

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.

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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 a recent diagnosis of hypertension. A Venereal Disease Research Laboratory (VDRL) test was negative. No HIV test was done. He was removed from exposure to solvents and reported short-term memory improvement and less somnolence. Repeat neuropsychological testing noted substantial improvement in some test scores but persistent severe impairment of verbal memory. The patient accepted voluntary retrenchment in February 2001 and has not sought further employment because of his intellectual difficulties.

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 prn, ipratropium bromide inhaler prn, 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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She was awarded 20% permanent disablement in 2005 and received a lump sum of approximately R31 000. During 2006, formoterol 50 µg twice daily and prednisone 5 - 10 mg daily were added to her regimen. A request in 2007 to the Commissioner's office to have her ongoing medication costs covered on presentation of a 6-monthly medical assessment and prescription, as per an undertaking made by the Commissioner's office regarding such cases, went unanswered.

In 2008, an application was made to the Commissioner's office to reconsider the 20% permanent disablement award in view of her total work incapacity and heavy medication load including steroid dependence. In accordance with the schedule for occupational asthma issued by the Commissioner's office, the claimant should be rated at a score of 5 based on lung function impairment and medication need, equivalent to a permanent disablement of 50%.² Five written requests between 2008 and 2010 remain unanswered as of June 2011.

Discussion

The COIDA system for occupational diseases in South African has been functioning poorly for a long time.³⁻¹³ These cases exemplify perennial problems – delay in finalising claims, non-responsiveness to requests or inquiries, and inadequate assessment of disability.

Delay

Case 1 took 2 years to be finalised after the final report was submitted, a typical experience of occupational disease claimants under COIDA.^{4,8-11} Of 59 occupational dermatitis cases submitted between 2007 and 2009, only 7 (12.3%) had been accepted by 2010 and only 2 claimants confirmed receipt of an award.¹¹ The Commissioner's office had no record of a further 29 of these claims. In Case 1 above, the delay in getting an objection hearing scheduled was even worse – 5 years, and then only after the Public Protector intervened. This was followed by a (so far) 16-month delay in communicating the finding to the claimant.

Non-response to inquiries

In case 1, the patient's clinic file recorded 4 unanswered communications addressed to the Commissioner's office, and in the second case 5. In reply to a previous complaint to the Public Protector, the Commissioner argued that it was impossible to acknowledge or reply to the huge volume of correspondence received by the Commissioner's office.¹⁴ The Public Protector rejected this argument in a recent opinion, which affirmed the claimant's right to a response, on both constitutional grounds and in terms of the Promotion of Administrative Justice Act of 2000.^{12,13}

Failure to deal with correspondence or queries is also another way in which costs are shifted to clients. Burdensome delays in submitting and resubmitting documents, and making repeated inquiries and unnecessary visits to medical practitioners, all add to the costs and breed cynicism about the system. The Commissioner's office has recently devoted resources to improving its telephonic inquiry system, but our experience is that such inquiry frequently results in a request for all the documents to be resent or faxed. This experience is shared by others,^{12,13} which suggests enormous duplication – and/or a chaotic filing system – in the Commissioner's office.

Inadequate assessment of disability

In both of the described cases, low permanent disablement awards were made – 15% and 20% respectively. How these percentages were arrived at is not known since there was no professional communication about these decisions to the medical practitioner. 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.¹⁵ 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.¹⁶ 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.^{12,13}

The 2009/10 Annual Report of the Compensation Fund reports an annual performance target of '70% of new... claims finalized'.¹⁶ It further reveals that, of 200 599 'registered claims' (mostly injuries on duty), 69% had been 'finalized'. No information is given on claim ages (i.e. time since receipt and registration), processing backlogs or time to finalisation. A similar information gap exists for occupational diseases. Although the claim is made in the Annual Report that 1 111 out of 2 642 occupational diseases had been 'approved', the origin of this figure of 2 642 is not given, nor a breakdown of claim ages. The term 'approved' also does not specify how long it takes for claimants to receive disablement awards. 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.^{8,17,18} 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.⁸ 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.¹⁹ 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 1994 and March 1998 (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 timeous

communication with clients and improvement of the telephone call centre within the Commissioner's office.^{12,13} 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

1. Feldman RG, Ratner MH, Ptak T. Chronic toxic encephalopathy in a painter exposed to mixed solvents. *Environ Health Perspect* 1999;107:417-422.
2. Republic of South Africa. Department of Labour. Circular Instruction Regarding Compensation for Occupational Asthma. No. 176. Government Gazette 2003;24231(82):6-11.
3. Myers JE, Garisch D, Cornell JE. Compensation for occupational diseases in the RSA. *S Afr Med J* 1987;71:302-306.
4. White NW, Cheadle H, Dyer RB. Workmen's compensation and byssinosis in South Africa: a review of 32 cases. *Am J Ind Med* 1992;21:295-309.
5. Ehrlich I. Workmen's compensation in South Africa - an overview. In: Coetzer GJ, Kinghorn J, van der Berg S, eds. Working Documents on the Post-Apartheid Economy. No. 5: Social Safety Nets. Stellenbosch: Stellenbosch Economic Project, 1992:1-9.
6. Ehrlich RI, White N. Obstacles to submitting occupational disease claims (letter). *S Afr Med J* 1994;84:227-228.
7. Ehrlich RI. Compensation for occupational disease: insult to injury. *Occupational Health Southern Africa* 1995;1:18-19.
8. Goodman KC, Rees D, Arkles RS. Compensation for occupational lung disease in non-mining industry. *S Afr Med J* 1994;84:160-164.
9. Onwuchekwe U, Ehrlich R, Jeebhay M, et al. Failure of the compensation system for occupational diseases and injuries. *Occupational Health Southern Africa* 2002;8:8-11.
10. Jeebhay M, Omar F, Kisting S, Edwards D, Adams S. Outcome of workers' compensation claims submitted by the worker's clinic in Cape Town. *Occupational Health Southern Africa* 2002;8:4-7.
11. Carman H, Fourie A. The problem of compensation for occupational skin disease in South Africa. *Occupational Health Southern Africa* 2010;16:12-21.
12. Public Protector of South Africa. Report on a systematic investigation into allegations of poor service delivery by the Compensation Fund. Report No. 28 of 2009/10. Part 1; 2010. http://www.pprotect.org/library/investigation_report/2010/docs/investigation%20report%20for%20media%20briefing%2009%20june/Report%2028%20Part%202.pdf (accessed 21 June 2011).
13. Public Protector of South Africa. Report on a systematic investigation into allegations of poor service delivery by the Compensation Fund. Report No. 28 of 2009/10. Part 2. 2010. http://www.pprotect.org/library/investigation_report/2010/docs/investigation%20report%20for%20media%20briefing%2009%20june/Report%2028%20Part%201.pdf (accessed 21 June 2011).
14. Mkhwebane-Tshehla BJ. Response to complaint: failure of the Compensation Commissioner to perform statutory functions adequately. *Occupational Health Southern Africa* 2002;8:16-18.
15. Supreme Court of Appeal of South Africa (Harms J). *Mankayi v AngloGold Ashanti* (126/2009)[2010] ZASCA 46.
16. Republic of South Africa. Annual Report of the Compensation Fund for the year ending March 31 2010. Pretoria: Department of Labour, 2010.
17. Loewenson R. Occupational disease in Southern Africa: causes and consequences of underreporting. *Occupational Health Southern Africa* 1998;4:8-22.
18. Govender M, Ehrlich RI, Mohammed A. Notification of occupational diseases by general practitioners in the Western Cape. *S Afr Med J* 2000;90:1012-1014.
19. Bateman C. A costly waiting game. *S Afr Med J* 2005;6:370-371.
20. Gantsho M. COID Update. *SAMA Insider* 2008;June:13.
21. Naidoo R, Jeebhay M. COID Update (letter). *SAMA Insider* 2008;September:6.
22. SAMA (South African Medical Association). Retraction. *SAMA Insider* 2008;September:6.
23. Baker M. Is there a case to partially privatise the state compensation fund for occupational injuries and diseases? *Occupational Health Southern Africa* 1998;4:15-23.

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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, when in fact it is chromosomes 9 and 22. The online guideline was corrected on 23 November 2011.

The full reference is: V J Louw, L Dreosti, P Ruff, V Jogessar, D Moodley, N Novitzky, M Patel, A Schmidt, P Willem. Recommendations for the management of adult chronic myeloid leukaemia in South Africa. *S Afr Med J* 2011;101:840-846.