Guest editorial

Occupational and environmental health

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In the last special issue on occupational health in September 1996 several predictions were made in respect of policy, legal and systems issues, which we can now evaluate. The changing political scene back then gave rise to expectations and hopes, through various policies and white papers, of an improved occupational health and safety dispensation. Many of these have to a greater or lesser degree not been fulfilled.

Policy issues

The restructuring of occupational health systems which then seemed likely (the Abdullah report) did not really eventuate within the public sector, which with time arguably regressed, along with the quality of occupational health services provided by burgeoning private sector agencies. There has been little public-private sector interlinkage, and the focus everywhere remains almost exclusively on primary clinical care rather than occupational health.

Disastrous policies (e.g. the 'one-stop shop') for labour inspection of factories have resulted in the loss of specialist expertise and institutional memory required for effective and competent labour inspection. New regulations under existing legislation are, practically speaking, unenforceable due to weakness in the inspectorate, which relies on outsourced government-approved inspection authorities, whose poor quality and vested interest frequently compromise their preventive utility and their independence. The mining industry has been no exception, and the decline in safety prompted the recent Presidential audit of mines, which exposed the lack of capacity of that inspectorate to enforce the Mine Health and Safety Act (MHSA).

Legal issues

Welcome laws in the 1990s (Occupational Safety and Health Act (OHSA) and MHSA) have proved difficult to update (e.g. the occupational exposure limits in the Hazardous Chemical Substances Regulations). Despite their vast improvement on prior legislation they have been amenable to overwhelming manipulation by vastly superior industry resources (e.g. MHSA and its structures including SIMRAC). The Compensation Fund under the Compensation of Occupational Injuries and Diseases Act (COIDA), while improving its documentation and to some extent its claims processing efficiency, has proved unable to break the power of the mining industry in blocking the integration of fair, just and constitutional compensation for miners on an equal basis with the rest of industry's workers. Having played such a key role in generating occupational disease (tuberculosis, pneumoconiosis and HIV/AIDS) over more than a century, this industry continues to ignore mineworkers' occupational health needs and to block efforts at prevention or a just compensation dispensation.

Service issues

For the public sector at national level there has been a noticeable decline in the coverage and quality of workers' compensation services provided to ex-miners under the Occupational Diseases in Mines and Works Act (ODMWA) as evidenced by long delays in the resolution of claims. While important circular instructions for the diagnosis and compensation of common occupational diseases have been promulgated by the COIDA Commissioner, the provincial medical advisory panels initially established in 2004 in the Western Cape, and a year later in KZN, were precipitately closed down for dubious reasons despite providing a much more efficient and cost-effective service at provincial rather than central level. The public sector provincial health services failed to incorporate occupational health, and there has been deterioration in the enforcement capacity of the Labour Department inspectorate.

The private sector has suffered from 'churn' – the never-ending shift from one occupational health services provider to the next, with serious loss of institutional memory and continuity of personnel and services at workplaces.

The primary prevention or engineering approach to occupational health has not been adopted anywhere, despite its proven superiority. Hazardous exposures leading to adverse health effects have increased with increasing economic development. Old and new hazards abound. Occupational hygiene, which is the key occupational health profession tasked with the most important primary prevention interventions, viz. to reduce or eliminate hazardous exposure, has failed to develop sustainably. While some master's level programmes in occupational hygiene have commenced in the past decade, what is needed is a programme that produces a cohort of doctoral level occupational hygiene scientists located in university departments of engineering or science, serving as a solid base for high-level professional development. Without this, primary prevention is crippled.

While most energy should be expended on primary prevention and reduction of harmful exposure, most emphasis in our current

system is on secondary and tertiary prevention. Indeed the strongest part of the occupational health system is at the level of secondary prevention or medical surveillance. Occupational health nurse practitioners accompanied by a smaller number of occupational medical practitioners are the mainstay of our occupational health services where they are burdened by unmet primary care needs. In workplaces one encounters a disturbing tendency to engage in secondary prevention activities which de-emphasise the primary preventive imperative to reduce harmful exposures. Instead, health professionals go through formalistic motions of screening, surveillance and biomonitoring aimed at minimal compliance with legislation while clearly hazardous exposures continue to cause harm. Often these activities are easier and cheaper for industry to institute than containing exposure.

Large industries like mining are engaged almost entirely in tertiary prevention (compensation of disability) and are not doing a good job of it either, as is evidenced by the high prevalence of undetected and preventable silicosis and tuberculosis in current and ex-miners across southern Africa. The mining industry has consistently obstructed a fair compensation deal for miners with occupational respiratory disorders, including currently in the courts, where they are refusing to take full responsibility for historically poor occupational hygiene, medical surveillance and compensation practices that have caused much occupational disease, disability and suffering. In particular, the industry has strongly resisted any merger of the two compensation systems (COIDA and ODMWA) that would do away with systematic disadvantages suffered by current and ex-miners.

All in all a rather depressing picture. The prospect of being a worker in today's South African workplace is not alluring.

Future opportunities

Some rays of light in this gloomy picture include increasing outputs of doctors with postgraduate diplomas in occupational health qualifications, and the birth of an occupational medicine specialty in 2006. Since that time several health science faculties have trained registrars and produced three specialists to join the new Division of Occupational Medicine within the College of Public Health Medicine of the Colleges of Medicine of South Africa.

While lawyers and doctors are not always the best of friends, other glimmers of light include successful lawsuits against Cape Asbestos, resulting in the establishment of the Asbestos Relief Trust to compensate victims of past asbestos exposure. Various attempts to sue the mining industry for negligence in respect of worker exposures to silica and being at increased risk for silicosis and tuberculosis are also ongoing, and may result in some restitution for the many who have forfeited their health and lives over the past century.

Future challenges and opportunities include better policies for providing specifically occupational health services at all levels; serious movement towards a national integrated agency for health and safety; the development of occupational hygiene on a strong academic and professional base; improved education and training for occupational health nurses and other key allied health professionals; along with ensuring the active involvement of all social actors including workers and their organisations in the occupational health enterprise.

In this issue of *CME* Westerholm discusses the intricacies of occupational health ethics, which remain as thorny a topic as ever given occupational health professionals' tricky role in a contested terrain beset by the promise of material gain at the expense of personal integrity and workers' health. Closely related issues of fitness assessment and medical certification are outlined by Kew and Adams. Occupational diseases in South Africa still reflect the predominance of the extractive industry, as Ehrlich and Naidoo, and London and Rother show for mining and agriculture respectively. Toxic metals discussed by Dalvie and Myers feature ever more strongly. Work-related asthma, according to Jeebhay, is increasing with a complex array of causes. Tuberculosis as an occupational infectious disease discussed by Naidoo takes on a particularly nasty character in the context of our HIV/AIDS epidemic and in working populations exposed to silica and other environmental and social conditions typical of South African industries both historically and currently. In a country haunted by such infectious plagues there is the added social curse of unemployment. In this context Meintjies, in a careful case report, shows how critically important appropriate methods of disability assessment are to individual and social well-being. And we have so much disability and so much unemployment, that this tertiary preventive practice takes on heightened importance for well-being.

We very much wish and hope that 13 years hence, the next special issue in occupational health or medicine will record that it is more pleasant and less hazardous to be a worker in South Africa.