Persistent failure of the COIDA system to compensate occupational disease in South Africa

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Cases of occupational disease, solvent encephalopathy and occupational asthma are used to exemplify failings of the workers’ compensation system in South Africa, that include delays in processing claims, non-response to requests for information, and inadequate assessment of disability. These and other systemic deficiencies in administration of the Compensation for Occupational Injuries and Diseases Act of 1993 (COIDA) reduce access by workers with occupational disease to private medical care, and shift costs to workers and to public sector medical care. Another unintended effect is to promote under-reporting of occupational disease by employers and medical practitioners. Reforms have been tried or proposed over the years, including decentralisation of medical assessment to specialised units, which showed promise but were closed. Improved annual performance reporting by the Compensation Commissioner on the processing of occupational disease claims would promote greater public accountability. Given the perennial failings of the system, a debate on outsourcing or partial privatisation of COIDA’s functions is due.

Two compensation case histories are described and lessons drawn about perennial deficiencies in the system of compensating occupational diseases in South Africa. Compensation system failures demoralise clients and medical practitioners, and transfer the costs of occupational disease to workers and public sector medical facilities. Both patients gave written consent for their case details to be used.

Case 1
A 46-year-old man was seen at the Occupational Medicine Clinic, Groote Schuur Hospital, Cape Town, in April 2000 with a diagnosis of organic solvent encephalopathy.1 He had a 16-year history of working in the raw materials section of a paint manufacturing plant, exposed to a variety of solvents including xylene, toluene, other aromatics, ketones, alcohols and lacquer thinners. A respirator was provided only in the latter years of his employment. He had suffered somnolence and headaches for about 2 years, and more recently inability to remember the product codes.

Neuropsychological testing showed ‘relatively global intellectual difficulties and indications of organic impairment’. CT scanning demonstrated generalised brain atrophy. He had no history of alcohol or drug abuse, head trauma or seizures. The only comorbidity was hypertension. A Venereal Disease Research Laboratory (VDRL) test was negative. No HIV test was done. He was provided only in the latter years of his employment. He had suffered somnolence and headaches for about 2 years, and more recently inability to remember the product codes.

The case was reported by the employer to the Compensation Commissioner under the Compensation for Occupational Diseases and Injuries Act, 1993 (COIDA) in August 2000. A final medical report submitted in August 2001 expressed the view that, given his poor powers of concentration and memory including difficulty remembering instructions, the claimant would be unlikely to sustain normal employment. In 2003, the patient was awarded 15% permanent disablement and awarded a lump sum award of approximately R23 000.

In February 2004, the claimant submitted an objection in terms of Section 91 of COIDA on the grounds that 15% was inadequate to compensate for the loss of earnings capacity caused by his severe impairment. The Compensation Commissioner office did not respond to this objection or to 4 written inquiries over the following 4 years.

A complaint regarding both non-response and delay on the part of the Commissioner was lodged with the Public Protector in December 2008. The Public Protector secured an undertaking from the Commissioner that a hearing would be held in September 2009. No reasons for the 4½-year delay were forthcoming. The promised hearing was cancelled without reason and eventually held in February 2010. As of June 2011, no finding from this hearing had been communicated to the claimant – a period of 7 years, without resolution, since the objection was lodged.

Case 2
A 41-year-old female employee of a chicken processing plant was first seen by us in September 2004. She had been employed in the plant for 21 years and had been diagnosed with asthma in 2003. Her main exposure of relevance was to chlorinated water used as a sterilant for wet work with chicken parts, including products of chlorine such as chloramines. Serial peak flow testing showed a clear pattern of decline on work days and improvement on days off.

The case was reported to the Compensation Commissioner by the employer, and a first medical report of an occupational disease was submitted in September 2004 and a final report in December 2005. At that time, her forced expiratory volume in one second (FEV1) was 72% of predicted, and her medication consisted of fenoterol inhaler pnr, ipratropium bromide inhaler pnr, budesonide 800 µg daily, and oral theophylline 300 mg twice daily, all obtained from her local provincial hospital. Her asthma deteriorated, with persistent severe work exacerbations. After a long period of temporary incapacity leave, she was certified as permanently medically incapacitated for her occupation in December 2006.

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Under the Act, a disablement percentage of 30% or less entails the award of a lump sum – equivalent to about 8 and 10 months’ wages in these 2 cases respectively – with no further payments. If disablement is assessed as >30%, inflation-adjusted monthly payments are made for life. In both cases, the worker was forced to give up employment, with little or no chance of re-employment – the first owing to intellectual difficulties and the second to severe asthma. The sums awarded are clearly insufficient to provide income replacement in cases where employment capacity has been lost or to cover the cost of ongoing medication.

The Act provides for payment of medical aid, including medication, for up to 24 months; thereafter, responsibility for medication costs reverts to the claimant. Since many claimants lack medical aid, this reversion effectively transfers these costs to public sector medical services or to patients’ pockets if they continue to work but fail to qualify as state patients on income grounds. For the patient with chronic persistent asthma, these costs currently add up to approximately R2 400 per year at state tender prices and up to R8 900 (undiscounted) per year in the private sector. The Commissioner has the discretion to pay these ongoing costs. In a meeting of the Chief of Operations of the Compensation Fund and a Fund medical officer with the Western Cape Provincial Medical Advisory Panel on 18 February 2008 (unpublished minutes), the Fund’s officers acknowledged that few, if any, private pharmacies accepted COIDA prescriptions. The Fund officers confirmed that it was policy to reimburse the costs of prescriptions for claimants with occupational disease on submission of 6-monthly medical reports and prescriptions. Our clinic has been unsuccessful in having a single such case afforded this benefit, as exemplified by case 2 above.

**Conclusions**

COIDA is based on the principle that employees give up their right to common law remedies against their employer in return for a no-fault insurance system. Since the Compensation Fund took in R4.8 billion in premiums from private employers in 2009/10, there is a reasonable expectation that the system will be administered efficiently. The Fund is also an important form of social insurance and, as a public entity, is subject to constitutional and statutory requirements governing fairness in administrative action, transparency, efficiency and proper use of financial resources.

The 2009/10 Annual Report of the Compensation Fund reports an annual performance target of ‘70% of new… claims finalized.’ It further reveals that, of 200 599 ‘registered claims’ (mostly injuries and non-medicolegal claims), 81% had been ‘closed’ in 2009. The Report states: “Any claimant can submit evidence, junto to its original, which is otherwise made ‘legal’ in the law court system.” It is therefore not possible to judge the Fund’s performance in settling occupational disease claims from these official statistics.

Although not applicable to the cases above, it is acknowledged that failure of medical practitioners and employers to report occupational disease or to submit required documentation contributes to the problems of delay. Reasons for employers failing to report include: recalcitrance or ignorance, long delay in some instances between exposure and disease, lack of past personnel records, or even disappearance of the company as a going concern. Although current employers are required in terms of the Act to report occupational diseases within 14 days of having been informed of the existence of a suspected occupational disease in an employee, delays are the...
norm. It is not clear that the Commissioner has the wherewithal to act against recalcitrant employers. Employer impunity is one consequence. There is also an obvious circular relationship between underreporting of occupational diseases by medical practitioners and a system that is unable to process claims for these diseases and reimburse practitioners accordingly.

The deficiencies described have several adverse consequences. One effect is to reduce access of workers with suspected occupational disease to private medical practitioners who are reluctant to take on such COIDA patients with only a remote chance of being paid and a good chance of being drawn into unproductive paperwork. This is part of a broader problem of delayed payment to doctors, pharmacists and hospitals for COIDA work.17 The costs of assessment, diagnosis and treatment are then transferred to the public sector (or private medical insurance for the minority of employees with such coverage). The costs of temporary incapacity are also effectively transferred to the worker who has to use statutory sick leave or alternatively remain at work in a situation where removal from adverse exposure conditions may be medically indicated.

Periodic recommendations are made to improve or reform the system. Partly as a result of representations by occupational medicine practitioners, the Commissioner set up a system of provincial medical assessment panels (PMAPs), with 2 successfully operating in Cape Town and Durban. (This author was a member of the Western Cape panel). By the end of its operations, the Western Cape PMAP, operating with a full-time occupational medicine registrar and office manager and a panel of part-time specialists, had dealt with approximately 1 550 claims between January 2004 and March 2008 (Adams S. Quarterly Report of Activities for the Period 1 January 2008 - 14 April 2008. Western Cape Medical Advisory Panel 2008 (unpublished)). The panel had achieved a median delay from claim registration with the Compensation Fund to final medical adjudication of 28 days (mean 107 days). These panels were summarily shut down by the Department of Labour in 2008, in my view on spurious grounds.20-22

In 1998, Baker23 argued for partial privatisation of the Compensation Fund by allowing additional mutual associations to be licensed under COIDA, on the grounds that the Fund had failed to contain costs and was imposing premium increases on employers that were outstripping inflation. Baker mentioned administrative inefficiency as a problem, but did not consider the costs imposed on employers and medical personnel in time and effort wasted in dealing with COIDA matters and benefits delayed or simply foregone by claimants. These costs are externalised but must be taken into account in reviewing the functioning of the COIDA system.

A report by the Public Protector contains recommendations to reduce delays in claims processing and payment, to promote timely communication with clients and improvement of the telephone call centre within the Commissioner's office.21,23 However, despite the participation of a trade union federation in government, there seems to be little political will to ensure that these recommendations are followed. A full public accounting of the actual situation regarding occupational disease (and injury) claim backlogs and their reasons would be a good start, as the Annual Report of the Compensation Fund provides inadequate information about such matters. A debate on the merits of outsourcing the Fund's administration to proven claims administrators is also due. Such outsourcing could be done without modifying the powers of the Commissioner to set premiums or the State to pursue social insurance policy goals under the Act.

References


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ERRATUM

We regret that an error occurred on page 840 of the November 2011 SAMJ, in the guideline ‘Recommendations for the management of adult chronic myeloid leukaemia in South Africa’. In the third line of the abstract, as the result of a typographical error, the chromosomal translocation was stated as being between the long arms of chromosomes 9 and 12, in fact it is chromosomes 9 and 22. The online guideline was corrected on 23 November 2011.