Fitness Certification, Incapacity and Disability

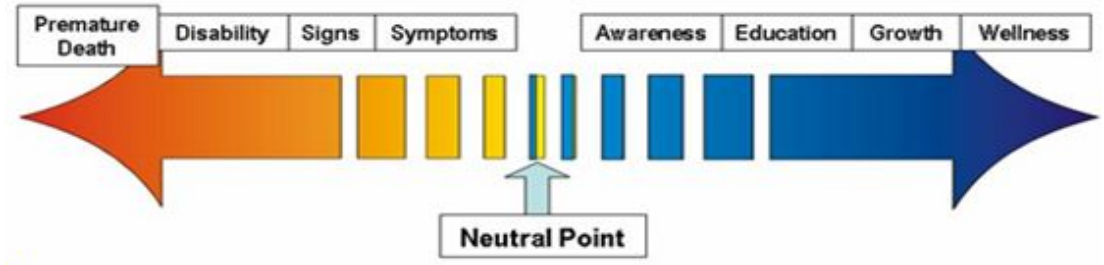
A Management Guide

Table of Contents

List of Tables

1 INTRODUCTION AND IMPORTANT CONCEPTS

The management of fitness to work should be considered holistically. A useful mechanism by which to consider this is through an understanding of the concept of the "Wellness Continuum".

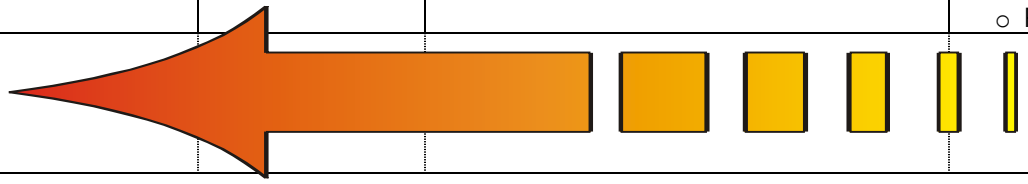


Ultimately, performance management aims to achieve optimum employee productivity. In the image above, poor performance (for whatever reason) is represented by the red/orange arrow pointing to the left, whereas good performance is represented by the blue arrow pointing to the right.

Therefore, performance management aims to shift employees to the right of the "Wellness Continuum".

The main purpose of this document focuses on managing issues that drive employees towards the left. These issues and circumstances are illustrated in the table below.

The purpose of the Wellness Program is to focus on interventions that drive employees to the right.

Premature death	**Disability**	**Sickness Absence/Incapacity**	**("Neutral point")**
Death Benefits claims management	**Fitness to work evaluation here**		
• Death Benefits Policy	• Disability Management and possible medical boarding	• Incapacity Management (accommodation or redeployment) ○ Sickness Absence ○ "Presenteeism" ○ Substance Abuse	• Routine Fitness to Work evaluation (as per inherent requirements in OREPs): ○ Recruitment (incl disabled employees) ○ Pre-transfer ○ Periodic.
			

This table illustrates the spectrum of related issues, as circumstances shift from right to left. These should all be considered together, as one theme.

1.1 The basis for medical adjudication

One of the most fundamental responsibilities placed upon the Occupational Health Unit is to adjudicate regarding fitness to work, or conversely suitability for disability "boarding". This adjudication takes place in a variety of settings, including:

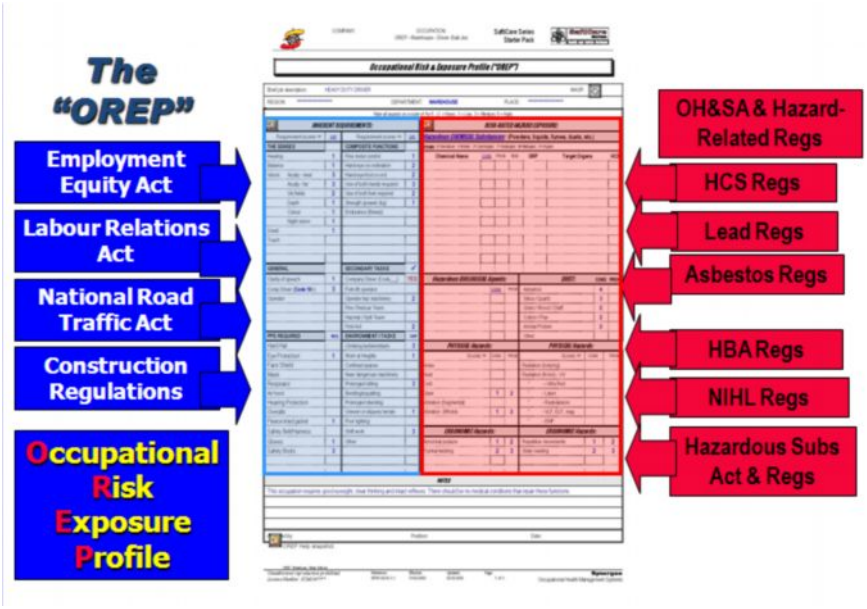
- Routine screening (pre-employment, etc.)
- "Return-to-work" (post-illness) evaluation
- Incapacity or disability assessment; referred by management, union, or even an insurance company (most commonly, as a result of **excessive sickness absence**)

South African law (notably the Occupational Health and Safety Act and the Mines Health and Safety Act, but many others, as well) requires employees in certain occupations to be in possession of medical certificates of fitness.

The two main categories of fitness are determined driven by:

- Capability to perform certain tasks safely & effectively ,such as the operation of hazardous mobile equipment, (forklifts, vehicles on the open roads, aircraft, trains, boats, etc.), as well as underwater diving, working at heights, and other hazardous tasks.
- Exposures to hazards, such as noise, lead, hazardous chemical substances and hazardous biological agents (the presence of sufficient physiological reserve to be able to work in the presence of these hazards, or the absence of medical conditions that may be seriously aggravated by the hazards)

The OREP provides a valuable tool by which to assist in this adjudication, by providing the information required for the decision, as follows. The blue areas refer to "capability", and the red areas refer to "hazards".



Some of these occupations require statutory certification, and for many categories of occupation, there are minimum qualifications for the OH professionals who perform the assessments. These are described in detail in the *Management Guide on the roles of the OH Team*.

1.2 The potential outcomes of medical adjudication

Ultimately, the decision regarding "fitness to work" comes to one of the following outcomes.

- Fit
- Not fit , but can do the job if certain restrictions are applied (ie requires accommodation)
- Not fit, under any circumstances

These are described in detail overleaf.

Table 1: Permutations of the outcomes of medical adjudication.

Outcome	Meaning	

FIT	**No exclusions present**	Meets the minimum inherent requirements of the job assigned, including:
		• The capability to perform the tasks required:
		  ○ to the required standard (quality & efficiency)
		  (**Quality** – may require good vision (eg quality control worker) or dexterity (eg. working on PC boards)
		  (**Efficiency** – may require strength (eg. heavy manual work) or flexibility (eg. maintenance work in confined spaces)
		  ○ without undue risk to him/herself or others (safety)
		  (eg. may require good vision such as a professional driver, or the absence of certain illnesses such as uncontrolled epilepsy in an airline pilot)
		• The ability to function in the working conditions associated with the job (ie. potential to be exposed to certain **hazards**), without undue risk to his or her health.

NOT FIT, but can do the job, with restrictions (accommodation)	**Relative exclusions present**	Does not meet one or more of the above minimum inherent requirements of the job, or the presence of work-related decline in the health of a target organ (ie lung function or audiometry) **but is able to do the job**, should certain restrictions be applied. These restrictions could be: • **Task** restrictions: such as exclusion of certain tasks (*eg. no climbing of ladders*), reduction in performance (the speed or duration) of the work (*eg. only to drive for short distances, or only work half-day*). • **Place** restrictions: working conditions may restrict employee from being allowed to work in certain workplaces (ie. the presence of particular hazards which pose a threat to the health of the employee) (*eg. no working with chemicals that are irritant to the lungs*). • **Administrative** restrictions: the employee can do the job as long as he/she remains under regular medical review to ensure: ○ Adequate control of a chronic condition(ie. blood glucose or blood pressure)
NOT FIT	**Absolute exclusion(s)**	Does not meet one or more critical minimum inherent requirements of the job, for which no accommodation is possible. Examples include: • The requirements of a law are transgressed (ie a minimum legal standard) • The employee's life is at risk (ie can trigger a life-threatening situation) Continued deterioration of an occupational disease leading to permanent disability, despite reasonable protection from exposure.

Notes:

Even if an employee is certified to be “Not Fit”, this does not mean “unemployable”; it simply means that options for re-deployment to another job need to be explored. Separation on the grounds of medical incapacity should only be considered after all options prescribed by the Labour Relations Act have been explored.

The DURATION of the restrictions or “unfitness’ should be stated (ie. permanent or temporary) on the certificate.

1.3 The concept “Inherent Requirements”

The inherent requirements of a job refer to the physical, cognitive and psychological demands necessary to safely complete the essential tasks of a job, to a satisfactory standard (quality & efficiency).

The Employment Equity Act forbids medical testing unless the occupation has specific inherent requirements, and that the tests used are designed to address the person’s fitness in terms of those “inherent requirements”. These are also known as the “minimum medical standards of fitness” for an occupation.

EEA, Chapter II, section 7.
(1) Medical testing of an employee is prohibited, unless-
(a) legislation permits or requires the testing; or
(b) it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the ***inherent requirements of a job****."*

Hence, “inherent health requirements” or minimum medical standards of fitness are prescribed in the following terms of reference: (see Table 1)

- The capability to perform the tasks required:
  - to the required standard (quality & efficiency)
  - without undue risk to him/herself or others (safety)
- The ability to function in the working conditions associated with the job (ie. potential to be exposed to certain hazards), without undue risk to his or her health.

1.4 The relationship between fitness to work and risk:

Risks of relevance to medical adjudication fall into two broad categories:

Exposure Risk

This refers to health risks associated with exposure to hazards (noise, heat, dust, ergonomic hazards) in that occupation. The hazard exposure may:

- Cause an illness to develop.
- Aggravate a pre-existing medical condition.

The “inherent health requirements” of tasks associated with *exposure risks* would be minimum levels of organ function, relevant to the target organs of exposure. Hence, should the exposures be to agents that are lung irritants, a requirement may be the absence of poorly controlled asthma. In the presence of heavy manual labour in hot environments, a requirement may be normal cardiac function (not in cardiac failure).

Whilst it is incumbent on the employer to reduce or minimise the hazards to which employees are exposed, in certain circumstances there will always remain inherent health and safety risks. This is particularly so in hazardous industries, such as mining.

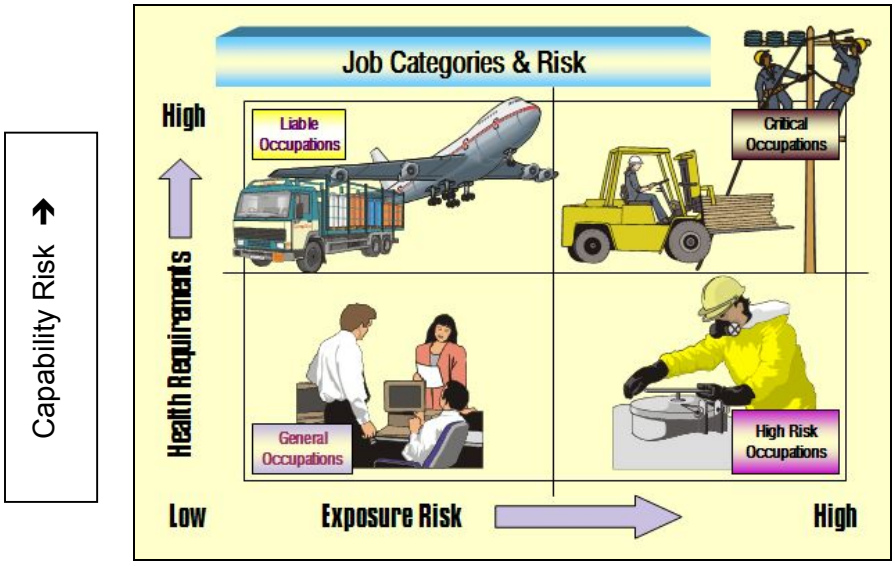
Capability Risk

This refers to the health & safety risks consequent on inability to perform an occupation safely. Certain occupations have the potential to cause substantial harm to people (self or others) should there be operator failure. These capability issues could be:

- Sub-optimal function (intermittent or constant) of an organ system that may lead to operator failure. (eg. poor vision in a driver)
- The presence of a medical condition that unacceptably increases the likelihood of operator failure. (eg. uncontrolled diabetes mellitus increases the likelihood of hypoglycaemia and cognitive dysfunction, leading to operator failure)

This dual view of risk can be seen graphically below.

Figure 1: The relationship between capability risk and exposure risk.



This illustrates the two basic axes of risk – the vertical axis represents increasing health requirements and the horizontal axis represents increasing potential exposure to hazards. This leads to four main "risk-groups" of occupations:

- Those with high health requirements, but low hazard exposure – the "liable occupations". (eg. bulk truck drivers, heavy passenger vehicle drivers)
- Those with high health requirements, and high hazard exposure – the "critical occupations". (eg. crane operators, forklift drivers, certain machine operators).
- Those with low health requirements, but high hazard exposure – the "hazardous occupations". (eg. welding, maintenance, or any work entailing exposure to significant hazards).
- Those with low health requirements, and low hazard exposure – the "general occupations". (eg. general workers, office and admin staff, etc.).

This model shows the dual requirement of the Medical Screening Programme to evaluate employees for both of these axes of risk. The programme should ensure that minimum medical requirements are met by employees, and also that any adverse health effects from the exposure to hazards in the workplace are detected at an early stage, enabling effective remedial action to be taken. This is dealt with in detail in the Medical Surveillance guideline.

1.5 The meaning of physical & psychological fitness:

Sometimes the legislation calls upon the occupational health professional to certify that the applicant/employee is "physically & psychologically" fit to perform the tasks assigned to the position. This is a quirk of the legal interpretation of the concepts described above.

Here the term "physically fit" refers to the ability to meet the physical demands of the job, to the required performance standard and without undue risk of injury or illness to self or others.

The term "psychologically fit" refers to the absence of medical conditions of a psychological nature (cognitive or emotional) that may impair the applicant's/employee's ability to meet the demands of the job, to the required performance standard and without undue risk of injury or illness to self or others.

Psychological fitness does not imply that a "psychological" test is required. Remember that the certification is to be provided by an Occupational Medicine Practitioner, NOT a psychologist. Furthermore, psychological testing as a screening tool for fitness to work adjudication *is forbidden* by the Employment Equity Act (section 8), unless it is validated.

Summary:

From the above it is clear that a central theme in the concept of "fitness to work" is that of required minimum "standards of fitness", or "inherent requirements". These minimum standards of fitness can be regarded as the factors that are required for specific occupations, and are determined by the capability & exposure risk profiles of those occupations. These minimum standards need to be established in a way

that is fair and rationally defendable and expressed in a way that is measurable, to ensure consistent application.

2 LEGAL REFERENCES

1. The Employment Equity Act 55 of 1998.
2. The Code of Good Practice on the Employment of People with Disabilities (19 August 2002, No. 237183) (linked to the Employment Equity Act)
3. The Labour Relations Act No 28 of 1956 as amended in 1996.
4. The Occupational Health and Safety Act (OHSA), No 85 of 1993 and Regulations.
5. The Mines Health and Safety Act (MHSA), No. 29 of 1996 and Codes of Practice.
6. The other Codes of Good Practice (including Hours of Work, Pregnancy, HIV & testing, Disability, etc.)
7. The Basic Conditions of Employment Act 75 of 1997 (BCOEA)
8. The National Road Traffic Act No. 93 of 1996, and Regulations.

Various statutes and regulations, guidelines and guidance notes published in terms of these statutes govern fitness to work. This is now covered in the Roles & Responsibilities of OH staff Guideline. The provisions relevant to work fitness and disability are summarised below.

Occupational Health and Safety Act 85 of 1993 (OHSA)

The OHSA provides for the protection of the health and safety of employees and other persons at companies and requires risk assessment, exposure measurement and risk control. The duties of employers in this regard are stated clearly (section 8). The ways in which this act refers to fitness to work is largely within it's regulations, such as the construction regulations, driven machinery regulations, hazardous chemical substances regulations, the hazardous biological agents regulations, the lead regulations, and the noise induced hearing loss regulations.

Mine Health and Safety Act 29 of 1996 (MHSA)

The MHSA also provides for the protection of the health and safety of employees and other persons at companies and requires risk assessment, exposure measurement and risk control. It is a specific requirement of each company to establish a number of Codes of Practice, one of which is a Code of Practice for the minimum standards of fitness to perform work on a mine".

Labour Relations Act 66 of 1995 (LRA) (Chapter 8: Unfair Dismissal, and Schedule 8: COGP – Dismissal)

The LRA regulates unfair dismissal and unfair labour practices directed at employees, including disabled employees. In terms of the LRA, dismissal of a person solely on the grounds of disability is automatically unfair, and constitutes an unfair labour practice.

Conversely, the Act provides mechanisms for the fair dismissal of an employee who is incapable of doing his or her job because of poor health or injury. Such a dismissal must be both *substantively* and *procedurally* fair. (see appendix 3). Substantive fairness relates to the reason for the dismissal, i.e. the employee's ill health or injury. Procedural fairness relates to the manner in which the case is conducted, prior to the decision to dismiss. The detail of these instructions is contained in the document "Code of Good Practice: Dismissal", to which reference is made in the Act.

Employment Equity Act 55 of 1998 (EEA) (Chapter 2: Prohibition of Unfair Discrimination)

The EEA provides for the eradication of unfair discrimination in the workplace (including discrimination against the disabled) and affirmative action in the workplace in respect of Blacks, women and disabled persons.

The EEA makes provision for two defences against an allegation of unfair discrimination (section 6), namely:

- that the employer acted in terms of an affirmative action policy; or
- that the *inherent requirements* of the job are such that the disabled person would not be able to do the job.

Medical testing is also regulated. Medical testing of an employee is prohibited (section 7) unless:

- legislation permits or requires the testing (such as prescribed by the MHSA or the OH&SA); or
- it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the *inherent requirements* of the job.

Extract from the Employment Equity Act

7 Medical testing

(1) Medical testing of an employee is prohibited, unless-

(a) legislation permits or requires the testing; or

(b) it is justifiable in the light of medical facts, employment conditions, social policy, the fair distribution of employee benefits or the inherent requirements of a job.

(2) Testing of an employee to determine that employee's HIV status is prohibited unless such testing is determined to be justifiable by the Labour Court in terms of section 50 (4) of this Act.

The Basic Conditions of Employment Act 75 of 1997 (BCEA)

The BCEA contains a number of provisions that relate to the issue of fitness for work such as paid sick leave, **medical certificates**, maternity leave, protection of employees before and after birth of a child and night (shift) work. (See Appendix 7)

The provisions regarding sick leave do not apply to an inability to work caused by an accident or an occupational disease as defined in the COID Act, or in the ODMWA, except in respect of any period during which no compensation is payable in terms of these acts.

3 DEFINITIONS

There are no definitions for fitness to work, incapacity or impairment in South African law.

Inherent requirements of the job

The inherent requirements of a job refer to the physical, cognitive and psychological demands necessary to safely complete the essential tasks of a job, to a satisfactory standard (quality & efficiency).

Minimum medical standards of the job (Inherent health requirements)

The minimum medical standards of a job are the minimum physiological thresholds of function, or the degrees of tolerance for physical, emotional or psychological dysfunction, necessary to meet the inherent requirements of a job, safely and effectively.

Impairment

Impairment refers to a partial or total loss of a bodily function or body part. These could be “physical impairments which include functional losses of organ systems, such as hearing, vision, muscles, joints, etc. They could also be “mental” impairments, which include clinically recognized conditions or illnesses that affect thought processes, judgment or emotions.

Incapacity

Incapacity is present when an employee is unable to fulfil the inherent requirements of the job; this may be on the grounds of ill health or simply poor performance.

Disability

A disability is a long-term or recurring physical or mental impairment, which substantially limits prospects of entry into, or advancement in, employment.

This is derived from section 1 of the Employment Equity Act defines people with disabilities as “*people who have a long-term or recurring physical or mental impairment, which substantially limits their prospects of entry into, or advancement in, employment*”.

The impairment may either be physical or mental or a combination of both.

- Long-term - the impairment has lasted or is likely to persist for at least twelve months.
- “Recurring - is likely to happen again and to be substantially limiting (see below). It includes a constant chronic condition, even if its effects on a person fluctuate.
- ‘Progressive conditions’ are those that are likely to develop or change or recur. People living with progressive conditions or illnesses are considered as people with disabilities once the impairment starts to be substantially limiting. Progressive or recurring conditions which have no overt symptoms or which do not substantially limit a person are not disabilities.

- Substantially limiting - in its nature, duration or effects, it substantially limits the person's ability to perform the essential functions of the job for which they are being considered.
- Some impairments are so easily controlled, corrected or lessened, that they have no limiting effects. For example, a person who wears spectacles or contact lenses does not have a disability unless even with spectacles or contact lenses the person's vision is substantially impaired.
- An assessment to determine whether the effects of an impairment are substantially limiting, must consider if medical treatment or other devices would control or correct the impairment so that its adverse effects are prevented or removed.

For reasons of public policy certain conditions or impairments may **not be considered disabilities**. These include but are not limited to —

- sexual behaviour disorders that are against public policy;
- self-imposed body adornments such as tattoos and body piercing;
- compulsive gambling, tendency to steal or light fires;
- disorders that affect a person's mental or physical state if they are caused by current use of illegal drugs or alcohol, unless the affected person is participating in a recognized programme of treatment;
- normal deviations in height, weight and strength; and conventional physical and mental characteristics and common personality traits.

Hence:

- A relatively minor impairment, the loss of a finger, would be both a major disability and an occupational handicap to a concert pianist, but not to a labourer.
- A relatively common impairment, defective colour vision, limits the ability to discriminate between certain hues. This may occasionally be a disability at work (eg. quality control technicians in the textile industry).

More about Impairment & Disability in Appendix 2.

4 APPROACH TO SETTING UP A CERTIFICATION AND ADJUDICATION PROCESS

The process of certification of fitness to work can be regarded as comprising three phases (see algorithm in Appendix 4).

1. Setting minimum medical standards of fitness, derived from OREPs.
2. Test selection & test frequency
3. Outcomes management. (ie. management of incapacity and disability).

The first two steps are dealt with in the Management Guide for Medical Surveillance/Testing.

This Guide focuses on the third step; the management of the employee found to be "unfit".

It is particularly useful to set up a database of people with incapacities, and to establish a regular forum (ie "Incapacity Management Committee") at which these cases are addressed. The adjudicating panel should include all relevant stakeholders, including HR, line management occupational health and even shop stewards.

4.1 The roles of these stakeholders include:

Human Resources:

- Provide the profile of sickness absence utilisation
- Provide a review of the possible entitlements or benefits available (disability insurance, provident fund, early retirement option, etc.)
- Maintain the list of incapacitated (or disabled) employees on the company payroll
- Keep the minutes of the meetings

Line Management

- Provide a review of the areas in which the employee's work performance is sub-standard.
- Provide an understanding of what the requirements of the job are, and the degrees to which the incapacity may be accommodated.

Occupational Health

- Provide an understanding of the medical issues, including:
    - The extent and duration of the incapacity (via access to relevant medical reports)
    - The prognosis for return to work, and probable maximum medical improvement

Shop Stewards

- Act as an ombudsman for the employee, so as to reassure the employee that his/her interests are being fully considered

4.2 The procedure for the Incapacity Management Committee meetings:

The aim of the meetings is to ensure that cases are handled as efficiently and fairly as possible, either ending with effective deployment to work, or separation with applicable benefits. This is achieved through the availability of all the required information and relevant people at a single forum.

Each quarter, the Incapacity Management Committee convenes a meeting, chaired by Human Resources or a senior line manager, at which each case of incapacity on the Incapacity database is presented, and progress is discussed. If information that is needed for decisions to be taken, the appropriate members of

the committee are given the responsibility to close the gaps, and feedback is required at the next meeting (or sooner, as appropriate).

The proceedings are the meetings are minuted, so as to ensure effective case-tracking and task delegation.

5 THE EMPLOYEE FOUND TO BE "UNFIT" DURING MEDICAL SCREENING

The status, "unfit", can be considered in the same way as for incapacity (next section).

6 STEP-WISE APPROACH TO HANDLING THE INCAPACITATED EMPLOYEE

See the algorithm in the appendix.

Important:

The evaluation of the severity of the impairment is the main area of expertise of any medical professional. The focuses of impairment evaluation is on the loss of function of, or damage to, organs or organ systems. It makes **NO** attempt to translate this into a "Fitness to Work" or "Disability" decision.

However, the evaluation of the incapacity is the main area of expertise of the occupational medical professional. He/she decides whether or not the impairment is an incapacity.

The evaluation as to whether the incapacity is a disability is complex, and often involves legal interpretation.

Ultimately, the differentiation between incapacity & disability is often of little value, as the management of the two is practically identical. Arguably, the distinction may be of value, as there is greater pressure on the employer to accommodate a disability than an incapacity.

The first step in handling incapacity is to identify the key contributory factors. These areas summarised in the following table.

Table 2: Key factors to consider when handling incapacity.

Employee factors (the impairment)	Workplace factors (the setting)

• Impact on the job ("extent")
• Prognosis: treatable? If so,
  ○ When will employee return to work ("duration")?
  ○ What will be the residual impairment after treatment ("maximum medical improvement")?
	• Any adjustments possible, by which to reduce the impact of the incapacity?
	  ○ Physical (access, workstation, etc.)
	  ○ Administrative (work hours, conditions of service)
	• Is redeployment possible, even if temporary?

These steps are further discussed below:

6.1 Step 1: How severe is the incapacity (**extent**)?

This is the degree of severity or impact of the failure to meet the inherent requirements of the job. ie. The possible consequences, should the person continue working in that occupation. Many of the inherent job requirements, particularly the exclusions, are *relative* exclusions rather than *absolute*.

- Relative exclusion: this is a failure to meet the minimum standard of fitness, but the consequences of which to not automatically render the applicant unfit. A measure of decision latitude exists, according to circumstance.
- Absolute exclusion: this is a failure to meet the minimum standard of fitness, the consequences of which automatically renders the applicant unfit. No decision latitude exists.

The task of the Occupational Health Practitioner is to gather all relevant information regarding the extent of the incapacity, based on reports from appropriate practitioners, and, where relevant, on his/her own examination. Using all this, and applying his/her knowledge of the workplace, the OHP determines fitness to work.

(Note: in complex cases, or where the law requires it, the assessment may have to be conducted by an Occupational Medicine Practitioner.) In this case, the preliminary work of gathering information is done by the Occupational Health Nurse Practitioner.)

6.2 Step 2: Is the incapacity treatable? (**permanent/temporary**)?

Is the impairment treatable under optimal conditions? If a medical treatment is available, the condition should be regarded as temporary.

Unfortunately, many factors influence this, including the reality that some conditions are treatable but the optimal medical treatment is not available for various reasons (financial, geographic or even cultural).

Once the decision is made that the incapacity is permanent, a decision needs to be made as to whether or not the incapacity can be accommodated, with workplace adjustments.

6.3 Step 3: If treatable, how long to maximum medical improvement (**duration**)

Whilst the period of recovery is often difficult to predict, estimates are useful for company management, as the matter requires human resource planning. Often estimation in terms of “days”, “weeks” or “months” is sufficient. If the incapacity is to last longer than 2 years, it is deemed to be permanent, and is handled accordingly.

The duration of the incapacity may have a significant influence on whether or not the employer can accommodate it, especially if the recovery may only be partial.

6.4 Step 3: Return to work (**re-integration**)

After considering the extent and prognosis of the employee's incapacity, a clearer understanding of the possibility of returning to work is possible; whether this be to the employees' original occupation, or an alternative.

Important: the return to work may happen at any stage of the journey to maximum medical improvement, even if this is in a position which is a "temporary accommodation", by addressing various "workplace factors". See table above.

The next important decision point is when the employee has reached "maximum medical improvement", and a decision has to be made regarding whether or not he is fit to return to his own occupation.

Key aspects to consider:

- Is there any residual incapacity?
    - If so, the employer will be required to seek ways in which to accommodate the incapacity (reasonable accommodation), through addressing the "workplace factors".
    - At this point, the employer may require the assistance of an experienced occupational therapist, who will evaluate the employee's functional capacity, and attempt to match this with available workplace options.
- At this phase of the "return to work" sequence, the role of the physiotherapist, occupational therapist and biokinetician is essential for an optimal outcome. Rehabilitation flows into reintegration. At the reintegration phase, when workplace accommodation is contemplated (especially redeployment), the key question to ask is "What can this person do?" This is in contrast to the previous phase, in which the key question is "What can this person NOT do?"?

Depending upon the severity of the residual incapacity or disability, the employer is required to attempt to accommodate the employee. The following issues should be addressed:

- Can the affected employee be **re-deployed** in an alternative effective occupation, even if this means a reduction in income? Where available, the pension provident fund could be approached for a "top-up" of the reduced income. This is a favourable option for the insurance fund, as it constitutes a far lesser cost than a payout for total disability.
- If not, can the affected employee be **re-trained** to meet the requirements of an alternative effective occupation?
- If none of the above, can the employee's **occupation (or any other occupation) be reasonably adjusted** to accommodate the disability, which affects the relevant employee? This could include:
    - engineered adjustments, such as re-designed work area (ramps, etc.), re-designed work station (alterations to surface height)
    - administrative adjustments, such a reductions in hours of work (such as a "5-8ths" post), or restricted duties

At this point, thought needs to be given to whether or not the "incapacity" constitutes a "disability", in terms of the EEA legal definition. (see definitions above). If this is a disability, the employer should follow the guidelines prescribed in the Code of Good Practice for the employment of employees with disabilities.

- If the employer still cannot accommodate the employee, even by addressing the workplace factors (the accommodation would cause undue hardship),
    - Are there any insurance options that would facilitate on-going employment ("top-up" insurance,
    - If not,
        - Are there any insurance options available to sustain the unemployed person (disability pension) (step 4 below)?

Rehabilitation generally begins whilst the affected person is under medical treatment (even as early as whilst the employee is still in hospital). It is all about the *restoration of optimal function*, given the circumstances of the impairment. Programmes follow different courses, including complex psychomotor skills training, and restoration of fine motor control, gross motor strength, and mechanical range of motion. An important element of rehabilitation, particularly regarding employees involved in major accidents, is aimed at minimising the psychological effects of the injury. Work readiness is generally a function of physical capability and emotional readiness. Sometimes intervention measures may be psychological, such as for employees with post-traumatic stress disorder. This is sometimes identified by an unexplained delay in return to physical readiness.

In circumstances in which the working conditions are particularly hostile, such as in the underground mining environment, the return to work process should not be too hasty. Some mining complexes have the advantage of simulated underground environments, where rehabilitating employees can be *re-integrated* to the underground environment in a safe and controlled manner. Structured incremental task requirements are given to the participants of the programme and their progress is monitored and scored. As their performance improves so does their confidence in their ability to return to work. Protracted recovery times are identified readily and the appropriate intervention measures can be implemented without delay.

6.5 Step 4: Are there are **benefits or entitlements** applicable (compensation or disability award)?

These entitlements come in various forms. For employees with *occupational* injuries or illnesses, there is a statutory entitlement, which is provided for under the Compensation for Occupational Injuries and Diseases Act (COIDA), administered by the Department of Labour. For employees of mines, quarries, and "Works", they are covered by COIDA and also by the Occupational Diseases in Mines and Works Act (ODYMWA), administered by the Department of Health. This mechanism is activated by means of the relevant reports, which are submitted to the relevant authority.

Affected employees who are not covered by statutory compensation mechanisms have the following further options to be considered:

- Permanent disability application from a private insurance company
- Access to provident fund entitlements proportionate to the affected person's contributions.
- Ex-gratia award made at the discretion of the company.

These three options are dependent upon what benefits or entitlements are available. The most beneficial of these is a *permanent disability* award, which is *subject to the provisions of the relevant insurance product*.

Provident fund payouts follow a less complicated course. When the decision is reached that the employee is no longer employable, the provident fund is notified and the relevant entitlements are requested.

The ex-gratia ("out of gratitude") award to which is referred above, is an optional payout, which is made at the discretion of the company, by the company, to the employee. This is a kind of "golden handshake", a reward for good work, to employees who have been financially disadvantaged by their circumstances.

6.6 Regular communication (**counselling**)

Where no misconduct is established, the employee should be informed that the excessive sickness absence (or poor performance) has negative operational implications. It should be pointed out that the employee might ultimately be dismissed, unless there is an improvement in his/her attendance.

The counselling session should focus on:

- The negative operational consequences for the employer, of the poor performance
- Sickness does not provide an indemnity from performance appraisal
- Action should be taken to rectify the absence profile (poor performance), with an agreed schedule (time-span) for improvement
- The consequences if the situation does not improve.

The Synergee forms provide useful templates by which to conduct these counselling sessions and written warnings.

The exact requirements in terms of how many informal discussions, formal counselling sessions, warnings (verbal and written), varies according to circumstance. Legal opinion indicates that this is determined by permutations such as:

- How critical is the attendance (and optimal function) of the appropriate employee, on the operation? The more critical, the greater the demand to return to effective work, with commensurately reduced tolerance on the part of the employer.

- How easily can an alternate person be found to replace the employee, temporarily? For employees that are easily replaced temporarily, there should be greater tolerance for the absence or incapacity.

Some important points:

Point 1: An employer is not obliged to create a new post for the incapacitated employee, even for work-related illness.

However, the employer who rules "undue hardship" will have to demonstrate that all attempts at accommodating the employee have been made.

Point 2: The examining doctor does not make the decision regarding disability.

It should be emphasised to the relevant affected employee that this is an application for a permanent disability payout and is subject to the decision of the insurer (including statutory funds, such as the Compensation Commissioner). At no stage should the responsible medical practitioner lead the employee to believe what the final outcome of the application will be. This sometimes leads to unreasonable expectations and drastic disappointment.

Point 3: The insurer, not the company, decides on the eligibility of a claim.

A relationship should be established between the employee, the employer and the responsible medical practitioner such that this is a combined effort in order to obtain the maximum possible benefit on behalf of the employee. However, the ultimate decision regarding whether or not a claim will be paid out lies with the insurer. All too often the employee is under the impression that it is the company that provides the payout and makes the decision regarding illegibility for the award. This should be clarified and it should be understood that all three are combining their efforts in this application to the insurance company.

Point 4: The pay-out is subject to the provisions of the insurance product purchased by the employer.

Various insurance products exist in the market. These vary in complexity and in their provisions. The worst of these is the product that provides only for employees with permanent disabilities that render them *totally unemployable* in the marketplace. This is a cheap group insurance product, previously widely purchased by companies, but which, fortunately, is seen less frequently today. A preferred option is cover for disability to perform specific work, such as the work in which the employee was involved when the disability occurred. This insurance product makes available a sum of money that the affected employee can use whilst re-engaging a new type of work. This provides a sort of "bridging finance" for a change of career. Some insurance companies also insist on a periodic review of the affected person in order to establish that they are indeed permanently disabled. This may take the form of a medical review every two years to establish whether or not some form of rehabilitation programme might not enable the affected employee to return to effective employment, thereby releasing the insurance company of its obligation of continued payments, as well as restoring the affected person to normal active life (a kind of win-win situation).

7 Document History

Version Number	Change	Date
06	COIDA requirement added to section on statutory Certifications required in occupational health.	07/06/2009
07	Appendix 1 removed - What qualifications are required to adjudicate on fitness to work (was in the fitness to work guideline)	09/06/2009
08	Substantive re-write of the whole section covering fitness to work. Inclusion of the Incapacity Management Committee. Removal of the algorithm of the "overall program", as this is covered in the Management guide on medical surveillance. Removal of the management of sickness absence management (now in a separate document).	26/11/2009
09	Amendments to the table summarising the meaning of "Fit" and "Not Fit".	10/01/2010

8 APPENDIX 1: Who is legally mandated to adjudicate on fitness to work?

This is now covered in the Roles & Responsibilities of OH staff Guideline.

9 Appendix 2: The concepts of Impairment & Disability

"Impairment"

The term "impairment" refers to specific deviations from the functional capabilities that would be expected of an average healthy individual. Hence losses of hearing or lung function, or a joint which loses a certain degree of it's range of motion, are all references to impairments. These impairments are NOT necessarily disabilities, nor do they render a person automatically "unfit". The degree to which the impairment becomes a disability is determined by the degree to which the impairment impacts on a variety of issues, such as the ability to earn an income, or to function independently in society (see later in this introduction).

An example of an impairment that does not translate automatically into a disability is that of hearing loss. The formula that is used widely for calculating disability for hearing loss (and, therefore, compensation), places a much higher weighting on the frequencies that affect speech, than those in the very high frequencies. Hence the impairment can be substantial, with a calculated disability of zero.

The difference between impairment and disability is particularly important. It is important to remember that the members of the medical evaluation team should only focus on the level of impairment and should try to avoid making inferences regarding the degree of disability, which should be left to the insurer (who will be guided by professionals knowledgeable in insurance medicine).

"Disability/Disablement"

The term "disability" refers to an impairment, which prevents the person from accomplishing certain tasks, or from performing an occupation, thereby impacting on his/her ability to live a normal life, or to earn an income. The calculation of disability is therefore complex and is determined by legal, ethical and actuarial influences. The process of converting impairment to disability is important to the insurance industry, and also in the awarding of damages in legal claims.

The scope of protection for people with disabilities in employment focuses on the effect of a disability on the person in relation to the working environment, and not on the diagnosis or the impairment. A closer look at these definition elements is warranted:

As described above, the Compensation Commissioner has established tables that enable the conversion from impairment to disability. Examples include the tables for loss of hearing and loss of lung function. Interestingly, the COIDA uses the term "*disablement*", rather than the more widely used term, "disability".

Note that a person with a disability is not necessarily unfit for the job which they hold. An example of this is an employee who loses the tip of a finger in an accident (thereby incurring a disability), but who is still perfectly able to continue in his/her job. Hence the disability only renders the person "unfit", if it changes their health status in a way that becomes an "exclusion" in terms of the job's "inherent requirements" (see above).

9.1 Grades of impairment and disability

In order to improve consistency in medical adjudication, and therefore the calculation of disability, impairments should be graded in a structured and objective manner. Various grading systems have been developed around the world for this very reason. Probably the most well established is the AMA Guide to the evaluation of Permanent Impairment. This is a complex and detailed methodology for the measurement and calculation of impairment, based on deviations from an established "norm".

The COID Act makes extensive use of the grading of impairment, and provides mechanisms by which the measured impairments are converted to disability. Examples include:

- Internal Instruction 171 (Hearing impairment and Disability)
- Internal Instruction 157 (Musculoskeletal impairment and Disability)
- Schedule 2 of the COID Act.

Another commonly applied example is the classification of impairment of lung function established by the American Thoracic Society (ATS):

Table 3: Grading of severity of loss of lung function (ATS).

ASSESSMENT OF SEVERITY	NORMAL	MILD	MODERATE	SEVERE
ATS GRADING (%)				
FVC (% predicted)	>80	60-79	51-59	<50
FEV1 (% predicted)	>80	60-79	41-59	<40
FEV1/FVC (%)	>75	60-74	41-59	<40

Point to Ponder:

When one refers to an employee being impaired or disabled, there are two important descriptors that should be used to define the problem for completely. These are:

1 Extent

2 Duration

Extent of disability (impairment):

Total Disability

This refers to a disability, which renders the affected person totally unable to perform any form of recognised occupation.

Partial Disability

This refers to a disability, which interferes specifically with tasks or activities that render the affected person unable to perform certain occupations only.

Duration of disability (impairment):

Temporary Disability

This refers to a disability, which affects a person for a discreet and temporary period of time. This may be brief, such as somebody with an injury, which recovers within a few days to weeks, or may be long, such as a person with an illness or injury with a prolonged convalescence (tuberculosis, major injuries).

Permanent Disability

This refers to a disability, which affects the person permanently, or which is untreatable. A typical example of this would be noise-induced hearing loss, spinal injuries, silicosis and asbestosis. To the Compensation Commissioner, “permanence” also has an administrative definition of “permanent” – conditions which have a temporary disability for longer than two years are regarded as “permanent”. This is in order to prevent protracted case dockets. This is not so in the private insurance industry, which often continues to review even long-term cases every one to two years, in order to ascertain whether or not the affected party has recovered sufficiently to reverse the status of “disabled”.

Hence the permutations of these circumstances are as follows:

Temporary partial disability (TPD): this refers to those employees on “light duty” (able to perform alternative, less demanding work). It should be remembered that the practice of making available light duty is not universally practiced in companies – this is something negotiated between the company and the employee.

Temporary total disability (TTD): this is the situation for employees on sick leave or accident leave. They are totally unable to continue in their usual occupation and are sent home (or to hospital) to recover.

Permanent partial disability (PPD): this applies in the same manner as temporary partial disability, but the disability is permanent. That is to say it is not medically treatable.

Permanent total disability (PPD): this applies in the same manner as temporary total disability, but the disability is permanent. That is to say it is not medically treatable.

10 Appendix 3: Substantive and Procedural "Fairness".

10.1 Substantive fairness

Factors that should be considered to ensure substantive justice are the following:

- Is the employee capable of doing the required work and fulfilling his tasks?
- The type, severity and duration of the disability
- Is absence from work temporary or permanent? (Medical information is of major and decisive importance)
- The impact of this on the employer's operations
- The size of the employer's business
- The length of the person's employment
- The cause of the disability (in case of alcohol – or drug abuse, for instance, the employer should consider reasonable aid by way of consultations and rehabilitation)
- Can the post possibly be adapted to accommodate the employee?
- Possibility of alternative suitable posts before dismissal.

Where an employee's disease or disability is related to his work, the obligations of the employer increase.

Two factors are decisive when establishing what weighting the length of absence should carry when making decisions:

- The need of the employer to replace the employee with a healthy worker (the type of post held and the size and nature of the business concern is of importance in this case), and
- The effect the employee's absence has on other employees, e.g. are they expected to work overtime to do his work?

10.2 Procedural fairness

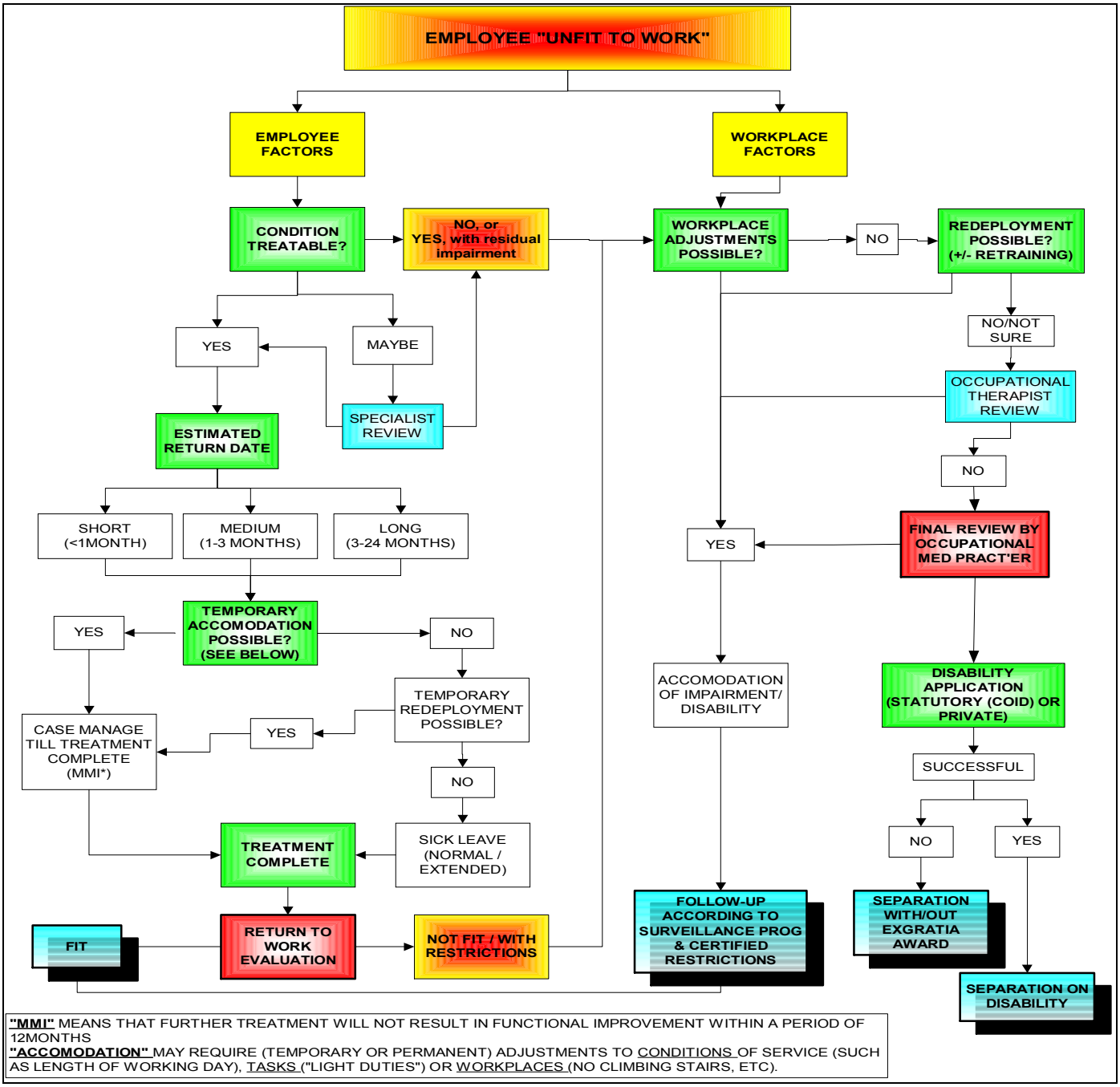
To ensure a fair and just process in case of disability caused by disease or an accident, it is necessary to establish all the facts. The employer should be part of the process by way of consultation. Discussions should be held with the employee, to ensure that the impact of the absence on the normal operation of the company is fully understood.

The employee must be aware that sick leave may only be used in genuine cases of illness and that it is not to be used as a type of annual leave without really being ill. The employee must also be informed that:

- Regular absence causes operational problems;
- The company and other workers have expectations about the attendance and work performance of a co-worker.

11 Appendix 4: Algorithm for the Medical Adjudication Sequence in Fitness Certification

The following algorithm clarifies the steps associated with medical adjudication.



12 Appendix 5: World Health Organisation and disability

The most commonly cited definition of disability is that of the World Health Organisation, which draws a three-fold distinction between impairment, disability and handicap, each defined as follows.

- An *impairment* is any loss or abnormality of psychological, physiological or anatomical structure or function
- A *disability* is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being;
- A *handicap* is a disadvantage for a given individual, resulting from an impairment or a disability, that prevents the fulfilment of a role that is considered normal (depending on age, sex and social and cultural factors) for that individual'.

According to activists in the disability movement, the World Health Organisation has confused the definitions of 'disability' and 'impairment'. They maintain that impairment refers to physical or cognitive limitations that an individual may have, such as the inability to walk or speak. In contrast, disability refers to socially imposed restrictions, that is, the system of social constraints that are imposed on those with impairments by the discriminatory practices of society.

According to the United Nations Standard Rules on the equalization of Opportunities for Persons with disabilities:

- The term "disability" summarizes a great number of different functional limitations occurring in any population in any country, of the world. People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. Such impairments, conditions or illnesses may be permanent or transitory in nature.
- The term "handicap" means the loss or limitation of opportunities to take part in the life of the community on an equal level with others. It describes the encounter between the person with a disability and the environment. The purpose of this term is to emphasize the focus on the shortcomings in the environment and in many organized activities in society, for example, information, communication and education, which prevent persons with disabilities from participating on equal terms.
- The use of the two terms "disability" and "handicap", as defined in the two paragraphs above, should be seen in the light of modern disability history. During the 1970s there was a strong reaction among representatives of organizations of persons with disabilities and professionals in the field of disability against the terminology of the time. The terms "disability" and "handicap" were often used in an unclear and confusing way, which gave poor guidance for policy-making and for political action. The terminology reflected a medical and diagnostic approach, which ignored the imperfections and deficiencies of the surrounding society.

In 1980, the World Health Organization adopted an international classification of impairments, disabilities and handicaps, which suggested a more precise and at the same time relativistic approach. The International Classification of Impairments, Disabilities, and Handicaps(3) makes a clear distinction between "impairment", "disability" and "handicap". It has been extensively used in areas such as

rehabilitation, education, statistics, policy, legislation, demography, sociology, economics and anthropology. Some users have expressed concern that the Classification, in its definition of the term "handicap", may still be considered too medical and too centred on the individual, and may not adequately clarify the interaction between societal conditions or expectations and the abilities of the individual. Those concerns, and others expressed by users during the 12 years since its publication, will be addressed in forthcoming revisions of the Classification.