the Food and Canning Workers' in the Western Cape already have medical benefit schemes that have been in existence for many years (2). Other unions feel that they are still too weak organisationally to introduce an industrial health care system because it will detract from the essential task of the union which is to have strong shop-floor representation. Unions are therefore at different positions regarding the provision of health services to workers. Regardless of these differences I would like to propose the following industrial health care system for the consideration of worker organisations. Although particular aspects of the system may not be suitable or relevant to certain unions, the most important feature of the system is the principle upon which it is based. These are that workers should increasingly assume responsibility for their own health and safety and that unions should introduce and use health care systems to strengthen their organisation, not to weaken it.
The basis of the scheme should be the factory where workers elect their own factory health workers as members of a health and safety committee. This committee will operate as a sub-committee of the shop stewards committee and bring to the attention of shop stewards those issues regarding health and safety that require negotiation with management. If the union deems such a health and safety committee to be redundant, the shop stewards committee itself could assume full responsibility for health and safety issues in the factory. There is, however a danger that they could neglect these issues because of the shop stewards many other responsibilities.

The factory health workers would primarily be responsible for the health and safety needs of the workers within their own factories. Insofar as it is possible they must be acquainted with the legal requirements which the firm has to comply with in order to protect workers from industrial diseases and accidents. They could strive to ensure that management complies with these requirements. This would require the participation of the union and entail discussing health and safety issues with workers.

doctor. Other duties would also include the training and supervision of both the factory and clinic health workers, delegating to them as much responsibility as is possible.

The doctor would thus become a consultant, trainer supervisor and researcher. The training of health workers and nurses would be monitored or undertaken by him where necessary. An important function of the doctor would be to research the incidence and causes of industrial diseases and accidents. This information would be fed to the trade union to strengthen its hand in negotiating with management and statutory bodies. Regular meetings between the doctor, nurses, clinic and factory health workers will be necessary to make certain that the health service is geared to the needs of the workers.

These proposals are not meant as blue-prints for trade unions to implement, but as concrete ideas which they can consider (and accept or reject) when they are developing their own industrial health care system. There is, however, an important distinction to bear in mind with regards to the provision of health care to workers. This distinction rests on the role workers play in it. They can either passively receive medical services from the clinic at the exclusive hand of doctors, dentists and nurses. In such a case the union plays the role of purely a benefit society. Or the workers can actively participate in the provision of their own health and safety in co-operation with the medical personnel. In such a case the union would be increasing its bargaining power by organising workers on issues that are of immediate relevance to them and their families. Workers' health and organisation would thus be closely linked to each other.

FOOTNOTES

1. See South African Outlook, Vol. 108, No. 1288, Oct. 1978, for some papers delivered at the Conference that are relevant to this article. Also see Social

The reasons for, and adequacy of, the safety regulations and clothing might, for instance, be discussed. The factory health workers should be trained to identify the industrial diseases that workers are most likely to contract at their work-place. They should keep records of such cases and refer them to the trade union's health clinic which is described below. The factory health workers require training in first aid that is geared to the requirements particular to their factories in case of accidents or disasters. They should train workers to know what they have to do in case they fall ill or have an accident in order to make certain that workers receive their sick pay, Workmen's Compensation and any other benefits to which they are entitled. They must also check that the employers have the correct home address (urban and rural addresses in the case of contract and other workers with rural families) of an injured worker and his dependents who are entitled to Workmen's Compensation claims.

The health clinic of the trade union should be within easy reach of the workers. For that reason it need not be too rigidly tied to the union offices. The clinic should be staffed by health workers, nurses and a doctor. The health workers could be drawn from the industry the union serves and may be workers who would otherwise be unemployed. The clinic health workers would be trained in administering elementary health services such as dressing and sterilising wounds, taking temperatures and contact tracing. They could also handle administrative work by taking down personal records and details, helping in the dispensary, and so on.

The nurses would play an important diagnostic role. They could be trained, as is already happening in Soweto, in history-taking, examination, comprehensive patient care and counselling. This means they might deal with as many as 80% of cases presented, referring the remainder to the

Dynamics, Vol. 4 No. 2, for a valuable summary of the whole Conference.

2. See the Case Studies in the article by Diane Cooper in this Bulletin.