Governance of occupational healthcare services in South Africa: Cohesion or conflict?

K Michell[1] and LC Rispel[2]

[1] School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa; SASOHN honorary life member
[2] Centre for Health Policy & DST/NRF SARChI Chair on the Health Workforce, School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

Correspondence: Karen Michell, School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, 27 St Andrew's Road, Parktown, 2193, South Africa. e-mail: karen@cosafety.co.za

Karen Michell is a SASOHN member.

ABSTRACT

Background: Effective governance of healthcare services is essential for achieving national health objectives and safe quality care. The governance of occupational healthcare services has received scant scholarly attention both globally and in South Africa. This paper uses ILO Convention 155 as a conceptual framework for the review of the governance of occupational healthcare services in South Africa.

Objectives: To investigate the nature and extent of involvement of legislated bodies in the governance of occupational healthcare services in South Africa and explore stakeholders' perceptions of occupational healthcare services governance.

Methods: There were three components to the study: a review of relevant legislation and policy documents; 12 key informant interviews; and 11 focus group discussions in three South African provinces. The data were analysed using thematic content analysis.

Results: Occupational healthcare services occupy a relatively low priority on the health reform agenda and are delivered in a fragmented and complex legislative framework with multiple government departments tasked with various occupational health functions. The results suggest that there are gaps in governance because of conflicting or overlapping relationships, and poor cohesion among the statutory departments. These, in turn, contribute to poor quality control of occupational healthcare service delivery and insufficient accountability.

Conclusion: The improvement of occupational healthcare services governance requires intersectoral collaboration, enforcement of existing legislation, and involvement of all relevant stakeholders.

Keywords: enforcement, legislation, statutory structures, perceptions, fragmentation

INTRODUCTION

Globally, health systems governance has received increased attention[1,2] as it influences the core goals of good health outcomes, responsiveness to community expectations, and fair financial contribution.[3-5] The World Health Organization (WHO) has proposed six building blocks of a health system (Box 1) that are essential to achieve these goals,[6] with leadership and governance as the most important building block.[5,7] The 2015 sustainable development goals have underscored the importance of governance in achieving health and development objectives.[8] Numerous definitions of health systems governance have been proposed.[1,5,9] King has proposed that effectiveness and ethical leadership constitute the most important characteristics of organisational governance.[10] This paper uses the WHO definition which states that health systems governance is a national function that requires the existence of strategic frameworks 'combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, and accountability'.[4]

In South Africa, many government policies emphasise leadership and governance as critical success factors for the achievement of health, social and economic development goals.[11-13] However, numerous scholars have highlighted weaknesses in relation to: the stewardship of both the public[14] and private health sector,[15] achievement of health outcomes,[16] financial management, and the prevention of corruption[17] of the entire health system.[18,19] Notwithstanding the increasing global focus on health

Box 1. The WHO six building blocks for a health system[6]

1. Service delivery
2. Health workforce
3. Health information systems
4. Access to essential medicine
5. Financing
6. Leadership/governance

governance, there has been insufficient scholarly focus on the governance of occupational healthcare services (OHS) both at an international level[20,21] and in South Africa.[22] The reasons for this relatively low priority accorded to OHS are multi-factorial, and include inadequate understanding of the nature and benefits of OHS, financial and human resource constraints, and insufficient technical capacity.[21]

The International Labour Organization (ILO) Convention 161 defines OHS as 'services entrusted with essentially preventive functions and responsible for advising the employer, the workers and their representatives on matters relevant to establishing a healthy and safe working environment.[23] OHS are regarded as specialised healthcare services, of which one of the goals is to monitor and protect workers' health in their place of employment.[20,24] OHS governance is critical as ineffective governance contributes to financial losses through work-related ill-health, injuries and sickness absenteeism,[25] and the large burden of occupational disease and injury.[26,27] Evidence also shows that poorly-regulated health services lead to distortions in the type, quantity, distribution, quality and price of services,[3,28] a concern that has been raised in the occupational health (OH) sector.[29,30]

South Africa is a member state of the ILO ratified International Convention 155,[31,32] known as the Occupational Safety and Health Convention. In consort with the WHO building blocks for a health system (Table 1),[6] this Convention requires that member states develop a national policy for health and safety with objectives; indicate the roles, functions and responsibilities of stakeholders; apply a system of inspection with adequate penalties to enforce the laws and regulations; provide guidance to employers and stakeholders on compliance with legal obligations; and, through consultation, ensure necessary co-ordination between stakeholders to give effect to Convention 155. The Convention also recommends the establishment of a central, oversight body.

The objectives of Convention 155 were endorsed at the 13th Joint ILO/WHO Committee on Occupational Health, which recommends that basic occupational health services (BOHS) should be available to all workers.[21,33] The objective of BOHS is the provision of OHS to all workplaces that either do not have such services or have services that do not meet the current OH needs. It is estimated that 10% to 15% of the global working population have access to some form of OHS,[33] and that coverage is required in all sectors of the economy, including formal, informal and self-employed, regardless of occupation, size of workforce, geographical location or mode of employment. The BOHS model proposes four levels of service delivery, ranging from services to employees where there are no on-site OH services to comprehensive OHS delivered through multi-disciplinary teams,[33] creating a diverse system of service delivery.

The legislative framework within which OH is practiced in South Africa is complex, with several government departments having a legislative responsibility. Two government departments administer OH activities in the workplace, i.e. the Department of Mineral Resources (DMR) through the Mine Health and Safety Act (MHSA)[34] which administers OH in mines and quarries, and the Department of Labour (DoL) through the Occupational Health and Safety Act (OHSA)[35] which administers OH in all other sectors. In addition, all healthcare establishments are administered by the Department of Health (DoH) through the National Health Act (NHA).[36] The activities and scope of practice of OH professionals is regulated by their autonomous professional councils and Acts, i.e. the Health Professions Council of South Africa (HPCSA), through the Health Professions Act,[37] regulates the practice of doctors, and the South African Nursing Council (SANC), through the Nursing Act, regulates the practice of nurses.[38]

We could not find empirical studies on the governance of OHS in South Africa. In the light of this knowledge gap, we argue that a critical discussion on OHS governance is an important component of achieving universal health coverage in South Africa because of the 15 million workers in formal sector employment[39] and the recognised burden of occupational diseases in the country.[26,27]

METHODS

There were three components to the data collection: review of legislation and policy documents, key informant interviews, and focus group discussions. This research used the principles of ILO Convention 155 as a conceptual framework; data from 12 key informant interviews (KIIs) and 11 focus group discussions (FGDs); and thematic content analysis of legislation and policy documents to explore governance of OHS.

Review of legislation and policy documents

From July 2013 to July 2014, a review was conducted of the South African legislation and policy documents governing OH, OHS and occupational healthcare establishments. Reviewed data sources included the websites of the ILO, WHO, South African National Government, Department of Health, Department

Table 1. Comparison between the objectives of the WHO Building Blocks for Health Systems and ILO Convention 155

WHO Building Blocks objectives	ILO Convention 155 objectives
Develop a framework to monitor and improve a country's health system	Protection of workers' health in the workplace arising from safety and hygiene concerns
Maintain and implement policy direction for health services	Develop a national policy for health and safety with objectives
Detect and control undesirable trends in service delivery	Apply a system of inspection with penalties to enforce laws and regulations
Regulate the behaviour of role players	Indicate the roles, functions and responsibilities of stakeholders
Establish mechanisms of accountability	Ensure necessary coordination between stakeholders Create central body to achieve the objectives

of Labour, Department of Mineral Resources, and Sabinet. Key words in the document review included: occupational health, occupational healthcare services, occupational health legislation, and governance of occupational health. The specific laws reviewed were the South African Constitution, OHSA, MHSA, NHA, Civil Aviation Act, Merchant Shipping Act, Health Professions Act, and the Nursing Act.

Key informant interviews

The purpose of the KIIs was to explore the complexities and nuances of the governance of OHS from the perspective of major stakeholders. Interviews were conducted from June to November 2014. Participants were purposively selected, based on the location of the relevant OH authorities, location of the national health authorities, and the participant's being active in the occupational healthcare sector.

Semi-structured recorded interviews were conducted with the key informants, using an interview guide developed for the study. The questions covered government departments' involvement in OH, the current controls for establishment of OHS, and factors that influence the governance of OHS. The interview schedule was pre-tested with an OH expert to test clarity of questions. All interviews were conducted in English. Probes were used to clarify responses and obtain more detailed information.

Each key informant interview lasted approximately one hour. Interviews were digitally recorded, and detailed notes were taken. The recorded interviews were transcribed verbatim. Data cleaning consisted of an iterative process of checking the transcribed interviews against the original recordings, correcting the text, checking the recordings again, and making final corrections. Prior to analysis, each key informant was allocated a code to ensure confidentiality.

Focus group discussions

FGDs were conducted from June to August 2014 in Gauteng, KwaZulu-Natal and Western Cape provinces by one researcher (KM). These provinces were selected based on the concentration of industries, and the availability of and researchers' access to stakeholder interest groups. FGD participants were recruited through the South African Society of Occupational Health Nurses (SASOHN), the South African Society of Occupational Medicine (SASOM), recognised OH service provider companies, tertiary institutions offering OH qualifications, and employers who engage OHS. Only OH nurses or doctors currently practicing OH, or service providers offering – or employers engaging OHS – were included in the FGDs. The FGDs sought to explore a range of perspectives from diverse OH interest groups that differed in terms of industry, geographic location, model of service delivery (e.g. company or service provider), and sector of service delivery. Some groups were homogenous, based on characteristics such as employer representation and professional registration. FGDs comprised four to 14 participants.

The principal investigator (KM) facilitated the FGDs and used a FGD guide for discussion. The questions focused on the current controls for establishment of OHS, government involvement in the control of these services, and the perceived strengths and weaknesses of these controls. Each FGD lasted one to two hours and was audio recorded.

The recorded FGDs were transcribed verbatim. Data cleaning consisted of an iterative process of checking the transcribed FGDs against the original recordings, correcting the text, checking the recordings again, and making final corrections. Prior to analysis, each FGD was allocated a code to ensure confidentiality of information.

Data analysis

The data were analysed using thematic content analysis. First, the words and phrases of the participants in the KIIs and FGDs were examined without preconceived notions or classification. Two researchers with OH experience were given the same two transcripts to code independently from the first researcher, to ensure reliability. The coded transcripts were reviewed to ensure the same coding had been applied. Where there was inconsistency in coding, these differences were discussed until agreement was reached, and a code book was developed based on the recurring themes. All KII and FGD transcripts were analysed using the code book and employing MAXQDA version 11; all identifying statements were removed prior to publication of the results.

Ethical approval

The University of the Witwatersrand Human Research Ethics Committee (Medical) granted approval for the study (clearance certificate no. M140442). All participants received a study information sheet and were required to sign informed consent, including consent to be audio recorded where appropriate, prior to data collection.

RESULTS

Profile of FGD and KII participants

Eleven FGDs (n=69) and 12 KIIs were conducted (Table 2) with participation from private quality assurance providers, the DoL, the Office of Health Standards Compliance (OHSC), a professional council, a professional non-profit association, the National Institute for Occupational Health (NIOH), service providers, employers, OH practitioners, and academia. Study participants included the public and private sectors as well as OH service providers in rural and urban settings.

Fragmentation of governance structures

The analysis of legislation and policy documents revealed a complex, fragmented structure and framework with numerous government departments tasked with different responsibilities in OH, summarised in Tables 3 and 4.

Two government departments, i.e. the DoL and DMR, legislate the provision of a healthy and safe work environment, as well as the need for medical surveillance and medical examinations to determine fitness for work. Neither the OHSA nor the MHSA prescribe how these activities should be performed, nor do

Table 2. Stakeholders and sectors included in the focus group discussions and key informant interviews

Key Informant Interviews n = 12	Focus Group Discussions n = 11
Department of Labour	Occupational health nurses
Department of Health – Office of Standards Compliance	Occupational health doctors
National Institute for Occupational Health	Employers
Professional councils	Service providers
Professional organisations	Professional organisations
Academia	Academia
Voluntary accreditation body	

Table 3. Statutory bodies governing occupational health services in South Africa

Governing Body	Legislation	Scope
Constitutional Court	South African Constitution	Makes strong provision for the rights to health and basic health services. Provides for the right to a safe and healthy work environment.
Department of Health and Office of Health Standards Compliance (OHSC)	National Health Act No. 61 of 2003	OHSC is a regulated body under this Act. Requires all healthcare establishments to comply with quality requirements and national core standards for health establishments. OH services have not been included at this time.
Department of Labour	Occupational Health and Safety Act No. 85 of 1993	To provide for the health and safety of persons at work and of persons in connection with the use of plant and machinery; . . . to establish an advisory council for occupational health and safety; and to provide for matters connected therewith.
Department of Mineral Resources	Mines Health and Safety Act No. 29 of 1996	To safeguard the health and safety of mine employees and communities affected by mining operations.
Department of Civil Aviation	Civil Aviation Act No. 74 of 1962, as amended (Part 67)	Regulates the medical examinations required for persons employed in this sector.
Department of Maritime Affairs	Merchant Shipping Act No. 57 of 1951, as amended	Regulates the medical examinations required for persons employed in this sector.
Health Professions Council South Africa	Health Professions Amendment Act No. 29 of 2007	The Act entitles the Council to oversee doctors' training in order to maintain standards, describe the scope of practice, and register professionals who have met the prescribed training requirements.
South African Nursing Council	Nursing Act No. 33 of 2005	The Act entitles the Council to oversee nurses training in order to maintain standards, describe scope of practice and register professionals who meet the prescribed training requirements. Includes training as an occupational health nurse.
National Institute for Occupational Health	Department of Health	Responsible for supporting occupational health at all levels, promoting occupational health services, and fulfilling statutory obligations.
Medical Bureau for Occupational Diseases	Department of Health	Responsible for discharging duties in terms of, and administering, the Occupational Diseases in Mines and Works Act of 1973, as amended.

Table 4. Role players in the governance of OHS

State	Service Providers	Client
Department of Health	Private	Employers
Department of Labour	Public	Employees
Department of Mineral Resources	Occupational Health Nurses	
South African Nursing Council	Occupational Medical Practitioners	
Health Professions Council of South Africa		
Department of Aviation		
Department of Maritime Affairs		
National Institute for Occupational Health		
Medical Bureau for Occupational Diseases		

they provide guidelines on the establishment of OHS that stem from this legislation, a critical omission from the legislation. The Departments of Aviation and Maritime require medical examinations to be conducted on workers by service providers approved and registered for the purpose, but do not stipulate that this should be done by an OH practitioner. The Department of Health, through the NHA and, more specifically, the recently established Office of Health Standards Compliance, is concerned with the quality of healthcare in all healthcare establishments; by implication, this should include occupational healthcare establishments /services. The two professional councils (Nursing and Health Professions) are concerned with the training of OH as a specialisation and the practice of nurses and doctors, respectively, with no further role in service delivery or establishment.

The document analysis found that, although South Africa has ratified two conventions, viz. ILO convention C155 – the

"The perception was that the only control over OHS is through the DoH with the inspection of premises for the issuing of dispensing licences, which is not applicable to all OHS, resulting in many practices never being inspected. This was highlighted by doctors and nurses . . ."

Occupational Health and Safety Convention, 1981, which requires member states to formulate and implement a national policy on occupational health and safety in the workplace; and C176 – Safety and Health in Mines, 1995, which addresses health and safety in the mining sector, there is no national policy on occupational health and safety.

The study participants identified the statutory structures responsible for the governance of OHS in South Africa, namely three government departments (Labour, Health and Mineral Resources), and two professional councils (Nursing and Health Professions). The roles of the Departments of Aviation and Maritime were recognised by only one focus group participant and by both DoL key informants. FGD participants identified two voluntary professional organisations, i.e. SASOHN and SASOM, as promoting the development of OHS but with no statutory authority. They were of the opinion that these organisations should be given more authority for OHS in South Africa.

FGD participants indicated that the poor inter-sectoral collaboration among the DoH, DoL and DMR around OHS delivery has created a fragmented approach, contributing to poor quality of service delivery. This is exacerbated by the lack of national standards for the establishment of OHS. In those instances, where codes of OH practice have been published by the DMR, they are only applicable in sectors governed by this department.

Perceptions of OHS governance

The main themes that emerged from the FGDs and the KIIs were: the low prioritisation of OH by the Department of Health, insufficient control over OHS delivery, inadequate understanding of what OHS delivery involves, insufficient resources to steer OHS, and the lack of a national policy and guidelines for occupational health and safety in South Africa.

Low prioritisation of OHS

Study participants were of the opinion that there was low prioritisation of OHS on the government's agenda, and that the concern for improvements in governance came primarily from voluntary OH organisations and service providers. An OHN stated:

"We are currently sitting with a system where the authoritative structures don't support it [OHS]." (FGD 2, OHN, 100)

This statement was supported by key informants who stated:

"It [OHS] *is not on the list of the most important services that needs to be put in place in terms of the government's policy around national health."* (KII 8, OHSC)

"I know that there are an awful lot of other things on his [Minister of Health] *plate and he may not feel that it* [referring to OHS] *is addressing the needs of a sufficiently large trunk of the population to warrant his attention . . . I think that his track record would give me faith that if it was successfully placed on his agenda, then I think he would step up to the plate, and he would achieve."* (KII 7, COHSASA)

Participants were of the opinion that the relevant government departments have different priorities. They reported that the DoH focuses primarily on the quadruple burden of disease which includes HIV and AIDS and other communicable diseases, maternal and child conditions, non-communicable diseases, and violence and injuries; the DoL focuses primarily on the safety of workers with limited focus on OH (FGD 6 and KII 2 and 3); and the DMR is believed to be losing its focus on OH as its attention has shifted to tuberculosis prevention and HIV programmes (FGD 8). Although workers are also affected by these conditions, a dedicated OH focus is missing. Furthermore, the DoH's mandate is to govern all healthcare establishments, but it pays insufficient attention to the OH clinics and the quality of OHS delivery.

Study participants were of the opinion that there is insufficient accountability from service providers. This creates gaps in governance because of different focus areas, conflicting or overlapping functions and relationships, and poor cohesion among the statutory departments. These, in turn, contribute to poor quality control of OH service delivery and insufficient accountability. Although the professional councils register OH qualifications and provide professionals with a licence to practice within their areas of specialisation, they do not play a central role in OHS governance.

Insufficient oversight over OHS

Despite both the OHSA and the MHSA legislated requirement for employers to conduct medical surveillance and medical examinations, participants believed that few or no controls exist to manage the establishment of OHS. As stated by key informants from two state structures and a service provider:

"From us [DoL] *as a regulator there is nothing [referring to control] . . . and I know from the health side that there is nothing and any person can be a* [OH] *service provider."* (KII 2, DoL)

"I don't think we have controls that are governing us in OH . . . As long as you can get the practice number from SANC, then that's it, you can do whatever you like." (FGD 2, OHN)

"In South Africa . . . everybody can open an OH service . . . it's still a free for all." (KII 10, NIOH)

The perception was that the only control over OHS is through the DoH with the inspection of premises for the issuing of dispensing licences, which is not applicable to all OHS, resulting in many practices never being inspected. This was highlighted by doctors and nurses who stated:

"*Ever since we started* [offering OH services] *there is nothing* [referring to controls]. *There is absolutely nothing, the only thing*

that you need to have is when you need to dispense medication, you need to have a dispensing licence." (FGD 8, OMP)

"The controls that we have . . . it depends on the services you are going to deliver. If you dispense [medication] *then you find that there is control because you have to meet those requirements . . . but for OH there is nothing."* (FGD 2, OHN)

The DMR has qualified health inspectors inspecting OHS at mines and quarries governed by the MHS Act, and both discussants and informants believe the control over DMR-regulated services is better than that of the DoL, but remains sub-optimal. The majority of OHS are provided to workers outside the public health sector in unregistered facilities and are often provided by non-medical personnel. Although the Health Professions and Nursing Acts prohibit the provision of healthcare services by non-medical persons, in practice, the legislation is poorly enforced. As stated by an OMP:

" . . . that's one of the big arguments . . . around the whole notion of companies that are non-registered entities performing health services, which is an illegal practice. So the only control . . . is a breach of health services and health professions law. But whether it is policed or not, or whether there are means to address it, is apparently very problematic." (FGD 11, OMP)

Lack of understanding of OHS delivery

The power of the DoL and DMR is seen to lie in penalties imposed for non-compliance with legislation but the perception is that these penalties are applied with insufficient insight and understanding of health issues as opposed to issues of safety. Respondents believe that the situation is exacerbated by insufficient expertise in OH as opposed to safety within the DoL. As stated by a discussant:

"At the moment, the DoL is like a scarecrow. You just scare people with the DoL but you never see them anywhere . . . So, if the DoL was functioning as a DoL, I think it would have been different. But at the moment I think it is just the lack of resources, the staff, the competence in the DoL, it is not there." (FGD 4, OMP)

A lack of understanding of what OHS delivery involves was expressed by a discussant who stated:

"I have encountered the DoH and they have absolutely no understanding of OH, to the point of being obstructive." (FGD 11, OMP)

This statement was supported by the OHSC representative (KII 11) and consultant (KII 8) who stated that OH services/clinics established outside a healthcare setting, e.g. a hospital or primary health clinic, are not classified as healthcare establishments (HCE) as defined in the NHA. However, after reviewing the definition, it was agreed that these services meet the criteria to be defined as HCE. This lack of understanding of what OHS delivery involves contributes to the low prioritisation of OHS on the government agenda.

Insufficient resources within government departments

Study respondents raised concerns about the poor implementation of inspections for the issuing of dispensing licences, insufficient resources within the DoH, and the apparent inability of the DoH to cope with its existing work load. The majority of KIIs and FGD participants were unfamiliar with the OHSC, established in 2014.

The absence of a national policy with guidelines for establishing OHS was viewed as a contributing factor to suboptimal governance. Although the NIOH is a national OH resource financed by the DoH, study participants considered the involvement of the NIOH in OH policy development as insufficient, a situation exacerbated by inadequate human and financial resources. Resource constraints also hinder the DoL's ability to enforce basic OHSA safety requirements, and discussants were not confident that the DoL would cope with inspection and enforcement of the additional health component. The fact that health is not seen as a DoL core function and the Department's lack of skill and knowledge in health, exacerbate this concern. As stated by one discussant when describing where the statutory control of OHS should lie:

"Well . . . I suppose to me it will be a toss-up between the DOL and the DOH but from the point of view of looking at what can go wrong in OH, I think for the DOL probably health would not be on their agenda. They would acknowledge that it's important but that's not their core business, so they would be distracted into the things that are their core business and I think that it is more likely that they would overlook the health aspect." (FGD 4, OMP)

Study participants indicated that the DoL appears motivated to address these concerns and improved governance could result from intersectoral collaboration among all statutory and voluntary professional organisations, which will enable the sharing of knowledge, skills and expertise.

DISCUSSION

The governance of OHS globally and in South Africa has received scant attention.[20, 22] This study found a lack of cohesion and, at times, conflict, in the governance of OHS, despite policy pronouncements on the importance of these services in both the 1997 White Paper for the Transformation of the Health System[40] and ILO Convention 155.[31] The study participants' perceptions of the low prioritisation of OHS are supported by the South African health sector reform proposals that are silent on the governance and integration of OHS into the healthcare system.[41,42] The study found that there are multiple statutory stakeholders in OH, but no one structure takes the lead responsibility for governance of the OHS. In addition, OH legislation tends to be governed by the Departments of Labour[43] and Mineral Resources[34] and not the Department of Health, creating role confusion with regard to accountability for the OHS offered by nurses and doctors.

Leadership and governance are important building blocks of a health system[6] as emphasised in many South African policies.[10,11,12] Furthermore, South Africa has strong OH legislation.[34,35] However, this study found that leadership and governance in OHS are sub-optimal. This complex and fragmented framework within which OHS are delivered, with multiply stakeholders assuming varied authority, has created gaps in governance in terms of directing and overseeing the services established to protect workers' health. The low prioritisation of OHS within the DoH, accompanied by

a perceived lack of OH expertise, the historical inability of the government departments to form collaborative inter-sectoral partnerships,[16] and insufficient resources, are important issues to address.

Greater cooperation and cohesion are required between the statutory authorities to improve the governance of OHS, an approach that would align OHS governance to the objectives of both ILO Convention 155[31] and the WHO Building Blocks for Health Systems.[6] The various departments would be required to develop a national strategic framework that clearly defines the roles and responsibilities of each of the departments in the governance of OHS, with one body assuming overall responsibility for the coordination of this strategy. The strategy would also require attention to the monitoring of quality of OHS delivery through reporting and inspections, and a combination of incentives and penalties to ensure legislative compliance.

Governance is a key responsibility of the state but achieving sound governance requires stakeholder collaboration.[3] In OH there are multiple stakeholders,[24] each with differing objectives,[24] creating a complex environment within which OHS are delivered, a situation similar to that in other countries. At the same time, this complex environment creates an opportunity where engaging and utilising the skills and knowledge within the diverse stakeholder groups could present a solution to the limited availability of resources within government structures.[44] Both SASOHN and SASOM, as voluntary professional organisations and stakeholders in OH, have the required skills, knowledge and motivation to collaborate with government structures to intensify and support the development and implementation of a system of sound governance. These are resources that can be used to effectively augment the capacity of the statutory bodies.

The impact of poor health sector regulation has been described, and includes a rapid expansion of unregistered clinics, poor inspection of facilities, and unregistered persons providing healthcare.[14,45] In the broader PhD study of which this paper is a part, stakeholders[29] have identified similar concerns in OHS delivery and have recommended that service providers are held accountable for their acts and omissions through a system of inspection and enforcement. A strong legislated framework is in place for healthcare in South Africa[46] but with limited control over the behaviour of service providers in the private sector[28] where governance is perceived as voluntary.[29] This situation is exacerbated by gaps in governance in terms of confusion or conflict in the roles and responsibilities of the statutory bodies. Evidence suggests that self-regulation is successful under conditions of effective governance.[3,28] Given the gaps in governance in the occupational healthcare sector, it follows that quality of care and service delivery should not be reliant on self-regulation. In accordance with Convention 155,[31] regulation of service provider behaviour should be managed through a system of laws and regulations enforced through inspection which will require cohesion, power sharing and collaboration between the government departments. Historically, this inter sectoral collaboration has been difficult to achieve[44] but in the current political environment, where improving governance is a priority, this cohesion among the statutory authorities is critical to success.

Workplace exposures have the potential to cause debilitating ill-health in workers[47-49] with a resultant financial burden on both the individual and society, which could be ameliorated through quality OHS.[50-52] A significant burden of occupational disease has been described in South Africa[26,27] and the sub-optimal governance of these services, with resultant poor enforcement and compliance, might be contributing factors. Study participants were of the opinion that OHS are low on the DoH policy agenda as they serve a relatively small sector of the population. However, statistics estimate that, of the 51 million population in South Africa, more than 15 million are employed[39] – a significant proportion and one worthy of greater policy attention. In a country with limited resources, the effective and efficient use of these resources is imperative. OHS need to become a priority item on the government policy agenda in order to improve governance and service delivery.

A key recommendation of the study is that the Departments of Labour, Health and Mineral Resources, in consultation with stakeholders, need to develop a strategic framework to improve workers' health and OH service delivery, with an outline of roles and responsibilities, as well as a robust system of OHS governance.

Limitations

Despite attempts to include representation from the Department of Mineral Resources and trade unions, this study does not include the views of these stakeholders. Further research is required to explore client (employer and employee) perceptions of governance. The study was conducted at one point in time and is influenced by context, and the perceptions and characteristics of the key informants and focus group discussants.

CONCLUSION

This is one of the first studies to explore stakeholders' perceptions of the governance of OHS in South Africa. Notwithstanding policy pronouncements and recognition of the importance of effective OHS governance, this is hindered by a complex and fragmented legislative environment, perceptions of low prioritisation, insufficient control over OHS delivery, inadequate understanding of what OHS delivery involves, insufficient resources, and the lack of a national policy and guidelines for OH in South Africa. The findings of the study suggest that there are gaps in governance because of conflicting or overlapping relationships, and poor cohesion among the statutory departments. These in turn, contribute to poor quality control of OH service delivery and insufficient accountability. South Africa has ratified ILO Conventions 155 and 161, and is obliged to achieve the objectives outlined in these Conventions, which include developing a national policy for OHS, indicating responsibilities of stakeholders, enforcing laws and regulations through inspection and, through consultation, ensuring the coordination between stakeholders. The improvement of OHS governance requires intersectoral collaboration, enforcement of existing legislation, and involvement of all relevant stakeholders.

DECLARATION

The authors declare that they have no conflicts of interest.

LESSONS LEARNT

1. Globally and in South Africa, the governance of OHS has received insufficient scholarly focus
2. The identified obstacles to governance include the fragmented and complex legislated framework, low prioritisation of OHS by the DoH, and insufficient resources
3. The improvement of OHS governance requires intersectoral collaboration, enforcement of existing legislation, and involvement of all relevant stakeholders

REFERENCES

1. Scott V, Schaay N, Olckers P, Nqana N, Lehmann U, Gilson L. Exploring the nature of governance at the level of implementation for health system strengthening: the DIALHS experience. Health Policy and Planning. 2014;29(Supplement 2):ii59-ii70.
2. Mikkelsen-Lopez I, Wyss K, de Savigny D. An approach to addressing governance from a health system framework perspective. BMC Int Health Hum Right. 2011;11(1):1-11.
3. Brinkerhoff DW, Bossert TJ. Health governance: principal–agent linkages and health system strengthening. Health Policy and Planning. 2014;29(6):685-693.
4. World Health Organization. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: WHO; 2007. Available at: http://www.who.int/healthsystems/strategy/everybodys_business.pdf (accessed 9 Jan 2017).
5. Siddiqi S, Masud TI, Nishtar S, Peters DH, Sabri B, Bile KM, et al. Framework for assessing governance of the health system in developing countries: Gateway to good governance. Health Pol. 2009;90(1):13-25.
6. World Health Organization. Monitoring the building blocks of health systems: a handbook of indicators and their measurement. Geneva: WHO; 2010 Available at: http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf (accessed 24 Nov 2016).
7. World Health Organization. Health systems: Governance 2016. Available from: http://www.who.int/healthsystems/topics/stewardship/en/ (accessed 25 Feb 2016).
8. United Nations. Transforming our world: The 2030 agenda for sustainable development; 2015.
9. Howlett M, Ramesh M. Achilles' heels of governance: Critical capacity deficits and their role in governance failures. Regulation and Governance. 2016;10: 301-313.
10. Institute of Directors in Southern Africa. King Report on Corporate Governance for South Africa - 2002 (King II Report). IoDSA; 2002.
11. South Africa, The Presidency.Twenty year review South Africa, 1994-2014. Pretoria: Government Printing Works; 2014.
12. National Planning Commission. National Development Plan: Vision 2030. Pretoria: National Planning Commission; 2011.
13. South Africa. Department of Health. National Health Insurance for South Africa: Towards universal health coverage - Version 40; 2015.
14. Basu S, Andrews J, Kishore S, Panjabi R, Stuckler D. Comparative performance of private and public healthcare systems in low- and middle-income countries: a systematic review. PLoS Medicine. 2012; 9(6):[14 p.].
15. Rispel L, Setswe G. Stewardship: Protecting the public's health In: Harrison S, Bhana R, Ntuli A, editors. South African Health Review 2007. Durban: Health Systems Trust; 2007.
16. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. Lancet. 2009;374:817-834.
17. Rispel LC, De Jager P, Fonn S. Exploring corruption in the South African health sector. Health Pol Plan. 2016;31:239-249.
18. Van Rensburg HCJ. Health and healthcare in South Africa. Pretoria: Van Schaik; 2012.
19. Rispel L. Analysing the progress and fault lines of health sector transformation in South Africa. In: Padarath A, King J, Mackie E, Casciola J, editors. South African Health Review 2016. Durban: Health Systems Trust; 2016.
20. World Health Organization. Global strategy on occupational health for all. Recommendations of the 2nd meeting of the WHO collaborating centers in occupational health. Beijing China. Geneva: WHO; 1995.
21. International Labour Organization. Thirteenth session of the joint ILO/WHO committee on occupational health. 9-12 December 2003. Geneva: ILO; 2003. p. 1-17.
22. Jeebhay M, Jacobs B. Occupational health services in South Africa. Durban: Health Systems Trust, 2000; 1999. Available at: http://www.hst.org.za/uploads/files/chapter19_99.pdf (accessed 17 Mar 2017).
23. International Labour Organization. ILO Convention No. 161: Occupational Health Services Convention; 1985. Available at: http://ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312306:NO (accessed 9 Oct 2016).
24. Rantanen J, Lehtinen S, Iavicoli S. Occupational health services in selected International Commission on Occupational Health (ICOH) member countries. Scand J Work Environ Health. 2013;39(2):212-216.
25. Boardman J, Lyon A. Defining best practice in corporate health and safety governance Report No. 506. London: Acona Limited; 2006.
26. Murray J, Davies T, Rees D. Occupational lung disease in the South African mining industry: research and policy implementation. J Publ Health Pol. 2011;32: S65-S79.
27. Ndlovu N, te Water Naude J, Murray J. Compensation for environmental asbestos-related diseases in South Africa: a neglected issue. Global Health Action. 2013 (Supp 1):82-88.
28. Doherty JE. Regulating the for-profit private health sector: lessons from East and Southern Africa. Health Policy Plan. 2015;30(suppl 1):i93-i102.
29. Michell K, Rispel L. "Mindless medicals": stakeholders' perceptions of the quality of occupational health service delivery in South Africa. Workplace Health & Safety 2016;65:100-108.
30. Venables KM, Allender S. Quality of occupational health provision: two rating scales and their determinants. Occup Med. 2008;58(6):439-442.
31. International Labour Organization. ILO Convention No. 155. Occupational Safety and Health Convention; 1981. Available at: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::p12100_instrument_id:312300 (accessed 6 Feb 2016).
32. International Labour Organization. Ratifications for South Africa; 2015. Available from: http://www.ilo.org/dyn/normlex/en/f?p=1000:11200:0::NO:11200:P11200_COUNTRY_ID:102888 (accessed 27 Sep 2015).
33. Rantanen J. Basic occupational health services - their structure, content and objectives. Scand J Work Environ Health. 2005;Supplement(1):5-15.
34. South Africa. Mine Health and Safety Act No. 29 of 1996.
35. South Africa. Occupational Health and Safety Act No. 85 of 1993.
36. South Africa. National Health Act No. 61 of 2003.
37. Health Professions Council South Africa. Protecting the public and guiding the professions; 2013. Available at: http://www.hpcsa.co.za/Professionals (accessed 29 Feb 2016).
38. South African Nursing Council. South African Nursing Council functions 2016. Available from: http://www.sanc.co.za/aboutfunctions.htm (accessed 29 Feb 2016).
39. Statistics South Africa. Quarter 4, 2014. Quarterly labour force survey. Pretoria: Statistics South Africa; 2014.
40. South Africa. Department of Health White Paper for the transformation of the health system in South Africa; 1997. p. 140.
41. South Africa. National Public Health Institute of South Africa Bill, No. 1092; 2015. Published 11 Nov 2015.
42. South Africa. Department of Health White paper on National Health Insurance; 2015.
43. Frumkin H, Câmara VdM. Occupational health and safety in Brazil. Am J Public Health. 1991;81:1619-1624.
44. Kula N, Fryatt R. Public–private interactions on health in South Africa: opportunities for scaling up. Health Policy and Planning. 2014;29(5):560-569.
45. Kumaranayake L, Lake S, Mujinja P, Hongoro C, Mpembeni R. How do countries regulate the health sector? Evidence from Tanzania and Zimbabwe. Health Policy and Planning. 2000;15(4):357-367.
46. Doherty J. Legislation on the for-profit healthcare sector in east and southern Africa. Harare: EQUINET; 2013.
47. Delclos GL, Gimeno D, Arif AA, Burau KD, Carson A, Lusk C, et al. Occupational risk factors and asthma among healthcare professionals. Am J Respir Crit Care Med. 2007;175:667-675.
48. Fingerhut M, Driscoll T, Imel Nelson D, Concha-Barrientos M, Punnett L, Pruss-Ustin A, et al. Contribution of occupational risk factors to global burden of disease- a summary of findings. Scand J Work Environ Health. Suppl 2005(1):58-61.
49. Davis MV, Cannon MM, Corso L, Lenaway D, Baker EL. Incentives to encourage participation in the national public health accreditation model: a systematic investigation. Am J Publ Health. 2009;99:1705-1711.
50. Yodaiken R, Zeitz P. Accreditation policies in occupational healthcare. J Occup Med. 1993;35:562-567.
51. Macdonald E. Audit and quality in occupational health. Occup Med. 1992;42:7-11.
52. Loewenson R. Globalization and occupational health: a perspective from Southern Africa. Bull World Health Organ. 2001;79:863-868.