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. 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 Western Cape Medical Advisory Panel 2008 (unpublished)).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. In 1998, Baker29 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.21,22 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, when in fact it is chromosomes 9 and 22. The online 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.