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NEWSLETTER

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Dear Reader,

AIDS mortality: This is an extremely complex issue characterised by inadequate statistics and the need for a lot of informed guesses:

In 1999 the incidence of HIV in South Africa was, in round percentages, 3% for whites and asians, 15% for coloureds and 25% for blacks.

The Actuarial Society of South Africa (ASSA) through Prof Dorrington of UCT has developed a model for the future incidence of HIV/AIDS in South Africa (websearch for "ASSA+AIDS" or "www.assa.org.za"). This model suggests that by the year 2010 45% of the South African working population will be testing positive for HIV/AIDS. A person who has just become HIV positive has a life expectancy of 10 years according to HIV/AIDS survival table used in the ASSA model. There is no distinction between males and females. A person who has been positive for HIV/AIDS for 10 years has a life expectancy of 2½ years, ie can expect to survive for a total of 12½ years from date of infection. This is a feature of actuarial life tables that was the issue in *Wigham v British Traders Insurance* 1963 3 SA 151 (W). The average life expectancy of the South African population is expected to reduce from a pre-AIDS level of 61 years at birth to 41 years at birth. Projections done by the World Health Organisation (publication ESA/P/WP.152 02/99) are based on HIV/AIDS survival tables which assume that 10% of those testing positive for HIV/AIDS will not die of AIDS. The paper does not explain the reason for this curious assumption, but there is good reason to believe that a small proportion of the population will be AIDS resistant, that is to say will never develop full blown AIDS despite testing HIV positive. Such immune carriers, if they exist, will over time form an increasing proportion of the population. A somewhat scary thought.

A child born HIV positive has a life expectancy of only 2 years.

The ASSA model predicts that AIDS deaths will be concentrated in the 25 to 50 age groups with the onset of HIV/AIDS for females being some 4 years earlier than for males and with 50% more females being infected than males.

Infection levels in the work force are expected to peak at 30% for labourer/semi-skilled workers, 23% for skilled workers, and 13% for highly skilled workers/professionals. AIDS-related illnesses can be expected to reduce attendance at work. For informal sector workers this will usually mean a loss of earnings.

From the point of view of damages claims it is most important that the HIV status of the claimant be known if the calculation of future loss is to be based on a fair and proper life expectancy. Even if the claimant is not HIV positive at the time of settling the claim there remains the substantial risk of future infection. The AIDS model developed by Dorrington identifies 4 population categories in the age group 14 to 60:

page 2....

1. Individuals whose level of sexual acivity is such that that their HIV prevalence is similar that of sex workers (prostitutes etc) and their clients (about 1% of population; close to 100% infection expected);
2. Individuals whose level of sexual activity is such that their HIV prevalence is similar to that of persons being treated for sexually transmitted diseases (about 19% of population; close to 100% infection expected);
3. Individuals with a lower level of sexual activity but who are still at risk from HIV (about 40% of population; close to 60% infection expected);
4. Individuals whose lifestyle precludes the risk of HIV except in the most bizarre circumstances such as rape or a tainted blood transfusion (about 40% of population; negligible infection expected).

The future risk of AIDS for a claimant will depend on the sexual-behaviour category. Persons who are sexually active with multiple partners will be at high risk. So too persons with sexually transmitted diseases.

There is good reason to anticipate that evidence on these issues will soon find its way into damages litigation for personal injury and death. Claimants proven to be in the highest risk groups (1 and 2) can expect their life expectancies for calculation purposes to be slashed by as much as 20 years. One anticipates that many in this category will already test HIV positive at the time of claiming. Persons whose medical record shows past treatment for sexually transmitted diseases would *prima facie* fall into category 2 above.

Road Accident Fund policy is that HIV testing is not done on claimants (a remarkable decision considering the pressures on the Fund to otherwise save costs). However, RAF AIDS policy does not seem to preclude allowance being made for the future risk of AIDS.

All this doom and gloom about AIDS must be tempered by the consideration that social behaviour can change quite rapidly and safe sexual practices may well become fashionable far more quickly than the ASSA model anticipates. The development of effective medication is also a real possibility. The ASSA model explicitly assumes that no medical solution will be found and is under continual review in the light of the latest developments.

Young girls from the rougher end of South African society may, if brain injured, be vulnerable to sexual abuse which may increase their risk of AIDS over and above that had the injury not happened. The costs of proper protection (if such is possible) against this risk would be a reasonable future expense for which compensation can be claimed.

Paraplegics and quadriplegics are usually unable to engage in risky sexual practices. For some life expectancy may well be longer after the accident than before. This may also prove true for young widows who have lost wayward husbands.

Disputes over the AIDS status of a claimant would be largely eliminated if compensation for loss of earnings and loss of support is paid by instalments. Even for RAF claims instalments are only possible if both parties agree thereto (*Coetzee v Guardian National* 1993 3 SA 388 (W)). There is thus no alternative other than to argue the contentious issues and lead evidence as to the sexual behaviour of the claimant. The law does not prohibit a non-RAF defendant from calling for an AIDS test.

Although I have relied heavily on the ASSA projections and tables the views expressed above are entirely my own interpretation of events. **finis**