Post-Apartheid Occupational Health Services: What about small industry and the informal sector?

by Grant Rex

This article acknowledges the need for business to contribute to the provision of ccupational health services (OHSs). The author,however, also stresses the need for OHSs to be based on comprensive PHC principles in line with the broad development of an NHS. The model that is argued for here points to a distinction between the need for business to finance OHSs and the need for the state to manage this important service.

The contribution by Fareed Abdullah to discussion about future occupational health service (OHS) provision is extremely welcome(1). It identifies a number of important needs, in particular, the need for employees to finance occupational health services,and the need for state funding to focus on prevention, training, evaluation and monitoring. In addition it makes valuable proposals around future OHS provision and even goes on to listshortcomings with the proposed model.

However, there are additional shortcomings which were not mentioned and which need further discussion. The most important of these arises from the problem of providing services to smaller industry and the informal sector. The model proposed by Abdullah will result in either the neglect of these sectors, or else, the state will have to bear the financial burden of providing OHSs single-handedly. The stress in the

article on links with comprehensive primary health care (PHC) services is also contradicted by a conclusion which favours management based OHSs. A management based service parallel to a state based comprehensive PHC network, lays the basis for division as these services develop, even if managements subscribe to comprehensive PHC. A third problem with the model relates to the failure to distinguish between financing, provision, and the location of health services. The distinction between financing and provision of the service is drawn initially, but is lost in the rest of the discussion. Instead, if an approach to OHS provision is made witht his distinction in mind, then the option of capital financing the OHS without controlling it, becomes possible, and an alternative model becomes viable.

A State controlled Primary Health Care based Model

The strength of a factory based model can largely be retained,and the weaknesses eliminated, with a PHC based OHS model which is controlled by the state and financed by capital. This separation can be achieved by way of charging each workplace on a capitation basis for a service located at a local PHC centre as part of the state controlled PHC network. The model which will be presented, is based on the experiences of an OHS recently launched at the Alexandra Health Centre and which is currently functioning along these lines.

While the success of a state controlled model depends in part on a state more sympathetic to worker interests, this is a far cry from the control which management could assert over a service entirely under their control. And while worker organisation is ultimately the only guarantee of a safe and healthy workplace, a state sympathetic to workers' interests can bring valuable weight to bear in favour of this process of democratisation. Well motivated health workers employed by such a state would also have the space to engage in activities without fear of harassment, and without the danger of being ignored and deprived of resources.

However, the most important features of a state controlled model are the advantages which result from economies of scale, especially for smaller workplaces. What is meant by this, is that the coordination which results from services which are larger in size or scale, allows for cheaper provision of infrastructure, including buildings, transport, lab facilities, and other special investigations, referral systems, drug supply, environmental and biological monitoring and, importantly, research. While it is easy to assert that employers must provide OHSs, and that smaller workplaces must combine resources, unless this is organised by the state, the capacity of small workplaces are not part of any organisation or federation and are poorly

covered by legislation. PHC based services also have the option of reducing costs by increasing scale in more ways than do private employers.This can take place even if the PHC deals with the same number of workers, but simply focuses on a wider spectrum of diseases.The potential to serve more people simply by being PHC based and offering services to nearby communities is also possible.

By being part of regional health care delivery the OHS also benefits from a functioning referral system. Even more important may be access to basic special investigations and drug purchasing and distribution. The cost of these services is significantly reduced by being part of an established national network.

However, it is not only the cost of running such facilities, but the cost of setting them up that also needs to be taken into account. If a regional service with capacity to accommodate OHS demands is in existence, then there is no risk of duplicating such services if the OHS is PHC based and plugs into this facility.

The need for research is also met more easily if the OHS is PHC based. Rather than relying on national and regional centres which, with likely increase in demand are going to be even more overextended than they are now, a PHC based service has the potential to conduct at least some basic research of relevance. In contrast, management based services are currently conducting little if any research even in large factories.

Occupational health services should be provided at even the smallest of worklaces. Photo: Medico Health Project

There is also more potential for formal on-going training. This is important for a developing service, and is also unlikely to take place if the service is management based.

Potential Problems

Several problems are associated with a PHC based OHS. Two of these are identified by Abdullah. The first relates to the advantages of a service actually located at the workplace. This is clearly important. However, a PHC controlled service can also be permanently located at those factories large enough to use the services of a permanent health worker and provide premises. Some of the advantages of a factory based service in terms of early detection of occupational disease, can even be retained in a PHC located service which conducts regular on-site medical examinations and appropriate screening.

Secondly, there is the problem of existing management based OHSs. This has political dimensions and obviously needs to be dealt with sensitively. Initially they can simply be maintained alongside state based OHSs. Later with a flexible approach and a process of negotiation, they can be incorporated to a greateror lesser extent appropriate to each circumstance.

The most serious potential problem identified by Abdullah, however, is that of OHSs "being lost in a sea of general health" if they are part of comprehensive health care delivery. Rather than detract from OHS, however, PHC may in fact assist development by contributing resources. In the case of theAlexandra Workers Health Outreach, surplus skills and technical resources which were available at the Alexandra Health Centre (AHC) were put at the disposal of the fledgling service. This made for an easy start to the service, and helped to overcome the significant inertia associated with developing OHSs, especially for small workplaces, and relates back once again to the size of the PHC and economies of scale which it allows.

Conclusion

The initial experience of the Alexandra Workers Health Outreach which has been described elsewhere (2), therefore points strongly in the direction of a state controlled service with a PHC network. While there is a financial imperative to involve management, ways need to be found of ensuring that the OHS is not under their

control. Although this depends ultimately on strong worker organisation, the location of OHS under state control allows for economies of scale, national coordination, and diminishes management influence, while affording to health workers not directly involved in the acquisition of profits, the chance to make a contribution.

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References

1. Abdullah F. Post-Apartheid occupational health services. Critical Health #33 (November 1990).
2. Rex G. Launching a problem service. SAMJ 1991 (awaiting publication).

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