Evaluation of the Impact of the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR) on Sick Leave Trends in the Public Service

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THE PUBLIC SERVICE COMMISSION
Commission House
Cnr. Hamilton & Ziervogel Streets
Arcadia, 0083

Private Bag x121
Pretoria, 0001

Tel: (012) 352-1000
Fax: (012) 325-8382
Website: www.psc.gov.za

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Custodian of Good Governance

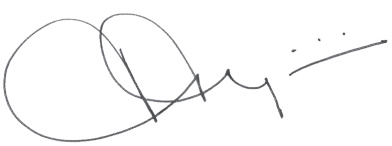
Foreword

The Public Service Commission (PSC) has produced a series of reports that focus on a number of issues pertaining to Human Resource Management Practices. One of the key areas in which the PSC has produced reports is the management of leave in the Public Service. Three reports in this area were produced in the past. The findings from these three reports indicated that the abuse and poor management of sick leave has had serious financial implications for the State and a negative impact on service delivery due to the lack of capacity resulting from a high rate of absenteeism.

Resulting from the findings of these reports, a need for a policy to be developed was established in order to reduce the widespread abuse of sick leave and to improve the poor management of incapacity leave and ill-health retirement in the Public Service. The Department of Public Service and Administration (DPSA) developed the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR) to assist departments in managing Incapacity Leave and Ill-Health Retirement. Following a successful pilot study, the policy was approved by Cabinet as determined by the Minister for Public Service and Administration in terms of the provisions of the Public Service Act, 1994, as amended, for implementation in 2006.

It is in this context that the PSC embarked on a project to evaluate the impact of PILIR on Sick Leave Trends in the Public Service. For comparative purposes the evaluation of the implementation of PILIR covered the period before it was introduced in January 2004 until June 2009.

It gives me great pleasure to present the report on this evaluation. The effective management of sick leave is one of the key challenges that line function managers and human resource practitioners in the Public Service are faced with on a daily basis. I trust that you will find this assessment useful, and deliberate on the findings and recommendations. The only way in which government can serve its people properly is through maximum and strategic use of its human resources. PILIR is one such measure in that direction.



DR RR MGIJIMA
CHAIRPERSON: PUBLIC SERVICE COMMISSION

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List of Acronyms

PILIR	Policy and Procedure on Incapacity Leave and Ill-Health Retirement
DPSA	Department of Public Service and Administration
SMS	Senior Management Service
HoD	Head of Department
PERSAL	Personnel Salary System
LRA	Labour Relations Act
PSA	Public Service Act
PSC	Public Service Commission
TIL	Temporary Incapacity Leave
IHR	Ill-Health Retirement
BCEA	Basic Conditions of Employment Act

Executive Summary

1. INTRODUCTION

The Public Service is a labour intensive employer who is dependent on the quality, skills and performance of its employees. Therefore, it is of paramount importance that the leave of absence of Public Service employees is managed properly to avoid lack of capacity which has a negative impact on service delivery. The abuse and poor management of sick leave does not only impact negatively on service delivery but also has serious financial implications for government as a whole.

The findings of reports of the PSC and the Auditor-General on the management of sick leave have illustrated abuse of sick leave and poor management of incapacity leave within the Public Service. In order to address these problems, Cabinet approved the implementation of the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR) and the concept of utilising Health Risk Managers. The Health Risk Manager is tasked with the function of assessing employees' applications, including the supporting information, for Temporary/Permanent Incapacity Leave and Ill-Health Retirement from employees. After assessing the application, the Health Risk Manager provides advice to the employer in respect of an employee's application for Incapacity Leave and Ill-Health Retirement within specified timeframes.

The objectives of PILIR are to set up structures and processes which would ensure suitable interventions and management of incapacity leave in the workplace to accommodate temporary or permanently incapacitated employees and to provide for appropriate consequences on such incapacity where necessary. PILIR was implemented in all government departments in a phased approach with effect from June 2006. The implementation of PILIR is intended to address challenges and contribute to an improvement in the management of sick leave in the Public Service. There has, however, not been any assessment on how effective the implementation of PILIR has been in addressing the concerns identified in the PSC's and Auditor-General's reports on Sick Leave Trends and Ill-Health Retirement. It is for this reason that the PSC has undertaken the Evaluation on the Impact of PILIR on Sick Leave Trends in the Public Service.

2. OBJECTIVES OF THE STUDY

Through this report the PSC aimed to:

- Assess the sick leave trends and reasons thereof, in the national departments of Labour, Health, Basic and Higher Education and Training and provincial departments of Health and Education in all nine provinces.

- Do a comparative analysis per financial year reflecting trends prior to implementing PILIR in order to assess whether or not there has been any change in sick leave trends.
- Identify success factors that are critical to the effective implementation of PILIR in the Public Service.
- Identify barriers impacting on the implementation of PILIR in the Public Service.
- Generate recommendations for the improvement of the implementation of PILIR and sick leave management in the Public Service.

3. METHODOLOGY

The methodology followed in the gathering of data was as follows:

- A desktop study of previous reports published by the PSC, the Auditor-General and other institutions on sick leave and ill-health was conducted.
- PERSAL reports on sick leave, Temporary and Permanent Incapacity Leave and Ill-Health Retirements for the period January 2004 to June 2009 for the sampled departments were obtained.
- Statistical information on Temporary/Permanent Incapacity Leave and Ill-Health Retirement applications assessed and finalised by the Health Risk Managers was obtained and analysed.
- Health Risk Managers reports on the assessed applications for Temporary/Permanent Incapacity Leave and Ill-Health Retirement were obtained.
- Interviews with Human Resource Managers in the sampled departments were conducted using a structured questionnaire.
- Leave policies of sampled departments were obtained to assess their compliance including the procedures to process Temporary and Permanent Incapacity Leave and Ill-Health Retirement.

4. FINDINGS

4.1 Sixty percent (60%) of the respondents said that they understand PILIR as well as the functions of key role players. Leave policies were in place in all the sampled departments except for the provincial departments of Health and Education in the Northern Cape. 100% of the sampled departments were using the services of Health Risk Managers.

4.2 In national departments there has been an average of 3.8% reduction in the number of sick leave days taken after the implementation of PILIR. This is in line with the 3% observed, at provincial level where a decrease was observed in only 66% of the departments of Education and Health. The PSC has also observed that the management of leave records is generally inadequate, and as a result it would be premature to regard these leave trends as an indicator of the extent to which PILIR has curbed sick leave abuse.

4.3 Despite the reduction in the sick leave days taken post PILIR, the total cost of sick leave taken in the three sampled national departments increased by 26% post PILIR. Although part of this increase can be attributed to the cost of living adjustments for public servants' salaries, it is also evident from the Health Risk Managers' reports that departments are still experiencing an escalation of costs with regards to incapacity leave taken by their employees. The same finding regarding the increase in costs was made in the provincial departments of Health and Education. This may imply that PILIR has failed to achieve its main objective of reducing sick leave costs in departments.

4.4 Another key objective for implementing PILIR was to change people's mindsets with regards to the management of sick leave. In both the national and provincial departments it was found that employees are absent on sick leave on Mondays and this practice has not changed even post PILIR.

With regard to the processing of applications for and the overall administration of Incapacity Leave and Ill-Health Retirement the following findings were made:

4.5 There is non-adherence to timeframes for processing the applications by all parties involved in the process and implementation of PILIR (namely employees, designated offices, Health Risk Managers and Heads of Department).

4.6 Medical Practitioners from private practices and public hospitals are generally reluctant to complete the Temporary/Permanent Incapacity Leave forms when requested by employees, as they feel the forms are bulky and time consuming. As a result, there are delays in submitting the forms by employees which cause further delays in the forwarding of the forms to the Health Risk Managers. In addition the PSC was informed that, employees end up being charged an additional fee by some Medical Practitioners for the completion of the forms.

4.7 Many managers are not managing the absenteeism of employees whose Temporary/Permanent Incapacity Leave applications have been declined.

4.8 Some departments are not processing Temporary/Permanent Incapacity Leave applications that are submitted late by employees. There is no indication as to what happens to such applications and how the employees and managers account for such absence. There is also no indication who gives authorisation for such practices.

4.9 The redeployment of employees as per Health Risk Managers' recommendations pose a challenge as no suitable jobs are available in the Public Service to accommodate such employees.

4.10 PILIR has resulted in an increase in the workload of role-players internally as well as an increase in costs for departments. Departments are experiencing problems in processing PILIR due to the lack of administrative capacity.

4.11 Departments experience problems with Temporary/Permanent Incapacity Leave applications where the Health Risk Managers require Medical Practitioners to explain the diagnoses in cases where the employees' illness is of a sensitive nature. Medical Practitioners are reluctant to breach confidentiality especially in cases where employees do not give them consent to do so. This thus results in a number of such applications being declined by the Health Risk Managers due to insufficient information. These employees have no option but to return to work and are unable to perform their duties due to poor health.

5. RECOMMENDATIONS

5.1 Managers in all departments must monitor sick leave closely and this information should form part of the employees' performance agreements and discussed during the time of assessments. Trends should be periodically reported to top management within all departments so that remedial action can be taken. Further, all supervisors and employees should be extensively educated on the provisions contained in the, *"Determination on Leave of Absence in the Public Service"* as well as on the stipulations contained in the, *"Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR)"* in order to ensure proper implementation and management of sick leave.

5.2 Human Resource Managers need to be more accountable in ensuring that their units capture the sick leave records on PERSAL timeously and accurately. In the case of institutions without HR Managers (functions) for example small hospitals, the responsibility to carry out this function lies effectively with the General Manager of the institution.

5.3 In the case of Long Term Incapacity, the Permanent Incapacity Leave and Ill-Health Retirement application forms should be reviewed by the DPSA within twelve months, taking into consideration the challenges experienced by employees when requesting completion of such forms by the Medical Practitioners. DPSA needs to refine the forms and make them more user-friendly.

5.4 Stakeholders need to meet the 30 days timeframe for processing applications of Temporary Incapacity Leave as well as communicating the outcome to the employer. Therefore HoD's need to hold Health Risk Managers accountable for non-compliance with the 16 days timeframe as stipulated in the service level agreements and the policy.

5.5 The DPSA must add a clause to the policy whereby in the event of a deceased employee, Human Resource units must ensure that outstanding Temporary/Permanent Incapacity Leave and/or Ill-Health Retirement applications are completed and the outcome processed before any pension payout is processed.

6. CONCLUSION

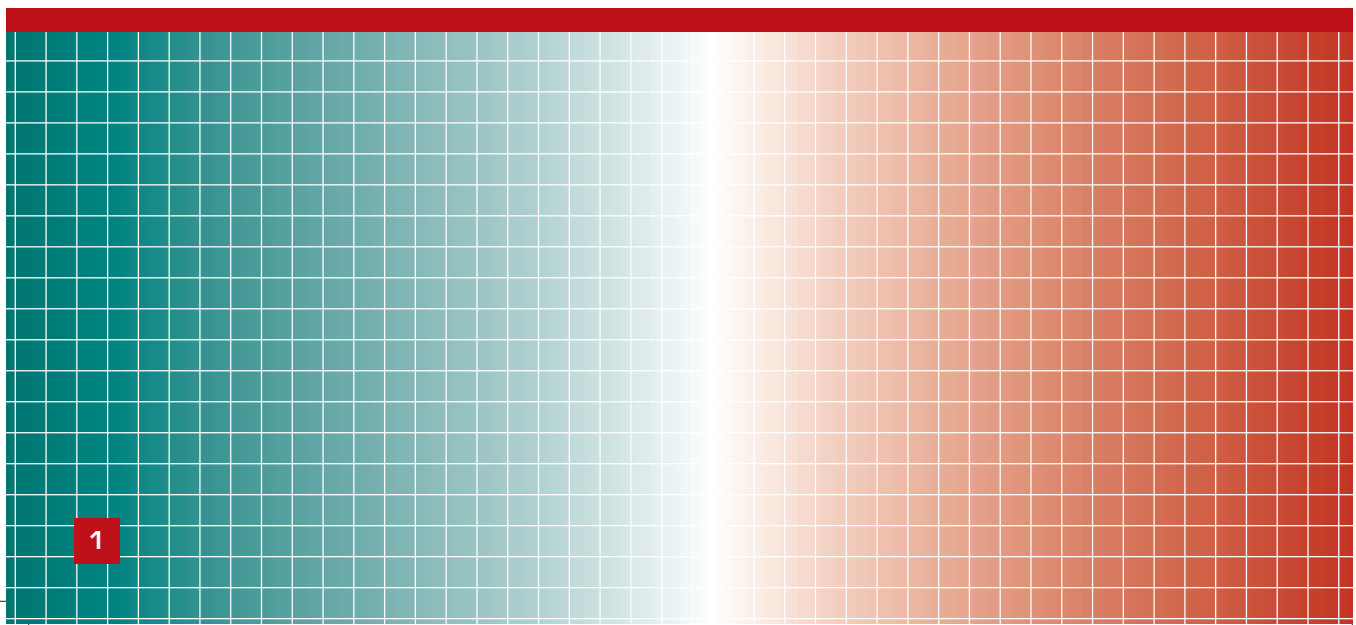
This assessment was conducted to evaluate the impact of PILIR on sick leave trends in the Public Service. It can be concluded that although there has been a slight decrease of 3.4% on average in the number of days taken after the implementation of PILIR in the sampled departments, many challenges still remain. It should be noted however, that despite this reduction, the sampled departments actually experienced an escalation of costs with regards to incapacity leave taken. Further, it was observed that the paradigm shift in terms of the practice of taking leave on Mondays had not changed even post PILIR.

In terms of information received from the questionnaires and the interviews, respondents indicated that there were challenges regarding the application process for Incapacity Leave and Ill-Health Retirement. These challenges included non-adherence to timeframes for processing applications by employees, Health Risk Managers and Heads of Department. Medical Practitioners were reluctant to complete the Temporary/Permanent Incapacity Leave Forms because of their bulkiness, officers experienced difficulties in processing applications due to a lack of administrative capacity and some application forms were not processed because employees submitted them late.

It should however, be noted that at the time this project was conducted PILIR was only three years old, it is hoped that if the implementation process challenges are resolved then its effectiveness will be felt within departments.

Chapter One

Introduction



1.1 BACKGROUND

Human resource management is of critical importance in that it ensures that human capital is well managed and that all policies and systems pertaining to this resource are effectively and efficiently implemented. The Public Service is a labour intensive employer who is dependent on the quality, skills and performance of its employees. Therefore it is of paramount importance that the leave of absence of Public Service employees is managed properly to avoid lack of capacity which has a negative impact on service delivery.

Since its establishment, the Public Service Commission (PSC) has produced a series of reports that focus on a wide variety of issues covering the whole spectrum of human resources management practices. The PSC, in particular produced three reports on the management of leave namely; *"A Report on Management of Leave in the Public Service"*, in 1999[1], a report on *"Sick Leave Trends in the Public Service"*, in March 2002[2] and a report on the *"Investigation into the Re-Employment of Persons due to Ill-Health"* in February 2004[3].

The findings of the PSC's 1999 report indicated amongst others a lack of departmental policies to supplement the national policy on leave, insufficient control measures, abuse of and poor management of sick leave and excessive leave accrual. To address this, the Public Service adopted with effect from 1 July 2000 a new leave dispensation aligning itself with the provisions of the Basic Conditions of Employment Act, 1997, as amended, which established certain rights pertaining to leave. Emanating from the collective bargaining process that informed the new dispensation, the sick leave benefits for employees were reduced from 120 days paid and 120 days with half pay to 36 working days with full pay. At this time the concept of incapacity leave, i.e. additional sick leave granted at the employer's discretion following an investigation was introduced for the first time[4].

Subsequent to the introduction of this new dispensation, the PSC conducted further studies on sick leave and ill-health and the reports were produced in 2002 and 2004[5], respectively. The findings of these two reports indicated that:

- There was a lack of a systematic and consistent approach in the management of Incapacity Leave and Ill-Health Retirement.
- There was limited consideration of alternative approaches to Ill-Health Retirement.
- There was inappropriate use of Ill-Health Retirement provisions.
- There was limited employer understanding of ill-health information which led to poor decision making in the granting of Temporary/Permanent Incapacity Leave and Ill-Health Retirement.

1 *Republic of South Africa. Public Service Commission. Report on Management of Leave in the Public Service, 1999.*
2 *Republic of South Africa. Public Service Commission. Sick Leave Trends in the Public Service. March 2002.*
3 *Republic of South Africa. Public Service Commission. Investigation into the Re-Employment of Persons due to Ill-Health. February 2004.*
4 *Republic of South Africa. Public Service Coordinating Bargaining Council (PSCBC) Resolution 7 of 2000. Leave dispensation effected from July 2000.*
5 *Republic of South Africa. Public Service Commission. A Report on Sick Leave Trends in the Public Service. March 2002.*

- The findings on ill-health were based on insufficient evidence and there were inter-departmental differences in managing incapacity leave, and
- PERSAL sick leave records were not being updated on a regular basis.

The Auditor-General also produced a report on a *Performance Audit of the Management of Sick Leave Benefits*[6], and the findings of this report indicated that approximately 12,6 million days of sick leave were used by government employees during the three year period commencing from 1 January 2001 until 31 December 2003. This represented in monetary terms an estimated cost of R3 257 000 during the three-year period covering January 2001 to December 2003. The findings of that report demonstrated that the abuse and poor management of sick leave had serious financial implications for the State and in turn had a detrimental effect on departments regarding the provision of effective and efficient services to the public due to the lack of capacity resulting from high rates of absenteeism.

Emanating from the findings of the reports produced by the PSC, and the report from the Auditor-General, the Department of Public Service and Administration (DPSA) then developed a Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR) to assist departments in managing Incapacity Leave and Ill-Health Retirement. Cabinet approved the implementation of PILIR and the concept of utilising Health Risk Managers which was rolled-out in 2005. The objectives of PILIR are to set up structures and processes, which will ensure intervention and management of incapacity leave in the workplace to accommodate temporary or permanently incapacitated employees; and where appropriate the rehabilitation, re-skilling, re-alignment and retirement, where applicable, of temporary or permanently incapacitated employees are facilitated. PILIR therefore seeks to adopt a holistic approach to health risk management, by seeking synergies with wellness and disease management programmes provided by employees' medical schemes and by implementing sick leave management as well as rehabilitation and re-skilling structures in conjunction with health risk management; prevent abuse of sick leave by managing incapacity or ill-health as far as possible; adopt a scientific approach to health risk management based on sound medical, actuarial and legal principles; involve the various stakeholders in the health risk management processes and structures; implement health risk management that is consistent, fair and objective; and support health risk management that is cost effective and financially sound.

PILIR was implemented in all government departments effective from June 2006 in a phased approach, the implementation of PILIR was intended to contribute to an improvement in the management of sick leave in the Public Service, by managing Incapacity Leave and Ill-Health Retirement. There has, however, not been any assessment conducted of how effective the implementation of PILIR has been in addressing the concerns identified in the above reports of the PSC and AG on Sick Leave Trends and Ill-Health Retirement. It was for this reason that the Evaluation of the Impact of PILIR on Sick Leave Trends in the Public Service was undertaken.

6 *Republic of South Africa. Auditor-General. Report of the Auditor-General on a Performance Audit of the Management of Sick Leave Benefits at certain National and Provincial Departments. December 2005.*

1.2 MANDATE OF THE PUBLIC SERVICE COMMISSION

In terms of section 196 (4) (b) of the Constitution, 1996[7], read in conjunction with section 9 and 10 of the Public Service Commission Act, 1997[8], the Commission is empowered "to investigate, monitor and evaluate the organization, administration and personnel practices of the Public Service". According to section 196 (4) (f)(iv) of the Constitution, 1996, the PSC may "of its own accord or on receipt of a complaint, advise national and provincial organs of state regarding personnel practices in the Public Service including those relating to the recruitment, appointment, transfer, discharge and other aspects of the careers of employees in the Public Service". The PSC is therefore mandated to investigate the effectiveness of implementation of PILIR as one of the mechanisms for the improvement of personnel practice in the Public Service.

1.3 OBJECTIVES OF THE EVALUATION

The overall objective of the study was to establish the effectiveness of the implementation of PILIR in assisting departments to manage Incapacity Leave and Ill-Health Retirement with the aim of improving sick leave trends in the Public Service. Through this report the PSC aimed to:

- Assess the sick leave trends and reasons thereof, in the national departments of Labour, Health, Basic and Higher Education and Training and provincial departments of Health and Education in all nine provinces.
- Do a comparative analysis per financial year reflecting trends prior to implementing PILIR in order to assess whether or not there has been any change in sick leave trends.
- Identify success factors that are critical to the effective implementation of PILIR in the Public Service.
- Identify barriers impacting on the implementation of PILIR in the Public Service.
- Generate recommendations for the improvement of the implementation of PILIR and sick leave management in the Public Service.

1.4 SCOPE OF THE EVALUATION

The study was conducted within national departments of Labour, Health, Basic and Higher Education Training and the provincial departments of Health and Education and covered the period January 2004 until the end of June 2009. These departments were selected based on their delivery of crucial services aimed at alleviating poverty through the Unemployment Insurance Fund (Labour), providing free health care services (Health) and education for the development of the people of South Africa (Basic Education and Higher Education and Training).

7 *Republic of South Africa. The Constitution of the Republic of South Africa Act 108, 1996.*
8 *Republic of South Africa. Public Service Commission. Public Service Commission Act of 1997.*

1.5 METHODOLOGY

The following methodology was used:

- A desktop study of previous reports produced by the PSC and the AG on sick leave and ill-health was conducted.
- PERSAL reports on normal sick leave, Temporary and Permanent Incapacity Leave and Ill-Health Retirement terminations for the period January 2004 to June 2009 for the sampled departments were obtained and analysed.
- Statistical information on Temporary Incapacity Leave and Ill-Health Retirement applications assessed and finalised by the Health Risk Managers was obtained and analysed.
- A questionnaire was used during interviews with the Human Resource Managers responsible for the administration of leave in the sampled departments.
- Leave policies of the sampled departments were obtained to assess their compliance with the DPSA's Determination on Leave of Absence in the Public Service which stipulates inclusion of procedures to process Temporary and Permanent Incapacity Leave and Ill-Health Retirement uniformly as per the PILIR policy across all government departments.

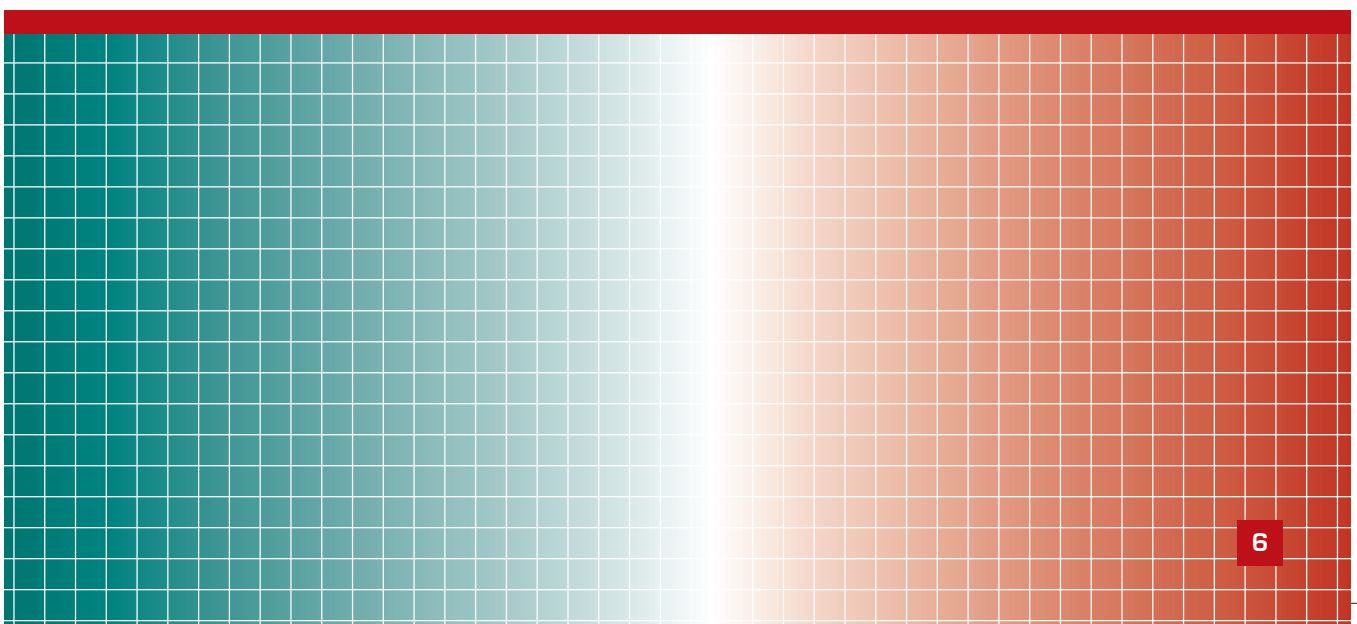
1.6 STRUCTURE OF THE REPORT

The report is structured as follows:

Chapter 2: Provides the analysis of the applicable legislative framework.
Chapter 3: Provides the statistical overview of trends in the utilisation of sick leave and incapacity leave.
Chapter 4: Provides the qualitative analysis of the findings on the implementation of PILIR.
Chapter 5: Provides the recommendations and conclusion.

Chapter Two

Analysis of the Legislative Framework



2.1 INTRODUCTION

In order to effectively manage sick leave, Temporary/Permanent Incapacity Leave and Ill-Health, proper policies and procedures are necessary. This chapter provides an analysis of the legislative framework for dealing with Temporary/Permanent Incapacity Leave and Ill-Health Retirement in the Public Service. The framework provides the requirements for the processing of and management of Temporary/Permanent Incapacity Leave and Ill-Health Retirement as stipulated in the legislation, regulations, policies and resolutions. The chapter also presents a brief analysis of PILIR as developed and introduced by the DPSA.

2.2 LEGISLATIVE PROVISIONS REGULATING TEMPORARY/PERMANENT INCAPACITY LEAVE AND ILL-HEALTH RETIREMENT

The legislative provisions regulating Temporary/Permanent Incapacity Leave and Ill-Health Retirement in the Public Service are stated in **Table 1** below:

Table 1: Legislative framework regulating Temporary/Permanent Incapacity Leave and Ill-Health Retirement in the Public Service

SOURCE	PROVISION
Labour Relation Act (LRA), 1995[9]	**Schedule 8 - Code of Good Practice: Dismissal** **Item 10 - Incapacity: Ill-health or injury** 1) Incapacity on the grounds of ill-health or injury may be temporary or permanent. If an employee is temporarily unable to work in these circumstances, the employer should investigate the extent of the incapacity or the injury. If the employee is likely to be absent for a time that is unreasonably long in the circumstances, the employer should investigate all the possible alternatives short of dismissal. When alternatives are considered, relevant factors might include the nature of the job, the period of absence, the seriousness of the illness or injury and the possibility of securing a temporary replacement for the ill or injured employee. In cases of permanent incapacity, the employer should ascertain the possibility of securing alternative employment, or adapting the duties or work circumstances of the employee to accommodate the employee's disability.

9 *Republic of South Africa. Department of Labour. Labour Relations Act, 1995 as amended.*

SOURCE	PROVISION
	2) In the process of the investigation referred to in subsection (1) the employee should be allowed the opportunity to state a case in response and to be assisted by a trade union representative or fellow employee. 3) The degree of incapacity is relevant to the fairness of any dismissal. The cause of the incapacity may also be relevant. In the case of certain kinds of incapacity, for example alcoholism or drug abuse, counselling and rehabilitation may be appropriate steps for an employer to consider. 4) Particular consideration should be given to employees who are injured at work or who are incapacitated by work-related illness. The courts have indicated that the duty on the employer to accommodate the incapacity of the employee is more onerous in these circumstances. **Guidelines in cases of dismissal arising from ill-health or injury** Any person determining whether a dismissal arising from ill-health or injury is unfair should consider: a) whether or not the employee is capable of performing the work; and b) if the employee is not capable: • the extent to which the employee is able to perform the work; • the extent to which the employee's work circumstances might be adapted to accommodate disability, or, where this is not possible, the extent to which the employee's duties might be adapted; and • the availability of any suitable alternative work.
PSCBC Resolution 7 of 2000, read with Resolution 5 of 2001[10]	This resolution, provides for: **Temporary Incapacity Leave:** a) An employee whose normal sick leave credits in a cycle have been exhausted and who, according to the relevant practitioner, requires to be absent from work due to incapacity which is not permanent, may be granted sick leave on full pay provided that: • her or his supervisor is informed that the employee is ill; and • a relevant registered medical and/or dental practitioner has duly certified such a condition in advance as temporary incapacity except where conditions do not allow.

10 *Republic of South Africa. Public Service Collective Bargaining Council. PSCBC Resolution 7 of 2000 as amended by PSCBC Resolution 5 of 2001.*

SOURCE	PROVISION
	b) The employer shall, during 30 working days, investigate the extent of inability to perform normal official duties, the degree of inability and the cause thereof. Investigations shall be in accordance with item 10(1) of Schedule 8 in the Labour Relations Act of 1995. c) The employer shall specify the level of approval in respect of applications for incapacity leave. **Permanent Incapacity Leave:** a) Employees whose degree of incapacity has been certified as permanent shall, with the approval of the employer, be granted a maximum of 30 working days paid sick leave, or such additional number of days required by the employer to finalise the process set out in (b) and (c) below. b) The employer shall, within 30 working days, ascertain the feasibility of: • alternative employment; or • adapting duties or work circumstances to accommodate the incapacity. c) If both the employer and the employee are convinced that the employee will never be able to perform any type of duties at her or his level or rank, the employee shall proceed with application for ill-health benefits in terms of the Pension Law of 1996.
Public Service Act, 1994 as amended[11]	**Section 17 – Termination of employment** S17 (1) (a) reads, "subject to paragraph (b), the powers to dismiss an employee shall vest in the relevant executive authority and shall be exercised in accordance with the Labour Relations Act. S17 (2) (a) reads, "An employee of a department, other than a member of the services, an educator or a member of the Intelligence Services, may be dismissed on account of incapacity due to ill-health or injury.

2.3 ANALYSIS OF THE LEGISLATIVE PROVISION IN RELATION TO PILIR

The Leave Determination[12], read with the applicable collective agreements[13] provides for 36 working days normal sick leave in a sick leave cycle of three years. If an employee has

11 *Republic of South Africa. Department of Public Service and Administration. Public Service Act, 1994 as amended.*
12 *Republic of South Africa. Department of Public Service and Administration. Determination on Leave of Absence in the Public Service (produced annually).*
13 *Republic of South Africa. Public Service Collective Bargaining Council. PSCBC Resolution 7 of 2000 as amended by PSCBC Resolutions 5 of 2001, PSCBC Resolution 15 of 2002 and PSCBC Resolution 1 of 2007.*

exhausted his/her normal sick leave, the employer, may at his/her discretion grant Temporary Incapacity Leave and, where applicable, Permanent Incapacity Leave. For this purpose the employer is required to conduct an investigation into the nature and extent of the employee's incapacity. Such investigation must be carried out in accordance with item 10 (1) of Schedule 8 of the Labour Relations Act (LRA). However managers were not consistent in managing Temporary Incapacity Leave and Ill-Health Retirement within their departments because of among other the lack of a uniform policy.

As a result PILIR was introduced by the Department of Public Service and Administration for departments to outline the objectives, adopting among other the concept of health risk management that is scientific, objective and fair, the policy provisions and procedures that should inform the investigation of applications for Incapacity Leave and/or Ill-Health Retirement as required in terms of item 10(1) of Schedule 8 of the LRA. PILIR clearly defines consistent, fair and objective processes and procedures that need to be followed to assess an application for Temporary/Permanent Incapacity Leave and/or Ill-Health Retirement. This enables the employer when exercising its discretion, to make an informed decision based on sound advice from medical experts.

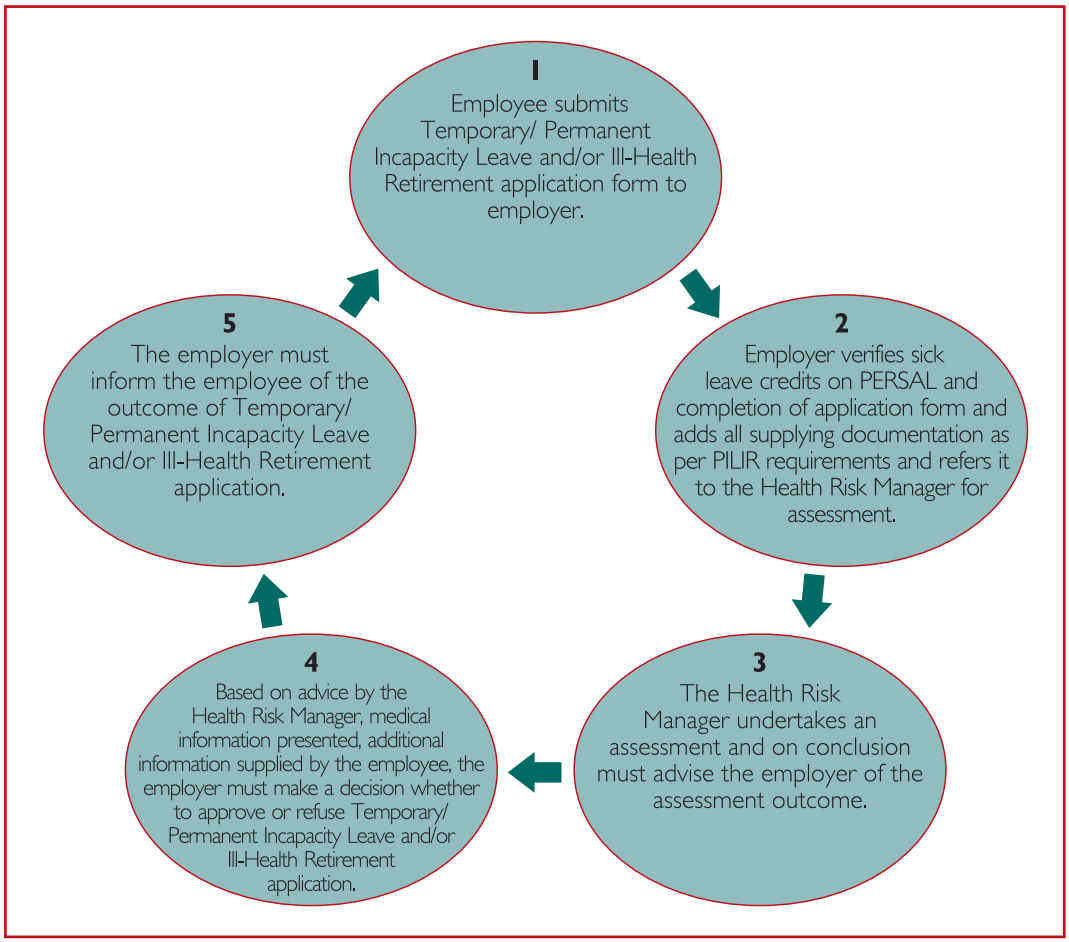
The medical experts are referred to as Health Risk Managers, which are independent legal entities which comprise of independent multi-disciplinary medical experts, specialising in occupational medicine. The Health Risk Managers were in the centralised roll-out appointed by the DPSA for each implementation area. Within the decentralisation with effect from 1 April 2009, the DPSA appoints a Panel of Accredited Health Risk Managers from which provincial departments and national departments could select and appoint a Health Risk Manager for the provincial administration or cluster of national departments. The role of the Health Risk Managers is to assess the validity of applications for Temporary Incapacity Leave, the need for ongoing Temporary Incapacity Leave, the appropriate duration of the leave, preliminary advice on the management of the condition, whether a full health assessment should be conducted to ascertain whether the condition is permanent and whether other interventions such as work place adaptation, etc is needed. Similarly the Health Risk Manager is to assess the validity of applications for Ill-Health Retirement, the management of the condition, if applicable and whether the employer should investigate and consider alternative employment, work place adaptations, etc. The Health Risk Manager, on the basis of its findings, is to provide advice to the employer in respect of employees' applications for Incapacity Leave and/or Ill-Health Retirement within specified timeframes.

PILIR also obligates departments to investigate and consider, short of Ill-Health Retirement, ways to accommodate incapacitated employees within the workplace either through rehabilitation, re-skilling, re-alignment and replacing, and only if none of these methods of assistance is feasible, the department may implement the Ill-Health Retirement processes. The procedure to follow is outlined in PILIR, as amended[14]. A summarised version of the

14 *Republic of South Africa. Department of Public Service Administration. Policy and Procedure on Incapacity and Ill-Health Retirement (Amended Policy Version 3). July 2008.*

key stages to follow when processing a Temporary/Permanent Incapacity Leave and/or Ill-Health Retirement application is shown below:

Diagram 1: The Temporary/Permanent Incapacity Leave and/or Ill-Health Retirement application processing flow



Based on the above, it is clear that incapacity leave is not an unlimited amount of additional sick leave days at an employee's disposal. Incapacity leave is additional sick leave granted at the *employer's discretion*, as provided for in the Leave Determination, read with the applicable collective agreements. Incapacity leave is not leave of right which is covered under the Basic Conditions of Employment Act (BCEA), 1997. Therefore, employers have a greater obligation to properly manage sick leave and incapacity leave using the applicable legislative provisions. The onus is on departments to ensure that the managers and human resource management practitioners receive the necessary training in order for the implementation of PILIR to be effective.

Chapter Three

Statistical Overview of Trends in the Utilisation of Sick Leave and Incapacity Leave

3.1 INTRODUCTION

This chapter provides a quantitative overview of trends in the utilisation of sick and incapacity leave pre and post the implementation of PILIR. This overview is an important basis for assessing the extent to which PILIR has influenced the sick leave trends within the Public Service, including the financial implications pre and post its implementation. The statistical information was obtained from PERSAL and the Health Risk Managers' reports on the sampled national and provincial departments for the periods January 2004 to December 2006 (pre PILIR) and January 2007 to June 2009 (post PILIR).

The following categories of data were used as the basis to determine whether the implementation of PILIR has made an impact on the management of sick leave in the Public Service:

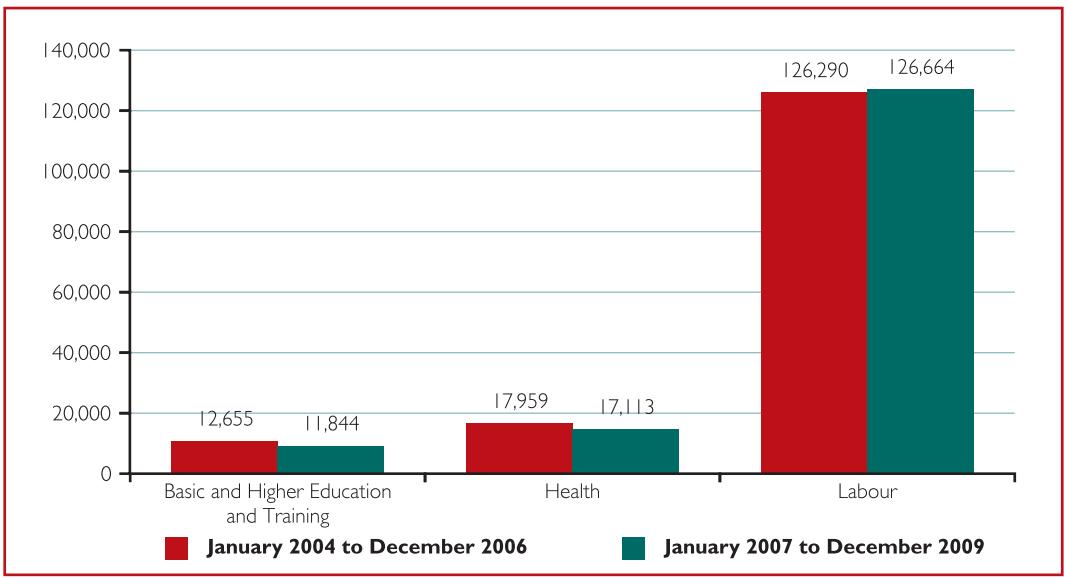
- Information from PERSAL on the total number of sick leave days taken pre and post PILIR for sampled national and provincial departments.
- Information from PERSAL on the total number of people that took sick leave by gender pre and post PILIR for sampled national and provincial departments.
- Information from PERSAL on the total number of sick leave days taken by level and the cost implications pre and post PILIR for sampled national and provincial departments.
- Information from PERSAL on the number of people and days of the week when sick leave was taken for the sampled national and provincial departments.
- Information from the Health Risk Managers' reports for sampled national and provincial departments.

3.2 SICK LEAVE STATISTICS PER NATIONAL DEPARTMENT PRE AND POST PILIR

(a) Total number of sick leave days taken per department during the period January 2004 to June 2009

This section provides statistical data on the total number of sick leave days taken in the national departments of Labour, Health, Basic and Higher Education and Training. **Figure 1** on the following page presents the analysis of the total number of sick leave days taken per department.

Figure 1: Total number of sick leave days taken per department during the period January 2004 to June 2009



Source: PERSAL (National Treasury)

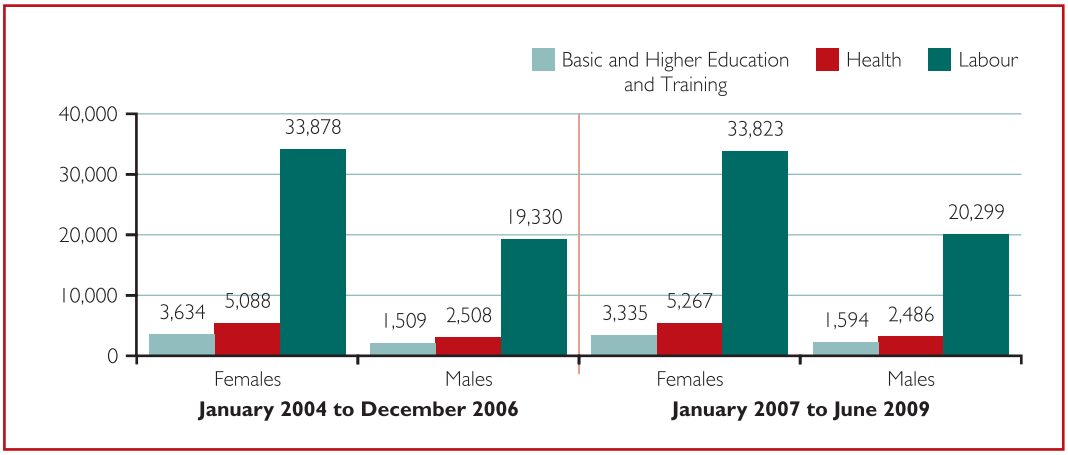
According to Figure 1 the highest number of sick leave days taken at the national level was in the Department of Labour where 126 290 days were taken pre PILIR and 126 664 post PILIR, representing an increase of 376 leave days. For the same period the departments of Health and Basic and Higher Education and Training experienced a decrease of 846 and 811 leave days respectively. Even though the decrease in the departments of Health and Basic and Higher Education and Training was not significant it does suggest that there has been a reduction in the number of sick leave days taken after the implementation of PILIR. However, the PSC would like to caution that at this stage these figures should be regarded as indicative of the general trends and not as absolute given the inadequate management of leave records in the departments[15].

(b) Total number of people that took sick leave by gender during the period January 2004 to June 2009

This section provides statistical data on the total number of people who took sick leave by gender in the sampled national departments of Labour, Health and Basic and Higher Education and Training.

15 *During the study the PSC found that the Department of Labour kept better leave records compared to the other departments in the sample.*

Figure 2: Total number of people that took sick leave by gender during the period January 2004 to June 2009



Source: PERSAL (National Treasury)

Figure 2 above indicates that overall in all three departments female employees continued to take more sick leave than their male counterparts after the implementation of PILIR. The combined total for all the three departments indicates that pre PILIR 42 600 female employees took sick leave as compared to 23 347 male employees, and post PILIR 42 425 female employees took sick leave as compared to 24 379 male employees.

This trend shows that more female employees take sick leave than their male counterparts and this has not changed as noted in the last report prepared by the PSC on, *Sick Leave Trends in the Public Service*[16]. This may be attributed to the fact that there are more women employed in the Public Service than male employees especially in salary levels 1-10. Other factors such as maternity leave and child rearing responsibilities could be regarded as contributing to more women taking sick leave than their male counterparts. The Health Risk Managers' reports also confirmed that an average of 30% more applications for incapacity leave were received from women when compared to applications received from male employees.

(c) Total number of sick leave days taken per level and costs for the period January 2004 to June 2009

Table 2 on the following page provides statistical data on the total number of sick leave days taken per level together with the cost implications in the sampled national departments of Labour, Health and Basic and Higher Education and Training. The cost information contained in the table below was obtained from PERSAL.

16 *Republic of South Africa. Public Service Commission. Sick Leave Trends in the Public Service. March 2002.*

Table 2: Total number of sick leave days taken per level and costs for the period January 2004 to June 2009

Departments	Level	Period January 2004 to December 2006		Period January 2007 to June 2009	
		Total number of sick leave days taken	Total cost of sick leave taken in Rand	Total number of sick leave days taken	Total cost of sick leave taken in Rand
Education	Senior Management (level 13-16)	568	627 381	678	897 443
	Highly skilled supervision (level 9-12)	3 210	2 474 975	3 281	3 023 014
	Lower - Highly skilled production (level 1-8)	8 876	2 325 970	7 514	2 331 390
	Other	1	192	475	518 279
	Total Education	**12 655**	**5 428 520**	**11 948**	**6 770 125**
Health	Senior Management (level 13-16)	863	973 833	884	1 177 614
	Highly skilled supervision (level 9-12)	4 309	2 858 913	4 252	3 457 756
	Lower - Highly skilled production (level 1-8)	12 787	3 480 419	12 591	4 150 136
	Other	0	0	25	18 008
	Total Health	**17 959**	**7 313 165**	**17 752**	**8 803 515**
Labour	Senior Management (level 13-16)	488	571 888	679	981 072
	Highly skilled supervision (level 9-12)	8 112	5 179 254	9 294	7 969 671
	Lower - Highly skilled production (level 1-8)	117 682	32 544 321	116 688	39 859 621
	Other	8*	0	3	3 660
	Total Labour	**126 290**	**38 295 462**	**126 664**	**48 814 026**
GRAND TOTAL		**156 904**	**51 037 150**	**156 364**	**64 387 666**

*Where sick leave days were taken but no costs allocated to those days, this was due to the fact that these employees were not in service at the end date of the leave period.

Source: PERSAL (National Treasury)

Sick leave days taken cost the Department of Labour R38 295 462 pre PILIR as compared to R48 814 026 post PILIR. This suggests that sick leave costs increased by ten percent (10%) for the department. With regard to the departments of Health and Basic and Higher Education and

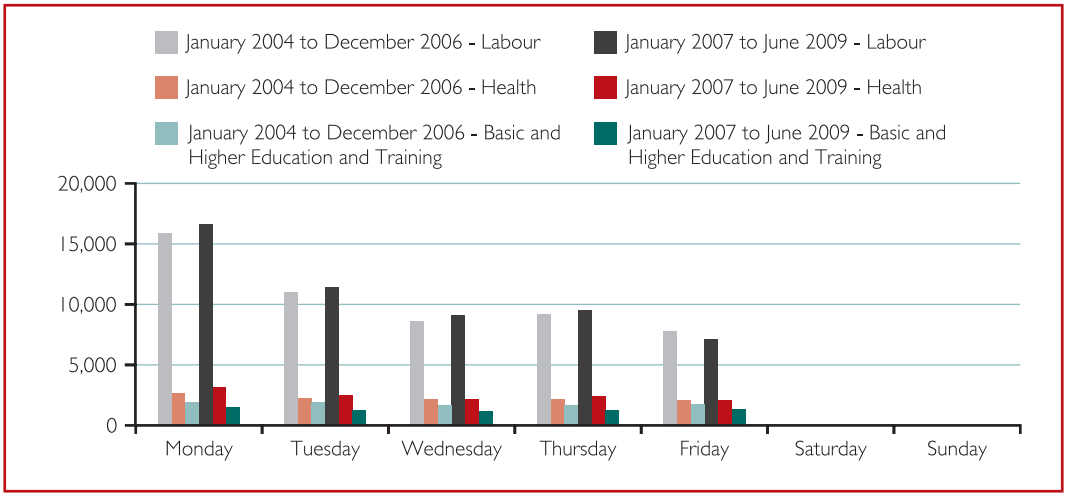
Training, even though there were slight increases, overall these were not of material significance. The total cost of sick leave taken in the three sampled departments combined increased by 26% to (R13 350 516) post PILIR. Although part of this increase can be attributed to the cost of living adjustments for public servants' salaries, it is also evident from the Health Risk Managers' reports that departments are still experiencing an escalation of costs with regards to incapacity leave taken by their employees[17]. The same finding regarding the increase in costs was made in the provincial departments of Health and Education. This entails that PILIR has failed to achieve its main objective of reducing sick leave costs in departments.

Table 2 also provides information on the total number of sick leave days taken per level. There was an increase in the number of sick leave days taken by senior managers post PILIR from all the three sampled departments. In the Department of Labour sick leave days taken by SMS members increased by 39% post PILIR. This is a cause for concern because employees at the SMS level are instrumental in translating departmental strategies into concrete operations which should result in service delivery. If there is no strategic guidance, this impacts negatively on departmental performance. Further, the Health Risk Managers reports indicated that a total of 95 SMS members occupying salary levels 13 – 16 took incapacity leave from June 2006 to June 2009.

(d) Days of the week on which sick leave is taken per department during the period January 2004 to June 2009

Figure 3 below provides statistical data on the days of the week on which sick leave is taken in the sampled national departments of Labour, Health and Basic and Higher Education and Training.

Figure 3: Days of the week on which sick leave was taken per department during the period January 2004 to June 2009



*Some employees take sick leave on Saturday and Sunday because their work requires that they be at work over weekends.
Source: PERSAL (National Treasury)

17 *For comparative purposes it should be noted, that this applies only to costs incurred with regards to Temporary/Permanent Incapacity Leave taken, because Health Risk Managers only become involved in the monitoring and reporting of leave when employees apply for incapacity. Thus normal sick leave costs are not included in the Health Risk Managers Reports.*

Figure 3 on the previous page indicates that there has been a slight increase in the number of employees who took sick leave on Mondays in the departments of Health and Labour after the implementation of PILIR. It is clear that the largest number of incidences of sick leave take place on Mondays, the first working day of the week. This progressively reduces towards the end of the week. Less than half the number of employees who take sick leave on Mondays take sick leave on Fridays.

The PSC's report on *Sick Leave Trends in the Public Service*[18] indicated that the situation was the same in 2002, and this has not changed with the implementation of PILIR. The trend may be attributed to employees using sick leave as a convenient method to extend their weekend. One of the key aims for introducing PILIR was also to create a paradigm shift where employees had to become acutely aware of their responsibilities in utilising their normal sick leave[19]. However, trends shown in **figure 3** on the previous page suggest that the abuse of normal sick leave may still persist.

3.3 SICK LEAVE STATISTICS FOR PROVINCIAL DEPARTMENTS PRE AND POST PILIR

(a) Total number of sick leave days taken per department during the period January 2004 to June 2009

This section provides the statistical data on the total number of sick leave days taken in sampled provincial departments of Health and Education.

Table 3: Total number of sick leave days taken per province in the sampled departments

Province	Departments	January 2004 to December 2006	January 2007 to June 2009
		Total number of days taken	Total number of days taken
Eastern Cape	Education	550 819	585 217
	Health	463 793	446 633
Free State	Education	380 191	328 350
	Health	231 323	218 513
Gauteng	Education	679 734	675 642
	Health	631 144	607 378
KZN	Education	741 733	708 935
	Health	786 934	871 227

18 *Republic of South Africa. Public Service Commission. Sick Leave Trends in the Public Service. March 2002.*
19 *Republic of South Africa. Department of Public Service and Administration. The Implementation of the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR). August 2007.*

Province	Departments	January 2004 to December 2006	January 2007 to June 2009
		Total number of days taken	Total number of days taken
Limpopo	Education	286 415	275 490
	Health	268 594	290 476
Mpumalanga	Education	286 109	275 344
	Health	148 823	154 223
Northern Cape	Education	98 368	88 086
	Health	73 957	79 469
North West	Education	324 258	239 734
	Health	123 882	201 514
Western Cape	Education	467 152	460 876
	Health	472 026	434 436
TOTAL		**7 015 255**	**6 941 543**

Source: PERSAL(National Treasury)

Table 3 above shows that with the exception of the Eastern Cape Province, all the provincial departments of Education experienced a decrease in the number of sick leave days taken. Overall a total decrease of 211 503 sick leave days taken was observed. The decrease ranged from 84 524 days in the North West Province to 10 925 days in the Limpopo Province. Fifty five percent (55%) of the provincial departments of Health experienced an increase in the number of sick leave days taken post PILIR. No reasons could be determined for the increase.

From the data presented above, it can be deduced that the implementation of PILIR has been somewhat effective in reducing sick leave days taken in the provinces, given that in 66% of the provincial departments of Education and Health a decrease in the number of sick leave days taken was observed. However, it still remains a major concern that 44% of the departments experienced an increase in sick leave days taken instead of a decrease as per the intentions of the PILIR policy. One factor that should also be noted is that not all departments update their PERSAL records timeously, and this could have impacted on the accuracy of the data availed.

(b) Total number of sick leave days taken per level and the costs for the period January 2004 to June 2009 for the provincial departments of Education and Health

Tables 4 and **5** on the following page provide statistical data on the total number of sick leave days taken per level together with the cost implications in the sampled provincial departments of Education and Health respectively.

Table 4: Total number of sick leave days taken per level and costs for the period January 2004 to June 2009 in the Department of Education

Department	Level	January 2004 to December 2006		January 2007 to June 2009	
		No of days	Cost in Rand	No of days	Cost in Rand
Eastern Cape					
Education	Senior Management (level 13-16)	477	518 732	619	792 214
	Highly skilled supervision (level 9-12)	16 252	12 023 156	11 572	9 774 792
	Lower - Highly skilled production (level 1-8)	534 085	200 176 584	260 149	106 578 691
	Other	5	325	312 877	169 119 479
Education Total		**550 819**	**212 718 798**	**585 217**	**286 265 178**
Free State					
Education	Senior Management (level 13-16)	368	418 582	438	611 429
	Highly skilled supervision (level 9-12)	9 203	6 839 075	5 912	4 953 089
	Lower - Highly skilled production (level 1-8)	370 620	129 168 180	186 831	69 320 919
	Other	0	0	135 169	72 417 565.77
Education Total		**380 191**	**136 425 837**	**328 350**	**147 303 001**
Gauteng					
Education	Senior Management (level 13-16)	307	369 306	277	391 479
	Highly skilled supervision (level 9-12)	15 982	11 794 619	9 131	7 596 037
	Lower - Highly skilled production (level 1-8)	663 293	240 674 278	359 874	134 608 256
	Other	152	21 855	306 360	168 803 600
Education Total		**679 734**	**252 860 058**	**675 642**	**311 399 373**

Department	Level	January 2004 to December 2006		January 2007 to June 2009	
		No of days	Cost in Rand	No of days	Cost in Rand
KwaZulu-Natal					
Education	Senior Management (level 13-16)	307	342 346	566	731 734
	Highly skilled supervision (level 9-12)	17 647	12 629 703	10 839	8 662 902
	Lower - Highly skilled production (level 1-8)	723 779	265 509 651	374 984	147 811 231
	Other	0	0	322 546	167 300 634.20
Education Total		**741 733**	**278 481 700**	**708 935**	**324 506 502**
Limpopo					
Education	Senior Management (level 13-16)	219	255 127	195	277 198
	Highly skilled supervision (level 9-12)	6 670	4 961 402	3 462	2 850 151
	Lower - Highly skilled production (level 1-8)	279 526	106 488 966	117 750	49 371 763
	Other	0	0	154 083	83 704 149
Education Total		**286 415**	**111 705 495**	**275 490**	**136 203 261**
Mpumalanga					
Education	Senior Management (level 13-16)	236	262 245	154	204 454
	Highly skilled supervision (level 9-12)	6 874	4 963 568	4 451	3 685 160
	Lower - Highly skilled production (level 1-8)	278 999	99 043 642	141 567	51 637 372
	Other	0	0	129 172	68 170 377
Education Total		**286 109**	**104 269 456**	**275 344**	**123 697 364**

Department	Level	January 2004 to December 2006		January 2007 to June 2009	
		No of days	Cost in Rand	No of days	Cost in Rand
Northern Cape					
Education	Senior Management (level 13-16)	85	72 041	196	269 822
	Highly skilled supervision (level 9-12)	2 628	1 978 672	1 896	1 578 049
	Lower - Highly skilled production (level 1-8)	95 654	33 857 452	51 841	30 944 558
	Other	1	0	34 153	18 941 819
Education Total		**98 368**	**35 908 165**	**88 086**	**51 734 248**
North West					
Education	Senior Management (level 13-16)	250	276 974	288	375 334
	Highly skilled supervision (level 9-12)	8 231	6 020 174	4 249	3 533 181
	Lower - Highly skilled production (level 1-8)	315 736	113 103 022	120 298	47 509 651
	Other	41	5 173	114 899	61 705 875
Education Total		**324 258**	**119 405 344**	**239 734**	**113 124 042**
Western Cape					
Education	Senior Management (level 13-16)	303	359 225	506	634 610
	Highly skilled supervision (level 9-12)	8 770	6 489 863	6 438	5 415 551
	Lower - Highly skilled production (level 1-8)	458 079	164 984 855	263 322	99 312 440
	Other	0	0	190 610	105 149 212
Education Total		**467 152**	**171 833 944**	**460 876**	**210 511 814**
GRAND TOTAL		**3 263 960**	**1 210 889 999**	**3 052 457**	**1 409 479 605**

Source: PERSAL (National Treasury)

Trends between the national and provincial departments with regards to the total number of sick leave days taken per level and costs are not that different. It can be observed that similar to national departments, provinces also experienced an increase in the number of sick leave days taken by the SMS members, with the exception of the provincial departments of Education in Gauteng, Limpopo and Mpumalanga. The PSC report on *Sick Leave Trends in the Public Service*[20], indicated that the highest number of sick leave days taken was amongst the lower-highly skilled production employees levels 1-8. This has not changed with the implementation of PILIR. This could be due to the fact that the organisational establishments in provinces are concentrated at lower levels.

Within the provincial departments of Education overall, all but one (i.e. the Eastern Cape Province) experienced a decline in terms of sick leave days taken post PILIR. The decrease in the number of sick leave days taken is an encouraging trend, however, the costs, have increased with the exception of the North West. This means that PILIR has not achieved one of its main objectives of reducing sick leave costs to departments. This may also be attributed to the costs of employment which have increased over the years.

Table 5: Total number of sick leave days taken per level and cost for the period January 2004 to June 2009 in the Department of Health

Department	Level	January 2004 to December 2006		January 2007 to June 2009	
		No of days	Cost in Rand	No of days	Cost in Rand
Eastern Cape					
Health	Senior Management (level 13-16)	902	941 837	812	1 040 348
	Highly skilled supervision (level 9-12)	17 354	11 247 349	37 841	26 528 691
	Lower - Highly skilled production (level 1-8)	445 421	120 059 694	407 976	142 396 093
	Other	116	6 901	4	493
Health Total		**463 793**	**132 255 782**	**446 633**	**169 965 626**
Free State					
Health	Senior Management (level 13-16)	425	468 747	525	740 247
	Highly skilled supervision (level 9-12)	9 300	6 305 214	14 292	12 391 101

20 *Republic of South Africa. Public Service Commission. Sick Leave Trends in the Public Service. March 2002.*

Department	Level	January 2004 to December 2006		January 2007 to June 2009	
		No of days	Cost in Rand	No of days	Cost in Rand
	Lower - Highly skilled production (level 1-8)	221 591	59 913 206	203 683	71 712 297
	Other	7	0	13	14 038.49
Health Total		**231 323**	**66 687 168**	**218 513**	**84 857 685**
Gauteng					
Health	Senior Management (level 13-16)	1 314	1 460 766	1 778	1 642 083
	Highly skilled supervision (level 9-12)	29 368	19 867 875	37 752	32 657 113
	Lower - Highly skilled production (level 1-8)	600 320	144 529 321	567 783	182 021 922
	Other	142	0	65	66 709
Health Total		**631 144**	**165 857 964**	**607 378**	**216 387 829**
KwaZulu-Natal					
Health	Senior Management (level 13-16)	808	891 634	1 468	1 918 008
	Highly skilled supervision (level 9-12)	23 648	15 903 822	44 755	38 697 036
	Lower - Highly skilled production (level 1-8)	762 433	191 239 911.00	824 976	262 589 297.10
	Other	45	13 356	28	16 573
Health Total		**786 934**	**208 048 724**	**871 227**	**303 220 915**
Limpopo					
Health	Senior Management (level 13-16)	462	514 462	500	685 591
	Highly skilled supervision (level 9-12)	11 879	7 810 822	19 823	17 235 360
	Lower - Highly skilled production (level 1-8)	256 249	68 360 078	270 153	92 266 384

Department	Level	January 2004 to December 2006		January 2007 to June 2009	
		No of days	Cost in Rand	No of days	Cost in Rand
	Other	4	0	0	0
Health Total		**286 594**	**76 685 362**	**290 476**	**110 187 336**
Mpumalanga					
Health	Senior Management (level 13-16)	315	342 110	165	209 440
	Highly skilled supervision (level 9-12)	5 668	3 721 360	9 406	8 154 286
	Lower - Highly skilled production (level 1-8)	142 840	36 404 237	144 636	47 496 553
	Other	0	0	16	13 177
Health Total		**148 823**	**40 467 708**	**154 223**	**55 873 457**
Northern Cape					
Health	Senior Management (level 13-16)	140	156 812	139	182 749
	Highly skilled supervision (level 9-12)	2 157	1 399 641	2 885	2 359 807
	Lower - Highly skilled production (level 1-8)	71 660	18 650 486	76 424	26 066 282
	Other			21	13 421.28
Health Total		**73 957**	**20 206 940**	**79 469**	**28 622 860**
North West					
Health	Senior Management (level 13-16)	213	234 011	566	764 040
	Highly skilled supervision (level 9-12)	4 393	2 912 320	10 619	9 248 853
	Lower - Highly skilled production (level 1-8)	119 269	31 003 507	190 297	62 435 229
	Other	7	0	32	22 319
Health Total		**123 882**	**34 149 838**	**201 514**	**72 470 441**

Department	Level	January 2004 to December 2006		January 2007 to June 2009	
		No of days	Cost in Rand	No of days	Cost in Rand
Western Cape					
Health	Senior Management (level 13-16)	714	801 532	621	858 960
	Highly skilled supervision (level 9-12)	21 970	14 732 186	28 232	23 856 203
	Lower - Highly skilled production (level 1-8)	449 325	114 297 387	405 553	136 855 981
	Other	17	149	30	11 275
Health Total		**472 026**	**129 831 255**	**434 436**	**161 582 420**
GRAND TOTAL		**3 200 476**	**874 190 741**	**3 303 869**	**1 203 159 569**

Source: PERSAL (National Treasury)

Table 5 above provides the total number of sick leave days taken in the provinces in the Department of Health per level pre PILIR and post PILIR together with the costs incurred.

Unlike the national departments and the provincial departments of Education, implementation of PILIR has not been effective in reducing the overall number of sick leave days taken for the Department of Health in the provinces. In the provincial Health departments it has also been determined that after the implementation of PILIR there has been an increase in the overall costs incurred for the sick leave taken from R 874 190 741 to R 1 203 159 569. No reasons could be determined for such an increase.

(c) Combined total number of people that took sick leave by gender during the period January 2004 to June 2009 in the provincial departments of Education and Health

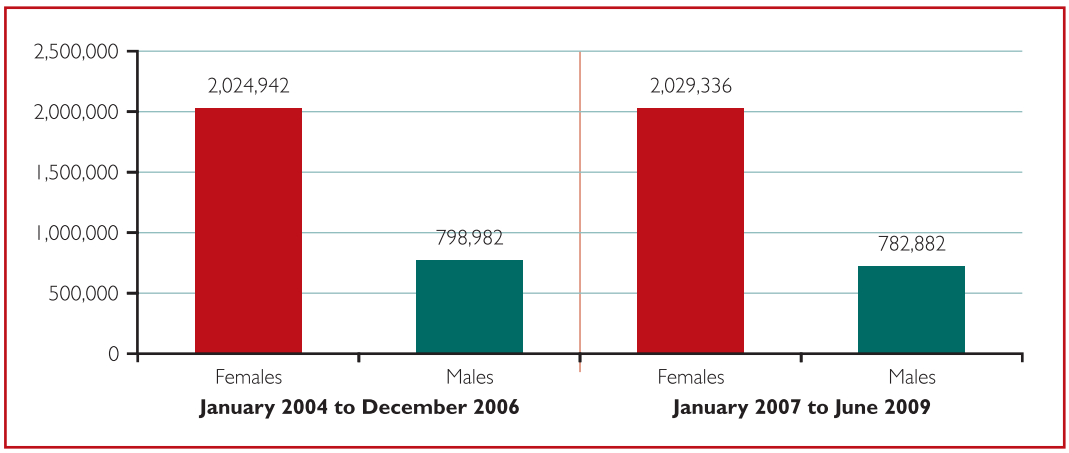
This section provides the statistical data on the combined total number of employees who took sick leave by gender during the period January 2004 to June 2009 in the provincial departments of Education and Health.

Figure 4 on the following page illustrates that a total of 2 029 336 sick leave episodes occurred among female employees post PILIR compared to the 2 024 942 episodes pre PILIR. Thus 4394 more sick leave episodes occurred among female employees after the implementation of PILIR. This trend was also confirmed by the Health Risk Managers' reports where

for example in the North West Department of Education, the gender distribution of applications for long Temporary Incapacity Leave showed that more female employees submitted applications than males. The PERSAL statistics in **Figure 4** below further show that 782 882 sick leave episodes occurred among male employees compared to the 798 982 sick leave episodes accessed by males pre PILIR, which shows a slight decrease in the sick leave episodes that occurred among the male employees post PILIR.

The sick leave episodes among male employees in the sampled provincial departments decreased by 16 100. Similar to the statistics of the national departments, in the provincial departments female employees still remain the higher of the two genders with respect to the number of sick leave days taken and this has not changed since 2002[21]. This trend was also observed in national departments and could be attributed to the fact that there are more women employed in the Public Service than male employees especially in salary levels 1-10. Other factors such as maternity leave, child rearing and household-headship responsibilities could be regarded as contributing to more women taking sick leave than their male counterparts. Although post PILIR the number of sick leave days taken amongst the male employees has gone down this cannot be said for the female employees in the provinces.

Figure 4: Combined total number of people that took sick leave by gender during the period January 2004 to June 2009 in the provincial departments of Education and Health



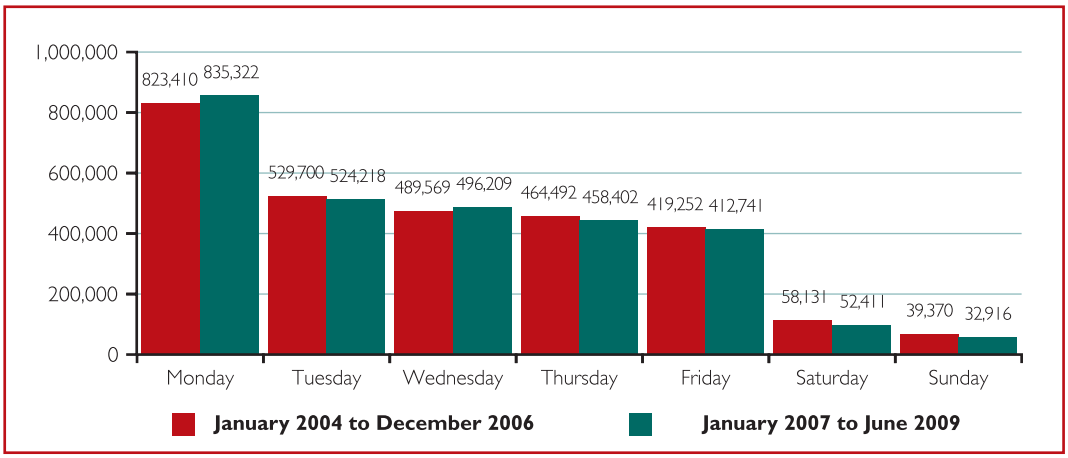
Source: PERSAL (National Treasury)

(d) Days of the week on which sick leave is taken per department during the period January 2004 to December 2006

Figure 5 on the following page provides statistical data on the days of the week on which sick leave is taken in the sampled provincial departments of Health and Education combined.

21 *Republic of South Africa. Public Service Commission. Sick Leave Trends in the Public Service. March 2002.*

Figure 5: Number of people and days of week when sick leave was taken during the period January 2004 to June 2009 in the departments of Health and Education



Source: PERSAL (National Treasury)

Figure 5 above indicates that there has been no significant decrease in the number of employees that take sick leave on a Monday within the provinces. It is evident that more employees are absent on sick leave on a Monday with the number progressively reducing towards the end of the week.

As seen with the national departments on Fridays less than half the number of incidences of sick leave recorded as compared to Mondays and there has been no change in this regard since 2002[22] and even after the implementation of PILIR.

3.4 SUMMARY

In this chapter it is evident from the statistics reflected in the tables and figures above that the Public Service has a long way to go in reducing the rate of absenteeism, and managing the abuse of sick leave. PILIR has shown to have had an impact although not a significant one at this stage. There has been a decrease in absenteeism to some degree, although leave taken by employees in levels 1-8 still remains the highest. In addition there has not been much of a change in numbers of females and males taking sick leave and of great concern are the high numbers of employees taking sick leave on a Monday, a pattern which still remains a challenge in departments. Also the costs have increased after PILIR implementation. The Auditor-General's report on a *Performance Audit of the Management of Sick Leave Benefits at certain National and Provincial Departments*[23] indicated that during the period of 1 January 2001 to 31 December 2003 government employees used approximately 12.6 million sick leave days at an estimated cost of R3 257 million. From the statistical data analysed above it is evident

22 *Republic of South Africa. Public Service Commission. Sick Leave Trends in the Public Service. March 2002.*
23 *Republic of South Africa. Auditor-General. Report of the Auditor-General on a Performance Audit of the Management of Sick Leave Benefits at certain National and Provincial Departments. December 2005.*

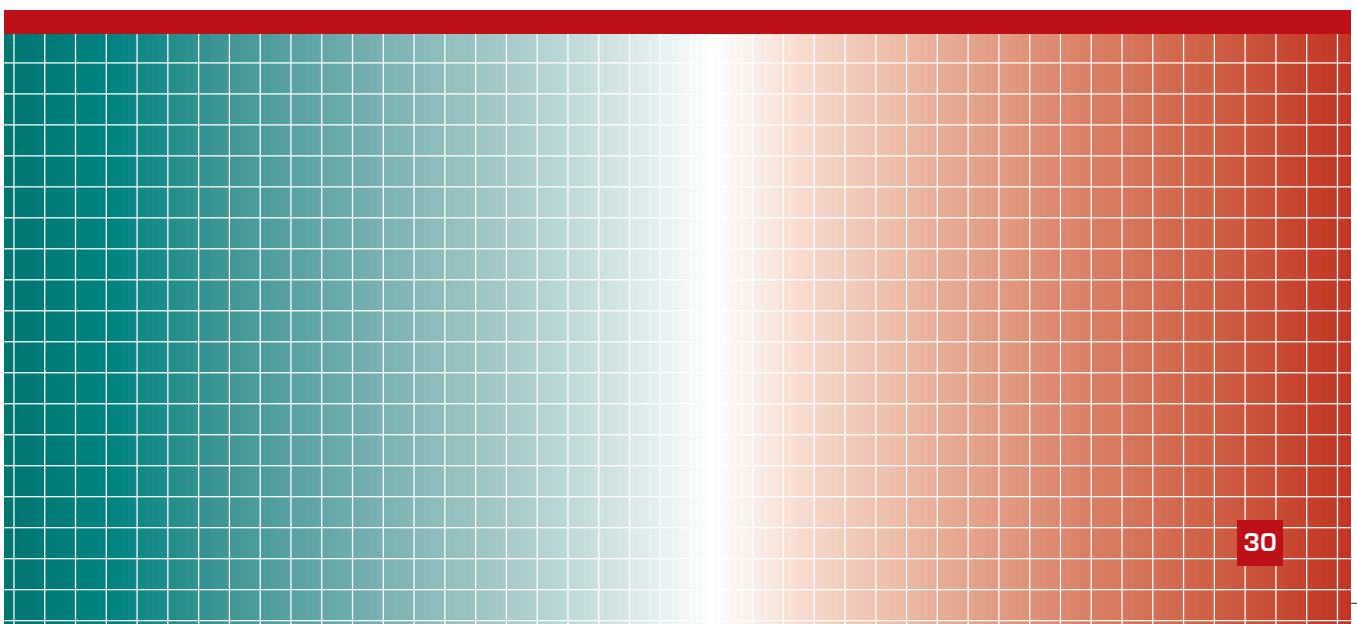
that PILIR has thus far not made a significant difference in the cost that the State is incurring for the number of sick leave days taken.

Although the number of sick leave days has slightly decreased in the Public Service, the costs have increased. This may be attributed to the rising costs of employment over the years. Also it must be noted that over and above the sick leave costs incurred by the Public Service, there are additional costs on the utilisation of Health Risk Managers who assess the validity of Incapacity Leave and Ill-Health Retirement applications.

However, it must be noted that PILIR is a fairly new policy which has only been implemented in the last three year cycle. It is clear that there are many challenges that still persist, it is hoped however that once these challenges have been addressed and given more time PILIR would be an effective tool in the management of the abuse of sick leave and a decrease in costs would be experienced.

Chapter Four

Qualitative Analysis of the Findings on the Implementation of PILIR



4.1 INTRODUCTION

The purpose of this chapter is to provide the findings on the experiences and challenges faced by the Human Resource Practitioners in the sampled departments and other role-players in the implementation of PILIR. What emerged from the information collated through the questionnaires and the interviews conducted was that even though departments have experienced a decrease in the rate of absenteeism there have been many challenges experienced with the implementation of PILIR. The interviews provided rich insights on the complexities involved with PILIR. These insights can serve as a meaningful basis for understanding the impediments that must be addressed in order to ensure effective implementation.

4.2 APPLICATION OF THE POLICY ON INCAPACITY LEAVE AND ILL-HEALTH RETIREMENT

4.2.1 There is inadequate understanding of the provisions of PILIR and their application

From the responses to the questionnaire and the interviews conducted the following was established from questionnaires:

- Of the human resource officials who participated in the study 60% said that they had an adequate understanding of PILIR as well as the functions of key role-players involved in the process. The majority of those who indicated that they did not understand the policy adequately were from the national Department of Basic and Higher Education and Training and the provincial Departments of Health in the Eastern Cape, Northern Cape and North West. This is a cause for concern given that the majority of public servants are employed in provincial departments and that it is therefore, at this sphere of government that capacity is necessary to implement the policy effectively. It is unacceptable that three years after implementation public servants are displaying a lack of understanding of the policy.

- Of the human resource officials that participated in the study 100% indicated that they are using the services of the Health Risk Managers and are implementing the recommendations of the Health Risk Managers. From the sampled departments 90% indicated that they have a leave policy in place and of these departments, 76% indicated that PILIR forms part of their general leave policy.

- It is of great concern that the provincial departments of Education and Health in the Northern Cape do not have a Leave Policy in place. This is very concerning as this indicates that there is no tool in place to guide and regulate leave taken by employees

including PILIR. This is a bad practice with regards to the implementation of Human Resource policies and prescripts.

4.2.2 Turnaround times for processing applications are often not met

In terms of the policy there are four types of incapacity leave namely; short period of Temporary Incapacity Leave (1-29 working days requested per occasion), long period of Temporary Incapacity Leave (30 working days or more requested per occasion), Permanent Incapacity Leave and Ill-Health Retirement. For each of these applications there are certain processes and procedures that need to be followed. Management, HR units and employees need to fully commit themselves to the following:

- An understanding of and the management of sick leave, Ill-Health Retirement and the introduction and application of PILIR.
- They need to co-operate when processing the applications for PILIR.
- They need to adhere to timeframes outlined for in the policy.
- Facilitate the final decision-making outcome promptly.
- Ensure that the outcome of the application is communicated to employees immediately.
- Maintain sound administrative and record-keeping systems.

The turnaround time for applications is as follows:

- **Temporary Incapacity Leave:** *the employee* – must within *5 working days after the first day of absence* submit an application form for incapacity leave personally or through a relative, fellow employee or friend.
- *The employer* - must within *5 working days* from receipt of the employee's application for Temporary Incapacity Leave verify that the employee has completed the form correctly, ensure all compulsory information is attached for example the medical certificate and any other optional information, must conditionally grant a maximum of 30 consecutive working days Temporary Incapacity Leave with full pay and immediately complete the department's report to the Health Risk Manager.
- *The Health Risk Manager* – must acknowledge receipt of the abovementioned report within *2 working days* and confirm in writing that the employer shall receive feedback on the application within *12 working days*[24].

It was established from the questionnaires analysed, that 85% of the sampled departments are not adhering to the turnaround time of processing the Temporary Incapacity Leave, Permanent Incapacity Leave and Ill-Health Retirement as stipulated in PILIR. The sampled departments indicated that some applications take a month or two before they can be forwarded to the Health Risk Managers. This therefore results in further delays from the Health Risk Managers in meeting the stipulated dates.

24 *Republic of South Africa. Department of Public Service Administration. Policy and Procedure on Incapacity and Ill-Health Retirement (Amended Policy Version 3). July 2008.*

The following challenges were identified as contributory factors for non-adherence to time-frames when implementing PILIR:

- The Heads of Department or delegated authority delay in making the final decision on the outcome of the Temporary Incapacity Leave application after the Health Risk Manager has provided the recommendations to the department.
- In the Northern Cape and North West Provinces which are 80% rural, the lack of specialists poses a problem as employees need to be sent to other provinces to be assessed. This therefore creates further delays in the processing of the application forms.
- Health Risk Managers also do not adhere to the specified timeframes for assessing the applications. At times they also do not forward the outcomes of the assessments to the departments in the specified timeframe. As a result, the HR units cannot capture the information on PERSAL timeously.
- Inadequate information provided by Medical Practitioners when completing the forms also results in delays as clarity has to be sought before a decision can be made.
- The forms are seen to be cumbersome, and Medical Practitioners are thus reluctant to complete them as this requires them to spend additional time beyond the set time for the consultation. They therefore request the employee to make another appointment to complete the forms which results in added costs for the employee. This is of concern as not all public servants are on medical aid and also cannot afford to pay for the added costs of an additional consultation. This is not just a problem being experienced by Medical Practitioners at private hospitals but also within the public hospitals the Medical Practitioners do not readily complete the forms as required.
- The workload has increased with PILIR and the lack of capacity within the HR units in some departments is a challenge which further results in delays.

4.2.3 Challenges with Temporary Incapacity Leave applications for terminally ill employees and the outcome of an application in the event of a death of an employee

- Departments are experiencing problems with Temporary Incapacity Leave applications where the Health Risk Manager requires the Medical Practitioner to explain the diagnoses in cases where the employee's illness is of a sensitive nature. The Medical Practitioners are reluctant to breach confidentiality especially in cases where the employees do not give them consent to do so. This thus results in a number of such applications being declined by the Health Risk Manager due to insufficient information. These employees have no option but to return to work and are unable to perform due to poor health.
- Some of the sampled departments indicated that they experienced difficulty in finalising the Temporary Incapacity Leave applications after the death of an employee. Sometimes an employee dies before the outcome of the application has been received from the Health Risk Manager and if the application for Temporary Incapacity Leave is de-

clined there are no guidelines in the policy specifying which type of leave must be used to compensate for the declined Temporary Incapacity Leave.

4.2.4 The responsible management of leave by employees is still not adequate

PILIR was introduced as a management mechanism to manage Incapacity Leave and Ill-Health Retirements in a holistic manner but it also serves as a change management tool. The policy also sought to change undesirable employee behaviour such as the abuse of sick leave and Ill-Health Retirement benefits and to encourage employees to respond in a responsible manner in the utilisation of, and application for sick and incapacity leave and IHR. An impact analysis study conducted by the DPSA, indicated that to some degree employees became responsible in utilising their sick leave. Incidents were also mentioned where employees either converted applications for Incapacity Leave into applications for annual leave and in cases of Ill-Health Retirement it was reported that employees tendered their resignations[25].

From the data analysed the departments indicated that even though PILIR has had a positive impact on some employees in the management of their sick leave, there are still a number of employees who are not managing their sick leave responsibly. This has resulted in an increase in the amount of vacation leave taken by these employees when they are sick or they end up taking leave without pay. The resistance to change has not only posed a great risk but the ability and willingness of the employees to manage their sick leave responsibly remains a challenge. This is a cause for concern because despite clear directives contained in the, "*Determination on Leave of Absence in the Public Service*[26]" poor implementation of the directives and poor management of sick leave still persist. SMS members as well as employees seem not to be adequately aware of the stipulations contained within these determinations especially the eight (8) week rule which is intended to curb such sick leave abuse.

4.2.5 Financial implications incurred with the implementation of PILIR

Since the implementation of PILIR, selected departments indicated that unplanned additional costs have been incurred. This is in contrast to the original intentions of PILIR of supporting health risk management that is cost effective and financially sound. Such unintended costs are as follows:

- Some of the departments stated that they had to pay costs for transportation when an employee is referred to a medical specialist or occupational therapist by the Health Risk Manager.
- It also has been established that departments are experiencing budget constraints, as in some special cases of very ill employees, both the employee and the person who cares for him or her have to be transported.

25 *Republic of South Africa. Department of Public Service and Administration. The Implementation of the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR). An Impact Analysis. August 2007.*

26 *Republic of South Africa. Department of Public Service and Administration. Determination on Leave of Absence in the Public Service. Made by the Minister for Public Service and Administration. July 2009.*

- Also, there is an accommodation cost that is additional - due to the fact that some provinces have no specialist within their areas. Thus employees and their caregivers have to be sent to other provinces, for medical examination.
- Furthermore, there are costs related to telephone and stationery due to follow ups that the departments have to make with Health Risk Managers regarding the outcome of the assessments. In the Department of Education, temporary educators have to be employed while the permanent educators are on Temporary Incapacity Leave and waiting for the assessment outcomes. This is an added cost to the department.

The implementation of PILIR has not made a significant difference in the costs that the State incurs with regards to sick leave taken, above that the Health Risk Managers costs seem to increase costs rather than reduce them.

4.2.6 Increase in the number of grievances lodged with the implementation of PILIR

The policy on PILIR makes provisions and outlines the timeframes within which applications for incapacity leave should be processed. Most departments fail to comply with the stipulated timeframes for processing applications. As a result employees end up being penalised when their applications are declined, this leads to an increased number of grievances being lodged against departments.

Of the sampled departments 76% confirmed that there has been an increase in the number of grievances lodged by employees who are dissatisfied with the outcome of a declined Temporary Incapacity Leave application. This has increased the workload for the Labour Relations component and Human Resource Management units. The other reason for grievances being lodged is due to the HR unit not forwarding the Temporary Incapacity Leave applications to the Health Risk Managers timeously. This, resulted in some instances, with the Temporary Incapacity Leave being deducted as a day's vacation leave or unpaid leave. The grievances emanating from the implementation of PILIR have therefore become a serious challenge for most of the selected departments.

4.2.7 Re-deployment of employees

The selected departments indicated that when the outcome of a Temporary Incapacity Leave application states that an employee must be re-deployed, they are unable to find suitable posts to re-deploy such employees and they do not have the financial resources to create posts in which to accommodate the employee.

4.2.8 Positive effects of the policy on incapacity leave and Ill-Health Retirement

Of all the departments that participated in the study, 66% indicated that since the implementation of PILIR there has been a reduction in the rate of absenteeism and they also found that some employees are taking more responsibility in the management of their sick leave. The sampled departments indicated that this number should increase as PILIR grows in strength as a policy. This was further confirmed by the Health Risk Managers report from the North West, which indicated that a positive aspect experienced with the implementation of PILIR is that there has been a substantial reduction in lost man hours through the effective implementation of the PILIR process. The report also indicated that there has been an increase in the organisational productivity[27].

4.3 TRAINING AND CAPACITY

One of the problems which may be a serious risk to the successful and effective implementation and management of PILIR is the lack of or little training. As stipulated in the policy, training plays a crucial role in the understanding of PILIR and the importance of the objectives it seeks to achieve. The lack of proper training and adequate knowledge and understanding, results in inaccurate policy application which can lead to unnecessary labour disputes.

The implementation of PILIR is complex and extensive and the availability of capacity to achieve the objectives of PILIR is crucial. Limited capacity amongst the role-players can jeopardise the effective and efficient implementation and undermine the objectives of PILIR and the employer's obligation. After analysing the data in this area the following findings were made:

4.3.1 Inadequate training of managers hampers the progress of the policy

Of the sampled departments, all indicated that they received training on PILIR from the respective service providers in each province. Seventy one percent (71%) of these departments also indicated that follow up and in-house training was provided to employees by the service providers and in some instances by the human resource training officials within departments. This therefore suggests that the availability of training is not necessarily a problem. However, departments indicated that the greatest challenge is a lack of commitment from SMS members (managers) to attend training sessions. Due to non-attendance by managers there is a poor understanding of PILIR which impacts negatively on implementation.

27 *Republic of South Africa. Department of Public Service and Administration. Steering Committee Report on the Policy and Procedure on Incapacity Leave and Ill-Health Retirement, North West Province. 1 October 2006 to 30 June 2009.*

4.3.2 Limited human capacity to deal with the workload of PILIR

The PSC's report on the *Abilities of the departments to deal with the devolved authority regarding remuneration and conditions of service*[28] stated that departments are not in all instances coping with the demands placed on them through the new Public Service Regulations (PSR). Furthermore, departments do not have the ability and human capacity to deal with devolved authority related to conditions of service and HR management practices. This is of concern since the lack of human capacity within departments would pose a risk in the successful implementation of a policy of such a nature. Data in this area was analysed and the findings were as follows:

Of the selected departments 71% indicated that there is limited human capacity within the Human Resources components to deal with the enormous administrative workload that accompanies the implementation of PILIR. Clearly this is a cause for concern as this affects the effective and efficient implementation of PILIR.

As recommended in the report on the *Abilities of the departments to deal with the devolved authority regarding remuneration and conditions of service*, the PSC continues to hold the view that greater care should be taken to determine the impact of regulatory amendments, on both the objectives these attempt to address as well as the ability of departments to put the necessary resources and processes in place to implement these regulatory requirements.

4.3.3 Monitoring of employees performance

According to the sampled departments some employees who are requested to return to work when their applications for Temporary Incapacity Leave have been declined, tend to become de-motivated and do not perform to the best of their ability. Reasons for such behaviour include the fact that some of these employees are sick but due to the Health Risk Manager's recommendations have to return to work. Others are said to be unhappy with the outcome of the application and thus resort to becoming rebellious and demonstrate a 'don't' care' attitude towards their work. This is a cause for concern especially given that the majority of the sampled departments acknowledged that they do not always monitor the performance of the employees whose applications have been declined. From the questionnaire responses it was established that only 19% of the sampled departments actually monitored the performance of employees whose Temporary Incapacity Leave applications were declined.

The reason advanced by departments for not ensuring proper performance monitoring is that there is not always the necessary capacity for such performance monitoring. The PSC believes that effective performance monitoring and management is a critical part of every manager's job and it is thus unacceptable that this important responsibility is neglected in this way by managers. It should, however be realised that poor performance management prac-

28 *Republic of South Africa. Public Service Commission. Report on the Abilities of the Departments to deal with the Devolved Authority Regarding Remuneration and Conditions of Service. January 2004.*

tices are not only limited to instances involving employees whose application for Temporary Incapacity Leave have been declined. Instead, this is a general problem in many departments as shown in previous PSC studies on the implementation of the Performance Management and Development System for Senior Managers[29]. Indeed, this is a problem that is common even at the level of Heads of Department where many of them still do not get their performance evaluated because their Executive Authorities do not take the initiative to do so despite ongoing reminders by the PSC[30]. If performance management is being neglected at this highest level of executive and administrative leadership, it should, therefore not come as a surprise that the lower echelons of the bureaucracy follow suit.

4.4 SUMMARY

From the information above it is clear that PILIR has made a difference in the management of sick leave trends in the Public Service even though it has not been a significant change. It must be stated that this has been achieved despite the many challenges experienced. The lack of commitment by managers to attend training sessions is concerning as managers are instrumental in the proper management of sick leave within their departments. Their lack of training will continuously hamper the progress on implementation of the policy.

The other concern is the financial implications of PILIR. The aim of the policy was to reduce the abuse of sick leave which in turn would improve the financial burden of departments, but this is not the case with PILIR.

29 *Republic of South Africa. Public Service Commission. Report on the Implementation of the Performance Management Development System for Senior Managers in (Eastern Cape, North West, 2008 and Northern Cape, 2009).*

30 *Republic of South Africa. Public Service Commission. Fact Sheet on the Evaluation of Heads of Departments for the 2006/2007 Financial Year. September 2008.*

Chapter Five

Recommendations and Conclusion

5.1 INTRODUCTION

The PSC has made a number of findings with regards to the implementation of PILIR. After analysing the data from the PERSAL, the Health Risk Managers and the questionnaires it was established that the sampled departments in both national and provincial government were faced with the identical challenges in the implementation of PILIR. The findings reached guided the process on the recommendations and the conclusion provided by the PSC in this chapter.

5.2 RECOMMENDATIONS

The overall conclusion is that the Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR) will definitely need to be reviewed in order for it to be more cost effective with less bulky forms to be filled. The end of the next three year cycle (2010 to 2012) will determine whether PILIR has indeed made a difference in the management of sick leave in the Public Service.

The following are the specific recommendations that should be considered:

5.2.1 Managers in all departments must monitor sick leave closely and this information should form part of the employees' performance agreements and discussed during the time of assessments. Trends should be periodically reported to top management within all departments so that remedial action can be taken. Further, all supervisors and employees should be extensively educated on the provisions contained in the, "*Determination on Leave of Absence in the Public Service*" as well as on the stipulations contained in the, "*Policy and Procedure on Incapacity Leave and Ill-Health Retirement (PILIR)*" in order to ensure proper implementation and management of sick leave.

5.2.2 Human Resource Managers need to be more accountable in ensuring that their unit's capture the sick leave records on PERSAL timeously and accurately. In the case of institutions without HR Managers (functions) for example small hospitals, the responsibility to carry out this function lies effectively with the General Manager of the institution.

5.2.3 In the case of Long Term Incapacity the Temporary Incapacity Leave and Ill-Health Retirement application forms should be reviewed by the DPSA within twelve months, taking into consideration the challenges experienced by employees when requesting completion of such forms by the Medical Practitioners. DPSA needs to refine the forms and make them more user-friendly.

5.2.4 Stakeholders need to meet the 30 days timeframe for processing applications of Temporary Incapacity Leave as well as communicating the outcome to the employer.

Therefore HoD's need to hold Health Risk Managers accountable for non-compliance with the 16 days timeframe as stipulated in the service level agreements and the policy.

5.2.5 The DPSA must add a clause to the policy whereby in the event of a deceased employee, Human Resource units must ensure that outstanding Temporary Incapacity Leave and/or Ill-Health Retirement applications are completed and the outcome processed before any pension payout is processed.

5.3 CONCLUSION

This assessment was conducted to evaluate the impact of PILIR on sick leave trends in the Public Service. It can be concluded that although there has been a decrease in the rate of absenteeism and a greater sense of responsibility of sick leave by employees, many challenges still remain.

Absenteeism in any organisation is a major problem as service delivery is dependent on the availability of effective human capital. The fact that the Public Service is a labour intensive employer that is dependent on the quality, skills and performance of its employees, it is therefore of paramount importance that the leave of absence of all Public Service employees be managed properly to avoid lack of capacity which has a negative impact on service delivery. This requires that departments should have effective human resource management capabilities.

The selected departments used in this evaluation belong to the key priority areas which the new government has stipulated as being the areas of focus. These departments provide essential services and they interface with the public. Therefore it is imperative that in order to meet with the demands of the public, these departments need to be fully capacitated so they are able to function effectively and efficiently to execute the necessary goals and objectives set out to meet the needs of society at large.

Given the above scenario the abuse and mismanagement of sick leave places an immense strain in meeting the service delivery plans as set out by government. Therefore it is imperative that human resources are managed to ensure that continuous services to the public are carried out effectively and efficiently so as to avoid poor service delivery.

Whilst the entitlement for leave of absence as stipulated in the Basic Conditions of Employment Act (BCEA) need not be infringed upon, government is expected to deliver services. The abuse and poor management of sick leave does not only impact negatively on service delivery but also has serious financial implications.

It is trusted that the findings and recommendations of this report will assist the DPSA together with departments in addressing the shortcomings in the implementation of PILIR. It is evident from the assessment that organisational cultures need to be revisited specifically relating to the provincial departments, and changes need to be made to address the manner in which PILIR is being implemented. The policy needs to be reviewed with specific emphasis to the cumbersome forms, timeframes and diagnoses from Medical Practitioners. Putting policies and programmes in place is but one strategy that needs to be strengthened. Since its inception in June 2006 to date PILIR has made a difference in reducing absenteeism, and reduced the abuse of sick leave within departments. From this it is evident that if the challenges are addressed PILIR would be an effective tool in the management of sick leave in the Public Service.

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Notes