

ABSENTEEISM IN THE GAUTENG DEPARTMENT OF HEALTH

By

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DECLARATION

I declare that *Absenteeism in the Gauteng Department* of Health is my own work and that all the resources that I have used or quoted have been indicated and acknowledged by means of complete references.

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ABSTRACT

The research is a quantitative descriptive survey. The sample is a stratified random sampling of the workforce (n=4,010) of the four hospitals in Gauteng that fall under the jurisdiction of Tshwane, Ekurhuleni and Johannesburg Metropolitan Councils. The research examines the extent of the impact of age, gender, occupation, salary level, tenure and race on workplace absenteeism. The data were collected in three phases involving auditing of hard copy files, structured interviews and information technology system.

The findings of the research reflect high workplace absenteeism in females by 83.2%, age group between 45 to 49 years by 22.35%, salary range of 2 to 3 by 35.3%, African race group by 96.3%, tenure of 11 to 20 years by 44.3%, nurses by 20.8% and administration support by 35.4%. The research found that the mature employee in age and of higher year of tenure presented comparatively with lower rate of absenteeism.

Key words:

Workplace; absenteeism; workplace absenteeism; employee; abscondment and desertion; employment relationships; leave cycle; quality; standard.

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GLOSSARY

ANC = African National Congress

BCEA=Basic Conditions of Employment

CNA=Canadian Nurses Association

CAT= Catastrophic Model

CIPD= Chartered Institute of Personnel Development

CCMA = Commission for Conciliation, Mediation and Arbitration

CSRS=Civil Service Retirement System

DPSA=Department of Public Service and Administration

EAP= Employee Assistance Programme

EFILWC=European Foundation for the Improvement of Living and Working Conditions

FERS=Federal Employees Retirement System

GDoH=Gauteng Department of Health

GHP=Gross Health Product

HRIM=Human Resource Information Management

HRDS=Human Resource Development Strategy

RSA=Republic of South Africa

PILIR=Policy and Procedures on Incapacity Leave for Ill-Health Retirement

PERSAL= Personnel Remuneration Administration System

PSCBC=Public ServiceCo-ordinating Bargaining Council

PTO= Paid Time off Model

PSC= Public Service Commission

SACOB=South African Chamber of Business

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CHAPTER 1

GENERAL INTRODUCTION

1.1 INTRODUCTION

The Gauteng Province is viewed as a province of opportunities by South Africans as well the neighbouring countries such as Mozambique and Zimbabwe. The impact of these perceptions has placed a heavy demand on services including health provided within the confines of the province, the results being an increase in the workload of the employees. The indirect results of the increase in the workload have been unacceptably high levels of absenteeism, seemingly sub-standard levels of health care and high cost of delivering the health care services. Absenteeism poses a threat and can lead to the collapse of health care services if absenteeism is poorly managed. The research examines the management and control of absenteeism in four out of thirty four hospitals that service the province. The hospitals that have been targeted for the research are ODI District Hospital, Germiston Hospital, TARA Moross Centre Hospital and George Mukhari Hospital.

This chapter explains the background and motivation for the research. The research highlights the problem statement, which focuses on the effective management of absenteeism. The objectives of the study, the research methodology and structure of the research are explained. The relevant literature review was consulted for the research. The key concepts that are used in the research are conceptually defined. The research design is a descriptive, stratified random survey. The data that were used were collected in three phases, the unit of analysis were the employees of the Gauteng Department of Health in the four target hospitals and the unit of observations were observations of the employees of the four hospitals. The construct of validity was achieved through using a variety of data collection methods. Ethical considerations were taken into account during the research process. Limitations of the research were imposed by the uniqueness of each of the target hospitals. The structure of the research and the reference technique is explained in this chapter. The research on absenteeism in the Gauteng Department of Health is confined to the period of 1 January 2008 to 31 December 2008 and focused on the working-man days lost, how absenteeism is managed and employee well-being and rehabilitation.

1.2 BACKGROUND AND MOTIVATION FOR THE RESEARCH

The Gauteng Department of Health received a qualified report in 2008 on the control of sick leave. A performance audit was conducted by the Public Service Commission (PSC) (2002: xvi) into the information required to effectively manage sick leave in the public service.

The research on absenteeism in Gauteng Department of Health seeks to examine the extent of workplace absenteeism in the ODI District Hospital which is in a transitional stage from North West to the Gauteng Province. The hospital falls under Tshwane Metropolitan Municipality and is in Region C. The Germiston Hospital falls under Ekurhuleni Metropolitan Municipality in Region B, TARA Moross Centre Hospital is in Region A under the Johannesburg Metropolitan Municipality and George Mukhari Academic Hospital is Region C under the Tshwane Metropolitan Municipality. The research seeks to examine the degree of compliance by the four hospitals with the recommendations of the performance audit of management of sick leave in the light of the qualified report received by the Gauteng Department of Health (Human Resources) in 2008/9.

1.3 PROBLEM STATEMENT

The Gauteng Department of Health provides health care services as the core business of the Department. The Health care services are labour intensive and high levels of absenteeism by its employees undermine the Departmental efforts to deliver quality health care to the people of Gauteng. The problem statement therefore is to examine to what extent the effective management of absenteeism can enhance the effectiveness of the Gauteng Department of Health.

1.4 AIM AND OBJECTIVES OF THE RESEARCH

The aim and objectives of the research are explained in this section.

1.4.1 AIM

The aim of the research is to determine how the effective management of absenteeism can contribute to the effective health care of Gauteng's communities.

1.4.2 Objectives

The objectives of the study are:

- to determine the impact of the variables such as age, gender, occupational category and salary level on workplace absenteeism;
- to determine whether the correlation between absenteeism levels and tenure of service does exist;
- to determine trends of workplace absenteeism in different employee categories; and
- to establish the different challenges confronting the different hospitals in management and control of absenteeism in terms of size, complexity and location.

1.5 LITERATURE REVIEW

Various studies have been conducted to examine workplace absenteeism in different fields in government and private institutions. Van Der Westhuizen (2006:36) research focused on high and low combinations of job involvement and organisational commitment. The outcome was not emphatic on the findings as predictors of the turnover and absenteeism. The research noted that women are more absent from the workplace than men. De Wit (2006) focused on the nature of absenteeism, the impact of absenteeism on the organisation, reasons for and causes of absenteeism and measurement of absenteeism and the findings were not able to find a high coefficient in the test sample.

Camp and Lambert (2005:4) found that the use of sick leave as an incentive to reduce sick leave by the employees under the Civil Service Retirement System (CSRS) led to a reduction of absenteeism as a result of sick leave when compared with employees who functioned under the conditions of the Federal Employees Retirement System (FERS) who, within the same company, lost the unused sick leave when they retired.

Ferguson, Ferguson, Muedder and Fitzgerald (2001:38) focused on the impact of absenteeism and cost in terms of time lost in the Total Absence Management (TAM) concept and found that the aging employee exposes institutions to high levels of absenteeism through higher probability of becoming incapacitated for longer periods of time.

Serneels, Lindelow and Lievens (2008:210) claim absenteeism is high among employees in the public sector in developing countries due to a lack of accountability and a lack of punishment for transgression.

The research seeks to determine the extent of the problem of workplace absenteeism, its impact and management in the identified hospitals. It seeks to establish the relationship, if any, between the various variables and absenteeism such as age, occupation, tenure, salary level, gender and race.

1.6 TERMINOLOGY

Key concepts that are used in the research are conceptually defined, however a comprehensive concept clarification will be done in chapter 2.

Workplace absenteeism: Workplace absenteeism is the absence of employee at the workplace that is defined by Du Toit and Van Der Waldt in (1998:139) as the place that the institution makes available and where officials have to perform their work.

Workplace forms part of the internal environment for public administration in the public service. Robbins, Odendaal and Roodt (2004:15) define absenteeism as the failure of an employee to report for work as scheduled, regardless of the reason.

Abscondment and desertion: According to Grogan (2005:237) abscondment is deemed to have occurred when an employee is absent from work for a considerable period of time and the employer infers that the employee does not intend to return to work. According to Venter (2003:267) desertion occurs when the employee leaves the place of employment without the intention to return to work.

Employee: An employee is defined as any person employed in terms of the Public Service Act, 1994 irrespective of rank or position (Public Service Act, 1994: Subsection 1.5). Todd (2001:1) refers to an employee as any person, excluding an independent contractor, who works for another person and is entitled to be paid for it, or who in any manner assists in carrying on or conduct the business of the employer. Bendix (2000:123) defines an employee as a person in a workplace except a “senior managerial employee” whose status and contract of service grants the employee the authority to represent the employer in interactions with the workplace forum, to determine policy on behalf of the employer and make decisions which might conflict with representation of workers at the workplace.

Employer: An employer as an individual person who may be the employer in legal terms, as well as the organisation which is responsible for implementing Public Service human resource management policies (RSA 1997: Section 1.5).

Leave cycle: The Public Service Act 1994 refers to the leave cycle as 36 months employment with the same employer.

Quality: Is defined as getting the best results possible within the available resources (RSA 2011).

Standard: Is a statement of an expected level of quality delivery. A standard reflects the ideal performance level of a health establishment in providing quality care (RSA 2011).

1.7 RESEARCH DESIGN AND METHODOLOGY

This section deals with the research design and methodology.

1.7.1 Research design

Research design is the overall plan for relating the conceptual problem to relevant empirical research. It is a quantitative descriptive research that involves the systematic collection of numerical information under conditions of considerable control (Polit & Hungler 1994: 24,175).

The choice of the research design influences subsequent research activities such as identifying the target subjects, what data to collect and how they should be collected. The research design is a descriptive stratified random survey which is concerned with characteristics of a specific population subject, at a fixed point in time for comparative purposes. The focus is on a representative sample of the relevant population. It is concerned with the accuracy of the findings and their generalisability. The survey is used to gain deeper insight of the behaviour of employees with regards to motivation, satisfaction and grievances (Babbie 1992:89; Ghauri, Gronhaug & Kristianslund 1995:27, 60; Brink 1996:11, 6; Welman, Kruger & Mitchell 2001:52).

1.7.2 Methodology

The Gauteng Department of Health has thirty four hospitals that deliver health care services. Four hospitals of the thirty four health care delivery institutions have been identified for the research.

Each hospital is unique in its character in terms of specialisation of health care delivery service. The four hospitals are located in Tshwane, Johannesburg and Ekurhuleni Metropolitan Municipalities. The sample is a stratified random sampling which is composed of various clearly recognisable, non-overlapping sub-populations (strata) that differ from one another mutually, in terms of variables that are a combination of more than one variable such as age, sex, income level or educational level. The purpose is to ensure that every part of the population (every stratum) is represented. The members of a particular stratum are homogeneous in the population at large. The sample is representative of a population with clearly distinguishable strata with a greater degree of certainty (Babbie 1992:67; Brynard & Hanekom 2005:44; Ghauri *et al* 1995:78; Brink 1996:138; Welman & Kruger 2001:55-56; Welman *et al* 2010:61; Polit and Hungler 1995:18). The data were collected in three phases.

The first phase of data collection was done through auditing of hard copies of identified personnel files, representing ten files per hospital and using the tool in annexure A & B. The forty employees' profiles were accessed through the Human Resource Information Management system (HRIM) located in the Gauteng Department of Health Head Office. The respective employees' profiles were handed over to the human resource manager in the respective hospitals on the morning of the audit, for the human resource practitioner to draw out the hard copy files for auditing. The characteristics of the individuals that were identified for the first phase were males and females and the different race groups. The auditing of the files was for the complete working life of the employees and not confined to 2008 only. Registers that are used by the human resource administration to control the movement of the leave forms were inspected as evidence of the control system in place.

The purpose of auditing the files is to gain insight into how leave in general was captured, managed and controlled by the hospitals. The second phase of data collection was done through structured interviews with the four human resource managers, who were directly accountable for management and control of leave of absence in general, in the four hospitals.

A structured interview provides for a more organised approach and a more stable basis for assessment of the different candidates (Erasmus, Swanepoel, Schenk, Van der Westhuizen & Wessels 2005:250). The structured interview was conducted using the tool in annexure C. Tara Moross Centre Hospital had been functioning without a manager in human resource and the manager that was interviewed had been in the post for three months. The human resource practitioner who was at salary level 8 acting in the Assistant Director's post (manager) was invited to join the manager and be part of the structured interview. ODI District Hospital had three human resource practitioners including the accounting officer at level 8 and in an acting capacity.

The third phase of data collection was through the Human Resource Information Management (HRIM). This system used Personnel Remuneration Administration System (PERSAL) to collect data. Data in this system are categorised in salary level, date of appointment, occupational category, gender, age in units of five, race, employing hospital, employment status in different categories such as session, contract and full-time and the different types of leave of absence.

The research used primary and secondary data in analysing sick leave utilised by full time employees in the identified hospitals for the period of 1 January to 31 December 2008 using the Personnel Remuneration Administration System. The total population sample was four thousands and ten (n=4,010).

The research during data collection and analyses used characteristics in the sample such as occupational groups, age, tenure of service, race, gender and salary range at level 1 to 12. The research used past events such as sick leave utilised by employees, using secondary data from Personnel Remuneration Administration System, falling into the category of a historical, empirical research. The interval scale of measurement was used in the quantitative research and actual numbers are ordered with equal measurement between each category (Brink 1996: 149; Brynard & Hanekom 2005: 28-29; Mouton 2005: 52,100,170).

1.7.3 Unit of analysis

The unit of analysis refers to what or who is studied (Babbie 1992:92; Brink 1996:133). The unit of analysis in the context of the research refers to observation of work attendance by the employees of Gauteng Department of Health in the four hospitals.

The observation deals with the historical events such as employees who have already utilised sick leave in the workplace. The subjects that are studied are the core health care providers such as doctors, nurses and support employees such as allied, administration and administration support (Mouton 2005:51-52; Welman *et al* 2001: 52-53).

1.7.4 Unit of observations

The observations that are made are of health care workers and support teams in Tara Hospital, Germiston Hospital, ODI Hospital and George Mukhari Hospitals. The unit of observations describes the characteristics of a large number of individual people, such as gender, age, salary range, occupational category, tenure of service, and race in relation to absenteeism in the workplace. In the descriptive research, the individual characteristics are aggregated for the purpose of describing a larger group (Babbie 1992:92).

1.8 CONSTRUCT VALIDITY

Construct validity is concerned with the question "what construct is the instrument actually measuring?" (Brink 1996:170). The research used a multi-trait, multi-method approach in construct validity. A variety of data collection methods were used such as auditing of forty hard copy employees' files in phase one. In phase two a structured interview was conducted with the four accounting officers in leave management. The third phase was collecting of personnel data through the Persal system.

1.9 ETHICAL CONSIDERATIONS

Ethical considerations included among other issues the protection of the unit of analysis and unit of observations from discomfort and harm, by not revealing information which can cause physical, emotional, spiritual, economic, social or legal harm.

The researcher has to ensure the protection of the subjects' interests and well-being by protecting the subjects of observations' identity through anonymity. Anonymity is achieved when the researcher cannot link a given response with a given respondent and reporting aggregate data only. When data are collected at one sitting and not over a period of time makes it possible to achieve anonymity as the need for follow up is eliminated. Subjects of observations are selected for reasons directly related to the problem being studied as the principle of justice.

Confidentiality is about the researcher's responsibility to protect all data gathered within the scope of the research and shared only with people involved in the research (Babbie 1992:465–466; Brink 1996:40–41, 45).

The human resource managers who were interviewed were identified by the hospitals they represented and therefore remained anonymous. The interview was part of the actual audit that was done as part of monitoring and evaluation that was in progress in the Department of Health following a negative auditor general's report about management of leave in general. The managers were put at ease as they were given the check list afterwards for self-monitoring for future self-auditing.

The data that were collected through Personnel Remuneration Administration System (Persal) identified employees through the Persal number and kept their identity anonymous. The data that were collected through the hard copy of employees' files were used to point out areas of concern to the managers, and the files did not leave the office of the manager at the end of the process, once more protecting the identity of the employee.

1.10 LIMITATIONS OF THE RESEARCH

The research was conducted on four hospitals of different sizes, specialisation and three metropolitans with unique challenges. The period of the research was confined to a calendar year (2008) and not a financial year. The focus was on absenteeism due to sick leave of full time employees. There is no distinction that is drawn between the working-man days that are lost between shift and non-shift workers. The findings may be different if all absenteeism of employees at the time were considered for the research.

1.11 STRUCTURE OF THE RESEARCH

Chapter 1: It provides a general introduction to the research. It includes an introduction, the background and motivation for the research that provides the context, the problem statement and the significance of the research. The key concepts are defined. The research design, the method of data collection, the sampling method, data analysis and interpretation, limitations to the research are explained in this chapter.

Chapter 2: This chapter considers the theoretical foundations, concepts, characteristics, theories, approaches and classifications of workplace absenteeism. Conceptual framework of absenteeism, predictors of absenteeism and various models of absenteeism are explained. Measures to control workplace absenteeism, the impact of absenteeism in the institution and management intervention strategies are explained.

Chapter 3: It describes the research design, different aspects of the research methods applied and the data collection techniques used, unit of analysis, units of observations, construct validity and ethical considerations.

Chapter 4: This chapter provides the organisational structure of the Gauteng Department of Health, comparisons of hospital employees, different race groups of the four hospitals, gender comparisons in different hospitals and comparisons of the different occupational groups. It provides a short description of the target hospitals. The research interpretation is discussed in terms of the different occupational groups and absenteeism, different races and absenteeism, tenure of service and absenteeism, salary range and absenteeism, age in relation to absenteeism and gender in relation to absenteeism.

The week days absenteeism pattern and contributions by the four hospitals to absenteeism are presented in this chapter.

Chapter 5: It provides a discussion of the research, evaluation of workplace absenteeism, findings, recommendations and limitations.

1.12 REFERENCE TECHNIQUE

The reference technique that is applied in the research involves all sources that have been consulted while doing the research. When legislation is used as a source of information reference to the specific act is used.

1.13 CONCLUSION

Chapter 1 provides a discussion on the background and motivation of the research, problem statement and the objectives. The significance of the research in South African public institutions and private institutions of other countries and the possible contribution of the study are explored. The terminology that is used in the research is contextualised for the purpose of the research. The research design and methodology are presented in this chapter. The units of analysis, the units of observation, construct validity, ethical considerations and limitations to the research are also presented in this chapter.

The next chapter discusses the theories of absenteeism.

CHAPTER 2

MANAGING ABSENTEEISM

2.1 INTRODUCTION

The Gauteng Department of Health is classified as a public institution whose existence is justified on the grounds that it renders health care services to the public. The health care system is encouraged to develop delivery systems and practices that are in line with international standards, management practices that promote efficient and compassionate delivery of services and ensures respect for human rights and accountability to the public (African National Congress 1994:43-44). This objective can only be achieved if the resources to provide such services are available. The human resources are a vital factor for the health care sector as it is labour intensive. Public institutions such as the Gauteng Department of Health are funded from public funds and if the human resources do not report for work, service delivery is compromised and the cost to the department in the form of salary expenditure becomes exorbitant, as the department must find replacement staff and pay for overtime as well. It is when all these factors are taken into consideration that workplace absenteeism becomes a cause for concern for the Gauteng Department of Health.

In this chapter absenteeism is discussed from a theoretical perspective and informed by literature review. The classification of workplace absenteeism, theoretical perspective, definitions, dimensions of employment relationship, conceptual framework of absenteeism, structural model of absenteeism, legislative framework that regulates the employment relationship and intervention strategies to control workplace absenteeism are explored.

2.2 THEORETICAL PERSPECTIVE OF ABSENTEEISM

According to Viviane (2011:1) the term "absenteeism" was first used in Britain during the First World War in dealing with employed persons. It is during the times when production is of pressing national importance that the absence of employees from the workplace is keenly felt. Absenteeism is considered a good barometer of staff morale, an indirect measure of employees' health and well-being and is found to be associated with health-related absences from work. Employees who are motivated and committed to their work and employer have to be very sick before they book off sick (Griep, Rotenberg, Chor, Toivanen & Landsbergis 2010:179).

McCormick and Ilgen (1985:56-57) describe job attendance criteria as relating to a tendency of employees to withdraw from or attend to their jobs. The criteria identified were job tenure, occupational category, absenteeism and tardiness. According to Markussen, Rogeberg and Gaure (2009:6) employee characteristics such as age, gender, education and occupation have a substantial impact on absence behaviour.

Chaudhury and Hammer (2003:3) identified that medical skills and nursing skills are marketable and greatly in demand. Doctors and nurses used this opportunity to make money and work as private health care providers as well as public health care providers, holding two jobs. The absence is considered in terms of morning or afternoon absence by these categories as they are viewed as having a great deal of discretion over where and when to discharge their public responsibilities. The criteria identified were job tenure, absenteeism and tardiness.

Breetzke (2009:1), Camp and Lambert (2005:4) and Jankowitz (1991:1) refer to absenteeism as non-attendance when an employee is scheduled to work. The theoretical perspective of absenteeism takes into account the physical and or psychological absence of the employee from the workplace or work station at a time when the employee is contractually expected to be at the workplace. According to Andrews (1997:34-35) the behaviour and actions of public officials are determined by specific ethical codes of conduct and it is assumed that their actions are for the benefit of the communities that are serviced by the public officials. Social ethics focus on how the clients of the Department are treated and are therefore concerned with the impact of decisions on people inside and outside the institution, individually and collectively.

Grogan (2005:237) states that employees have a fundamental duty to render services, and their employers have a right to expect them to do so. Deliberate workplace absenteeism is regarded as a violation of this contractual obligation. The manager in public service is to look for trends and patterns that indicate abuse of sick leave as the manager is held accountable when an employee abuses sick leave in terms of the Public Service Regulations, 2001, section F(c). In the public sector contractual employee benefits are modified by collective agreements. These benefits are material gains for the employees and have a monetary value and a cost factor to the employer.

The contract of employment often includes insured benefits such as incapacity, ill health and early retirement as the total package, other than the remuneration for the time worked as it is intended to attract, retain and motivate employees (Breetzke 2009:1; Ferguson *et al* 2001:37; LexisNexis 2006:670; LexisNexis 2007:176; Markussen, Rogeberg & Gaure 2009:3; Tustin 1994:52). The policy on Determination on Leave of Absence requires a medical certificate for sick leave of three or more days and for every sick leave day utilised when the eight week rule has been transgressed (DPSA 2009 Section 14 subsection 14.7).

Political ideologies influence the work environment resulting in some areas being highly unionised where unions are perceived to be capable of exerting control over the employer and employee relations for the primary benefit of the employees.

It is the work environment which is highly unionised that is characterised by high workplace absenteeism (Andrews 1997:36; Breetzke 2009:1; Du Toit & Van Der Waldt 1998:170,139; Tustin 1994:52). Allen (1984:331) claims that union members might be absent more frequently from the workplace than non-members because they face smaller penalties for absenteeism. According to Markussen *et al* (2009:5, 21) workplace environments do have an impact on absenteeism and are influenced by social interaction processes among colleagues. Absenteeism is affected by social norms. Workplaces with high employee turnover rate tend to have high absenteeism. The turnover rate is defined on a quarterly basis as $\frac{\text{Min (number of entries, number of existing persons)}}{\text{number of employees at the start of the quarter}}$. The Chartered Institute of Personnel and Development (CIPD) (2008:11) claim that the 2006 survey of absence management portrays the public sector employees as less likely to be dismissed for reasons of workplace absenteeism. A report by the National Institute of Labour Studies (Tonya 2001:1) found the rate of absenteeism increased among full-time employees from 2.4% to 2.5% within two years.

The services that are provided by the Department of Health are divided into two distinct categories. Direct services are those services that are rendered to the clients who are patients who receive medical treatment from the core employees, usually referred to as line functionaries. Direct services can only become effective and efficient when supported by the services of the support staff that provide indirect health care services. When employees do not present themselves for work when scheduled to work and do so on a regular basis the situation becomes habitual absenteeism (Du Toit & Van Der Waldt 1998:18). The Gauteng Department of Health's core function is to provide health care services to the people of Gauteng Province. The provision of health care services is labour intensive and requires large numbers of personnel for effective service delivery.

The workplace which may be physical or virtual for the public service employees, represent the internal environment of the institution. The employer who is represented by the manager determines the workplace for employees.

Rogers and Hertin (1993:217) explain the Decision Model Theory as a conscious decision by the employee to stay away from work or come to work based on which motivation is stronger at that moment. It is not based on the ability to come to work.

Serneels *et al* (2008:210) claim that absenteeism is rife in the public sector, especially where employees hold two jobs. The actions of public officials in the performance of their duties should be ethically justified as it impacts on the decisions of people within and without the institution, individually and collectively. Tension and job insecurity in the workplace manifests as absenteeism (Andrews 1997:33-137).

Frontline nurses' absenteeism contribute to discontinuity of patient care, decreased staff morale and high cost to health care (Davey & Cummings 2009:312-313). It is suggested that on average health care workers are likely to be absent from work as a result of illness or injury rather than other occupations. Dagmara (2000:2) states that absenteeism may be a benchmark of what is happening in the hospital setting. Absenteeism is defined as habitually not coming to work when scheduled to. It is an indicator of psychological, medical, or social adjustment to work.

Absenteeism is measured by frequency or duration of work-days missed. Frequency measures provide a reasonable index of voluntary absenteeism whereby each incidence or episode of absence is counted regardless of the duration of absence. It is defined as the number of days absent over a given period of time. Other measures used were total days, duration and percentage. Duration measures provide an index of involuntary absenteeism such as time lost index. To assess absence duration, the total number of days is tallied, regardless of the number of incidents (Davey & Cummings 2009:313). High workload is identified as one of the factors that affect absenteeism rate among health care workers (Oi-ling 2002:3).

Workplace absenteeism is costly for an institution in terms of lost working-man days, hiring of staff to close the shortage, absent or sub-standard service delivery and poor quality of services. The total cost of employment risk approach is about the estimation of the possible cost of any absent employee to an institution per hour. The annual cost to the institutions per employee is in terms of direct and indirect costs, such as overtime, low productivity and a decline in morale among workers who are expected to cover for an absent employee (Bangali 2004:27; Dagmara 2000:1; Ferguson *et al* 2001: 38).

The public service employees enjoy security of tenure, which may be a contributory factor of absence from work without good cause. This practice is fostered by the knowledge that they cannot be easily dismissed from their jobs, therefore have the belief it is right to stay away from work. Misuse of sick leave is considered to be an overriding problem in instances where the employee does not uphold the standard of honesty and incorruptibility or these values are not considered to be the corporate values and norms of the institution (Andrews 1997: 221-222; MINTRAC 2009:3).

Bangali (2004:3-5) describes age function in the sociological theory as a natural characteristic of human beings, but also an integral aspect belonging to the structure of the society. The age definition in the labour market is influenced by the structural functionalism. The employee's age is categorised in the workplace in terms of functions to be performed, be it physical or intellectual. The age group of 35 years to 49 years old employees comprise the largest age group in the labour market.

The employees who are less than 20 years of age reflect the highest absenteeism rate, while employees above 50 years of age reflect a decrease in the absenteeism rate. The disadvantage of the older workers is that their disabilities last longer once they are injured and are more likely to be absent as frequently and more likely to be injured than younger workers. Keese (2006:2) states that ageism is evident in the public service and describes the age group 25 years to 49 years old as prime age. Rogers and Hertin (1993:219) found a significant correlation between the use of sick leave and age. Employees with advanced age used comparatively more sick leave in comparison with the younger employees. The Canadian Nurses Association (2006:5) noted a reduction in workplace absenteeism rate among nurses who are less than 45 years of age, and an increase in the absenteeism rate among nurses above 55 years of age.

Camp and Lambert (2005:4) found that the use of sick leave retention as an incentive to reduce use of sick leave by the employees under the Civil Service Retirement System (CSRS) leads to a reduction of absenteeism as a result of sick leave compared to the Federal Employees Retirement System (FERS) who, within the same company, lost the unused sick leave when they retired. The Employees Retirement System (FERS) applies the same principle of handling sick leave as the Gauteng Department of Health in the sense that unused sick leave is forfeited at the end of the three year cycle (DPSA 2009:Section 14).

Unruh and Strickland (2007:674) found that absenteeism from the workplace does contribute to a vicious cycle of a negative work environment which leads to more absenteeism and increased turnover. Absenteeism has been found to be higher in employees who are over 50 years of age and the phenomenon is attributed to age and changing abilities that increase when work is performed on a full time basis. Part-time arrangements reduce absenteeism as well as the cost of paying for a senior employee even if seniority is just in tenure. Age has been linked to a negative turnover in an institution. The older employee is less likely to leave the organisation. An institution is healthier for a spread of ages. Some organisations consider employees to be older in batches or cohorts of five such as 40 years to 44 years up to 64 years (Nichols & Evangelisti 2001:285; McGoldrick & Arrowsmith 2001:84; MINTRAC 2009:3; Reday-Mulvey 2005:79-194).

MINTRAC (2009:4-8) states that gender moderates the age turnover relationship. Women are more likely to remain in their jobs the older they get than men do. Turnover is occasionally related or preceded by high workplace absenteeism. The occupational category is linked to skill levels and salary levels. The lower skill employees are concentrated in the lower skill occupations and easily replaceable.

Hirschfield, Schmitt and Bedeian (2002:553) conducted a research on low-wage public sector clerical employees and found that those employees who perceived limited performance-reward expectancies were likely to be absent more often. The link between skilled employees and absenteeism suggested that employees may have utilised absenteeism as a means of compensating for perceived workplace contributions not extrinsically rewarded.

According to Gaudine and Gregory (2010:599) the Canadian Institute for Health Information (2007) found that absenteeism was a problem among health care workers in comparison to other employees in other sectors. Unruh *et al* (2007:673) found the combination of high registered nurse absenteeism and high patient load could be a strong factor in lowering health care delivery. Markussen *et al* (2009:21) claim that the type of occupation an employee is engaged in has an impact on absenteeism.

2.2.1 Classification of absenteeism

The employees of the Gauteng province and their attendance at work are the focal point of the province in relation to service delivery that is customer focused. Health care services are labour intensive and require employees to be at work when scheduled to do so (Gauteng Province 2010:15). Workplace absenteeism can present in different forms and levels as a result of a combination of variables (Andrews 1997:5; Breetzke 2009:1). McCormick and Ilgen (1985:57) and Davey and Cummings (2009:313) classify absenteeism as voluntary when the absence is based on the conscious decision by the health care giver to withhold contractual services. The absence is uncertified, unauthorised and unexcused, while involuntary absenteeism occurs for reasons beyond the control of the health care giver, such as illness, injury or family responsibility. Employers are challenged with the task of differentiating between the absence due to elective workplace absence and absence due to illness incapacity. The differentiation is based on whether the illness incapacity is validated by a legitimate medical certificate in terms of the prescript of section 23 of the Basic Conditions of Employment Act (BCEA) 75 of 1997 (RSA 1997).

2.2.2 Definition of key concepts

Concepts are defined for common understanding in the context of the study.

Workplace absenteeism: Workplace absenteeism is absence of the employee at the workplace that is defined by Du Toit and Van Der Waldt (1998:139) as the place that the institution makes available and where officials have to perform their work. It forms part of the internal environment for public administration in the public service. Bamford, Klein and Engelbrecht (1999:11) refer to absenteeism as employees taking time off that has not been scheduled.

Breetzke (2009:1), Camp and Lambert (2005:4) and Jankowitz (1991:1) claim that absenteeism is non-attendance when an employee is scheduled to work. The European Foundation (1997:11) views absenteeism as temporary or permanent incapacity for work as a result of sickness or infirmity. According to Robbins, Odendaal & Roodt (2004:15) absenteeism is a failure of an employee to report for work as scheduled, regardless of the reason.

Abscondment and desertion: According to Grogan (2005:237) abscondment is deemed to have occurred when an employee is absent from work for a considerable period of time and the employer infers that the employee does not intend to return to work. The employee should actually intimate expressly or by implication the intention not to return to work. According to Venter (2003:267) desertion occurs when the employee leaves the place of employment without the intention to return to work.

Employee: The Basic Conditions of Employment Act, no 75 of 1997 Section 1 (a) (RSA 1997) and Todd (2001:1) refers to an employee as any person, excluding an independent contractor, who works for another person and is entitled to be paid for it, or who in any manner assists in carrying on or conduct the business of the employer. The courts use the control test which identified employees on the basis that they were part of the employer organisation. Bendix (2000:123) claims that an employee is a person in a workplace except a senior managerial employee whose status and contract of service grants the employee the authority to represent the employer in interactions with the workplace forum, to determine policy on behalf of the employer and make decisions which might conflict with representation of employees at the workplace. Du Toit, Bosch, Woolfrey, Godfrey, Rossouw, Christie, Cooper, Giles and Bosch (2003:68) state that an employee is a person who works for a single employer, in a permanent, fulltime capacity, is subject to the supervision of the employer, and receives regular monthly or weekly remuneration and is obliged during working hours to place his or her productive capacity at the employer's prescribed disposal.

Employer:

Bendix (2000:129) defines an employer as any person, except an independent contractor, working for another person or the State and who receives remuneration, or any manner assists in carrying out or conducting the business of an employer. DPSA (PILIR) (2009:4) states that an employer is the Head of Department or a designated office which will be responsible for the handling and investigation of incapacity leave applications and ill- health retirement applications.

2.3 EMPLOYMENT RELATIONSHIPS

The employment relationship is about balancing the simultaneous convergent and divergent interests of the employer and the employee in a regulated manner with the aim of getting the work of the institution done. According to Erasmus *et al* (2005:442) an employment relationship exists when an individual is employed by someone else to be available to work for that person in exchange for some remuneration. It is through this employment relationship that reciprocal rights and obligations are created between the employer and the employee. The employment relationship is conflictual in nature (Andrews 1997:36). The employees, through this relationship are enabled to gain access to the rights and benefits associated with their employment. The Labour Relations Act, no. 66 of 1995 (RSA 1995) regulates the management of the conflict in the employment relationship through dispute resolution structures such as the Commission for Conciliation, Mediation and Arbitration (CCMA) Labour Court and Labour Appeal Court when internal processes fail to resolve the conflict. The employment relationship can be traditional or typical and terms and conditions of service of employment are regulated by collective agreements. This is a tacit acknowledgement of the existence of a typical employment relation.

2.3.1 Employment relationship as a multi-dimensional phenomenon

Industrial relations and human resource management are bound together by the employment relationship through labour, employer and industrial relation triangle. The employment relationship is characterised by various dimensions as is the case in a broader society. The dimensions are economic, legal, individual, collective and psycho-social (Grogan 2003:47).

2.3.1.1 Economic dimensions

The economic dimension arises through the provision of labour by the employee in the form of skill, knowledge, energy, abilities and productive time to the employer in exchange for remuneration. Barker (2007:79) states that a reduction in working hours increases the hourly cost of production in a unit unless there is a commensurate increase in productivity. The economic dimension is highly regulated. The contract of employment includes insured benefits such as incapacity, ill health and early retirement. The tendering of services by the employees is a prerequisite to the employee's right to claim remuneration (Grogan 2003:47). According to LexisNexis (2007:176) and the Public Service Regulations, 2001 Section E E.1 the actual contractual benefits are modified by collective agreements in the public service sector. Employee benefits are material gains for employees that have monetary value and are a cost factor to the employer. The Public Service Regulation, 2001 Section F (a) states that the Head of Department shall promote economic and efficient use of resource to improve the functioning of the public service (RSA 2001).

According to Ferguson *et al* (2001:37) and Erasmus *et al* (2005:380) employee benefits are the total compensation package, other than the pay for time worked, offered to employees either partially or completely funded by the employer contributions. In 2006 about R19 billion was lost on account of absenteeism from sick leave (LexisNexis 2006:670; Patrick 2001: 17).

Employee benefits are intended to attract, retain and motivate employees. Some of the benefits offered to employees are mandated by law such as minimum leave provision as contained in the Basic Conditions of Employment Act 75 of 1997 and Resolution 7/2000 of the Public Service Co-ordinating Bargaining Council (PSCBC 7/2000; RSA 1997).

2.3.1.2 Legal dimension

The Labour Relations Act 66 of 1995 Section 3 of Schedule 8 requires that while employees should be protected from arbitrary action, employers are entitled to satisfactory conduct and work performance from their employees. The legal framework provides for the regulatory requirements for human resource management in the working environment.

Grogan (2003:47) and Grogan (2005:120) view the employment relationship as formalised by a legally binding agreement which is the contract. The contract is regulated by specific laws and formal rules with all the inherent rights and responsibilities to the employer and the employee. In terms of the employment contract one of the responsibilities of the employee is to render service to the employer at specified agreed upon time except where the employer has authorised the absence of the employee from the workplace. Employees have a fundamental duty to render services, and the employer has a right to expect the employees to tender such services. A basic element of the duty to render service is that the employee must be at the workplace at the specified agreed upon times, unless there is adequate reason to be absent. Bendix (2000:120) states that a contract is subject to the terms and conditions of collective agreements. The contract is subject to automatic changes whenever a new collective agreement is in place. The contract and its inherent benefits are breached by elective absence behaviour of the employee. The legal dimension has an impact on the individual dimension.

2.3.1.3 Individual dimension

The employee enters into a working contract with the employer on an individual basis. The contents of the contract are subject to the Basic Conditions of the Employment Act 75 of 1997. The terms and conditions of employment in the public service are subject to collective bargaining and collective agreements which influence the employment contract in the Public Service Co-ordinating Bargaining Council (PSCBC 7/2000; RSA 1997).

The contract of employment is entered into between the employer and the employee under the supervision of the employer and for remuneration purposes.

2.3.1.4 Collective dimension

According to Slabbert and Swanepoel (2001:7) the collective dimension of the employment relationship refers to the organised group aspect of the employment relationship which is between labour as a group and employers and or their representative public sector institutions. The collective dimension aspect of employment relationship pertains to legislation relating to bargaining, dispute resolution and industrial action.

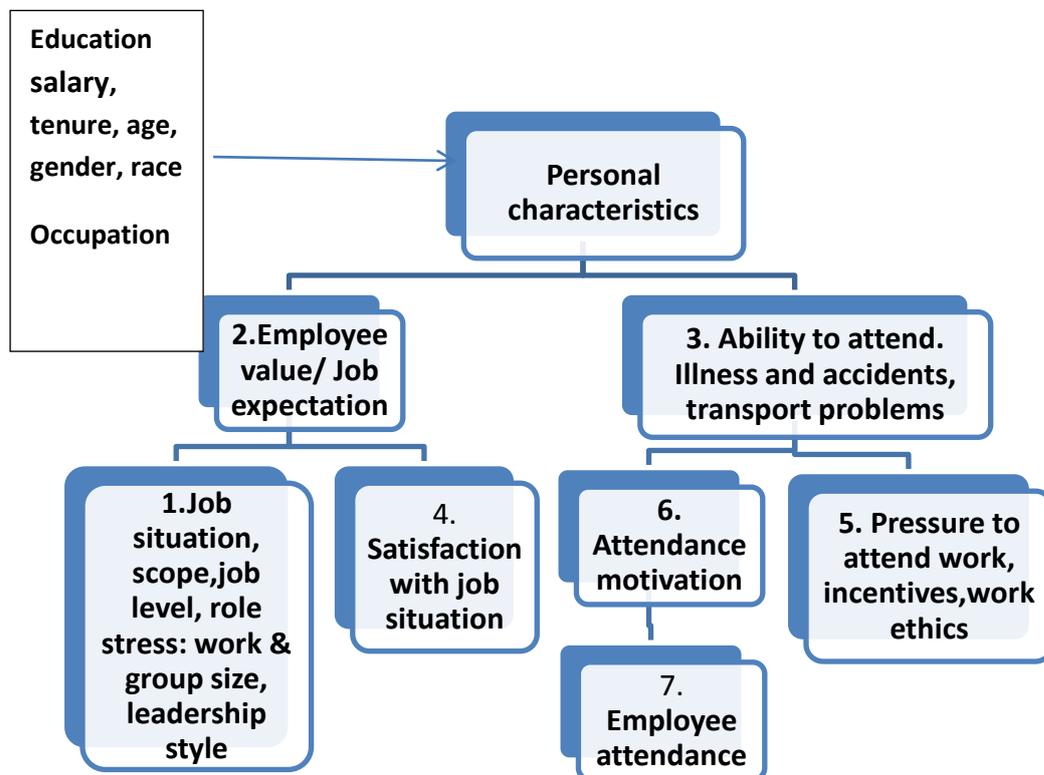
2.3.1.5 Psycho-social dimension

The psycho-social dimension of the employment relationship represents the unexpressed needs and expectations of the employer and employees. It refers to behaviour in the public sector institutions within the context of the collective dimension (Davey & Cumming 2009: 313; Erasmus *et al* (2005:442). The Public Service Regulation, 2001 Section B states that the Head of Department shall determine the working time of employees and take into consideration their personal circumstances which have a social dimension (RSA 2001).

2.4 CONCEPTUAL FRAMEWORK OF ABSENTEEISM

Davey and Cummings (2009:322) amalgamated two theories to create a theoretical framework with the premise that employee attendance is based on two factors, the ability to attend and motivation to attend. The theoretical framework focuses on individual work ethics, demographics and from the work environment. Some form of absenteeism may be difficult to prove in a situation where the employer has two or more operational stations or the employee occasionally operates from a virtual office. The duty to render service is breached by the employee when the employee is physically present and mentally absent as would be the case of sleeping on duty. Workplace absenteeism is multi-dimensional, such as changes in the work environment that overburden the coping mechanism. As a result of this approach, a multi-dimensional framework of absenteeism clouds the causative factors of absenteeism (Breetzke 2009:1; Patrick 2001:24; Tustin 1994:52).

FIGURE 2.1 CONCEPTUAL FRAMEWORK MODEL



(Adapted from Davey & Cummings 2009:320)

The conceptual model uses individual predictors of absenteeism such as age, salary level, tenure, race, gender, occupation, educational level, job satisfaction, and organisational commitment, ability to attend and pressure to attend. Organisational commitment is described as having loyalty to the organisation, identifying with its core values and influences whether or not an employee feels it is appropriate to take unauthorised, unscheduled absences. Group level absenteeism is not viewed as a predictor of individual absenteeism (Davey & Cummings 2009:320; Lambert, Camp, Edward & Saylor 2005:8-9).

2.5 PREDICTORS OF ABSENTEEISM

Oi-ling (2002:3-6) claims that in Hong Kong there were 47,500 work days lost as a result of employee sick leave in 1998 and suggests the examining of stress levels for nurses in different cultures to enable a fuller understanding of the predictors of absenteeism as different cultures accept some predictors, and some reject the same reasons for illness.

Lambert *et al* (2005:8) claim that organisational commitment, job satisfaction, job stress, health issues and personal characteristics correlate as regards employee absenteeism. The findings of the research by Van Der Westhuizen (2006:136) focused on high and low combination of job involvement and organisational commitment and the outcome was emphatic on the turnover as predictor of absenteeism.

According to Unruh and Strickland (2007:674) absenteeism from the workplace contributes to a vicious cycle of a negative work environment which leads to more absenteeism and increased turnover. McCormick and Ilgen (1985:56) describe turnover as dysfunctional where an employee wishes to leave the institution and the employer prefers to retain the individual, and is functional where the employee wishes to leave the institution and the employer accepts the termination of services by the employee.

De Wit (2006) focused on attitudes towards job factors that had an influence on absenteeism and was not able to find a high coefficient in the test sample. McGoldrick and Arrowsmith (2001:8) claim that an organisation is healthier for a spread of ages. Ferguson *et al* (2001:38) state that aging employees expose organisations to high levels of absenteeism through higher probabilities of becoming disabled for longer periods.

Oi-ling (2002:3-6) and Patrick (2001:24) found that gender and age among other predictors of absenteeism have a significant influence on absenteeism. Age was positively related to well-being in managers and negatively related to absence frequency among hospital employees. Older employees were shown to have higher responsibility at work and utilised minimal days for sick leave. Female employees were observed to have utilised more absences than males.

Andrews (1997:221-222) and MINTRAC (2009:3-8) state that gender moderates the age turnover relationship. Women are more likely to remain in their jobs the older they get than men do. Turnover is occasionally related or preceded by high workplace absenteeism. The occupational category is linked to skill levels and salary levels. The lower skill employees are concentrated in the lower skill occupations and easily replaceable. Public service employees enjoy security of tenure, which maybe a contributory cause of absence from work without good cause, a practice that is encouraged by the knowledge that they cannot be easily dismissed from their jobs, therefore have the belief it is right to stay away from work.

Rogers and Hertin (1993:217-222) found a correlation between the use of sick leave and age. Employees with advanced age comparatively, used more sick leave in comparison with younger employees. The level of education seems to have influenced the use of sick leave where the lower level categories of employees were found to have a higher level of absenteeism than higher educated individuals.

Robbins *et al* (2004:47) state that married women employees have fewer absences and undergo fewer job turnovers. Rogers and Hertin (1993:222) express tenure as work experience in years that is viewed as a predictor of employee productivity where seniority has been found to be inversely related to absenteeism in terms of frequency and total number of work-man days lost. The level of education was found to have an influence where the lower category of employees was found to have higher levels of absenteeism than higher educated employees. Jacobs and Roodt (2011:425) and Davey and Cummings (2009:320) state that an organisational culture in hospitals can contribute towards lower turnover as the turnover rate is a predictor of absenteeism. The process can be facilitated by promoting knowledge sharing that can provide opportunities that may meet employee expectations.

Pousette and Hanse (2002:229-231) suggest that theories that make predictions about antecedents to ill health and sickness absence make the assumption that the relationships are the same in different occupations. Reduced job autonomy is suggested to be associated with higher sickness absence. The occupation specific model is used in order to identify the variance in the patterns in terms of occupation-groups. Davey and Cummings (2009:320) found that turnover was significantly related to absenteeism.

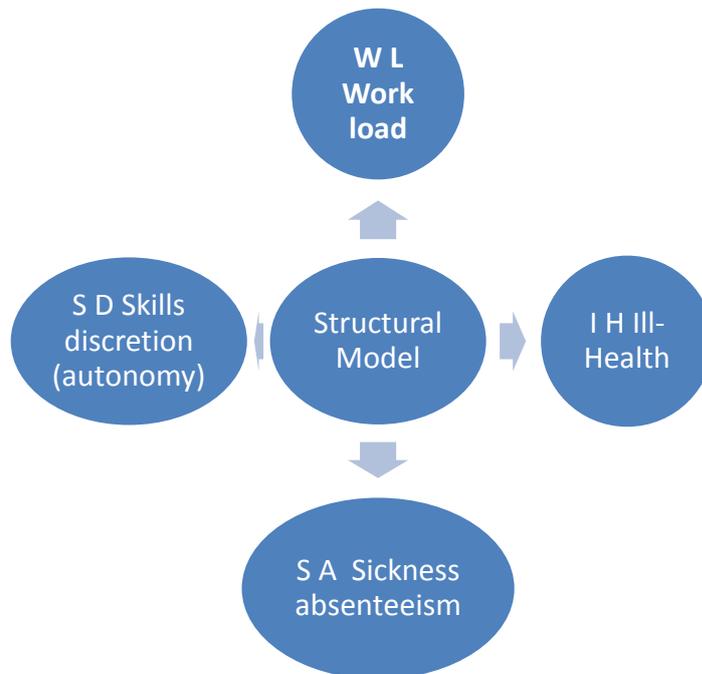
Hirschfield *et al* (2002:553) conducted a research on low-wage public sector clerical employees and found that those employees who perceived limited performance-reward expectancies were likely to be absent more often. The link between skilled employees and absenteeism suggested that employees may have utilised absenteeism as a means of compensating for perceived workplace contributions not extrinsically rewarded. Unruh *et al* (2007:674) found that absenteeism from the workplace does contribute to a vicious cycle of a negative work environment which leads to more absenteeism and increased turnover.

2.6 A MULTI-GROUP INVARIANCE MODEL

A multi-group invariance structural model represents different types of occupations such as industrial blue-collar workers, industrial collar workers, elderly care workers and child health care workers. The focus of this model relates to the extent to which a model that is assumed to include a general population also includes sub-populations such as different occupational types. The occupation specific model allows different relationships between variables in different occupations. The specific model approach allows for identification of the most common reasons for absenteeism and early retirement in the workplace and was successfully utilised in Sweden. A common model proposes that absenteeism is a behavioural response to dissatisfaction with the job (Pousette & Hanse 2002:230-244). Nyathi (2000:59) found that professional nurses were absent from work because they wanted to prolong their weekends.

Davey and Cummings (2009:313) argue that on average health care employees are more likely to be absent from work as a result of illness or injury than other occupations. Paton (2010:4) acknowledges that line managers are the fundamental building blocks for reducing absenteeism and must be provided with the tools to manage absence. The absence rate at 3% is considered very high and must be vigorously and progressively managed.

FIGURE 2.2 MODEL SPECIFICATION



(Adapted from Pousette & Hanse 2002:232)

Pousette and Hanse (2002:232-245) make the assumption that low job autonomy and low skill discretion deprive the employees of the opportunity to handle work obstacles and regulate workload to a manageable level, implying a negative relationship to workload has an impact on absenteeism rate. Patrick (2001:23-24) states that changes in the working conditions overburden the coping mechanism. Work-related stress can lead to deteriorating physical and emotional well-being. The work object is the distinguishing quality between occupations in the different occupational groups whereby the blue-collar employee works with things that are tangible such as materials and machines whereas the white-collar employee is knowledge based employee who is working with data.

2.7 CATASTROPHIC MODEL (CAT)

According to Buschak, Craven and Ledman (1996:28) the catastrophic model (CAT) caters for major illness that keeps the employee away from work for extended periods of time. This model is similar to short and long term incapacity sick leave, whereby the employee has exhausted the normal sick leave of 36 days, which is catered for by DPSA section 14 (RSA 2009).

2.8 MEASURES TO CONTROL WORKPLACE ABSENTEEISM

The general behaviour and actions of public officials are determined by specific ethical codes of conduct and the unethical conduct results in effective administration and unsatisfactory service delivery (Andrews 1997:33). Effective control of workplace absenteeism requires an absenteeism policy to be in place, management to establish the magnitude and patterns of absenteeism, and raise awareness about the consequences of breaking these rules (Bamford, Klein & Engelbrecht 1999:2).

The Determination on Leave of Absence in the Public Service (DPSA 2009 section 14, 14.1), the Public Service Co-ordinating Bargaining Council Resolution (PSCBC 7/2000), Davey and Cummings (2009:313), and DPSA (PILIR) 2009 section 3, 3.1 state that an employee is entitled to 36 working days sick leave with full pay in a three year cycle with the same employer. Any unused leave credits shall lapse at the end of the three year cycle. The employee is expected to utilise and manage the normal leave circumspectly. The employee who chooses to utilise sick leave days must submit a medical certificate for every occasion of three or more sick leave days utilised. The medical certificate must be issued and signed by a practitioner or persons who are registered with the Professional Councils established by the Act of Parliament. Incapacity leave is additional sick leave granted conditionally at the employer's discretion. An employee who has exhausted the normal sick leave during the prescribed sick leave cycle, and who requires to be absent from work due to a temporary incapacity, may apply for temporary incapacity leave with full pay. According to the Policy and Procedures on Incapacity Leave for Ill-Health Retirement (PILIR) (DPSA 2009) an employer is not required to pay an employee if the employee has been absent from work for more than two consecutive days or more than two occasions during an eight week period and, on request does not produce a medical certificate.

The Public Service Regulations, 2001 F (c) holds the manager accountable when an employee abuses sick leave (RSA 2001). According to Parbhoo (2003:6) and Nel *et al* (2008:145) the doctor patient confidentiality is not above reach to the employment relationship, by suggesting that the employer can question the authenticity or contents of the medical certificate if there is sufficient reason to do so within the confines of confidentiality.

According to Breetzke (2009:2) South African employees are challenged by global trends to seek mechanisms to deal with excessive absenteeism at the workplace. The Chartered Institute of Personnel and Development (CIPD) (2008:11) claims that the 2006 survey showed that public sector employees are less likely to be disciplined or dismissed for reasons of workplace absenteeism.

2.8.1 Measuring absenteeism

Measuring absenteeism in the workplace enables the employer to determine the extent and nature of the problem. Absenteeism is measured using two measures, total time lost and absence frequency Nel *et al* (2001:584). In institutions total time lost is determined for every group of employees and category of absence such as sick absence, authorised and unauthorised absence. The recognised international norm is 3%. Institutions challenged whether to accept the international norm as the given or strive to bring workplace absenteeism down in the interest of quality and quantity of service delivery. The total time lost index is calculated as the: Total number of days lost due to absence over the period multiplied by a thousand and divided by the average number of employees multiplied by a thousand and divided by an average number of employees multiplied by total work-days over the period (Amin, Das & Goldstein 2008:6; Breetzke 2009:4; Nel *et al* (2001:584).

According to Nel *et al* (2001:584) high workplace absenteeism rate is suggestive of incidence that is of short duration and therefore more disruptive to the operational plans of an institution as prior knowledge of pending workplace absenteeism allows for forward planning and reduction of the costs associated with absenteeism. The absence frequency rate is calculated as: Number of absence incidence over the period divided by the average number of employees employed over the period (Breetzke 2009:4; Nel *et al* 2001:254).

2.9 IMPACT OF WORKPLACE ABSENTEEISM

Lambert *et al* (2005:6, 36) claim that absenteeism has adverse effects on those employees who are good attenders as they are shuffled around to fill in the positions of absent employees. Organisations suffer the detrimental effects and consequences of employee absenteeism. Management expend valuable time to modify employee assignments to respond to absences. When employees who are in management or in highly specialised job assignments report sick, the work assigned to them remains undone because their positions remain vacated and the work remains for them to complete. The responsibility and accountability these employees are entrusted with may influence less use of sick leave by them.

The White Paper on Transforming Public Service Delivery (DPSA 1997) holds management responsible for the specific level of resources and for obtaining value for money in these resources.

Madibana (2010:22) found in the research about absenteeism amongst nurses, that the high rate of absence had an impact in the reduction of quality care rendered by nurses.

2.9.1 Cost to the institution

Andrews (1997:8,221) describes an institution as the process through which activities are grouped logically into the distinct areas and assigned to managers. It results in the logical grouping of activities in a department. Workplace absenteeism influences the cost of an institution, which influences the quality of the product or service that is rendered by the institution. Employee attendance is a vital element for managing productivity of any institution and its individual members. The unfilled posts reflect the absence of public health care employees and do not absorb budget resources for salary and upkeep of facilities. Absent personnel still receive their salaries. If public servants are not on the job, the expenditures embodied in them do not reach their beneficiaries (Chaudhury & Hammer 2003:2; Lambert *et al* 2005:5). The cost is direct in terms of salary expenditure or indirect in terms of staff replacement.

Ferguson *et al* (2001:38) argue that the cost of employment risk approach is about estimation of the possible cost of any absent employee to an institution per hour per day. Robbins, Odendaal and Roodt (2004:15) estimate that absenteeism costs South African institutions millions of rand a year in decreased efficiency and increased benefit payments. Fakie (2005:3) notes that sick leave costs the national government 1.5% of the total basic salary expenditure for the National Department of Health from 1 January 2001 to December 31 2003.

The South African Chamber of Business (SACOB) (Patrick 2001:17) acknowledges that in 2006 about R19 billion were lost on account of absenteeism resulting from sick leave. According to the European Foundation (1997:7), United Kingdom lost 11 billion pounds in 1994, Germany lost 30, 5 billion EUC in 1993 and Belgium lost 2.4 billion EUC in 1995. Breetzke (2009:2) describes indirect costs as hidden costs, harder to measure and may include economic value of lost productivity. Indirect costs relate to loss of production that may arise by engaging some experts to provide service in the field where they are closing the staff shortage gap. Rogers and Hertin (1993:9) and the European Foundation (1997:8) view the individual employee and his or her dependants in a social dimension aspect, as exposed to reduced income as a result of extended workplace absenteeism related to ill health where long term incapacity is involved.

The total cost of employment risk approach is about estimation of the possible cost of any absent employee to an institution per hour. The cost may be direct and indirect, such as overtime, low productivity and a decline in morale among workers who are expected to cover for an absent employee (Bangali 2004:27; Dagmara 2000:1; Ferguson *et al* 2001: 38).

2.9.2 Low productivity

According to Jankowitz (1991:1) high levels of absenteeism are disruptive to production where operators are interdependent, or where levels of service have to be maintained. Buschak, Craven and Ledman (1996:26) argue that absenteeism generates costs for the institution and productivity problems put an unreasonable burden on the rest of the employees who are at work. An absent employee, be it physical or psychological, remains an unproductive employee. Absenteeism viewed from an employer's perspective is regarded as a problem that impacts negatively on service delivery while the employees' believe their mere presence in the workplace is being productive.

2.10 MANAGEMENT INTERVENTION STRATEGIES IN WORKPLACE ABSENTEEISM

Managing workplace absenteeism remains a challenge for all employers and the Gauteng Department of Health has not been spared the challenges faced by other institutions as it provides health care services to the citizens of Gauteng. The provision of good quality health care is vital for the development of human capital. The implications of declining quantity and quality of care is grave when the human capital, equity and efficiency which are the cornerstones of health care service delivery are threatened by employees who are not at work when expected to be (Gauteng Province 2007:11). Misuse of sick leave is considered to be an overriding problem in instances where the employee does not uphold the standard of honesty and incorruptibility or these values are not considered to be the corporate values of the institution (Andrews 1997: 221-222; MINTRAC 2009:3).

According to Grogan (2005:237) employees have a fundamental duty to render services, and their employers have a right to expect them to do so. Deliberate workplace absenteeism is regarded as a violation of this contractual obligation. The manager in public service is to identify trends and patterns that indicate abuse of sick leave as the manager is held accountable when an employee abuses sick leave in terms of the Public Service Regulations Part V Section F(c) (RSA 2001). The workplace can be a virtual office. Workplace absenteeism is perceived to be high in unionised workplace environments where unions are perceived to be capable of exerting control over the employer and employee relations for the primary benefit of the employees. In the public sector contractual employee benefits are modified by collective agreements.

Public service managers are to focus towards results achievement and be accountable for the performance of their institutions (Gauteng Province 2010:23). Workplace absenteeism can be reduced by tightening up policies and procedures relating to control of absenteeism and intensifying monitoring processes on absent employees.

According to Cloete (2004:290-297) public institutions are to provide quality goods and services. The public institutions require an appropriate infrastructure to enable them to perform their core functions (Bamford *et al* 1999:1; Buschak *et al* 1996: 28; Munro 2007:22).

2.10.1 Effective communication

According to Oi-ling (2002:12) managers should alter the psycho-social environment at work and cultivate an institutional climate that supports staff and facilitate effective communication. Institutions should raise awareness to employees of their rights and responsibilities regarding leave of absence and the consequences of abusing it (Bamford *et al* 1999:2). The policies should be clearly written and well communicated to all employees and be readily available and accessible. In a highly unionised environment, these policies are debated in bilateral or multi-lateral forums between management or employer representatives and labour representatives. The human resource practitioners must conduct periodic in-house training on these policies for management and employees, to facilitate uniform interpretation and enforce compliance by all stakeholders. The policies must be couched in simple understandable language that is free of legal terms for ease of comprehension by all users. The policies on workplace absenteeism must be explicit of actions to be taken when policies have been violated or employees are aggrieved.

2.10.2 Empowerment of managers

Workplace absenteeism is multi-dimensional, requiring inputs from all related fields. Managers require on-going support and training on issues that relate to absenteeism at the workplace. The human resource unit works with managers to establish performance standards, training of employees on the importance of execution, and assists managers to focus on continuous improvements, superior execution and employee empowerment (Bergdahl 2001:9; RSA 2011).

The labour relations unit supports the training of managers on grievance handling, bilateral and multi-lateral encounters with employee representatives with employee education issues specific to workplace absenteeism. The Chartered Institute of Personnel and Development (CIPD) (2008:35) reported that 70% of managers in the public service have been trained in workplace absenteeism handling.

Employment relationships bind human resource and industrial relations together with the common objective of achieving institutional goals and labour peace. Managers focus on managing the institution for productivity at the lowest possible cost by providing quality care, therefore reducing the risk of litigation, control of absence from work and work efficiency.

It is the delays in dealing with issues that give the employees the feeling of being unfairly treated and demoralised. Consistency in upholding these processes is essential for creation of a stable employment relationship while any deviation from the set processes give rise to worker unfriendly environment (Bergdahl 2011:8-9) .

2.10.3 Monitoring of workplace absenteeism

The manager is expected to keep accurate records for all leave of absence taken by employees. In terms of the management of ill-health absence's the manager has to ensure that the eight week rule is observed, whereby the employee who has been absent from work on more than two occasions during an eight- week period must regardless of the duration of the sickness or injury, submit a medical certificate (RSA Part V section F (b); DPSA, 2009 section 14, 14.8). Pierce (2009:21) believes that management of human capital may be achieved through the integration of employee benefits, employee assistance programmes and human capital.

Monitoring of absenteeism is a human resource function that gets lost in the competing functions that are carried out by human resource practitioners. High levels of absenteeism are an indication of poor management and or conflict within the employment relationship. The methods to monitor workplace absenteeism vary from one institution to the other. It is human resource management that establishes common guidelines that are used by management to monitor workplace absenteeism. In monitoring absenteeism the manager considers each employee's case on its merit.

The manager focuses on certain aspects of the case such as failure to call in on the day of absence, pattern of use of sick leave before or after holidays and sick absence occurring on certain days of the week or month. Monitoring systems to monitor and record attendance of work are put in place to assist management with simple accurate functional data that facilitates informed decision- taking at management level. The employees of the province and their attendance at work become the focal point of the province in relation to service delivery. Peer pressure monitoring comes from colleagues at the same facility. Hierarchical monitoring of employees by management may lead to more attendance for fear of being discovered (Chaudhury & Hammer 2003:19; Gauteng Province 2010:15). A health care service institution may use Health Information System and Personnel and Salary Administration System (PERSAL) among others, to ease the burden of the monitoring process. All these tools combined are useful in gathering administrative data for management.

2.10.4 Visits to facilities

The role of human resource at institutional level is to support and guide management as well as monitor compliance issues. Workplace absenteeism remains a key focus area because of its impact on the budget of an organisation. Unscheduled facility visits are conducted with the view to audit workplace absenteeism. The audit is to be done in line with the auditor-general or internal risk management's approach to encourage consistency. A check list that is used is prepared by human resource practitioners and institutions are familiar with. A human resource accounting officer of the institution should be involved when an audit is done.

The institution must have evidence available of sporadic visits to employees who have been identified as having developed absenteeism patterns with the view to rule out elective absence. The European Foundation (1997:13) and Munro (2007:22) state that ill- health is the main reason for workplace absenteeism. Employees who present with ill- health are generally and frequently more absent from work than the healthy ones. The authors also observe that not all employee assistance programmes aimed at reducing workplace absenteeism have an effect on the ill-health of the employees, which render the unscheduled visit to the employees vital to see where the caring employer could be of assistance.

2.10.5 Incentive system

According to Buschak *et al* (1996:28) the catastrophic model (CAT) caters for major illness that keeps the employee away from work for extended periods of time. This model is similar to short and long term incapacity sick leave which is catered for by PILIR subsection 7.3 (DPSA 2009). The managers require special training for successful implementation of the policy. The paid time off model (PTO) has hidden benefits incentives for employees not to use unnecessary sick days which are then paid for at retirement. The research by Lambert and Camp (2005:4) compares the Civil Service Retirement System (CSRS) and the Federal Employees Retirement System (FERS) and showed that in the final analysis and when novelty wore off, workplace absenteeism was not necessarily reduced by the incentive system.

Management should use the strategy to raise awareness about responsible utilisation of sick leave through workshops about PILIR and the "eight week rule". It should show the benefits of good sick leave management when employees are challenged with temporary or permanent incapacity leave.

The "use it or lose it" approach of the current system reward the abuse of sick leave as it is viewed as not being beneficial by the employees to act responsible towards the use of sick leave. There is no deterrent not to abuse sick leave in the public sector.

2.10.6 Team support

Institutions value team effort over individual achievement. Operational competencies are viewed as essential. Managers encourage effective communication among team members, motivating others and the development of problem-solving skills. Managers through the team development effort encourage nurturing and transmitting of the institutional culture. Institutional culture refers to a system of shared meaning within an organisation that determines how employees behave in the workplace. Culture and people are like glue that ensures that institutional standards are upheld. Individuals become units that form the team and conversations at work are encouraged to strengthen team work, knowledge transfer and productivity (Bergdahl 2001:8-10; Goldsmith & Morgan 2003:78; Robbins & Decenzo 2001:174).

2.10.7 Return-to-work interviews

According to Paton (2010:1–5) a phased return-to-work data management and remote services are among the approaches employers may use to manage workplace absenteeism. The intervention can involve use of Information Technology systems and telephone discussions. Good absence management is about good people management. The return-to-work interviews provide management with the opportunity to get to know the employee better and for the employee to substantiate his or her case. The employee is afforded privacy during the sessions which should happen as soon as the employee comes back to work. The key success in this strategy is unthreatening follow ups that are done. A multi-faceted approach is used to get people back to work such as phoning, maintaining regular contact and taking medical advice.

The Chartered Institute of Personnel Development Annual Report (2008:35) reported 90% of public services that use the strategy and 77% use the risk assessment to aid return- to-work. The manager should have private counselling sessions with the employee as soon as the employee returns to work. These sessions provide the employee with the opportunity to put his or her case across and for the employer to get a first-hand opportunity to assess if the employee is fit enough to come back to work. The employer has to make the employee aware of the status of the meeting that it is formal and proceedings are recorded. The employer is to keep accurate records of all counselling sessions.

2.10.8 Employee assistance programme (EAP)

DPSA (PILIR2009) prescribes that the PILIR committee promotes EAP in the workplace and each institution to establish a committee. The PILIR committee consists of a labour relations officer, an EAP practitioner, a health practitioner, an employee wellness practitioner and any other relevant practitioner who is co-opted on a needs basis. The purpose of the committee is to manage short and long term incapacity which is sick leave utilised after the employee has exhausted the 36 days normal sick leave in a three year cycle. The short term incapacity sick leave is of longer than three days and less than 29 days and long term incapacity is sick leave longer than 29 days. The short spells of sick leave become a concern when there is evidence of a pattern of abuse. It is a call for the manager to intervene. Every organisation should provide EAP that is funded by the employer, to the employees. A health risk manager is used by the employees who are expected to honour referrals and stay with the programme until such time that there is evidence of recovery, failure by the employee to accept the programme should attract a disciplinary process.

According to Mellor, Arnold and Gelade (2009:8) the amount of support that followers receive from their transformational leader or co-worker may help reduce levels of absence by making the workplace a more pleasant place to be, and perhaps by helping the person find solutions to work out family conflict or other problems that produce absence. Landstad et al (2001:1) suggest that the individuals in the preventive intervention group who were less than 42 years of age, total absence due to sickness decreased. The change was obvious to the cleaners who had a previous history of high absence due to sickness. The Chartered Institute of Personnel Development (2008:36) focused on working-man days lost, management of absenteeism, employee well-being and employee rehabilitation. The skilled employees were reported as 12% who were using rehabilitation programmes. Yende (2005:35) and Fakie (2005:17) state that EAP, despite having been around since 1996 for the National Department of Health, has not actually been managed and utilised to its full extent whereby if fully utilised would assist in the management of employee workplace absenteeism.

2.10.9 Occupational and safety committee

The focus of this committee is on the provision of a safe working environment by the employer (RSA Part VI section D. 2001). It monitors issues of compliance and adopts the employee advocacy role. The committee consists of all the major stakeholders, such as employee representatives, labour representatives that represent employees in the institution on issues of safety at the workplace. In the context of the Gauteng Department of Health the committee engages with the labour representatives and employer representatives at bilateral and provincial multi-lateral scheduled meetings.

According to Du Toit and Van Der Waldt (1998:139) the International Labour Organisation recommends creation and maintaining of a pleasant work environment in order to improve productivity. The environment must stimulate the employee to ensure efficiency and effectiveness.

2.10.10 Review committee

This structure is essential when dealing with incapacity leave. It is composed of management, human resource practitioner, employee representative, labour relations officer, employee wellness and any adhoc person needed in terms of the case under discussion (DPSA PILIR 2009). The employee reserves the right to lodge a grievance about the outcome of his incapacity request if it is negative. The role of the committee is to provide a transparent forum, reduce hostility against management and to protect the rights of the employee through involvement of the employee representative.

2.11 CONCLUSION

The literature review that has been consulted explores the workplace absenteeism and its impact on the institution. The employment relationships represent a triangle that consists of the employer, the employee and the industrial environment. The relationship is multi-dimensional and highly regulated with built in mechanisms to handle conflict in the workplace. Conflict is inherent to the employment relationship and structures and mechanisms such as bargaining councils, the Commission for Conciliation, Mediation and Arbitration and Labour Courts are structures for recourse. The theory of absenteeism and employment relationship were explored. Management intervention strategies were explained. Controlling absenteeism in the workplace begins with a sound absenteeism policy that is incorporated into an employee induction programme. Communicating and educating the employees about the absenteeism policy takes the centre stage in the employment relationship. Vigilant monitoring of workplace absenteeism is the responsibility of the manager closest to the employee, such as the supervisor. Workplace attendance problems of employees can be handled using sound judgement, keeping accurate attendance records and administering the policy fairly and consistently.

Chapter 3 will collect data which will confirm or negate the literature review that has been explored in chapter 2.

CHAPTER 3

METHODOLOGY OF THE RESEARCH

3.1 INTRODUCTION

Chapter 3 focuses on the methodology used to determine the absenteeism in the four hospitals of the Gauteng Department of Health. The research design and the methodology that have been used to collect data are discussed below. The data are collected in terms of the characteristics of the stratified random sample such as absenteeism of the different occupational categories, gender, age, tenure of service, race groups, and salary.

3.2 RESEARCH DESIGN

A research design is the overall plan for relating the conceptual problem to relevant empirical research. It is a quantitative descriptive research that involves the systematic collection of numerical information under conditions of considerable control. The choice of the research design influences subsequent research activities such as identifying the target subjects, what data to collect and how they should be collected. The research design is a descriptive survey which is concerned with characteristics of a specific population subject, at a fixed point in time for comparative purposes. The focus is on a representative sample of the relevant population. It is concerned with the accuracy of the findings and their generalisability. The survey is used to understand the behaviour of employees with regards to motivation, satisfaction and grievances (Babbie 1992: 89; Ghauri *et al* 1995:27, 60; Brink 1996:11; Welman *et al* 2001:52).

3.2.1 Methodology

The Gauteng Department of Health has thirty four hospitals that deliver health care services. The four hospitals that have been targeted for the study of absenteeism are Tara Moross Centre Hospital in Region A under the Johannesburg Metropolitan Municipality, Germiston Regional Hospital which is in Region B under Ekurhuleni Metropolitan Municipality, ODI District Hospital in Region C under Tshwane Metropolitan Municipality and George Mukhari Academic Hospital in Region C under Tshwane Metropolitan Municipality. Each hospital is unique in its character in terms of specialisation of health care delivery service. The sample is a stratified random sampling which is composed of various clearly recognisable, non-overlapping sub-populations (strata) that differ from one another in terms of variables that are a combination of more than one variable such as age, sex, income level or educational level. The purpose is to ensure that every part of the population (every stratum) is represented. The members of a particular stratum are homogeneous with the population at large.

The sample is representative of a population with clearly distinguishable strata with a greater degree of certainty (Babbie 1992:7; Brink 1996:138; Brynard & Hanekom 2005: 44; Ghauri *et al* 1995:78; Welman & Kruger 2001:55-56; Polit & Hungler 1995:18).

The data were collected in three phases. The first phase of data collection was done through auditing of hard copies of identified personnel files, encompassing ten files per hospital and using the tools in annexure A and B. The forty employees' profiles were accessed through the Human Resource Information System (HRIM) located in the Gauteng Department of Health Head Office. The respective employees' profiles were handed over to the human resource manager in the respective hospital on the morning of the audit, for the human resource practitioner to draw out the hard copy files for auditing. The characteristics of the individuals that were identified for the first phase were males and females as well as representatives from the different race groups. The auditing of the files were for the complete working life of the employees and not only confined to 2008 calendar year. Registers that are used by human resource administration to control the movement of the leave form were inspected as evidence of the control system in place. The purpose of auditing the files was to gain insight into how leave in general was captured, managed and controlled by the hospitals.

The second phase of data collection were done through structured interviews with four human resource managers, who were directly accountable for management and control of leave of absence in general, in the four hospitals. A structured interview provides for a more organised approach and a more stable basis for assessment of the different candidates (Erasmus *et al* 2005:250). The structured interview was conducted using the tool in annexure C. Tara Moross Centre Hospital had been functioning without a human resource manager and the manager that was interviewed had been in the post for three months. The human resource practitioner who was at salary level 8 and acting in the Assistant Director's post (manager level 9) was invited to join the manager and be part of the structured interview. ODI District Hospital had three human resource practitioners, including the accounting officer at level 8 in an acting capacity. The third phase of data collection was through the Human Resource Information Management System (HRIM). This system uses the Personnel Remuneration Administration System (PERSAL) to collect data. Data in this system is categorised in characteristics such as salary level, date of appointment, occupational category, gender, age in units of five, race, employing hospital, employment status in different sub-categories such as session, contract and full-time and the different types of leave of absence. The continuous sick leave of four to five days was excluded from processing and focus was laid on sporadic days to the start and end of a weekend.

The research used secondary data in analysing sick leave utilised by full time employees in the identified hospitals for the period of 1 January to 31 December of 2008 using Persal. The total population sample was four thousand and ten (n=4010).

The research during data collection and analyses used characteristics in the sample such as occupational groups, age, tenure of service, race, gender and salary range from level 1 to 12. The research used past events such as sick leave utilised by employees, using secondary data from Persal, falling into the category of historical, empirical study. The interval scale of measurement was used in the quantitative research and actual numbers are ordered with equal measurement between each category (Brink 1996: 149; Brynard & Hanekom 2005:28-29; Mouton 2005:52,100,170).

3.3 UNIT OF ANALYSIS

The unit of analysis refers to what or who is studied (Babbie 1992:92; Brink 1996:133). The unit of analysis in the context of the study refers to observation of work attendance by the employees of Gauteng Department of Health in the four hospitals. The observation deals with the historical events as employees have already utilised the sick leave in the workplace. The subjects that are studied are the core health care providers such as doctors, nurses and support employees such as allied, administration and administration support (Mouton 2005 :51-52; Welman et al 2001: 52-53).

3.4 UNIT OF OBSERVATIONS

The observations that are made are of health care employees and support teams in Tara Moross Centre Hospital, Germiston Hospital, ODI Hospital and George Mukhari Hospital, and describe the characteristics of a large number of individual people, such as sex, age, salary range, occupational category, tenure of service, and race in relation to absenteeism in the workplace. The descriptive study and the individual characteristics are aggregated for the purpose of describing a larger group (Babbie 1992:92).

3.5 CONSTRUCT VALIDITY

Construct validity is concerned with the question "What construct is the instrument actually measuring?" (Brink 1996:170). The research used a multi-trait, multi-method approach in construct validity. A variety of data collection methods were used such as auditing of forty hard copy employees' files in phase one. In phase two a structured interview was conducted with four of the accounting officers in the leave managements. The third phase was collecting of personnel data through the Persal system.

3.6 ETHICAL CONSIDERATIONS

Ethical considerations will include amongst other issues such as the protection of the units of analysis and units of observations from discomfort and harm, by not revealing information which can cause physical, emotional, spiritual, economic, social or legal harm. The researcher has to ensure the protection of the subjects' interests and well-being by protecting the subjects of observations' identity through anonymity.

Anonymity is achieved when the researcher cannot link a given response with a given respondent and reporting aggregate data only. When data are collected at one sitting and not over a period of time makes it possible to achieve anonymity as the need for follow up is eliminated. Subjects of observations are selected for reasons directly related to the problem being studied as the principle of justice. Confidentiality is about the researcher's responsibility to protect all data gathered within the scope of the study and shared only with people involved in the research (Babbie 1992:465–466; Brink 1996:40–41, 45; Polit & Hungler 1995: 31-36).

The human resource managers who were interviewed were identified by the hospitals they represented and therefore remained anonymous to the researcher. The interview was part of the actual audit that was done as part of monitoring and evaluation that was in progress in the Department of Health following a negative auditor general's report about management of leave in general. The managers were put at ease as they were given the checklist afterwards for self-monitoring and for future self-auditing.

The data that were collected through Persal identified employees through the Persal number and kept their identities anonymous. The data that were collected through the hard copy of employees' files were used to point out areas of concern to the managers, and the files did not leave the office of the manager at the end of the process, once more protecting the identity of the employee.

3.7 CONCLUSION

This chapter dealt with the research design which is the overall plan for relating the conceptual problem to relevant empirical research. The methodology used a stratified random sample which is composed of various clearly recognisable, non-overlapping sub-populations that differ from one another, in terms of variables that are a combination of more than one variable. The data collection was done through three phases. The unit of analysis refers to the persons who are studied. The unit of observations are health care workers and support teams in the four identified hospitals. The construct validity used a multi-trait, multi-method approach. Ethical considerations include among other issues protection of the unit of analysis and the unit of observations from discomfort and harm. Chapter 4 discusses the analysis and interpretation of the data gathered in chapter 3.

CHAPTER 4

INTERPRETATION AND ANALYSIS OF DATA

4.1 INTRODUCTION

This chapter focuses on the research analysis and interpretation of data gathered on workplace absenteeism in the Department of Health of the Gauteng Province. It seeks to identify differences or similarities in the leave trends in the 2008 calendar year between the four identified hospitals chosen for the study in the Municipality of Tshwane, Ekurhuleni and Johannesburg. The year 2008 was chosen as a second year in the leave cycle that started in 2007. The type of leave of absence is interpreted as a collective that does not specify the type of sickness or illness or it being acute or chronic. Workplace absenteeism is absence of the employee at the workplace that is defined by Du Toit and Van Der Waldt (1998:139) as the place that the institution makes available and where officials have to perform their work. It forms part of the internal environment for public administration in the public service. Direct public administration is directly concerned with the rendering of services to the citizens of the country.

Chapter 4 discusses the study of workplace absenteeism in the four identified institutions namely Tara Moross Centre Hospital, Germiston Hospital, ODI District Hospital and George Mukhari Hospital. In this research the following factors will be examined: the organisational structure and absenteeism of the different workforce categories such as, medical and nursing professionals, administrative staff, allied professionals and various categories of the general assistants workforce and their relation to absenteeism in the institution.

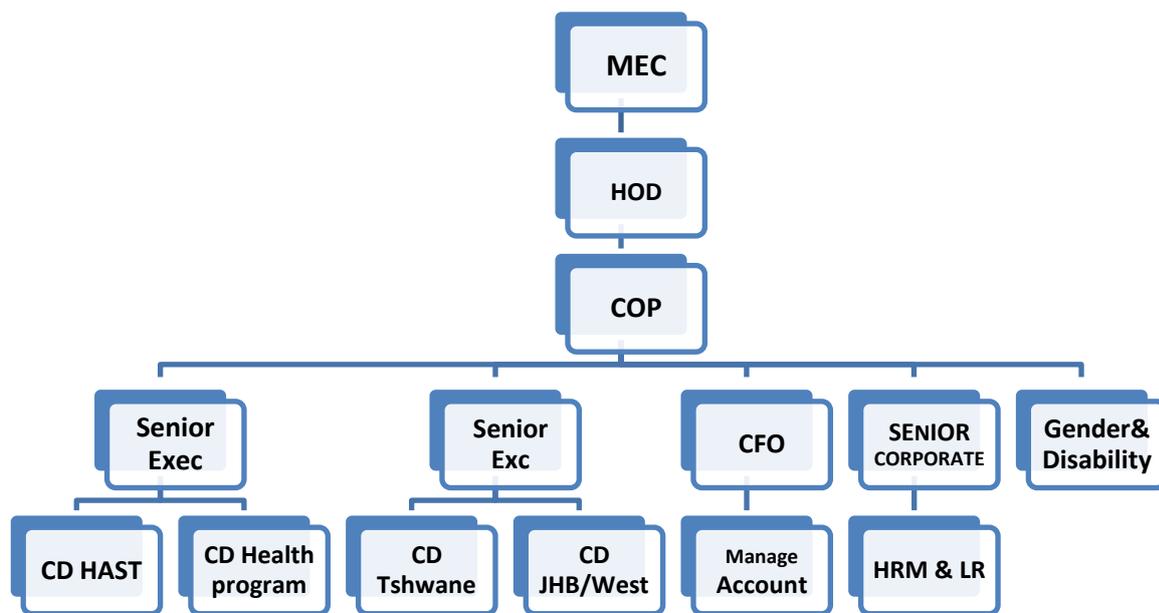
4.2 THE STRUCTURE OF THE ORGANISATION

The Gauteng Province is one of the nine provinces of South Africa. In 2005 the auditor-general conducted an audit of sick leave performance in six national departments and the Gauteng Province was among those that were omitted from the audit. The research focuses on the Gauteng Department of Health (GDoH) whose core function is to provide health care services to the people of Gauteng. The provision of health care services is labour intensive and requires large numbers of personnel for effective service delivery. The GDoH is serviced by thirty-four hospitals, four of which have been identified for the study of management of sick leave. The employee attendance to work is essential to the achievements of the Departmental goals. The Determination on Leave of Absence determines the leave policy for public service employees (DPSA 2009). The employees of GDoH represent the staff component as reflected in the organisational structure of the department.

The Gauteng Department of Health (GDoH) provides the basic health services to the people of Gauteng, who as internal or out-patients are clients or consumers of the services referred to as line functions. Public administration services rely heavily on support services such as the personnel department that renders support to line functions that provide the actual service of patient care. Support services are considered as indirect public administration services and essential in efficient public service delivery. Workplace absenteeism has a negative impact on productivity. Employees of the Gauteng Department of Health and their attendance to work are the focal point of the Province in terms of effective health care service delivery that is customer focused.

Political ideologies as those espoused by labour representatives are part of the external factors in the workplace environment that consequently have an impact on public administration and management and workplace attendance by employees (Du Toit & Van Der Waldt 1998:139,170).

FIGURE 4.1 INTERGRATED ORGANISATIONAL STRUCTURE



(Adapted from Gauteng Department of Health organisational structure 2010)

4.3 GAUTENG PROVINCIAL GOVERNMENT COMMITMENT TO SERVICE DELIVERY

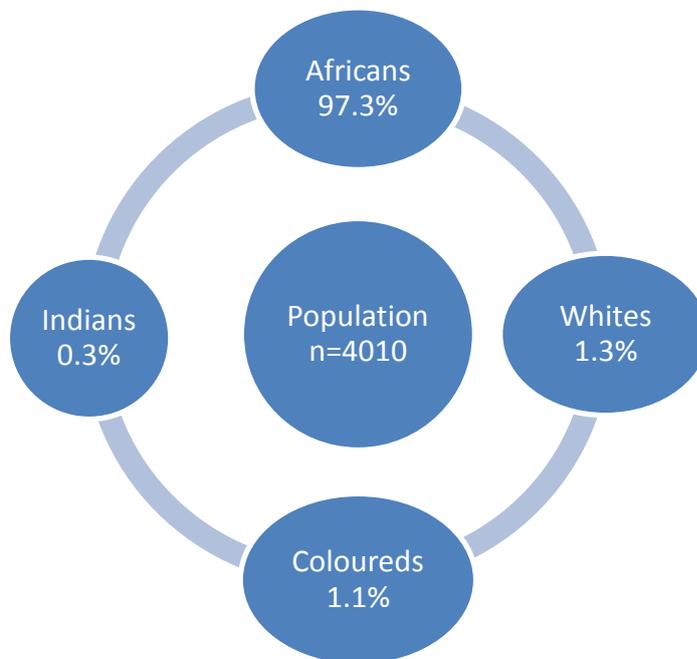
The Gauteng Provincial Government has made a commitment to its people to account for the delivery of services as its electoral mandate. This commitment will be achieved only when monitoring and evaluation of its performance is enforced by all Gauteng Department of Health service providers.

The Gauteng Government’s commitment to provision of health care services to all its citizens is demonstrated by the decentralisation of management of service delivery with the view to foster accountability, increase efficiency and accountability (ANC 1994:19–20; Goldstein 2008:1,5). The interpretation of the analysed data takes the sector performance approach into consideration when the interpretation of absence is across all the occupational groups for the 2008 calendar year (Gauteng Province 2010:15).

4.4 COMPARISON OF HOSPITALSPERMANENT EMPLOYEES

Gauteng employees are counted at 51,475 from the Personnel Salary Administration System (PERSAL) as of March 2008. The population from the four chosen hospitals has been counted at 4,010 reflecting 8% of the total population. The different groups of employees were identified as Africans represented as n=3902, Whites as n=51, Indians as n=14 and Coloureds as n=43.

FIGURE 4.2 DIFFERENT RACE GROUPS OF THE FOUR HOSPITALS



(Source: Compiled by the researcher C S Ndhlovu 2012)

Figure 4.2 reflects the racial split percentage of the workforce (n=4,010) of the hospitals.

The population from the four hospitals has been counted as 4,010 reflecting 8% (n=51,475) of the total working population for Gauteng Department of Health as from 1 January to 31 December 2008. The different groups of employees were identified as Africans represented by 97.3% (n=3,902), Whites as 1.3% (n=51), Indians as 0.3% (n=14) and Coloureds as 1.1% (n=43). The George Mukhari Hospital has a female dominated workforce at 73.9% (n= 2097) in a total workforce of n=2,836.

TABLE 1 PERMANENT EMPLOYEES OF THE FOUR HOSPITALS

| RACE | TARA HOSPITAL | GERMISTON | GEORGE MUKHARI | ODI | TOTAL |
|-------------------|----------------------|------------------|-----------------------|------------|--------------|
| Africans | 227 | 367 | 2836 | 472 | 3902 |
| Whites | 23 | 24 | 3 | 1 | 51 |
| Coloureds | 5 | 37 | 0 | 1 | 43 |
| Indians | 13 | 1 | 0 | 0 | 14 |
| Population | 268 | 429 | 2839 | 474 | 4010 |

(Source: Compiled by the researcher C S Ndhlovu 2012)

Table 1 focuses on the distribution of race and the population of the total workforce. The geographical area of the hospital determines the demographics and the tendency of some groups being poorly represented or totally absent. The research focused on permanent employees of the four hospitals. The George Mukhari Hospital employees are reflected as 70.79% (n=2839), ODI Hospital as 11.82% (n=474), Germiston Hospital as 10.69% (n=429) and Tara Moross Centre Hospital as 6.68% (n=268) of the total working population. Tara Moross Centre and Germiston Hospitals are located in cosmopolitan areas while the George Mukhari and the ODI Hospitals are in rural and semirural areas. The positioning of the latter hospitals may account for the high African workforce.

TABLE 2 COMPARISONS OF NUMBERS OF ADMINISTRATION AND SUPPORT STAFF IN THE DIFFERENT HOSPITALS.

| OCCUPATIONAL GROUP | TARA | GERMISTON | GEORGE MUKHARI | ODI | TOTAL |
|-------------------------------|-------------|------------------|-----------------------|------------|--------------|
| Administration staff | 48 | 60 | 297 | 61 | 466 |
| Administration support | 103 | 140 | 719 | 133 | 1095 |
| TOTAL | 151 | 200 | 1016 | 194 | 1561 |

(Source: Compiled by the researcher C S Ndhlovu 2012)

Table 2 presents the administration employees and the administration support in the four hospitals. Tara Moross Centre Hospital is represented by 31.79% (n=151) of administration and 68.22% (n=103) administration support. The George Mukhari Hospital has the highest representation by the administration support at 70.77% (n=1016). The high representation of the administration support staff at George Mukhari Hospital could be partly because of the semi-rural environment. A semi-rural environment is usually characterised by poverty which may have a negative influence on opportunities to access education and skills. Doctors and nurses are highly marketable because of the educational levels and skills that are lucrative and enable this group to be highly mobile geographically (Chaudhury & Hammer 2003:3).

TABLE 3 GENDER COMPARISON IN DIFFERENT HOSPITALS

| GROUPS | HOSPITALS | MALE | FEMALE | POPULATION |
|--------------------|----------------|-------------|-------------|-------------|
| Africans | Tara | 83 | 144 | 227 |
| | Germiston | 52 | 315 | 367 |
| | George Mukhari | 739 | 2097 | 2836 |
| | ODI | 109 | 363 | 472 |
| TOTAL | | 983 | 2919 | 3902 |
| Whites | Tara | 5 | 18 | 23 |
| | Germiston | 5 | 19 | 24 |
| | George Mukhari | 3 | 0 | 3 |
| | ODI | 1 | 0 | 1 |
| TOTAL | | 14 | 37 | 51 |
| Indians | Tara | 1 | 12 | 13 |
| | Germiston | 0 | 1 | 1 |
| | George Mukhari | 0 | 0 | 0 |
| | ODI | 0 | 0 | 0 |
| TOTAL | | 1 | 13 | 14 |
| Coloureds | Tara | 1 | 4 | 5 |
| | Germiston | 6 | 31 | 37 |
| | George Mukhari | 0 | 0 | 0 |
| | ODI | 1 | 0 | 1 |
| TOTAL | | 8 | 35 | 43 |
| GRAND TOTAL | | 1006 | 3004 | 4010 |

(Source: Compiled by C S Ndhlovu 2012)

Table 3 focuses on gender distribution in the population of the research represented by males and females in the different racial groups.

The geographical area of the hospital determines the demographics and the tendency of some groups being poorly represented or totally absent. The males of the different hospitals account for 25.1% (n=1,006), while the females account for 74.9% (n=3,004).

The George Mukhari Hospital has a female dominated workforce at 73.94% (n=2,097) out of a total workforce of n=2,836. White male employees are represented by 0.11% (n=3) against the total workforce of the hospital (n=2,839). There are no Indians and nor any Coloured employees. African males are represented by 26.03% (n=739). The same hospital has no white female employees, no Indians, no Coloureds and 73.95% (n=2,097) African females. The table reflects a predominantly African female workforce. The hospital is situated in a rural setting and this may have an impact on the vast difference in the gender representation.

The Tara Moross Centre and Germiston Hospitals are located in cosmopolitan areas. They have 1.87% (n=5) and 1.117% (n=5) White male employees respectively and 6.72% (n=18) and 4.43% (n=19) female employees respectively. Tara Moross Centre Hospital has 4.48% (n=12) female Indian employees while Germiston Hospital has only 0.24% (n=1). Germiston Hospital has 7.23% (n=31) female Coloured employees while Tara Moross Centre has 1.50% (n=4). The core function of the various hospitals may have influenced the gender distribution.

TABLE 4 COMPARISON OF TENURE OF SERVICE IN RELATION TO ABSENTEEISM IN THE FOUR HOSPITALS

| TENURE IN YEARS | DAYS OF ABSENCE | PERCENTAGE |
|-----------------|-----------------|-------------|
| 1-10 | 4451 | 30% |
| 11-20 | 6577 | 44,3% |
| 21-30 | 2934 | 19,8% |
| 31-40 | 878 | 5,9% |
| TOTAL | 14840 | 100% |

(Source: Compiled by C S Ndhlovu 2012)

Table 4 reflects the level of tenure of the total workforce from 1 year to 40 years of service. Tenure of 11 years to 20 years of service reflects 44.3% (n=6,577) utilisation of leave of absence and remains the highest rate of absenteeism followed by tenure of 1 to 10 years of service at a 30% absenteeism rate.

TABLE 5 COMPARISON OF THE OCCUPATIONAL GROUPS IN THE DIFFERENT HOSPITALS

| OCCUPATIONAL CATEGORIES | TARA | GERMISTON | GEORGE MUKHARI | ODI | TOTAL |
|--------------------------------|-------------|------------------|-----------------------|------------|--------------|
| Doctors | 12 | 12 | 354 | 19 | 397 |
| Professional nurse | 47 | 81 | 548 | 109 | 785 |
| Staff nurse | 15 | 53 | 358 | 56 | 482 |
| Nurse assistant | 16 | 50 | 308 | 55 | 429 |
| Social worker | 4 | 4 | 8 | 3 | 19 |
| Occupational therapists | 4 | 0 | 15 | 1 | 20 |
| Radiographer | 0 | 3 | 27 | 6 | 36 |
| Clinical Psychologists | 4 | 0 | 10 | 2 | 16 |
| Physiotherapists | 0 | 1 | 9 | 1 | 11 |
| Dieticians | 0 | 0 | 5 | 3 | 8 |
| Finance | 4 | 11 | 59 | 9 | 83 |
| Speech therapists | 0 | 0 | 5 | 1 | 6 |
| Pharmacists | 2 | 9 | 36 | 5 | 52 |
| Dentists | 0 | 0 | 0 | 3 | 3 |
| Technicians | 2 | 5 | 51 | 6 | 64 |
| Librarian | 1 | 0 | 0 | 0 | 1 |
| Security | 6 | 0 | 30 | 1 | 37 |
| Administration and support | 151 | 200 | 1016 | 194 | 1561 |
| TOTAL | 268 | 429 | 2839 | 474 | 4010 |

(Source: Compiled by the researcher C S Ndhlovu 2012)

Table 5 reflects a great difference in terms of number of occupational groups in the four hospitals.

The core function and the size of the hospital seems to have a bearing on how many occupational categories of employees are to be found in that hospital as well as the actual figures of these categories. The George Mukhari Hospital is an academic hospital that trains medical doctors. This hospital has 12.47% (n=354) doctors in a staff establishment of n=2,839, Tara Moross Centre has 4.48% (n=12) in a staff establishment of n=268, Germiston has 2.80% (n=12) in a staff establishment of n=429 and ODI District hospital has 4.01% (n=19) in a staff establishment of n=474. This trend of vast differences in figures represented by the occupational groups, is evident in the category of professional nurses where George Mukhari Hospital reflects 19.31% (n= 548) nurses, Tara Moross Centre is represented by 17.54% (n=47), Germiston by 18.89% (n=81) and ODI District hospital by 23% (n=109). The impact of absenteeism is pronounced when viewed against the level of facility capacity in terms of human resources of the core occupational groups.

4.4.1 The Tara Moross Centre Hospital

Tara Moross Centre Hospital is a speciality psychiatric hospital in Region A with a workforce of 6.69% (n=268) of the total workforce (n=4010). The core function of the hospital is "specialised" such that some occupational categories are not available in the hospital as part of the workforce and patients are referred out to other facilities for specialised treatment. Tara Moross Centre Hospital falls under the jurisdiction of the Johannesburg Metropolitan Municipality.

4.4.2 The Germiston Hospital

Germiston Hospital is a regional general hospital in Region B with a total permanent staff establishment of 10.70% (n= 429) of the total workforce (n=4,010). The hospital falls under the Ekurhuleni Metropolitan Municipality. It does not have occupational therapists, clinical psychologists, dieticians, speech therapists and dentists in its permanent staff.

4.4.3 The ODI District Hospital

The ODI District Hospital is in Region C and is in transition due to boundary changes. It is being transferred from the North West Province to the Gauteng Province. The hospital is in a semi-rural area with a staff component of 11.8% (n=474) of full-time employees (n=4,010), and falls under Tshwane Metropolitan Municipality. It is a general district hospital.

4.4.4 The George Mukhari Hospital

The George Mukhari Hospital is an academic hospital in Region C under Tshwane Metropolitan Municipality. The hospital trains doctors and employs 0.10% (n=3) White male employees, 26% (n=739), African males and 71.84% (n=2,097) African females out of the total female workforce (n=2,919).

This phenomenon may be as a result of the hospital having the highest general assistants workforce at 20.65% (n=586) out of the workforce (n=2,839). The George Mukhari Hospital has the highest number of general assistants out of the four hospitals, represented as 25% (n=719) in a total workforce of n=2,836 African employees.

4.5 RESEARCH INTERPRETATION

The interpretation of leave of absence is confined to salary level 1 to 12 full time employees of the Gauteng Department of Health who took leave of absence from the workplace for the calendar year in 2008. It excludes the contract employees, periodic remuneration, foreign employees and permanent employees above salary range 13.

The Basic Conditions of Employment Act 75 of 1997 Section 9 (3) (RSA 1997) prescribes procedures in terms of progressive reduction of the maximum working hours to the goal of a 40-hour working week and an eight-hour working day. Finnemore and Van Rensburg (2002:462) state that the reduction of maximum working hours to 40 hours a week is done through collective bargaining with due regard to job creation, efficiency and health, safety and welfare of employees. Du Toit and Van Der Waldt (1998:232) use the formula to aggregate lost working-man hours due to ill health and disability as aggregate lost hours in the survey period divided by 40 hours in a week and x number of hours in a year. A formula to work out the absenteeism rate by Pierce (2009) is represented as $A=B/C$, A= Absenteeism rate, B= Total number of days lost due to absenteeism in a given period, C= Total number of working- man days available in the given period, $C=D \times E$, D=Total number of employees planned to work in the given period, E=Number of available working days in the given period.

The approach of the research uses the principle of absence from the workplace when due to work to identify the lost working hours (Pierce 2009; Davey & Cummings 2009:313). The study applies a retrospective approach.

The working-man lost days for the Province in the four hospitals is approached in terms of lost working -man days, simplified refers to the number of days meant to have been worked but actually not worked due to illness or disability by the employees in a year divided by the total number of employees of the public sector (PXVI). Barker (2007:79) argues that a reduction in working hours increases the hourly cost of production and unit production unless there is a commensurate increase in productivity. This approach has a similar effect on workplace absenteeism when the workload of those employees who are present increases as they carry the double load to meet the demands of service delivery. The cost of absence to the Province is expressed as salary expenditure for each day of leave of absence from the workplace (PSC 2002 xiii; Pierce 2009).

The salary range is laid down according to Annexure in DPSA Circular 1 of 2008. The Gauteng Government experienced a cost estimated at R29 million in 2000 and approximately R54 million in 2001 from absenteeism and loss of working time (Parbhoo2003:1).

The formula that is used in this research to calculate lost man work-hours is, collective working days of absence multiplied by 8 hours in a working day resulting in the total working hours that are lost. This formula can be represented as:

- Lost days x hours (8*) in a working day = lost working hours.

*As stipulated by the Basic Conditions of Employment Act, 75 of 1997 section 9 1(c), 3.

TABLE 6 RACES IN RELATION TO ABSENTEEISM

| RACE | TOTAL DAYS OF ABSENTEEISM | PERCENTAGE |
|------------------|----------------------------------|-------------------|
| Africans | 14295 | 96,3% |
| Whites | 242 | 1,6% |
| Coloureds | 201 | 1,4% |
| Indians | 102 | 0,7% |
| TOTALS | 14840 | 100% |

(Source: Compiled by the researcher 2012)

Table 6 represents absenteeism in the diverse races in the workplace. The absenteeism rate seems to be proportional to the number of employees. The Employment Equity Act 55 of 1998 defines the term “black” as a generic term which means Africans, Coloureds and Indians. The Africans as a race group is represented by 96.3% (n=14,295) of the total working days lost (n=14,840). The high figure of lost working-man days reflects the demographics of the four hospitals. The George Mukhari Hospital is in a rural setting that is predominantly African populated and employs the highest number of Africans as represented in table 3, Whites are presented by 1.6% and not represented in all occupational categories and salary ranges that could explain the low figures and percentages associated with working-man days lost. Africans constitute the highest number of employees as well as the highest percentage of working-man days lost. Absenteeism percentage is proportional to the employment figures for this race group. The Indian race group is represented by the lowest figure of employment and lowest percentage of leave of absence which is proportional to the employment figure.

TABLE 7 OCCUPATIONAL GROUPS IN RELATION TO ABSENTEEISM

| OCCUPATIONAL GROUPS | TARA | GERMISTON | ODI | GEORGE MUKHARI | TOTALS |
|----------------------------|-------------|------------------|------------|-----------------------|---------------|
| DOCTORS | 22 | 118 | 5 | 290 | 435 |
| PROFESSIONAL NURSE | 272 | 346 | 20 | 2459 | 3097 |
| STAFF NURSE | 128 | 247 | 13 | 1568 | 1956 |
| NURSE-ASSISTANT | 150 | 126 | 25 | 1145 | 1446 |
| FINANCE | 0 | 0 | 0 | 386 | 386 |
| ADMINISTRATION | 57 | 272 | 20 | 1923 | 2272 |
| ADMIN SUPPORT | 754 | 547 | 163 | 3784 | 5248 |
| TOTAL | 1383 | 1656 | 246 | 11555 | 14840 |

(Source: Compiled by C S Ndhlovu 2012)

Table 7 reflects the working-man days lost by the different occupational groups. The doctors' workload in terms of the annual report for Gauteng Department of Health (2008/9:51) was 22.6% as against the target of 22.7% while the national target was 18.7%. The bed occupancy rate target for the same time was 75% while the actual figure was 65.3%. The annual report interpreted in conjunction with the data of leave of absence for doctors reflects a negative impact in terms of service delivery and the cost factor to the department.

4.5.1 Occupational groups in relation to absenteeism

The multi-group invariance structural model presents different types of occupations and is used to identify variance in the patterns in terms of occupational groups. The model allows different relationships between variables in different occupations. The different occupational groups are doctors, professional nurses and sub-categories, administration staff and administration support staff (Pousette & Hanse 2002:230). According to Gaudine and Gregory (2010:599) absenteeism was a problem among health care workers in comparison to other employees in other sectors. The cornerstone of an efficient health care service delivery is equity and efficiency which is threatened when employees are not at work when expected to be (Andrews 1997:34-35; DPSA: 1997).

According to the Chartered Institute of Personnel Development (2008:11) the survey that was conducted found that public sector employees are less likely to be disciplined or dismissed for reasons of workplace absenteeism.

Tables 5 and 6 and 7 reflect the different occupational groups and the level of absenteeism in the four hospitals of the Gauteng Department of Health.

4.5.1.1 Doctors

Doctors are represented by 10% (n=397) of the total working population (n=4010). The 2.9% (n=435) indicates the number of working-man days lost in relation to the total working- man days lost (n=14840). The percentage of working- man days lost in relation to the total number of full time employees of the four hospitals is reflected as 435 divided by n=4,010 times the percentage which results in 10.8% (n=435) working-man days lost multiplied by 8 hours that represent a working day. The outcome is n=3,480 working-man hours. The cost to the Province is calculated in terms of the salary expenditure as direct and indirect salary payment for lost working-man hours estimated at 3,480 hours at salary level 10 at R217, 482 to salary level 12 at R 407,745 as well as indirect costs such as replacement of staff and overtime.

The doctors' workload in terms of Gauteng Province 2008/9 annual report (2008/9:51) reflects the doctor's workload as 22.6% as against the target of 22.7% while the national target is reflected as 18.7%. The bed occupancy rate target for the same time is 75% while the actual target rate is 65.3%. The annual report when interpreted in conjunction with the data of leave of absence for doctors reflects a negative impact in terms of service delivery and the cost factor to the Department when considering a loss of n=3,480 man hours of work.

Chaudhury and Hammer (2003:11) found in their research that the doctors presented the highest absenteeism rate. Serneels *et al* (2008:210) argue that absenteeism is rife in the public sector where employees hold two jobs and is highest among doctors. The doctor absenteeism rate in the research does not stand out as high in comparison with the other occupational groups. The doctor absenteeism rate is 2.9 % when compared to the total workforce. This occupational group is represented by 10% of the total population. The doctors' absenteeism rate does not seem to be outstandingly high in comparison with the other occupational groups in relation to the total number of permanent doctors.

4.5.1.2 Professional nurses

The professional nurses' absenteeism is reflected as 20.8% (n=3088) that indicates the number of working-man days lost in relation to the total working-man days lost (n=14840). The percentage of working-man days lost in relation to the total number of full time employees (n=4010) in the four hospitals is reflected as 77%. The cost to the Province translates into direct and indirect salary expenditure which is spread from salary level 4 to 12 at R64, 410 to R407, 745 in 2008 for the total duration of lost working days.

Du Toit and Van Der Waldt (1998:232) pointed out a crisis in four other public hospitals in the Gauteng Province that was caused by budget cuts and shortage of doctors and nurses in 2008. The vacancy rate of 69.7% in the professional nurse category and the absence rate of 20.8% in 2008 in the four hospitals seem to point to a lack of adequate human resources for effective health care delivery. The extent of working-man hours lost in the findings of the research suggest a high rate of absenteeism and not a good reflection of happiness as suggested in the annual report. Professional nurses are second to the administration support in absenteeism at 20.8% at a total of (n=785) nurses in the four hospitals with absenteeism of n=3,088 working-man days lost or n=20,704 working-man hours lost. This category of employees is classified as skilled to highly skilled at salary range of 4 to 12. The total vacancy rate was at 69.7% as against the national target at 15% in 2008 with absenteeism of 20.8%. Madibana (2010:22) found in the research about absenteeism among nurses, that the high rate of absence had a negative impact in the quality of health care rendered by nurses.

4.5.1.3 Staff nurses

Staff nurses are reflected in tables 4 and 5 as representing 12% (n=482) of the total working population (n=4,010). The 13.2% (n=1,956) indicates the number of working-man days lost in relation to the total working-man days lost (n=14,840) times the percentage. The percentage of working-man days lost in relation to the total number of full time employees in the four hospitals is reflected as 48.8%. The cost to the Department is expressed as direct and indirect salary expenditure for n=15,648 working-man hours lost. The impact of leave of absence to health care services and cost to the Department is the same as the professional nurses as staff nurses are a sub-category of the nursing profession.

4.5.1.4 Nursing assistants

Nursing assistants are reflected in tables 4 and 5 as represented by 10.7% (n=429) of the total working population (n=4,010) and 9.7% (n=1,446) represent working-man days lost in relation to the total working-man days lost (n=14,840) times the percentage. The percentage of working-man days lost is reflected as 36% (n=1,446) in relation to the total number of employees in the four hospitals (n=4,010).

The cost of leave of absence to the Department is expressed as the salary expenditure at salary levels 3 to 6. Salary level 3 is at R54, 876, salary level 4 is at R64, 410, salary level 5 at R76, 194 and salary level 6 is at R94, 000 for n=11,568 working-man hours lost and staff replacement and overtime.

4.5.1.5 Finance officers

Finance officers are reflected in tables 5 and 7 as represented by 2.1% (n=83) of the total working population (n=4,010) and 2.6% (n=386) indicates the working-man days lost in relation to the total working-man days lost (n=14,840) times the percentage. The cost to the Department is reflected as salary expenditure from salary level 2 at R47, 787 to salary level 10 at R217, 482 for R2, 728 working hours lost. The institutions reflected a small number of this occupational category as permanent employees place them in the category of scarce skills.

4.5.1.6 Administration staff

The administration staff is represented in tables 2 and 4 and 5 by 11.6% (n=466) in the total working population (n=4,010) and 15.3% (n=2,272) indicates the working-man hours lost in relation to the total working-man days lost (n= 14,840) times the percentage. The percentage of 56.7% represent the working-man days lost in relation to the total number of full time employees in the four hospitals (n=4,010). The cost of leave of absence to the department is reflected as salary expenditure at salary level 4 to 12. Salary 4 at R64, 410 to salary level 12 at R407, 745 for 18,176 working hours lost.

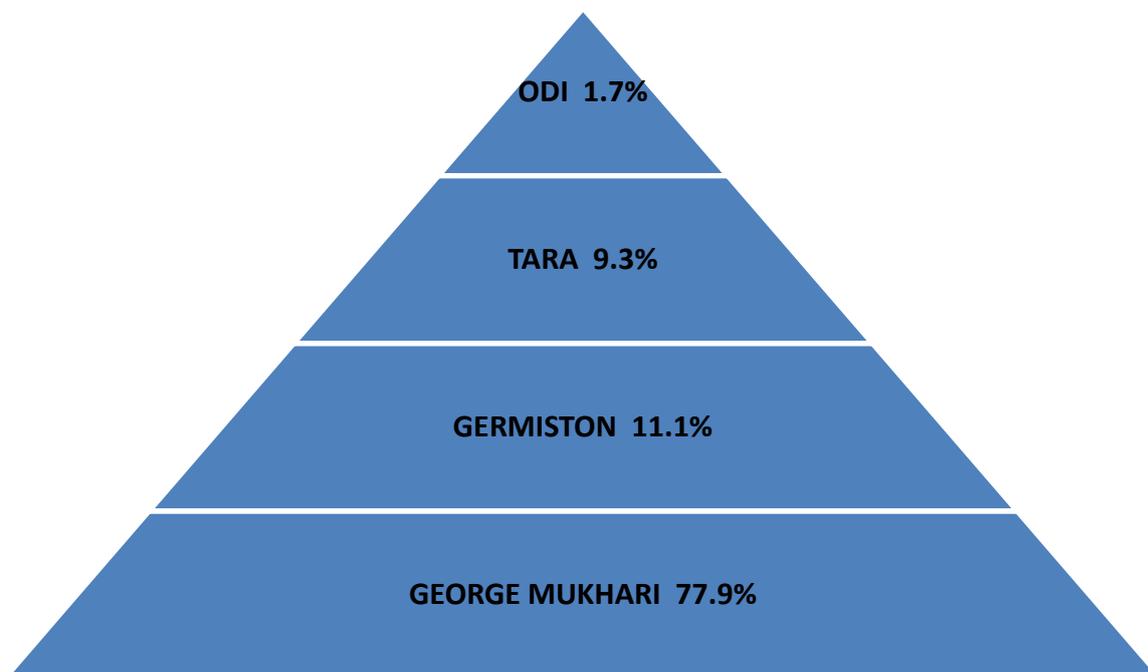
4.5.1.7 Administration support

The administration support is reflected in tables 2 and 4 and 5 as represented by 27.3% (n=1,095) of the total working population. 35.4% (n=5,248) indicates the working-man days lost in relation to the total working-man days lost (n= 14,840) times the percentage. The percentage of 130.9% (n=5,248) indicates the working-man days lost in relation to the total number of employees in the four hospitals (n=4,010). The total cost to the Department is reflected as salary expenditure at salary level 2 to 3 at a cost of R47, 787 to R54, 879 for 41,984 working -man hours lost.

The highest percentage of absenteeism in the different categories of employees in the four hospitals is identified in the administration support category. It is this category that falls into the salary range of 2 and 3 which is classified in the Gauteng Province 2008/9 annual report (2008/9:325) as lower skilled employees. This category represents the highest single category of employees for the Department at n=1,095.

The impact to the core service delivery employees that require support from administration staff would seem to be negative as the absence of employees from the workplace would hamper the smooth workflow. Barker (2007:214-224) acknowledges the decline in the flow-through rate in the school education higher grades namely Grade 11 and Grade 12, and ventures to give possible reasons for this phenomenon. The Gauteng Department of Health as a possible employer has attracted a high percentage of the labourer category as identified in table 3 totalling n=1,095 which is 27.3% of the total workforce. Pousette and Hanse (2002:230-231) suggest that the employee's authority to make decisions in his or her job and the breadth of use of skills used by the employees at work become different aspects of control with human service at work. This approach suggests that reduced job autonomy is associated with higher sickness absence. The administrative support employees are involved in mechanical or manual labour that predisposes them to musculo-skeletal problems. The work environment could have a negative impact to the high absenteeism rate in this group.

FIGURE 4.3 OCCUPATIONAL GROUPS IN RELATION TO ABSENTEEISM AS REPRESENTED BY THE HOSPITALS



(Source: Compiled by C S Ndhlovu 2012)

Figure 4.3 reflects the absenteeism rate of the different occupational groups as represented by the hospitals. The George Mukhari Hospital contributes 70.79% to the total workforce and contributes about 77.9% to absenteeism. The absenteeism rate does seem to be low at 7% when considered in the light of the contribution. The question that maybe be raised is whether the relative low absenteeism is indicative of high morale of a happy workforce.

Germiston Hospital contributes 10.6% to the total workforce and the absenteeism is reflected as 11.1% which seems to be above its contribution to the workforce by 1%. The professional nurse and the administration category present with the highest rate of absenteeism in this hospital. The Tara Moross Centre Hospital contributes 6.7% of the total workforce and the absenteeism rate is at 9.3% which is 2.6% higher. The administration support and professional nurses present with the highest level of absenteeism in this hospital. The ODI Hospital contributes 6% to the total workforce and the absenteeism rate which seems to be low is reflected as 1.7%. This hospital has no access to the Persal system and is dependent to a neighbouring hospital. It is highly probable that the information is not accurate.

Allen (1984: 331) found that union members might be absent more frequently from the workplace than non-members because they face smaller penalties for absenteeism. The Chartered Institute of Personnel and Development (CIPD) (2008:11) claim that the 2006 survey of absence management portrays the public sector employees as less likely to be dismissed for reasons of workplace absenteeism.

TABLE 8 SALARY RANGE IN RELATION TO ABSENTEEISM (SALARY RANGE 1-12)

| SALARY RANGE | DAYS OF ABSENCE | PERCENTAGE |
|---------------------|------------------------|-------------------|
| 1-2 | 178 | 1.2% |
| 3-4 | 5235 | 35.3% |
| 5-6 | 2044 | 13.8% |
| 7-8 | 5139 | 34.6% |
| 9-10 | 1878 | 12.6% |
| 11-12 | 366 | 2.5% |
| TOTAL | 14840 | 100 |

(Source: Compile by the researcher C S Ndhlovu 2012)

Table 8 reflects the salary range with the lowest working days lost as salary level 1 to 2. This is proportional to the number of employees. The highest absenteeism rate has been noted in the salary range at level 3 to 4, while salary ranges at level 11 to 12 reflected a low rate of absenteeism. The latter salary range is at middle management level and the responsibility the employees carry may be responsible for the low absenteeism rate. Rogers and Hertin (1993:219) noted that the level of education seem to have influenced the use of sick leave where the lower level category employees were found to have higher level of absenteeism than higher educated employees.

TABLE 9 AGE IN RELATION TO ABSENTEEISM

| AGE IN YEARS | DAYS OF ABSENCE | PERCENTAGE |
|---------------------|------------------------|-------------------|
| 20 to 24 | 16 | 0.10% |
| 25 to 29 | 405 | 2.72% |
| 30 to 34 | 733 | 4.93% |
| 35 to 39 | 1582 | 10.66% |
| 40 to 44 | 2676 | 18.03% |
| 45 to 49 | 3318 | 22.35% |
| 50 to 54 | 3046 | 20.52% |
| 55 to 59 | 2235 | 15.06% |
| 60 to 64 | 829 | 5.58% |
| TOTAL | 14840 | 99.99(100) |

(Source: Compiled by the researcher C S Ndhlovu 2012)

Table 9 reflects age in relation to absenteeism in the four hospitals. The age group at 20 to 24 years reflects the lowest figure in working-man days lost at 0.10% (n=16 days).

Reday-Mulvey (2005:79) observed that employees over 45 years take marginally fewer short sick leave days per year than those under 45years.

The QUALSA REPORT (2009:17) reflected the age group of 45 years to 49 years as presenting with a high number of short temporary claims. It is in this age group that a number of applications were declined by QUALSA which suggest that the health risk manager found in their assessment the claims to be invalid. The report defines the age group of 35 to 55 years as middle -age and shows this group as presenting with a high incapacity leave usage. In the research the age group 45 to 49 years presented with 22.35% (n=3,318) working-man days lost and is the highest figure of absenteeism in all age groups. The age group at 20 to 24 years is reflected as the lowest absenteeism rate in working-man days at 0.10% and this could be related to the number of employees in this age group.

According to Reday-Mulvey (2005:79,88) and the Canadian Nurses Association (2006:5) employees that are over 45 years take marginally fewer short sick leave periods but take slightly longer sick days per year than those under 45 years and reflect higher absenteeism in the age group above 50 years.

Weeks (2004:54) found that employees at the age group represented by 51 to 60 years show less absence which may be because of ill health retirement benefits. The age 31 to 40 and 41 to 50 years show higher absenteeism than other groups. Reday-Mulvey (2005:79) postulates that absenteeism is very high in the age group above 50 years as age advances and changes in abilities set in to those employees who hold full time jobs, and suggests that part-time work reduces absenteeism which increases with age, and the cost of the senior employee. In the study the age group 55 to 59 years show a decline in absenteeism in comparison to 50 to 54 while age 60 to 64 shows the lowest rate.

The aging employee has been found to expose the institutions to high levels of absenteeism through a higher probability of becoming incapacitated for longer periods (Ferguson *et al* 2001:38) and the current research have pointed differently. Rogers and Hertin (1993:219) found a significant correlation between the use of sick leave and age, suggesting employees with advanced age used more sick leave in comparison with the younger employees. The current socio-economic culture encourages retirement from active employment at the age of 65 years and the research adopted that approach as a cut off point for employment (Nichols & Evangelisti 2001:285).

TABLE 10 GENDER IN RELATION TO ABSENTEEISM

| GENDER | TOTAL NUMBER | DAYS OF ABSENCE | PERCENTAGE |
|----------------|---------------------|------------------------|-------------------|
| Males | 1006 | 2490 | 16.8% |
| Females | 3004 | 12350 | 83.2% |
| Total | 4010 | 14840 | 100% |

(Source: Compiled by C S Ndhlovu 2012)

Table 10 reflects gender in relation to absenteeism. The duration of working-man days lost is higher in female employees at 83.25 (n=12,350) and is represented by 74.9% (n=3,004) in relation to the total number of employees in the four hospitals (n=4,010) as represented in table 3. The male employees employed by the Department are reflected as absent from work by 16.80% (n=1006) and represented as 25.1% in relation to the total number of employees in the four hospitals (n=4010).

The Public Service Commission (PSC 2002:22) found that more males took sick leave than females except for the age group of 16 to 19 years. QUALSA (2009:23) noted that females had the highest number of incapacity applications in comparison to their male counterparts. Qualsa attributed this pattern to the fact that female employees constitute a higher percentage of the employee population within the Gauteng Department of Health.

Roger and Hertin (1993:222) noted that in terms of gender women are viewed as absent from their workplace more than men. The total number of female employees could have an impact on the high number of absenteeism reflected by the women.

4.5.2 Race in relation to absenteeism

The working population of the four hospitals is represented by four race groups such as Africans, Whites, Coloureds and Indians.

4.5.2.1 Africans

Africans represent 97.3% (n=3,902) of the total working population (n=4,010) and 96.3% (n=14,295) indicates the working-man days lost in relation to the total working-man days lost (n= 14,840) times the percentage. 356.5% (n= 14,295) reflects the working-man days lost in relation to the total number of employees in the four hospitals (n=4,010). The 14,295 working-man days lost are multiplied by 8 hours that represent a day and translates into 96.3% (n=114,360) working-man hours lost. The cost to the Department is translated as salary expenditure for n=114,360 working-man hours lost and the indirect cost of staff replacement and overtime. Africans constitute the highest number of employees as well as the highest percentage of working-man hours lost. Absenteeism percentage is proportional to the employment figures for this race group.

4.5.2.2 Whites

Whites are represented as 1.3% (n=51) of the total workforce (n=4,010) and 1.6% (n=242) represent the working-man days lost in relation to the total working-man days lost (n=14,840) times percentage. 6.1% (n=242) represent working- man days lost in relation to the total number of employees in the four hospitals. The 232 working-man hours lost are multiplied by 8 hours that represent a working- man day that translates into 1.6% (n=1,856) working-man hours lost. The cost to the Department is represented as salary expenditure of (n=1,856) working-man hours lost that is paid to the unproductive employees. This race group of employees is not represented in all occupational categories and salary ranges which may explain the low figures and percentages associated with working-man days lost (n=242). The demographics of the different hospitals may contribute to the low representation of this group in the total workforce.

4.5.2.3 Coloureds

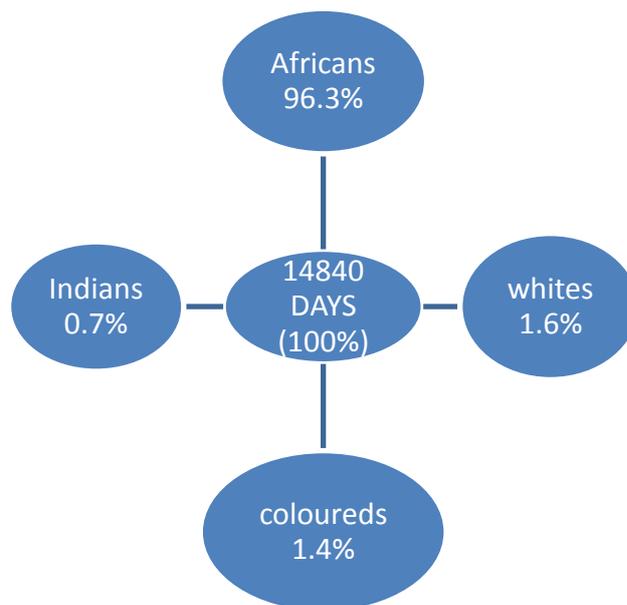
Coloureds are reflected as 1.1% (n=43) of the total workforce (n=4,010). 1.4% (n=201) represent working- man days lost in relation to the total working- man days lost (n=14,840). 5% (n=201) indicates working- man days lost in relation to the total number of employees in the four hospitals (n=4,010).

The cost to the department is represented as salary expenditure for n=1,608 working-man hours that are lost. This race group is represented in three of the four hospitals and not in all categories and salary ranges, which may explain the low representation and absenteeism.

4.5.2.4 Indians

Indians represent 0.3% (n=14) of the total workforce (n=4,010) in table 6. 0.7% (n=102) represent working- man days lost in relation to the total working- man days lost (n= 14,840) times percentage. 25% (n=102) indicates working- man days lost in relation to the total number of employees in the four hospitals (n=4,010). The 102 working- man days lost are multiplied by 8 hours that represent a working-man day and translates into 0.7% (n=816) working- man hours lost. The cost to the Department is expressed as salary expenditure paid to the unproductive employees for duration of (n=816) working-man hours lost. This race group is not represented in two of the four hospitals, in some occupational categories and salary ranges. The Indian race group is represented by the lowest figure of employment and lowest percentage of leave of absence which is proportional to the employment figure.

FIGURE 4.4 RACES IN RELATION TO ABSENTEEISM



(Source: Compiled by C S Ndhlovu 2012)

Figure 4.4 reflects the different races in relation to absenteeism. The Africans as a race group is represented by 96.3% of working-man days lost (n=14,840). The high figure of lost working-man days reflects the demographics of the four hospitals.

The George Mukhari Hospital is in a semi-rural setting that is predominantly African populated and employs the highest number of Africans as represented in table 1 (n=2,836) Whites are presented by 1.6% absenteeism rate and not represented in all occupational categories and salary ranges which could explain the low figures and percentages associated with lost working days. The absenteeism rate for Indians is represented as 0.7% and Coloureds as 1.4%.

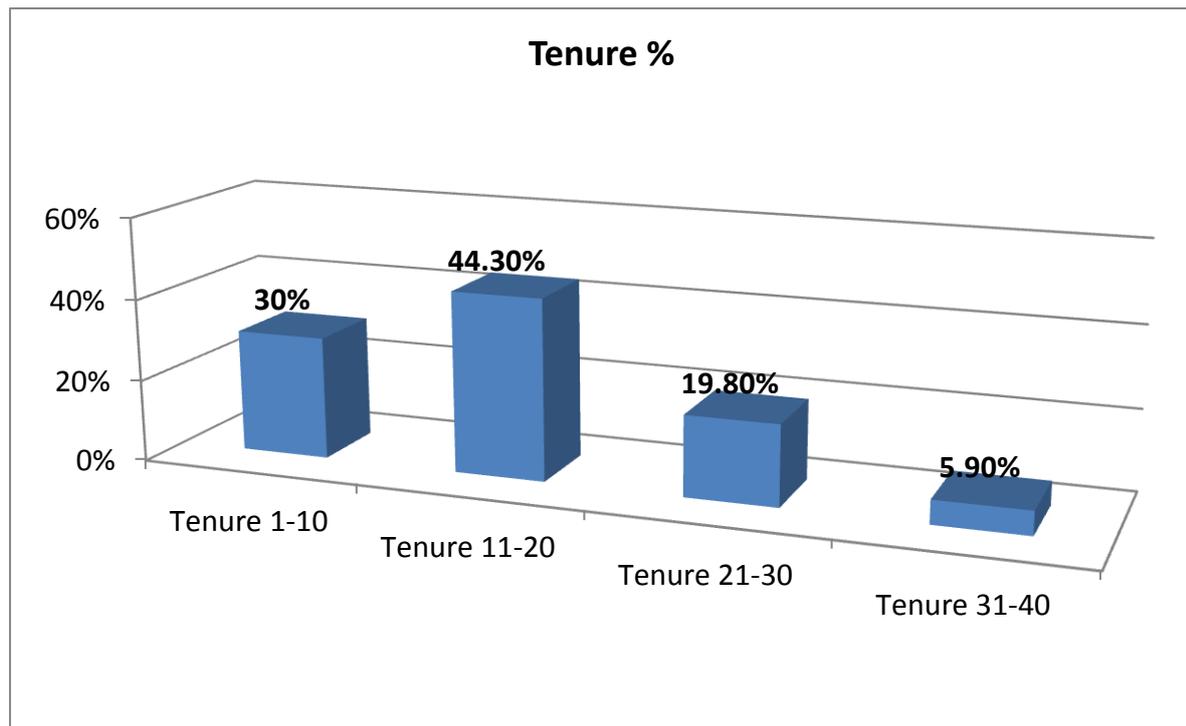
The Africans as a race group constitute the highest number of employees as well as the highest percentage of working days lost. Absenteeism percentage is proportional to the employment figures for this race group. The Indian race group is represented by the lowest figure of employment and lowest percentage of leave of absence which is proportional to the employment figure. The South African Survey Millennium (1999-2000:28) reflected the African males in 1998 as 35.4% and females as 34.8%, the Coloured males as 3.9% and females as 4.6%, Indian males as 3.9% and females as 1.5% and White males as 8.3% and females as 9.4%. There has been no significant change in the race group representation in the working population of the four hospitals.

4.5.3 Tenure in relation to absenteeism.

Tenure in years is grouped in units of ten (10). Tenure in 1 to 10 years, 11 to 20 years, 21 to 30 years, 31 to 40 years of all occupational groups are represented in figure 2.7 as the total leave of absence utilised by the full-time employees of different occupational groups in terms of tenure which translates into n=14,840 working-man days lost. The lowest hours lost is at tenure 31 to 40 years of service which is reflected as 5.9% (n=878) working- man days lost. The highest working-man days lost is at tenure of service of 11 to 20 years reflected as 44.3% (n= 6,577) working- man days lost. Tenure of service of 1 to 10 years reflects 30% (n=4,451) working-man days lost and tenure of years at 21 to 30 years reflects 19.8% (n= 2,934) working- man days lost.

Rogers and Hertin (1993:222) express tenure as work experience in years that is viewed as a predictor of employee productivity where seniority has been found to be inversely related to absenteeism in terms of frequency and total number of work days lost. The Canadian Nurses Association (2006:5) suggests that job tenure increases with age as illustrated in their research where nurses were found to have both job tenure of 20 years or more and are over 45 years of age. In the research the tenure of 31 years to 40 years presented with the lowest absenteeism rate in agreement with Rogers and Hertin (1993:222).

FIGURE 4.5 TENURE OF SERVICE IN RELATION TO ABSENTEEISM



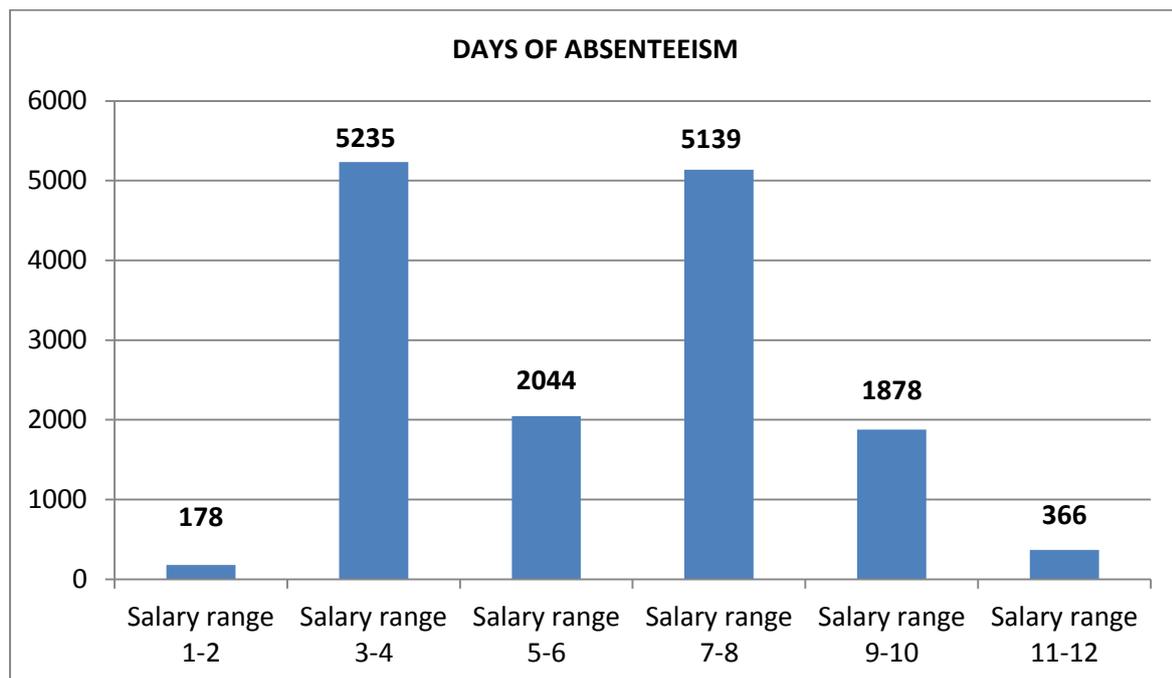
(Source: Compiled by C S Ndhlovu 2012)

Figure 4.5 reflects the total leave of absence from tenure of 1 year to 40 years. The PERSAL system reflected 40 years as representing more or less 64 years of age and 65 years is the cut off point for full time employees in the system. The lowest working- man days lost is at tenure of 31 to 40 years of service which is reflected as 5.90% and represents the older employee in general. The highest working- man days lost is reflected at tenure of 11 to 20 which is presented as 44.30% representing the younger employee. This is an area of concern as table 5 reflects professional nurses' absenteeism rate at 20.8% and administration support staff at 35.6% and is possible that the absenteeism rate of the two occupational categories may be a bigger contributor to the high absenteeism rate reflected in the tenure of 11 years to 20 years.

4.5.4. Salary range in relation to absenteeism

The salary range is interpreted in the study as a salary broad band that is represented in table 9 and ranges from level 1 to 12. Rogers and Hertin (1993: 219) claim that the level of education does seem to have a bearing on the salary range use of sick leave where the lower level category employees were found to have higher levels of absenteeism than the higher educated employee. The Human Resource Development Strategy (Gauteng Province 2008:15,214) claims that the chances of entering into a higher income bracket in South Africa rises noticeably after people have twelve years of education. The ages 20 to 24 years are greatly affected by this assumption.

FIGURE 4.6 SALARY RANGE IN RELATION TO ABSENTEEISM



(Source: Compiled by C S Ndhlovu 2012)

Figure 4.6 above reflects the salary range from 1 to 12 in relation to working- man days lost as salary range 1 to 2 as n=178 working-man days lost which converts to 1.2%. The highest absenteeism rate has been noted in the salary range at level 3 to 4 at 35.30% (n=5,235) working-man days lost while salary ranges at level 7 to 8 is reflected as the second highest level of absenteeism at 34.6% (n=5,139) lost working-man days.

Salary range at 5 to 6 is reflected as the third highest in absenteeism at 13.8% (n=2,044) lost working-man days. Salary range 9 to 10 is regarded as the entry point to middle management and is reflected as the fourth highest at 12.6% (n=1,878) working-man days lost. Salary range at 11 to 12 is regarded as middle management entrusted with high levels of authority and accountability. This group is reflected as losing 2.5% (n=366) working- man days lost which is considered to be a reasonable low level of absenteeism.

4.5.5 Age of full time employees in relation to absenteeism

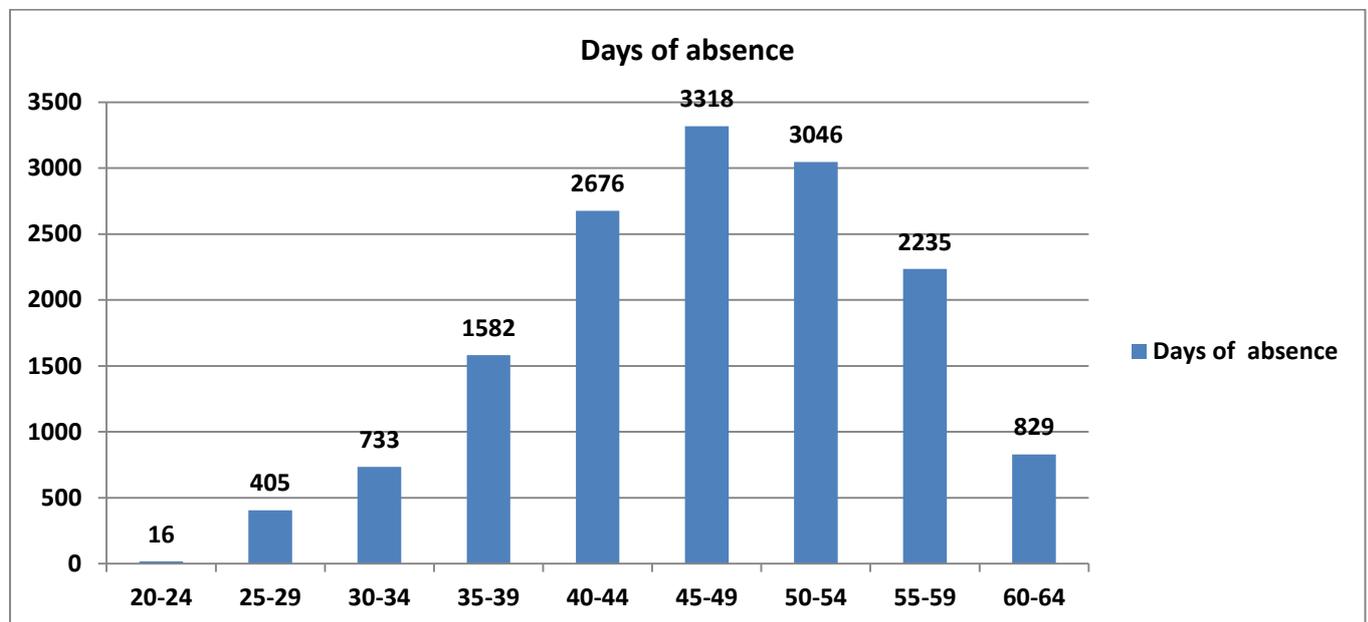
The QUALSA REPORT (2009:17) reflected the age group of 45 years to 49 years as presenting with a high number of short temporary claims. It is in this age group that a number of applications were declined by QUALSA which suggest that the health risk manager found in their assessment the claims to be invalid. The report defines the age group of 35 years to 55 years as middle-age and shows this group as presenting with a high incapacity leave usage. In the research the age group of 45 years to 49 years is represented with 22.35% (n=3,318) working- man days lost and is the highest figure of absenteeism in all age groups.

Reday-Mulvey (2005:79,88) and Canadian Nurses Association (2006:5) observed that employees over 45 years take marginally fewer short sick leave periods but take slightly longer sick days per year than those under 45 years and reflect higher absenteeism in the age group above 50 years.

Weeks (2004:54) claims that the age group at 51years to 60 years show less absence may be because of ill health retirement benefits. The age group of 31 years to 40 years and 41years to 50 years show a higher absenteeism than other groups. Reday-Mulvey (2005:79) postulates that absenteeism is very high in the age group above 50 years as age advances and changes in abilities set in to those employees who hold full-time jobs. He suggests that part-time work reduces absenteeism which increases with age, and the cost of the senior employee. The aging employee has been found to expose the institutions to high levels of absenteeism through higher probability of becoming incapacitated for longer periods (Ferguson *et al* 2001:38).

Rogers and Hertin (1993:219) claim that there is a significant correlation between the use of sick leave and age, suggesting employees with advanced age comparatively used more sick leave in comparison with the younger employees. The current socio-economic culture encourages retirement from active employment at the age of 65years and the research adopted that approach as a cut off point for employment (Nichols & Evangelisti 2001:285).

FIGURE 4.7 AGE IN RELATION TO ABSENTEEISM IN THE FOUR HOSPITALS



(Source: Compiled by C S Ndhlovu 2012)

Figure 4.7 reflects the number of working-man days lost by full-time employees through absenteeism related to a specific age.

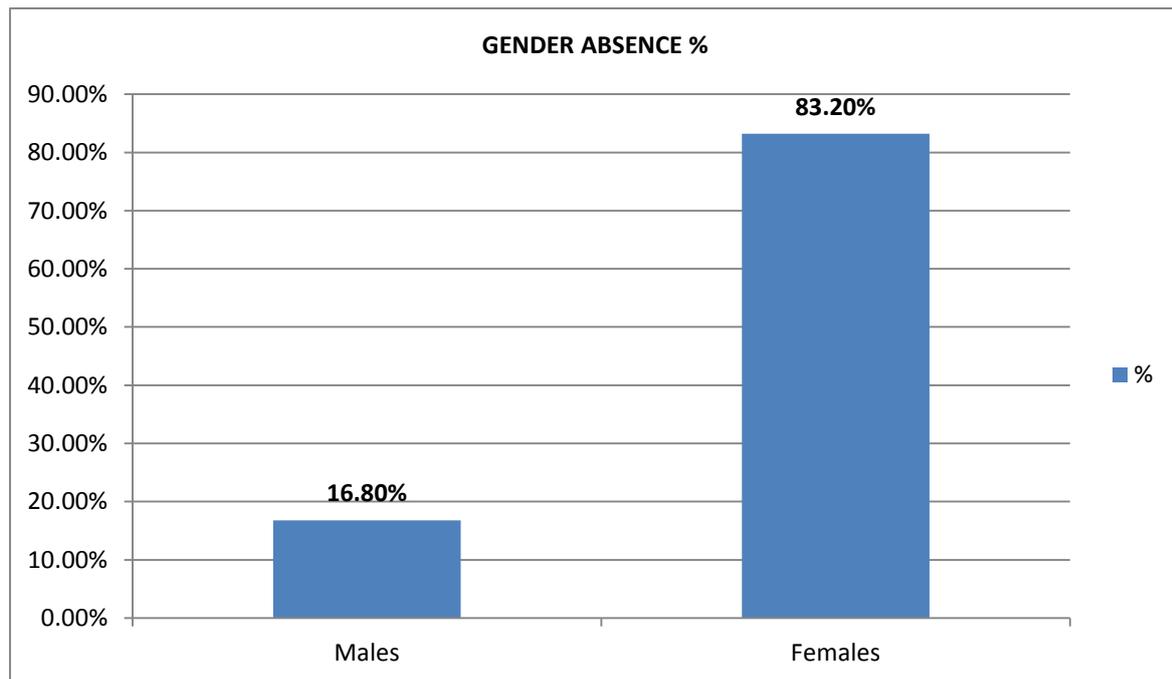
Age groups are organised in units of 5 to be consistent with the Personnel and Salary Administration System (PERSAL). The age group at 20 years to 24 years reflects the lowest percentage of absenteeism at 0.10 % (n=16) working-man days lost and the age group of 45 years to 49 years reflect the highest days of absenteeism at 22.35% (n=3,318).

4.5.6 Gender in relation to absenteeism

The females employed in the Department of the four hospitals are represented as 74.9% (n=3,004) in relation to the total number of employees in the four hospitals (n=4,010) and lost 83.20% (n=12,350) working-man days. This absenteeism rate is considered high considering that not every female employee may have used sick leave. The male employees employed in the Department are represented by 25% (n=1,006) of the total workforce (n=4,010) and lost 16.8% (n=2490) working-man days. The findings suggest that males utilised fewer days of sick leave considering the fact that not every male employee may have utilised sick leave for the duration of the study.

The Public Service Commission (PSC 2002:22) claims that more males took sick leave than females except for the age group of 16 years to 19 years. QUALSA (2009:23) noted that females had the highest number of incapacity applications compared to their male counterparts. Qualsa attributed this pattern to the fact that female employees constitute a higher percentage of the employee population within the Gauteng Department of Health. Rogers and Hertin (1993:222) argue that in terms of gender women are viewed as absent from their workplace more than men. The total number of female employees may have an impact on the high rate of absenteeism.

FIGURE 4.8 GENDER IN RELATION TO ABSENTEEISM



(Source: Compiled by C S Ndhlovu 2012)

Figure 4.8 reflects gender in relation to absenteeism. The females employed by the department in the four hospitals are reflected as absent from work at a rate of 83.20% (n=12,350) working-man days, and represented by 74.9% (n=3,004) in relation to the total number of employees (n=4,010) in the four hospitals. The male employees employed by the Department are reflected as absent from work at 16.80% (n=2,490) and represented as 25.1% (n=1,004) in relation to the total number of employees in the four hospitals (n=4,010).

4.5.7 Week days in relation to occupational groups

Table 11 reflects the trends in terms of days of the week that show high utilisation by the different occupational groups. Mondays, Fridays and Thursdays reflect a high utilisation rate by the employees suggesting a pattern of high absenteeism rate over weekends.

Professional nurses and sub-categories and the administration support group reflected the highest absenteeism over the weekends.

TABLE 11 WEEK DAYS IN RELATION TO ABSENTEEISM IN THE FOUR HOSPITALS

| OCCUPATIONAL CATEGORY | MONDAY | TUESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|-------------------------------|----------------|------------------|------------------|------------------|-----------------|------------------|
| Doctors | 18 | 8 | 13 | 17 | 0 | 0 |
| Professional Nurse | 135 | 86 | 94 | 137 | 0 | 0 |
| Staff Nurse | 52 | 38 | 56 | 65 | 2 | 0 |
| Nursing Assistant | 62 | 27 | 34 | 45 | 2 | 0 |
| Administration Staff | 64 | 38 | 58 | 73 | 1 | 0 |
| Administration support | 252 | 147 | 98 | 126 | 26 | 15 |
| Finance officer | 17 | 4 | 8 | 16 | 0 | 0 |
| TOTAL | 600(4%) | 348(2.3%) | 361(2.4%) | 479(3.2%) | 31(0.2%) | 15(0.10%) |

(Source: Compiled by C S Ndhlovu 2012)

Table 11 reflects the pattern of how the different occupational groups utilised sick leave on the different days of the week. It illustrates the days that sick leave started on each day of the week. The largest number of incidences of sick leave commence on Monday the first working day of the week as reflected by 4% (n=600) of the days of the weekend. Fridays are the second highest days of absenteeism represented by 3.2% (n=479). Tuesdays and Thursday are almost the same in utilisation as reflected by 2.3% and 2.4% respectively. Professional nurses' absenteeism was pronounced on Mondays as 22.50% (n=135) and Fridays as 28.61% (n=137) a trend that shows possible long weekend absenteeism.

The administration support staff has been reflected as mostly absent on Mondays 42% (n=252 days) and Fridays 26.31% (n=126 days). The administration support reflected the highest days of absenteeism on Saturday (n=26) and Sunday (n=15). The Canadian Nurses Association (CNA) (2006) focused on seasonal pattern of absenteeism in the different categories in the different hospitals. The PSC (2002) report identified a trend by provincial employees of using sick leave to extend their weekends. The research considered working-man days lost in terms of days of absence as in accordance with evidence of a medical certificate. Administration support is the only group that seem to have utilised Saturdays for sick leave 83.87% (n=26) and Sundays 100% (n=15) days.

TABLE 12 CONTRIBUTIONS TO ABSENTEEISM BY THE FOUR HOSPITALS

| INSTITUTIONAL CONTRIBUTION | TARA MOROSS CENTRE | GERMISTON | ODI | GEORGE MUKHARI | TOTAL |
|------------------------------------|---------------------------|------------------|------------|-----------------------|--------------|
| Contribution to Sample | 6.68% | 10.70% | 11.82% | 70.80% | 100% |
| Contribution to Absenteeism | 8.42% | 11.77% | 1.65% | 78.16% | 100% |

(Compiled by C S Ndhlovu 2012)

Table 12 reflects the contribution of each hospital to absenteeism. Tara Moross Centre Hospital contributed 6.7% to the sample and the absence rate is higher than the contribution at 8.4%. The Germiston Hospital contributed 10.7% to the sample and the absenteeism rate is higher at 11.7%. The George Mukhari Hospital contributed 70.8% to the sample and absenteeism rate is at 78.2% and ODI Hospital contributed 11.8% and absenteeism rate is at 1.7%. The latter hospital has no computers at. The reflection of the status of absenteeism is likely to be inaccurate. The George Mukhari Hospital has the highest contribution to the sample yet leave of absenteeism is tolerable. It raises questions as to what should be the contributory factor to the leave of absence status in this hospital.

4.6 CONCLUSION

Chapter 4 presented the analysed data in terms of the characteristics as determined in the stratified random sampling. The characteristics and their association with absenteeism have been presented such as occupational categories, age, gender, tenure of service and race. The research identified which days of the week were utilised for sick leave absence. The contribution of each hospital to absenteeism was identified and a brief overview of each hospital was presented.

Chapter 5 presents the findings, conclusion and recommendation of the research.

CHAPTER 5

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 1 provides a general introduction to the research. It included the background and motivation for the research that provides the context, the problem statement and the significance of the research. The key concepts are defined. The research design, the method of data collection, the sampling method, data analysis and interpretation and limitations to the research are explained in this chapter.

Chapter 2 considers the theoretical foundations, concepts, characteristics, theories, approaches and classifications of workplace absenteeism. The discussions on the conceptual framework of absenteeism, predictors of absenteeism and various models of absenteeism are presented. Measures to control workplace absenteeism and the impact of absenteeism in an institution and management intervention strategies in workplace absenteeism were discussed.

Chapter 3 describes the research design and the different aspects of the research methods that were applied to the research. The chapter explains the various data collection techniques that are used, unit of analysis, units of observations, construct validity and ethical considerations.

Chapter 4 provides the organisational structure of the Gauteng Department of Health, comparisons of hospital employees, different race groups of the four hospitals, gender comparisons in different hospitals and comparisons of the different occupational groups. It provides a short description of the target hospitals. The research interpretation is discussed in terms of the different occupational groups and absenteeism, different races and absenteeism, tenure of service and absenteeism, salary range and absenteeism, age in relation to absenteeism and gender in relation to absenteeism. The trends of week days of absenteeism in the four hospitals and contributions to absenteeism by the four hospitals are presented.

Chapter 5 explains a synthesis of the study and evaluation of workplace absenteeism. The findings of the research and recommendations are discussed.

5.2 FINDINGS

The findings of the research reflect doctors as represented by 10.8% in the total workforce (n=4010), have an incidence of 2.9% (n=435) of the total work-man days lost (n= 14840) by the employees in the four hospitals, translating to a total of n=3480 working hours lost.

The working-time lost is considered against the doctors' workload of 22.6 in contrast to the target of as 22.7 while the national target was 18.7. The bed occupancy rate target was 75% while the actual figure was 65.3%. The annual report when it is interpreted in conjunction with the sick leave absence of doctors at 2.9% shows no negative impact on the workload in terms of service delivery. The negative impact is mainly on the cost factor to the state as the doctor's salary level is from salary level 10 at a cost of R217,482 to salary level 12 at R407,745 (Gauteng Province annual report 2008/9:51). Serneels *et al* (2008:210) claim that absenteeism occurs primarily in the public sector, associated with people who hold two jobs and that is highest and more frequent amongst doctors. The findings of the research of absence of 2.9% with a contribution of 2% to the sample are in disagreement with the Serneels *et al* findings.

Professional nurses represent 19.6% (n=785) of the total workforce (n=4,010). The workplace absenteeism is represented as 77% (n=3,088) of the total workforce (n=4,010), translating into 21% of working-man days that are lost (n=14,840). The absenteeism rate appears to be very high given the fact that nurses by virtue of their numbers are the backbone of health care service delivery (DPSA 2009). The Gauteng Province annual report of 2008/9:51 reflects the total vacancy rate of nurses at 69.7% as against the national target of 15%. The absenteeism rate of 77% is very high when compared with the total vacancy rate and 19% contribution to the sample. Staff nurses are a sub-category of the nursing profession and the impact of their absence to service delivery is the same as the professional nurses. The findings of the study reflect staff nurses representing 12% (n=482) of the total working force (n=4,010). The absenteeism from staff nurses is reflected as 13% (n=1,956) of the total working-man days lost (n=14,840). The absenteeism rate does appear to be high when considering the contribution of 13% to the absence rate by a sample of 12% to the total working-man days lost. Nursing assistants are a sub-category of the nursing profession that is reflected as 10.7% (n=429) of the total number of employees (n=4,010) and represent 9.7% (n=1,445) of the total working-man days lost (n=14,840). This absence rate is considered as high when compared with the total number of employees.

The nursing occupational group considered collectively contributed to absenteeism at the workplace at 99.7% which is extremely high. Davey and Cummings (2009:312-313) claim that frontline nurses' absenteeism contribute to discontinuity of patient care, decreased staff morale and high cost to health care. The high absenteeism rate has a negative impact on health care service delivery.

The findings of the research reflect administration staff as 11.6 % (n=466) of the total number of employees (n=4,010) represented by 15.4 % (n=2,286 days) of the total working-man days lost (n=14,840). Administration support is at salary level 1 to 2 with exceptional instances of salary level 3 to 4.

Administration support staff is reflected as 27.3% (n=1,095) of the total workforce (n=4,010) represented by 35.6% (n=5,289 days) of the total working-man days lost (n=14,840), translating to n=42,312 lost working-man hours.

The administration staff viewed collectively contributed 51% to absenteeism which is very high with the support staff reflected as 35.6%. Rogers and Hertin (1993:219) claim that the level of education seem to have influenced the use of sick leave where the lower skilled category of employees were found to have higher levels of absenteeism than higher educated or skilled employees. The findings of the research reflect the administration support staff to be in line with the Roger and Hertin findings.

The Gauteng Department of Health has a limited number of finance officers causing them to be a scarce skill occupational group. The finance officers represent 2% (n=83) of the total workforce (n=4,010). The working-man days lost are reflected as 2.3% (n=341) of the total working-man days lost (n=14,840). The total absence at 2.3% is higher than the actual contribution to the sample at 2%.

The age group of 45 years to 49 years reflects the highest absenteeism rate at 22.4% (n=3318), the age group at 50 years to 54 years is reflected as 20.5% absenteeism. The age group 40 years to 44 years reflected as 18% absent from the workplace. The age group of 55 years to 59 years is reflected as 15% absenteeism. Employees of advanced age used more sick leave in comparison with the younger employees. This phenomenon could be attributed to the ageing process of the body and the onset of incapacity. Absenteeism has been found to be higher in employees who are over 50 years of age and the phenomenon is attributed to age and changing abilities that increase when work is performed full-time. The findings of the research reflect the age group over 50 years at 20,5% and reflect the highest absenteeism rate at age 45 years to 49 years as 22.4% (McGoldrick & Arrowsmith 2001:84; MINTRAC 2009:3; Nichols & Evangelisti 2001:285; Reday-Mulvey 2005:79-194). According to Ferguson *et al* (2001:38) the aging employee presents with high levels of absenteeism through higher probabilities of becoming disabled for longer periods. The findings of the study reflect absenteeism of the age group of 55 years to 59 years at 15% which is the lowest in the age groups. The Canadian Nurses Association in (2006:5) noted a reduction in workplace absenteeism rate among nurses who are less than 45 years of age, and an increase in the absenteeism rate among nurses above 55 years of age. According to Bangali (2004:3-4) the falling rate of the older employee age group could be influenced by the practice of early retirement or voluntary severance which was used in the 1990s as a method of restructuring in institutions. Rogers and Hertin (1993:219) claim employees with advanced age used more sick leave in comparison with the younger employees.

The group at tenure 11 to 20 years presented with the highest level of absenteeism at 44.3%. The employee at tenure of 21 to 30 years presented with 19.8% of absenteeism rate while the employees at 1 to 10 years presented with the rate of 30%. The findings of the research reflected tenure of 31 to 40 years to have presented with the lowest absenteeism rate at 5.9% (n=878 days). This low absenteeism rate could be ascribed to the fact that numbers of employees are reduced in this group or could also be commitment to their jobs or could have higher ambition levels to aspire to higher posts.

Van Der Westhuizen (2006:136) and Rogers and Hertin (1993:222) express tenure as work experience that may be viewed as a predictor of employee productivity where seniority has been found to be inversely related to absenteeism in terms of frequency and total number of working-man days lost. The public service employees enjoy security of tenure which may contribute to the unacceptably high levels of absenteeism (Andrews 1997:221–222; MINTRAC 2009:3).

The findings of the research reflect females as 75% of the total workforce (n=4,010) represented by 83.2% (n=12,350) of the total working-man days lost (n=14,840). The males represent 25% of the total workforce (n=4,010) and are reflected as absent at 16.8% (n=2,490) of the total days of absence (n=14,840). The absenteeism rate is very high for females in this research. Rogers and Hertin (1993:22) and Van Der Westhuizen (2006:136) suggest that women are absent from workplace more than men are. Landstad *et al* (2001:1) found that women cleaners, who received preventive personnel support, depicted a reduction in absenteeism rate. Hoxsey (2010:562) claims that although women presented with a high score of job satisfaction than men, they maintained higher levels of absenteeism. MINTRAC (2009:4–8) found that gender moderates the age turnover relationship. Women are more likely to remain in their jobs the older they get than men do.

The findings of the research reflect Africans as represented by 26% of the working population and utilised 96.3% of the total working-man days lost due to sick leave. It is possible that the overall number of Africans influenced what seems to be a high level of absenteeism at 96.3%. Whites represented 0.3% of the working population and absenteeism is reflected as 1.6% of the total working-man days lost. Coloureds are represented by 0.3% of the working-man population and absenteeism was recorded as 1.4% of the working-man days lost. The Indians are represented by 0.1% of the total working population and are reflected as 0.7% of the working-man days lost.

The findings of the research reflect the salary range at level 11 to 12 utilised 2.5% working-man days for sick leave, salary level 7 to 8 which is the supervisory level utilised 34.6% working-man days lost, salary level 3 to 4 which is the entry level of skilled workers utilised 35.3% working-man days lost. The findings suggest management used fewer days of sick leave in comparison to the supervisory level and entry skilled worker level.

This can be ascribed to the fact that they are ultimately responsible for the institution's effectiveness and productivity.

The George Mukhari Hospital contributed 70.8% to the sample and reflected 77.1% absenteeism which is relatively low in comparison to the size of the contribution. It could be that processes and procedures of controlling leave of absence are in place. The Tara Moross Centre Hospital contributed 6.7% to the sample and reflected 9.3% absenteeism rate that is high by 2.6%.

Professional nurses reflected a trend of high absence over the weekend including Thursdays. This could be a sign of burn out and extending the period of rest from possible high workloads resulting from high vacancy rates (Gauteng Province annual report 2008/9). Nyathi (2000:59) and the PSC (2002) found that employees are absent from work because they want to prolong the weekend.

5.3 CONCLUSIONS

The absenteeism rate is very high for females in this research. The aging employee presents with high levels of absenteeism through higher probabilities of becoming disabled for longer periods. The use it or lose it approach of the current system rewards the abuse of sick leave as it is viewed as not being beneficial by the employees to act responsibly towards the use of sick leave.

The vacancy rate of 69.7% in the professional nurse category and the absence rate of 20.8% in 2008 in the four hospitals can only suggest inadequate levels of human resource for effective, efficient, quality health care services at a high cost to the Province. The nurses may not be aware of the actual absenteeism, or they under-estimate it. The combination of high registered nurse absenteeism and high patient load could be a strong factor in lowering health care delivery.

Professional nurses and administration support staff have absented themselves from the workplace predominantly on Mondays and Fridays. It could be for various reasons ranging from feelings of burn out to extending the weekend.

The percentage of working-man days lost in relation to the total number of full-time employees in the four hospitals is reflected as 48.8% which is very high, as there is no deterrent not to abuse sick leave in the public sector. The findings of the research found a significant correlation between the occupation and use of sick leave, age and the use of sick leave, gender and use of sick leave and tenure and use of sick leave.

The biggest hospital George Mukhari presented the lowest rate of absenteeism for its size and complexity which reflects an empowered management. The Tara Moross Centre Hospital is the smallest hospital, highly specialised and presented with high rate of absenteeism for its contribution, which may be a reflection on the skills of its management, or the type of health care service that is offered by the institution.

The international norm of absenteeism is 3%. The research established the absence rate at 48.8%. The Gauteng Department of Health is held at ransom by the five trade unions it has signed agreements with and that makes it difficult for managers to manage absenteeism. The practise of Gauteng Department of Health Head office to remove managers from institutions when there is a labour unrest, exacerbates the problem of managing institutions.

The findings of the research could not establish a representative reflection of race and absenteeism as Indians, Coloured and Whites were not represented in some institutions' demographics.

5.4 RECOMMENDATIONS

The White Paper on Transforming Public Service holds management responsible for delivering specific levels of services and for obtaining value for money in wider utilising of resources. This strategy is to be translated into action. The Gauteng Department of Health should probably benefit by adopting the total absence management philosophy by cultivating a culture that is not tolerant of high levels of absenteeism, through building it in as a key performance area of the performance of all managers and all employees. The current performance dimension system should lay explicit emphasis on this aspect.

The re-engagement of knowledge based and professional retirees at reasonable remuneration levels to reward their expertise may assist in reviving good work ethics by mentoring the new and generally young recruits. The retired professionals are currently resisting the call for re-employment on a contract basis at entry level.

The Gauteng Department of Health can encourage flexitime in terms of 5/8 or 6/8 to allow the mature employee to remain within the system with the view to share their knowledge and skills with the young employees who may be highly qualified but lack experience. This approach may deal with the need for adequate human resources for health care delivery at reduced cost as two employees on flexitime basis can occupy one full-time employee's post.

Managers should use the return-to-work counselling strategy to solicit feedback from the employee about the actual absenteeism. The counselling should be on a one-to-one basis. This approach may raise self-awareness to the employees in terms of the impact of the employee's absence frothed workplace.

Currently this intervention strategy is not adequately utilised for fear of confrontation with labour representatives.

Managers should have attendance policies in place, effectively communicate policies to employees, adhere to policies and procedures and use absence control strategies consistently. This approach will minimise the feeling of injustice by employees. Currently the human resource unit is challenged by a high staff turnover due to promotions from the human resource area, a situation that creates a vacuum and lack of continuity weakening the process of empowering line managers by human resource practitioners. This high staff turnover may be controlled through upgrading of the human resource salaries as the salaries fall out of the occupation service dispensation (OSD).

Managers in the public service are expected to be responsible and accountable for their portfolios including management of leave of absence and should not shift it to the human resource unit as is currently the practice. It should be possible to charge a manager as an accomplice for failing to manage the absence of employees where there is no evidence of corrective remedial action where it has been warranted. The researcher takes cognisance of the fact that the public service is highly unionised and this approach may trigger industrial action.

The employer needs to revive on the job in-service education and training as a way of imparting institutional values such as attendance at the workplace in partnership with recognised labour representatives, through bilateral and multilateral forums and through institutional skills development committee which should be representative of all stakeholders with the view to promote stability in the workplace and indirectly enhance productivity and reduce workplace absenteeism. Currently the bilateral, multilateral and skills development committees are inactive in the institutions that were targeted and management seems to be intimidated by the militant labour representatives.

High levels of absenteeism among some occupational groups do suggest a need for an active employee assistance programmes at all hospitals. Employee wellness committees are currently inactive. There is a sporadic intervention approach at some institutions where PILIR Committees are active. Employee assistance programmes should be budgeted for as a standing on-going programme in all hospitals. There is a need for a thorough research as to why absenteeism remains high in the public service and focus on absenteeism broadly.

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ANNEXURES: A. B. C.

ANNEXURE A

| PROCESS | EVALUATION QUESTION | COMPLIANCE YES/NO | ACTION PLAN |
|------------------------------|--|-------------------|-------------|
| Retention and Reward - leave | 1. Are there complete and accurate Z 1(Leave application forms) forms on file? | | |
| | 2. Have all application forms been approved, stamped and registered? | | |
| | 3. Have all forms been captured on the Persal with the following requirements: <ul style="list-style-type: none"> • Supporting documents? • A 10 day compulsory leave processed within the annual leave cycle Determination of Leave. | | |
| | 4. The remaining days are utilized 6 months from the end of the leave cycle. | | |
| | 5. Are there unutilized leave days? | | |
| | 6. Has there been adequate checking of leave reasons? <ul style="list-style-type: none"> • Leave credits • Adherence to leave categories (i).Normal (ii) Incapacity (iii) Injury on duty (iv) Maternity (v)Adoption (vi) Family responsibility (vii). Office bearers/shop stewards and Casual Employees. | | |
| | 7. Have work reasons been provided for leave days. | | |

(Source: Compiled by C S Ndhlovu 2012)

ANNEXURE B

| Retention and reward –sick leave | Evaluation Question | Compliance Yes/No | Action Plan |
|----------------------------------|---|-------------------|-------------|
| | 1. Are there medical certificates that have been submitted to all medical claims, with the following: <ul style="list-style-type: none"> • Specific illness stated • Supporting documents on file | | |
| | 2. Has the 8 week rule for 36 days in a 3 year cycle been adhered to? | | |
| | 3. Are there complete medical certificates for 3 days or more sick leave days for normal sick leave? | | |
| | 4. Are all other leave days above 3 days utilized after 36 days treated as temporary incapacity leave? | | |
| | 5. Are temporary incapacity leave forms submitted within 5 working days after the first day of absence? | | |
| | 6. Is there a register for temporary incapacity leave, for 1 to 29 days lead time for reporting leave applications | | |
| | 7. Has the employer approved/declined the leave application within 30 working days of receipt? | | |

(Source: Compiled by C S Ndhlovu 2012)

ANNEXURE C

CHECK LIST

Is there a leave register in place for all leave applications?

1. Is leave approved prior to the employee proceeding on leave?
2. Area attendance registers maintained and up to date?
3. Are periodic audits for leave carried out?
4. Is there evidence of G.S.S.C's approval on leave applications?
5. Are leave forms accurately captured on Persal?
6. Are leave forms accurately completed by applicants?
7. Is movement of leave forms monitored between the G.S.S.C and institutions?
8. How is rejected leave application dealt with?

(Source: Compiled by C S Ndhlovu 2012)