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Regulating access to the disability grant in South Africa, 1990-2013

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Regulating access to the disability grant in South Africa, 1990-2013

Abstract

Disability is a universally difficult concept to define and assess for social assistance and social insurance purposes and these benefits have proven difficult to administer internationally because of ambiguities present in the process of determining the employability of people with physical impairments. In post-apartheid South Africa, disability grants (DGs) have proved especially difficult to regulate because of the added complexities of high levels of structural unemployment and poverty, an HIV epidemic and a social security system which does not cater adequately for all groups in need of support. The paper identifies three periods in the state's attempts to improve DG administration through legislative and regulatory measures since 1990: 1) a period of extending access and overcoming administrative barriers, supported by a socio-economic rights discourse; 2) a period of growth and generous access, resulting in growing concern about over-generosity and fiscal sustainability; 3) a period of action or 'rationalisation' in which the state places new limits on access to the grants, leading to decline in the number of social grant recipients. Common to all three periods are numerous and ongoing problems in the disability assessment process. These exist because disability is a complex, multi-dimensional concept, which is difficult and expensive to properly assess, especially in a context of high demand and significant resource limitations within the healthcare system.

Introduction

Over the past 10 years the South African disability grant has received significant attention in academic, civil society, media and government circles, largely because it has raised major questions about social development and poverty alleviation strategies that extend well beyond concerns about disability. The administration of the grant has also raised serious questions about who should be considered disabled and the purpose of social security in the context of chronic illness (Macgregor, 2010). This paper sets out to examine the development of disability grant (DG) policy and regulations in post-apartheid South Africa and in doing so, explore understandings of disability, as well as how the rights of the sick and disabled to social security have been negotiated and decided by policymakers and legislators in government.

The South African disability grant is a non-contributory, means-tested cash transfer of R1290 (as of October 2013), available on a permanent or temporary basis to people deemed unfit to work as a result of functional impairment and who do not have sufficient other means of support. As of July 2013, the South African Social Security Agency (SASSA) awards the DG to 1.14 million people – or approximately 3.4 percent of the working age population.[1] SASSA also administers two other disability-related grants, the Grant-in-Aid and Care Dependency Grant, paid to caregivers of disabled adults or children who are in need of permanent care but this paper will focus exclusively on the DG. South Africa is unusual amongst developing countries for having such an established and generous disability grant program (Gooding & Marriot, 2009). Social assistance targeted specifically at disabled people is more common in developed welfare states, where lower levels of unemployment and absolute poverty are present, and where typically these programmes are supported by social assistance for the chronically ill and better social insurance coverage. The South African DG exists in quite a different space and high unemployment, together with an HIV epidemic, has complicated targeting and regulation of the grant.

Hansen & Sait (2012) argue that the process of conceptualising disability in South Africa can be divided into two distinct phases: a period of reconciliation (1994 - 2001) when discrimination and subjective experiences of disabled people came into play and the focus was ‘extending grants to those in need rather than to ask the question of *who* was in need’ (2012: 96). The second phase (2001 onwards) represents a period of controlling access to the grant when the discourse of dependency was invoked along with a narrower biomedical conception of disability and a focus on *who* is disabled. However, this analysis overlooks the fact that in 2001 disability assessment was in fact adapted to incorporate a more social understanding of disability. This led to an unprecedented growth in DG beneficiaries until 2004, where a narrower, strictly biomedical model of disability was reintroduced.

This paper therefore argues that there have in fact been three phases to how disability grants have been managed by the state. The first phase represents a period of extending access and overcoming administrative barriers, supported by a ‘rights’ and administrative justice discourse. This was followed by a period of growth and generous access (2001 – 2007), resulting in growing concern about over-generosity and fiscal sustainability. This culminated in a set of actions by

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[1] According to the 2011 Census, 33.2 million people are of working age (between 16 and 35)

the state that places new limits on access to the grants and a period of decline in the number of social grant recipients from 2007 onwards.

The disability grant system at the end of apartheid

Grant uptake and welfare spending

Cash transfers targeted specifically at people with disabilities have a relatively long history in South Africa and social assistance for disabled people was first introduced through the Blind Persons Act (Act 11 of 1936) and the Invalidity Pension Scheme, which the Department of Welfare offered to white South Africans from 1937 onwards.[2] The Disability Grants Act (Act 36 of 1946) formalised this scheme in the form of a disability grant made available to white, coloured, Indian and black people. The applications of both of these Acts and their later iterations were complex and the means test criteria and amounts paid to the defined racial groups varied enormously. In 1946 disabled white people were offered 60 pounds a year whilst black people, who received substantially less than all of the other groups were offered only 12 pounds a year (Disability Grants Act 36 of 1946). White applicants became eligible for the grant if their disability was expected to last 6 months or more but DGs were only awarded to black applicants if the disability was certified for a period of 12 months or more (Baron, 1992).

From the 1970s onwards, racial differences in the value of benefits were reduced as the real value of pensions for black people rose whilst they fell for the white population. The difference between white and African disability grants decreased from 7:1 (R28:R4) in 1965/6 to 1.2:1 (R354:R293) in 1992/1993 (Race Relations Survey 1991/1992 in Lawrence, 1992). By 1990 white people accounted for only 23 percent of welfare spending, whilst coloured and Indian people received 24 percent and black people 52 percent (Kruger, 1992; Terreblanche, 2003; Van der Walt, 2000 in Visser, 2004: 5). In 1991 the government made commitments to parity in terms of the Social Pensions Act 37 of 1973. Discrimination in benefit levels based on race was finally eliminated and equal benefits were extended to all South African citizens through the South African Social Assistance Act of 1992 and parity in disability grants and other benefits was reached in 1993 (Ardington and Lund, 1995).

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[2] This was never formally legislated.

Although social grants formed approximately 96 percent of the social welfare budget in 1990 (Lund, 1990), the system of grants and pensions was ‘organisational chaos’ (Matisonn and Seekings, 2003). In the final years of apartheid the social grants system was composed of 14 different departments serving different population groups and homeland bureaucracies (Department of Welfare, 1997a). Both Lund (1992, 1997) and Van der Berg (1997) warn of the gaps and inaccuracies of social grant data in the early 1990s.[3] As beneficiary data was held by the various welfare administrations rather than centrally and because data in the homeland was not computerised, few consolidated statistics on beneficiary numbers exist (Lund, 1992). Breaking down welfare spending according to grant type is also challenging as not all of the homeland or TBVC states differentiated between pensions and disability grant spending in their records.[4] As a result, much of the data over this period was based on estimates, especially data from the independent TBVC states. Lund (1992) analysed estimates of expenditure, auditor general reports, parliamentary debates and policy speeches and interviewed members of various government departments, finding significant discrepancies in the information on social grants provided by these sources. Table 1 below presents spending on disability grants in 1990 based on the best available data. No accurate data on the number of DG beneficiaries over this period appears to exist.[5]

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[3] An attempt has been made to note all discrepancies in disability grant data found during the course of writing this paper and, where possible, provide explanations for these differences. This information is presented in the footnotes and summarised in the appendix at the end of the paper.

[4] It is also difficult to compare disability grant figures because it is not always clear when the disability grant has been grouped together with other disability related grants available at the time (blind persons grant, leprosy grant and single-care grant).

[5] The only data on beneficiary numbers available is reported in the South African Institute for Race Relation survey, which cites a 1992 report from the Human Science Research Council. The report claimed that 803 000 people received the DG in 1990/1991 and that a total of 3.9 million people received social grants over this period, representing R4.43 billion of expenditure. Unfortunately no proper reference to this report was given and it cannot be located. However based on data from 1993 and 1994, which estimate the number of DG beneficiaries to be around 500 000, it appears that the beneficiary numbers reported by the HSRC are inflated.

Table 1 Amount spend on disability grant payments in Rand 1990

Tri-cameral	368 278 000
Provinces	197 824 000
Homelands	158 714 000
Independent States	102 876 000
Total	**827 692 000**

Source: Lund, 1992

Between 1991 and 1995, the welfare budget grew faster than any other government department (22.6% per annum) as a result of equalising benefits (Ardington and Lund, 1995). As a result, there was concern about the growing welfare 'burden' and social security reform was informed by a need to manage costs leading to a push to 'rationalise' the social grant system (Department of Welfare, 1994) and increase administrative efficiency.

In January 1992, the *New Social Welfare Dispensation for the Republic of South Africa* document outlined the development of a new welfare policy that would incorporate welfare policy under a number of umbrella Acts, increase the allocation of social welfare services from 1.6 to 3.2 percent of GDP and achieve full parity of social grants by 1 April 1996, which was generally rejected by welfare organisations. This led to the promulgation of the Social Assistance Act 59 of 1992.

The Social Assistance Act of 1992

The Social Assistance Act 59 of 1992 was passed in parliament in May 1992 and repealed the Social Pensions Act 37 of 1973, the War Veterans' Pensions Act of 1968, the Disability Grants Act 27 of 1968, the Social Aid (House of Assembly) Act 37 of 1989 and various welfare acts promulgated by the formerly independent homeland states. The Blind Persons Act 26 of 1968 was not repealed through this act or amended by later legislation and social assistance for blind people appears to have been incorporated under general disability in the Social Assistance Act of 1992. No legislation governed the administration of the leprosy grant and in 1992 only a tiny number of people were receiving the leprosy grant as the disease had almost completely disappeared in South Africa (Lund, 1992).[6].

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[6] There was less than 1 case of leprosy per 10,000 people, which the World Health Organisation considers elimination of the disease.

The Social Assistance Bill, which was initially proposed in February 1992, had faced widespread criticism from civil society and the ANC, which called for the withdrawal of the Bill because it removed the statutory right to grants by giving the Director-General discretion over payment through the Section 6(3) which read: ‘If the Director-General *is of the opinion* that the applicant is entitled to the social assistance applied for, he may authorize the rendering of the relevant social assistance’ (emphasis own). The Bill was however passed with Section 6(3) intact. Although the Department of National Health and Welfare responded that anyone who satisfied the prescribed conditions would be eligible, the concern remained that the insertion of this clause was intended to limit the payment of pensions and would reduce security for the elderly and people with disabilities (SAIRR, 1993; Ardington and Lund, 1995).[7]

Other than eliminating racial disparities and increasing the age of eligibility from 16 to 18, the 1992 Social Assistance Act changed little in the way that disability grants were managed or the disability assessment process. Discrimination within the system remained due to inefficiencies and inequities in service delivery.

Attempts by the post-apartheid government to extend access and overcome administrative barriers: 1994-2001

On coming to power, the new ANC government committed itself to building a social welfare system that promised ‘the attainment of basic social welfare rights for all South Africans, irrespective of race, colour, religion, gender and physical disability, through the establishment of a democratically-determined, just and effective social delivery system’ (Republic of South Africa, 1994: 2.13). However, the administrative complexities of the previous system and poor capacity for delivering social security services, especially in more rural areas, made this an extremely challenging task. In the case of the disability grant, existing administrative difficulties were compounded by the complicated nature of identifying and targeting beneficiaries who were particularly marginalised and were doubly discriminated against by the apartheid system in terms of both race and their disabilities (Nkeli, 1998).

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[7] The applicant for a social grant has no substantive right to receive a grant in terms of the SAA, but from 1996 had the right of access to social assistance in terms of s 27(1)(c) of the 1996 Constitution (de Villiers, 2002: 322).

The apartheid government was notoriously secretive and its systems extremely complex and over-bureaucratised and at the end of apartheid little was known about the social policy in South Africa and no intensive studies on the social security system or policies existed (Lund, 1997). Given this massive learning curve, policy makers faced significant challenges in conceptualising a system for the new South Africa that was both just and affordable.

Difficulties in managing a messy system

When the ANC government took power in 1994, poverty and inequality were massive problems and 52 percent of the population accounted for less than 10 percent of total income, whilst 6 percent of the population captured 40 percent of income (Taylor Committee, 2002). However, despite this prolific poverty, grants were awarded to only 2.4 million out of a population of 40 million people (Seekings and Matisonn, 2010).[8] The new government therefore faced the daunting task of both consolidating and extending the complex and discriminatory administrative structures inherited from the previous regime. The existing social security system it inherited was fragmented, inequitable and administratively inefficient and was designed to serve a minority of the population.

Given low levels of unemployment in the white population, the system was focused on providing unemployment insurance to white people working in the formal labour market, with social assistance only forming a residual ‘safety net’ function for specifically targeted categories of people considered vulnerable to poverty, namely disabled people, children and the elderly (Liebenberg, 2007 in Brockerhoff, 2010: 8). This design did not take into account the large numbers of previously excluded poor and unemployed black people (Woolard *et al.*, 2010). Service delivery structures of the social welfare system were based on the British and American models, which were inappropriate to the South African political, economic and socio-cultural context (Patel, 1992: 46). However, budget constraints made re-imagining a new system fairly challenging. In the six years after apartheid a series of commissions were assembled to examine how to re-structure the existing system: the Chikane Committee for Restructuring Social Security (1996), the Lund Committee on Child and Family Support

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[8] This conflicts with other data the 1994 Annual Report of the Department of Welfare, which reported there were 3.6 million recipients and grants represented 86% of social welfare budget. Van Der Berg (1997) suggests there were 2 532 700 social grant beneficiaries in 1993. According to the South African Race Relations Survey, the Department of National Health and Population Development reported that there were a total of 2 634 218 grant beneficiaries in September 1993 and 2 768 077 in September 1994.

(1996), the Public Service Commission Investigation into Social Security Services (1998) and the Taylor Committee on Comprehensive Social Security for South Africa (2000[9]).

The draft White Paper for Social Welfare, published in 1995 and adopted by cabinet in 1997, outlines the creation of a developmental social welfare system in-line with the goals and strategies of the government's Reconstruction and Development Programme (RDP). The White Paper was aimed at guiding the consolidation of welfare policy. Apartheid legislation was largely developed in an ad hoc fashion, reflecting reactions to particular issues and the White Paper for Social Welfare attempts to set the tone for more comprehensive and consultative welfare policy: 'A comprehensive and integrated social security policy is needed to give effect to the Constitutional right to social security''(Department of Welfare, 1997a: 55).

The White Paper acknowledges that welfare services were underfunded and sought to increase welfare spending and the number of social grant beneficiaries over time, reintroducing promises of a universal social security system.

> 'There will be universal access to an integrated and sustainable social security system. Every South African should have a minimum income, sufficient to meet basic subsistence needs, and should not have to live below minimum acceptable standards. The social security system will also work intersectorally to alleviate poverty' (Department of Welfare, 1997a: 33).

Although there was clear recognition within government that government needed to extend access to social assistance, there was also a need to address the wasteful expenditure caused by the inefficiencies and confusion within the highly disjointed existing system. To this end, in 1995 the Department of Welfare began a project to amalgamate and clean up social grant records of the 14 different systems into one national database. In 1997 the Cabinet instructed the Department of Welfare to undertake a national re-registration drive intended to reduce fraud and discrepancies in the system and a national social security system was phased in from 1 April 1998. The clean-up process included removing deceased beneficiaries (ghost beneficiaries) and duplicates from the system as well as Temporary Disability Grants (TDGs) that had not been cancelled. Prior to 1998, disability pensions could only be terminated after an annual medical review and if the person concerned was less than 100 percent

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[9] The commission was assembled in 2000 but the findings of the report were only published in 2002.

disabled. In 1998, amendments to the Regulations of the Social Assistance Act 59 of 1992 provided for the automatic lapsing of temporary disability grants granted before 1998.

Between July 1997 and February 1998, 60 000 ghost beneficiaries were removed from the system and 45 000 TDGs were suspended. As a result of these efforts, between August 1997 and August 1998 there was a 17.8 percent decrease in the number of DG beneficiaries (Department of Finance, 1998 in Bredenkamp, 2001) and from 1997 to 1999 the number of disability grant recipients dropped from 732 322 to 631 372. Although the clean-up process resulted in significant savings for the Department of Welfare, administrative problems in carrying out the re-registration -- poor communication about the process as well as the lack of identity documents of many beneficiaries -- caused massive financial stress for those whose grants were suspended or cancelled, especially in rural areas.

The blanket cancellations of temporary disability grants and the grants of ‘suspect’ beneficiaries without notice over this period resulted in litigation by beneficiaries in which judgment was given in favour of the applicants (Olivier and Mpedi, 2009).[10]

Poor coverage of the population eligible for the disability grant

Although the efforts to improve administration were effective in reducing the number of illegitimate beneficiaries in the system, in 2001 the Director of Social Grants in the Department of Social Welfare acknowledged that the number of social grant beneficiaries was only a small fraction of the total number of eligible individuals (Makiwane, 11 September 2001). There were also additional barriers to access specific to the administration of the disability grant that needed to be addressed. This is recognised in the post-apartheid government’s initial proposals for managing disability and social security issues in South Africa - the Integrated Disability Strategy White Paper (1997) and the White Paper on Social Welfare (1997):

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[10] These cases included: Bushula and others v Permanent Secretary, Department of Welfare, Eastern Cape and another 2000 (2) SA 849 (E) (van Rensburg J); Rangani v Superintendent-General, Department of Health and Welfare, Northern Province 1999 (4) SA 385 (T) (Kirk-Cohen J); Bacela v MEC for Welfare (Eastern Cape Provincial Government) 1998 1 All SA 525 (E); Mpofu v MEC Welfare and Population Development, Gauteng and Another JD 0833 (W), (Mpofu).

> ‘People who receive social security benefits in South Africa tend to be totally dependent on them for their survival. The majority of people with disabilities, however, receive no grant at all.’ (Office of the Deputy President, 1997)
>
> ‘The present social security legislative framework, its administration and allocation systems, tend to be discriminatory, punitive, insensitive to the specific needs of people with disabilities, uncoordinated, inadequate and riddled with high levels of fraud’ (Office of the Deputy President, 1997).

In 1993 only 593 162 people, or 1.6 percent of the total population and 30 percent of the people with disabilities received the disability grant (Office of the Deputy President, 1997; SAIRR, 1995).[11] Although not all disabled people would necessarily be eligible for the grant, it is likely that uptake of the grant was low relative to the number of disabled persons living in poverty, largely because of punitive means testing and medical assessment processes (Department of Welfare, 1997a).

Coverage of black South Africans with disabilities was relatively low compared to coloured and Indian people, despite a higher prevalence of disability and high likelihood of unemployment within this group (see Table 2 below). This is likely because of discriminatory practices during apartheid as well as spatial discrimination because of lower literacy levels and poor access to welfare services within rural areas.

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[11] Data from Van Der Berg (1997) suggests that only 499 200 received the grant in 1993. This data was sourced from the Department of National Department Population Development. However, according to the SAIRR Race Relations Survey of 1995, in September 1993 the Department of National Health and Population Development reported that there were a total of 548 224 DG beneficiaries and a total of 2 634 218 grant beneficiaries overall and 593 162 in September 1994 and 2 768 077 total beneficiaries. Please see appendix for further notes.

Table 2 Disability grant coverage by population group

Population group	Number of DG recipients per 1000 people in population (1997)	% Disability in population (1999)	% of disabled people employed full-time (1999)
White	8	5.7%	19%
Indian	23	4.7%	9%
Coloured	31	4.5%	4%
Black	12	6.1%	6%

Source: Van Der Berg, 1997 and Schneider *et al.*, 1999 in Bredenkamp, 2001.

Problems of accessibility

The social grant system in the early 1990s was both inaccessible and 'ironically over-administered' (Lund, 1997: 9). In 1997 the Community Agency for Social Enquiry (CASE) was commissioned by the Department of Welfare to research social security policy options for people with disabilities. As part of this work CASE convened a task team that included representatives from the disability sector[12] and the Department of Welfare. The report (Schneider and Marshall, 1998) was entirely qualitative and primary data collection, conducted in the Eastern Cape, Gauteng, Western Cape and KwaZulu-Natal, included focus groups and life story narratives developed through interviews. The research explored the experiences of disabled people and the parents of disabled children in accessing the Disability Grant and Care Dependency Grant, how the grants are used, as well as the assessment process itself. The report found that administrative inefficiencies presented a serious barrier to accessing the grant. Beneficiaries reported that the application process was frustrating and complex and that the success of an application frequently depended on being lucky enough to find a sympathetic official (Schneider and Marshall, 1998: 44). In focus groups run with healthcare professionals responsible for assessing grants for private insurance companies and the DG, assessors pointed out the challenges disabled people face in navigating the application process:

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[12] This included representatives from Disabled Persons South Africa, Rural Development and Disability Helpline, Disabled Children Action Group, National Council for Persons with Physical Disabilities in SA, Office of the Status of Disabled People, Black Sash and South African Federal Council on Disability

> ‘We’ve joked in the past at our hospital that if you can actually get through the whole system, get to all the places and see all the people, you probably aren’t disabled enough to qualify.’ (Medical assessor in Schneider and Marshall, 1998: 50)

Black Sash, which provided paralegal advice on social security issues, reported that Disability grant enquiries constituted 60 percent of the advice given by their paralegals (Black Sash, 2000a). This was likely a result of high demand for the grant, challenges faced by those seeking access to the grant and the suspension of disability grants without notice.

At the time all disability grant forms were filled out by Medical Officers (MOs) and assessed by Pension Medical Officers (PMOs), who were employed by the state to oversee the administration of disability grants from a medical perspective. This practice was criticised for creating significant backlogs (Baron, 1992) and for allowing PMOs to make important decisions affecting patient welfare without actually examining patients (Simchowitz, 2004). The massive shortage of medical doctors available to perform assessments in rural areas also lead to significant assessment backlogs in some provinces. The Department of Welfare estimated that in 2000 there was a backlog of 86,951 grants across the country (see Table 3 below). The Eastern Cape and Northern Province faced the largest backlogs.

Table 3 Backlogs per province as of May 2000

KwaZulu-Natal	10000
Eastern Cape	30000
Mpumalanga	6000
Gauteng	2951
Northern Cape	400
Western Cape	500
North West	7000
Northern Province	30000
Free State	100
Total	86951

Source: Department of Welfare, 2000a

Based on the policy that no one should wait longer than three months for a grant, payment of arrears was restricted to three months regardless of how long an applicant waited to receive their grant (South African Federation for Mental Health, 1999; Black Sash, 2000a). Although this policy was meant to incentivise administrators to speed up the application process, given the backlogs discussed, delays in administering grants were common and another study by CASE found that only 27 percent of DG applicants received their grants within the stipulated three months (Schneider *et al.*, 1999).

Physical access and transport to welfare offices for applications and collection of payments was often challenging and expensive for disabled or very ill people who had mobility issues and for whom the costs of transport or the time spent in long queues proved physically difficult. People who had moved from their hometowns had to travel back to these towns to collect their grant money (Schneider and Marshall, 1998).

Temporary disability grant applicants were often not told that their grants were temporary and their records were often deleted completely from the system without notice, forcing recipients to apply and wait without support for several months whilst their new applications were processed from scratch. The right to appeal grant refusals or cancellations was poorly understood by many applicants and beneficiaries. The appeals system itself was also deeply faulty and inconsistent and significant backlogs existed in the appeals process (de Villiers, 2006).

Inefficiencies and inequities in grant administration such as those discussed above undermined the constitutional requirement of lawful and reasonable administrative action outlined in Section 33 of the Bill of Rights in the Constitution of the Republic of South Africa Act 108 of 1996 and the Promotion of Administrative Justice Act 3 of 2000 that expanded on this right. This lead to litigation by the Legal Resource Centre and the Black Sash against the Department of Social Development on behalf of applicants and beneficiaries facing delays and cancellations (Black Sash, 2000b; Makiwane, Social Development Portfolio Committee, 21 June 2000; Department of Welfare, 2000a).[13] One of the most prominent cases over this time was the class action brought forward by the Legal Resources Centre on behalf of Ngxuza and two other defendants as well, as 37,000 other temporary grant beneficiaries in the Eastern Cape, who had their disability grants suspended or cancelled without

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[13] This included *Department of Welfare, Eastern Cape v Ngxuza and others 2001 (4) SA 1184 (SCA)* discussed on page 9 as well as *Mashishi and others v the Minister of Social Development and others*, unreported Transvaal Provincial Division case number (4239/03) 2003. *Mbanga v MEC for Welfare (2001) 8 BCLR 821 (SE)* and *Nomala v Permanent Secretary, Department of Welfare (2001) 8 BCLR 844 (E)* (the State-provided social assistance grant must be made within a reasonable time of application). The Department of Social Welfare (2000a) reported that litigation against the department at the time included a class action of approximately 30 000 cases in the Eastern Cape (Ngxuza) and another 150 cases in the Gauteng.

proper procedure or notice (Department of Welfare, Eastern Cape v Ngxuza and others 2001 (4) SA 1184 (SCA)).

Problems in DG Assessment

The disability grant assessment process has been the most problematic and contentious aspect of regulating access to the DG. In the 1990s difficulties in the assessment process included: the lack of a proper definition of disability for social assistance purposes; a lack of standardised assessment tools; inconsistent and subjective application of assessment tools; the medical focus of the assessment process, which did not take social or environmental factors into account; and a shortage of medical doctors to perform assessments, especially in rural areas.

Lack of definition

Disability is a complex, multidimensional concept and it has been difficult to create a universally encompassing definition of disability, which has led to confusion and misuse of disability terms (Altman, 2001).

It is not easy to make binary distinctions between disabled and non-disabled people and there are a variety of different definitions, models and tools for understanding and measuring disability, which are used for very different purposes, from allocating rights to social security benefits to public health planning. Various models of disability have existed over time, including the individual or medical model, the charity model, the social model, the administrative model and the human rights model.

The two dominant models of disability, the medical and the social model, exist as dichotomous concepts and significant debate exists within the disability studies literature around how disability and related ideas about impairment should be conceptualised. In the medical or individual model of disability, or what Oliver (1990) calls ‘personal tragedy theory’, disability is seen as directly related to the functional limitations of the individual or physical handicap - a personal tragedy in a society of normal people (Ross and Deverell, 2010; Priestly, 2006). The individual/medical model typically categorises people according to labels such as deaf, blind and crippled. As a result of this labelling, the individual and his or her social identity become conflated with their medical condition. The social model of disability, promoted by disability rights activists, considers disability to be a social issue that stems from the characteristics of a disabling society such as discrimination, prejudice and inadequate services and infrastructure rather than from a function of physical impairment (Gathiram, 2008). As a result, 'disability ceases to be something that a person *has,* and becomes instead something that is done to a person' (Swain *et al.*, 2003: 23) and is considered a form of social oppression (Oliver, 1990). South Africa's White Paper on an Integrated National Disability Strategy (1997) supported the social model of disability and advocated for this approach to be incorporated into government policy across all sectors. The White Paper therefore criticised disability assessment practices in place at the time for being exclusively medically tested and not taking the social aspects of disability in actually determining ability to work.

Although Section 9 of the Social Assistance Act of 1992 outlined the criteria for eligibility for disability grants, there was no clear definition of what classified as 'physical or mental disability':

> '9. A person is, subject to section 5, eligible for a disability grant, if he or she-
> (a) has attained the prescribed age; and
> (b) is owing to a physical or mental disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him or her to provide for his or her maintenance.'

In fact, since the introduction of disability grants in 1946, the concept of *disability* had never actually been formally defined in any of the social assistance legislation and related regulations. Although the definition of disability was vague, the Act required that an applicant's disability be confirmed by a medical report, meaning that the assessment of disability was heavily biased towards medical diagnosis and the medical model of disability.

> 'The assessment is clearly done in the medical framework and does not consider the socio-economic impact of disability. The functional assessment is limited to physiological inabilities and does not extend to environmental factors and barriers to community participation' (Guthrie and Sait, 2001: 93).

In the 1990s a person was eligible for a grant if the degree of their disability was certified as greater than 50 percent on an open labour market (Brown, 1990: 31; Guthrie and Sait, 2001). The assumption that there is a norm of physiological function and that deviations from this norm can be measured in terms of a percentage of disability does not take into account social and economic factors that may act as barriers to people's ability to participate in productive work (Schneider and Marshall, 1998; Kimani, 1999). Whilst the Workmen's

Compensation Act 30 of 1941 and the Compensation for Industrial Injuries and Diseases Act 130 of 1993 that later replaced it provide a 'meat chart'[14] to categorise the degree of anatomic loss in workplace injuries, no such guidelines existed in the case of the DG (Lund, 1997). This meant that the judgement of what constituted 50 percent disablement was left to the discretion of medical officers. A general assessment of 'fitness to work' also did not take into account whether an applicant was able to carry out the type of work they were specifically trained for (Bredenkamp, 2001: 198) and it was not clear to what extent medical officers could or should take highly variable economic factors into account in assessing disability (de Villiers, 2002). This very one-dimensional assessment also left no room for self-representation by people with disabilities in the application process (Guthrie and Sait, 2001).

In addition, the 1992 Act referred only to physical or mental disability, excluding people with sensory impairments, often causing administrative problems for deaf or sight-impaired applicants. There was also no clear definition of and delineation between temporary and permanent disability, meaning that these decisions were often made arbitrarily. The temporary classification was frequently misapplied by officials and doctors and used as a 'convenient half-grant' (de Villiers, 2006: 3) where they felt a permanent classification was not justified or where insufficient supporting evidence was supplied. There were also cases where people with temporary disabilities received permanent grants for conditions such as epilepsy, which are in theory manageable (Interview with SASSA Doctor, 2013).

In the 1990s, given the spectre of a growing HIV epidemic and the lack of widely available anti-retroviral therapy, the White Paper on Social Welfare (1997) predicted an increased demand for disability benefits and there was growing concern in government about the possible burden that AIDS-sick people would have on the DG system (Department of Welfare, 1997a). Although disability grants were not technically available to people with chronic illness, people who were functionally disabled by illness were eligible, making it difficult to establish at which point someone with a chronic illness such as HIV should receive a grant. In the absence of proper guidelines, doctors were offering the grant on a temporary or permanent basis to people of varying levels of health and disability, creating confusion amongst applicants about who was eligible for grants.

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[14] A meat chart assigns a value to each body part and assists in categorising the severity of an injury. For example, in the Workmen's Compensation Act of 1941, the loss of an eye would result in 20% impairment, whilst the loss of a leg was valued at 70%.

Inconsistencies in the medical assessment process

Given inadequate definitions and vague and unclear guidelines, state doctors struggled with conducting DG assessments (Baron, 1992; Segar, 1994; Schneider and Marshall, 1998). Most doctors are not adequately trained to determine impairment and functional capacity (Govender and Miiji, 2009: 229) and doctors are therefore more likely to assess disability in terms of the presence of a medical condition rather than actual limitations in activities of daily living (Interview with Margaret Schneider, 2013). Disability grants are also premised on the idea de Villiers (2002: 324) calls ‘economic disability’. Economic disability is a function of both medical disability and the relative availability of economic opportunities for persons with disabilities at any given time, a decision which medical doctors are not necessarily properly equipped to make.

Although a national grants system was created in 1998, provinces remained responsible for administering grants and implementing grant policy. Without national guidelines, provinces operated their own systems very differently and used different application and medical forms and guidelines for the disability grant application process (Black Sash, 2000a; de Villiers, 2002). In most of the provinces guidelines for assessing disability were inadequate or did not exist at all (Lund, 1997).[15] Without proper training, a clear definition of disability or clear universal guidelines for disability assessment, the system was subjective and arbitrary, resulting in confusion and inconsistency (Schneider and Marshall, 1998: 49; Swartz and Schneider, 2006; Welfare and Population Portfolio Committee Minutes, 10 November 1999; Department of Welfare, 2000b; 2000c). In a very small and non-representative study in the Cape Province, Baron (1992) presented one patient to 15 family practitioners and their assessments of his degree of disability ranged from 15-100 percent. In the same study all of the 20 doctors surveyed indicated that the DG assessment form was unclear and asked questions they were not able to answer (Baron, 1992).

Qualitative research conducted into the disability grant application process in the 1990s (Segar, 1994; Baron, 1992), as well as government documents and parliamentary discussions prior to 2000, all reveal concern about the pressure placed on doctors by the growing numbers of people seeking the DG. As already overworked medical officers were conducting assessments in addition to their regular workload, medical officers generally did not have time to properly consider each case and thus made rapid assessments (Schneider and Marshall, 1998; Kimani, 1999). This meant that those with more obvious disabilities were more likely to receive grants. Schneider *et al.* (1999) found that people using

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[15] This came under attack in *Msiza v Director of Social Security, North West Province Bophuthastswana HC 702/2001*

assistive devices were significantly more likely to receive a DG than to not receive one. Given that the doctor had such influence over access to the grant, the process was further undermined by bribery, fraud and threats to doctors by people demanding the grant (Naicker, Welfare and Population Portfolio Committee Minutes, 21 June 2000).

In a context of high poverty levels, it is difficult to distinguish between disability-related poverty and other generalised poverty and there was often confusion as to whether someone was receiving a grant because they were disabled or unemployable (Schneider and Marshall, 1998). This was often the case amongst applicants over the age of 55 who were not yet eligible for the Old Age Pension and were awarded temporary disability grants because were no longer competitive in the labour market (Schneider and Marshall, 1998).

There were also emerging concerns that in a context of high unemployment people were using temporary disability grants as a ‘ticket’ (Segar, 1994) to an income. Segar’s (1994) ethnography of patient compliance to epilepsy medication in the epilepsy clinic of an Eastern Cape day hospital, developed on the basis of observations of patient consultations and interviews, indicates that patients were strategically using the illness to access the disability grant. In the case of her study, patients and doctors became ‘locked into a kind of negotiation where the issues of disease and therapy may themselves become of secondary importance’ (Segar, 1994: 295). In a letter to the South African Medical Journal, a tuberculosis researcher focusing on patient compliance raised concerns that it was ‘financially advantageous for the indigent TB patient to remain in the ‘sick role’ for as long as possible’ (Dick, 1995), affecting adherence to treatment. In recommendations to the Department of Welfare, Schneider and Marshall (1998) recommended the elimination of the temporary disability grant for this reason. This strategic use of the disability grant to placed healthcare workers in a position of acting as both detectives and judges (Baron, 1992: 428), roles that were beyond the scope and training of their medical role.

A new strategy on disability

Although the INDS White Paper and the White Paper on Social Welfare recommend changes to improve and extend access to DGs, government took little action to change policy, legislation or regulations around the DG until 1999/2000. In response to the obvious need to improve DG administration, the Department of Welfare convened a Disability Task Team including legal experts, academics, civil society and government representatives from the nine provinces to look at the existing legislation, regulations and implementation challenges (Department of Welfare, 2000c; Black Sash, 2000a). In June 2000 the Department of Welfare presented a new strategy on disability grants to the Department of Welfare and Population Development in Parliament (Department of Welfare, 2000b).

> ‘The strategy attempts to address the concerns and difficulties with administration of social grants in respect of disability and attempts to involve the disability sector in the assessment panels, to assess applications for a social grant. The strategy proposes a clear definition, clear assessment criteria and uses a combination of the medical and social model in the assessment process. Applicants will no longer be forced to go to a medical officer of health for a medical report but can obtain a report from any doctor who is familiar with his/her medical history’ (Department of Welfare, 2000a).

This strategy proposed amendments to the disability grant system which included: creating a new definition for disability, reducing reliance on medical officers who were often not present in rural areas, creating a timeframe for temporary disability and specifying an appeals process for those claimants opposing suspensions and rejections. The medical assessment process was considered time consuming, expensive and duplicative[16] and the document recommended that this process be relaxed to allow any physician, psychiatrist, psychologist or optometrist of the applicant’s choice to make recommendations on grant applications. This report would however only form part of the process and multi-disciplinary adjudicating panels would perform the actual assessment. The multi-disciplinary nature of assessment panels (APs) were expected to move disability assessment away from a biomedical understanding of disability by incorporating more social considerations into assessment of applicants’ ability to work. This would bring the disability grant process in-line with the INDS White Paper (1997), which advocated a social model of disability. Including community members and the disability sector in the panels was expected to break the bias towards physical disability inherent in the medical examination.

> ‘Practitioners other than medical practitioners, and community members who have had the opportunity to observe applicants over a long period of time, may, it was hoped, be better placed to detect ‘invisible’ disabilities’ than would a medical practitioner forced to undertake a quick assessment, with limited resources’ (Swartz and Schneider, 2006: 239).

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[16] As the grant had to be approved by both a medical officer and a pension medical officer

Given the shortage of medical doctors, especially in more rural areas, the DSD hoped that APs would help to reduce the large backlog of disability grant applications and reduce the growing threat of litigation against backlogs and unclear or improper processes for DG cancellations or classifications or permanent and temporary disability.

Based on these proposals, amendments to the Social Assistance Act 59 of 1992 were introduced in September 2000, with the main purpose of the amendments explained by the Department of Social Development (DSD)[17] as follows:

> ‘To remove constraining factors towards administrative justice. Remove incentives for unscrupulous individuals to enrich themselves. Regulation to be aligned with a more developmental approach to empowering people with disabilities to become self-sustaining’ (DSD, 2000).

The DSD also hoped that introducing APs would decrease the individual discretion of doctors and thus the amount of perceived fraud present in the system. As the DSD Chief Director of Social Security, Fezile Makiwane, explained, ‘panels were mooted to shift the process of decision making from one individual to a group of persons’ (Makiwane, Social Development Portfolio Committee, 9 May 2001).

> ‘Mr Makiwane did, however, agree with the Chair that the problem of fraudulent claims is a critical one and calls for a multisectoral approach. Capacity building by the government is needed to stamp it out. He hoped that with the setting up of the panel system the problem would abate to a considerable level’ (Makiwane, Social Development Portfolio Committee, 4 April 2001).

The multi-disciplinary nature of APs was expected to increase the reliability and validity of assessments. According to the 2000 proposal APs consist of a senior social security official, a rehabilitation therapist (nurse, social workers, psychologist, occupational therapist or audio-visual therapist) and either a representative from the disability sector or other reputable community member.

> ‘The idea, she underscored, was to incorporate people with the *locus standi* to testify to the applicant's disability status. The panels, she said

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[17] In July 2000 the Department of Welfare was re-named the Department of Social Development. At the beginning of 2001 the Welfare and Population Development Portfolio Committee in the National Assembly was re-named the Social Development Portfolio Committee.

> further, are poised to inject some efficiency and reliability in the disability assessment process. The current set up is inadequate since it involves a single medical officer of health' (Matholengwe, Social Development Portfolio Committee, 4 April 2001).

Discussions around amendments of regulations to the Social Assistance Act highlighted the need to create a clear definition of disability for social grant purposes:

> 'The MP pointed out that the definition of disability needs to be made clear. Because of high unemployment, people are using this avenue to obtain money, especially by claiming temporary disability benefits. In terms of the definition of temporary disability, how would one differentiate gout from arthritis?' (Unknown Member of Parliament,[18] Minutes of the Welfare & Population Development Portfolio Committee, September 27, 2000).

Amendments made to the Regulations of the Social Assistance Act (Act 59 of 1992) in July 2001 removed the role and regulatory function of the Pension Medical Officer, allowing assessors to function independently of their oversight. This amendment also introduced Assessment Panels (APs) as possible substitutes for Medical Officers (MOs) in areas where there were no medical officers. Further amendments were made in November 2001, which allowed APs to be used in all areas and for Care Dependency Grant assessments. According to the Regulations as amended in November 2001 an assessment panel was defined as 'a group of individuals appointed by the Director-General in accordance with regulation 2(4), who have the relevant experience and expertise to assess disability and care dependency'.

However, despite an obvious need to clearly define disability, no definition of disability was included in the amendments to the regulations.

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[18] This MP was not named in the Parliamentary Monitoring Group minutes.

A period of unbridled growth in DG beneficiaries: 2001 – 2007

Outcomes of new regulations

In a 1997 paper, Van der Berg commented that given the extent of unemployment in SA, the take-up of benefits such as the DG are likely to be as great as administrative leniency allows (Van der Berg, 1997: 494). This proved to be the case when 2001 amendments to the Social Assistance Act increased the leniency of DG administration, contributing significantly to the massive increase in beneficiaries from 2001 to 2007.

As a result of the amendments, which came into effect in December 2001, provinces had two available routes for assessing disability for social grant purposes. Provinces could either continue to use medical officers without PMO oversight, or assessment panels could be used to make a final recommendation to social security officials. Although new regulations were aimed at improving DG administration, the removal of the PMO oversight function and the lack of training or guidelines for APs in fact further reduced the control the DSD had over the assessment process and created what one provincial official described as a 'free for all' (Delany *et al.*, 2005). Although panels were meant to include medical professionals such as occupational therapists, physiotherapists, doctors and nurses, two APs in the North West Province observed in a study conducted by Goldblatt (2009) did not always include these professionals and panellists often did not understand medical reports (Goldblatt, 2009: 376). Based on legal casework, de Villiers (2002) also reported that APs worked off scantily detailed, poorly explained and often illegible medical reports. Without the presence of MOs, the panels were often incapable of weighting the value of the medical report relative to the psychosocial circumstances of the applicant (de Villiers, 2002). Panels observed in Goldblatt's (2009) study also lacked confidentiality and panel members were reported to be unprofessional.

As the administration of grants was neither centralised nor standardised across provinces, different provinces introduced APs at different times and used them to varying degrees and in various combinations with MOs and PMOs. For instance Mpumalanga introduced three APs to work with MOs and retained an oversight role through a senior social security official. The Free State and KwaZulu-Natal eliminated the PMO role and ran dual systems that allowed either MOs or APs to make assessments. The North West and Limpopo provinces were most organised in implementing APs but also implemented quite different systems. The North West province introduced 26 APs linked to 26 social security offices that worked alongside MOs in the assessment process and were the only province to provide trainings for panel members. Limpopo situated APs within hospitals where they worked alongside the Medical Officer to recommend the grant, with the MO conducting the medical assessment component. On the other hand, the Western Cape and Gauteng never introduced APs. Gauteng abandoned the PMO function while the Western Cape retained it, although they could no longer override an MO recommendation. The Eastern Cape and Northern Cape briefly piloted APs but abandoned them for logistical reasons (Simchowitz, 2004), with the Northern Cape retaining its original system (with the PMO) and the Eastern Cape using MOs exclusively (Delany *et al.*, 2005).

Medical assessment forms and the criteria used to define AIDS-related disability also differed widely across provinces, with some provinces offering the DG very generously and others having no HIV/AIDS guidelines available until 2004 or later (Delany *et al.*, 2005; Simkins, 2005; Nattrass, 2007).[19]

Figure 1 below demonstrates the increase in beneficiaries between 2001 and 2007, when the number of DG beneficiaries peaked at 1,442,808. The unexpectedly large increase in the number of disability grants from 2002 onwards has been largely attributed to the 2001 regulatory changes (Simchowitz, 2004; Delany *et al.*, 2005; Simkins, 2005; Nattrass, 2007). Delany *et al.* (2005) reported that between October 2001 and September 2004 the number of permanent disability grants increased by 143percent and temporary disability grants increased by 61 percent, whilst the CDG uptake increased by 119 percent. By 2007 over 1.4 million people accessed the DG, up from 600,000 in 2001. SOCPEN data demonstrate that the percentage of rejected/not recommended applications dropped significantly from 8 percent in 1997 to less than 1 percent in March 2005 (Steele, 2006). In addition, of those who registered as rejected in March 1999 and who reapplied later, 60 percent were successful in claiming a DG (either a PDG 5% or TDG 55%) by March 2001 (Steele, 2006).

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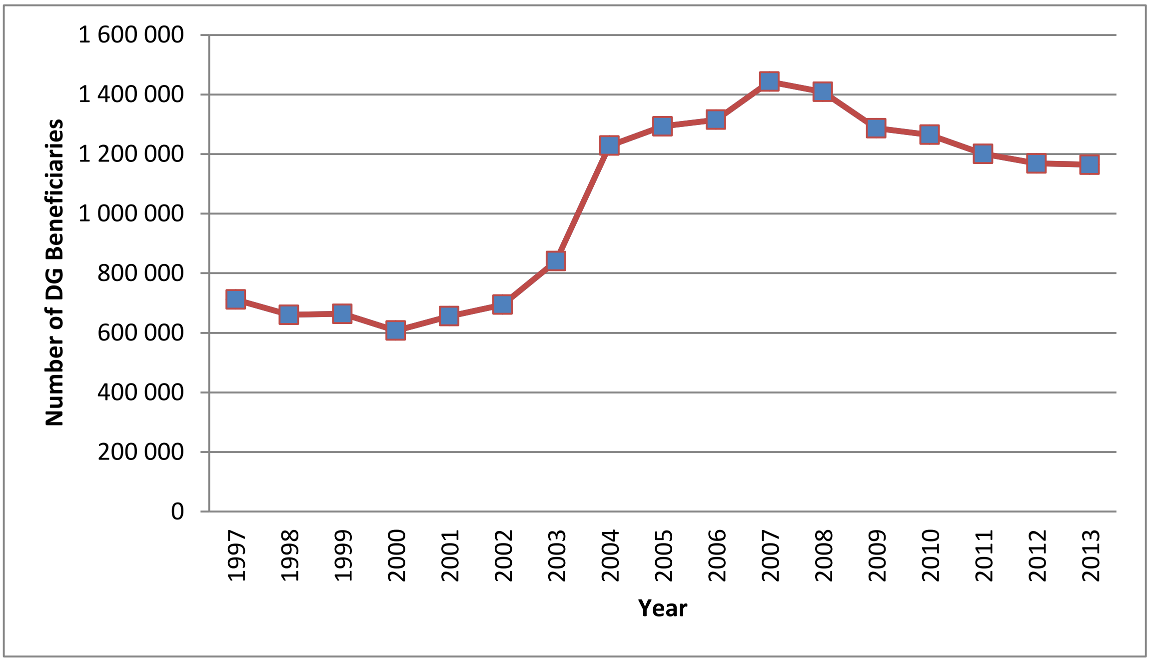
[19] Northern Cape and Mpumalanga did not develop any guidelines and left assessment of HIV positive patients to the complete discretion of MOs.



Source: Department of Welfare and DSD Annual Reports 1997-2013.

Figure 1 Changes in DG beneficiary numbers 1997-2013.

In 2004, driven by anxiety about the budgetary implications of the growth in DG numbers, the DSD commissioned the Community Agency of Social Enquiry (CASE) to carry out new research into the increase in DG uptake (see Delany *et al.*, 2005). The study employed a multi-stage, mixed-method approach. This included: 1) a review of policy and legislation; 2) the development of qualitative case studies at selected sites in all nine provinces through in-depth interviews with social security staff, doctors, AP members, beneficiaries and NGO staff; 3) a quantitative analysis of SOCPEN data; and 4) a review of the medical reports for a representative sample of files of new beneficiaries receiving the grant in the months of December 2001 and December 2003.

This and other studies have attributed this growth to relaxation of grant assessment criteria, the reduction in oversight brought about by the elimination of Pension Medical Officers and introduction of Assessment Panels, the lack of a framework for assessments, the increase in the prevalence of HIV/AIDS and TB and high levels of unemployment (Delany *et al.*, 2005; Simchowitz, 2004; Steele, 2006; Nattrass, 2007). According to these studies, the social aspects of disability applications became the strongest factor in applications and the disability grant was often awarded more out of sympathy on the basis of poverty than actual physical capability (Simchowitz, 2004; Delany *et al.*, 2005; Simkins, 2005; Nattrass, 2007). The confusion between medical diagnosis and actual functional capacity also meant that disability grants were often awarded to people who may have been able to work. This was the case with HIV positive patients who were often given the temporary grant on the basis of their positive status rather than their actual fitness for work (Schneider and Goudge, 2007) and there appeared to be a popular perception that people with HIV/AIDS would automatically qualify for the disability grant (De Koker *et al.*, 2006). As HAART was rolled-out from late 2003 and people with HIV/AIDS were able to recover their health, awarding the grant to those with HIV/AIDS became increasingly complicated and created further confusion around eligibility criteria. Rumours about possible disincentives towards recovery by TDG recipients continued to grow and was thought to create what Standing (2008: 22) called a ‘bizarre sickness-poverty trap’. Anecdotal evidence that TB and AIDS patients were reluctant to take medication that could restore their health or that people were incentivised to intentionally infect themselves with TB or HIV/AIDS have been presented in several research studies (Delany *et al.*, 2005; Leclerc-Madlala, 2006; Nattrass, 2006; Hardy and Richter, 2006; De Paoli *et al.*, 2010; 2012). However, no quantitative evidence that beneficiaries would choose the grant over their health has been found (Venkataramani *et al.*, 2010; Peltzer, 2012).

It should also be noted that temporary disability grant numbers increased as a result of the reinstatement of 35,529 temporary DGs, mainly in KwaZulu-Natal and the Western Cape, following the Mashishi class action[20] in May 2003 as a result inappropriate lapsing procedures for TDGs (Steele, 2006; Delany *et al.*, 2005). The Mashishi ruling also halted further lapses of TDGs until correct review procedures were instituted. Given that most provinces only instituted these procedures between late 2004 and 2005, many TDG beneficiaries received their grants longer than initially intended.

Tightening the assessment process

As the result of such massive increases in the number of DG beneficiaries, all provinces except the North West Province abandoned the experiment with APs by 2004. Assessment Panels were formally removed from the regulations to the Social Assistance Act 59 of 1992 when the social security system was centralised through the new Social Assistance Act 13 of 2004 and South Africa

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[20] *Mashishi and others v the Minister of Social Development and others*, unreported Transvaal Provincial Division case number (4239/03) 2003.

Social Security Agency Act 9 of 2004.[21] Regulations to the Act in 2005 and subsequent amendments in 2008 required that disability be exclusively determined by the medical assessment of medical officers and confirmed by a medical report. However, the oversight role of the PMO was never reintroduced.

The purpose of the Social Assistance Bill [B57-2003] and the South African Social Security Agency Bill [B51-2003] was to consolidate the administration of social grants under one national agency and undo the assignment of social assistance functions to provinces, which had struggled to administer social grants. Both bills were introduced at a time when the report of the Committee of Inquiry into a Comprehensive System of Social Security for South Africa (known as the Taylor Committee) was still being considered by cabinet. This committee had been commissioned in 2000 to evaluate and propose a new design for the social security system in South Africa. As no clear policy framework for social security reform (including reform of the disability grant) had yet been developed, civil society organisations suggested in submissions to the Social Development Portfolio Committee that the introduction of the bill was premature.

The Taylor Committee report had raised some major issues related to the administration of the DG and the definition and assessment of disability and made a number of recommendations on radically reforming the DG system, none of which were included in the Bill and few of which have informed actual policy change. This is likely because the report recommended extending access and reducing the reliance on medical assessment, which may not have seemed appropriate given the failure of the AP system and growing panic about the number of DG beneficiaries. The Taylor Committee report had recommended that people with sensory and intellectual disabilities as well as those with chronic illnesses such as HIV/AIDS be eligible for the grant. It also recommended that the work capacity element of eligibility be removed and that a needs-based, capabilities-focused assessment based on the World Health Organisation's International Classification of Impairment, Disability and Handicaps (ICIDH-2) be used for categorising and measuring disability. The report proposed that assessment be conducted by multi-disciplinary panels that included members of the disability sector and would not only consider medical diagnosis, but also other social, economic, physical and environmental factors. The report also suggested the development of a proper review and appeals system and the increase in back pay from three to six months. It also recommended that needs-based assessment replace means testing and that a

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[21] The South African Social Security Agency Act of 2004 created the South African Social Security Agency (SASSA), which is the agency under the Department of Department of Social Development now responsible for the administration of all social grants.

sliding scale of monetary and in-kind benefits be introduced. The committee further recommended that relevant training and reintegration measures be tied to grants as part of the social security package.

Although the new (2004) Social Assistance Act did not address problems in DG administration, the DSD quickly began to investigate ways to contain the growth of the grant. In order to contain the use of the Disability Grant as a poverty alleviation tool, the CASE report discussed earlier (Delany *et al.*, 2005) recommended the introduction of standardised assessment tools, clear eligibility criteria and educating frontline staff about the rules of disability management. These recommendations were focused on ensuring that the disability grant was given exclusively to the people with functional impairments that limit their ability to participate in the labour market. However, by focusing on what Nattrass (2007: 184) describes as a 'narrow set of managerial solutions' and not the underlying social reasons for the growth in disability grant applications and the overgenerous awarding of grants by assessors, the state ignored an important message about the gaps in the social security system made obvious by demand for this grant.

The issue of subjectivity in the medical assessment process raised in 2000 in the proposals for disability grant reform had not been solved by APs and the DSD therefore remained concerned that the process allowed personal views on who 'deserves' social assistance to influence decision-making around disability grants. Although the DSD put out a tender for the development of a tool for DG assessment in 2003, piloting showed that the tool was too complex and theoretical for practical use (Margie Schneider Interview, 2013). Although APs were removed no useful tools, standardised guidelines or proper oversight yet existed for medical assessment by MOs and reports presented to parliament by the Special Investigating Unit (PMG Minutes, 2006) indicated that sympathy felt by doctors for their patients lead to overgenerous, even fraudulent behaviour on the part of the doctor.

> 'Referring to the disability fraud cases, he said that one of the main concerns were doctors who certified people as disabled even though they were not. Many of them get paid to do this. This was organised crime and was one of the focus areas at present. There were cases as well where doctors classified people as disabled because the case was not very clear and they felt sorry for them. People with AIDS were a problem as classification depended on their CD4 count and these counts could fluctuate' (Waters, National Assembly Social Development Portfolio Committee, 30 Aug 2006).

The Report on Incentive Structures of Social Assistance Grants in South Africa, produced for the Department of Social Development in 2006 to investigate the possible unintended effects of grants, also noted that the increase in grants was not only driven by applicants but those referring or assessing them for disability grant applications:

> ‘It is sometimes not the potential recipients themselves that respond in unanticipated ways to incentive structures. It may, for example, be gatekeepers such as doctors or social workers, or even social security staff, acting in the perceived best interests of their client’ (Steele, 2006: iii).

The Harmonised Assessment Tool

In 2003 the Department of Health (DoH) introduced a Policy of Free Health Care at Hospitals for People with Disabilities, which offered free services to those with moderate to severe disabilities of a permanent nature.[22] The need for doctors to assess patients’ eligibility for these free services led to growing irritation amongst healthcare professionals who were already struggling under the pressure of DG assessments. To simplify this process and overcome the ongoing lack of tools and guidelines for disability assessment, the DSD and DoH jointly developed a Harmonised Assessment Tool (HAT), which was piloted in 2006. The HAT was based on a definition of disability specifically created for determining eligibility for the DG and FHC, which was approved by Cabinet in May 2005. The definition reads as follows:

Disability means a moderate to severe limitation in a person’s ability to function or ability to perform daily activities as a result of physical, sensory, communication, intellectual or mental impairment.

The definition clarifies that disability is neither a medical condition, nor the symptoms or impairments arising from a medical condition (DoH and DSD, 2009). Instead disability is defined in terms of the limitations in daily functioning and activities that a person is able to perform. The HAT was designed to assess what activity or participation restrictions exist for each individual. The tool has two components, a medical assessment and an Activity Limitation Assessment. The medical assessment component would act to confirm the existence of particular health condition, whilst the Activity

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[22] This was introduced by Manto Tshabalala-Msimang, who was the Minister of Health at the time.

Limitation component assesses disability by measuring activity limitations in terms of specific categories of impairment through observation, information gathering through interviews and testing.[23] The Activity Limitation Assessment would be undertaken by a registered health professional who had received specific training in use of the tool and related assessment guides (DoH and DSD, 2009).[24] This focus on activity limitations over medical diagnoses promised to shift the responsibility for assessment from doctors to other healthcare professionals who are better-trained in assessing functionality than doctors. This focus was expected to ensure that only genuinely disabled people received the grant and also make the assessment process more sensitive to hidden disabilities than had not been possible through medical assessment alone. The introduction of HAT would also bring the assessment process more in line with international guidelines such as the World Health Organisation's International Classification of Functioning, Disability and Health (ICF).

The DSD hoped that the introduction of the tool would 'ensure uniformity in the assessment of disability, thereby contributing to more efficient management of disability benefits' (PMG Minutes, National Assembly EPC, 28 March 2007). As well as reducing access to DGs by the chronically ill, which was seen by the DSD as a 'major error of inclusion' (DSD, 2010: 10), it was hoped that a more standardised process would also reduce the number of appeals against decisions and reduce the threat of litigation by applicants. The HAT was to be implemented in conjunction with SASSA's plans for a Disability Management Model, which was also aimed at standardising provincial procedures for disability assessment.

The disability rights movement, which promotes a multi-disciplinary approach to disability assessment and which had long opposed the use of medical doctors who are trained to focus on medical conditions rather than functionality, favoured the introduction of the HAT. The disability sector argued that disability grants should be specifically targeted at the permanently disabled rather than

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[23] The tool measures categories of activity limitations in terms of self-care, elimination (including toileting), mobility differentiated in separated body parts, vision, hearing, communication (understanding and producing language), cognition (problem solving and memory), Global Assessment of Function (GAF) assessing spatial awareness and psychological or mental health (DSD, 2010).

[24] The tool was designed to be used by a registered health professional and it was expected that audiologists, occupational therapists, physiotherapists or speech therapists would perform most AL assessments, but clinical psychologists, optometrists, orthotists and prosthetists or registered nurses were also able to perform assessments if necessary.

those with chronic diseases. ANC MP Henrietta Bogopane-Zulu,[25] a vocal disability rights activist, made this argument in a number of parliamentary debates:

> ‘Ms Bogopane-Zulu said that they had told the DSD many times that doctors should not be used to certify disabled people. A doctor could be used for a chronic illness, which was not a disability. She requested SASSA to address this. A disability was permanent normally and a panel should be used to certify disabled people. Those with AIDS should be classified as chronic and not as disabled’ (PMG Minutes, Social Development PC, 30 August, 2006).
>
> ‘Ms Bogopane-Zulu suggested that a chronic illness grant be established for such a purpose, as such persons did not fit the profile for a disability grant’ (PMG Minutes, Social Development PC, 7 September, 2005).

With its strong emphasis on functionality, implementation of the HAT would imply that a significant number of people who had been accessing the grant based on their chronic illness would lose their grants.

The Department of Social Development acknowledged that if the chronically ill were to be excluded by the new definition of disability and the HAT, some provision needed to be made for the chronically ill living in poverty. In 2007 the DSD commissioned the Human Science Research Council (HSRC) to investigate policy options to provide social security benefits to people with chronic illnesses. Research was based on a desktop review of national and international literature on the provision of social security for chronic conditions as well as a review of existing data sets on the prevalence of chronic conditions in South Africa.

The HSRC report recommended two policy options: 1) the introduction of the HAT alongside a Chronic Illness Grant (CIG) for people with chronic illnesses not eligible for the DG; and 2) the roll-out of the HAT and provision of a coordinated set of general poverty alleviation programmes (Schneider and Goudge, 2007). The introduction of a Chronic Illness Grant (CIG) had already been recommended in the National Strategic Plan on HIV/AIDS drafted by the South African National AIDS Council (SANAC) and then approved by cabinet in 2007. The CIG was a popular option amongst AIDS activist organisations

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[25] Bogopane-Zulu is now Deputy Minister in the Department of Women, Children and People with Disabilities

such as the Treatment Action Campaign and National Association of People Living with AIDS.

The DSD initially appeared supportive of the CIG option and according to Parliamentary Monitoring Group minutes, ‘it was felt that perhaps there was a need for a special chronic illness grant, or, as another option, the provision of food vouchers by the Department of Health’ (Rakoloti, Social Development Portfolio Committee, 2 November 2009). The DSD presented the CIG as a policy option to the Social Transformation Committee at the 2007 ANC Policy Conference, but this proposal was rejected. Although the committee acknowledged ‘the need to provide some form of safety net for those people, who do not have any income and are not eligible for any form of social grant under the existing policy framework’, the discussion was ‘characterised by a realisation by both commissions that the ANC in government should discourage dependence on social grants and therefore should seek to develop comprehensive measures to fight poverty’ (ANC Social Transformation Committee Minutes, 30 June 2007). As a result the committee decided that the chronically ill should continue to be excluded from the definition and that no social grant would be issued to the chronically ill. Instead responsibility for the chronically ill was seen as the mandate the Department of Health (DoH) and the Integrated Food and Nutrition Task Team (PMG Minutes, Social Development Portfolio Committee, 2 November 2009). A decision was made that food vouchers rather than grants would be provided to the chronically ill to ensure that they had adequate nutrition to ensure they would be able to adhere to their medication.

The Social Assistance Act Amendment Bill of 2010

In order to make the implementation of a Harmonised Assessment Tool legally possible, it was necessary to insert a definition of disability into the Social Assistance Act 13 of 2004. In 2010, the Social Assistance Amendment Bill (B5-2010) was introduced to parliament to insert the following definition of disability into the Act to support the implementation of the HAT.

> ‘“**disability**”, in respect of an applicant, means a moderate to severe limitation to his or her ability to function as a result of a physical, sensory, communication, intellectual or mental disability rendering him or her unable to—

> (a) obtain the means needed to enable him or her to provide for his or her own maintenance; or
> (b) be gainfully employed;

According to the Minister of Social Development, the amendments were intended to create 'a more rational and less arbitrary means of assessing disability through limiting the discretion of individual doctors and our officials' (Dlamini, Social Development PC, 2 June 2010). The amendments would legally remove the right of the chronically ill to access disability grants. The DSD hoped that this would reduce inclusion errors and that fewer inconsistencies in DG assessment would reduce the backlog of appeal cases against the rejection of grant applications or lapsing of disability grants, which had remained an ongoing problem for the department in the absence of harmonised regulations. The Bill also sought to regulate the eligibility requirements for other disability-related grants, enable applicants and beneficiaries to apply to the SASSA to reconsider its decision and amend the process of appeals against SASSA's decisions (Portfolio Committee on Social Development, 2010).

Civil society organisations were invited to consult on the 2010 Bill through oral and written submissions. Their submissions suggest that these organisations were as concerned as the DSD about the administration of disability grants and, specifically, how doctors' discretion lead to unequal applications of the law (AIDS Law Project, 2010; Black Sash, 2010; SPII, 2010; Treatment Action Campaign, 2010; South African Council of Churches). These submissions agreed that chronic diseases were presenting a challenge to social security programmes. However, those that submitted argued that the wording of the amendments not only did little to address the lack of clarity around the definition of disability, but that the definition and the application of HAT would be regressive in its exclusion of persons with chronic illnesses if no separate grant was provided for this group. Organisations that presented at the hearings argued that intentionally excluding groups of people already receiving DGs from accessing social security was counter to the state's obligation to take reasonable legislative measures to achieve the progressive realisation of social security rights as outlined in Article 27(2) of the Bill of Rights in the Constitution of the Republic of South Africa 1996 (Act 108 of 1996).

Disability organisations, the Disability Action Research Team and Disabled People South Africa, made no comment on the issue of chronic illness and only recommended that 'impairment' be used to replaced disability in the definition of disability. The argument against the proposed amendments was led by a coalition of NGOs[26] outside of the disability sector that argued that the Act should make provision for a chronic illness grant in recognition of the daily struggle against illness and poverty that chronically ill people face.

Civil society organisations argued that although incorporating the chronically ill into the labour market was an important goal, given high levels of unemployment and the inability of the chronically ill to compete in it, the majority of the people concerned were not employed anyway and that excluding them from social assistance would only increase poverty and hunger rather than push them into the labour market. The discourse employed by civil society in the debates around the bill recognises that chronically ill people face dual disadvantages of illness and poverty and are therefore deserving of grants. Underpinning this discourse is the belief that social grants have ‘transformative’ potential and as well as the ability to promote inclusion and social justice (Devereux, 2010). The Chronic Illness Grant was seen as a way to create independence by supporting people with chronic conditions to lead healthy lifestyles, which would allow them to participate in society as active citizens and potentially find work.

Employing a conflicting discourse, one that sees grants as creating dependency and work disincentives rather than development, members of the Social Development Portfolio Committee argued that failures of the labour market and the burden of chronic illness should not be addressed through social grants. In their view, unemployment and poverty were not the exclusive problems of the DSD thus an intersectoral approach was necessary and, therefore, discussions about these issues were not relevant to the amendments at hand. Issues around exclusion of the chronically ill, especially those with HIV/AIDS, were seen as part of a bigger labour market issue which should be addressed by employer education programmes and job creation strategies rather than social grants.

Whilst the Portfolio Committee on Social Development accepted a recommendation that impairment rather than disability be used within the definition of disability, it ultimately rejected the idea of a chronic illness grant and aimed to proceed with the Bill as planned.

As the Department of Health would be responsible for conducting assessments, it was invited to present to the committee on its readiness to implement HAT. To the surprise of the committee, the DoH indicated that not only did it have insufficient healthcare professionals such as medical doctors, occupational

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[26] This group included the Treatment Action Campaign, the AIDS Law Project, Black Sash, DART, DPSA, NAPWA, SPII and the South African Council of Churches.

therapists and physiotherapists to conduct these assessments, but that it had no trained professionals outside of the sites where the HAT was initially piloted. The DoH therefore declared it was not ready to implement the tool. However, the DoH promised that it was addressing the issue of chronic diseases and disability through prevention and health promotion efforts aimed at reducing risky behaviour that could lead to illness or disablement.

As a result of the DoH's presentation, all six sections of the bill relating to disability were ultimately excluded from the bill. The DSD is currently re-developing the HAT to address the issue of chronic illness in disability grant assessment more adequately. SASSA have reported there has been no substantive change in the status quo and that they are still not clear as to when or if they will be able to implement the tool (Personal correspondence with SASSA Disability Management Unit, 2013). A doctor contracted to SASSA indicated that the problem with the HAT tool 'starts and ends with the Department of Health' and that 'while the theory is nice, the practicality is not so straightforward' (Interview with SASSA Doctor, 2013) because the healthcare system is unlikely to have the capacity to carry out Activity Limitations assessments for some time. As a result, the disability grant assessment process remains purely medically focused.

The Disability Management Model

During the 2007/2008 financial year the DSD and SASSA drafted guidelines for a Disability Management Model to standardise the medical assessment processes for the DG, CDG and Grant-in-Aid in all the regions and improve control over assessors and the standard of assessments.

The new model was piloted in the Eastern Cape, Free State and KwaZulu-Natal regions in 2008/2009 and the following year SASSA implemented changes in priority areas of the model in six regions across the country. These priority areas include: a gatekeeping and national booking procedure that detects rejected applicants reapplying before the required three month waiting period, standardised medical assessment processes, medical form management, training for assessors and the implementation of claims procedures for service providers (SASSA, 2011).

Despite the failure of its attempt to change legislation and implement HAT, the SASSA Disability Management Unit has continued to roll out processes focused on reducing DG numbers and eliminating discretion in the assessment process (SASSA, 2011). The agency has implemented a number of oversight measures and has decreased the relative influence of medical officers in the assessment process. As the model is progressively implemented, the role of the patient's own doctor will be limited to the pre-screening process and will only be able to provide a referral letter on a SASSA referral form template. SASSA officials then use this and other documentation to book an applicant for a formal disability assessment with a formal disability assessor. SASSA now appoints specifically contracted medical assessors, either through Memorandum of Understandings (MOUs) with Provincial Health Departments and healthcare facilities for assistance in conducting disability assessments, or by contracting medical assessors directly. These assessors should be specifically trained by SASSA in the application of their specific procedures, but assessors are able to begin assessing grants after only few hours of training. Medical assessors use a standardised form (ICD10) and very specific guidelines are given to assessors during training that indicates which conditions or impairments are considered for grants and what percentage of impairment is required before the disability grant is offered.[27] Grant assessors make their decisions on a purely medical basis and typically conduct a folder review, although they may ask patients questions or perform medical examinations or tests if required. Doctors who are contracted by the Department of Health typically work for corporate locum agencies and have little incentive to conduct high quality assessments. SASSA does however perform periodic reviews on doctors to track the quality of their work and reduce non-compliance with assessment guidelines.

The *SASSA Guidelines for the Medical Assessment of Disability for Social Assistance Purposes* contain particular sections reinforcing which conditions do not qualify applicants for disability grants or care-dependency grants. The guidelines discourage awarding the grant for chronic diseases by focusing very specifically on functional impairment and the awarding of Temporary Disability Grants is discouraged, based on ideas about limiting dependency.

> 'Unfortunately there is a tendency for temporary grants to create dependency and poor motivation for recovery. Due to this component of secondary gains these grants must be given out cautiously' (SASSA, n.d.: 25).

These guidelines also actively discourage doctors from recommending grants on a humanitarian basis.

> 'Disability grant is not [the] Basic Income Grant (Employability not Availability of Employment)' (SASSA, 2012).

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[27] Significant impairment (25-40%): patient qualifies depending on age, functional independence, education and employment history and socioeconomic factors or opportunities for referral. Major impairment (over 40%): patient automatically qualifies.

> ‘Certainly most of our population live in very poor social circumstances that cause a lot of suffering, but this alone does not constitute grounds for a disability grant’ (SASSA, n.d.: 5).

In its 2012/13 annual report, the DSD claims that the proficiency of assessors has improved significantly, this led to ‘purging of ineligible beneficiaries during medical reviews and a general decline in inclusion errors’. This resulted in a net decrease of 20 789 in the total number of disability-related grants[28] in the 2012/13 period (DSD, 2013: 138). Overall, as result of the efforts of the DMM, the number of beneficiaries has been reduced by 20.8 percent from 1.44 million in 2007 to 1.14 million people in 2013.

Social security reform and the promise of a new system

The government has struggled to accurately target disabled people for receipt of DGs because the chronically ill and the able-bodied unemployed sitting on the margins of the social security system have also attempted to access DGs, sometimes with the help of sympathetic social workers, doctors and government officials. Without a coherent policy on social assistance or the political will to extend social grants to these groups, combined with a failure to create jobs, these problems have been difficult to resolve, even with increased regulation of the DG. Although there has been some ‘parametric reform’ (Seekings and Matisonn, 2010) and extension of the social grant system there has been little actual reform in the social grant system since the end of apartheid. This historical overview of the DG has demonstrated that despite efforts to change the DG system and significant improvement in administration, both the DG system and the context in which it operates remain substantially similar to the system inherited from the apartheid regime. However, there are plans for future social security reform, largely through improved social insurance provisioning that may change the nature of social security provisioning for the disabled in future years.

The South African National Development Plan, the state’s latest blueprint for creating social and economic change, has a strong focus on reducing poverty and inequality through social protection. The diagnostic report prepared by the National Planning Committee (NPC) on social protection acknowledges the role that social grants have played in reducing poverty and social unrest. The plan recognises that ‘there is no protection for able-bodied unemployed people in

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[28] This also includes the care-dependency grant and the grant-in-aid.

South Africa who have little choice but to depend on ‘goodwill transfers’ from those with access to income through employment or some form of social grant’ (NPC, 2012: 327) and that the dependency on social grant recipients dilutes the anti-poverty effects of social grants. The plan looks beyond social grants towards the development of a comprehensive social protection offering by the state. This social protection ‘basket’ includes National Health Insurance, unemployment insurance, pension fund arrangements, education, public work programmes, work related benefits, food and nutrition security programs and labour market incentives. It acknowledges in particular the importance of social protection for the able-bodied unemployed:

> *‘The main thrust of social policies should be to enable and support labour market participation and provide protection against labour market risks including the loss of employment. Social protection is also essential to protecting the old and the young as well as* ***adults of working age who are unable to work because of structural unemployment, illness or disability****’* (NPC, 2012: 327, emphasis own).

The National Development Plan also ties in with the plans of the Inter-ministerial Committee on Social Security and Retirement Reform. This committee was established in 2007 and is composed of the National Treasury, DSD, Department of Labour, Department of Transport, Department of Home Affairs and Department of Public Services Administration. The aim of the committee is to drive social security reform by consolidating and extending social insurance provisioning. In 2011/2012 the committee published the Consolidated Government Paper (CGP), a policy discussion document that outlines the government’s vision for improving the social security system (DSD, 2012) and in June 2012 a Position Paper on Social Security Reform was presented to the Cabinet for consideration (DSD, 2013). These documents proposed introducing the National Social Security Fund, a mandatory state contributory pension, death, unemployment and disability insurance system that will reduce the burden that income shocks and inadequate pension planning put on the state.

Although the government will continue to provide the Disability Grant to those who have been unable to contribute to the social insurance scheme due to unemployment, the state will be moving the risk of disablement from the state to individuals who are in the position to contribute to public social insurance schemes. Better social insurance provisioning for disability, illness and general unemployment would significantly reduce pressure on the disability social grant system. Although these plans have been in development for several years, cabinet has delayed moving forward with a broader consultative process until it has had more opportunity to explore the implications of the complex proposals and consider the needs of expectations of those working in the informal sector that do not have regular incomes (DSD, 2013: 56). Although new social insurance reforms remains a long-term goal, the DSD and SASSA do not appear to have any plans to change the existing DG system in the more immediate future.

Conclusion

Before moving onto some concluding thoughts, a brief overview of the history of the DG from 1990 to 2013 is provided below.

Although racial parity in the value of social grants was achieved in 1993, the ANC government inherited a highly fragmented, unequal and poorly managed social grant system from the apartheid government. Large differences in the social grant systems existed within the 14 different welfare bureaucracies that managed grants towards the end of apartheid. The ANC government was tasked with both amalgamating this system and extending access to black people previously excluded by racial and geographic inequality and poor service delivery. Although during the late 1990s the number of DG recipients was effectively reduced by a process of consolidating and cleaning social grant databases, the overall intention of the Department of Welfare during this period was to extend access to all grants, including the DG.

In 2001, problems in the medical assessment of DG eligibility, severe backlogs in the application and appeals process and a commitment to the social model of disability, led the Department of Welfare to introduce a new set of regulations for the Social Assistance Amendment Act of 1992. These amendments introduced Assessment Panels for the assessment of disability and eliminated the role of the Pension Medical Officer, effectively reducing the level of oversight in the assessment process. Largely as a result of increased leniency and poor management of the disability assessment process, there was a rapid increase in temporary DGs between 2001 and 2007.

Concerned by the cost implications of such rapid growth in beneficiaries, APs were removed and disability is again exclusively medically tested. The DSD and its implementing agency, SASSA, have also embarked on a series of efforts to better regulate the DG application and assessment process and constrain opportunities for differentiated interpretations of disability and the level of discretion in the system overall. This work has included the development of standardised tools and training, attempts to better define disability within legislation and increased oversight of medical officers and SASSA administrative staff through a recently introduced Disability Management Model. As a result of these efforts, the number of beneficiaries has been reduced by 20.8 percent from 1.44 million in 2007 to 1.14 million people in 2013.

Instead of focusing on systemic issues, regulation of the DG has been focused on defining and guarding the boundaries of disability to ensure that the grant is properly targeted at those who are functionally disabled. This has however proved extremely difficult in a context of high poverty-driven demand for the grant and a high burden of chronic illness. Although the DSD has made attempts to move away from pure medical assessment of grants, the complexities and costs of assessing activity limitations and their relation to social, economic context and the physical environment, are too high for the current healthcare or social security system to manage effectively. This has meant that the state has remained stuck with largely the same system that has been in place since apartheid. Although the DSD and SASSA now have greater oversight and control of the assessment process, uneven application of assessment criteria continues due to ‘grey areas’ within the assessment process.

Many changes to the regulation of social grant policy and efforts to extend rights to social security through the legal, policy and programmatic roll-out of resources have been driven reactively by legal action by disgruntled applicants and beneficiaries (South African Human Rights Commission, 2010). This lack of motivation to reform the whole social grant system approach appears to be as a result of a government discourse that has been strongly dominated by talk of the dangers of a ‘culture of handouts’ and ‘dependency’ on the state and fears about the financial sustainability of the system (Surender *et al.*, 2010; Meth, 2004; Seekings and Matisonn, 2010; Barchiesi, 2011a, 2011b).

Aside from documenting a litany of regulatory failures, what this historical account of DG regulation demonstrates is that regardless of how disability and chronic illness are defined or measured, the conversation on how to incorporate people whose participation in society is limited by their physical capabilities cannot be separated from a wider conversation about poverty in South Africa. Without adequate protection to support everyone living in or at risk of falling into poverty, the disability grant system has served a purpose for which it was not originally intended. According to Whitworth *et al.* (2006):

> *‘The most effective systems of social protection for those with a disability are those which are buttressed by a comprehensive safety net. This reduces the possibility of moral hazard, tackles chronic poverty and destitution and provides a more effective bridge into the labour market when peoples’ health improves and the labour market conditions permit’ (Whitworth et al., 2006: 41).*

While trying to control administration of the grant is important, in the process of trying to define disability more narrowly, the political and public debate has lost sight of the objectives of the DG, which is to 'provide individuals with the means to disrupt forces which maintain their predicament of chronic impoverishment' (Andrews *et al.*, 2006). The focus on cutting out people who do not deserve the grant has distracted policymakers and legislators from developing a disability grant system that promotes the inclusion and development of disabled people in society.

Without more jobs or a social security system that better serves the able-bodied unemployed, the fundamental underlying issue of people, both disabled and non-disabled, needing a 'foot-up' out of poverty will not disappear and neither will the high demand for disability grants or ongoing pressure on DG recipients to support entire households with their grant incomes. Although the Disability Grant has the potential to promote the livelihoods of those suffering from permanent or temporarily disabling conditions, if it is used for general household maintenance DG recipients remain trapped in poverty and an unfair burden is placed on a category that the state has explicitly defined as vulnerable.

Appendix: Gaps in Disability Grant Data Available from 1990 to 1997

	DG beneficiaries	**Expenditure on DG (R million)**	**Total social grant beneficiaries**	**Expenditure social grants**
1990		R827.8 million (Van De Berg, 1994; Lund, 1992 based on data from Dept of National Health and Population Development)		R3.9 billion (Van Der Berg, 1994; Lund, 1992 on data from Dept of National Health and Population Development)
1991	803 000 (HSRC, 1992 in SAIRR, 1993) #		3.9 million (HSRC, 1992 in SAIRR, 1993) #	R4.4 billion (HSRC, 1992 in SAIRR, 1993) R4.7 billion (Lawrence, 1992, source of data unreported)
1992				R5.2 billion (Lawrence, 1992, source of data unreported)
1993	499 200 (Van De Berg, 1994, based on data from Dept of National Health and Population Development *) 548 224** (Dept of Welfare, 1995) 593 162 (Office of the Deputy President, 1997, source of data unreported) 500 599 (SA Statistics, 2001: 6:1-3)	R1.82 billion (SA Statistics, 2001: 6:1-3)	2.5 million (Van de Berg, 1994 based on data from Dept of National Health and Population Development) 2.6 million (SAIRR, 1995, based on Dept of Welfare data)	R8.3 billion (Dept of Welfare, 1993, budgeted for 1993/1994*****) R8.3 billion (SA Statistics, 2001: 6:1-3)
1994	593 162*** (SAIRR, 1995, based on Dept of Welfare data)	R7.6 billion (SAIRR, 1995, based on Dept of	2.4 million^^ (Seekings & Matisonn, 2010, based on data from SA	R10.5 billion (SA Statistics, 2001: 6:1-3)

	545 760 (SA Statistics, 2001: 6:1-3)	Welfare data) R2.42 billion (SA Statistics, 2001: 6:1-3)	Statistics, 2001: 6:1-3) 2.8 million (SAIRR, 1995, based on Dept of Welfare data) 3.6 million (Dept of Welfare, 1994) #	R10.7 billion (Dept of Welfare, 1994) R13 billion^^ (Lund, 1997)
1995			2.8 million**** (Dept of Welfare, 1997a)	R10.7 billion (SAIRR, 1995 based on Social Welfare Budget for 1994/95)^^^
1996			2.8 million (Dept of Welfare, 1996)	R11.5 billion (Dept of Welfare, 1996) R10.8 billion (SAIRR, 1995 based on Social Welfare Budget for 1995/1996^^^)
1997	732 322 (Dept of Welfare, 1997b; Dept of Welfare, 1997c) 711 609 (DSD, 2008) 732 322 (SA Statistics, 2001: 6:1-3)	R3.1 billion (Dept of Welfare, 1997b) 2.6 billion (Dept of Welfare, 1997c)	2.9 million (Dept of Welfare, 1997b)	R12.4 billion (Dept of Welfare, 1997c) R12 billion (Dept of Welfare, 1997b)

Much of the data was collected at different points in time during the year and this may have contributed to smaller discrepancies in data. Where the specific date is available this has been noted.

Data from the HSRC report and the Department of Welfare Annual Report present the only really dramatic differences in data presented in this table. In the case of the HSRC 1990 data it is unlikely that the number of beneficiaries dropped dramatically between 1990 and 1993 given that the amalgamation and clean-up process only began in later years. The same applies to the Department of Welfare 1994 report. It is therefore presumed that other data presents a more accurate representation of the number of beneficiaries.

*This figure does not include grants for blind people (18 700). Using this data Lund (1997) presents 518 000 as the total number of disabled beneficiaries because she added the 18 700. It is likely that most other figures include blind person's grants. Some figures may also include the single care grant available to the carers of the disabled, but the difference this should make to the data is negligible - in 1993 only 2100 received this grant. It was also often not included because it was usually administered through the health rather than the welfare budget.

** September 1993

*** September 1994. The same figure is presented by the Department of Welfare as the 1993 figure. This may be because the data would have been reported in the 1993/1994 report but is generally collected at the end of the period. This may have caused confusion.

****As of 31 May 1995

***** R7.6 billion was allocated for the year with an additional R694 million allocated to eliminate racial disparities in social grants, effective from September 1993.

^ First post-election budget for social security

^^ This figure excludes State Maintenance Grants to Mothers, meaning that only children receiving the SMG are counted and their mothers. Also mothers accounts for an additional 200 000 beneficiaries and double-counting in this way would increase the figure to 2.6 million. This indicates that other figures provided over this period may be counting both mothers and children.

^^^ Based on budgeted expenditure

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