

Disabling health: the challenge of incapacity leave and sickness absence management in the public health sector in KwaZulu-Natal Province

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Sickness absence and long-term incapacity leave contribute substantially to the national service delivery challenges that are particularly evident in the public health sector. The Auditor-General's reports, and the Department of Public Service and Administration, have highlighted these challenges.

Recognising this as an area requiring intervention, the Department of Public Service Administration developed the 'Policy and Procedure on Incapacity leave and Ill-health Retirement' and outsourced the management of sickness absence to private agencies. Management of ill-health among health-care workers is not addressed at the workplace; this has resulted in poor decision-making about fitness to work, and to work incapacity contributing to levels of absenteeism that exceed international benchmarks for the healthcare sector.

This chapter reviews and critiques current approaches in the management of ill-health among healthcare workers and assessment of their ability to work. A review was done of the literature on current benchmarks and approaches to managing sickness absence; secondary data from national and provincial Department of Health reports were also reviewed. A description is given of a small sample of short-term sickness-absence cases (n=151) at a hospital in KwaZulu-Natal. Two of the cases are highlighted.

Healthcare workers experience a significant burden of disease caused by a range of workplace hazards. This, together with inadequate institutional management of sickness absence, results in a high number of lost work-days. In 2004–2006 and 2007–2009, the national cost of sickness absence was R7.3m and R8.8m respectively, while the provincial costs were R208m and R303m respectively. In 2014, sickness absence resulted in an average of seven days (senior management), eight days (skilled supervisors) and eight days (lower categories), among all those workers taking sick leave.

The authors propose an approach that ensures institutional responsibility for sickness absence, involvement of the Employee Health Service in the case of five days of absence, and involvement of the Occupational Medical Practitioner in cases of repeated short-term absence and assessment of fitness to work.

Management of ill-health among healthcare workers is not addressed at the workplace, resulting in poor decision-making about fitness-to-work and work incapacity contributing to levels of absenteeism that exceed international benchmarks for the healthcare sector.

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Introduction

Healthcare workers (HCWs) form a substantial percentage of the South African public sector workforce. The Human Resources for Health (HRH) Strategy for the Health Sector 2012/13–2016/17 forms part of the State's 10 Point Plan, and focuses on the improvement, planning, development and management of human resources within the National Department of Health (NDoH).¹ From 2004 to 2010, the health sector has seen an estimated 37% increase in the number of health professionals within the public sector.¹

The health of HCWs, particularly those in the public sector, persistently occupies a low priority in the broader South African health agenda. The strategic plans and policy statements of the NDoH reflect minimal attention to the need to ensure a healthy workforce in the public health sector, or to how the health of the HCW impacts on the delivery of the NDoH's mandates. While this is symptomatic of the approach for workers in the public sector in general, the greatest impact of a lack of such focus is felt in key service delivery arenas such as health and education.²

One of the nine priorities of the National Development Plan 2030 is to "Improve Human Resources in the health sector" to achieve an effective health system. While this focus centres on training and accountability, it fails to take cognisance of the inadequate management of the health of the 'health workforce', either in identifying work-related ill-health or managing the impacts of ill-health on the ability of workers to provide the services they have been employed to deliver.

Over the last few years medical surveillance of HCWs has increased; however, this is largely to identify workers with tuberculosis (TB). As such, the surveillance is not representative of a systematic approach to determine the capacity of workers to perform their work functions or to identify those at risk for developing occupational diseases.³

The current burden of occupational and non-occupational disease being reported among HCWs in South Africa covers the spectrum of communicable and non-communicable diseases.^{4–9} These health outcomes also vary across the different categories of HCWs, from clinical (doctors, nurses, clinical assistants) to laboratory staff, general assistants, and administrators in the healthcare sector. The growing burden of these diseases and their natural progression in the presence of modern medical interventions can result in HCWs developing related chronic health disabilities. These disabilities can impact on the individual's work performance in the healthcare setting and impacts negatively on service delivery.

Inadequate management of chronic illnesses results in increased sickness absence in the workplace. This takes the form of short-term absences or long-term sick leave, and is a global phenomenon, prompting much research and review in the private and public sectors worldwide. In the United Kingdom (UK), the average number of days of absence per employee per annum in the private sector is approximately 5.5, compared with eight days for those in the public sector.¹⁰ Approximately 140 million work-days have been reported as lost each year to sickness absence in the UK.¹¹ While in the majority of instances, these are short-term absences, approximately 300 000 employees annually failed to return to work following long-term absences. According to this 2011 report, the total cost of sickness absence to the UK public sector was estimated at £4.5 billion.

Within the UK's National Health Service (NHS), long-term absence accounts for 56% of working days lost, and 70% of the costs of absence.¹² According to a 2009 report, staff absenteeism in the NHS was 10.7 days a year, compared with 9.7 days per year in the public sector, and 6.4 days in the private sector. This translates into a loss of 10.3 million working days each year, costing the NHS £1.7 billion each year.¹³ Although the NHS is not directly comparable to the South African context, the extent of the problem in the UK, with its established management system, would suggest that this issue is likely to be substantially greater in South Africa.

In other developing countries, the problem is considerably more severe. In a district in Kenya, it was estimated that the average health staff absenteeism (sickness and general absenteeism) rate was 25%, resulting in a loss of US\$51 000 per month to each health facility.¹⁴ In India, the estimated average absenteeism rate is 40%.¹³ In a study of several developing countries, including India, Bangladesh, Uganda, Peru and Indonesia, health staff absenteeism rates ranged from 25% to 40%, with higher-skilled staff (doctors) as compared to general assistants being more likely to be absent.¹⁵

The need for appropriate disease management of HCWs in public health facilities in South Africa is of growing concern. In this chapter, we present the current legislative context and practices for disability management of HCWs in public sector healthcare facilities in South Africa. Using our experiences in public sector hospitals in KwaZulu-Natal Province (KZN) and through a review of the literature, we propose a model for managing HCW disability and sickness absence in South African public healthcare facilities. We focus our critique on data available for KZN, and compare these with national data where available.

Methodology

We reviewed documents addressing the problem of sickness absence in other countries, particularly the UK, with a special focus on the NHS. Several government-level investigations have been conducted by the NHS and they have made recommendations and proposed solutions. These documents were identified using Google Scholar and PubMed, using the keywords 'sickness absence' and 'health care', and by means of a targeted search through the UK NHS and UK government websites. The key documents identified were "Health at work – an independent review of sickness absence",¹¹ "Guidelines on prevention and management of sickness absence",¹² and the "NHS Health and Well-being Review".¹³

Reports were also reviewed from the Public Services Commission of South Africa, the Department of Public Services and Administration, and the national and KZN Departments of Health, accessed through a Google search using the keywords 'sickness absence', 'health care' and 'South Africa'. A search was also done on the websites of these government agencies. This approach provided the following documents: "Report of the Auditor-General on a Performance Audit of the Management of Sick Leave Benefits at certain National and Provincial Departments";² "Evaluation of the Impact of the Policy and procedure on Incapacity Leave and Ill-health Retirement (PILIR) on Sick Leave Trends in the Public Service";¹⁶ "Incapacity leave and ill-health retirement: briefing by Departments of Public Service and Administration, Health, Correctional Services. Committee

minutes";¹⁷ "KwaZulu-Natal Department of Health Annual Report – 2014/2015";¹⁸ and "South African National Department of Health Annual Report 2013/2014."¹⁹ The latter two documents are produced biennially by the national and provincial Departments of Health and only the most recent reports were reviewed.

The authors also reviewed a small sample of employees from a single department within a healthcare institution. All employees who had made an application to the Human Resource Management (HRM) in the previous cycle (January 2013 – December 2015) were reviewed. Eighteen of 303 employees submitted 151 short-term incapacity leave applications for short-term leave during the 2013/2015 leave cycle. The authors reviewed all 151 applications.

The purpose of the document and patient review was to describe and identify challenges with current disability management of HCWs in the public health system with a view to proposing a model for managing sickness absence at an institutional level.

In the subsequent section based on a review of the existing literature, information is presented on the burden of disease among HCWs, the legislative and policy framework for managing illness, and the process for incapacity management of HCWs. Further information is presented on secondary data analysis of clinical assessments of disability in HCWs.

Burden of disease among healthcare workers

The common communicable diseases reported among HCWs include TB^{8,20} and HIV.⁵ The HIV prevalence rate among HCWs in two public sector hospitals in Gauteng was reported as being 11.5%, with the prevalence rate among nurses being 13.7%.⁵ A systematic review of the epidemiology of and programmatic response to TB among HCWs in South Africa showed that the incidence of TB among HCWs ranged from 138 per 100 000 population to 1 133 per 100 000 population. The reported prevalence rate for active TB ranged from 1.4% to 5%, and that of latent TB infection from 26.6% to 84%.²¹ There was no consistent association between age and risk category among the studies reviewed.

The availability of antiretroviral treatment (ART) for persons living with HIV has resulted in an increased life expectancy,²² placing them at risk of complications associated with chronic diseases of lifestyle. The presence of HIV infection has been shown to increase the incidence of TB infection among HCWs,⁸ while complicated and uncomplicated TB among HCWs has resulted in considerable morbidity within this population.^{20,23} Complications associated with TB have resulted in HCWs experiencing pneumonectomies, hearing loss and neurological disorders,²³ resulting in incapacity.

Obesity, diabetes, hypertension, non-infective respiratory diseases, musculoskeletal disorders (MSDs), and dermatological diseases are non-communicable disease presentations typically found among HCWs.^{6,7,9,24} In a survey of 200 HCWs in a tertiary hospital in Pretoria, the prevalence rates for obesity, diabetes and hypertension were reported as 37%, 10.5% and 19% respectively.⁹ The prevalence rate of lower-back pain in South African HCWs has been reported to range from 25% to 58%,^{4,7} and a high number of HCWs seek medical help for their musculoskeletal-related pain.⁷ The natural complications associated with chronic diseases of lifestyle and musculoskeletal disorders are likely to present within this population as HCWs age. Asthma and allergic dermatitis due to latex exposure

in the workplace is a well-recorded presentation among South African HCWs leading to disability.^{4,6,25} The estimated prevalence rate for latex allergy among HCWs is reported at 3%–12%.^{7,26–28}

The actual prevalence of blood-borne pathogens among HCWs is unknown but mimics that of the general population, with the risk of occupational infection being the highest for hepatitis B (30%) and lowest for HIV (0.3%).²⁹ Data for occupation-related infectious disease prevalence among HCWs in Limpopo Province submitted to the Compensation Commissioner between 2007 and 2009 included TB (83.9%), cholera (10.7%) and chicken-pox (5.4%).³⁰

Lack of organisational support, job demands and nursing of patients lead to stress and burnout among HCWs.^{31–33} In the process of caring for patients, HCWs are often victims of physical violence, which is an added stressor in the work environment.³⁴ The burden of caring for terminally ill patients and those living with HIV and AIDS is also a source of stress among HCWs.³⁵ These workplace factors lead to psychosocial stress among HCWs, with the potential to increase absenteeism in healthcare facilities.²⁷ Absenteeism triggers a vicious cycle as it leads to staff shortages, which contribute to increased organisational stress resulting in further absenteeism.

Despite the extensive body of literature on the relationship between working conditions and ill-health, neither the NDoH's Human Resources of Health strategy document,¹ nor the country's National Development Plan 2030,³⁷ nor the Lancet Special Issue on "Health Challenges for South Africa",^{38,39} provide any indication of the need to address the health of the health workforce, or how the health of the HCW impacts on the ability to address the health challenges facing the country. Furthermore, despite our knowledge about the prevalence of these diseases, our understanding of the disabling chronicity among HCWs and its impact on their capacity to work is largely unknown.

Legislative and policy framework for managing illness in the Department of Health

The primary reason for HCW health status being obscured is the approach of the NDoH and the healthcare institutions, in that ill workers generally seek private health care, and no system exists to monitor the health of the ill worker at the workplace. A national guideline on medical surveillance is available,⁴⁰ providing a detailed approach to the pre-placement of workers, ongoing medical surveillance, and sickness absence management. However, these guidelines have not been translated into actual policy at provincial or institutional level. In some KZN institutions, medical surveillance programmes are managed by sessional doctors, mostly without any specific training in occupational health, and in others there is no medical doctor. Approximately four KZN hospitals employ full-time doctors to manage their Employee Health Services (EHS). This under-resourcing of EHS implies that the health of HCWs is inadequately monitored by health professionals with the appropriate skills. Doctors without the necessary training are not able to assess hazards and the risks posed by such hazards, nor are they able to recommend interventions to control these hazards or to implement risk-based medical surveillance to detect workers who are likely to acquire work-related diseases.

The World Health Organization/International Labour Organization Guidance Note on improving HCW access to TB and HIV

management at their workplaces emphasises the need for employee health services for HCWs to be instituted at both national and workplace level.⁴¹ The NDoH's 2014 National TB Management Guidelines specify that medical surveillance programmes for HCWs should be established and maintained.⁴² However, while these policy documents are crucial for the detection of those likely to develop occupationally acquired diseases, and are important in the management of those with acute illness, they make no reference to those HCWs whose ailments develop into disability.

To address work-caused health outcomes, most institutions implement the legal requirements as set out in the Compensation for Occupational Injuries and Diseases Amendment Act (130 of 1993) (COIDA). Obtaining statistics at provincial or national level for HCW cases submitted to the Compensation Commissioner for compensation is difficult, as this process occurs at institutional level and no official reports are published at provincial or national level. Based on limited research, approximately 18.35% of 583 known cases of TB among HCWs were reported to the Compensation Commissioner between 1999 and 2004 in hospitals in eThekweni, KwaZulu-Natal.⁴³ In Limpopo Province, only 56 cases of occupational disease among HCWs were reported to the Compensation Commissioner between 2007 and 2009.³⁰

These findings are in the context of generally low reporting of occupational diseases to the Compensation Commissioner in South Africa.⁴⁴ In addition, the failure of COIDA to effectively address the rehabilitation of injured and diseased workers, either back into the working environment or into alternative jobs, is a notable shortcoming.

Legislative context for incapacity management of HCWs in the public sector

The employment, retirement and termination of services among HCWs in public sector facilities is governed by the Public Service Act (103 of 1994) (PSA).⁴⁵ As determined by the Minister of Public Service and Administration in terms of the PSA, incapacity leave is defined as additional sick leave granted at the discretion of the employer. This leave allocation is guided by the Policy and Procedure on Incapacity Leave for ill-health Retirement (PILIR).⁴⁶ The PSA makes provision for the dismissal of an employee on the basis of ill-health or incapacity, with due observance of the Labour Relations Act (66 of 1995) (LRA).⁴⁷ The Basic Conditions of Employment Act (75 of 1997) (BCEA),⁴⁸ the Employment Equity Act (55 of 1998) (EEA),⁴⁹ and the LRA⁴⁷ provide a supporting framework to the PSA. The Public Service Co-ordinating Bargaining Council (PSCBC) Resolutions 7 of 2000⁵⁰ and 5 of 2001⁵¹ provide further guidance on the management of incapacity among HCWs in the public sector. In terms of the BCEA, all employees are entitled to 36 days of paid sick leave in a three-year cycle. The EEA allows for medical testing of employees where needed,⁴⁹ while the LRA⁴⁷ allows for termination of services on the basis of ill-health after full investigation of the case and all potential alternatives have been considered.

COIDA makes provision for compensation of injuries and diseases "arising out of and in the course of an employee's employment". The procedures for compensation applicable to HCWs (and public sector workers in general) differ somewhat from those workers in the private sector. Government departments, including the NDoH, are considered 'employers individually liable'. As such, the Department

does not pay annual levies to the Compensation Fund (exempted employer status), and becomes responsible for all expenses arising from occupational injuries and diseases, including medical aid, compensation for temporary and permanent disability, as well as funeral expenses, as defined by the law. In terms of the law, it is the provincial Department of Health (DoH) that is directly registered as an 'employer individually liable' – and not the provincial administration (Office of the Premier) or the NDoH. Thus, individual healthcare institutions are not classified as 'employers' in their own capacity. All institutional submissions must therefore be made through the provincial head office of the DoH. The latter is then responsible for onward submission of claims to the Compensation Commissioner. The Commissioner will determine liability for the injury or disease, and inform the DoH accordingly. If liability is accepted, the DoH is then expected to cover the necessary costs (for medical aid, compensation for temporary disability and funeral expenses). Pension, lump-sum compensation and dependents' payments are paid through the National Treasury (Pensions Administration).⁵²

This 'internalised' liability in the compensation process leads to further complexities in the management of HCWs with chronic incapacitating illnesses. During the period of temporary disability as defined by COIDA, an injured or diseased worker is either provided with alternative work (generally without consultation of the EHS or a doctor with occupational health training) or is placed on leave if no alternative work is available. In the case of the latter, this leave is generally incorrectly deducted from the employee's standard sick leave allocation. Once this temporary disability period is over, and a decision on permanent disability is made, the employee is rarely informed of this decision by the Commissioner. The employee either continues with the alternative work indefinitely or remains on sick leave, without the option of challenging the decision of the Commissioner, as is provided for in law. It is unclear whether the employee receives full pay throughout this period, or a portion as stipulated by the Act.

Process for incapacity leave management in public sector hospitals

In terms of the PILIR⁴⁶ policy in public sector hospitals, HCWs who have exhausted their 36-day sick-leave cycle may apply for temporary incapacity leave, which may be short-term (≤ 29 days) or long-term (≥ 30 days) incapacity leave. Up to the 36th day, the leave process is based on sick notes submitted by the employee to the line manager who then submits the documentation to the Human Resources Department. There is no discussion about the absence from work between any member of the institution's management and the employee up to this critical point, nor are any referrals to the EHS activated.

The application to the Health Risk Manager (HRM) must be made within five working days of the first day of absence (Figure 1). The HCW submits the requisite documentation together with all medical reports and certificates to the Human Resource Department of the facility. Within five days, the employer must verify all documentation and submit it together with a departmental report to the HRM while granting the employee conditional temporary incapacity sick leave for a maximum of 30 days. The HRM must acknowledge receipt of the documentation within two working days and confirm in writing that a response will be generated within 12 working days. The

HRM reviews the application (primary assessment) and determines whether (1) the application is invalid and hence no incapacity leave will be granted, (2) the application is valid and incapacity leave must be granted, (3) the application is valid but the applicant must undergo specified treatment, or (4) the application is valid but the applicant must undergo a secondary assessment. The employer must, within 30 days, make a decision on granting or refusing the employee's application and inform the HCW in writing of the decision. If incapacity leave is granted, the conditional leave is converted to incapacity leave. However, if the application is rejected, the employer must indicate whether the conditional leave should be considered as annual leave or unpaid leave.

In the case of long-term incapacity leave, the HRM may request that the HCW be subjected to a full assessment, which entails a secondary or further medical assessment to determine functional capacity. Based on this assessment, a decision is made as to whether the HCW should continue with temporary incapacity leave and if so, the duration of the leave period.

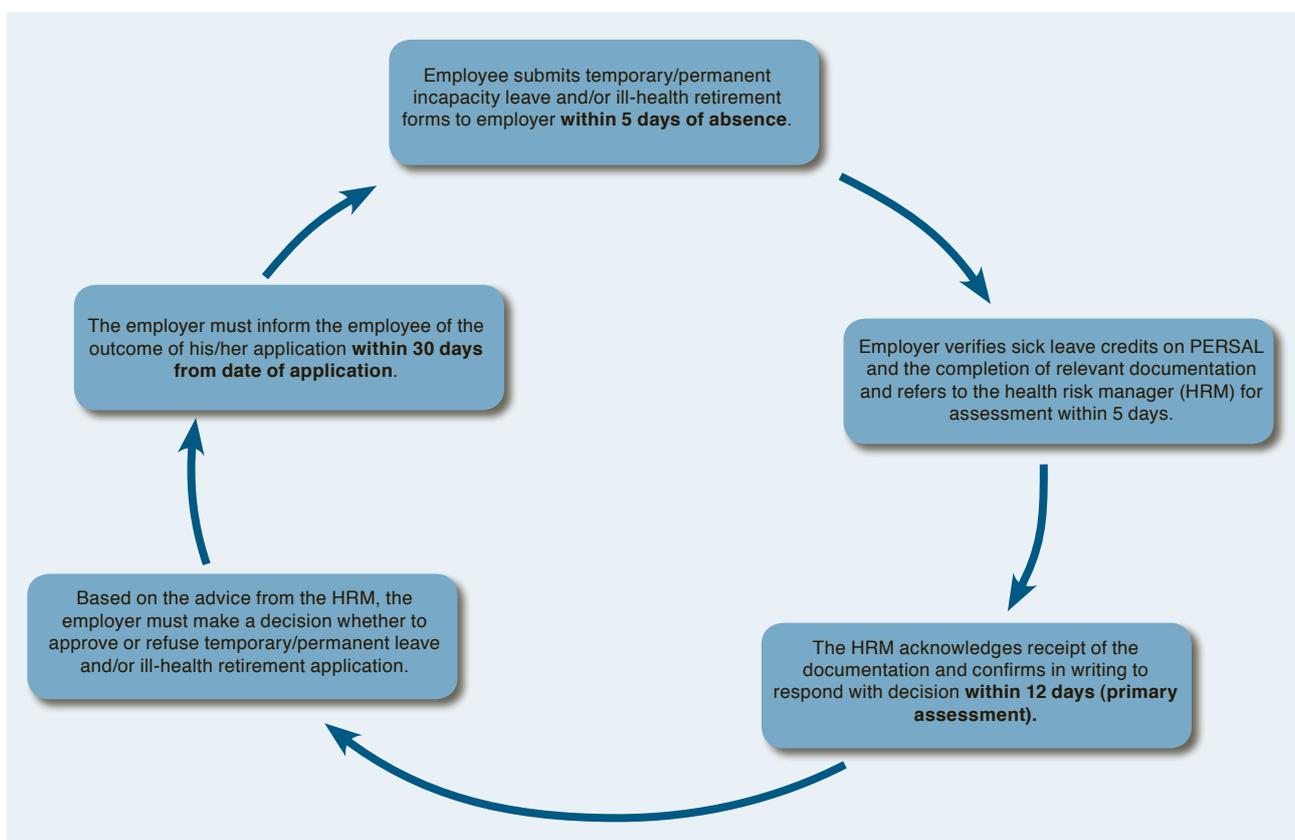
If the HCW's condition is determined to be a permanent incapacity, the employer may grant permanent incapacity leave for a maximum of 30 days. During this period, the employer, based on the advice of the HRM, determines the feasibility of either alternative employment or duties or workplace adaptation to accommodate the HCW. If the permanent incapacity is such that the HCW cannot be effective at his/her rank, then a process to terminate the employee's services on the basis of ill-health is commenced.

In terms of this process, the HRM essentially makes the decision based on third-party medical reports. The HCW is not seen in person by the HRM prior to the HRM making this decision; hence if the documentation is incomplete or does not reflect the actual extent of the HCW's incapacity, inappropriate decisions can be made.

Sickness absence among healthcare workers in the public sector

According to a report by the Auditor-General, in the three-year period from 1 January 2001 to 31 December 2003, government employees accounted for 12.6 million days of sick leave, at a cost of R3 527 million.² HCWs in the Western Cape Province and KZN took approximately 600 000 and 1.8 million days of sickness absence respectively from January 2001 to December 2003, amounting to R127 million and R461 million in each province respectively.² It may be argued that this occurred before the introduction of the PILIR strategy. The absence of data since implementation of the PILIR in 2006 does not permit proper evaluation of this system. The Department of Public Service and Administration (DPSA) presents data showing that in the period immediately following implementation of the PILIR, the NDoH experienced a decrease of just 846 sick days from a total of approximately 18 000 sick leave days.¹⁶ Of all the workers taking sick leave during these two periods, each worker took an average of 2.3 and 2.2 days respectively. Clearly, the PILIR did not result in any meaningful improvement in the early days of its implementation.¹⁷ The latter report states

Figure 1: Process flow for temporary/permanent incapacity leave and/or ill-health retirement application when an employee has exhausted 36 days in a three-year leave cycle



Source: Adapted from the Public Service Commission, 2010. ⁵³

that for the NDoH, the cost of sickness absence during these two periods (2004–2006 and 2007–2009) was R7.3m and R8.8m respectively.¹⁶ At provincial level, the situation was substantially worse: KZN as the leading province recorded 786 934 and 871 227 days of sick leave in these periods, at a cost of R208m and R303m respectively (Tables 1 and 2).¹⁶ According to the recent KZN DoH Annual Report, sick and disability leave cost approximately R452m in 2014,¹⁸ compared with the NDoH's bill of R15m in 2014 (Table 3).¹⁹ In 2014, the average length of sick leave taken at a national level had substantially increased to 42 days¹⁹ compared to the 2010 DPSA Report.¹⁶

Table 1: Total number of sick leave days taken in government health and education departments per province, 2004–2009

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

Source: Adapted from Public Service Commission; 2010.¹⁶

The trends emerging from this data across the two periods suggest that the rate of absenteeism among senior levels of staff may be a cause for concern, with an almost 44% increase among senior management and a 47% increase among skilled supervisors, compared to only a 7.6% increase among the lower categories of staff (Table 2). However, in terms of cost, it is the latter category that contributes the greatest (89%) loss to the Department.

However, by 2014, these numbers had dramatically changed (data not shown):¹⁸ in a single year, senior management had utilised 2 763 days of sick leave, while skilled supervisors had taken 84 060 days and the lower categories had taken 341 403 days. This resulted in an average of seven days (among senior management), eight days (among skilled supervisors) and eight days (among lower staff categories), of all those workers taking sick leave.

Approximately 8.6% (n=16 234) of employees in the KZN public sector applied for temporary incapacity leave to the HRM during the period November 2006 to December 2012, having exhausted their allocated 36 days over the three-year cycles. It is reported that within the same period, 11.8% (n= 8 138) of the KZN DoH employees had utilised all their allocated 36 leave days and had to apply for temporary incapacity leave through the HRM.⁵⁴

Apart from the 2010 DPSA evaluation,¹⁶ no further recent evaluations of the PILIR have been conducted, despite HRM's concerns about the delivery of services as expressed to Parliamentary oversight structures.¹⁷ According to statements provided to Parliament, various government departments indicated that there were delays on the part of the HRM in responding to the submissions.¹⁷

Table 2: Total number of sick leave days taken per level and cost for the period from January 2004 to June 2009, KwaZulu-Natal Department of Health

Department of Health level	January 2004 to December 2006		January 2007 to June 2009	
	No of days	Cost in Rand	No of days	Cost in Rand
Senior management (level 13–16)	808	891 634	1 468	1 918 008
Highly skilled supervisor (level 9–12)	23 648	15 903 822	44 755	38 697 036
Lower – highly skilled production (level 1–8)	762 433	191 239 911	824 976	262 589 297
Other	45	13 356	28	16 573
Totals	786 934	208 048 724	871 227	303 220 915

Source: Adapted from Public Service Commission, 2010.¹⁶

Table 3: Leave utilisation in the South African National Department of Health⁵⁴ and the KwaZulu-Natal Department of Health,⁵³ 2014

Government sector	Total number of days	Percentage of days with medical certification ¹	Number of employees using sick/disability leave	Percentage of total employees using sick/disability leave	Average number of days per employee	Estimated cost	Total number of days with medical certification
National ²							
Sick leave	11 153	96	1 543	100	42	14 261 044	10 704
Disability leave ⁴	1 054	100	62	100	17	1 295 844	1 054
Province ³							
Sick leave	438 812	86	55 117	100	8	399 457 000	378 562
Disability leave	57 151	100	1 933	100	30	52 135 000	56 982

1 Total number of days in excess of two days

2 National leave utilisation from 1 January 2014 to 31 December 2014

3 Provincial leave utilisation from 1 January 2014 to 31 December 2014

4 Disability leave (includes temporary and permanent disability)

Source: The South African National Department of Health¹⁹ and KwaZulu-Natal Department of Health.¹⁸

The 2014 data represent the second year of the last leave cycle (2013–2015). It can be expected that the patterns of leave will vary across the three-year cycle, with a greater number of employees utilising allocated sick leave in the final year of the cycle.

Case study

The authors reviewed 151 submissions for short-term leave applications, of which 58% had been decided upon by the HRM. These employees accounted for almost 1 200 days of leave. None of these employees was assessed by the institutional EHS prior to submission to the HRM, despite having already taken 36 days of sick leave in the previous three years. From this point forward, despite the policy requiring a 30-day turnaround time, the average turnaround time within our sample was 110 days, with 29 days' delay from the date on which the employee had submitted the sick note (range of days: 1–170 days), and 28 days (range of days: 1–136 days) in the Human Resources Department submitting to the HRM. For the cases on which the HRM had reached a decision, this was done in an average of 53 days (range: 9–124 days). Our estimates of the cost in lost productivity, based exclusively on income (assuming Grade 1 levels) was approximately R613 000.

In the event of the HRM rejecting the application, the management at the institution is faced with the dilemma of insisting that an ill employee continue working. Should the employee accept this position, the employee either returns to his/her usual area of work or is arguably given 'light duty'. In the first instance, the return to work against the wishes of the employee creates much resentment, resulting in further poor work performance. The poor performance and reduced productivity (possibly with increased frequency of short-term leave) impacts on patient care and on fellow workers in the Department. Should the employee be placed on light duty (generally a decision made by line or senior managers, without consultation of an occupational medical practitioner), the post held by the employee is retained, resulting in a compromised workforce in the employee's original work area. In many instances, placing an individual on light duty results in that individual remaining in this position until retirement, because there is no internal mechanism for ill-health review.

Two scenarios of sickness management

The scenarios presented in Box 1 and Box 2 reflect the presentation and management of two HCWs on short- and long-term sickness absence in the public health sector. These cases are representative of the current situation in the sector.

Box 1: Short-term sickness absence case study: Sick leave not approved and employee to return earnings for non-sanctioned days off

In the last three-year leave cycle (1 January 2013–31 December 2015), a HCW from a healthcare institution had exhausted the 36-day allocation within the first year. Despite this extreme usage, the HCW was not referred to the EHS. In the following year (2014), the HCW took a further 36 days, once again with no review by an occupational medical practitioner. In line with the relevant policy, the HCW submitted sick notes on return to work for each of the six spells of absence. On each occasion, applications were submitted to the HRM. Following review by the HRM, each of these six periods was declined. The HCW was informed that R13 669 was owed for these non-sanctioned days off. Thus, an employee who is likely to have some form of chronic ailment resulting in these above-average days of sick leave, is now facing economic stress, still with no appropriate management of the underlying ill-health.

Box 2: Long-term sickness absence case study: Application still under review and employee not at work

As in the previous case, a HCW had exhausted the 36-day sick leave allocation early in the cycle. Subsequent submissions to the HRM for short-term absences were approved. The HCW was not assessed by the EHS at the institution at any point. Subsequently, due to the chronic ailment diagnosis by and related advice from her private doctors, the HCW applied for long-term sickness absence. Three periods of long-term absence accounted for 185 days of sick leave. The HCW's applications are still under review by the HRM. Even during this period of long-term absence applications, the HCW has not been assessed by the institution's EHS. It is likely that during the period of repeated short-term absences, a proper clinical evaluation could have resulted in an earlier diagnosis of the chronic ailment, appropriate medical intervention, and thus efficient workplace management. To date, despite her chronic ailment and long terms of sickness absence, no assessment has been undertaken to determine the level of disability or impairment for the HCW to function in her post. The HCW is currently not at work, and has submitted another application for long-term sickness absence.

Discussion

Review and critique of the existing institutional processes for managing the health of the health workforce

The current management of ill HCWs at health institutions is almost non-existent and lacks a systematic approach. While workers will report to the EHS for follow-up of their chronic illnesses or to collect medication for chronic ailments, workers who fall ill or are chronically ill are usually managed by private healthcare providers, with little or no involvement of the EHS, until their prescribed sick leave (36 days) usage over the three-year cycle is exhausted. Currently, a HCW returning to work within two days has no obligation to present a medical certificate, while those taking more than two days leave and taking leave on more than two occasions during an eight-week period are required to present a medical certificate to their line manager, who submits this to the Human Resources Department for placement in the employee's personal file.

Line managers receive no guidance on how to manage HCWs taking short-term sick leave, until the number of sick days taken over the three-year cycle exceeds 36 days.

The PILIR policies of the DPSA entrench this 'externalised' approach (directed by the employee's private healthcare providers), largely because the DPSA is focused on the control of lost productivity days rather than on managing the health of the health workforce. This outsourcing continues after the 36th day through management by

the HRM. In terms of appropriate service management, the 'lost productivity' paradigm is not inherently flawed. However, it enables management of the problem only after an extended period of ill-health (36 days), and seeks redress from an external agent (the HRM) thereafter. This persistent externalisation of ill-health management is certainly flawed, and in attempting to manage sickness absenteeism effectively, certain key assumptions are made. The current approach assumes that:

- > The private healthcare provider assessing a HCW has adequate training in occupational health.
- > When declaring a HCW unfit to work, the private healthcare provider understands the nature of the healthcare working environment and the work demands, and is able to determine the level of incapacity of the worker in this context.
- > The line manager is able to determine the HCW's level of fitness to return to work, and place him or her appropriately within the working environment.
- > The human resources officer monitors and intervenes appropriately when there are long or repeated periods of absence.
- > When making a decision on an application, the HRM, understands the nature of the working environment of the specific worker and the associated work demands.

Rather than adopting a systematic approach to the ill-health of workers, the management of the institution (and the Department) engages the EHS when the HRM rejects an employee's application. Managers either accept the HRM recommendation and insist that the worker return to work, or believe that the recommendation was incorrect and request the medical doctor at the EHS to intervene. In most instances, when insisting that the worker returns to work, the employee believes otherwise and seeks out the assistance of the EHS doctor. In both scenarios, the EHS doctor (who has not been involved in the prior management of the HCW, nor in making the decision on the HCW's ability to work) is now expected either to challenge the HRM decision or convince an ill employee that he or she should return to work. Clearly, this results in human resource mismanagement and frustration for the employer and the employee.

In summary, these data support the concerns that sickness absence in itself compromises healthcare service delivery through the numbers of days lost – in excess of 500 000 days in KZN at a cost of about R452m in 2014 alone. This provides strong evidence that the strategies employed by the DPSA (the PILIR model) are not effective. Ensuring the health of the health workforce requires a more focused, institutional intervention, driven by the appropriate experts in occupational medicine.

Strategies for change

In the UK, the NHS recognised the challenges resulting from sickness absence at its hospitals; it conducted a systematic analysis of the problem¹³ and proposed institutional 'evidence-based strategies' to address these. The philosophy adopted was not framed around control of sickness absence, but rather around employee wellness and health.¹² The Boorman Review estimated that the NHS loses approximately 10 million working days each year due to sickness absence.¹³ The Review estimated that through appropriate intervention, early detection of ill-health, proper management of the

illness and determination of capacity to work, a one-third reduction in sickness absence is possible, and would result in a saving of approximately £555 million per year.¹³

The EHS-driven approach has been recognised in the UK, where an assessment of sickness absence concluded that "where occupational health was provided, 39% of companies recorded a decline in short-term absence, whilst 28% experienced a reduction in long-term absence".¹⁰

As the roll-out of National Health Insurance (NHI) gathers pace, and a renewed vigour in the Human Resource for Health Strategy takes shape, the 'health of the health workforce' has to assume a central position in the debate on restructuring our healthcare system. Failure to recognise the impact of ill-health on the productivity of HCWs and failure to adopt an internalised, systematic approach will continue to result in inadequate service delivery.

In developing the model proposed by the authors, the NDoH in collaboration with the DPSA should adopt a multi-pronged strategy relating to the health of the health workforce. A comprehensive systematic evaluation must be undertaken, and the full extent of the problem of absence from work (and 'under-work' in the 'light-duty' approach) should be documented, along with the impact on employees, service delivery and patient care, and the resulting costs. This requires multi-stakeholder participation undertaken by appropriate experts. We suggest that consideration be given to the fact that use of external disability managers creates major pitfalls in managing ill-health in HCWs, and that this should be addressed.

Developed in consultation with stakeholders and taking cognisance of local and institutional-level circumstances, specific strategies should be implemented. The UK NHS response, along which South Africa's NHI is modelled, provides useful insights and some ideas for confronting the problem. It argues for a work-focused approach that respects the right to sick leave, recognises that work is generally good for physical and mental health, and encourages management to develop temporary workplace adaptations to enable the HCW to work despite his/her adverse health status. The approach also recognises that being '100% fit' is not always the requirement for work. The NHI argues that this work-focused approach is substantially different from their previous approaches to managing employee ill-health because "it focuses on what the employee can do or might be capable of doing with reasonable help, rather than what they cannot do due to illness or injury".¹²

In the interim, a short-term strategy for managing ill employees at healthcare institutions is essential. The management of these workers must be internalised at the institutional level, such that appropriate intervention can be implemented for individual workers well before the 36th day in a three-year cycle is reached. The externalised approach currently in use in the public sector serves to exacerbate the problem, and undermines or even negates the health care of ill workers.

Our proposal (Figure 2), while both simple and cost-effective, does require the investment of resources. However, based on the anticipated savings from lost productivity and improved patient care, we argue that the return on investment may be substantial.

It is proposed that workers who are absent from work for more than five days in a single sick-leave period or for 10 days collectively over a two-month period, or those who are declared unfit to work

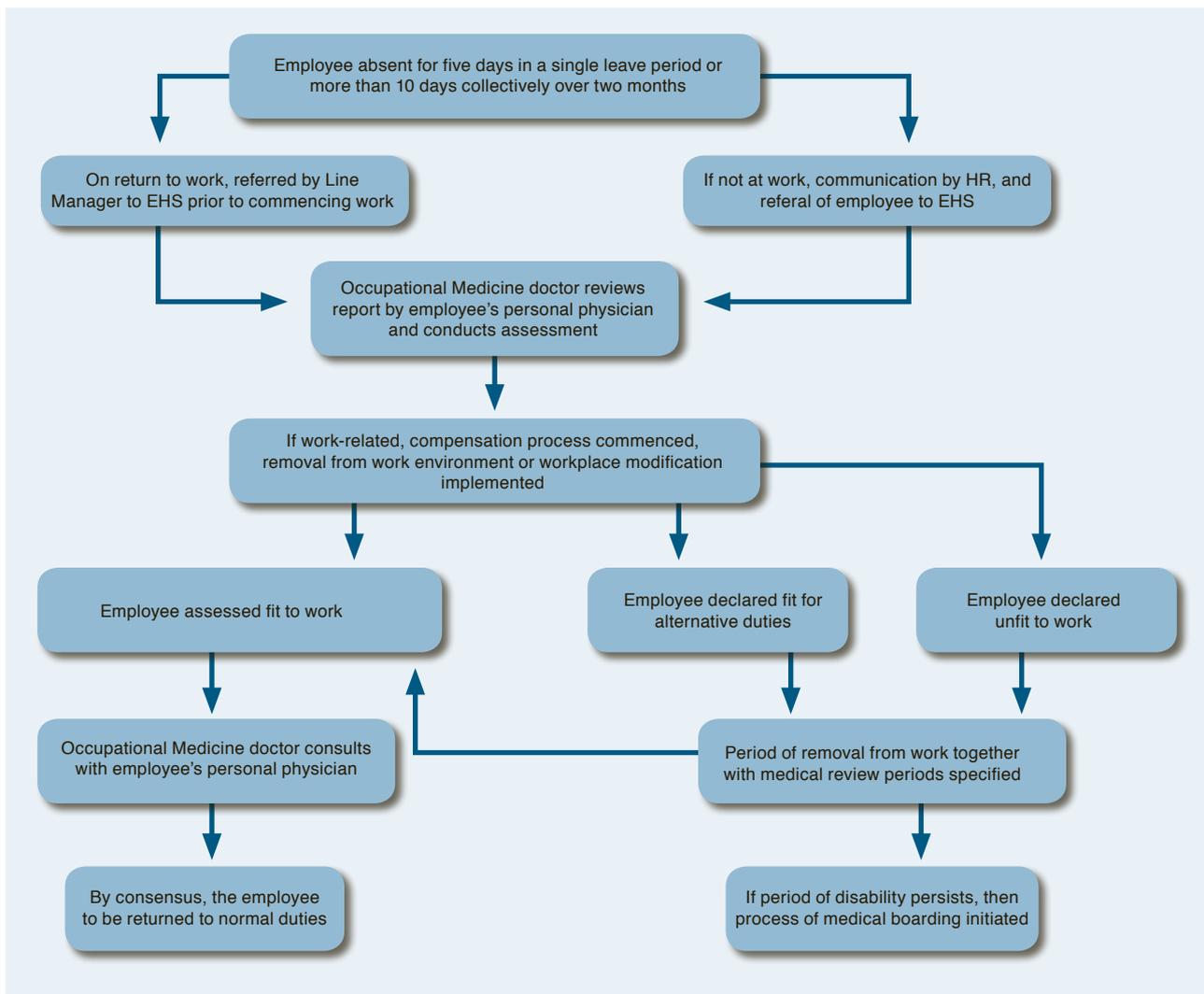
by a medical practitioner outside the institution for similar periods of time, must be referred to the institution's EHS for an evaluation. Line managers and human resource practitioners should be trained to recognise this requirement, and to make appropriate and timeous referrals to the EHS. These workers must be assessed by a doctor with training in occupational health. The responsibility of the EHS doctor is to determine whether the worker is fit for usual duties, fit for alternative or adapted duties, or completely unfit to work. In the latter two cases, the doctor must determine the duration of the modified work duties. The period of review must also be specified. If the ill worker is still at work, the line manager assumes responsibility for ensuring review of the HCW by the EHS. If the worker is totally unfit and no longer at the institution, the Human Resources Department assumes responsibility for maintaining contact with the employee.

In assessing the ill HCW, the EHS doctor is also expected to determine whether any work-related factors can be shown to have caused or exacerbated the illness. If so, the doctor must refer the worker to an occupational medicine specialist for further decision-making on the HCW's ability to work. If, in the opinion of the specialist, the disease is caused by the HCW's work environment, the procedure for reporting an occupational disease to COIDA must apply, supported

by the required evidence. If the disease is aggravated by work, the occupational medical practitioner, together with the line manager, must determine whether alternative placement is necessary or job modification is possible.

If the worker is assessed as being totally unfit for work, and job modification or alternative work are not feasible, the worker should be processed for medical boarding. Again, this should be an internal process, without the involvement of the HRM. However, the Department and its stakeholders should define 'total incapacity' by stipulating whether this would pertain to 'own' or 'any' occupation, and providing guidance to the medical doctors involved in the individual assessments. For example, in the case of a HCW employed as an Intensive Care Unit nurse, who is no longer able to work in such an environment but is able to perform basic nursing duties – i.e. total incapacity for 'own' occupation, but capable of working in any other occupation – it should be determined whether this HCW should be medically boarded or placed in another healthcare occupation in keeping with his/her capacity, but vacating the original post, such that service delivery is not compromised.

Figure 2: Proposed institutional management of workers with ill-health and sickness absence



Clearly, institutional-level interventions that internalise the management of ill HCWs require additional human resources – particularly in strengthening the EHS at hospitals and clinics in the public sector. We propose that a network of health professionals with varying levels of skills in occupational health be established. Ideally, there should be at least one occupational medicine specialist for 3 000 HCWs. While this may not be immediately achievable, a decentralised approach integrated into the district health system model is more practical. At regional hospital level, an occupational medical specialist should be appointed to lead the EHS and to provide outreach to district hospitals. As is the practice in any other clinical service at healthcare institutions, this specialist should be assisted by one to four occupational medicine registrars, depending on the numbers of HCWs within the catchment of district hospitals and clinics served by the regional hospital. These registrars, under the supervision of the specialist, would provide the required specialist support at district level. In addition, depending on the employee population at the district hospital, the appointment of either a full-time or a sessional doctor with postgraduate training in occupational health is required.

Currently, no healthcare institutions in the country have employed occupational medicine specialists to manage their EHS. This limits the availability of evidence in support of our proposed model being successful. However, anecdotal evidence from KZN shows where occupational medicine registrars, working under the supervision of the occupational medicine specialist, have been able to make decisions on cases of long-term incapacity leave, resulting in either a return to work, job modification or alternative job descriptions.

Training of the occupational medicine specialist focuses on understanding and assessing the working environment, assessing the risk to health, performing a clinical evaluation of an employee, and determining the best placement of the employee within the working environment, or modification of the working environment to protect the health of employees. This can only be done at local or institutional level.

Management of the EHS by an occupational medicine specialist is further strengthened by the ability of the specialist to perform monitoring and evaluation of the various programmes implemented by the EHS, and to conduct trends analysis to identify at-risk environments or tasks. The latter allows for early intervention to protect the health of employees.

Limitations

Apart from our generic description of the HRM process described, we lacked access to information on the tendering process for the issue of these contracts to the various HRMs. We also have no information on the approaches adopted by the HRM in arriving at various decisions on each case, the extent to which independent specialists are used, and whether these specialists are trained in occupational medicine. We submit that these gaps in information do have an influence on the proposed model.

We relied substantially on the reports developed by the government agencies in South Africa, including the Public Services Commission, the Department of Public Service Administration and the national and KZN Departments of Health and there are no means of validating this information. We are, however, confident of the veracity of the data, as these were extracted from national databases such as the PERSAL system and from the HRM sources.

Most of the available information from these agencies focuses on cost savings rather than on the effectiveness of promoting the health of HCWs. Generally, there is a lack of a systematic critique of the current PILIR system and the functioning of the HRM. We trust that this chapter opens the debate on this system, with a view to fundamental policy change.

In presenting the information from these various government agencies, we focused on KZN, and to some extent on the national level. Although several of the national DPSA and PSC reports contained information on the other provinces, we purposely chose to describe only KZN scenarios because of the size of the provincial public health sector, and because the impacts in costs and average days lost were substantial in this province.

Another key limitation is the use of a small sample size from the KZN institution, largely for illustrative reasons, and therefore the results are likely to be biased in various ways. However, this research was not intended as an analytic investigation, but rather as an exploration of the challenges. For reasons of confidentiality, we are unable to provide further descriptions of this sample.

Conclusion

The ill-health of South Africa's health workforce is having a disabling effect on the health of the nation. Substantial numbers of HCWs are either incapable of performing the tasks for which they have been employed because of their health status, or have been inadequately assessed and inappropriately managed through the existing systems of ill-health management. The State has attempted to improve control of sickness absence through externalised management; instead, it is necessary to improve the management of ill-health among the health workforce, and to adopt a work-focused approach. Through a concerted effort to support the health of the health workforce, it is possible to reduce the number of sick leave and disability leave days taken. Institutional-level approaches can simultaneously address the health of HCWs, ensure that more workers are at work, and improve productivity and patient care.

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