

The Long and Winding Road. A look at applications for disability grants in South Africa — G S Baron



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Curriculum vitae

Geoff Baron obtained the MBChB at UCT in 1985. He completed his internship at Groote Schuur Hospital and then did two years of National Service in the SADF. He has since completed the Vocational Training rotation at Frere Hospital and is registered at MEDUNSA as a part time student for the MPrax Med degree. His interests include Health Resource Utilisation and patients' perceptions of quality of care. He is married to Ceri and they have two children.

Summary

The question of application for disability grants is a subject that was shrouded in mystery at our clinic - everybody professed ignorance and bewilderment with the processes involved and a lack of faith in the system as it is operating. No one knew of any guidelines, so by using a specific patient as a poignant example, I have tried to explore the processes involved and the guidelines that exist for the approval of applications. The wider implications of a disability grant request for the patient and the doctor-patient relationship are also briefly discussed. It is hoped that the following will be of use to GPs who are required to take part in the process of application for a disability grant on behalf of their patients.

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Introduction

The question of application for disability grants is a subject that was shrouded in mystery at our clinic. Patients, social workers, hospital medical officers and the local district surgeons all professed ignorance and bewilderment with the processes involved and a lack of faith in the system as it is operating. No one knew of any prescribed guidelines

laid down to promote uniformity and to assist those who had to complete the application forms.

"I've come for the grant" is a common opening offer by patients at our clinic. Using a specific patient as a poignant example, I have tried to explore the processes involved in applying for a disability grant and the guidelines that exist for the approval of applications. The wider implications of a disability grant request for the patient and the doctor-patient relationship, are also briefly discussed.

It is hoped that the following will be of use to medical practitioners who are required to take part in the process of application for a disability grant on behalf of their patients.

The Patient

Mr D is a 50 year old man who was employed as a manual labourer until three years ago. He has been unable to find employment since being laid off by a building concern. He achieved standard 4 at school and has never worked as anything other than as a labourer. He is married with a wife and three dependent children (two are of working age but cannot find work and one is in standard 6 at school). The family live in a shack in Duncan Village. His wife does odd jobs but does not have regular employment. They do not own any livestock and the only regular income for the household is the old age pension of his wife's mother.

Mr D had pulmonary TB diagnosed in 1980 and was treated as an in-patient for 6 months. He dates the beginning of his respiratory troubles back to this time. He has been seen intermittently at our clinic for the last

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five years. His main complaints have been of decreased effort tolerance and a chronic cough which is intermittently productive of sputum which varies in colour and consistency. He has presented on average 5-6 times per year for chest complaints and is intermittently on aminophyllin preparations and antibiotics. He has had sputum examinations for acid-fast bacilli on several occasions and they have been negative.

An old X-ray report (1987) showed evidence of old destructive lung disease and bilateral basal bronchiectasis but no radiological features of active TB. His spirometry showed an FEV1/FVC of 1,7/2,7 (62%) with minimal response to bronchodilators.

He did not complain of any acute exacerbation or problem at this consultation - he had come to have the grant application filled in. He said that he had a chronic productive cough and that his sputum varied. He became dyspnoeic on exertion after walking briskly for approximately a kilometre on the flat but this was

15 GPs assessed his disability; it ranged from 15 to 100%.

much less uphill or when carrying something. There was no history of orthopnoea or other symptoms of cardiac failure. He did not smoke and was currently on Nuelin SA 250 mg BD.

On examination he was not distressed after climbing onto the examination couch. He was clubbed, not cyanosed

or pale and there were no peripheral signs of right ventricular failure. His chest was clinically hyperinflated and his respiratory rate was 18/min. Air entry was fair and equal bilaterally with slightly prolonged expiration and there were bilateral coarse crackles and wheezes at the bases which changed in character with coughing. His sputum was not purulent. The pulmonary component of his second heart sound was loud, indicating early pulmonary hypertension.

I was now faced with the task of filling out an application for a disability grant for him based on the above information. The form, as I completed it, is appended. I later on had the opportunity to present this very patient and his problem to a group of 15 family practitioners and I asked them to independently complete a form for him. Their assessment of his degree of disability ranged from 15-100%! This was based only on an impersonal clinical presentation as above, without being able to form a subjective opinion about the patient and thus influence things one way or the other.

The importance of taking the above problem seriously will become apparent.

Three Stage Diagnosis

Stage 1 - Clinical

Old pulmonary tuberculosis with resultant bronchiectasis.
Functional respiratory impairment with decreased effort tolerance.
Intermittent superadded infections.
Pulmonary hypertension.

Stage 2 - Personal

Poorly educated man trained only for manual labour.
Poor economic and social circumstances.
Probable feelings of inadequacy at

Not a compensation for injury - rather a social welfare grant for the destitute.

not being able to provide for his family.
Realisation at age 50 that things are not going to get better physically.
Possible feelings of despair and defeat at not being able to find work and requiring "charity".

Stage 3 - Contextual

Chances of finding employment very slim in depressed economy.
Living in a poor community where existence is hand to mouth - neighbours likely to be too caught up in their own struggle for survival to be able to offer much assistance.
Family caught up in the vicious circle of poverty; children have to leave school for economic reasons and thus do not receive sufficient education.

THE STUDY

Disability Grants: Process

There is some merit in presenting this part of the study in a very impersonal and non-patient oriented way, as this is practically how these applications are administered.

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Introduction

Social pensions and disability grants are made available to needy people who qualify for them by the South African government through various bureaucratic agencies. At present the systems for the administration and distribution of disability grants appear to be in a state of disarray - particularly with regard to the disability grants of black South Africans.

Under the present system the various racial groups within South Africa have separate systems for the administration of disability grants. "White" grants are administered by the House of Assembly, "Coloured" grants by the House of Representatives, "Indian" grants by the House of Delegates and "Black" grants by the provincial authorities. In this patient's case, it is the Cape Provincial Administration (CPA) that is involved.¹

State disability grants should not be seen as being equivalent to disability compensation such as is legislated for under the Occupational Diseases in

No grading - a total win or lose all.

Mines and Works Act (Act 78 of 1973) and the Workman's Compensation Act (Act 30 of 1941). The problems relating to disability compensation under these acts has been reported by other authors.^{2,3} State disability grants are intended for persons who have no other source of income and are precluded from obtaining gainful employment by

virtue of a medical condition. These persons should not be covered by either of the above acts. The monthly grants are thus not intended to be compensation for injury but rather as a social welfare grant for the destitute.

Legislation decrees that a person who wishes to qualify for a disability grant must be 50% disabled or more. In the

One CPA official processes 3 000 new applications per month, reviews about 6 000 - with no formal official guidelines!

case of blacks, he (or she) must have been so disabled for at least 12 months prior to any grant being payable. For other race groups this period is 6 months.¹ From a medical point of view the application is either approved or rejected - a total win or lose situation. This contrasts with the Occupational Disability grading where patients are graded with respect to their disability in categories of percentage disability viz:

1. 1 - 5%
2. 6 - 30%
3. 31 - 99%
4. 100%

Compensation under these acts is based on a percentage of the wage the worker earned at the time of the accident and the extent of the disability as defined by the Workman's Compensation Act. If the disability is rated as <30% a lump

sum is paid. If partial disability is >30% the worker is paid a pension in proportion to the percentage disability. If the worker is totally disabled (100%) a pension equal to 75% of his or her former monthly earnings is paid.² The rating and grading of degree of disability is fairly rigidly set forth in published guidelines. This is not the case with social grants.

Types of Social/Welfare Grants Available

Blacks:

Disability Grants:

Requirements: Age 16 years or more
Possession of RSA identity document.
Permanent residence in RSA.
Must be at least 50% disabled for a period of 12 months.
Must qualify in terms of the "means test".

Maximum pension payable: R235/month

Blind Grants

Requirements: As above but must be 19 years of age

Old Age Pension (OAP)

Requirements: Age: male - 65 years or more.
female - 60 years or more.
Permanent resident in RSA.
In possession of RSA identity document (age taken as stated in document).
"Means test".

Maximum pension payable: R235/month

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Patients are not permitted to obtain more than one grant in total so should a patient who qualifies for a OAP, apply for a disability grant, it is far easier for all concerned to apply for the OAP.

Whites*Disability Grants*

Requirements mostly as for blacks (age, residence, documents).
Different means test.
Duration of disability need only be 6 months before grant becomes payable
Maximum grant payable R304/month.

Blind/OAP

Requirements as for blacks except for different means test.

The Means Test

There is no universal means test for all population groups. As with the other areas discussed there is obviously a need for a central, unified system.

The means test usually takes the form of a declaration under oath by the

No guidelines at all to assist the GP with the forms.

applicant that his or her assets do not exceed the limits laid down in the law. Based upon the means test a disability grant or OAP may be paid out in various amounts on a sliding scale depending on the applicant's means (but not on their degree of disability). For whites this scale of

payment is R90-304/month and for blacks it is R90-235/month.

Means Tests: Whites (to qualify for grant)⁴

Total assets worth less than R42 000
Property owned worth less than R15 200
Monthly income (other sources)
Single < R304/month
Married < R608/month

Blacks

Enquiries seem to reveal a far less rigid means test for black applicants. Cognizance is taken of property and livestock owned and other assets by a professional assessor. There appear to be no clearly defined figures laid down as is the case with white applicants.⁵

The Doctor and Disability Grants

In the past all disability grant (DG) applications had to be channelled via a district surgeon (DS). This is no longer the case and any state employed doctor may now complete the relevant forms. Patients may still apply via the DS who may then request information about the patient from the patient's regular practitioner.

In many instances the patient is assisted in the application process by a social worker. This is not compulsory. There are thus two possible processes by which patients can go about applying for a DG.⁶

- Process A:
1. See social worker and get medical forms
 2. See hospital doctor or DS and get forms completed
 3. Go to CPA offices (or

others in the case of other population groups) and be interviewed by clerical staff. Undergo means test and submit proof of age, residence, ID documents etc.

4. Application forms forwarded to Cape Town for approval (both medical and administrative)

How disabled is 50% disabled?

- Process B:
1. Go to CPA offices and be interviewed as above and obtain medical forms
 2. See hospital doctor who completes forms
 3. Go back to CPA offices to hand in the forms
 4. Application goes to Cape Town as above

Once the medical forms have been completed by the DS or hospital medical officer, the forms are forwarded to a central office in Cape Town (in the case of CPA administered grants). The forms are then processed and checked over by a single medical practitioner who administers the medical aspects of ALL disability grant applications in the CPA. This practitioner does not have contact with the patient at all and must thus make any decisions on the basis of the information contained on the form as filled out by the original practitioner. The

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importance of filling in the form carefully and thoroughly becomes most apparent when this is taken into account.

At this stage (in Cape Town) the application may either be

1. Approved
2. Rejected
3. Referred back for more information

DGs are payable (if approved) from the date of application but there may be considerable delay involved if the application is referred to and fro because the forms are not adequately completed. Should an application be rejected, the patient may re-apply as often as he or she chooses. The impression of our local social workers is that an application without any mishaps takes about 3 months to be fully processed.

No guidelines exist to assist medical practitioners with the filling in of these application forms. The forms as

Illness becomes a strategy for survival – making the doctor take the role of a detective.

they exist at present (see appendaged form) are somewhat ambiguous in parts and not clearly understood by many practitioners (a snap survey of 20 doctors at our hospital revealed that ALL felt that the form was unclear and asked questions that were often not answerable)

Insurance companies, the Workman's Compensation Act and Military

Pensions have laid down clear guidelines as to the degree of disability or percentage disability incurred with specific problems. It is interesting that in 1984, of 12 577 patients examined by Rand Mutual, only 2,02% were assessed as being > 30% disabled.² No such guidelines exist in the sphere of state DGs except insofar as grants are only payable to patients who are at least 50% disabled.

It would seem imperative that some guidelines for practitioners be made available by the state to facilitate the grading of disability. How disabled is 50% disabled – and disabled for what? There is no provision made on the form currently in use at our hospital for details of educational standard achieved and details of past employment. Illness such as left ventricular failure secondary to hypertensive heart disease may be disabling for a manual labourer but not for a clerical worker.

There is a severe problem of unemployment in South Africa at present. It could thus be argued that anyone with health problems may be severely disadvantaged in terms of obtaining employment in the open labour market. At present this argument is not accepted by the CPA. This point of view can be difficult to explain to a patient with epilepsy who has lost his job due to seizures at the workplace and cannot now find alternative employment – but who does not qualify for a disability grant.

The View From The Top

In response to the vast number of queries that still remained for me, I managed to contact the medical practitioner in charge of processing

all CPA disability grants. She estimates that she processes about 3 000 new applications per month and reviews about twice that number. She is the only person doing this in the CPA. She stressed that there existed *no* formal guidelines as regards assessing people's degree of disability and that no guidelines existed to help her in her work. She

One set of criteria for all groups is needed in SA.

has sole responsibility for medically processing all CPA applications and thus has the power to approve or reject an application on her own. Should she be unsure about a specific patient's problem, she has two senior directors who may be called upon for advice.

With respect to the completion of application forms by practitioners, she felt that a large proportion of application forms received contained incomplete and insufficient information for her to make an informed decision. She stressed that the depressed economy and lack of employment opportunities was not a relevant factor in determining who should qualify for a grant. There is also not absolute uniformity amongst the various provinces.

It is obviously not easy to be specific in the abstract, but she did offer me some general guidelines (of her own) for the processing of applications. It is apparent that these guidelines are not necessarily applicable to other authorities and that they could change radically if someone else were to assume her position.

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Diabetes Mellitus: Grants only considered if complications exist

Hypertension: As above

Tuberculosis: As above

Asthma/COAD: Clinical history reflecting the grading (New York Heart Association) of dyspnoea and the clinical signs present. Evidence of patient compliance with prescribed treatment and the current treatment regimen. Peak expiratory flow rate and any other relevant special investigations.

Epilepsy: Type of seizures and number of seizures per month. Evidence of compliance with treatment regimen eg serum anticonvulsant levels.

Chronic Arthritis (of whatever origin): A functional assessment of the joint including the range of active and passive movement, X-ray reports and the prognosis with treatment.

Polio: A functional assessment of the patient with degree of muscle weakness and limbs affected. A specific example quoted was that a polio victim with one leg disabled would not be considered for a grant as this would constitute a disability of less than 50%.

Psychiatric disease: Patients with minor problems would not be considered disabled.

The onus is therefore on the applicant to prove that he or she has a disabling illness which is not curable or controllable with therapy. Compliance is thus of great importance in this context. The forms need to be completed accurately and need to contain sufficient detail to adequately support the application.

At present all disability grants are reviewed; - at 5 yearly intervals for "permanent" grants and at yearly intervals for temporary grants. These reviews concern the patient's financial

status as well as their medical condition.

The percentage disability as reflected on the form should be > 50% for the application to succeed. We have already seen in the WCA figures that in their case only 2% of the applicants are classified as > 30% disabled judged on their rigid criteria.

In summary therefore, it is clear that the practitioner who completes the application forms has an immense responsibility to do so correctly and objectively. In a sense the practitioner is caught in a dilemma - having to act in the interests of both the patient

To look beyond the application forms to the person holding them.

and the state. It is impossible not to feel sympathy for applicants who are obviously in dire financial circumstances. There is thus the very real factor of subjective overlay involved - it is easier to feel that a meek supplicant patient deserves a grant than a loud and aggressive one.

Negotiating The Illness: Some Processes At Work in This Type of Consultation

The metaphorical analysis of disease has been explored by a number of writers and popularised by Sontag in "Illness as Metaphor".⁷ Moral significance is attached to certain incurable diseases such as AIDS and TB. Segar argues that while some epileptics may view their treatment as a "ticket" to normality, in poor

communities epilepsy itself is regarded as a different type of ticket, a ticket to a source of income in the form of a disability grant.⁸ This idea is held in varying degrees by both patients and health workers, as are images of moral worth. Doctors believe that patients should deserve their grant by being compliant to treatment regimens. Many patients, on the other hand, feel that unemployment and attending poverty - which they often attribute in part or whole to their illness - make them deserving candidates for disability grants.

In this situation it is not difficult to lose sight of the patient himself, the illness and the treatment. The question of compliance looms large in this situation, being one of the criteria by which patients are judged worthy of the precious resource of a disability grant.

Segar investigated the question of disability grants amongst epileptics in Grahamstown, a community with an estimated unemployment rate of 60%. Of the 42 patients interviewed, only 7 (17%) were in formal employment and the average wage was R226/month (range R100-400/month). Ten of the households (24%) were entirely dependent on the disability grants of one or more of their members.⁸

In this context the disability grant is a big incentive for maintaining the sick role. Some local practitioners suspected patients of faking epilepsy in order to apply for a disability grant. The district surgeon likened the job of the doctor to a detective who with careful questioning can establish whether or not individuals are genuinely disabled.

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Thus for both patient and doctor there is a degree to which illness is being seen as a strategy. Disability grants are themselves part of poor people's strategies for survival and are not necessarily tied to ideas about disability as such. On the other hand the idea that illness may be used as a strategy leads health care workers to view themselves as both detectives and judges and the two parties become locked into a kind of negotiation where the issues of disease and therapy are themselves of secondary importance.

Returning to the Patient

What about Mr D - the original patient in this long story? I failed to form any meaningful relationship with him and have not seen him again since that first day. However, I do believe that our brief interaction was conducted along the lines described above and we did not recognise or address several important issues concerning him, his illness and the correct approach to managing the problem as a whole. The nature of the presenting complaint was only partly responsible for this. I am really sorry that he saw me before I sorted out some of these issues as I would be able to offer much more to him now.

Conclusion

The current state of disability grants in South Africa is obviously in need of urgent attention. Universal guidelines need to be drawn up and distributed to district surgeons and hospital staff. There should be one set of criteria for all groups administered by a single administration and there should be a single application form containing the following broad headings:

Clinical Problem - History
- Examination
- Investigation

Duration of disability
Educational standard achieved
Type of work done previously
? fit for previous type of work
? fit for other work that is possible with the achieved level of education
? > 50% disabled
? compliant on treatment
Prognosis on treatment

Medical practitioners need to be aware of the machinery involved in the application for a disability grant. They also need to be aware of the potential that exists for bypassing many of the patient's health needs that may be obscured by the negotiations in progress. We need to look beyond the application forms to the person holding them.

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