OCCUPATIONAL HEALTH IN SOUTH AFRICAN INDUSTRY*

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During recent years, we have often been reminded[1] that, besides our mining industry, we have an established and expanding secondary industry supplying the essential needs of our community[2] and exporting to markets beyond its borders. 'With the steadily increasing competition on both the home and export markets, many industrialists will have to face for the first time the absolute necessity of limiting waste of all kind, including that of labour.'[3]

This item is the one with which we as medical men interested in industry are primarily concerned. The Chairman of Iscor has said, 'We must stop deluding ourselves with the popular claim that we have a vast store of cheap labour.'[4] In a similar vein, Charles Bedaux, the management consultant, has stated, 'We all know that South Africa, compared with the rest of the world, has its special and quite acute problems of man-power, its lacks and its shortages.'[5] Organized labour has recognized the need for conservation of our man-power resources. The late J. J. Venter, President of the Trades and Labour Council in 1953, actively cooperated with the City Council of Johannesburg in sponsoring the Conservation of Manpower Unit, concerned with the combating of alcoholism, which is eroding our man-power pool.[6] It is obvious then that management and organized labour are interested in the conservation of man-power in common with the medical profession.

Industry has become a major employer of labour on whom the heterogenous community of South Africa has become dependent; it can amply supply employment for the youth of all races without their resorting to emigration as they have had to do in many other countries.

What have we as medical men to do with the problem of the conservation of labour or man-power in industry? In answering this question, we must remember that the care and maintenance of the health of the individual (often referred to as personal health) is the business of the medical man in general practice, while environmental conditions in industry, together with the personal health of the employees, known as occupational health, is the concern of the medical man in industry. Today the doctor in industry must solve problems of a complex nature concerned with inter-human behaviour, among which priority is given to interrelations between management and labour which, if maintained in an industrial organization, facilitate communication and cooperation, resulting in such practical benefits as low sickness absenteeism and improved or increased production.[7]

The doctor in industry is in contact with workers all the time and becomes aware of their likes and dislikes in relation to management. With discrimination he can sort out the various facts, and can give definite indications of defects in managerial structure. The effects of these activities are far reaching; I. K. M. Scheepers, the Director of National Development Foundation of South Africa, aptly summed them up in the following dictum: 'The actions of the medical man in industry, his decisions and his responsibilities, are far-reaching and have management implication'.[8]

In addition to clinical examination and treatment, the medical man in his day-to-day relationship with his patients, is concerned with human relations in industry, and the doctor's diagnosis leads to the direction of the worker to his sick bed at home or in hospital for treatment and rehabilitation, or back to his normal occupation. These decisions are usually reflected in the medical certificate, which puts the medical man into the responsible position of arbiter between labour and management.[9]

This function of the doctor has a close bearing on management and in order to fulfil it efficiently the medical man needs an economic status which will give him complete independence, and will enable him to afford the time needed for full investigation of his patients' problems as well as to keep abreast of advances in medicine. By his adequate investigation of his patients, together with his skilled observation of human behaviour under specific conditions, the doctor is able to supply a medical certificate which is a safeguard both to the worker and to management. These are economic measures of direct interest and importance to labour and management.

The medical man in industry can watch fluctuations in the sickness absence rate, and can help management in deciding to what degree it is real and what apparent; for an inflated sickness absence rate does not necessarily indicate a poor standard of medicine, but often points to some inherent weakness in labour-management relationship[9] which could be adjusted. Correct certification may uncover occupational hazards which affect the health and the efficiency of the workers in a particular factory or industry. The statistics derived from such certification may localize faults in the occupational environment of the workers, and enable management to take effective preventive measures.

SICK BENEFIT FUNDS

The bulk of the European workers employed in mining, railways, municipal undertakings and secondary industry belong to various sick benefit funds or societies. The doctors on the panels of these organizations are giving yeoman service but, under present conditions, they are not able to cooperate with industry in the manner suggested by Scheeper's dictum.

The sick benefit organizations are supposed to cater for the lower income group of workers in whom nutritional standards are low and the incidence of sickness high, thus increasing the pressure on the already work-harassed doctor. The following are a few examples: 'A Commission of Inquiry into certain Sick Benefit Societies' (1952), instituted by the City Council of Johannesburg, found that medical men in these organizations were perforce examining patients at the average rate of one patient every 5 minutes. A large urban district surgeoncy in the Transvaal manages to allocate an average of 3 minutes to each patient. These district surgeoncies supply medical treatment to certain civil service grades, paupers and state dependants as well as to sheltered employees. The senior District Surgeon in this instance aptly called this 'a token medical service'. Many of our colleagues connected with the S.A.R. & H. Sick Fund in the large urban areas work under similar pressure, which the recent annual report of the General Manager of Railways courageously confirms on the basis of sickness absentee rates. During the sittings of a Committee of Enquiry into the City Health Department (Johannesburg) (1952-1954) a medical witness, when asked how much time he was able to devote to the examination of the average patient, after some thought gave the answer as 45 seconds.

Such a situation leads to certification which bears no relation to the true clinical position, and in industry results in inflated sickness absenteeism. This, of course, is detrimental to industry which is trying to keep its head above water in a competitive field. It is costly because of the direct loss of man hours and of productivity and the general lowering of the level of efficiency. Over-all costs are raised, as jobs are maintained on overtime which, besides being costly, results in fatigue, with attendant increase in the accident rate. All this leads to increased cost of commodities and service,[10] creating additional burdens on the public generally and the workers in particular.

Medical men on sick benefit society panels have often been accused of partisanship during periods of strained labour-management relations. Panel doctors have been accused of over-lenient or over-stringent certification according to whether labour or

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management was in control of their sick benefit society. Such incidents destroy confidence in the doctor's decisions and certificates and nullify his position as an arbiter.

In the present climate of benefit society practice, management, perhaps unaware of the true position, is asking the medical profession to furnish a token health service, in effect subsidized by the panel doctors, who are unable through circumstances beyond their control to fulfil their function in the field of occupational health.

The evils of the capitation system produce economic hardship on the medical practitioners, who must of necessity compete for large panels in order to eke out a living.

The paucity of the present capitation fee paid to medical men is well illustrated by an advertisement which appeared in the *South African Medical Journal*. It reads: 'The remuneration for these (G.P.) services is 7s. per month in respect of members residing within the municipal area of Johannesburg, and 7s. 3d. per month in respect of *families* (note: families) outside the said municipal area'.

Astonishment is often expressed in industrial management not only at the low remuneration offered, but also that the medical profession with a tradition of service to the community allows the exploitation of its members, which of necessity must reflect in the nature of the service it renders and is not in the best interests of the community it serves.

These sick benefit organizations were of definite value in the early days of our industrial development, but today therapeutic medicine has made such strides that by reason of costs alone these organizations cannot cope with the demands made on their finances, so that they are forced to economize on their services, including specialist services, in order to give some semblance of therapeutic efficiency. No provision can be made for the practice of preventive medicine, which should include the time-consuming and therefore expensive periodic examination of orkers.[11]

Economic stringency usually determines the constitutions of these societies, resulting in the exclusion from treatment of various illness. For example, to this very day, the treatment of venereal diseases is usually excluded by the rule book, as is chronic alcoholism, a disease that is draining our man-power resources, while in many instances the old pensioner receives so called 'limited benefits' as his thanks for years of service in the industrial organization.

These sick benefit organizations have long existed by the grace of a benevolent medical profession. As industry has developed they have grown in number and in membership strength, and what was originally a matter of grace on the part of the medical profession, became a matter of current usage in industry. The control exercised by certain of these sick benefit organizations over their panel doctors, many of whom have given long years of faithful service, has often threatened the doctor-patient relationship as well as human relations generally. These medical men in the main, have long become conditioned to a practice of medicine in which they function as mere scribes of certificates and prescriptions, and to which they cannot conscientiously subscribe.

This Conference, which is industrially biased, must ask what practical steps can be taken to bring the practice of occupational health onto a satisfactory footing of real service to industry. The answer lies in making medical men in industry independent of control. This in effect means changing the present structure of the sick benefit society and bringing these bodies into line with the medical aid societies. Already there are 142 management-supported medical aid schemes operating in South African industry, where the worker has free choice of doctor and where the fees are regulated by a tariff which is arrived at by negotiation between management-labour and the Medical Association of South Africa.

Progressive labour has likewise entered the arena of the medical aid society. An example of such a labour-sponsored organization is the Printing Industry Medical Aid Society, which caters for members of the South African Typographical Union, and has the blessing and the support of its rank and file. It is obvious that labour is not insensitive to the needs of industry in this country.

The principle of payment by the job has long been recognized under the Workmen's Compensation Act. This Act is an example of what can be achieved in the interests of the injured workman, when the medical man is permitted to act freely in the interests of his patients.

It is most gratifying to those concerned with the development of occupational health in industry, that Dr. Maurice Shapiro, the Director of the South African Blood Transfusion Service, with his keen foresight has been able to persuade the Medical Association to accept the sponsorship of the Medical Services Plan. This Plan is to be controlled by the medical profession itself but will, in the not too distant future, render a complete medical service to those workers and other members of the public who participate in it. This again will be a further and progressive step in the fulfilment of the dictum of Scheepers in the field of occupational health.

Management must not merely maintain existing industrial levels, but must continue to make strenuous efforts to further the pace of industrial progress in South Africa. It should rally the support of those who are able actively to assist in this direction. It must now approach a medical profession which is willing to cooperate and assist in the furtherance of this national effort, but can only do so if the economic and the professional freedom of the medical man in industry is first fully assured.

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