

The South African OHS Commissions

Benjamin and Greef

1997

Report Of The Committee Of Inquiry
Into A
National Health And Safety Council
In South Africa

Electronic Copy By

David W. Stanton

Notes

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The author is grateful to Dr. Stuart Shearer, Gold Fields, and Dr. Charles Mbekeni, COM, for proofreading the electronic copy.

If you spot any mistakes in this copy of the ***Benjamin and Greef Report*** please notify the contact below who will correct the PDF file which is available on the Internet (Commissions section at asosh.org).

The original report at the bottom of page 26 has some errors on the NCOH directorates. These should be: Occupational Hygiene and Toxicology (Includes Analytical Services and Technical Advisory Services), Occupational Medicine and Epidemiology and Pathology.

Dr. David W. Stanton

Association of Societies for Occupational Safety and Health (ASOSH) and
Chamber of Mines of South Africa

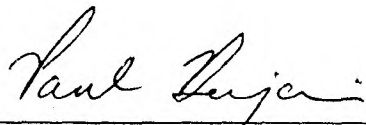
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21 October 2003

REPORT OF
THE COMMITTEE OF INQUIRY
INTO A NATIONAL HEALTH
AND SAFETY COUNCIL
IN SOUTH AFRICA

**Presented to Mr Tito Mboweni, Minister of
Labour by:**



PAUL BENJAMIN



JOHAN GREEF

29 MAY 1997

3.2 **National Centre for Occupational Health (NCOH)**

The NCOH was established as the Pneumoconiosis Research Unit in the 1950s as part of the South African Institute of Medical Research, with the brief of carrying out statutory autopsies in terms of the (then) Silicosis Act on miners, and conducting lung research into mining lung disease. It was subsequently transferred to the Council for Scientific and Industrial Research and then to the Medical Research Council and expanded its research into non-mining industry. The Department of Health inherited the NCOH in 1979 and in 1983 the jointly appointed post of Professor in Occupational Health at Wits and Chief Director was established. The Chief Director serves as head of the NCOH. While the NCOH is not currently a statutory organisation, the draft National Health Bill provides for the statutory establishment of the NCOH.²⁴

The broad functions of the NCOH are to provide support and referral level services to the occupational health system as a whole, including the public and private occupational health services and the enforcement agencies. Distinct national support and referral level functions of the NCOH have been identified as provision of -

- Advisory services - including consultancy and medico-legal services;
- Training - involving capacity building in collaboration with training institutions and provision of specialist training;
- Research & surveillance - including contributing to coordinating and priority setting; conducting national research projects and developing model surveillance schemes for key occupational conditions.

²⁴ Draft National Health Bill, Provisional Draft 9, (6 November 1996)

- Laboratory - including conducting priority laboratory-based analyses and assessments where these are of limited availability elsewhere;
- Technical information dissemination - involving collaborative proactive campaigns to improve practice in key industries or sectors; building network of practitioners to support information dissemination;
- Produce standards, guidelines and protocols - including those regarding specialised laboratory procedures and toxicology;
- International liaison - involving the development of agreements at national and sub-national level;
- Health hazard evaluation - involving selected priority evaluations where these cannot be done regionally, -
- Occupational health indicators - including identifying valid indicators of occupational health practice and health service performance indicators;
- Formulate concrete programmes to develop capacity in the provinces - in collaboration with advisory committee to the Chief Director: Occupational Health.

Current restructuring of the NCOH will provide 70 scientists, technicians and practitioners to perform these functions. It has been proposed that the restructured NCOH will have three directorates: Occupational Hygiene and Toxicology; Occupational Medicine, Epidemiology and Pathology Analytical Services; and Occupational Hygiene, Epidemiology and Technical Advisory Services. The restructuring will establish national support and referral systems for the occupational health system as a whole.

The NCOH has run an Eastern Cape Project to develop occupational health services in the province. This project provided these services on an ad hoc basis until the end of March 1997. It has now been replaced by the comprehensive consultancy and advisory services developed by the Eastern Cape Department of Health and Welfare.

3.3 **Occupational Diseases in Mines and Works Act**

The ODMW Act provides for the compensation of mineworkers who contract certain occupational diseases. These are primarily pneumoconiosis, tuberculosis and chronic obstructive pulmonary disease. Prior to 1984 it was administered by the Department of Mines. Three institutions within the Department of Health provide the services required for the compensation system established by the ODMW Act. These are the Medical Bureau for Occupational Diseases, the office of the Compensation Commissioner for Occupational Diseases and the Pathology Division of the National Centre for Occupational Health.

Prior to March 1994, compensation under the Act was paid according to race with white workers receiving up to 13 times as much as black workers with similar medical conditions. From 1 March 1994, this discriminatory system was replaced with an earnings-based system of lump-sum compensation payments.

Certification can take place after an applicant has been examined by the MBOD or in facilities on those mines which are authorised to conduct their own examinations. The Act provides for two degrees of compensation: for permanently disabled workers and temporary benefits for workers receiving treatment for tuberculosis. The improved benefits introduced in 1994 apply retrospectively and are therefore available to ex-mineworkers who are now diagnosed as having contracted a compensable disease.

The 1994 amendments also changed the system for the compensation of tuberculosis; compensation now occurs on account of disability and not merely diagnosis. This has resulted in a significant decrease in the number of employees compensated.

The office of the Compensation Commissioner for Occupational Diseases which administers the ODMW Act is a sub-directorate of the Department of Health. The staff complement of the office consists of 28 people. There are eight vacant posts at present. The Office is as yet not computerised.²⁵

The ODMW Act sets up a fund which is administered by the Commissioner and which derives its income from levies received from the owners of controlled mines and works. The levies are determined according to the number of risk shifts worked in a particular mine or works. The total assessments paid by the mines for 1994-5 amounted to R22,812 million, increasing to R38,049 million in 1995/96. In addition, the state contributes to a separate state Compensation Fund. This Fund is used for the payment of pensions to white miners who contracted an occupational disease prior to 1973, for compensation to employees of mines or works that were run by the state or that have closed down. In 1997/98 R12,700 million has been budgeted for this purpose; this is a decrease on the figure for the previous financial year of R16,350 million.

According to the 1995 Annual Report, there has been a dramatic decline in the number of employees receiving benefits. For example, while in 1993-94, a figure of 1 984 persons are recorded as receiving benefits for first degree disability diseases, the 1994-95 figures, which include those workers who have been awarded benefits after the amendment to the Act, amount to only 352 and the 1995/96 figures to 1 095. The Annual Report contains no explanation for this decline in the number of beneficiaries. However, the Compensation Commissioner has explained the drop in the number of benefits as due to a change in administrative procedures. Workers must fill in-an

²⁵ Report of the Compensation Commissioner for year ended 31 March 1995 and information supplied by the Compensation Commissioner.

application form for benefits which they receive only after certification by the MBOD has been completed. In the past, the required paperwork was completed, in the case of black workers, when the worker was examined by a medical specialist and the documentation was then sent to the Office of the Commissioner. This change in procedure has a negative impact on migrant workers who return to the rural areas when they are ill.

Figures presented in the Report show a discrepancy between the number of certifications that take place in a given period with the number of benefits awarded for the same period. According to the Commissioner this is as a result of the backlog in the processing of claims. While the backlog before the 1994 amendment, amounted to about three months it has increased to a nine month period.

3.4 **Medical Bureau for Occupational Diseases (MBOD)**²⁶

The MBOD has its origins in the Silicosis Board, later the Pneumoconiosis Board, established by succeeding Acts covering compensation of lung diseases in miners. It currently functions in terms of the ODMW Act. Its administration was transferred from the then Department of Mines to the Department of Health in 1984. It has a staff complement of 76 persons plus an additional 20 support staff. The MBOD also does certification work for the Office of the Compensation Commissioner under the COID Act by non-statutory arrangement.

The MBOD has sub-bureaux at Welkom, Rustenburg and Witbank. The closure of the sub-bureaux is currently under consideration.

²⁶ Information from Department of Health: Report of the Committee on Occupational Health (January 1996).

The ODMW Act requires the MBOD to perform medical examinations for the initial certification of fitness of prospective mineworkers, periodic examinations for the renewal of the certificates and examinations to determine eligibility for compensation benefits. The MHS Act now stipulates that the responsibility for determining employee fitness before and during employment and supplying certificates, rests with the employer. The MBOD will, as a result, function as a centre for benefit examinations. For this purpose, the Bureau has retained the capacity to perform lung and x-ray tests.

All mineworkers, including former mineworkers, are entitled to be medically examined at no cost to determine whether they have a compensable disease. The MBOD may refuse to perform the examination if the employee has been medically examined in terms of the ODMW Act in the past six months.

Two panels of medical practitioners are established to adjudicate on applications for compensation benefits under the ODMW Act. The Medical Certification Committee, chaired by the Director of the MBOD, determines whether a mineworker is entitled to compensation. Its findings are subject to review by the Medical Reviewing Authority for Occupational Diseases.

At the time of preparing this report, the ODMW Act has not yet been amended to create consistency with the MHS Act and the MBOD's obligations to conduct initial, periodical and exit examinations overlap with those of the MHS Act.

Three factors will determine the future functioning of the MBOD. These are the enactment of the Mine Health and Safety Act, the possible merger of the two compensation funds (under the COID Act and the ODMW Act) and the reservoir of ex-mineworkers who are potential beneficiaries under the ODMW Act.

3.5 **Epidemiology Research Unit (ERU)**²⁷

The ERU research unit was established in 1979 as a result of an initiative by the Chamber of Mines in terms of section 120(2) of the ODMW Act to conduct research on occupational diseases among mineworkers. In the past, its research focused on diseases such as silicosis, asbestosis, cancers, respiratory and hearing disorders among white mineworkers. It is funded by the Ministry of Health from the Research Account established by the ODMW Act from levies raised in terms of s.63(1), and at the Minister's discretion from monies appropriated by Parliament. The ERU currently has funding up until April 1998 when the new Safety in Mines Research Advisory Committee (SIMRAC) arrangements come into force: its funding arrangements after that are unclear.

In 1994 a new Director was appointed to the Unit and four senior scientists have joined the Unit. The ERU has been in the process of restructuring and prioritising its work. In so doing the Unit has taken the following considerations into account:

1. The need to identify and address the most important diseases as they affect all mineworkers through the building of a data base of disease on the mines in relation to the work history of miners.
2. The need to carry out research that would lead to effective and sustainable management of diseases on the mines and reduce the burden of disease on the mines.
3. The need to have a thorough understanding of the social circumstances of miners and of their knowledge and perceptions of disease i.e. social sciences to become an essential part of the work of the ERU.

²⁷ Information supplied by Dr. Brian Williams, Director ERU.

4. The need to address the significant burden of disease amongst ex-miners and establish the extent of such disease amongst rural communities in this regard.

3.6 **Technical Cooperation Programme with the World Health Organisation (1996 - 2003)**²⁸

This program was authorised by the WHO and the Department of Health in the third quarter of 1996 to strengthen the capacity of the Government to develop and implement occupational health programmes at all levels. The programme consists of key national workshops on policy and strategy, research, education and training, primary health care, AIDS, bridge building between the inspectorates and trade unions, and key provincial workshops to kick start occupational health and safety activities in the provinces. Under the occupational health and safety training programme, a wide variety of courses are being funded including specialised training for the Departments of Health, Labour, Minerals and Energy and provincial and local authority staff. These include courses on -

- Audiometry and noise measurement;
- Benefit examinations (lung function, x-ray reading);
- B readers for ILO classification of pneumoconioses;
- Biological agents (water contamination, regulations for hazardous biological agents);
- Biological monitoring;
- Occupational epidemiology;
- Ergonomics;

²⁸ Information supplied by Dr. David Stanton, Head Occupational Hygiene and Toxicology Division, NCOH.

successful claims for compensation for diseases scheduled in terms of the Workmen's Compensation Act. Of these 80 were for silicosis or asbestosis. In 1996, the number of claims under the COID Act was 2 482 broken down as follows -

Occupational diseases reported under COID Act - 1996

Asbestosis	129
Silicosis	59
Pneumoconiosis	52
Pleural Thickening	29
Bronchopulmonary Disease	37
Byssinosis	16
Occupational Asthma	141
Dermatitis	305
Mesothelioma	52
Tuberculosis	205
Hearing impairment - noise induced	1219
"Major depression"/post traumatic stress	192
Fibrosis of the lung/lung conditions	14
Overstraining of muscular tendinous insertions	8
Other conditions	24
TOTAL	2482

Even then, this remains less than 1 % of total compensation claims. Changes in the criteria for compensation under the ODMW Act which took effect in 1994 have resulted in a sharp decline in compensable cases. The total number of compensable cases has declined from 7 957 in 1992 to 2 032 in 1995/96. Due to a change in the criteria for compensation, discussed in Chapter Two, the number of compensable cases of tuberculosis declined from 5 220 to 694. According to the Report of the Department of Health's Committee on Occupational Health, the expected number of

greater allocation of state funding to the MHS Inspectorate. As is indicated in Chapter Four, a very considerable proportion of state resources devoted to OHS are expended on the mining industry. The Leon Commission envisaged that the future direction of mining OHS policy must occur within the framework of a broader national policy and that the MHS Inspectorate must participate in the National OHS Council.¹²⁶

The Leon Commission¹²⁷ highlighted four critical areas in occupational health and safety in which they recommended that urgent steps be taken:

- accidents from falls of ground;
- accidents from underground haulage and transport;
- coal mine explosions; and
- respirable dust.

Guidelines for the preparation of codes of practice have been, or are being developed, in respect of the first three issues and a set of occupational health regulations are being prepared.

There is extreme fragmentation of authority for the monitoring of occupational health and safety and related issues in the mining industry. The application of the provisions of the Nuclear Energy Act, the Explosives Act and the Hazardous Substances Act to the mining industry are all monitored by separate inspectorates, applying different, and sometimes conflicting, precautionary principles. In addition, environmental inspections are required by the Minerals Act, the Water Act and the Atmospheric Pollution Prevention Act, each with their own inspectorates.

¹²⁶ Commission of Inquiry into Safety and Health in the Mining Industry Report (1995); Vol 2 at 4.

¹²⁷ Commission of Inquiry into Safety and Health in the Mining Industry Report (1995) Vol 1 at 158-161.

Court. (The duplication of judicial responsibility is exacerbated by the fact that all matters arising from the COID Act, including appeals from decisions of the Compensation Commissioner, in terms of the COID Act are heard by the High Court. (This duplication creates the potential for the Labour Court and the High Court to adopt different approaches to the interpretation of key areas of OHS law.)

Like the Labour Relations Act, the MHS Act has been drafted in "plain language" greatly improving its accessibility to mine personnel. This includes designing forms in a clear and user-friendly manner. It is a statute enacted during the new constitutional era and key aspects of the Act such as the powers of the inspectorate are tailored to comply with the Constitution.

The inconsistency in legislative framework is accentuated by the application of different standards in regulations published under the two statutes. Examples where the standards in regulation for the mining industry differ from those applicable to other sectors include standards for elevators, lifting-gear and boilers.

The inconsistencies between the two compensation laws are discussed later. Significantly, the coverage of the MHS Act and the ODMW Act are not consistent because of different definitions of a "works".¹⁴¹

This continued disparity in legislation, standards and structures cannot be justified and the national policy will have to develop mechanisms to ensure the consistent application of legislation and standards across all sectors. It is a cause of considerable uncertainty and confusion: many businesses operate under both Acts, and there is a considerable movement of personnel between the two jurisdictions. The Department of Labour has included the revision of its legislation as one of its objectives for 1997

¹⁴¹ The definition of "works" in the ODMW Act is not consistent with that in the MHS Act. The Minerals Act 50 of 1991 adopted a narrower definition of "works" than that contained in previous mining legislation with the result that "works" (such as Sasol and Iscor) fall under MOSA and then the OHS Act while remaining under the ODMW Act. Since the OHS Act hazardous substances regulations came into effect these "works" have had to comply with the different, and inconsistent, requirement of the OHS Act and the ODMW Act in regard to monitoring dust levels.

If, however, these priorities are jointly determined they can produce a synergy that enhances compensation and prevention.

It is now generally acknowledged that the ODMW Act's compensation system contributed significantly to the poor control of health hazards in the mining industry as noted by the Leon Commission. First, the extremely low levels of compensation paid to black mineworkers under the ODMW Act prior to 1994, and the correspondingly low compensation assessment paid by mines, meant that the compensation system contained no financial incentive for employers to tackle dust problems in the mines. The cost of the compensation system to employers is further reduced by the fact that the State covers the cost of administering this compensation system. Second, larger mines were permitted to monitor dust levels to determine their compensation levies. In the case of small mines, the state performed this function. The method of measurement adopted (gravimetric sampling) did not provide any meaningful feedback to effectively control hazardous dust levels. The result was a system in which more was spent on determining air quality indices for mines for the purpose of calculating contributions and on anatomical pathology than on either controlling and rectifying hazardous conditions or on compensating workers. This approach has been criticised by the Department of Health, the Leon Commission and the mining employers and trade unions.

The absence of an integrated prevention approach has also been commented on in the Compensation Commissioner's Cost Containment Plan. Most of the persons interviewed in the study stated that the Commissioner should place a greater emphasis on the prevention of accidents, the promotion of workplace safety, management of health and safety risks and on research. The consequences of the absence of an integrated preventative strategy involving the prevention and compensation agencies can be illustrated by examining the impact of one of the most significant innovations introduced by the COID Act. Schedule 3 of the COID Act includes all diseases due to "overstraining of muscular tendinous insertions" caused by any work involving repetitive movements. Diseases of this type represent one of