THE AFTERMATH OF EMPLOYMENT INJURIES FROM THE HEALTH CARE PERSPECTIVE

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1. Introduction

In South Africa workers who are injured in the cause of their employment are entitled to compensation in terms of the law, Compensation for Occupational Injuries and Diseases Act 1993 (COIDA). While there is one employment law that governs compensation of workers who are injured on duty there are three organisations which administer compensation of workers who are injured in the course of duty. These are,

a) Office of the Compensation Commissioner for occupational injuries and diseases.
b) The Federated Employer Mutual Association Company (FEM)
c) Rand Mutual Assurance Company (RMA)

(b) and © are concerned with the administration of the provisions of COIDA in build and mining industries respectively. The office of the Compensation Commissioner deals with any other industries that are not covered by the two. This is not withstanding the fact that recently RMA had its coverage increased to include workers in metal industry, in addition to mining.

This paper attempts to caution against the general perception that money is a solution to all the problems that disabled former mineworkers are confronted with. Hence the paper provides empirical evidence which demonstrates that not all consequences of disabling workplace injuries can be addressed through financial means alone. It argues that whilst financial compensation for injuries sustained is important in maintaining the livelihoods of disabled former mineworkers, the consequences that confront these workers on day to day living are far bigger and have far reaching consequences than just the issue of financial reward. This paper probes these consequences in so far as they relate to healthcare and support of mining victims.
However, it starts by providing a lens through which disability should be viewed by underscoring a journey travelled leading to disability. Thus, through this lens it briefly covers introductory issues after which it addresses methodological issues and then delves into the empirical findings before it draws a conclusion.

2. Methods

This paper is an extract of a larger thesis of my PhD research work which investigates consequences of seriously disabling workplace injuries using a case study of former mineworkers in the Eastern Cape, South Africa and in Lesotho. As such, what is being presented here is still very much work in progress. The larger thesis notes that the consequences of disabling workplace injuries can affect other groupings such as employers, colleagues and trade unions but has restricted its scope only to injured former mineworkers and their household.

The study was conducted using open ended life history interviews with disabled former mineworkers and involved about 20 seriously disabled former mineworkers with varying degrees and types of disabilities. In addition, to the 20, two other members within the mineworkers’ household were interviewed. In most cases these were a spouse who is a caregiver and one of the children of the disabled. However, there were families that did not have a child while others did not have a spouse. As a result, only 57 interviews were conducted instead of 60. Participants were selected from the RMA database which contains the list of all the current pensioners under RMA payroll. The word “Serious” is defined in this context to mean those mineworkers whose percentage of disability is in excess of 30% and as a result are drawing on compensation benefits from RMA by way of a periodic pension as opposed to a lump sum. The sample was selected using the stratified random sampling. This involved grouping pensioners into clusters (strata) according to their nature or type of their injuries/disabilities. After which then from each strata a sample was randomly selected. There were six clusters which comprised the following, serious head injuries, wheelchair bound, vision impairment, lower & upper limbs amputees, hearing impairment and head injuries. Due to sensitivity of information in this paper participants have been given pseudonyms in order to protect their real identity. In this paper “participants” mean the disabled former mineworkers who participated in the study.
Women who are caring for these participants are referred to as care givers or women while children are just addressed as children. In addition, to interviews I have held one focus group discussion comprising 15 disabled former mineworkers in Lesotho and have also studied personal files of the disabled in custody of RMA. Whilst the exercise of perusing the files is not yet complete already there is excruciating information coming from these files.

3. Findings of the study

The study has uncovered a lot of things that are often taken for granted under the disguise that money should be able to take care of them. Whilst the importance of money is very much appreciated it is equally just a myth to think or suggest that money can be a panacea to all the problems that confront disabled former mineworkers.

Talking about money and whilst they appreciated its relevance in maintaining their livelihoods, many participants voiced their discontentment about its inadequacy. Whilst they appreciated that money will probably never be available in abundance, participants advanced the following reasons in support of their view.

They said whatever they receive as compensation is not enough even to meet some of their basic needs such, basic food, basic education for their children, transport and medical requirements. They said the fact that the income replacement rate is 75% and not 100% creates a gap in their income which is hard to replace since they now are not able to perform certain household chores that they would be able to perform whilst they were still able bodied. Another reason put forward was that the annual pension increments are often based on consumer prize index and not the actual inflation. Some participants indicated that they went to work in the mines because they wanted a better life for themselves and their families. Yet, when they sustain injuries calculation of compensation excludes certain members of their families. According to RMA (2012) if a seriously injured individual has a wife and one child then the two are excluded from the calculation of compensation. The calculation of family allowance only takes into account the second and third children and not more and not less. Even more depressing those who were not married at the time of accident said the system does not take into account their new families. This is substantiated by a minute on a letter written by
Moshoeshoe, a social worker to Peter of RMA where in this letter Moshoeshoe wanted to inquire whether his client’s child can access certain benefits from RMA in which Peter responded,

“Cannot help: child after accident does not qualify”

Peter’s response is in line with the employment injury legislation of South Africa as it currently stands. However, participants view this policy as double jeopardy since they claim that they are already disabled and now it’s like they cannot get married and have children. Meanwhile, Millard (2009) argues that a disabled man does not suffer alone but with members of his family. Yet, it is beyond comprehension why the compensation law is organized in this manner.

Top on the list of discontentment, participants unanimously described as disheartening to say the least, the fact that their pensions would not be transferred to members of their families in the event of death if such is not related to the mining accident. Some said they find the policy unfortunate as sometimes to establish whether or not the cause of death is related to the mining accident can be a difficult task. Moreover, they submitted that man exists to provide for his family and it does not sound good to have a policy that denies the family support when the head passes on. They exclaimed that, it feels like when they die their families too are condemned to death.

3.1 Premonition prior to the accident

Many participants confirmed to having prior tacit feeling about the accidents. Thus, they either felt something within themselves or something unusual did happen but at the time they never really read anything unto it. But only after the incident that they started to connect the dots and realize that the feeling or a particular incident which they disregarded could have been signaling probable danger. To this end they shared some of the stories. One said that he felt very much uneasy that day and when he was on the way to work he had to go back to the hostel to get his rosary. Another said as he began his normal work he could see there was a loose stone hanging above where he was supposed to start working and was undecided on whether to remove it or call a supervisor until he decided to remove it. He said before he could
remove it he heard what he perceived to be a voice saying, “o qala la ho qetela” meaning “you are removing those hangings for the last time” Before he knew it he said that he found himself under a heap of rocks and his legs were badly injured and could not move and all he heard were just bones of his leg rattling inside like a bag of crushed stones.

Others said they only heard things afterwards or began to make sense of warning signals that were there but could not understand them at the time. For example, one participant affirmed that he was later told that his newly built house had cost him his legs “indlu yakho ikuthathele imilenze” while another said close to the incident he used to have a dream where in this dream he could see his wife wearing a black mourning cloth but could not see for whom she was wearing it for until after the accident.

3.2 Causes of mining accidents

Leger and Mothibeli (1988) note that mineworkers have a tacit skill where they are able to sense danger before it strikes. For instance, when the surface or the rocks are going to fall they always give early warning signals known to the miners as “pit sense”. Yet, their supervisors would always dismiss their claims as being unfounded. Then a rock or surface would fall and people would die and many more would survive with serious injuries such as crushed limbs, back injuries, and head injuries. Besides falling rocks or surfaces, Allen (2003) provides that other causes of mining deaths and injuries include inrushes of water caused by blasting, toxic fumes. Neglect, fatigue, poor supervision, lack of experience and training as well as running after profitability were identified by Maloka (2004) as further causes of major mine injuries. Interviews of participants in my study identified misfires as a cause of visual impairment.

Notwithstanding the fact that conditions in the mining industry have improved quite considerably in recent years mining industry in South Africa is still considered one of the major causes of disability. Using words of an old Sotho miner this is what Moodie (1994:16-17) had to say about mining conditions in South Africa,

“Working in the mines is an agonising painful experience........Your work is in an extremely dangerous place. Anything can happen to you at any place. Whenever you go down the shaft
you are not sure that you will come out alive. You don’t want to think about it. But it keeps coming. Whenever, an accident occurs and someone is either killed or badly injured you think of yourself in the position, you think of your family and you become very unstable and lonely. You feel you want to see them for the last time, because the inevitable will come to you sometime.....Death is so real you keep on praying and thanking God each time you come out alive”

3.3 Healthcare and support – the consequences of disabling workplace injuries

“Life of a disabled mineworker is determined by the number of pills he swallows per day” According to some of the participants interviewed this is the routine they have become so accustomed to that only death will separate them from it. However, situations differ from one individual to another depending mostly on the nature of disability. This piece therefore carries the reader through health care consequences disabled former mineworkers’ face from the time they are injured up to when they are at home and living with disability.

3.4 Medical costs defined by law

Smit (2003) notes that medical benefit ranks first amongst the expenses that are incurred by employers/carriers in relation to occupational injuries sustained by the workers. This makes sense because any reportable accident would probably require medical attention without necessarily qualifying for a financial compensation. According to the RMA “get to know your benefits” guide of 2012, medical expenses include the following:

- Reasonable hospitalisation, medical treatment including supply and maintenance of artificial limbs and supplies, necessary medication which will be provided by RMA for up to a period of two years. Treatment beyond this period will be as per RMA authorisation and must be directed at reducing the permanent disablement.
- Reimbursements relating to travelling to a place where necessary medical treatment is obtainable\(^1\). The issue of reimbursement is also a tricky one because at the time of travelling disabled workers may not be having cash at their disposal. It is proposed

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\(^1\) These reimbursements are done using public transport rates. Yet, this may not favour certain categories of disabled particularly those higher percentages of disability.
that arrangements should be made by RMA to maintain some petty cash at its satellite offices to cater for these realities.

- In other cases employers would accept responsibility for medical treatment for the first two years after which RMA would then take over.

### 3.5 Pain and suffering

A serious injury on duty marks a turning point in the lives of victims and those of their family members. All of a sudden from what a minor perceived as a very promising future, calamity strikes and all the dreams and future plans of a mineworker are instantly shuttered, thereby forcing for a different trajectory to life. In the process of sustaining injuries many mineworkers reported experiencing excessive loss of blood, passing out and only regaining consciousness in hospital. Some were thought to be dead and as a result taken straight to the mortuary and later brought back to hospital. They referred to the ordeals as being “beyond pain” for example, Teboho, who was hit by an avalanche of stones was quoted as saying “*ke ile ka utlwoa hore shwababa*” then my whole body went numb and I could not feel it anymore then he said he passed out. However, many who remained conscious after the accident said they endured a lot of physical pain. Generally, victims received immediate help from colleagues who gave them first aid, quickly shipped them out of the mine and rushed them to hospital. Be that as it may there were still some outliers who reported having been rescued a few days following the accident. International Association for the Study of Pain Task Force on Taxonomy, (1994) defines physical pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage.

### 3.6 Hospitalisation

With respect hospital treatment, the general response by participants was that care and support by hospital staff including nurses and doctors was generally satisfactory. However, there were incidents of participants who appeared not ready to deal with what had happened to them. As a result, they found hospitalization to be disturbing for them. For instance one
participant who is an upper limb amputee said he did not want his arm amputated because he thought it would heal and be able to function again, only to be told by doctors that he was reading false alarms. Even more important he said he could not imagine living without a hand, at that time he said, “I could not even recall whether I had ever seen anyone without a hand” and was wondering how he would survive without a hand. He then related a story of how the doctors deliberately let his hand rot so that they could have it amputated until he later conceded.

Participants’ period of hospitalization following the injuries ranged from a few months up to several years. Whilst many of them said that the reception and handling at the hospital was generally good others had peculiar stories to tell. For instance one participant who was hit by falling stones and later declared 100% disabled pointed out that he spent 3 days in hospital without treatment because the doctor who was supposed to attend to him was said to be on his way from Uganda. In the interim he said he was given pain killers and yet he needed urgent operation and later when saved he was told that he was lucky to have survived.

3.7 Tribulations of disabled continue to haunt them at home

At home disabled mineworkers continue to face challenges with respect to a number of issues. Yet, as Taylor (2002) notes, workers do not suffer alone but always have members of their family by their side. To this end about 75% of disabled participants interviewed indicated that they are being cared for by their spouses. The remainder relies on other family members and domestic workers for care and support. In earlier sections of this piece we have seen consequences faced by disabled mineworkers immediately after the accident up until when they are hospitalised. However, this section will deal with those consequences in so far as they confront participants at home after being discharged from hospital.

During the interviews participants had a lot to say about their health experiences since coming home following their ordeal. Many avowed that living with disability is one of the most difficult things that unless you are in it you might not fully appreciate it. They said usually it takes a longer time to acclimatize after being discharge from the hospital, particularly, given the fact that many spent long periods of time in hospital. More so if one is not born with disability but
acquires it during the process of life. Some participants avowed that they were told in hospital that pain will be their companion and from then on they must learn to live with it. Another pulled out a heap of pills from a bag where he kept them and put them on the coffee table and said, “look here, is this how a human being is supposed to live?” The point he was trying to make is that he is so dependent on drugs that they have become his second nature as he cannot survive without them. Another who is a daughter to a crippled man said her father also lives on pills. She said it is highly unlikely that she would clean the house without picking pills on the floor (see figure 2 below).

**Figure 2**

![A picture of pills taken from the home of one of the participants](image)

Besides forced reliance on drugs and medication participants also reported that they do not have any problems with health services per se except on some occasions where they indicated that drugs would not be available and would have to go and buy them from the private pharmacies and these charge exorbitantly. Instead, to my surprise participants hailed service providers including health care specialists that wherever they go to access services they do not usually stand in queues but are always given preference as disabled people. In fact I can recall

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2 Interview with a participant who was identified himself as Bit002
one of the children whom I interviewed saying she prefers to go to the bank with her disabled father because they would not stand on those long bank queues.  

Be that as it may, I have not been able to reconcile the opinion of participants about health care services with what I recently witnessed going through some of their personal files held by RMA Company recently. These file revealed harrowing conditions that some participants went through with respect their health and bad treatment at some health care centres. This tormenting experience affected a participant in Lesotho. Apparently, this man, who is just identified as Mr. Tsebo, had to be transferred to one of the South African hospitals by RMA when they became aware of the bad treatment he received at one of his local hospitals in Lesotho which saw his condition deteriorating even further. This is what the referral hospital in South Africa had to say about his treatment in Lesotho.

“it came to our attention that Mr Tsebo was admitted to a hospital in Lesotho after he became sick, I am still unable to trace which hospital. He is very traumatized by the treatment of the nursing and medical staff of this hospital. According to him he was shouted at, left to lay on his own faeces for long periods, insufficient nutrition provided to the point that his family had to travel to come and care for him in the hospital. He also had the same bad experience with his wife going blind and not receiving medical care for TB. He really has no faith in the medical and nursing professions and our team will rally to make sure that we win his trust again”  

If the pictures found in the file which said to have been taken at the time of his arrival are anything to go by then Mr. Tsebo was indeed in a bad shape when received by referral hospital in South Africa. The pictures show that his lower body was badly encroached by open bedsores caused by prolonged sleeping and these were visible from the buttocks and legs. He is one of the participants in my study.

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3 Interview with Matseliso Seboko
4 Staff of South African referral hospital which treated Mr. Tsebo
Meanwhile, correspondence between RMA and the South African hospital reveals that the condition of Mr. Tsebo’s wife has also deteriorated culminating in loss of sight and now she is also forced to sit on wheelchair. As a result, care is now being provided by a daughter. In the correspondence the hospital is even questioning availability of money at home to maintain the household and was asking RMA if anything could be done.

To this end a number of studies have been conducted to establish workers’ satisfaction with work related medical care (Borba, et al., 1994; Appel and Borba, 1994). The outcome of this studies point to the fact that victims of employment injuries are generally not satisfied with health care provided through workers’ compensation systems. Pransky et al (2000) note that some victims of employment accidents have a feeling that some health professionals do not consider their conditions seriously. Yet, it is a surprise that victims of employment injuries in South Africa seem to be generally content.

During the interviews one of the participants, an upper limb amputee indicated that his wife is like his other hand because he cannot do anything without her. This issue provoked some thoughts within me as a researcher with respect some of the challenges that could befall disabled people such as, what happen to ‘single hand amputees’ if they lose the other arm from causes not related to employment? I interviewed someone in this predicament. He was in hospital at the time of the interview because his arm had an infection caused by prolonged inoculation necessitated by his diabetic status. Consequently, he could not send his wife to U-Bank to withdraw money to pay hospital bills because he could not sign the withdrawal slip. It was only after I advised her to see the manager at The Employment Bureau of Africa (TEBA) that a solution was found, even though just temporary. RMA does not cover non-injury related illnesses (RMA, 2012).

In another interview a participants landed in hospital because he was eaten by the rats at home. This brings about issues of hygiene in this particular household into question especially considering the fact that this man lives alone with his daughter and uses condom bag to dispose
off urine. Therefore, this calls for more compelling policy initiatives that seek to address predicaments such as this one. The doctor who treated him describe his condition as follows,

“The patient was admitted on the 17\textsuperscript{th} November 2009. A known case of paraplegia bitten by rats at home a week ago. Now seen with swollen left leg and wounds on first, second, third and forth toes of the leg.”

3.8 Environmental barriers impeding access to health care

Almost unanimously participants (90\%) agreed that one way or another at some point they have had a bad experience accessing public transport. Whilst they are not able to walk for long distances many see road transport as a key to accessing health care yet participants provide that it is difficult for them to access public transport or any kind of transport for that matter. This reminds me of an award winning 2003 South African movie called Yesterday. Leleti Khumalo is the main character and walks long a distance to and from the health care service centre because she could not afford public transport. Yet, the paradox is that disabled mineworkers whilst they can perhaps afford they are not allowed access. Who then is better off here?

Participants who complained more about public transport were those confined to wheelchairs followed by lower limb amputees. They said transport owners do not take them on board, even on few occasions that they do, they demand that they pay for their wheelchairs as well. A quadriplegic who sits on an automated wheelchair pointed out that he does not even dream of using public transport because even if they would want to take him his wheelchair would not fit in those canopied vans (Quqa) that are a normal means of transport in the Eastern Cape. As a result, he spends a lot of money on transport. For he argues that in order to get to a particular place an able bodied individual would normally pay a lesser amount using public transport whereas a disabled man would have to pay ten times that amount. According to COIDA workers insured under RMA are paid medical expenses up to a period of two years with possibility of extension. The expenses include transport to a place where health care service will
be received (ISSA, 2011: RMA, 2012). Participants whom I interviewed and can access public transport said they do not usually claim back from RMA, expenditure incurred on local transport for accessing local health care services. They pointed out that usually separately the amounts of claims are smaller relative to the process of claiming. These sentiments support Keogh et al., (2000) where it is submitted that many people suffering from work related injuries end up using own resources or resort to inferior public health care for work related conditions.

Participants reported that health care service centres that they go to are generally accessible by disabled people including those on wheelchair. WHO (2002:72) sums up these quite well that people with disabilities face a number of environmental barriers relating to their mobility. These include access to infrastructural entities such as buildings, schools, offices shops etc. WHO goes further to say most public buildings are not accessible for people with disabilities as they do not have ramps. According to WHO Taxis and buses represent the only possible public transport options for people with disabilities to carry out daily activities such as banking, shopping, medical appointments and yet the modes of transport are not designed to accommodate their needs.

3.9 Women as Care givers

As indicated at the beginning of this section, disabled people are being cared for by either spouses, other members of their family or domestic workers. Banes and Mercer (2003) remark that impairment forces reliance on other people such as family and friends. In this study only 75% of the participants were still living with their spouses at the time of interview. However, of the 25% that were not with their spouses, 20% were never married, 40% were found to be seriously injured with spinal cord injuries or serious head injuries. Consequently, their spouses felt they would not cope with their condition and decided to leave them. The other 40% left because they felt that they needed more income and as a result left home in search of better opportunities. Strunin and Boden (2004) affirm that disabilities usually results in the restructuring of households and swapping of roles and responsibilities like in this case where women are the ones who leave their homes to go and look for employment leaving men with children at home.
Women as care givers submit that it is not easy to look after physically impaired individuals. The severity of disability also plays a vital role in informing the extent of care required. Thus the more severe the disability the more constant help is required. Many indicated that care giving is tantamount to disability to them since they cannot live their lives the way they like. For example a few of them said they are not able to look for employment or run any other errand for that matter without having to think of their disabled partners. One of the participants provides that if her disabled husband has to go to town for example, she has to be there with him in order to provide the necessary assistance.

The situation becomes even more difficult where a care giver falls sick. In fact one of the participants pointed out that she usually asks her married sister to come with her husband to assist them. It is beyond imagination what happens to those household who do not have such relatives to resort to. In another interview one of the participants was found to be caring for her brother in law who is mentally retarded as a result of serious head injuries he sustained and was never married. The sister in law told a poignant story of how a full grown man can suddenly be reduced to an infant because of an injury on duty. She said on daily basis they have to wash, clothe and feed him like a baby. She said he uses nappies like a baby which they have to make sure they change as and when it is necessary. If it is full he won’t tell you like a babies don’t tell. Going to sleeping is the same thing, he cannot sleep on his own unless someone takes him by a hand and place him on bed. The story goes on..........................

The story of this man is a sad one and is even more demanding on the care giver. However, what disturbs me in this story as an onlooker is the fact that whilst these care givers seem to be playing this critical role of caring for the disabled relatives, they on the other are not being cared for by anyone. As they were being interviewed almost all care givers indicated that they did not receive any form of counseling but one who said she could have left her husband a long time ago had she not received counseling from HIV/AIDS support group in the village to which she is affiliated. Many of these women reported having been diagnosed with, depression, high blood pressure, sugar diabetes and many other stress triggered sicknesses for which they were
currently being treated for. Under these circumstances counseling would go a long in terms of proactively dealing with some of these conditions.

Zastrow (2000) affirms that counseling plays a pivotal role for disabled households as it helps them to look at the world from a different perspective and encourages them to continue to live positively as before.

3.10 Social exclusion – disabled former mine workers

Although my fieldwork did not focus on the community at large but just the households of disabled former workers, participants indicated that whilst the community still respect them they on the other hand feel excluded and isolated. They gave examples of funerals, churches, public gatherings “imbizos” and other forums where communities meet that they are unable to participate in these anymore owing to disability. They pointed out that they are not able even to partake on family gatherings that take place in villages other than their own and are always represented by their wives. Something which they said “eats a man up”. Here again the degree of disability also matters a great deal.

3.11 Conclusion

Employment injury schemes provide a financial incentive which is necessary for victims to maintain their livelihoods. Be that as it may it would appear that health care consequences of to disabled former mineworkers have far reaching consequences than just the issue of financial compensation. As seen in this piece there are myriad of challenges that do not just involve the issue of money such as, social issues where disabled individuals are excluded from participating on societal matters such as funerals, imbizo’s, church etc. Moreover, these people have restricted freedom of movement as some are not able to walk long distances on foot. Yet, at the same time they are not allowed access in public transport. We have also seen how disability does not only adversely affect the victims alone but how it extends to care givers and other members of the family and society as a whole.
References


RMA, (2012). Get to know your benefits: Compensation for occupational injuries and diseases Act, including RMA augmentation benefits.
