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Social security for people with disabilities

Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence the management of the problem requires social action, and it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. The issue is therefore an attitudinal or ideological one requiring social change, which at the political level becomes a question of human rights. (Source: World Health Organisation, International Classification of Functioning, Disability, and Health (ICIDH-2)¹)

The emphasis is on a fundamental shift in how we view disabled people, away from the individual medical perspective, to the human rights and development of disabled people. (Source: President Thabo Mbeki² Forward to the 1997 White Paper on an Integrated National Disability Strategy [INDS])

9.1 *Evaluation of disability in South Africa*

9.1.1 The scope of disability

As noted by the 1997 White Paper on an Integrated National Disability Strategy (INDS), there is a lack of reliable information on disability in South Africa.³ Greater attention to disability on the part of statistical authorities could improve the quality of our data in this area, but certain practical constraints will continue to limit the extent of our knowledge about people living with disabilities in South Africa.⁴

Although available data cannot provide a perfect portrait of disability in South Africa, they can provide some useful insights. We can use these data to gain a rough sense of the scope of disability. Internationally, it has been suggested that as much as 10 per cent of the world's population live with disability. Estimates suggest that moderately to extensively disabled people constitute around 5 per cent of developing country populations.⁵ A special disability survey of South Africa conducted in 1998 by the Department of Health and the Community Agency for Social Enquiry (Case) estimates that approximately 5,9 per cent of South Africa's population live with disability.⁶ This compares with an estimate of 5,2 per cent from the 1995 October Household Survey (OHS),⁷ 12,8 per cent of the National Health & Population Development: South African national survey of 1996 and 6,6 per cent from the 1996 census,⁸ and 3,7 per cent from the 1999 OHS.⁹ The variance of these measurements illustrates the difficulty of making a reliable estimate of disability; since the underlying population characteristics are unlikely to have changed dramatically since 1995, differences in prevalence estimates mostly reflect differences in the survey instruments and techniques.

The broad scope and the many socio-economic repercussions of disability make it, by any measure, an important policy issue for South Africa. Judging from the estimates noted above, it seems likely that people with moderate to severe disabilities comprise over 5 per cent of South Africa's population. The impact of disability extends well beyond these roughly 2,5 million individuals; disability touches the lives of friends, family, and fellow community members. This is a very important point. While individuals bear the brunt of illness and impairment, disability also creates hardships for those who care for and depend on disabled family members. At least 16 per cent of South Africans are themselves disabled or live in a household with a person who is disabled, according to the 1999 OHS—and this is a conservative estimate.¹⁰ A first step in formulating a national policy framework to address disability is to acknowledge the scope of the problem.

9.1.2 The demographics of disability

Disability tends to follow certain patterns with respect to age, income, and employment. Older people are more likely to have a disability, due in part to increased probability of serious health problems and in part to accumulated risk of suffering a disabling accident over the course of their lifetimes. While the elderly account for the largest share of the disabled population, children account for a disproportionately small portion of national disabilities. Disability among children is, however, a major concern. The impact of disability on the lifetime outcomes of children can be extraordinarily high. Children with disabilities tend to have lower school attendance rates, less education, and ultimately, additional barriers to independent living and engagement with society. According to the 1999 OHS, nearly 30 per cent of school-age children with disabilities were not attending school or not attending full time, compared with 10 per cent of children without disabilities.

Poor individuals make up a disproportionately large share of the disabled population. Disability tends to be more common among poor people for two reasons:

- First, poverty increases vulnerability to disability, chiefly through poor nutrition, difficulty accessing adequate basic healthcare, lack of knowledge about prevention, and the greater concentration of poor workers in dangerous jobs.
- Second, disability increases vulnerability to poverty: lower education, discrimination in the labour market (both active and institutional), special disability-related costs, and in some cases the need for other household members to spend time and resources supporting disabled family members increases the likelihood that disabled people will remain—or become—poor.¹¹

The 1999 OHS suggests that while less than 2 per cent of individuals living in households with monthly incomes above R10 000 are categorised as disabled, the disability rate was more than twice as high for individuals living in households with monthly incomes below R1 200.

Disability is no less prevalent in rural areas than in urban areas. Although there is no statistically significant difference in urban and rural prevalence rates, there is probably a significant difference

in experience. The greater availability of healthcare, transport, and basic services in urban areas likely improves the ability of urban households to manage disability compared to rural households.

Men are slightly more likely to live with disability after accounting for age effects, probably due to the dangerous jobs many men hold. Although men may be marginally more likely to experience disability, the qualitative experiences of women with disabilities may be much more difficult. The 1997 White Paper on INDS acknowledges that disabled women must endure the oppression of a patriarchal society, which can be magnified for those women who cannot perform even the traditional roles of motherhood and homemaking. Women who bear disabled children may even in some cases be subject to the scorn and rejection of the community.¹²

The demographic character of disability is complex. The preceding observations note some of the broader trends in the data, yet the multi-dimensional nature of disability defies attempts at a simple descriptive analysis. Although quantitative evidence suggests that men bear a slightly greater burden of disability, the qualitative and anecdotal evidence suggests the reverse. In general, quantitative data cannot do justice to the experience of disability, and a more nuanced reading of the data is required for decision making.

9.1.3 The imperative to act

Not only is the impact of disability widespread but it is likely to increase for the foreseeable future. This trend has been noted at the international level, where violence and ageing populations are driving forces. In sub-Saharan Africa the situation is considerably worse, due in large part to the projected impact of HIV/AIDS on the health and well-being of the region.¹³ Therefore, not only must we recognise the scope of disability as it affects society, but so too must we recognise the urgent need to put in place measures to address the growing threat of disabling disease.

These imperatives to action are not new. Indeed, South Africa has for some time recognised the need to provide special protection to people living with disabilities. The foundation for this protection is established in section 9 of the Constitution, which prohibits discrimination on the basis of disability. These notions have found affirmation in the decisions of the Constitutional Court and in a series of international agreements to which South Africa is committed.¹⁴ The 1997 White Paper on an INDS provides the basis for national disability policy.

Addressing disability is a national priority

- Disability affects a significant share of the country—at least 16 per cent of the population—and places a significant drain on the human resources of people with impairments as well as their families.
- The incidence of disability in South Africa is set to rise, in line with international trends.
- South Africa has a clear legal commitment to address disability. This commitment is enshrined in the Constitution, affirmed by the Constitutional Court and reaffirmed by international agreements to which South Africa is a signatory.

(Source: 1997 White Paper on INDS)

9.1.4 Definition of disability and implications for national policy

“Disability” is a broad concept, encompassing traditional notions of physical and mental impairment as well as the social and economic barriers deriving from these handicaps. Impairment may be permanent or transitory, severe or slight, physical or mental. Over the past decade there has been a growing recognition that impairment itself constitutes only a portion of the burden borne by people living with disabilities. The social exclusion that so often accompanies impairment comprises a further barrier to opportunity and engagement that is an equal if not greater source of hardship for many people with disabilities. Recognition of these environmental issues—physical, social, and attitudinal—is critical for addressing the reality of disability.¹⁵ For this reason the INDS emphasises the importance of moving beyond the medical model of disability to a social model that explicitly considers the complex institutional discrimination to which people with disabilities are exposed in their daily lives.

Disability: “... an umbrella term for impairments, activity limitations or participation restrictions”. (Source: World Health Organisation, International Classification of Functioning, Disability, and Health (ICIDH-2)¹⁶)

Acknowledging that disability has social as well as medical dimensions places national policy within the broader framework of social protection. This highlights the need for a coordinated multi-sectoral, multi-dimensional approach to meeting the state’s obligations to fighting poverty and social exclusion. The 1997 White Paper on INDS established these ideas at the core of national policy on disability. It underscored the need to take an integrated approach to addressing disability:

... there must be an integration of disability issues in all government development strategies, planning and programmes. There must be an integrated and co-ordinated management system for planning, implementation and monitoring at all spheres of government. And, to complement the process, there must be capacity building and wide public education.¹⁷ (Source: 1997 White Paper on INDS)

Suggestions concerning an amended definition of disability and the implications thereof are discussed below.

9.1.5 Economic consequences of disability

Disability is closely related to poverty. On one hand, disability makes households more vulnerable to poverty and poverty-creating shocks. Households must divert resources to the care of disabled members even as they lose the potential income-earning capacity of the impaired individual. Disabled people themselves face additional barriers to education, employment, and access to basic services (like transport) that conspire to keep them poor.

While disability increases exposure to poverty, poverty increases the risk of disability. The poor nutrition and poor access to quality healthcare, basic services, or even shelter experienced by many poor households reduces the resources available for preventing, managing, and coping with disability.¹⁸ Poor people are also more likely to work in more dangerous jobs, have less access to important information on the prevention or treatment of illness, and have less recourse in general to the management of potentially disabling injuries and diseases. For many reasons, then, poor people are more likely to be disabled.

9.1.6 Social consequences of disability

The social consequences of poverty manifest themselves in the awareness and attitudes of the public. Sometimes overtly, sometimes unintentionally, society discriminates against people with disabilities. Legal measures, even fundamental constitutional rights, cannot alone redress the prejudices of the public.

9.2 *Standards and norms of disability policy*

Government has worked on many fronts to address the needs of the disabled: programmes of formal social assistance have been broadened; social insurance funds have been established to cover disabilities caused in work-related accidents or road accidents; efforts to strengthen health, education, and transport systems are taking note of the disabled community. While these efforts have benefited and will continue to benefit many individuals and households, the majority of people with disabilities do not have access to these measures.¹⁹

The past two decades have seen the emergence and rapid growth of a strong human rights advocacy movement for persons with disabilities, which has succeeded, both at national and international levels, in placing disability rights on the national and international human rights and social development agendas.

This has led to the recognition of the right of persons with disabilities to be treated with the same status of citizenship that applies to the rest of society through the adoption of policies and the passing of laws that ensure the attainment of this goal, examples of which are discussed below.

9.2.1 International standards and norms

9.2.1.1 The UN World Program of action concerning disabled persons

The past 20 years have seen significant developments in international standard setting to promote equity for persons with disabilities. Some of the highlights in this regard were the declaration by the United Nations (UN) of 1981 as the International Year of the Disabled. This event generated a momentum within the international community towards policy and law reform on disability.

This momentum led to the adoption by the UN General Assembly, on 3 December 1981, of the World Program of Action Concerning Disabled Persons (WPA), which, to date, remains one of the most significant international policy documents on disability that fundamentally transformed global thinking on disability. In order to sustain this momentum, the UN also declared 1983-1992 as the International Decade of Disabled Persons, setting this as a timeframe within which the WPA was to be implemented by member states which committed themselves to its implementation.

The WPA introduced, for the first time in the history of international standard setting, the most progressive and comprehensive approach to disability management policy framework. It focuses on prevention, rehabilitation and the equalisation of opportunities for persons with disabilities. Central to this policy framework, is the concept of “equalisation of opportunities” and “equal participation” for persons with disabilities. The effect of introducing this concept was to shift the focus on disability from a health paradigm to a human rights approach. The WPA emphasises that too often the lives of persons with disabilities are handicapped by the social and physical barriers in society that hamper their full participation in social life.

It proceeds to define the notion of equalisation of opportunities for persons with disabilities as opportunities equal to those of the whole population and an equal share in the improvement in living conditions resulting from social and economic development.

9.2.1.2 The UN Standard Rules

An evaluation conducted at the end of the International Decade of Disabled Persons, on the implementation of the WPA throughout the world, showed that very little progress had been achieved. One of the criticisms made against the WPA was that it did not provide sufficient guidance for practical implementation at a national level, hence the need for a supplementary instrument to augment for this shortfall. This led to the adoption, in 1993, of a new instrument by the UN General Assembly, namely, the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UNSREO). Its purpose is summarised under clause 15, on page 8 as follows:

The purpose of the rules is to ensure that girls, boys, women and men with disabilities, as members of their societies may exercise the same rights and obligations as others. In all societies of the world there are still obstacles preventing persons with disabilities from exercising their rights and freedoms and making it difficult for them to participate fully in the activities of their societies. It

is the responsibility of states to take appropriate action to remove such obstacles. Persons with disabilities and their organisations should play an active role as partners in this process. The equalization of opportunities for persons with disabilities is an essential contribution in the general and world wide effort to mobilize human resources..

The Standard Rules sets out areas of awareness-raising, medical care, rehabilitation and support services as preconditions for equal participation, and then proceeds to set policy guidelines in areas for equal participation, namely, accessibility, education, employment, income maintenance and social security, family life and personal integrity, cultural, recreational and sports activities and religion. Finally, with regard to implementation measures, the Standard Rules contain a set of recommendations, regarding information and research, policy-making and planning, legislation, economic policies, coordination of work, the role of organisations of persons with disabilities, training, monitoring and evaluation of programmes, technical and economic cooperation and international co-operation.

The Standard Rules, which became one of the principal guides for the INDS, therefore identifies four preconditions (see above) for equal participation of people with disabilities. These preconditions not only serve to guide national disability policy, but also serve as benchmarks of progress and measures by which we may evaluate the successes and the failures of policy.

Together, these preconditions for participation and objectives for national disability strategy provide a set of useful standards and norms against which the current policy framework may be evaluated.

9.2.1.3 International Labour Organisation conventions and recommendations

Various International Labour Organisation (ILO) conventions and recommendations dealing with disabled people have also been adopted. These are valuable instruments to help develop aspects of disability policy in South Africa and also serve as tools to measure the extent to which law and practice meets with international standards. The Vocational Rehabilitation and Employment (Disabled Persons) Recommendation (No. 159) together with Rehabilitation and Employment (Disabled Persons) Recommendation (No. 186) deal with the vocational training of disabled people, promote the integration of these people into the open labour market and strive to ensure equality of treatment for disabled workers. Several conventions relating to employment injury schemes exist. ILO Convention No. 102 of 1952 deals with minimum standards of social security.

9.2.2 National standards and norms

9.2.2.1 Constitutional framework

The Constitution of 1996²⁰ provides for protection against the contingency of disability in the South African social security system. Constitutionally the protection occurs primarily via the anti-discrimination clause, which protects *all* people against direct and indirect discrimination. Disability is mentioned as one of the prohibited arbitrary grounds.²¹ However, people with disabilities are not specifically and separately defined as a protected class, as is the case in, for

example, Germany²² and Canada. The general constitutional entitlement to access to social security,²³ linked to the duty on the state to realise the said right, implies protection of the disabled as well. Any restructuring of the South African social security system has to be based on a human rights approach which must address the needs of disabled people as well.

9.2.2.2 Equalisation of opportunities legislation

The United States (US) was the first country to introduce equality legislation for persons with disabilities, covering a several key areas targeted for equal participation by the international instruments as discussed above. This statute, called the Americans with Disabilities Act, 1990, outlaws discriminatory practices in areas such as public accommodation, public transport and employment. It goes further to introduce a novel and progressive concept in law called “reasonable accommodation”, which as will appear later, has become part of South African equity legislation as well. This statute, however, is not an affirmative action statute and although it has significantly revolutionised the law on disability, it has suffered, we are told, major setbacks in recent court decisions in the US and its validity under the US Constitution is apparently under threat.

In South Africa, progress was made as early as 1994, when the Interim Constitution of 1993 took effect and provided for the right of persons with disabilities to equality, under the chapter on Fundamental Rights. This right was further entrenched under the new Constitution of 1996, which went even further, to sanction the promotion of sign language as one of the languages used in South Africa.

The first legislative response to the constitutional challenge of protecting all persons against unfair discrimination, including persons with disabilities, was expressed in the new Labour Relations Act, 1995,²⁴ which, under its “unfair labour practice” definition, expressly prohibited discrimination based on various grounds, including disability.

The South African Schools Act, 1996, followed suit, by prohibiting the refusal of learners with disabilities to admission in ordinary schools.

The Employment Equity Act, 1998,²⁵ is one of the most advanced legislative measures in the field of equity and disability, in that it combined most of the progressive concepts in labour law. The Act prohibits unfair discrimination in “any employment policy or practice” against disabled people as well,²⁶ and provides for the taking of affirmative action measures in favour of the disabled. This includes “making reasonable accommodation for people from the designated (i.e. the historically disadvantaged) groups to ensure that they enjoy equal opportunities”,²⁷ the setting of numerical goals to address the under-representation of these groups in the workplace, and the training and development of people from these groups.

Most recently, parliament passed the Preferential Procurement Policy Framework Act and the Promotion of Equality and Prevention of Unfair Discrimination Act of 2000.²⁸ This was in accordance with the requirements of the Constitution, which, upon commencement, will

significantly enhance the legal situation of persons with disabilities, as will be the case with other categories of persons disadvantaged by disability. It gives special attention to unfair discrimination on the ground of disability. It recognises that the failure to take steps to reasonably accommodate the needs of persons with disabilities would constitute unfair discrimination. For example, a public school which denies a child in a wheelchair admission to the school because the school does not have a ramp, would be failing in its duty to reasonably accommodate the needs of children with disabilities. In this example, the child's right to equality, right to education, the principle of inclusion and the child's right to participate in everyday society would be affected. The Act also imposes a clear and unequivocal duty on the state to take special measures to promote the rights of persons with disabilities.²⁹

9.2.2.3 Evaluation of effectiveness of equality laws pertaining to disability

The Employment Equity Act is indeed welcomed by the disability sector as progressive on the basis that it attempts to address the disadvantages faced by people with disabilities in the workplace. However, the definition used in the Act of persons with disabilities is criticised as being based on the medical model and views the impairment as the cause of the inability to attain success or promotion in the workplace.³⁰ Unfortunately the Act fails to cover large groups of people who are not in formal employment. Furthermore, the affirmative action chapter of the Act, as a rule, does not apply to an employer with less than 50 employees. This implies that small and medium-sized employers have little legislative incentive or prompting to appoint and accommodate applicants who suffer from a disability.

9.2.2.4 Administrative justice

The poor and inefficient administration of the grant system, in particular the disability grant system, and the flagrant disregard of basic legal tenets have been dealt with harshly by South African courts. In several cases the courts have found that the unilateral suspension or withdrawal of grants is unlawful and invalid.³¹ In one of the most recent cases the Eastern Cape High Court allowed a class action to be brought in this regard. Upon finding in favour of the applicants, the court ordered the reinstatement of the (disability) grants, some of which go back as far as 1996.³² This judgement has recently been upheld by the Supreme Court of Appeal.³³ The courts consistently held that an affected individual has a right to be heard before a grant is to be suspended or withdrawn; that notice of the intention to review the grant has to be given; and that reasons for the suspension or withdrawal have to be provided.³⁴

The Promotion of Administrative Justice Act³⁵ gives expression to the constitutional requirement that national legislation be enacted to provide the details of the broad framework of administrative law rights enshrined in the Bill of Rights.³⁶ The Act stipulates guidelines and benchmarks for administrative action³⁷ and decisions.³⁸ It requires a fair procedure in the event that administrative action materially and adversely affects the rights or legitimate expectations of any person.³⁹ What constitutes fair administrative procedure depends on the circumstances of each case,⁴⁰ but must, as a rule,⁴¹ include the following:⁴²

1. Adequate notice of the nature and purpose of the proposed action

2. A reasonable opportunity to make representations
3. A clear statement of the action
4. Adequate notice of any right of review or internal appeal, where applicable
5. Adequate notice of the right to request reasons.

If reasons have not been given to any person whose rights have been materially and adversely affected by administrative action, the person may within a 90-day period⁴³ request that written reasons be furnished.⁴⁴ Failure to furnish adequate reasons will be presumed to imply that the administrative action was taken without good reason.⁴⁵

It is accordingly suggested that the regulatory environment and enforcement of the Social Assistance Act and its concomitant regulations be adapted in order to comply with the tenets of administrative justice as required by the Constitution, the statutory law, and well-founded common law principles. It is further recommended that officials responsible for dealing with matters pertaining to grants, for example, when approving, turning down or reviewing applications, be made aware of the obligations on the state and the rights of applicants in this regard.

9.2.2.5 Policy framework: major areas of government action

Several instruments outlining and impacting on government policy with regard to the treatment of persons with disabilities have recently seen the light. It is suggested that the recommendations made in these instruments be fully explored, endorsed and implemented.

The White Paper for Social Welfare foresees the formulation of a policy on social security for people with disabilities. Social security must be made more accessible in terms of the physical environment, procedures and communication methods. The government has undertaken to endorse the WPA, the UN Standard Rules and the UN Charter on Rights for People with Mental Handicaps.⁴⁶

In 1997, under democratic rule, South Africa introduced a new policy on disability⁴⁷—the INDS. It is useful to consider what progress has been made in achieving its objectives, articulated in the 1997 White Paper on INDS. It focused on four objectives for disability strategy:

1. The facilitation of the integration of disability issues into government developmental strategies, planning and programmes.
2. The development of an integrated management system for the coordination of disability planning, implementation and monitoring in the various line functions at all spheres of government.
3. The development of capacity building strategies that will enhance government's ability at all levels to implement recommendations contained in the White Paper on INDS.
4. A programme of public education and awareness raising aimed at changing fundamental prejudices in South African society.

In an effort to integrate and orient national disability policy, The 1997 White Paper on INDS identified guidelines for reform and made recommendations for 15 major policy areas.⁴⁸ That there are so many functional areas of disability underscores the need for integrated policy and coordination, but also indicates the degree to which the broad scope and complexity of disability pose obstacles to efficient action.

The major functional areas of disability policy identified by the 1997 White Paper on INDS are:

1. Prevention
2. Public education and awareness raising
3. Healthcare
4. Rehabilitation
5. Barrier-free access
6. Transport
7. Communications
8. Data, information and research
9. Education
10. Employment
11. Human resource development
12. Social welfare and community development
13. Social security
14. Housing
15. Sport and recreation.

A detailed evaluation of each of these 15 policy areas is beyond the scope of this chapter. Policymakers in each of these areas have been required to identify strategies for addressing disability.

The CASE Report⁴⁹ has been published to recommend ways to attain the objectives set out in the White Paper on INDS. To overcome the exclusion of people with disabilities the document recommends a comprehensive strategy on social security.⁵⁰ It stresses the need for inter-departmental efforts, as well as public and private sector commitment.⁵¹ It further argues in favour of a social model of disability and that the criteria for establishing eligibility should look beyond medical diagnosis.⁵² Disability is seen as the result of the social environment's failure to adjust to the needs of this minority group. Retraining and vocational rehabilitation are seen as important mechanisms in dealing with diminished functional capacity. Current employment practices fall short of international standards in this regard.

Certain conclusions are also reached on the disability grant system currently in place. It is recommended that a clear distinction should be drawn between long-term disability grants needed by permanently, severely disabled people in a poverty situation, and short-term disability grants that are available whilst a person is receiving treatment and during that time is unable to work. The latter should be replaced by social relief available under other provisions, such as illness benefits under the Unemployment Insurance Act.⁵³

9.3 Mainstreaming and independent living

Previously the emphasis in the provision of social security and social services to people with disabilities was placed on separation from the mainstream systems of provision for the general population, based on the philosophy that persons with disabilities were different and thus required a different approach to that which applies to the rest of society. This marked the birth and development of the medical model of disability which is discussed in more detail, below.

However, nowadays policy aims to emphasise independent living—not merely institutional care—for people with disabilities. The ability to engage with society is an issue of dignity, self-respect, and empowerment; enabling people with disabilities to live independently is an important statement to society in general that people with impairments can be and are in fact *able* and *capable* individuals.

These ideas lie at the core of efforts to “mainstream” people with disabilities into the existing system of services. Incorporation into the mainstream framework of service provision has a variety of advantages:

- It promotes engagement, understanding, and social inclusion
- It challenges the service system and society to engage people with disabilities
- It opens up a world of valuable resources and experiences to people with disabilities.

Mainstreaming has drawbacks as well, however. These have provoked an international debate about the trade-offs involved in moving from a system of special services for people with disabilities to a mainstreamed approach. Many people with disabilities would doubtless be better served by specialised service systems that are designed to address their particular needs. For example, should children with sight or hearing disabilities attend regular schools, or would they be better served in a special school for the seeing impaired? This debate can be difficult and emotional for some.

While a special school may provide a more encouraging and enabling environment, it may also isolate students with special needs from the broader society of their peers, inadvertently encouraging social ignorance of disability. Also, providing special services provokes a tension between legal requirements for equal access and opportunity and the practical need to use scarce fiscal resources to improve access for all South Africans. Government cannot feasibly provide

special services for all disabled people. It may be more practical to work to improve the ability of mainstream facilities to meet the needs of this group.

9.4 Progress and gaps in the current framework

A detailed, programme-by-programme review of disability measures is beyond the scope of this chapter. Each policy area has its unique complexities, the details of which cannot be captured in a summary such as this. Speaking broadly, however, we may note some general successes and broad gaps in the current framework.

The INDS states that “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”.

However, when we compare the South African system with those of countries of similar socio-economic status, then it must be acknowledged that the state has managed to create and maintain a system of adequate coverage for a relatively large group of adults with disabilities. However, the provisioning for children with disabilities is far less successful.

Progress, therefore, has been mixed. In general, the INDS has correctly identified the major issues and has been successful on orienting strategy in a direction consistent with national and international norms and standards. Government has acted to focus policy on people with disabilities in a number of important areas:

- The efforts of the Department of Education in establishing policies for special needs education (ELSEN) and early childhood development (ECD) are one example of this.
- The Department of Transport has devoted special consideration to the issues of disability in its Moving South Africa programme.
- Department of Labour reformulated Workers’ Compensation partly in response to The 1997 White Paper on INDS.

These actions testify to the ability of government to take initiative, on multiple fronts, in the area of disability policy.

Progress has, however, been wanting in many other areas. Civil society and people with disabilities have noted certain themes and issues requiring more attention from government. Submissions to the Committee from civil society have consistently emphasised these points.⁵⁴ Although they apply in varying degrees to different functional areas of disability policy, these themes are generally relevant to all efforts to address disability. They may be summarised as the following major weaknesses in the current framework of disability policy:

1. Access
2. Administration

3. Information
4. Assessment.

9.4.1 Access

The theme of access is the broadest. Although policy has explicitly recognised the problem, people with disabilities remain excluded from society both physically and socially. They are prevented by a variety of obstacles from even engaging in formal support mechanisms for which they are legally entitled.

Of most immediate concern to government is the need to improve access to official support, basic services, and also effective means of adjudication when they are deprived of these rights. To accomplish this, policymakers must take direct action such as establishing dedicated legal avenues for people to seek redress of non-payment of social assistance grants. Policymakers must also focus on the indirect obstacles to access, of which improving administration, information, and assessment of disability are key concerns.

9.4.2 Administration

Among the most consistent complaints in the social security system are those concerned with the poor administration of public support for disability.⁵⁵ The administrative capacity of the system cannot cope with the scale of its responsibilities. Indeed, this is a theme that applies generally to the system of social welfare. The experience with re-registration of welfare beneficiaries is an example of well-meaning and appropriate policy that can be damaging due to a lack of administrative capacity.

9.4.3 Information

There is a general failure to provide people with the most basic information on disability. The ability to disseminate accurate information about the rights and entitlements of people with disabilities is among the most basic requirements of a system of social protection that seeks to address disability. Often, even the most basic information about disabilities and how to cope with them is lacking.⁵⁶ Equally if not more important is the need to disseminate information on simple health and hygiene measures that can help prevent disabilities resulting from malnutrition and illness. In short, the need for clear, accessible information for people living with disability, their families, and their supporters has long been recognised, yet this remains a principle weakness in the system.

9.4.4 Assessment

Access to formal support under social assistance, the Road Accident Fund (RAF), or the Compensation for Occupational Injuries and Diseases Act (COIDA) requires a medical assessment of disability. The inconsistency with which such assessments are administered is a major problem. The system of medical assessment lacks universal guidelines and standards that are required for the just and equitable administration of social support for the disabled.

9.5 *The need to reconceptualise disability*

9.5.1 Integrating the medical and social model in developing an interactionist approach

The INDS suggested a paradigm shift in policy formulation and implementation, by replacing the traditional “medical model”, with the progressive “social model” on disability.

The medical model is understood as follows:

The medical model views disability as a personal problem, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals. Management of disability is aimed at cure or the individual’s adjustment or behaviour change. Medical care is viewed as the main issue, and at a political level, the principal response is that of modifying or reforming healthcare policy.

The social model, on the other hand, is understood as follows:

... [It] sees the issue mainly as a socially created problem, and mainly as a matter of the full integration of individuals into society. Disability is not an attribute of individual but rather a complex collection of conditions, most of which are created by the social environment. Hence the management of the problem requires social action, and it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of life. The issue is, therefore, an attitudinal or ideological one requiring social change, which, at political level becomes a question of human rights. Disability becomes, in short, a political issue. (Source: ICIDH-2, July 1999, World Health Organisation)

As a general rule, the definitions of “disability” contained in the South African laws have in common that they make use of a medical and/or occupational, as opposed to a social, concept of disability. This is in particular true of the specific labour⁵⁷ and social security laws⁵⁸ of South Africa, which define disability with reference to a particular medical model of disability. This model focuses on the effect the impairment has on the ability to attain success and be promoted/accommodated in the workplace. No mention is made of the role that structural and attitudinal barriers play in excluding people with disabilities from the open labour market.⁵⁹

Of course, the need for a proper disability definition or model becomes less apparent in the event of a properly constructed and broadly accessible social insurance and social assistance system, as suggested above. However, a proper definition or model is needed to ensure access to specialised provisioning.

As far as the present disability definitions are concerned, it has to be noted that they are for various reasons unacceptable, as they are constructed in such a way (a) as to serve as a disincentive to work; and (b) that they overemphasise capacity for labour market participation, and do not take into account social and labour market barriers, as well as broader social and environmental factors.

It is, therefore, proposed as a short-term measure that the said definitions be amended so as to reflect an interactive approach, which takes into account both medical condition and social and environmental factors.

It is further proposed that the definitions be widened in order to include four main categories of disability, namely physical, mental, sensory and intellectual disability.

It is also suggested that the International Classification of Functioning, Disability and Health (ICIDH-2) approach to the definition of disability could be helpful, despite its problematic classification framework (discussed below), as it stresses three main elements, namely:

1. Anatomical malfunctioning
2. The impairment of normal human functions as a result of the condition
3. The question whether the condition hamper or impair the ability to socially integrate.

An amended definition should serve two main purposes, namely, firstly, to identify whether the person concerned is indeed covered according to the revamped (wider) definition and, secondly, to identify the appropriate range and level of transfers (cash or in-kind benefits, goods and/or services) required to address the needs of the particular person according to the particular kind of disability suffered by the individual.

It is further recommended, in adopting such a needs-based approach, that reliance on cash transfers be limited, and that government invest substantially in the development of a range of appropriate (public) goods and services to deal effectively with the range of disability conditions.

9.5.2 Classifying disability?

More recently, an initiative has been taken by the World Health Organisation to develop an instrument for the classification of disability, called the ICIDH-2, to substitute the previous classification instrument developed in 1980, called the International Classification of Impairments, Disabilities and Handicaps, (ICIDH0), which defined and drew a distinction between, “impairment”, “disability” and “handicap”.⁶⁰

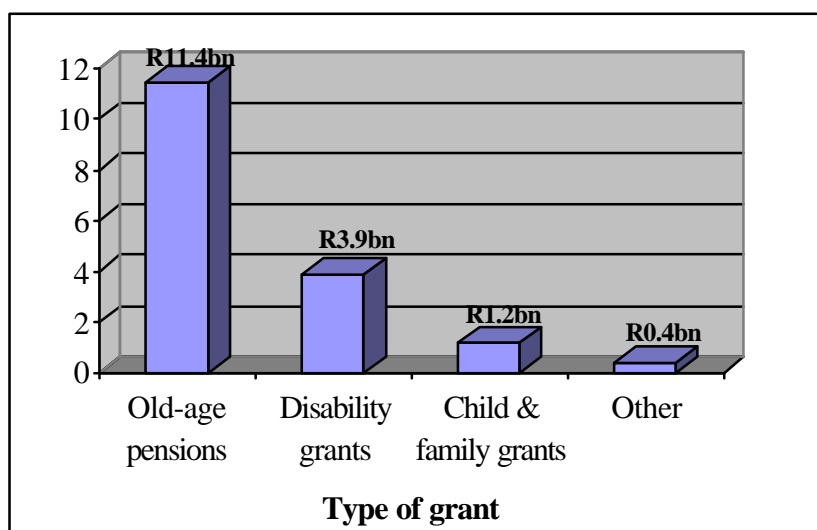
Persons with disabilities generally reject any form of classification as it entrenches labelling, stigmatisation, prejudice and thus, marginalisation.

9.6 Mon-contributory income transfers—social assistance act (no. 59 of 1992) and regulations

9.6.1 General

The Social Assistance Act provides for the rendering of social assistance to persons, national councils and welfare organisations.

Figure 9.1: Breakdown of social security budgets (1999/2000)



Source: Estimate by Budget Office, Dept. of Finance 2000

Figure 9.1 indicates that: 61 per cent of social security budget is spent on pensions

- 10 per cent on children from poor families
- 25 per cent on grants to people with disabilities, of which 2 per cent is for children
- The Care Dependency Grant (CDG) = 0,5 per cent of total social security budget. (Source: Provincial Expenditure on Disability Grants 1999/2000-2000/2001)

9.6.2 The social grant for disabled persons

9.6.2.1 Qualification

To qualify for a disability grant under the Act, the applicant must be over the age of 18 years and have a physical or mental disability that is projected to last for six months or a year (in the case of a temporary grant), or for a longer period (in the case of a permanent grant renders him or her unfit to provide sufficiently for his or her maintenance (in terms of the prescribed means test). In addition, he/she must:

- Be a South African citizen
- Be resident in South Africa at the time of the application

- Be a disabled person, who has attained the age of 18 and as a result of the disability is unable to obtain employment or does not have any other resources to support him- or herself
- The period of disability must either be permanent or for a continuous period of six months or one year
- Not refuse to undergo the necessary medical treatment, unless the treatment may be life-threatening
- If the applicant is married, the means test is based on the combined income of the two
- Not be maintained or cared for by a state-run institution
- Must not be in receipt of another social grant, in respect of him- or herself.

9.6.2.2 Lapsing or termination

The temporary disability grant will continue to be received by the recipient until it lapses. If it is a permanent grant then it will continue until the recipient reaches the age of 60 or 65 years, at which stage it will then be converted into an old-age grant. The grant will also lapse on the last day of the month in which the beneficiary dies or when the beneficiary is admitted to an institution.

The grant also lapses when the recipient becomes employed and his/her income rises above the threshold amount of the means test. This creates perverse incentives and a poverty trap—most people with disabilities receiving the grant are totally dependent on it and are discouraged to seek out alternative sources of income for fear of losing the grant.

9.6.2.3 Means test and amount payable

Means tests are currently applied in one way or another to all the benefits provided by the Department of Social Development, as well as access to public hospitals and housing benefits. In addition, exemptions from municipal services and school fees are means tested.

The tests are not consistent and very poorly administered. If they were, however, correctly administered, the net effect would be marginal rates of benefit claw- back from 50 per cent to over 100 per cent.

This is because the means tests are independently applied. An increase in income from R500 monthly to R600, could lead to the loss of disability grant, medical benefits and exemption from municipal services and school fees with a combined value of well in excess of R100.

The disability grant is payable on a monthly basis and the current maximum amount payable per grant is R570 per month (having increased from R540 as of June 2001), determined in accordance with a set formula. The maximum amount payable is multiplied by one-and-a-half times the applicant's income if he or she is single (or by half of the applicant and his or her spouse's income) and is subtracted there from. If the amount is less than R100 then no grant is payable. In addition,

where the applicant's assets exceeds 30 times the maximum annual grant payable (or 60 times the total assets of the applicant and spouse) no grant is payable.

In practice this sliding scale of benefits is rarely used as the majority of applicants fall well below the means test and therefore qualify for the full amount.

9.6.2.4 Assessment

Disability assessments are undertaken by a medical officer with the final approval given by the medical pensions officer, who effectively reviews the former's medical report without having to re-examine the applicant. However, the amending regulations to the Social Assistance Act provide that the assessment is to be undertaken by an assessment panel.⁶¹

9.6.2.5 Uptake

In January 2001, SOCPEN recorded that almost 650 000 disability grants were paid out, amounting to R370 million.

The South African Council for Disability and the Child Health Unit (SAFCD/CHU) Report avers that if between 5 per cent and 12 per cent of the South African population have a disability, then it may be estimated that approximately 7 per cent have a severe disability, which equates to around 3 million persons, of which nearly 1 million would fall in the poorest quintile (30 per cent). This would equate then to approximately 60 per cent uptake of the persons eligible for the grant.

9.6.3 The CDG

9.6.3.1 Qualification

Section 2(g) of the Act, empowers the Minister to pay "a care-dependency grant to a parent or foster parent in respect of a care-dependent child".⁶²

Section 1 of the Act defines a care-dependent child as a child:

- Between the ages of one and 18 years
- Who requires and receives permanent home care
- Due to his or her severe mental or physical disability.

"Permanent home care" and "severe disability" are not defined in the Act or the regulations.

Regulation 5 gives more detail on who is eligible for CDGs.

9.6.3.2 Assessment

A parent of a care dependent child is eligible for a CDG if:

- The medical report from a medical officer⁶³ confirms that the child in question is a care dependent child as defined in the Act.
- The medical report has been approved by a medical pensions officer.

The application process involves two forms, the first being a general application form for all applicants for grants and the second, being the medical assessment form which is specific to the CDG which must be filled in by a medical officer.⁶⁴

9.6.3.3 Means test and amount payable

A monthly payment of R570 is paid to the parent/s or foster parent/s of the child.

The grant is payable if the combined income of the family, after all permissible deductions, does not exceed R48 000 per year, or such higher amount as the Minister may from time to time determine. In the case of a foster parent the means test is not applicable, as in the case of foster care grants.

Regulation 14 specifies how the income of the family is determined, and Regulation 15 lists the permissible deductions.

9.6.3.4 Special conditions

In terms of Regulation 22, the child must remain in the parent's care, with accommodation, food and clothing and necessary medical and dental care. When the child is six years old, the parent must take the child to be evaluated to determine his or her educability and trainability for attendance of a school for specialised education, nor must the child be permanently cared for in a state-run psychiatric hospital or care and rehabilitation centre.⁶⁵

9.6.3.5 Lapsing of grant

The CDG shall lapse when the parent or child dies; when the child reaches the age of 18 years; or when the child is admitted to a state-run psychiatric hospital or a care and rehabilitation centre (this does not include temporary admission to a psychiatric hospital for a period not exceeding six months). (Regulation 24).

9.6.3.6 Amendments proposed by the Department of Social Development

With regard to CDGs, the draft amendments propose that the definition of care dependent child be amended by the substitution of the words “permanent home” with the phrase “24 hour care”.

Regulation 22 which deals with “special conditions regarding CDGs” is to be amended by the deletion of sub-regulation (c)—the requirement that a care-dependent child must be evaluated at age six to determine whether he or she can attend a school.

9.6.3.7 Uptake

In April 1999, 17 721 beneficiaries received the CDG, this increased by 30,9 per cent to 23 200 in April 2000, and to 30 737 in January 2001. It is a positive trend that these numbers are steadily increasing, indicating improving accessibility.

9.6.4 Gaps, limitations, discrepancies in and suggested improvements to social assistance provisioning

9.6.4.1 A lack of synergy

There are different pieces of policy and legislation which govern the different parts of social protection in South Africa. These pieces of legislation tend to contradict each other, for example the Employment Equity Act (EEA) promotes employment of people with disabilities. On the other hand, the social assistance policy, in the way that it is currently constructed, discourages people with disabilities from seeking formal employment (as shown below).

9.6.4.2 Perverse incentives—poverty trap inducing

Targeting of the poorest persons through the application of a means test discourages persons from taking measures to raise their own levels of income. They thus become increasingly dependent on the grant.

This is especially aggravated by the fact that access to other services such as free healthcare and public transport, is often dependent on the receipt of the grant.

Although a person with disabilities may be formally employed, added disability expenses incurred such as healthcare and transport needs are not always considered, and inevitably the fear of losing a disability grant becomes a disincentive for persons to work.

9.6.4.3 Purpose

The poverty alleviating purpose of the grants for persons unable to provide for themselves and their incapacity to work due to the disability is essential and obviously necessary. However, as mentioned above, there are many other additional costs and needs that are not considered in this narrow purpose of social assistance.

9.6.4.4 Definitions and measurement of disability

In terms of defining disability, the legislation on social security seems to have different approaches. On the one hand the Social Assistance Act concentrates on the diagnostic approach in determining the degree of disability, whilst COIDA adopts a percentage-based approach, on the other.

The latter focuses, for example, on the number of limbs lost as a result of the injury (refer to Appendix 11 COIDA Schedule). In terms of the Social Assistance Act formula, you are seen as permanently disabled if the assessment shows 50 per cent or more disablement based on your

diagnosis. In terms of the COIDA schedule the more severe the disability, the higher the percentage of disability will be. For example, the highest percentage of disability arising from injury is fixed at 100 per cent. An example of such a percentage would be total paralysis. The smallest injury is fixed at 1 per cent disability (e.g. loss of a toe).

The underlying rationale behind these divergent approaches is based on the fact that social assistance is designed to provide uniform benefits, regardless of the degree of disability between the different beneficiaries, with differentiation in benefits being linked to the degree of poverty, measured through a means test.

COIDA, on the other hand, neither considers the degree of need based on the disability specific needs nor considers the degree of poverty being experienced by the beneficiary concerned.

Needless to say that disability, no matter how severe, is not, *per se* a sufficient inhibitor for a person to obtain or retain gainful employment or partake in any gainful economic activity, especially with the support of currently available innovative technology.

9.6.4.5 Assessment procedures

The assessment procedure is entirely the subjective decision of the district surgeon, who acts as the medical officer, and then the final approval by the pensions medical officer who has not physically seen the applicant. The medical officer produces a report on the person applying for the disability grant. In that report the district surgeon attempts to reflect the level of disability suffered by the individual as a percentage; where the report reflects more than 50 per cent disablement the person is then entitled to receive a disability grant. Thus the right to administrative justice and self-representation for people with disabilities is non-existent.

Persons with hearing impairments are particularly discriminated against in the assessment process as usually the medical officer cannot communicate with the applicant.

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.

The Act identifies disability type by category for eligibility and excludes large numbers of disabled people that do not meet the criteria, for example sensory and intellectual disabilities, and non-evident disability like epilepsy. In addition, the application forms are designed in such a way that they exclude certain disabilities such as blindness and autism.

The means test is inappropriate as it is in practice applied only once—when an application for a disability grant is made, and it does not take into account changes in income and other socio-economic circumstances of the beneficiary. The means test is based on the income bracket and ignores disability specific needs.

9.6.4.6 Review processes

The disability assessment for disability grants is at the discretion of a medical officer. It used to disadvantage people with disabilities as it took away their right to state their case during the review. Changes to the regulations now provide for appearance of a beneficiary before an attesting officer. Where a temporary disability is concerned and a grant is given there are many instances where the grant comes up for review. There is no consistency in terms of the time period applied to when the grants should come up for review and in many instances the grant is simply deleted from the system and in order to receive the grant, the person must reapply.

9.6.4.7 Purpose of the CDG

- The current purpose of the CDG to enable permanent home care, only for permanently disabled children, is limiting and inadequate, and open to different interpretations.
- The purpose of the CDG should not be poverty alleviation, but rather to meet the extra needs of the child due to the illness or disability. It should be to promote their survival, development, protection and participation.
- Eligibility criteria should be determined by the needs resultant from the particular disability or illness, and not dependent on the nature or severity of the disability or illness.
- Attention should be paid to the family context of the child, to improving their environment.

9.6.4.8 Definitions

There is a lack of clear definitions (disability, severe/moderate, permanent home care) in the current legislation. This has serious implications for inclusion/exclusion criteria and makes targeting extremely difficult.

There is lack of clear definition between non-disabling or intermittent chronic illnesses and those that lead to disablement.

The current definition is purely a medical definition of disability. Economic and social aspects are not considered, nor the “cost”, or burden on the family.

9.6.4.9 Eligibility criteria

- Currently the CDG benefits only severely disabled children permanently at home, and do not cater for the many others with milder disabilities, or those in day care facilities.
- There is no provisioning at all for children with chronic illnesses, including HIV/AIDS. These children have many additional needs and expenses and caring for them constitutes a large burden on the family’s resources.

- It is extremely difficult for care-givers (non-parents and “non-formal” foster parents) to access the grant. Access should be granted to this group of carers, and should include child-headed households.
- There is a lack of clarity regarding the eligibility of children in day-care centres or Schools for Learners with Special Needs (LSEN) schools for the CDG, and there exists differing practices among different provinces. Uniformity in definition and eligibility criteria is essential.
- There are many children who are not in receipt of the CDG and who attend state subsidised special schools, yet require special home care after school hours and during the school vacation. There are no policy guidelines for special after care.
- There is a lack of clarity with regard to foster parents receiving a foster grant as well as receiving the CDG. Some provinces do allow receipt of both grants. Again, clarification and uniformity in practice are necessary.
- It should be noted that the grants are for different purposes, and therefore these parents should be entitled to both. It would encourage people to foster children with disabilities and HIV/AIDS.

9.6.4.10 Means testing

- While means testing enables targeting of the poorest quintiles, in practice it is rarely used correctly, is administratively demanding and has been reported as demeaning.
- Sometimes the extra expenses incurred by tighter targeting mechanisms cannot be justified and make the programmes unsustainable. The costs of administration could be channelled into providing a universal grant to more recipients.
- It is therefore recommended that eligibility criteria for a needs test, which considers the extra needs and costs, should determine social assistance incurred by the child due to his/her illness or disability. There could be a scale of benefits depending on the need.
- It is difficult to target expenditure within households, and thus to ensure that the child benefits from the social assistance. Provisioning to the primary caregiver is based on the assumption that if the household benefits, then the child within the household should also benefit. Other forms of social assistance such as vouchers and subsidies would target the child more directly.

9.6.4.11 Assessment procedures

- Due to the unclear eligibility criteria, the assessment test can be highly subjective and open to the personal interpretation of the medical officer.
- There is lack of training and guidelines in the assessment procedure.
- A child can only be assessed and qualify once one year old. This delay can cause suffering to new-born babies requiring extra care due to their disability or health condition.

- Currently the assessment is on purely medical grounds. It should also take into account the costs of the required medical treatment, the level of care required (hours and intensity), the costs of assistive devices, specialised clothing and nutritional needs, transport costs and the need for special schooling.
- There are problems identifying what constitutes “permanent home care”. Perhaps this clause should be removed entirely, and eligibility determined by need.
- Reviewing of cases must also be examined.

9.6.4.12 Administrative challenges

- Delays, inconsistencies and confusion in assessments, demeaning attitudes of officials etc.
- Lack of awareness of the grants available.
- Current systems, delays and frustrations are degrading and embarrassing for carers. Any new system must be streamlined for efficiency and must have due consideration and respect for human dignity.
- Attitudes of welfare officials contribute to the process being humiliating for the applicants. They remain disrespectful and inconsiderate towards recipients of grants.
- Delay and 3-month limitation on back pay: given that applications invariably take at least 4-5 months to be processed.
- Problems with incorrect documentation.
- Lack of awareness of processing requirements and eligibility by welfare officials. This may be due to inadequate training of officials and there needs to be standard and comprehensive training to facilitate a smooth processing procedure.
- There is need for uniform standards, assessment guidelines and procedures, with the possibility of one means test for eligibility to all the grants.
- Provincial budget allocation and administration does not correlate to national standards and norms.
- Efforts must be made to educate the public on their rights, on the grants available and the procedures for accessing these.
- Lack of inter-sectoral collaboration. This is essential to the development of a holistic approach to the provision of social security. There must be the involvement of all the relevant departments, with perhaps one department to guide and co-ordinate the process.

9.7 Health coverage

9.7.1 General

9.7.1.1 Restructuring and inadequate resourcing

The South African Human Rights Commission (SAHRC) report (2000)⁶⁶ states that, central to the government’s provision of healthcare services has been the transformation of the public healthcare

sector to a district based service providing primary healthcare (PHC). District health services accounted for one of the largest programme allocation increases in spending.

A disproportionately high amount of the budgetary increases has been spent on personnel, to the detriment of non-personnel expenditure. Whereas personnel expenditure increased by 32,8 per cent from 1996/1997-1998/1999, non-personnel expenditure decreased by 83 per cent over the same period.

Although the redistributive policy that underpins the current allocation of resources has seen an increase in the allocations to historically marginalised service sectors, it has, at the same time, resulted in a reduction in the capacity of previously advantaged services to cope with the increased demands for those services under the current non-segregated environment.

This particularly affects people with disabilities as they are unable to access private healthcare and are dependent on public healthcare. Often, people with disabilities are forced to use their disability grants to pay for private or public healthcare, and are therefore completely dependant on social assistance.

Most people with disabilities are resident in the rural or peri-urban settings. PHC services are almost non-existent to disabled people as their needs are catered for at district level due to the lack of adequate facilities in the primary healthcare environment.

The frequent unavailability of medicines and medical supplies in the primary healthcare environment, often results in numerous hospital visits which results in the latter becoming unnecessarily overloaded.

9.7.1.2 Community-based rehabilitation (CBR)

CBR is not seen as a viable alternative for addressing some of these needs, irrespective of the fact that there are proven good CBR models in the country, for example the Department of Health & Disabled People South Africa's (DPSA) partnership in Mpumalanga.

The situation is exacerbated by the fact that there is no national rehabilitation policy, as the policy has been in a draft format for the past four years. Provincial health departments have to date not seriously addressed rehabilitation needs of people with disabilities.

Presently some provincial health strategies are not inclusive of rehabilitation at district level. For example, rehabilitation services are currently centralised at specialist hospitals and are not available to people outside urban areas. Also most people with disabilities who need assistive devices are without them as they are not easily available, appropriate and affordable. This further results in people with disabilities being dependant on the health system developing secondary disabilities, which, in turn, generates an opportunity cost for the state.

Currently, for example, there is no national policy on the manufacturing, distribution and maintenance of wheelchairs (which currently falls within the rehabilitation services in health). Provinces supply these assistive devices through their rehabilitation sections without any policy or legislative framework providing for such allocations.

9.7.2 The mission of the Department of Health

The stated mission of the Department of Health is to “provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa, and to provide caring and effective services through a primary healthcare approach.” (See p. 13 of the White Paper on the Transformation of the South African Health System). Flowing from this mission, the Department of Health has specified various goals it wishes to achieve. The following are relevant to people with disabilities:

1. Promote equity, accessibility and utilisation of health services
2. Extend the availability and ensure the appropriateness of health services
3. Foster community participation across the health sector
4. Improve health sector planning and the monitoring of health status and services.

In attempting to achieve these goals, the Department of Health has developed a specific policy relating to people with disabilities. The broad thrust of the policy is to integrate services for people with disabilities into a package of primary healthcare services, and move away from vertical services and institutional care for those with mental disabilities.

9.7.3 Causes of disability

In 1997, the Department of Health commissioned a comprehensive analysis of the nature and extent of disability in South Africa, to assist in the planning and provision of appropriate services for people with disabilities. The study was completed in October 1999 by the Community Agency for Social Enquiry CASE disability survey.

The research results suggest significant differences in the cause of disability between the races, although similar proportions of African and white male respondents reported events prior to or at birth as the cause of disability. Illness, birth defects and accidents are the top causes of disability among all respondents. Coloured males face the highest risk of disability from violence, while Indian males were more likely to state ageing as the cause of disability. Coloured and African females were the only females reporting violence as a cause of disability, while Africans were the only ones reporting “witchcraft” as a cause of disability. The high percentage of Africans reporting ignorance of the cause of their disability is of concern.

9.7.4 Reflections on the quality of health services

The most common illnesses given as a cause of disability were:

- High blood pressure (14 per cent of all illness)

- Epilepsy (8 per cent)
- Ear infections (7 per cent)
- Psychiatric illness, hereditary illness (7 per cent)
- Diabetes (6 per cent)
- Arthritis (6 per cent)
- Polio (4 per cent)
- Unspecified illness (8 per cent).

These statistics are a matter of concern, as they reflect important inadequacies in the provision of immunisation and chronic disease management. The South African Demographic and Health Survey also highlights the problem of inadequate chronic disease provision (SADHS,1998).

In addition, the fact that rural Africans were more likely to be disabled at birth (20 per cent) than their urban counterparts (16 per cent) is a reflection of the poor quality of rural health services. Finally, the extent of ignorance among Africans regarding the cause of their disability is a negative reflection on the quality of services provided to them.

9.7.5 Access to services

Access to disability services play an important role in the quality of life of disabled people, and have a major influence on their ability to access other services. For example, those disabled people with assistive devices have a higher chance of employment than those without. There is a good link between the use of assistive devices and access to grants—those with assistive devices were more likely to access grants, and those with grants were more likely to use assistive devices.

The Case disability survey reflects a relatively high level of need and access to health services, which is a reflection on the ease of access of health services for disabled people. However, it is a point of serious concern that according to the survey only 37 per cent of those requiring assistive devices were able to access them. The survey found that 60 per cent of the disabled people received their services from public facilities, while 20 per cent used private facilities and the remaining 20 per cent used a mixture.

Access to these devices tends to be biased towards white and urban residents. Children attending special schools are more likely to access assistive devices than those attending mainstream schools. Assistive devices are a critical determinant of the person with disabilities' perception of the severity of disability. 58 per cent of respondents with no assistive devices viewed their disability as severe. When an assistive device was provided, the number rating their disability as severe dropped to 12 per cent. The provision of an assistive device and a personal assistant reduced the perception of severity to only 4 per cent of respondents.

However, the Case disability survey shows very low levels of assistive device provision, which could be a reflection of both limited access and limited knowledge of the availability of the services. More recent information from the provincial departments of health suggests significant backlogs in the provision of assistive devices. Clearly, there is a need to educate people about the resources available, and to increase access to them.

9.7.6 Issues relating to people with mental disabilities

Extreme poverty, family disruptions and high levels of violence put South Africans at a high risk of mental illness. Despite this, few studies have attempted to assess prevalence rates of psychiatric disorders among the population. A rough estimate provided by the South African Health Review suggests that at least 15 per cent of youth suffer from mental health problems, while one in 10 children have a physical or mental disability.

In the past, mental healthcare was run as a vertical programme, with poor intersectoral liaison and co-ordination of services, leading to duplication and fragmentation. The services were largely custodial, and focused on occupational therapy and in- and outpatient psychotherapy and counseling. Access to the services tended to be skewed in favour of the urban, wealthier population. Since 1994, vigorous policy development has occurred with the aim of achieving greater integration of mental health services in the broader national health system.

9.7.6.1 Policy interventions

The Department of Health has given due cognisance to the needs of people with disabilities, through the establishment of the directorates for chronic diseases, disabilities and geriatrics, and the mental health directorates. In addition to these directorates, other units within the Department of Health have developed some policies which have a direct bearing on disability. These policies will be described in turn:

9.7.6.2 National policy on rehabilitation

The policy framework was published in November 2000. A central tenet of this policy is a strategic move towards community-based rehabilitation, which is defined as a strategy for the rehabilitation, equalisation of opportunities and social integration of people with disabilities. The policy takes on an interdepartmental approach, specifying specific responsibilities for each leading department.

In the case of the Department of Health, the main goal is to prevent an impairment from arising or worsening, to reduce as far as possible the degree of disability for a given impairment and to reduce any social disadvantage arising from a given disability. The strategies identified to achieve this goal include:

- Community based campaigns
- Implementation of screening programmes to enable early detection
- Sufficient hospital stay to achieve rehabilitation goals

- Prioritisation of family involvement and education on the prevention of disability
- Follow-up and evaluation
- Functional assessment in order to prevent any secondary emotional, cognitive, mental, motor-sensory and social effects of impairment
- Counseling and psychological support programmes
- Clear referral systems to ensure that clients are followed up in the community after discharge
- Provision of treatment and devices in the natural social setting wherever possible
- Equipping rehabilitation personnel with the skills and tools necessary to design effective treatment programmes as well as the provision of appropriate therapeutic devices
- Optimal utilisation of all resources through collaboration amongst the different levels of healthcare.

The policy document also suggests that user fees for assistive devices should be uniform, and that a list of basic assistive devices to be provided free or at a nominal fee should be developed. It is also suggested that free healthcare for children under six should also apply to the provision of assistive devices, within affordable levels.

9.7.6.3 The Mental Health Bill

The Mental Health Bill aims to:

1. Enable the provision of the best possible mental healthcare, treatment and rehabilitation that available resources can afford
2. Make effective mental healthcare, treatment and rehabilitation services available to the population equitably, efficiently and in the best interests of the mental healthcare user
3. Coordinate access to and the provision of mental healthcare, treatment and rehabilitation services
4. Integrate access to and the provision of mental healthcare services within the general health services environment.

In addition, the Bill attempts to protect the rights of mentally ill patients by specifying the following:

- Specific accreditation criteria that must be met in order to be designated as a health establishment to provide mental healthcare services.
- Obligation on all health establishments to ensure the protection of mentally ill patients from exploitation, physical or other abuse, neglect and degrading treatment. Failure in this regard is a criminal offence punishable by a maximum of R5 000 fine and/or six months imprisonment.

- Circumstances under which mentally ill patients may receive involuntary care, treatment and rehabilitation.
- Circumstances under which mentally ill patients may be transferred to maximum security facilities.
- Care for, treatment and rehabilitation of prisoners with mental illness.
- Significantly, the Bill also aims to regulate the manner in which the property of those with a mental illness may be dealt with by courts of law.

The Mental Health Bill does not deal specifically with the needs of children, although their inclusion could be inferred in the definition of “mental healthcare user”. In order to pay specific attention to the needs of children, the Department of Health produced draft policy guidelines for Child and Adolescent Mental Health, in January 2001.

9.7.6.4 Draft Policy Guidelines for Child and Adolescent Mental Health

The guidelines take account of other national policies, legislation and treaties that address themselves to the needs and rights of children and adolescents. The guidelines identify causal factors that can affect mental health, in both the physical, emotional and social domains of children and adolescents. In view of the risks identified, the Department of Health prioritises prevention of mental illness, and proposes the following areas for special focus:

- Prevention of delays in emotional and intellectual development
- Introduction of life skills education
- Prevention of substance-related problems such as fetal alcohol syndrome.

In addition to these priorities, the guidelines adopt an intersectoral and interdepartmental approach, and specify five intervention strategies to address the mental health needs of children and adolescents. These are:

- Providing a culturally sensitive, safe and supportive external environment.
- Providing information, to empower not only the children but also parents and other carers
- Building skills, including life skills provision with the possible employment of children and adolescents themselves as trainers.
- Providing counseling, to be provided by professionals such as teachers, health workers or religious leaders, and where necessary trained peers or other lay people.
- Improve the accessibility of healthcare services, by ensuring that the health sector can provide a continuum of mental healthcare services from primary care to highly specialised services for the severely mentally ill.

9.7.6.5 Inclusion of mental health services and rehabilitation services in the Primary Healthcare Package

In line with Department of Health's philosophy regarding the PHC approach, it has developed a comprehensive Primary Healthcare Package, which all South Africans should be able to access at any public primary facility. All services for people with physical and mental disabilities have been included as part of the core package, and the intention is for these norms to be achieved in the next five years, at both primary healthcare facilities and district hospitals. Institutional care for patients with severe mental illness is provided at psychiatric hospitals across the country, with an estimated capacity of 10 000 beds as at February 2001.

9.7.7 Critique of policy interventions

Clearly, the policies are merely a framework to be adapted by individual provinces according to their situation and financial means. There is much progress in the development of appropriate policy, although the pace of implementation is likely to lag far behind.

The immediate challenge of all policy guidelines is their reliance on provincial implementation, as provincial budgets are already constrained by the current budget environment. The lack of province-specific data also mitigates against speedy implementation of the policies.

A critical shortcoming in the rehabilitation policy is the lack of integration between norms and budget in that it proposes a dedicated budget for rehabilitation services, without stating any norms or standards. While such norms are developed in the Primary Healthcare Package, there is no budget attached to these. Instead, there is a fuzzy reference to inclusion in the PHC budget, despite the fact that the PHC budget has been declining steadily as a result of declines in the rest of the health budget over the past few years.

Although there is a significant backlog of assistive devices in the country, the Department of Health does not specify any intention to institutionalise data collection in this important area, nor does it propose any strategy to address the backlog. In addition to the above, the policy does not set any targets for the achievement of the goals set out.

The policies tend to rely a great deal on intersectoral cooperation, without putting sufficient thought into the institutional requirements for successful implementation.

While substance abuse is viewed as a major contributor to mental illness, alcohol abuse has received less than tobacco abuse, despite its extremely damaging impact on mental health.

In general, the profile of disability in the health sector tends to be fairly low, resulting in less than optimal implementation of even the most basic policies. The proposed policies do not make any attempts to address this.

9.7.8 Recommendations

1. All provinces should be required to routinely provide data on their budgets for assistive devices, and specify plans to address the backlogs.
2. The provision of free health services for the indigent should be extended to the provision of free assistive devices for all people with disabilities who are indigent.
3. The Department of Health must actively engage the national Treasury to ensure the protection of funding for the Primary Healthcare Package, in order to ensure that the budgets for disability services do not remain relegated to a subsection of a Cinderella budget, as is currently the case.

9.8 Services and non-cash benefits to persons with disabilities

9.8.1 Constitutional imperative

The Constitution of the Republic of South Africa Act 108 of 1996 calls on the state to “respect, protect, promote and fulfil the rights in the Bill of Rights”.⁶⁷ These rights include the right to access to housing, healthcare, food, water, social security, education and environment.⁶⁸ The obligation on the state to provide is not an absolute or unlimited one. It is expected of the state to realise these rights progressively (i.e. over a period of time), within the available means, and to take reasonable measures to give effect to these rights.⁶⁹ In a recent Constitutional Court judgement⁷⁰ it was stressed that the plight of particularly vulnerable groups of people⁷¹ cannot be ignored by government, even though a programme may otherwise appear to be statistically sound. It is submitted that most people with disabilities would fall within this category.

9.8.2 Food

Despite the constitutional provisions for the right to food, vulnerability to food insecurity continues to impact on the lives of many South Africans. The challenges that need to be addressed to improve on the right to have access to sufficient food are that, more policies should be developed to target women, children the elderly, people with disabilities, people living with HIV/AIDS and people living in rural areas (including farm workers) and informal settlements. The SAHRC report (2000) recommends that:

- School feeding programmes need wider coverage, as the majority of children with disabilities are not found in the formal schooling system and therefore not benefiting from the scheme.
- Addressing the problems of stunting and wasting in children under five, and in particular children with disabilities, as they are vulnerable beyond the age of five.
- Providing an enabling environment for people to gain access to food.

9.8.3 Education

Educational opportunities are less available and affordable. Service delivery and focus has been mostly on special schools, which are primarily focused on white children with disabilities and the

legacy of the past is still carrying over. Schooling for poor disabled children is still limited and most black disabled children do not get education at all, and where there are special schools within their community, the subjects offered are limiting the children from ever going to a high school or a university, or going for formal employment as they are not equipped with skills to work. The current composition and curriculum for poor children with disabilities in these special schools is still inherently flawed. In some provinces there are schools which still remain predominantly for white and Indian children.

According to the SAHRC report (2000), the National Department of Education has made significant progress in policy developments. The programme on ECD has reached about 2 800 non-governmental early childhood learning sites serving approximately 70 000 disadvantaged learners.

Despite the progress of the ECD policy, some questions remain unanswered. For example, how many disabled children are integrated within these sites, and how many of these sites are specifically targeted towards disabled children? Many children continue to be cared for by their mothers at home, and this results in mothers not being able to be economically active; and ultimately they become solely dependant on social assistance

Furthermore on the report it is stated that, Adult Basic Education and Training (ABET), which addresses the problem of adult illiteracy, is seen by government as an important tool for social participation and economic development. A number of provinces have formal ABET programmes with learning centres for adults and youth. ABET is one the most critical ways of alleviating dependency on social assistance, because it creates opportunities for persons with disabilities to access formal employment. However, it is quite evident that almost of all the mainstream learning centres are inaccessible for disabled adults. This results in organisations for people with disabilities setting up their own learning centres, thereby drawing up on limited resources to operate and maintain these centres.

The report also states that the Education for Learners with Special Education Needs (ELSEN) policy is meant to make education more responsive and sensitive to learners with special education needs. In KwaZulu-Natal there are 58 ELSEN schools with the necessary support resources and the Western Cape instituted a policy on the inclusion of learners with disabilities into mainstream schools.

The report emphasises that, the South African Schools Act 84 of 1996 provides for compulsory education for learners between the ages of seven to 15 years. The adoption of national norms in April 1999 has meant that no learner can be denied education due to inability to pay school fees. Expenditure for education constitutes almost 22 per cent. However, schools spend more money on personnel than on non-personnel issues.

The progress by the Department of Education in terms of mainstreaming learners with special needs has to be acknowledged. It is, however, discouraging to note that there is still no national policy in South Africa (i.e. the White Paper on Inclusive Education is still a draft due to lack of financial

resources for implementation). A majority of disabled children are still denied their right to education in both mainstream and ELSEN/special schools. In mainstream schools the problems arise from the infrastructure and incompetence of educators to teach learners with special needs.

Within special schools the issue is around the rigid assessment procedures, and another one is that most ELSEN schools are urban based, as a result inaccessible to rural learners with special needs. Therefore most disabled children of school-going age are predominantly cared for at home, dependent on social assistance and are never going to access any educational subsidy. If at 10 per cent of the total education expenditure can be spent on mainstreaming learners with special needs/disabilities, then the current expenditure on specials will decrease significantly.

9.8.4 Transport

Transportation services are inadequate and exclude the majority of poor people with disabilities. Currently the mainstream transport services remain inaccessible for people with disabilities, and no access to transport has serious effects on people with disabilities' integration and economic activity. Physical environment presents people with disabilities with many difficulties, as most facilities have been built by and for non-disabled people without consultation with disability sector.

Access to public transport is integral to the independence and development of people with disabilities, but it receives the least attention. There is no national policy on access to transport for people with disabilities, which informs implementation at provincial level. An assessment of what needs to be done has been captured in a report on Moving South Africa, but still needs to be transformed into concrete policy guidelines.

The lack of proper transport services has led to organisations for people with disabilities taking this responsibility on themselves and receiving subsidies from the Department of Social Development. The financial resources spent on "specialised" transport is costly and could be used elsewhere if the Department of Transport took its responsibility by ensuring that people with disabilities had accessible public transport that would enable them to actively participate in society. Various initiatives on making public transport accessible for people with disabilities have been undertaken by some provincial and local authorities, but this is almost useless in the absence of a national transport policy that demonstrates the commitment of the ministry towards people with disabilities.

9.8.5 Housing

In respecting the right of access to housing, the Department of Housing assisted vulnerable and previously disadvantaged groups with housing subsidies through the national Housing Subsidy Scheme (HSS). The national HSS is aimed at assisting the vulnerable groups in realising the right of access to adequate housing (Human Rights Commission, 1998/99). The housing subsidy programme comprises of a once-off capital subsidy to households whose income is below R3 500 per month. (The household income comprises the applicant's income plus the income of his/her spouse or partner.)

There are four different types of subsidies, all of which are allocated by provincial housing boards (Nedlac, 2000):

- Project-linked subsidies are made available to developers undertaking projects on behalf of beneficiaries. The projects must be approved by a housing board. They are intended to enable people to purchase residential properties.
- Individual subsidies are made available to individuals for the purposes of acquiring a new or existing property.
- Consolidation subsidies are granted to beneficiaries who own a site in a state-financed site and service scheme such as Independent Development Trust's capital subsidy scheme. This helps individuals to build or upgrade a house on the site. These subsidies are only approved on a project basis once individual beneficiaries have entered into agreement with a developer.
- Institutional subsidies are made available to organisations or co-operatives in order to acquire and/or develop residential property.

In addition to the above, there are two situations in which the subsidy amount can be increased. These are:

1. **Geophysical variation:** in situations where development costs are particularly high because of locational, geotechnical and topographical conditions.
2. **Disability variation:** in situations where the subsidy is being awarded where the beneficiary or a member of the household is disabled.

The White Paper on Housing was developed with the principal aims of stabilising the housing environment and providing subsidised affordable homes to the disadvantaged. The amended subsidy scheme allows persons with disabilities access to additional subsidy money for the necessary improvements to their units such as ramps, special doors, handrails and other design interventions.

However, access to this intervention for people with disabilities is non-existent and attitudes of administrative staff towards people with disabilities when applying is normally negative resulting in the abandoning the application process.

The NEDLAC Job Summit agreement around housing obligates the Department of Housing to ensure that 10 per cent of all new units must be accessible to people with disabilities. The problem, however, arises at implementation level as accessibility is only limited to physical disability and people with other disabilities do not access this provision. This results in them being "trapped" in their house or residing in informal dwellings where they acquire secondary disabilities. For example a person who has a physical disability, who due to inaccessibility of his/her home falls and sustain a head injury that results in an intellectual disability.

9.8.6 Social welfare services

Social services to persons with disabilities are complex due to the wide range of disabilities and organisations working in the field. The focus has over the years changed from a medical model which focuses on providing care, treatment and support to a social model which is a human rights based approach. The Department of Social Development subsidises a large number of non-governmental organisations (NGOs), community-based organisations (CBOs) and Faith Based Organisations FBOs for the rendering of services to people with disabilities

The following services are subsidised by the Department of Social Development:

- Protective workshops
- Parent empowerment programmes
- Homes for people with disabilities
- Transport services
- Counselling.

A critical issue that threatens stability and transformation in the disability sector, is funding. Some government departments are still currently funding organisations for people with disabilities to the exclusion of organisations of people with disabilities. The former continue to build institutions, which separate people with disabilities from their families. Contrary to popular belief, it is often within these institutions that human rights violations against persons with disabilities occur. In many of these institutions people with disabilities are not empowered to take action to improve their living conditions.

Services for people with disabilities remain very institutionalised and “top down”, and people with disabilities still suffer at the mercy of some service providers. This means the majority of poor people with disabilities’ needs remain unmet and their potential remains undeveloped.

9.9 Active labour market measures

9.9.1 Protective workshops

Employment opportunities for people with disabilities are few and far between, or only in the form of sheltered or protective employment. This form of employment furthermore perpetuates the image of people with disabilities as expensive burdens, for whom special provision must be made.

Protective workshops have a long history in the country. They are initiated and managed by NGOs. They started as therapeutic means to occupy people with disabilities. Through the years they evolved into income-generating projects to supplement the disability grants. The Department of Social Development aims to transform protective workshops which act as employment facilities for people with disabilities, into financially viable entities, thus reducing dependency on government for their sustenance. Due to the previous conservative legislative framework, people with

disabilities were excluded from participating in economic activities. This phenomenon led to poverty among the majority of this designated group, especially those in rural communities and informal settlements. The Department of Social Development, in consultation with its provincial counterparts, is engaged in piloting models for economic empowerment of people with disabilities through financing the protective workshops and poverty alleviation projects.

9.9.2 Expenditure

In 1998 a decision was taken to award R20 million to the disability sector for economic empowerment. The Thabo Mbeki Development Trust manages these funds for people with disabilities. The project commenced with implementation in 2000. It is estimated that the projects will require support, both technical and financial, for two years.

9.9.3 Community Based Public Works Programme (CBPWP)

The CBPWP is a short-term programme aimed at poverty alleviation, skills training, delivery of needed assets and capacity building. Persons with disabilities are required to make up at least 1,5 per cent of the total local labour employed.

9.9.4 Skills development strategy

The government's commitment to promote active labour market policies is well demonstrated in the Skills Development Act, 1998 and the Skills Development Levies Act, 1999. These two pieces of legislation introduce new institutions, programmes and funding policies designed to increase investment in skills development. There are two overriding priorities that this legislation seeks to address. The first is the ever-present reality of the global economy and the imperative to increase skills to improve productivity and the competitiveness of industry, business, commerce and services. The second is to address the challenges of social development and the eradication of poverty (Department of Labour, 2000).

The Skills Development Programme seeks to ensure that youth, women and persons with disabilities are able to improve their access to the labour market and their skills development within the labour market.

9.9.5 Bursary Scheme for Persons with Disabilities

The Bursary Scheme for Persons with Disabilities enhances employment opportunities for persons with disabilities by awarding bursaries for career-orientated training. In 1996, 108 learners received bursaries, while bursaries were awarded to 98 learners in 1997. Owing to lack of funds no new bursaries could be awarded to learners during 1998. In 1999, 50 learners were awarded bursaries.

9.9.6 Wage Subsidy Scheme

Work seekers with disabilities often experience difficulties in finding work in the open labour market. The Wage Subsidy Scheme is intended to provide employers with an incentive to employ some of these work seekers by subsidising the salaries of these workers for a limited period. The

scheme was reviewed and adjusted to be of greater benefit to workers with disabilities and their employers.

9.10 Contributory social security systems

9.10.1 RAF

The way, in which the RAF has been formulated since the inception of the introduction of the compulsory motor vehicle insurance in 1942, has done little to improve the instrument into an efficient and effective of the method of compensation. In addition to this the primary legal premise that this RAF has been derived from a principle of liability cover for the guilty party. This has created a compensation system, which is out of line with other the compensation instruments such as COIDA, and the Unemployment Insurance Fund (UIF).

The primary objective of the 1996 RAF, “is the payment of compensation in accordance with the applicable statutes for personal loss or damage wrongfully caused by the driving of motor vehicles”.⁷² The current RAF provides a compensation system which indemnifies the driver of a motor vehicle against the liability incurred as a result of loss or damage caused to a third party or victim of the motor vehicle accident as a result of negligent driving.

9.10.1.1 Administration and policies

The structure of the RAF, and the infrastructure which is has developed, has done little to improve the efficacy and cost of the process of delivering compensation. The financial management of the RAF and the underwriting principles used by it, continue to be the subject of debate and criticism. Claiming from the RAF is generally regarded as problematic and it is suggested that the general policy adopted by the RAF is to contest any claim except the lowest levels of compensation.

The focus of the RAF seems to be more akin to insurance practice of minimising the settlement value of a claim, as opposed to providing adequate compensation. This has provided a fertile framework for litigation and protracted legal process, which generally provide settlement years after the date of the accident.

9.10.1.2 Financing

Unlike other compensation instruments the revenue base for the RAF is achieved by levies associated with the consumption of motor vehicle fuel. While in principle it may seem appropriate, comparison with other areas of personal liability, it generates questions related to the equity of this type of taxation.

The large deficits reported by the RAF have generated a great deal of anxiety and confusion regarding the sustainability of it. This has called into question the nature and level of compensation offered by the RAF.

9.10.1.3 Gaps in the scope of cover

The RAF has very significant gaps and anomalies in the scope of cover:

- Paying passengers on motorcycles are excluded for reasons which are no longer understood.
- The primary negligent party or the person who caused the accident may not claim from the RAF, as well as that person's spouse and any member of the person's household, or anyone receiving maintenance from the person. The fact that the spouse, family and dependants of the deemed guilty party are excluded from access to compensation from the RAF seems to be in direct conflict with the constitutional rights of the individual.

It is suggested that cover be extended to cover at least paying passengers on motorcycles, and the spouse, member of a household and other dependants of the person who caused the accident.

9.10.1.4 Questionable limitations

In general there is no limitation placed on the value of the claim within the current RAF and combined settlements in excess of R5 million have been awarded. The value of compensation is, however, limited to R25 000 for any victim who was a passenger in a vehicle, which is operated for reward or as a business passenger of the owner of the vehicle or as a member of a lift club. This limitation includes persons travelling within a legal or illegal commuter vehicle, including unregistered mini-bus taxis.

The limitation of R25 000 has its basis in expediency related to the level of risk exposure. It offers little equity to these victims, who are often at very high risk in vehicles owned and driven by unscrupulous private transport operators, fly by night businessmen and ruthless farmers. It also impacts on the potential claims from domestic workers. It is suggested that this limitation be removed.

9.10.1.5 Access to compensation

The RAF is essentially a system based on a highly legalistic approach to achieving compensation. This makes it inaccessible and beyond the comprehension of most laypersons. The process includes a number of points of exclusion, based purely on not meeting procedural requirements.

The process of claiming has developed a component of the legal fraternity who specialise in processing claims and generate the perception that there is not other viable means of accessing fair compensation from the RAF. This has been reinforced to some extent by its approach and unwritten policy, with respect to contesting the larger claims. In cases where attorneys have succeeded in securing multi-million rand awards, victims have sacrificed large components of the legal costs to their legal fees.

The perception that the public can only access RAF compensation by engaging legal assistance, saps a large proportion of funds which should essentially be allocated to compensation. It is

currently estimated that on aggregate one third of the compensation is paid in legal costs and administration costs. In certain cases legal professionals are absorbing as much as three quarters of the claim to cover their legal services.

It is recommended that the RAF claim structure be amended to provide for simple and user-friendly access to the system. It is in particular recommended that the system be reconstructed in such a way to minimise the need to rely on legal expertise.

9.10.1.6 Revisiting the basis on which awards are made, managed and to be accessed

Once awards have been made the lump sum or certified awards both pose potential problems:

- Lump sum awards are often mismanaged by both the victims or their families who gain access to significant resources, with little understanding of the lifetime expenses of the victim. The result is these resources are depleted within years of the award and the later more problematic years of the victim's life are left unresourced.
- In cases where a curator is appointed to administer lump sum awards, misadministration and fraud are often linked to high administration fees. The inability of victims to generate legal remedies against the curators is exacerbated by their lack of access to their own resources.
- Certified awards generate an onerous obligation on the victim to motivate every component of expenditure in a system that is steeped in bureaucracy. The burden is so severe that most victims give up their right to claim this compensation, as it requires an extensive commitment of time and resources, which are already at a premium.

It is, therefore, recommended that the system of granting lump sum awards be amended to provide for pension-type payments. It is further recommended that the system of certified awards be amended to make it more user-friendly to victims.

9.10.1.7 Disability representation

While there is provision for the appointment of “members who command extensive experience ... in matters related to disabled persons”, to date there has been no formal representation of the disability sector, which constitutes a large component of the victims that the RAF seeks to serve. It is recommended that the RAF Act be amended to allow for formal disability sector representation.

9.10.1.8 Creating greater synergy with the rest of the social security (insurance) system

The existing RAF is full of anomalies and inconsistencies, linked to mismanagement and the fundamentally unsustainable levels of compensation offered currently. It is essential that the primary concept of compensating motor accident victims in a different framework from the main social security system, should not be taken as a given.

In the context of providing a seamless holistic social security framework, the RAF as an integrated instrument of compensation generates the fundamental debate, as to why a victim of motor vehicle accident should receive an essentially unlimited level of compensation, while victims of occupational accidents and illness should receive limited levels of compensation and victims of violence receive no compensation at all.⁷³

It is recommended that appropriate steps be taken to create greater synergy and consistency between the RAF system and the system for the compensation of employment injuries and diseases. This could occur on the basis of certain shared principles, such as capped benefits, removing the requirement of fault, and sharing interlinked database information. It could—as a medium- or long-term measure—include the development of an integrated and general impairment (social insurance) fund which could benefit people with disabilities who are presently excluded from both systems.⁷⁴

9.10.2 Compensation for occupational injuries and diseases

9.10.2.1 COIDA and the Occupational Diseases in Mines and Works Act (ODMWA)

COIDA⁷⁵ provides for the oldest form of employment-based social security existing in South Africa.⁷⁶ The scheme provides for the payment of benefits to workers who are injured on the job or who develop occupational diseases, as well as for survivor benefits for dependants of victims of employment related fatalities, on a no fault-basis. Separate statutory provision exists in respect of certain lung diseases contracted within the mining context, in the form of the ODMWA.⁷⁷

Many of the detailed issues, gaps and limitation of the present compensation system have been discussed in a separate paper prepared for the Committee of Inquiry.⁷⁸ Only some of the relevant matters will, therefore, be addressed here.

9.10.2.2 Administration

There is no provision for official representation of a disability expert on the COIDA board who is conversant with the impact of disability and the needs of people with disabilities. It is suggested that this be addressed by the legislature.

9.10.2.3 Coverage

Some accidents may fall out of the ambit of what is defined in the Act. For example, in most cases people with disabilities provide for their own transport to and from work. Should they meet with an accident during this process they would automatically not be compensated, given the narrow coverage of commuting injuries under COIDA.

As indicated elsewhere,⁷⁹ numerous categories of those who work are not covered under the current compensation dispensation, such as domestic workers, non-standard workers, in particular informal sector workers, independent and dependent contractors, and other self-employed persons are consequently excluded, and individuals, families and communities with environmentally acquired diseases due to exposure from industrial pollutants, asbestos contamination of mine dumps,

industrial disasters (e.g. AECI sulphur fire). It is submitted that many of these categories are prone to be victims of disabling employment-related circumstances. Appropriate legislative interventions are needed to provide for some cover for them.

9.10.2.4 Benefit calculations and payments

Calculation of the compensation benefits payable, uses a schedule which is inappropriate and punitive to people with disabilities. It does not consider environmental barriers, socio-economic circumstances of the individuals, the individual's skills base, and individual's specific support system that might be needed post accident, and retraining and re-skilling.

As the composition of the COIDA board is mostly legal and medical, the degree of disability is determined against a financial background without looking at the needs of the person facing that particular disability.

Similarly, claims of the dependants of the deceased employee are calculated on the basis of the employee being permanently disabled (inappropriately determined in the first place), and not on the basis of how the deceased employee would have provided for his or her dependents needs.

There is also an assumption that people who are permanently disabled will never work again, therefore compensate for the loss, which could be on a lump sum basis (depending on the degree of disability). It is not considered what is to happen when the COIDA money runs out, but these people fall back on social assistance, and the vicious cycle continues.

It is, therefore, recommended that a stronger needs-focused approach be introduced when calculating the benefits (which could be capped) a disabled employee or his/her dependants should be entitled to. It is also recommended that lump sum payments be done away with in the event of permanent disability, and pension-oriented payments be introduced for all categories of permanent disablement.

9.10.2.5 A lack of emphasis on rehabilitation and re-skilling

While it is maintained that a person has freedom of finding work after receiving compensation, he/she is simultaneously expected to find work without being re-assessed and retrained to find work, in the other words there is often no and usually insufficient (medical and vocational) rehabilitation available after compensation. It is recommended that this be addressed as a matter of urgency by the legislature and government.

9.10.2.6 Gaps in the process of claiming for compensation

Notice of the accident must be given within seven days, but the employer in most cases does this at their own discretion (it can sometimes take up to 107 days to report). Who provides for the employee's needs during this time?

People's right to just administration is often violated because often people do not have access to application forms and the offices are not accessible as they are centralised in Pretoria.

There are also many people with disabilities who are injured at work but have never been compensated. Employers are reluctant to report accidents at work due to the levy linked to the number of accidents sustained at work.

The assessment is solely medical, as the doctor is the only person who can assess the severity of the disability. The outcome of the medical examination is not the only means of assessing the extent of the disability.

Most people do not have access to appeal hearings due to the fact that the venue, and communication used during the hearing, are not accessible. Therefore this person does not have any recourse when appealing a decision because of the above barriers.

It is recommended that these gaps be addressed by taking the necessary measures to grant better access and to enforce employer obligations, where applicable.

9.10.3 UIF

9.10.3.1 Gaps in the provisioning of UIF

Most people with disabilities are in the informal sector. They are either self-employed or working in protective or sheltered workshops or else working on a casual basis due to lack of skills, and they are excluded from this form of social insurance.

The small percentage of people with disabilities that are able to access UIF are faced with negative attitudes from administrative officials who are implementing the act due to the lack of disability knowledge.

Migrant workers (who are due to return at the expiry of their contracts) are faced with disability and are not covered by the Act, and can also not apply for a disability grant. These migrant workers have no state support system. Pregnant disabled woman, who exhaust their maternity benefits are not able (under the current (1966) legislation) to access a disability grant.

On the UIF board there is no disability sector nor any other NGO representation.

9.11 *Occupationally-based and private insurance schemes, pensions and provident funds*

9.11.1 General considerations

There are many private insurance companies who offer individuals a wide range of insurances to cover for social risks, including disability, illness, retrenchment and death.

It is important to stress that only a small percentage of persons with disabilities can afford to access these schemes. In addition, they are penalised for their disability by higher premiums, even when the disability type does not incur any extra costs itself.

The middle-income persons with disabilities are also particularly discriminated against. They do not qualify for a disability grant, due to their income, yet they also cannot afford private medical coverage and the higher premiums due to their disability. They cannot access free assistive devices and so have to pay all their medical and devices expenses themselves. Often, in order to maintain their positions, they must have the latest technology, which is extremely expensive. The maintenance and up-keep costs of this equipment is also high. They in essence have no form of assistance or support available to them.

9.11.2 Creating options and safeguarding the position and interests of people with disabilities⁸⁰

Professor Asher suggests, in the fifth draft of a paper on Old Age and Insurance Position prepared for the Committee of Enquiry, that much can and should be done in the area of developing and protecting disability insurance.

The suggestions include:

- Some categories of people with disabilities are unable to work, while others are able to make a full contribution if given appropriate opportunities. In the middle are many whose earning capacity is impaired by their disability.
- There is a need for income replacement insurance for those whose earning capacity is impaired. An alternative would be for people to be compensated by their employers. This approach would, however, appear to be unfair unless they are responsible for the impairment.
- Cover will be needed during temporary and permanent periods of lost income, and regardless of whether the disability is complete or partial.
- Resuming employment may require additional costs of training, equipment or medication. It would seem that insurance for these costs should be combined with disability insurance.

It is further suggested that lump sum income replacement benefits are entirely inappropriate as disability cover and should be discouraged. It is advocated that the necessary (statutory) changes be introduced to allow retirement funds to pay disability benefits. In fact, Professor Asher argues that retirement funds should not only be permitted, but compelled, to offer disability benefits of at least 40 per cent of the member's monthly income. The benefits should be fully taxable, but the contributions tax-free.

It is recommended that this income—although at a low level, should offer complete cover:

- It should be payable whether the disability is permanent or temporary.

- The waiting period before the member can claim benefits should be the same length as the sick leave payable by the employer. This would limit the period during which the member was without any form of income.
- The benefit should be reduced pro rata to the extent that the member is able to earn an income, or if the member has other sources of income. The rules should provide for the payment of rehabilitation costs. Given uncertainty as to the costs that might be involved, it would be acceptable for them to be granted at the discretion of the fund. The discretion would then have to be exercised if it was likely to ultimately save the fund money, but the making payments over and above this minimum should not be prohibited.
- The benefit should be increased annually in line with inflation—if the financial condition of the retirement fund permits.

It is estimated that the cost of this insurance, in spite of its low level, is likely to amount to at least 1 per cent of payroll even if there are few AIDS-related claims.

In addition, it is suggested that certain general protective measures should be introduced. The payment of commission from any third party to those who purport to advise the public should be prohibited. Professor Asher also advocates the introduction of measures to enhance competition in the life and disability insurance.

While the combination of these measures could in the long run lead to less need for a separate workers' compensation system, it could ideally be seen as a way in which the largely inadequate COIDA and ODMWA benefits could be augmented.

9.12 Social protection for all

The vision of the INDS, that government must pursue an integrated and coordinated approach to disability, is appropriate. It is also difficult to achieve. Progress will be slow and this can be hard to accept. As always, the people desire faster action and more immediate redress of the many clear problems in the system. The challenge, as always, is to balance the many competing needs of the population in such a manner as to provide the fastest, most economical, and the most effective solutions to the problems policy has identified.

Disability is characterised by a collection of risks and vulnerabilities that push households into poverty and otherwise threaten the quality of living for a substantial portion of the population. While it is imperative that government should take steps to mitigate these risks and promote full social and economic participation for people with disabilities, the task is immensely complex and difficult to coordinate despite our best efforts.

In addition to the many initiatives underway among the departments of government, a Basic Income Grant would provide a simple, relatively fast, and enormously helpful benefit to all households touched by disability. Because these households are more likely to be poor and also tend to be more

vulnerable to adverse shocks, a steady flow of basic income would be likely to have a stronger impact among these households.

There are numerous ways in which a steady flow of basic assistance could improve the ability of households to both live with and prevent disability. A Basic Income Grant has a number of attractive features for improving the capacity of persons and households touched by disability to take charge of and address their own problems with greater independence and dignity. For households in which one or more members have a disability, a steady flow of financial assistance can help to cope with the added expenses of living with impairment. Where disability is transient, as with non-permanent injuries or illnesses, a Basic Income Grant would help to overcome the shock of lost earnings or temporary medical costs incurred by temporary impairment. One of the most important mechanisms by which a Basic Income Grant might affect disability is through helping relatively healthy households to avoid the malnutrition that leads to lasting disability in children.

9.13 *An integrated comprehensive social security system*

9.13.1 Fundamental principles and legislative framework

It must be recognised that people with disabilities are not a homogenous group, but have a wide range of needs and circumstances that contribute to their well-being and opportunities in life. Even persons with similar disability types have completely different social, financial and physical environments that directly impinge on their capacity to function at their maximum potential. This must be recognised when designing a sensitive and holistic social security system that attempts to meet the needs of this group.

9.13.1.1 Currently the different pieces of legislation regarding the various schemes of social security are fragmented, sometimes contradictory, and make for gaps in provisioning. Hence the attempt to arrive at a comprehensive system might necessitate one overriding piece of legislation, such as a Social Security Act, which would incorporate the concept of social security, its aims and objectives, as well as highlighting the purposes and eligibility criteria of each scheme, including the social assistance programmes.

9.13.1.2 There may still be need for separate legislation and regulations to guide each of these schemes, but these must be consistent with the fundamental principles embodied in the Act. There needs to be some “linking” and cohesiveness between the different social insurances and the legislation. For example, at present the Employment Equity Act calls for the employment of persons with disabilities, while reintegration into the labour market is not a goal of COIDA. This mix of policy and legislation should ensure that the guidelines set out in the various policies are achieved and enforced through the necessary legislation and regulations.

9.13.1.3 Particular attention should be paid to clear definitions in the Act(s) that can be operationalised in the regulations, with accompanying guidelines for their implementation.

9.13.1.4 With regard to legislation for children, both the Child Care Act and the Social Assistance Act should provide for social security for children with disabilities. A combined approach, with the Child Care Act determining the rights and the package of benefits, while the Social Assistance Act incorporates the finer practical details and regulations, might be useful and ensure a comprehensive approach, but may be cumbersome for implementation.

9.13.2 Concept of social security

9.132.1 Social security systems should be seen not merely as safety nets and poverty alleviating measures, but also as measures to promote self-sufficiency and independence.

9.13.2.2 Social security should protect societal members from and compensate for, the financial consequences of a number of social contingencies or risks, including those preventative and rehabilitative measures. It should be a poverty alleviating measure, a mechanism of active redistribution of resources, and it should ultimately aim at societal solidarity, and at the full development, equality and participation of persons with disabilities (UN Committee on Economic and Social Rights—General Comment No. 3. Para 11.)

9.13.3 Definition of disability

9.13.3.1 In light of the differing definitions and measurements of disability used in the various pieces of legislation regarding social security, it is suggested that a broad concept of disability be used. This could be adapted for more specific definitions in each scheme, dependent upon the purpose and coverage of each. Obviously the definitions must be ‘operationalised’ in the assessment tools, which must accurately translate the concepts within the purpose into simple and measurable criteria.

9.13.3.2 It must also be stressed that the system should not define beneficiaries according to the disability, but should rather determine provisioning in response to need.

9.13.4 Purposes and eligibility criteria

Within the broad concept of social security mentioned above, there could be specific purposes of each of the social security measures. For example, the purpose of COIDA could be to provide for the compensation of an injured person or his/her dependants for work-related incidents resulting in injury, death, or an occupation disease, in order to enable their full rehabilitation, retraining and re-integration into the labour market.

9.13.4.1 Persons with disabilities, physical, sensory, mental and intellectual, who cannot provide for their basic needs, should be eligible for the disability grant. In addition, it is suggested that persons with chronic illnesses, including HIV/AIDS, should also qualify for the grant.

9.13.4.2 Eligibility should not be based on the person's 'incapacity' to work, as often their lack of work is due to the poor economic climate and prejudice in the work place, as opposed to their physical or mental inability to perform the job.

9.13.4.3 The provision of the grant to non-symptomatic HIV positive children would improve their nutritional status and well-being and thus prevent the progression of the illness, also reducing medical costs to the state. The costs of providing AZT to pregnant mothers would reduce the rates of infection of the babies by over 50 per cent. These costs would be far less than the resultant costs in caring for sick children.

9.13.4.4 Eligibility should be determined by a Needs-based Assessment. This should replace the current means testing.

9.13.5 Assessment procedures

9.13.5.1 The assessment procedure should encompass a "needs-assessment" which considers not only the type and severity of disability or illness, but other social, economic, physical and environmental factors. Persons with the same disability can have very different needs, depending on all these factors and on the support structures and resources available to them.

9.13.5.2 The assessment should also focus on the applicant's capabilities, rather than only on the degree of disability, as well as their potential for re-training and re-employment. Relevant training and reintegration measures should also form part of the package of social security.

9.13.5.3 The ICIDH-2, which is currently being developed by the World Health Organisation, may be useful in indicating the main categories and indices for measurement.

9.13.5.4 Obviously a sliding scale of benefits would have to be established to cater appropriately for the range of needs presenting.

9.13.5.5 The assessment form must include all the disability categories, i.e. physical, mental, sensory and intellectual (currently it only includes physical and mental).

9.13.5.6 The assessment should ideally be done by a multi-disciplinary team, including: nurses/health workers, social workers, and a representative of the disability sector. Alternatively, there should be at least one community-based worker trained in the health and social fields. Assessment must be of the holistic needs of the child, not limited to purely medical aspects.

9.13.5.7 Administering officers would obviously require extensive training in the use of the Tool. There must be consistency and clear eligibility criteria in assessment, with adequate guidelines and training for assessors.

9.13.5.8 An appeal mechanism (such as a Review Tribunal) is necessary for those rejected applications, and must consist of relevant intersectoral representatives.

9.13.6 Targeting

- 9.13.6.1** The issue of means testing versus universal provisioning is complex and represents the contradiction, or struggle, between the fundamental rights to social security and the available resources.
- 9.13.6.2** Obviously resources are not infinite and personal or company income tax systems are exhaustible as sources of financing for social security systems. Thus efficient allocation of resources to suit the presenting needs of the population is required. In the face of limited resources, some form of targeting measure, to identify the most in need, is essential. However, this must be viewed within the rights-based framework as stipulated by the South African Constitution and the various international instruments, which stress the basic rights of persons with disabilities to social security and social assistance, with progressive realisation and within the constraints of available resources.
- 9.13.6.3** It is suggested that a thorough system of ‘needs-assessment’ as described above, would include analysis of a person’s financial situation and their need. Some threshold level of income, in relation to need, would have to be determined. It is suggested that the Disability Sector and economists undertake this.
- 9.13.6.4** It is important that the tools of targeting be sensitive and accurate in determining “need” versus purely a medical diagnosis emphasising categories of disability.
- 9.13.6.5** This assessment should be undertaken at regular intervals, so as to re-assess the level of need and to adjust the benefits accordingly. Sudden termination of grants is strongly discouraged. There should be adequate warning of the gradual ‘phasing’ out of payments.

9.13.7 Benefits

- 9.13.7.1** A system making use of a needs-based assessment as described above, would then provide a sliding scale of benefits, to suit the range of presenting needs within available resources. This should incorporate cash transfers and other indirect forms of social security.
- 9.13.7.2** The provision of cash transfers is an essential means to alleviate poverty, to smooth the income cycle, to meet those special needs due to the disability, and to overcome barriers that many persons with disabilities face in maximising their development and potential. For these reasons the disability grant and the CDG must be maintained and kept at their current level, if not increased.
- 9.13.7.3** The Committee recommends persons with disabilities and in poverty receive income support in the form of a basic income grant as a first step in the package of benefits. Thereafter, consideration should be given to their special needs and provision be made in the form of “topping up” in relation to cash benefits, in-kind benefits and other essential services.
- 9.13.7.5** It is recommended that the Grant-in-Aid be re-examined and its usefulness and relevance determined. In addition, a brief analysis of the Department of Social Development’s

provisioning of “personal assistants” should be undertaken. Some scope of choice in personnel by the beneficiary would be advised.

9.14 Financing

COSATU⁸¹ suggests increasing the progressive taxes moderately, in particular the personal income tax, as well as increasing government’s borrowing,. Reallocation of resources from other departments’ budgets is encouraged, such as from Defence’s. Further macro-economic analyses must be conducted by the Department of Social Development and appropriate economic institutions.

9.15 Short-term measures

- Suggested immediate amendments to the Social Assistance Act and regulations and to the Department of Social Development’s administrative structures.
- Extend coverage of the disability grant and the CDG to persons with chronic illnesses, including HIV/AIDS.
- Remove the clause of “permanent home care” for eligibility of the CDG.
- Extend the CDG to children with moderate disabilities and those in special schools or day centres.
- Revamp the current medical and assessment forms. Include sensory and intellectual disabilities. The disability sector could assist with this process.
- Utilise a multi-disciplinary panel for assessments.
- A disability representative should be present on all the boards examining claims for insurances.
- Develop clear eligibility criteria and guidelines for assessors.
- Remove the criteria of spouse’s income in the means test. Only the income of the person with the disability should be measured, not the “household” income.
- Provide free health services to persons with disabilities.
- Establish a review process for cases at regular intervals.
- Establish an appeal mechanism.
- Increase the back-pay to 6 months.
- Speed up the time of processing claims for grants and insurances.
- Educate the public on the social security available to them.

9.15.1 Disability care and insurance

9.15.1.1 Different needs

Of concern in this section are the possibilities of their re-incorporation into the workplace, and the need for insurance cover that relate to adults unable to participate normally in paid employment.

9.16 Recommendations

In general, policy should stay focused on improving the preconditions for equal participation, even as more general efforts at bolstering the capacity for governance and administration in the system of social protection move forward. The emphasis should be on promoting independent living, not institutional care. Specific and *achievable* policy recommendations are needed to promote action and not just further deliberation.

9.16.1 Summary list of recommendations

- Retain existing social assistance disability benefits until such time as income support measures are universally implemented, with the real value of the current disability grant being taken into account as well as other government measures.
- In-kind benefits should be de-linked from cash benefits. If people with disabilities take jobs and become disqualified from receiving public income support, they should not be required to give up access to non-cash support. De-linking cash and non-cash benefits may help to reduce the strength of the welfare trap around the means test.
- The present disability definitions are for various reasons unacceptable, as they are constructed in such a way (a) as to serve as a disincentive to work; and (b) that they overemphasise capacity for labour market participation, and do not take into account social and labour market barriers, as well as broader social and environmental factors. It is, therefore, proposed as a short-term measure that the said definitions be amended so as to reflect an interactive approach, which takes into account both medical condition and social and environmental factors.
- It is further proposed that the definitions be widened in order to include four main categories of disability, namely physical, mental, sensory and intellectual disability.
- It is also suggested that the ICIDH-2 approach to the definition of disability could be helpful, as it stresses three main elements, namely: (i) anatomical malfunctioning; (ii) the impairment of normal human functions as a result of the condition; and (iii) the question whether the condition hamper or impair the ability to socially integrate.
- An amended definition should serve two main purposes, namely, firstly, to identify whether the person concerned is indeed covered according to the revamped (wider) definition and, secondly, to identify the appropriate range and level of transfers (cash or in-kind benefits, goods and/or services) required to address the needs of the particular person according to the particular kind of disability suffered by the individual.

- It is further recommended, in adopting such a needs-based approach, that reliance on cash transfers be limited, and that government invest substantially in the development of a range of appropriate (public) goods and services to deal effectively with the range of disability conditions.
- Provision should be made for the purchasing of *essential* assistive devices. Procedures for acquiring simple assistive devices should be simple and costs should be subsidised.
- As far as health services for people with disabilities are concerned, the following are recommended:
 1. All provinces should be required to routinely provide data on their budgets for assistive devices, and specify plans to address the backlogs.
 2. The Department of Health must actively engage the national Treasury to ensure the protection of funding for the Primary Healthcare Package, in order to ensure that the budgets for disability services do not remain relegated to a subsection of a Cinderella budget, as is currently the case.
 3. The provision of free health services for the indigent should be extended to the provision of free assistive devices for all disabled people who are indigent.
- Clear national guidelines on access to the various forms of indirect social security need to be developed, in particular accessible housing, transport, education, and rehabilitation should be developed. These guidelines must in particular address those areas where policy has not been developed or underdeveloped (e.g. in the area of transport), must provide mechanisms to ensure that policy decisions are actually implemented, and target particular vulnerable groups among those who are disabled, in particular those living in rural areas—given the poorly targeted services in these areas.
- Promote standardisation of holistic medical assessment practices. Integrate assessment of disability with standardised medical assessment model that takes account of barriers to both function and participation. Such a model would include clear guidelines for assessment and possibly require that assessments be conducted by certified practitioners. Such requirements may require adjusting to ensure access. It would be problematic if a scarcity of certified assessors unintentionally excluded some citizens from the system. A guidebook approach may be more feasible.
- Promote links between assessment, information, and support resources. Medical assessors should provide people with disabilities with basic information on their condition as well as information about available support mechanisms and organisations.
- Expand coverage to include people living in institutions. Some people with particularly severe disabilities live in institutional arrangements subsidised by both private and public sources. (1997 White Paper on INDS.)
- Simplify administrative procedures. Although administration needs greater resources and capacity building, it should also be an aim of government to reduce bureaucratic

complexities that further complicate applications for social assistance and impede access to entitlements.

- Pursue reforms of the RAF in line with recommendations of the Satchwell Commission.
- It is recommended that the RAF cover be extended to cover at least paying passengers on motorcycles, and the spouse, member of a household and other dependants of the person who caused the accident.
- The limitation of an RAF claim of certain victims to R25 000 is inequitable and subject particular vulnerable commuters to even greater disadvantage. It is recommended that this limitation be removed.
- It is recommended that the RAF claim structure be amended to provide for simple and user-friendly access to the system. It is in particular recommended that the system be reconstructed in such a way to minimise the need to rely on legal expertise.
- It is recommended that the system of granting lump sum awards under the RAF system be amended to provide for pension-type payments. It is further recommended that the system of certified awards be amended to make it more user-friendly to victims.
- In particular, it is recommended that the RAF Act be amended to allow for formal disability sector representation.
- It is recommended that appropriate steps be taken to create greater synergy and consistency between the RAF system and the system for the compensation of employment injuries and diseases. This could occur on the basis of certain shared principles, such as capped benefits, removing the requirement of fault, and sharing interlinked database information. It could—as a medium- or long-term measure—include the development of an integrated and general impairment (social insurance) fund which could benefit people with disabilities who are presently excluded from both systems.
- On COIDA it is recommended that provision be made for official representation of a disability expert on the COIDA board who is conversant with the impact of disability and the needs of people with disabilities.
- COIDA coverage should be extended in order to cover categories of people who are particularly prone to sustaining disabilities in or as the result of the work environment, but who are presently excluded—such as those injured in the course of commuting to and from work, domestic servants, and excluded categories of non-standard workers.
- It is further recommended that a stronger needs-focused approach be introduced in the employment injury and disease dispensation when calculating the benefits (which could be capped) a disabled employee or his/her dependants should be entitled to. It is also recommended that lump sum payments be done away with in the event of permanent disability, and pension-oriented payments be introduced for all categories of permanent disablement.
- The lack of proper (medical and vocational) rehabilitation services must be addressed as a matter of urgency by the legislature and government.

- It is recommended that the gaps in claiming compensation be addressed by taking the necessary measures to grant better access and to enforce employer obligations, where applicable.
- Unemployment insurance for people with disabilities needs to be revamped—in particular in relation to extending coverage to those in the informal sector, sensitising officials who work with people with disabilities, protecting migrant workers and pregnant disabled women, and ensuring proper disability representation on the UIF board.
- Occupational-based and private insurance potentially plays an important role in protecting the position and interests of people with disabilities. Note should, however, be taken of the fact that disability attracts higher premiums. Middle-income persons with disabilities are also particularly discriminated against, as they do not qualify for state support.
- Tailor-made disability insurance, which also provides for rehabilitation, should be encouraged. Retirement funds should be allowed to offer this, and measures to enhance competition should be introduced.
- Strengthen training for public officials in positions related to disability.
- Integrate disability into the proposed framework for a special legal mechanism for adjudication of social security claims.
- Establish better monitoring mechanisms to ensure progress.
- Establish a series of quantitative indicators and benchmarks in consultation with civil society. These benchmarks can provide measurable targets for policy as well as standards by which civil society can monitor the progress of reforms.
- It is recommended that the regulatory environment and enforcement of the Social Assistance Act and its concomitant regulations be adapted in order to comply with the tenets of administrative justice as required by the Constitution, the statutory law, and well-founded common law principles. It is further recommended that officials responsible for dealing with matters pertaining to grants, for example, when approving, turning down or reviewing applications, be made aware of the obligations on the state and the rights of applicants in this regard.
- The discriminatory elements in the provisioning of grants and insurance coverage should be removed. In particular it is recommended that the citizenship restriction for purposes of entitlement to social assistance grants be removed. All that should be required is lawful residence in South Africa.

In order to avoid further unnecessary fragmentation, it is recommended that administrative and institutional arrangements concerning people with disabilities be included in a new national framework developed for social security delivery.

REFERENCES

- Department of Health. 1997. White Paper for the Transformation of the South African Health System.
- Department of Health. Annual Reports, 1995, 1996, 1997, 1999.
- Community Agency for Social Enquiry. October 1999. We also count! The Extent of Moderate and Severe Reported Disability and the Nature of the Disability Experience in South Africa. Report researched for the Department of Health.
- Department of Health. November 2000. The Primary Healthcare Package for South Africa—a set of norms and standards.
- Department of Health. November 2000. Rehabilitation for All: National Rehabilitation Policy.
- Department of Health. January 2001. Mental Health Bill.
- Department of Health. January 2001. Draft Policy Guidelines for Child and Adolescent Mental Health.
- Department of Social Development. 1997. White Paper on an Integrated National Disability Strategy.
- Department of Transportation. 1999. Moving South Africa: A Transport Strategy for 2020.
- Department of Transportation. 2000. National Land Transportation Act. No.22.
- Dudzic, P, and Mcleod, D. 2000. Including the Most Vulnerable: Social Funds and People with Disabilities. World Bank: Washington DC.
- Babson, O. 2001. Disability in South Africa: Evidence from the 1999 October Household Survey.
- Black Sash. 2000. Submission to the Committee of Inquiry into a Comprehensive Social Security System.
- Elwan, A. 1999. Poverty and Disability: A Survey of the Literature. World Bank Social Protection Discussion Paper No. 9932. World Bank: Washington DC.
- Federal Council on Disability and Child Health Policy Institute. March 2001. Social Security Policy Options for People with Disabilities in South Africa: An International and Comparative Review, (Research paper prepared for the Committee of Inquiry into a Comprehensive Social Security System).
- Health Systems Trust. South African Health Review, 2000.
- Klinck, E. 2001. Social Security for the Disabled. Submission to the Committee of Inquiry into a Comprehensive Social Security System (Research Paper).
- United Nations. 1993. Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, adopted by General Assembly resolution 48/96, annex.
- Van Niekerk, R, Lloyd, M, Noble, M, Howard, M, and Webb, J. 2001. Alleviating Poverty and Building Citizenship in South Africa Through Social Security: What Lessons from the UK Experience? Joint submission of the Centre for the Study of Social Policy in South Africa, Department of Social Policy and Social Work, and the University of Oxford.
- World Health Organisation. 2001. International Classification of Functioning, Disability, and Health (ICIDH-2). WHO: Geneva, Switzerland.

ENDNOTES

- 1 WHO [2001] p.18
- 2 Ibid. Foreword
- 3 White Paper on an Integrated National Disability Strategy [1997] Chapter 1
- 4 Gathering accurate data on disability is notoriously difficult. This is for many reasons, but is in large part due to the many competing definitions of disability itself and to practical difficulties with identifying people with disabilities. Definitions of disability differ from survey to survey; people answering household questionnaires respond to questions differently depending on their personal notions of disability; the stigma associated with disability may cause some people to conceal their status; since the disability tends to be more prevalent in poorer households and communities, precisely those communities where it is most difficult to gather data, it can be more difficult to capture people with disabilities in standard household surveys. Such problems are common to many efforts at obtaining a quantitative profile of people with disabilities in developing countries
- 5 WHO [1981] *ICIDH*, p.10 and Helander [1992], both cited in Elwan [1999] p.5.
- 6 CASE [1999] p.39
- 7 White Paper on an Integrated National Disability Strategy [1997] Chapter 1.
- 8 Figures cited by *Summary of Literature: Disability and Chronic Illness Prevalence in Children in South Africa* (submission prepared for the Committee of Enquiry by the Child Health Policy Institute) (June 2001) 6.
- 9 Rosenblum and Babson [2001] Table 1.
- 10 This figure is derived from the 1999 OHS, which provides the lowest estimate of disability prevalence among available surveys. It is quite likely that the share of the population living in households where one or more people suffer from some disability is higher than 16 per cent per cent. Elwan [1999] p.8 reports that evidence from the 1990 United States census suggested that nearly 29.2 per cent per cent of the population had a family member who was disabled in some respect.
- 11 Elwan [1999] p.11
- 12 White Paper on an Integrated National Disability Strategy [1997] Chapter 1.
- 13 Dudzic, P. and McLeod, D. [2000] p.1
- 14 Klinck [2001] p.4-5. These include, among others, the Universal Declaration of Human Rights (1948), the African Charter on Human and People's Rights (1981), the United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993), and The Convention on the Rights of the Child.
- 15 WHO [2001] p.8
- 16 Ibid. p.1
- 17 White Paper on an Integrated National Disability Strategy [1997] p.19
- 18 Elwan [1999] p.v
- 19 Schneider *et al* [1999] p.247 and October Household Survey 1999.
- 20 Act 108 of 1996.
- 21 Section 9.
- 22 See article 3(3)(2) of the German *Grundgesetz*.
- 23 Including, if anyone is unable to support him-/herself and his/her dependants, appropriate social assistance: section 27(1)(c).
- 24 Act 66 of 1995.
- 25 Act 55 of 1998.
- 26 Section 6.
- 27 Section 15(2)(c). "Reasonable accommodation" is defined as "any modification or adjustment to a job or to the working environment that will enable a person from a designated group to have access to or participate in or advance in employment": section 1.
- 28 Act 4 of 2000.
- 29 Section 28.
- 30 The EEA defines persons with disabilities as "people who have long-term or recurring physical or mental impairments which substantially limit their prospects of entry into or advancement in employment"—section 1.
- 31 In *Bacela v MEC for Welfare (Eastern Cape Provincial Government)* 1998 (1) All SA 525 (E) the decision of the MEC to suspend payment of arrear pensions, payable in terms of the *Social Assistance Act 59 of 1992*, due to budgetary constraints, was successfully challenged. See also *Ngxuzza & others v Secretary, Department of Welfare*,

Eastern Cape Provincial Government & another 2000 BCLR 1322 (E); *Bushula & others v Permanent Secretary, Department of Welfare, Eastern Cape Provincial Government & another* 2000 BCLR 728 (E); *Rangani v Superintendent-General, Department of Health and Welfare, Northern Province* 1999 (4) SA 385 (T); and *Mpofu v MEC for the Department of Welfare and Population Development in Gauteng Provincial Government* unreported WLD case 2848/99 of 18 February 2000.

³² See also *Ngxuza & others v Secretary, Department of Welfare, Eastern Cape Provincial Government & another* 2000 BCLR 1322 (E).

³³ The Permanent Secretary, Department of Welfare, Eastern Cape Provincial Government v Member of the Executive Council for Welfare, Eastern Cape Provincial Government (judgement delivered on 31 August 2001) (Case 493/2000).

³⁴ See *Bushula & others v Permanent Secretary, Department of Welfare, Eastern Cape Provincial Government & another* 2000 BCLR 728 (E); *Rangani v Superintendent-General, Department of Health and Welfare, Northern Province* 1999 (4) SA 385 (T); *Mpofu v MEC for the Department of Welfare and Population Development in Gauteng Provincial Government* unreported WLD case 2848/99 of 18 February 2000.

³⁵ Act 3 of 2000.

³⁶ See section 33(3) of the Constitution. In terms of section 33(1) everyone has the right to administrative action that is lawful, reasonable, and procedurally fair.

³⁷ which is defined to include any decision taken, or any failure to take a decision, by an organ of state when exercising a constitutional power or a public power or performing a public function, or by a natural or juristic person when exercising a public power or performing a public function: s 1. Certain executive and other functions and decisions are specifically excluded from the purview of the definition.

³⁸ The Act contains a wide definition of the concept: see section 1.

³⁹ Section 3(1).

⁴⁰ Section 3(2)(a).

⁴¹ If it is reasonable and justifiable in the circumstances, an administrator may depart from any of these requirements: section 4(a). Certain relevant factors to be taken into account to determine whether the departure is reasonable and justifiable, are indicated (section 4(b)).

⁴² Section 3(2)(b).

⁴³ After the date on which that person became aware of the action or might reasonably have been expected to have become aware of the action.

⁴⁴ Section 5(1). The reasons must be furnished within a period of 90 days: section 5(2).

⁴⁵ Section 5(3).

⁴⁶ At 77 of the White Paper.

⁴⁷ South Africa's first attempt at responding to the international call for national action in terms of the WPA, dates back to 1985, when the then Cabinet decided to declare 1986 as a national year of the disabled and the establishment in that year, of an Inter-departmental Coordinating Committee on Disability (ICCD), which, in 1987, produced a 37 volume report on disability (HSRC, 1987). Although this initiative did introduce **some improvements** in national policy (e.g. in the area of environmental access—Part S of the Regulations made in terms of the National Building Regulations and Building Standards Act, 1979), it is needless to say, that the policies of apartheid that were applicable at the time, presented an irreconcilable dichotomy between themselves and the philosophy of equalisation of opportunities, thus making it utterly impracticable to implement the goals of full participation set out in the WPA.

⁴⁸ Chapter III of the WPINDS.

⁴⁹ Schneider M and Marshall S (Community Agency for Social Enquiry) *Social Security for People with Disabilities* (1998).

⁵⁰ Executive Summary v—vi.

⁵¹ *Ibid* 21ff.

⁵² *Ibid* vi, 16ff.

⁵³ *Ibid* 33.

⁵⁴ See, amongst others, submissions from Black Sash, CASE.

⁵⁵ Black Sash Submission on Disability in South Africa [2000]

⁵⁶ CASE [1999] p.138-139

- ⁵⁷ The *Employment Equity Act* 55 of 1998 (EEA) defines disabled people as “people who have long-term or recurring physical or mental impairments which substantially limit their prospects of entry into or advancement in employment”—s 1.
- ⁵⁸ According to the *Social Assistance Act* 59 of 1992 a disabled person under the Act means a person older than 18 years who have a physical or mental disability of longer than 6 months’ duration, which makes him/her unfit to provide sufficiently for his/her own maintenance—s 1.
- ⁵⁹ The so-called “social model” of disability is based on the premise that the integration of disabled people entails the removal of physical and attitudinal barriers and not on “normalisation” or cure. Internationally there is a move away from the medical model to the acceptance of the social model—Waddington L *Disability, Employment and the European Community* (1995) 60.
- ⁶⁰ The WPA adopted the WHO International Classification of Impairments, Disabilities and Handicaps—ICIDH (Geneva, 1980), which introduced for the first time in human history, the conceptual separation of “disability”, “impairment” and “handicap”. These concepts have always been used interchangeably and without any regard to the fundamental philosophical distinctions existing between these concepts. It reads as follows:
- “*impairment*”: any loss or abnormality of psychological, physiological, or anatomical structure or function.”
 - “*disability*”: any restriction or lack (resulting from any impairment), of ability to perform an activity in the manner or within the range considered normal for a human being.”
 - “*handicap*”: a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal, depending on age, sex, social and cultural factors for that individual.”
- ⁶¹ Regulation 2(b) as amended.
- ⁶² A “parent” means the legal parent of the child, while a “foster parent” means any person, except a parent of the child concerned, in whose custody a foster child has been placed under Chapter 3 or 6 of the Child Care Act, 1983, or section 290 of the Criminal Procedure Act, 1977, or a tutor to whom a letter of tutorship has been issued in terms of the Administration of Estates Act, 1965.
- ⁶³ The regulations (Reg.1) define a “**medical officer**” as any medical practitioner in the service of the State, including a provincial government.
- ⁶⁴ A “parent” means the legal parent of the child, while a “foster parent” means any person, except a parent of the child concerned, in whose custody a foster child has been placed under Chapter 3 or 6 of the Child Care Act, 1983, or section 290 of the Criminal Procedure Act, 1977, or a tutor to whom a letter of tutorship has been issued in terms of the Administration of Estates Act, 1965.
- ⁶⁵ A “care and rehabilitation centre” is not defined in the Act or the Regulations.
- ⁶⁶ SAHRC. Second Economic & Social Rights Report (1998-1999). September 2000.
- ⁶⁷ Section 7(2) of the Constitution of the Republic of South Africa Act 108 of 1996.
- ⁶⁸ See, amongst others, section 27(1) of the Constitution.
- ⁶⁹ See, amongst others, section 27(2) of the Constitution.
- ⁷⁰ *Government of RSA v Grootboom and others* 2000 BCLR 1169 (CC).
- ⁷¹ In this case, those without any form of temporary shelter.
- ⁷² Road Accident Fund Act 1996
- ⁷³ In addition to this the basis for compensation is steeped in socio economic stereotypes, where an attorney defending the claim of a daughter of a white affluent family may succeed in persuading a judge that she would have become a famous concert pianist and should be awarded a multi-million rand compensation package. In stark contrast to this a son of a family living on the Cape Flats in an informal settlement, is unlikely to succeed in persuading the legal system that he was destined to become Benny McCarthy and should be compensated accordingly.
- ⁷⁴ See par 16 of the paper entitled “Coverage against employment injuries and diseases” (Paper prepared for the Ministerial Committee of Inquiry into a Comprehensive Social Security System by Prof MP Olivier and Adv E Klinck) July 2001 as well as par 17 of the paper entitled “Road Accident (Fund) Insurance” ((Paper prepared for the Ministerial Committee of Inquiry into a Comprehensive Social Security System by Prof MP Olivier) July 2001.
- ⁷⁵ Act 130 of 1993.
- ⁷⁶ Truter L. “People with Disabilities” in Olivier MP, Okpaluba MC, Smit N, Thompson M (eds) *Social Security Law—general principles*. Butterworth. 1999.
- ⁷⁷ Act 78 of 1973.
- ⁷⁸ See the paper entitled “Coverage against employment injuries and diseases” (Paper prepared for the Ministerial Committee of Inquiry into a Comprehensive Social Security System by Prof MP Olivier and Adv E Klinck) July 2001.

- ⁷⁹ See par 9 of the paper entitled “Coverage against employment injuries and diseases” (Paper prepared for the Ministerial Committee of Inquiry into a Comprehensive Social Security System by Prof MP Olivier and Adv E Klinck) July 2001.
- ⁸⁰ The following suggestions are contained in the Fifth Draft of a paper on Old Age and Insurance Position, prepared by Professor A Asher for the Committee of Enquiry. See par 13.2, 13.3 and 14.2 of the said document.
- ⁸¹ COSATU. Submission on Comprehensive Social Security. Dec 2000.