

A HEALTH GAP IN GHANA'S WORKMEN'S COMPENSATION ACT 1987 (PNDC 187): EMBRACING THE STARRING ROLE OF PSYCHOLOGISTS

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ABSTRACT

Background: Globally, thousands of deaths and disabilities occur because of work-related injuries. Research is replete with workplace safety strategies. However, workplace safety research is plagued with the lack of depth into the provisions of the law on compensation in the event of an accident. As a result of Ghana's legislation, each workplace accident case is adjudged and compensated for on the basis of quantifiable support to physical loss.

Purpose: The purpose of this paper is to highlight the gap in psychological considerations in compensating employees for work-related injury as it exists in Ghana's current Workmen Compensation Act of 1987.

Methodology: The paper uses an illustrative case study and adopt a content analysis of clinical documentation of a typical case of a man who suffered a work-related injury that resulted in both physical and psychological injury.

Findings: The inadequacy of solely acting on the recommendation of a medical officer in executing compensation to an accident victim was established. The discovery of Post-Traumatic Stress Disorder that had rendered the victim non-functional even after years of physical loss assessment compensation cements the limited nature of the provisions of the law. The provision of psychological intervention by mental health workers proved exhaustive in handling individual and family level psychological challenges. The Act allowed for the lapses in none psychological referral, intervention or assessment of damage from mental injury to estimate compensation. At the macro and micro level, Occupational Health and Safety is not of a priority in healthcare promotion and intervention in Ghana.

Practical Implications: Based on the findings, the authors advocate for a review of the Ghana's Workmen's Compensation Act to include psychologists, social workers, and other health practitioners to be involved in the assessment for compensation in work-related injuries. By application, the use of medico-legal criteria should be extended to medico-psycho legal criteria for determining compensations for victims of workplace accidents. It proposes a sensitization drive by the Mental Health Authority of Ghana and Ghana Psychological Association to the populace and the inclusion or expansion of mental health curriculum in other stakeholder's education.

Originality: This paper is has highlighted the need for psychological assessment and compensation for work-related injury in Ghana. The findings of this case suggest that compensation should encompass psychological disability as a result of workplace accident. The principle of the law should therefore be reviewed to incorporate psychologist and other mental health workers, to holistically assess and compensate victims of work-related injury in Ghana.

Keywords: Workmen's Compensation Act 1987, psychological injury, occupational health and safety, work-related injury, Ghana

INTRODUCTION

Work plays an important role in the mental well-being and health of many individuals and without employment many people may develop some mental health problems (McKee-Ryan, Song, Wanberg & Konicki, 2005). Many studies in some African countries such as Uganda, Nigeria, South Africa and Ghana have confirmed that people in Africa suffer similar psychological distress when they are unemployed (A Moran, Lawoyin, & Oni, 2005; Canavan et al., 2013; Muhwezi, Agren, Neema, Maganda, & Musisi, 2008; Myer, Stein, Grimsrud, Seedat & Williams, 2008). In Ghana, a study done by Canavan et al. (2013) showed that there is a lot of psychological distress suffered by the unemployed. Yet in as much as we need employment for our psychological health, some work may also inflict psychological injury. Canavan and his colleagues (2013) confirmed in their study shows that Ghanaian employees suffering psychological distress are responsible for a significant amount of lost productivity. Although the impact of unemployment on psychological wellbeing is well established, the type of work one does and other work related issues may also result in physical and /or psychological injury.

Mental health problems are a significant part of the world's burden of diseases and disabilities with five of the top ten leading causes of disability being mental rather than physical (Harnois, & Gabriel, 2000). Yet, the emphasis is mostly put on physical health without recognizing that health

is not 'merely the absence of infirmity or disease but a complete state of physical, mental and social wellbeing' (WHO, 1946).

Ghana is experiencing an ascendancy in industrialization with its resultant effect of employee exposure to work related injuries and death in certain cases (Adei & Kunfaa, 2007; Annan, 2010; Annan, Addai & Tulashie, 2015). Physically, such injuries may result from direct impact, ergonomics, mechanical and chemical hazards. In most cases, such work-related injuries arise from sources such as noise, vibration, fire, poor sanitation, radiation and extreme temperatures. Chemical hazards arise from liquids, solids, dusts, fumes, vapour and gases (World Health Organization, 2001). The ergonomics covers all aspects of a job including the physical stresses it places on employees' nerves, joints, tendon, bones and muscles as well as the environmental factors which in most cases can affect employees' vision, hearing, feelings and the general health and safety. In a sense, ergonomic hazards relates to equipment used and the work environment's adverse contribution to the comfort, efficiency, safety and productivity (Hagberg, Silverstein, Wells, Smith, Hendrick, Carayon, & Pirusse, 1995). Thus, all forms of accidents may cause injury physically and psychologically to employees with resultant social impact.

Many work accidents injuries and work-related diseases in Ghana are not reported (Annan et al., 2015). This may be partly due to the lack of and fear of voice. Many Ghanaians by orientation are socially oriented not to complain even on discomforts. Moreover, the high level of unemployment places those employed and are working in an unsafe work environment better off thereby promoting a culture of silence in the event of an accident. All the same, it appears that injury in the formal sector has become more of a focus while the informal sector is neglected. Reports indicate that the Ghanaian informal sector has an annual occupational injury rate of about 11.5 injuries/1,000 persons in the urban areas and 44.9/1,000 in the rural areas (Mock, Adjei, Acheampong, Deroo, & Simpson, 2005). Focus therefore is that certain aspects of work related injury has been neglected. The neglected bit of the injury that is hardly addressed is the psychological injury that may be directly work-related or a result of physical work related injuries (Adjotor, 2013).

Despite the fast industrialization seen in Ghana, the country does not have a governing body to ensure that the many fragmented legislative instruments and policies that seek to give workplace safety is coordinated (Agyemang, Nyanyofio & Gyamfi, 2014; Annan et al., 2015; Annan, 2010; Norman, London, Aikins & Binka, 2014). The Factories, Offices and Shops Act of 1970, Workmen's Compensation Law Act 187 (1987), and Labour Act 651 (2003) are the main legislative documents that advocate occupational health and safety in Ghana (Adei & Kunfaa, 2007; Annan, 2010). Thus, Occupational health and Safety is a neglected area in Ghana (Norman et al., 2014) and so is mental health (Roberts, Morgan & Asare, 2013).

Piavi, Kaija, and Jukka, (2009) in their study revealed that Ghana's poor health and safety practices result in high injury rates with recorded fatalities increasing from 1,852 cases in 1998 to 9,661 in 2005. Such occupational injuries are pervasive in both urban and rural areas. In the urban setting, transport related injuries were the largest accounting for 12.7% and traders (19.4%), most of which were road-traffic-related. Since Ghana's economy is supported by almost 60% of farmers, it was not surprising in the rural areas, most injuries (71.6%) were to farm workers. Common among these injuries were falls, burns, machine and vehicle related accidents. Even though current official statistics on occupational accidents is practically difficult to ascertain, that of the transport sector exist. According to the Motor Traffic and Transport Department (MTTD) of the Ghana Police Service, 2076 and 2084 people died out of transport related accidents (MTTD, 2017). It is also reported that 12522 and 12166 individuals suffered minor to severe injuries in 2016 and 2017 respectively (MTTD, 2017). It is conclusive that work-related injuries are becoming a weightier burden in Ghana.

Data from the Ghana Health Service and Ministry of Health (2012) shows that many workers in the manufacturing sector suffer injuries such as slips, falls, burns, and electrical shocks. Little

emphasis is placed on workplace health and safety measures by Ghanaian employers (Agyemang et al., 2014, Oppong, 2010). It is clear from the statistics shared that, much of the focus has been on the physical injury reports. To the best of our knowledge, there is no data on work related psychological injury in Ghana. There is the need to give recognition to work related psychological injuries and disabilities as much as is given physical injuries. This is because psychological injuries can often be extremely disabling and distressing for the sufferer than is with physical injuries. Most physical injuries may invariably elicit untold hardship on immediate family members creating more psychosocial concerns.

Ghana's Workmen's Compensation Act does not take cognisance of psychological injuries and therefore the Act leaves a gaping wound in the area of injury evaluation and extent of damage for which the injured worker and immediate family can be compensated. On the contrary, in line with international best practices, some African countries such as South Africa and Nigeria (Compensation for Occupational Injuries and Disease Amendment Act of South Africa, 1997; Employee Compensation Act of Nigeria, 2010) have revised their existing laws to incorporate compensation for mental health injuries. It must be mentioned that any work-related accident could potentially lead to a mental health problem. Indeed, workers who are injured need to be compensated for their total loss and not merely the physical loss as the indirect cost to the worker may far outweigh the direct cost of injury (Adjotor, 2013). When workers compensation schemes are unable to provide adequately for the individual workers, the cost is not limited to the individual but ripples onto the family and the community as a whole (McPhilbin, 2012). Occupational health seeks to ensure the wellbeing of workers and the WHO /ILO definition (1950) does not limit, its scope only to occupational medicine but rather extends to occupational hygiene, psychology, safety, physiotherapy, and rehabilitation to mention a few (Hughes & Ferrelt, 2008).

This paper uses a case example to make an argument for the need to define injury and damage to the worker in terms of a more holistic biopsychosocial rather than a biomedical perspective. It looks at Ghana's workmen's compensation Act 1987 (PNDC 187) as it exists presently and advocates for the need to expand the medical damage to include psychological injury so that psychologists can be part of the assessment or evaluative phase of damage to the injured worker. The paper also elaborates on the starring role of psychologist in compensations as there could be other extenuating psychosocial effects on family members of victims of workplace accidents. The paper concludes with a clarion call for immediate review of Ghana's Workmen's Compensation Act to embrace contemporary issues of compensations.

GHANA'S WORKMEN COMPENSATION LAW AND THE PHYSICIAN'S ROLE:

Ghana has in place legislations and policies that would ensure that its worker populace both in public and private sector are protected from unsafe hazards in the rendering of their duties. The Constitution of Ghana's provision for work related health and safety, the Labour Act 2003 [Act 651], Factories, Offices and Shops Act, 1970 [ACT 328], the Mining Regulations, 1970 [LI 665], the Radiation Protection Instrument, 1993 (LI 1559), and the Workmen's Compensation Act 1987 [PNDC 187] (Annan, 2010; Norman, et al., 2014) all seek to give occupational health and safety protection to the Ghanaian worker.

This paper however explores the Workmen's Compensation Act 1987 [PNDC 187] which elaborates the role the physician plays in worker compensation claims. Indeed, the physician serves as the fulcrum on which the workers' claims hinge. Norman et al. (2014) argue that there are a number of challenges that face the Ghanaian worker in successfully going through the process of compensation claims which includes the '*burden*' placed on the physicians in the determination of degree of disability in work-related injury or disease.

The Workmen Compensation Law 1987 (PNDC 187) is a law that relates to employees in public and private sector to benefit from a compensation for accidental personal injuries in the work setting. The law states in section 2(3) and 2(4) as follows:

“Where an attending medical officer assesses an Incapacity in respect of an injured employee, the employer shall pay the injured employee compensation commensurate with the incapacity so assessed” [Workmen Compensation Act 1987 PNDCL 187 Sec. 2(3)] and “...where the injury results in death or serious and permanent incapacity, the Court on consideration of the circumstances, may award the appropriate compensation under this Act” [Workmen Compensation Act 1987 PNDCL 187 Sec. 2(4)].

By these two points, it behooves the physician or medical officer to ensure that the worker has been injured in the line of their duties before an assessment is made and subsequent recommendations that commensurate with the provisions of the law are made for compensation to be paid. In case of death however, this role is shifted onto the courts. In other words, in the main stay, the physician determines if the worker qualifies to receive the workmen compensation claim. The whole of section 14 of the act elaborates on the medical care and processes. It states in section 14 that:

“Where an employee has given notice of an accident, the employer shall, as soon as reasonably possible arrange to have the employee medically examined free of charge to the employee, by a medical practitioner named by the employer or by a medical practitioner named by the employee with the employer's approval, and an employee who is in receipt of periodical payments under section 6 shall submit to the medical examination as from time to time required by the medical practitioner” [Workmen Compensation Act 1987 PNDCL 187 Sec. 14].

Section 38 (b) of the law interprets a “medical practitioner” to mean a “*medical practitioner registered under the medical and dental Act, 2003 (Act 651)*” [Workmen Compensation Act 1987 PNDCL 187 Sec. 14]

These sections of the law further emphasise the pivot that the medical practitioner or physician serves whether provided by the employee or the employer. The issue here is that, although the law does not define injury, it refers the matter to the only a medical practitioner or physician in the light that this is a health problem. It is not out of place in the strict sense of the law to say that it is only the medical practitioner, who could interpret what an “injury” is, and subsequently make recommendations for compensation.

Health is not managed or assessed only by the physicians. Health has been defined by the World Health organization for more than six decades as ‘a complete state of physical, mental and social wellbeing and not merely the absence of disease’ (WHO, 1946). Contemporary management of patients especially with physical disability adapts a multidisciplinary approach needing such disciplines as physicians of varied sub-specialties, psychologists, social workers, physiotherapists, speech therapist, occupational therapists etc. With this in mind, the statement of ‘*medical practitioner*’ in the law is very limiting in the perspective of injury that a worker may incur. It is limited to a biomedical perspective.

The gap of ignoring the psychological/mental and social wellbeing of the injured worker is huge. Damage from an occupational injury or illness can affect the mental health of the victim and even workers in a number of ways beyond the observable physical harm. For instance, injured workers are more likely to suffer the following mental health challenges:

- psychological trauma of suffering an accident
- poor eating habits/smoking/excessive drinking/sleeplessness
- the thoughts of or actuality of coping with chronic pain as a result of the injury
- the anxiety of the bureaucratic processes involve in assessing support from employer
- the anxiety of soliciting financial and social support from family members in the short term
- the likelihood of social isolation, especially having lost routine worktime
- the possibility of depression as a result of change in circumstance
- the stress of dealing with unstructured paperwork processes for compensations the injured person is not sure of
- the associated stigma in the case of visible and obvious physical injury to victims

- the possibility of post-traumatic stress disorder and vivid flashes of the memory
- can alter family unity, harmony and financial stability

While these mental health challenges may not be exhaustive, it present a picture of some of the latent psychological challenges that may be associated with physical injury. It is worth noting that such mental health challenges spills over and affect the family (nuclear or extended). This is because most African workers do not live or work for themselves but live and work for other dependents. An injury to a worker must be viewed not only as an individual problem but a social one.

Occupational injuries that disfigure the victim can have far reaching psychosocial implications than merely the disadvantages of the physical harm or outlook. Section 8 of the Ghana's workmen's compensation law, indicate the scheduling structure to be followed for compensation after assessment (of disfiguring of victim) and onward recommendations of the medical practitioner.

Schedule one depicts percentage allocations of compensation to be paid to the injured worker after an assessment and recommendations of a medical practitioner confirming the disfiguring.

"Where in an employment personal injury of the description specified in an entry in the first column of the First Schedule by accident arising out of and in the course of the employment, is caused to an employee, the employer shall pay as compensation an amount of money for the injury determined by a medical practitioner recognised by the Government, not exceeding the percentage of the compensation payable in the case of permanent total incapacity that is specified in the corresponding entry in the second column of that Schedule" [Workmen Compensation Act 1987 PNDCL 187 Section 8 (a)]

The first determination schedule has the following details;

	% of calculated package
(1) Mutilation or amputation of one ear	15
(2) Deformity of the hand through the loss of all the three phalanges of a finger and the metacarpals of the hand	20
(3) Mutilation or amputation of nose	30
(4) Conspicuous deformity of face generally	50
(5) Conspicuous deformity of external appearance generally, other than face	40
(6) Functional loss of genital organs	85

Using the above schedule as a test case, it is practical to say that all the above disfigurements potentially have psychological overtones as far as self-esteem, self-worth, adjustment and other mental health challenges are concerned.

It is therefore logical to reason that the law limits injury assessments to biomedical rather than a biopsychosocial perspective of injury. The international community is on a drive to improve mental health in the workplace focusing on the prevention of mental stress in the workplace through facilitating access to curative and restorative care for work-related mental health problems, and incorporating workers who suffered mental health injuries in employee compensation schemes (Atilola, 2012). This drive has been provoked by numerous research findings that indicate that mental health problems in the workplace affect productivity than physical health problems (Goetzel, Hawkins, Ozminkowski, & Wang, 2003). The drive does not appear to have caught up in many Sub-Saharan African countries including Ghana. Many countries have embraced mental health in workplaces and have laws and policies that take cognisance of mental health claims. Mental health disability claims constituted 35%, 40% and 56% of workplace disability claims for the year 2007 in Netherlands, United Kingdom and Austria respectively alone (European Communities, 2008). One may argue that these European countries are in the developed world hence, their ability to enact and make functional such policies. Notwithstanding, the fact that the

occupational mental health drive has not caught up in Sub-Saharan Africa, some African Countries such as South Africa and Nigeria have taken the lead in making the necessary steps towards modifying their laws to encompass claims for psychological/ mental health injuries in workers compensation claims. South Africa has a legal provision that ensures that a worker may retire from work on the basis of mental health problems (Emsley & Coetzer, 1996). It is remarkable to say that neighbouring Nigeria has since 2011 repealed its Workmen Compensation Act of 2004 to embrace among other issues, mental health injuries or illness (ECA, 2011). The Employee Compensation Act 2004 of Nigeria states that

“ an employee shall be entitled to compensation for mental stress not resulting from an injury for which the employee is otherwise entitled to compensation, only if the mental stress is (a) an acute reaction to a sudden and unexpected traumatic event arising out of or in the course of the employee's employment; or (b) diagnosed by an accredited medical practitioner as a mental or physical condition amounting to mental stress arising out of the nature of work or the occurrence of any event in the course of the employee's employment”.

This indicates that this is a paradigm that can be adopted in Ghana because we would not be inventing the wheel, instead we would simply adopt to suit our particular needs and capability while we strive to meet best practice. The illustrative case of Mr. AB (dummy name for the sake of confidentiality) aptly captures the gap in employee compensation law that this paper addresses.

A CLINICAL CASE STUDY OF GHANA'S WORKMEN'S COMPENSATION APPLICATION

Case Selection and Background

Clinical case studies have long tradition in the medical and health literature. The use of such illustrative cases help to generate novelties and allows for in-depth understanding of a phenomenon (Nissen & Wynn, 2014). Even though some researchers (e.g. Enoch, 2005; Rison, 2013) argue about the lack of generalizability of using case research, it is the most efficient option for some sensitive works such as this. Such advantages of using illustrative case such as Mr AB, may not be achieved if other forms of research strategies were used. Mr AB in his quest for change in compensation structure having benefited from some form of psychological insurance and care, nominated himself to be used as a clinical illustrative case for this paper.

Mr AB is a thirty eight year old family man with a wife and two children aged six and four. He completed Junior High School and has no skilled training. He worked with a private security company for the past 12 years before he suffered a work related injury. He was referred by his human resource manager to see a clinical psychologist because had not been unable to work for nearly two years and was perceived to be malingering. He had told the human resource manager that he is unable to sleep, generally feels uneasy at his work premise and always feels frightened. Based on these complaints the referral was made. According to AB when he saw the psychologist, these symptoms had started following a significant deleterious event in his work life.

Mr AB was at post with a police officer one late afternoon at a bank when they were attacked by robbers who shot at them, killing the police officer instantly, and leaving AB 'shocked' with a bullet wound through his left thigh, penis and right hip. He went into a state of dissociation following the attack and his recollection of events after the shooting is vague but he remembers when he arrived at the hospital. He was in hospital for six months managed by the Urologist and the Orthopaedic surgeon. As far as his physical health is concerned, he has recovered most of his functioning with a shortening of the left thigh bone that leaves him with a slight limp. Additionally, he suffers some discomfort in his penis when he has intercourse. Percentage damage/ disability

given by his attending surgeons (orthopaedic and Urologists) for his physical injury was estimated at 35% for his insurance claims.

In his own words, Mr AB states;

'My employers have been very supportive paying all my medical bills and salary in spite of the fact that I have been unable to work over the past two years since this incident happened'

DISCUSSION OF CASE

While this may sound normal in many developed and developing countries, it is unusual for many Ghanaian companies to do same in the event of a workplace accident for employees below the middle work class. In most cases a victim of workplace accident who may be treated as did Mr AB, may have gone through rigorous and winding legal pursuit or may have fallen on the begrudging strength of "Who Knows You" (a Ghanaian popular usage to imply that you may have to know an influential person(s) in some sensitive position(s) to make a case for you or champion your course, find justice and or to have some advantages).

At the time he was seen by the psychologist, the situation was that he was unable to stay asleep throughout the night; waking up at the slightest of noise including dog barks. When he is able to sleep, he wakes up drenched in sweat and having palpitations because of nightmares that were usually themed with a stranger shooting at him. He has become irritable both in and out of home and gets into a rage over minor issues with immediate family members. He panics easily and never wants to be left alone as he gets flashbacks during such moments. He is constantly afraid especially when he is confronted by a stranger. He gets negative thoughts about hurting others and himself. All these symptoms started six months after the injury when he left hospital. To sum it all up his wife said *'he is a different man from the man I married'*.

Mr AB was diagnosed as having Chronic Post Traumatic Stress Disorder (PTSD) with delayed onset. He had been exposed to a traumatic event in his line of work in which he witnessed death and had a near death experience and injury. This event evoked such fear, horror and helplessness in him that more than two years after the event, he persistently re-experiences the event in the form of recurrent intrusive distressing recollections, nightmares, feelings of apprehension that the event would recur. The feeling of anxiety and apprehension was worse whenever he was faced with certain triggers such as seeing a policeman with a gun, observing a policeman and private security guarding bank and seeing unfamiliar faces with intense physiological responses. He shows avoidant behaviour and has persistent symptoms of increased arousal in the form of irritability and outbursts of anger, difficulty staying asleep, difficulty concentrating, hyper-vigilance and exaggerated startle responses. His immediate family has been receptacle for such unusual behavioural displays and outburst. All these had left him clinically distressed, impairing his social, occupational and family life functioning. He met the DSM-V criterion for Post-Traumatic Stress Disorder (PTSD). This was confirmed by testing him with the Post Traumatic Stress Disorder Checklist Civilian Version (PCL – C).

Although his mental health management was going well, it became obvious that he would not be able to go back to his security job role. In fact, AB did not even want to be reassigned a role by his employers since every time he went to the head office, it triggered some distress for him. He was therefore happy to take his insurance compensation and his meagre end of service and severance package to change career and start life all over again. His displeasure was that the compensation awarded him was not commensurate with the life changing experience he had. The questions this case raises are;

1. Why did AB get compensation only for the physical damage caused him when the psychological impact of the traumatic experience is even greater than the physical?
2. Who should have initiated evaluation and management of his psychological injury; the surgeons, or his employers?

3. Does the Workmen's Compensation in Ghana take into account psychological injury to the victim and the resultant psychosocial effect on the victim's immediate family members?

AB underwent a year's treatment on pharmacotherapy, psychotherapy and rehabilitation which was paid for by his employers. Additionally, the psychologist advocated on behalf of AB to have the very little amount of cash compensation that was paid him by insurance to be increased by at least 40%. Although admittedly this amount was woeful, the intervention yielded results by increasing his cash compensation.

This is evident in the case of A.B. Although he had gone through the medical system and been attended to by more than one physician in at least two different specialties and two different hospitals, he had not had opportunity to be assessed and managed for his mental health needs until almost two years following the incident. Interestingly, the initiation for psychological care had come from his employers because of non-productivity. If a routine assessment involving a psychologist or any other mental health professional had been done as part of his medical examination for damage assessment, the problem would have been prevented, diagnosed earlier or had a better prognostic outcome depending on the time lapse between time of injury and time of mental health assistance received.

It is in the best interest of all involved; worker, employer, insurer and the physician to have a comprehensive medical examination before claims are made. The worker receives good health, the employer gets his worker back at work quicker and healthier in a productive state, and the issue of possible challenge of the compensation through litigation is something the insurer, employer and physician would like to avoid. All parties remain satisfied when such a comprehensive medical examination has been conducted without the feeling that a singular person has determined the benefits of the worker. Section 14(7) of the law stipulates that '*The normal medical treatment includes a specialist treatment which the medical practitioner may require the employee to undergo*'.

This point could be interpreted to mean that the attending physician could ask for further specialist treatment. Such specialist treatment could include the psychologist, physiotherapist or any other medical specialty. One would assume then that a medical board or conference between the attending physician and the other specialist practitioners could be constituted to deliberate on the damage and claims to be made. In practice however, this does not often happen. Such a multidisciplinary evaluation of the injured worker is more likely to give a truer picture of the deficits the worker may have sustained following the physical injury. The physician would then have had expert advice in all the health aspects that matter, enabling the worker to get compensation that is comparable and commensurate to the total injury suffered.

Although the law in section 8, stipulates a schedule for what percentage damage must be ascribed to a type of damage, this does not give clear guidelines to the physician on how to assess disability, permanent or temporary (Norman et al., 2014). This definitely qualifies as a burden for the physician because he/she may be at a loss as to how much percentage damage to give. AB was given a damage of 35%. What about the fact that his life's trajectory has been totally changed? He now needs to learn new work skills and find a new career path. The psychosocial well-being was not factored into his claim. Does he qualify for '*Functional loss of genital organs*' or in part damage to his genitals in this particular case? Functional loss of the genital organ alone should have guaranteed him 85% per the schedule of percentage damage in the Ghana's Workmen Compensation. 85% is so far removed from the 35% that he was given.

When workers compensation schemes are unable to provide adequately for the individual workers, the cost is not limited to the individual but ripples onto the family and the community as a whole (McPhilbin, 2012). Gleaning from Agyemang and Otoo's (2013) *Indigenous Cultural and Family Insurance Concept (ICFIC)* which describes how Ghanaians tend to assume the pain and share the worries, challenges, debts, trauma of other family members and relatives, Ghana's

Workmen Compensation Act falls short as it only considers family members in the event of death of the person in question. This is explained in Section 3 of the act as follows:

“(1) Where death results from the injury, (a) if the employee leaves dependants, the amount of compensation shall be a sum of money equal to sixty month's earnings: but where in respect of the same accident compensation has been paid under section 5, 6 or 7, there shall be deducted from the sum payable under this paragraph the sums so paid as compensation”

This therefore suggests that, the family's involvement is recognized only if a fatality occurs.

In sum, the law is limiting in its health orientation in terms of what it defines as injury (mental health excluded), who determines the injury and how the injured worker is assessed to determine the damage that earns them compensation commensurate to the injury suffered.

PROPOSED WAY FORWARD

Sub-Saharan Africa is at risk of suffering many repercussions of low productivity, if the mental health aspect of work place injury is not addressed. Gleaning from the clinical case, Mr. A.B had to be severed from his line of work as a security officer because of the psychological injury rather than the physical. This is a loss of his 12 year experience gathered in his line of work and the loss of an experienced skill to the community.

The workmen compensation as it exists in Ghana now is already more three decades old and does not meet contemporary needs. A review of the law to take into account the contemporary needs of workers should make it more useful. It is understandable that mental health was not included in the law because there is a low level of mental health literacy and poor attitude towards mental health in Africa and Ghana is no exception (Atilola, 2012; Robert et al., 2013). When more contemporary issues are taken into account, a revision of the law acknowledging other health professionals in the assessment of injured workers in arriving at the degree of damage for compensation claims could be addressed. Indeed, this would relieve the 'burden' that is placed on the physician and be advantageous to the victim of workplace accident and diseases.

Ghana's Workmen Compensation law also assumes that the medical officer would evaluate for mental health problems and incorporate into the degree of damage. This is evident in that the law gives a guide on the percentage incapacity of the injury in section 38, third schedule. It allocates 100% damage to loss of mental capacity. This assumes that the medical officer knows how to assess properly for the loss of mental capacity. Mental health is not a priority in Ghana as Robert and his colleagues have demonstrated. Only 2% of Ghanaians having mental health needs receive assessment or treatment (Roberts et al, 2013). Ghanaian physicians receive very little mental health training in the entire course of their Medical education. A miserly 3-7% of the undergraduate medical training is in mental health (Ofori-Atta, Read, Lund & MHapp Research Consortium, 2014; Roberts et al., 2013). Neither is there enough training in occupational health for Ghanaian physicians. According to Norman et al. (2014), medical training in Ghana in all the four existing medical schools is devoid of occupational health training. Therefore physicians learn to do such assessments on the job by trial and error or apprenticeship with the exception of those who may have trained in other jurisdictions that factor such knowledge into their education.

Ghana's Workmen Compensation Act like similar Acts worldwide was enacted for good intent. Like all Acts or Laws, they fulfill a purpose at any point in time making it relevant. Indeed most workers' compensations have gone through many transformations to their present state. The time is due for Act 187 to be reviewed to meet contemporary Ghanaian worker's needs. With Ghana's Oil find, it is expected that diverse groups of people from all walks of life with different orientations as far as compensation of accident victims are concerned would be found in the country. This paper calls for a review of Ghana's Workmen Compensation Act.

For efficiency, this call extends to stakeholders interactions. The Ghana Employers Association, Employee Associations, Labour Ministry, Ghana Bar Association, Judiciary, Insurance

Commission, Ghana Medical Association, the Ghana Psychological Association, and Allied Health professionals, and any other institution(s) of relevance to the issue must come together to find better methods of evaluating injured workers. Issues such as the time lapse between injury, assessment of damage resulting from injury and the relevant professionals (e.g. psychologists, social workers) other than the medical officer should be incorporated in the medical evaluations for compensation.

The issue of having a singular office or compensation commissioner who would coordinate and ensure that all parties are playing their role in the best interest of the injured worker is a matter that needs to be addressed.

Stakeholders must have discourse on the review of the law's definition of injury to include the psychosocial impact of injury, and find practicable ways of implementing the law. The definition of injury must take a biopsychosocial orientation.

Further, all health professionals that are expected to be involved in the comprehensive biopsychosocial assessment of the injured worker must have training to that effect. Admittedly, there are more physicians than psychologists or any other mental health practitioners in Ghana (MDC Gazette, 2014; Robert et al., 2013) and therefore in practical terms there would be many circumstances that could require the physician to do the mental health assessment rather due to non-availability of a psychologist or psychiatrist. Ghanaian medical school curricula have to be beefed up with more occupational health and mental health content. This would arm physicians with the necessary skill to determine from the onset mental health related cases and refer or involve psychologists as soon as practicable in such cases.

Lastly, health professional training must incorporate 'laws of relevance' to the medical community. Many Ghanaians including physicians are unaware of the existence of the Workmen's Compensation Law (Dwumfour-Asare & Asiedu, 2013). There must be a concerted effort at educating the general population. The mental health community which has more psychologists than psychiatrists (Roberts et al., 2013) must lead the discourse on the value of mental health to the general population. The Ghana Psychological Association (GPA) has the role to enlighten the Ghanaian that mental health can be more disabling than physical disability. Ghana needs to join the drive that is pushing for better occupational mental well-being of its populace. This must not simply be in the interest of compensation claims but to enhance the mental wellbeing of the populace in general and especially to have workers who are productive.

Implications for Policy, Theory and Practice

The Workmen Compensation law 1987 (PNDC 187) has served a purpose to a great extent. There are obvious gaps in practice in how injured workers are evaluated to be awarded compensation claims. The law puts such emphasis on the medical practitioner who is not equipped with the knowledge and skill to be able to do so effectively and holistically, hence short changing the injured client. There is no clear definition of *injury* in the law but there appears to be a bias towards physical rather than a comprehensive biopsychosocial interpretation that would consider not only the physical injury but the psychological injury that the worker suffers although psychological ill health has been shown to be more disabling than physical. It is relevant that we shift the sense of injury and associated compensation from a biomedical to a biopsychosocial (BPS) perspective (Engel, 1977; Henriques, 2015). The skillful blend of the biopsychosocial model will shape policy and practice, in that the goal of compensating an injured worker as a restorative way of improving wellbeing will be defined as the overall state of health and happiness at the biological, psychological and social levels. The BPS model in our view, encapsulates holism and diversity of perspectives in approaching the law meant to protect and give succor to injured worker. It is our singular view that insurance processes on occupational health injuries take into cognisance the relevance of mental health evaluation before executing compensations to victims. With *Indigenous Cultural and Family Insurance Concept (ICFIC)* of Ghanaians in mind, the law should reflect on relatives and family members of victim of work place accident. There is the need



to review the law to embrace all the contemporary issues especially in the matter of mental health injuries as has been done in most developed countries such as United States of America and Canada and in some African countries like South Africa and Nigeria. Stakeholders must come together to advocate for this review. In the long run, the injured worker gets their rightful commensurate compensation and country is the winner because the worker feels properly compensated and psychologically well to give off their best at work.

CONCLUSION

In the view of Kofi Annan (former UN Secretary General), safety of workers is a part and parcel of human security and safety issues to the barest should be viewed as a human right (2002). The import of this statement is the relevance of workplace safety in the life of humankind. It is imperative that social scientists attempt engage stakeholders on occupational health and safety issues with a holistic compensation package in view. The full sense of treating safety as a human right is to ensure victims of workplace accidents are holistically compensated. This require that a biopsychosocial model shape the viewpoint of policy framers and health practitioners as is deemed as a central pathway in satisfying all parties involved in such occupational accidents (Engel, 2009). The time has arrive for policy makers to consider a review of the Workmen's Compensations Act of Ghana to include mental health considerations. It will be relevant that such considerations factor the possibility of having traumatic mental and social policies which encapsulates mental health injuries as worthy of compensation.

REFERENCES

- Adei, D. &Kunfaa, E. Y. (2007). Occupational Health and Safety Policy in the Operations of the Wood Processing Industry in Kumasi, Ghana. *Journal of Science and Technology*, 27(2),161 -173
- Adjotor, F. N. (2013). *The Effects of Occupational Safety and Health on Labour Productivity: A Case Study of Some Selected Firms in The Greater Accra Region of Ghana*.University of Ghana Dissertation. <http://ugspace.ug.edu.gh>
- Agyemang, C. B.,Nyanyofio, J. G., &Gyamfi, G. D. (2014). Job Stress, Sector of Work, and Shift-Work Pattern as Correlates of Worker Health and Safety: A Study of a Manufacturing Company in Ghana. *International Journal of Business and Management*, 9(7), 59-69.
- Agyemang, C. B. &Otoo, E. (2013). HIV/AIDS Stigmatization on Relatives and Associates of People Living with HIV/AIDS: A Psychological Study. *International Journal of Health and Psychology Research*, 1(2), 1-13
- Amoran, O.E., Lawoyin, T.O., Oni, O.O. (2005). Risk Factors Associated with Mental Illness in Oyo State, Nigeria: A Community based study. *Annals of General Psychiatry*,4, 1-6-17
- Annan, J. S. (2010). Occupational and Industrial Safety and Health in Ghana. Published 22nd November, 2010 retrieved on 15th December, 2014 from www.ghanaweb.com/GhanaHomePage/NewsArchive/artikel.php?ID
- Annan, J. S., Addai, E. K. & Tulashie, S. K. (2015). A Call for Action to Improve Occupational Health and Safety in Ghana and a Critical Look at the Existing Legal Requirement and Legislation. *Safety and Health at Work*, 6, 146-150
- Atilola, O. (2012). Partaking in the global movement for occupational mental health: What challenges and ways forward for sub-Sahara Africa? *International Journal of Mental Health Systems*, 6, 15. doi:10.1186/1752-4458-6-15
- Canavan, M.E., Sipsma, H.L, Adhvaryu, A., Ofori-Atta, A., Jack ,Udry, C., Osei-Akoto, I., & Bradley, E.H. (2013). Psychological distress in Ghana: associations with employment and lost productivity. *International Journal of Mental Health Systems*, 7(7), 9-23
- Dwumfour-Asare, B. &Asiedu, S. R. (2013). Awareness of the Factories, Offices and Shops Act 1970 (Act 328) at KNUST, Ghana. *Developing Country Studies*,3(10), 1-10 www.iiste.org ISSN 2224-607X
- Emsley, R. &Coetzer, P. (1996). Disability claims on psychiatric grounds. *South African Medical Journal*, 86, 646-654.
- Engel, GL (1977). *The need for a new medical model: a challenge for biomedicine*. *Science*. 196 (4286), 129–36.
- Engel, G. L. (2009). *The Need for a New Medical Model: A Challenge for Biomedicine*. *Holistic Medicine*. 4 (1), 37–53
- European Communities (2008): *European Communities Consensus Paper: Mental Health in Workplace Settings*. Luxembourg: European Communities
- Federal Government of Nigeria Employee's Compensation Act Abuja: FGN; 2011.
- Ghana Health Service/Ministry of Health (2002). *Handbook on Occupational Health*. Accra, Ghana: Authors.
- Goetzel, R.Z., Hawkins, K., Ozminkowski, R. J., &Wang, S. (2003). The health and productivity cost burden of the "top 10" physical and mental health conditions affecting six large U.S. Employers in 1999. *Journal of Occupational, Environment and Medicine* 45, 5–14
- Harnois, G. & Gabriel, P. (2000). *Nations for Mental Health: Mental Health and Work: Impact, Issues and Good Practice*. WHO/ILO.WHO/MSD/MPS/00.2 MSD.
- Hagberg, M., Silverstein, B., Wells, R., Smith, M. J., Hendrick, H. W., Carayon, P., &Pirusse, M. (1995). *Work related musculoskeletal disorders (WMSD): A reference book for prevention*. In I. Kuorinka& U. Forcier (Eds.). London: Taylor & Francis
- Hughes, P., &Ferrelt, E. (2008). *Introduction to Health and Safety In Construction Industry* (3rd ed.). Butterworth-Heinemann, Imprint of Elsevier, USA, pp. 2-4.

- McKee-Ryan, F. M., Song, Z., Wanberg, C. R. & Kinicki, A. J. (2005). Psychological and Physical Well-Being during Unemployment: A Meta-Analytic Study. *Journal of Applied Psychology*, 90(1), 53–76.
- McPhilbin, J. (2012). *Workers Compensation: Time to take a stand*. Workers Health Center. Granville
- Mock, C., Adjei, S., Acheampong, F., Deroo, L., & Simpson, K. (2005). Occupational injuries in Ghana. . *International Journal of Environmental Health*, 11, 238-245.
- Muhwezi, W.W Agren, H., Neema, S., Maganda, A.K., Musisi, S. (2008). Life Events Associated With Major Depression in Ugandan Primary Healthcare (PHC) Patients: Issues of Cultural Specificity. *International Journal of Social Psychiatry*.54,144-164.
- Myer, L., Stein, D.J., Grimsrud, A., Seedat, S., & Williams, D.A. (2008). Social determinants of psychological distress in a nationally-representative sample of South African adults. *Social Science & Medicine*, 66(8), 1828-1840.
- Nissen, T. & Wynn, R. (2014). The history of the case report: a selective review. *JRSM Open*. 5, 4. [[10.1186/1756-0500-7-264](https://doi.org/10.1186/1756-0500-7-264)]
- Norman, I. D., London, L., Aikins, M. S. & Binka, F. N. (2014). The Delaying of Workmen's Compensation in Ghana: Review Article. *Occupational Medicine & Health Affairs*, 2(2), 1-8
- Ofori-Atta, A., Read, Lund, U.M. & the MHapp Research Consortium (2014). *An updated Situational Analysis of Mental Health Services and Legislation in Ghana: Challenges for Transformation*. In Changing Trends in Mental Health Care and Research in Ghana Ofori-Atta & Ohene. Sub-Saharan Publishers.
- Opong, S. (2010). *Preparedness of Ghana to Manage Occupational health and Safety in the Oil and Gas Industry*. Unpublished Manuscript, Regent University College of Science & Technology, Ghana.
- Piavi, H., Kaija, L.S, & Jukka, T. (2009). Global Trend according to Estimated Number of Occupational Accidents and Fatal Workrelated Disease at Region and Country Level. *Journal on safety research*, 40, 125-139.
- Rison, R.A. (2013). A guide to writing case reports for the Journal of Medical Case Reports and Bio Med Central Research Notes. *J Med Case Reports*, 7, 239. doi: 10.1186/1752-1947-7-239.
- Roberts, M., Asare, J., & Morgan, C. (2013). An overview of Ghana's Mental Health Services: Results from an Assessment using the world health organization Assessment Instrument for Mental Health Systems (WHO-AIMS). *International Journal of Mental Health Systems*, 8, 16-32
- WHO (1946). Preamble of the World Health Organization Constitution as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States. Official Records of the World Health Organization, 2, p. 100
- WHO (2001). Occupational Health: A Manual for Primary Health Workers Retrieved from http://www.who.int/occupational_health/regions/en/oehemhealthcareworkers.pdf

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