# Men, pensions and wellbeing in rural South Africa: Tracking effects through policy shifts

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## Short Abstract

Pensions play an important role in older persons' wellbeing in rural South Africa, with men *and* women reporting improved wellbeing in the years directly following pension-eligibility. Women's age-eligibility has been set at 60 since the inception of South Africa's non-contributory state-funded pension, whereas men until recently have begun receipt at age 65. As of 2010, men's age of eligibility equalized with that of women. Using two panels of the WHO-Study of Global Aging and Adult Health study, collected in 2006 and 2010 in the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt), we examine if "improvements" in men's reports of wellbeing mirror men's age-eligibility—65-69 in 2006, and 60-64 in 2010—thus tracking the pension-eligibility policy change. If "improvements" in wellbeing shift to younger ages in 2010, this would confirm that the age patterns of reported wellbeing may be attributed to the pension and its effects.

## Introduction

Pensions play an important role in older persons' health and wellbeing in South Africa (Schatz et al. 2011; Ardington et al. 2010; Gómez-Olivé et al. 2010). Women's age eligibility has been set at age 60 since the inception of South Africa's non-contributory state-funded pension, whereas men have until recently begun receipt at age 65. As of 2010, the men's age of eligibility equalized with that of women—i.e. men's age-eligibility was lowered from 65 to 60 years. This is a major policy shift, argued on the basis of gender equality (Case number Case No: 32838/05 in the High Court of South Africa). In this paper we investigate whether this policy shift provides evidence of a strong associate between pension receipt and reports of improved wellbeing among rural Black South African men.

In Schatz et al. (2011) we examined the relationship between gender, pensions and wellbeing. We found a striking, but temporary improvement in reports of wellbeing upon reaching pension eligibility, with the relationship being stronger for women than for men. Since the downward shift in men's age-eligibility began in 2008, the data presented represented a baseline prior to the policy change. The shift to younger age-eligibility for men, captured in a second wave of WHO-SAGE collected in 2010, allow us to assess the impact of this policy change on age patterns in wellbeing. Shifting "improvements" in wellbeing outcomes at younger ages, 60-64 in the 2010 data, compared to at 65-69 years as seen in the 2006 data, would confirm that the age pattern differences we are finding could be attributed to the pension and its effects. In addition, in 2006, men showed a pre-pension eligibility drop in wellbeing; at ages 60-64 men reported worse wellbeing than at ages 55-59.

In this analysis we also will investigate if the pre-pension-eligibility drop in men's wellbeing remains, or if women and men's beginning the pension at the same age in 2010 reduces this pre-pension effect for men.

While HIV/AIDS rates in elders are currently lower than among their younger peers, increasing prevalence stresses families and household systems. Older people, more often women, assume roles as caregivers, particularly in multigenerational households affected by the illness (Munthree & Maharaj, 2010; Møller & Devey, 2003; Møller, 1998). Because of the differentiation in gendered roles surrounding caregiving, much of the research on the effects of the HIV/AIDS on households has focused on the experiences of women. However, men may be just as vulnerable to the increased stress caused by the illness. Given their lack of experience with caregiving roles, men may try to relieve unprecedented emotional and physical demands of caregiving through alcohol and other escapist behaviors (Mudege & Ezeh, 2009). Thus, stress also could be associated with early deaths among older men (Ice et al., 2010). While much literature to date has focused on women, this paper begins to explore older men's experiences of living in an AIDS-endemic community.

In order to examine these issues, we will examine seven measures of wellbeing—four individual indicators based on men's reports in response to questions from the WHO-SAGE survey, and three composite measures constructed by the WHO from multiple questions from the WHO-SAGE survey. We will first show relevant descriptive statistics for men in the two panels of survey data (2006 and 2010). We will then run models for each panel to see if similar patterns emerge in 2010 as in 2006. Finally, for those individuals interviewed in both 2006 and 2010, we will investigate if there are shifts in wellbeing with the on-set of pension eligibility.

**Background**

While the pension is available to all South Africans, it is an important stable economic resource for the majority of black South African households (May, 2003; Sanger & Mtati, 1999). More than 90% of black older South Africans access the pension (Ferreira, 2006; Burns, Keswell, & Leibbrandt, 2005), and the cash transfer is as much as twice the median per capita income of the black population (Case & Deaton, 1998). Thus, pension receipt may significantly increase the income in black South African households (Barrientos et al., 2003; May, 2003; Møller & Devey, 2003). In 2005, the monthly pension was SAR780 (approximately USD130) (Samson, MacQuene, & van Niekerk, 2006); it has increased incrementally in the intervening years in relation to inflation and cost of living.

Many rural households depend on a variety of social grants to sustain them; income-pooling of pensions and other social grants provides a reliable and regular safety net for the needs of older persons and their households (May, 2003; Sanger & Mtati, 1999). Because of older persons' income–pooling, the pension has also been shown to improve overall food security and wellbeing in older people's households (Barrientos et al., 2003; Møller & Devey, 2003). In many cases pensions are viewed as a household resource, covering family members' health and everyday needs (Case & Deaton, 1998; May, 2003). The presence of a pensioner, particularly of a woman,

enhances the wellbeing of other household members (Ardington et al., 2010; Burns et al., 2005; Duflo, 2003).

As a monetary asset, pensions may directly help older persons purchase better nutrition, health care, and services to reduce their physical expenditure. This results in improvements in their own food security and overall health and wellbeing, as well as for their household members (Case & Menendez, 2007; Twine & Hunter, 2010; in press). In addition, pensions affect older persons' relationships within and beyond their households as it provides capital available for exchange, which may prove a means of diversifying a household's resource portfolio to reduce worry and anxiety (Rakodi, 2002). Older persons may use their pensions to cover household costs for school fees and/or to support migrants seeking employment (Collinson, 2009; Schatz & Ogunmefun, 2007). Older persons may invest in these areas as insurance, creating a contract of sorts with the younger generation for the pensioner's care later in life.

However, having access to regular durable capital may negatively impact older persons' livelihoods. It may attract additional burdens to the individual and his/her household. There is evidence from the Agincourt community that labor migrants return home to die (Clark et al., 2007), which further burdens already poor households. The need to help kin reduces older persons' resources for their own health, and these burdens may increase worry and negatively impacts older persons' health and wellbeing.

While income-pooling may decrease the direct benefits of the pension to pensioners, recent research suggests that pensions receipt improves health and wellbeing of pensioners, as well. Ardington and colleagues (2010) find that pensions buffer financial and emotional impacts of an adult child's death, and the resulting carework for grandchildren left behind (Ardington et al., 2010). A study from the Eastern Cape show older South Africans' (aged 60 plus) perceptions of their ability to provide care for children is primarily dependent on their knowledge about accessing pensions (Boon et al., 2010). Gómez-Olivé et al. (2010), WHO-SAGE 2006 data from Agincourt, found despite having aged, 60-69 year olds did not report significantly worse health status or function compared to 50-59 year olds. Gómez-Olivé and colleagues suggest that the plateau in reported health and wellbeing may be related to receipt of pensions "which allow [pensioners] to have a better life with higher food security and, importantly, with higher capacity to help the children in their households who have also higher food security and higher schooling" (p.32). Schatz et al. (2011) extended the Gómez-Olivé et al. (2010) analysis by examining the same outcomes, but in 5-year rather than 10-year age groups. Across age and sex groups, the findings point to a greater impact of pension receipt on wellbeing for women than men, but with a transitory effect for both (Schatz et al., 2011). Women report better wellbeing during a striking "honeymoon" period in the first years of pension-eligibility (ages 60-64). While, men's wellbeing drops pre-pension eligibility (ages 60-64), increases at pension-eligibility (65-59), then declines (70-74). Pensions may enhance financial wellbeing, but results from previous papers show their effect on social wellbeing is gendered and temporary. This paper further extends this work to examine how policy changes and longitudinal data can provide additional insight into the relationship between pensions and wellbeing.

**Data & Methods**

*Data:* The WHO-INDEPTH Study of Global Ageing and Adult Health Survey (WHO-SAGE) was conducted in 2006 and 2010 in the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt) site as part of a multi-country longitudinal project to increase understanding of health and wellbeing of adult populations in developing countries (http://www.who.int/healthinfo/systems/sage/en/index.html). The Short Version of the WHO-SAGE questionnaire was incorporated as a census-module in the Agincourt Health and socio-Demographic Surveillance System (AHDSS) for persons over the age of 50 in 2006 and again in 2010. The module included questions on self-reported health, functionality, and wellbeing. The census collected additional demographic and household-level data.

In 2006, approximately 65% (N=4085) of the target population completed the module. Nearly two-thirds of those who completed the module were women due to high and persisting male labor migration even in the older age groups. [For details of the sample and data collection, see Gómez-Olivé et al., 2010 and Kowal et al., 2010.] In 2010, 60% (N=10,152) of the target population completed the questionnaire with only 0.4% of refusal and the rest either not found at the time of the census (35%), ineligible (4%) or dead (1.6%).

*Variables:* The basic measures that we use to explore issues of social wellbeing come from two constructs of subjective wellbeing—affect and quality of life. These constructs are often put together, with a number of others, to determine overall quality of life (e.g. as in WHOQoL). We also examine four individual domains to assess whether some reveal greater age differences than others. We created four dichotomous variables: *sad, worry, dissatisfied and unhappy*. Respondents were asked the extent to which, in the last 30 days, they felt sad, low, or depressed (*sad*), felt worry or anxiety (*worry*), were satisfied with life as a whole (*dissatisfied*) and felt happy in general (*unhappy*).

We add covariates into later models that include: education, marital status, household assets (as a proxy for socio-economic status (SES)), nationality of origin, employment status, and household structure. We report age in five-year intervals to capture recent pension-eligibility. Since virtually all Agincourt households meet the means test, we use age as a proxy for pension-receipt; there was no direct measure in 2006. We test whether using a direct measure of receipt for 2010 changes the results.

Education is categorized as no formal education, less than 6 years of education, and more than 6 years of education or some education. Marriage unions in this area may be traditional, civic, and a minority is polygamous. Thus, to simplify we dichotomize marital status—currently married or single (those never married, separated, divorced, or widowed). To evaluate the relationship of health to other measures, we used self-rated health, categorized as "bad" or not. Employment status, collected for 2004 in the 2005 Agincourt census, and again for 2008 in the 2009 census, is coded as currently working or not. The majority of those not working were not looking for work but had retired, having concluded their working

career. Employment status focused on those with permanent formal work, so may underestimate those doing informal income-generating activities.

We used a household asset score derived from 34 variables collected in 2005 for the 2006 models and collected in 2009 for the 2010 models (including information about the type and size of dwelling, access to water and electricity appliances and livestock owned and transport available) to assess the potential role of socio-economic status. The score was derived through principal component factor analysis and then divided into quintiles. We use the dichotomous version from Gómez-Olivé et al. (2010), in which those in the three lowest quintiles were categorized as poor.

About one-third of the Agincourt population is of Mozambican origin. They largely came to Agincourt during the Mozambican civil war from the mid-1970s to early 1980s. "Nationality of origin" captures self-identification as South African or Mozambican. Previous research from Agincourt has shown that self-identified Mozambicans are less well off than the host South African population in terms of education, household assets, and child mortality (Gómez-Olivé et al., 2010; Hargreaves, Collinson, Kahn, Clark, & Tollman, 2004). Prior to 2006, Mozambican permanent residents were not eligible for South African social grants; however, even before the Constitutional Court ruling, a large number of Mozambicans managed to access pensions (Schatz, 2009).

We also consider three household structure variables to capture the multi-generational nature of many Agincourt households (Kahn et al., 2007). These include *household size* (grouped in the descriptive table, but continuous in the regression analysis), *older persons' living arrangements* (whether they lived alone, in skipped-generation households, or in multi-generational households), and the *percent of individuals in the household under age 15*.

*Analysis:* We first describe characteristics by age groups in 2006 and 2010. We then present logistic regression models assessing relationships of wellbeing to age, with particular attention to changes pre-pension-eligibility, post-pension-eligibility and post-post-pension eligibility. One focus is to assess whether the age pattern seen in the 2006 data is replicated with a downward shift in age in the 2010 data. The next set of models will present regression analyses for each 2006 and 2010 that include additional covariates, again attention will be paid to age patterns of wellbeing and how these relate to pension age-eligibility. Finally, for those individuals who were interviewed in both 2006 and 2010, we will assess the relationship of pre-pension, post-pension and post-post pension eligibility with wellbeing over time.

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