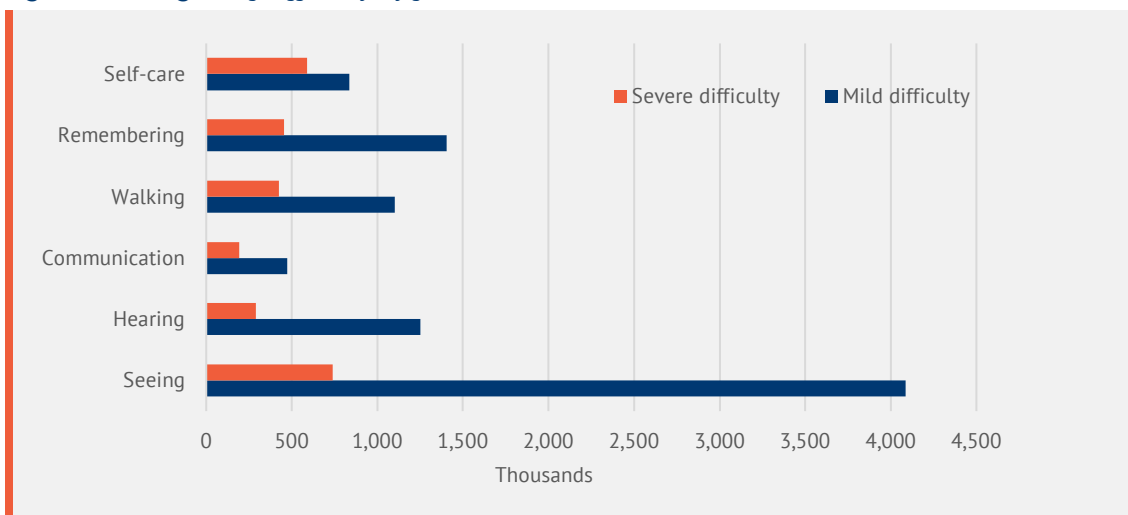
<sup>10</sup> South Africa has been collecting census data on disability since 1996 (1996, 2001, 2011 censuses) but unfortunately it is not possible to make direct comparisons over time because the definitions used, and the methods adopted for enumeration, were all quite different (see Annex 1 for more details).

**Figure 3-1: Functional domain breakdown based on all levels of difficulty<sup>11</sup>**



Prevalence changes considerably when measuring only those with severe difficulties. As Figure 3-2 shows, whilst seeing is still the most common difficulty (27 per cent) its predominance reduces considerably for this group whilst self-care (22 per cent), communication (17 per cent) and walking (16 per cent) become more prominent.

**Figure 3-2: Degree of difficulty by functional domains<sup>12</sup>**

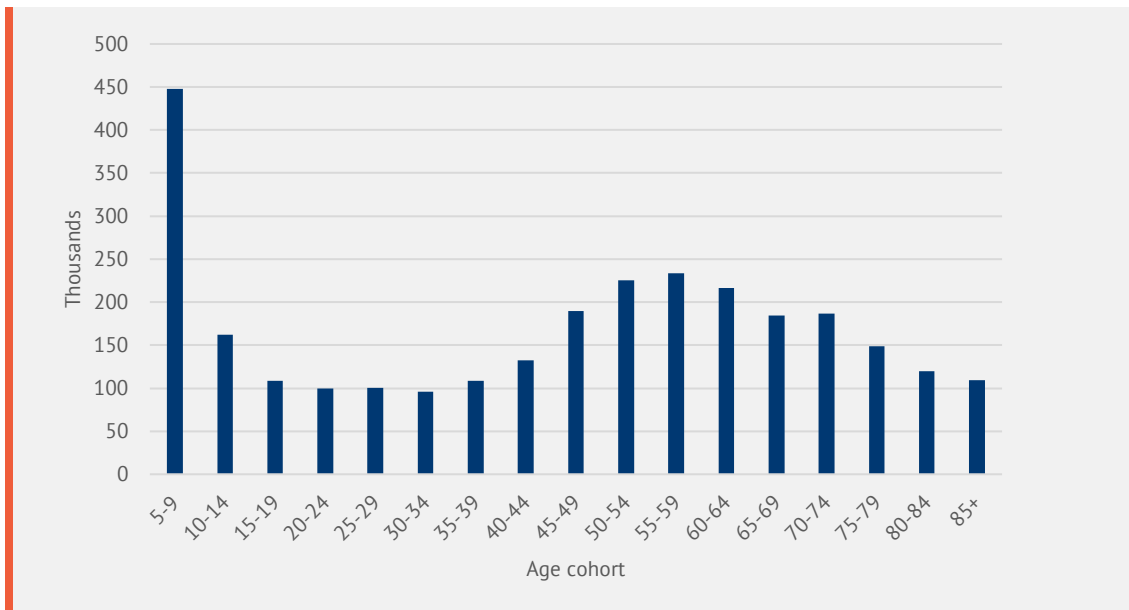


In absolute terms the largest numbers of disabled people are found between the ages of 50 and 64 years (see Figure 3-3). Whilst there are very large numbers recorded for those aged 5-9 years, this is not reliable because of the problems associated with the way data was collected for children aged 5 years (see Annex 1).

<sup>11</sup> Source: Census 2011. Statistics South Africa.

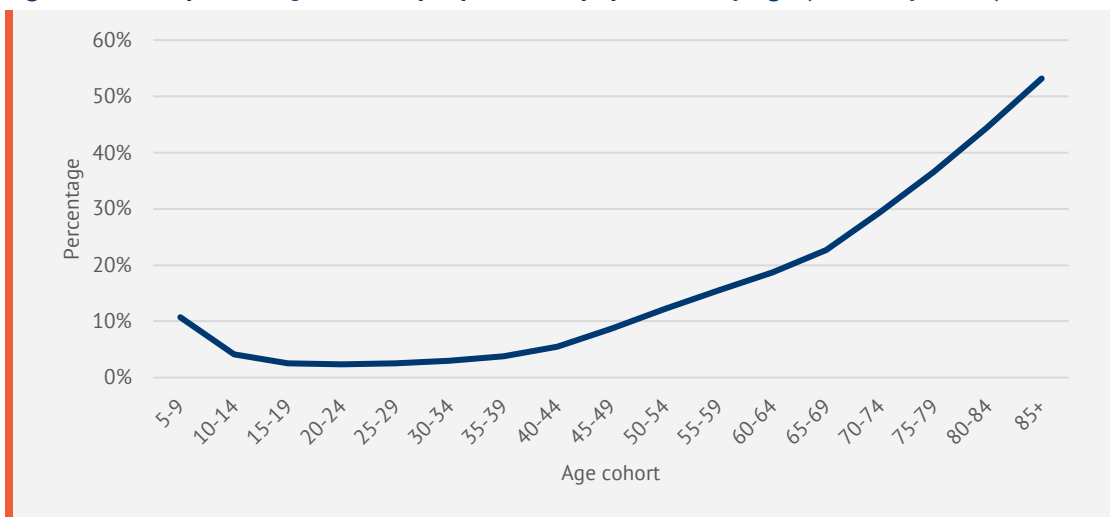
<sup>12</sup> Source: Census 2011. Statistics South Africa.

**Figure 3-3: Absolute numbers of disabled people by age (disability index)<sup>13</sup>**



However, as Figure 3-4 shows, the proportion of disabled people in each age group varies greatly, rising from 4 per cent among those aged 10-14 years to 53 per cent of those aged 85 years or older. In fact, the average age for disabled people is 47 years as compared with 34 years among the non-disabled population.<sup>14</sup>

**Figure 3-4: Proportion of disabled people in the population by age (disability index)<sup>15</sup>**



<sup>13</sup> Source: Census 2011. Statistics South Africa. Data for children aged under 10 are disproportionately more likely to report a difficulty, particularly on the self-care functional domain. This is most likely due to parents misreporting. Therefore, caution should be exercised when interpreting estimates on the prevalence of children 5-9 with functional limitation or overall self-care limitation prevalence.

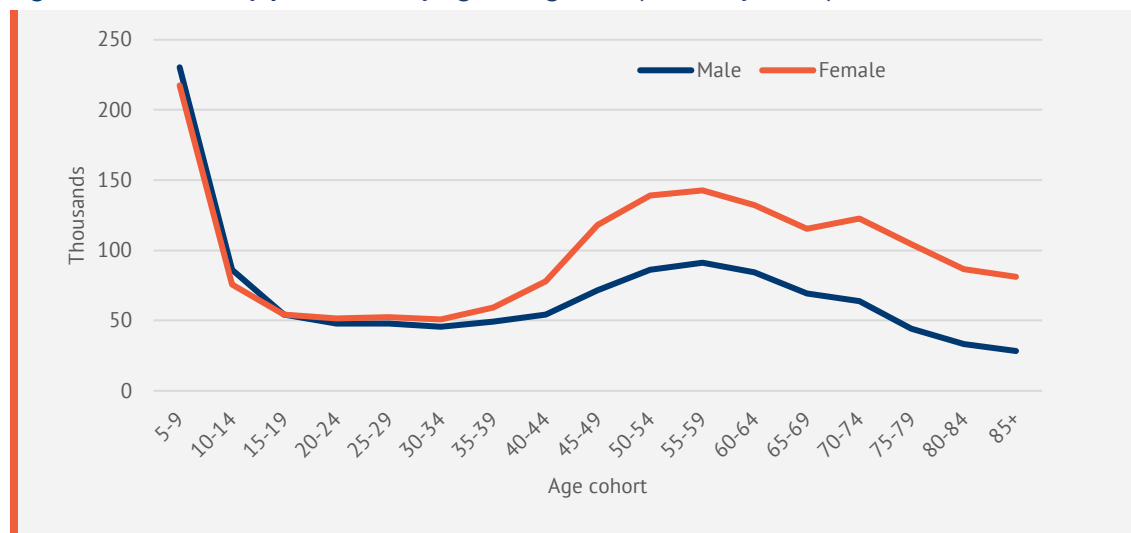
<sup>14</sup> Graham L. et al. (2014).

<sup>15</sup> Source: Census 2011. Statistics South Africa.

### 3 Description of the National Population of Persons with Disability

Furthermore, the numbers of disabled women increase relative to men as people age, which is a reflection of the higher life expectancy of females compared with males in general. In the 2011 Census, life expectancy at birth for women was 60 years compared to 56 years for men.

**Figure 3-5: Disability prevalence by age and gender (disability index)<sup>16</sup>**



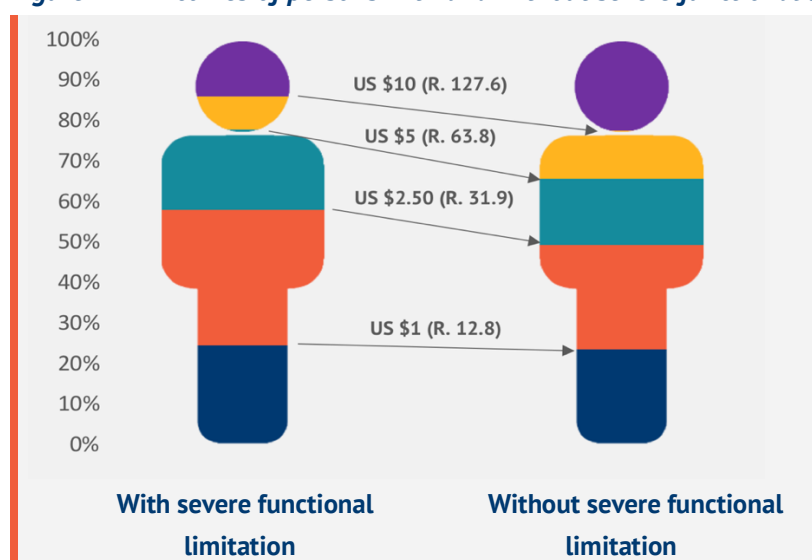
<sup>16</sup> Source: Census 2011. Statistics South Africa.

## 4 Challenges Faced by Persons with Disabilities

Disability has a significant impact on both income and productivity. For example, lost earnings have been documented at an average of US\$4,798 per adult with severe depression or anxiety disorder per year (about half of GDP per capita) totalling US\$3.6 billion when aggregated to the national level.<sup>17</sup>

Analysis from the GHS (2015) reveals that households with members with severe functional limitations were significantly more likely to be living below the food poverty line<sup>18</sup> (44.5 per cent compared to 29.3 per cent for households with no-one with a disability) while experiencing a higher food poverty gap (19.1 per cent compared to 13.8 per cent). Furthermore, as Figure 4-1 indicates, overall incomes of persons with a severe functional limitation are lower than those of persons without: in fact, almost 80 per cent of persons with a severe functional limitation have incomes below R.64 (US\$5.00) per day.

**Figure 4-1: Incomes of persons with and without severe functional limitations<sup>19</sup>**



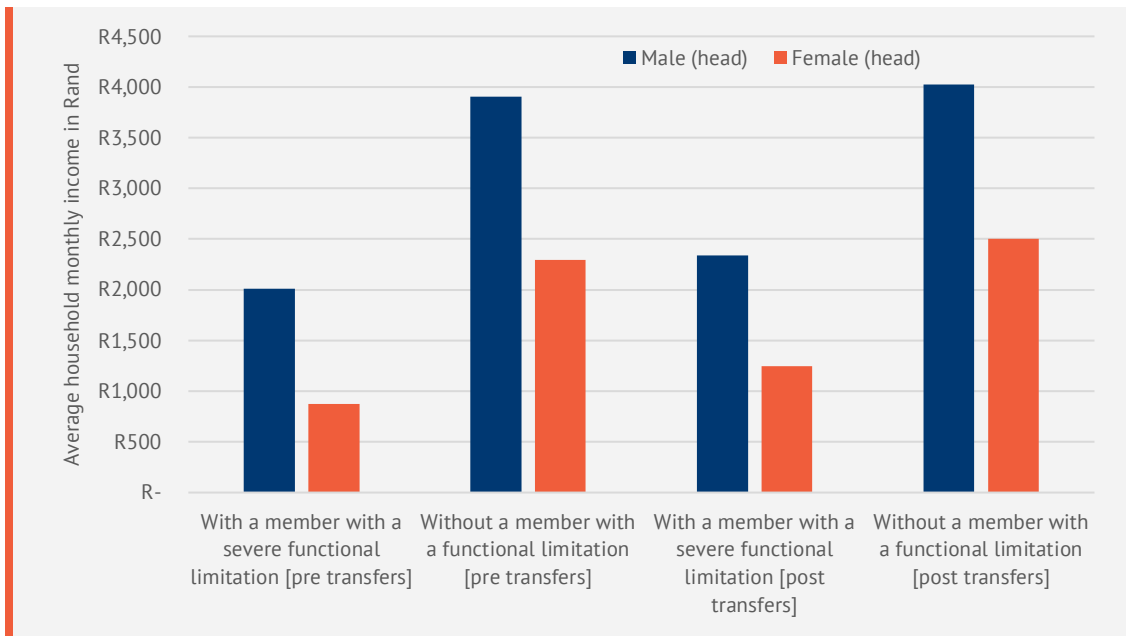
Data from the GHS (2015) also reveals that households headed by women with at least one member with a severe functional limitation have the lowest average monthly income per capita (pre- and post-transfer) of any group (see Figure 4-2).

<sup>17</sup> Banks and Polack (2014).

<sup>18</sup> Food poverty line of R501 per person per month (in 2011 values).

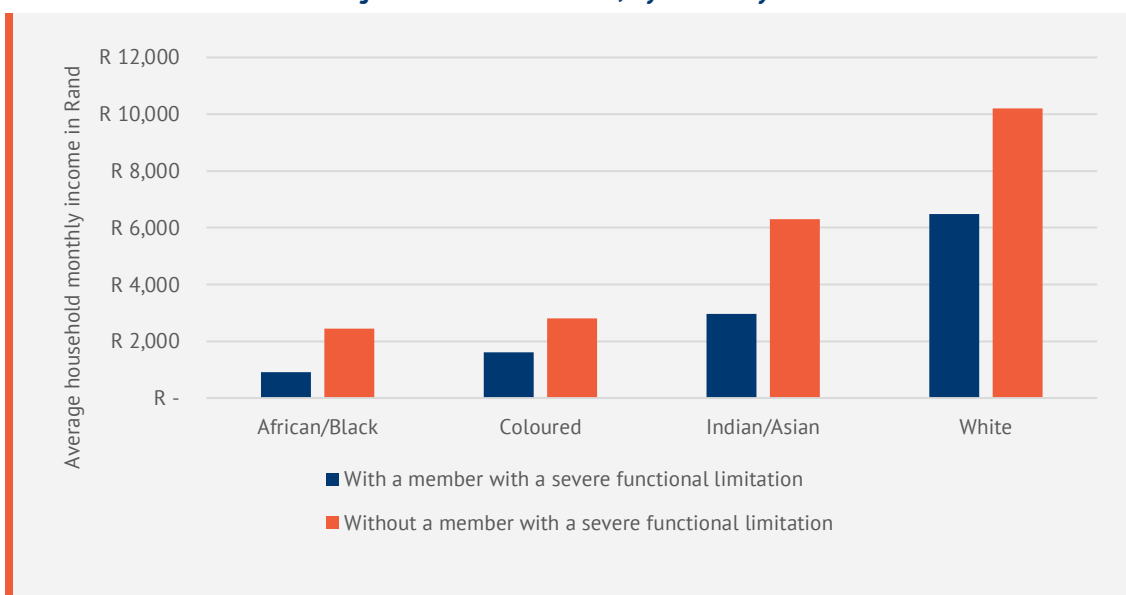
<sup>19</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015.

**Figure 4-2: Average household monthly income, pre- and post-transfers, for households with and without members with severe functional limitations<sup>20</sup>**



The ethnicity of the household head also has a significant impact on levels of income. Figure 4-3 shows that households with an African/Black head and a member with a severe functional limitation have incomes of R.905 per month (pre-transfer) compared to R.6,473 per month (pre-transfer) for households with a White head and no disabled members.

**Figure 4-3: Average household monthly income (pre-transfers) for households with and without members with severe functional limitations, by ethnicity<sup>21</sup>**



<sup>20</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015

<sup>21</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015

Further analysis of the GHS data estimates that the additional cost of disability for those with severe functional limitations is an average of R.895 per month. But for those households with up to two members with severe functional limitations aged 60 years or more, this rises to R.1,383 per month. So, not only do households with members with severe functional limitations have lower incomes than those without, their overall expenditure due to disability is higher, significantly so for those aged 60 years or more.

The challenges faced by persons with disabilities vary across the lifecycle and some of the key challenges are outlined below.

### 4.1. Early childhood

Currently there are issues in relation to how data is collected on disability in the population below the age of 6. It is impossible therefore to gain a correct picture of prevalence at this level. Early detection of disability remains weak and, as a result, there are many children with disabilities who are unsupported. For example, research has shown that only 1 in 10 public health facilities can screen infants for hearing impairments and less than 1 per cent provide universal infant screening. Furthermore, informants report that there are indications that the number of children born with disabilities is rising, due to an increase in foetal alcohol syndrome.

Children with disabilities are also at higher risk of living in households that have inadequate access to water and sanitation and are more likely to live in traditional houses in unplanned settlements with outside toilets and general overcrowding.<sup>22</sup> Access to pre-school education is also limited, with just a quarter of children aged 0-6 years receiving the Care Dependency Grant attending a crèche or child-minding group.<sup>23</sup> As in many other countries around the world, disabled children continue to experience high levels of stigma and discrimination which is a contributory factor to household vulnerability. Furthermore, children with disabilities often face abandonment by their fathers. Women with disabled children are especially vulnerable to becoming single parents because of the stigma around disability and, in addition, may face exclusion from social and economic activities that could offer support. This leaves disabled children vulnerable to neglect and abuse either from within the household or from wider family and community members. NGOs that support families with disabled children describe how women often have to struggle to provide their children with the care and support that is needed, many being forced into giving up full time work as a consequence. Many also rely on the child's

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<sup>22</sup> DSD, DWCPD and UNICEF (2012)

<sup>23</sup> de Koker et al. (2006)



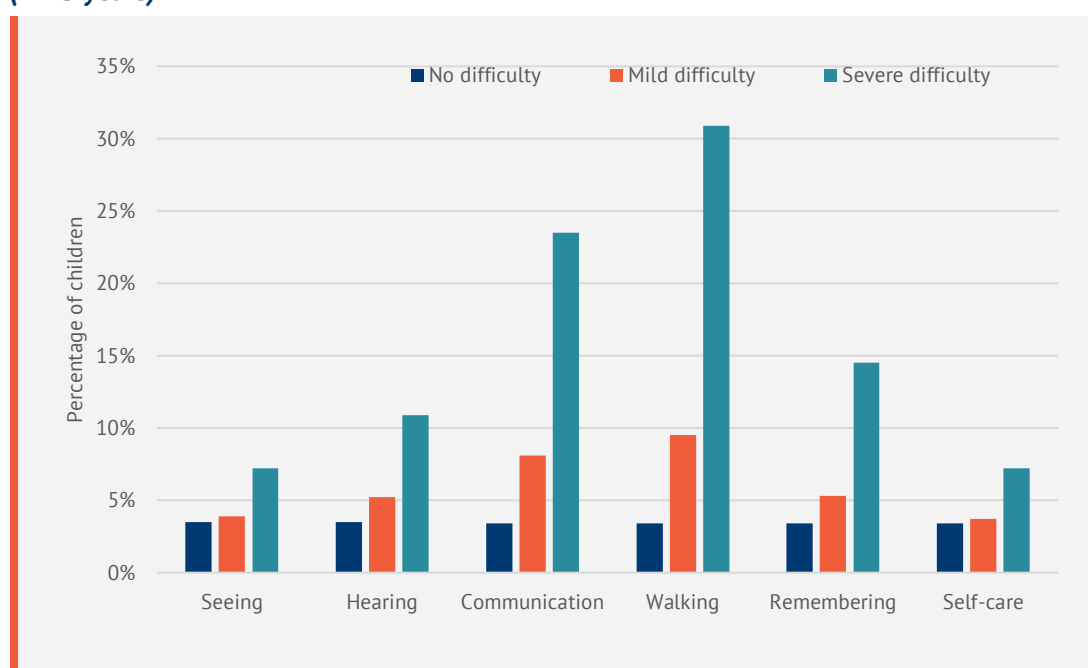
grandmother(s) for care and support, a difficult situation when the grandmother herself may have impairments or chronic health conditions. Overall, women (and their households) in this situation are isolated, excluded and highly vulnerable.<sup>24</sup>

### 4.2. School age

On reaching school age, disabled children continue to face considerable barriers both in accessing school and in terms of learning. Whilst the gap is closing, disabled children are still much less likely to attend school than non-disabled children, which has significant implications for their rates of literacy and ability to gain the qualifications needed to enter the formal labour market.

The type of functional domain and degree of difficulty impacts significantly on access to education. As Figure 4-4 shows, those with severe difficulties in walking (30.9 per cent) and communication (23.5 per cent) are considerably less likely to be in primary school than any other group of children. Disabled children are much less likely to progress from primary to secondary and post-secondary education with non-disabled people having, on average, 2.7 years more schooling than disabled people.<sup>25</sup>

**Figure 4-4: Children not attending primary school by functional domain and level of difficulty (7-13 years)<sup>26</sup>**



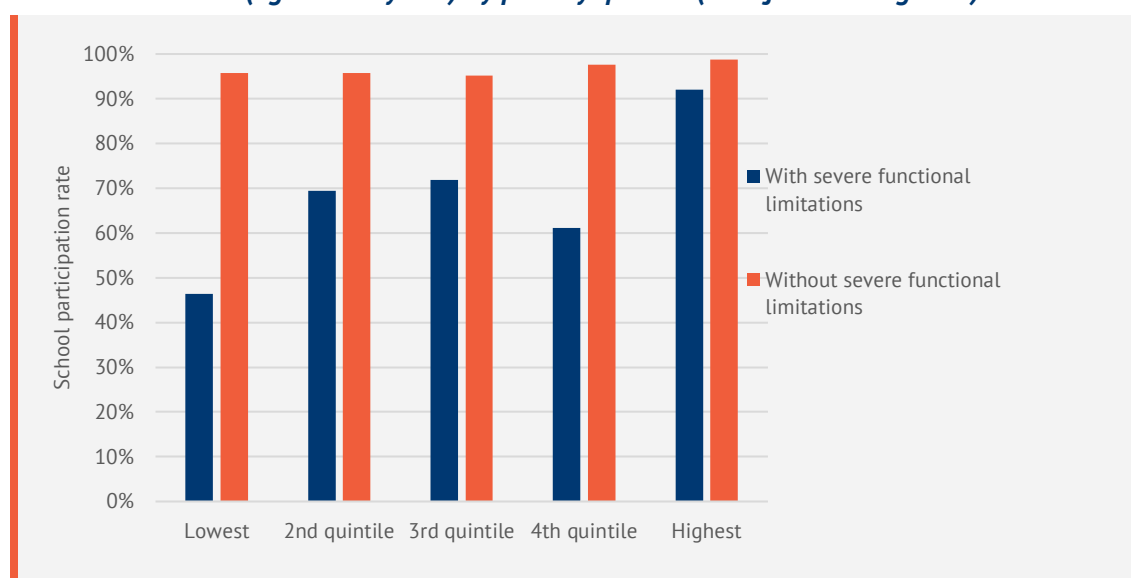
<sup>24</sup> Key informant interviews: Downs Syndrome Association, Pretoria, 8<sup>th</sup> November 2016; Afrika Tikkun Uthando Centre, Johannesburg, 9<sup>th</sup> November 2016

<sup>25</sup> Graham et al. (2014)

<sup>26</sup> Source: Census 2011. Statistics South Africa.

According to the GHS (2015), only 63.9 per cent of young people with severe functional limitations (age 12-17 years) were attending school compared to 96.1 per cent of young people without disabilities, which puts them at even greater disadvantage in the labour market. Moreover, young females with severe functional limitations had the lowest attendance levels at 57.7 per cent (compared to 96.2 per cent for non-disabled girls). Further, as Figure 4-5 shows, poverty has a significant impact on school attendance among this age group with just 46.4 per cent of young people with severe functional limitations (age 12-17 years) in the poorest quintile attending school (compared with 95.7 per cent of non-disabled young people in the same quintile). Without access to the skills and social networks that education provides, these young people face a future with very limited opportunities.

**Figure 4-5: School participation rates of young people with severe functional limitations and without disabilities (age 12-17 years) by poverty quintile (net of all social grants)<sup>27</sup>**



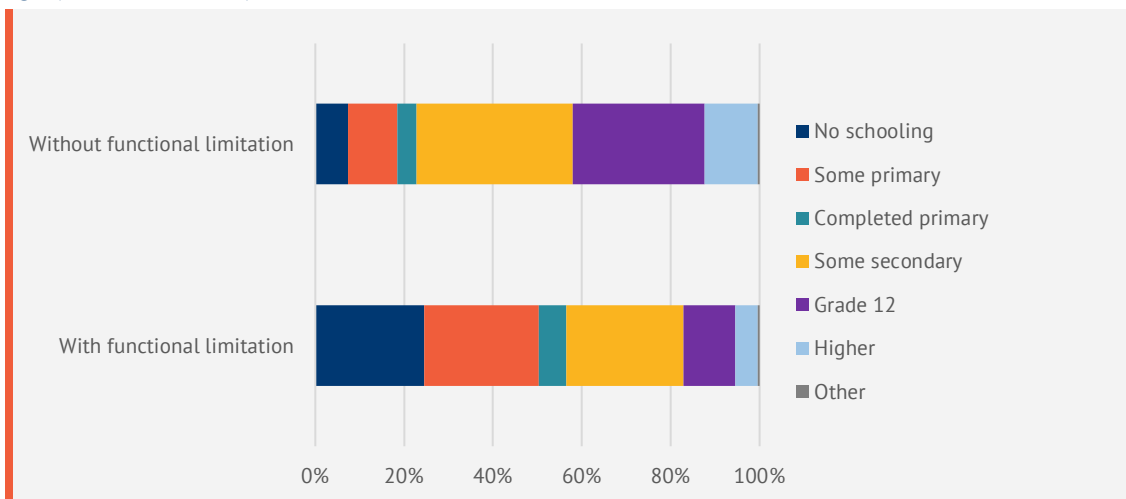
### 4.3. Working age

The challenges that disabled people face as children are carried through to later life. As Figure 4-6 shows, those aged above 20 years with functional limitations are much more likely to have no schooling (24.6 per cent) or some primary schooling (25.7 per cent) with very few achieving grade 12 (11.7 per cent) or higher (5.1 per cent).<sup>28</sup> The lower levels of educational attainment reduce the chances of persons with disabilities accessing decent employment, as they are placed at a disadvantage when compared to their non-disabled peers.

<sup>27</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

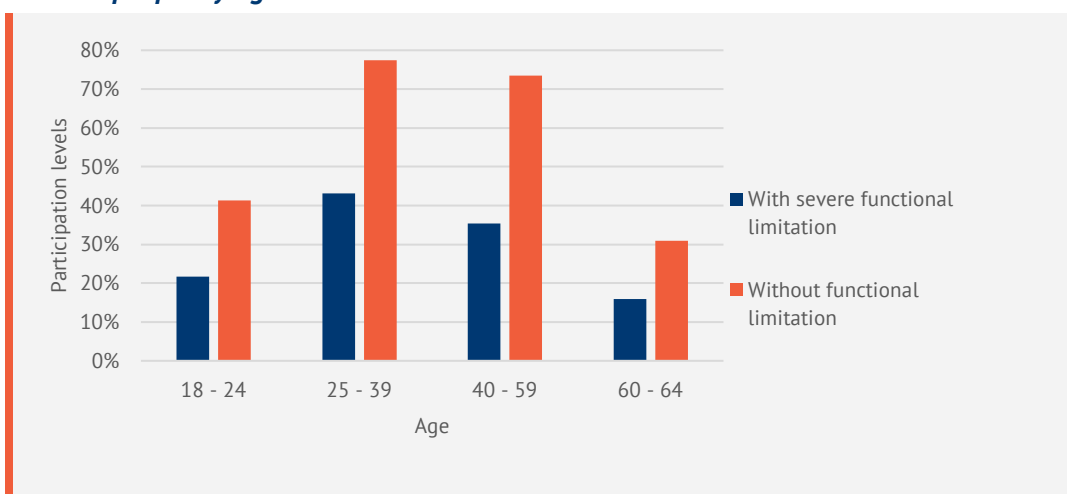
<sup>28</sup> Department of Education, South Africa (2001), Op. cit.

**Figure 4-6: Education attainment by functional limitation status for those above 20 years of age (disability index)<sup>29</sup>**



A significant factor explaining higher poverty rates among persons with disabilities is the disadvantages they face in the labour market and the impact this has on household income. Results from the recent GHS (2015) show that labour force participation for people aged 15 years and above is significantly lower for those with severe functional limitations: it is just 21.8 per cent compared to 57.2 per cent for those without disabilities. Figure 4-7 shows how labour force participation varies across age groups, with persons with severe functional limitations disadvantaged in each age group.

**Figure 4-7: Labour force participation of persons with severe functional limitations and non-disabled people by age cohort<sup>30</sup>**



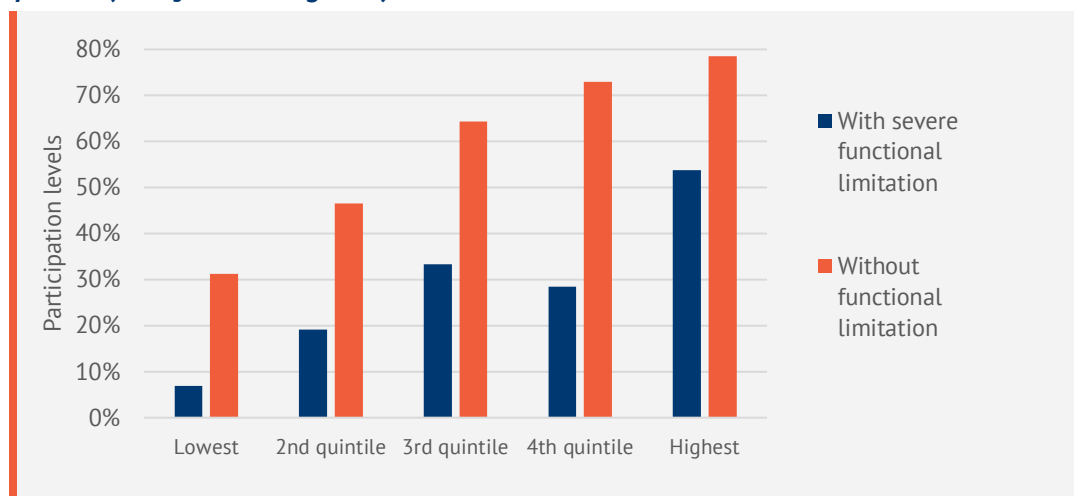
<sup>29</sup> Source: Census 2011. Statistics South Africa.

<sup>30</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

#### 4 Challenges Faced by Persons with Disabilities

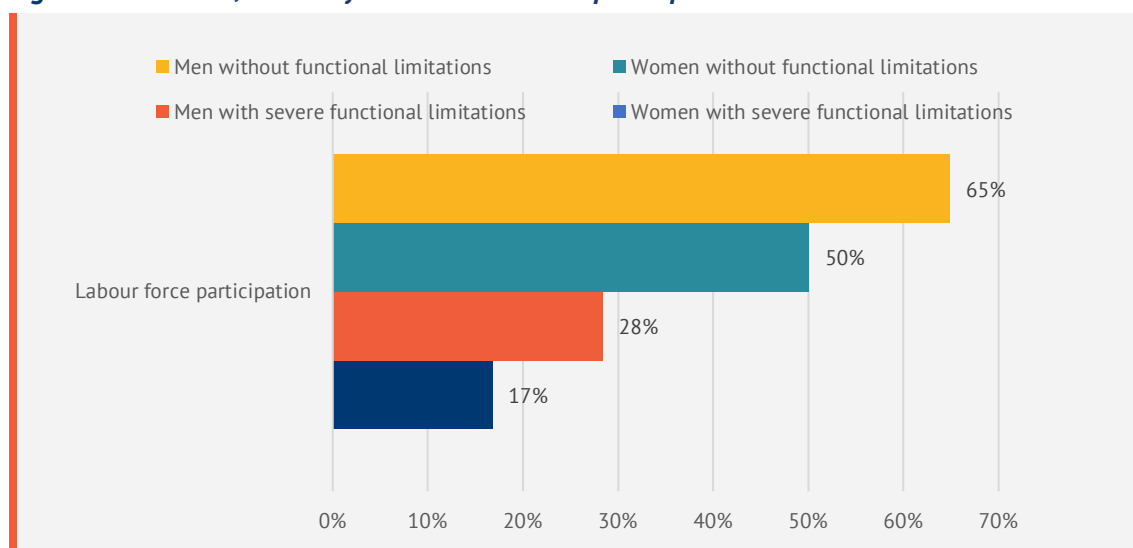
Poverty is correlated with the labour force participation of persons with severe functional limitations. Figure 4-8 shows a labour force participation rate of just 6.1 per cent among the poorest quintile of persons with severe functional limitations, compared to 31.3 per cent for the non-disabled population. An inability to access work is a major factor explaining poverty.

**Figure 4-8: Labour force participation of severely disabled and non-disabled people poverty quintile (net of all social grants)<sup>31</sup>**



For women the situation is more pronounced, with women with severe functional limitations considerably less likely to be in the labour force when compared to both men with severe functional limitations and non-disabled women (Figure 4-9)

**Figure 4-9: Gender, disability and labour market participation<sup>32</sup>**



<sup>31</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

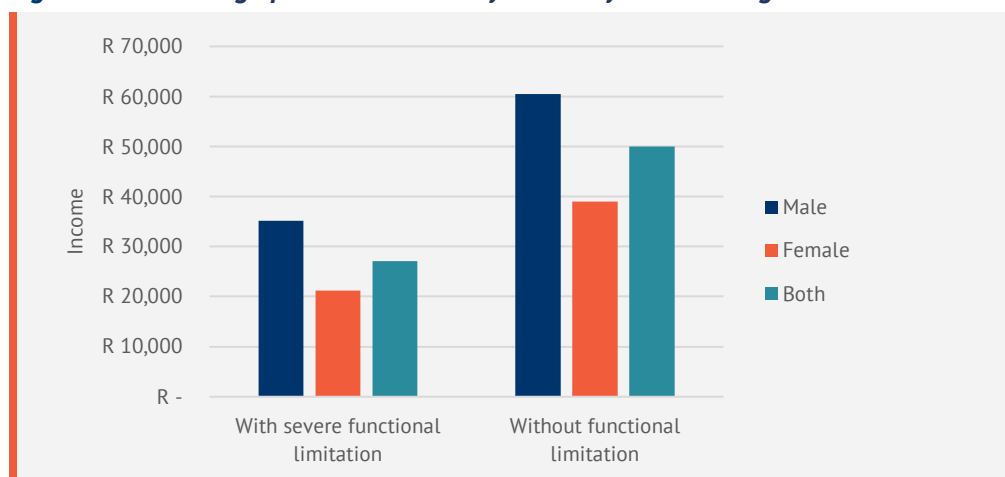
<sup>32</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

#### 4 Challenges Faced by Persons with Disabilities

In absolute terms, there are very few disabled people in the formal employment sector: in 2015 they represented just 0.9 per cent of the total population of economically active people in South Africa. The more severe the difficulty, the less likely the person is to be economically active, with women affected more than men, reflecting systemic challenges in accessing the labour market.<sup>33</sup>

There are also significant differences in terms of personal income measurements. As Figure 4-10 indicates, persons with functional limitations have much lower personal incomes when compared to non-disabled people, with women with functional limitations especially disadvantaged.

**Figure 4-10: Average personal income by disability status and gender<sup>34</sup>**

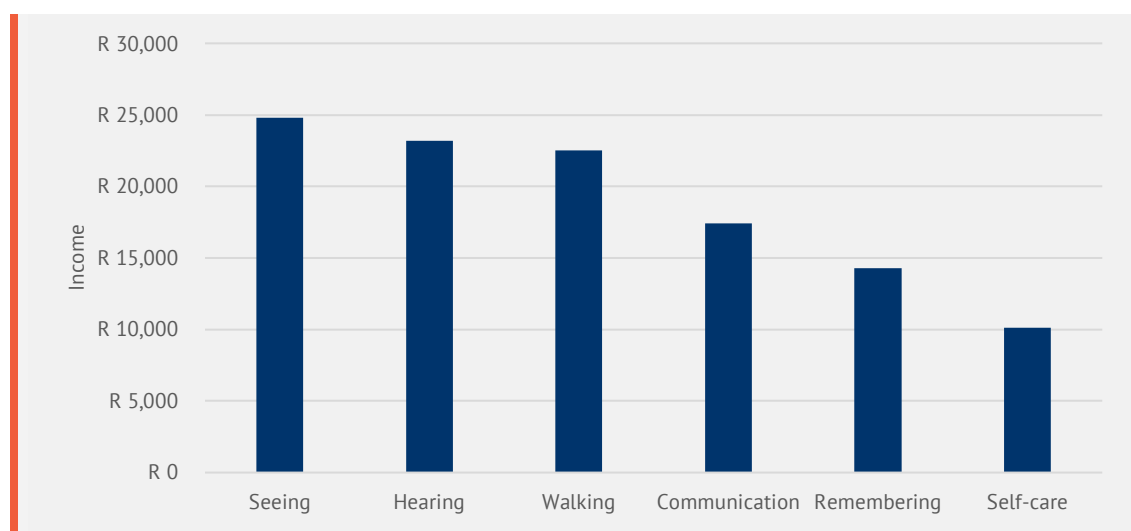


Moreover, the type of impairment also impacts on average personal earnings with people expressing severe difficulties in seeing, hearing and walking earning higher personal incomes than those with severe self-care, remembering or communication difficulties.

<sup>33</sup> Department of Social Development, South Africa (2015).

<sup>34</sup> Source: Census 2011. Statistics South Africa.

**Figure 4-11: Average personal income by disability type, among persons with severe difficulty in each domain<sup>35</sup>**



#### 4.4. Old Age

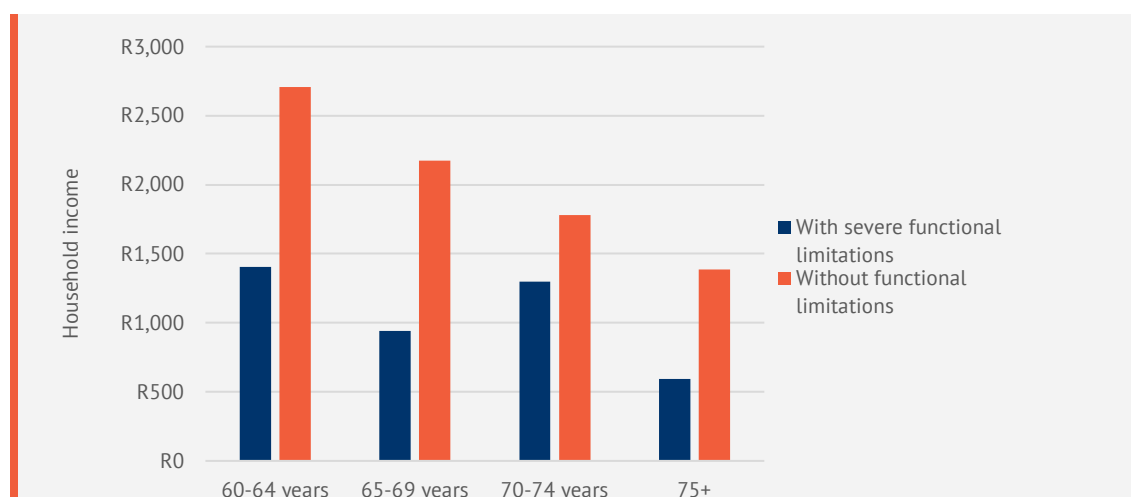
As was shown by Figure 3-4, the incidence of disability increases with age, which implies that disability in South Africa is a particular problem amongst older people.<sup>36</sup> Overall, households with older people (60+ years) who have severe functional limitations tend to be larger than those without: 4.6 members (average) for those with older people with severe limitations compared with 3.7 members (average) for households without.<sup>37</sup> Moreover, average monthly income levels for households with older members with severe functional limitations are significantly lower than for comparable households and, as people age, income levels decrease further (see Figure 4-12).

<sup>35</sup> Source: Census 2011. Statistics South Africa.

<sup>36</sup> Graham et al. (2010)

<sup>37</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways

**Figure 4-12: Average household income - net all social grants - by age and severe functional limitation<sup>38</sup>**



While there is little specific research on disability and older people, studies of ageing and social isolation highlight the link between vulnerability and loss of social status with declining health and physical or sensory impairment. As people age and acquire impairments, their social exclusion increases.<sup>39</sup> A lack of capacity to contribute towards sustaining the household can lead to lower social status. Furthermore, this can have an impact on gender roles in households with women (daughters or granddaughters) assuming most responsibility for caring and supporting older family members.<sup>40</sup> Overall there is a significant research gap on the combined impact that disability and old age have on peoples' levels of poverty, social exclusion and vulnerability. This is partly a result of older people (and researchers) failing to define themselves as disabled, assuming impairments and/or mental health conditions are just a part of becoming older.<sup>41</sup>

<sup>38</sup> Source: Census 2011. Statistics South Africa.

<sup>39</sup> Kidd (2016)

<sup>40</sup> Kidd (2016)

<sup>41</sup> See for example: Burns and Oswald (2014)

## 5 Overview of the National Social Security System

According to the 1996 Constitution of South Africa:

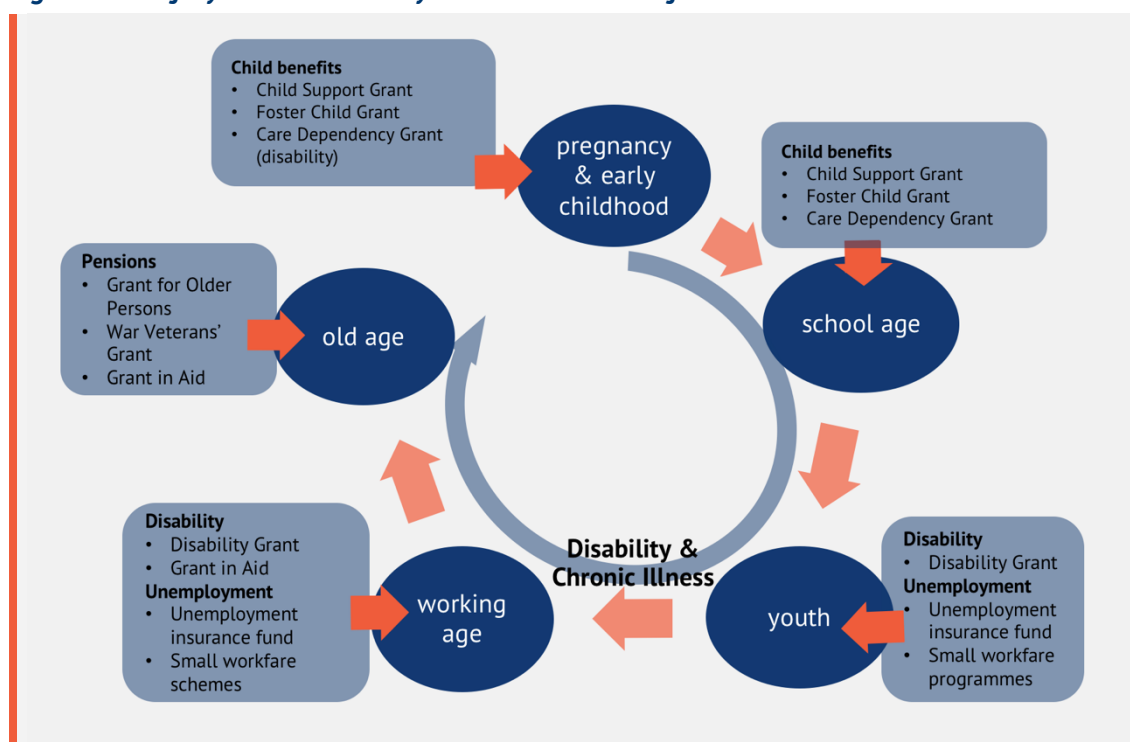
*'Everyone has the right to have access to ..... social security, including, if they are unable to support themselves and their dependents, appropriate social assistance....'*

The Social Assistance Act of 2004 – which came into being following recommendations from the Taylor Commission (2002) – outlines the tax-financed social grants available in South Africa, with eligibility criteria updated in an amendment to the Act in 2009. Although the social grants in South Africa are regarded as entitlements, they are targeted at those living in poverty and access is determined via a means test. As a result, the grants are referred to as social assistance and conceptualised as for 'the poor'. The only exception is the Foster Care Grant, for which no means test is applied. However, to ensure that the social assistance schemes function as entitlements – and, therefore, are available to everyone when eligible – the means test has been made very simple: applicants only have to sign an affidavit stating their income, which is not independently verified, although, if they claim an income, they should bring evidence (such as a pay-slip).

Since the fall of apartheid, South Africa has significantly increased its investment in tax-financed social security schemes. Its focus has been on developing a social security system that addresses key risks faced across the lifecycle, as outlined in Figure 5-1. In addition, there are a small number of social insurance programmes, the largest an unemployment insurance programme with around 7 million members, as well as schemes offering maternity and sickness insurance. The latter is offered for up to 8 months, although Parliament is currently considering extending it to 12 months. There is no mandatory social insurance disability and old age pension: instead, all contributory schemes are private. However, for a number of years, the Government has been considering introducing mandatory contributory disability and old age pensions as a second tier to the pension system.



Figure 5-1: Lifecycle social security schemes in South Africa



Addressing the challenges faced by persons with disabilities has been a key focus of South Africa’s social security system: there is a Care Dependency Grant for children with disabilities, a Disability Grant for those aged between 18 and 59 years, and an old age pension for those aged 60 years and above. In addition, recipients of the Disability and Old Age Grant can access the Grant-in-Aid, which is intended to help them purchase additional support from carers. Persons with disabilities can also access other benefits on an equal basis with the rest of the population. The only exception is the Child Support Grant which cannot be accessed by children in receipt of the Care Dependency Grant. The rationale for this exclusion is questionable, since both schemes have different objectives: in effect, children with disabilities are being excluded from a scheme that could make an important contribution to their nutrition (this is discussed further in Section 8).

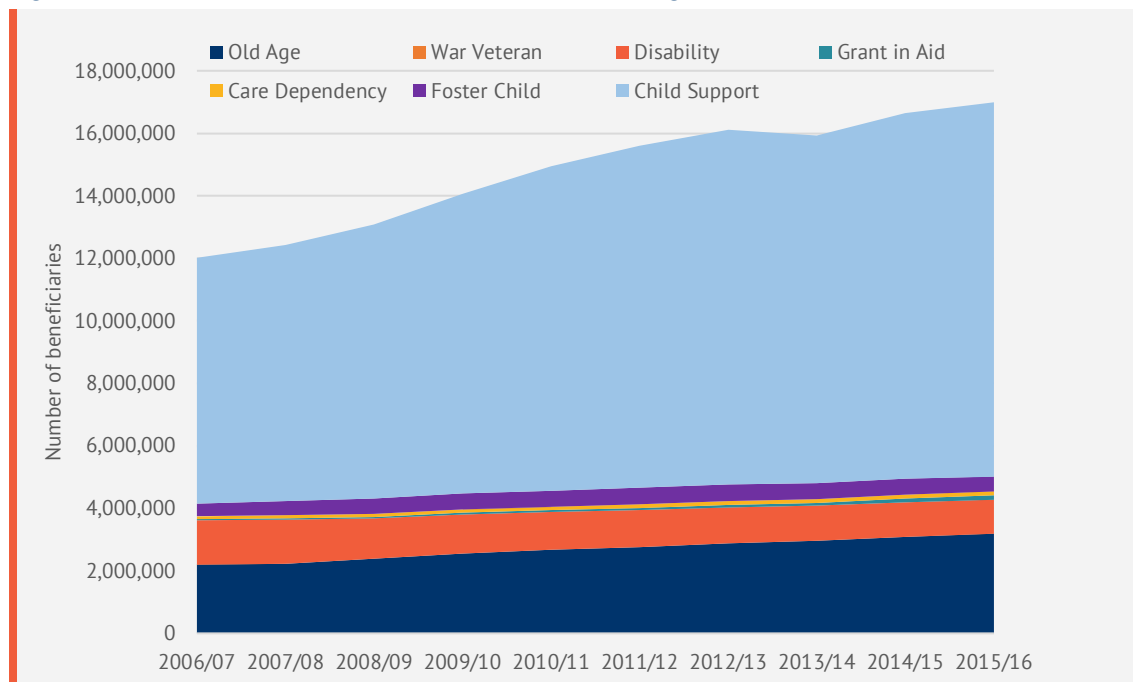
Figure 5-1 offers more detail on South Africa’s tax-financed social security schemes. As Figure 5-2 indicates, the number of recipients has grown significantly over the past 10 years. Overall, in September 2016, there were 17,150,000 social grants paid each month to a total of 10,528,000 recipients. This compares to 2.4 million people receiving grants in 1994 – out of a total population of 40 million – when the ANC took power.<sup>42</sup> Around 61 per cent of South Africans live in a household in receipt of at least one social grant, with

<sup>42</sup> Source: Seekings and Matisonn (2010)

## 5 Overview of the National Social Security System

many households with multiple vulnerabilities accessing a range of benefits.<sup>43</sup> Coverage is high among certain categories of the population: around 65.8 per cent of children receive either a Child Support Grant or Care Dependency Grant, while 77.2 per cent of those over 60 years receive an Old Age Grant, with many other older people accessing a private pension. Around 0.04 per cent of the working age population receive a Disability Grant, which is the only social grant directly targeted at that age group.

**Figure 5-2: Growth in number of beneficiaries of social grants from 2006-2015<sup>44</sup>**



<sup>43</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015. Around 46 per cent of households receive a social grant.

<sup>44</sup> Source: SASSA (2016)

## 5 Overview of the National Social Security System

**Table 5-1: Tax-financed social security schemes in South Africa (2016)<sup>45</sup>**

Scheme	Eligibility	Number of recipients <sup>46</sup>	Recipients as proportion of category <sup>47</sup>	Value of transfer (Rand per month)	Value of transfer (GDP per capita) <sup>48</sup>	2016 Budget (US\$)	2016 Budget (% of GDP)
<b>Childhood</b>							
Child Support Grant	0-17 years, plus means test, no CDG	12,045,291	63.4%	350	5.5%	3,542,769,735	1.26%
Foster Care Grant	Court order and universal	504,541	2.7% <sup>49</sup>	890	13.9%	376,572,449	0.13%
<b>Disability</b>							
Care Dependency Grant	0-17 years, disability assessment and means test	143,043	0.75% <sup>50</sup>	1,510	23.50%	182,546,013	0.07%
Disability Grant	18-59 years, disability assessment and means test	1,081,866	3.4% <sup>51</sup>	1,510	23.50%	1,392,434,288	0.50%
Grant in Aid	Recipient of CDG, DG or OAG, with additional care needs	152,070	No data	350	5.5%	34,081,883	0.01%
<b>Old Age</b>							
Old Age Grant	60+ years, plus means test	3,247,008	74.9%	1,510 <sup>52</sup>	23.5%	4,018,559,362	1.43%
War Veteran's Grant	Those serving in Korean War and previous World Wars, and aged over 60 years or disabled	207	No data	1,520	23.8%	247,002	0.00%
<b>Total</b>		<b>17,174,026</b>		<b>7,640</b>	<b>119.21%</b>	<b>9,581,308,233</b>	<b>3.42%</b>

<sup>45</sup> Sources: SASSA (2016)

<sup>46</sup> Numbers are for September 2016.

<sup>47</sup> Source: Population figures estimates from UN-DESA's population database.

<sup>48</sup> Source: IMF World Economic Outlook Database (2016).

<sup>49</sup> Recipients as proportion of all children below 18 years.

<sup>50</sup> Recipients as proportion of all children below 18 years.

<sup>51</sup> Recipients as proportion of working age population (18 – 59 years).

<sup>52</sup> Those aged over 75 years receive an additional R.20 per month.

South Africa's social security system is designed to address challenges faced by persons with disability across the lifecycle:<sup>53</sup>

- **Childhood:** The Care Dependency Grant is provided to the carer of a child aged up to 17 years with a disability that 'requires and receives permanent care and support services'.
- **Working Age:** The Disability Grant is provided to those aged between 18 and 59 years who, as a result of their disability, 'are unable to enter the open labour market or to support himself or herself in light of his or her skills and ability to work'. People also should not refuse employment that is within their capabilities or refuse to undergo medical or other treatment recommended by a medical officer. The Disability Grant can be provided as a temporary benefit – if the disability continues for between 6 and 12 months – and as a permanent benefit if it is expected to continue for more than 12 months. However, permanent does not mean it will be provided until the age of 60 years: people on permanent benefits can be required to have their disability re-assessed and, if they no longer qualify, be removed from the scheme.
- **Old age:** At age 60 years, all recipients of the Disability Grant are transferred on to the Old Age Grant. In addition, anyone who becomes disabled after reaching the age of 60 years is eligible to access the Old Age Grant.
- **Care support:** The Grant-in-Aid is paid to beneficiaries of the Disability Grant, Old Age Grant and War Veterans' Grant who have been certified by a Medical Officer as requiring regular attendance by another person.

However, the grants cannot be paid to those in state-run care institutions. This restriction does not apply to those in care institutions run by the private sector or charities.

As indicated above, access to these grants is determined by a means test, which is applied on the basis of the income and assets of the applicant alone, if unmarried, or the joint income of the applicant and his/her spouse. It is not dependent on the income of the household so does not generate disincentives for persons with disabilities to abandon more affluent households. The means test for the benefits is set out in Table 5-1. In effect, the means test functions as a form of affluence test in that it does not try to identify the poorest but, rather, attempts to exclude the more affluent.

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<sup>53</sup> Information on eligibility criteria is taken from Government of South Africa (2009), which outlines amendments to the 2004 Social Assistance Act.

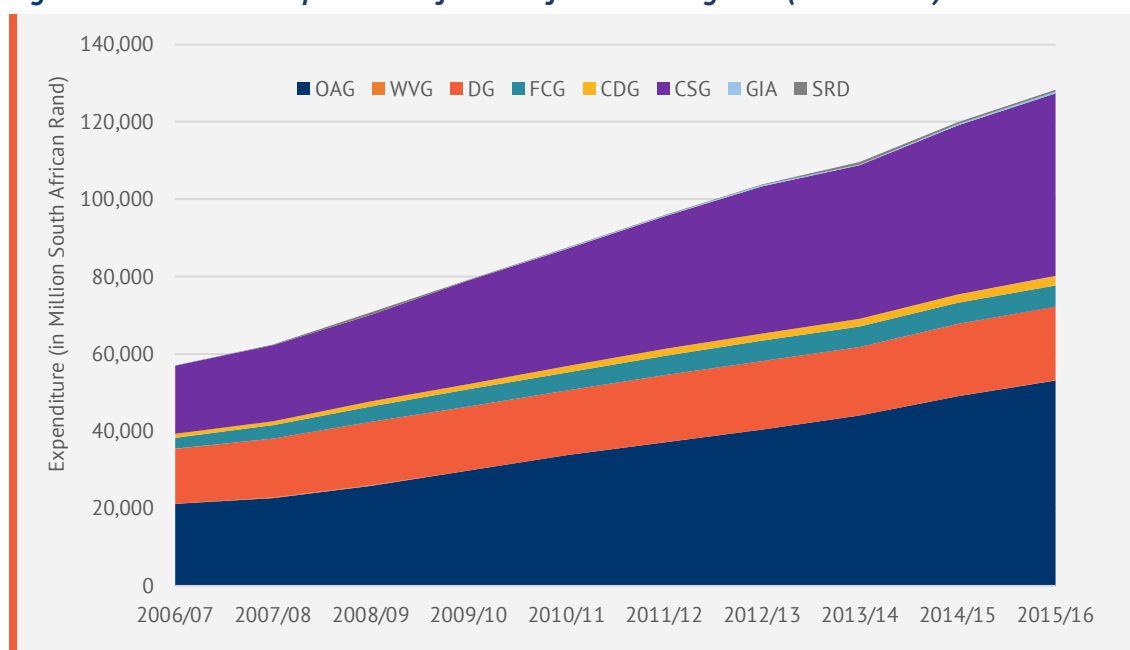
**Table 5-1: Summary of social assistance grants for disabled and older people<sup>54</sup>**

Grant	Age qualification	Marital status	Means test (annual income threshold)	Means test (annual asset threshold)
Old Age Grant (OAG)	60 years or older	Single	R 69,000	R 990,000
		Married	R 138,000	R 1,980,000
Disability Grant (DG)	18-59 years	Single	R 69,000	R 990,000
		Married	R 138,000	R 1,980,000
Care Dependency Grant (CDG)	Under 18 years	Single	R 180,000	n/a
		Married	R 360,000	n/a
Grant-in-aid (GiA)	Over 18 years	n/a	n/a	n/a

## 5.1. Expenditure on social grants

Expenditure on South Africa’s social grants has grown significantly over the past 10 years, as shown by Figure 5-4. In 2006, the overall expenditure was the equivalent of 3.1 per cent of GDP and, by 2015, it had risen to 3.2 per cent of GDP.

**Figure 5-3: Growth in expenditure of South Africa’s social grants (2006-2015)<sup>55</sup>**

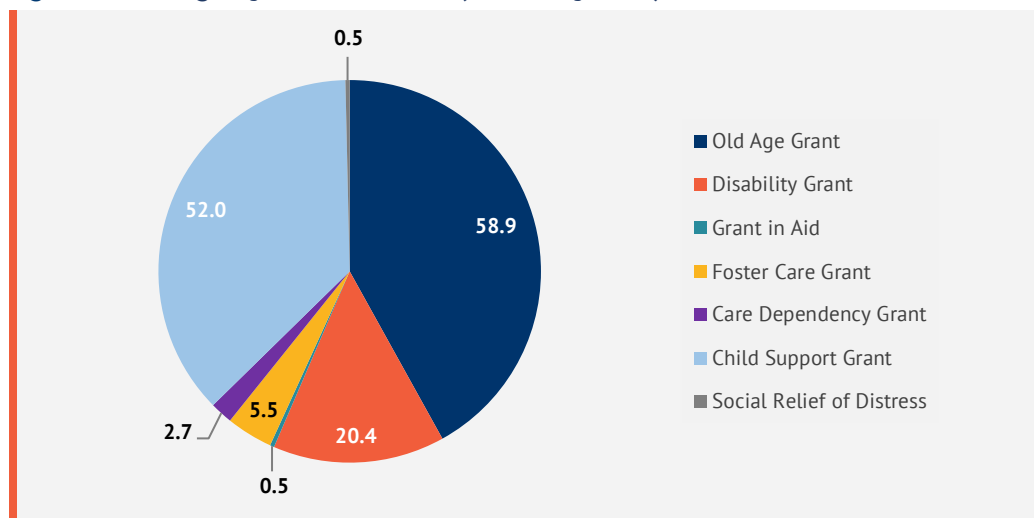


<sup>54</sup> Source: SASSA (2017)

<sup>55</sup> Source: SASSA (2016)

The 2016/17 budget for social grants was R.140.5 billion which is the equivalent of 3.3 per cent of expected 2016 GDP, which compares favourably with most other developing countries. By the mid-point of the financial year 2016/17, 49 per cent of the budget had been expended.<sup>56</sup> The highest budget was for the Old Age Grant, followed by the Child Support Grant. The other large area of expenditure was the adult Disability Grant.

**Figure 5-4: Budgets for Social Grants (billions of Rand)<sup>57</sup>**



Overall, the budget for the disability-specific grants was R.23.6 billion, or 0.55 per cent of GDP, while the Old Age Grant budget was around 1.38 per cent of GDP. However, the amount spent specifically on the Disability Grant has reduced from 25 per cent to 15 per cent of the total spend between 2006 and 2015, probably due to an increase in expenditure in the Child Support Grant and a reduction in the number of Disability Grant beneficiaries (see Figure 5-5).

<sup>56</sup> SASSA (2016)

<sup>57</sup> Source: SASSA (2016). The budget for the War Veterans' Grant is excluded, since it is so small (at R 0.0036 billion)

**Figure 5-5: Comparison spend on the disability grant between 2006 and 2016<sup>58</sup>**

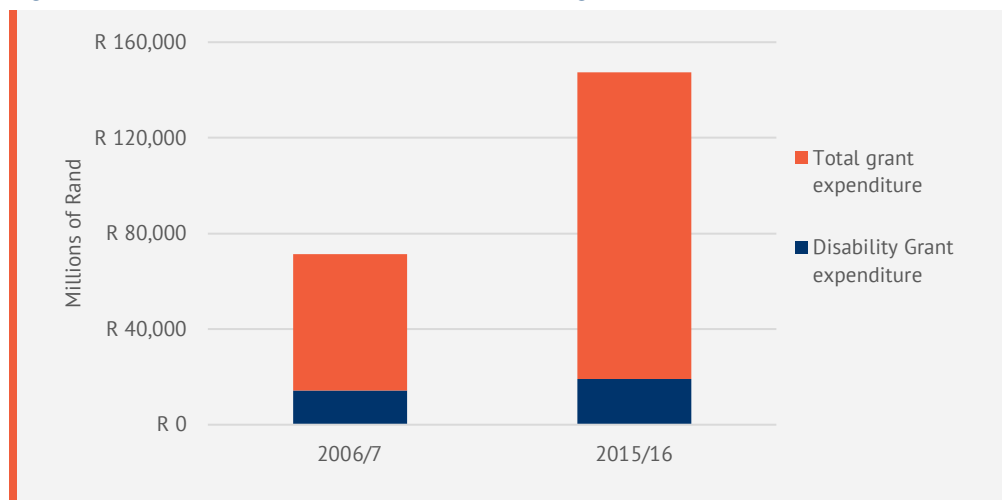
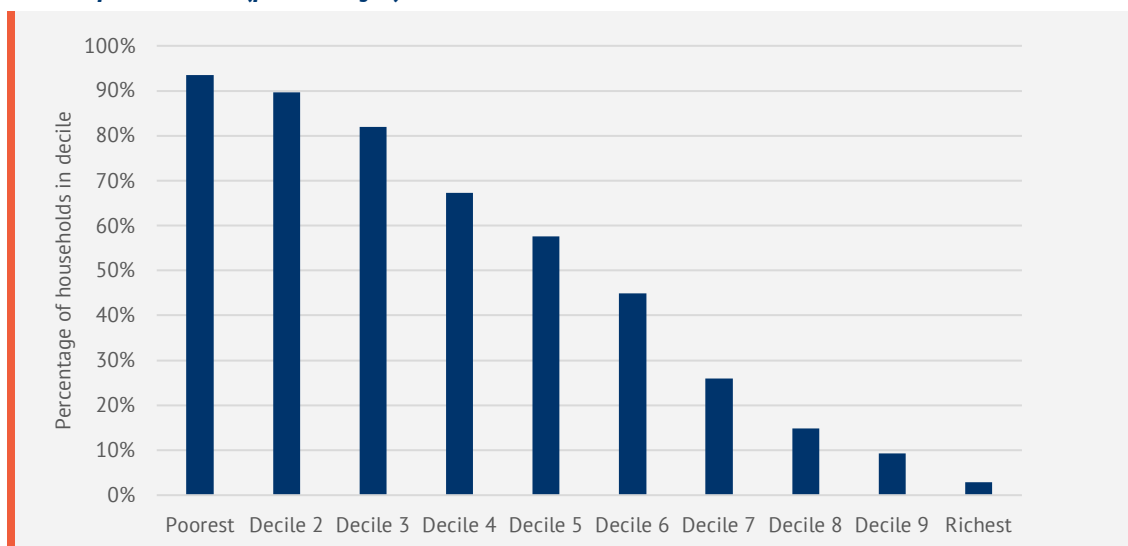


Figure 5-6 indicates the coverage of South Africa’s grants across consumption deciles and shows that, among those households living in the greatest poverty, coverage is very high. Over 90 per cent of those in the poorest decile are in receipt of at least one tax-financed social security benefit while coverage is still relatively high among those in the insecure middle. The means test appears very effective in excluding those in the wealthiest categories of the population: indeed, many of those receiving social grants in the upper three deciles may well be those that are eligible. For example, since the means test is based on individual or married couples’ income, it may indicate that some recipients with low incomes live in larger households that are wealthier; or, it may show maids with children living in wealthy households.

<sup>58</sup> Source: Source: SASSA (2016)

**Figure 5-6: Coverage of households in South Africa by tax-financed social security benefits, by consumption decile (pre-transfer)<sup>59</sup>**



## 5.2. Application process for the tax-financed social security transfers

The application processes for the Child Support Grant and Old Age Grant are relatively simple. Applicants need to attend local SASSA offices and provide the relevant documentation. For the Old Age Grant, for example, this includes documentation to prove age, residency, marital status, assets and income. An affidavit suffices to prove both assets and income. All applicants should have a 13-digit bar-coded Identity Card but people without an Identity Card can still apply (they will be asked to complete an affidavit in the presence of a Commissioner of Oaths, which can be done at SASSA offices, and bring along a sworn statement signed by a local official).<sup>60</sup>

On arrival, the applicant is registered (SASSA call this ‘Engagement’) and asked to wait for a SASSA officer to assist them.<sup>61</sup> Once available, a SASSA officer starts the application process (called ‘Screening’) by creating a new file on the Social Assistance MIS (SOCPEN) database and reviewing all the documentation brought by the applicant. The SASSA officer then assists the applicant to fill out an application form and carries out a short interview to ensure all the required information is gathered. At the end of the interview the applicant is provided with a receipt which acts as proof of registration. According to

<sup>59</sup> Source: Secondary analysis of Statistics South Africa’s General Household Survey (GHS) 2015 by Development Pathways.

<sup>60</sup> South African Government, Social Benefits, Old age pension – [www.gov.za](http://www.gov.za)

<sup>61</sup> Registration is important because SASSA monitor how long applicants take to get through the application process.



official guidelines, the application should be processed within three months but, according to SASSA (2016), 81.1 per cent of applications were approved or rejected within one day and only 1.5 per cent took more than 15 days. Regardless, if the applicant is successful, s/he will be paid from the date of the original application.

The process for the disability specific grants is longer and more difficult. At the initial screening, applicants are given a date for undergoing a disability assessment which is meant to happen within two weeks. The disability assessment is carried out by SASSA and, following the assessment, applicants should once more visit a SASSA office to be told the result of the assessment and be subjected to the means test.

### 5.3. Governance of the national social security system

South Africa's social assistance grants are delivered by the South African Social Security Agency (SASSA), a semi-autonomous state agency that reports into the Department for Social Development. Its mandate is 'to ensure the provision of comprehensive social security services against vulnerability and poverty within the constitutional and legislative framework.' SASSA's head office is in Pretoria, but its management is devolved to regional SASSA offices, which means that there is a degree of variability in how the social grants are delivered. SASSA has a wide range of offices across the country which are responsible for receiving applications and complaints as well as the local management of the grants.

The Ministry of Labour is responsible for the oversight and delivery of the social insurance benefits. When SASSA was established, it was intended that it would take over responsibility for all social security benefits in South Africa. However, the transfer of responsibilities for social insurance schemes from the Ministry of Labour has still not taken place.

## 6 The Legislative and Policy Framework on Disability

South Africa was an early adopter of the UN Convention on the Rights of Persons with Disabilities, which was ratified in 2007. This reflects a commitment to disability equality which is also evident in a relatively progressive Constitution.<sup>62</sup> In fact, South Africa played quite a significant role in campaigning for and eventually shaping the CRPD, guided at the time by a progressive White Paper on an Integrated National Disability Strategy (INDS), 1997, which promoted mainstreaming across government and was based on the UN's Standard Rules on the Equalisation of Opportunities for Persons with Disabilities.<sup>63</sup> The post-apartheid Government worked very much on the grounds of non-discrimination, democracy and equality for all and spent time consulting with the disability rights movement as the new Constitution was being put together.<sup>64</sup> Consequently the issue of disability runs throughout the Constitution and it protects against discrimination on the grounds of disability.<sup>65</sup>

The links between poverty and disability are also well recognised such that South Africa's current National Development Plan (2012) pays particular attention to the fact that disabled people are disadvantaged when it comes to accessing education, employment, healthcare and other basic services. Most recently, a new White Paper on the Rights of Persons with Disabilities has been produced (2015) which, although not substantively different to the INDS, nevertheless updates and reinforces its provisions so that it falls more in line with the CRPD and the National Development Plan.<sup>66</sup> An important and recurrent theme across all of these policies is a commitment to the social model of disability. In fact, the new White Paper states that disability:

*"..results from the interaction between persons with impairments and attitudinal and environmental barriers." (p. 18)*

However, it falls short of actually providing a definition of disability within the context of the White Paper, which may lead to problems in the implementation of its four Strategic Pillars.

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<sup>62</sup> Moodley et al (2014)

<sup>63</sup> Department of Women, Children and People with Disabilities, South Africa (2013).

<sup>64</sup> Department of Women, Children and People with Disabilities, South Africa (2013).

<sup>65</sup> Moodley et al (2014)

<sup>66</sup> Department of Social Development, South Africa (2015).

Despite the importance of social security transfers to citizens across South Africa, the White Paper says very little about them. Its only recommendation is:

*‘Social assistance must be aligned with the actual cost of disability, and must be structured in a way that encourages social assistance beneficiaries with disabilities to transition to sustainable livelihoods and decent work.’*

Indeed, by promoting a transition from social assistance grants to employment, the policy may well undermine persons with disabilities by encouraging their exit from social assistance, despite strong evidence from around the world that access to regular and predictable social transfers offers income security and facilitates greater labour market engagement.

Significantly, it remains the case that South Africa has no specific disability rights legislation in place. While the Constitution protects the rights of disabled people and mandates that national legislation should not unfairly discriminate against disabled people, gaps in disability rights legislation means that the implementation and monitoring of inclusive legislation is weak. As a consequence, the disability sector itself has produced a growing number of documents expressing the needs of disabled people and outlining some mechanisms needed for implementation.<sup>67</sup> The Human Rights Commission has argued strongly that a Disability Act is required.

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<sup>67</sup> Sibanda (n.d.)

## 7 Governance of Disability

Reflecting the importance of disability, soon after the fall of apartheid a Disability Programme was established in the Reconstruction and Development Program (1995) which then became the Office on the Status of Disabled Persons within the Presidency (1997), eventually evolving into the Department of Women, Children and People with Disabilities (2009).

More recently, however, disability was moved into the Department for Social Development and is now managed by the Rights of Persons with Disabilities team. Their mandate is to promote the mainstreaming of disability across government, in recognition of the intersectoral nature of disability. They carry out a range of different activities from advocacy to planning and monitoring.<sup>68</sup> According to a number of informants, the latest move appears to have weakened cross-departmental working on disability since the Department for Social Development has limited influence. Many people regard the move of responsibility for disability affairs from the Presidency to the Department of Social Development as a form of downgrading of the issue.

The Disability Rights Movement effectively began in South Africa in 1981, when the United Nations declared its first International Year of Disabled Persons. This gave impetus to individual groups to come together in order to coordinate national and local events. Over the next few years, increasing attention was paid to ensuring disabled people assumed the leadership. This culminated in 1984 with the establishment of Disabled People South Africa (DPSA) which continues to be a cross-impairment, multi-ethnic and non-political coalition of disability organisations and self-help groups. The disability movement has been successful in promoting a strong human-rights based approach which has helped improve attitudes and ensure self-representation, especially within government. In terms of current challenges, the disability movement in South Africa is faced with issues around how to sustain itself into the future as the initial wave of activists are replaced by younger people. As with many disability movements in Africa, engaging with young people (and women) has proven to be more difficult which, to some extent, has impacted on its initial momentum. There are also ongoing challenges with how to support government and service providers in implementing social model programmes and how to meet the specific needs of parents with disabled children, those with HIV/AIDs and those with mental health issues.<sup>69</sup>

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<sup>68</sup> Key informant interviews, Dpt of Social Development, Disability Team, 11<sup>th</sup> November 2016, Pretoria.

<sup>69</sup> Howell et al (2006.)

## 8 Evidence on Access

This section will examine the evidence on the access of persons with disabilities to different social grant schemes in South Africa. The following section will subsequently examine some of the reasons for persons with severe disabilities not accessing the schemes.

As noted earlier, access to social assistance schemes overall has increased considerably from 1999, when there were 2.5 million beneficiaries, to the current 16 million.<sup>70</sup> Much of this increase, however, has been the result of the expansion of the Child Support Grant, which now has just below 12 million beneficiaries, followed by the Old Age Grant with just over 3 million.

In contrast to the increase in beneficiaries across other programmes, as Table 8-1 indicates, recipients of the Disability Grant have declined by 31 per cent since 2006 as part of a plan to remove people from this scheme who were not regarded as eligible (see Section 10 for a further discussion).<sup>71</sup> However, both the Care Dependency and Grant-in-Aid schemes have seen increases, although beneficiary numbers remain low when compared to the likely need.

**Table 8-1: Number of grant beneficiaries between 2006 and 2015<sup>72</sup>**

	2006	2015	Difference
Disability Grant	1,422,808	1,085,541	-31%
Care Dependency Grant	98,631	131,040	25%
Grant in Aid	31,918	137,806	77%

### 8.1. Access to the overall tax-financed social security system

Overall, 65 per cent of persons with a severe functional limitation and 23 per cent of persons without a disability receive a social grant.<sup>73</sup> This is, in part, likely to be the result of having established disability specific schemes and an extensive old age pension. However, it is also due to a policy of equal access of persons with disabilities to mainstream grants, such as the Child Support Grant and the Foster Care Grant.

<sup>70</sup> SASSA (2016)

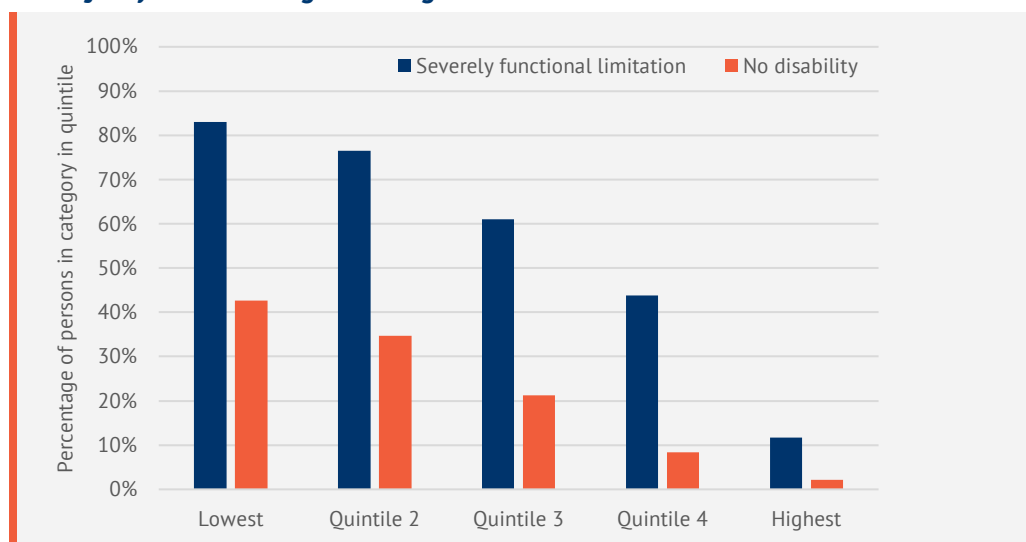
<sup>71</sup> Key informant interviews, Disability Management Unit, SASSA, Pretoria, 7<sup>th</sup> November 2016.

<sup>72</sup> Source: SASSA (2016)

<sup>73</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

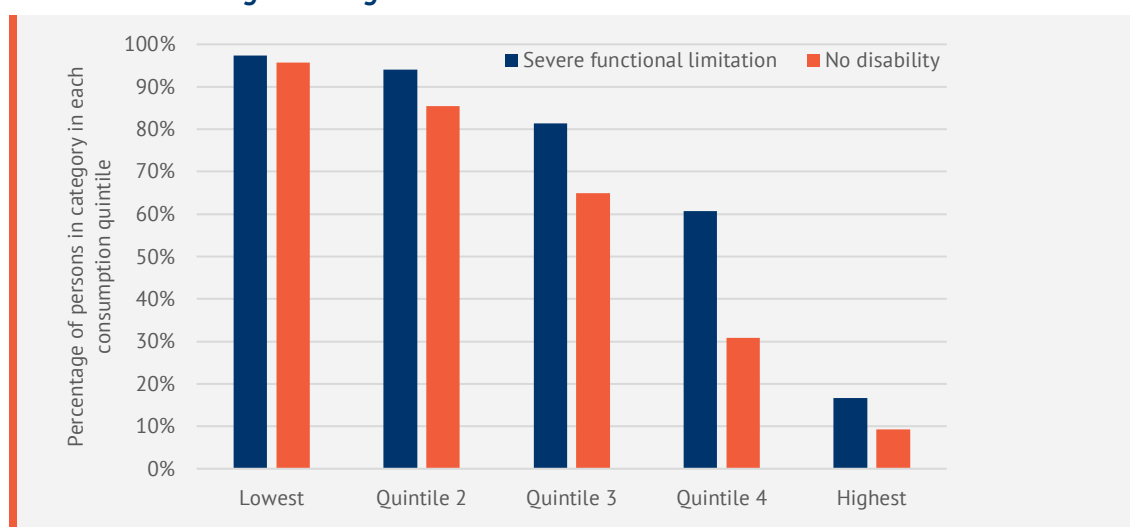
As Figure 8-1 indicates, those persons with a severe functional limitation in the poorest consumption quintiles of the population are more likely to receive a social grant than those in higher consumption quintiles.

**Figure 8-1: Percentage of persons with a severe functional limitation and no disability aged above five years receiving a social grant<sup>74</sup>**



Furthermore, around 80 per cent of persons with a severe disability live in a household receiving at least one social grant, compared to 60 per cent of those without a disability. Again – as Figure 8-2 indicates – wealthier households are less likely to receive a social grant.

**Figure 8-2: Percentage of persons with a severe functional limitation and no disability living in households receiving a social grant<sup>75</sup>**



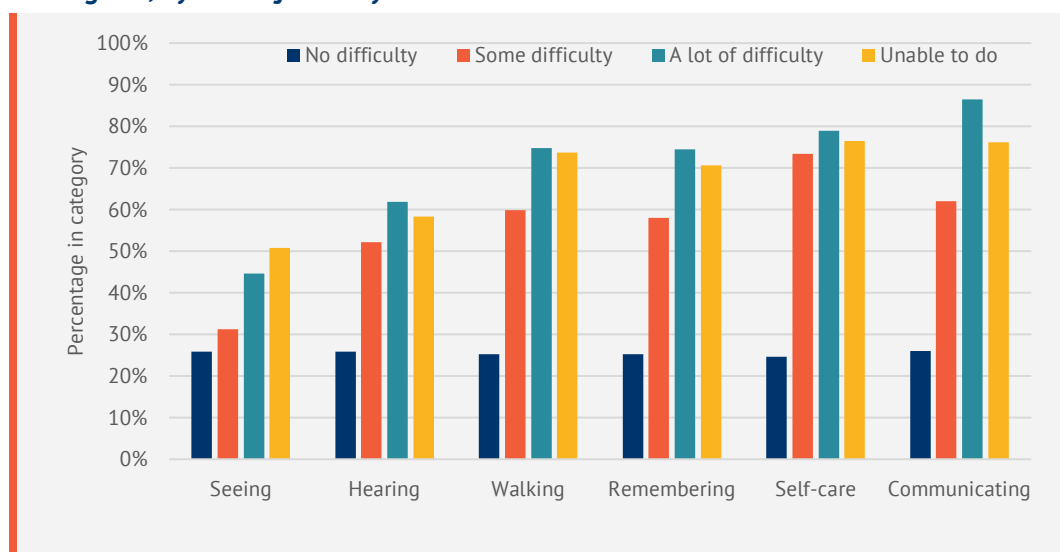
<sup>74</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

<sup>75</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

However, there are still around 35 per cent of persons with a severe functional limitation not in receipt of a social grant. Some may have been excluded by the means test but, as indicates, many of those excluded live in extreme poverty. In the third quintile of the population, exclusion of persons with a severe disability reaches around 40 per cent, yet very few in this group should have been excluded by the means test. The small number of persons with severe functional limitations in the richest quintile should not necessarily be regarded as exclusion errors: they could, for example, be people without any income – who, therefore, qualify through the means test – living in wealthier households.

There is also some indication that those with the most severe functional limitations, in specific functional domains, are less likely to live in households accessing social grants. As Figure 8-3 shows, persons assessed as ‘unable to do’ are less likely to access social grants than those with less severe functional limitations.

**Figure 8-3: Percentage of people within each domain of functioning that are in receipt of a social grant, by level of severity<sup>76</sup>**



## 8.2. Access to the Disability Grant

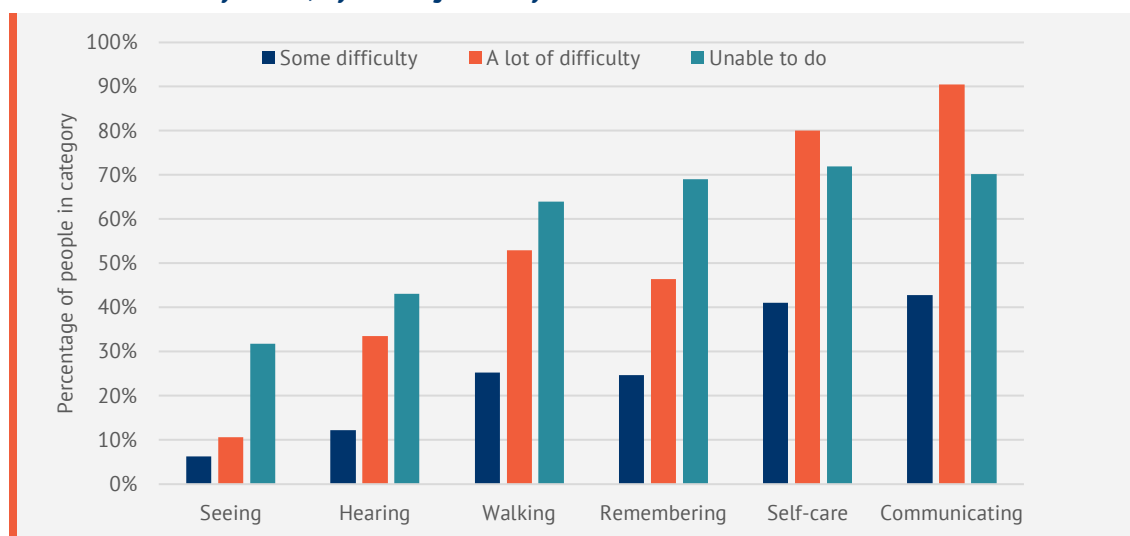
Only 36 per cent of persons with a severe functional limitation aged 18-59 years receive the Disability Grant, which suggests a significant level of exclusion. Women are more likely to be recipients: 41 per cent receive the grant compared to 31 per cent of men. Across ethnic groups there are surprising differences: while 37 per cent of Africans receive the grant, the proportion is higher among the Coloured population (42 per cent) and Indians (47 per cent), although among the White population the figure is 19 per cent.

<sup>76</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

Controlling for other factors, it appears that, when compared to the African population, Coloured people are 3.7 times more likely to receive the grant and Indians are 2.9 times more likely, while the White population is much less likely (only 0.3 times as likely).<sup>77</sup> Therefore, when Section 10 discusses the reasons for exclusion from the Disability Grant, it should be borne in mind that many of the factors identified are more likely to apply to the African population than other ethnic groups.

In terms of the disability profile, the General Household Survey 2015 indicates that access to the Disability Grant varies according to the type of disability. As Figure 8.4 shows, access is lowest among those with seeing and hearing challenges. Furthermore, the more severe the disability, the more likely that people are to receive the Disability Grant. Overall, 56.8 per cent of persons classified as ‘unable to do’ access the Disability Grant compared to 27.8 per cent of those with ‘a lot of difficulty’ in at least one domain, while 1.9 per cent of persons without a disability are recipients. However, coverage of the Disability Grant varies across functional domains: as Figure 8-4 indicates, among those with communication or self-care limitations, access falls among those classified as ‘unable to do’ when compared to those with ‘a lot of difficulty.’ This indicates greater access challenges for those with severe cognitive or mental disabilities. And, of course, the exclusion of 43.2 per cent of persons ‘unable to do’ across all functional domains is a significant proportion of the potentially eligible population.

**Figure 8-4: Percentage of people aged 18-59 years within each domain of functioning that receive a Disability Grant, by level of severity.<sup>78</sup>**



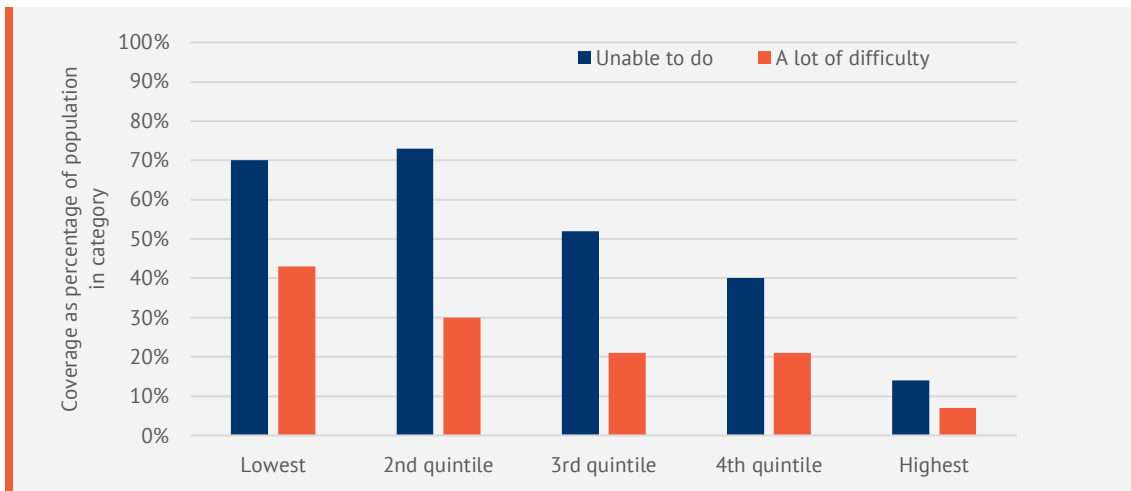
<sup>77</sup> In interpreting these figures, it is only the result for the Coloured population that is statistically significant, at the 5 per cent level. The other results can be regarded as indicative.

<sup>78</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.



As Figure 8-5 shows, the coverage of persons with disabilities by the Disability Grant is higher among those households with lower incomes. However, even so, the coverage among those in the poorest quintiles is only just over 70 per cent which indicates that, while the means test may exclude some people, it is not the only cause.

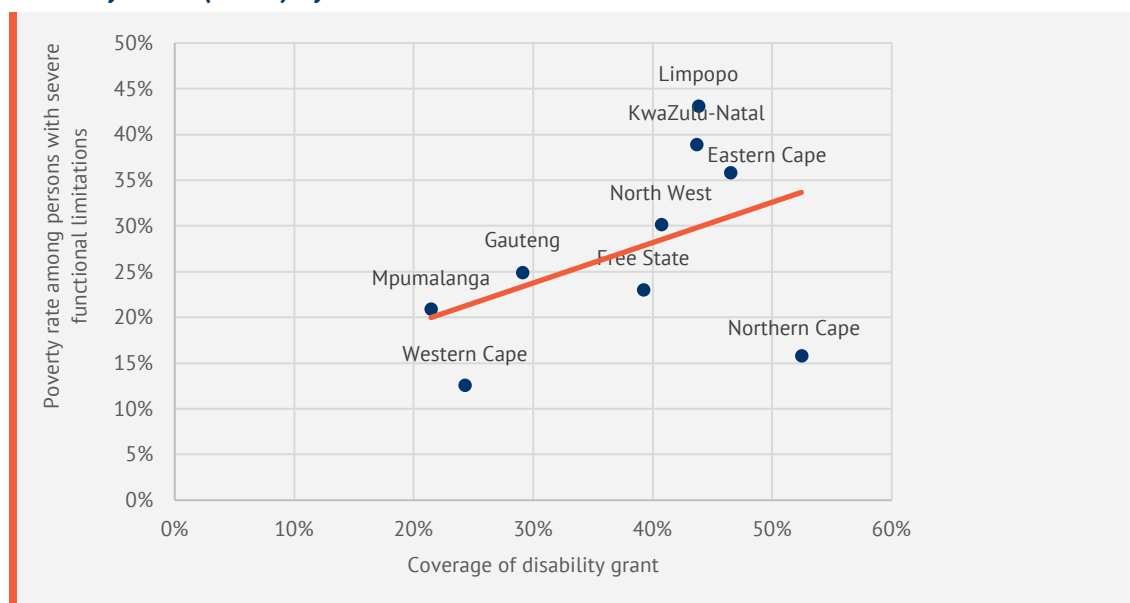
**Figure 8-5: Coverage of persons aged 18-59 years with severe disabilities across consumption quintiles by the Disability Grant, pre-transfer<sup>79</sup>**



The coverage of persons with severe functional limitations varies geographically across South Africa. Coverage is lowest in Western Cape – at around 24 per cent - but reaches 52 per cent in Northern Cape. Figure 8-6 indicates that some of the difference in coverage may be explained by the relative poverty among persons with disabilities across Provinces. However, it is only a partial explanation: for example, the highest coverage is in Northern Cape which also has one of the lowest poverty rates among persons with severe functional limitations. Therefore, other explanatory factors are at play.

<sup>79</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

**Figure 8-6: Correlation between poverty rates of persons with severe functional limitations (y axis) and proportion of persons aged 18-59 with severe functional limitations receiving the Disability Grant (x axis) by Province**

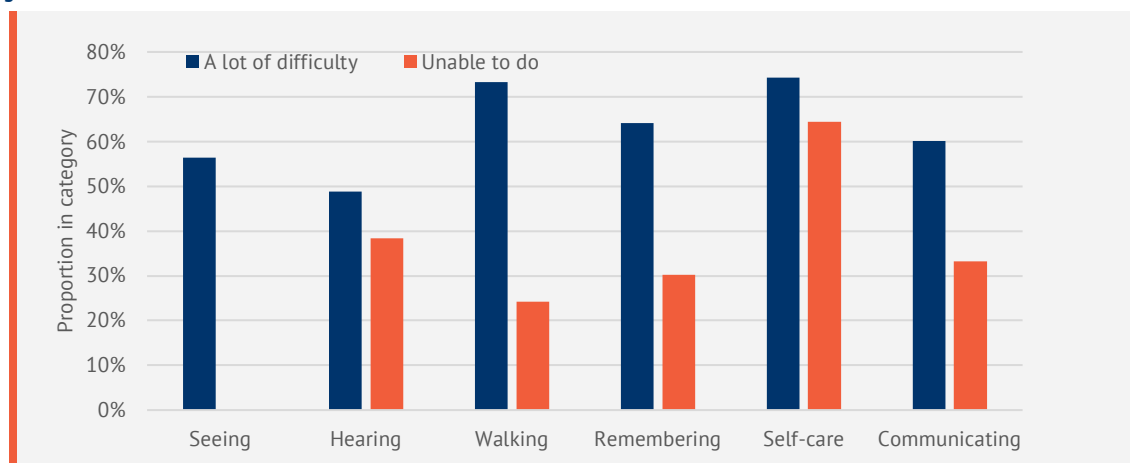


### 8.3. Coverage of the Care Dependency Grant

In the GHS 2015 dataset there are insufficient recipients of the Care Dependency Grant identified to know the proportion of children with severe functional limitations receiving the grant. Furthermore, there is no information in the GHS dataset on disability among children aged 0-5 years while, among those aged 5-11 years, the rates of functional limitations may well be over-estimated due to the way in which people answered questions on self-care. However, the number of recipients of the Care Dependency Grant – at around 131,000 – is low, a fact recognised by SASSA which is actively attempting to make people more aware of the grant through more effective communications.

Given that recipients of the Care Dependency Grant cannot receive a Child Support Grant, receipt of the Child Support Grant by children with no ability to undertake a particular function would indicate children who are likely to be eligible for the Care Dependency Grant, but do not receive it. As Figure 8-7 indicates, a high proportion of children with ‘unable to do’ or ‘a lot of difficulty’ were accessing the Child Support Grant in 2015 rather than the Care Dependency Grant. While the proportion accessing the Child Support Grant was lower among those assessed as ‘unable to do,’ the data does not indicate that they were receiving the Care Dependency Grant: indeed, many children classified as ‘unable to do’ were receiving neither the Care Dependency or Child Support Grants.

**Figure 8-7: Receipt of the Child Support Grant by children with no ability to undertake specific functions<sup>80</sup>**



Therefore, overall, there would appear to be a significant proportion of children with severe functional limitations not accessing the Care Dependency Grant. Whether or not they are eligible on the grounds of needing full-time care is another question, which is examined in Section 9.

#### 8.4. Coverage of the Grant-in-Aid

The Grant-in-Aid is the only benefit in South Africa that resembles a carer's benefit. Again, there is an insufficient sample in the GHS 2015 dataset to gain reliable information on its coverage. However, the number of recipients – 137,000 – appears very low given that it is on offer to all recipients of the Disability and Old Age Grants fulfilling the criteria.

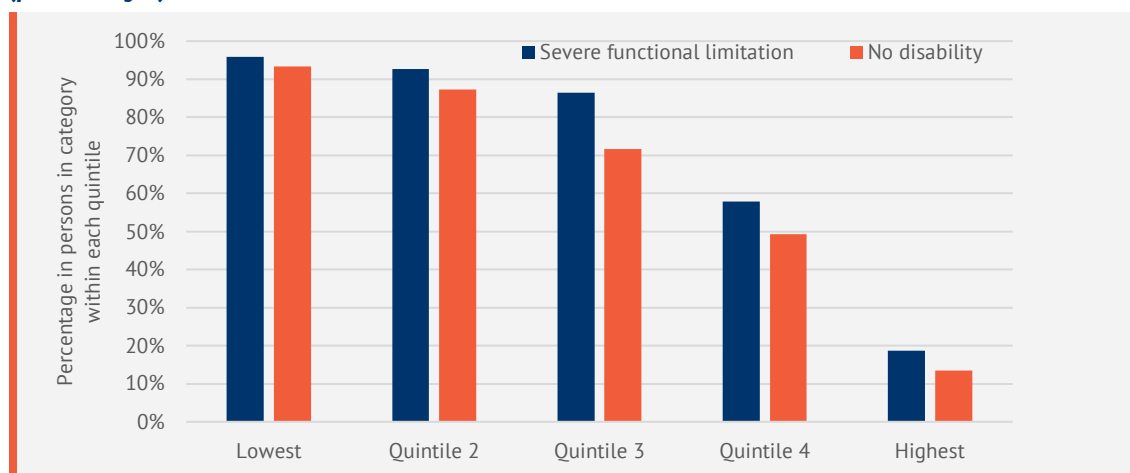
#### 8.5. Coverage of the Old Age Grant

Overall, around 67 per cent of persons aged over 60 years receive the Old Age Grant, while coverage of those with severe functional limitations is around 80 per cent, indicating that the Old Age Grant is particularly effective in including persons with disabilities (indeed, it is more effective than the Disability Grant). The difference in coverage may, in part, be the result of the means test since persons with severe disabilities are less likely to have independent sources of income. However, as Figure 8-8

<sup>80</sup> There was an insufficient sample to estimate coverage of the Child Support Grant by children with no ability to see. Also, caution needs to be exercised with the other results on “unable to do” since all, apart from self-care, had less than 50 children in receipt of the Child Support Grant.

indicates, while coverage among the poorest quintiles of the population is high, there is still some exclusion of eligible older people.

**Figure 8-8: Coverage of older persons with severe functional limitations by Old Age Grant (pre-transfer)<sup>81</sup>**

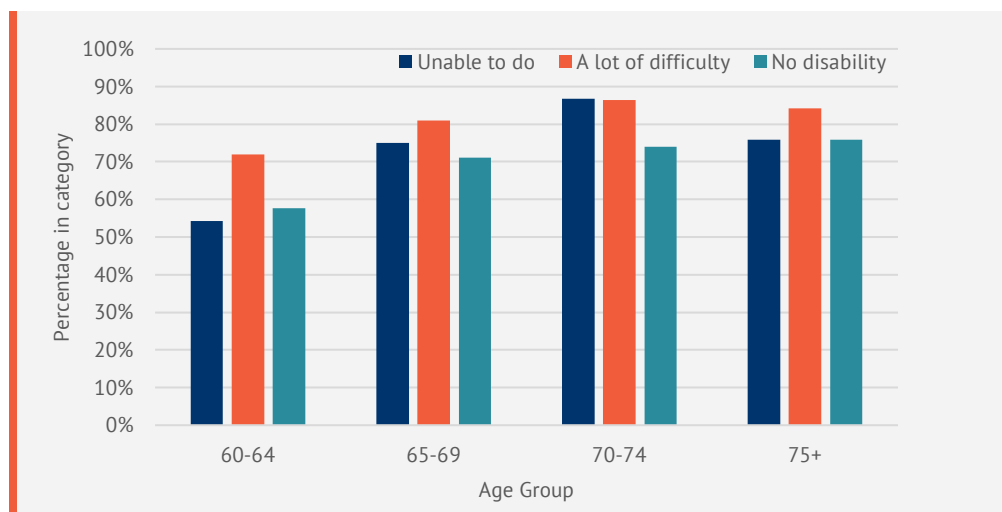


There is a strong gender difference with regard to access of the Old Age Grant among persons with severe disabilities. Only 72 per cent of men over 60 years with a severe functional limitation access the Old Age Grant compared to 84 per cent of older women. In part, this may be related to incomes and the means test, since the poverty rate of older men is lower than that of older women (42 per cent compared to 53 per cent).

As indicated by Figure 8-9, coverage of the Old Age Grant increases by age, including among those with severe functional limitations. However, it begins to fall among the oldest people with severe functional limitations (i.e. 'unable to do'), at a point where it would be expected to increase. This fall does not occur among those without a disability. The reasons for the greater challenges in access among those experiencing the most severe functional limitations are unclear, although they are likely to be directly linked to the nature of the limitation which means that those with severe mental and cognitive impairments may be less able to access the grant as they are less likely to be capable of helping themselves. It is also unclear at which stage in the process of application and remaining on the programme that people face the greatest challenges.

<sup>81</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

**Figure 8-9: Access to the Old Age Grant disaggregated by age group and severity of functional limitation<sup>82</sup>**

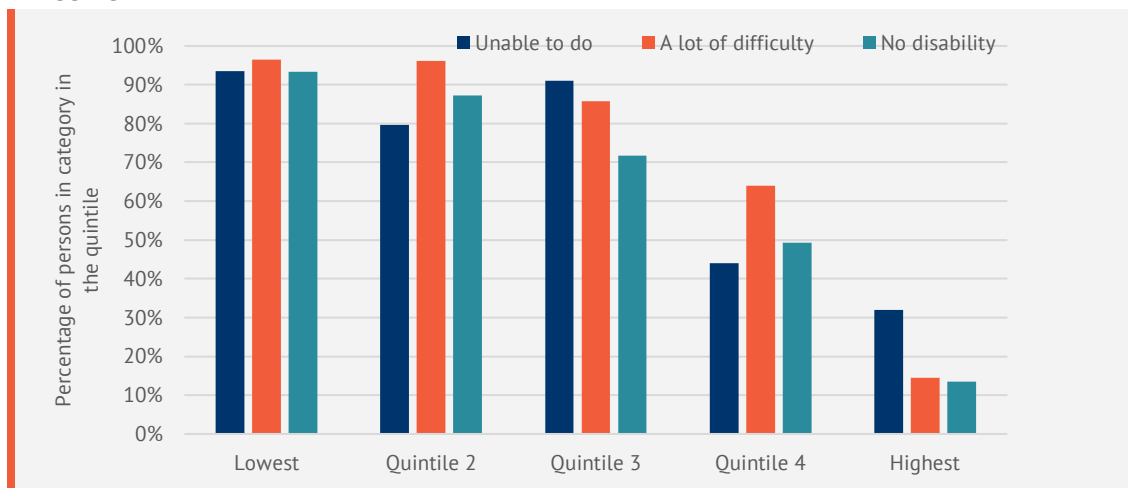


The lower access among older persons with severe functional limitations to the Old Age Grant may be linked to the level of severity. While 81.5 per cent of those classified as having a ‘lot of difficulty’ access the grant, the rate of access is only 72.8 per cent for those classified as ‘unable to do.’ As Figure 8-9 indicates, the biggest gap between those ‘unable to do’ and ‘a lot of difficulty’ is at the ages of 60-64 years, where it is 17.6 percentage points (and those ‘unable to do’ are, in fact, less likely to receive the grant than those with no disability). This may indicate challenges in applying for the grant once people with very severe functional limitations become eligible for the scheme at 60 years and may reflect their previous exclusion from the Disability Grant. The next largest gap is at age 75+ years, at 8.4 percentage points. This may reflect the need to report to SASSA every five years for a ‘proof of life’ check and suggests that some recipients drop out at this point, as they are unable to comply. People ‘unable to do’ in the remembering, communicating and self-care domains may be less capable of both applying for the grant and complying with the ‘proof of life’ regulation.

Figure 8-10 indicates that the main challenge to access for those ‘unable to do’ is among those living in the poorest 80 per cent of households, while those in the most affluent quintile are more likely to receive the grant if they are ‘unable to do’ compared to those with no disability or ‘a lot of difficulty.’ This suggests that those ‘unable to do’ in the highest quintile live in households that are more likely to support them in accessing and remaining on the grant. This, almost certainly, is the result of the greater capacity of their households, for example in terms of education and income.

<sup>82</sup> Source: Secondary analysis of Statistics South Africa’s General Household Survey (GHS) 2015 by Development Pathways.

**Figure 8-10: Proportion of persons receiving the Old Age Grant in each consumption quintile, disaggregated by severity of functional limitation<sup>83</sup>**

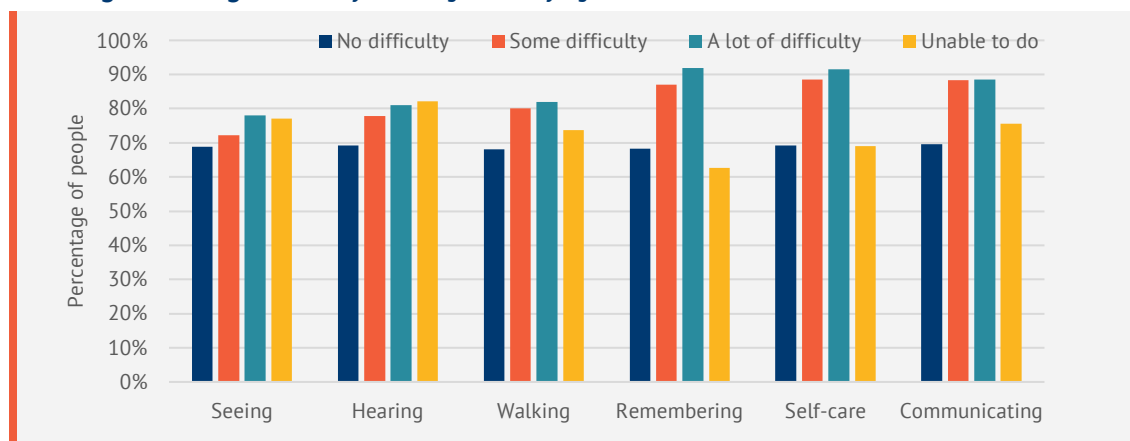


In addition, there are gender and ethnic dimensions linked to the challenge of access for those with the most severe functional limitations. While men are 7.3 percentage points less likely to receive the Old Age Grant if they are classified as ‘unable to do’ when compared to ‘a lot of difficulty,’ the gap is larger among women, at 9.4 percentage points. And, while among White people those ‘unable to do’ are 8.6 percentage points *more* likely to receive the Old Age Grant than those with ‘a lot of difficulty,’ among the African population they are 8.6 percentage points less likely.

As Figure 8-11 shows, the greater challenge in accessing the Old Age Grant is linked to certain types of functional limitation. Those expressing that they are ‘unable to do’ in communicating, self-care and remembering are less likely to be recipients than those expressing they have ‘a lot of difficulty,’ or ‘some difficulty’ in these domains.

<sup>83</sup> Source: Secondary analysis of Statistics South Africa’s General Household Survey (GHS) 2015 by Development Pathways.

**Figure 8-11: Percentage of people aged 60+ within each domain of functioning that are receiving an Old Age Grant by level of severity of limitation<sup>84</sup>**



SASSA – at least in Western Cape – is expected to visit people’s homes if they are over 75 years. However, this may not be enough to capture all those who may be at risk of defaulting due to cognitive and physical limitations.<sup>85</sup> Given that the SASSA database SOCPEN does not capture data on people’s functional limitations or levels of difficulties and staff generally have not had disability awareness training, it may be hard for staff to track whether or not individuals need specific assistance to comply with grant regulations.<sup>86</sup>

There are significant differences in access to the Old Age Grant linked to ethnic background. As indicated by Figure 8-12, coverage is highest among African older people with severe functional limitations and a little lower among the Coloured and Indian populations. It is significantly lower among the White population. These differences are probably largely the result of the means test. However, when correcting for other factors – such as income – Coloured people with severe disabilities are 1.78 times more likely to receive the Old Age Grant compared to Africans, Indians are 0.89 times as likely to receive the grant, while the White population with severe functional limitations is particularly under-represented, as they are 0.1 times as likely to receive the Old Age Grant.<sup>87</sup>

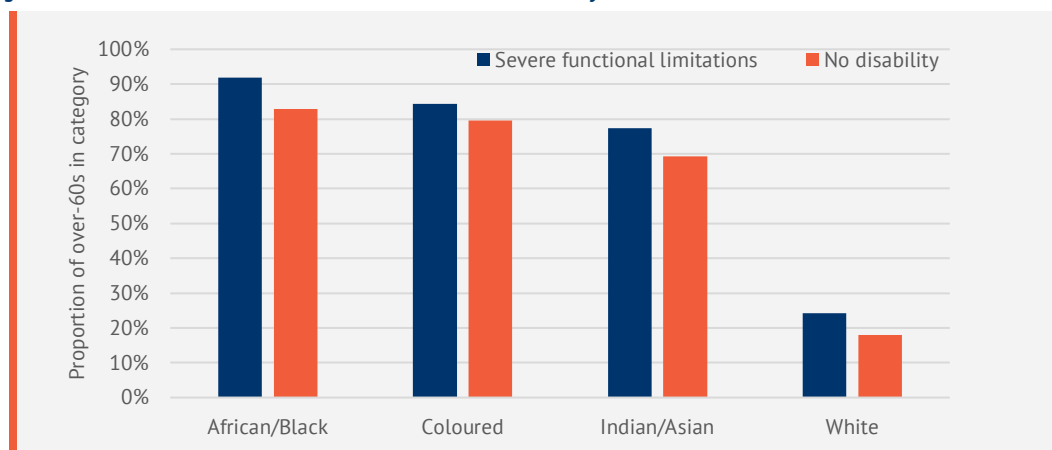
<sup>84</sup> Source: Secondary analysis of Statistics South Africa’s General Household Survey (GHS) 2015 by Development Pathways.

<sup>85</sup> Key informant interviews, SASSA Disability Management Staff, Western Cape, Cape Town, 14<sup>th</sup> – 16<sup>th</sup> November 2016.

<sup>86</sup> SASSA office observations: Khayekitsha Local Office, 14<sup>th</sup> November 2016; Paarl Local Office, 15<sup>th</sup> November 2016; Athalone Local Office, 16<sup>th</sup> November 2016.

<sup>87</sup> These results should be treated with caution, since only the result for the White Population is statistically significant, although this is at the 1 per cent level.

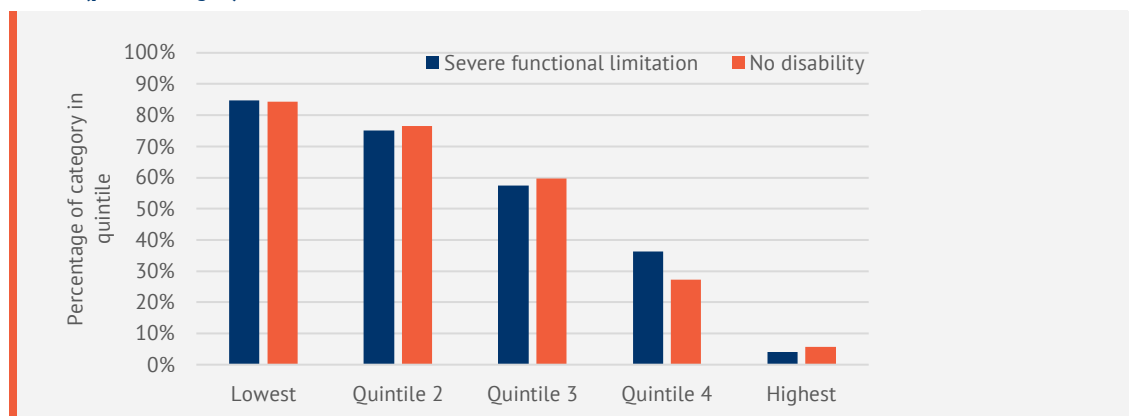
**Figure 8-12: Coverage of the Old Age Grant, by ethnic group, comparing those with severe functional limitations and those with no disability<sup>88</sup>**



## 8.6. Access to the Child Support Grant

Around 67 per cent of children aged 5-17 years with a severe functional limitation access the Child Support Grant compared to 63 per cent with no disability. However, among those aged 12-17 years the proportion falls: only 32 per cent of children with a severe functional limitation receive the Child Support Grant while receipt was 58 per cent among those without a disability. As noted earlier, according to the GHS 2015, this is unlikely to be caused by access to the Care Dependency Grant since very few of those aged 12-17 years not receiving the Child Support Grant are in receipt of the Care Dependency Grant. Instead, it is likely to indicate that older children with severe functional limitations face greater challenges in accessing the Child Support Grant.

**Figure 8-13: Coverage of children with severe functional limitations by the Child Support Grant (pre-transfer)<sup>89</sup>**



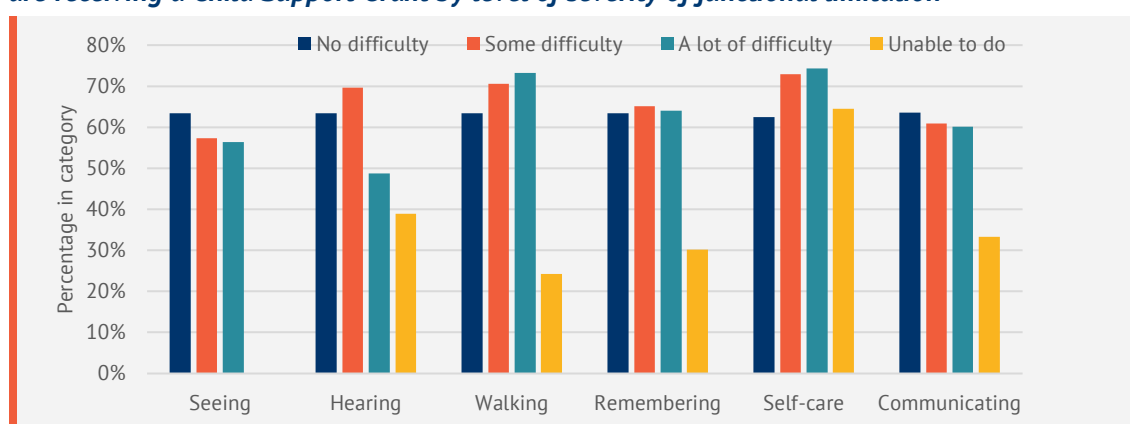
<sup>88</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

<sup>89</sup> Caution needs to be taken with the result in quintile 5 of children with severe disabilities as there were less than 50 cases of recipient children with a severe disability in the quintile



As Figure 8-14 indicates, there is some indication that children with more severe disabilities find it more challenging to access the Child Support Grant. While the numbers are small for those 'unable to do' there is a clear pattern of lower coverage by the Child Support Grant. According to the GHS 2015 data, this does not appear to be the result of these children receiving the Care Dependency Grant and indicates that the children with the most severe disabilities may be receiving no support at all.

**Figure 8-14: Percentage of children aged 5-17 years within each domain of functioning that are receiving a Child Support Grant by level of severity of functional limitation<sup>90</sup>**



Research has been undertaken by SASSA – in collaboration with UNICEF – on the access of carers with functional limitations to the Child Support Grant.<sup>91</sup> As Figure 8-15 shows, it indicates that, while carers with functional limitations have slightly higher exclusion from the Child Support Grant, rates are higher for those with difficulty walking and, in particular, for those unable to walk. However, this mainly affects those with children aged 0-1 years, indicating that many of these children eventually access the grant. The other age group with caregivers with severe functional limitations experiencing higher rates of exclusion is 12-17 years. There are also significant gender differences: the exclusion of mothers with a severe functional limitation is 34 per cent while, for those without, it is 22.8 per cent; however, among fathers, exclusion rates for those with a severe functional limitation and no disability are the same, although it is higher among fathers with some functional limitation.<sup>92</sup>

<sup>90</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways. Caution needs to be taken with these results since, apart from the functional domain 'self-care,' there are less than 50 observations for the category 'unable to do.' And, for the functional domain 'seeing' there were not sufficient observations in the category 'unable to do' to register.

<sup>91</sup> UNICEF and SASSA (2013). DSD, SASSA and UNICEF (2016).

<sup>92</sup> DSD, SASSA and UNICEF (2016)

**Figure 8-15: Rates of exclusion from South Africa's Child Support Grant for carers with functional limitations<sup>93</sup>**

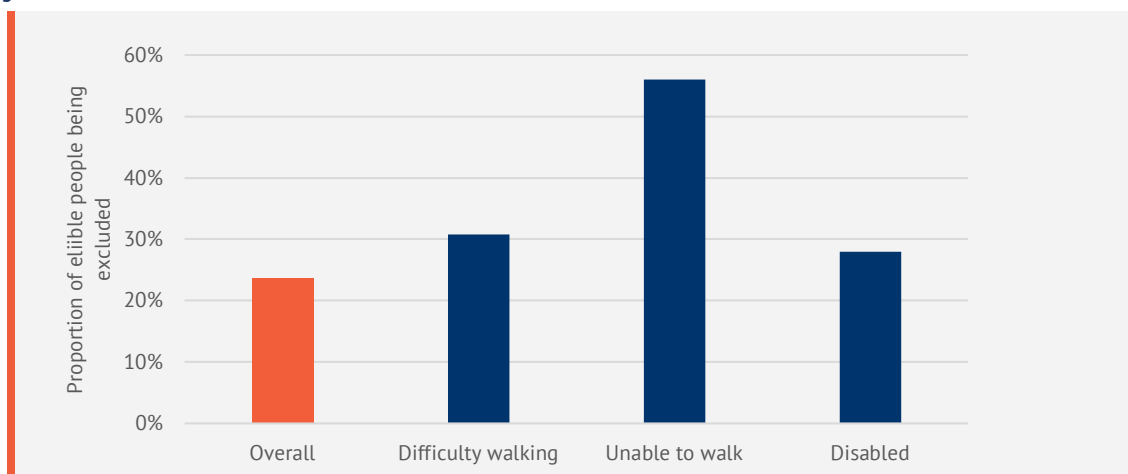
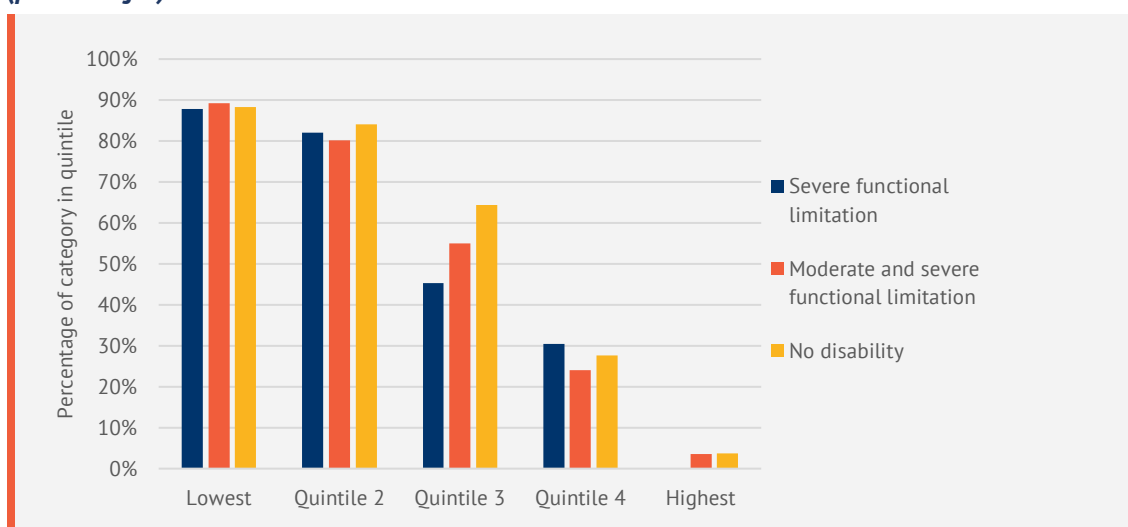


Figure 8-16 indicates that, specifically among parents of children with severe functional limitations, access to the Child Support Grant is slightly lower across all consumption quintiles when compared to parents with no disability. However, mothers with severe functional limitations have higher access to the Child Support Grant than fathers with severe functional limitations (68 per cent compared to 50 per cent). Potentially, this may be partly explained by higher incomes among children with fathers in the household when compared to those with mothers, which would lead to exclusion as a result of the means test.

**Figure 8-16: Coverage of parents with severe functional limitations by the Child Support Grant (pre-transfer)<sup>94</sup>**

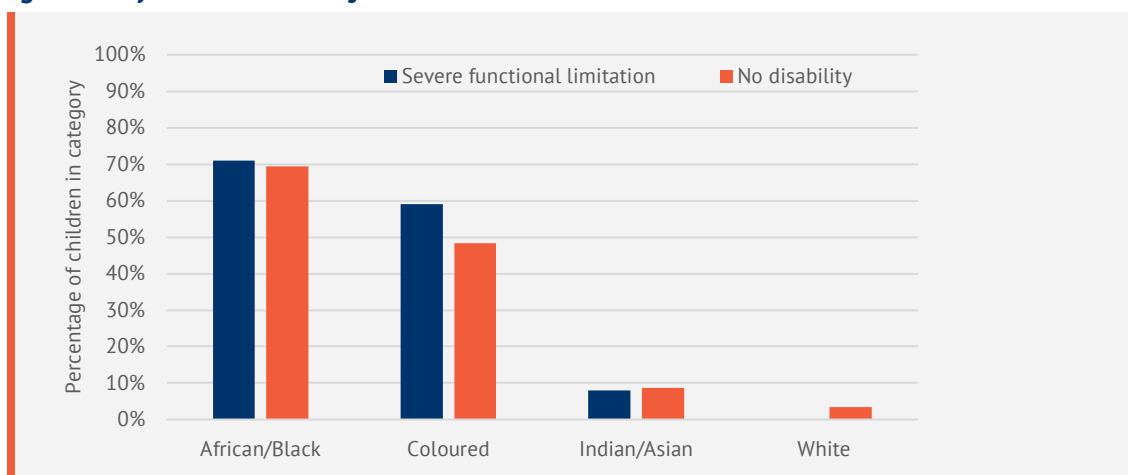


<sup>93</sup> Source: UNICEF and SASSA (2013).

<sup>94</sup> Caution needs to be taken with the results for Quintiles 3 to 5 of the "severely disabled" category since there were less than 50 parents with severe functional limitations in each quintile who were in receipt of the grant.

There is a significant difference in coverage rates for the Child Support Grant across ethnic groups (see Figure 8-17). Indeed, among White children with severe functional limitations, not one in the GHS 2015 sample was accessing the Child Support Grant. Coverage is also particularly low across the Indian population. The samples are, however, too small to determine the extent to which this is related to the means test.<sup>95</sup>

**Figure 8-17: Coverage of the Child Support Grant across ethnic groups, comparing children aged 5-17 years with severe functional limitations and no disabilities<sup>96</sup>**



<sup>95</sup> Odds ratios were not calculated for the Child Support Grant.

<sup>96</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

## 9 Disability Assessment Mechanisms

Before discussing the causes of exclusion of persons with disabilities from the social grants, this section will describe the disability assessment mechanism used for accessing the disability-focused grants (although, as Box 9-1 indicates, there are other disability assessment mechanisms in South Africa). A challenge for disability assessment in South Africa, however, is that disability has still not been defined by the Government, even within the context of the social assistance grants system. This creates challenges for the disability assessment mechanism.

### **Box 9-1: Disability assessment mechanisms within South Africa**

In reality, South Africa has a number of disability assessment mechanisms since disability assessments are undertaken for specific social programmes, since they all have different eligibility criteria. There is no generic disability assessment and no requirement for disabled people to undergo assessments unless they wish to apply for specific benefits. So, while SASSA is responsible for disability assessments for social assistance schemes, it plays no role in disability assessments for benefits linked to the Mining Sector, Employment Injury benefits, etc. Indeed, if applicants for disability grants come to SASSA with assessments from other sectors, they still have to be re-assessed by SASSA. This section will focus on the disability assessment mechanism implemented by SASSA.

### 9.1. History of the disability classification for social assistance schemes

Prior to 2001, South Africa implemented a purely medical disability assessment mechanism. The Department of Welfare – the predecessor to the Department of Social Development – undertook assessments through local medical officers, which were verified by Pension Medical Officers (PMOs). The PMOs relied on the medical reports for their decisions and did not meet the applicants in person. Eligibility for the Disability Grant depended on someone being assessed as having a disability greater than 50 per cent, but no impairment tables were provided to Medical Officers who had to use their own judgement (although there were impairment tables used for workers' compensation). Furthermore, assessments of fitness for work did not take into account whether citizens were able to undertake the work for which they were trained nor the variability in external economic factors.<sup>97</sup>

At the time, there was concern that only around 30 per cent of disabled people were receiving the Disability Grant when, given the high levels of poverty, a much greater uptake would have been expected. A raft of litigation had exposed weaknesses in the disability grants system, including: long waiting lists for applications; poor access to

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<sup>97</sup> Kelly (2016).

welfare offices by disabled people; suspension of Temporary Disability Grants without due warning; and an appeal system that was poorly communicated. Research also found a number of barriers for both the Disability Grant and Care Dependency Grant, including a “frustrating and complex” application process which “frequently depended on being lucky enough to find a sympathetic official”.<sup>98</sup> The courts also declared it illegal for PMOs to make decisions on disability assessments without a physical examination.

In 2001, after much consultation, the Department of Welfare decided that the disability assessment mechanism would become more needs based and involve a wider selection of people in the decision-making process.<sup>99</sup> Provinces were given the choice of either retaining a purely medical based assessment process or introducing a new panel-based mechanism. Panels removed the need for reliance on only medical personnel and incorporated representation from communities.<sup>100</sup> The intention was to move from a purely medical approach to assessment to one incorporating considerations of how the context was affecting people’s opportunities and functioning.

Four provinces adopted this new method, one kept both options but varied implementation depending on the district, while four retained the old process but without the PMOs. A key motivating factor in deciding which process to adopt was the desire to increase access in rural areas where there were few trained medical professionals or suitable health clinics.<sup>101</sup>

The new panels were set up to include community representatives and other professionals such as occupational health specialists and physiotherapists. In Western Cape – where the new system was adopted – an applicant would first obtain a medical certificate and then make an application to the panel for assessment.<sup>102</sup> Problems started to emerge with this system for a number of different reasons. Applicants complained of a lack of confidentiality and, in particular, were concerned about having to reveal personal medical information to people in the community with whom they could be familiar. Some panels were criticised for having no medical-based professionals represented at all, for being inefficiently run (for example running late), for not respecting the dignity of applicants, and for lacking transparency over their decision-making process. In addition, panels were criticised for being physically inaccessible.<sup>103</sup>

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<sup>98</sup> Kelly (2013)

<sup>99</sup> MacGregor (2006)

<sup>100</sup> Mitra (2010)

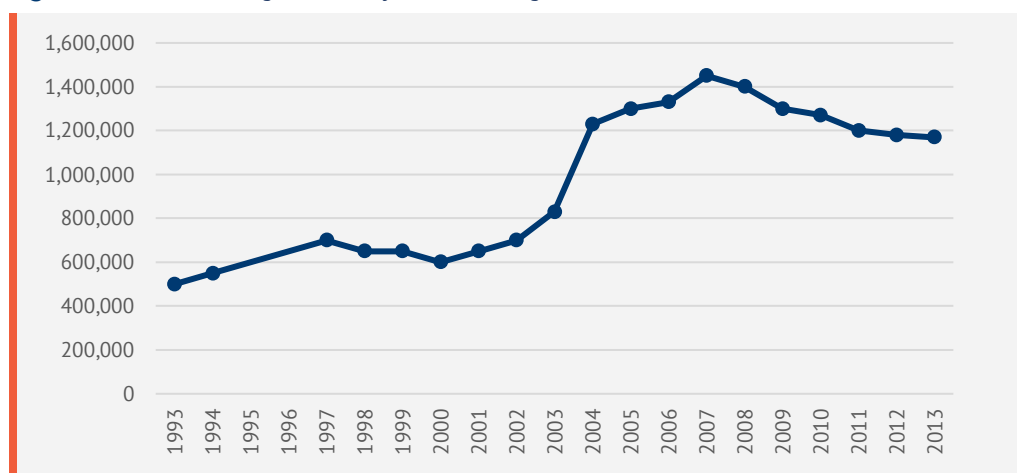
<sup>101</sup> MacGregor (2006)

<sup>102</sup> Goldblatt (2009)

<sup>103</sup> Goldblatt (2009).

Perhaps not surprisingly, in a context of high unemployment, low incomes, significant levels of chronic ill health (especially HIV and TB) and no alternative forms of social assistance for those of working age, uptake of the Disability Grant rose significantly. As Figure 9-1 indicates, between 2001 and 2007 the numbers of Disability Grant beneficiaries more than doubled, following the introduction of the panel-based framework. Furthermore, the proportion of rejected applications fell from 8 per cent in 1997 to less than 1 per cent in 2005.<sup>104</sup>

**Figure 9-1: Number of Disability Grant beneficiaries over time<sup>105</sup>**



Studies at the time highlighted that economic and social considerations became key factors in the decisions made by panels rather than capacity to work, with poverty becoming a more important factor than disability. Panels were also often more likely to be sympathetic to giving grants to those from their own communities. In addition, with the rise in cases of HIV, many more people with chronic health conditions were applying and being recommended by Medical Officers on the basis that they would be more likely to be compliant with treatment if they could afford the associated transport, medication and nutrition costs. This belief became so strong that people began to assume that being HIV positive would automatically qualify a person for the Disability Grant (a legacy that medical officers are still dealing with today).<sup>106</sup>

By 2004 the government – and, in particular the Ministry of Finance – had become sufficiently concerned by the rising numbers of Disability Grant applicants that a new Social Assistance Act was devised (which also saw the establishment of SASSA as the administrative agency). The contentious Assessment Panels were removed and, by 2008 – when SASSA came into being – disability could, once again, only be officially determined by a medical assessment undertaken by medical officers.

<sup>104</sup> Steele (2006).

<sup>105</sup> Source: Kelly (2013).

<sup>106</sup> SASSA office clinic observations: Khayekitsha Local Office, 14<sup>th</sup> November 2016; Paarl Local Office, 15<sup>th</sup> November 2016; Athalone Local Office, 16<sup>th</sup> November 2016.

However, the government – in around 2006/07 – tried to develop a more sophisticated disability assessment model, known as the Harmonised Assessment Tool. It was based on the Taylor Commission's (2002) recommendations which stated that the assessment process should:

- Encompass a needs-assessment to consider not only the type and severity of disability or illness, but other social, economic, physical and environmental factors.
- Focus on the applicant's capabilities, rather than only the degree of disability, as well as their potential for re-training and re-employment.
- Include all categories of disability – i.e. physical, mental, sensory and intellectual – since, at the time, it only included physical and mental.

The Commission recommended using the International Classification of Functioning, Disability and Health which was under development at the time. The Harmonised Assessment Tool had two components: a medical assessment and an activity limitation assessment. The move to assessing activity limitations over medical diagnoses was expected to shift the responsibility for assessment from doctors to other healthcare professionals better trained in assessing functionality than doctors (Kelly 2016). However, it was also expected to move many people with chronic illness off the Disability Grant, which caused concerns. The DSD attempted to gain support for a grant for people with chronic illness, but the initiative was rejected. The Harmonised Assessment Tool was never adopted since it was regarded as too complex and expensive to implement, while there was no evidence that the Department of Health had the capacity to implement it.

### 9.2. The current disability assessment model

SASSA currently implements a Disability Management Model, which was introduced in 2007 as a means of standardising the medical assessment process for the Disability Grant, Care Dependency Grant and Grant-in-Aid.

The medical assessment is undertaken once a person has applied for the Disability Grant, the Care Dependency Grant and the Grant-in-Aid. Those wishing to apply for these grants must bring a referral letter from a medical professional, as part of the pre-screening process (although this requirement does not seem to apply in all SASSA offices). The letter should outline their medical history and the impairment for which they are seeking assessment. According to the medical guidelines, in the case of a temporary disability the report must have been made within the past three months while, for a permanent

disability, the medical report can be more than three months old.<sup>107</sup> SASSA have a template referral letter format – which was in evidence in Western Cape<sup>108</sup> – but medical facilities may not have copies. In such cases, the applicant should first collect the form from a SASSA office before meeting their treating physician. At the time of initial registration, the applicant is also informed of all the additional documentation that will be required to process the application (including identity card, residency, marital status, asset threshold and income).

On application, the SASSA officer checks the social assistance MIS – SOCPEN – to make sure there have been no previous application attempts within the past six months. Once it is ascertained that this is the case, a booking is made for the applicant with a SASSA approved medical officer for the purpose of carrying out a medical assessment. The appointment should be made within one month of the application and SASSA believe that most are undertaken within 2 weeks although the researchers found evidence of assessments taking place up to 3 months after the application, due to the lack of resources. Furthermore, the assessment point should, ideally, be within 5 kilometres of the applicant's residence. No transport costs are covered by SASSA for attending these assessments.<sup>109</sup>

All applicants have to be assessed by a government appointed medical officer. Ideally, the Department of Health (DoH) should be responsible for undertaking the medical assessments with its current medical staff. However, the DoH faces significant human resource challenges and, in many places, there are insufficient staff to carry out the assessments. Furthermore, Medical Officers working for the Department of Health are more interested in using their limited time available to help patients rather than assessing them for grants. Therefore, SASSA has taken on the responsibility of resourcing the assessment process, paying R.135 for each assessment as well as the Medical Officers' travel costs (also, occasionally, accommodation costs are paid if Medical Officers need to travel away from the health facility to conduct assessments). Guidelines also state that assessments should not take more than 15 minutes which means that there is no time for diagnostic testing and only minimal time for physical examinations.<sup>110</sup>

The SASSA Provincial Offices have a number of ways of resourcing the assessments. In the Gauteng Province, for example, SASSA directly contracts Medical Officers to work

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<sup>107</sup> Guidelines for the Medical Assessment of Disability for Social Assistance Purposes, n.d. p.3.

<sup>108</sup> Key informant interview, Medical Officer, clinic connected to Athlone Local Office, 16<sup>th</sup> November 2016.

<sup>109</sup> Key informant interviews, Disability Management Unit, SASSA, Pretoria, 7<sup>th</sup> November 2016.

<sup>110</sup> Key informant interviews: medical officer, clinic linked to Khayelitsha Local Office, 14<sup>th</sup> November 2016; medical officer, clinic linked to Paarl local office, Western Cape, 15<sup>th</sup> November 2016; medical officer, clinic connected to Athlone Local Office, 16<sup>th</sup> November 2016.



specifically on disability assessments, which usually take place in a SASSA office. Medical Officers are paid by SASSA for each assessment, at the agreed rate of R.135. Previously, this process resulted in Medical Officers undertaking far too many assessments each day so SASSA has set out guidance that they can carry out no more than 40 assessments per day and a maximum of 20 clients per hour.<sup>111</sup> Since the assessments are undertaken in SASSA offices, the Medical Officers do not have access to the medical records of patients, since these should not leave clinics.

In contrast to Gauteng, in Western Cape SASSA works mainly via Service Level Agreements (SLAs) with local medical facilities (from primary to tertiary level healthcare). In the SLA, medical facilities agree to provide medical officers (which may be locum staff), an assessment space and any associated assessment resources. SASSA books appointments at agreed times at medical facilities and, in most cases, applicants are assessed at their local medical facility. The day before the assessment, Facility Managers collect the medical record files for each patient to have them ready for the assessment. SASSA pays the DoH for the assessments and the DoH is responsible for paying the Medical Officers, which appears to be based on specific sessions rather than on a per client basis.<sup>112</sup>

As indicated earlier, the criteria used in the assessments vary between grants:<sup>113</sup>

- The **Care Dependency Grant** is for those requiring and receiving permanent care and support services.
- The **Disability Grant** is for those unable to enter the open labour market or to support themselves due to their skills and ability to work. According to SASSA, the decision should be taken in the context of the prevailing labour market.<sup>114</sup>
- The **Grant-in-Aid** is for those requiring regular attendance by another person.

However, as noted earlier, the Social Assistance Act does not actually define disability, although it requires that the disability is confirmed by a medical report. As a result, the focus of the current assessment process has tended towards simply defining the medical condition of the applicant.

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<sup>111</sup> Key informant interviews, Disability Management Unit, SASSA, Pretoria, 7<sup>th</sup> November 2016.

<sup>112</sup> Key informant interview, Grants Administration Dpt, Disability Management, SASSA Western Cape, Cape Town, 14<sup>th</sup> November 2016; Khayekitsha Local Office, 14<sup>th</sup> November 2016; Paarl Local Office, 15<sup>th</sup> November 2016; Athalone Local Office, 16<sup>th</sup> November 2016.

<sup>113</sup> Criteria are taken from the 2009 Amendment to the Social Assistance Act (Government of South Africa 2009).

<sup>114</sup> Source: Interview with SASSA staff responsible for disability guidance.

In the absence of any direct policy guidance, SASSA has produced a document for medical assessments: *SASSA Guidelines for the Medical Assessment of Disability for Social Assistance Purposes*. Medical Officers are expected to use the Guidelines for the Disability Assessment. They are required to check that the person has been optimally treated and that they have been compliant with all treatment (as noted earlier, someone found to have deliberately defaulted treatment can be refused social assistance). The Guidelines stress repeatedly that chronic health conditions (such as epilepsy, cancer, HIV, hypertension, diabetes, psychiatric illness, asthma and tuberculosis) can be successfully controlled with medication and do not necessarily result in the person being disabled for the purpose of the Disability Grant or Grant-in-Aid:

“Please be aware that when considering a person for a disability grant we are looking for a medical condition that is causing significant functional loss and limitation of normal daily activities..... Medical conditions that can be controlled on medication have little impact on daily function and therefore do not cause any significant impairment.”  
(p.7-8)<sup>115</sup>

Medical Officers need to determine the percentage disability of the applicant based on their condition. A table is provided detailing the percentage disability allocation for a list of predetermined conditions (for example, ‘amputation of hand at wrist – 40 per cent;’ ‘hypertension, controlled – 0-5 per cent;’ ‘total loss of vision one eye – 20-25 per cent;’ ‘unable to hear normal conversation – 30 per cent;’ ‘mild mental retardation – 25-40 per cent;’ etc.). The Medical Officer is required to state whether the person has minimal impairment (0-25 per cent); significant impairment (25-40 per cent); or major impairment (>40 per cent). Those with minimal impairments should not qualify for the Disability Grant. Those with significant impairments will be considered depending on how the medical officer then assesses a series of social factors which are specified as:

- Level of functional independence (activities of daily living);
- Education + skills, employment history;
- Discriminating factors:
  - Age: > 50;
  - Geographical area and socio-economic factors; and,
  - Opportunities for referral, community projects or sheltered workshops.

Finally, the medical officer is required to state whether the applicant qualifies for a temporary grant (6-12 months), a permanent grant with review (between 2-5 years), or a

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<sup>115</sup> Guidelines for the Medical Assessment of Disability for Social Assistance Purposes, n.d

permanent grant without need for medical review (although applicants will be reviewed every five years to confirm they comply with other conditions, in effect the means test).<sup>116</sup>

The Medical Officers must fill in a standardised medical assessment form (commonly referred to as the 'Big Book' – see Annex for a copy). The first section of the assessment form is administrative and some Medical Officers in the Western Cape complete this using a patient's medical file prior to the appointment.<sup>117</sup> The medical assessment begins with the medical officer confirming the identity of the applicant through the identity card and the impairment for which they are seeking the grant. The next section in the form requires the medical officer to provide details of the applicant's disability.<sup>118</sup>

In Western Cape, assessments are undertaken without a SASSA officer being present. The completed medical assessment forms (the 'Big Book') are collected each week by a SASSA official and copies of individual assessments are taken and put into the applicants file. In Gauteng, since the assessment takes place within SASSA offices, there is no need for them to be collected. The result of the disability assessment is entered into SOCPEN (along with any recommended medical review date) but no other information is logged. In Western Cape, the applicant was told to return to the SASSA office two weeks after the assessment, to receive their result.

Grant-in-aid assessments are usually undertaken at the same time as the Disability Grant. During the disability assessment the Medical Officer has the option of recommending the applicant for the Grant-in-Aid. The assessment can, however, be undertaken separately from the Disability Grant, such as when an older person applies for it.

The assessment for the Care Dependency Grant is similar to that of the Disability Grant. However, since the grant depends on the impairment of a child, Medical Officers are given extra assistance in the form of a developmental milestones table which can help them determine age appropriate skills and abilities. Using the table, a child qualifies for the Care Dependency Grant if s/he: is unable to demonstrate three or more of the age appropriate skills; is unable to demonstrate two skills and needs assistance to a level that is much higher than would usually be required; has behavioural problems which require a lot of attention; has a caregiver who has to stay at home; needs special schooling or extra classroom assistance; or has treatment that incurs a high cost to the caregiver.<sup>119</sup>

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<sup>116</sup> Key informant interviews, Disability Management Unit, SASSA, Pretoria, 7<sup>th</sup> November 2016.

<sup>117</sup> Key informant interview, medical officer, clinic linked to Paarl local office, Western Cape, 15<sup>th</sup> November 2016.

<sup>118</sup> Kelly (2013); Key informant interviews: medical officer, clinic linked to Paarl local office, Western Cape, 15<sup>th</sup> November 2016; medical officer, clinic connected to Athlone Local Office, 16<sup>th</sup> November 2016.

<sup>119</sup> Guidelines for the Medical Assessment of Disability for Social Assistance Purposes, n.d

## 10 Causes of Exclusion of Persons with Disabilities from Social Grants

As described in Section 8, many persons with disabilities do not access South Africa's social grants, although the rates of exclusion vary across grants. This section will, therefore, explore in more detail the potential causes of exclusion. It examines, first of all, the disability specific grants before moving on to causes of exclusion that cut across all grants. Finally, it examines the factors explaining exclusion from both the Old Age Grant and Child Support Grant.

### 10.1. Exclusion from disability specific grants

There is a range of causes of exclusion from the disability specific grants which are discussed below.

#### 10.1.1. Barriers to disability specific grants generated by policy decisions

A number of policies have created barriers within the disability assessment process which make it more challenging for people with disabilities to access disability specific benefits.<sup>120</sup>

##### *Lack of clarity over the purpose of the Disability Grant*

SASSA is still struggling with how to contain the uptake of the Disability Grant in communities where there are high levels of chronic ill health, poverty and unemployment. It would appear that most applicants for the Disability Grant have chronic health conditions (tuberculosis, asthma, HIV-AIDS, hypertension and diabetes being the most commonly cited) rather than disabilities.<sup>121</sup> This is not surprising since there are no other social grants for persons of working age, yet a high proportion of the population live on low and insecure incomes and are in desperate need of support. Therefore, applying for the Disability Grant appears to be a logical response, especially if they are experiencing chronic ill health, since the application may be successful.

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<sup>120</sup> Given the short period of this research, the issues identified here should be regarded as indicative and researched in more depth in future.

<sup>121</sup> This was certainly the case in the assessment centres visited during this review including interviews at: Grants Administration Department, Disability Management, SASSA Western Cape, Cape Town, 14<sup>th</sup> November 2016; SASSA office + clinic observations: Khayekitsha Local Office, 14<sup>th</sup> November 2016; Paarl Local Office, 15<sup>th</sup> November 2016; Athlone Local Office, 16<sup>th</sup> November 2016.

Most informants agreed that if SASSA could communicate the purpose of the Disability Grant more clearly, including making it more explicit that having a chronic health condition is not an automatic qualification for the grant, it might help reduce some of the pressure on the assessment mechanism. However, SASSA staff cannot refuse anyone who makes an application. So everyone is put through a disability assessment process, leaving Medical Officers with the task of screening out people who do not qualify. But, the significant pressures on a poorly resourced system means that the quality of disability assessments falls resulting in a greater likelihood of eligible people being excluded from the system.

One option may be to establish an initial screening process for those that clearly do not fit the criteria for the disability specific grants, to reduce the pressure on the main assessment. Additional resources and time could then be invested in the core assessment process for those who have an impairment.

### ***Permanent nature of the Care Dependency Grant***

The Care Dependency Grant can only be given as a permanent benefit and cannot be withdrawn until a child has reached 18 years of age. As a result, Medical Officers are reluctant to give a Care Dependency Grant to children with a severe but temporary disability, irrespective of the challenges this causes. Families who would benefit from a temporary Care Dependency Grant are those whose children are seriously ill but who are undergoing treatment, such as children born with organ abnormalities that can be corrected by surgery; those who develop cancer; or, children involved in accidents. Families would benefit from financial support to help cover their repeated hospital trips, time away from work and additional medical expenses. Yet, currently none of these families qualify for the Care Dependency Grant. There is, therefore, an urgent need to introduce a temporary Care Dependency Grant.

### ***Criteria for the Care Dependency Grant***

As discussed earlier, children qualify for the Care Dependency Grant if they require and receive permanent care and support services. These criteria can be difficult for Medical Officers to interpret in the time they have available for assessments and, if interpreted very literally, may exclude many children who are in significant need. For example, some Medical Officers ask questions such as whether a child can wash or feed themselves and, if the answer is affirmative, they can exclude them from the grant. Yet, many children with severe disabilities – such as those with Down Syndrome – are able to wash and feed themselves, while still needing significant support in other areas.

Indeed, it is not clear whether the Care Dependency Grant is meant to compensate caregivers for lost income or cover the additional costs of disability of the child. This should be made clear to Medical Officers to facilitate their decision-making when undertaking assessments.

### ***Use of state Medical Officers***

South Africa's medical system is largely private and the Department of Health (DoH) struggles to employ doctors. Assessments have to be undertaken by doctors employed by the state. Yet, many persons with disabilities have been treated by private doctors. By not allowing the judgement of private doctors to be used in assessments, a significant burden is placed on the state system which has to repeat assessments that could easily be undertaken by patients' own doctors. It should be possible to adopt a system that enables SASSA to accept the recommendations of private doctors, alongside a process that monitors these recommendations to minimise fraud.

Furthermore, the assessment system applied in some provinces, such as Gauteng, results in the recommendation of state doctors being rejected, even when they are significantly more competent than SASSA medical officers or know the patient much better. For example, in Gauteng, children treated by a specialised paediatrician, who writes referral letters for children to receive the Care Dependency Grant, has found that her advice has been frequently rejected, despite having undertaken extensive examinations and tests of children. This has happened even with straightforward cases such as Down Syndrome and cerebral palsy. Again, it should be possible to design a system that enables the advice of specialists to be taken into account.

Indeed, in contrast to Gauteng, in Cape Town, recommendations from the Red Cross children's hospital are accepted by SASSA, with all applications for the Care Dependency Grant taking place at the local SASSA office. This model should offer lessons for other parts of South Africa where appropriate Department of Health facilities are in place.

### ***Residential care prohibition barriers***

As indicated earlier, those in residential care provided by the State are not eligible to receive social grants, which appears to have been interpreted – at least in some cases – as not being able to apply for a grant either. This can create barriers for a number of people living in residential care. For example, if children have been in hospital for six months, their carers are no longer able to receive the Care Dependency Grant, despite the fact that they may still be experiencing high costs in supporting their children.

Furthermore, people with disabilities wanting to leave residential care cannot apply for the grant until they have left residential care. Yet, they may not be able to receive the grant for a number of months, during which time they may have no income. So, they are unable to leave, which creates a vicious circle from which they cannot escape. The researchers heard of a case of one person who wanted to leave residential care to live with his sister but could not do so because she could not afford to support him during the time between leaving residential care and accessing the grant, which would have been a period of months.

### ***Fitness for work assessment***

Irrespective of the perverse incentives that may be created by the fitness for work assessment, its use creates challenges because Medical Officers do not have the training to make an assessment on whether people are able to gain employment. The assessment is meant to take into account the context of the actual labour market, which is not within the capacity of doctors to assess. They may, therefore, assess that someone is able to work when, due to the interaction of the social and economic environment with the person's impairment and skills, he or she may, in reality, be unable to find employment.

The extent to which Medical Officers do, in fact, implement the capacity to work assessment is unclear. As indicated earlier, the assessment of severity of disability has three categories: mild (0-25 per cent); moderate (25-40 per cent); and, severe (40 per cent and over). In Western Cape, it appeared that everyone scoring above 40 per cent received the grant while those assessed as moderate were likely to receive the benefit, once other factors were taken into account (which may have been likely capacity to work).<sup>122</sup>

If the assessment of work capacity is not, in fact, applied – at least above a particular level of disability – it is questionable whether it should continue, since it may well be disincentivising people from engaging in the labour market.

### ***Means test and the Disability Grant***

The Disability Grant is means-tested which may well be a cause of excluding many persons with disabilities due to their income or assets. However, when assessed against the GHS (2015) dataset, the means test for the grant should only exclude 3 per cent of all persons with severe functional limitations, since 97 per cent declare incomes below those

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<sup>122</sup> Source: interview with key informant. See also Kelly (2016).

of the means test (although some may be excluded by the asset test).<sup>123</sup> Overall, around 59 per cent of those with severe functional limitations who are eligible for the Disability Grant according to their income are excluded, as well as 36 per cent of those classified as 'unable to do'. Much of the exclusion is likely to be the result of the employability test used for the Disability Grant (see above). When this is taken into account, the exclusion errors among those classified as 'not in employment' are reduced slightly: among those with severe functional limitations the exclusion rate is 50 per cent and 28 per cent among those classified as 'unable to do.' Therefore, even among the target group, exclusion is high.

Furthermore, the vast majority of persons with disabilities experience additional costs as a result of their disability. If these were taken into account, almost all persons with severe functional limitations would be eligible for the disability benefit if the employability test were not taken into account.

While the current policy of the Government of South Africa is to exclude persons with disabilities with incomes and assets above a certain threshold, the existence of the means test – and the belief that the Disability Grant is for the 'poor' – is likely to put off many people from applying. The means test thresholds are relatively high yet many people who are eligible appear to incorrectly believe that they are too wealthy to apply. This is more likely to be the case among persons with disabilities with minimal personal incomes but who live in wealthier households. The confusion caused by the existence of the means test may be a key reason explaining lower access than expected among the White population. The same reason is likely to apply across other grants, in particular the Old Age Pension and Child Support Grant.

One of the main conclusions from the analysis, therefore, is that there is little point in having a means test for the Disability Grant given that almost everyone with a severe functional limitation is eligible. It seems that it serves more to exclude eligible people rather than exclude those who are not eligible.

### ***Back-dating of payments for disability-specific social grants***

With the non-disability specific social grants, recipients are paid the grant from the day that they first apply or, in the case of the Foster Care Grant, to the date of the court decision. However, this is not the case with disability benefits. They are only paid from the date of filling in the application form, which takes place at least two weeks after the

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<sup>123</sup> Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways. This estimate is based on the income test only. It does not include the asset test.



disability assessment, rather than from the time when they initially request the grant. This is particularly problematic when assessments are not undertaken for a number of months following the initial request for the grant. Yet, these delays are rarely the result of the applicants not being available for assessment but are due to lack of capacity within SASSA to undertake the assessment: in Western Cape, we found instances of people being given disability assessment dates three months after their initial request for the grant. Furthermore, if the Medical Officer incorrectly determines that a person is not eligible for a disability-specific grant, the rejected applicants often re-apply which creates further delays, especially if they have to re-apply a number of times.

The implication is, however, that all applicants are excluded from the disability-specific grants for the period between the initial notification of application and receiving the result of the disability assessment. It would make sense for disability-specific grants to be treated the same way as other social grants, so that the first payment is back-dated to the date of the first application.

### 10.1.2. Human resource capacity

Many of the causes of exclusion from disability grants are the result of inadequate human resource capacity within the Government of South Africa, in particular in SASSA and the Department of Health (DoH). Some of the issues linked to human resource capacity are discussed below.

#### *Insufficient numbers of Medical Officers*

South Africa's medical system means it is difficult for the Department of Health and SASSA to contract doctors for medical assessments. Doctors are well-paid in South Africa – earning European-level salaries – and many are unwilling to accept the level of payment given by SASSA for disability assessments. Furthermore, other disability assessment mechanisms pay more, so are more attractive to doctors.

Undertaking SASSA disability assessments can be dangerous, which can deter doctors.<sup>124</sup> There are many experiences of doctors being put under moral pressure or being threatened by applicants, having their tyres slashed or even being physically assaulted. Often doctors share information on assessment centres to be avoided due to challenges

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<sup>124</sup> Grants Administration Dpt, Disability Management, SASSA Western Cape, Cape Town, 14<sup>th</sup> November 2016; SASSA office plus clinic observations: Khayekitsha Local Office, 14<sup>th</sup> November 2016; Paarl Local Office, 15<sup>th</sup> November 2016; Athalone Local Office, 16<sup>th</sup> November 2016.

with applicants – often via Whatsapp or Facebook – which makes recruitment for those areas even more difficult.

In many remote areas, doctors are a scarce resource, travelling there only rarely for diagnostic work. Finding Medical Officers willing and able to travel to remote areas can be a challenge, making regular and frequent access to assessments particularly challenging.

If South Africa wishes to have a more effective disability assessment system for social grants, it will have to both increase its investment in the Department of Health and the payments made to medical officers undertaking the assessments.

### ***Capacity of Medical Officers and SASSA staff***

Many Medical Officers undertaking disability assessments do not have adequate training or the capacity to undertake them to the required standard. Given the breadth of disability that they have to assess, there are many areas of specialisation that go beyond the competence of many general practitioners. Very few have professional training in occupational health, which makes work assessments particularly problematic.

SASSA provides training for Medical Officers, but the initial training is only for four hours and only two hours of the training is repeated each year. Moreover, the training is administrative, provided by SASSA staff, and does not teach the Medical Officers how to undertake assessments. In addition, the medical guidance is only available to those who have undergone briefings by SASSA, which does not include locum staff who are brought in by medical facilities at short notice to cover rota gaps<sup>125</sup>.

Observations of Medical Officer assessments in Western Cape by Kelly (2016a; 2016b) indicated significant flaws in the process. She never saw a Medical Officer refer to the medical assessment guidance nor the specific Care Dependency Grant guidance. Her impression was that the doctors took educated guesses based on their experience.<sup>126</sup> Indeed, Kelly (2016b)

#### ***Box 10-1: Awareness raising can make a difference***

The Down Syndrome Association informed us that it was common for applicants with Down Syndrome to struggle in gaining an adequate assessment. Indeed, we heard many cases of Down Syndrome being assessed as a temporary disability, which indicates poor training among the medical practitioners. However, there is an example of a SASSA office in Gauteng where one of the SASSA officers has a child with Down Syndrome. She has built the awareness of her colleagues on Down Syndrome and that office has a reputation for treating children with Down Syndrome sympathetically and to a high standard.

<sup>125</sup> Grants Administration Department, Disability Management, SASSA Western Cape, Cape Town, 14<sup>th</sup> November 2016.

<sup>126</sup> Source: interview with Gabby Kelly.

argues that doctors need to be recognised as “human actors with their own agency and set of personal experiences, norms, moral dispositions and notions of social justice, who are likely to have subjective reactions to claimants and use their discretion to insert their own ideas and values into the assessment process”.

As a result of the lack of capacity among assessors, decisions can be very arbitrary, with each Medical Officer applying different criteria. In Gauteng, we were told that Medical Officers had reputations for the level of sympathy they showed to applicants, so people would seek out the more sympathetic and avoid those with reputations for turning people down. Many doctors, however, make more sympathetic decisions because they recognise the extreme poverty of many applicants and the challenges they face in finding work in the context of high unemployment. Kelly (2016b) found a tendency for doctors to be more lenient with older claimants who were sick and just a few years from accessing the Old Age Grant. Doctors also often give temporary grants for sick people who they believe need time and resources to enable them to recover. As one doctor said to Kelly (2016b), when referring to other doctors:

“They do understand that the patients are often unemployed and that it is a process for them to get to us. Although the patients are not necessarily physically disabled, they are disabled by their disease. They will give the patient a 6- or 12-month grant and there is difficulty about loopholes – the reality is that they are sick and unemployed and need to get to the hospital and the grant plugs that hole. Some of them don’t necessarily deserve the grant but you put them on a temporary grant. You put them on a temporary grant while they recover – although sometimes by the time they get the grant they are already better.”

SASSA staff do not monitor the medical assessment process itself and focus only on the administrative side of the process. Therefore, they are not familiar with how Medical Officers operate or the basis upon which they are making their recommendations.

In fact, despite dealing with disabled people on a daily basis, SASSA has not committed to providing disability awareness training to staff or contracted Medical Officers<sup>127</sup>. This means that there is no consistency in the understanding of or approach to disabled people and a lack of appreciation for the adjustments that might have to be made in order to accommodate the different needs of disabled people. SASSA staff who were approached during this review were unable to communicate even on a basic level with

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<sup>127</sup> Key informant interviews: Disability Management Unit, SASSA, Pretoria, 7<sup>th</sup> November 2016; Grants Administration Department, Disability Management, SASSA Western Cape, Cape Town, 14<sup>th</sup> November 2016.

sign language users (since they had not had SASAL training). One person we followed during an application interview potentially had a cognitive impairment which made it difficult for him to recall information. In fact, he had come to the wrong centre for his follow up appointment: had staff been able to recognise that he might need some additional support, they could have offered to write down the time and location of his new appointment.<sup>128</sup> An increased level of sensitivity to disability could help improve the experience for some applicants.

### 10.1.3. Exclusion due to implementation challenges during the application process

A number of the causes of exclusion from disability-specific grants are the result of how the Disability Grants are implemented, as discussed below.

#### *Lack of time for appropriate assessments*

Overall, very little time is available for Medical Officers to assess patients: even in a scenario of a maximum of 40 assessments in an 8-hour day, only around 10 minutes would be available for each consultation and that would include the time spent filling in the form. Consultations with clients and NGOs indicated that many Medical Officers in Gauteng spend minimal time on the assessments: some claimed that assessments lasted little more than one minute and involved no more than confirmation of name and a visual or verbal inspection.<sup>129</sup> While 40 assessments per day is also the maximum in Western Cape, it would appear that Medical Officers can have fewer assessments per day and some last for up to 20 and 30 minutes. Since the doctors in Western Cape have medical records available, they have a stronger focus on reviewing the medical records as well as a physical and verbal assessment, if required. Nonetheless, in her research, Kelly found many instances of assessments taking only a few minutes, sometimes with no physical examination or without talking to the patient.

When Medical Officers are contracted directly by SASSA and paid on a per assessment basis there is a significant perverse incentive for Medical Officers to spend as little time with applicants as possible so that they can maximise their income.<sup>130</sup> SASSA does not appear to keep records of how long Medical Officers spend undertaking the assessments.

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<sup>128</sup> SASSA office observation, Paarl Local Office, 15<sup>th</sup> November 2016.

<sup>129</sup> Key informant interviews: Downs Syndrome Association, Pretoria, 8<sup>th</sup> November 2016; Afrika Tikun Uthando Centre, Johannesburg, 9<sup>th</sup> November 2016.

<sup>130</sup> Key informant interviews, Disability Management Unit, SASSA, Pretoria, 7<sup>th</sup> November 2016.

### ***Evidence as the basis for decisions***

As is appropriate, Medical Officers are expected to base their decisions on evidence. However, this causes a significant challenge when the evidence is not available and they do not have the skills or time to collect that evidence themselves. Often Medical Officers do not have time to undertake physical examinations and they are also unable to request tests.<sup>131</sup> The situation is somewhat better in a context such as the Western Cape where patient files are made available to doctors but, in areas such as Gauteng, the Medical Officers have no access to medical records unless patients bring them themselves, which is challenging since medical records should not leave clinics or hospitals.

Medical Officers in the Western Cape reported often giving a temporary Disability Grant to those who they think would qualify but who do not yet have enough medical evidence (or indeed any medical report). They advise the applicants to use the time to seek further treatment or testing before returning for re-assessment. However, as there is no temporary Care Dependency Grant, this option is not available for children.

The need for evidence means that people with more visible impairments or those who are more articulate are more likely to be certified as eligible for disability-specific grants.<sup>132</sup> Key informants from groups representing adults and children with cognitive, mental and psycho-social impairments report struggling in this situation and having to make repeated applications in order to find a “sympathetic doctor”.<sup>133</sup>

### ***Absence of translation***

The requirement for evidence is exacerbated due to an absence of translation for applicants during the assessment sessions. If the Medical Officer and the claimant do not speak the same language, communication is not possible unless a family member of the claimant is present. Further, in many indigenous languages, there are no words for a range of cognitive and mental conditions, which makes communication even more problematic: a mental illness is, for example, often referred to as being ‘sick in the head.’ Similarly, SASSA does not provide sign language for deaf claimants which means, again, that they may well have to communicate through family members, if accompanied.

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<sup>131</sup> Clinic observations: Khayekitsha Local Office, 14<sup>th</sup> November 2016; Paarl Local Office, 15<sup>th</sup> November 2016; Athalone Local Office, 16<sup>th</sup> November 2016.

<sup>132</sup> Kelly (2016a)

<sup>133</sup> Key informant interviews: Downs Syndrome Association, Pretoria, 8<sup>th</sup> November 2016; Afrika Tikun Uthando Centre, Johannesburg, 9<sup>th</sup> November 2016; South Africa Federation for Mental Health, Johannesburg, 17<sup>th</sup> November 2016.

### **Opportunity cost to the applicants**

The application processes for the disability-specific grants are complex and lengthy. Applicants need, in effect, to make four visits to institutions including undergoing two medical assessments: first, they need to have a referral letter before they start the pre-application process; then, they have to undergo SASSA's own medical assessment process.<sup>134</sup>

For many South Africans, obtaining the referral letter – which for more complex and less visible disabilities should come from a specialist – is challenging. There are very few psychiatrists, paediatricians or audiologists who can provide the necessary medical reports which can mean long waits for appointments and expensive journeys.<sup>135</sup> For example, children with complex disabilities in the Orange Farm area of Johannesburg have to travel 50 kilometres to see a specialist, to obtain a referral letter.<sup>136</sup> The situation in rural areas is even more difficult.

Applicants then need to visit SASSA offices to make their application. Although, in many cases, applications can be made locally – through SASSA's use of temporary Service Points – queues are usually still very long: some claimants stated that queues can start forming at 4 a.m. in the morning. Those applying for Disability Grants need to wait in line with applicants for other grants and, even if they experience personal challenges, they are not fast-tracked. Claimants with children also have to find solutions to childcare or they must be accompanied by their children.<sup>137</sup> The ease of the process varies between SASSA offices since some are more efficient than others.

The next stage is the SASSA medical assessment, with the same costs in terms of time and resources. Sometimes doctors do not turn up so the claimants will be given yet another date to return. If the medical assessment is significantly delayed, the applicant may then find their original referral letter is out of date – since referrals are only valid for three months – and they have to obtain yet another one, with the same challenges as before.

Finally, the claimant has to return to the SASSA office to find out the result of their assessment and be subjected to the means test. Again, this means time to travel, long

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<sup>134</sup> In some parts of Western Cape, at least, it is possible to obtain an appointment for a SASSA disability assessment without a referral letter.

<sup>135</sup> Key informant interviews: Downs Syndrome Association, Pretoria, 8<sup>th</sup> November 2016; Afrika Tikun Uthando Centre, Johannesburg, 9<sup>th</sup> November 2016; South Africa Federation for Mental Health, Johannesburg, 17<sup>th</sup> November 2016.

<sup>136</sup> Key informant interview, Afrika Tikun Uthando Centre, Johannesburg, 9<sup>th</sup> November 2016.

<sup>137</sup> Observations at Service Point, Athlone Local Office, Cape Town, 16<sup>th</sup> November 2016 and discussions with SASSA staff

queues and potentially significant opportunity costs. Indeed, it would be preferable to undertake the means test earlier in the process so that, if someone does not qualify, they do not have to go through the demands of the disability assessment.

Persons with less visible – but severe – disabilities are the most likely to be turned down. In these cases, they most often have to start the process again, after waiting for three months. Often, these are some of the most vulnerable individuals and families who find it more challenging than others. In Orange Farm, Johannesburg, there were, for example, many cases of children with profound disabilities having to undergo the process a number of times until their application was approved.

Navigating the disability application process is, therefore, difficult as well as time and resource intensive especially when considering that many people have additional expenses due to their disability. This could be a factor in excluding those who are more profoundly disabled from accessing the grants.

### ***Transport costs***

The opportunity costs for applicants for disability specific grants are exacerbated by the costs of transport. The many journeys can add up to a significant expense for families and, of course, for many disabled people transport costs are higher: a blind person may require a guide or a wheelchair user may be charged extra for the wheelchair. And, of course, children with disabilities need to be accompanied by carers.

SASSA has attempted to reduce transport costs by placing offices and service points close to applicants and, as noted earlier, the aim is for people to travel less than 5 kilometres, although this is difficult to achieve for everyone, especially in rural areas. However, SASSA has not taken into account the cost of travel to obtain a medical referral letter, in particular for those with the most profound or invisible disabilities who require support from specialists.

At present, SASSA does not compensate for travel costs, despite the fact that these can create significant challenges for some of the most vulnerable people with disabilities. Nor do they compensate for transport costs when SASSA is at fault for people having to take additional journeys, such as when a Medical Officer is unavailable, or makes a mistaken assessment. The costs of transport – or, indeed, the absence of transport – may well contribute to people not accessing both disability-specific and other grants.

## 10.2. Barriers to access across the social grants

There is a range of barriers to access for persons with disability that apply across most of the social grants. Some of the key barriers discussed above – such as the opportunity and transport costs – are also relevant to other grants and are not discussed further here. Other barriers are outlined below.

### 10.2.1. Inadequate communication to persons with disabilities

While SASSA has produced a range of materials for communications – many in different languages – the quality of communications about the grants to persons with disabilities is relatively weak (though much stronger than in most developing countries). There is relatively good awareness of the Old Age Grant and Child Support Grant across the population which means that uptake is good, but this may have resulted in SASSA not investing sufficient resources to ensure effective communications to persons with disabilities, including on disability-specific grants. A key challenge is with the Care Dependency Grant which many carers of children with disabilities are unaware of. Furthermore, even among NGOs offering services to children with severe disabilities, there is a lack of knowledge that carers can receive both the Foster Care Grant and the Care Dependency Grant: therefore, many people in receipt of the Foster Care Grant do not apply for the Care Dependency Grant, which is more likely to be the case for older persons caring for foster children.

There is a need for SASSA to invest in developing a communications strategy for persons with disabilities, linked to the development of a range of leaflets, posters, infographics and videos which more simply outline the eligibility criteria and application processes. They should be designed for people with limited literacy and numeracy skills and in a range of accessible formats (including large print, plain language, Braille, SASL). SASSA offices should have large posters that display and explain the steps required for each grant with other venues such as hospitals, clinics schools, and day centres, stocked with posters and leaflets. In particular, details of issues like the means test and the sliding scale for grant payments (which is actually not detailed in any of the public literature) need to be made very clear. Likewise, details around the appeal process should be much more in evidence. As discussed in Section 10.2.5 this review found repeatedly that people

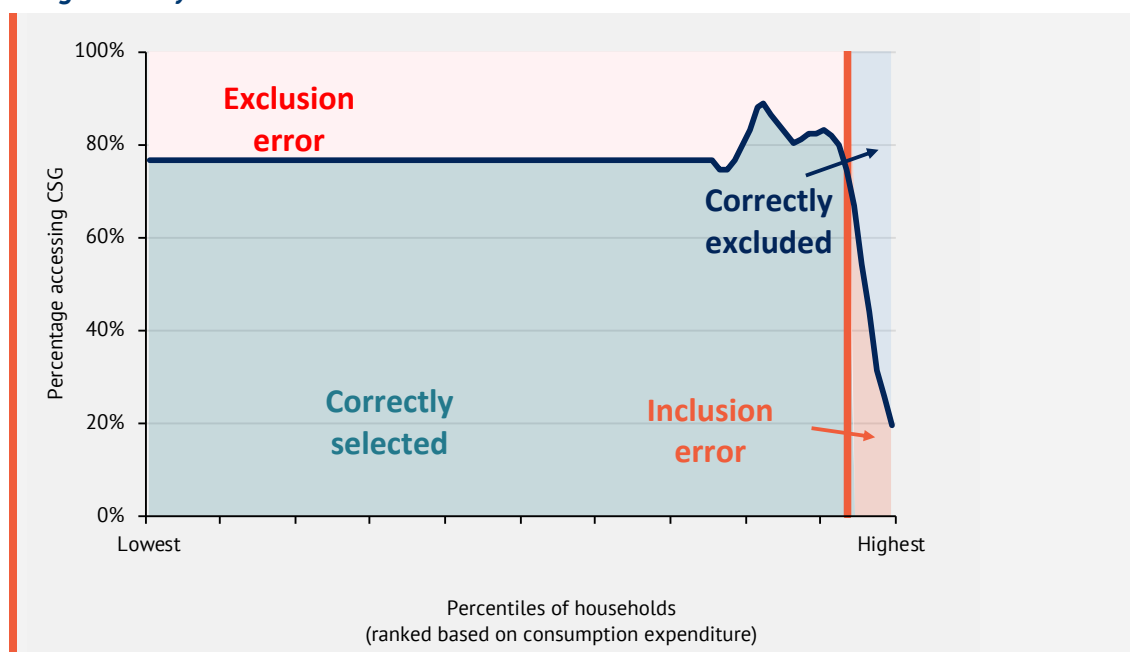


thought they were undertaking an appeal when in fact they were simply undertaking a new application.<sup>138</sup>

### 10.2.2. The means test and the additional costs of disability

Overall, the unverified means test is effective in excluding those who are non-eligible on the grounds of their income from the social grants. Figure 10-1, for example, shows the targeting effectiveness of Child Support Grant for single primary caregivers. The vertical red line indicates eligibility and it can be seen that there is a sharp drop-off at that point, suggesting that the means test works in terms of its effectiveness in excluding those who are not eligible. Much of the success in excluding this group is probably the result of self-exclusion: applicants have to queue for long periods, which probably puts off many people with incomes above the eligibility line while few White households apply. A bigger concern, however, is the exclusion of those who are eligible, although the extent to which this is due to the existence of a means test or other factors is not known (although it is known that some exclusion is linked to ethnicity, lack of birth certificates and older children dropping out of the scheme).

**Figure 10-1: Accuracy of targeting of Child Support Grant in South Africa, for single primary caregivers only<sup>139</sup>**



<sup>138</sup> Key informant interviews: Downs Syndrome Association, Pretoria, 8<sup>th</sup> November 2016; Afrika Tikkun Uthando Centre, Johannesburg, 9<sup>th</sup> November 2016; SASSA office observations: Khayekitsha Local Office, 14<sup>th</sup> November 2016; Paarl Local Office, 15<sup>th</sup> November 2016; Athlone Local Office, 16<sup>th</sup> November 2016.

<sup>139</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2016 by Development Pathways. The analysis looks at families in general rather than those with persons with disabilities, due to the small sample size of the latter.

However, one challenge with the means test for persons with disabilities is that, although disability-related costs are significant in South Africa – see Section 10.2.2 - the means test does not take these costs into account. As a result, disabled persons – and their households – have, in effect, a higher threshold of eligibility when compared to non-disabled people and do not enjoy equality of opportunity. Therefore, many persons with disabilities with similar standards of living to non-disabled persons – and who are just above the income test eligibility line – are excluded. The means test should, therefore, be adjusted to enable equality of opportunity between disabled and non-disabled people.

### 10.2.3. Physical barriers in SASSA offices

In general, there are few physical barriers impeding the access of persons with disabilities to SASSA offices, but they exist in some instances. Most SASSA offices are on the ground floor, but not all. Where there are lifts, SASSA headquarters is encouraging regions to put braille in lifts, but only when they are refurbished. SASSA is currently putting in place ramps to all offices – currently 90 per cent have ramps – and there is a standard for the gradient of the ramp. Not all offices have disability accessible toilets and regions are currently being encouraged to put them in place. There are, however, no standards for certain physical access issues, such as the width of doors or the height of door handles. There are also no automatic doors: however, SASSA argue that they have security guards in place that open the doors for those experiencing difficulties.

SASSA has tried to undertake an accessibility audit. However, there was an issue with the service provider and so the audit was not finished. As a result, they still do not have one. Reports were undertaken of the improvements to offices but the information was not captured electronically.

A recent ruling within SASSA means that Regions are now responsible for budgeting to improve access to offices. There are concerns that this may reduce the funding available.

### 10.2.4. Exclusion during payments

SASSA is aware that persons with severe disabilities may find it difficult to collect their payments. Therefore, they allow recipients of social grants to name a ‘procurator’ – or deputy – who can pick up the payment on behalf of the recipient. If SASSA becomes aware of procurators abusing their position, it is able to name an alternative. No one is allowed to be procurator for more than six recipients.

A challenge that has happened in the past couple of years is deductions being made from grants, allegedly by the Payment Service Provider (PSP). According to Black Sash, the PSP owns a number of other businesses – such as mobile phone companies and funeral insurers – and these companies have allegedly deducted payments from recipients without their knowledge or authorisation. Between January and August 2016, SASSA received 90,000 complaints about automatic deductions, but this is believed to be only the tip of the iceberg. In reality, all social grant recipients are at risk. Black Sash believes that the most vulnerable recipients of the grants – in particular those with disabilities – are more likely to be targeted and lose their grants. By early 2017, there had not yet been any restitution of the grants.

### 10.2.5. Complaints mechanism

SASSA has an official appeals process for those whose applications for grants are rejected. Every applicant is provided with a letter detailing the results of their application and, when someone is rejected, they should be told that they have the right of appeal and must do so within 30 days. The appeal process has a number of stages:

- The first stage is a ‘reconsideration’ – or internal review – by SASSA using the documentary evidence available.
- If the initial decision is upheld, the applicant can appeal to a Tribunal which is independent of SASSA and reports to the Minister of Social Development. In the case of appeals on disability-specific grants, the DSD prepares a legal and medical report for the Tribunal, but it makes its decision independently. The Tribunal also makes its decision on the basis of the documentation available but, when the Tribunal considers that the documentary evidence is inadequate, it can request that an additional medical assessment be carried out.<sup>140</sup> This is most likely to happen in complex cases (such as for people with cognitive impairments, traumatic brain injuries or psycho-social impairments) when the tribunal considers that the original medical assessment was not comprehensive enough. The Tribunal makes an appointment for the applicant to see the relevant specialist. However, since these must be made via the public health system they can take anywhere between three to nine months, making this a potentially lengthy process. The decision of the Tribunal is binding on SASSA.
- If the Tribunal upholds the original decision, the applicant can have a final recourse to a judicial review. Again, the decision of the judicial review is binding on SASSA. However, SASSA defends all cases. In the past, under a previous

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<sup>140</sup> Key informant interview, Department for Social Development, Pretoria, 11<sup>th</sup> November 2016.

minister, SASSA did not defend itself in judicial reviews, taking the view that the courts should determine policy for SASSA.

However, it is not clear how well-informed rejected applicants are about the appeal process. It would appear that people are, in fact, encouraged to re-apply rather than appeal. This may be because SASSA staff recognised that they were unlikely to have the decision overturned during the internal SASSA reconsideration process.<sup>141</sup> In fact, in 99.5 per cent of cases, SASSA upholds its original decision and is only likely to change its decision if an administrative error had occurred. Or, it may have been that some SASSA staff were not aware of the appeal process and believed that a new application was an appeal.

The high rejection rate during the reconsideration process has, it appears, led to a degree of disillusionment with the process so, out of 13,000 reconsiderations last year, only 3,000 reached the tribunals. At the Tribunal stage, 93 per cent of the original decisions are upheld. The high proportion is because many appellants have misunderstood the Disability Grant criteria and have appealed, for example, even though they have a chronic illness rather than a disability. However, the DSD believe that the Tribunal is likely to uphold appeals made by persons with complex disabilities who have been rejected by Medical Officers.<sup>142</sup>

In fact, most SASSA appeals are related to the Disability Grant (94-96 per cent) since the criteria for the Child Support, Foster Care and Old Age Grants are quite straightforward.

However, as suggested above, it is likely that most applicants for the Disability and Care Dependency Grants are guided towards a re-application rather than an appeal. This means that many fewer cases pass through to a judicial review, which reduces the chances of jurisprudence being established that may enhance the chances of persons with disability accessing the social grants.

Finally, as with the Medical Officers undertaking the assessments, DSD finds it challenging to recruit specialist doctors onto the Tribunals – which operate in each region – since the pay is not regarded as high enough. This, therefore, reduces the capacity of the Tribunals to make the correct decisions.

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<sup>141</sup> Key informant interviews: Downs Syndrome Association, Pretoria, 8<sup>th</sup> November 2016; Afrika Tikun Uthando Centre, Johannesburg, 9<sup>th</sup> November 2016; Steve Biko Academic Hospital, Pretoria, 10<sup>th</sup> November 2016; SASSA office observations: Khayekitsha Local Office, 14<sup>th</sup> November 2016; Paarl Local Office, 15<sup>th</sup> November 2016; Athlone Local Office, 16<sup>th</sup> November 2016

<sup>142</sup> Op.cit.

### 10.2.6. Monitoring

There is a range of mechanisms used by the Government of South Africa to monitor the social grants. SASSA produces monthly monitoring reports, presumably based on SOCPEN data. However, apart from information on the number of recipients of the disability specific grants and expenditure, there is no further information on disability access. Similarly, SASSA's annual report has limited information on disability. A major challenge is that SOCPEN is a very old Management Information System (MIS) and does not capture the details of specific impairments so it is unable to monitor internally whether there are groups of people facing particular barriers to access.<sup>143</sup> However, it is likely that, even without improvements to SOCPEN, some additional information could be included in monitoring reports, such as further disaggregation of information on specific types of benefits (e.g. providing specific information on the time it takes to complete the registration of disability-specific benefits). There is a disability-specific module in the MIS used in the Eastern Cape region, although this review was unable to examine it.

SASSA has a quality assurance mechanism for disability assessments. A panel of medical experts regularly examines 20 per cent of the assessments. However, they do not change decisions by SASSA but monitor trends among Medical Officers to try and ensure that they are fulfilling their role effectively.

The government's Department of Planning, Monitoring and Evaluation (DPME) has three monitoring systems in place that are applied across government. The Frontline Service Monitoring (FSM) focuses on unannounced visits to government service centres and 8 areas are assessed, including access, signage and the treatment of clients. However, most of the challenges faced by persons with disability in accessing social grants are unlikely to be picked up and, indeed, FSM monitoring does not examine the extent to which persons with disability are accessing the grants. The DPME also practices Citizen Based Monitoring, which involves consultations with focus groups. According to DPME, it emphasises "the building of capacity, of both citizens and officials at the point where services are delivered to (i) monitor how citizens experience service delivery, (ii) analyse this feedback, (iii) take actions for improvements and (iv) communicate to all stakeholders".<sup>144</sup> However, again, there is little evidence that this picks up specifically on the challenges faced by persons with disabilities in accessing their grants. There is also a Presidential Hotline, about which this review has little information.

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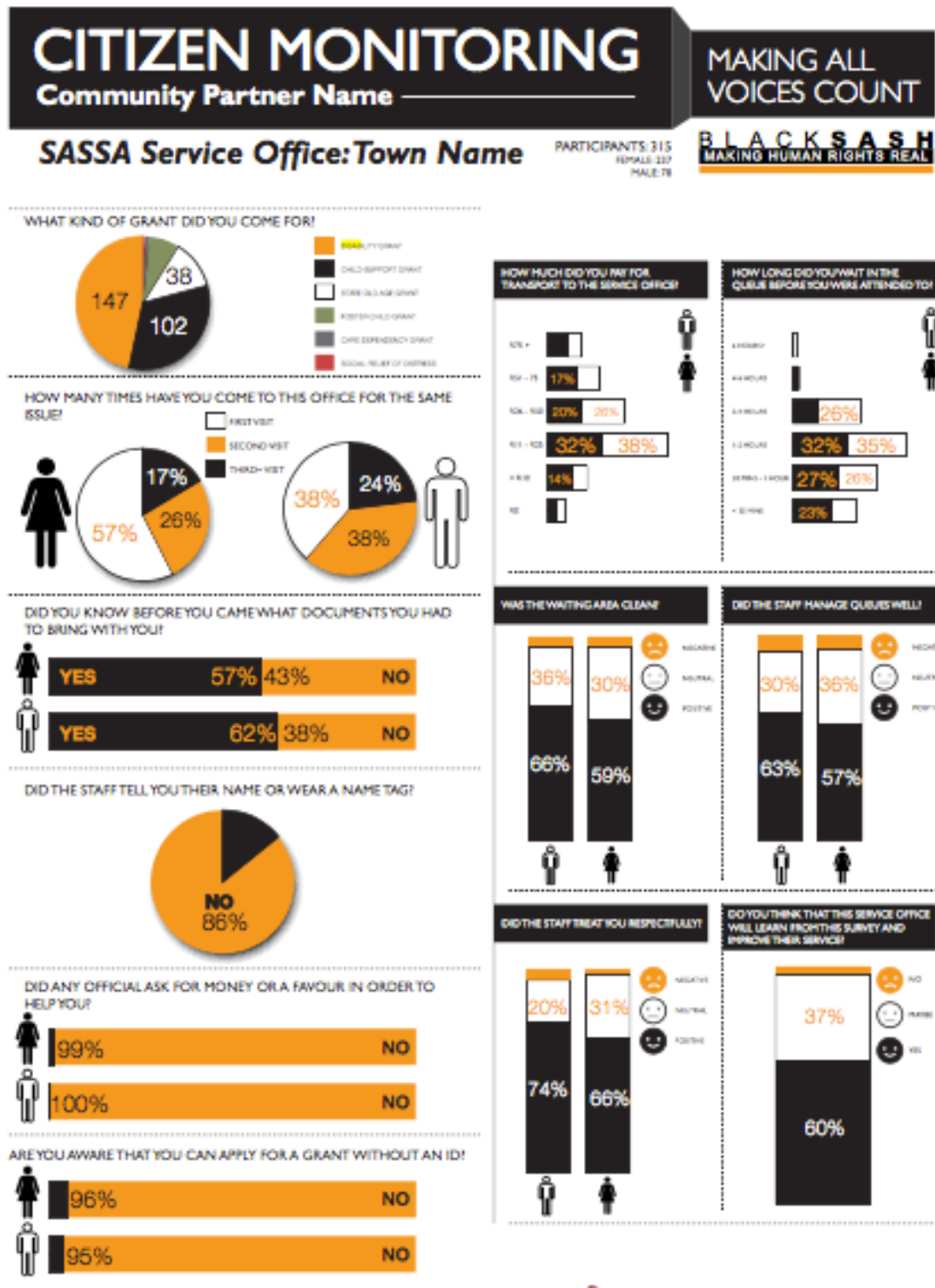
<sup>143</sup> Key informant interviews: Disability Management Unit, SASSA, Pretoria, 7<sup>th</sup> November 2016; Grants Administration Dpt, Disability Management, SASSA Western Cape, Cape Town, 14<sup>th</sup> November 2016.

<sup>144</sup> Department of Planning, Monitoring and Evaluation, South Africa (2013)

There are other state bodies that can engage in monitoring, including the Chapter 9 organisations established under the Constitution. These include the Human Rights Commission (HRC), which has a mandate deriving from the Promotion of Equality Act of 2000. It receives complaints from the public and can choose to act on those complaints. The HRC has taken up some disability issues. For example, it engaged with Standard Bank to change the height of its ATM machines so that they would be accessible for wheelchair users. However, it has not yet taken up specific issues on disability within SASSA. At the time of writing, the HRC was weakened since it had only one commissioner out of eight. Furthermore, it is still under debate whether it is mandatory to comply with the rulings of the HRC.

Since 2014, the NGO Black Sash has undertaken community-based monitoring of SASSA offices, in partnership with the international NGO Making All Voices Count. The mechanism enables local organisations to build relations with SASSA offices, monitor their service delivery and engage with them in dialogue on how to improve these services. An example of the type of output delivered by this approach can be found in Figure 10-2. However, again, there is no evidence that this monitoring specifically examines disability.

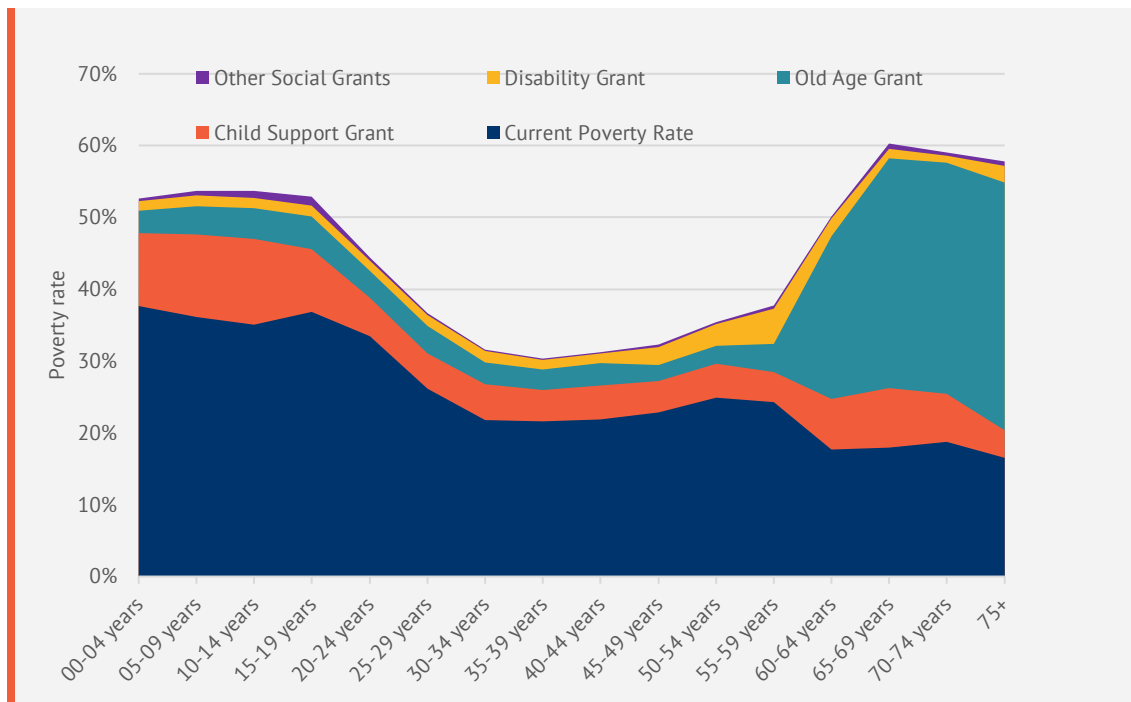
Figure 10-1: Example of the type of poster generated by Black Sash's Community Based Monitoring project



## 11 Impacts of Social Grants on Persons with Disabilities

South Africa’s social security system has significant impacts on poverty and inequality. According to simulations undertaken of the GHS 2015 dataset, as a result of the social security transfers, the poverty rate falls from 47.9 per cent to 41.6 per cent, a 13 per cent reduction, while the poverty gap falls by 37 per cent. They also reduce the difference between the incomes of the richest and poorest decile from 61 times greater to 35 times, a significant fall. Figure 11-1 shows the impacts on the poverty rate across age groups by different social security schemes, with the highest reduction among older people, but large reductions across all age groups. There is also a wide range of evidence on the impacts of specific social security schemes in other areas, such as child nutrition, education and access to the labour market. Indeed, without its significant investment in inclusive, lifecycle social security, South Africa would be in a much more challenging situation than it is now.

**Figure 11-1: Impacts on poverty rate across age groups of social security benefits in South Africa<sup>145</sup>**



<sup>145</sup> Source: Secondary analysis of Statistics South Africa’s General Household Survey (GHS) 2015 by Development Pathways.



Similarly, simulations indicate that South Africa’s social grants have significant impacts on poverty among persons with severe functional limitations. The poverty rate among persons with severe functional limitations falls from 71.9 per cent to 59.9 per cent - or a reduction of 16.7 per cent - while the poverty gap falls by 46.8 per cent, as a result of the social grants. South Africa’s social grants, therefore, have a larger impact on persons with severe functional limitations than on the population as a whole.

Figure 11-2 Figure 11-2 indicates the impacts of the social grants across different age groups of persons with severe functional limitations, with the highest impacts among older people, as a result of the Old Age Grant. Compared to its impact on the national population, the Disability Grant has a larger role in reducing poverty among persons with severe disabilities.

**Figure 11-2: Impacts on poverty rate across age groups of persons with severe functional limitations of social security benefits in South Africa<sup>146</sup>**

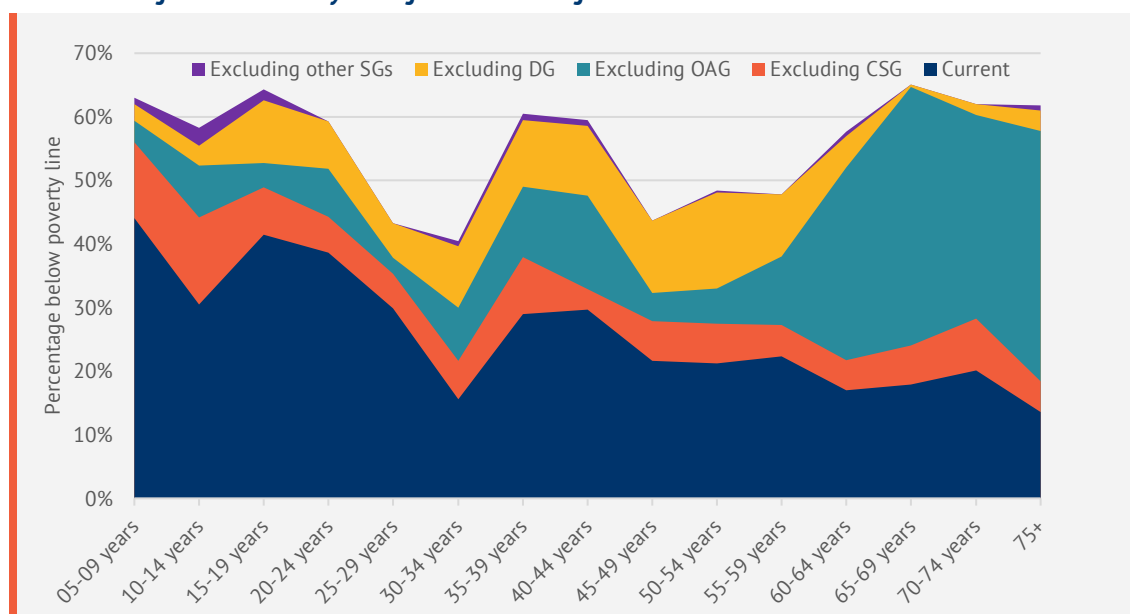
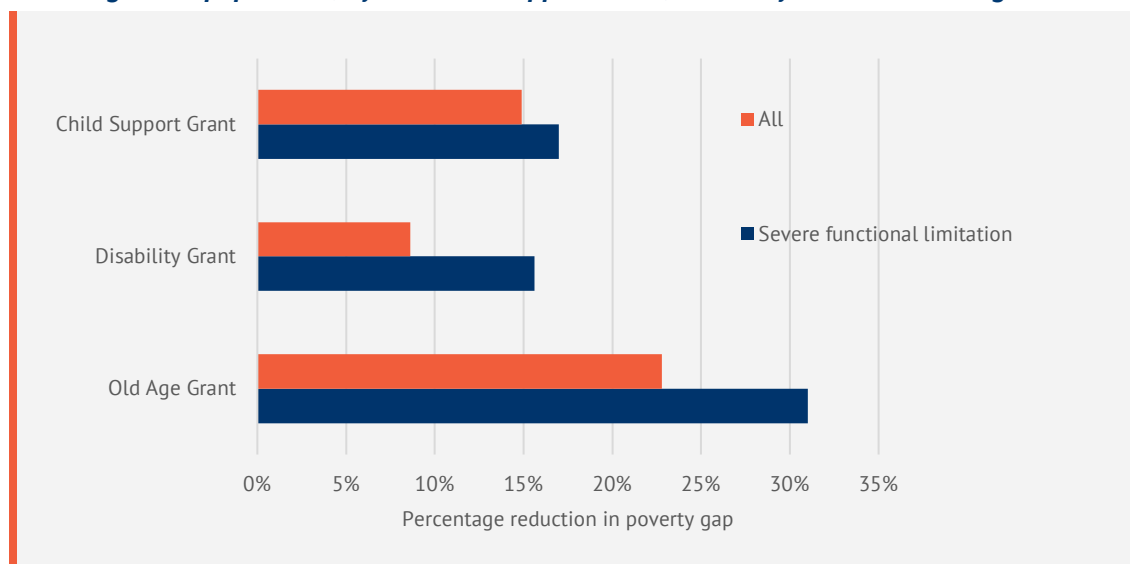


Figure 11-3 indicates the impacts of the largest social grants on the poverty gap among persons with severe disabilities, compared to their impacts on the population as a whole. The Old Age Grant has the greatest impacts across both the national population and persons with severe functional limitations but is much more effective among the latter group. The Disability Grant and Child Support Grant have similar impacts on persons with severe functional limitations but the relative contribution of the Disability Grant is much greater, when compared to the general population.

<sup>146</sup> Source: Secondary analysis of Statistics South Africa’s General Household Survey (GHS) 2015 by Development Pathways.

**Figure 11-3: Reduction in the poverty gap among persons with severe functional limitations and the general population, by the Child Support Grant, Disability Grant and Old Age Grant<sup>147</sup>**

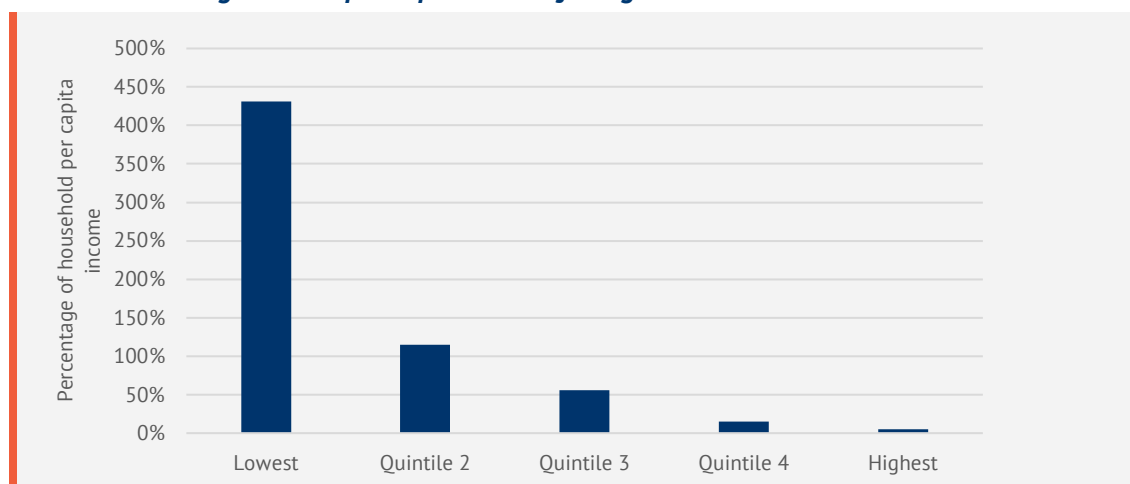


A key concern is whether the value of the disability-specific grants and the Old Age Grant is high enough to cover the needs of the recipients. The Disability Grant, Care Dependency Grant and Old Age Grant currently pay R.1,510 per month. This is the equivalent of 109 per cent of the average per capita income of households with a member who is severely disabled, net of all social grants. However, the relative value of the transfer varies depending on the gender of the head of the household: the grants are 171 per cent of the average per capita income of households with a female head and 75 per cent of the average per capita income of households with a male head, again net of all social grants. However, when if distributed to the household as a whole, the value of the grants is only 23 per cent of per capita income, a relatively small percentage of household needs.

Figure 11-4 shows the relative value of the grants across consumption quintiles when compared to per capita household income net of all social grants, when measured against the per capita value of the grants. It indicates that, among the poorest 20 per cent of the population, the Disability Grant makes a very significant contribution to household incomes.

<sup>147</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways.

**Figure 11-4: Relative value of the Old Age, Disability and Child Dependency Grants across consumption quintiles when compared to per capita household income net of all social grants, when measured against the per capita value of the grants**



As Section 9 indicated, the extra cost of disability among households including a person with a severe functional limitation was around 40 per cent of household income. However, the Disability, Care Dependency and Old Age Grants provide only 23 per cent of average household income, which suggests that they are not at a high enough level to even compensate for the disability-related costs faced by households including a person with a severe functional limitation to bring them to the same level as households with no disabled members, never mind having further impacts on household well-being. There is evidence that the Disability Grant is sufficient to enable people to meet their basic subsistence needs, but does not cover the additional costs faced by persons with disabilities.<sup>148</sup> In fact, according to a recent analysis of data on beneficiaries of the Disability Grant, approximately 25 per cent of households with beneficiaries still experienced hunger in the preceding year (a higher incidence than for the general population) and a third of households receiving the benefit had experienced running out of money to buy food (compared to a fifth of the general population).<sup>149</sup>

Indeed, during this review a number of informants indicated that the value of the Disability and Care Dependency Grants was too low. In particular, it was noted that the Care Dependency Grant would, in many cases, not even cover the costs of sending a disabled child to school or medical treatment (including the transport costs incurred). In these cases, they would certainly not compensate carers who have had to give up work to care for children. Furthermore, a number of informants noted that often the disabled child does not benefit much from the Care Dependency Grant: due to the low incomes of

<sup>148</sup> Goldblatt (2009).

<sup>149</sup> Department of Sociology and Social Anthropology (2014).

recipient families, carers often prioritise non-disabled children with the money they receive. Mji (2006) and Coulson et al (2006) also note that some recipients of the Disability Grant can lose control of their grant and find it is spent mainly on others.

The value of the Grant-in-Aid is particularly low, at only R.350 per month. It is meant to cover the costs of additional care – including compensating carers of persons with severe disabilities – but it comes nowhere near to covering these costs. There is clearly room in South Africa's portfolio of social grants for a Personal Support Grant but it should be set at a level that compensates the carer for lost income. However, at present such a grant is not on the policy agenda and was not included in the White Paper on the Rights of Persons with Disabilities.

Nonetheless, a range of studies have indicated that the Disability and Care Dependency Grants have brought a range of benefits to recipients, although the studies are limited in scope. In Eastern Cape, household incomes and possessions were found to be higher among households with persons with disabilities than among those in a control group, while in the Western Cape they were similar.<sup>150</sup> De Paoli et al (2012) have argued that, for many beneficiaries, the Disability Grant is their only source of income and is, therefore, used for general household expenses. De Koker et al (2006) found that purchasing food was the main priority for over 75 per cent of beneficiaries of the Disability Grant and 74 per cent of Child Dependency Grant recipients, with other priorities being clothes, electricity and services.

In South Africa, Mitra (2010) found that the mean household consumption for households on the Disability Grant was 61 per cent higher than for households not on the benefit, although caution should be exercised in interpreting this result as some of the non-beneficiary households would be earning more than the eligibility line for the means test. She also argued that non-beneficiaries have worse living conditions, in terms of access to piped water, flushing toilets and electricity. While female beneficiaries can also receive the Child Support Grant, they can be obliged to use this for additional care costs rather than for the child.

However, 93 per cent of Disability Grant beneficiaries have stated that the benefit had improved the general health of the household, with most saying this was down to consuming higher quality food while others indicated that it had helped them purchase medicines or pay medical fees.<sup>151</sup> The Care Dependency Grant was reported to have

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<sup>150</sup> Loeb et al (2008); Booysen and van de Berg (2005)

<sup>151</sup> de Koker et al (2006)

improved the general health of 98 per cent of beneficiary households.<sup>152</sup> In fact, 84 per cent of beneficiaries indicated that the Grant helped them care for sick household members.

Mitra (2010) found that the average number of children in households with Disability Grant beneficiaries was 1.99 compared to 1.4 in other households. This may mean that the Disability Grant is attracting other people to live with beneficiaries, as happens with the Old Age Grant. Indeed, Mitra (2010) argues that it may be an important benefit for helping children, as happens with the Old Age Grant.<sup>153</sup> De Paoli et al (2012) similarly note that South Africa's Disability Grant is used to help not just household members but the wider extended family.

In many parts of the world, there is good evidence of social security transfers being used for investment. However, Lorenzo (2003) describes how, in South Africa, it is difficult to use the Disability Grant for investment, since it needs to be shared with others and, as mentioned above, most of the grant is needed to cover basic expenses.<sup>154</sup> As one beneficiary stated:

“I wish I could have a business because the amount paid per month by the Disability Grant is little because all my siblings are dependent on me because our parents left us [died]. So I need more money because I have to send some money to the homelands [rural areas], give those who are here and I'm left with nothing.”<sup>155</sup>

Nonetheless, Samson et al (2004) found that households incorporating a recipient of the Disability Grant have higher labour market participation rates than those without social grants, although it is unclear whether the work is done by the person with a disability or by other members of the household.

There is some limited evidence that the Disability Grant in South Africa may help women escape abusive relationships, since they could move out of the home.<sup>156</sup> However, Goldblatt (2009) argues that South Africa's Disability Grant is of less help to women than men, because women with disabilities experience higher costs than men, since the woman is likely to be poorer, receive less support from others, and has to spend more of the grant on others.

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<sup>152</sup> de Koker et al (2006)

<sup>153</sup> See Case and Deaton (1998).

<sup>154</sup> Gooding and Marriot (2009) make the same point.

<sup>155</sup> Lorenzo (2003) in Gooding and Marriot (2009)

<sup>156</sup> Gooding and Marriot (2007)

## 12 **Perverse Incentives and the Disability Grant**

There are concerns that the Disability Grant has engendered some perverse incentives in particular linked to the management of chronic illness and access to work. These are discussed further below.

### 12.1. **The Disability Grant and chronic illness**

As noted earlier, much of the pressure on the Disability Grant comes from people experiencing chronic illness but who are not necessarily disabled. In part, this is the result of the use of panels for disability assessments in the past when many people with chronic illness were placed on the grant. But, it is also the result of the fact that many people with chronic illnesses are living in extreme poverty and are unable to obtain work and see the Disability Grant as their only option.

There has been significant debate about whether the Disability Grant has resulted in people living with HIV-AIDs refusing to take ARV treatment so that they can continue to be ill and receive the benefit. As de Paoli et al (2012) note, with the introduction of ARVs people living with AIDS and in extreme poverty face a dilemma: if they take their ARVs, their health would improve so that they would no longer qualify for the Disability Grant; but, without the Disability Grant, they would be unable to obtain adequate nutrition, which would reduce the effectiveness of the ARVs. Furthermore, obtaining employment is not an option for the majority and, even if employment were available, there are certain jobs that they cannot take, since they would exacerbate their condition (such as working nightshifts or outside, as this could increase the chance of an infection).

However, in a study undertaken by de Paoli et al (2012), they did not find that the vast majority of people living with HIV/AIDS choose not to take their ARVs to regain access to the Disability Grant. Yet, at the same time, losing the grant had a negative impact on their physical and emotional wellbeing. People adopt an alternative strategy to remain on the grant: prior to the disability assessment, they can take measures to lower their CD4 count temporarily so as to qualify for the benefit. This includes increasing alcohol consumption before attending the clinic and skipping some days of treatment to become slightly more ill. Others follow a pattern of being on a temporary Disability Grant for six months, then off it for six months, before returning to the scheme.

As noted earlier, there has been a significant debate on whether to introduce a Chronic Illness grant into South Africa's system of social grants. However, to date, this policy has

been rejected, despite significant support from some quarters.<sup>157</sup> Nonetheless, the introduction of a Chronic Illness benefit would take much of the pressure off the Disability Grant. Another policy suggested – including by the Taylor Commission (2002) – has been the introduction of a Basic Income Grant. Again, this is still a long way from gaining adequate support within government.

## 12.2. The Disability Grant and work disincentives

As discussed earlier, the Disability Grant is only supposed to be awarded to those not in employment. Many people believe that this has created disincentives for recipients not to work. For example, the Taylor Commission (2002) noted that:

“assessments ..... are constructed in such a way as to undermine the policy objective of maximising full participation in the world of work by creating a disincentive to work.”

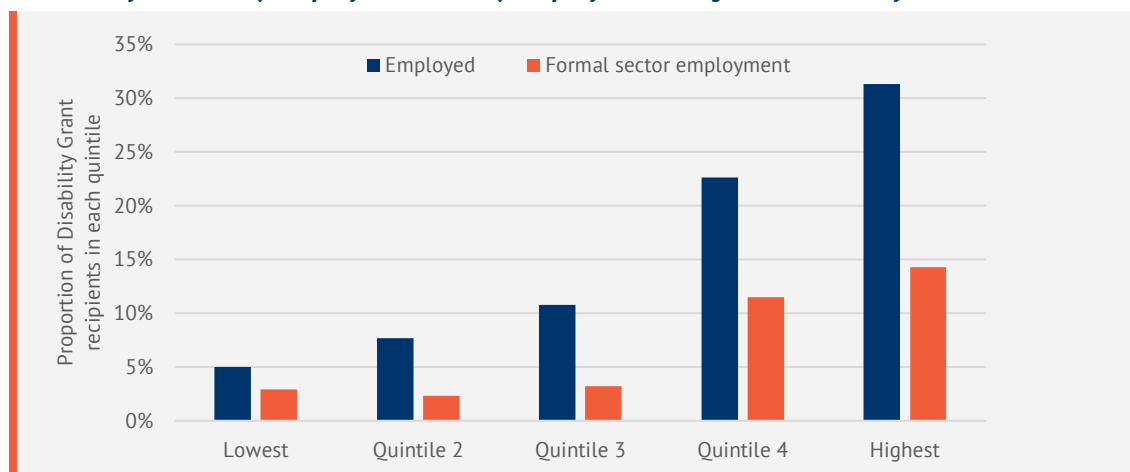
As Figure 12-1 shows, the vast majority of recipients of the Disability Grant are not in employment. Overall, only 10.3 per cent of Disability Grant recipients – with a moderate or severe disability – are in work (although this is defined as having spent at least one hour in the previous 7 days in employment). However, only 4 per cent were in formal sector employment although, among those receiving a permanent Disability Grant, the proportion was 2.8 per cent. A recent report that has analysed SASSA data has shown that 96 per cent of beneficiaries are not involved in economic activities, only 2 per cent are involved in self-employed business activities, and only 8 per cent would have liked to have worked during the week prior to enumeration.<sup>158</sup>

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<sup>157</sup> See Kelly (2016a) for further information

<sup>158</sup> Department of Sociology and Social Anthropology (2014)

**Figure 12-1: Proportion of recipients of the Disability Grant in each consumption quintile who stated they were in 1) employment and 2) employed in the formal economy<sup>159</sup>**



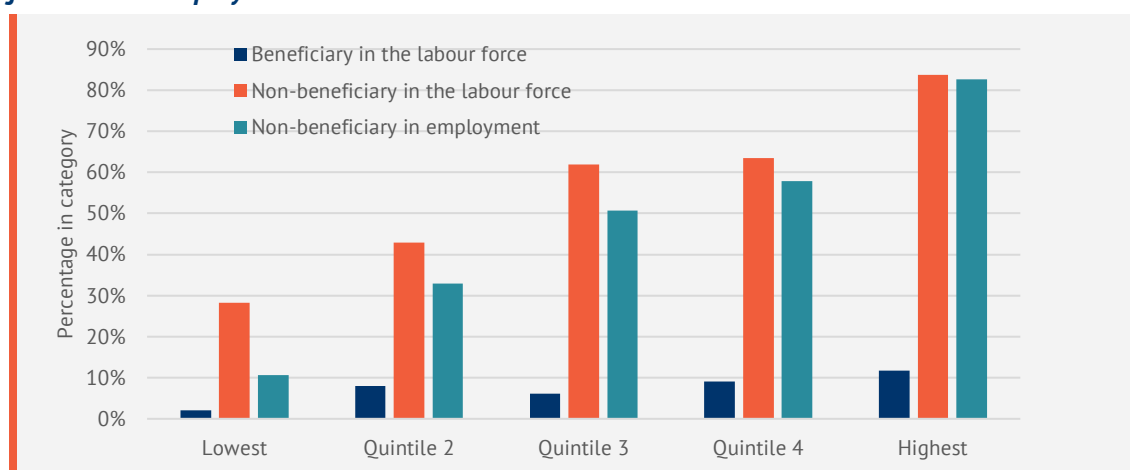
It is difficult to know whether the ‘unfit to work’ criteria for the Disability Benefit does, in fact, act as a deterrent to employment. Nonetheless, when a comparison is made between recipients and non-recipients of the Disability Grant who have a severe functional limitation and are aged between 18 and 59 years, around 4.2 per cent of recipients were in employment compared to 44 per cent of non-recipients (while 33 per cent of non-recipients are in formal sector employment).

Figure 12-1 indicates the differences across consumption quintiles among those with severe disabilities, showing low labour market engagement of recipients across all consumption quintiles, while many more non-recipients are in employment, in particular in the most affluent three quintiles.

<sup>159</sup> Caution should be exercised on formal sector employment figures, as there were less than 50 beneficiaries of the Disability Grant in formal sector employment in each consumption quintile. In addition, there were less than 50 beneficiaries in the richest quintile in any form of employment.



**Figure 12-1: Proportion of recipients and non-recipients of the Disability Grant in the labour force and in employment<sup>160</sup>**



Mitra (2008) found that the Disability Grant may explain part of the decline in the employment of working age persons with disabilities that has happened in recent years. In a later survey, she also found that only 6.6 per cent of Disability Grant beneficiaries would be willing to accept a job, if offered one, which Mitra (2010) found surprising given that almost a third of beneficiaries were on a temporary benefit. However, she argued that the expansion of the Disability Grant may not have actually reduced the labour supply since it effectively absorbed those who were already out of the labour force. Furthermore, there is qualitative research showing that individuals do not seem to change their attitudes to work due to the Disability Grant.<sup>161</sup>

However, perhaps the bigger policy question is why disability benefits are not used to support people to enter and remain in employment. Given that persons with disabilities face significant additional costs compared to the non-disabled, which makes it more challenging to access employment, a case could be made for offering a grant that increases their capacity to find and stay in work. The current conflation of severe disability and incapacity is not helpful - and creates a negative impression of persons with disabilities - since many persons with severe disabilities are very capable of working. This would require a re-design of the disability grant system, potentially introducing two grants: one that compensates people for the additional costs they face and is focused on creating equality of opportunity; and the other which is income replacement for those who are unable to work (in effect, a pension). Of course, the challenge remains that many persons with severe disabilities who are physically capable of work are unable to access

<sup>160</sup> Source: Secondary analysis of Statistics South Africa's General Household Survey (GHS) 2015 by Development Pathways. There was not a large enough sample to provide figures on the proportion of recipients with severe disabilities in employment.

<sup>161</sup> Noble et al (2008).

## *12 Perverse Incentives and the Disability Grant*

unemployment due to the prevailing high levels of unemployment, their lower skills and discrimination.

In fact, there are indications that the capacity to work criteria is not consistently applied. For example, the Ministry of Labour oversees nine Sheltered Accommodation Factories which provide employment to around 6-7,000 people with disabilities.<sup>162</sup> The wages are set at a level that means that workers can also pass the means test and access the Disability Grant.

Indeed, the use of both a means test and a 'fitness-for-work' test for the Disability Grant seems to be creating a double disincentive for persons with disability. At least one of them should be removed or, indeed, both. The continuation of these policies is almost certainly harming the economy by not incentivising persons with disabilities to engage in the labour force, a potentially massive loss of resources.

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<sup>162</sup> Source: Informant in the Ministry of Labour. The White Paper on the Rights of Persons with Disabilities states that employees in these enterprises receive the Disability Grant plus a "small, discretionary additional weekly payment for the work provider."

## 13 Links Between Social Security and Other Services for Persons with Disability

Government departments in South Africa work in siloes, so there are few linkages between services. For example, as noted earlier, the Department of Health (DoH) is not responsible for medical assessments but hands this responsibility over to SASSA. Of course, this reflects the inadequate investment in the national health system which means that the DoH is unable to effectively offer primary and curative health services to the majority of the population, never mind taking on additional services. Indeed, there are significant inequalities in health services: around 16 per cent of the population make use of 84 per cent of health services, so around 15 per cent of the resources serve over 80 per cent of the population.<sup>163</sup> In recent years, the DoH has recruited additional specialists that could serve persons with disabilities but the numbers are still small for a country the size of South Africa.

**Table 13-1: Increase in numbers of selected professionals in the Department of Health<sup>164</sup>**

Profession	2009 <sup>165</sup>	2016
Occupational Therapists	675	1251
Optometrists	50	2545
Physiotherapists	790	1600
Psychologists	406	774

Persons with disabilities are regarded as a separate group from the rest of the population, with some responsibilities delegated to the Department of Social Development (DSD) rather than being effectively mainstreamed across government. For example, DSD is responsible for distributing assistive devices rather than this being the responsibility of the DoH.

The Government of South Africa offers tax rebates on medical expenses to taxpayers with disabilities or with disabled dependants. These include: attendant-care expenses; travel and other related expenses; the acquisition and maintenance of assistive devices; service animals; and, alterations to assets.<sup>166</sup> One challenge with this system is that it is linked to the tax bracket of the individual rather than being an equitable rebate on the actual

<sup>163</sup> Information provided by Black Sash.

<sup>164</sup> Source: informant in the Ministry of Finance.

<sup>165</sup> The informant stated that the numbers were from 6 or 7 years ago.

<sup>166</sup> Department of Social Development, South Africa (2015).

expense. Furthermore, it is a subsidy that is more likely to help those who are better-off and does not reach the vast majority of those receiving the Disability Grant.

Social workers should play a critical role in enabling particularly vulnerable persons with disability to access services, including social security transfers. In 2014, there were 14,500 government social workers while 2,907 were employed by NGOs.<sup>167</sup> The ratio of state social workers to the population is 1:3,800, which compares favourably to many other developing countries, as well as the recommended ratio reported by the Ministry of Finance of 1:5,000 for developed countries.<sup>168</sup> In recent years, there has been a significant push to train more social workers, to the extent that many graduates cannot find work in the profession. However, South Africa is a traumatised society with high levels of poverty and the social work system is overburdened. So, even though the DSD social work department and SASSA often share the same office premises, there are indications that social workers are unable to effectively fulfil their role of linking vulnerable people and families to a range of services, including social security. As a result, many opportunities to build links between social security and other services are lost.

Social care services are weakening, which is impacting on persons with disabilities. In Gauteng, recently, around 2,000 people were released into the community from residential accommodation offered by NGOs, due to cuts in government subsidies. As a result, 37 died. If people are to be supported in the community, the resources must be there to help them and institutional care should remain an option.

The South African government has a range of initiatives to encourage persons with disabilities to enter the labour force, including an Employment Equity Act which was passed in 1997. Initiatives such as Extended Public Works seek to enable persons with disabilities to access work opportunities. There are also equity targets for the public and private sectors. However, according to the White Paper on the Rights of Persons with Disabilities, the Employment Equity Act has not resulted in a significant improvement in the employment status of persons with disabilities. The equity targets are below the disability prevalence rates and much affirmative action benefits those who are white and male, who do not require significant support. Persons with psychosocial, mental, intellectual and hearing disabilities are less likely to access affirmative action. Indeed, the Mental Health Association argues that people with mental disabilities are often discriminated against in accessing affirmative action work opportunities. Furthermore, as noted above, the 'fitness-for-work' assessment for the Disability Grant works against the other government strategies for encouraging persons with disability to access work.

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<sup>167</sup> Source: sheet of report provided by Ministry of Finance.

<sup>168</sup> Source: Global Social Service Workforce Alliance (2015)

## 14 Conclusion

South Africa is one of the few low- and middle-income countries that has established a lifecycle system of social security transfers for persons with disabilities, potentially enabling support to be accessed by persons with disabilities at any time of their lives. Children and their carers can benefit from a Care Dependency Grant, working age adults a Disability Grant, older persons with disabilities are able to access an old age pension, while there is a small additional support grant for carers. These benefits are within a broader system of social security transfers which is among one of the most generous across middle-income countries. Overall, the social security system has a major positive impact on the lives of persons with disabilities in South Africa.

Nonetheless, there are still a range of challenges to address if the effectiveness of the social security system in supporting persons with disabilities is to be enhanced. Key issues include: many persons with severe functional limitations face challenges in accessing benefits; children on the Care Dependency Grant are prohibited from accessing the Child Support Grant; the Disability Grant discourages people from working; and the registration process for the disability benefits is complex and exclusionary while the costs of applying are not compensated, despite many people incurring high expenditures.

There is a range of improvements to the system that the South Africa Social Security Agency (SASSA) could consider implementing:

### **To improve the disability classification process:**

- Establish an initial screening process to identify those that clearly do not fit the criteria for the disability specific grants, to reduce the pressure on the main assessment. Additional resources and time could then be invested in the core assessment process for those that have an impairment, in particularly those that are more severe or more difficult to identify.
- Consider allowing private medical officers who are already treating persons with disabilities to undertake assessments, but under the quality control of the Department of Health (DoH) and/or SASSA.
- Similarly, accept the recommendations of specialists working in hospitals or other specialised facilities, in particular if they work for the DoH.
- Ensure that medical records are available for assessments by medical officers, following the example of Western Cape.

## 14 Conclusion

- Train medical officers to be specialists in assessments and bring in a range of expertise to undertake assessments, not only generalist medical officers.
- Ensure translation services are available in medical assessments – and the broader application process for grants – including sign language.
- Develop a referral process to the medical system, following a disability assessment.
- Recognise that the disability classification process will only improve if sufficient funding is allocated, so that higher fees can be paid to assessors, more time can be spent on assessments, specialised tests can be undertaken, etc. This may also enable a social assessment to be re-integrated into the disability classification process.

### **To improve the application and registration process for the disability benefits, including the disability assessment:**

- Develop a communications strategy for the disability benefits – in particular the Care Dependency Grant – to make people aware of the grants, to increase applications from those eligible but not yet applying, but also to clarify the actual criteria for the Disability Grants, to reduce applications from those with a chronic illness but without an impairment. Communications should be tailored to the requirements of persons with disabilities.
- Develop a strategy to streamline application processes to speed it up and reduce costs to the applicants.
- Offer support to persons with disabilities who find it challenging to access application points.
- Cover the costs of those applying who are successful or pay an additional monthly benefit to cover the costs.
- Backdate payments of the disability benefits to the initial application date, prior to the disability assessment being undertaken.
- Continue to improve accessibility to SASSA offices and undertake an accessibility audit.

### **To improve monitoring and evaluation so that it is more disability sensitive:**

- Within the GHS and other household surveys, ensure adequate samples of recipients of all grants, including the Care Dependency Grant, so that the incidence of access by different categories of the population can be more accurately assessed.

## 14 Conclusion

- Develop a panel survey with both the Washington Group set of Questions and questions on social grants to monitor changes over time.
- Modify SOCPEN so that it is able to record functional limitation or disability classification and include data on disability in SASSA's regular monitoring reports.
- Social accountability mechanisms should be enhanced to focus on disability. The Human Rights Commission should consider whether to investigate the barriers experienced by persons with disabilities.
- State monitoring agencies should pay greater attention to the challenges faced by persons with disabilities.

### **To improve the design of the social security system:**

- Consider introducing two grants for disabled adults: one that offers income replacement and another that compensates people for their disability related costs and which is not linked to employment.
- Alternatively, remove the work capacity element of the Disability Grant, so as not to discourage persons with disabilities from working.
- Introduce a temporary Care Dependency Grant.
- Clarify the criteria and purpose of the Care Dependency Grant: is it meant to compensate caregivers for lost income, or to cover the additional costs of disability of the child?
- Children accessing the Care Dependency Grant should also be able to access the Child Support Grant, as a basic human right.
- Consider introducing a Personal Support Grant for persons who have had to give up work to care for disabled relatives.
- Remove the means test from the Disability Grant, since all disabled persons face additional costs and virtually everyone qualifies anyway.
- Adjust the means test for mainstream grants when the applicant is disabled, to recognise the additional disability-related costs that they experience, so as to place them on a level playing field.
- Rethink the criteria around residential care and access to disability grants, to be more flexible and respond to the real needs of people.
- For all grants, develop communications tools that are adapted for persons with disabilities.

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## Annex 1: Disability Data Collection in South Africa

South Africa has been collecting census data on disability since 1996 (1996, 2001, 2011 censuses) but unfortunately it is not possible to make direct comparisons over time due to differences in the definitions used and methods adopted for enumeration.<sup>169</sup> In fact, a significant drop in prevalence rates between the 1996 and 2001 censuses was put down largely to a change in the way the introductory paragraph to the disability question was worded. So, prevalence dropped from 6.5 per cent in 1996, to 5 per cent in 2001, even despite adding more details to the possible response categories, as a result of the introduction being changed (Table A 1). Investigations revealed that disabled people had a tendency to respond ‘no’ to the question, on the basis that they were participating fully in life activities.

**Table A 1: Evolution of South Africa’s census questions on disability<sup>170</sup>**

1996 census	
Question	Response categories
Does this person have a serious sight, hearing, physical or mental disability?	1 = Sight (serious eye defects) 2 = Hearing/speech 3 = Physical disability (e.g. paralysis) 4 = Mental disability 5 = No disabilities
(If ‘Yes’) Circle all the applicable disabilities for this person.	
Question	Response categories
Does (the person) have any serious disability that prevents his/her full participation in life activities (such as education, work, social life)?	0 = None 1 = Sight (blind/severe visual limitation) 2 = Hearing (deaf, profoundly hard of hearing) 3 = Communication (speech impairment) 4 = Physical disability (needs wheelchair, crutches or prosthesis; limb, hand usage limitations) 5 = Intellectual (serious difficulties in learning) 6 = Emotional (behavioural, psychological)
Mark any that apply.	
Question	Response categories
Does (name) have difficulty in the following: A = Seeing even when using eyeglasses? B = Hearing even when using a hearing aid? C = Communicating in his/her language (i.e. understanding others or being understood by others)? D = Walking or climbing stairs? E = Remembering or concentrating? F = With self-care such as washing all over, dressing or feeding?	1 = No difficulty 2 = Some difficulty 3 = A lot of difficulty 4 = Cannot do at all 5 = Do not know 6 = Cannot yet be determined  <i>Write the appropriate code in the box</i>

<sup>169</sup> Census 2011: Profile of Persons with Disabilities in South Africa. Statistics South Africa

<sup>170</sup> Source: Census 2011. Statistics South Africa.

As shown in Figure 3-1, by the time of the 2011 census Statistics South Africa had chosen to base their question on the Washington Group Short Set of Questions (WG) which had already been adopted for use in General Household Surveys (GHS) from 2009.<sup>171</sup> Thorough testing revealed that the use of the WG questions led to higher estimates particularly as a result of replacing of the word 'disability' with 'difficulty' which was regarded as being more acceptable to people who did not self-identify as disabled. Further, the use of levels of difficulty from 'none' through to 'cannot do at all' helped provide for gradations in experiences therefore avoiding the issue of forcing people to provide a simple 'yes / no' response.<sup>172</sup>

To derive data on functional limitations and disability prevalence in the 2011 census two sets of measures were used for the analysis. Firstly, a broad measure analysis was applied to determine levels of difficulty in which 'no difficulty' was categorised as 'none'; 'some difficulty' as 'mild difficulty'; and 'a lot of difficulty' and 'cannot do at all' as 'severe difficulty'. This was applied to a range of demographic and socio-economic variables to identify patterns amongst people with different needs. A second measure was then applied to determine the overall disability rate (disability status index). Here a person would be categorised as being disabled if they expressed having some difficulty in two or more functional domains, or a lot of difficulty, or unable to do, in one domain.

The main problem with the 2011 census has been its inability to collect data on children below the age of 5 years because the WG short set cannot measure functionality in young children. In fact, it is not recommended for use in children below the age of 4 years so that data for the 2011 census on children at age 5 years is highly unreliable. Further there are still issues around potential under-reporting of people with cognitive and psycho-social impairments because of a lack of sensitivity within the WG questions and the fact that answers are provided on a household basis rather than in direct consultation with each member.

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<sup>171</sup> In general, the 2011 census shows slightly higher estimates in all six functional domains as compared with the 2011 GHS.

<sup>172</sup> Census 2011: Profile of Persons with Disabilities in South Africa. Statistics South Africa.