COMMENT 1
INDUSTRIAL DISEASES AND ACCIDENTS IN SOUTH AFRICA

This Bulletin deals with a much neglected aspect of health care in South Africa - industrial diseases contracted and accidents suffered by workers. It draws mainly on papers delivered to the Economics of Health Care Conference held at the University of Cape Town in September, 1978. This was jointly sponsored by SALDRU (Southern Africa Labour and Development Research Unit) and SAMST (South African Medical Scholarships Trust). While a very useful summary of all the papers dealing with Occupational Health has been published in Social Dynamics (Vol. 4, No. 2, Dec. 1978) we are printing a selection of amended papers together with other contributions.

The most recent source of information about industrial diseases - the Erasmus Commission of Enquiry into Industrial Health of 1976 - is summarised by Phillipa Green and Shirley Miller. Some of its findings are devastating: lead absorption among workers in lead - using industries in South Africa is so high that if Swedish standards were applied, 45,6% of the workers would have to be withdrawn because they showed an overdose of lead. Many of the factories, were they located in Sweden, would have to be closed. In a survey of a chrome factory, workers revealed that they expected to suffer perforated nasal septa in the course of their working-lives. *Seventy-five per cent of workers in fact had active* lesions of the nasal passages and 4% had complete perforations. Green and Miller also make justifiable criticisms of the Erasmus Commission. In the light of its own findings it makes astonishingly lenient recommendations about employers' responsibilities and it would apparently like to restrict the role of autonomous worker organisation in industrial health issues.

The Erasmus Commission also decided that occupational accidents did not fall within its terms of reference even though it acknowledged that 'a great many accidents are so

closely bound up with a particular industry that they may be regarded as acute diseases and indeed as occupational diseases' (para.2.36).

In order to correct this omission to some extent, we include a paper on accidents on South African mines by Alide Kooy. The results show how serious the omission of accidents by the Erasmus Commission is. On average, every year between 1970 and 1977, approximately 28 000 workers were injured. H.J. Matthysen of the National Occupational Safety Association has calculated that every year South Africa's workers suffer serious injury to 110 000 hands, 50 000 feet and 40 000 eyes. In addition more than 2 000 workers are killed.

These high rates of mutilation and injury are an indictment of our social system. They also raise further issues which are considered in this Bulletin: namely the reasons why industrial diseases and accidents are so prevalent in South Africa; the principles on which Workmen's Compensation is based; and the nature and extent of medical services for workers.

These issues are examined by four other contributors to this Bulletin. Taffy Adler argues that industrial accidents are so frequent because they are often not perceived by managements as a major cost. The Workmen's Compensation Act ensures that medical expenses and compensation are paid by the Workmen's Compensation Commissioner and that management is protected from any claims instituted directly against it by injured workers even if the accident is a result of the employer's negligence. Adler also shows that the principle on which protective legislation is based - that adequate protection can be established purely by statutory bodies - is incorrect. The essential requirement is for safety and health conditions at work to be part of the collective bargaining process between management and unions. This is demonstrated by the experience of the Metal and Allied Workers' Union: the union has been denied access to the

details of the rules concerning the prevention and protection measures required at factories, by the Department of Labour's Factory Inspectorate. The union has also found that workers have no right to hear the outcome of any investigations they might have requested. A letter informing the union that such an investigation was 'strictly a matter between the employer and the department' underlines the validity of Adler's argument.

In a paper dealing mainly with the incidence and prevalence of silicosis on the gold mines in the first quarter of this century, Elaine Katz also points out the discriminatory nature of compensation between white and African mine workers. In the case of compensation for tuberculosis the ratio of white to African awards has increased from 5,9 to 8,3 between 1921 and 1973. It is noteworthy that white mine workers have a strong trade union whereas African mine workers do not.

The provision of medical services for workers is considered by Diane Cooper who examines Industrial Council medical schemes. The paper reveals a bias in favour of skilled and white workers. It also calls into question whether the sick pay benefits which are part of the medical benefit schemes are really an improvement on the sick leave provisions of the Factories Act and the Unemployment Insurance Act, which by law they should be. Whereas workers are not required to pay contributions under the Factories Act, they contribute an amount equal to employer's contributions to sick pay benefits. Furthermore although sick pay benefits are paid for a longer period, full pay is accorded by the Factories Act whereas sick pay benefits are on average 45% of the minimum wage (as calculated by Cooper on available statistics).

The mutilation of many workers in South Africa's industries indicates the need for drastic action. There is much that has to be done and we want to pinpoint only three areas requiring careful attention. The first is that much more research is required into the incidence, causes and prevention of industrial accidents and diseases. The Erasmus Commission for instance found that there is no schedule of maximum threshold limit values for hazardous substances used in various industries in South Africa (nor did they recommend such a schedule). Research is required to establish these limits.

The second concern stems from the fact that symptoms resulting from exposure to hazardous substances and submission to poor working conditions sometimes only become evident years later, often only after the worker has left the work place where he contracted the disease. In the United States of America, for instance, the National Cancer Institute and National Institute of Environmental Health Sciences have recently calculated that at least 20% of the cancer incidence in the United States is attributable in whole or in part to occupational exposure to carcinogenics in the work place. The carcinogenics include asbestos, arsenic, benzene, chrome, iron oxide and nickel. However, most of these cancers will only manifest themselves in the next 30 to 35 years. Although diseases could have multiple causes, it is important to establish which diseases have occupational links, which industries are responsible for the diseases, how these can be prevented and how to calculate financial responsibility for compensation. The latter is an aspect that the Erasmus Commission totally neglects, while the Workmen's Compensation Act makes inadequate provision for it.

The third concern is about the period of time which has lapsed before any action has followed the Erasmus Commission findings and recommendations. The recent appointment (December 1978) of the Commission of Inquiry into Compensation for Occupational Diseases is very welcome. However, legislation based on the Erasmus Commission recommendations has still to be introduced, and the question arises of how effective such laws can be when the Commission omits industrial accidents from its purview, relies mainly on voluntary persuasion of management to attain desirable health standards and wishes to exclude trade unions from direct participation in the determination and enforcement of health conditions at work.

Workers cannot expect employers to improve working conditions when this involves additional costs unless they are forced to do so. Nor can they expect the State to introduce - and enforce - strict statutory protection which would run counter to employer interests. What is required are strong trade unions to bargain effectively for improved working conditions. In order to achieve this, full trade union rights for African workers becomes a necessity. Experience in Industrial Councils has shown that the interests of African workers are severely neglected because they do not have direct trade union representation. (See, for instance, the article by Scheiner in SALB Vol. 3 No. 10). There is also an awareness of this need amongst some members of the medical profession as the article by a group of Johannesburg doctors indicates.

It has been argued that trade unions can strengthen their bargaining power by incorporating health and safety issues into their organisational strategy. How precisely each union does so depends upon the situation in which it finds itself. Some argue that at present the unions are too weak and to set up sub-committees on safety is premature. We publish in this edition an article by Johann Maree which proposes one way that a union could proceed. Whatever

strategy is pursued, an essential requirement for a union that provides medical services is to incorporate the services in such a way that workers are mobilised to assume as much responsibility as possible for their own health. Care needs to be taken however, not to start turning the union into a mere benefit society by the introduction of medical services.