OCCUPATIONAL HEALTH SERVICE DELIVERY
IN SOUTH AFRICA

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INTRODUCTION
Occupational Health (OH) in South Africa can be considered to be in its infancy. Legislation for the control of OH was first promulgated in 1993 for implementation from 1994. Much development has taken place since this time but a great deal more progress is required before it could be said that there are sufficient practitioners providing effective services to the workforce. Legislation is both formal and informal. This paper will provide a summary of factors that have shaped the environment of OH.

LEGISLATIVE FRAME WORK

Two laws in SA govern Occupational Health. These are the Occupational Health and Safety Act (OHS) Act No 85 of 1993 and the Mines Health and Safety Act (MHS) Act No 29 of 1996. The two laws are enforced by separate parastatals. The MHS Act considered to be a “tougher” piece of legislation is enforced by the Department of Minerals and Resources. On the other hand the OHS Act is enforced by the Department of Labour through the Occupational Health and Safety Division. Both are considered to be well written legislation but the application and enforcement less than ideal. Common compensation legislation exists in the form of the Compensation for Occupational Injuries and Disease Act No 130 of 1995 which covers all formal employment sectors. Additional legislation i.e. the Occupational Diseases in Mines and Works Act, addresses compensation for respiratory diseases in the South African mining sector. Occupational Health Clinics are controlled by the Department of Health and the Pharmacy Council. No form of regulation is being applied to the establishment of occupational health clinics but the new National Health Act No 61 of 2003 should change this. Currently minor regulation is seen with regulations such as the control of medicines at clinic sites.

AVAILABLE SERVICES

The following specialties can be found within the country: medicine, nursing, hygiene and safety. The first three specialties are represented by professional societies (SASOM, SASSOHN and SAHOH) whereas a number of bodies represent the interests of safety practitioners. The public sector supports a national body that serves as a referral and resource center for both the public and the private sector i.e. the National Institute of Occupational Health. In addition there are six provincial referral centers around the country located at major centers and generally linked to the national OH center.

Private sector services are better organized than public sector. Despite the fact that legislation is written by the Government, services for the public sector employees are limited. In other words Government which is imposing standards of care for the private sector is not offering its own employees the same care. These employees are exposed to the same risks that private sector employees are, as well as others. Reasons cited include: lack of facilities, lack of training, lack of understanding of responsibilities by managers, inadequate budgets, lack of resources to improve facilities and attitude of employees.

In the private sector occupational health service delivery may be hampered by the provision of primary medical care. Many employees are not covered by any form of medical insurance and are thus dependent on access into the healthcare service through the occupational health clinic. Much of the OMP and OHNP’s time is taken up by the provision of primary medical care reducing the time available to focus on the occupational health issues.

HUMAN RESOURCES

Occupational health medical and nursing services in SA are offered by the OMP and OHNP. Poor statistics are available on the number of practitioners available to provide OH services. The WAMSA program reports there are 8 OMPs and 41 OHNPs per 10 000 population in SA. The shortage of these resources raises concerns. A 2007 survey showed that in some cases one OHNP may be responsible for the health workers in high risk environments as opposed to 1 OHNP being responsible for 100 employees. In a low risk setting. Many factors are responsible for this including geographical location, insufficiency of training programmes, lack of enforcement of legislation and lack of understanding of the need for OH service delivery. In addition to a shortage of practitioners the number of hours of coverage by each of the professional categories varies. Few companies engage the services of a full time OMP and OHNP to employ on an hourly basis for various reasons. The OHNP is more likely to be employed on a full time basis and as a result will be the person who assumes responsibility for service delivery. OHNPs in many cases are used for a few hours a day once a week to meet a legal minimum of 1 hour a week where medicines are kept on site. Occupational health nursing has been identified as a scarce skill but the limited number of training facilities make it difficult to train more nurses and in addition nurses in general in South Africa are a scarce skill.

CHALLENGES TO SERVICE DELIVERY:

- Increase the number of trained professionals
- Increase number of training facilities
- Geographical disparity in the distribution of trained professionals
- Referral centers are needed closer to the rural areas
- Lack of reliable statistics on injuries and diseases needs to be improved
- OH for the informal sector needs to be developed
- Increase the fragmented service delivery
- Address the needs and challenges of a changing workforce

REFERENCES